APS Healthcare

Final Report

CAEQRO Report, FY12-13

Sacramento

Conducted from

September 5-7, 2012

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❖INTRODUCTION❖

BACKGROUND AND METHODOLOGY

The California Department of Health Care Services (DHCS) 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 2012-13 (FY12-13) 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, September 5-7, 2012.

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) V7.3

❖FY12-13 REVIEW FINDINGS❖

STATUS OF FY11-12 REVIEW RECOMMENDATIONS

In the FY11-12 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY12-13 site visit, CAEQRO and MHP staff discussed the status of those FY11-12 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 FY11-12

- 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:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  The MHP reports a variety of actions to improve status tracking and provider/consumer communications to reduce delays in care. These actions include a combination of using the existing stage of implementation of the Practice Management (PM) component of Avatar and programmatic changes during FY11-12. Also, the MHP has fully

implemented a flexible response Community Support Team (CST) to respond to consumers proactively and fill gaps in linkages between providers and consumers needing care, especially as they await services to begin. Access processes to authorize services at providers has been refined so that providers can view new service authorizations through a variety of Avatar reports. The Child Access Team and providers have also refined processes to ensure re-authorization mechanisms are prompt and comply with medical necessity and appropriate service planning. As the Clinicians Work Station (CWS) rolls out fully throughout FY12-13, the Access Teams will maximize use of the Avatar system's authorization capacity. Further, as additional staff training has occurred, they report feeling more knowledgeable about available reports (this includes contractors), having an increased proficiency and better information sharing. More resource sharing overall was reported and contractors are satisfied with the new child access process and confirmation of (re)authorizations.

- Develop strategies and assign staff resources to reprocess FY10-11 previously denied claims for beneficiaries with Medicare and Medi-Cal eligibility or Other Health Coverage (OHC) eligibility and complete the work by June 2012; including:
  - A review of each provider's guarantor business claiming rules.
  - Obtain clients Medicare or private insurance carriers billing information to verify Avatar client insurance information is correct or update same.
  - Provide ongoing training and support to county and contract providers staffs' of Short Doyle/Medi-Cal (SD/MC) II claims processing requirements and how to resolve denied claims.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

The MHP's Fiscal department continues to bill OHC and has increased staff resources this past year with two full-time (FTE) positions. Two more FTE positions are in the interviewing stage.

Strategies to improve the identification of OHC, including Medicare, and processing denied claims continues to be an ongoing endeavor that both providers and the MHP work to resolve. Avatar Advanced Billing Training is offered the second Tuesday of every month and focuses on various billing processes that meet the State requirements for the SD/MC II system. Denial reports are reviewed by contract monitors to look at the reasons for denial and proactively assist providers in resolving these denials; however no in-depth MHP analysis of denials has been performed in the past year. Further, they still have not billed Medicare and as a result, all the dual eligibles service claims for last year are still in denied status.

The MHP has held meetings/forums with contract providers to address the challenges involved with denied claims as issues arise or policies change. These meetings are co-chaired by the Director of County Health and Human Services along with the MHP Director. In addition, the contract language for each provider was refined this last year

to reflect both IT and fiscal realities. Unfortunately, State delays and other factors outside the MHP control have impacted the timelines for resolution.

The MHP and its providers have suffered delays in becoming certified for Medicare billing. As a result, no Medicare claims have been submitted to date. The MHP expects to begin Medicare billing this fall and will resubmit denied 'Medi-Medi' services once those initial claims have been processed.

- 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:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  The MHP continues to address this recommendation in a variety of ways. Effective July 1, 2012, a new 16-bed Psychiatric Health Facility (PHF) was opened in conjunction with Crestwood to create additional inpatient capacity. An Intake & Stabilization Unit (ISU) is to open at the Mental Health Treatment Center (MHTC) this fall. In addition, the MHP continues to develop options from sub-acute placements into outpatient services as their now-complete PIP began developing pathways to step-down stable adult Regional Service Team (RST) consumers to primary care providers. A plan exists to consolidate the two existing Adult outpatient clinics into one site on the same campus as the MHTC. Also a countywide workgroup has begun developing more respite options (Respite Partnership Collaborative) to reduce crises and inpatient hospitalizations.

  Despite these recent efforts, adult outpatient providers report being significantly overcapacity and yet are receiving large numbers of new referrals. Contractors in general reported difficulty in finding appropriate resources for consumers who are ready for a lower level of service. Further, the MHP lacks sufficient psychiatry capacity as MHP tracking indicates an average wait of 35 days for an adult initial medication evaluation (which exceeds the MHP's standard of 30 days); about only one-third of consumers are being seen timely. Capacity is further negatively impacted by high no show rates at contractors (although strategies are in place to attempt to defray this concern); no shows at the MHP are not being routinely monitored.

- 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:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

The MHP has many initiatives to expand the use of wellness and recovery concepts across its system. They have rewritten their mission statement to include wellness and recovery principles and have developed administrative policy to proliferate these values, and a sense of resiliency, throughout the system at all levels. They continue to have two very active, full-time Wellness Centers (Marconi and Franklin) in which consumers are exposed to the principles in practice.

There is a large number of peer staff available as mentors in various programs and settings, and *Recovery 101* training was developed in-house by peer employees to be provided to all system consumer and family member (C/FM) employees and staff to explain the principles and WRAP planning. All new staff is now exposed to Wellness/Recovery principles in a variety of trainings. In FY11-12, 32 wellness and recovery trainings were held throughout the system. Providers reported they also subscribe to and educate consumers on wellness and recovery, employing those with lived experience as well. Community members have been exposed to wellness and recovery principles through the 22 training sessions the MHP has offered of Mental Health First Aid this last year, using consumers and family members to co-train with MHP staff. In a collaborative effort with UC Davis, peers also deliver a training seminar to second year Psychiatry residents on wellness and recovery philosophy

- Complete CSI testing and begin to submit monthly data:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  The transition to the Avatar system resulted in significant difficulties in transmitting CSI data for the MHP. It has been working diligently with DHCS staff to resolve the data transmission problems. This past year, the MHP submitted test CSI data claims to DHCS, and in July 2012 the CSI test file was successful in reporting the September 2009 CSI System data under the allowable error thresholds. As of the review, files have been submitted and processed up to December 2009. The MHP is currently correcting processed reports in less than a week. Based on current progress, the MHP expects CSI submissions to be up-to-date by the end of the year.

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 has a total budget of $197 million for FY12-13, up $1 million from last year.

- In FY11-12, 25,963 consumers were served, an increase of 2,000+ consumers over the prior year. (CAEQRO data for this time frame is not yet available, but CY10 to CY showed an increase in over 900 Medi-Cal beneficiaries served.)

- Sacramento County, in partnership with Contra Costa County Mental Health, was awarded an Institute for Mental Disease (IMD) Demonstration Project sponsored by the Centers for Medicare and Medicaid Services (CMS). This three-year project will enable the County to be reimbursed for some Medi-Cal beneficiaries hospitalized for acute care in an IMD with over 16-bed capacity for ages 22 through 64, who were previously excluded. The planning process began in February 2012 and the Operational Plan was submitted to CMS in April 2012. As a result, a number of private hospitals have provided MHP Utilization Review staff with electronic communication to monitor quality assurance functions

- The *Napper* (Napper v. Sacramento) class action lawsuit resulted in a Consent Decree which requires the County to submit a written plan by December 2012. The MHP is in the final stage of compliance as a plan is now being developed. During the settlement process, four community meetings were held to facilitate agreement and seven outreach meetings were scheduled for consumer input.

- The Community Support Team (CST) completed staffing its peer support specialist component. The peer support specialists, staff with lived experience, are able to use their life stories to foster hope and support individuals seeking help.

- The Mental Health for Crisis Responder Training for law enforcement, first implemented in March 2011 by MHP Workforce, Education and Training (WET) project staff completed training all Sacramento Police Department officers/dispatchers in November 2011. The project staff has completed 16 trainings for the Sacramento County Sheriff's Department and fully trained the Citrus Height Police Department, as of September 2012. Plans exist to implement training with the Rancho Cordova Police Department in the near future. The training curriculum was developed by multiple stakeholder groups represented on the Training Partnership Team and uses peers, along with MHP staff, to deliver the material. As a result, consumers report recent improvement in the quality of contact with local law enforcement [this was validated among a number of consumers interviewed during the review].

- The Respite Partnership Collaborative, a public-private partnership of the MHP, the Sierra Health Foundation and the community at large, began this year. The Respite Partnership seeks to alleviate crises and reduce psychiatric hospitalizations through a continuum of respite services and is funded by MHSA Innovation monies. This collaborative planning began in November 2010 and in November 2011; Sierra Health Foundation was awarded the contract to administer this project. In August 2012, a

Request for Proposals for Respite Services was posted with the Bidders Conference and project launch was scheduled for August 30, 2012.

- An Integrated Health and Wellness project – the Screening, Assessment, and Brief Treatment Program – is now underway. This MHSA program is designed for implementation in primary care settings, and a Request for Letters of Interest was posted in July 2012. Qualified vendors must provide screening and assessment for behavioral health conditions such as depression, anxiety, substance abuse, and trauma.

- County Patient's Rights Advocates serve on the ongoing Community Partnership Coalition meeting to address consumers' concerns about local hospitals and also visit all 45 county Board and Care facilities annually; although a drop in the number of facilities of this type countywide has occurred recently. In the past year, a Room and Board Coalition has begun (based on a model created in San Bernardino County) that will create a set of minimum standards for these unlicensed facilities based on stakeholder input. The result is expected to be a fluid list of available rooms in which high quality options are indicated to potential users.

- The MHP's website was redone in the last six months as the County expected each department to upgrade their platforms. Each department now maintains a point-of-contact for information posting and various C/FM Advocates have noted increased community access as they now receive direct calls from the public who accessed the site.

- In the last year, Case Based Collaborative meetings began bringing together all involved staff members from anywhere in the system on specific cases to review treatment and other pertinent issues, such as program transitions and follow-up care. Three such meetings have occurred to date.

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's Quality Improvement Committee (QIC) meets monthly and answers directly to the Executive Quality Improvement Committee (which meets as needed) and to Executive Management bi-weekly. The various Program Coordinators answer to the Quality Management (QM) Program Manager, who in turn directly answers to the MHP Director. However, the QIC is an internal MHP committee only with the addition of consumers and family members being represented by the three co-located contracted C/FM Advocate employees.
  - This last year, the Secretary of the County Mental Health Board and a representative from Alcohol and Other Drug (AOD) services joined the QIC. Numerous ongoing

MHP sub-committees also report up to the QIC, including Research and Evaluation (and County Research/Evaluation staff), Pharmacy and Therapeutic (P&T), Credentialing, Medication Monitoring, Cultural Competency, Utilization Review, Education, Focused Clinical Quality Review, and Grievance.

- The annual evaluation of last year's Quality Improvement Work Plan revealed, as a result of 32 tests calls to the MHP's Access line for cultural competency assurance, the need for additional training and feedback, which was given to Access staff specifically about working on cultural sensitivity and how to use the language line. The QM and Cultural Competency departments are now working on an ongoing staff orientation for language line use to increase staff comfort and utility.
- Also noted within the QI Work Plan Evaluation, 1,214 charts were reviewed for completeness and care appropriateness; 152 instances were found in need of corrective action (or 12.5 percent) which has increased since last year; the biggest concern was incomplete consumer consents and medication side effects documentation in MHTC charts. This is now being handled in the P&T committee.

- The MHP tracks all pertinent timeliness indicators quarterly. Annually they also track changes in the number of system providers (both organizational and network) as well as any changes in contracts. While still doing POQI surveys for the state, they are working on developing their own system-wide survey to pilot with adult consumers. They track annual retention and penetration rates and continue to develop quality measures that can be monitored by Avatar reports, such as access to care.

  Specific projects were data-driven/informed, such as:

  - Complete implementation of the Children's Access team in February 2011 which created a new procedure for initial authorization; providers reported this works much more efficiently. As 30 percent of child consumers never show up for scheduled services, the MHP used service/no shows data to plan program changes to increase efficiency.
  - Reopening crisis stabilization services in the form of an ISU as a result of a noted increase in county hospitalizations.
  - Looking at service demand among AB3632 consumers as this dedicated funding was lost; they reallocated resources to better to meet the remaining Educationally-Related Mental Health Services consumer needs based on geographic distribution.
  - Informing the Innovation workgroup surrounding Crisis Respite Collaborative and IMD project.
  - Using private hospitalizations data, (i.e., usage and rates), to inform conversations with these hospitals about services and capacity for both child and adult consumers.

- The MHP's Information System (IS) is budgeted for full implementation of an Electronic Health Record (EHR), including Electronic Data Interchange. The MHP has intranet

access for staff and extensive online resources for contractors. Four new IS staff were added this year, primarily for training and support of the EHR implementation.

- Implementation of HIPAA 5010 compliant claims have been delayed, but this has not resulted in any delays in claims submissions or payment processing. The MHP is in the processes of hiring and training four new Senior Account Clerks who will assist with claims processing and fiscal reporting. Claims and payment data are regularly exported to an external database which is used for fiscal analysis and generating reports. Claims submissions are up-to-date, though processing of Medi-Cal 835 electronic remittance advice files are backlogged due to processing delays by the State and processing limitations of the IS.
- Numerous examples of effective communication between the MHP leadership and various stakeholder groups were evidenced. These include:
  - Bi-weekly Quality Policy Council and Executive Management Team meetings; monthly QIC meetings. Other internal MHP committees meet monthly, bimonthly or ad-hoc.
  - Information dissemination of system-wide issues/changes first by email to all staff and providers, and then in quarterly information sessions held by the MHP Director at all sites. Every two months, the Director meets with the Executive Directors of all contract providers and monthly there are program specific (MHP and contractor staff combined) meetings (i.e., Wraparound, Flexible Integrated Treatment [FIT], Full Service Partnership [FSP]). The Director also maintains an open email/door policy. The system uses email, the department intranet, a shared drive, and various webinars to communicate to staff and contractors.
  - Monthly IS User Forums and Drop-in sessions; Avatar 101 is offered monthly as is training on Advanced Billing and CWS/Infoscriber.
  - Consumers can access their own records via the Network of Care website and contract providers use the MHP's Avatar system.
  - The Mental Health Promotions multimedia project using radio and tv ads, billboards and literature in numerous languages to communicate to the community as of early 2012.
  - Continued monthly Expert Pool Town halls for C/FMs, peer employees and community. The Speaker Bureau continues – there are now 116 trained C/FMs available to speak at trainings and for community presentations.
  - A family member employee holds bi-weekly Family Support groups at the MHTC to provide support/resources to family members of hospitalized consumers.
  - A *Consumer Speaks* conference in December 2011; 200 participants, of which 100+ were C/FMs, attended. A Transitional Aged Youth (TAY) consumer conference was held in March 2012.

- Meeting with providers to address the challenges involved with addressing denied claims as State delays and other factors outside the MHP control. This has improved the timelines for resolution. The MHP is also working with providers to complete the Medicare certification process which is cumbersome and complicated to navigate.

Nevertheless, despite these efforts, on-site review revealed communication inconsistencies between line staff and supervisors, and interviewed consumers felt they did not have effective two-way communication either direction, and the interviewed peer employees were not aware they could apply to be a part of the Speakers' Bureau. Peer staff also felt that there was limited communication upwards above their direct supervisors in some programs. Contractors reported a overall lack of information and difficulty getting clear answers to questions regarding policies and procedures from their liaisons or the MHP administration, despite a monthly provider forum.

- The MHP has developed a number of ongoing or project specific venues to gather stakeholder input, such as:
  - Inviting the community routinely to give input on various campaigns/strategies/ fund allocations for MHSA capital funding beginning April 2012.
  - Including C/FMs as a part of the UC Davis Resident Training program, and providing these new MDs with a community resource directory.
  - Creating a video with the *Mental Health Matters* television show crew to use as a part of the Sacramento County Sheriff's training curriculum. C/FMs with lived experience specifically with law enforcement shared their personal stories in an effort to help enliven and personalize this training video. C/FM peer advocates are also recruiting additional C/FMs to participate in this ongoing training as co-presenters.
  - Involving the community, contractors, and county staff on the System-wide Community Outreach & Engagement (O & E) Committee. Meeting minutes revealed this committee has reached into various communities to identify members to be spokespeople for the multimedia campaign. Further, community focus groups were used to create and vet the campaign prior to roll-out.
  - Including both youth and family peer partners on the new Child PIP committee. This PIP was created partly because "our diverse stakeholder community in the planning process identified trauma as a key area of unmet needs. It therefore makes sense to adopt system-wide policies that focus on a trauma informed system that is cognizant of its diversity," reported the MHP.
  - Creating an Evidences-Based Practice (EBPs) committee comprised of community members, youth consumers, family members and providers to decide on which child EBPs to implement.
  - Having C/FM Advocate staff or peer staff on the QIC, the O&E Committee, the Adult Provider team, the MHSA steering committee, the Prevention and Early Intervention Planning/Implementation committee, in Crisis Responder meetings, on

the Mental Health Board stakeholder committee, the P & T committee, the Suicide Prevention Planning committee, and the Vocation/Employment Collaboration.

- Inviting clinical staff last year to give input on CWS implementation, and this year including four MDs who are using CWS as a pilot to provide implementation feedback from their perspective, leading to various compromises on user needs vs. IT functionality.
- Giving consumers a real voice at the Wellness Centers and at some contract providers.
- Forming the new Respite Partnership Collaborative, stemming from the Innovations workgroup, that includes C/FMs, providers, and community members.

However, despite regular contractor meetings with Executive staff and participation in division meetings, contractors feel that they have little input in program planning and system changes. Peer staff did recall limited opportunities to give provider agency or system input, but agreed more is needed as there is no tool in place for management to be held accountable by consumers or peer staff. In some instances when peers have expressed their concerns or opinions, they perceive having been 'shut down' by their superiors.

- The MHP has a number of contracted employment opportunities for C/FMs through the system, (i.e., in administration/leadership, at the two adult aftercare clinics, at the two Wellness Centers. Peer positions also exist at various contractors, such as Turning Point, Crossroads, California Self-Help Network, and Mental Health America/Hmong Women's Center). A career ladder exists for qualified consumers; peer employees throughout the system hear of new opportunities from their supervisors/mentors, see them on bulletin boards, or in emails. C/FM employees report they regularly get performance reviews and feel they are supported in career expansion; however, many feel they do not get enough training in group facilitation skills, how to develop certain class curriculum, or encourage certain skill sets in consumers. All feel well integrated into the 'regular' staff ranks and accepted by non-peer staff. They did lament the lack of resource information available to them to properly mentor/support MHP consumers and great concern that there are no viable options for them to effectively address their own mental health needs as they arise, while still being an employed peer. While the message is to "take care of themselves" (just as it is to all staff), no employment accommodations such as schedule flexibility, respite, or last minute options are reportedly available.

  Employed consumers (i.e., peer support specialists) are encouraged to use their life stories to foster hope and support in individuals seeking help. All have been through Peer Mentoring 101 training but most felt another, more advanced training, like a 'Peer Mentoring 102' is needed. The use of trained consumers as part of an Expert Pool has continued and now over 116 prepared C/FMs are involved; inclusion in the Pool is open to anyone, not just MHP consumers. A *Recovery 101* training was created in-house by two C/FM employees and has been used this last year to educate staff and other C/FM

employees on Wellness and Recovery principles and WRAP planning. C/FM representatives from the Speaker Bureau continue to attend various Police Department Trainings and are being deployed into the community as a continued effort to reduce stigma. *A Consumer Speaks* conference was held in December 2011 and a consumer-operated Warm Line began in September 2011. A number of youth consumers advocates will begin speaking at CSU-Sacramento in various Social Work courses this year and the MHP is considering the development of a Family/Youth Expert Pool to ensure the voice of TAY consumers is heard, especially in instances where it may counter parental wishes.

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:

- The MHP's Cultural Competency Committee (CCC) meets monthly, as does the System-wide Community O&E Committee, which reports to the CCC. The county's Cultural Competence Plan (CCP) Update was updated in spring 2012 with the state indicating its recommendation to move forward with the plan's implementation. There remain six threshold languages in the county: English, Spanish, Hmong, Vietnamese, Cantonese, and Russian, and all information and services are available in these languages as well as in numerous other sub-threshold languages. System-wide, stakeholders felt many worthwhile activities have been planned by CCC and consumers specifically felt their

physical/mental health needs are assessed competently during the intake process and they are referred to the appropriate culturally responsive services.

This last year saw the roll-out of a very large multi-media anti-stigma campaign countywide on TV, radio, the web, billboards/buses/bus shelters and by way of pamphlets/literature. It was translated into all threshold languages and used representatives from each cultural community as spokespeople. The MHP is now working on a way to assess the positive effect of this anti-stigma campaign (i.e., increased access and penetration rates).

In an effort to reach their CCP goals, the MHP also:

- Provides stipends to attract culturally diverse staff (bilingual/bicultural), especially for C/FM employees.
- Works with the Central Region Partnership Collaborative to leverage MHSA WET funds to send more county residents to community college for peer training.
- Continues to mentor/support students at the local Health Professionals High School.
- Provides stipends for consumers who pursue leadership opportunities.
- Has now trained 85 percent of identified staff as interpreters and is training all staff on how best to use these staff.
- Has trained 332 staff using the California Brief Multicultural Scale (CBMCS) Training Program; all staff will be trained by July 2013.
- Has seven ongoing Supported Community Connections programs and other programs that target Asian-Pacific Islanders (API), older adults, TAY, Latinos, Eastern Europeans, Native Americans, African Americans, disabled persons including the deaf, Lesbian/Gay/Bisexual/Transgendered/Questioning (LGBTQ) people, homeless people, college students, Hmong/Vietnamese, and refugees. The relevant community for each of these efforts was engaged in the planning process.
- Will administer the biennial Agency Cultural Competence Self-Assessment this year; it was last given in FY2010.

- The MHP uses annual service utilization data by age, number of services, gender, race, ethnicity, language and diagnosis to track capacity. They also track the geographic delivery of services to cover county need. The MHP's use of contracted legal entities has remained stable since last year with 43 providers at 89 physical sites; these cover all types of programs for various age groups and/or specialized populations.

  Other capacity-building efforts include:

  - As part of the final settlement in the *Napper* Case, the plan is to consolidate the existing two adult outpatient clinics into one. The space will be at the Stockton Blvd. Campus which includes the former 50-bed section of the MHTC, now unused. Public

comment/input will be collected from community stakeholders and consumers in October and/or November for any adult system redesign.

- Having 601 new housing units funded by MHSA by 2013 – 25 percent of which will be for homeless, mentally ill consumers.
- Applying better use of existing resources by prioritizing Medi-Cal eligibles to either of the two Crestwood PHFs for inpatient treatment and reserving MHTC beds for indigent consumers (the second 16-bed PHF opened on July 1, 2012.)
- Fully staffing the Community Support Team (CST), a partnership with Crossroads Diversified Services, to provide field-based support, education and mental health connections to people of all ages/diverse groups in the community to reduce crises/hospitalization.
- The planning/implementation of the ISU, including managing MHTC capacity to accommodate the need for those who are unable to be stabilized within 23 hours.. The ISU plans to open in October 2012 and admit clients from Emergency Rooms (ERs) to its 23-hour stabilization unit, in order to avoid inpatient hospitalization, whenever clinically appropriate. ISU staff then become the 'gatekeepers' to hospitalization and ensure consumer are medically cleared prior to transport. The MHP envisions this service to provide capacity in the area of a crisis stabilization unit for individuals who are screened at the ERs to prevent inpatient hospitalization. This fills a current gap in the MHP service system. Practicalities will need to be addressed as the program is implemented.
- Using a weekly census of all adult contracted programs to monitor caseload.
- Tracking open provider slots daily at either Access program so as to refer callers to places with appropriate services in closest location, which also have the most availability to minimize wait time to initial access.

A year ago, the MHP decided to give consumers discharging from hospital a scheduled follow-up appointment before their hospital release to increase more timely engagement. However, this increased no show rates at the various RST programs to about 50 percent, despite follow up by the CST following hospitalization discharge. In response, each RST has been encouraged to develop and implement their own strategies around managing these no shows, such as double booking, having drop in times for follow-ups, and flexible scheduling. The MHP also endeavors to help RSTs close cases quickly for referred inpatient discharges that ultimately upon outpatient assessment do not meet medical necessity.

- The MHP used low penetration rate data in certain areas/populations to support the development of their Supportive Community Connections plan. They also use prevalence data to measure potential unmet service needs throughout the county using state data for program planning. They have looked at retention data across ethnicity, age, gender, language for FY10-11 and 11-12 and have noted an overall drop in retention

rate in some groups. That is, PR rate comparisons between FYs reveal a very small decrease in child consumers and White consumers, but a large decrease in Native American/Alaskan consumers. Large increases in PR were seen for children aged 0-5 years, and in both Other Ethnicity and Hispanic beneficiaries. The MHP also tracks its AB109, Child Welfare and Juvenile Justice consumers, and maintains a daily census of bed capacity at the MHTC and two Crestwood PHFs.

- The MHP continues a number of collaborative relationships and efforts, as well as has begun new ones, such as:
  - The MHP Director now also heads County AOD services; she is hoping to get better collaboration between the two advisory boards, if not have them function as one. AOD counselors are also housed at the two adult outpatient sites and there are weekly meetings between AOD and mental health staff as part of a multi-disciplinary team effort.
  - Delivering evidence-based Mental Health First Aid training to the community in partnership with a provider, using MHP staff, consumers, and family members. To date, about 370 people in the community have been trained.
  - Housing mental health clinicians at all three day reporting centers for AB109 consumers.
  - Collaborating with Child Protective Services (CPS) regarding the implementation of the County's response to the *Katie A.* settlement agreement; the settlement involves ensuring mental health services to foster care children who need them.
  - A Wraparound Program Reinvestment in which CPS, Probation and mental health are finalizing recommendations for the use of system wide savings realized through the use of Wraparound providers.
  - Collaborating with the Child Abuse Prevention Council and CPS in applying for a federal grant focused on community-wide infrastructure development for 0-5 year olds.
  - Providing minority students/graduates with opportunities to learn about skills needed for Health Care (HC) management through the USC Diversity in HC Leadership program.
  - Working with the County Public Defender's Office to coordinate with the jail to assess inmates with mental health needs who might qualify for the Mental Health court. This is a small program in Sacramento..

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 reports quarterly tracking of time from service request at Access to provider follow-up (which is not necessarily a face-to-face contact) and then time from first face-to-face contact/assessment to first appointment for both adults and children. Their target is 14 calendar days /10 business days; recent data reveals adults meet the standard 25 percent of time, with a median wait time of 22 days. Children meet the standard 76 percent of the time. Recent data on time from assessment to first clinical appointment reveals, and the MHP's target is 30 calendar days /20 business days, adults meet the standard 83 percent of the time and children meet it 97 percent of the time. Combining the two MHP standards results in a six week standard for time from point of access to first clinical appointment for any age consumer.

