PR. 3
9-13-16

Contra Costa
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CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

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

Current (2016) Members of the Contra Costa County Mental Health Commission
Greg Beckner, District IV; Duane Chapman, District I (Chair); Douglas Dunn, District III; Diana MaKieve, District II; Tess Paoli, District III; Lauren Rettagliata, District II; Barbara Serwin, District II (Vice Chair); Connie Steers, District IV; Gina Swirsding, District I; Sam Yoshioka, District IV; Candace Andersen, BOS Representative; Mary Piepho, BOS Alternate Representative

Commissioners Emeritus
Marie A. Goodman • David Kahler

September 13th, 2016

Dear Clerk of the Board,

Enclosed you will find the *FY 15-16 External Quality Review Final Mental Health Plan Report* for Contra Costa County. It is background information for the Mental Health Commission's presentation today on its paper entitled *White Paper: Mental Health System and Budget Crisis in Contra Costa County FY/16/17*. I would greatly appreciate it if you would include the report in the meeting minutes. In case you might need it, here is a link to the document:
http://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2015-2016.pdf

Sincerely,

Barbara Serwin

Barbara Serwin, Vice-Chair, Mental Health Commission

FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Contra Costa

Conducted on

February 9-11, 2016

Prepared by:

Behavioral Health Concepts, Inc.

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INTRODUCTION

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

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

- MHP information:
  - Beneficiaries served in CY14—13,786
  - MHP Size—Large
  - MHP Region—Bay Area
  - MHP Threshold Languages—Spanish
  - MHP Location—Martinez

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the Contra Costa mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP

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

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

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

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY14-15

In this section we first discuss the status of last year's (FY 14-15) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY 14-15 REVIEW RECOMMENDATIONS

In the FY 14-15 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 15-16 site visit, CalEQRO and MHP staff discussed the status of those FY 14-15 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
  - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY14-15

- Recommendation #1: Examine the leadership processes and adjust for improved communications and stakeholder input.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP indicated that its communication audience spans internal, external with community, and within the larger Health Services Department under which it functions.
  - The MHP is considering adding another executive staff meeting; the new meeting consists of executive staff and program managers across the Behavioral Health system of care. This platform of communication will allow program managers and mid management the opportunity to share initiatives and discuss changes. In addition, it will be an opportunity to invite management from

primary care and the Contra Costa Health Plan to discuss integration and how each system works together in serving mutual consumers.

- In an effort to foster greater communication, improve collaboration with the stakeholder groups, and ensure consistent messaging, the executive staff are providing regular division wide updates to various stakeholder groups such as the Specialty Mental Health clinics, Mental Health Commission, the MHSA Consolidated Planning Advisory Workgroup, Quality Management, and National Alliance on Mental Illness (NAMI).
- While many of the efforts cited are to be commended and are notably worthwhile, many of the activities highlighted by the MHP are customary business practices and not far reaching into the system of care.
- The MHP was encouraged to think in more expansive terms and to implement activities which would cut across all elements of the system, reaching the consumer level. The idea is to put on the "face" of the MHP leadership as a welcoming source for all stakeholder groups.
- It is prudent for the MHP executive team to expedite the efforts it has outlined to infuse the stakeholders with the vision it intends to manifest. The leadership was receptive to consideration of further activities as discussed on site, such as attendance at consumer groups and line staff meetings, all staff meetings, newspaper inserts, media reports, brown bag lunches, suggestion box, and speaker's bureau.

- Recommendation #2: Select and implement an EHR system immediately to meet standards and regulatory mandates.

☐ Fully addressed ☐ Partially addressed ☒ Not addressed

- While the MHP has worked with its county information system (IS) department to meet operational demands on some of its management information systems (MIS) it has made little or no significant progress on meeting the clinical quality improvement demands of a contemporary, data-informed, consumer-centric outpatient system of care.
- The MHP has made some progress in remediating the legacy NetPro system for its network service providers however, this system has yet to become operational.
- The MHP has also made progress in crafting a consumer relations management (CRM) system for its ACCESS team. This system, when fully implemented, will allow the MHP to have the data points necessary to do actual timeliness to service calculations for a broader segment of its system of care. MHP staff are already examining the practical utility brought of this system's (TAPESTRY) reporting paradigm.

- Recommendation #3: Select and implement system wide use of an outcome tool to inform the MHP of consumer progress.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP is utilizing the LOCUS/CALOCUS suite of Level of Service/Level of Care instruments across its entire System of Care including its contract providers. These tools are primarily being used to provide immediate clinical intelligence to line staff for individual treatment needs.
  - While the MHP has been amassing a substantial longitudinal database (greater than 10,000 records according to its evaluation team) the MHP is only now examining this data in an organized manner to obtain administrative intelligence. The evaluations team expects to have made significant progress in this area by the next reporting period.
  - It is worth considering collecting and analyzing this data more timely in the future to inform the MHP consumers of progress in real-time and to analyze the data to inform effective program delivery.
  - The MHP has convened an Outcomes Workgroup consisting of key management staff, started communication with other counties about lessons learned in implementing an outcomes measure, and is at the beginning stages of considering other outcome tools/measures for implementation.

- Recommendation #4: Examine current barriers and complete the hiring process to fill the QM Program Coordinator position.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The Quality Management (QM) Program Coordinator position became vacant on July 10, 2014 and the position posted in April 6, 2015. The Quality Management Program Coordinator was filled July 2015.
  - While the MHP did complete the hiring process to fill the QM Program Coordinator position, the other senior position within the QI team, the Quality Improvement Coordinator continues to be an interim staff person. This person appears to have done due diligence to maintain appropriate stewardship of this function.

    It was suggested that the MHP review its staffing for this unit in the era of new mandates and emerging standards, given the Drug Medi-Cal Waiver submission plans the MHP has underway and the accompanying workload.

- Recommendation #5: Address PIP topics to include a method to measure consumer benefits

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- This year the MHP incorporated satisfaction surveys in both of its performance improvement projects (PIPs). In addition, the clinical PIP includes pre and post surveys which measure consumer benefits such as perceived recovery, functioning, and quality of life. The non-clinical PIP survey queries the benefits of the new Televox reminder call system to consumers.
- Additionally, for the clinical PIP, consumers will be asked to self-rate their physical and mental health at each visit. Vital signs will be collected and both physical health and mental health levels of functioning will be assessed by project staff at each visit, and clients attendance and referrals made will be tracked.
- Satisfaction and achievement on self-identified wellness goals will be recorded at post-program. Standardized forms have been created internally to capture data.
- Other indicators that will be tracked in the Insyst/PSP billing system and Epic system include appointment attendance, PES visits, and in-patient hospitalizations.

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

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

- Access to Care
  - The MHP has been working in conjunction with clinical and county IT staff to appropriately configure and implement Epic TAPESTRY system and its Consumer Relations Management (CRM), acuity screening, and provider modules at its centralized access call in center. This functionality should provide a number of immediate benefits to the ACCESS team as well as remediate some timeliness tracking issues to provide enhanced functionality for service metrics.
- Timeliness of Services
  - The MHP continues to experience significant barriers to hiring enough medical staff (psychiatrists, nurses, nurse practitioner) to fulfill its need to provide timely access to psychiatric service. In spite of a reportedly successful venture into tele-psychiatry, the MHP has yet to expand the use of tele-psychiatry to alleviate the current extended wait times to see a psychiatrist.
- Quality of Care
  - Stakeholders report a freeze on hiring that has been implemented at the county level. This barrier has created an impediment to timely hiring of staff needed to fill allocated positions within the MHP. The executive team acknowledges that it

will need to work diligently to modify this situation. This situation is creating an impediment to the delivery of quality and cost effective services to consumers.

- Consumer Outcomes
    - The Research and Evaluations team has embarked on a longitudinal study of LOCUS/CALOCUS data to provide the executive team with knowledge to help them craft and tailor service provision for improved consumer outcomes.

PERFORMANCE MEASUREMENT

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2016.

TOTAL BENEFICIARIES SERVED

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

Table 1—Contra Costa MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity

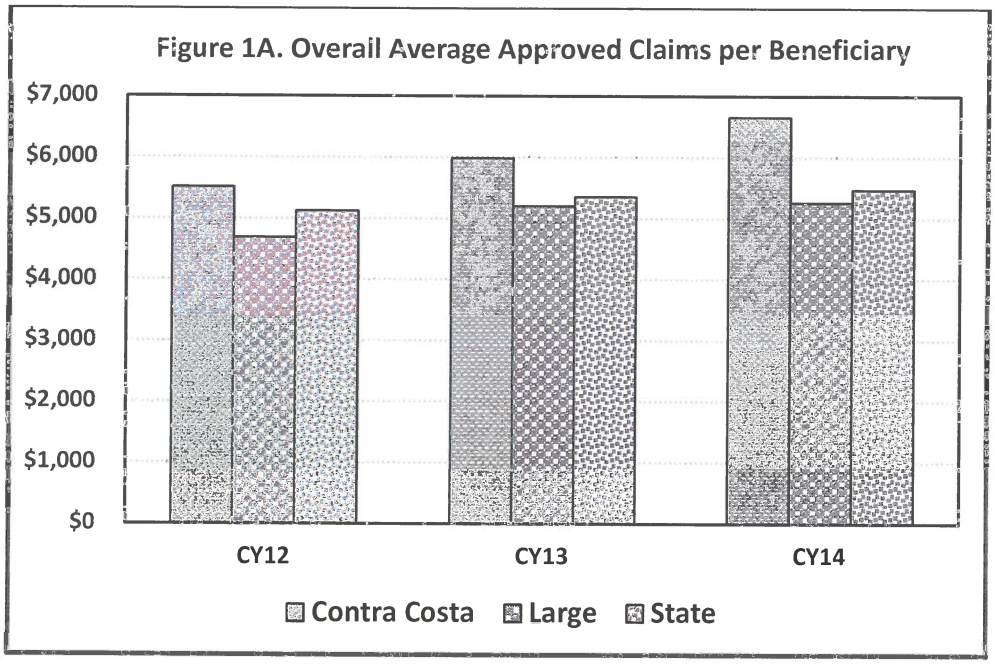
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	36,237	4,211
Hispanic	72,635	3,251
African-American	32,534	3,366
Asian/Pacific Islander	23,393	844
Native American	566	75
Other	27,322	2,039
Total	192,684	13,786

