FY 14-15

Medi-Cal Specialty Mental Health

External Quality Review

MHP FINAL Report

Contra Costa MHP

Conducted on

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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 Independent Health Plans (PIHPs) and their contractors to recipients of Managed Care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid Managed Care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

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

- MHP information:

    o Beneficiaries served in CY13—13,170

    o MHP Size—Large

    o MHP Region—Northern

    o MHP Threshold Languages—Spanish

    o MHP Location—Martinez

This report presents the fiscal year 2014-2015 (FY 14-15) findings of an external quality review of the Contra Costa mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

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

- Total Beneficiaries Served by each county MHP

- Total Costs per Beneficiary Served by each county MHP

- Penetration Rates in each county MHP

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

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark.

- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay

- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates

- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

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

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

(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 one 90-minute focus group 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.

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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.

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

PRIOR YEAR REVIEW FINDINGS, FY13-14

In this section we first discuss the status of last year's (FY13-14) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY13-14 REVIEW RECOMMENDATIONS

In the FY13-14 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY14-15 site visit, CalEQRO and MHP staff discussed the status of those FY13-14 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—

  o resolved the identified issue

- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:

  o made clear plans and is in the early stages of initiating activities to address the recommendation

  o 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 FY13-14

- Recommendation #1: Prioritize providing space and staffing resources to the MHP access function that are commensurate with the demands on that service.

  ☒ Fully addressed   ☐ Partially addressed   ☐ Not addressed

  o The MHP has added two clerical staff to triage incoming calls and make referrals to appropriate resources. A Community Support Worker (peer provider) has been assigned to conduct test calls to the Access Line. Six licensed clinical staff were added in 2014 to meet the demands on this service.

  o The Provider Network function of Care Management Unit was relocated to a different county building to offer Access Line additional space to accommodate the growth.

  o To further support the integration efforts, a substance use counselor has been placed at the Access Line to more effectively respond to the needs of the population with co-occurring disorders.

- Recommendation #2: Upon EHR vendor contract finalization, assure adequate personnel resources are provided to meet the implementation schedule. Create a work-around for the unsupported Netpro product in which CPT codes cannot be updated.

  ☐ Fully addressed   ☒ Partially addressed   ☐ Not addressed

  o The MHP has hired consulting expertise to assist them in testing and working out an alternative for the aging NetPro system. The MHP has chosen to expand use of the county's EPIC system for this functionality and is in the active process of configuring a system to accommodate and remediate referral functionality for its network providers. This group will act as a feasibility study to gauge if use of the entire EPIC product suite can be made appropriate to the MHP's behavioral EHR needs.

  o The Behavioral Health tapestry Project will replace the antiquated NetPro Authorizations and Claims Processing System for the Access Lina and Care Management Unit (CMH) with epic's tapestry modules, as well as third party applications to further automate and integrate the systems of care workflows. The Expected launch date is the fourth quarter in 2015.

  o While this first project launch is limited in scope, the MHP anticipates additional phases to this data system allowing more coordination of care across the system and ensuring that the MHP can obtain relevant data such as access to timely care.

  o The MHP's intentions have been focused toward a more unified approach of aligning Behavioral Health with Primary Care Services resulting in a single unified shared EHR. The electronic health record project has made progress and remains committed to meeting the following goals originally identified in the MHSA Technological Needs Plan.

    - Implementation of an Electronic Health Record (EHR) to replace its current paper-based charting of clinical records, including shared decision-making functionality;

    - Implementation of e-prescribing to replace its current paper-based pharmacy orders;

    - Implementation of a Personal Health Record (PHR) system to allow clients to access parts of their medical record, make appointments and communicate with providers; and

    - Implementation of computer resources in the different regions of the county to allow consumer access to their PHR, and other resources available through the Internet.

- Recommendation #3: Identify and enhance step down services and graduation pathways for consumers and utilize the available level of care measures on a consistent basis to promote movement towards wellness and resiliency goals and flow through the MHP

system. Additionally continue to support community capacity to provide mild to moderate mental health services to those who need them.

☒ Fully addressed   ☐ Partially addressed   ☐ Not addressed

- o The MHP has added and refined step-down services and other pathways to promote beneficiary movement toward recovery and resiliency. Some of these efforts include:
    - Hope House – A 16-bed, short-term Crisis Residential Facility for adults age 18 and older who require crisis support to avoid hospitalization, or are discharging from the hospital or long-term locked facilities and would benefit from step-down care to transition back to community living. Hope House is located adjacent to the Regional Medical Center campus.
    - Miller Wellness Center – An Assessment and Recovery Center for adults and children focused on diversion and step down from higher levels of care in an effort to better transition patients from PES to outpatient services on the same day. The Center is open 6 days per week with up to 11 hours Monday through Friday and up to 8 hours on Saturday.. It is intended as a place for acute assessments, brief interventions and transition into the county clinics.
    - Regional Rapid Access Teams – To improve access and support to the most vulnerable, severely mentally ill clients who frequent PES, inpatient services, and county detention unit and who can be served through specialty mental health clinics.
    - Three behaviorists have been hired at regional county health clinics to offer not only improved behavioral health services in each clinic but also to help patients navigate appropriate external resources. There are plans to hire additional behaviorists to place in the county's eastern region in 2015.
    - Rubicon's Wellness and Recovery Continuum – A regional FSP step-down program focused on assisting individuals in moving forward in their recovery and improving the overall quality of their lives.
    - Expansion of the Provider Network capacity to meet the mild to moderate mental health needs and referrals from Contra Costa Health Plan

- Recommendation #4: Examine staffing ratios by type of service to determine the MHP capacity to deliver timely and effective services within its continuum of care. The system's large proportion of high cost beneficiaries appears to be impacting the ability for the system to provide for those beneficiaries who have needs along the continuum of care, perhaps including some high cost beneficiaries who could step down in services if such services were available. Examine the movement of consumers through key junctures in the service delivery system including intake, initial stabilization, treatment, and planned step down from or completion of services to determine whether staffing deployment is optimal.

☐ Fully addressed   ☒ Partially addressed   ☐ Not addressed

- o Due to key staff retirements and departures, the MHP was unable to carry out any formalized effort to address this recommendation but plans to do so in 2015 after additional staff have been hired and assigned. Despite the obstacles in tracking these movements, the MHP was able to develop multiple step-down services to address the underlying issue present in this recommendation. These efforts are addressed above in the response to recommendation #3 which highlights the details.

- • Recommendation #5: Utilize and expand peer staffing resources to augment the MHP's capacity to provide timely access to services.

☒ Fully addressed   ☐ Partially addressed   ☐ Not addressed

- o The Office of Consumer Empowerment's goal to develop the Wellness and Recovery Education for Acceptance, Choice, and Hope (WREACH) Speakers' Bureau composition by recruiting a minimum of six diverse consumers, family members, and providers from underserved communities was met in 2014. WREACH provides valuable information to help connect consumers and family members to the MHP's services in a timely manner. The WREACH Speakers' Bureau has three members who identify as bi-lingual in Spanish and English, and eleven other members who identify as representing underserved communities, including consumers, family members, and providers who identify as African American, Hispanic/Latino origin or decent, Pacific Islander, and Native American. Many of the WREACH speakers' bureau identify themselves as having lived experience navigating Alcohol and Other Drugs (AOD) services and/or Homeless Services, and willingly share their recovery story in these areas with others.

- o The MHP created and has now filled a Community Support Worker (CSW) position in Quality Management to perform quality calls to ensure that beneficiaries are receiving appropriate services in a timely manner and to create a flow of information for management to make any essential changes. Additionally, this CSW will conduct test calls to the Access Line to assist in improving the quality and overall experience of connecting beneficiaries to services available through the MHP.

- o In 2014 the OCE implemented plans to expand the number of Community Support Workers (CSWs) that are trained and certified WRAP facilitators. In May of 2014, the OCE collaborated with county service delivery sites to send six CSWs (peer and family providers) to WRAP Facilitator Certification Training facilitated by Stephen Marks with the Mental Health Association of San Francisco. All 6 participants were certified. This allowed the county to offer WRAP trainings at the East County Adult Mental Health Clinic, the Central County Adult Mental Health Clinic, and the OCE Service Provider Individualized Recovery Intensive Training (SPIRIT) program, and gave OCE the resources to begin teaching WRAP at community based organizations (CBOs).

