FY 16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Alpine

Conducted on

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Introduction

Alpine Mental Health Plan (MHP) is located in a small rural frontier county that is the least populated in California, and is geographically isolated in the Central Sierra Nevada mountain range south of Lake Tahoe and bordering the State of Nevada. Alpine County has no incorporated cities, but has five distinct communities that are separated in winter by closed mountain passes. The largest employers are government and the tourism industry. The Washoe Tribe makes up about one-third of the population of this county.

During the FY16-17 review, CalEQRO found the following overall significant changes, efforts and opportunities related to Access, Timeliness, Quality and Outcomes of the MHP and its contract provider services. Further details and findings from External Quality Review Organization (EQRO) mandated activities are provided in the body of this report.

Access

While the MHP continues to experience capacity challenges, in the past year it has expanded its workforce by hiring five new staff members including a clinical coordinator, a clinician, an Mental Health Services Act (MHSA) coordinator, an MHSA program specialist, and an administrative assistant. The MHP recently lost their MHSA Native Wellness Advocate/Ethnic Services Manager, and their Alcohol and Other Drug (AoD) Counselor (the only male staff member). Tele psychiatry is available in the Markleeville Clinic (serving Markleeville, Hung-A-Lel-Ti, Woodfords and Sierra Vista).

The MHP has very high penetration rates (PR) and average approved claims per beneficiary for most age groups, both genders, Whites, Native Americans, and core outpatient services compared to the Small-Rural MHP and statewide rates. Females are served at twice the PR (15.91%) as males (7.69%). The Transitional Age Youth (TAY) population remains the most difficult to serve due to the small size of the community and the lack of privacy, along with cultural challenges for Tribal youth.

As there are no clinical services provided in Bear Valley, the MHP is encouraged to investigate the level of need among local residents and determine how best to address them.

Timeliness

The MHP provides timely services, and consumers can be seen as frequently as needed. There are no waitlists. The MHP has valid methodologies for calculating all CalEQRO Timeliness Self-Assessment (TSA) measures except for no-shows which may not summarize the full spectrum of engagement needs and activities for the MHP. The MHP is encouraged to evaluate the effectiveness of maintaining a 60-day baseline standard for measuring timeliness from initial contact to first psychiatric appointment. The MHP has discussed with their Application Services Provider (ASP) Kings View Behavioral Health Systems (Kings View) the feasibility of uploading their locally maintained Access Log or part of it into their EHR.

Quality

The MHP submitted no Clinical Performance Improvement Plan (PIP). The MHP will need to ensure that they have two active PIPs that are data driven with consumer input, using sufficient data to establish the prevalence of an issue impacting Alpine's consumers.

The MHP does not routinely produce nor analyze Electronic Health Record (EHR) data and they have no internal data analyst staff. The MHP is encouraged to identify and increase staff hours/percentage of Full-Time Equivalent (FTE) staff devoted to working with Kings View to upgrade the EHR, develop and analyze reports based on EHR capabilities and provide staff training.

The MHP is working towards institutionalizing a Continuous Quality Improvement (CQI) approach throughout the system of care and they have begun to evaluate lengths of stay appropriateness in relation to the use of clinical Evidence-based Practice (EBP) and consumer outcomes. They have also begun tracking data by diagnostic categories and some social determinants to improve clinical service delivery. To date there is no integration between mental health (MH) and primary care, although discussions have begun.

Outcomes

With an expansive list of engagement and outreach activities for which transportation is provided, the MHP is excelling in their efforts to dramatically increase community participation in wellness and recovery activities throughout the county, particularly with Washoe Tribal members.

The MHP trained staff on the use of the Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) tools, and instituted these tools for all clients at reassessments and/or new assessments. These tools were embedded in the EHR in December 2015. The MHP will need to institute regular and consistent application of these tools for baseline and follow up measures of all consumers, and develop individual and aggregate level reports to monitor consumer outcomes and guide clinical care.

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

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

This report presents the FY 16-17 findings of an EQR of the Alpine MHP by CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

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

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

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

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two PIPs during the 12 months preceding the review; Aline MHP submitted one PIP for validation through the EQRO review. The PIPs are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

[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.

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

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

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

Assignment of Ratings

- Fully addressed:
  - resolved the identified issue
- Partially addressed means 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 means the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY15-16

- Recommendation #1: Collaborate with Kings View and other Anasazi counties to establish the viability of creating automated timeliness reporting tools for the Anasazi system.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP has discussed with Kings View the possibility of creating automated timeliness reporting tools for the Cerner system.
  - The MHP improved the utility of their manual Access and Referral Form and Excel spreadsheet Access Log to be able to calculate the timeliness measures contained in CalEQRO's Timeliness Self Assessment (TSA). The MHP has valid methodologies to calculate the first five measures, though their calculation of no-shows does not include all types of missed appointments.
  - Though the Cerner/Anasazi EHR product does not include a standard pre-admission function, uploading some Access Log information to the EHR may allow the MHP to more easily correlate timeliness data with other data in their Quality Improvement Work Plan (QIWP), Cultural and Language Competency Plan (CLCP) and annual Kings View Information Technology "Alpine County Penetration Reports" which are produced from the EHR.

- Recommendation #2: Collaborate with Kings View and other Anasazi counties to incorporate client functioning outcome measures within the EHR allowing for regular reporting to guide clinical care.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP has begun using several forms of outcome measures within the EHR including the CANS assessment, the Milestones of Recovery Scale (MORS), the ANSA, the PTSD Checklist (PCL), the Patient Health Questionnaire 9-Item (PHQ-9) for depression, and the Generalized Anxiety Disorder 7-Item (GAD-7) for anxiety.
  - The MHP is in the process of systematizing the use of these tools, and it expects to be able to produce data reports later this year. The MHP is planning to administer these tools to consumers at initial assessment and every six months.

- Recommendation #3: Develop two active PIPs, one clinical and the other non-clinical that are data driven with consumer input. Use sufficient data to establish the prevalence of an issue impacting Alpine's consumers. Focus both PIPs on consumer outcomes, with measurable client focused indicators and interventions with repeated measures to assess implications over time.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP did not submit a Clinical PIP this year.
  - The MHP submitted a Non-Clinical PIP focused on improving staff response to the 24/7 Crisis and Access Line. This PIP was previously submitted last year and at that time it was determined to be "Concept Only". Without making the changes recommended during and after last year's review, the MHP resubmitted the same PIP this year and added one set of data measurements post baseline.
  - During discussion at this year's review, the MHP reported that they were not interested in continuing this PIP, and considered it complete.

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 expanded its workforce by hiring five new staff members including a Clinical Coordinator, a clinician, an MHSA Coordinator, an MHSA Program Specialist, and an Administrative Assistant. The MHP has one vacancy for the

Addition Counselor position. However, their MHSA Native Wellness Advocate/Ethnic Services Manager resigned last week.

- The hours have been increased from 32 to 40/week for an MHP Driver, facilitating additional transportation for clients to/from therapeutic services thereby increasing attendance and decreasing no-shows.
- The MHP continued to significantly expand the depth and breadth of consumer groups that support outreach activities, engagement, wellness, and recovery for the entire population.

- Timeliness of Services
  - The MHP's timeliness improved for their FY15/16 services per Alpine's FY16/17 Timeliness Self-Assessment.
  - The MHP's measure of no-shows may not summarize the full range of service engagement needs and activities.
- Quality of Care
  - The Alpine County Behavioral Health Services Director has initiated and organized a "Very Small Counties Group".
  - While the MHP screens and assesses all children, there have been no Katie A. or Pathways clients in Alpine County to date. The MHP plans to use MHSA Workforce, Education and Training (WET) Program funding to train Health and Human Services (HHS) and Behavioral Health Services (BHS) staff on the CCPM in 2016-2017.
  - The MHP has a number of major programs including: i) Field Capable Clinical Services (FCCS) which extends services to homes and community settings; ii) Full Service Partnerships (FSPs) for all ages; and iii) school-based mental health services at Diamond Valley School which includes a school-based mental health clinician, Primary Intervention Program, playgroups, and Positive Behavior Intervention Support (PBIS).
  - The MHP continues their Mental Health First Aid (MHFA) Training and Suicide Prevention programs.
  - The MHP sponsors: i) a Talking Circle for Alcohol and Other Drug (AoD) recovery; ii) Family, Teen and Community Movie nights; iii) one or more weekly yoga classes each in Bear Valley, Kirkwood, Markleeville, Hung-a-Lel-Tei Washoe Community and Woodfords; and iv) many other community events and activities.
- Consumer Outcomes
  - The MHP implemented the spring and fall Performance Outcome and Quality Assurance (POQI) consumer satisfaction surveys in 2015. The MHP distributed the results system wide, but did not analyze them.

- Three peers/consumers participated in the White Bison Training for Wellbriety (sober and well).

PERFORMANCE MEASUREMENT

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

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

TOTAL BENEFICIARIES SERVED

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

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

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	83	14
Hispanic	17	n <= 11
African-American	n <= 11	n <= 11
Asian/Pacific Islander	n <= 11	n <= 11
Native American	122	14
Other	20	n <= 11
Total	248	30

**The total is not a direct sum of the averages above it. The averages are calculated separately. The actual counts are suppressed for cells containing n <= 11.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

Alpine MHP has penetration rate data published and provided to CalEQRO in two different documents as detailed below.

