



California External Quality Review Organization

San Diego County MHP January 21-23, 2009

Introduction and Scope

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 fifth year 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, on January 21-23, 2009.

CAEQRO customizes each MHP review drawing upon the prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Designed to identify both quantitative and qualitative trends and evaluate system improvements, pre-site review of approved claims data and MHP documentation, served as a foundation for discussion during the site review. The CAEQRO review focused on the following areas:

- 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 access, timeliness, quality, and outcomes of services
- Strategies to decrease disparities in service delivery to diverse populations
- Implementation of wellness/recovery and other best practices throughout the system
- Information Systems Capabilities Assessment V6.1 (ISCA)
- Two active Performance Improvement Projects (PIPs) — a clinical and a non-clinical
- Interviews with key staff within a wide variety of service functions, including clinical, administrative, information systems, and clerical/data entry
- Interviews with stakeholders, including but not limited to the MHP's contracted providers, advisory groups, and other community organizations that interface with the MHP or its consumers
- Three 90-minute focus groups with beneficiaries and family members

The review agenda and the list of participants follow the report as Attachments A and B. A description of the source of data for Figures 5 through 20 follows as Attachment C. The Medical approved claims data summary and any other data CAEQRO provided to the MHP follow as Attachment D. The detailed results from applying the PIP validation tool and the MHP's PIPs as submitted follow as Attachments E and F respectively.

Review Findings for Fiscal Year 2008-2009

Status of Fiscal Year 2007-2008 Recommendations

In the FY07-08 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY08-09 site visit, CAEQRO and MHP staff discussed the status of those FY07-08 recommendations, which are summarized below.

The ratings are assigned as follows:

- ◇ 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 FY07-08

- Develop a business strategy that permanently retains InSyst archival data:
 Fully addressed Partially addressed Not addressed
 - The recommendation when written, assumed the Anasazi cutover would occur on November 1, 2007, as originally planned. Subsequently the Anasazi cutover date was revised to October 1, 2008, which made this recommendation less important for FY07-08. A similar recommendation will be made in this report, as the MHP needs a strategy to access InSyst data for cost reporting settlement purposes in future years.
 - The MHP deployed a date certain cutover strategy to implement the Anasazi system. For consumer services provided prior to October 2008, the MHP continues to use InSyst for claims and CSI data reporting purposes. It is expected that the transition period will take from six to twelve months to fully process all InSyst claims and submit CSI data while Anasazi claims and CSI data submissions ramp up for services provided after October 1, 2008.

- Include more than one year of data for comparative or trend line analysis purposes:
 Fully addressed Partially addressed Not addressed
 - The June 2008 Dashboard Report compares June 2007 data to June 2008 data. The report labels these comparisons as trends, though trend data should consist of at least three data points.
 - The draft Disparities Report dated 1/14/2008 compares two data points, FY01-02 with FY06-07 by age and ethnicity for penetration, retention, types of service, and diagnosis.

- Evaluate system-wide issues which affect timeliness to services. Determine what issues are affecting disparate reports in average waits for services:
 Fully addressed Partially addressed Not addressed
 - The MHP evaluated system-wide issues regarding timeliness to services, addressed some key issues, and monitored the results. The MHP found that wait time was more of a problem in adult services, with a range of one to 45 days wait for routine services. Lack of trust in the data was identified as an issue.
 - The Director of Systems of Care led discussions at the Ad Hoc Program Managers Meeting with representatives of up to 23 outpatient clinics that are mostly contract providers. A significant challenge facing the clinics is the lack of outpatient care for indigent consumers, and clinics report half of consumers seeking services are indigent. Program Managers were “pushed” to be creative in addressing wait times by being given latitude to change operations in how to deal with crises and providing walk-in hours, as well as actively collaborating with primary care and hospital emergency departments in their regions. It was challenging to clinic psychiatrists who expected a full evaluation by a clinician prior to a medication evaluation and a certain amount of time for the medication evaluation. The MHP encouraged providers to focus on seeing targeted individuals in a timely way and to eventually move consumers who no longer need specialty care to primary care. As a result, most clinics currently offer walk-in services and consumers are able to obtain medications the same day. The Primary Care Integration Project has assisted this process by establishing behavioral health liaisons in primary care clinics, increasing primary care trust in behavioral health consultation, and increasing the acceptance of referrals.
 - The MHP reported five to six years of data on wait times which have been trending downward for routine services and trending upward for psychiatric assessments. The average wait time for routine services in Children’s Services for FY07-08 was 4.68 days; it was 5.29 days in Adult and Older Adult Services. The average wait time for psychiatric evaluation for adults in FY07-08 was 13.89 days. The MHP does not track timeliness of psychiatric services for children.
 - During the review, the MHP reported current wait times of 6-10 days for routine appointments and 12-13 days for psychiatrist appointments for adults. While most individuals interviewed corroborated these average wait times, there were some reports of up to four months wait for children to access outpatient services.

- Implement a structured decision-making process into Contract Officer’s Technical Representative (COTR) training in order to ensure consistent approaches and directives

when they interact with providers. Additionally, consider assigning only one COTR to each provider:

Fully addressed Partially addressed Not addressed

- The MHP evaluated COTR structure, processes, and training to ensure consistency in messages to providers. The MHP was unable to assign a COTR to each provider due to the large number of providers.
- The agency contract support unit, which includes Public Health and Human Resources, oversees COTRs and provides standardized training through the Contract Academy. While in the past there was one COTR and many program monitors, due to the high risk status of contract liability and increased administrative work requirements, program monitors have been trained and transitioned into COTRs. During the transition, COTRs, monitors, fiscal staff, and QI met weekly, then bi-weekly, and now monthly. In addition, Analyst IIIs have been hired to oversee Analyst IIs who are assigned to each of the eight COTRs. Chiefs and Regional Coordinators provide local oversight of COTRs, who are working alongside analysts to give consistent messages to providers.
- COTR roles include participating in writing MHPA plans, contract procurement, amendments, orientation, technical advisories, contract monitoring, training new providers, supervising program managers, dealing with personnel issues, and conducting site visits. With increased workload issues, the MHP is aware of the need for another level of manager to accomplish the workload.
- Promote opportunities for expanded consumer and family member involvement on committees and forums designed to obtain their input:

Fully addressed Partially addressed Not addressed

 - All MHP contracts require an Advisory Board consisting of 51% of individuals who use their services.
 - The MHP newly contracts with Jewish Family Services (JFS) for advocacy for consumers receiving inpatient and 24-hour services, due process hearings, and complaints, grievances, and appeals. JFS employs two consumers, holds advocacy meetings for consumers, and reports that there is more meaningful consumer involvement, increased feelings of empowerment, and fewer grievances filed.
 - Staff members report that almost all meetings include consumer and family members.
 - A Family Liaison from Children's Services participates in executive management committees.
 - The MHP contracts with two peer organizations, Recovery Innovations of California (RICA) and with Labors Community Services Agency for the Partners in Care program (PIC). Peer-run RICA provides a 70-hour peer employment training and recovery education such as Wellness Recovery Action Plan (WRAP), WELL life skills, and Medication for Success classes. PIC provides consumer liaison services and recruits consumers to participate in meetings. PIC implemented a Meaningful

- Consumer Involvement Plan, a consumer advocacy plan, and formed a committee to provide input to the Adult Council and Director's Office.
- A Program Advisory Group (PAG) was established to ensure Chaldean/Middle Eastern consumers and family members would have a voice/input into the Chaldean Outpatient Services Program.
 - Prioritize CSI data reporting to avoid delays to the Anasazi system implementation:
 Fully addressed Partially addressed Not addressed

The Anasazi implementation cutover date was October 1, 2008. InSyst CSI data submissions to DMH were successfully brought current through September 2008.

Changes in the MHP Environment

CAEQRO views changes in the MHP environment as those external events having a significant effect on the quality of the overall service delivery system since the last review. These include changes that are not within the scope of responsibility or control of the MHP, but have the potential to affect an MHP's business practices, strategic planning, and program development.

For the MHP, significant events include the following:

- The MHP lost a development opportunity for twenty supported housing units dedicated to the mentally ill in the southern region when the City Council pulled out of the project due to "NIMBY" issues.

Significant Changes within the MHP

Changes within the MHP 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.

- San Diego County has instituted a hiring freeze to contend with a budget shortfall which has affected county operated programs. The MHP expects budgetary challenges in FY09-10, but not in this fiscal year as they have a risk reserve of over \$5M.
- The MHP has collaborated with the Council of Community Clinics (CCC) on a Mental Health and Primary Care Integration Project. Participating in the project are nine community health center corporations at fifteen sites. Eleven psychiatrists, 38 primary care providers and 42 behavioral health clinicians are enrolled as providers. MHP goals include: to provide a medical home for all consumers, to neutralize the effects of stigma and reluctance of Hispanic/Latino to seek treatment, and to engage providers in long-term planning so that behavioral services are not siloed.
 - In North County, a psychiatrist provides technical assistance and consultation to primary care physicians at a community health clinic.

- The MHP is developing a PEI rural health initiative in East County through a behavioral health consultant on the primary care team.
- Using the Impact Model, an evidence based practice for treating uncomplicated depression, nine “depression care managers” provide services in seven primary care clinic sites. At each visit consumers are asked to complete the Patient Health Questionnaire-9 (PHQ-9). The average score at enrollment was 16.6 and after four sessions, the average scores were below 10 and remained so for the duration of treatment. The depression care managers meet monthly and receive training and consultation.
- CCC trained Promotora Coordinators and held monthly meetings since the training to improve outreach and increase community referrals to the Impact program.
- In September of 2008, CCC received a grant from the Tides Foundation for the Integrated Behavioral Health Project (IBHP) to expand collaboration and enhance integration. On November 19, 2008, CCC held a half day Integrated Behavioral Health Conference that 47 clinic staff members attended. There are plans for additional training to educate PCPs on psychiatric medications, service delivery, and chronic disease management.
- In order to increase communication between primary care and behavioral health providers, clinics are now being reimbursed for staff time to convene multidisciplinary treatment team planning conferences for identified consumers. By November 30, 2008, 46 charges were submitted for team conferences.
- MHS Employment Solutions program provides vocational training and employment services using SAMHSA’s EBP. Fidelity assessment of the program was rated as good. In FY07-08 it served 65 adults who were employed for at least 30 days, with 35 individuals who remained employed for over 90 days.
- In partnership with UCSD, Heritage Clinic developed the Geriatric Mental Health and Evidence-based Best Practices with Older Adults training Certificate Curricula. Heritage also implemented a Senior Peer Counseling Program.
- In October 2007, 1,646 families lost their homes to fires in San Diego County. The county received a \$1.5M federal grant to provide immediate mental health services for fire victims and a \$1.3M grant for long-term services that ended in November 2008. The MHP contracted with three agencies to provide services, including support groups at fire recovery centers. More than 4,000 individuals were served by the Wildfire Recovery Project.

