Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

FY17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

CONTRA COSTA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

February 6-8, 2018

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CONTRA COSTA MHP SUMMARY OF FINDINGS

Beneficiaries Served in Calendar Year 2016 — 16,777

MHP Threshold Languages — Spanish

MHP Size — Large

MHP Region — Bay Area

MHP Location — Martinez

MHP County Seat — Martinez

Introduction

Contra Costa County Mental Health Plan (MHP) is located in the California East Bay Area. The Contra Costa County Behavioral Health Services (CCBHS) combines what was formerly the mental health and substance use disorder programs into a single system of care. The MHP has adopted a core philosophy of "any door is the right door," and implemented a dual substance and mental health screening through its Access Line as of July 1, 2017. This additional screening process utilizes the SUD American Society of Addiction Medicine (ASAM) screening instrument is part of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

The CCBHS approach to DMC-ODS includes planned dual certification of MHP clinics (four site applications so far submitted) as mental health and substance abuse sites. SUD specialists will be stationed at the homeless shelters. All SUD referrals involve authorization by the MHP for specific programs and level of services.

During the fiscal year 2017-2018 (FY17-18) review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the MHP and its contract provider services. Further details and findings from EQRO-mandated activities are provided in this report.

Access

The MHP directly operates services in the three major Contra Costa County regions; west, central, and east. Each region contains an adult and children and youth clinic, with a central-located older adult program which also provides services countywide. Other specialized services augment these programs, including an adult psychiatric emergency service (PES). However, the MHP lacks some levels of services, such as a distinct crisis stabilization (children/youth must use the adult PES program), and a children/youth inpatient facility.

Historically, there have been challenges with sustaining adequate staffing in the eastern part of the county, with psychiatry and licensed clinical staff particularly difficult to maintain, largely due to lack of interest in working that region, travel time to work, compounded by salary differentials between the MHP and local competition.

Timeliness

As in the prior review period, the MHP has continued to improve the fidelity and accuracy of timeliness reporting, with fine-tuning of the Tapestry and Cadence software. The initial timeliness reporting appears the same or slightly improved for initial access. Psychiatry timeliness appears to have significantly lengthened for children and youth. The implementation of the Epic ccLink electronic health record (EHR) shows the potential for improving data fidelity, but the enhancements are expected in Phase 2 of implementation.

Challenges with hiring psychiatrists and psychiatric nurse practitioners (PNP) are numerous. A component of this problem is the county health system job categories and pay for PNPs. The consolidation of nurse practitioners into a single county job category prevents PNPs from being offered regionally competitive salaries, which typically offer a differential for the psychiatry sub-specialty. Overall, the MHP's psychiatry pay is one of the lowest regional pay scales, reportedly the third lowest, creating recruitment challenges with so many other MHPs nearby and health plans providing ample competition. Telepsychiatry has been used on a limited basis in an attempt to improve redistribution of capacity, but a larger and more comprehensive solution is needed.

Quality

The MHP implemented two evidence-based practices (EBPs) across the entire adult and older adult system of care in 2017. These EBPs are Cognitive Behavioral Social Skill Training (CBSST) and Cognitive Behavioral Therapy for Psychosis (CBTp).

Trauma-informed care has been a system wide focus of the MHP, seeking to improve services through the lens of this practice, and utilize the principles in system operations.

In September of 2017, the MHP implemented the Epic EHR throughout directly operated clinic services. Of significant benefit is the availability to MHP treating practitioners of County Health Department outpatient and hospital clinical information.

Outcomes

The MHP has utilized the Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) for many years, tracking level of service needs of its consumers. Efforts are underway to prepare for the implementation of the Child and Adolescent Needs and Strengths (CANS) in the summer of 2018. The MHP has identified four new outcome measures that will be implemented in 2018.

Employing individuals who possess lived-experience at the MHP's clinics and wellness centers continues to be a focus of the BHS. RI International continues to provide wellness centers in all three regions.

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care 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 State Medicaid 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.

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

This report presents the FY17-18 findings of an EQR of the Contra Costa MHP by the California External Quality Review Organization, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS. The eight PMs 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 Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;

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

[2] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

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

MHP Health Information System Capabilities[4]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO 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 a review of the MHP's reporting systems and methodologies for calculating PMs.

Validation of State and County Consumer Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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[3] 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.

[4] 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 inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY16-17

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, CalEQRO and MHP staff discussed the status of those FY16-17 recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY16-17

Recommendation #1: Consider standardized processes and cross-regional referrals for access to care and subsequent services to enhance the seamless and consistent delivery of service.

Status: Met

- Changes in the electronic tracking of referrals started in September of 2017 and now includes tracking of internal behavioral health referrals, totaling 51 as of February 2018. The Access Line Customer Relationship Management (CRM) module report for all of calendar year 2017 indicates 1,074 contacts, 404 CRMs, relating to 386 members. This data does not reflect the extensive collection of detailed clinical information which is part of this process and is available to those who subsequently provide treatment services.
- This recommendation targeted the varying standards for referrals and unique processes existent across the MHP regions. These differences can create barriers and confusion for individuals seeking treatment. While the CRM process does retain information and make if broadly available, it does not resolve the various operational differences that exist among the MHP's regional services. The electronic record and efforts to

standardize performance language within organizational provider contract language will likely improve standardization. However, the MHP's consumers would benefit from direct efforts to resolve and standardize regional operating practices.

Recommendation #2: Include timeliness metrics, request quarterly reports, and analyze for adherence to standards as a component of the contract provider performance measures.

Status: Partially Met

- The MHP acknowledges the decentralized approach resulted in contracts lacking consistency in structure and expectations across divisions. The new Chief of Operations may bring about consistency in this process and lead contractor interactions.
- The contracting process will be incorporating the network adequacy requirements, ensuring consistency in standards and data collection process. This will result in all contracts utilizing a 10-day initial access standard.
- As of this review, the MHP has explored some of the issues of this recommendation. However, no specific changes that result in data production for contract providers has yet been implemented. The MHP is still exploring some of the aspects of timeliness standards and reporting.

Recommendation #3: Utilize existing equipment to provide tele-psychiatry services in the regions showing the greatest need.

Status: Met

- The MHP launched its telepsychiatry pilot serving East County in October of 2017. Considering the current and recurring challenges in provision of adequate psychiatry coverage to this area, the MHP needs to fast-track solutions to the barriers that exist to the regular use of this modality. The MPH should strive to swiftly analyze and resolve issues associated with hardware needs, network speed adequacy, and billing issues for this functionality to become a significant element in provision of psychiatry services for consumers.
- The MHP has pursued redistribution of existing telepsychiatry capacity. Given the acknowledged shortage of psychiatrists, the MHP should aggressively pursue external resources that have an established record of success with other MHPs. Given the operational environment, telepsychiatry would be a great asset to stable provision of quality psychiatric care.
- The importance of this topic is underscored by the reports from various sources that initial psychiatry access in the eastern part of the county is currently nine months out. Hopefully this will soon be remedied by either locum hires, robust telemedicine functionality and external providers, or direct hires of psychiatrists and other prescribers. The shortage is clearly critical at this time.

Recommendation #4: Review services designed for transition age youth (TAY) and increase as warranted for this target population.

Status: Partially Met

- With the assistance of input from the TAY Advisory Council, the MHP determined a need for expanded TAY services, particularly those related to transitioning to adult life. The specific areas of focus include housing, work, relationships and school. The services targeted for expansion include a combination of transitional residential (up to 18 months), combined with supportive services. Due to complications, a second round of Request for Proposals (RFP) was initiated, which closed in September 2017.
- The MHP provided information about the participants who furnished input, but did not provide information about the specific recommendations made.

Recommendation #5: Develop a communication plan that includes contract providers in the planning and implementation of electronic interoperability of EHR data between disparate systems.

Status: Not Met

- The MHP is planning to include contract providers in the Phase 2 of the Epic EHR. The MHP is developing an integrated contracts unit, which will work with the Chief of Operations to discuss plans for communication between the MHP and contract providers.
- A communications plan has not been developed. The pace of the EHR implementation during the review period likely did not afford the MHP the resources to comply with this recommendation.

Changes in the MHP Environment and Within the MHP—Impact and Implications

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

Access to Care

- The MHP is seeking to provide integration of SUD and mental health services at its clinics through obtaining dual DHCS certification of those sites and to co-locate substance abuse specialists. Four site applications are in process and awaiting approval.
- Expansion of the Access Line includes American Society of Addiction Medicine (ASAM) screening of SUD callers and authorization of services.
- The Oak Grove TAY residential program and supportive services is focused on assisting those individuals with challenges in functioning in the community outside of a structured environment.
- The adult services Mobile Crisis Response Team (MCRT) is scheduled to go live March 1, 2018. Staffing of this unit includes a therapist, peer provider, and a family nurse practitioner. The intent is to improve crisis response, reduce PES visits and hospitalizations, and improve outcomes.

Timeliness of Services

- The MHP has been able to track and report timeliness data regularly without reliance upon the prior sampling approach. Contract provider information remains unreported.
- Efforts to improve timeliness are embedded in the current non-clinical PIP, which has a focus on initial access and psychiatric first appointment timeliness.

Quality of Care

- The MHP went live with the Epic ccLink electronic health record (EHR) in late September 2017. Supported by local super users, the system rollout has been quite successful with more than 40,000 progress notes written. There are many elements that have supported the success of this process, including the functionality for a user to immediately notify system support of system problems and submit suggestions for improvement.
- During 2017, two EBPs were implemented across the adult and older adult services in all regions. These include CBSST and CBTp.

- Trauma-informed care has been adopted by the MHP to improve the quality of care, and these principles are included in the development of practices and policies, which are also used to inform clinic operations.

- TAY services are enhancing coordination for those who age out of the children's system of care through a Crossover Meeting and in the adult system of care the support of a TAY lead at each MHP clinic.

- Children and youth are receiving Trauma Focused Cognitive Behavioral Treatment (TF-CBT) and Child-Parent Psychotherapy (CPP) when symptoms of post-traumatic stress disorder are identified. Dialectical Behavior Therapy (DBT) is utilized for adolescents engaging in risk behaviors, and Family-Based Therapy for Eating Disorders is also implemented with relevant consumers.

Consumer Outcomes

- The MHP's expansion of services provided by those with lived experience is evident. There are adult Family Support Workers in each of the three adult clinics. The function of these individuals is to provide support and services to the caregivers of adults in treatment.

- The Service Provider Individualized Recovery Intensive Training (SPIRIT) program is 10-week college course designed to prepare individuals with lived experience for employment as a peer in mental health. Two Peer and Family Vocational Specialists have been added to assist with job placement, retention, and career development.

- Outcome instruments planned for implementation during 2018 include: Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), Independent Living Skills (ILSS), and Recovery Assessment Scale (RAS).

- Children's services formed a CANS implementation team, to prepare for the addition of the CANS and the Pediatric Symptoms Checklist – 35 (PSC-35) later in 2018 to the set of outcome instruments. The CANS is already incorporated in the Epic ccLink health system.

PERFORMANCE MEASUREMENT

As noted above, 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 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 LOS;
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

HIPAA Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1: Contra Costa MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	56,775	20.2%	4,863	29.0%
Latino/Hispanic	88,852	31.6%	3,737	22.3%
African-American	42,571	15.1%	3,505	20.9%
Asian/Pacific Islander	45,480	16.2%	1,289	7.7%
Native American	849	0.3%	104	0.6%
Other	46,505	16.5%	3,279	19.5%
Total	**281,031**	**100%**	**16,777**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

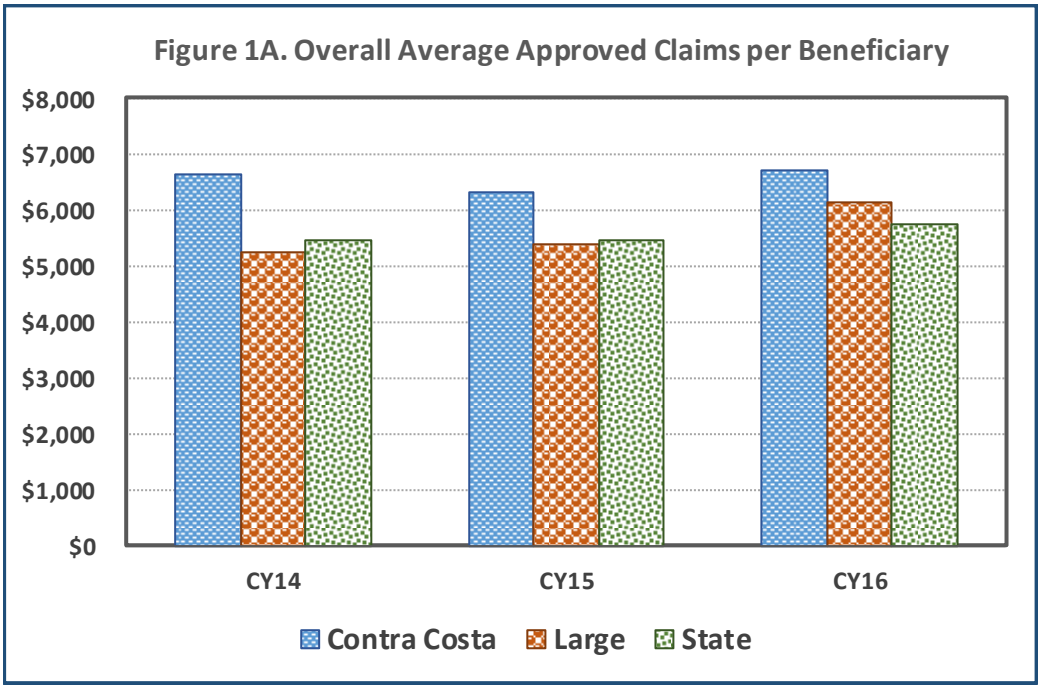
Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

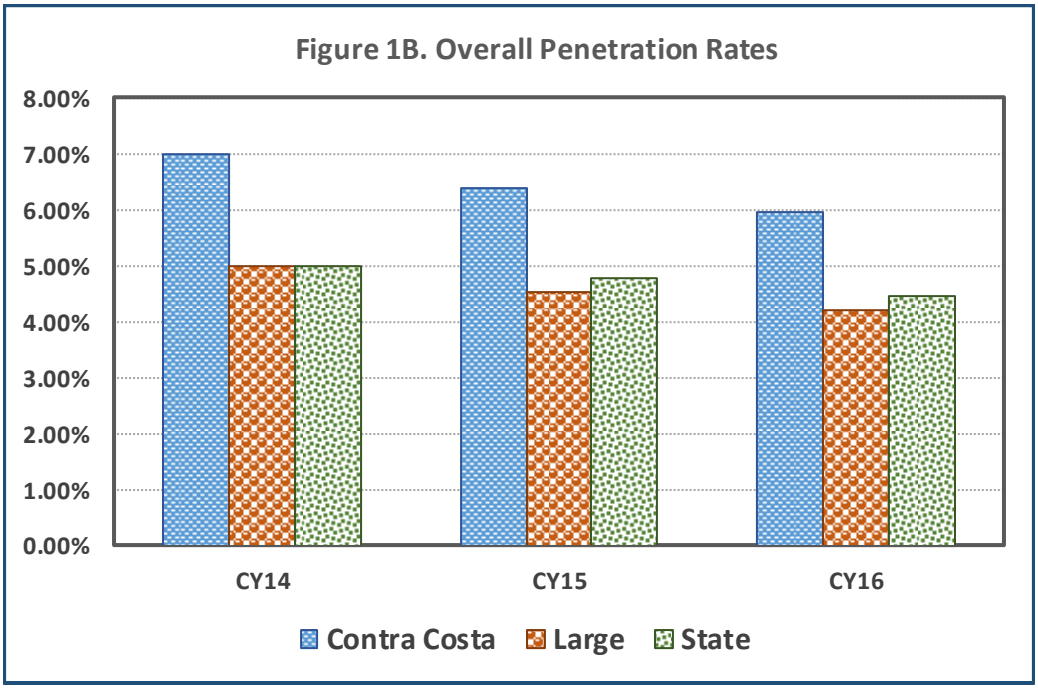
Penetration Rates and Approved Claim Dollars per Beneficiary

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.

