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FY 2018–19
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

ALAMEDA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 30 – November 2, 2018

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INTRODUCTION

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

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

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2018-19 findings of an EQR of the Alameda MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Large

MHP Region — Bay Area

MHP Location — Oakland

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 21,991

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

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.calegro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2017-18 Review of Recommendations

In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY 2017-18

Recommendation 1: 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.

Status: Met

- Providing vision and foundation for leadership has been moved forward by the December 2017 appointment of a Health Care Services Agency (HCSA) Director, Colleen Chawla. In the support of continuity and stability of leadership, Director Chawla extended the contract of (Alameda County) Behavioral Health Care Services (BHCS) Interim Director Carol F. Burton through June 2019.
- BHCS Director Burton has launched potentially transformative initiatives in four focus areas for the department, which are intended to impact the relationship between leadership, staff, providers and stakeholders. The four areas are: organizational stability, stakeholder alignment, departmental transparency and department image and reputation.

- BHCS Director Burton and Agency Director Chawla held department-wide meetings and attended monthly Operational Leadership meetings to solicit feedback from staff and share their vision for the department. BHCS also held five day-long meetings with the objective to develop priorities for the department and to foster a cohesive, highly collaborative executive team with a shared vision for the department going forward.

- BHCS launched an initiative to work with providers who have unique challenges in providing core services to beneficiaries. BHCS is working with the African American Health and Wellness Steering Committee, consumers and BHCS staff to improve engagement and responsiveness of their systems of care to African Americans. BHCS regularly meets with Alameda Council of Community Mental Health Agencies (ACCMHA), an association of California nonprofits that contract with BHCS, to improve service delivery and address barriers for providers.

Recommendation 2: 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 need to be explored and remedied.

Status: Met

- Effective May 2018, BHCS and HCSA discontinued the ShareCare (Echo VHR) contract with The Echo Group. The decision was made after a thorough assessment by County Information Technology Department (ITD) and Mental Health Finance consultants.

- Recent business decisions to support future EHR developments include:

    - Extend the InSyst (current practice management system) with The Echo Group for three years, with an option for two additional years.

    - Reconsider when to pursue an EHR product, given changing state requirements and new vendors entering the California market.

    - EHR product demonstrations from vendors of interest will be scheduled. Continue to involve ITD and state Mental Health Finance systems consultants to determine next steps.

- To address InSyst and Clinician's Gateway slow system response time reported by end-users, both BHCS and ITD undertook the following improvements:

    - Increased storage resources to eliminate disruption. Continue to run tests, evaluate, and enhance performance to ensure this issue does not recur.

    - Increase bandwidth and upgraded network switches at 5h3 Eastmont campus.

- Fairmont campus upgrade delayed due to construction issues; is currently scheduled for January 2019.
- To improve end-users experience, an eight-hour inactivity “session time-out” for Clinician’s Gateway (Citrix) and 20-minute inactivity screen lock-out for re-entering end-user password was implemented.

Recommendation 3: Communication: Implement a vigorous communication effort to ensure consistency in the manner in which messages are sent, offer easy categorization as to "information" versus "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.

Status: Met

- BHCS has been working with an external communication and marketing firm to understand and capture MHP operational complexities. The effort includes building consensus through staff and stakeholders to develop cohesive messaging about BHCS and its services.
- The objective is to facilitate communication of BHCS mission and goals to external and internal audiences that reduces stigma, shows BHCS services in the best light, and the captures input of the department.
- New logos, colors, messaging and revised value statements have been finalized, with a rollout event during November of 2018.
- BHCS is redesigning the provider and external (public) website, to make it more understandable and more easily navigable. Website redesign includes improved ways for providers to communicate with the department and improve the “feedback loop” and timely processing of response and circulation of updated information to include: Introduction of a bimonthly employee newsletter highlighting newsworthy events of general interest to the department that includes: profiles of employees and programs; calendar of events; updates on new policies and procedures; and other items of general interest.
- BHCS Network Office conducts contractor meetings each Spring to kick-off contract renewal process and communicate changes to providers. Provider Relations and Quality Assurance unit staff present key changes, so providers can hear a consistent message from the different functional areas in the one setting. Quality Assurance, Network Office, Provider Relations, ACCESS, and IS meet quarterly to discuss cross-functional issues and develop departmental responses to specific issues.
- BHCS is making a more concerted effort to vet communications with providers across functional areas before releasing information to the provider community.

Recommendation 4: 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.

Status: Met

- The MHP addressed this recommendation through a number of specific actions. These include the Office of Consumer Empowerment (OCE) engaging consumers with monthly departmental leadership meetings.

- The Pool of Consumer Champions (POCC) and OCE was involved in the development of peer employment opportunities, creating up to 18 employment slots from an expanded peer training program. The last training cohort was scheduled to complete the process by November 2018.

- Specialized Forensic Peer Specialist training occurred in April of 2018, and included 35 individuals. A second training on that topic occurred later that month.

- The OCE developed and ran a consumer survey of consumer-operated programs, with 50 POCC members responding and providing feedback.

Recommendation 5: Quality and Compliance: In addition to the Quality Assurance (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.

Status: Partially Met

- In November 2017, the QA Department formed a committee of County and Contracted providers to examine California Department of Health Care Services (DHCS) Information Notice No.: 17-040. This information notice included many clarifications that impacted BHCS's Policies and Procedures and QA Manual. Feedback elicited from the committee on what standards BHCS should adopt to reflect these clarifications was presented to the Quality Improvement Committee.

- On March 1, 2018, BHCS issued a memo to providers detailing the changes that went into effect. The QA Manual was updated to reflect these changes to documentation requirements and has been released to providers for review and comment. Providers have been sending QA corrections and requests for clarification on the QA Manual.

- Recent guidance by DHCS regarding the Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC)-35 requirements

resulted in the QA department to updating the manual again. BHCS expects to finalize and post the updated manual in the next month.

- BHCS has developed and introduced forms with added options for providers of different types of services to streamline the process and reduce required documentation. These updated forms include Interim Assessment templates, Assessment update templates, examples of short and long full assessment templates, and Medication only.

- Feedback onsite confirmed efforts to streamline documentation, with several process and format changes reportedly approved, but due to inadequate resourcing much remains to be implemented. Some contract providers are unaware of these changes that have been in process over the last year.

- The current review received continued mention of distant top-level agency compliance contacts, and absence of compliance presence at the program level. Participants who were not involved in the prior review verbatim identified the same issues with quality and compliance.

Recommendation 6: 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.

Status: Partially Met

- The MHP has engaged in development of crisis services during the last year, and is prepared to increase mobile teams from one to ten county-wide.

- During July 2018, the MHP expanded crisis teams to seven days a week throughout the county, 10 a.m. to 8 p.m.

- In October 2018, the MHP secured approval and funding for Community Alternative Transport Teams (CATT), which will be comprised of a clinician and an emergency medical technician (EMT), which will enable direct admission of most individuals to crisis stabilization units (CSU) or psychiatric inpatient units (IPU), by directly assessing for physical health conditions. The MHP expects to request applicants who are interested in participating, and implementing by July 2019.

- Other SB82 funded projects to address crisis needs, totaling $3.7 million, include: A Transitional Aged Youth (TAY) discharge team at the Santa Rita jail; two post-crisis follow-up teams, who attempt to engage individuals who have been discharged from the CSU. The teams will divide up and respond to “familiar faces,” with the other team responding to those not known.

- The partially met rating is due to the status of these enhancements mostly pending implementation.

PERFORMANCE MEASUREMENT

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

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a calendar year (CY).
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

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

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

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[4] Public Information Links to SB 1291 Specific Data Requirements:
1. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx
2. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

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

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity Alameda MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	53,068	11.9%	3,565	16.2%
Latino/Hispanic	133,910	30.0%	5,812	26.4%
African-American	81,692	18.3%	6,445	29.3%
Asian/Pacific Islander	104,827	23.5%	1,688	7.7%
Native American	1,200	0.3%	107	0.5%
Other	71,659	16.1%	4,374	19.9%
Total	**446,354**	**100%**	**21,991**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

Penetration Rates and Approved Claims per Beneficiary

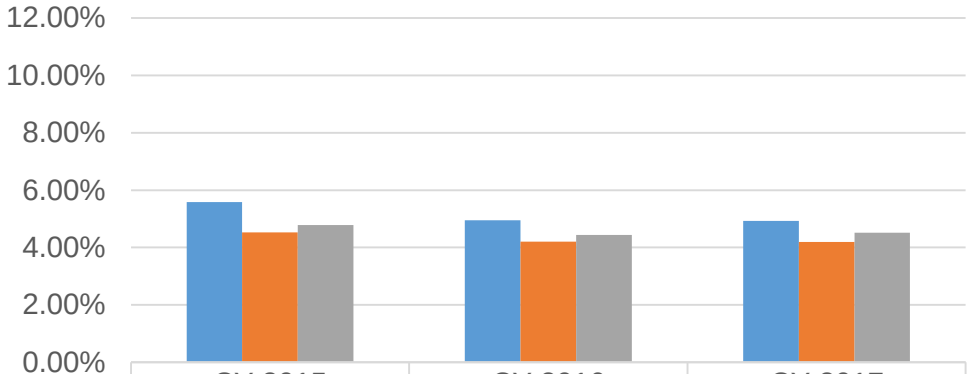
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA Penetration Rate and Approved Claims per Beneficiary.

Regarding the calculation of penetration rates, the Alameda MHP uses the same method used by CalEQRO.

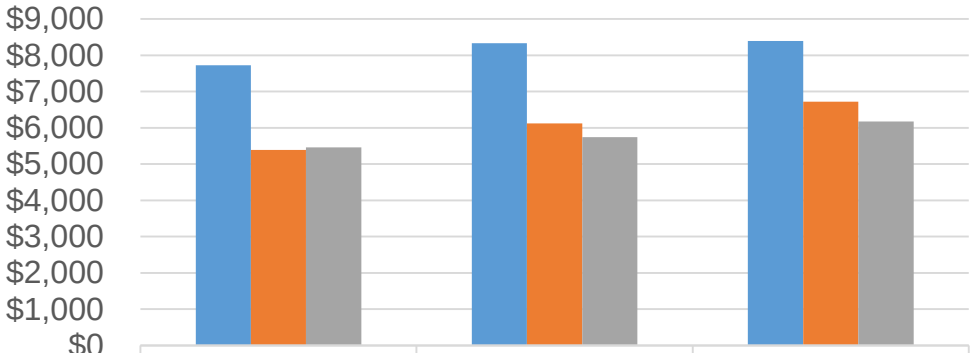
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1A. Overall Penetration Rates
Alameda MHP



	CY 2015	CY 2016	CY 2017
MHP	5.58%	4.95%	4.93%
Large	4.53%	4.20%	4.19%
State	4.78%	4.44%	4.52%

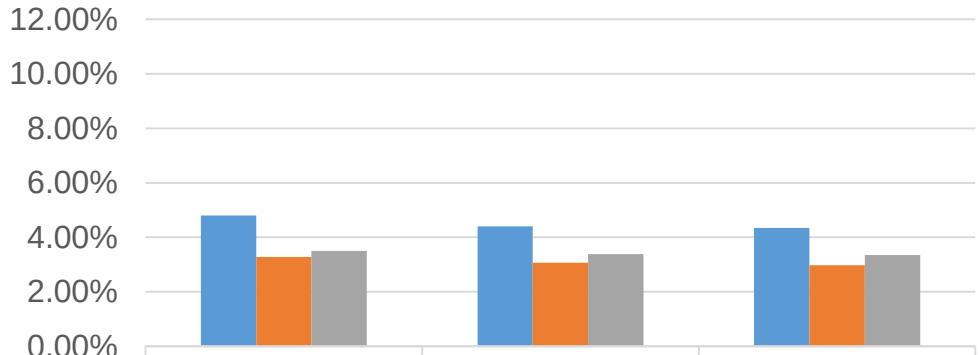
Figure 1B. Overall ACB
Alameda MHP



	CY 2015	CY 2016	CY 2017
MHP	$7,724	$8,335	$8,395
Large	$5,393	$6,121	$6,723
State	$5,458	$5,746	$6,170

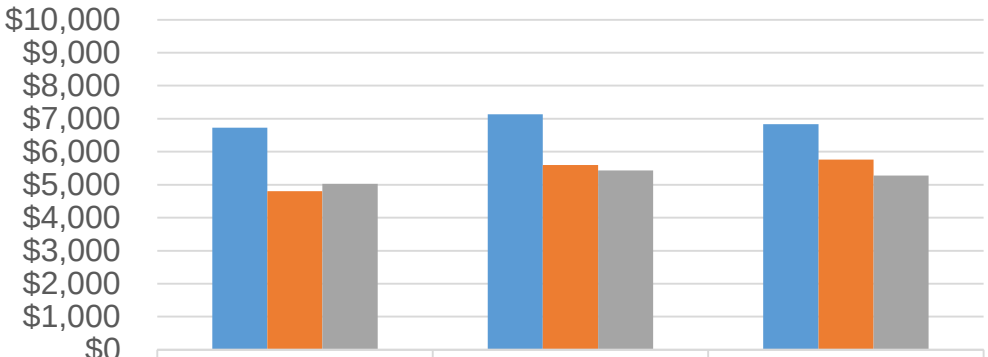
Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
Alameda MHP



