



Final Report

CAEQRO Report, FY10-11

San Diego

Conducted on

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❖ INTRODUCTION ❖

BACKGROUND AND METHODOLOGY

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

This report presents the fiscal year 2010–11 (FY10–11) findings of an external quality review of the San Diego County mental health plan (MHP) by the California External Quality Review Organization (CAEQRO), a division of APS Healthcare, from February 9-11, 2011.

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

- Changes, progress, or milestones in the MHP’s approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for Key Components associated with the four domains: quality, access, timeliness, and outcomes. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups and other stakeholders serve to inform the evaluation within these domains. Detailed definitions for each of the review criterion can be found on the CAEQRO Website www.caeqro.com
- Analysis of Medi-Cal Approved Claims data
- Two active Performance Improvement Projects (PIPs) – one clinical and one non-clinical – to include the state-required PIP focused on EPSDT youth and another PIP of the MHP’s selection
- Four 90-minute focus group with beneficiaries and family members
- Information Systems Capabilities Assessment (ISCA) V7.1

❖ FY10–11 REVIEW FINDINGS ❖

STATUS OF FY09-10 REVIEW RECOMMENDATIONS

In the FY09-10 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY10-11 site visit, CAEQRO and MHP staff discussed the status of those FY09-10 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 FY09–10

- Continue to monitor and analyze access, retention, and utilization patterns to address any service inequities to consumers with lower approved claims:

<input checked="" type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
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- The MHP completed an update to its Cultural Competence Plan (CCP) as required by the State that includes an analysis of access, retention, and utilization patterns used to address service inequities for consumers.
- The MHP completed an analysis of service disparities based on lower approved claims amounts for CY08 which was the last year of approved claims data provided

- by CAEQRO. Findings include the penetration rate (PR) for older adults, Hispanic, and Asian/Pacific Islander (API) populations that is below the MHP-expected prevalence rate of 8% and that improvement in retention is needed for foster care youth beyond four services.
- With 31% of adult consumers identifying Spanish as preferred language, the MHP identified the need for 245 language proficient providers and difficulty filling licensed bilingual positions. The MHP did not report the number/percentage of current Spanish speaking staff. The MHP reports that Latino 0-5 years and older adults are underserved and that there is poor engagement with 13% of adults and 12% of children receiving one visit only.
 - The MHP displayed comparison pie graphs of percentages of race/ethnicity of county population versus percentages served by the MHP. The MHP identified access, cognitive, affective, and value barriers to help-seeking behaviors. The MHP also identified barriers unique to Latino/Hispanic, Native American/Alaskan Natives, and Asians. The MHP identified factors influencing high utilization in African-Americans. Strategies to increase utilization and retention among different ethnicities were also identified.
 - The MHP continues its goal of serving 2% of the county population. The MHP started monitoring this indicator in FY05-06 and recorded a service provision of 1.81%. In FY09-10, the MHP provided services to 61, 219 consumers or 1.92% of the population.
 - Continue to address high 24-hour service and high cost, emergency services for consumers through data analysis and QI processes:

<input checked="" type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
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 - The MHP is involved in a High Utilizer Project with Health and Human Service Agency (HHSA) that is addressing high levels of utilization across mental health, alcohol and drugs, physical health, emergency rooms, and the jail. This project will identify 50 top utilizers across all systems that meet a vulnerability index and will offer them services and housing.
 - The MHP has implemented a new program, Bridges to Recovery, that utilizes peers to work with individuals who are utilizing the Emergency Screening Unit (ESU) with mental health symptoms and a primary substance abuse problem to help them connect to Alcohol and Drug Services (ADS) programs.
 - The MHP is working on a Readmission Study through the University of California, San Diego (UCSD) Health Services Research Center.

- The MHP continues to track the number of monthly hospitalizations for FFS hospitals for adults and minors and numbers of readmissions within 30 days on the MHB Dashboard Indicators Report. OptumHealth continues to provide monthly reports on hospital average length of stay (ALOS) for acute and administrative days for adults and minors.
- Implement the previously developed business strategy that permanently retains InSyst archival data:
 - Fully addressed Partially addressed Not addressed
- The MHP business strategy is to maintain InSyst in an available status, but powered down when not needed, until all State Cost Report audits are settled for InSyst service and claims data.
- Once the InSyst system is no longer needed the MHP will consider moving archival data to some type of data warehouse.
- Review current protocols on the use of Anasazi data to ensure that the MHP is fully taking advantage of the expanded and rich dataset:
 - Fully addressed Partially addressed Not addressed

In addition to the standard Anasazi reports the MHP has developed additional reports using an expanded dataset. The following are some examples:

- New reports have been developed that focus on service units for both program use and Cost Reports.
- Productivity reports have been developed and are operational.
- No Show reports have been developed and are operational.
- Clinical assessment data has been collected system wide for over a six-month period. The MHP is developing a plan to use the collected assessment data.
- Automate the dashboard indicator report production process:
 - Fully addressed Partially addressed Not addressed
- The MHP has made many reports easier to locate by setting up a Shared Folder that can be accessed through a desktop icon short cut.
- The MHP has begun the process of developing strategies to automate dashboard indicator reporting. The project is not currently a priority.

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.

- Live Well San Diego. The MHP is participating in a county wide 10-year strategic initiative with the county's Health and Human Services Agency (HHS) called "Building Better Health" through the vision of "A County that is Healthy, Safe, and Thriving". The initiative which started in 2010 targets poor nutrition, lack of physical activity, and tobacco use contributing to diseases related to deaths of 50% of the population. Strategies include promoting a medical home, integrated services, stigma reduction, community partnerships, disease management, and foster care coordination.
- Medicaid Section 1115 Demonstration Waiver. San Diego has elected to participate in the model waiver proposal that includes Medi-Cal Coverage Expansion to low income residents that will help the state transition to the federal reforms that take effect in January 2014.

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	A current strategic plan/initiatives drives the service delivery system	X			
1B	Quality management and performance improvement are organizational priorities	X			
1C	Data is used to inform management and guide decisions	X			
1D	Investment in information technology infrastructure is a priority	X			
1E	Integrity of Medi-Cal claim process, including determination of beneficiary eligibility and timely claims submission		X		
1F	Effective communication from MHP administration		X		
1G	Stakeholder input and involvement in system planning and implementation				X
1H	Consumers and family members are employed in key roles throughout the system		X		

Issues associated with the components identified above include:

- 1A. The MHP has a Behavioral Health Services Strategic Plan. Stakeholders are included in the development of the Plan. Initiative examples include:
 - “It’s Up To Us” Campaign to reduce stigma, The Housing Matters Campaign, and the Fotonovela Campaign.
 - The Behavioral Health Services (BHS) Initiative to integrate alcohol, drug, and mental health services continues.
 - Electronic health record (EHR) implementation continues.
 - Five Behavioral Health and Physical Health Integration Projects continue.
 - Transitioning Long Term Care to Skilled Nursing Facilities was completed in FY 09-10.
 - Regionalizing walk-in urgent care for Adult/Older Adults and TAY was completed in the Fall of 2010.
 - Developing a Program Evaluation process to address budget cuts was completed and is being reviewed by stakeholders.

- The MHP is reviewing Laura's Law for possible implementation in San Diego County.
- 1B. The MHP has a FY 10-11 QI Work Plan with measurable goals and objectives, and an annual evaluation of FY09-10 activities and indicators. The MHP has a functional Quality Review Council. The MHP submitted minutes for five meetings in 2010.
- 1C. Data is used to inform management and guide decisions. The MHP monitors quality indicators, consumer outcomes, measures progress towards goals, and reports findings for reviews
- 1D. The MHP continues to contract with UCSD - Child and Adolescent Services Research Center (CASRC) and UCSD – Health Services Research Center (HSRC) who provide data reporting and analysis support.
- The MHP's MHSA technology plan was developed, submitted, and approved by State DMH. The MHP is in the process of implementing a number of these technology projects.
- 1E. The MHP elected to submit Medi-Cal claims more than once a month, but less than weekly. Despite challenges with Short-Doyle Phase II implementation, the MHP's claim submissions during CY2010 have been somewhat consistent, but not timely as measured by Medi-Cal approved claims and revenue produced by State DMH.
 - A significant portion of unbilled Medi-Cal services can be attributed to Short-Doyle Phase II implementation challenges faced by all MHPs. It is anticipated that by July 2011 most Medi-Cal claims for FY10-11 will have been submitted to the State for adjudication.
 - The MHP's Medi-Cal claim denial rate was well below the median for FY08-09 (ranked 50).
- 1F. The MHP has many processes for regular ongoing communication in a variety of modes and venues. Line staff and managers report effective two-way communication and feel that their concerns are heard.
- 1G. Consumer and family member involvement.
 - The central advisory body for children's services continues to be the Children's Mental Health Services System of Care (CSOC) Council. The Family/Youth Liaison (FYL) program coordinates family youth professional partnerships in Children's Services and works closely with MHP administrative staff to ensure that family and youth voice and values are incorporated into MHSA services. The FYL conducted eight focus groups on the development of PEI programs, targeting Native American, African American, Hispanic/Latino, Asian/Pacific Islander, Refugee/Immigrant, Lesbian, Gay, Bisexual, Transsexual and Questioning

(LGBTQ) populations. During FY09-10, the FYL also conducted MHSA Innovations Plan Review forums.

- In order to provide feedback and recommendations to the Mental Health Director on the design and implementation of new MHSA programming in the Adult/Older Adult Mental Health System of Care (ASOC), the following bodies were established early on in the MHSA CSS planning phase: the Adult Mental Health System of Care Council, the Older Adult Mental Health System of Care Council, the Mental Health Services Housing Council, and the Transition Age Youth (TAY) Workgroup.
 - Program Advisory Groups (PAGs), composed of at least 51% mental health consumers and/or family members, are a required program component for Outpatient Programs. PAGs, which are ideally facilitated by peers/family members, provide feedback and ideas to mental health programs about improving recovery services. Through Recovery Innovations of California (RICA), PAGs have established implementation guidelines across the ASOC.
 - The MHP's Quality Review Council involves a culturally diverse and representative group of stakeholders including community mental health organizations, clients and family members, service providers, client run services, and educational organizations. The Council makes recommendations to Mental Health Administration through the Director of Quality Improvement.
 - RICA conducts many local consumer meetings and holds monthly regional meetings on what is working and not working in service delivery. The Chief of Adult/Older Adult Services attends the monthly regional meeting to hear issues and concerns and follow up with feedback. For example, RICA held a focus group in the North Central area, to obtain input and feedback on the design of a consumer engagement program that would be an alternative to Laura's Law. The FYL Roundtable provides similar input from consumers and family members on children's services.
- 1H. The MHP has developed consumer and family positions through contract programs. A Family Liaison attends executive meetings of the MHP. With the Children's system primarily contracted, the MHP reports that 23 contract organizations employ 85.2 Parent and Youth Partners. The Family and Youth Roundtable (FYRT) is a family and youth led organization that provides system navigation, training, coaching, consultation, and peer support. FYRT

has engaged over 652 families and youth in the past year. FYRT’s Family Youth Professional Partnership Training Academy provides parent and youth partners with supervision, training, and training for professionals on how to work with consumer/family member employees as co-workers.

- Recovery Innovations of California (RICA) is a peer-run contractor that provides recovery services for adults with COD, peer training and employment, and classes in WRAP, Wellness, and Medication for Success. Peer Liaisons carry community feedback to the MHP after gathering information by attending up to 20 monthly meetings held by the MHP. RICA holds the annual Wellness and Recovery Summit in March which has been attended by over 1,000 individuals. There are 13 clubhouses for MHP consumers that are mostly consumer-run.

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 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:

- 2A. The MHP assesses the cultural, ethnic, racial, and linguistic needs of its eligibles, and implements strategies to address the needs of eligibles. While the MHP has evaluated many strategies, it has not compared results or trended outcomes over time.

- The MHP developed a Fotonovela Campaign in 2010 to engage Latino families. The fotonovela is called *Salir Adelante: Como una familia aprende sobre la salud mental* (Moving Forward: How a Family Learns About Mental Health). The fotonovela is published in Spanish and English in one booklet and is available at the San Diego County Library and its 33 branches among other sites.
- As part of the MHA's Breaking Down Barriers work group, in July 2009, the group completed "Addressing Barriers to Mental Health Services for Native Alaskan and Native American Populations in San Diego County". The report identified issues such as inconsistent care due to intern turnover and only 1.5 therapists for a population of 45,000 (with a particular need in the Eastern region), the need for services for addressing multiple traumas, and the need to address the collective cultural frame of reference rather than individual. The report gave six recommendations, including:
 - Create crisis teams and follow up
 - Provide case management teams that link consumers to food and housing.
 - Provide coordination of care by the service provider.
 - Provide transportation to services
 - Collaborate with law enforcement on cultural competency development
 - Combine traditional medicine with western medicine.
- "Addressing Barriers to Mental Health Services..." for military populations participating in the global war on terrorism was completed in 2009 and for LGBTQ populations was completed in 2010.
- The FY09-10 QI Work Plan Evaluation included the strategy of increasing access to services for all ethnic/racial groups and females by implementing the MHSA program to provide more mental health services in community clinics. Another strategy was to provide linguistically and culturally appropriate services in settings that are more acceptable to ethnically diverse individuals and have less stigma associated with them, such as primary care clinics and school-based programs.
- Of 30 PEI programs started in FY09-10, some highlights include:
 - The Alliance for Community Empowerment provides a community violence response team and services to siblings of

- identified gang members in an effort to increase community resiliency and combat the negative effects of violence.
- Teen Recovery Centers across the county providing AOD and COD treatment and recovery services.
 - Kick Start: Services for individuals at risk for developing or experiencing a first break of serious mental illness that includes outreach, education, and intervention.
 - South Region Trauma Exposed Services: provides services and referrals to prevent re-traumatization of children and families who experience trauma related to exposure to domestic and/or community violence.
 - Bridge to Recovery provides early intervention services to individuals presenting at crisis emergency facilities who have high substance use issues and early mental health concerns.
- 2B. Capacity. The MHP assesses, identifies, and implements strategies to adapt capacity to meet service needs. The MHP is beginning to evaluate those strategies as budget limits and system demand and flow changes.
- The MHP uses service utilization and wait times data to assess and monitor system flow and identify capacity problems. Contractors submit monthly status reports to managers that includes numbers of admits, discharges, active and year to date caseload sizes, and number of referrals.
 - The ASOC improved capacity and shortened wait times by changing to a walk-in clinic service delivery model and increasing referrals to primary care through primary care partnerships with paired clinics. The ASOC conducted a system transformation on access that includes walk in capacity. The MHP provides a half hour triage by a licensed clinician with risk-based prioritization of service need. If needed, the consumer can be seen by a psychiatrist the same day and receive a full assessment within one week. Walk-ins have been monitored in the past year. Out of 6,861 individuals served, 55.2% were admitted to MHP services, 18.9% were deemed urgent, and 18.6% were referred to a primary care clinic.
 - The MHP is starting to track the percentage of consumers who have primary care physicians in the electronic health record (EHR) through the initial assessment. An effort to collect baseline data resulted in a low number (about half) which is thought to be related to problems in making it a required field of the assessment and the 400,000 historical consumer records that were transferred over from the InSyst system.

- Nineteen participating mental health clinics have been paired with 22 primary care clinics (mostly FQHCs) through MOUs in an effort to link individuals to a patient-centered medical home and reserve specialty mental health services through the MHP for SPMI and SED consumers. Some primary care clinics have behavioral health providers and the MHP has used MHSA funds to create IMPACT programs for depression, promotoras, and other integrated services over the past five years.
- In this population management effort, the MHP and primary care (PC) partners have worked on team relationship building consisting of many meetings, guideline and form development, trainings, and sharing of point of contact and phone numbers. The MHP has provided training for primary care providers and office staff on destigmatization and working with the mentally ill. The MHP provides consultation to PCPs and ensures that consumers can go back and forth between the MHP and PC as needed. The MHP has learned that it is important to manage expectations by educating the consumer that access to a PCP will not be as fast as the MHP (same day), that MHP program managers must build relationships with primary care providers they refer to, and staff must ensure that sufficient information goes with the consumer who is referred. Over 200 consumers have been successfully referred to primary care. The MHP tracks PC acceptance through a completed form that PC can email back to the MHP.
- The CSOC improved capacity by changing to a short-term model of treatment. The MHP collected the average session estimates for nine empirically supported treatments and found the most clinical improvement between 13 and 20 sessions. The MHP assessed individual consumer outcomes through the CANS and CFARS and found that while consumers were being treated for longer periods of time, there was not much improvement after six months of treatment. The MHP has moved to a short-term approach and conducts more intensive utilization review after six months of treatment. A focus on more effective treatment through evidence based practices (EBP) and internal contractor training has resulted in most contractors now using EBP treatments. In addition, the average wait time for a routine appointment decreased from 5.1 days in FY09-10 to 4.0 days in FY 10-11.
- 2C. The MHP monitors penetration rates (PR) to measure uneven access and to improve access. A goal of the QI Work Plan is to provide services to 2% of the county population. FY09-10 evaluation found that the MHP served 61,219 consumers or 1.92% of the county population. The MHP has identified disparities within target populations, Medi-Cal, and 200% of poverty by age

and ethnicity. The MHP has identified a need for language proficient providers as a result of the analysis.

The MHP has not analyzed penetration rates of cross departmental consumers in need of mental health services such as those served by the justice system, primary care, social services, or schools.

- 2D. Integration and Collaboration. The MHP has worked on improving service coordination and integration among alcohol, drug, and mental health services providers in its Behavioral Health Services (BHS) Initiative since 2005. In FY09-10, the MHP continued to develop and track outcomes for individuals with co-occurring substance abuse disorders (COD) and complete the annual evaluation report on COD consumer outcomes, established integrated quality improvement activities, and integrated BHS data units under one manager.
- Primary Care Integration
 - Mental Health and Primary Care Integration Project via contract with Community Clinics Health Network (CCHN). CCHN manages nine community health center corporations at 16 sites to provide age-appropriate mental health services to unserved and underserved individuals within a physical healthcare environment under two treatment models.
 - Specialty Pool Services (SPS) includes assessment, therapy, and medication management for seriously mentally ill/seriously emotionally disturbed (SMI/SED) individuals.
 - Improving Mood Promoting Access to Collaborative Treatment (IMPACT) is an EBP for the treatment of depression. Treatment includes Behavior Activation, Pleasant Activity Scheduling, and Problem Solving Therapy provided by a Depression Care Manager (DCM), combined with medication management by a Primary care Provider (PCP). Currently 11 DCMs are employed by seven clinic organizations to provide IMPACT services for SMI adults/older adults. CCHN has also implemented Promotoras.

CCHN coordinates training, both in-person and via Webinars, to train both behavioral health staff and physical health staff to understand their contribution to the care of these individuals.

- East County Integrated Health Access Pilot – this pilot referred existing East County Mental Health Clinic (ECMHC) consumers using the Health Strategy Agenda 3-4-50 parameters (the healthcare concept that three behaviors lead to four chronic diseases attributed to more than 50% of all

deaths) to address their qualifying physical health needs at East County physical health clinics. The data that shows that SMI consumers have a shorter life span by 25 years than non-SMI individuals, mainly due to the lack of basic physical care, provided the basis for this pilot. To assist these consumers to access care at physical health clinics, a HSS staff stationed at ECMHC provided each consumer referred with an initial County Medical Services (CMS) intake process and approval as appropriate. This process of providing an in-office eligibility assessment greatly shortened the usual timelines involved, reduced the stress for ECMHC consumers, and helped to increase the communication of information between ECMHC and area physical health care providers. This pilot began in October 2009 and ended in September 2010. Several consumers demonstrated markedly improved personal physical parameters with the opportunity and encouragement to seek proper care.

- Rural PEI – Vista Hill Foundation project provides integration of medical and preventive behavioral health care in a rural setting for traditionally unserved/underserved individuals. The project will assist to establish a medical home for those served as well as reduce the stigma associated with seeking these services by promoting environmental changes within the clinics. Outreach and educational opportunities in the communities are expected to extend the reduction of stigma related to behavioral health issues.
- Physical Health Integration Pilot with Family Health Centers of San Diego (FHCS) via MHSA Innovations contract will provide for a fully integrated medical and behavioral health treatment by a local FQHC. The FQHC, FHCS, will share SMI consumers with a County mental health provider and provide appropriate medical and behavioral health care as appropriate. This pilot will provide for increasing access of SMI clients to medical care.
- Project Enable will allow a medical health care provider located in the same complex as a mental health care provider to share consumers and provide appropriate medical care.
- The MHP reported that in FY09-10, programs began working on pairing with FQHCs for physical health care for consumers and regional integration collaboratives were formed or continued.
- FY10-11 goals include:
 - Developing additional support for HHSA Initiative “Building Better Health”

- Developing new system to increase healthcare coverage for indigent consumers in coordination with HHSA- County Medical Services and begin to plan for system changes related to Medi-Cal Coverage Expansion (MCE) and 2014 Health Care Reform plans.
- First Five, CWS, and the MHP collaborated on KidSTART Center with a contract to Rady Children’s Hospital of San Diego that opened in July 2010. See section on “Clinical PIP” for further information.
- Justice System Collaboration
 - The MHP continues its five-year history of FSPs for adults that include a probation officer on the team to coordinate with contractors on legal issues. One FSP team is focused solely on consumers coming out of the jail and related best practices.
 - UCSD, Probation, Jails, and the MHP collaborated on a study of jail data that included inpatient and outpatient treatment. The data analysis is being used to plan the new In Home Outreach Team (IHOT) program along with the Psychiatric Emergency Response Team (PERT) that will target consumers with Schizophrenia and Bipolar Disorder who are resistant to treatment and are not in mental health services.
 - MHP children’s staff and contractors provide juvenile forensic services to consumers at Juvenile Hall and Honor Camps. The Reflections Day Treatment Program is a collaboration of Probation, Mental Health and AOD. The STAT Team assists consumers transitioning out of Juvenile Hall and links consumers to community and MHP services.
- Alcohol and Drug Services (ADS) Collaboration
 - The MHP and ADS collaborated on a PEI funded program during the last year and a half in which ADS employed mental health staff to screen and provide brief interventions for consumers.
 - The MHP and ADS also partnered to provide COD services at nine Teen Recovery Centers throughout the county serving mainly youth on probation.

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	Has a mechanism to assure timely access (within 7 days) to follow up appointments after hospitalization			X	
3E	Tracks and trends No Shows and implements quality improvement activities to improve overall timeliness to services		X		

Issues associated with the components identified above include:

- 3A. The MHP sets a minimum standard for length of time between initial contact and first appointment. The standard is eight days for adults and five days for children. The MHP reported that the average time to first appointment for adults is 6.4 days (well below the standard) and 5.1 days for children. The MHP measures access time from the client contact to the first available appointment, rather than the appointment date chosen by the client.
 - The MHP monitors wait times monthly and reports them on the MHP Dashboard Report which is distributed to the Mental Health Board. The reports compare month to month and to the previous year.
 - The MHP provided examples of performance improvement activities initiated when the MHP falls below performance expectations. For example, wait times and access barriers are discussed regularly by management and remedies are applied such as referring consumers to programs with shorter wait times. The MHP implemented walk-in services in most of the 23 clinics during September and October 2010 as a result of an initiative to shorten wait times and increase capacity.
 - Children's Services monitors timeliness monthly and conducts an analysis mid-year. Information alerts are sent to contracted programs and programs performing below expectations are requested to produce a plan to improve performance.

- 3B. The MHP does not set a minimum standard for length of time between initial contact and first psychiatric appointment. The MHP reported that the average time to first appointment for adults is 9.4 days. The MHP reports that few children see an MHP psychiatrist for medications, so this indicator is not tracked.
- 3C. The MHP reports that measurement of timeliness for urgent conditions is in development.
- 3D. The MHP reports that measurement of timeliness for follow up appointments after discharge (within 7 days) from a psychiatric facility is in development.
- 3E. The MHP reports that measurement of no show for appointment data is in development; this indicator is monitored periodically. The MHP reports that program staff have been instructed to enter missed appointments, but there is no formal process to monitor this practice. Some programs use the Anasazi Scheduler module that can record missed appointments. Most program staff have access to client services reports for no show appointments.

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 functional outcomes of consumers served	X			
4C	Clinical PIP is active and ongoing	X			
4D	Clinical PIP shows post-intervention results			X	

Figure 4. Outcomes					
Component		Present	Partial	Not Present	Not Rated
4E	Non-Clinical PIP is active and ongoing	X			
4F	Non-Clinical PIP shows post-intervention results	X			
4G	Utilizes information from DMH/POQI Satisfaction Surveys		X		
4H	Utilizes information from Consumer Satisfaction Surveys		X		

Issues associated with the components identified above include:

- 4A. Consumer-run programs.
 - The Consumer Center for Health, Education, and Advocacy (CCHEA) is a project of Legal Aid of San Diego, Inc.
 - NAMI San Diego provides a Client Warm Line staffed by peers from 4:00 to 11:00 p.m. daily.
 - There are twelve consumer clubhouses in the San Diego area.
 - Recovery Innovations of California, Inc. (RICA) provides peer support and employment support services.
 - The Oasis Clubhouse, a member-run clubhouse for TAY, is provided through a contract with Providence Community Services.
 - Mental Health America (MHA) of San Diego County provides a self-help directory, Visions Clubhouse in Chula Vista, and the Breaking Down Barriers Program for LGBTQ, Latino, Military, and Native Americans.
- 4B. Outcomes
 - The MHP collects and analyzes consumer level outcomes for various programs, including system wide functional outcomes. Adult Services uses the Illness Management and Recovery Scale (IMR), The Recovery Markers Questionnaire (RMQ), and MHSIP/QOL tools. Children’s Services uses the MHSIP Youth Services Survey (YSS), Child and Adolescent Needs and Strengths (CANS), and Child and Adolescent Functional Assessment Rating Scale (CFARS). The MHP produces annual reports with findings for ASOC and CSOC. Reports are reviewed by administration, QRC, program managers, and contract monitors.

- The Child and Adolescent Resource Center produced an outcomes report in September 2010 with CAMS and CFARS data from April to June 2010.
 - In October 2010, the Stigma Baseline Report was produced for the MHP, with results from a telephone survey of 602 county residents.
 - The MHP produces and reviews many MHSA and FSP report evaluations.
 - The MHP used outcome information to improve services when it examined CAMS and CFARS data in planning to move to a short-term treatment model.
- 4G. POQI. In May 2010, the MHP conducted the adult satisfaction survey. 80.6% of the 2,429 returned surveys were completed. The MHP found that 89.1% of consumers were generally satisfied with services. The MHP also conducted the YSS survey in May 2010.
 - The Child and Adolescent Services Research Center (CASRC) provided a PowerPoint presentation on November 2009 survey YSS results entitled “Predictors of Dissatisfaction” for child services. 67% of families/youth completed surveys. Dissatisfaction was defined as one standard deviation below the mean score on any of the three domains (services, outcomes, and support). Highest dissatisfaction scores included that 15% of parents were dissatisfied with outcomes and 13% of youth were dissatisfied with support. They found that parents without Medicaid are more likely to be dissatisfied with services and Hispanic parents and youth are less likely than Non-Hispanics to be dissatisfied with services. While results were shared with staff and service providers, it was not clear if any improvement projects were initiated as a result of the findings.
 - UCSD’s Health Services Research Center provided a PowerPoint presentation on May 2010 survey results entitled “Predictors of Dissatisfaction” for adult services. 42% of adult consumers completed surveys on 7 domains. Highest dissatisfaction scores included 15.8% perception of functioning and 15.0% on perception of social connectedness. Those more likely to be dissatisfied with services are those that are indigent/do not have Medicare or Medi-Cal, have a diagnosis of Schizophrenia or Schizoaffective Disorder, who utilize FSP services, and have utilized EPU/PERT or inpatient services previously.
 - 4H. Satisfaction
 - The MHP continued to develop an enhanced understanding of consumer concerns by tracking all incoming contacts via emails through the County website or Network of Care, phone calls to Directors or to HHSA, or via the Board Aides. Both the County website and the Network of Care website contain specific places for stakeholders to post concerns,

comments, and items of interest. The MHP continues to develop a process for all feedback to be consolidated and reviewed by one individual at the MHP. The Quality Improvement Director is currently acting as a central point of contact for the principle avenues of consumer/family feedback.

