APS Healthcare

Final Report

CAEQRO Report, FY11-12

Sacramento

Conducted on

September 14 - 16, 2011

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❖INTRODUCTION❖

BACKGROUND AND METHODOLOGY

The California Department of Mental Health (DMH) is charged with the responsibility of evaluating the quality of specialty mental health services provided to beneficiaries enrolled in the Medi-Cal managed mental health care program.

This report presents the fiscal year 2011-12 (FY11-12) findings of an external quality review of the Sacramento County mental health plan (MHP) by the California External Quality Review Organization (CAEQRO), a division of APS Healthcare, from September 14-16, 2011.

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

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for Key Components associated with the four domains: quality, access, timeliness, and outcomes. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups and other stakeholders serve to inform the evaluation within these domains. Detailed definitions for each of the review criterion can be found on the CAEQRO Website www.caeqro.com
- Analysis of Medi-Cal Approved Claims data
- Two active Performance Improvement Projects (PIPs) – one clinical and one non-clinical
- Three 90-minute focus groups with beneficiaries and family members
- Information Systems Capabilities Assessment (ISCA) V7.2

❖FY11-12 REVIEW FINDINGS❖

STATUS OF FY10-11 REVIEW RECOMMENDATIONS

In the FY10-11 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY11-12 site visit, CAEQRO and MHP staff discussed the status of those FY10-11 recommendations, which are summarized below.

ASSIGNMENT OF RATINGS

- Fully addressed – The issue may still require ongoing attention and improvement, but activities may reflect that the MHP has either:
  - resolved the identified issue
  - initiated strategies over the past year that suggest the MHP is nearing resolution or significant improvement
  - accomplished as much as the organization could reasonably do in the last year

- Partially addressed – Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues

- Not addressed – The MHP performed no meaningful activities to address the recommendation or associated issues.

KEY RECOMMENDATIONS FROM FY10-11

- Develop specific measurable indicators for the adult service delivery system in order to evaluate the effectiveness of services, the impact of the current programmatic limitations recently implemented, and any future system redesigns that will affect overall outcomes for the adult population:
  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  To address this recommendation, the MHP has:

  - developed measurable timeliness indicators for both Adult and Children's programs

- disseminated these timeliness indicators through the Quality Improvement Committee (QIC) and Adult and Children providers meetings; timeliness language was added to provider contracts
- dedicated resources to train providers and county staff on using AVATAR reports to monitor timeliness criteria

However, the MHP has not yet:

- reviewed timeliness data captured by AVATAR as system implementation is underway
- assessed if there are current or different programmatic limitations for Adult versus Child Systems of Care (SOC)
- evaluated program capacity, as they are waiting on the first cycle of data

- Implement the no-show codes and a formal process of tracking timeliness for all consumers seeking services. Initiate quality improvement activities to address areas that indicate poor performance related to the MHP's minimum performance standards for timeliness:

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

The MHP has created no-show, cancelled and engagement codes to track types and timeliness of services. Further, training on the use of these codes was incorporated into both AVATAR and Quality Management Clinical documentation trainings to ensure that both clinical and administrative staff were fully informed. Since then, a number of quality improvement (QI) activities have started at both the MHP and providers to review the use of these codes to inform practice and services. Presently, three AVATAR reports are produced to monitor these activities.

- Examine strategies to improve the inclusion of consumer/family members including currently employed consumer and family members (CFMs) for future planning regarding the adult service system and elicit ideas about how to effectively communicate outcomes of a final court decision:

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

The MHP has implemented or continued a number of strategies/initiatives to improve CFM input and involvement.

- CFMs/caregivers continue to play an active role on the MHSA Steering Committee with the goal that they constitute 50 percent of members. A sub-committee was formed comprised solely of CFMs to help develop agenda items and topics of discussion.

- CFMs from diverse cultural, racial and ethnic communities are actively recruited to serve on program development teams.
- The MHP actively recruited and supported the inclusion of CFMs and caregivers throughout the Workforce, Education and Training (WET) and Prevention and Early Intervention (PEI) community planning processes and early implementation phases.
- An Innovation Workgroup, including CFMs and youth advocates, was formed in October 2010 to provide input on the proposed redesign of the Adult SOC.
- CFMs and caregivers from diverse cultures are active participants on MHP Evaluation Teams for various programs as applicants are considered in the competitive bid process. They are a part of the final recommendations made to the Department of Health and Human Services (DHSS) Director and MHP Deputy Director.
- The MHP contracts with Mental Health America (MHA) of Northern California to provide advocacy and support services for children, youth, older adults, and family member and caregivers. MHA works closely with the MHP to solicit CFM input and participation in various initiatives and an Expert Pool has been developed. Participants in the Expert Pool:
    - provide input on future planning activities for both SOCs
    - serve as members on Training Partnership Teams that provide education
    - provide trainings to community members and stakeholders
    - participate in a Mental Health Promotion Project which focuses on the promotion of mental health awareness and reducing stigma and discrimination
    - are members of the MHP Speaker's Bureau to promote awareness and understanding of mental health and wellness
    - attend trainings/conferences paid by the MHP to promote learning and enhance leadership skills.

While still awaiting the final court decision regarding pending litigation about redesign of the Adult SOC, the MHP Director keeps the Mental Health Board and other appropriate committees apprised of updated information.

- Develop trainings and quality improvement activities that will ensure providers will correctly document identification of primary care providers and physical health conditions that will promote coordinated care with medical providers and support the MHP's PIP regarding coordination of care for persons with serious mental illness and co-morbid health issues:

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

The MHP's Non-Clinical PIP is focused on Primary Care (PC) integration and is targeting how PC provider and consumer medical information documentation is being

incorporated into the treatment plan, IT system and then monitored for quality improvement.

Further, the MHP has partnered with its PC Division to achieve the following:

- Provide in-service training on integration, what it means and how to do it, to clinicians at the four Regional Support Teams (RSTs).
- Provide good health care information to consumers at the annual Consumer Speaks Forum, focusing on the importance of physical health, self management of chronic conditions and advocacy for their own treatment, in addition to how to work with both their mental health and primary care provider.
- Train/educate CFMs on common health issues.
- Train MHP Program Directors and Psychiatrists.

- Continue the collaborative efforts with the Hospital Council members to promote overall transparency for consumers who engage with local emergency departments, psychiatric hospitals and urgent care providers to ensure appropriate utilization of services and short wait times for medical clearance and admissions, if appropriate:
☒ Fully addressed ☐ Partially addressed ☐ Not addressed

The Community Mental Health Partnership, formerly the Hospital Council, consists of small groups of community health care providers, mental health care providers, CFMs, patients' rights advocates and law enforcement personnel. A strategic plan for crisis response in Sacramento County is still being addressed; meetings facilitate community dialogue, idea exchange, ongoing system redesign efforts, and community collaboration.

In the past year, to address the issue of crisis response and hospital discharge planning, the MHP has:

- Expanded the Intake and Referral Team to a 24 hour capacity to coordinate care of consumers who enter a local emergency room (ER)/other psychiatric facility, and to provide linkage and clinical information for MHP staff/contract providers.
- Worked with the UC-Davis ER to have a MHP clinician responds to support and coordinate care of consumers. The clinician has real-time access to AVATAR system to provide linkage and collateral information to the UC-Davis psychiatric team.
- Developed a process to alert the adult and children outpatient systems when a consumer is hospitalized to ensure that linked outpatient providers are notified that one of their consumers is currently hospitalized so discharge planning with the acute care provider can occur.
- Tasked the ACCESS team with providing expedited outpatient referrals for hospitalized clients to ensure, when discharged, consumers are linked the aftercare services to mitigate re-hospitalizations.

- Made Intensive Placement Team (IPT) staff available to meet consumers in hospital to support the discharge planning process, provide consultation and LOCUS evaluations so that the most appropriate and least restrictive level of care can be provided.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

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

- The MHP plans in 2010 to restructure their Adult outpatient system prompted a federal court lawsuit and subsequent court injunction (see *Napper v. County of Sacramento).* No agreement between parties could be reached and an impartial expert review of the system was ordered (see following bullet point). The Expert's recommendations are now being considered by the court and two parties, and settlement is pending. The points of agreement will direct MHP redesign efforts and initiatives going forward. In order to sustain the system at the level of service at the time of the court injunction, the County general fund contributed $8 million.

- In May 2011, the Independent Expert Review was released publicly. It included recommendations on a variety of practice and programmatic changes and impacts timeliness, quality and access to services.

- The MHP developed and shared their "Vision for Crisis Services" with various committees and stakeholder groups. This vision encompasses a continuum of pre-crisis/prevention, crisis, and post-crisis services.

- Full Electronic Health Record (EHR) implementation continued per the MHP's Five-Year IT Plan. This involved the refinement of administrative and tracking reports, and conducting 22 clinical requirement gathering sessions with at least 364 attendees (clinicians, psychiatrists, supervisors, consumers, family members, and administrative staff). As a result, a Clinicians Work Station (CWS) was created and the pilot phase of this initiative is starting to rollout at three sites.

- The MHP was certified by the Special Master as achieving the 4 percent Therapeutic Behavioral Services (TBS) threshold. They did this with help of their Transition Age Youth (TAY) targeted programming and the creation of a Full Service Partnership (FSP) called the Juvenile Justice Diversion and Treatment Program. It provides mental health

services and supports for youth and their families involved in the juvenile justice system that have a serious emotional disturbance, both pre- and post-adjudication.

- The Assessment and Treatment of Onset of Psychosis program was awarded to UC-Davis to expand its internationally recognized Early Diagnosis and Preventive Treatment (EDAPT) of Psychotic Illness program. The program, named SacEDAPT, now provides services to children and youth ages 12 to 25 who meet criteria for early onset of psychosis.

- PC service integration continued. This includes the following initiatives:
  - CALMEND collaboration - Sacramento has been one of seven counties developing an integrated service approach to better meet PC needs for consumer.
  - Development of a Low Income Health Plan in Sacramento County involving PC/Behavioral Health collaboration.
  - A PIP focusing on improving access to primary care services and treatment for consumers served in adult mental health system.
  - Creation of an MHSA PEI program to develop and expand behavioral health services through County Federally-Qualified Health Center (FQHC) and Community health care clinics to provide screenings, assessments, and brief treatment for early detection of depression, anxiety, substance abuse and trauma-related symptoms.

- The submitted Cultural Competence Plan (CCP) update of 2010 builds on the previous plan of 2003 and incorporates more recent research that identifies eight domain levels that are necessary to affect change and progress towards a culturally and linguistically competent mental health system.

- A 22-week training for the Sacramento Police Department was conduced by CFMs and clinical staff. This Crisis Responder Training started in March 2011, and is integrated into the regular police department in-service to provide all field officers a time in the curriculum to understand mental illness, the perspective of CFMs' lived experiences, and alternatives. As of the review, 11 of the 22 trainings have been completed for 330 police officers.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Quality

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

Figure 1. Quality

Component		Present	Partial	Not Present	Not Rated
1A	Quality management and performance improvement are organizational priorities	X			
1B	Data is used to inform management and guide decisions	X			
1C	Investment in information technology infrastructure is a priority	X			
1D	Integrity of Medi-Cal claim process, including determination of beneficiary eligibility and timely claims submission		X		
1E	Effective communication from MHP administration	X			
1F	Stakeholder input and involvement in system planning and implementation	X			
1G	Consumers and family members are employed in key roles throughout the system	X			

Issues associated with the components identified above include:

- The MHP demonstrates a commitment to the QI function. The Executive Management team/Quality Policy Council meets bi-weekly and the Executive QI committee meets as needed. The formal QIC meets monthly and has various subcommittees that report to it, including Research/Evaluation, Pharmacy/Therapeutic, Credentialing, Medication Monitoring, Utilization Review (UR), Cultural Competency (CCC), Education, Focused Clinical Quality Review, and Grievance. Data of various kinds is used by the QIC to inform performance, initiatives, and policies. In the last year, the committee developed policy and procedures pertaining to 5150 designees, certification and facilities; AVATAR

billable/non-billable activities and codes; and a service code training guide. The QIC also has an Adverse Incident review process that engages in performance review for every consumer death.

- The MHP's use of Crystal Reports is excellent and they also employ Excel and Access software tools. The QIC set baselines for system improvement in four areas stemming from information collected during their FY09-10 External UR. Improvements were seen in two of four areas compared to FY08-09 data. In addition, results from various outcomes measures are reported on at different reporting periods. These outcome reports are distributed to interested parties, including internal staff/management and interested stakeholders. Quarterly timeliness statistics are reported to the QIC and Management Team. The MHP also implemented the use of unique codes to identify no-show, cancellation and engagement appointments to track types of services and service timeliness.

- Since the FY10-11 CAEQRO review, the MHP hired one full-time technology staff person and also contracted with Netsmart Technologies for one full-time experienced Analyst to assist with AVATAR CWS implementation. However, Information Technology staffing remains understaffed with too many work duties for too few staff for a large MHP. They currently have four full-time technology staff; three of the staff has advanced level subject-matter expertise to support their technology-related projects.

- Since the implementation of Short Doyle/Medi-Cal (SD/MC) II system in early 2010, claim submissions have not been timely for beneficiaries with Medicare/Medi-Cal eligibility or Other Health Coverage (OHC) eligibility. Medicare and OHC claims must be billed before the submission of Medi-Cal claims. This year the MHP began to analyze denied claims data to determine the causes of various denials, leading to strategic changes to decrease the associated loss of revenue.

- The MHP's effective communication efforts/initiatives including the following:
  - Providing IS access to contract providers so they may enter consumer data and submit claims electronically
  - Various ongoing staff trainings on AVATAR, billing, etc.
  - Creation of a County/Provider Executive Leadership series to communicate issues with executive management
  - Email, webserver, web-ex usage to communicate to MHP staff
  - External memos regarding coding, training, changes in policy etc., to providers, inpatient hospitals, new policies from MHP leadership
  - Online records access for consumers through the Network of Care system
  - Flyers in all threshold languages advertising available services for consumers.

- The MHP evidences numerous opportunities for stakeholders to provide input on system planning and implementation, including:
  - The Adult PC PIP Committee is comprised of representatives from internal MHP staff from various service teams, contract providers, family advocates, and PC providers with CALMEND
  - Participation in the County Emergency Task Force
  - Surveying Staff to provide user input to aid AVATAR implementation
  - Contractors now have various forums for involvement – AVATAR user forums, leadership meetings, and focused AVATAR implementation meetings
  - A system-wide Community Outreach and Engagement Committee (an outgrowth of the CCC) engages diverse providers, CFMs, community advocates and Community-Based Organizations (CBOs)
  - The MHSA Steering Committee and MHSA Innovations Workgroup includes CFMs and youth from diverse communities
  - The Patients Rights Advocate sits on the Hospital Council in an effort to make local emergency rooms more consumer friendly
  - CFMs are now a part of the MHP's Competitive Bid Evaluation Teams and participate in making final recommendations to Executive Management
  - MHP leadership has shared their Vision for Crisis Services with various committees and stakeholder groups
  - Youth/consumer, family member/caregiver voice from diverse communities has been expanded into numerous programmatic and training initiatives
  - Continued development of the consumer Expert Pool to develop more capacity for all programs incorporating the consumer voice - meetings are monthly and this has led to the creation of a consumer panel which participates in the law enforcement training
  - Inclusion of the consumer voice into the training of UC-Davis psychiatric residents as part of ongoing curriculum
  - Expansion of the use of peer partners - Four are involved in teamings as Recovery Educators, including Vietnamese and Hmong speaking peers

- The MHP contracts with a number of providers for CFM employees. While a few are embedded in MHP Administration and liaise with Executive Management, a larger representation of CFM staff are peer parents at contractors such as Transitional Community Opportunities for Recovery & Engagement (T-Core) or Human Resource Consultants (HRC), or serve consumers of various cultures/languages at one of the two

county aftercare clinics. A number of CFM employees supervise other CFM employees as Program Coordinators or Consumer Affairs staff.

Access

CAEQRO identifies the following components as representative of a broad service delivery system which provides access to consumers and family members. Examining capacity, penetrations rates, cultural competency, integration and collaboration of services with other providers form the foundation of access to and delivery of quality services.

Figure 2. Access

Component		Present	Partial	Not Present	Not Rated
2A	Service accessibility and availability are reflective of cultural competence principles and practices	X			
2B	Manages and adapts its capacity to meet beneficiary service needs	X			
2C	Penetration Rates are used to monitor and improve access	X			
2D	Integration and/or collaboration with community based services	X			

Issues associated with the components identified above include:

- Sacramento County has five threshold languages and the MHP provides forms, flyers, and notices in all five languages while also maintaining document translation in two additional languages that have been threshold languages in the past. The MHP uses service availability data by race/ethnicity and age to assess new consumer service access. This year, they also developed a continuum of services from prevention to intervention relating to crisis response capabilities in the community.

  In addition, multiple PEI initiatives are being operationalized this year, including:

  - Expansion of Suicide Prevention Crisis Line to include more volunteers and expand language capacity of volunteers
  - Development of a consumer-operated Warm line
  - Continued support of community connections which targets outreach and education to multiple diverse communities (including Hmong, Vietnamese, Cantonese, Latino, Russian/Slavic, Native American, African American, Older

Adults, college students and faculty, and TAY, with emphasis on LGBTQ, the homeless, and foster children)

- Creation of SeniorLink, an outreach and support service to multicultural older adults experiencing isolation and depression
- Implementation of a Social Skills, Violence Prevention and Family Conflict Management school- and community based-program, a collaborative effort between the MHP, a CBO, Sacramento County Office of Education and 13 local school districts. This includes the launch a county-wide Bullying Prevention Training and Education Program.

- The MHP engaged in a number of efforts to manage and adjust overall system capacity. This includes:
  - Significantly improving the client tracking process for admissions and discharges with local hospitals by expanding the Intake and Referral Team to a 24 hour capacity
  - Using a daily report to alert the adult and children outpatient SOC when a client is hospitalized or a discharge is planned
  - Adjusting referral strategies at Children's Access in order to refer youth and families to sites closer to their homes
  - Adding at least three new providers/stakeholders - "Goals for Women" which focuses on African American women, the Slavic Assistance Center, and the CA Rural Indian Health Board
  - Implementation of a TAY FSP to provide mental health services and supports for youth involved in the juvenile justice system who have a serious emotional disturbance
  - Expanding The Mental Health Treatment Center's (MHTC) care coordination services for Adult Intake Unit to 24/7, 365 days. While they still do not accept patient arrivals at night, they do provide phone case consultation, resource linkage/networking, and case prioritization for day-shift admission.

  Unfortunately, the service authorization process for both adult and children outpatient services remains burdensome and paper-driven. Some initial service authorizations can take months to obtain and there is no process that permits providers to monitor or estimate when an approval will be completed.

- The MHP uses consumer demographic data including race/ethnicity, age group, and gender to measure uneven access, measured penetration, and unmet/prevalence rates. In some instances where low penetration rates were

found, the MHP is working on program development and data analysis protocols to improve access and quality of care and more accurately measure consumer participation. For example, in response to low API penetration rates, the MHP has specifically developed programs such as the Transcultural Wellness Center FSP, the Peer Partners Program, and the PEI funded API Supporting Community Connections PEI program.

- Numerous collaborations and integration initiatives across public and private agencies were demonstrated, including:
  - Development of a common mental health screening tool for use in local emergency rooms (through the Community Mental Health Partnership)
  - Coordination with the Sacramento County Jail to discontinue its practice of releasing persons with mental health needs in the middle of the night to an emergency room
  - Working with local FQHCs and Community Health Care clinics to provide mental health screenings, assessment and brief treatment through a MHSA PEI program
  - Collaboration with The Effort to secure new housing units for consumers which will also offer FQHC and behavioral health provider services on the building's first floor
  - Provision of Mental Health First Aid training to community organizations (there is currently a waiting list for additional community group involvement)
  - Implementation of 22-week Crisis Responder Training for the Sacramento Police Department
  - The response of a mental health clinician to the UC-Davis ER for psychiatric crises
  - Partnership of MHP staff with Arthur Benjamin Health Professionals High School students as community advisors, mentors and audience for end-of-year presentations.

Timeliness

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

Figure 3. Timeliness					
Component		Present	Partial	Not Present	Not Rated
3A	Tracks and trends access data from initial contact to first appointment		X		
3B	Tracks and trends access data from initial contact to first psychiatric appointment	X			
3C	Tracks and trends access data for timely appointments for urgent conditions			X	
3D	Tracks and trends timely access to follow up appointments after hospitalization.	X			
3E	Tracks and trends No Shows		X		

Issues associated with the components identified above include:

- The MHP demonstrates consistent tracking of time to initial MHP contact for consumers from service request. They acknowledge they have only just begun to track timeliness in any respect after setting the relevant benchmarks and thus, have had no opportunities for perform improvement activities as of yet. Further, the MHP acknowledges delays in providing routine initial appointments for consumers, as priority for appointments is given to hospital discharged follow-ups and this impacts their daily capacity.
  - They set a target of 10 business days/14 calendars in which to see a consumer for a first appointment after service request. They track this timeliness indicator quarterly; on average in the last quarter of FY2010-11, consumers were first seen in 11 to 17 days and at least 59 percent of consumers were seen within the target timeframe.
  - The MHP also tracks timeliness from intake appointment to first clinical appointment. They set target of 20 business days/30 calendar days and tracking in the last quarter of FY2010-11 revealed an average of 9-16 days; at least 82 percent of consumers were seen within the benchmark.

- The MHP also demonstrated consistent tracking of timeliness in regards to first psychiatric appointment.
  - The MHP set a benchmark of 28 calendar days for a consumer to have an initial psychiatric/medication evaluation appointment from time of service request. Quarterly tracking revealed that, for the fourth quarter FY2010-11, on average adult consumers were served within 38 days and 45 percent of consumers were seen within the benchmark.

- The MHP reports that overall, there has been an increase in MD capacity but not due to the addition of any new MDs per se or formal performance improvement activities. Instead, each clinic has endeavored to use better business practices and manage medication appointment scheduling more efficiently to best use available MD time. For example, some Program Coordinators reported their clinics have set aside 'walk-in' appointment times and sometimes can fill no shows with walk-ins, depending on the MD.

- The MHP reports no mechanism for tracking urgent service requests and that all adult consumers with urgent/emergent needs are directed to local emergency rooms. The Children's SOC operates the Minor Emergency Response Team (MERT) located at the Mental Health Treatment Center for child urgent/emergent needs. Currently there is no AVATAR screen or process for tracking urgent service requests.

- In the last year, the MHP has made positive strides towards timely follow-up with and tracking consumers discharged from hospital. Renewed attention and effort has been directed at post-hospitalization connection to outpatient systems.
  - The MHP has established two relevant benchmarks pertaining to hospital follow-ups; 5 business days/7 calendar days for a clinical follow-up appointment and 20 business days/30 calendar days for a psychiatric follow-up appointment. Quarterly tracked data indicates that, in fourth quarter FY2010-11, on average consumers were seen anywhere from 5 to 10 days for a clinical follow-up and 15 to 19 days for a psychiatric follow-up. Overall, at least 67 percent of consumers discharged from hospital were seen within 7 days.
  - The MHP has recently begun to use four Community Support Teams (CST), consisting of Peer/Family Support Specialists and Mental Health Counselors. These mobile teams serve consumers that may benefit from early intervention, advocacy, or access to resources to ameliorate a crisis and the potential need for psychiatric emergency or acute care services as well as ensures discharged consumers attend their first scheduled follow-up appointment and have support in the interim, as well as after-care planning and safety plans. This additional service is too recent to be evaluated or show a marked effect on the data.
  - The IPT is available to meet consumers in hospital to support discharge planning process. The IPT also provides consultation and LOCUS evaluations for level of care determination so that the most appropriate and least restrictive level of care can be provided post-hospital discharge.
  - While the MHP discontinued use of a standalone database that tracked hospitalization data as it was duplicative, the MHP has developed a process where outpatient system is alerted to presence of consumer in hospital. Daily Reports are generated listing new Sacramento County Medi-Cal/indigent consumers who are hospitalized in one of the five local acute care facilities. These reports are reviewed

by MHP contract monitors to ensure that linked outpatient providers are notified if one of their clients is currently hospitalized so care and discharge planning can be coordinated with the acute care provider. All psychiatric hospitalizations for current/eligible MHP participants are provided expedited outpatient referrals through the ACCESS team.

- In response to last year's CAEQRO recommendation, the MHP created a billing code to begin tracking no-shows and cancellations which is being implemented with CWS. However, no standards have been established. In past years, the MHP did regularly look at no-show rates/data, but at present, they report concerns with integrity of provider-entered data and thus believe the reported 2.9 percent of no shows this year is an underestimation as so little total data exists in the system.

Outcomes

CAEQRO identifies the following components as essential elements of producing measurable outcomes for beneficiaries and the service delivery system. Evidence of consumer run programs, viable performance improvement projects, consumer satisfaction surveys and measuring functional outcomes are methods to evaluate the effectiveness of a service delivery system as well as identifying and promoting necessary improvement activities to increase overall quality and promote recovery for consumers and family members.

Figure 4. Outcomes

	Component	Present	Partial	Not Present	Not Rated
4A	Consumer run and or consumer driven programs	X			
4B	Measures clinical and/or functional outcomes of consumers served		X		
4C	One active and ongoing clinical PIP	X			
4D	Clinical PIP shows post-intervention results	X			
4E	One active and ongoing non-clinical PIP	X			
4F	Non-Clinical PIP shows post-intervention results			X	

Figure 4. Outcomes					
Component		Present	Partial	Not Present	Not Rated
4G	Utilizes information from Consumer Satisfaction Surveys	X			

Issues associated with the components identified above include:

- The MHP has come a long way in the last two years in regards to consumer-run/driven programs. Two active and well-developed Wellness Centers exist in Sacramento County; Marconi and Franklin. A third program, called the Transcultural Wellness center, was created to address the treatment needs of local Asian-Pacific Islander populations. The Executive Director of both Wellness Centers and each on-site Program Coordinator are CFM employees and all consumers are encouraged to attend a Wellness Center at the time of the service request through the ACCESS Line. Unfortunately, as both Wellness Centers are located in the Sacramento metro area, consumers who live in other/outlining regions of the County need to travel a far distance to access a center and transportation is a major barrier.

