Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

1340 Arnold Drive, Suite 200
Martinez, California 94553
Ph (925) 957-5140
Fax (925) 957-5156
ccmentalhealth.org/mhc

*The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.*

# QUALITY OF CARE Committee Meeting

**October 19, 2017 ♦ 3:15 pm-5pm**

**2425 Bisso Lane, in Concord**

**Second floor conference room**

## AGENDA

**I. Call to order/Introductions**

**II. Public comments**

**III. Commissioner's comments**

**IV. Chair announcements**

**V. APPROVE minutes from September 21, 2017 meeting**

**VI. DISCUSSION regarding an overview and Summary of Eternal Quality Review Organization (EQRO)- Priscilla Aguirre, MPP- Quality Management Program Coordinator**

**VII. DISCUSS updates from Psych Emergency Services (PES) with PES Program Chief, -Victor Montoya**

**VIII. DISCUSS and REVIEW the Quality of Care Committee's activities for 2017**

**IX. DISCUSS potential Committee goals for 2018 as follows:**

1. **Goals not completed or addressed in 2017**
2. **Potential new goals for 2018**

**X. Adjourn**

*In accordance with the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item may occur. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute time limit.*
*If special accommodations are required to attend any meeting, due to a disability, please contact the Executive Assistant of the Mental Health Commission, at: (925) 957-5140*

**Mental Health Commission**
**Quality of Care Committee Minutes**
**September 21, 2017- DRAFT**

| | Agenda Item / Discussion | Action / Follow-up |
|---|---|---|
| **I.** | **Call to Order / Introductions @3:28pm**<br><br>**Members Present**:<br>Chair- Barbara Serwin, District II<br>Gina Swirsding, District I<br>Meghan Cullen, District V<br><br>**Members Absent**: none<br><br>**Others Present**:<br>Margaret Netherby, NAMI member<br>Teresa Pasquini, NAMI member<br>Doug Dunn, District III<br>Lauren Retagliatta, District II<br>Victor Montoya, Program Chief for PES<br>Erika Raulston, *submitted application for MHC appointment<br>Leslie May *submitted application for MHC appointment<br>Jill Ray, Field Rep for District II Supervisor Andersen<br>Duane Chapman, District I<br>Adam Down, BHS Admin<br>Liza A. Molina-Huntley, Executive Assistant (EA) for MHC | **Executive Assistant:**<br>• **Transfer recording to computer.**<br>• **Update Committee attendance**<br>• **Update MHC Database** |
| **II.** | **Public Comment**<br>• None | |
| **III.** | **Commissioner Comments**<br>• None | |
| **IV.** | **Chair announcements/comments:**<br>• None | |
| **V.** | **APPROVE Minutes from July 20, 2017 meeting**<br>• **Gina Swirsding moved to motion to approve the minutes, without corrections, Meghan Cullen seconded the motion**<br>• **VOTE: 3-0-0**<br>• **YAYS: Gina, Meghan and Barbara**<br>• **NAYS: 0 ABSTAIN: 0 ABSENT: none** | • **Executive Assistant will correct the minutes, finalize and post the minutes on the Mental Health County website.** |
| **VI.** | **REVIEW and DISCUSS updates on the Family and Human Services committee meeting regarding the Grand Jury –Barbara Serwin**<br>• Chair informed that Duane Chapman, Barbara Serwin, Teresa Pasquini and Lauren Rettagliata are attending a series of meetings, with the Behavioral Health Division Director and staff, regarding the Grand Jury Report and other meetings regarding the White Paper. With respect to the Grand Jury, with Family and Health Services (FHS), Behavioral Health Services (BHS) is collaborating with the Mental Health Commission (MHC) mentioned representatives, to negotiate cooperative terms, moving forward, to achieve common ground. Behavioral Health Services has provided updates regarding recent changes that are in progress. The changes do explain, some of the differences, in regards to obtaining a greater understanding of the current status within the division's programs. Another meeting is scheduled, regarding the | • |

| Agenda Item / Discussion | Action / Follow-up |
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| Grand Jury Report with FHS, in October. The White Paper will be presented at the same meeting in October, with FHS. The expectation is that the MHC will work with the BHS Administration to update the White Paper and reflect mutual understanding of the status quo of the main issues identified in the document. The goal is to have all of the representation, from the MHC, BHS and PES, assuring that there is full representation. Focusing on the issues related to children and beyond. Various meetings are scheduled to meet with BHS and PES, to update the information and either the MHC agrees with BHS or not. MHC will try to maintain an objective viewpoint, in respect to BHS Administration's perspective. The MHC is unclear regarding the number of Psychiatrists, currently on staff, and expects further updates and clarification, to come from BHS Administration; including the name of the current Medical Director and the names of the Psychiatrists at each program. Behavioral Health will respond to all of the inquiries, from the Commission, accordingly in a comprehensive report, as agreed.<br>• Other participants, with family members in the mental health system, have been invited to participate in the process and will be involved in tracking progress<br>• The bulk of the attention has been on the children's system of care and will cover other areas as well. | |
| **VII. DISCUSS updates from Psych Emergency Services (PES) with PES Program Chief, Victor Montoya**<br>• Currently involved with hospital services, at Contra Costa Regional Medical Center (CCRMC), with PES, for the last two years; and was previously the Program Chief for Adults and Older Adults for 15 years, in Behavioral Health Services and has worked for other counties as well, in a variety of levels, including Alcohol and Other Drugs (AOD) Administrator.<br>• Focused on 4C and the operational structure of the inpatient unit, identifying gaps and working in Psych Emergency Services that runs 23 hours a day, seven days a week.<br>• Several months ago started working with the hospital Social Workers on the medical units with the goal to look at the consumers that are high users, across systems, rather than one system at a time.<br>• One of the opportunities and changes is the development of cross systems approaches. Identifying gaps and discovering how to increase communication and coordination across different departments and units.<br>• The subject matter is vast and will need to be carried out beyond several meetings. PES is not a single subject matter.<br>• A questionnaire was distributed, amongst consumers, to obtain information regarding their experiences with the services they received and to identify gaps and areas of need.<br>• PES is licensed for 18 beds; four beds are assigned for children and adolescents. There is a designated medical clearance room, a family room and interview rooms. There is a pod, where the clinicians and the doctor's work and a separate nurses station. There are two adult dorms, separated by gender, ages range from 18 years old to 74 years old.<br>• Regarding service, service delivery and intervention. Due to the large range of needs and services, a greater range of skills sets is required and different forms of approaches are required.<br>• Some individuals that use the services have different forms of insurance and are private pay, Kaiser, Blue Cross, Medi-Cal, VA, uninsured and Medi-Cal from outside counties and that process alone, can complicate the process for | ***Invite PES for the next meeting** |

| Agenda Item / Discussion | Action / Follow-up |
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| providing services<br>• There are various forms of treatment, not just stabilization, engagement in discharge planning; if the person is homeless then other considerations need to be addressed. Insurance can dictate discharge planning. Establishing relationships with providers on going care is crucial for ongoing care and placements can be difficult in coordinating planning.<br>• Teams of Social Workers try to do coordination of families, of care, of placement, providers and helping individuals hopefully find the skill set to reduce recidivism, by providing better placements and care.<br>• The goal is to provide better discharge planning, with the patient, to obtain better treatments and outcomes.<br>• The population, coming into PES, has changed dramatically in the last five years; 60% to 65% of the utilization was open to the county and the remaining amount was either privately insured or not open. Now, the population being received at PES has reversed roles.<br>• PES is most recently working with Health, Home and Homelessness (H3) to obtain shelter placement upon discharge, taking a more multidisciplinary approach to care<br>• The Medi-Cal, limiting 23 hour constraint, makes providing adequate care and placements difficult, the search for placement begins upon admission<br>• Over 10,000 individuals are being seen, per year, at PES.<br>• PES is doing a better job at treatment planning at the beginning and working more efficiently, moving consumers into appropriate placement faster due to proactive planning, the stay time has reduced to 12 to 13 hours, on average. Working cooperatively with H3 and discharging into the hospital, not leaving consumers out on the streets, are all actions that are helping services and care.<br>• PES is looking into creating changes to the vestibule, to improve it and make it more inviting and conducive for waiting families. Currently, PES shares the entrance with incoming ambulances, minimum space and no seating area<br>• A performance improvement project was done, with the aid of Vicky White, to identify needs better and improve operations<br>• The Program Chief of Children's and Adolescents, Vern Wallace, hired a new clinician for children and adolescents, full time, which has helped a lot with the challenges. Most children admitted are between 10 years old to 17 years old. The current location for children, under 18, requires more effort to obtain placement after discharge. A lot of family work/therapy is done initially.<br>• Children have multiple pair systems; if the child has insurance through Kaiser, then Kaiser will take responsibility regarding placement. PES cannot do placement planning with Kaiser insured patients. A lot of children are from out of county and due to the changes in legislation; many group homes have closed, or are in the process of closing and have to go into Foster Family Agencies. Level 14 is the highest level of group homes for children with extreme need of care, are closing rapidly.<br>• There has been an increase in children coming from outside the county, which provides additional challenges. If the incoming, out of county children, do not have what is known as a JV220, which is defines and awards responsibility to provide psychotropic medications. A court order must be obtained and a physician declaration also is required, which is sent to a judge for signature (JV220) in order for the county to administer the medications needed for an underage patients. The process is very challenging.<br>• In the Children's Unit, once the 23 hours have been expired, there is not a | |

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| reimbursement of costs is received for the County services provided or for staffing. The County must absorb all costs and staff requirements are more stringent for children.<br>• There is consideration, towards proposing a separate, protected, pace for children and adolescents that will have to be both cost effective, within the premises and with minimal initial investment.<br>• PES is a different certification than an inpatient unit and by regulation; Medi-Cal pays for both children and adults, up to 23 hours. It affects children more due to the small current unit. Children treatment is a priority. Children that are coming in, that do not need acute care, but need extended period of time waiting for the group home to become available. PES allows the child to remain, until the child can be placed, which is difficult, due to the closing of group homes. The hoped outcome is to strive towards wrap around care.<br>• The process is in a conceptual phase, at the moment, analyzing where the ideal areas are, with the least amount of potential startup costs that does not affect or disrupt the flow of the hospitals services. Finding funding streams is part of the process as well. The next step is defining the space, creating a cost analysis, funding streams, develop a formal proposal with architectural drawings, staffing, everything will need to be in accordance to safety, fire and building codes<br>• Attendees agreed that PES is not an appropriate unit for children<br>• Attendee asked if there is aggregate data available regarding PES that is broken down.<br>• Recently, a Quality Assurance data staff has been hired to start the task of creating data that captures more current information. More information will become available in the future. There are some limitations that will be improving in the near future. | |
| **VIII. DISCUSS Contra Costa County Regional Medical Center's programs for consumer advocacy, grievance resolution and empowerment**<br>. | ***invite Quality Assurance rep, from CCRMC, to discuss process-** |
| **IX. Adjourned at 4:58 pm** | |



Submitted by
Liza Molina-Huntley
ASA II- Executive Assistant for MHC
CCHS- Behavioral Health Administration

# FY16-17

## Medi-Cal Specialty Mental Health

# External Quality Review

# MHP Final Report

## *Contra Costa*

***Conducted on***

*January 31- February 2, 2017*

Prepared by:

Behavioral Health Concepts, Inc.

5901 Christie Avenue, Suite 502

Emeryville, CA 94608

www.caleqro.com

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# CONTRA COSTA MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—13,223
- MHP Threshold Language(s)—English, Spanish
- MHP Size—Large
- MHP Region—Bay Area
- MHP Location—Martinez
- MHP County Seat—Martinez

**Introduction**

Contra Costa County Mental Health Plan is a large Bay Area Mental Health Plan (MHP). The county seat is Martinez. The Contra Costa County Behavioral Health Services Division combines what was formerly the Mental Health and Substance Use Disorder programs into a single system of care that supports independence, hope, and healthy lives by making services more accessible.

The MHP has moved forward to more fully implementing integrated behavioral health services. The overarching model is contained in its five-year Strategic Plan and guides the care delivery transformation from 2017-2022. The Plan is anchored in its philosophy of "Any Door is the Right Door" so that consumers have entry where they are when they are in need. This is supported by a framework of strategies, actions and measures that will propel action for its key priorities, including Comprehensive Coordinated Care, Treatment, Housing and Supports, Data Systems and Evaluation, and Division Operations and Infrastructure. The intended outcome is a system of care that is welcoming, recovery and resiliency oriented, culturally-capable, accessible, continuous and comprehensive, all to promote physical, social and emotional wellness and well-being.

**Access**

The MHP operates its clinics regionally based in three primary areas of the East, West and Central parts of the county. This affords consumers access near their residence and in familiar regions. The clinics operate uniquely offering individualized treatment yet varying protocols for cross-regional referrals and may unintentionally impact access.

The MHP has continued its work with clinical and county IT staff, to appropriately configure and implement improvements to the centralized Access Line via its TAPESTRY Consumer Relations Management (CRM), acuity screening, and provider modules. This functionality should provide benefits to the ACCESS team as well as remediate some timeliness tracking issues to provide enhanced functionality for service metrics.

**Timeliness**

The MHP created new reports and improved existing reports including going live with Tapestry and Cadence, thus increasing the MHP's reporting capability for timely appointment data collection.

Reports through Tapestry for timely access to care and first offered appointment are captured with increased fidelity. Dashboards are now being created.

The MHP continues to experience significant barriers to hiring enough medical staff to fulfill its need to provide timely access to psychiatric service. Simultaneous hiring and subsequent staff departures prevent the MHP from a full complement of staff. The MHP does not fully engage in the use of telepsychiatry to alleviate the wait times to see a psychiatrist.

**Quality**

The MHP shared its five-year strategic plan and includes integrated health service delivery with public health, substance use, primary care and mental health services. It has begun to engage more broadly with its initiatives in this arena, thus multiplying the benefits for consumer care.

The ambitious goals it has set will require dovetailing the filling staffing resources to meet them. Conjointly, a succession plan to address future vacancies due to staff retirements and departures would be advantageous.

**Outcomes**

The MHP continues to embrace its peer consumer employees and offers them full benefits. Consumers report assignments are meaningful and they continue to feel valued. The Office for Consumer Empowerment (OCE) promotes wellness and employees peer consumers and provides consumer education. The MHP utilizes a peer certificated model with its continued use of the SPIRIT training program via the community college.

The MHP created a Welcome Handbook to disperse information system-wide for consumers, with surveys for consumers to provide feedback. It will be distributed in the coming year.

The MHP has engaged in data collection to analyze and identify underserved populations within its beneficiary population for targeted treatment and better outcomes.

# INTRODUCTION

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

The State of California Department of Health Care Services (DHCS) contracts with 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 FY16-17 findings of an EQR of the Contra Costa MHP by the California EQRO (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

## (1) VALIDATING PERFORMANCE MEASURES[1]

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

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

[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) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

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

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

## (4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

- Changes, progress, or milestones in the MHP's approach to performance management emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders serves to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

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

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

# PRIOR YEAR REVIEW FINDINGS, FY15-16

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

## STATUS OF FY15-16 REVIEW RECOMMENDATIONS

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

### Assignment of Ratings

- Fully addressed is assigned when the identified issue has been resolved:
  - resolved the identified issue
- Partially addressed is assigned when the MHP has either:
  - made clear plans, and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

### Key Recommendations from FY15-16

- Recommendation #1: Engage in a stakeholder process to select an Electronic Health Records (EHR) system. Include subject matter expert stakeholders from the MHP management and clinical programs, quality improvement, fiscal and billing, and information technology to identify and prioritize functional requirements. Assign sufficient staff resources to complete functional requirements, EHR selection, and contract negotiations timely

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP established a stakeholder group and included Behavioral Health administration, Contra Costa Health Services (CCHS), and Health Information Technology (IT) representatives to select an Electronic Health Record (EHR) and replacement for the existing practice management software.
  - The customized Epic EHR (ccLink) currently utilized by CCHS ambulatory care was selected for Behavioral Health and Echo ShareCare was selected to replace the existing practice management system.

- Two Project Managers have been hired, one to lead the EHR ccLink clinical documentation implementation and the other to lead the Share Care implementation.
- A project plan for the EHR implementation has been completed and steering committees are being established.
- Initial components of the EHR including e-prescribing and lab ordering and results have been implemented.
- Epic's Tapestry Customer Relationship Management (CRM) module (supporting referrals, practice management and call center documentation) was implemented in the Access Line/Care Management Unit in 2016 and will be expanded to contract providers in the coming year.
- Epic Cadence, the scheduling module, was implemented in County clinics in January 2017.
- External stakeholders such as contract providers will be part of phase 2 of the ccLink clinical documentation and Share Care implementations.

- Recommendation #2: Engage in a stakeholder process with the MHP contract provider agencies which have operational EHR system. Research what other MHPs have implemented for data interoperability solutions. Implement electronic data interchange (EDI) standards for the exchange of healthcare data between systems.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has completed a survey of EHR and billing systems utilized by the organizational providers.
  - The MHP has indicated that a provider portal will be implemented in the new EHR, but its requirements have not been determined.
  - Although the MHP indicates that electronic interoperability with contract providers is an important goal, no stakeholder process has been planned.

