FY 16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Alameda

Conducted on

November 1-3, 2016

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ALAMEDA MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—19,717
- MHP Threshold Language(s)—Spanish, Vietnamese, Cantonese, Mandarin
- MHP Size—Large
- MHP Region—Bay Area
- MHP Location—Oakland
- MHP County Seat—Oakland

Introduction:

Alameda is a large-sized, Bay Area Mental Health Plan (MHP), located in an urban growth region adjacent to the San Francisco Bay Area. Alameda is the seventh most populous county in California, and has 14 incorporated cities and several unincorporated communities. Oakland is the seat of County government and the largest city. Alameda County is characterized by rich diversity and culture. Alameda County is now one of the most ethnically diverse regions in the Bay Area.

During the FY 16-17 review, CalEQRO found the following overall significant changes, efforts and opportunities related to access, timeliness, quality and outcomes of MHP and its contract provider services. Further details and findings from the External Quality Review Organization (EQRO) mandated activities are provided in the rest of the report.

Access

The MHP has outlined efforts to increase service delivery to vulnerable populations addressing: adult and older adult initiatives, transition age youth, gay, lesbian, transgender groups, and homeless and high cost users of high end services. These initiatives include increased psychiatric provider capacity at the psychiatric emergency services, increased timely crisis response in the field, older adult services, and transition aged youth (TAY) expansion, with some representation of these groups in committees and the community. Despite these initiatives, the MHP continues to have a declining penetration rate for the past three years and few improvements have become standard practice.

The MHP has formulated two Performance Improvement Projects (PIPs) that are both in the Concept Only stage of development. The MHP was advised to engage in continued technical assistance to produce actions for these PIPs. It has initiated a clinical PIP to increase engagement into outpatient services with its Latino population. This could prove to enhance culturally sensitive service provisions. The MHP has initiated a Non-Clinical PIP focused on decreased use of high end services such as crisis encounters and in-patient hospitalization. It identified a group of revolving users of these services and is poised to provide strategies to engage consumers in the use of lower end services with a bridging team to outpatient care.

Timeliness

The MHP appears to continue to be challenged in creating a useful methodology to track its timeliness metrics, resulting in low confidence in the numbers it is tracking. Currently they do not have the capability to track timeliness for community based contractors (CBOs). The MHP continues to track its initial assessment and initial psychiatry appointments with no improvements. It does not track its urgent nor no-show rates which may inadvertently be negatively impacting the metrics it does track. CalEQRO continues to strongly encourage the MHP to establish standards, track and most critically to improve the metric upon need.

Quality

The Quality Improvement Unit appears to have a full staffing complement, however, the quality activities such as the evaluation of prior activities and the on-going robust actions associated with active PIPs remains nominal. The MHP again is encouraged to seek on-going consultation for its PIP activities early into the review cycle.

An area the MHP may not fully be developing is the on-going need to establish succession planning, especially for key positions. While simultaneously filling staffing vacancies it is critical in the revolving door of employment opportunities and the inevitable retiring of seasoned workers that the MHP begin to address the mentoring of individuals for increased job skill-building upon entry into the workplace.

Departmental communication efforts seem to have favorable effect with various stakeholder groups. These efforts could be enhanced by actively including line staff and considering the input of contract providers on a predictable basis throughout the year. Initial steps could begin with reviewing data and brainstorming improvement opportunities elicited from this broader group. This information could assist the MHP in its improvement initiatives and achieving more satisfactory results.

Outcomes

The MHP is implementing the Child and Adolescent Needs and Strengths (CANS), an outcome instrument with children, across its system of care and beginning to address the adult arena with the initiation of the Adult Needs and Strengths (ANSA) outcome tool. Consistent use of such tools can provide the MHP with information in managing services of the increasing treatment populations.

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.

This report presents the fiscal year 2016-2017 (FY 16-17) 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 **eight (8) Mandatory Performance Measures** (PM) as defined by DHCS. The eight 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
- Count of TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

[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.

- High Cost Beneficiaries ($30,000 or higher)

(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 PIP(s) are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM 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 two 90-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:

- 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.

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

In this section, we first discuss the status of last year's (FY15-16) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

In the FY15-16 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY16-17 site visit, CalEQRO and MHP staff discussed the status of those FY15-16 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 FY15-16

- Recommendation #1: 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.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP conducted a feasibility study to determine the capacity of its current dashboard software, Emanio as a solution for proving meaningful and actionable data to its community-based organizations (CBOs). Limitations in the existing dashboard software required the MHP to migrate data to a different dashboard vendor.
  - The MHP's executive team approved a budget modification for an annual contract release and the product Yellow Fin was selected secondary to its ability to migrate all the MHP's existing visualization into their platform while also

offering better accessibility to community-based organizations (CBOs). Its software integrates with the existing dashboards and carries the potential to leverage the existing 100 dashboards created by the MHP's unit called Decision Support and to stay on track with the goal to deliver data to CBOs. An expected go live pilot date is January 2017 for five CBOs.

- There has been no formal planning or needs analysis for CBOs. Contract providers report current inability to access data needed to fully evaluate contract performance.

- Recommendation #2: Investigate the feasibility to improve the ShareCare electronic health record (EHR) project plan to include viable solutions that address health information exchange initiatives for community based organizations which maintain their own EHR systems.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP is implementing Phase I of the ShareCare electronic health record (EHR) system. Phase I specifications are all the components to completely build-out the Practice Management component. This includes encounters, claims, and billing, all comprising the functionality of ShareCare implementation. This phase includes a feasibility study of the steps to initiate inter-operability related to data exchanges between the MHP management information systems (MIS) including the ShareCare, EHR, Clinicians Gateway and the contracted providers' MIS and EHR systems.
  - The MHP will be working with its vendor, Echo Management, to develop a Web Portal for interface and data upload activities in collaboration with community base organizations. The goal of this solution is to allow any EHR utilized by the CBOs to upload their native data to ShareCare. Currently there is double entry by CBOs not using the county system as their EHR.
  - When the Practice Management implementation phase stabilizes and Medi-Cal revenue streams are on target, the MHP will explore more initiatives to exchange data including solutions to further address health information exchange (HIE). The MHP has discovered that Stanislaus County is exploring an HIE project and affiliation with San Joaquin County. Alameda MHP will closely follow their progress and network with these counties to determine best practices for implementing viable solutions for HIE initiatives with stakeholders and CBOs with their own EHR systems. The MHP has not developed a specific plan or timeline.
  - If awarded the Whole Person Care Pilot grant from the California Department of Health Care Services (DHCS), the MHP will help to plan, test, and implement its HIE. These additional resources will incentivize the county to build the infrastructure for an HIE. Without this infrastructure, it will be a challenge to have an HIE environment.

- Recommendation #3: 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.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP initiated a concept PIP which reviewed the high-cost, high-need beneficiaries; those who had 12-month retrospective charges more than $49K. The MHP identified adult consumers in the high-cost cohort without outpatient care and intends to link them to supportive resources.
  - The MHP submitted several new strategies based on addressing this issue which impacts the community and it will need to analyze its new efforts to determine which of these will have the most impact. These recent activities are outlined below.
  - The MHP increased its outpatient crisis capacity with the goal to reduce high cost psychiatric emergency services/inpatient utilization through addressing both diversion and step-down services by implementing the following:
    - ▷ Opened a new Crisis Residential Treatment program called the Jay Mahler Recovery Center, with a 16-bed capacity.
    - ▷ Obtained two additional SB82 grants to increase the crisis residential treatment (CRT) and crisis support capacity with an additional 20 hours per day of psychiatric services at John George Psychiatric Hospital, an in-patient facility, operated by Alameda Health System network.
    - ▷ Extended the Mobile Engagement Team (MET) to three teams, in which both a law enforcement officer and a clinician provide a team response to crisis in the field.
  - Despite these, CY2015 claims data shows an increase in the percent of high cost beneficiaries and the average approved claims per high cost beneficiary.
  - The MHP increased low cost, high impact services available by implementing the following strategies and initiatives:
    - ▷ Used MHSA funding for its In-Home Outreach Teams (IHOT) linkage program to improve consumer connections to outpatient care. The team consists of a case manager, peer specialist, and family member. Its purpose is successful linkage to supports, to avoid unnecessary hospitalizations and reduce interaction with the criminal justice system.
    - ▷ Launched case and care management outreach in Santa Rita jail and provided linkages to critical social programs such as healthcare, social security and disability benefits and outpatient care upon release.
    - ▷ Increased peer recovery service teams to six service teams in four clinics with peer navigators on each service team.

        - ▷ Launched a county-wide course on the Seeking Safety Program, an evidence-based practice used as a general model to teach coping skills which assists people to attain safety from trauma and/or substance abuse.
    - Leveraged existing crisis and transitional support programs to help connect beneficiaries to outpatient care and reduce crisis utilization through the re-engineering of the following programs and services:
        - ▷ Initiated the Hope Intervention Program (HIP) for TAY youth which provides contact in PES and People's Park.
        - ▷ Implemented the Geriatric Assessment and Response Program (GART) for older adults which provides outreach, assessment and support to older adults in the community.
        - ▷ Continued the Multi-Disciplinary Forensic Team for adults with law enforcement (LE) to respond to high-need, high utilization consumers engaged by LE with goal of linking with right-matched outpatient care to defer incarceration when possible.
- Recommendation #4: Implement processes for tracking, reviewing, and analyzing the timeliness data in regard to monitoring urgent conditions and the no-show metrics.

    ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

    - A project team consisting of the managers for Decision Support, Information Systems, and Quality Management units is developing a scope of work for tracking, reviewing, and analyzing the timeliness data. The team developed a three-phase implementation plan to collect timeliness metrics and is currently in the initiation process having convened a work group in September and October 2016. The three phases are as follows:
        - ▷ Phase 1: Through Clinician's Gateway, development of the forms that will collect client contact information to include Name/Client ID, Appointment Offered Date, and Disposition.
        - ▷ Phase 2: Build the form into the existing infrastructure of data collection available at all points of entry.
        - ▷ Phase 3: Establish internal responsibility for analyzing provider compliance (decision support), train and convey standards for compliance to all front doors (systems of care) and develop MHP's protocols for compliance and review & monitor timeliness (quality management).
    - Although a formidable plan has been identified, unfortunately, the MHP has not provided a standard or data for either metric which continues from prior review cycles as well.

- Recommendation #5: 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.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - A Peer Mentorship program was funded and began July 1, 2016.
  - In addition to the above, a Peer Navigator program bidders' conference took place on October 12-13, 2016 with the pending awards announcement by December 26, 2016 and is expected to start in April 2017.
  - Four In-Home Outreach Teams (IHOT) throughout the county were funded. Each of the four teams includes peer employees conducting warm-handoffs through supported referrals to outpatient services. A program description of the IHOT is included in the write up for the non-clinical PIP section of this report.

- Recommendation #6: Strategize ways, such as using the culturally and linguistically appropriate services (CLAS) standards, to prioritize staffing resource needs and engage the County Human Resources to address the approximately one hundred unfilled full-time equivalent (FTE) positions, including quality management, supervisory and direct service provider positions.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP is strategizing about ways to better utilize culturally and linguistically appropriate services (CLAS) standards when recruiting, hiring and developing their workforce for both county and organizational providers.
  - The CLAS standard is now included in the CBO contract deliverables. Additionally, the MHP is collaborating and partnering with the county office of diversity, county office of human resources, and the County Administrative Officer (CAO) to prioritize the recruitment and hiring of bilingual and bicultural staff utilizing the vacant funded positions at the MHP.
  - Since more than 85% of the MHP direct services are delivered through a network of CBO's, SENECA, Inc. is implementing CLAS standards to accompany their basic value of promoting social justice. Seneca, Inc. has launched its own internal PIP for recruiting and hiring employees to implement the CLAS standards.
  - Although several staffing vacancies continue to exist, the MHP recognizes the importance of continuing to develop an agency culture that is inclusive of the wide range of perspectives represented within these constituent groups and has conducted CLAS presentations throughout the year.

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 increased psychiatric provider capacity to respond to psychiatric emergency services (PES) by co-locating additional triage doctors to work with individuals who are high cost utilizers cycling in and out of crisis service.
    - The MHP initiated potential solutions to the capacity issues at the inpatient facility, John George Hospital, for example by stablishing the IHOT teams, contracted for a Crisis Stabilization Unit (CSU), and provided peer respite.
    - Healthcare Integration expansion includes eight Federally Qualified Health Centers (FQHCs) in which the MHP has co-located staff throughout the county in 80 geographic locations.
    - The MHP has supported Oakland Thrives (a citywide effort forming with the ambitious aim of making Oakland the Healthiest City in the Nation) and Youth Ventures Joint Powers Authority which focuses its efforts on three action areas to achieve the greatest impact for youth: health, wealth (earnings and savings), and education.
    - Adult focused expansion included:
        - ▷ Increased funding to expand services specifically for older adults with mental health and co-occurring substance abuse issues.
        - ▷ Increased funding to build a competent geriatric behavioral health workforce to meet the demands of the rapidly aging population.
- Timeliness of Services
    - It has initiated a concept for the Clinical Performance Improvement Project (PIP) to increase timely response and decrease no-show rates for Latino consumers.
    - The telepsychiatry pilot is taking place at the emergency room departments at the local healthcare hospitals, aimed at reducing wait times for crisis care.
- Quality of Care
    - The MHP initiated a Strategic Mapping Plan which begins at the executive level in which the team will conduct strategic planning within the department. Beginning with Phase 1, leadership will focus on gathering this input from individuals and teams within the department.

