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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

ALAMEDA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on access, timeliness, and quality of 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 considers 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) 2020-21 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) 2019 — 21,372

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

CalEQRO obtained the MHP threshold language information from the DHCS Information Notice (IN) 13-09. The MHP also recognizes Tagalog and Arabic as threshold languages, in accordance with more recent Medi-Cal eligibility data.

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.

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed Assembly Bill (AB) 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and BHINs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

(AAS) and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, CalEQRO will review AAS and ONA information as part of its annual EQR.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

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:

- 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 five domains: access to care, timeliness of services, quality of care, beneficiary

progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

Made clear plans and is in the early stages of initiating activities to address the recommendation; or

Addressed some but not all aspects of the recommendation or related issues.

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

Recommendations from FY 2019-20

PIP Recommendations

None noted.

Access Recommendations

Recommendation 1: Evaluate ACCESS Call Center staffing capacity and response times, adding additional staff as needed.

Status: Met

- The Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) program evaluated staffing capacity and determined additional staff were necessary to maintain adequate response times. ACCESS approved and initiated hiring for up to two full time equivalents (FTE) in the role of clinical review specialist, commonly a part-time position; however, the lack of

qualified applicants resulted in only two new hires. Despite the new additions, ACCESS remains short-staffed due to retirements.

- ACCESS initiated a new round of hiring, which was then delayed due to the Coronavirus (COVID-19) pandemic. In July 2020, ACCESS was permitted by Human Resources (HR) to appoint provisional staff until the new civil service exam could be given. HR is actively recruiting to fill vacancies.

- The ACCESS Division Director continues to review ACCESS' monthly outcomes to determine further increases in staffing. The MHP meets the 10-day requirement 86.3 percent of the time for the entire system of care (SOC) with an average length of time of 6.63 days.

Recommendation 2: Develop and implement a level of care screening tool/checklist and protocol for ACCESS Call Center staff to use to ensure consistency of call responses and appropriate level of care referrals.

Status: Met

- The ACCESS program and the Adult SOC collaborated with the Quality Improvement Committee (QIC), consumer leadership (including Office of Consumer Empowerment), CBO providers, and the Office of Family Empowerment (OFE) Manager to develop a level of care screening tool and protocol." The new tool and protocol determine the appropriate level of care for beneficiaries.

- ACCESS staff piloted the tool in October 2020. Feedback was expected in November 2020 and then will be incorporated when the tool is expanded to the entire ACCESS program.

Timeliness Recommendations

Recommendation 3: Complete the implementation of the new timeliness policy and data tracking processes for network adequacy across the entire SOC, including the production and furnishing of performance data reports to Quality Improvement (QI) and leadership teams for use on system and program management and resource allocation determinations. *(This recommendation is a carry-over from FY 2018-19.)*

Status: Partially Met

- The MHP completed the implementation of the new timeliness policy and data tracking processes for network adequacy across the entire SOC, including the production of a timeliness performance dashboard.

- Timeliness performance data was presented to the QIC timeliness workgroup throughout the year; however, the data submitted was incomplete. The workgroup determined that the reports were insufficiently accurate to share with leadership teams for the purpose of system, program management and resource allocation determinations.

- To help address the limited data availability, Information Systems (IS) and QI are collaborating to create timeliness completion reports by provider and month showing overall timeliness completion rate by program and a beneficiary level report by program.

- The workgroup also plans to add reports on disparities based on geography, demographics, and the connection rate of referrals to services to the timeliness dashboard.

Recommendation 4: Increase the percent of beneficiaries meeting the 7-day post-hospitalization follow-up standard.

Status: Partially Met

- The MHP's Assessment of Timely Access FY 2020-21 indicates that 32 percent of post-hospitalization follow-up appointments meet the 7-day standard, with 30 percent for adults, and 62 percent for children. The prior year's submission, FY 2019-20, showed that 33.6 percent of appointments overall met the standard, with 30.5 percent for adults and 51.8 percent for children.

- The MHP has implemented multiple initiatives to increase the percentage of beneficiaries meeting the 7-day post-hospitalization follow-up standard for outpatient services.

    - The MHP launched two post-crisis follow-up teams, Community Connections (connecting beneficiaries who are not securely housed and not currently linked to ongoing mental health treatment) and Familiar Faces (post-crisis follow-up services for beneficiaries who are high utilizers of psychiatric emergency services and mobile crisis team services).

    - The MHP developed a post-hospitalization dashboard that allows both program managers and clinicians to see aggregate post-hospitalization follow-up outcomes identifying individuals released from hospitals who may need follow-up care.

    - The QIC Performance Measurement and Management Group found that for adults the readmission rates were higher when open to case management.

- Although the adult SOC is conducting research to determine the reason for high readmission rates, the MHP is still analyzing data for actionable findings, including exploring whether post-hospitalization follow-up could be improved to prevent readmission.

Recommendation 5: Evaluate the reason(s) for the high hospital readmission rates for adults (20.2 percent) and foster care youth (26.5 percent).

Status: Met

- The QIC closely analyzed the hospital readmission rates in May 2020 through July 2020. The workgroup reviewed Alameda County's rates compared to 20 other counties' rates using data provided by BHC as they noted that Alameda has the highest readmission rates for both the 7-day and 30-day metrics.

- For adults, the MHP surprisingly found that the readmission rate was higher for beneficiaries who were already engaged in outpatient services. The workgroup examined the readmission rates for specific adult hospitals in Alameda County, and the adult SOC's program and clinical staff are now engaging in an in-depth chart review to identify specific reasons for readmission followed by trending. The QIC continues to monitor this data.

- For FC beneficiaries, the QIC examined the readmissions rates for specific children's hospitals and found that the readmission rate was lower for beneficiaries who were engaged in outpatient services. Unstable placements and frequent moving contribute to higher rates of readmission.

Recommendation 6: Establish a standard for no-show rates for psychiatrists and clinicians, implementing it system-wide.

Status: Not Met

- As a first step, the MHP has established a system-wide 15 percent no show rate standard for psychiatrists and clinicians.

- Historically, the MHP was not able to establish a system-wide standard for no-show rates due to tracking issues related to its EHR. The MHP included the necessary scheduling functions in the specifications for the Request for Proposal for its new EHR with implementation planned for early 2021.

Quality Recommendations

Recommendation 7: Build sufficient dedicated QI and data analytic staffing and capacity necessary to fulfil the quality improvement requirements, separate and distinct from Quality Assurance (QA) and Utilization Management (UM), for both mental health and the Drug Medi-Cal Organized Delivery System (DMC-ODS) in this large and complex SOC. Consider reviewing the QI department structures and functions in similarly-sized Bay Area MHPs. (This recommendation is a carry-over from FY 2018-19.)

Status: Partially Met

- The MHP reviewed and compared its QI department structures and functions with other QI at a professional trade meeting in March 2020. The MHP's triennial audit peer reviewer also provided the MHP information on how Bay Area counties (including San Francisco, Marin, Contra Costa, and Solano) structure their quality improvement and data analytics functions.

- In August 2020, the MHP filled the Quality Management Program Director position, which has responsibilities to improve Quality Management (QM) structure, QI activities and data analytics functions, while IS continues to provide data analytic staffing for dashboards and reports.

Recommendation 8: Develop a formal structure for ongoing collaboration between QI and the IS, with full concurrence on decision-making regarding report and dashboard development and ongoing continuous system-wide quality improvement efforts. (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The QI meets with IS on a biweekly basis to rank and manage QI and QM priorities for report and dashboard development. IS established an online interface that allows QI to track and update these priorities at any time. Reports and dashboards created as a result include the timeliness dashboard, as well as the dashboards for the QI work plan performance outcomes.

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

Status: Met

- The QI manager and the QA interim administrator meet monthly to coordinate workflow efforts and to ensure consistency in messaging to providers and other units on areas such as network adequacy implementation.
- Since many of the QI monitoring activities are conducted by QA staff (including grievances and appeals, unusual occurrences, and clinical documentation standards), QA staff coordinate with QI to present these on a quarterly basis at QIC meetings. They also share trends and QI efforts with county and contract provider staff. QI ensures that QA is represented at all relevant QIC meetings to ensure coordination.
- QA and QI are co-located in the same suite, which facilitates frequent and informal coordination as needed.

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

Status: Met

- The FY 2020-21 QI work plan incorporates quantifiable performance metrics and baseline indicators into its QI activities, including key quality management metrics such as timeliness, hospital readmission, access to care (penetration rates), and quality of care.
- In addition, the QI work plan now includes an appendix which provides a more thorough analysis of disparities in services by looking at the Medi-Cal penetration rates for all age groups, analyzed by race/ethnicity, gender, language, and geographic region, as well as for FC beneficiaries and adults with disabilities.
- The appendix also includes data on timeliness (outpatient, psychiatry, and urgent requests), acute recidivism, and post-hospitalization outpatient follow-up.

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

Status: Met

- Since October 2019, the QIC agendas have included monthly review, analysis, and discussion of a comprehensive list of quality management metrics and their application for continuous system-wide quality improvement. Mental health metrics covered at QIC have included:
    - Performance outcomes for PIPs
    - Mental Health Consumer Perception Survey results
    - QI work plan mid-year evaluation
    - EQRO report summary, including performance measures
    - Medi-Cal penetration rates
    - Adult hospital recidivism
    - QI work plan including baseline indicators for performance outcomes measurements
- The QIC Performance Measurement and Management workgroup also discussed quality management metrics at its monthly meetings, including both adult and children's hospital readmission and follow-up rates.
- The QIC's timeliness workgroup similarly discussed timeliness metrics at its meetings, reviewing the timeliness information at its monthly meetings in May, June, and July 2020.

Beneficiary Outcomes Recommendations

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

Status: Partially Met

- The MHP does not formally aggregate CANS-50 or ANSA outcome data; however, performance outcome measurement dashboards (i.e., CANS-50, ANSA) display collective information on outcomes for departmental and system decisions.

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

Status: Met

- The MHP engaged in additional strategic planning and outreach to ensure there are sufficient beneficiaries and family members participating in this year's focus groups, especially in light of the pandemic.
- The MHP assigned a project coordinator consultant to work with the QI lead for the QIC beneficiary workgroup and family workgroup to manage this project. They worked to recruit more beneficiaries than requested to account for no-shows. In addition, they will partner with Pool of Consumer Champions (POCC) members to call or text individuals to provide courtesy reminders prior to the scheduled focus groups.
- The MHP coordinated with EQRO staff to schedule the focus groups at a time when attendees are more likely to be available to avoid virtual school time for those supporting school-age children during the day.
- Three focus groups were held, with a combined total of 14 attendees. Conditions beyond the MHP's control including COVID-19 restrictions and the shift to a video conference format likely had a significant impact on the attendance numbers.

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

Status: Partially Met

- The MHP's Office of Consumer Empowerment (OCE), office of the medical director, and Mental Health Services Act (MHSA) workforce education and training officer are collaborating to develop a training for prescribers on informed consent and beneficiary input regarding treatment alternatives to medication. They are coordinating with the POCC Asian American Committee to outreach to API beneficiaries. Once the training is scheduled, the MHP will also reach out specifically to organizations serving API beneficiaries to encourage participation.
- The OCE is also reviewing the informed consent policy and procedures to revise as needed.

Foster Care Recommendations

None noted.

Information Systems Recommendations

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

Status: Met

- The MHP included an expansion of Yellowfin software and other performance measurement dashboards as a QI project in its QI work plan both for FY 2019-20 and FY 2020-21. These projects included the following action items:
    - Create or improve Yellowfin dashboards that enable providers to review performance data for quality improvement, including hosting a public website with aggregate performance dashboards.
    - Improve the process for connecting providers to Yellowfin accounts for provider specific and beneficiary-level data, in coordination with the IS network team and privacy officer to publish a guide.

  - Distribute access to providers – both entities and individuals – who are not yet on Yellowfin.
  - Provide regular trainings for providers to support and improve utilization of Yellowfin data.
  - Create a public-facing data dashboard.