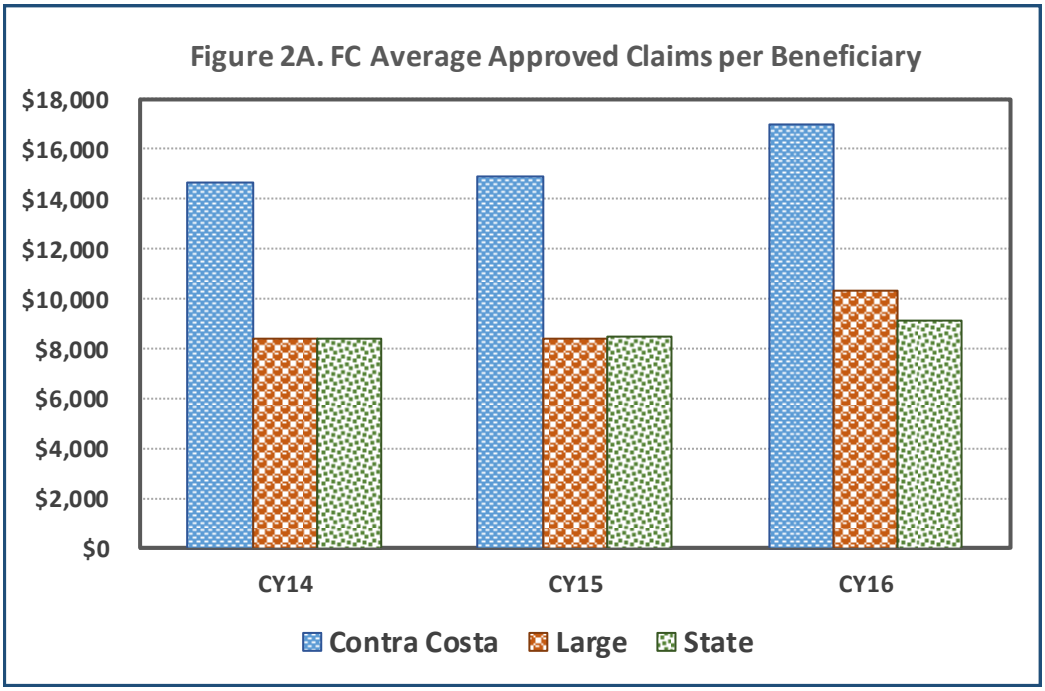
Regarding calculation of penetration rates, the Contra Costa MHP uses a different method than that used by CalEQRO.

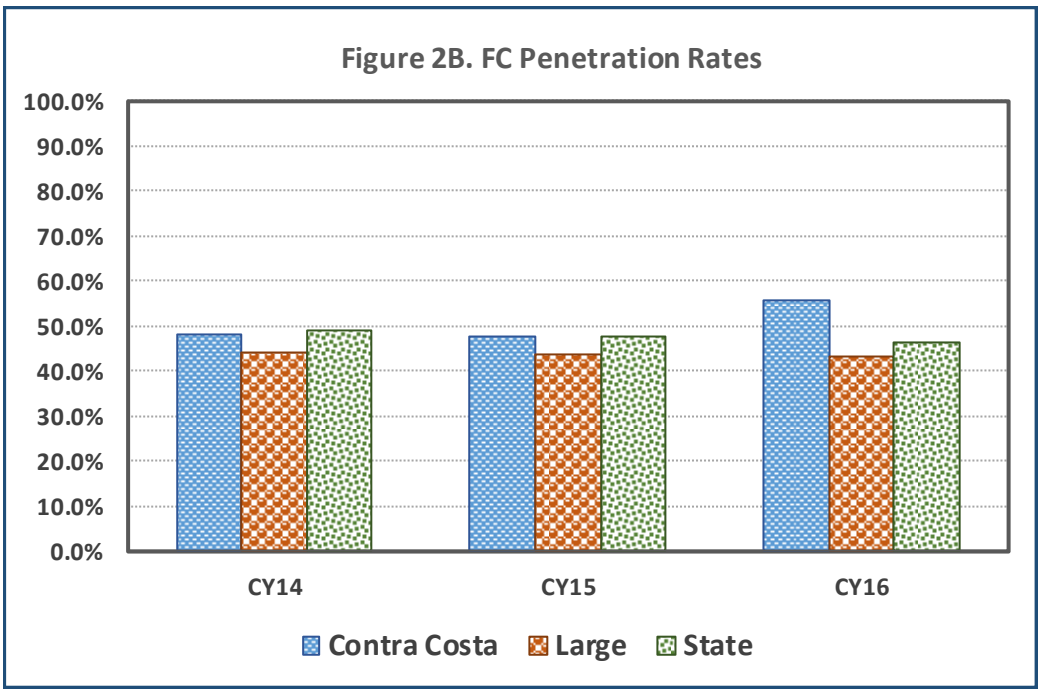
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



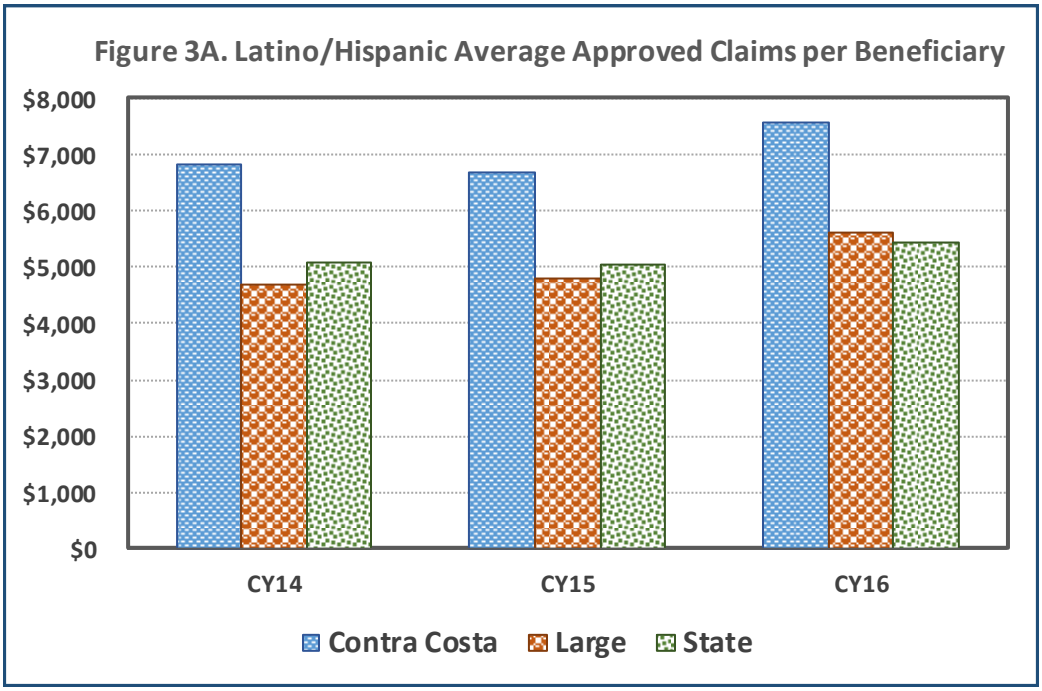


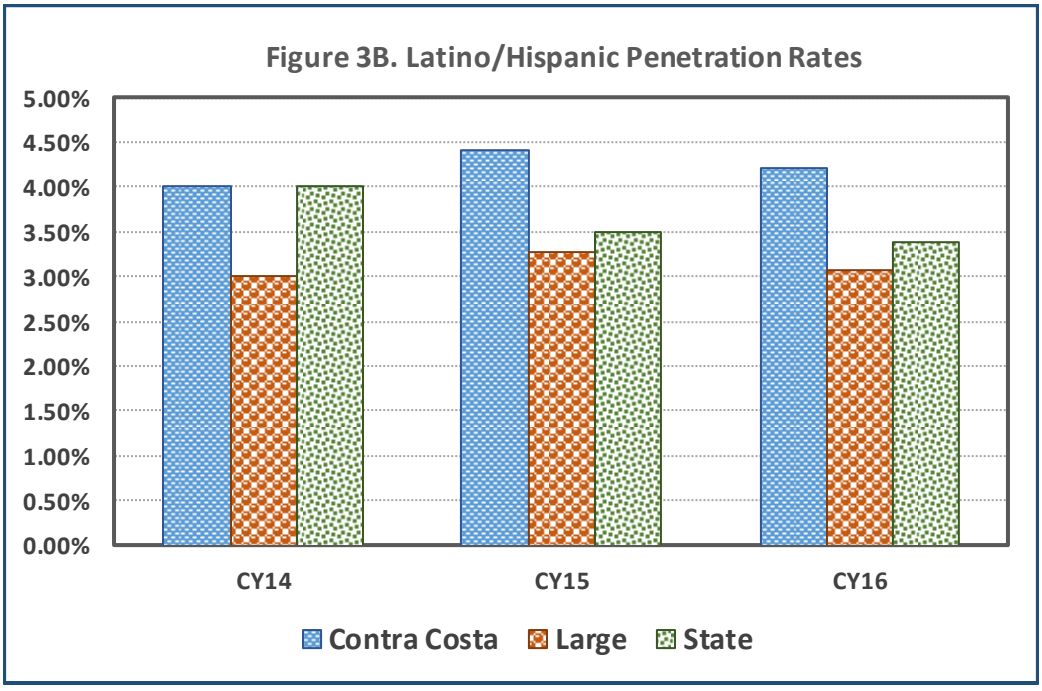
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/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 for CY16 with the MHP's data for CY16, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2: Contra Costa MHP 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	CY16	19,019	609,608	3.12%	$53,215	$1,012,099,960	28.90%
Contra Costa	CY16	853	16,777	5.08%	$59,951	$51,137,801	45.40%
	CY15	808	17,174	4.70%	$58,015	$46,875,859	43.20%
	CY14	660	13,772	4.79%	$54,866	$36,211,807	40.89%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost 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 CY15 and CY16.

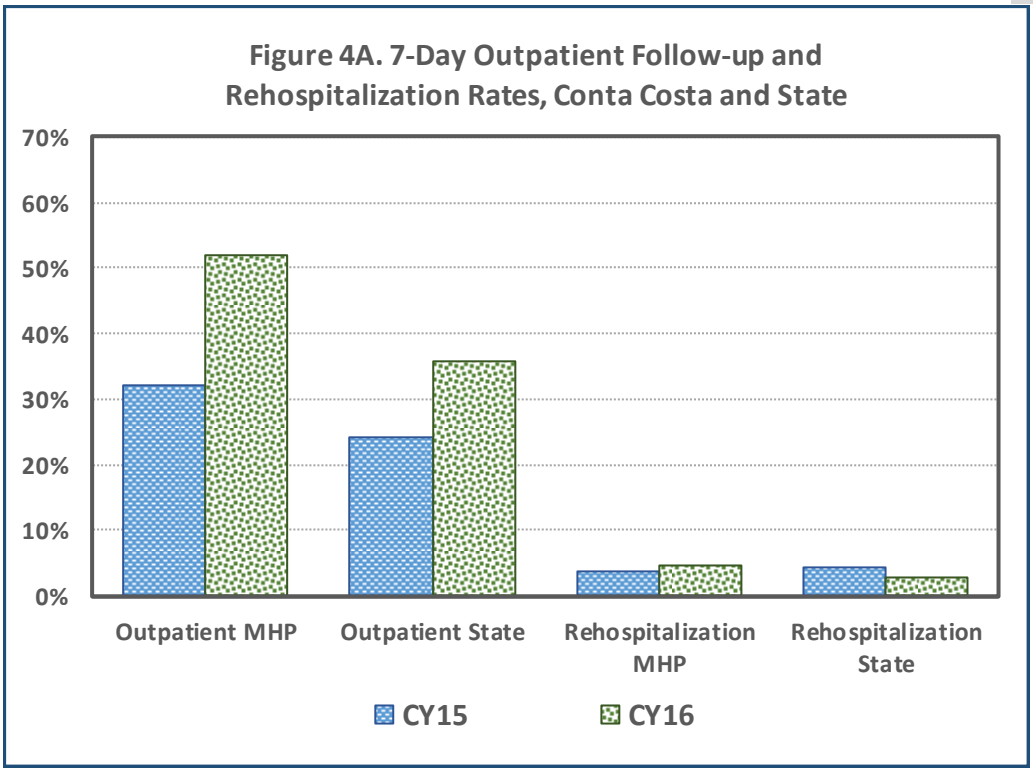


Figure 4A. 7-Day Outpatient Follow-up and Rehospitalization Rates, Conta Costa and State
70%
60%
50%
40%
30%
20%
10%
0%
Outpatient MHP
Outpatient State
Rehospitalization MHP
Rehospitalization State
CY15
CY16