	CY 2015	CY 2016	CY 2017
MHP	4.80%	4.40%	4.34%
Large	3.28%	3.07%	2.97%
State	3.50%	3.38%	3.35%

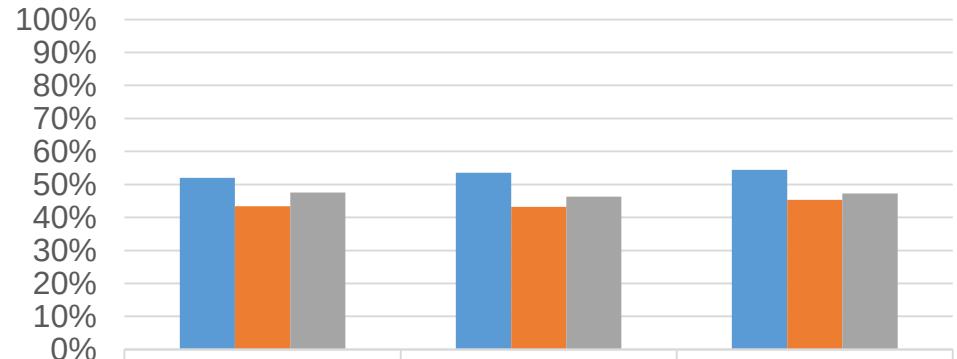
Figure 2B. Latino/Hispanic ACB
Alameda MHP



	CY 2015	CY 2016	CY 2017
MHP	$6,729	$7,134	$6,834
Large	$4,804	$5,599	$5,758
State	$5,029	$5,430	$5,278

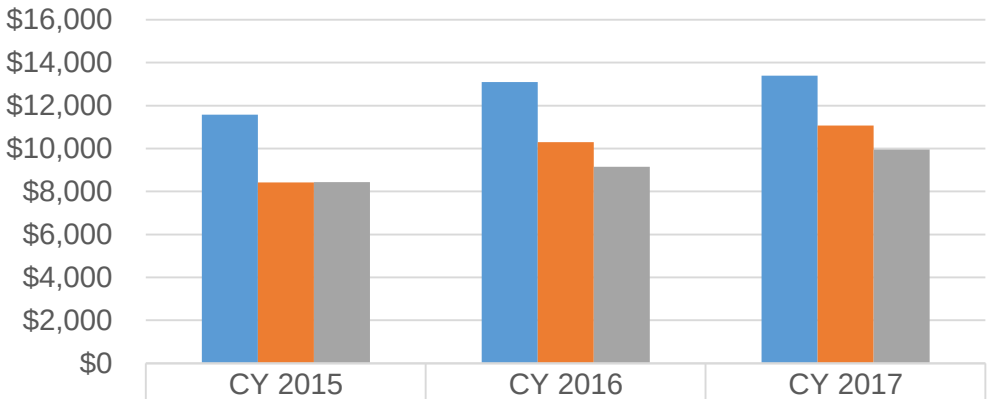
Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A. FC Penetration Rates
Alameda MHP



	CY 2015	CY 2016	CY 2017
MHP	52.03%	53.58%	54.46%
Large	43.42%	43.22%	45.37%
State	47.52%	46.26%	47.28%

Figure 3B. FC ACB
Alameda MHP



	CY 2015	CY 2016	CY 2017
MHP	$11,581	$13,095	$13,396
Large	$8,425	$10,301	$11,064
State	$8,432	$9,147	$9,962

High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP's data for CY 2017, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2. High-Cost Beneficiaries
Alameda MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2017	21,522	611,795	3.52%	$54,563	$1,174,305,701	31.11%
MHP	CY 2017	1,183	21,991	5.38%	$50,715	$59,996,380	32.50%
	CY 2016	1,357	22,481	6.04%	$51,865	$70,381,279	37.56%
	CY 2015	1,304	24,622	5.30%	$52,345	$68,257,272	35.89%

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

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-2017) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

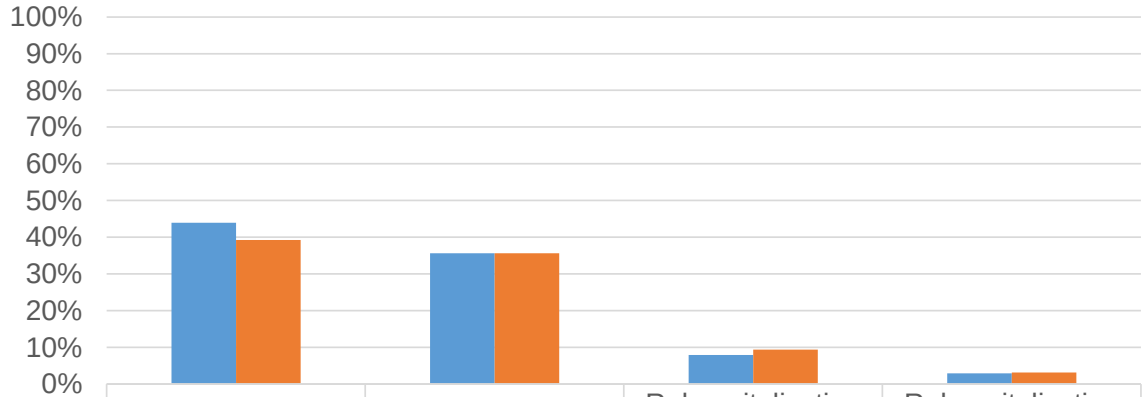
Table 3. Psychiatric Inpatient Utilization - Alameda MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	2,207	5,684	6.39	$10,834	$23,910,126
CY 2016	2,063	5,702	6.87	$12,068	$24,896,518
CY 2015	2,138	5,829	6.9	$5,901	$12,617,390

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

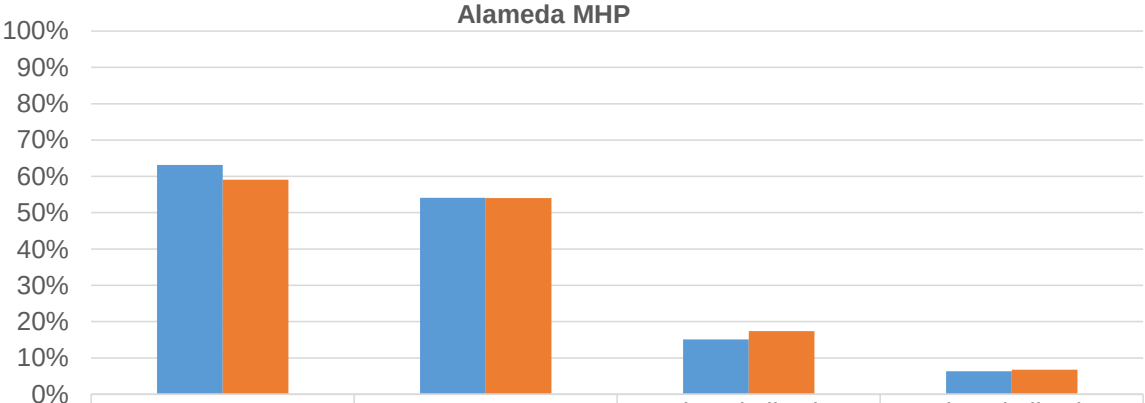
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	44%	36%	8%	3%
CY 2017	39%	36%	9%	3%

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



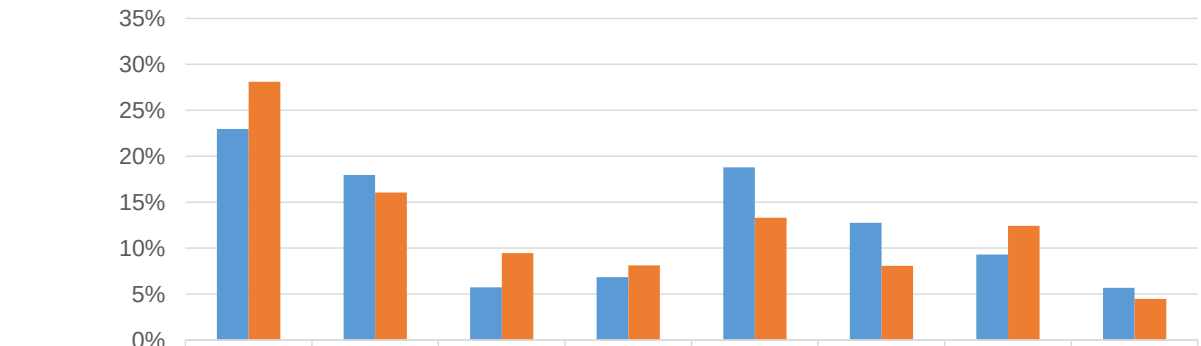
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	63%	54%	15%	6%
CY 2017	59%	54%	17%	7%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

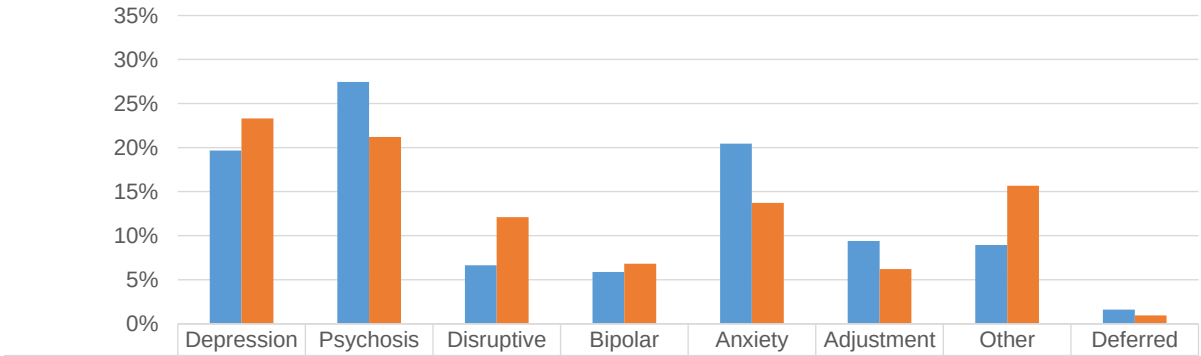
MHP self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 17.4 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Alameda MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	23%	18%	6%	7%	19%	13%	9%	6%
State CY 2017	28%	16%	9%	8%	13%	8%	12%	4%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	20%	27%	7%	6%	20%	9%	9%	2%
State CY 2017	23%	21%	12%	7%	14%	6%	16%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Alameda MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. The MHP presented a clinical PIP before the review, which was discussed during the review. This submission was determined to be "not a PIP."

Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward.

Table 4 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 4: 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	0	The MHP did not submit a Non-clinical PIP

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

[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 5: PIP Validation Review					
Step	**PIP Section**	**Validation Item**		**Item Rating**	
				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

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-clinical**
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 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	NR	NR
Number Partially Met	NR	NR
Number Not Met	NR	NR
Unable to Determine	NR	NR
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	NR	NR
Overall PIP Rating ((#M*2)+(#PM))/(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: N/A

Date PIP began: N/A

End date: N/A

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

The MHP provided a submission for the clinical PIP that was essentially the same as the prior year, which had been determined to be not a PIP, because this submission lacked results data collected throughout the course of this effort, and no changes to the interventions were in evidence. It was also described as having ended March 2018. Therefore, the PIP is not rated.

The technical assistance (TA) provided to the MHP by CalEQRO consisted of identification of challenges in the topics and format used by the MHP in the design and operation of PIPs. EQR encouraged the MHP to utilize the PIP Outline, which provides the necessary structure to meet requirements.

The utilization of presentation format materials is best reserved for the completed PIP, where summary information is being presented, and does not negate the necessity of attending to the PIP Development Outline and providing appropriate entries.

Several potential PIP topics were identified in the course of this review. One topic related to underserved ethnic/racial populations, such as Asian and Pacific Islander

(API) beneficiaries, for whom preliminary data indicates trends of accessing care at the crisis or acute level data. In another possible PIP topic, the African American (AA) population was mentioned as experiencing disproportionate severe mental illness diagnoses and higher use of certain medication classes. Discussion indicated that the MHP has already been exploring topics.

For the potential topics, further exploration of the data and related literature may produce a useful PIP topic.

Other TA focused on the importance of the MHP checking in with EQRO periodically in the PIP process, for assistance and TA feedback. The importance of having an active PIP at all times was highlighted.