- Consumer Focus Groups.

Members of the Quality Review Council noted that family members of adult consumers often feel that they are not being kept as informed as they would like to be best able to provide support. Since many Spanish speaking consumers live with their families, two focus groups were conducted in FY 09-10 in Spanish with families to get a better understanding of what the needs of Latino family members were. Families reported the following:

- Families had the expectation that their relative/friend would be treated with dignity and given the best care possible.
- Caregivers wanted more information on medications, indicating that they had experimented with dosages when their relative/friend appeared to be having severe side effects or was only mildly effective.
- Confidentiality regulations acted as a barrier to keeping families informed.
- Classes and support groups for caregivers were identified as extremely helpful.
- Caregivers need to have more information about available services and facilities.
- Caregivers felt that the Access and Crisis Line could provide more helpful assistance.

This information was shared with MHP Administration.

❖ CURRENT MEDI-CAL CLAIMS DATA FOR MANAGING SERVICES ❖

Information to support the tables and graphs, labeled as Figures 5 through 18, is derived from four source files containing statewide data. A description of the source of data and summary reports of Medi-Cal approved claims data – overall, foster care, and transition age youth – follow as an attachment. 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 CY09. 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 CY09. Figure 6 shows the same information for the MHP’s eligibles and beneficiaries served. Similar figures for the foster care and TAY populations are included in Attachment D following the MHP’s approved claims worksheets.

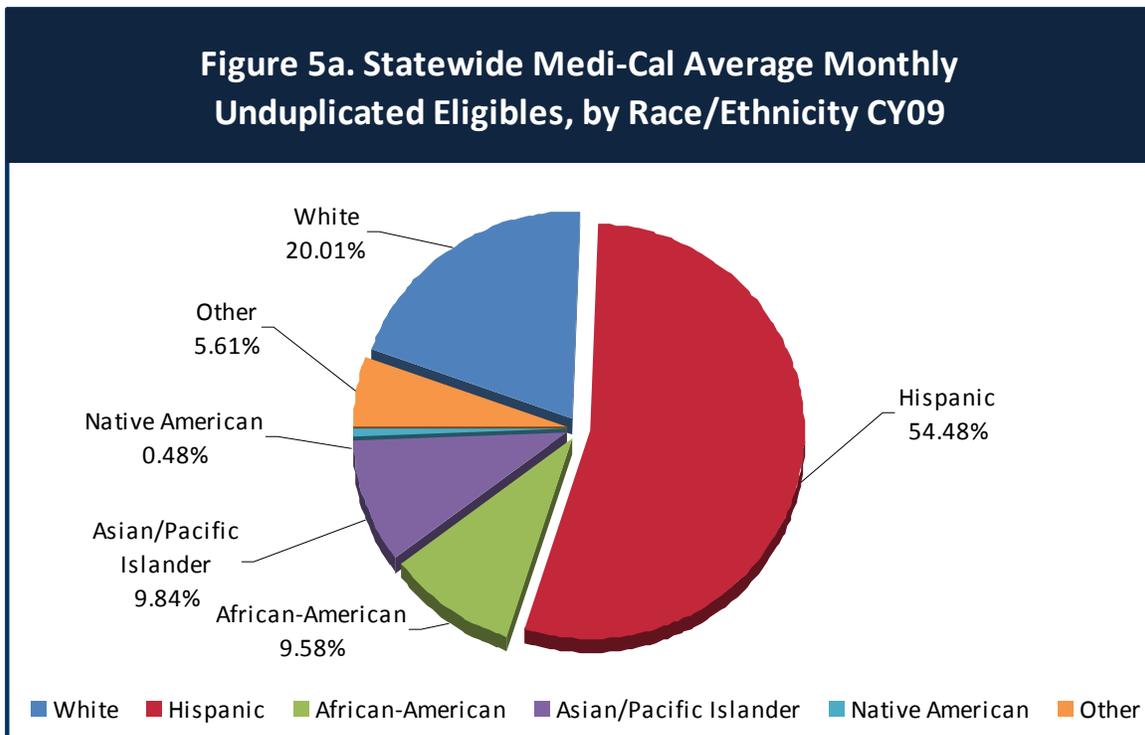


Figure 5b. Statewide Medi-Cal Beneficiaries Served, by Race/Ethnicity CY09

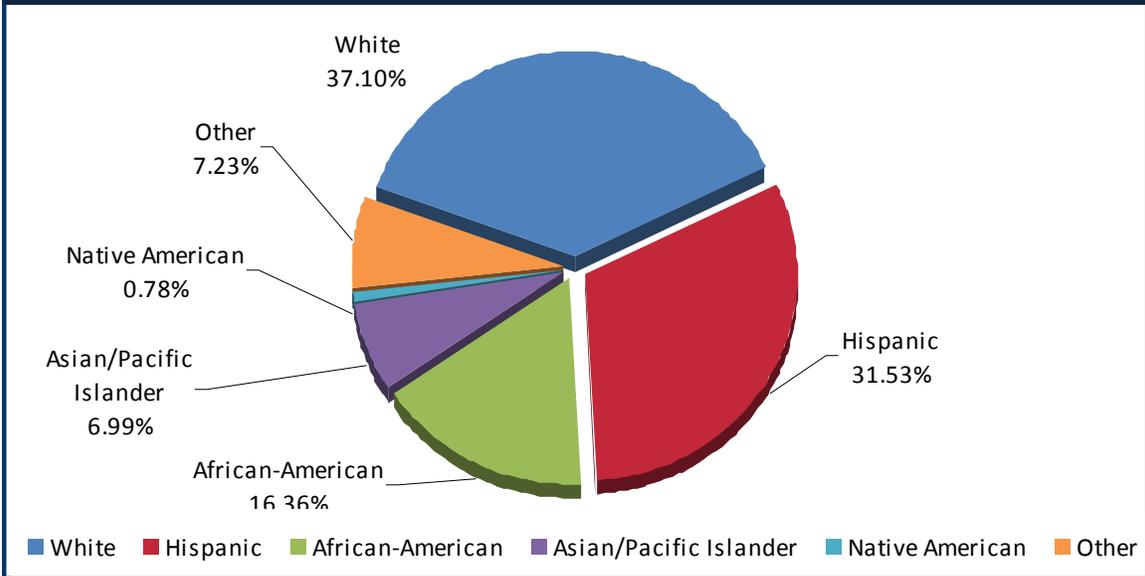
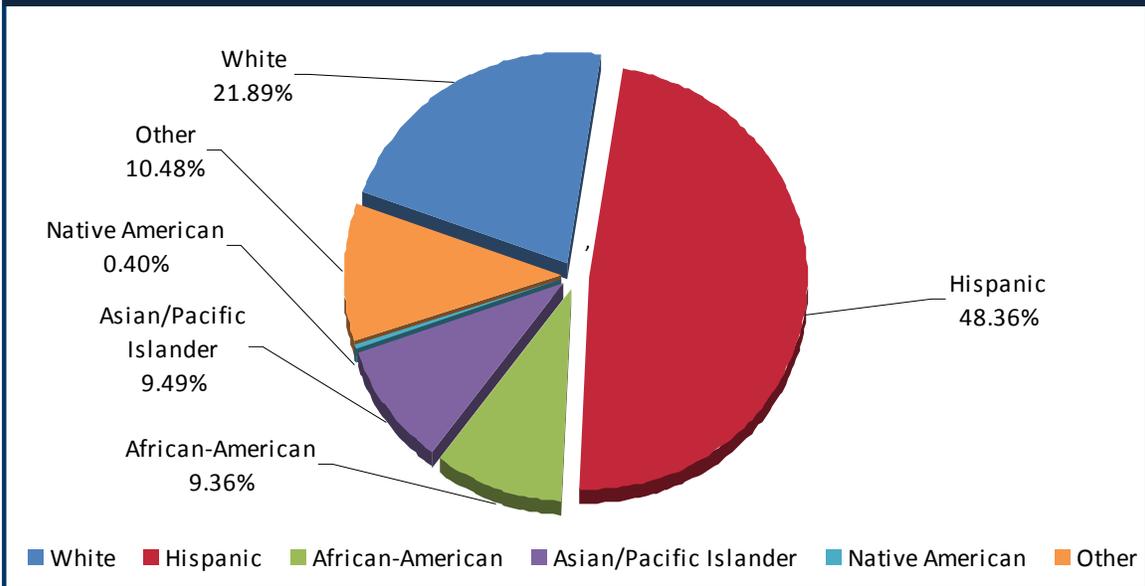
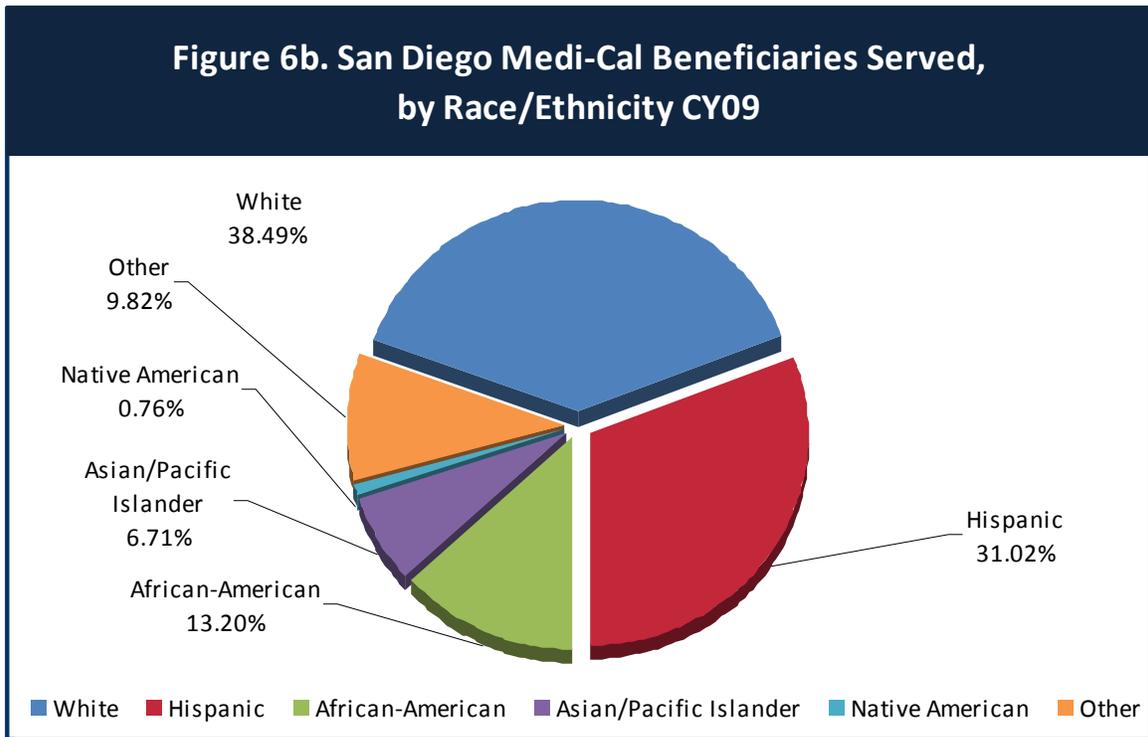


Figure 6a. San Diego Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY09





PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

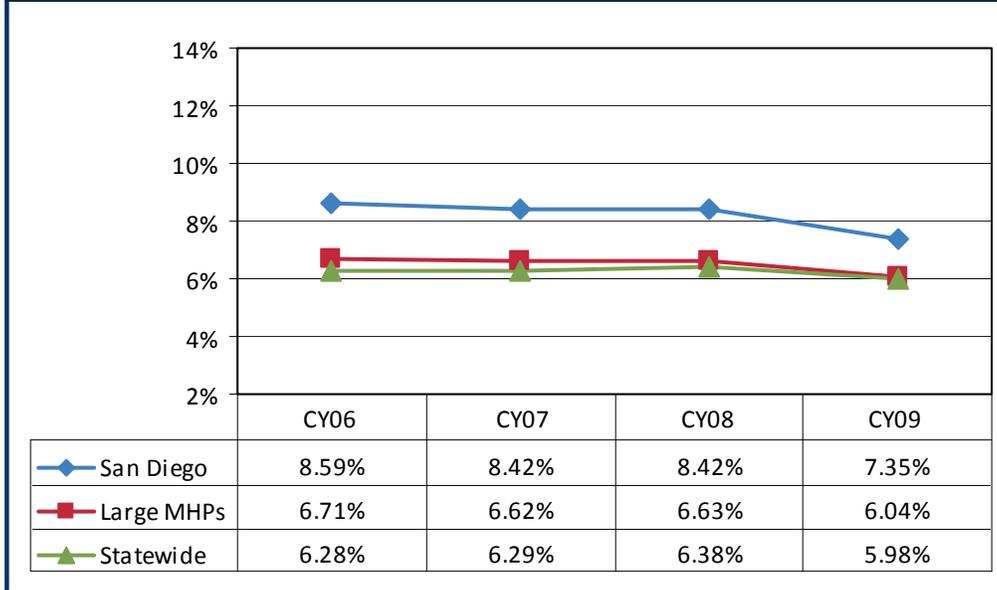
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

Figure 7 displays key elements from the approved claims reports for the MHP, MHPs of similar size (large, medium, small, or small-rural), and the state.

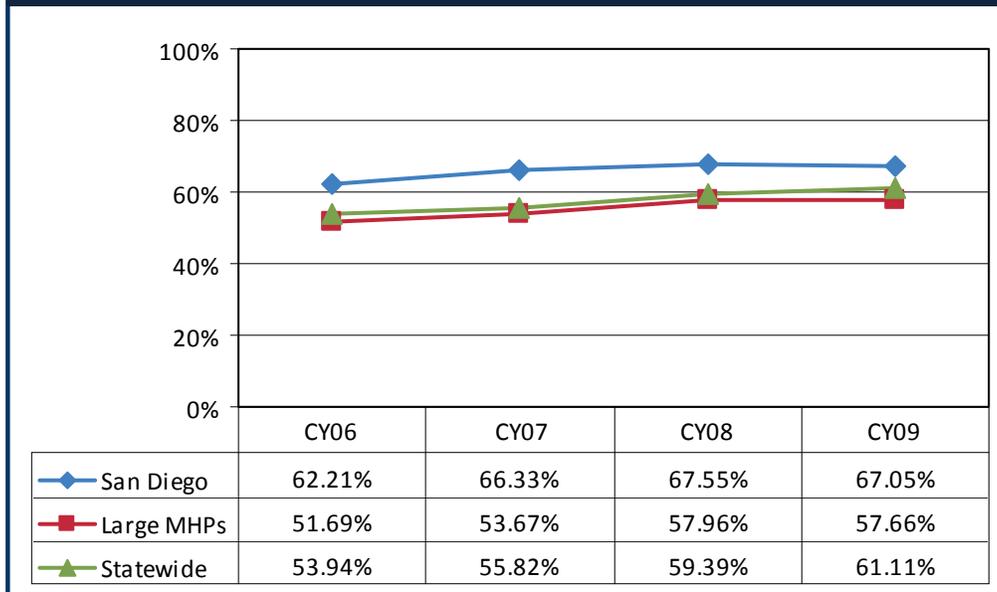
Figures 8 through 11 highlight four year trends for penetration rates and average approved claims.

Figure 7. CY09 Medi-Cal Approved Claims Data				
Element	San Diego	Rank	Large MHPs	Statewide
Total approved claims	\$95,035,844	N/A	N/A	\$2,113,209,089
Average number of eligibles per month	408,194	N/A	N/A	7,381,253
Number of beneficiaries served	29,991	N/A	N/A	441,682
Penetration rate	7.35%	31	6.04%	5.98%
Approved claims per beneficiary Served	\$3,169	40	\$4,335	\$4,784
Penetration rate – Foster care	67.05%	19	57.66%	61.11%
Approved claims per beneficiary served – Foster care	\$5,861	33	\$7,287	\$7,619
Penetration rate – TAY	8.32%	31	6.91%	7.01%
Approved claims per beneficiary served – TAY	\$4,455	29	\$5,461	\$5,966
Penetration rate – Hispanic	4.71%	12	3.43%	3.46%
Approved claims per beneficiary served – Hispanic	\$3,164	33	\$3,933	\$4,580
Penetration rate – Asian/Pacific Islanders	5.19%	18	4.27%	4.25%
Approved claims per beneficiary served – Asian/Pacific Islanders	\$2,060	39	\$3,328	\$3,493

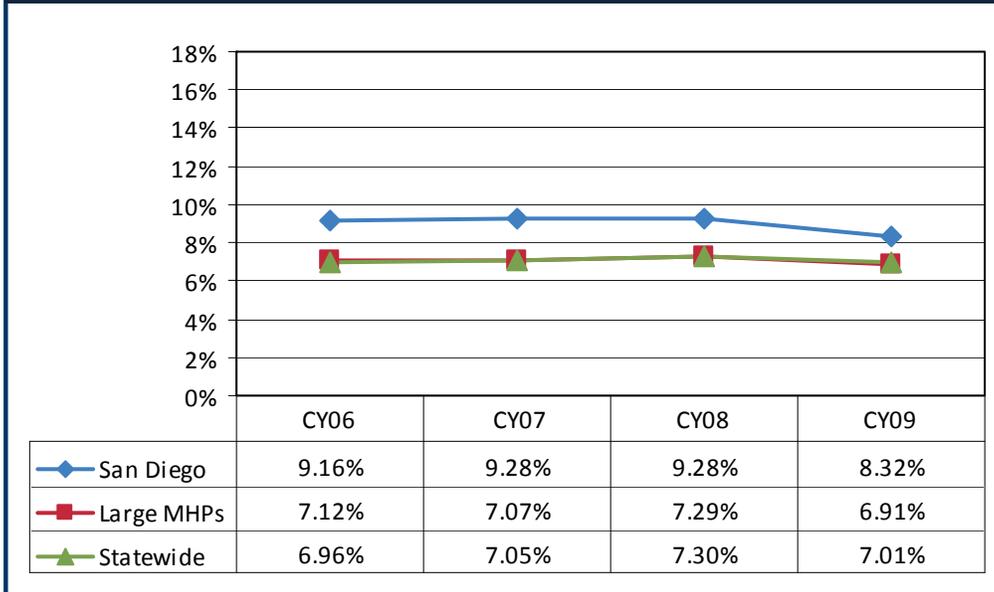
**Figure 8. Overall Penetration Rates
CY06-CY09**



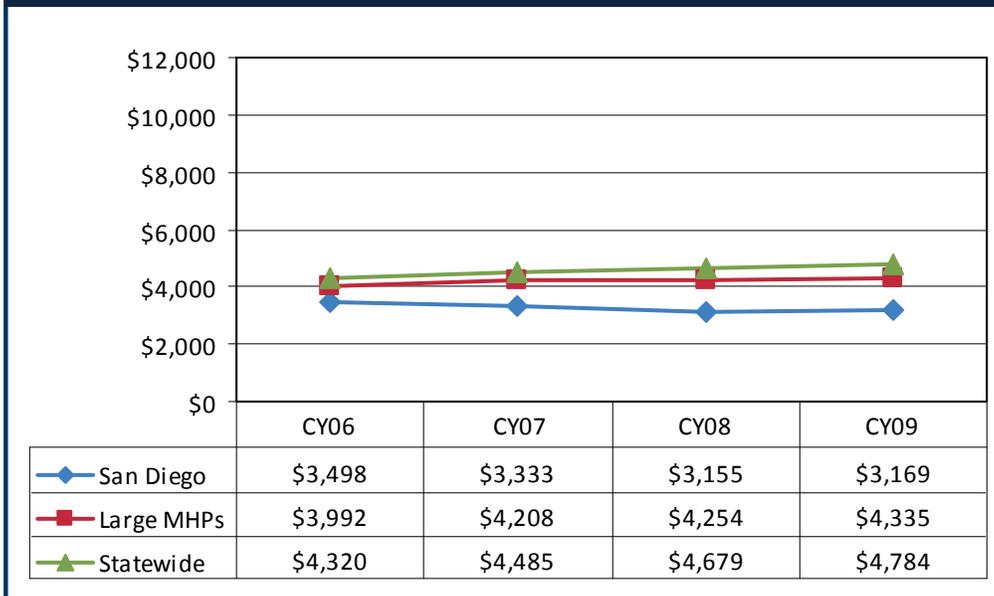
**Figure 9. Foster Care Penetration Rates
CY06-CY09**



**Figure 10. Transition Age Youth Penetration Rates
CY06-CY09**



**Figure 11. Average Approved Claims per Beneficiary Served
CY06-CY09**



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. San Diego 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
FY08-09	395,179	31,855	8.06%	28	\$103,583,170	\$3,252	38
FY07-08	373,433	31,422	8.41%	25	\$95,486,775	\$3,039	43
FY06-07	363,383	29,977	8.25%	24	\$108,578,396	\$3,622	32
FY05-06	357,677	31,320	8.76%	23	\$107,068,826	\$3,419	34
FY04-05	357,856	32,537	9.09%	23	\$104,112,317	\$3,200	34

MEDI-CAL DENIED CLAIMS HISTORY

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

Figure 13. Medi-Cal Denied Claims Information					
Fiscal Year	San Diego Denied Claims Amount	San Diego Denial Rate	San Diego Denial Rate Rank	Statewide Median	Statewide Range
FY08-09	\$1,347,082	1.36%	50	3.86%	0.41% - 29.87%
FY07-08	\$1,394,451	2.06%	43	4.91%	0.23% - 25.89%
FY06-07	\$1,290,508	1.30%	47	3.55%	0.23% - 18.18%
FY05-06	\$1,296,533	1.26%	41	3.02%	0.57% - 22.69%
FY04-05	\$1,393,216	1.35%	47	3.24%	0% - 36.78%

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

- For CY09, San Diego's overall penetration rate (7.35%) is higher than other large MHPs (6.04%) and the statewide average (5.98%). For the four calendar years shown in Figures 8 and 10, San Diego's PR has consistently exceeded other large MHPs and statewide figures.
- For CY09, San Diego's average claim per beneficiary served (\$3,169) is lower than large MHPs (\$4,335) while the statewide average is \$4,784. For the four calendar years shown in Figure 11, San Diego's average claim per beneficiary has shown this pattern.
- While San Diego's penetration rates for Hispanics (4.71%) and Asian/Pacific Islanders (5.19%) lags their overall PR (7.35%); their PR for these groups is higher than other large MHPs (3.43% and 4.27%) and statewide rates (3.46% and 4.25%) respectively.
- San Diego's foster care penetration rates for the four calendar years have consistently exceeded other large MHPs and statewide figures.
- As of February 2011, San Diego has processed 835 claim files and received payments from Short-Doyle Phase II (SD 2) system for both FY09-10 and FY10-11. However, claims volume for FY10-11 is currently considerably less than FY09-10.
- San Diego's denied claim rate for FY08-09 was significantly lower (1.36%) than the statewide median (3.86%). San Diego has made continued improvements to decrease claim denials over the past four fiscal years. As of February 2011, the denied claim analysis by CAEQRO for FY09-10 was not available.

HIGH-COST BENEFICIARIES

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

Figure 14. High-Cost Beneficiaries (greater than \$30,000 per beneficiary)

	Beneficiaries Served			Approved Claims		
	# HCB	# Served	%	Average per HCB	Total Claims for HCB	% of total claims
Statewide CY09	10,919	441,682	2.47%	\$48,892	\$533,854,301	25.26%
San Diego CY09	378	29,991	1.26%	\$42,313	\$15,994,211	16.83%
San Diego CY08	398	31,844	1.25%	\$44,309	\$17,634,794	17.55%
San Diego CY07	498	30,934	1.61%	\$44,840	\$22,330,473	21.66%
San Diego CY06	541	30,774	1.76%	\$44,516	\$24,083,277	22.37%

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 CY09, 37.43% of the approved Medi-Cal claims funded 4.87% of the beneficiaries served when this second tier of high cost beneficiaries is included. For the MHP, 30.18% of the approved Medi-Cal claims funded 3.02% of the beneficiaries served. This information is also depicted in pie charts in Attachment D.

- San Diego continues to serve fewer high cost beneficiaries than the statewide average both in percent of beneficiaries who received more the \$30,000 of Medi-Cal services and the percent of total claims by high cost beneficiaries. This pattern has been maintained for four consecutive calendar years.
- Claims data shows a decrease in high cost spending in CY09 (16.83%) compared to CY08 (17.55%) while statewide high cost spending increased slightly in CY09 (25.26%) compared to CY08 (25.19%).

- For CY09 San Diego funded the balance of its services (97% or 29,991 beneficiaries) with 69.8% of its claim dollars. The average cost for the balance of these beneficiaries who received less than \$20K services was \$2,281.

❖ PERFORMANCE MEASUREMENT ❖

Each year CAEQRO is required to work in consultation with DMH to identify a performance measurement (PM) which will apply to all MHPs – submitted to DMH within the annual report due on August 31, 2011. These measures will be identified in consultation with DMH for inclusion in this year’s annual report.

❖ CONSUMER AND FAMILY MEMBER FOCUS GROUPS ❖

FOCUS GROUPS SPECIFIC TO THE MHP

CAEQRO conducted one 90-minute focus group with consumers and family members during the site review of the MHP. Due to unforeseen circumstances, CAEQRO was unable to conduct two other focus groups as planned.

The MHP staff conducted three other focus groups in order to obtain their input. The findings from these focus groups are included as Attachment G in this report.

As part of the pre-site planning process, CAEQRO requested focus groups as follows:

1. Consumers of various ethnicities who have started services in the past year. This group was conducted by CAEQRO staff.
2. Family members of Arabic adults and youth who are receiving services from the MHP or its contractors. This group was conducted by MHP staff.
3. Arabic consumers who are receiving services from the MHP or its contractors. This group was conducted by MHP staff.

In addition, the MHP conducted a fourth focus group with consumers from Project Enable “Friendship” Clubhouse, a consumer-run wellness center in San Diego.

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

CAEQRO conducted a focus group for consumers who started services in the past year at County Case Management in San Diego. There were fourteen group attendees.

The group participants described the following services as helpful: The Clubhouse, housing, psychiatrist, case manager, Patient Assistance Medication Program, RICA, and crisis housing.

Participants agreed that the staff were culturally sensitive, but that hearing impaired consumers had problems with access and had experienced cultural insensitivity.

Participants reported that they experienced the impact of MHP budget challenges in that there were co-payments for medications, decreased housing subsidies, and if the consumer improves, service support is reduced.

Participants reported varying times to access services from one week to two months. The wait time for psychiatric services was described as "long". Several consumers reported good experiences with crisis houses, but that there were waiting lists to be accepted and that one may not be seen by the counselor and psychiatrist in the same month. Participants reported that individual therapy is available at the Clubhouse.

Participants reported difficulty accessing SSI and Medi-Cal benefits and trouble finding assistance in completing paperwork.

Group recommendations included the following:

- Provide more mandated Clubhouse visits, with long-term follow up and outreach to the consumer.
- Provide more consumer advocates and benefits specialist. "Get clients benefits".
- Provide a safety net for high functioning consumers until the individual says they are able to live without added support.
- The Clubhouse needs to be a more structured and safe environment.
- Provide on site employment support with more concrete support such as job listings, not just telling us how to do it.

