Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

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MISSION STATEMENT: To assist Contra Costa County mental health consumers, family members and the general public in advocating for the highest quality mental health services and supports delivered with dignity and respect

QUALITY OF CARE COMMITTEE

Thursday January 18, 2018, 2017
AT: 2:30 pm-4:15pm
1340 Arnold Drive, suite 200, Martinez, CA
Large conference room

❖ ***PLEASE NOTE NEW LOCATION AND EARLIER START TIME OF 2:30***

AGENDA

I. Call to order/Introductions

II. DISCUSS JOINTLY Hope House Program Review with the MHSA/Finance Committee

III. Public comments

IV. Commissioner's comments

V. Chair announcements
- **Holding off on goals for 2017 until new membership in place**

VI. APPROVE minutes from November 16, 2017 meeting

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

VIII. DISCUSS and affirm Committee members and elect Chair and Vice Chair

IX. 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
November 16, 2017- DRAFT

	Agenda Item / Discussion	Action / Follow-up
I.	**Call to Order / Introductions @3:33pm** **Members Present**: Chair- Barbara Serwin, District II (arrived @3:31pm) Gina Swirsding, District I (arrived @3:33pm) **Members Absent**: Meghan Cullen, District V **Others Present**: William Edwards, Reentry Specialist –Reentry Success Center Lynnette Watts, MSOD-Health Services Administrator, Patient-Family Advisory @CCRMC Margaret Netherby, (pending applicant) Sam Yoshioka, District IV Doug Dunn, District III Lauren Retagliatta, District II Jill Ray, Field Rep for District II Supervisor Andersen Adam Down-MH Project Manager Liza A. Molina-Huntley, Executive Assistant (EA) for MHC	**Executive Assistant:** • **Transfer recording to computer.** • **Update Committee attendance** • **Update MHC Database**
II.	**Public Comment** • Discussed NAMI newsletter, copy not provided, interested in outcomes for consumers.	
III.	**Commissioner Comments** • Also discussed NAMI'S current newsletter, copy not provided- view on NAMI's website at: https://www.nami.org/ - did clarify that although some need treatment, not all consumers accept treatment and encourages others to advocate for the seriously mentally ill. Referred public member to contact Assisted Out Patient Treatment (AOT) program to inquire regarding personal family issue • Shared concerns regarding a possible correlation with social media and the increase in the suicide rate among teens	
IV.	**Chair announcements/comments:** • None	
V.	**APPROVE Minutes from October 19, 2017 meeting** • **Gina Swirsding moved to motion to approve the minutes, without corrections, Barbara Serwin seconded the motion** • **VOTE: 2-0-0** • **YAYS: Gina and Barbara** • **NAYS: 0 ABSTAIN: 0 ABSENT: Meghan Cullen**	• **Executive Assistant will correct the minutes, finalize and post the minutes on the Mental Health County website.**
VI.	**DISCUSS Contra Costa Regional medical Center (CCRMC) CONSUMER ADVOCACY, EMPOWERMENT AND GRIEVANCE RESOLUTION PROGRAM- with *Lynnette Watts*, MSOD-Health Services Administrator, Patient-Family Advisory Council/patient Experience at CCRMC** • The purpose of the office is to provide all patients, with the information regarding their rights and the grievance process and connect patients to the right resources. The information is provided in a welcome packet, in the hospital lobby, clinics and offered in person as well. • Provided and distributed copies of the "Patient Relations Department Grievance Summary and Guidelines" • The department is a regulatory department, commissioned by CMS, the State and joint Commission- the department is mandatory, to provide a process for patients to file grievances • As referenced in the guidelines, a 30 day period is provided to respond to a patient's	• **See attachment provided at meeting** • **Patient Relations Department can be contacted at CCRMC: Phone (925) 370-5144** • **MOTION –forward to the Mental Health Commission to write a letter to the Patient Relations Department, requesting or**

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grievance • The difference between a complaint and a grievance is that a complaint is a verbal discontent of services rendered, that is easily resolved; a grievance is a written formal, filed complaint, via email, fax or verbal, from the patient or the patient's representative related to the patient's care that is not resolved with a staff member at the time the complaint is made. • The department investigations, collect findings and provides a response and sent to the patient, the patient can choose to be satisfied with the resolution offered, or appeal/reject the resolution • Grievance forms are readily available at all units in the hospitals, inpatient, Psych Emergency Services (PES), all staff is made aware of the forms and can provide forms to patients upon request. On the website, patients can enter their comments and it will be sent to the communications team and they will forward the comments to the department • The Patient Relations Department staff does make rounds, throughout the hospital, they are visibly accessible and all staff can contact the department directly for the patient. • The number one priority is to resolve all issues as quickly as possible and assure that all patients are satisfied with their care and services received • Reports are done biannually. • The total amount of grievances received, for all areas in 2016, was approximately 300; which has declined from previous years receiving 700 to 600 grievances. • The decline in grievances filed is due to the improvement and effectiveness of the program. One of the improvements to services is instituting "Patient's Experience Rounds" at the hospital, daily, in the second day of admission into the hospital. Connecting with patients, talking to patients, asking questions, documenting- any patients having any concerns are dealt with immediately to resolve the issue. Follow up is done to assure that the issue is resolved, if not- the department will provide the patient with the form and inform the process for filling a grievance • Service recovery has also been instituted and principles that are being applied towards patient care, the new procedure has not been implemented in the PES/4C units, as of this moment. All staff in PES is aware of the program and can contact the department or provide the patient, family member or care giver with the department's contact information and forms • The role of the department is to advocate for the patient and their wellbeing • The Commission members and Committee members encourage that the department include PES/4C in their "Patient's Experience Rounds (PER)" and request to motion to recommend the action be taken. Request to forward to the Mental Health Commission to write a letter that the action is incorporated as a practice for PES/4C • Department head will consider and update the Committee regarding incorporating such action and staffing availability. • Currently, the department has a total of three staff members to cover all the hospital. The department handles all grievances for the hospital, with a total of 169 beds, Miller Wellness Center and all outpatient clinics and 4C. The department staff only provides the PER to patients staying at CCRMC, not including PES/4C. • **Barbara makes a MOTION that the Committee recommends to forward the issue to the Mental Health Commission to write a letter to CCRMC to recommend to incorporate the practice for PES/4C, Gina seconds the motion** • **VOTE: 2-0-0 YAYS: Barbara Serwin and Gina Swirsding NAYS: none ABSTAIN: none ABSENT: Mehgan Cullen**	**recommending for the department to incorporate the PER practice in PES/4C** • **Department head will consider to follow up regarding the Committee's suggestion to implement PER at PES/4C**
VII. DISCUSS updates from Psych Emergency Services (PES) with PES Program Chief, Victor Montoya • Unavailable due to schedule. Reschedule for next meeting.	***Invite PES for the next meeting**
VIII. REVIEW and DISCUSS the Quality of Care Committee 2017 activities for purposes of drafting the Committee's 2017 Year End Report • Goal #1- 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- the Chair	***Committee decided not to meet on December 21, due to the holidays**

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will write a brief description regarding the discussion w/Dr. Barham in August of 2017 • Goal #2- Started the dialogue regarding the need for a children/adolescent inpatient unit • Goal #3- Consumer Advocacy, Empowerment and Grievance Resolution program- Lynnette Watts • Goal #4- "Research specialty mental health services for consumers who have chronic health difficulties and/or dual diagnosis of developmental disabilities and mental illness (goal for 2018?) • Goal #5- work with the Criminal Justice Committee and full Commission to advocate for improvements in the care of inmates who are mentally ill- (was done at the Commission level and will be ongoing) • Goal #6- External Quality Review Organization (EQRO) and Consumer quality care focus groups- Priscilla Aguirre and Ann Isbell ** will report the findings, to the full Commission, possibly in January 2018? The MHSA/Finance Chair claimed that both Committees worked together, in the creation of the White Paper/Grand Jury Report and the meetings and reports that followed. • Goal # 7- Gathering information regarding consumer advocacy and grievance policies and forms- several meetings were focused on the presentations of the following, throughout 2017: - Department of Consumer Grievances- Bernadette Banks - Office of Consumer Empowerment (OCE)- Jennifer Tuipulotu and Roberto Roman - Quality Improvement and Grievance Compliance Coordinator- Steven Wilbur - Difficult to assess the services being delivered without reaching out to the community - Committee member stated that they had directed several consumers to the various department and all had positive outcomes and the departments did follow through with the consumers, addressed their grievances and worked on resolving their issues or concerns - Committee Chair suggests that members collectively continue to dialogue regarding their different experiences and perspectives • The Chair of the Committee would like to recruit more members for the Committee	
IX. REVIEW and DISCUSS Committee's Mission Statement • **Changes will be as follows:** **"To advocate for the highest quality mental health services to be delivered with dignity and respect"**	***EA will make changes and attach new Mission Statement to the next meeting's agenda packet and incorporate statement on all agendas**
X. DISCUSS potential committee goals for 2018 as follows: **1. Goals not completed or addressed in 2017** • During 2017, the second goal, "Continue to advocate for the creation of crisis inpatient and residential facilities for children and adolescents"- was a focus, during several meetings throughout the year, including the meeting with the Chief Operating/Financial Officer regarding the financial feasibility of creating a children/adolescent inpatient unit. The unit was deemed financially unfeasible and a state/federal wide problem. It was identified that there is a need to lobby, both at the state and federal levels, to advocate for funding for the unit project. • Other Commissioners in attendance clarified that if the Committee, or Commission, would develop the concept of what is needed for the residents/unit, along with a proposal with potential scenarios/solutions regarding how the unit can operate. • Will the Committee/Commission advocate for the development of the proposal, to other local Mental Health Commissions and other advisory boards, to gather their support to jointly advocate for funding for the unit; or will the Committee/Commission request surrounding counties, Behavioral Health Administration Divisions, to collectively commit to the	***Forward to the November meeting**

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need and use of the beds in the proposed unit, to raise the funding needed to create the unit? • Commissioners present, suggested to investigate the matter further and look into what the surrounding counties are doing regarding the issue and if it was resolved, how? Maybe write a letter, to neighboring county's Commissions and advisory boards, to obtain a response regarding their needs for an inpatient crisis unit for children and adolescents. Maybe collectively, the counties can advocate for funding and developing a proposal for, how to create the inpatient unit for children and adolescents • Another suggestion was to start a dialogue and collaborate with the Behavioral Health Services division, to move the ideas forward- the development should start at the administration department level, first. **2. Potential new goals for 2018**	
XI. Adjourned at 5:09 pm	

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

Mental Health Services Act (MHSA)

Program and Fiscal Review

I. Name of Program: Telecare – Hope House
300 Ilene Street, Martinez, CA 94553

II. Review Team: Stephanie Chenard, Betsy Orme, Warren Hayes

III. Date of On-site Review: February 10 and 15, 2017
Date of Exit Meeting: July 27, 2017

IV. Program Description: Telecare Corporation operates Hope House, a voluntary, highly structured 16-bed Short-Term Crisis Residential Facility (CRF) for adults. Hope House serves individuals who require crisis support to avoid hospitalization, or are discharging from the hospital or long-term locked facilities, and need step-down care to transition back to community living. The focus is client-centered and recovery-focused, and underscores the concept of personal responsibility for the resident's illness and independence. The program supports a social rehabilitation model, which is designed to enhance an individual's social connection with family and community so that they can move back into the community and prevent a hospitalization. Services are recovery based, and tailored to the unique strengths of each individual resident. The program offers an environment where residents have the power to make decisions, are supported as they look at their own life experiences, set their own paths toward recovery, and work towards the fulfillment of their hopes and dreams. Telecare's program is designed to enhance client motivation to actively participate in treatment, provide clients with intensive assistance in accessing community resources, and assist clients develop strategies to maintain independent living in the community and improve their overall quality of life. The program's service design draws on evidence-based practices such as Wellness Action and Recovery Planning (WRAP), motivational interviewing, and integrated treatment for co-occurring disorders.