- Focused on transition age youth (TAY)activities and engaging community agencies in these endeavors:
  - ▷ Appointed a TAY System of Care Director to the Executive Team.
  - ▷ Initiated Results Based Accountability (RBA) with stakeholders and providers by including performance deliverables within contracts to measure consumer progress.
  - ▷ Received a grant to establish a countywide In Home Outreach Team (IHOT) for TAY young adults 18-24 years old to increase field based engagement.
  - ▷ Seneca Inc., created its Youth Advisory Board (YAB) Program which consists of a group of current and former youth who are motivated to see change with empowering youth by providing ideas, problem solving, advocating, mentoring, and community involvement.

- Consumer Outcomes
  - The MHP completed Cognitive Behavioral Therapy for Psychosis (CBTp) introductory training with consultation for children, TAY and adult providers using Mental Health Block Grant to address First Episode Psychosis programs**.**
  - The MHP spread the use of the CANS across all children's services.
  - It has implemented the ANSA for adult and older adult services to improve treatment strategies and measure consumer progress.
  - The MHP prioritized an Older Adult System of Care via funding from the Mental Health Services Act (MHSA) Innovation Grants for Older Adults.
  - A team at John George Psychiatric Emergency Services (PES) is a peer-based program designed to assist patients discharged from PES transition back into the community through mentorship and support (with an ultimate goal of reducing recidivism).

PERFORMANCE MEASUREMENT

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

TOTAL BENEFICIARIES SERVED

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

Table 1—Alameda MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	35,314	3,726
Hispanic	104,798	4,904
African-American	66,966	6,622
Asian/Pacific Islander	78,925	1,817
Native American	908	85
Other	43,813	3,013
Total	**330,722**	**19,717**

**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.

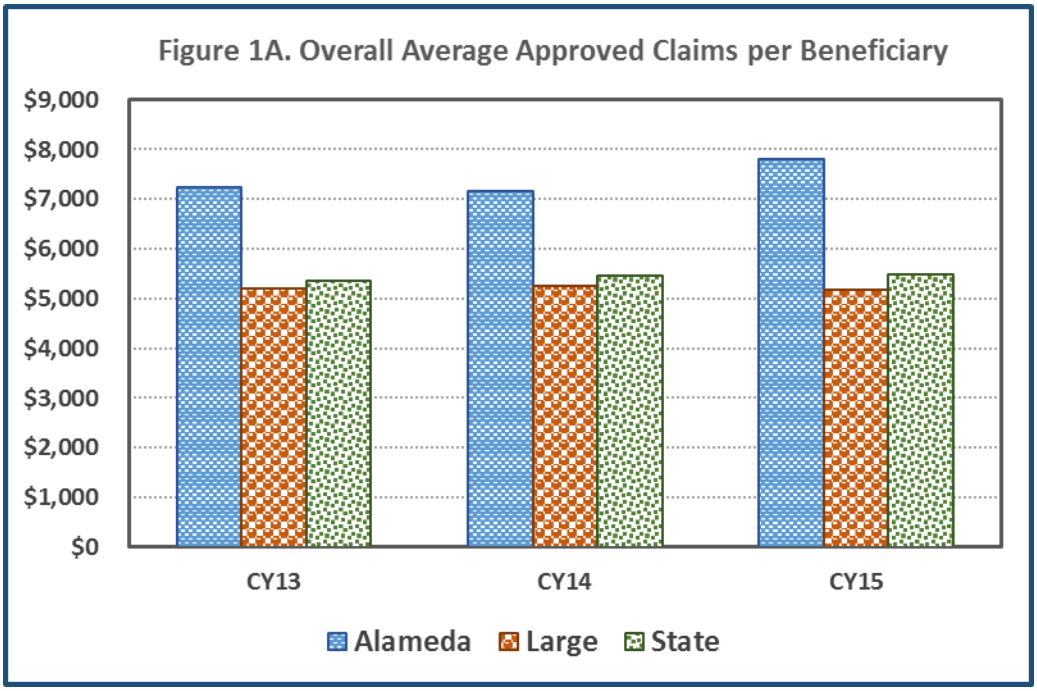
Regarding calculation of penetration rates, the Alameda MHP:

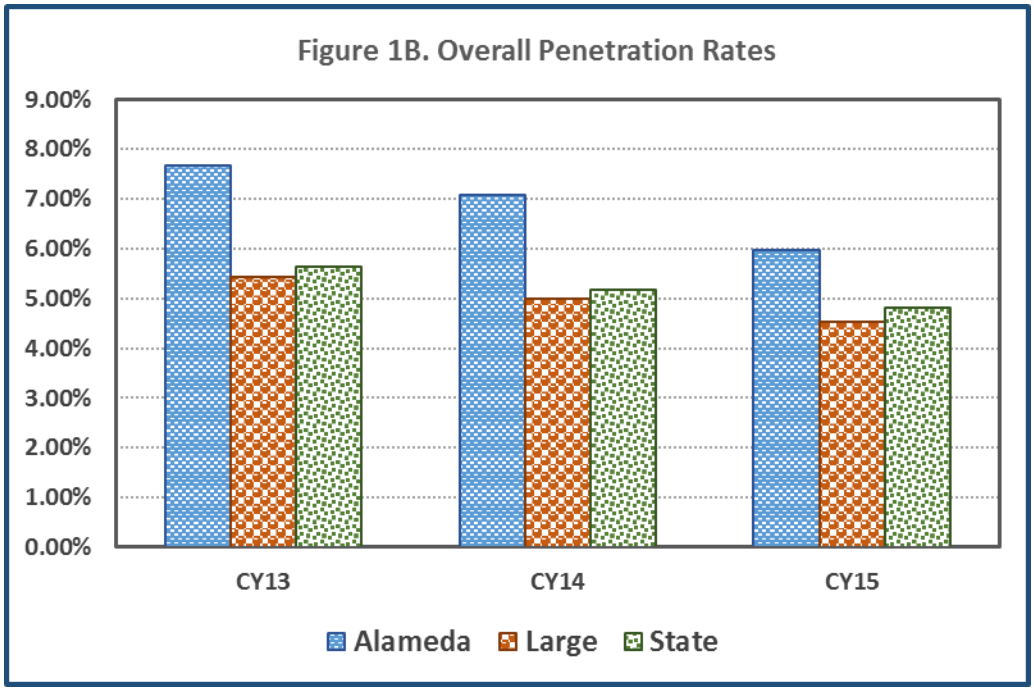
☒ Uses the same method as used by the EQRO.

☐ Uses a different method.

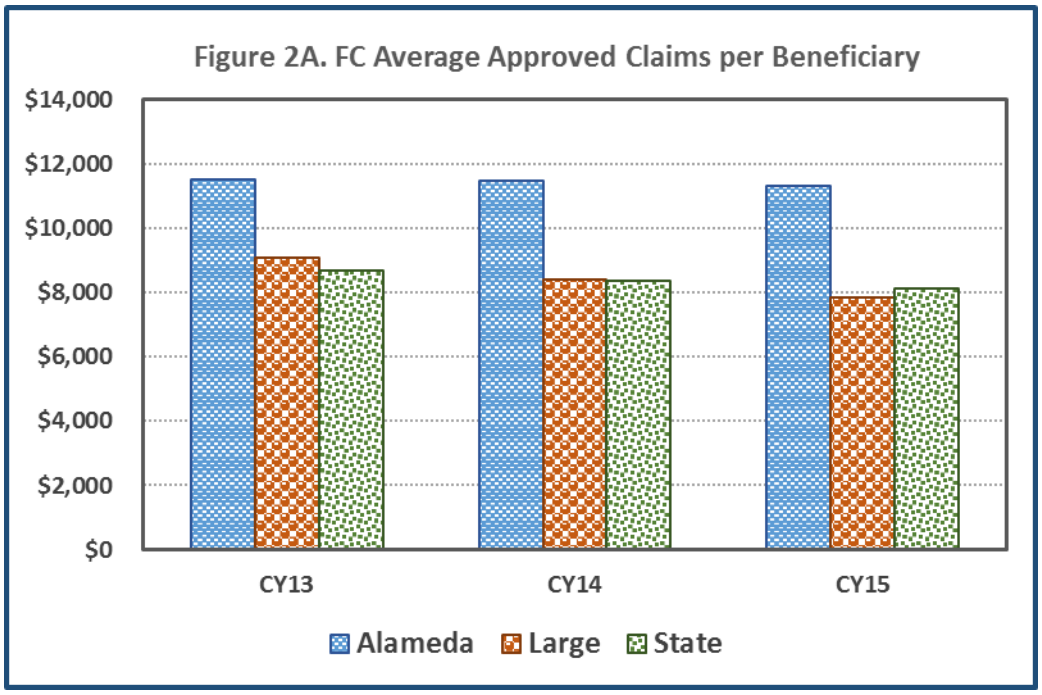
☐ Does not calculate its' penetration rate.

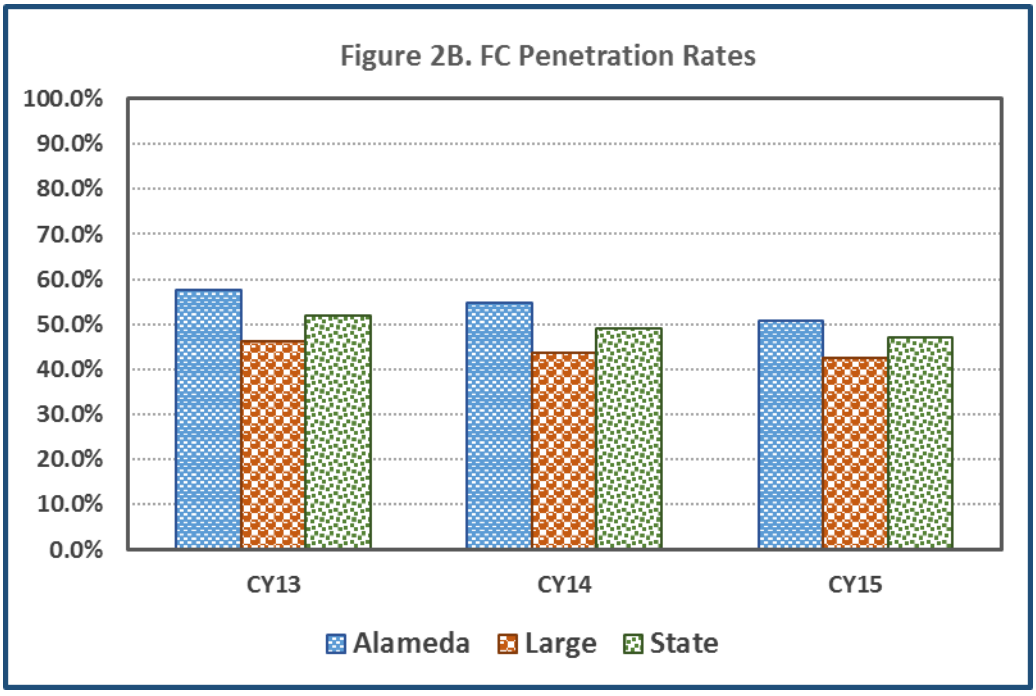
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