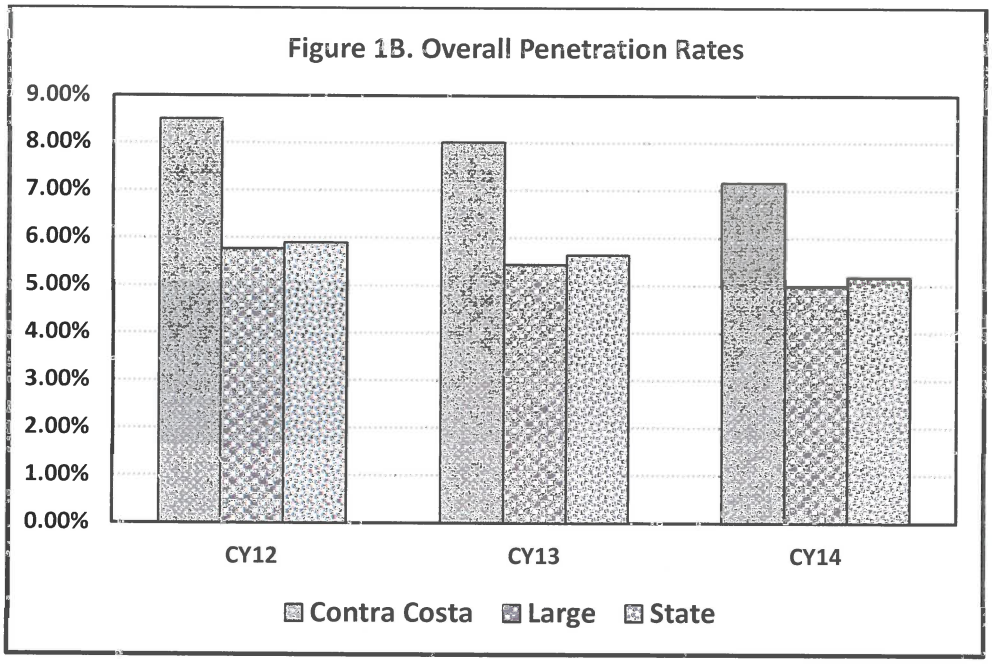
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

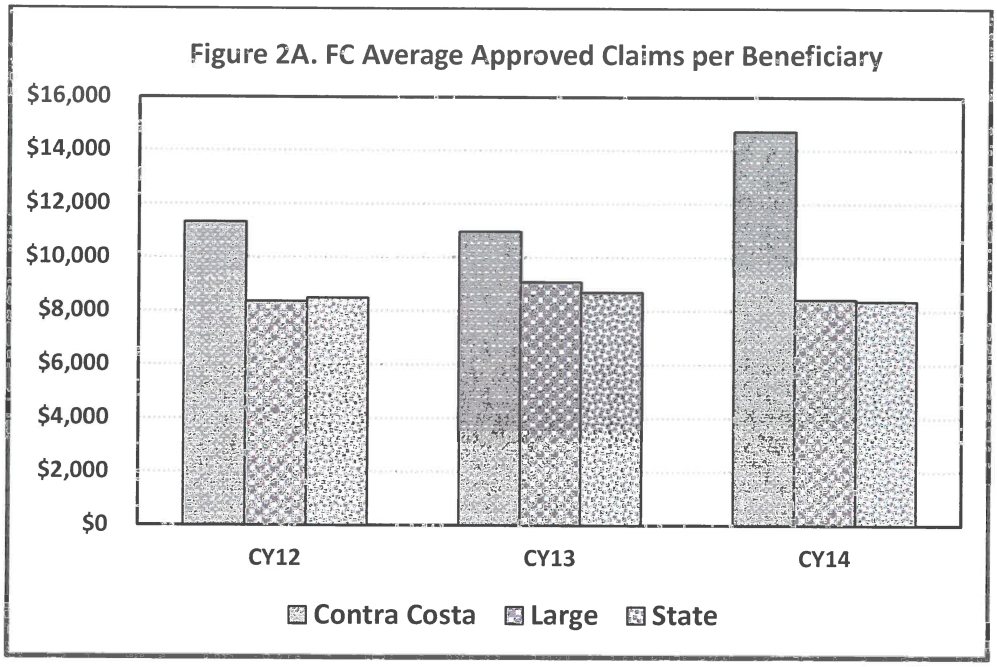
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

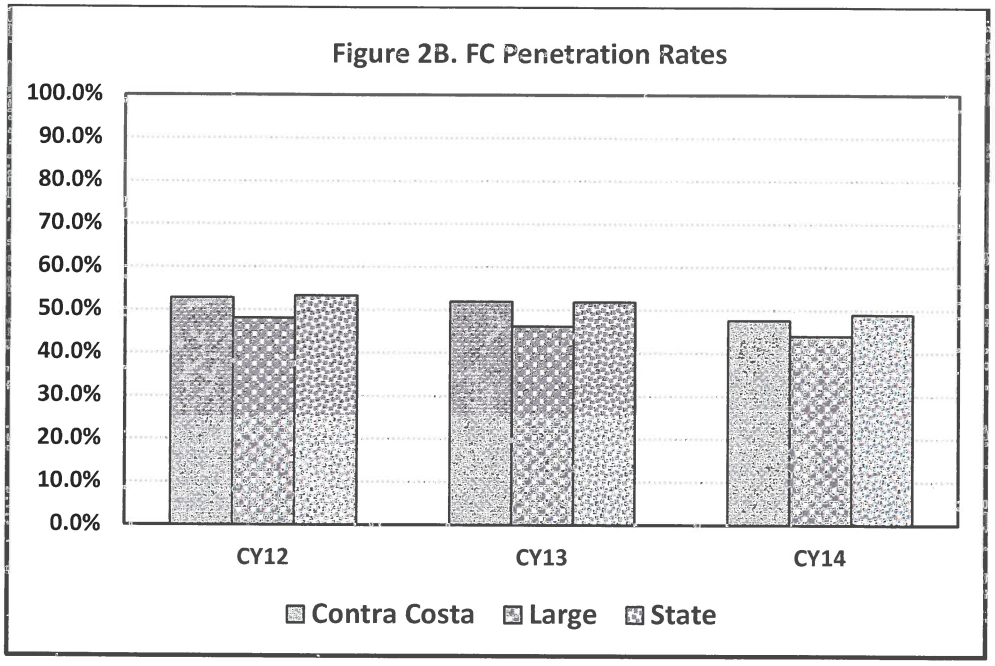
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



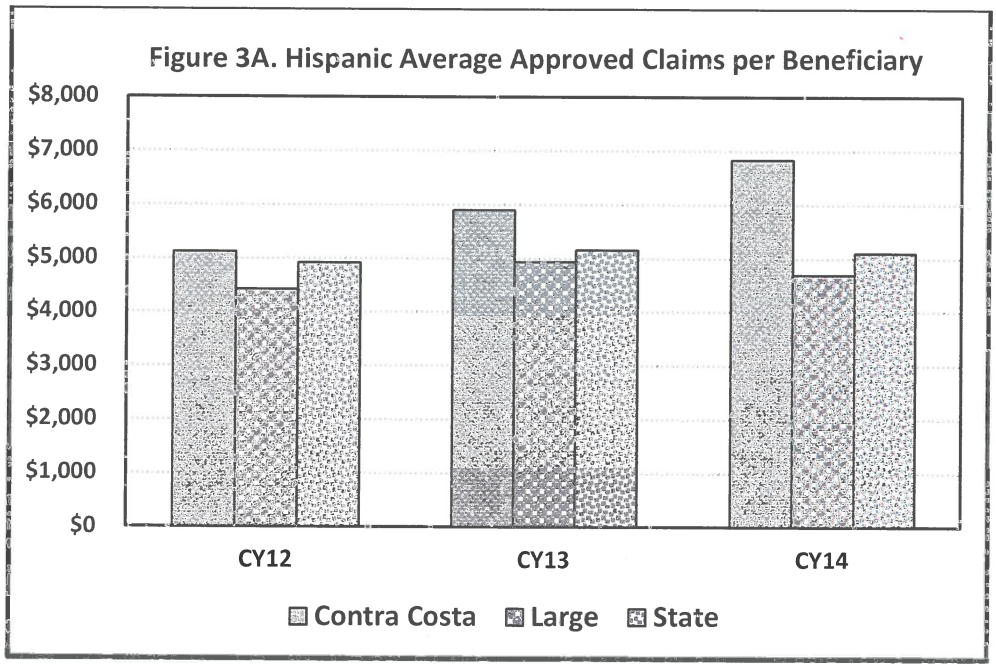


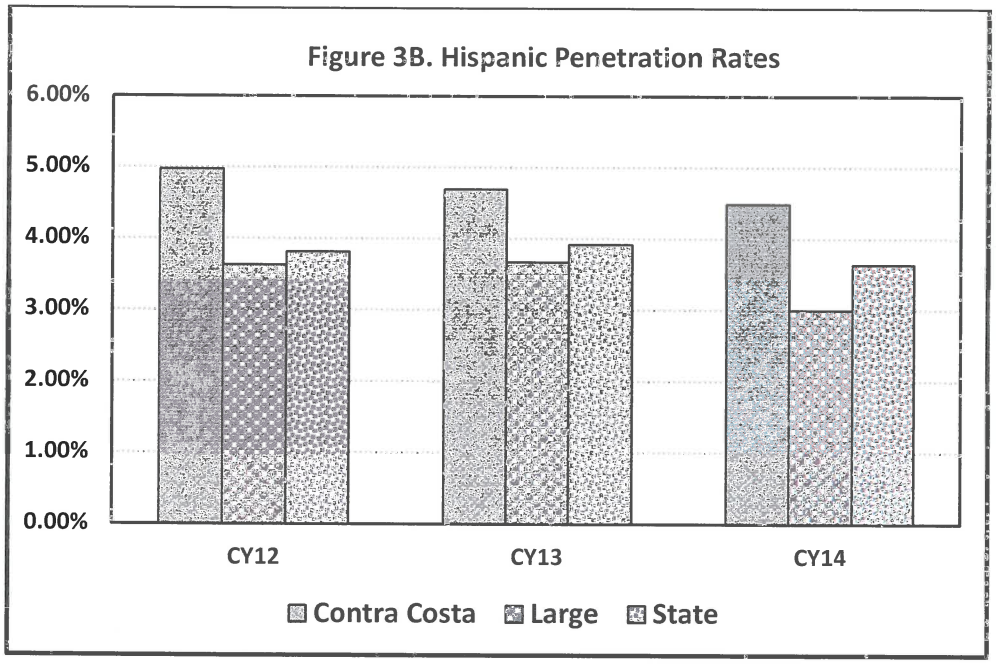
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