V. Purpose of Review. Contra Costa Behavioral Health Services (CCBHS) is committed to evaluating the effective use of funds provided by the Mental Health Services Act (MHSA). Toward this end a comprehensive program and fiscal review was conducted of Telecare's Hope House Crisis Residential Program. The results of this review are contained herein, and will assist in a) improving the

services and supports that are provided; b) more efficiently support the County's MHSA Three Year Program and Expenditure Plan; and c) ensure compliance with statute, regulations and policy. In the spirit of continually working toward better services we most appreciate this opportunity to collaborate together with the staff and clients participating in this program in order to review past and current efforts, and plan for the future.

VI. Summary of Findings.

Topic	Met Standard	Notes
1. Deliver services according to the values of the MHSA	Met	Services promote recovery, wellness and resiliency.
2. Serve the agreed upon target population.	Met	Residents meet target population.
3. Provide the services for which funding was allocated.	Met	All MHSA funds directly support approved crisis residential services.
4. Meet the needs of the community and/or population.	Met	Residents verify services meet their needs.
5. Serve the number of individuals that have been agreed upon.	Not Met	Hope House does not meet their target monthly census goal.
6. Achieve the outcomes that have been agreed upon.	Partially Met	Hope House is currently meeting several of its outcomes.
7. Quality Assurance	Partially Met	The County needs to assist in implementing Level 1 utilization review process.
8. Ensure protection of confidentiality of protected health information.	Met	The program is HIPAA compliant
9. Staffing sufficient for the program	Not Met	Staffing level not sufficient to support targeted service numbers
10. Annual independent fiscal audit performed.	Met	No audit findings were noted.

11. Fiscal resources sufficient to deliver and sustain the services	Met	Resources appear sufficient.
12. Oversight sufficient to comply with generally accepted accounting principles	Met	Experienced staff implements sound check and balance system.
13. Documentation sufficient to support invoices	Met	Uses established software program with appropriate supporting documentation protocol.
14. Documentation sufficient to support allowable expenditures	Met	Method of accounting for personnel time and operating costs appear to be supported.
15. Documentation sufficient to support expenditures invoiced in appropriate fiscal year	Met	No billings noted for previous fiscal year expenses.
16. Administrative costs sufficiently justified and appropriate to the total cost of the program	Met	Methodology supports indirect rate of 16%.
17. Insurance policies sufficient to comply with contract	Met	Necessary insurance is in place
18. Effective communication between contract manager and contractor	Partially Met	County needs to solidify roles of Transition Team and contract manager to enable regular, coordinated program and contract communication.

VII. Review Results. The review covered the following areas:

1. **Deliver services according to the values of the Mental Health Services Act** (California Code of Regulations Section 3320 – MHSA General Standards). Does the program/plan element collaborate with the community, provide an integrated service experience, promote wellness, recovery and resilience, be culturally competent, and be client and family driven.
   Method. Consumer, family member and service provider interviews and consumer surveys.
   Discussion. As part of the site visits 10 consumers were interviewed as a group, and additional input was obtained by 7 consumers who completed a written survey prior to the site visits. We also spoke to several different staff

members, including staff from the organization management team, program management staff, administrative staff, and line staff.

Survey Results:

Questions	**Responses: n=7**				
Please indicate how strongly you agree or disagree with the following statements regarding persons who work with you:	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1	I don't know n/a
1. Help me improve my health and wellness.	Average score: 3.42 **(n=7)**				
2. Allow me to decide what my own strengths and needs	Average score: 3.14 **(n=7)**				
3. Work with me to determine the services that are most helpful	Average score: 2.86 **(n=7)**				
4. Provide services that are sensitive to my cultural background.	Average score: 2.8 **(n=5)**				
5. Provide services that are in my preferred language	Average score: 3.29 **(n=7)**				
6. Help me in getting needed health, employment, education and other benefits and services.	Average score: 3.17 **(n=6)**				
7. Are open to my opinions as to how services should be provided	Average score: 2.86 **(n=7)**				
8. What does this program do well?	• Helped with school • Non-judgmentally (sic) • Providing quality meals & shelter				
9. What does this program need to improve upon?	• Help with housing • Expression of desires • Staff being interrupted by their cell phones while working with clients.				
10. What needed services and supports are missing?	• Housing • Transportation • Being treated with respect not like a problem. Staff doing things in a timely manner.				

11. How important is this program in helping you improve your health and wellness, live a self-directed life, and reach your full potential?	Very Important 4	Important 3	Somewhat Important 2	Not Important 1
	Average score: 3.00 (n=4)			
12. Any additional comments?	• I really appreciate the help			

Consumer Interview

The resident consumer group interview was attended by approximately 10 consumers of mixed genders, ethnicities, and ages. The individuals interviewed had been staying at Hope House from a couple of days to a few weeks.

Overall, the interview participants were very appreciative of the services provided by Hope House and most reported that Hope House staff are very responsive to their needs. During the interviews, things that the residents specifically identified as positives of the program were:

- Feeling safe and secure
- Assistance with things like haircuts, new clothes/shoes, and other grooming and hygiene needs
- The schedule of classes and activities felt manageable – the residents did not feel rushed, or like they were forced to participate.
- The Hope House staff and County worked together to help create a safe support system
- The program helped some residents improve their relationships with their families.

These positives speak squarely to the MHSA values. However, there were also some areas identified by the residents for improvement. Some of these issues were:

- More time with the doctor who came to conduct assessments and evaluations
- More focused one-on-one time with staff
- A few residents noted that staff were often on their cell phones, which felt like a distraction
- More assistance with getting connected with County case managers
- Some of the resource materials made available were out of date.

Staff Interview:

Five program staff members were interviewed during the site visit. Staff shared that each of them have had some kind of personal background with mental illness and recovery in their lives, several of whom had been with Telecare in other capacities for a number of years. Most of the staff have specific roles (administration, medical, counseling, etc.) and shifts are staggered to ensure adequate coverage and support for residents 24/7. The residential counselors are trained in the Telecare curriculum to be able to offer the various classes. Staff also indicated that a portion of the classes and activities are driven by resident request.

Results. Hope House staff appear to implement services according to the values of the Mental Health Services Act.

2. **Serve the agreed upon target population.** For Community Services and Supports, does the program serve adults with a serious mental illness. Does the program serve the agreed upon target population (such as age group, underserved community).

   Method. Compare the program description and/or service work plan with a random sampling of client charts or case files.

   Discussion. As a matter of regular practice Hope House staff verify with County staff that all residents meet medical necessity, experience serious mental illness, and are in need of crisis stabilization. This referral and billing practice was matched by verifying observation of residents participating in the consumer group meeting.

   Results. The program serves the agreed upon target population.

3. **Provide the services for which funding was allocated.** Does the program provide the number and type of services that have been agreed upon.

   Method. Compare the service work plan or program service goals with regular reports and match with case file reviews and client/family member and service provider interviews.

   Discussion. A review of the monthly report shows that the program appears to provide the number and type of services that have been agreed upon in the Service Work plan, and discussion with the staff and residents reveals that the program is providing a clear level of crisis stabilization services around medication support, basic living tasks, crisis mitigation techniques, and other intensive mental health services.

   Results. Appropriate crisis residential services are provided by Hope House with appropriate intensive mental health specialty services for the residents.

4. **Meet the needs of the community and/or population.** Is the program meeting the needs of the population/community for which it was designed. Has the program been authorized by the Board of Supervisors as a result of a community program planning process. Is the program consistent with the MHSA Three Year Program and Expenditure Plan.
   Method. Research the authorization and inception of the program for adherence to the Community Program Planning Process. Match the service work plan or program description with the Three Year Plan. Compare with consumer/family member and service provider interviews. Review client surveys.
   Discussion. These crisis residential services have been authorized by the Board of Supervisors after a community program planning process identifying crisis housing services as a priority need. Consumer interviews and surveys indicate that Hope House is meeting their needs.
   Results. Hope House appears to be meeting the needs of the population for which it was designed.

5. **Serve the number of individuals that have been agreed upon.** Has the program been serving the number of individuals specified in the program description/service work plan, and how has the number served been trending the last three years.
   Method. Match program description/service work plan with history of monthly reports and verify with supporting documentation, such as logs, sign-in sheets and case files.
   Discussion. Supporting documentation indicates that there are 16 possible beds open to the County. Due to the short-term nature of the program, the average census for each month can vary, however, the established census goal is a monthly average of 12. This allows them to be immediately responsive to consumers in high-need situations. In FY 15/16, Hope House achieved 11.25, and monthly and quarterly reports in the FY 16/17 indicate between 10 to 12. While Hope House often comes close to this outcome goal, they frequently do not meet this outcome. Hope House works with several programs for referrals, including the County Psychiatric Emergency Services, the County hospital in-patient psychiatric unit, other psychiatric hospitals in the Bay Area, and other community referrals. Discussions with several County departments and programs that have contact with Hope House revealed that there have been enough referrals from the County recently and there is demonstrated need for Hope House beds; enough to hit or exceed their goal census. However, Hope House's admission process has been slow and has delayed placements, often for several days. This may be due to recent staff turnover, as well as the referral/admission process itself. County staff from these departments have

indicated the necessity for greater flexibility and responsiveness in the Hope House admission process to more smoothly place consumers in high-need situations. County staff have also indicated a desire for more clarity and shared definitions on admission criteria for potential referrals.
Results. The program does not meet the target number of individuals that have been referred to their facility by Contra Costa County. It is recommended that Hope House work with the County on a process to streamline their admission process in order to be more responsive to the referrals in a timely manner.