Performance 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 rated in the following four tables. Information which supports the ratings of the categories is discussed below each table.

Organizational Culture

An organizational culture in which strong leadership effectively communicates the MHP's priority issues and values quality improvement principles is a critical foundation for effective performance management. In addition, system planning requires involvement of various key stakeholders whose perspectives promote additional understanding of system needs and experiences.

Figure 1 – Organizational Culture

Component		Rating			
		Present	Partially Present	Not Present	Not Rated
Organizational Culture					
1	Leadership promotes a clear mission, vision, and priority initiatives	X			
2	Quality improvement and performance management are organizational priorities	X			
3	Stakeholders actively participate in system planning and delivery	X			
4	Communication among MHP administrative and program staff		X		
5	Input and involvement by MHP staff		X		
6	Communication with contract providers	X			
7	Collaboration with contract providers	X			
8	Involvement of consumers	X			
9	Involvement of family members	X			
10	Involvement of community stakeholder groups	X			

Issues related to the components of organizational culture noted above include:

- Information flow within the organization is described as “top-down” and line staff supervisors are often unable to answer line staff questions due to lack of information.
- While staff members have been surveyed and asked for input in the past and have opportunities to be on committees, staff members describe little input into current system initiatives such as the new MIS and the programmatic changes anticipated due to the budget shortfall.

Performance and Quality Management

Effective performance management – data-driven decision making – requires strong collaboration among staff working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing available data for analysis must be present. Further, the CAEQRO review emphasizes that MHPs demonstrate that analytic findings are used to guide clinical and programmatic decisions.

Figure 2 – Performance and Quality Management

Component		Rating			
		Present	Partially Present	Not Present	Not Rated
1	Data is used to inform management and guide decisions	X			
2	Access to data via standard and ad hoc reports	X			
3	Staff with data analytic skills	X			
4	Routine data analysis	X			
5	Routine business process analysis	X			
6	Measures consumer outcomes	X			
7	Analyses lead to program/process changes	X			
8	Investment in information technology infrastructure is a priority	X			
9	Electronic Health Record			X	
10	Data integrity – timely, accurate, and consistent data collection and entry throughout MHP				X
11	Contract providers submit data timely and accurately, and are able to access data via standard reports				X
12	Contract and network providers are paid timely and accurately for services rendered				X
13	Integrity of Medi-Cal claim process, including determination of beneficiary eligibility and timely claims submission		X		

The effective use of data to support program management includes the following issues:

- Historically, the dashboard indicators have reported key system wide indicators. The use of data to support and manage operations was identified as an exemplary practice by CAEQRO in a prior year report.

- The Quality Review Council (QRC) includes 21 members with strong consumer/family member/advocate presence and up to eight individuals reimbursed by stipends. The QRC meets every other month and has access to leadership. In the past year, the QRC reviewed grievances and wait times to services and successfully addressed identified issues. Over the past year the Council's accomplishments include the following:
 - Identified a cluster of complaints about a specific psychiatrist, worked with the network's Credentialing Committee, and the individual is no longer on the panel
 - Identified a grievance cluster regarding one large organizational provider, issued a Plan of Correction, and grievances have greatly decreased
 - Identified a cluster of complaints regarding lack of provider staff kindness and sensitivity to consumers and family members. The Council developed a training for providers paid by MHPA funds which is currently in process.
- Since the MHP's FY09 CAEQRO review was in January 2009, less than four months after the cutover to Anasazi, it is too early to assess components 10 and 11 in the figure above. It should be noted that in prior year CAEQRO reports, San Diego's data integrity (timely, accurate and consistent data collection and entry) for both county-operated clinics and contract providers was consistently rated as present/met.
- Contract and network providers were paid timely and accurately for services rendered through October 2008. This component has consistently been rated present/met in prior year CAEQRO reports. While there is no evidence that suggests that the MHP is not maintaining its compliant payment process during the Anasazi start-up phase, it is too early to rate component 12.
- The MHP continues to submit InSyst claims for services rendered prior to October 2008. Test claims from Anasazi system for services rendered after October 2008 have been produced and submitted to the State. As of January 2009, the MHP remains in testing phase for Anasazi claims.

Service Delivery

CAEQRO identifies the following components as representative of a broad service delivery system which provides timely services tailored to consumer and family needs. Principles of recovery, cultural competence, evidence based practices, and integrated services form the foundation for access to and delivery of quality services.

Figure 3 – Service Delivery

Component		Rating			
		Present	Partially Present	Not Present	Not Rated
1	Recovery principles drive service delivery	X			
2	Services provided in a welcoming environment	X			
3	Consumer-run and/or consumer-driven programs	X			

Component		Rating			
		Present	Partially Present	Not Present	Not Rated
4	Clinical staff supports recovery orientation	X			
5	System supports planned discharge	X			
6	Cultural competence principles and practices drive service delivery	X			
7	Accessible community based services	X			
8	Disparities evaluated and addressed		X		
9	Integrated service delivery strategies to key populations	X			
10	Primary health care	X			
11	Co-occurring disorders	X			
12	Law enforcement and criminal justice	X			
13	Schools and other education systems	X			
14	Other:				X
15	Timely access to services throughout the system	X			
16	Evidence based practices present and monitored	X			

Review of the service delivery system includes the following issues:

- The Meeting Place, California's first International Center for Clubhouse Development (ICCD) certified clubhouse was modeled after the Fountain House in New York, was founded by a consumer and follows the 36 international standards of the organization. ICCD developed a software package which allows members and staff to track clubhouse activities. The Meeting Place operates the first peer-operated warm line in San Diego, provides supported education through a community college, and provides transitional and supported employment services.
- A consumer Program Advisory Group (PAG) located at the Morena Drop In Center in San Diego provides input regarding the activities of the drop in center. Staff volunteers are trained for three months after passing a background check. Members would like additional training on peer support, expanded hours of operation during evenings and weekends, and more flexible supported employment opportunities.

- While the MHP is actively implementing programs and monitoring progress in addressing disparities, penetration rates have not significantly improved for populations with disparities such as Hispanic/Latino.
- Caring Helpers program through a contract with Mental Health Systems, Inc. engages in outreach to Latino and Asian/Pacific Islander (API) youth who have previously been involved in juvenile justice and mental health programs to develop leadership, mentoring, and advocacy skills. The teen leadership group provides monthly forums in the community to de-stigmatize mental health. Caring Helpers also provides Family Support Basics training to Latino and API adults.
- Breaking Down Barriers, a program of Mental Health America (MHA), provides community outreach and development of cultural brokers, particularly to the Latino, Native American, and lesbian, gay, bisexual, and transgender (LGBT) communities. Breaking Down Barriers partnered with Neighborhood House Association (NHA) in 2007 to give presentations at Head Start Centers and NHA parent meetings. Families served are 80% Latino.
- The Chaldean/Middle Eastern Center Clinic in the Eastern region, where 50,000 immigrants reside, serves Arabic consumers. El Cajon, a suburb of San Diego, is currently the second largest Iraqi population in the U.S. Another contractor, Survivors of Torture, also serves this population.
- The MHP has implemented many evidence based practices (EBP), including BioPsychoSocial Rehabilitation Practices, Assertive Community Treatment, Supported Housing, Supported Employment, Multi-Dimensional Foster Care, Family Visitation, Strategic Family Therapy, and Parent Child Interaction Therapy. The MHP is measuring fidelity for many practices, such as Integrated Dual Diagnosis Treatment, as well as measuring outcomes.

Workforce Development

CAEQRO identifies the following components as necessary to support a fully functional service delivery system. Employee recruitment, retention, and training are part of assuring adequate program and provider capacity as well as quality services.

Figure 4 – Workforce Development

Component		Rating			
		Present	Partially Present	Not Present	Not Rated
1	Program capacity to provide clinically appropriate services		X		
2	Staff recruitment and retention issues are actively addressed	X			
3	Consumers and family members are employed in key roles throughout the system	X			
4	Consumer and family employment opportunities	X			

Component		Rating			
		Present	Partially Present	Not Present	Not Rated
5	Initial training with role definition		X		
6	Ongoing training and support		X		
7	Career ladder			X	
8	Supports for community-based consumer employment		X		
9	Relevant staff training is provided and evaluated		X		

Review of workforce issues that support the service delivery system includes the following issues:

- While the MHP is aware of program capacity needs and has data to describe them, in most service areas the MHP has sufficient capacity.
 - The MHP reports a need for more psychiatrists, but also reports short wait times for consumers in adult and child programs.
 - To address a shortage of psychiatrists, the MHP has increased the salary of county psychiatrists by reducing other staff, increased outreach to psychiatrists at conferences, provided a cultural stipend for psychiatric residents, and is developing a policy promoting psychiatric nurse practitioners. As part of the MHP's Workforce, Education and Training (WET) Plan, the MHP is collaborating with California State University San Marcos on a new psychiatric nurse practitioner program and with UC Santa Barbara and UC Irvine on an expanded psychiatric residency community fellowship program.
 - With only two psychiatrists in North County, the MHP developed crisis clinics with telepsychiatry, increasing capacity and decreasing wait times.
 - With the county hiring freeze, vacancies are not being filled, creating increased workload on remaining staff.
 - Adult case management staff describe caseloads of 120-160, except for conservatee caseloads of 50-60, with most attention going to those in crisis. Case managers would like to be supported by the addition of staff dedicated to the roles of housing specialist, employment specialist, and benefits worker with a specialty in assisting consumers in transitioning from SSI.
 - Staff report a decrease in Board and Care facilities with 99 facilities currently in the county. There is also a need for an adult residential facility for consumers with COD.
 - With six crisis residential facilities in the county that are usually full, more capacity is needed, particularly in the north inland area.

- With eleven clubhouses serving 30 to 40 consumers per day out of an MHP population of 38,000 adults, only a small percentage of consumers benefit from these programs.
- Consumers at juvenile hall with intensive mental health needs require locked residential services in the county or service alternatives that are currently unavailable, resulting in longer stays at juvenile hall.
- While planning is in process, the MHP described a lack of current housing and supported housing options.
- There does not appear to be a formal process for training new staff, some reporting that new hires receive no training and must rely on shadowing co-workers and learning on the job.
- Staff report a decrease in clinical trainings and are now charged a fee for receiving continuing education units. Some staff report long delays in receiving reimbursement for conference attendance. While there have been many COD trainings for staff, staff would be interested in receiving clinical training by psychiatrists and psychologists employed by the MHP.
- The MHP currently has 83 consumer positions or 52 FTE, mostly through contract agencies. While some clubhouses have positions that consumers can move up into, most consumer employees report no career ladder and additional problems with lack of a living wage, high medication co-payments, poor healthcare coverage, and challenges with decisions regarding SSI versus full-time employment. There are potential plans for a career ladder through WET funding.
- Some family member employees started employment without a written job description, but job descriptions are currently available. Family members feel pressure from their employers to obtain a BA degree, although many do not feel that it is necessary to be effective in their jobs.
- The Family Youth Roundtable conducts trainings for clinical staff on peer workers. Staff reported that no professional staff attended the last training although this information had been communicated to the COTR.
- Consumers report a lack of supported employment opportunities in the community and a lack of job developers.
- While staff training opportunities are available, there is not consistent evaluation of training.