- Provide mediation as needed.
- Provide a skilled case manager or life coach for each consumer.
- Bring consumers who have been successful back to the Clubhouse to tell their stories.
- Ensure that every manager and staff believe in recovery.
- Provide a new and improved Clubhouse.

Figure 15. Consumer/Family Member Focus Group 1

Number/Type of Participants	
Consumer Only	8
Consumer and Family Member	
Family Member of Adult	5
Family Member of Child	
Family Member of Adult & Child	1
Total Participants	14

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	4
Adult (approx 25-59)	9
Older Adult (approx 60 and older)	1

Preferred Languages	
English	14

Estimated Race/Ethnicity	
Caucasian	8
Latino	2
African American	2
Arabic	1
Asian/Pacific Islander	1

Gender	
Male	11
Female	3

Interpreter used for focus group 1: No Yes

❖ PERFORMANCE IMPROVEMENT PROJECT VALIDATION ❖

CLINICAL PIP

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

“Will implementing activities such as identification of predictors of high service utilization and the development of appropriate early childhood interventions lead to enhanced quality, effectiveness, and efficiency of service delivery to children, ages 0-5, receiving EPSDT funded mental health services? “

Year PIP began: November 2008

Status of PIP:

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

In July 2008, in collaboration with CAEQRO and other stakeholders, DMH determined that each MHP will focus one of its two required PIPs on high cost beneficiaries of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services. Work groups began meeting in June 2008 and included CAEQRO, CMHDA, CiMH, MHPs, contract providers, and other stakeholders involved in services to youth. DMH provided an overarching study question and a mandate that MHPs develop MHP-specific study questions. Please refer to last year's report for detailed background information. The state is now in the third year of what is currently intended to be a three-year statewide project.

The MHP has not made much progress on the improvement project since the PIP submission for the previous year's review mostly due to program start up timeframes. While the study design has not changed, the MHP has not presented data for baseline (except for Indicator 3) or follow up measures. The MHP planned to develop KidSTART Center in partnership with HHSA with First Five Commission tobacco tax funds to provide services to CWS foster children 0-5 years, including EPSDT mental health services. The KidSTART Center EPSDT South Clinic opened in July 2010 in Chula Vista and provides assessment of developmental needs and mental health needs, referrals, and treatment. For children with mental health needs, a variety of evidence-based treatments are available, including cognitive focused treatment, trauma informed treatment, psychotherapy, and Parent Child Interaction Therapy. KidSTART services are the main intervention for the PIP.

The planned study indicators include:

- Percentage of foster care consumers age 0-5 that receive developmental screening at DSEP
- Lack of retention: percentage of children who receive assessment only (1 visit, but no continued MH treatment)
- Percentage of children 0-5 in CWS receiving mental health services
- Percentage of children assessed after referral to KidSTART Center and EPSDT Clinic using ASQ-SE and ECBI and who attended four or more sessions
- Placement instability: percentage of children changing placements due to behavior problems or caregiver stress
- Percentage of children with caregiver participation at ICT meetings (new indicator)
- Percentage of children with caregiver participation in treatment sessions at least two times per month (new indicator)

- Percentage of children with outcome measure improvement on ASQ-SE, CBLC, or CFARS after receiving 26 sessions (new indicator)

The percentage of children 0-5 receiving inpatient services indicator proposed during the previous year was eliminated.

The percentage of children 0-5 years in CWS receiving mental health services in FY08-09 was reported as 15.2%. This rate has not appreciably changed since FY06-07.

The specific interventions include:

- Partnership with CWS to develop a co-located EBP screening, triage, assessment, referral, and treatment center (KidSTART) and EPSDT Clinic.
- Developmental screening of all children entering foster care through the Developmental Screening and Evaluation Program (DSEP)
- Use of developmental screening and assessment instruments which includes caregiver report (ASQ-SE, ECBI)
- Increase involvement of caregivers in services
- Increase access to FSP and TBS programs for children 0-5
- Provider trainings on 0-5 service models

The MHP reports that 100 children have been assessed and 37 children have received mental health treatment by the end of February 2011. The MHP perceives that the system wide collaboration on this project has improved coordination among agencies and the quality of services for foster children.

CAEQRO recommends the following regarding the PIP:

- Provide timelines for baseline and remeasurement of data.
- Include the date of program start up.
- Remeasure often enough to assess if interventions are working (such as quarterly) and prepare for possible adverse outcomes with contingency plans or rapid response for revising interventions.

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.” Because the MHP does not have an active clinical PIP, all items are rated as “not met” for purposes of analysis.

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 16. Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
2	The study question identifies the problem targeted for improvement			X
3	The study question is answerable/demonstrable			X
4	The indicators are clearly defined, objective, and measurable			X
5	The indicators are designed to answer the study question			X
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
7	The indicators each have accessible data that can be collected			X
8	The study population is accurately and completely defined			X
9	The data methodology outlines a defined and systematic process			X
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes			X
11	The analyses and study results are conducted according to the data analyses plan in the study design			X
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			X
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			X
Totals for 13 key criteria		0	0	13

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIPs as submitted by the MHP are included in an attachment to this report. If the MHP did not submit any PIPs, the requested format for PIP submission is included.

NON-CLINICAL PIP

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

“Will instituting new procedures increase client perception that they are involved in treatment planning and program planning? The new procedures are:

- The use of a client self-assessment tool as a way to increase opportunities for client input in treatment planning (RMQ)
- The use of a broad scope, recovery oriented, validated assessment tool by clinicians (IMR) and education for clinicians on how best to utilize the tool information to build a recovery oriented, clinical treatment plan
- The use of the Recovery Self-Assessment to allow clients to rate the recovery orientation of their services.
- New planning workgroups that include clients and family members
- New positions that are added to contracts for clients and family members”

Year PIP began: 2009

Status of PIP:

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

The MHP identified a problem of client involvement and client voice in recovery not improving as rapidly as expected in spite of system wide implementation of client centered, recovery oriented model of services.

The MHP identified a study population of all TAY, adult and older adult populations receiving outpatient and case management services who have received services long enough to have a six-month measurement for outpatient services and a one-year measurement for case management.

The MHP identified the following indicators:

- Recovery Self-Assessment (RSA) mean involvement score
- RSA summary score for providers on recovery orientation of their services
- Consumer satisfaction with outcomes score on the annual state consumer survey

The Recovery Markers Questionnaire (RMQ) consumer self-report rating on recovery data was collected but not reported for the PIP (as planned in last year's submission).

The Illness Management and Recovery Scale (IMR) clinician rating scores were removed as an indicator from last year's proposal, but continue to be used clinically.

The MHP reported baseline measurements from May 2008 and reported May 2010 remeasurement results for eight RSA client and eight RSA provider subscales, overall scores, and state consumer survey satisfaction with treatment outcomes rates.

Interventions were identified as follows:

- Implementation of new Recovery-based, broad scope client assessment tool for clinicians (IMR)
- Implementation of new Recovery-based client self-assessment tool (RMQ)
- Implementation of clinician training on the clinical use of outcomes tools in treatment planning
- Creation of a brochure for clients on the Recovery Model for distribution throughout the outpatient and case management programs

Recovery trainings began in October 2010 and continue. The recovery brochure has not yet been developed. The MHP plans annual remeasurements.

The MHP plans to develop the following technology tools to support consumers:

- A computer available to consumers in outpatient clinic waiting rooms with a menu including access to individual treatment plans.
- A web-based consumer database that includes information on medications and side effects, diagnoses, and issues of recovery as part of a wider health literacy program.

Results:

The MHP reported that fifty programs implemented IMR and RMQ into client assessment and treatment planning updates. As of September 2010, 7,500 clients were assessed with the IMR and 6,000 clients were assessed with the RMQ. Anecdotal reports include the agreement by staff that the tools encourage clinical staff to discuss recovery during client sessions and that the self-assessments are easy to use.

Client involvement ratings from 2008 to 2010 showed statistically significant improvement on all subscales except two, but they still increased.

Overall, provider involvement remained approximately the same. However, this was interpreted as an improvement that the staff realized they were not as recovery oriented as possible.

Treatment outcome satisfaction results decreased somewhat and the numbers surveyed decreased with the change from state mandated to county administered. The MHP did not discuss possible reasons for the decrease in client satisfaction with outcomes.

CAEQRO makes the following recommendations regarding the PIP:

- Consider the PIP completed, but monitor the results until sustained improvement is achieved.
- Remeasure more frequently so that contingencies may be addressed.
- Continue to explore reasons for lack of improvement in consumer survey question about satisfaction with treatment outcomes.

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 17. 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		

Figure 17. Non-Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
8	The study population is accurately and completely defined	X		
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X		
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes	X		
11	The analyses and study results are conducted according to the data analyses plan in the study design	X		
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion	X		
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement	X		
Totals for 13 key criteria		13	0	0

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIPs as submitted by the MHP are included in an attachment to this report. If the MHP did not submit any PIPs, the requested format for PIP submission is included.

❖ 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 7.1, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

MHP Information Systems Overview

CURRENT OPERATIONS

San Diego continues to use the same core information systems as in past years. See Figure 18 for details. The following bullets highlight key IS operations:

- The MHP uses Anasazi information system to support the mental health service delivery system. Both county-operated and contract providers enter data directly into the system.
- Generally, large contract providers perform redundant data entry into Anasazi and their agency's information system. Currently, there is no electronic interface for transferring consumer demographic and service data into Anasazi.
- Contract and network providers account for approximately 83% of all services provided.

Major Changes Since Last Year

- Anasazi system Phase 1 project deliverables have been implemented and are operational.
- Electronic clinical assessments have been implemented and are operational.
- Short-Doyle Phase II Medi-Cal claims have been implemented and are operational.
- State OSHPD reporting has been implemented and is operational.
- CSI reporting has been implemented and completed through April 2010.
- The Cost Report for FY09-10 has been completed.

Priorities for the Coming Year

- Implement Anasazi system Phase II clinical components: E-prescribing, electronic treatment plans and progress notes.
- Convert Monthly Medi-Cal Eligibility File from 1339 format to 1770 format.
- Develop Disaster Recovery System
- Archive for legacy systems – InSyst and e-Cura data.
- Develop business strategy to implement HIPAA 5010 transactions.
- Bring State CSI data submissions up to date.

Other Significant Issues

- The MHP is not current with Medi-Cal claims submissions for FY10-11.

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 electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Figure 18. Current Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
Anasazi	Practice Management, Electronic Assessments	Anasazi	2	MHP IS, Agency IS, ASO - Optum IS
ChartOne	Psychiatric Hospital EHR	Anacomp	5	Vendor IS
Inpatient	Medications, Meds Locker, Vital Signs, Alerts	Cerner	1	Vendor IS
Pharmacy	Meds Inventory	Etreby	1	Vendor IS
InSyst (Legacy)	Billing, Reporting, Practice Management	The Echo Group	13	ASO – Optum IS
e-Cura (Legacy)	Managed Care	InfoMC	12	ASO- Optum IS

PLANS FOR INFORMATION SYSTEMS CHANGE

The overall Anasazi system implementation project remains in progress. The MHP has successfully implemented Phase I and has begun to implement Phase II tasks which include more advanced electronic health record functionality such as scheduling, e-prescribing, treatment plans, and progress notes. Current plans are to have Phase II operational by early 2012.

ELECTRONIC HEALTH RECORD STATUS

At present, the MHP does not have system wide electronic health record functionality, but it uses some EHR components that are noted below. The MHP and contract providers continue to rely on the paper medical record for consumers.

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

Figure 19. Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Anasazi	X			
Document imaging	ChartOne Available to SD County Psychiatric Hospital staff		X		
Electronic signature-client				X	
Electronic signature-provider	ChartOne Available to SD County Psychiatric Hospital staff		X		
Laboratory results				X	
Outcomes				X	
Prescriptions	Cerner and Etreby Available to SD County Psychiatric Hospital staff		X		
Progress notes				X	
Treatment plans				X	

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

- The MHP implemented a series of electronic assessment forms that are required to be used by clinical staff and contract providers.
- ChartOne system provides access to imaged documents for San Diego County Psychiatric Hospital staff.
- Cerner system tracks medications dispensed at San Diego County Psychiatric Hospital. The Etreby system maintains medication inventory information.

❖ SITE REVIEW PROCESS BARRIERS ❖

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

- Part of the CAEQRO review team was in a motor vehicle accident after the first day of the review, resulting in the cancellation of the following two days of interviews. The MHP proceeded with scheduled focus groups and provided consumer/family member feedback. The MHP later participated in phone interviews with CAEQRO regarding PIPs and an additional information session. However, one of the Key Components items was not rated as a result of the shortened review process.

❖ CONCLUSIONS ❖

During the FY10-11 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 MHP continues to demonstrate a strong culture of quality and performance improvement, and data informed decision making in the midst of change.
[Quality, Outcomes]
2. The MHP continues to be a leader in developing integrated and strongly collaborative services, particularly with the KidSTART Center for 0-5 years CSW-involved families and with primary care service integration.
[Access, Quality, Other: Collaboration]
3. The MHP used recovery measures and staff training to improve recovery oriented treatment planning and consumer involvement in treatment planning.
[Quality, Outcomes]
4. With Arabic as a threshold language, the MHP has provided specialty mental health services for the county's Chaldean population that consumers and family members report high satisfaction with.
[Access, Quality, Other: Cultural Competence]
5. The MHP and contract providers remain committed to the multi-year Anasazi system implementation project. The continued supervision and daily involvement by senior administrators and program managers reflect their strong commitment to the project.
[Information Systems]
6. San Diego's overall PR, foster care, and TAY penetration rates for the past four years have consistently exceeded other large MHPs and statewide rates.
[Access]
7. The MHP has achieved excellent results reducing the number of high cost beneficiaries served during the past 4 calendar years. The number of identified high cost beneficiaries have been reduced from 541 in CY06, to 498 in CY07, to 398 in CY08, to 378 in CY09, a reduction of 30% over the four-year period.
[Quality, Outcomes]

OPPORTUNITIES FOR IMPROVEMENT

1. Consumers and family members reported a lack of input and involvement in system planning and evaluation. They often were not aware of how to provide input or feedback about the system.
[Quality, Other: Stakeholder Input and Involvement]
2. The MHP is not routinely measuring and reporting timeliness to psychiatry appointments for children, timeliness to appointments following hospital discharge, and urgent appointments. The MHP has not set a minimum standard for timeliness to psychiatric or urgent appointments.
[Timeliness]
3. No Show procedure codes are inconsistently used system wide. Therefore, it is difficult to measure missed appointments to determine overall system capacity and timeliness to services.
[Access, Timeliness]
4. As identified in CAEQRO FY09-10 report, the MHP has not expedited the planning process to automate their dashboard indicator reports as the current process is labor intensive.
[Information Systems, Other: Quality]
5. The implementation of Short-Doyle Phase II claims and modification in statewide Medi-Cal claim processing policies and claims adjudication business rules has affected many counties. As a result, the MHP's Medi-Cal revenue for FY10-11 is currently being delayed or reduced.
[Information Systems]
6. The MHP has not yet developed business strategies to implement HIPAA 5010 transaction code sets.
[Information Systems]
7. While the MHP has strategically changed its access and service provision systems in order to maintain and improve capacity in an environment of fiscal risk management, several stakeholder groups identified service barriers of provider capacity and difficulty accessing needed services.
[Access, Timeliness]

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 processes of communication and outreach to educate consumers and family members of existing methods/forums for collecting input and involving them in system planning and evaluation.
[Quality, Other: Stakeholder Input and Involvement]
2. Develop routine processes for measurement, review, and performance improvement of timeliness to psychiatry appointments for children, timeliness to appointments following hospital discharge, urgent appointments, and no shows. Establish a minimum standard for timeliness to psychiatric and urgent appointments.
[Timeliness]
 - a. Implement the use of no-show codes in all outpatient programs.
 - b. Consider adopting a formal process of tracking timeliness for all consumers seeking outpatient services.
3. Complete the planning process to automate dashboard indicator reports and develop the business processes to implement the production process.
[Quality, Information Systems]
4. Address the significant Medi-Cal revenue shortfall caused by not being current with claims submissions for FY10-11.
[Information Systems, Quality]
5. Work with the Anasazi California User Group, CMHDA, and the State DMH and DHCS to implement HIPAA 5010 transaction code sets prior to January 1, 2012.
[Information Systems]
6. Continue to monitor provider capacity, timeliness to services, and penetration rates for underserved populations in order to improve access and timeliness when needed.
[Access, Timeliness]

❖ 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

Time		Wednesday, February 9 – Day 1 Activities		
9:00–12:00	<p style="text-align: center;"><u>Performance Management</u> Access, Timeliness, Outcomes, and Quality</p> <ul style="list-style-type: none"> • Introductions of participants • Overview of review intent • Significant MHP changes in past year • Strategic initiatives – progress & plans • Last Year's CAEQRO Recommendations • Performance improvement measurements utilized to assess access, timeliness, outcomes, and quality • Examples of MHP reports used for to manage performance and decisions • CAEQRO approved claims data <p>Participants – those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions – including but not limited to:</p> <ul style="list-style-type: none"> ○ MHP Director, senior management team, and other managers/senior staff in: fiscal, programs, IS, medical, QI, research, patients' rights advocate ○ Involved consumer and family member representatives <p style="text-align: center;"><i>SD CBHS Office, 3255 Camino Del Rio South, San Diego</i></p>			
12:00–1:00	APS Staff – Working Lunch			
See specified times	<p style="text-align: center;"><u>1:00 – 2:15</u> <u>IS Manager/Key IS Staff</u> <u>Group Interview</u></p> <ul style="list-style-type: none"> • Review and discuss ISCA • FY09-10 CAEQRO information technology recommendations 	<p style="text-align: center;"><u>1:00 – 2:30</u> <u>Program Managers</u></p> <p>6-8 county-operated program managers representing various programs and sites serving all age groups</p>	<p style="text-align: center;"><u>1:30 – 3:00</u> <u>Consumer/Family</u> <u>Member Focus Group –</u> <u>Consumers who started</u> <u>services in the past year</u></p> <p>8-10 participants as noted in the notification letter</p>	
See specified times	<p style="text-align: center;"><u>2:30 – 3:30</u> <u>Fiscal/Billing/Finance Group</u> <u>Interview – SD/MC Claims</u> <u>Processing</u></p> <ul style="list-style-type: none"> • Short-Doyle Phase 2 claim process • Medicare/Medi-Cal claim submissions for Contract Providers • Void & Replace claim transactions • New policies & procedures since last review 	<p style="text-align: center;"><u>2:45 – 4:30</u> <u>Consumer Employee</u> <u>Group Interview</u></p> <p>6-8 Consumers employed by MHP contractors (all peers)</p>	<p style="text-align: center;"><u>3:30 – 5:00</u> <u>Family Member</u> <u>Employee Group</u> <u>Interview</u></p> <p>6-8 Children's Liaisons and other family members employed by the MHP or contractors (all peers)</p>	
See specified times	<p style="text-align: center;"><u>3:30 – 5:00</u> <u>IS Implementation Work</u> <u>Group Interview</u></p> <ul style="list-style-type: none"> • Users and planners • Clinical & non-clinical staff • MHP and provider staff 			

Time				Thursday, February 10 – Day 2 Activities			
See specified times	<p style="text-align: center;"><u>9:00 – 10:30</u></p> <p style="text-align: center;"><u>Wellness/Consumer-run Center Site Visit</u></p> <p style="text-align: center;">Discussion with consumer leaders and Steering Committee</p> <p style="text-align: center;"><i>Project Enable Clubhouse- "Friendship", 286 Euclid Ave, #104 SD, CA 92114</i></p>	<p style="text-align: center;"><u>9:00 – 10:15</u></p> <p style="text-align: center;"><u>Clinical Line Staff Group Interview</u></p> <p style="text-align: center;">7-9 clinical line staff from various county operated outpatient programs and geographical areas serving children, TAY, adults and older adults</p> <p style="text-align: center;">SDCBHS</p>	<p style="text-align: center;"><u>8:30 – 10:00</u></p> <p style="text-align: center;"><u>Contract Provider Site Visit</u></p> <p style="text-align: center;">Administrative, IS, Billing & Clinical supervisors, & key staff</p> <ul style="list-style-type: none"> • Overview of services and population • QI issues, participation with county efforts • Access, timeliness of services • Outcome Measures • Overview of IS systems and procedures • Discussion of key reports and other data analysis procedures • Discussion of information sharing with MHP <p style="text-align: center;"><i>Jane Westin Wellness & Recovery 1568 6th Ave, SD 92101</i></p>	See specified times	<p style="text-align: center;"><u>11:00 – 12:30</u></p> <p style="text-align: center;"><u>Consumer/Family Member Focus Group – Chaldean</u></p> <p style="text-align: center;">8-10 participants as specified in the notification letter</p> <p style="text-align: center;"><i>Union Bank Building, 343 East Main, #201, El Cajon</i></p>	<p style="text-align: center;"><u>10:30 – 12:00</u></p> <p style="text-align: center;"><u>Disparities in Service Access, Retention, Quality, or Outcomes</u></p> <ul style="list-style-type: none"> • Review of MHP 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 <p style="text-align: center;">SDCBHS</p>	
12:00-1:00	APS Staff – Working Lunch						
See specified times	<p style="text-align: center;"><u>1:30 – 3:00</u></p> <p style="text-align: center;"><u>Consumer/Family Member Focus Group – Chaldean</u></p> <p style="text-align: center;">8-10 participants as specified in the notification letter</p> <p style="text-align: center;"><i>Union Bank Building</i></p>	<p style="text-align: center;"><u>1:00 – 2:30</u></p> <p style="text-align: center;"><u>Contract Provider Group Interview</u></p> <p style="text-align: center;">Group Interview with clinical and business administrators from 6-8 identified contract providers</p> <p style="text-align: center;">SDCBHS</p>	<p style="text-align: center;"><u>1:30 – 3:00</u></p> <p style="text-align: center;"><u>Administrative Analyst Interview</u></p> <ul style="list-style-type: none"> • Behavioral Health Revenue • Contract and Data Coordination • Contract Fiscal Invoice Review • Contract Fiscal Provider • MH Performance Outcomes • Strategic Planning <p style="text-align: center;">SDCBHS</p>	See specified times	<p style="text-align: center;"><u>3:30–5:00</u></p> <p style="text-align: center;"><u>County Provider Site Visit, KIDS START 0-5 Services</u></p> <p style="text-align: center;"><i>Rady Children’s Hospital Plaza, 3665 Kearny Villa Road, Suite 501, San Diego</i></p>		

Time	Thursday, February 11 – Day 3 Activities	
9:00–10:30	<p align="center"><u>Performance Improvement Projects</u></p> <p>Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans</p> <p>Participants should be those involved in the development and implementation of PIPs, including, but not necessarily limited to:</p> <ul style="list-style-type: none"> ○ PIP committee ○ MHP Director and other senior managers <p align="center"><i>SDCBHS</i></p>	
10:45–12:00	<p align="center"><u>Collaborative/Community Based Services</u></p> <p>Examples of collaborative relationships with community providers and other agencies:</p> <ul style="list-style-type: none"> • With Law Enforcement • With Alcohol and Drug Services • With Child Welfare Services <p align="center"><i>SDCBHS</i></p>	<p align="center"><u>Outcomes/Timeliness</u></p> <p>MHP examples of data used to measure timeliness, functional outcomes and satisfaction</p> <p align="center"><i>SDCBHS</i></p>
12:00–1:00	<p align="center">APS Staff – Working Lunch</p>	
1:00–2:30	<p align="center"><u>Advocacy Interview</u></p> <p>6-8 Advocacy Contractors</p> <ul style="list-style-type: none"> • Review of role of advocates and improvement activities • Stakeholder involvement and input • Consumer Satisfaction <p align="center"><i>SDCBHS</i></p>	<p align="center"><u>Primary Care Integration</u></p> <ul style="list-style-type: none"> • Examples of collaborative relationships and service integration with community primary care providers <p align="center"><i>SDCBHS</i></p>
2:45–3:45	<p align="center"><u>Final Questions Session</u></p> <p>MHP Director, QI Director, senior leadership, and APS staff only</p> <ul style="list-style-type: none"> • Clarification discussion on any outstanding review elements • MHP opportunity to provide additional evidence of performance • CAEQRO Next steps after the review <p align="center"><i>SDCBHS</i></p>	

**** It should be noted that this agenda reflects the review as planned. As noted in the report, motor vehicle accident resulted in an abridged on-site review and conference calls to complete the process.**

B. Attachment—Review Participants

CAEQRO REVIEWERS

Elizabeth Harris, Lead Reviewer
Bill Ullom, Senior Data Analyst
Marilyn Hillerman, Consumer/Family Member Consultant
Saumitra SenGupta, IS Director

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

County Case Management, 1250 Morena Boulevard, San Diego
San Diego County Administrative Offices, 3255 Camino Del Rio South, San Diego

Contract provider organizations

No contract provider sites were visited by the review team due to the abridged on-site component

PARTICIPANTS REPRESENTING THE MHP

Alexander Heyer, Providence Services, Catalyst
Alfredo Aguirre, Director of Mental Health
Amelia Gaingab, Staff, Forensic Medical Unit
Ana Briones-Esperioza, Senior Trainer, Optum Health
Andrew Sarkin, UCSD, HSRC
Angie DeVoss, Program Manager, Information Systems
Anna L. Palid, Program Coordinator, Northern Regions
Anselma Danque, Associate Accountant, Fiscal
April Espinoza, MHS
Basam Subhi, Family Member, Family Member Group
Bashar Basheer, Consumer, Family Member Group
Bill Simpson, Contractor Representative, Community Research Foundation
Brian Newcomer, Contractor Representative, Mental Health Systems Inc
Buchra Hamna, Family Member, Family Member Group

Candace Milow, Director, Quality Improvement
Carlos Benitez, Analyst, QI
Carol Davis, Support Desk, Optum Health
Cecilia N. Redondo, Chief, Forensic Medical Unit
Chona Penalba, Accountant, Fiscal
Christine Canelies, PSS, IMPACT
Deborah Powell, Analyst, QI
Dunia Shameaon, Consumer, Family Member Group
Ericka Mancillas, Providence Services, Kickstart
Eva Zaya, Consumer, Family Member Group
Fareeda Shatah, Family Member, Family Member Group
Frances Edwards, Chief, Child/Adolescent
Greg Watson, Program Manager
Henry Tarke, Assistant Deputy Director, Children's Mental Health Services
Jamie Picker, Program Manager
Jan Winn, Project Contractor Representative, Rady Children's Hospital
Janan Ghazi, Consumer, Family Member Group
Jane Timmons, Analyst, Information Systems
Jeff Rowe, Supervising Psychiatrist
Jeffery Johnson, PSS, IMPACT
Jennifer Mallory, Administrative Analyst, SPA
Jerry Wilkins, Administrative Analyst
Jim Lardy, Financial Officer, Fiscal
John Yaakoub, Consumer, Family Member Group
Kathleen Sherber, Program Manager
Katie Astor, Chief, Outpatient/TBS
Kathy Anderson, Quality Improvement
Kya Fawley-King, Post Doc, CASRC
Laura Colligan, Program Manager
Lauretta Monise, Chief, Children's Mental Health Services
Layla Samoqa, Family Member, Family Member Group
Leslie Saunders, Heritage Clinic
Linda C. Somers, Heritage Clinic
Luvone Lucas, Health Services Representative, Forensic Medical Unit
Luz M. Fernandez, Program Manager
Mayseloon Ismail, Family Member, Family Member Group
Michalene Holtsley, Supervisor, Quality Improvement
Michelle Galvan, Director of Finance, Optum Health
Mike Phillips, JFS, Patient Advocacy
Mitch Glict, SDPH
Moneera Pollos, Family Member, Family Member Group
Najm Qarandal, Family Member, Family Member Group
Nilsa Rubenstein, System Maintenance Manager, Optum Health

