FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Alameda

Conducted on

January 12-14, 2016

Prepared by:

BHC

Behavioral Health Concepts, Inc.

400 Oyster Point Blvd., Suite 124

South San Francisco, CA 94080

www.caleqro.com

TABLE OF CONTENTS

INTRODUCTION **5**

PRIOR YEAR REVIEW FINDINGS, FY14-15 .... **7**

STATUS OF FY14-15 REVIEW RECOMMENDATIONS 7
Assignment of Ratings *7*
Key Recommendations from FY14-15 .... *8*
CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS 11

PERFORMANCE MEASUREMENT **13**

TOTAL BENEFICIARIES SERVED 13
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY 14
HIGH-COST BENEFICIARIES 18
TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE 18
DIAGNOSTIC CATEGORIES 20
PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS 21

PERFORMANCE IMPROVEMENT PROJECT VALIDATION **23**

ALAMEDA MHP PIPS IDENTIFIED FOR VALIDATION 23
CLINICAL PIP—REDUCTION OF USE OF RESTRAINT AND SECLUSION IN SUBACUTE PROGRAMS 26
NON-CLINICAL PIP—HIGHEST COST CONSUMER 28
PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS 29
PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS 30
Access to Care *30*
Timeliness of Services *32*
Quality of Care *34*
KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS 38

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S) **41**

CONSUMER/FAMILY MEMBER FOCUS GROUP 1 41
CONSUMER/FAMILY MEMBER FOCUS GROUP 2 43
CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS 44

INFORMATION SYSTEMS REVIEW **47**

KEY ISCA INFORMATION PROVIDED BY THE MHP 47
CURRENT OPERATIONS 48
MAJOR CHANGES SINCE LAST YEAR 49
PRIORITIES FOR THE COMING YEAR 49
OTHER SIGNIFICANT ISSUES 50
PLANS FOR INFORMATION SYSTEMS CHANGE 50
ELECTRONIC HEALTH RECORD STATUS 51
INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS 52

SITE REVIEW PROCESS BARRIERS **52**

CONCLUSIONS **52**

STRENGTHS AND OPPORTUNITIES 53
Access to Care *53*

Timeliness of Services *53*
Quality of Care *53*
Consumer Outcomes *54*
RECOMMENDATIONS 54

ATTACHMENTS 57

ATTACHMENT A—REVIEW AGENDA 59
ATTACHMENT B—REVIEW PARTICIPANTS 63
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA 71
ATTACHMENT D—PIP VALIDATION TOOL 75

INTRODUCTION

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

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

- MHP information:
  - Beneficiaries served in CY14—22,254
  - MHP Size—Large
  - MHP Region—Bay Area
  - MHP Threshold Languages—Spanish, Vietnamese, Cantonese, Mandarin
  - MHP Location—Oakland

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the Alameda mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

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

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

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

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

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

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

CalEQRO also conducted two90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

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

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

---

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

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

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

- Ratings for Key Components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders serve to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY14-15

In this section we first discuss the status of last year's (FY14-15) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY14-15 REVIEW RECOMMENDATIONS

In the FY14-15 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY15-16 site visit, CalEQRO and MHP staff discussed the status of those FY14-15 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
    - resolved the identified issue

- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
    - made clear plans and is in the early stages of initiating activities to address the recommendation
    - addressed some but not all aspects of the recommendation or related issues

- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY14-15

- Recommendation #1: Proceed with the business of implementing its EHR as soon as possible to gain a unified data source for a comprehensive data source for clinical quality improvement efforts.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP indicates the implementation is moving forward as planned. To date, the following deliverables have been provided by the vendor in partnership with MHP staff, Community Based Organization (CBO) staff, and other community stakeholders:
    - ▷ Conducted a kickoff planning meeting with a wide array of stakeholders
    - ▷ Developed a timeline of milestones and contract deliverables
    - ▷ Formed workgroups and committee structures detailing roles, responsibilities, and reporting lines
    - ▷ Comprised an Echo Report of Project Planning Workgroup Meetings
    - ▷ Completed the installation of the ECHO EHR software for testing and end user verification
  - As of January 2016 the MHP and IS vendor were finalizing the project plan to include the details for deliverables and associated timelines.
  - Current anticipated ShareCare Practice Management 'Go Live' is May 2017.

- Recommendation #2: Establish methods, venues or forums in which to regularly meet with contract provider staff on issues; provide regular training, establish a point of contact, and provide technical assistance to contract providers.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - This is being accomplished at three levels and coordinated by Executive leadership team and includes the following activities:
    - ▷ The MHP Director and executive team are meeting monthly with CBO executives.
    - ▷ The MHP Director and the Quality Management Director have been meeting with Alameda Council of Community Mental Health Agencies (ACCMHA) Executive Directors monthly.
    - ▷ Joint PIPs are being launched by CBOs and the MHP staff.
  - Quality Assurance (QA) Office of Activities has provided a schedule of trainings, brown bags, and technical assistance to all providers.

- Points of contact for technical assistance have been established by QA for documentation and compliance issues including grievances, appeals, and expedited appeals.
- In 2015, the MHP Quality Assurance Office made significant efforts to provide more support, training, and technical assistance to contract providers as well as county programs that provide Medi-Cal funded services. The following summarizes these efforts:
  - All contracted providers and county programs have been assigned a Quality Assurance Technical Assistance contact person to provide support in regards to chart documentation, regulatory compliance, and other related QA matters. This will continue in 2016.
  - The cycle of trainings was increased from four to five times annually. This will continue in 2016.
  - The capacity of each training was increased from 35 to 55 participants and each provider was invited to send up to three QA staff per year (up from two per year). A week prior to each training, if space was available, an announcement was sent out inviting providers to send additional staff (more than 3 per year allowed in this case). This will continue in 2016.
  - The “QA Brown Bag” was developed as a monthly drop-in forum in which provider and county QA staff could bring questions related to QA activities for BHCS QA staff to answer. This will continue in 2016.
  - Group Technical Assistance (GTA) was developed as a training opportunity for contracted and county providers to receive peer feedback and technical assistance from BHCS QA staff in regards to chart documentation, compliance, and authorization of services. Three cohorts of four to five providers each began the six-month training which met monthly for three hours.
  - In 2016, GTA is being modified to a monthly drop-in training opportunity rather than a six-month commitment as providers found the 6-month commitment difficult. A drop-in GTA will allow more providers to participate as their schedule permits. Providers will give and receive feedback with peers as well as be able to receive technical assistance from BHCS QA staff.
- The BHCS Quality Assurance Office continues to evaluate the training needs of its providers and to incorporate the feedback from providers in regards to training needs. In 2016, trainings on DSM-5 and ICD-10 are being planned. The “Clinical Documentation Training Standards” training has been redesigned to include “Train the Trainer Training” and “Counseling and Coordination of Care.” The Quality Assurance Office is planning its trainings to reach the maximum number of providers with the most pertinent topics.

- Recommendation #3: Set parameters for timeliness standards, provide data collection and reporting timelines and distribute to stakeholders for analysis to inform service delivery improvements.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - As a result of the 1915(b) waiver special terms and conditions and the county's requirement to develop dashboards for publicly sharing their performance and outcomes of care to the residents of Alameda county, leadership teams in conjunction with the Committee on Performance Outcomes have set the following timeliness standards:
    - ▷ Routine requests for an outpatient mental health service: 10 days from initial request for service to assessment appointment.
    - ▷ Routine requests for an outpatient psychiatry (medications support) service: 14 days from initial request to psychiatric evaluation/assessment appointment
    - ▷ Urgent Care service: Within a 24-hour rolling period, 100% of clients will be triaged from first urgent contact to triage and referral to appropriate level of care and/or provider.
    - ▷ Discharges from inpatient psychiatric hospital follow-up: 80% of all discharges shall be provided an aftercare appointment/linkage within 7-days post-hospital discharge; 100% of all discharges shall be provided an aftercare appointment/linkage within 30-days post-hospital discharge.
  - Implemented four Emanio Dashboard reports on timeliness data which are available to MHP staff.
  - Although the MHP has established timeliness standards, it appears some of these were only recently identified and they have yet to track the urgent conditions and the medications support metrics on a regular basis.

- Recommendation #4: Continue with the vision of the new executive management team and develop extensive bi-lateral communications with stakeholders to enhance system planning and development.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP reports this has occurred through a number of joint planning and development processes, including the following venues:
    - ▷ MHSA Stakeholder Input
    - ▷ Crisis Planning Stakeholder input
    - ▷ 5150 Planning and designation of non-designated facilities and non-law enforcement personnel

▷ AB 1421 stakeholder planning process.

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

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

- Access to Care
  - The MHP currently has approximately one hundred open/unfilled full-time equivalent (FTE) positions, including supervisory and direct service provider positions. Leadership is currently involved with county personnel to eradicate this situation.
  - Moving from the pilot phase to program implementation phase with Mobile Evaluation Team (MET), a partnership with Oakland Police Department pairing a mental health clinician with a police officer to respond to 5150/mental health assistance requests. MHP will be meeting with other city police departments to discuss developing more teams throughout the county.
  - Increased crisis residential with an additional 16 beds.
  - Augmenting Katie A. Services by 1.5 million dollars for ICC and IHBS Services.
  - Developed MOU with the Juvenile Court for review of all JV 2220's for psychotropic medication.
  - Final stages of hiring a psychiatrist to do the review of all JV 220's submitted to the court for foster youth.
- Timeliness of Services
  - Tele psychiatry pilot project was initiated with Bonita House to provide timely access for medications support services.
  - The staff vacancies appear to result in potential adverse effects in timely appointments for initial assessments and follow up treatment.
- Quality of Care
  - The MHP currently has approximately one hundred open/unfilled FTE positions which results in lack of infrastructure that impacts quality of care. As mentioned, leadership is currently discussing the critical nature regarding the need to fill these positions.
  - Created an Older Adult Dashboard.