Current Medi-Cal Claims Data for Managing Services

Source of data for Figures 5 through 20

Information to support the tables and graphs, labeled as Figures 5 through 20, is derived from four source files containing statewide data. A description of the source of data follows in Attachment C.

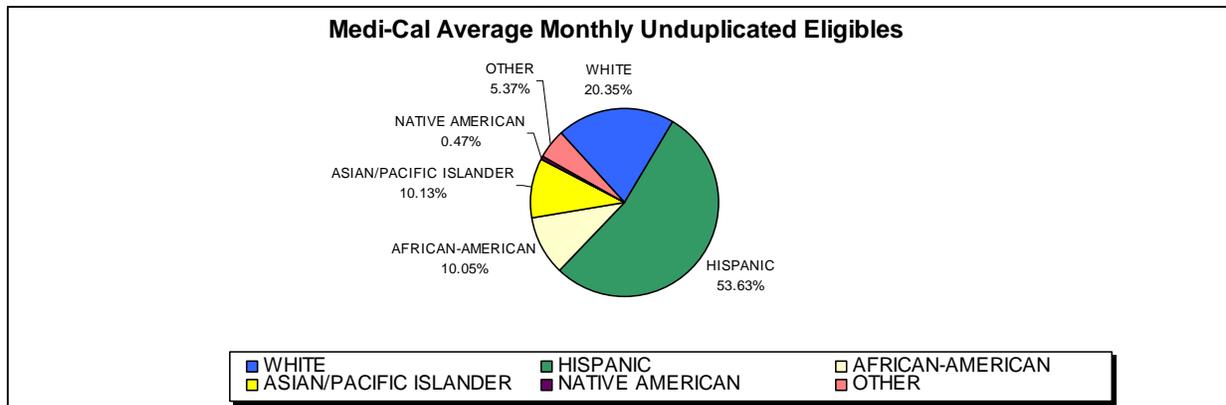
CAEQRO provided the MHP with three summary reports of Medi-Cal approved claims data – overall, foster care, and transition age youth – which follow as Attachment D. The MHP was also referred to the CAEQRO Website at www.caegro.com for additional approved claims data useful for comparisons and additional analyses.

Demographics of Medi-Cal Eligibles and Beneficiaries Served

The following charts show the ethnicities of Medi-Cal eligibles compared to those who received services in CY07. Charts which mirror each other would reflect equal access based upon ethnicity, in which the pool of beneficiaries served matches the ethnicities of the Medi-Cal community.

Figure 5 shows the ethnic breakdown of Medi-Cal eligibles statewide, followed by those who received at least one mental health service in CY07. Figure 6 shows the same information for the specific MHP’s eligibles. Similar figures for the foster care and TAY populations are included in Attachment D following the MHP’s approved claims worksheets.

Figure 5 – CY07 Statewide Medi-Cal Eligibles vs. Beneficiaries Served by Race/Ethnicity



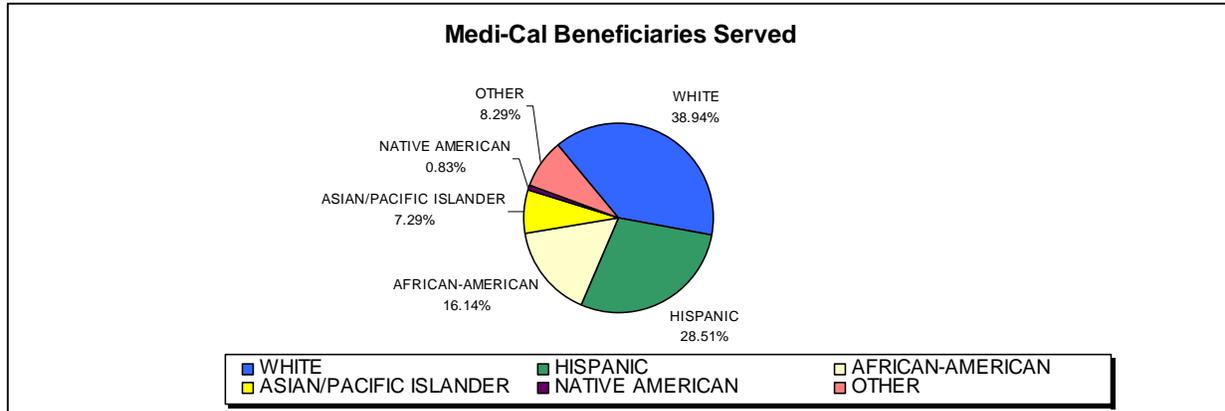
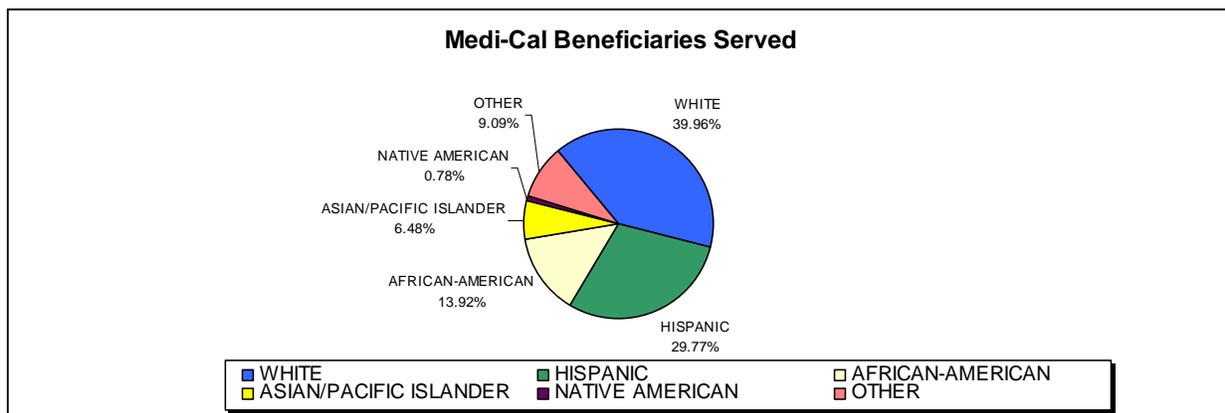
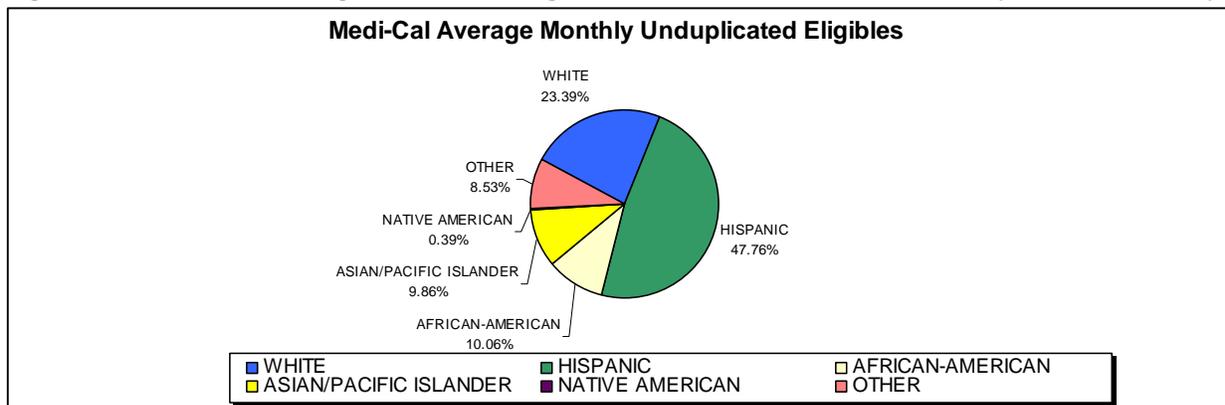


Figure 6 – CY07 San Diego Medi-Cal Eligibles vs. Beneficiaries Served by Race/Ethnicity



Penetration Rates and Average Approved Claims

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 statewide average.

Figure 7 – CY2007 Medi-Cal Approved Claims Data

Element	San Diego	Rank	Large MHPs	Statewide
Total approved claims	\$101,207,150	N/A	N/A	\$1,882,865,260
Average number of eligibles per month	367,173	N/A	N/A	6,837,351
Number of beneficiaries served	30,503	N/A	N/A	423,037
Penetration rate	8.31%	24	6.52%	6.19%
Approved claims per beneficiary Served	\$3,318	36	\$4,155	\$4,451
Penetration rate – Foster care	65.79%	10	53.12%	55.25%
Approved claims per beneficiary served – Foster care	\$5,876	23	\$6,709	\$7,054
Penetration rate – TAY	9.12%	26	6.96%	6.94%
Approved claims per beneficiary served – TAY	\$4,502	26	\$5,255	\$5,559
Penetration rate – Hispanic	5.18%	11	3.48%	3.29%
Approved claims per beneficiary served – Hispanic	\$3,308	32	\$3,725	\$4,185
Penetration rate – Asian/Pacific Islander	5.46%	N/A	4.54%	4.45%
Approved claims per beneficiary served – Asian/Pacific Islander	\$2,192	N/A	\$3,173	\$3,197

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

Figures 8 through 10 display penetration rates – overall, foster care youth, and transition age youth. Three years are included to depict changes over time.