- During FY 2019-20, IS piloted Yellowfin access for two new agencies and five new contract provider staff and is in the process of determining the impact of access on privacy protection.
- IS hosted weekly "Yellowfin hours" to provide one-on-one assistance for Yellowfin users; at least two contract providers attended during FY 2019-20.
- In April 2020, IS, the security team, and the MHP's privacy officer developed a Yellowfin request form and work-flow to coordinate the processing of Yellowfin access requests from contract providers. This team is currently working to increase automation of the process while ensuring that privacy and security frameworks are in place.
- At the August 2020 QIC meeting, the IS manager presented an overview of Yellowfin, its uses, and the procedures for requesting access to Yellowfin to provide MHP staff and contracted providers with more information.

Structure and Operations Recommendations

Recommendation 16: Further improve two-way communication throughout the SOC, ensuring opportunities for dialogue and consistent messaging with county-operated and contracted staff and leadership. This is particularly important with regards to ongoing changes in policies/protocols for contract providers, and transparency/inclusion in the upcoming strategic planning process.

Status: Met

- The MHP has improved its two-way communications with contracted providers and staff through the following activities:
  - Creating a position for a public information officer reporting to the director; this position is expected to be filled this coming year.
  - Requiring the review of all systemwide communication to contract providers and staff by the deputy director to ensure consistency and clarity of messaging.

- Providing daily updates on announcements through the MHP website, including memoranda on strategic planning, the reorganization of leadership structure and the reorganization of the children's SOC.
- Communicating announcements at joint MHP and provider stakeholder forums.

Recommendation 17: Implement a communication strategy and plan to support new EHR and billing system RFPs as the project will be a multi-year effort and ongoing communications with staff, providers, and stakeholders critical to support successful project implementation.

Status: Met

- See response to recommendation number 16 above regarding how the MHP is improving its strategic communications for significant initiatives. The MHP is streamlining communication for the EHR and billing system through the deputy director for plan administration position, as this position has responsibility for information systems, billing, and related areas.

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

Status: Met

- The MHP has improved representation of beneficiaries and families in system planning and implementation throughout all levels within the SOC, including the following:
  - QI: In Fall 2019, the QIC created two new workgroups for CFMs, managed by a QI staff person with lived experience as a beneficiary and family member. These workgroups review and provide feedback on all proposed systemwide policies and procedures, performance improvement projects, and QI work plan documents. In addition, these workgroups developed several QI initiatives presented at the QIC in August 2020 and incorporated into the QI work plan for FY 2020-21.
  - Fiscal: The MHP established a new budget stakeholder advisory committee to provide input on MHP strategies and priorities in budget and financial planning. The stakeholder advisory committee supports the decision-making of the budget executive (senior leadership) and budget workgroup (MHP staff). The stakeholder advisory committee includes a beneficiary, a family member, as

well as contract providers and federally qualified health center representatives.

- MHSA: The community program planning process for the FY 2020-23 Plan included focus groups for beneficiaries and other opportunities for beneficiary and family member involvement.
- Office of Ethnic Services (OES): The MHP revised its cultural responsiveness committee governance charter to include a position for at least one beneficiary and one family member representative. As a result, the committee currently includes both beneficiary and family member representation.
- Criminal Justice Programs: The local advisory committee under Proposition 47 oversees MHP state-funded criminal justice re-entry treatment. On an ongoing basis, the MHP recruits representatives with criminal justice lived experience for the five community member positions on the committee.

- To improve representation from communities of color and ethnicities that do not generally participate, the OCE and POCC outreach to and engage beneficiaries from diverse communities to participate in system planning and implementation. The MHP has over 80 beneficiaries participating in fifteen POCC committees and other MHP committees.

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

Status: Met

- The OCE manager and the OFE manager both participate in the monthly department operational leadership meeting, which includes clinical operations and other department leaders such as quality management, fiscal, information systems, and integrated health.
- The MHP will add a new health equity director to the executive team. This position will oversee the OCE, OFE, OES, and Patients' Rights and will represent stakeholder perspectives at executive level meetings.

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

Status: Met

- During FY 2020-21, the MHP has added multiple peer employee positions within its SOC to enhance service quality and capacity by leveraging the knowledge and lived experience of these staff members. These peer employee additions include two mental health specialists with lived experience on the new mobile crisis teams, Community Connections and Familiar Faces.
- The OCE manager is working with the department director and HR to develop a new mental health peer support specialist job classification within the MHP. The OCE is drafting policies and essential duties for the classification

PERFORMANCE MEASURES

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

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

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

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx

3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- 5A (1&2) Use of Psychotropic Medications

- 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, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- 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).

- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found athttps://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

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 Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, 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: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Alameda MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Beneficiaries	Percentage of Medi-Cal Beneficiaries	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
White	44,907	10.8%	3,355	15.7%
Latino/Hispanic	124,595	29.8%	5,981	28.0%
African-American	73,240	17.5%	6,259	29.3%
Asian/Pacific Islander	95,929	23.0%	1,630	7.6%
Native American	1,030	0.2%	102	0.5%
Other	77,786	18.6%	4,045	18.9%
Total	**417,484**	**100%**	**21,372**	**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.				

Table 2 provides details on beneficiaries served by threshold language identified in DHCS IN 13-09. The MHP also recognizes Tagalog and Arabic as threshold languages, in accordance with more recent Medi-Cal eligibility data.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Alameda MHP		
Threshold Language	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
Spanish	3,652	17.1%
Cantonese	248	1.2%
Vietnamese	136	0.6%
Mandarin	52	0.2%
Other Languages	17,284	80.9%
Total	**21,372**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

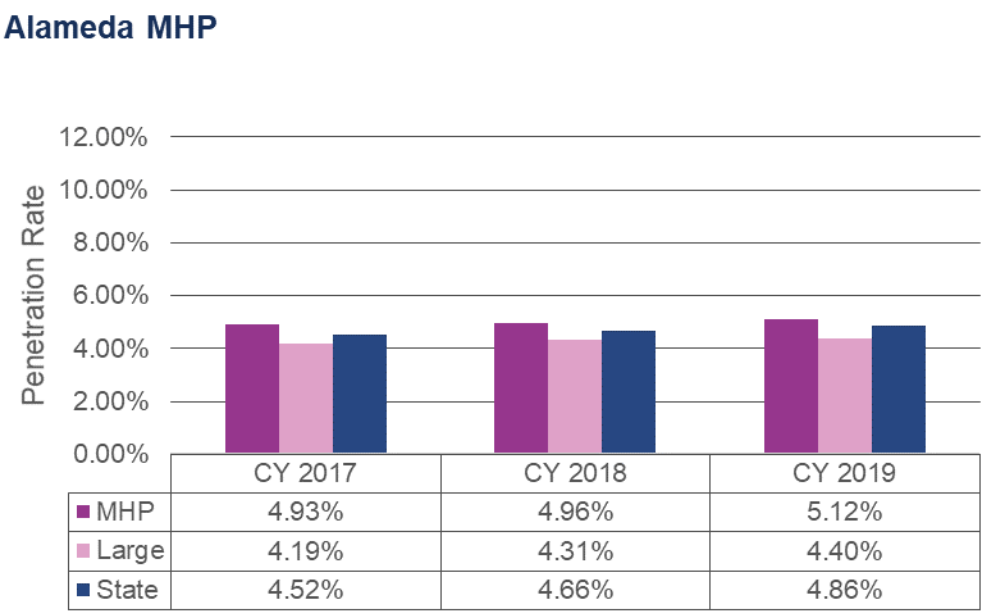
Penetration Rates and Approved Claims per Beneficiary

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 2019. See Table C1 for the CY 2019 ACA penetration rate and ACB.

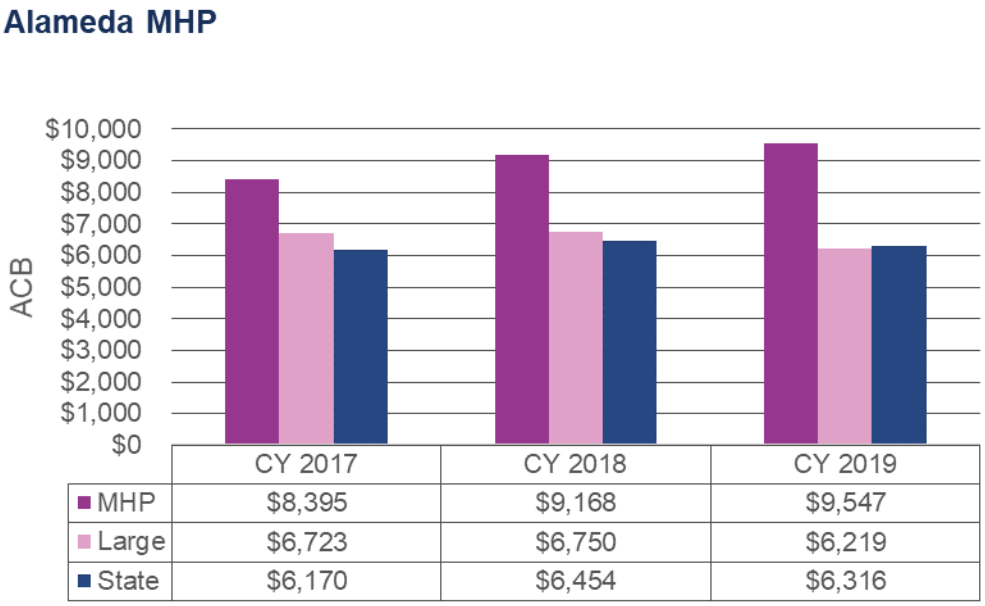
Regarding the calculation of penetration rates, the Alameda MHP uses a different method than that used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	4.93%	4.96%	5.12%
Large	4.19%	4.31%	4.40%
State	4.52%	4.66%	4.86%

Figure 2: Overall ACB CY 2017-19



Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19

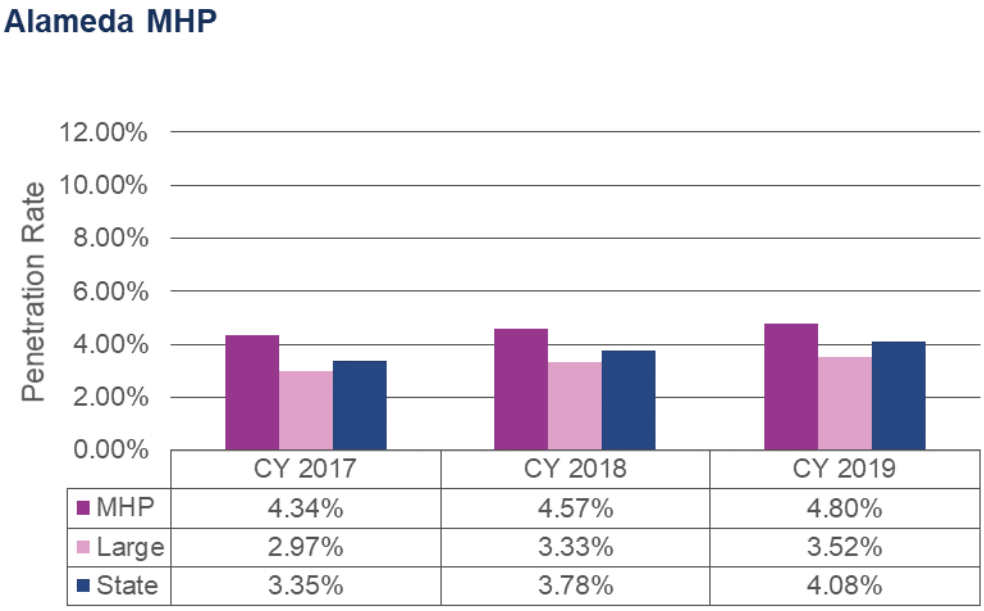
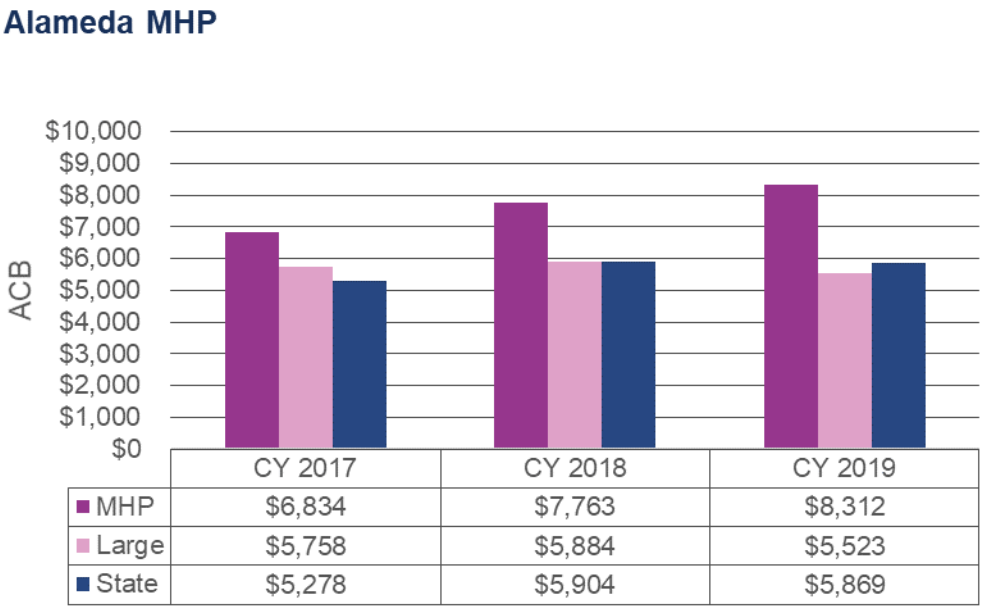