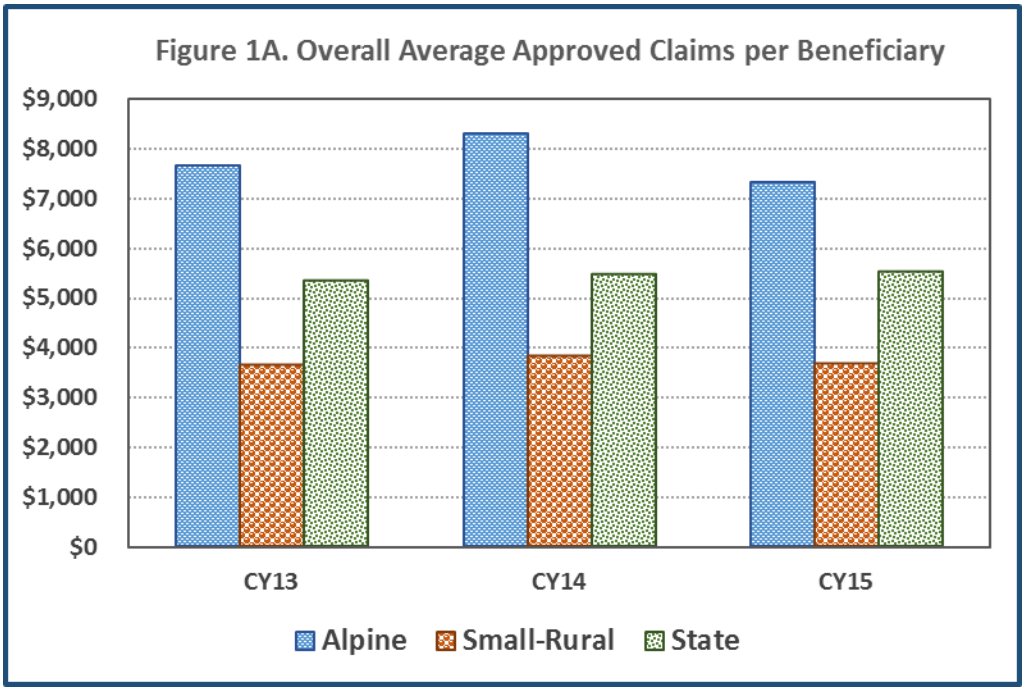
Regarding calculation of penetration rates, the Alpine MHP:

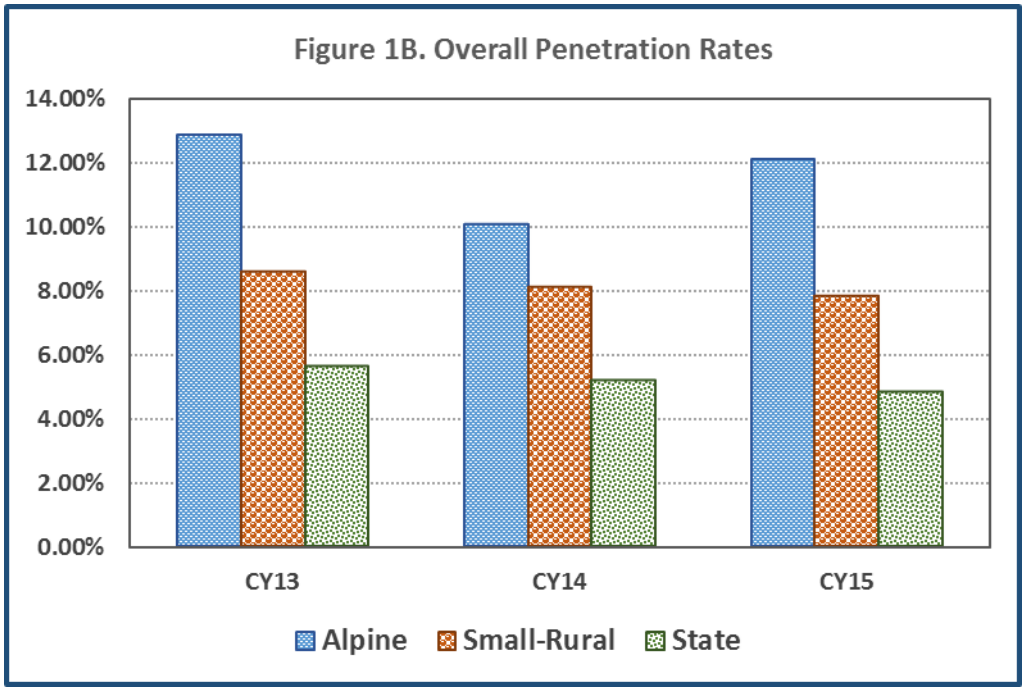
☒ Uses the same method as used by the EQRO. Penetration Rate data is included in the annual and monthly-updated Kings View Alpine County Penetration Reports for FY14/15 and FY15/16, which use roughly the same method as CalEQRO.

☒ Uses a different method: The FY 2015-16 CLCP update includes as the numerator all unique consumers who received either Medi-Cal or MHSA-only funded services, and divide this sum by the denominator of the Alpine County total population per the 2010 U.S. Census by age, race/ethnicity, language distribution, and gender.

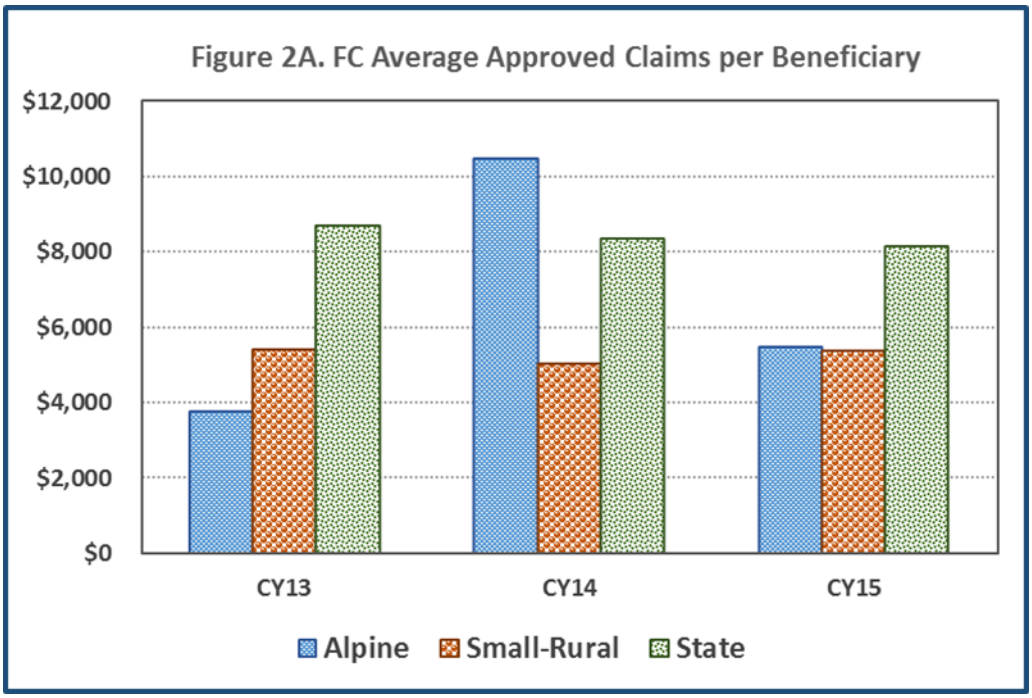
☐ Does not calculate its penetration rate.

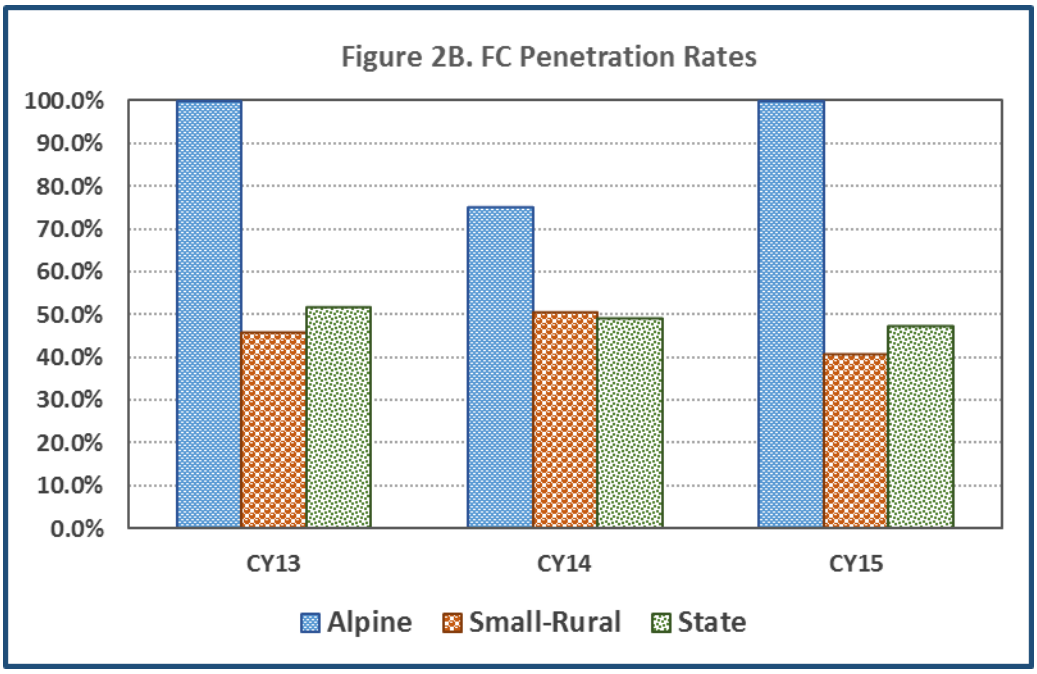
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small Rural MHPs.