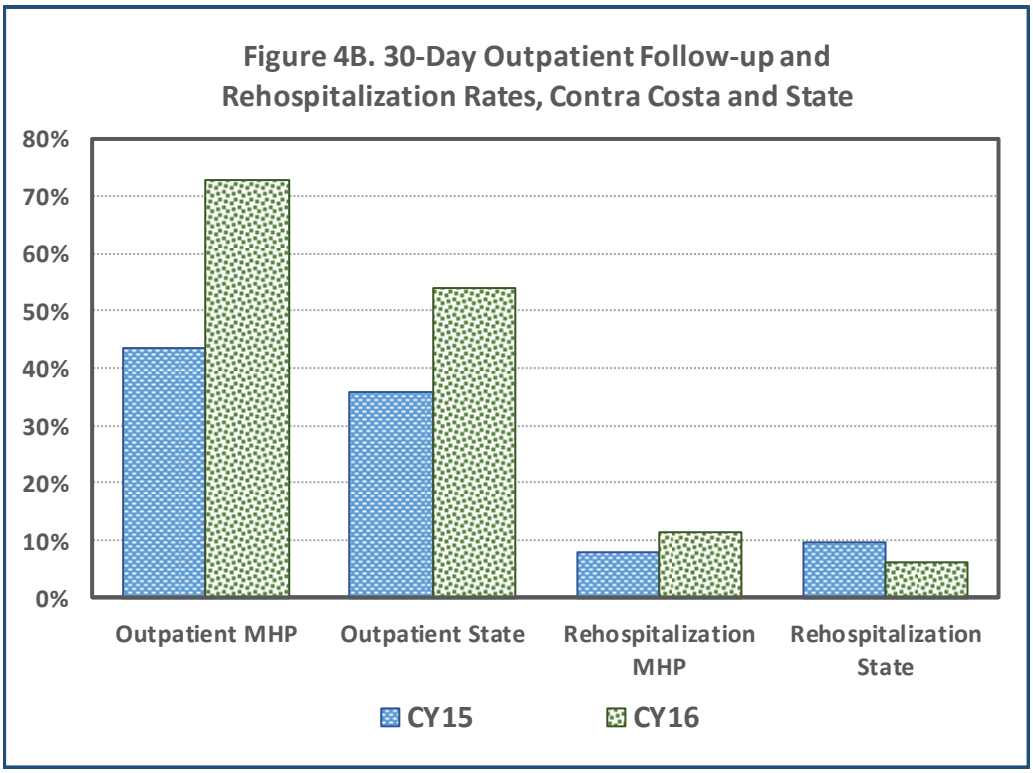
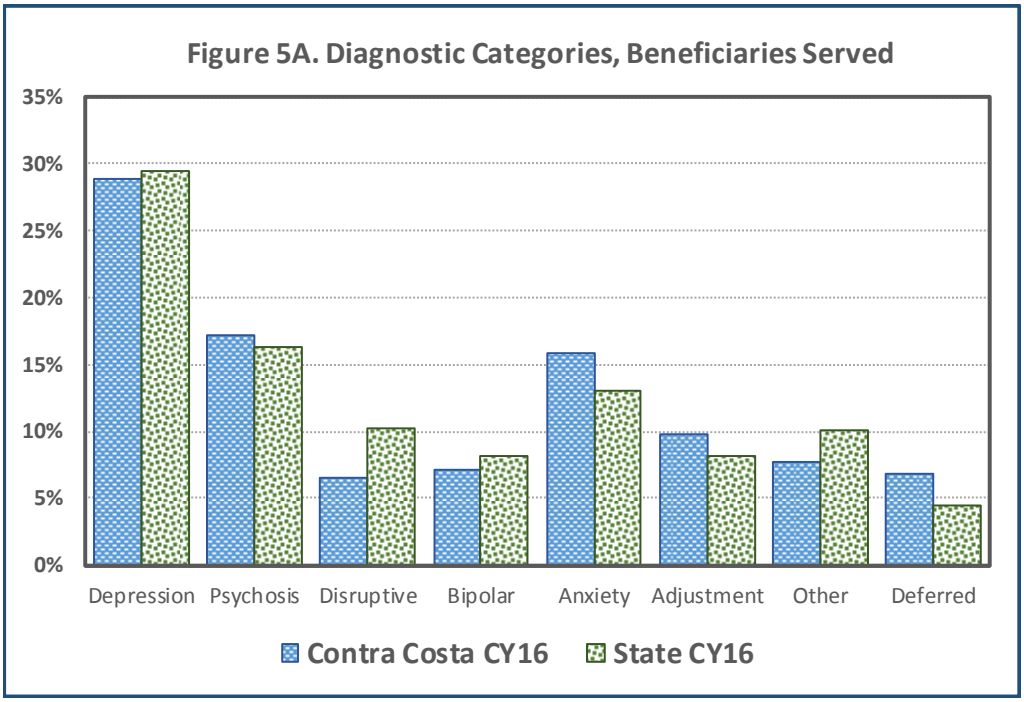


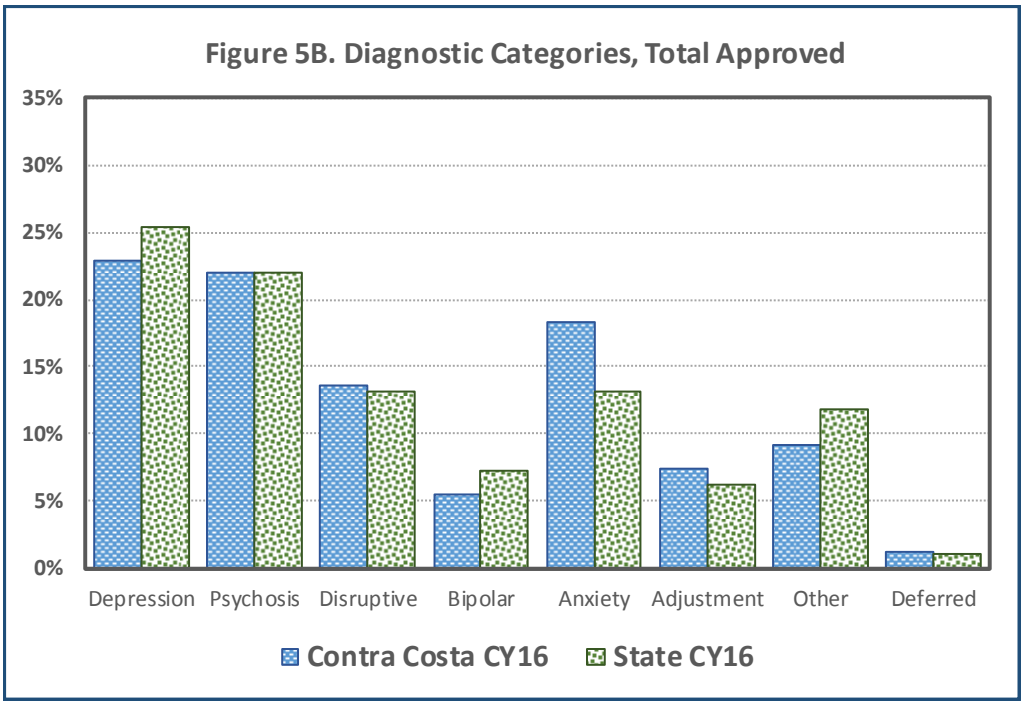
Figure 4B. 30-Day Outpatient Follow-up and Rehospitalization Rates, Contra Costa and State
80%
70%
60%
50%
40%
30%
20%
10%
0%
Outpatient MHP
Outpatient State
Rehospitalization MHP
Rehospitalization State
CY15
CY16

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 CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 18%.





Performance Measures Findings—Impact and Implications

Access to Care

- While the MHP's number of eligibles increased from CY15 to CY16, beneficiaries served demonstrated a slight downward trend. This correlates to a year over year drop in overall penetration rate of approximately 0.3 percentage points. However, even with this slight decrease, the MHP's CY16 overall penetration rate is approximately 1.7 percentage points more than the large MHP average.
- After flat Foster Care penetration rates from CY14-CY15, the MHP's Foster Care penetration rate rose between CY15 and CY16. The MHP's current penetration rate is above both the large MHP average and overall statewide experience. The MHP's Foster Care penetration rate is approximately 9 percentage points more than the statewide average.
- While the MHP's Hispanic penetration has declined very slightly from CY15, it is more than the large average and exceeds the statewide average by approximately 0.8 percentage points.

Timeliness of Services

- The MHP's CY16 7-day and 30-day outpatient follow-up rates after discharge from a psychiatric inpatient episode increased between CY15 and CY16 and are higher than the statewide average.

Quality of Care

- The MHP's average overall approved claims per beneficiary has remained relatively stable from CY14 to CY16. It is approximately 10 percentage points more than the large average and about 17 percent more than the statewide average in CY16.
- The MHP's average foster care approved claims per beneficiary increased from CY14 to CY16. It remains well above both the large and statewide averages.
- While the MHP's average approved claims per Hispanic beneficiary increased from CY15 to CY16, it remains less than the large average.
- Consistent with the statewide diagnostic pattern, a primary diagnosis of depressive disorders accounted for the largest percentage of beneficiaries served by the MHP. The MHP had a notably lower rate of disruptive disorders, a higher rate of anxiety disorders and a higher rate of deferred diagnoses when compared to statewide averages.
- The MHP continues to have a rising high cost beneficiary (HCB) percentage of consumers compared to the statewide average and has established a rising trend (see

Table 2). The HCBs by percentage of total approved claims continues to escalate as well and is now a full 16.50 percentage points above the statewide average.

Consumer Outcomes

The MHP had relatively unchanged 7-day rehospitalization rates between CY15-CY16. The CY16 30-day rehospitalization rate is about four percentage points higher than the statewide average.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (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.

Contra Costa 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 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 3: PIPs Submitted by Contra Costa MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Coaching to Wellness
Non-clinical PIP	1	Improving MHP Timeliness

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] *2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.*

Table 4: PIP Validation Review

				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-clinical**
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	PM	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	PM	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	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
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	M	NM
		6.5	Prospective data analysis plan including contingencies	M	NM
		6.6	Qualified data collection personnel	M	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	M	NA
		8.2	PIP results and findings presented clearly and accurately	M	NA
		8.3	Threats to comparability, internal and external validity	PM	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	PM	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	PM	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NM	NA
		9.3	Improvement in performance linked to the PIP	NM	NA
		9.4	Statistical evidence of true improvement	NM	NA
		9.5	Sustained improvement demonstrated through repeated measures	NM	NA

Table 5 provides a summary of the PIP validation review.

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	16	13
Number Partially Met	5	1
Number Not Met	4	2
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	16
Overall PIP Rating ((#Met*2) + (#Partially Met))/(AP*2)	**74%**	**84%**

Clinical PIP—Coaching to Wellness

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

"Will implementation of a wellness program for consumers with comorbid health and mental health issues improve the recovery of 45% of consumers from pre to post program participation?"

Date PIP began: December 2015 (ended December 2017)

Status of PIP: Active and ongoing

The MHP focused on the needs of adult consumers who are receiving medication-only services. These individuals receive no organized approach to ensure physical health issues like obesity, diabetes, or hypertension are identified and treated. Based on literature, the prevalence of untreated medical conditions in this group is high, and results in significant illness and premature death among these consumers.

The MHP utilized an additional survey to obtain more information about health care status and conditions, which provided confirmation of existent health concerns, as well as negative consumer perception of health status.

The key aspect to this PIP is the involvement of a wellness nurse and a wellness coach. Individual and group attention is provided to the consumers, as are Wellness Recovery Action Plan (WRAP) and Facing Up to Health (FUTH) groups. The PIP did not simply seek to track health metrics such as weight, BP, or blood sugar, but included tracking perception and the involvement in activities that would positively impact the health values.

A significant issue that was discussed during the onsite review was the low number of involved consumers. As of November 2017, 272 individuals had been referred by psychiatry, 79 of those had enrolled, and 18 graduated. This low enrollment could be related to the requirement that each participant be identified by and referred by the attending psychiatrist, which was mentioned as a barrier to broader participation.

Newly developed for 2018 was the addition of a clinician and capacity to provide individual and group therapy. Beginning in the East County Adult Clinic, the pilot has expanded to the Central and then West County Adult Clinics.

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 telephonic consultation before the review to provide feedback. Considering the duration and limited scope of impact of this PIP, the MHP would be advised to develop a new clinical PIP topic with broader scope of impact on the consumer population. The coaching to wellness presents beneficial addition to MHP services and would be assisted through the engagement of leadership champions who would promote wider interest in referring to this service.

Non-clinical PIP—Improving MHP Timeliness

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

"Will implementing direct consumer outreach improve timely access to mental health services so that the rate of consumers who miss their initial outpatient mental health appointment improves from 37% to 25%? Will implementing telepsychiatry as a practice for conducting initial psychiatric appointments improve the rate of psychiatry appointments scheduled within 15 days of referral from 24% to 80%?"

Date PIP began: December 2017

Status of PIP: Active and ongoing

The MHP has examined timeliness data for initial access to care and initial psychiatry services. The data for overall averages understates the circumstances relating to specific sites and those relating to children/youth and adult/older adults.

While the larger goal of this PIP is to improve initial timeliness countywide, the initial focus is on the East County region. The plan includes the utilization of Community Support Workers (CSWs) and Family Support Workers (FSWs) to make early contact with individuals who are scheduled for an intake or psychiatry appointment and assist in navigating any barriers that may arise. For the initial psychiatric assessment, there is the additional intervention of telemedicine, which is more of a capacity increase with related impact on timeliness.

This PIP intervention needs to incorporate some of the descriptive elements that are present elsewhere in the narrative as related to intervention #1 direct contact with new consumers. As written, it is not clear who does that specified direct contact and the specifics of intervention activities. The lack of detailed specifics is problematic.

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 pre-review telephone consultation and feedback. This PIP was started two months before the current review, and the first data run has not occurred. The MHP must not only run data reports quarterly, at minimum, but review them and make adjustments if the desired outcomes are not occurring. Lastly, it should be noted that a key issue not directly addressed within this PIP is the underlying difficulty in sustaining capacity particularly of psychiatry practitioners. Capacity must exist before any other issues of timeliness can effectively be addressed. While capacity was identified as an issue in the narrative, no mention of actions to improve that factor were made.

PIP Findings—Impact and Implications

Access to Care

- The Coaching to Wellness clinical PIP improves access to physical health care and supports life style changes that help to reverse pathological health conditions.

Timeliness of Services

- Improving MHP timeliness is focused on both initial clinical access and initial psychiatric access.
- The telemedicine intervention linked to the non-clinical timeliness PIP can be used to redistribute existing capacity, or to provide a portal for utilizing external capacity.

Quality of Care

- The clinical PIP improves the quality of care of SMHS by incorporating services that focus on the improvement of physical health conditions.
- The MHP's non-clinical timeliness PIP needs to include a focus on a key element of prescriber timeliness, which requires an intervention to have an immediate and lasting solution to unresolved capacity issues.

Consumer Outcomes

- Coaching to Wellness assists consumers in achieving their self-identified outcomes, which include life-style adjustments that improve overall health and linkage to specific treatment resources.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 6 lists the components that CalEQRO considers 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 6: Access to Care Components

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

The MHP operates with a Cultural Competence Plan Requirement (CCPR) dated 2017. The CCPR is strongly focused on issues relating to the Mental Health Services Act (MHSA) elements and funding categories. The program categories, such as Early Intervention, break out service needs and target recipients by age, preferred/primary language, race/ethnicity, sexual orientation, gender and gender identity, and more.

