Attachment 2.2.3

Communication

Project Charter – Communication Plan Format

Phase/ Item	Goal	Message	Vehicle/ Receiver	Developer	Approver	Deliverer	Timing: Development	Timing: Approval	Timing: Delivery	Feedback Method	Owner
Start-Prototype											
Wellness Matters newsletter	Update	Project Status	Internet / All stakeholders	LS	LR	ECC	M	M	M	Meetings, Email, verbal, phone	LS
Presentations	Update	Project Status	Verbal/ Boards	LR	LR	BHRS	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal/ All Staff, Contractors	ECC	LR	ECC	M	M	M	Verbal	LR
Reports	Update	Project Status	Written/ Boards, all	ECC	LR	TBD	M	M	M	Written	LR
Reports	Update	Open Issues	Written/ Team, others	RM	LS	RM	M	M	M	Written	RM
Reports	Update	Contact List	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Reports	Update	Vacation Schedules	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Prototype Phase I											
Email	Update	Project Status	Email/ list	Trainer	LR	ECC	M	M	M	Email, meetings	LS
Wellness Matters newsletter	Update	Project Status	Internet / All stakeholders	LS	LR	ECC	M	M	M	Meetings, Email, verbal, phone	LS
Presentations	Update	Project Status	Verbal/ Boards	LR	LR	BHRS	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal/ All Staff, Contractors	ECC	LR	ECC	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal / Consumers, Family Members, Community	ECC	LR	Clinical Implementer	Quarterly	Quarterly	Quarterly	Verbal, Email, phone	LR
Reports	Update	Project Status	Written/	ECC	LR	TBD	M	M	M	Written	LR

Project Charter – Communication Plan Format

Phase/ Item	Goal	Message	Vehicle/ Receiver	Developer	Approver	Deliverer	Timing: Development	Timing: Approval	Timing: Delivery	Feedback Method	Owner
			Boards, all								
Reports	Update	Open Issues	Written/ Team, others	RM	LS	RM	M	M	M	Written	RM
Reports	Update	Contact List	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Reports	Update	Vacation Schedules	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Phase I- Phase III											
Email	Update	Project Status	Email/ list	Trainer	LR	ECC	M	M	M	Email, meetings	LS
Fliers	Update	Go-Live Events	Post/ locations	ECC	LR	ECC	Episodic	Episodic	Episodic	Email, Meetings	LR
Intranet	Update	Project Status	Intranet/ All	ECC	BHRS	ECC	M	M	M	Meetings	LS
Wellness Matters newsletter	Update	Project Status	Internet / All stakeholders	LS	LR	ECC	M	M	M	Meetings, Email, verbal, phone	LS
Presentations	Update	Project Status	Verbal/ Boards	LR	LR	BHRS	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal/ All Staff, Contractors	ECC	LR	ECC	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal / Consumers, Family Members, Community	ECC	LR	Clinical Implementer	Q	Q	Q	Verbal, Email, phone	LR
User Surveys	Update	Project Status	Written/ PM, CL	ECC	ECC	ECC	Q	Q	Q	Written	LS/ PM?
Focused Neilen User Survey	Update	Project Status	Interview/ PM, CL	ECC	ECC	ECC	Q	Q	Q	Verbal/ written	LS
Reports	Update	Project Status	Written/ Boards, all	ECC	LR	TBD	M	M	M	Written	LR
Reports	Update	Open Issues	Written/ Team,	RM	LS	RM	M	M	M	Written	RM

Project Charter – Communication Plan Format

Phase/ Item	Goal	Message	Vehicle/ Receiver	Developer	Approver	Deliverer	Timing: Development	Timing: Approval	Timing: Delivery	Feedback Method	Owner
			others								
Reports	Update	Contact List	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Reports	Update	Vacation Schedules	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Post Phase III											
In Person	Updates	Issues	Staff Mtgs/PM, CL	S	BH	S	M	M	M	Verbal	S
Intranet	Updates	All	All County	Trainer	BH	Trainer	Q	Q	Q	TBD	LR

Key to Above Table:

AD= Administrative Staff
BH= BHRS Management
C = Consumers
CL= Clinical Staff
ECC= eCC Project Leader
LR= Louise Rogers
LS= Lorrie Sheets
M= MH Advisory Board
P= Contracted Providers
PM= Pat Miles
RM= Rand Miyashiro
S= MH Supervisors
T = eCC Project Team

Attachment 2.2.4

ISCA

Information Systems Capabilities Assessment

(ISCA)

California Mental Health Plans

FY 2007

Version 6.1
August 2, 2006

This document was produced by the California EQRO in collaboration with the California Department of Mental Health and California MHP stakeholders.

Information Systems Capabilities Assessment (ISCA) FY2007

California Mental Health Plans

General Information

This information systems capabilities assessment pertains to the collection and processing of data for Medi-Cal. In many situations, this may be no different from how a Mental Health Plan (MHP) collects and processes commercial insurance or Medicare data. However, if your MHP manages Medi-Cal data differently than commercial or other data, please answer the questions only as they relate to Medi-Cal beneficiaries and Medi-Cal data.

- *Please insert your responses after each of the following questions. If information is not available, please indicate that in your response. Do not create documents or results expressly for this review. Be as concise as possible in your responses.*
- *If you provide any attachments or documents with protected health information ("PHI"), please redact or remove such information.*
- *Return an electronic copy of the completed assessment, along with documents requested in section F, to CAEQRO for review by* (January 12, 2007)

Contact Information

Insert MHP identification information below. The contact name should be the person completing or coordinating the completion of this assessment.

Note: This document is based on Appendix Z of the External Quality Review Activity Protocols developed by the Department of Heath and Human Services Centers for Medicare and Medicaid Services (Final Protocol, Version 1.0, May 1, 2002). It was developed and refined by the California EQRO in collaboration with the California Department of Mental Health and California MHP stakeholders.

MHP Name:	San Mateo
ISCA contact name and title:	Doreen Avery, Administrative Services Mgr.
Mailing address:	225 37th Avenue
Phone number:	650-573-2284
Fax number:	650-573-2110
E-mail address:	davery@co.sanmateo.ca.us
Identify primary person who participated in completion of the ISCA (name, title):	Doreen Avery
Date assessment completed:	January 18, 2008

ISCA OVERVIEW

PURPOSE of the Information System Capabilities Assessment (ISCA)

Knowledge of the capabilities of a Mental Health Plan (MHP) information system is essential to evaluate effectively and efficiently the MHP's capacity to manage the health care of its beneficiaries. The purpose of this assessment is to specify the desired capabilities of the MHP's Information System (IS) and to pose standard questions to be used to assess the strength of a MHP with respect to these capabilities. This will assist an External Quality Review Organization (EQRO) to assess the extent to which an MHP's information system is capable of producing valid encounter data[1], performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its beneficiaries.

If a prior assessment has been completed by private sector accreditation or performance measures validation, and the information gathered is the same as or consistent with what is described in this assessment, it may not be necessary to repeat this assessment process. However, information from a previously conducted assessment must be accessible to EQRO reviewers.

OVERVIEW of the Assessment Process

Assessment of the MHP's information system(s) is a process of four consecutive activities.

Step one involves the collection of standard information about each MHP's information system. This is accomplished by having the MHP complete an *Information System Capabilities Assessment (ISCA) for California Mental Health Plans.* The ISCA is an information collection tool provided to the MHP and developed by the EQRO in cooperation with California stakeholders and the California Department of Mental Health. The California Department of Mental Health defined the time frame in which it expects the MHP to complete and return the tool. Data will be recorded on the tool by the MHP. Documents from the MHP are also requested through the tool and are summarized on the checklist at the end of this assessment tool. These are to be attached to the tool and should be identified as applicable to the numbered item on the tool (e.g., 1.4, or 2.2.3).

Step two involves a review of the completed ISCA by the EQRO reviewers. Materials submitted by the MHP will be reviewed in advance of a site visit.

Step three involves a series of onsite and telephone interviews, and discussion with key MHP staff members who completed the ISCA as well as other knowledgeable MHP staff members. These discussions will focus on various elements of the ISCA. The purpose of the interviews is to gather additional information to assess the integrity of the MHP's information system.

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[1] "For the purposes of this protocol, an encounter refers to the electronic record of a service provided to an MCO/PIHP [MHP**]** enrollee by both institutional and practitioner providers (regardless of how the provider was paid) when the service would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provides substantially the same type of information that is found on a claim form (e.g., UB-92 or CMS 1500), but not necessarily in the same format." – Validating Encounter Data, CMS Protocol, P. 2, May 2002.

Step Four will produce an analysis of the findings from both the ISCA and the follow-up discussions with the MHP staff. A summary report of the interviews, as well as the completed ISCA document, will be included in an information systems section of the EQRO report. The report will discuss the ability of the MHP to use its information system and to analyze its data to conduct quality assessment and improvement initiatives. Further, the report will consider the ability of the MHP information system to support the management and delivery of mental health care to its beneficiaries.

INSTRUCTIONS:

Please complete the following ISCA questions. For any questions that you believe do not apply to your MHP, please mark the item as "N/A." For any ISCA survey question, you may attach existing documents which provide an answer. For example, if you have current policy and procedure documents that address a particular item, you may attach and reference these materials.

Please complete this survey using Microsoft Word. You may supply your answers in the areas indicated by tabbing through the fields.

Section A – General Information

1. List the top priorities for your MHP's IS department at the present time.

Implementation planning for the new Mental Health eClinical Care System.
Achieve compliance with Federal NPI requirements and other HIPAA security requirements.
Participate with Department's Health Client Data Store Project.
Participate in County E-Learning Cornerstone Initiative
Continue to monitor compliance with Short-Doyle Medi-Cal billing requirements after transitions from case rate. Monitor compliance with Care Advantage Medicare billing and claims payment requirements

2. How are mental health services delivered?

Note: For clarification, Contract Providers are typically groups of providers and agencies, many with long-standing contractual relationships with counties that deliver services on behalf of an MHP and bill for their services through the MHP's Short-Doyle/Medi-Cal system. These are also known as organizational contract providers. They are required to submit cost reports to the MHP and are subject to audits. They are not staffed with county employees, as county-run programs typically are. Contract providers do not include the former Medi-Cal fee-for-service providers (often referred to as network providers) who receive authorizations to provide services and whose claims are paid or denied by the MHP's managed care division/unit.

Of the total number of services provided, approximately what percentage is provided by:

	Distribution
County-operated/staffed clinics	63%
Contract providers	32%
Network providers	5%
Total	100%

Of the total number of services provided, approximately what percentage is claimed to Medi-Cal:

	Medi-Cal	Non-Medi-Cal	Total
County-operated/staffed clinics	50%	50%	100%
Contract providers	58%	42%	100%
Network providers	65%	35%	100%

3. Provide approximate annual revenues/budgets for the following: FY 07/08 budget

	Medi-Cal	Non-Medi-Cal	Total
County-operated/staffed clinics	$6,700,000	$ 985,000	$7,685,000
Contract providers	$7,915,000	$1,100,000	$9,015,000
Network providers	$385,000	$ 115,000	$500,000
Total	$1,5000,000	$2,200,000	$17,200,000

4. Please estimate the number of staff that use your current information system:

Type of Staff	Estimated Number of Staff
MHP Support/Clerical	37
MHP Administrative	44
MHP Clinical	302
MHP Quality Improvement	5
Contract Provider Support/Clerical	14
Contract Provider Administrative	3
Contract Provider Clinical	114
Contract Provider Quality Improvement	

5. Describe the primary information systems currently in use.

The following several pages allow for a description of up to four of the most critical and commonly used information systems. For clarification, certain terms used in this part are defined below:

Practice Management – Supports basic data collection and processing activities for common clinic/program operations such as new consumer registrations, consumer look-ups, admissions and discharges, diagnoses, services provided, and routine reporting for management needs such as caseload lists, productivity reports, and other day-to-day needs.

Medication Tracking – Includes history of medications prescribed by the MHP and/or externally prescribed medications, including over-the-counter drugs.

Managed Care – Supports the processes involved in authorizing services, receipt and adjudication of claims from network (formerly fee-for-service) providers, remittance advices, and related reporting and provider notifications.

Electronic Health Records – Clinical records stored in electronic form as all or part of a consumer's file/chart and referenced by providers and others involved in direct treatment or related activities. This may include documentation such as assessments, treatment plans, progress notes, allergy information, lab results, and prescribed medications. It may also include electronic signatures.

Master Patient Index – The function to search and locate patients using an index mechanism. The index synchronizes key patient demographic data including name, gender, social security number, date of birth and mother's name. The synchronization of data is crucial to sharing information across systems.

Current information system 1:

Name of product: VAX Client Informationand Reporting System and Managed Care	Name of vendor/supplier: County IS - Kathy Luisotti (Programmer)
When was it implemented? (An estimate is acceptable) Month: Year: 1985 for the VAX and April 1995 for Managed Care	

What are its functions? (Check all that currently are used)

☒ Practice Management	☐ Appointment Scheduling	☐ Medication Tracking
☒ Managed Care	☐ Electronic Health Records	☐ Data Warehouse/Mart
☒ Billing	☒ State CSI Reporting	☒ MHSA Reporting
☐ Staff Credentialing	☐ Grievances & Appeals	☒ Master Patient Index

☒ Other (Describe) Tracks prescriptions filled by client through our PBM

Who provides software application support?

☐ MHP IS ☐ Health Agency IS ☒ County IS ☐ Vendor IS ☐ Contract Staff

☐ Other (Describe)

Who is responsible for daily operations of the system?

☐ MHP IS ☐ Health Agency IS ☒ County IS ☐ Vendor IS ☐ Contract Staff

☐ Other (Describe)

What type of Short-Doyle/Medi-Cal claims does it currently produce?

☐ SDMC proprietary ☒ HIPAA 837 ☐ No claims or N/A

Does this system interface or exchange data with other systems? If so, please list them.

Med Impact, InfoImage, State database, Research and Evaluation database, A/R database, San Mateo County Medical Center, Jail data system also file from Aging and Adult and HIllcrest, Health Plan of San Mateo

Current information system 2:

Name of product: Accounts Receivable	Name of vendor/supplier: Ruby Trauner
When was it implemented? (An estimate is acceptable) Month: July Year: 2002	

What are its functions? (Check all that currently are used)

☐ Practice Management	☐ Appointment Scheduling	☐ Medication Tracking
☐ Managed Care	☐ Electronic Health Records	☐ Data Warehouse/Mart
☐ Billing	☐ State CSI Reporting	☐ MHSA Reporting
☐ Staff Credentialing	☐ Grievances & Appeals	☒ Master Patient Index

☒ Other (Describe) Accounts Receivable

Who provides software application support?

☐ MHP IS ☐ Health Agency IS ☐ County IS ☐ Vendor IS ☒ Contract Staff

☐ Other (Describe) support provided by Ruby Trauner (contractor). Effective 1/1/2007, ICounty IS staff will be supporting the application

Who is responsible for daily operations of the system?

☐ MHP IS ☐ Health Agency IS ☒ County IS ☐ Vendor IS ☐ Contract Staff

☐ Other (Describe)

What type of Short-Doyle/Medi-Cal claims does it currently produce?

☐ SDMC proprietary ☐ HIPAA 837 ☒ No claims or N/A

Does this system interface or exchange data with other systems? If so, please list them.