Please see Appendix A for Program Response

6. **Achieve the outcomes that have been agreed upon.** Is the program meeting the agreed upon outcome goals, and how has the outcomes been trending.
Method. Match outcomes reported for the last three years with outcomes projected in the program description/service work plan, and verify validity of outcome with supporting documentation, such as case files or charts. Outcome domains include, as appropriate, incidence of restriction, incidence of psychiatric crisis, meaningful activity, psychiatric symptoms, consumer satisfaction/quality of life, and cost effectiveness. Analyze the level of success by the context, as appropriate, of pre- and post-intervention, control versus experimental group, year-to-year difference, comparison with similar programs, or measurement to a generally accepted standard.
Discussion. Outcome goals are reported in terms of "MHSA Mandated Objectives" and "Contra Costa County Mandated Objectives." The MHSA-specific objectives/outcomes for Hope House center on "supporting family members and significant others" as a key part of the treatment plan. To address this, Hope House welcomes family members into the treatment whenever possible. In FY 15/16, they worked with 154 resident's families and facilitated 113 face-to-face sessions with family members at the facility. The program employed 2 Peer Counselors to help better serve this objective. They are presently on-track to meet goals for the current fiscal year.

   Contra Costa Behavioral Health Services outcomes focus on 1) maintaining a monthly average census of at least 12 residents, and 2) an average length of stay of 14 days or less. Please see above discussion for the census topic. As for the average length of stay, Hope House reported for FY 15/16 an average stay of 18 days – higher than the stated outcome. However, at the time of the review, it was revealed that County Case Managers were having difficulties finding placements before the 30 day closing time period for the program.

Moreover, it was also disclosed that many consumers can benefit from a longer stay. In recent monthly reports, Hope House has indicated average lengths of stay being reduced down to 11 days, meeting this outcome measure.
Results. Hope House appears to be partially meeting the prescribed outcomes in the service agreement. It is recommended that the County revisit the Service Work Plan to adjust the 14 day stay outcome to better reflect the needs of the consumers. Recommendations for the census outcome have been previously noted.

Please see Appendix A for Program Response

7. **Quality Assurance.** How does the program assure quality of service provision.
Method. Review and report on results of participation in County's utilization review, quality management incidence reporting, and other appropriate means of quality of service review.
Discussion. CCBHS did not receive any grievances associated with Hope House's crisis residential program. The program has an internal grievance procedure in place, and clients receive information on how to file complaints as part of the agency's Notice of Privacy Practices. The program has not undergone a regular Level 1 utilization review conducted by the County Mental Health utilization review teams to ensure that program services and documentation meet regulatory standards. On October 13, 2016, a Level Two Centralized Utilization Chart Reviews and a Focused Review were conducted by County Mental Health on Hope House's charts. The results show that charts generally met documentation standards, but there were several compliance issues, including missing forms (consent for treatment, consumer guide, etc.), and other incomplete or incorrect forms that were identified in the review. There were several other findings related to disallowances for Initial Assessments that were not completed, illegible, improperly billed, or unclear on diagnosis. There were also significant disallowances based on Partnership Plans that were missing, incomplete, or not updated to accurately reflect a resident's length of stay. There were additional, smaller disallowances regarding a variety of issues with progress notes: missing progress notes, incomplete notes, not documenting billable services, mis-categorized notes, and other related issues. Hope House's Program Director submitted a Plan of Correction to the County November 26, 2016 indicating the new protocols for quality assurance, training, and increased communication with the County to address the issues in the Focused Review. The newly implemented processes were confirmed during the chart review process at the site visit by the review team.

Further, with the recent implementation of the DSM-V, the County Transition team has expressed that Hope House's clinical documentation frequently does not match the new DSM-V diagnostic criteria, which impacts the utilization review compliance for these charts.

Results. The program has a quality assurance process in place. However, it is recommended that the County's Transition Team work with Hope House to institute regular Level 1 reviews to ensure compliance criteria are communicated with the program. It is also recommended that Hope House work with the Transition Team to get current with DSM-V guidelines.

Please see Appendix A for Program Response

8. **Ensure protection of confidentiality of protected health information.** What protocols are in place to comply with the Health Insurance Portability and Accountability Assurance (HIPAA) Act, and how well does staff comply with the protocol.
   Method. Match the HIPAA Business Associate service contract attachment with the observed implementation of the program's implementation of a protocol for safeguarding protected patient health information.
   Discussion. Hope House staff demonstrated their protocol as well as provided their written policy for protection of patient health information. All were in accordance with the HIPAA Business Associate service contract attachment.
   Results. Hope House appears to be in compliance with HIPAA requirements.

9. **Staffing sufficient for the program.** Is there sufficient dedicated staff to deliver the services, evaluate the program for sufficiency of outcomes and continuous quality improvement, and provide sufficient administrative support.
   Method. Match history of program response with organization chart, staff interviews and duty statements.
   Discussion. Telecare has an organizational structure of filled positions indicating a sufficient number and type of staff to support their operations, and particularly for the Hope House program. The Program Director recently left, and the organization restructured the administrative configuration by hiring a Clinical Director to oversee the clinical programmatic portions, and the Program Administrator oversees the administrative and business duties. This restructuring and redefining of duties and roles seems to have streamlined Hope House's management process.

The experience level of the line staff appeared to range toward a more experienced level of mental health care. Telecare has a robust internal training program, and is still aiming to identify and address a variety of mental health issues in their training process. However, there were some areas of improvement that staff identified could help improve service offerings. This was mostly in the area of increasing bilingual staffing. There was at least one person who was bilingual in Spanish, but an additional staffer fluent in Spanish would be a benefit to their community, or someone fluent in an Asian language, such Tagalog or Cantonese. Lastly, there was a desire expressed for possible consultation with a dietician to help more effectively plan meals for residents with specialty needs, such as diabetic or vegetarian meals.

It was noted, however, that there were no mental health clinical staff present during the staff interviews. The roster indicated 3 licensed, or license eligible clinicians, but none were present during the day of the site visit. It was later indicated that a short time after the site visit, two of these staff resigned, leaving only one clinician and the Clinical Director to conduct clinical duties. This may contribute to the delay in processing referral admissions as well as other programing. A written response dated May 22, 2017 from the Hope House management detailed a plan to help cover service gaps including engaging an outside agency to provide contract clinician time, as well as “borrowing” a clinician from another Telecare facility.

Moreover, interviews with County staff have revealed episodes where a few clients have experienced reactions to medications while at Hope House. Medication programs for consumers are normally prescribed through their normal system of care or hospital staff outside of Hope House; however, with more engaged monitoring from the licensed and clinical staff at Hope House, early indicators may possibly be identified more quickly and communicated promptly to County staff to reduce instances and severity of complications with medications.

Results. Staffing is not sufficiently in place to serve the number of clients outlined in the Service Work Plan. It is recommended that Hope House review its recruiting and retention practices to ensure adequate coverage of clinical staff. It is further recommended that the County work with Hope House to create a plan for stronger coordination of care for consumers’ medication regimens.

Please see Appendix A for Program Response

10. **Annual independent fiscal audit.** Did the organization have an annual independent fiscal audit performed and did the independent auditors issue any findings.
    Method. Obtain and review audited financial statements. If applicable, discuss any findings or concerns identified by auditors with fiscal manager.
    Discussion. Audited financial statements for Telecare were reviewed for fiscal years ending 2014, 15 and 16. Telecare Corporation operates behavioral health treatment programs in ten states and several California counties under cost reimbursed and fee for service contracts, primarily with government agencies. The corporation has been steadily growing over the years, and it's totally owned subsidiary, TLC Behavioral Health and Psychology Corporation operates in California through a management agreement. The contract for operation of the Hope House is the only contract that Telecare has with Contra Costa County. The independent auditors did not any report any material or significant weaknesses.
    Results. No audit findings were noted.

11. **Fiscal resources sufficient to deliver and sustain the services.** Does the organization have diversified revenue sources, adequate cash flow, sufficient coverage of liabilities, and qualified fiscal management to sustain program or plan element.
    Method. Review audited financial statements. Review Board of Directors meeting minutes. Interview fiscal manager of program.
    Discussion. Telecare is an S Corporation that owns and issues significant stocks and stock options, has diversified resources, significant operating reserves, and a line of credit. Telecare is in the first year of a two year contract with CCBHS, and staff report that budgeted amounts for the two year period appear sufficient to cover operating expenses.
    Results. Resources appear sufficient.

12. **Oversight sufficient to comply with generally accepted accounting principles.** Does organization have appropriate qualified staff and internal controls to assure compliance with generally accepted accounting principles.
    Method. Interview with fiscal manager of program.
    Discussion. The Budget Manager and Senior Financial Analyst were both interviewed and described the processes that staff utilized to implement generally accepted accounting principles. Both have extensive experience managing accounting staff for organizations of this size. Supporting documentation to monthly invoicing depict appropriate time keeping documents for tracking staff time, proper allocation of operating costs, and segregation of duties.

Results. Experienced staff implements sound check and balance system.

13. **Documentation sufficient to support invoices.** Do the organization's financial reports support monthly invoices charged to the program and ensure no duplicate billing.
    Method. Reconcile financial system with monthly invoices. Interview fiscal manager of program or plan element.
    Discussion. Supporting documentation for a randomly selected monthly invoice for each of the last three years were provided and analyzed. Telecare utilizes Crystal Reports as the database for reconciling staff payroll. Staff budgeted as part-time to this contract and other contracts periodically reconcile and document actual time spent to ensure that only actual time is billed.
    Results. Uses established software program with appropriate supporting documentation protocol.

14. **Documentation sufficient to support allowable expenditures.** Does organization have sufficient supporting documentation (payroll records and timecards, receipts, allocation bases/statistics) to support program personnel and operating expenditures charged to the program or plan element.
    Method. Match random sample of one month of supporting documentation for each fiscal year (up to three years) for identification of personnel costs and operating expenditures invoiced to the county.
    Discussion. Supporting documentation reviewed for monthly invoices appeared to support the method of allocating appropriate costs to agreed-upon budget line items.
    Results. Method of accounting for personnel time and operating costs appear to be supported.

15. **Documentation sufficient to support expenditures invoiced in appropriate fiscal year.** Do organization's financial system year end closing entries support expenditures invoiced in appropriate fiscal year (i.e., fiscal year in which expenditures were incurred regardless of when cash flows).
    Method. Reconcile year end closing entries in financial system with invoices. Interview fiscal manager of program or plan element.
    Discussion. The County Auditor's expense summaries for the last three fiscal years were reviewed. Expenses were allocated to the correct fiscal year, and close out appeared timely, as no expenditures surfaced after the County's closeout date.
    Results. No billings noted for previous fiscal year expenses.