- Recommendation #3: Investigate the feasibility to expand tele-psychiatry service system-wide to support staffing gaps, expedite screening, provide targeted expertise (e.g. Spanish speaking child psychiatry) and decrease time to service.

  ☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - The MHP has been conducting a pilot project using Health Care Interpreter Network (HCIN) equipment to provide consultations to primary care physicians.
  - Although there is a shortage of psychiatrists at many of the MHP operated programs, there is no plan to utilize the HCIN equipment to provide additional coverage or utilize outside practitioners.
  - Early consultations have been by telephone and will continue in the short-term while the Division focuses on hiring additional psychiatrists.

- Recommendation #4: Review and analyze high cost beneficiaries' service patterns as both percentages of consumer counts and billed Medi-Cal services are significantly higher than statewide experience. Implement strategies to create step-down program or alternative services for these beneficiaries where and when appropriate.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - A High Cost Beneficiary (HCB) Work Group with a broad representation of managers and evaluators was launched in May 2016 with monthly meetings.
  - The HCB Work Group reviewed interventions and best practices related to cost and quality management, including some examples of performance improvement projects or other strategies related to cost management, capacity management, step-down capacity expansion.
  - The HCB workgroup analyzed a small group of "Super High Cost Beneficiaries" (SHCBs) using $112,000 or more in total costs (as measured by charges) in calendar year 2015. The team also explored the potential for an EPIC EHR module called Treatment Intervention Plan (TIP) to be used in tracking frequent utilizers of Psychiatric Emergency Services (PES).
  - Another group, the Coordinated Levels of Care (CLOC), worked on mapping community services according to level of care and referral processes.
  - More analysis and work is expected regarding step-down capacity, barriers and facilitators to step-down referrals, and partnership with Full Service Partnership (FSP) programs to manage complex care needs.
  - A critical topic in all this work is addressing the need for additional step-down services for those in recovery with ongoing mental health, substance abuse, physical and/or psychosocial needs.

- Recommendation #5: Create a welcome packet for consumers with system navigation information; consider rosters of community resources, the mental health newsletter and how to access the Behavioral Health website.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - A Welcoming Environments Workgroup was proposed at the March 2016 Quality Management Committee meeting with the first task of creating a Welcoming Handbook. Workgroup members include the Family Services Coordinators, Clerical Coordinator, as well as staff members from MHSA, Research & Evaluation, and the Office for Consumer Empowerment (OCE).
  - The table of contents was vetted with the Quality Management Committee and subsequently the Welcome Handbook content was reviewed with clinical program managers and the MHP's executive team.
  - The Welcome Handbook will be piloted for six months and consumers will have the opportunity to provide feedback via a feedback form or a focus group.

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

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

- Access to Care
  - Substance Use Disorder (SUD) Medi-Cal Waiver planning is underway.
  - California Child Welfare Continuum of Care Reform (CCR) planning will be modeled after the Katie A. implementation based on collaboration.
  - A new named Division of Health, Housing, and Homeless Services was created at the county level.
  - A Welcome packet has been developed and is being phased in by the MHP.
- Timeliness of Services
  - The MHP is capturing electronic timeliness data with the Epic Tapestry/CRM Launch for Access Line.
  - Epic system e-Prescribing has been utilized across the system to address timely medications support.
- Quality of Care
  - Development is underway of a five-year Strategic Planning for Integrated Behavioral Health Services.
  - Implementation is underway for Family Based Therapy for Eating Disorders (DBT for ED). Extensive planning efforts to implement Cognitive Behavioral Social Skills Training (CBSST) and expand evidence based practices in the adult system of care.
  - Mobile Crisis Response is being strengthened system-wide.
  - The implementation of Epic Cadence appointment system module will allow for greater consistency and a one system approach to calendaring appointments across clinics.
  - The e-Prescribing (e-Rx) implementation across County programs and clinics is an important change in the MHP.
- Consumer Outcomes
  - There is expanded involvement of peers in Behavioral Health Services including the new Commute Navigation Specialist position.

- The MHP is focusing on enhancing welcoming environments with the creation of the Welcome Handbook.
- The newly formed Evidence Based Practices (EBPs) and Outcomes Workgroup is strengthening EBPs currently in the system of care and selected two new EBPs to implement in the adult system of care and is piloting a few outcomes measures such as the PHQ-9, GAD-7. In addition the workgroup developed a short list of specific validated tools to measure client outcomes and will select one to pilot based on adopted EBPs. Additionally, the EHR will support data management to demonstrate individual and population outcomes.

# PERFORMANCE MEASUREMENT

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

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

## TOTAL BENEFICIARIES SERVED

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

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

| Race/Ethnicity | Average Monthly Unduplicated Medi-Cal Enrollees* | % Enrollees | Unduplicated Annual Count of Beneficiaries Served | % Served |
|---|---|---|---|---|
| **White** | 38,500 | 18.45% | 3,878 | 29.33% |
| **Hispanic** | 76,184 | 36.52% | 3,230 | 24.43% |
| **African-American** | 33,623 | 16.12% | 3,131 | 23.68% |
| **Asian/Pacific Islander** | 28,137 | 13.49% | 866 | 6.55% |
| **Native American** | 557 | 0.27% | 55 | 0.42% |
| **Other** | 31,622 | 15.16% | 2,063 | 15.60% |
| **Total** | 208,621 | 100% | 13,223 | 100% |

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

***The actual counts are suppressed for cells containing n ≤11.***

## 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.

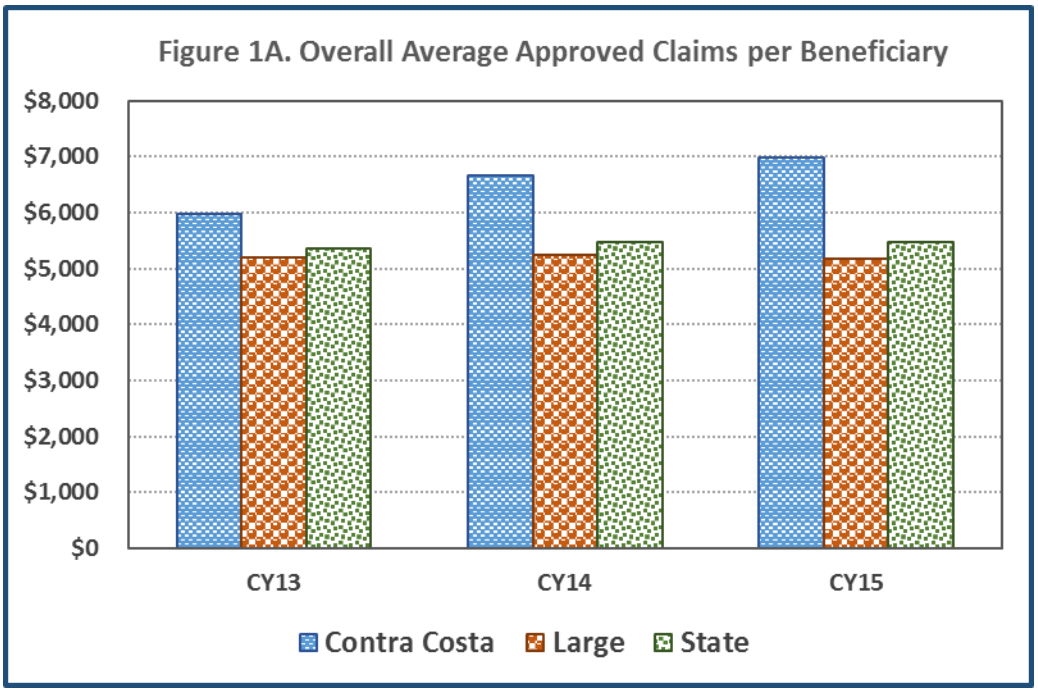
Regarding calculation of penetration rates, the Contra Costa MHP:

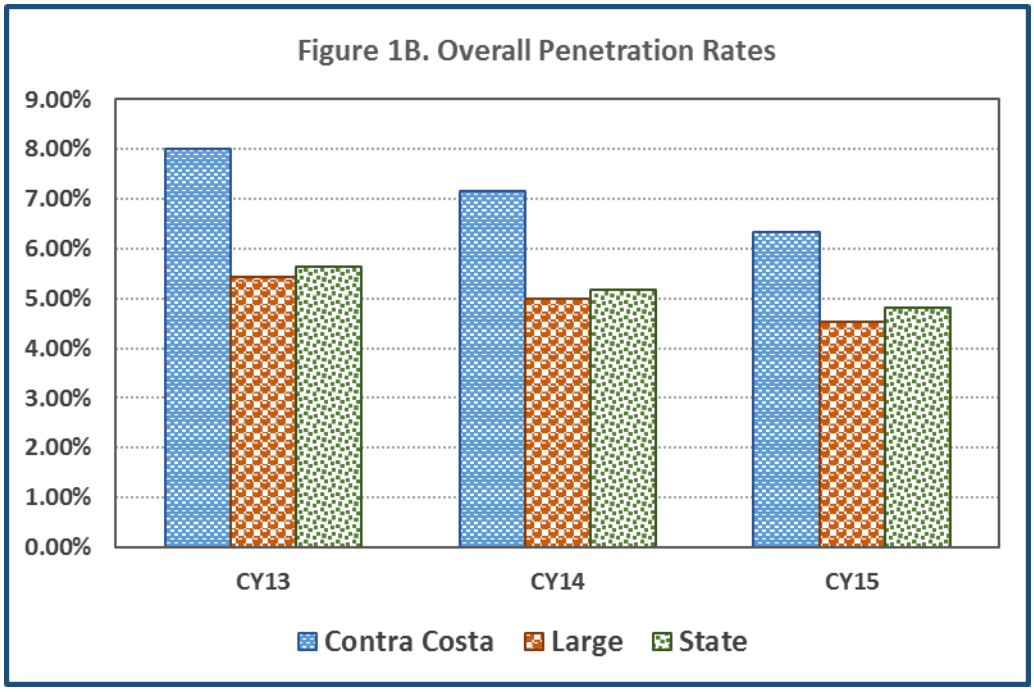
☒ Uses the same method as used by the EQRO.

☐ Uses a different method.

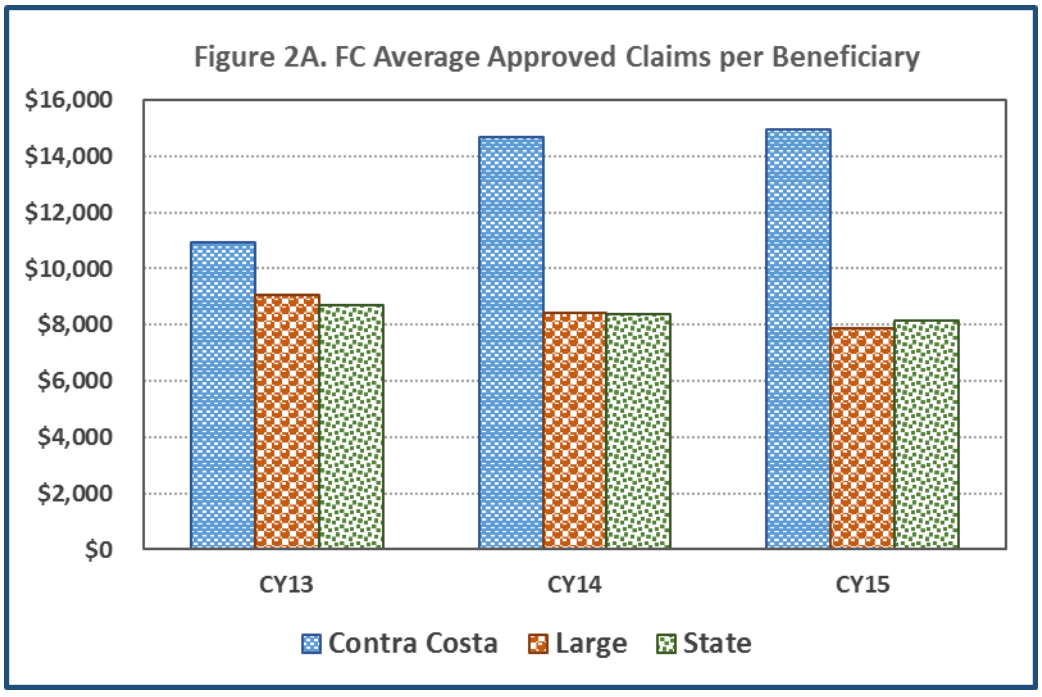
☐ Does not calculate its penetration rate.

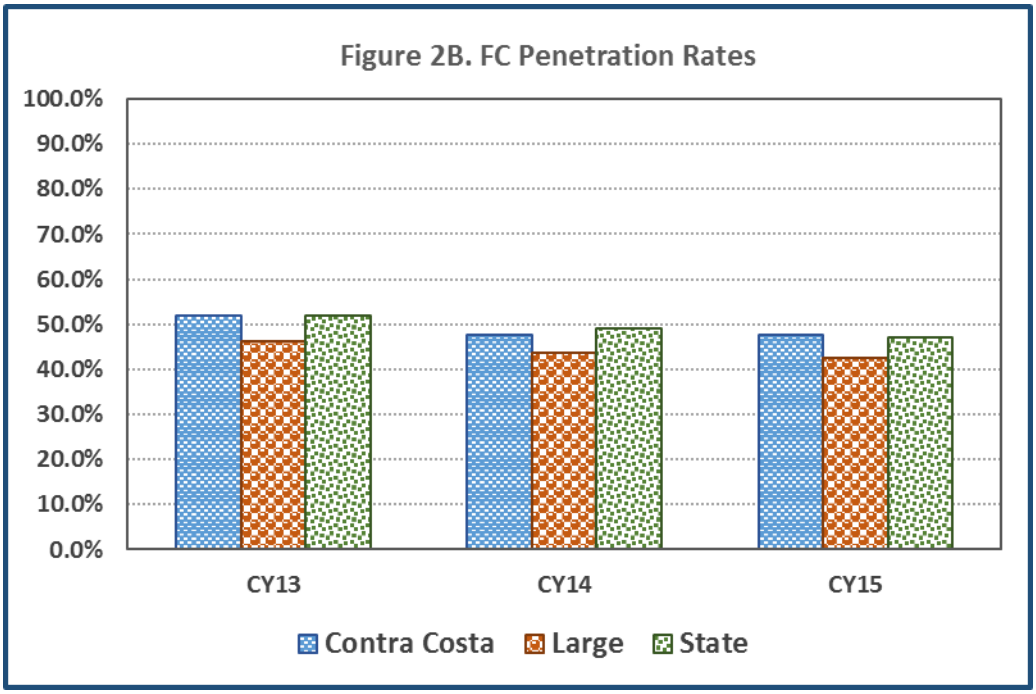
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



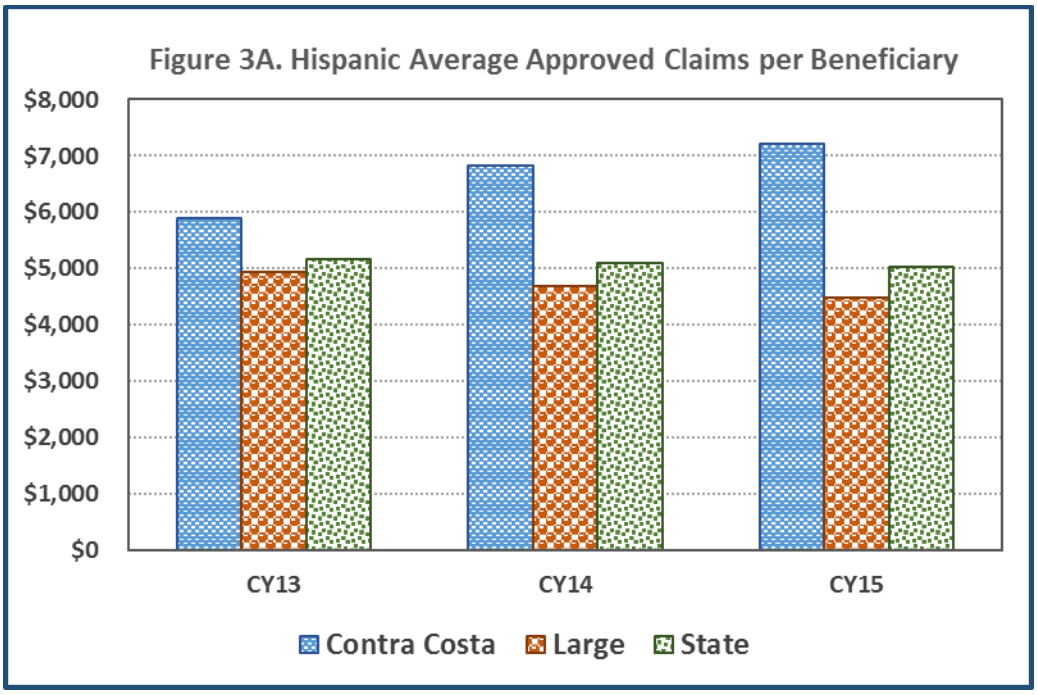


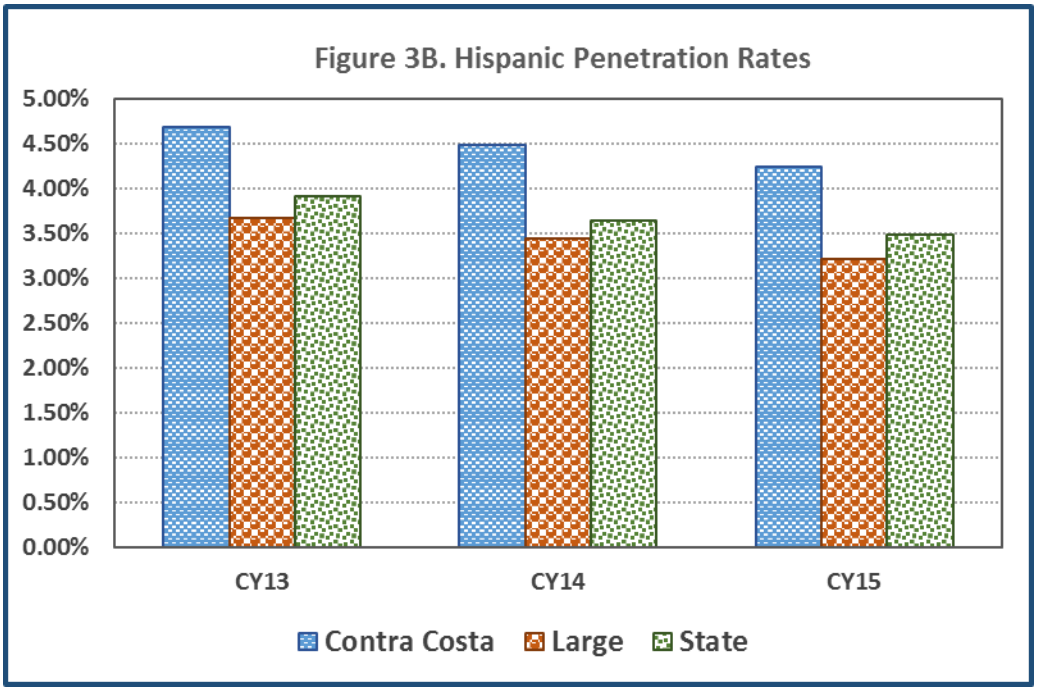

Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.