1) VAX Mental Health System. 2)Pulls down SDMC payments from state database and posts to the A/R

Current information system 3:

Name of product: Progress Notes Application	Name of vendor/supplier: County
When was it implemented? (An estimate is acceptable) Month: Jan Year: 2005	

What are its functions? (Check all that currently are used)

- ☐ Practice Management
- ☐ Appointment Scheduling
- ☐ Medication Tracking
- ☐ Managed Care
- ☒ Electronic Health Records
- ☐ Data Warehouse/Mart
- ☐ Billing
- ☐ State CSI Reporting
- ☐ MHSA Reporting
- ☐ Staff Credentialing
- ☐ Grievances & Appeals
- ☐ Master Patient Index
- ☒ Other (Describe) Clinicians can key progress notes and view recently submitted notes. Online viewing is restricted to the clinician who created the note

Who provides software application support?

- ☐ MHP IS
- ☐ Health Agency IS
- ☒ County IS
- ☐ Vendor IS
- ☒ Contract Staff
- ☐ Other (Describe)

Who is responsible for daily operations of the system?

- ☐ MHP IS
- ☐ Health Agency IS
- ☒ County IS
- ☐ Vendor IS
- ☒ Contract Staff
- ☐ Other (Describe) Ruby Trauner (Contractor) through 2006. County IS ongoing

What type of Short-Doyle/Medi-Cal claims does it currently produce?

- ☐ SDMC proprietary
- ☐ HIPAA 837
- ☒ No claims or N/A

Does this system interface or exchange data with other systems? If so, please list them.

VAX -registration/admissions are uploaded every 5 minutes into the progress notes application. The application creates services records which go to the VAX

Current information system 4:

Name of product:	Name of vendor/supplier:
When was it implemented? (An estimate is acceptable) Month: Year:	

What are its functions? (Check all that currently are used)

- ☐ Practice Management
- ☐ Appointment Scheduling
- ☐ Medication Tracking
- ☐ Managed Care
- ☐ Electronic Health Records
- ☐ Data Warehouse/Mart
- ☐ Billing
- ☐ State CSI Reporting
- ☐ MHSA Reporting
- ☐ Staff Credentialing
- ☐ Grievances & Appeals
- ☐ Master Patient Index
- ☐ Other (Describe)

Who provides software application support?

- ☐ MHP IS
- ☐ Health Agency IS
- ☐ County IS
- ☐ Vendor IS
- ☐ Contract Staff
- ☐ Other (Describe)

Who is responsible for daily operations of the system?

- ☐ MHP IS
- ☐ Health Agency IS
- ☐ County IS
- ☐ Vendor IS
- ☐ Contract Staff
- ☐ Other (Describe)

What type of Short-Doyle/Medi-Cal claims does it currently produce?

- ☐ SDMC proprietary
- ☐ HIPAA 837
- ☐ No claims or N/A

Does this system interface or exchange data with other systems? If so, please list them.

6. Selection and Implementation of a new Information System:

Mark the box that best describes your status today and respond to the associated questions.

☐	A) No plans to replace current system

☐	B) Considering a new system
	What are the obstacles?

☐	C) Actively searching for a new system
	What steps have you taken? When will you make a selection?

☒	D) New system selected, not yet in implementation phase
	What system/vendor was selected? Netsmart Technologies, Inc. Projected start date — March, 2008 Go live date — Feb, 2009 for pilot clinic Projected end date — September, 2010 Please attach your project plan. Please see Attachment XIV

☐	E) Implementation in progress
	What system/vendor was selected? Implementation start date Go live date Projected end date Please attach your project plan.

7. Implementation of a new Information System

If you marked box D, or E in 6 above, complete the following questions. Otherwise, skip to Section B.

7.1. Describe any strategies or safeguards you plan to use to ensure timely and accurate continuation of Medi-Cal claims and CSI reporting during the transition to a new system.

We are developing a comprehensive implementation and test process to ensure timely and accurate continuation of Medi-Cal claims and CSI reporting during the transition to a new system. Our acceptance criteria for Netsmart Technologies' application will include the criterion that our Medi-Cal claims and CSI reporting match the quality of our current application. We will use State Error Correction Reports and services billed comparisons between the two systems as metrics to determine when we will accept the new application. We will continue to use VAX MIS to submit Medi-Cal claims and perform CSI reporting until we complete formal testing with the State for Medi-Cal claims and CSI reporting and satisfy the requirements of our acceptance tests.

7.2. If you are converting/transferring data from a legacy system, describe your conversion strategy, such as what general types of data will be transferred to the new system and what data will be left behind or archived.

Please refer to Attachment XI "DataConversion.doc" that lists all of the fields we expect to convert from VAX MIS to a new information system. Netsmart Technologies has reviewed the list and understands that we expect to convert all historical data (around 20 years of data) for all the fields listed.

7.3. Will the new system support conversion of the existing consumer identifier as the primary consumer identifier?

☒ Yes ☐ No

7.3.1. If No, describe how the new system will assign a unique identifier (you may identify the number as the consumer ID, patient ID, medical record number, unit record number) to new consumers.

7.4. Describe what features exist in the new system to prevent two or more unique identifiers being assigned to the same consumer by mistake (“duplicate charts”).

Netsmart Technologies' application uses client lookups based on multiple fields to prevent assigning more than one unique identifier to the same consumer. The lookups are by standard fields (Social Security Number, Last Name, First Name, Birthdate, Alias, etc.) as well as several fields selected by the user for lookup. The user may define what fields are displayed for the matches that are found. In the event a

consumer is assigned more than one unique identifier, the application allows users to merge the records to a single identifier.

7.5. Specify key modules included in the system:

What are its functions? (Check all that are currently planned)

☒ Practice Management	☒ Appointment Scheduling	☒ Medication Tracking
☒ Managed Care	☒ Electronic Health Records	☒ Data Warehouse/Mart
☒ Billing	☒ State CSI Reporting	☒ MHSA Reporting
☒ Staff Credentialing	☐ Grievances & Appeals	☒ Master Patient Index

☒ Other (Describe) HL7 and Web Services interface modules.

7.6 What departments/agencies will use the system? (Check all that apply)

☒ Mental Health
☒ Mental Health Contract Providers
☐ Alcohol and Drug
☐ Public Health
☐ Hospital

Section B – Data Collection and Processing

Policy and Procedures

1. Do you have a policy and procedure that specifies the timeliness of data entered into the system?

☒ Yes ☐ No

1.1. If Yes, describe your recent experience using any available data collected on timeliness.

Please refer to Attachment VII - QI Policy 91-05 Compliance Documentation Standards - Section 2: Documents. In addition to the policy, the VAX tracks the date that a service is entered into the system so that we can track the time between the service date and the date entered into the system. Each month the VAX produces a report of all nonbillables due to late entry. Any service record with a service date that is more than 30 days prior to the date entered into the VAX is flagged as nonbillable. In addtion, our QI Unit provides monthly reports

aimed at clinical leadership and line staff that identifies the amount of nonbillables due to late documentation.

2. Do you have a policy and procedures specifying the degree of accuracy required for data entered into the IS?

☒ Yes ☐ No

2.1. If Yes, describe your recent experience using any available data collected on data accuracy.

We have specific procedures in place to ensure data accuracy.
At the point of data entry, the VAX incorporates all CSI edits as well as local county edits. In addition QI performs retrospective audits that begin with looking at the service record in the VAX and then checking the client chart for accurate documentation.

3. Does your MHP perform periodic verification of data in the IS compared to the medical record, such as ethnicity, language, birth date, and gender?

☒ Yes ☐ No

3.1. If Yes, please provide a description of your current policy and procedure or a report of a past data validity review.

We have instituted all of the State CSI (Client Services Information) edits. Please refer to Attachment I– CSI Data Dictionary. In addition, we verify clients ethnicity, birthdate, gender in the MMEF file to data in the VAX and research any discrepancies. We also have billing edits as described in the State DMH Billing Documentation Manual.
We track our CSI error rate which is less than 1%. Please see Attachment VIII for a report of our CSI errors.

4. Do you have a policy and procedures for detection and reporting of fraud?

☒ Yes ☐ No

4.1. If Yes, describe your procedures to monitor for fraud.

We have a compliance plan and a Compliance Committee that tracks and resolves compliance issues. The Committee meets once a month. The Committee is chaired by the Asst. Director of Mental. Other participants on the Committee include Mental Heatlh Managers and the County Counsel for Mental Health.

5. Describe any recent audit findings and recommendations. This may include EPSDT audits, Medi-Cal audits, independent county initiated IS or other audits, OIG audits, and others.

DMH has scheduled a system review for the Feb 4-8, 2008. This review will include an outpatient chart audit.

DMH reviewed additional outpatient sites for certification the week of May 14, 2007. Findings were positive and the sites were recertified pending minor changes and updates of fire clearance.

System Table Maintenance

6. On a periodic basis, key system tables that control data validations, enforce business rules, and control rates in your information system must be reviewed and updated. What is your process for management of these tables?

The information comes to Doreen Avery, Administrative Services Manager. She determines who to inform and that follow through occurs. She consults as needed with Assistant Director of Mental Health and QI Manager.

6.1. Are these tables maintained by (check all that apply):

- ☒ MHP Staff
- ☐ Health Agency Staff ("Umbrella" health agency)
- ☒ County IS Staff
- ☐ Vendor Staff

7. Who is responsible for authorizing and implementing the following system activities?

Activity	Who authorizes? (Staff name/title or committee/workgroup)	Who implements? (Staff name/title or committee/workgroup)
Establishes new providers/reporting units/cost centers	Adult and Youth Program Managers and MH Administration	Doreen Avery/Adminstrative Services Mgr.
Determines allowable services for a provider/RU/CC	Quality Improvement	Doreen Avery/Adminstrative Services Mgr.
Establishes or decides changes to billing rates	Patrick Sutton/Accounting	Doreen Avery/Adminstrative Services Mgr.
Determines information system UR rules	Quality Improvement	Doreen Avery/Adminstrative Services Mgr.
Determines assignments of payer types to services	Doreen Avery/Adminstrative Services Mgr.	Doreen Avery/Adminstrative Services Mgr.
Determines staff billing rights/restrictions	Quality Improvement	Doreen Avery/Adminstrative Services Mgr.
Determines level of access to information system	Quality Improvement	Doreen Avery/Adminstrative Services Mgr.

Activity	Who authorizes? (Staff name/title or committee/workgroup)	Who implements? (Staff name/title or committee/workgroup)
Terminates or expires access to information system	Doreen Avery/Adminstrative Services Mgr.	Doreen Avery/Adminstrative Services Mgr.

Staff Credentialing

8. Who ensures proper staff/provider credentialing in your organization for the following groups of providers?

County-operated/staffed clinics	Quality Improvement Unit
Contract providers	Quality Improvement Unit performs credentialing for County contract providers. Organizational contract providers are responsible for doing their own credentialing.
Network (formerly fee-for-service) providers	Initial and annual credentialing verification is performed by MHP Provider Relations Coordinator.

9. Are staff credentials entered into your information system and used to validate appropriate Medi-Cal billing by qualified/authorized staff?

☒ Yes ☐ No

Staff Training and Work Experience

10. Does your MHP have a training program for users of your information system?

☒ Yes ☐ No

10.1. If Yes, please check all that apply.

	Classroom	On-the-Job	One-On-One Trainer	New Hires Only
Clerical/Support Staff	☐	☒	☒	☒
Quality Improvement Staff	☐	☐	☒	☒
Program Manager	☐	☐	☒	☒
Billing/Fiscal Staff	☐	☒	☒	☒
Administration Staff	☐	☒	☒	☒
Managed Care Staff	☐	☒	☒	☒
Clinical Staff	☐	☒	☒	☒
Medical Staff	☐	☐	☒	☒

11. Describe your training program for users of your information system. Indicate whether you have dedicated or assigned trainers and whether you maintain formal records of this training. If available, include a list of training offerings and frequency, or a sample of a recent calendar of classes.

Currently, we have one staff who provides one-on-one training to all county and contract administrative support staff who use our system. In addition, one-on-one and/or group training is provided to any existing staff who request training. The training covers how to use the VAX Mental Health system, the Progress Notes Application (if applicable), Managed Care (if applicable) basic Groupwise email and the basics of the Microsoft applications (Excel, Word, Access) if requested . In addition, the County has regularly scheduled trainings in Groupwise Email and Microsoft Excel, Word , Access applications.

12. What is your technology staff turnover rate since the last EQRO review?

Number of IS Staff	Number - New Hires	Number - Retired, Transferred, Terminated
2.0	0	0

Access to and analysis of data

13. Who is the person(s) most responsible for analyzing data from your information system? Describe the working relationship between this person(s) and your QI unit. If there is no such person, please state "NONE."

Staff Name/Title	Organization/Dept/Division	Describe relationship to QI unit or "None"
David Williams, Jan Perez, Chad Kempel Lorrie Sheets	Research and Evaluation Unit IT Project Manager	Reporting meeting where we monitor reporting efforts. In addition QI meets individually on specific projects with all of these parties
Pat Miles	QI- Mental Health	
Doreen Avery	MIS/Billing	on-going meetings

14. Considering the reports and data available from your information system, list the major users of this information (such as billing department, program clerical staff, QI unit, management, program supervisors, etc).

Administration: Billing (daily operations reports and monthly billing reports). Accounting (cost report and other claiming reports) Program clerical staff (monthly MMEF reports, billing reports and documentation reports
Clinical: Program managers, program supervisors, line staff, contract agencies and QI: Monthly documentation reports, utilitzation/services delivery reports, productivity reports and nonbillable reports.

15. Does your information system capture co-occurring mental health and substance abuse diagnoses for active consumers?

☒ Yes ☐ No

15.1. If Yes, what is the percent of active consumers with co-occurring diagnoses?

29%

16. Does your information system maintain a history of diagnoses, as they are changed over time during an episode of care?

☒ Yes ☐ No

Staff/Contract Provider Communications

17. Does your MHP have User Groups or other forums for the staff to discuss information system issues and share knowledge, tips, and concerns?

Please complete all that apply	Meeting frequency (weekly, monthly, quarterly, as needed)	Who chairs meetings? (name and title)	Meeting minutes? (Yes/No)
Clerical User Group	Quarterly	Linda Drake	
Clinical User Group	Monthly	Lorrie Sheets	
Financial User Group	as needed		
Contract Providers	monthly	Louise Rogers	Yes
IS Vendor Group			
Other			

18. How does your organization know if changes are required for your information system in order to meet requirements of the State Medi-Cal Program?

We receive email notifications from the State ITWS, or written notices and letters from DMH. Sometimes changes to our contract with State DMH trigger the need for information system changes. In addition our Quality Improvement Unit performs internal compliance reviews and notifies billing in writing if there's an audit exception for a specific case or cases.

19. How are required State and local policy changes communicated to the staff or vendor responsible for implementing the policy change in the information system?

Doreen Avery, Administrative Services Manger communicates changes to ISD staff to ensure that they are implemented.

20. Does your organization use a Web server, intranet server, shared network folders/files, content management software, or other technology to communicate policy, procedures, and information among MHP and contract provider staffs?

☒ Yes ☐ No

20.1 If Yes, briefly describe how this is used and managed. Include examples of information communicated.

All policy and procedures are stored on a folder on a network shared drive. Access to these folders is determined at user set up.

In addition, through the web, people can access the Mental Heatlh Network of Care for the Documentation Manual and clinical forms used by Contractors. We have begun to explore computer based traning options and are participating in the rollout of the County learning management system Cornerstone.

Pat Miles, QI Manager has developed 12 or so trainings in MS PowerPoint that reside on the shared network drive.

Other Processing Information

21. Describe how new consumers are assigned a unique identifier (you may identify this number as the consumer ID, patient ID, medical record number, unit record number).

It is a sequential number that is auto-generated by the VAX

22. Describe how you monitor missed appointments ("no-shows") and provide a brief report or any available data regarding your rate of missed appointments.