- Medication monitoring database developed and implemented for youth in Juvenile Hall.
- Emanio Dashboard developed for monitoring State paid Medi-Cal claims for youth on psychotropic medication.
- Received a Zellerbach Family Foundation grant to hire a BHCS Trauma Coordinator.
- Older Adult System of Care (OA SOC) joined Executive Team.
- Developed a "floor training" on Trauma Informed Care that will be rolled out across all of BHCS for County and Provider staff.
- As part of a Bay Area 7 County Partnership was awarded a 4 year SAMHSA Trauma Grant.
- Transitioned the Early Connections SAMHSA grant program into the Children System of Care (CSOC) including a cross system formal celebration/report out on the accomplishments, lessons learned/take away integrated and evaluation results.
- The MHP's Older Adult System of Care is requesting to release a Request for Proposal (RFP) to develop a program which will train Older Adult LGBTQ Peer Support staff for the priority high risk target population of LGBTQ older adults aged 60 and older with mental health needs.
- The Transition Aged Youth System of Care (TAYSOC) began training TAY, children and adult providers on high yield Cognitive Behavioral Therapy for Psychosis (CBTp). This is an evidence informed intervention for case managers, family supports, peers supports and clinicians. In addition staff received increased assessment skills for identifying first episode psychosis. One cohort of children and TAY providers has completed the training. Adult providers will be included in next year's cohort.

- Consumer Outcomes
  - Wellness Centers exist with barrier-free access for all those community members with known or those exhibiting mental health symptoms.
  - Development of the Results Based Accountability (RBA) implementation in which the Transition Age Youth System of Care (TAYSOC) provided RBA introductory training for TAY providers and other stakeholders in preparation for developing TAYSOC outcomes in 2016.
  - Schreiber Center became operational in September, 2015. The Schreiber Center offers specialty mental health services for Alameda County residents aged eighteen and over who are diagnosed with developmental disabilities and experience severe mental health symptoms.
  - CANS/ANSA implementation which includes:

- All Children's System of Care (CSOC) providers began using the CANS as of Sept. 2015 with a continued roll out of providers entering data on line in Objective Arts data base.
- TAYSOC began using the ANSA-T designed by TAY providers with some TAY from the Pool of Consumer Champions (POCC) TAY group.
- Development of an Older Adult ANSA Tool.

PERFORMANCE MEASUREMENT

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2016.

TOTAL BENEFICIARIES SERVED

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

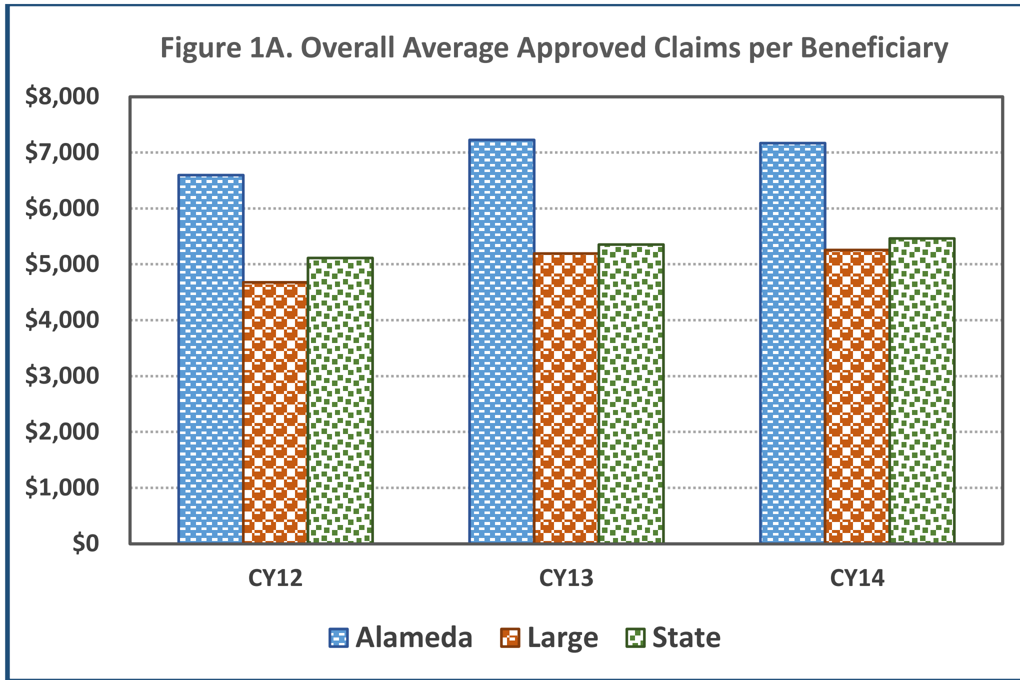
Table 1—Alameda MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	33,612	3,868
Hispanic	101,223	5,182
African-American	66,304	7,625
Asian/Pacific Islander	71,207	2,144
Native American	870	103
Other	41,030	3,332
Total	314,244	22,254

**The total is not a direct sum of the averages above it. The averages are calculated separately.*

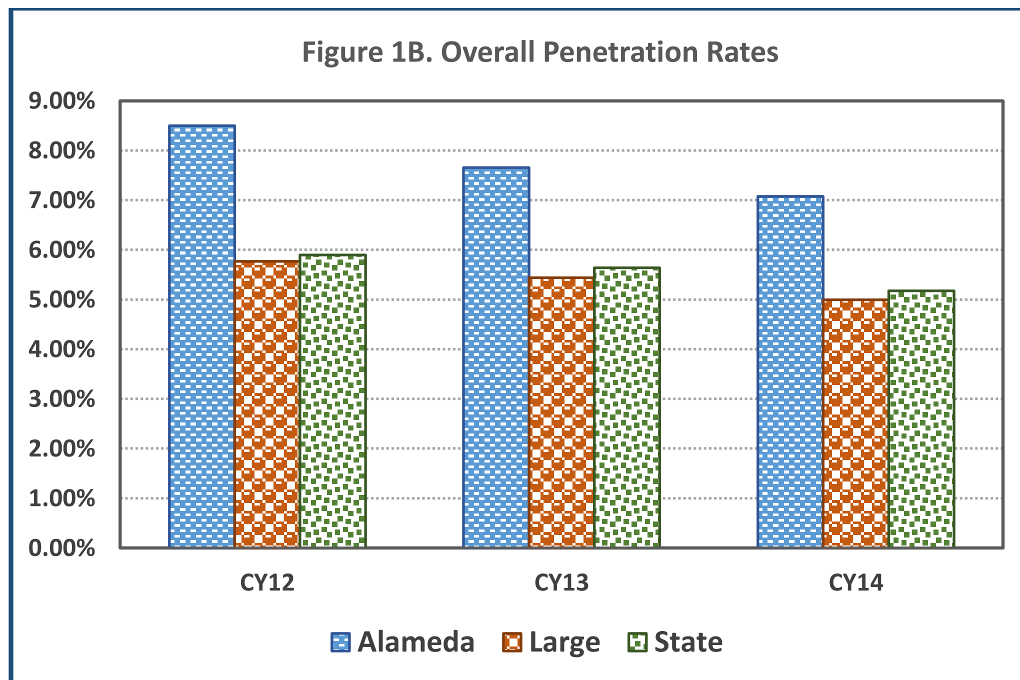
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

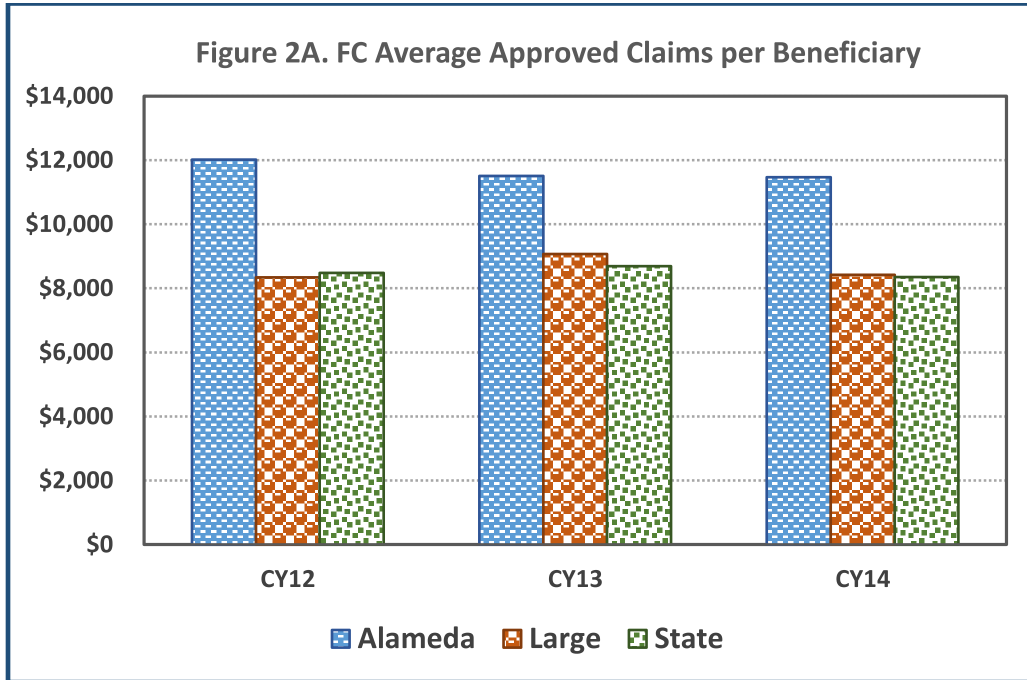
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.