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

  - Access Line Referrals to Regional Clinics Through ccLink
  - Expansion of Provider Network to CCHP
  - Grand Opening of Hope House Crisis Residential Facility
  - Rapid Access Program
  - Hiring of Additional Behaviorists at Health Clinics as Part of Integration with Primary Health
  - Opening of a New Forensic Mental Health Clinic
  - Medi-Cal Outreach and Enrollment Project Grant

- Timeliness of Services

  - Mobile Crisis Support Services
  - Tele psychiatry services added

- Quality of Care

  - Continued Primary Health and Behavioral Health Integration
  - Start-up of Epic – Tapestry Module at Access Line
  - Hire Staff in Key Organizational Positions

- Consumer Outcomes

  - Received Peer Personnel Preparation Grant
  - Grand Opening of the George and Cynthia Miller Wellness Center
  - Deployed a Consumer Support Worker at East County Adult Mental Health to facilitate WRAP and provide peer support
  - Moved Transitional Homelessness Services to a Clinic-Based Site

PERFORMANCE MEASUREMENT

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

- Total Beneficiaries Served by each county MHP

- Total Costs per Beneficiary Served by each county MHP

- Penetration Rates in each county MHP

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark

- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay

- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates

- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2015.

TOTAL BENEFICIARIES SERVED

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

Table 1—Contra Costa Medi-Cal Enrollees and Beneficiaries Served in CY13 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Unduplicated Annual Count of Beneficiaries Served
White	31,073	4,256
Hispanic	64,831	3,038
African-American	30,343	3,540
Asian/Pacific Islander	16,774	746
Native American	533	84
Other	20,576	1,506
Total	164,128	13,170

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

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

Figure 1A. Overall Average Approved Claims per Beneficiary

Figure 1B. Overall Penetration Rates
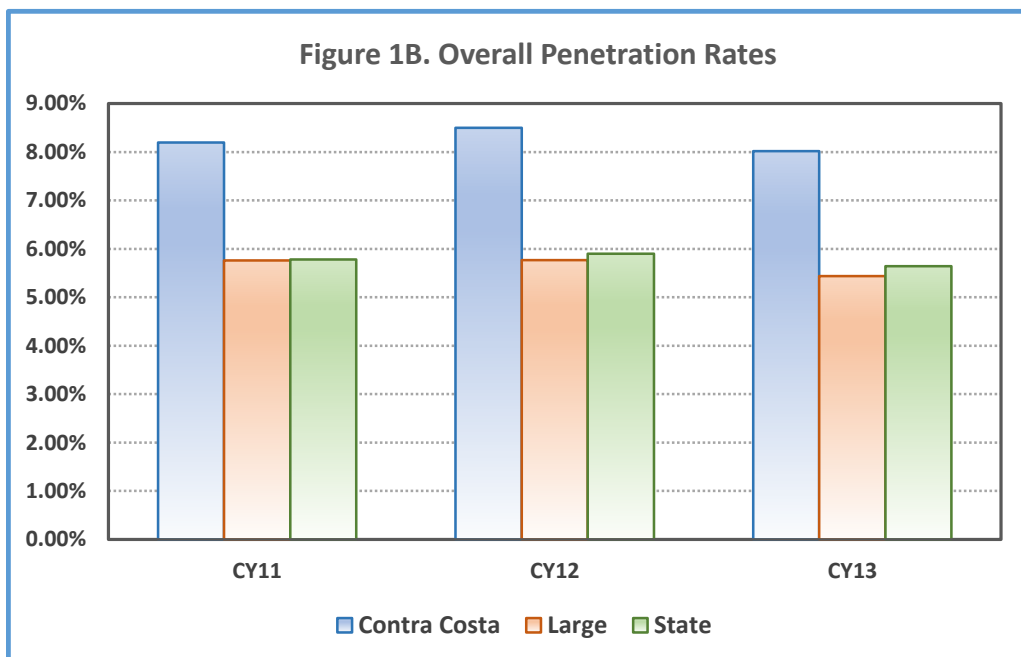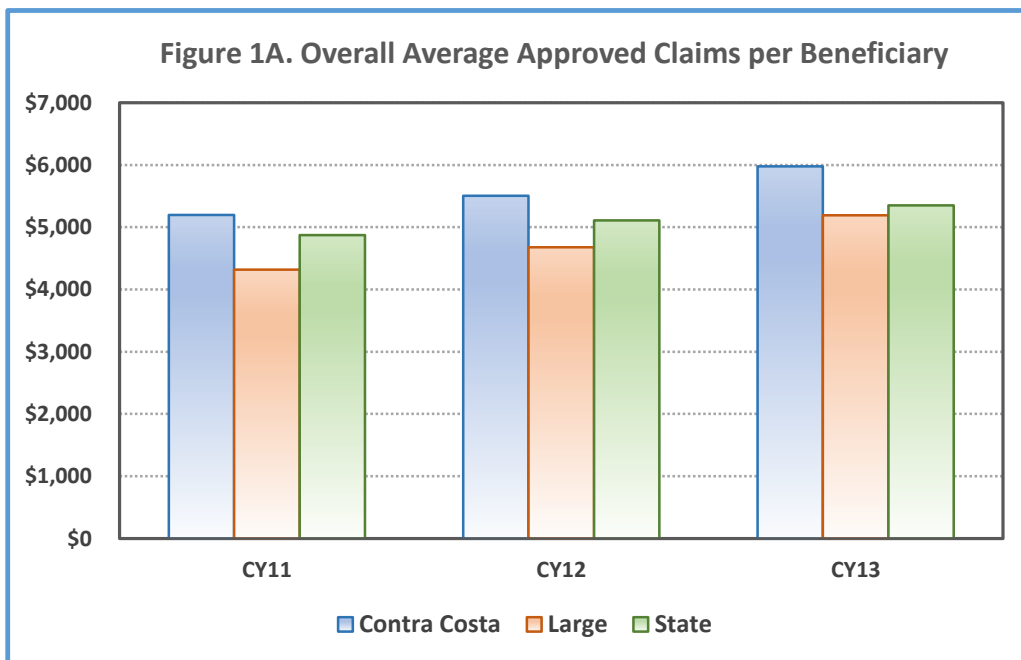
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.