- While the MHP demonstrates various efforts to measure consumer outcomes, it remains program specific and nothing system-wide as of yet.
  - Consumer outcome reports for those served in Evidenced–Based Practices programs and FSPs exist (i.e. the PAF, KET and 3M).
  - The Child and Adolescent Needs and Strengths (CANS) tool began pilot testing in some childrens' outpatient program in FY2009-10. The MHP added a TAY component to the tool and it is now used throughout the assessment process, to inform treatment planning and to increase family engagement for specific consumers. The MHP trained all Level IV child providers to give the tool at treatment start and every six months thereafter. Presently, the CANS is being incorporated into CWS and the plan is to train the rest of the children's SOC providers on the tool's use to enable outcome monitoring at all service levels.
  - Some adult programs are using the LOCUS tool for treatment planning and LOC changes, specifically at the Adult point of access by the IPT for Level III/IV consumers. It is also used for referrals to FSP programs and repeated every six months afterwards.
  - The Ages and Stages Questionniare – Social/Emotional (ASQ-SE) is being used in one PEI child program.

- The MHP's Clinical PIP focusing on EPSDT youth has been ongoing since FY08-09. The goal was to create outpatient alternatives for high cost/high need youth to avoid disruptive crisis stabilization (MERT) episodes. To avoid inpatient hospitalization or repeated MERT stays, the designated intervention was to refer these youth to intensive services (i.e. TBS). While a decrease was noted in the three indicators (number of kids returning to the MERT unit, returning to inpatient care or transferring from MERT to an inpatient facility), the MHP was unable to determine whether these improvements were due to the intervention or other mitigating factors. Further, while the overall number of children using these high-costs services dropped as well, so did the availability of the MERT unit to serve these children's needs.

- The interventions in the MHP's Non-Clinical PIP are designed to increase efforts to document issues regarding the client's physical health (PC provider, medical issues, coordination of care efforts), to increase dialogue between the client and the mental health provider about medical issues that affect the client, and to assist with coordination of medical issues as appropriate. It was decided to limit the PIP to medical issues that align with the greatest mortality as established in national studies (i.e. High/Low Blood Pressure, Cholesterol, Cardio/ Cardiovascular Disease, Cerebrovascular Disease, Diabetes, and Liver disease). Four RST clinics are hosting the project as 60 percent of their consumers were noted to have at least one of these focus medical diagnoses during a random chart review, and these clinics predominantly serve Medi-Cal consumers and are not already participating in other projects. Prepatory PC Service Coordination trainings were provided by Primary Health medical staff to the four RSTs and to interested CFMs. A protocol was developed and rolled out pertaining to PC Physician/medical issue information collection and documentation at consumer intake and then ongoing.

- The MHP administered the former DMH-POQI survey in May 2011 and presented the compiled results during the review. While these results had only just been tabulated, the plan is to give all providers a report detailing their own program as well as their SOC. The survey was available in all threshold languages, and used during the May 2011 reporting period. However, afterwards some consumers reported that the survey was not given to them in their preferred language so now the MHP is working with provider agencies to ensure that training and monitoring is sufficient to address this issue. The results will also be shared with the QIC, and as with previous consumer satisfaction survey results, will inform two or three elements to focus QI efforts on and incorporate into each year's QI work plan. As consumer response rates were less-than-hoped-for this time, the QIC is looking at ways to increase response and have interviewed Peer Program Coordinators for their ideas.

❖CURRENT MEDI-CAL CLAIMS DATA FOR MANAGING SERVICES❖

Information to support the tables and graphs, labeled as Figures 5 through 18, is derived from four source files containing statewide data. A description of the source of data and summary reports of Medi-Cal approved claims data – overall, foster care, and transition age youth – follow as an attachment. It should be noted that significant claims lag may exist due to SD/MC Phase II processing issues. The claims lag varies across the MHPs. The MHP was also referred to the CAEQRO website at www.caeqro.com for additional claims data useful for comparisons and analyses.

RACE/ETHNICITY OF MEDI-CAL ELIGIBLES AND BENEFICIARIES SERVED

The following figures show the ethnicities of Medi-Cal eligibles compared to those who received services in CY10. Charts which mirror each other would reflect equal access based upon ethnicity, in which the pool of beneficiaries served matches the Medi-Cal community at large.

Figure 5 shows the ethnic breakdown of Medi-Cal eligibles statewide, followed by those who received at least one mental health service in CY10. Figure 6 shows the same information for the MHP's eligibles and beneficiaries served. Similar figures for the foster care and TAY populations are included in Attachment D following the MHP's approved claims worksheets.

Figure 5a. Statewide Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY10

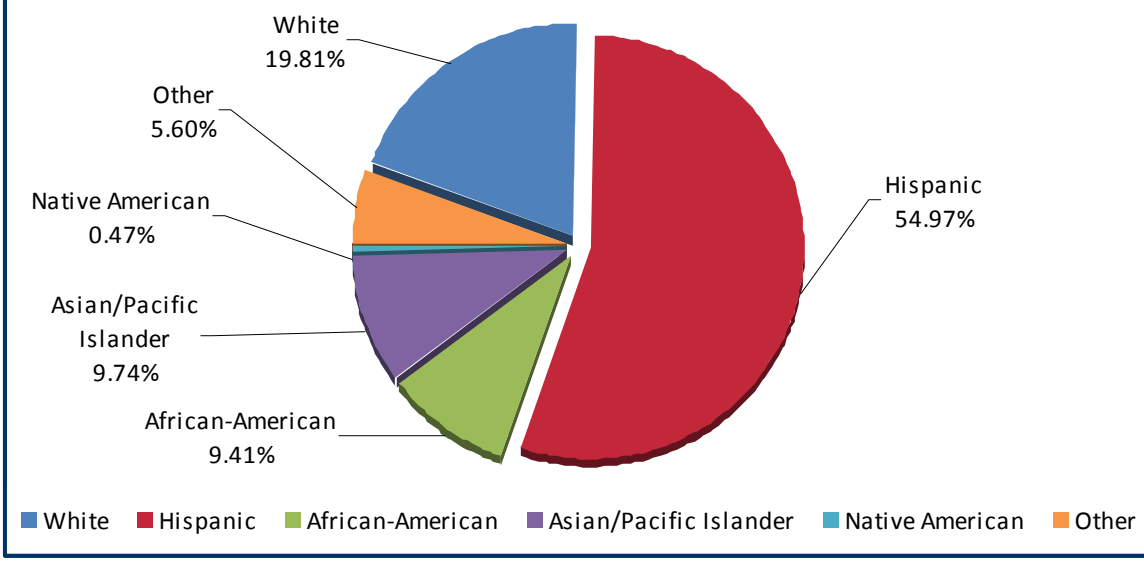


Figure 5b. Statewide Medi-Cal Beneficiaries Served, by Race/Ethnicity CY10

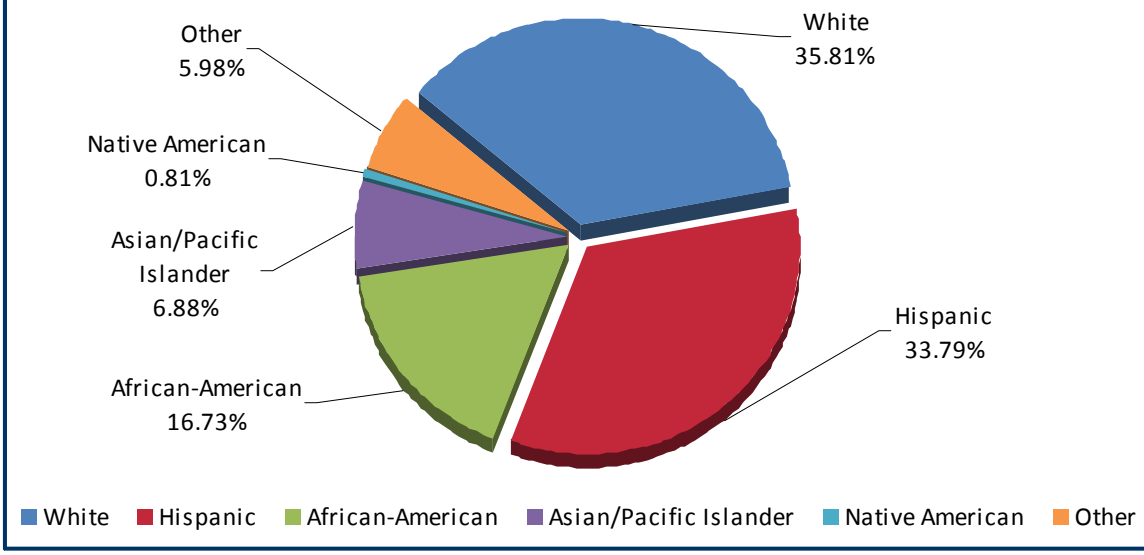


Figure 6a. Sacramento Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY10

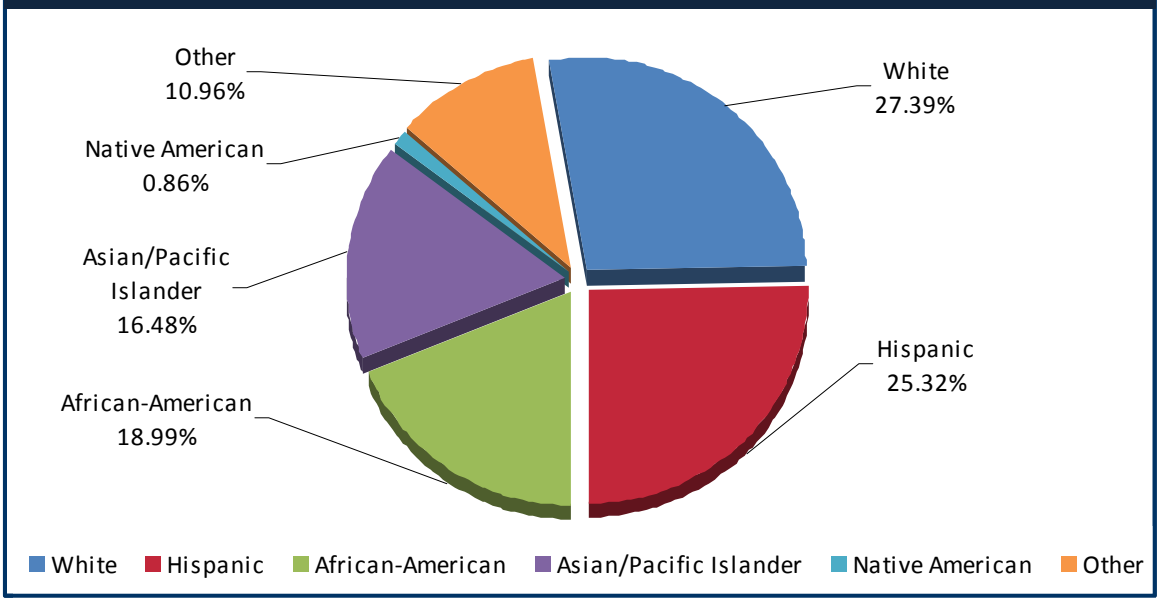
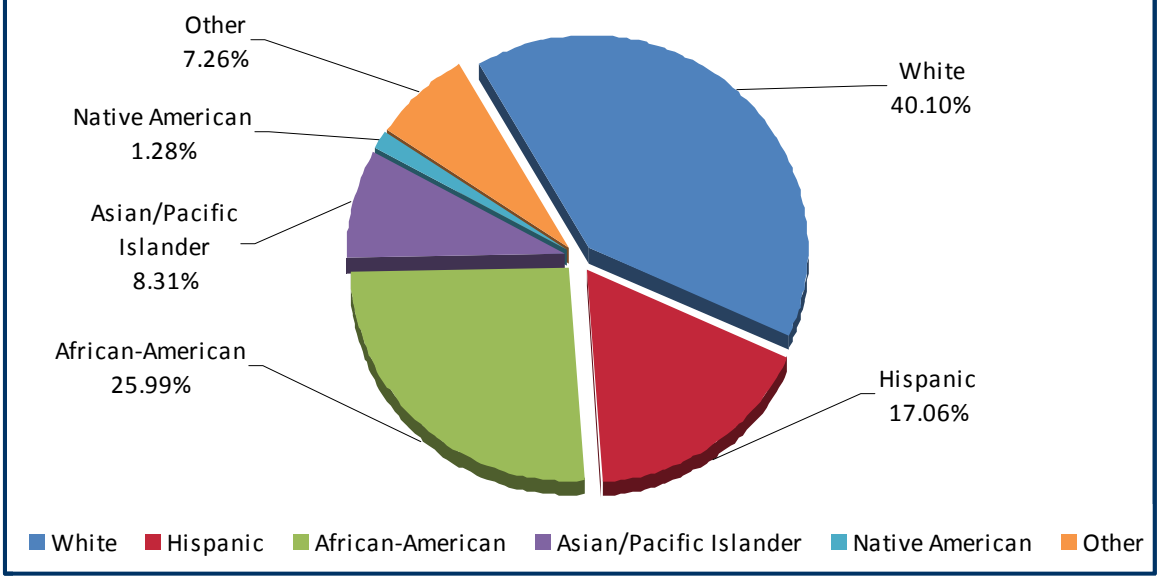


Figure 6b. Sacramento Medi-Cal Beneficiaries Served, by Race/Ethnicity CY10



PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Rankings, where included, are based upon 56 MHPs, where number 1 indicates the highest rate or dollar figure and number 56 indicates the lowest rate or dollar figure.

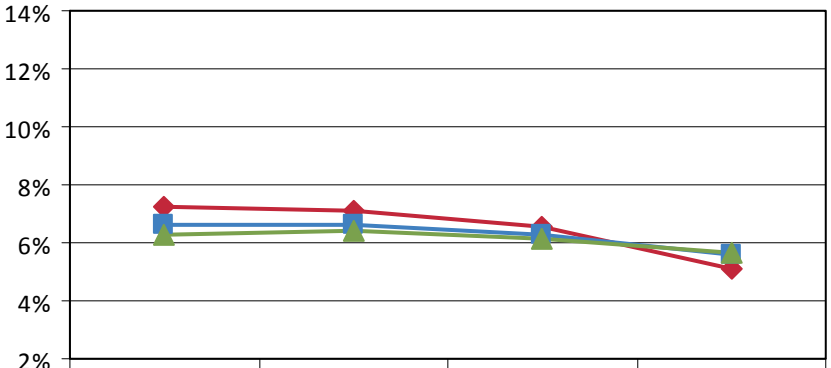
Figure 7 displays key elements from the approved claims reports for the MHP, MHPs of similar size (in this case - large) and the state.

Figure 7. CY10 Medi-Cal Approved Claims Data

Element	Sacramento	Rank	Large MHPs	Statewide
Total approved claims	$70,700,405	N/A	N/A	$1,862,527,947
Average number of eligibles per month	318,937	N/A	N/A	7,478,296
Number of beneficiaries served	16,209	N/A	N/A	422,183
Penetration rate	5.08%	42	5.61%	5.65%
Approved claims per beneficiary Served	$4,362	21	$4,031	$4,412
Penetration rate – Foster care	56.69%	30	56.77%	61.29%
Approved claims per beneficiary served – Foster care	$7,623	19	$6,934	$7,268
Penetration rate – TAY	5.44%	47	6.73%	6.82%
Approved claims per beneficiary served – TAY	$6,023	17	$5,120	$5,515
Penetration rate – Hispanic	3.43%	25	3.39%	3.47%
Approved claims per beneficiary served – Hispanic	$4,168	21	$3,757	$4,280
Penetration rate – Asian/Pacific Islander	2.56%	49	3.91%	3.99%
Approved claims per beneficiary served – Asian/Pacific Islander	$3,346	26	$3,144	$3,333

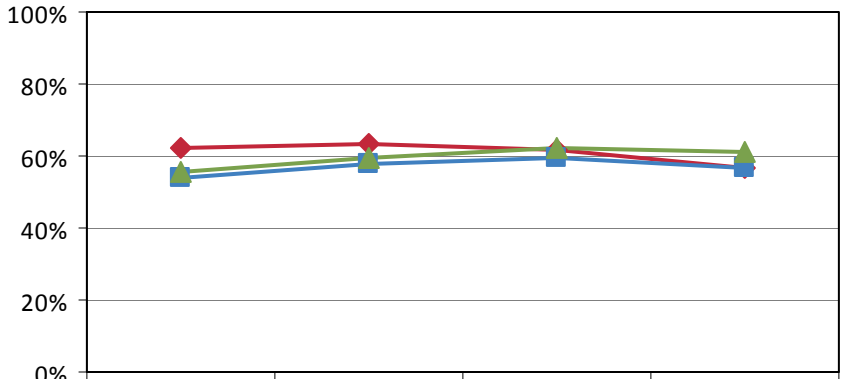
Figures 8 through 11 highlight four year trends for penetration rates and average approved claims.

Figure 8. Overall Penetration Rates CY07-CY10



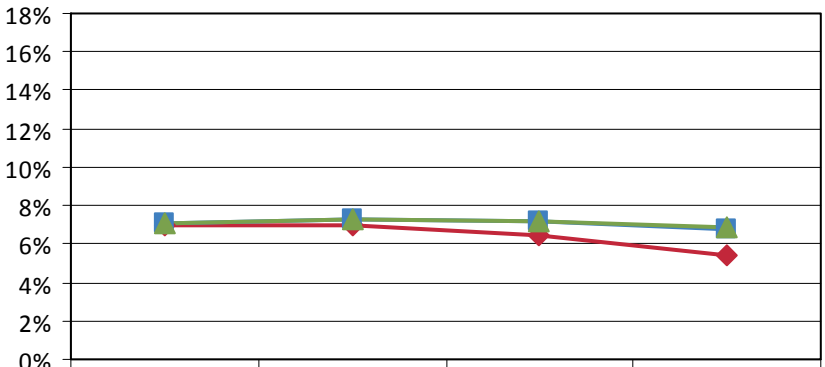
	CY07	CY08	CY09	CY10
Sacramento	7.26%	7.12%	6.54%	5.08%
Large MHPs	6.62%	6.63%	6.25%	5.61%
Statewide	6.29%	6.38%	6.15%	5.65%

Figure 9. Foster Care Penetration Rates CY07-CY10



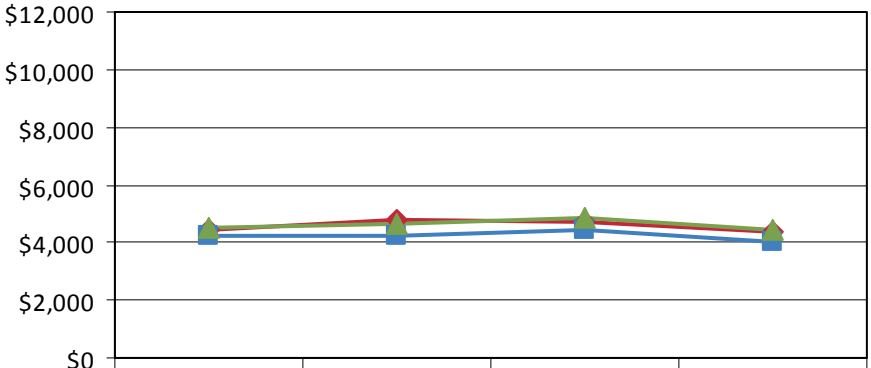
	CY07	CY08	CY09	CY10
Sacramento	61.95%	63.53%	61.92%	56.69%
Large MHPs	53.67%	57.96%	59.43%	56.77%
Statewide	55.82%	59.39%	62.43%	61.29%

Figure 10. Transition Age Youth Penetration Rates CY07-CY10



	CY07	CY08	CY09	CY10
Sacramento	6.94%	6.99%	6.44%	5.44%
Large MHPs	7.07%	7.29%	7.17%	6.73%
Statewide	7.05%	7.30%	7.21%	6.82%

Figure 11. Average Approved Claims per Beneficiary Served CY07-CY10



	CY07	CY08	CY09	CY10
Sacramento	$4,444	$4,753	$4,744	$4,362
Large MHPs	$4,208	$4,254	$4,410	$4,031
Statewide	$4,485	$4,679	$4,841	$4,412

MEDI-CAL APPROVED CLAIMS HISTORY

The table below provides trend line information from the MHP's Medi-Cal eligibility and approved claims files from the last five fiscal years. The dollar figures are not adjusted for inflation.

Figure 12. Sacramento Medi-Cal Eligibility and Claims Trend Line Analysis

Fiscal Year	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate		Total Approved Claims	Approved Claims per Beneficiary Served per Year	
			%	Rank		$	Rank
FY09-10	322,288	17,570	5.45%	40	$85,762,859	$4,881	20
FY08-09	307,246	20,238	6.59%	36	$87,413,863	$4,319	26
FY07-08	291,374	20,545	7.05%	38	$95,483,507	$4,648	23
FY06-07	283,011	20,556	7.26%	37	$90,947,819	$4,424	23
FY05-06	285,760	20,995	7.35%	37	$89,322,381	$4,254	23

MEDI-CAL DENIED CLAIMS HISTORY

Denied claims information appears in Figure 13. These are denials in Medi-Cal claims processing, not the result of disallowances or chart audits, and the rates do not reflect claims that may have been resubmitted and approved. Denial rate rank 1 is the highest percentage of denied claims; rank 56 is the lowest percentage of denied claims.

Figure 13. Medi-Cal Denied Claims Information

Fiscal Year	Sacramento Denied Claims Amount	Sacramento Denial Rate	Sacramento Denial Rate Rank	Statewide Median	Statewide Range
FY09-10	N/A	N/A	N/A	N/A	N/A
FY08-09	$7,837,417	6.33%	20	3.86%	0.41% - 29.87%
FY07-08	$4,590,486	5.75%	24	4.91%	0.23% - 25.89%
FY06-07	$4,492,469	5.51%	17	3.55%	0.23% - 18.18%
FY05-06	$3,926,852	4.39%	21	3.02%	0.57% - 22.69%

Review of Medi-Cal approved claims data, displayed in Figures 5 through 13 in Section III-C above, reflect the following issues that relate to quality and access to services:

- It is noted that a significant claims lag problem exists statewide due to SD/MC II processing issues at the state level; claims lag varies across the MHPs. CAEQRO estimates that Sacramento's CY2010 approved claims data presented in this report is approximately 75 percent complete. Therefore, comments on the claims data are limited in meaning due to the degree that it is incomplete. Year over year trends in Figures 8-11 are not discussed for that reason.
- As illustrated in Figure 7, the MHP's penetration rate for Hispanics (3.43 percent) lags its overall PR (5.08 percent). The Hispanic PR is equal to other large size MHPs (3.39 percent) and statewide rate (3.47 percent) respectively.
- As illustrated in Figure 7, the MHP's penetration rate for Asian/Pacific Islander (2.56 percent) lags its overall PR (5.08 percent). The Asian/Pacific Islander PR is significantly lower than other large size MHPs (3.91 percent) and statewide rate (3.99 percent) respectively.
- Denied claims: no update was available at the time of the review. CAEQRO is currently updating its analytics for denied claims as the data structure has changed considerably due to SD/MC II transition.
- Based on preliminary analysis, the bulk of Sacramento's FY10-11 denied claims were accounted for by two denial codes - "Medicare must be billed prior to submission of Medi-Cal claim" and "Other health coverage must be billed prior to submission of Medi-Cal claim".

HIGH-COST BENEFICIARIES

As part of an analysis of service utilization, CAEQRO compiled claims data to identify the number and percentage of beneficiaries within each MHP and the state for whom a disproportionately high dollar amount of services were claimed and approved. A stable pattern over the last three calendar years of data reviewed shows that statewide, roughly 2 percent of the beneficiaries served accounted for one-quarter of the Medi-Cal expenditures. The percentage of beneficiaries meeting the high cost definition has increased in each of the four years analyzed. For purposes of this analysis, CAEQRO defined "high cost beneficiaries" as those whose services met or exceeded $30,000 in the calendar year examined—this figure represents roughly three standard deviations from the average cost per beneficiary statewide.

Figure 14. High-Cost Beneficiaries (greater than $30,000 per beneficiary)						
	Beneficiaries Served			Approved Claims		
	# HCB	# Served	%	Average per HCB	Total Claims for HCB	% of total claims
Statewide CY10	8,754	422,183	2.07%	$48,934	$428,372,290	23.00%
Sacramento CY10	251	16,209	1.55%	$43,250	$10,855,695	15.35%
Sacramento CY09	466	20,582	2.26%	$45,435	$21,172,488	21.69%
Sacramento CY08	492	21,125	2.33%	$47,342	$23,292,201	23.20%
Sacramento CY07	476	20,715	2.30%	$48,526	$23,098,397	25.09%

CAEQRO also analyzed claims data for beneficiaries receiving $20,000 to $30,000 in services per year. Statewide, this population also represents a small percentage of beneficiaries for which a disproportionately high amount of Medi-Cal dollars is claimed. Statewide in CY10, 34.74 percent of the approved Medi-Cal claims funded 4.21 percent of the beneficiaries served when this second tier of high cost beneficiaries is included. For the MHP, 26.72 percent of the approved Medi-Cal claims funded 3.59 percent of the beneficiaries served. This information is also depicted in pie charts in Attachment D.

- As the MHP's CY2010 approved claims data presented in the report is approximately only 75 percent complete for the year, it is not meaningful to comment on Figure 14 data.

❖PERFORMANCE MEASUREMENT❖

Each year CAEQRO is required to work in consultation with DMH to identify a performance measurement (PM) which will apply to all MHPs – submitted to DMH within the annual report due on August 31, 2012. These measures will be identified in consultation with DMH for inclusion in this year's annual report.

❖CONSUMER AND FAMILY MEMBER FOCUS GROUPS❖

FOCUS GROUPS SPECIFIC TO THE MHP

CAEQRO conducted three 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CAEQRO requested focus groups as follows:

1. Culturally diverse Adult consumers that have been discharged from an inpatient psychiatric stay in the last year, receiving services at T-Core or at another MHP setting.
2. Culturally diverse Adult consumers using the services offered at either the Marconi or the Franklin Wellness Centers (prefer Franklin).
3. Parents and/or caregivers whose children are served by a large contractor provider.

A culturally diverse Adult consumers group using the services offered at the Marconi Wellness Center was conducted, and a number of consumers from the Franklin Wellness Center were brought in to participate.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

The first focus group of the review took place at T-Core. It was comprised of ten adult consumers who had been discharged from inpatient hospitalization in the last year (most in the last six months) and one consumer presently in the Crisis Residential Program who had never been hospitalized. Most had a history of numerous hospitalizations over the years. All were currently receiving some form of MHP service, either at T-Core or another program. Length of MHP service for the group ranged from two weeks to 30 years.