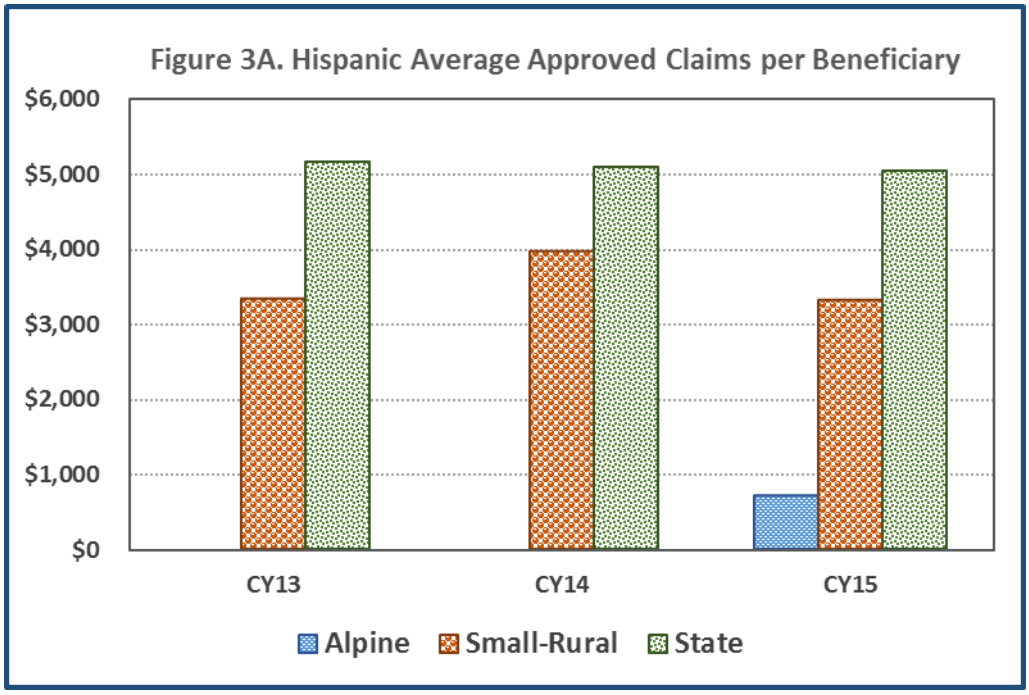


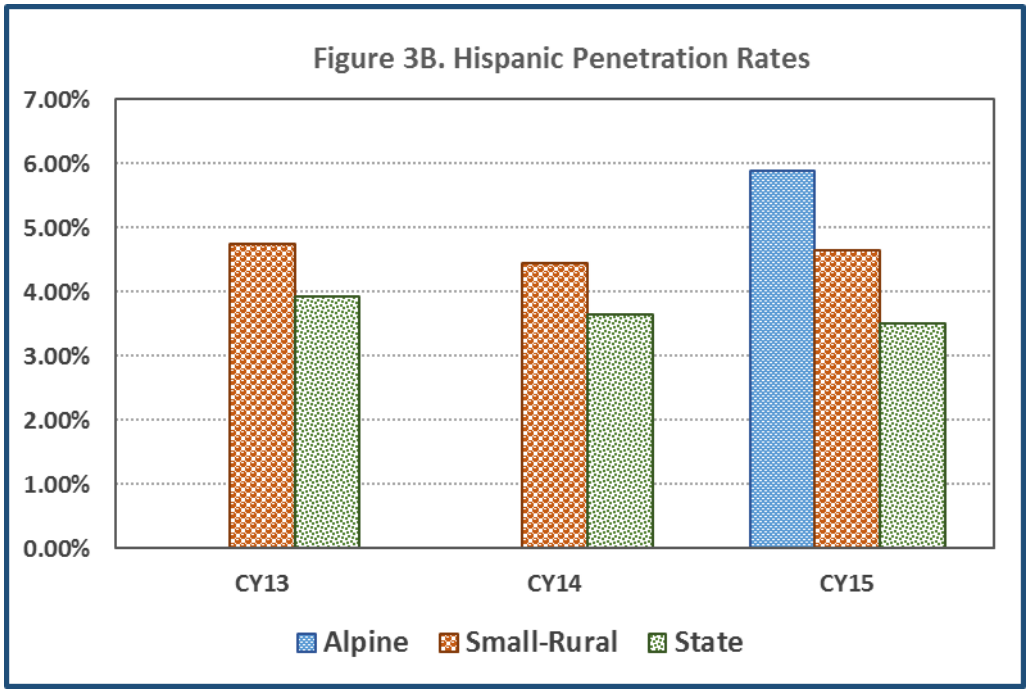
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small Rural MHPs.





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 Small Rural MHPs.





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

HIGH-COST BENEFICIARIES

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

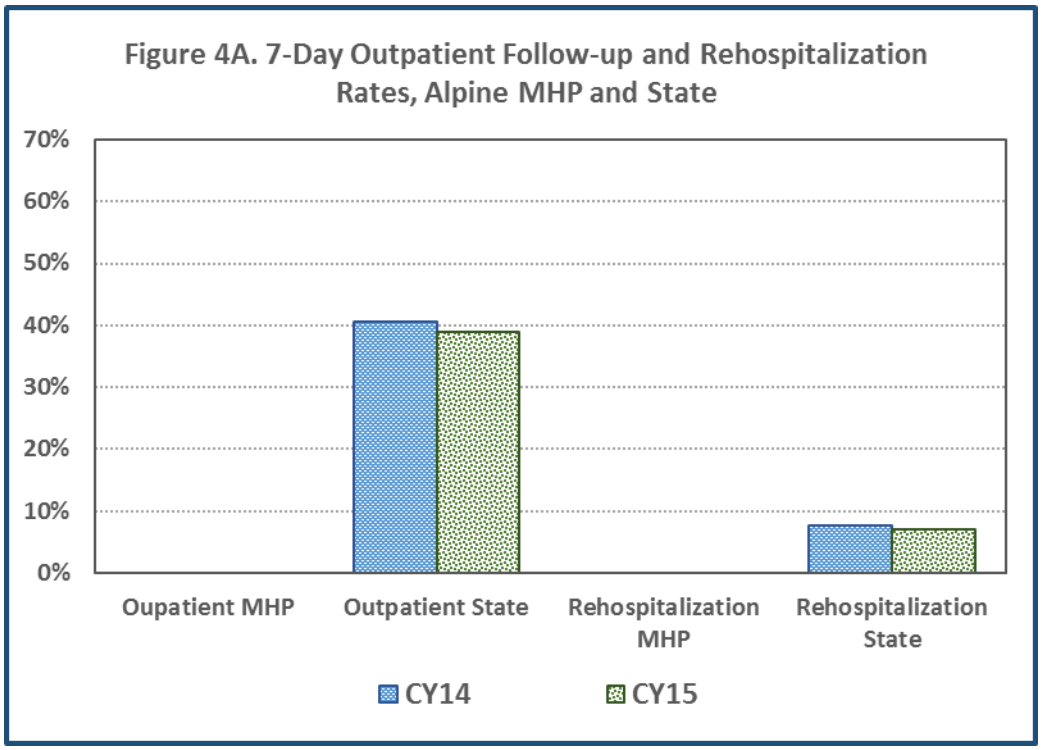
Table 2—High-Cost Beneficiaries

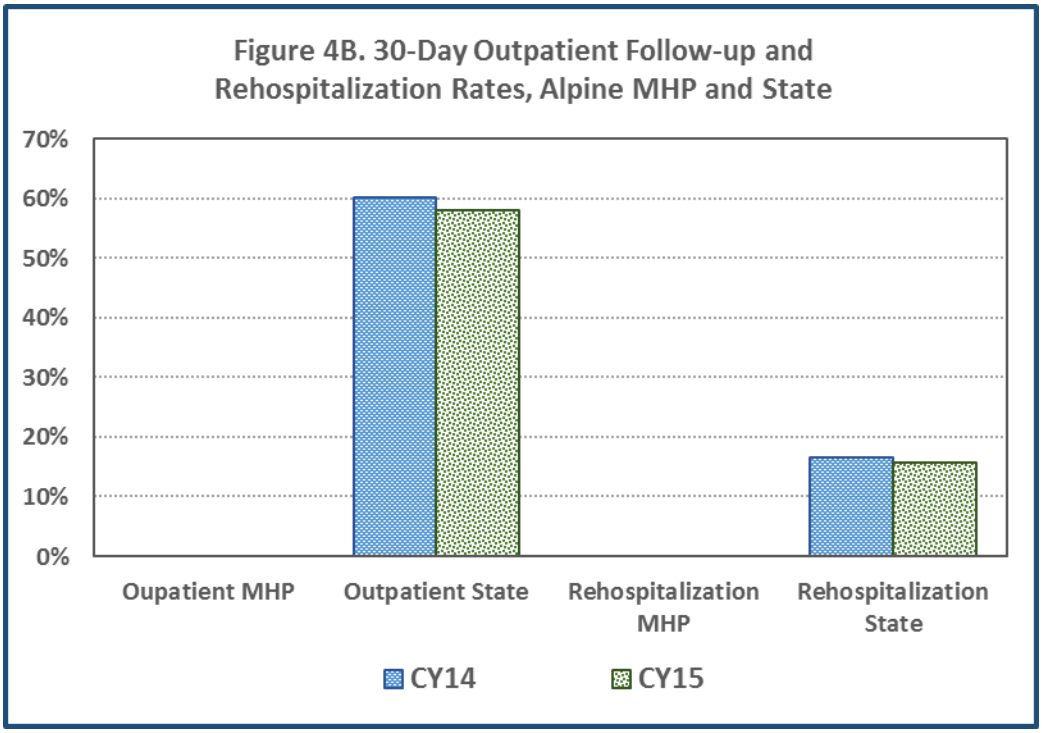
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
Alpine	CY15	0	30	0.00%	$0	$0	0.00%
	CY14	0	26	0.00%	$0	$0	0.00%
	CY13	0	27	0.00%	$0	$0	0.00%