Figure 2A. FC Average Approved Claims per Beneficiary

Figure 2B. FC Penetration Rates
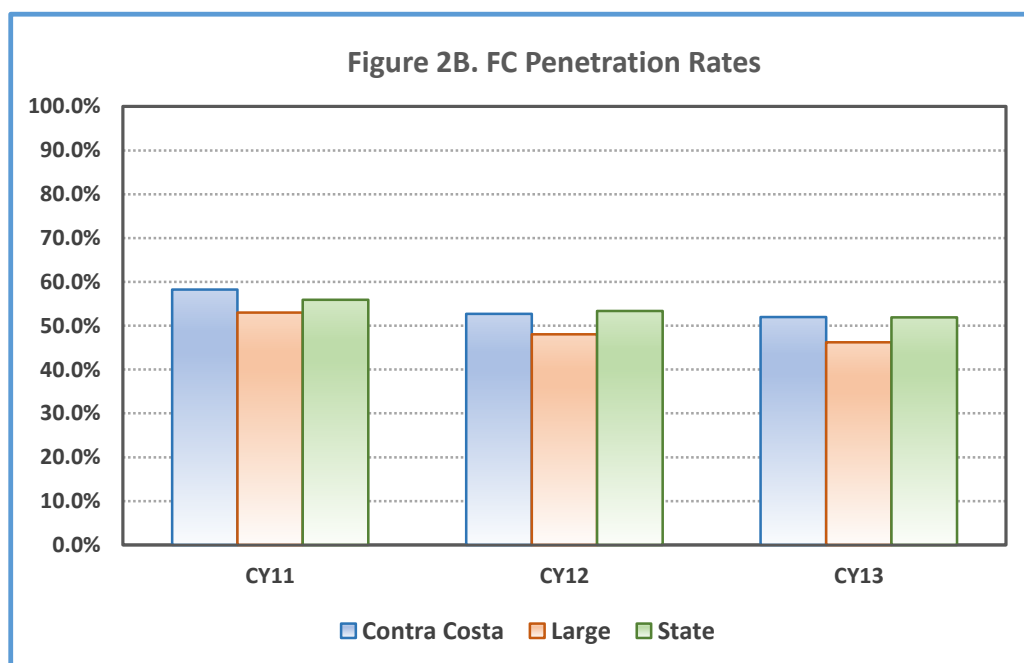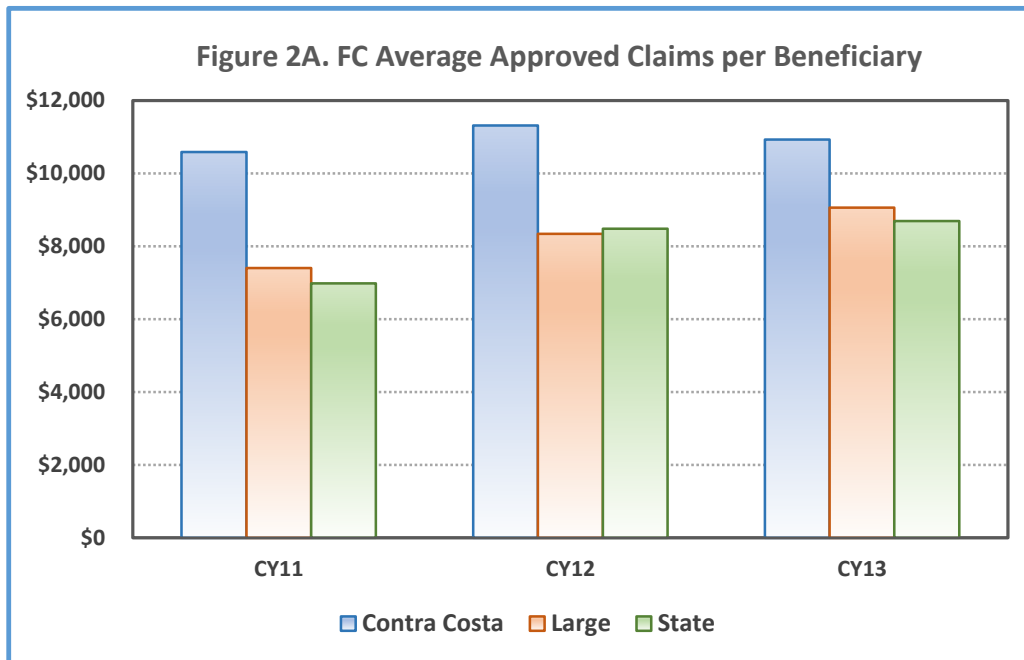
Figures 3A and 3B show 3-year trends of the MHP's Hispanic approved claims per beneficiary and penetration rates, compared to the statewide average and the average for Large MHPs.

Figure 3A. Hispanic Average Approved Claims per Beneficiary

Figure 3B. Hispanic Penetration Rates

HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY13 with the MHP's data for CY13, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

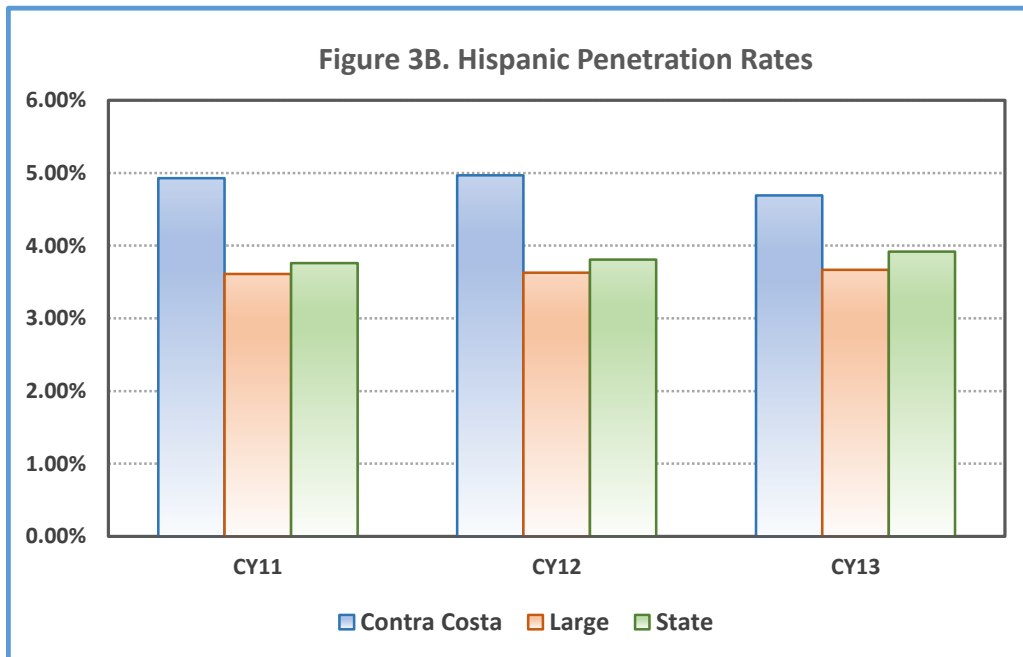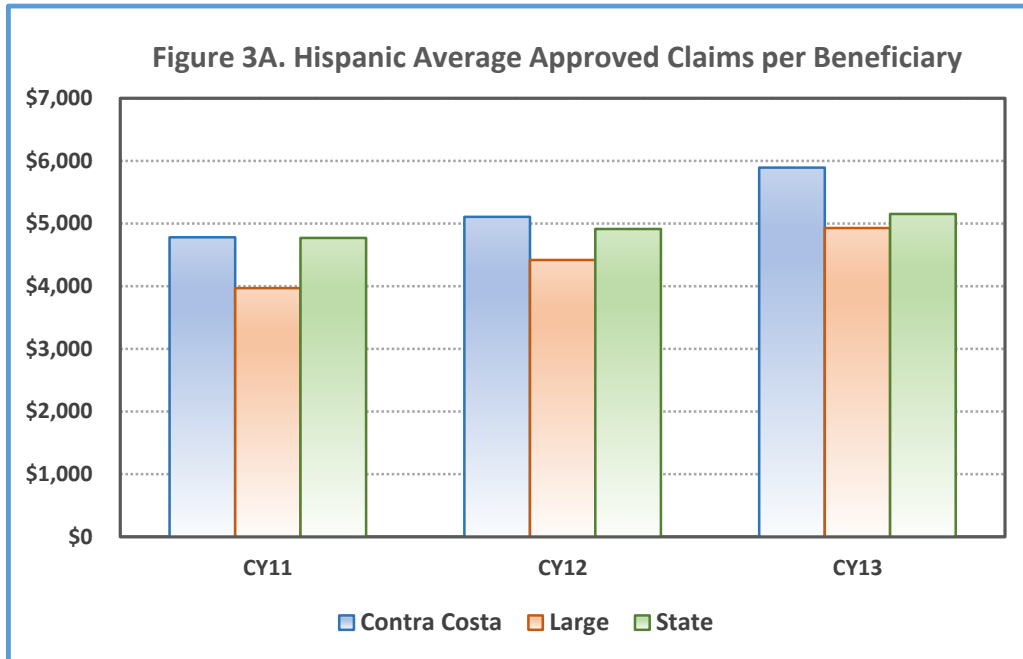| MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
			Table 2—High-Cost Beneficiaries				
Statewide	CY13	13,523	485,798	2.78%	$51,003	$689,710,350	26.54%
Contra Costa	CY13	556	13,170	4.22%	$54,069	$30,062,163	38.17%
	CY12	501	12,877	3.89%	$52,080	$26,091,910	36.82%
	CY11	443	12,178	3.64%	$50,347	$22,303,624	35.12%

THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED

Table 3 compares the CY13 statewide data for TBS beneficiary count and penetration rate with the MHP's data. These figures only reflect statistics available from Medi-Cal claims data and therefore do not take into account TBS-like services that were previously approved by DHCS for individual MHPs.

MHP	TBS Level II	EPSDT Beneficiaries Served by MHP	TBS Beneficiary Count	TBS Penetration Rate
		Table 3—TBS Beneficiary Count and Penetration Rate, CY13		
Contra Costa	Yes	5,571	233	4.18%
Statewide	No	15,621	199	1.27%
	Yes	222,295	7,499	3.37%
	Total	237,916	7,698	3.24%

TIMELY FOLLOW-UP AFTER HOSPITAL DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day psychiatric inpatient follow-up rates, respectively, by type of service for CY12 and CY13.