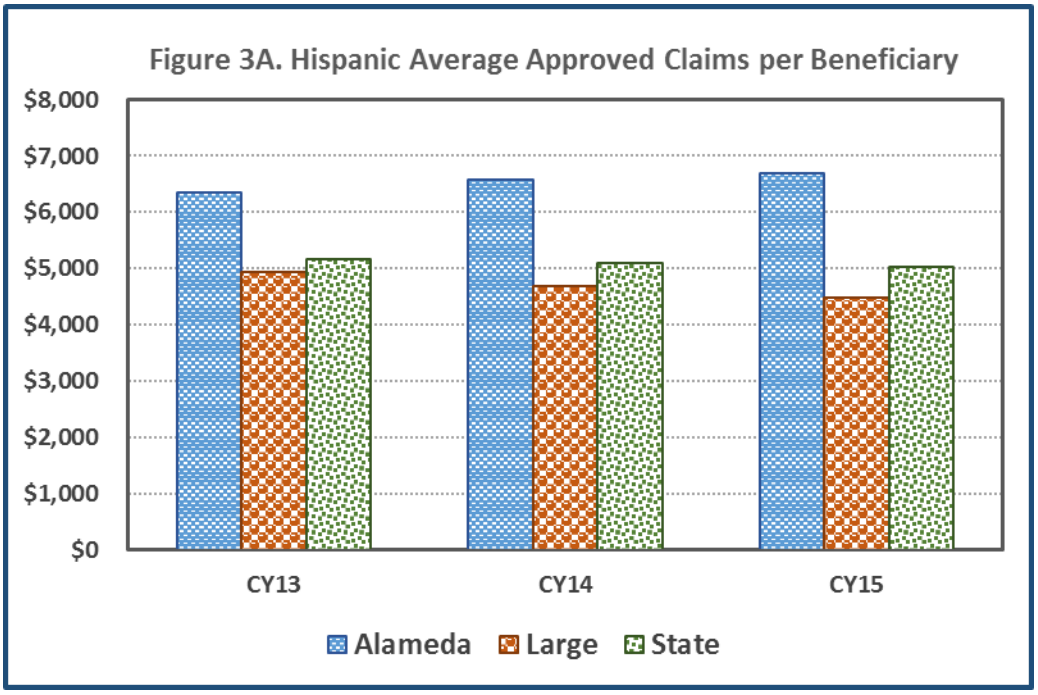


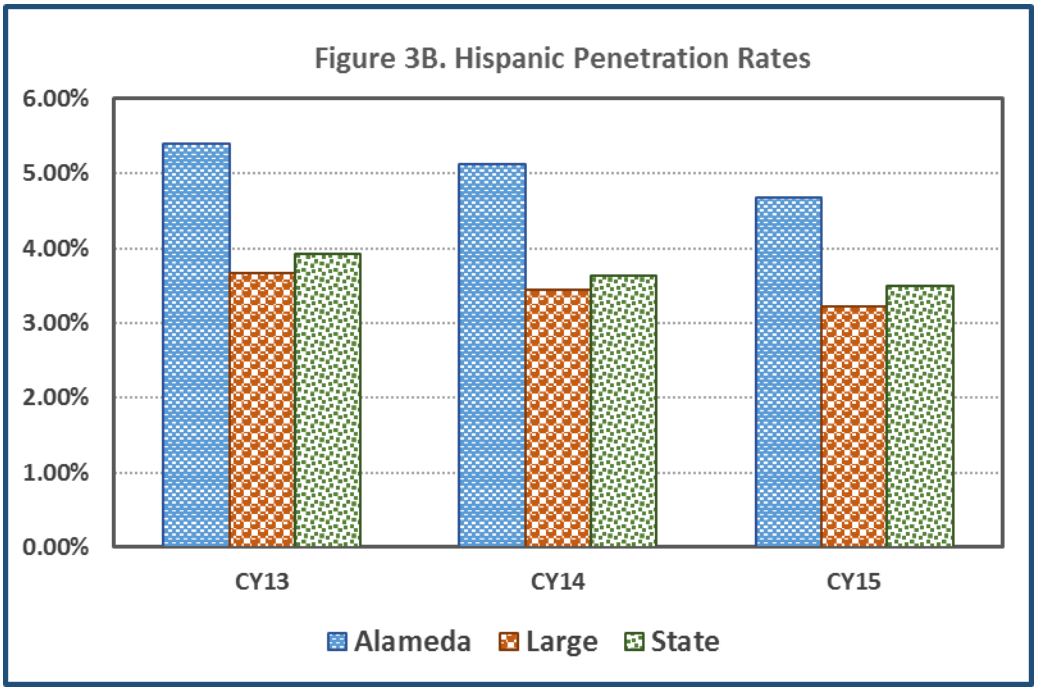
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





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 CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2—High-Cost Beneficiaries

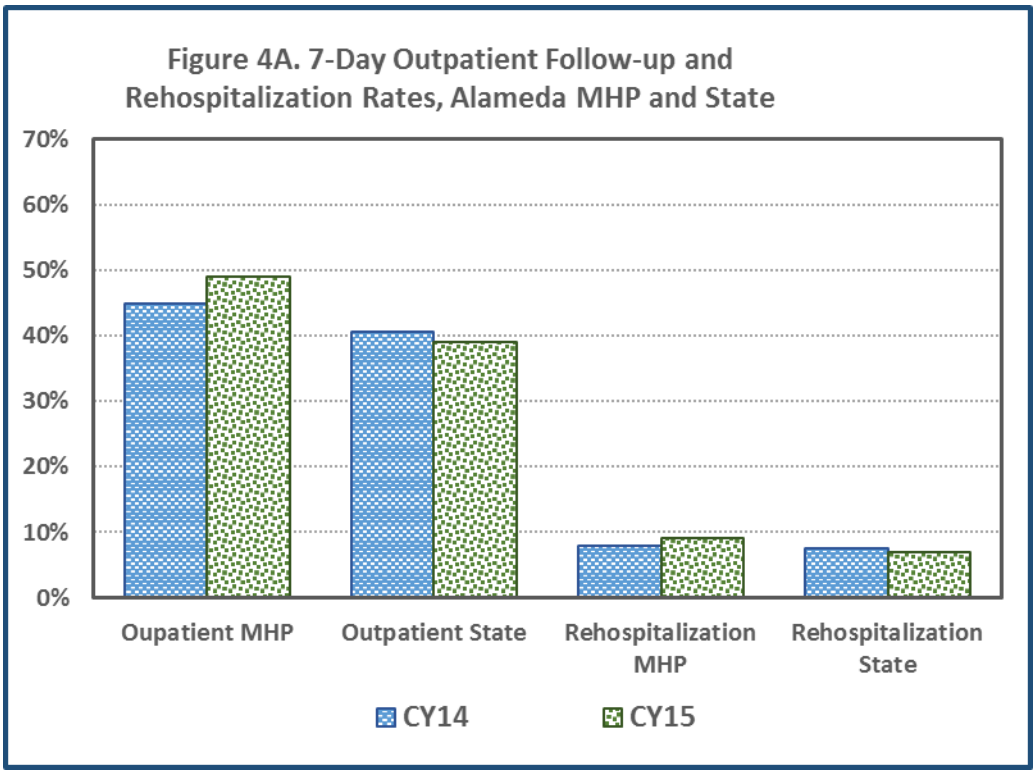
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
Alameda	CY15	1,049	19,717	5.32%	$50,282	$52,746,331	34.26%
	CY14	1,005	22,222	4.52%	$49,887	$50,135,990	32.30%
	CY13	1,073	21,744	4.93%	$49,514	$53,128,819	33.81%

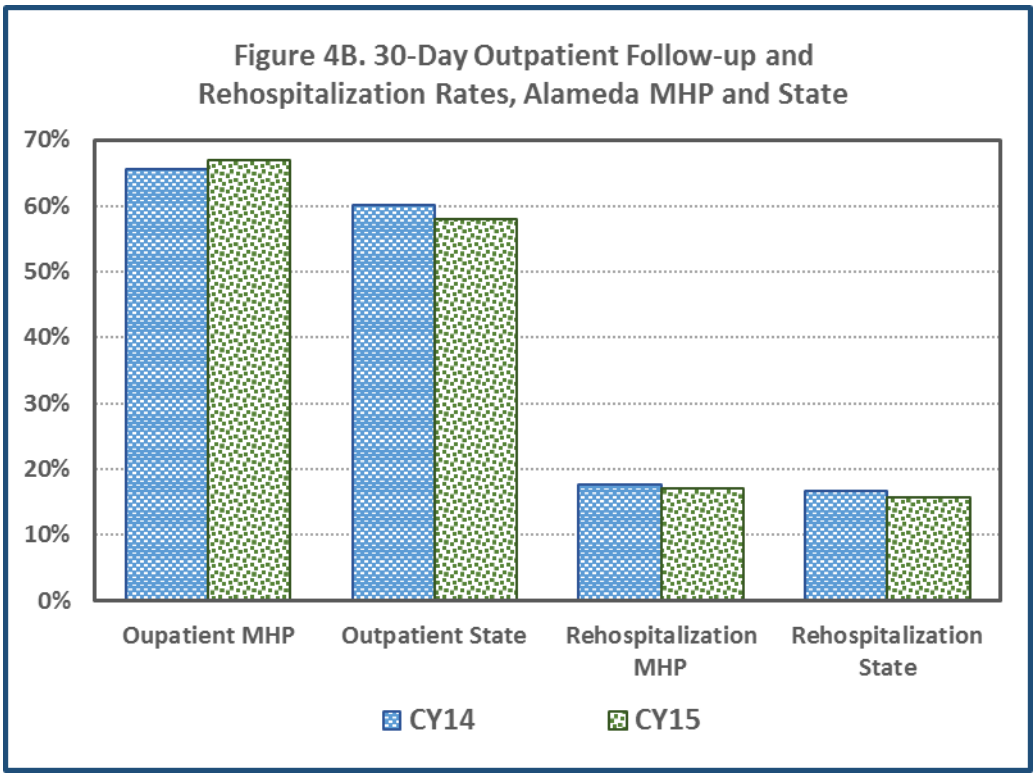
Table C1 (Attachment C) shows the penetration rate (PR) and approved claims per beneficiary for the CY15 Medi-Cal Expansion Affordable Care Act (ACA) Penetration Rate and Approved Claims per Beneficiary (ACB).

Table C2 (Attachment C) show the distribution of the MHP CY15 Distribution of Beneficiaries by Approved Claims per Beneficiary Range for the various categories; under $20,000; $20,000 to $30,000, and those above $30,000.

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY14 and CY15.

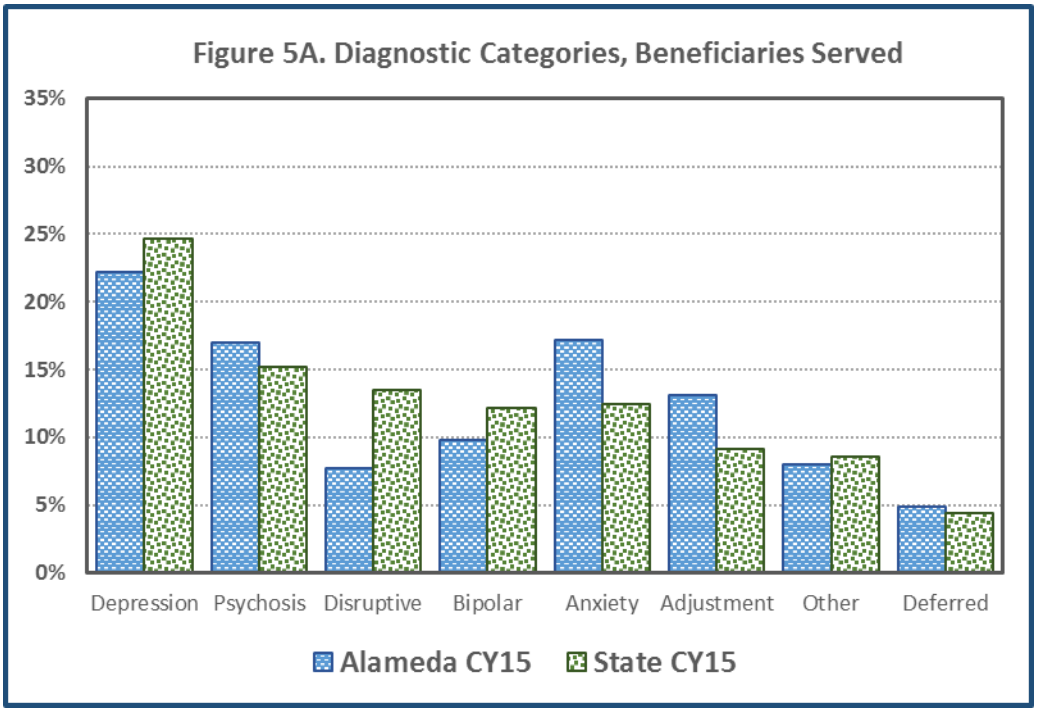


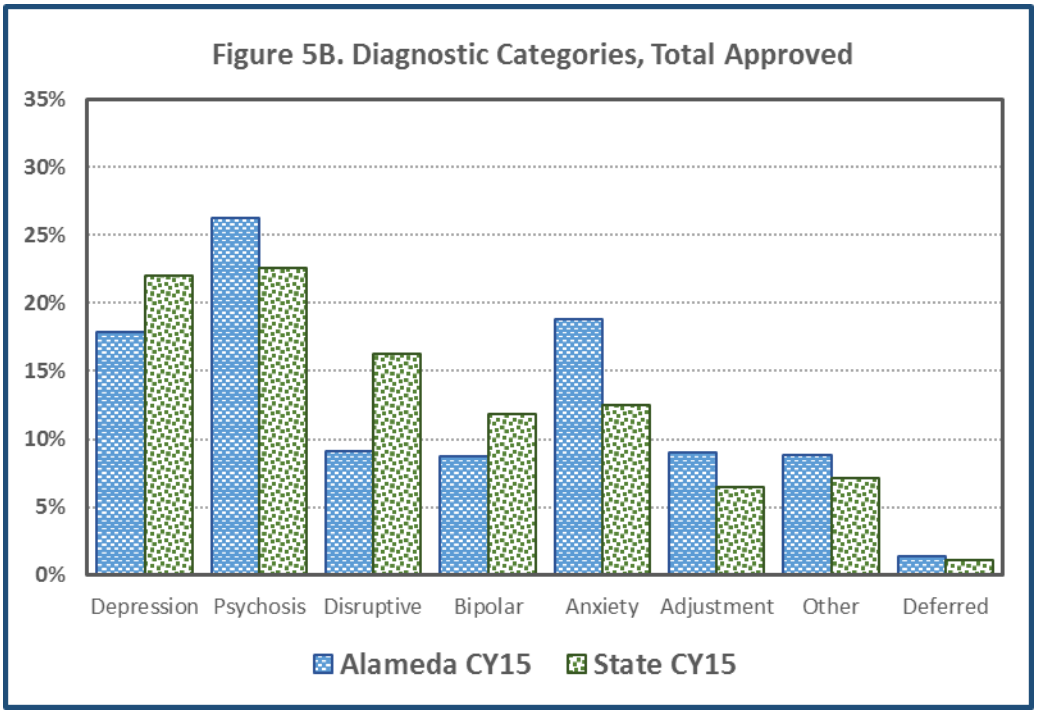


DIAGNOSTIC CATEGORIES

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 CY15.

- MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 14%





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - While the MHP's number of eligibles increased from 314,244 in CY14 to 330,722 in CY15, the number of beneficiaries served decreased from 22,254 in CY14 to 19,717 in CY15. This correlates to a penetration rate decrease during this period, from 7.08% in CY14 to 5.96% in CY15.
  - The Affordable Care Act (ACA) increased the MHP's eligibles by 81,940 in CY15, of which 4,084 were served, with a penetration rate of 4.98% (see Table C1 in Appendix C).
  - The foster care penetration rates show a decrease similar to the overall averages, but remain above the statewide and similar sized MHP averages.
- Timeliness
  - The MHP 7-day rehospitalization rate increased 1% from the prior year and was 2% higher than the statewide average.
  - The MHP 30-day rehospitalization rate decreased 1% from the prior year, but was 1% above the statewide average.
- Quality of Care
  - The MHP 5.32% of high cost beneficiaries receiving more than $30,000 in services remains above the statewide average of 2.86% and accounted for 34.26% of MHP claims compared to 26.95% statewide. These MHP rates reflect

increases from the prior year. The MHP has embarked on several initiatives this year to address these high rates, as discussed above.

  - The MHP occurrences for depression, disruptive, bipolar, and "other" diagnoses were lower than the statewide averages, while the occurrences of psychosis, anxiety, adjustment, and deferred were higher than the statewide averages.
  - The percent of approved claims by diagnosis aligned with the level of occurrence.

- Consumer Outcomes
  - The MHP showed a 4% increase in meeting the 7-day post hospitalization follow- up visits from the prior year and a 1% increase in meeting this within 30-days and remained above the statewide averages.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." 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 2015.

ALAMEDA MHP PIPS IDENTIFIED FOR VALIDATION

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

Table 3A—PIPs Submitted

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improving Engagement for Psychiatric Care for Latinos
Non-Clinical PIP	1	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]

Since these PIPs were determined to be at the Concept Only stage, these are not rated.

[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 3B—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	NR
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	NR
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	NR
		1.4	All enrolled populations	NR	NR
2	Study Question	2.1	Clearly stated	NR	NR
3	Study Population	3.1	Clear definition of study population	NR	NR
		3.2	Inclusion of the entire study population	NR	NR
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	NR
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	NR
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NR
		5.2	Valid sampling techniques that protected against bias were employed	NR	NR
		5.3	Sample contained sufficient number of enrollees	NR	NR
6	Data Collection Procedures	6.1	Clear specification of data	NR	NR
		6.2	Clear specification of sources of data	NR	NR
		6.3	Systematic collection of reliable and valid data for the study population	NR	NR
		6.4	Plan for consistent and accurate data collection	NR	NR
		6.5	Prospective data analysis plan including contingencies	NR	NR
		6.6	Qualified data collection personnel	NR	NR
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	NR

Table 3B—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	NR
		8.2	PIP results and findings presented clearly and accurately	NR	NR
		8.3	Threats to comparability, internal and external validity	NR	NR
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	NR
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	NR
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	NR
		9.3	Improvement in performance linked to the PIP	NR	NR
		9.4	Statistical evidence of true improvement	NR	NR
		9.5	Sustained improvement demonstrated through repeated measures.	NR	NR

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

NR= Not rated

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

Table 3C—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met		
Number Partially Met		
Number Not Met		
Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling)		
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	0%	0%

CLINICAL PIP—IMPROVING ENGAGEMENT IN PSYCHIATRIC CARE FOR LATINOS

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

- "Does the inclusion of the consumers' therapists/case managers in psychiatric care act as an effective modifier and improve engagement, adherence and satisfaction for Latinos?
- Date PIP began: June, 2016
- 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 submitted its Clinical PIP which remains at the Concept Only stage as it has not presented its baseline data nor implemented its intended interventions. This PIP will implement and evaluate a culturally responsive program model for Latinos with severe mental health conditions. Specifically, this PIP will assess whether the participation of the therapist/case manager in psychiatric sessions with the psychiatrist and consumer improves engagement in clinical care through:

Qualitative indicators which aid in improved team-based psychiatric care demonstrated by:

- Increased willingness of consumers to raise concerns and ask questions related to prescribed medication.
- Increased accuracy of reporting of symptoms to psychiatrist.
- Improved confidence by psychiatrists that medications are being taken as prescribed.

Quantitative assessments which demonstrate:

- Decreased no-show rates
- Increased consumer satisfaction regarding psychiatric services.

The MHP presented information stating throughout California, Latinos are a dramatically underserved ethnic minority population. In Alameda County, Latinos are served at half the rate of the general population (MHSA Planning data) which mirrors the rates in most counties in California. There are many barriers to care which have been extensively written about including stigma, lack of knowledge about care, transportation, lack of linguistic and culturally accessible providers. Among the barriers is consumer/family discomfort with the lack of programs demonstrating culturally welcoming and responsive services that are sought by Latino families.

The MHP will need to determine the extent to which this data is reflected in the clinic it intends to use as a pilot program. Baseline data to which improvements can be compared will need to be submitted. As proposed, the MHP indicated the study will include Latino consumers receiving psychiatric treatment at La Clínica de La Raza with severe mental illness and severe emotional disturbance who are being served in three county funded treatment programs: (1) Latino Adults with severe mental illness, (2) Latino Adults in crisis receiving brief treatment services (less than 6 months) and (3) Latino Children/Adolescents with severe emotional disturbance. The majority of adults are mono-lingual Spanish-speaking consumers, anecdotally up to 85%.

La Clínica de La Raza, a community based organization, contracts with the MHP to provide services to a primarily Latino population. La Clínica has developed a treatment model that anecdotally appears to demonstrate promising results in improving psychiatric care wherein all consumers who are assigned a therapist/case manager who worked with the consumer and his/her family on a regular basis also co-participates in psychiatry services.

This clinical intervention was designed to mitigate against patterns that were observed by therapist/case managers and psychiatrists who noted the cultural norm of "*respecto*" impeding engagement in psychiatry services. The focus of this PIP is to implement this clinical approach along with an evaluation to demonstrate effectiveness of this clinical strategy to improve consumer/family satisfaction and accuracy of information for Latinos who receive psychiatric services. The data demonstrating the cultural norms will need to be identified, along with the details of the case manager intervention. Details on how this approach differs from the current practice would also be necessary to show the basis of the problem.

The MHP will need to address basic elements in identifying the need for this PIP, which includes establishing baseline data to indicate the basis of the problem especially within the pilot agency, La Clinica. In addition, the MHP will need to indicate which clinical interventions have been identified that can potentially improve the desired outcome, and to further indicate how this will be measured for improvements. Some of these elements are highlighted by the MHP submission yet these are absent of baseline data and improved measurable indicators of progress.

The MHP identified the following indicators it intends to track for improvements:

- No-show rates
- Improved Satisfaction Survey Score
- Consumer efficacy to raise concerns/ask questions related to prescribed medications
- Consumer accuracy of symptom reporting

- Medication adherence

By demonstrating an effective clinical approach to increasing engagement of Latinos in psychiatric care, the MHP intends to improve the quality of psychiatric care, increase the confidence/comfort for consumers and their families in participating and adhering to psychiatric care, improve engagement, decrease stigma regarding psychiatric care and decrease no-shows for Latinos in the Medi-Cal system of care. The MHP will need to quantify its indicators with measurable, objective improvements.

The indicators appear promising. However, there is no data provided to indicate baseline data and subsequent anticipated goals for improvements. Thus, the extent to which this is a problem has not been reflected through data. The MHP was advised that without this critical information, the relevancy to its own target population is not demonstrated. Progress cannot be measured without this data.

At this point, the MHP has not submitted data to support the baseline and intended data improvement goals of the PIP. The MHP will need to identify these elements. Interventions have not been implemented or reported to date. Secondary to the absence of these critical elements, the scoring of the PIP is not rated in Table 3B above, as the PIP status is Concept Only.

Comments are provided in the PIP Validation Tool for technical assistance purposes only. The MHP is encouraged to continue to include input of the consumer representation in the formulation of this PIP and ongoing during its PIP team meetings. Secondary to the limited activities of this PIP, the MHP is not meeting the PIP submission standard and has not provided the data to show the actual significance of this PIP to their population. Again, it remains crucial to submit an active PIP and it is noted that the MHP has failed to meet compliance with the submission standard of active or completed PIPs. The prior review cycle was the sole year within the past three years that a clinical PIP was considered active. It is prudent for the MHP to seek technical assistance and implement an active PIP.

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

The technical assistance provided to the MHP by CalEQRO consisted of an overview of the PIP process covering data collection to verify a problem, stakeholder input regarding the PIP, methods to identify a study question, the use of interventions, identifying baseline data and goals for improvements, designing a method to validate success and determine indicators for outcomes to measure success.

The CalEQRO team emphasized the critical nature regarding this PIP activity. The MHP was encouraged to seek consultation early into this PIP, to complete written documents reflecting its intentions, and to outline timelines to complete a PIP. To ensure the PIP will meet the required elements for review, it was noted to submit materials for technical assistance early. CalEQRO offered on-site technical assistance which was welcomed and encouraged on-going telephone consultation to continue for the MHP. CalEQRO offered to schedule conference calls to follow-up on this topic.

NON-CLINICAL PIP—HIGH COST USERS

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

- "Will a decrease in the utilization of high cost services and an increase in the utilization of outpatient services improve the functional status and wellbeing of consumers?
- Date PIP began: December 2015
- 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 submitted its Non-Clinical PIP which remains at the Concept Only stage as it has not presented implemented its intended interventions. The MHP identified several beneficiaries who utilize high end services psychiatric emergency services (PES), inpatient hospital and sub-acute services) and are not connected to outpatient care. Thus, the individuals frequently recidivate to high end services, while their outcomes remain stagnant or deteriorate.

The MHP reviewed a 12-month retrospective cost data for all beneficiaries which used the health plan's (HP's) high end services and reported the following:

- 3% (n=700) of consumers over 18 years of age were accountable for about 35% of all charges ($70M)
- 83% of the charges were attributable to high end services (PES 10%, Hospital 27% & Sub Acute 43%) and
- 14% (n=100 of 700) of the highest cost consumers were not connected to outpatient services.

The study will include health plan (HP) beneficiaries in the 97% cost structure, those generating mental health services with costs more than $49,000 over the prior 12-month period, who are in the community and not currently connected to outpatient care (approximately 100 beneficiaries). In addition, the MHP has indicated:

- Demographic data has been captured for this study group including: age, gender, ethnicity, primary language, diagnosis, health plan coverage, Supplemental Security

Income (SSI), Social Security Disability Insurance (SSDI) benefit status and city of residence.

- Service utilization data over the prior 12 months has been captured for this population including service modality, number of visits and charges.

Referrals will be made to the program referenced by the MHP as the In-Home Outreach Team (IHOT). The team consists of a case manager, a peer specialist, and a family member. The goal is to connect people into services. The current intervention is to link unassigned high-need, high cost beneficiaries to assess the consumer's treatment goals and ultimately link the beneficiary to sustainable right-matched outpatient treatment.

Though the team does not provide treatment, it uses specific engagement strategies. Motivational Interviewing (MI) is used as an evidence-informed practice to promote engagement. The beneficiaries assigned to these teams have not received services within 90 days, but a majority have had treatment histories, indicating that it is hard to maintain these individuals in services. MI is practice designed to help engage consumers at the pre-contemplative stage of recovery.