Figure 8

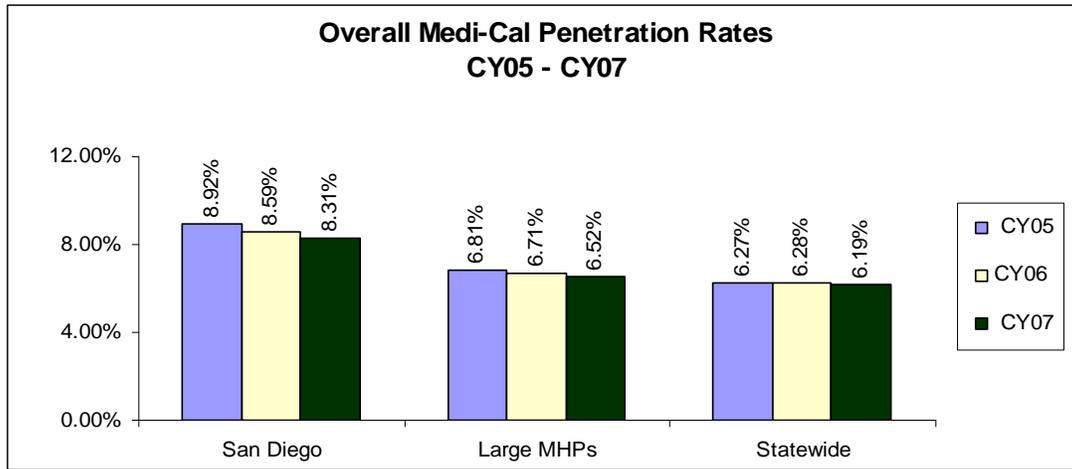


Figure 9

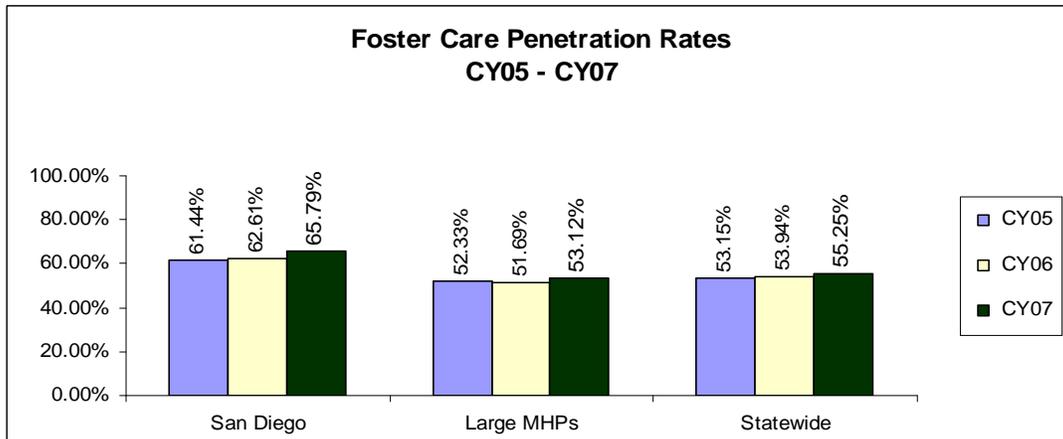


Figure 10

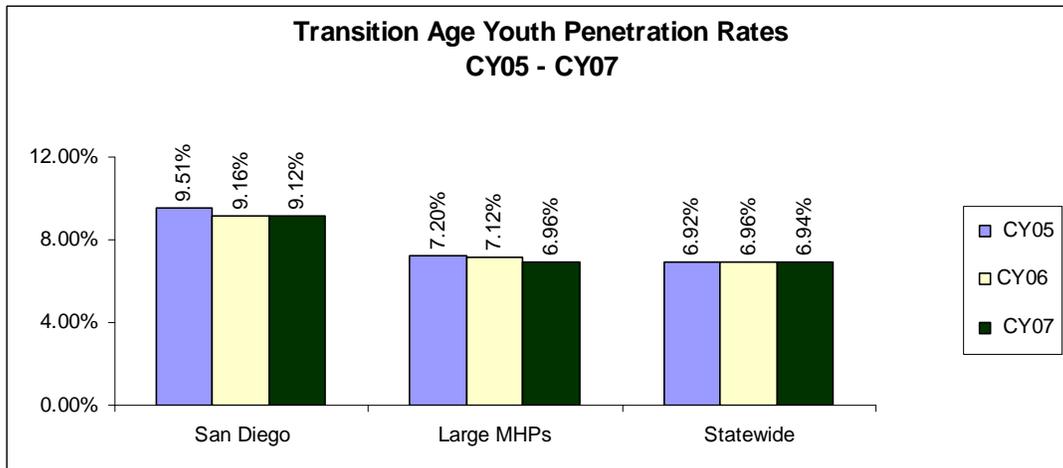
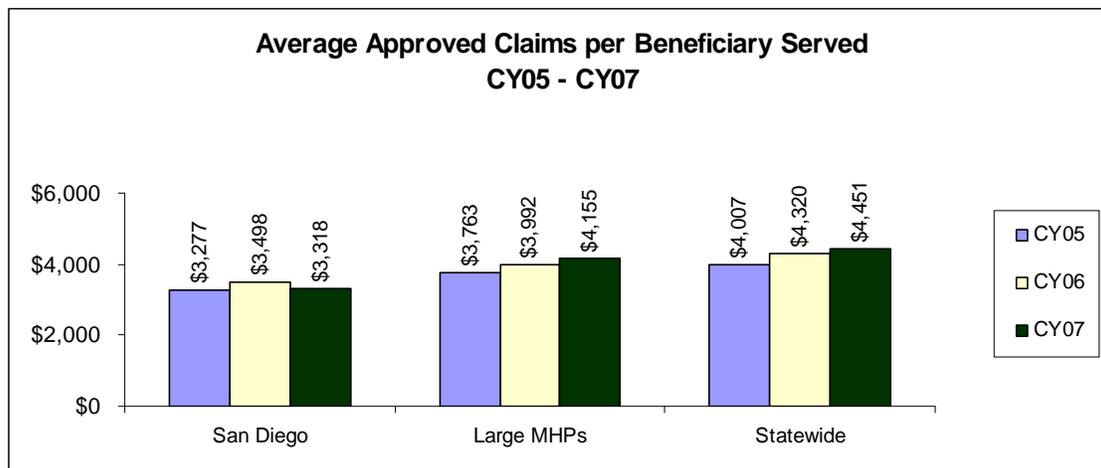


Figure 11 below displays the MHP's average approved claims per beneficiary served for CY05, CY06 and CY07, as well as for similar size MHPs and the statewide average.

Figure 11



Review of Medi-Cal approved claims data, summarized in the table and figures above, included the following issues that relate to quality and access to services:

- Though decreasing over the prior three years, the MHP's penetration rate remains over 30% higher than the rates for similar size MHPs and the statewide rate average over the three-year period. San Diego ranks 24th out of 56 in overall Medi-Cal penetration rate for CY07.
- The foster care penetration rate over the three-year period exceeds similar size MHPs and the statewide rate. San Diego ranks 10th out of 56 in foster care penetration rate for CY07.
- Similarly, the transition age youth (TAY) penetration rate is over 30% higher than the rates for similar size MHPs and the statewide average over the three-year period. San Diego ranks 26th out of 56 in TAY penetration rate for CY07.
- The average approved claims per beneficiary served lags behind similar size MHPs and the statewide average over the three-year period. The MHP's extensive use of network providers with lower reimbursement rates accounts for a significant portion of the difference. San Diego ranks 36th out of 56 in approved claims per beneficiary served for CY07.

Retention Rates

Figure 12 displays the MHP's CY05, CY06 and CY07 Medi-Cal approved claims data showing retention rates – the percentage of beneficiaries who received the specified number of services during each annual period. Statewide data for CY07 is also presented for comparison. Figure 13 follows, depicting the raw numbers of beneficiaries who received the specified number of services, as well as the average amount of approved claims for each category for the MHP and the state.

Figure 12

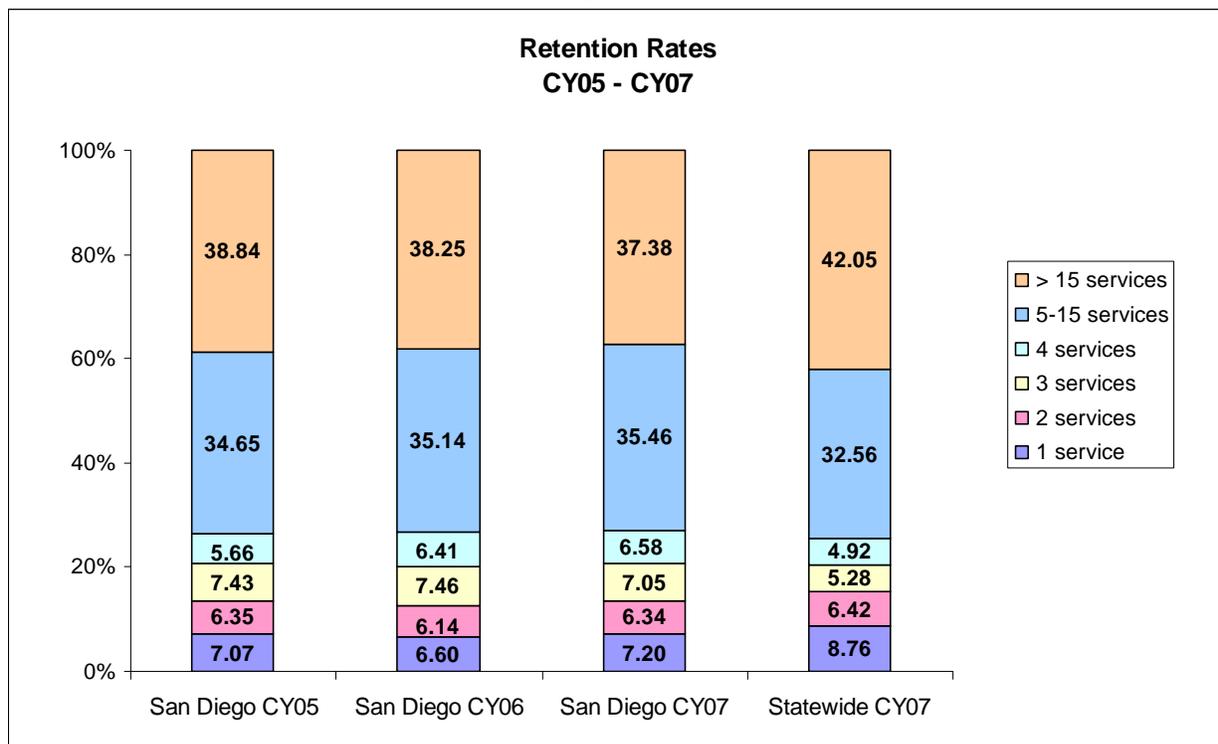


Figure 13 – CY2007 Retention Rates with Average Approved Claims per Category

Number of Services Approved per Beneficiary Served	San Diego Number of beneficiaries served	San Diego \$ per beneficiary served	Statewide \$ per beneficiary served
1 service	2,195	\$140	\$262
2 services	1,933	\$235	\$391
3 services	2,149	\$354	\$529
4 services	2,007	\$472	\$655
5 – 15 services	10,817	\$1,016	\$1,327
> 15 services	11,402	\$7,696	\$9,299

Review of the retention data included the following issues:

- The percentage of MHP beneficiaries who receive four or fewer services has increased each year. For CY07 it slightly exceeds the statewide pattern (27.17% for the MHP versus 25.44% statewide). This upward trend may indicate an increase of barriers during the early service engagement period or could also indicate a shift towards more targeted consumers and increased referrals to the community.