Non-clinical PIP—The MHP did not submit a Non-clinical PIP

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

Date PIP began: n/a

End date: n/a

Status of PIP: No PIP submitted (not rated)

The topic of high-utilizers was discussed in the non-clinical PIP session. A formal non-clinical PIP was not submitted before or after this review. The topic and submission had been determined at the prior EQR FY 2017-18 review to not meet the criteria for a PIP.

The TA provided to the MHP by CalEQRO consisted of discussions about the PIP requirements and process. Early and frequent TA is important, and following the PIP Development Outline is essential ensure a successful project. This includes the need to establish a problem through the analysis of local data, the development of interventions based on literature review and best practices, and regular PIP committee meetings that review data and consider possible needs for intervention changes. The MHP's Quality Improvement (QI) department must take a strong role in the PIP process as well.

A possible non-clinical PIP was identified that related to expediting access to Full Service Partnership (FSP) services as an approach to better serving seriously ill beneficiaries who are difficult to engage and tend to experience repeat crisis and inpatient admissions. The MHP has already initiated action in this area by bringing the FSP referral process into Access in early 2019. There could be additional aspects and potential interventions.

Before and during the review onsite, the MHP provided no indication that there was a Non-clinical PIP that had been developed or was in process. Approximately three weeks following the CalEQRO review, the MHP submitted a non-clinical PIP that focused on engaging jailed individuals with services that will provide benefits and care post-release, testing the MHP's understanding of PIP requirements. As written, it would have spanned the last two years. It had not been presented before, and was described

as ending in December 2018. This PIP was not rated for this review period because it had not been submitted at any point during its ostensibly active period. This effort clearly demonstrates the MHPs ability to conceptualize and develop PIPs, and to do so successfully.

INFORMATION SYSTEMS REVIEW

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

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

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

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 2.33 percent.

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

Table 7 shows the percentage of services provided by type of service provider.

Table 7: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	20.65%
Contract providers	78.40%
Network providers	0.95%
Total	**100%**

Table 8 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System	
Type of Input Method	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Monthly
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Weekly
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☐ Yes ☒ No ☐ In pilot phase

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 9.

Table 9: Technology Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
29	2	0	1

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

Table 10: Data Analytical Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
11	5	2	5

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

- Table 10: The two new FTE technology positions will support Drug Medi-Cal-Organized Delivery System (DMC-ODS) Demonstration Wavier project and duties will focus on modifying Clinician's Gateway for Drug-Medi-Cal functionality.
- Table 10: Some technology positions are being filled by temporary employees.
- Table 10: Includes staff who provide Help Desk support.
- Table 11: The five FTE new Analytical positions will support Whole Person Care Pilot (WPC) program.
- Data analytical staff work assignments are dedicated to specific roles. Of the 11 FTE positions 3 are assigned to support Quality Management; 5 support WPC/IS activities; 2 support IS activities; and 1 position supports Health Agency, Office Medical Director.

Current Operations

- BHCS continues to use three legacy systems to support clinical, program, quality improvement, and managed care operations. See table 11 for details.

- The ongoing development of Yellowfin, business intelligence application, is making it the “go to source” for data and dashboard reporting. Plans are underway for a pilot that permits contract providers access to their data by early 2019.

Table 11 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 11: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
InSyst	Practice Management	The Echo Group	28	MHP/County ISD
Clinician’s Gateway	Clinical Record	Platton Technologies	11	MHP/County ISD
eCura	Managed Care	InfoMC	19	MHP/County ISD
Objective Arts	CANS, ANAS, PSC-35	Objective Arts	3	Vendor/County
Yellowfin	Business Intelligence	Yellowfin	2	Vendor/HSA

The MHP’s Priorities for the Coming Year

BHCS identified 26 technology projects currently in various stages of development, testing, and implementation. MHP IS identified 13 of those projects as the highest priority and are listed below.

- Network Adequacy Certification Tool (NCAT): The MHP is using Salesforce/forms to implement a pilot project for contract providers to support new forms and data collection for Provider Directory and Network Adequacy for state data reporting compliance.
- Clinician’s Gateway EHR improvements to support the following: electronic signatures; appointment scheduling; release of information templates and tracking. Project staff was recently hired.
- Implement APTTUS (contract lifecycle management system) on Salesforce cloud platform. The kick-off occurred in October 2018, with the intention to go-live in June 2019.

- Upgrade network storage devices.
- Revamp three databases to improve functionality: contract providers treatment incentives, CalWorks, and Cost Reporting.
- Upgrade BHCS website (internal) and Provider website (external): develop a fresh look that is easy to navigate for both websites.
- Upgrade desktop user workstations to Windows 10.
- Upgrade CSI to capture timeliness data for state data reporting compliance.
- Develop and provide data reporting tools to support Alameda County Care Connect (AC3)/WPC(WPC) initiatives.
- Implementation of Social Health Information Exchange (SHIE) system and warehouse partnership between BHCS and AC3 to secure data sharing with partners as well as universal release of information (ROI) and enterprise master patient index (EMPI) tools.
- American Society of Addiction Medicine (ASAM)/Level of Care (LOC) tools to be developed, and implement DMC-ODS data collection for state reporting requirements.
- Implement Drug Medi-Cal claim transactions for Organized Delivery System as part of 1115 Demonstration Waiver project.
- Expand Substance Use Disorder (SUD) referral portals from one to four sites.

Major Changes Since Prior Year

- Upgraded desktop users to Microsoft Office 2013.
- Upgraded users to Microsoft Outlook 365 for secure email.
- Migrated Clinician’s Gateway to new .net framework.
- Completed Phase 1, BHCS website improvement project - upgraded end-user interface.
- Re-built Provider Directory to comply with CMS Final Rule requirements.
- Completed data submission using NACT. The data was submitted timely to comply with CMS Final Rule requirements.
- Completed integration of new CANS-50 and PSC-35 with vendor, Objective Arts.
- Developed in-house programming capability for EHR forms.

- Incorporated new Assessment and Treatment Plans (TP) versions allowing "Golden Thread" of bringing TP objectives from the plans onto note templates.
- DMC-ODS– develop Clinician's Gateway EHR to meet DMC-ODS implementation requirements for 1115 Demonstration Waiver Project.
- HCSA – Office of the Agency Director (OAD) projects:
    - Develop and implement a Ticket and Tracking system for OAD.
    - Develop and implement a Ticket and Tracking system for WPC Pilot - AC3.

Other Areas for Improvement

- Communications and project planning with the legacy IS vendors are critical to maintain operational functionality, as these systems require ongoing support to implement federal (CMS Final Rule) and State (Information Notices) requirements timely.
- InSyst system replacement plans include release of a Request for Proposal (RFP) during 2019 for new system to replace practice management and claims functionality. Sponsorship of RFP development and selection of the system needs to be delegated to a senior executive level person who is a county employee.
- Since a new EHR system selection and implementation is not achievable in the foreseeable future; expand the use of Clinician's Gateway to all contract providers, to include electronic signatures. As this effort will further reduce reliance on a hybrid (paper and electronic) medical record environment.

Plans for Information Systems Change

- The MHP is considering a new system, but no formal project plan in place and no project team currently assigned to support it.

Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12: 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	Clinician's Gateway/ Laserfiche	X			
Electronic Signature—MHP Beneficiary	Clinician's Gateway	X			
Laboratory results (eLab)	Clinician's Gateway	X			
Level of Care/Level of Service	Clinician's Gateway	X			
Outcomes				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:		9	0	3	0
FY 2018-19 Summary Totals for EHR Functionality:		9	0	3	0
FY 2017-18 Summary Totals for EHR Functionality:		6	3	3	0
FY 2016-17 Summary Totals for EHR Functionality:		6	2	2	0

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

- Clinician's Gateway functionality are used by county-operated programs and some of the contract providers. Generally, the larger providers have their local EHR systems already in place.

- Clinicians' Gateway also supports the DMC-ODS (1115 Demonstration Waiver) project, and incorporated EHR functionality enhancements during the year. Additional improvements are planned to support: electronic signatures, appointment scheduling, and release of information and tracking of same.

Personal Health Record (PHR)

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

☐ Yes ☐ In Test Phase ☒ No

Have no future plans to implement consumer personal health record.

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Excel, Access database supported by MHP staff

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 13 summarizes the MHP's SDMC claims.

Table 13. Summary of CY 2017 Short Doyle/Medi-Cal Claims
Alameda MHP

Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Claim Adjustments	Dollars Approved
677,922	$192,788,687	**10,852**	$3,446,825	1.79%	$189,341,862	$9,968,762	$179,373,100

Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2017 was **2.73 percent.**

Table 14 summarizes the top three reasons for claim denial.

Table 14. Summary of CY 2017 Top Three Reasons for Claim Denial Alameda MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficary not eligible. Or emergency services or pregnancy indicator must be "Y" for aid code.	3,981	$1,367,410	40%
Medicare or Other Health Coverage must be billed prior to submission of claim.	4,500	$1,229,856	36%
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	1,020	$358,206	10%
Total	10,852	$3,446,825	NA
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with reason Medicare or Other Health Coverage must be billed prior to submission of Medi-Cal claim are generally re-billable within the State re-submission guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted four 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested four focus groups with 10 to 12 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. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift cards to thank the consumers and family members for their participation.

Consumer/Family Member Focus Group One

The first requested focus group consisted of culturally diverse Spanish speaking adult beneficiaries, the majority of whom initiated services within the prior 6 through 15 months. This session was conducted at the La Clinica program, located at 1415 Fruitvale Avenue, Oakland, CA 94601.

Number of participants: Eight participants, the majority female.

The single participant who entered services within the past year described their experiences as the following:

- This beneficiary received assistance quickly, with an appointment quickly following the initial request.

Participants' general comments regarding service delivery included the following:

- Individual therapy sessions occur on a widely varying frequency, from weekly, every three weeks, to monthly. Some are receiving only group interventions, which can be as infrequently as monthly. Another has been discharged but invited to return if issues recur.

- Length of treatment varies, with experiences in treatment extending as far back as the 1990s. This length of treatment is associated with a major mental illness diagnosis, and the expectation that medications will be required lifelong.

- Experience with treatment and mental illness can go back, for some, to life in another country. No treatment was provided at that time. For this beneficiary, referral and access to care came as part of obtaining treatment for a child. Psychotherapy and medications provided by a psychiatrist were initiated. However, the prescribed psychotropic medications were incompatible with a health condition, and had to be discontinued. In the place of medications various

supportive interventions are provided in the form of four groups. The primary care provider and clinic staff are in communication.

- Other experiences also include medications involving one participant's child. This individual reported positive experiences with therapist interventions, but not with medications. This child receives groups, art therapy, and other Intervention modalities.
- Therapist and case manager communication was characterized as positive and responsive. They call back the beneficiary promptly.
- Part of the treatment includes creation of a safety plan for urgent or crisis needs. All participants knew the number to call and a list of five items including: the number of the Casa Del Sol clinic, La Familia, a reliable family member, and a list of medications currently taken in case a hospitalization occurs. There is also a number for afterhours help.
- Some mentioned not experiencing a crisis since starting treatment. Another mentioned that if needed, a call to the receptionist will result in being connected with the psychiatrist. Rides and outings are facilitated through with the help of the agency van.
- All beneficiaries feel their cultural and linguistic needs are being met, with groups in either English or Spanish.
- While there is outreach into the community, many who are in need will not seek out help due to fear of gossip within their community.
- All beneficiaries have completed a satisfaction survey at one point. Each time one comes to the clinic there is a survey seeking feedback about the experience.
- Support services bring contact phone numbers and addresses to the vocational services training.

Participants' recommendations for improving care included the following:

- More therapists and funding are needed so that services are more widely available to those in need.
- The current services would be very expensive and difficult to obtain outside of the MHP, and participants hope that funding continues.
- There is not always sufficient transportation assistance. One beneficiary has submitted requests for transportation help three times. Reportedly, there are people who attend every day and need that type of help.

Interpreter used for focus group one: Yes Language(s): Spanish

Consumer/Family Member Focus Group Two

The second focus group requested consisted of a culturally diverse group of 10-12 TAY youth in treatment, the majority of whom initiated services within the prior 6 through 15 months. This session took place at The Spot, operated by the Bay Area Community Services (BACS), and located at 629 Oakland, Avenue, Oakland, CA 94611.

Number of participants: Nine beneficiaries participated in this focus group, three males, and six females.

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

- Initial access wait of two weeks for assessment were experienced, but received appointments the first time when calling in.
- A therapist appointment took a month for one; for the other beneficiary, both case manager and therapist appointments took one month.
- Access to psychiatry took two days.
- BACS (the clinic) made a difficult situation easier for both beneficiaries.
- A California state identification card delayed therapist appointment for one, but this was acknowledged to be outside of the MHP's control.
- Both participants were contacted by BACS at the hospital.