Nuha Butrus, Family Member, Family Member Group
Patricia Honeycutt, Chief, Contract Coordinator
Piedad Garcia, Assistant Deputy Director, Adult/Older Adult Services
Raad Somo, Consumer, Family Member Group
Rana Jameet, Family Member, Family Member Group
Rick Heller, UCSD, HSRC
Ruth Cook, Heritage Clinic
Ruth Kenzelmann, Executive Director, Optum Health
Sabrina Mincy, MHS
Salma Aboona, Family Member, Family Member Group
Sami Khaleel, Consumer, Family Member Group
Scott Wade, Administrative Analyst
Stephanie Hansen, QI Specialist
Steve Jones, Program Manager, Quality Improvement
Steve Jones, QI Program Manager
Steven Tally, UCSD, HSRC
Suheir Silho, Consumer, Family Member Group
Tabatha Lang, Mental Health Program Coordinator
Virginia West, Program Coordinator, Central and North Central
Waleed Ali, Consumer, Family Member Group
Yael Koenig, Chief, CMH

C. Attachment—Approved Claims Source Data

- **Source:** Data in Figures 5 through 14 and Appendix D is 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 Services via DMH (originating from Electronic Data Systems, the Medi-Cal Fiscal Intermediary)
 - Monthly MEDS Extract Files (MMEF) from the Department of Health 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.
 - CY2009 includes SD/MC and IPC approved claims with process date April 2010
 - 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 approved claims with process date October 2007 and IPC process date November 2007
 - CY2005 includes SD/MC and IPC approved claims with process date July 2006
 - FY08-09 includes SD/MC and IPC approved claims with process date December 2009
 - FY07-08 includes SD/MC and IPC approved claims with process date April 2009
 - FY06-07 includes SD/MC and IPC approved claims with process date May 2008
 - FY05-06 includes SD/MC and IPC approved claims with process date October 2007
 - FY04-05 includes SD/MC and IPC approved claims with process date April 2006
 - FY03-04 includes SD/MC and IPC approved claims with process date October 2005
 - FY02-03 includes SD/MC and IPC approved claims as of final reconciliation
 - FY08-09 denials include SD/MC claims (not IPC claims) processed between July 1, 2008 and June 30, 2009 (without regard to service date) with process date November 2009. Same methodology is used for prior years.
 - Most recent MMEF includes Medi-Cal eligibility for April 2010 and 15 prior months
- **Data Definitions:** Selected elements displayed in many figures within this report are defined below.
 - Penetration rate – The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
 - Approved claims per beneficiary served per year – The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year
- **MHP Size:** Categories are based upon DMH definitions by county population.
 - Small-Rural MHPs = Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Plumas, Siskiyou, Trinity
 - Small MHPs = El Dorado, Humboldt, Imperial, Kings, Lake, Madera, Mendocino, Napa, Nevada, San Benito, Shasta, Sutter/Yuba, Tehama, Tuolumne, Yolo
 - Medium MHPs = Butte, Marin, Merced, Monterey, Placer/Sierra, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare
 - 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 SAN DIEGO County MHP Calendar Year 09



Date Prepared:	05/12/2010, 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:	04/14/2010, 04/20/2010, and 04/07/2010 - Note (3)

	SAN DIEGO					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									
	408,194	29,991	\$95,035,844	7.35%	\$3,169	6.04%	\$4,335	5.98%	\$4,784
AGE GROUP									
0-5	81,652	1,416	\$1,860,685	1.73%	\$1,314	1.47%	\$3,654	1.46%	\$3,886
6-17	111,689	10,346	\$47,175,327	9.26%	\$4,560	7.44%	\$5,647	7.71%	\$6,316
18-59	146,779	15,756	\$40,499,504	10.73%	\$2,570	8.47%	\$3,753	8.03%	\$4,057
60+	68,075	2,473	\$5,500,327	3.63%	\$2,224	3.46%	\$3,062	3.41%	\$3,174
GENDER									
Female	233,092	15,689	\$43,605,460	6.73%	\$2,779	5.57%	\$3,790	5.46%	\$4,213
Male	175,103	14,302	\$51,430,383	8.17%	\$3,596	6.66%	\$4,927	6.67%	\$5,391
RACE/ETHNICITY									
White	89,368	11,544	\$35,844,252	12.92%	\$3,105	11.17%	\$4,290	11.09%	\$4,894
Hispanic	197,421	9,304	\$29,435,702	4.71%	\$3,164	3.43%	\$3,933	3.46%	\$4,580
African-American	38,226	3,958	\$15,897,714	10.35%	\$4,017	10.10%	\$5,296	10.22%	\$5,218

	SAN DIEGO						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	38,753	2,011	\$4,142,009	5.19%	\$2,060		4.27%	\$3,328		4.25%	\$3,493
Native American	1,642	228	\$1,020,653	13.89%	\$4,477		11.38%	\$4,661		9.80%	\$5,120
Other	42,787	2,946	\$8,695,513	6.89%	\$2,952		7.46%	\$4,882		7.71%	\$5,344
ELIGIBILITY CATEGORIES											
Disabled	73,109	14,269	\$43,704,344	19.52%	\$3,063		18.94%	\$4,434		18.93%	\$4,710
Foster Care	3,957	2,653	\$15,548,604	67.05%	\$5,861		57.66%	\$7,287		61.11%	\$7,619
Other Child	182,173	8,731	\$27,822,992	4.79%	\$3,187		3.84%	\$4,042		4.06%	\$4,661
Family Adult	77,086	4,404	\$6,020,283	5.71%	\$1,367		4.38%	\$1,881		4.21%	\$2,239
Other Adult	78,535	796	\$1,939,620	1.01%	\$2,437		0.96%	\$3,205		0.96%	\$3,324
SERVICE CATEGORIES											
24 Hours Services	408,194	2,772	\$17,628,632	0.68%	\$6,360		0.48%	\$8,026		0.46%	\$8,248
23 Hours Services	408,194	879	\$796,658	0.22%	\$906		0.44%	\$1,677		0.31%	\$1,601
Day Treatment	408,194	1,489	\$11,362,848	0.36%	\$7,631		0.12%	\$10,712		0.10%	\$11,632
Linkage/Brokerage	408,194	8,286	\$7,846,704	2.03%	\$947		2.46%	\$1,004		2.61%	\$898
Outpatient Services	408,194	24,584	\$43,531,637	6.02%	\$1,771		4.83%	\$2,774		5.00%	\$3,228
TBS	408,194	311	\$2,360,574	0.08%	\$7,590		0.08%	\$12,173		0.06%	\$13,830
Medication Support	408,194	14,931	\$11,508,791	3.66%	\$771		3.34%	\$1,032		3.19%	\$1,212

Footnotes:

- 1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs
- 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 processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report
- 4 - County total number of yearly unduplicated Medi-Cal eligibles is 303,732

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY09

Number of Services Approved per Beneficiary Served	SAN DIEGO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	2,397	7.99	7.99	8.88	8.88	0.00	19.70
2 services	2,104	7.02	15.01	6.24	15.11	3.60	17.61
3 services	2,706	9.02	24.03	5.46	20.58	0.00	10.75
4 services	1,668	5.56	29.59	4.87	25.45	2.04	10.45
5 - 15 services	10,626	35.43	65.02	32.24	57.69	20.08	46.67
> 15 services	10,490	34.98	100.00	42.31	100.00	11.34	61.48

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 04/14/2010; Inpatient Consolidation approved claims as of 04/20/2010

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 SAN DIEGO County MHP Calendar Year 09

Foster Care



Date Prepared:	05/13/2010, 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:	04/14/2010, 04/20/2010, and 04/07/2010 - Note (3)

	SAN DIEGO					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									
	3,957	2,653	\$15,548,604	67.05%	\$5,861	57.66%	\$7,287	61.11%	\$7,619
AGE GROUP									
0-5	1,137	511	\$617,995	44.94%	\$1,209	33.44%	\$3,532	37.16%	\$3,521
6+	2,821	2,142	\$14,930,609	75.93%	\$6,970	66.07%	\$7,947	69.07%	\$8,351
GENDER									
Female	1,939	1,278	\$7,030,782	65.91%	\$5,501	56.22%	\$7,041	58.77%	\$7,361
Male	2,019	1,375	\$8,517,823	68.10%	\$6,195	59.04%	\$7,511	63.35%	\$7,847
RACE/ETHNICITY									
White	1,093	775	\$4,548,030	70.91%	\$5,868	62.00%	\$7,374	58.99%	\$8,606
Hispanic	1,644	1,082	\$5,355,881	65.82%	\$4,950	54.79%	\$5,926	64.19%	\$5,808
African-American	943	631	\$4,784,065	66.91%	\$7,582	57.33%	\$8,747	61.77%	\$8,046

	SAN DIEGO						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	148	91	\$397,659	61.49%	\$4,370		62.67%	\$7,750		62.05%	\$7,390
Native American	78	39	\$286,662	50.00%	\$7,350		49.25%	\$5,863		46.37%	\$6,371
Other	54	35	\$176,307	64.81%	\$5,037		55.67%	\$9,722		71.14%	\$8,718
SERVICE CATEGORIES											
24 Hours Services	3,957	106	\$479,101	2.68%	\$4,520		2.03%	\$7,115		2.22%	\$8,147
23 Hours Services	3,957	50	\$36,335	1.26%	\$727		1.70%	\$1,200		1.19%	\$1,225
Day Treatment	3,957	857	\$6,394,102	21.66%	\$7,461		4.46%	\$10,892		3.57%	\$12,014
Linkage/Brokerage	3,957	549	\$229,763	13.87%	\$419		25.62%	\$1,339		28.84%	\$1,024
Outpatient Services	3,957	2,391	\$6,716,310	60.42%	\$2,809		54.43%	\$4,773		58.37%	\$5,229
TBS	3,957	113	\$822,580	2.86%	\$7,279		3.10%	\$12,279		2.77%	\$13,415
Medication Support	3,957	892	\$870,415	22.54%	\$976		18.44%	\$1,243		20.01%	\$1,563

Footnotes:

- 1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs
- 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 processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report
- 4 - County total number of yearly unduplicated Medi-Cal eligibles is 3,138

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY09

Foster Care

Number of Services Approved per Beneficiary Served	SAN DIEGO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	69	2.60	2.60	6.31	6.31	0.00	22.90
2 services	138	5.20	7.80	4.97	11.28	0.00	16.67
3 services	433	16.32	24.12	4.85	16.14	0.00	16.32
4 services	81	3.05	27.18	3.53	19.66	0.00	22.22
5 - 15 services	578	21.79	48.96	24.86	44.52	12.50	52.38
> 15 services	1,354	51.04	100.00	55.48	100.00	22.22	76.38

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 04/14/2010; Inpatient Consolidation approved claims as of 04/20/2010

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 SAN DIEGO County MHP Calendar Year 09

Transition Age Youth (Age 16-25)



Date Prepared:	05/13/2010, 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:	04/14/2010, 04/20/2010, and 04/07/2010 - Note (3)

	SAN DIEGO					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									
	57,319	4,769	\$21,247,703	8.32%	\$4,455	6.91%	\$5,461	7.01%	\$5,966
AGE GROUP									
16-17	17,899	2,140	\$12,045,017	11.96%	\$5,629	9.93%	\$6,455	10.21%	\$7,023
18-21	25,054	1,684	\$6,299,100	6.72%	\$3,741	6.02%	\$4,958	6.13%	\$5,469
22-25	14,366	945	\$2,903,586	6.58%	\$3,073	5.00%	\$4,262	4.83%	\$4,469
GENDER									
Female	34,987	2,384	\$9,612,130	6.81%	\$4,032	5.66%	\$5,098	5.74%	\$5,618
Male	22,332	2,385	\$11,635,573	10.68%	\$4,879	8.86%	\$5,826	8.96%	\$6,306
RACE/ETHNICITY									
White	10,892	1,613	\$6,745,317	14.81%	\$4,182	11.87%	\$5,376	12.72%	\$6,173
Hispanic	30,704	1,883	\$7,956,018	6.13%	\$4,225	4.61%	\$4,839	4.70%	\$5,525

	SAN DIEGO					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
African-American	6,760	720	\$4,017,385	10.65%	\$5,580	11.05%	\$6,170	10.92%	\$6,199
Asian/Pacific Islander	3,947	174	\$755,219	4.41%	\$4,340	3.60%	\$5,881	3.64%	\$5,853
Native American	275	38	\$259,858	13.82%	\$6,838	11.78%	\$6,672	10.06%	\$6,812
Other	4,744	341	\$1,513,906	7.19%	\$4,440	9.09%	\$6,560	9.21%	\$7,128
ELIGIBILITY CATEGORIES									
Disabled	6,028	1,370	\$6,010,912	22.73%	\$4,388	21.39%	\$6,470	22.24%	\$6,767
Foster Care	847	745	\$5,851,543	87.96%	\$7,854	75.12%	\$8,071	81.84%	\$8,275
Other Child	16,182	1,479	\$5,663,393	9.14%	\$3,829	7.52%	\$4,507	7.88%	\$5,064
Family Adult	26,898	1,173	\$2,881,378	4.36%	\$2,456	3.94%	\$2,823	4.21%	\$3,306
Other Adult	7,566	249	\$840,476	3.29%	\$3,375	2.60%	\$3,834	2.46%	\$4,253
SERVICE CATEGORIES									
24 Hours Services	57,319	592	\$2,837,430	1.03%	\$4,793	0.83%	\$7,088	0.77%	\$7,292
23 Hours Services	57,319	167	\$150,548	0.29%	\$901	0.70%	\$1,435	0.49%	\$1,430
Day Treatment	57,319	515	\$4,695,597	0.90%	\$9,118	0.24%	\$10,866	0.21%	\$12,256
Linkage/Brokerage	57,319	1,324	\$1,353,263	2.31%	\$1,022	2.78%	\$1,305	3.06%	\$1,067
Outpatient Services	57,319	4,039	\$10,010,347	7.05%	\$2,478	5.87%	\$3,364	6.18%	\$3,953
TBS	57,319	66	\$459,074	0.12%	\$6,956	0.14%	\$10,912	0.11%	\$11,402
Medication Support	57,319	2,198	\$1,741,443	3.83%	\$792	3.22%	\$1,031	3.15%	\$1,248

Footnotes:

- 1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs
- 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 processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report
- 4 - County total number of yearly unduplicated Medi-Cal eligibles is 49,013

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY09

Transition Age Youth (Age 16-25)

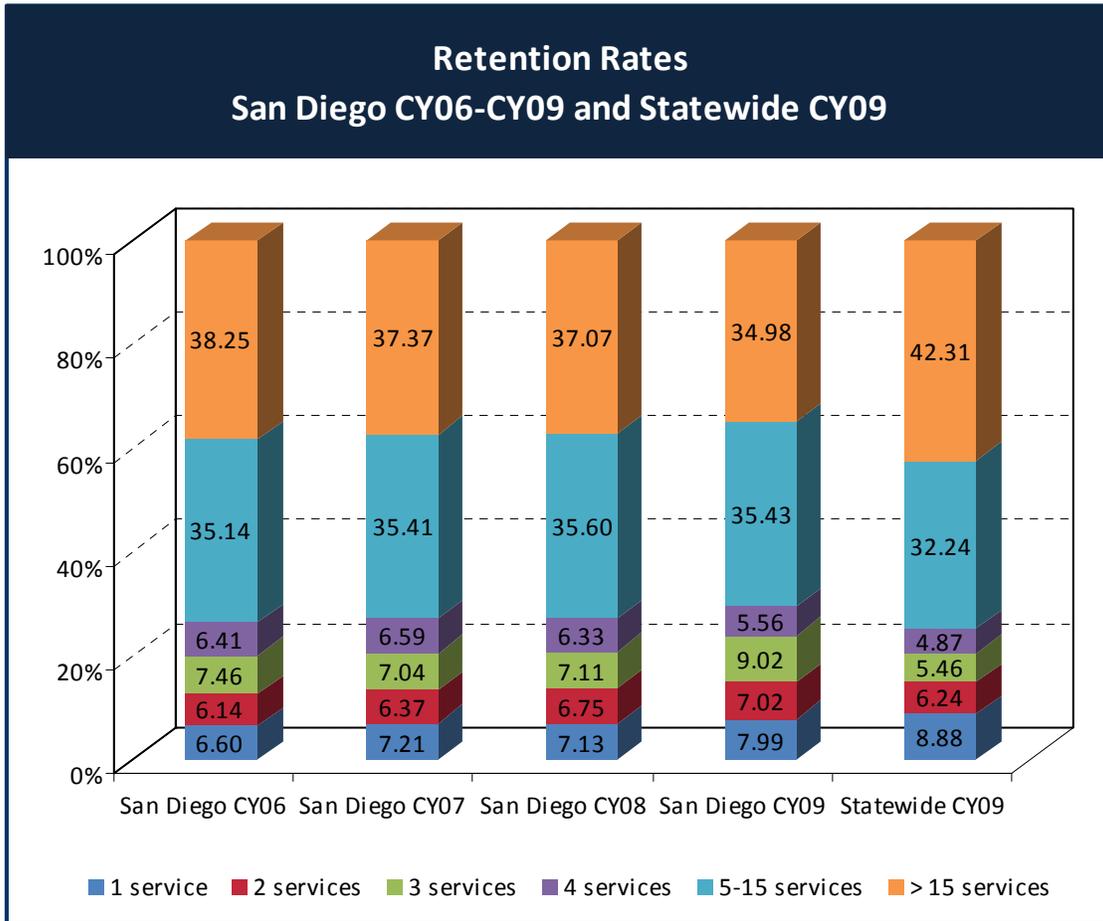
Number of Services Approved per Beneficiary Served	SAN DIEGO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	389	8.16	8.16	9.99	9.99	0.00	24.86
2 services	289	6.06	14.22	6.74	16.73	0.00	20.25
3 services	347	7.28	21.49	5.24	21.96	0.00	10.17
4 services	262	5.49	26.99	4.73	26.69	0.00	20.34
5 - 15 services	1,467	30.76	57.75	28.35	55.04	19.39	100.00
> 15 services	2,015	42.25	100.00	44.96	100.00	0.00	61.77

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 04/14/2010; Inpatient Consolidation approved claims as of 04/20/2010

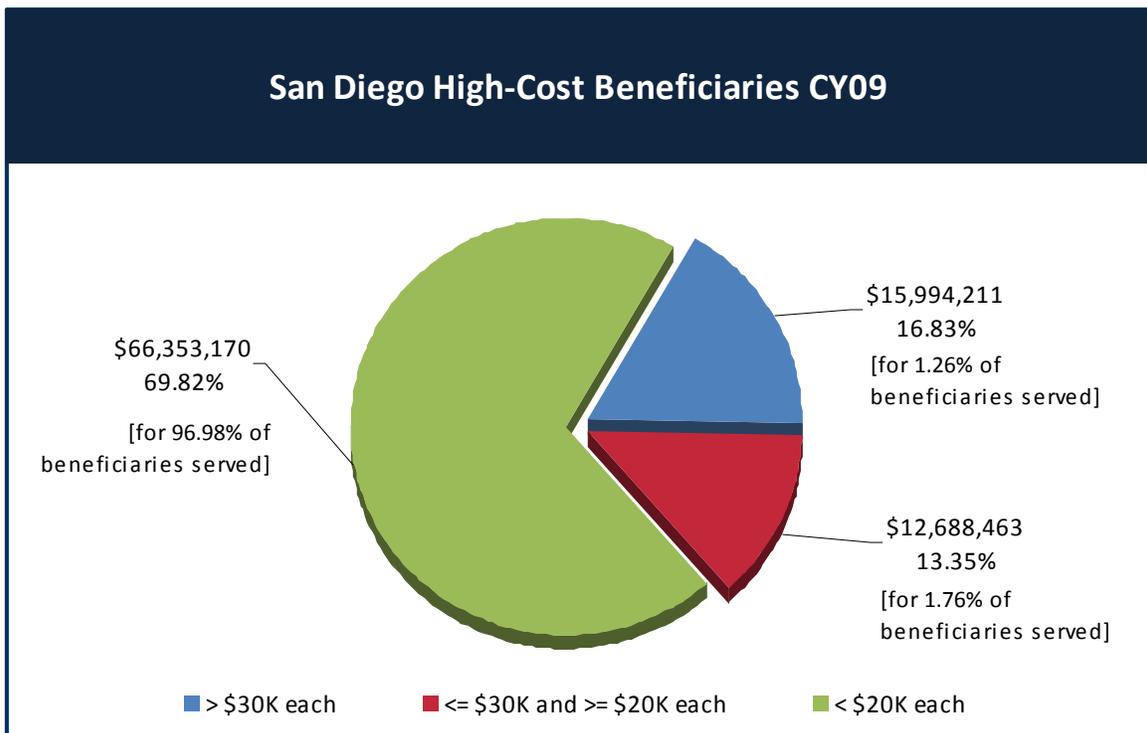
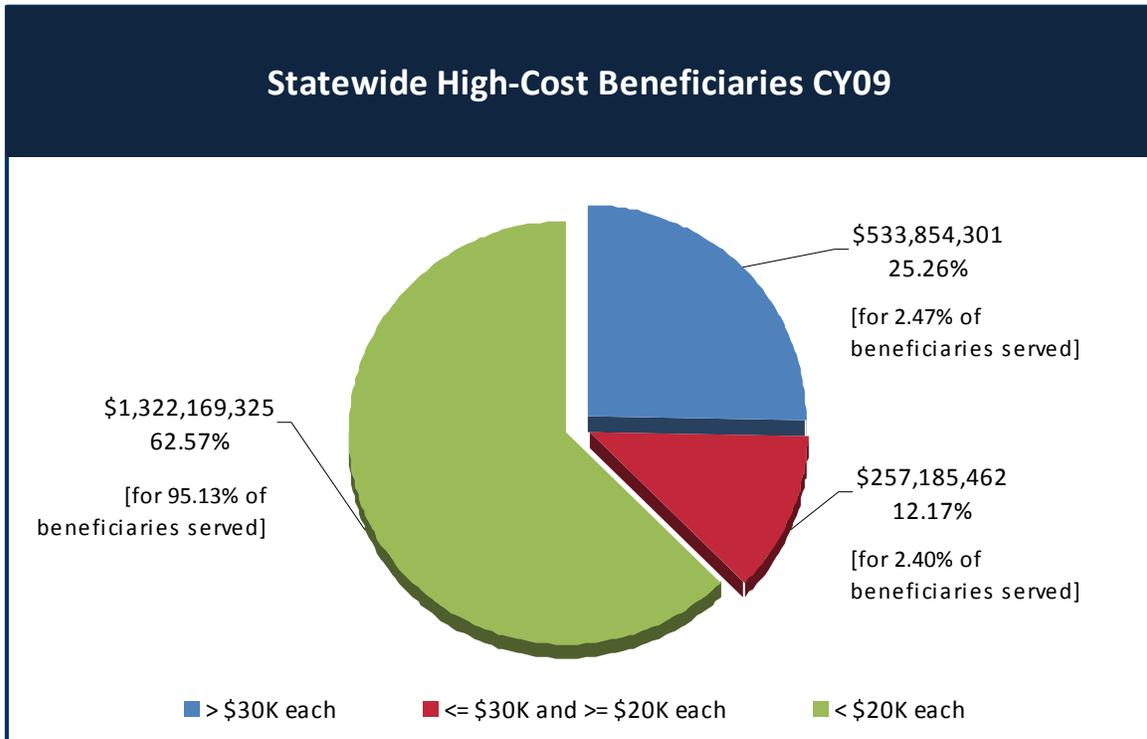
Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Retention Rates



CY2009 Retention Rates with Average Approved Claims per Category			
Number of Services Approved per Beneficiary Served	San Diego Number of beneficiaries served	San Diego \$ per beneficiary served	Statewide \$ per beneficiary served
1 service	2,397	\$135	\$281
2 services	2,104	\$257	\$434
3 services	2,706	\$419	\$564
4 services	1,668	\$501	\$696
5 – 15 services	10,626	\$1,079	\$1,440
> 15 services	10,490	\$7,696	\$9,934

High Cost Beneficiaries CY09



EXAMINATION OF DISPARITIES

Statewide disparities remain for Hispanic and female beneficiaries:

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

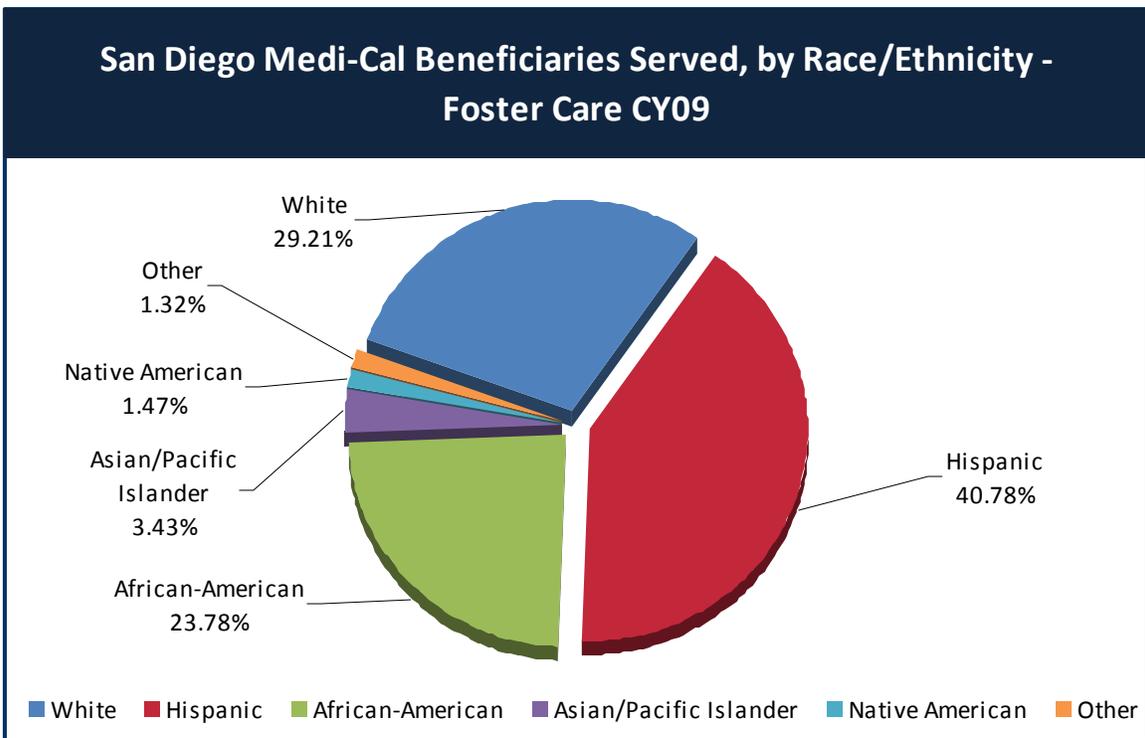
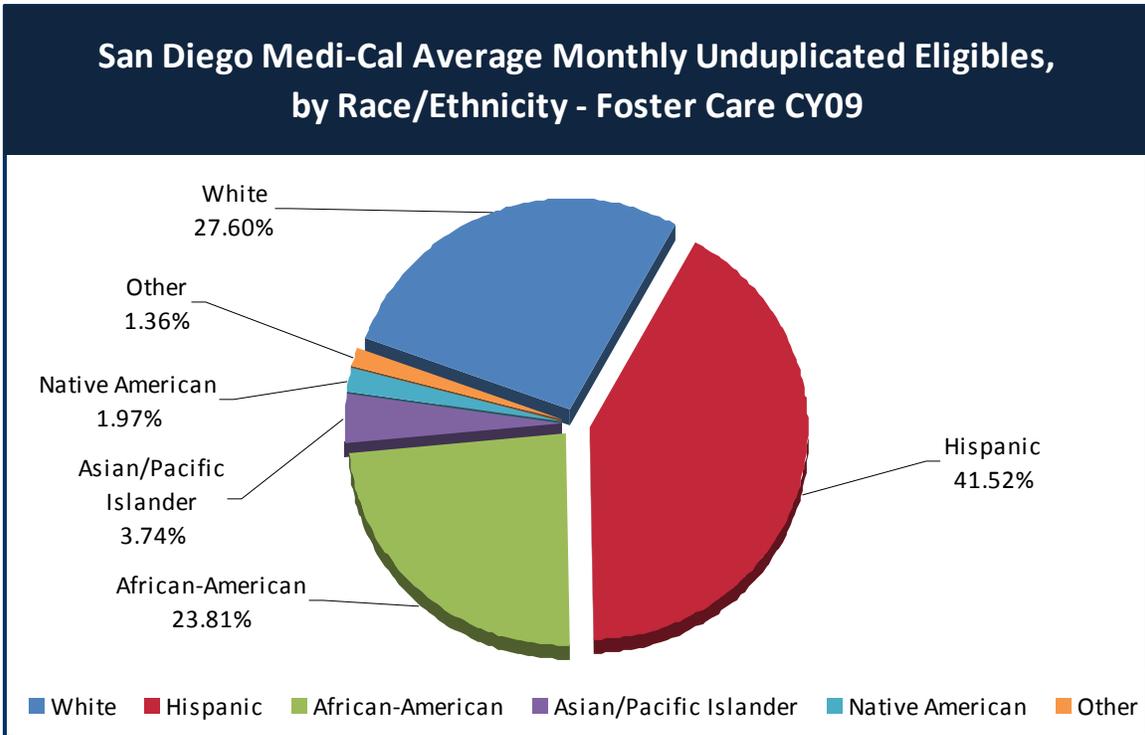
For each variable (Hispanic/White and female/male), two ratios are calculated to depict relative access and relative approved claims. The first figure compares approved claims data and penetration rates between Hispanic and White beneficiaries. This penetration rate ratio is calculated by dividing the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