While all participants reported seeing a Psychiatrist and presently taking medication, some additionally saw a therapist, a case manager, a Personal Service Coordinator (who is a peer), an employment specialist, and/or received home visits. Group members were admitted to an inpatient hospital setting after presenting at a local ER, their PC physician's office, a private psychiatric clinic, or as a result of a 5150 by law enforcement. A few reported knowing how to

get help while in crisis as a result of the SacPort course they were given while in the MHP's Psychiatric Health Facility (PHF) previously. In a few cases, consumers were assessed by MHTC staff at an ER and admitted to the MHTC after a long ER wait, but then discharged within 24 hours, only to return later to an ER, still in crisis. All agreed being hospitalized was a scary situation which makes a person feel vulnerable, one that is only amplified when a 5150 with law enforcement occurs.

Consumers reported a number of incidents were medical providers in hospital were very interested in consumer opinions and experience, especially regarding medication side effects and compliance. Further, some consumers said they learned how to monitor some of their own illness symptoms (surrounding self-care and grave disability) and better manage their stress from group treatment sessions in hospital. In many cases, upon hospital discharge, most consumers report being actively engaged in aftercare services effectively; seven of the ten discharged from hospital reported a follow-up call from MHP staff (the CST) checking on their transition to outpatient treatment.

Many participants felt patients are discharged too quickly from hospital in general, and for some of them, this resulted in frustration, panic or apathy regarding not getting the help they needed. The majority of the group endorsed the belief that the MHP's outpatient Psychiatrists are rushed through appointments and do not have the time to truly "hear" consumers. Further, the availability of non-medical clinicians in terms of schedule and being present in a session varies by setting and provider. Consumers reported what they perceived as random reassignment between clinics and/or providers which caused great distress and trauma, even a return of crisis. Many agreed once it has occurred, a consumer lives in a state of fear it will happen again and again, thereby damaging the trust they have in subsequent providers. Many reported concern over recent instances of staff using stigmatizing language, such as "frequent flyers, 5150's, patients."

Overall, the group reported they receive good care at the MHP and that some staff have a genuine investment in their recovery, want to help and will do "whatever works." No participant expressed a need for Alcohol and Other Drug (AOD) services, nor knowing of the availability of them, besides twelve-step groups. Half the group knew of one or both Wellness Centers and only two in the group have ever been to one. While only half reported having seen their service/treatment plan, all felt they are included in the treatment planning process.

The group's suggestions for system improvement included:

- Improving law enforcement understanding of mental health issues and the lived experience of being 5150'd
- An increase in overall clinical staff so time spent with consumers is ample and appropriate
- An increase in space/programs as there is not enough capacity for those who need it

- Outreach into the general community to reduce stigma surrounding mental illness
- Provision of more groups at all clinics, either run by peers or clinicians
- Help staff and the system as a whole to "hear" consumers when they ask for help when in distress, rather than waiting until full-blown, and possibly avoidable, crisis
- Transportation stipends/reimbursement to use the existing public system
- Use of Wellness/Recovery verbiage and model consistently; including a system change to the term "consumer."

Figure 15. Consumer/Family Member Focus Group 1

Number/Type of Participants	
Consumer Only	8
Consumer and Family Member	3
Family Member of Adult	
Family Member of Child	
Family Member of Adult & Child	
Total Participants	11

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	1
Adult (approx 25-59)	8
Older Adult (approx 60 and older)	2

Preferred Languages	
English	11

Estimated Race/Ethnicity	
Hispanic/Latino	1
Caucasian	9
African/American	1

Gender	
Male	5
Female	6

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

The second focus group of the review occurred at the Marconi Wellness Center. Ten consumers participated. While many had been coming to the Center for two or more years, a few were new to the program in the last six months. In addition to Wellness Center services, such as yoga and nutrition/health groups and/or medication support, consumers reported presently or historically using other MHP/contractor programs such as Crisis Residential, Carol's Place, the MHTC, HRC, El Hogar and the Crestwood PHF.

Two participants reported facilitating various groups at the Center and many reported a notable increase in Center staff the last year. Participants reported skill acquisition groups as most helpful, and the overall peer support, decrease in social isolation, and exposure to a non-judgmental, non-stigmatizing environment the Center provides as "lifesaving." All appreciated the lived experience of peer facilitators and that the program does not use the Medical model of mental illness. Many opined their use of Center services and supports has decreased both their need for inpatient/intensive services and the concerns expressed by family and friends for their safety/well-being. Most agreed the Center gives them hope and a sense of productivity just by getting up and out of the house most days. Consumers reported a variety of resources are available to them when in distress or crisis, from calling Wellness Center mentors and peers, to private providers, to 911. A few say they are now better parents, advocating more effectively for themselves and their children. They have been helped with homelessness as well as safety planning. Overall, the Center was described as a respectful environment, with a variety of programs, good structure and excellent peer support.

While no participant had ever served on an MHP committee or Board to address system change or development, they report being empowered by the Center to rally the Board of Supervisors to save programs. At the Center itself, they feel valued and see the results of their efforts, such as asking for increased programming. No one knew of any available AOD services at the Center or locally. While no participant reported family member involvement in their treatment, they all reported feeling they could ask for their inclusion as all are welcome at the Wellness Center and some have seen couples getting support.

The following suggestions for improvement were made by participants:

- Addition of more physical outlet or relaxation groups on the group schedule
- Extension of opening hours to include Sundays
- Better advertisement in the community and throughout the MHP system of the concept of wellness
- Addition of more prevention programs

Figure 16. Consumer/Family Member Focus Group 2

Number/Type of Participants	
Consumer Only	9
Consumer and Family Member	1
Family Member of Adult	
Family Member of Child	
Family Member of Adult & Child	
Total Participants	10

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	1
Adult (approx 25-59)	9
Older Adult (approx 60 and older)	

Preferred Languages	
English	1

Estimated Race/Ethnicity	
Caucasian	4
Hispanic/Latino	5
Native American	1

Gender	
Male	4
Female	6

Interpreter used for focus group 2: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

The last focus group of the review took place at a Children's contract provider, River Oak Center for Children, in Elk Grove, CA. Ten family members/caregivers were in attendance, including parents, grandparents, and foster mothers. Three attendees were non-English speaking, two Spanish and one Japanese; simultaneous translation by headsets was provided by the MHP for these participants.

Participants reported at least one child presently being served in the MHP's Children's SOC. Service periods ranged in length from one to seven years and child consumers ranged in age from 6 to 18 years old. While in a few cases, the child/youth consumer was presently only receiving medication services, the bulk of participants reported their child and/or family was or had additionally received behavioral specialist services (for parents, for children or for both parties together), family therapy, case management, individual child therapy, family advocacy, autism services, and/or parenting classes over the span of treatment. Overall, the individual providers, such as a case manager or therapist/Psychologist, were reported as the most helpful, in addition to family therapy sessions, group therapy sessions for the child/youth consumer, and school program specialists. All agreed overall parental support and advocacy for the child/youth consumer made the biggest contribution to positive outcomes; two parents

presently have a parent partner. In cases where a child had a history of trauma, family members reported the use of Trauma-Focused Cognitive Behavioral Therapy was of great help, especially as caregivers were kept connected to each session and the treatment was tailored to an individual child's needs.

In many cases, participants reported extended wait times to get into services, from three to four months. That is, the time to service provision post-intake assessment once the County approved the child's authorization. Referrals for service stemmed from Sacramento County Head Start, school Psychologists, a local ER, Connect Center (a Sacramento County United School District referral center) or a domestic violence shelter. About half of the families had a child with an Individualized Education Plan (i.e., enrolled in the former-AB 3632 program).

During a discussion of system/provider cultural competency, participants reported their own cultural expectations/ideals surrounding mental illness often created an unsupportive environment when pursuing help for their child. Further, a few reported the MHP system made them feel like they had to beg for services, and that caregivers were in some way "less than" or deficient for asking for help. A number of Caucasian attendees reported personally observing caregivers of color be treated rudely by staff, in comparison to themselves. Nevertheless, in other cases, caregivers reported culturally sensitive and competent services and treatment from clinicians.

Attendee suggestions for improvement included:

- Development of a more complete continuum of care and overall care coordination, bridging other agencies/organizations
- Inclusion of more school-based providers on the whole
- Assistance for foster parents to communicate/plan with a child/youth's school, despite not holding legal rights
- Strengthening partnerships with other school districts, besides Sacramento Unified
- More complete and transparent discharge planning for Child Welfare, Probation, and aging-out consumers and their families
- Increased individual therapy appointments from once every two weeks to weekly

Figure 17. Consumer/Family Member Focus Group 3

Number/Type of Participants	
Consumer Only	
Consumer and Family Member	
Family Member of Adult	1
Family Member of Child	8
Family Member of Adult & Child	1
Total Participants	10

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	
Adult (approx 25-59)	7
Older Adult (approx 60 and older)	3

Preferred Languages	
English	7
Spanish	2
Japanese	1

Estimated Race/Ethnicity	
Caucasian	3
Hispanic/Latino	3
Asian/Pacific Islander	2
African American	2

Gender	
Male	2
Female	8

Interpreter used for focus group 3: ☐ No ☒ Yes – Spanish, Japanese

❖PERFORMANCE IMPROVEMENT PROJECT VALIDATION❖

CLINICAL PIP

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

> "Will providing a TBS referral to all Med-Cal eligible clients receiving outpatient services in the MHP experiencing a crisis stabilization episode at MERT lead to reduced hospitalization and need for intensive mental health services in the future?"

Year PIP began: July 2008

Status of PIP:

- ☐ Active and ongoing
- ☒ Completed - active for review period
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

The MHP continued its EPSDT PIP, formerly a statewide PIP requirement. Please refer to prior year reports for the history of this project.

The underlying goal of this MHP PIP was to create outpatient alternatives for high cost/high need youth to avoid disruptive crisis stabilization episodes. To avoid inpatient hospitalization or repeated MERT stays, the designated intervention was to refer these youth to intensive services (i.e. TBS). While a decrease was noted in the three indicators (number of kids returning to the MERT unit, returning to inpatient care, or transferring from MERT to an inpatient facility), the MHP was unable to determine whether this was due to the intervention or other mitigating factors. Further, while the overall number of children using these high-costs serves dropped, so did the availability of the MERT unit to serve these children's needs.

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either "met," "partial," "not met," or "not applicable." Relevant details of these issues and recommendations are included within the comments of the PIP validation tool. Thirteen of the 44 criteria are identified as "key elements" indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 18. Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
2	The study question identifies the problem targeted for improvement	X		
3	The study question is answerable/demonstrable	X		
4	The indicators are clearly defined, objective, and measurable	X		
5	The indicators are designed to answer the study question	X		
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
7	The indicators each have accessible data that can be collected	X		
8	The study population is accurately and completely defined	X		
9	The data methodology outlines a defined and systematic process	X		
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes	X		
11	The analyses and study results are conducted according to the data analyses plan in the study design	X		
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion		X	
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement	X		
Totals for 13 key criteria		**12**	**1**	

NON-CLINICAL PIP

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

> "Will increasing efforts to document, coordinate, and follow-up on medical issues with the consumer's primary care provider lead to improved primary care access/follow-up and treatment for mental health consumers served in standard outpatient clinic care?"

Year PIP began: December 2010

Status of PIP:

- ☒ Active and ongoing
- ☐ Completed
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

This Non-Clinical PIP is part of a multifaceted plan to increase the access to coordinated and/or integrated care for persons with mental illness and co-occurring physical health needs. The interventions are designed to increase efforts to document issues regarding the client's physical health (PC provider, medical issues, coordination of care efforts), to increase dialogue between the consumer and the mental health provider about medical issues that are affecting the client, and to assist with coordination of medical issues as appropriate for MHP consumers. It was decided to limit the PIP to medical issues that align with the greatest mortality as established in national studies (i.e. High/Low Blood Pressure, Cholesterol, Cardio/Cardiovascular Disease, Cerebrovascular Disease, Diabetes, and Liver disease). Four RST clinics are hosting the project as 60 percent of their consumers were noted to have at least one of these focus medical diagnoses, during a random chart review, and these clinics predominantly serve MediCal consumers and are not already participating in other projects. Prepatory PC Service Coordination trainings were provided by Primary Health medical staff to the four RSTs and to interested consumers and family members. A protocol was developed and rolled out pertaining to PC Physician/medical issue information collection and documentation first at consumer intake and then ongoing; all interventions stem from key junctures/actions within the protocol. Initial measurement for all indicators will take place one year after protocol roll out.

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either "met," "partial," "not met," or "not applicable." Relevant details of these issues and recommendations are included within the comments of the PIP validation tool. Thirteen of the 44 criteria are identified as "key elements" indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 19. Non-Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
2	The study question identifies the problem targeted for improvement	X		
3	The study question is answerable/demonstrable	X		
4	The indicators are clearly defined, objective, and measurable	X		
5	The indicators are designed to answer the study question	X		
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
7	The indicators each have accessible data that can be collected	X		
8	The study population is accurately and completely defined	X		
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X		
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes	X		
11	The analyses and study results are conducted according to the data analyses plan in the study design			X
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			X
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			X
Totals for 13 key criteria		**10**		**3**

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or future PIPs. The PIPs, as submitted by the MHP, are included as an attachment to this report.

❖INFORMATION SYSTEMS REVIEW❖

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. CAEQRO used the written response to standard questions posed in the California-specific ISCA Version 7.2, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

CURRENT OPERATIONS

- The technology staff works in close collaboration with Fiscal, Research & Evaluation, and QI to provide strong data operations support for the MHP. Their primary support roles currently include:
  - Ongoing AVATAR deployment and user training which currently includes CWS design, user testing, and three pilot-site implementation
  - Designing custom AVATAR reports
  - Facilitating monthly AVATAR Implementation User Forum meetings that currently focus on SD/MC II , user training, and ongoing support
  - Supporting research and evaluation, QI, and quality assurance activities

- Approximately 90 percent of outpatient services are provided by contract providers and about 1 percent by network providers. Over 80 percent of services are billed to SD/MC.

- As the MHP relies upon a large number of contract providers to deliver the bulk of outpatient services, this requires the MHP to have strong two-way communication and collaboration activities with providers, along with a strong training program and ongoing support activities. It was mentioned by a number of contract providers that the MHP's IS and Fiscal unit staff were subject matter experts and were very responsive to questions and technical issues.

- At present, IS staffing provides for five full-time (FTE) positions. Since the FY10-11 CAEQRO review, the MHP hired two new FTE staff – one is a county employee, the other is a Netsmart Technologies programmer/analyst on contract with the MHP for up to a five-year period. As of August 2011, there was one unfilled IS position.

MAJOR CHANGES SINCE LAST YEAR

- Completed the design requirements and user acceptance testing for CWS and began pilot program implementation.
- Achieved "current" status with SD/MC claims processing.
- Made significant process with CSI testing.

PRIORITIES FOR THE COMING YEAR

- Continue to implement CWS and InfoScriber (e-prescribing) pilot projects.
- Resolve remaining CSI testing issues.
- Implement AVATAR Order Entry and eMAR for the PHF.
- Continue AOD services implementation as part of the overall Behavioral Health service integration initiative.
- Begin the AVATAR Document Management project design and requirements phase. Continue to implement the AVATAR system to achieve a behavioral health information system with electronic health record functionality. The target completion date is CY2015.
- Implement HIPAA 5010 transaction code sets prior to January 1, 2012.

OTHER SIGNIFICANT ISSUES

- SD/MC II claims for beneficiaries with Medicare/Medi-Cal eligibility or with OHC eligibility have not been successfully processed (paid) by the State, as Medicare and OHC must be billed before the submission of a SD/MC claim.

The table below lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce SD/MC and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Figure 18. Current Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
AVATAR - Cal-PM	Practice Management	Netsmart Technologies	2	MHP IS Vendor IS
AVATAR – CWS	EHR	Netsmart Technologies	>1	MHP IS Vendor IS
AVATAR - InfoScriber	e-Prescribing	Netsmart Technologies	>1	MHP IS Vendor IS

PLANS FOR INFORMATION SYSTEMS CHANGE

There are no plans to replace the current AVATAR system. The MHP is in the third year of a multi-year systems implementation, with the projected completion date being mid-2015.

ELECTRONIC HEALTH RECORD STATUS

See the table below for a listing of EHR functionality currently in widespread use at the MHP.

Figure 19. Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments				X	
Document imaging				X	
Electronic signature-client				X	
Electronic signature-provider				X	
Laboratory results				X	
Outcomes				X	
Prescriptions	Info Scriber		X		
Progress notes	Avatar CWS		X		
Treatment plans	Avatar CWS		X		

Progress and issues associated with implementing an EHR over the past year are discussed below:

- Prescriptions (InfoScriber) pilot project was implemented in September 2011.
- In August 2011, the MHP began a three-site pilot project implementation of CWS that includes progress notes and treatment plan functionality.
- The MHP made incremental progress during the past year to implement EHR functionality. This is multi-year implementation, with the projected completion date currently being mid-2015.

❖SITE REVIEW PROCESS BARRIERS❖

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

- There were no barriers affecting the preparation or the activities of this review.

❖CONCLUSIONS❖

During the FY11-12 annual review, CAEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CAEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access and timeliness of services and improving the quality of care.

STRENGTHS

1. IS and Fiscal staff are very knowledgeable and experienced on a wide range of AVATAR technology and Medi-Cal billing issues.
   [Information Systems]

2. Focusing attention on acute services – crafting a vision of a continuum of care, and expanding use of the Intake and Referral Team, the IPT and the CST – has strengthened the safety net for consumers in crisis and during/after hospital discharge.
   [Quality, Outcomes]

3. There is a notable commitment to QI and Performance Management, informed by data usage, establishing baselines and overall initiatives.
   [Quality]

4. A clear investment has been made in making the system as diverse as the county by its document and service translation; staff, contract provider and peer diversity; and ongoing Outreach and Engagement subcommittee efforts.
   [Access, Quality, Other: Cultural Competency]

5. Efforts to engage various stakeholders in EHR and CWS rollout and provide ongoing support is evident.
   [Information Systems, Other: Collaboration]

OPPORTUNITIES FOR IMPROVEMENT

1. The Access Team service authorization process for adults, child and family outpatient programs remains a paper-driven process that is prone to status tracking and excessive delays.
   [Access, Timeliness, Information Systems]

2. Most of FY10-11 Medi-Cal claims for beneficiaries with Medicare and Medi-Cal eligibility or Other Health Coverage eligibility were originally denied by Medi-Cal. These claims can be reprocessed by first submitting them to Medicare or private insurance carriers for adjudication before submitting to SD/MC II for final processing.
[Information Systems, Other: Claims processing]

3. Proliferation of Wellness and Recovery concepts throughout all staff and service levels is needed. Growth of Wellness and Recovery Center services and/or the creation of additional such programs/centers will grow the personal empowerment and positive outcomes evidenced in present Center participants.
[Outcomes]

4. The MHP's IS and Fiscal staffing needs should be assessed, as the complexity of SD/MC II claim processing has impacted Medi-Cal revenue and the budget, which requires a higher level of scrutiny and review than previously.
[Information Systems, Other: Workforce]

5. In light of expected system changes once a court settlement is reached, the MHP should assess system/program capacity and how redesign might limit consumer access or diminish positive consumer outcomes. Further, efforts to inform consumers individually or at least in small groups about provider, program and/or service changes are needed to diminish disengagement/distress.
[Access, Outcomes]

6. CSI testing remains unfinished and monthly data submissions are on hold until testing is final and approved by State DMH.
[Information Systems]

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the review process, identified as an issue of access, timeliness, outcomes, quality, information systems, or others that apply:

1. Improve status tracking and provider and consumer communications, and reduce delays in Access Team initial service authorization and re-authorization processes; consider using the AVATAR system for automation.
[Access, Information Systems]

2. Develop strategies and assign staff resources to reprocess FY10-11 previously denied claims for beneficiaries with Medicare and Medi-Cal eligibility or OHC eligibility and complete the work by June 2012; including:

a) A review of each provider's guarantor business claiming rules.

b) Obtain clients Medicare or private insurance carriers billing information to verify AVATAR client insurance information is correct or update same.

c) Provide ongoing training and support to county and contract providers staffs' of SD/MC II claims processing requirements and how to resolve denied claims.

[Information Systems, Other: Claims processing]

3. To evaluate overall program capacity, review utilization/timeliness data captured as AVATAR implementation continues; assess if there are programmatic limitations for Adult versus Child systems, such as multiple outpatient clinics, lack of sub-acute and intensive outpatient services, and limited access points.
[Access, Timeliness, Outcomes]

4. Expose all levels of staff/system providers to Wellness and Recovery concepts systematically, so that the appropriate language/work model is adopted and consumers are treated equitably across providers. Consider outlying locations to roll-out Wellness Center-type services to reach more consumers.
[Quality]

5. Complete CSI testing and begin to submit monthly data.
[Information Systems]

❖ATTACHMENTS❖

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: Data Provided to the MHP

Attachment E: CAEQRO PIP Validation Tools

Attachment F: MHP PIP Summaries Submitted

A. Attachment—Review Agenda

<table>
<tr><th>Time</th><th colspan="2">Wednesday, September 14, 2011 – Day 1 Activities</th></tr>
<tr><td>9:00-12:00</td><td colspan="2"><u>Performance Management</u>
Access, Timeliness, Outcomes, and Quality
• Introductions of participants
• Overview of review intent
• Significant MHP changes in past year
• Strategic initiatives – progress & plans
• Last Year's CAEQRO Recommendations
• 1115 Waiver discussion
• Performance improvement measurements utilized to assess access, timeliness, outcomes, and quality
• Examples of MHP reports used for to manage performance and decisions
• CAEQRO approved claims data

Participants – those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions – including but not limited to MHP Director, senior management team, and other managers/senior staff in: fiscal, programs, IS, medical, QI, research, patients' rights advocate; and involved consumer and family member representatives.
ASC Conference Room 2 - 7001A East Parkway Sacramento, CA 95823</td></tr>
<tr><td>12:00–1:00</td><td colspan="2">APS Staff – Working Lunch ASC</td></tr>
<tr><td>See scheduled times</td><td><u>1:00 – 2:30 p.m.</u>
<u>Performance Improvement Projects</u>
Topic/study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans. Participants should be those involved in development & implementation of PIPs, including PIP committee, MHP Director, other sr. managers.
ASC Conf. 301</td><td><u>1:00 – 1:30 p.m.</u>
<u>Travel Time</u></td></tr>
<tr><td>See scheduled times</td><td><u>2:30 – 3:00 p.m.</u>
<u>Travel Time</u></td><td><u>1:30 – 3:00 p.m.</u>
<u>System Hands on Review of Avatar</u>
• CWS implementation
• Status of Avatar pending software updates
• Use of test server or separate environment
Tech Center</td></tr>
<tr><td>3:00-4:30</td><td><u>Consumer Focus Group-
Discharged Inpatient Consumers</u>
8-10 adult consumers discharged from an inpatient setting in the last 12 months, and now served by various MHP services, including TCORE
T-CORE
3077 Fite Circle Suite 6
Sacramento, CA 95827</td><td><u>IS Manager/Key IS/Fiscal/Billing Staff Interview</u>
• Review and discuss ISCA
• SD/MC II claim processing issues
• Contract provider billing
• Denied claims review process
• Void & replace transactions
ASC Conf. 301</td></tr>
</table>

<table>
<tr><th>Time</th><th colspan="3">Thursday, September 15, 2011 – Day 2 Activities</th></tr>
<tr><td>9:00-10:30</td><td colspan="2"><u>Wellness Center Visit and Consumer Focus Group</u>

8-10 diverse adult consumers, as specified in the notification letter

Wellness Recovery Center
3815 Marconi Avenue #1
Sacramento, CA 95821</td><td><u>Avatar Implementation Work Group Interview</u>

• Communication with stakeholders
• Staff training & support
• Status of CWS rollout

ASC Conf. 301</td></tr>
<tr><td>10:45–12:15</td><td colspan="2"><u>Outcomes/Timeliness</u>

MHP examples of data used to measure timeliness, functional outcomes and satisfaction.

ASC Conf. 301</td><td><u>Contract Provider Group Interview</u>

Executive leadership and clinical/business administrators from 6-8 contract providers representing providers for both children and adults.

ASC Conf. 2</td></tr>
<tr><td>12:15–1:15</td><td colspan="3">APS Staff – Working Lunch ASC</td></tr>
<tr><td>1:15–2:45</td><td colspan="2"><u>Disparities in Service Access, Retention and Quality</u>

• Review of CAEQRO approved claims data, penetration rates, utilization patterns by age, gender and ethnicity
• Review of Cultural Competency activities to improve access
• Review of capacity building activities and strategies

ASC Conf. 301</td><td><u>1:00 - 2:30pm</u>

<u>Avatar User Forum</u></td></tr>
<tr><td>3:00–4:30</td><td><u>MHP Program Coordinator Group Interview</u>

6-8 MHP program coordination staff (all peers) representing various programs and geographical areas

ASC Conf. 2</td><td><u>Collaborative/Community Based Services</u>

• Examples of collaborative relationships with community providers
• Service integration with other providers
• Services to foster care youth

ASC Conf. 301</td><td><u>Contract Provider Site Visit</u>

Travel time to, site visit, and return travel time included.

CHW
9837 Folsom Blvd.
Sacramento, CA 95828</td></tr>
</table>

<table>
<tr><th>Time</th><th colspan="2">Friday, September 16, 2011 – Day 3 Activities</th></tr>
<tr><td>9:00–10:30</td><td><u>Consumer Employee Group Interview</u>

6-8 MHP or contract employees who are consumers, such as Peer Advocates, Peer Support Specialists, or Consumer Liaisons.