The assumption is that helping connect a consumer to sustainable outpatient services will reduce their utilization of high end services and increase their self-sufficiency as evidenced by their self-sufficiency matrix score. The self-sufficiency survey is a scaling matrix with ratings from 1 to 5 and is aggregated by functional domains. The self-sufficiency matrix is an assessment and outcome measurement tool based on the federal outcomes standard Results Oriented Management and Accountability (ROMA). This impact measurement tool has 25 individual scales, each measuring observable change in some aspect of self-sufficiency. It will be distributed by staff and the evaluation will be done by Research Development Associates (RDA), an independent evaluator. Additionally, focus groups will be held with consumers and staff separately to inform the MHP of improvements and successes.

Successful linkage has the potential to avoid unnecessary hospitalizations and reduce interaction with the criminal justice system. The MHP intends to connect the HP's high-cost consumers to sustainable, right-matched outpatient care to promote the use of lower end outpatient services, reduce the utilization of high end services and improve their outcomes as measured by the self-sufficiency survey.

The following areas will be measured by the PIP for high-cost consumers not connected to outpatient care. The initial cohort of 100 consumers was narrowed to 31 consumers secondary to multiple variables including receiving treatment elsewhere and unable to locate. These 31 high-cost unconnected consumers referred to the IHOT will be tracked for these metrics:

- Utilization of outpatient services after referral to IHOT
- Service charges and utilization after referral to IHOT
- Changes in HP coverage, SSI/SSDI after referral to IHOT referral

By demonstrating effective outpatient engagement to the high-cost, high-need population through timely, client centered, culturally competent care, it hopes to increase the beneficiaries'

engagement in outpatient services and reduce their reliance on high end services. Providing services in the community verses the hospital reduces stress and trauma to the beneficiary and research indicates proactively treating psychosis (versus solely in crisis) can reduce memory and cognitive impairment.
The indicators for which improvements are identified by the MHP include the following:

- Number of PES service days in 12 months (15%reduction)
- Number of Inpatient Hospitalization days in 12 months (10% reduction)
- Minutes of Outpatient Service in 12 months (10% increase)
- Number of consumers receiving outpatient care post PES discharge over 12 months (10% increase)
- Timeliness metrics for outpatient services at 14 days and 30-days following PES discharge over 12 months (5% increase)
- Self-Sufficiency Matrix score

IHOT program outcomes are being evaluated by an independent evaluator (RDA). This evaluation includes quantitative and qualitative measures, conducting focus groups with beneficiaries, families and providers and the use of a Self Sufficiency Matrix used to track client outcomes.

Provider feedback is gathered in a monthly meeting between the IHOT provider teams and members of the MHP staff.

The MHP will need to, to identify the measurable indicators for improvement as reflected on the Self-Sufficiency Matrix, and implement its interventions to be considered active. These have not been completed nor this data reported to date. Secondary to the absence of these critical elements, the scoring of the PIP is not included in Table 3B above as the PIP status is Concept Only.

The MHP was encouraged to review its goals for improvements as well. Goals would hopefully reflect a significant impact on the improvements designed to benefit the consumer, simultaneously reflect the ability of the MHP to reach its aspirations. The cohort is for 31 consumers and these percentage goals may be low and not reflect significant impact. For a large MHP, it is anticipated a goal will impact a large portion of its consumers and the percentage increase may under-represent its intended impact.

Comments are provided in the PIP Validation Tool for technical assistance purposes only. It is dutiful for the MHP to continue to include input of the consumer representation in the formulation of this PIP and ongoing during its PIP team meetings.

Secondary to the limited activities of this PIP, the MHP again is not meeting the active PIP standard and has not provided the data to show interventions. Again, it remains crucial to submit an active PIP and it is noted that the MHP has failed to meet compliance with the submission standard of active or completed PIPs. This is the third year in a row that the MHP has not had an active non-clinical PIP. It is prudent for the MHP to seek technical assistance and implement an active PIP.

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

The technical assistance provided to the MHP by CalEQRO consisted of an overview of the PIP process covering data collection to verify a problem, stakeholder input regarding the PIP, methods to identify a study question, the use of interventions, identifying baseline data and goals for improvements, designing a method to validate success and determine indicators for outcomes to measure success. CalEQRO staff recommended that the MHP outline the indicators and interventions, create a data collection timeline and review its data on a regular basis. CalEQRO offered on-site technical assistance which was well received and encouraged on-going telephone consultation to continue for the MHP.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Reducing the no-show rate for consumers potentially establishes regular, consistent care aimed at mitigating symptoms.
    - Access to care with culturally appropriate interventions can lead to engagement and use of outpatient care.
- Timeliness of Services
    - Increased availability of timely appointments can lead to decreased use of high end crisis and hospital services.
- Quality of Care
    - Provision of culturally appropriate and sensitive service delivery can enhance consumer engagement.
    - Culturally matched services exemplify the foundation of recovery principles.
    - Outpatient services versus use of high end services proactively treats symptom reduction.
    - Timely service accompanied by culturally sensitive staff can increase consumer satisfaction and lead to reduced stressors.
- Consumer Outcomes
    - Direct feedback via focus groups and stakeholder surveys provides venues for the MHP to implement increased positive outcomes.
    - Functional impairments are potentially reduced with consistent, established care.

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 include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below.

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	FC	The MHP continues its culturally and linguistically appropriate services (CLAS). The training provides a detailed overview of the concepts and principles of the CLAS Standards to ensure their successful implementation into all aspects of service delivery. Participants in this training acquire increased competence, and the ability to meaningfully incorporate these critical components into their work. Participants learn how to assess their services and align their work with the enhanced National CLAS Standards developed by the US Dept. of Health and Human Services, Office of Minority Health. Effective strategies for working with consumers cross-culturally and how to embed cultural competency into each step of agency planning processes potentially improves sensitive service delivery. Each year the MHP identifies an "Everyone Counts" group. Its focus is to assist in building resources with representation and development from the community. This next year focus on Latinos and recovery culture. The MHP contracted with Rocco Cheng and Associates to provide a strategic plan to serve its Asian American, Native Hawaiian, Pacific-Islander (AANHPI) groups to reduce mental health disparities and to make improvements to the current system to better address the mental health needs of the AANHPIs. The African-American Steering Committee was formed to address disparities with 22 community providers and stakeholders county-wide. Additionally, the Institute of Black Family and Culture contracted with the MHP, this comprises 50% consumers with lived-experience.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			The MHP demonstrates its rich and extensive cultural trainings throughout the year, its commitment to reach underserved groups including African Americans, Latinos, Asian, TAY, and the gay, lesbian, and transgender communities with its initiatives. As previously mentioned in this report, the MHP has outlined numerous new activities for its older adult, high cost, high end users, and TAY populations.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	An initial first step in achieving adequate service delivery for the high-level needs of those consumers using crisis service and hospitalization was the co-location and tasking a MHP manager at the John George Psychiatric Hospital. Continued analysis of how best to utilize this effort could lead to quality resolutions for consumers. A broader more defined continuum of care which is demonstrated among its providers and staff is critical in the today's climate of healthcare integration. The MHP has demonstrated continued cooperative working relationships with its social service partners to serve the Katie A. population; 43% placed out of county with the majority within neighboring counties. The MHP hired 14 staff for ICC coordinator roles. Approximately 526 youth in subclass with approximately 42% of the subclass with members served with ICC/IHBS.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP continues to contract services, with over 85% delivered by organizational providers. The vast array includes children's services, crisis residential, adult wellness, Latino, TAY, AANHPI, LGBTQ, and older adults. The MHP continues to engage in dynamics addressing the critical nature of collaborative response with law enforcement to urgent conditions. The Children's System of Care (CSOC) in collaboration with Social Services and Probation are working together around Continuum of Care Reform (CCR) Legislation that becomes effective January 1, 2017. The well-established working relationships with the Social Services Department and enhanced with serving the Katie A. members could prove to be a solid foundation to build on with the CCR. The MHP expanded its school based services 29 school districts in over 180 schools. Collaboration with the county Housing and Community Development Department continues with the submission to the Housing and Urban Development (HUD) Youth Homelessness Demonstration Program proposal. The MHP has engaged and awaits its approval for the Drug Medi-Cal Organized Delivery System (DMC/ODS), which will

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			expand its substance use disorder (SUD) service continuum. Recent collaboration with the courts and Department of Motor Vehicles (DMV) to pilot a project focused on decreasing court no-shows for persons arrested for driving under the influence (DUI) will be initiated. If this loop is closed a significant decrease is shown in freeway-related deaths.

**FC =Fully Compliant; PC = Partially Compliant; NC = Non-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	PC	The MHP reports a standard of 14 days with an overall average of 20 days and reports it meets this 53%. For its adult services, the MHP reports an average of 19 days meeting this 53% of the time. For its children's services, the MHP reports an average of 23 days meeting this 46% of the time. These metrics aligned with the prior year's report from the MHP. No improvements have been made to these indicators. The MHP exceeds their own14 day baseline standard for county-operated programs. 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. The MHP indicated that they remain unable to track wait times for beneficiaries who make initial contact and are admitted directly by CBOs which accounts for over 85% of services delivered. Although the MHP regularly reviews its dashboard reports for timeliness to service and its penetration rates across populations and locations, it appears to have made little progress in initial timeliness.
2B	Tracks and trends access data from initial contact to first psychiatric	PC	The MHP reports a standard of 21 days with an overall average of 28 days and reports it meets it 33% of the time. For its adult services, the MHP reports an average of 28 days

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
	appointment		meeting this 24% of the time. For its children's services, the MHP reports an average of 30-days meeting this 35% of the time. Stakeholders voiced concern in being able to access required medications in a timely manner. The metrics for this indicator have diminished since the prior year. The MHP appears to have reviewed this metric for improvements for services since this is met less than half of the time. Stated in its QI Work Plan is to reduce the no-show rates for non-urgent psychiatric appointments by 30 % year-over-year.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP does not track this metric. The MHP stated its intended goal is within 24 hours. The MHP does deploy mobile emergency teams, yet reporting this indicator is not provided. The MHP will need to consider tracking, reviewing this metric and applying improvements if required.
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 4.4 days and reports it meets it 34%. For adult services, it reports an average of 4.9 days with 31% meeting this metric. For children's services, it reports an average of 1.6 days and reports meeting this 80% of the time. While the MHP reports an average length of time within its goal metric of 7-days, it meets this standard at an improved rate for its children's services and continues to meet it far below for its adult services. The MHP presented a Concept Only PIP focused on high cost users geared toward improvements in engagement of this vulnerable group.
2E	Tracks and trends data on re-hospitalizations	PC	The MHP reports a goal of no more than 18% with an overall average of 17%. For adult services, it reports an 18% readmission rate and for children's services it reports a 13% readmission rate. The MHP stated its PIP focused on reducing high end users and improved engaging strategies may result 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 = Non-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, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	PC	The Quality Improvement Committee (QIC) continues to meet monthly and produce minutes. The committee is comprised of a broad-based multi-disciplinary team and the QI staff positions appear to be filled. It established a goal to increase the number of QI Professional and support staff during FY16/17 by two full-time positions. Upon review of the minutes, agenda items are addressed in an informational manner, that is, reporting is limited to updates and current changes. While some of the goals are measurable, many remain without a measurable, objective indicator to demonstrate progress. Limited data is reviewed or analyzed for improvements. A structural change to include nine subcommittees under the QIC will serve as a working model and report relevant activities to the monthly committee on a rotational basis. This structure may prove to increase actions relevant to change and improvements. Documentation of data reviews and subsequent improvements could be reported in the minutes. Consideration to include additional stakeholders at the line staff, consumer and CBO level may accelerate and contribute to effective ownership in these changes. The MHP was advised that is it critical to include two Active PIPs each review cycle. This is the second review cycle with limited information submitted and absence of documented interventions and outcomes of those interventions, limiting its ratings to Concept Only status. It was emphasized at the review by CalEQRO staff that technical assistance is highly recommended which can be initiated immediately to assist the MHP to meet this requirement.
3B	Data are used to inform management and guide decisions	FC	It appears the Decision Support team, which comprises the Information Systems (IS) staff works to respond to all IS report requests initiated by leadership. The IT team presents detailed summaries of its data