Our data system tracks missed appointments. We can run adhoc reports at any time to obtain number/percentage of missed appointments/no shows. .

23. Does your MHP track grievances and appeals?

☒ Yes ☐ No

23.1 If Yes, is it automated or manual?

☐	Automated – Integrated into primary information system
☐	Automated – Separate system
☒	Manual
	Please describe: We track inquiries and complaints related to billing issues in an Excel file. The information that is collected is: Caller name/relationship to client, client, responsible party, phone number, date of call, recipient of call, source of call, name of person who took call, inquiry/complaint, action. The MHP's Consumer Affairs/Quality Management Unit tracks consumer grievances/appeals in an Excel file.

24. How does your MHP plan to address MHSA reporting requirements for Full Service Partnerships?

☐	Integrate into primary information system, by vendor or in-house staff
☐	Use separate on-line system developed by DMH
X	Use separate system developed by in-house staff – Edgewood
X	Use separate system developed by vendor – Telecare FSP
☐	Have not decided

Section C - Medi-Cal Claims Processing

1. Who in your organization is authorized to sign the MH1982A attestation statement for meeting the State Medi-Cal claiming regulatory requirements?
   (Identify all persons who have authority)

Name: Louise Rogers	Title: Director Mental Health Services
Name: Patrick Miles	Title: Ass. Director Mental Health Services
Name:	Title:
Name:	Title:

2. Indicate normal cycle for submitting current fiscal year Medi-Cal claim files to DMH.

   ☒ Monthly ☐ More than 1x month ☐ Weekly ☐ Daily ☐ Other

3. Provide a high-level diagram depicting your monthly operations activity to prepare a Medi-Cal claim. Note the steps your staff takes to produce the claim for submission to DMH.

   Please refer to State DMH Billing Documentation Manual - Steps 2 through 5

4. If your IS vendor controls some part of the claim cycle, describe the Medi-Cal claim activities performed by your information system vendor.

   n/a

5. Does your MHP use a standard review process for claims before submission?

   ☒ Yes ☐ No

   5.1. If yes, please describe the claims review process. What criteria are used to ensure that a claim is accurate before submission to DMH?

   Please refer to Steps 2-5 in the State DMH Billing Documentation Manual

6. Briefly describe your strategy to implement the National Provider Identifier (NPI), as required by HIPAA.

   Attachment XIII and XIV are the documents we used to inform staff of HIPAA requirements for NPI and for collecting NPI application information from staff. We distributed the NPI application forms to staff and gave them the choice of authorizing San Mateo Mental Health Services Division to get an NPI for them, report their NPI if they already had one or elect to get an NPI on their own. Letters and forms to obtain

NPI numbers have also been distributed to contract agency community based organizations and the private provider network.
In addition, the VAX computer system has been modified to capture the NPI for both individuals and sites.

The BHRS Payroll/Personnel employee has a list of all BHRS positions that require an NPI. Whenever an employee is hired into a position that requires an NPI, s/he is asked to provide their NPI number. If the employee doesn't have an NPI, they receive information on how to obtain one.

An NPI is required by our information system to create a new Therapist ID for both County and Contractor service providers. Since a Therapist ID is required to bill for services, this requirement is a very effective method to collect NPI's from individuals.

Organization NPI's are also required for billing and this requirement is, once again, a very effective method to collect NPI's.

7. Please describe how beneficiaries' Medi-Cal eligibility is stored and updated within your system in order to trigger Medi-Cal claims. Include whether automated matches to the State's MMEF file are performed for the purpose of mass updates to multiple consumers.

Each month the MMEF file is compared to Medi-Cal beneficiary information in the VAX. Any discrepancies are produced on a report for research. We chose not to automatically update the VAX because the MMEF is not real-time and we may have more current information from the real-time MEDS.

8. What Medi-Cal eligibility sources does your MHP use to determine monthly eligibility? Check all that apply

☐	IS Inquiry/Retrieval from MEDS	☐	POS devices
☐	MEDS terminal (standalone)	☐	AEVS
☒	MEDS terminal (integrated with IS)	☒	Web based search
☒	MMEF	☐	FAME
☐	Eligibility verification using 270/271 transactions	☐	Other:

9. When checking Medi-Cal eligibility, does your system permit storing of eligibility information – such as verification code (EVC), county of eligibility, aid code of eligibility, share of cost information?

☒ Yes ☐ No

9.1. If Yes, identify which of these fields are stored and describe if a user needs to enter this information manually, or if the process is automated (system does it).

We store 15 months of eligibility data from the MMEF file, including all of the data elements listed above.

10. Does your MHP use the information system to create ad hoc reports on Medi-Cal claims and eligibility data?

☒ Yes ☐ No

10.1 If Yes, please indicate the software reporting tools used by your staff and include a brief description of a recent ad hoc report.

Access and SPSS. Attachment XII is a report of services in the month of August 2007 provided by one of our programs that were billed and later disallowed

11. Describe your most critical reports for managing your Medi-Cal claims and eligibility data.

Medi-Cal Claims: Monthly reports
- Potential Nonbillables Due to No Treatment Plan
- Documentation At a Glance Report
- Billing and Revenue reports
- Eligibility: MMEF reports

12. Do you currently employ staff members to extract data and/or produce reports regarding Medi-Cal claims or eligibility information?

☒ Yes ☐ No

13. Please describe your MHP's policy and procedure and timeline for reviewing the Error Correction Report (ECR).

Please refer to Step 7 (Short-Doyle Medi-Cal Error Correction Report (ECR) in the State DMH Billing Documentation Manual

14. Please describe your MHP's policy and procedure for reviewing the Medi-Cal Explanation of Benefits (EOB or 835) that is returned to the MHP.

Please refer to Step 6 (Short-Doyle Medi-Cal EOB's) in the State DMH Billing Documentatin Manual

15. What percent of Medi-Cal claims were denied during:

FY 2004	0%	FY 2005	1%

Section D – Incoming Claims Processing

Note: "Network providers" (commonly known as fee-for-service providers or managed care network providers) may submit claims to the MHP with the expectation of payment. Network providers do not submit a cost report to the MHP.

1. Beginning with receipt of a Medi-Cal claim in-house, provide a diagram of the claim handling, logging, and processes to adjudicate and pay claims.

Please refer to Step 4 (Services - MHP Private Provider Network) in the State DMH Billing Documentation Manual. Upon receipt of claim, the Claims Specialist reviews the claim to ensure that it has been properly completed: -checks demographic information -checks for authorization -checks for service dates -check for cpt codes -check for private provider number If claim passes this visual review, then it can be keyed and passed through the automated edits. Please refer to Attachment V: Claims Process Edit Checks

2. How is Medi-Cal eligibility verified for incoming claims?

Please refer to Step 2: Eligibility for Services in the State DMH Billing Documentation Manual

3. How are claims paid to network providers billed to Short-Doyle/Medi-Cal?

Please refer to Step 4 Services and Step 5: Billing for Medi-Cal Services in the State DMH Billing Documentation Manual.

4. Have any recent system changes influenced, even temporarily, the quality and/or completeness of the Medi-Cal claims data that are collected? If so, how and when?

The state denying claims as duplicates when the claims were actually valid. The state didn't inform counties that DHS was putting a new edit in place

5. What claim form does the MHP accept from network providers?

☒	CMS 1500
☒	UB-92
☐	837I
☐	837P
☒	MHP specific form (describe): Community based organizational providers submit claims on internally developed service reporting forms.

6. Please indicate which code sets are required by your MHP on claims received from network providers.

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Outpatient Diagnosis	Outpatient Procedure
ICD-9-CM	☒	☒	☒	☒
CPT-4		☒		☒
HCPCS		☐		☒
UB Revenue Code		☒		☐
DSM-IV-TR	☒		☒	
MHP Internal Code	☐	☒	☒	☒
Other	☐	☐	☐	☐

7. Please indicate whether you require the following data elements on claims submitted by network providers.

Data Elements	Yes or No	
Patient Gender	☒ Yes	☐ No
Patient DOB/Age	☒ Yes	☐ No
Diagnosis	☒ Yes	☐ No
Procedure	☒ Yes	☐ No
First date of service	☒ Yes	☐ No
Last date of service	☒ Yes	☐ No
Financial Responsibility	☒ Yes	☐ No
Provider Specialty	☒ Yes	☐ No
MHP consumer identification number	☒ Yes	☐ No
Place of service	☒ Yes	☐ No

8. How does your MHP monitor the accuracy and productivity of individual staff members who have responsibility for adjudicating incoming Medi-Cal claims from network providers?

The MHP does an annual satisfaction survey of the provider network. The survey specifically addresses timeliness of claims adjudication. Please refer to Attachment IX - MHP Survey Results.
In addition, our billing inquiry/complaint database tracks claims adjudication issues and actions steps taken to resolve the issues.

9. What is the average length of time between claim receipt and payment to network provider? (An estimate is acceptable.)

Two weeks on average

10. Does your MHP maintain provider profiles in your information system?

☒ Yes ☐ No

10.1. If Yes, please describe what provider information is maintained in the provider profile database (e.g., languages spoken, special accessibility for individuals with special health care needs).

The Managed Care application includes the ability to track the following information items:Provider relations staff maintains a provider database that includes: provider name, hospital affiliation, age, gender, gender issues, language, specialty area, contract start and end date, provider phone, provider claims address, provider service location, type of provider, provider number (unique identifier), professional license, license expiration date, insurance, general liability, professional liability and workers compensation expiration date, DEA license and expiration date, agreement number, open or closed to referrals, comments section We also have an Access database that tracks this information.

11. Please describe how network provider directories are updated, how frequently, and who has “update” authority.

Providers are added to our billing system and contracts database as we add them to our network, on a flow basis. The provider information is obtained from the manager involved in negotiating the contract or their designee on a "contract initiation form" that is used by the contracts office, and other sections of the division to establish the contract and provider information for the database. The Billing Manager has "change" authority for the VAX billing system. There is a provider relation’s staff person that initiates all the private practitioner contracts and assures their information is entered correctly in the information systems. She has change authority for the managed care information system and the Vax billing system for information about particular providers but would work with the Billing Manager if any data parameters or elements needed to be changed. The paper Medi-Cal provider directory we provide to clients at admission and upon request is updated annually. This directory is based on information contained in the Contracts database maintained by contracts office staff. The contracts office updates this Access database as contracts are renewed or amended.

12. Does your MHP use a manual or an automated system to process incoming claims, and adjudicate and pay claims?

☐ Manual ☒ Automated ☐ Combination of Both

If you marked either “Automated” or “Combination of Both,” complete the following questions. Otherwise, skip to Section E.

13. What percent of claims are received electronically? 0%

14. What percent of claims are auto adjudicated? 100%

15. How are the fee schedule and network provider compensation rules maintained in your IS to assure proper claims payment by your MHP? Who has "update" authority?

The system maintains a Provider Profile table as well as a historical Rate table for all providers. The tables are maintained by the MHP Provider Relations Coordinator and the Administrative Services Manager.

16. Does the system generate a remittance advice (e.g., EOB)?

☒ Yes ☐ No

16.1. If Yes, does your system generate a HIPAA transaction for the remittance advice?

☒ Yes ☐ No

17. Does the system generate an authorization advice (i.e., letter)?

☒ Yes ☐ No

17.1. If Yes, does your system generate a HIPAA transaction for the authorization letter?

☐ Yes ☒ No

Section E – Information Systems Security and Controls

1. Please describe the frequency of back-ups that are required to protect your primary Medi-Cal information systems and data. Where is the back-up media stored?

Offsite backups are stored at: Iron Mountain29555 Kouthek St.Union City, Ca 94587. Backups are stored in a fireproof vault with halon protection. ISD does the backups daily and these are kept in the computer room and rotated each day. On the weekends, they backup everything on the VAX and on Tuesday, the backup goes offsite in a locked box. No one can access the data. It remains locked during storage. There are three complete system backups stored offsite. These are rotated each weekend so that the data remains recent and up to date.

2. Describe the controls used to assure that all Medi-Cal direct services are entered into the system (e.g., control numbers, daily audits, and/or service activity logs).

Please refer to Step 4 (Services) in the State DMH Billing Documentation Manual

3. Please describe your policy and procedure for password control on your Medi-Cal system(s). For example, how often do you require passwords to be changed?

PC logon: The county has an Information Security Policy that specifically addresses the use of passwords. Please refer to Attachment III Section III: Password Management in the San Mateo County Information Technology Security Policy.Vax passwords expire every 90 days and the passwords must be between 6 and 32 characters

4. Please describe the provisions in place for physical security of the computer system(s) and manual files. Highlight provisions that address current HIPAA security requirements.

4.1. Premises

All MHP regional clinics should have separate lockable chart rooms. Charts should be returned to the administrative office at the end of the workday. At the end of the day charts are triple locked – outside door to building, door to administrative office and chart room door.

4.2. Documents

Manual files: Mental Health records management is described in attached policy #MH 00-04, which was amended based on HIPAA regulations and specifies policy governing medical records management and procedures concerning oversight, storage, and destruction of mental health medical records. The policy specifies that open charts should be stored in compliance with state and federal requirements

4.3. Computer room/server room

Please refer to Attachment III: San Mateo County Information Technology Security Policy

4.4. Workstation access and levels of security

Please refer to Attachment III: San Mateo County Information Technology Security Policy

5. Describe how your MHP manages access for users. Do you use templates to standardize user access? Is so, describe the levels of access for both MHP and contract provider staffs.

Only individuals authorized and set-up for access to the system by the Administrative Systems Manager have access. This includes some of our contracted providers who have access to the VAX through the VPN (Virtual Private Network) as well as some consumer/family member employees employed by our Office of Consumer Affairs and involved in responding to grievances. The MHP has several different access profiles which are determined by the type of work the user does.

6. Describe your procedures to remove/disable access for terminated users. Explain the process for both MHP and contract provider staffs. Include frequency it is done for both groups of users.

Program Managers, contract agency administrative staff and the MHP payroll personnel will notify the MIS Unit that an employee/contractor

has been terminated. MIS Unit then submits an account termination form to County ISD to disable the account.

Section F – Additional Documentation

1. Please provide the documentation listed in the table below. Documentation may be submitted electronically or by hardcopy. Label documents as shown under the "Requested Documents" column.

Requested Documents	Description
A. Organizational chart	The chart should make clear the relationship among key individuals/departments responsible for information management.
B. County-operated programs and clinics	A list of those who can bill Medi-Cal, including name, address, and type of program (i.e., outpatient, day treatment, residential, and inpatient).
C. Contract providers	A list of those who can bill Medi-Cal, including name, address, and type of program (i.e., outpatient, day treatment, residential, and inpatient).
D. Procedures to monitor accuracy and timeliness of data collection	Provide copies of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers that address standards for data collection accuracy and timeliness.
E. Procedures to determine consumer/beneficiary eligibility status	Provide copies of the current policies and procedures, desk procedures, and/or written instructions to the staff and providers that describe how to determine consumer/beneficiary eligibility status.
F. Procedures to produce Medi-Cal claims and review error/denied claims	Provide copies of the current policies and procedures, operations manual, flowchart, calendar, and/or written instructions that document production of the Medi-Cal claim and resolving error/denied claims.
G. Procedures to monitor timeliness of claims processing and payments to network providers	Provide copies of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers that describe standards for monitoring timely claims processing/payment.
H. Procedures for the following topics: new user authorization, disable user accounts, password standards, data security standards, unattended computers, electronic security audits.	Provide a copy of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers for these activities.
I. Prior Internal Audits	If you have recently done an internal audit of your Medi-Cal claims submissions or your Medi-Cal claims adjudication from network providers, please attach a copy for review.
J. Ethnicity/race, language code translations	Provide a cross-reference list or table showing what codes are used internally by the staff on source documents for data entry and how they are translated into valid codes for Medi-Cal claims and CSI reporting.
K. Crosswalk from locally used service/procedure codes to CPT/HCPCS codes used in the Medi-Cal claim.	Provide a crosswalk for mapping codes used to record services to codes used to bill Medi-Cal. Include those used by network providers.
L. Index of your Reports Manual	If available, provide a list of all current vendor-supplied and internally developed reports and report titles. Do not include ad hoc reports developed to meet temporary or one-time needs.