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






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

## HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than $30,000 in a year.

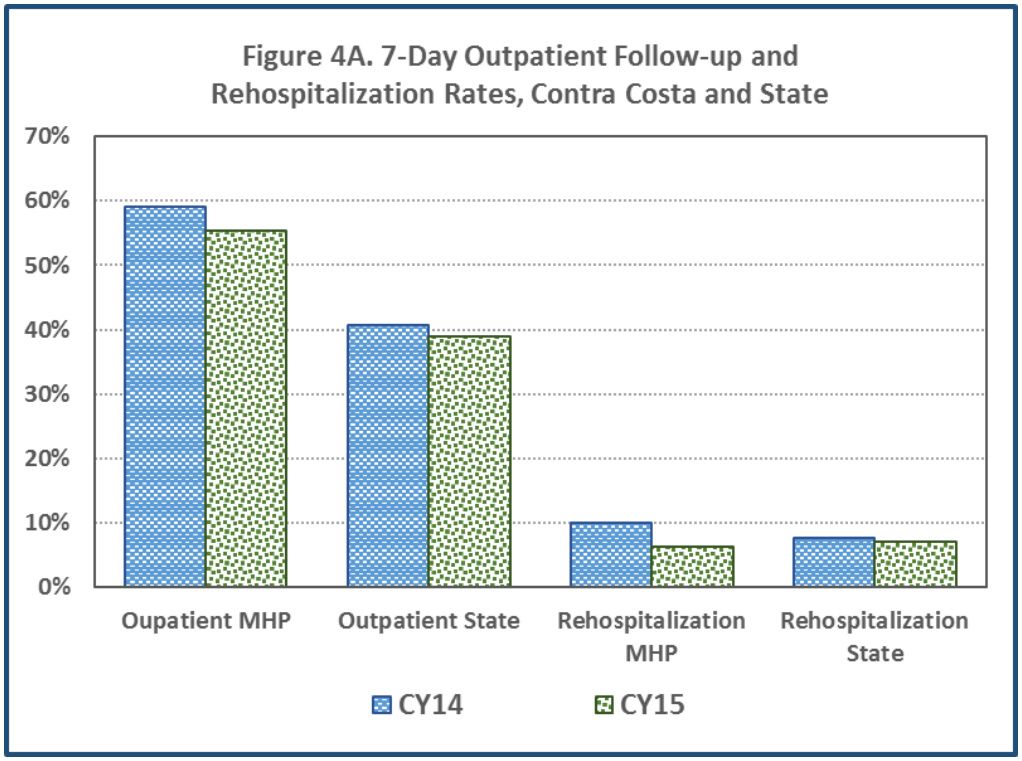
**Table 2—High-Cost Beneficiaries**

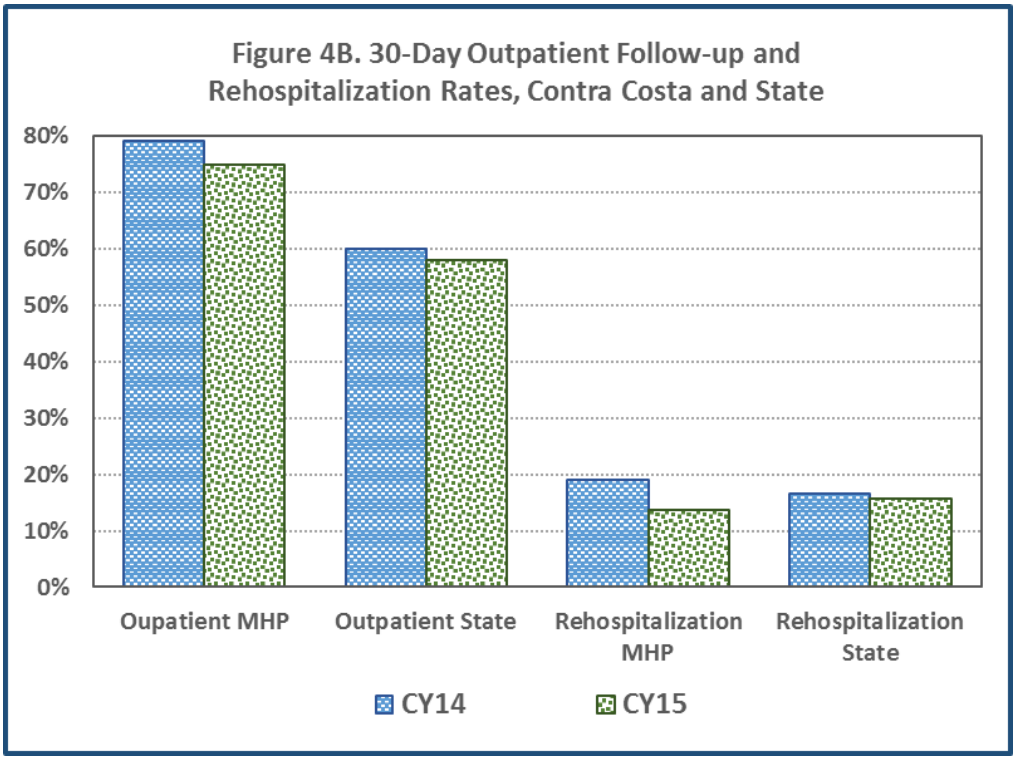
| MHP | Year | HCB Count | Total Beneficiary Count | HCB % by Count | Average Approved Claims per HCB | HCB Total Claims | HCB % by Approved Claims |
|---|---|---|---|---|---|---|---|
| Statewide | CY15 | 13,851 | 483,793 | 2.86% | $51,635 | $715,196,184 | 26.96% |
| Contra Costa | CY15 | 701 | 13,222 | 5.30% | $56,090 | $39,319,388 | 42.61% |
| | CY14 | 660 | 13,772 | 4.79% | $54,866 | $36,211,807 | 40.89% |
| | CY13 | 556 | 13,170 | 4.22% | $54,069 | $30,062,163 | 38.17% |

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 CY14 and CY15.



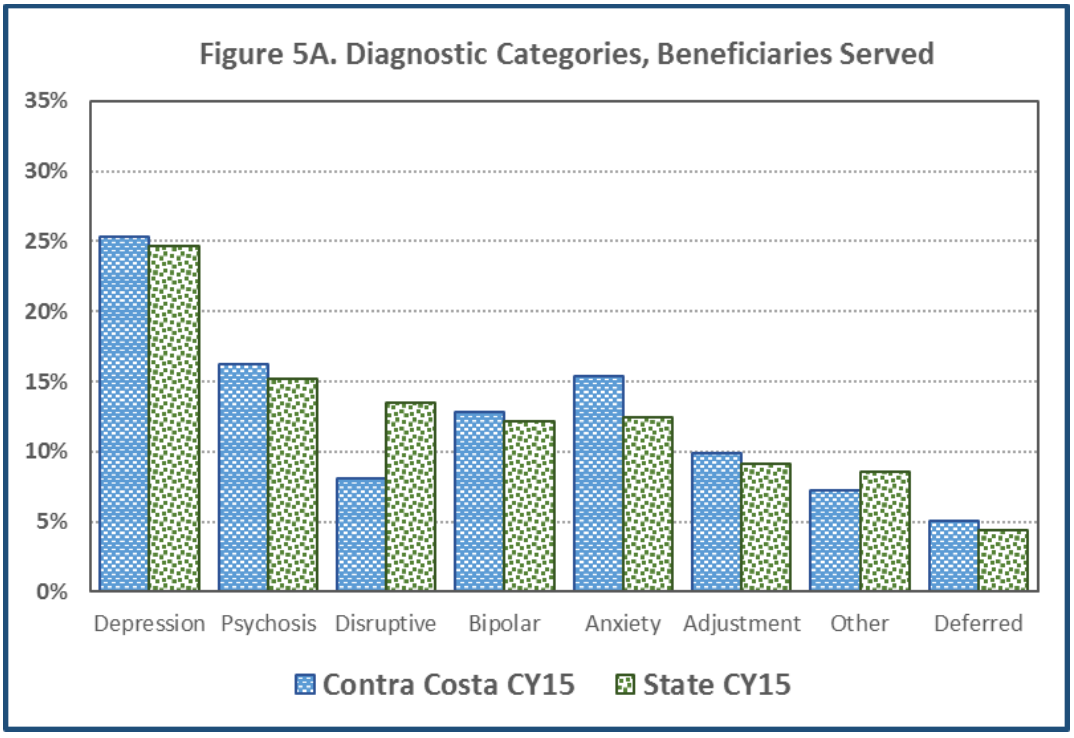



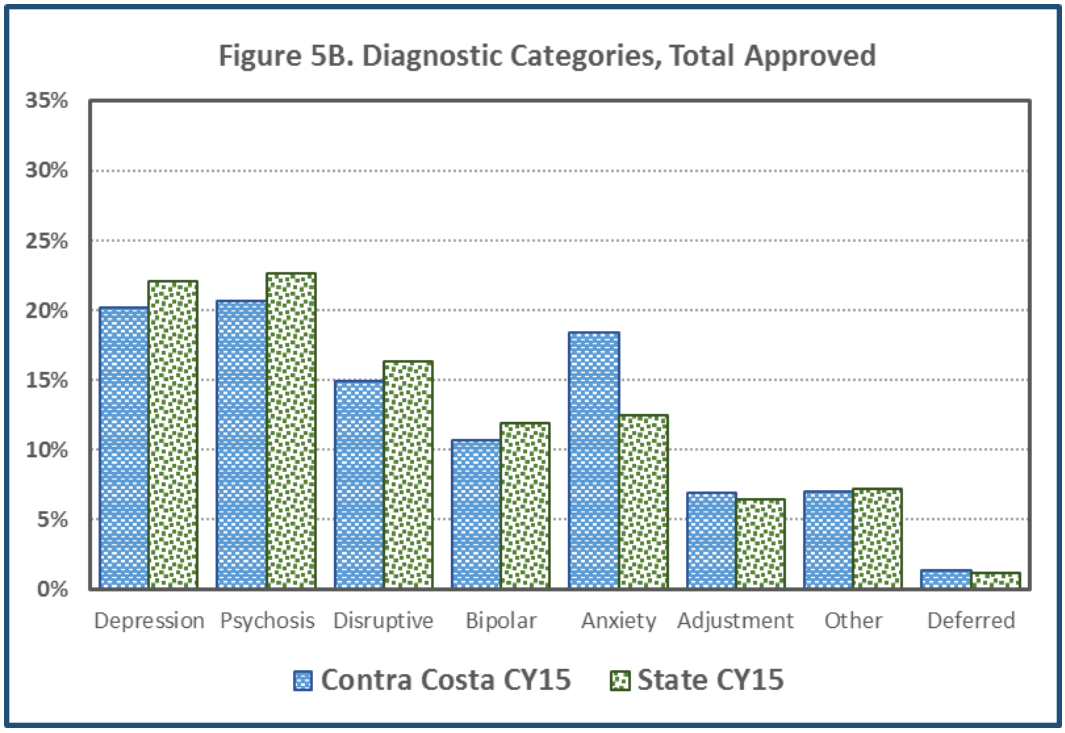
## DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY15.

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

| 20 % |
|---|



## PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The total unduplicated Medi-Cal eligibles increased from 226,650 in CY14 to 249,855 in CY15 while the total number of beneficiaries served decreased from 13,786 to 13,223. This resulted in a decrease in the overall penetration rate from 7.15% in CY14 to 6.34% in CY15, but remains above the statewide average of 4.82% and the 4.52% average for similar sized MHPs.
  - The MHP's Affordable Care Act (ACA) average monthly number of eligibles for CY15 total was 62,334 and the beneficiaries served was 3,828, resulting in a penetration rate of 6.14% for this sub-group (see Table C1 in Appendix C).
  - When combining the Medi-Cal and ACA data, the MHP's CY15 average monthly eligibles increased to 270,965 with 17,051 beneficiaries served during the period.
  - The penetration rate for Hispanics of 4.24% remains above the statewide average of 3.49% and the 3.22% average for similar sized MHPs.
  - The 47.55% penetration rate for foster care youth is above the 47.19% statewide average and 42.62% for large MHPs.
  - The MHP average claim rates per beneficiary served remains above the statewide and similar sized averages for overall, Hispanic and foster care measures.
- Timeliness of Services
  - The CY15 post hospitalization outpatient follow-up rate decreased from 59% for CY14 to 55% for CY15 at 7-days and 79% to 75% at the 30-day mark. The MHP rates were above the statewide average for both measures.
  - The MHP 7-day rehospitalization rate decreased from 10% for CY14 to 6% for CY15. The CY15 rate was similar to the 7% statewide average.
  - The MHP 30-day rehospitalization rate decreased from 19% for CY14 to 14% for CY15 compared to statewide averages of 17% for CY14 and 16% for CY15.
- Quality of Care
  - High cost beneficiaries, receiving more than $30,000 in services, accounted for 5.3% of beneficiaries served compared to a statewide average of 2.86%. This group accounted for 42.61% of approved claims. The MHP reports a significant number of hospital administrative days for the highest cost users that aged 20 and younger. It was suggested that this occurs when waiting for a suitable alternative placement.
  - Diagnostic categories by percent of beneficiaries served were close to the statewide averages except for Disruptive and Psychosis diagnoses (lower than

the statewide average) and Anxiety diagnoses (higher than the statewide average).

- Consumer Outcomes
  - No measures were presented.

# PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2015.

## 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—PIPs Submitted**

| PIPs for Validation | # of PIPs | PIP Titles |
|---|---|---|
| Clinical PIP | 1 | Coaching to Wellness |
| Non-Clinical PIP | 1 | Improving Outpatient Appointment Adherence |

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

**Table 4—PIP Validation Review**

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

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

| Table 4—PIP Validation Review | | | | | |
|---|---|---|---|---|---|
| Step | PIP Section | Validation Item | | Item Rating* | |
| | | | | Clinical PIP | Non-Clinical PIP |
| 3 | Study Population | 3.1 | Clear definition of study population | M | M |
| | | 3.2 | Inclusion of the entire study population | M | PM |
| 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 | PM |
| 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 | PM |
| | | 6.3 | Systematic collection of reliable and valid data for the study population | M | PM |
| | | 6.4 | Plan for consistent and accurate data collection | M | NM |
| | | 6.5 | Prospective data analysis plan including contingencies | M | PM |
| | | 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 | PM | NA |
| | | 8.2 | PIP results and findings presented clearly and accurately | M | NA |
| | | 8.3 | Threats to comparability, internal and external validity | NM | 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 | NA | NA |

| Table 4—PIP Validation Review | | | | | |
|---|---|---|---|---|---|
| Step | PIP Section | Validation Item | | Item Rating* | |
| | | | | Clinical PIP | Non-Clinical PIP |
| | | 9.3 | Improvement in performance linked to the PIP | NA | NA |
| | | 9.4 | Statistical evidence of true improvement | NA | NA |
| | | 9.5 | Sustained improvement demonstrated through repeated measures. | NA | NA |

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine; NR = Not Rated (Concept Only or None Submitted)*

Table 5 gives the overall rating for each PIP, based on the ratings given to the validation items.

| Table 5—PIP Validation Review Summary | | |
|---|---|---|
| Summary Totals for PIP Validation | Clinical PIP | Non-Clinical PIP |
| Number Met | 17 | 9 |
| Number Partially Met | 3 | 6 |
| Number Not Met | 1 | 1 |
| Number Applicable (AP)<br>(Maximum = **28** with Sampling; **25** without Sampling) | 21 | 16 |
| Overall PIP Rating ((#Met*2) + (#Partially Met))/(AP*2) | 88% | 75% |

## 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 consumers?"
- Date PIP began: August 2015
- Status of PIP:

  ☒ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year *(Not Rated)*

☐ Concept only, not yet active *(Not Rated)*

☐ Submission determined not to be a PIP *(Not Rated)*

☐ No PIP submitted *(Not Rated)*

Coaching to Wellness is a Performance Improvement Project (PIP) and an MHSA Innovation Project implemented by the MHP and submitted for the second year of this project. The Coaching to Wellness program provides an additional level of support for adult mental health consumers with certain chronic health conditions through intensive peer and nurse support.