Participants' general comments regarding service delivery included the following:

- Nearly 80 percent have therapy sessions weekly, with therapists available between sessions when needed. Phone calls are quickly returned.
- All participants were informed about the process of changing therapists at the beginning of treatment. One is currently involved in that process.
- The availability of therapy was mentioned. One of the participants is seen three times each week. This was experienced as an assistance in completing school.
- Family therapy, and the inclusion of caregivers, is easily arranged.
- Support groups are provided as needed by Fred Finch Youth Center.
- Medications are generally experienced by most as part of a collaborative process. Involvement in treatment planning was identified by some of the beneficiary participants. But not every participant felt positive about the direction psychiatry was taking with medications, and whether the beneficiary's input was actually considered.

- When the case manager and therapist role is performed by one individual, the experience is usually positive.
- Employment specialists are available at Fred Finch, which can lead to supported employment and work success.
- Outings are available.
- Fred Finch performs surveys and seeks feedback about care.
- A participant identified working in two different jobs with the vocational help provided.

Participants' recommendations for improving care included the following:

- Some would like to find more places where it would be possible to connect with same-age individuals in a safe environment.
- Employment services are helpful.

Interpreter used for focus group two: No

Consumer/Family Member Focus Group Three

The third focus group requested consisted of a culturally diverse group of 10-12 parents/caregivers of children and youth in treatment, the majority of whom initiated services within the prior 6 through 15 months. This session was conducted at the Health Care Services Agency, 500 Davis Street, Room B, San Leandro, CA 94577.

There were four participants including one Spanish-speaking caregiver. The majority of participants have two or more children in treatment. A small element experiences the complicating factor of developmental disability and regional center related needs.

The complexity of the participants' families made determination of recent initial access issues impossible to address.

Participants' general comments regarding service delivery included the following:

- Parents and caregivers involved in the transition from TAY to Adult services found the process very difficult and dissatisfying. This issue centers around the youth attaining the age of majority, and as such consent for treatment must be obtained in order for information to be shared with the parent/caregiver.
- Some participants, when advocating for their children, feel they are perceived as inappropriately inserting themselves in the treatment of their now adult children. They assert that they are trying to assure continuity of treatment for their children 18 years and older, yet they feel mistreated in the process.

- Involvement with acute care treatment was relevant for half of the focus group participants and their experiences varied widely.
- Medication support services experience varied. However, multiple participants noted the discontinuation of needed medications that occurred during the transition between child and adult services.
- For some, transportation is a significant issue.
- Case managers may change with no advance notice.
- There is no respite care available for these caregivers, who feel it is greatly needed.
- Adult clinics do not provide follow-up with parents who were trying to initiate services for their children who are 18 years of age. These caregivers felt they were alone in the process of migrating to adult services, without assistance from the MHP. Several parents abandoned all efforts in seeking services.

Participants' recommendations for improving care included the following:

- Children's services to facilitate transition to adult care, and include parents/caregivers in the process.
- More funding for staffing and services as current levels seem insufficient to meet needs.
- Provide easier access to intensive services like TBS and Wraparound.
- Respite care for families.
- Support groups to help parents.
- Purposefully paying attention to the needs of caregivers.
- Case managers to help direct and connect parents to services.
- Services for borderline autism.

Interpreter used for focus group three: Yes Language(s): Spanish

Consumer/Family Member Focus Group Four

The fourth and last requested focus group consisted of a culturally diverse group of 10-12 Cantonese speaking adult beneficiaries, a significant component having initiated services within the prior 6 through 15 months. This session was conducted at the Rolland & Kathryn Lowe Medical Center, a component of Asian Health Services, sited at 835 Webster Street, Oakland, CA 94607.

Number of participants: Eight.

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

- Initial access to an assessment occurred within a month or less.
- First therapy appointment thereafter occurred within a week to several weeks.
- Initial psychiatry access occurred within a month to six weeks.
- The overall experience was positive, with that contact characterized as courteous and responsible. Another commented feeling “pretty good,” and optimistic from the first visit, and that the clinician wanted to help.
- Initial information about mental health treatment came from either a family doctor or psychiatrist.
- There were no obstacles or barriers to treatment by the process or provider.

Participants’ general comments regarding service delivery included the following:

- All of the beneficiaries see a therapist, which ranges in frequency from weekly to bi-weekly. In one instance, the individual felt progress had been made and sessions now occur every four to six weeks. At the extreme end, one individual sees a therapist every one to three months.
- Opinions are mixed about services being sufficient to produce progress. One beneficiary would prefer to return to prior treatment program and provider, but was informed this is not possible. Another would like to have more therapist time to discuss issues, but feels pressured to take medications and not address issues in talk therapy. Another identifies needing more intensive treatment, including possibly someone coming to the home, and is considering intensive outpatient or day treatment.
- For medication needs, some state the family doctor prescribes psychotropic medications. Another sees a psychiatrist regularly for medication evaluation. Usually medication visits occur every three to six weeks.
- Regarding quality of care, some mentioned the need to have interpreters.
- There are mixed reactions to clinician versus psychiatrist care. Some do not have good communication with the psychiatrist, but do with the clinician. For others it is reversed. Comments were provided about the clinician not taking notes, and not remembering what has been discussed before. While changing therapists is an option, it also brings with it the need to start over, requiring one to retell history.

- Knowledge of urgent care options is variable, with many unaware of the warm line or phone numbers to use when in crisis. Some mentioned experiencing a crisis but staying at home until is abated.

Participants' recommendations for improving care included the following:

- Greater inclusion in the development and content of the treatment plan was an issue for some. The ability to include one's significant other in the treatment is also an aspect identified, which is not always respected by treatment staff.

- Addressing parental traditional cultural stigma about mental health issues is a need that some identified. No specific approach to this issue was recommended by participants, but the stigma against mental health issues is experienced at home and within the community at large.

- Continuity of care was lacking, as noted by some participants, including repeatedly needing to obtain prior treatment records and becoming familiar with them. When this does not occur, the same topics are repeatedly covered, and perceived as wasteful of treatment time.

- Timely clinic operations are an issue for some group participants. Arriving for a 9 a.m. appointment to find the doors locked was an issue. If scheduled for an early appointment, the doors should be open in advance of the appointment time, allowing the beneficiary to come in and wait.

- Develop Cantonese language support groups, none of which are known by participants to exist.

- Provide opportunities to participate in MHP or program committees about services and needs. None can recall being surveyed for satisfaction, and would like to be able to provide this input.

- Printed Chinese/Cantonese language information about services was needed by these individuals. None could recall having been provided this in the past. This includes the clinic waiting room, and therapists' offices. Printed information regarding various illnesses in their language would be appreciated.

- Readily available information about the warmline would be helpful to have individually and be posted within the clinic waiting room.

Interpreter used for focus group four: Yes Language(s): Cantonese

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include 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 described below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 15: Access to Care Components

Component		Quality Rating
1A	Service accessibility and availability reflective of cultural competence principles and practices	PM

The Cultural Competence Plan (CCP) was updated in 2017 and addresses the diverse set of ethnicities, cultures and languages of the beneficiaries. A component of the CCP is focused on the disparities, particularly with the AA and API populations that have received significant focus of improvement efforts.

The MHP has identified some API cultural values that create barriers to accessing care, including stigma regarding mental health treatment. However, within the global API category, great diversity of culture and language exists, and requires different approaches for the various cultures. Overall, API cultures generally tend to access care through crisis services and hospitals, but not jails. Stigma is strong, and can be challenging to overcome. The numerous languages can create additional challenges in arranging aftercare following high level services.

The AA beneficiary population has been the topic of significant study efforts due to identified trends in the disproportionate diagnosing of more serious mental health conditions, and in the use of psychotropic medications, particularly antipsychotics. Also, the greater use of high-level treatment environments has been observed with this population which can involve higher utilization of crisis, acute inpatient and residential treatment for youth. Questions about the development of appropriate

Table 15: Access to Care Components	
Component	**Quality Rating**
treatment approaches for the AA population was discussed within various sessions of this review. The MHP tracks and reports a fair amount of data regarding service utilization patterns for the served populations. Clear initiatives have been developed to address disparity issues. The MHP will benefit from a continued granular focus on the tracking of outcomes as related to specific ethno-cultural initiatives. It would appear that the MHP does have access to the requisite data, and that Yellowfin provides a useful environment to perform outcome analysis. The feedback provided during this review indicated stakeholder support for the development of a separate language and cultural proficiency pay differentials. It is important to have staff that speak the languages of its beneficiaries; however, language skills are not always associated with cultural awareness and competence. Providing separate compensation for each element could attract and retain staff who have both abilities at a higher rate. The network adequacy requirements initial access programs, locally called “front door clinics,” providing clinical intake to beneficiaries within ten days of first contact can be challenging in both raw capacity and with the many languages that exist in this region. While interpreters and the language line meet the minimum requirements, it is also accepted that the best practice is to have sufficient clinical staff fluent in the required languages and knowledgeable of cultural values. For the Katie A. and Pathways populations, foster care services comprise 25-30 percent of the EPSDT budget. The MHP reports having sufficient capacity to serve current demand including the expansion population. They have identified 23 non-subclass eligibles. The reported need for Therapeutic Foster Care (TFC) families is 55. In the reporting period, the MHP states 339 subclass members were identified, 221 received ICC, and 82 received IHBS. Alameda County has decided not to perform certifications for any short-term residential treatment program (STRTP) agencies, opting to have the State perform this function and license them. The MHP will decide if they want to contract with these agencies as STRTPs. In some counties, this is delegated to an attorney who is representing the child/youth, which can result in delays. This MHP reports that it initiates needed treatment and will not allow consents and release of information issues become an interruption to treatment. However, they would suggest that this is not universally the case and that delays may occur in some counties. The need for universal send/receive presumptive transfer documents was strongly underscored; as well, the legislation should provide broader authority as to who is permitted to provide consent.	

Table 15: Access to Care Components		
Component		**Quality Rating**
1B	Manages and adapts its capacity to meet beneficiary service needs	M

The MHP developed a level of care system many years ago, originally designed with five levels. Numerous factors have emerged that have simplified and consolidated the levels to consist of level one and full-service partnerships (FSP) as the highest service levels, and level three which serves as largely medications-only, with other treatment and case management services provided as needs emerge.

The MHP is working on the development of a functional level of care algorithm that will facilitate determination of service needs, including referral to non-SMHS levels, provided by local health plan behavioral health services. Efforts are being made to also improve the flow between MHP services and primary care, with the area of greatest success continuing to be in those integrated programs, where health and mental health are co-located.

In preparation for the FY 2018-19 budget cycle, FSP programs were re-bid with a specific focus to improve operational functionality, including the referral process and in- and out-flow of beneficiaries. The FSP rebidding process intentionally sought out providers that would retain individuals within the high service level program only as long as needed, and then facilitate step-down.

In addition, starting in January 2019, FSP referrals will come directly from the Access Team, which ensures the slots receive beneficiaries with the greatest need, at times identified by other agency partners. Until that time, Crisis Response Programs are open, serving beneficiaries who have urgent medication needs arise. The MHP leadership is seeking to see programs adopt a more comprehensive approach to serving beneficiaries, and are able to flex and provide unscheduled urgent medication services and manage urgent response needs.

Sausal Creek, a crisis stabilization program, was converted into a level-three primarily meds-only program in July 2018. The program had been evaluated and determined not to be fulfilling the defined CSU function, and was instead serving as an outlet for other programs that identified urgent needs of consumers.

The MHP is considering the urgent response protocols of existing programs and how this need can be incorporated into these programs when medication or clinical urgent care needs arise. Currently, it would seem that the process is unique to each program and inconsistently addressed.

The MHP has plans to develop a medication-only support telehealth service in three locations, which will help to add capacity to the psychiatry shortage issue, and adjust distribution of telehealth according to need.

Table 15: Access to Care Components		
Component		**Quality Rating**
There are multiple strategies being developed by the MHP to address the psychiatry/mid-level prescriber shortage, but challenges remain. Contract organizational providers also have significant problems obtaining sufficient capacity for medication services. Remedies include seeking to utilize psychiatry residents from Stanford and UCSF, expansion of telehealth services, and broader mid-level utilization. But the issue of insufficient availability of prescribers remains an issue, even with the creative use of clinical pharmacists in targeted prescribing roles.		
1C	Integration and/or collaboration with community-based services to improve access	M
BHCS contract agencies provide nearly 80 percent of all services, which results in this MHP being strongly integrated with community partners and community-based organizations (CBOs). Many of the providers are local programs with a rich history of services in the Bay Area, such as Telecare Corporation, BACS, Bonita House, Fred Finch Youth Center, Seneca Family of Agencies, Stars Community Services, and many more. There are nine Federally Qualified Health Centers (FQHCs) that have behavioral health and WPC level one beneficiaries. Locally, WPC is called AC3. The beneficiaries have a single plan of care across all serving agencies, with 3,000 served, with a goal of 20,000 by the year 2020. A significant aspect of AC3 is the care coordination that occurs within and among participating agencies. The MHP also has strong integration and co-location with physical health programs such as Lifelong and the Path Clinics, of which there are currently two and one other under development. These programs provide easy access for physical health care for mental health and substance abuse treatment as well as easy consultation for patients of physical health practitioners. A secondary benefit reported is that in this integrated environment, referral back to primary care of stabilized mental health beneficiaries is more easily accomplished.		