Linguistic needs of beneficiaries are met through interpreter services and bilingual staff, with nearly 25 percent of staff receiving bilingual pay. The recently activated electronic health record captures the involvement of an interpreter with services. It does not capture the language in which a service is delivered. While Spanish is the only threshold language, Vietnamese, Farsi, Chinese, and other languages are increasingly in demand and several of these have potential for soon meeting threshold criteria.

The MHP has made progress with Continuum of Care Reform (CCR) and has been working through issues including the AB 1299 presumptive transfer. MHP staff were fluent in the issues that arise, and how it is not always ideal to transfer eligibility to another MHP when it is unclear if the child may be involved in serial rehoming. Also identified was the assumption that transfer of eligibility will occur quickly and automatically, but not all social workers in the child welfare system are aware they must initiate the presumptive transfer process. The process relies upon one or two key staff within social service departments to achieve reassignment of benefits. This

does not always occur as quickly or seamlessly as intended. The process seems to require the development of forms which were not developed as part of the AB 1299 process. The MHP has been working with 10 nearby counties, and in partnership with Probation and Child Welfare departments, in the creation of creating their own forms that support notification of sending and the other acknowledgement of receiving presumptive transfer cases.

In many areas, the MHP has enhanced programs that meet the specific needs of eligibles. This includes programs serving the homeless, and whole person care targeting those with health, substance use and mental health conditions.

This year, the MHP has two planned crisis service expansions which include expanded services for children and youth, as well as adult mobile crisis. The services are intended to attempt crisis resolution and are staffed accordingly, with family partners and consumer employees attached, and improving response across all county regions.

The MHP partners with the Public Health Department's Federally Qualified Health Clinics (FQHCs) which include behaviorists to provide clinical staff to augment and improve the capabilities of primary care. At times, there has been a MHP psychiatrist assigned to provide telephone consultation, which expanded the comfort of these general practitioners in the use of psychopharmacologic interventions.

The local Whole Person Care project is health services focused and includes behavioral health and substance abuse treatment involvement. Participants receive a cell phone so that they may receive updates on appointments and improve follow-through. Automated appointment reminders reach this population.

1B	Manages and adapts its capacity to meet consumer service needs	PM

The MHP displays efforts to adjust capacity with the emergence of changing demands. Efforts to develop TAY residential program coupled with supportive services is one example. Expanded crisis services are another area, while incomplete, these efforts have been undertaken to improve a longstanding problem area. This is particularly in the area of field crisis resolution, intended to avoid taking consumers to the psychiatric emergency service facility.

The MHP has contractually assumed the provider role for mild to moderate consumers, utilizing the existing provider network (12 percent of all services) to furnish the needed capacity.

A recurring issue is evident this review cycle with the recruitment and retention of psychiatrist and mid-level psychiatric nurse practitioners. A long-term problem, this issue has been most extreme in the East County region. This last year, recent retirements, along with turnover of locum hires, has conspired to worsen this situation. Reportedly, the first psychiatric appointment for new East County adult consumers is being scheduled nine months out, in late November 2018. While this could change as soon as additional resources are brought on board, clinical staff are very concerned about the impact on the quality of care for both new and continuing consumers.

The prior EQR identified telemedicine as a recommendation to help with this coverage problem last year. Technical issues have been identified with equipment, such as bandwidth adequacy that result in image pixilation and a telemedicine panel with an insufficient 10-inch diagonal screen. While these hardware related barriers should be easily resolved, it is not clear if internal prescriber excess capacity exists to support telemedicine redistribution to East County.

Challenges exist in timely recruitment for positions, further hampered by the reported compensation differentials between this MHP and its immediate neighbors. Reportedly, this differential directly effects the ability to hire psychiatrists and psychiatric nurse practitioners, and possibly other licensed clinical staff. The Personnel Service Unit of the Human Resources Department provides the MHP with the support in filling vacancies. The MHP does not seem to possess direct access to the database that details all authorized positions and was not able to completely respond to questions about numbers of authorized positions by program and location during the review. Some respondents indicated that this separation of information has resulted, at times, in authorized position vacancies existing of which the MHP was unaware for quite some time.

Program leadership identify using the reporting functionality of the outgoing Echo Group Insyst product to run caseload and other reports to support their program management activities. Clinical history is also available from this reporting functionality. The upcoming Sharecare transition will present a different service paradigm and require some adaptation to provide similar reports to those that managers currently utilize.

The MHP does track productivity of staff. Review input identified the difficulties that exist in developing appropriate and reasonable productivity standards for field-based workers who face the additional challenges of difficult commutes.

It would seem that some of the MHP's recruitment and retention challenges for key categories are the result of Personnel Service Unit's efforts to create a uniform categorization for physicians and nurse practitioners across health and behavioral health systems. While the effort may be logical, in the highly competitive local health care personnel market the MHP may not be able to resolve these issues on a long-term basis without the development of separate compensation structures. Furthermore, actual position costs may be even higher if the MHP is forced to heavily rely upon costly locum companies, and also absorb the hidden costs involved with turnover, orientation time of replacement personnel to the EHR, e-prescribing, and familiarization with the local environment.

At this time, the MHP's success at implementing strategies to resolve these key position vacancies is very limited. It is also likely that the solutions are not completely within the MHP's direct control and may require direction from county leadership.

1C	Integration and/or collaboration with community-based services to improve access	M

Contract organizational providers comprise 61 percent of services. These augment the MHP's directly operated programs, which comprise 27 percent of services, and serve as the main

children/youth and adult service entry sites.

The MHP has taken steps this last year to improve the consistency of contract language and monitoring, including the hiring of a Chief of Operations, who is charged with bringing together the contracts development and monitoring, among other important activities. This function is intended to reduce the amount of variance in program design and operations.

RI International provides comprehensive wellness centers for adult consumers, with a location in each of the three major geographic areas of the county. This program considers its members citizens and operates with a unique paradigm.

Important issues were identified by caregivers of children and youth. Universally, TBS, and Wraparound services were acclaimed as positive by caregivers. However, many of the other additional supportive services that are available are delivered by separate agencies. This aspect introduces issues of coordination and communication which often involves families having to tell their stories many times over. Furthermore, the clinical approach and perspective of each agency has potential for conflicts. Each service also has its own unique wait time.

Significant integration occurs with the Contra Costa Health Services FQHC outpatient clinics and hospital.

Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. This ensures successful engagement with consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 7: Timeliness of Services Components

Component		Quality Rating
2A	Tracks and trends access data from initial contact to first appointment	PM

The MHP has targeted initial access timeliness with a non-clinical PIP that started in December of 2017. Results will be tracked by adult, older adult, and children/ youth and by the three service regions. The MHP is aware of the significant variation that occurs in this metric across the service regions, which is reflective of the disparate resources and demand. This PIP will also include psychiatry timeliness, which is mentioned in 2B, below.

The data from which the timeliness results are reported includes FY16-17 and CY17 through December.

The first offered appointment standard is 10 business days. The mean access time for first

offered appointment is 5.4 days for adults and 10.0 days for children, with adults achieving the standard 88 percent of the time, and children at 59 percent. First kept assessment appointment mean is 12.7 days for adults and 19.5 days for children.

Consumer and family member focus groups presented only small number of participants with recent intake experience. Their timeliness experience varied between closely tracking the results reported by the MHP, and others who have much longer experiences. Throughout the review common reference was made to "wait lists."

Clinical staff of all levels reported concerns about the variances in initial access and psychiatric access times that significant impact certain regions.

2B	Tracks and trends access data from initial contact to first psychiatric appointment	NM

The MHP utilizes a 15-day standard for first psychiatry appointment. The data referenced by the MHP for this metric is derived from the Cadence system, and spanned January 3 through November 22, 2017.

The MHP notes that a routine clinical assessment must first be performed before the psychiatry session occurs. This practice produces longer psychiatry wait times than would be reflected were the data based on the date of assessment.

The analysis indicated a 44 day mean for adults and a 67.1 day mean for children. Achievement of standard is reported as 27.9 percent for adults and 0.7 percent for children.

The MHP initiated a timeliness improvement PIP which is targeted on initial access, but also includes psychiatry timeliness as well. In that PIP, the MHP tracks and reports timeliness for both initial and psychiatry access by site. Based on the variances in staff and demand at the three main regions, this approach is an informed decision.

It should be noted that numerous sessions identified the severe psychiatry coverage issue that exists in East County, with separate sources stating the first available psychiatry appointment for new consumers being calendared for nine months hence – November 2018.

Review participants reported that children and youth can experience wait times for psychiatric access up to six months. Referrals to George Miller Center for temporary psychiatry care often occurs, but it not clear what capacity that program has and what wait times are, as well as the accessibility of that location for those being referred.

While recruitment and hiring of psychiatrists and psychiatric nurse practitioners is a long-term system problem, the acuity of this shortage and related issues are severely impacting timeliness.

2C	Tracks and trends access data for timely appointments for urgent conditions	PM

The MHP reported on the January 3 through November 22, 2017 timeframe for urgent services. Noted is the reliance on cross-referencing information from its Tapestry and Cadence systems. The MHP notes that 25 percent of urgent referred individuals no-showed for their appointment,

inflating data. The MHP uses a two-business-day standard for urgent care access. The data shows adults with a 7 day mean, and children reflecting no data. Children with urgent needs are referred to the Miller Wellness Center, an FQHC located in Central County, for which data is not currently available.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM
The MHP adheres to the 7-day HEDIS post-hospital discharge follow-up standard. For the period of January 1 through November 13, 2017, the MHP reports a mean of 17 days for adults and 19 days for children, meeting the standard at 48.6 percent for adults and 80.3 percent for children and youth.		
2E	Tracks and trends data on rehospitalizations	M
The MHP's 30-day rehospitalization rates was reported as 10.5 percent for adult services and 13.3 percent for children's. This data includes all hospitals and spans almost all days in CY17. The MHP reports this information is reviewed annually.		
2F	Tracks and trends no-shows	PM
The MHP tracks and reports no-show rates for county operated services only, which comprises 27 percent of all events. The MHP provided no-show data for CY17, reporting consumer no-show categories of consumer cancelled, provider cancelled, and other cancellations. The analysis included percentage of no-show events. This information is reviewed once annually. In the EQR Timeliness Self-Assessment, the MHP indicates a 10 percent standard as the no-show expectation across all services. Psychiatry no-shows are 20 percent for adults and 26 percent for children's. Non-psychiatrist clinicians experience a 16 percent rate for adults and a 28 percent rate for children.		

Quality of Care

In Table 8, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 8: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
The MHP operates with a current FY17-18 Quality Improvement Work Plan (QIWP), which is founded on the evaluation of the FY16-17 QIWP results. The evaluation is a densely packed review of MHP progress improving specific areas of focus and provided clear, understandable insights into the status of the MHP's efforts. The MHP's evaluation of work plan results would benefit from limiting evaluation of results to whether or not a standard was met. In some instances, success was ascribed to establishment of a process and not from the resultant data. The MHP is approximately one year into the new five-year Strategic Plan, which is intended to guide the development of services that correspond to identified regional and population needs. This document provides significant analysis and focus on the direction being taken with service expansion efforts. The MHP has been operating two PIPs, the clinical is focused on coaching to wellness and improving the health care of consumers, and the non-clinical is focused on improving initial timeliness of access with a secondary focus on initial psychiatry services. Contractors report occasional peripheral involvement in PIPs and would likely be able to provide more contribution if offered greater inclusion in PIP teams. The Quality Improvement Committee (QIC) Meeting meets monthly and the minutes reflect a review of numerous quality issues, including a MHP-developed improvement survey. This instrument captured the reasons consumers missed appointments, and the area of least satisfaction with services. Consumers were also asked for feedback regarding plans to include volunteers in waiting rooms. The QIC minutes furnish much greater detail on discussed topics and plans for future actions than are often seen. An area that should be improving is the periodic review of timeliness data by the QIC. Most of the elements were reviewed annually in the past, while this year plans have the data being run and reviewed quarterly. Medication monitoring, and access line test call data were among many topics discussed in QIC meetings.		
3B	Data are used to inform management and guide decisions	PM
The MHP acknowledged that until the recent move to the Epic ccLink EHR much of the routine performance data was not captured without extensive workarounds. That said, Cadence and Tapestry software used by the Access Line have been producing some of the data and basis of recent reporting during the last year. Clinical staff voiced their appreciation for immediate		

Table 8: Quality of Care Components

Component		Quality Rating
access to any crisis or other contacts with those they directly treat, improving the quality of care. The discussions and material presented during this EQR onsite gave clear indications of the efforts that the MHP is and will be expanding to develop data streams that support analytic efforts in many different areas. One example was the ability of the medication monitoring process to mine prescriber data and identify potential medication interactions with physical health medications prescribed by health practitioners. Automated monthly reports integrate labs results for prescribers, demonstrating the benefits of health information exchange and information sharing. The benefits of this sort of integrated health care information and awareness of other treated conditions makes medication reconciliation a hands-off process and alerts providers to conditions and drugs they would otherwise rely upon consumers' ability to recall. Tracking and reporting of medication monitoring results occurs within the QIC and includes a breakdown of strength and challenge areas. Within its MHSA Three Year Program and Expenditure Plan, FY17-18 through FY18-20, the MHP reviewed LOCUS/CALOCUS data and compared to benchmarks, concluding that overspending occurs in the highest level of services. Onsite discussion included challenges created by over 60 individuals awaiting beds at a state hospital or IMD level, who would await this bed at the acute hospital level. The same data analysis identified a compensation-related shortage of psychiatric time, related to compensation, as a related issue. The MHP would benefit from a concurrent approach to tracking, reporting and analysis of impact of important data elements such as in the above cited report.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	PM
A significant pillar of the MHP's communication efforts is contained in the "Behavioral Health Connection," an online newsletter that continues links to the programs discussed, and importantly also contains a feedback link. The newsletter has a survey link enabling the reader to provide feedback, comments or questions. Each major section of the newsletter identifies the email of a key person involved in that topic, which enables questions to be sent directly to the section author. It might be helpful for the MHP to establish a related link that contains all the curated comments or suggestions submitted and, where relevant, identify actions taken in response. Providing responses to feedback tends to encourage viewers to provide more responses when they		