Coaching to Wellness is a wellness program with a strong peer provider component in the role of the Wellness Coach. Peers have a unique set of attributes that help form a therapeutic relationship, such as instilling hope that recovery is possible, role-modeling self-management skills, and empathy (Davidson, Bellamy, Guy, & Miller, 2012). Peer support programs have been linked to improvements in several areas, including decreased hospitalizations (Canady, 2011; Sledge, Lawless, Sells, Wieland, O'Connell, & Davidson, 2011), reduction in mental health symptoms (Chapin, Sergeant, Landry, Leedahl, Rachlin, Koenig, & Graham, 2013; Cook et al., 2012), and improved quality of life (Chapin et al., 2013).

Contra Costa County for many years had peer providers located at each of the adult clinics to work with consumers as referred by psychiatrists and case managers. The Coaching to Wellness pilot adds a more systemic and structured role for the Wellness Coach peer providers. The pilot also introduced a new health component to the adult clinics. The Wellness Coaches work closely with the current Wellness Nurse who provide comprehensive nursing services including measuring vitals such as BMI, blood pressure, etc., at each contact, linking consumers to primary care, and developing wellness supports such as groups, activities, and materials. These efforts should result in greater coordination between the delivery systems.

With components from intensive peer support models, coupled with leveraging existing resources within the County, the Coaching to Wellness program provides a holistic team approach to providing care to its consumers.

The goals of the Coaching to Wellness program are to:

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

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.

These four indicators were selected because improvement in participants' self-reports of their health and mental health, perceived recovery, functioning, and quality of life indicate consumer-rated improvement in mental health and functional status. The MHP is committed to ensuring that consumers' perceptions are accounted.

The indicators for Goal 2 (Increase healthy behaviors and decrease symptoms for consumers) are:

- Number and percentage of consumer-identified goals related to wellness
- Number and percentage of wellness goals achieved
- Attendance in meetings with Wellness Nurse, Coach, and Group activities
- Physical Health Vital Signs and Labs
- Level of Support
- Number of appointments scheduled and attended
- Number of PES, hospitalization episodes.

These seven indicators were selected because they directly related to activities of the Wellness Nurse and Coach.

The indicators for Goal 3 (Increase cross-service collaboration among primary and mental health care staff) are:

- Number of staff participating in project from mental health, primary care, etc.
- Number and type of referrals and linkages.

These two indicators were selected to measure and encourage greater collaboration between primary and mental health care. These indicators reflect an initial stage of collaboration and are used to help assess the care consumers are receiving.

In addition, beneficiary surveys measure consumer feedback regarding satisfaction with the pilot.

The pilot program began in December 2015 at the East County specialty mental health clinic in Pittsburg, serving adult mental health consumers with cardiac, respiratory, metabolic or weight condition. In June 2016, the MHP expanded its services to the Central County Adult Mental Health Clinic in Concord. Later it expanded to the West County Adult Mental Health Clinic in San Pablo, with all three regions now participating.

Consumers work with peer coaches and nurses to access resources and to develop wellness plans that improve overall health and wellbeing, including work to minimize side effects of psychotropic medications.

Program activities include health and skill-building education, referrals to community resources, assistance in obtaining and advocating for mental health and medical care, and wellness groups including Wellness Recovery Action Plan (WRAP) and Facing Up to Health.

The pilot program has enrolled 48 consumers, 12 completed the program, and seven graduated, and psychiatrists continue referring consumers. The MHP indicates increasing its study group is a priority.

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 telephone consults periodically this past year. The MHP has carried over the focus of the PIP from a prior year, yet the activities have included a low number of consumers for its study group. The intent of the PIP appears to be beneficial and will need increased participants so the data reflects an adequate population to determine its effectiveness and to consider the standardization of the activities. Although the MHP recognized it has a small study population, it is recommended it expand its pool to collect representative data of the interventions. Ongoing consultation is recommended for adequate progress to be encouraged and completed.

## NON-CLINICAL PIP—IMPROVING OUTPATIENT APPOINTMENT ADHERENCE

The MHP presented its study question for the Non-Clinical PIP as follows:

- "Will providing appointment reminders, educational materials, and transportation skill-building to consumers, as well as other systems-wide efforts, improve appointment adherence?"
- Date PIP began: April 2015
- Status of PIP:

  ☐ Active and ongoing

  ☒ Completed:

  ☐ Inactive, developed in a prior year *(Not Rated)*

  ☐ Concept only, not yet active *(Not Rated)*

  ☐ Submission determined not to be a PIP *(Not Rated)*

  ☐ No PIP submitted *(Not Rated)*

In 2014-2015, the MHP's PIP on "Consumer Non-Adherence to Mental Health Outpatient Clinic Appointments" piloted the Televox automated appointment reminder system at the East Adult specialty mental health clinic. This was an extension of the prior year's work on appointment adherence. Interventions and movement towards the goals remained limited.

The automated call reminder system was piloted beginning in October 2014 and the process finalized over the next few months in the East Adult clinic before gradually being implemented in other clinics. For analyses, the baseline period was April –September 2014 and the follow-up period is April – September 2015. Implementation of the automated call reminder system helped to improve overall appointment adherence and decreased the no-show rate at East Adult clinic from 14.50% (*SD* = .03) in April – September 2014 to 13.80% (*SD* = .02) in April – September 2015. This was a statistically non-significant 4.83% improvement. Similarly, the appointment adherence among Spanish speaking beneficiaries showed an improvement in no-show rate from 11.43% (*SD* = .07) to 9.40% (*SD* = .07). Although not statistically significant, this was a 17.76% improvement in Spanish speaking beneficiaries' no-show rate to appointments and met the goal of at least a 10% improvement. In addition, perfect attendance rate increased from 50.6% to 56.3%.

Although the above results are modest, it was decided to expand Televox to the other clinics. The MHP explored other ways to use Televox as a communication tool such as staff appointment cancellations, blast message (e.g., flu season), follow up to appointment no-shows, and data collection (e.g., brief telephone survey).

This year's PIP was an extension of the prior year's activities. However, based on the submission tool, limited new interventions had been applied, especially to increase the attendance to appointments. Several activities were completed; these lay the foundation for the interventions to occur. These included the creation of the Welcome Handbook for consumer navigation, hiring of two peer Commute Navigation Specialists to support and foster transportation independence, Televox reminders were extended to all sites, and using the Cadence module application for scheduling electronically. Some additional surveys were conducted such as the County staff Peer Survey and the Improvement Survey. The County staff Peer Survey was focused on peer service time for transporting consumers, and surveys of consumers' mode of transport and confidence in using transportation to appointments. The Improvement Survey to clients focused on assessing barriers to appointments, satisfaction level by type of provider (front desk, psychiatrist, nursing, clinician, peers etc.). These were focused on the peer service time for transporting consumers, and surveys of consumers' mode of transport and confidence in using transportation to appointments.

However, the larger issue was the data collection since it was not provided as the above-mentioned activities were needed for the next steps and to accurately record non-attendance rates. This was hindered by the lack of an available universal appointment system. In addition, the MHP operates without an electronic health record, making the documentation of non-attendance cumbersome. For example, there was no method to document non-attendance to an initial appointment in its legacy Insyst PSP system, meaning that when consumers did not attend their first appointment at a clinic, this no-show was not recorded electronically.

Variances were also noted by the methods by which psychiatrists document appointments, as well as variance in methods of keeping schedules, given that many psychiatrists maintain their own. Given the higher no-show rate of 22% and the indicated staff shortage for this service, it remains prudent for the MHP to determine a systematic approach to documenting appointments and no-shows.

The MHP has indicated interventions for improvements addressing appointment adherence such as assigning Peer Partners to increase consumer engagement, navigation specialists to introduce a

welcoming packet, a transportation hotline, and telephone consultation and potentially telepsychiatry, are geared to eliminate barriers to appointment adherence. The MHP will need to determine its timeline for introducing these interventions, and apply them timely, collect results and continue to assess on a regular basis and ultimately determine successful interventions.

It was determined that based on the submission of this project for the past two years, and the limited interventions and conclusions, CalEQRO recommends that this PIP be retired and a new PIP be implemented for next year.

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

The technical assistance provided to the MHP by CalEQRO consisted of technical assistance via telephone consults periodically this past year recommending the MHP to outline a timeline, expand and provide interventions, assess them in a timely manner and determine those adopted for success. The MHP was provided on-site technical assistance and addressed the limited data collected since the other activities were addressed first for the next steps to occur. The MHP was advised for future PIPs to consider having these preliminary activities in place prior to the start of the PIP so that interventions could occur timely. As of the CalEQRO review, the data provided for interventions and subsequent impact on the indicators was limited to the first year of the PIP when Televox was piloted. Since this was the second year submitted, it was advised that the PIP be retired. The MHP was encouraged to seek increased consultation for the upcoming year.

## PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Consumers who utilize scheduled appointment times potentially engage with services regularly.
  - Reducing no-show rates potentially decreases barriers with consumer engagement and reducing the number of re-scheduled appointments.
- Timeliness of Services
  - Consistent attendance at timely appointments encourages earlier engagement with service.
  - Increased availability of appointment slots lends to increased timely follow- up appointments.
- Quality of Care
  - Significant non-attendance leads to non-productive staff time, and exacerbates consumer symptoms secondary to inconsistent care.
  - Utilizing peer mentors aligns with wellness and recovery principles.
  - Engaging consumers in continued care potentially leads to increased responsibility for health.

- Consumer Outcomes
  - Employing peer mentors establishes hope for recovering consumers.
  - Regular and consistent care potentially leads to increased functioning and health.

## PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

### Access to Care

As shown in Table 6, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

**Table 6—Access to Care**

| Component | | Compliant (FC/PC/NC)* | Comments |
|---|---|---|---|
| 1A | Service accessibility and availability are reflective of cultural competence principles and practices | FC | The MHP has a cultural competence committee. They provide services in its threshold language-Spanish and utilize a health care linguistic access unit with certified medical interpreters. The MHP also uses the Video Interpreter Network unit and the ATT language line.<br><br>Of the approximate four hundred staff, eighty-seven staff receive bilingual differential pay with Spanish, Vietnamese, Chinese, Drahi, Farsi, Hindi and Kimu, and American Sign Language (ASL) capability. Thirty-five staff are bilingual Spanish speaking. About 1200 consumers were surveyed regarding preferred language through the Consumer Satisfaction Survey (MHSIP).<br><br>The MHP also created a new form capturing demographic data for the Prevention and Early Intervention (PEI) programs and includes seven strategies, with special emphasis on disparities. The form contains demographic data points, was followed by a vetting with their contract providers and stakeholder |

| Table 6—Access to Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | groups for content and information to consumers. The MHP conducts semi-annual reporting of this data.<br><br>Analysis of service areas and strategic planning initiatives are inclusive of cultural and ethnic groups. |
| 1B | Manages and adapts its capacity to meet beneficiary service needs | FC | The MHP utilizes a form through its PEI program to help build capacity and identify needs. Providers complete this form, it is scanned and tallied into a spreadsheet.<br><br>The MHP has a data governance committee at health services level with representation for each division. The Quality Management Program Coordinator sits on the Data Governance Committee as well as meets regularly with the Business Analytics Team to prioritize data and reporting for the BH division.<br><br>The MHP has committees for medication monitoring and inpatient bed availability. The role of UR is also to identify the availability and gaps in resources (i.e. to determine a need to increase beds at the board and care).<br><br>To ensure fidelity to the core practice model (CPM) for its Katie A. subclass, the MHP holds regular weekly meeting for case consultation regarding the CFT process and issues that come in up in CFT meetings. Surveys will be distributed for consumers to validate fidelity. MHP created the survey to determine consumer feedback.<br><br>The MHP uses data to measure/monitor Access Line contacts and referrals through the Customer Relationship Management software and Tapestry project; this replaces paper phone logs. The MHP collects data for disposition, frequency, and age for consumers accessing services. The data group has designed over 25 reports.<br><br>Caseloads are monitored and informants indicate variation in size but remain at capacity for most units. Productivity requirements are 55% however, clinical line staff report that the daily goal is 75%. A weekly triage meeting with supervisors to assign cases is conducted.<br><br>Consumers will soon have access to a comprehensive |

| Table 6—Access to Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | program of substance use disorder (SUD) treatment options including residential treatment, intensive outpatient services and new medication-assisted therapies, via the Drug Medi-Cal Organized Delivery System demonstration waiver.<br><br>To help create a safer work environment, the training, "Nonviolent Crisis Intervention," emphasizes early intervention and nonphysical methods for preventing or managing disruptive behavior. It is required for all staff.<br><br>Additional work that the MHP has carried out related to capacity analysis to address client and community needs include the MHSA Community Needs Assessment and Coordinating Levels of Care (CLOC) Work Group. |
| 1C | Integration and/or collaboration with community based services to improve access | FC | The MHP contracts with several community agencies to provide increased access across the community. These include but are not limited to Lincoln Child Center, the Hume Center and Anka Behavioral Health. The MHP also provided CIT training to law enforcement and has a strong partnership with the sheriff's department for its 5150 services.<br><br>Contract monitors regularly communicate with contractors, including monthly meetings and telephone support.<br><br>The Homeless Program uses volunteers and service providers for Project Homeless Connect, a one-stop annual event to connect residents experiencing homelessness to benefits, medical care, behavioral health and social services, shelter and housing.<br><br>This program will be aligned with the Coordinated Assessment Resource (CARE) Centers that perform all the immediate, drop-in functions of the multi-service centers, such as access to food or showers, but also offer expanded services such as housing programs, healthcare services and case management. |

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

## 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. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

**Table 7—Timeliness of Services**

| Component | | Compliant (FC/PC/NC)* | Comments |
|---|---|---|---|
| 2A | Tracks and trends access data from initial contact to first appointment | FC | The MHP reports a standard of 15 days with an overall average of 7.5 days and meets this 92% of the time. For adult services, it reports an average of 5.6 days and meets this 100% of the time. For children's services, it reports an average of 14 days and meets this 65.2% of the time.<br><br>From its prior year data, the metric for children's services was 6.1 days with 98.2% meeting this. Hence, the MHP would be prudent in examining this trend as timeliness has extended, so the MHP can be informed as to what contributed to the change.<br><br>Performance improvement activities aimed at the amelioration of wait times for children were not presented.<br><br>Data reflects first available appointment and is reported through ACCESS.<br><br>The wait times reported do not include direct intakes by contract providers and other programs. |
| 2B | Tracks and trends access data from initial contact to first psychiatric appointment | FC | The MHP reports a standard of 30 days with an overall average of 44 days and meets the standard 44.3%. Wait times for psychiatry have increased from last year's average of 15.8 days and meeting the standard 84.6% of the time.<br><br>For adult services, it reports an average of 60.2 days (last year being 23.6 days) and meets this 23.0% (last year 75.8%) of the time.<br><br>For children's services, it reports an average of 16.5 days (last year 4.3 days) and meets this 80.6% (last year 97.6%) of the time. |

| Table 7—Timeliness of Services | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | Psychiatry wait times have increased significantly this last year with no effective or rigorous effort employed to improve wait times or staffing in this area across the system.<br><br>In children's, additional psychiatry services were offered but the remainder of the system has long wait times.<br><br>Data reflects first available appointment and is a projected metric. By emailing the regional clinics, MHP obtains information on the first available appointments with psychiatrists in each regional clinic. The first available appointments are used in the data analysis.<br><br>The MHP reports this measure will become "real" time once the Cadence module is in place later this year.<br><br>Again, this standard deviated from the prior year's data and validation of this is recommended, given the downward movement. |
| 2C | Tracks and trends access data for timely appointments for urgent conditions | PC | The MHP reports a standard of two days with an overall average of one day response and meets this 100% of the time. For adult services, it reports the same metric. For children's services, it did not provide data.<br><br>The Central Clinic Child Triage program is being piloted and will provide urgent appointments for children within psychiatry with the goal of moving towards the appropriate therapy.<br><br>Data reflects first available appointment and is reported through ACCESS. |
| 2D | Tracks and trends timely access to follow up appointments after hospitalization | FC | The MHP reports a standard of 7 days with an overall average of 17 days and meets this 56.7%. Adult services report an average of 17 days and meets this 51.3%. Children's services report an average of 18 days and meets this 78.7% of the time.<br><br>Hospital discharge planners bypass the Access Line and can schedule a follow up appointment for a new client with Rapid Access clinicians at the MH clinics. This service is for adults only and allows for patients discharging from psychiatric emergency to receive |

| Table 7—Timeliness of Services | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | priority appointments.<br><br>For children, there is a discharge liaison to arrange follow up appointments. On-site informants reported follow-up can vary for children.<br><br>The MHP continues its strategies to address high cost beneficiaries as this target group often involves hospital costs. |
| 2E | Tracks and trends data on rehospitalizations | FC | The MHP reports a goal of 10% with an overall average of 14.3%. Adult services report a rate of 15.2% and children's reports a rate of 10.6%. |
| 2F | Tracks and trends no-shows | FC | The MHP reports a standard of 10% for all staff with an overall average of 3.9% for clinicians and 29.2% for psychiatrists. For adult services, it reports an average of 3.5% for clinicians and 30.6% for psychiatrists. For children's services, it reports an average of 4.7% for clinicians and 20.1% for psychiatrists. |