  In the last year, child initial assessments were moved from the MHP's Authorization unit to individual child providers to reduce wait times. Adult providers reported an increased number of inappropriate referrals and pressure to accept intakes despite being well over capacity in some instances (especially at RSTs), and they feel there has been no effort to improve the adult intake process. The MHP confirms no recent performance improvement activities to date in this regard, but they do plan to look at the adult capacity issue across different sectors, especially at RSTs. The 2009 lawsuit has prevented changing any adult system protocol/process.

- The MHP has a timeliness standard of 28 days from service request to first psychiatrist appointment; recent data reveals a median wait time for adults of 35 days and 34 percent

met the standard. Priority for MD capacity is given to consumers coming out of the hospital and the MHP reported adapting MD capacity is still very hard to do quickly enough as demand grows. But, to aid MDs to best use their time, they have empowered each provider to develop their own strategies/internal mechanisms to best fill MD no shows. The MHP is also looking to hire more Nurse Practitioners but in doing so, will reduce existing MD FTEs. Various contractors reported using Locus Tenems MDs.

- Contract providers have internal procedures for urgent service requests from existing clients, but do not track or report urgent contacts/services to the MHP. The MHP collects urgent service information on a client specific basis but does not track and trend such information systemwide. However, the MHP is reinstating a re-developed crisis unit which is intended to reduce hospital admissions resulting from ER visits and this urgent service use can be tracked once the program opens. This unit, however, will not have any drop-in capacity for consumers with urgent needs, only those referred out of ERs.

- The MHP has a seven calendar day/five business day standard from hospital discharge to first MD follow-up appointment; recent data reveals a median of four days for adults with 66 percent meeting the standard, and a median for children of two days, with 76 percent meeting standard. They also have a 30 calendar day/ 20 business day standard from hospital discharge to first clinical appointment; recent data reveals a median of 16 days for adults, with 76 percent meeting the standard, and a median for children of seven days with 84 percent meeting the standard.

  The Adult Access team schedules follow-up appointments for every consumer coming out of a hospital prior to their discharge after being notified by a local hospital discharge planner. Consumers are given an appointment reminder upon release. Further, the CST also works with hospitals to ascertain who is coming out of a hospital, and then calls/confirms the scheduled follow-up appointment with a consumer. The CST staff of ten (most of whom are consumer/peer employees) offer assistance to consumers to ensure they can make their appointment and provide support and resource information as needed until then.

  Each RST has denoted hospital discharge follow-up sessions and adult providers are notified daily by way of a census regarding who is being released and which follow-up sessions are now filled. If more capacity is needed, Access contacts a provider to have more sessions added on any particular day.

- The Avatar system records missing appointments, both No Shows and cancellations. The submitted ISCA reported an average monthly No Show rate of 8.9 percent, but this timeliness indicator is not yet tracked nor examined for process improvement by QM. No Show reports are run by administration and MHP contract monitors review No Show data monthly for each provider. This does not effectively provide data on a systemwide level to make improvements.

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	
4G	Utilizes information from Consumer Satisfaction Surveys	X			

Issues associated with the components identified above include:

- The MHP maintains two contracted Wellness Centers – Franklin in the south and Marconi in the north. Last year the consumers at Marconi spoke highly of the wellness and recovery services and this year, consumers at Franklin felt they form a strong team and 'family' at their center. Full-time peer mentors and staff provide consumers a sense of hope. Monthly Wellness Center calendars reveal a wide variety of groups/services, such as yoga, games, life skills, outings, anger management, SacPORT, recovery, conflict resolution, movies, trauma healing, self-esteem, and diagnosis specific groups. The Executive Director of Consumer Self-Help, who runs the Wellness Centers, is a self-disclosed consumer and it is evident recovery principles abound. In addition, peer partner services and the *Recovery 101* curriculum has been provided to consumers at

both Adult county clinics, as well as the Centers. While no formal mechanisms exist to educate consumers about the two existing centers, peer mentors inform consumers at the two county clinics upon initial contact and flyers are posted on bulletin boards throughout the MHP advertising the Centers' services and other resources.

In July 2012, the Older Adult Sierra Wellness program began reviewing and refreshing existing groups. The MHP reports a new calendar of groups based on usage and preferences was still in development when this review occurred. Consumers continue to give input on what groups to change and adopt but made it clear on-site they desperately wish their wellness services resume/continue as presently there is nothing offered, and they were not aware of any review process in action.

- The Level of Care Utilization System (LOCUS) is being built into the CWS for use by the Adult Placement Team as a step-down/up tool to and from Intensive treatment options. The Child and Family System of Care plans to implement the Child and Adolescent Needs and Strengths (CANS) for all of their contract providers, who will begin CANS training in conjunction with their Avatar CWS start date. The CANS was initially implemented in February 2010 for FIT and Wraparound programs. MHP continues to use the required MHSA FSP Forms (i.e. PAF, KET and 3M) and the Ages and Stages Questionnaire-Social/Emotional with consumers aged 0-5 year. Train-the-trainer training was provided in June 2012 by creator of CANS for select staff. The MHP also plans to utilize the Adult Needs and Strengths Assessment as one of the tools for adult outcome measurement. It will be rolled out in November 2012.

  Outcome tool results are presently communicated through reports on varying schedules (quarterly, annually) and are distributed to interested parties including internal staff, the management team and interested stakeholders. There already exists targeted focus group meetings with certain providers to discuss use/outcome results, and the hope is to compare results between providers and types of service once more data becomes available when the tools are more broadly used.

- As their ongoing non-clinical PIP, the MHP worked with four chosen RSTs who serve adult outpatient consumers and 1,252 consumers with at least one of the six focus medical conditions as part of a Primary Care/Behavioral Health collaborative. By training staff at all four sites and offering information sessions for consumers at these same sites, as well as developing appropriate new forms and tracking mechanisms, the goals were to improve primary care documentation in the chart (i.e., progress notes and treatment plan), and the EHR, in addition to better coordinate overall consumer care for both physical and mental health needs.

  Randomized chart review of 175 charts over three occasions during a seven-month period provided an ongoing feedback loop between the MHP and providers as well as valuable data. Statistical analysis revealed significant improvement ($p < .01$) in all indicators but one. That is, performance on the following indicators surpassed apriori-

established goals: primary care provider documentation in EHR and the service plan; medical condition documentation in EHR (in correct place), the service plan, and in the progress notes; and coordination of care documentation in the service plan and progress notes. As a result of the PIP, the MHP's focus is now on developing a bridge from the MHP to primary care as a whole and to begin successfully stepping-down consumers to primary care providers for ongoing medication management.

- For a second PIP, the MHP has decided to use CANS data to identify the collection of needs and strengths that have a high likelihood of resulting in hospitalization or crisis stabilization services in child consumers. The expectation is that the PIP interventions will prevent future hospitalizations (which ultimately lead to a better quality of life, less disruption in achieving developmental milestones and community integration, and lower mental health costs). This PIP will compare CANS scores between four groups of 50 child consumers each – hospitalized vs. not hospitalized and those with or without trauma – as indicated by the CANS Adjustment to Trauma subscale presently in Wraparound and FIT programs. After a year of expanded CANS training for staff and C/FM employees and use of the CANS Trauma module, chart reviews (undertaken with a developed chart review tool) for all 200 subjects will provide the comparison data. As interventions are just now being implemented (although the CANS has been in use since February 2011), no data is yet available for post-intervention comparison.

- The MHP shared the results of the May 2011 POQI consumer satisfaction survey with various stakeholder groups and internal committees. The CCC made a recommendation surrounding the importance of linguistic competence in survey administration and proper document translation to encourage diverse consumers to complete the survey. CCC minutes revealed "Surveys were available in all the threshold languages and we provided the translated surveys throughout the system; however, not all the consumers and family members were aware of this." As a result, the MHP worked with each agency and created training so all providers are aware of the 24 POQI versions available (four age groups in six different languages). The QM department used the May 2011 results to focus on responses to predetermined questions to direct improvement (for the adult, child and older adult systems individually). Results were broken down by provider and distributed.

  In late August 2012, the MHP again administered the POQI survey, for a one week period. They gathered about 4,139 completed surveys (2,000 adult, 100 older adult, 1,040 youth, and 1,901 caregivers); this reflects an increased completion rate over past administrations in all age categories. The MHP also conducted pre-administration training at eight locations system-wide on required policies and procedures. The MHP is very aware that a more culturally diverse tool than the POQI is needed, and so they are a part of the state workgroup to improve/change the statewide tool.

  The MHP has also now begun to use the Common Ground tool by Pat Deegan to engage consumers in their treatment. This tool helps people prepare to meet with their

psychiatrist right before the appointment and arrive at the best decisions for treatment and recovery collaboratively in session. Using a one-page Health Report with a few question helps a consumer summarizes how they are doing and what their concerns are to be addressed in their MD appointment. As they do every year, the MHP also undertook their annual Adult Access team survey, gathering 281 surveys in 2011 (up from 114 in 2010), and found adult consumers reported the highest level satisfaction to date with such things as wait time; staff support, helpfulness and professionalism; and culturally appropriate services since FY09-10.

❖CURRENT MEDI-CAL CLAIMS DATA FOR MANAGING SERVICES❖

Information to support the tables and graphs, labeled as Figures 5 through 15, is derived from four source files containing statewide data.[1] A description of the source of data and summary reports of Medi-Cal approved claims data – overall, foster care, and TAY – follow as an attachment. 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 CY11. 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 CY11. 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.

[1] Percentages may not add up to 100% in some of the figures due to rounding of decimal points.

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

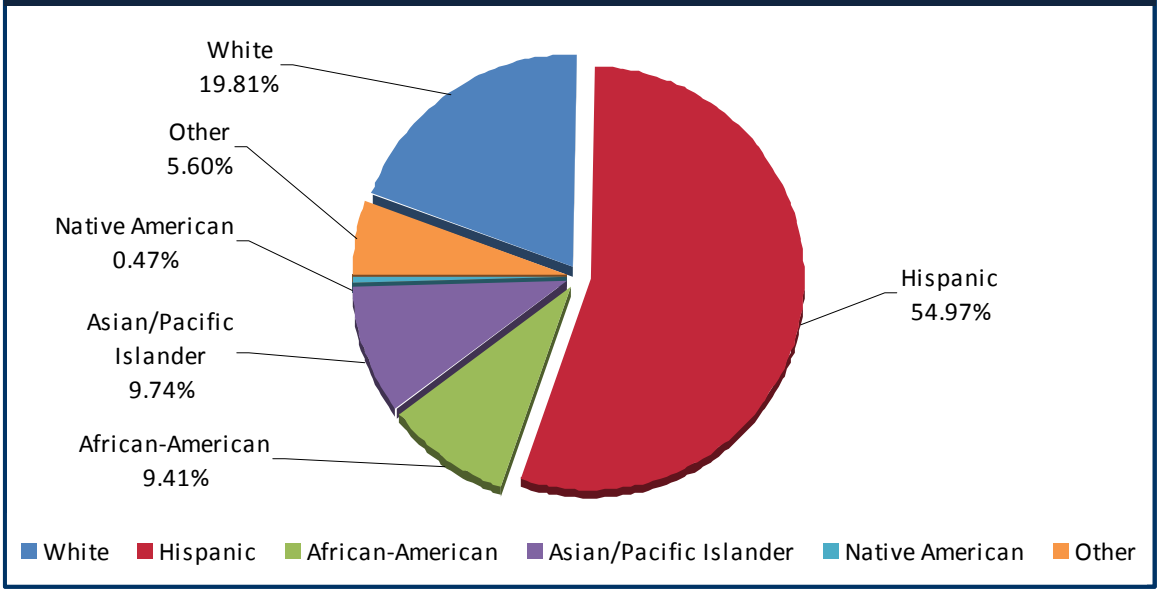


Figure 5b. Statewide Medi-Cal Beneficiaries Served, by Race/Ethnicity CY10

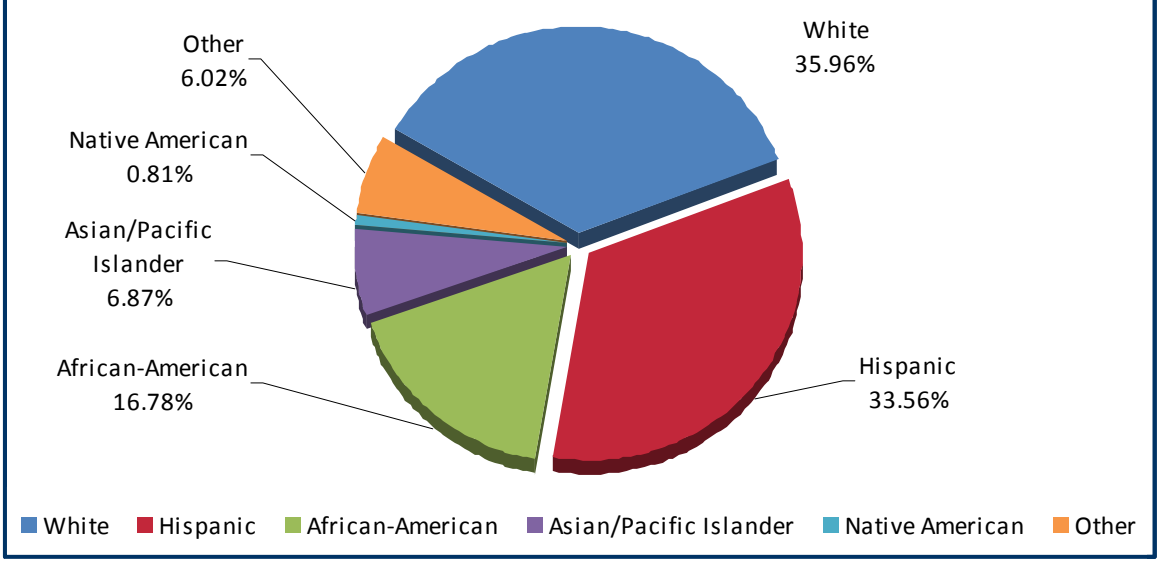


Figure 6a. MHP Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY11

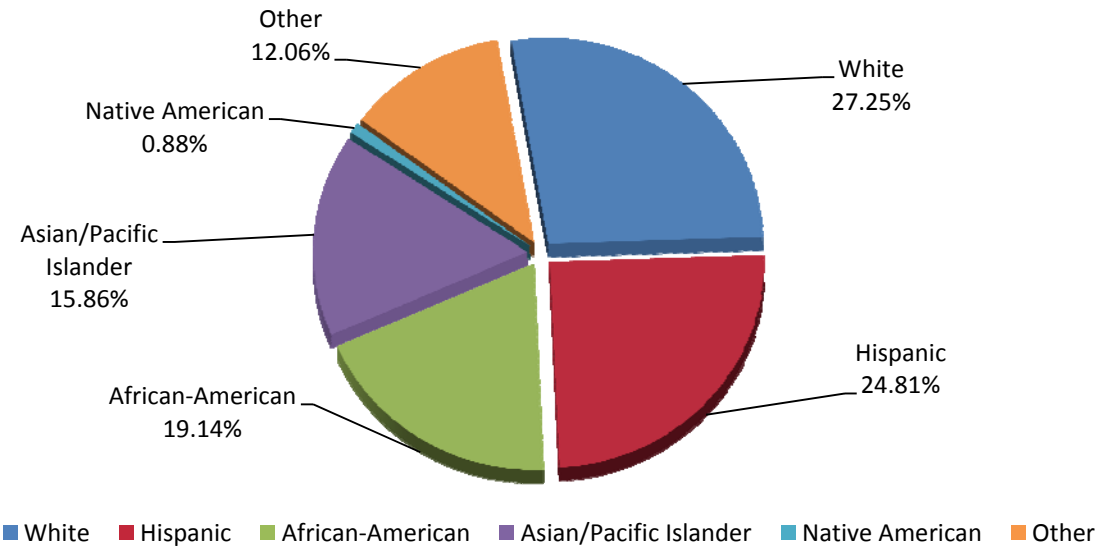
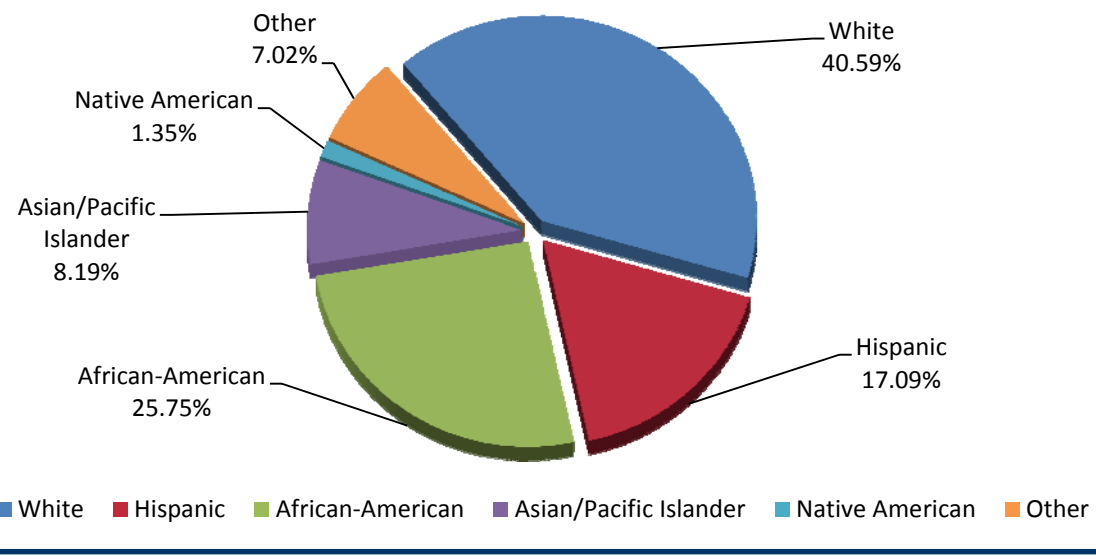


Figure 6b. MHP Medi-Cal Beneficiaries Served, by Race/Ethnicity CY11



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 large size, and the state.

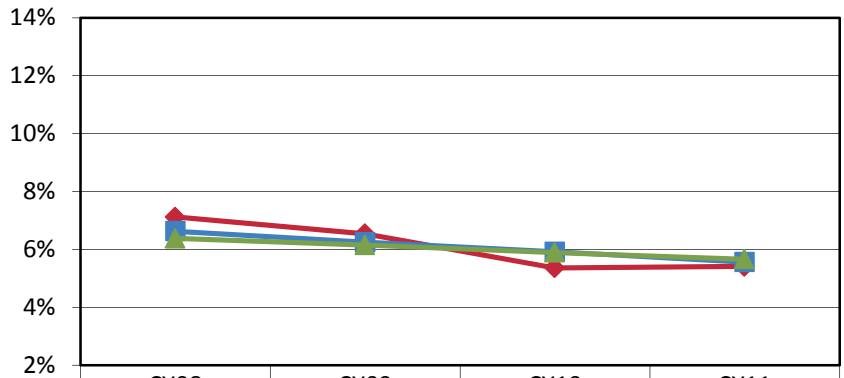
Figure 7. CY11 Medi-Cal Approved Claims Data

Element	MHP	Rank	Large MHPs	Statewide
Total approved claims	$83,309,177	N/A	$860,852,770	$2,133,800,328
Average number of eligibles per month	331,589	N/A	3,707,783	7,909,312
Number of beneficiaries served	17,954	N/A	206,267	447,585
Penetration rate	5.41%	38	5.56%	5.66%
Approved claims per beneficiary Served	$4,640	22	$4,173	$4,767
Penetration rate – Foster care	52.59%	31	51.31%	54.96%
Approved claims per beneficiary served – Foster care	$8,244	16	$7,350	$6,910
Penetration rate – TAY	5.97%	42	6.60%	6.72%
Approved claims per beneficiary served – TAY	$6,281	15	$5,236	$6,000
Penetration rate – Hispanic	3.73%	25	3.48%	3.68%
Approved claims per beneficiary served – Hispanic	$4,280	23	$3,873	$4,706
Penetration rate – Asian/Pacific Islander	2.80%	46	3.89%	4.00%
Approved claims per beneficiary served – Asian/Pacific Islander	$3,488	26	$3,396	$3,587

Figure 7. CY11 Medi-Cal Approved Claims Data				
Element	MHP	Rank	Large MHPs	Statewide
Penetration rate – African American	7.29%	48	9.70%	10.30%
Approved claims per beneficiary served – African American	$4,984	24	$5,082	$5,163

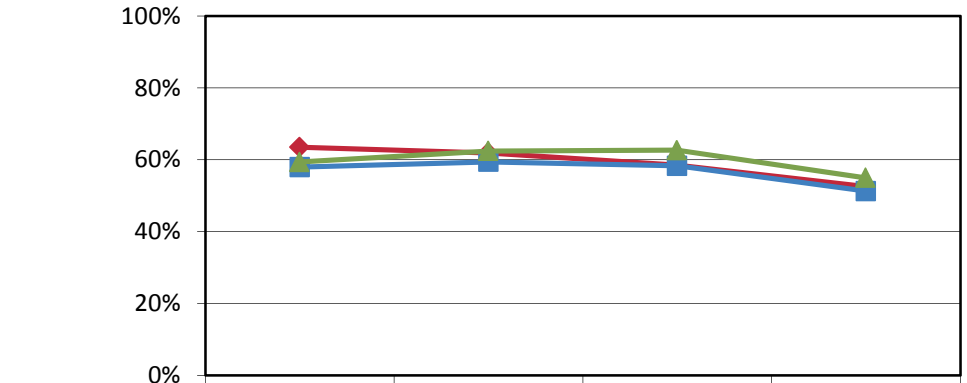
Figures 8 through 11 highlight four year trends for penetration rates and average approved claims.

Figure 8. Overall Penetration Rates CY08-CY11



	CY08	CY09	CY10	CY11
MHP	7.12%	6.54%	5.36%	5.41%
Large MHPs	6.63%	6.25%	5.92%	5.56%
Statewide	6.38%	6.15%	5.89%	5.66%

Figure 9. Foster Care Penetration Rates CY08-CY11

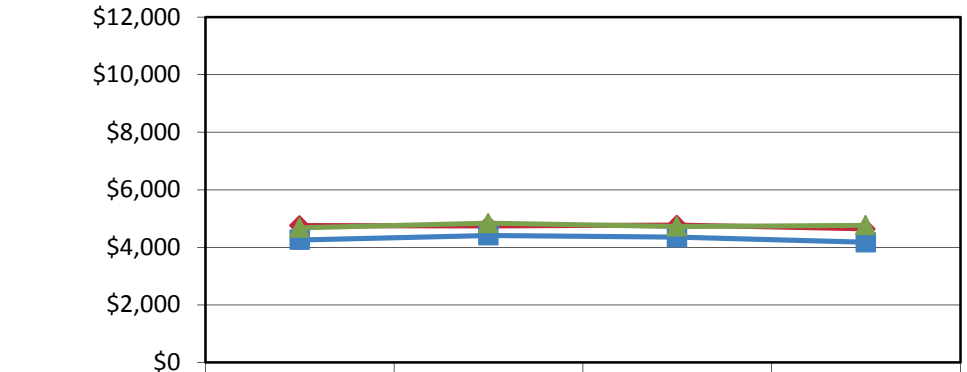


	CY08	CY09	CY10	CY11
MHP	63.53%	61.92%	58.51%	52.59%
Large MHPs	57.96%	59.43%	58.33%	51.31%
Statewide	59.39%	62.43%	62.67%	54.96%

Figure 10. Transition Age Youth Penetration Rates CY08-CY11

	CY08	CY09	CY10	CY11
MHP	6.99%	6.44%	5.73%	5.97%
Large MHPs	7.29%	7.17%	7.05%	6.60%
Statewide	7.30%	7.21%	7.06%	6.72%

Figure 11. Average Approved Claims per Beneficiary Served CY08-CY11



	CY08	CY09	CY10	CY11
MHP	$4,753	$4,744	$4,774	$4,640
Large MHPs	$4,254	$4,410	$4,351	$4,173
Statewide	$4,679	$4,841	$4,723	$4,767

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. MHP 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
FY10-11	316,661	17,148	5.42%	42	$80,351,774	$4,686	20
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

Review of Medi-Cal approved claims data, displayed in Figures 5 through 12 reflect the following issues that relate to quality and access to services:

- The overall penetration increased from 5.36 percent in CY10 to 5.41 percent in CY11, resulting in a rate slightly lower than the statewide average and that of other large MHPs. This is a reversal of the trend of decreasing rates during the prior two year period.
- Foster care penetration has decreased steadily from 63.5 percent in CY08 to 52.6 percent in CY11. This rate places the MHP between the statewide average of 55 percent and the large MHP average of 51.3 percent.
- The 3.73 percent penetration rate for Hispanics in CY11 was above the statewide average of 3.68 percent and the 3.48 percent for large counties. Penetration rates for API (2.80 percent) and African Americans (7.29 percent) were noticeably lower than the statewide averages of 4.0 percent and 10.30 percent respectively.