16. **Administrative costs sufficiently justified and appropriate to the total cost of the program.** Is the organization's allocation of administrative/indirect costs to the program commensurate with the benefit received by the program or plan element.
    Method. Review methodology and statistics used to allocate administrative/indirect costs. Interview fiscal manager of program.
    Discussion. Telecare produced its methodology that justifies the 16% indirect rate charged to the contract.
    Results. Indirect rate justified as per OMB Circular A-122.

17. **Insurance policies sufficient to comply with contract.** Does the organization have insurance policies in effect that are consistent with the requirements of the contract.
    Method. Review insurance policies.
    Discussion. The program provided general liability insurance policies that were in effect at the time of the site visit**.**
    Results. The program complies with the contract insurance requirements.

18. **Effective communication between contract manager and contractor.** Do both the contract manager and contractor staff communicate routinely and clearly regarding program activities, and any program or fiscal issues as they arise.
    Method. Interview contract manager and contractor staff.
    Discussion. The County has multiple staff interacting with Hope House staff. This includes Adult Services management negotiating care, analysts to generate and process Hope House contracts and sign and forward submitted invoices, case managers to interact with Hope House staff regarding residents, the hospital or psychiatric emergency services to refer potential residents or to refer back for emergent care, County Public Works or Behavioral Health Services Purchasing to address facility maintenance and needs, County Housing Coordinators to attend to facility compliance issues, and MHSA staff performing program and fiscal reviews and issuing a report with finding and recommendations. This has resulted in challenges for Hope House staff when issues arise needing a timely, coordinated response with follow-up toward resolution.

    Results. It is recommended that the County re-visit how it communicates with Hope House with the objective of strengthening the County's Transition team, and the contract manager roles as a central program and fiscal points of contact.

    Please see Appendix A for Program Response

VIII. Summary of Results.

Telecare's Hope House provides appropriate crisis residential services to adults challenged with serious mental illness. It is a voluntary service facility that is part of a large, national for profit organization consisting of a wide variety of mental health programs in several states. Staff and clients alike agree that service response is based on strength based psychosocial rehabilitation principles that promote recovery, wellness and resiliency. Staffing appears sufficient and qualified to meet self-prescribed service objectives. Support from Hope House's corporate and administrative headquarters appears sufficient to enable the program to focus on service delivery.

Issues for attention pertain to the communication with the County, and staff recruitment and retention.

IX. Findings for Further Attention.

- The County's Transition Team should work with Hope House to institute regular Level 1 reviews to ensure compliance criteria are communicated with the program, and to get current with DSM-V guidelines.

- It is recommended that Hope House work on a process to streamline their admission process in order to be more responsive to the referrals in a timely manner.

- It is recommended that the County revisit the Service Work Plan to adjust the 14 day stay outcome to better reflect the needs of the consumers.

- It is recommended that Hope House review its recruiting and retention practices to ensure adequate coverage of clinical staff.

- It is further recommended that Hope House work with the County to create a plan for stronger coordination of care for consumers' medication regimens.

- The County should also strengthen the County's Transition team, and the contract manager roles as a central program and fiscal points of contact, as well as provide assistance and oversight for connectivity and transition to the County's adult system of care.

X. Next Review Date. February 2020

XI. Appendices.

Appendix A – Response from Program to Report

Appendix B – Program Description/Service Work Plan

Appendix C – Service Provider Budget

Appendix D – Yearly External Fiscal Audit

Appendix E – Organization Chart

XII. Working Documents that Support Findings.

Consumer Listing

Consumer, Family Member Surveys

Consumer, Family Member, Provider Interviews

County MHSA Monthly Financial Report

Progress Reports, Outcomes

Centralized Utilization Review Reports

Program's Response to UR Report

Monthly Invoices with Supporting Documentation

Indirect Cost Allocation Methodology/Plan

Board of Directors' Meeting Minutes

Insurance Policies

MHSA Three Year Plan and Update(s)

APPENDIX A

Service Provider's Response to Report

TELECARE Hope House
300 Ilene Street
Martinez, CA 94553
(925) 313-7980

TELECARE
CORPORATION

August 10th, 2017

Stephanie Chenard, MBA
Analyst/ASA III, Mental Health Services Act
MHSA Workforce Education and Training Coordinator
Contra Costa Behavioral Health Services
Mental Health Administration
1340 Arnold Drive, Suite 200
Martinez, CA 94553

Re: Plan of Correction for Hope House MHSA Program and Fiscal Review dated February 10 and 15, 2017

Dear Ms. Chenard,

Below is the plan of correction to the Hope House MHSA Program and Fiscal Review dated February 10 and 15, 2017.

Summary of Findings:

Section 5. Serve the number of individuals that have been agreed upon.

Results. The program does not meet the target number of individuals that have been referred to their facility by Contra Costa County. It is recommended that Hope House work with the County on a process to streamline their admission process in order to be more responsive to the referrals in a timely manner.

Response:

1. Hope House already started the process of streamlining our admission process. We have reduced response times to 2 hours during regular business hours upon receiving a hospital referral.
2. We are teaming with our County consultant on implementing a process by which our referral sources inform us of planned discharges with a 2-day advance notice; this will facilitate a "warm handoff" of our residents between agencies.

3. Hope House target number of individuals is dependent upon the number of referrals we receive. There have been extended periods in which we have had minimal referrals, resulting in a lower census. This may have impacted Hope House serving the target number of individuals that have been agreed upon.

Section 6. Achieve the outcomes that have been agreed upon.

Results. Hope House appears to be partially meeting the prescribed outcomes in the service agreement. It is recommended that the County revisit the Service Work Plan to adjust the 14 day stay outcome to better reflect the needs of the consumers. Recommendations for the census outcome have been previously noted.

Response:

1. Starting in January 2017, we have greatly reduced the length of stay of our residents. Over the past 6 months, we have been working closely with county case management agencies to facilitate a faster discharge process. This has resulted in the monthly average length of stay being reduced to 11 to 14 days over the past 6 months. We plan to continue this process to ensure timely discharges of our residents.
2. We are working with our county partners to revise the Hope House Service Plan to modify IX. Outcome Measures to state that the average length of stay will be 14 days, not to exceed 30 days.

Section 7. Quality Assurance.

Results. The program has a quality assurance process in place. However, it is recommended that the County's Transition Team work with Hope House to institute regular Level 1 reviews to ensure compliance criteria are communicated with the program. It is also recommended that Hope House work with the Transition Team to get current with DSM-V guidelines.

Response: We are currently working with the County's transition Team to institute regular Level 1 reviews to ensure that Hope House meets compliance criteria. The County implemented the new DSM-V guidelines on April 1, 2017; Hope House was not informed of these changes until June 15, 2017. Upon learning of the new DSM-V guidelines, we immediately implemented the changes in the documentation process. Hope House is current with all DSM-V guidelines.

Section 9. Staffing sufficient for the program.

Results. Staffing is not sufficiently in place to serve the number of clients outlined in the Service Work Plan. It is recommended that Hope House review its recruiting and retention practices to ensure adequate coverage of clinical staff. It is further recommended that the County work with Hope House to create a plan for stronger coordination of care for consumers' medication regimens.

Response:

1. From Hope House's perspective, we have had sufficient staffing in place to serve the number of clients outlined in the Service Work Plan. Residents report a very high level of satisfaction with the services provided by Hope House. Over the past year, the clinical team has consisted

of 2-3 clinicians, supervised and supported by the Clinical Director. There was a brief period between April and May, 2017 during which there was a single clinician working with the Clinical Director; the Clinical Director performed clinician duties as well as his regular duties, ensuring excellent quality of care for our residents. Hope House has since hired new clinicians to complete the clinical team.

2. Hope House follows all Telecare guidelines in recruiting and retaining staff. Telecare advertises on several major recruiting websites; in addition, the Clinical Director have attended several job fairs at local universities to recruit qualified clinicians. We have also utilized a social work temporary agency to fill one of the positions when we were short-staffed. Overall, we thoroughly vet our staff to ensure that our facilities maintain excellent quality of care.
3. Hope House is currently working on implementing a process by which our psychiatrist more closely works with psychiatrists from our local referral sources and case management teams. It must be noted that there was only one instance of a severe medication reaction from one resident, not several. This reflected a resident who was refusing abilify; her case management team was notified. After a week of refusing abilify, she started to become psychotic; she was sent to the CCRMC Emergency Department after having severe vertigo. It was only later discovered, after she had been assessed by both the Emergency Department as well as Psychiatric Emergency Services, that she also had high levels of lithium in her system, which may have compounded her psychosis after refusing her abilify. Hope House's first priority is to provide quality psychiatric and medical care for all our residents.

Section 18. Effective communication between contract manager and contractor.

Results. It is recommended that the County re-visit how it communicates with Hope House with the objective of strengthening the County's Transition team, and the contract manager roles as a central program and fiscal points of contact.

Response:

1. The Clinical Director of Hope House has been attending ongoing County meetings, such as the monthly System of Care meeting, to better coordinate communication and care of our residents. The Clinical Director also has multiple daily contacts with Betsy Orme, the supervisor of the Transition Team.
2. The Program Administrator of Hope House is now currently meeting monthly with the Adult/Older Adult Mental Health Program Chief to facilitate ongoing communication.

APPENDIX B

Program Description/Service Work Plan

Telecare Corporation

Point of Contact: Clearnise Bullard, Program Administrator
Jim Christopher, Clinical Director
Contact Information: 300 Ilene Street, Martinez, CA 94553, (925) 313-7980
cbullard@telecarecorp.com, jchristopher@telecarecorp.com

1. **General Description of the Organization**
   Telecare Corporation was established in 1965 in the belief that persons with mental illness are best able to achieve recovery through individualized services provided in the least restrictive setting possible. Today, they operate over 100 programs staffed by more than 2,500 employees in California, Oregon, Washington, Arizona, Nebraska, North Carolina, Texas, New Mexico and Pennsylvania and provide a broad continuum of services and supports, including Inpatient Acute Care, Inpatient Non-Acute/Sub-Acute Care, Crisis Services, Residential Services, Assertive Community Treatment (ACT) services, Case Management and Prevention services.
2. **Program: Hope House Crisis Residential Facility - CSS**
   Telecare Corporation operates Hope House, a voluntary, highly structured 16-bed Short-Term Crisis Residential Facility (CRF) for adults between the ages of 18 and 59. Hope House is serves individuals who require crisis support to avoid hospitalization, or are discharging from the hospital or long-term locked facilities and need step-down care to transition back to community living. The focus is client-centered and recovery-focused, and underscores the concept of personal responsibility for the resident's illness and independence. The program supports a social rehabilitation model, which is designed to enhance an individual's social connection with family and community so that they can move back into the community and prevent a hospitalization. Services are recovery based, and tailored to the unique strengths of each individual resident. The program offers an environment where residents have the power to make decisions and are supported as they look at their own life experiences, set their own paths toward recovery, and work towards the fulfillment of their hopes and dreams. Telecare's program is designed to enhance client motivation to actively participate in treatment, provide clients with intensive assistance in accessing community resources, and assist clients develop strategies to maintain independent living in the community and improve their overall quality of life. The program's service design draws on evidence-based practices such as Wellness Action and Recovery Planning (WRAP), motivational interviewing, and integrated treatment for co-occurring disorders.