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

## Quality of Care

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

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| 3A | Quality management and performance improvement are organizational priorities | FC | The Strategic Plan was developed using a rigorous six-month planning process, engaging the executive team and community-based organization leadership across all programs, services, and management functions. Additionally, the MHP analyzed input from programs and conducted one-on-one interviews with managers |

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | and subject-matter experts. The Strategic Plan, not only defines key integration strategies and actions in alignment with its mission, vision, and guiding principles, but also serves as its roadmap for system-wide integration of behavioral health services into the future.<br>Data analysis is prioritized in a variety of way.<br>• . The Quality Management Program Coordinator oversees and chairs the Quality Management Committee (QIC) and the committee is guided by the goals and objectives in the QI workplan. This consists of required elements based on state regulations/ mandates as well as recommended initiatives identified for continuous quality improvement. Recommendations are presented to executive leadership for approval.<br>• There is a Data Governance Committee at the health services level with representation for each division including the MHP Quality Management Program Coordinator to determine prioritization of data, reporting, etc. |
| 3B | Data are used to inform management and guide decisions | FC | The MHP went live with Tapestry, a module of ccLink, Contra Costa Health Services' (CCHS) electronic health record.<br>Tapestry allows Behavioral Health users to access features of ccLink for managing the access line, referrals to network providers and related claims.<br>Data integration work continues with Contra Costa Regional Medical Center leadership to forge new connections through the Health Leads, whole-person care and PRIME initiatives.<br>Data is used for analysis or summary of consumer outcomes as follows:<br>• CaLocus/Locus –aggregated data, reporting is reviewed in Quality Management (QM).<br>• Consumers utilize a paper self-report and this is scanned into Teleform. Results are provided to individual providers to assist in treatment planning. Score data is aggregated but not yet mapped to services system wide. The MHP |

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | wants the form built into EPIC.<br>• CSOC utilizes outcome measures specific to its EBPs and reporting includes enrollment and service utilization to ensure accuracy of data. Additionally, data is aggregated, including reporting outcomes pre/post hospitalizations, and the number of mobile response treatment visits. QM is working on standardizing the use of these reports and pairing them with service utilization data. They will use this information to determine how outcomes can be built into their new system.<br>• Treatment Intervention Program (TIP) report is In Epic, and is used for planning treatment and communication across the system for continuity of service. This provides access to consumer service history if seen in PES. The TIP report helps identify and address barriers, especially for use of mobile services, and helps notify the regular provider when a consumer is in PES.<br>New reports and improvement to existing reports since previous CalEQRO review including going live with Epic Tapestry, e-prescribing and Cadence, thus increasing the MHP's reporting capability. These include new reports through Cadence on timely access to care and first offered appointment. Dashboards are now being created.<br>There is a yearly staff development survey, to identify training needs and interests. |
| 3C | Evidence of effective communication from MHP administration | PC | The executive team encourages all staff to provide feedback about what is and is not working through a feedback link that appears in every edition of the quarterly Behavioral Health Connection.<br>Contractor providers indicated communication often seems punitive, perhaps an unintentional consequence regarding emphasis on continued review of the documentation standards. Informants report a disconnect regarding communication between UR/UM and the documentation protocols and the provision of updates to staff and agencies. |

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | Program supervisors/managers have the capability to produce reports. In Epic Tapestry information is provided via an executive dashboard.<br><br>The provider portal allows for providers to see consumer case load, eligibility for specific services. MHP estimates that 85% of its providers are using the system, with 99 users to date.<br><br>The MHP surveys its staff, CBO's and consumers/family members for various initiative developments, such as the Welcome Packet, transportation concerns and satisfaction. The MHP communicates with staff and supervisors via a system alerts/messages.<br><br>Trainings are provided regularly. The BH division was recognized as a health care quality leader for LGBTQ. Reducing Health Disparities committee is a work group committee for equity throughout system.<br><br>The MHP conducts weekly departmental and unit meetings, various committee with all levels of staff participation, QIC meetings, training groups, and work groups. However, across the system, consistent and advance information on regulations and documentation requirements is lacking, based on informant feedback.<br><br>Consumer and Family Members (CFMs) are formally included as stakeholders in various committees such as Strategic Planning, MHSA Consolidated Planning Advisory Workgroup, and Quality Management (QM). Consumer informants indicated increased venues for feedback regarding services such as focus groups are welcome.<br><br>While subscription to the MHP's website is open to consumers and families, no one was aware of it in the focus groups.<br><br>The MHP publishes a quarterly newsletter (available for online subscription); however, it is not available in Spanish.<br><br>Consumer focus group participants stated that communication was not consistent and not always timely and learned most from either therapists or |

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | flyers posted in the clinics or at the schools. Informants noted informational bulletin boards in clinics and electronic newsletters were limited and the newsletter is not available in Spanish.<br><br>Office for Consumer Empowerment regularly participates at community health fairs, sharing information about their programs. |
| 3D | Evidence of stakeholder input and involvement in system planning and implementation | FC | The Service Planning Integration and Implementation Plan Design (SPIID) team continues as its management change group and oversees completion of its service goals.<br>Leadership requested all program managers to revisit the COMPASS-EZ self-assessment tool for each program to help identify opportunities to improve and plans to incorporate updated quality improvement goals and objectives into the new strategic plan.<br><br>The MHP has a robust MHSA stakeholder feedback and involvement process. Staff, supervisors and contractors report being involved in strategic planning or participate in different work groups.<br><br>Participation in various workgroups, such as the Consolidated Planning Advisory Workgroup (CPAW) and AOT (Assisted Outpatient Treatment) Work Group continue.<br><br>The MHP's Office for Consumer Empowerment is staffed by consumers and family members and are directly involved in planning efforts on a regular basis. Ten of the sixteen positions on the County Mental Health Commission are designated for family and consumer members. |
| 3E | Evidence of strong collaborative partnerships with other agencies and community based services | FC | Staff are co-located at the Miller Wellness center, with behaviorists at each FQHC. Strong ties continue with the Interfaith Homeless/Housing supports, law enforcement, local hospitals, and school services. |
| 3F | Evidence of a systematic clinical Continuum of Care | PC | Children's services use promising and evidence-based practices such as wraparound services, TF-CBT, DBT, and family-based therapy for eating disorders. When First Episode Psychosis (FEP) is in place, the MHP will have cognitive remediation for people experiencing |

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | psychotic symptoms.<br><br>The MHP surveyed staff related to attitudes and perceptions for EBPs to inform training needs (developed by Gregory Aarons, PhD. Its goal is to have each staff trained in three different EBPs. With each EBP contract there is a period of consultation post-implementation to ensure fidelity to the model.<br><br>Transition-Aged Youth (TAY) services are limited. Increased efforts for youth who are "aging out" of the system and need assistance in transitioning to adult care is needed.<br><br>Coordinating Level of Care (CLOC) are strategies to assist with the step-down process of recovery principles to provide a seamless navigation of treatment options.<br><br>Although the MHP has orchestrated an array of multiple services, variances appear to exist among the three main regions of the West, East and Central area clinics. On-site informants from multiple sources indicated that the regions have individualized procedures. Inadvertently, this may contribute to making it difficult to cross regions should a consumer move or need a specific service. There was no indication that the MHP has standardized processes to assist consumers to cross regions when needed. |
| 3G | Evidence of individualized, consumer-driven treatment and recovery | FC | Coaching to Wellness, a program to support mental health consumers with co-occurring medical conditions, is expanding its services and the MHP has conducted a PIP with this service.<br><br>A new medication-assisted treatment (MAT) "Choosing Change" clinic began at the West County Health Center in San Pablo in May, expanding treatment options for patients struggling with opioid addiction.<br><br>There are three Wellness and Recovery Centers (known as "Wellness Cities") located within the East, West and Central regions of the MHP. WRAP (Wellness and Recovery Action Planning) is an integral part of |

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | services offered to consumer participants.<br><br>Central and Eastern Region Wellness Cities are open during regular business hours; the Western Wellness City is open half-days, Monday-Friday.<br><br>First Hope is a good example of family education for engagement wherein training and outreach (using evidence based practices) are key components for connecting with families and children.<br><br>The MHP offers parent groups in English and Spanish. |
| 3H | Evidence of consumer and family member employment in key roles throughout the system | FC | Peer Certification is available at the local community college. There are numerous peer positions with different classifications. A career ladder beyond the peer level does not seem available.<br><br>The MHP has collaborated with Contra Costa Community College for over 20 years in the administration of its "SPIRIT" Program (Service Provider Individualized Recovery Intensive Training). The purpose of SPIRIT is to help CFMs make an important contribution to the behavioral health system by preparing them to work in either a paid or volunteer capacity within an agency that provides behavioral health services.<br><br>The SPIRIT Training helps them to develop core skills to empower themselves by attaining and maintaining recovery and resiliency through self-awareness and peer, family support, while learning to assist others in doing the same. Graduates are placed in volunteer or paid positions throughout the MHP.<br><br>MHP has 43 permanent, fully-benefitted, full-time positions designated for consumers and family members. (Numbers were not available for the additional extensive use of CFM employees in positions with contract providers.)<br><br>Mental Health Community Support Worker I/II positions are used for a variety of meaningful jobs located throughout the system including peer support, family partner, speaker's bureau/outreach, |

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | wraparound facilitator, peer employment coordinator and case management.<br><br>The MHP has developed a proposal for a higher-level classification of Mental Health Community Support Worker Specialist that is fully supported by executive management and is currently under administrative review in Human Resources. |
| 3I | Consumer run and/or consumer driven programs exist to enhance wellness and recovery | FC | The MHP contracts with RI International to run three Wellness and Recovery Centers (known as "Wellness Cities") located in the three regions of the county. These centers have open access, are staffed and run by consumers, and provide a full range of programs. A fourth program, "Putnam Clubhouse," receives a portion of its funding from the county and is by referral only, but serves mental health consumers who are members and help to administer and run the program.<br><br>Few focus group participants were aware of the Wellness Centers. Increased outreach and sharing of information in clinics as planned by the MHP in the coming year should help increase access and involvement of consumers. |
| 3J | Measures clinical and/or functional outcomes of consumers served | PC | MHP uses the Child and Adolescent Level of Care Utilization System (CALOCUS) for youth and the Level of Care Utilization System (Locus) for adults. MHP has aggregated data but has not mapped outcomes to services to replicate successful outcomes. These appear to be limited to the individual provider level<br><br>Other outcome tools are program specific. For example, the TF-CBT program uses the Youth Outcome Questionnaire to determine functional outcome and reduction of symptoms) and the UCLA PTSD-Reaction Index to assess PTSD symptoms and frequency.<br><br>The Adult program plans to pilot use of the Patient Health Questionnaire-9 item (PHQ-9) to assess depressive symptoms and the Generalized Anxiety Disorder 7-item (GAD-7) to assess anxiety. These tools are already built into the EHR, which should facilitate a smooth transition to use. There are also plans to train adult clinic staff in EBPs. The MHP has adopted a |

| Table 8—Quality of Care | | | |
|---|---|---|---|
| Component | | Compliant (FC/PC/NC)* | Comments |
| | | | wellness and recovery model, however, changes in regulations are requiring a more medical model approach and can be alienating to consumers in treatment planning, based on informants' feedback. |
| 3K | Utilizes information from Consumer Satisfaction Surveys | FC | In addition to the bi-annual statewide Consumer Perception Survey, the MHP conducts a variety of surveys to receive feedback from consumers. Examples of this include transportation needs survey, a component of the non-clinical PIP, and primary care needs, a component of the clinical PIP.<br><br>The MHP initiated using peer navigators who will use survey feedback to assess consumer confidence in using public transportation from feedback. |

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## KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Tapestry allows users to efficiently log calls to the Access Team and Care Management Unit and process referrals, service requests and claims.
  - The MHP continues to provide collaborative, co-located services for the Katie A. target population.
  - The lack of standardized processes may hinder consumer access to care across regions.
  - The MHP continuously seeks qualified mental health professionals to join its regional clinics to address access and capacity to serve.
- Timeliness of Services
  - The MHP remains limited in meeting its standard for first psychiatric appointment especially for the adult population.
  - The MHP strives to improve the collection of appointment data to capture accurate wait times to evaluate system capacity strengths and challenges.

- First appointment for adult services reflects 100% compliance with an average of 5.6 days and potentially should be verified, given the excellent range in meeting this metric.
- The MHP continues to use a modified data collection method for collecting timeliness indicators for psychiatric appointments by using sample data for this indicator.
- In CY 2016, the MHP implemented Tapestry, a module of the EPIC electronic health record now use actual data from the Tapestry system.
- Contract providers indicate timeliness metrics are not included as a performance measurement.

- Quality of Care
  - The MHP has thoughtfully and judiciously created a Five Year Strategic Plan for its service delivery.
  - The MHP thoughtfully outlines its PIP intentions and is encouraged to address the foundation work prior to the formal submission to expedite the interventions used in its PIP processes.
  - In 2016, there were a total of 50 psychiatrists, 39 of whom are part-time, and one full-time nurse practitioner. The development in 2016 was the hiring of eight new psychiatrists. However, there were nine psychiatrists who resigned during the year.
  - The MHP continues to seek qualified professional to join its regional clinics. These efforts are hampered secondary to higher salaries being offered in neighboring counties and the private health plans offering lucrative benefit packages.
  - The caseloads may be excessive and contributing to staff work fatigue.
  - Communicating the documentation updates in a timely and consistent manner may assist contractor providers.
- Consumer Outcomes
  - The MHP embraces peer employees, are fully benefitted, and utilized for broad based assignments.
  - The project to improve access is a welcome packet for new consumers and their families, to help them navigate the services at all sites.
  - For hospital discharge data, the MHP uses actual data for appointments attended. Since there may be a substantial difference between the first available appointment and the first appointment attended, the MHP will continue to revise its Tapestry reports to accommodate hospital discharge appointments as well.
  - The MHP drafted a dashboard posted on its website, utilizes supplemental improvement surveys to gain consumer and family feedback to inform pilot

projects, and evidence-based practices such as IMPACT and PIER models which include the collection and monitoring of outcomes data for high risk populations, older adults and transition aged youth.

## CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted two 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups with 8 to 10 participants each, the details of which can be found in each section below.

The Consumer/Family Member Focus Group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions 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

CalEQRO requested a group as follows:

> A culturally diverse group of adult beneficiaries, including a mix of existing and new consumers who have initiated/utilized services within the past 12 months. The group was held at a community venue located at 1875 Arnold Drive, Martinez.

Number of participants – 14

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

- Consumers were aware of how to best access crisis service if needed.
- Many noted provider staff were increasingly stressed; most noted the front desk reception can be impolite.
- Those involved with WRAP and the Welcome Centers found these to be useful and supportive to treatment.
- Overall, consumers felt recovery possible and welcome more venues for input.

Recommendations for improving care included the following:

- Increase opportunities for focus groups to provide feedback.
- Provide licensed Board and Care facilities in the community.
- Services to the mentally ill homeless seem limited.

- Continue to embrace and promote family support, seen as essential to recovery.

Interpreter used for focus group 1: ☒ No ☐ Yes

## CONSUMER/FAMILY MEMBER FOCUS GROUP 2

CalEQRO requested a group as follows:

> A culturally diverse group of parents/caregivers of child/youth beneficiaries, including a mix of existing and new consumers who have initiated/utilized services within the past 12 months. The group was held at Children's Mental Health offices at 2425 Bisso Lane, Concord.

Number of participants – 11

For the four participants who entered services within the past year described their experience as the following:

- The contact with the Access Line varied, some stated a timely return call would be useful.
- Satisfaction for those receiving school-based services or wraparound services was expressed.