Please see Attachment C, Table C2 for the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under $20,000; $20,000 to $30,000, and those above $30,000.

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY14 and CY15.

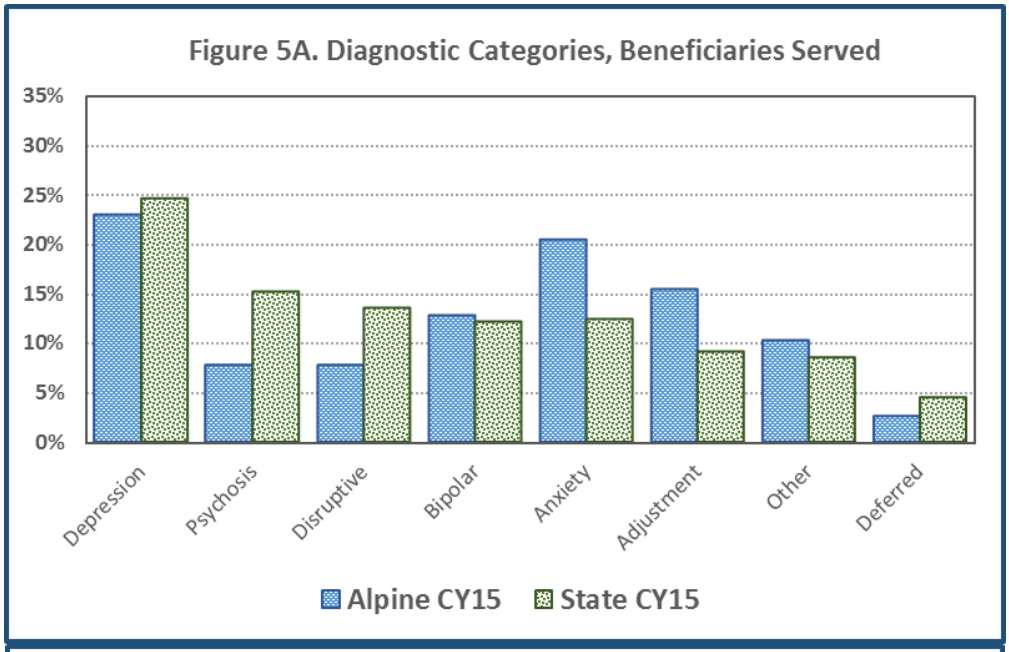


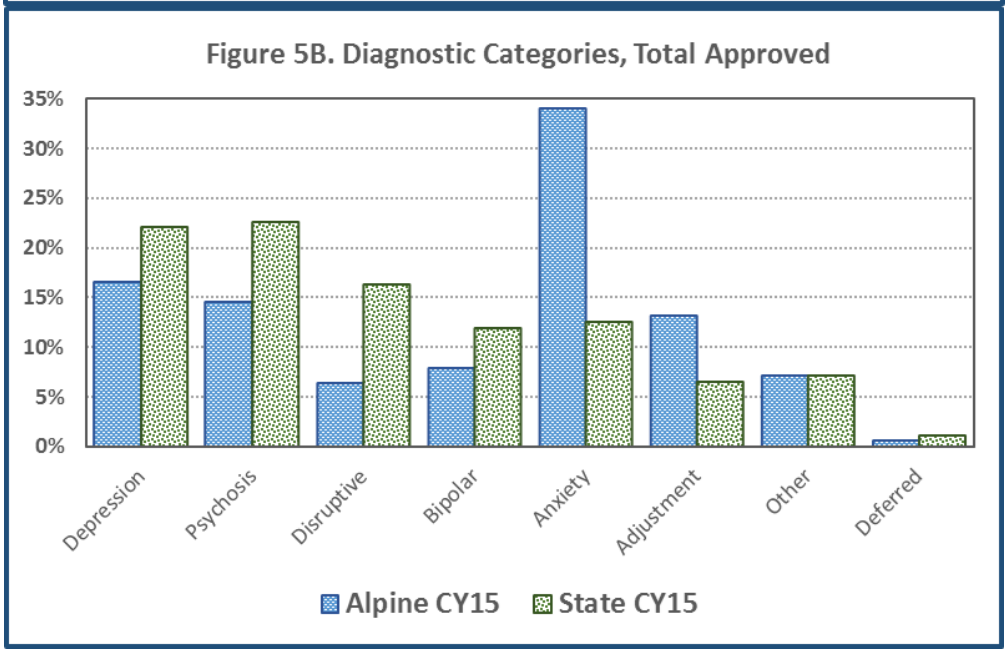


DIAGNOSTIC CATEGORIES

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

- MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: **35.3%**
  - 35.3% of FY15-16 consumers have co-occurring mental health and AoD disorders, which equals national prevalence estimates. The MHP calculates this rate by matching consumers receiving both MHP and Substance Abuse Prevention and Treatment (SAPT) services.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - As in CY13 and CY14, the MHP's CY15 overall and foster care penetration rates continue to be significantly greater than small-rural MHP and statewide averages.
  - The MHP served Hispanic enrollees exceeding both the Small-Rural and statewide penetration rates for CY15.
- Timeliness of Services
  - The MHP had no recorded inpatient rehospitalizations/recidivism during CY15.
- Quality of Care
  - The MHP had no high cost beneficiaries with approved claims over $30K in CY15.
  - The MHP's CY15 average approved claims per beneficiary: i) significantly exceeded the Small-Rural MHP and statewide averages for Overall; ii) were approximately equal to the Small-Rural but well below the statewide averages for Foster Care; and iii) were significantly below both Small-Rural and statewide averages for Hispanics.
  - The MHP has notably higher rates of anxiety and adjustment disorders and lower rates of depressive, psychotic, disruptive and bipolar disorders compared to statewide averages. The MHP has a comparable rate compared to statewide of individuals with a deferred diagnosis.
- Consumer Outcomes
  - None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

ALPINE MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed and validated one MHP submitted PIP as shown below.

Table 3A—PIPs Submitted

PIPs for Validation	# of PIPS	PIP Titles
Clinical PIP	0	None submitted
Non-Clinical PIP	1	24/7 Crisis and Access Line

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

Table 3B—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	NR	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	PM
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	PM
		1.4	All enrolled populations	NR	PM
2	Study Question	2.1	Clearly stated	NR	PM

[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 3B—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	NR	PM
		3.2	Inclusion of the entire study population	NR	NM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	PM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NA
		5.2	Valid sampling techniques that protected against bias were employed	NR	NA
		5.3	Sample contained sufficient number of enrollees	NR	NA
6	Data Collection Procedures	6.1	Clear specification of data	NR	PM
		6.2	Clear specification of sources of data	NR	PM
		6.3	Systematic collection of reliable and valid data for the study population	NR	PM
		6.4	Plan for consistent and accurate data collection	NR	PM
		6.5	Prospective data analysis plan including contingencies	NR	NM
		6.6	Qualified data collection personnel	NR	PM
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	NM
		8.2	PIP results and findings presented clearly and accurately	NR	NM
		8.3	Threats to comparability, internal and external validity	NR	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	NM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	NM
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	NM

Table 3B—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		9.3	Improvement in performance linked to the PIP	NR	NM
		9.4	Statistical evidence of true improvement	NR	NM
		9.5	Sustained improvement demonstrated through repeated measures.	NR	NM

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

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

Table 3C—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	NR	0
Number Partially Met	NR	14
Number Not Met	NR	11
Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling)	NR	25
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	NR	28.00%

CLINICAL PIP—NONE SUBMITTED

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

- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

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

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

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

☒ No PIP submitted *(Not Rated)*

The technical assistance provided to the MHP by CalEQRO consisted of onsite discussion regarding potential Clinical PIP topics such as assessing their continuum of care and evidence based practices, and the use of outcomes tools for clinical evaluation and aggregate level program guidance. During the PIP session, the PIP Development Outline was reviewed, and the MHP was encouraged to utilize the PIP Validation Tool as a guide for section development.