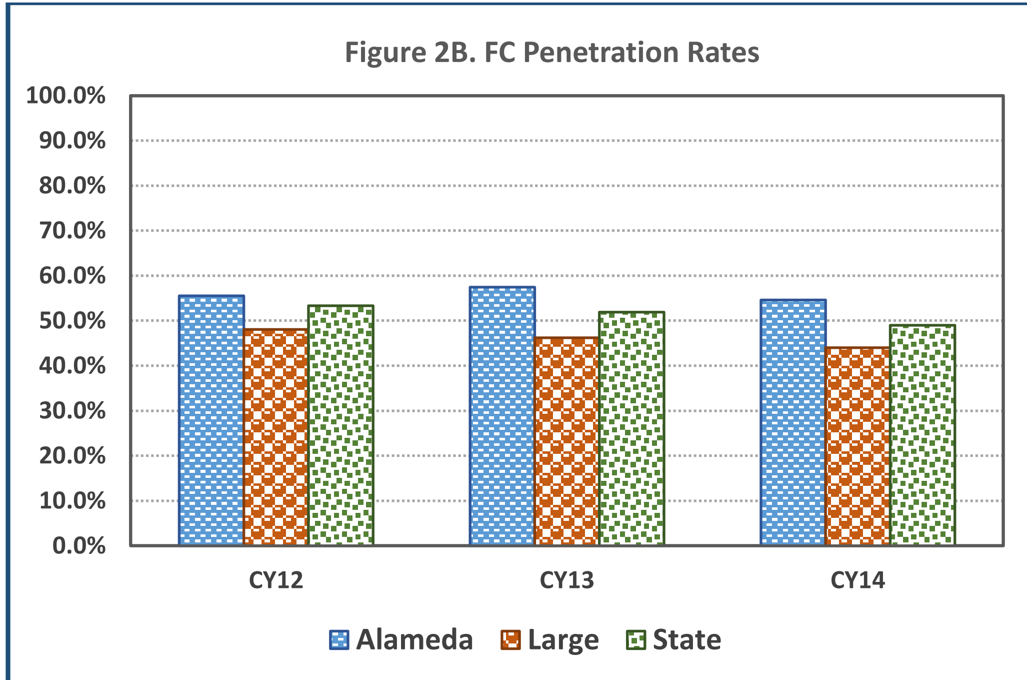


.

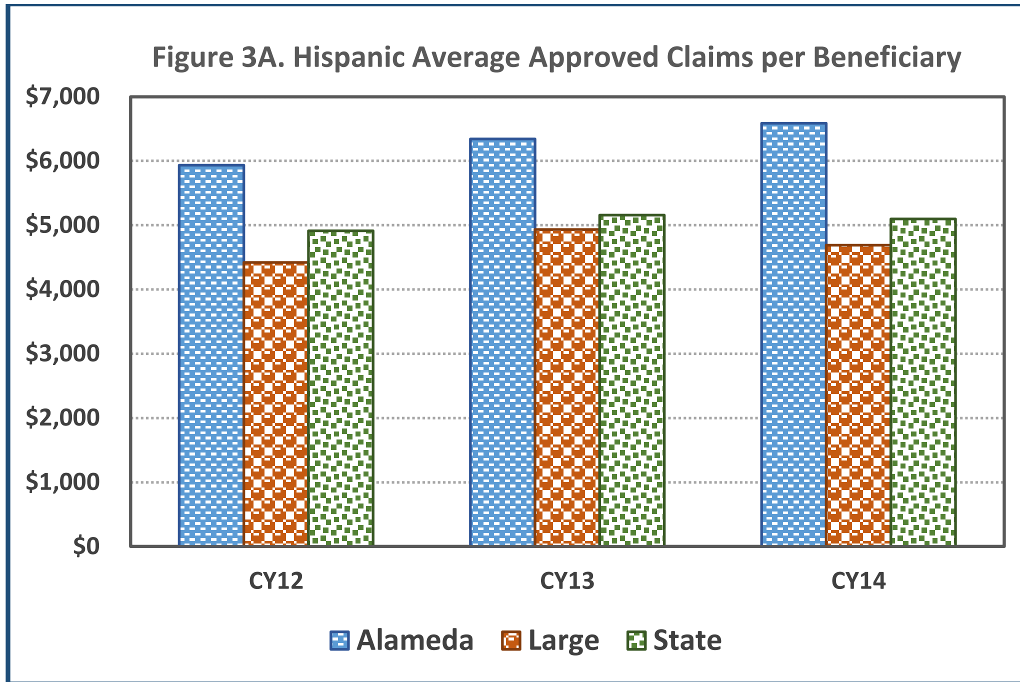


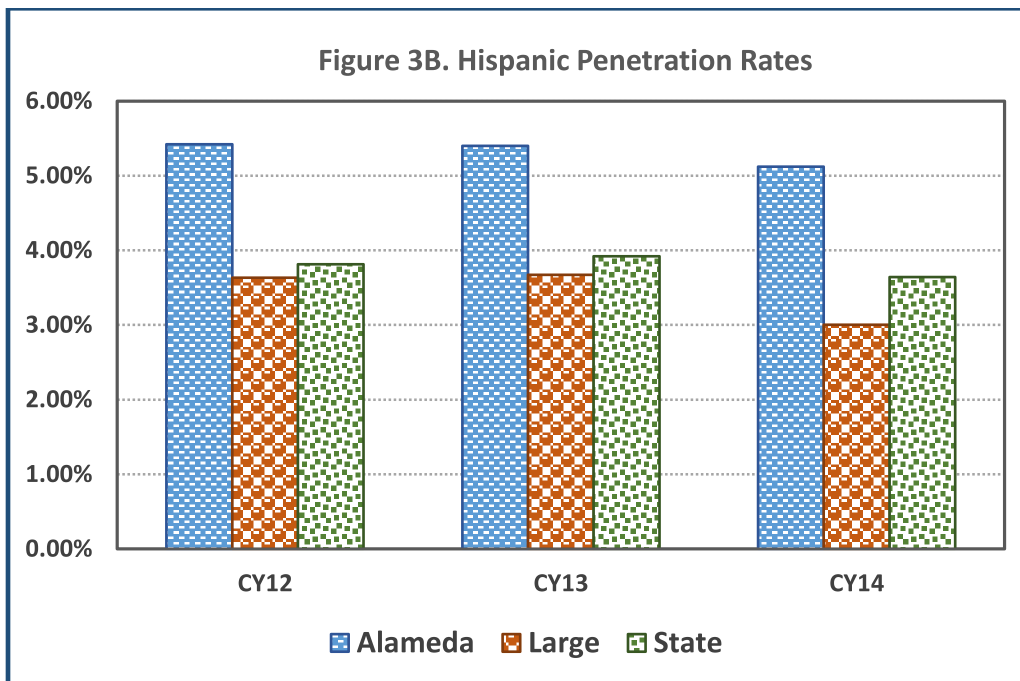
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





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





HIGH-COST BENEFICIARIES

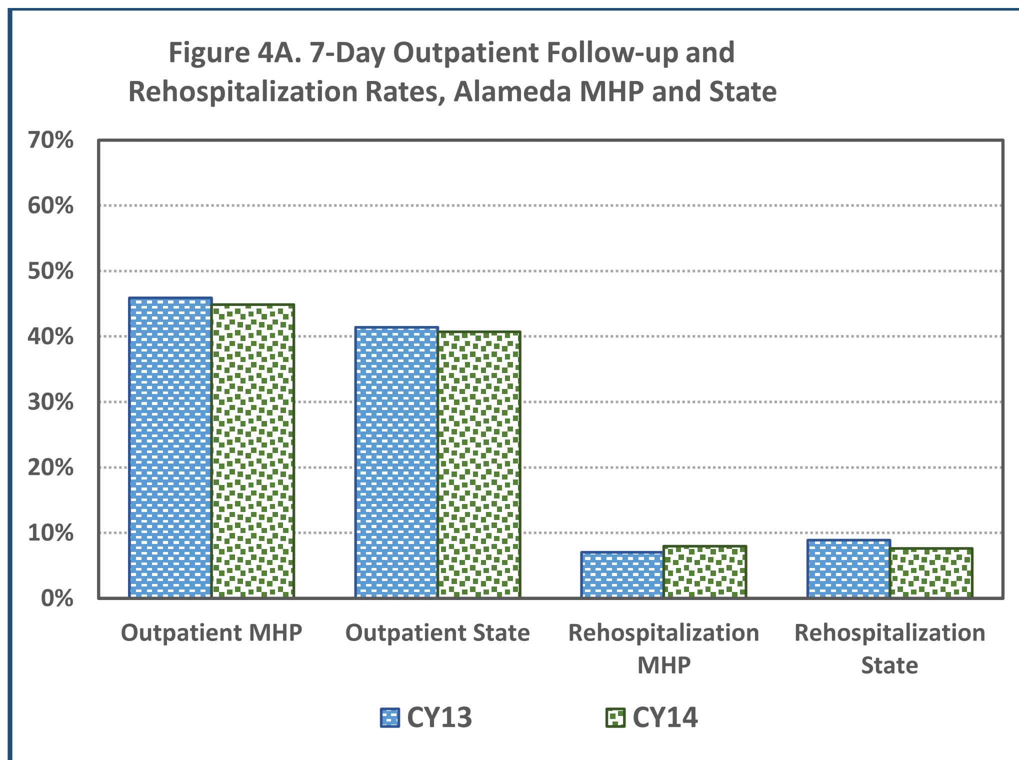
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	$50,358	$617,293,169	24.41%
Alameda	CY14	1,005	22,222	4.52%	$49,887	$50,135,990	32.30%
	CY13	1,073	21,744	4.93%	$49,514	$53,128,819	33.81%
	CY12	1,008	22,812	4.42%	$49,856	$50,254,411	33.39%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY13 and CY14.