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





HIGH-COST BENEFICIARIES

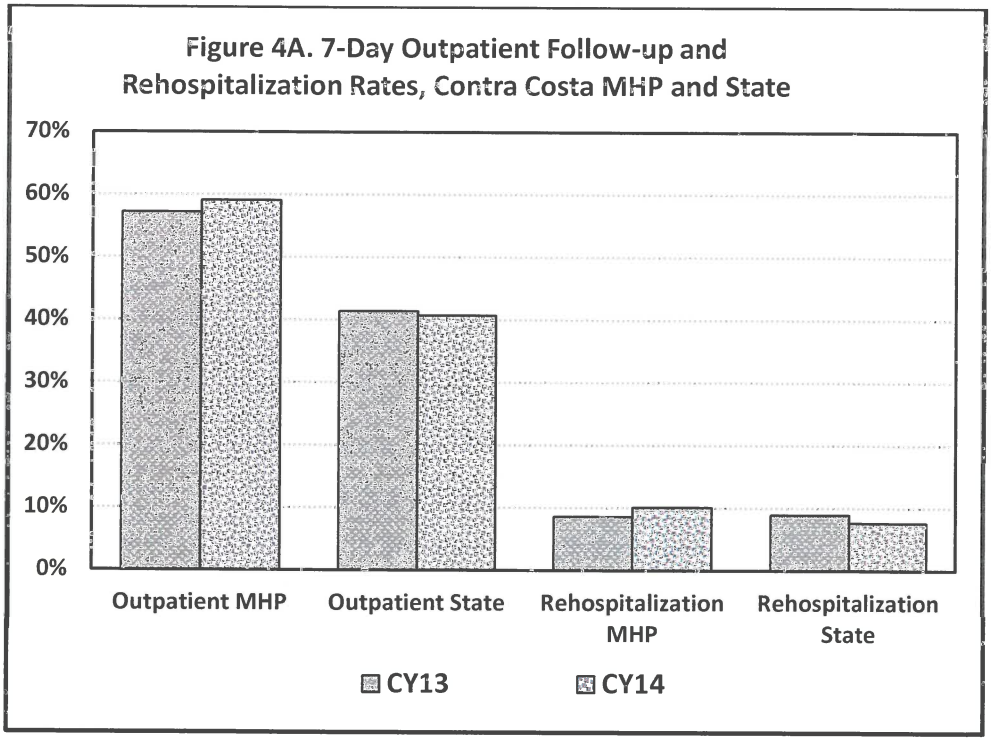
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	$50,358	$617,293,169	24.41%
Contra Costa	CY14	660	13,772	4.79%	$54,866	$36,211,807	40.89%
	CY13	556	13,170	4.22%	$54,069	$30,062,163	38.17%
	CY12	501	12,877	3.89%	$52,080	$26,091,910	36.82%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY13 and CY14.



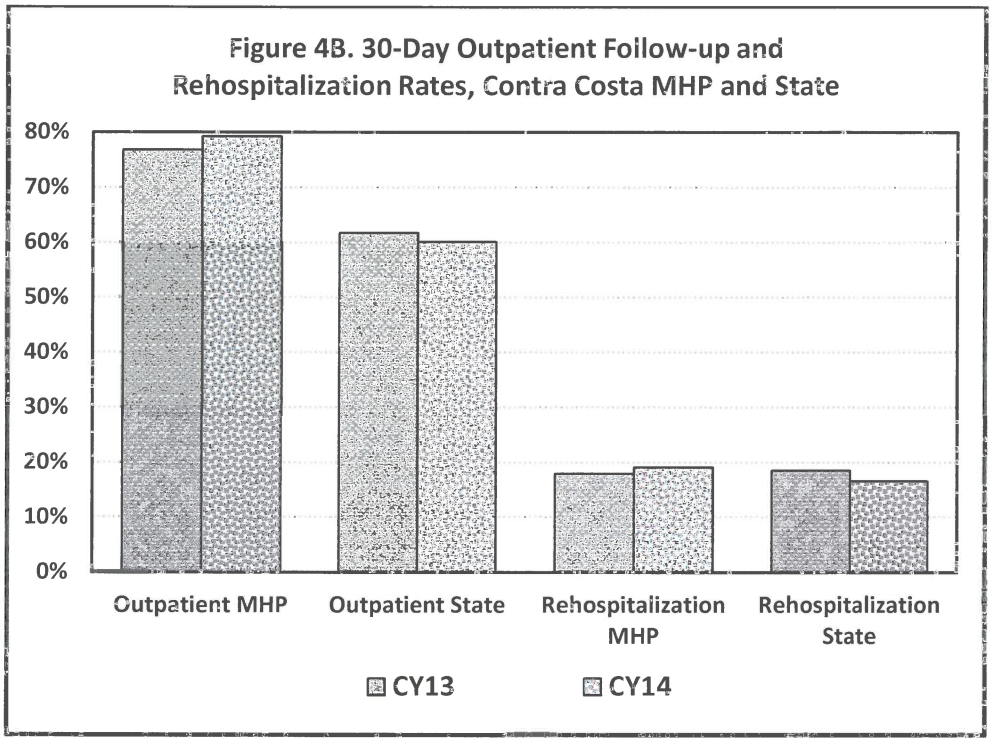
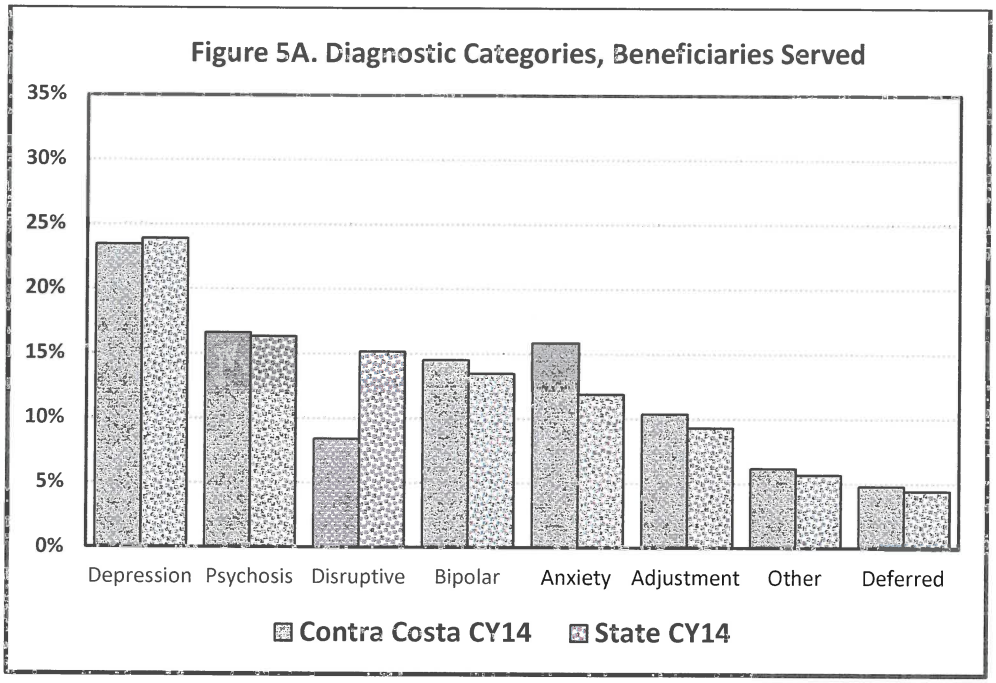
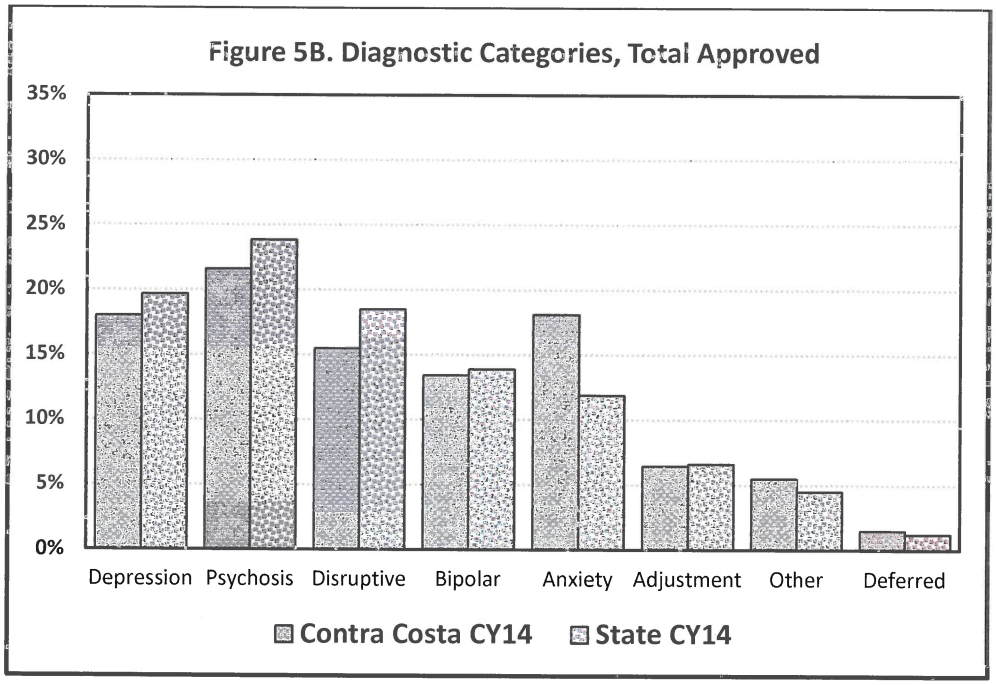