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 five 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 13. 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 CY11	10,905	447,585	2.44%	$48,955	$533,858,819	25.02%
MHP CY11	280	17,954	1.56%	$45,358	$12,700,326	15.24%
MHP CY10	316	17,089	1.85%	$44,676	$14,117,730	17.30%
MHP CY09	466	20,582	2.26%	$45,435	$21,172,488	21.69%
MHP CY08	492	21,125	2.33%	$47,342	$23,292,201	23.20%

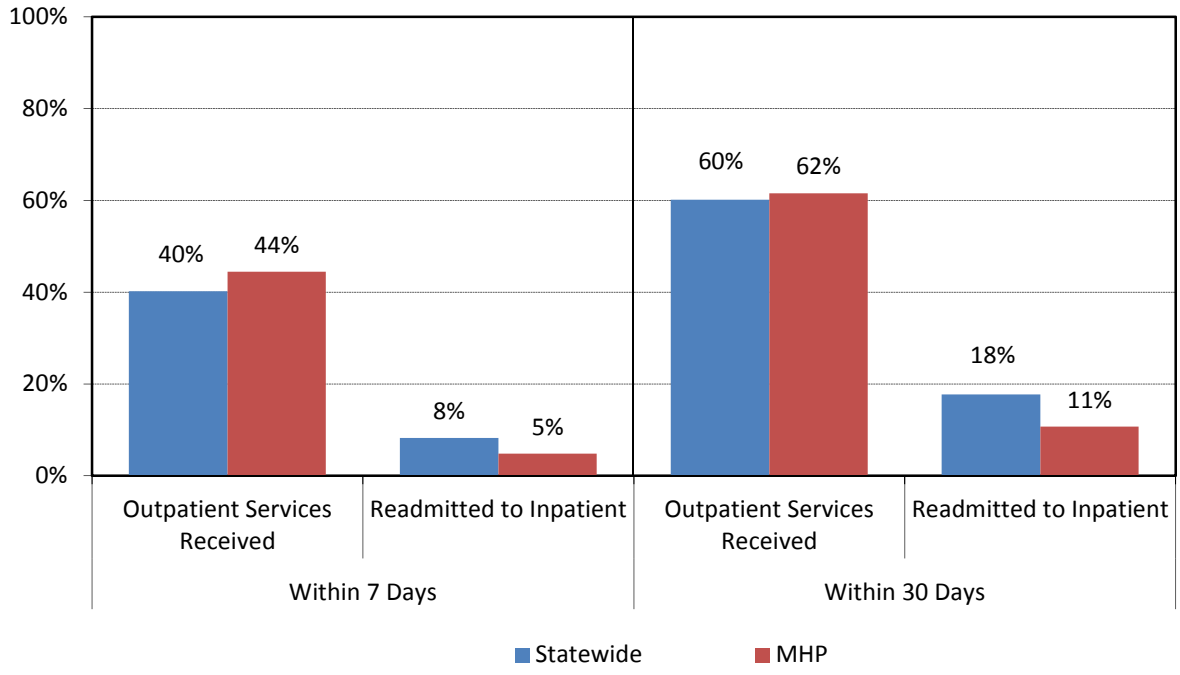
CAEQRO also analyzed claims data for beneficiaries receiving $20,000 to $30,000 in services per year. Statewide, this population also represents a small percentage of beneficiaries for which a disproportionately high amount of Medi-Cal dollars is claimed. Statewide in CY11, 37.09 percent of the approved Medi-Cal claims funded 4.81 percent of the beneficiaries served when this second tier of high cost beneficiaries is included. For the MHP, 25.91 percent of the approved Medi-Cal claims funded 3.61 percent of the beneficiaries served. This information is also depicted in pie charts in Attachment D.

- The MHP has shown a steady decrease over the four year period in the rate of high cost beneficiaries receiving over $30,000 in services from 2.33 percent in CY08 to 1.56 percent in CY11 despite a shift significant from non-Medi-Cal PHF beds to Medi-Cal billable beds during that period.
- In a similar fashion, the percent of total claims for high cost beneficiaries has decreased from 23.20 percent in CY08 to 15.24 percent in CY11.

TIMELY FOLLOW-UP AFTER HOSPITAL DISCHARGE

CAEQRO reviewed Medi-Cal approved claims to identify what percentage of beneficiaries statewide and within each MHP received a follow-up service after discharge from an inpatient setting -- within seven days and thirty days. Similarly, this analysis shows the percentage of beneficiaries who were re-hospitalized during those time frames. It should be noted that when Medi-Cal beneficiaries are admitted to inpatient facilities that do not bill Medi-Cal, those inpatient episodes are not represented in the claims analysis.

Figure 14. Timely Follow-up: 7 and 30 days After Hospital Discharge Percentage Receiving Outpatient Service or Readmitted MHP and Statewide CY11



Statewide in CY11, within seven days of discharge, 40 percent of beneficiaries received at least one non-inpatient service. Also within that time frame, 8 percent of beneficiaries were readmitted to an inpatient setting. Within a thirty day time frame, 60 percent of beneficiaries received a non-inpatient service after discharge, and 18 percent returned to an inpatient setting.

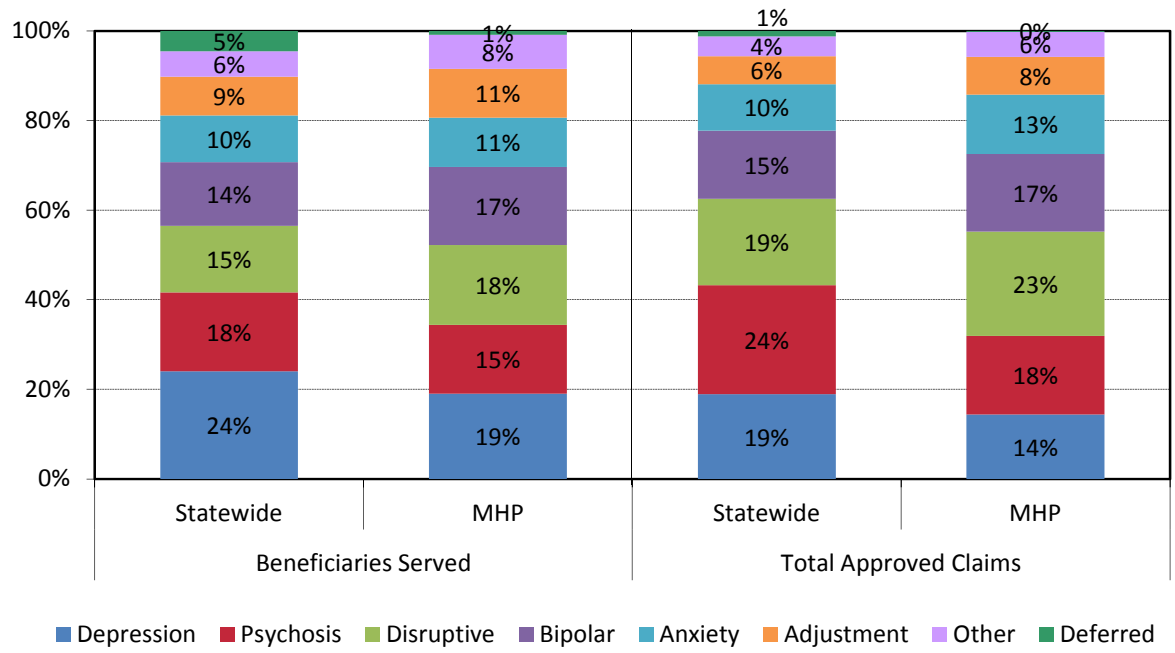
For the MHP, the follow-up and readmission rates reflect the following:

- The MHP demonstrated a slightly higher level of outpatient follow-up in CY11than the statewide average for both the 7 day and 30 periods.
- Hospital readmissions for both the 7 day and 30 day periods were also lower than the statewide average.
- It should be noted that while the MHP has contracted with two Medi-Cal PHFs in the past few years, this represents a minority of the inpatient beds within the system.

DIAGNOSTIC CATEGORIES

CAEQRO reviewed approved claims to analyze the frequency of primary diagnoses throughout the state and each MHP. Similarly, this analysis examined the dispersal of approved claims by diagnostic category. For a complete list of the diagnoses within each diagnostic category, please refer to the CAEQRO Website at www.caeqro.com. The diagnoses reflect the primary diagnosis as reported on the Medi-Cal approved claims.

Figure 15. Diagnostic Categories
MHP and Statewide CY11



Statewide in CY11, Depressive disorders are most frequent at 24 percent. This is followed by Psychotic disorders at 18 percent, Disruptive disorders at 15 percent, and Bipolar disorders at 14 percent. When examining approved claims, there are proportionately more funds expended on Psychotic disorders (24 percent) and Disruptive disorders (19 percent) and proportionately fewer funds expended on Depressive disorders (19 percent) and Adjustment disorders (6 percent). Statewide, 5 percent of diagnoses are deferred, though they represent only 1 percent of claims.

For the MHP, diagnostic categories show the following:

- The MHP serves slightly fewer beneficiaries with Depressive and Psychotic diagnoses than statewide. Conversely, the MHP serves slightly more consumers with Disruptive and Bipolar diagnoses compared to statewide representation.
- When it comes to claiming patterns as related to diagnostic categories, unlike statewide, the MHP claims less for Depressive and Psychotic diagnoses but more for the remaining diagnostic categories (Disruptive, Bipolar, Anxiety, Adjustment and Other). Disruptive disorders represent the largest dollar category compared to Psychotic Disorders statewide; a more heavily resourced children's system would drive this pattern.
- In regards to which diagnostic categories account for higher proportions of total claims statewide, more services are provided to consumers with Psychotic and Disruptive diagnoses and less services are provided for those with Depressive and Adjustment disorders. The MHP evidences this same pattern.

❖PERFORMANCE MEASUREMENT❖

Each year CAEQRO is required to work in consultation with DHCS to identify Performance Measures (PM) which will apply to all MHPs – submitted to DHCS within the annual report due on August 31, 2013. These measures will be identified in consultation with DHCS 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. A culturally diverse group of adult consumers who use the services offered at the Franklin Wellness Center.

2. A culturally diverse group of older adult consumers presently receiving services through the MHP and/or a contractor.

3. A culturally diverse group of older adult consumers presently receiving services through the MHP and/or a contractor, outside of the Elk Grove/South Sacramento areas.

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

This focus group of adult consumers was held at the Franklin Wellness Center and included ten participants. Participants had received county mental services from anywhere for one to 27 years. Everyone in attendance was a regular visitor to either the Franklin or Marconi Wellness Centers.

Participants were very complimentary and positive about Wellness Center services in general. Most agreed getting out of bed every day to come to the Center gives them a purpose, as well as provides good support, and they all noted an overall decrease in distress and symptoms as a result. A few participants reported relocating their services to Sacramento County because they had heard such positive things about the wellness and recovery services available; all felt the recovery model effectively highlights consumers' strengths with guidance from peer mentors. Mindfulness classes, as well as yoga and meditation, are offered and consumers reported some of their family members even feel a sense of hope as a result. All present reported some system provider, including their psychiatrist, recommended they seek out Wellness Center services.

Consumers reported seeing case managers infrequently, (i.e., once or twice a month for a quick check-in) and seeing a psychiatrist every two to three months. If an urgent issue arises, they can see a doctor more frequently. A few consumers had also attended therapy in the past, but none did presently. Many have been in Cognitive-Behavioral Therapy groups and continue to use those skills going forward.

Peer mentors and other staff are perceived as readily available and providing great support and modeling for recovery. A few peer staff has been seen struggling through symptom relapse but seeing recovery in real-time has been a great learning tool; having people around who talk from lived experience, rather than from education like most providers, was reported as invaluable.

Consumers felt that they were a part of their own treatment, especially in regards to services at the Centers. Many have medication mentors which help liaise with psychiatrists. They feel their treatment is a team effort and that any peer is available when an assigned mentor is not; this creates a feeling of safety and family. Also the Center helps consumers address family issues, especially as they arise from mental health struggles.

No one reported any delays in initial access to service; everyone recalled initial access came by way of the Adult Access team which referred them to local services. No one waited longer than a few weeks and in some cases, a few received same-day services. Attendees reported the plan to use 911, their Wellness Center peer mentors, or informal safety plans when they felt a crisis approaching. No one knew of the peer-operated warm line but did feel if they presented at a Center near closing in crisis staff would stay past closing time to assist them.

Some attendees reported already noting positive outcomes from the County's Anti-stigma campaign, and they felt it was empowering to put real stories of real people out in the public. All were aware that opportunities exist for consumer employment, both at the Wellness Centers and some contract providers, however there are no openings presently. Participants felt a lot of information is available on various bulletin boards, on the County website, the *Wellness Matters* TV show, as well as through peers and other consumers. They all spoke highly of the available Center technology resources also; however, there was consensus that peer mentors lack adequate access to resources/information from outside of the Center to effectively serve consumers in need in all concerns.

Many knew of the weekly Wellness Center Resolution and Vision committee to resolve problems at each location; one attendee was on the Wellness Center Advisory committee. Another attendee has been asked to serve on the County Mental Health board. Only one person new of the monthly Consumer Town halls held at headquarters. One attendee had been asked to be an Expert Pool member.

The group suggested the following:

- More effective police response or the need for security guard to address crisis situations, in response to some personal and group experiences that have occurred at the Centers
- Crisis training and/or self-defense training for peer mentors, especially if a consumer is decompensating
- Having a medical staff person scheduled to give medication injections when the regular nurse or doctor will not be available.

Participants from the group provided the following demographic information:

Figure 16. Consumer/Family Member Focus Group 1

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

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

Preferred Languages	
English	10

Race/Ethnicity	
Caucasian/White	6
Asian Pacific Islander	1
Hispanic/Latino	1
Native American	1
Mixed	1

Gender	
Male	6
Female	4

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This focus group of older adults was held at Sierra Wellness Center. There were eight participants, some who received services at the location of the focus group and others who were served at various contract providers (T-CORE, El Hogar, Visions, and Turning Point).

Most individuals had been in services for several years, so the participants' ease of access was not relevant to this review period. Participants noted a decrease in services offered (this was particularly the case for those who attended Sierra Wellness Center, where it appeared that there were formerly several groups throughout the day and now there is only one group on certain days). While the aforementioned site is called a "wellness center," there was no evidence during the visit/focus group of ongoing wellness activities available to consumers on-site, although some of the program's services are also delivered in the field. In particular, the consumers wished for increased opportunities to socialize with others.

Consumers were discouraged by multiple changes in clinicians and psychiatrists over time – even changes in front desk workers were noted as concerning and the group concurred with one person's statement that they "feel like a yo-yo". In addition, they felt that there was too much emphasis on medication and not enough support in dealing with their problems.

Regardless, they were happy to receive the services that were actually available and did not register any significant complaints about the quality of care received.

Individuals were aware of resources available to them in case of crisis. Those with medical conditions felt that their mental health provider was involved in their medical care as well. Participants were very aware of their providers having "many clients to see and paperwork to do".

Participants from the group provided the following demographic information:

Figure 17. Consumer/Family Member Focus Group 2

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

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

Preferred Languages	
English	8

Race/Ethnicity	
Caucasian/White	4
African American	2
Hispanic/Latino	1
Other	1

Gender	
Male	1
Female	7

Interpreter used for focus group 2: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

This group of caregivers of children receiving services within the MHP (namely its contract providers) was held at Stanford Family Services. Participants in the focus group represented various programs within that agency (outpatient, Therapeutic Behavioral Services, FIT) as well as Sacramento Children's Home. Three couples represented a single family. One parent spoke Spanish and an interpreter was provided.

Most families had been in services for one year or less. Experiences in obtaining the first appointment after making a request varied; a couple of families talked about trying for a year or more, unaware of where mental health resources were. When they finally learned where to

connect, it most commonly took three to eight weeks. One individual reported waiting four to five months because of apparent delays in processing at Access.

Parents receiving services through the Stanford Family Services described a full array of services with multiple visits a week and after-hours support. This was notably not typical for others in general outpatient services. Those at Stanford felt great support if they were in a crisis situation and felt confident that a home visit would occur if needed. Parents who had been involved with Minor Emergency Response Team (MERT) for crisis stabilization did not find the experience to be useful; one parent noted that they refused to pick up their child from MERT due to his behaviors and the MERT worker drove him home.

Most were aware of a process existing to request changes of providers if needed. However, those who had tried (three different parents) had been refused a change of provider. One parent opted to have her child go without medications for a several week period and then went back through Access in order to get a referral to a new psychiatrist. Others had to stay with the therapist they had been initially assigned. They were not aware of formal grievance procedures but most knew they had been provided information relevant at the time of their intake; however it was part of a very large packet of information and difficult to remember what was involved.

The most significant concern was for parents whose children were in time-limited programs (e.g., six months or one year). They did not express a sense of being prepared for when that happens. Some parents were aware of a parent support group and thought it would benefit others who are likely just unaware of its availability.

Participants from the group provided the following demographic information:

Figure 18. Consumer/Family Member Focus Group 3

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

Ages of Participants	
Under 18	
Young Adult (18-24)	
Adult (25-59)	11
Older Adult (60 and older)	

Preferred Languages	
English	10
Spanish	1

Race/Ethnicity	
Caucasian/White	2
Mixed race	4
Native American	2
Hispanic/Latino	3

Gender	
Male	2
Female	9

Interpreter used for focus group 3: ☐ No ☒ Yes Language: Spanish

❖PERFORMANCE IMPROVEMENT PROJECT VALIDATION❖

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 (active during the review period)
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

As part of the former CalMEND Project, this MHP was selected to address the development of a Primary Care and Behavioral Health collaborative initiative. By working with four chosen RSTs who serve adult outpatient consumers, 1,252 consumers (approximately 27 percent of all RST consumers) with at least one of the six focus medical conditions were included in this pilot project. By training staff at all four sites and offering information sessions for consumers at these same sites, as well as developing appropriate new forms and tracking mechanisms, the goals were to improve primary care documentation in the chart (i.e. progress notes and treatment plan), and the EHR, in addition to better coordinate overall consumer care for both physical and mental health needs.

Randomized chart review (of 175 charts total or 14 percent) on three occasions at each site over a seven-month period by dedicated research staff provided an ongoing feedback loop between the MHP and providers as well as valuable data. It also resulted in data for an unintended comparison group of non-PIP enrolled consumers. Statistical analysis revealed significant improvement ($p < .01$) in all indicators but one. That is, performance on the following indicators surpassed apriori-established goals: primary care provider documentation in EHR and the

service plan; medical condition documentation in EHR (in correct place), the service plan, and in the progress notes; and coordination of care documentation in the service plan and progress notes. The only indicator not met was documentation of primary care provider appointments in the progress notes. As a result of the PIP, the MHP's focus is now on developing a bridge from the MHP to primary care as a whole and to begin successfully stepping-down consumers to primary care providers for ongoing medication management.

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. 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		

Figure 19. Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
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		**13**		

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

NON-CLINICAL PIP

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

> "Can CANS data be used to identify clients with needs that correlate to hospitalization or ISU usage so that subsequent (new and continuing) CANS assessments can be used to focus on interventions to prevent hospitalization and use of ISU? Is the Adjustment to Trauma element useful in correlating trauma to hospitalization or ISU usage or suggesting the need to adopt the Trauma Module in CANS?"

Year PIP began: January 2012

Status of PIP:

- ☒ Active (but interventions are not yet in place)
- ☐ Completed
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

The MHP has decided to use CANS data to identify the collection of needs and strengths that have a high likelihood of resulting in hospitalization or crisis stabilization services in child consumers; the expectation is that the PIP interventions will prevent future hospitalizations (which ultimately lead to a better quality of life, less disruption in achieving developmental milestones and community integration, and lower mental health costs). This PIP will compare

CANS scores between four groups of child consumers – hospitalized vs. not hospitalized and those with or without trauma – as indicated by the CANS Adjustment to Trauma subscale). Children presently served in Wraparound and FIT programs will comprise the sample and four groups of 50 (some subjects will be chosen randomly within a specific condition) will be used in this pilot. After a year of expanded CANS training for staff and C/FM employees and use of the CANS Trauma module, chart reviews (undertaken with a developed chart review tool) for all 200 subjects will provide the comparison data.

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 20. 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		

Figure 20. Non-Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
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 PIP. The PIP, as submitted by the MHP, is included in 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 7.3, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Type of Provider	Distribution
County-operated/staffed clinics	8%
Contract providers	91%
Network providers	<1%
	100%

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

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

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

  24%

- Reported average monthly percent of missed appointments:

  8.9%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

  ☒ Yes ☐ No

- Although the MHP reported a co-occurring diagnosis rate of 24 percent based on the Axis I and Axis II diagnoses tables in their IS, it was felt that this figure is probably understated. It is expected that a more accurate figure will be available once electronic assessments are initiated.

CURRENT OPERATIONS

- The MHP continues to utilize the Avatar Behavioral Health System licensed from and hosted by NetSmart Technologies.
- Technology and billing staffing have increased by 12 positions including four IS trainers, one Training Coordinator, two support staff, and four account clerks.

MAJOR CHANGES SINCE LAST YEAR

- Resumption of production of CSI files
- Successful completion of Avatar CWS pilot

PRIORITIES FOR THE COMING YEAR

- Implementation of Avatar CWS, Order Connect and EHR
- Implementation of HIPAA 5010 compliant claims
- Bringing CSI submissions up-to-date
- Implementing Medicare claiming
- Ensuring that Meaningful Use requirements can be met

OTHER SIGNIFICANT ISSUES

Implementing CWS will involve an increase in Avatar users from the current 650 to over 2,000. The MHP is unable to utilize some IS processes, such as running the Avatar Cost Report Tool, due to excessive processing time.

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 21. Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
AVATAR - Cal-PM	Practice Management	Netsmart Technologies	3	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

The MHP has no plans for information systems change. They are continuing with the planned Avatar implementation with a planned completion in 2015.

ELECTRONIC HEALTH RECORD STATUS

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

Figure 22. Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Avatar CWS		X		
Clinical Decision Support				X	
Document imaging				X	
Electronic signature - client	Avatar CWS		X		
Electronic signature - provider	Avatar CWS		X		
Laboratory results (eLab)				X	
Outcomes				X	
Prescriptions (eRx)	Info Scriber		X		
Progress notes	Avatar CWS		X		
Treatment plans	Avatar CWS		X		

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

- The MHP has completed a one year pilot of CWS and is beginning a rollout of electronic assessments, treatment plans, and prescriptions for all providers.
- Once CWS is implemented, all clinicians will have access to CANS and LOCUS tools, e-Prescribing, electronic lab results, document management, electronic client signature pads, and document management. Data submission via Electronic Information Exchange with providers with compliant information system is planned for future implementation.

❖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 FY12-13 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. The roll-out of the multi-media anti-stigma campaign, using real stories and developed with extensive stakeholder input, was exemplary and is already evidencing some positive results.
   [Access, Other: Stakeholder involvement]

2. Proliferation of Wellness and Recovery principles throughout the system, not just by the large number of C/FM staff, appears to benefit consumers greatly.
   [Quality, Outcomes, Other: Wellness and Recovery]

3. Collaborative education, specifically with area law enforcement agencies, is reducing the negative impact of contact between police, mental ill county residents, and their families, and consumer contact with other county/community providers.
   [Quality, Other: Collaboration]

4. The MHP uses of various types of data (billing, service use, county, clinical) to direct both system-wide and population-specific projects and considers necessary evaluative mechanisms when implementing new strategies/initiatives.
   [Quality, Outcomes]

5. Expansion of both IS and billing staffing should assist with successful implementation of the Avatar EHR system.
   [Information Systems]

OPPORTUNITIES FOR IMPROVEMENT

1. Contract providers have difficulty getting clear and consistent responses to their questions and concerns from their contract liaisons; there is an apparent lack of information sharing internally between executive management/leadership and MHP staff that interface with contractors.
   [Quality, Other: Communication]

2. As the EHR/CWS implementation proceeds, there is yet no clear process/plan to identify the specific performance indicators which will need reports developed for tracking and monitoring.
   [Quality, Outcomes, Information Systems]

3. True support for the mental health needs and ongoing recovery of C/FM employees is unclear. No respite or quiet area for appropriate time off for necessary self-care exists and while the philosophy of self-care has been proliferated, it is not evidenced in this aspect of practice.
   [Quality, Other: Wellness & recovery]

4. While the older adult Sierra Wellness/FSP program delivers a variety of clinic and field-based services, wellness and recovery principles/services need to be a focus of the program's continued improvement. The consumer voice must also be a part of the programming.
   [Quality, Outcomes]

5. The MHP has not endeavored to specifically track nor assess the group of consumers discharged from local hospitals that fail to engage through scheduled MHP follow-up appointments, resulting in possible continued overuse of crisis services.
   [Access, Outcomes]

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. Develop a Quality Improvement process or workgroup to identify performance management indicators to monitor which will become available as CWS implementation is completed.