Table 8: Quality of Care Components		
Component		**Quality Rating**
perceive their input has a response. As evident from the previous EQR report, feedback from stakeholders expressed that communication seemed compliance focused and often related to documentation standards. This communication typically comes from Utilization Review and Provider Services units and lacks a collaborative approach and customer focus. This includes slow processes for contractors to achieve approval and addition of new employees the authorized service delivery list, including issuance of a staff identification number. This lag results in new staff being on payroll for months before their services may be claimed. To the positive, there is ample evidence that points to the MHP's efforts to survey staff, CBOs, consumers and family members regarding initiatives. This has occurred with the Welcome Packet, transportation challenges, as well as satisfaction reported from all levels. The involvement of organizational providers occurs when specifications for new programs have been established and the MHP is at the request for proposal (RFP) phase. Providers often have been performing similar work and may have creative suggestions for the project itself and would like to see their input solicited earlier in the process and with greater transparency. A related aspect of provider communication, which will hopefully be improved with the new Chief of Operations, has been the multiple points of contact for operations questions. During this review, some stakeholders felt they had been specifically excluded from the review process. While this could not be definitively established, the MHP clearly engaged in efforts to control the review process and limited session participation.		
3D	Evidence of a systematic clinical continuum of care	PM
The MHP has developed a number of higher intensity programs to support a variety of populations. These include Coco Lead Plus, an initiative to halt the reoffending and incarceration of those with co-occurring disorders, and bring housing, treatment, and vocational services to this population. The Mobile Crisis Response Team (MCRT) is a 24/7, multi-disciplinary unit, which includes a peer, and has a focus on crisis resolution and averts unnecessary use of the PES and inpatient resources. The MCRT is expanding into East and West County regions. In addition, there is the Mobile Response Team (MRT) expansion that includes a family support partner for responding to children and youth, which historically was focused on Central County and is now expanding to East and West through services delivered by Seneca. The need for a child and youth crisis stabilization unit (CSU) was consistently expressed in various session by participants. Usually this came out in the context that the County Medical Center emergency department does not present a therapeutic environment for children and youth. Parents/caregivers and staff were aware of the efforts beneficiaries would go to in order		

Table 8: Quality of Care Components	
Component	**Quality Rating**
to avoid that setting. The Children's PES was closed some time ago and is viewed as an important element that is not likely going to be replaced by the mobile crisis expansion. Considering the size and scale of this MHP, a children and youth focused CSU would be a useful resource. The MHP is moving forward with the expanded EBPs which within the children and youth system which include DBT specifically targeting the emotionally unstable consumer; TF-CBT for children and youth experiencing post-traumatic stress disorder (PTSD) symptoms; and Wraparound for families with complex needs. In addition, CPP for young children with trauma exposure and Family Based Therapy for Eating Disorders are being offered.. CBTp and CBSST are targeted for adults. An interesting and unique approach was taken by the MHP in establishing an Overcoming Transportation Barriers Innovations Project that included that two Commute Navigation Specialists. During the review, the MHP shared that 80 percent of adult consumers served by county-operated clinics were considered medications only, and received no other planned services than those from a prescriber. The use of the provider network is included for those who improve and become mild-to-moderate through the course of treatment, as well as those who are screened by the access line to meet mild-to-moderate at first contact. The MHP has reportedly utilized mechanisms to ensure that provider network practitioners receive rates that are higher than the common Medi-Cal payment and enables them to retain these practitioners. While the LOCUS and CALOCUS have been utilized for many years as instruments to track service level needs, the sense from participants is that the MHP still lacks a thoughtful, organized comprehensive level of care system. These instruments do not drive service levels, and some concerns were voiced that the instruments may be rated to confirm the existent treatment level. Many believe that external resources are not sufficient to support individuals who are ready to step down service to lower levels, evidenced by the data and the clinical assessment. The psychiatrist who was assigned to offer telephone consultations to primary care providers was an example cited of a system that supported step-downs, but that no longer exists. Re-establishing that type of support and robustly assuring other levels exist is necessary for caseloads to be appropriately reduced. Many of these issues are blocked by what staff identify as compensation hurdles which results in the MHP being unable to compete with neighboring counties and large health care organizations, a factor that all participants seemed aware. Despite the frequent conversations within leadership about level of care and stepdown in services, therapists do not report much pressure to discharge consumers from their caseloads in order to make room for new consumers. Although there exists an annual review of medical	

Table 8: Quality of Care Components		
Component		**Quality Rating**
necessity by the utilization management division, there are not clear criteria for stepping down levels of care in children and youth once the utilization review threshold has been met. Related questions were raised regarding the scoring of LOCUS and CALOCUS instruments, and whether the scores are gamed to create the levels that justify continued treatment.		
3E	Evidence of consumer and family member employment in key roles throughout the system	M
The MHP employs individuals with lived-experience in CSW and FSW positions. Beyond these positions, there is not a comprehensive career ladder available. Peer certification is available through a course in the local community college in which the MHP collaborates, which is called the SPIRIT program. This program prepares consumers to participate in either a volunteer or paid capacity. The Office of Consumer Empowerment is closely linked to consumer employment within the MHP. There is consideration of the creation of a more robust career ladder. Feedback indicated that numerous consumers had participated in administrative workgroup sessions intended to gain information related to improving the system for lived experience employment. Some of the challenges reported by individuals with lived-experience during this review include: clinical staff must obtain a release of information before involving the lived-experience employee with a given consumer. When that occurs, often a cold-call to that consumer must occur, which is not as effective as an in-office warm-handoff. This group also noted there exists a need for ongoing training which involves licensed clinical staff in re-learning about the recovery culture and the role of individuals with lived-experience. The MHP's positive early addition of individuals with lived-experience to their treatment teams may have in the long term resulted in a decreased awareness and appreciation of the tasks and work that consumer-employees may accomplish. This can result in the silos that separate clinical services from consumer support services. Due to the separation and required release process, lower utilization of the valuable contributions that CSWs and FSWs can occur.		
3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	M
RI International is a large and robust organization creating what are called "wellness cities," where participants are known as "citizens." In Contra Costa County, there is a location in each of the three regions, 100 percent staffed by consumer/family member employees. Full-time and part-time employment is offered. For this review, a visit and orientation to the Antioch center occurred.		

Table 8: Quality of Care Components

Component		Quality Rating
Core elements of the programming focuses on illness management and recovery skills. Safety classes are directed at the prevention of substance abuse and suicide. Family Support nights are scheduled quarterly, with presentations on substance abuse, restorative justice and question and answer elements. Drawn from the review contacts with participants in this program, recommendations include: Increase the hiring of FSWs who can help navigate resources for parents of adult consumers. Prioritize hiring of FSWs within the Mobile Crisis Response Team. Provide quarterly recovery culture training, particularly involving clinicians working at adult programs, who may lose touch with the recovery culture partly due to the number of lived-experience workers at the MHP clinic sites and the separation of their roles from clinical services.		
3G	Measures clinical and/or functional outcomes of consumers served	PM
The MHP has long utilized the CALOCUS for youth and the LOCUS for adults to assist with the routine utilization and annual re-authorization process. In November 2015, the MHP initiated an EBP and Outcomes Workgroup to provide a thoughtful shift to practices that show the promise of improving consumer outcomes. This workgroup was also tasked with the identification of effective outcome measures to help in the determination of individual progress in treatment. In 2017, CBSST and CBTp were selected for implementation with adults, and the Recovery Assessment Scale (RAS) and Independent Living Skills Survey Self-Report (ILSS-SR) were identified to track progress. The MHP has identified Patient Health Questionnaire-9 item (PHQ-9) to assess depressive symptoms and the Generalized Anxiety Disorder 7-item (GAD-7) to assess anxiety as potential system wide measures for all consumers, which will be piloted at one adult mental health clinic and a substance use residential treatment facility in 2018. TF-CBT utilizes the Youth Outcome Questionnaire to track reduction of symptoms and the UCLA Post-Traumatic Stress Disorder Reaction Index to follow progress in the use of TF-CBT. The MHP is preparing to initiate use of the CANS instrument and the Pediatric Symptom Checklist (PSC-35) in October 2018. These instruments are built into the MHP's EHR. Systematic use of this information and aggregation for identification of best practices has yet to occur.		
3H	Utilizes information from Consumer Satisfaction Surveys	M
For this EQR cycle the MHP provided November 2016 and May 2017 consumer satisfaction reporting. The November reporting included 1,283 total surveys, (522 adult and older adult surveys and 761 youth and parent/caregiver responses) Both time periods included the demographic analysis of participants, and the language of completion. The scores reflected a		

Table 8: Quality of Care Components	
Component	**Quality Rating**
continuation of the high levels of consistency across domains, which is common across the state. Included in reports were recommendations derived from the data. These recommendations covered survey administration methodology, service quality and appropriateness from a cultural perspective. The recommendations section noted that lowest satisfaction scores were with outcomes and functioning. This gives support to the MHP's efforts to identify EBPs and relevant outcome instruments with the expectation that this approach could improve self-ratings of progress from treatment. Finally, the MHP described ideas about how to involve consumers and staff in using survey data to inform treatment. The in-depth approach used by this MHP in analyzing satisfaction survey information is commendable. The depth and breadth of this analysis and incorporation of methodologic factors, results, recommendations and potential use is very comprehensive.	

Key Components Findings—Impact and Implications

Access to Care

- Securing adequate prescriber staff of psychiatry and psychiatric nurse practitioners is a system wide challenge. The East County was the most severely impacted and during the review, psychiatry coverage was described in multiple sessions as at crisis level, with reliance on inadequate alternative solutions.
- The MHP established two crisis service expansions: broadening service availability for children and youth across all regions and improving the capacity and crisis resolution focus of crisis services for adults and older adults.
- In support of the CCR Reform, the MHP has developed presumptive transfer documents, so that the necessary information is communicated whether sending or receiving a foster care child or youth. This has involved the collaboration with numerous neighboring MHPs to standardize the process. The development of practical operational guidelines for the use of presumptive transfer is key to serve the foster care individuals effectively. This also requires clear identification of those situations wherein transfer is deferred and alternately a service authorization request (SAR) is provided.
- The MHP has a system for providing the necessary education and training to individuals with lived-experience to be able to utilize that background in provision of services. Each

site has individuals with lived-experience in roles for supporting individual consumers or family members. System navigation and outcomes are enhanced by this presence.

Timeliness of Services

- The data presented for initial timeliness reflected relatively quick access that is no longer based on the prior sampling methodology. Participants and consumers both reported significant and frequent variances from that reported data. The data continues to exclude contract providers, which are a significant component of services. The MHP has instituted a PIP that targets initial access, and secondarily psychiatry initial access.

- Initial psychiatry assessment average access times exceed 30 days for adults and more than 60 days for children and youth. The input of staff and consumers confirms that prescriber access is often long and difficult. This area might well serve as the focus of the timeliness PIP.

- Throughout the review, frequent references were made by programs to "wait lists". DHCS has informed MHPs that wait lists are not appropriate and directed MHPs to focus on alternate referrals to meet the timeliness standards. For Contra Costa's East County consumers, the alternatives are, per review participants, not easy to access due to long commutes and the capacity of the facility commonly utilized.

- The urgent care timeliness data produced by the MHP indicates a relatively long timeline for services. Youth timeliness is not captured currently; these needs are met through referral to a specific youth provider. The MHP would be advised to implement tracking of the youth urgent care timeliness through collaboration with its contract provider. The practicality of this single site resource should also be evaluated for the capacity to meet countywide need.

- Timeliness data has historically been reportedly reviewed annually, although the current QI Work Plan and timeliness non-clinical PIP appears focused on more frequent reporting by site and population served.

Quality of Care

- The MHP operates with a comprehensive QI Work Plan and utilized the results of the prior year to inform the current plan development. Changes in the MHP internal environment, which includes the EHR implementation in late September 2017, is furnishing a level of timely data access that will provide the opportunity to track monthly and review quarterly or semi-annually on many parameters.

- The EHR is offering the opportunity to improve quality through the automation of prescribing and monitoring of concomitant physical health conditions and treatment. Alerts regarding drug interactions between health and mental health providers can be

automatically provided. Currently, lab reports are provided to psychiatry practitioners monthly.

Consumer Outcomes

- The MHP continues to collect LOCUS and CALOCUS scores and anticipates further useful information coming from the results of additional instruments that are slated for incorporation, including this year with CANS implementation.

- The MHP data dashboards posted online include up through the FY14-15 period. For adults the inpatient acute bed utilization is very slightly trending downward over time, and the administrative bed days have made a sudden and significant increase in the FY14-15 fiscal year period, along with expected increases in crisis residential bed days. This corresponds to MHP observations during this review related to the high-cost beneficiary claims increases.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

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 are specific to the MHP being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift certificates to thank the consumers and family members for their participation.

Consumer/Family Member Focus Group 1

This focus group consisted of parents and caregivers of children and youth beneficiaries receiving services, of whom the majority initiated services within the prior 6 to 12 months. The participants were all English speakers, except for a very late arrival who was unable to participate and whose preferred language was Spanish. It was conducted at the Antioch Children's Behavioral Health Clinic, 2335 Country Hills Drive, Antioch, CA 94509.

Number of participants: 6

The participants who entered services within the past year described the experience as the following:

- Initial access took approximately six weeks.
- Psychiatry services were in place four months following the initial assessment.
- A wraparound team was arranged within one month.
- The first assigned clinician lacked essential trauma treatment training, which the caregiver experienced as four months of time misspent.
- There are too many different clinical participants in care, which results in a slow and cumbersome care delivery system and the caregiver having to interface with four different organizations.

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

- Several participants' children receive therapy three times each week, the remainder once weekly. Those who receive TBS have clinician contact twice each week.

- Additional services include a kinship group, and after-hours parent/partner services. There was assistance provided to some participants regarding inpatient hospital admissions.

- Psychiatry services for the children of the caregivers was characterized as frustrating. They have difficulty obtaining appointments, usually described as offering appointment windows, which lack date and time specificity. Often the window disappears and the effort to obtain an appointment starts anew.

- All caregivers were completely unfamiliar with case management support services. However, upon further discussion, it seemed that two received case management with the Wraparound team. Some were not able to receive case management because, they believed, of a current TBS staff assignment. One received case management through a community-based organization (CBO) but not from county staff.

- Frequent changes of clinicians was described as a barrier to care, some having received four clinician changes in two years. The child in treatment cannot count on clinician consistency and has shifted attachment to school-based clinicians where the therapist assignment is stable.

- Additional barriers to care include schools not incorporating parental/caregiver feedback regarding adherence to the plan and needed services. They perceive that clinical staff do not ask caregivers about the children's' needs or preferences. They hear clinicians assert their status and inform the caregivers that they (the clinician) know best what the child or youth needs. Other comments reference staff who do not listen to consumers and a lack of continuity of care while the assigned clinician is on leave. Clinical staff do not seem to appreciate that the youth will deceive at times, and clinical staff will believe the child/youth without efforts to verify with the parent/caregiver.