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 roughly 2% of the beneficiaries served accounted for nearly one-quarter of the Medi-Cal expenditures. 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)

	MHP Beneficiaries Served			Approved Claims		
	# HCB	# Served	%	Average per HCB	Total Claims for HCB	% of total claims
Statewide CY07	9,764	423,037	2.31%	\$49,590	\$484,200,157	25.72%
San Diego CY07	485	30,503	1.59%	\$44,429	\$21,548,281	21.29%
San Diego CY06	541	30,774	1.76%	\$44,516	\$24,083,277	22.37%
San Diego CY05	453	32,023	1.41%	\$44,812	\$20,299,896	19.38%

Statewide in CY07, 37.14% of the approved Medi-Cal claims funded 4.41% of the beneficiaries served. For the MHP, 33.71% of the approved Medi-Cal claims funded 3.28% of the beneficiaries served. This information is depicted in the figures 15 and 16, first for the state and then for the MHP.

These figures also include additional analysis of beneficiaries receiving \$20,000 to \$30,000 in services per year as a second level of high cost beneficiaries. Statewide, this population also represents a small percentage of beneficiaries for which a disproportionately high amount of Medi-Cal dollars is claimed.

Figure 15

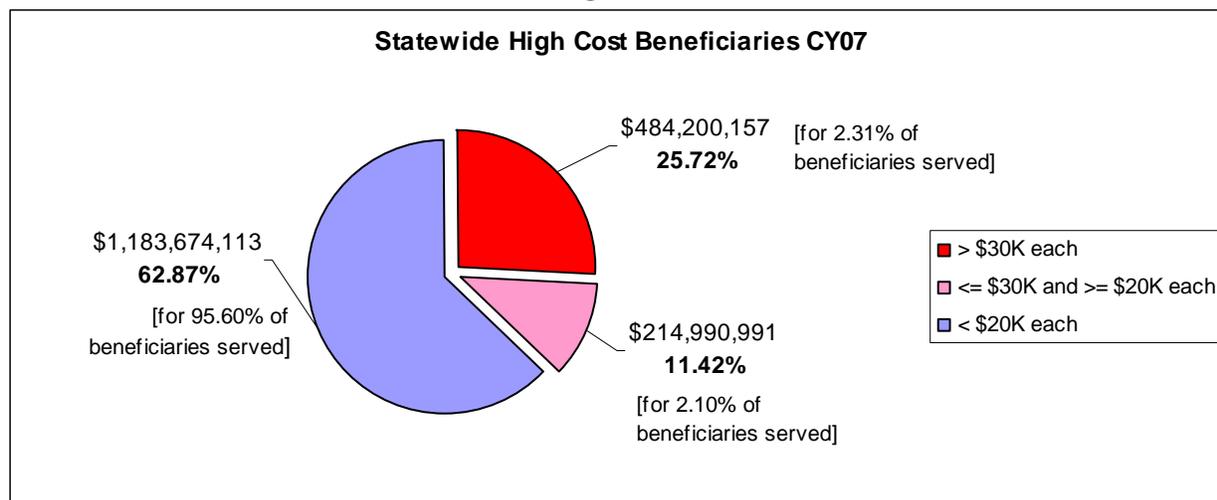
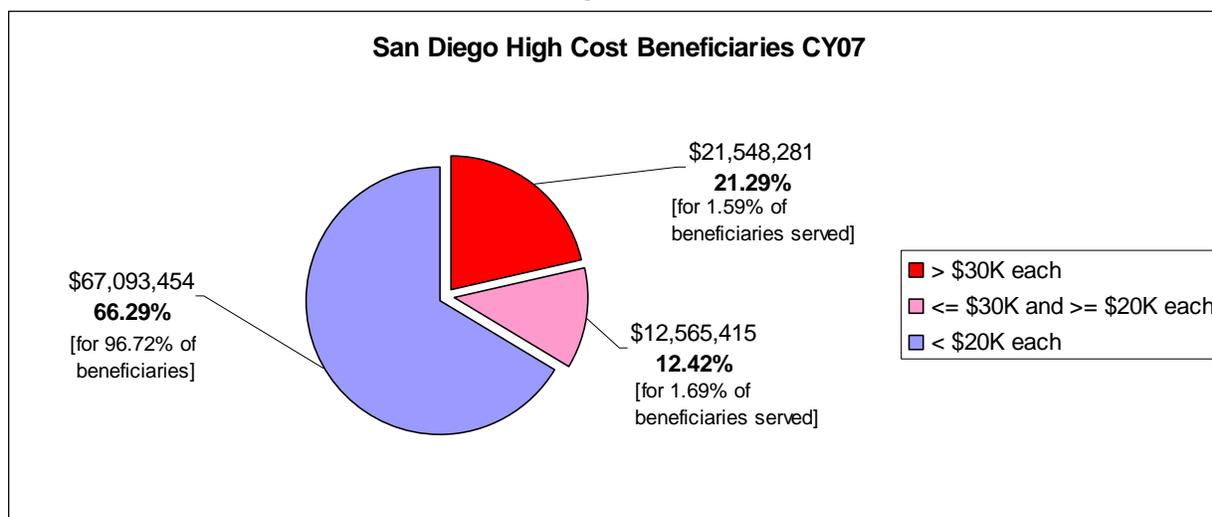


Figure 16



Review of the above high cost beneficiary data included:

- The MHP has a lower percentage of approved claims for high cost beneficiaries than the statewide average (21.29% vs. 25.72%). High cost beneficiaries also make up a smaller proportion of the MHP’s consumers than the statewide average (1.59% vs. 2.31%).
- For San Diego, 66.29% of Medi-Cal dollars were available to fund services for the bulk of beneficiaries served (96.72%) who receive less than \$20,000 per year in services. The statewide average is 63% of approved claim dollars funding 95% of low cost beneficiaries served.
- In CY07, the MHP showed a decrease its higher number of high cost beneficiaries in CY06 – closer to the number in CY05.

Medi-Cal Approved Claims History

The table below provides trend line information from the MHP’s Medi-Cal eligibility and approved claims files since FY02-03. The dollar figures are not adjusted for inflation.

Figure 17 – Medi-Cal Eligibility and Claims Trend Line Analysis

Fiscal Year	Average Number Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate		Total Approved Claims	Approved Claims per Beneficiary Served per Year	
			%	Rank		\$	Rank
FY06-07	363,383	30,756	8.46%	24	\$110,915,237	\$3,606	33
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
FY03-04	357,998	33,197	9.27%	20	\$104,175,140	\$3,138	36

Fiscal Year	Average Number Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate		Total Approved Claims	Approved Claims per Beneficiary Served per Year	
			%	Rank		\$	Rank
FY02-03	347,152	31,703	9.13%	21	\$111,674,386	\$3,523	31

Discussion of trends in Medi-Cal approved claims data over time included these issues:

- Over the past five fiscal years, the average number of eligibles per month increased 4%, while the number of beneficiaries served has remained relatively stable during the period, which accounts for the penetration rate slowly decreasing over time.
- During the past five fiscal years, the total approved claims dollars trended downward during the middle years and is now almost back to FY02-03 total amount. However, the total amount does not account for any inflation rate adjustments.

Medi-Cal Denied Claims History

Denied claims information appears in the following table. 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 18 – 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
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%
FY03-04	\$2,099,656	2.13%	41	3.82%	0% - 30.11%

Discussion of Medi-Cal denied claims included:

- For five consecutive fiscal years, the MHP has had a consistently low denied claim rate, indicating that staff has good knowledge of Medi-Cal claiming processes and that effective operational controls are in place.
- The MHP denied claims rates for the five-year period were less than the statewide median.

Disparities for Hispanics & Females

Since CY05, CAEQRO has analyzed penetration rates and approved Medi-Cal claims for females versus males and Hispanics versus Whites and discovered significant disparities in both populations. CAEQRO continues this analysis in CY07 and noted the following patterns:

- The relative access and the average approved claims for female beneficiaries were lower than for males. These disparities are equal to those identified in the CY05 and CY06 data.
- The relative access and the average approved claims for Hispanic beneficiaries were lower than for White beneficiaries. Over the past three years of data, these disparities decreased slightly.

The tables below show the results of these analyses – penetration rates, approved claims averages, and the respective ratios – comparing the MHP's CY07 results with the statewide results for CY07 as well as the MHP's data for CY06 and CY05.

Below, for each variable (Hispanic/White and female/male), two ratios are calculated to depict relative access and relative approved claims. Figure 20 reflects 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 Figure 21 for female to male beneficiaries.

For all elements, ratios depict the following:

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

Figure 19 – Examination of Disparities – Hispanic versus White

	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 CY07	120,591	3.29%	164,717	11.84%	\$4,185	\$4,536	.28	.92
San Diego CY07	9,080	5.18%	12,190	14.19%	\$3,308	\$3,243	.36	1.02
San Diego CY06	8,879	5.22%	12,706	14.69%	\$3,482	\$3,441	.36	1.01
San Diego CY05	8,707	5.24%	13,926	14.70%	\$3,162	\$3,267	.36	.97

Figure 20 – Examination of Disparities – Female versus Male

	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 CY07	220,260	5.67%	202,777	6.88%	\$3,892	\$5,058	.82	.77
San Diego CY07	16,152	7.63%	14,351	9.23%	\$2,842	\$3,853	.83	.74
San Diego CY06	16,316	7.90%	14,458	9.53%	\$2,952	\$4,114	.83	.72
San Diego CY05	16,973	8.28%	14,824	9.79%	\$2,759	\$3,870	.85	.71

Discussion of the disparities data included:

- The penetration rate ratio at .36 for Hispanics to Whites remained constant for the three-year period and is significantly higher than the statewide CY07 average of .28, indicative of less disparity in Latino access within the MHP than observed statewide.
- The MHP's approved claims ratio for CY06 and CY07 demonstrates parity in claims for Hispanic beneficiaries and White beneficiaries, unlike the statewide disparity.
- For the three-year period, the ratio of female to male penetration rate and approved claims indicates slightly less disparity than exists statewide. However, gender disparity for both access and services continues to exist within the MHP.

Performance Measurement – EPSDT Utilization Patterns

Each year CAEQRO is required to work in consultation with DMH to identify a performance measurement (PM) which will apply to all MHPs. In past years, the PM focused on an analysis of disparities in access and utilization by both female and Hispanic beneficiaries. While this analysis is still conducted annually, described in the section above, this year's specified PM will involve a variety of analyses of EPSDT service utilization. These data – also in support of the statewide EPSDT PIP outlined by DMH and its related work groups – will be shared with DMH and MHPs on a routine basis. Early analyses are available on the CAEQRO Website www.caeqro.com, and additional data will be posted as analyses are conducted.

Consumer/Family Member Focus Groups

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

1. Hispanic/Latino consumers of county operated or contract services, ages 18 and over

2. Consumers with a co-occurring substance abuse and mental illness receiving services for at least one year
3. Family members of children and adolescents receiving services from the MHP or its contractors, including individuals of various ethnicities

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 – Co-occurring Disorders

The focus group was held at the main clinic offices on Camino Del Rio in San Diego. Participants were very positive about the services they were receiving, including dual diagnosis, co-dependency, and life skills groups, housing, and Able/Disable community youth developer program.