[Timeliness, Quality, Outcomes, Information Systems]

2. Formalize/standardize communications between providers and MHP liaisons with clear timelines, policies and response tracking.
   [Quality, Other: Communication]

3. Consider the development of systemwide policies that speak to ADA responsiveness specific to C/FM employee mental health needs and strategies to address the ongoing recovery of staff with lived experience.
   [Quality, Outcomes, Other: Wellness & recovery]

4. Reassess/create/refine a variety of true wellness and recovery services/treatment approaches, as well as additional treatment options, for older adult consumers..
   [Access, Outcomes]

5. Consider a quality improvement/tracking project that specifically addresses community consumers discharged from inpatient hospitalization that fail to engage actively with the MHPs system, despite scheduled follow-up appointments.
   [Access, Outcomes]

❖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 5, 2012 – Day 1 Activities
7001A East Parkway, Sacramento
Conference Room 2</th></tr>
<tr><td rowspan="3">9:00 – 12:00</td><td colspan="2"><u>Performance Management</u>
Access, Timeliness, Outcomes, and Quality</td></tr>
<tr><td>• Introduction of participants
• Overview of review intent
• Significant MHP changes in past year
• Strategic Initiatives – progress & plans
• Last year's CAEQRO recommendations
• Quality Improvement activities
• 1115 Waiver/LIHP</td><td>• Performance improvement measurements utilized to assess access, timeliness, outcomes, and quality
• Examples of MHP reports used to manage performance and decisions
• CAEQRO approved claims data</td></tr>
<tr><td colspan="2">Participants – Those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions –including but not limited to: the MHP Director, senior management team, and other managers/senior staff in Fiscal, program, IS, medical, QI, research, patients' rights advocate, and involved consumer and family member representatives, as well as other key representatives from the P&T, QIC, CC and O&E committees.</td></tr>
<tr><td>12:00 – 1:00</td><td colspan="2">APS Staff – Working Lunch</td></tr>
<tr><td>See scheduled times</td><td>1:00 – 2:45 pm
<u>Wellness Center visit and Adult Consumer Focus Group</u>
Franklin Wellness Center
7000 Franklin Blvd, Suite 110
Tour of Wellness Center and focus group with 8-10 adult consumers from South County.</td><td>1:00 – 2:30 pm
<u>Fiscal/Billing/Finance Manager Group Interview</u>
Conference Room 301
• Review and discuss ISCA
• SD/MC claims process
• Contractor provider billing
• Denied claims review process
• Revenue projection and cost reporting.</td></tr>
<tr><td>See scheduled times</td><td>3:00 – 4:30 pm
<u>Disparities in Service Access, Retention, Quality, or Outcomes</u>
Conference Room 2
• Review of MHP data or CAEQRO approved claims data to examine penetration rates and utilization patterns by age, ethnicity, or gender
• Review of Cultural Competency strategies to improve access/engagement and improve health equity
• Review of activities to address overall capacity
• Evidence based or best practices for diverse or high risk populations</td><td>2:45 – 4:15 pm
<u>IS Management and Avatar Implementation Workgroup Interview</u>
Conference Room 301
• Communication with stakeholders
• Staff training and support
• Status of Avatar implementation
• Health information exchange plans</td></tr>
</table>

Time	Thursday, September 6, 2012 – Day 2 Activities 7001A East Parkway	
See scheduled times	**9:00 – 10:30 am** **MHP/Contractor Program Manager Group Interview** Conference Room 2 6-8 program managers/supervisors (all peers) representing various programs and geographical areas	**9:00 – 11:00 am** **Performance Improvement Projects** Conference Room 301 Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans. Participants should be those involved in the development and implementation of including, but not necessarily limited to PIP committee, involved contractors, MHP Director and other senior managers.
See scheduled times	**10:30 – 11:00** *Travel Time* Sierra Elder Wellness Program 3870 Rosin Court, Suite 130 **11:00 – 12:30 pm** **Older Adult Consumer Focus Group** 8-10 older adult consumers	**11:00 – 12:30 pm** **Contract Provider Group Interview** Conference Room 301 Group interview with clinical and business administrators from at least 6 identified contract providers
12:30 – 1:40	**APS Staff – Travel Time/Working Lunch (at MHP)**	
See scheduled times	**1:40 – 2:00 pm** *Travel Time* Stanford Youth Solutions 8912 Volunteer Lane **2:00 – 3:30 pm** **Family Member Focus Group** 8-10 parents/caretaker of child consumers	**1:45 – 3:15pm** **Outcomes/Timeliness** Conference Room 301 MHP examples of data used to measure timeliness, functional outcomes, and consumer satisfaction.
3:30 – 5:00	**3:30 – 4:00 pm** **Travel Time** Conference Room 301 **4:00 – 5:15 pm** **Collaborative/Community Based Services** • Examples of collaborative relationships with community providers- CBOs, FBOs • Service integration with other providers, including other Sac County depts. • Information exchange efforts • Services to foster care youth	**3:30 – 4:00 pm** **Travel Time** CAPS Children's Clinic 3331 Power Inn Rd. Suite 140 **4:00 – 5:00 pm** **County Provider Site Visit**

Time	Friday, September 7, 2012 – Day 3 Activities Turning Point ISA 6950 65th St, Sacramento	
9:00 - 10:30	**Contract Provider site visit** (at 9:00 am) **and Consumer Employment Group Interview** (at 9:30 am) 6-8 MHP and/or contracted consumer and/or family member employees, such as Peer or Family Advocates/Liaisons, Peer or Family Support Specialists, Family or Consumer Liaisons. **10:30-10:40 am** **Travel Time**	
10:45 – 12:10	**MHP Clinical Line Staff Group Interview** Conference Room 2 6-8 clinical line staff (all peers) representing various programs and geographical areas	**Mental Health Treatment Center site visit** including tour of soon-to-be-reopened ISU 2150 Stockton Blvd **11:45 – 12:10 pm** **Travel Time** Conference Room 2
12:10 – 1:00	**APS Staff – Working Lunch/Staff Meeting (at MHP)**	
1:00 – 1:45	**Wrap-up Session** Conference Room 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	

2:00 – 3:00	**Monthly Expert Pool Town Hall meeting- Recovery 101** already in progress

B. Attachment—Review Participants

CAEQRO REVIEWERS

Mila Green, Ph.D. - Lead Reviewer
Jerry Marks - Information Systems Reviewer
Kathy Robb - Consumer/Family Member Consultant
LaVaughn King - Consumer/Family Member Consultant
Sandra Sinz, LCSW, CPHQ - 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

Child and Adolescent Psychiatric Clinic (CAPS)
3331 Power Inn Rd. Suite 140
Sacramento, CA 95826

Franklin Wellness Center
7000 Franklin Blvd, Suite 110
Sacramento, CA 95823

Mental Health Treatment Center (MHTC)
2150 Stockton Blvd.
Sacramento, CA

Contract provider organizations

Sierra Elder Wellness Program
3870 Rosin Court, Suite 130
Sacramento, CA 95834

Turning Point ISA
6950 65th Street
Sacramento, CA

Stanford Youth Solutions
8912 Volunteer Lane
Sacramento, CA 95826

PARTICIPANTS REPRESENTING THE MHP

Alex Rechs, SCBHS, Program Coordinator-QM
Amanda Divine, El Hogar Inc., Acting Executive Director
Anthony Madariaga, SCBHS, MHTC Crisis Director
Billee Willson, SCBHS, Program Planner-CFSU
Blia Cha, Hmong Women's Center, Peer Partner Program Coordinator
Bonnie Cooper, SCBHS, MHTC-Registered Nurse
Carolin Funderburg, Turning Point ISA, Program Director
Carrie Harper, Cross Creek Counseling, Executive Director
Chris McCarty, Sacramento Children's Home, Director-Community Program
Chris Eldridge, SCBHS, Senior Mental Health Clinician
Corwin Miller, SCBHS, Senior Mental Health Clinician
Cynthia Lopez, Visions Unlimited Inc., Clinical Lead
Dawn Williams, SCBHS, Program Planner-REPO
Elena Spektorov, SCBHS, Senior Mental Health Clinician
Gail Erlandson, Consumer Self Help, Wellness & Recovery Mentor
Gay Teurman, SCBHS, Team Lead-Avatar
Glenn Potter, Sacramento Children's Home, Program Manager-SCH/TAP
Gretchen Bishell, Consumer Self Help, Wellness & Recovery Mentor
JaneAnn LeBlanc, SCBHS, MHSA Program Manager
Jeff King, SCBHS, Senior Administrative Analyst
Jesus Cervantes, SCBHS, Program Coordinator-QM
JoAnn Johnson, SCBHS, Program Manager-CC/REPO
John Sawyer, SCHHS, IT Analyst
Kacey Vencill, SCBHS, Project Manager
Karen Brockopp, Transitional Living & Community Support (TLCS), Associate Director-Programs
Karen Cameron, Consumer Self Help, Program Director-Patients' Rights
Kathy Aposhian, SCBHS, QM Program Manager
Kaybee Alvarado, Hmong Women's Center, Peer Partner Specialist
Kelli Weaver, SCBHS, Program Manager
Kyle Silva, Turning Point ISA, Peer Mentor
Lafika Algarwani, TLCS, Clinical Director-New Directions
Lisa Sabillo, SCHHS, Program Planner-Office of the Director
Lisa Bertaccini, SCBHS, Chief-Child & Family Mental Health
Lisa Harmon, SCBHS, Program Planner-REPO

Lynn Place, Human Resources Consultants Inc., Executive Director
Lynn Keune, La Familia Community Counseling, Clinical Director
Mai Moua, Hmong Women's Center, Peer Partner Specialist
Marie Cerillo, SCBHS, Senior Mental Health Clinician
Marilyn Hillerman, MHA, Adult/Family Advocate Liaison
Mark Kliwefelten, Turning Point ISA, Janitor
Marlyn Sepulveda, Transitional Community Options for Recovery, Program Coordinator
Mary Ann Carrasco, SCBHS, Director
Mary Nakamura, SCBHS, Program Coordinator-CC
Mary Ann Wong, EMQ Families First, Research Specialist
Paul Heffner, El Hogar Inc., Program Director
Paul Cecchettini, Turning Point Community Program, Director-Adult Services
Rikke Addis, Sacramento Children's Home, QI Manager
Robert Horst, SCBHS, CAPS Children's Medical Director
Robert Gilletto, SCHHS, Accounting Manager
Shannon Bellencourt, SCBHS, Senior Mental Health Clinician,
Shannan Taylor, Telecare/SOAR Corp., Clinical Director
Sharon Saulsberry, SCBHS, Senior Mental Health Clinician
Silas Gulley, MHTC Clinical Director
Stephanie Ramos, MHA, Family & Youth Coordinator
Sue Chow, Asian Pacific Community Counseling, Clinical Program Manager
Uma Zykofsky, SCBHS, Chief-Adult Mental Health
Wendy Greene, SCHHS, Health Program Manager
Will Benda, Terkensha Association, Executive Director

C. Attachment—Approved Claims Source Data

- **Source:** Data in Figures 5 through 15 and Attachment 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.

  - CY2011 includes SD/MC and IPC approved claims with process date June 2012
  - CY2010 includes SD/MC and IPC approved claims with process date June 2012
  - 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
  - FY10-11 includes SD/MC and IPC approved claims with process date November 2011
  - 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 2011 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 11

Date Prepared:	08/23/2012, 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:	06/11/2012, 08/21/2012, and 04/02/2012 - Note (3)

	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									
	331,589	17,954	$83,309,177	5.41%	$4,640	5.56%	$4,173	5.66%	$4,767
AGE GROUP									
0-5	60,011	1,101	$3,958,102	1.83%	$3,595	1.51%	$3,733	1.72%	$3,761
6-17	91,370	7,406	$45,363,680	8.11%	$6,125	6.92%	$5,296	7.38%	$6,268
18-59	139,079	8,377	$30,008,759	6.02%	$3,582	7.51%	$3,668	7.19%	$4,059
60+	41,130	1,070	$3,978,636	2.60%	$3,718	3.26%	$2,821	3.36%	$3,053
GENDER									
Female	185,163	9,259	$39,677,994	5.00%	$4,285	5.06%	$3,686	5.10%	$4,269
Male	146,426	8,695	$43,631,183	5.94%	$5,018	6.21%	$4,683	6.37%	$5,278
RACE/ETHNICITY									
White	90,373	7,288	$33,947,388	8.06%	$4,658	10.38%	$4,007	10.06%	$4,726
Hispanic	82,268	3,068	$13,131,047	3.73%	$4,280	3.48%	$3,873	3.68%	$4,706
African-American	63,456	4,624	$23,044,130	7.29%	$4,984	9.70%	$5,082	10.30%	$5,163
Asian/Pacific Islander	52,591	1,471	$5,130,718	2.80%	$3,488	3.89%	$3,396	4.00%	$3,578

	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
Native American	2,909	242	$1,310,415	8.32%	$5,415	12.12%	$4,983	10.23%	$5,213
Other	39,994	1,261	$6,745,478	3.15%	$5,349	4.52%	$4,888	4.49%	$5,595
ELIGIBILITY CATEGORIES									
Disabled	65,492	8,397	$34,301,327	12.82%	$4,085	17.29%	$4,252	17.62%	$4,631
Foster Care	3,244	1,706	$14,064,201	52.59%	$8,244	51.31%	$7,350	54.96%	$6,910
Other Child	141,235	6,366	$28,310,534	4.51%	$4,447	3.86%	$3,980	4.36%	$4,828
Family Adult	81,408	1,875	$5,124,403	2.30%	$2,733	3.92%	$2,011	3.76%	$2,452
Other Adult	40,667	402	$1,508,713	0.99%	$3,753	0.97%	$3,163	0.95%	$3,184
SERVICE CATEGORIES									
Inpatient Services	331,589	1,028	$6,911,365	0.31%	$6,723	0.45%	$7,368	0.45%	$7,439
Residential Services	331,589	67	$290,239	0.02%	$4,332	0.07%	$7,544	0.06%	$7,673
Crisis Stabilization	331,589	247	$223,926	0.07%	$907	0.40%	$1,768	0.33%	$1,615
Day Treatment	331,589	49	$898,091	0.01%	$18,328	0.10%	$10,872	0.07%	$12,061
Case Management	331,589	13,566	$9,974,447	4.09%	$735	2.14%	$908	2.37%	$839
Mental Health Serv.	331,589	16,405	$52,271,376	4.95%	$3,186	4.30%	$2,705	4.57%	$3,269
Medication Support	331,589	9,961	$10,267,207	3.00%	$1,031	2.93%	$963	2.88%	$1,164
Crisis Intervention	331,589	761	$393,132	0.23%	$517	0.43%	$700	0.57%	$949
TBS	331,589	316	$2,079,393	0.10%	$6,580	0.10%	$9,109	0.09%	$11,835

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 401,464

SACRAMENTO County MHP Medi-Cal Services Retention Rates CY11

	SACRAMENTO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	779	4.34	4.34	9.65	9.65	4.34	20.66
2 services	742	4.13	8.47	6.51	16.16	4.05	16.67
3 services	658	3.66	12.14	5.56	21.73	2.35	11.11
4 services	632	3.52	15.66	5.20	26.92	2.60	10.71
5 - 15 services	5,663	31.54	47.20	32.45	59.37	20.45	44.44
> 15 services	9,480	52.80	100.00	40.63	100.00	16.67	62.08

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 06/11/2012; Inpatient Consolidation approved claims as of 08/21/2012

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 CY11

Foster Care

Date Prepared:	08/24/2012, 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:	06/11/2012, 08/21/2012, and 04/02/2012 - Note (3)

	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									
	3,244	1,706	$14,064,201	52.59%	$8,244	51.31%	$7,350	54.96%	$6,910
AGE GROUP									
0-5	844	267	$952,607	31.64%	$3,568	31.62%	$3,501	37.08%	$3,167
6+	2,400	1,439	$13,111,594	59.96%	$9,112	58.89%	$8,147	61.73%	$7,762
GENDER									
Female	1,599	805	$6,559,226	50.34%	$8,148	50.43%	$7,216	53.90%	$6,779
Male	1,645	901	$7,504,975	54.77%	$8,330	52.12%	$7,472	55.95%	$7,029
RACE/ETHNICITY									
White	1,014	590	$4,722,601	58.19%	$8,004	56.37%	$6,968	43.73%	$7,075
Hispanic	540	281	$2,465,957	52.04%	$8,776	48.88%	$6,524	70.22%	$6,194
African-American	1,292	717	$5,889,964	55.50%	$8,215	53.78%	$8,565	68.34%	$7,657

	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
Asian/Pacific Islander	163	73	$539,161	44.79%	$7,386	55.32%	$9,299	63.74%	$7,988
Native American	51	25	$271,285	49.02%	$10,851	48.03%	$8,088	44.84%	$7,206
Other	186	20	$175,233	10.75%	$8,762	20.00%	$9,309	20.67%	$9,158
SERVICE CATEGORIES									
Inpatient Services	3,244	53	$519,084	1.63%	$9,794	1.81%	$7,539	2.03%	$7,271
Residential Services	3,244	0	$0	0.00%	$0	0.00%	$0	0.01%	$4,618
Crisis Stabilization	3,244	36	$22,784	1.11%	$633	1.33%	$1,183	1.06%	$1,389
Day Treatment	3,244	24	$454,196	0.74%	$18,925	3.28%	$11,970	2.46%	$12,246
Case Management	3,244	1,415	$2,235,717	43.62%	$1,580	21.22%	$1,395	23.90%	$1,044
Mental Health Serv.	3,244	1,666	$9,226,212	51.36%	$5,538	48.14%	$4,954	52.22%	$4,753
Medication Support	3,244	648	$897,794	19.98%	$1,385	16.35%	$1,290	17.05%	$1,397
Crisis Intervention	3,244	68	$38,808	2.10%	$571	2.49%	$920	3.25%	$1,313
TBS	3,244	107	$669,606	3.30%	$6,258	3.36%	$9,279	3.14%	$10,236

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 4,388

SACRAMENTO County MHP Medi-Cal Services Retention Rates CY11

Foster Care

	SACRAMENTO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	45	2.64	2.64	6.60	6.60	0.00	50.00
2 services	46	2.70	5.33	5.53	12.13	0.00	16.13
3 services	50	2.93	8.26	4.51	16.64	0.00	13.51
4 services	40	2.34	10.61	4.03	20.66	0.00	9.38
5 - 15 services	355	20.81	31.42	27.15	47.82	4.76	66.67
> 15 services	1,170	68.58	100.00	52.18	100.00	22.97	80.95

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 06/11/2012; Inpatient Consolidation approved claims as of 08/21/2012

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)

Date Prepared:	08/23/2012, 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:	06/11/2012, 08/21/2012, and 04/02/2012 - Note (3)

	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									
	52,433	3,130	$19,660,664	5.97%	$6,281	6.60%	$5,236	6.72%	$6,000
AGE GROUP									
16-17	14,966	1,400	$10,093,846	9.35%	$7,210	9.05%	$6,111	9.56%	$7,120
18-21	23,003	1,342	$8,058,230	5.83%	$6,005	6.08%	$4,820	6.07%	$5,422
22-25	14,464	388	$1,508,588	2.68%	$3,888	4.61%	$4,161	4.46%	$4,526
GENDER									
Female	30,966	1,600	$9,420,545	5.17%	$5,888	5.49%	$4,950	5.58%	$5,772
Male	21,468	1,530	$10,240,119	7.13%	$6,693	8.24%	$5,517	8.36%	$6,220
RACE/ETHNICITY									
White	13,185	1,137	$7,547,636	8.62%	$6,638	11.12%	$4,864	11.51%	$6,037
Hispanic	12,669	561	$3,158,381	4.43%	$5,630	4.75%	$4,660	4.94%	$5,647
African-American	12,420	997	$6,212,788	8.03%	$6,231	10.75%	$6,223	10.76%	$6,328

	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
Asian/Pacific Islander	8,513	199	$1,031,592	2.34%	$5,184	3.57%	$5,844	3.63%	$6,086
Native American	567	46	$325,897	8.11%	$7,085	12.38%	$6,503	11.60%	$6,069
Other	5,082	190	$1,384,371	3.74%	$7,286	5.74%	$6,973	5.41%	$7,949
ELIGIBILITY CATEGORIES									
Disabled	6,320	1,033	$6,630,696	16.34%	$6,419	19.69%	$5,952	20.78%	$6,528
Foster Care	780	498	$4,431,424	63.85%	$8,898	65.93%	$8,560	71.42%	$7,950
Other Child	13,187	909	$4,685,439	6.89%	$5,154	7.30%	$4,554	8.09%	$5,585
Family Adult	26,886	721	$3,018,527	2.68%	$4,187	3.90%	$2,948	4.06%	$3,631
Other Adult	5,425	228	$894,579	4.20%	$3,924	3.31%	$4,109	2.91%	$4,186
SERVICE CATEGORIES									
Inpatient Services	52,433	335	$2,388,915	0.64%	$7,131	0.82%	$6,878	0.80%	$6,702
Residential Services	52,433	14	$63,259	0.03%	$4,518	0.06%	$7,833	0.05%	$8,119
Crisis Stabilization	52,433	91	$54,930	0.17%	$604	0.65%	$1,396	0.53%	$1,405
Day Treatment	52,433	21	$282,196	0.04%	$13,438	0.20%	$11,545	0.16%	$13,082
Case Management	52,433	2,408	$2,637,762	4.59%	$1,095	2.63%	$1,106	2.91%	$973
Mental Health Serv.	52,433	2,853	$11,742,669	5.44%	$4,116	5.35%	$3,296	5.63%	$4,077
Medication Support	52,433	1,588	$1,926,565	3.03%	$1,213	3.04%	$996	3.00%	$1,223
Crisis Intervention	52,433	182	$88,166	0.35%	$484	0.67%	$736	0.88%	$1,012
TBS	52,433	85	$476,201	0.16%	$5,602	0.14%	$8,456	0.14%	$10,247

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 72,629

SACRAMENTO County MHP Medi-Cal Services Retention Rates CY11

Transition Age Youth (Age 16-25)

	SACRAMENTO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	162	5.18	5.18	10.23	10.23	0.00	25.69
2 services	142	4.54	9.71	6.65	16.89	2.94	20.00
3 services	120	3.83	13.55	5.32	22.20	0.00	17.14
4 services	117	3.74	17.28	4.59	26.79	0.00	15.38
5 - 15 services	757	24.19	41.47	28.87	55.66	16.67	40.54
> 15 services	1,832	58.53	100.00	44.34	100.00	10.81	64.29

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 06/11/2012; Inpatient Consolidation approved claims as of 08/21/2012

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

Figure D-1. Retention Rates
MHP CY08-CY11 and Statewide CY11

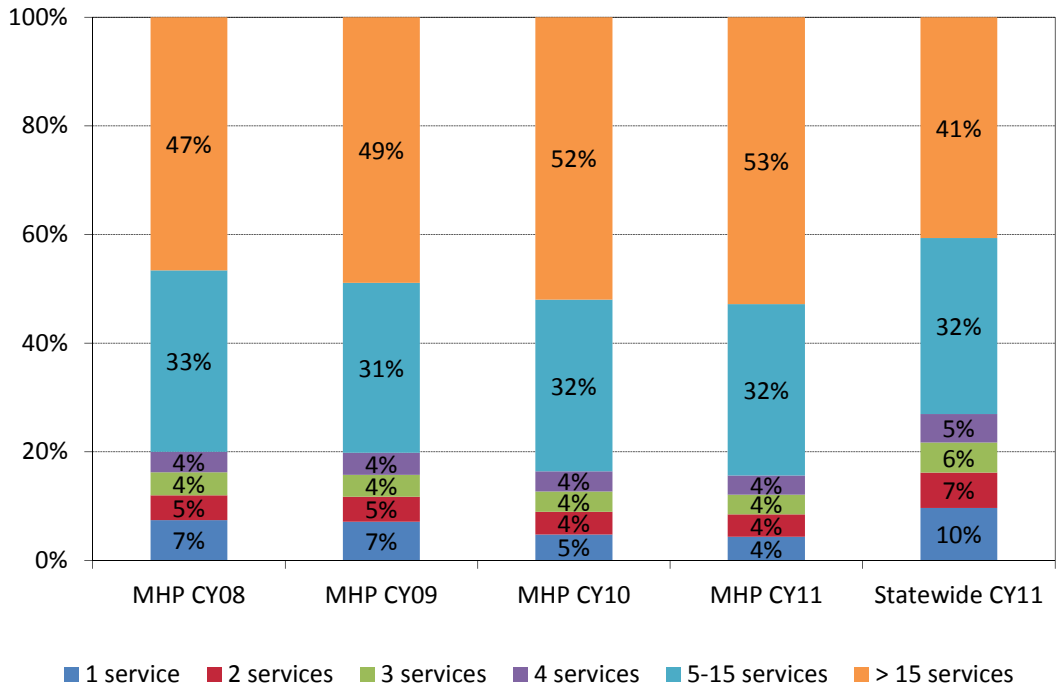


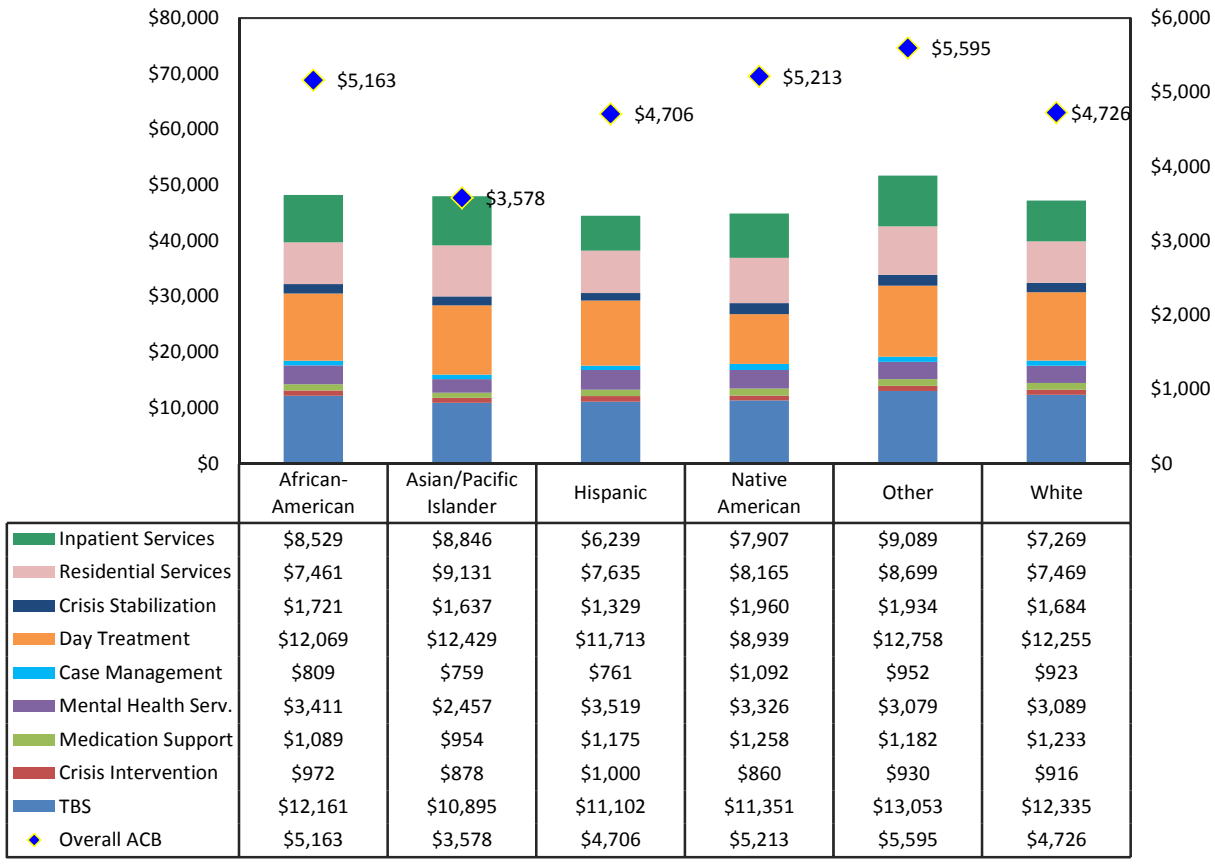
Figure D-2. CY11 Retention Rates with Average Approved Claims per Category

Number of Services Approved per Beneficiary Served	MHP Number of beneficiaries served	MHP $ per beneficiary served	Statewide $ per beneficiary served
1 service	779	$229.00	$301
2 services	742	$403.00	$472
3 services	658	$582.00	$604
4 services	632	$744.00	$754
5 – 15 services	5,663	$1,450.00	$1,543
> 15 services	9,480	$7,781.00	$10,175

SERVICE TYPE BY ETHNICITY - STATEWIDE

The following stacked bar charts show the average claims by service modality and ethnicity. It should be noted that these elements are not additive (i.e., the height of the bar has no meaning), and the main use for comparison is the differential use of particular services across various ethnicities. The blue diamond shows the average approved claims by ethnicity for all service modalities. Again, there is no direct relationship between the height of the bar (claims per service modality) and the average claims for that ethnicity.