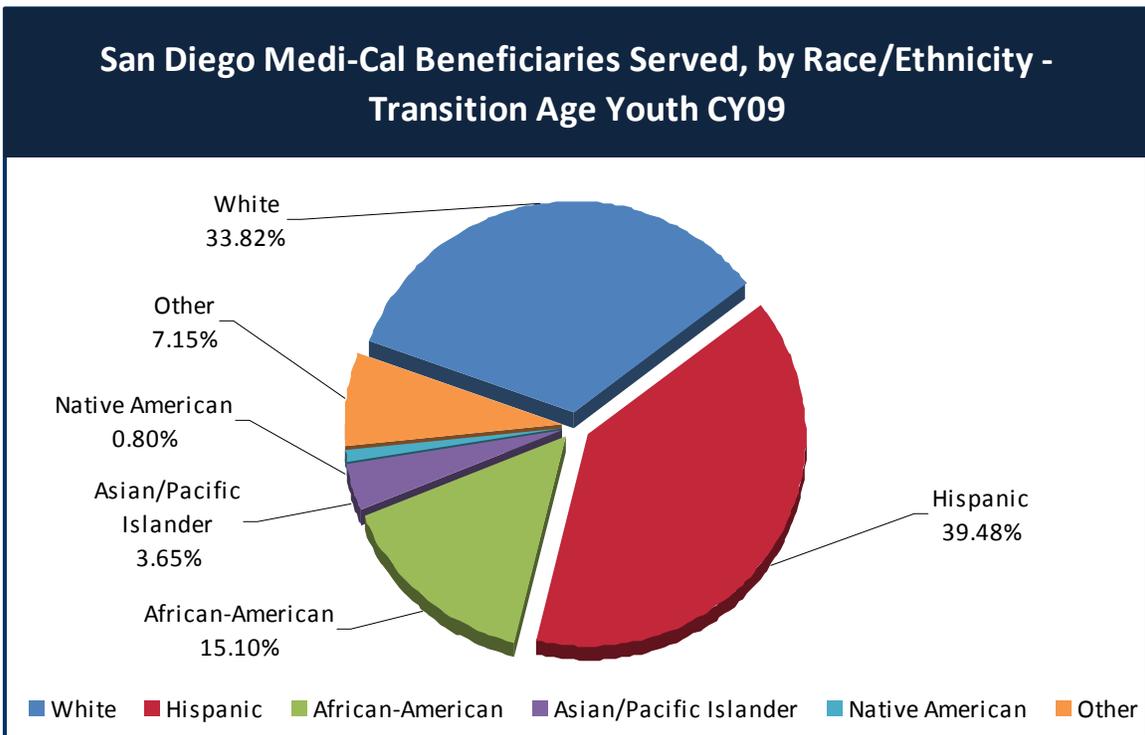
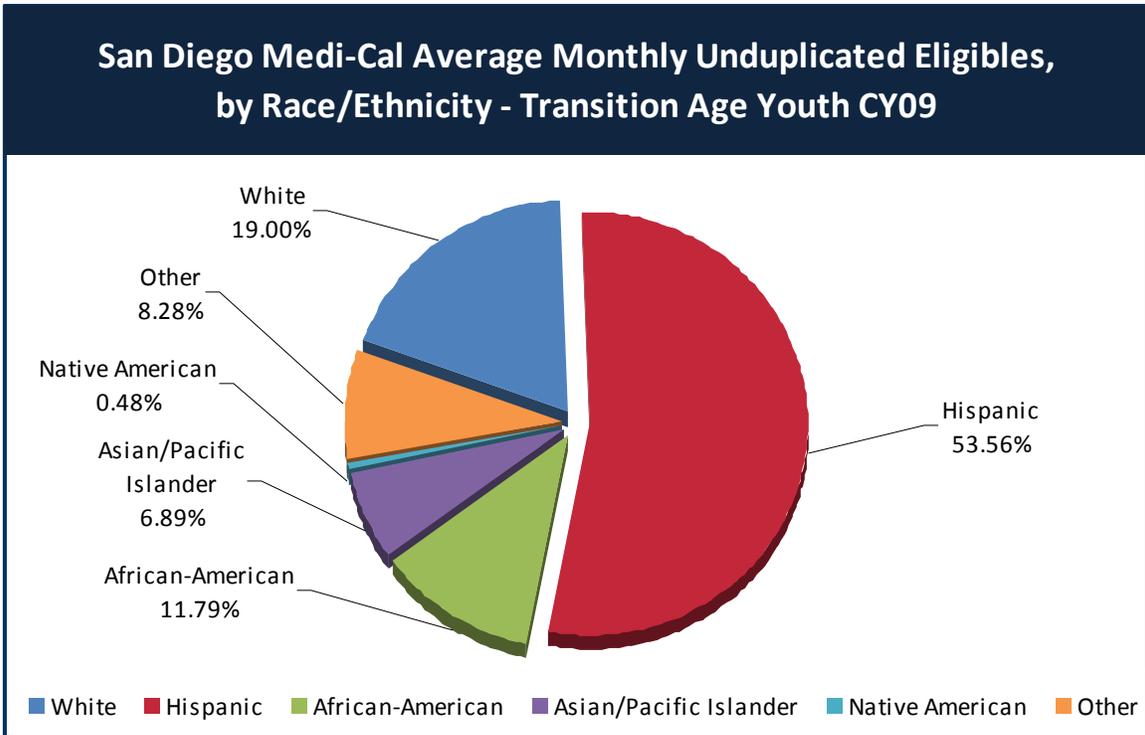
For all elements, ratios depict the following:

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

Examination of Disparities—Hispanic versus White								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY09	139,264	3.46%	163,864	11.09%	\$4,580	\$4,894	.31	.94
San Diego CY09	9,304	4.71%	11,544	12.92%	\$3,164	\$3,105	.36	1.02
San Diego CY08	9,618	5.31%	12,530	14.58%	\$3,123	\$3,113	.36	1.00
San Diego CY07	9,192	5.24%	12,361	14.39%	\$3,303	\$3,274	.36	1.01
San Diego CY06	8,879	5.22%	12,706	14.69%	\$3,482	\$3,441	.36	1.01

Examination of Disparities—Female versus Male								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Female versus Male for	
	Female		Male		Female	Male	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY09	227,299	5.46%	214,383	6.67%	\$4,213	\$5,391	.82	.78
San Diego CY09	15,689	6.73%	14,302	8.17%	\$2,779	\$3,596	.82	.77
San Diego CY08	16,766	7.70%	15,078	9.38%	\$2,776	\$3,577	.82	.78
San Diego CY07	16,363	7.73%	14,571	9.37%	\$2,860	\$3,864	.82	.74
San Diego CY06	16,316	7.90%	14,458	9.53%	\$2,952	\$4,114	.83	.72





San Diego High Cost (over \$30k) Data - CY2009

Demographics	Age Group	Gender	Race Group	Total Beneficiary Served	% Total Beneficiary Served Distribution	High Cost Beneficiary Served	% HC Beneficiary Served	High Cost Beneficiary Served Distribution	Total Approved	High Cost Approved	High Cost Approved Percent	Average Payment High Cost Client	Median Payment High Cost Client	Average Payment Std. Dev. High Cost Client	Average Payment All Client	Median Payment All Client	Average Payment Std. Dev. All Client
Overall				29,991	100%	378	1.26%	100%	\$95,035,844	\$15,994,211	16.8%	\$42,313	\$37,915	\$13,664	\$3,169	\$962	\$6,418
Race/Ethnicity			White	11,544	38%	134	1.16%	35%	\$35,844,252	\$5,883,514	16.4%	\$43,907	\$38,590	\$15,849	\$3,105	\$915	\$6,480
Race/Ethnicity			Hispanic	9,304	31%	96	1.03%	25%	\$29,435,702	\$3,958,699	13.5%	\$41,236	\$36,621	\$12,295	\$3,164	\$1,220	\$5,795
Race/Ethnicity			African-American	3,958	13%	76	1.92%	20%	\$15,897,714	\$3,206,728	20.2%	\$42,194	\$36,853	\$13,055	\$4,017	\$1,136	\$7,679
Race/Ethnicity			Asian/Pacific Islander	2,011	7%	15	0.75%	4%	\$4,142,009	\$625,462	15.1%	\$41,697	\$39,301	\$10,800	\$2,060	\$450	\$5,041
Race/Ethnicity			Native American	228	1%	9	3.95%	2%	\$1,020,653	\$366,231	35.9%	\$40,692	\$38,007	\$8,784	\$4,477	\$1,304	\$9,006
Race/Ethnicity			Other	2,946	10%	48	1.63%	13%	\$8,695,513	\$1,953,577	22.5%	\$40,700	\$36,485	\$12,180	\$2,952	\$768	\$6,632
Gender		Female		15,689	52%	172	1.10%	46%	\$43,605,460	\$7,359,670	16.9%	\$42,789	\$37,931	\$14,766	\$2,779	\$806	\$6,069
Gender		Male		14,302	48%	206	1.44%	54%	\$51,430,383	\$8,634,541	16.8%	\$41,915	\$37,876	\$12,693	\$3,596	\$1,196	\$6,755
Age Group	0-5			1,416	5%	1	0.07%	0%	\$1,860,685	\$49,183	2.6%	\$49,183	\$49,183		\$1,314	\$612	\$2,476
Age Group	6-17			10,346	34%	220	2.13%	58%	\$47,175,327	\$8,947,833	19.0%	\$40,672	\$36,633	\$11,670	\$4,560	\$1,846	\$7,630
Age Group	18-20			1,416	5%	19	1.34%	5%	\$5,676,688	\$784,189	13.8%	\$41,273	\$40,059	\$9,420	\$4,009	\$1,145	\$6,994
Age Group	21-59			14,340	48%	121	0.84%	32%	\$34,822,816	\$5,384,587	15.5%	\$44,501	\$40,115	\$14,729	\$2,428	\$720	\$5,554
Age Group	60+			2,473	8%	17	0.69%	4%	\$5,500,327	\$828,419	15.1%	\$48,731	\$37,012	\$26,206	\$2,224	\$576	\$5,578

Overall - over \$30k	29,991	378	1.26%	\$95,035,844	\$15,994,211	16.8%	\$42,313	\$37,915	\$13,664	\$3,169	\$962	\$6,418
Overall - \$20-\$30k	29,991	527	1.76%	\$95,035,844	\$12,688,463	13.4%	\$24,077	\$23,628	\$2,771	\$3,169	\$962	\$6,418
Overall - under \$20k	29,991	29,086	96.98%	\$95,035,844	\$66,353,170	69.8%	\$2,281	\$901	\$3,360	\$3,169	\$962	\$6,418

San Diego Middle Cost (\$20k to \$30k) Data - CY2009

Demographics	Age Group	Gender	Race Group	Total Beneficiary Served	% Total Beneficiary Served Distribution	Middle Cost Beneficiary Served	% Middle Cost Beneficiary Served	Middle Cost Beneficiary Served Distribution	Total Approved	Middle Cost Approved	Middle Cost Approved Percent	Average Payment Middle Cost Client	Median Payment Middle Cost Client	Average Payment Std. Dev. Middle Cost Client	Average Payment All Client	Median Payment All Client	Average Payment Std. Dev. All Client
Overall				29,991	100%	527	1.76%	100%	\$95,035,844	\$12,688,463	13.4%	\$24,077	\$23,628	\$2,771	\$3,169	\$962	\$6,418
Race/Ethnicity			White	11,544	38%	208	1.80%	39%	\$35,844,252	\$4,997,409	13.9%	\$24,026	\$23,574	\$2,845	\$3,105	\$915	\$6,480
Race/Ethnicity			Hispanic	9,304	31%	127	1.37%	24%	\$29,435,702	\$3,049,228	10.4%	\$24,010	\$23,226	\$2,805	\$3,164	\$1,220	\$5,795
Race/Ethnicity			African-American	3,958	13%	114	2.88%	22%	\$15,897,714	\$2,755,910	17.3%	\$24,175	\$23,896	\$2,732	\$4,017	\$1,136	\$7,679
Race/Ethnicity			Asian/Pacific Islander	2,011	7%	23	1.14%	4%	\$4,142,009	\$537,742	13.0%	\$23,380	\$23,255	\$2,630	\$2,060	\$450	\$5,041
Race/Ethnicity			Native American	228	1%	4	1.75%	1%	\$1,020,653	\$105,442	10.3%	\$26,361	\$26,178	\$2,903	\$4,477	\$1,304	\$9,006
Race/Ethnicity			Other	2,946	10%	51	1.73%	10%	\$8,695,513	\$1,242,732	14.3%	\$24,367	\$24,283	\$2,496	\$2,952	\$768	\$6,632
Gender		Female		15,689	52%	227	1.45%	43%	\$43,605,460	\$5,490,985	12.6%	\$24,189	\$23,810	\$2,870	\$2,779	\$806	\$6,069
Gender		Male		14,302	48%	300	2.10%	57%	\$51,430,383	\$7,197,478	14.0%	\$23,992	\$23,524	\$2,695	\$3,596	\$1,196	\$6,755
Age Group	0-5			1,416	5%	2	0.14%	0%	\$1,860,685	\$42,808	2.3%	\$21,404	\$21,404	\$483	\$1,314	\$612	\$2,476
Age Group	6-17			10,346	34%	321	3.10%	61%	\$47,175,327	\$7,739,106	16.4%	\$24,109	\$23,647	\$2,789	\$4,560	\$1,846	\$7,630
Age Group	18-20			1,416	5%	39	2.75%	7%	\$5,676,688	\$929,843	16.4%	\$23,842	\$22,885	\$2,790	\$4,009	\$1,145	\$6,994
Age Group	21-59			14,340	48%	150	1.05%	28%	\$34,822,816	\$3,611,748	10.4%	\$24,078	\$23,761	\$2,687	\$2,428	\$720	\$5,554
Age Group	60+			2,473	8%	15	0.61%	3%	\$5,500,327	\$364,958	6.6%	\$24,331	\$23,520	\$3,367	\$2,224	\$576	\$5,578

Overall - over \$30k	29,991	378	1.26%	\$95,035,844	\$15,994,211	16.8%	\$42,313	\$37,915	\$13,664	\$3,169	\$962	\$6,418
Overall - \$20-\$30k	29,991	527	1.76%	\$95,035,844	\$12,688,463	13.4%	\$24,077	\$23,628	\$2,771	\$3,169	\$962	\$6,418
Overall - under \$20k	29,991	29,086	96.98%	\$95,035,844	\$66,353,170	69.8%	\$2,281	\$901	\$3,360	\$3,169	\$962	\$6,418

E. Attachment—PIP Validation Tool

FY10-11 Review of: San Diego

Clinical Non-Clinical

PIP Title: EPSDT

Date PIP Began: November 2008

PIP Category: Access Timeliness Quality Outcomes Other

Descriptive Category: Improved treatment and referral process

Target Population: Foster youth ages 0-5 and EPSDT consumers who meet the threshold cost criteria of \$3,000 for three months and who entered services at age 7 and younger

The MHP did not submit an active Clinical PIP. All elements are rated as “not met” for purposes of analysis, but comments and recommendations are included for purposes of technical assistance.

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
1	Study topic <i>The study topic:</i>					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations			X		High risk and underserved populations
1.2	Was selected following data collection and analysis of data that supports the identified problem			X		
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		
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
Totals for Step 1:		0	0	5	0	
2	Study Question Definition <i>The written study question: "Will implementing activities such as identification of predictors of high service utilization and the development of appropriate early childhood interventions lead to enhanced quality, effectiveness, and efficiency of service delivery to children, ages 0-5, receiving EPSDT funded mental health services? "</i>					
	2.1	Identifies the problem targeted for improvement			X	"Quality, effectiveness, and efficiency" could be more specifically defined such as "improved screening, retention, and improved outcomes"
	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:		0	0	0	5	
3	Clearly Defined Study Indicators <i>The study indicators:</i> <ul style="list-style-type: none"> • Percentage of foster care consumers age 0-5 that receive developmental screening at DSEP • Lack of retention: percentage of children who receive assessment only (1 visit, but no continued MH treatment) • Percentage of children 0-5 served in MH and CWS • Percentage of children assessed after referral to KidSTART Center and EPSDT Clinic using ASQ:SE and ECBI • Placement instability: percentage of children changing placements due to behavior problems or caregiver stress • Percentage of children with caregiver participation at ICT meetings (new indicator) • Percentage of children with caregiver participation in treatment sessions at least two times per month (new indicator) • Percentage of children with outcome measure improvement on ASQ-SE, CBLC, or CFARS after receiving 26 sessions (new indicator) 					
	3.1	Are clearly defined, objective, and measurable			X	Percentage of children 0-5 receiving inpatient services indicator was eliminated.
	3.2	Are designed to answer the study question			X	
	3.3	Are identified to measure changes designed to improve consumer mental health outcomes,			X	

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	functional status, satisfaction, or related processes of care designed to improve same					
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		No baseline data presented.
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:		0	0	7	0	
4	Correctly Identified Study Population <i>The method for identifying the study population:</i>					
4.1	Is accurately and completely defined			X		All children 0-5 years open to CWS will receive an initial assessment. It is expected that approximately 250 of the 800 total will receive more mental health services each year based in the ASQCS score of 57 or higher.
4.2	Included a data collection approach that captures all consumers for whom the study question applies			X		
Totals for Step 4:		0	0	2	0	
5	Use of Valid Sampling Techniques <i>The sampling techniques:</i>					
5.1	Consider the true or estimated frequency of occurrence in the population				X	
5.2	Identify the sample size				X	
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:		0	0	0	5	

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
6	Accurate/Complete Data Collection <i>The data techniques:</i>					
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		
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:		0	0	5	0	
7	Appropriate Intervention and Improvement Strategies <i>The planned/implemented intervention(s) for improvement:</i> <ul style="list-style-type: none"> Partnership with CWS to develop a co-located EBP screening, triage, assessment, referral, and treatment center (KidSTART) and EPSDT Clinic. Developmental screening of all children entering foster care through the Developmental Screening and Evaluation Program (DSEP) Use of developmental screening and assessment instruments which includes caregiver report (ASQ-SE, ECBI) Increase involvement of caregivers in services Increase access to FSP and TBS programs for children 0-5 Provider trainings on 0-5 service models 					
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		
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			X		
7.4	Are standardized and monitored when an intervention is successful			X		
Totals for Step 7:		0	0	5	0	
8	Analyses of Data and Interpretation of Study Results <i>The data analyses and study results:</i>					

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
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		
8.3	Are presented in an accurate, clear, and easily understood fashion			X		
8.4	Identify initial measurement and remeasurement of study indicators			X		
8.5	Identify statistical differences between initial measurement and remeasurement			X		
8.6	Include the interpretation of findings and the extent to which the study was successful			X		
Totals for Step 8:		0	0	6	0	
9	Improvement Achieved <i>There is evidence for true improvement based on:</i>					
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:		0	0	4	0	
10	Sustained Improvement Achieved <i>There is evidence for sustained improvement based on:</i>					
	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:		0	0	1	0	

FY10-11 Review of: **San Diego**

Clinical Non-Clinical

PIP Title: **Client Involvement**

Date PIP Began: **2009**

PIP Category: Access Timeliness Quality Outcomes Other

Descriptive Category: **Improved treatment process and outcomes measurement**

Target Population: **Adult consumers receiving outpatient and case management services**

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
1	Study topic <i>The study topic:</i>					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	X				High volume
1.2	Was selected following data collection and analysis of data that supports the identified problem	X				
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				
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X				
Totals for Step 1:		5	0	0	0	
2	Study Question Definition <i>The written study question: "Will instituting new procedures increase client perception that they are involved in treatment</i>					

Step		Rating				Comments/Recommendations	
		Met	Partial	Not Met	N/A		
	planning and program planning? The new procedures are: <ul style="list-style-type: none"> • The use of a client self-assessment tool as a way to increase opportunities for client input in treatment planning (RMQ) • The use of a broad scope, recovery oriented, validated assessment tool by clinicians (IMR) and education for clinicians on how best to utilize the tool information to build a recovery oriented, clinical treatment plan • The use of the Recovery Self-Assessment to allow clients to rate the recovery orientation of their services. • New planning workgroups that include clients and family members • New positions that are added to contracts for clients and family members” 						
2.1	Identifies the problem targeted for improvement	X					
2.2	Includes the specific population to be addressed			X		Does not specify TAY and adult populations, though this is described in the study design.	
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:		4	0	1	0		
3	Clearly Defined Study Indicators <i>The study indicators:</i> <ul style="list-style-type: none"> • Recovery Self-Assessment (RSA) mean involvement score • RSA summary score for providers on recovery orientation of their services • Consumer satisfaction with outcomes score on the annual state consumer survey 						
	3.1	Are clearly defined, objective, and measurable	X				Illness Management and Recovery Scale (IMR) clinician rating scores was removed as an indicator. The RMQ data was collected but not reported for the PIP.
	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				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
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				
3.6	Identify relevant benchmarks for each indicator			X		Not identified or presented.
3.7	Identify a specific, measurable goal(s) for each indicator	X				
Totals for Step 3:		6	0	1	0	
4	Correctly Identified Study Population <i>The method for identifying the study population: All TAY, adult and older adult populations receiving outpatient and case management services except for short-term programs like the Walk In Assessment Center. Projected N=1,976–2,101.</i>					
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	0	0	0	
5	Use of Valid Sampling Techniques <i>The sampling techniques:</i>					
5.1	Consider the true or estimated frequency of occurrence in the population				X	
5.2	Identify the sample size				X	
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:		0	0	0	5	
6	Accurate/Complete Data Collection <i>The data techniques:</i>					
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	X				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	remeasurement data					
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:		4	1	0	0	
7	Appropriate Intervention and Improvement Strategies <i>The planned/implemented intervention(s) for improvement:</i> <ul style="list-style-type: none"> • Implementation of new Recover-based, broad scope client assessment tool for clinicians (IMR) • Implementation of new Recovery-based client self-assessment tool (RMQ) • Implementation of clinician training on the clinical use of outcomes tools in treatment planning • Creation of a brochure for clients on the Recovery Model for distribution throughout the outpatient and case management programs 					
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				Recovery trainings began in October 2010 and continue. The recovery brochure has not yet been developed.
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful	X				
7.4	Are standardized and monitored when an intervention is successful			X		
Totals for Step 7:		3	0	1	0	
8	Analyses of Data and Interpretation of Study Results <i>The data analyses and study results:</i>					
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				
8.3	Are presented in an accurate, clear, and easily understood fashion	X				
8.4	Identify initial measurement and remeasurement of study indicators	X				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
8.5	Identify statistical differences between initial measurement and remeasurement	X				
8.6	Include the interpretation of findings and the extent to which the study was successful	X				
Totals for Step 8:		6	0	0	0	
9	Improvement Achieved <i>There is evidence for true improvement based on:</i>					
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				<p>Fifty programs implemented IMR and RMQ into client assessment and treatment planning updates. As of September 2010, 7,500 clients were assessed with the IMR and 6,000 clients were assessed with the RMQ. Anecdotal reports include the agreement by staff that the tools encourage clinical staff to discuss recovery during client sessions and that the self-assessments are easy to use.</p> <p>Client involvement ratings from 2008 to 2010 showed statistically significant improvement on all subscales except two, but they still increased.</p> <p>Overall, provider involvement remained approximately the same. However, this was interpreted as an improvement that the staff realized they were not as recovery oriented as possible.</p> <p>Treatment outcome satisfaction results decreased somewhat and the numbers surveyed decreased</p>

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
						with the change from state mandated to county administered. The MHP did not discuss possible reasons for the decrease in client satisfaction with outcomes.
9.4	Statistical evidence for improvement		X			
Totals for Step 9:		3	1	0	0	
10	Sustained Improvement Achieved <i>There is evidence for sustained improvement based on:</i>					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			X		Repeat measurements have not yet been collected.
Totals for Step 10:		0	0	1	0	

F. Attachment—MHP PIPs Submitted



CAEQRO PIP Outline via Road Map – EPSDT PIP

MHP: San Diego County Behavioral Health Services, Children’s Mental Health
Date PIP Began: Nov 1, 2008
Title of PIP: EPSDT PIP
Clinical or Non-Clinical: Clinical

Assemble multi-functional team

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

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

The following table lists San Diego County’s EPSDT PIP stakeholder committee members including their position and affiliation:

Name	Affiliation	Position
Alexander, Tom	Fred Finch Youth Center	Program Director
Anderson, Kathy	County of San Diego Behavioral Health Services	Performance Outcomes Principal Administrative Analyst
Astor, Katie	County of San Diego-Children’s Mental Health Services	Outpatient Services and Therapeutic Behavioral Services Chief
Chavarin, Claudia	Child & Adolescent Services Research Center	Research Analyst

Name	Affiliation	Position
Culver, Shirley	San Diego Unified School District Special Education	Children's Mental Health Services System of Care Council- Performance Outcomes Committee Chair
Danon, Patty Kay	County of San Diego Child Welfare Services	Adolescent/Residential/Special Services Assistant Deputy Director
Engelman, Celia	County of San Diego Mental Health Services	Quality Improvement Specialist
Fox, Barry	County of San Diego Child Welfare Services	Residential Services Chief
Frink, Kim	County of San Diego Child Welfare Services	Health Planning and Program Specialist
Ganger, Bill	Child & Adolescent Services Research Center	Statistician
Garland, Ann	Child & Adolescent Services Research Center	Associate Director
Hilton, Victoria	County of San Diego Behavioral Health Services	Quality Improvement Program Manager
Leal, Melinda	County of San Diego Children's Mental Health Services	Therapeutic Behavioral Services Program Manager
Lewis, Marshall	County of San Diego Behavioral Health Services	Clinical Director
Marto, Donna	Family and Youth Roundtable CEO	Children's Mental Health Family Liaison
Messel, Ryan	Family and Youth Roundtable Communications Coordinator	Children's Mental Health Services System of Care Council- Performance Outcomes Committee
Milow, Candace	County of San Diego Behavioral Health Services	Quality Improvement Director
Mohler, Edith	County of San Diego Children's Mental Health Services	Administrative Analyst
Myers, Roseann	County of San Diego Children's Mental Health Services	Policy and Program Support Assistant Deputy Director
Peleska, Theresa	County of San Diego Child Welfare Services	Residential Services Protective Services Supervisor
Picker, Jamie	County of San Diego Children's Mental Health Services	Emergency Screening Unit Program Manager
Rolls-Reutz, Jennifer	Child & Adolescent Services Research Center	Research Coordinator
Rowe, Jeff	County of San Diego Behavioral Health Services	Supervising Psychiatrist
Tarke, Henry	County of San Diego-Children's Mental Health Services	Assistant Deputy Director

“Is there really a problem?”