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

- Those with a longer history of services indicated consumer progress was made and had improved. Service provisions were adequately offered in outpatient.
- Many participants had a negative experience with hospital discharge procedures. Most felt youth were prematurely discharged and follow-up support was not provided.
- The Educate, Equip, and Support materials, First Hope project, school-based services and wraparound services were found to be helpful.
- Participants felt support by each provider, yet expressed more staff are needed.
- Services were available in the preferred language.
- Transportation is available to appointments as well as bus vouchers.

Recommendations for improving care included the following:

- Increase productive transfer of services for Transition Age Youth (TAY).
- Provide updated communications such as postings on bulletin boards in lobbies.
- Translation needed at the front desk.
- Return a follow-up call from a request for access.

- Consider appointing a benefits support staffer for those who need insurance.

Interpreter used for focus group 1: ☐ No ☒ Yes Language(s): Spanish

### CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Initial appointments were available and timely.
- Timeliness of Services
  - Follow-up care varies depending on the service.
  - Wait time for psychiatric evaluation can be excessive and access to psychiatrists outside of scheduled appointments is often difficult.
- Quality of Care
  - Crisis care was available and accessible, but linking to ongoing care after crisis visits can be difficult.
  - Hospital discharges could be reviewed for quality and follow up.
  - Providers show support; however, staff shortages were noted.
  - Services are provided in a consumer's preferred language.
- Consumer Outcomes
  - Those using wellness centers perceive benefit.
  - Consumers value being offered input into the service delivery.
  - Comprehensive treatment appeared valuable to those involved in wraparound and WRAP.

## INFORMATION SYSTEMS REVIEW

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

### KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

| Table 9—Distribution of Services by Type of Provider | |
|---|---|
| Type of Provider | Distribution |
| County-operated/staffed clinics | 32% |
| Contract providers | 57% |
| Network providers | 11% |
| Total | 100% |

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

<2%

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

☐ Yes ☐ In Testing/Pilot Phase ☒ No

If yes or in-testing phase, fill in box below with name of product being used.

- MHP currently provides services to consumers using a telepsychiatry application:

☐ Yes ☐ In Testing/Pilot Phase ☒ No

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

n/a

  - Direct services through telepsychiatry practitioners are available in the following languages (does not include the use of additional translators) (e.g. English, Spanish): not applicable as MHP does not provide telepsychiatry services.

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

| Table 10 – Summary of Technology Staff Changes | | | |
|---|---|---|---|
| Number of IS Staff | Number of New Hires | Number of Staff Retired, Transferred, Terminated | Current Number of Unfilled Positions |
| 7 | 0 | 0 | 0 |

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

| Table 11 – Summary of Data Analytical Staff Changes | | | |
|---|---|---|---|
| Number of Data Analytical Staff | Number of New Hires | Number of Staff Retired, Transferred, Terminated | Current Number of Unfilled Positions |
| 10 | 3 | 2 | 4 |

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

- The Contra Costa Health Plan, provides primary care for three-quarters of the MHP consumers, has a consumer portal called MyCCLink and this provides access to appointment and other information. No information regarding mental health care is currently available to consumers.
- Health Services IT supports all mental health and substance use disorder staff. Additional contract staff have been added for the EHR and practice management implementation projects.

## CURRENT OPERATIONS

- The MHP is currently in transition from its legacy Insyst practice management software to new practice management and EHR systems.
- Initial Epic ccLink modules have been implemented for intake and referral tracking, Managed Care Organization (MCO), prescribing, and labs.
- An external data warehouse is utilized for report production and data analysis.
- All data systems are staffed and managed by CCHS IT staff.

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 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 | Practice Management | The Echo Group | 28 | Health Services IT |
| Epic Tapestry | Customer Relationship Management | Epic | <1 | Health Services IT |
| Epic ccLink | ePrescribing, Lab results, referrals | Epic | <1 | Health Services IT |

## PLANS FOR INFORMATION SYSTEMS CHANGE

- Implementation is in progress for EHR. New system has been selected, but not yet in implementation phase for replacement of current practice management system.
- Implementation of Epic ccLink EHR is currently in the configuration phase. The EHR is scheduled to go-live in September 2017. The MHP has not decided whether to do a phased implementation or all at once.
- The MHP has contracted with the Echo Group for their ShareCare practice management software. The ShareCare implementation is scheduled to done simultaneously with the ccLink clinical documentation implementation with an integrated approach with go-live planned for early 2018.
- The MHP plans for electronic transfer of data between ccLink and ShareCare for billing and mandated State reporting.
- The interface between ccLink and ShareCare will be developed by Epic. No electronic interface with the existing Insyst billing system is planned.

## ELECTRONIC HEALTH RECORD STATUS

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

| Table 13—Current EHR Functionality | | | | | |
|---|---|---|---|---|---|
| | | Rating | | | |
| Function | System/Application | Present | Partially Present | Not Present | Not Rated |
| Alerts | | | | x | |

| Table 13—Current EHR Functionality | | | | | |
|---|---|---|---|---|---|
| | | Rating | | | |
| Function | System/Application | Present | Partially Present | Not Present | Not Rated |
| Assessments | | | | x | |
| Document imaging/storage | Epic/Onbase | x | | | |
| Electronic signature—consumer | | | | x | |
| Laboratory results (eLab) | Epic ccLink | x | | | |
| Level of Care/Level of Service | | | | x | |
| Outcomes | | | | x | |
| Prescriptions (eRx) | Epic ccLink | x | | | |
| Progress notes | | | | x | |
| Treatment plans | | | | x | |
| Summary Totals for EHR Functionality | | 3 | 0 | 7 | 0 |

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

- Contract providers have read-only access to some ccLink modules including CPOE and document imaging and storage. Consumer's Chart of Record for county-operated programs (self-reported by MHP):

  ☒ Paper ☐ Electronic ☐ Combination

## MAJOR CHANGES SINCE LAST YEAR

- Design and implementation of a new NPI validation and provider exclusion database.
- CCBHS served as a test site for the migration of CSI data reporting from ITWS to BHIS and was the first county to go live.
- Implementation of Epic Tapestry CRM for the Access Line and Care Management Unit.
- Completion of implementation of Epic prescribing at county clinics.
- Completed pilot implementation of Epic Cadence appointment scheduling application.

## PRIORITIES FOR THE COMING YEAR

- Replacement of Echo Insyst practice management system with ShareCare.

- Implement system of conversion of FQHC clinics from InSyst/PSP to Epic billing and implement Epic clinical documentation, CPOE, and patient scheduling for those facilities.
- Completion of implementation of e-prescribing for all county run clinics.
- Implementation of Cadence appointment scheduling at all county-operated mental health and substance use disorder clinics.

## OTHER SIGNIFICANT ISSUES

- Although the MHP has declared that electronic interoperability with organizational providers is a priority, there has been little, if any, contractor involvement in planning access and sharing of EHR data.
- Timeliness data from contract providers remains largely unavailable. These providers deliver more than 50% of all direct client services.

## MEDI-CAL CLAIMS PROCESSING

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

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

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

☒ Yes ☐ No

If yes, product or application:

Local spreadsheets and database

- Method used to submit Medicare Part B claims:

☒ Clearinghouse ☐ Electronic ☐ Paper

| Table 14—Summary of CY15 Processed SDMC Claims—Contra Costa | | | | | | | |
|---|---|---|---|---|---|---|---|
| Number Submitted | Gross Dollars Billed | Dollars Denied | Percent Denied | Number Denied | Gross Dollars Adjudicated | Claim Adjustments | Gross Dollars Approved |
| 389,548 | $101,831,823 | $3,727,573 | 3.66% | 13,225 | $98,104,250 | $10,986,580 | $87,117,670 |
| *Note: Includes services provided during CY15 with the most recent DHCS processing date of May 19,2016* | | | | | | | |

## INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP continues to evaluate penetration rates annually by ethnicity, age, service type, and retention.
- Timeliness of Services
  - Implementation of Tapestry and Cadence has improved the MHPs ability of tracking timeliness of services for consumers with initial contact via the Access Line or the ER.
  - Timeliness tracking for contract providers remains largely unavailable.
- Quality of Care
  - The MHP Quality Improvement/Quality Assurance Unit and CCHS Business Intelligence staff can extract data from the IS and the data warehouse to perform data analysis and generate reports utilizing data from multiple sources.
- Consumer Outcomes
  - The MHP continues to collect, compile, and analyze LOCUS and CALOCUS assessments from all programs.
  - The MHP has developed a data dashboard of performance indicators and posted it to department's website.

# SITE REVIEW PROCESS BARRIERS

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

- There were no barriers noted.

# CONCLUSIONS

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

## STRENGTHS AND OPPORTUNITIES

### Access to Care

- Strengths:
  - Expansions in the system of care include substance use disorders delivery system of care, Continuum of Care Reform for children involved with child welfare services, suicide prevention and first break psychosis interventions.
  - Implementation of the Tapestry and Cadence software for the Access Unit and the Care Management Unit has created a smoother flow of client data for referrals to the county run clinics and FQHCs.
- Opportunities:
  - Network providers have electronic access to referral information (and other information in the patient record) through a "read only" portal. Contract providers (in CBOs) do not yet have this access, but the IT Plan of December 2016 states the plan to extend TAPESTRY to network providers in 2017. This will give contract providers in CBOs electronic access to referral information.
  - Specific substance use assessments for youth have not yet been initiated, a nominal assessment is limited to the initial mental health intake process.

### Timeliness of Services

- Strengths:

  - Initial implementation of the Tapestry and Cadence software are providing an additional source of timeliness performance data.
  - Improvements in tracking reliable timeliness data will enhance productive use of appointments.
  - The MHP has focused on decreasing its no-show rate, potentially increasing available appointment time slots.
- Opportunities:
  - Shortages in psychiatric staffing have resulted in disparate wait times across the county.
  - Telepsychiatry is limited to a pilot consultation methodology.
  - Collecting, reporting, and reviewing timeliness metrics for contract providers is not performed.
  - From stakeholder feedback, improvements could be considered for the process from the approved intake to a referral for service to eliminate any timeliness barriers.

### Quality of Care

- Strengths:
  - The MHP Quality Improvement/Quality Assurance Unit and the Business Intelligence units continue to make effective use of available data to analyze data and produce reports.
  - The Quality Management unit strives to continually improve and update its goals, monitoring its progress and remaining open to change as new initiatives are embraced.
  - Peer employees appear to be valued and provided meaningful assignments.
  - Contract monitors provide support and are an asset to contract providers.
- Opportunities:
  - Processes in access, scheduling, referrals and service provision are unique to each region, unintentionally creating confusion regarding access.
  - While peer employees value their work, indications that on-going support and increased job training would be beneficial.

### Consumer Outcomes

- Strengths:
  - The MHP has thoughtfully presented a continuum of care aimed at recovery with its five-year strategic planning.

- Increased opportunities for peer employees continues as a priority.

- Opportunities:
  - Comprehensive services to youth aging out of the children's services are limited.
  - Regionally-based standards varying among the clinics prohibit a seamless flow for consumer care across the system.

## RECOMMENDATIONS

- Consider standardized processes and cross-regional referrals for access to care and subsequent services to enhance the seamless and consistent delivery of service.
- Include timeliness metrics, request quarterly reports, and analyze for adherence to standards as a component of the contract provider performance measures.
- Utilize existing equipment to provide tele-psychiatry services in the regions showing the greatest need.
- Review services designed for transition age youth (TAY) and increase as warranted for this target population.
- Develop a communication plan that includes contract providers in the planning and implementation of electronic interoperability of EHR data between disparate systems.

# ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

# *ATTACHMENT A—REVIEW AGENDA*

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 |
| Health Plan and Mental Health Plan Collaboration Initiatives |
| Clinical Line Staff Group Interview |
| Clinical Supervisors Group Interview |
| Program Managers Group Interview |
| Consumer Employee Group Interview |
| Consumer Family Member Focus Group(s) |
| Contract Provider Group Interview – Administration and Operations |
| Community-Based Services Agencies Group Interview |
| Validation of Findings for Pathways to Mental Health Services (Katie A./CCR) |
| ISCA/Billing/Fiscal |
| EHR Deployment |
| Wellness Center Site Visit |
| Contract Provider Site Visit |

# ATTACHMENT B—REVIEW PARTICIPANTS

## CalEQRO Reviewers

Jovonne Price, Quality Reviewer Consultant
Cyndi Eppler, Quality Reviewer
Jerry Marks, Information Systems Reviewer
Debbie Strong, Consumer/Family Member Consultant
Bill Manov, Drug Medi-Cal Reviewer

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

## Sites of MHP Review

### MHP SITES

Contra Costa County Behavioral Health Services (CCCBHS)
1340 Arnold Drive
Martinez, CA 94553

Children's Mental Health
2425 Bisso Lane
Concord, CA 94520

### CONTRACT PROVIDER SITES

Putnam Clubhouse
3024 Willow Pass Rd Ste 230
Concord, CA 94519

IBEW Local 302.
1875 Arnold Drive
Martinez, CA 94553

# PARTICIPANTS REPRESENTING THE MHP

| Name | Position | Agency |
|---|---|---|
| Adam Down | Administrative Services Assistant | CCC Behavioral Health |
| Amanda Dold | MH Program Supervisor | CCC Behavioral Health |
| Amy Linsao | MH Clinical Specialist | CCC Behavioral Health |
| Ana Sachs | MH Program Supervisor | CCC Behavioral Health |
| Anita De Vera | MH Program Manager | CCC Behavioral Health |
| Ann Isbell | HS Planner/Evaluator | CCC Behavioral Health |
| Anne Staunton | HS Planner/Evaluator | CCC Behavioral Health |
| Barbara Serwin | Mental Health Commissioner | Mental Health Commission |
| Bernie Sanabria | MH Program Supervisor | CCC Behavioral Health |
| Betsy Hanna | MH Program Supervisor | CCC Behavioral Health |
| Betsy Orme | MH Program Manager | CCC Behavioral Health |
| Beverly Furhman | MH Program Manager | CCC Behavioral Health |
| Bles Surio | UR Program Manager | CCC Behavioral Health |
| Brett Beaver | MH Program Manager | CCC Behavioral Health |
| Brian Newton | Director of Research & Operations | Hume Center |
| Carol Frank | Associate Director | Early Childhood Mental Health Program |
| Chad Pierce | MH Program Manager | CCC Behavioral Health |
| Charlene Bianchi | MH Program Manager | CCC Behavioral Health |
| Chet Spikes | Asst. HS IT Director | CCHS Info Technology |
| Chris Stahl | Clinical Director | Familias Unidas |
| Christina Boothman | HS Planner/Evaluator | CCC Behavioral Health |
| Christine Bohorquez | UR Coordinator | CCC Behavioral Health |
| Christine Madruga | MH Program Supervisor | CCC Behavioral Health |
| Christopher Pedraza | AOD Program Manager | CCC Behavioral Health |
| Cynthia Belon | Behavioral Health Services Director | CCC Behavioral Health |
| Dan Batiuchok | MH Program Manager | CCC Behavioral Health |
| Debra Beckert | Nursing Program Manager | CCC Behavioral Health |
| Alicia Diaz | MH Clinical Specialist | CCC Behavioral Health |
| Denise Chmiel | MH Program Manager | CCC Behavioral Health |
| Eileen Brooks | MH Program Manager | CCC Behavioral Health |

| Name | Position | Agency |
|---|---|---|
| Ellen Shirgul | MH Program Supervisor | CCC Behavioral Health |
| Fatima Matal Sol | AOD Chief | CCC Behavioral Health |
| Faye Ny | HS Accountant | CCHS Finance |
| Gerold Loenicker | MH Program Manager | CCC Behavioral Health |
| Grethel Leff | MH Clinical Specialist | CCC Behavioral Health |
| Heather Sweeten-Healy | MH Program Manager | CCC Behavioral Health |
| Helen Kearns | MH Project Manager | CCC Behavioral Health |
| Jan Cobaleda-Kegler | Adult/Older Adult Program Chief | CCC Behavioral Health |
| Jennifer Tuipulotu | MH Children's Family Services Coordinator | CCC Behavioral Health |
| Jon Whalen | Behavioral Health Medical Director | CCC Behavioral Health |
| Jorge Pena | Lead PSP/InSyst Support Analyst | CCHS Info Technology |
| JR Ang | Director of Patient Accounting | CCHS Finance |
| Juanita Garrison | Clerical Supervisor | CCC Behavioral Health |
| Karen Gonzalez | HS Systems Analyst II | CCHS Info Technology |
| Karen Powers | MH Program Supervisor | CCC Behavioral Health |
| Karen Wise | Senior Vice President | Anka Behavioral Health |
| Katy White | MH Program Manager | CCC Behavioral Health |
| Kelly Coolyer | Directory of Family Therapy | Lincoln Child Center |
| Ken Gallagher | Research & Evaluation Manager | CCC Behavioral Health |
| Kennisha Johnson | MH Program Manager | CCC Behavioral Health |
| Kimberly Nasrul | MH Program Supervisor | CCC Behavioral Health |
| Lavonna Martin | Health, Housing & Homeless Services Director | Health, Housing, and Homeless Services |
| Linda Arzio | MH Program Manager | CCC Behavioral Health |
| Lisa Colvin | MH Clinical Specialist | CCC Behavioral Health |
| Margie Burton-Flores | MH Program Supervisor | CCC Behavioral Health |
| Marie Scannell | MH Program Manager | CCC Behavioral Health |
| Mark Messerer | AOD Program Manager | CCC Behavioral Health |
| Matthew Luu | Behavioral Health Deputy Director | CCC Behavioral Health |
| Megan Rice | Epic Project Manager | CCHS Info Technology |
| Michelle Collins | Clerical Supervisor | CCHS Finance |