T-CORE
3077 Fite Circle, Ste. 6
Sacramento, CA 95825</td><td><u>County Provider Site Visit</u>

APSS-Aftercare Clinic
2130 Stockton Blvd
Sacramento, CA</td></tr>
<tr><td>10:30–11:00</td><td>Travel Time</td><td>Travel Time</td></tr>
<tr><td>11:00–12:30</td><td><u>Family Member Focus Group- Parents/Caregivers of Child Consumers</u>

8-10 diverse parents/caregivers of child consumers, as specified in the notification letter

River Oak
9412 Big Horn Blvd. Ste. 6
Elk Grove, CA 95758</td><td><u>MHP Clinical Line Staff Interview</u>

8-10 clinical line staff from either the Adult or Children’s System of Care

ASC Conf. 301</td></tr>
<tr><td>12:30–1:30</td><td colspan="2">Travel Time, APS Working Lunch and Staff Meeting All - ASC</td></tr>
<tr><td>1:30–2:15</td><td colspan="2"><u>Wrap Up Session</u>

MHP Director, QI Director, senior leadership, and APS staff only
• Clarification discussion on any outstanding review elements
• MHP opportunity to provide additional evidence of performance
• CAEQRO next steps after the review

ASC Conf. 301</td></tr>
</table>

B. Attachment—Review Participants

CAEQRO REVIEWERS

Mila Green, Lead Reviewer
Bill Ullom, Information Systems Reviewer
Walter Shwe, Consumer/Family Member Consultant
Sandra Sinz, Director of Operations

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

SITES OF MHP REVIEW

CAEQRO staff visited the locations of the following county-operated and contract providers:

County provider sites

Sacramento County Administrative Offices
7001A East Parkway
Sacramento, CA 95823

Adult Psychiatric Support Service (APSS) Clinic
4875 Broadway, Suite 180
Sacramento, CA 95820

Tech Center
9333 Tech Center Drive, Suite 100
Sacramento, CA 95826

Wellness & Recovery Center - North
3815 Marconi Ave., Suite 1
Sacramento, CA 95821

Contract provider organizations

Catholic HealthCare West (CHW)
9837 Folsom Blvd.
Sacramento, CA 95828

River Oak South
9412 Big Horn Blvd., Suite 6
Elk Grove, CA 95758

T-CORE (Transitional Community Opportunities for Recovery & Engagement)
3077 Fite Circle, Suite 6
Sacramento, CA 95827

PARTICIPANTS REPRESENTING THE MHP

Alexis Lyon, Turning Point, Program Director
Alex Rechs, Program Coordinator
Allison Matney, HCSSAC, Employment Specialist
Andrea Hillerman-Crook, MHA, Consumer Affairs Advocate Liaison
Ann Edwards, DHHS Director
Bob Vaugh, Cross Creek, Clinical Director
Carter Haynes, CHW, Therapist
Cheryl Brant, CHW, Administrative Assistant
Chou Moua, Hmong Women's Heritage Association, Peer Partner Specialist
Chris Eldridge, DBH, Senior Mental Health Counselor
Chris McCarty, Sacramento Children's Home, Community Programs Director
Davina Cuellar, MHA, Peer Partner Specialist
Dawn Williams, DHHS, Program Planner
Debbie Magistrado, Sierra Forever Families, Social Work Supervisor
Donna Cardoza, River Oaks Center for Children, Business Support Specialist
Erika Adams, Stanford Home for Children, Wraparound Facilitator
Gayaneh Karapetian, Sacramento Children's Home, Program Director
George McElroy, DBH, Accounting Manager
Glen Xiong, DBHS, MHTC Medical Director
Gloria Lyles, Northgate Point, Caseworker
Grainger Brown, CHW, Program Coordinator
Huy Nguyen, Hmong Women's Heritage Association, Peer Partner Specialist
Jesus Cervantes, DBHS, Quality Management Program Coordinator
Jill Dayton, El Hogar, Program Director
JoAnn Johnson, DBHS, Ethnic Services/Cultural Competency; Research; & Workforce Program Manager
John Sawyer, DHHS, IT Analyst II
Joyce Bartlett, DBHS, Senior Mental Health Counselor
Kacey Vencill, DBHS, SacHIE Project Manager
Kathy Aposhian, DBHS, Interim Quality Management Program Manager
Kaybee Alvardo, MHA, Peer Partner Specialist
Kelli Weaver, DBHS, Acting Program Health Manager
Kevin Kiser, DBHS, Senior Office Assistant
Kim Narvaez, Turning Point-Pathways, Clinical Team Leader
Laurie Clothier, River Oak Center for Children, Chief Executive Officer
Leslie Andrus-Hacia, CHW, Therapist
Lisa Bertaccini, DBHS, Child/Family Programs Chief
Lisa Sabillo, DBHS, Program Planner
Lisa Thorn, DBHS, Senior Mental Health Counselor
Lou DeVille, MHA, Program Coordinator
Mai Xiong, Hmong Women's Heritage Association, Peer Partner Specialist

Maria Curameng Teresi, CHW, Mental Health Counselor
Marilyn Hillerman, MHA, Adult Family Advocate Liaison
Marilyn Sepulveda, T-Core, Program Director
Mary Nakamura, DBHS, Program Coordinator
Mary Ann Corpus, DBHS, Senior Accountant
Matt Quinley, DBHS, Program Coordinator
Meeyoung Kim, DBHS, Mental Health Counselor
Meloney Ibarra, DBHS, Account Clerk III
Michelle Callejas, DBHS, MHSA Program Manager
Mutsumi Hartmann, Asian Pacific Community Counseling
OKeema Polite, DBHS, APSS/Aftercare Program Coordinator
Pat Williams, DBHS, Administration
Paul Cecchettini, Turning Point, Director of Adult Services
Regina Range, MHA, Peer Partner Specialist
Robin Howard, Terra Nova, Children's Services Director
Sherri Mikel, Program Coordinator
Silas Gulley, DBHS, MHTC, Clinical Director
Stacy Gannon, MHA, Peer Partner Specialist
Stephanie Ramos, DBHS, Family Coordinator
Susan Faitos, DBHS, CAPS/Co-op Program Coordinator
Tara Givens, Turning Point, Personal Services Coordinator III
Terry Nichols, DBHS, Adult Program Coordinator
Tracy Herbert, DHHS, Deputy Director
Tracy Woo, CHW, Therapist
Toi Gray, Turning Point, Database Manager
Uma Zykofsky, DBHS, Adult Programs Chief
Valerie Hitchcock, El Hogar, Personal Services Coordinator
Wendy Green, DBHS, Program Manager
Victoria Roberts, T-Core, Transportation Specialist
Vildana Fulton, Paradise Oaks, Quality Assurance Specialist
Youa Her, DBHS, Mental Health Clinician
Yvette Munoz-Russell, HRC/T-Core, Benefits/Resource Coordinator

C. Attachment—Approved Claims Source Data

- **Source:** Data in Figures 5 through 14 and Appendix D are derived from four statewide source files:
  - Short-Doyle/Medi-Cal approved claims (SD/MC) from the Department of Mental Health (DMH)
  - Short-Doyle/Medi-Cal denied claims (SD/MC–D) from the Department of Mental Health
  - Inpatient Consolidation claims (IPC) from the Department of Health Care Services via DMH
  - Monthly MEDS Extract Files (MMEF) from the Department of Health Care Services via DMH

- **Selection Criteria:**
  - Medi-Cal beneficiaries for whom the MHP is the "County of Fiscal Responsibility" are included, even when the beneficiary was served by another MHP
  - Medi-Cal beneficiaries with aid codes eligible for SD/MC program funding are included

- **Process Date:** The date DMH processes files for CAEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2008 file with a DMH process date of April 28, 2009 includes claims with service dates between January 1 and December 31, 2008 processed by DMH through March 2009.

  - CY2010 includes SD/MC and IPC approved claims with process date May 2011
  - CY2009 includes SD/MC and IPC approved claims with process date February 2011
  - CY2008 includes SD/MC and IPC approved claims with process date December 2009
  - CY2007 includes SD/MC and IPC approved claims with process date April 2009
  - CY2006 includes SD/MC and IPC approved claims with process date October 2007
  - CY2005 includes SD/MC and IPC approved claims with process date July 2006
  - FY09-10 includes SD/MC and IPC approved claims with process date February 2011
  - FY08-09 includes SD/MC and IPC approved claims with process date December 2009
  - FY07-08 includes SD/MC and IPC approved claims with process date April 2009
  - FY06-07 includes SD/MC and IPC approved claims with process date May 2008
  - FY05-06 includes SD/MC and IPC approved claims with process date October 2007
  - FY04-05 includes SD/MC and IPC approved claims with process date April 2006
  - FY03-04 includes SD/MC and IPC approved claims with process date October 2005
  - FY02-03 includes SD/MC and IPC approved claims as of final reconciliation
  - FY08-09 denials include SD/MC claims (not IPC claims) processed between July 1, 2008 and June 30, 2009 (without regard to service date) with process date November 2009. Same methodology is used for prior years.
  - Most recent MMEF includes Medi-Cal eligibility for April 2010 and 15 prior months

- **Data Definitions:** Selected elements displayed in many figures within this report are defined below.
  - Penetration rate – The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
  - Approved claims per beneficiary served per year – The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year

- **MHP Size:** Categories are based upon DMH definitions by county population.
  - Small-Rural MHPs = Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Plumas, Siskiyou, Trinity
  - Small MHPs = El Dorado, Humboldt, Imperial, Kings, Lake, Madera, Mendocino, Napa, Nevada, San Benito, Shasta, Sutter/Yuba, Tehama, Tuolumne
  - Medium MHPs = Butte, Marin, Merced, Monterey, Placer/Sierra, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Yolo
  - Large MHPs = Alameda, Contra Costa, Fresno, Kern, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Ventura
  - Los Angeles' statistics are excluded from size comparisons, but are included in statewide data.

D. Attachment— Medi-Cal Approved Claims Worksheets and Additional Tables

Medi-Cal Approved Claims Data for SACRAMENTO County MHP Calendar Year 10

Significant Claims Lag May Exist Due to SD/MC Phase II Processing Issues. The Claims Lag Varies across the MHPs.

Date Prepared:	07/20/2011, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	05/06/2011, 07/08/2011, and 04/04/2011 - Note (3)
Important Changes:	Note (5)

	SACRAMENTO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	318,937	16,209	$70,700,405	5.08%	$4,362	5.61%	$4,031	5.65%	$4,412
AGE GROUP									
0-5	57,463	1,184	$4,584,880	2.06%	$3,872	1.54%	$3,527	1.59%	$3,666
6-17	85,384	7,074	$42,599,234	8.28%	$6,022	7.29%	$5,290	7.56%	$5,895
18-59	135,907	7,023	$20,989,749	5.17%	$2,989	7.44%	$3,457	7.19%	$3,708
60+	40,184	928	$2,526,542	2.31%	$2,723	3.13%	$2,458	3.21%	$2,560
GENDER									
Female	177,994	8,237	$33,198,640	4.63%	$4,030	5.10%	$3,523	5.10%	$3,929
Male	140,944	7,972	$37,501,765	5.66%	$4,704	6.25%	$4,562	6.34%	$4,909
RACE/ETHNICITY									
White	87,349	6,499	$27,478,437	7.44%	$4,228	10.43%	$3,857	10.21%	$4,417

	SACRAMENTO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Hispanic	80,741	2,766	$11,528,331	3.43%	$4,168	3.39%	$3,757	3.47%	$4,280
African-American	60,574	4,213	$20,777,550	6.96%	$4,932	9.54%	$4,914	10.04%	$4,774
Asian/Pacific Islander	52,570	1,347	$4,507,513	2.56%	$3,346	3.91%	$3,144	3.99%	$3,333
Native American	2,741	208	$913,750	7.59%	$4,393	11.50%	$4,396	9.77%	$4,739
Other	34,965	1,176	$5,494,823	3.36%	$4,672	5.57%	$4,923	6.02%	$5,310
ELIGIBILITY CATEGORIES									
Disabled	64,244	7,397	$26,727,994	11.51%	$3,613	16.81%	$4,021	17.30%	$4,227
Foster Care	3,565	2,021	$15,406,680	56.69%	$7,623	56.77%	$6,934	61.29%	$7,268
Other Child	132,129	5,818	$24,328,040	4.40%	$4,182	3.90%	$3,907	4.09%	$4,392
Family Adult	78,450	1,407	$3,397,519	1.79%	$2,415	3.81%	$1,892	3.68%	$2,218
Other Adult	40,696	302	$840,174	0.74%	$2,782	0.92%	$2,779	0.93%	$2,764
SERVICE CATEGORIES									
Inpatient Services	318,937	691	$4,561,321	0.22%	$6,601	0.40%	$7,067	0.41%	$6,864
Residential Services	318,937	59	$214,485	0.02%	$3,635	0.07%	$7,460	0.06%	$7,665
Crisis Stabilization	318,937	196	$197,139	0.06%	$1,006	0.40%	$1,700	0.30%	$1,575
Day Treatment	318,937	46	$910,635	0.01%	$19,796	0.10%	$10,850	0.07%	$11,519
Case Management	318,937	12,394	$10,289,766	3.89%	$830	2.22%	$917	2.44%	$827
Mental Health Serv.	318,937	14,141	$44,322,288	4.43%	$3,134	4.24%	$2,689	4.45%	$3,075
Medication Support	318,937	8,179	$7,878,728	2.56%	$963	2.88%	$951	2.87%	$1,106
Crisis Intervention	318,937	569	$302,006	0.18%	$531	0.43%	$756	0.59%	$927
TBS	318,937	275	$2,024,037	0.09%	$7,360	0.08%	$11,366	0.07%	$13,005

Footnotes:

1 - Includes approved claims data on MHP eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 10,435

5 - Beginning with CY10 data, CAEQRO made the following Service Category Changes:

- "24 Hours Services" is no longer a unique service category. The components of "24 Hours Services" are reported as "Inpatient Services" or "Residential Services"
- "23 Hours Services" has been relabeled "Crisis Stabilization", which includes Urgent Care
- "Linkage/Brokerage" has been relabeled "Case Management"
- "Outpatient Services" is no longer a unique service category. The components of "Outpatient Services" are reported as "Mental Health Serv." or "Crisis Intervention"

SACRAMENTO County MHP Medi-Cal Services Retention Rates CY10

	SACRAMENTO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	852	5.26	5.26	9.93	9.93	5.26	18.53
2 services	717	4.42	9.68	6.72	16.66	4.15	15.79
3 services	723	4.46	14.14	5.82	22.48	2.96	10.53
4 services	686	4.23	18.37	5.12	27.60	0.00	8.87
5 - 15 services	5,270	32.51	50.89	33.00	60.60	22.39	41.45
> 15 services	7,961	49.11	100.00	39.40	100.00	18.01	57.59

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 05/06/2011; Inpatient Consolidation approved claims as of 07/08/2011

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Medi-Cal Approved Claims Data for SACRAMENTO County MHP Calendar Year 10

Foster Care

Significant Claims Lag May Exist Due to SD/MC Phase II Processing Issues. The Claims Lag Varies across the MHPs.

Date Prepared:	07/20/2011, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	05/06/2011, 07/08/2011, and 04/04/2011 - Note (3)
Important Changes:	Note (5)

	SACRAMENTO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	3,565	2,021	$15,406,680	56.69%	$7,623	56.77%	$6,934	61.29%	$7,268
AGE GROUP									
0-5	939	328	$1,369,734	34.93%	$4,176	35.01%	$3,179	42.17%	$3,299
6+	2,626	1,693	$14,036,945	64.47%	$8,291	64.38%	$7,648	67.95%	$8,126
GENDER									
Female	1,769	978	$7,097,760	55.29%	$7,257	55.38%	$6,722	59.51%	$7,120
Male	1,796	1,043	$8,308,919	58.07%	$7,966	58.09%	$7,128	62.98%	$7,401
RACE/ETHNICITY									
White	1,094	680	$5,452,983	62.16%	$8,019	62.64%	$6,909	53.00%	$8,098

	SACRAMENTO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Hispanic	629	358	$2,538,906	56.92%	$7,092	54.36%	$5,694	72.72%	$5,835
African-American	1,465	845	$6,528,824	57.68%	$7,726	57.01%	$8,302	68.13%	$7,815
Asian/Pacific Islander	180	85	$481,740	47.22%	$5,668	65.02%	$7,954	69.93%	$7,502
Native American	44	23	$138,975	52.27%	$6,042	52.63%	$5,851	45.51%	$7,087
Other	155	30	$265,252	19.35%	$8,842	25.58%	$12,414	36.93%	$10,525
SERVICE CATEGORIES									
Inpatient Services	3,565	53	$374,042	1.49%	$7,057	1.64%	$7,155	2.16%	$7,147
Residential Services	3,565	0	$0	0.00%	$0	0.01%	$1,972	0.01%	$3,695
Crisis Stabilization	3,565	26	$24,910	0.73%	$958	1.39%	$1,146	1.05%	$1,232
Day Treatment	3,565	23	$443,269	0.65%	$19,273	3.56%	$12,329	2.88%	$12,176
Case Management	3,565	1,726	$2,829,541	48.42%	$1,639	23.75%	$1,296	28.18%	$957
Mental Health Serv.	3,565	1,951	$10,075,822	54.73%	$5,164	53.21%	$4,643	58.53%	$5,037
Medication Support	3,565	748	$952,826	20.98%	$1,274	18.05%	$1,219	19.23%	$1,510
Crisis Intervention	3,565	52	$34,149	1.46%	$657	3.05%	$1,045	4.03%	$1,425
TBS	3,565	96	$672,120	2.69%	$7,001	3.14%	$10,613	3.00%	$12,351

Footnotes:

1 - Includes approved claims data on MHP eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 136

5 - Beginning with CY10 data, CAEQRO made the following Service Category Changes:

- "24 Hours Services" is no longer a unique service category. The components of "24 Hours Services" are reported as "Inpatient Services" or "Residential Services"
- "23 Hours Services" has been relabeled "Crisis Stabilization", which includes Urgent Care
- "Linkage/Brokerage" has been relabeled "Case Management"
- "Outpatient Services" is no longer a unique service category. The components of "Outpatient Services" are reported as "Mental Health Serv." or "Crisis Intervention"

SACRAMENTO County MHP Medi-Cal Services Retention Rates CY10

Foster Care

	SACRAMENTO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	47	2.33	2.33	6.48	6.48	0.00	22.97
2 services	47	2.33	4.65	5.23	11.71	0.00	16.89
3 services	50	2.47	7.13	4.64	16.34	0.00	16.30
4 services	49	2.42	9.55	3.65	19.99	0.00	15.15
5 - 15 services	451	22.32	31.87	26.21	46.20	7.14	54.55
> 15 services	1,377	68.13	100.00	53.80	100.00	18.18	80.00

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 05/06/2011; Inpatient Consolidation approved claims as of 07/08/2011

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Medi-Cal Approved Claims Data for SACRAMENTO County MHP Calendar Year 10

Transition Age Youth (Age 16-25)

Significant Claims Lag May Exist Due to SD/MC Phase II Processing Issues. The Claims Lag Varies across the MHPs.

Date Prepared:	07/20/2011, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	05/06/2011, 07/08/2011, and 04/04/2011 - Note (3)
Important Changes:	Note (5)

	SACRAMENTO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	51,419	2,798	$16,851,277	5.44%	$6,023	6.73%	$5,120	6.82%	$5,515
AGE GROUP									
16-17	14,440	1,345	$9,554,915	9.31%	$7,104	9.75%	$6,021	10.07%	$6,474
18-21	22,683	1,162	$6,312,777	5.12%	$5,433	5.98%	$4,636	6.04%	$5,011
22-25	14,297	291	$983,586	2.04%	$3,380	4.62%	$4,044	4.46%	$4,236
GENDER									
Female	30,353	1,406	$8,022,766	4.63%	$5,706	5.58%	$4,763	5.65%	$5,250
Male	21,067	1,392	$8,828,511	6.61%	$6,342	8.45%	$5,469	8.51%	$5,771
RACE/ETHNICITY									
White	12,778	1,010	$6,685,338	7.90%	$6,619	11.75%	$4,862	12.17%	$5,728

	SACRAMENTO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Hispanic	12,703	508	$2,552,554	4.00%	$5,025	4.66%	$4,677	4.77%	$5,112
African-American	12,027	909	$5,591,177	7.56%	$6,151	10.86%	$5,818	10.81%	$5,655
Asian/Pacific Islander	8,753	198	$938,083	2.26%	$4,738	3.56%	$5,601	3.57%	$5,703
Native American	527	35	$151,842	6.64%	$4,338	10.29%	$5,531	9.99%	$5,614
Other	4,632	138	$932,284	2.98%	$6,756	6.84%	$6,488	7.15%	$7,037
ELIGIBILITY CATEGORIES									
Disabled	6,197	921	$5,933,838	14.86%	$6,443	19.84%	$5,829	20.91%	$6,119
Foster Care	803	567	$4,312,744	70.61%	$7,606	72.67%	$8,019	79.64%	$8,030
Other Child	12,568	771	$3,834,191	6.13%	$4,973	7.58%	$4,326	7.92%	$4,747
Family Adult	26,120	596	$2,198,979	2.28%	$3,690	3.79%	$2,781	3.97%	$3,198
Other Adult	5,796	154	$571,525	2.66%	$3,711	2.95%	$3,968	2.70%	$3,950
SERVICE CATEGORIES									
Inpatient Services	51,419	229	$1,582,386	0.45%	$6,910	0.72%	$6,655	0.72%	$6,255
Residential Services	51,419	12	$42,974	0.02%	$3,581	0.06%	$7,496	0.05%	$8,210
Crisis Stabilization	51,419	58	$43,959	0.11%	$758	0.68%	$1,432	0.48%	$1,412
Day Treatment	51,419	26	$439,717	0.05%	$16,912	0.22%	$11,173	0.18%	$11,401
Case Management	51,419	2,175	$2,660,280	4.23%	$1,223	2.70%	$1,135	3.01%	$937
Mental Health Serv.	51,419	2,458	$10,037,437	4.78%	$4,084	5.42%	$3,289	5.65%	$3,775
Medication Support	51,419	1,329	$1,496,627	2.58%	$1,126	3.09%	$998	3.05%	$1,189
Crisis Intervention	51,419	125	$74,834	0.24%	$599	0.73%	$821	0.94%	$960
TBS	51,419	74	$473,063	0.14%	$6,393	0.13%	$10,525	0.11%	$10,933

Footnotes:

1 - Includes approved claims data on MHP eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 1,940

5 - Beginning with CY10 data, CAEQRO made the following Service Category Changes:

- "24 Hours Services" is no longer a unique service category. The components of "24 Hours Services" are reported as "Inpatient Services" or "Residential Services"
- "23 Hours Services" has been relabeled "Crisis Stabilization", which includes Urgent Care
- "Linkage/Brokerage" has been relabeled "Case Management"
- "Outpatient Services" is no longer a unique service category. The components of "Outpatient Services" are reported as "Mental Health Serv." or "Crisis Intervention"

SACRAMENTO County MHP Medi-Cal Services Retention Rates CY10

Transition Age Youth (Age 16-25)

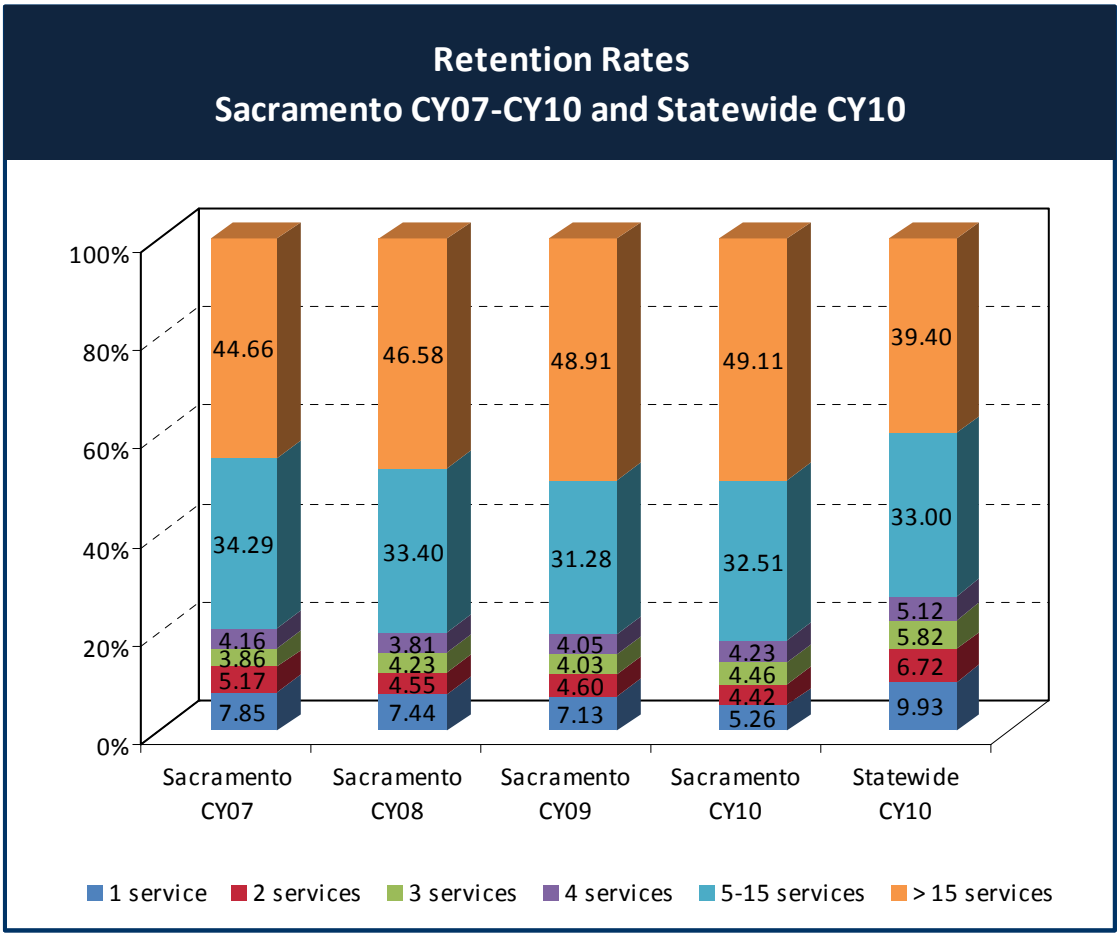
	SACRAMENTO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	138	4.93	4.93	10.52	10.52	0.00	27.03
2 services	122	4.36	9.29	6.76	17.28	0.00	18.18
3 services	118	4.22	13.51	5.35	22.63	0.00	13.08
4 services	106	3.79	17.30	4.54	27.17	0.00	12.16
5 - 15 services	762	27.23	44.53	29.61	56.78	0.00	42.31
> 15 services	1,552	55.47	100.00	43.22	100.00	10.81	100.00

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 05/06/2011; Inpatient Consolidation approved claims as of 07/08/2011