Figure 4A. 7-day Discharge Follow-up

Figure 4B. 30-day Discharge Follow-up
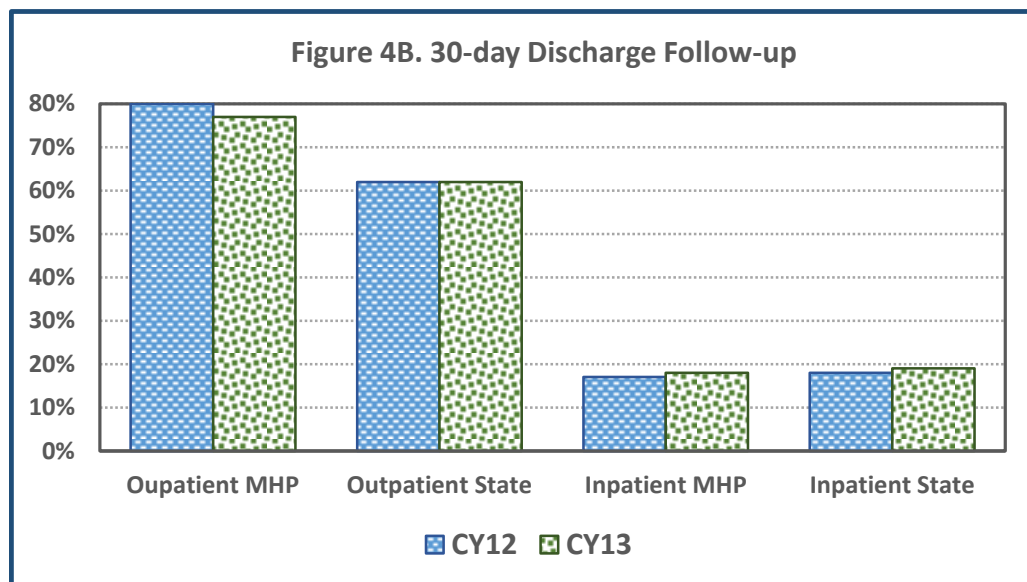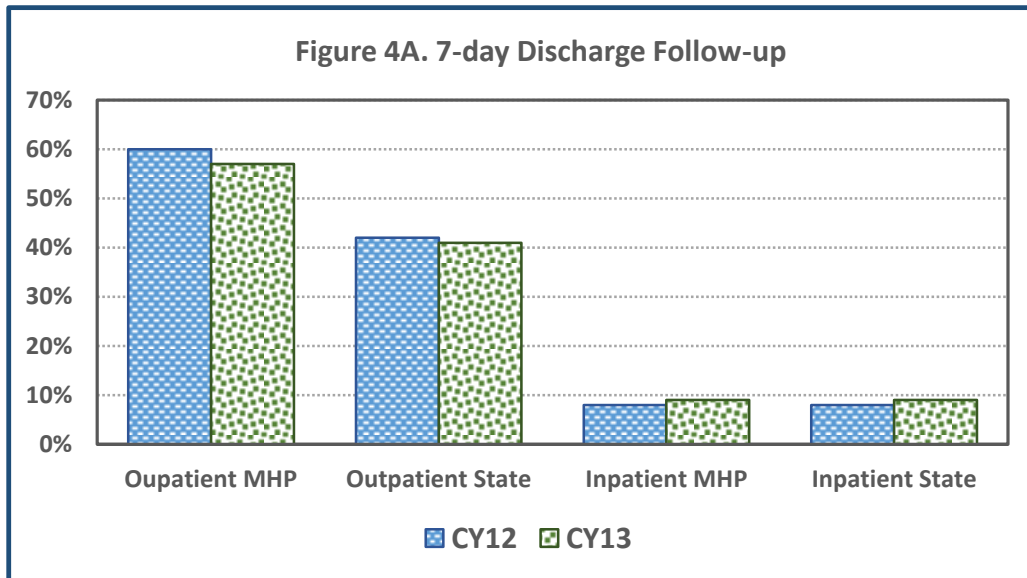
DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown of diagnostic categories of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY13.

Figure 5A. Diagnostic Categories, Beneficiaries Served

Figure 5B. Diagnostic Categories, Total Approved
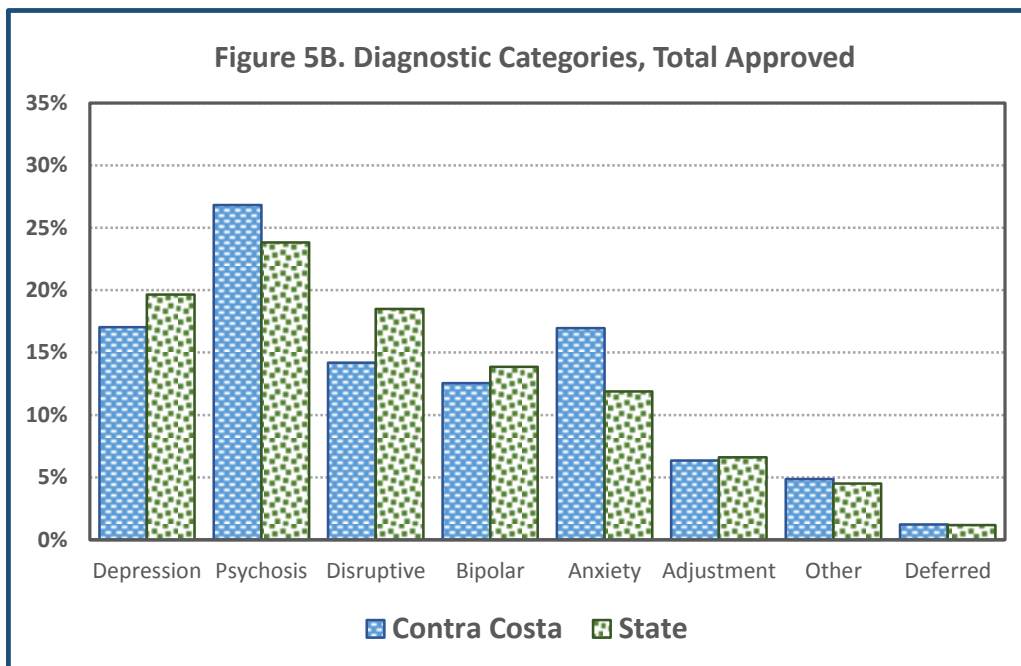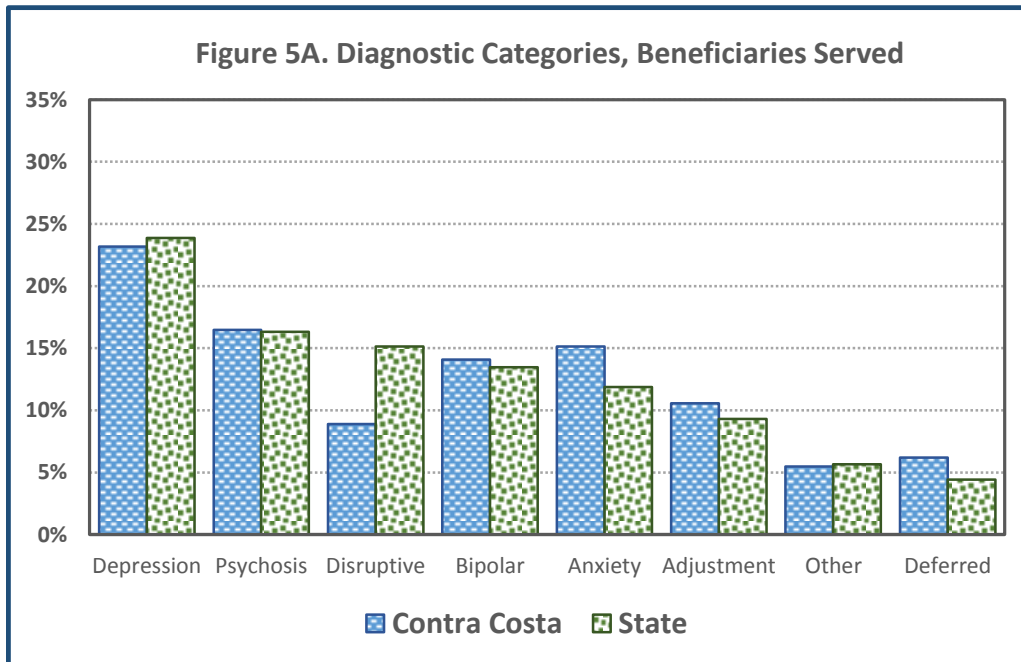
PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

  o The MHP's overall penetration rate is significantly higher than both the large county average and statewide average.

  o The MHP's foster care penetration rate is slightly above the large county average and similar to the statewide average.

  o The MHP's Hispanic penetration rate is moderately higher than both the large county average and statewide average.

  o The MHP is a TBS Level II county. The TBS penetration rate is moderately higher than the statewide TBS Level II penetration rate.