NON-CLINICAL PIP—24/7 CRISIS AND ACCESS LINE

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

- "Will training staff from Alpine County Behavioral Health Services (ACBHS) and Crisis Support Services of Alameda County and providing feedback on the results of the Crisis Line Test Calls led to an improved crisis line response by persons answering the Crisis Line during the day and after hours?"
- Date PIP began: January 2015
- Status of PIP:

  ☐ Active and ongoing

  ☒ Completed

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

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

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

  ☐ No PIP submitted *(Not Rated)*

The MHP is attempting to improve the responsiveness and accuracy of the 24/7 crisis line by both the MHP and their contracted partner, Crisis Support Services of Alameda County (after hours and on weekends / holidays). Specifically, they are using test calls to assess whether calls are successful, answered by staff, evaluated for emergency, linked to interpreter, and logged. The PIP focuses on improving staff capacity through training. The PIP does not include actual calls by consumers, and does not focus on any actual consumer outcomes. While the MHP has made some small gains, it appears that additional interventions are needed to achieve and sustain real and substantial improvements.

There do not seem to be any substantive changes in the PIP Development Outline from last year's submission to this year's submission, despite specific Technical Assistance provided by the EQRO onsite last year and via email after last year's review.

During discussion at this year's review, the MHP reported that they were not interested in continuing this PIP, and considered it complete. 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 onsite discussion regarding potential Non-Clinical PIP topics such as timeliness of services. During the PIP session, the PIP Development Outline was reviewed, and the MHP was encouraged to utilize the PIP Validation Tool as a guide for section development.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The MHP is attempting to improve the responsiveness of the 24/7 crisis line by both the MHP and their contracted partner, Crisis Support Services of Alameda County (after hours and on weekends/holidays).
    - No data was presented on the number of access and crisis calls the MHP and Crisis Support Services of Alameda County actually receive on a daily/weekly/monthly/annual basis, and the needs of /responses to those calls.
- Quality of Care
    - The MHP is attempting to improve the accuracy of the 24/7 crisis line by both the MHP and the Crisis Support Services of Alameda County (after hours and on weekends/holidays).
    - Staff training was conducted, and a protocol and script was introduced to standardize call response accuracy.
    - The PIP uses only test calls, and not actual client calls to assess the effectiveness of data logs.
    - No Clinical PIP was submitted.
- Consumer Outcomes
    - No consumers were included on the PIP team or during development.
    - The PIP did not focus on any consumer outcomes.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 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 MHP has an active Cultural Competency Committee (CCC) with a standing agenda and regular meeting minutes. A Cultural and Linguistic Competence Plan exists and is updated annually. The MHP monitors its penetration rates on a regular basis. Calendar Year 2015 (CY15) CalEQRO penetration rates and average approved claims (AACs) per beneficiary significantly exceeded the Small-Rural and statewide rates/averages for: all age groups (except age 0—5), both genders, Whites, Hispanics, Native Americans, Foster Care, Other Children, Family Adults and Other Adults. The MHP has lower penetration rates, but since CY13, very high AACs, for the Disabled. With an expansive list of engagement and outreach activities for which transportation is provided, the MHP is excelling in their efforts to dramatically increase community participation in wellness and recovery activities throughout the county. This is particularly effective with building a strong and trusting relationship with the Washoe Tribal members who make up nearly 30% of the population. The TAY population remains the most difficult to serve due to the small size of the community and the lack of privacy, along with cultural challenges for Tribal youth. The CY15 PR for Females (15.91%) is almost double that for Males (7.69%). The MHP cites this gender disparity in their FY 2014 – 2017 MHSA 3-Year Plan. Though still a small population – Hispanic enrollment increased with federal Medicaid Expansion in CY15.
1B	Manages and	FC	The MHP has expanded its workforce by hiring five new staff

Table 4—Access to Care			
	Component	Compliant (FC/PC/NC)*	Comments
	adapts its capacity to meet beneficiary service needs		members including a Clinical Coordinator, a clinician, an MHSA Coordinator, an MHSA Program Specialist, and an Administrative Assistant. The MHP has one vacancy for the Addition Counselor position. Their MHSA Native Wellness Advocate/Ethnic Services Manager resigned last week. The MHP also has no Male or Hispanic/ Spanish-speaking clinicians or staff. The MHP maintains tele psychiatry services for consumers as no MDs live or work in this remote county. There is no public transportation in the County. The MHP has purchased several new vehicles, and now has a full time driver who transports consumers to/from appointments and activities. The MHP has robust penetration rates/utilization rates and AACs for Case Management, Mental Health Services, Medication Support and Crisis Intervention. Tele psychiatry is available in the Markleeville Clinic (serving Markleeville, Hung-A-Lel-Ti, Woodfords and Sierra Vista). Therapists accompany consumers to tele psychiatry appointments. Clinical services are not provided in Kirkwood and sporadically in Bear Valley, which are the MHP's two smaller population centers at about 150 residents each. The MHP's CLCP indicates that 8% of MHP consumers in FY15-16 were from Bear Valley and 6% from Kirkwood.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP contracts with the Tahoe Youth and Family Services. The MHP has a contract with Crisis Support Services of Alameda County to answer their 24/7 Access and Crisis Line after hours and on weekends/holidays. For crisis response and 5150s, the MHP collaborates with the County Sheriff's Department and Barton Memorial Hospital in El Dorado County. The MHP has a Memorandum of Understanding (MOU) with the Washoe Tribe to provide mental health services. The MHP collaborates with County Public Health (PH) on a medication monitoring client trial. PH does not have an EHR. Alpine County has no Federally Qualified Health Centers (FQHCs), Indian Health Clinics (IHCs), Rural Health Centers (RHCs) or other primary care clinics. Contracting discussions are ongoing with California Health and Wellness, which is one of the two Medi-Cal MCPs responsible for Alpine County. No discussions are occurring with the other Medi-Cal MCP, Anthem/Blue Cross. The MHP does not have a Drug Medi-Cal (DMC) program, but provides AoD services through their federal SAPT Block Grant.

**FC =Fully Compliant; PC = Partially Compliant; NC = Non-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	FC	The MHP's standard is 14 days which they met 100% of the time. Average wait time was 4.2 days for adults and children. This was a significant improvement from 12 days in last year's TSA. The MHP maintains no wait list for initial access. The MHP calculates this measure from their Access Log using the date of: i) initial phone or "walk-in" contact; and ii) first scheduled clinical appointment.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP's standard is 60 days which they met 100% of the time. Average wait time was 17 days for all consumers, adults and children. This was a significant improvement from last year's 60 days, though a different methodology was used then. The MHP calculates this measure from their Access and Referral Form and Access Log: i) now using the date of the clinician's first referral for tele psychiatry as the initial request for psychiatric services; and ii) date of first tele psychiatry appointment in the Access Log.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The MHP's standard is one day which they met 100% of the time for all consumers, adults and children. The MHP calculates this from their Access Log by: i) denoting phone calls or "walk-ins" in the initial contact field which are urgent in "red"; and ii) comparing this to the date of first appointment. The MHP has a contract with Crisis Support Services of Alameda County to answer their 24/7 Access and Crisis Line after hours and on weekends/holidays. There is no hospital, emergency room (ER) or Crisis Stabilization Unit (CSU) in Alpine County. Clients are taken by the Sheriff on a 5150 to the Emergency Room at Barton Memorial Hospital in El Dorado County.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP's standard is seven days. The MHP met this 100% of the time with an average wait time of five days, reflecting improvement from last year's six days. The MHP uses their Inpatient Log for hospital discharge date and the Access Log or EHR for first post-discharge appointment date.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2E	Tracks and trends data on re-hospitalizations	FC	The MHP's standard is 0% re-hospitalizations, and their data shows n <= 11. CalEQRO data showed no Medi-Cal psychiatric inpatient re-hospitalizations for CYs 12 through 15.
2F	Tracks and trends no shows	FC	The MHP's standard for "No-shows" is 10% for Clinicians/Non-Psychiatrists and 2% for Psychiatrists. The MHP met these standards 100% of the time. Average "No-shows" were 3.1% for Clinicians/Non-Psychiatrists and 0.07% for Psychiatrists. This reflects a significant improvement for both groups over last year. The MHP has an attendance policy that consumers must sign, and they are working towards implementing it more systematically. No-show tracking includes all clients in the EHR. However, the MHP does not track no-shows for consumers who: i) miss their first scheduled appointment; or ii) receive an initial call from the clinician but do not schedule an appointment.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-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, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP has an active Quality Improvement Committee (QIC) with a standing agenda and regular meeting minutes. A QIWP exists and is evaluated annually. The MHP hired a full time Quality Improvement (QI) Coordinator who is learning the role for QA, QI, QM and working towards institutionalizing a CQI approach throughout the system of care. Alpine's County Administrative Office hired an IT staff person. It is unclear what percentage of time this staff person will