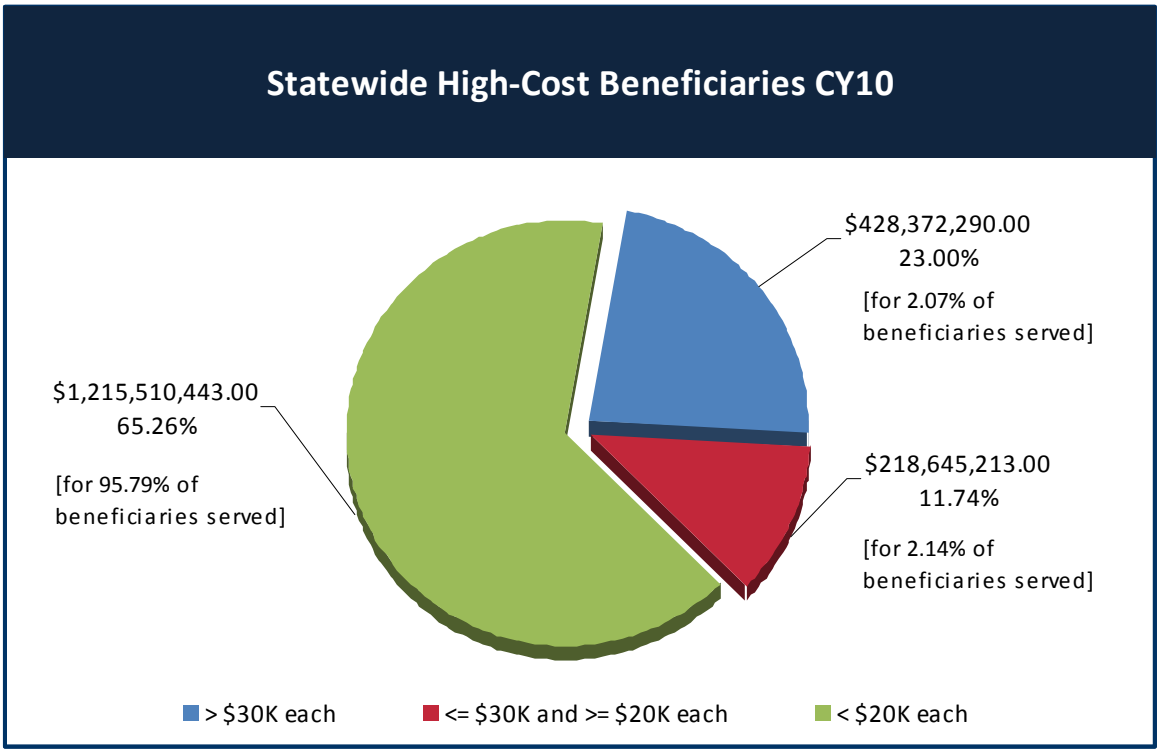
Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

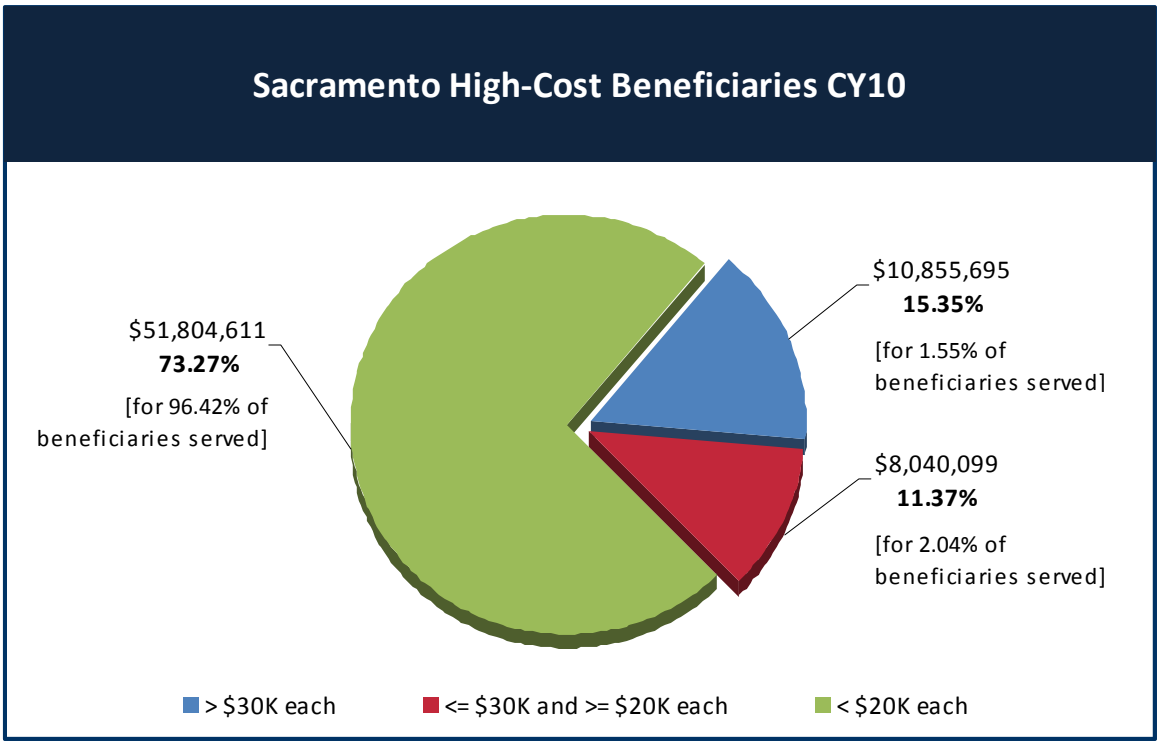
Retention Rates



CY2010 Retention Rates with Average Approved Claims per Category			
Number of Services Approved per Beneficiary Served	Sacramento Number of beneficiaries served	Sacramento $ per beneficiary served	Statewide $ per beneficiary served
1 service	852	$197	$286
2 services	717	$366	$448
3 services	723	$522	$598
4 services	686	$673	$731
5 – 15 services	5,270	$1,366	$1,496
> 15 services	7,961	$7,817	$9,613

High Cost Beneficiaries CY10





EXAMINATION OF DISPARITIES

Statewide disparities remain for Hispanic and female beneficiaries:

- The relative access and the average approved claims for Hispanic beneficiaries were lower than for White beneficiaries. Over the past four years of data, these disparities decreased slightly – approaching parity in approved claims but a continued remarkable disparity in access.
- The relative access and the average approved claims for female beneficiaries were lower than for males. These disparities have remained stable over the last four years.

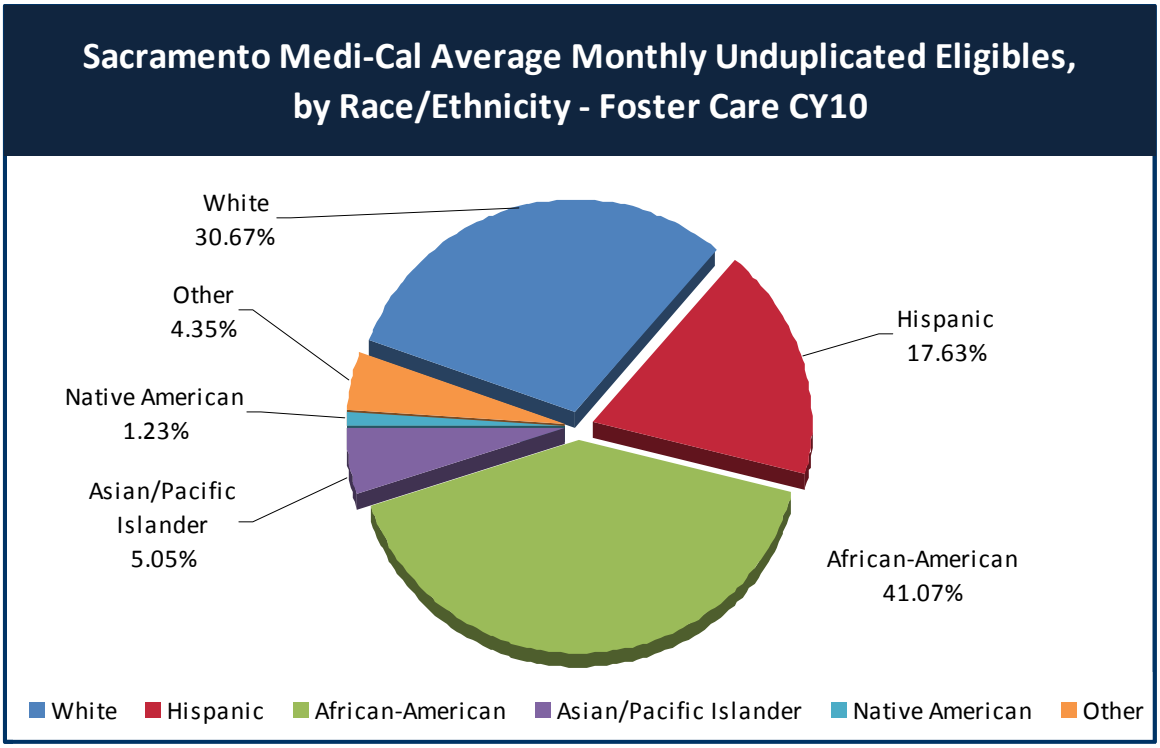
For each variable (Hispanic/White and female/male), two ratios are calculated to depict relative access and relative approved claims. The first figure compares approved claims data and penetration rates between Hispanic and White beneficiaries. This penetration rate ratio is calculated by dividing the Hispanic penetration rate by the White penetration rate, resulting in a ratio that depicts the relative access for Hispanics when compared to Whites. The approved claims ratio is calculated by dividing the average approved claims for Hispanics by the average approved claims for Whites. Similar calculations follow in the second figure for female to male beneficiaries.

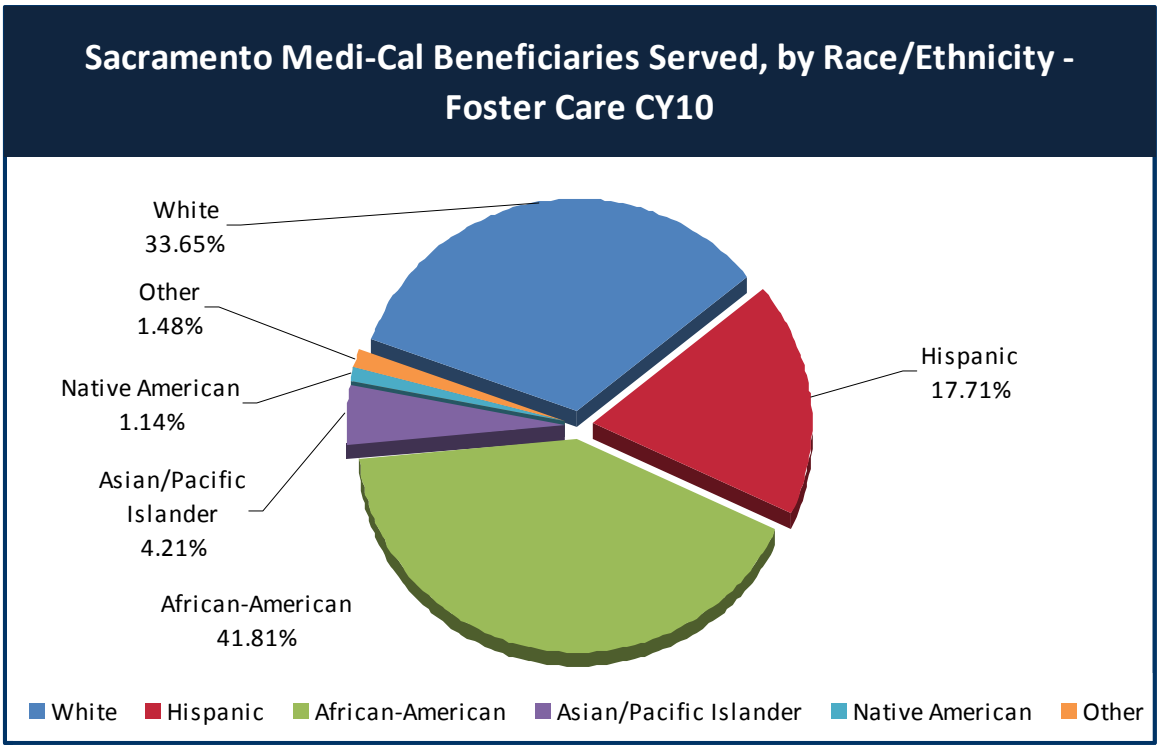
For all elements, ratios depict the following:

- 1.0 = parity between the two elements compared
- Less than 1.0 = disparity for Hispanics or females
- Greater than 1.0 = no disparity for Hispanics or females. A ratio of greater than one indicates higher penetration or approved claims for Hispanics when compared to Whites or for females when compared to males.

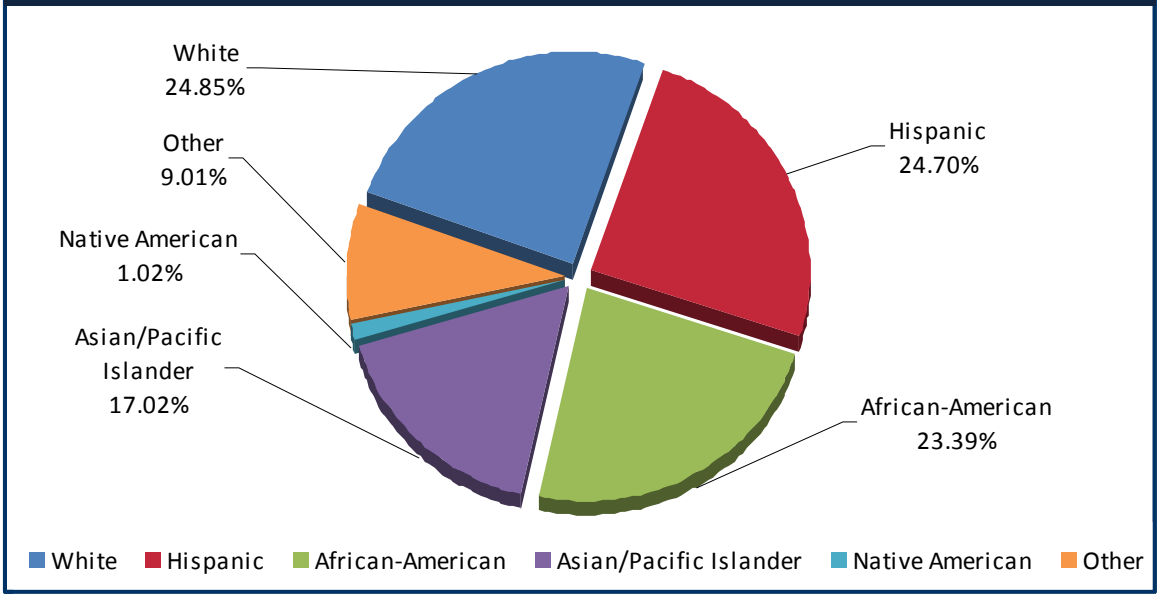
Examination of Disparities—Hispanic versus White								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY10	142,652	3.47%	151,185	10.21%	$4,280	$4,417	.34	.97
Sacramento CY10	2,766	3.43%	6,499	7.44%	$4,168	$4,228	.46	.99
Sacramento CY09	3,224	4.04%	8,427	9.63%	$4,692	$4,621	.42	1.02
Sacramento CY08	3,228	4.34%	8,727	10.51%	$4,645	$4,653	.41	1.00
Sacramento CY07	3,156	4.51%	8,674	10.85%	$4,427	$4,395	.42	1.01

Examination of Disparities—Female versus Male								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Female versus Male for	
	Female		Male		Female	Male	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY10	214,174	5.10%	208,009	6.34%	$3,929	$4,909	.81	.80
Sacramento CY10	8,237	4.63%	7,972	5.66%	$4,030	$4,704	.82	.86
Sacramento CY09	10,837	6.14%	9,745	7.05%	$4,209	$5,338	.87	.79
Sacramento CY08	11,170	6.67%	9,955	7.70%	$4,187	$5,389	.87	.78
Sacramento CY07	10,889	6.74%	9,826	7.94%	$3,960	$4,980	.85	.80

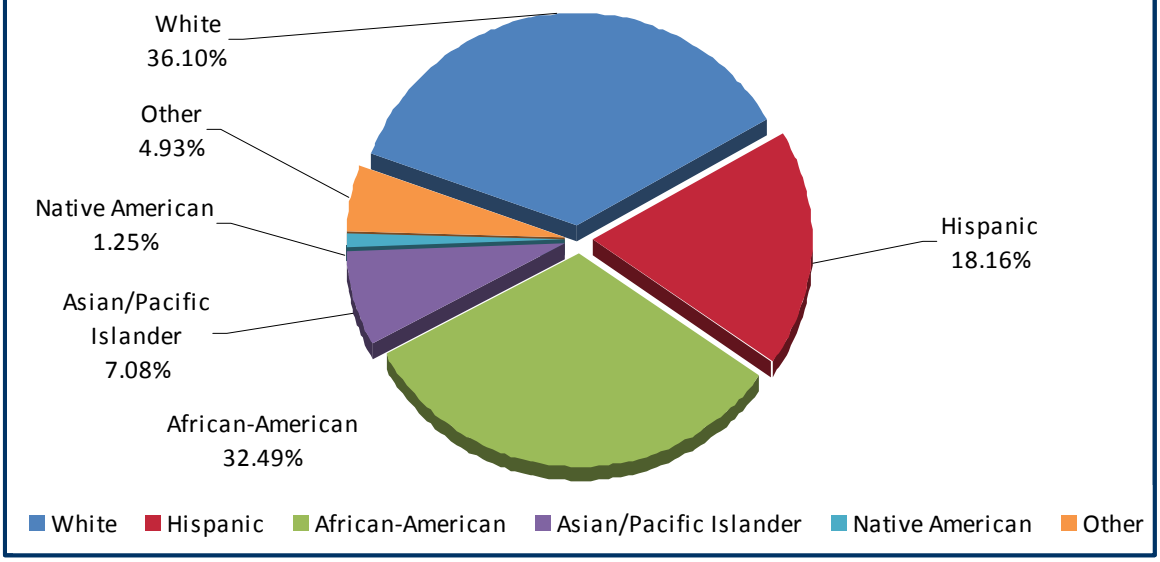

Sacramento Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Foster Care CY10
White 30.67%
Hispanic 17.63%
African-American 41.07%
Asian/Pacific Islander 5.05%
Native American 1.23%
Other 4.35%
White
Hispanic
African-American
Asian/Pacific Islander
Native American
Other


Sacramento Medi-Cal Beneficiaries Served, by Race/Ethnicity - Foster Care CY10
White 33.65%
Hispanic 17.71%
African-American 41.81%
Asian/Pacific Islander 4.21%
Native American 1.14%
Other 1.48%
White
Hispanic
African-American
Asian/Pacific Islander
Native American
Other

Sacramento Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Transition Age Youth CY10



Sacramento Medi-Cal Beneficiaries Served, by Race/Ethnicity - Transition Age Youth CY10



E. Attachment—PIP Validation Tool

FY11-12 Review of: Sacramento ☒ Clinical ☐ Non-Clinical

PIP Title: Improvement of Outpatient Treatment Alternatives for High Risk/High Need EPSDT Beneficiaries

Date PIP Began: 7-23-2008

PIP Category: ☐Access ☐Timeliness ☒Quality ☐Outcomes ☐Other

Descriptive Category: Improved diagnosis or treatment process

Target population: Other- High Cost EPSDT users

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
1	**Study topic** *The study topic:* creating outpatient alternatives for high cost/high need youth to avoid disruptive crisis stabilization episodes					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	x				Just fewer than 50% of the 120+ youth seen at MERT every month experience an acute psychiatric hospitalization following the crisis stabilization episode. In addition, 22% of youth hospitalized experience a subsequent acute hospitalization within 90 days of being discharged. Again, considering the existing Children's system of care, This information represents a high cost to the MHP.
1.2	Was selected following data collection and analysis of data that supports the identified problem	x				Looking more closely at the sub-group of youth comprising the top 25% of open high cost clients (N=197), data were mined to generate hypotheses about possible causes of the high cost.
1.3	Addresses key aspects of care and services	x				
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs	x				Medi-Cal eligible clients receiving outpatient services in the MHP experiencing a crisis stabilization episode at MERT.
1.5	Has the potential to improve consumer mental health outcomes, functional status,	x				Therefore, there may be up to 600 youth annually who could benefit from TBS services to

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	satisfaction, or related processes of care designed to improve same					prevent both crisis stabilization and subsequent hospitalization.
Totals for Step 1:		**5**				
2	**Study Question Definition** *The written study question:* Will providing a TBS referral to all Med-Cal eligible clients receiving outpatient services in the MHP experiencing a crisis stabilization episode at MERT lead to reduced hospitalization and need for intensive mental health services in the future?					
2.1	Identifies the problem targeted for improvement	**x**				
2.2	Includes the specific population to be addressed	**x**				Use of MERT = TBS referral
2.3	Includes a general approach to interventions	**x**				
2.4	Is answerable/demonstrable	**x**				
2.5	Is within the MHP's scope of influence	**x**				
Totals for Step 2:		**5**				
3	**Clearly Defined Study Indicators** *The study indicators:* 90-day inpatient recidivism rate, 90-day crisis stabilization rate, % of crisis stabilizations that lead to inpatient tx,					
3.1	Are clearly defined, objective, and measurable	**x**				
3.2	Are designed to answer the study question	**x**				
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	**x**				MHP is improving the process of care by attending to the needs evidenced by youth who do present in a crisis stabilization episode.
3.4	Have accessible data that can be collected for each indicator	**x**				
3.5	Utilize existing baseline data that demonstrate the current status for each indicator	**x**				Used FY 2007-08 data.
3.6	Identify relevant benchmarks for each indicator				**x**	
3.7	Identify a specific, measurable goal(s) for each indicator	**x**				5% in each indicator.
Totals for Step 3:		**6**			**1**	
4	**Correctly Identified Study Population** *The method for identifying the study population:*					
4.1	Is accurately and completely defined	**x**				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
4.2	Included a data collection approach that captures all consumers for whom the study question applies	x				
Totals for Step 4:		**2**				
5	**Use of Valid Sampling Techniques** *The sampling techniques:* no sampling technique used					
5.1	Consider the true or estimated frequency of occurrence in the population				x	
5.2	Identify the sample size	x				103 initially, but do not provide updated size, nor info if children added throughout.
5.3	Specify the confidence interval to be used				x	
5.4	Specify the acceptable margin of error				x	
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population				x	
Totals for Step 5:		**1**			**4**	
6	**Accurate/Complete Data Collection** *The data techniques:*					
6.1	Identify the data elements to be collected	x				Info on TBS referral form, was services authorized, did they begin, process/outcome of service provision.
6.2	Specify the sources of data	x				IS system and TBS forms.
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data	x				
6.4	Provides a timeline for the collection of baseline and remeasurement data	x				Pre-post design only, no repeated measurement
6.5	Identify qualified personnel to collect the data	x				Good description.
Totals for Step 6:		**6**				
7	**Appropriate Intervention and Improvement Strategies** *The planned/implemented intervention(s) for improvement:* referral to TBS program					
7.1	Are related to causes/barriers identified through data analyses and QI processes	x				
7.2	Have the potential to be applied system wide		x			Intensives services like in TBS not appropriate

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	to induce significant change					for other consumers, so there are some inherent limitations in system-wide application. It has increased awareness throughout the system of TBS as a viable alternative.
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			x		Did look at data frequently enough to figure out if intensive services did make the difference
7.4	Are standardized and monitored when an intervention is successful	x				
Totals for Step 7:		**2**	**1**	**1**		
8	**Analyses of Data and Interpretation of Study Results** *The data analyses and study results:* pre/post methodology, comparison between groups of children in high intensity programs (WRAP/FIT) to those not,					
8.1	Are conducted according to the data analyses plan in the study design	x				Measured twice after one-year intervals
8.2	Identify factors that may threaten internal or external validity			x		Not true
8.3	Are presented in an accurate, clear, and easily understood fashion		x			Increase vs. decrease in performance indicators (not all according to Table D) - no detailed interpretation
8.4	Identify initial measurement and remeasurement of study indicators	x				Had planned to use CANS data as well, but was a delay in CANS implementation so in remeasurement timeframe was not enough repeat data to analyze.
8.5	Identify statistical differences between initial measurement and remeasurement			x		
8.6	Include the interpretation of findings and the extent to which the study was successful	x				
Totals for Step 8:		**3**	**1**	**2**		
9	**Improvement Achieved** *There is evidence for true improvement based on:* NOT achieved					
9.1	A consistent baseline and remeasurement methodology	x				
9.2	Documented quantitative improvement in processes or outcomes of care		x			For some child consumers yes, but not all.
9.3	Improvement appearing to be the result of the			x		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	planned interventions(s)					
9.4	Statistical evidence for improvement		x			Was a drop in recidivism rates
Totals for Step 9:		**1**	**2**	**1**		
10	**Sustained Improvement Achieved** *There is evidence for sustained improvement based on:* Not achieved					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			x		
Totals for Step 10:				**1**		

FY11-12 Review of: Sacramento ☐ Clinical ☒ Non-Clinical

PIP Title: Primary Care

Date PIP Began: 12-2010

PIP Category: ☐Access ☐Timeliness ☐Quality ☒Outcomes ☐Other

Descriptive Category: Physical Health Care

Target Population: All population (adults)

Step		Rating				Comments/Recommendations
		Met	**Partial**	**Not Met**	**N/A**	
1	**Study topic** *The study topic:* Physical ailment co-morbidity in SMI patients. Improving the physical health of SMI patients with co-occurring chronic medical conditions.					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	**x**				Good literature review to establish basis of PIP.
1.2	Was selected following data collection and analysis of data that supports the identified problem	**x**				Selected as 1 of 6 pilot counties in CALMEND project on PC and BH collaboration/integration. Sac did gap analysis on issue of primary care for consumers. Random chart review of 10% of open case files (n = 773).
1.3	Addresses key aspects of care and services	**x**				
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs	**x**				PIP includes all beneficiaries for whom the question applies. However, it will start at the standard outpatient programs. The initial phase of this PIP is a pilot project involving all clients receiving outpatient services at the four Regional Support Teams (RST's) in the MHP. It is our goal to test this intervention on a small scale to determine the benefits to applying the intervention system wide.
1.5	Has the potential to improve consumer mental	**x**				91% of DBH consumers had at least one