Figure D-3. Statewide Approved Claims per Beneficiary CY11 - Race/Ethnicity by Service Type



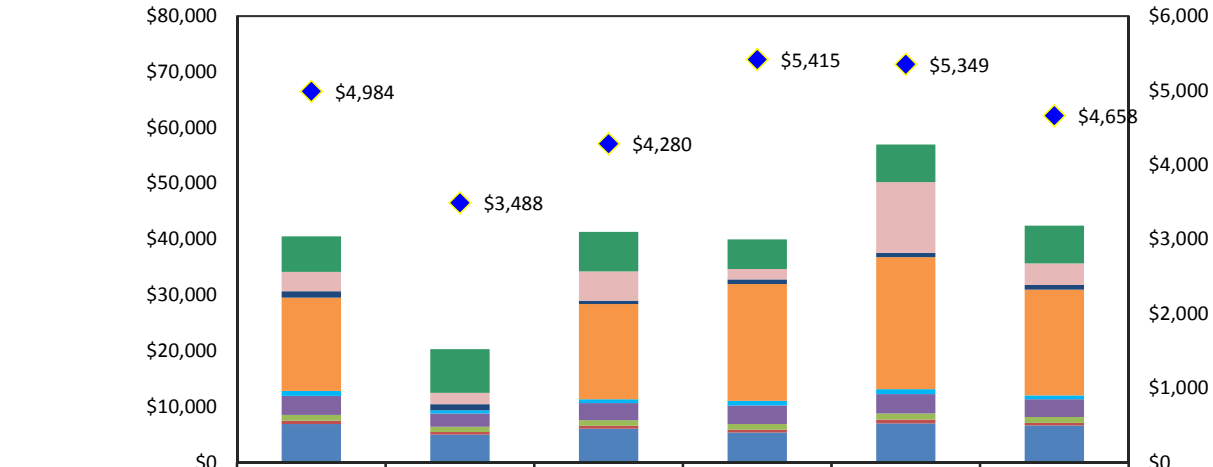
	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
Inpatient Services	$8,529	$8,846	$6,239	$7,907	$9,089	$7,269
Residential Services	$7,461	$9,131	$7,635	$8,165	$8,699	$7,469
Crisis Stabilization	$1,721	$1,637	$1,329	$1,960	$1,934	$1,684
Day Treatment	$12,069	$12,429	$11,713	$8,939	$12,758	$12,255
Case Management	$809	$759	$761	$1,092	$952	$923
Mental Health Serv.	$3,411	$2,457	$3,519	$3,326	$3,079	$3,089
Medication Support	$1,089	$954	$1,175	$1,258	$1,182	$1,233
Crisis Intervention	$972	$878	$1,000	$860	$930	$916
TBS	$12,161	$10,895	$11,102	$11,351	$13,053	$12,335
Overall ACB	$5,163	$3,578	$4,706	$5,213	$5,595	$4,726

Note: The left axis refers to the columns, and the right refers to the diamonds (overall ACB for each category)

Figure D-4. Statewide Number of Beneficiaries Served CY11 - Race/Ethnicity by Service Type						
	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
Inpatient Services	6,655	1,696	10,655	341	3,130	12,768
Residential Services	859	235	678	50	345	2,523
Crisis Stabilization	6,668	1,269	6,763	265	1,351	9,883
Day Treatment	1,479	230	1,428	54	313	1,804
Case Management	32,519	12,362	66,204	1,671	9,702	65,353
Mental Health Serv.	59,477	21,795	137,393	2,980	17,363	122,188
Medication Support	40,075	19,905	62,633	1,850	14,599	88,994
Crisis Intervention	7,929	1,810	12,995	504	2,170	19,654
TBS	1,313	139	2,643	57	348	2,490
All	75,231	29,822	158,486	3,730	24,481	155,835

SERVICE TYPE BY ETHNICITY - MHP

Figure D-5. MHP Approved Claims per Beneficiary CY11 - Race/Ethnicity by Service Type



	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
Inpatient Services	$6,401	$7,805	$7,105	$5,303	$6,729	$6,739
Residential Services	$3,440	$2,037	$5,255	$1,880	$12,670	$3,881
Crisis Stabilization	$1,147	$1,106	$605	$804	$756	$835
Day Treatment	$16,754	$0	$17,059	$20,952	$23,691	$18,968
Case Management	$855	$532	$682	$811	$865	$697
Mental Health Serv.	$3,422	$2,404	$3,041	$3,350	$3,472	$3,195
Medication Support	$1,044	$943	$1,015	$1,025	$1,096	$1,038
Crisis Intervention	$577	$455	$522	$516	$698	$469
TBS	$6,901	$5,008	$6,055	$5,353	$6,988	$6,617
Overall ACB	$4,984	$3,488	$4,280	$5,415	$5,349	$4,658

Note: The left axis refers to the columns, and the right refers to the diamonds (overall ACB for each category)

Figure D-6. MHP Number of Beneficiaries Served CY11 - Race/Ethnicity by Service Type

	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
Inpatient Services	269	56	125	21	81	476
Residential Services	19	3	8	1	4	32
Crisis Stabilization	78	10	35	6	15	103
Day Treatment	12	0	12	2	3	20
Case Management	3,533	1106	2289	180	935	5523
Mental Health Serv.	4,273	1277	2884	211	1116	6644
Medication Support	2,373	1048	1231	141	755	4413
Crisis Intervention	195	46	114	10	41	355
TBS	101	9	48	7	27	124
All	4,624	1,471	3,068	242	1,261	7,288

HIGH COST BENEFICIARIES

Figure D-7. Statewide High-Cost Beneficiaries CY11

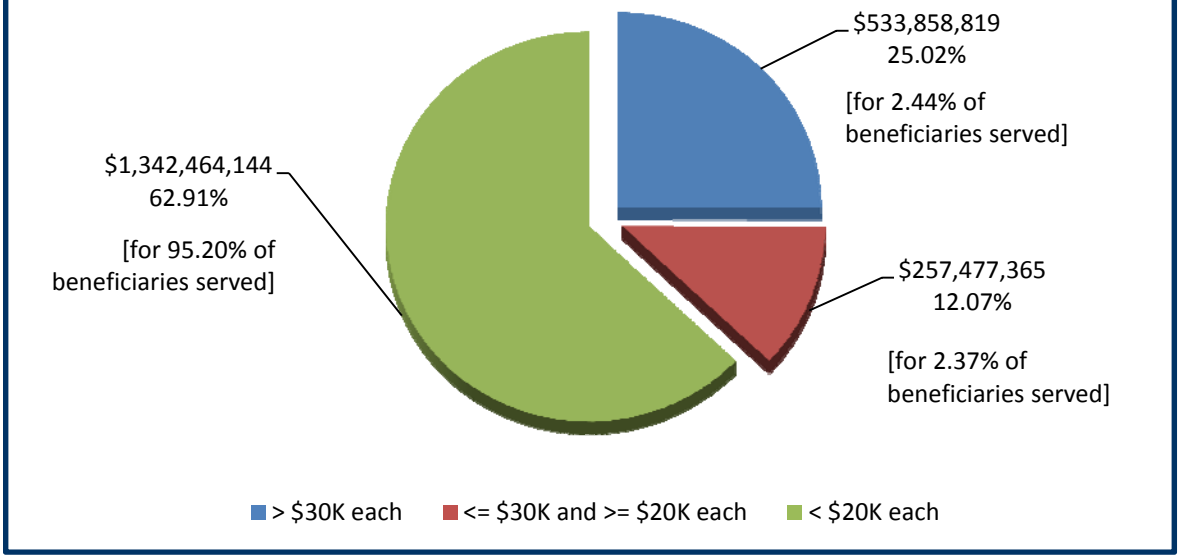
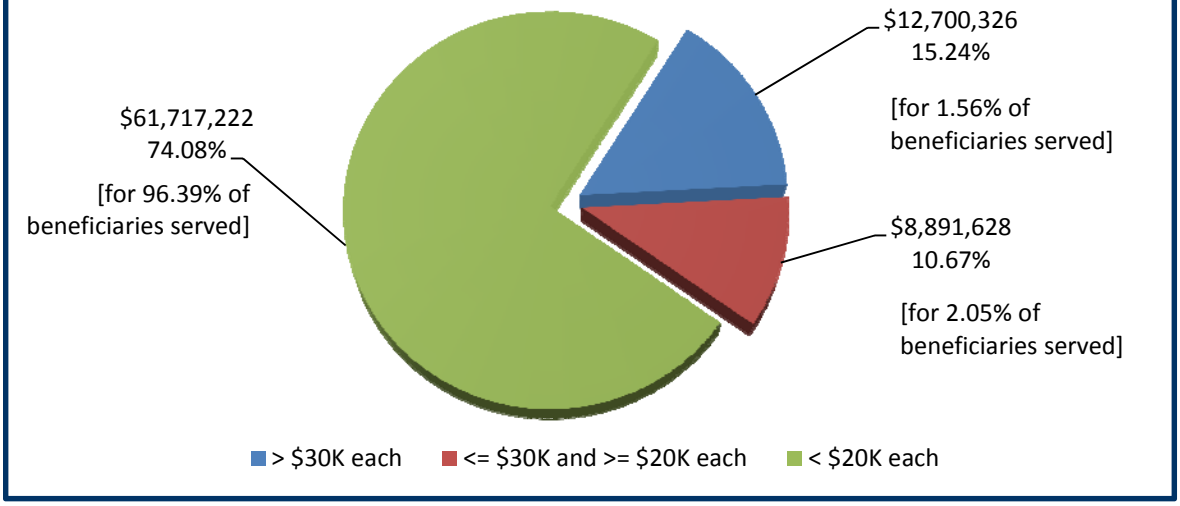


Figure D-8. MHP High-Cost Beneficiaries CY11



EXAMINATION OF DISPARITIES

Statewide disparities remain for Hispanic and female beneficiaries:

- Approved claims for Hispanic beneficiaries are now at parity with White beneficiaries. While the relative penetration rate disparity has decreased significantly, due to both a decrease in White penetration rate and an increase in Hispanic penetration rate, there remains 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 five 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.

Figure D-9. 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 CY11	158,486	3.68%	155,835	10.06%	$4,706	$4,726	.37	1.00
MHP CY11	3,068	3.73%	7,288	8.06%	$4,280	$4,658	.46	.92
MHP CY10	2,917	3.61%	6,884	7.88%	$4,504	$4,685	.46	.96
MHP CY09	3,224	4.04%	8,427	9.63%	$4,692	$4,621	.42	1.02
MHP CY08	3,228	4.34%	8,727	10.51%	$4,645	$4,653	.41	1.00

Figure D-10. 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 CY11	226,580	5.10%	221,005	6.37%	$4,269	$5,278	.80	.81
MHP CY11	9,259	5.00%	8,695	5.94%	$4,285	$5,018	.84	.85
MHP CY10	8,682	4.88%	8,407	5.96%	$4,443	$5,117	.82	.87
MHP CY09	10,837	6.14%	9,745	7.05%	$4,209	$5,338	.87	.79
MHP CY08	11,170	6.67%	9,955	7.70%	$4,187	$5,389	.87	.78

ELIGIBLES VERSUS BENEFICIARIES SERVED - FOSTER CARE

Figure D-11. MHP Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Foster Care CY11

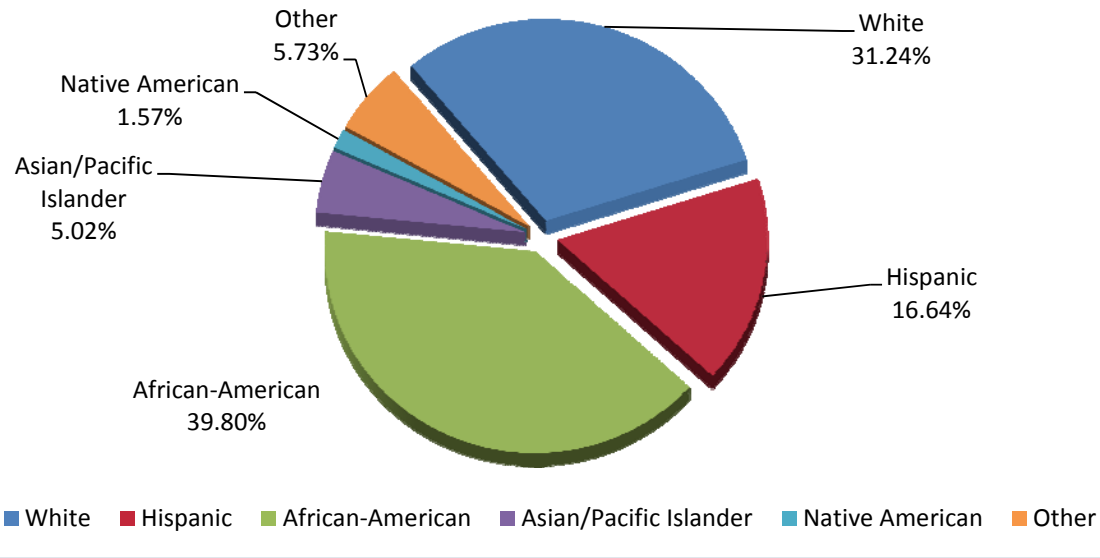
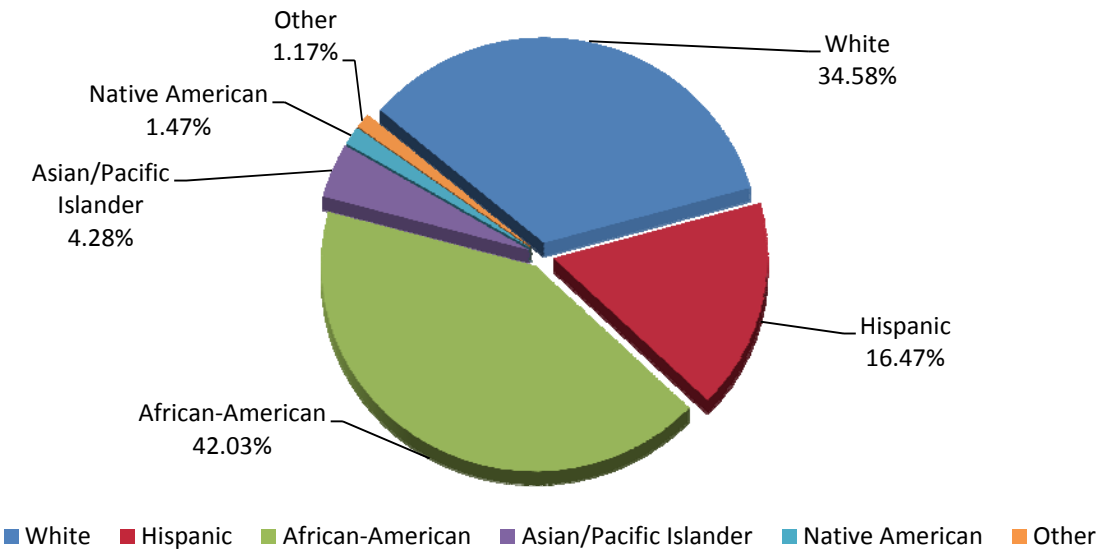


Figure D-12. MHP Medi-Cal Beneficiaries Served, by Race/Ethnicity - Foster Care CY11



ELIGIBLES VERSUS BENEFICIARIES SERVED - TRANSITION AGE YOUTH

Figure D-13. MHP Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Transition Age Youth CY11

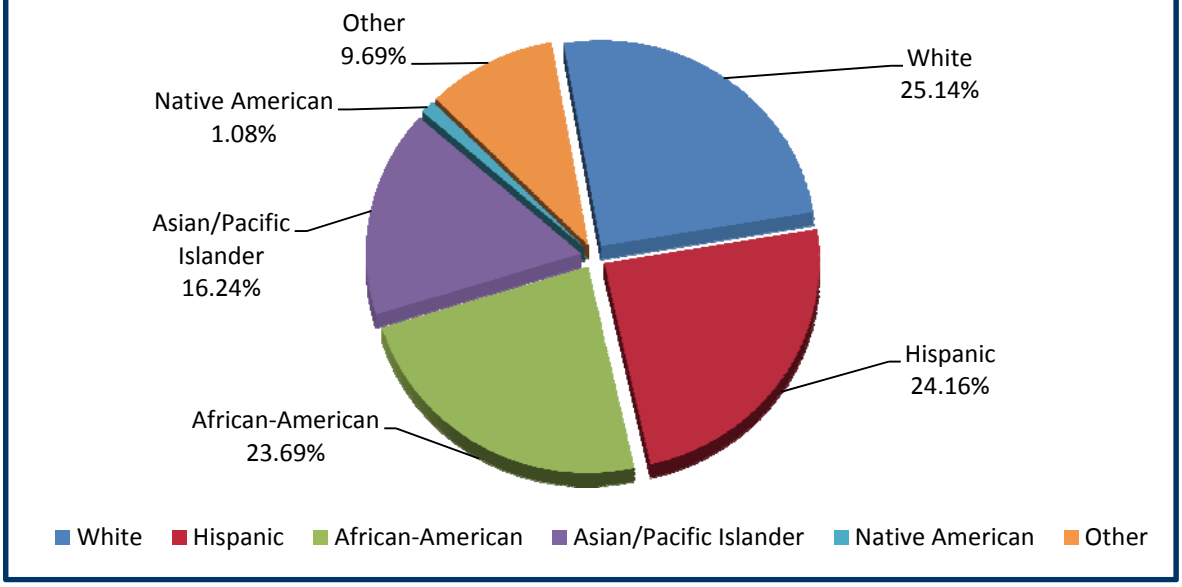
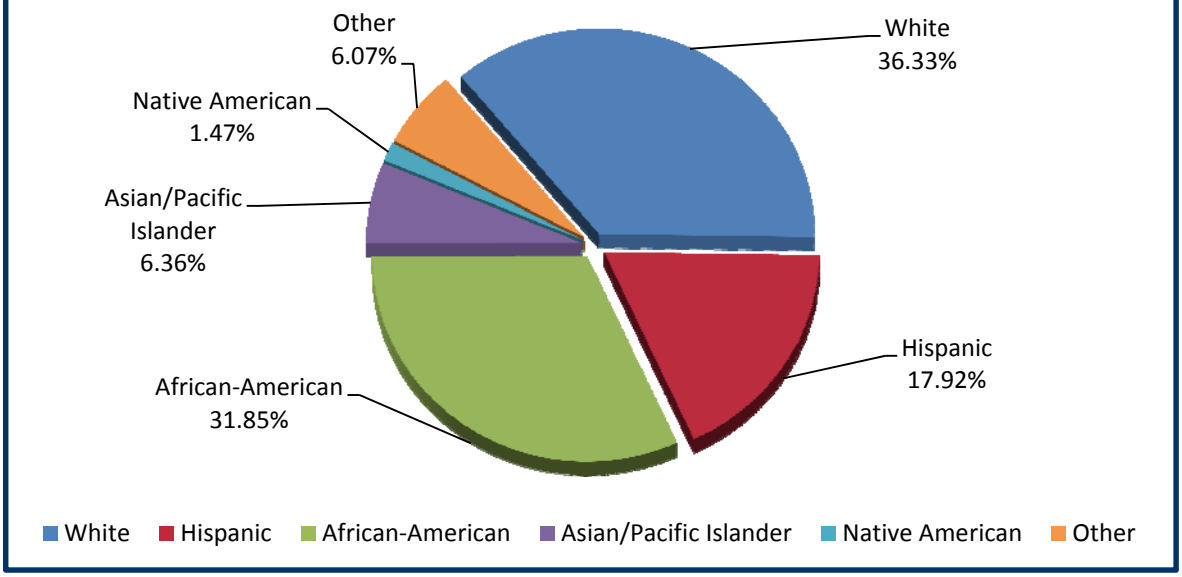


Figure D-14. MHP Medi-Cal Beneficiaries Served, by Race/Ethnicity - Transition Age Youth CY11



E. Attachment—PIP Validation Tool

FY12-13 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 (RSTs) in the MHP. It is their 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 health outcomes, functional status, satisfaction, or related processes of care designed to improve same	**x**				91% of DBH consumers had at least one documented medical issue in chart.
Totals for Step 1:		**5**				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
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				
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 appts in progress notes, coord of care with PCP in service plan, coord 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 identifying 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				
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				All consumers receiving outpt 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:* unintended					
5.1	Consider the true or estimated frequency of occurrence in the population				X	
5.2	Identify the sample size				X	1252 - as literature says issue is present in 40-60% of population, sample represented about 27% of all RST consumers (which is ½ of 54% range)
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:					**5**	
6	**Accurate/Complete Data Collection** *The data techniques:* included chart review documentation example					
6.1	Identify the data elements to be collected	x				All match indicators.
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				Randomized chart review of PIP enrollees. As well as creating a comparison group of non-PIP enrollees.
6.4	Provides a timeline for the collection of baseline and remeasurement data	x				Quarterly for RST use and annually for PIP tracking.
6.5	Identify qualified personnel to collect the data	x				Dedicated Research staff.
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 with CFMs beginning in Sept 2011 through Feb 2012 with CFMs at the RSTs. Then roll out of all forms and tracking mechanisms at RSTs once all trained. Why so long for last two? Chart review first in Dec 2011, then again in March 2012, and then July 2012; Avatar data pull reviewed with contractors on four occasions.					

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
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				Has already seen this as interventions have generalized over to non-PIP adults at the RSTs.
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. Also, after each data pull/chart review- had feedback session (3) with providers to improve process when onsite.
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. Chart review teams supervised by same two MHP management staff.
Totals for Step 7:		**4**				
8	**Analyses of Data and Interpretation of Study Results** *The data analyses and study results:* data entry in early August 2012 after all chart reviews complete. Findings presented onsite at review.					
8.1	Are conducted according to the data analyses plan in the study design	x				
8.2	Identify factors that may threaten internal or external validity	x				Good discussion
8.3	Are presented in an accurate, clear, and easily understood fashion	x				Of 1252 enrolled consumers, reviewed 175 charts (14%).
8.4	Identify initial measurement and remeasurement of study indicators	x				
8.5	Identify statistical differences between initial measurement and remeasurement	x				Statistical sign of p<.01, using ANOVA and Chi-Square for all but one indicator
8.6	Include the interpretation of findings and the extent to which the study was successful	x				
Totals for Step 8:		**6**				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
9	**Improvement Achieved** *There is evidence for true improvement based on:* met/surpassed goals for all indicators but one					
9.1	A consistent baseline and remeasurement methodology	x				PC follow-up in chart (this indicator hard to initially measure for PIP baseline as could only be in charts with already listed PCPs).
9.2	Documented quantitative improvement in processes or outcomes of care	x				Now 3000+ consumers in Avatar with documented PC info- indicated change in clinician beh and understanding of issues
9.3	Improvement appearing to be the result of the planned interventions(s)	x				Improvement in all indicators except documentation of PC appts/f-u in chart
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**		

FY12-13 Review of: Sacramento ☐ Clinical ☒ Non-Clinical

PIP Title: Decreasing Child Psychiatric Hospitalization Through The Use of CANS

Date PIP Began: January 2012

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

Descriptive Category: Improved diagnosis or treatment processes

Target Population: Other- youth

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
1	**Study topic** *The study topic:* decided to use the CANS data to identify the collection of needs and strengths that have a high likelihood of resulting in hospitalization or crisis stabilization services. It is expected the interventions identified and implemented to prevent future hospitalizations will ultimately lead to higher quality of life, less disruption in achieving developmental milestones and community integration, and lower mental health costs.					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	x				Great literature review summary
1.2	Was selected following data collection and analysis of data that supports the identified problem	x				Three studies were conducted to understand the causes of hospitalization. The first examined the results of initial CANS assessments as they related to hospitalization. The second piggybacked on the first to look specifically at two areas identified in the study to be high needs areas. The final study compared the hospitalization rate in the first six months of the FIT Program (prior to the implementation of CANS) to a six month period beginning twelve months after the CANS was implemented.
1.3	Addresses key aspects of care and services	x				integration of existing resources
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs		x			No, being piloted on two treatment program groups first- Wraparound and FIT
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care	x				prevent future hospitalizations

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	designed to improve same					
Totals for Step 1:		**4**	**1**			
2	**Study Question Definition** *The written study question:* Can CANS data be used to identify clients with needs that correlate to hospitalization or ISU usage so that subsequent (new and continuing) CANS assessments can be used to focus on interventions to prevent hospitalization and use of ISU? Is the Adjustment to Trauma element useful in correlating trauma to hospitalization or MERT usage or suggesting the need to adopt the Trauma Module in CANS?					
2.1	Identifies the problem targeted for improvement	**x**				
2.2	Includes the specific population to be addressed	**x**				In the first year of CANS implementation with FIT and Wraparound providers, there were 889 unduplicated youth served in the program
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:* # of consumers hospitalized, # of consumers with ISU contacts, LOS in hospital, # of repeat MERT/Hospitalization					
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**				
3.4	Have accessible data that can be collected for each indicator	**x**				Using Avatar the Trauma drill-down module of CANS to better integrate the info with treatment
3.5	Utilize existing baseline data that demonstrate the current status for each indicator	**x**				
3.6	Identify relevant benchmarks for each indicator			**x**		
3.7	Identify a specific, measurable goal(s) for each indicator		**x**			5% decrease for each of the four indicators- but have no clear rationale for these; need to reassess these goals- discussed in depth on site
Totals for Step 3:		**6**		**1**		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
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				
Totals for Step 4:		**2**				
5	**Use of Valid Sampling Techniques** *The sampling techniques:* charts for any group larger than 50 will be chosen randomly from an open chart list					
5.1	Consider the true or estimated frequency of occurrence in the population	x				The non-hospitalized clients who are sampled for chart review will be 5%, which is approximately 50 clients and is slightly more than the hospitalized clients with Adjustment to Trauma (42).
5.2	Identify the sample size	x				About 50
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				A sampling will only be used for the non-hospitalized client groups (with trauma and non-trauma) for chart review purposes, due to the large number of beneficiaries in these two group.
Totals for Step 5:		**3**		**2**		
6	**Accurate/Complete Data Collection** *The data techniques:* Clients served by FIT and Wraparound programs will have CANS assessment data and any relevant hospitalization data collected to understand the impacts of training provided and the implementation of the Trauma Module. In addition, a chart review tool will identify whether or not the CANS assessment was used in developing the treatment plan. The tool will also include: modality changes, diagnosis, medications and living situations. This data will be collected for four groups.					
6.1	Identify the data elements to be collected	x				
6.2	Specify the sources of data	x				
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data	x				At the end of one year following the implementation of the PIP, data will be summarized and analyzed for trends and relationships. Data collected on all clients included in the PIP will be analyzed against performance indicators to measure

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
						improvement. As the CANS is given every six months, data should be analyzed at least twice a year.
6.4	Provides a timeline for the collection of baseline and remeasurement data	x				
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:* expanded CANS training, training CFM employees (peer mentors/family partners) on CANS, use CANS Trauma Module, chart reviews for all four groups. **(TO BEGIN in Fall 2012)**					
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 to induce significant change		x			All child consumers
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			x		Consideration of need to revisit fidelity of CANS Trauma Module use if differences not seen at first data run.
7.4	Are standardized and monitored when an intervention is successful			x		Plan to use a chart review tool; Interventions not yet in place.
Totals for Step 7:		**1**	**1**	**2**		
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		There are no post-intervention findings yet; all items hereafter are rated as “not met” based upon the state of the PIP at the time of the review.
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			x		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	extent to which the study was successful					
Totals for Step 8:				**6**		
9	**Improvement Achieved** *There is evidence for true improvement based on:*					
9.1	A consistent baseline and remeasurement methodology			**x**		
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

CAEQRO PIP Outline via Road Map

Sacramento County MHP, 2011-2012 PIP UPDATE.