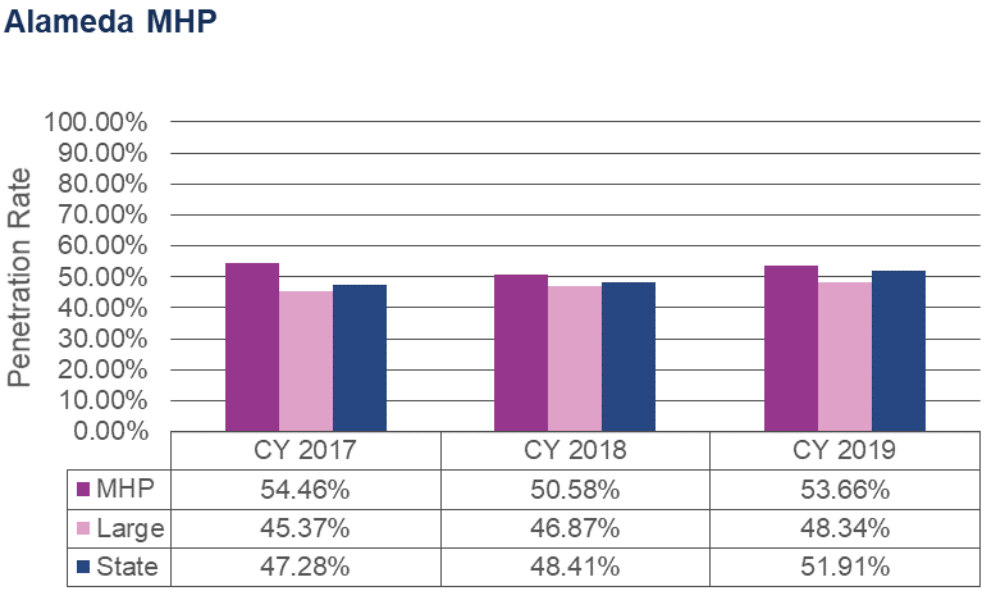
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,834	$7,763	$8,312
Large	$5,758	$5,884	$5,523
State	$5,278	$5,904	$5,869

Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

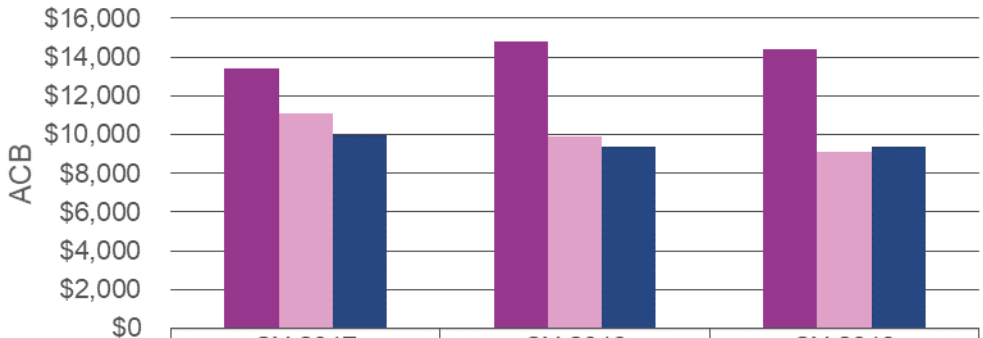
Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	54.46%	50.58%	53.66%
Large	45.37%	46.87%	48.34%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

Alameda MHP

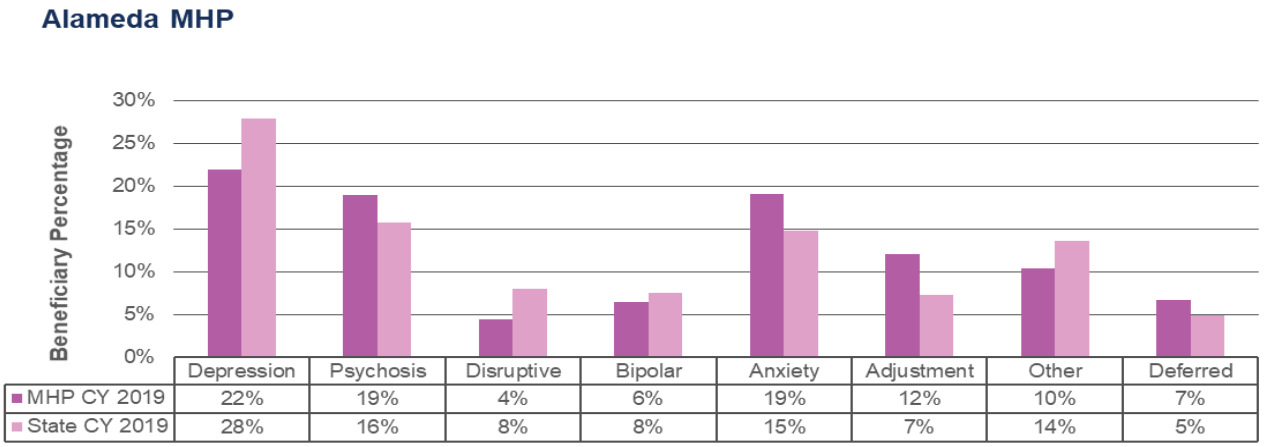


	CY 2017	CY 2018	CY 2019
MHP	$13,396	$14,803	$14,418
Large	$11,064	$9,895	$9,125
State	$9,962	$9,340	$9,360

Diagnostic Categories

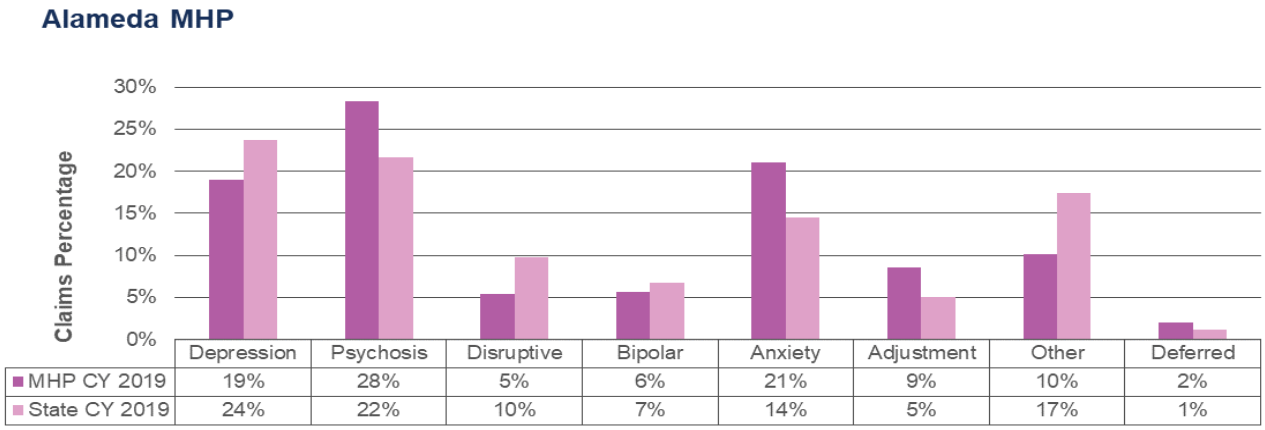
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	22%	19%	4%	6%	19%	12%	10%	7%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	19%	28%	5%	6%	21%	9%	10%	2%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Alameda MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	1,454	21,372	6.80%	$55,267	$80,358,031	39.39%
	CY 2018	1,413	21,657	6.52%	$54,245	$76,648,595	38.60%
	CY 2017	1,183	21,991	5.38%	$50,715	$59,996,380	32.50%

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 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

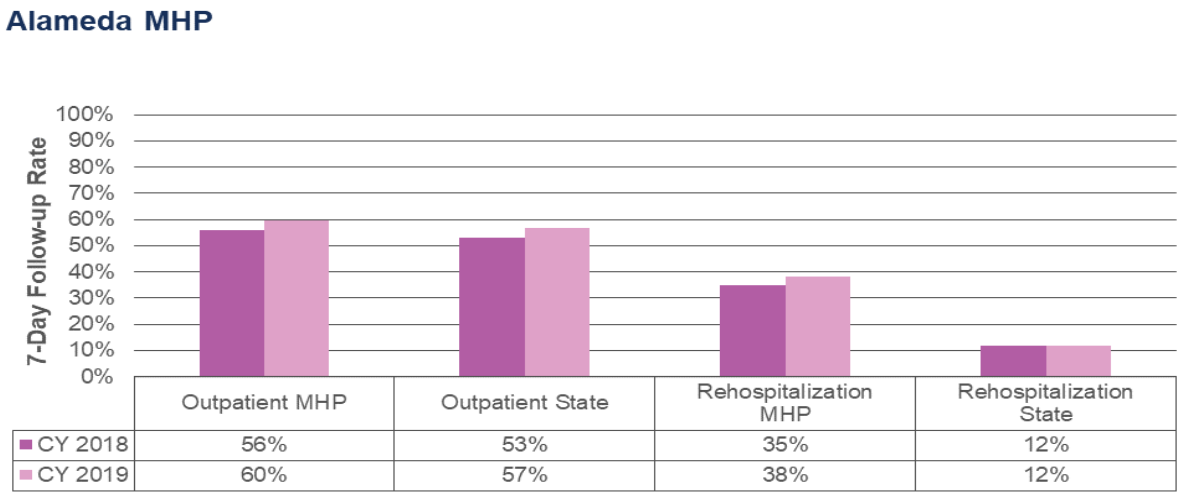
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Alameda MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	1,991	6,674	6.46	7.80	$14,698	$10,535	$29,263,228
CY 2018	2,150	5,610	6.71	7.63	$13,580	$9,772	$29,196,526
CY 2017	2,207	5,684	6.39	7.36	$10,834	$9,737	$23,910,126