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	health outcomes, functional status, satisfaction, or related processes of care designed to improve same					documented medical issue in chart.
Totals for Step 1:		**5**				
2	**Study Question Definition** *The written study question:* Will increasing efforts to document, coordinate and follow-up on medical issues with the consumer's primary care provider lead to improved primary care access/follow-up and treatment for mental health consumers served in standard outpatient clinic care?					
2.1	Identifies the problem targeted for improvement	**x**				
2.2	Includes the specific population to be addressed	**x**				Consumer has one of 6 chronic medical conditions with high mortality rates
2.3	Includes a general approach to interventions	**x**				
2.4	Is answerable/demonstrable	**x**				
2.5	Is within the MHP's scope of influence	**x**				
Totals for Step 2:		**5**				
3	**Clearly Defined Study Indicators** *The study indicators:* documented PCP info in chart, PCP info in service plan, medical condition in service plan, medical conditions in progress notes, medical condition and PCP info recorded in Avatar in correct place, PCP appointments in progress notes, coordination of care with PCP in service plan, coordination of care with PCP in progress notes					
3.1	Are clearly defined, objective, and measurable	**x**				came up with these indicators from chart review process
3.2	Are designed to answer the study question	**x**				
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	**x**				
3.4	Have accessible data that can be collected for each indicator	**x**				
3.5	Utilize existing baseline data that demonstrate the current status for each indicator	**x**				Good job id'ing these through data from chart review being processed
3.6	Identify relevant benchmarks for each indicator				**x**	
3.7	Identify a specific, measurable goal(s) for each indicator	**x**				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
Totals for Step 3:		**6**			**1**	
4	**Correctly Identified Study Population** *The method for identifying the study population:*					
4.1	Is accurately and completely defined	**x**				
4.2	Included a data collection approach that captures all consumers for whom the study question applies	**x**				All consumers receiving outpatient services at four RSTs who report one of the six focus medical conditions.
Totals for Step 4:		**2**				
5	**Use of Valid Sampling Techniques** *The sampling techniques:*					
5.1	Consider the true or estimated frequency of occurrence in the population				**x**	
5.2	Identify the sample size		**x**			60% of all adult outpatient consumers to begin with, adding new consumers as they go along.
5.3	Specify the confidence interval to be used				**x**	
5.4	Specify the acceptable margin of error				**x**	
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population				**x**	No sampling used.
Totals for Step 5:			**1**		**4**	
6	**Accurate/Complete Data Collection** *The data techniques:*					
6.1	Identify the data elements to be collected	**x**				
6.2	Specify the sources of data	**x**				Avatar, charts
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data	**x**				
6.4	Provides a timeline for the collection of baseline and remeasurement data	**x**				Quarterly for RST use and for PIP
6.5	Identify qualified personnel to collect the data	**x**				
Totals for Step 6:		**5**				
7	**Appropriate Intervention and Improvement Strategies** *The planned/implemented intervention(s) for improvement:* Trainings at 4 contractors were in June 2011. Second set scheduled for					

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	August with CFMs. Then roll out of all forms and tracking mechanisms at RSTs once all trained.					
7.1	Are related to causes/barriers identified through data analyses and QI processes	x				Trainings on physical health issues, how to address them in treatment, stressed imp of coordinated care, dialogue on barriers to coordination (this was the pre-intervention to lay foundation for PIP and helped to ID barriers).
7.2	Have the potential to be applied system wide to induce significant change	x				
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful	x				Found a failure of subjects to return PCP appt forms, so just met with team on issue and revising the form to make it compatible for both MHP and PCP usage
7.4	Are standardized and monitored when an intervention is successful	x				All forms will be filled out by trained program services cords at all 4 sites, plus ongoing tech support offered directly by MHP.
Totals for Step 7:		**4**				
8	**Analyses of Data and Interpretation of Study Results** *The data analyses and study results:*					
8.1	Are conducted according to the data analyses plan in the study design			x		The PIP has not yet reached this stage.
8.2	Identify factors that may threaten internal or external validity			x		
8.3	Are presented in an accurate, clear, and easily understood fashion			x		
8.4	Identify initial measurement and remeasurement of study indicators			x		
8.5	Identify statistical differences between initial measurement and remeasurement			x		
8.6	Include the interpretation of findings and the extent to which the study was successful			x		
Totals for Step 8:				**6**		
9	**Improvement Achieved** *There is evidence for true improvement based on:*					
9.1	A consistent baseline and remeasurement			x		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	methodology					
9.2	Documented quantitative improvement in processes or outcomes of care			x		
9.3	Improvement appearing to be the result of the planned interventions(s)			x		
9.4	Statistical evidence for improvement			x		
Totals for Step 9:				**4**		
10	**Sustained Improvement Achieved** *There is evidence for sustained improvement based on:*					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			x		
Totals for Step 10:				**1**		

F. Attachment—MHP PIPs Submitted

California EQRO
560 J Street, Suite 390
Sacramento, CA 95814

Regarding this PIP Submission Document:

- **This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that CAEQRO uses in evaluating PIPs. The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP.**
- **You are not limited to the space in this document. It will expand, so feel free to use more room than appears to be provided, and include relevant attachments.**
- **Emphasize the work completed over the past year, if this is a multi-year PIP. A PIP that has not been active and was developed in a prior year may not receive "credit."**
- **PIPs generally should not last longer than roughly two years.**

CAEQRO PIP Outline via Road Map

MHP: *Sacramento County*
Date PIP Began: *December 13, 2010*
Title of PIP: *Primary Care*
Clinical or Non-Clinical: *Non-Clinical*

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.

The Sacramento County Mental Health Plan (MHP) established an Adult PIP Committee to develop and implement this PIP. The Committee consisted of a cross section of administration, service provider and advocacy. A series of committee meetings were held as well as sub-committee meetings where specific tasks were the focus of attention. The Adult PIP Committee was comprised of representatives from: MHP Adult Access Team, County Operated programs and Contract Monitors, Quality Management, Research & Evaluation, Cultural Competence, Mental Health Services Act (MHSA) representatives, contract providers, representatives and family advocates. The brainstorming activities to understand the gaps and needs of the system to frame this Adult PIP began with an Adult PIP Committee meeting on December 13, 2010 and have continued through a series of committee and sub-committee meetings, individual communications with members of Adult PIP Committee, chart reviews at program sites as well as through the Quality Improvement Committee (QIC) monthly meeting report process.

The Adult PIP Committee membership is as follows:

County Participants
Uma Zykofsky, LCSW, Program Manager, Quality Management, Chair, QIC, Chair PIP Committee
Rod Kennedy, LMFT, Program Manager, Adult Mental Health Programs
Dawn Williams, Program Planner, Research & Evaluation
Lisa Sabillo, Program Planner, Research & Evaluation
Jesus Cervantes, Psy D. / LMFT, Mental Health Program Coordinator, Quality Management
Mary De Souza, MA, Planner, Quality Management
Terry Nichols, LCSW, Mental Health Program Coordinator, Adult Mental Health Programs
Kelli Weaver, LCSW, Acting Program Manager, Adult Mental Health Programs
Steve Ballanti, LCSW, Mental Health Program Coordinator, Adult Mental Health Programs
Okeema Polite, LCSW, Mental Health Program Coordinator, Adult Mental Health Programs
Robin Skalsky, LCSW, Mental Health Program Coordinator, Adult Mental Health Programs
Karen Giordano, LMFT, Mental Health Program Coordinator, Adult Mental Health Programs

Provider and Advocate Participation
Rene Reis, LCSW, El Hogar - Adult Outpatient: Regional Support Team
Rian W, Smith, LMFT, El Hogar - Adult Outpatient: Regional Support Team
Robert Kesselring, MA, El Hogar-Guest House- Homeless Program
Paul Cecchettini, Ed. D Psychologist, Turning Point –Adult Outpatient: Regional Support Team
Leslie Springler, ASW, Turning Point- Crisis Residential
Kathleen Heggun, LMFT, Turning Point-ISA- MHSA Full Service Partnership Program
Amadasun Igbinosa, MFTI, Turning Point-ISA- MHSA Full Service Partnership Program
Lynn Place, MHRS, Human Resource Consultants-Adult OP: Regional Support Team
Marlyn Sepulveda, ASW, Human Resource Consultants -T-CORE-
Sherri Mikel, MHRS, Human Resource Consultants-Adult Outpatient: Regional Support Team
Wendy Hoffman-Blank, LCSW, Visions Unlimited- Adult Outpatient: Regional Support Team
Karen Brockopp, LCSW, Transitional Living & Community Support- MHSA Full Service Partnership Program
Latika Alqarwani, LMFT, Transitional Living & Community Support- MHSA Full Service Partnership Program
Shannon Taylor, LMFT, Telecare SOAR-- MHSA Full Service Partnership Program
Alexis Lyon, MFTI, Turning Point, Pathways - MHSA Full Service Partnership Program
Jan Morgan, Turning Point-Pathways- MHSA Full Service Partnership Program
Tammy Dyer, ASW, Consumer Self Help - Wellness and Recovery Center
Meghan Stanton, BA, Consumer Self Help - Wellness and Recovery Center
Mutsumi Hartmann, MHRS, Asian Pacific Counseling Center-Transcultural Wellness Center- MHSA Full Service Partnership Program

Contributions from Sacramento County CALMEND participants from Primary Care Division:
Shannon Suo, MD, Psychiatry/Family Medicine
John Onate, MD, Psychiatry/Family Medicine
Dr. Robert McCarron, MD, Psychiatry/Family Medicine
Dr. Jaesu Han, MD, Psychiatry/Family Medicine

"Is there really a problem?"

2. Define the problem by describing the data reviewed and relevant benchmarks. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

The excess mortality associated with severe mental illness (SMI) is well known and has long been documented (Brown, 1997; Harris and Barraclough, 1998; Saha ert al., 2007). About 16 years ago, it was established that approximately 60% of individuals with mental illness develop serious medical co-morbidities that result in a lost life span of 15 to 20 years compared to the general population (Berren, Hill, Merkile, Gonzalez, & Santiago, 1994). Individuals with SMI are more likely to have physical co-morbidities, more likely to have physical health problems that are not being treated, and more physical co-morbidities are associated with worse mental health (Dixon et al., 1999). There are many factors that contribute to the poor physical health of people with SMI including lifestyle factors, medication side effects and disparities in healthcare. In a literature review published in the Journal of Psychopharmacology November 2010 (Lawrence and Kisely, 2010) the issues of physical co-morbidities and inequalities in medical treatment are attributed to a combination of factors including system issues, such as separation of mental health services from other medical services, healthcare provider issues including the pervasive stigma associated with mental illness, and consequences of mental illness and side effects of it's treatment.

There have been a number of solutions proposed to tackle these barriers. To address systemic barriers having to do with the separation of mental healthcare and physical healthcare a range of integrated models have been proposed (Vreeland,2007). These include co-location of services, having staff from one service visit another on a regular basis, or appointing case managers to act as liaisons between mental health and physical healthcare providers. Griswold et al, (2005,2008) found that nurse case managers were effective in increasing the percentage of patients with SMI who were successfully linked to primary care services. In another study, the use of case managers as liaisons with primary care physicians was associated with significant improvements in the quality and outcomes of primary care (Druss et al., 2010). It is well known that the stigma surrounding mental health pervades all aspects of society, including the healthcare system. One issue in the reduced access to primary care for people with SMI is that some practitioners regard people with SMI as being difficult or disruptive. Most often primary care physicians receive little to no training in mental health issues and are ill-equipped to address mental health issues and behaviors. Sartorius (2007b) has suggested that a campaign to reduce stigma and discrimination within the entire healthcare sector should be a high priority in an effort to reduce stigma associated with mental illness in the population at large. Mental health case managers and psychiatrists working in partnership with primary care physicians also provides the opportunity to cross train both sectors and heighten awareness of both the mental and physical health needs of people with SMI.

The importance of integrating mental health and primary care was acknowledged in 2003 with the release of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. One of many responses to this report was the establishment of the Primary Care/Mental Health Integration Workgroup, commonly referred to as the "Integration Workgroup". The overall mission of the Integration workgroup is to improve the health of people with and at risk for mental illnesses through expanded access to integrated health care services. Evidence indicates that integrated care improves access to and service outcomes for persons with or at risk of mental illness. Integrated services help maintain mental wellness and prevent the occurrence of mental distress or the exacerbation of existing mental illnesses. Integrating mental health and physical health for persons with SMI is not only a National need and priority, but is a local need as well.

In May 2010, the State Department of Health Care Services (DCHS), the State Department of Mental Health (DMH) and the California Institute of Mental Health initiated a six-county pilot collaborative to improve the health of individuals with severe mental illness and co-occurring chronic medical disorders through more effective partnerships between mental health and primary care providers. Sacramento County's Primary Care and Behavioral Health Division are one of six counties in this pilot collaborative through the CALMEND project. The six counties represent different local health care models and this project provides each county technical assistance and opportunity to locally improve coordination and/or integration of primary care and mental health services.

The CALMEND project has acknowledged the following challenges and realities concerning services to persons with Serious Mental Illness (SMI):

- Individuals with serious mental illness die, on average, 25 years earlier than the general population
- According to an analysis of Medi-Cal data, in 2007, the prevalence of diabetes, ischemic heart disease, cerebrovascular disease, arthritis and heart failure was three times higher among the SMI Medi Cal population compared to the general Medi-Cal population
- There is growing evidence that physical health problems are often caused and/or exacerbated by mental health problems
- Severe mental illness is associated with a 31.2% increase in the odds of being hospitalized in a given year
- Nationally, Medi-Caid beneficiaries who are disabled represent a minority of all Medi-Caid beneficiaries (16%) but account for a substantial portion of Medi-Caid expenditures (45%). (Pilot Collaborative to Integrate Primary Care & Mental Health Services)

Sacramento County Department of Health and Human Services (DHHS), through its Primary Care Division and Behavioral Health Division, is embarking on a multifaceted plan to increase the access to coordinated and/or integrated care for persons with mental illness and co-occurring physical health needs. While the MHP serves consumers with specialty mental health needs, physical care falls outside the direct system of care. However costs of this care or lack thereof impact mental health outcomes and general health outcomes for consumers. Increased costs for either physical or mental health impacts

community and consumer resources. The consumer populations affected by this PIP are Medi-cal eligible adult consumers meeting target population and being served in the Sacramento County MHP.

In Sacramento County, co-occurring physical health issues are reported in the current clinical or administrative records however follow-up and coordination with primary care continues to represent a gap in service needs. This PIP is designed to increase efforts to document issues regarding the client's physical health (primary care provider, medical issues, coordination of care efforts), to increase dialogue between the client and the mental health provider about medical issues that are effecting the client and to assist with coordination of medical issues as appropriate for our clients. By doing this we hope to assist our clients in maintaining both mental and physical wellness and decreasing the negative impacts that medical issues have on our clients mental health.

Team Brainstorming: "Why is this happening?"
Root cause analysis to identify challenges/barriers

3. a) Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

On December 13, 2010, the Adult PIP committee met to begin a gap/barrier analysis for the primary care PIP. Members of the committee represented a diverse mix of service providers, quality management staff, evaluation staff, and consumer and family representation. Brainstorming on barriers/causes of integrating and coordinating health care for Sacramento County's mental health consumers was completed and documented in meeting minutes. The committee recognized several areas where barriers exist:

- No Primary Care Provider: (1) Consumers may not have insurance to cover medical needs, (2) they don't want a primary care physician (PCP), (3) they are fearful, paranoid, (4) they don't understand the importance of taking care of their health needs, (5) they have to wait for service, and (6) they don't want to wait
- Access to Health Care: (1) No insurance, (2) hard to get appointments, (3) don't know how to select a doctor, (4) transportation to the doctor, (5) undertreated for pain, (6) inability to express discomfort or ask for help
- Training Needs: (1) how does the consumer talk to PCP, (2)what questions should they ask, (3) understanding what the PCP has told them, (4) supports to help the client navigate the PCP system, (5) cross system training of staff in the both mental health sector and primary care sector, (6) role and manner in which mental health staff can assist consumer in seeking health care and talking to MD

In an effort to further explore the barriers and gaps, it was decided that chart reviews of 10% of the open cases at Adult outpatient providers in the Sacramento County MHP would be conducted. A chart review form was presented and reviewed during the meeting to ensure key information was being captured. The committee gave feedback on the form, changes were made to the form and the finalized form was sent to committee members for approval. Providers were responsible for review of their own cases, however the County provided technical support and chart review assistance to providers as requested. The Research and Evaluation Unit provided a randomized list of 10% of open cases to each adult outpatient provider. The randomization was done using SPSS statistical software. The chart review form collected the following data:

- Were medical issues documented in the client chart and if so where were they documented?
- Did client have a PCP documented in the chart and if so where was the PCP documented?
- If client had medical issues was there documentation of follow-up and coordination of care?
- Were PCP appointments documented in the chart and was there follow-up following a documented PCP appointment?

Chart reviews were completed by January 28, 2010 on 773 of the 781 cases that were to be reviewed (99% review completion rate). Data from the chart review was analyzed and presented to a sub-committee of the Adult PIP committee. Initial data suggested that most clients had at least one medical issue documented in the chart (91%). These medical issues ranged from minor seasonal allergies to more serious issues such as diabetes and cardiovascular disease. With over 3202 documented medical issues, the sub-committee recommended that the scope of the PIP be limited to medical issues that align with the greatest mortality as established in national studies. The list of medical issues was categorized and sent to Dr. Shannon Suo and Dr. John Onate (dually licensed psychiatry/family medicine) to assist in identifying medical issues to focus on. The following table illustrates the category and examples of included diagnoses that Dr. Suo and Dr. Onate indicated were diagnoses with the highest mortality. Diagnoses in these categories represent approximately 27% of the total 3202 diagnoses from the chart reviews and 60% of all client's were noted to have at least one of these focus medical diagnoses. These categories are consistent with the focus diagnoses of the CALMEND project.

Categorized diagnoses:
Due to the extensive list of diagnoses, diagnoses were categorized and forwarded to Adult MH to obtain medical consultation on which diagnoses might be used as "focus" diagnoses for the PIP. The diagnoses suggested for focus of the PIP are highlighted in pink below.

Category	Examples of included diagnoses
High/Low Blood Pressure	Mostly HTN (only 2 with low bp)
Cholesterol	High cholesterol, dyslipidemia, hyperlipedemia, lipid d/o, low HDL, elevated triglyrcerides
Cardio/Cardiovascular Disease	Heart disease, arterial sclerotic disease, coronary artery disease, angina, CHF, murmur…
Cerebrovascular Disease	CVA, Stroke, hydocephalus
Diabetes	diabetes, hyperglycemia, diabetic neuropathy, low blood sugar
Liver disease	Hepatitis, Cirrhosis, jaundice, liver disease, hepatomegaly

Based on the data collected, suggestions for areas of focus for the PIP were discussed by the sub-committee and a plan to present the data to the larger committee was set for April 27, 2011. The data was presented broken down into program type and reviewed by the Adult PIP Committee on April 27, 2011. After the data review and discussion the Committee provided recommendations and feedback on the focus of the PIP. While the data showed that medical conditions were being documented in the chart, the location of the documentation was inconsistent and did little more than merely state the presence of a diagnosis without addressing the impact the medical condition was having on the client. Documentation addressing the need for follow-up/coordination of care was also absent. Without consistent and adequate documentation of medical issues and coordination of care it was difficult to assess the extent to which coordination and follow-up were being completed by mental health staff. It was the general consensus by the committee that if the primary care provider, medical issues and follow-up were documented in the case file it would lead to better coordination of care and better mental and physical health outcomes for the client. A consistent process for documenting the PCP, medical issues and follow-up were discussed and a plan to start the PIP intervention on July 1, 2011 was agreed on. Mental health service provider members of the Adult PIP Committee were asked to contact the County if they were interested in participating in the PIP. Most providers expressed an interest in participating. The decision to include only the RSTs in the PIP was based on the following considerations:

- Some of the other providers were already participating in pilot programs with the County and inclusion in the PIP may cause an excessive burden on limited provider resources
- Some of the other providers serve larger numbers of indigent and non medi-cal clients and the PIP focuses on Medi-cal eligible clients

(Initial thoughts were to include only 2 programs in the PIP, but because all 4 RSTs were eager to participate the decision was made to include all 4 RSTs.)

As additional support for the PIP, Sacramento County Quality Management coordinated trainings/forums for both providers and consumers regarding the integration of primary care and mental health:

- At the Consumer Speaks Conference held in Sacramento on December 16, 2010, Shannon Suo, MD, Psychiatry/Family Medicine Primary Health Division, Integrated Behavioral Health presented: "Beating the Odds: Improving Health for Consumers". Dr Suo's presentation focused on how to integrate mental and physical health. Dr. Suo not only spoke about the need to integrate the two systems but provided information to consumers on the importance of physical health, self management of chronic conditions and advocacy for your own treatment.

- The MHP along with the Primary Health Division collaborated to co-sponsor Primary Care Coordination trainings after meeting with service providers to identify some of key areas of concern for mental health

consumers in obtaining access to and receiving primary health care services. The trainings provided education about physical health issues and how to address issues that are identified during routine PCP office visits. The training also addressed the importance and need for coordinated/integrated mental and physical health care. Dialogue regarding the barriers to integrating mental and physical health care was discussed. These trainings were held at the 4 RST sites (Visions, El Hogar, Turning Point and Human Resource Consultants) with the intended audience being line staff/clinicians. There were a total of 69 clinicians at four RSTs that received these trainings on June 7, 8, 9 and 17, 2011. Clinicians at the RST's received training from primary care providers (MD's) on:

- Health care needs for adults with severe mental health conditions/health disparities
- How to approach the consumer to get them to engage with primary care
- Importance of coordination among providers
- How does the consumer talk to the primary care provider
- What questions should consumers be asking about follow-up
- Understanding what the primary care provider told the consumer
- Supports to help the client navigate the system

A second group of trainings/focus groups are currently being scheduled throughout August for consumers and their families. These trainings for consumers will focus on education about common health issues and the importance of taking care of them. The topics will be similar to what the service providers were trained on and will provide an opportunity to hear from the consumers on their needs through a question and answer forum.

Quality Management and REPO staff involved in the development and implementation of the PIP were in attendance at all of the trainings. Information from both the presentation at the Consumer speaks conference and the RST's provided information used in the planning and design of this PIP.

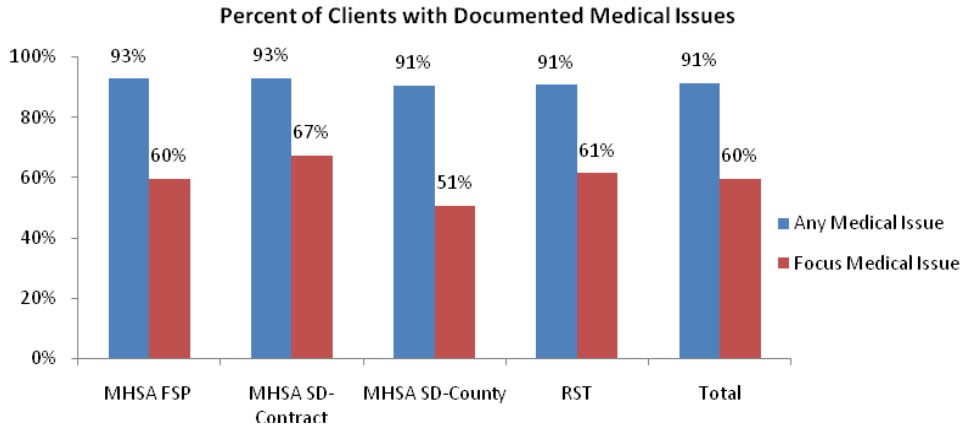
Based on feedback from the April 27, 2011 PIP Committee meeting and the trainings, a protocol for the PIP was developed and presented to the RST PIP providers on June 20, 2011. The RSTs provided feedback on the protocol and it was finalized and sent out to all providers to begin implementing on July 1, 2011 (see attached).

b) What are barriers/causes that require intervention? <u>Use Table A, and attach any charts, graphs, or tables to display the data.</u>

A randomized review of 10% of the open cases (N=773) in our adult MH system was completed in an effort to explore the healthcare issues that our clients face, the extent to which these healthcare issues are documented in the mental health chart, and the amount of follow-up/coordination of care being done on behalf of our clients with healthcare issues. Table 1

illustrates that across all providers 91% of our mental health clients have some type of medical issue/concern and 60% have a serious medical concern (Focus Medical Issue) that could lead to death if not treated and/or monitored.

Table 1



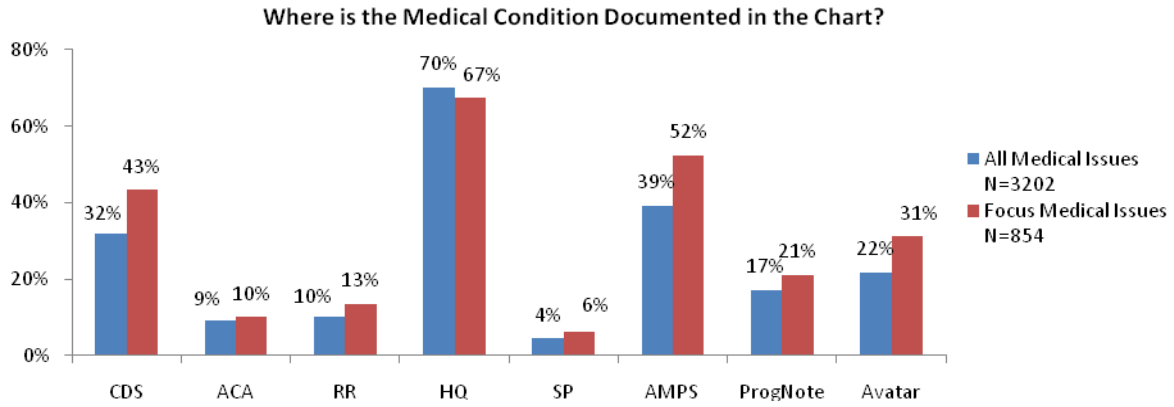
We then asked ourselves out of all the medical issues that our clients have told us about how many of those are medical issues that if untreated or monitored could lead to death. Table 2 illustrates that out of all the documented medical issues (3202), 27% were noted to be medical issues of serious concern (Focus medical issues). If we look at the clients that reported medical issues (707), we see an average of 5 medical issues per client. For clients that reported serious medical issues (461), we see an average of 2 serious medical issues per client. It is apparent that our clients are faced with multiple medical issues, including multiple serious medical issues that have a great effect on not only there quality of life, but their lifespan. The need to assist our clients obtain the healthcare they need to maintain and control their physical health issues is imperative to their overall mental and physical health.