Figure 4B. 30-Day Outpatient Follow-up and Rehospitalization Rates, Contra Costa MHP and State
80%
70%
60%
50%
40%
30%
20%
10%
0%
Outpatient MHP
Outpatient State
Rehospitalization MHP
Rehospitalization State
CY13
CY14

DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY14.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP continues a trend of declining penetration rates across the majority of categories from CY12 through CY14. These declines are very similar to those experienced statewide for the same period.
  - The MHP's foster care penetration rate, while slightly down, is very comparable to the state's experience but somewhat higher than other large MHPs.
  - The MHP's Hispanic penetration rate is more than a percentage point higher than other large MHPs across the state.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates after discharge from inpatient episodes were slightly higher than the statewide experience and similar to its experience in CY13.
- Quality of Care
  - The MHP's percentage of high cost beneficiaries (HCB) was slightly less than twice the statewide rate. The HCB percentage has shown a steady and significant increase from CY12-14 increasing almost a full percentage point. The MHP's average approved claim per HCB is also well above the statewide experience.
  - The average approved claim per beneficiary served (AACBS) has been steadily increasing from CY12-14 and is also well above both large MHP and statewide experience.
  - The MHP's AACBS for foster care youth is 176% of the statewide experience for this group.
  - Except for disruptive and anxiety disorder diagnoses (disruptive = lower, anxiety = higher) the MHP's diagnostic categories were very similar to statewide distribution.
  - The MHP's total approved claim per diagnostic category was near the state experience in all categories except anxiety where it was significantly higher than the state.
- Consumer Outcomes
  - The MHP's high percentage of HCB approved claims (40.89%) and increasing beneficiaries in this category diverts a significant budget portion from the system of care to a relatively tiny (4.8%) fraction of consumers.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2014.

CONTRA COSTA MHP PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	PIP Titles
Clinical PIP	Coaching to Wellness
Non-Clinical PIP	Consumer Non-Adherence to Mental Health Outpatient Clinic Appointments

Table 3A lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

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

Table 3A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	PM	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	M	M
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	PM	M
		6.4	Plan for consistent and accurate data collection	PM	M
		6.5	Prospective data analysis plan including contingencies	PM	M
		6.6	Qualified data collection personnel	M	M
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	NA	M
		7.2	Interim data triggering modifications as needed	NA	PM
		7.3	Data presented in adherence to the plan	NA	M
		7.4	Initial and repeat measurements, statistical significance, threats to validity	NA	PM
		7.5	Interpretation of results and follow-up	NA	PM

Table 3A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	NA	M
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NA	M
		8.3	Threats to comparability, internal and external validity	NA	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	PM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	M
		9.3	Improvement in performance linked to the PIP	NA	PM
		9.4	Statistical evidence of true improvement	NA	PM
		9.5	Sustained improvement demonstrated through repeated measures.	NA	NM

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

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

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	12	23
Number Partially Met	4	6
Number Not Met	0	1
Number Applicable (AP) (Maximum = 30)	16	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	87.5%	86.6%

CLINICAL PIP—COACHING TO WELLNESS

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

- Will implementation of a wellness program for consumers with comorbid health and mental health issues improve the recovery of consumers?
- Date PIP began: August 2015
- Status of PIP:

☐ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☒ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

This PIP was initiated by the MHP in the midst of an improvement project from last year which focused on improving the no-show rate to appointments. The pilot was initiated in the East County Adult Clinic. The addition of the Coaching to Wellness intervention emerged from the No- Show PIP Committee. This PIP's origins go back to 201l when a state innovative project for Wellness Coaches was approved and re-emerged from East County Adult Clinic, Office of Consumer Empowerment and Quality Management staff.

Research shows that many consumers with serious mental illness have co-occurring chronic health conditions that are often treatable, confirmed by the MHP psychiatrists. Contra Costa County was one of six Counties that formed the pilot Integration of Mental Health and Primary Care (CPCI) learning collaborative in FY 2010-2011, a quality improvement initiative of CalMEND (the California Mental Health Care Management Program). Recommendations that emerged from this initiative were that consumers would benefit from health education and training on self-management skills, as well as several lessons learned, are addressed by this PIP.

The MHP reviewed its data from the billing system which suggests that East County Adult Clinic consumers who chronically no-show to clinic appointments were more likely to visit psychiatric emergency services (PES) compared to those with perfect attendance. In addition, the chronic no-show study population was more likely to be non-white, African-American, English as the preferred language, and are younger than East County Adult Clinic consumers who regularly attended their appointments.

A review of the literature indicated that intensive peer support programs are effective at reducing the number of psychiatric hospitalizations among those in recovery from a mental illness. With the

support of an intensive peer support model coupled with leveraging existing resources within the county, the Coaching to Wellness intervention is designed to provide a holistic team approach to providing care to consumers.

The MHP also used data collected from consumers who had an outpatient specialty mental health appointment during the consumer satisfaction survey administration week and had the opportunity to complete the survey. Of those consumers who submitted surveys, 36.3% (n = 443) replied their physical health is "poor" or "fair" and 40.6% (n = 429) replied their mental health is "poor" or "fair" in comparison to those who responded that their physical or mental health was "good," "very good," or "excellent". This means that more than one-third of these consumers perceived themselves not to be in good physical health and two-fifths rated their mental health low. This supports the premise that the MHP consumers may benefit from education and training to learn skills to better self-manage their mental and physical health conditions. These two questions are indicators of the PIP that will be collected regularly from participating consumers.

Wellness is defined by consumers and included in the individual's Wellness Recovery Action Plan (WRAP) treatment. Using this model, consumers learn to identify what makes them well, and use their own wellness tools to relieve difficult thoughts and feelings, maintain wellness, and accomplish personal, social, educational and vocational goals.

Coaching to Wellness creates an additional level of care for those consumers who would otherwise be receiving psychiatric-only services. Coaching to Wellness is a wellness program with a strong peer provider component in the role of the Wellness Coach. The goals seek to improve consumer wellness, to increase healthy consumer behaviors and to increase cross-service collaboration among primary care and mental health. All of which potentially lead to increased consumer functioning.

The Coaching to Wellness pilot provides intensive peer and nurse support for consumers with mental health and medical comorbidity. For up to six-months, pilot participants will receive individual and group services to empower them in their recovery. The nurses and coaches will work with consumers to help them in meeting their wellness goals, be they mental health, physical health, or overall functioning goals, so that the consumer is using self-management skills to be in charge of his/her wellness. In addition to the wellness indicators, beneficiary satisfaction is an indicator as participants will be able to provide feedback on their satisfaction with the pilot.

Supports to be provided include:

- Facing Up To Health (by Recovery Innovations), a nine content area peer facilitated group intervention that focuses on whole health and empowering consumers to be a partner with their health care providers in the maintenance of their whole health plan.
- Wellness Recovery Action Plan Program (WRAP), an evidence-based practice that is a ten-week group facilitated by peer providers for persons with mental illness. WRAP guides participants through identifying and understanding their personal wellness resources and helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness.

- Individual sessions with the coach and nurse aimed at providing personalized support to consumers in achieving their wellness goals. Components of these sessions will vary.
- Referrals, including to primary care, case management, financial, alcohol and other drugs as needed.

The target population for the Coaching to Wellness program is consumers who are:

- Receiving psychiatric-only services
- Diagnosed with a serious mental illness
- Diagnosed with a chronic health risk condition of weight, cardiac, metabolic, and/or chronic obstructive pulmonary disease (COPD) issues.

The goals of the Coaching to Wellness program are to:

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

A prolific set of fourteen measurable indicators are designed to measure the goals which are outlined in the PIP Submission Tool. The MHP has begun collecting baseline data and has plans to continue surveying the consumer for progress/results. The MHP has formed three teams, one per region, with a peer wellness coach and a wellness nurse. All teams are currently completing training and program standardization in the pilot location of East County Clinic.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of on-site discussion of the need to include a larger study population as it rolls this PIP out into the clinic and eventually to other clinics; to encourage regular data review to inform it of its progress and to make provisions or adjustments intermittently and prior to completion of this PIP; and to review the consumer feedback and incorporate this on-going for effective interventions. TA was offered using the CalEQRO staff to discuss interventions and the adjustments to its concepts and consider engaging in TA phone consults while formulation of its next steps to ensure addressing the PIP study question.

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

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

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

- Date PIP began: August 2014
- Status of PIP:

☐ Active and ongoing

☒ Completed

☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

This is the second year of this PIP for the MHP which focused on improvements to the no-show rate and was initiated at the East County Adult Clinic.

The MHP utilized research that showed significant non-attendance contributes to clinic inefficiency, productivity loss, reduced service capacity, client disengagement, and lack of quality mental health care, exacerbated client symptoms, and an increase in psychiatric emergency recidivism.

The East County Adult Clinic averaged 1,328 total clients per month and 2,450 clinic appointments per month (that is approximately 1.8 appointments per client a month) during the 6-month period of April to September 2014. Of these appointments, there was an average of 344 missed appointments per month for an average 14.50% non-attendance rate (range of 10.8% - 16.3%).

According to the MHP data, East County Adult Clinic has the greatest non-attendance rate of all the Contra Costa Mental Health clinics. With a large number of appointments not being kept, clients continue to experience significant wait times for rescheduled appointments.