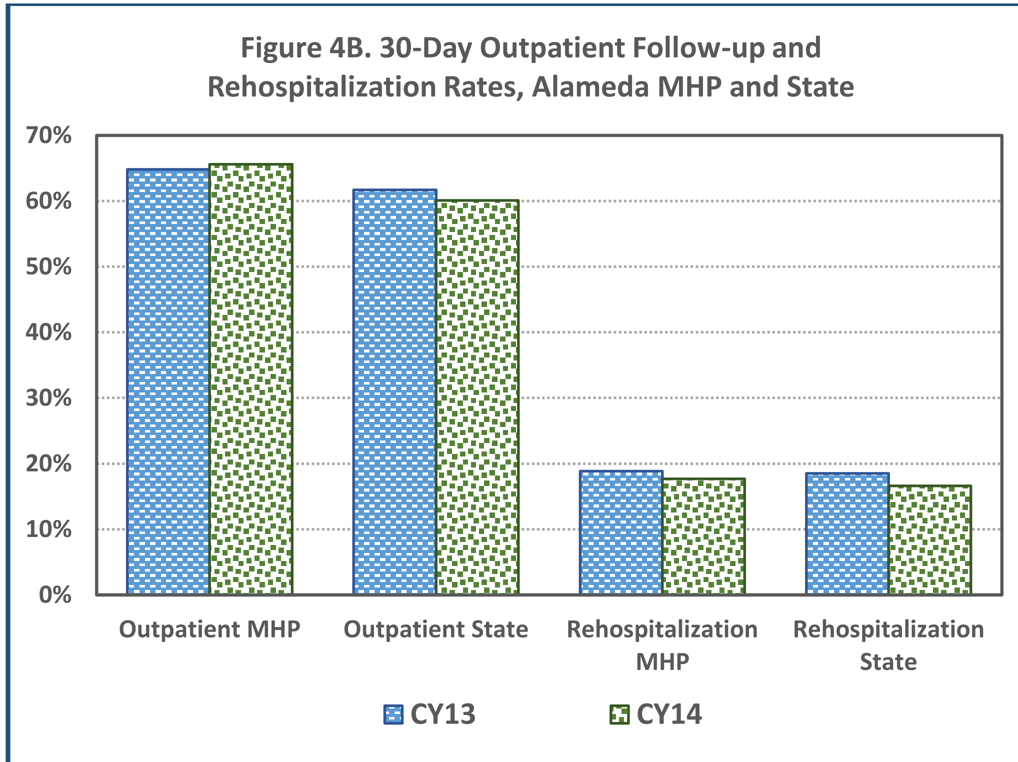
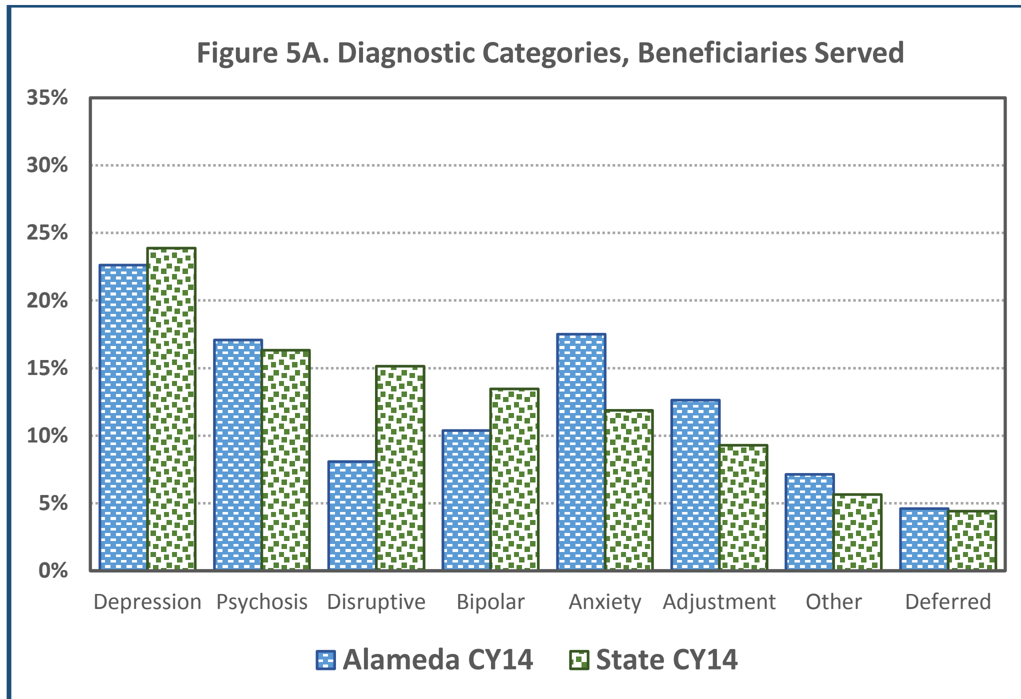
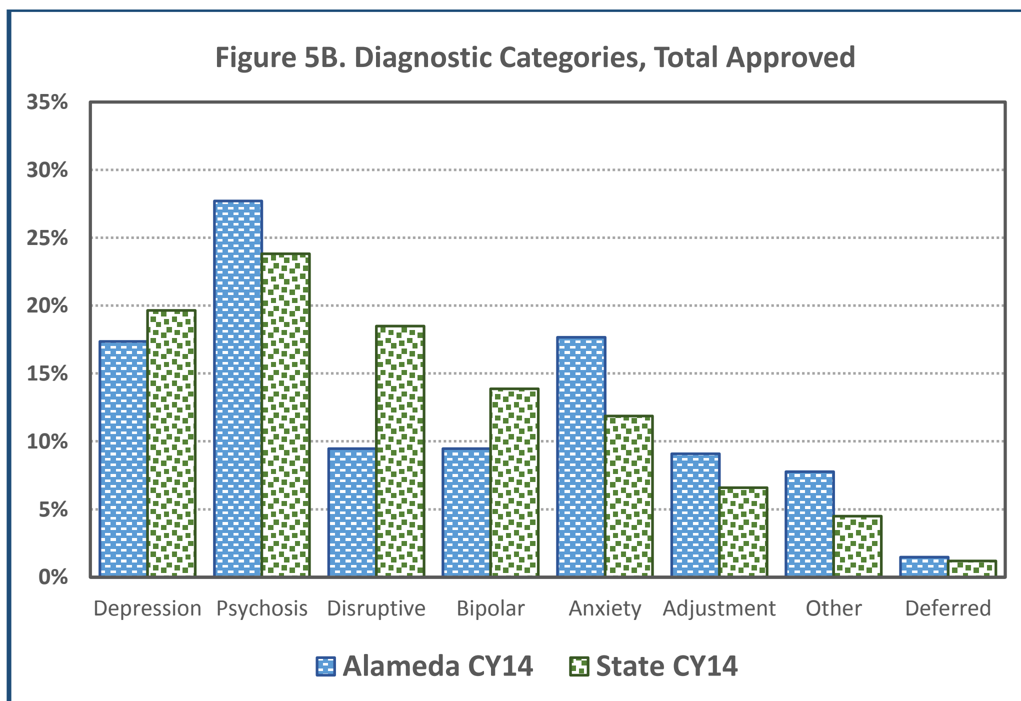


Figure 4B. 30-Day Outpatient Follow-up and Rehospitalization Rates, Alameda MHP and State
70%
60%
50%
40%
30%
20%
10%
0%
Outpatient MHP
Outpatient State
Rehospitalization MHP
Rehospitalization State
CY13
CY14

DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY14.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Although the MHP penetration rate slightly declined over the three-year period, the MHP's penetration rate remains substantially higher than both large MHPs and statewide averages. (See Fig. 1B.)
  - The MHP Approved Claims per Beneficiary Served (ACBS) continues a three-year upward trend and is significantly above similar size MHPs and the statewide experience. (See Fig. 1A.)
  - The Foster Care penetration rate during the three-year period was stable (50%-55%) and trends were similar to both large MHPs and statewide averages. (See Fig. 2B.)
  - Foster Care ACBS continues a three-year trend upward and was significantly above large MHPs and the statewide experience. (See Fig. 2A.)
  - The MHP Hispanic beneficiary penetration rates continue to be significantly higher than the statewide experience, and the Hispanic ACBS was significantly higher than large MHPs and the statewide experience. (See Figs. 3A&B.)
- Quality of Care
  - The MHP percentage of High Cost Beneficiaries (HCB) rose in CY14 to 4.52%, which was almost twice the statewide experience at 2.48%. The MHP's total percentage of approved claims for HCBs in CY14 at 32.30% was almost eight points higher than the statewide figure at 24.41%. (See Table 2.)
  - The MHP use of Anxiety and Adjustment diagnoses is higher than statewide figures. Also, the claims dollars approved for these categories is higher than that of the statewide average. (See Figs. 5A&5B.)
  - The MHP's use of Disruptive and Bipolar diagnoses is significantly lower than statewide figures. Also, the claims dollars approved for this category is lower than that of the statewide average. (See Figs. 5A&5B.)
- Consumer Outcomes
  - The MHP 7-day and 30-day outpatient follow-up rates for CY14 are similar to its CY13 rates. (See Figs. 4A and 4B.)

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2014.

ALAMEDA MHP PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	PIP Titles
Clinical PIP	Reduction of use of restraint and seclusion in subacute programs
Non-Clinical PIP	High Cost Users

Table 3A lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

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

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

Table 3A—PIP Validation Review					
				Item Rating*	
Step	PIP Section	Validation Item		Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	NA	NA
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NA	NA
		8.3	Threats to comparability, internal and external validity	NA	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NA
		9.3	Improvement in performance linked to the PIP	NA	NA
		9.4	Statistical evidence of true improvement	NA	NA
		9.5	Sustained improvement demonstrated through repeated measures.	NA	NA

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

Table 3B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	14	2
Number Partially Met	2	4
Number Not Met	0	10
Number Applicable (AP) (Maximum = 30)	16	16
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	93.75 %	25%

CLINICAL PIP—REDUCTION OF USE OF RESTRAINT AND SECLUSION IN SUBACUTE PROGRAMS

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

- "By having a more recovery centered culture, could the organizational provider Telecare lower the rate of seclusion and restraint, while also creating a healing environment?"
- Date PIP began: June 2014
- Status of PIP:

☒ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

The MHP presented documents at the time of the review for consideration of a clinical PIP which its organizational contract provider Telecare has initiated. The local implementation of this PIP was initiated in late June 2015 in which Telecare launched its pilot kick-off focused on "Data Management, a Roadmap to Adverse Events". However, the baseline data and pertinent information applicable to the MHP consumers at these facilities had not been determined. Overall data was provided for all programs served by Telecare. This summary addresses the background of its proposed PIP.

The kick-off was the orientation to a culture change and focused on the foundation of the methodology for improvement in these facilities stressing the importance of data driven quality programs. Telecare was founded on the belief that rehabilitation and recovery from serious mental illness are possible, and that people can recover their hopes, dreams and life roles.

Telecare provides services for the seriously mentally ill consumers of the MHP in sub-acute inpatient facilities. Over the course of the past 18 years Telecare has trended its data on adverse events, specifically use of restraints, seclusion and assaults in its facilities. Specific data for the MHP had not been submitted therefore it was unclear whether improvements were applicable to the MHP facilities. Overall, Telecare reported trends for these elements which continue to decrease, with the exception of its assault metrics which did not decrease as rapidly as the other metrics. Stemming from its quantitative data on these adverse events, Telecare determined that a culture of change was required to actually move beyond the quantitative aspects and push towards the

quality of recovery culture. It has consolidated its learning and experience into the Recovery-Centered Clinical System (RCCS), a richly personal, holistic, comprehensive approach to recovery.

The RCCS is based on a belief that recovery can happen, but it does not cause recovery to happen. Instead, the RCCS strives to create an environment that supports recovery. It does this by concentrating on two distinct but complementary areas: culture and conversations.