Attachment 2.2.5

Workflows

San Mateo County Behavioral Health and Recovery Services Division: Proposal for As-is Workflow Analysis in preparation for eClinical Care System Implementation

FOR:

SAN MATEO HEALTH DEPARTMENT

By: Jyotsna Nimkar, IT Analyst
Stella Charbakshi, Relationship Manager
September 2007

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Project Specifics

Account: Health Department

Org: 1J882
StarPro Service Request: S04356

ISD Lead Analyst: Jyotsna Nimkar
ISD Relationship Manager: Stella Charbakshi

Project Goals

The project goal is to collect and present the existing Behavioral Health workflows required to establish a baseline for and successfully implement the new replacement information system for Behavioral Health and Recovery Services Division, also known as PG6 “eClinical Care.”

Business Goals

This project will provide source documentation to allow Behavioral Health to evaluate the effectiveness of the project in maintaining or improving existing workflows after the implementation of eClinical Care. It will serve as the primary reference for the vendor, ISD staff, and MH Project staff when developing future (“To-be”) workflows and also for planning, configuring, and testing application software. Its preparation ahead of project start will help to maintain the project on time and on budget goals.

Project Scope

The scope of this project is limited to (1) performing all activities necessary to review previous work to date on workflows, assessing the gaps between existing documentation and the benchmarks needed to implement and assess the new system. (2) document the existing processes in a flowchart, diagrammatic or summary narrative form for project documentation, project communication, project references, and staff and consumer training.

This Proposal includes:

- Project management, planning, and written description of the tasks to be performed as part of this project, and as further described under ISD responsibilities.
- Assessment of workflow efforts and documentation to date.
- Review and client approval of the existing macro-processes.
- Facilitation of client review of existing micro processes.
- Project management to assess via gap analysis as to remaining workflow analysis and documentation required.
- Meetings, interviews, observation, and other work necessary to develop workflow necessary for Behavioral Health staff review.
- Project management and meeting facilitation as necessary so that the Behavioral Health Steering Committee may reach consensus that adequate benchmarks have been established for relevant workflows affected by the eClinical project.
- Documentation including a one page graphic display per workflow among Behavioral Health and integrated units, so that that any participant, or PG6 project stakeholder may reference workflow. For clarity and ease-of-use, the documentation will focus on high-level steps and decisions for each process and will use standardized graphical notation such as Business Process Modeling Notation (BPMN).
- For workflows with additional steps or complexity beyond the goals or scope of this project, a list will be compiled.

This Proposal excludes:

- Non ISD staff time.
- Evaluation as to correct workflow for any process or comparisons and recommendations with “Best Practices” research with other workflows
- Any impact to existing workflows due to new projects such as consolidation of Alcohol and Drug Unit and relocation to Alameda.
- Workflows that are not Behavioral Health business processes or are non-standardized.
- Any workflow re-engineering resulting from gathering this information.
- Any new workflows that may be subsequently identified during the detailed information gathering process or any changes to existing workflows after their documentation. These new workflows will be listed for further analysis and documentation.

Project Staffing

ISD:

Will provide Jyo Nimkar as the IT Lead Analyst and Stella Charbakshi as the relationship manager for this engagement. Lead Analyst will summarize workflows as Visio diagrams and will facilitate interviews, meetings, and otherwise assist each Behavioral Health and affiliated workgroups in documentation of affected workflows. Other ISD staff will serve as subject matter experts (SMEs) for their portion of workflow (e.g. managed care system, billing) to contribute to workflow drafts.
ISD may assign additional resources to this project as necessary.

Refer to Appendix IV for an outline of the as-is workflow analysis process as needed.

Behavioral Health:

Will (a) provide a single point of contact to all the affected groups within Behavioral Health to coordinate interviews (b) identify and provide Subject Matter Expert for each workflow to participate in workflow development (c) identify and provide a review team for the workflow/process areas (d) provide appropriate operational personnel to validate the workflow against actual provider and consumer work in the field.

Behavioral Health Steering Subcommittee:

Will (a) review high level workflows in a timely manner. (b) delegate detailed development of workflows to Behavioral Health Specialists in that area (c) approve or require changes in a timely manner.

Project Costs:

Effort per workflow

Tasks	Task Description	ISD Labor Hours	MH Hours
Preparation	Identify team structure and participation	0.1	
	Plan for and schedule meetings with SME, review team, validation team	0.2	.2
	Gather preliminary/background information to prepare for meetings	1	
Workflow Development	Gather detailed information from SME- triggers, steps, major decisions, and results of the process being studied	1.1	1
	Develop draft workflow, review information gathered and identify areas requiring clarifications	1	
	Refine draft workflow with SME	0.3	0.3
	Update draft workflow document	0.3	
Review	Review the workflow with review team	0.4	1.2
	Update workflow document	0.3	
Validation	Validate the workflow with line-staff using typical scenarios	0.4	1.2
	Finalize workflow document	0.2	
	Subtotal for Each Workflow	**5.3**	**3.9**

Effort based on estimated 109 workflows

Task	ISD Hours
Subtotal for 109 workflows	578
Contingency Costs (15%)	87
Project Management (20%)	173
Project Total	**838**

Project Schedule:

Date	Milestone:	Responsibility
Sept 2007	Project Proposal review and approval	MH Steering Committee
Aug-Sept 2007	Review of existing workflow list	ISD
Sept-Dec 2007	Workflow Interviews and meetings	ISD, MH Staff
Sept-Jan 2008	Workflow diagramming	ISD
Jan-Feb 2008	Review and approval by MH Team	MH Staff

Feb-Mar 2008	Validation of workflows by front line staff	ISD, MH Staff
End March 2008	Final pre-project workflow review and approval	MH Steering Committee

Risk Assessment

There is a risk that the assessment will take longer than anticipated because personnel may not be available in a timely manner to complete the milestones outlined above. Delays in staff availability will delay the planned completion, but not affect scope or budget.

The workflows will be developed based in interview with subject matter experts and not by direct observation of operational processes. There is a risk that the final validation with the line-staff will uncover significant deviations in actual practice. If Behavioral Health subcommittee decides to incorporate these deviations in the workflow documentation, it may delay the planned completion date.

Other Relevant Information

The hours used for meetings, gathering information, updates and design changes and testing will be charged in half-hour increments at the hourly labor rate for the fiscal year in which the work performed. All charges will be billed through a Health Department Authorization.

Acceptance of Project

Louise Rogers _____(Sign) Date: _____
Assistant Director, Behavioral Health and Recovery Services Division

Dorothea Curtin _____(Sign) Date: _____
Deputy Director, ISD

Appendix I

List of workflows identified

A. Initial Contact

#	Process	Description
1.	Regional clinics	Logging all calls, Behavioral Health services or others, and gathering initial information and call disposition.
2.	Access	
3.	Pre to three	
4.	26.5	
5.	PES	
6.	Youth Services Campus	
7.	Pathways (criminal justice)	
8.	Same-day access (e.g. EPA)	
9.	Primary care interface	

B. Intake and Registration

#	Process	Description
10.	Regional clinics	• Intake screening to determine nature of service required - crisis, hospitalization, outpatient or CBO • Registration, episode opening and screenings
11.	Access	
12.	Pre to three	
13.	26.5	
14.	PES	
15.	Youth Services Campus	
16.	Pathways (criminal justice)	
17.	Same-day access (e.g. EPA)	

C. Authorization and Utilization Management

#	Process	Description
18.	Prior authorization of contracted providers by Access	Initial/Reauthorizations/Extension authorizations for Behavioral Health services issued by Access, QI and Claims Unit.
19.	Specialty authorizations for psychiatric testing and medication management by Access	

20.	Out of county authorizations by Access	
21.	Retrospective authorization of certain private providers by Claims unit	
22.	Retrospective authorization of hospital claims by QI team (no authorizations for county operated hospital services)	
23.	Prior authorization of day treatment service by county and contractors by QI	
24.	Authorization by QI for TBS services by contractors	
25.	PPN Provider registration and credentialing	Registration and credentialing of network providers.
26.	Registration and credentialing of employee and OCHA clinicians	Credentialing of employee clinicians and other contract care providers that operate in county locations.
27.	Contracts and site certifications for contract agencies.	Medi-Cal site certification e.g. fire inspections, storage of charts etc. The system must capture site certification status. No services can be claimed from Medi-Cal for sites not certified.
28.	Provider Communication Management	Track communications with individual and organizational providers
29.	Utilization Management with external participants	Case assist meetings for Transition Age youths, high-profile cases etc
30.	Utilization management	Case review internal to MH
31.	Transfer to Residential facility	Transferring a client to a residential facility

D. Assessment

#	Process	Description
32.	IEP and renewals for 26.5 youth	Eligibility determination/renewal process by Youth Assessment Team to direct/refer the 26.5 youth to appropriate level of care
33.	Assessments for adults and youths	• Initial and annual clinical assessments

		performed for Adults and Youths • Include Dual Dx assessments
34.	PPN Assessment	Initial and annual assessment process for network providers
35.	Residential assessments	Initial and annual assessments performed at Residential facilities
36.	Functional Family Therapy	Functional family therapy for Hillcrest clients
37.	Conservatorship investigation assessments	Assessments required for conservatorship investigations.
38.	Medical assessments	Psychiatric assessments for a client

E. Treatment Planning

	Process	**Description**
39.	Treatment Planning by Private Provider Network clinicians	Initial and annual treatment planning by Private Provider Network clinicians
40.	Treatment Planning for regional clinics	Initial and annual treatment planning by regional clinics
41.	Treatment Planning for contract agencies	Initial and annual treatment planning by contract agencies

F. Service Delivery

	Process	**Description**
42.	Non-medical Individual Services	Individual clinical services delivered to adults and youths. Includes collateral services and services delivered by peer counselors and community workers.
43.	Group Services	Group services delivered to adults and youths.
44.	Day Treatment Services	Day treatment services delivered to youths.
45.	Medication services	Ordering medications and prescription refills.
46.	Lab services	Ordering of lab services and receiving results.
47.	Injection services	Giving injections/medications and recording their administration.

48.	Consents	Consents to treatment, medications, speaking to a lawyer/family member including 26.5 youths.
49.	Med Room Management	Ordering, receiving, labeling and discarding medication as necessary.
50.	Urgent care plan	Urgent care messages setup by MH care providers for PES, 3A/B staff that may be helpful in providing care for their client.
51.	Notification for client admission	Email notifications sent to appropriate MH Staff when a client has an admission to PES or 3A/B.
52.	Drug Formulary Management	Determine whether a medication is on local formulary or is a drug of "first choice".
53.	Pharmacy Management	Inventory control, ordering and dispensing support. May not be included.
54.	Patient Assistance Program	Applying for free medications sponsored by pharmaceutical companies for eligible clients

H. Case Closure/Referrals

	Process	**Description**
55.	Youth to Adult Transfer	Referrals and transfers from one provider to another
56.	Transfer from one regional provider to another	
57.	Transfer from PPN to regional provider and from regional provider to PPN	
58.	Transfer from contract agencies to regional provider	
59.	Transfer to external organizations	
60.	Case Closure	Closing a client episode

I. Admin processes

	Process	Description
61.	Open and close client episodes	Manage client episodes in Vax
62.	Check-in clients and log arrivals	Process for logging client arrival for service
63.	Collection and transmittal of co-pays	Tracking clients with outstanding payments
64.	Client Interviews	Client registration and financial assessments
65.	UMDAP fee adjustments	Submission and approval of UMDAP fee adjustments
66.	Share of cost	Clear Medi-cal client share of cost
67.	Support lab orders and results	Print labels, collect and dispatch specimens, and receive results.
68.	Support Pharmacy orders	Faxing/calling in prescriptions and following up on PBM errors.
69.	Chart creation and maintenance	Manage creation, receiving, maintenance, transfers, closing, and archival of charts
70.	Track documents in charts	Track assessments, consents and treatment plans in charts
71.	Service entry/OAR	Enter all services from progress notes for individual, group, medication, and assessment services
72.	Follow up on MIS reports	Use MIS reports to identify and correct billing and documentation related problems
73.	Release of Information	Tracking and completing requests for release of information
74.	Group service management	Creation of groups and members.

J. Billing

#	Process	Description
75.	MEDS file upload and follow-up	• Loading of eligibility information of all county eligibles for Medi-Cal , medicare and other health plans received from state • Reports are generated and

		eligibility status of a client is updated manually **Note:** The Meds and HPSM file upload will be replaced by new Meds file that will contain Meds and Part D information.
76.	HPSM file upload and follow-up	• Loading of eligibility information from the care advantage file containing PDP information from HPSM • Reports are generated and eligibility status of a client is updated automatically
77.	Batch upload of service file from contract agencies	Contract agencies like Caminar, Telecare, Edgewood send service files that are uploaded. Edit checks determine whether services should be marked as unbilled (if treatment plans not complete). The payments are handled manually by Accounting
78.	Fee billing	Generation of monthly client statements. The report is FTPed to InfoIMAGE for printing client statements
79.	Client Payments/ adjustments	Manual entry of client payments in AR system. This information is uploaded into Vax.
80.	Pre-billing validations for Medi-Cal	The edit checks are run prior to billing and reports listing missing information are printed out for follow up by clinics.
81.	Claim submissions- Primary Billing	Submission of claims to primary payor - Medi-Cal/ Medicare/ other insurances 26.5 billing built-in a edit checks
82.	Claim Submissions-Secondary Billing	Submission of claims to secondary payor - Medi-Cal/ Medicare/ other insurances
83.	Claim adjustments	Over-billing /under-billing for Medi-Cal is entered in the state's "Disallowed system". This will be replaced by "Void and Replace"

		electronic submissions in the near future.
84.	Medi-Cal and Medicare payment posting	Electronic payments that are automatically uploaded to Vax and AR systems.
85.	Insurance Payment Posting/adjustments	Manual process for insurance payments.
86.	Resubmission of denials	Follow-up on claims denials and canceling the “billed” flag for the service. Such services will be billed in the next billing cycle.
87.	Follow-ups/Reminders	Reports are generated from the AR system
88.	LabCorp billing	The process has been manual since Quest lab was replaced by LabCorp
89.	Grant billing	Using grant funding sources as quasi-insurance for clients that meet grant funding.
90.	Capitation and grant-in-aid payment management	Processing of bills that are covered by capitated or grant-in-aid funding streams.
91.	Tracking service costs	Track actual costs or California Schedule of Maximum Allowables
92.	Medi-Cal cost reporting	Annual cost reporting for Medi-Cal
93.	Hospital Claims Can be consolidated in Medi-Cal Billing and this entry replaced by 24 hour care	SMMC bills for Medicare and insurances, they send the Medi-Cal claims to Vax for consolidation with other Medi-Cal claims
94.	Hospital Payments Can be consolidated in Medi-Cal Billing and this entry replaced by PBM Billing	The Medicare and other payments received by SMMC are uploaded to Vax.
95.	Outpatient claims	Psych outpatient claims from clinics e.g. Ron Robinson will be billed to Behavioral Health. The claim denials are used for FQHC claiming.
96.	Claims from Contracted providers	Entering of claims in Managed Care system, validation of authorization and payment to contracted providers.