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

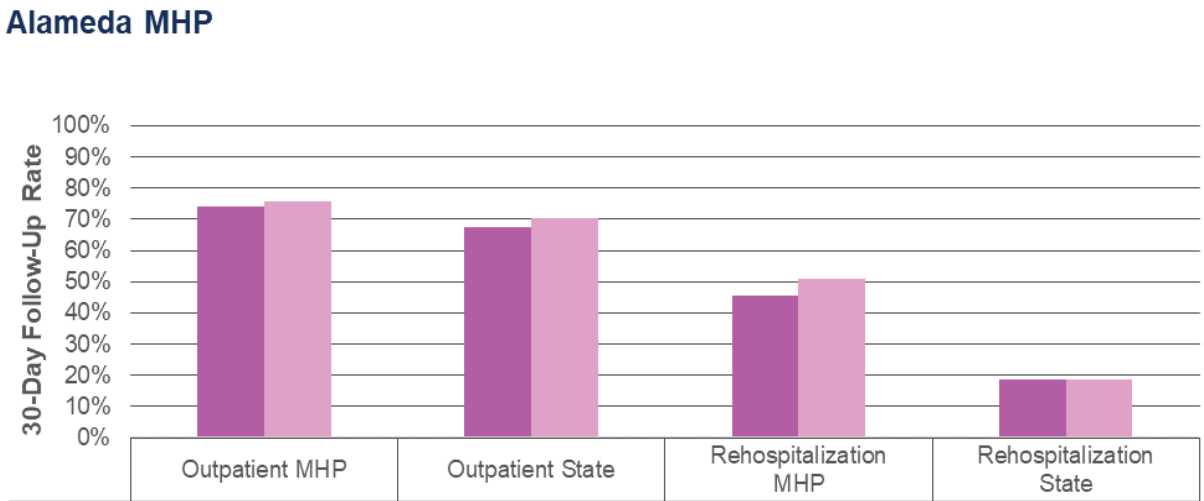
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	56%	53%	35%	12%
CY 2019	60%	57%	38%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	74%	67%	45%	19%
CY 2019	76%	70%	51%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

Alameda MHP PIPs Identified for Validation

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

Table 5: PIPs Submitted by Alameda MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Reducing Psychiatric Emergency Services Recidivism Through Mobile Diversion Teams
Non-Clinical	1	Using Language Line to Improve Penetration Rates

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Alameda
PIP Title	Reducing Psychiatric Emergency Services Recidivism Through Mobile Diversion Teams
PIP Aim Statement	"This PIP will determine whether deploying a mobile team pairing a licensed behavioral health clinician with an emergency medical technician that transports clients to appropriate alternative services in response to 911 behavioral health emergency calls can reduce psychiatric emergency services admissions and recidivism for adults over a thirty-month period."
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	Alameda
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The eligible population for this program is all individuals in Alameda County referred through the county's 911 call center system who are experiencing a mental health crisis, not in need of emergency medical services, and assessed by law enforcement to be in a "safe" situation. The target population is individuals who are users of psychiatric emergency services (PES) and receive emergency medical services (EMS).	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Deploy crisis transport teams in response to 911 calls for behavioral health crises to connect beneficiaries to appropriate alternative services.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): 1. Use beneficiary community health record to support care coordination. 2. Use Reddinet, a web-based emergency communications system that provides up-to-date information regarding services availability.

Table 8: Performance Measures and Results – Clinical PIP

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percent of beneficiaries who end up on involuntary holds at PES.	FY19-20	82.2%	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Rate of readmission to PES within 7, 30, and 60 days.	FY19-20	16.1% (7-day) 34.6% (30-day) 43% (60-day)	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of beneficiaries who connect to outpatient services within 7, 30, and 60 days after discharge from PES	FY 19-20	20.1% (7-day) 27.3% (30-day) 29% (60-day)	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of EMS Mental Health Calls that result in 5150s	FY 19-20	TBD	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Was the PIP validated? ☒ Yes ☐ No

Validation phase:

☐ PIP submitted for approval

☐ Planning phase

☒ Implementation phase

☐ Baseline year

☐ First remeasurement

☐ Second remeasurement ☐ Other (specify):
Validation rating: Though the PIP is early in activation, the PIP is rated as having “moderate confidence.” PIP planning is well set-up and likely to yield intended results. ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: None currently. This PIP is straightforward in its goal, planned intervention and measures. Alameda County has the highest rate of 5150 holds in California. Beneficiaries who do not qualify for hospitalization often are not connected to more appropriate outpatient services, so they continue to over-use emergency services. Alameda County also has the highest rate in the state of psychiatric hospital readmission rates within 7 and 30 days. The improvement strategy is to implement crisis transport teams with access to updated beneficiary and services information to connect beneficiaries to appropriate services as an alternative to PES. The COVID-19 pandemic has significantly impacted MHP services and operations from March 2020 to the present and as a result, baseline data would provide an incomplete picture of true impact of the intervention(s).
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: TA provided during the review focused on the development of new PIP ideas as the MHP was encouraged to do by CalEQRO. Ideas included the API Low Penetration rate and possibly using primary health collaboration to reduce stigma, reducing recidivism in psychiatric hospitals, and looking at Full-Service Partnership (FSP) in and outpatient case managers to increase engagement. Also considered was an evaluation on the increased number of emergency room (ER) visits that do not have a follow-up physical health appointment with an intervention of care coordination and development of a case management tool to identify those who need exams. CalEQRO recommended that a thorough barrier analysis be completed to correctly identify causes and contributors to the identified problems. Following a barrier analysis, CalEQRO recommends that the intervention be chosen based on the causes identified, and not before.

*PIP is in planning and implementation phase if n/a is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Alameda
PIP Title	Using Language Line to Improve Penetration Rates
PIP Aim Statement	"Does implementing a language assistance line for all providers and services improve the penetration rates for beneficiaries whose primary language is not English, especially for Asian and Pacific Islander languages, within a 19-month period?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The study population for this PIP is all beneficiaries whose primary language is not English, with special focus on the API language speakers.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1) Implement language line for all providers and services.

PIP Interventions (Changes tested in the PIP)
2) Train and redeploy providers to use best practices for phone interpretation services. 3) Implement video remote interpretation for pilot providers.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Develop MHP policy requiring all providers use language line to accommodate all language needs.

Table 11: Performance Measures and Results – Non-Clinical PIP

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Performance measures (be specific and indicate measure steward and NQF number if applicable):	Base line year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Medi-Cal Penetration Rate for beneficiaries whose primary language is not English	FY18-19	2.70% (5,266/195,186)	☐ Not applicable—PIP is in Planning or implementation phase, results not available Final Measurement: 10/2019 – 9/2020	2.51% (4,574/182,593)	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): The MHP did not present any significance testing.
Medi-Cal Penetration Rate for API beneficiaries whose primary language is not English	FY18-19	1.23% (724/59,098)	☐ Not applicable—PIP is in Planning or implementation phase, results not available Final Measurement: 10/2019 – 9/2020	1.17% (655/55,938)	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): The MHP did not present any significance testing.

Number of providers who served an API beneficiary whose primary language is not English	FY18-19	Language / Arabic 1 / Cambodian 6 / Cantonese 26 / Farsi 7 / Japanese 2 / Korean 8 / Lao 3 / Ilocano 2 / Mandarin 11 / Mien 1 / Other Chinese 1 / Samoan 2 / Spanish 11 / Tagalog 18 / Thai 1 / Vietnamese 24	☐ Not applicable—PIP is in Planning or implementation phase, results not available Final Measure: 10/2019 – 9/2020	Language / Arabic 3 / Cambodian 8 / Cantonese 23 / Farsi 10 / Japanese 2 / Korean 5 / Lao 3 / Ilocano 2 / Mandarin 13 / Mien 4 / Other Chinese 3 / Samoan 1 / Spanish 11 / Tagalog 7 / Thai 12 / Vietnamese 24	☐ Yes ☐ No Mixed.	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): The MHP did not present any significance testing.
The median number API beneficiaries whose primary language is not English served per provider	FY18-19	3 beneficiaries /provider	☐ Not applicable—PIP is in Planning or implementation phase, results not available Final Measure: 10/2019 – 9/2020	4 beneficiaries /provider	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): The MHP did not present any significance testing.

Was the PIP validated? ☒ Yes ☐No

Validation phase:

☐ PIP submitted for approval

☐ Planning phase

☐ Implementation phase

☐ Baseline year

☐ First remeasurement

☐ Second remeasurement

☒ Other (specify): Closure

Validation rating:

☐ High confidence

☐ Moderate confidence

☒ Low confidence. The MHP carried out the PIP with acceptable methodology for the design and data collection phases, and interpretation of results. The interventions did not

have the intended positive effect, thereby disallowing the intervention's application to the larger system. ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The EQRO recommends more frequent data analysis. While the data collection occurred monthly, the analysis of the data did not occur often enough for the MHP to course correct considering the little impact of interventions. The MHP should consider expanding the barrier analysis during the planning phase and using pilot projects before undertaking a PIP on a larger scale for submission to the EQRO. The improvements may have resulted from the PIP interventions, but the impact was diminished by COVID-19 and the overall declining penetration rate.
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: TA provided during the review focused on the development of new PIP ideas. Ideas included addressing the API Low Penetration rate and possibly collaborating with primary health to reduce stigma, reduce recidivism in psychiatric hospitals, and evaluating FSP in- and out-patient case managers to increase engagement. Also considered was an evaluation on the increased number of ER visits that do not have a follow-up physical health appointment. CalEQRO recommended that a thorough barrier analysis be completed to correctly identify causes and contributors to the identified problems. Following a barrier analysis, CalEQRO recommends that the intervention be chosen based on the causes identified, and not before.

*PIP is in planning and implementation phase if NA is checked.

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 responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key ISCA Information Provided by the MHP

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

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Alameda	3.67%	2.43%	2.33%	2.50%
Large MHP Group	N/A	2.81%	2.59%	2.88%
Statewide	N/A	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

- ☐ Under MHP control
- ☐ Allocated to or managed by another county department
- ☒ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the MHP uses an Application Service Provider (ASP) model to host EHR system which provides 24-hour operational support.	☐ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☒ Yes	☐ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	19.27%
Contract providers	79.87%
Network providers	0.86%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

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 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	38	0	3	6
2019-20	41	13	2	4
2018-19	29	2	0	1

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	7	0	1	0
2019-20	8	2	4	0
2018-19	11	5	2	5

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

- The decrease in FTE positions is due to budget challenges because of the COVID-19 pandemic.
- Temporary staffing is used to augment data analytics staffing when workload and workflow require additional support.

- The Information Systems Unit (ISU) manages MHP applications including InSyst, Clinicians Gateway and eCura, and the technical infrastructure supporting access to these systems.
- The data services team within ISU is responsible for data management, research, evaluation analytics and modeling. They also develop performance measurement dashboards and reports through Yellowfin.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by the MHP and does not account for users' log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	168	175	343
Clinical Healthcare Professional	480	857	1,337
Clinical Peer Specialist	0	97	97
Quality Improvement	18	32	50
Total	666	1,161	1,827

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Large MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	38.00	37.85
Total EHR Users Supported by IT (Source: Table 17)	1827.00	2084.00
Ratio of IT Staff to EHR Users	1:48	1:55

- The staff ratio of 1:48 versus large MHP average 1:55 is consistent with the IT budget noted in Table 12 for a Bay Area county.
- To further assess the IT staff level of EHR support refer to tables 19, 20, and 21 for additional information.

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
The MHP utilizes an ASP model to support EHR operations.	☐ Yes	☒ No
The MHP also utilizes QI staff to directly support EHR operations.	☐ Yes	☒ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☒	☐	☐
Screen workflow and navigation	☐	☒	☐	☒

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	259
Number of county-operated telehealth sites	15
Number of contract providers' telehealth sites	244
Total number of beneficiaries served via telehealth during the last 12 months	7,697
Adults	2,954
Children/Youth	4,431
Older Adults	312
Total Number of telehealth encounters (services) provided during the last 12 months:	65,315

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

- ☒ Hiring healthcare professional staff locally is difficult
- ☐ For linguistic capacity or expansion
- ☒ To serve outlying areas within the county
- ☒ To serve beneficiaries temporarily residing outside the county
- ☒ To serve special populations (i.e., children/youth or older adult)
- ☒ To reduce travel time for healthcare professional staff
- ☒ To reduce travel time for beneficiaries
- ☒ To support NA time and distance standards
- ☒ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- MHP ISU assisted several hundred county employees with hardware and software requests so that they could work from home due to COVID-19.
- Citrix infrastructure, in place for many years, had many more accounts created to support the COVID-19 response.
- Teams and Zoom are the video conferencing platforms used to deliver telehealth services.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☒	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☒	Mandarin	☒	Other Chinese
☐	Russian	☒	Spanish	☒	Tagalog
☒	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Serving beneficiaries 20 or younger	215
Serving beneficiaries 21 and over	200
Total	244

Current MHP Operations

- The MHP continues to use several legacy systems to support clinical, billing, and managed care operations.
- The MHP relies on and continues to expand its use of the Yellowfin application for business intelligence reporting as it is integral to support a data warehouse which includes data from the legacy systems noted in Table 24 along with other department beneficiary-level data.
- In August 2020, the MHP published an RFP to procure an enterprise technology solution(s) to replace its legacy billing and fee-for-service (FFS) managed care systems.