Timeliness of Services

As shown in Table 16, 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 beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first offered appointment	NM
As of this review, the MHP lacks a method of tracking offered appointments, and is able only to report on first kept appointment. Plans exist to make the necessary changes to bring the first-offered capability online. The first kept appointment metric is collected from both directly operated and contract providers. For the FY 2017-18 period, a 14-day kept appointment standard was in place. The reported adult mean was 16.5 days, and the children/youth mean was 19.8 days. FC services showed a 22.1 day mean. Achievement of standard varies from 53 percent for foster care, to 62 percent for adult services, with children and youth slightly above FC, at 54 percent. The MHP standard exceeds the state offered appointment parameter of within 10 business days, and a recommendation will be made for the MHP to comply with this state timeliness metric as per Information Notice (IN) 18-011. Furthermore, it is yet unable to track initial offered appointments for FC children and youth.		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
The MHP reports a 14-day standard for initial psychiatry access during the FY 2017-18 period. The mean access times are: adults 28.3 days, children and youth 22.5 days, and FC 33.3 days. Attainment of standard is 30.8 percent for adults, 46.5 percent for children and youth, and 30.6 percent for FC. The tracking of timeliness in this area does not include offered appointments, and is limited to actual kept psychiatry first appointments. The self-imposed standard was more rigorous than required by network adequacy; however, actual results universally exceed that standard, and attainment of standard is quite low. Throughout the review process, the challenges presented of recruitment and retention of prescribers were often noted. Lacking a robust EHR, challenges exist with the capture of mid-treatment referral decisions to psychiatry, events which may frequently occur with children and youth. The MHP is aware of and focused on development of solutions to psychiatry timeliness. The planned expansion of medications/level three clinics, and a telemedicine initiative which will support dynamic resource redistribution and also recruitment of prescribers who reside outside of the area. The tracking of mid-treatment referral to psychiatry decisions will require some creative system developments.		

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2C	Tracks and trends access data for timely appointments for urgent conditions	NM
As of this review, the MHP does not have the capacity to report urgent care timeliness. This information is impacted by several issues, which include the lack of a robust EHR, and the circumstances presented by contract organizational providers utilizing many varied systems of their own. Communication between these varied systems for performance tracking can be challenging. The process of this review identified the various urgent responses to clinical and prescriber/psychiatry services. Programs often refer to external resources for urgent medication needs or crisis events of their beneficiaries, rather than utilizing internal staffing for this need. MHP clinical and psychiatry leadership is aware of these differences and expressed plans to review program policies for this area, and seek to establish uniform protocols that have greater focus on internal resources and response. Urgent care access for FC children and youth is an important metric to track, reflecting access to an important service.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	Met
A seven-day (HEDIS) standard is utilized for post-hospital discharge follow-up. Performance in this area is averaging 7.05 days for adults, 4.95 days for children and youth, and 5.0 days for FC. Adult services, at 27.9 percent, demonstrate the lowest attainment of this standard, whereas children and youth reflect 79.8 percent, and FC 52.4 percent. The FC attainment of standard is of particular concern since it would be expected these individuals are receiving intensive attention. This area deserves more focused investigation. The MHP has continued efforts to improve follow-up after CSU and inpatient episodes with the use of peer support specialists. Standards of response are also imbedded in contracts with programs who serve individuals at all levels. Innovative programs were designed to create teams that follow-up with “familiar faces,”(known beneficiaries) and another team that seeks to serve those “new faces” (new beneficiaries). These added services will hopefully improve engagement post-hospitalization and stabilization.		
2E	Tracks and trends data on rehospitalizations	Met
Out of a reported total of 3,741 acute inpatient admissions, the 30-day readmission rate is 18.7 percent for adults, 21.1 percent for children and youth, and 25.1 percent for FC.		

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
Review discussion raised questions about the total admission number appearing to be understated. A related issue was whether or not psychiatric health facility (PHF) admissions were excluded. The acute psychiatric admission area merits accurate tracking, reporting and evaluation of data on a regular basis. The QIC minutes for this review did not indicate review of this data. The topic of crisis and acute mental health care would seem to merit the establishment of a QI or system subcommittee specifically targeting review of related data and of the programs that are intended to improve these services.		
2F	Tracks and trends no-shows	NM
The MHP was not able to systematically report on no-shows of any type. No-show tracking can be of great help with monitoring system efficiency issues, and in the development of interventions to improve utilization of services. For this MHP, no-show reporting of directly operated programs requires a robust EHR which includes a calendaring component. The contracted organizational providers commonly utilize other EHRs, which are often different from those typically operated by California MHPs. However, contractor EHRs should provide support for no-show reporting. The MHP would be assisted by providing an expectation that no-shows be routinely summarized and reported to the QIC.		

Quality of Care

In Table 17, 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 17: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M

The MHP performed an evaluation of the FY 2017-18 Quality Improvement Work Plan (QIWP). Each item is rated according to whether or not the element was addressed and to the extent of attainment. The FY 2018-19 QIWP established goals by percentage improvement but did not identify specific baselines or standards that are part of network adequacy requirement, including first offered clinical assessment and first offered psychiatry session.

In preparation for the DMC-ODS waiver and the creation of a joint mental health/substance abuse QIWP, general goals that address SUD residential services have been added. There remain many other logical SUD areas that would welcome additional and more detailed metrics.

The Alameda County Quality Improvement Committee (QIC) Minutes submitted for this review start in September 2017 and end in August 2018. The content of these minutes typically reflects discussion of high-level quality and compliance issues. It is noteworthy that the specific metrics established in the QIWP are not discussed in the submitted minutes. However, broader topics are reviewed, particularly those which relate to Network Adequacy and other changes that require implementation. These comments include scope of practice clarification discussions, and conclusions regarding needed greater participation of beneficiary and family members in the QIC.

Due to the scope of important topics, it seems that the MHP's QIC could have a greater impact were it to develop specific subcommittees targeting key operational issues. These might include acute, crisis and urgent care, primary care and physical health coordination, documentation streamlining, timeliness and network adequacy, and others.

Currently, the QIC agenda and minutes lack the presentation of data elements and review of granular data that is needed to inform decisions and support recommendations to the leadership team.

The MHP has identified concerns about the lower penetration rates for AA and API populations. Continued efforts to examine data by race and ethnicity seems indicated, and could benefit from application to the timeliness indicators for initial access, initial psychiatry access, urgent services, no-shows, and post-hospital follow-up. Review of this disaggregated data may offer potential solutions when viewed through the lenses of language and culture.

Some stakeholders continued to report that documentation requirements have quadrupled over the past four years, and cited some instruments requiring hours for

completion. Also mentioned was the inconsistent manner in which staff are informed of required update processes, which varies by agency and EHR utilized. Some review sessions provided suggestions that quality and compliance representatives meet with all directly operated and contract provider teams to present changed requirements and solicit feedback.

The MHP's efforts to identify opportunities to streamline documentation and compliance processes have received greater attention in the last year, and should continue. By some reports, the other challenges, such as network adequacy and DMC-ODS waiver preparations, have displaced compliance and quality staffing resources. The additional workload may have impacted the intended very positive streamlining efforts with initial assessment format and brief plan of care. Many contract provider staff have heard of this development but have yet to experience the benefits. This function of ongoing streamlining efforts merits discrete staffing and will realize disproportionate gains.

Some participants mentioned that five forms are required to complete an assessment, and with the annual updates now including instruments such as the PSC-35 and CANS-50 that it takes several hours to complete all of the routine requirements. While additional requirements are outside of the MHP's control, many review participants mentioned that the usual assessment process covers the majority of these questions, and that it is an area in which some other MHPs have addressed through integration of CANS and Adult Needs and Strengths Assessment (ANSA) questions into the assessment format.

MHP medication monitoring activities demonstrate an impressive scope of review. The SB 1291 standards are tracked where possible, as well as other expanded prescribing metrics. The larger issue remains with the significant amount of prescribing that occurs outside any system that the MHP can access. The MHP has been able to obtain data directly from DHCS to support their process, but this is not a regular event, and does not include lab information for many programs.

Considering the discussions regarding race/ethnicity disproportionate diagnoses, medication practices, and ineffective interventions, the MHP may wish to automate ongoing periodic profiling of diagnoses and medication prescribing practices by race/ethnicity to help inform conversations around treatment. This topic might serve as the basis of a PIP.

Medication monitoring efforts of the MHP provide a robust review of prescribing practices that encompass the SB1291 criteria, as well as track and report other prescribing standards. A 15 percent caseload review occurs with each physician. Screening against the MHP's prescribing standards is performed. Each physician receives an annual report card that compares the individual to average of all prescribers.

Other targeted areas include comprehensive medication management, targeting the high-risk Projects for Assistance in Transition from Homelessness (PATH) consumers. As well, the children's review focuses on the key elements of SB1291.

The challenge for this MHP is obtaining quick and timely access to state prescribing data, which has greater importance with the 80 percent contracted services. Those contracted agencies do not use the MHP's e-prescribing software nor its EHR. As well, the lab claiming activities are not easily accessible to the MHP for providing oversight review.

3B	Data used to inform management and guide decisions	M

The Health Agency data warehouse continues to include additional information from disparate data sources. Yellowfin provides a platform for quick access to many of the MHP's data elements. Also, the data analytical staff have knowledge and the expertise with both data and Yellowfin to answer complex questions regarding services and program operations. Without a functional EHR, the data warehouse lacks sufficient client-level clinical data elements to measure and monitor clinical performance.

3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M

Communication was an area identified by the prior EQR report. The MHP specifically targeted this area with efforts to promote improvement. These efforts include work with an external communication and marketing firm to understand the broad needs of stakeholders, and develop a cohesive messaging approach that meets those needs.

Communication improvement efforts also targeted the internal and external web presence of the organization, accompanied by the development of a new logo, messaging and revised values statements.

Interim Director Burton provides a monthly newsletter addressing consumer involvement, quality, compliance and other current issues.

The review provided information about the integration of QI with contract providers and even directly operated programs. The majority of participants related awareness for compliance, and particularly documentation and service updates. Few were aware of performance or quality initiatives, much less participation in the same.

The efforts to improve communication were reported during various sessions of this review. The full benefit of the MHP changes are yet to reach all elements of the system and continued efforts in this area is merited.

3D	Evidence of a systematic clinical continuum of care	M

While the MHP has been in expanding service elements for crisis stabilization and support of individuals post-hospital and post-crisis events, challenges were identified

in the depth of mobile crisis response throughout all regions of the county in the prior review.

The crisis response has expanded from five to seven days each week with mobile teams. An innovative, grant-funded program was developed that pairs a clinician with an EMT, which results in most cases bypassing emergency department (ED) for physical health screenings. Direct admissions to crisis stabilization programs (CSUs) and acute inpatient units can then occur.

A three-year pilot program, staffed with 85 percent peers provides follow-up calls to beneficiaries with a crisis or crisis stabilization programs. The focus has been upon John George Psychiatric Pavilion acute inpatient discharges; however, plans for system-wide expansion and team meetings to discuss progress are under way.

There are plans for up to ten mobile teams to be created, but significant elements remain yet to be implemented.

The MHP is seeking to improve the efficiency of its system through the standardization of Access referrals to programs, which is particularly important with the FSPs. Operationalizing this process will be a key challenge for the MHP to create a practical, effective and responsive process. It will also likely impact Access staffing needs.

The MHP is finalizing plans for mobile crisis expansion up to ten teams, but yet to be implemented. The addition of telemedicine hubs will be developed for providing medication only services in a more accessible format and locations.

In a number of sessions, the issue of urgent medication needs and clinical response was discussed. It seems that various approaches to this issue are taken by each contract entity and program, and there lacks a uniformity of approach specified in contracts. This issue was highlighted by the dissolution of the Sausal Creek crisis stabilization program that was observed to be operating as an urgent medication and other services program, instead of meeting significant crisis needs.

The MHP would benefit from the development of protocols for urgent medication and clinical service access that would, in most cases, be met by the internal resources of each program. Greater flexibility and assumption of treatment responsibility for serving the needs of clinic beneficiaries will benefit the care recipient and the system operational efficiency.