- Timeliness of Service

  o The MHP's 7 and 30-day outpatient follow-up rates after psychiatric inpatient discharge are significantly higher than the statewide rate.

  o The MHP's 7 and 30-day recidivism rates are very similar to the statewide rate.

- Quality of Care

  o The MHP's percentage of high-cost beneficiaries and the corresponding percentage of total approved claims are significantly higher than statewide.

  o The MHP's overall, foster care and Hispanic averages for approved claims per beneficiary are all significantly higher than both the large MHP average and statewide average.

  o The MHP's distribution of diagnostic categories is similar to the statewide distribution. The MHP has a moderately higher incidence of anxiety diagnosis and a significantly lower incidence of disruptive diagnosis than the statewide rate.

  o The MHP has a slightly higher incidence of deferred diagnosis than statewide but total approved claims for deferred diagnosis is very similar to the statewide figure.

- Consumer Outcomes

  o None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care…that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2013.

CONTRA COSTA PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	PIP Titles
Clinical PIP	Consumer Non-Adherence to Mental Health Outpatient Clinic Appointments
Non-Clinical PIP	Consumer Access Line and Linkage (CALL)

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

Step	Table 4A—PIP Validation Review		Validation Item	Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	PM	M

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[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.

Step	Table 4A—PIP Validation Review		Validation Item	Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	M	M
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	NM	M
		6.5	Prospective data analysis plan including contingencies	M	M
		6.6	Qualified data collection personnel	M	M
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	NM	M
		7.2	Interim data triggering modifications as needed	NM	M
		7.3	Data presented in adherence to the plan	NM	M
		7.4	Initial and repeat measurements, statistical significance, threats to validity	NM	M
		7.5	Interpretation of results and follow-up	NM	M
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	NA	M
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NA	M
		8.3	Threats to comparability, internal and external validity	NA	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	M
9	Validity of	9.1	Consistent methodology throughout the study	NA	M

Step	Table 4A—PIP Validation Review		Validation Item	Item Rating*	
				Clinical PIP	Non-Clinical PIP
	Improvement	9.2	Documented, quantitative improvement in processes or outcomes of care	NA	M
		9.3	Improvement in performance linked to the PIP	NA	M
		9.4	Statistical evidence of true improvement	NA	M
		9.5	Sustained improvement demonstrated through repeated measures.	NA	M

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

Table 4B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 4B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	14	30
Number Partially Met	1	0
Number Not Met	6	0
Number Applicable	21	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	69.05%	100%

CLINICAL PIP—CONSUMER NON-ADHERENCE TO MENTAL HEALTH OUTPATIENT CLINIC APPOINTMENTS

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

- "Does an automated call reminder system result in reducing the appointment non-attendance rate of beneficiaries at Contra Costa County East Adult Mental Health clinic? "

- Date PIP began: August 2014

- Status of PIP:

    ☒ Active and ongoing

    ☐ Completed

    ☐ Inactive, developed in a prior year

    ☐ Concept only, not yet active

    ☐ No PIP submitted

The MHP has initiated a clinical PIP following data collection activities surrounding consumer attendance and appointment compliance. The intention is to improve consumer appointment attendance with the goal of improved consumer functioning, satisfaction, and overall consumer wellness.

The MHP's clinics experience significant appointment non-attendance rates. Improving appointment adherence would have a direct impact on timely appointments by reducing the non-attended appointments that would otherwise result in an appointment reschedule, further exacerbating the issue of timeliness.

The non-attendance rates ranged from 3.8% - 13.8% among Contra Costa mental health clinics during FY 2012-2013 with a mean countywide rate of 9.6%. The East County adult mental health clinic routinely experiences the highest appointment non-attendance rate out all county mental health clinics. However, two very important issues must be considered when examining the non-attendance rates at the outpatient clinics: 1) issues surrounding non-attendance documentation and 2) the lack of uniformity in appointment scheduling across clinics.

The MHP identified the East County clinic as the pilot clinic to introduce improvements with the intention to duplicate its successes across clinics system-wide.

To date, the MHP has identified interventions which address improvements in reminder calls, consumer education regarding the benefits of compliance, and stakeholder inclusion as to the role each member holds in terms of consumer quality care. The question as presented is clear, however, the MHP would need to consider methods to inform them of consumer success, such as surveys or self-reports of increased satisfaction, increased medications compliance, improved functioning via increased attendance, and measurements used to step down from current level of care.

As this is in the relatively early stages, the MHP can initiate these or other components to inform it of the success as this PIP continues.

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 emphasizing the critical nature by which to measure consumer success. Interventions will need to be applied that can measure the clinical benefit to consumers. The MHP was advised to continue to consult as needed regarding the implementation of this improvement.

NON-CLINICAL PIP—CONSUMER ACCESS LINE AND LINKAGE (CALL)

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

- "Does increasing the number of clinical staff at the Access Line result in a reduction in the percentage of calls that are abandoned by beneficiaries and a reduction in the amount of time beneficiaries wait on hold to have their call answered?"

- Date PIP began: June 2013

- Status of PIP:

  ☐ Active and ongoing

  ☒ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ No PIP submitted

This is a continuation of the prior year's submission. The MHP determined that the call response time required a performance improvement secondary to the volume of abandoned calls and subsequent risk to timely consumer access. It determined that the number of abandoned calls was sourced to being short staffed, inadequate workflows and a lack of technological tools to efficiently respond.

The MHP's original benchmark indicators of calls abandoned within two minutes was revised to include these indicators: to the percent of calls answered within six minutes, percent of calls that waited more than 12 minutes, and the percent of calls that waited at least two minutes before the call was abandoned. Continuing its activities from the prior year, the MHP consulted with a comparable sized MHP which was producing results via its call system. This visit informed the MHP that it was comparably understaffed and the host MHP operated a "call-back" system which allows for immediate response and a follow-up longer query that same day. The MHP continues to review this type of system for its own application.

All consumer calls were included with the data collected for both English and Spanish-speaking consumers. Data elements that were collected regularly included wait time, call volume and abandonment rates. With the deployment of two additional full-time access staff, success was demonstrated with an increase in calls answered within six minutes (58% English, 8.3% Spanish),

decrease in calls waiting more than 12 minutes (31.4% English, 20.5% Spanish), and a decrease in calls abandoned after two minutes (33.1% English, 1% Spanish).

The MHP experienced unanticipated staffing vacancies which impacted its data beyond this PIP timeline. Subsequently, the calls abandoned simultaneously increased with the staffing shortage. The MHP anticipates filling the vacancies and continuing its work in access line improvements. The MHP suggested that the nominal improvements regarding Spanish-speakers was perhaps a result of the low volume of fewer Spanish-speaking consumers during the data collection timeline resulting in difficulty detecting change among these calls.

The MHP experienced success and demonstrated improvements which it intends to translate into improved timely access and increased consumer satisfaction. The MHP has become more informed via this PIP process and will continue to address improvements for these indicators. Since this is the final year of this submission the MHP seeks to initiate a new PIP in the coming year.

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 encouraging the MHP to identify and initiate a new non-clinical PIP, to utilize CalEQRO staff on-going for advisement, and to include all stakeholders potentially involved in the PIP, to identify each of the steps involved in the PIP as a component of the interventions and to measure the success of each intervention. The MHP will need to consider the method which to measure consumer benefit as well when it engages in future PIP activities.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

  - The non-clinical PIP addressed improved timely access to initial calls potentially creating earlier engagement with services.
  - Improved attendance leads to accessibility when compliance with appointments is maintained.

- Timeliness of Services

  - Timely access was improved via the Access Line PIP.
  - Adherence to appointments can create a routine and stable calendar for consumers.

- Quality of Care

  - The MHP utilized comparable MHP consultation with the Santa Clara MHP to inform it of methods to consider for beneficiaries calling in for access to care.
  - The MHP utilized data driven reports to confirm its hypotheses.
  - The MHP continually collected its data to keep current in its endeavors.
  - Call back mechanisms typically show improved care via attendance compliance.

- Consumer Outcomes

  o Improved access and timeliness lend themselves to increased consumer satisfaction.

  o Improved attendance is instrumental in the recovery process.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 5, 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 5—Access to Care			
	Component	Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PC	While the MHP does implement strategies to address its population needs it is lacking in its ability to create hiring policies which secure results of those strategies system-wide. This leaves programs understaffed and limits service capacity.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	Consistent feedback from focus group participants indicate that while the MHP may be aware of capacity needs, it is impaired in meeting the staffing demands to serve increased consumer populations. The MHP employs financial counselors which assist consumers in benefits applications.