Access issues:

- Participants reported that it took from one week to two months to obtain an appointment with a psychiatrist, and there was no problem with rescheduling if an appointment was missed.
- Individual sessions were only available with a student intern.
- Appointments with psychologists/licensed clinicians were not available.

Employment issues:

- Participants would like job assistance that is appropriate to the individual. One consumer who deals with COD issues received job finding services that resulted in a job that entailed serving drinks.
- Consumers were not informed that accepting employment with benefits meant that they were ineligible for continued services as the MHP does not serve privately insured consumers.

Figure 21 – Consumer/Family Member Focus Group 1

Number/Type of Participants	
Consumer Only	11
Consumer and Family Member	0
Family Member of Adult	0
Family Member of Child	0
Family Member of Adult & Child	0
Total Participants	11

Estimated Ages of Participants	
Under 18	0
Young Adult (approx 18-24)	2
Adult (approx 25-59)	9
Older Adult (approx 60 and older)	0

Preferred Languages	
English	11

Estimated Race/Ethnicity	
Caucasian	6
Latino	5

Gender	
Male	3
Female	8

Interpreter used for focus group 1: No Yes

Consumer/Family Member Focus Group 2 – Family Members of Children/Adolescents

The focus group was held at Families Forward in San Diego. Participants included parents of children involved with multiple agencies who were receiving wraparound services from Families Forward. Participants were very appreciative of services, saying that the services had “saved” their families. Most participants would have preferred earlier intervention.

Feedback included:

- All participants felt the MHP referral line was not helpful to them in accessing services.
- Participants were unaware of any Parent Partner or System Navigators assistance availability. Some parents were unaware of NAMI resources.
- Participants expressed a need for training on finding behavioral health resources, and then on accessing and fully utilizing the resources.
- Several participants expressed dissatisfaction with TBS services received from other providers, stating that the behavioral interventions used were in conflict with their parenting styles.
- Parents had the most difficulty obtaining Individual Education Plans (IEP) through the numerous (41) school districts in the county and described situations in which IEPs occurred without parents being present.
- Participants desired respite services. Foster care participants requested respite services from the Department of Social Services and were told that they could have four hours of respite service several months from the request.

Figure 22 – Consumer/Family Member Focus Group 2

Number/Type of Participants	
Consumer Only	0
Consumer and Family Member	2
Family Member of Adult	0
Family Member of Child	6
Family Member of Adult & Child	0
Total Participants	8

Estimated Ages of Participants	
Under 18	0
Young Adult (approx 18-24)	0
Adult (approx 25-59)	7
Older Adult (approx 60 and older)	1

Preferred Languages	
English	8

Estimated Race/Ethnicity	
Caucasian	6
Latino	1

Gender	
Male	
Female	

Interpreter used for focus group 2: No Yes

Consumer/Family Member Focus Group 3 - Latino

The focus group was held at the main clinic offices on Camino Del Rio in San Diego.

Participants were satisfied with the services they received, such as housing, clubhouses, and medication services, feeling that they have learned to cope with monthly “meds only” visits. All felt respected and had no difficulty accessing services in their own language.

Participants felt they would like more assistance with the following:

- Medicare Part D: Consumers with Medi/Medi were having difficulty with the increased co-payments when their pharmacy benefits company changed on January 1. Some psychiatrists have provided samples for those unable to afford the co-payments.
- Obtaining legal status for residency for themselves and their families
- Transportation assistance as there has been a decrease in bus services in North County

Figure 22 – Consumer/Family Member Focus Group 3

Number/Type of Participants	
Consumer Only	11
Consumer and Family Member	0
Family Member of Adult	0
Family Member of Child	0
Family Member of Adult & Child	0
Total Participants	11

Estimated Ages of Participants	
Under 18	0
Young Adult (approx 18-24)	0
Adult (approx 25-59)	10
Older Adult (approx 60 and older)	1

Preferred Languages	
English	8
Spanish	3

Estimated Race/Ethnicity	
Latino	11

Gender	
Male	
Female	

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

Performance Improvement Project Validation

Clinical PIP validation

Statewide study question:

“Will implementing activities such as, but not limited to: improved utilization management, care coordination activities, data collection, review and validation, 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 study question:

The MHP’s specific study question for the EPSDT PIP has not yet been developed.

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 one of each MHP's two PIPs must focus on 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. With an overarching study question noted above, the first year of this statewide initiative focuses on youth who are high utilizers of EPSDT services.

CAEQRO provided technical assistance to DMH to identify criteria for a definition of "high utilization." In order to assist the MHPs in beginning this study, CAEQRO reviewed approved claims from June 2007 through September 2008 to identify youth for initial consideration. Youth whose monthly services correspond with one of the following criterion must be considered for inclusion in the study:

- Criteria A – \$3,000 in any given month in FY07-08 – San Diego falls within this category
- Criteria B – The average monthly dollar value that corresponds with the top 5% of the MHP's EPSDT beneficiaries. The generally small and small-rural MHPs, where the average value ranged from \$477 to \$2,875

Each MHP is expected to consider for inclusion in the study any EPSDT beneficiary who meets the MHP's dollar threshold in any given month – beginning with those youth identified by the above noted data analysis and continuing to identify new individuals who meet the monthly criteria. In addition to the dollar threshold as an initial criterion, each MHP is responsible for creating its own study question based upon its analysis of issues associated with its EPSDT youth and services. The study question must focus on MHP processes and consumer outcomes; a reduction in monthly approved claims is not a suitable indicator.

The MHP established a 22-member EPSDT Stakeholder Committee. FY05-06 approved claims data revealed that 738 beneficiaries received at least \$3000 of approved services within a one month period. The MHP analyzed the data for these beneficiaries and found that compared to the overall consumer population, this group had the following characteristics in which they were more likely to:

- be white or African American
- English speaking
- have a diagnosis of Oppositional/Conduct Disorders followed by Bipolar Disorder
- Use all types of services and more minutes of services
- Use inpatient services, but did not use more inpatient days or have longer length of stays

Alcohol and Drug Services involvement was not found to be significant.

The MHP reviewed characteristics of consumers who had no day treatment with those who used day treatment residential services. The MHP also reviewed those who reached \$3000 in paid services for a minimum of two months and three months.

The MHP proposed studying those that received at least \$3000 in services for a minimum of three months in a fiscal year to see if they are receiving an appropriate level of services. The study population is estimated to be 350 consumers and the MHP intends to conduct a chart review of a sample of 50 to 70 consumers to gather further information. However, CAEQRO cautioned the MHP during the site review regarding the need to consider for inclusion all consumers who meet the initial cost criteria in one month and to give a clear rationale for excluding any groups of consumers who meet the initial criteria.

The MHP identified preliminary barriers as follows:

- Children may not need the level of services they are receiving
- Children may be receiving too much service
- Children may be receiving this level of service because the service that would be more appropriate is not available

At the end of the fiscal year, CAEQRO will assist DMH in evaluating preliminary statewide results. To that end, CAEQRO will contact MHPs in Spring 2009 for the current status of the EPSDT PIP as well as specific evidence of that status. This process will not affect the findings for this site review.

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 23 – Clinical PIP Validation Review – Summary of Key Elements

Step	Key Elements	Met	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
2	The study question identifies the problem targeted for improvement			X
3	The study question is answerable/demonstrable			X
4	The indicators are clearly defined, objective, and measurable			X
5	The indicators are designed to answer the study question			X
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
7	The indicators each have accessible data that can be collected			X
8	The study population is accurately and completely defined			X
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data			X

Step	Key Elements	Met	Partial	Not Met
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes			X
11	The analyses and study results are conducted according to the data analyses plan in the study design			X
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			X
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			X
Totals for 13 key criteria		0	0	13

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. Attachment F includes the clinical and non-clinical PIPs submitted by the MHP.

Non-clinical PIP validation

The MHP did not submit a formal study question, but stated the following:

“The MHP plans to study the unexplained variances in the results of the State mandated client satisfaction survey to identify why satisfaction scores are better in some settings and worse in others. The MHP will specifically focus on the administrative or operational factors that result in some scores being higher than others.”

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

The MHP identified a problem of state consumer satisfaction survey results not being valued, not being used for quality improvement efforts, and not expressing the full range of experiences of some consumers in the system. However, the MHP did not provide any data validating the problem.

The identified barriers included:

- contract supervision is “diffused”
- program monitors have their own approach to complex issues
- there is a lack of understanding of how to interpret the data and how to work with programs to resolve problems

The MHP proposes to study the last four cycles of mandated state consumer satisfaction surveys for unexplained variances, to identify the programs in the top and bottom quartile on MHSIP, Cal-QOL, and YSS, and to examine program differences.

The MHP identified the following interventions:

- Obtain data in a usable format
- Assemble a team to analyze process for responding to MHSIP, CalQOL, and YSS data complaints
- Select a specific process for Plan-Do-Study-Act cycles with a goal of reducing unexplained variance
- Develop a system that routinely uses the data and complaints to work with programs to spread best practices and minimize inter-program variance

Proposed indicators include survey scores by program over four survey periods with goals of reducing the difference from the norm and improving scores by 3-5% within 1-2 years.

CAEQRO recommended that if the goal is to improve consumer satisfaction as the indicators suggest, the MHP needs to analyze why satisfaction is lower in some programs and choose interventions that will raise consumer/family satisfaction. If the goal is to improve staff understanding of the surveys and change staff behavior, then staff indicators need to be identified for measurement. In either case, further data drill downs are necessary to establish baselines.

Because the MHP does not yet have an active non-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 24 – Non-Clinical PIP Validation Review – Summary of Key Elements

Step	Key Elements	Met	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
2	The study question identifies the problem targeted for improvement			X
3	The study question is answerable/demonstrable			X
4	The indicators are clearly defined, objective, and measurable			X
5	The indicators are designed to answer the study question			X
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
7	The indicators each have accessible data that can be collected			X
8	The study population is accurately and completely defined			X
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data			X
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes			X

Step	Key Elements	Met	Partial	Not Met
11	The analyses and study results are conducted according to the data analyses plan in the study design			X
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			X
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			X
Totals for 13 key criteria		0	0	13

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. Attachment F includes the clinical and non-clinical PIPs submitted by the MHP.

Additional PIPs completed or discontinued since the last review

Status of last year's clinical PIP: Improving outcomes with integrated COD services

- Discontinued
- Completed, and the MHP plans to continue monitoring
- None submitted last year
- Unknown

Status of last year's non-clinical PIP: Improving Latino access

- Discontinued
- Completed, and the MHP plans to continue monitoring
- None submitted last year
- Unknown

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

MHP information systems overview

Current operations

The MHP deployed a date certain cutover strategy to implement the Anasazi system. For services provided prior to October 2008, the MHP continues to use InSyst for claims and CSI data reporting. As reporting of InSyst services decreases, the reporting of Anasazi services is increasing. It is expected that transition period will take from six to twelve months to fully process InSyst claims and submit CSI data. The Anasazi system will produce claims and CSI data for services provided after October 1, 2008.