97.	Claims payment history	Tracking of contract limits by contractors. Support yearly generation of IRS 1099 documents
98.	CSI	Client and Service Information (CSI) should be included during registration. Includes Client Master File, Periodic, Record Control, and Submission Control data elements.
99.	Follow up on MIS reports	Follow up using MIS reports eg HPSM /CareAdvantage terminations
100.	Inpatient care management	Tracking inpatient episodes for clients admitted to SMMC/Peninsula/Sequoia and capture key inpatient information for inpatient clients.

K. Outcomes

#	Process	Description
101.	Consumer survey	
102.	Staff survey	

L. QI

#	Process	Description
103.	Critical incidents	Critical incidents reported by contracted providers and agencies; pharmacy errors
104.	Subpoenas and release of records	Responding to requests and legal orders for client records.
105.	Chart review	Periodic review of client charts maintained at county facilities, contract agencies and hospitals. QI informs the MIS staff is informed if any services should be disallowed.
106.	Representative Payee	County may manage finances of certain adult clients. An account is opened for such a client to

		receive social security payments and pay client bills and other disbursements. There are currently 300-350 rep payee accounts being managed.
107.	Grievances and appeals	Grievances received by MH services need to be logged in 24 hours and resolved in 60 days. Notice of Action is issued to client/provider when services are disallowed/reduced and appeals, if any are handled by QI.
108.	Oversight of 5150	Designated MH staff can authorize holding an individual likely to harm self/ others for 72 hours for psychiatric evaluation (5150). The receiving facility (PES/3AB/Mills Peninsula) sends the 5150s back to QI for tracking.
109.	Reports on performance improvement projects	QI requires ad-hoc reports to support/track performance improvement projects that are reported back to the State.

New Workflows

110.	PBM Billing	PBM Billing

Appendix II

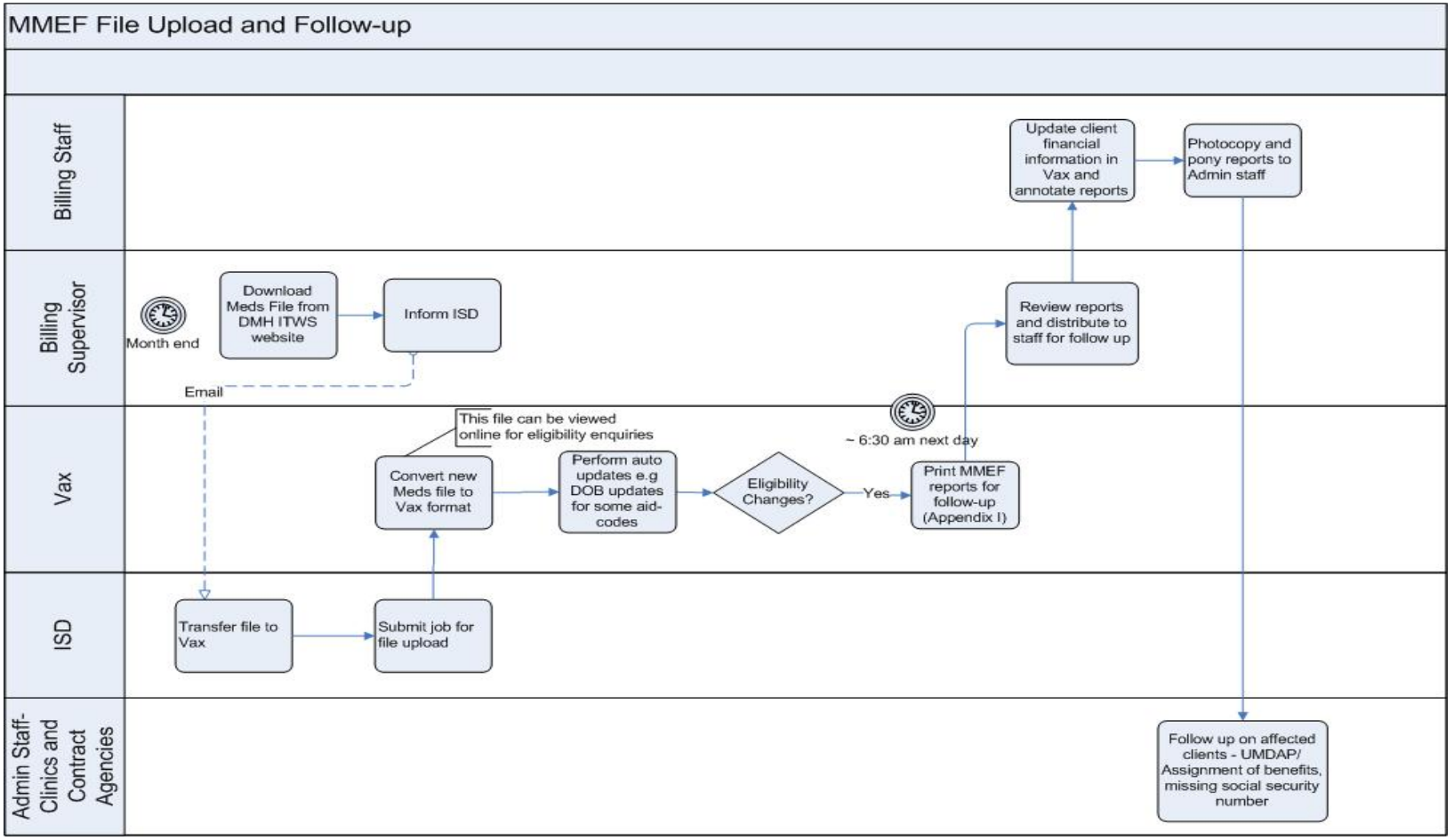
List of functional requirements excluded as it is not applicable for our site or does not qualify for an as-is workflow study

RFP Requirements	Functional Requirement	Status
2.1.6	Wait List Management	Not Applicable
2.3.1	Crisis Plans	Not Applicable
2.4.4	Claims Payment History	Not Applicable
2.5.3	Duplicate Checking & Merge	Not a workflow
2.5.11	Diagnosis Management	Not a workflow
2.5.15	Service Validations	Not a workflow
2.5.21	Dietary Tracking	Not Applicable
2.5.22	Property Inventory	Not Applicable
2.5.23	Policy & Procedure Documentation	Not a workflow
2.5.24	Alias Names	Not a workflow
2.6.1	State of California Billing Structure	Not a workflow
2.6.5	Authorization System Linkage	Not a workflow
2.6.6	Multiple Payors, Fee Schedules and Reimbursement Methods	Not a workflow
2.7.4	Wellness and Recovery Plans	Not Applicable
2.7.11	Pharmacy Management	Not Applicable
2.7.18	Clinical Evidence Based Practice Libraries	Not a workflow
2.7.19	Electronic and Paper Interface	Not Applicable
-	Full Service Partnership Referral assessments	Phase II
-	2034 homeless program	Phase II

Appendix III

San Mateo County Behavioral Health and Recovery Services
eClinicalCare System

DRAFT As-Is Process
Updated: 8/27/2007



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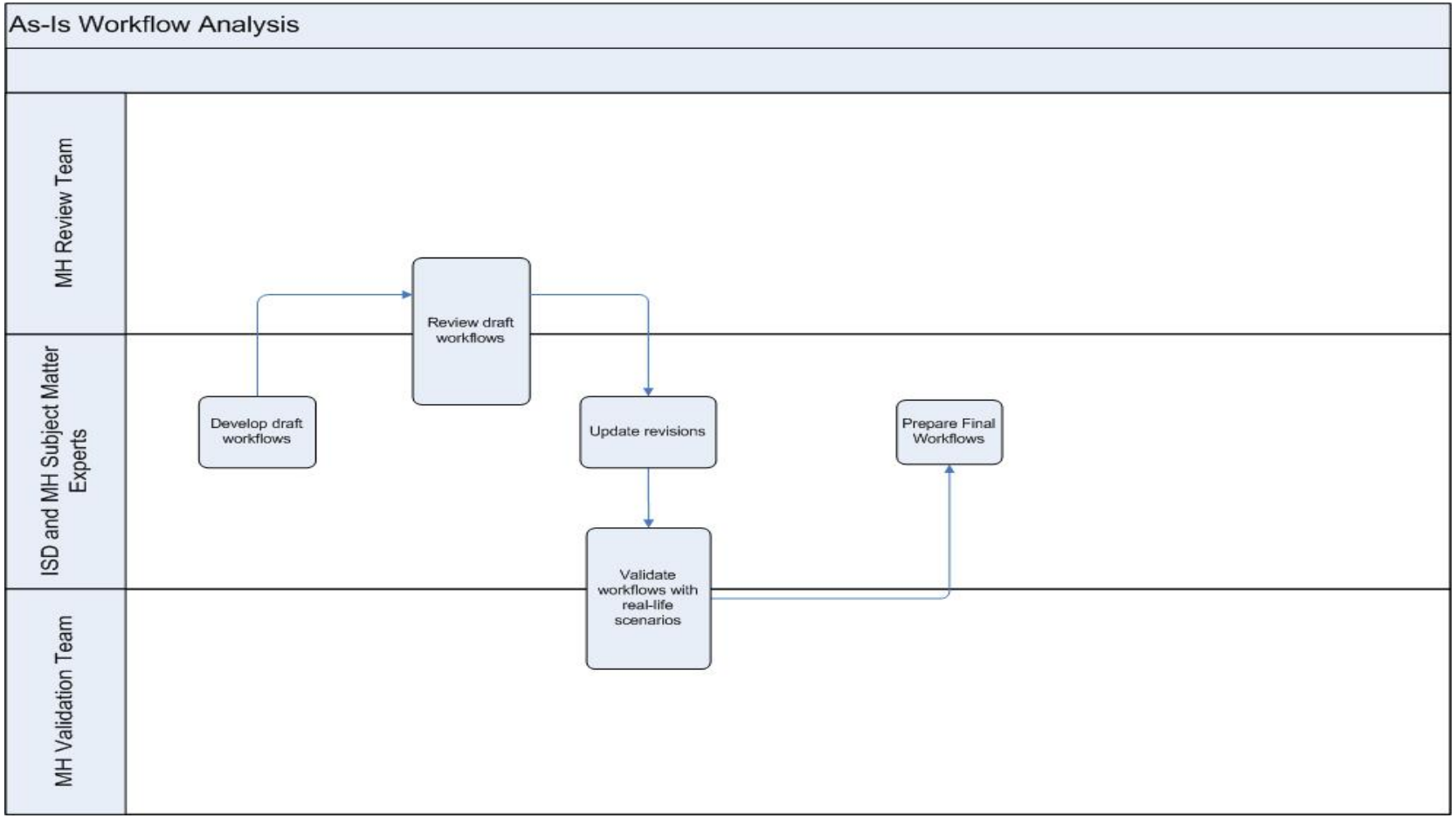
Appendix IV

San Mateo County Behavioral Health and Recovery Services
eClinicalCare System

DRAFT
Updated: 8/27/2007



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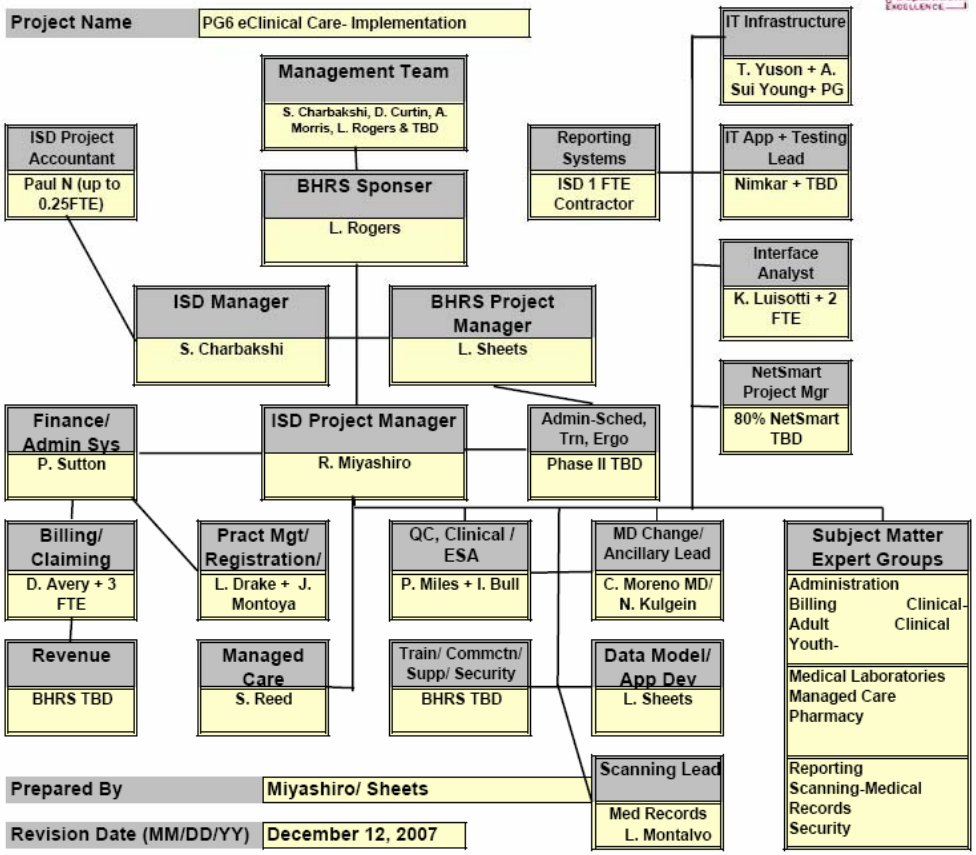
Attachment 3.1