- Culture is focused on the recovery environment which includes not only the individuals served, but also staff and the interpersonal relationships that create a supportive program setting. Culture work focuses on five areas of awareness — judgment, power, uniqueness, respect, and motivation, which help cultivate an environment where recovery can grow and thrive.
- Conversations are focused on the individual. Conversations includes five components — identity, hope, choice, harm, and connection, which help individuals to awaken and enliven their recovery process.

The ongoing results of the RCCS model are collected through the Telecare Recovery Centered Measure (RCM) survey tools. These were developed to quantify culture effectiveness through a rigorous three year longitudinal validation process resulting in the development of three surveys. These measure qualitative factors in which data from three perspectives are collected. These include staff's view of staff interactions with each other, staff's view of staff interactions with consumers, and consumers' view of staff interactions with consumers. Each survey consists of 25 questions with a choice of six responses from Strongly Agree to Strongly Disagree. The scales are designed to measure program culture change and compare recovery-focus among programs. The results report changes for each question categorized as thriving, healthy, unhealthy, and harmful. In addition, the quantitative factors continue to be collected and measure the decrease of the use of seclusion, restraints, and assaults within the sub-acute inpatient facilities.

The baseline status and the results of the RCCS and its outcome tools have not been reported from the PIP for the MHP as yet. The model appears to be a solid and quality model to infuse within the sub-acute facilities. Telecare has utilized the RCCS model and its data is reported cumulative across all its programs both in California and other states which leaves a void in isolating the data for the MHP consumers. In addition, the PIP submission tool was not provided as a format, although extensive documents were distributed at the time of the review.

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

The technical assistance provided to the MHP by CalEQRO consisted of extensive discussion regarding the MHP's role and involvement in this PIP. Sensitive to the fact that the MHP contracts the greater majority of its services, CalEQRO staff indicated that the efforts of this PIP are worth consideration. The format of the PIP will need to be completed on the requested "BHC PIP Development Outline" for future ratings should this continue. However, since the MHP is not involved in this directly, it will need to ascertain the degree to which it will require reporting on these efforts and the by its contracting agency and what the MHP will expect in terms of outcomes and goals. The outcomes reported data will need to be specific to the local MHP facilities and report

on its consumer outcomes. The CalEQRO staff reinforced its availability ongoing to discuss this PIP effort.

NON-CLINICAL PIP—HIGHEST COST CONSUMER

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

- “Will increased case-coordination using an intensive case-management (FSP, ACT or service team) service delivery model improve client/system outcomes for high cost clients, as measured by the following metrics:
    - Number of clients successfully stepped down to a lower level of care
    - Improved level of functioning as measured by GAF and/or ANSA scores
    - Lower rates of hospital, PES/CSU, and/or Sub-Acute service utilization
    - Lower average costs per client
    - Increase in utilization of appropriate outpatient planned services”.
- Date PIP began: November 2014
- Status of PIP:

☐ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☒ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

The MHP presented its concept PIP in a power point presentation at the time of the review for consideration of its non-clinical PIP. The MHP examined its data for its highest utilization/cost consumers beginning in November 2014 over the course of a year through November 2015. The date findings indicated the following results:

- Finding #1: Cost of top 3% of adult consumers (N=670) totaled $64.7 million (37% of budget). Average 12-month cost greater than $49K per client/consumer.
- Finding # 2: 63% of adult consumers received less than $1k of services during the measurement period.

- Finding # 3: The majority of services delivered to the highest cost consumers utilize Sub-Acute, Inpatient Hospital, and Crisis stabilization/PES.

The MHP subsequently queried itself with the question: "Are the highest cost consumers connected to a service team or FSP?" The following data was presented as a result of this question:

- 448 (66%) had a service team, Level II or FSP episode in the past 12 months (N= 670)
- Of the 222 not on a service team, 100 were in sub-acute sometime in the past 12 months
- 122 did not have service team episode or sub-acute episode in the past 12 months.

Following the presentation, discussion ensued crediting the MHP with the value of this PIP given both the percentages of client count and billed Medi-Cal services are higher than statewide experience and this could better inform the MHP of its service pattern usage. Also, discussion regarding whether this PIP question was reflective of the MHP's intentions secondary to its findings which indicated a majority of the high cost users are already connected to a service team (66%). It was discussed whether the original question applies or perhaps the MHP would consider detailing the activities of the current service teams which comprise this service delivery. The next question, how could the MHP effectively impact this service in order to reduce high costs, may be worthy of consideration. It is customary for a service delivery teams/FSP episode to include a more robust service delivery, with consumers assigned a personal service coordinator and infuses a wraparound approach to treatment. If this applies, it would benefit from a deeper understanding of how its service teams are functioning and what barriers are preventing this model to be fully applied. Options to consider a step down program may apply as well.

Although, the question is worthy to pursue the PIP is considered at the early stage secondary to a void of interventions applied, the remeasurement data has not been completed, and the fact that the current study question may not be specific to its data findings. The format of the PIP will need to be completed on the requested "BHC PIP Development Outline" for future ratings should this continue.

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

The technical assistance provided to the MHP by CalEQRO consisted of recommending the MHP survey the manner in which its current service delivery/FSP teams provide treatment. If the process of reviewing this service delivery should reveal a specific component for which to improve, perhaps including it in its study question. Also, discussion ensued which suggested the MHP consider a strategy to intervene in the service teams that provides a real-time intervention that can address those consumers utilizing the high cost services, such as a specific treatment team that reviews this population on a timelier basis, discusses appropriate next steps in treatment, applies the intervention and then measures the results. Results could be measured through surveys as well or interventions using peer mentors to follow-up post high service usage could be considered.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

  - Addressing appropriate service treatment and goal setting will potentially lead to accessing the lowest level of care for consumer needs.
- Timeliness of Services
  - Timely follow up with high end service consumers potentially impacts functionality with engagement strategies.
- Quality of Care
  - Provision of intensive wraparound approach services to users of high cost services can impact consumer health and lead to increased independence.
  - Coordinated and appropriate treatment planning can lead to productive choices for consumers over time.
- Consumer Outcomes
  - Applications of innovative strategies such as the RCCS model for consumers can lead to positive outcomes and reduced need for outdated methodologies in sub-acute settings.
  - Use of consumer input and feedback through tools such as surveys, involvement in care plans, and increased functioning scores contributes to the principles of recovery and wellness for consumers.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 4, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PC	The MHP consistently utilizes its data dashboard to support decision-making process to identify unserved and underserved ethic/racial populations. The MHP reviews data dashboard reports to inform it of consumer access to service timeliness metrics and penetration rates across populations. Although the MHP strives to provide cultural and linguistic match for consumer needs, stakeholder groups indicated the need still exists, especially for Spanish and the various Asian languages. The MHP has engaged the interpreter services of a new vendor which stakeholders indicate continues to be difficult to obtain.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The MHP engages in analysis of service capacity and capacity utilization patterns noting the location and types of services received. To more fully serve its Katie A. subclass, the MHP has dedicated $1.5 million from its EPSDT funding to provide for an additional 14 FTE staff to provide ICC and IHBS services. The MHP has focused recent initiatives on service provisions to the older adult population and received funding to expand this endeavor.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP has enhanced its collaborative efforts with its CWS partners to screen, assess and provide services to Katie A. subclass members. The CWS partners were not present as requested for the session at the site review. The MHP continues its collaboration with organizational providers for service delivery including healthcare agencies, primary care clinics, law enforcement, homeless integration, as well as specialized children's providers.

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

Timeliness of Services

As shown in Table 5, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 5—Timeliness of Services			
	Component	Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP reports a standard of 14 days with an overall average of 19 days and reports it meets this 54%. For its adult services, the MHP reports an average of 18 days meeting this 57% of the time. For its children's services, the MHP reports an average of 21 days meeting this 47% of the time. It would benefit the MHP to analyze this metric for improvements, especially for children's services since this is met less than half of the time. Overall, the MHP regularly reviews its dashboard reports for timeliness to service and its penetration rates across populations and locations. Children's providers indicated it is routine maintain their own individual appointment schedules for consumer contacts.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP reports a standard of 21 days with an overall average of 28 days and reports it meets it 45%. For its adult services, the MHP reports an average of 8 days meeting this 46% of the time. For its children's services, the MHP reports an average of 29 days meeting this 43% of the time. Again, it would benefit the MHP to analyze this metric for improvements for both services since this is met less than half of the time. In addition, stakeholders often voiced concern in being able to access required medications in a timely manner.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP does not track this metric. The MHP anecdotally reports a goal of 24 hours. The MHP will need to consider tracking, reviewing this metric and applying improvements if required.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	The MHP reports a goal of 7 days with an average of 7.4 days and reports it meets it 22.7%. For adult services it reports an average of 7.79 days with 36% meeting this metric. For children's services it reports an average of 6.6 days and reports meeting this 19% of the time. While the MHP reports an average length of time within its goal metric of 7 days, it meets this standard at a rate far below. This metric appeared to be met at a much higher rate during the last review cycle. The MHP presented a PIP focused on high end users which may elicit some improvements in engagement of this vulnerable group.
2E	Tracks and trends data on rehospitalizations	PC	The MHP reports a goal of no more than 18% with an overall average of 27%. For adult services it reports a 28% readmission rate and for children's services it reports a 25% readmission rate. As previously mentioned, the PIP focused on reducing high end users may create more engaging strategies in lower end service use.
2F	Tracks and trends No Shows	NC	The MHP does not track this metric. The information from this could inform the MHP of strategies to address its provider's workload capacity and consumer engagement.