- After-hours crisis responses include: Police tend to just write 5150s without efforts to de-escalate the event. Those programs (Seneca) that furnish after-hours crisis response have a 9:00 pm cutoff, after which law enforcement is the only available response. There were comments about a provider that sent three staff to the home and could not obtain a resolution after 12 hours. Crisis events in school have required the parent to respond to the school and then take the child to crisis services.

- The TBS program was cited as the only service that connects with the family/support system. TBS had generally positive reactions from these caregivers.

- Stigma related issues include a child's reluctance to board a "yellow bus" because all the other youth knew it was for a mental health special school. Another mentioned bullying occurring at school because of diagnosis.

Recommendations for improving care included the following:

- Seek more parental/caregiver input, and routinely validate perceptions with the caregiver.
- Clinical staff needs to coordinate more with the schools, providing them with information about the needs of these children. Otherwise, the school may operate in a way that interferes with efforts to help the child.
- Provide more Wrap/Wraparound services as they are essential for success in working with the children/youth.
- Youth mentors are extremely important and need greater availability.
- The MHP needs to stabilize the psychiatry and clinician staffing through whatever means it takes. The turnover is destructive to the progress of the youth in treatment.
- Hire more female clinical staff.
- Eliminate the long waits when changes in services or additional services are needed.

Interpreter used for focus group 1: No

Consumer/Family Member Focus Group 2

The second focus group was requested to consist of 8-10 diverse adult beneficiaries, the majority of whom initially accessed services within the prior 6-12 months. All participants were English-preferred individuals, with an almost even mix of males and females. The location of this session was East County Mental Health, 2311 Loveridge Road, Pittsburg, CA 94565.

Number of participants: 7

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

- The overall initial access experience for those with recent intake was mixed, from very positive and quick to another extreme of a six month wait. Another experience with system intake was via an acute admission to inpatient care, which occurred rapidly.
- The overall experience was two-thirds positive with one-third very negative.

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

- For those who have received services for greater than one year, the frequency of psychiatrist contact varies from monthly to once every eight weeks.
- Participants were pleased with the fact that their psychiatrists could see all the medications ordered by physical healthcare through the ccLink tool.

- Most participants had received case management services but sometimes this person is not formally designated as a case manager. The frequency of the case management services varied from several times per month to once every week.

- The urgent and crisis services received mixed reviews. Usually a crisis involved going to PES, with no other response available. The psychiatric hospital received poor reviews. While there is a suicide hotline, a warmline is not available for people who are not suicidal. For people who need medications, PES will not fill prescriptions, but John Muir Hospital emergency department will administer injectable emergency medications.

- Other feedback was about the overall helpfulness of department clinical staff. Positives were stated about assistance with housing and with adjusting medications to have the optimal effect. Some participants mentioned setting goals with their staff and working towards wellness. Another comment reflected that the participant felt recovery was progressing well, and others would not know of the illness unless self-identified.

- Participants mention appreciation of RI International wellness centers, and the Putnam Center. Transportation is a challenge for consumers, but once accessed the services and support offered is valuable. There are also medically-focused wellness centers which the participants did not like. The nearly identical names made it easy to confuse the two centers.

Recommendations for improving care included the following:

- Consumers believe the ideal structure would co-locate wellness programs with clinic services, easing the burden of transportation.

- Incorporate Schedule II medications in the e-prescribing module, so that electronic submission to pharmacies can be achieved for all drugs. Currently a separate trip to the clinic is required, and transportation is locally difficult.

- Provide responses to phone messages, particularly those messages left for nursing and psychiatry.

Interpreter used for focus group 2: No

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- Caregivers report the psychiatry turnover creates difficulties in making and keeping appointments for the children and youth in treatment. This also apparently applies as well to the turnover of clinicians, resulting in loss of trust and trauma.
- Wraparound services are highly valued and considered effective by parents and caregivers of youth in treatment. TBS is another highly valued service.
- Increased availability of youth mentors is considered vital by caregivers.
- Caregivers believe there are insufficient numbers of female staff available to work with their children.

Timeliness of Services

- For the participants with initial access experiences in the last year, their experience widely varied and seemed related to the portal of entry. Some experienced long wait times; for others it was quite short. Those entering outpatient services following hospitalization or a crisis event tended to experience short or no wait times. Otherwise no specific trends could be identified.

Quality of Care

- Caregivers identify the negative impact of the involvement of multiple agencies in treatment, each with their own care specialty, collaborating in the treatment process. It creates a large time commitment for caregivers and a disjointed process, compounded by the possibility of contradictory treatment approaches.
- The destructive impact of clinician and psychiatry staffing instability is evident in the feedback of parents and caregivers, who experience this as disruptive to regular appointments and damaging to the trust and willingness of their children to engage in treatment.

Consumer Outcomes

- Adult consumers identified successes and improvements that they relate to treatment.
- No specific positive outcomes were noted by the caregivers of children and youth.

INFORMATION SYSTEMS REVIEW

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

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

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

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	27%
Contract providers	61%
Network providers	12%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, IT staff): **1.1%**

- The MHP's IS/IT needs are served by an umbrella agency providing service to the MHP as a service provider. As such, the above listed percentage does not accurately list all MHP allocated costs.

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

The budget determination process for information system operations is:

MHP currently provides services to consumers using a telepsychiatry application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: **2**

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

- ☒ Hiring healthcare professional staff locally is difficult
- ☐ For linguistic capacity or expansion
- ☐ To serve outlying areas within the county
- ☐ To serve consumers temporarily residing outside the county
- ☐ Reduce travel time for healthcare professional staff
- ☐ Reduce travel time for consumers

Telepsychiatry services are available with English speaking practitioners (not including the use of interpreters or language line).

Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
23	16	0	1

MHP self-reported data analytical staff changes (in FTEs) that occurred since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
11.5	4	3	4.5

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

- During the implementation of the Epic EHR, MHP access to technology staff increased dramatically.
- Staff listed in Table 11 are almost exclusively MHP resources and this allocation does not reflect either fiscal subject matter experts or resources available to the MHP via the Health Agency's Business Intelligence unit which is currently engaged in materially expanding the MHP's access to operational data.

Current Operations

- The MHP migrated its EHR operations to the Epic product suite this review period. The MHP is utilizing a "best of breed" approach to supply the wide array of functionality mandated to accommodate State operations mandates. This approach has the added benefit of providing tighter than usual integration with already existent physical health systems deployed across the county.
- Current billing operations continue to use the Insyst system from The Echo Group as their practice management resource. This interface has not been without challenges but is reported to be functional until a successor system becomes operational. The MHP is planning to use the Sharecare system, also from The Echo Group, as that successor system. Current operational tempo is on track to have the Sharecare system in place by May 2018.
- The MHP has chosen to handle the provision of mild to moderate (M2M) service provision utilizing its Network Provider community. The MHP has chosen to provide parity payment for Network Providers equal to SD/MC rates and has created a favorable environment, as noted in Table 9, for this system of care. This has serious potential to benefit county beneficiaries.

Table 12 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 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Insyst/PSP	Practice Management	Echo Group	17	County IT
Tapestry	CRM	Epic	1	County IT
ccLink	CPOE/eRX	Epic	5	County IT
ccLink	Clinical Medical Record	Epic	1	County IT

Priorities for the Coming Year

- Replace current Echo Insyst/PSP system with the Echo Sharecare billing system for Mental Health and Substance Abuse Disorder systems of care.
- Continue with initiative to migrate paper-based clinical records into existing Epic ccLink EHR system for county-operated programs.
- Plan to implement automated data exchange interface between Epic ccLink EHR and new Sharecare billing system.
- Ensure current SUD billing system is properly set up to bill DMC-ODS waiver requirements.

Major Changes Since Prior Year

- Implementation of Behavioral Health EHR clinical records into the Epic ccLink Tapestry system for Network Providers.
- The IT began implementation of new Echo Sharecare Billing system. Completed first database conversion of Client and Provider data from old system into Sharecare.
- The MHP expanded Provider Exclusion checks to include County and Network Provider. We are currently planning to launch an initiative to build and maintain a Death Master Index.
- The MHP completed implementation of the Epic Cadence appointment scheduling application and integration with our TeleVox appointment reminder Call processing and text messaging system.

- The MHP's CSI data errors continue to remain at or near zero percent over the past year with 100 percent accuracy reported by the California Department of Health Care Services (DHCS) for all CSI data submissions.

- The SUD program (a.k.a. Alcohol and Other Drugs Services [AODS]) began billing under the 1115 DMC-ODS Waiver program on July 1, 2017.

Other Significant Issues

- During the onsite review, stakeholders provided examples that highlighted the MHP's lack of understanding of the difference between risk management and risk avoidance. Operationally, it is impossible to mitigate risk entirely. The MHP does not seem to understand the balance that needs to be struck between acceptable risk and the ability to reasonably serve its beneficiary population. For example, the effort to investigate appropriate telepsychiatry hardware appears to have gotten in the way of rational telepsychiatry deployment across the system of care. This deployment would have been a reasonable short-term solution to mitigate lack of psychiatry resources. Simple polling of peer MHPs could have yielded functional intelligence to move forward rapidly. This kind of dysfunction seems to be happening broadly across the system of care simply to avoid risk or comply with a perceived regulatory requirement. There is also a general impression conveyed that the MHP must craft long-term grade solutions for issues that may necessarily be transient in nature.

- The MHP is on the cusp of deployment of multiple outcomes tools within its EHR. This is the first step to sound utilization of these resources. The MHP has yet to fully craft pragmatic utilization protocols that both honor immediate clinical utility and secondary longitudinal analysis. Much practical discussion needs to be had before these issues are functionally balanced. The MHP could potentially use the methodologies available to its business intelligence team to craft 100 percent automated review protocols to improve consumer outcomes.

- The MHP's pharmacy leadership is working with medically competent business intelligence experts to craft suitable medical surveillance protocols using its eRx database. This effort has already allowed the MHP to investigate poly-pharmacy issues across the system of care to increase beneficiaries' safety.

- The MHP has not yet decided on the pragmatic extension of its EHR resources to its organizational provider community. Given that 61 percent of service delivery to consumers is done by these providers, it is concerning that this is not a higher priority. The MHP needs to conduct its due diligence on how this process will proceed in a timely manner. Current timelines verbalized by stakeholders appears to be artificially excessive.

- Broad and varied feedback from stakeholders indicated that the interaction with two divisions, Quality Review (QR) and Personnel Services (PS), creates challenges and

barriers to effective operations. QR is not experienced as a partner, providing guidance and input, but is experienced as risk-averse and punitive. Personnel Services is experienced as slow and inadequately responsive to urgent needs to fill positions essential to consumer care.

- Discussions with stakeholders pointed to internal dialog that acknowledges the potential benefits of data analysis. One conversation meriting further discussion was the MHP's internal understanding that they are now in possession of the tools to begin objective discussions around system capacity. There will need to be significant discussions held between QI and clinical management but the potential for creating a more dynamic system of care appears to be on the MHP's radar.

- During discussions with varied stakeholder groups it was noted that while the new EHR can record the use of an interpreter during therapy, it cannot record that a linguistically competent service was provided by a fluent clinician.

Plans for Information Systems Change

- The Epic ccLink clinical medical record (ccLink) went live in late September 2017 for Behavioral Health.

- The initial primary deployment of the EHR to county-operated providers now complete, preparations for Phase 2 of its deployment strategy are being readied, which will refine and expand functionality.

Current Electronic Health Record Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality					
		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	Epic	x			
Assessments	Epic	x			
Care Coordination	Epic			x	
Document imaging/storage	Hyland OnBase	x			
Electronic signature—consumer				x	
Laboratory results (eLab)	Epic/CPOE	x			
Level of Care/Level of Service				x	
Outcomes	Epic		x		
Prescriptions (eRx)	Epic	x			
Progress notes	Epic	x			
Referral Management	Epic/Tapestry	x			
Treatment plans	Epic/TIP	x			
Summary Totals for EHR Functionality:		8	1	3	0

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

- The MHP is in the process of functionally implementing its outcome measure suite within EHR workflows. This project has been only partly realized due to several factors such as the diversity of measures used, and the establishment of rational measure use to balance direct clinical utility with secondary analysis needs.
- It should be noted that even where feasible tool deployment could be implemented for organizational providers (e.g. read-only access for medical staff of CPOE/eRx tools) this has not been broadly pursued.

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

☐ Paper ☐ Electronic ☒ Combination

Personal Health Record

Do consumers have online access to their health records either through a Personal Health Record (PHR) feature provided within the EHR, consumer portal, or third-party PHR?

☐ Yes ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Behavioral Health Data Error Correction (BHDECOR) Process

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: Contra Costa MHP Summary of CY16 Short Doyle/Medi-Cal Claims

Number Submitted	Gross Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
453,768	$124,142,722	**14,707**	$5,309,116	4.28%	$118,833,606	$16,480,469	$102,353,137

Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017.
The statewide average denial rate for CY2016 was 4.48 percent.
Change to the FFP reimbursement percentage for ACA aid codes delayed all claim payments between the months of January-May 2017.

Table 15 summarizes the most frequently cited reasons for claim denial.

Table 15: Contra Costa MHP Summary of CY16 Top Three Reasons for Claim Denial			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Other coverage must be billed prior to submission of this claim	6,499	$1,877,246	35%
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	5,170	$1,757,089	33%
Late claim denial	331	$816,160	15%
Total Denied Claims	14,707	$5,309,116	100%

Information Systems Review Findings—Implications

Access to Care

- The MHP's functional deployment of broad internal access to the Epic EHR suite has materially aided improving appropriate access to care for MHP beneficiaries.
- The MHP is conceptually discussing use of data to facilitate quantitative capacity analysis. This discussion is commendable as it holds the potential to create a more resilient system of care that values access and capacity to treat beneficiaries.

Timeliness of Services

- The MHP's access to acceptable levels of psychiatry providers has materially impacted timely provision of this resource.
- Rapid, focused analysis and resolution of telemedicine barriers could significantly have improved the contribution this technology provides to mitigating psychiatry staffing issues.

Quality of Care

- The MHP's use of its Network Provider community to link mild to moderate beneficiaries to care is commendable. Adding EHR resources to this paradigm is a critical component to quality care.
- The MHP has committed significant data analytics resources to its clinical quality improvement efforts but much hard work is pending to turn the mountain of available data into robust and resilient mechanisms for long-term analysis. These efforts have high potential to improve consumer wellbeing.
- The MHP's pharmacy leadership has begun medical surveillance efforts utilizing the EHR's eRx database to improve beneficiaries' safety.
- The MHP has been generally slow to allow organizational provider access to its EHR based data. This is a matter of immediate concern where simple read-only access that could be provided to provider medical staff has not been prioritized.

- Challenges remain in implementing successful interoperability functionality between the Epic ccLink/Tapestry systems and Sharecare. The needs include provision of state-mandated reporting and claims submission requirements, which is potentially a lengthy process during which significant support by knowledgeable subject matter experts will be required.