Implementation Structure

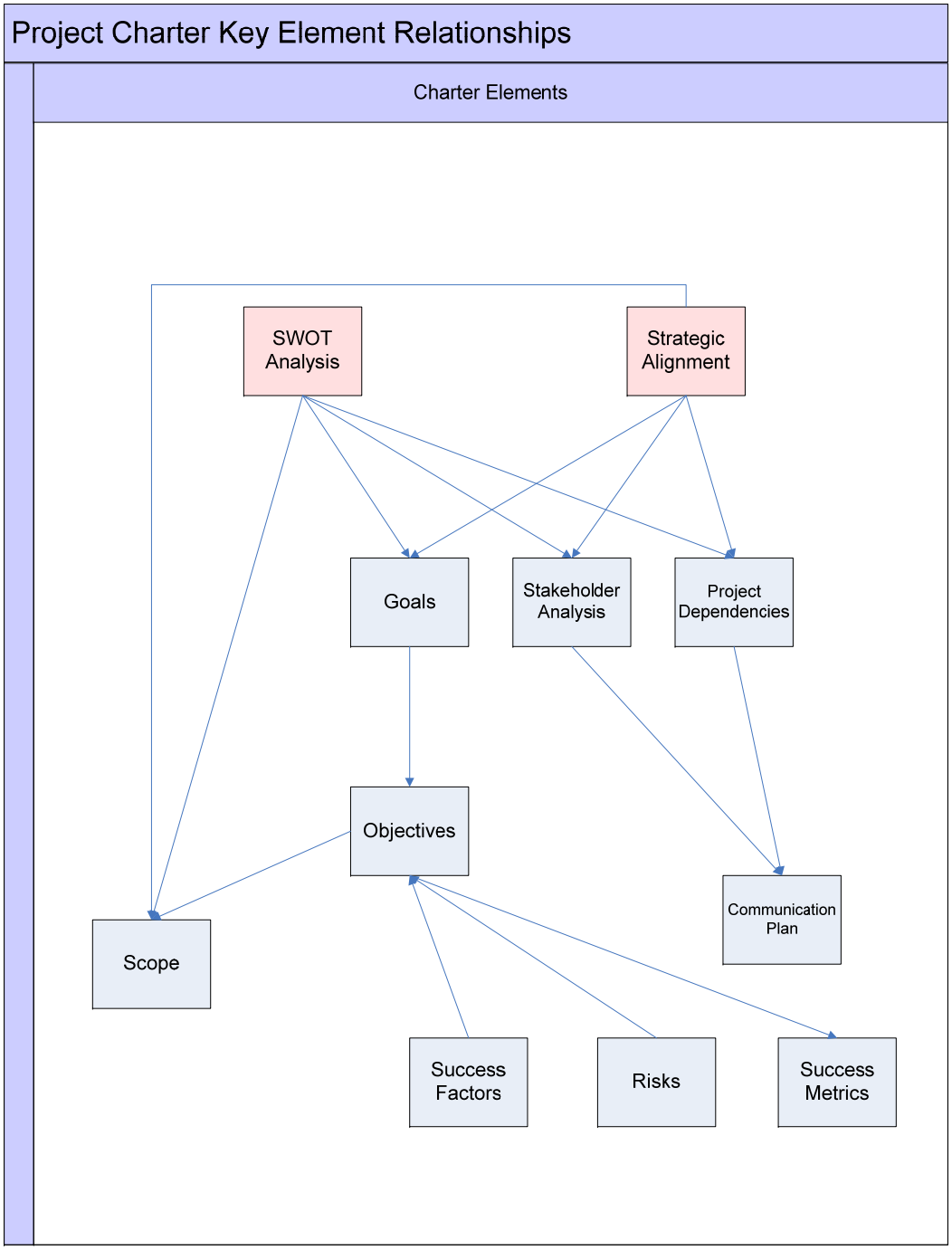
Proposed Implementation Structure



Attachment 3.2

Project Charter

Project Charter Key Element Relationships



Project Charter – SWOT Analysis Format

Strengths	Weaknesses	Opportunities	Threats
• Because of VAX, we know what we want and do • Talented Leadership • Humor • Optimistic Staff • Super-users – Staff who know how to use • E-progress notes exercise	• Staff turnover and retirement → Ongoing training orientations • Absence of effective solution for translations • Lack of computer proficiency in some staff • Jaded staff, failed exercises • Access to printers • Staff overwhelmed with current workload • Learning curve is long • Physical workspace – ergonomics • Diverse business practices • Scope of project is large; easy to make project mistakes • Staff may feel system is a threat to job function / organization	• Better, improved quality • MHSA money potentially available • State movement to Electronic Health Records • Network of care more available and accessible • Opportunity to work on best practices for EHR with other counties • Move at La Selva is an opportunity for better workstations, equipment • Personal Health Record potential for consumers / family • Opportunity to do more	• Increasing audits / risks • Directives may need (to) influence priorities against other factors • State regulations shift • Moves add stress

Project Charter – Strategic Alignment Format

System Goal	Initiative	eClinical Care System Alignment	Opportunities
Coordinated, integrated system	Full Service Partnerships	1. Clinical workstation with electronic health record/chart and treatment plan 2. Coordination and integration will also be supported through more timely access to clinical information from other providers including contract providers. 3. Coordination and integration through improved clinical reporting, due to more clinical information available electronically.	Offers possibility of improving coordination and integration of treatment planning and treatment
	Supported Education		
	Supported Employment		
System of care oriented to individual consumer and goals for wellness/recovery	Housing	1. Greater accessibility of client record, including tx plan, to client. 2. More timely accessibility. 3. Client information to support wellness/recovery around illness, recovery, meds.	Med sheets normally emphasize side effects

System Goal	Initiative	eClinical Care System Alignment	Opportunities
			and not what it's supposed to do.
	Senior Peer Counseling		
	Drop-in Center		
	Acute/Subacute coordination process-ghostbusters		
	Katie A response		
	Health Plan of San Mateo projects		
Consumer/family guided system of care	Paving the Way	1) More substantial clinical aggregate data available to consumer, family, policy makers and public.	May include info to what extent people making progress toward meeting goals.
	Consumer/Family Workers-Inspired At Work		
Consumer Financial Empowerment to support wellness/recovery	Financial Empowerment Project (FEP)	1) Increased accessibility of bills 2) Eligibility information and reminders	1) Making appts 2) Confirming appts
	Medicare Part D Prescription Coverage		
	Eligibility Improvements—MediCal, Healthy Families, Healthy Kids, CareAdvantage		
Cost Effective, Efficient Financial Mgmt of Mental Health System	Stabilize transition to FFS billing from case rate—billing edits, logic, compliance	1) Individualized Reporting and Help staying on top of finances for supervisors, managers, clinicians. 2) Contract limits and adjudication against contract limits.	1) Electronic notification and reminders to tie back to documentation.
	Rebuild revenue assumptions in FFS environment		
	Budget monitoring—revenues and expenditures		
Quality Improvement	Implement new E Clinical Care electronic health record, billing and other	1) Confidentiality – assist with security levels, encryption. 2) Improved Project Mgmt – BCAP tools	1) Make Policies & Procedures, QI FAQ and definitions available online through Help system.

System Goal	Initiative	eClinical Care System Alignment	Opportunities
	functionality.	3) QI Meds monitoring – review meds utilization	
	Implement strategies for improved communication/dialogue with MH workforce		
	Health Data store project as part of Health Dept for integrated data set for program planning and coordination of care		
	Documentation compliance and improvement training, reporting and monitoring		
	Peer Utilization Mgmt/Review process incorporating LOCUS/CALOCUS		
	QI Team youth EPSDT and other audits to prep for State audits		
	Confidentiality improvement		
	Contracting monitoring reporting tools		
	Improved project mgmt—BCAP tools		
Cultural Competence Improvement	Linguistic Access initiative	1) Technical assistance around tx planning that's culturally/linguistically focused.	1) Using alerts to flag special needs for clients 2) Reporting at team level 3) Translation of documents online
	Cultural competence retreat		

System Goal	Initiative	eClinical Care System Alignment	Opportunities
	Updated cultural competence plan tying original plan with MHSA initiatives		
	Cultural/linguistic intern program		
	MHSA Cultural disparity initiatives		
Learning organization/evaluating/accountability--QI	OBM--revisiting	1) Include OBM measures in data collection 2) Integrate Data Book into eCC reporting.	1) Reports will be accessible online to the level of individual clinicians.
	Performance Outcomes--MHSIP		
	Databook for 05-06		
	System reporting for program monitoring	1) We will collect an expanded data set in Avatar and can provide clinical reporting in addition to business performance. 2) Track individual client response to meds 3) Review prescribing patters of MDs by cost and dosage. 4) Provide guidelines for lab results of individual clients. 5) Flag when prescriptions are not refilled by clients. 6) Follow trends of which contacts become clients and which don't.	
	MHB reporting		
Consumer, community engagement through more welcoming, immediate, integrated, timely system of access	EPA access redesign pilot through Best Clinical and Admin Practices learning collaborative	1) Staff will have more timely access to integrated clinical data down to the level of front line clinicians. 2) Contact Tracking provides more flexibility. Can track work we do for those people who don't become clients. Don't need to collect as much info about Contacts. 3) Access points will have more information available about clients that	1) Web Services offer the opportunity to have "portals" for other constituents including Consumers, Primary Care, AOD services, Inpatient services, etc. 2) Create a Clinical Face Sheet based on feedback from clinical staff. Summarize critical info.

System Goal	Initiative	eClinical Care System Alignment	Opportunities
		have a history with us. 4) Create referral forms for other consumer services within eCC. Staff can complete and fax forms from eCC. Completed forms can be stored in client's chart. 5) Online forms will decrease number of times consumers are asked the same question to complete our forms. 6) Making clinicians' schedules available to front desk and other clinic staff is helpful to clients.	
	MHSA Outreach navigators/promotoras		
	Primary care interface expansions	Avatar facilitates a shared treatment plan.	We have the opportunity to share treatment plans. We have to identify what part of the treatment plan belongs to each provider.
	SMART		
	YFES hotline enhancement		
	Pathways Mental Health Court		
Improved physical plant more supportive of system goals and workforce	Youth Services Campus implementation	Having smaller physical charts may mean more physical space at clinics.	Won't have the same space requirements if charts are smaller.
	La Selva replacement	Use web services for client information portals.	Opportunity to provide computer access in clinic waiting rooms.
	New RWC site	Workflow analysis may show opportunities to improve use of space.	With upcoming clinic moves we have opportunity to place people differently.
	Renovations-North, Coast		
	Ergonomic improvements		
Workforce development	Workforce development and training plan for MHSA proposal	Avatar clinical software provides more information for analysis of individual and aggregate caseloads. Will have facts to support or dispel theories/ideas about caseloads.	
		1) Provide some decision support tools	Identify experts on diagnosis within our

System Goal	Initiative	eClinical Care System Alignment	Opportunities
		through treatment plan libraries and customized help system. 2) Provide definitions of clinical terms.	system. Develop best practices for diagnosis with them.
		Include Mental Health Policies and Procedures as part of customized Help.	

Project Charter – Goals & Objectives: Strategies & Tactics Format

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
1) Ensure timely adoption by all users.	i. Workflow of each user enhanced by timely access to relevant data.	User survey – Do you feel the workflow is enhanced in eCC? Are forms easy to understand and use? Compare pre-implementation and post-implementation time it takes users to: 1. get a client chart and 2. review client history		After each implementation, the eCC team will review whether their expectations of implementation were reasonable and if they need to change their approach.
	ii. Comprehensive user training	Percent of users trained at go-live. Percent of trained users using eCC over time. Number of transactions by user over time.	Use treatment plan libraries as a training device. Need to have training about what and how to chart for our clients. Concern expressed about immigration problems and associated notes as an example.	
	iii. Effective downtime procedures			Get a copy of SMMC downtime policies and procedures to use as a model for ours.
	iv. Emulate and enhance usability and accessibility of paper chart			
2) Enhance Coordinated, integrated system that improves quality of care by: i. Building upon and expanding integration of clinical, financial,	a1. Building upon and expanding access to existing electronic registration, eligibility / financial information, demographic, and tracking capability.	How many milestones from the work plan are completed on time? What percentage of functionality is available on go live?		Is all development work finished before we go live?
	a2. Provide clinical staff with user friendly views of relevant financial information.	Survey staff for user friendliness and relevance of financial information.		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
administrative and management systems. ii. Implementing comprehensive electronic health record instantly accessible to all authorized users. iii. Usable and useful Clinical Decision Support	a3. Ability to electronically input, store, and transmit Wraparound flexible funding requests and federally subsidized housing (Section 8 housing).			
	a4. Create tickler for SMI Medi-Cal clients' Section 8 application and re-certification.			Very hard to keep up with applications and due dates now. Part of the pipeline project with the Hope Project.
	b1. Convenient, current shared knowledge of consumer treatment and recovery plans, history and services.	At least 95% of VAX data is successfully converted and accessible on go live. User survey – Is access to client history, treatment plans and service data (better / worse / the same) than it was pre implementation?		To achieve this goal, active clients will need an active Treatment Plan. How will treatment plans be entered? Will clinical staff enter all for their caseload? Part of their caseload? None of their caseload?
	b2. Field-based access to records	What percent of users need field based access to charts and what percent of those users have field based access?		
	b3. Reduce time it takes to access client charts	Compare pre-implementation and post-implementation time it takes users to: 1. get a client chart and 2. review client history		
	b4. Comprehensive medication and laboratory history	eCC medication and laboratory data must equal or exceed 100% of what is available in VAX.		
	b5. Automated drug interaction database	Is it available on go live? How many users use the function? User survey – Are you using it and is it useful?		
	b6. Reduce time to transmit legible prescriptions to			

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	pharmacies			
	b7. Facilitate timely documentation	QI measures of late treatment plans and progress notes. Compare pre and post implementation results.		
	b8. Comprehensive clinical alert system	Maintain same level of service alerts that exist in VAX.		Alerts include Inpatient/PES notification, Jail booking/discharge notification, Urgent care plans, etc.
	b9. Integrate necessary client information from other sources	User survey: Is workflow to scan documents efficient? Are the criteria to select documents to scan clear and sufficient? Is the historical chart information useful? If not, what do you need to see? Are chart documents easy to review and find?		The objective will measure the success of chart scanning and the historical chart information.
	b10. Readable and legible charts			The objective will measure the success of chart scanning and the historical chart information.
	b11. Online access to best practice resources for specific clinical scenarios (i.e. co-occurring disorders)			
	b12. Include Release of Information within the chart. Include beginning and ending dates as well as what areas of information are covered by the release.			
	b13. Improve Client transfers among clinics		Need lots of work on workflow for these transfers. Primary informants are Unit chiefs. Line staff don't have	

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
			knowledge of client movement within the system. Need to interview Unit Chiefs directly.	
	b14. Facilitate receipt of SMMC Hospital discharge summaries for clinicians		Could summaries be faxed to an electronic fax server? Clinicians would be happier to have an interface with Invision or GUI as they call it to get discharge summaries delivered to them electronically.	
	b15. Have notifications of Inpatient/PES admissions and discharges to go to all clinicians involved with client's care			
	b16. Include meds info on the discharge summary to facilitate refills decisions for MDs			When clients are discharged from 3AB they often only have enough meds for several days. These clients then come to MH clinics for refills. Psychiatrists have very little information to go on when asked for refills and feel uncomfortable authorizing refills of a prescription made by another MD. If meds info was included on the discharge summary it would be easier for MDs to make decisions about refills.
	b17. Create Urgent Care notifications in order to communicate with medical staff at ER and primary care.			Alert them that clients requesting drugs are being seen at Mental Health. Also want to alert other clinicians of clients at risk of violence or suicide.
	b18. Develop ability to electronically refer clients from Mental Health to other agencies and/or services, particularly			Could the forms be consolidated – all the common elements appear on one form. When a form type is selected, only those fields required for the selected referral would

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	for the most common referrals – VRS, Housing, Contractors			display or those fields would be highlighted to be filled out (Caminar referral would have one set of highlights, VRS would have another set of fields highlighted.)
	b19. Facilitate communication between County Clinics and PPN providers – get info PPN submits for assessments, auths and re-auths. In return transmit information to PPN provider about treatment at the clinic.			Some clients are treated in clinics and PPN. A client may go to North County clinic for medication management and to the PPN for therapy
	b20. Combine PIN (Physician's Initial Note) and Purple (Adult Assessment)			
	b21. Ability to search progress notes by Treatment Goals – search by selected goals as well as finding those progress notes without a reference to goals.			
	c1. Clinic Report ideas: • Clients that haven't had an appointment for a user set time period • Clients that are no-show for a user selected time period and/or count of no-shows • Clients who show up in PES more than 3 times in two weeks.			