It is the intention of the study to investigate the problem and monitor the intervention and its results to determine what can be learned from this study. Therefore, the MHP anticipates that this will be replicated throughout all the mental health clinics for the benefit of all beneficiaries in the system of care.

The research on the impact of telephone reminder calls on appointment adherence has found that reminder calls improve attendance and that consumers prefer a phone call to other media reminders. Since the goal of this PIP is to decrease the appointment non-attendance of beneficiaries, all consumers with appointments at East County Adult Clinic were contacted with an automated reminder call from a new program called Televox during the intervention period. In addition, the MHP surveyed consumers regarding the value and satisfaction with the automated Televox reminder call system.

The MHP outlined four indicators with improvement goals for which it retrieved data, as follows:

- Percentage of unattended appointments relative to total appointments made at the East County Adult Clinic (10% reduction)
- Percentage of unattended appointments relative to total appointments made at the East County Adult Clinic for clients who receive services in Spanish (10% reduction)
- Percentage of clients with perfect attendance (zero missed appointments) to their scheduled appointments at the East County Adult Clinic (10% increase)
- Percentage of clients satisfied with Televox automated call system intervention (70% satisfied).

The automated call reminder system began its implementation in October 2014 and the process was finalized over the next few months. For analyses, the baseline period is April-September 2014 and the follow-up period is April- September 2015. There were no issues to report around data cycles.

Results of the implementation of the automated call reminder system has helped to improve overall appointment adherence and decrease the no-show rate at East County Adult clinic from 14.50% (SD = .03) in April- September 2014 to 13.80% (SD = .02) in April-September 2015. This was a 4.83% improvement; thus the MHP did not meet its 10% goal. The MHP determined that several calls went to voice message leaving a void in knowing the consumer response to this notification process.

Similarly, the appointment adherence among Spanish speaking beneficiaries showed an improvement in the no-show rate from 11.43%. Although not statistically significant, this was a 17.76% improvement in Spanish speaking beneficiaries' no-show rate to appointments, which meets the goal of at least a 10% improvement.

The goal of at least a 10% increase in consumers who had perfect attendance was met. Perfect attendance rate increased from 50.6% to 56.3%.

For data related to appointment adherence, appointment no-show rates were calculated on a monthly basis. The data indicated a trend toward improved appointment adherence; however, this trend was not statistically significant. The measurement method of tracking appointments remained consistent at East County Adult Clinic across the PIP timeframe.

Currently, the MHP has expanded its intervention with the Televox system to other adult clinics in both Central and West County. The data will need to be measured, tracked and analyzed for improvements as well. The PIP is considered complete as it has conducted this for the past two review cycles and has provided limited data regarding the interventions. As the MHP continues to conduct this strategy in other clinics it was advised to consider further interventions and modifications to these as it seeks solutions to its no-show rate focused on improvements to service delivery to consumers. The sole implementation of the Televox system has not sufficiently met the goals of the MHP for improvements. The MHP was encouraged to implement further interventions to address the no-show rate. The MHP could benefit from reviewing its overall system protocols, including the actual appointment scheduling process to determine its effects on attendance. It could

utilize the benefit of the peer specialist to continue to inform it of consumer's barriers to attendance.

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

The technical assistance provided to the MHP by CalEQRO consisted of discussion encouraging the MHP to pursue lessons learned from the implementation of the Televox, given the voice message default and to address modifications as needed to meet the goals to reduce the no-show metric. The MHP was advised to review its data regularly and to apply modifications based on the data results on-going. The MHP is advised to submit a new PIP for the next review cycle. It can seek consultation from the CalEQRO staff as it identifies a new PIP, identifies indicators and interventions. Data should be collected in regular cycles and reviewed for modifications ongoing to the new PIP.

The MHP was advised to consider enhancing the survey with queries to consumers about what would be useful and to initiate those ideas. Originally the MHP indicated that often consumers self-report that transportation is a barrier and this could be brainstormed for solutions/improvements in consumer attendance. Perhaps the MHP can use the Peer Specialists to follow up more frequently with no-show consumers, and begin to determine alternatives to the continued no-show rate. Options may include consideration of what other comparable MHPs use such as double booking, walk in for 2 or more missed appointments, mass transit vouchers or gas vouchers etc.

Continued data collection was encouraged at the other sites to which the MHP has rolled-out this PIP. Surveys to consumers regarding the barriers to "forgetting" an appointment following a reminder call could also be explored.

TA was offered using the CalEQRO staff to discuss future PIP concepts and consider engaging in phone consults while formulation of its next steps to ensure the viability of the PIP study question.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Reducing no-show rates potentially decreases barriers to consumer engagement and reduces the number of re-scheduled appointments.
    - Consumers who utilize scheduled appointment times potentially engage with services regularly.
- Timeliness of Services
    - Increased availability of appointment slots lends to increased timely follow- up appointments.
    - Consistent attendance at timely appointments encourages earlier engagement with service.
- Quality of Care

- Utilizing peer mentors aligns with wellness and recovery principles.
- Engaging consumers in continued care potentially leads to increased responsibility for health.
- Significant non-attendance leads to non-productive staff time, and exacerbate consumer symptoms secondary to inconsistent care.

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

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 4, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	The Division's Reducing Health Disparities workgroup ensures the services and programs provided by the mental health plan meet state and federal standards for cultural and linguistic appropriateness. The Workgroup includes members from the Office for Consumer Empowerment, Quality Management, as well as community based organizations to ensure service accessibility and availability are culturally appropriate. The MHP has prioritized its assessment process for its Katie A subclass members and emphasizes consumer and family involvement at its Child/Family Treatment (CFT) team meetings.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	The MHP engages in detailed reporting of its underserved populations and reviews its penetration rates for analysis. The MHP has assessed up to 800 foster youth for potential eligibility in the Katie A. subclass group. The MHP can serve its 300 subclass members, however it reports delays in timely provision of service. Secondary to limited providers of the Intensive Care Coordination (ICC) services, consumers may experience a delay of 2-3 weeks. The MHP appears to be limited in its ability to adapt contemporary business practices overall to its service delivery such as a centralized appointment calendar, implementing a continuum of care, and incorporating treatment modalities for "step down" activities. The MHP has initiated and is in the beginning stage of implementation of its Consumer Relations Management (CRM) module within Epic's Tapestry system, partially centralizing access to care for the Access team.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP continues with its collaborative ties with probation, public health, primary care, and faith based communities.

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

Timeliness of Services

As shown in Table 5, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	PC	The MHP reports a standard of 15 days with an overall average of 6.8 days and meets this 89.5% of the time. For adult services it reports an average of 7.7 days and meets this 78.9% of the time. For children's services it reports an average of 6.1 days and meets this 98.2% of the time. Data reflects first available appointment and is a projected metric.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP reports a standard of 30 days with an overall average of 15.8 days and meets this 84.6% of the time. For adult services it reports an average of 23.6 days and meets this 75.8% of the time. For children's services it reports an average of 4.3 days and meets this 97.6% of the time. Data reflects first available appointment and is a projected metric.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2C	Tracks and trends access data for timely appointments for urgent conditions	PC	The MHP reports a standard of 30 days with an overall average of 15.8 days and meets the standard 84.6% of the time. For adult services it reports an average of 23.6 days and meets this 75.8% of the time. For children's services it reports an average of 4.3 days and meets this 97.6% of the time. Protocols in collecting data differ between adult and children's services. Adult data is collected from a scheduled appointment. Children's clinics vary and the projected wait time is recorded to reflect the capacity to serve.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP reports a standard of 7 days with an overall average of 3.8 days and meets this 91%. Adult services reports an average of 3.6 days and meets this 83.9%. Children's services reports an average of 3.6 days and meets this 97.9% of the time.
2E	Tracks and trends data on rehospitalizations	FC	The MHP reports a goal of 10% with an overall average of 14.9%. Adult services reports a rate of 16.3% and children's reports a rate of 10.2%.
2F	Tracks and trends No Shows	FC	The MHP reports a standard of 10% for all staff with an overall average of 4.0% for clinicians and 28.0% for psychiatrists. For adult services it reports an average of 3.3% for clinicians and 29.4% for psychiatrists. For children's services it reports an average of 5.7% for clinicians and 19.0% for psychiatrists.

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

Quality of Care

As shown in Table 6, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and

utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The Quality Management Program Coordinator position is filled, the committee meets monthly and maintains minutes, and an evaluation of last year's progress and the current QI work plan were submitted. Examining the staffing resources would be prudent given the multiple demands forthcoming with the Drug Medi-Cal Waiver and its eventual EHR implementation.
3B	Data are used to inform management and guide decisions	PC	Data is collected through various methodologies given the lack of a comprehensive electronic health record system.
3C	Evidence of effective communication from MHP administration	PC	While the executive team appears to genuinely want to have broad-based, transparent communications with its stakeholders, feedback from a wide array of focus groups indicate that the current methods appear ineffective.
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	Stakeholder input appears nominal although leadership asserts its desire for transparency. On-site informants collectively inferred that leadership is not communicating its vision.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	Numerous examples of collaboration were given to indicate efforts working with faith based groups, schools, law enforcement and primary care.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3F	Measures clinical and/or functional outcomes of beneficiaries served	PC	The MHP utilizes the CALOCUS within children's services, the LOCUS within adult services, and is in discussions regarding additional tools. The MHP's use of its outcomes tools is beginning to be mined for to assist consumers' recovery processes. The MHP is part of the seven Bay Area collaborative using Trauma Informed therapy, funded by Substance Abuse and Mental Health Services Administration (SAMHSA) over four years. This informed practice will span across these seven counties for regional coordination of care. The MHP has initiated a clinical PIP which intends to collect data to measure consumer progress and functional outcomes.
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP distributes the statewide consumer perception survey during the required timeline. It compiles an extensive report of its survey findings and uses the feedback to incorporate changes within its system.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	Multiple Peer Specialists and Family Partners are used in various programs. Minimal career steps are in place for consumers, with one CFM employee reporting to the Deputy Director and one identified supervisory role, and limited Peer Specialist II positions exist. The SPIRIT program, which is connected to the local community college system, continues to provide training and certification in peer employee job skills. The Office for Consumer Empowerment (OCE) promotes wellness and employs peer consumers and continues to provide consumer education.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	Miller Wellness Center (FQHC) has primary care services as well as mental health services and is open until 9 pm to help with the access needs of consumers. Contra Costa continues with its three Wellness and Recovery Centers. Contra Costa County contracted with Recovery Innovations (RI) using MHSA Innovation dollars for the three Wellness Centers. As mentioned in the prior year's report, consumers seem ill-informed of resources within the MHP. None indicated receiving an orientation or welcome packet for services at the time of an initial assessment.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP appears limited in its resources to serve Katie A. subclass members in a timely and quality manner. The ICC staff carries a caseload of 30-40 consumers which limits quality of care. It remains prudent to evaluate the additional resources to provide this service.
  - Previously, the MHP had a set of protocols for the regular examination of staff productivity and program capacity. During the management changes of recent years the MHP acknowledged that the use of these protocols diminished. There may be efficiencies to be gained by reinstating these analyses to gain insight into optimizing staffing resources.
  - The lack of an effective EHR system was apparent throughout the overall review sessions. Some examples of barriers to the MHP progress include these items: inhibits timely collection of access metrics; prohibits regular data collections for the PIPs; limits information regarding staffing capacity, program capacity and other data for which the MHP currently has to delay due to cumbersome paper collections, telephone surveys to clinics or spreadsheets for data provisions.