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			driven focused reported, drilling down to demographic in regions, clinics and/or programs. Currently the IS Director position is vacant, a critical leadership component in the conversion of its EHR system. Conversely, most of organizational providers felt the electronic health record system was not adequate to coordinate care or capture and share critical documentation. The IS staff were noted to be very responsive given the limits of the existing system.
3C	Evidence of effective communication from MHP administration	PC	Focus group participants were well-informed via emails, newsletters and participation by consumer in family member committees. Consumer family member (CFM) employees participate in regular staff meetings and have access to management when issues arise and/or they have ideas for change. The MHP holds a monthly meeting with CFMs in leadership positions for both county and contract provider CFMs. It should be noted that the website is in English-only with the exception for Consumer Grievance forms and limited links to other resources and services offered with no reference to Wellness Centers. The MHP indicated that updating is again considered yet remiss of a timeline to address this issue secondary to the priority of EHR. The MHP will include CFMs in the review process. A majority of all stakeholder groups indicated although communication efforts have improved, often announcements come after decision making has occurred and may not be distributed cohesively, thus some receive delayed notifications.
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	The MHP includes organizational providers on committees yet most indicate a voice regarding decision making is limited and restricted. Organizational providers indicated claims processed had been improved, communication was better and indicated interest in the move towards performance contracts and deliverables. There were not significant performance measures at this point but programs were heading in this direction. Some of the contractors did quarterly reports focused on outcomes. Focus groups involving staff indicate little opportunity is offered for participation in committee work and similar to organizational providers, a venue for input and feedback is absent.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	Integration with primary care and substance use was demonstrated with multiple projects geared towards expansion of services, emphasizing psychiatric care. Alameda County has an active NAMI with groups offered in threshold languages, as well. The MHP has increased its initiatives focused on adults, older adults and homeless populations. Housing increased to 150 permanent units, and Homestretch-Healthcare for homeless was enacted. More is expected with concrete services in the coming year. Although the MHP has engaged in training with law enforcement, a theme of insensitivity continues with the law enforcement response as noted by stakeholder groups.
3F	Evidence of a systematic clinical Continuum of Care	PC	Under leadership of the medical director and the staff, there was evidence of a strong partnership between the primary care safety net and the MHP. MHP provided psychiatric consultation to eight legal entities who were FQHCs (with a total of 80 sites) and one non-FQHC. This included the funding for fellowships at UC Davis School of Medicine for primary care providers. There were eight initial fellowships funded and this was being expanded to ten in the next year. The combination of consultation, training, and addition of billable behavior therapists under the FQHC umbrella (LCSWs, PhD psychologists, and soon MFTs) was dramatically expanding capacity for treatment of consumers from both mild/moderate and in some clinics targeting the homeless and the SMI adult and older adult populations. The standardized continuum of care is not apparent in outpatient treatment planning. Consumers reflected participation in treatment, however, were limited in knowing how long or what constitutes discharge for lower end services. CBOs report limited availability of timely information regarding consumer hospitalizations and no access to data reports leaves a gap in treatment.
3G	Evidence of individualized, client-driven treatment and recovery	PC	The MHP focuses on the use of individualized care with the WRAP treatment plan. While traditionally a recovery focused base for treatment, the MHP could use an expanded systematic service delivery with identified points of entry and exit related to care. It could structure its current continuum to define gaps and inform stakeholders of its levels of service. It could consider a sensible brief treatment package with

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			incremental programs as consumer progress is made. Evidence based practices continue to expand with the Multi- Dimensional Family Therapy (MDFT) delivered by Lincoln Child Center. The MHP trained 15 children's staff in Dialectic Behavioral Treatment. Eating disorder training for six CBOs was provided by the University of Berkeley for this group. A Trauma Informed Care workforce initiative with 4 hour monthly trainings over an 18-month period occurred with over 300 staff trained. A website is maintained for ongoing updates. The Transition to Independence Project (TIP) an evidence informed practice for youth aged 16-20 was launched. Creating dashboards with the outcomes will be forthcoming. Results Based Accountability (RBA), a significant MHP initiative, will introduce performance-based contracts which could extensively provide quantitative information of service delivery.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	Line staff comprise consumer family members (CFMs) who are employed in permanent, full-time and benefitted positions within the Office of Consumer and Family Empowerment. Additional CFMs (up to a total of approximately 185) are active in either the Pool of Consumer Champions(POCC) receiving stipends, or work within the county provider networks as part-time, full-time-benefitted, and/or volunteers. Focus group member volunteers felt a greater sense of empowerment and opportunity to advance beyond their positions. Those who were employed in county MHP positions felt that the growth and advancement opportunities were limited to that office. The Pool of Consumer Champions (POCC) now includes 1,500 members with over 900 consumers and/or family members involved in actively providing ongoing CFM input into issues related to service delivery in the MHP. This grass-roots program began in 2007 and continues to serve the purpose of ensuring that the consumer and family voice is heard and considered in the delivery of behavioral health services in Alameda County. The POCC is now a formal part of the MHP Behavioral Health Care organization, with staff of the Office of Consumer Empowerment providing support. POCC also has a Facebook page with current information regarding activities. POCC members serve on important

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			Behavioral Health Care Services Advisory and Planning Committees, including the Asian American Committee, Healing Trauma Committee, African American Empowerment Committee, Latino Committee, TAY Committee, and the Consumer Employment Advisory Taskforce. The MHP stated in its QI Work Plan a goal to increase the number of consumers, providers, and family members active in the planning, design and execution of QI Programs through active recruitment in QI Committee and sub-committees.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	The MHP currently has five Wellness Centers (a sixth is planned for Berkeley). The most recent (Casa Ubuntu Creative Wellness Center) opened at the beginning of November, serving the East Oakland community. Centers are drop-in with regular business hours, some also including limited weekend hours. Programs offered are peer-driven with a focus on wellness and recovery. Linkages to other supports are also provided, such as employment, housing, medication management, case management, primary care. 2,700 consumers were served this past year. Wellness and Recovery Action Plan (WRAP) training is well-integrated into Wellness Center programs and is facilitated by peers who have been certified. The QIC has a WRAP Subcommittee; 312 consumers currently have active WRAP plans. In July, the MHP launched its "IHOT" (In-Home Outreach Team) linkage program to improve consumer connections to outpatient care. Each of the four teams has a Peer Specialist and a family member offering warm-handoffs.
3J	Measures clinical and/or functional outcomes of consumers served	PC	The implementation of CANS throughout the children's system was hopefully going to provide outcome and improvement information. This product is fully integrated into the EHR system. The adult system of care has plans to implement the ANSA to achieve outcomes for adults and older adults. It is not yet integrated into its data collection system.
3K	Utilizes information from Consumer Satisfaction Surveys	FC	In addition to the required statewide Consumer Perception Survey, the MHP has created a QI goal to increase consumer participation in the survey. It continues to work collaboratively with its peer partners for strategies in accomplishing this. A survey of the consumer experience is provided at discharge from John George Psychiatric Hospital. A survey of peer providers, developed at the consumer

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			leadership meeting, focused on four categories: improving hope, welcoming hope, personal power, and satisfaction. The peer employee motto is "Measure what you treasure". Improvements are made at the peer level when recommendations arise.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP has initiated several activities to improve access and capacity to serve its target populations of older adults, incarcerated persons, TAY, and homeless groups.
  - The MHP has conducted multiple trainings consistent with the CLAS standards to improve initial and ongoing consumer relationships, especially with engagement strategies.
- Timeliness of Services
  - The MHP appears reticent to analyze its timeliness metrics and review these regularly for immediate improvements.
  - An objective review and analysis of the metrics for the initial appointment could improve access.
  - The MHP again is encouraged to begin tracking and reviewing its metrics for urgent conditions and no-show appointments. Analysis of these can provide insights for procedural changes and the stakeholder responses to crisis care.
- Quality of Care
  - The evaluation of the prior year's QI Work Plan was not provided nor was the implementation of two PIPs to be considered active presented.
  - Challenges indicated by stakeholder groups often included some barriers potentially impacting service delivery: significant and ongoing leadership changes including having an Interim Healthcare Services director and vacant staffing positions, significant workforce challenges with competing urban employment, problems with the cost of living, especially high-cost housing and the lack of adequate cost of living adjustments.
  - Integration of healthcare is an area of excellence anticipated to expand with the Whole Person Care grant which includes evaluation and infrastructure funding.

One of the areas for anticipated growth was telepsychiatry and pharmacy skills linked to substance use disorder (SUD) populations.

- Consumer Outcomes
    - The MHP has implemented the use of CANs for all CSOC youth and initiated the use of the ANSA for adults to provide increased information regarding consumer progress and ultimately consumer service needs.
    - TAY expansion is occurring with Seneca, Inc., an organizations provider for youth which includes venues for TAY in:
        - ▷ Training and outreach- training newly hired staff and foster parents,
        - ▷ Peer Partnerships and mentoring-youth act as peer partners and mentor youth who experienced similar issues, and
        - ▷ Leadership development and youth participate in program developments.

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

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This focus group was held at the MHP Administrative Offices at 2000 Embarcadero Cove, Oakland and the MHP was asked to organize the focus group with 8 to 10 participants with the following criteria:

- A culturally diverse group of adult beneficiaries, including a mix of existing and new clients, who have initiated/utilized services within the past 12 months.

Number of participants – 2

Given the small number of attendees at this session, the specific comments are not included secondary to maintaining the anonymity of the participants. Overall, the size of the group may not represent the service delivery for the adult population without an adequate number of consumers. Additionally, the demographics for this session are not reported for the same reasons.

It may be useful for the MHP to be aware that these consumers noted similar items, feeling included at the Wellness Centers in which participation was encouraged. Also, increased staffing and enhanced provisions for consumer safety at John George Psychiatric Hospital would be in order.

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This focus group was held at the Lincoln Child Center at 1266 14th Street, Oakland and the MHP was asked to organize the focus group with 8 to 10 participants with the following criteria:

- A culturally diverse group of parents/caregivers of child/youth beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months.

Number of participants – 3

For the three participants who entered services within the past year, they described their experience as the following:

- Access to services was timely.
- Youth could schedule with the counselor when needed.
- Each youth's cultural preferences were honored.

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

- Youth received services on school sites.
- Services were easily accessible to students as needed.
- Although not a barrier, parents noted that family sessions were not conducted or scheduled.

Recommendations for improving care included the following:

- Increase outreach, educate parents and school personnel regarding services.
- Provide flyers and guest speakers regarding mental health recovery.
- Distribute mental health information to students**.**

Interpreter used for focus group 2: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
    - Parents indicated access is simplified at the school site settings and scheduling remains flexible.
- Timeliness of Services
    - Parents stated services were timely.
- Quality of Care
    - Parents shared their perspective that youth felt respected and valued by their provider.
    - Family sessions were not provided, perhaps inadvertently to school based services.
- Consumer Outcomes
    - Parents were not aware of any formal plans or outcome tools used.

- Parents indicated the treatment helped their youth.

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	18.32%
Contract providers	80.39%
Network providers	1.20%
Total	100%

- Percentage of total annual MHP budget is dedicated to support information technology operations: (includes hardware, network, software license, IT staff)

  1.34%

- Consumers have on-line access to their health records either through a Personal Health Record (PHR) feature provided within EHR or a consumer portal or a third-party PHR:

  ☐ Yes ☐ In Test/Pilot Phase ☒ No

- MHP currently provide services to consumers using a tele-psychiatry application:

  ☐ Yes ☐ In Test/Pilot Phase ☒ No

  - If yes, the number of remote sites currently operational:

    N.A.

- MHP self-reported technology staff changes since the previous CalEQRO review (FTE):

Table 9 – Summary of Technology Staff Changes			
Number IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
23	1	1	4

- MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE):

Table 10 – Summary of Data Analytical Staff Changes			
Number Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
6	0	0	1

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

- Vacant IS positions include that of IS Director which will be at the Health Agency level.

CURRENT OPERATIONS

- The MHP and all CBOs continue to utilize InSyst for client registration, service entry, and billing. The MHP utilizes eCura Managed Care software for billing and payments for network providers.
- Clinician's Gateway is linked to InSyst and is used by all MHP operated programs and 29 CBOs who have chosen to use it as their EHR.
- Decision support software is being migrated from Emanio to Yellowfin, which is a later version of the same software and is now being licensed directly from the developer. The software extracts data from InSyst, Clinician's Gateway, and Objective Arts databases daily and currently provides over 100 dashboards/reports.

- Insyst training continues to be scheduled monthly and more frequently as needed. The MHP utilizes designated "Super Users" at the agency/program level to provide hands on training and support as well as a phone based Helpdesk.

Table 11 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide 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 11— Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
InSyst	Practice Management	The Echo Group	26	MHP/County
eCura	Managed Care	InfoMC	17	MHP/County
Clinicians Gateway	Clinical Record	Platton Technologies	9	MHP/County
Emanio/YellowfIn	Decision Support	EMANIO Inc	3	Vendor/HCA
Footprints	CRM – Help Desk	BMC – Footprints	>2	MHP/County
CANS	Outcomes	Objective Arts	1	MHP/County

PLANS FOR INFORMATION SYSTEMS CHANGE

- Implementation in progress.
- The MHP is in progress of implementing Sharecare from the Echo Group (Echo) to replace the current InSyst and eCura applications. All providers will have access for registration and service entry.
- ShareCare is expected to go-live for all users in the July 2018 (tentative date.)
- The MHP plans to begin implementing the Visual Health Record (VHR) electronic health record (EHR), also from the Echo, following the completion of the ShareCare implementation.
- CBO's will have the option to utilize ShareCare and VHR as their primary information system or can utilize their own EHR and enter clients and services directly into ShareCare.