Table 5—Access to Care		
Component	Compliant (FC/PC/NC)*	Comments
1C Integration and/or collaboration with community based services to improve access	FC	The MHP utilizes its ten FQHC sites county-wide to improve access and integrate with physical healthcare. It remains innovative with its law enforcement partners by establishing a forensics clinic, enhanced juvenile hall services; dedicating clinics for youth; one-stop center at the new Georg and Cynthia Miller Center; geriatric psychiatry using home visits; and enhancing consumer employment with a grant through the Office of Statewide Health Planning and Development (OSHPD).

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

Timeliness to Services

As shown in Table 6, 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 6—Timeliness to Services		
Component	Compliant (FC/PC/NC)*	Comments
2A Tracks and trends access data from initial contact to first appointment	FC	The MHP has a 15 day standard to first appointment with an overall average of 13.4 days and meets it 65.4% of the time. Adult services averages 12.1 days and meets it 68.1%. Children services average 14.5 days and meets it 63.2%. Data is collected per the third appointment offered.

	Table 6—Timeliness to Services		
	Component	Compliant (FC/PC/NC)*	Comments
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP reports a 30 day standard with an overall of 21.4 days and meets it 74.6% of the time. Adult services report an average of 31.6 days and meets it 54.8%.Children services report an average of 11.6 days and meets it 93.8%. Data is collected per the third appointment offered.
2C	Tracks and trends access data for timely appointments for urgent conditions	PC	The MHP reports a 2 day standard with an overall average of 4.9 days and meets it 43.8% of the time. Adult services report an average of 3 days and meets it 56.3%. Children services report an average of 8.6 days and meets it 20%. Protocols differ between adults and youth and vary among the children's clinics. This may contribute to the ability to meet its standards.
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	The MHP reports a standard of 7 days with an overall average of 11.2 days and meets it 34.1%. Adult services report an average of 8.5 days and meets it 53.8%. Children services report an average of 14 days and meets it 14.1%. Protocols differ among clinics creating a tracking workaround through the access line documentation for follow up appointments rather than the actual number of appointments kept.
2E	Tracks and trends data on rehospitalizations	FC	The MHP reports a goal of 10% with an overall average readmission rate of 13.7%. Adult services report a rate of 14.1% and children services report a rate of 12.1%.

Table 6—Timeliness to Services		
Component	Compliant (FC/PC/NC)*	Comments
2F Tracks and trends No Shows	PC	The MHP reports a standard of 10% with an overall of average for clinicians at 18.5% and psychiatrists at 28.5%. Adult services report 22.9% for clinicians and 30.7% for psychiatrists. Children services report 8.3% for clinicians and 16.7% for psychiatrists. The MHP implemented an automated call system at the East County Adult MH Clinic which will be rolled out to other regions to assist with the show rate.

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

Quality of Care

As shown in Table 7, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of services. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 7—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	PC	Due to recent multiple staff departures and restructuring of the Quality Management unit, the MHP appears impacted and understaffed to meet the needs of an agency its size. The MHP does a commendable job at succinctly capturing its QI objective and goals and consistently updates its results. QI initiatives cover a breadth of improvement activities and QM extends into the realm of true improvement and not solely confined to the required compliance activities.
3B	Data are used to inform management and guide decisions	PC	While the MHP has accumulated data to measure quality in the past, it has not measurably demonstrated that system-wide measurement is a priority. What data is collected is primarily used for individual treatment purposes. Data collection is limited secondary to its inability to engage in a comprehensive electronic system that would serve it system-wide. Some methodology remains confined to basic retrieval means.

Table 7—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
3C Evidence of effective communication from MHP administration	PC	The MHP produces a document outlining its communication strategies including both formal and informal processes. Examples include representatives from varied stakeholders on committees, brochures, consumer feedback cards, social inclusion meetings, website publications, peer speakers bureau, bulletin boards and classes. A disconnect seems apparent as stakeholders on site indicated the executive team does not appear to be consistently engaged in an open transparent dialogue with staff, providers, consumers or family members on a regular basis.
3D Evidence of stakeholder input and involvement in system planning and implementation	PC	Evidence as indicated above in item 3C.
3E Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP is amply engaged with its community partners to advance its service delivery system and engages its partners in these efforts throughout care.
3F Measures clinical and/or functional outcomes of beneficiaries served	NC	The MHP appears to only be engaged in measurement of functional outcomes in specific programs and only is used for individual treatment purposes.
3G Utilizes information from Consumer Satisfaction Surveys	FC	The MHP conducts the statewide consumer perception survey twice annually, quantifies and analyzes the data for improvements throughout its system.

Table 7—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
3H Evidence of consumers and family members' employment in key roles throughout the system	FC	The MHP shows promising practices with its Consolidated Planning and Advisory Workgroup (CPAW) which is used to inform it of consumers' needs. While CFM employees are widely used in the SOC they are typically limited to a very small portion of the treatment continuum. The Office for Consumer Empowerment (OCE) updated team roles which outline paths to advancement. Further distribution and discussion of this is warranted to inform consumers.
3I Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	While, in the past, the MHP may have had processes to inform CFMs about Wellness programs, stakeholders indicate that this process, although unintended, has diminished.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

  o The MHP has maintained seven regional clinics throughout the county for an extended period of time.

  o The MHP initiated the Rapid Access Program for consumers not engaged in treatment which have been recently discharged from PES or the 4C inpatient facility. Stakeholder consensus indicated that access may be impacted secondary to longer psychiatry wait times. Enhanced use of tele psychiatry that has recently begun could prove profitable.

  o Coordination of care for vulnerable incarcerated, homeless, foster care youth, physical healthcare and consumer employment interests are focused initiatives which provide improvements to access services.

- Timeliness of Services

  o Timeliness indicator data is collected biweekly, however, the data points for first appointment and psychiatry are collected from the third available appointment. This does not reflect actual appointment delivered which could skew the results, potentially against its standard.

  o The MHP could review its protocols for urgent care and post-hospitalization appointment timeliness for youth as results appear delayed according to its standard. Standardized protocols across clinics would benefit the MHP for comparison data.

  o Tracking of hospital discharge appointments would benefit from review for actual appointments kept and provide accurate data in the event consumer follow up was indicated.

  o Improvement activities addressing the no-show data, especially for adult psychiatry, would serve to inform the MHP.

- Quality of Care

  o The MHP experienced restructuring secondary to the creation of the Behavioral Health Department. This rendered three units composed of mental health, alcohol and drug services and homeless services. Combining these units requires expertise in behavioral health.

  o Leadership will benefit from a revised mission, vision and goals philosophy with stakeholder input which addresses its new strategies.

  o It requires leadership expertise in the mental health regulations, initiatives and strategies to address them within the infrastructure creation. A visible presence statewide is recommended to inform leadership and keep abreast of the ever-changing climate involved in healthcare.

  o The MHP currently experiences a vacancy in the QM Program Coordinator position which it intends to fill but currently leaving a void in a critical position and rendering work overload for others.

  o Leadership would benefit from focused succession planning to avoid the dilemma of multiple vacancies in the future.

  o The MHP has displayed robust endeavors with its community partners and continues to participate in consortiums dedicated to improved care.

  o Outcome tools utilized system wide will inform stakeholders of the level of care/level of service needs.

- Consumer Outcomes

  o The MHP conducts consumer perception surveys among its clinics for all age-targeted populations and produced results from two timelines over the past year. It analyzes and distributes results to various stakeholders.

- o Level of care/level of service outcome tools are not utilized system wide to inform it of consumer progress, minimizing effective strategies to step consumer to a lower level of care.
- o The Office of Consumer Empowerment (OCE) has a representative on a broad spectrum of the MHP committees. This lends itself to a widespread consumer voice which potentially impacts consumer wellness outcomes.
- o Provision of consumer recovery in employment opportunities is visible throughout the system.
- o The Office of Consumer Empowerment employs consumers in supervisory roles. There appears to be a career ladder within the OCE. According to the document entitled "2015 Overview of Office for Consumer Empowerment Team Roles": CSW II Lead, OCE Team Lead – responsible for offering oversight, support and training to OCE Team members.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to services, 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 group of twelve older adult beneficiaries was held at the MHP campus at 2425 Bisso Lane in Concord. Overall participants were complementary of services provided to them by the MHP. They noted few difficulties entering services and were grateful to have services targeted to their needs. The group observed that staff were generally respectful of their specific needs and were culturally competent. They did note that some psychiatrists at times did not exhibit wellness and recovery oriented principles.