- While the MHP engages in very broad collaborations with its service partners to enhance access to care for beneficiaries there appears to be a limited standardized evaluation of the effectiveness on service delivery/service capacity. This may be due, in large part, to the lack of an EHR to provide a repository of data.

- Timeliness of Service

  - While serving as an operational proxy, the MHP's current methodology for determining timeliness to first service is only a projection and not a calculation based on data. The MHP, as yet, lacks a fully operational management information system (MIS) to accomplish this task.
  - Data for routine appointments, appointments with psychiatrists and wait times for hospital discharge appointments are based on "projected" average wait times. By calling the Access Line and regional clinics, the MHP collects information on the first available appointments for all regional clinics. The first available appointments are used in the data analysis.
  - For urgent appointments, the MHP uses appointment data from appointments scheduled by the regional clinic.
  - For numbers of hospital discharge appointments, hospital readmissions and appointment no-shows, CCMHP collects these data by analyzing data from PSP/Insyst billing data system.
  - The Rapid Access program expanded to all regional clinics and is designed to serve consumers not currently engaged with County services. It also has the capacity to see some "walk-in" consumers on a limited basis.
  - Stakeholders voice serious concerns about the long wait times to functional psychiatric service throughout the entire system of care. The MHP's timeliness data reflects less significant timeliness issues which questions the accuracy of the data collection system.
  - The MHP makes little use of its no-show data. Since this is one of the few areas of clinically oriented data collected by the MHP's legacy practice management system it is unclear why the MHP staff are not exploring this data source to enhance service delivery. No-show metrics provided for psychiatric staff appear high and it was unclear that MHP strategies to remediate this are effective.
  - Numerous informants noted the lack of adequate psychiatric staffing for medication support. In spite of reporting a successful tele-psychiatry pilot program the executive team does not appear to be exploring the use of this resource as a cost effective treatment to urgent medications support delivery or the triaging of consumer needs.

- Quality of Care

  - While the MHP's commitment to CQI appears to be genuine, the MHP struggles to maintain and expand supervisory, subject matter expert (SME), and data analyst staff to meet current needs. This potentially contributes to added

workload to current staff with expanding responsibilities brought on by healthcare integration, interoperability and the Drug Medi-Cal Waiver.

- Some unintended consequences emerged from the site review that provide examples of the limited communication flow. Examples include these items: the MHP distributes a quarterly newsletter and although mentioned by leadership in the opening session, no one from the two CFM focus groups were aware of the newsletter; additionally, one line staff focus group was not aware of who the MHP director was currently; stakeholders at various levels indicated some reluctance in disclosures to the CalEQRO review team secondary to the management style. These examples are intended to provide information to the MHP that could result in proactive ways of sharing the vision of the new leadership.
- Senior management at the MHP are fully aware that they are significantly behind the rest of the state in acquiring a contemporary EHR. Unfortunately, the process at the county level, of acquiring this critical support infrastructure does not appear to be forthcoming in a timely manner.
- Staff report numerous committees have been involved in developing an EHR workflow without resulting in implementation. The executive staff seem aware of the urgency and committed to serving the beneficiaries.

- Consumer Outcomes
  - While the MHP makes significant use of Level of Service/Level of Care instruments within its System of Care, these tools are primarily limited to feedback on individual consumer treatment with most of this information primarily collected on paper forms.
  - The wellness centers are located throughout the county in Concord (central), Antioch (east), and in San Pablo (west) and mirror the MHP's business hours of operation. The Center's mission is, "empowering people to recover, succeed in accomplishing their goals, find meaning and purpose in life and reconnect with themselves and others". The staff have lived experience, the centers are open to the public, and families are invited on Fridays.
  - Consumer staff are trained in WRAP (Wellness and Recovery Action Plan), an evidence-based model for recovery and WRAP groups are held at the centers and clinics.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This was a group of twelve parents/caregivers of youth beneficiaries including a mix of existing and new clients who have utilized services within the past 12 months and was held at the MHP offices at 2425 Bisso Lane, Concord.

Each of the group participants had a different experience in accessing initial services, with some able to acquire counseling immediately, some had delays with medications evaluations, some indicated barriers at the school site secondary to school policies, and some with delayed initial assessments. For those whose youth were involved in the Wraparound program, service delivery was reported as efficient. Overall, for the group, once involved in services, a relatively routine schedule was established.

Group participants indicated that some staff did not provide them with the confidence to help their child, and others thought the provider staff were most helpful. Some parents indicated that staffing changes were disruptive to the youth's treatment and subsequent progress.

Some peripheral barriers involved getting Medi-Cal transferred from another county, transportation was limited for several, and assigning multiple parent partners over the course of treatment took adjustments.

Recommendations arising from this group include:

- Provide staff who culturally match the consumer
- Increase psychiatric services
- Provide support group for parents

- Consider options to support transportation, such as vouchers for gas or bus.

Table 7A displays demographic information for the participants in group 1:

Table 7A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants*		12
Number/Type of Participants	Consumer Only	
	Consumer and Family Member	4
	Family Member	8
Ages of Focus Group Participants	Under 18	
	Young Adult (18-24)	
	Adult (25–59)	11
	Older Adult (60+)	1
Preferred Languages	English	10
	Spanish	2
	Bilingual_____/_____	
	Other(s) _____	
Race/Ethnicity	Caucasian/White	4
	Hispanic/Latino	5
	African American/Black	
	Asian American/Pacific Islander	
	Native American	
	Other(s): Mixed race/ethnicity	3
Gender	Male	
	Female	12
	Transgender	
	Other	
	Decline to state	

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This was a group of eleven adult beneficiaries including a mix of existing and new clients who have utilized services within the past 12 months and was held at the MHP offices at 2425 Bisso Lane, Concord.

Group participants indicated that access to initial services was varied with most able to acquire an assessment from 1-3 weeks. Delays in seeing the psychiatrist occurred initially, but routine appointments were scheduled after the evaluation. Most of the participants were satisfied with the staff who assisted them, especially in regard to the case managers. Many would welcome seeing their provider more often, with most citing the psychiatrist.

Participants shared that the level system was confusing to them and were not clear on the status of their treatment level because of this. To access crisis care, consumers indicated they were told to either call 911 or the sheriff.

Participants indicated it was difficult for them to get referrals to outside agencies for supportive services. Overall, group participants indicated the information regarding the MHP activities was obtained at the wellness centers.
Recommendations arising from this group include:

- Increase family member involvement in consumer treatment
- Provide a welcoming environment for family members
- Consider providing a referral list of community resources
- Streamline ways to access services.

Table 7B displays demographic information for the participants in group 2:

Table 7B—Consumer/Family Member Focus Group 2

Category		Number
Total Number of Participants*		11
Number/Type of Participants	Consumer Only	6
	Consumer and Family Member	
	Family Member	5
Ages of Focus Group Participants	Under 18	
	Young Adult (18-24)	1
	Adult (25–59)	6
	Older Adult (60+)	4

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Preferred Languages	English Spanish Bilingual_____/_____ Other(s) _____	11
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)_____	8 3
Gender	Male Female Transgender Other Decline to state	1 10

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 2: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Access to care initially was obtained; delays occurred in acquiring psychiatry appointments as a follow-up service.
  - Consumers had limited knowledge of community resources.
  - Awareness of navigating the system was limited.
- Timeliness of Services
  - The consumer experience was varied and unpredictable with initial service obtained between 1-3 weeks.
  - Psychiatry services were often delayed for consumers.
- Quality of Care
  - Multiple staff changes were found to be disruptive to treatment flow.

- School based services had barriers to treatment due to school policies.
- Once involved in services, most consumers experienced routine appointments.

- Consumer Outcomes
  - Consumers were confused about the level of care each required and could not anticipate the length of treatment.
  - Consumers often had difficulty in getting transportation to the site.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

Table 8 shows the percentage of services provided by type of service provider:

Table 8—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	57%
Contract providers	32%
Network providers	11%
Total	100%

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

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

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

20%

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

12%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- The MHP currently calculates penetration rates once per year. These calculations are used to identify underserved groups such as ethnicities or age who may be experiencing barriers to enter the System of Care. The MHP has taken its findings for its API, TAY and Older Adult populations and set measurable goals within its current QI Plan.
- While the MHP does list a missed appointments rate it does not currently engage in broad-based systemic no-show (NS) analysis to remediate issues or identify training opportunities.