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	• Client costs • $$ earned by team			
3) Readily accessible information about consumers' treatment goals.				
	i. Family/consumer goals and objectives are easily available to the treatment team.	How many and what percentage of consumers have a wellness/recovery plan?		
	ii. Availability of up to date clinically supportive information and community resources for families and consumers.	How many times is the information database accessed? How many and what percent of users access the information database? Survey consumers and family members – How useful is the information from the database?		We need a process to collect and update information. Investigate if it's possible to link to the Network of Care resources database. It's a librarian function that logically is part of the QI workflow so that resource information is reviewed prior to being added. Information includes medication sheets, treatment and diagnosis information sheets, and referrals to community resources among others.
4) Consumer and Family guided system of care				
	i. Provide families/consumers information about the mental health system and best practices to inform their input and feedback to the system.	How soon after go live is aggregate reporting available on demand? Can report data be filtered by pre-set filters (e.g. time, program, age)? Survey – Are existing reports useful? What other information do you need?		The objective for this goal and the following one measures the ability to provide aggregate reporting. Can we get the right data out to the people requesting it in a timely way?
	ii. More readily accessible aggregate information to guide us in development programs that are	How soon after go live is aggregate reporting available on demand? Can report data be filtered by pre-set filters (e.g. time,		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	more responsive to consumer needs.	program, age)? Survey – Are existing reports useful? What other information do you need?		
	iii. Automated support for matching clients to clinically and culturally appropriate providers.	Survey the Access team authorizers – Do you use client provider matching? Is it useful? What would make it more useful? Search utilization report - How frequently is the Search used?		Refine the process based on survey feedback.
5) Increased accessibility of current eligibility status and changes to support family and consumer financial empowerment.				
	a. Additional assistance to families and consumers with eligibility linkages, concerns and follow-up.	Staff survey: What percent of staff time is spent on assisting consumers with eligibility linkages, concerns and follow-up? Is more time available than pre-implementation? Consumer survey: Have staff assisted you with eligibility linkages, concerns and follow-up?		This objective measures whether admin staff has more time to devote to assisting consumers with eligibility questions and concerns. Because of the demands of start-up, wait three months from clinic go live to survey.
	b. Staff reminders about appointments and follow-ups needed.	Staff survey - Is the tickler system working? Is it providing the reminders you need? Are there other reminders that you want to add?		
	c. Improved aggregate information to assist in population focused eligibility outreach.	Are reports available on demand?		
6) Continue to meet the financial performance of the legacy billing system in order to provide cost effective, efficient financial management of mental				
	a. Establish billing system equivalent to the performance of the legacy billing system.	Can eCC produce claims that meet or exceed VAX claims?		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
health system	b. Establish equivalent reporting tools for monitoring accounts receivable, productivity and revenues.	Can eCC produce the same reports and information available through the MH Accounts Receivable application?		
	c. Facilitate timely documentation.	QI measures of late treatment plans and progress notes. Compare pre and post implementation results.		
	d. Track contract limits	How soon after go live are contract limits for SOC and Managed Care providers enabled? User survey: Are the contract limit reports useful?		eCC will track contract limits of System of Care and Managed Care Providers. The functionality will be a little different for the two. System of Care contract limits will report on provider payments against the contract limit. Managed Care contract limits will be used for both reporting and claims adjudication.
	e. Use authorizations to control billing where necessary.	Does eCC's performance in allowing and blocking claims for authorized services meet or exceed VAX performance?		Authorizations are used for Day treatment, TBS and Managed Care. Managed Care auths are through the MSO module. The remaining auths are through Cal-PM.
	f. Expand Contracted Provider access to the electronic system. a. Sending/receiving electronic claims b. Access to client clinical and demographic information.	How many active users are Contracted Provider staff? Can eCC accept and process all electronic claim files submitted by contracted Providers? Is compliance documentation available to Contracted Providers electronically? Can providers lookup client eligibility information from eCC online?		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	g. CSI reporting	eCC's CSI reporting error rate must equal or be better than the VAX CSI error rate.		
7) Readily accessible individual and aggregate information to support quality improvement initiatives carried out at every level to support system wide continuous quality improvement.				
	a. Information to develop and carry out studies.	Are reports available on demand? Are all data elements available for reporting? How easy is it to add user defined fields to eCC? Utilization report – How often is each type of report used? User Survey – Are reports easy to use?		
	b. Information to support medication monitoring	Are reports available on demand?		
	c. Easier methods to review charts.	Can chart reviews be done online? User survey – How effective are online chart reviews?		
	d. Application of appropriate security rules for confidentiality			This objective will measure whether eCC's security matrix has the appropriate level of security.
	i. Implement security roles matrix	95% of users have the appropriate access at go live. What percentage of all help desk calls are from users with security problems – too much or too little?		
	ii. Implement security rules for remote laptop solutions	Same as above.		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	e. Readily accessible policies and procedures and QI Frequently Asked Questions			
	i. Customize electronic Help system to include easy look up of Mental Health policies and procedures and QI's Frequently Asked Questions.	User survey – Is the Help system useful? Can you locate policies and procedures easily? Do you use the policies and procedures in the Help system?		
	ii. Readily accessible policies and procedures and QI FAQ's	Survey or time users. How long does it take to get answers to your questions? Set a baseline now and compare with system implemented.		We won't have FAQ's in the Help system but the information within them will be in the Help system
8) Readily accessible individual and aggregate information to support improved cultural competence				
	a. Readily accessible consumer record that highlights individual cultural and linguistic attributes	User survey – Do you feel the workflow is enhanced in eCC? Are forms easy to understand and use? (from 1.a.) How often are the forms used?		
	b. Treatment planning library of goals and objectives that are culturally and linguistically proficient and speak to recovery based service.	Utilization reports		QI will need procedures for adding to the Treatment planning library. Measurement cannot start at go-live. Culturally and linguistically proficient goals and objectives will be developed over time.
	c. Accessible user-defined reports that will support team planning for unique characteristics of	Can users run reports on demand? User survey – Are reports		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	their population	useful?		
	d. Availability of translated documents and patient information forms			
9) Mental Health Services as a learning organization with continuing evaluation and accountability				
	a. Readily accessible aggregate information to support reporting on organizational performance and goal setting for continued improvement.	Can users run reports on demand? User survey – Are reports useful?		
	b. Improve co-occurring capability		Related to training staff for co-occurring disorders	
10) Consumer and community engagement through more welcoming, immediate, integrated and timely system of access				
	a. Readily accessible individual and aggregate information to support welcoming			
	i. Integrated contact tracking	Is the contact tracking log available at all access points? Baseline measure is the availability of the ICI at access points versus the Contact tracking log. Also, the time it takes to look up a contact.		
	ii. Providing information for a uniform level and quality of engagement procedures at all access points			
	1. Referral forms to county and	Are the forms available? Utilization of referral forms –		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	community services	which ones are used and how often? User survey – Do you use referral forms? Are there other forms you want to include?		
	2. Updated service eligibility information	Is service eligibility information available at all access points?		
	3. Reduction in the time to get a chart and or an ICI	Compare pre-implementation and post-implementation time it takes users to: 1. get a client chart and 2. review client history		
	4. Access to real-time scheduling	Is real-time scheduling available? User survey – Do you use scheduling for your appointments?		
	b. Increase welcoming and openness of access the Mental Health system of care.			
	1. Reduce redundancies in gathering information from clients.	Consumer survey – Have you been asked to provide redundant information? If so, have you experienced a reduction in the number of times you're asked for the same information?		We need to identify what redundant information is collected from clients and family members. We can collect some information from reviewing forms.
	2. Track Initiation and Engagement rates by program	Can users run reports on demand? User survey – Are reports useful?		
	3. User interface facilitates response to urgent client needs			

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
11) Workforce development				
	a. Readily accessible individual and aggregate information to provide information to clinicians, teams and the system about where there is a need for education, training and other supports.	Can users run reports on demand? User survey – Are reports useful?		
	b. On-line readily accessible FAQs, policies and procedures and other information.	Are Mental Health Policies and Procedures and QI FAQs available to providers online? Provider Survey – Do you use the online resources? Are Policies & Procedures and QI FAQs easy to access?		
	c. Build technical comfort and proficiency to support user adoption of future innovation.	User Survey – use the same survey from the eCC Team meetings. Send them our every 6 months and track the results.		
12) Project Management				
	a. On time	How many milestones are completed by the projected date in the work plan? How much earlier or later are the milestones completed?		
	b. On budget	Is the Netsmart contract within budget according to the Agreement, Exhibits and Project Plan? If not, what percent are they over/under? Are ISD costs within budget? If not, what percent are they over/under?		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	c. Change control process	All projects (Netsmart and internal) – Is the change control process clearly defined? Is the change control process used? User survey – Is the change control process too restrictive? Too loose?		
	1. Vendor			
	2. Internal development			
	3. Issues management			
	d. Inclusive decision making			
	e. Effective change management through frequent communication.			
	f. Establish project governance to manage change control processed			
	g. Effective risk analysis and management			
	h. Assure vendor contract compliance			
	i. Assure effective project management and ongoing maintenance through an effective working relationship with the vendor and ISD			
	j. Develop budget, resources and processes for ongoing maintenance of eCC			
	k. Work effectively with other Netsmart customers in a statewide organization to influence the alignment of Vendor			

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
	and State goals with our own.			
13) IT Goals	a. Build foundation for interoperability and enterprise health information integration.	Perform a gap analysis between County standards and the tools and standards supporting eCC every six months.		
	b. Implement a system that is maintainable and upgradable.	Maintain a list of product customizations, maintenance cost for each and how each is handled in product upgrades.		
	c. Usable system response times.			
	1. Hardware and software design and capacity to support usable response times.	Perform speed tests to determine if the metrics outlined in the Agreement Exhibit C are met. Test every six months.		
	d. Continuous system availability during standard business hours.	Maintain a log of uptime within Mental Health project team. Request a monthly report of uptime from ISD.		
	e. System provides minimal downtime and data loss because of robust backup and recovery systems.	The system was designed for no more than one hour of downtime during standard business hours (M-F, 7 a.m. until 7 p.m.). Every six months perform disaster recovery tests.		
		What percent of users have ready access to ergonomic workstations as of the date staff are trained at each implementation site?		
14) Infrastructure – Sufficient infrastructure to support ergonomically appropriate, ready	a. All County staff have access to equipment needed to access the electronic system.	Does staff have 100% access at training for each implementation site?		

Goals	Related Objectives	Measures	Strategies / Tactics	Notes
access to the electronic system.				

Project Charter – Stakeholder Analysis Format

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
Within Org.										
Admin, BH Management	Improve care, speed communication	There will be far reaching change both within each individual worksites, and among all clinics and central offices as staff will be able to see all activity related to a consumer and may have the ability to schedule at any clinic.	High	Enthusiastic, especially regarding scheduling.	Regular communication, identification of users requiring computer preparatory skills, and multi-modes of delivery, at least on-line and classroom for each application or function they will use.	Yes, for operational flow and user adoption.	Very Willing	Ready	Special participation in development and design of workflow and certain user screens. Direct Training and involvement	L. Drake
Finance/ MIS	Affect as aspects of worklife	Although their workflow may not change too much, each step and process will require retraining. In addition the project has ambitious parallel processing goals which will require long periods of dual work on two systems.	Highest	There will be a great deal of change involving almost every aspect of their worklife, but that at best, the change will result in a system that functions as well or nearly as well as what they already have.	Backfill, extensive conversion, testing, training, cash impact	Yes, direct Financial accountability	Willing	Ready	Special participation in development and design of interfaces, workflow, and certain user screens. Direct Training and involvement	P. Sutton
BH Clinical Users	Improve care, speed communication	Many clinical workflow processes	There will be far reaching change both within	Based on surveys, most staff are looking forward to the new system.	Regular communication, identification of users requiring	Yes for user adoption	Most users are willing with a few unwilling and a few very willing.	Most users are ready, with ranges from completely unready to	Newsletter, supervisor updates, training	P. Miles

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
			each individual worksites, and among all clinics and central offices as staff will be able to see all activity related to a consumer and may have the ability to schedule at any clinic.		computer preparatory skills, and multi-modes of delivery, at least on-line and classroom for each application or function they will use.			more than ready		
BH Supervisors	Improve care, speed communication	Far reaching changes relating to the logistics of finding records, updating progress notes, updating records, and other tasks.	High, change between and among sites.	Supervisors expect to server as cheer leaders for the project.	The same as for clinical staff. In addition, supervisors will need 2nd and 3rd level support to help them in their roles as on-site trainers and supervisors.	BH Supervisors will have a high level of accountability for user acceptance	Very Willing	Ready	Meetings, surveys, BH suggested modes of engagement	Training Project Lead (BHRS staff TBD)
BH Clinical Medical Users	Quality and communication	Electronic prescribing, Electronic signature	There will be a high degree of change in most aspects of physician transactions. They will move from a large paper environmental to a largely electronic	Medical users believe that they will have new features of electronic prescribing, electronic medical records and that these applications will work. Dr. Shah remarked that physicians expect that	There will be a high degree of change in most aspects of physician transactions. They will move from a large paper environmental to a largely electronic one especially in medication management and medical	Low	Willing	Ready with realistic expectations	Engagement through Physician centered events and training	C. Morena

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
			one especially in medication management and medical records.	there will be kinks to work out after go-live.	records.					
Health Dept Administration	Meet Goal 8 (see below)	BHRS System Improvements	As below	Expectations as below	As below	Operational, and fiscal oversight	Willing	Ready	Meetings, reports, and demonstrations	C. Silva, A. Morris
SM County CMO and Board	Meet County 2010 Visioning Commitment: Ensure basic health and safety for all. Goal 8: Help vulnerable people—the aged, disabled, mentally ill, at risk youth and others—achieve a better quality of life. The new system contributes by providing an electronic health record and other electronic tools to improve coordination of care and the delivery of mental health services.	Behavioral Health Care improvements	New electronic means of sharing appropriate clinical and administrative care to speed care and documentation to consumers, providers, and County government	Project will be successful in scope, time, budget, and quality	Sustained annual support through operational and capital budgets	Oversight by County Manager's Office—primarily fiscal	Willing	Ready	Periodic Meetings	C. Silva, L. Rogers, A. Morris
Partner User Agencies	Timeliness of information	On-line and existing reports	Moderate to high	Unknown	Periodic updates, and classroom training	Low	unknown	Unknown	Periodic meetings	L. Rogers
Partner Non-User Agencies	Timeliness of information	Ability to get information during project	Low to moderate	Expectations in-line with mgmt	Periodic briefings	Low	Neutral	Neutral	Periodic meetings	L. Rogers
ISD (Information Services Dep)	The existing BHRS system consumes 2.75 FTEs for support and at	All aspects of BHRS system support.	For some operational staff every aspect of interfacing	Some believe it will be a difficult and problematic implementati	Extensive training, and support. For at least two ISD team	High	Willing	Ready	Frequent Meetings	S. Charbakshi

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
	least that number again will be in implementation. This affects ISD operations and reputation as support department.		will change. In addition the parallel processing during conversion will involve a heavier workflow for many months.	ons with many features and interfaces not functioning. Others believe the project will work as designed, but will require a high degree of management to bring it to completion on time and on budget.	members, extensive back fill will be required for them to devote much of their time to this project.					
Outside Org.										
State of CA DMH	That the project will further the State's goals of having consumers served by electronic health records that improve quality of patient care and enhanced reporting and monitoring capabilities.	Clinical, Billing, Reporting, State Health Goals	The system improvements in clinical care in help bring the County and State in line with State and Federal goals.	Unknown	The DMH will require periodic formal written and oral reports, as well as participation in DMH work groups to prepare DMH staff to follow and monitor the benefits of this project.	Accountable for MHSA funds allocated towards this project	Very Willing	Very Ready	MHSA Grant application, periodic meetings, formal reports	L. Rogers
NetSmart	Company reputation, concern for quality product	Implementation and post-live enhancements.	Relatively low, customization requests by BHRS	Project will be complete on-time and on-budget	Netsmart and BHRS will need to develop better communication systems and improve their working relationship.	Yes	Partly willing to change	Unknown	Contracting process and meetings.	L. Sheets
BH	Quality and	Practice of	Varies by	Unknown	In person and	Partial	Unknown	Unknown	Meetings and	S. Reed