For participants who entered services within the past year, the experience was described as

- Positive and helpful but there were notes that overall levels of service seemed to be decreasing within the past year.
- Participants noted that communications was not especially transparent around program availability and was mostly word of mouth.
- Participants observed that there are wide variations in the welcoming attitude presented by staff but particularly reception with some staff being listed as having poor demeanors in this area.

Recommendations arising from this group include:

- Provide an in-service to reception staff in welcoming strategies.
- Educate medications support staff especially with new psychiatrists in the recovery focused process.
- Increase consumer opportunities to communicate with the executive team.

Table 8A displays demographic information for the participants in group 1:

Table 8A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants		
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	12
Ages of Participants	Under 18 Young Adult (18-24) 25–59 Older Adult (60+)	 12
Preferred Languages	English Spanish Bilingual Other	12
Race/Ethnicity	Caucasian/White African-American Other	7 4 1
Gender	Male Female	4 8

Interpreter used for focus group 1:   ☒ No   ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

The CalEQRO staff requested a focus group of parents/caregivers of child/youth beneficiaries which was to be held at 2425 Bisso Lane in Concord.

Unfortunately, no participants showed up to the event which was apparently the result of a staff scheduling miscommunication. Therefore, this will be void of a summary.

Table 8B displays demographic information for the participants in group 2:

Table 8A—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants		
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	 0
Ages of Participants	Under 18 Young Adult (18-24) 25–59 Older Adult (60+)	 0
Preferred Languages	English Spanish Bilingual Other	 0
Race/Ethnicity	Caucasian/White Hispanic/Latino Other	 0
Gender	Male Female	 0

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care

  o Consumer accessibility was noted as available per the older adults.

- Timeliness of Services

  o No barriers to initial requests to timely service was noted.

  o Psychiatric services at times is impacted depending on staffing resources.

- Quality of Care

  o Recovery oriented approaches were noted to be limited in specific staffing categories.

- Consumer Outcomes

  o Consumers were not aware of standardized progress outcome tools.

  o Overall, group participants indicated recovery was instilled from clinical staff.

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 9 shows the percentage of services provided by type of service provider:

Table 9—Distribution of Services by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	37%
Contract providers	54%
Network providers	9%
Total	100%

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

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

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

20%

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

12%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒   Yes   ☐   No

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

- The MHP notes, that while it does conduct PR analysis, it does so only once per year.

CURRENT OPERATIONS

- The MHP continues to use the legacy Insyst practice management system as its primary MIS. Staff report claiming is up to date but that the final denial rate for FY13-14 has crept up to 7.3% which is significantly up from the 4.5% reported last year to the EQRO.

MAJOR CHANGES SINCE LAST YEAR

- Implemented State mandated CARC/RARC code changes to billing system.

- Implemented Katie A. modifications to system and started preparing to add user level security to Katie A. data fields.

- Developed preliminary crosswalk for diagnosis codes for DSM IV to ICD-10 coding in preparation for system conversion.

- Launched initiatives to clean up CSI reporting data errors and decreased total CSI errors by 80%.

- Implemented referral system for Primary Care and Care Management Unit.

- Opened Miller Wellness Center.

PRIORITIES FOR THE COMING YEAR

- Initiate new project to migrate the Network Providers billing system (NetPro) to Epic EMR

- CRM Module call management system

- Compliance with claiming issues regarding CCHP Mental Health/AOD low acuity referrals

- Reporting consistency for Katie A. sub-class beneficiaries

- Ongoing billing issues with ERMHS contracts with school districts

- Delineating workflows, Cross training, and data exchange with the Epic System

OTHER SIGNIFICANT ISSUES

- The MHP continues to defer a number of significant data centric projects which are now beginning to impact its ability to manage a data informed system of care. These include but are not limited to the deferral of the MHP's CANS project, replacement of its legacy practice management system (PSP/Insyst billing system), and implementation of an EHR. For reasons that are not particularly clear, resources to operationalize these much needed projects are not being made available to the MHP. Resources have been committed and made available to the MHP and the budget does not seem to be at issue. The MHP provided documentation of the budget for the bulk of these projects via MHSA CTFN funding.

- The MHP is currently exploring the implementation of the EPIC Tapestry system to replace its aging NetPro system. The MHP hopes to have this system operational within the next 18 months. It hopes this exploration will provide it with concrete intelligence to make informed decisions on where to proceed with EHR acquisition.

Table 10 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 10 - Current Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
Insyst	Practice Management	The Echo Group	26	Health Services IS
NetPro	Managed Care	Health Services IS	15	Health Services IS
Epic	Provider Portal	Epic	3	Health Services IS
Panoramic	Conservatorship	Panasoft	4	Health Services IS
Vocational Services	Vocational Services	ETO	4	Health Services IS

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP continues to investigate options to select a new EHR. It currently reported no firm timeframes for system selection.

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 11—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Assessments				x	
Clinical decision support				x	
Document imaging				x	
Electronic signature—client				x	
Electronic signature—provider				x	
Laboratory results (eLab)				x	
Outcomes				x	
Prescriptions (eRx)				x	
Progress notes				x	
Treatment plans				x	
Summary Totals for EHR Functionality				10	

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

Findings

- Access to Care

  o The MHP has begun to explore the use of tele psychiatry to improve access to psychiatric and medication support services across its system of care. These efforts are redistributive of current medical resources and have not yet begun to factor in the possibility of contracted psychiatrists.

- Timeliness of Services

- o The MHP does not appear to be actually analyzing timeliness data but is rather utilizing a proxy analysis due to the difficulty in obtaining appropriate data from its legacy MIS. This is materially degrading the quality of information provided to the executive team to make informed programmatic decisions.

- Quality of Care

  - o The MHP has been slow to adopt Level of Service/Level of Care tool sets in a broad fashion. It has put one such project (CANS) in abeyance. This is materially preventing the objective analysis of program and care effectiveness as well as the timely dissemination of individual treatment feedback. The QI staff did not articulate broad protocols to use outcomes data to assess level of care transitions.

  - o The MHP's reticence to implement an EHR is materially denying consumers a level of clinical service that meets minimum national standards.

- Consumer Outcomes

  - o The MHP does not appear to have an objective system in place to retrieve data, system-wide, to answer the question "How do you know consumers are getting well?"

Recommendations

- Select and implement an EHR immediately to bring treatment standards to acceptable minimums.

- Select a Level of Service/Level of Care instrument appropriate for its service delivery system and begin system-wide use so that it can accrue both consumer level treatment data and broader system performance data. This should begin to address the MHP's need to evaluate if its treatment paradigms are effectively helping consumers to be well.

- Consider expanding the use of tele psychiatry beyond current redistribution of capacity to enable it more fully to serve its ethnic and underserved populations.

SITE REVIEW PROCESS BARRIERS

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

- The second consumer/family member focus group which was requested by CalEQRO was not conducted secondary to the no-show of participants. This potentially affected the overall ability to demonstrate the consumer voice in regard to service delivery.

CONCLUSIONS

During the FY14-15 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 and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:

    o The MHP has successfully created regional clinics for consumer access.
    o The Rapid Access Program provides recently discharged consumers from PES or the 4C inpatient facility more immediate appointments.

Timeliness of Services

- Opportunities:

    o The MHP could improve its timeliness metrics in regard to the urgent response for children's services and for post hospitalization appointment indicators for adults and children.

Quality of Care

- Strengths:

    o Current QI staffing appear to be genuinely addressing the barriers to quality care.

- Opportunities:

    o Stakeholder groups indicate leadership support for its initiatives is negatively impacted secondary to limited communication and an opaque executive style.
    o The MHP has not replaced its legacy electronic health record system.
    o Staff indicate input is not valued and venues to provide input are minimal.
    o The QM Program Coordinator position remains vacant.
    o An unintended consequence of communication issues is producing low staff morale which appears to be at a low point.

Consumer Outcomes

- Strengths:

    o Consumer employees are apparent throughout the system delivery.

- Opportunities:

    o The MHP PIP processes could improve by identifying consumer benefits.

    o An outcome tool to measure consumer progress and treatment effectiveness remains limited to the individual level.