CURRENT OPERATIONS

- The MHP's System of Care currently budgets 58.74% of its operating revenue from SDMC. Community based organizations (CBOs) now account for 35.62% of the revenue dollars for the entire system of care.
- The MHP continues to use the legacy Insyst practice management software as its primary MIS. The MHP is one of the last MHPs in the state to remain on this legacy product which does not facilitate the capture of contemporary clinical data elements.
- County IT has investigated the possibility of replacing the Insyst system with the current vendor's (ECHO Management) SHARECARE product. A quote for replacement functionality for the practice management modules has been obtained and budgetary approval formalized. However, the MHP has not yet entered into contract negotiations for the new practice management system and no definitive project plan was provided.
- The MHP currently employs seven IS staff which is a net loss of one staff member from the previous review period. There are no currently unfilled positions.

MAJOR CHANGES SINCE LAST YEAR

- The MHP completed the implementation of an 837/835 data error and reconciliation application.
- The MHP implemented ICD-10 changes by the mandated start date.
- The MHP implemented and tested ICD-10 compliant CSI submissions with the State and has substantially reduced its error rate.
- MHP implemented a new referral system for Primary Care and the Care Management Unit.

- The MHP's IS support spent significant resources and time during the review period to remediate and facilitate operations. The ICD-10 remediation project was a success. Additionally, the MHP remediated and improved efficiencies for both its CSI reporting and denials processing for claiming.

PRIORITIES FOR THE COMING YEAR

- The MHP will finish implementing Epic TAPESTRY and its CRM, AP claims, Acuity Screening and provider modules.
- To implement the call management system.
- To attain compliance with CCHP Mental Health claiming and substance use disorders low acuity referrals.
- Increase billing generation cycles to reduce contractual issues with educationally related mental health services (ERMHS) in school districts.
- Delineate workflows, cross training and data exchange with EPIC system.

OTHER SIGNIFICANT ISSUES

Table 9 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 9—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Insyst	Practice Management	The Echo Group	27	Health Services IT
NetPro	Managed Care	Health Services IS	16	Health Services IT
Epic	Provider Portal	Epic	4	Health Services IT
Panoramic	Conservatorship	Panasoft	5	Health Services IT

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP currently has no concrete plans for system change. They are exploring the possibility of replacing its current practice management system, Insyst, with the SHARECARE product by the same vendor.
- The executive team has formed both stakeholder and clinical teams to help them explore the practical realities of getting an EHR project off the ground within the Contra Costa County system. This includes executive team members formally exploring their options within the Health Department IS committee system.

ELECTRONIC HEALTH RECORD STATUS

Table 10 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 10—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments				x	
Clinical decision support				x	
Document imaging	EPIC/OnBase	x			
Electronic signature—client				x	
Electronic signature—provider				x	
Laboratory results (eLab)	EPIC	x			
Outcomes				x	
Prescriptions (eRx)	EPIC		x		
Progress notes				x	
Treatment plans				x	
Summary Totals for EHR Functionality		2	1	7	0

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

- The MHP does not possess contemporary clinical EHR functionality.
- The MHP medical staff are currently able to query the primary care utilization of the EPIC eRx system via the ccLINK tool. They are also able to manually enter some data into this system. The MHP will begin a pilot of the eRx tool in about 30 days to develop operational knowledge so that this clinical tool can be extended to all MHP medical staff.

- The MHP has had EPIC eLabs functionality for about two years according to informants. MHP medical staff can order labs and obtain results via the EPIC toolset. Staff noted, however, that not all utility for the system is being utilized as appropriate lab results are not being automatically forwarded to the pharmacy system to get appropriate medication releases for consumers. This transfer of information is still falling to line staff to accomplish by fax which is a burden to quality consumer care.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
    - The MHP is engaging in more detailed analysis of its penetration rates for underserved populations to make appropriate adjustments to its QI plan. It may be able to utilize data from its new TAPESTRY system for similar analysis once the system is up and sufficient operational data has been acquired.
- Timeliness of Services
    - While doing some timeliness reporting, the MHP acknowledges that predominately paper-based systems constitute the single greatest impediment to continuous quality improvement (CQI) analysis in this area of inquiry.
    - The MHP has broad-based no-show data from its legacy MIS but is not currently exploiting this dataset for knowledge to eliminate barriers or identify training opportunities.
- Quality of Care
    - The MHP is poised to broadly utilize its Level of Service/Level of Care data again for administrative and CQI purposes thereby providing targeted clinical rightsizing of care to beneficiaries.
- Consumer Outcomes
    - The MHP currently utilizes broad outcomes measures like the LOCUS/CALOCUS/DCR suites for individual treatment but has not, as yet, fully repurposed this data for broader CQI utility.

SITE REVIEW PROCESS BARRIERS

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

There were no significant barriers to conducting the review.

CONCLUSIONS

During the FY15-16 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - The MHP shared its future strategic plans which include integrated health service delivery with public health, substance use, primary care and mental health services.
  - The MHP is engaging in broader analysis of its penetration rates within its underserved and ethnic populations to gain better insight for improved engagement.
  - The MHP is poised to broadly adopt the TAPESTRY system to provide enhances support to the ACCESS team.
- Opportunities:
  - The MHP will benefit from analyzing its capacity to serve the Katie A. subclass with sufficient staffing resources.
  - Given the tumult in staffing and management coupled with the Affordable Care Act (ACA) during the past few years the MHP dropped the regular systemic capacity analyses that it had been doing. Reinstituting these protocols may give administration new insight into program effectiveness.
  - The lack of sufficient medical staff may be causing a cascading effect of deferred care across the entire system of care. The MHP does not appear to be seriously considering alternatives to the current paradigm such as broad use of tele-psychiatry.
  - The MHP could consider reengaging with proven protocols for the analysis of clinical productivity and programmatic capacity analysis to ensure the right mix of program and staff are available to serve beneficiaries.

- The lack of sufficient medical staff, not just psychiatrists, may be causing a cascading escalation of unintended consequences for services to consumer which the CQI team should investigate.

Timeliness of Services

- Strengths:
  - The MHP appears to be making consistent progress in the monitoring of service delivery to beneficiaries recently discharged from an in-patient event.

- Opportunities:
  - The MHP stated its metric for first appointment data is a result of projected appointments and not indicative of actual collection of appointment data which may give the appearance of timely service.
  - The MHP does not appear to be mining its store of no-show data to provide opportunities for the provision of training or reduction of barriers to service. This is especially evident within the psychiatric staff.
  - The MHP needs to consider the ubiquitous use of tele-psychiatry to circumvent practical hiring issues with its medical staff. It should also consider use of tele-psychiatry for triage/screening functions when consumers enter service.

Quality of Care

- Strengths:
  - The MHP has successfully filled the majority of its executive positions as well as its quality management coordinator.
  - The MHP has joined Cohort I with its intent to submit its Drug Medi-Cal Implementation Plan to DHCS.
  - The MHP recently filled numerous supervisory positions, promoting several from within its current workforce.
- Opportunities:
  - The MHP is thwarting its progress in its initiatives without an EHR system to provide current business structures and practices across its service delivery within its system of care, such as timely data collection and outcome tool reporting.
  - The MHP does not have a structured succession plan to address future vacancies due to staff retirements and departures.

- The MHP does not have a manual for reference or a shared model to memorialize its history or replicate its successes.
- Staff stakeholder groups indicate performance evaluations are limited and untimely, leaving a void in feedback for job performance.
- The adult organizational providers indicated limited bi-directional communication with limited regularly scheduled meetings.
- The MHP is poised to utilize Level of Service/Level of Care tools for administrative and CQI purposes in a system-wide way and should encourage Evaluations staff to pursue this dataset.
- The MHP's escalating trend toward increased HCBs is worth investigating with the aim of reversing this trend significantly.
- The MHP's reticence to implement a contemporary EHR is materially denying consumers minimum necessary standard tools for quality care.

Consumer Outcomes

- Strengths:
  - The MHP has made efforts to analyze and identify underserved populations within its beneficiary pool. This will allow more targeted treatment and better outcomes.
  - The MHP utilizes a peer skill building model with its continued use of the SPIRIT training program via the community college.
- Opportunities:
  - The MHP is beginning to explore its wealth of longitudinal outcomes data. The CQI staff needs to pursue this enquiry to assist the executive team in tailoring program to meet identified trends and potential barriers.
  - The consumer informants indicate a resource packet or welcome packet coupled with the initial assessment/orientation would be useful.

RECOMMENDATIONS

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

- Engage in a stakeholder process with the MHP contract provider agencies which have operational EHR systems. Research what other MHPs have implemented for data interoperability solutions. Implement electronic data interchange (EDI) standards for the exchange of healthcare data between systems.
- Investigate the feasibility to expand tele-psychiatry service system-wide to support staffing gaps, expedite screening, provide targeted expertise (e.g. Spanish speaking Child psychiatry) and decrease time to service.
- Review and analyze high cost beneficiaries' service patterns as both percentages of client counts and billed Medi-Cal services are significantly higher than statewide experience. Implement strategies to create step-down program or alternative services for these beneficiaries where and when appropriate.
- Create a welcome packet for consumers with system navigation information; consider rosters of community resources, the mental health newsletter and how to access the Behavioral Health website.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 386-3776
www.calEQRO.com

Contra Costa County MHP CalEQRO Agenda

February 9-11, 2016

Time	Day 1 Activities-February 9, 2016	
9:00 -10:15	Opening Session 2425 Bisso Ln. (Large Conference Room) Concord, CA 94520 • Introduction to BHC • MHP Team Introductions **Review of Past Year, Disparities and Performance Measures** • Response to Previous Year's Recommendations • Significant Changes and Key Initiatives • Use of Data in the Past Year • Access and Retention, Capacity Building • Cultural Competence Inclusion Strategies *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders, Cultural Competence Staff*	
10:15-10:30	**Break**	
10:30-11:45	**Quality Improvement Activities** 2425 Bisso Ln. (Large Conference Room) Concord, CA 94520 Quality, Access, Timeliness, Outcomes • Use of Evidence Based Practices • Performance Management-Timeliness Strategies • Review of EQRO Performance Measures and Approved Claims Summaries • Access, Threshold Languages, Engagement, (Timeliness, Outcomes)	
11:45-12:00	**Travel Time**	
12:00 – 1:00	**BHC Cal-EQRO Working Lunch at 1340 Arnold. CCC to pickup**	
1:00-2:30	**Katie A. Implementation** 1340 Arnold Dr. #250 (Large Conference Room) Martinez, CA 94553 • Collaboration between MHP and CWS • Implementation and provision of services, i.e. - numbers served, Core Practice Model, CFT, claiming • Policies and procedures • Current challenges • Next steps	**IS Staff Group Interview** 1350 Arnold , #175 Martinez, CA 94553 • Review and discuss ISCA • Discussion of prior year recommendations • Timeliness Self-Assessment Document • Status of Timeliness Calculations - Challenges, Solutions and barriers in tracking timeliness