The Anasazi system is housed on the county network, as the County Technology Office (CTO) is responsible for network access to all county data systems. Security and maintenance of the

county network was outsourced to the County's Information Technology Outsourcing Contractor (ITOC), with overall direction and oversight controlled by CTO. The ITOC is responsible for the set up and maintenance of Citrix user network accounts and the support of county servers that hosts the Anasazi system.

Anasazi system administration responsibilities are shared between MHP's Mental Health MIS Unit (MH MIS) and the Administrative Services Organization (ASO), which is United Behavioral Health.

- MH MIS is responsible for coordination activities among the CTO, ITOC, and the ASO. In accordance with County, State and Federal HIPAA regulations, MH MIS manages access, security, and menu management for the Anasazi system.
- The ASO is responsible for table management, system maintenance and updates to Anasazi, managing the five Anasazi environments, producing reports for legal entities, electronic submissions of state reporting, coordination with the software vendor, and providing Help Desk support for users.

Major changes since last year

- Implementation of the Anasazi system.
- Continuation of support to InSyst and e-Cura systems after Anasazi cutover

Priorities for the coming year

- Completion of the Anasazi Phase 1 implementation
- Implementation of Anasazi Phase 2 appointment scheduler and mission critical forms
- National Provider Identifier (NPI) implementation
- Implementation of Anasazi CSI state reporting
- MHPA implementation – IT Plan
- Short Doyle (SD) Phase 2 implementation

Significant issues

- Medi-Cal claims – As of January 2009 Anasazi claim submissions were in the testing phase with DMH. The MHP is aware of the State “six month claims submission” rule and subject matter expert staff is working to achieve live claims submissions by April 2009.
- Anasazi Transition Phase In – The date certain cutover strategy requires the MHP to maintain and support both InSyst and Anasazi systems for an extended time period. The challenge will be to maintain InSyst operational knowledge as its use diminishes.

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 25 – Current Systems/Applications

System/ Application	Function	Vendor/Supplier	Years Used	Operated By
Anasazi	Practice Management and Managed Care	Anasazi	4 Months	MHP IS, Agency IS
Chart One	Admission, Discharge, Transfer	Anacomp	3 Years	Vendor IS
InSyst (Legacy)	Practice Management	The Echo Group	11 Years	ASO-UBH
e-Cura (Legacy)	Managed Care	The Echo Group	10 Years	ASP-UBH

Plans for information systems change

The Anasazi system current status is “implementation in progress.” As of January 2009, the MHP was completing phase one project milestones. Phase one final acceptance is pending some system improvements. The overall project implementation is on schedule according to the Project Action Plan.

Certain phase two milestones are under development, while the remaining milestones are scheduled for implementation during 2009 and 2010. The final acceptance milestone is currently scheduled for December 2011.

Clinical and programmatic functionality

The Anasazi system includes clinical functionality which the MHP will implement during phase two. Major implementation milestones for the appointment scheduler, assessment, treatment plan, and progress note forms, are in the planning and form design stage.

Site Review Process Barriers

CAEQRO considered the following as significantly affecting the ability to conduct a comprehensive review:

- The lack of contractors for the contract provider interview session prevented CAEQRO from obtaining feedback from a variety of providers and contributing to a comprehensive review.

Conclusions: Strengths and Opportunities for Improvement

During the FY08-09 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 routinely monitor and analyze relevant performance indicators, and use data to inform decisions regarding system change.
[Quality, Information Systems]
2. The MHP continues to prioritize quality improvement and performance management. There is active involvement of stakeholders in quality improvement efforts.
[Quality, Other: Leadership]
3. The commitment of the MHP to the three-year Behavioral Health Services integration project has resulted in the implementation of COD screening, staff training, joint advisory meetings, four new COD programs, hiring of a clinical director, and administration of the SAMHSA Fidelity Scale.
[Access, Quality]
4. Through the Mental Health and Primary Care Integration Project, IMPACT implementation, and collaborative relationships, the MHP has developed integrated service programs with primary care clinics.
[Access, Other: Collaboration]
5. Hands-on involvement by top-level administration and program managers demonstrates a strong commitment and support for implementation of the Anasazi system.
[Information Systems, Other: Communication]
 - a. Long-term employees who are subject matter experts in IS, billing, and fiscal issues maintain the institutional knowledge during this critical transition from InSyst to Anasazi.
 - b. Contract providers report improved communication, collaboration, and a positive experience regarding the MHSA and Anasazi implementations.
6. The MHP successfully addressed timeliness to services issues system-wide and consistently monitors this important indicator.
[Timeliness]
7. The MHP reviewed outcome measurement tools for future administration and chose the following for adults: Functional Assessment Rating Scale, Illness Management and Recovery Scale, and Recovery Self-Assessment Scale.
[Outcomes]
8. The MHP's high penetration rates over four years shows evidence of provision of access to services for Medi-Cal beneficiaries.
[Access]
9. The MHP's consistently low Medi-Cal claims denial rate over four years shows evidence of knowledgeable claims staff and effective processes.
[Quality, Information Systems]

Opportunities for Improvement

1. Consumer and family member employees appear to have difficulties based upon the lack of a living wage, career ladder, supported employment, and assistance transitioning off disability payments.
[Outcomes, Other: Employment Services]
2. The MHP lacks or is in under capacity in certain areas, such as supported employment, supported housing, benefits specialists, adult residential co-occurring disorder services, new hire training, and warm line services.
[Access, Timeliness]
3. While the MHP has been able to handle budget shortfalls through fiscal reserves, the inability to fill vacancies due to a county hiring freeze is resulting in increased workloads. While leadership is communicating with and preparing staff and provider partners, the uncertainty regarding probable future downsizing and restructuring is resulting in stress among staff.
[Quality, Other: Workforce]
4. The Anasazi Medi-Cal claim submissions are in testing mode with DMH. The MHP is aware of the “six month claims submission” rule and needs to submit “real” claims by April 2009.
[Information Systems]
5. The MHP has yet to develop a strategy to access InSyst archival data for cost reporting settlement purposes in future years and to permanently retain historical episodic and service data.
[Information Systems]
6. The current version of the dashboard indicators report is labor-intensive to produce and requires a certain degree of knowledge and experience with the data to identify themes and trends – difficult for many of the interested stakeholders.
[Quality]
7. Communication does not always filter down to line staff supervisors in a consistent and timely way.
[Quality, Other: MHP communication]
8. While the MHP did not provide rates of readmission, MHP data monitoring shows increasing numbers of adults readmitted to the hospital within 30 days; 87 compared to 58 in FY06-07. The CY07 Medi-Cal Claims 24 Hour Services rate of 0.77%, reflecting inpatient and residential services, was higher than similar sized counties and the statewide average, suggesting a possible area of study for improvement.
[Quality, Outcomes]

Recommendations

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

1. Develop supported employment opportunities, career ladders for consumers and family members, and availability of benefit consultants specializing in assisting consumers in transitioning off of disability benefits as they secure employment.
[Access, Other: Employment Services]
2. Prioritize testing of Medi-Cal claims with DMH to avoid delays and assure claim submission and full payment according to the DMH six-month time limits
[Information Systems]
3. Develop a business strategy and implement a plan that permanently retains InSyst archival data.
[Information Systems]
4. Automate dashboard indicators report production process.
[Quality]
 - a. Revise certain system wide indicators to improve the report readability, so the typical stakeholder can identify and understand the data themes and trends.
 - b. In addition to system wide level of reports, add program level reports for children, transition age youth, adults, and older adults.
5. Analyze rates of adult hospital admissions and readmission within 30 days to identify utilization trends, identify reasonable utilization goals, and address any identified problems.
[Quality, Outcomes]
6. Explore two-way communication flow throughout the organization to ensure consistent, timely flow of information through all layers of the organization. Continue to encourage and provide opportunities for staff input into service planning.
[Other: Communication]
7. Review staff training protocols, particularly for new hires or transfers, to ensure sufficient orientation and training.
[Other: Workforce]

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

Attachment A

Review Agenda

Wednesday, January 21, 2009 – Day 1

Time	Activities		
<p>8:30 – 12:30</p> <p>With break about 10:15</p>	<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 • BHS 3-Year strategic plan • MIS implementation project • Last Year’s CAEQRO Recommendations • Achievements in reducing disparities and improving Cultural Competence • Performance improvement measurements utilized to assess access, timeliness, outcomes, and quality • Examples of MHP reports used to manage performance and decisions • Review of 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, Patient Rights Advocate ○ Involved consumer and family member representatives 		
12:30 – 1:30 APS Staff – Working Lunch			
<p>See specified times</p>	<p style="text-align: center;"><u>1:30 – 2:30</u> <u>IS Update/ISCA Review</u></p> <p>MIS Project Chief, MIS Admin Services Manager and UBH Director of MIS</p> <ul style="list-style-type: none"> • Changes since year three review • Top IS priorities • ISCA review • CMHDA IT / DMH meetings and workgroup participation 	<p style="text-align: center;"><u>1:30 – 3:00</u> <u>Program Monitors/Chiefs</u></p> <p>6-8 program monitors or chiefs representing various programs and sites serving all age groups</p>	<p style="text-align: center;"><u>1:30 – 3:00</u> <u>Consumer/Family Member Focus Group – COD</u></p> <p style="text-align: center;">3255 Camino Del Rio South</p> <p>8-10 participants as specified in the notification letter</p>
<p>See specified times</p>	<p style="text-align: center;"><u>2:30 – 3:30</u> <u>Medi-Cal and other Billing Issues</u></p> <p>HHSA FSSD MHP Billing Unit staff and other Subject Matter Expert staff</p> <ul style="list-style-type: none"> • NPI • SD Phase 1 & 2 • Participation in DMH Workgroups 	<p style="text-align: center;"><u>3:30 – 5:00</u> <u>Consumer Employee Group Interview CCHEA</u></p> <p>6-8 Consumer Liaisons for adult services and other consumers employed by the MHP or contractors (no supervisors of staff in same group)</p>	<p style="text-align: center;"><u>3:15 – 4:45</u> <u>Family Member Employee Group Interview Roundtable</u></p> <p>6-8 Children’s Liaisons and other family members employed by the MHP or contractors (no supervisors of staff in same group)</p>

Time	Activities		
See specified times	<p align="center"><u>3:30 – 5:00</u></p> <p>Mental Health MIS Implementation</p> <p>Phase I Project Management Team: PM Conversion</p>		