Table 24 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 24: Primary EHR Systems/Applications

System/ Application	Function	Vendor/ Supplier	Years Used	Hosted By
Clinicians Gateway	Clinical Record	Krassons, Inc	13	MHP/ County ISD
InSyst	Practice Management	Echo	30	MHP/ County ISD
eCura	Managed Care	InfoMC	21	MHP/ County ISD
RxNT	e-Prescribing	Networking Technology, Inc	11	Vendor
Yellowfin	Business Intelligence	Yellowfin	4	Vendor
Imaviser	Document Imaging	Krassons, Inc	11	MHP/ County ISD
Objective Arts	CANS/ANSA/ PSC35	Objective Arts	5	Vendor

The MHP's Priorities for the Coming Year

- Complete RFP that was issued in August 2020 for a replacement of the InSyst billing system. Vendor selection is expected to happen in late December 2020. Contract finalization and project planning are scheduled for March through June 2021 with an estimated completion date of July 2023.
- Migrate the active directory of approved staff and contract providers to the MHP's system's domain to support better management of user permissions.
- Upgrade the eCura managed care system.

- Develop a customer relationship management system for substance use disorders (SUD) and homeless beneficiaries at the COVID-19 hotels for contact tracing and management.
- Implement a new timely access data tool (TADT) for NACT data reporting.
- Implement a new scheduling application for the Santa Rita Jail.
- Collaborate with HCSA on the Alameda County Care Connect and Thrasys, Inc. integrated community health record system to support data file uploads from the MHP.
- Develop Yellowfin public facing dashboards for contract provider access.
- Implement standards for exchange of data between organizations using the American National Standards Institute (ANSI) for electronic data interchange (EDI), including the 274 expansion which should simplify transmission of provider network data to DHCS and replace the State NACT form.
- Expand beneficiary e-signature via signature pads to treatment plans and release of information templates, including tracking in Clinicians Gateway.
- Incorporate lab results in Clinicians Gateway and enable the placement of lab orders and the receiving of test results electronically via Clinicians Gateway.
- Create a secure data portal for distributing reports to users via ShareFile.
- Recruitment of staff to fill vacancies.

Major Changes since Prior Year

- Migrated to multi-factor authentication.
- Migrated the confidentiality, security, and usage agreement and electronic signature agreement to an electronic form so that staff could submit it from home during shelter-in-place.
- Assisted several hundred county employees with hardware and software requests so that they could work from home during the COVID-19 pandemic.
- Upgraded all 3Par array storage systems to solid-state drives (SSD).

- Implemented Apttus services, a contract lifecycle management system for mental health systems, as needed and FFS contracts.
- Upgraded all MHP devices to Windows 10.
- Developed reports for timeliness monitoring.
- Started work to create a secure data portal for distributing reports.
- Started to implement a provider portal that has a public access component, i.e., webpage, as well as a secured community login for providers to view their information.

Other Areas for Improvement

- The rollout of Yellowfin to contract providers remains an unfinished project that began almost two years ago. The data warehouse includes tremendous volume of clinical, eligibility, and billing data that will validate and support decision-making process to improve contract provider operations.
- It is imperative that the ISU is adequately resourced to support the new system implementation project as well as manage all current legacy systems.

Plans for Information Systems Change

- The MHP is actively searching for a new system to replace its legacy billing and managed care systems, a project plan is in place and an external project management vendor has been retained.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Clinicians Gateway	☒	☐	☐	☐
Assessments	Clinicians Gateway	☒	☐	☐	☐
Care Coordination	Clinicians Gateway	☒	☐	☐	☐
Document Imaging/Storage	Clinicians Gateway – Imaviser	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Clinicians Gateway	☐	☒	☐	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service	Clinicians Gateway	☐	☒	☐	☐
Outcomes	Clinicians Gateway/ Objective Arts	☒	☐	☐	☐
Prescriptions (eRx)	Clinicians Gateway	☒	☐	☐	☐
Progress Notes	Clinicians Gateway	☒	☐	☐	☐
Referral Management	Clinicians Gateway	☒	☐	☐	☐
Treatment Plans	Clinicians Gateway	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		9	2	1	0
FY 2019-20 Summary Totals for EHR Functionality:		10	1	1	0
FY 2018-19 Summary Totals for EHR Functionality:		9	0	3	0

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

- The MHP converted three different versions of CANS into one version (CANS Birth to 24). The new version went live in July 2020.
- Care-teams were added.
- A Level of Care tool is being piloted.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 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 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
EDI uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	40%	Daily
Direct data entry into MHP EHR system by contract provider staff	60%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used

Type of Input Method	Percent Used	Frequency
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Not used

The rest of this section is applicable: ☒ Yes ☐ No

Some contract providers have EHR systems which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission

EHR Vendor	Product	Count of Providers Supported
EPIC	EPIC	7
Welligent Inc.	Welligent	6
CIRCE Software	Circe	2
Next Gen	Next Gen	1
PIMSY	PIMSY	1
AdvancedMD, Inc.	AdvancedMD	1
Netsmart	myEvolv	1
Netsmart	Avatar	1
Exym LLC	Exym	1

Personal Health Record

The beneficiaries have online access to their health records through a personal health record (PHR) feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☐ Yes ☒ No ☐ Implementation Phase

Expected implementation timeline:

☐ Already in place
☐ Within 6 months ☐ Within the next year
☒ Within the next two years ☐ Longer than 2 years

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☐ Yes	☒ No
Have ability to both send/receive secure text messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☐ Web-based application, including the MHP EHR system, supported by vendor or staff
- ☐ Web-based application, supported by MHP or DMC staff
- ☒ Local SQL database, supported by MHP/Health/County staff
- ☒ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

Alameda MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**692,359**	**$220,061,118**	**16,197**	**$5,551,644**	**2.46%**	**$214,509,474**	**$198,112,244**
JAN19	64,770	$19,815,728	1,331	$402,690	1.99%	$19,413,038	$18,125,624
FEB19	60,924	$18,504,233	1,352	$382,098	2.02%	$18,122,135	$16,870,698
MAR19	65,992	$20,466,651	1,608	$526,007	2.51%	$19,940,644	$18,557,308
APR19	68,470	$21,064,806	1,697	$631,343	2.91%	$20,433,463	$18,867,690
MAY19	67,745	$20,603,625	1,785	$520,952	2.47%	$20,082,673	$18,623,166
JUN19	47,745	$16,194,901	1,263	$391,595	2.36%	$15,803,306	$14,449,463
JUL19	45,155	$16,078,179	954	$341,054	2.08%	$15,737,125	$14,472,702
AUG19	48,882	$16,818,651	1,139	$345,940	2.02%	$16,472,711	$14,980,173
SEP19	55,355	$17,220,275	1,232	$352,095	2.00%	$16,868,180	$15,647,756
OCT19	64,244	$19,928,827	1,512	$569,308	2.78%	$19,359,519	$17,863,047
NOV19	52,051	$16,744,323	1,232	$491,012	2.85%	$16,253,311	$15,019,023
DEC19	51,026	$16,620,920	1,092	$597,550	3.47%	$16,023,370	$14,635,593

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent**.

The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments by Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Alameda MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible.	5,747	$2,033,609	37%
Medicare or Other Health Coverage must be billed before submission of claim.	7,712	$1,967,231	35%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	1,556	$818,273	15%
Beneficiary not eligible or non-covered charges.	581	$401,306	7%
Service not payable with other services rendered on the same date.	322	$132,930	2%
Total	16,197	$5,551,644	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with reason description “Medicare or Other Health Coverage must be billed before submission of claim” are generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Alameda, the time and distance requirements are 30 minutes and 15 miles for mental health services, and 30 minutes and 15 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted three consumer and family member focus groups, three stakeholder interviews, three staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

At the time of the review, there were three zip codes with conditional passes and pending approval for AAS in Alameda County. These zip codes (95371, 95391, 94550) are in the remote eastern areas of the county far from urban centers and were not meeting time or distance standards for mental health for adults or psychiatry services for youth and adults. The other zip codes for the MHP for youth and adult mental health services and psychiatry services met time and distance standards as required by DHCS.

In November 2020, the MHP submitted an appeal to DHCS for the three aforementioned zip codes. While awaiting DHCS appeal response, the MHP submitted an AAS in accordance with the DHCS submission deadline. In December 2020, the MHP received DHCS approval of the appeal. Hence, the AAS submitted by the MHP is no longer applicable since DHCS has determined the MHP has met time and distance standards in full.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

Not Applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	0
NPI Type 1 and 2 numbers are the same	89
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	108
NPI Type 1 number reported is associated with two or more providers	2
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	5
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	11

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested two groups - a culturally diverse group of English-speaking parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services in the past 12 months and a culturally diverse group of Spanish-speaking parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services in the past 12 months. The groups were combined into one remote group due to COVID-19. The group was held by Zoom video conferencing. The group was consistent with that requested by CalEQRO.
Total number of participants	Nine
Number of participants who initiated services during the previous 12 months	Four
Interpreter used	Yes If yes, specify language: Spanish

Topic	Description
Summary of the main findings of the focus group:	
Access - new beneficiaries	Participants were connected to services in various ways including referrals from John George Hospital, social workers, or private practitioners. It took between three weeks and two months to start services. All were satisfied with services and spoke positively about staff.
Access – overall	Other sources of referrals were pediatrician offices and schools. Services were provided in the field. Participants said they knew that transportation could be made available. Participants also indicated that they knew about the availability of services in other languages. Some participants reported a language barrier with psychiatry.
Timeliness	Some participants received weekly services while others had biweekly or monthly services. Participants were satisfied regarding timeliness and frequency of services.
Urgent care and resource support	If extra care is needed, participants reported calling their provider directly or the program from which they receive services. Services are available right away. Participants reported that getting extra services was not problematic, but that premature discharge of youth and providers not utilizing parental feedback in treatment planning was. Additionally, the intake process which requires the teenager to check themselves in for services (and minimizes parent/caregiver input for a complete assessment) is also seen as problematic by parents/caregivers.
Quality	Parents/caregivers report that children are feeling “over-zoomed” although they are somewhat engaged in video and phone services with providers.
Peer employment	No information was provided.
Structure and operations	No information was provided.
Recommendations from this focus group	• Offer more programs that focus on families and mental health. • Reduce bureaucracy to get services (referrals to other services, reduce wait times for specialty services, documentation, etc.)

Topic	Description
	• Involve parents and caregivers in discharge and safety planning; do not prematurely release youth. • Review the referral process between mild-to-moderate providers and the MHP; there needs to be a clearer process. • Provide more resources to parents/caregivers and guidance on how to navigate the system, i.e., a roadmap and resource list. • Provide a way for parents to share resources with one another. • Establish parent groups by topic/age, i.e., parents of children with an eating disorder.
Any best practices or innovations (optional)	• None identified.