| Name | Position | Agency |
|---|---|---|
| Michelle Nobori | Acting MH Project Manager | CCC Behavioral Health |
| Michelle Richardson | AOD Program Manager | CCC Behavioral Health |
| Michelle Rodriguez-Ziemer | MH Program Supervisor | CCC Behavioral Health |
| Monica Reynoso-Gonzalez | MH Program Supervisor | CCC Behavioral Health |
| Nancy O'Brien | MH Clinical Specialist | CCC Behavioral Health |
| Nancy Williams | MH Clinical Specialist | CCC Behavioral Health |
| Neil Sachs | Psychiatrist | CCHS Hospital and Health Centers |
| Oleg Andreev | HS Info Systems Programmer / Analyst | CCHS Info Technology |
| Paolo Gargantiel | Mental Health Clinical Specialist | CCC Behavioral Health |
| Paula Williams | MH Clinical Specialist | CCC Behavioral Health |
| Phyllis Mace | MH Program Manager | CCC Behavioral Health |
| Priscilla Olivas | Quality Management Program Coordinator | CCC Behavioral Health |
| Robert Thigpen | MH Family Services Coordinator | CCC Behavioral Health |
| Robin O'Neill | MH Program Supervisor | CCC Behavioral Health |
| Rusty Hernandez | Contractor | CCHS Finance |
| Sara March | Director of Support Services | CC Interfaith Housing |
| Stacey Tupper | MH Program Manager | CCC Behavioral Health |
| Steve Wilbur | MH Quality Improvement Coordinator | CCC Behavioral Health |
| Susan Kalaei | BH Pharmacist | CCC Behavioral Health |
| Teresa Gibson | Acting MH Program Supervisor | CCC Behavioral Health |
| Tom Tamura | Division Director | Seneca Family of Agencies |
| Vern Wallace | Child & Adolescent Program Chief | CCC Behavioral Health |
| Warren Hayes | MH Program Manager | CCC Behavioral Health |
| Ziba Rahimzadeh | MH Program Manager | CCC Behavioral Health |
| Ates Temeltas | Manager,Health Plan Systems | CCHS Info Technology |
| Belkys Teutle | Health Plan Patient Services Supervisor | Contra Costa Health Plan |

| Name | Position | Agency |
|---|---|---|
| Bernice Zamora | MH Community Support Worker | CCC Behavioral HealthCCHS Info Technology |
| Bhumil Shah | Asst. IT Director, Analytics and Reporting | CCC Behavioral Health |
| Brandon McGuire | MH Community Support Worker | CCC Behavioral Health |
| Carol Mott | Registered Nurse | Transition Team |
| Crystal Whitehead | MH Community Support Worker | CCC Behavioral Health |
| Cyndie Cook | Registered Nurse | Transition Team |
| Dave Runt | Director, IT | CCHS Behavioral Health |
| Gloria Menjivar | MH Community Support Worker | West County Adult |
| Heidi Wintermantel | Manager | CCC Child and Family Services |
| Ida Mack | Contractor | CCHS Behavioral Health |
| James Deaton | Registered Nurse | CCC Behavioral Health |
| James Lancaster | MH Clinical Specialist | CCC Behavioral Health CCC Behavioral Health |
| Jane Yoo | MH Clinical Specialist | CCC Behavioral Health |
| Janet Costa | MH Community Support Worker | CCC Behavioral Health |
| Jennifer Greats | MH Community Support Worker | CCC Behavioral Health |
| Jessica Johnson | MH Clinical Specialist | CCHS Behavioral Health |
| Jie Zhou | HS IT Project Manager | OAMH |
| Jimmy Jun | MH Clinical Specialist | CCC Behavioral Health |
| Joe Ortega | Registered Nurse | Financial Counseling |
| Krista Harrington | MH Community Support Worker | West Adult MH |
| LaShawn Miggins | MH Clinical Specialist | CCC Behavioral Health |
| Lucy Espinoza | MH Community Support Worker | OAMH |
| Melanie Ropelato | MH Clinical Specialist | CCC Child and Family Services |
| Nancy Fernandez | Manager | Contra Costa Health Plan |
| Patricia Tanquary | CEO, Contra Costa Health Plan | CCC Behavioral Health |
| Peggy Harris | MH Community Support Worker | OAMH |
| Philip Cooper | MH Community Support Worker | CCC Behavioral Health |
| Rajiv Pramanik | Chief Medical Informatics Officer | CCC Behavioral Health |
| Renee Owens | MH Community Support Worker | CCC Behavioral Health |
| Roberto Roman | MH Community Support Worker | CCHS Info Technology |
| Robin Melendez | HS Info Systems Specialist | CCHS Finance |
| Ronnie Perseveranda | Reimbursement Manager | CCC Behavioral Health |
| Ronnie Potts | MH Clinical Specialist | CCC Behavioral Health |
| Sakura Barrientos | Registered Nurse | CCC Hospital and Health Centers |
| Stephanie Chenard | Administrative Services Asst III | Health,Housing,Homeless Services |
| Steve Blum | Program Manager | East County Adult |
| Susan Waters | MH Community Support Worker | CCC Behavioral Health |
| Sybil Meyer | MH Clinical Specialist | CCHS Info Technology |
| Teri Williams | HS Systems Analyst II | CCC Hospital and Health |
| Troy Kaji | Dir of Ambulatory Medical Informatics | Transition Team |
| Vicki White | MH Community Support Worker | CCC Behavioral Health |
| Windy Murphy | Administrative Services Asst | |

| Name | Position | Agency |
|---|---|---|

# ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

Approved Claims Summaries are separately provided to the MHP in a HIPAA-compliant manner.

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands. The actual counts are suppressed for cells containing n ≤11.

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

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

| Entity | Average Monthly ACA Enrollees | Number of Beneficiaries Served | Penetration Rate | Total Approved Claims | Approved Claims per Beneficiary |
|---|---|---|---|---|---|
| Statewide | 3,045,306 | 131,350 | 4.31% | $533,318,886 | $4,060 |
| Large | 1,497,986 | 63,298 | 4.23% | $263,166,307 | $4,158 |
| Contra Costa | 62,344 | 3,828 | 6.14% | $11,506,275 | $3,006 |

Table C2 shows 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.

**Table C2—CY15 Distribution of Beneficiaries by ACB Range**
**Contra Costa**

| Range of ACB | MHP Count of Beneficiaries Served | MHP Percentage of Beneficiaries | Statewide Percentage of Beneficiaries | MHP Total Approved Claims | MHP Approved Claims per Beneficiary | Statewide Approved Claims per Beneficiary | MHP Percentage of Total Approved Claims | Statewide Percentage of Total Approved Claims |
|---|---|---|---|---|---|---|---|---|
| $0K - $20K | 12,050 | 91.14% | 94.46% | $41,442,365 | $3,439 | $3,553 | 44.92% | 61.20% |
| >$20K - $30K | 471 | 3.56% | 2.67% | $11,506,504 | $24,430 | $24,306 | 12.47% | 11.85% |
| >$30K | 701 | 5.30% | 2.86% | $39,319,388 | $56,090 | $51,635 | 42.61% | 26.96% |

# ATTACHMENT D—PIP VALIDATION TOOL

**PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 CLINICAL PIP**

| GENERAL INFORMATION | |
|---|---|
| **MHP**: Contra Costa | |
| **PIP Title**: Coaching to Wellness | |
| **Start Date**: 08/11/2015<br><br>**Completion Date:** ongoing<br><br>**Projected Study Period** (#of Months):36<br><br>**Completed**: Yes ☐ No ☒<br><br>**Date(s) of On-Site Review**: January 31- February 2, 2017<br><br>**Name of Reviewer**: Jovonne Price | **Status of PIP (Only Active and ongoing, and completed PIPs are rated):**<br><br>**Rated**<br><br>☒ Active and ongoing (baseline established and interventions started)<br><br>☐ Completed since the prior External Quality Review (EQR)<br><br>**Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.**<br><br>☐ Concept only, not yet active (interventions not started)<br><br>☐ Inactive, developed in a prior year<br><br>☐ Submission determined not to be a PIP<br><br>☐ No Clinical PIP was submitted |
| **Brief Description of PIP** (including goal and what PIP is attempting to accomplish): Coaching to Wellness is a Performance Improvement Project (PIP) and Innovation Project implemented by the MHP and submitted for the second year of this project. The Coaching to Wellness program provides an additional level of support for adult mental health consumers with certain chronic health conditions through intensive peer and nurse support. With components from intensive peer support models, coupled with leveraging existing resources within the County, the Coaching to Wellness program | |

provides a holistic team approach to providing care to its consumers.

The goals of the Coaching to Wellness program are to:

- Improve consumer perception of their own wellness and wellbeing.
- Increase healthy behaviors and decrease symptoms for consumers.
- 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<br>☐ Partially Met<br>☐ Not Met<br>☐ 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<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Statistically, many consumers with serious mental illness (SMI) have co-occurring chronic health conditions that are often treatable. Health professionals widely recognize the association between physical and behavioral health (see World Health Organization and World Organization of Family Doctors, 2008). Moreover, mental health consumers face a disproportionate burden of physical health problems and risky health behaviors as compared to the general population.<br>The data on physical health conditions are not systematically collected or entered mental health consumer charts. The data are also unavailable in health services electronic health record as less than 10% of the mental health consumers are active in the County's primary care service.<br>To learn more about how consumers perceive their health, included in the state consumer perception survey administered from November 16-20, 2015 were two County-specific self-rated health questions asking consumers, "In general, would you say your physical health is…excellent, very good, good, fair, or poor" and "In general, would you say your mental health is…excellent, very good, good, fair, or poor." All consumers who had an outpatient specialty mental health appointment during the survey administration week had the opportunity to complete the survey. Of those consumers who submitted surveys, 36.3% (n = 443) replied that their physical health is "poor" or "fair" and 40.6% (n = 429) replied their mental health is "poor" or "fair." This means that more than one-third of the consumers perceive themselves not to be in good physical health and two-fifths of consumers rate their mental health low. |

***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?<br>*Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.* | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Its goals focused on key aspects denoting health and recovery:<br>• Improve consumer perception of their own wellness and wellbeing.<br>• Increase healthy behaviors and decrease symptoms for consumers.<br>• Increase cross-service collaboration among primary and mental health care staff. |
| 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)?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The PIP focuses on adult consumers who have comorbid chronic mental health and health conditions. Specifically, the sample criterion includes consumers:<br>• Ages 18+.<br>• Receiving psychiatric-only services.<br>• Diagnosed with a serious mental illness (but at a stage to engage in recovery).<br>• Diagnosed with a cardiac, metabolic, respiratory chronic obstructive pulmonary disease (COPD) chronic health risk condition and/or have weight issues.<br>• Expressing an interest in the program.<br>• With moderate to high composite score on mental health and medical levels of support needed. |
| | **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?<br>Does the question have a measurable impact for the defined study population?<br>*Include study question as stated in narrative:*<br>Will implementation of a wellness program for consumers with comorbid health and mental health issues improve the recovery of consumers? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |
| **Totals** | 1 Met 0 Partially Met 0 Not Met 0UTD | |
| **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?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | See Item 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?<br>*Methods of identifying participants:*<br>☒ Utilization data ☒ Referral ☐ Self-identification<br>☐ Other: | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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?<br>*List indicators:*<br>The indicators for Goal 1 (Improve consumer perception of their own wellness and wellbeing) are:<br>• Self-Rated Health and Mental Health<br>• Perceived Recovery<br>• Functioning<br>• Quality of Life<br>The indicators for Goal 2 (Increase healthy behaviors and decrease symptoms for consumers) are:<br>• # and % of consumer-identified goals related to wellness<br>• # and % of wellness goals achieved<br>• Attendance in meetings with Wellness Nurse, Coach, and Group activities<br>• Physical Health Vital Signs and Labs<br>• Level of Support<br>• # appointments scheduled and attended<br>• # of PES, hospitalization episodes<br>The indicators for Goal 3 (Increase cross-service collaboration among primary and mental health care staff) are:<br>• # staff participating in project from mental health, primary care, etc.<br>• # and type of referrals and linkages.<br><br>Additionally, the MHP distributed a consumer Satisfaction survey.<br>• Satisfaction | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |

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|---|---|---|
| 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.<br>☒ Health Status ☒ Functional Status<br>☒ Member Satisfaction ☐ Provider Satisfaction<br><br>Are long-term outcomes clearly stated? ☒ Yes ☐ No<br><br>Are long-term outcomes implied? ☐ Yes ☐ No | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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:<br>a) True (or estimated) frequency of occurrence of the event?<br>b) Confidence interval to be used?<br>c) Margin of error that will be acceptable? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | A sampling technique was not used. |
| 5.2 Were valid sampling techniques that protected against bias employed?<br><br>*Specify the type of sampling or census used:* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 5.3 Did the sample contain a sufficient number of enrollees?<br><br>_____N of enrollees in sampling frame<br>_____N of sample<br>_____N of participants (i.e. – return rate) | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| | **Totals** | Met Partially Met Not Met UTD |

| STEP 6: Review Data Collection Procedures | | |
|---|---|---|
| 6.1 Did the study design clearly specify the data to be collected? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | See the fourteen identified indicators in Item 4.1. |
| 6.2 Did the study design clearly specify the sources of data?<br>*Sources of data:*<br>☒ Member ☐ Claims ☒ Provider<br>☒ 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<br>☐ Partially Met<br>☐ Not Met<br>☐ 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<br>☐ Partially Met<br>☐ Not Met<br>☐ 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.<br><br>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.<br><br>Satisfaction and achievement on self-identified wellness goals are recorded at post-program.<br><br>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. |

| | | |
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| 6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?<br>*Instruments used:*<br>☒ Survey ☒ Medical record abstraction tool<br>☐ Outcomes tool ☐ Level of Care tools<br>☐ Other: | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |
| 6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | See Item 6.3. |

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| 6.6 Were qualified staff and personnel used to collect the data?<br>*Project leader:*<br>Priscilla Olivas, Quality Management Program Coordinator | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The 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?<br><br>*Describe Interventions:*<br>• Wellness Coach provides individual intensive peer support (in coordination with Wellness Nurses), including individual and group education and training and linkages to the community<br>• Wellness Nurse provides individual intensive nurse support (in coordination with Wellness Coaches), including individual and group education and training and linkages to the community<br>• Provide Facing Up to Health groups<br>• Provide WRAP groups<br>• Track program phase (Engagement and Planning, Implementation, Transition and Maintenance, and Care Monitoring) participants are in currently. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |
| | **Totals** | 1 Met 0 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?<br><br>*This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)* | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The data analysis was provided in detail and was collected as of November 30, 2016, this is contained in the narrative PIP Submission tool submitted by the MHP.<br><br>As only 12 participants have been closed with only 7 having graduated from the program, statistical significance testing was not conducted.<br><br>Given the timeline of more than a year in process, the numbers should reflect an increased participation. The MHP is encouraged to assess the processes of enrolling and engaging consumers in this worthwhile endeavor. |
| 8.2 Were the PIP results and findings presented accurately and clearly?<br>Are tables and figures labeled? ☒ Yes ☐ No<br>Are they labeled clearly and accurately? ☒ Yes ☐ No | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | Detailed charts, graphs, and matrix results were submitted. |

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| 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?<br><br>Indicate the time periods of measurements: _____<br>Indicate the statistical analysis used: _____<br>Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |

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| 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?<br>*Limitations described:*<br>*Conclusions regarding the success of the interpretation:*<br>*Recommendations for follow-up:* | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | During the first year of the program, it was decided to add a follow-up survey to better assess program impact. Graduated participants are contacted at 1, 3, and 6-month post-graduation to inquire about health and mental health statuses and community integration. In December 2016, this follow-up survey was reviewed and revised to provide more useful data, including a format that can be mailed to graduates to complete and a decision to also follow up at 12 months. As participants, have started graduating from the program, the participation timeframe has recently been revisited as it has become apparent that some participants need more time to transition into and out of the program. Indeed, there has been difficulty in closing participants at 6-months with the average timeframe for participants being 7.4 months [range 4.7 – 11.6 months]. One graduate was recently re-referred to the program and two other participants who had greater levels of support scores requested additional time. Thus, it was discussed that participants fall into 3 categories:<br>•Engagement and Planning (1-3 months) --participants are enrolled, relationships built, and goals planned.<br>•Implementation (up to 6 months) -- participants are actively participating in the program.<br>•Transition and Maintenance (1-3 months) --participants are transitioned out of the program with contacts with the coaching team incrementally reduced and appropriate linkages put in place.<br>•Care Monitored, also known as the follow up survey phase.<br><br>The program will be kept at the original 6-month timeframe but will allow up to two 3-month extensions, a justification will need to be submitted by the provider. Processes will need to be put in place to track program phase. Another next step is to start billing for services for sustainability purposes. |
| | **Totals** | 1 Met 2 Partially Met 1 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?<br>*Ask: At what interval(s) was the data measurement repeated?*<br>*Were the same sources of data used?*<br>*Did they use the same method of data collection?*<br>*Were the same participants examined?*<br>*Did they utilize the same measurement tools?* | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ 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.<br><br>Participants complete measures related to their wellness and wellbeing perceptions and program satisfaction, however, some participants are not always accommodating in completing.<br><br>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.<br><br>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.<br><br>A data analysis indicates satisfaction, but it is too early to assess improvement. Initial data indicates that there is improvement, but 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.<br><br>When appropriate, data will be analyzed through difference of means tests once an appropriate sample size is attained. |

| | | |
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| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?<br>Was there: ☐ Improvement ☐ Deterioration<br>Statistical significance: ☐ Yes ☐ No<br>Clinical significance: ☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ 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?<br>*Degree to which the intervention was the reason for change:*<br>☐ No relevance ☐ Small ☐ Fair ☐ High | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 9.4 Is there any statistical evidence that any observed performance improvement is true improvement?<br>☐ Weak ☐ Moderate ☐ Strong | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| | **Totals** | 0 Met 1 Partially Met 0 Not Met 4 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<br>☒ No | |

**ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS**

*Conclusions:*

*Recommendations:*

The MHP is encouraged to increase its target pool of consumers for improvements to be demonstrated for this PIP.