ELECTRONIC HEALTH RECORD STATUS

Table 12 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 12—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Clinician's Gateway	x			
Assessments	Clinician's Gateway	x			
Document imaging/storage	Laserfiche	x			
Electronic signature—consumer				x	
Laboratory results (eLab)				x	
Level of Care/Level of Service	Clinician's Gateway		x		
Outcomes	CANS		x		
Prescriptions (eRx)	Clinician's Gateway	x			
Progress notes	Clinician's Gateway	x			
Treatment plans	Clinician's Gateway	x			
Summary Totals for EHR Functionality		6	2	2	0

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

- Clinician's Gateway is utilized by MHP staff and a minority of CBOs (29 agencies).
- CANS data entry and scoring is utilized by all child providers using an external web based application which is not linked to Clinician's Gateway. No adult outcomes instrument is available.

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

  ☐ Paper ☐ Electronic ☒ Combination

MAJOR CHANGES SINCE LAST YEAR

- Initial configuration of ShareCare is near ready.
- ICD-10 diagnosis codes incorporated into InSyst.
- Footprints helpdesk and change management tracking software has been configured.

- Clinician's Gateway configured to allow Patient Portal & Lab interfaces.
- System requirements near completion for Salesforce software to be used for contract management.
- SUD Call Center module developed within Clinician's Gateway.
- SUD environment added to Clinician's Gateway.
- CANS system application implemented.

PRIORITIES FOR THE COMING YEAR

- Finalization of ShareCare System Options and delivery of "Golden Database" for testing.
- Completion of Footprint software implementation.
- Continued deployment of Laserfiche document management software.
- Implementation of DSM-5 diagnosis and Patient Portal in Clinician's Gateway.
- Development of CANS data analysis.
- Begin development and analysis of ANSA application.
- Implementation of disaster data recovery site.
- Completion of upgrade of decision support software and creation of public dashboards on behavior health website.

OTHER SIGNIFICANT ISSUES

- The IS/EHR implementation does not have a full time dedicated project manager or staff despite the complexity of the project. Without full-time dedicated project management staff by the MHP their EHR implementation is at-risk for delays beyond the targeted go-live date of July 2018.
- CBO providers continue report significant overhead in performing dual entry in InSyst as well as their own system.
- Dashboard reports remain unavailable to CBOs.
- The MHP reports a large backlog void and replace and CSI corrections.
- CBOs report difficulty in getting timely notification of ER admissions and discharges.

- Accurate and complete tracking of wait times for services regardless of entry point remains an issue.
- The MHP continues to lack access to a shared appointment scheduler.

MEDI-CAL CLAIMS PROCESSING

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

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

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

☒ Yes ☐ No

If yes, product or application:

Internally developed spreadsheets and database.

- Method used to submit Medicare Part B claims:

☐ Clearinghouse ☒ Electronic ☐ Paper

Table 13 - Alameda MHP Summary of CY15 Processed SDMC Claims

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
661,448	$162,713,510	$4,181,696	2.57%	14,467	$158,531,814	$4,595,660	$153,936,154

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP produces a detailed demographic report annually and performs additional analysis of data regarding underserved populations as needed.

- Timeliness of Services
    - Multiple entry points for initial contact and services raises concerns about the completeness of wait time for initial services tracking.
    - Lack of a shared scheduler prevents use or tracking of offered appointments.
- Quality of Care
    - The Quality Improvement Committee reviews the annual penetration report and other data as requested.
    - Although a Data Collection, Analysis and Reporting QI subcommittee was established earlier this year, there is no indication of any activity or reporting.
- Consumer Outcomes
    - The completion of the CANS implementation allows tracking of individual outcomes for children.
    - Tracking of adult outcomes remains unavailable.

SITE REVIEW PROCESS BARRIERS

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

- Given the relatively low attendance at each of the two consumer family focus groups (two and three participants, respectively) the perspectives of consumers may not fully be represented.

CONCLUSIONS

During the FY16-17 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
    - The MHP has begun to include performance-based measures in its organizational provider contracts.
    - The MHP engaged in expanded efforts geared toward ending the cycling in and out of Santa Rita and John George Psychiatric Hospital and reduce the number of mentally ill people who are incarcerated at Santa Rita.
    - Understanding how integration of physical care with mental health case management is delivered to consumers continues to be demonstrated within its Healthcare Integration expansion into the FQHCs.
    - Ongoing tracking of demographic data has permitted the MHP to begin to identify needs and prioritize services to Asian/Pacific Islanders and Afro American beneficiaries.
- Opportunities:
    - Developing a formal continuum of care which addresses consumer needs at the point of entry to unanticipated need for hospitalization could enhance its prolific constituency organizational provider network.
    - It appears there is a need for an Intensive Outpatient Program level of care and increased availability to urgent outpatient mental health intake appointments given the high census at John George PES unit.

Timeliness of Services

- Strengths:
    - The MHP has increased timely field-based crisis response in which paired teams of a clinician and law enforcement officer respond; and the psychiatric Mobile Emergency Teams which provide field-based assessments.

- Implementing effective crisis response may prove to positively affect the over-crowding at the John George Psychiatric Hospital.

- Opportunities:
  - Dedicated attention is encouraged regarding setting measurable timeliness standards, conducting regular reviews and making improvements to these metrics upon analysis, to comply with quantitative metrics that address quality service delivery for county and CBO programs.
  - The MHP continues to struggle with the dynamics of over-crowding and perhaps inefficient use of the only local inpatient hospital John George Psychiatric Hospital operated by Alameda Health System network.

Quality of Care

- Strengths:
  - Culturally sensitive and culturally inclusive data is collected to track ethnicity, user needs, and hiring trends of psychiatrists and clinical staff within the MHP and community based organizations to represent workforce capacity to match consumer needs.
  - The MHP continues to demonstrate its commitment to peer partners with its ever-expanding activities developed through its Pool of Consumer Champions.
  - The MHP administration and QI staff continue make use of reports and dashboards provided by the Decision Support team.

- Opportunities:
  - Although the MHP has begun the implementation of its new information system, it has not produced a strategic implementation plan and timeline, nor identified staff training barriers, which may lead to gaps in its success.
  - The future EHR system is a mission-critical project for timely, quality services and successful consumer outcomes. The executive management team must take a leadership role to guide and monitor project plan implementation and become involved with critical project decisions.
  - The MHP would benefit from a comprehensive structured continuum of care to address consumer needs at the lowest level possible, eventually reflected in its data to reduce high cost users of high end services.
  - A review of the key junctures in the service delivery system including intake, treatment, and planned step down from services is optimal.
  - The efforts to involve stakeholders could be enhanced with inclusion of line staff, family members and increased input with contract providers, on a consistent basis. Initial steps could begin with committees which review data and in its EHR implementation and PIP initiatives.

- The MHP could review its succession planning strategies to address the mentoring of individuals for job skill building for its revolving vacancies, especially at the leadership level.
- The activities for two mandated active PIPs require consistent on-going interventions which remain at the Concept Only level.
- Access to data produced via the MHP's Decision Support unit remains very limited for CBO providers with no formal planning or needs analysis for CBOs. Contract providers report an inability to access data required to fully evaluate contract performance.
- The MHP has not developed a specific plan or timeline for the HIE implementation, critical given its 85% reliance on CBO providers.
- The MHP would benefit from additional resources to incentivize the county to build the infrastructure for an HIE. Without a confident funding source, it will be a challenge to have an HIE environment.

Consumer Outcomes

- Strengths:
  - The MHP has sought funding for a Peer Respite Treatment Program, another form of treatment options, moving in the direction of innovative programing.
  - The implementation of the CANS database for all child providers has provided a resource for evaluating outcomes.
- Opportunities:
  - The reported lengthy wait times in the psychiatric emergency services (PES) may lead to a high readmission rate at John George Psychiatric Hospital which contributes to chronic overcrowding due to lack of available beds. Solutions such as IHOT and the community crisis centers are not yet fully implemented.
  - The lack of a system-wide use of a global level of care or outcome tool for adults remains an outstanding issue.

RECOMMENDATIONS

- Address the collection of all timeliness indicators to include all county and community-based organization (CBO) programs, review performance at least quarterly, and develop immediate corrections when goals are not being met.
- Engage in a review of the outpatient care continuum to identify gaps and deficiencies. Continue to establish a comprehensive, integrated system offering a seamless continuum of care to seriously mentally ill populations.

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

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

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

- Develop goals and priorities for the Data Collection, Analysis and Reporting Quality Improvement subcommittee and incorporate into the Quality Improvement (QI) agenda.

ATTACHMENTS

Attachment A: Review Agenda

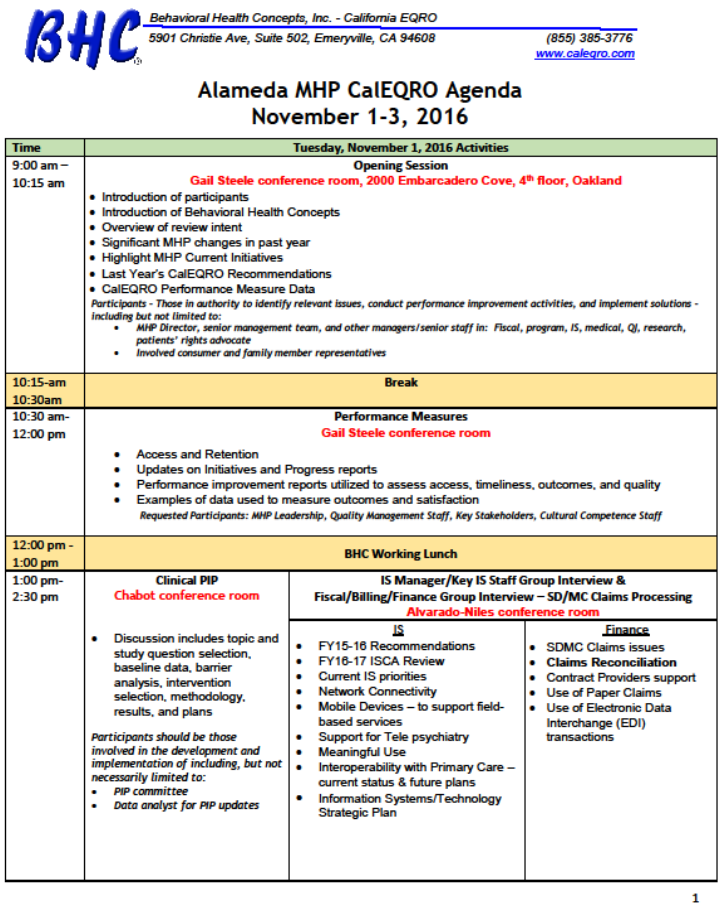
Attachment B: Review Participants

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:



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Alameda MHP CalEQRO Agenda
November 1-3, 2016

Time	Tuesday, November 1, 2016 Activities		
9:00 am – 10:15 am	**Opening Session** **Gail Steele conference room, 2000 Embarcadero Cove, 4th floor, Oakland** • 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** • 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** **Chabot conference room** • 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 & Fiscal/Billing/Finance Group Interview – SD/MC Claims Processing** **Alvarado-Niles conference room** **IS** • FY15-16 Recommendations • FY16-17 ISCA Review • Current IS priorities • Network Connectivity • Mobile Devices – to support field-based services • Support for Tele psychiatry • Meaningful Use • Interoperability with Primary Care – current status & future plans • Information Systems/Technology Strategic Plan	**Finance** • SDMC Claims issues • **Claims Reconciliation** • Contract Providers support • Use of Paper Claims • Use of Electronic Data Interchange (EDI) transactions

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ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Jovonne Price, Quality Reviewer
Saumitra SenGupta, Executive Director
Jerry Marks, Information Systems Reviewer
Judith Toomasson, Information Systems Reviewer
Deb Strong, 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

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

Alameda County Behavioral Health Care Services Administration
1900 Embarcadero Cove,
Oakland, CA

CONTRACT PROVIDER SITES

John George Psychiatric Hospital
2060 Fairmont Drive,
San Leandro, CA 94578

Lincoln Child Center
1266 14th Street,
Oakland, CA 94607

Participants Representing the MHP

Name	Position	Agency
Alcorn, Radawn	Interim TAY System of Care Director	BHCS *

Alley, Martha	Program Contract Manager	BHCS
Arrieta, Rudy	Quality Management Program Director	BHCS
Arrizon, Fidelia	Family Partner	BHCS
Aslami, Khatera	Consumer Empowerment Manager	BHCS
Basra, Sona	Supervising Financial Services Specialist	BHCS – Fiscal Unit
Becton, Neisha	Executive Director	Pathways to Wellness
Bennet, Ola	Director, Behavioral Health Services	West Oakland Health Council
Bergman, Bev	Family Advocate	Mental Health Association
Biblin, Janet	Decision Support Manager	BHCS
Blake, Benjamin	Chief Clinical Strategy Officer	BACS
Branagh, Fiona	Director, Network Office	BHCS
Bruner, Kaitlin	Management Analyst, Children & Family Services	Social Services Agency/CWS
Cantrell, Regina	Personal Services Coordinator	Fred Finch STAY Program
Cardenas, Jennifer	Quality Improvement Director	Seneca Family of Agencies
Chapman, Aaron	Medical Director	BHCS
Cook, Bonnie	Behavioral Health Clinician	BHCS – Criminal Justice Mental Health
Costello, Maureen	Behavioral Health Care Manager	BHCS – Oakland Community Support Center
Courson, Natalie	I.S. Program Manager	BHCS – Information Systems
Davis, Kenneth	Steering Committee Member	POCC
DeSantis, Adrianne	Program Assistant	BHCS
Diedrick, Sheryl	Information System Analyst	BHCS
Eady, Rashad	Program Specialist, Ethnic Services	BHCS
Engstrom, John	Decision Support Manager	BHCS
Fone, Donna	Quality Assurance Administrator/Quality Management	BHCS
Foster, Bettye	Family Advocate Supervisor	FERC **