a. Scope of Services:
   - Individualized assessments, including, but not limited to, psychosocial skills, reported medical needs/health status, social supports, and current functional limitations within 72 hours of admission.
   - Psychiatric assessment within 24 hours of admission.
   - Treatment plan development with 72 hours of admission.
   - Therapeutic individual and group counseling sessions on a daily basis to assist clients in developing skills that enable them to progress towards self-sufficiency and to reside in less intensive levels of care.
   - Crisis intervention and management services designed to enable the client to cope with the crisis at hand, maintaining functioning status in the community, and prevent further decompensation or hospitalization.
   - Medication support services, including provision of medications, as clinically appropriate, to all clients regardless of funding; individual and group education for consumers on the role of medication in their recovery plans, medication choices, risks, benefits, alternatives, side effects and how these can be managed; supervised self-administration of medication based on physician's order by licensed staff; medication follow-up visit by a psychiatrist at a frequency necessary to manage the acute symptoms to allow the client to safely stay at the Crisis Residential Program, and to prepare the client to transition to outpatient level of care upon discharge.
   - Co-occurring capable interventions for substance use following a harm reduction modality in addition to weekly substance abuse group meetings as well as availability of weekly AA and NA meetings in the community.
   - Weekly life skills groups offered to develop and enhance skills needed to manage supported independent and independent living in the community.
   - A comprehensive weekly calendar of activities, including physical, recreational, social, artistic, therapeutic, spiritual, dual recovery, skills development and outings.
   - Peer support services/groups offered weekly.
   - Engagement of family in treatment, as appropriate.
   - Assessments for involuntary hospitalization, when necessary.
   - Discharge planning and assisting clients with successful linkage to community resources, such as outpatient mental health clinics, substance abuse treatment programs, housing, full service partnerships, physical health care, and benefits programs.
   - Follow-up with client and their mental health service provider following discharge to ensure that appropriate linkage has been successful.
   - Daily provision of meals and snacks for residents.
   - Transportation to services and activities provided in the community, as well as medical and court appointments, if the resident's case manager or county worker is unavailable, as needed.

b. Target Population: Adults ages 18 to 59 who require crisis support to avoid psychiatric hospitalization, or are discharging from the hospital or long-term locked facilities and need step-down care to transition back to community living.
c. Payment Limit: FY 16/17: $2,077,530.00
d. Number served: Number to be served yearly: 200. Hope House served 193 clients in FY 15/16.
e. Outcomes:
    - Reduction in severity of psychiatric symptoms: Discharge at least 90% of clients to a lower level of care.
    - Consumer Satisfaction: Maintain an overall client satisfaction score of at least 4.0 out of 5.0.

APPENDIX C

Service Provider Budget

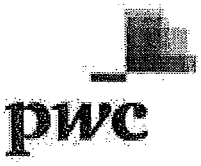
CONTRACTOR DETAILED BUDGET				
Telecare Corporation				
Program Budget FY 2016-2017				
Term: July 1, 2016 - June 30, 2017				
CONTRACT # 24-712				
Organization Name: Telecare Hope House Crisis Residential Center				
		Cash Match/		
	Proposed	In-kind Budget	Total	
Personnel Costs	**Budget**	**(if applicable)**	**Proposed Budget**	**Budget Justification**
Regional Operations Director ($155,389 @ .10FTE)	15,539		15,539	
Program Director ($133,679 @ 1.0 FTE)	133,679		133,679	
Clinician ($56,465 @ 3.20 FTE)	193,196		193,196	
LVN/LPT ($50,296 @ 2.80 FTE)	140,828		140,828	
PSC III ($56,987 @ 1.0 FTE)	56,987		56,987	
Residential Counselor ($35,295 @ 7.0 FTE)	247,062		247,062	
Peer ($32,216 @ 1.40 FTE)	45,103		45,103	
Clinical Director ($94,560 @ 1.0 FTE)	88,230		88,230	
Business Office Manager/HR ($70,344 @ 1.0 FTE)	70,344		70,344	
Clerk Typist ($32,185 @ 1.0 FTE)	32,185		32,185	
Total Salaries	**1,023,153**	**-**	**1,023,153**	
Benefits @ 33%	337,593		337,593	
Total Salaries and Benefits	**1,360,745**	**-**	**1,360,745**	
Operating Costs				
Office Space	12		12	
Printing/Photocopies	3,000		3,000	
Supplies	14,596		14,596	
Postage/Communications	13,467		13,467	
Travel/Training	19,902		19,902	
Clinical Services	206,850		206,850	
Physical Plant	39,983		39,983	
Dietary Services	51,394		51,394	
Consultant	-		-	
General & Administrative	60,688		60,688	
Medical Records Services	1,075		1,075	
Depreciation	6,041		6,041	
Vehicle Lease	6,222		6,222	
Ancillary	7,000		7,000	
Total Operating Costs	**430,228**	**-**	**430,228**	
Total Expenses	**1,790,974**	**-**	**1,790,974**	
Indirect Costs @ 16%	286,556		286,556	
Total Project Costs	**2,077,530**	**-**	**2,077,530**	
Projected Medi-Cal & Medicaid Expansion	**618,920**	**-**	**618,920**	
Total County Cost	**1,458,609**	**-**	**1,458,609**	

APPENDIX D

Yearly External Fiscal Audit

Telecare Corporation and Subsidiaries

Consolidated Financial Statements
June 30, 2016 and 2015



Telecare Corporation and Subsidiaries
Index
June 30, 2016 and 2015

Independent Auditor's Report

To the Board of Directors
of Telecare Corporation

We have audited the accompanying consolidated financial statements of Telecare Corporation and subsidiaries (collectively, the "Company"), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of income and comprehensive income, of stockholders' equity and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

pwc

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Telecare Corporation and subsidiaries at June 30, 2016 and 2015, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP

San Francisco, California
September 22, 2016

Telecare Corporation and Subsidiaries
Consolidated Balance Sheets
June 30, 2016 and 2015

(in thousands of dollars except per share amounts)	2016	2015
Assets		
Current assets		
Cash and cash equivalents	$ 11,217	$ 9,928
Restricted cash	114	102
Accounts receivable, net of allowance for doubtful accounts of $673 in 2016 and $372 in 2015, respectively	35,565	29,828
Prepaid expenses and other current assets	2,545	2,082
Total current assets	49,441	41,940
Property and equipment, net	23,620	21,109
Other assets	7,318	7,215
Total assets	$ 80,379	$ 70,264
Liabilities and Stockholders' Equity		
Current liabilities		
Accounts payable and accrued liabilities	$ 31,700	$ 27,738
Current maturities of long-term debt	630	495
Contract advances	3,330	3,064
Total current liabilities	35,660	31,297
Long-term debt, net of current maturities	13,696	8,424
Other liabilities	13,102	12,856
Total liabilities	62,458	52,577
Commitments and contingencies (Notes 4 and 14)		
Stockholders' equity		
Common stock, no par value; 12,000,000 shares authorized; 2,003,127 and 2,025,057 shares issued and outstanding at June 30, 2016 and 2015, respectively	6,438	5,254
Retained earnings	12,176	12,963
Accumulated other comprehensive loss	(693)	(530)
Total stockholders' equity	17,921	17,687
Total liabilities and stockholders' equity	$ 80,379	$ 70,264

The accompanying notes are an integral part of these consolidated financial statements.

Telecare Corporation and Subsidiaries
Consolidated Statements of Income and Comprehensive Income
Years Ended June 30, 2016 and 2015

(in thousands of dollars)	2016	2015
Revenue		
Net patient service revenue	$ 276,272	$ 255,715
Provision for doubtful accounts	619	515
Net patient service revenue less provision for doubtful accounts	275,653	255,200
Costs and expenses		
Patient care services	152,032	146,345
General and administrative	105,797	91,493
Rent	9,064	8,359
Depreciation and amortization	3,409	3,248
Interest	700	641
	271,002	250,086
Income from continuing operations before income taxes	4,651	5,114
Income tax expense	86	98
Income from continuing operations	4,565	5,016
Other comprehensive (loss) income		
Unrealized (loss) gain on interest rate swap	(425)	373
Comprehensive income	$ 4,140	$ 5,389

The accompanying notes are an integral part of these consolidated financial statements.

Telecare Corporation and Subsidiaries
Consolidated Statements of Stockholders' Equity
Years Ended June 30, 2016 and 2015

(in thousands of dollars except per share amounts)	Common Stock Shares Outstanding	Common Stock Amount	Retained Earnings	Accur Ot Compr Lo
Balances at June 30, 2014	2,046,146	$ 4,438	$ 12,010	$
Net income	-	-	5,016	
Unrealized gain on interest rate swap	-	-	-	
Vesting of 15,000 shares of restricted common stock	-	543	-	
Issuance of common stock				
Vested	10,000	365	-	
Restricted unvested	10,000	-	-	
Exercise of stock options	39,000	540	-	
Stock repurchase	(80,089)	(632)	(2,291)	
Dividend distribution	-	-	(1,772)	
Balances at June 30, 2015	2,025,057	5,254	12,963	
Net income	-	-	4,565	
Unrealized loss on interest rate swap	-	-	-	
Termination of interest rate swap	-	-	-	
Vesting of 17,500 shares of restricted common stock	-	516	-	
Issuance of common stock				
Vested	20,100	806	-	
Restricted unvested	20,000	-	-	
Exercise of stock options	27,764	448	-	
Stock repurchase	(89,794)	(586)	(3,033)	
Dividend distribution	-	-	(2,319)	
Balances at June 30, 2016	2,003,127	$ 6,438	$ 12,176	$

The accompanying notes are an integral part of these consolidated financial statements.