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

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

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

Preliminary analysis of high utilizers:

San Diego County Mental Health Services (SDCMHS) agrees with the State Department of Mental Health stakeholders on the importance of further studying the highest-cost-of-service cohorts. After taking a closer look at the 4% of SD clients who were identified by DMH as having a monthly cost for services equal to or greater than \$3000 in at least one month in FY0708 (N= 738), SDCMHS determined that the initial focus would be a subset (N=313). This subset of clients have a monthly cost for services equal to or greater than \$3000 in at least three months during a fiscal year. A review of our data showed that this subset of clients had a mean cost for services of \$33,153 in FY 0708 (range \$11,046 - \$106,626) compared to a mean cost of \$22,533 for all clients on the high user list provided by the State. The EPSDT service dollars used by this group totaled \$10,377,066. A review of client specific services for this subset of EPSDT clients identified questions about service levels and possible gaps in services.

Data and relevant benchmarks:

We chose to focus on clients who used \$3000 worth of services in three or more months because these children are likely to have severe and persistent mental health problems. It is possible for a child with mild or moderate mental health problems to have a mental health crisis that requires short-term treatment in high intensity services such as TBS, day treatment, and wraparound. In San Diego, use of one of these services could easily boost the total cost of the children’s mental health care to more than \$3000 during a single month.

However, these children are unlikely to continue to require a costly amount of services once their crisis has abated. In contrast, children who frequently use \$3000 worth of services are likely to be significantly impaired and require extensive mental health treatment.

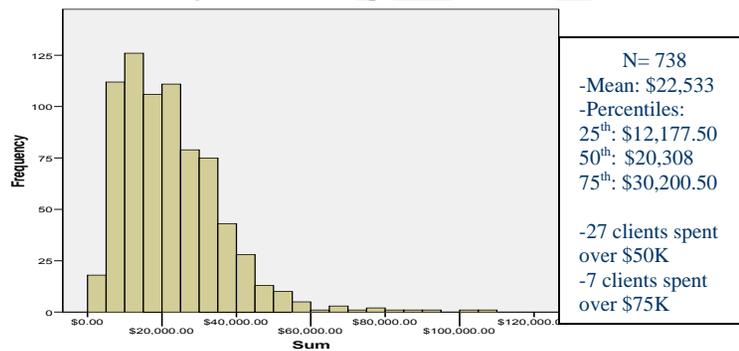
In San Diego County a total of 17,609 EPSDT clients were served in FY 0708. Of these clients, 4% were identified by DMH as having a monthly cost for services equal to or greater than \$3000 in at least one month in FY0708. This represents a baseline of 738 clients. San Diego County completed claims data analysis of all beneficiaries identified by DMH to be high users. The file for this period included claims for 738 clients totaling \$16,629,685 service dollars.

Demographics and costs for these clients are described below:

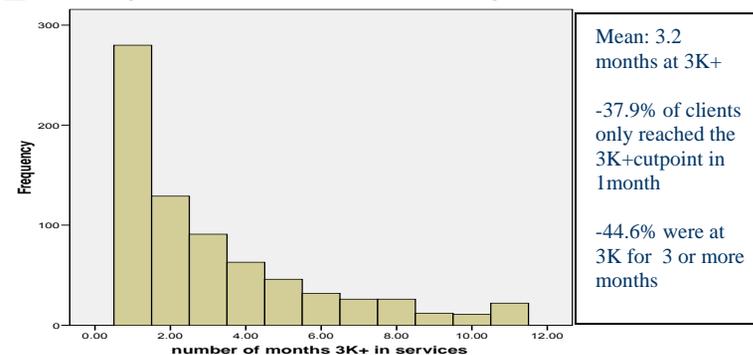
Table 1A – Demographic Characteristics and Comparison with FY 07-08 Children’s MH Population

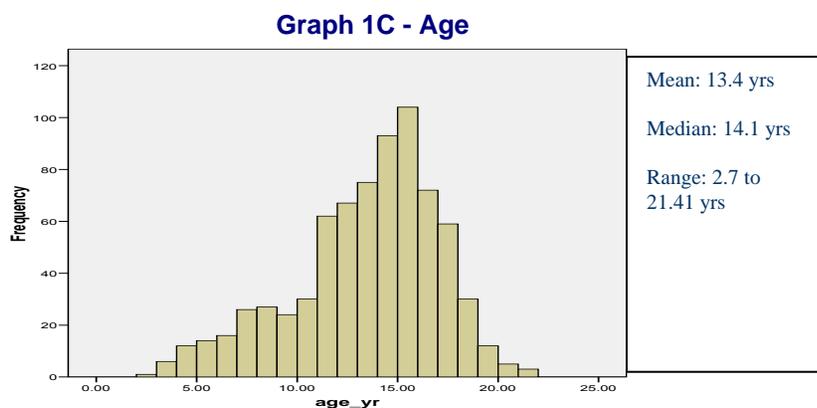
	EPSDT PIP Eligible FY 07-08 (N=738)	All Children’s Mental Health System FY 07-08 (N=17,609)
Gender		
Female	36.4%	39%
Male	63.2%	61%
Race/ Ethnicity		
Hispanic	37.4%	48%
White	31.4%	27%
African-American	19.8%	15%
Asian/Pacific Islander	2.3%	2%
Native American	0.4%	1%
Other/Unknown	8.6%	7%

Graph 1A - Average Costs



Graph 1B - Months above 3K cutpoint





Extensive data analyses were carried out to examine these high cost users and determine how they differed, if at all, from the overall Children’s Mental Health Services (CMHS) population. We examined service utilization patterns, intensity of service usage, and types of diagnosis. Other than more time in service and more types of services used, no significant difference was found; however, our analyses did show that many of these clients were receiving services from several sectors of care, particularly Special Education and CWS. It was also noted that use of high-end services, such as TBS, Day Treatment, or Wraparound, would automatically boost service billings to over \$3,000 during a single month. Since these services are designed to prevent out-of-home placements or ease transition back from a placement, it is reasonable that a child would appropriately enter high end service for a short term (one or two months alone) to ease a critical situation and then move to lower intensity service.

Of the 738 clients on the high-cost list, 37.9% of the clients were shown to have used over \$3,000 in services for one month only, while an additional 17.5% of the clients reached the \$3,000 cutpoint for two months only, and 44.6% in three or more months. We conducted analyses based on the number of months a client was above the \$3,000 cutpoint, using three groups: clients that reached the cutpoint in one month, clients that reached the cutpoint in two months, and clients who reached the cutpoint for three or more months.

Logistic modeling was conducted to identify predictors of high service utilization among the three groups. Across several models, only age at initial service and numbers of episodes per year were significant predictors of being in the three months or higher group. The younger a client entered services, the more likely he/she would become a multiple month high cost utilizer; similarly, higher episode count per year of service also predicted being in the highest cost of service cohort. Data that supports the above findings include mean age at first episode of sample: 7.9 yrs compared to overall system mean of 9.0 yrs and mean episode count per year of service: 5.59

compared to overall system mean of 1.78. In addition, children in the 3+ months above the cutpoint group were significantly more impaired at intake according to the standardized outcomes assessment, and their first episode in services was more likely to occur in the inpatient, emergency screening unit, or residential day treatment setting.

Given these significant statistical differences between the three groups, the EPSDT PIP workgroup decided to initially focus on children who reached the \$3K+ threshold for three or more months to determine whether they were receiving the most timely, effective and efficient services. These clients represent 44.6% (N=313) of the initial high cost list. After taking a closer look at this study sample (N=313), data showed that these clients had a mean cost of \$33,153 in FY 0708 (range \$11,046 - \$106,626) compared to a mean cost of \$22,533 for all clients on the high user list (N=738). The EPSDT service dollars used by this group totaled \$10,377,066.

Comprehensive analysis of the identified study sample (N=313) revealed even more significant differences when compared to all clients on the high user list (N=738) and the overall CMHS population (N=17609). The data demonstrated that youth in the high cost study group were younger at service entry, had more episode counts overall, used more costly services such as Day Treatment, TBS, and Inpatient, had multiple sector involvement such as Special Education and CWS, and had a much higher bipolar rate when compared to the CMHS population. **Table 2** summarizes these findings.

Table 2 – Striking Differences in Service Utilization Patterns

	All CMHS FY 07-08 (N=17,609)	All High Cost FY 07-08 (N=738)	* High Cost Study Sample (N=313)
Mean Age at First Episode	9.0 yrs (+/- 4.6)	8.14 (+/- 3.6)	7.9yrs (+/- 3.4)
Mean Episode Count	4.24 (+/- 6.26)	17.26 (+/- 16.1)	21.68 (+/- 17.5)
Mean Episode Count Per Year of Service	1.78 (+/- 1.75)	4.69 (+/- 4.87)	5.59 (+/- 5.94)
Mean Cost		\$22,533.	\$33,153.40
Day Treatment Use	~10%	61.8%	74%
TBS Use	~2%	25.7%	32%
Inpatient Use	~4%	19.4%	26%
CWS Involvement	22.3%	54.4%	51.4%
Special Education Services	34.8%	68.1%	73.5%
Emotional Disturbance	9.6%	38.6%	49.2%
Bipolar Diagnosis	5.2%	11.1%	22%

* Clients reaching the \$3K+ threshold for three or more months in 12 month period

While San Diego’s findings, thus far, began linking increased severity to the higher average monthly costs for these children, a thorough evaluation of the appropriateness, effectiveness, coordination, and efficiency of service delivery was warranted. In addition, given that younger age at initial entry to the mental health system was significantly associated with going on to become a high cost utilizer across our analyses, the workgroup also decided to further examine children who entered the system at a young age. The committee determined that an in depth clinical review of a random sample of twenty-five clients from the high cost study group (3+ months above

\$3,000) who entered the mental health system below age 8 (mean age of entry for the high cost group) could provide additional detail to help explain the differences noted.

The medical records of these clients were thoroughly analyzed focusing on a number of indicators for high utilization such as, but not limited to social, family, clinical, and treatment history in order to understand the reasons for the patterns of utilization (the workgroup developed a medical record review tool to record all these elements and is included as **Attachment 1**). Results of the chart review are shown in **Table 3**.

Defining the problem:

We did not find evidence of overutilization of services; records we reviewed demonstrated that children received appropriate services given their level of need. What we did identify was the need for early interventions to prevent the need for higher service utilization later on.

Population:

This records review resulted in a decision to define the current study population as children ages 0-5 who have child welfare involvement. Our analysis determined that this cohort may have a gap in services and could experience long term benefits if problems were addressed at earlier ages. Comprehensive rationale for this decision is in item 3a.

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?

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

While San Diego’s findings, thus far, began linking increased severity to the higher average monthly costs for these children, a thorough evaluation of the appropriateness, effectiveness, coordination, and efficiency of service delivery was warranted. In addition, given that younger age at initial entry to the mental health system was significantly associated with going on to become a high cost utilizer across our analyses, the workgroup also decided to further examine children who entered the system at a young age. As noted above the committee determined that an in depth clinical review of a random sample of twenty-five clients from the high cost study group (3+

months above \$3,000) who entered the mental health system below age 8 (mean age of entry for the high cost group) could provide additional detail to help explain the differences noted.

Table 3 summarizes findings recorded on the medical record review tools. A complete report of the findings is included as **Attachment 2**.

Table 3 – Medical Records Review Summary of Findings

Trauma Risk Factors		Totals	%	
1	Physical abuse	9	36	92% had CWS involvement
2	Emotional abuse	9	36	88% had displayed aggressive behavior
3	Sexual abuse	5	20	
4	Neglect	10	40	84% had problems at school
5	CWS involvement	23	92	
6	Criminal Justice System involvement	0	0	84% had substance abuse exposure in the home
7	Home removal [specify destination]	16	64	
8	Multiple placements [specify #]	8	32	76% had other behavioral risk factors not specified on the tool that included: self harming behaviors such as head banging and face scratching, trichotillomania, enuresis, encopresis, nightmares, severe tantruming, thumb sucking, attachment issues, and other unsafe and not age appropriate behaviors.
9	Other trauma	14	56	
Biological Risk Factors				
1	Intrauterine exposure to TOB, ETOH, or drugs	12	48	
2	Birth complications	7	28	
3	Injury (brain trauma, etc.)	1	4	
4	Infection	1	4	72% had a family psychopathology history
5	Toxin exposure (lead, etc.)	0	0	
6	Pre-existing conditions	3	12	68% witnessed domestic violence
7	Other	5	20	
Psychosocial Risk Factors				
1	Family psychopathology [specify]	18	72	68% had other psychosocial risk factors not specified on the tool such as: parent's separation, frequent moves, sibling separation during home removals, exposure to detrimental health/living conditions.
2	Economic hardship [specify]	13	52	
3	Substance abuse in house	21	84	
4	Substance abuse by client	0	0	
5	Incarceration of family member	12	48	64% had home removal
6	Caretaker death	1	4	
7	Caretaker physical illness	4	16	
8	Domestic Violence	17	68	56% had other trauma not specified on the tool such as exposure to pornography and sexual activity, extreme violence, homelessness.
9	Military rotation [specify]	1	4	
10	Lack of insurance	2	8	
11	Other psychosocial	17	68	48% had intrauterine exposure to tobacco, alcohol and/or drugs
Severe Behavioral Risk Factors				

1	Aggression to people	22	88
2	Aggression to animals	4	16
3	Destruction of property	17	68
4	Abnormal sexual behavior	9	36
5	Social impairment	12	48
6	School problems	21	84
7	SI/HI	6	24
8	Other	19	76

48% had family history of incarcerations

6 children had suicidal ideation and/or homicidal ideation

5 children had documented history of sexual abuse

As is evident, there is a high incidence of CWS involvement among high end users in San Diego County. In addition, the retrospective review of services demonstrated that these clients have a high incidence of trauma, biological and psychosocial risk factors, as well as clinically significant behavioral problems at a young age. It is well known that these problems can have tragic and costly outcomes, including developmental delay, academic difficulties, frequent placement failures, institutionalized care, and delinquency, to name but a few.

San Diego's findings are not surprising; numerous studies have identified that children in foster care have greater needs for mental health treatment than children in the general population. What is disconcerting is the fact that the majority of the predictors or risk factors for high utilization documented in the histories of these children occurred during their first years of development, a time where experiences literally shape the developing brain. Extensive research indicates that the early experiences of life lay the foundation for a child's development now and during the course of his or her life. Unfortunately, signs and symptoms of early social and emotional issues are not always as obvious in babies and very young children as they are in older children. As a result and as commonly seen in the PIP sample, mental health assessment and treatment is delayed until later in life when symptoms are clearly evident and other areas of learning and development are affected.

An examination of the available mental health services for young children in San Diego County was conducted by the workgroup. First, it must be pointed out that significant strides have been made in services for young children in recent years that, unfortunately, came too late for many of the children in the high cost sample: they had aged out of young childhood before the changes were implemented. Also, the involvement of many of the young mental health clients in the child welfare system adds an extra complexity to their situation – they often are experiencing placement and caregiver changes that affect their ability to receive consistent, quality care.

The workgroup identified that while improvements had been made, there was still a lack of sufficient quality services to meet the needs of these young children. Limited evidence-based practices exist for children ages 0-5 and those that do, such as PCIT and the Incredible Years (both of which are offered by San Diego County) typically require consistent caregiver involvement. Children involved in the CWS may be at a disadvantage to access these services, as they may not have a consistent caregiver over time. In addition, these programs were typically not designed to meet the complex needs of children involved in the child welfare system.

In sum, while the initial focus of the PIP was to evaluate the appropriateness of the amount and level of services utilized by the high cost study group, this in-depth medical records review of a sample of clients from the high cost study group indicated that these youth received the right amount and level of services given their age and functioning. The medical records review also identified that 92% of the high cost service users sampled had CWS involvement. Further, the findings from the PIP workgroup indicated that there is a lack of quality services available to meet the needs of children ages 0-5. Therefore, it was decided that it would be beneficial to focus on young clients (defined as ages 0-5) with child welfare involvement who are at-risk for becoming high cost service utilizers.

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

Table A – List of Validated Causes/Barriers:

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
1. Poor coordination between CWS and MH staff	Lack of consistent communication between these two sectors – no formal data sharing in place. Providers may not know that child is receiving services from both sectors, especially when child remains in their own home or with kin.
2. Poor identification of children with need when entering CWS	Most young children entering CWS receive a developmental assessment, but there is no consistent effort to examine their mental health needs. In addition, there may not be a caregiver to report on mental health status when a child initially enters out-of-home care – it may take several weeks to determine what services the child needs.
3. Poor identification of early indicators of risk for development, behavioral, or social delays	Child Welfare is primarily concerned with the safety of children at the time a case opens, and child well-being may take a back seat, at least initially. Sufficient systems are not currently in place to assess all young children entering the CW and MH systems for risk of development, behavioral, and social delays.
4. Poor utilization of outcomes measures by providers (CAMS and CFARS)	Although standardized outcomes measures have been used in the mental health system for several years, they are not consistently being obtained from all caregivers and used by providers for treatment planning. In particular, children in CWS present a problem for these measures, as out-of-home caregivers, such as foster parents and group home providers, may not have sufficient information at intake to complete the assessments, which rely on caregiver report of symptom and behavior history.
	Both parents and foster parents in San Diego County report not feeling that they are involved in

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
5. Limited inclusion of parent/foster parent in treatment	<p>treatment sufficiently to be aware of what is going on and to reinforce the therapy work outside of the session.</p> <p>In particular, foster parents report that they are often restricted from obtaining information on services the child has and is receiving, due to CWS policies.</p>
6. Need for better care coordination of high users	<p>Our analyses showed that many of the high cost users initially received disjointed services, had large gaps in service, and typically went on to receive services from more than one provider at the same time. It is not always clear that transition plans have been established at discharge from services, especially when stepping down from higher levels of care.</p>
7. Fewer services available to young children.	<p>Services to children under age 6 are limited in the County and in mental health in general – there are few evidence-based practices for this age group and most are parent-mediated interventions, which may be problematic for a CW involved population.</p>

Formulate the study question

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

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

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

Will implementing activities such as identification of predictors of high service utilization and the development of appropriate early childhood interventions lead to enhanced quality, effectiveness, and efficiency of service delivery to children, ages 0-5, receiving EPSDT funded mental health services?

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

Yes

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

All children ages 0-5 in the Child Welfare system will receive an initial assessment (Ages and Stages). It is expected that approximately 250 of these children will receive more in-depth mental health services each year, as indicated by the assessment.

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

All children ages 0-5 open to CWS (there were approximately 800 children who met this criteria in FY08-09) will be screened for inclusion in the PIP.

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

No sampling technique was employed.

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

Eligibility is based on a score, tentatively set at 57 or higher on the ASQCS, as agreed upon by CMHS and CWS. We expect to serve approximately 20-30% of the screened population.

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

Planned interventions

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

9. a) Why were these performance indicators selected?

The performance indicators were selected as the quality measure as they address structural, procedural changes that are planned as well as outcomes measures expected from enhanced services.

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

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

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal	Methodology for data collection
1	Developmental screening of foster children, age 0-5, through the Developmental Screening and Evaluation Program (DSEP)	Number of foster children, age 0-5, that were screened at DSEP	Total number of children, age 0-5, that entered foster care	09/10 data - % foster children screened at DSEP	100%	CWS/DSEP data
2	Number of services provided to children age 0-5 (retention)	Number of children, age 0-5, receiving assessment only (1 visit) (MH)	Total number of children, age 0-5	TBD	At least 5% decrease in children 0-5 receiving assessment only (1 visit)	MH - Anasazi
3	Number of children age 0-5 in CWS receiving services in the CMH System	Number of children, age 0-5, served in both the CWS and CMH Systems (CWS/MH)	Total number of children, age 0-5, served in the CWS System (CWS)	Percent of CWS clients 0-5 receiving CMH services: FY0607—15.9% FY0708—15.2% FY0809—15.2%	increase by 5%	MH

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal	Methodology for data collection
4	Assessment of all children referred to KidSTART Center using a standardized measure such as Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) or Child Behavior Checklist (CBCL)	Number of unduplicated children assessed using standardized measures (KidSTART Center)	Total number of unduplicated children referred (KidSTART Center)	N/A	95%	KidSTART Center
5	Evaluation of all children referred to KidSTART EPSDT Clinic, with an eligible referral and who attended 4 or more sessions, using standardized measures, such as Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) and Eyberg Child Behavior Inventory (ECBI)	Number of unduplicated children with an eligible referral and who attended 4 or more sessions who were assessed using standardized measures (KidSTART EPSDT Clinic)	Total number of unduplicated children with an eligible referral and who attended 4 or more sessions (KidSTART EPSDT Clinic)	N/A	95%	KidSTART EPSDT Clinic
6	Stability in placements of children with intervention (KidSTART Center and EPSDT Clinic)	Number of children changing placements due to behavior problems or caregiver stress (KidSTART Center and EPSDT Clinic)	Total number of children served (KidSTART Center and EPSDT Clinic)	N/A	<20% will change placement due to behavior problems or caregiver stress	KidSTART (Center and EPSDT Clinic)
7	Family participation of children with intervention (KidSTART Center) "family" includes biological, extended, or surrogate family	Number of children with KidSTART Center ICT meetings with caregiver participation	Total number of children with KidSTART ICT meetings (with caregiver participation requested by KidSTART Center)	N/A	90%	KidSTART Center
8	Family participation of children with intervention	Number of children served through	Total number of children served at	N/A	95%	KidSTART EPSDT Clinic

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal	Methodology for data collection
	(KidSTART EPSDT Clinic) "family" includes biological, extended, or surrogate family	KidSTART EPSDT Clinic with caregiver participation in treatment sessions (at least two times per month)	KidSTART EPSDT Clinic			
9	Outcome measures show improvement in behavioral and/or emotional problems after 26 sessions (KidSTART EPSDT Clinic)	Number of children receiving 26 sessions at KidSTART EPSDT Clinic that showed improvement on the ASQ-SE, CBCL, or CFARS	Total number of children that received 26 sessions at KidSTART EPSDT Clinic (and had an intake and 26 session/ discharge assessment)	N/A	* - 80% of discharged clients will show improvement between intake and discharge on the ASQ-SE, CBCL, and CFARS	KidSTART EPSDT Clinic

*-ASQ-SE - 80% of discharged clients will show improvement between intake and discharge on the ASQ-SE [with a score less than or equal to the cutoff score for clinically significant problems (determined by the questionnaire age interval) at discharge]
 -CBCL - 80% of discharged clients will show improvement between intake and discharge (as measured by a 9 point or greater decrease in the total problems raw score)
 -CFARS - for 80% of discharged clients whose episode lasted 3 weeks or longer, the CFARS score shall be at least one level lower at discharge than at intake in at least one index area

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

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	Partnership between CWS and CMHS to develop a Screening, Triage, Assessment, Referral and Treatment (KidSTART) Center and EPSDT Clinic co-located within	All barrier(s)/causes listed in Table A	FY 2010-11

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
	<p>1 facility that will focus on providing timely intervention when treatment can be most efficient and cost-effective</p> <p>(See Attachment 3: Minute Order for San Diego KidSTART Center)</p>		
2	Systematic developmental screening of all children entering foster care through the Developmental Screening and Evaluation Program (DSEP)	#2 in Table A	
3	Use of developmental screening and assessment instruments which also include caregiver report on social and emotional development for young children such as: ASQ-SE, ECBI	#3 in Table A	
4	KidSTART EPSDT Clinic shall operate an evidence based practice for children 0-5	#7 in Table A	
5	Increase involvement of caregivers in services (Note: caregiver participation has been selected as a performance indicator)	#5 in Table A	
6	Increase access to FSP and TBS programs for children ages 0-5	#6 & 7 in Table A	
7	MH trainings for providers on service models appropriate for the 0-5 age group	#3, 5, 7 in Table A	

Apply Interventions: “What do we see?”

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

The following measures will be used for all clients unless otherwise noted:

- Eyberg Child Behavior Inventory
- Child Functional Assessment Rating Scale
- Child Behavior Checklist
- UCLA PTSD Reaction Index, parent version
- Trauma Symptom Checklist for Young Children
- Center for Epidemiologic Studies—Depression Scales (only for Child Parent Psychotherapy (CPP) clients)
- Parenting Stress Index (only for CPP and Parent Child Interaction Therapy clients)

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

Existing Anasazi data will be collected and supplemented with outcome and demographic data from KidStart, CWS, First 5, and CASRC DES databases. Data on measures list in Q. 11 will be collected at intake, UM cycle, and discharge.

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

Descriptive information, placement changes, changes in scores on measures listed in Q. 11.

Contingency plans/Issues inherent to the special population served by this intervention (kids new to foster care) include a “grace periods” of model behavior when children enter new foster homes. This can be addressed with more frequent administration of the ECBI. Additionally, there is the potential problem of caregiver change-- this can be addressed in part with additional questions on measures to identify respondent.

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

Lauren Brookman-Frazeo, PhD is an Assistant Professor of Psychiatry at UCSD and licensed Clinical Psychologist. She provides consultation to KidSTART Center on program evaluation and outcome measurement.

Andrea Hazen, PhD is a Research Scientist at Rady Children's Hospital and licensed clinical psychologist. Dr. Hazen is responsible for data collection, management and analysis of outcomes for children receiving mental health treatment through KidSTART EPSDT Clinic.

Gina Misch, MPH is the Evaluation Coordinator for the KidSTART Program. She is responsible for data collection, management and analysis of outcomes for children receiving triage, assessment, care coordination, and developmental treatments through KidSTART Center.

Vyan Nguyen, MD is the KidSTART Center program manager and Ginger Bial, LCSW is the KidSTART EPSDT Clinic Program Manager.