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

The Sacramento County Mental Health Plan (MHP) through a Committee consisting of a cross section of administration, service provider and advocacies established, developed and implemented this Adult PIP. During the implementation year the Adult PIP Committee was comprised of representatives from: Quality Management, Research & Evaluation, Contract Monitors and Adult Contract Providers from the four Regional Support Teams (RST's) representatives.
From the beginning the four RST's have been actively participating in the implementation of the Adult PIP. Throughout FY 2011-2012 series of committee meetings were held as well as sub-committee meetings where specific tasks were the focus of attention. There were several meetings of brainstorming activities to understand the gaps and needs of the implementation of this Adult PIP. All these meetings have continued through a series of committee and sub-committee meetings, individual communications with members of Adult PIP Committee, quarterly chart reviews at program sites as well as through the Quality Improvement Committee (QIC) monthly meeting report process. In addition a series of trainings at the RST's and contractor providers had been facilitated with consumers, administrators and line staff to support the implementation of this Adult PIP.

The Adult PIP Committee membership is as follows:

County Participants

Kathy Aposhian, RN, Acting Program Manager, Quality Management, Chair, QIC, Chair PIP Committee
Uma Zykofsky, LCSW, Chief of Adult Programs
Kelli Weaver, LCSW, 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
Melody Boyle, LCSW. Senior Mental Health Counselor
Terry Nichols, LCSW, Mental Health Program Coordinator, Adult Mental Health Programs
Steve Ballanti, LCSW, Mental Health Program Coordinator, Adult Mental Health Programs
Bernice Zaborski, MPH, Mental Health Program Coordinator, Adult Mental Health Programs
Karen Giordano, LMFT, Mental Health Program Coordinator, Adult Mental Health Programs

Provider and Advocate Participation

Amanda Divine, LMFT, El Hogar - Adult Outpatient: Regional Support Team
Rian W, Smith, LMFT, El Hogar - Adult Outpatient: Regional Support Team
Jill Dayton, LMFT, El Hogar- Adult Outpatient: Regional Support Team
Paul Heffner, MFTI, El Hogar- Adult Outpatient: Regional Support Team
Paul Cecchettini, Ed. D Psychologist, Turning Point –Adult Outpatient: Regional Support Team
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
Cindy Lopez, MFTI, Visions Unlimited- Adult Outpatient: Regional Support Team
Alexis Lyon, MFTI, Turning Point, Pathways - MHSA Full Service Partnership Program
Amos Johnson, MSW, Visions Unlimited- Adult Outpatient: Regional Support Team

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

SACRAMENTO COUNTY MENTAL HEALTH PLAN
ADULT PERFORMANCE PROJECT IMPROVEMENT (PIP)

PROJECT DEVELOPMENT-Adult PIP Time Lines

#	DATE	ACTIVITY	RESPONSIBLE
1	7/01/11	Adult PIP Implementation	Participating agencies
2	8/22/11	Primary Care/Mental Health Training with Adult Providers (Power Point, sign-in sheets)	Adult Programs, County's Primary Care.
3	9/07/11	Consumers training at North Gate RST	MHP
4	9/09/11	Consumers training at El Hogar RST	MHP
5	9/12/11	September PIP meeting (Agenda, sign-in sheet, minutes)	QM, REPO, Adult Programs, Providers
6	11/18/11	November PIP meeting (Agenda, sign-in sheet, minutes)	QM, REPO, Adult Programs, Providers
7	12/12/11-12/22/11	PIP site chart reviews	QM, REPO, Adult Programs
8	2/17/2012	February PIP meeting (Agenda, sign-in sheet, minutes)	QM, REPO, Adult Programs, Providers
9	2/23/12	Consumers training at HRC RST	MHP
10	2/24/12	Consumers training at VISIONS RST	MHP
11	3/23/12-3/30/12	PIP site chart reviews	QM, REPO, Adult Programs
12	4/27/12	April PIP meeting (Agenda, sign-in sheet, minutes)	QM, REPO, Adult Programs, Providers
13	6/28/12	MHP committee meeting	QM, REPO
14	7/31/12-8-3-12	PIP site chart reviews	QM, REPO
15	8/6/12-8/10/12	PIP chart review Data entry	QM,REPO
16	8/13/12-8/17/21	Write up of DRAFT report	QM,REPO
17	8/20/12	PIP DRAFT review by Management team	Management Team
18	8/24/12	Editing Final PIP report	QM,REPO
19	8/27/12-8/31/12	Final report	QM,REPO

The goal of the Primary Care PIP is to improve primary care access/follow-up and treatment for our mental health consumers through increased efforts to coordinate and follow-up on medical issues with the consumer's primary care provider. It does not replace any current policy/procedure regarding documentation or follow-up for medical issues, but increases coordination/documentation/follow-up efforts for consumers identified with specified focus medical issues. This document provides the protocol to be followed for the PIP.

FOCUS MEDICAL ISSUES FOR PRIMARY CARE PIP

The following table lists the categories of medical issues that are the focus of this PIP. The included diagnoses/conditions column lists examples of conditions that fall within the categories. If the consumer reports a diagnosis/condition that is not listed, but which you feel may be appropriate for the category, please contact Sacramento County staff to discuss whether to include the consumer or not. ALL consumers with at least one of the focus medical issues will be included in the PIP.

Category	Included diagnoses/conditions
Blood Pressure	• Hypertension - High blood pressure, Hypotension - Low blood pressure
Cholesterol	• Hypercholesterolemia- High cholesterol • Dyslipidemia - abnormal amount of lipids, e.g. cholesterol and/or fat, in the blood • Hyperlipedemia - elevated levels of lipids in the blood • Lipid disorder • Low HDL (high-density lipoprotein) cholesterol • Hypertriglycericemia - Elevated triglyrcerides
Cardio/Cardiovascular Disease	• Heart disease • Arterial sclerotic disease, Coronary artery disease • Angina (chest pain/discomfort caused by reduced blood flow to the heart) • Congestive Heart Failure (CHF) • Heart murmur • Myocardial Infarction (MI) - heart attack
Cerebrovascular Disease	• Cerebrovascular accident (CVA) - Stroke • Hydrocephalus - "water on the brain", excess fluid builds on brain
Diabetes	• Diabetes Mellitus • Hyperglycemia - high blood sugar, Hypoglycemia - low blood sugar • Diabetic Neuropathy - complication of diabetes causing damage to the nerves
Liver disease	• Hepatitis • Cirrhosis • Jaundice • Other Liver disease • Hepatomegaly - Enlarged liver

The following tables list the protocol to be followed for the Primary Care PIP.

Task	Timeline	Actions Needed	Responsible Party
Determine if consumer is to be included in the PIP by identifying or confirming at least one of focus medical issues exists	1) For ALL existing consumers at first face to face visit after July 1, 2011 2) For ALL new consumers upon intake assessment	1)Discuss medical issues with consumer, document ***all*** medical issues per existing protocols 2)If no focus medical issues exist consumer is NOT included in the PIP 3) If at least one of the focus medical issues are present, consumer IS included in the PIP and the following need to be completed: • Document identified focus medical issues: 1. in clinical progress notes 2. on page 2 of the Service Plan (Service Coordination Section) 3. on the CDS 4. In AVATAR in the diagnosis option on page 4 in the "General Medical Condition Summary" field. (see attached guidelines) Note: If consumer has at least one of the focus medical issues but refuses to sign a release of information and/or refuses coordination of care efforts the consumer IS STILL INCLUDED in the PIP, but the refusal is documented in the progress notes. It is expected that staff will continue to work with the consumer to improve coordination of care efforts.	Provider staff (case manager, nurse, dr)
Identify or confirm Primary Care Physician (PCP) Status	1) For ALL existing consumers at first face to face visit after July 1, 2011 2) For ALL new consumers upon intake assessment	1) If consumer has no PCP consumer should be encouraged and provided assistance in finding a PCP. This should be documented on the Service Plan under the coordination of care section. Referral and follow-up should be documented in the chart. 2)If consumer has a PCP • If not documented already, document PCP on the service plan, CDS and in AVATAR in the Consumer Resources option (see attached guidelines)	Provider staff (case manager, nurse, dr)

Follow-up/Coordinate Care	Coordination of Care and follow up should be done as needed. Issues of concern will be tracked monthly.	1)Document follow-up and coordination of care in clinical notes • Samples of coordination of care and clinical documentation shall include but is not limited to: ♦ Reminder of medical appointments over the phone, letters, post cards, etc. ♦ Phone calls to set up medical appointments while the consumer is in the office with service coordinator ♦ Keep track of appointments-help consumer develop a tracking system-document PCP appointments and follow up in clinical notes ♦ Arrange/assist with transportation issues for medical appointments ♦ Role Play with consumer to prepare for upcoming appointment ♦ Accompanying consumer to medical appointment ♦ Other 2) For every consumer with one of the 6 focus medical issues AND who have a PCP appointment scheduled. In conjunction with the consumer, complete the Primary Care Visit Form. Maintain the original in the chart, fax a copy of the form with the cover letter to the PCP, and give a copy to the consumer to take to the dr. appointment. (The cover letter asks the PCP to complete and return the form to the provider after the PCP appointment) 3)If consumer has any new conditions that are one of the 6 targeted medical issues, these should be documented in the clinical notes, the service plan and AVATAR 4) If PCP information has changed, changes should be documented in the appropriate chart documents as well as in AVATAR in the Consumer Resources option. 5) PCP appointments that staff have knowledge of should be documented in chart in the progress notes	Provider staff (case manager, nurse, dr)

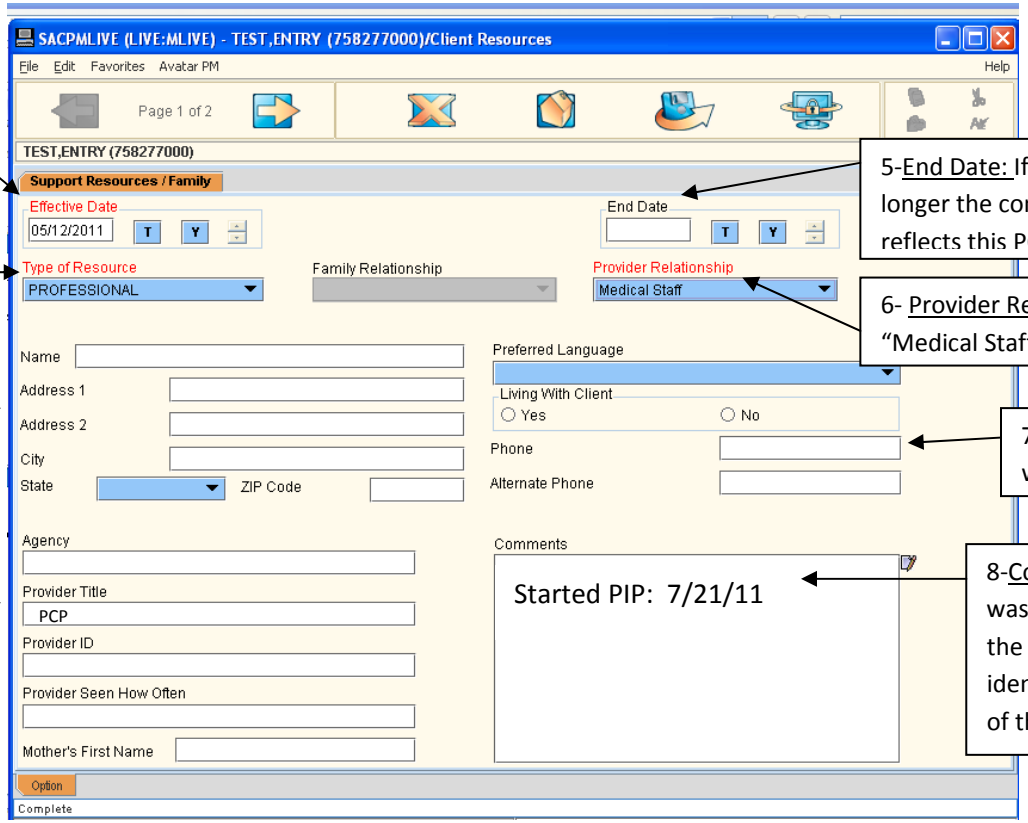
CLIENT RESOURCES OPTION IN AVATAR: The "Client Resources" option is where the Primary Care Physician (PCP) will be documented in Avatar.

1-Effective Date: Enter date PCP was obtained. If not known, use best estimate

2- Type of Resource: Always choose "PROFESSIONAL"

3-Name/Address: Enter PCP name and address when known

4- Provider Title: Always enter "PCP"



5-End Date: If PCP changes to another PCP or PCP is no longer the consumer's PCP enter an end date that reflects this PCP is no longer the consumer's PCP

6- Provider Relationship: Always choose "Medical Staff"

7-Phone: Enter the PCP phone number when known

8-Comments: Indicate the date the consumer was identified for inclusion in the PIP. This is the date of the face to face visit where it was identified that the consumer has one or more of the 6 focus medical issues

It is suggested that information pertaining to the PCP be completed on a CDS (on the client resource lines) so that data entry staff have all available information to enter. It is understood that initially detailed information such as address and phone number may not be known, but it is anticipated that as the information becomes available the client resource screen will be updated to reflect the necessary information needed to coordinate care with the PCP.

If a PCP changes:

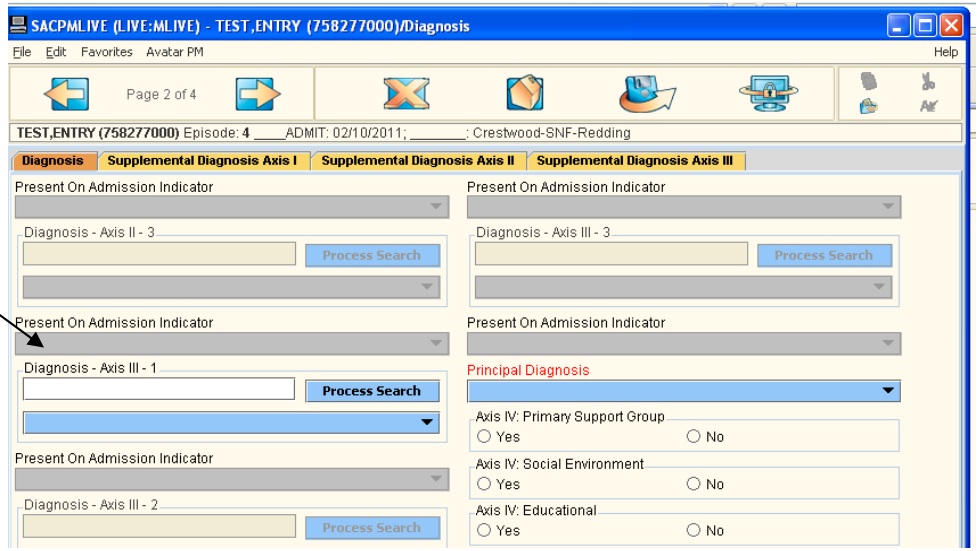
1. Go back in to Consumer Resource option and enter an "end date" for the old PCP, save and close the option
2. Go back in to the Consumer Resource option and enter the information as outlined above 1-8 into the Client Resource option

Note: you may complete other fields than the ones listed above if information is available and you so desire.

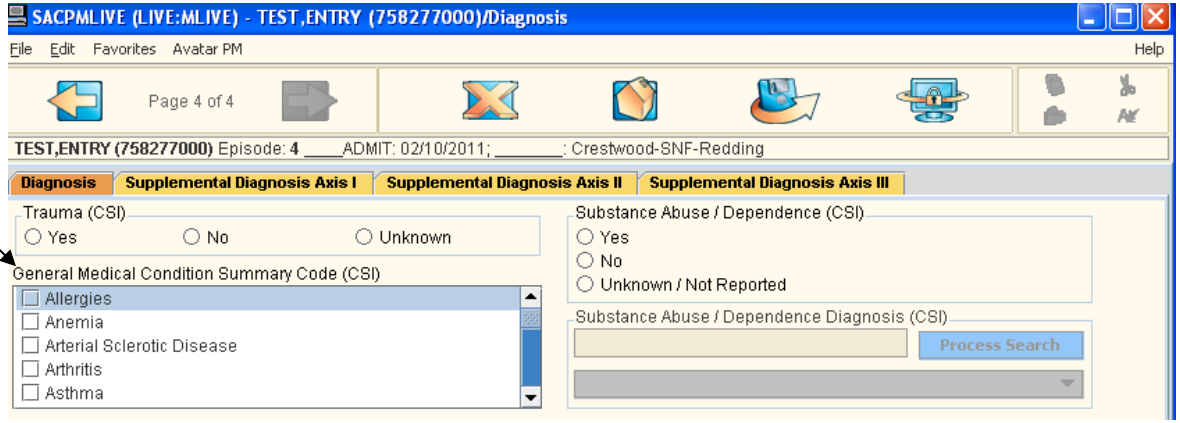
DIAGNOSIS OPTION: The "Diagnosis Option" is where the medical diagnosis (if applicable) and medical issues/concerns will be documented in AVATAR.

1-Diagnosis- Axis III: If the consumer has an Axis III diagnosis it is documented as usual on page 2 of the diagnosis option.

Note: this is the same as normal business processes with or without being included in the PIP



1-General Medical Condition: General medical conditions are documented on page 4 of the diagnosis option. Can check up to 3 medical conditions (see below for instructions)



AVATAR allows you to check up to THREE (3) medical conditions in the "General Medical Condition Summary Code (CSI)" field. Use the following guidelines when completing this field:

1. If the consumer has more than 3 of the focus medical conditions for this PIP, choose the medical conditions that are the consumer's priority or most problematic (note: ALL medical conditions should be documented in the consumers chart even though only 3 can be documented in this screen)
2. If a diagnosis that falls within the 6 focus medical conditions for this PIP is not on the drop down list use the "other" category to indicate that the consumer has one of the 6 focus medical conditions.

QUARTERLY ADULT PIP CHART REVIEW
7/01/2011 - 9-30-2011

Review the (CDS, Service Plan, and Progress Note) on every chart and complete below form for each client enrolled into the Adult PIP starting July 1, 2011.

DATE: _____ Reviewer:_____

AGENCY: _____

CLIENT'S NAME: _____ ID: _____

In PIP with Focus Issues □Yes **Focus Issues not in PIP** □Yes

Client Data Sheet (CDS) FORM			
Client's Resource (PCP Name)			
Provider Relationship	PCP?	□ YES	□ NO
General Medical Conditions (Please list written)	Primary	Secondary	Terteary

SERVICE PLAN FORM (Page 2 of 3)				
Primary or Specialty Health □ Non Applicable	Note Specific Need	Task	Date Started	Date Resolved

NOTED IN PROGRESS NOTE:		□ YES		□ NO
IF YES, DATE		NEW CLIENT	EXISTING CLIENT	REFUSE HELP

Is PCP referral form in the chart? □Yes □No □ NA

□ In PIP
Start Date:_____
□ Not In PIP

ADULT PIP CHART REVIEW
7/01/2011 - Present (March 3012)

Date: _____ Reviewer: _____ Provider: _____

Client Name: _____ ID: _____ Client is: □New □Existing □Refuses Help

Client Data Sheet (CDS) -Review of most recent CDS (Date of CDS:)

1. Is the PCP name listed in the "Client Resource" field on the CDS?	□YES □NO		
2. Does the "Provider Relationship" field on the CDS show the resource is the PCP?	□YES □NO		
3. Please list the "General Medical Conditions" listed on the CDS	Primary	Secondary	Tertiary
4. Comments:			

Service Plan (page 2 of 3)- Date of Service Plan:

Performance Indicator 2: Client will have PCP information documented in Service Plan (SP)					
Performance Indicator 3: Medical conditions will be documented in the Service Plan (SP)					
Performance Indicator 7: Coordination of Care will be documented in Service Plan (SP)					
5. Write the specific need, task and start date associated with "Primary or Specialty Health" section on page 2					
Specific Need	Task	Date Started	Date Resolved	Check if meets Performance Indicator?	Is Start date after the start of PIP date?
				□2 □3 □7	□YES □NO
				□2 □3 □7	□YES □NO
6. □ Check if there are NO specific needs identified in the Primary or Specialty Health section					

Progress Notes

Performance Indicator 4: Medical conditions will be documented in the Progress Notes		
Performance Indicator 6: PCP appointments will be documented in Progress Notes		
Performance Indicator 8: Coordination of care will be documented in the Progress Notes		
7. Is there a progress note indicating client was started in the PIP? □YES □NO □NA	Date of Note:	
8. Review ALL progress notes on or after the start date of the PIP, indicate date of each progress note whether or not the progress note addresses the need/tasks in the SP, and if the progress note relates to a Perf. Indicator.		
Date of Progress Note	Does PN relate to need/tasks in Primary or Specialty Health section of SP?	Check Performance Indicator that relates to PN
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care

Is PCP referral form in the chart? □Yes □No □ NA

Primary Care Integrated Behavioral Health Services

Sandy Damiano, PhD
Jae Han, MD
Marcia Jo, JD/MBA

August 22, 2011

Focus for Today

Importance of Primary Care and Coordinated Care for Adults with Serious Mental Health Conditions

Agenda Review

- Why are we meeting?
- Health Disparities
- Training for MH Plan Staff & Consumers
- County Primary Care IBH
- Medi-Cal Managed Care
- Low Income Health Program
- Closure

Why are we here?

- Our interests and commitment to adults with serious mental health conditions
- Health Disparities & Access to Health Services
- Our CalMEND Experience
- Health Care Reform

Key Points

- Reduce health disparities for adults with serious mental illness
- Increase access to primary care
- Linkage is insufficient! Integration or coordination is required.
- Best practice model

Health Disparities

- Consumers receive suboptimal preventive and primary medical care
- Adults with a severe mental illness (SMI) have 25 – 30% lower life expectancy relative to those without SMI
- Rates of medical co-morbid conditions are increased for those with Schizophrenia

Health Disparities - continued

- Less than half of primary care patients with mental illness receive ANY treatment
- 50 – 70% of Major Depression (MDD) is not accurately diagnosed or adequately treated in primary care
- Approx. 80% of all anti-depressants are prescribed by non-psychiatrists (Mark, et. al 2009)

Physician Training Issues

- More than half of primary care patients on antidepressants do not meet criteria for MDD. (Perez-Stable 1990, Tiemens 1999, Klinkman 1998)
- Only 1/3 of internal medicine residents are comfortable treating MDD (JAMA 2002)
- Many residents report a suboptimal amount of psychiatry training experience (Hospital Psychiatry 2007)

Medical Home

- Physical health primary care provider and MH Specialty provider have distinct roles and expertise
- All clients need a primary care "medical home"
- For those ready to "step-down" from MH Specialty, always check with client's PCP for service integration

Training Efforts

- Regional Support Teams - 69 staff
- Adult MH Providers – Aug 2011
- Pharmacy & Therapeutics (P&T) – Nov 2011
- 2010/11 trainings: PCC, Consumer Speaks, MH Leadership, CalMEND, Conferences
- Health Clinics - TBD

CalMEND Pilot Collaborative

- Program of State DHCS in partnership with State DMH. Funded by MHSA.
- Mission – To improve the health of individuals with SMI and chronic medical conditions through more effective partnerships.
- Six Counties selected including Sacramento; various change efforts

Focus of Staff Training

- Health Disparities
- Understanding primary care services
- Consumer engagement & education
- Motivational interviewing
- What should consumers ask their PCP
- Care Coordination

County Primary Care IBH

- Focus: specialized expertise
- Training role: UCD Psychiatry, UCD Internal Medicine, MH Plan
- Two services: (1) direct services (2) consultation & support

Direct Services for Adults with SMI

- Psychiatric Services – for adults not meeting MHP target population
- Physical Health Services – for adults in MHP specialty services; FFS
- Psychiatric "AND" Physical Health Services – for those desiring both and who are not in mandatory managed care

IBH Consultation & Support / CMISP

- PCP evaluates need and level of Behavioral Health Specialist (BHS) consult needed Consultation also available by a Combined Trained Physician as indicated
- Tools – Behavioral Health History, PHQ-9, CAGE, etc.

Consultation & Support / CMISP

- Depression Pathway: Collaborative Care Model for depression treatment algorithm
- Combined trained physicians refers to Adult Access (adults requiring specialty Mental Health Plan services) when clinically indicated

Medi-Cal Managed Care

- Sacramento County has a Geographic Managed Care (GMC) Model
- Seniors & Persons with Disabilities (SPD) mandatory transition in process
- Maximus selects the health plan
- Health Plan selects the provider

Sacramento County Medi-Cal Managed Care Stakeholders Advisory Committee

- Authorized in SB 208; W&I 14089.07
- Meetings began April 2011
- Current topic of discussion – SPD Transition
- See webpage:

  http://www.sacdhhs.com/article.asp?ContentID=2205

Low Income Health Program (LIHP)

- Under the Section 1115 Medicaid Waiver
- New funding for childless adults meeting low federal poverty level and eligibility criteria
- Expands health care coverage
- See webpage for details:

  http://www.sacdhhs.com/article.asp?ContentID=2183

Changes coming…

- SPD Transition in process…
- Low Income Health Program (LIHP)
- MH Parity Regulations forthcoming for Medi-Cal Managed Care
- Federal rules on eligibility
- Federal Health Care Reform

Questions?

Health Disparities - continued

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- Federal Health Care Reform

Questions?

DIVISION OF BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH
MENTAL HEALTH ADULT PIP

AGENDA

DATE: September 12, 2011
TIME: 3:00 a.m. to 4:30 p.m.
PLACE: 7000 A East Parkway Suite 300
Conference Room 301
Sacramento, CA. 95823

1. Introductions
2. Purpose of the meeting
3. Adult PIP Data review
4. Feed back from providers regarding implementation of PIP
5. PCP referral form
6. Brainstorming
7. Q & A

SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH
Adult PIP Meeting

Date: September 12, 2011

Present: Jesus Cervantes, Jill Dayton, Mary DeSouza, Wendy Hoffman-Blank, Alexis Lyon, Sherri Mikel, Lynn Place, Lisa Sabillo, Rian Smith, Uma Zykofsky, Kathy Aposhian.