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Jovonne Price, LMFT, CPHQ, Quality Reviewer Consultant
Duane Henderson, Information Systems Reviewer Consultant
Marilyn Hillerman, Consumer/Family Member Consultant
Rama Khalsa, BHC Reviewer
Ewurama Shaw-Taylor, BHC Reviewer

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

Sites of MHP Review

MHP SITES

2425 Bisso Lane
Concord, CA 94520

1340 Arnold Drive #200
Martinez, CA 94553

1350 Arnold Drive #103
Martinez, CA 94553

2975 Treat Blvd, Suite C-8
Concord, CA 94518

Participants Representing the MHP

Name	Position	Agency
Jennifer Tuipulotu	Family Services Coordinator	
Heather Sweeten-Healy	Mental Health Program Manager	
Warren Hayes	MHSA Program Manager	
Stacey L Tupper	Mental Health Program Manager	
Anita de Vera	West County Adult Mental Health Program Manager	
Kennisha Johnson	Central County Mental Health Program Manager	
David Seidner	Forensic Mental Health Program Manager	

Name	Position	Agency
Katy White	Mental Health Access Line/CMU Program Manager	
Susan Kalaei	Medication Monitoring Clinical Pharmacist	
Ziba Rahimzadeh	Provider Services Program Manager	
Gerald Loenicker	Central County Children's Mental Health Program Manager	
Fatima Mata Sol	AOD Program Chief Behavioral Health	
Lavonna Martin	Chief , Homeless Services	
Vern Wallace	Chief, Child & Family Mental Health	
Eric Duran	IT Project Manager	
Christine Bohoquez	Utilization review Coordinator	
Ann Isbell	Planner /Evaluator	
Charlene Bianchi	Mental Health Program Manager	
Helen Kearns	Project Manager	
Steve Wilbur	Acting Mental Health Quality Improvement Coordinator	
Jan Cobaleda-Kegler	Mental Health Program Manager	
Jon Whalen	Interim Medical Director Behavioral Health Services	
Matthew Luu	Deputy Director, Behavioral Health Services	
Christina Boothman	Planner/Evaluator	
Anne Staunton	Planner/Evaluator	
Susan Medlin	Program Coordinator, Office for Consumer Empowerment	
Phyllis Mace	Mental Health Program Manager	
Michelle Nobori	Planner/Evaluator	
Lakema Sams	Administrative Service Analyst	
Windy Murphy	Administrative Service Analyst	
Kim Stokem	Mental Health Provider's Services	
Chet Spikes	Assistant IT Director Business Systems	
Eileen Brooks	East County Children's Program Manager	

Name	Position	Agency
Brett Beaver	Mental Health Program Manager	
Monica Reynoso	Program Supervisor	
Michelle Rodriguez-Ziemer	PEI Program Supervisor	
Caroline Sison	Ethnic Services Manager and training Coordinator	
Beverly Fuhrman	Program Manager	
Rich Weisgal	Program Manager	
Nancy Fernandez	Child & Family Services Division Manager	
Heidi Wintermantel	Child & Family Services Division Katie A Supervisor	
Teresa Gibson	Team Lead Evidence Based Practices	
Bill Bowers	Katie A. Intensive Case Coordination	
Herb Chew	Mental Health Liaison	
Andrew Lindeman	Mental Health Clinician	
Nancy O'Brien	Mental Health Clinician	
Paula Williams	Mental Health Children's Services	
Sharon Page-Prisstey	Mental Health Clinical Specialist	
Tracy Ward	Director	YMCA of the East Bay, T-Team
Sara Marsh	Director Of Support Services	Contra Costa Interfaith Housing
Chris Withrow	CEO	Anka Behavioral Health
Janice Washburn	CFO	Anka Behavioral Health
Adeline Buye	Supervisor/Clinical	La Clinica Oakley
Liz Varon	Clinical Director	Lincoln
Kirk Helnett	Director	Bay Area Community Resources
Robin O'Neill	Program Supervisor West County Adult Mental Health	
Amanda Dold	Program Supervisor Transition Team	
Ellen Shirgul	Program Supervisor Older Adult	
Betsy Hanna	Program Supervisor Central Children's Mental Health Clinic/ Interim Training Coordinator	
Denise Chmiel	Program Supervisor Mt. Diablo Mental Health Program	
Marie Scannell	Program Supervisor Forensics	

Name	Position	Agency
Bernie Sanabria	Program Supervisor East County Adult Clinic	
Adam Down	Mental Health Analyst	
Cynthia Belon	Behavioral Health Director	
Ori Tzvieli	Ambulatory Medical Director	
Juanita Garrison	Clerical Supervisor	
Michelle Collins	Clinical Supervisor	
Paolo Gargantiel	Clinical Lead	
Jorge Pena	Legacy Team Lead	
Kimberly Nasrul	Mental Health Program Supervisor	
Teri Williams	Information Technician	
JR Ang	Director of Patient Accounting	
Rusty Hernandez	Accountant	
Peggy Harris	Community Support Worker II	
Robert Thigpen	Acting Adult Family Coordinator	
Elizabeth Siliezar	Community Support Worker II	
Jennifer R. Grewats	Community Support Worker II	
Paula Serrano-Cardenas	Community Support Worker II	
Tina Lindsey	Community Support Worker II	
Oleg Andreev	Programmer/Analyst	
Carol Malt	Transition Team Case Manager	
Steven Polivka	Older Adult West County Team Lead	
Jimmy Jun	Older Adult East County Team Lead	
Loan Tran	Adult Case Manager	
Vincent Solaris	Concord Adult Case Manager	
Jonel Mizerak	Concord Adult Case Manager	
Jean Cantrell	Forensic Case manager	
Louis Jumonville	East County Adult Team Lead	
Michele Simes	Clerical Supervisor	
Duane Chapman	Mental Health Commissioner	
Sakura Barrientos	Wellness Nurse	
Crystal Whitehead	Wellness Coach	
Priscilla Olivas	Quality Management Program Coordinator	

Name	Position	Agency
Stephen Boyd, Jr.	Lead Community Support Worker, Office for Consumer Empowerment	
Debra Beckert	Nurse Program Manager	
Ken Gallagher	Research and Evaluation Manager	

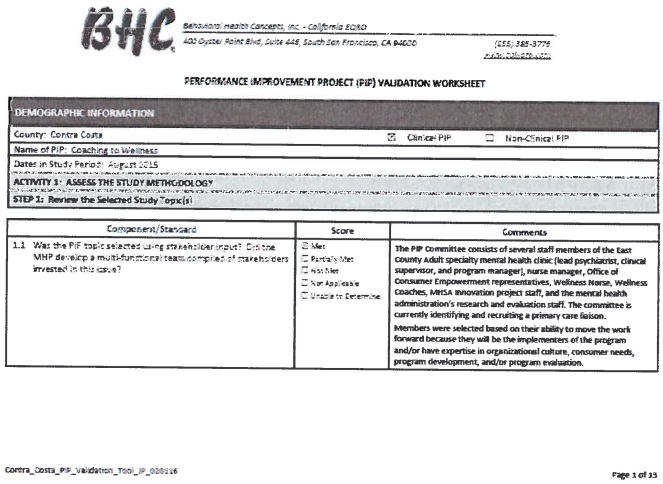
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:



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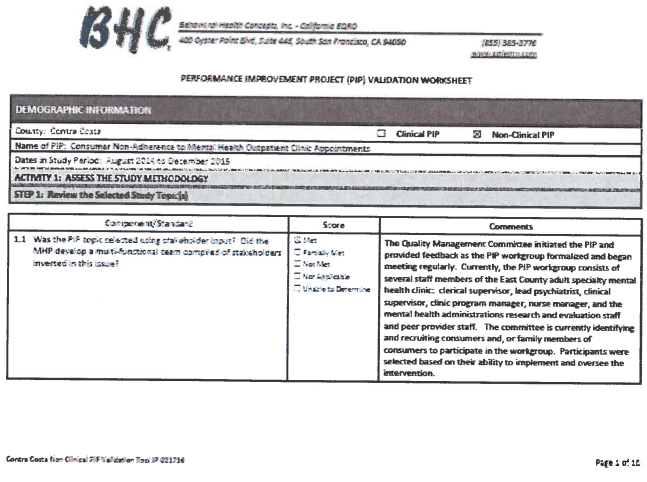
PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Contra Costa	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Coaching to Wellness		
Dates in Study Period: August 2015		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team comprised of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP Committee consists of several staff members of the East County Adult specialty mental health clinic (lead psychiatrist, clinical supervisor, and program manager), nurse manager, Office of Consumer Empowerment representatives, Wellness Nurse, Wellness Coaches, MHSA innovation project staff, and the mental health administration's research and evaluation staff. The committee is currently identifying and recruiting a primary care liaison. Members were selected based on their ability to move the work forward because they will be the implementers of the program and/or have expertise in organizational culture, consumer needs, program development, and/or program evaluation.

Contra_Costa_PIP_Validation_Tool_IP_020116 Page 1 of 13

Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Contra Costa	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Consumer Non-Adherence to Mental Health Outpatient Clinic Appointments		
Dates in Study Period: August 2014 to December 2015		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

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

Contra Costa Non-Clinical PIP Validation Tool IP 021716 Page 1 of 12