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of English-speaking adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held by Zoom video conference.
Total number of participants	Four
Number of participants who initiated services during the previous 12 months	None
Interpreter used	No If yes, specify language: NA
Summary of the main findings of the focus group:	
Access - new beneficiaries	NA
Access – overall	Participants were referred through John George Hospital, social services, or ACCESS. Transportation was available via vans, social workers providing rides, and shuttle/bus stops. Participants were aware of services available in other languages.
Timeliness	Some participants said that once COVID-19 started, services were limited and no longer available on a first come first served basis.
Urgent care and resource support	Participants reported that extra help could be obtained through the 24/7 crisis line, at Amber House or by calling 911. Participants also reported that groups were available by Zoom video conferencing through Bonita House and at the Berkeley Drop-In Center.
Quality	All participants reported involvement in treatment planning and receiving information on medications from their providers. Participants also reported awareness of

Topic	Description
	communication between their psychiatrists and primary care doctors for coordination of care.
Peer employment	No information was provided.
Structure and operations	Participants received information on adjunct services and other resources by word of mouth and by flyers and postings in the community.
Recommendations from this focus group	• Reinstate face-to-face services and groups. • Add the EQRO flyer in an information folder. • Promote mental health services like the 211 ACCESS Line on television. Advertise available resources. • Add/use more non-profit organizations to help people, combine services with MHP services so people are not turned away.
Any best practices or innovations (optional)	• None identified.

CFM Focus Group Three

Table 34: Focus Group Three Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of Spanish-speaking adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held via Zoom video conferencing.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	None
Interpreter used	Yes If yes, specify language: Spanish
Summary of the main findings of the focus group:	
Access - new beneficiaries	NA
Access – overall	Participants entered services in a variety of ways – school psychologists, clinics, outside therapists, and hospitals. Prior to COVID-19, participants were aware of transportation assistance (bus pass from POCC). Participants were aware that services were available in other languages.
Timeliness	Regarding frequency of services post COVID-19, participants used to have hour-long sessions; however, sessions are now reduced to the minimum. More groups and classes are offered via Zoom. Psychiatry services are provided within one to two months.
Urgent care and resource support	Participants reported that if urgent services are needed, they would call 211, ACCESS line, or 911.
Quality	Participants reported that they are involved in treatment planning or groups. Some have Wellness Recovery Action Plans and attend groups. Participants also report that primary care doctors and psychiatry communicate with each

Topic	Description
	other for care coordination. Medication information is provided by psychiatry.
Peer employment	No information was provided.
Structure and operations	No information was provided.
Recommendations from this focus group	• Provide radio advertisement or similar, to let the community know about available services. • Provide housing priority to those who receive mental health services and who are on waitlists.
Any best practices or innovations (optional)	• None identified.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 35 lists the components that CalEQRO considers representative of a broad service delivery system in providing 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 35: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
The MHP centralized the adult SOC initial screening and referral process for new intakes and existing beneficiaries, all of which now come through the ACCESS Call Center. The children's SOC continues to have multiple contracted Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs that each have their own point of entry and as such, manage their own screenings and referrals. The MHP also monitors the number of ACCESS calls received, wait times, dropped calls, and referrals to mental health services through various venues. The MHP reports that additional staff are needed in the ACCESS program to maintain adequate response time. Pandemic-related issues caused a delay in hiring new staff. Though HR recruited heavily in August 2020 to fill four vacancies, the positions remain vacant. The MHP has four threshold languages including Spanish, Cantonese, Vietnamese, and Mandarin. The MHP has a language line contract that provides on-demand access to over 200 languages, ensuring that all beneficiaries will have access to some level of interpretation at their appointments.			

Component		Maximum Possible	MHP Score
Beneficiaries are made aware of services through the ACCESS call center, clinical staff and case managers, outreach and engagement efforts, and written materials (e.g., flyers and brochures) located at many contract provider locations. Stakeholder feedback in EQRO focus groups confirmed that beneficiaries are aware of language services throughout the SOC.			
1B	Capacity Management	10	10
The MHP assesses the cultural, ethnic, racial, and linguistic needs of its Medi-Cal eligibles for the purpose of identifying strategies and resources to address disparities in access. The MHP monitors penetration rates, system demand, caseloads by provider type and service location, and productivity. The MHP implemented strategies to address these disparities and has made additional efforts to ensure equity. The MHP works collaboratively with community leaders and contract providers to provide culturally affirming public service announcements. Beneficiaries in focus groups report knowledge of the county's outreach efforts. As part of a COVID-19 health equity campaign, the MHP launched a vigorous community outreach endeavor (i.e., flyers, mural, posters) to address the unique needs of the Latin, African American, and Asian American populations; the focus is to reduce mental health stigma, provide information on MHP services, and to provide support during the pandemic. In contrast, the entire SOC is struggling with recruitment and retention challenges, particularly for bilingual and bicultural licensed clinicians who mirror the community served, primarily due to the high cost of living in the Bay Area.			
1C	Integration and Collaboration	24	24
The MHP provided multiple examples of integrated and collaborative programs and services with partnering agencies and community-based organizations. These included primary care, hospitals, law enforcement agencies, schools, faith-based, organizations, public health, managed care organizations, and employment and housing agencies, among others. The MHP and Alameda Alliance for Health, a managed care plan, have quarterly meetings with attendance from operational and executive leads, and directors from both entities. The Alameda Alliance currently provides health care coverage to over 250,000 children and adults. The MHP is leading the justice-involved mental health task force, a county-wide effort to reduce the number of individuals who have mental illness who are in jail. The task force is focused on data sharing, diversion/alternatives, judicial training and advocacy, housing, peer advocate recruitment/training, and a forensic inpatient unit. Collaborative meetings are held each month between steering committee members. The MHP works closely with the County of Alameda, Alameda County Health Care for the Homeless, Health Care Services Agency, Abode Services, and the State of			

Component	Maximum Possible	MHP Score
California to connect beneficiaries to Project Room Key and Operation Comfort (COVID-19 isolation housing), as well as Operation Safer Ground, a safe housing program for individuals at high-risk for experiencing homelessness. Positive beneficiary feedback was given in EQRO focus groups related to Operation Comfort.		

Timeliness of Services

As shown in Table 36, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 36: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	15
The MHP has a 10-business day standard for the length of time from initial request to first offered appointment and met the requirement 86.3 percent of the time for the entire SOC (89.24 percent for adults, 86.05 percent for children, and 87.14 percent for FC). The average length of time from first request to first offered appointment is 6.63 days (4.96 days for adults, 7.01 days for children, and 6.74 days for FC). In response to COVID-19, most services are provided via telehealth; however, in-person appointments are provided on a case-by-case basis. The MHP completed the implementation of the new timeliness policy and data tracking processes for network adequacy across the entire SOC, including the production of a timeliness performance data dashboard in January 2020; however, data from contract providers was limited. The MHP is using timeliness data from two separate sources, ACCESS, and Client Services Information (CSI) and reported that not all clinics are capturing this data. The MHP reports that timeliness data integrity is impacted when contract providers do not complete the required timeliness tracking forms for reasons that are outside of their control (i.e., cannot connect with a beneficiary). Beginning in January 2021, the MHP plans to enter CSI data into InSyst, a billing and encounter data application. The MHP projects that this activity will make the timeliness data more reliable and allow for tracking provider submissions. IS and QI are collaborating to create timeliness completion reports by provider and month showing overall timeliness completion rates. For the dashboard, the workgroup plans to add reports on disparities based on geography, demographics, and rate of referral connection to services.			

Component		Maximum Possible	MHP Score
2B	First Offered Psychiatry Appointment	12	11
The MHP has a 15-business day standard for the length of time from initial request to first offered psychiatry appointment. The MHP met the requirement 54.21 percent of the time for the entire SOC (55.03 percent for adults, 51.11 percent for children, and 61.54 percent for FC). The average length of time from first request to first offered appointment is 14.43 days (13.91 days for adults, 15.88 days for children, and 14.31 days for FC). Psychiatry appointment timeliness has improved from 21 business days for all services in FY 2019-20 to 14.43 business days in FY 2020-21.			
2C	Timely Appointments for Urgent Conditions	18	15
The MHP has a 48-hour standard for the length of time from service request for urgent appointments to actual encounter. The MHP met this standard 78.66 percent of the time for the entire SOC (97.01percent for adults, 33.3 percent for children, and 28.57 percent for FC). The average length of time for urgent appointments that do not require prior authorization is 16.33 hours (2.74 hours for adults and 68.41 hours for children). The MHP did not disaggregate the data for FC. Timeliness data was not presented for urgent appointments requiring prior authorization (96-hour standard).			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	10
The MHP has a seven-day standard for the length of time for follow-up appointments post psychiatric discharge and met this standard 32 percent of the time for all hospitals and the entire SOC (30 percent for adults, 62 percent for children, and 38 percent for FC). The average length of time for follow-up is 4.74 days (4.97 days for adults and 2.54 days for children, and 3.01 days for FC). Individuals who were discharged from the hospital and then served in a subacute setting prior to receiving outpatient follow-up services are excluded from the MHP follow-up appointment rates. The MHP determined that for adults, the readmission rates were higher for beneficiaries who are already open to case management programs. The adult SOC is conducting research to determine the reason for the high readmission rates despite receiving outpatient services prior to readmission, including exploring whether post-hospitalization follow-up could be improved to prevent readmission.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The MHP reported 4,023 total number of hospitalizations from FY 2019-20 through FY 2020-21; of the total amount of hospitalizations, 903 were readmitted within 30 days. The 30-day readmission rate is 22.3 percent (22.7 percent for adults, 16.3 percent for children's services and 29.2 percent for FC).			

Component		Maximum Possible	MHP Score
2F	Tracks and Trends No-Shows	10	6
The MHP tracks no-show rates for psychiatrists and clinicians only for county-operated programs. The average no-show rate for psychiatrists is 10 percent (7 percent for adults, 17 percent for children, and 14 percent for FC). The average no-show for clinicians other than psychiatrists is 11 percent (5 percent for adults, 21 percent for children, and 14 percent for FC). The MHP has not set a no-show standard for psychiatrists and clinicians.			

Quality of Care

In Table 37, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 37: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	11
The health equity division is run by the health equity officer (currently vacant) who oversees the ethnic services manager, consumer empowerment manager, and the family empowerment manager. The MHP's OES oversees the Cultural Responsiveness Committee (CRC) and is tasked with the overall planning and implementation of services, providing reports to QA and QI programs and providing cultural competence trainings. The CRC convenes a meeting every other month and has two sub-committees that meet quarterly (compliance and communications). Community stakeholders are invited to these committee meetings, and submitted documents reflect participation from contract providers. The MHP did not submit an updated cultural competence plan because it was under development at the time. It was completed in December 2020 and subsequently submitted post-review.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP has a centralized adult SOC initial screening and referral process for new intakes and existing beneficiaries. The children's SOC continues to have multiple contracted EPSDT programs, with each having individual procedures and management approaches for screenings and referrals. Stakeholder feedback in			

Component		Maximum Possible	MHP Score
EQRO focus groups reflect that sufficient options for lower levels of care (LOC) are not plentifully available in Alameda County; consequently, beneficiaries may cycle through MHP services more frequently.			
3C	Quality Improvement Plan	10	10
The MHP submitted a QI workplan and mid-term evaluation for FY 2019-20 which was reviewed during the January 2020 QIC meeting. The QI workplan appendix now includes data on timeliness (outpatient, psychiatry, and urgent requests), penetration rates, various demographics, acute recidivism, and post-hospitalization follow-up. It also includes a more in-depth analysis of disparities.			
3D	Quality Management Structure	14	14
The MHP hired a Quality Management Program Director who QM structure, QI activities and data analytics functions, while IS continues to provide data analytic staffing for dashboards and reports. IS supports QI requirements by developing performance measurement dashboards and reports. IS developed the performance outcomes dashboards and reports for the FY 2020-21 QI workplan to track timeliness for the QIC NACT workgroup and for SUD QI projects. . The QI manager/senior management analyst and the QI senior program specialist have met with IS on a biweekly basis since August 2019 to discuss QI projects. The MHP has a QIC with membership representative of the entire SOC, including beneficiaries, beneficiaries, family members, and contract providers.			
3E	QM Reports Act as a Change Agent in the System	10	10
The MHP's QI activities and PIPs are now data driven. IS oversees the use of over 80 Yellowfin performance measure dashboards (i.e., contract monitoring, penetration rates, capacity, medication support, and telehealth) and over 300 users have access to the data reports.			
3F	Medication Management	12	12
The MHP has a medication monitoring process that includes randomly sampling 10 percent of each physician's caseload once per quarter. The screening criteria used is the "Standards for Psychotropic Medication Practices," as approved by the MHP's psychiatric practices committee. Findings are recorded in an electronic database that generates reports for oversight of and feedback for providers. Deviations from the standards generate a request from the medical director to correct deficiencies within a specific timeframe. Concerning cases of deviation can be selected for review the following quarter. The MHP children's SOC is currently engaged in a QI project aimed at educating the SOC and developing processes to increase comprehensive			

Component	Maximum Possible	MHP Score
treatment planning and strategies that ensure safe and quality psychotropic medication treatment for all children and youth in Alameda County. Beneficiaries in focus groups report open communication between their psychiatrist (and/or pharmacist) with their primary care physician.		