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

Quality of Care

As shown in Table 6, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and

utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	PC	The MHP has a broad base representation in its Quality Improvement committee. It meets consistently on a monthly basis and produces minutes documenting its activities. The MHP underwent a vacancy in its Quality Management unit with the departure of a long time QI Coordinator. This contributed to its lack of an evaluation of its prior year's work progress, and resulted in a draft QI work plan for FY1516. This proved unfortunate as this leaves the MHP void of documenting its accomplishments. Additionally, the focus on its PIPs was limited. Although, the MHP submitted two PIPs neither of the PIP activities were documented throughout the year and were submitted at the site review.
3B	Data are used to inform management and guide decisions	FC	The MHP engages extensively in the use of its Emanio system to produce detailed data dashboards to keep informed of numerous measures.
3C	Evidence of effective communication from MHP administration	FC	Stakeholders report an increase in communication effectiveness. The MHP responded to recommendations and created a collaboration with local newspapers, distributing a quarterly full four page insert on current themes in mental health. This resulted in a 400,000 distribution county-wide. Leadership presence at community events, organized presentations, newsletters, emails and brown bag lunches have been initiated. Stakeholders report an open door policy and responsiveness have evolved favorably.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	The MHP leadership has created numerous meetings to engage its stakeholders. It has voiced its mission, goals and vision to its stakeholders. This includes its executive team, its extended leadership team, the supervisory team and various subcommittees to address its goals and initiatives. The new leadership has demonstrated an impact within its system of care within a short time and continues to engage all levels of stakeholder presence. It is noted that consumer presence exists and some indicated this was marginally present. Stakeholders welcome increased representation within the various committees.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP utilizes its contracted organizational providers to deliver services to over 85% of its consumers. Services continue across a spectrum of care. Most recently, a focus on foster care youth, older adults, LGBTQ2S, the homeless and food secure initiatives have begun.
3F	Measures clinical and/or functional outcomes of beneficiaries served	PC	CANS is used extensively with the foster care youth population. One community-based organization is engaged in the pilot phase implementation using the CANS. The MHP has plans to roll-out CANS to all county clinics during early 2016. CANS is standalone database. Reports will be generated and reviewed in the coming year.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP distributes the statewide required Consumer Perception Survey twice a year during a 2 week timeline. The MHP relies on the state for the results and has not applied improvements based on the feedback from consumers for this survey. The MHP also distributes surveys for its initiatives such as the Prevention and Early Intervention Community Survey, the Crisis Intervention Training, the LGBTQ2S groups, and Isolated Adults and Older Adult Consumers for which it publishes results for committee review and applies improvements.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP continues to employ its Pool of Consumer Champions (POCC) as employees throughout its system of care. A wide range of services are provided such as participation in the MHP expanded leadership team, advocacy, training, education, and its speaker's bureau. Its focused committees identify needs and provide input to MHP for improved services, homeless outreach, and support services in clinics and hospitals. There are approximately 85 consumers which participate in committees and receive a stipend for participating. Although, recovery training is provided, the POCC stakeholders indicated that the principles of recovery and wellness are not accepted by some providers and doctors. The MHP could benefit from re-occurring updates on applying the principles of recovery and wellness.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	Consumer run and driven wellness and recovery centers, the POCC and various drop in centers are a presence throughout the MHP.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The MHP will need to determine effective and reliable methods for which consumers will receive culturally and linguistically appropriate services.
    - The MHP has increased its collaborative efforts to provide for Katie A. subclass members with screening and referral processes with CWS partners and funding for providers in hiring new ICC and IHBS workers. It was unfortunate that the CWS partners were not in attendance at the on-site session.
- Timeliness of Services
    - Given the breadth of data available to the MHP and its forward thinking, a review of the outdated process of staff keeping their own schedules could impact the timeliness metric.
    - The MHP will need to consider tracking and reviewing its metrics for urgent conditions and no-show appointments. Analysis of both these may provide insights for procedural changes given the clinicians appointment schedule and the stakeholder responses to crisis care.
- Quality of Care
    - The MHP will need to prioritize a review of its current QI staffing to ensure its goals are maintained.
    - The MHP has established increased community collaborations with its law enforcement teams, homeless coordinators, and its older adult and TAY populations.
    - The MHP could consider distributing an annual staff survey in the use of the wellness and recovery process.
    - Although peers are well integrated in many committees, the MHP could consider additional venues. Examples include a potential unmet need which exists for peer specialist/navigators in clinics and a consumer run warm line for after hours.
    - To its credit, the MHP has extended strategies to increase effective communication with its organizational providers.
- Consumer Outcomes
    - The MHP could benefit from timely review of its CANS and ANSA tools to inform it of potential program changes and assess consumer progress.

- The MHP initiated specialized versions of the outcome tools for its TAY and older adult populations (ANSA-T). Versions were designed by TAY providers and TAY from the Pool of Consumer Champions.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

- A culturally diverse group of adult beneficiaries including both high and low utilizers of MHP services
- A culturally diverse group of parents/caregivers of child/youth beneficiaries, including both high and low utilizers of MHP services

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This was a well-attended group for a total of 16 adult consumers and transition-age youth (TAY) beneficiaries which received MHP services. It should be noted that this led to an unanticipated logistic. The group room was at capacity and given the shape of the room led to some extra chairs placed away from the larger group to accommodate this size group.

The majority of group participants received medications support services beginning within the last year to over five years. The group consensus was expressed as a need to incorporate additional services such as counseling to benefit from the medications support. Some members expressed concern in not fully understanding the access criteria and how to become eligible for other service needs. In addition, it was felt that a lack of sufficient support services including housing, employment, services for homeless individuals, trainings, and workshops were not readily available.

Group participants were aware of how to access crisis services, however, most indicated this was not the most helpful route to assistance. Others knew to contact their provider during business hours. Overall, participants indicated the psychiatric providers did not provide adequate education for consumers to understand their treatment. The majority of the group expressed a lack of a culturally appropriate and preferred linguistic match with the consumer preference to the provider.

Recommendations arising from this group include:

- Improve transitions into and exiting TAY services to avoid gaps in service
- Provide community based programs in neighborhoods were consumers live; Provide specialized programs to help Latinos and Black youth

- Establish family education and family support groups to better understand needs/behaviors of consumer
- Provide appropriate cultural and linguist consumer/clinician match

Table 7A displays demographic information for the participants in group 1:

Table 7A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants*		16
Number/Type of Participants	Consumer Only	16
	Consumer and Family Member	
	Family Member	
Ages of Focus Group Participants	Under 18	
	Young Adult (18-24)	6
	Adult (25–59)	7
	Older Adult (60+)	3
Preferred Languages	English	16
	Spanish	
	Bilingual__________/___________	
	Other(s) ______________________	
Race/Ethnicity	Caucasian/White	3
	Hispanic/Latino	3
	African American/Black	5
	Asian American/Pacific Islander	4
	Native American	1
	Other(s)______________________	
Gender	Male	9
	Female	7
	Transgender	
	Other	
	Decline to state	

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This group consisted of seven parents of youth beneficiaries and was held the Eden Children Services Clinic at 2045 Fairmont Drive, San Leandro, CA.

Most parents were very satisfied with current services and spoke highly of services received from Parent Partners. The youth have been receiving services for several years and parents have noted improvement in their children's behavior. Entry into mental health services for most came through an outside referral, primarily from school, social service agency, law enforcement, and 5150 admissions at Willow Rock. All indicated that prior to referral they had no knowledge of available mental health services for their children. Family members felt respected by staff and that they listened to their concerns. In a crisis most would rely on a friend, family member or parent partner. Some were not aware of any type of crisis services and those who did use this felt the crisis services were not responsive or experienced a delayed call-back.

Parents expressed a lack of appropriate services for their children at other major medical healthcare plans and felt there was a need for coordination between these and the MHP providers.

Parents expressed a lack of publicly accessible information regarding mental health resources in their community and language. Others stated law enforcement was ill-trained to deal with crisis.

Parents would welcome increased involvement with the youth's treatment and stated limited availability of family therapy existed. Parent who remained in the clinic lobby while treatment occurred stated they could use an area for child care while a family member is meeting with the clinician.

Recommendations arising from this group include:

- To increase the availability of family therapy
- Increase availability/numbers of Family Partners
- Provide effective and responsive crisis services
- Disperse community based mental health information at schools, churches, neighborhood stores, use of non-English speaking media
- Consider an area with child care during parent sessions with clinician.

Table 7B displays demographic information for the participants in group 2:

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants*		**7**
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	 7
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 7
Preferred Languages	English Spanish Bilingual__________/___________ Other(s) ______________________	6 1
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)______________________	2 5
Gender	Male Female Transgender Other Decline to state	 7

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 2: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Consumers voiced that the needs of non-English speaking consumers are not being adequately met. It was mentioned there appears to be limited availability of interpreters including Spanish and Asian languages.

  - Concern was expressed regarding the lack of after-hour and weekend services. Some indicated difficulty in accessing an after-hour crisis assessment.
- Timeliness of Services
  - Concern was voiced regarding the unpredictability of crisis responses, leaving a gap in responsiveness to consumers.
- Quality of Care
  - There are avenues for bi-lateral communication and staff are aware of changes taking place at the MHP. There are various forms of medium used for communication and updates.
  - Most parents expressed concern and difficulty coordinating services and effective/satisfactory referrals between service providers.
  - A majority of parents felt that their input with clinician staff has been appreciated and treatment led to improved consumer outcomes. This led to a developing relationship based on mutual trust and understanding.
- Consumer Outcomes
  - The need to continue to provide training to law enforcement to enable positive outcomes with consumers was indicated.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

Table 8 shows the percentage of services provided by type of service provider:

Table 8—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	18.38%
Contract providers	80.10%
Network providers	1.52%
Total	100%

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

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

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

10.5%

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

n/a

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- No-show data is inconsistently reported by clinical staff. Therefore no-show rates are not calculated or used to measure a clinic's capacity to serve additional consumers.
- The MHP calculates Medi-Cal beneficiary penetration rates annually. The analyses includes services delivered by County Regions, including the amount and type of services provided. They also produce penetration rate data by ethic, cultural and linguistic populations to support the Cultural Competence Plan.

CURRENT OPERATIONS

- The MHP continues to use InSyst, a legacy practice management system, and eCURA, for managed care tracking purposes. The MHP also uses Clinicians Gateway system for clinical reporting capability. Clinicians Gateway is used for the treatment plan, assessment, progress note, medication record, e-prescribing, and the facesheet.
- Incremental database backup is done daily. In addition, full backups are done weekly. The backup media is stored off-site.
- The MHP technology support is currently allocated twenty-one full-time equivalent positions. Since the previous CalEQRO review, the MHP has hired one FTE and another FTE staff has either retired, transferred, or terminated employment. Currently there are four unfilled positions.
- Newly hired data input or administrative support staff and clinical users are required to attend formal classroom training before their user id is assigned. InSyst training generally is provided once a month, or on as-needed basis. Clinicians Gateway training is provided on an as-needed basis when new staff are hired. If user error occurs on a frequent basis the supervisor is consulted for supplemental training.
- Decision Support group produces informative and meaningful dashboard data using Emanio's Context, a web-based application. They currently have over 5 years of historical data and support 80 reports/dashboards, most support filters for granular reporting.