3E	Evidence of consumer and family member employment in key roles throughout the system	M

The MHP has established designated positions for consumers and family members within both directly operated and contract provider programs. OCE manager is considered part of the leadership team, providing input at the highest level.

Regarding the existence of peer or family member supervisory positions and career ladder opportunities, options exist within contracted programs. The MHP has engaged

in efforts to provide additional training of peer support workers, including specialized forensic training in the last year.

This review included discussions that reflected an awareness that individuals who have not pursued traditional education paths may, in fact, possess characteristics that suggest success in leadership roles. This includes those with lived experience, and also those with needed culture and language skills. The MHP expresses awareness for their need to respond to this phenomenon, and to make changes that supports leadership roles when not fitting into traditional pathways.

This subject merits follow-up in future reviews.

3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	M

The MHP provides wellness centers in a number of locations throughout the county, and includes a TAY focused center. Wellness centers operate with similar hours to the MHP clinical services. There are no limitations as to who may attend. Information about the centers is available through case managers and initial points of access and treatment providers.

3G	Measures clinical and/or functional outcomes of beneficiaries served	PM

For over a year the MHP has been utilizing the CANS and ANSA instruments to collect outcome information. Administration occurs at intake and every six months thereafter, and at beneficiary closing.

These instruments reside within the Objective Arts software, and are accessible to all providers. It is too early for any significant aggregation and analysis of data to have occurred.

While these instruments provide a consistent approach to collecting outcome information, frequently staff comment on how much of this information is part of the existing standard assessment or assessment update process. This creates the perception of redundancy, and is a barrier to beneficiary engagement which comes from being asked the same questions as in the assessment.

Some MHPs have addressed this potential for redundancy through integration of CANS and ANSA questions into the initial assessment and update templates. Any questions that are CANS/ANSA specific are added to that template. This was also mentioned by stakeholders who had worked in other MHPs, who also noted other differences in Alameda system. Some of these other items include electronic notices of actions due that are more limited in the Alameda system.

These issues are operational issues that could potentially be improved with the implementation of a modern, robust EHR. The challenge for this MHP is that the majority of services are delivered by contract providers who have numerous varied

EHR systems. These are issues the MHP will be grappling with in upcoming months as it determines EHR needs and issues an RFP.

Staff raised the issue of ANSA required certification and re-certification. Comments include, suggestions that it requires suspension of clinical skills to pass the test.

There are other areas in which instruments are utilized to measure beneficiary progress. Most frequently these are associated with MHSA or other programs with dedicated funding and the use of an evidence-base practice (EBP), which is associated with a specific instrument. These include: Seeking Safety (SS), Motivational Interviewing (MI), Feedback Informed Treatment (FIT), Dialectical Behavioral Therapy (DBT), and many others. EBPs are often associated with a specifically designed instrument to collect data on progress. Lastly, fidelity tools to ensure the practice is being applied in alignment with the EBP model are available. The fidelity tool use is another task that staff who feel overburdened by the workload identify as a barrier to clinical care.

The key takeaways from this topic include: Staff experience the use of numerous required instruments as consuming more of the limited time they have for the clinical work. When instruments mirror 90 percent of the assessment, it seems wise to make efforts to integrate the two. Directions to contract agencies and support in the integration process would likely also create efficiencies for those agencies that use other EHRs.

Throughout the review discussions and questions arose about the relevance of clinical approaches (EBPs) and clinical instruments that are being applied to populations which differ significantly from those in the development of these interventions. Significant uncertainty exists and many believe more work needs to be done in this area; that validation with other cultures needs to occur.

It is clear the MHP has performed some analysis of data results by ethnicity, although not with CANS and ANSA data. More work in this area would seem appropriate, to determine if the CANS and ANSA tools are clinically relevant with all populations.

The integration of clinical outcome instruments into the EHR workflow should be a priority consideration of the MHP and its documentation streamlining process when a new system is selected.

3H	Utilizes information from Consumer Satisfaction Surveys	M

The MHP provided a multi-dimensional analysis of consumer perception survey results over the CY 2015 through Fall CY 2017 periods. Awareness for low participation numbers was expressed, and development of new and better strategies was discussed. Clearly, by the relatively low numbers, this merits improvement efforts.

An observation stated by many participants from all levels and providers is that this information is significantly dated by the time it is available for analysis, which is problematic for efforts to use this information to improve care.

The MHP also performed an analysis of consumer perception survey results related to those law enforcement contacts from those who have received treatment for less than one year, and of those who had received for more than one year. This was drawn from CY 2015 through CY 2017 data. The data was broken out by adults 18-59 years, older adults 60 plus years, and youth 13-17 years. One example: Adults reported reduced law enforcement contacts by 20 percent for those served for greater than one year. Overall, there was little significant differences between the reported years.

Particularly relevant to this MHP's diverse beneficiaries is the analysis of race/ethnicity in survey participation. This approach helps to inform whether it is proportionately engaging race/ethnicity groups with this survey. For the Fall 2017 survey, AA participation comprised 45 percent, white/Caucasian was 30 percent, and Latino/Hispanic 21 percent.

Among the youth respondents, AA and Latino/Hispanic participants were each more than 35 percent of the participants for the three years reported. The ethnicity survey of parents and caregivers reflected a higher participation of Latino/Hispanic caregivers, and much lower involvement of AA caregivers.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of Alameda MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities and Recommendations

PIP Status

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

Non-clinical PIP Status: No PIP submitted (not rated)

Recommendations:

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

Access to Care

Changes within the past year:

- The MHP has finalized planned service expansions, such as broadening mobile crisis response teams from office-based to field-based seven days per week.
- A combined, voluntary crisis response team (CRT) and CSU program (Amber House) is being developed, with the expected opening date before the end of FY 2018-19.
- In this current review year, the MHP has launched a partnership program with Alameda County Probation Department, embedding clinicians in the Oakland and Hayward probation offices.
- During FY 2017-18, the MHP closed the Alameda adult and children's clinic, and realigned resources to better fit the geographic distribution of beneficiaries.
- The MHP has continued its efforts to better understand and allocate services to underserved or inappropriately ethno-cultural populations. Reporting data for Hispanic/Latino, API and AA populations is part of this effort.
- The FSP contract rebidding process enabled the MHP to utilize contractors who are focused on dynamic level of care transitions, freeing up intensive service slots for those with the greatest need.

- Level of care determination and access to FSPs will be reassigned to the Access Center as of January 2019.

- The FSP program was the focus of an RFP process in FY 2017-18 which has resulted in some changes in the agencies that provide these services. In addition, the process added capacity for children, TAY, and forensic populations.

Strengths:

- The MHP has engaged in efforts to revamp the referral process and utilization of the longer stay CRTs, empowering mobile crisis teams and CSUs to refer directly.

- Post-crisis follow-up teams, primarily peer-staffed, have been approved, and with anticipated opening date of July 2019.

- Local EMT/paramedic protocol has changed to include field administration of oral olanzapine to individuals in mental health crisis, providing immediate treatment to individuals in distress or agitated. Previously, treatment has been delayed until emergency department arrival. This approach will likely decrease the time spent in EDs or CSUs.

- The MHP has prepared an Innovations grant to fund alternative transport teams that will include both a clinician and an EMT. This will permit initial health screenings to be performed in the field without detours to EDs, reducing unnecessary delays and inappropriate use of emergency services.

Opportunities for Improvement:

- Stakeholders report that in transitions from FSP and Level One to Level Three programs often requires a move to a different provider and service location. This type of disruption can result disconnection of beneficiaries during the transition. Throughout the review process, stakeholders suggested that vertical integration of all levels of care into each contracted program would likely improve beneficiary retention and reduce time served at higher levels.

- Challenges in recruiting and retaining all types of personnel were identified throughout this review. Economics factors were identified that include cost of living, housing, and competition for workers significantly impacts recruitment and hiring of licensed clinical staff as well as prescribers – both psychiatrists and mid-level psychiatric nurse practitioners. This affects both directly-operated, and to a greater extent, contract organizational providers due their difficulties in offering competitive salaries and limited benefits, such as retirement plans. Meeting the linguistic and ethnic/cultural needs of those served is also impacted because these individuals get hired away by competing agencies. The reality that the MHP serves the most ill population, and those reluctant to engage in treatment creates a work environment that is often less attractive than a typical health plan clinic environment. Recruitment and hiring challenges also apply to unlicensed

staff. Within the highly competitive Bay Area, there are numerous other employment opportunities.

- The compensation approach to needed language skills is reportedly minimal and does not provide any specific differential for cultural competence of staff.

Recommendations:

- Consider opportunities to increase the vertical integration of FSP and levels of care within each site, such as when rebidding or expanding services. This can create opportunities for greater efficiency and improved outcomes for consumers who may then move between service levels at a convenient location and familiar staff, without the risks associated with the change of physical program sites.
- Identify additional approaches to improving recruitment and retention of staff at all levels, focusing on supporting the educational advancement of unlicensed staff and creatively working to address the scheduling and economic needs of applicants and existing staff.
- Evaluate the development of a bifurcated differential which separates language from culture, and supports an incentive for each separately. Study the competitiveness of the differential level with other similar types of agencies to determine if the compensation is adequate to impact recruitment and retention needs.

Timeliness of Services

Changes within the past year:

- The MHP has engaged in collaboration strategies with internal and external stakeholders regarding the development of tracking metrologies that will support reporting requirements for the Final Rule and Network adequacy.

Strengths:

- The MHP was able to expand the tracking of first kept appointment to include FC beneficiaries.
- The initial access times for kept appointments reported by the MHP corresponded fairly well with those reported by the very limited focus group participant experiences accessing care recently.
- Post-hospital follow-up adheres to the seven-day HEDIS standard, and reports very brief means of seven days for adults, five days for children and youth, and five days for FC. Achievement of standard, however, is fairly low for adults, at 28 percent. Children and youth are at 80 percent; and FC is at 52 percent.

Opportunities for Improvement:

- In the prior review (FY 2017-18), the MHP reported that timeliness data was limited to those beneficiaries who initiated services through contact with the Access Team, which for that review period consisted of nine percent of the all events. Coding and tracking methodologies are being developed to permit the MHP to report per Final Rule and Network Adequacy requirements. The MHP continued to lack the ability to track first offered appointments for the FY 2017-18 (CY 2017) data reported in this review.

- Attainment of the 14-day initial psychiatry standard attainment remains low for adults and FC, at approximately 30 percent meeting the standard. Children and youth are at 46 percent.

- The MHP reports that currently no data is available for attainment of urgent care timeliness. Furthermore, onsite discussion in various sessions indicated that there exists no system-wide policy or procedure for how each contract provider is to respond to urgent need requests. At times, provider staff assume that function, and in other instances beneficiaries are referred to the various crisis programs and/or urgent medication services throughout the county. It would seem that a common definition of urgent needs and response process should be developed system-wide. It would also help to develop separate protocols and tracking/reporting for urgent medication needs versus clinical services.

- Urgent care response is impacted by the finding that each individual program utilizes a unique and non-systematic approach for response to beneficiaries who have an urgent psychiatry or clinical service need. Urgent medication needs are often referred to external resources, including emergency departments. Urgent clinical needs are sometimes responded to by program staff, and often referred to crisis or CSU resources. Providers reportedly operate without standardized written protocols that govern urgent medication and/or clinical needs.

- The MHP lacks the ability to formally report on no-show events. This is complicated by the current limited EHR, and the varied EHRs in use by contract organization providers.

Recommendations:

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

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

- The MHP needs to develop a system-wide protocol that explicitly addresses the issues of urgent medication and clinical needs of its beneficiaries. This protocol should directly and clearly impart expectation of response by programs, and

when referral to EDs or crisis teams are appropriate. Tracking, reporting and regular evaluation of the data is imperative.

Quality of Care

Changes within the past year:

- The MHP targeted improvements in the quality of care for older adults (OAs) with serious mental illness through a collaborative multi-agency effort to assess services and needs, and to develop targeted efforts to improve this system. Services were also enhanced through a contract with the Felton Institute to serve 90 Seriously Mentally Ill (SMI) individuals over the age of 60 who meet Level One criteria.
- Improvements in the California State University continuing education program has been facilitated by the MHP's collaboration on training related to infant and early childhood mental health, which also assists with workforce development.
- The MHP has invested significant time developing responses to the Medicaid Final Rule and State DHCS's direction relating to grievance and appeal system, redesign of the provider directory, revamping the credentialing and re-credentialing process, making adjustments to the system in order to comply with network adequacy, establishing systems that accurately monitor timely access requirements, and expanding language capacity.
- A clinical review specialist supervisor was hired into a management position, to improve oversight quality.
- The MHP provided guidance on the DHCS-mandated CANS-50, ANSA, and PSC-35 functional assessment tools.