Beneficiary Progress/Outcomes

In Table 38, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 38: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	15
The ACCESS program and the adult SOC developed a LOC screening tool and protocol to determine the appropriate level of care for a beneficiary. The pilot began in October 2020. ACCESS clinicians are slated to provide feedback on the pilot in November 2020. This LOC tool will expand to the entire ACCESS program if the pilot is successful. The MHP adult SOC uses the California Outcomes Measurement System Treatment (CalOMS Tx) admissions questionnaire, and the ANSA. Children's SOC uses the Pediatric Symptom Checklist (PSC-35) and the CANS-50. IS oversees the use of performance outcome measurement dashboards (i.e., CANS-50, ANSA, PSC-35).			
4B	Beneficiary Perceptions	10	10
The MHP administers the Consumer Perception Survey (CPS) twice a year (Spring and Fall) on behalf of DHCS to a sampling of adults, older adults, youth, and family/caregivers of youth beneficiaries who receive mental health services. Of the 1,410 beneficiaries and family members/caregivers who participated in the Fall 2019 survey, approximately 90 percent said they were satisfied with the mental health services received. CPS results are discussed in QIC meetings, the QIC Consumer workgroup, the QIC Family Member workgroup, and are posted on the agency website. The MHP monitors the results of the beneficiary surveys and analyzing trends based on demographics and services provided. The MHP includes in their QI			

Component		Maximum Possible	MHP Score
workplan a goal to improve participation across all providers, program types, and demographics to ensure representative responses.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
QIC meeting notes reflect that peer staff have lower turnover than clinicians. The OCE staff noted that they plan to collaborate on a policy to incorporate peer support specialists in services. The MHP Community Connections and Familiar Faces teams conduct follow-up visits and care coordination after a beneficiary has contact with a mobile crisis team or CSU. The team is staffed 80 percent by peer or family member mental health specialists.			

Structure and Operations

In Table 39, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 39: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	29
The MHP offers a full spectrum of specialty mental health services and corresponding levels of care including outpatient, urgent, crisis, residential, medication support, and others. The MHP does not have day treatment but can refer to daily groups or outpatient services as needed. The MHP does provide day rehabilitation for transition aged youth and for adults, residential programs are available through Bonita House and Casa De La Vita.			
5B	Network Enhancements	18	18
The MHP currently has 15 county-operated telehealth sites and 244 contract provider telehealth sites. The MHP served 7,697 beneficiaries via telehealth in the past CY (2,954 adults, 4,431 children/youth, and 312 older adults). Telehealth services are available in Spanish, Cantonese, Vietnamese, Mandarin, Tagalog, Cambodian and other Chinese dialects. The MHP has six peer-run wellness centers located throughout the county. Prior to COVID-19, these drop-in centers were open to the public. The MHP also provides respite services through La Familia Counseling Center and Sally's Place, a peer-run non-clinical crisis respite home. Stakeholder feedback			

Component		Maximum Possible	MHP Score
indicated the need for additional children's groups which address stigma, anxiety, and depression.			
5C	Subcontracts/Contract Providers	16	16
County-operated and staffed clinics deliver approximately 20 percent of mental health services; contract providers provide nearly 80 percent of mental health services; with network providers under 1 percent. QIC meeting minutes provides evidence of large participation from community stakeholders and contract providers. The MHP's reports and data analyses are increasingly inclusive of data from contract providers, network providers, and directly operated programs; however, there are unresolved barriers for contractors' submission of timeliness data.			
5D	Stakeholder Engagement	12	12
The OCE manager and the OFE manager both participate in the monthly department "operational" leadership meeting, which includes clinical operations and other department leaders. The health equity director is included in the MHP executive team. This position oversees the OCE, OFE, OES, and Patients' Rights in addition to representing stakeholder perspectives at executive level meetings. The QIC meeting minutes reflect participation from various stakeholders in the MHP, family members, beneficiaries, CBO providers, Mental Health Advisory Board, Consumer Empowerment Manger, and patients' rights and family empowerment advocates.			
5E	Peer Employment	8	8
The MHP has added multiple peer employee positions this CY to enhance service quality and capacity. Peer employee additions include two mental health specialists with lived experience, each assigned to a mobile crisis teams. The OCE manager is working with the department director and HR to develop a new mental health peer support specialist job classification within the MHP. OCE is drafting policies and essential duties for the classification.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Alameda MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Completed

- The non-clinical PIP, the implementation of a language assistance line for all providers, is a heavy lift even in the best of circumstances. While there was some success, the impact was diminished by COVID-19 and the overall declining penetration rate.
- Had the PIP not encountered such a challenge, more frequent data analysis could have occurred thereby allowing time to adjust, as necessary. During TA, CalEQRO also discussed piloting the intervention before application to the system at large. The MHP is already engaged in PIP TA for the development of its next PIPs.

Access to Care

Changes within the Past Year:

- The MHP now has all referrals come through the ACCESS call center. The centralized process allows for better tracking and follow-up.

Strengths:

- The MHP conducted a COVID-19 health equity campaign, including mental health stigma reduction, which consisted of billboards, a mural, fliers, and posters to promote the needs and resources for the Latin, African American, and Asian American populations.

Opportunities for Improvement:

- Provider choices for lower LOC are not readily available in Alameda County which may cause beneficiaries to worsen without support, and then return to MHP services.

Timeliness of Services

Changes within the Past Year:

- The MHP implemented a timeliness performance data dashboard to improve tracking.

Strengths:

- Psychiatry appointment timeliness has improved from 21.0 business days for all services in FY 2019-20 to 14.43 business days in FY 2020-21.
- The MHP is completing an in-depth chart review to identify and trend specific reasons for adult hospital readmission and find appropriate interventions.

Opportunities for Improvement:

- The MHP met the 48-hour standard for children's urgent appointments only 33.3 percent of the time.
- For first offered psychiatry appointments, the MHP meets the standard of 21 calendar days 54.21 percent overall; likewise, 55.03 percent for adults, 51.11 percent for children, and 61.54 percent for FC.
- The MHP only tracks no-show rates for psychiatrists and clinicians for county-operated programs and does not have an established standard.

Quality of Care

Changes within the Past Year:

- Of the 20 recommendations from FY 2019-20, 14 were met, 5 were partially met, and 1 not met.
- The QI work plan added an in-depth analysis of disparities in services for all age groups, analyzed by race/ethnicity, gender, language, and geographic region.

Strengths:

- The MHP has a robust peer employment program with peer representation at the decision-making level and on committees, in management positions and with an advancement path.
- QI management and IS work together to accomplish QM and QI goals.

Opportunities for Improvement:

- Stakeholders indicate the need for increased parent/caregiver inclusion during assessment, treatment planning and post-discharge planning of youth in crisis and hospital services.

Beneficiary Outcomes

Changes within the Past Year:

- In July 2020, the MHP combined the three different versions of CANS-50 into one version (CANS Birth to 24).

Strengths:

- The ACCESS program piloted a LOC screening tool and protocol and plans to expand the use of the tool to the entire SOC.

Opportunities for Improvement:

- None noted.

Foster Care

Changes within the Past Year:

- Urgent appointments for FC met the timeliness goal of 48 hours 28.57 percent of the time.
- Presumptive transfers for FC from Alameda County dropped by 20 percent while presumptive transfers for FC youth to Alameda County increased by 9 percent. The MHP posits that the change could be a correlation due to the reduced number of Short-Term Residential Therapeutic Program (STRTP) placements after conversion.

Strengths:

- MHP staff and contracted prescribing staff chart and monitor caseloads with youth whose treatment includes psychotropic, ADHD, and antipsychotic medications and any concurrent use thereof.

Opportunities for Improvement:

- For FC, the MHP meets the timeliness standard for follow-up post hospital discharge appointments 38 percent of the time.
- The 30-day hospital readmission rate for FC has increased from 26.5 percent in FY 2019-20 to 29.2 percent in FY 2020-21.
- Due to COVID-19 “Shelter-in-Place” orders, FC referrals for services decreased between April 2020 through September 2020.
- The MHP had several families interested in providing TFC; however, COVID-19 led to a shift in interest. Recruitment continues to be a challenge.

Information Systems

Changes within the Past Year:

- In August 2020, the MHP published an RFP to seek a new solution to replace its legacy billing and managed care systems.

Strengths:

- The MHP's data warehouse receives feeds from 30 external data sources including managed care plans and other Alameda county departments (Probation, Child Welfare, Sheriff and Homeless).

Opportunities for Improvement:

- The MHP has yet to complete the rollout of Yellowfin dashboards and reports to all contract providers.
- It is unclear whether the ISU has sufficient staffing resources to support implementation of the new system implementation project as well as manage current systems operations.

Structure and Operations

Changes within the Past Year:

- The ISU provided computer hardware and software to several hundred county employees to support work from home efforts, including the addition of video conferencing platforms for telehealth services.

Strengths:

- None noted.

Opportunities for Improvement:

- None noted.

FY 2020-21 Recommendations

PIP Status

None note.

Access to Care

None noted.

Timeliness of Services

Recommendation 1: Investigate reasons for children's urgent appointments not meeting the 48-hour standard. Implement interventions as barriers to timely access are identified.

Recommendation 2: The MHP must offer a psychiatric appointment within the 15-business day standard. The MHP should comply with the state timeliness metric as per IN 18-011.

Quality of Care

Recommendation 3: Evaluate the current role of parents/caregivers in assessment, treatment planning and post-discharge planning of youth. Include parents/caregiver feedback in evaluation. Expand/augment opportunities where appropriate.

Beneficiary Outcomes

None noted.

Foster Care

Recommendation 4: Investigate reasons for low rate of timely post-hospital discharge appointments for Foster Care (FC) youth. Implement interventions as barriers to timely post-hospital discharge appointments are identified.

Recommendation 5: Investigate reasons for increasing readmission rate for FC. Implement interventions as causes are identified.

Information Systems

Recommendation 6: Continue work on hosting a public website with aggregated Yellowfin performance dashboards and expand access to all contract providers as soon as practical.

Recommendation 7: Monitor project management staffing closely during the new billing/managed care systems implementation, with special attention to the use of subject matter staffing resources adequate to support the project as well as efficiently manage current systems.