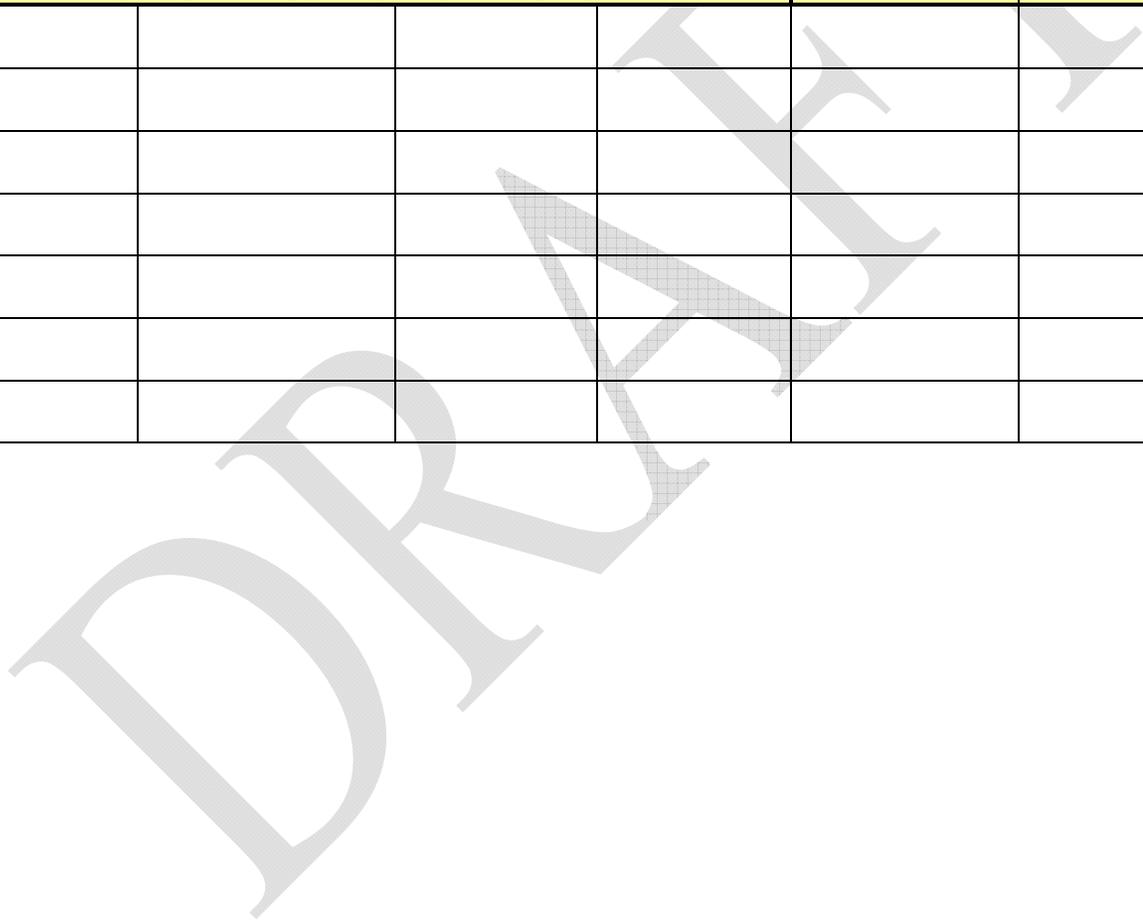
15. **Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects? What might be next steps in the EPSDT PIP?**

Staff at the Child and Adolescent Services Research Center who have been trained in statistical methodology will analyze the data. They will use the numerators and denominators listed in Table B to calculate the performance indicators.

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

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

Describe performance indicator	Date of baseline measurement	Baseline 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?

DRAFT

Attachments

Attachment 1: San Diego County EPSDT PIP Medical Record Data Elements Recording Tool

Attachment 2: In-Depth review of 25 Case Files from EPSDT PIP Study Sample – Key Findings Report

Attachment 3: Minute Order for KidSTART Center

DRAFT

SAN DIEGO COUNTY EPSDT PIP MEDICAL RECORD DATA ELEMENTS RECORDING

Client Name	Sample Case#	DOB	
1st Service Date		MRN	
1st Service Type		SSN	

Primary presenting problem:

		Yes	Unknown or No Data Documented	Prior to Receiving Services Age	While Receiving Services Age	Notes
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Trauma Factors

1	Physical abuse					
2	Emotional abuse					
3	Sexual abuse					
4	Neglect					
5	CWS involvement					
6	Criminal Justice System involvement [specify type]					
7	Home removal [specify destination]					
8	Multiple placements [specify #]					
9	Other trauma					

Biological Risk Factors

1	Intrauterine exposure to TOB, ETOH, or drugs					
2	Birth complications					
3	Injury (brain trauma, etc.)					
4	Infection					
5	Toxin exposure (lead, etc.)					
6	Pre-existing conditions (Mental retardation, Chromosomal sd, Develop. d/o)					
7	Other					

Sample Case#		Page 2						
		Yes	Unknown or No Data Documented	Prior to Receiving Services Age		While Receiving Services Age		Notes
Psychosocial risk Factors								
1	Family psychopathology [specify]							
2	Economic hardship [specify]							
3	Substance abuse in house							
4	Substance abuse by client							
5	Incarceration of family member							
6	Caretaker death							
7	Caretaker physical illness							
8	Domestic Violence							
9	Military rotation [specify]							
10	Lack of insurance							
11	Other psychosocial							
Behavioral Risk Factors								
1	Aggression to people							
2	Aggression to animals							
3	Destruction of property							
4	Abnormal sexual behavior							
5	Social impairment							
6	School problems							
7	SI/HI							
8	Other							

Sample Case#		Page 3					
		Order of Service Use and length of episodes					
History of Treatment Settings							
1	IP						
2	OP						
	Crisis Stabilization						
	Crisis Intervention						
	ESU						
3	CM						
4	DT						
5	TBS						
6	Wraparound						
7	Other						
		Yes	No	Notes			
1	Client compliance						
2	Caregiver involvement in treatment						
3	Service gap noted [specify]						

Case # Notes

Page

**In-Depth Review of 25 Case Files from EPSDT PIP Study Sample
Review Period: 2006 to October 2008**

In depth MRRs were conducted on 25 children who met the following criteria:

- o Were on state list of EPSDT users with \$3K+ in expenditure for 3 or more months
- o Entered the system before age 8

The service history of the 25 clients included services from 84 different reporting units and resulted in over 100 medical records reviewed

1. Significant Findings:

Table 1 includes predictors or risk factors for high utilization recorded on the medical record review tool. The most significant findings are described to the right.

Table 1

Trauma Risk Factors		Totals	%
1	Physical abuse	9	36
2	Emotional abuse	9	36
3	Sexual abuse	5	20
4	Neglect	10	40
5	CWS involvement	23	92
6	Criminal Justice System involvement	0	0
7	Home removal [specify destination]	16	64
8	Multiple placements [specify #]	8	32
9	Other trauma	14	56
Biological Risk Factors			
1	Intrauterine exposure to TOB, ETOH, or drugs	12	48
2	Birth complications	7	28
3	Injury (brain trauma, etc.)	1	4
4	Infection	1	4
5	Toxin exposure (lead, etc.)	0	0
6	Pre-existing conditions	3	12
7	Other	5	20
Psychosocial Risk Factors			
1	Family psychopathology [specify]	18	72
2	Economic hardship [specify]	13	52
3	Substance abuse in house	21	84
4	Substance abuse by client	0	0
5	Incarceration of family member	12	48
6	Caretaker death	1	4
7	Caretaker physical illness	4	16
8	Domestic Violence	17	68
9	Military rotation [specify]	1	4
10	Lack of insurance	2	8
11	Other psychosocial	17	68
Severe Behavioral Risk Factors			
1	Aggression to people	22	88
2	Aggression to animals	4	16
3	Destruction of property	17	68
4	Abnormal sexual behavior	9	36
5	Social impairment	12	48
6	School problems	21	84
7	SI/HI	6	24
8	Other	19	76

92% had CWS involvement

88% had displayed aggressive behavior

84% had problems at school

84% had substance abuse exposure in the home

76% had other behavioral risk factors not specified on the tool that included: self harming behaviors such as head banging and face scratching, trichotillomania, enuresis, encopresis, nightmares, severe tantruming, thumb sucking, attachment issues, and other unsafe and not age appropriate behaviors.

72% had a family psychopathology history

68% witnessed domestic violence

68% had other psychosocial risk factors not specified on the tool such as: parent's separation, frequent moves, sibling separation during home removals, exposure to detrimental health/living conditions

64% had home removal

56% had other trauma not specified on the tool such as exposure to pornography and sexual activity, extreme violence, homelessness.

48% had intrauterine exposure to tobacco, alcohol and/or drugs

48% had family history of incarcerations

6 children had suicidal ideation and/or homicidal ideation

5 children had documented history of sexual abuse

As is evident, there is a high incidence of CWS involvement among high end users.

2. Other Findings:

- Significantly younger at service entry: 16 out of 25 were in the 0-5 age group at first episode
- Most of these children had or were in the process of obtaining an IEP and some were classified as ED
- Prescription of multiple psychotropic meds and multiple placements due to behavior problems in the early years was common
- Siblings' involvement with CWS and MHS as well as parent involvement with CWS as minors were recurring findings
- 2 children were registered as "969" youth needing highest level of foster home placement
- 1 child had profound bilateral deafness and was initially placed in foster home with no sign language knowledge

2. Reviewer Observations:

- Records indicate that in many cases, although intensive services were provided, these clients routinely needed higher levels of care.
- Caregivers' frustration with clients' behaviors was frequently identified as a problem, but there was little or no documentation of resources or referrals provided to caregiver.
- Caregivers frequently used emergency response teams as a means of dealing with crisis resulting in frequent client hospitalizations (72hr holds- some of these episodes do not show on INSYST).
- System data shows that only 3 out of the 25 clients used IP; however all three were readmitted within 30 days of discharge.
- Little or no collateral services being provided to the family were documented in records; however administrative collateral services were documented.
- Even though substance abuse, domestic violence, and mental health issues in the family were commonly identified, only 1 case had documentation of services or referrals to address these issues.
- Even though attachment issues were frequently documented, diagnosis of attachment disorder was not made by treating providers.
- Multiple providers involved in treatment, but little or no communication among them was noted on records.
- Client and family history documentation was noted to be frequently poor.
- Age of mother or caregiver was only found on one of the records.
- In many of the cases providers did not routinely request or evaluate prior client's records which appeared to result in duplication of services and/or delay in treatment provision.
- Most of the FFS provider records had inconsistent and incomplete documentation. The quality of records varied greatly, some kept documentation on notebook paper with only 2 sentences for entire assessment.

**COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, JANUARY 12, 2010**

MINUTE ORDER NO. 2

SUBJECT: COMPETITIVE PROCUREMENT FOR SAN DIEGO KIDSTART CENTER (DISTRICTS: ALL)

OVERVIEW:

The Board of Supervisors has demonstrated a long-term commitment to providing programs designed to specifically meet the needs of abused, neglected or abandoned children placed in foster care.

The Health and Human Services Agency (HHS), Child Welfare Services (CWS) is mandated to ensure child safety, permanency of living situations and well being. Studies indicate that fifty to seventy-five percent of children entering foster care exhibit developmental delays, behavioral and/or mental health issues. Today's recommendation, if approved by the Board, will address the need to serve children with the most complex issues by implementing a KidSTART Center at a centralized location.

In line with State law, the First 5 Commission of San Diego oversees funds from a tobacco tax initiative approved by voters in 1998. By law, First 5 funding is earmarked for programs that help children ages 0-5 to become "school ready." On September 11, 2009, the First 5 Commission of San Diego approved funding of \$5,000,000, over six years, for CWS to develop and implement a KidSTART Center. The KidSTART Center will provide comprehensive assessment, individualized service plans, treatment and coordinated care to promote healthy child development.

As part of this effort, CWS will partner with HHS Children's Mental Health Services to provide mental health treatment to children at the Center who meet medical necessity for mental health services and are full scope Medi-Cal beneficiaries. If approved, CWS will utilize First 5 funding to leverage additional funds from the State Children's Mental Health Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, beginning in FY 2010-11. The combined total six year amount of First 5 and EPSDT funding for the project will be \$9,250,000, through FY 2014-15.

The development of the KidSTART Center supports the Board's vision of providing critical services to the most high-risk children with complex developmental challenges. Today's action requests authority for the Director, Department of Purchasing and Contracting to issue a competitive solicitation for the KidSTART Center, and subject to successful negotiations, award new contracts to provide services for the most vulnerable population of children, ages 0-5.

FISCAL IMPACT:

Fiscal Impact for Child Welfare Services:

Funding for this request is not included in the FY 2009-11 Operational Plan for the Health and Human Services Agency. If approved, this proposal will result in an increase in costs and revenue of \$4,250,000 spread over six years, including \$500,000 in the current year. The funding source is the First 5 Commission of San Diego. There will be no change in the net General Fund cost and no additional staff years.

Fiscal Impact for Mental Health Services:

Funding for this request is not included in the FY 2009-11 Operational Plan for the Health and Human Services Agency. If approved, this proposal will result in an increase in costs and revenue of \$5,000,000 spread over five years, beginning in FY 2010-11. The funding source is State Children's Mental Health EPSDT in the amount of \$4,250,000, with \$750,000 matching funds from First 5 Commission of San Diego. There will be no change in the net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT:

N/A

RECOMMENDATION:

CHIEF ADMINISTRATIVE OFFICER

1. Establish appropriations of \$500,000 in FY 2009-10 in the Health and Human Services Agency, Child Welfare Services for the KidSTART Center based on unanticipated revenue from the First 5 Commission of San Diego. **(4 VOTES)**
2. In accordance with Section 401 et. seq. of the County Administrative Code, authorize the Director, Department of Purchasing and Contracting to issue a competitive solicitation for assessment and treatment for developmental delay services to children, ages 0-5, for the KidSTART Center, and upon successful negotiations and determination of a fair and reasonable price, award a contract for assessment and treatment of developmental delay services to the identified population for a term of one year and two months, with four option years, and up to an additional six months if needed, and to amend the contracts as needed to reflect changes to services and funding, subject to funding availability and approval of the Director, Health and Human Services Agency.
3. In accordance with Section 401 et. seq. of the County Administrative Code, authorize the Director, Department of Purchasing and Contracting to issue a competitive solicitation for mental health treatment services to children 0-5, in conjunction with the KidSTART Center, and upon successful negotiations and determination of a fair and reasonable price, award a contract for mental health treatment services to the identified population for a term of one year, with four option years, and up to an additional six months if needed, and to amend the contracts as needed to reflect changes to services and funding, subject to approval of the Director, Health and Human Services Agency.

ACTION:

ON MOTION of Supervisor Cox, seconded by Supervisor Roberts, the Board took action as recommended, on Consent.

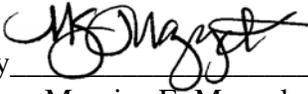
AYES: Cox, Jacob, Slater-Price, Roberts, Horn

State of California)
County of San Diego) §

I hereby certify that the foregoing is a full, true and correct copy of the Original entered in the Minutes of the Board of Supervisors.

THOMAS J. PASTUSZKA
Clerk of the Board of Supervisors



By 
Marvice E. Mazyck, Deputy

DRAFT



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: San Diego

Date PIP Began:

Title of PIP: Increasing Client Involvement

Clinical or Non-Clinical: Non-Clinical

Assemble multi-functional team

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

The following groups participated in developing and implementing this PIP:

MENTAL HEALTH OUTCOMES COMMITTEE		
Name	Affiliation	Position
Kathy Anderson	SD County Behavioral Health Services	Principal Analyst Quality Improvement
Myra Buby	EHC-SD	Clinical Supervisor
Bernard Carrasco	Project Enable	Program Manager
Todd Gilmer	UCSD Health Services Research Center	Principal Investigator
Paula Goncalves	Community Research Foundation	
Michael Juan	South Bay Guidance Center	Program Director
Tabatha Lang	SDAMHS System of Care	Regional Program Manager
Marshall Lewis	SDBHS	Clinical Director
Deborah Malcarne	SDAMHS System of Care	Regional Program Manager
Candace Milow	SDBHS	Director of Quality Improvement
Minerva Morales-Moreno	Logan Heights FHC	Program Manager
Jennifer Whelan	CRF Douglas Young Center	Program Director
Andy Sarkin	UCSD Health Services Research Center	Staff Research Assoc. III Supervisor
Virginia West	SDAMHS System of Care	Regional Program Manager
Elizabeth. Whitteker	Telecare ACT, ACCESS, Transition Team	Clinical Director
Luz Fernandez	East County Mental Health Center	Program Manager
Kathleen Sherber	County Case Management	Program Manager
Caroline Atterton	MHS Case Management North	
Dixie Galapon	UPAC	Mental Health Director
Karen Hempstead	Areta Crowell Center	Program Manager
Collette Lord	Jane Westin Wellness & Recovery Center	Program Director
Giovanna Zerbi	UCSD Gifford Clinic	Program Manager
Phillip Leon	Southeast Mental Health Center	Registered Nurse

QUALITY REVIEW COUNCIL		
Name	Affiliation	Position
Gay Ames	Family Member	Family Member
Bob Brooks	San Diego Coalition on Mental Health	Representative of North Coast NAMI
Jim England	Family Member, NAMI	Family Member
Jim Fix	PERT, Inc	Program Manager
Mitchell Gluck	SDC Psychiatric Hospital	Assistant Director
Paula Goncalves	Community Research Foundation	Quality Improvement Manager

Mary Joyce	Optimum Health	Director of Quality Improvement
Lee Laurence	Jewish Family Services	Patient Advocate
Marshall Lewis1	HHSA – Behavioral Health Services	Clinical Director
Karen Luton	Heritage Clinic	Program Manager
Manalo, Markov	Recovery Innovations of California	Client Representative
Milow, Candace	HHSA – Quality Improvement	Director
Neidenberg, Carol	CCHEA	Consumer Advocate
Nichols, Linda	New Alternatives	
Phillips, Mike	Jewish Family Services	Patient Advocate
Sanchez, Nicole	CASRC	Family Member
Sturm, John	Mental Health Board	Client Representative
Thomas, David	HSRC	Client Representative

CONTRACT RESEARCH CENTERS		
Name	Affiliation	Position
Todd Gilmer PhD	Health Services Research Center--UCSD	Principal Investigator
Andrew Sarkin PhD	Health Services Research Center--UCSD	Staff Research Assoc. III Supervisor
Marisa Sklar	Health Services Research Center--UCSD	PEI Evaluation Coordinator
Rick Heller	Health Services Research Center--UCSD	Client Representative
David Thomas	Health Services Research Center--UCSD	Client Representative
Jennifer Rolls-Reutz	Child & Adolescent Services Research Center	Project Coordinator

Also included among the stakeholders who participated in this project are members of 4 client focus groups held by the Health Services Research Center who participated on a confidential basis.

“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.

For almost ten years, the San Diego County MHP has been transforming TAY, Adult, and Older Adult (for the purposes of this report, identified generally as Adult Mental Health Services) to a client centered, recovery oriented model. During that time period, the MHP has been improving the mental health system in a number of ways to reflect this new direction, including expanding the client voice in contractor program planning and review, expanding the client voice in system planning, implementing MHPA new services targeted to more completely meet the recovery needs of the un-served and underserved, and expanding the focus of quality improvement to recovery measures.

The number and diversity of adult clients (ages 18 on) has increased in that time, as new populations of Transitional Age Youth and Older Adults became important targets for new services:

Percent Growth in Client Populations	
	FY 06-07 to FY 08-09
TAY	26%
Adult	14%
Older Adult	33%
Total Clients	15%
FY 06-07 Clients	38,124
FY 08-09 Clients	43,691

While the focus and number of mental health services was changing, the MHP noted that the degree of client involvement and client voice in recovery did not appear to be shifting as rapidly as expected. Three indicators reinforced the MHP's decision to take action in this area:

1. In the November 07 State Client MHSIP Survey, satisfaction in Treatment Planning had dropped from a 91.3% of respondents reporting being satisfied or very satisfied to 78.8% and the satisfaction with the outcomes dropped from 79.8% to 69.2%. (Other domain scores had dropped to a lesser degree.)
2. The recommendation from the FY 07-08 EQRO to promote opportunities for expanded consumer and family member involvement on committees and forums designed to obtain their input was taken by the MHP as another indicator of the need for increased client involvement in the changeover to the recovery model.
3. In May, 2008, the MHP administered the Recovery Self Assessment (RSA), as a pilot, to outpatient and case management programs in conjunction with the State Survey. Of the 5 subscales in the RSA, the client assessment of involvement had the lowest scores with 3 items in the 40% range.

The MHP made a number of changes to improve client involvement and client voice including the following:

- Additional emphasis on the requirement to have in place Advisory Boards for MHP contracts, with at least 51% consumers.
- Addition of consumer representatives to the MHP Administration Core Planning Group which meets weekly.
- Two peer organizations received contracts to provide client trainings on the Wellness Recovery Action Plan, life skills, and medication from a lived perspective.
- Continuation of the requirement as new MHSA contracts rolled out to have two clients or a client and family member employed by new programs to bring the client voice into everyday operation.

As these changes to the MHP were made between FY 06-07 and FY 08-09, the State MHSIP client satisfaction scores reflected the system transformation/perturbation, first decreasing and then improving or returning to previous levels in the areas of General Satisfaction, Access, Quality and Appropriateness, Participation in Treatment Planning. The MHSIP scores for perception of outcomes of services, functioning, and social connectedness have continued to be significantly lower than the other areas (as is the pattern across the State), although they have come back to near the base level of May 07. However, Client Satisfaction with Outcomes declined from a high of 79.8% in the May 07 State Survey to a low of 69.2% in November, 2007, only coming back to 74.6% in May 09. The very slow and small improvement in client satisfaction with the outcomes of services is postulated to be a proxy indicator of a continued lack of client involvement and lack of understanding of the recovery model.

MHSIP Scores

	"May 07"	"Nov 07"	"May 08"	"Nov 08"	"May 09"
General Satisfaction	90.9	90.8	91.5	91.4	92.9
Perception of Access	89.8	84.7	85.9	86.5	89.8
Percept. of Quality & Appropriateness	90.8	87.8	88.4	88.4	90.4
Percept. of Participant in Tx Planning	91.3	78.8	90.2	89.3	92.0
Percept. of Outcomes	79.8	69.2	71.2	71.3	74.6
Percept. of Functioning	72.6	68.8	67.0	67.8	71.3
Percept. of Social Connectedness	73.5	66.4	72.2	72.3	73.7

In order to address the slow improvement of client satisfaction with the outcomes of services, the MHP is seeking to increase client involvement with aspects of the recovery model by increasing their awareness, education and input. To achieve this goal, the MHP will be focusing on both clients and clinicians. The intervention for clinicians has two elements: changing outcomes measuring tools to focus on recovery thus reinforcing consciousness of the new model, and providing clinicians with education about usage of recovery oriented tools to foster recovery oriented treatment planning and treatment skills. The

MHP is targeting clients with two interventions to increase the client involvement and voice by, first, adding a self-evaluation of progress toward recovery to the MHP adult assessment tool and secondly by giving clients a chance to rate the recovery orientation of their services. A new descriptive brochure is being crafted to provide a brief educational tool for clients about the basics of the recovery model. As clinicians, guided by the new assessment tools, incorporate elements of recovery into treatment planning and consequent treatment, client awareness of how the recovery model fits together is expected to increase. Additional consideration is being given to piloting the Shared Decision Making Process at several programs.

The MHP, within its scope of influence, can ensure that more client input is gathered by implementing and requiring the use of an evidence based, validated, client self assessment tool and by giving clients a chance to rate the recovery orientation of their services. The MHP can also change its measuring tools to require the system-wide use of recovery oriented, validated, evidence based assessment tool, and provide clinician training on how to use data from both these tools to build a recovery oriented Treatment Plan. The Quality Improvement Unit of the MHP has the ability to create a descriptive brochure on the Recovery Model and to track the results of the implementation of new assessment tools and report the results.

Changes in the assessment tools and educational materials will affect Transitional Age Youth, Adult and Older Adult client populations who are in most outpatient and case management programs.

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?**

As discussed above, the MHSIP scores by domain are routinely analyzed for trends and the slow recovery of the scores for Satisfaction with Outcomes was felt to be an important indicator of a problem with client buy-in to San Diego’s transformation to the recovery model, as were the comparatively low scores on the RSA for client involvement.

As the MHP began to revamp its outcome measuring tools to reflect the systemwide transformation to a client centered, recovery model, the MHP called together the Adult Mental Health Outcomes Committee, a primary stakeholder group composed of provider clinical directors, program managers, and quality improvement staff, and the UCSD Health Services Research Center (HSRC) with its client employees. Over a period of two years, the group researched and discussed how to create the most effective, efficient way to measure outcomes of the system transformation without a corresponding overwhelming workload for clinicians or clients. HSRC specialists researched possible tools for the Committee, recognizing

an additional need to fit any tools chosen into a framework of a new Management Information System, as the MHP changed from InSyst to Anasazi in October, 2008.

Early on in the Committee’s process, a void was noticed among outcomes measurement tools being used by the MHP. There was no opportunity for clients to provide input on whether or not services were contributing toward their recovery. In prior years, clinicians had expressed their lack of confidence about the capability of many clients receiving services for serious mental illness to provide meaningful, valid self-evaluation. In 2007, HSRC conducted a series of focus groups with clients, facilitated by client-staff, to determine if these expectations were justified. The focus groups discussed their expectations about outcomes of mental health services and the use of a self evaluation tool. Several sample questionnaires/tools were tested to see if clients were able to provide meaningful input. The focus group participants indicated that they were very willing to do a self-evaluation and believed that client completed questionnaires “could help their providers give them better treatment because of having a better understanding of the clients and their needs.” Clients also expressed the belief that if doctors spent less time assessing client progress, they could spend more time on client treatment. Only 1 or 2 members of all 4 groups needed assistance to be able to complete the questionnaire/tool. (“Client Focus Groups Report on Measuring Outcomes”, December 20, 2007).

The Mental Health Outcomes Committee considered possible use of the following tools: the Functional Assessment Rating Scale (FARS), the Recovery Self-Assessment (RSA) for both clients and the Mental Health system as a whole, the Illness Management and Recovery Scale for clinical input (IMR), the Recovery Markers Questionnaire for clients (RMQ), and the Recovery Oriented Systems Indicators measurement (ROSI). To see how clients would handle completing the Recovery Self Assessment, it was piloted in conjunction with the May, 2008 State Survey. Very few clients needed help completing the survey. Of the 5 subscales in the RSA, the client assessment of involvement was the only subscale with three responses in the 40% range. (Involvement with agency advisory boards and management meetings—41.9%; Agency staff actively help me become involved with activities that give back to my community—47.50%; the development of my leisure interests and hobbies is a primary focus of my services—49.59%).

Table A– List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Client lack of knowledge about recovery	<ul style="list-style-type: none"> • Limited information given out by individual providers about recovery model. No system-wide materials available in threshold languages.
Client lack of understanding of the purpose of a treatment	<ul style="list-style-type: none"> • Client agreement to sign off on same treatment plan goals repeatedly. • Lack of a basic client information sheet describing what services and processes

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
plan	constitute the recovery model.
Client language and cultural barriers	<ul style="list-style-type: none"> • Provider sites piloting the proposed client self-assessment tools reported that clients not reading English were unable to complete the tool.
Clinical lack of knowledge of methods to use in discussing recovery and goals with clients	<ul style="list-style-type: none"> • No standardized broad scope assessment tool was used to support a multi-faceted conversation on recovery goals prior to FY 09-10. • Anecdotal feedback from clinicians who piloted broad scope recovery tools had a significant number of clinicians expressing the idea that the tool directed them to explore new areas of recovery which they hadn't previously thought about or discussed with their clients.
Historical focus of treatment plans on symptoms and functioning rather than progress toward recovery	<ul style="list-style-type: none"> • Medical record review tool used in FY 06-07 and 07-08 with focus on details of record completion, in accordance with State and federal regulations. • The focus of the FY 08-09 Medical Record Review changed with the goal of starting to explore quality of care issues such as the tie-in between the client assessment, the treatment plan, and progress notes.
Clinician discounting of clients' ability to give meaningful information	<ul style="list-style-type: none"> • The MHP's Mental Health Outcomes Committee included members from Case Management services who expressed concern about whether or not their clients would be able to give meaningful information without a large amount of clinician assistance.
Training on Treatment Planning focused on administrative requirements	<ul style="list-style-type: none"> • Medical Record Reviews in FY 08-09 showed that in a significant number of cases, clinicians were repeating the same or very similar treatment plan goals every six months, which suggested that the Treatment Plan was being used to satisfy an administrative requirement rather than being used as a plan for clinical activity.
Time burden to get additional input from clients or to complete additional assessment tools perceived as high	<ul style="list-style-type: none"> • The County began the process of changing over from InSyst to Anasazi MIS which is resulting in both County and Contractor administration and clinical staff needing to attend trainings and implement new processes, creating a an initial significant, time demands . • Case Management Programs, primarily, have consistently reported unhappiness with time demands of working with their more severely ill clients to complete twice-yearly State surveys. • Additional tools for clinicians, administrative staff, and clients to complete and enter, could cut into client services, without the rewards justifying the time expenditure.
Effect of implementing new tools on staff productivity is a rising concern	<ul style="list-style-type: none"> • MHP Administration has indicated that contractor and county staff productivity will be one factor considered in possible funding cutbacks coming for FY 10-11. • MHP Administrative concern about rising caseloads, in the face of budget cutbacks.