AGENDA ITEMS	DISCUSSION	ACTION
INTRODUCTIONS	• Representatives from the 4 pilot project providers (El Hogar, HRC, Northgate, Visions) were present along with county staff	•
REVIEW MINUTES	• Minutes from previous Adult PIP meeting (June 20, 2011) were reviewed and approved by attendees	•
POINTS OF DISCUSSION	• Purpose of the meeting was to see where we are so far , and look at the data to make adjustments • Attendees reported that they still in the process of entering information into AVATAR. • A question was raised regarding the Adult Health Questionnaire to match or include the targeted diagnostic criteria into it. Uma advised that due to AVATAR moving toward the electronic implementation, it was a good idea not to modify the current AHQ. • Handouts (attached) were reviewed by attendees • Attendees were asked to refer to PIP Protocol on where PCP information should be documented. • Lisa presented the data to all attendees, she explained that this data is based on what we could see in AVATAR and she indicated that data entry by providers is still behind. • County staff informed attendees that Lisa, Mary and Jesus will provide all four RST's with a quarterly data report • Attendees were pleased with information provided by county staff and agreed to continue entering data as needed • County staff encouraged attendees to contact Jesus or Lisa as needed if any questions arise.	• Lisa and Jesus asked attendees for feed-back regarding PIP implementation • Lisa and QM staff will prepare quarterly reports
ADJOURN	• Meeting was adjourned on time	•
NEXT MEETING	• Next meeting will be scheduled in 2 months and an email will be sent out	• Jesus will email information regarding next meeting time

DIVISION OF BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH
MENTAL HEALTH ADULT PIP

AGENDA

DATE: November 18, 2011
TIME: 1:00 p.m. to 2:30 p.m.
PLACE: 7000 A East Parkway Suite 300
Conference Room 301
Sacramento, CA. 95823

1. Introductions
2. Purpose of the meeting
3. First Quarter Adult PIP Data review
4. Feed back to providers regarding data input
5. Proposed chart review form
6. Brainstorming
7. Q & A

SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES
ADULT PIP MEETING MINUTES
NOVEMBER 18, 2011

Participants:

Jesus Cervantes, Lisa Sabillo, Jill Dayton, Mary DeSouza, Amos Johnson, Alexis Lyon, Sherri Mikel, Rian Smith, Steve Ballanti.

AGENDA ITEM	POINTS OF DISCUSSION	ACTION NEEDED	DUE DATE
WELCOME	▪ Jesus welcomed meeting participants, introductions were completed, and the agenda and materials were reviewed.	N/A	
REVIEW MINUTES	▪ Minutes from previous meeting (September 12, 2011) were reviewed and approved by attendees.	N/A	
POINTS OF DISCUSSION	▪ Jesus explained that the purpose of the meeting was to look at the first Quarterly Adult PIP Data (July 1st through September 30th.) to see where we are so far, as well as to look at the data and get feed back from RST's. ▪ Lisa briefly explained and gave an overview regarding data collected based on AVATAR information. ▪ A couple of providers shared their concern about their First Quarter Data Report being "low" and explained that they were behind on data entry. Staff are getting used to the protocol but it is a time consuming process. Providers will work on catching up and ensuring that staff understand and follow the protocol.		
POINTS OF DISCUSSION	▪ Lisa presented the data report to all attendees , she explained that obtained data is based on what is entered into AVATAR system, therefore if there are "inconsistencies" with it, it need to be fixed by data entry at each site to get reliable information. Also Lisa informed that, it is important to encourage staff who enters data to pay close attention to following areas on the CDS form when completing AVATAR data entry:		

POINTS OF DISCUSSION	1. Provider Relationship: to look at the drop down and enter appropriate information 2. Always use PCP or Medical Staff and go back and correct those that indicate "other". Under provider Title always enter PCP. 3. On "Comments" section to always enter at least the word "PIP". However; if further information is entered, it will be OK ▪ RST's asked county staff if data could be provided in alphabetical order and if they could get a list of clients with documented focus issues that were not in the PIP, Lisa responded that she will send alphabetize, add a worksheet for clients with documented focus issues not in PIP and resend the files as soon as possible. ▪ RST 's reported that consumers participating in PIP are not interested completing the "Referral Form"; however, PSC's will continue to ask consumers about it. ▪ It was reported by RST's that PCP's in the community are not collaborating/coordinating with them when a consumer is referred for medical services. It was discussed the need to follow up with Primary Care Doctors to get training regarding "Coordination of Care" between mental health and medical health. ▪ NGP stated that their Psychiatrists do not have time to contact PCP's ▪ HRC reported that they have been getting back some referral forms from PCP's. Also, HRC asked if the enrollment into the PIP could be done over the phone. ▪ Jesus and Lisa reiterated that it acceptable to do it if needed; however, information must be reflected in Client's Service Plan and in the progress note. ▪ Jesus informed RST's that the chart review will take place within the next couple of weeks at the RST's. All participants provided with dates/times. ▪ Jesus informed that once the chart review calendar is ready, it will be sent out to all RST's	Data staff at each RST will follow these directions Lisa will work on this request Jesus will follow up with Uma and Sandy Damiano Jesus will work on it	
ADJOURN	Next meeting – after Adult PIP Chart Review (TBD)	*Thank you!*	

Minutes taken by: Jesus Cervantes

DIVISION OF BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH
MENTAL HEALTH ADULT PIP

AGENDA

DATE: February 17, 2012
TIME: 10:00 a.m. to 12:00 Noon.
PLACE: 7000 A East Parkway Suite 300
Conference Room 301
Sacramento, CA. 95823

1. Introductions
2. Purpose of the meeting
3. First Chart Review Results
4. Feed back to providers regarding chart review results
5. Next steps regarding future chart reviews and data reports
6. Brainstorming
7. Q & A

SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES
ADULT PIP MEETING MINUTES
FEBRUARY 17, 2012

Participants:

Lisa Sabillo, Jesus Cervantes, Paul Heffner, Melody Boyle, Lyn Place, Alexis Lyon, Sherri Mikel, Wendy Hoffman-Blank, Steve Ballanti.

AGENDA ITEM	POINTS OF DISCUSSION	ACTION NEEDED	DUE DATE
WELCOME	▪ Jesus welcomed meeting participants, introductions were completed, and the agenda and materials were reviewed.	N/A	
REVIEW MINUTES	▪ Minutes from previous meeting (November 18, 2011) were reviewed and approved by attendees.	N/A	
POINTS OF DISCUSSION	▪ Jesus explained that the purpose of the meeting was to look at the December 2011 Chart review results and the AVATAR Data Check-Review from 7-11-11 thru 2-13-12. ▪ Steve B. stated that all RST's are loosing some of their participants in the PIP due to moving out of RST's and or many other reasons. Lisa stated that it is OK and it will not affect the PIP results. ▪ Jesus provided a brief explanation of the chart review process and thanked each RST for their support of the project. ▪ Lisa briefly explained and gave an overview regarding data collected based on AVATAR information as well as chart review.		
POINTS OF DISCUSSION	▪ Lisa described results from chart review emphasizing on the difference between PIP and Non-PIP participants results. ▪ All participants agreed that staff is getting more comfortable entering PIP information into AVATAR, Service Plan, and Progress Notes; however, some improvements are still needed to improve outcomes. ▪ Lisa explained that one of our PIP's goal is for the next chart review to increase to 50% of Total Clients Served with Documented Focus Issues.		

POINTS OF DISCUSSION	▪ Lisa provided individual reports to each RST and in response to requests for an electronic version, Lisa will email chart review results to all participants. ▪ Lisa indicated that PIP "performance indicators" must be reflected in the chart review tool to measure performance level of the PIP. ▪ Jesus informed participants that the PIP performance indicators will be added to the chart review tool and implemented during our next chart review. ▪ Jesus informed participants that due to PIP requirements, the next chart review will take place the last week of March 2012. Jesus asked participants to let him know about potential dates/times to review charts. ▪ Jesus informed participants that he will create a chart review calendar and it will be will be send out to all RST's previous to the chart review. ▪ It was agreed that 50 charts total for RST will be reviewed.	Lisa will send e-copy of the reports. QM will develop the new chart review tool. RST's will provide QM with dates/times for chart review	
ADJOURN	Next meeting – after Adult PIP Chart Review (TBD)	*Thank you!*	

Minutes taken by: Jesus Cervantes

Mental Health Adult PIP Meeting
(Performance Improvement Project)

February 17, 2012

Sign-In Sheet

10:00 a.m. - 12:00 p.m.

#:	Name (Please Print)	Agency	Agency Type: Children/Adult	E-Mail or Phone #
01	Mandy Boyl.	4M - County.		875-6585
02	Paul Heffner	El Hogar	RST	441-3819 x243
03	Lynn Plew	HRC	Adult	485-6500
04	Sherri Mikel	HRC	Adult	485-6500
05	Wendy Hoffman-Black	Visions	Adult	394-0800
06	STEVE BALLANTI	ADULT MH	ADULT PT	875-6164
07	Alexis Lyon	TPCP NGP	Adult	968-3607
08	Lisa Sabillo	SAC Co - DHHS		5-0840
09	Jesus Cervantes	Q-A.		5-9875
10				
11				
12				
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17				
18				

Facilitator: Jesus Cervantes

Mental Health Adult PIP Meeting

(Performance Improvement Project)

April 27, 2012 10:00 a.m. - 12:00 p.m.

Sign-In Sheet

#	Name (Please Print)	Agency	E-Mail or Phone #
01	Lisa Sabatino	SAC Co	875-0840
02	Amanda Divine	EL Hogar	477.7374
03	Paul Heffner	El Hogar RST	441-3819 x243
04	Benice Zabarski	DHHS	875 4131
05	Cynthia Lopez	Visions Unlimited	394-0888
06	Lynn Peace	HRC	485-6500
07	Alexis Lyon	TP NGP	567-4222
08	Kathy Apperman	QM	875-5164
09	Jesus Cervantes	QM.	
10	Mellody Boyle	QM	875-6280
11	Steve Ballanti	Adult MH TFL/QM	875-6181
12			
13			
14			
15			
16			

Mental Health Adult PIP Meeting

Facilitator: Jesus Cervantes

DIVISION OF BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH
MENTAL HEALTH ADULT PIP

AGENDA

DATE: April 27, 2012
TIME: 10:00 a.m. to 12:00 Noon.
PLACE: 7000 A East Parkway Suite 300
Conference Room 301
Sacramento, CA. 95823

1. Introductions
2. Purpose of the meeting
3. Chart Review Results
4. Feed back to providers regarding chart review results
5. Next steps regarding future chart reviews and data reports
6. Brainstorming
7. Q & A

SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES
ADULT PIP MEETING MINUTES
APRIL 27, 2012

Participants:

Lisa Sabillo, Amanda Divine, Paul Heffner, Bernice Zaborski, Cynthia Lopez, Lynn Place, Alexis Lyon Kathy Aposhian, Jesus Cervantes, Melody Boyle, Steve Ballanti.

AGENDA ITEM	POINTS OF DISCUSSION	ACTION NEEDED	DUE DATE
WELCOME	▪ Jesus welcomed meeting participants and introductions were made. Agenda and printed materials were distributed.	N/A	
REVIEW MINUTES	▪ Minutes from previous meeting (February 17, 2012) were reviewed and approved by attendees.	N/A	
POINTS OF DISCUSSION	▪ Jesus explained that the purpose of the meeting was to look at the PIP Data report collected from last chart review for 7/01/11 thru 4/18/12 ▪ Lisa and Jesus explained that results are looking favorable for all providers, and there is significant improvement when entering information regarding Primary Care Providers and Targeted Medical Conditions into AVATAR. ▪ Alex with Turning Point RST reported that Service Coordinators at her agency are responsible fro filing completed CDS and clerical staff enter information in AVATAR. ▪ All providers report they are pleased to see positive results since implementation of the PIP, while acknowledging additional work load for their staff.		
POINTS OF DISCUSSION	▪ Kathy shared importance of the PIP project given future impact it will have on continuation of care. This impact is reported to benefit the clients and families we serve. ▪ Lisa briefly gave an overview of data collection from 7/01/11 thru 4/18/12 and, as in the last report, described results from chart review		

	emphasizing differences between PIP and Non-PIP participant results. ▪ Lisa and Jesus described the importance of paying attention to the PIP indicators obtained during the last PIP review and how the results are improving. ▪ Lisa explained in detail how those indicators were tabulated and interpreted. Lisa responded to several questions raised by providers, and encouraged them to share it with their staff. Providers thanked Lisa for the presentation. ▪ Jesus explained to al participants that the next chart review will take place the last week of July. Also, he informed providers that this time it will be a "full blood" review, and more likely a higher number of charts will be requested from each agency. ▪ Lisa explained that county staff will develop a new "chart review tool" to reflect all PIP indicators, as well as very important information that needs to be included to finalize the Annual PIP report for EQRO. ▪ Lisa and Jesus encouraged providers to continue to enter PIP information in AVATAR until June 30th. ▪ Jesus advised providers that county staff expect to spend at least one full day per agency fro the PIP chart review. Providers report the time needed to review will be fine.		
ADJOURN	Next meeting: TBD	Thank you!	

Minutes taken by: Jesus Cervantes

SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES
ADULT PIP MEETING MINUTES
JUNE 28, 2012

Participants:

Jesus Cervantes, Lisa Sabillo, Melody Boyle.

AGENDA ITEM	POINTS OF DISCUSSION	ACTION NEEDED	DUE DATE
WELCOME	▪	N/A	
REVIEW MINUTES	▪ Purpose of the meeting is to discuss next chart review.	N/A	
POINTS OF DISCUSSION	Following is a description of time lines for the completion of the Adult PIP report. ▪ The first week of July send out email to providers asking for chart review dates ▪ PIP meeting to develop chart review tool on July 11, 2012 ▪ Send PIP client's list to providers the week of July 16, 2012 ▪ Chart review From July 3rd trough August 3rd. (Approximately 6-8 hours per agency) ▪ From August 6th – 10th Data entry	Jesus will send email to providers Lisa, Melody, Jesus Lisa Lisa, Melody, Jesus and 2 more staff Melody, Lisa, Jesus	
POINTS OF DISCUSSION	• From August 13th – 17th Write up Report • August 20th DRAFT of the report to be reviewed by Management Team • Editing of Final report August 24th	Jesus, Lisa, Melody Management Team	

	• Final Report week of August 27t	Lisa, Jesus, Melody	
POINTS OF DISCUSSION	▪ Based on everybody's calendars/meetings/commitments, the following dates are the ones that we are available to review charts: July 23, 24, 30 and 31, August 1, 2 and 3. Once providers select their dates Jesus will let everybody know.		
ADJOURN	Next meeting July 16th	Thank you!	

Minutes taken by: Jesus Cervantes

Mental Health Adult PIP Meeting

(Performance Improvement Project)

12 #5 Entered

Sept 12, 2011

Sign-In Sheet

3:00 - 4:30 p.m.

#:	Name (Please Print)	Agency	Agency Type: Children/Adult	E-Mail or Phone #
01	J. Il Dayton	El Hogar RST	Adult	530. [redacted] 627-0377
02	Terry Nichols	Sacto Co MH	Adult	875-5878
03	Kathy Agosmin	QM	—	875-5164
04	Lynn Place	HRC	Adult	458-6500
05	Jesus Cervantes	Q-M.	Q M.	5-9875
06	Mary DeSouza	QM	QM	876-5128
07	Ima Zyloprn	Adult Program SAC Co	Adult	875-3321
08	Wendy Hoffman-Dunk	Visions	Adult	3947080
09	Lisa Sabo	Sac. OOD	Research	5-0840
10	Ken Smith	El Hogar	Adult	441-0226 202
11	Paul Cecchettini	TPCP	Adult	567-4222
12	Sherri Mikel	HRC	Adult	485-6500 *220
13				
14				
15				
16				
17				
18				
19				

Facilitator: Jesus Cervantes

ADULT PROVIDER MEETING
MONDAY AUGUST 22, 2011
3:00PM – 5:00PM

Please Print

NAME	PROGRAM	JOB TITLE	PHONE	E-MAIL
Jill Dayton	El Hogar RST	Program Dir.	(627-0377	jdayton@elhogar.org
John Hubert	~~HOA MAS~~	Director	(530) 305-5115	John.hubert@uihs.inc.com
Alexis Bernard	Pathways	Program Director	283-8280	alexisbernard@tfcp.org
Lynn Place	HRC	Exec. Director	485-6500	lplace@hrcrsd.org
David Rolston	PA/PG/PC	Sup Deputy	875-3197	Rolstond@saccounty.net
Kevin Henry	Heritage Oaks Hospital	Community Liaison	830-2239	Kevin.Henry@uihsinc.com
Sherri Mikel	HRC	Prog. Coor.	485-6500	Smikel@hrcrsd.org
Terry Nichols	EasttoCo	Prog Coor	875-5878	nicholst@saccounty.net
Dalthell	Ser Co	Exec Dir.	5-1010	—
Jesus Cervantes	Q.M.	Prog. Coord.	5-9875	cervantesj@crcds.org
Karen Brockopp	TLCS	Assoc Director Prog Svs	441-0123 x402	kbrockopp@tlcss.net
Denise Zabosky	Co. MAS	Program	875-4131	Zaboskyd@saccounty.net

ADULT PROVIDER MEETING
MONDAY AUGUST 22, 2011
3:00PM – 5:00PM

Please Print

NAME	PROGRAM	JOB TITLE	PHONE	E-MAIL
Robert Kesselring	El Hogar Guardianship	Program Director	916-440-1500 x120	Same
Rosalen Hanner	DHHS/MA	Program Planner		
MICHAEL LAZAR	TLCS	EXEC DIR	441-0123 x109	MLAZAR@TLCSSAC.ORG
Courtt Telsford	A. Access			
Dennis Dow	SOAR	Admin.	916-216-4370	ddow@telecarecorp.com
Shannan Taylor	SOAR	Clinical Dir.		
Meghan Stanton	CSHC/WRC	Exec Dir.	916.333.3800	
MARIANO	guest	DIR. AFFILIATED SERVICES	916-386-3014	
PAT PRENTICE	SCP			

ADULT PROVIDER MEETING
MONDAY AUGUST 22, 2011
3:00PM – 5:00PM

Please Print

NAME	PROGRAM	JOB TITLE	PHONE	E-MAIL
Paul Cecchettini	TPCP	Dir. of Adult Service	567-4222	paul.cecchettini@tpcp.org
Terry Hunley	Crestwood PHF	Clinical Director	977-0946	thunley@cbhi.net
CAROLIN FUNDERBURG	TPCP	Program Director	393-1222	carolinfunderburg@tpcp.org
RICK PEARSON	PA-PG-PC	Program Manager	875-3687	PEARSONR@SACCOUNTY.NET
Roleder Bates	Visions	Director	394-0800	RBates@V4inc.org
Wendy Hoffman-Ortiz	Visions	Program Manager	"	WHoffman-BL@v4inc.org
Christ DeLaloa	Sierra Vista	Bus Dev Dir.	280-0429	chris.delaloa@dhcs.ca.gov
Angela Green	Sierra Elder Wellness	PD	363-1553	agreen@elnogar.com
Gavin McCluskey	Sierra Vista	Dir. Soc. Ser.	288-0766	gavin.mccluskey@dhcs.ca.gov
Ryan Smith	El Hogar	Clinical Dir	441-0226	rsmith@elhogarinc.org
Marilyn Hilperna	MHA		875-5644	
Stacy Hart	TPCRP	Pgm Director	737-9202	Stacyhart@tpcp.org

DMH

ADULT PROVIDER MEETING
MONDAY AUGUST 22, 2011
3:00PM – 5:00PM

Please Print

NAME	PROGRAM	JOB TITLE	PHONE	E-MAIL
✓ Marlyn Sepulveda	TCORE	Director	247-5516	msepulveda@TCORE.org.
✓ Sue Chow	APCC	Program Manager	383-6784	schow@apccounseling.org

ADULT PIP FORMS USED BY SACRAMENTO COUNTY MHP DURING THE SITE CHART REVIEWS 2011-2012

Case Review PIP: Improvements in Primary Care Access and Treatment for Adults with Serious Mental Illness

Date of Review:	Name of Reviewer:
Agency/Program:	
Client ID:	Client Name:

Identified Medical Issue	Diagnosed (D) or Self Report (S)	Where is Med Issue documented? Check all that apply							
		CDS	ACA	R&R	HQ	Serv. Plan	AMSP	Progress Note	Avatar*

*Medical Issues are entered on pages 2 & 4 in the "Diagnosis" option in Avatar.

Does client have a PCP? IF yes, where is it documented in the client record?	ACA	R&R	Service Plan	HQ	ROI	Med Note	PAF (FSP only)	3M (FSP Only)
Describe:								

Are medical issues followed-up/addressed in client chart?		YES		NO			
If yes, where?	Pg 5 -ACA		Pg1& 4-R&R		ROI's		
	Pg2-Service Plan:		Noted In Progress Notes:		Other:		

Are PCP appointments documented in chart?	YES	NO
If Yes, is there documentation indicating coordination of care?	YES	NO
Comments Regarding coordination of care:		

Additional Comments:

QUARTERLY ADULT PIP CHART REVIEW
7/01/2011 - 9-30-2011

Review the (CDS, Service Plan, and Progress Note) on every chart and complete below form for each client enrolled into the Adult PIP starting July 1, 2011.

DATE: _____ Reviewer:_____

AGENCY: _____

CLIENT'S NAME: _____ ID: _____

In PIP with Focus Issues □Yes **Focus Issues not in PIP** □Yes

Client Data Sheet (CDS) FORM			
Client's Resource (PCP Name)			
Provider Relationship	PCP?	□ YES	□ NO
General Medical Conditions (Please list written)	Primary	Secondary	Terteary

SERVICE PLAN FORM (Page 2 of 3)				
Primary or Specialty Health □ Non Applicable	Note Specific Need	Task	Date Started	Date Resolved

NOTED IN PROGRESS NOTE:			□ YES	□ NO
IF YES, DATE		NEW CLIENT	EXISTING CLIENT	REFUSE HELP

Is PCP referral form in the chart? □Yes □No □ NA

□ In PIP
Start Date:_____
□ Not In PIP

ADULT PIP CHART REVIEW
7/01/2011 - Present (March 3012)

Date: _____ Reviewer: _____ Provider: _____

Client Name: _____ ID: _____ Client is: □New □Existing □Refuses Help

Client Data Sheet (CDS) -Review of most recent CDS (Date of CDS:)

1. Is the PCP name listed in the "Client Resource" field on the CDS?	□YES □NO		
2. Does the "Provider Relationship" field on the CDS show the resource is the PCP?		□YES □NO	
3. Please list the "General Medical Conditions" listed on the CDS	Primary	Secondary	Tertiary
4. Comments:			

Service Plan (page 2 of 3)- Date of Service Plan:

Performance Indicator 2: Client will have PCP information documented in Service Plan (SP)
Performance Indicator 3: Medical conditions will be documented in the Service Plan (SP)
Performance Indicator 7: Coordination of Care will be documented in Service Plan (SP)
5. Write the specific need, task and start date associated with "Primary or Specialty Health" section on page 2

Specific Need	Task	Date Started	Date Resolved	Check if meets Performance Indicator?	Is Start date after the start of PIP date?
				□2 □3 □7	□YES □NO
				□2 □3 □7	□YES □NO

6. □ Check if there are NO specific needs identified in the Primary or Specialty Health section

Progress Notes

Performance Indicator 4: Medical conditions will be documented in the Progress Notes
Performance Indicator 6: PCP appointments will be documented in Progress Notes
Performance Indicator 8: Coordination of care will be documented in the Progress Notes
7. Is there a progress note indicating client was started in the PIP? □YES □NO □NA Date of Note:
8. Review ALL progress notes on or after the start date of the PIP, indicate date of each progress note whether or not the progress note addresses the need/tasks in the SP, and if the progress note relates to a Perf. Indicator.

Date of Progress Note	Does PN relate to need/tasks in Primary or Specialty Health section of SP?	Check Performance Indicator that relates to PN
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care
	□YES □NO	□4- Med Cond □6-PCP Appt □8-Coordination of Care

Is PCP referral form in the chart? □Yes □No □ NA

Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services,
Quality Management Services

Primary Care for Consumers with Mental Health Services

Opportunities and Challenges

Where: Northgate Point RST
601 North Market St., #100
Sacramento, CA 95834

When: Wednesday, September 7, 2011
1:00 – 2:30

Target Audience: Consumers and family members

This workshop will give consumers and family member an opportunity to hear from a primary care doctor about how to better get primary care needs met.

Topics:

- Health care needs for adults with mental health conditions
- Importance of coordination with your mental health provider and your primary health provider
- How to talk to your primary care provider to best get your needs met
- 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

Please encourage available consumers to attend.

For questions, please contact Mary DeSouza, desouma@saccounty.net or (916) 876-5128.

Sponsored by Primary Health Division & Behavioral Health Division

Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services,
Quality Management Services

Primary Care for Consumers with Mental Health Services

Opportunities and Challenges

Where: HRC RST
3727 Marconi Ave.
Sacramento, CA 95825

When: Thursday, February 23, 2012
10:00 a.m.

Target Audience: Consumers and family members

This workshop will give consumers and family member an opportunity to hear from a primary care doctor about how to better get primary care needs met.

Topics:

- Health care needs for adults with mental health conditions
- Importance of coordination with your mental health provider and your primary health provider
- How to talk to your primary care provider to best get your needs met
- 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

Please encourage available consumers to attend.

For questions, please contact Mary DeSouza, cervantesj@saccounty.net or (916) 875-9875.

Sponsored by Primary Health Division & Behavioral Health Division

Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services,
Quality Management Services

Primary Care for Consumers with Mental Health Services

Opportunities and Challenges

Where: VISIONS RST
6833 Stockton Blvd. # 485
Sacramento, CA 95823

When: Thursday, February 24, 2012
12:00 Noon

Target Audience: Consumers and family members

This workshop will give consumers and family member an opportunity to hear from a primary care doctor about how to better get primary care needs met.

Topics:

- Health care needs for adults with mental health conditions
- Importance of coordination with your mental health provider and your primary health provider
- How to talk to your primary care provider to best get your needs met
- 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

Please encourage available consumers to attend.

For questions, please contact Mary DeSouza, cervantesj@saccounty.net or (916) 875-9875.

Sponsored by Primary Health Division & Behavioral Health Division

APS Healthcare
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: January 3, 2012
Title of PIP: Decreasing Child Psychiatric Hospitalization Through The Use of CANS
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 a Children's PIP Committee to develop and implement this PIP. The core committee consisted of County staff representing Program Development and Support (PDS) staff, Research, Evaluation and Performance Outcomes (REPO) staff, and Quality Management (QM) staff. The in-development PIP was presented to representatives from the contracted provider community in a special Provider Input meeting and to members of the Children's Stakeholder Committee at their regular meeting. The input received at both of these venues is included.