MAJOR CHANGES SINCE LAST YEAR

- Signed a new IS system (ShareCare) contract and began initial project steps – hired project staff, hardware sandbox, and planning and gap analysis.
- Upgraded Clinicians Gateway to meet ICD-10 and Meaningful Use requirements.
- Upgraded InSyst to meet ICD-10 requirements.
- Implemented BMC – Footprints tracking system. Nearly ready to deploy new Help Desk system to replace current in-house Access version. Also, developing a ShareCare configuration DB complete with on-going tickets, history of system updates and customizations as well as a Change Management Tracking.
- Completed system and hardware upgrade to LincWare – online e-forms application.
- Completed the program build of Child and Adolescent Needs and Strength (CANS) application.
- Began testing new Appointment Schedule application for Clinicians Gateway.

PRIORITIES FOR THE COMING YEAR

The following summarizes the planned priorities for the MHP:

- Continue EHR (ShareCare) system implementation that replaces InSyst and eCURA systems. The ShareCare contract was signed late spring 2015; implementation began in the fall of 2015; and its projected "go-live" date is currently January 1, 2018.
- Continue to support Clinicians Gateway, the MHPs interim electronic health record.
- Complete systems updates to InSyst and Clinicians Gateway for ICD-10 compliance as well as charting requirements for DSM-5.
- Complete Footprints implementation to support Change Management Tracking for ShareCare implementation project.
- Continue deployment of Laserfiche – a document management system that provides electronic storage, retrieval, and workflow business processes for clinical documentation and other related business processes.
- Implement CANS application at county sites. Begin a pilot phase implementation with one community-based organization. When complete, then begin a roll-out to other CBO service sites. The MHP is partnering with Praed Foundation and Objective Arts for the implementation.

- Begin development and installation of Adult Needs and Strengths Assessment (ANSA) application. The target populations are adults and older adults.
- Upgrade the Citrix Servers and infrastructure. Migrate all Citrix users to the new XenDesktop environment.

OTHER SIGNIFICANT ISSUES

- Community based organizations have not received guidance which supports their future electronic health record systems. The ShareCare EHR project does not currently include viable solutions. The MHP indicates a data upload portal will be developed for service record uploads to reduce double-data entry. In addition, planning for health information exchange initiatives for these providers has not yet been developed.
- Sharing Emanio dashboard data with community based organizations should to be a priority as it includes many years of meaningful and actionable data.
- Clinicians Gateway Appointment Scheduler is ready for deployment but awaits 'meet and confer' resolution between unions and county to resolve workplace issues. Configuration build to begin in May 2016 for an Appointment Scheduler Module.

Table 9 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 9—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
InSyst	Practice Management	The Echo Group	25	MHP/County
eCura	Managed Care	InfoMC	16	MHP/County
Clinicians Gateway	Clinical Record	Platton Technologies	8	MHP/County
Emanio	Decision Support	EMANIO Inc	2	Vendor/HCA
Footprints	CRM – Help Desk	BMC – Footprints	>1	MHP/County

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP is currently implementing an electronic health record system ShareCare. The schedule date to begin the clinical usage is currently January 2019.

ELECTRONIC HEALTH RECORD STATUS

Table 10 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 10—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Clinicians Gateway	X			
Clinical decision support					X
Document imaging	Clinicians Gateway/ Laserfiche		X		
Electronic signature—client					X
Electronic signature—provider	Clinicians Gateway	X			
Laboratory results (eLab)					X
Outcomes	CANS		X		
Prescriptions (eRx)	Clinicians Gateway	X			
Progress notes	Clinicians Gateway	X			
Treatment plans	Clinicians Gateway	X			
Summary Totals for EHR Functionality		5	2	0	3

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

- The MHP continues to use a hybrid (electronic and paper) medical records environment.
- Not all Community Based Organizations (CBO) use Clinicians Gateway. The larger-size CBO's have their own EHR systems and need to do double data entry into InSyst and or Clinicians Gateway.
- Both Laserfiche and CANS are standalone systems. The MHP is able to integrate CANS data into Emanio's web-based application.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - Emanio dashboard includes data to support decision-making process to identify unserved and underserved ethic/racial populations.
- Timeliness of Services
  - Emanio dashboard reports the access to service timeliness and penetration rates across populations.
- Quality of Care
  - Emanio dashboards provides analysis of service capacity and capacity utilization patterns (location where clients receive services and types of services received).
- Consumer Outcomes
  - Currently CANS is in pilot phase implementation with one community-based organization. They have plans to roll-out CANS to county clinics during early 2016. CANS is a standalone database.

SITE REVIEW PROCESS BARRIERS

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

- The consumer family focus group physical setting was too small to adequately accommodate the well-attended group.

CONCLUSIONS

During the FY15-16 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - The MHP and LifeLong Medical Care, an FQHC, have a pilot program which integrates primary care and mental health services for consumers. Currently it is located at two sites.
  - The Trust Clinic is new county-operated program which started in November 2015. This is supported by Public Health, Social Services, and Behavioral Health departments and provides the following services: transitional housing, assist with food security, connect to behavioral health and primary care treatment, bureaucracy/system navigation, benefits enrollment, and referral to legal assistance.
- Opportunities:
  - The stakeholder input reflected inconsistent availability and use of interpreters for linguistic needs.

Timeliness of Services

- Strengths:
  - The MHP is focusing on a PIP to address high cost users of high end services which could inform it of potential effective engagement strategies earlier to reduce reliance on these services.
- Opportunities:
  - The MHP has not implemented its electronic scheduler program, leaving a void in measuring its timeliness efficiencies.
  - Without the review of urgent conditions and the no-show rate, the MHP remains insufficiently informed about its metrics of service delivery and the unintended results of clinical gaps in appointments and crisis care triage.

Quality of Care

- Strengths:
  - The MHP has dedicated resources to address vulnerable target populations such as the Katie A. subclass members, TAY groups, the older adults, the LGBTQ2S, and the homeless.
- Opportunities:

  - The MHP will need to review and improve its staffing ratios in its Quality Management unit to address its initiatives and goals.
  - The MHP will need to consider provisions for engaging the organizational providers with its data driven reporting and the mandates for health information exchange.

Consumer Outcomes

- Strengths:
  - The MHP has engaged in creative strategies with the foresight to adapt its outcome tools for specialized groups such as its TAY and older adults.
  - The MHP intends to train, track and trend all youth across its system with the use of the CANS.
- Opportunities:
  - The MHP could involve its consumer champions in the process of a warm hand off in addressing its high cost users and assisting with outpatient service access or other step down strategies by assigning consumer advocates to assist with these activities.

RECOMMENDATIONS

- Develop and implement plans to share Emanio dashboard data with community based organizations given that it includes meaningful and actionable data that could be useful to these groups. Provide training and support on use of data for access, timeliness, and quality.
- Investigate the feasibility to improve the ShareCare EHR project plan to include viable solutions that address health information exchange initiatives for community based organizations which maintain their own EHR systems.
- Review and analyze high cost beneficiaries' service patterns as both the percentages of client count and billed Medi-Cal services are higher than statewide rates. Consider strategies to provide step-down services for these beneficiaries where appropriate.
- Implement processes for tracking, reviewing, and analyzing the timeliness data in regard to monitor urgent conditions and the no-show metrics.
- Consider engagement strategies with the use of peer employees or consumer champions to provide a warm hand-off following high end services and/or to provide peer navigators in clinic settings.

- Strategize ways such as using the CLAS standards to prioritize staffing resource needs and engage the County Human Resources to address the approximately one hundred open/unfilled full-time equivalent (FTE) positions, including quality management, supervisory and direct service provider positions.

ATTACHMENTS

Attachment A: Review Agenda

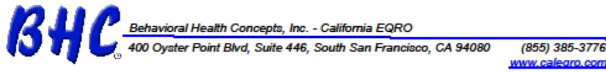
Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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



BHC Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 446, South San Francisco, CA 94080 (855) 385-3776
www.calegro.com

Alameda MHP CalEQRO Agenda
January 12-14, 2016

Time	Tuesday, January 12, 2016 Activities	
9:00 am – 10:15 am	**Opening Session** **Gail Steele conference room** **2000 Embarcadero Cove, 4th floor, Oakland, CA 94606** • Introduction of participants • Introduction of Behavioral Health Concepts • Overview of review intent • Significant MHP changes in past year • Highlight MHP Current Initiatives • Last Year's CalEQRO Recommendations • CalEQRO Performance Measure Data *Participants - Those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions -including but not limited to:* • *MHP Director, senior management team, and other managers/senior staff in: Fiscal, program, IS, medical, QI, research, patients' rights advocate* • *Involved consumer and family member representatives*	
10:15-am 10:30am	**Break**	
10:30 am- 12:00 pm	**Performance Measures** **Gail Steele conference room** **2000 Embarcadero Cove, 4th floor, Oakland, CA 94606** • Access and Retention • Updates on Initiatives and Progress reports • Performance improvement reports utilized to assess access, timeliness, outcomes, and quality • Examples of data used to measure outcomes and satisfaction *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders, Cultural Competence Staff*	
12:00 pm – 1:00 pm	**BHC Working Lunch**	
1:00 pm- 2:30 pm	**Clinical PIP** **Alvarado-Niles conference room** **2000 Embarcadero Cove, 4th floor** **Oakland, CA 94606** • Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans *Participants should be those involved in the development and implementation of including, but not necessarily limited to:* • *PIP committee* • *Data analyst for PIP updates*	**IS Manager/Key IS Staff Group Interview** **IS conference room** **1900 Embarcadero Cove, 4th floor** **Oakland, CA 94606** • FY14-15 Recommendations • ISCA Review • Current IS priorities • EHR System Performance • Network Connectivity • User Training and Technology Support • Mobile Devices – to support field-based services • Support for Tele psychiatry / Tele-health • Paperless chart – status & barriers, future plans • Meaningful Use • Interoperability with Primary Care – current status & future plans • Information Systems/Technology Strategic Plan

1

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Jovonne Price – Lead Quality Reviewer
Rudy Lopez–Reviewer Consultant
Bill Ullom – Chief IS Reviewer
Mark Schmidt – 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, ultimately, in the recommendations within this report.