Strengths:

- The MHP is providing ongoing TA to contract providers through brown-bag sessions, Clinical Quality Review Team meetings, clinical documentation trainings, response to phone and email inquiries from providers, and presentations at provider meetings.
- The MHP is transitioning the rate structure for contracted services to increase accountability and share risk, as well as implementing incentive payments.
- A streamlined, virtual site visit Medi-Cal certification process has been created for public school-based programs for all county and contractor sites.
- The MHP has initiated a process for streamlining documentation and compliance requirements, creating simplified processes that reduce the time spent on duplicative documentation and speeding up time to treatment for new intakes.
- The CANS and ANSA were implemented over one year ago.

- The MHP completed a Plan-Do-Study-Act (PDSA) project to study and improve access to primary care by SMI consumers. In addition, baseline data was collected relating to improved primary care access, care coordination, and integration of services.

- A clinical pharmacist was added in August 2018, whose role is to provide pharmacologic consultation to mental health, primary care, and SUD providers, to ensure achievement of the best possible health outcomes.

- The MHP worked with a provider stakeholder group to review and develop implementation strategies for DHCS Information Notice No.: 17-040, regarding an update of practice and documentation standards.

- The MHP demonstrates strong medication monitoring activities as well as other SB1291 data elements. Additional monitoring categories include “high dose, second look,” “prescriptions to flag,” and reflect longitudinal results tracking. The pharmacy review provides each prescriber with an individual report card each year, comparing the individual’s prescribing results with the overall peer average.

Opportunities for Improvement:

- Despite recent changes in communication process and improvement activities, communication about compliance and quality issues continues to warrant more effective and consistent messaging throughout the system of care, particularly to the program and treatment team levels.

- The efforts to streamline process and documentation to reduce redundancy and unnecessary treatment barriers have yet to be rolled out to contact providers. In fact, many review participants were unaware of these helpful changes being in process.

- The Quality Improvement Work Plan identifies very limited quantifiable goals for improvement in areas such as timeliness, but rarely presents standards, baseline data, nor the specific improvement results. Considering the scale of this MHP’s operations, the targeted improvement areas are very limited.

- The CANS and ANSA instruments are housed in the Objective Arts offsite database, and contains content which is repetitive with many assessment and assessment update elements. While this approach may be relevant due to the high number of providers that use disparate EHRs, integration of these instruments with the assessment and re-assessment instruments should be the long-term goal, and reduce redundant activities, improve engagement with beneficiaries, and increase available clinical hours. The MHP needs a contemporary and robust EHR to effect this change, and strong partnering with contractor-operated programs so that they are supported in the adoption of this streamlining process.

- Quick access to DHCS Medi-Cal prescribing and lab claiming information would enable the MHP to expand its review from approximately 10 percent to 100 percent of prescribing that occurs with its consumers.

Recommendations:

- The MHP needs to adequately staff and empower the compliance/QI that provides updates on required compliance areas, with a priority of merging processes when new compliance areas are identified. Elimination of redundancies has the potential of improving the beneficiary experience of the treatment process and also increasing the availability of staff clinical hours.
- The MHP's compliance and communication activities need to involve MHP QI direct presentation to clinic/program sites, partnering with contact agency QI staff, which provides the ability to clarify protocol changes and clarification of complex issues, as well as receive feedback.
- The QIWP and process would benefit from greater identification of measurable objectives, such as timeliness measures that incorporate baseline data and target goals for improvement. The resultant data needs routine, periodic review by the QIC or relevant subcommittees, or blended forums of leadership and QI.
- Consider opportunities to integrate mandated outcome instruments and other requirements– such as the CANS and ANSA – for integration with the initial assessment and assessment update, which creates a more coherent workflow.

Beneficiary Outcomes

Changes within the past year:

- The POCC and OCE were engaged in the development of peer employment opportunities, which included an expanded peer training program and up to 18 increased positions. A specialized Forensic Peer Specialist training occurred early in 2018, and reached 35 participants.
- OCE developed a consumer survey of consumer-operated programs, which reached 50 POCC members who completed the survey.
- Centralized housing subsidies have been linked with FSPs, so that housing subsidies remain in place even when the need for clinical services diminishes. This supports continued housing, and also ensures as many individuals as possible are housed with supportive subsidies.
- MHSA and Alameda Care Connect funds are utilized to create landlord liaison contracts, to incentivize property owners to partners with the subsidy program.
- Feedback from POCC members reflected the renewed efforts of MHP leadership to engage with and communicate with this important stakeholder group.

Strengths:

- Beneficiary feedback is positive about the availability and quality of supported employment services, an area in which the MHP is also Commission on Accreditation of Rehabilitation Facilities (CARF) accredited.
- A number of initiatives are in place with the Office of Family empowerment:
    - Family partner inclusion curriculum in the children's system of care.
    - Parent Tools to Thrive curriculum, for birth through eight years.
    - Coaching Family Partners and Clinical Supervisors, early childhood and school-age.
    - Training Spanish-speaking coaches.
    - Confidentiality guidelines for clinicians.
- The MHP has utilized MHSA funds to assist the start-up and ongoing implementation of Alameda County's coordinated entry system to address homelessness, linking MHSA housing units to the homeless system.

Opportunities for Improvement:

- The transition of youth into the adult system of care is fraught with barriers that severely impact the parents and caregivers, with whom many beneficiaries reside. At 18 years of age, the youth is suddenly thrust into a world where s/he must request services at a different provider, and provide authorization to share information with the caregiver. This transition event often occurs without the planned support of children's services. This can result in the caregiver facing one of two unpleasant options: ejecting the youth from his/her home, or living with unsafe behavior.
- Opportunities for alternative treatments in lieu of medications is a strong interest of both adult consumers and parents/caregivers of children and youth. At times they experience an emphasis upon medications and less upon talk therapy.
- Preferred language information regarding mental health conditions was noted lacking by API focus group participants, as well as a prescriptive approach to treatment that de-emphasizes beneficiary input. Concerns about early appointments not having waiting room access before the 9am appointment were also identified.
- While individuals with lived experience, particularly POCC members, have received renewed involvement in this past period, other beneficiary elements expressed continued disconnection from involvement.
- Focus group beneficiaries were interested in involvement with MHP planning activities but typically were unaware of how this could occur.

Recommendations:

- The MHP must develop an effective mechanism for the support of youth transitioning into adult services. This includes development of a beneficiary and care-giver supportive approach that assists each family throughout the process to the completion of an open adult episode. As described to the review team, this is a disheartening process, one fraught with potential poor outcomes for the caregiver family and for the youth.
- The MHP and its providers need to explore attitudes and provide refreshed training that helps practitioners welcome the input of beneficiaries' wishes to explore alternatives to medications, whenever feasible. This may require special attention with those agencies serving API consumers, and particularly with physician/prescriber staff.
- Continued efforts to connect and gain input from peer support specialists and other employed people with lived experience remains a priority for this MHP to pursue, building upon the successful work with POCC members.

Foster Care

Changes:

- An RFP for TFC was released for review and application by local foster family agencies (FFA), which closed early in November 2018. The MHP is unsure regarding the extent that application interest may exist among local FFAs, particularly with other neighboring counties having reached out to fill their own needs.
- There have been 11 requests for SRTP status, from which only three have been determined to present viability for meeting the requirements.

Strengths:

- Child Welfare has incorporated safety operated practice (SOP), and is working on rolling it out.
- The MHP has created a manual for ICC and IHBS that assists in maintaining fidelity.
- The MHP is evaluating the need for expanded contracting with West Coast Children's Center for the annual re-screening of children and youth who are not participating in mental health services, and for those who do not come in through the Assessment Center.
- In addition to IHBS and ICC, the MHP offers TBS, Wraparound and other intensive treatment services.

- The MHP's medication monitoring includes SB1291 HEDIS measures for beneficiaries served by directly operated programs, where access to lab work and prescribing is available. This includes DHCS Medi-Cal data, e-prescribing, and uninsured prescriptions. Medication monitoring is consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and HEDIS measures related to psychotropic medications, including, but not limited to, the following: use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC); use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP); and metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).

Opportunities for Improvement:

- The TFC RFP process and selection of the FFA agencies was incomplete as of the current review.
- The Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD) has been periodically captured in the process of medication monitoring reviews, but does not yet exist as a formal and regular reporting function.
- Access to contract provider information on prescriptions and lab order is variable, which results in consistent availability of data limited to approximately 10 percent of all served.

Recommendations:

- Completion of the TFC RFP process and selection of the FFA agencies that will be involved, providing TA as required.
- Pursue development of a reporting function that will provide information on the follow-up care of children and youth prescribed stimulants, per the HEDIS ADD standard.
- Advocate with DHCS for rapid access to Medi-Cal claiming information regarding prescribing, and lab claiming data for all Alameda MHP beneficiaries with a rolling three-month post claim window.

Information Systems

Changes within the past year:

- None noted.

Strengths:

- Yellowfin, a business intelligence application, is providing the "go to source" for dashboard reporting and other data visualization projects.

Opportunities for Improvement:

- To reduce reliance on hybrid (paper and electronic) medical record environment expand the rollout of Clinician's Gateway to all contract providers who deliver outpatient services.
- Continue to assign resources to Yellowfin pilot that allows 4 contract providers to use Yellowfin application for data mining. With a goal to allow 5 pilot users access to aggregate data by early 2019.

Recommendations:

- Continue to expand Yellowfin roll-out to remaining contract providers as resources permit. Provide training and technical assistance to ensure successful use of the data.

Structure and Operations

Changes within the past year:

- BHCS and HCSA made the decision to discontinue ShareCare (Echo VHR) contract with The Echo Group. The decision was made after a thorough assessment by ITD and Mental Health Finance consultants.
- The extension of the Interim Director's contract through the end of FY 2018-19 has provided the opportunity for action to be taken on the varied systems issues that have evolved with leadership changes in recent years.

Strengths:

- An Assistant Director for the overall system of care was hired in May of 2018. This has provided support to the Interim Director's initiatives, and seems to have been well-received by staff who note appreciation for the greater presence of leadership at the program level.
- The leadership of the Children's system of care was enhanced by the hire of an Assistant Director in May 2018.The MHP has initiated action on four key focus areas: organizational stability, stakeholder alignment, departmental transparency and department image and reputation.
- The MHP continues to examine the functionality of existing programs and referral processes -- such as Sausal Creek – and look for opportunities to redesign and achieve improved consumer access and outcomes.

Opportunities for Improvement:

- As the MHP proceeds to release a RFP to replace IS system practice management and claims functionality, sponsorship of RFP development and

selection of the system needs to be delegated to a senior executive level person who will support the core team of subject matter experts

Recommendations:

- As the InSyst system replacement RFP process launches it is critical to identify the core project team as soon as practical. The core team leadership needs to include at least 4 roles: The Executive Sponsor, Overall Project Director/Manager, Clinical Project Manager, and Technology Project Manager. Additional subject matter expertise to be assigned as the project plans develop and unfolds.

Summary of Recommendations

FY 2018-19 Recommendations:

- Strongly consider the vertical integration of FSP and levels One through Three programs when rebidding contracts, which creates opportunities for greater efficiency and improved outcomes for consumers who may then move between service levels without changing locations, and at a convenient site, with familiar staff.

- Identify innovative strategies to improving recruitment and retention of staff at all levels, focusing on supporting the educational advancement of unlicensed staff and creatively working to address the scheduling and economic needs of applicants and existing staff.

- Evaluate the viability of a bifurcated differential which separates language from culture, and supports an incentive for each separately. Study the competitiveness of the differential level with other similar types of agencies to determine if the compensation is adequate or there exist other strategies to impact recruitment and retention.

- Develop the mechanisms for tracking all network adequacy timeliness measures, and incorporate a process that through the year periodically produces performance data that is furnished to QI and leadership teams, is evaluated and is used in resource allocation determinations. Specifically, these include initial clinical access, initial psychiatry access, and urgent services access.

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

- Urgent needs require the development a system-wide protocol that explicitly addresses the issues of urgent medication and clinical needs of beneficiaries. This protocol should directly and clearly impart expectation of response by programs, and when referral to EDs or crisis teams or other resources are appropriate. Tracking, reporting and regular evaluation of the data is also imperative for informing resource allocation decisions.

- The MHP needs to adequately staff and empower the compliance/QI section that seeks to identify streamline documentation practices. This will target redundancies in process and documentation inefficiencies which create barriers to quick treatment, and potentially alienate beneficiaries with repeating their histories on multiple occasions. Streamlining also reduces the likelihood of re-traumatizing individuals who have been victimized.

- The MHP's compliance communication activities should test MHP direct presentation to clinic/program sites, partnering with contact agency QI staff,

which will provide the ability to clarify protocol changes and provide clarification of complex issues.

- The QIWP needs greater identification of measurable objectives, such as timeliness measures that incorporate baseline data and target goals for improvement. The resultant data needs routine, periodic review by the QIC or relevant subcommittees, or blended forums of leadership and QI.