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
Contracted Providers	communication	SMMH Patients	percentage of patients who are from BHRS		mail-surveys will need to be conducted to gauge provider expectations for change and for training. In addition the project will need to offer periodic meetings and County sited training events.				mailings	

Project Charter – Stakeholder Analysis Format

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
Within Org.										
Admin, BH Management	Improve care, speed communication	There will be far reaching change both within each individual worksites, and among all clinics and central offices as staff will be able to see all activity related to a consumer and may have the ability to schedule at any clinic.	High	Enthusiastic, especially regarding scheduling.	Regular communication, identification of users requiring computer preparatory skills, and multi-modes of delivery, at least on-line and classroom for each application or function they will use.	Yes, for operational flow and user adoption.	Very Willing	Ready	Special participation in development and design of workflow and certain user screens. Direct Training and involvement	L. Drake
Finance/ MIS	Affect as aspects of worklife	Although their workflow may not change too much, each step and process will require retraining. In addition the project has ambitious parallel processing goals which will require long periods of dual work on two systems.	Highest	There will be a great deal of change involving almost every aspect of their worklife, but that at best, the change will result in a system that functions as well or nearly as well as what they already have.	Backfill, extensive conversion, testing, training, cash impact	Yes, direct Financial accountability	Willing	Ready	Special participation in development and design of interfaces, workflow, and certain user screens. Direct Training and involvement	P. Sutton
BH Clinical Users	Improve care, speed communication	Many clinical workflow processes	There will be far reaching change both	Based on surveys, most staff are looking forward to the	Regular communication, identification of users	Yes for user adoption	Most users are willing with a few unwilling and a few very	Most users are ready, with ranges from completely	Newsletter, supervisor updates, training	P. Miles

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
			within each individual worksites, and among all clinics and central offices as staff will be able to see all activity related to a consumer and may have the ability to schedule at any clinic.	new system.	requiring computer preparatory skills, and multi-modes of delivery, at least on-line and classroom for each application or function they will use.		willing.	unready to more than ready		
BH Supervisors	Improve care, speed communication	Far reaching changes relating to the logistics of finding records, updating progress notes, updating records, and other tasks.	High, change between and among sites.	Supervisors expect to server as cheer leaders for the project.	The same as for clinical staff. In addition, supervisors will need 2nd and 3rd level support to help them in their roles as on-site trainers and supervisors.	BH Supervisors will have a high level of accountability for user acceptance	Very Willing	Ready	Meetings, surveys, BH suggested modes of engagement	Training Project Lead (BHRS staff TBD)
BH Clinical Medical Users	Quality and communication	Electronic prescribing, Electronic signature	There will be a high degree of change in most aspects of physician transactions. They will move from a large paper environmental to a largely	Medical users believe that they will have new features of electronic prescribing, electronic medical records and that these applications will work. Dr. Shah remarked that physicians	There will be a high degree of change in most aspects of physician transactions. They will move from a large paper environmental to a largely electronic one especially in medication management	Low	Willing	Ready with realistic expectations	Engagement through Physician centered events and training	C. Morena

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
			electronic one especially in medication management and medical records.	expect that there will be kinks to work out after go-live.	and medical records.					
Health Dept Administration	Meet Goal 8 (see below)	BHRS System Improvements	As below	Expectations as below	As below	Operational, and fiscal oversight	Willing	Ready	Meetings, reports, and demonstrations	C. Silva, A. Morris
SM County CMO and Board	Meet County 2010 Visioning Commitment: Ensure basic health and safety for all. Goal 8: Help vulnerable people—the aged, disabled, mentally ill, at risk youth and others—achieve a better quality of life. The new system contributes by providing an electronic health record and other electronic tools to improve coordination of care and the delivery of mental health	Behavioral Health Care improvements	New electronic means of sharing appropriate clinical and administrative care to speed care and documentation to consumers, providers, and County government	Project will be successful in scope, time, budget, and quality	Sustained annual support through operational and capital budgets	Oversight by County Manager's Office—primarily fiscal	Willing	Ready	Periodic Meetings	C. Silva, L. Rogers, A. Morris

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
	services									
Partner User Agencies	Timeliness of information	On-line and existing reports	Moderate to high	Unknown	Periodic updates, and classroom training	Low	unknown	Unknown	Periodic meetings	L. Rogers
Partner Non-User Agencies	Timeliness of information	Ability to get information during project	Low to moderate	Expectations in-line with mgmt	Periodic briefings	Low	Neutral	Neutral	Periodic meetings	L. Rogers
ISD (Information Services Dep)	The existing BHRS system consumes 2.75 FTEs for support and at least that number again will be in implementation. This affects ISD operations and reputation as support department.	All aspects of BHRS system support.	For some operational staff every aspect of interfacing will change. In addition the parallel processing during conversion will involve a heavier workflow for many months.	Some believe it will be a difficult and problematic implementations with many features and interfaces not functioning. Others believe the project will work as designed, but will require a high degree of management to bring it to completion on time and on budget.	Extensive training, and support. For at least two ISD team members, extensive back fill will be required for them to devote much of their time to this project.	High	Willing	Ready	Frequent Meetings	S. Charbakshi
Outside Org.										
State of CA DMH	That the project will further the State's goals of having consumers served by electronic health records that improve quality of patient care and enhanced reporting and	Clinical, Billing, Reporting, State Health Goals	The system improvements in clinical care in help bring the County and State in line with State and Federal goals.	Unknown	The DMH will require periodic formal written and oral reports, as well as participation in DMH work groups to prepare DMH staff to follow and monitor the benefits	Accountable for MHSA funds allocated towards this project	Very Willing	Very Ready	MHSA Grant application, periodic meetings, formal reports	L. Rogers

Stakeholder	Why They Care	Aspects They are Affected By	Type and Degree of Change	Their Expectations	What Project Requires	Accountability	Willingness	Readiness	Engagement Strategy	Owner
	monitoring capabilities.				of this project.					
NetSmart	Company reputation, concern for quality product	Implementation and post-live enhancements.	Relatively low, customization requests by BHRS	Project will be complete on-time and on-budget	Netsmart and BHRS will need to develop better communication systems and improve their working relationship.	Yes	Partly willing to change	Unknown	Contracting process and meetings.	L. Sheets
BH Contracted Providers	Quality and communication	Practice of SMMH Patients	Varies by percentage of patients who are from BHRS	Unknown	In person and mail-surveys will need to be conducted to gauge provider expectations for change and for training. In addition the project will need to offer periodic meetings and County sited training events.	Partial	Unknown	Unknown	Meetings and mailings	S. Reed
Consumers and Families	Quality of Care and timelines of clinical information	Behavioral Health Care improvements	High	Mixed and cautious. Looking forward to personal health record.	On-going communication during implementation continuing through maintenance.	Low/None	Unknown	Unknown	Meetings, BHRS web site, Network of Care web site	L Sheets and Clinical Implementer

Project Charter – Risks, Mitigation Strategies, and Contingency Plans Format

Risk	Probability 1= low, 5 = high	Importance 1=low, 5 =High	Projected Impact	Stakeholders Impacted	Mitigation Strategy	Contingency Plan	Risk Owner
Budget	1	5	All	All		Delay Project	L. Rogers
Facilities	3.5	5	Schedule, Budget, Quality	ECC Users	Temporary space	Delay Project	L. Rogers
Personnel to Start	4	5	Schedule, Budget, Quality	ECC Users	User temporary staff and consultants	Delay Project	L. Rogers
AOD Integration Competition	4	3	Schedule, Budget	Implementation Team			L. Rogers
Paradigm Shift	2	5	Quality	All	Spot Training		L. Sheets
Brief Project Schedule	3	5	All	Project Management Team	Relax impact constraint(s)		R. Miyashiro
Vendor Capability	3	5	Schedule, Quality	Project Team and Sponsers		Stop project, change vendor	Miyashiro/Sheets
Technology	3	4	Quality	ECC Users			L. Rogers
Personnel Turnover	4	4	Schedule, Budget	Implementation Team, Sponser	Maintain ability to hire temps/consultants quickly	Engage NetSmart to fill in.	L. Rogers
Training staff to use new and old systems	4	3	Schedule, Quality	Implementation Team, ECC Users			MH Supervisors
Running to MH systems in parallel	4	3	Schedule, Budget, Quality	Billing			P. Sutton
Interactions w/ other departments	5	5	Schedule, Budget, Quality	All			L. Rogers
Project Visibility and Size	5	5	Schedule, Budget, Quality	All County			L. Rogers
Level of Integration	5	5	Schedule, Budget, Quality	All			L. Rogers
Security	5	4	Quality	Consumers, ECC Users			Project Training Lead
Involvement of Consumers & Families	Unknown		unknown	All			L. Rogers

Project Charter – Critical Success Factors Format

Critical Success Factor	Strategies to Maintain CSF	CSF Owner
Factor 1		
On Time	All tasks within four weeks at time of monthly Steering Committee meeting.	Rand Miyashiro
Factor 2		
On Budget	Steering Committee review will be triggered if project is 5% over budget overall, or if the latest month is 15% overbudget	Rand Miyashiro
Factor 3		
Improving Patient access by decreasing appointment time for previously registered patients		Pat Miles
Factor 4		
Improving Patient care by decrease in time in first availability of patient progress notes, treatment plans		Pat Miles
Factor 5		
User Satisfaction with system	Steering Committee review will be triggered if the 2nd Quarterly survey after user go-live has 30% or more unsatisfactory responses.	Lorrie Sheets
Factor 6		
Other clinical measures		Pat Miles
Factor 7		
Timely Adoption of system by end users	Preparatory surveys of ergonomics, computer equipment, training delivery and user testing.	Louise Rogers

Project Charter – Success Indicators and Metrics Format

Success Indicator	Stakeholders Benefited	Defined Metrics	Target Outcome for Metric	How to Implement Metric	Owner
Objective 1					
On Time	All	Deliver project modules on schedule	Plus or minus 1 weeks	Project Plan	R. Miyashiro
Objective 2					
On Budget	County, Health, BHRS Administration	Deliver project modules on or under budget	Plus or minus one US dollar (including contingency)	Project Budget	R. Miyashiro
Objective 3					
Improving Patient access by decreasing appointment time for previously registered patients	All	Decrease average pt appt time by x % based on East Palo Alto			R. Miyashiro
Objective 4					
Improving Patient care by decrease in time in first availability of patient progress notes, treatment plans	All	Decrease in unavailability of docs by x % based on time study			L. Sheets
Objective 5					
User Satisfaction Survey	All	Decrease in end user satisfaction by x percent			L. Sheets
Objective 6					
Other clinical measures		consult clinical team leaders			Pat Miles
Objective 7					
Adoption of Phases Pilot-Phase 3 by end users		95% adoption within 2 weeks by end users			L. Rogers

Project Charter – Project Dependencies Format

Project	Nature of Dependency	Strategies to Prevent Conflicts	Owner
Division Level Projects			
None identified			
Department Level Projects			
Alameda Avenue Office Buildout	Space for new staffing	Delay project until space is available	L. Rogers
County Level Projects			
None identified			
State Level Projects			
MHSA Funding for Electronic Health Record	Financing for E.H.R. and other clinical portions of system.	Set up project accounting and management to identify clear clinical goals and financial tracking to be able to clearly apply future MHSA funding to qualified project areas.	P. Sutton
Federal Level Projects			
None identified			

Phase/ Item	Goal	Message	Vehicle/ Receiver	Developer	Approver	Deliverer	Timing: Development	Timing: Approval	Timing: Delivery	Feedback Method	Owner
Start-Prototype											
Wellness Matters newsletter	Update	Project Status	Internet / All stakeholders	LS	LR	ECC	M	M	M	Meetings, Email, verbal, phone	LS
Presentations	Update	Project Status	Verbal/ Boards	LR	LR	BHRS	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal/ All Staff, Contractors	ECC	LR	ECC	M	M	M	Verbal	LR
Reports	Update	Project Status	Written/ Boards, all	ECC	LR	TBD	M	M	M	Written	LR
Reports	Update	Open Issues	Written/ Team, others	RM	LS	RM	M	M	M	Written	RM
Reports	Update	Contact List	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Reports	Update	Vacation Schedules	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Prototype Phase I											
Email	Update	Project Status	Email/ list	Trainer	LR	ECC	M	M	M	Email, meetings	LS
Wellness Matters newsletter	Update	Project Status	Internet / All stakeholders	LS	LR	ECC	M	M	M	Meetings, Email, verbal, phone	LS
Presentations	Update	Project Status	Verbal/ Boards	LR	LR	BHRS	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal/ All Staff, Contractors	ECC	LR	ECC	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal / Consumers, Family Members, Community	ECC	LR	Clinical Implementer	Quarterly	Quarterly	Quarterly	Verbal, Email, phone	LR
Reports	Update	Project Status	Written/ Boards, all	ECC	LR	TBD	M	M	M	Written	LR

Phase/ Item	Goal	Message	Vehicle/ Receiver	Developer	Approver	Deliverer	Timing: Development	Timing: Approval	Timing: Delivery	Feedback Method	Owner
Reports	Update	Open Issues	Written/ Team, others	RM	LS	RM	M	M	M	Written	RM
Reports	Update	Contact List	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Reports	Update	Vacation Schedules	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Phase I- Phase III											
Email	Update	Project Status	Email/ list	Trainer	LR	ECC	M	M	M	Email, meetings	LS
Fliers	Update	Go-Live Events	Post/ locations	ECC	LR	ECC	Episodic	Episodic	Episodic	Email, Meetings	LR
Intranet	Update	Project Status	Intranet/ All	ECC	BHRS	ECC	M	M	M	Meetings	LS
Wellness Matters newsletter	Update	Project Status	Internet / All stakeholders	LS	LR	ECC	M	M	M	Meetings, Email, verbal, phone	LS
Presentations	Update	Project Status	Verbal/ Boards	LR	LR	BHRS	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal/ All Staff, Contractors	ECC	LR	ECC	M	M	M	Verbal	LR
Presentations	Update	Project Status	Verbal / Consumers, Family Members, Community	ECC	LR	Clinical Implementer	Q	Q	Q	Verbal, Email, phone	LR
User Surveys	Update	Project Status	Written/ PM, CL	ECC	ECC	ECC	Q	Q	Q	Written	LS/ PM?
Focused Neilen User Survey	Update	Project Status	Interview/ PM, CL	ECC	ECC	ECC	Q	Q	Q	Verbal/ written	LS
Reports	Update	Project Status	Written/ Boards, all	ECC	LR	TBD	M	M	M	Written	LR
Reports	Update	Open Issues	Written/ Team, others	RM	LS	RM	M	M	M	Written	RM
Reports	Update	Contact List	Written/ TBD	TBD	RM	TBD	M	M	M	Written	RM
Reports	Update	Vacation	Written/	TBD	RM	TBD	M	M	M	Written	RM

Phase/ Item	Goal	Message	Vehicle/ Receiver	Developer	Approver	Deliverer	Timing: Development	Timing: Approval	Timing: Delivery	Feedback Method	Owner
		Schedules	TBD								
Post Phase III											
In Person	Updates	Issues	Staff Mtgs/PM, CL	S	BH	S	M	M	M	Verbal	S
Intranet	Updates	All	All County	Trainer	BH	Trainer	Q	Q	Q	TBD	LR

Key to Above Table:

AD= Administrative Staff
BH= BHRS Management
C = Consumers
CL= Clinical Staff
ECC= eCC Project Leader
LR= Louise Rogers
LS= Lorrie Sheets
M= MH Advisory Board
P= Contracted Providers
PM= Pat Miles
RM= Rand Miyashiro
S= MH Supervisors
T = eCC Project Team