Telecare Corporation and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended June 30, 2016 and 2015

(in thousands of dollars)	2016	2015
Cash flows from operating activities		
Net income	$ 4,565	$ 5,016
Adjustments to reconcile net income to net cash provided by operating activities		
Depreciation and amortization	3,400	3,240
Amortization of debt issuance costs	9	8
Provision for doubtful accounts	619	515
Loss on disposal of property and equipment	479	10
Stock-based compensation expense	2,737	1,803
Changes in assets and liabilities		
Accounts receivable	(4,877)	(816)
Prepaid expenses and other current assets	(463)	691
Accounts payable and accrued liabilities	2,547	1,828
Contract advances	266	637
Other assets and liabilities	(29)	673
Net cash provided by operating activities	9,253	13,605
Cash flows from investing activities		
Purchase of property and equipment	(6,390)	(5,749)
Change in restricted cash	(12)	10
Net cash used in investing activities	(6,402)	(5,739)
Cash flows from financing activities		
Net repurchase of stock	(3,171)	(2,383)
Dividend distribution to stockholders	(2,319)	(1,772)
Additional borrowings	9,748	-
Principal payments on debt	(5,820)	(465)
Net cash used in financing activities	(1,562)	(4,620)
Net increase in cash and cash equivalents	1,289	3,246
Cash and cash equivalents		
Beginning of year	9,928	6,682
End of year	$ 11,217	$ 9,928
Supplemental disclosures of cash flow information		
Cash paid for interest	$ 708	$ 640
Cash paid for income taxes	33	70
Supplemental disclosure of noncash investing and financing activities		
Asset acquisition financed with payable to seller	$ 1,479	$ 225

The accompanying notes are an integral part of these consolidated financial statements.

(in thousands of dollars except per share amounts)

1. Business and Organization

Telecare Corporation and subsidiaries (the "Company") operate behavioral health treatment programs in California, North Carolina, Oregon, Washington, Arizona and Nebraska under cost reimbursed and fee for service contracts primarily with governmental agencies. The Company also manages psychiatric units under contracts with acute care hospitals in California, New Mexico, Pennsylvania, Oklahoma, and Texas.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Telecare Corporation, its wholly owned subisidiaries and TLC Behavioral Health and Psychology Corporation ("TLC"), an affiliated company in which Telecare has a long-term relationship through a Management Agreement. TLC is a professional organization that engages psychologists, psychiatrists and allied health professionals to provide professional services in the state of California. Telecare engages TLC under a professional services agreement to provide professional services to their programs. Telecare is TLC's sole customer.

Under a management service agreement, Telecare provides administrative and management support services to TLC. The management service agreement is permanent, subject only to the termination rights stated in the agreement. The management fee charged by Telecare to TLC is calculated based on the actual cost of the services provided.

TLC is a variable interest entity for which the Company is the primary beneficiary and, therefore, the results of TLC are consolidated with those of the Company. All significant intercompany accounts and transactions, including the management fee and professional services revenue, have been eliminated in consolidation. Patient care service expenses of TLC are presented in the accompanying statement of operations.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include all highly liquid instruments with an original maturity of three months or less at the time of purchase.

Restricted Cash

At June 30, 2016 and 2015, the Company maintained restricted cash balances of $114 and $102, respectively, which represents escrow amounts held at financial institutions designated for employee flexible spending accounts.

(in thousands of dollars except per share amounts)

Fair Value of Financial Instruments

Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The fair value hierarchy requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 — Quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities.

Level 2 — Quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active; and model-derived valuations in which all significant inputs and significant value drivers are observable in active markets.

Level 3 — Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as instruments for which the determination of fair value requires significant management judgment or estimation.

A financial instrument's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value investment.

Accounts Receivable and Allowance for Doubtful Accounts

Accounts receivable are recorded at net realizable value and do not bear interest. The allowance for doubtful accounts represents the Company's estimate of the amount of probable credit losses in existing accounts receivable. The Company reviews the allowance for doubtful accounts monthly and determines the allowance based on historical write-off experience. Past due balances are reviewed on a pooled basis by type of receivable. Account balances are charged off against the allowance when management believes it is probable the receivable will not be collected.

The following are the changes in the allowance for doubtful accounts during the years ended June 30:

	2016	2015
Balances at beginning of year	$ 372	$ 543
Additions	619	515
Write-offs	(318)	(686)
Balances at end of year	$ 673	$ 372

(in thousands of dollars except per share amounts)

Concentration of Credit Risk
Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of trade receivables and cash and cash equivalents. The Company performs ongoing credit evaluations of its customers' financial condition and generally does not require collateral. The Company maintains an allowance for doubtful accounts to provide for potential credit losses.

For the years ended June 30, 2016 and 2015, two government entities accounted for approximately 29% and 31% of the Company's consolidated revenue, respectively. At June 30, 2016, one government entity accounted for approximately 16% of the Company's gross accounts receivable. At June 30, 2015, two government entities accounting for approximately 23% of the Company's gross accounts receivable. No other single customer accounted for 10% or more of the Company's consolidated revenue or accounts receivable as of or for the years ended June 30, 2016 and 2015.

At times, the Company maintains cash deposits in excess of the United States Federal Deposit Insurance Corporation coverage of $250,000 in an institution, but does not expect any losses due to the financial stability of these financial institutions.

Property and Equipment
Property and equipment are stated at cost less accumulated depreciation and amortization. Depreciation is calculated using the straight-line method over the assets' estimated useful lives. Leasehold improvements are amortized using the straight-line method over the term of the lease or the estimated useful life of the improvements, whichever is shorter. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts and any resulting gain or loss is recognized in income for the period. The cost of maintenance and repairs is charged to income as incurred; significant renewals and betterments are capitalized.

The estimated useful lives of depreciable asset classifications are:

Building and improvements	5–30 years
Furniture and fixtures	3–10 years
Equipment	3–10 years
Vehicles	3–5 years

Impairment of Long-Lived Assets
Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured as the amount by which the carrying amount of the asset exceeds its fair value. No impairment charge was recognized for the years ended June 30, 2016 and 2015.

Contract Advances
Contract advances represent both payments received in excess of net allowable reimbursement under contracts with certain government agencies and payments received in advance that are expected to be recognized as revenue in future periods.

(in thousands of dollars except per share amounts)

Derivatives
The Company has engaged in interest rate swap contracts which are derivative instruments recognized on the balance sheet at settlement value (Note 5 and 7). The Company has designated the interest rate swap contracts as cash flow hedges and accounts for them using the simplified hedge accounting approach. The interest rate swap liability is presented as a component of other liabilities on the accompanying balance sheet and amounted to $693 and $530 at June 30, 2016 and 2015, respectively. Changes in the settlement value of the interest swaps are recorded to other comprehensive income (loss).

Net Patient Service Revenue
Net patient service revenue is reported at the estimated net realizable amounts. The Company has agreements with third-party payors that provide for reimbursement to the Company at contracted rates. Final determination of amounts reimbursable by third-party payors is subject to audits by the payors. Adequate provisions have been made for any adjustment that may result from such audits. Differences between estimated provisions and final settlements are applied to revenue in the period final settlements are determined.

Income Taxes
As described in Note 8, the Company elected S corporation status for both federal and state tax purposes, effective July 1, 2005. Pursuant to this election, the Company's income, deductions, and credits are reported on the individual shareholders' income tax returns for federal and state purposes. Accordingly, no provision for federal income taxes has been made for the years ended June 30, 2016 and 2015. California assesses a corporate level income tax on S corporations which is included in the 2016 and 2015 tax provision.

The U.S. GAAP standard for unrecognized tax benefits requires a more-likely-than-not threshold for financial statement recognition and measurement of tax positions taken or expected to be taken in a tax return. The Company establishes a reserve for the tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when the Company believes that certain positions might be challenged despite the Company's belief that the tax return positions are fully supportable. The reserves are adjusted in light of changing facts and circumstances, such as the outcome of a tax audit. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate. The Company recognizes interest accrued related to unrecognized tax benefits in interest expense and penalties in general and administrative expenses.

Stock-based Compensation
The Company has stock-based compensation plans available to grant stock options, stock appreciation rights, restricted common stock and restricted common stock units to key employees as described in Notes 9 and 11. Share-based compensation cost is measured at the grant date, based on the fair value of the award, and is recognized as an expense over the service period (generally the vesting period of the award).

Comprehensive Income
The Company reports comprehensive income, which includes net income plus other comprehensive income, which for the Company consists of unrealized gain or loss on its interest rate swaps.

(in thousands of dollars except per share amounts)

Recently Adopted Accounting Pronouncements
In January 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-03, *Derivatives and Hedging*, for nonpublic companies to have the option to use a simplified hedge accounting approach to account for swaps that are entered into for the purpose of economically converting a variable-rate borrowing into a fixed-rate borrowing. The simplified hedge accounting approach provides nonpublic companies with a practical expedient to qualify for cash flow hedge accounting based on certain criteria being met. Under the simplified hedge accounting approach, a nonpublic company has the option to measure the designated swap at settlement value instead of fair value. The Company early adopted this standard for the year ended June 30, 2015 and elected to use the full retrospective approach. There was no impact on the consolidated financial statements.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall Recognition and Measurement of Financial Assets and Liabilities*, which impacts the recognition and measurement of equity instruments, liabilities under the fair value option and the presentation and disclosure of financial instruments. The guidance is effective for fiscal years beginning after December 15, 2018. Early adoption is permitted for the omission of fair value disclosures for financial instruments reported at amortized cost. The Company early adopted this standard for the year ended June 30, 2016, but is still in the process of assessing the impact of the remaining provisions in the financial statements.

3. Property and Equipment

Property and equipment consists of the following at June 30:

	2016	2015
Land	$ 4,496	$ 3,193
Buildings and improvements	29,583	29,308
Furniture and fixtures	2,089	2,329
Equipment	17,856	17,919
Vehicles	91	91
	54,115	52,840
Less: Accumulated depreciation and amortization	(35,655)	(34,777)
	18,460	18,063
Capital projects in progress	5,160	3,046
Property and equipment, net	$ 23,620	$ 21,109

Depreciation and amortization expense for the years ended June 30, 2016 and 2015 was $3,400 and $3,240, respectively.

(in thousands of dollars except per share amounts)

4. Commitments

Operating Leases

The Company's administrative offices, the majority of its operating facilities, and a portion of its equipment are leased under non-cancelable operating leases which expire at various dates through 2036.