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			devote to the MHP, if any. The MHP has worked with Kings View to implement six outcome reporting tools in the EHR, which clinicians are beginning to use.
3B	Data are used to inform management and guide decisions	PC	The MHP is encouraged to increase their use of data (and dashboard reports) within the QIC and the Cultural Competence Committee (CCC) as a standing agenda item to guide clinical care and wellness and recovery activities, and to monitor their effectiveness. The MHP's CLCP includes: i) data and analysis of penetration rates of Medi-Cal and MHSA services for county residents by gender, age and race/ethnicity; ii) disparities in service provision; and iii) mental health and SUD hours by service type. The MHP has a complete "Alpine County Penetration Report" and is receiving monthly updates to it from Kings View for FY15/16 (data through February 2016). These reports include Medi-Cal penetration rates and Holzer Prevalence Rates by age, race/ethnicity, gender, and language, as well as Medi-Cal monthly eligibles and MHP caseload distribution by these factors. It is unclear to what degree the MHP is using/analyzing these reports.
3C	Evidence of effective communication from MHP administration	FC	Weekly staff meetings for all clinical staff. Multidisciplinary Team Meetings monthly. Victim Response Team meetings quarterly. Provider List dated July 2016 which lists all individual providers and facilities utilized. Printed monthly calendar for July 2016 including all Wellness Programs and groups, distributed at clinics and door-to-door for consumers. On the back is listed the 24-hour Crisis Line number, as well as the Suicide Prevention Network number. Comprehensive website regularly updated.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	QIC and CCC meetings are open to both staff and stakeholders, however participation fluctuates. Representatives include Alpine Kids, Tahoe Youth and Family Services, Bear Valley Parents Group, the Alpine School District, a local domestic violence group, the Washoe Tribal Council, AoD and Health and Human Services. There are no recognized faith-based organizations, residential facilities or jails in the county.
3E	Evidence of strong collaborative partnerships with other agencies and community based	FC	The MHP contracts with the Tahoe Youth and Family Services. The MHP works closely with the only Primary School in Alpine County. For crisis response and 5150s, the MHP collaborates with the

Table 6—Quality of Care			
	Component	Compliant (FC/PC/NC)*	Comments
	services		County Sheriff's Department and Barton Memorial Hospital in El Dorado County. The MHP works closely with the Washoe Tribe for community engagement and outreach, as well as recovery and wellness activities. The MHP has many community-based programs including: i) four Wellness Projects; ii) mentoring program; iii) Senior Socialization and Exercise; iv) "Create the Good" weekly luncheons and presentations; v) Combining Past and Present; and vi) summer programs for children in Bear Valley. The MHP collaborates with County Public Health on a medication monitoring client trial. To date there is no integration between MH and primary care, although discussions have begun. The MHP works closely with Barton Memorial Hospital in El Dorado County for crisis response. The MHP collaborates with Probation Services and the Court on AoD and MH cases.
3F	Evidence of a systematic clinical Continuum of Care	PC	The MHP has begun to evaluate lengths of stay appropriateness in relation to the use of clinical EEBPs and consumer outcomes. The MHP and Kings View have a Practice Guidelines for Physicians/Mid-Level & Medication Monitoring Plan and Procedure for tele psychiatry, revised 2016. Medication monitoring process review is a standing item in the QIC agenda and minutes. The MHP provides different levels of care tailored to individual needs through their: i) FFCCS; ii) FSP for all ages; and iii) school-based mental health services programs. Outcome Measures are being rolled out for new and re-assessments for all clients throughout the system of care. The MHP does not have any medical staff and there are no pharmacy or primary care clinics in the county. Therapists accompany consumers to tele psychiatry, and MHP consumers must go out-of-county or out-of-state (Nevada) to receive/be dispensed psychotropic medications. The MHP has begun tracking data by diagnostic categories and some social determinants to improve clinical service delivery.
3G	Evidence of individualized, client-driven treatment and recovery	PC	The MHP has adopted a Wellness and Recovery model of care, and uses consumer and family education for engagement. While the MHP includes consumers their own treatment planning and care, they do not yet measure and monitor consumer engagement.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	The MHP does not have designated CFM employment positions or a defined career ladder. However, the org chart has four positions with a preference to fill with CFMs and the ACBHS Director has worked with HR to update job descriptions. This includes vacancies for the MHSA Specialist, and the Native Wellness Advocate position which was filled by a CFM who resigned unexpectedly two weeks prior to the EQR.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	PC	The Wellness Center is fully operated and driven by the MHP with no peer staff either hired or participating in leading programs directly. The Wellness Center does not have a regular open schedule for drop-ins, but is opened and used for scheduled events and activities. The MHP does support many outreach and engagement activities run by consumer volunteers, and they are attempting to recruit consumers who would like to become peers. However, cultural stigma around mental health issues is a significant influence in the Washoe community, making many community members reluctant to become involved as peers. The MHP sponsored three peers/consumers to participate in the White Bison Training for Wellbriety (sober and well).
3J	Measures clinical and/or functional outcomes of consumers served	PC	Outcomes tools were added to the EHR December 2015. The MHP has instituted ANSA and CANS for all clients at reassessments and/or new assessments. The MHP is developing a baseline and is not yet using any outcomes data to guide clinical treatment at the individual or aggregate level.
3K	Utilizes information from Consumer Satisfaction Surveys	PC	The MHP administers Consumer Satisfaction Surveys twice a year with results provided for CY15. However, there is no detailed analysis of the findings or examples of their use to improve quality of care.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The MHP has very high penetration rates and average approved claims per beneficiary for all age groups (except 0-5), both genders, Whites, Hispanics, Native Americans, children in foster care, and other Eligibility Categories.

- The MHP's CY15 Retention in Services rate exceeds the statewide average for Overall, Foster Care, and TAY, with over 80% of consumers in each group receiving 5 or more services. The MHP has high penetration rates/utilization rates for the core outpatient services of case management, mental health services, medication support, and crisis intervention.
- The MHP is excelling in their efforts to increase community participation in wellness and recovery activities throughout the county. This is particularly effective with building a strong and trusting relationship with the Washoe Tribal members who make up nearly 30% of the population.
- The TAY population remains the most difficult to serve due to the small size of the community and the lack of privacy, along with cultural challenges for tribal youth.
- The MHP has lower penetration rates, but since CY13, very high average approved claims, for the disabled.
- CY15 CalEQRO data shows a disparity in serving females (15.93% penetration rate) compared to males (7.69% penetration rate) and the MHP's current 3-Year MHSA Plan describes this disparity.

- Timeliness of Services
  - While the MHP's timeliness is very good and methodology for calculating timeliness measures valid, their current 60-day standard for time to first psychiatric appointment should be reduced to a 30-day standard to make it more meaningful.
  - The MHP only tracks no-shows for consumers who present for their first clinical appointment but do not return for their next scheduled appointment. The MHP does not track no-shows for consumers who: i) missed their first scheduled appointment; or ii) receive an initial call from the clinician but do not schedule an appointment.
- Quality of Care
  - The MHP hired a full time QI Coordinator who is learning the role for QA, QI, QM and working towards institutionalizing a CQI approach throughout the system of care.
  - The MHP has begun to evaluate lengths of stay appropriateness in relation to the use of clinical EBPs and consumer outcomes.
  - The MHP has begun tracking data by diagnostic categories and some social determinants to improve clinical service delivery.
  - The MHP is encouraged to increase their use of data and dashboard reports within the QIC and the CCC as a standing agenda item to guide clinical care and wellness and recovery activities, and to monitor their effectiveness.

- The MHP is collaborating with existing community services and stakeholders in both Alpine and surrounding Counties to leverage resources due to the small population size and limited local availability.
- The MHP recently lost their only male and Native American staff persons and does not have any Hispanic/Spanish-speaking staff.
- Alpine's CAO hired a full-time IT staff person. It is unclear how many hours this staff person will devote to the MHP, if any.
- Kings View has begun completing annual and monthly "Alpine County Penetration Reports", which include penetration and prevalence rates by age, race/ethnicity, gender and language as well as monthly eligible and caseload distribution by these factors.

- Consumer Outcomes
  - Outcomes tools were added to the EHR December 2015. The MHP has instituted ANSA and CANS for all clients at reassessments and/or new assessments. The MHP is developing baselines and is not yet using any outcomes data to guide clinical treatment at the individual or aggregate level.
  - The MHP does not have designated consumer/family member employment positions and a defined career ladder.
  - The MHP does support many outreach and engagement activities run by consumer volunteers, and they are attempting to recruit consumers who would like to become peers.
  - The MHP administers Consumer Satisfaction Surveys twice a year. Results were provided for CY15, but no detailed analysis of the findings or examples of their use to improve quality of care were presented.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

The Consumer/Family Member Focus Group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions are specific to the MHP being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

The EQRO requested one culturally diverse group of 8-10 adult beneficiaries and parents/caregivers of child/youth beneficiaries who are mostly new clients that have initiated / utilized services within the past 12 months.

Alpine County Behavioral Health Services invited six Consumer/Family Members (CFMs) to participate in the CFM Focus Group. However, only one Consumer/Family Member attended the session. For this reason no further description of the group is provided here in order to preserve anonymity and confidentiality. The focus group was held in the MHP Conference Room.

Number of participants – One

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Because there was only one participant, no findings are presented.

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

Table 7—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	75%
Contract providers	0%
Network providers	25%
Total	100%

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

  1%

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

  ☐ Yes ☐ In Test/Pilot Phase ☒ No

- MHP currently provides services to consumers using an tele-psychiatry application:

  ☒ Yes ☐ In Test/Pilot Phase ☐ No

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

    1

- Languages supported (e.g. English, Spanish): Not stated.