County Participants

Kathy Aposhian, RN, Interim Program Manger, Quality Management, Sponsor of the EPSDT PIP Committee
Lisa Bertaccini, LCSW, Chief, Child and Family Mental Health, Chair of the EPSDT PIP Committee
Wendy Greene, MA, Program Manager, Child and Family Mental Health Contracts & Access Team
Lisa Harmon, Program Planner, Research, Evaluation and Performance Outcomes
JoAnn Johnson, Program Manger Cultural Competence and Interim Program Manager Research, Evaluation and Performance Outcomes
Matt Quinley, LCSW, Program Coordinator, Quality Management
Alex Rechs, LMFT, Program Coordinator, Quality Management
Anne-Marie Rucker, MBA, PMP, Program Planner, Child and Family Mental Health
Michelle Schuhmann, LCSW, MPH, Program Planner, Research, Evaluation and Performance Outcomes
Kathryn Skrabo, MSW, Program Planner, Mental Health Services Act
Billee Willson, MBA, Program Planner, Child and Family Mental Health

Provider and Advocate Participation

Rikke Addis, MA, Sacramento Children's Home
Ebony Chambers, Youth Peer Mentor, Stanford Youth Solutions
Teressa Dane, Family Partner, San Juan Unified School District
Belle Darsie, Stanford Youth Solutions
Kimberly, Diggles, Stanford Youth Solutions
Linda Fong-Somera, MPH, Program Planner, First 5 Sacramento Commission

Julie Kauffman, MSW, PPSC, Learning Support Services Specialist II, Sacramento City Unified School District
Pam McPhail, Family Partner, Sacramento Children's Home
Alex Poe, Youth Peer Mentor, Dignity Health
Princess Rehman, Youth Peer Partner, Sacramento Children's Home
Pamela Robinson, Sacramento County Office of Education
Lynette Thorlakson, EMQ Families First
Tina Traxler, River Oak Center for Children
Karen Vang, River Oak Center for Children
Kao Vue, Family Partner, Mental Health America of Sacramento

"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.

In the 2010 and 2011 Performance Improvement Plan, the MHP developed and implemented a performance improvement plan focused on the high cost of hospitalization among the EPSDT clients. While the PIP was not effective is showing a significant decrease in the high costs nor a decrease in the number of high cost clients, the MHP is still concerned with these high cost clients and examined other factors that lead to hospitalization. During the EQRO meetings with the MHP on September 23, 2011, it was suggested the MHP use the Child and Adolescent Needs and Strengths (CANS) data that the MHP had started collecting on a pilot basis with the intensive services programs, Flexible Intergraded Treatment (FIT) and Wraparound to determine if the administration of the CANS assessment would decrease the occurrence of hospitalization and the use of crisis stabilization services and to identify the areas where interventions could be developed to address specific needs and ultimately reduce hospital and crisis stabilization costs.

In the previous PIP, demographic data for high cost clients was displayed of the high cost clients, broken out by the top 25% and the bottom 75%.

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%

Diagnosis and trauma data were presented along with other characteristics such as age, ethnicity, gender, language and substance use. It was noted that the incidence of Bipolar Disorder was slightly higher in the top 25% but the remaining characteristics were very similar.

Since the MHP desires to infuse trauma informed practices system-wide, it is noted that trauma was also slightly higher in the top 25%.

Here's why trauma-informed services make sense: Within a Behavioral Health Department, our target population of adults with a psychiatric disability, children with a serious emotional disturbance, youth and adults with substance abuse disorders, Individuals who receive services in outpatient, inpatient, residential, and crisis settings all have a significant sub-population of clients who have experienced trauma. Whether it is trauma from physical, sexual, or emotional abuse, trauma from witnessing violence at home or in the community, trauma from being removed from a home, trauma from living through a refugee experience, trauma for immigrants acclimating, historical trauma for individuals with long and deep roots tied to the trauma experienced by ancestors, or trauma tied to the stigma of a significant mental health or substance abuse disorder, there is an overarching theme of trauma that is too frequently minimized or ignored in mental health treatment. When trauma is not identified and treated, challenging, internal and external thoughts and behaviors interfere with a client's stability, functioning, and quality of life. In addition to mental health literature that speaks to this, our diverse stakeholder community in the MHSA planning process identified trauma as a key area of unmet needs. It therefore makes sense to adopt systemwide policies that focus on a trauma informed system that is cognizant of its diversity. So that wherever a client presents him or herself - an inpatient setting, a detox program, a children's mental health clinic, trauma is screened for and assessed, with appropriate treatment planning and services provided. In this way, the addressing of trauma can be the platform from which mental health recovery can begin to occur.

In the previous PIP, the workgroup displayed the same characteristics used for High Cost Clients for Wraparound. The Wraparound clients were divided into two groups: high cost and low cost.

Table 2
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		---	---

In this group the diagnosis of Bipolar Disorder fell to the lower cost group while Anxiety, Disruptive Disorders, ADHD and trauma were most common in the high cost group.

Since the diagnosis data differs in each group, the data suggested the MHP look beyond the diagnosis to determine which clients were more likely to be hospitalized or use Crisis Stabilization services. The CANS assessment tool provides data that uses family and youth input in identifying the strengths and needs of the youth. An analysis of the data provided by the tool give the ability to identify action items that have a relationship to hospitalization or the use of crisis stabilization services on a macro level. Action items are items that score in the range that suggests the youth's treatment plan should include a related action.

Given the historical perspective and the data available from the CANS pilot, the workgroup decided to use the CANS data to identify the collection of needs and strengths that have a high likelihood of resulting in hospitalization or crisis stabilization services. It is expected the interventions identified and implemented to prevent future hospitalizations 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?

From the last PIP, "high cost" users of mental health services are defined as youth who are hospitalized one or more times. They were the focus of the previous PIP. The high cost users continue to be a concern to the MHP because of both the excessive cost and the toll that it can take on families. Interventions in the previous PIP focused on referrals to specialized programs; the focus of this PIP has been redirected to integration of existing resources.

Three studies were conducted to understand the causes of hospitalization. The first examined the results of initial Child and Adolescent Needs and Strengths (CANS) assessments as they related to hospitalization. The second piggybacked on the first to look specifically at two areas identified in the study to be high needs areas. The final study compared the hospitalization rate in the first six months of the FIT Program (prior to the implementation of CANS) to a six month period beginning twelve months after the CANS was implemented.

<u>Study 1</u>

Sacramento County Division of Mental Health began preparation for the use of the CANS assessment in February 2010. After nearly a year of planning, the MHP decided to pilot the CANS with its intensive programs: FIT and Wraparound.

The CANS was selected for use in Sacramento County because of its usefulness as a part of the clinical assessment with: a) dual child and family focus, b) individualization (consideration of cultural and developmental factors), c) recovery and strengths based framework, d) family empowerment (caregiver participates in and/or reviews ratings), e)

clear identification of actions items (potential goals), f) holistic approach (facilitates multi-disciplinary approach by assessing multiple areas of a youth's life).

The implementation of the CANS began on February 1, 2011. All new clients admitted in FIT and Wraparound programs after February 1st received an initial CANS assessment and a re-assessment every six months. The existing clients also received a CANS assessment; but for data analysis purposes, it was not considered an initial CANS.

The MHP decided to analyze the CANS data collected for this population to determine if there were specific action items common to those youth who were hospitalized. The data was collected from the CANS assessments administered in the Flexible Integrated Treatment (FIT) and Wraparound programs beginning February 1, 2011.

This study focuses on the FIT and Wraparound clients admitted after January 1, 2011 who received a CANS assessment. The unduplicated clients (889) were then cross referenced for hospitalizations and (Minor Emergency Response Team) MERT visits. (MERT provides crisis stabilization services and for the ease of discussion, references to hospitalizations will include MERT visits for the remainder of this document.) Of these, 137 (15.4%) had one or more hospitalizations and 752 (84.6%) had no hospitalizations

For the 137 youth hospitalized there was a total of 536 hospitalizations; an average of 3.9 hospitalizations per client, with a range of 1 to 18 hospitalizations. The average length of stay in the hospital was 4.5 days, with a range of 0 to 39 days in the hospital.

The MHP decided it was important to identify the areas that youth were struggling with at the time they were hospitalized. Consequently, the focus was narrowed to youth with CANS assessments who were hospitalized 60 days before or after the completion of a CANS assessment. The intent was to identify areas that have higher numbers of action items on the CANS around the time of hospitalization.

There were 93 CANS assessments within 60 days of a hospitalization. The following charts show the action items in the seven areas of the CANS assessment for this sub-group of hospitalized youth and non-hospitalized youth.

Life Domain Functioning

In the Life Domain Functioning section, hospitalized youth had an average of 5.0 action items, whereas non-hospitalized youth had an average of 3.1 action items.

LIFE DOMAIN FUNCTIONING				
0=no evidence of problems, history: 1=mild 2=moderate 3=severe 2 or 3=Action Items				
	Hospitalized w/in 60 days +/- CANS Assessment N=93		Non-Hospitalized N=1080	
	# Action Items	%	# Action Items	%
Family	55	59.1	425	39.4
Living Situation	52	55.9	369	34.2
Social Functioning	49	52.7	374	34.6
Recreational	42	45.2	231	21.4
Developmental	9	9.7	68	6.3
Communication	22	23.7	149	13.8
Judgment	60	64.5	396	36.7
Job Functioning	3	3.2	26	2.4
Legal	17	18.3	109	10.1
Medical	10	10.7	47	4.4
Physical	5	5.4	25	2.3
Sexuality	18	19.4	43	4.0
Sleep	28	30.1	205	19.0
School Behavior	34	36.6	361	33.4
School Achievement	41	44.1	364	33.7
School Attendance	21	22.6	108	10.0

In every area of Life Domain Functioning, the hospitalized youth had a larger percentage of action items than non-hospitalized youth; showing the hospitalized youth had more life functioning needs.

Youth Strengths

In Youth Strengths, an action item is a 0 or 1, which is the opposite of all other domains on the CANS. Action items are the areas where youth have centerpiece or useful strengths to build on.

YOUTH STRENGTHS				
0=centerpiece 1=useful 2=identified 3=not yet identified			**0 or 1=Action Items**	
	Hospitalized w/in 60 days +/- CANS Assessment N=93		**Non-Hospitalized N=1080**	
	# Action Items	**%**	**# Action Items**	**%**
Family	48	51.6	743	68.8
Interpersonal	47	50.5	733	67.9
Optimism	34	36.6	730	67.6
Educational	62	67.7	742	68.7
Vocational	21	22.6	279	25.8
Talents/Interests	59	63.4	776	71.9
Spiritual/Religious	41	44.1	506	46.9
Community Life	45	48.4	557	51.6
Relationship Permanence	58	62.4	719	66.6
Resiliency	44	47.3	683	63.2
Resourcefulness	54	58.1	709	65.6

Hospitalized youth had an average of 5.5 action items, whereas the non-hospitalized youth had an average of 6.6 action items.

In every area of Youth Strengths, the non-hospitalized youth had a greater percentage of action items meaning the non-hospitalized youth had more areas of strength than the hospitalized youth.

Transition to Adulthood

In the Transition to Adulthood domain, hospitalized youth had an average of 1.1 action items, whereas the non-hospitalized youth had an average of 0.4 action items.

TRANSITION TO ADULTHOOD				
0=no evidence of problems history: 1=mild 2=moderate 3=severe 2 or 3=Action Items				
	Hospitalized w/in 60 days +/- CANS Assessment N=93		Non-Hospitalized N=1080	
	# Action Items	%	# Action Items	%
Independent Living	25	26.9	106	9.8
Transportation	14	15.1	64	5.9
Personality Disorder	4	4.3	7	0.6
Parenting Roles	6	6.5	27	2.5
Medication Adherence	13	14.0	29	2.7
Educational Attainment	24	25.8	100	9.3
Financial Resources	19	20.4	97	9.0

The hospitalized youth had a greater percentage of action items in every area; showing they had more transition to adulthood needs than non-hospitalized youth.

Acculturation

In the Acculturation section, hospitalized youth had an average of 0.3 action items, whereas the non-hospitalized youth had an average of 0.1 action items.

ACCULTURATION				
0=no evidence of problems history: 1=mild 2=moderate 3=severe 2 or 3=Action Items				
	Hospitalized w/in 60 days +/- CANS Assessment N=93		Non-Hospitalized N=1080	
	# Action Items	%	# Action Items	%
Language	6	6.5	55	5.1
Identity	5	5.4	52	4.8
Ritual	6	6.5	17	1.6
Cultural Stress	12	12.9	27	2.5

The hospitalized youth had a greater percentage of action items in every area; showing they had more acculturation needs than non-hospitalized youth.

Caregiver Strengths and Needs

In the Caregiver Strengths and Needs section, hospitalized youth had an average of 2.1 action items, whereas the non-hospitalized youth had an average of 1.2 action items.

CAREGIVER STRENGTHS AND NEEDS				
0=no evidence of problems history: 1=mild 2=moderate 3=severe 2 or 3=Action Items				
	Hospitalized w/in 60 days +/- CANS Assessment N=93		Non-Hospitalized N=1080	
	# Action Items	%	# Action Items	%
Supervision	30	32.3	171	15.8
Involvement	12	12.9	65	6.0
Knowledge	22	23.7	140	12.8
Organization	15	16.1	88	8.1
Social Resources	22	23.7	171	15.8
Residential Stability	5	5.4	48	4.4
Physical	14	15.1	86	8.0
Mental Health	17	18.3	93	8.6
Substance Abuse	2	2.2	16	1.5
Developmental	1	1.1	7	0.6
Access to Child Care	9	9.7	79	7.3
Family Stress	38	40.9	325	30.1
Safety	4	4.3	37	3.4

The hospitalized youth overall had a greater percentage of action items in every area; showing they had more caregiver needs than non-hospitalized youth.

Youth Risk Behaviors

In the Youth Risk Behaviors section, hospitalized youth had an average of 2.0 action items, whereas the non-hospitalized youth had an average of 0.7 action items.

YOUTH RISK BEHAVIORS				
0=no evidence of problems history: 1=mild 2=moderate 3=severe 2 or 3=Action Items				
	Hospitalized w/in 60 days +/- CANS Assessment N=93		Non-Hospitalized N=1080	
	# Action Items	%	# Action Items	%
Suicide Risk	42	45.2	53	4.9
Self Mutilation	22	23.7	28	2.6
Other Self Harm	14	15.1	59	5.5
Danger to Others	32	34.4	154	14.3
Sexual Aggression	9	9.7	26	2.4
Runaway	13	14.0	79	7.3
Delinquency	9	9.7	63	5.8
Fire Setting	3	3.2	29	2.7
Sanction Seeking Behavior	23	24.7	157	14.5
Bullying	15	16.1	105	9.7

In every area of Youth Risk Behaviors the hospitalized youth had a greater percentage of action items than non-hospitalized youth meaning hospitalized clients presented with more risk behaviors.

Youth Behavioral/Emotional Needs

In the Youth Behavioral/Emotional Needs section, hospitalized youth had an average of 4.1 action items, whereas the non-hospitalized youth had an average of 2.4 action items.

YOUTH BEHAVIORAL/EMOTIONAL NEEDS				
0=no evidence of problems history: 1=mild 2=moderate 3=severe 2 or 3=Action Items				
	Hospitalized w/in 60 days +/- CANS Assessment N=93		Non-Hospitalized N=1080	
	# Action Items	%	# Action Items	%
Psychosis	15	16.1	19	1.8
Impulse/Hyper	47	50.5	450	41.7
Depression	59	63.4	296	27.4
Anxiety	51	54.8	354	32.8
Oppositional	53	57.0	475	44.0
Conduct	24	25.8	147	13.6
Adjustment to Trauma	42	45.2	304	28.1
Anger Control	60	64.5	501	46.4
Substance Use	15	16.1	51	4.7
Eating Disturbance	12	12.9	38	3.5

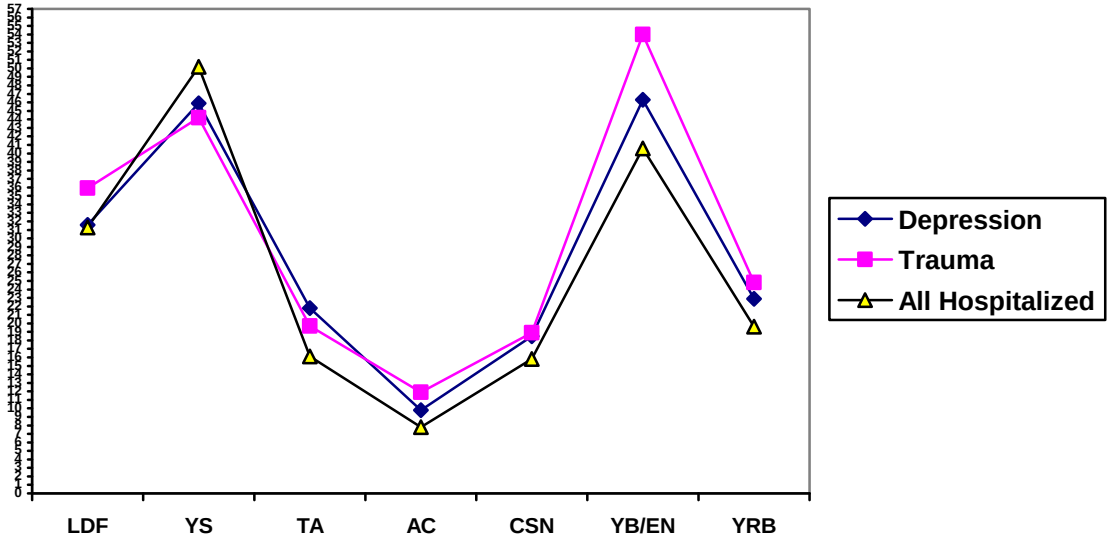
It was the intent of the MHP to use this information in the future to identify, at the time of a new assessment, youth at risk of hospitalization who need to be targeted for specific interventions. However, from the data collected it was found the hospitalized youth had a greater percentage of action items in every area showing they had more behavioral/emotional needs than non-hospitalized youth.

Overall, the CANS provided the evidence and detail to support the already known principle that youth with higher needs and less strength are more likely to be hospitalized than those possessing more strengths and fewer needs. While this outcome is to be expected, the detail of the needs and strengths areas in the CANS assessment allows the MHP to further focus on specific areas and provides support for the development of interventions to support the youth and families.

Study 2

Two particular areas of interest to the MHP resulting from the initial study are Depression and Adjustment to Trauma. The data was further analyzed for youth with action items of Depression and Adjustment to Trauma in the Youth Behavioral/Emotional Needs domain. This decision was made because there was an 131.4% increase in Depression and a 60.9% increase in Adjustment to Trauma for youth who had been hospitalized compared to those who had not.

The chart below displays the data that shows youth who have action items for Depression and Adjustment to Trauma have more needs and fewer strengths in every domain measured by the CANS when compare to all of the youth hospitalized.



Study 3 - Pre/Post CANS Analysis

Concerns raised during the course of the PIP planning moved the MHP to conduct another analysis to determine if the act of administering CANS assessment alone would impact the hospitalizations. Data for two time periods were analyzed: July to December 2010 and January to June 2012.

	2010		2012	
	All	**Unduplicated**	**All**	**Unduplicated**
FIT & WRAP	1028	996	833	864
Hospitalizations	151	67	129	69
Percentage	14.7%	6.7%	14.6%	8.0%
Difference			0.7%	19.4%

The study shows no decrease in hospitalizations and a slight increase in the percentage of unduplicated youth hospitalizations. It is evident that the CANS assessment alone did not reduced hospitalizations in this time period.

In an effort to further understand the role of trauma in relationship to hospitalization and to understand how trauma is related to the other high need areas identified in the initial study of literature associated with trauma treatments was sought out. The literature consulted gave the following information:

- Children subjected to severe maltreatment frequently present with other psychiatric disorders, such as depression and anxiety, and may at times manifest symptoms consistent with others, including ADHD and Pediatric Bipolar Disorder (NASMHPS/NTC, 2004)
- There is also misdiagnosis, which occurs when other psychiatric disorders are inaccurately diagnosed, based on over lapping symptoms and the lack of trauma as a diagnostic reference point. The following generalizations are made in the joint NASMHPS-NTAC Report:
    - The role of trauma frequently goes unrecognized. One example involves the child whose depression is missed, due to the prominence of trauma-related externalizing behaviors.
    - Internalized responses by females may involve social withdrawal and lack of response to adult efforts at engagement. More severe responses include depression, dissociative reactions, self-injurious behaviors, and suicidality.
    - Males also withdraw and become depressed, but rarely will acknowledge depression.
- Posttraumatic Stress Disorder (PTSD) is not the most common psychiatric diagnosis in children with histories of chronic trauma. However, because there currently is no other diagnostic entity that describes the pervasive impact of trauma on child development these children are given a range of “comorbid” diagnoses. By relegating the full

spectrum of trauma-related problems to seemingly unrelated "comorbid" conditions, fundamental trauma-related disturbances may be lost to scientific investigation, and clinicians may run the risk of applying treatment approaches that are not helpful. (van der Kolk, B.A., 2005)

The literature consultation suggests there is a relationship between other high need areas related to hospitalization, identified in the initial study, and to trauma.

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

The PIP workgroup presented Study 1 and Study 2 to the FIT and Wraparound provider representatives and members of the Children's Stakeholder Committee (a group that represents internal and external partners). In these meetings, the barriers for the use of CANS in reducing hospitalization were identified. They included the perceived failure on the part of some clinicians to integrate the CANS assessment into treatment planning and the lack of understanding by family partners and youth peer mentors concerning the usefulness of the CANS assessment. These are barriers that require system interventions.

While there was active support from the provider group for development of trauma informed treatment, they felt their staff needed more options for the treatment of trauma. The lack of options for treating youth with adjustment to trauma issues is a barrier for providing trauma informed treatment modalities.

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Lack of integration of CANS in treatment planning	Pre/Post CANS Analysis showing no reduction of hospitalization and provider feedback.
Families and Advocates not always understanding CANS assessment.	Provider feedback.
Adjustment to Trauma is a specific area that needs further treatment options.	Provider feedback.

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.

Can CANS data be used to identify clients with needs that correlate to hospitalization or MERT usage so that subsequent (new and continuing) CANS assessments can be used to focus on interventions to prevent hospitalization and use of MERT?

Is the Adjustment to Trauma element useful in correlating trauma to hospitalization or MERT usage or suggesting the need to adopt the Trauma Module in CANS?

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

No. Currently the CANS assessment is being piloted with all FIT and Wraparound beneficiaries. The roll out of the CANS instrument to all Sacramento County Children's Mental Health beneficiaries is tied to the Avatar Clinical Workstation rolling implementation beginning in calendar year 2012. These beneficiaries are not included in this PIP.

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

In the first year of CANS implementation with FIT and Wraparound providers, there were 889 unduplicated youth served in the program (admitted after January 1, 2011).

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

Currently, all FIT and Wraparound clients, who also have a completed CANS assessment, will be included in the collection of data. Those clients will be broken out into four categories, those who have been hospitalized versus those who have not and within each of those groups, those who have identified Adjustment to Trauma as an action item and those who have not.

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

A sampling will only be used for the non-hospitalized clients for chart review purposes, due to the large number of beneficiaries in this group.

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

The non-hospitalized clients who are sampled for chart review will be 5%, which is approximately 50 clients and is slightly more than the hospitalized clients with Adjustment to Trauma (42).

"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?

As outlined in section three, reduction of hospitalizations is the primary goals. Both are very high cost services and are disruptive to the lives of youth and families. It is hoped that by reducing both the number of youths hospitalized and the duration of their hospitalizations costs will be decreased and the lives and function of youth and caregivers improved.

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	Number of Hospitalized Clients	Number of FIT & Wrap Clients with Hospitalizations (201)	Total number of FIT & Wrap Clients (972)	Percent of Unduplicated Clients Hospitalized (20.7%)	5% Decrease (19.7%)
2	Number of MERT Clients	Number of FIT & Wrap Clients with MERT Usage (54)	Total number of FIT & Wrap Clients (972)	Percent of Unduplicated Clients with MERT Usage (5.6%)	5% Decrease (5.3%)
3	Length of Hospital Stay	Total Number of Days in Hospital (2,419)	Number of FIT & Wrap Hospitalizations (536)	Average Number of Days in Hospital (4.5)	5% Decrease (4.3 days)
4	Number of Clients Hospitalized or using MERT more than one time	Number of clients with more than one hospitalization or MERT visit (122)	Total number of FIT & Wrap Clients (972)	Percent of Clients Hospitalized or using MERT more than one time (12.6%)	5% Decrease (11.9%)

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.

The interventions selected are directly related to the barriers that hinder the CANS from being used to reduced hospitalization and developing staff skills in treatment of trauma. The first two interventions will support both the clinician and the family partner or youth peer mentor in using the CANS assessment to support the treatment planning and service delivery.

The chart reviews will occur twice, once in the first quarter of FY 12/13 and a year later in the first quarter of FY 13/14. The first chart review will establish a baseline and the second will measure the effectiveness of the interventions.

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	Expanded training on CANS utilization for clinicians	• Lack of integration of CANS in treatment planning	
2	New training on CANS assessment for Family Partners and Youth Peer Mentors	• Family partner and youth peer mentor involvement in CANS process and utilization	
3	Implement CANS Trauma Module	• Provide specific information on the trauma type to be treated	
4	Chart Reviews for four groups (Hospitalized vs. Non-Hospitalized and Adjustment to Trauma identified vs Non)	• Identify what services and resources are currently being used when a client has Trauma marked as a need • Measure the changes resulting from applied interventions	August and September 2012 & July to September 2013

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

11. Describe the data to be collected.

Clients served by FIT and Wraparound programs will have CANS assessment data and any relevant hospitalization data collected to understand the impacts of training provided and the implementation of the Trauma Module. In addition, a chart review tool will identify whether or not the CANS assessment was used in developing the treatment plan. The tool will also include: modality changes, diagnosis, medications and living situations. This data will be collected for four groups. The two categories are all hospitalized and a sample of non-hospitalized. Both categories will include clients with Adjustment to Trauma identified and clients without Adjustment to Trauma identified for a total of four groups.

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.

The Hospitalization data is gathered through Sacramento County's existing data information system, Avatar. CANS data is collected from FIT and Wraparound programs via a Sacramento County created Access database. Data is submitted biannually by the providers. Once the Clinical Workstation is rolled out, CANS data will be accessible via Avatar.

Chart Reviews will be conducted by Quality Management (QM), REPO and Children's Mental Health staff at the provider sites. All files of FIT and Wraparound clients who were hospitalized and a 5% sampling of the non-hospitalized clients will be conducted using a chart review tool designed for this data collection activity.

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

At the end of one year following the implementation of the PIP, data will be summarized and analyzed for trends and relationships. Data collected on all clients included in the PIP will be analyzed against performance indicators to measure improvement.

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

The Research, Evaluation and Performance Outcome (REPO) staff are responsible for collecting the data from the agency and extracting Avatar information system data have at least a BA degree in Psychology, Social Services or other related fields and have been analyzing and reporting on data for the REPO unit for over seven years. The REPO staff has received

continuous training on data analysis and performance outcomes. Quality Management staff will conduct the chart reviews and have a Master's degree and are licensed in a field of clinical work and extensive experience in chart reviews.

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?