Ongoing, regular data collection and follow up analyses to alter interventions and analyze the results of the indicators to meet its goals is encouraged.

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 FY16-17 NON- CLINICAL PIP

### GENERAL INFORMATION

**MHP**: Contra Costa

**PIP Title**: Improving Outpatient Appointment Adherence

**Start Date**: 04/11/15

**Completion Date:** ongoing

**Projected Study Period** (#of Months): 36

**Completed**: Yes ☒ No ☐

The MHP intends to continue this PIP, however, with limited results for its indicators reported over two years, it is rated complete for rating purposes**.**

**Date(s) of On-Site Review** :01/31-02/03/2017

**Name of Reviewer**: Jovonne Price

**Status of PIP (Only Active and ongoing, and completed PIPs are rated):**

**Rated**

☐ Active and ongoing (baseline established and interventions started)

☒ Completed since the prior External Quality Review (EQR): CalEQRO recommends retiring this PIP due to the inactivity for the results of its indicators and expects to see a new PIP for next year's review.

**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 Improving Outpatient Appointment Adherence project is a systemic approach to improve appointment adherence with the intent to improve access to mental health services. The project targets consumers throughout the mental health system of care through various interventions aimed at addressing issues regarding appointment documentation, failure to remember, communication, and staff shortages.

| 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<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Efforts of the PIP are carried out by multiple Workgroups. Currently there are two active Workgroups:<br>• Welcoming Environments Workgroup began meeting in April 2016 and is composed of family services coordinators, quality improvement coordinator, intake clinician, clerical supervisor, and representatives from the Office for Consumer Empowerment, Mental Health Services Act (MHSA), and Research and Evaluation Unit.<br>• Overcoming Transportation Barriers Workgroup was formed in August 2016 and consists of family services coordinators, family partner, and representatives from the Office for Consumer Empowerment, MHSA Innovative, and Research and Evaluation Unit. Once the peer transportation coordinators are hired, they will be incorporated into the Workgroup. Representatives from health clinics and community-based organizations may be invited to join. |
| 1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | A review of Contra Costa Mental Health clinic data suggests that, on average, non-attendance rates fall near the lower range cited in the literature with an overall 11% rate (with individual clinic rates ranging from 5% to 14%; see Figure 1).[5] However, it should be noted that appointment non-attendance contributes to clinic inefficiency, productivity loss, reduced service capacity, consumer disengagement, lack of quality mental health care, exacerbated consumer symptoms, and an increase in psychiatric emergency services. With a large number of appointments not being kept, consumers continue to experience significant wait times for rescheduled appointments. |

[5] Data obtained from direct services entered into legacy Insyst PSP system. See next Appointment Documentation section for PSP data concerns.

| ***Select the category for each PIP:***<br>*Clinical:*<br>☐ Prevention of an acute or chronic condition ☐ High volume services<br>☐ Care for an acute or chronic condition ☐ High risk conditions | | *Non-Clinical:*<br>☒ 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?<br>*Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.* | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Improving appointment adherence, reducing wait times, and increased provider productivity lend to quality care for consumers.<br><br>Given this is the second year of work on this concern, the MHP has continued to work on this issue with nominal improved processes over time. |
| 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)?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The project will provide services to individuals from all geographic regions of Contra Costa County, racial, and ethnic groups as well as diverse sexual orientations and gender identities and expressions. Some of the interventions will first be piloted at a clinic or region before system-wide implementation. |
| | **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?<br>Does the question have a measurable impact for the defined study population?<br>*Include study question as stated in narrative:*<br>"Will providing appointment reminders, educational materials, and transportation skill-building to consumers, as well as other systems-wide efforts, improve appointment adherence?" | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | See Item 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?<br>*Methods of identifying participants:*<br>☒ Utilization data ☐ Referral ☒ Self-identification<br>☐ Other: | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Results include limited target population. |
| | **Totals** | 1 Met 1 Partially Met 0 Not Met 1 UTD |

| STEP 4: Review Selected Study Indicators | | |
|---|---|---|
| 4.1 Did the study use objective, clearly defined, measurable indicators?<br>*List indicators:*<br>This PIP currently includes six indicators:<br>• Percentage of unattended appointments relative to total appointments made (i.e., overall no-show rate).<br>• Percentage of unattended initial appointments relative to total initial appointments made (i.e., initial appointment no-show rate).<br>• Percentage of new consumer unattended appointments relative to total new consumer appointments made (i.e., new consumer no-show rate).<br>• Percentage of consumers satisfied with information and resources about the mental system.<br>• Percentage of consumers who list transportation as a barrier to appointment adherence.<br>• Percentage of unattended psychiatric appointments relative to total psychiatric appointments made (i.e., psychiatric no-show rate). | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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.<br>☐ Health Status ☐ Functional Status<br>☒ Member Satisfaction ☐ Provider Satisfaction<br><br>Are long-term outcomes clearly stated? ☐ Yes ☐ No<br><br>Are long-term outcomes implied? ☒ Yes ☐ No | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Indicators are outlined, results are provided for some of the indicators. |
| | **Totals** | 1 Met 1 Partially Met 0 Not Met 0 UTD |
| **STEP 5: Review Sampling Methods** | | |
| 5.1 Did the sampling technique consider and specify the:<br>a) True (or estimated) frequency of occurrence of the event?<br>b) Confidence interval to be used?<br>c) Margin of error that will be acceptable? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | Sampling not done. |
| 5.2 Were valid sampling techniques that protected against bias employed?<br><br>*Specify the type of sampling or census used:*<br><Text> | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 5.3 Did the sample contain a sufficient number of enrollees?<br><br>_____N of enrollees in sampling frame<br>_____N of sample<br>_____N of participants (i.e. – return rate) | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| | **Totals** | Met Partially Met Not Met UTD |

| STEP 6: Review Data Collection Procedures | | |
|---|---|---|
| 6.1 Did the study design clearly specify the data to be collected? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | See Item 4.1. |
| 6.2 Did the study design clearly specify the sources of data?<br>*Sources of data:*<br>☐ Member ☐ Claims ☐ Provider<br>☐ Other: | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Appointment data may be collected from two sources: the PSP billing system and Cadence's Epic scheduling module. The MHP currently utilizes the PSP billing system for appointment scheduling but is in the process of transitioning to utilizing Cadence for scheduling in January 2017. Data consist of number of appointment total visits, number of non-attended, and the non-adherence percentage rate. This data will be needed for all consumers (indicator 1), intake appointments (indicator 2, currently not captured in PSP), new consumers first 6-month (indicator 3), and psychiatric appointments (indicator 6). Consumer data on satisfaction with information and materials provided (indicator 4) and barriers to appointment adherence (indicator 5) will be gathered through a County-developed Improvement Survey.<br><br>In addition, intervention-specific data will also be examined. For the Televox automated call reminder system.<br><br>Results not submitted. |
| 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<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Data collection methods identified, timelines for data collection not specified. |

| | | |
|---|---|---|
| 6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?<br>*Instruments used:*<br>☐ Survey ☐ Medical record abstraction tool<br>☐ Outcomes tool ☐ Level of Care tools<br>☐ Other: | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | Not completed yet. |
| 6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results? | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Pre- and post-intervention data on the indicators will be analyzed through difference of means tests, or t-tests. This method allows us to test for mean differences between the two periods. When no baseline data are available, frequency and means will be calculated. If untoward results are discovered, the MHP Executive Committee will be notified so that they may determine how to best manage the situation.<br>The analysis plan is identified; however, results are not completed. |

| | | |
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| 6.6 Were qualified staff and personnel used to collect the data?<br>*Project leader:*<br>Name: Priscilla Olivas<br>Title: Quality Management Coordinator<br>Role: Chair/Facilitator<br>*Other team members:* | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Personnel identified. Research and Evaluation Unit staff, experienced in data collection, will work with Business Intelligence to develop data reports that extract data from PSP and/or Cadence that can be run on an ongoing basis. Survey development and analysis will be monitored by Research and Evaluation staff. All the staff involved in this PIP are full-time MHP employees. Data will be reviewed on a regular basis by the appropriate Workgroup and larger Quality Management Committee. |
| | **Totals** | 2 Met 3 Partially Met 1 Not Met UTD |
| **STEP 7: Assess Improvement Strategies** | | |
| 7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?<br><br>*Describe Interventions:* | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | This year the PIP appears to be an extension of the prior year's activities. However, based on the submission tool, limited new interventions have been applied, especially to increase the attendance to appointments. Some additional survey results were conducted. These focused on peer's service time for transporting consumers, and surveys of consumer's mode and confidence in use of transportation to appointments.<br>The larger issue seems to be the ability for administration to accurately gauge non-attendance rates and this was hindered by the lack of an available universal appointment system. In addition, the MHP operates without an electronic health record, making the documentation of non-attendance cumbersome.<br>For example, there was no method to document non-attendance to an initial appointment in its legacy Insyst PSP system, meaning that when consumers do not attend their first appointment at a clinic, this no-show is not recorded.<br>Variances were also noted by the method psychiatrists document appointments, as well as variance in methods of keeping schedules, many of whom maintain their own. Given the higher no-show rate of 22% and the indicated staff shortage for this service, it is prudent to determine a systematic approach to documenting appointments and no-shows. |

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| | **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?<br><br>*This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 8.2 Were the PIP results and findings presented accurately and clearly?<br>Are tables and figures labeled? ☐ Yes ☐ No<br>Are they labeled clearly and accurately? ☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ 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?<br><br>Indicate the time periods of measurements: _____<br>Indicate the statistical analysis used: _____<br>Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ 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?<br>*Limitations described:*<br>*Conclusions regarding the success of the interpretation:*<br>*Recommendations for follow-up:* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| | **Totals** | Met Partially Met Not Met NA UTD |
| **STEP 9: Assess Whether Improvement is "Real" Improvement** | | |
| 9.1 Was the same methodology as the baseline measurement used when measurement was repeated?<br>*Ask: At what interval(s) was the data measurement repeated?*<br>*Were the same sources of data used?*<br>*Did they use the same method of data collection?*<br>*Were the same participants examined?*<br>*Did they utilize the same measurement tools?* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?<br>Was there: ☐ Improvement ☐ Deterioration<br>Statistical significance: ☐ Yes ☐ No<br>Clinical significance: ☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ 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?<br>*Degree to which the intervention was the reason for change:*<br>☐ No relevance ☐ Small ☐ Fair ☐ High | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 9.4 Is there any statistical evidence that any observed performance improvement is true improvement?<br>☐ Weak ☐ Moderate ☐ Strong | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ 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<br>☒ No | |

**ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS**

*Conclusions:*

*Recommendations:*

Continue technical assistance via telephone consults periodically this next year to outline a timeline, expand and provide interventions, assess them in a timely manner and determine the interventions to be adopted for success. Once the interventions are complete, the data collection for the indicators to provide results would require consistent review and subsequent changes for untoward results. The MHP was encouraged to seek increased consultation for the upcoming year.

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

# Quality of Care Committee
# Mental Health Commission
# *2016 Annual Report*

## Changes in Membership

The Quality of Care Committee has had many changes in membership since late 2015: We lost Chair Peggy Black, Dave Kahler, Tess Paoli and Greg Beckner; and we gained Gina Swirsding and Connie Steers. Currently, we stand at three committee members rather than target of four. These changes significantly impacted our ability to consistently form a quorum for meetings. Fortunately, Commission by-laws were changed recently to permit an Executive Committee member to stand in at a meeting to form a quorum, so we should be able to meet regularly in 2017.

## Scheduled Injectable Medication Procedure at Clinics

The Quality of Care Committee heard direct testimony from a family member whose son was not given a scheduled long-acting anti-psychotic injection medication at a BHS clinic. Typically, patients receiving an injectable are severely ill and lapses in medication can have serious consequences. Commissioners had experience with or were familiar with other incidences in our County. The Committee recognized that clinics should have the same accountability for medications that a hospital has when administering anti-psychotic medications to severely mentally ill patients. Committee and subsequent Commission efforts resulted in a revised procedure to improve effectiveness and timeliness of medication fulfillment. A Nursing Program Manager presented the revised procedure to the Commission. Our next step will be to circle back to look at the impact of the changes.

## Shelter Deaths

The Committee tracked on two deaths that occurred last winter at the Brookside Shelter and one death at the Family Courtyard. We were concerned that the deaths might have a mental health component. We visited these sites and asked questions, e.g. Were there lapses in care or safety procedures that contributed to the circumstances of the deaths? What type of quality assurance reviews take place after mortality? Who is going out to identify the mentally ill in areas that have overflow emergency shelters? What is the quality of outreach? Despite numerous attempts we were unable to obtain a coroners report or learn specific details regarding the deaths. We did, however, contribute to keeping these incidents visible. We plan to moniter the investigations around these deaths for progress and to continue efforts to keep the deaths in the spotlight.

## Consumer Rights

Many issues that the Committee learns of have a consumer rights aspect, whether it's a lapse in care or patient-to-patient violence. With the closure of services operated by Mental Health Consumer Concerns program in 2013, there is no longer a comprehensive consumer advocacy resource for clinic out-patients such as there is for PES and 4C in the hospital setting. What we have left is more of a patchwork of different advocacy options associated with different consumer programs. There is still a strong need for consumer advocates so that consumers have a formal mechanism for problem resolution and as a means for the BHS to learn about problems in care. This year the Committee heard testimony and discussed mental health-related incidences that led to several discussions on this topic. New Committee member Connie Steers has significant expertise in the area of consumer rights and the Committee is likely to advocate for a robust consumer rights program to serve County clinics.

## Other Efforts

- The Committee continued to research issues around the creation of crisis in-patient and residential facilities for children and adolescents. We consolidated information collected to date and have begun regular attendance of the Children's group that reports to Vern Wallace. Our next step will be to develop a case for the creation of these facilities for presentation to the Board of Supervisors and BHS Finance.

- The Committee supported the efforts of the Sheriff's office to win the SB863 grant award for expanding the West County detention facility with the purpose of improving mental health care for inmates. We visited the Martinez and West County jails and participated in meetings with the Sheriff's Office, County mental health staff, and other law enforcement and detention facility staff to learn about the needs of mentally ill inmates and about the proposed supports. Committee members voted affirmatively for Commission support of the Sheriff's grant proposal.

- The Committee stayed abreast of Quality of Care issues at PES.

- The Committee developed stronger ties to the County hospital in the way of information sharing. We are fortunate to have Victor Montoya and Shelley Whalen attending our meetings to report on hospital mental health situations and to provide input to current issues.

- The Committee performed an in-depth analysis of the 2015 EQRO report on behalf of the full Commission. We also requested greater participation for the Commission in this coming year's EQRO program analysis.

**Quality of Care Committee**
**Mental Health Commission**
***2017 Goals / Action Plan***

I. Continue to address gaps in medical, psychiatric, social and cultural services

- Respond on an ad hoc basis to issues brought to the Committee's attention

II. Continue to advocate for the creation of crisis in-patient and residential facilities for children and adolescents

III. Continue to monitor quality of care issues at Psychiatric Emergency Services (PES)

IV. Research specialty mental health services for consumers who have chronic health difficulties and/or dual diagnosis of developmental disabilities and mental illness

V. Continue to work with the Criminal Justice Committee and full Commission to advocate for improvements in the care of inmates who are mentally ill

VI. Update the full Commission on key findings from the EQRO annual report and support quality of care-related challenges and opportunities for Behavioral Health Services as identified through the EQRO process

VII. Evaluate consumer rights and advocacy programs for gaps in the system