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

Table 8 – Summary of Technology Staff Changes			
Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
0	0	0	0

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

Table 9 – Summary of Data Analytical Staff Changes			
Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
0	0	0	0

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

- Kings View continues to provide support for both technology operations and data analytical support.
- The CAO has hired 1.0 FTE IT staff person. It is unclear what percentage of time this staff person will devote to the MHP.
- The MHP's Clinical Coordinator is their Subject Matter Expert/"super-user" of the EHR. It is unclear what percentage of time/number of hours this or other MHP staff devote to working with Kings View to update the EHR and develop and analyze data reports.
- The MHP is hosting an on-site Cerner training for all staff in August, 2016.

CURRENT OPERATIONS

- The MHP continues to implement Cerner Community Behavioral Health System (CCBH) by Cerner Corporation in an ASP model with Kings View. The MHP is regularly submitting claims in ICD-10 format.
- The MHP now receives annual and monthly-updated Penetration and Prevalence rate reports from Kings View.
- As of July 27, 2016, the date of the CalEQRO review, the MHP had submitted their regular June 2016 monthly claim and Supplemental May 2016 Claim to DHCS.

Table 10 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 10— Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
CCBH - Client Data	Practice Management	Cerner	3	Kings View
CCBH - ATP and Clinicians HomePage	Assessments, Progress Notes, Treatment Plans	Cerner	3	Kings View
CBH - Doctor's Homepage	ePrescribing	Cerner	3	Kings View

PLANS FOR INFORMATION SYSTEMS CHANGE

- Continue expanding the list of available assessments (clinical forms) that can be used within the EHR.
- Re-establish and Medi-Cal certify the Bear Valley clinic site.
- Utilize electronic consumer signature pads across the MHP.
- Upgrade the system with new Progress Note functionality.
- Convert to Non-Axial Diagnosis Review.

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for EHR functionality.

Table 11—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Alerts	CCBH – Client Data			X	
Assessments	CCBH – Client Data	X			
Document imaging/storage	CCBH – Client Data	X			
Electronic signature—consumer			X		
Laboratory results (eLab)				X	
Level of Care/Level of Service	CCBH - ATP	X			
Outcomes	ANSA, CANS, PCL,		X		
Prescriptions (eRx)	CCBH – Doctor's Homepage	X			
Progress notes	CCBH - ATP	X			
Treatment plans	CCBH - ATP	X			
Summary Totals for EHR Functionality		6	2	2	0

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

- Though the EHR has consumer signature capability which can be used in the two nearby Hung-A-Lel-Ti and Markleeville clinical sites, much/most of Alpine County does not have Wi-Fi or cellphone capability. The MHP states that Washoe Tribal and other Native American consumers also distrust having information taken electronically, especially for services provided in home and community settings.

- CCBH's standard package allows for implementation of electronic alerts for users based on programmed edits and audits of information entered into EHR fields. The MHP does not currently use this functionality. Currently, the MHP's fiscal/billing staff person manually conducts review of assessment, treatment plan, progress note, MEDS/aid code, diagnosis and other data after clinicians have entered it in the EHR.

- The MHP has recently implemented the above six outcome tools which clinicians are just beginning to use.

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

  ☐ Paper ☐ Electronic ☒ Combination

MAJOR CHANGES SINCE LAST YEAR

- The MHP converted to ICD-10 and submits claims and CSI files on time.
- The MHP now receives annual and monthly-updated Penetration and Prevalence rate reports from Kings View.

PRIORITIES FOR THE COMING YEAR

- Since this winter's flood of the Bear Valley clinic, the MHP is strategizing how or if to again begin providing direct services in either Bear Valley or Kirkwood.
- As the MHP plans for expansion of the Markleeville Clinic through MHSA funds, they are considering including a crisis room – though this would not be a certified CSU.
- The MHP's MHSA WET Plan includes programs/incentives to obtain a medical staff person (e.g. a Nurse Practitioner).

OTHER SIGNIFICANT ISSUES

- There is no T1 line capability to Bear Valley or Kirkwood, making tele psychiatry unfeasible in these locations.

MEDI-CAL CLAIMS PROCESSING

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

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

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

☒ Yes ☐ No

If yes, product or application:

MS Excel

- Method used to submit Medicare Part B claims:

☐ Clearinghouse ☒ Electronic ☐ Paper

Table 12 - Alpine MHP Summary of CY15 Processed SDMC Claims							
Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
591	$203,466	$6,738	3.31%	19	$196,728	$0	$196,728
Note: Includes services provided during CY15 with the most recent DHCS processing date of May 19,2016							

The MHP has an approximate 1% denied claims rate.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP now receives regular penetration and prevalence rate reports from Kings View.
  - The MHP included data from the EHR to calculate penetration rates in their 2015 CLCP.
  - Tele psychiatry remained stable during the year. Twenty consumers received tele psychiatry in FY15-16 compared to 19 consumers during the prior review period of FY14-15.
- Timeliness of Services
  - The MHP calculates timeliness measures through the Access Log, Access and Referral Forms, and Inpatient Log which are separate from the EHR.
- Quality of Care
  - The MHP does not have internal data analyst staff. The MHP's Clinical Coordinator appears to be the MHP's major Subject Matter Expert/"super-user" of the EHR, and it is unclear how many hours/percentage of staff time the MHP is currently able to devote to working with Kings View.
  - It is unclear how many hours or FTE percentage of time the CAO's new IT staff person will devote to the MHP.
  - The MHP appears to effectively calculate co-occurring mental health and AoD diagnosis rates.
- Consumer Outcomes
  - The MHP has implemented six outcome tools in the EHR.

SITE REVIEW PROCESS BARRIERS

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

- The MHP submitted the Non-Clinical PIP three days prior to the review. No Clinical PIP was submitted.
- Only one person attended the CFM focus group.

CONCLUSIONS

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

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - With an expansive list of engagement and outreach activities for which transportation is provided, the MHP is excelling in their efforts to dramatically increase community participation in wellness and recovery activities throughout the county. This is particularly effective with building a strong and trusting relationship with the Washoe Tribal members who make up nearly 30% of the population.
  - The MHP has high penetration rates and AACs per beneficiary and retention in service rates.
  - The MHP provides many services in home, community and school settings.
  - Seven of the MHP's 12 staff are located in the Hung-a-Lel-Ti Washoe Tribal Community clinic.
  - The MHP's Non-Clinical PIP is attempting to improve the responsiveness of the 24/7 crisis line by both the MHP and the Crisis Support Services of Alameda County (after hours and on weekends/holidays).
  - Consumers and family members are able to obtain the amount and type of services needed depending upon their acuity as adequate staffing exists and transportation is provided as needed.
  - The MHP filled all (five) vacancies. The MHP more recently lost their AoD Counselor who was the MHP's only male staff member.
- Opportunities:
  - The TAY population remains the most difficult to serve due to the small size of the community and the lack of privacy, along with cultural challenges for Tribal youth.

- The Non-Clinical PIP does not include data on how many access and crisis calls the MHP and Crisis Support Services of Alameda County actually receive on a daily/weekly/monthly/annual basis, and the needs of /responses to those calls.
- While the MHP does provide clinical services to the lesbian, gay, bisexual, transgender, and queer (and/or questioning) individuals/identities (LGBTQ) community, and staff has been trained in evidence based practices, they do not currently offer LGBTQ wellness and recovery activities. The MHP states that this is due in part to Washoe cultural issues and the challenges of maintaining privacy for consumers in a very small population.
- Females are served at twice the penetration rates (15.91%) as males (7.69%).

Timeliness of Services

- Strengths:
  - The MHP provides timely services, and consumers can be seen as frequently as needed. There are no waitlists.
  - The MHP has valid methodologies for calculating all CalEQRO TSA measures except for no-shows.
  - The MHP has discussed with their ASP Kings View the feasibility of uploading their locally maintained Access Log or part of it into their EHR.
- Opportunities:
  - The current measure for no-shows may not summarize the full spectrum of engagement needs and activities for the MHP. This includes consumers who: i) miss their first scheduled appointment; or ii) receive an initial call from the clinician but do not schedule an appointment.

Quality of Care

- Strengths:
  - The MHP's Non-Clinical PIP is attempting to improve the accuracy of the 24/7 Access and Crisis Line by both the MHP and the Crisis Support Services of Alameda County (after hours and on weekends/holidays).
  - Administrative staff training was conducted, and a protocol and script was introduced to standardize call response accuracy for the 24/7 Access and Crisis Line.
  - The MHP hired a full time QI Coordinator who is learning the role for QA, QI, QM and working towards institutionalizing a CQI approach throughout the system of care.
  - The MHP has begun to evaluate lengths of stay appropriateness in relation to the use of clinical EBPs and consumer outcomes.