Table 2

➢ 27 % of all documented medical issues are focus medical issues			
	# total medical issues	# of focus medical issues	% of medical issues that are focus med issues
MHSA FSP	575	164	29%
MHSA SD-Contract	636	151	24%
MHSA SD-County	658	164	25%
RST	1333	374	28%
Total	3202	854	27%

The next question we asked is "where is the medical condition documented in the chart?". What we found was that there is a disconnect in the case files regarding the documentation of all medical conditions. Most medical conditions were documented on the Health Questionnaire (HQ) and the AMPS, both are done usually at intake and annually. Follow up and coordination of care efforts on the medical issues identified on the HQ and AMPS should be documented on both the service plan and the progress notes. Table 3 illustrates that only 6% of charts documented medical needs on the Service Plan (SP) and 21% in the Progress Notes (ProgNote). Additionally only 22-31% of all medical conditions were documented in our Information System (Avatar).

Table 3



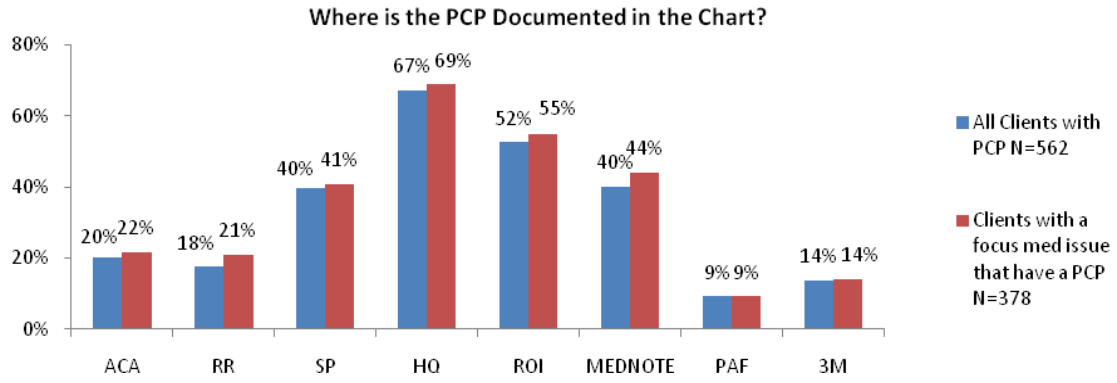
After examining the type and documentation of medical issues, we then examined whether or not the clients that had medical issues also had a primary care provider (PCP). Table 4 shows us the number and percent of clients that had a documented medical issue and that had a PCP documented in the chart as well. Overall clients that had a more serious "focus" medical issue had a higher percent of PCP documentation in the chart, however, depending on type of program there were still 10%-42% of clients with a serious medical condition ("focus") that **did not** have a PCP documented in their chart. This data clearly shows the need to increase efforts to document and assist the client with obtaining a PCP.

Table 4

Number of clients with any medical or focus medical issue that have a PCP documented in chart.						
	Clients with any medical issue			Clients with a focus medical issue		
	# with any med issue	# that have PCP	% that have PCP	# with focus med issue	# that have PCP	% that have PCP
MHSA FSP	154	117	76%	99	84	85%
MHSA SD-Contract	117	98	84%	85	73	86%
MHSA SD-County	154	77	50%	86	50	58%
RST	282	246	87%	191	171	90%
Total	707	538	76%	461	378	82%

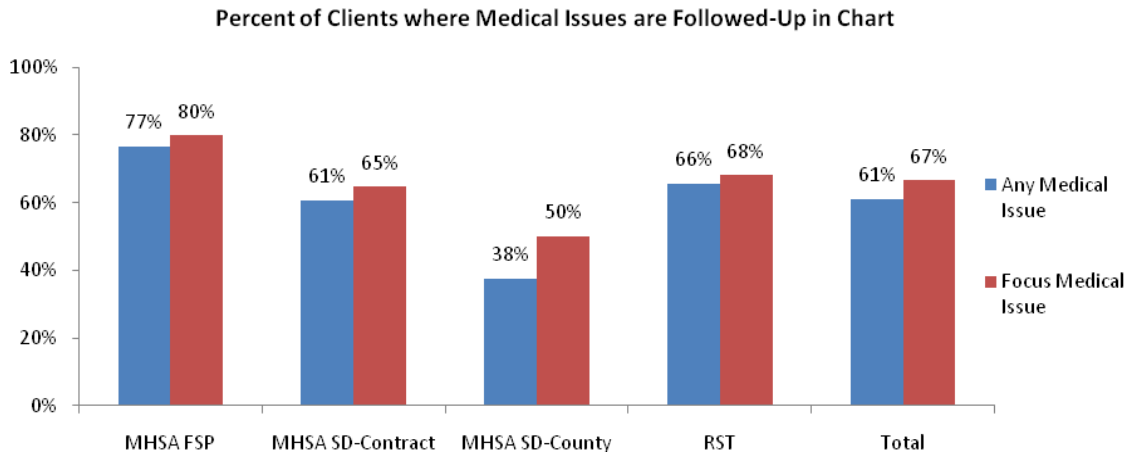
We then looked at if the client had a PCP where was this information documented in the chart. As with medical condition documentation that we saw in Table 3, documentation of PCP as seen in Table 5 illustrates a disconnect as well***. If coordination of care efforts were being done and documented appropriately we would see higher percentages of PCP documentation in both the Service Plans (SP) and the Medication Notes (Mednote), however percentages in both these areas are only in the 40%'s.***

Table 5



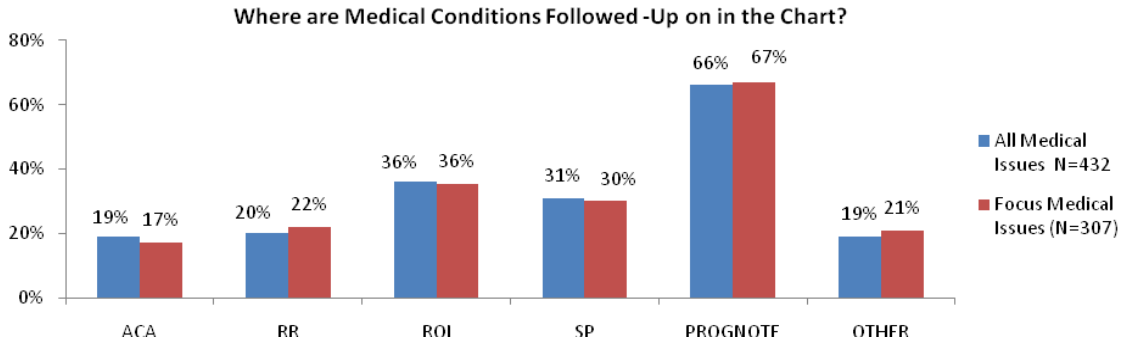
After establishing the medical issues and PCP status, we began looking for documentation that related directly to follow-up/coordination of care. Table 6 illustrates the percent of clients that had any kind of follow-up documented in their chart. Even though overall there were 61%-67% of all clients with some kind of follow-up documentation in the file***, that leaves 33%-39% of our clients with <u>no</u> documentation of any kind to show medical issues were being addressed.*** There is no documented evidence to show that one-third of the clients with a serious medical condition were being monitored and/or receiving needed healthcare for their medical issues.

Table 6



We then looked at if there was documented follow-up/coordination where was in it in the chart. Table 7 illustrates where medical issue follow up was documented in the client chart. All follow-up and coordination of care should be documented in the progress notes. Table 7 illustrates that only 67% of the medical conditions were documented in progress notes. ***Again, illustrating the lack of documentation, follow-up and coordination of care for clients with serious medical issues.***

Table 7



Last, we examined data relating to PCP appointments and documentation. Table 8 shows the number of clients that had a PCP documented in their chart that also had PCP appointments documented. While it is difficult to say the number of appointments that a client might need, it can be assumed that clients with serious medical conditions should have routine appointments and check ups with their PCP to monitor their health status. ***Table 8 tells us that regardless of the type of medical issue, only 28% of all clients had PCP appointments documented in their charts which leaves 72% of all clients that had no documentation of PCP appointments in their charts.***

Table 8

Number of clients with a documented PCP that have PCP appointments documented in the chart.						
	All clients with a documented PCP			Clients with a focus med issue that have a document PCP		
	# With a PCP	# where PCP appointments are documented	% where PCP appointments are documented	# With a PCP	# where PCP appointments are documented	% where PCP appointments are documented
MHSA FSP	124	45	36%	84	32	37%
MHSA SD-Contract	101	27	27%	73	18	25%
MHSA SD-County	80	22	28%	50	17	32%
RST	257	64	25%	171	43	24%
Total	562	158	28%	378	110	28%

After looking at the clients that did have PCP appointments documented in their chart we examined if there was follow-up and coordination following the PCP appointment. Although the numbers were small, clients that had a focus medical issue and PCP appointments documented in chart had a higher percentage of evidence of coordination of care. ***However, there were still 25% of clients overall that had documented PCP appointments with no evidence of coordination of care documented in the chart.***

Table 9

Number of clients that have PCP appointments in the chart where there is also evidence of coordination of care being documented.						
	All Clients			Clients with a focus medical issue		
	# with PCP appointments documented in chart	# with evidence of coordination documentation	% with evidence of coordination documentation	# with PCP appointments documented in chart	# with evidence of coordination documentation	% with evidence of coordination documentation
MHSA FSP	45	38	84%	32	29	91%
MHSA SD-Contract	27	19	70%	18	18	100%
MHSA SD-County	22	12	55%	17	11	65%
RST	64	26	41%	43	26	60%
Total	158	95	60%	110	84	76%

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Documentation of medical issues is not consistent	Data regarding the location in the case file that medical issues are documented was reviewed. Data show that medical issues are documented in the Service Plan 6% of the time, in the Progress Notes 21% of the time and in Avatar 31% of the time. The service plan and progress notes are core documents and Avatar is the client tracking system for Sacramento county. Medical issues should be documented equally across these three areas.
No Primary Care Provider (PCP) documented in case file	Charts were reviewed to determine if client had a PCP. Overall 18% of all clients had no PCP documented in the case file. Additionally data gathered from trainings and committee members indicated that there are challenges to obtaining a PCP and not all clients want or are able to have a PCP.
Medical issues are not addressed/followed-up in chart	Chart review data indicate that overall 33% of clients with a focus medical issue had no follow up documented in the case file.

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
PCP appointments are not documented in case file	Chart review data indicate that out of the 60% of the clients having a documented focus medical issue 72% had no documentation of a PCP appointment in their case file
Lack of coordination of care following PCP appointments	Chart review data indicate that 24% of clients with a documented PCP appointment had no evidence of coordination of care following the documented PCP appointment

Formulate the study question

4. State the study question. This should be a single question in 1-2 sentences which specifically identifies the problem that the interventions/approach for improvement.

Will increasing efforts to document, coordinate and follow-up on medical issues with the consumer's primary care provider lead to improved primary care access/follow-up and treatment for mental health consumers served in standard outpatient clinic care?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.

Yes, the PIP includes all beneficiaries for whom the question applies. However, it will start at the standard outpatient programs. The initial phase of this PIP is a pilot project involving all clients receiving outpatient services at the four Regional Support Teams (RST's) in the MHP. It is our goal to test this intervention on a small scale to determine the benefits to applying the intervention system wide.

6. Describe the population to be included in the PIP, including the number of beneficiaries.

All clients receiving outpatient services at one of the four RSTs in the MHP will be evaluated for inclusion in the PIP. If a client reports having one of the six focus medical conditions (Blood pressure, Cholesterol, Cardio/Cardiovascular Disease, Cerebrovascular Disease, Diabetes and Liver Disease) they will be included in the PIP intervention and data collection. Currently there are approximately a total of 3600 clients receiving outpatient services at the four RSTs. Data from the chart review indicate that approximately 60% of our clients have at least one of the 6 focus medical conditions. Based on this number it is anticipated that there will be approximately 2160 clients included in the PIP.

7. Describe how the population is being identified for the collection of data.

All clients receiving outpatient services at one of the four RSTs in the MHP will be evaluated for inclusion in the PIP. If a client reports having one of the six focus medical conditions (Blood pressure, Cholesterol, Cardio/Cardiovascular Disease, Cerebrovascular Disease, Diabetes and Liver Disease) they will be included in the PIP intervention and data collection. Inclusion in the PIP intervention and data collection will be rolled out in a systematic manner so as to not overburden the RST staff. Beginning July 1, 2011 the following protocol will be in place:

- Medical issues and PCP issues will be addressed at the first face to face visit with all existing clients. If the client reports at least one of the 6 focus medical issues, the client will be included in the PIP interventions and data collection
- Medical issues and PCP issues will be addressed at intake assessment for all new clients being served at a RST. If the client reports at least one of the 6 focus medical issues, the client will be include in the PIP interventions and data collection

8. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

N/A

b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

N/A

"How can we try to address the broken elements/barriers?"

Planned interventions

<u>Specify the performance indicators in Table B and the Interventions in Table C.</u>

9. a) Why were these performance indicators selected?

The performance indicators were selected to support the hypothesis of the PIP that if medical conditions are identified and documented appropriately in the chart and electronic health record (Avatar- Practice Management System), that a goal to coordinate and address medical issues is established in the service plan, that coordination efforts are documented consistently in progress notes, and that client's PCP is clearly documented that there will be a significant improvement in the coordination of care which will ultimately result in better mental and physical health outcomes for the clients we serve.

b) How do these performance indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes?

These performance indicators are able to measure a change in process of care with strong associations for improved mental and physical health outcomes. The change that will be measured is in relation to healthcare documentation and follow-up/coordination of care efforts by our providers. We have baseline data that shows the status of these performance indicators prior to implementing the PIP and will compare the baseline data to data collected after PIP implementation. We will be able to measure the change in these areas after PIP implementation. An increase in documentation and coordination of health care will lead to better access to services and healthier mental and physical outcomes for our clients.

Remember the difference between *percentage* changed and *percentage points* changed – a very common error in reporting the goal and also in the re-measurement process.

Table B – List of Performance Indicators, Baselines, and Goals

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	Clients will have PCP information documented in Avatar	Number of clients with PCP documented in Avatar	Number of clients in PIP	Chart Review Jan 2011: 0%	50% Increase (50.0%)
2	Client will have PCP information documented in Service Plan	Number of clients with PCP documented in Service Plan	Number of clients in PIP	Chart Review Jan 2011: 41%	20% Increase (49.2%)
3	Medical conditions will be documented in the Service Plan	Number of focus medical issues documented in Service Plan	Number of focus medical issues documented	Chart Review Jan 2011: 6%	244% Increase (20.6%)
4	Medical conditions will be documented in the Progress Notes	Number of focus medical issues documented in Progress Notes	Number of focus medical issues documented	Chart Review Jan 2011: 21%	145% increase (51.5%)

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
5	Medical condition will be recorded in Avatar under the "general medical condition" field	Number of clients with medical condition documented in Avatar	Number of clients in PIP	Chart Review Jan 2011: 31%	60% increase (49.6%)
6	PCP appointments will be documented in progress notes	Number of clients with PCP appointments documented in progress notes	Number of clients in PIP	Chart Review Jan 2011: 24%	50% increase (36.0%)
7	Coordination of care will be documented in Service Plan	Number of clients with coordination of care documented in Service Plan	Number of clients in PIP	Chart Review Jan 2011: 30%	150% increase (75.0%)
8	Coordination of care will be documented in the Progress Notes	Number of clients with coordination of care documented in Progress Notes	Number of clients in PIP	Chart Review Jan 2011: 67%	12% increase (75.0%)

10. Use Table C to summarize interventions. In column 2, describe each intervention. Then, for each intervention, in column 3, identify the barriers/causes each intervention is designed to address. Do not cluster different interventions together.

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	At each face to face meeting discuss medical issues and PCP issues with client and document in Progress Notes	• Medical issues are not addressed/followed up in chart	
2	Document all medical issues in both the case file and electronic file as appropriate	• Documentation of medical issues in not consistent	
3	Document PCP information in case file and electronic record	• No Primary Care Provider documented in case file	
4	If client does not have PCP encourage and provide assistance in finding a PCP-document efforts	• No Primary Care Provider documented in case file • Medical issues are not addressed/followed up in chart	
5	Document coordination of care efforts (including PCP appointments) in case file	• Medical issues are not addressed/followed up in chart	

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
		• PCP appointments are not documented in case file • Lack of coordination of care following PCP appointments • No Primary Care Provider documented in case file	
6	For all PCP appointments complete the Primary Care Visit form	• No Primary Care Provider documented in case file • Medical issues are not addressed/followed up in chart • PCP appointments are not documented in case file • Lack of coordination of care following PCP appointments	

Apply Interventions: "What do we see?"
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

Demographic data including age, gender and ethnicity will be collected on all RST clients. The date that the client is evaluated for and included in the PIP will be captured and collected. Data on whether client has a PCP, existing medical issues and where both are documented in the case file and electronic records will be collected on all clients included in the PIP (client's having at least one of the six focus medical conditions). Data on coordination of care as evidenced by case file documentation will also be collected on all clients included in the PIP.

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.

Data will be collected in two ways and from two primary sources. Data will be collected using queries to the data already captured in Sacramento County's existing data Information System, Avatar. Secondly data will be collected from chart reviews at each provider site. Demographic data on all clients served at the 4 RSTs will be collected from Avatar. For clients included in the PIP, data regarding start date of PIP, documentation of PCP in Avatar and documentation of general medical

condition will be obtained from Avatar. Data regarding documentation of PCP, medical issues and follow-up coordination of care will be obtained from chart reviews.

Periodic reviews of the data being collected will be completed by REPO and Quality Management staff and feedback regarding the completeness and accuracy of the data will be provided to the 4 RSTs and others involved in the implementation of this PIP. Data reviews are for the purpose of ensuring data integrity and adherence to the PIP requirements.

13. Describe the plan for data analysis. Include contingencies for untoward results.

At the end one year following the implementation of the PIP, data will be summarized and analyzed trends and relationships. Data collected on all clients included in the PIP will be analyzed against performance indicators to measure improvement. Data will be also be analyzed by demographic characteristics to look for differences. The MHP expects that some sub-groups may emerge for which additional interventions may be needed.

At the end of the PIP, a randomized chart review of RST client charts and electronic records will be conducted once again. There will be equal representation of RST clients that were included in the PIP and those not included in the PIP. Aggregate data from both groups will be compared to look at differences and statistical analysis completed to look for significant differences between the groups that can be attributed to PIP Interventions. It is anticipated that providers will may begin implementing strategies similar to those in the PIP for all clients and we will need to be cognizant of this when analyzing the data and reporting differences.

14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

Direct care staff (case managers, nurses, psychiatrists) at the 4 RSTs will collect data for the clients receiving services in their programs. The Research, Evaluation and Performance Outcome (REPO) staff responsible for collecting the data from the agency and for extracting Avatar information system data have at least a BA degree in Psychology, Social Services or other related field and have been analyzing and reporting on data for the REPO unit for over 9 years. The REPO staff has received continuous training on data analysis, performance outcomes and statistical analysis.

All clinical record reviews will be conducted under the direction of the Quality Management Manager under the umbrella of the QIC Committee structure.

15. **Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?**

16. **Present objective data results for each performance indicator. <u>Use Table D and attach supporting data as tables, charts, or graphs.</u>**

Include the raw numbers that serve as numerator and denominator!

Table D - Table of Results for Each Performance Indicator and Each Measurement Period

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							

"Was the PIP successful?" What are the outcomes?

17. **Describe issues associated with data analysis:**

a. **Data cycles clearly identify when measurements occur.**

b. **Statistical significance**

c. **Are there any factors that influence comparability of the initial and repeat measures?**

d. **Are there any factors that threaten the internal or the external validity?**

18. **To what extent was the PIP successful? Describe any follow-up activities and their success.**

19. **Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?**

20. **Does data analysis demonstrate an improvement in processes or client outcomes?**

21. **Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).**

22. **Describe statistical evidence that supports that the improvement is true improvement.**

23. Was the improvement sustained over repeated measurements over comparable time periods?

California EQRO
560 J Street, Suite 390
Sacramento, CA 95814

CAEQRO PIP Outline via Road Map – EPSDT PIP

MHP: Sacramento County
Date PIP Began: 7-23-2008, Updated August 2011
Title of PIP: Improvement of Outpatient Treatment Alternatives for High Risk and High Need EPSDT Beneficiaries
Clinical or Non-Clinical: Non Clinical

- For May 22 submission, the MHP should complete the Road Map to reflect the study as it is designed thus far. All applicable items are in RED. If the MHP has not reached a certain point, please state "not completed" for that item.
- Aggregate data may be included as attachments to support the problem definition, barriers associated with the problems, and reasons for intervention selection.
- Submit via e-mail to Sandra Sinz at ssinz@apshealthcare.com no later than August 2011.
- Also send a separate e-mail stating that the PIP has been e-mailed.

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.

Statewide: The stakeholders involved include California Mental Health Directors Association (CMHDA), Department of Mental Health (DMH), Mental Health Plan (MHP) Contract Providers, the California Mental Health Directors Association, the County Welfare Directors Association, the California Council of Community Mental Health Agencies, and the California Alliance of Child and Family Services.

MHP Level Committee: List local PIP committee members including their position and affiliation.

The Sacramento County Mental Health Plan (MHP) established an EPSDT PIP Committee under its Quality Improvement Committee (QIC) structure. This committee membership includes a cross section of administration, service provider and advocacy. Members work within the large committee as well as in subgroups where specific tasks are the focus of attention. Represented are: MHP Children's Access Team, Minor Emergency Response Team (MERT), County Operated Program and Contract Monitors, Quality Management, Research & Evaluation, Cultural Competence, Mental Health Services Act (MHSA) representatives, contract provider representatives and family advocates. The brainstorming activities to understand the gaps and needs of the system to frame this PIP began with a meeting on July 23, 2008 and have continued through a variety of Children's Provider meetings and workgroups as well as through the Quality Improvement Committee (QIC) monthly meeting reporting process. For example, the quarterly Children's Psychiatrists Meeting received a report on the work of this committee through Dr. Sison, the Children's Medical Director, which includes the larger psychiatric community to understand and participate in this project. Similarly, Children's Provider meetings have received reports and updates through various representatives of this larger committee and enables a large contract provider system to participate in this project.

The PIP EPSDT Committee membership is as follows:

County Participants:
Lisa Bertaccini, LCSW, Chief, Children's Mental Health, Sponsor of the EPSDT PIP Committee
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"Is there really a problem?"

2. Define the problem by describing the data reviewed and relevant benchmarks. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

Statewide: Approved EPSDT claims data for FY 2006-07 shows that the 3% of EPSDT clients with the highest average monthly claims account for 25.5% of total annual EPSDT spending. While it is reasonable to expect that this highest-cost-of-service cohort includes clients with severe conditions that justify higher average monthly costs, a review of client specific services received by a sample drawn from this cohort often include a complex pattern of use that raises questions about service levels, array of services, possible gaps in service, and multi-system involvement. Studies identified by the Department of Mental Health suggest of other pediatric health care system highest-cost-of-service cohorts suggest that the cost and complexity of these EPSDT services could indicate a need for improved coordination, enhanced capacity, and other improvements to ensure that each child is receiving services that are indicated, effective, and efficient, at the levels being provided. DMH has consulted with representatives from the California Mental Health Directors Association, the County Welfare Directors Association, the California Council of Community Mental Health Agencies, and the California Alliance of Child and Family Services on the concepts of this proposal as they relate to addressing quality, effectiveness and efficiency of service delivery to children.

MHP: Define local problem – Refer to data examined (include as an attachment if too detailed to add here). If Criterion B, include the MHP's initial dollar threshold for study population inclusion.

Approved EPSDT claims provided by APS showed the MHP had 1086 youth categorized as high cost during FY07-08. Of this group, only 769 were open to the MHP in November 2009. Looking more closely at the sub-group of youth comprising the top 25% of open high cost clients (N=197), data were mined to generate hypotheses about possible causes of the high cost. In most instances, comparisons were either made between the top 25% of high cost and the bottom 75% of high cost, or between the whole high cost list and clients who were NOT on the high cost list, but were similar in other respects.

Table 1 illustrates the demographic characteristics of the top 25% and bottom 75%. As is evident, there is a slightly higher incidence of Bipolar Disorder in the top 25%. The two groups are very similar on all other characteristics.

Table 1
Demographic Characteristics of High Cost Clients

Characteristic	Top 25% High Cost (N=197)		Bottom 75% High Cost (N=572)	
Age				
	Avg=13	Range, 4-20	Avg=13	Range, 2-21
Gender				
Male	120	60.9	337	58.9
Female	77	39.1	235	41.1
Ethnicity				
Caucasian	80	40.6	202	35.3
African American	52	26.4	178	31.1
Hispanic	38	19.3	99	17.3
Multi-Ethnic	19	9.6	64	11.2
Other	5	2.5	19	3.3
Unknown	3	1.5	10	1.7
Preferred Language				
English	194	98.5	550	96.2
Other		0.0	12	2.1
Unknown/Not Reported	3	1.5	10	1.7
Primary Axis I				
Bipolar	50	25.4	87	15.2
Anxiety	37	18.8	114	19.9
ADHD	37	18.8	108	18.9
Disruptive Disorders	24	12.2	72	12.6
Psychotic	10	5.1	26	4.5
Depressive	11	5.6	77	13.5
Adjustment	8	4.1	46	8.0
Other	20	10.2	42	7.3
Substance Use				
Yes	14	7.1	54	9.4
No	127	64.5	379	66.3
Unknown/Not Reported	56	28.4	139	24.3
Trauma				
Yes	139	70.6%	347	60.7
No	17	8.6%	66	11.5
Unknown	41	20.8%	159	27.8

Table 2 illustrates where these youth were receiving services and also indicates the inpatient hospitalization and juvenile hall experience they had during FY07-08. These data suggest that the top 25% high cost youth are much more likely to be receiving Wraparound services than the bottom 75%. Youth receiving Wraparound services are also costly to the local system of care because of the large number of dollars spent that are not reimbursable by EPSDT (e.g., group homes). In addition, although the total Wraparound and Focus caseloads are not presented in Table 2, the MHP data showed that while there are relatively high percentages of Focus clients (also a high intensity service), the overall percentage of youth in Wraparound who appeared on the High Cost list was very high (63% of total caseload) compared to that of Focus (38%).