Consumer Outcomes

- The MHP has begun to make broad implementation of outcomes tools a priority across the system of care to bolster evidence-based practice protocols.

- The MHP has not yet successfully deployed system-wide outcomes measures, such as the CANS, in a practical manner via its new EHR suite. Already deployed tools are not implemented in a manner amenable to 100 percent automated review by business intelligence methodologies.

SITE REVIEW PROCESS BARRIERS

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

- No barriers to this review were experienced.

CONCLUSIONS

During the FY17-18 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 co-certification of MHP clinic sites as SUD programs provides the MHP with integrated substance and mental health treatment capacity and improves access for those with co-occurring conditions.
- The MHP's functional deployment of the Epic EHR creates a smoother flow of consumer information and improves coordination of care throughout the system.
- The Tapestry and Cadence software for the Access Unit creates a smoother flow of consumer information, and facilitates referrals, and has materially aided beneficiary access to care.
- Forensic mental health is co-located with criminal justice and focused on low level offenders, providing services that are inclusive of wraparound, and diversion from incarceration.
- Penetration rates continue to be high relative to other large MHPs and the statewide average.
- The MHP and neighboring counties have taken on a lead role in the development of procedures and documents involved with presumptive transfer of foster care youth and children placed out of county.
- Closely integrated with the MHP, the SUD treatment services have implemented medication assisted treatment (MAT), providing 226 individuals with medications other than methadone. There are two methadone clinics, and there have been two trainings to encourage physician to become X-waivered as buprenorphine prescribers.

Opportunities:

- Regional discrepancies in psychiatry and mid-level prescriber staffing creates unacceptable delays in initial access and challenges to appropriate follow-up care.
- The telemedicine pilot in East County has been hampered by hardware difficulties – such as, screen size and network speed – and insufficient internal capacity for the re-distribution model currently prioritized.
- The EHR and related software systems provide the MHP with the opportunity to utilize quantitative data to conduct objective capacity analysis across the systems of care. This could support the development of capacity standards for each of the MHP's regions.
- The MHP has consistently experienced a higher proportion of consumers that are high-cost beneficiaries and percentage of approved claims related to these high cost services. While some analysis has been done to further understand this issue, it would seem important to have a deeper understanding.
- The dedicated psychiatry consultation function for primary care should be reconsidered for restoration when the full staffing of the psychiatry services is restored. The support available to primary physicians by a consultation will improve the ability of that service to provide medications for those with psychiatric conditions and decrease MHP clinic caseload sizes.
- Greater availability of group and individual treatment was cited as a need for those that are on medications-only caseloads.
- The need for a children's psychiatric emergency service was cited throughout the review.

Timeliness of Services

Strengths:

- The MHP's timeliness data is currently based on actual complete data, as opposed to prior sampling method.
- Initial access timeliness, on an aggregated countywide basis, appears to be within standard for first offered appointment.

Opportunities:

- Review informants report the existence of long wait times for initial access at specific regions that are not reflected in the overall initial access data of the MHP. This is particularly for children and youth, which may be related to the lack of focus or pressure to step-down caseloads. Caseload sizes are cited at 20-25 per clinician.

- The MHP's access to acceptable levels of psychiatry providers has impacted timely provision of this resource. This would merit a comprehensive analytic approach and development of multiple component solutions.

- Timeliness data continues to exclude data from contract organizational providers and the provider network.

Quality of Care

Strengths:

- The trauma-informed systems of care model adoption and related training is offering improvements to the quality of care received and will likely have a positive impact on outcomes. This model goes beyond the treatment of consumers to include a focus that targets the work environment and how staff are treated as well.

- The EHR receives positive reviews by clinical staff and is seen as an asset to the treatment process. The roll-out process received many positives, with local super users identified at each location, and mechanisms to resolve problems and submit wish-list recommendations in place.

- The Quality Improvement Work Plan demonstrates a focus on key operational areas and uses a quantifiable approach to goal-setting. Many of the previous annual reporting and review standards have been replaced with a quarterly standard.

- For children and youth, family-based treatment for eating disorders has been implemented.

- The MHP's use of its network provider community to link mild-to-moderate beneficiaries leverages an existing practitioner pool in serving consumers who may move between directly operated programs to network.

- The pharmacy leadership's use of the eRx database for medical surveillance is a commendable effort to improve beneficiaries' safety.

- The Operations Unit has the potential of creating more uniformity in contracts and program operations, which will result in a more consistent experience for consumers and staff within and between MHP regions.

- Children and youth would benefit from greater numbers of peer advocates, particularly in the work with the TAY population.

Opportunities:

- The MHP should consider the extension of EHR resources to its organizational provider community. At a minimum, the extension of read-only access should be expedited to organizational provider medical staff to improve consumer safety.

- The MHP should focus discussions among clinical quality improvement, research and evaluation, and business intelligence staff to formulate protocols for the extraction of knowledge from the large quantities of consumer data it now has available through the EHR. These discussions need to focus beyond operations to the broader consumer outcomes and well-being.

- MHP leadership should consider obtaining feedback regarding the perceptions of program staff in both contract and directly operated programs as to support provided by Utilization Review and Personnel Services units. There may be ways to optimize relationships to improve results and quality of care.

- Phase 2 of the EHR implementation involves bridging and switchover from INSYST to Sharecare practice management. System optimization will continue, and challenges in the process will need to be identified and resolved.

- In a number of areas, the MHP's protocols seem to create barriers to seamless service delivery. Examples can be found in the Coaching to Wellness PIP that required physician approval and referral for consumer to receive a physical health improvement service. In another example, adult consumers must complete a release or authorization before an individual with lived-experience can be involved in their care. These protocols that create a barrier should be evaluated as to necessity and when possible reduced or eliminated.

Strengths:

- The MHP continues to add Consumer Support Workers and Family Support Workers to many aspects of service delivery including wellness, crisis, and timeliness improvement activities.

- The MHP is expanding TAY services with residential beds and adding supportive services to that expansion.

- The MHP has begun to make broad implementation of targeted outcomes measures a priority across its system of care to bolster the MHP's evidence-based practice protocols.

- The MHP's website posts a newsletter that supports a feedback function and furnishes contact information of section authors, promoting a dynamic communication link.

- The MHP has adopted two universal adult measures, the PHQ-9 and GAD-7, along with the ILSS and RAS, but use is limited to individuals receiving the two associated EBPs.

Opportunities:

- Periodic summarizing of newsletter feedback comments, including responses or actions taken, and posting that along with the newsletter could increase engagement of users.

- The efforts to include FSWs and CSWs in virtually all aspects of service delivery has been accompanied by some inadvertent creation of silos for these individuals. Greater ongoing involvement of the Office of Consumer Empowerment to work with consumer employees and the clinic leadership may offer the opportunity to have greater integration of lived-experience staff with clinical services.

Recommendations

- Develop a set of effective procedures that are activated upon the loss of psychiatry coverage, bringing on additional resources until a permanent solution can be developed. This includes resolution of telepsychiatry barriers, and development of externally provided telemedicine resources, coupled with locum tenens providers.

- Include the Office for Consumer Empowerment in all aspects of policies and practices, such as direct operations of clinic programs where planned efforts are needed to ensure there are not silos between staff with lived experience and licensed clinical services. Prioritize hiring individuals with lived experience into newly expanded or developed programs such as mobile crisis.

- Continue to mature the deployment of EHR resources, including outcomes tools, to all parts of its system of care, but especially contract organizational providers. Attention should be made to prioritize organizational provider access to mental health history and medical data.

- Evaluate the results of expanded children's crisis services to determine if the need for a crisis stabilization unit for that population should be revisited, furnishing a safe, effective, family and child/youth friendly environment in which crisis events may be safely resolved outside of an emergency department environment.

- Fully investigate and explore the high percentage of high cost beneficiaries, then identify relevant actions that show potential or impacting that population.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO Performance Improvement Plan (PIP) Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - Contra Costa MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration, Including Health Plan
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
Prescriber Session
Wellness Center Site Visit
Contract Provider Site Visit

Attachment B—Review Participants

CalEQRO Reviewers

Rob Walton, Quality Reviewer, Consultant
Tom Trabin, Deputy Director, DMC-ODS EQRO
Duane Henderson, Information Systems Reviewer, Consultant
Luann Barnes, Consumer-Family Member, Consultant
Vivian Pan, BHC Controller, Observer

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

Sites of MHP Review

MHP Sites

Contra Costa County Behavioral Health
1350 Arnold Dr.
Martinez, CA 94553

Contra Costa County Behavioral Health
1340 Arnold Dr.
Martinez, CA 94553

East County Adult Mental Health
2311 Loveridge Rd.
Pittsburg, CA 94565

Antioch Children's Behavioral Health Clinic
23355 Country Hills Drive,
Antioch, CA 94509

Contract Provider Sites

RI International Wellness City
3701 Lone Tree Way,
Antioch, CA 94509

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Aguirre	Priscilla	Quality Management Program Coordinator	CC Behavioral Health
Anand	Avi	Vice President	Anka Behavioral Health
Andreev	Oleg	HS Info Systems Programmer/Analyst	CCHS Info Technology
Ang	JR	Director of Patient Accounting	CCHS Finance
Artiga	Oscar	Community Support Worker	CC Behavioral Health
Barrientos	Sakura	Registered Nurse	CC Behavioral Health
Batiuchok	Daniel	MH Program Manager	CC Behavioral Health
Battis	Claire	HS Planner/Evaluator	CC Behavioral Health
Beaver	Brett	MH Program Manager	CC Behavioral Health
Beckert	Debra	Nursing Program Manager	CC Behavioral Health
Becwar	Allison	CPO	Lincoln
Belon	Cynthia	Behavioral Health Services Director	CC Behavioral Health
Bergesen	David	CEO	Community Options for Families & Youth
Bergesen	Diana	CFO	Community Options for Families & Youth
Bianchi	Charlene	MH Program Manager	CC Behavioral Health
Bigol	Maria	Administrative Services Asst III	CC Behavioral Health
Blum	Vanessa	Clinical Director	Community Options for Families & Youth
Bohorquez	Christine	UR Coordinator	CC Behavioral Health

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Bowers	Bill	MH Clinical Specialist	CC Behavioral Health
Brooks	Eileen	MH Program Manager	CC Behavioral Health
Bruggeman	Jennifer	MH Program Supervisor	CC Behavioral Health
Burke	Sherry	COO	Community Options for Families and Youth
Burnett	Kersten	MH Clinical Specialist	CC Behavioral Health
Burton-Flores	Margie	MH Program Supervisor	CC Behavioral Health
Celio	Chris	Director of Clinical Programs	Hume Center
Chmiel	Denis	MH Program Manager	CC Behavioral Health
Clopton	Kristen	HS Planner/Evaluator	CC Behavioral Health
Coate	Anthony	MH Clinical Specialist	CC Behavioral Health
Cobelda-Kegler	Jan	Adult/Older Adult Program Chief	CC Behavioral Health
Cooper	Zabeth	MH Clinic Coordinator	CC Behavioral Health
Danko	Adam	Psychiatric Nurse Practitioner	CC Behavioral Health
Diaz	Alicia	MH Clinical Specialist	CC Behavioral Health
Dold	Amanda	Integration Services Manager	CC Behavioral Health
Donohue	Jessica	Regional Executive Director	Seneca
Down	Adam	MH Project Manager	CC Behavioral Health
Ebbert	Nancy	Lead Psychiatrist	First Hope
Espinoza	Lucy	MH Community	CC Behavioral

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		Support Worker	Health
Fam	Albert	MH Clinical Specialist	CC Behavioral Health
Fernandez	Nancy	Manager	CC Child and Family Services
Fox	Rebecca		Seneca
Frank	Carol	Associate Director	Early Childhood
Franklin	Marilyn	MH Clinical Specialist	CC Behavioral Health
Fuhrman	Beverly	MH Program Manager	CC Behavioral Health
Gallagher	Ken	Research & Evaluation Manager	CC Behavioral Health
Gargantiel	Paolo	MH Clinical Specialist	CC Behavioral Health
Garrison	Juanita	Clerical Supervisor	CC Behavioral Health
Gibson	Teresa	MH Program Supervisor	CC Behavioral Health
Girton	Jeryl	Psychiatric Nurse Practitioner	ANKA Behavioral Health
Gonzalez	Karen	HS Systems Analyst II	CCHS Info Technology
Hanna	Betsy	MH Program Supervisor	CC Behavioral Health
Hayes	Warren	MH Program Manager	CC Behavioral Health
Heher	Kirsten	Family Support Worker	CC Behavioral Health
Hernandez	Rustico	Contractor	CCHS Finance
Isbell	Ann	HS Planner/Evaluator	CC Behavioral Health
Jacob	Jean	HS Planner/Evaluator	CC Behavioral Health
Jeremy	Joanna	MH Clinical Specialist	CC Behavioral Health

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Johnson	Kennisha	MH Program Manager	CC Behavioral Health
Kalaei	Susan	BH Pharmacist	CC Behavioral Health
Kearns	Helen	BH Chief of Operations	CC Behavioral Health
Leung	Jude	MH Program Manager	CC Behavioral Health
Lindsey	Tina	Community Support Worker	CC Behavioral Health
Loenicker	Gerold	MH Program Manager	CC Behavioral Health
Luburic	Renee	Psychiatrist	CC Behavioral Health
Luu	Matthew	Behavioral Health Deputy Director	CC Behavioral Health
Madruga	Christine	MH Program Supervisor	CC Behavioral Health
Marquez	Mercedes	Community Support Worker	CC Behavioral Health
Marsh	Sara	Director of Support Services	CC Interfaith Housing
Matal Sol	Fatima	AOD Chief	CC Behavioral Health
McGuire	Brandon	Community Support Worker	CC Behavioral Health
McNutt	Steve	AOD Program Manager	CC Behavioral Health
Mejia	Robert	MH Clinical Specialist	CC Behavioral Health
Messerer	Mark	AOD Program Manager	CC Behavioral Health
Nasrul	Kimberly	MH Program Supervisor	CC Behavioral Health
Nawy	Jena	MH Clinical Specialist	CC Behavioral Health
Neilson	Jersey	HS Planner/Evaluator	CC Behavioral Health