RECOMMENDATIONS

- Examine the leadership processes and adjust for improved communications and stakeholder input.

- Select and implement an EHR system immediately to meet standards and regulatory mandates.

- Select and implement system wide use of an outcome tool to inform the MHP of consumer progress.

- Examine current barriers and complete the hiring process to fill the QM Program Coordinator position.

- Address PIP topics to include a method to measure consumer benefits.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: Data Provided to the MHP

Attachment E: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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

CONTRA COSTA COUNTY MHP

CalEQRO ON-SITE REVIEW AGENDA

Time	Day 1 Activities-March 11, 2015	
9:00 -10:30	**Opening Session** 2425 Bisso Ln. (Large Conference Room) Concord, CA 94520 • Introduction to BHC • MHP Team Introductions **Review of Past Year, Disparities and Performance Measures** • Significant Changes and Key Initiatives • Use of Data in the Past Year • Access and Retention, Capacity Building • Cultural Competence Inclusion Strategies *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders,* *Cultural Competence Staff*	
10:30-12:00	**Quality Management Activities** 2425 Bisso Ln. (Large Conference Room) Concord, CA 94520 Quality, Access, Timeliness, Outcomes • Use of Evidence Based Practices • Performance Management-Timeliness Strategies	**Fiscal & Billing** 2425 Bisso Ln. (Older Adult Conference Room) Concord, CA 94520 • FY13-14 Recommendations • Contract providers • Claim processing - denied & replaced transactions • Denial rates • Cost Reporting -potential issues ICD10 Remediation Plan
12:00 pm – 1:00 pm	BHC Cal-EQRO Working Lunch	
1:00-2:30	**Katie A. Implementation** 1340 Arnold Dr. #200 (Large Conference Room) Martinez, CA 94553 • Collaboration between MHP and CWS • Implementation and provision of services, i.e. - numbers served, Core Practice Model, CFT, claiming • Policies and procedures • Current challenges • Next steps	**IS Staff Group Interview** 1340 Arnold Dr. #112 Martinez, CA 94553 • Review and discuss ISCA • Discussion of prior year recommendations • Discussion of reporting role in support of QI functions • Health Information Exchange • Tele-psychiatry • Meaningful use

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Jovonne Price, LMFT, CPHQ, Quality Reviewer

Duane Henderson, Information Systems Reviewer

Walter Shwe, 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

Contra Costa Behavioral Health Department campuses:

2425 Bisso Lane, Concord, CA 94520

1340 Arnold Drive, Martinez, CA 94553

Participants Representing the MHP

Name	Position	Agency
Adam Down	Administrative Analyst	
Adeline Boye	Supervisor	
Anita de Vera	West County Program Manager	
Annett S. Mason	Community Support worker	
Azyadeth C. Martinez	Community Support Worker	
Bernie Sanabria	East County Program Supervisor	
Betsy Oswne	Program Supervisor	
Beverly Fuhrman	Program Manager	
Branden McGuire	Vocational Coordinator	
Brett Beaver	Program Manager	
Caroline Sison	Cultural Competency Manager	
Cassandra W. Robinson	Community Support Worker	
Chad Pierce	Program Manager	
Charlene Bianchi	UR Program Supervisor	
Chet Spikes	Assistant Health Services IT Director	
Christine Madery	Program Supervisor	
Cynthia Belon	Behavioral Health Director	

Crystal Whitehead	Community Support Worker	
D. Seid	Forensics Manager	
Dan Batinchor	Program Manager	
Debra Beckert	Nurse Program Manager	
Debra Cuevas	Community Support Worker	
Denise Chmiel	Program Supervisor	
Eileen Brooks	Program Manager	
Eric Duran	IT Project Manager	
Erin McCarty	MHSA Project Manager	
Faye Ny	Behavioral Health Finance Manager	
Gale Metrelle	Manager Child and Family Services	
Gerold Loenicker	Program Supervisor	
Heather Sweeten-Healy	Program Manager	
Helen Kearns	Project Manager	
Jan Cobaleda-Kegler	Program Manager	
Jennifer Tuipulotu	Family Services Coordinator	
Jessica Rojas	HOPE Program Manager	Lincoln Child Center
Jonathan E. San Juan	Community Support Worker	
Jorge Pena	Lead Legacy Support Team	
Joseph Ortega	IMD Liaison	
JR Ang	Director of Patient Accounting	
Juanita Garison	Clerical Supervisor	
Kassie Perkins	Regional Director	
Katy White	Access Line Program Manager	
Kellee Cathey	Mental Health Clinical Specialist	
Ken Gallagher	Research and Evaluation Manager	
Kenneth Underwood	Mental Health Clinical Specialist	
Kennisha Johnson	Program Manager	
Kirk Hewett	Director EPSDT	Bay Area Community Resources
Lisa Noriega	Community Support Worker	
Marilyn Thomas-Franklin	Mental Health Clinical Specialist	
Melissa Cesaro	Program Director	FFYC
Michael Macioci	Mental Health Behaviorist	
Michelle Collins	Mental Health Supervisor	
Michael Pertersen	Office for Consumer Empowerment Project Team Lead	
Michelle Nobori	Planner/Evaluator	
Michelle Simes	East County Clerical Supervisor	
Nancy O'Brien	Mental Health Clinical Specialist	
Natalie Dimidjian	Clinical Specialist	

Nicole Thigren	Social Work Supervisor	Child and Family Services
Phyllis Mace	Program Supervisor	
Priscilla Olivas	Planner/Evaluator	
Quincy Slatten	Community Support Worker	
Rich Weisgal	Program Supervisor	
Robert Span	Family Support Worker	
Robin O'Neill	Mental Health Clinical Specialist	
Ross Andelman	Medical Director	
Rubi Cuevas	Community Support Worker	
Sara Marsh	Director Support Services	
Sarah Solis	IHBS Program Manager	Lincoln Child Center
Shelley Okey	Program Manager	
Steve Wilbur	Program Supervisor	
Stephen Boyd	Community Support Worker	
Stacey Tupper	Project Manager	
Steve Hahn-Smith	Vice President, Quality Management	Anka
Susan Kalaei	Clinical Pharmacist	
Teresa Gibson	Mental Health Clinical Specialist	
Terese Pasquini	Mental Health Commissioner	
Thomas Tighe	Acting QI Coordinator	
Vannessa Castin	Clinical Specialist	
Vern Wallace	Children's Program Chief	
Vic Montoya	Adult Program Chief	
Vincent Perez	Psychiatrist Integration	
Warren Hayes	MHSA Program Manager	
Windy Murphy	Administrative Analyst	
Ziba Rahimzadeh	Program Manager	

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:

BHC Behavioral Health Concepts, Inc. - California EQRO

400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080   (855) 385-3776
www.caleqro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION					
County: Contra Costa		☒	Clinical PIP	☐	Non-Clinical PIP
Name of PIP: Consumer Non-Adherence to Mental Health Outpatient Clinic Appointments					
Dates in Study Period: August 2014					
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY					
STEP 1: Review the Selected Study Topic(s)					

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The Quality Management Committee initiated the PIP and provided feedback as the PIP workgroup formalized and began meeting regularly. Currently, the PIP workgroup consists of several staff members of the East County adult specialty mental health clinic: clerical supervisor, lead psychiatrist, clinical supervisor, clinic program manager, nurse manager, and the mental health administrations research and evaluation staff. The committee is currently identifying and recruiting consumers and, or family members of consumers to participate in the workgroup.

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Non-Clinical PIP:

BHC

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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION				
County: Contra Costa		☐ Clinical PIP	☒ Non-Clinical PIP	
Name of PIP: Consumer Access Line and Linkage (CALL)				
Dates in Study Period: June 2013 to January 2015				
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY				
STEP 1: Review the Selected Study Topic(s)				

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Access Line staff, Care Management staff, Hospital Discharge Coordinators, PES Discharge Coordinators, Clinic Managers, Research and Evaluation staff. To provide a consumer perspective, a Family Partner also participated in this PIP.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **_Select the category for each PIP:_** _Clinical:_ ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions _Non-Clinical:_ ☒ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Access Line for the Contra Costa Mental Health Plan (CCMHP) experiences continuously high call volumes from consumers needing access to services, providers requesting appointments in other areas of the system, and hospital/psychiatric emergency services discharge planners charged with linking clients to appropriate outpatient services. At times, this high in-coming and out-going call volume translates into long wait times for beneficiaries, which then leads to a high number of abandoned calls.

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