Sites of MHP Review

MHP Sites

Behavioral Health Administration
2000 Embarcadero Cove, 4th floor
Oakland, CA 94606

Behavioral Health Administration
1900 Embarcadero Cove, 4th floor
Oakland, CA 94606

Contract Provider Sites

Eden Children's
2045 Fairmont Drive
San Leandro, CA

Participants Representing the MHP

Name	Position	Agency
Barbara Saler	Access Program Clinical Manager	
Mary Hogden	POCC Manager	
James Wagner	ASOC Director	
Alex Jackson	Special Projects Director, QM	
Luvenia Jones	Mental Health Board	
Radawn Alcorn	Interim TAY Director	
Wilma Gaines	Consumer Assistant Specialist	

Name	Position	Agency
John Engstrom	Decision Support	
Chet Meinzer	Decision Support	
Sanjida Mazid	Workforce Education & training	
Rick DeGette	Vocational Services Director	
Lillian Schaechner	Older Adult SOC Director	
Tracy Hazelton	Prevention Services	
Carl J. Pascual	MHSA	
Charles Rayner	Director of Pharmacy	
Wendi Vargas	Assistant Director Network Office	
Daun Martin	Consultant	
Carol Silverman	Director Program Evaluation	Telecare
Brian Gilbane	Clinical Director	Telecare
Stacey Calhoun	VP Special Projects	Telecare
Nathan Hobbs	Children's System of Care	
Sonia Artiles	POCC	
Esther Wong	Program Director	ACMHS
Ellen Muir	Assistant Director CSOC	
Jeff Rackmil	Director CSOC	
Freddie Smith	Program Manager	
Rudy C. Arrieta	QM Director	
Manuel J. Jimenez, Jr.	BHS Director	
Karyn Tribble	BHCS Deputy Director	
Leda Frediani	Finance Director	
Aaron Chapman	Medical Director	
Natalie Cousen	IT Manager	
Jackie Mortensen	Provider Director	
Gigi R. Crowder	Ethnic Services Manager/CR Coordinator	
Diana Cunningham	Management Support Services	
Francesca Tenenbaum	Director-Patient's Rights Advocate	
Maria Murray	Director-Utilization Management/Authorization	
Fiona Branagh	Director-Network Office	
Cecilia Serrano	Fiscal services Officer	
Tony Limperopulos	Clinical Manager	

Name	Position	Agency
Dionne Brooks	Administrator	Telecare
Roya Sakhai	Executive Director	Multi-Lingual Counseling
Fawn Downs	Supervisor	Berkeley Mental Health
Satwinder Mahalorn	Clinical Director	Pathways to Wellness
Andrea Kiefer	Program Specialist	
Meredith Cadwallader	Program Coordinator	Stars TAY program
Vanessa Guillory	Supervisor	Stars School Success Program
Camille Peterson	Information Systems Specialist	
Sheryl Diedrick	Information Systems Analyst	
Jennifer Moore	Information Systems Manager	
Donne Fone	Interim QA Administrator	
Theresa Razzano	Rehabilitation Director	
Elizabeth Higgins	Clinical Supervisor	
Abu Kahimi	Committee Member	AASCHW
Leslie Ewing	Executive Director	Pacific Center
Yvonne Rutherford	Committee Member	AASCHW
Henning Schulz	Critical Care Manager	
Janet Biblin	Decision Support Manager	
Neisha Becton	CEO	Pathways to Wellness
Saleena Gupte	Director-Behavioral Health Integration	Alameda Health Consortium
Brenda Goldstein	Psychosocial services Director	Lifelong Medical Care
Sheilani Alix	Senior Management Analyst	
Nancy Halloran	PSP Director	
Karen Capece	Utilization Management/Authorization Supervisor	
Kirby Smith	Cost Report Manager	
Andrea Judkins	Finance-Medi-Cal Unit	
Sola Basra	Finance-Supervisor Fiscal Services	
Lisa Moore	Provider Relations Billing Manager	
Benjemin Blake	COO	BACS
Haydee Cuza	Executive Director	PEERS
Dana Smith	Director, Quality	Telecare
Anita Barnas	Supervisor, Operations	Telecare

Name	Position	Agency
Tom Alexander	CEO	Fred Finch Youth Center
Brian Newton	Director-Research & Operations	The Hume Center
Josh Leonard	CEO	EBAC
Desiree Kane	Director-QA	Fred Finch Youth Center
Bree Desmond	Quality Manager-Data Analyst	Fred Finch Youth Center
Alex Jackson	Director-Special Projects	
Tracy Hazelton	Prevention Coordinator	
Linda Leung Flores	Innovation/Planner	
Sadaya Zimmerle	Case Manager	
Michelle Lewis	Case Manager	
Lovely Whight	Case Manager	
Drea Marks	Clinical Case Manager	Pathways to Wellness
Nayne Rafus	Personal Services Coordinator	Bonita House, Inc.
Nasir Lyon	Personal Service Coordinator	STAGES
Shannon Singleton-Banks	Program Specialist-TAYSOC	
Robert Ratner	Housing Services Director	
Susan Crawford	Behavioral Health Clinician II	
Mike Sanders	Therapist	Phillips Academy School
Christina Rosetti	Postdoctoral Fellow	Portia Bell Hume Center
Viju Thomas	Therapist	
Teisha Levi	Mental Health Specialist II	
Patricia Serrano	Therapist	La Clinica
Michael Kessler	Program Specialist-Older Adults	
Nathan Hobbs	Program Specialist-CSOC	
Lori Delay	Clinical Care Manager-CSOC	
Chris Nettleton	Psychiatric Social Worker II	
Engedau Berhanu	Psychiatric Social Worker II	
Jamie Sayers	Mental Health Clinician	Portia Bell Hume Center
Jennie Yamartmo	Clinical Care Manager	Seneca Intensive Case Management
Danae Dunnigan	Mental Health Specialist II	Stars Community Services
Corrine Lee	Behavioral Health Clinician	
Leslie Marks	Behavioral Health Clinician	
Nick Hecht	Best Now Intern	
Kerrie Kinsey	POCC	

Name	Position	Agency
Haydee Cuza	Executive Director	PEERS
Mary Hogden	POCC Manager	
Paulette Franklin	POCC	
Khatera Aslami-Tamplen	Consumer Empowerment	
Adrianne De Santis	Consumer Empowerment	
Michele Moncrief	POCC	
Jaban Winn	Mental Health Worker	
Markeeta Parker	Program Peer Specialist	Health & Human Resource Education Center
Annie Kim	Director	Mental Health Association of Alameda County
Beverly Bergman	Family Caregiver Advocacy Specialist	Mental Health Association of Alameda County
Gabriela Zuloaga	Family Advocate	Mental Health Association of Alameda County
Mercedes Marquez	Family Partner	United Advocates for Children & Families
Vilme Salalauskatte	Peer Specialist Intern	PEERS
Heather Riemer	Program Coordinator	PEERS
Bettye Foster	Family Advocate Supervisor	Family Education& Resource Center
Katrina Killian	Executive Director	Alameda County Network of Mental Health Clinics

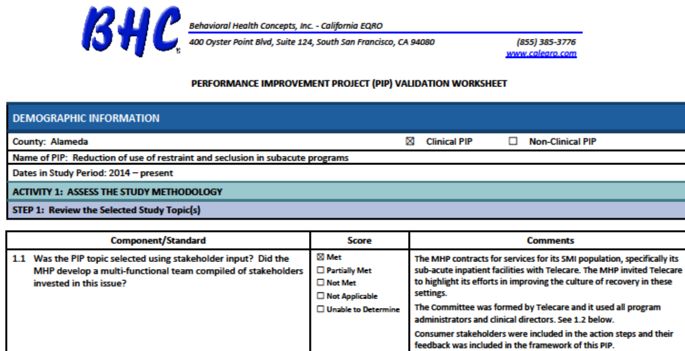
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:



BHC

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.caleqro.com

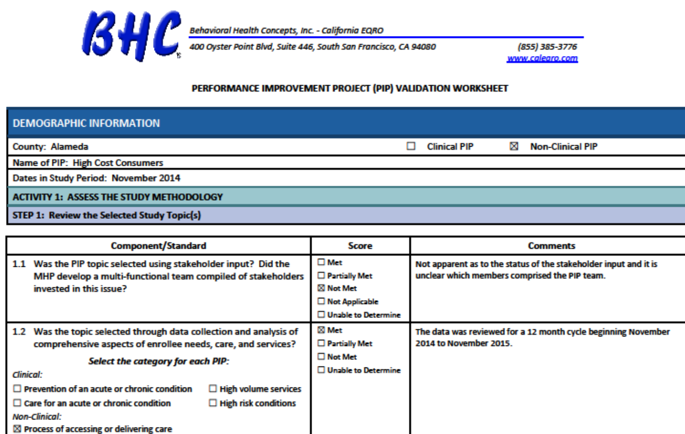
PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION
County: Alameda ☒ Clinical PIP ☐ Non-Clinical PIP
Name of PIP: Reduction of use of restraint and seclusion in subacute programs
Dates in Study Period: 2014 – present
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY
STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP contracts for services for its SMI population, specifically its sub-acute inpatient facilities with Telecare. The MHP invited Telecare to highlight its efforts in improving the culture of recovery in these settings. The Committee was formed by Telecare and it used all program administrators and clinical directors. See 1.2 below. Consumer stakeholders were included in the action steps and their feedback was included in the framework of this PIP.

Alameda_Clinical_PIP_FY1516_JP_011315 Page 1 of 11

Non-Clinical PIP:



BHC

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 446, South San Francisco, CA 94080 (855) 385-3776
www.caleqro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION
County: Alameda ☐ Clinical PIP ☒ Non-Clinical PIP
Name of PIP: High Cost Consumers
Dates in Study Period: November 2014
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY
STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Not apparent as to the status of the stakeholder input and it is unclear which members comprised the PIP team.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? *Select the category for each PIP:* *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data was reviewed for a 12 month cycle beginning November 2014 to November 2015.

Alameda_Non_Clinical_PIP-Validation-Tool_rated_FY15-16_JP_012116

Page 1 of 9