Frediani, Leda	Director, Office of Financial Services	BHCS
Franklin, Paulette	CED Staff	BHCS
Friedrich, Alane	MHB Co-Chair, Family Member	Mental Health Board
Fuller, Faith	Health Services Consultant	BHCS
Gaines, Wilma	Consumer/Family Assistance Specialist, MH Association	MHAAC
Gill, Gwendolyn	Health Center Director	Lifelong Medical Care
Gill, Harjit	LCSW	John George Psychiatric Hospital
Goldstein, Brenda	Psychosocial Services Director	Lifelong Medical Care
Haley, Fletcher	Community Services Worker	Fred Finch STAY Program
Hamner, Scott	Info Systems Analyst	BHCS – Information Systems
Hanson, Dawn	Employment Specialist	VOC
Harrison, Nicole	Family Advocate	FERC
Hazelton, Tracy	Prevention Coordinator	BHCS
Henry, John	Outpatient Mental Health Services Director	Girls, Inc.
Hernandez, Irma	POCC Chair	POCC
Hobbs, Nathan	Program Specialist, Children's System of Care	BHCS
Hogden, Mary	Pool of Consumer Champion Manager	BHCS
Jackson, Alex	CANS Project Director/Quality Management	BHCS
Jimenez, Manuel	Behavioral Health Director	BHCS
Jones, Kate	Division Director, Crisis Services	BHCS
Judkins, Andrea	Financial Services Specialist	BHCS
Kessler, Michael	Older Adult System of Care	BHCS
Klapcic, Mark	RN	John George Psychiatric Hospital
Le, Cindy	Doctor	John George Psychiatric Hospital

Lee, Anna	LCSW	John George Psychiatric Hospital
Lee, Eleanor		Stages
Lee, Sun	Program Contract Manager	BHCS
Leonard, Josh	Executive Director	EBAC
Leung-Flores, Linda	MHSA INNOVATIONS Program Specialist	BHCS
Limperopulos, Tony	Behavioral Health Care Manager	BHCS - Tri-City and Valley Community Support Centers
McManus, Veronica	Family	BHCS
Manoleas, Peter	Behavioral Health Consultant	La Clinica
Marks, Leslie	Behavioral Health Clinician	BHCS – Guidance Clinic
Martin, Daun	Health Care Consultant	HEALTH CARE SERVICES AGENCY
Martinez, Jennifer	Director, Indigent Care / Health Care System Planning & Improvement	HEALTH CARE SERVICES AGENCY
Mayoral, Leanna	Family Partner	BHCS
Mazid, Sanjida	Workforce and Training Manager	BHCS
Meinzer, Chet	Decision Support IS Analyst	BHCS
Mercader, Amber	Clinician	BAYC-Sunny Hills
Miller, Laura	Medical Director	Community Health Center Network (CHCN)
Molony, Natasha	Director of Training	Hume Center
Moncrief, Michele	POCC	BHCS
Muir, Ellen	Assistant Director, Children's System of Care	BHCS
Mullane, Jennifer	Assistant Director, Adult System of Care	BHCS
Murray, Marie	Acting Director, Utilization Management	BHCS
Newton, Brian	Manager, Data and Reporting Systems	Hume Center
Nguyen, Tam	Director, Behavioral Health Care Services	Tri-City Health Center
Orozco, Gabriel	Management Analyst	BHCS
Osborn, Scott	Regional Executive Director	Seneca Center
Padilla, Carolina	Family Partner	BHCS

Paris Mortensen, Jackie	Director, Provider Relations	BHCS
Park, Yeon	Mental Health Specialist	VOC
Parker, Alicia	Counselor	Bonita House Residential Program
Penserga, Luella	Chief Policy, Planning, External Affairs	Alameda Health Consortium
Perales, Joseph	Manager	La Clinica CASA Del Sol
Peter (only name provided)	PIP Consultant	La Raza
Ponce, Ryan	RN	John George Psychiatric Hospital
Rackmil, Jeff	Director, Children's System of Care	BHCS
Ratner, Robert	Director, Housing Services Office	BHCS
Rahman, Mark	Family Advocate	FERC
Raynor, Charles	Director, Pharmacy Division	BHCS
Renwicke, Vittito	Family Advocate	FERC
Riley, Robyn	Behavioral Health Clinician	TAY
Romano, Dennis	Executive Director	Alameda Council of Community Mental Health Agencies
Rueda, Jonathan	Peer Specialist	La Familia
Salamy, Nancy	Executive Director	Crisis Support Services
Saler, Barbara	ACCESS Program Clinical Manager	BHCS
Salvador, Johanna	Nurse Care Coordinator	PATH Clinic at Oakland Community Support Center
Sanders, Elizabeth	Counselor and Day Treatment Program Assistant Coordinator	East Bay Community Recovery Project – S/D Day Treatment
Schaechner, Lillian	Director, Older Adult System of Care	BHCS
Schultz, Henning	Critical Care Manager	BHCS
Serrano, Cecilia	Financial Services Officer	BHCS
Silverman, Carol	Evaluation Director	Telecare
Singleton, H.	Behavioral Health Clinician	BHCS
Smith, Dana	Quality Improvement Director	Telecare

Smith, Freddie	Manager, Primary Care Integrations Projects	BHCS
Sohn, Haeyoung	Director of Behavioral Health	John George Psychiatric Hospital
Takayanagi, Paul	Training Officer	BHCS
Tannenbaum, Francesca	Director, Patients' Rights Advocates of Alameda County	MHAAC
Taylor, Joan	Nurse Care Coordinator	BHCS
Teixeira, X.	Mental Health Clinician	AFS
Thomas, Tiffany	Clinician	Alameda Family Services
Tribble, Karyn	Deputy Director	BHCS
Trabin, Tom	Alcohol & Drug Program Administrator	BHCS
Vargas, Wendi	Assistant Director BHCS Network	BHCS
Wagner, James	Director, Adult System of Care	BHCS
Ware, Carrie	Behavioral Health Clinician	BHCS – Children's Specialized Services (CSS)
Wayne, Clyde	Clinicians & Fatherhood Program Coordinator	Brighter Beginnings
Wessner, Margaret	Housing Specialist and Counselor	Bonita House HOST Program
Williams, Bre	Program Coordinator	PEERS
Williams, Sage	Personal Services Coordinator	BACS
Wilson, Javarre	Ethnic Services Manager	BHCS
Wilson-Reynolds, Jada	Personal Service Coordinator/ Daily Program Coordinator	East Bay Community Recovery Project - FACT/TrACT Program
Winn, Jalean	CED Staff	BHCS
Wong, Jackie	Behavioral Health Services Manager	Asian Health Services
Woods, Schalon		CJMH
Yahya, Daniel	Doctor	John George Psychiatric Hospital
Zelaya, Rosaura	Behavioral Health Clinician	BHCS

* Beh *Behavioral Health Care Services (BHC (BHCS)

** Family Education and Resource Center (FERC)

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands.

Table C1 (Attachment C) shows the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal ACA Expansion Penetration Rate and Approved Claims per Beneficiary.

Table C1 - CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	2,001,900	131,350	6.56%	$533,318,886	$4,060
Large	950,222	63,298	6.66%	$263,166,307	$4,158
Alameda	81,940	4,084	4.98%	$20,559,698	$5,034

Table C2 (Attachment C) shows the distribution of the MHP CY15 Distribution of Beneficiaries by Approved Claims per Beneficiary (ACB) Range for the various categories; under $20,000; $20,000 to $30,000, and those above $30,000.

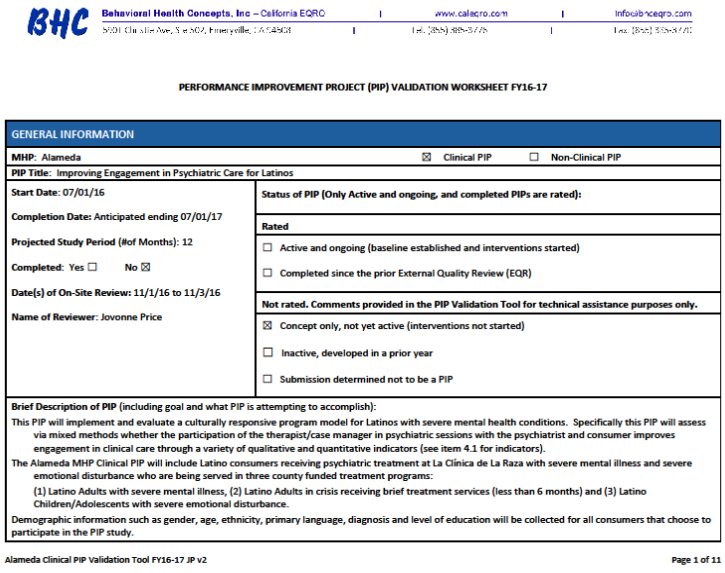
Table C2 - Alameda MHP CY15 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
$0K - $20K	17,782	90.19%	94.46%	$79,496,008	$4,471	$3,553	51.63%	61.20%
>$20K - $30K	886	4.49%	2.67%	$21,735,162	$24,532	$24,306	14.12%	11.85%
>$30K	1,049	5.32%	2.86%	$52,746,331	$50,282	$51,635	34.26%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:



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5901 Christie Ave, Ste 302, Emeryville, CA 94608 | Tel: (866) 388-5775 | Fax: (866) 855-3701

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION	
MHP: Alameda	☒ Clinical PIP ☐ Non-Clinical PIP
PIP Title: Improving Engagement in Psychiatric Care for Latinos	
Start Date: 07/01/16 **Completion Date:** Anticipated ending 07/01/17 **Projected Study Period (#of Months)**: 12 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review:** 11/1/16 to 11/3/16 **Name of Reviewer**: Jovonne Price	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP
Brief Description of PIP (including goal and what PIP is attempting to accomplish): This PIP will implement and evaluate a culturally responsive program model for Latinos with severe mental health conditions. Specifically this PIP will assess via mixed methods whether the participation of the therapist/case manager in psychiatric sessions with the psychiatrist and consumer improves engagement in clinical care through a variety of qualitative and quantitative indicators (see item 4.1 for indicators). The Alameda MHP Clinical PIP will include Latino consumers receiving psychiatric treatment at La Clínica de La Raza with severe mental illness and severe emotional disturbance who are being served in three county funded treatment programs: (1) Latino Adults with severe mental illness, (2) Latino Adults in crisis receiving brief treatment services (less than 6 months) and (3) Latino Children/Adolescents with severe emotional disturbance. Demographic information such as gender, age, ethnicity, primary language, diagnosis and level of education will be collected for all consumers that choose to participate in the PIP study.	

Alameda Clinical PIP Validation Tool FY16-17 JP v2 Page 1 of 11

Non-Clinical PIP:

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION	
MHP: Alameda	☐ Clinical PIP ☒ Non-Clinical PIP
PIP Title: High Cost Users	
Start Date: 12/2015 **Completion Date:** on-going **Projected Study Period** (#of Months): 24 **Completed:** Yes ☐ No ☒ **Date(s) of On-Site Review:** 11/1-11/3/2016 **Name of Reviewer:** Jovonne Price	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP identified a number of beneficiaries which utilize high end services (Psychiatric Emergency Room (PES), Inpatient Hospital and Sub-Acute Services) and are not connected to outpatient care. As a result, the individuals frequently recidivate to high end services, while their outcomes remain stagnant or deteriorate. The study will include health plan (HP) beneficiaries in the 97% cost structure, those generating MH service costs more than $49K over the prior 12-month period, who are in the community and not currently connected to outpatient care (approximately 100 beneficiaries). Referrals will be made to the program referenced by the MHP as the In-Home Outreach Team (IHOT). The team consists of a case manager, a peer specialist, and a family member. The goal is to connect people into services. The MHP intends to connect the high-cost consumers to sustainable, right-matched outpatient care to promote the use of lower end outpatient services, reduce the utilization of high end services and improve their outcomes.	