Future minimum annual lease payments required under non-cancelable operating leases as of June 30, 2016 are as follows:

Years Ending		
2017	$	7,674
2018		6,141
2019		4,777
2020		3,461
2021		637
Thereafter		1,143
	$	23,833

(in thousands of dollars except per share amounts)

5. Long-term Debt

Long-term debt consists of the following at June 30:

	2016	2015
Bank note payable at 30 day LIBOR (to be no less than 2.0%) plus 2.1% (4.10% at June 30, 2016), collateralized by the property located in the County of Multnomah, Oregon; principal payments of $4 plus interest are due monthly with the remaining balance due December 2023, as amended.	$ 857	$ 906
Bank note payable at 30 day LIBOR plus 1.91%, collateralized by property located in Oakland, County of Alameda, California. The remaining balance was paid in full in December 2015.	-	5,401
Bank note payable at 30 day LIBOR plus 2.0% (2.46% at June 30, 2016), effective interest rate swap at a fixed rate at 4.0% collateralized by property located in Oakland, County of Alameda, California; principal and interest payments of $50 are due monthly with the remaining balance due December 2022.	8,138	-
Bank note payable at 30 day LIBOR plus 2.0% (2.46% at June 30, 2016), effective interest rate swap at a fixed rate at 7.03% collateralized by property located in Oakland, County of Alameda, California; principal and interest payments of $23 are due monthly with the remaining balance due June 2018.	2,273	2,389
Note payable collateralized by property located in Portland, County of Multnomah, Oregon; no principal or interest payments are due monthly and the note is due in a prorated amount if called upon by demand prior to October 2044.	213	223
Note payable collateralized by property located in Federal Way, County of King, Washington; no principal or interest payments are due monthly and the note is due in a prorated amount if called upon by demand prior to April 2037.	1,479	-
Subordinated notes payable to retirees; principal and interest payments of $50 including simple interest at the rate of 1.85% per annum are due quarterly with the remaining balance due July 2023.	1,366	-
Total long-term debt	14,326	8,919
Less: Current maturities of long-term debt	(630)	(495)
Long-term debt, net of current maturities	$ 13,696	$ 8,424

In December 2015, the Company refinanced a bank note payable with the outstanding balance of $5,401 at June 30, 2015 with a new note payable in the amount of $8,250. As part of this refinance, the Company terminated its interest rate swap contract attached to the refinanced note payable. The termination of the swap contract resulted in a $116 charge to interest expense during 2016.

The use of floating rate debt exposes the Company to fluctuations in market interest changes creating volatility in interest charges and cash flows. Accordingly, the Company manages a portion of its interest rate risk related to floating rate debt by entering into interest rate swaps in which the Company collects floating rate payments and disburses fixed rate payments.

(in thousands of dollars except per share amounts)

In June 2009, the Company entered into an interest rate swap contract with a financial institution to limit its exposure from interest rate volatility by converting variable rate debt to an all-in fixed rate of 7.03%. The interest rate swap contract notional principal amount was $2,273 and $2,389 at June 30, 2016 and 2015, respectively. Total swap liability associated with this swap was $195 and $268 at June 30, 2016 and 2015, respectively.

In December 2015, the Company entered into an interest rate swap contract with a financial institution to limit its exposure from interest rate volatility by converting variable rate debt to an all-in fixed rate of 4.0%. The interest rate swap contract notional principal amount was $8,138 at June 30, 2016. Total swap liability associated with this swap was $498 at June 30, 2016.

As of June 30, 2016, the Company estimates that none of the net derivative losses related to its cash flow hedges included in accumulated other comprehensive income will be reclassified into earnings within the next twelve months.

The Company has a revolving credit agreement which provides for borrowings up to $15,000 on a revolving basis with interest at the bank's 30 day LIBOR plus 2.5% (2.96% at June 30, 2016), collateralized by accounts receivable and machinery and equipment. There were standby letters of credit issued under the revolving credit agreement as required by the Company's workers' compensation insurance carrier and in connection with security deposits for lease agreements in the amount of $4,548 and $4,448 at June 30, 2016 and 2015, respectively. At June 30, 2016 and 2015, the Company had no outstanding borrowings under this agreement.

The Company has an additional revolving credit agreement which provides for borrowings of up to $3,120 with interest at the bank's 30 day LIBOR plus 2.5% (2.96% at June 30, 2016), collateralized by property located in Oakland, California. At the Company's option, it may convert any portion of advances made under this agreement to a 48 month term loan with interest at the bank's prime rate less 0.25%, the 30 day LIBOR rate plus 2.5%, or a fixed rate at the conversion date equal to 2.5% above the cost of funds rate determined by the bank. At June 30, 2016 and 2015, the Company had no outstanding borrowings under this agreement.

The Company has certain credit agreements which contain various restrictive covenants, which include maximum levels of debt to net worth, maximum credit extensions and minimum cash flow coverage, as defined. As of June 30, 2016, management believes that the Company was in compliance with such covenants.

Scheduled principal repayments on long-term debt are as follows:

Years Ending June 30,		
2017	$	630
2018		2,670
2019		536
2020		552
2021		568
Thereafter		9,370
	$	14,326

(in thousands of dollars except per share amounts)

6. Other Liabilities

Other liabilities consist of the following at June 30:

	2016	2015
Deferred compensation	$ 6,897	$ 7,038
Long-term workers compensation liability	5,063	5,020
Interest rate swap liabilities	693	530
Other	449	268
	$ 13,102	$ 12,856

7. Fair Value of Financial Instruments

Disclosures on Fair Value
At June 30, 2016 and 2015, the carrying values of the Company's accounts receivable, other current assets, accounts payable and accrued liabilities, contract advances and long-term debt approximate fair value based on management's estimates of terms and conditions of the assets or liabilities.

Carried at Fair Value
As of June 30, 2016, the Company's assets measured at fair value on a recurring basis were as follows:

	At Fair Value as of June 30, 2016			
	Level 1	Level 2	Level 3	Total
Assets				
Deferred compensation investments	$ 6,897	$ -	$ -	$ 6,897

The Company also carries deferred compensation plans for certain key employees, for which investment assets are recorded on the basis of fair value (Note 10).

8. Income Taxes

On September 12, 2005, the Company filed an election to change its tax status from a C corporation to an S corporation, effective July 1, 2005. Pursuant to this election, for fiscal years 2006 and beyond, the Company's income, deductions and credits will be reported in the individual income tax returns of its stockholders. California assesses a corporate level income tax on S corporations and, therefore, the Company will remain subject to California state taxes at a maximum rate of 1.5%, which for the Company amounted to $86 and $98 for continuing operations for the years ended June 30, 2016 and 2015, respectively.

(in thousands of dollars except per share amounts)

As a result of the change from C corporation to S corporation tax status, the Company may be subject to a federal and state corporate-level tax on the net unrealized built-in gain recognized for tax purposes during the 10-year period after the election. The net unrealized built-in gain is the amount by which, in the aggregate, the fair market values of the corporation's assets exceed their tax bases at the date of election (July 1, 2005). Recognized built-in gain is the excess of proceeds over disposition-date tax basis on the disposition of any asset, recognized for tax purposes during the 10-year period after the election, unless the Company establishes that the asset was not held on the date of election or that the gain, or a portion thereof, is attributable to appreciation that occurred after that date. Thus, the built-in gain recognized for any asset will be limited to the unrealized built-in gain which existed for those assets at the conversion date. Since the Company does not plan to dispose of any properties subject to built in gains that would result in taxable obligations by the Company, no liability has been established.

The Company files U.S. state tax returns in jurisdictions with varying statutes of limitations. In the normal course of business, the Company is subject to examination by taxing authorities throughout the states in which the Company operates. These audits include questioning the timing and amount of deduction, the nexus of income among various tax jurisdictions and compliance with state and local tax laws. The Company is not currently under any examination by the U.S. state tax authorities. With few exceptions, the Company is not subject to examination by state tax authorities for tax years before 2010. As of June 30, 2016 and 2015, the Company did not have any unrecognized tax benefits that if recognized would impact the annual effective tax rate. During the years ended June 30, 2016 and 2015, the Company did not recognize any interest or penalties related to unrecognized tax benefits.

9. Employee Incentive Plans

Stock Appreciation Rights

In July 2006, the Company adopted the Telecare Corporation Stock Appreciation Rights Plan (the "SAR Plan"). Awards under the SAR Plan may be granted to officers, directors, and employees of the Company, vest over five years, and expire in ten years. Awards may be surrendered by the grantee for a cash payment or, at the Company's option, shares of its common stock, equal in value to the number of units surrendered times the increase in the fair market value per share of the Company's common stock from the grant date to the surrender date.
The SAR Plan is liability classified, and as of June 30, 2016 and 2015, the liability amounted to $3,937 and $3,886, respectively, which has been presented as a component of accounts payable and accrued liabilities on the balance sheet. In July 2010, the Company's board of directors increased the number of SARs authorized for issuance to 400,000.

(in thousands of dollars except per share amounts)

A summary of SARs activity under the SAR Plan as of June 30, 2016 and 2015, and changes during the years then ended are presented below:

	Units	Weighted Average Unit Base
Outstanding at June 30, 2014	268,100	$ 23.09
Granted	34,800	36.50
Forfeited	(12,200)	(30.78)
Surrendered	(3,750)	(26.48)
Outstanding at June 30, 2015	286,950	25.14
Granted	35,000	40.30
Exercised	(85,500)	(22.68)
Surrendered	(6,300)	(27.77)
Outstanding at June 30, 2016	230,150	$ 27.67
SARs vested at June 30, 2016	137,500	$ 23.62

The Company recorded stock compensation expense of $1,415 and $895 related to the SAR Plan for the years ended June 30, 2016 and 2015, respectively.

Stock Option Plan

The Company offers options to key employees to purchase shares of its common stock through a nonqualified stock option plan ("the Plan"). Options granted under the Plan are protected against dilution by stock splits and other changes in capitalization. Vesting in stock options occurs ratably over five years. Stock options expire after ten years. The Plan allows participants to purchase shares of the Company's common stock at prices equal to the fair market value of the Company's stock at the date of the option's grant. The number of shares authorized for issuance under the Plan is 590,000. All authorized shares have been granted and no shares remain outstanding as of June 30, 2016. As of June 30, 2015, 27,764 shares were outstanding with a weighted-average exercise price of $16.15.

Under the Plan, the Board of Directors of the Company may allow all or any part of the exercise price to be paid in cash, by issuance of a full-recourse loan or by surrendering common stock owned by the employee. In addition, upon request by the employee and at the discretion of the Board of Directors, the Company may purchase common stock from employees who acquired such stock by exercising stock option grants. During the years ended June 30, 2016 and 2015, the Company purchased 27,764 and 39,000 shares, respectively, of common stock for $1,119 and $1,424, respectively, pursuant to these provisions.

10. Employee Benefit Plans

The Telecare Employee Stock Ownership Plan ("ESOP"), created in 1997, is an employee noncontributory stock bonus plan under section 401(a) of the Internal Revenue Code ("IRC") and an employee stock ownership plan under IRC Section 4975 (e)(7). Employees who are at least 21 years of age, have completed one year of service and are not subject to a collective bargaining agreement are generally eligible to participate in the ESOP.

(in thousands of dollars except per share amounts)

The Company makes discretionary ESOP contributions which are allocated to the accounts of eligible employees based on employee compensation. The Company made contributions of $750 and $650 for each of the years ended June 30, 2016 and 2015, respectively, as authorized by the Board of Directors. At June 30, 2016 and 2015, the ESOP owned 741,944 and 765,390 shares of common stock of the Company, respectively.

Upon termination or retirement, ESOP participants receive a distribution of their account balances in cash. The distribution is made prior to the last day of the plan year following the plan year in which employment ends. At June 30, 2016, the fair market value of the common stock of the Company owned by the ESOP was estimated to be $47.20 per share.