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Nobori	Michelle	MH Project Manager	CC Behavioral Health
Ny	Faye	HS Accountant	CCHS Finance
O'Neill	Robin	MH Program Manager	CC Behavioral Health
Orme	Betsy	MH Program Manager	CC Behavioral Health
Ornelas	Cecilia	Student Worker	CC Behavioral Health
Osterman	Lindsay		ANKA
Pedraza	Chris	AOD Program Manager	CC Behavioral Health
Pena	Jorge	Lead PSP/InSyst Support Analyst	CCHS Info Technology
Pengel	Machtel	MH Clinical Specialist	CC Behavioral Health
Pierce	Chad	MH Program Manager	CC Behavioral Health
Pittella	Rosanna	Contractor	CCHS Info Technology
Powers	Karen	MH Program Supervisor	CC Behavioral Health
Purefoy	Darcell	Contractor	CCHS Info Technology
Rahimzadeh	Ziba	MH Program Manager	CC Behavioral Health
Retaggliata	Lauren	Mental Health Commissioner	Mental Health Commission
Richardson	Michelle	AOD Program Manager	CC Behavioral Health
Sachs	Neil	Psychiatrist	CC Behavioral Health
Sanabria	Bernardita	MH Program Supervisor	CC Behavioral Health
Scannel	Marie	MH Program Manager	CC Behavioral Health
Seastrom	Trisha	AODS Program Manager	CC Behavioral Health

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Serwin	Barbara	Mental Health Commissioner	Mental Health Commission
Shah	Bhumil	Asst. IT Director, Analytics and Reporting	CCHS Info Technology
Shirgul	Ellen	MH Program Supervisor	CC Behavioral Health
Siliezar	Elizabeth	Community Support Worker	CC Behavioral Health
Spikes	Chet	Asst. HS IT Director	CCHS Info Technology
Stahl	Chris		Familia Unidas
Surio	Bles	UR Program Manager	CC Behavioral Health
Sweeten-Healy	Heather	MH Program Manager	CC Behavioral Health
Tarvins	Denise	MH Clinical Specialist	CC Behavioral Health
Taylor	Windy	MHSA Project Manager	CC Behavioral Health
Temeltas	Ates	Asst. IT Director of Clinical Services	CCHS Info Technology
Thigpen	Robert	MH Family Services Coordinator	CC Behavioral Health
Tuipulotu	Jennifer	Office for Consumer Empowerment Coordinator	CC Behavioral Health
Tupper	Stacey	MH Program Manager	CC Behavioral Health
Underwood	Kenneth	MH Clinical Specialist	CC Behavioral Health
Waters	Susan	Family Support Worker	CC Behavioral Health
Whalen	Jon	Psychiatrist	CC Behavioral Health
Whitehead	Crystal	Community Support Worker	CC Behavioral Health
Williams	Teri	HS Systems Analyst II	CCHS Info

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
			Technology
Wintermantel	Heidi	Manager	CC Child and Family Services

Attachment C—Approved Claims Source Data

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

Table C1 shows the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: Contra Costa MHP CY16 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	3,674,069	141,926	3.86%	$611,752,899	$4,310
Large	1,778,582	67,721	3.81%	$318,050,214	$4,696
Contra Costa	72,270	3,915	5.42%	$13,625,887	$3,480

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

Table C2: Contra Costa MHP CY16 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
< $20K	15,416	91.89%	94.05%	$49,037,854	$3,181	$3,612	43.54%	59.13%
>$20K - $30K	508	3.03%	2.83%	$12,460,011	$24,528	$24,282	11.06%	11.98%
>$30K	853	5.08%	3.12%	$51,137,801	$59,951	$53,215	45.40%	28.90%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Contra Costa	
PIP Title: Coaching to Wellness	
Start Date (MM/DD/YY): 12/2015 **Completion Date** (MM/DD/YY): March 2018 **Projected Study Period** (#of Months): 2+ years **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review** (MM/DD/YY): 2/6-8/18 **Name of Reviewer**: Rob Walton	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP has a significant number of consumers who are meds only and receive no other services. Because of the high likelihood of co-occurring physical health conditions in the mentally ill population (68%), it is very likely that many would benefit from assistance with health conditions. Psychiatrists confirmed	

this hypothesis but noted that less than 10% are active in the county health system, which if so would be visible in the county EHR.

The consumer perception survey of November 2015 yielded data on the consumer health perception, with 36% rating physical health as poor or fair, and 40% rated their mental health as poor or fair. Another supplemental questionnaire also yielded information that would support the need for assistance in obtaining physical health treatment.

The concept of the coaching to wellness was developed utilizing a wellness nurse and a peer wellness coach.

The intent was to improve wellness in three areas:

1. Improve consumer perception of their own wellness and wellbeing.
2. Increase healthy behaviors and decrease symptoms for consumers.
3. Increase cross-service collaboration among primary and mental health care staff.

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 ☐ Unable to Determine	This PIP Committee originally consisted of East County Adult specialty mental health clinic's Program Manager, Nurse Manager, Wellness Nurse, Wellness Coaches, and Office for Consumer Empowerment, Mental Health Services Act (MHSA) Innovation, and the Research and Evaluation Unit staff. The Committee has since expanded to include the Program Manager or Supervisor from the Central and West County Adult specialty mental health clinics.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP utilized a combination of health condition prevalence in the SMI population, consumer perception survey results, and additional survey information.

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
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Measuring vitals such as BMI, blood pressure, etc., linking consumers to primary care, and developing wellness supports such as groups, activities, and materials.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	• Ages 18+. • Receiving psychiatric-only services. • Diagnosed with a serious mental illness (but at a stage to engage in recovery). • Diagnosed with a cardiac, metabolic, respiratory chronic health risk condition and/or have weight issues. • Expressing an interest in the program. • With moderate to high composite score on mental health and medical levels of support needed. • The limiting factor is that individuals must be referred by the treating psychiatrist.
	Totals	**3** Met **1** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will implementation of a wellness program for consumers with comorbid health and mental health issues improve the recovery of 45% of consumers from pre to post program participation?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	See 1.4
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The limiting factor is created by the psychiatry referral approval requirement, which meant that many eligible consumers were did not have the required step completed. In addition, the staffing challenges with hiring and retaining wellness nurses created an inability to respond even if all eligible were referred.
	Totals	**1** Met **1** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* The indicators for Goal 1 (Improve consumer perception of their own wellness and wellbeing) are: • Self-Rated Health and Mental Health • Perceived Recovery • Functioning • Quality of Life The indicators for Goal 2 (Increase healthy behaviors and decrease symptoms for consumers) are: • # and % of consumer-identified goals related to wellness • # and % of wellness goals achieved • Attendance in meetings with Wellness Nurse, Coach, and Group activities • Physical Health Vital Signs and Labs • Level of Support • # appointments scheduled and attended • # of PES, hospitalization episodes The indicators for Goal 3 (Increase cross-service collaboration among primary and mental health care staff) are: • # staff participating in project from mental health, primary care, etc. • # and type of referrals and linkages. Additionally, the MHP distributed a consumer Satisfaction survey. • Satisfaction	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☐ Yes ☒ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

	Totals	**0** Met **0** Partially Met **0 N**ot Met **3** NA **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	See 4.1
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☒ Provider ☒ Other: Contact summary form; data system-- Primary care and mental health service utilization data are collected from the Epic electronic health record and PSP billing system and the methodology of entering appointment data are stable.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Evaluation of the program includes pre- and post-surveys that measure key indicators in areas such as: Perceived recovery, functioning, and quality of life. In addition, self-rated health and mental health are collected by the Wellness Coaches and Nurses at most individual contacts each visit and levels of support assessed and vitals taken by the Wellness Nurses as appropriate at each visit, with attendance and referrals made tracked on an ongoing basis. Satisfaction and achievement on self-identified wellness goals are recorded at post-program. Other indicators tracked in PSP and Epic systems include appointment attendance, PES, and in-patient hospitalization. Thus, most data are either consumer-reported or provider (i.e., Wellness Nurse and/or Coach) assessed, with some data downloaded from the data management systems.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* *Priscilla Olivas, Quality Management Program Coordinator*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Wellness Nurses and Coaches are responsible for data collection, and Research and Evaluation Unit staff are responsible for data entry, monitoring, and analyses.
	Totals	**6** Met **0** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* • *Wellness Coach provides individual intensive peer support (in coordination with Wellness Nurses), including individual and group education and training and linkages to the community* • *Wellness Nurse provides individual intensive nurse support (in coordination with Wellness Coaches), including individual and group education and training and linkages to the community* • *Provide Facing Up to Health groups* • *Provide WRAP groups* • *Track program phase (Engagement and Planning, Implementation, Transition and Maintenance, and Care Monitoring) participants are in currently.* • ***Begin to offer therapy -2018***	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met **0** Partially Met **0** Not Met **0** UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The data analysis was provided in detail and was collected this is contained in the narrative PIP Submission tool submitted by the MHP. As of the prior review, there were 12 participants and 7 graduates. As of this current review there were 34 participants and 18 graduates. Given the timeline and continued difficulty obtaining participants, and wellness nurse staffing issues, it would seem wise to continue the efforts and program for the duration of funding but move the clinical PIP focus to a topic with greater breadth of impact.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* Low numbers of participants and graduates. *Conclusions regarding the success of the interpretation:* Numbers are too small to generalize from but there is some success *Recommendations for follow-up:* Move into maintenance and identify a new clinical PIP topic	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP described continued limitations to this PIP which include: low referral rates, difficulties with sustaining wellness nurse positions.
	Totals	**2** Met **2** Partially Met **0** Not Met **0** NA **0** UTD

STEP 9: Assess Whether Improvement is "Real" Improvement

9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Primary care and mental health service utilization data are collected from the Epic electronic health record and PSP billing system and the methodology of entering appointment data have not change. Participants complete measures related to their wellness and wellbeing perceptions and program satisfaction, however, some participants are not always accommodating in completing. The coaching team completes forms related to the remaining indicators. As different staff complete the forms, regular training and discussion on the evaluation forms are held. Forms are reviewed by Research and Evaluation Unit staff who contacts team members as needed. A Program Manual was drafted that includes a section on documentation and forms were revisited in December 2016 to ensure they are collecting necessary and useful data. Data collection for the indicators themselves has not changed. A data analysis indicates satisfaction, but it is too early to assess improvement. Initial data indicates that there is improvement, it is largely anecdotal at this stage. For example, one graduate at pre-test had no desire to address his diabetes and at post-test he is regularly checking his blood sugar numbers and attending a diabetes group. Another graduate has attained treatment on his own for his health condition and is following up on treatment.

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Changes occurred but are far from the numbers required for significance to be determine. Even clinical significance is difficult with the small number of participants.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☒ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Numbers are too small for statistical analysis.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Insufficient number of participants present to perform this determination.
	Totals	**0** Met **1** Partially Met **4** Not Met **0** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: *The number of participants has remained relatively low, and insufficient to determine any statistical significance of the change. The results, thus far, appear to be positive. The MHP efforts to improve results have included consideration of the addition of a clinician for group and individual therapy. Another element, addition of a part-time Alumni Coach was started on 8/14/17.* *In that this PIP has been in place for several years and the results are generally positive, the MHP needs to move this project into maintenance mode and seek another clinical PIP topic. Looking forward to that topic, the MHP needs to examine clinical data to identify a target of efforts.*		
Recommendations: Wind up and conclude this PIP and look for another clinical topic.		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☒ Confidence in PIP results cannot be determined at this time	

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Contra Costa	
PIP Title: Improving MHP Timeliness	
Start Date (MM/DD/YY): 12/1/2017 **Completion Date** (MM/DD/YY): 12/31/2019 **Projected Study Period** (#of Months): 24 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 2/6-8/2018 **Name of Reviewer**: Rob Walton	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP is targeting the improvement of timeliness for both initial mental health and initial psychiatry access. Despite current aggregate data pointing to relatively brief initial access, there exists a great deal of variation between the clinics at the major population areas and age groups served. The MHP seeks to have 90% of offered appointments for initial mental health access within 10 business days. Currently, 79% meet that standard, with the breakdown by adults (86%) and children (61%) reflecting that variation.	

Completed first assessment visit statistics indicates 37% miss their first scheduled assessment.

The first offered psychiatric appointment standard is 80% in 15 business days, but in adults the data indicates a 44-day average, and children 67 business days. The MHP notes that the methodology used for psychiatric appointments deserves consideration.

The current assumption is that the all first contact with eligibles involves a psychiatry/medication evaluation request. While this assumption is likely accurate for adults, within children and youth that is often not the case. Commonly caregivers of children, as well as psychiatric practitioners want to see alternatives to medications utilized first. Therefore, at least with children and youth, there needs to be an alternative way to establishing the psychiatrist referral point in time, and tracking first offered appointment based on that point in time.

The PIP appears to be focused on the use of CSW/FSWs to provide early engagement, and telemedicine. Both interventions are described with insufficient detail to understand the nature and frequency they will be applied, which are important elements to be addressed.

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 ☐ Unable to Determine	The nature of consumer and family member participation is not clear in the write-up. However, inclusion of these stakeholders is mentioned, and credit is given for that breadth of involvement.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

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

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Initial access is a key element of services, and timeliness impacts both engagement and outcomes.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ East County	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP is interested in improving all timeliness in all regions, the initial focus is on the East County. In that region, actions will be first taken to focus on the adult and children's services and improving initial routine access and routine psychiatry initial access. The MHP's presentation breaks out initial access by children and adults but is somewhat unclear as to if it is seeking to improve psychiatry access for both populations or just one.
Totals		**4** Met **0** Partially Met **0** Not Met **0** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will implementing Direct Consumer Outreach improve timely access to mental health services so that the rate of consumers who miss their initial outpatient mental health appointment improves from 37% to 25%? Will implementing Tele-Psychiatry as a practice for conducting initial psychiatric appointments improve the rate of psychiatry appointments scheduled within 15 days of referral from 24% to 80%?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**1** Met **0** Partially Met **0** Not Met **0** UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	East County is the focus.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☒ Other: information from Cadence and other software elements	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* First Scheduled Outpatient Mental Health Missed Appointment Rate Business Days from Referral to First Completed Routine OP Appointment (mean) First Available Psychiatric Assessment Appointments Scheduled within 15 business days (rate) Business Days from Referral to First Scheduled Psychiatric Assessment Appointment (mean) New Consumers Contacted for Initial Appointment Engagement	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

	Totals	**0** Met **0** Partially Met **3** Not Applicable **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Cadence	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Fairly straightforward running of reports off Cadence.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The PIP just started and quarterly reports should be due in March or April.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	There are no provisions for problems. The plan appears straightforward.

6.6 Were qualified staff and personnel used to collect the data? *Project leader Priscilla Aguirre:*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**4** Met **0** Partially Met **2** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Direct Contact with New Consumers Tele-Psychiatry Implementation	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP needs to describe what constitutes direct contact with consumers, how often, what it is, what technique is used. These actions must be described in a manner that another MHP could faithfully replicate without any further input. Telepsychiatry intervention, same applies, how much, how often, how many. But this also begs the question about available resources, which currently do not exist and likely also be the focus of this PIP.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **4** NA **0** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **5** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: None		
Recommendations: See comments in each section		
Check one: NA	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	