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

Table B– List of Validated Causes/Barriers

Client lack of knowledge about recovery	<ul style="list-style-type: none"> • Need for information to be given out by providers to clients about recovery method; material should be available in threshold languages.
Client lack of understanding of what the purpose of a treatment plan is	<ul style="list-style-type: none"> • Client need to be aware of relationship between treatment plan and treatment; clients had been signing off on same treatment plan goals repeatedly. • Clinical record reviews show lack of cohesion between Treatment Plan and treatment session activities/focus. • Lack of a basic client information sheet describing what services and processes constitute the recovery model.
Client language and cultural barriers	<ul style="list-style-type: none"> • Provider sites piloting the proposed client self-assessment tools reported that clients not reading English were unable to complete the tool.
Clinical lack of knowledge of methods to use in discussing recovery and goals with clients	<ul style="list-style-type: none"> ▪ Need for standardized broad scope assessment tool to support a multi-faceted conversation on recovery goals. • Medical Record Reviews in FY 08-09 showed that in a significant number of cases, clinicians were repeating the same or very similar treatment plan goals every six months, which suggested that the Treatment Plan was being used to satisfy an administrative requirement rather than being individualized and used as a plan for clinical activity. • Anecdotal feedback from clinicians who piloted broad scope recovery tools had a significant number of clinicians expressing the idea that the tool directed them to explore new areas of recovery which they hadn't previously thought about or discussed with their clients.
Historical focus of treatment plans on symptoms and functioning rather than progress toward recovery	<ul style="list-style-type: none"> • Medical record review tool used in FY 06-07 and 07-08 focused on details of record completion, in accordance with State and federal regulations. • The focus of the FY 08-09 Medical Record Review changed with the goal of starting to explore quality of care issues such as the tie-in between the client assessment, the treatment plan, and progress notes.
Clinician discounting of clients' ability to give meaningful information	<ul style="list-style-type: none"> • The MHP's Mental Health Outcomes Committee included members from Case Management services who expressed concern about whether or not their clients would be able to give meaningful information without a large amount of clinician assistance. • "Self-Determination Among Mental Health Consumer/Survivors: Using Lessons from the Past to Guide the Future. Judith A. Cook, PhD. and Jessica A. Sonikas, M.A. the University of Illinois at Chicago National Research and Training Center on Psychiatric

	Disability <u>Journal of Disability Policy Studies</u> , 202, (13(2), pp 87-95. The study traces the history of self-determination and offers ways in which self-determination and consumer control might be achieved both within and outside of service systems.
Training on Treatment Planning focused on administrative requirements	<ul style="list-style-type: none"> • Medical Record Reviews in FY 08-09 showed that in a significant number of cases, clinicians were repeating the same or very similar treatment plan goals every six months, which suggested that the Treatment Plan was being used to satisfy an administrative requirement rather than being used as a plan for clinical activity individualized for each client.
Time burden perceived as high to get additional input from clients or to complete additional assessment tools	<ul style="list-style-type: none"> • The County began the process of changing over from InSyst to Anasazi MIS which is resulting in both County and Contractor administration and clinical staff needing to attend trainings and implement new processes which made significant, extra demands time, initially. • Case Management Programs, primarily, have consistently reported unhappiness with time demands of working with their more severely ill clients to complete twice-yearly State surveys. • Additional tools for clinicians, administrative staff, and clients to complete and enter, could cut into client services, without the rewards justifying the time expenditure.
Effect of implementing new tools on staff productivity is a rising concern	<ul style="list-style-type: none"> • MHP Administration has indicated that contractor and county staff productivity will be one factor considered in possible funding cutbacks coming for FY 10-11 • MHP Administrative concern about rising caseloads, in the face of budget cutbacks.

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 is designed to address.

- Will instituting new procedures increase client perception that they are involved in treatment planning and program planning?
 The new procedures that SDCMHS is testing are:
- the use of a client self assessment tool as a way to increase opportunities for client input in treatment planning (RMQ)

- the use of a broad scope, recovery oriented, validated assessment tool by clinicians (IMR) and education for clinicians on how best to utilize the tool information to build a recovery oriented, clinical treatment plan
- use of the Recovery Self-Assessment to allow clients to rate the recovery orientation of their services.
- new planning workgroups that include clients and family members, and
- new positions that are added to contracts for clients and family members

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

The PIP will cover most TAY, adult and older adult populations receiving outpatient and case management. However, Institutional Case Management and programs treating clients only for a short time, such as the Walk-In Assessment Center and the Council of Community Clinics will not participate in this PIP.

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

The PIP will cover TAY, adult and older adult mental health populations receiving outpatient and case management services. in FY 08-09. The breakdown of these populations is as follows:

DRAFT

TAY, Adult, Older Adult Population Participating in Outcomes PIP

	Case Management	Est. 50% Medi-Cal	Outpatient	Est. 50% Medi-Cal	Total	Total Medi-Cal*
	Total	Total	Total	Total	Total	Est. 50% Medi-Cal
TAY	111	56	1623	816	1734	872
Adults	2222	1111	12,204	6,102	14426	7213
Older Adults	931	465	1689	844	2620	1309
Total	3264	1632	15516	7762	18780	9394

*The Medi-Cal population has been estimated at 50% of the total population. Clients receiving Institutional Case Management or services from the Walk-In Assessment Center or through the Council of Community Clinics will not be included.

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

The population will be identified through Anasazi Unit and Subunit numbers for all adult clients receiving Outpatient and Case Management services with the exceptions stipulated in Question 6.

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

State Survey does include a sampling technique. Only clients receiving services from the given treatment programs within the two-week window are asked to complete a state survey. As always, clients have the right to choose whether they will participate in the self-evaluation.

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

The client sample from 2008 and 2010 is much greater than minimum requirements to provide a valid representation of the population within which they were drawn. The sample size for clinician/administrative assessments is relatively small, which is particularly true of the 2010 data, limiting the ability to generalize from this data

“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?

1. The Recovery Self-Assessment (RSA) for clients was chosen as a tool to measure client perception of program recovery orientation over 5 subscales: Life goals, involvement, diversity of treatment options, choice, and individually-tailored services. It is a comparatively short, validated tool (36 items) and has little need for training to be able to implement. It will be administered annually in conjunction with the State Survey.
2. The Recovery Self Assessment for agency directors/administrators/ providers was chosen as the complementary tool to measure the recovery orientation of the program as a whole
3. The State Consumer Survey, which includes both MHSIP and CalQL elements has been State mandated to measure client satisfaction and client quality of life.
4. The Illness Management and Recovery Scale (IMR) is a brief and easily administered measure of illness management, done by a client’s therapist, based on the stress-vulnerability model of severe mental illness. Interaction between biological vulnerability and socio-environmental stressors is believed to cause mental illness and relapses. Both of these factors can be effected by treatment. The IMR is a 15 item, validated tool.
5. The Recovery Markers Questionnaire is a validated tool for use by clients, with minimal clinician burden required for administration, which allows clients to rate themselves on their progress toward recovery and degree of involvement in the recovery process and informs clinicians on their progress. The tool has 24 ratings items on 1 page.

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

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

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	Recovery Self Assessment: Clients participating in 2 week	Number of participants	Total Number of Survey	RSA Involvement Subscale	Involvement subscale

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
	State Surveys periods once a year will indicate their degree of improvement in perception of involvement	indicating that they agree or strongly agree with statements in the Involvement subscale.	participants varied by subscale item. Sample ranged from 256 to 494.	Pilot Test in May 2008 will be used as a baseline. The mean Involvement score was 53.08	scores will increase by 3%.
2	Recovery Self-Assessment for Agency Directors/administrators, providers to be administered annually.	Number of participants indicating that they agree or strongly agree with statements in the Involvement subscale.	Total Number of Survey participants varied by subscale item. Sample ranged from 85 to 139.	RSA Involvement Subscale in May 2009 will be used as a baseline. The mean Involvement score was 54.2	Involvement subscale scores will increase by 3%.
3	State Consumer Survey-- Clients participating in the 2 week State Consumer Survey	Number of participants indicating that they are satisfied or very satisfied with the outcomes of treatment.	Total Number of Survey participants answering those questions. Sample ranged from 1,976 to 2,101.	74.6% of respondents indicating that they were satisfied or very satisfied with the outcome of services on the May 2009 State Survey,	3% more respondents will report being satisfied or very satisfied with the outcomes of services
4	Recovery Markers Questionnaire--Clients self reported ratings	Total number of clients giving themselves improved	Total number of clients completing the RMQ	TBD	TBD

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
		ratings on recovery			

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

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	Implementation of new Recovery Based, broad scope client assessment tool for clinicians (IMR)	Lack of a broad scope, system wide, recovery oriented client assessment tool.	Dec 2009
2	Implementation of new Recovery Based client self assessment tool (RMQ)	Lack of a client voice through self evaluation of their recovery	Jan 2010
3	Implementation of clinician training on the clinical use of outcomes tools in Treatment Planning.	Lack of clinician understanding of how to use results from assessment tools to foster recovery oriented treatment .	Spring, 2010
4	Implementation of Recovery Self-Assessment to gain information on recovery orientation of program	Lack of a client voice in the evaluation of program progress toward a recovery orientation.	<u>Fall, 2009</u>
5	Creation of a brochure for clients on the Recovery Model for distribution throughout the Outpatient and Case Management programs.	Lack of client familiarity with recovery model and importance of treatment plan as a structure for change.	<u>Spring, 2010</u>
6	Implementation of Shared Decision Making Process pilot I	Lack of client involvement with treatment planning.	Winter, 2011

Apply Interventions: “What do we see?”

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

- Percentage of clients show improved scores on RSA Involvement subscale versus the total clients completing the RSA
- Percentage of clients showing increase in satisfaction with outcomes on the State Survey versus the total number of clients taking the survey
- Data will be aggregated by individual program, as well as by level of care

Secondary data the County will review:

- Percentage of clients showing improvement on the IMR scales versus the total number of IMRs conducted
- Percentage of clients showing improvement on the RMQ versus the total number of RMQs conducted
- Demographic analysis on improvement scores—ethnicity/race, gender, age

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.

Because San Diego changed from a predominately medical model to a psychosocial rehabilitation (recovery) orientation, the measurement tools used were no longer appropriate, nor were they in system wide usage. This data had not been collected in the previous InSyst system. Therefore, using data on previously administered tools would not provide us with systemwide, comparable data. With the new recovery oriented measurement tools, data will be gathered from clients at provider sites and from clinicians in conjunction with client assessments and reassessments. The data, in the form of completed tools, will be sent electronically to the UCSD Health Services Research Center where it will be entered into a database. Although we will not be using actual IMR and RMQ data for the purposes of this particular PIP, the IMR and RMQ data will be entered directly into Anasazi with results being shared with HSRC for analysis. The Recovery Self-Assessment will be administered with the MHSIP Client Satisfaction Survey conducted twice yearly by the the Research Centers for the SDCMHS. The data will be scanned into the aforementioned database with results being shared by HSRC and CASRC for analysis.

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

- Completed RSA tools and Client satisfaction surveys will have scores aggregated across program and level.
- The changes in aggregated scores for programs and levels of care will be analyzed.
- If there are untoward results, the MHP will evaluate the data, do a root cause analysis, make some modifications to the procedure and evaluate the subsequent changes.

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

Contractor staff from UCSD Health Services Research Center will be collecting the data and providing analysis. The staff include two PhDs in psychology, one PhD in Economics, MS in Program Evaluation, MPH, plus additional post graduate staff and students. PhD leadership has expertise in outcomes measurement and analysis and survey construction and administration.

To Be Completed When the PIP Is Implemented

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?

Data analysis went as planned. However, the limited responses we received on the follow-up administrator RSA triggered additional reminder emails to staff to complete the assessments.

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

Include the raw numbers that serve as numerator and denominator!

The following questions were chosen as being indicative of a program's recovery orientation:

- Q10—Staff at this agency listen to and follow the choices and preferences of participants
- Q17—Group meetings and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.
- Q12--This agency provides structured educational activities to the community about mental illness and addiction
- Q 15—Persons in recovery are involved with facilitating staff trainings and education programs
- Q 21—People in recovery are routinely involved in the evaluation of the agency's programs, services, and service providers.
- Q 27—People in recovery are regular members of agency advisory boards and management meetings.
- Q 30—People in recovery work along side agency staff on the development and provision of new programs and services.
- Q31—Agency staff actively help people become involved with activities that give back to their communities (i.e. volunteering, community services, neighborhood watch/cleanup)
- Q 32—This agency provides formal opportunities for people in recovery, family members , service providers, and administrators to learn about recovery.
- Q 35—The development of a person's leisure interests and hobbies is a primary focus of services.

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							
RSA Client: Involvement Subscale	May 2008		Increase of 3% in agreement		May 2010		
Q12*		494/764; 64.7%				902/1300; 69.4%	4.7/64.7%; 7.3%
Q15		355/697; 50.9%				663/1197; 55.4%	4.5/50.9%; 8.8%
Q21*		419/713; 58.8%				855/1276; 67.0%	8.2/58.8%; 13.9%
Q27*		256/611; 41.9%				548/1132; 48.4%	6.5/41.9%; 15.5%
Q30*		340/665; 51.1%				693/1188; 58.3%	7.2/51.1%; 14.1%
Q31*		332/399; 47.5%				702/1229; 57.1%	9.6/47.5%; 20.2%
Q32		442/732; 60.4%				815/1270; 64.2%	3.8/60.4%; 6.3%
Q35*		367/740; 49.6%				690/1199; 57.5%	7.8/49.6%; 15.7%
Overall Subscale*		424.9%/8; 53.1%				477.3%/8; 59.7%	6.6/53.1%; 12.4%
State Consumer Survey: Treatment Outcomes	May 2009	74.6%	Increase of 3% in agreement		May 2010	73.4%	-1.2/74.6%; -1.6%

* represents a statistically significant change between baseline and follow-up assessments at $\alpha=0.05$

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							
RSA Admin/Provider: Involvement Subscale	May 2008		Increase of 3% in agreement		May 2010		
Q12		85/175; 48.6%				65/133; 48.9%	0.3/48.6%; 0.6%
Q15		83/180; 46.1%				58/132; 43.9%	-2.2/46.1%; -4.8%
Q21		139/197; 70.6%				103/141; 73.0%	2.4/70.6%; 3.4%
Q27*		97/177; 54.8%				167/126; 53.2%	-1.6/54.8%; -2.9%
Q30		85/182; 46.7%				66/124; 53.2%	6.5/46.7%; 13.9%
Q31		109/196; 55.6%				79/138; 57.2%	1.6/55.6%; 2.9%
Q32		120/192; 62.5%				81/140; 57.9%	-4.6/62.5%; -7.4%
Q35		94/194; 48.5%				67/140; 47.9%	-0.6/48.5%; -1.2%
Overall Subscale		433.4%/8; 54.2%				436.7%/8; 54.6%	0.4/54.2% 0.7%

*represents a statistically significant change between baseline and follow-up assessments at $\alpha=0.05$

“Was the PIP successful?” What are the outcomes?

17. Describe issues associated with data analysis:

a. Data cycles clearly identify when measurements occur.

All ratings were collected during a specified two week State Survey period in Spring 2008, 2009, and 2010.

b. Statistical significance

Typical issues impacting statistical significance are sample size and variability. Client RSA data from 2008 and 2010 far surpass minimum requirements for sample size to provide a valid representation of the population within which they were drawn. Additionally, variability in the resulting item distributions between 2008 and 2010 were relatively equal, also meeting requirements for drawing inferences from data analysis.

Although the variability in item distributions between the 2009 and 2010 clinician/administrative RSA assessments are similar, the sample size of the 2010 assessment is relatively small. The small sample size from the 2010 clinician/administrative RSA limits the ability to generalize from these responses.

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

Yes. State Survey became “optional” in 2010 and the SDCMHS took over administering the survey for its own. There was some confusion among providers about whether they had to participate in the County-sponsored As a result, the distribution of the State Survey to clients at the individual treatment programs may have been less systematic in 2010 than 2008. As a consequence, the representation of clients from certain treatment programs may have changed between 2008 and 2010.

Interestingly, the sample size increased from 2008 to 2010, despite its “optional” nature.

Additionally, the sample size of participants completing the administrator/clinician version of the RSA also changed between the 2009 baseline and 2010 follow-up assessments such that far fewer participants completed the 2010 than 2009 administration.

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

There are several issues threatening internal validity. Changes in RSA scores between baseline and follow-up may have been influenced by the sampling differences described above. Additionally, other events occurring between 2008 and 2010 (budget differences, changes in service delivery requirements, implementation of Anasazi, etc.) may have impacted participants’ perceptions of the system’s recovery orientation and involvement of clients.

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

The implementation of recovery oriented assessments across treatment programs was quite successful. In total, approximately 50 outpatient, case management, and full service partnership treatment programs have incorporated the IMR and RMQ into regularly scheduled client assessment and treatment planning updates. As of September 1, 2010, the recovery of approximately 7,500 unique clients was assessed with a clinician IMR and approximately 6,000 unique clients rated their own recovery with an RMQ. Program representatives have reported the IMR assessment tools has broadened the scope of the treatment planning areas with clients and encouraged clinical staff to discuss recovery during their therapeutic sessions with clients. Clinicians also report that the RMQ client self-assessments and the RSA are easy for clients to answer.

The County is still in the process of developing of refining a client flyer on recovery. It is anticipated that the brochure will be completed by the end of FY 10-11 and made available to all providers.

The SDCMHS is also just beginning to implement its WET Plan which contains many opportunities for existing staff to obtain trainings to increase their understanding of the recovery system and of the importance of client cultures within that system. Most programs began in October, 2010 and results of the trainings are not currently available.

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

The methodology used at baseline measurement and follow-up measurement were almost identical within participating groups. For client assessments, baseline and follow-up ratings were provided via the Spring State Survey. However, the State Survey no longer required that the survey be done in 2010. There was some confusion among providers who heard this announcement but did not understand that the County was going to continue to administer the survey and was requiring participation. . As a result, treatment program participation was a little more spotty in spring 2010 than in 2008..

For the administrator/clinician RSA assessments, baseline and follow-up ratings were provided in precisely the same manner. Through email notifications, participants were provided with a link to an online version of the survey. However, the pool of participants did change between the 2009 and 2010 administrations of the administrator/clinician RSA assessment. In 2009 only treatment program representatives were encouraged to complete the assessment. In 2010, both treatment program representatives and County administrative staff/directors were encouraged to complete the assessment. County administrative staff/directors were excluded from the analyses presented here to facilitate direct comparisons between baseline and follow-up assessments.

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

Client ratings of the system's involvement of clients showed great improvements between 2008 and 2010. Client ratings increased by at least 6.3% on all involvement subscale items (most of which were statistically significant changes) with an overall average improvement of 12.4%. However, clinician/administrative ratings of the system's involvement of clients did not show the same level of improvement. Overall, their average involvement subscale ratings increased by only 0.7%. Additionally, only question 27 ("People in recovery are/can be involved with agency advisory boards and management meetings) changed in a statistically significant manner. This item decreased between the clinician/administrative assessments of 2009 and 2010.

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

The intention for selecting the IMR and RMQ assessments was for clients and clinicians to come together to compare their ratings and perceptions of the clients' recovery. At face value, asking the client to provide feedback regarding their own recovery, then using their perceptions to guide therapeutic dialogue and treatment planning between client and clinician, very clearly enhances client involvement. Feedback from program representatives suggests the implementation of IMR and RMQ assessments has enhanced the therapeutic dialogue between client and clinician, which may then lead to enhanced client involvement.

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

Client ratings of the system's involvement of clients showed statistically significant improvements on all subscale items from 2008 to 2010 except items 15 (I can be involved with facilitating staff trainings and educational programs at this agency) and 32 (This agency provides formal opportunities for me, family and significant others, service providers, and administrators to learn about recovery).

Clinician/administrative ratings of the system's involvement did not change in an equally substantial manner. Although some of the items showed marginal improvements/declines between 2009 and 2010, only question 27 (“People in recovery are/can be involved with agency advisory boards and management meetings) changed in a statistically significant manner. This item decreased significantly between the clinician/administrative assessments of 2009 and 2010. Since clinicians reported that the IMR broadened for many the scope of elements included in recovery, it is possible that some clinicians subsequently became aware that their programs were not as recovery oriented as originally thought. We consider this shift in perception positive since it can foster true movement away from the clinical model and toward recovery.

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

We will continue to measure change over time

***G. Consumer/Family Focus Groups
Conducted by the MHP***

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

The MHP conducted a Chaldean family member focus group at the Chaldean Middle Eastern Social Services (CMSS). The group was facilitated by an MHP QI Specialist. There were nine group attendees.

Attendees agreed that if one wanted information about mental illness for oneself or a family member/friend that they could obtain the information from CMSS because they know their language; this being the only location for communication. Another participant would ask the family doctor or go to Grossmont hospital.

Attendees agreed that if their child or family member needs to see someone, they must call for an appointment. They can usually access non-emergency appointments in a few weeks.

For emergencies, there was not common knowledge on how to access care. While some requested a same day service from CMSS or CMSS directed them to call the Access and Crisis Line (ACL), others did not know how to obtain services.

Many attendees stated that they would not know what to do if they are unhappy or have concerns about their mental health services or provider. Others would call CMSS, the therapist, or "emergency".

When asked about involvement in planning for mental health services, two participants said they were involved in treatment planning for their family member, but most said they had not been invited to a group to give their opinions.

Participants agreed that their child or family member's main service provider believes that child/family member's can improve and get better in their recovery. Participants were grateful for services. Some indicated that their family member was improving with treatment. However, some also commented that the volume of people who need to be seen is too high, the services are pressured, and that more doctors and staff are needed.

When asked if one's opinions are heard and valued by the County and if one can make a difference in how mental health recovery services are delivered, there was a mixed response. While there was a sense of being heard and valued in this particular group, the responses indicated a lack of involvement and request for input in the past, lack of knowledge of how to provide input, lack of knowledge of rights, and lack of experience of having input acted upon. "If we see the changes, we will know we were heard."

Group recommendations included the following:

- “This program needs help. The need is great and these workers are overwhelmed with the need. If it was only a little bigger it would serve so many more. We need a bigger program here, more doctors, and more staff.”
- “We need medical insurance and/or access to where we can go for free or inexpensive medical care and prescriptions.”
- “We need more information on resources in the community. We don’t really know where to go. The Family Resource Center doesn’t help us.”

Consumer/Family Member Focus Group 2

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

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

Preferred Languages	
Chaldean	9

Estimated Race/Ethnicity	
Chaldean	10

Gender	
Male	
Female	

Interpreter used for focus group 2: No

Yes Language: Chaldean

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

The MHP conducted a Chaldean consumer focus group at the Chaldean Middle Eastern Social Services (CMSS). The group was facilitated by an MHP QI Specialist. There were ten group attendees.

Participants were asked “What does recovery from mental health problems mean to you in your everyday life?” Participants answered that recovery meant help with depression and worry, solving problems, and guidance on what one can do to feel better. Participants reported that many services were helpful such as groups that teach how to handle emotions, medications, therapists, and help obtaining food. “We have no friends and family, some of us.” “When we come here and talk, they respond and we feel better.”

Participants reported gratitude for services received. They reported that some of the best things about MHP services are free help with paperwork (unlike some services that charge \$15 per page), help with obtaining medications that Medi-Cal will not cover, and obtaining help in the Chaldean language.

The group agreed that they feel safe to tell someone at their program about a concern or grievance about services.

Participants have not had a problem with running out of medications because of being unable to see the doctor in a timely way. Medication refills are available. Participants have been able to see someone when they need to or when upset. Although the doctor is only available once per week, “they have squeezed me in” for an appointment. “I come in and put my name on list. I don’t mind waiting. They see me when they can.”

None of the participants had been involved in planning for mental health services.

Participants agreed that provider believes in their recovery. “This is a hopeful place. They give us courage to deal with our problems.”

Group recommendations on how to improve services included the following:

- “We need medical coverage and prescriptions for free. We wish we had a clinic we could go to for therapy, medical, and medications for free.”
- “I need glasses and I cannot get them.”
- “I don’t know how to get medical insurance (for my husband and myself).”

Consumer/Family Member Focus Group 3

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

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

Preferred Languages	
Chaldean	10

Estimated Race/Ethnicity	
Chaldean	10

Gender	
Male	
Female	

Interpreter used for focus group 3: No

Yes Language: Chaldean

CONSUMER/FAMILY MEMBER FOCUS GROUP 4

The MHP conducted a focus group at the NHA Friendship Clubhouse which is operated by Neighborhood House Incorporated, a contractor. The group was facilitated by a UR/QI Specialist. There were nine group attendees including leaders and steering committee members.

Attendees agreed that if one wanted information about mental illness for oneself or a family member/friend that they could easily obtain the information by calling 211, OptumHealth's 24-hour Access Crisis Line, Project Enable (an outpatient clinic next to the Friendship Clubhouse), or the County's Psychiatric Hospital at the Health Service Complex, Rosecrans Street.

Attendees agreed that they are able to get into see someone at their program if they need to, either by requesting a counselor at the clubhouse or they could walk over to Project Enable.

Attendees agreed that they have always been able to see their doctor before running out of medications. If they call in a request their medications will be ready the next day or sample meds are available.

Attendees agreed that they know what to do if they need emergency mental health services. They would Call 911 and get the Psychiatric Emergency Response team (PERT), go to the Psychiatric Hospital at Rosecrans Street, or go to the closest hospital emergency department.

Attendees stated that they if they are unhappy or have concerns about their mental health services or mental health provider that they would use the suggestion box at Project Enable, tell the receptionist or counselors, discuss it in community meetings, or bring up in Patient Advisory Group meetings (PAGs). The consensus was that they would feel safe to tell someone at their program that they have a concern or grievance about services.

When asked about involvement in planning for mental health services, one attendee was transported to the Mental Health Board to voice opinions on possible changes to their program; others only participated in planning for mental health services provided at their program.

Group recommendations included the following:

- Counselors/staff should spend more time and show more personal interest in individuals.
- Counselors should really listen.
- Individuals need more understanding and praise when doing well.

- The program needs more funding and resources available for printers, more outings, special events, conferences, etc.

Consumer/Family Member Focus Group 4

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

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

Preferred Languages	

Estimated Race/Ethnicity	

Gender	
Male	
Female	

Interpreter used for focus group 4: No Yes