The Company also sponsors the Telecare Corporation 401(k) Savings Plan and a nonqualified deferred compensation plan for certain key employees. As of July 1, 2005, the 401(k) plan became a safe harbor plan under which the Company automatically contributes 3% of wages to eligible employees not covered under a collective bargaining agreement. There are no contributions required for the nonqualified deferred compensation plan. The Company also makes contributions to two qualified defined contribution plans for eligible union employees as defined in the union agreements. The assets of the nonqualified deferred compensation plan are held by the Company and are recorded within other assets on the basis of fair value of $6,641 and $6,782, as of June 30, 2016 and 2015, respectively, and a cash balance recorded within cash and cash equivalents of $256 and $256, respectively. The assets are held for trading purposes and stated at fair value. These assets are offset with a corresponding liability within other liabilities of $6,897 and $7,038, as of June 30, 2016 and 2015, respectively. Net realized gains and losses on investment transactions are determined on the specific identification method.

11. Related Party Transactions

Stock Grant

The Company granted shares of common stock to an executive under the 2009 Stock Incentive Plan ("Stock Incentive Plan") as presented below:

	Shares Granted	Shares Immediately Vested Upon Grant	Shares Vested
Year Ended June 30,			
2012	40,000	20,000	-
2013	40,000	20,000	5,000
2014	40,000	20,000	10,000
2015	20,000	10,000	15,000
2016	40,000	20,000	17,500
	180,000	90,000	47,500

(in thousands of dollars except per share amounts)

Unvested shares are restricted and held in escrow by the Company and will vest as follows:

Year Ending June 30,	
2017	17,500
2018	12,500
2019	7,500
2020	5,000
	42,500

The grantee retains the voting rights to both the vested and unvested shares.

In connection with the above stock grants, the Company recorded $1,322 and $908 of stock compensation expense during the years ended June 30, 2016 and 2015, respectively.

12. Professional Liability

Professional liability insurance coverage is maintained under a claims-made policy, which is renewable on an annual basis. It is management's belief that the Company will be able to renew or replace current levels of insurance coverage. It is the Company's policy to accrue for material loss contingencies relating to asserted and unasserted medical malpractice claims in the period in which they are determined to be probable and can be estimated. Management believes that settlement of such claims will not have a material adverse effect upon the financial condition or results of operations of the Company.

13. Workers Compensation Liability

The Company maintains workers' compensation insurance under a policy with a deductible limit of $250 per claim. As of June 2016 and 2015, management has accrued approximately $7,162 and $6,845, respectively, related to workers' compensation claims expected to be settled in future years, which is included in the accompanying consolidated financial statements as accounts payable and accrued liabilities for short-term liability of $2,099 and $1,825, as of June 30, 2016 and 2015, respectively, and other liabilities for long-term liability of $5,063 and $5,020, respectively.

14. Litigation

The Company is involved in various claims and legal actions arising in the ordinary course of business. The ultimate disposition of these matters will not have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

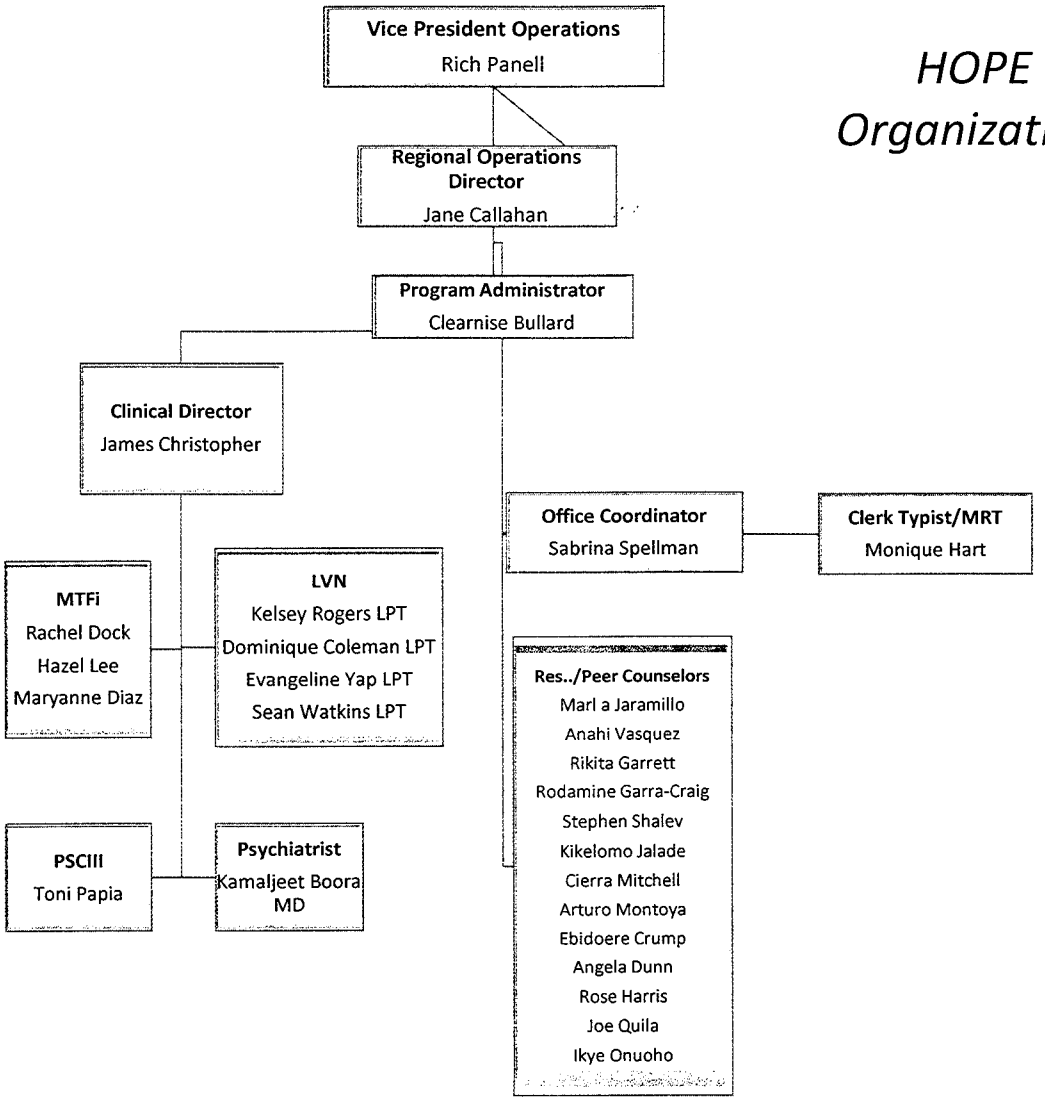
15. Subsequent Events

The Company evaluated subsequent events and transactions for potential recognition or disclosure in the financial statements through September 22, 2016, the date the financial statements were available to be issued.

APPENDIX E

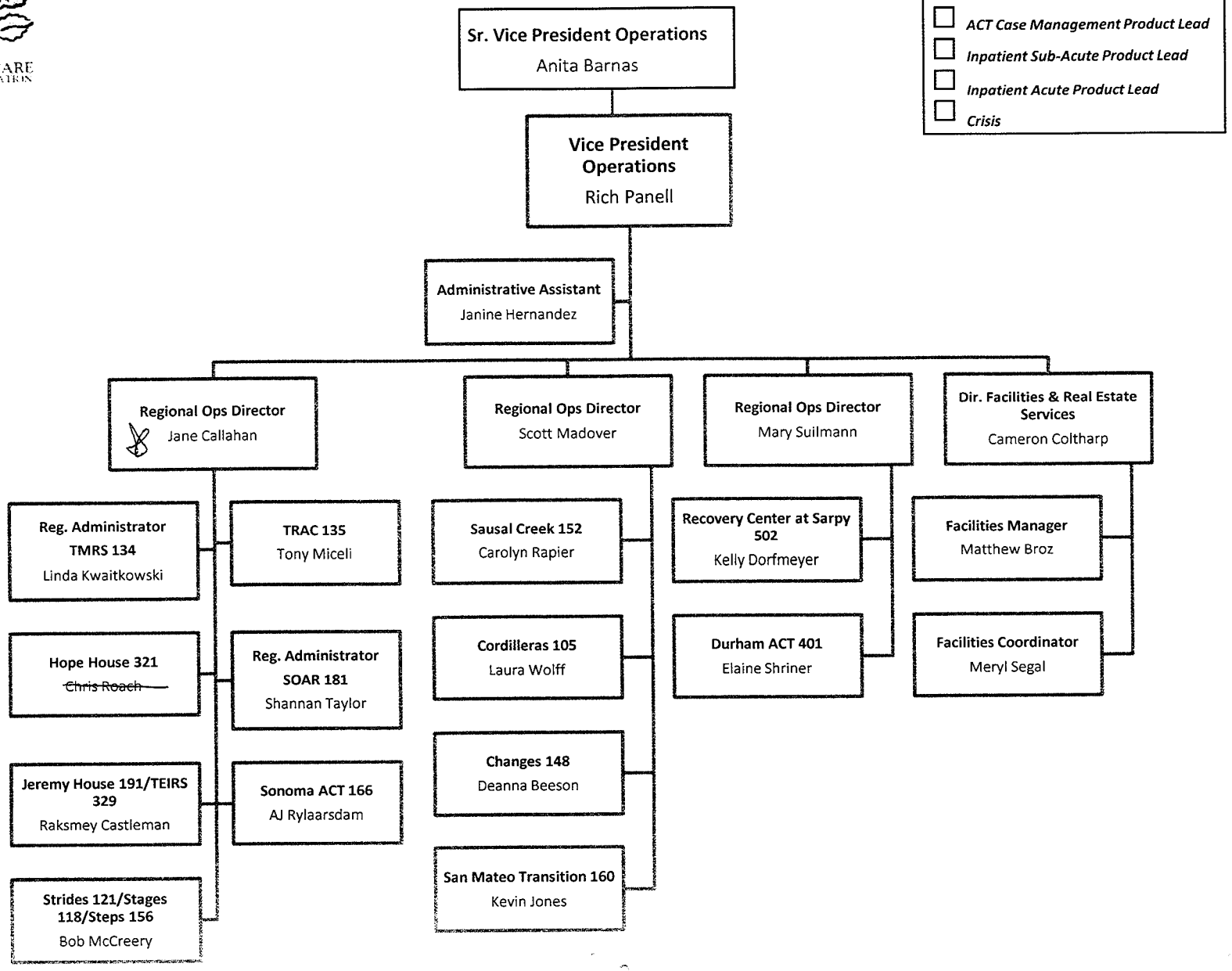
Organization Chart

HOPE HOUSE
Organizational Chart



TELECARE CORPORATION

OPERATIONS



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