Structure and Operations

None noted.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment A—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
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
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster, Lead Quality Reviewer
Angela Kozak-Embrey, Quality Reviewer
Caroline Yip, Lead Information Systems Reviewer
Bill Ullom, Information Systems Reviewer
Gloria Marrin, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Site

Alameda County Behavioral Health Care Services (ACBHCS)
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

The review was conducted via Zoom video conferencing.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Abraham	Jennifer	Family Partner	MHAAC
Acosta	Lisa	BH Medical Director	Anthem
Alfaro	Lilliana	Family Partner	MHAAC
Alter	Harrison	Interim Medical Director, Healthcare for the Homeless	Health Care Services Agency
Anderson	Gary	CAS I. SUD Treatment Service Provider	Options Recovery Services
Anderson	Kara	Department Human Resource Office Trainee to Administrative Specialist I	Health Care Services Agency
Aslami	Khatera	Consumer Empowerment Mgr.	ACBH
Baggeroer	Cheryl	Medical Director, Primary Care Psychiatry Consultation Program	ACBH
Becker	Barbara	Facilities Development Mgr.	ACBH
Becton	Neisha	Chief Executive Officer	Pathways to Wellness
Bernhisel	Penny	Clinical Program Supervisor for ACBH Court Programs	ACBH
Bhatt	Sanjay	Medical Director	Alameda Alliance for Health
Biblin	Janet	Performance Measurement Mgr.	ACBH
Boloix	Laura	Family Advocate	The Family Education & Resource Ctr, MHAAC
Bradley	Vanessa	Administrative Assistant	ACBH
Bryant	Seth	Peer Specialist, Sally's Place	La Familia Counseling Services

Last Name	First Name	Position	Agency
Capece	Karen	Quality Management Program Director	ACBH
Carlisle	Lisa	Child & Young Adult System of Care Director	ACBH
Carnahan	Kara	Vice President of Programs	Abode Services
Castilla	Michael	Sr. Program Specialist, Adult Older Adult System of Care	ACBH
Chapman	Aaron	Chief Medical Officer	ACBH
Chau	Mandy	Interim Financial Services Officer, Data and Cost Reporting Unit	ACBH
Chawla	Colleen	Agency Director	Health Care Service Agency
Chen	Jennifer	Clinical Supervisor	Asian Health Services
Clannon	Kathleen	Medical Director, AC3	Health Care Services Agency
Coady	Kim	Interim Quality Assurance Administrator	ACBH
Coffin	Scott	Chief Executive Officer	Alameda Alliance
Colthirst	Breje a	Family/Parent Advocate	East Bay Family Defenders
Courson	Natalie	IS Deputy Director	ACBH
Daniels	Roger	Program Director	Fred Finch Youth Ctr
Dela Cruz	Leah	Mental Health Rehabilitation Spec.	West Oakland Health Ctr
DeSantis	Adrianne	Consumer Empowerment Staff	ACBH
Dewees	Lisa	Family Advocate	The Family Education & Resource Ctr, MHAAC
Diamond	Marc	Clinical Supervisor, Eden Community Support	ACBH
Diedrick	Sheryl	IS Analyst	ACBH
Eady	Rashad	Program Specialist, QI	ACBH

Last Name	First Name	Position	Agency
Eaves	Damon	Assoc. Dir., Child & Young Adult SOC	ACBH
Eller	Kent	Chief Medical Officer	Telecare
Elliott	Ann	Critical Care Mgr., Adult & Older Adult SOC	ACBH
Engstrom	John	Sr. Management Analyst, QI	ACBH
Escobar	Selina	Program Mgr.	Anthem Blue Cross, Medi-Cal
Felton	Mystique	Operations Mgr.	La Clinica
Franklin	Paulette	Mental Health Specialist II	ACBH
Fuller	Faith	Consultant	FAS Services
Furuzawa	Adriana	Dir. of Felton Early Psychosis Prgrms.	Felton Institute
Gardner	Ryan	Chief Clinical and Admi. Officer	Bonita House
Goldstein	Brenda	Chief of Integrated Services	Lifelong Medical Care
Gong	Kay	Behavioral Health Clinician II	ACBH GARTT Program
Gray	Heidi	Clinical Supervisor	Fred Finch Youth Ctr
Grayson	Kellen	Director of Clinical Services	Pathways to Wellness
Hall	Tisa	Managed Care Coordinator	Tri-City Health Ctr
Halloran	Nancy	AC3 Deputy Director	Health Care Services Agency
Hazelton	Tracy	MHSA Division Director	ACBH
Hegde	Nandita	Behavioral Health Clinician II	ACBH
Hidalgo	Carmen	Parent/Family Advocate	East Bay Family Defenders
Hobbs	Nathan	SUD Continuum of Care Director	ACBH
Hogden	Mary	POCC Mgr.	ACBH
House	Bryan	Program Data Analyst	Bonita House

Last Name	First Name	Position	Agency
House	Dana	Program Director	Bonita House
Iannuzzi	Cristi	Care Connect Data Exch. Unit Dir.	C & C Advisors
Iglesias	Jovan	Director of Programs	Bay Area Community Services
Johnson	Damon	Pool of Consumer Champions	ACBH
Jones	Katherine	Adult & Older Adult SOC Director	ACBH
Jones	Lorna	Executive Director	Bonita House
Jones	Yvonne	Adult Forensic BH Director	ACBH
Judkins	Andrea	Supervising Financial Services Specialist, Budget & Fiscal Services	ACBH
Kasdin	Lucy	Dir., Health Care for the Homeless	Health Care Services Agency
Kolda	Deanna	Clinical Review Specialist Sup., UM	ACBH
Kong	Jennifer	FSP Supervisor, Strides	Telecare
Korha	Koffi	Intensive Care Coordinator Sup.	West Coast Children's Clinic
Lai	Sophia	Senior Program Specialist, QI	ACBH
Lau	Juan	Specialist Clerk II, Finance	ACBH
Lee	Sun Hyung	TAY Services Interim Division Director	ACBH
Lee	Veronique	Director of School-Based Services	STARS Behavioral Health Group
Lewis	Clyde	EPSDT Coordinator, Child Young Adult System of Care	ACBH
Lewis	Michelle	Clinical Mgr.	Oakland Community Support Ctr
Lewis	Stephanie	Crisis Services Division Director	ACBH

Last Name	First Name	Position	Agency
Linder	Sarah	Administrative Specialist II	ACBH
Lopez	Rickie	Assistant Finance Director	ACBH
Lopez	Tasha	Health Care Claims Mgr.	ACBH
Lott	Yesenia	BH Clinical Mgr., Crisis	ACBH
Louie	Jill	Budget & Fiscal Services Director	ACBH
Louis	L.D	Co-Chair	Mental Health Advisory Board
Lua	Juan	Specialist Clerk II, Finance	ACBH
Luqmaan	Madinah	Crisis Clinician at Willow Rock Crisis Stabilization Unit	Seneca Family of Agencies
Madaus	Matthew	Executive Director	Alameda Council of Community MH Agencies
Marshland	Susanna	Regional Vice President	Fred Finch Youth Ctr
Mayfield	Amber	AOT, CC & Steps Clinical Director	Telecare
McMonagle	Kieran	HEAT FSP Supervisor	Bay Area Community Services
Meinzer	Chet	Data Services Team Mgr.	ACBH
Miller	Laura	Chief Medical Director	Alameda Health Consortium
Momoh	Imo	Deputy Director/Plan Administrator	ACBH
Moniz	Brianna	Clinical Supervisor	Telecare
Moore	Lisa	Billings & Benefits Support Director	ACBH
Mukai	Christine	Critical Care Mgr., Youth Services, CANS Coordinator	ACBH

Last Name	First Name	Position	Agency
Mullane	Jennifer	Assistant Director of Adult & Older Adult SOC	ACBH
Murphy	Christina	Supervisor, Sally's Place	La Familia Counseling
Nandwana	Toni	IS Director	Health Care Services Agency
Nichols	Paul	Management Analyst, Fiscal	ACBH
O'Brien	Steve	Chief Medical Officer	Alameda Alliance for Health
Orozco	Tiffany	Behavioral Health Clinician I	ACBH
Orphanos	Maureen	Behavioral Health Clinical Mgr., Tri City and Valley Adult Outpatient clinics	ACBH
Osborn	Scott	Regional Executive Director	Seneca Family of Agencies
Ou	Sarah	Program Specialist, Crisis	ACBH
Paquin	Stephanie	Clinical Supervisor	East Bay Agency for Children
Penserga	Luella	Deputy Director	AC Health Care for the Homeless
Peterson	Camille	IS Analyst	ACBH
Pingali	Samira	Director of Behavioral Health	Community Health Ctr Network
Provost	John	IS Support Services Mgr.	ACBH
Rassette	Kim	Administrative Specialist II, QM	ACBH
Ratty	Caitlin	Clinical Care Mgr.	Felton Institute
Raynor	Charles	Pharmacy Services Director	ACBH

Last Name	First Name	Position	Agency
Razzano	Theresa	Vocational Services Interim Division Director	ACBH
Reed	Gordon	Pool of Cons. Champions	ACBH
Rosso	Stephanie	Director of Psychological Svs.	UCSF, Children's Hosp.
Sadusk	Lorna	Clinical Case Mgr.	Family Paths, Inc.
Sanders	Tony	Assistant QA Administrator	ACBH
Santos	Jesusa	Administrative Assistant, Office of the Medical Director	ACBH
Satchwell	Bridget	System Outreach Mgr., AC Care Connect	AC Health Care Services Agency
Saucier	Amy	Clinical Review Supervisor, QM	ACBH
Schrick	Julienne	Program Specialist, Adult & Older Adult SOC	ACBH
Schulz	Henning	Adult Outpatient Services Division Director, Adult & Older Adult SOC	ACBH
Schwartz	Katherine	Executive Director	Alameda Family Services
Shafer	Holly	Mental Health Clinician	STARS Beh. Health Grp.
Shelton	Sharemel	Billing & Provider Support Mgr.	ACBH
Silber	Ralph	Executive Director	Alameda Health Consortium
Singer	Carol	Director of Clinical Services	Jewish Children & Family Services

Last Name	First Name	Position	Agency
Smith	Freddie	Integrated Care Services Division Director	ACBH
Smith	Trina	Clinical Supervisor, Eastmont and Eden PATH	ACBH
Sneed	Rose	Sr. Director of Beh. Health	Richmond Area Multi-Svs
Stenson	Jon	Interim Division Director ACCESS	ACBH
Taizan	Juan	Juvenile Justice Ctr Health Care Director	ACBH
Tantiado	Angela	Mental Health Clinician	Telecare
Tribble	Karyn	Director	ACBH
Velasquez	Edilyn	Interim Contracts Director	ACBH
Wagner	James	Deputy Director, Clinical Operations	ACBH
Warder	Rosa	Family Empowerment Mgr.	ACBH
Washington	Tiffany	Program Mgr.	Anthem, Inc.
Williams	Donna	BH Clinician II	ACBH
Wilson	Javarre	Ethnic Services Mgr.	ACBH
Wilson	Peggy	Mental Health Clinician	West Oakland Heath Ctr.
Winn	Jaleah	Wellness Educator, Consumer Empowerment	ACBH
Wms Smith	Michele	Family Advocate	The Family Education & Resource Ctr.
Wolff	Laura	Regional Director of Operations	Telecare

Last Name	First Name	Position	Agency
Woods	Schalon	BH Clinical Supervisor, Office of Housing	ACBH
Yano	Aiko	Wraparound Supervisor, Crisis Stabilization Unit	Seneca Family of Services
Yuan	Eric	Mgr., Integrated Care Services	ACBH
Zone	Dominica	Center Mgr.	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 ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Alameda MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Large	1,791,890	69,726	3.89%	$372,190,347	$5,338
MHP	129,631	4,618	3.56%	$30,502,272	$6,605

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 2019 Distribution of Beneficiaries by ACB Range

Alameda MHP								
ACB Range	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	18,771	87.83%	93.31%	$95,885,937	$5,108	$3,998	47.00%	59.06%
>$20K - $30K	1,147	5.37%	3.20%	$27,784,734	$24,224	$24,251	13.62%	12.29%
>$30K	1,454	6.80%	3.49%	$80,358,031	$55,267	$51,883	39.39%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
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
CCBH	Community Care Behavioral Health
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIT	Crisis Intervention Team or Training
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSD	Community Services Division
CSI	Client Services Information
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

Acronym	Full Term
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
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
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

Acronym	Full Term
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health 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
NA	Network Adequacy
N/A (alt)	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
ONA	Out-of-Network Access
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PM (alt)	Partially Met
QI	Quality Improvement
QIC	Quality Improvement Committee

Acronym	Full Term
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration
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
STRTP	Short-Term Residential Therapeutic Program
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