Table 2
Services Received by High Cost Clients

Service Site/Program	Top 25% High Cost (N=197)		Bottom 75% High Cost (N=572)	
	N	%	N	%
Currently Open				
Wraparound	76	38.6	75	13.1
Residential Wrap	18	9.1	32	5.6
Focus	56	28.4	153	26.7
Focus II	6	3.0	16	2.8
Multiple programs	133	67.5	286	50.0
Mode 10 Services	16	8.1	17	3.0
Residential	43	21.8	89	15.6
Inpatient Unduplicated	41	20.8	88	15.4
Inpatient Total	68		135	
Juvenile Hall Unduplicated	16	8.1	57	10.0

The MHP workgroup then decided to look more closely at those youth in Wraparound and looked at all Wraparound clients on the high cost list (N=156) compared to Wraparound clients NOT on the high cost list (N=94). Table 3 illustrates these data. As is evident, there is a slightly higher incidence of Bipolar Disorder in Low Cost Wraparound clients and a higher incidence of Anxiety, ADHD and Disruptive behaviors in the High Cost Wraparound clients. In addition, High Cost Wraparound clients had significantly higher utilization of inpatient hospital and TBS than Low Cost Wraparound clients. Although the inpatient costs are not reflected in the cost data provided by APS, this difference between the two groups stood out for the workgroup.

Table 3
Demographic Characteristics of Wraparound Clients

	Wrap – High Cost		Wrap – Low Cost	
Characteristic	N=156		N=94	
Age				
	Avg.=13	Range, 6-18	Avg=14	Range, 7-18
Gender	N	%	N	%
Male	86	55.1	51	54.3
Female	70	44.9	41	43.6
Unknown	---	---	2	2.1
Ethnicity				
Caucasian	59	37.8	50	53.2
African American	55	35.3	10	10.6
Hispanic	25	16.0	18	19.1
Multi-Ethnic	10	6.4	9	9.6
Other	3	1.9	2	2.1
Unknown	4	2.6	5	5.3
Preferred Language				
English	150	96.2	88	93.6
Other	2	1.3	2	2.1
Unknown/Not Reported	4	2.6	4	4.3

Primary Axis I				
Anxiety	38	24.4	11	12.0
Bipolar	30	19.2	31	33.7
Disruptive Disorders	28	17.9	7	7.6
ADHD	27	17.3	8	8.7
Psychotic	2	1.3	2	2.2
Depressive	12	7.7	14	15.2
Adjustment	11	7.1	4	4.3
Other	8	5.1	15	16.0
Unknown	---	---	2	2.1
Substance Use				
Yes	15	9.6	11	11.7
No	87	55.8	43	45.7
Unknown/Not Reported	54	34.6	40	45.6
Trauma				
Yes	105	67.3	45	47.9
No	6	3.8	14	14.9
Unknown/Not Reported	45	28.8	35	37.2
Service Information				
Average Length of Stay	1.6 years	Range 0.4-4.4 Years	1.5 Years	Range 0.4-4.4 Years
Average Time in MH System	5.8 Years	Range 0.9-14.8 Years	4.8 Years	Range 0.8-13.7 Years
Inpatient				
Unduplicated Youth	28	17.9	3	3.2
Total Hospitalizations	45		6	
TBS Services				
Unduplicated Youth	39	25.0	---	---
Episodes	45		---	---

Next the workgroup investigated the differences between the two groups in terms of patterns of service utilization. Although some clients were open to multiple providers, the patterns of service provision did not appear unwarranted or extraordinary. Rather, they appeared appropriate for the need and non-duplicative. For example, an outpatient Wraparound provider working on bringing a youth out of a Level 12 group home might be billing for assessment or rehabilitation services on the same day the group home provider bills a different outpatient service.

After several months of data mining using the high cost list provided by APS, the workgroup decided to try a different tact at identifying a study question for the MHP. During discussion, it was recognized that by the time a youth is in Wraparound, they have typically already been in our system for quite a while and actually need high levels of service. In order to prevent these high levels of service in the first place, we hypothesized that an intervention prior to youth becoming so heavily involved in the system might be in order.

The MHP has a crisis stabilization unit for youth (MERT). Just under 50% of the 120+ youth seen at MERT every month experience an acute psychiatric hospitalization following the crisis stabilization episode. In addition, 22% of youth hospitalized experience a subsequent acute hospitalization within 90 days of being discharged. Again, considering the existing Children's system of care, this information represents a high cost to the MHP. One might further assume that different or more individualized intensive services might help to prevent hospitalization or progressively higher levels of non-

community based care. So the workgroup postulated that it would serve our client's best interests to intervene to prevent hospitalization, help reduce future costs, and improve quality of life for youth and their families.

Taking this hypothesis, we went back to the high cost list provided by APS to validate that MERT clients comprised a substantial enough subset to qualify as a population for the MHP to intervene with. Of the 1086 clients on the high cost list, 243/1086 (22%) had been served by MERT during the FY07-08. The average annual dollar value associated with claims for these youth was $28,939 (vs. $24,765 for the list as a whole). Validating from a different perspective, we sampled clients who had recently experienced a crisis stabilization episode, looked at the previous year of services, and determined each youth would have been classified as high cost using the criteria of at least one month of $3,000 worth of outpatient billable services.

Given these data, the workgroup decided to focus on the quality of care and quality of life of youth experiencing crisis stabilization episodes. We are assuming that intervention to prevent future hospitalization will ultimately lead to higher quality of life, less disruption in achieving developmental milestones and community integration and lower mental health costs.

Team Brainstorming: "Why is this happening?"

Root cause analysis to identify challenges/barriers

3. a) Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

Statewide: EPSDT claims data used in developing this proposal consists of FY 2006-07 approved claims data received as of March 2008; the most current EPSDT claims data available at this time. The Medi-Cal claims file for this period included claims for ~183,892 clients totaling ~ $949,967,324. MHPs, in collaboration with their providers, are responsible for the identification and collection of relevant data such as clinical data derived from chart reviews, billing/reporting data, treatment service factors, etc., and continuing data exchange and reporting to the Department of Mental Health to inform, measure and continuously improve services to children and their families.

Table 1
Distribution of Approved Claims for EPSDT
SFY 2006-07 Year Claims to date (Includes SGF, FFP, County Share funds)

Service	Approved $	% Total
PHF	$2,745,896	0.29%
Adult Crisis Residential	$725,573	0.08%
Adult Residential	$1,919,066	0.20%
Crisis Stabilization	$5,574,531	0.59%
Day Tmt Intensive Half Day	$5,601,497	0.59%

Day Tmt Intensive Full Day	$49,610,477	5.22%
Day Tmt Rehabilitative Half Day	$1,175,263	0.12%
Day Tmt Rehabilitative Full Day	$27,372,551	2.88%
Targeted Case Management	$69,504,927	7.32%
Mental Health Services	$637,266,489	67.08%
Collateral Services Assessments Plan Development Individual Services Group Services Rehabilitation Professional In-patient Visit		
Therapeutic Behavior Services	$54,744,405	5.76%
Medication Support	$79,440,321	8.36%
Crisis Intervention	$14,295,328	1.50%
EPSDT Total	$949,976,324	100.00%

Table 2 displays standard analytic metrics for the expenditure data as well as a distribution of clients' average monthly claims by quartiles. For purposes of this proposal, the DMH elected to set a cut-off point at the 97th percentile. This is the point at which 97 percent of the clients have an average monthly service cost below $3,000 and 3 percent have an average monthly cost for services equal to or greater than $3,000. Average monthly cost data was arrived at using only months during which a client received services for which an approved claim was submitted. The highest 3% group was found to represent 5,518 clients.

Table 2
Monthly EPSDT Approved Claims Metrics

		Quartiles	
Monthly	**Values**	**Quartile**	**Estimate**
Number	183,892	100.00%	$24,188
Mean	$742	99.00%	$4,693
Std Dev	$935	95.00%	$2,313
Median	$489	90.00%	$1,535
Mode	$313	75.00%	$850
IQR	$596	50.00%	$489
		25.00%	$254
		10.00%	$120
		5.00%	$78
		1.00%	$40
		0.00%	$1

Table 3 provides a breakdown of expenditures by the number of months of service for the 5,518 clients. These 3 percent of the total EPSDT caseload were found to have received services costing $242,277,620, or 25.5 percent of the total 2006-07 annual expenditures.

Table 3
Approved Annual Claims per Client
Where Monthly Claims are Equal To or Greater Than $3,000 per month
(For months in which Claims Were Submitted)

Months Pd Svc	Frequency	All $
All	5518	$242,277,620
1	185	$830,647
2	194	$1,688,992
3	206	$2,831,905
4	231	$4,168,661
5	215	$4,877,961
6	247	$6,421,969
7	220	$6,633,899
8	259	$9,561,421
9	323	$13,410,002
10	382	$17,594,196
11	515	$26,934,757
12	2541	$147,323,204

This quality improvement proposal is supported by a study of pediatric high health care service users. The study discusses that high-cost children use services of numerous types delivered in multiple venues, and concludes that "providing care coordination throughout the entire health care system is important to address both the cost and the quality aspects of health care for the most costly children". The study further concludes that "clinicians should review regularly the extent of care coordination that they provide for their high-need and high-cost patients, especially preteens and adolescents" and that "targeted programs to decrease expenditures for those with the greatest costs have the potential to save future health care dollars."(Liptak, GS et al. Short-term Persistence of High Health Care Costs in a Nationally Representative Sample of Children. PEDIATRICS Vol. 118 No. 4 October 2006). Historically, the growth in the EPSDT program has been driven by lawsuit activity that improved access to EPSDT funded services for children/youth and relied heavily on the clinical judgment of direct treatment providers. The state established a minimal requirement for utilization and quality management activities but has not historically required MHPs to conduct a focused review of EPSDT clients to establish that the array of services being provided to a child/youth is appropriate and that those services support the child/youth's desired treatment plan goals.

MHP 3a) Describe MHP issues associated with locally defined problem and patterns. What data supports the MHP's interpretation of the problems and reasons for the problems? Does the data suggest other problems as well? What other evidence within the MHP's system provide additional support to the MHP's interpretation of the data?

Youth who undergo acute inpatient hospitalization are at risk of negative long term outcomes, including future hospitalizations. During FY 07-08, Sacramento County (is this data EPSDT YOUTH ONLY IF SO WE SHOULD SAY SO) youth experienced 700 hospitalizations and the 90 day recidivism rate was 22%. Intervention to prevent future hospitalization will ultimately lead to higher quality of life and lower system cost.

The MHP has a crisis stabilization unit for youth (MERT). Table 4 shows the number of crisis stabilization episodes and number of resulting inpatient hospitalizations over two fiscal years (please note that FY08-09 data are annualized based on the first 10 months of the FY). The data show that just under 50% of the youth seen at MERT experience an acute psychiatric hospitalization following the crisis stabilization episode.

Table 4
MERT and Inpatient Episodes

FY	MERT Episodes	Acute Hospitalizations
2007-2008	1412	700
2008-2009	1493	701

Therapeutic Behavioral Services (TBS) is an individualized intervention that can be used to help prevent the need for both crisis stabilization and subsequent hospitalization. In order to receive TBS, youth must both be eligible for Medi-Cal and be receiving outpatient services in the MHP. Table 5 illustrates the frequency of youth who receive services at MERT who meet these criteria. Due to MHP funding restrictions, the vast majority (>90%) of youth who receive outpatient services are Medi-Cal eligible. Therefore, there may be up to 600 youth annually who could benefit from TBS services to prevent both crisis stabilization and subsequent hospitalization.

Table 5
Eligibility for TBS of MERT Clients

FY	MERT Episodes	Unduplicated Clients Served	% Medi-Cal Eligible	% Receiving Outpatient Services
2007-2008	1412	1274	62	48
2008-2009	1493	1369	62	47

b) What are barriers/causes that require intervention? Use Table A, and attach as an appendix any charts, graphs, or tables to display the data (preferably in aggregate form). **Do not include PHI.**

Table A – List of Validated Causes/Barriers:

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Inability to prevent both crisis stabilization and acute psychiatric hospitalization	High percentage of youth who are hospitalized following a crisis stabilization episode and the high 90 day recidivism rate following discharge from the hospital.

Formulate the study question

4. State the study question.
This should be a single question in 1-2 sentences which specifically identifies the problem that the interventions are targeted to improve.

Statewide: Will implementing activities such as, but not limited to: increased utilization management, care coordination activities and a focus on the outcomes of interventions lead to enhanced quality, effectiveness and/or efficiency of service delivery to children receiving EPSDT funded mental health services?

MHP: State the local study question which includes the problem as defined by the MHP and the MHP's general approach to addressing the associated causes/barriers.

Will providing a TBS referral to all Med-Cal eligible clients receiving outpatient services in the MHP experiencing a crisis stabilization episode at MERT lead to reduced hospitalization and need for intensive mental health services in the future?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.
This PIP is required to include all beneficiaries for whom the study question applies unless there are clear, data-driven reasons for exclusion. Any exclusionary criteria must be carefully considered.

This PIP includes all beneficiaries for whom the study question applies: Medi-Cal eligible clients receiving outpatient services in the MHP experiencing a crisis stabilization episode at MERT.

6. Describe the population to be included in the PIP, including the number of beneficiaries.
Exclusionary criteria are discouraged unless the MHP has clinically or programmatically driven reasons, supported by data, to create a study population that is smaller than those who meet the initial dollar threshold. Identify here the total clients who meet the dollar threshold, and for what time frame, as well as the number of clients to be included in the PIP.

All Medi-Cal eligible clients receiving outpatient services in the MHP experiencing a crisis stabilization episode at MERT will be enrolled in the PIP. One hundred and eight clients were enrolled in the first 3 months.

7. Describe how the population is being identified for the collection of data.
Because there is an initial dollar criterion for consideration of inclusion, the MHP needs to identify the process by which youth meeting that dollar threshold will be identified on a monthly basis. In particular, describe how beneficiaries for FY08-09 were selected and how youth will be routinely added to the study population.

All Medi-Cal eligible clients receiving outpatient services in the MHP experiencing a crisis stabilization episode at MERT will be enrolled in the PIP. MHP data suggest that clients who experience a crisis stabilization episode can be classified as high cost using the criteria of at least one month of $3,000 worth of outpatient billable services.

8. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

N/A

b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

N/A

"How can we try to address the broken elements/barriers?"
Planned interventions

Specify the performance indicators in Table B and the Interventions in Table C.

9. a) Why were these performance indicators selected?

The MHP's hypothesis is that referral for TBS services will impact the functional status of youth and their quality of life because the provision of intensive services will prevent the further need for acute psychiatric services (crisis stabilization and inpatient hospitalization). Therefore, three performance

indicators were selected to focus on initially: 1) the 90-day inpatient recidivism rate; 2) the 90-day crisis stabilization recidivism rate; and 3) the percent of crisis stabilizations resulting in inpatient hospitalization.

b) How do these performance indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes? **Indicators may not focus on the dollar threshold. Indicators should include raw numbers and also be represented as a percentage/rate.**

By its very nature, the mental health status and functional status of youth is enhanced to the extent that they do not experience crisis stabilization or inpatient recidivism. Moreover, the MHP is improving the process of care by attending to the needs evidenced by youth who do present in a crisis stabilization episode.

Remember the difference between *percentage* changed and *percentage points* changed – a very common error in reporting the goal and also in the re-measurement process.

Table B – List of Performance Indicators, Baselines, and Goals

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	90-day inpatient recidivism rate	Number of inpatient admissions within 90 days of an inpatient discharge	Number of inpatient admissions	FY07-08: 21.4%	5% decrease (20.3%)
2	90-day crisis stabilization recidivism rate	Number of crisis stabilization episodes within 90 days of a previous crisis stabilization episode	Number of crisis stabilization epidoses	FY07-08: 23%	5% decrease (21.9%)
3	Percent of crisis stabilizations resulting in inpatient hospitalization	Number of crisis stabilization epidoses	Number of inpatient admissions	FY07-08: 49.6%	5% decrease (47.1%)

10. Use Table C to summarize interventions. In column 2, describe each intervention. Then, for each intervention, in column 3, identify the barriers/causes each intervention is designed to address. Do not cluster different interventions together. **Interventions should be logically connected to barriers/issues identified as causes associated with the problem affecting the study population.**

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	Referral to TBS	Inability to prevent both crisis stabilization and acute psychiatric hospitalization	**2-1-09**

Apply Interventions: "What do we see?"
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

When youth receive crisis stabilization services at MERT, the MERT clinician determines whether they are receiving services in the outpatient system. If services are being provided, the clinician contacts the outpatient provider to communicate the occurrence of a crisis stabilization episode. For this PIP, outpatient providers are attempting a TBS referral for ALL Medi-Cal eligible clients who have been to MERT. A copy of the TBS Referral Summary Form is attached (Sacramento TBS Referral Form.doc).

In addition to the information collected on the TBS Referral Form, the MHP is gathering information from the outpatient provider regarding: 1) whether they submitted a referral form; 2) whether TBS was authorized; 3) if TBS was not authorized the reason why; 4) whether TBS services were provided; and 5) if TBS services were not provided, why.

In addition, from TBS providers, the MHP is gathering information regarding the process and outcome of TBS services (e.g., family participated, client met treatment goals, etc.)

Finally, the MHP is using administrative information from its Information System regarding demographics, diagnosis, service utilization, crisis stabilization episodes and inpatient episode.

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why. **Describe how the MHP will collect data for all individuals for whom the study question applies.**

See response to #11.

13. Describe the plan for data analysis. Include contingencies for untoward results. **What processes will the MHP have in place to ensure that the intervention is applied as intended? How will that be measured?**

The data collected will be summarized and analyzed for trends, and relationships. The MHP expects that sub-groups of youth will emerge for which additional interventions will need to be developed. Examples include youth for whom TBS referrals are not made (e.g., caregivers decline) or for whom TBS services are not effective. We will look for any relationships between demographic characteristics, diagnosis and outcome. The response to #11 indicates the process we have in place to ensure that a TBS referral is made and the services are provided.

14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

Direct care staff at the outpatient and TBS provides will collect data for the clients receiving services in their programs. The REPO staff responsible for collecting the data from the agency, and for extracting Information System data have at least a BA degree in Psychology, Social Services or other related field and have been analyzing and reporting on data for the REPO unit for over 7 years. The REPO staff has received continuous training on data analysis, performance outcomes, and statistical analysis.

All clinical record reviews, when required, are conducted under the direction of the Quality Management Manager under the umbrella of the QIC Committee structure.

15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects? **What might be next steps in the EPSDT PIP?**

The data analysis process followed a pre/post methodology. Baseline data, consisting of data one year prior to enrollment into the study, were compared to one year after enrollment. Analysis occurred as planned. Administrative data from our IT system was utilized to ensure accurate pre/post data. Due to the high rate of clients in the study receiving intensive level services (i.e. Wrap and FIT), we decided to compare the kids in the high intensity programs with those in other services. Because our high intensity outpatient programs are currently piloting the Child and Adolescent Needs and Strengths (CANS) it was our intention to compare the study clients that received a CANS to the study clients in other outpatient programs that did not receive a CANS to determine whether there was a difference in MERT recidivism and hospital utilization. Unfortunately, due to the 6-month re-assessment period of the CANS, there was not sufficient data to analyze. An analysis of the CANS data will be performed when more data is available. We expect that more data will be available in the next month or two. We believe, in its current state, the initial intervention for the EPSDT PIP has been completed. Findings from this PIP may lead to exploration of other interventions in the future.

16. Present objective data results for each performance indicator. Use Table D and attach supporting data as tables, charts, or graphs.

Table D - Table of Results for Each Performance Indicator and Each Measurement Period

Describe performance indicator	Date of baseline measurement	Baseline (num/ denom)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Results (num/ denom)	% Change	Date of re-measurement	Results (num/ denom)	% Change
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS										
90-Day Recidivism Rate to IP (all study clients)	*One Year Prior to Admission in Study*	*19.6%*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*27.1%*	*+38.3%*	*2nd Year after (annualized)*	*36.4%*	*+85.7%*
90-Day Recidivism Rate to IP (TBS clients)	*One Year Prior to Admission in Study*	*21.4%*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*30.0%*	*+40.2%*	*2nd Year after (annualized)*	*33.8%*	*+57.9%*
90-Day Recidivism Rate to IP (non-TBS clients)	*One Year Prior to Admission in Study*	*17.9%*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*19.8%*	*+10.6%*	*2nd Year after (annualized)*	*41.7%*	*+133%*
90-Day Recidivism Rate to MERT (all study clients)	*One Year Prior to Admission in Study*	*16.5%*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*33.7%*	*+104.2%*	*2nd Year after (annualized)*	*35.4%*	*+114.5%*
90-Day Recidivism Rate to MERT (TBS Clients)	*One Year Prior to Admission in Study*	*24.4%*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*37.8%*	*+54.9%*	*2nd Year after (annualized)*	*35.8%*	*+46.7%*

Describe performance indicator	Date of baseline measurement	Baseline (num/ denom)	Goal for % improvement	Intervention applied & dates applied						
90-Day Recidivism Rate to MERT (non-TBS Clients)	*One Year Prior to Admission in Study*	*8.5%*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*23.1%*	*+171.8%*	*2nd Year after (annualized)*	*33.3%*	*+291.8%*
# of MERT Visits Leading to an IP admission (all study clients)	*One Year Prior to Admission in Study*	*116*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*126*	*+8.6%*	*2nd Year after (annualized)*	*48*	*-58.6%*
# of MERT Visits Leading to an IP admission (TBS clients)	*One Year Prior to Admission in Study*	*70*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*102*	*+45.7%*	*2nd Year after (annualized)*	*40`*	*1*
# of MERT Visits Leading to an IP admission (non-TBS clients)	*One Year Prior to Admission in Study*	*46*	*5% decrease*	*TBS Referral at time of discharge from MERT*	*1 Year after (annualized)*	*24*	*-47.8%*	*2nd Year after (annualized)*	*8*	*-82.6%*

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

a. Data cycles clearly identify when measurements occur.

Due to the nature of our PIP there were not measurement cycles, per se. Data were collected on an ongoing basis based on the intervention that took place at any given time. Children that presented at the MERT unit were offered the TBS service and data were collect at that point. Data were then analyzed, based on a pre-post model. Baseline data were established by looking at the clients' outcomes one year prior to enrollment and comparing that with the year after enrollment. Data were annualized to adjust for clients not in the study the full year and for those in the study longer than one year. Because clients were in for more than one year, we analyzed two different study groups; those in the study less than a year and those open for greater than a year. We also looked at clients in an intensive program that received a CANS versus those in regular outpatient that did not receive a CANS. Unfortunately, due to the 6-month re-assessment period for the CANS, there were only 8 clients that had a re-assessment. Due to lack of data, an analysis was not done on those clients. Further analysis will be performed when more data becomes available.

b. Statistical significance

Due to the outcomes being at the intervention group level and not at the individual level, statistical tests were not performed. With that said, the results indicate a significant percent increase from baseline to both re-measurement periods in all performance indicators. In looking at the data, it was apparent that approximately one-third of the study clients were no longer receiving outpatient mental health services. Most of those clients declined further services. Of those that remained in outpatient services, one-third were in intensive level services.

c. Are there any factors that influence comparability of the initial and repeat measures?

There were no factors that influenced comparability. All study group participants were compared based on data the year prior to enrollment and one year after.

d. Are there any factors that threaten the internal or the external validity?

There wasn't any indication of any factors that threatened the validity of the study.

18. To what extent was the PIP successful? Describe any follow-up activities and their success.

In looking at the performance indicators referenced in Table D, it appears that the PIP was unsuccessful in decreasing certain performance indicators. Recidivism rates did, in fact, increase dramatically. With that said, it was a small percentage of clients that accounted for those recidivism rates. In looking at pre and post hospitalizations, hospital admissions and MERT visits dramatically decreased after enrollment into the study. With the exception of a few indicators, clients in both groups ranged between a 48% and 98% decrease in MERT and inpatient visits.

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?

The methodology used was the same for baseline and repeated measures. We used the pre/post methodology to compare clients prior to enrollment and after enrollment. Two groups were compared, those that received TBS services after their enrollment into the study and those that did not receive TBS after enrollment. We also looked at the differences in study clients receiving intensive services versus those in regular outpatient. We utilized the CANS to compare differences in MERT and hospitalization rates. Unfortunately, due to the 6-month re-assessment period for the CANS, there were only 8 clients that had a re-assessment. Due to lack of data, an analysis was not done on those clients.

20. Does data analysis demonstrate an improvement in processes or client outcomes?

Unfortunately there were very few improvements in client recidivism for both groups in the study. Although there was no improvement, the non-TBS kids saw a greater improvement in all of the performance areas The analysis indicated that the majority of non-TBS kids were in less intensive outpatient services as compared to the TBS kids that were in higher intensity programs, which would indicate that a TBS level of service was not necessary at the time of discharge from MERT. Although recidivism rates did not improve, hospital admissions and MERT visits dramatically decreased after enrollment into the study. With the exception of a few indicators, clients in both groups ranged between a 48% and 98% decrease in MERT and inpatient visits.

21. Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).

For those clients that received a TBS referral and, in turn, utilized TBS services the intervention appears to have face validity. Clients that received a TBS referral and actually utilized TBS improved in all areas, with the exception of average number of

MERT visits per child. This also speaks to the increase in recidivism. Although there were some clients that had a high return rate to both MERT and inpatient, the total number of children utilizing the high cost services dropped significantly.

22. Describe statistical evidence that supports that the improvement is true improvement.

N/A. Although there is no statistical significance per se, the magnitude of the change is significant. The study performance indicators increased, while other indicators (number of pre and post hospital admits and MERT visits) decreased dramatically from baseline to re-measurement.

23. Was the improvement sustained over repeated measurements over comparable time periods?

The recidivism rate, unfortunately increased in both re-measurement periods. However, as mentioned above, hospital admissions and MERT visits dramatically decreased after enrollment into the study. With the exception of a few indicators, clients in both groups ranged between a 48% and 98% decrease in MERT and inpatient visits.