  - The MHP has begun tracking data by diagnostic categories and some social determinants to improve clinical service delivery.
  - The MHP is collaborating with existing community services and stakeholders in both Alpine and surrounding Counties to leverage resources due to the small population size and limited local availability.
  - The MHP provides multiple and individualized levels of care in their FCCS, FSP and school-based mental health services programs.
- Opportunities:
  - The MHP did not submit a Clinical PIP.
  - The PIP uses only test calls, but not actual client calls to assess the accuracy of its Access and Crisis call logs.
  - The MHP does not have internal data analyst staff. Alpine's CAO hired a full-time IT staff person. It is unclear what percentage of time this CAO position will work for the MHP or continue to rely on Kings View exclusively for data analytical support.
  - The MHP is considering a Clinical PIP on the use of outcomes tools and their use for measuring clinical outcomes.
  - The MHP is encouraged to increase their use of data and dashboard reports within the QIC and the CCC as a standing agenda item to guide clinical care and wellness and recovery activities, and to monitor their effectiveness.
  - To date there is no integration between MH and primary care, although discussions have begun.
  - The Bear Valley clinic site flooded and there is currently no MHP clinical staffing in Bear Valley.

Consumer Outcomes

- Strengths:
  - Consumers participate in Consumer Satisfaction Surveys.
  - The MHP has embedded several outcomes tools into the EHR, and staff training has commenced.
  - Outcomes tools were added to the EHR December 2015. The MHP has instituted ANSA and CANS for all clients at reassessments and/or new assessments.
- Opportunities:
  - No consumers were included on the PIP team or during development, and the Non-Clinical PIP did not focus on any consumer outcomes.
  - The MHP is developing outcomes tool baselines and is not yet using any outcomes data to guide clinical treatment at the individual or aggregate level.

- The MHP does not have designated consumer/family member employment positions or a defined career ladder. However, the org chart has four positions with a preference to fill with CFMs.

RECOMMENDATIONS

- Evaluate the effectiveness of maintaining 60-day baseline standard to measure timeliness from initial contact to first psychiatric appointment.
- Identify and increase staff hours/percentage of FTE staff devoted to working with Kings View to upgrade the EHR, develop and analyze reports based on EHR capabilities and provide staff training.
- Build on the recent incorporation of client functioning outcome measures into the EHR, along with clinical staff training:
  - Institute regular and consistent application of these tools for baseline and follow up measures of all consumers; and
  - Develop individual and aggregate level reports to monitor consumer outcomes and guide clinical care. *(A variation of this recommendation is repeated from FY14-15 and FY15-16)*
- Develop two active PIPs, one clinical and the other non-clinical that are data driven with consumer input. Use sufficient data to establish the prevalence of an issue impacting Alpine's consumers. Focus both PIPs on consumer outcomes, with measurable client focused indicators and interventions with repeated measures to assess implications over time. *(This recommendation is repeated from FY15-16).*
- As there are no clinical services provided in Bear Valley, investigate the level of need among local residents and determine how best to address them (e.g. reopen the Bear Valley clinic; expand tele psychiatry services).

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:

ALPINE COUNTY MHP

CALEQRO ON-SITE REVIEW AGENDA

(Unless otherwise noted, all conference rooms are located at MHP Administrative Office at Alpine County Behavioral Health, 75-C Diamond Valley Road, Markleeville, CA 96120)

WEDNESDAY, JULY 27, 2016	
Time	Activity
8:30 am – 8:45 am **BHC Reviewers:** Della Dash, Lead Reviewer Richard Hildebrand, IS Reviewer Luann Baldwin, CPM Consultant	**Opening Session** • Introductions to BHC • MHP Team Introductions MHP Participants: Alissa Nourse-Director, Gail St. James-Clinical Coordinator & Nani Ellis-BHS Coordinator **BHC Participants: All** Location: HHS Conference Room 75C Diamond Valley Road, Markleeville, CA 96120
8:45 am- 10:00 am	**Review of Past Year** • Significant Changes and Key Initiatives • Response to FY15-16 Recommendations • Disparities, Cultural Competence, QM Activities MHP Participants: Alissa Nourse-Director, Gail St. James-Clinical Coordinator & Nani Ellis-BHS Coordinator **BHC Participants: All** Location: HHS Conference Room 75C Diamond Valley Road, Markleeville, CA 96120
10:00 am – 10:15 am	**Break**
10:15 am – 11:45 am	**Outcomes and Timeliness** • QM Activities (cont'd.) • Timeliness Self-Assessment • MHP Outcomes, Level of Care and or Functional Assessments MHP Participants: Alissa Nourse-Director, Gail St. James-Clinical Coordinator & Nani Ellis-BHS Coordinator **BHC Participants: DD** Location: HHS Conference Room 75C Diamond Valley Road, Markleeville, CA 96120
11:45am – 12:30 pm	CalEQRO Working Lunch Meeting

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ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Della Dash, Chief Quality Reviewer, Lead Reviewer
Richard Hildebrand, Information Systems Reviewer
Luann Baldwin, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP SITES

Alpine County Behavioral Health
HHS Conference Room
75-C Diamond Valley Road
Markleeville, CA 96120

Alpine County Behavioral Health
Wellness Center
Firehouse 96 Washoe Blvd
Markleeville, CA 96120

Participants Representing the MHP

Name	Position	Agency
Alissa Nourse	Director	ACBHS
Amy Broadhurst	MHSA Program Specialist	ACBHS
Cathy Angi, LMFT	Clinician	ACBHS
Crystal Pitts, LMFT	Clinician	ACBHS
Deb Goerlich	Admin. Assistant III	ACBHS
Gail St. James	Clinical Coordinator	ACBHS
Janet Stevens, ASW	Clinician	ACBHS
Nani Ellis	Behavioral Health Services Coordinator	ACBHS

Name	Position	Agency
Nichole Williamson	Director	Alpine County Health and Human Services
Sandra Turner	Director of Software Services	Kings View Information Technology

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands.

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

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

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statwide	2,001,900	131,350	6.56%	$533,318,886	$4,060
Small-Rural	17,753	1,992	11.22%	$5,569,311	$2,796
Alpine	108	n <= 11	n <= 11	$42,982	n <= 11

The actual counts are suppressed for cells containing n <= 11.

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

Table C2 - Alpine MHP CY15 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
$0K - $20K	29	96.67%	94.46%	$198,909	$6,859	$3,553	90.42%	61.20%
>$20K - $30K	n <= 11	n <= 11	2.67%	n <= 11	n <= 11	$24,306	n <= 11	11.85%
>$30K	n <= 11	n <= 11	2.86%	n <= 11	n <= 11	$51,635	n <= 11	26.96%

The actual counts are suppressed for cells containing n <= 11.

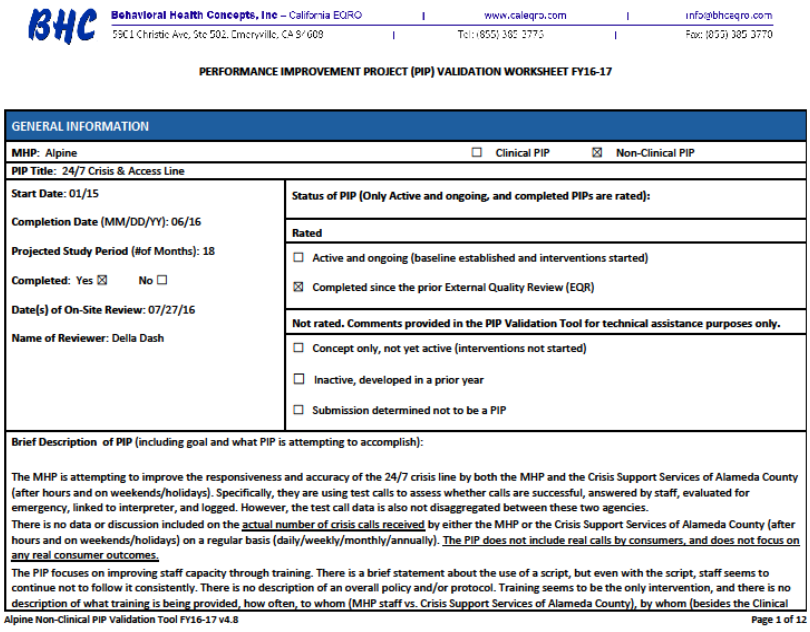
ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:

None submitted.

Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION	
MHP: Alpine	☐ Clinical PIP ☒ Non-Clinical PIP
PIP Title: 24/7 Crisis & Access Line	
Start Date: 01/15 **Completion Date** (MM/DD/YY): 06/16 **Projected Study Period** (#of Months): 18 **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review**: 07/27/16 **Name of Reviewer**: Della Dash	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP

Brief Description of PIP (including goal and what PIP is attempting to accomplish):

The MHP is attempting to improve the responsiveness and accuracy of the 24/7 crisis line by both the MHP and the Crisis Support Services of Alameda County (after hours and on weekends/holidays). Specifically, they are using test calls to assess whether calls are successful, answered by staff, evaluated for emergency, linked to interpreter, and logged. However, the test call data is also not disaggregated between these two agencies.
There is no data or discussion included on the actual number of crisis calls received by either the MHP or the Crisis Support Services of Alameda County (after hours and on weekends/holidays) on a regular basis (daily/weekly/monthly/annually). The PIP does not include real calls by consumers, and does not focus on any real consumer outcomes.
The PIP focuses on improving staff capacity through training. There is a brief statement about the use of a script, but even with the script, staff seems to continue not to follow it consistently. There is no description of an overall policy and/or protocol. Training seems to be the only intervention, and there is no description of what training is being provided, how often, to whom (MHP staff vs. Crisis Support Services of Alameda County), by whom (besides the Clinical

Alpine Non-Clinical PIP Validation Tool FY16-17 v4.8 Page 1 of 12