- Consider opportunities to integrate mandated outcome instruments and other requirements– such as the CANS and ANSA – with the initial assessment and assessment update formats, which creates a more coherent workflow decreases redundancy and loss of available clinical hours.

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

- The MHP and its providers need to perform targeted monitoring of programs, particularly those serving non-English speaking populations, to ensure that cultural attitudes and beliefs of clinical staff are not adversely impacting beneficiaries' treatment experiences. Receptiveness to wishes regarding treatment alternatives to medications is an important consideration, as other beneficiary-driven treatment options. This may require special attention to physician/prescriber staff among others.

- Continued efforts to connect with and gain input from peer support specialists and other lived experience employed individuals remains a priority for this MHP to pursue, building upon the successful work with POCC members.

- Initiate an InSyst system replacement RFP process that includes a key core project team as soon as practical. The core team leadership needs to include: The Executive Sponsor, Overall Project Director/Manager, Clinical Project Manager, and Technology Project Manager. Additional subject matter expertise to be assigned as the project plans develop and unfolds.

FY 2018-19 Foster Care Recommendations:

- Per SB 1291 prescription related monitoring, the MHP needs to continue its advocacy with DHCS to obtain all prescribing, laboratory, and any other needed Medi-Cal claiming activity within three months of service delivery so that it is able to monitor services delivered by contract providers who may not utilize easily accessible laboratory services or pharmacies.

- Complete process for production of routine report that tracks the HEDIS ADD follow-up evaluation of prescribing of stimulant data regarding.
- Participate in the completion of the FFA/TFC RFA process and selection of providers, furnishing TA throughout the process.
- Continue involvement in the STRTP process, providing monitoring and TA throughout the selection and utilization of contracted programs.

Carry-over and Follow-up Recommendations from FY2017-18:

- Quality and Compliance (revised): The MHP's efforts to prepare for DMC-ODS waiver needs and Final Rule/Network Adequacy requirements has had a considerable impact on QI and compliance resources. Efforts to functionally integrate process and documentation streamlining efforts require consistent, dedicated staffing, that can be sustained in the presence of competing demands. In addition, dentification of QI/QA MHP representatives that are empowered to meet simultaneously with contract agency QI and line staff at program sites will help to identify and clarify policy change areas and furnish feedback that can assist in prioritizing streamlining and efficiency actions.
- Consumer Involvement (revised): The MHP's efforts to effectively re-engage lived experience stakeholders from POCC merits continuation and expansion to target the inclusion of other lived-experience staff, such as peer support specialists and family advocate representatives employed both directly by the MHP and by contact agencies.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - Alameda MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Family Member Focus Group(s)
Consumer Employee/Peer Employee/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Community-Based Services Agencies Group Interview
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Wellness Center Site Visit
Contract Provider Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Rob Walton, Quality Reviewer
Della Dash, Senior Quality Reviewer
Saumitra Sengupta, Executive Director EQRO
Bill Ullom, Chief Information Systems Reviewer
Gloria Marrin, Consumer-Family Member

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

Sites of MHP Review

MHP Sites

Alameda County Behavioral Health Care Services
2000 Embarcadero Cove
Oakland, CA 94606

Path Integrated Health Clinic
7200 Bancroft Avenue, Suite 125 “C”
Oakland, CA 94605

Health Care Services Agency
500 Davis Street
San Leandro, CA 94577

Contract Provider Sites

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

La Clinica
1415 Fruitvale Avenue
Oakland, CA 94601

Bay Area Community Services (BACS) – The Spot Wellness Center
629 Oakland Avenue
Oakland, CA 94611

Rolland and Kathryn Lowe Medical Center / Asian Health Services
835 Webster Street
Oakland, CA 94607

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Alder	Veronica	POCC	BHCS
Anderson	Gary	SUD Coordinator	Options Recovery
Arenius	Gregory	ISA	BHCS
Artiles	Edgardo	POCC	BHCS
Artiles	Sonia	POCC	BHCS
Banks	Kevin	Peer Advocate	ACBHCS
Becker	Daniel	Clinical Director	Options Recovery
Becton	Neisha	Executive Director	Pathways To Wellness
Berkam	Engodaw	Care Manager Clinician	CSS
Black	Bernice	POCC	BHCS
Blake	Ben	COO	BACS
Branagh	Fiona	Director Network Office	BHCS
Briggs	Terriana	Peer Support Specialist	Bonita House
Bruno	Jo	Public Policy Education and Chair	PPEC & CAMHPRO
Bucholtz	Steven	Mental Health Specialist II	ACBHCS
Bunce	Dale	POCC	BHCS
Burton	Carol	Director	BHCS
Burton	Dominique	Dep	HCSA
Capece	Karen	Division Director, UM	BHCS
Chapman	Aaron	Medical Director	BHCS
Chavez	Mateo	Peer Counselor	BACS
Choo	Alyssa	Path Nurse Care Coordinator	BHCS
Clanon	Kathleen	Medical Director	HCSA
Cloutier	Mark	ED	HST

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Courson	Natalie	IS Director	BHCS
Cross	Traci	Network Office	BHCS
Daniels	Roger W.	Senior Director	Fred Finch Youth Center
DeVoss	Luann	Clinical Director	UCSF BHCO
Diaz	Elizabeth	Clinician I	BHCS
Diedrick	Sheryl	Information System Analyst	BHCS
Dumapias	Edilyn	Supervising Program Specialist	BHCS
Egan	Julia	Clinical Director	Telecare – Morton-Bakar
Engstrom	John	QI Manager	BHCS
Flores	Alma	POCC	BHCS
Flores	Linda	Sr. Planner MHSA	BHCS
Fone	Donna	QA Administrator	BHCS
Franck	Catherine	BHC Manager	BHCS
Fuller	Faith	Path Consultant	FAS Services
Furuzana	Adriana	Division Director	Felton Institute/FSASF
Furuzawa	Adriana	Division Director	Felton Institute/FSASF
Garcia	Sarai	Peer Counselor	BACS
Godoy	Shadia	QA Manager	AHS
Grolnic-McClurg	Steven	Mental Health Manager	City of Berkeley
Hall	Virginia	POCC	BHCS
Hall	Lorenza	Management Analyst	BHCS
Halloran	Nancy	Deputy Director – Care Connect	HCSA
Hanson	Dawn	Voc Rehab Counselor	ACBHCS
Hardmon	Ernest L.	POCC	BHCS

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Hogden	Mary	POOC Mngr	BHCS
Honeycutt	Shantell	PSC2	Stages/JAMR
Huerta	Amy	BH Clinician	Oakland Children's
Hyung-Lee	Sun	Program Specialist	BHCS
Iannuzzi	Christi	Director of Implement	Alameda Care Connect
Jacob	Ebony	Interim Coordinator	BHCS
Jennings	Vanessa	Path Peer Health Educator	BHCS
Johns	Jeffrey	Medical Director	City of Berkeley
Johnson	Bonnie	PSCII	Strides
Jones	Sharon	Sr. Program Contract Manager Network Office	BHCS
Jones	Kate	Director AOASOC	BHCS
Jones	Yvonne	Director AFBH	BHCS
Judkins	Andrea	Senior FFS	BHCS
Judkins	Andrea	Senior FSS	BHCS
Kong	Jenn	Team Lead – ICM	Telecare Changes
Kozi Arrington	Kenneth	Programs Outreach Coordinator	PEERS
Lai	Sophia	Sr. Program Specialist QI	BHCS
Lamas	Elena	POCC	BHCS
Lang, Jr.	Jackie	POCC	BHCS
Levine	Hal	Case Manager	Eden CSC
Ling	Jennifer	Program Specialist	BHCS
Lopez	Dulce	Behavioral Health Clinician	Alameda County Eden Children's Clinic
Louie	Jill	Budget	BHCS

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Loveseth	Sharon	QA/SUD	BHCS
Lynch	Tiffany	Admin Specialist	BHCS
Manuoleas	Peter	Interim Behavioral Health Director	La Clinica
Marshland	Susanna	Regional Vice President	Fred Finch Youth Center
Mazid	Sanjida	Workforce Edu Mngr	BHCS
McKetney	Chuck	Director HIS	HCSA
Meinzer	Chet	ISM	BHCS
Molley	Megan P.	QA	UCSFBCHO
Moore	Lisa	Supervising Financial Services Specialist	BHCS
Morales	Juliana	Peer Support Specialist	La Famila
Mullane	Jen	AOASOC Asst. Dir.	BHCS
O'Keefe	Kelley	PSCII	Telecare Change
Ochoa	Ana	Lead Case Manager	La Familia – IHOT
Ogle	Jane	Consultant	Sellers Dorsey
Olson	Scott	Regional Exec Dir	Seneca
Orozco	Gabriel	Management Analyst	BHCS
Orphanos	Maureen	Manager	BHCS
Pacana	Veronica	Employment Specialist	BACS
Pardo	Debbie	Clinical Pharmacist	BHCS
Perales	Joseph	Clinical Director	La Clinica
Pisani	Federico	ISM	BHCS
Rackmil	Jeff	CYASOC Director	BHCS
Randrup	Jerri	Communications	ACCC
Ratner	Robert	Housing Services Director	HCSA/BHCS

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Raynor	Charles	Director of Pharmacy	BHCS
Razanno	Theresa	Division Director	BHCS-Voc Svcs
Rios-Parada	Ramon	Program Supervisor	La Familia
Romano	Dennis	Exec. Dir.	ACCMHA
Ross	Diane	Clinical Supervisor	Abode Services - OH
Rowe	Kathryn	ISA	BHCS
Sacha	Suzie	Care Manager	BHCS
Saechao	Kao	Director	Asian Health Services
Saler	Barbara	Access Clinical Program Manager	BHCS
Sammis	Jeff	QA	BHCS
Sandez	Marina	POCC	BHCS
Sandus	Tony	QA	BHCS
Sass	Sarah	EPSDT Clinician	Ann Martin
Saucier	Amy	Clinical Review Specialist	BHCS
Schaechner	Lillian	OA Div	BHCS
Schrick	Juliene	Quality Manager	La Clinica
Schulz	Henning	Division Director – Case Management	BHCS
Shao	Jen	EPSDT Clinician	Ann Martin
Shepard	Teresa	QA	EBCRP
Silverman	Carol	Director Program Evaluation	Telecare
Smith	Anthony	Voc Specialist	BHCS
Smith	Trinia	Center Supervisor	Lifelong-Path
Smith	Freddie	Division Director	BHCS
Smith	Sandra	BHC Manager	BHCS

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Tenenbaum	Francesa	Director	Patient Rights Advocate
Thompson	DeAndre	Peer Counselor	BHCS
Thomson	Cleo	Case Manager	Bonita House
Tokhey	Khalil	Program Supervisor	BACS
Valdez	Heather	Program Manager	BACS
Vargas	Wendi	Network Office	BHCS
Wadson	Kate	Clinical Supervisor	CERT
Wagner	James	Deputy Director	BHCS
Ward	Michael	Sr. Director of Admin	BHCS
Wayne	Kimberly	Diversity Director	Seneca Center
Wedderburn	Charlene	Family Partner Specialist	Seneca
Wessner	Margaret	Assistant Program Director	Bonita House
Wilkins	Quincy	Management Analyst	CW
Williams	Donna	BHCII	BHCS
Wilson	Javarre	Ethnic Services Manager	BHCS
Wright	Lovely	BHCII	BHCS
Yau	Gladys	POCC	BHCS
Yuan	Eric	Dep Director IHCS	BHCS
Yuan	Eric	Dep. Directory Integrated Health	BHCS
Zone	Dominica	Center Manager	Lifelong-Path

Attachment C—Approved Claims Source Data

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

Table C1 shows the penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Alameda MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,816,091	147,196	3.86%	$703,932,487	$4,782
Large	1,848,772	68,086	3.68%	$362,898,987	$5,330
MHP	131,945	4,359	3.30%	$25,297,250	$5,803

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

Table C2. CY 2017 Distribution of Beneficiaries by ACB Cost Band
Alameda MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	19,660	89.40%	93.38%	$96,898,104	$4,929	$3,746	52.48%	56.69%
>$20K - $30K	1,148	5.22%	3.10%	$27,728,761	$24,154	$24,287	15.02%	12.19%

Attachment D—List of Commonly Used Acronyms

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

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

YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Alameda	
PIP Title: Developing Culturally Informed Quality Psychiatric Protocols for Latinos	
Start Date March 2017 **Completion Date** March 2018 **Projected Study Period**: 12 Months **Completed**: Yes ☐ No ☐ **Date(s) of On-Site Review** 10/30/11-1/2018 **Name of Reviewer**: Rob Walton	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☒ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP targeted improving the medication services provided to Hispanic/Latino beneficiaries through the inclusion of a linguistically and culturally competent individual in the session.	