Thursday, January 22, 2009 – Day 2

Time	Activities		
See specified times	<p align="center"><u>9:00 – 10:30</u></p> <p><u>Peer-Run/Wellness Center Site Visit</u></p> <p>Corner Clubhouse</p> <p>Informal discussion with members and staff</p>	<p align="center"><u>9:00 – 10:15</u></p> <p><u>Children’s Clinical Line Staff Group Interview</u></p> <p>7-9 clinical line staff from various programs and geographical areas serving TAY, adults and older adults</p>	<p align="center"><u>8:30 – 10:00</u></p> <p><u>Contract Provider Site Visit</u> Palomar Family Counseling, Escondido</p> <p>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

Time	Activities		
See specified times	<p align="center"><u>11:00 – 12:30</u> <u>Consumer/Family Member Focus Group – Family Members of Children/Adolescents</u></p> <p>9455 Farnham St., Suite 100, San Diego 92123</p> <p>8-10 participants as specified in the notification letter</p>	<p align="center"><u>10:30 – 11:45</u> <u>Adult Clinical Line Staff Group Interview</u></p> <p>7-9 clinical line staff from various programs and geographical areas serving children and adolescents</p>	<p align="center"><u>11:00 – 12:30</u> <u>County Provider Site</u> North Central Clinic</p>
12:00 – 1:00 APS Staff – Working Lunch			
See specified times	<p align="center"><u>1:30 – 3:00</u> <u>Consumer/Family Member Focus Group – Latino</u></p> <p>3255 Camino Del Rio South</p> <p>8-10 participants as specified in the notification letter</p>	<p align="center"><u>1:00 – 2:30</u> <u>Contract Provider Group Interview</u></p> <p>6-8 program executive directors representing various adult and child programs and geographical areas</p>	<p align="center"><u>2:00 – 3:30</u> <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
See specified times	<p align="center"><u>3:30 – 5:00</u> <u>Program Advisory Group Interview</u></p> <p>8-10 PAG consumers from a contracted entity</p>	<p align="center"><u>2:45 – 4:00</u> <u>Reducing Disparities in Service Access, Retention, Quality, or Outcomes</u></p> <ul style="list-style-type: none"> • Achievements in reducing disparities in underserved groups, foster care, Latino • Evidence based or best practices for diverse or high risk populations • Cultural Competence measurements & outcomes • Access and timeliness of services • Penetration and retention, outreach and engagement <p align="center"><u>4:00 – 5:00</u> <u>Data Analysis and Performance Outcomes</u> CASRC staff, HSRC staff and Reports Improvement Committee</p>	

Friday, January 23, 2009 – Day 3

Time	Activities	
9:00 – 10:15	<p style="text-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 	
10:30 –12:00	<p style="text-align: center;"><u>Quality Review Council Interview</u></p> <p style="text-align: center;">8-10 QRC members</p> <p>Discussion includes QRC quality improvement activities and data analysis</p>	
12:00 – 1:00	APS Staff – Working Lunch	
1:00 – 2:30	<p style="text-align: center;"><u>Mental Health MIS Implementation</u></p> <p>Phase II Project Management Team: EHR</p>	<p style="text-align: center;"><u>Evidence Based Practices</u></p> <p>Discussion of implemented EBP programs, monitoring procedures, and reports</p>
2:30 – 3:00	APS Staff Meeting	
3:00 – 3:45	<p style="text-align: center;"><u>Wrap-Up Session</u></p> <ul style="list-style-type: none"> • Closing the review with discussion of some preliminary themes and issues • CAEQRO next steps after the review 	

Attachment B

Review Participants

During the review, the following participants represented the MHP; as applicable, this also includes contract providers and other stakeholders:

Alfredo Aguirre, Mental Health Director
Amelia Guingab, Principal Analyst, Behavioral Health Services
Andrew Sarkin, Program Manager, UCSD, HSRC
Angela Wastrack, JFS, PCC
Angie DeVoss, MIS Manager, Mental Health Services
Ann Garland, CASRC, UCSD
Ann Park, MHSA, County HHSA
April Bolenbaugh, Case Management
Barbara Wohlander, Patient Advocacy
Barry C. Braun, ESU
Betty Lemos
Bill Simpson, MIS Contractor Representative, Community Research Foundation
Brian Newcomer, MIS Contractor Representative, MHS, Inc
Bruce Klier, Child Juvenile Forensic
Cana Sheeby, MH Billing, Financial Services, Behavioral Health Services
Candace Milow, QI Director, Mental Health Services
Carla Shelby, Administrative Services Manager, FSSD
Carol Neidenberg, CCHEA
Celia Engelman, QI Specialist
Cesar Brijandez
Connie German-Marquez, SEMH
Connie Rusch, CASRC, UCSD
Darryl Fromson, PIC
David Thomas, HSRC, UCSD
Debbie Malcarne, PSR Coordinator
Deni McLagan, MHS
Donald Lee, Vocational Coordinator, MRA
Donna Marto, CEO, Roundtable
Doug Blackwood, ECSCA, Friend to Friend
Edith Mohler, Administrative Analyst II
Emily Wang, Case Management
Frances Edwards, Chief, CMH
Gloria Jo Rast, Case Management, East County
Hammi McPherson, Data Entry, Palomar Family Counseling Services
Hannah Koh, Case Management
Henry Tarke, Assistant Deputy Director, Children's Mental Health Services
Ian Rosengarten, QI Unit, AMHS
Jan Winn, MIS Contractor Representative, Rady Children's Hospital
Jeff Tan, Senior Office Assistant, Adult Mental Health Services
Jennifer Dale, CASRC
Jennifer James
Jennifer Rolls Rentz, CASRC
Jennifer Schaffer, Director, Behavioral Health
Jim England, NAMI
Jim Fix, Executive Director, PERT, Inc.
JoAnn Scott, Senior PSW, ECMHC
Jody Pruitt, East County Case Management
Jorge Pena, MIS Director, United Behavioral Health

Junida Bersable, Principal Admin Analyst, Behavioral Health Services
Karen Luton, Business Manager, Heritage Clinic
Karen Ventimiglia, MHSA Int. Coordinator
Kathryn Grant, Chief MH Clinical Services, Mental Health Services
Kathy Anderson, PAA, QI Performance Outcomes
Kathy Rowe, Admin Analyst II, Children's Mental Health Services
Katie Astor, Chief, CMHS
Ken Jones, Principal Admin Analyst, Behavioral Health Services
La Rite, Social Services
Lavonne Lucas, AITS, Behavioral Health Services
Lisa Garcia, Peer Support
Liza Cabigas, Assistant Deputy Director, Behavioral Health Services
Luis E. Arevato, Peer Supp, Rehab Ass, CRF
Marilyn Van der Moer, Regional Program Coordinator
Marshall Lewis, Clinical Director, Behavioral Health
Mary Jo O'Brien, PIC, CCHEA
Michael Radclow, Food Serv. Manager, CRF
Michelle D. Mesa, MHA Visions Clubhouse
Michelle LaScala, RN, ECMHC
Michelle Wagner, Recovery Innovation of California
Mike Phillips, Supervising Attorney, JFS
Nilsa Rubenstein, MIS System Manager, United Behavioral Health
Pam Millan, Program Manager, Palomar Family Counseling Service
Pamela Dobson, Administrative, Palomar Family Counseling Service
Paulina Martinez, Contract and Data Coordinator, Behavioral Health Services
Piedad Garcia, Assistant Deputy Director
Qay Amee, NAMI
Rebekah Gastelum, Case Management
Richard Larrabee, PIC
Rick Heller, HSRC, UCSD
Robin Taylor, CASRC, UCSD
Ryan Messel, Communications Coordinator, Family & Youth Roundtable
Sabrena Marshall, Principal Admin Analyst, Health and Human Services Agency
Scott Wade, Administrative Analyst III, County QI
Sharron McLeod, Recovery Innovation of California
Sheryl Taylor, Admin Analyst III, Behavioral Health Services
Shirley Culver, Director, Unified School, SDUSD
Steven Tally, UCSD HSRC
Tabatha Lang, Regional Program Coordinator
Tami Peddie-Musser, LMFT
Todd Gilman, UCSD HSRC
Tracy Simoncini
Vernon Montoya, PIC Technical Advisor
Victoria Hilton, QI Program Manager
Virginia West, Regional Program Coordinator
Yael Koenig, Chief, CMH

The following CAEQRO reviewers participated in this year's site review process:

Elizabeth Harris, MS, APRN, Lead Reviewer
Bill Ullom, Senior Systems Analyst

Anita Shumaker, Consumer/Family Member Consultant
Mike Reiter, Pharm.D., Administrative 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.

Attachment C

Approved Claims Source Data

Approved Claims Source Data

- Source: Data in Figures 5 through 20 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
 - See “Medi-Cal Approved Claims Definitions” in Attachment D for more detail

- 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 CY2007 file with a DMH process date of May 22, 2008 includes claims with service dates between January 1 and December 31, 2007 processed by DMH through April 2008.
 - CY2007 includes SD/MC and IPC approved claims with process date May 22, 2008
 - 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
 - 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
 - FY06-07 denials include SD/MC claims (not IPC claims) processed between July 1, 2006 and June 30, 2007 (without regard to service date) with process date September 25, 2007. Same methodology is used for prior years.
 - Most recent MMEF includes Medi-Cal eligibility for April 2008 and 15 prior months

- Data Definitions: Selected elements displayed in Figures 5 through 20 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

Attachment D

Data Provided to MHP

Medi-Cal Approved Claims Data for SAN DIEGO County MHP Calendar Year 07



Date Prepared:	June 18, 2008 / 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:	May 22, 2008, May 22, 2008, and May 15, 2008 - 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									
	367,173	30,503	\$101,207,150	8.31%	\$3,318	6.52%	\$4,155	6.19%	\$4,451
AGE GROUP									
0-5	72,882	1,442	\$1,919,091	1.98%	\$1,331	1.46%	\$3,178	1.31%	\$3,508
6-17	102,222	10,461	\$49,574,643	10.23%	\$4,739	7.78%	\$5,305	7.71%	\$5,813
18-59	128,949	16,330	\$45,760,377	12.66%	\$2,802	9.55%	\$3,757	8.70%	\$3,883
60+	63,122	2,270	\$3,953,040	3.60%	\$1,741	3.52%	\$2,673	3.34%	\$2,705
GENDER									
Female	211,749	16,152	\$45,908,278	7.63%	\$2,842	6.03%	\$3,640	5.67%	\$3,892
Male	155,425	14,351	\$55,298,872	9.23%	\$3,853	7.16%	\$4,730	6.88%	\$5,058
RACE/ETHNICITY									
White	85,884	12,190	\$39,532,508	14.19%	\$3,243	12.08%	\$4,180	11.84%	\$4,536

	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
Hispanic	175,378	9,080	\$30,037,168	5.18%	\$3,308	3.48%	\$3,725	3.29%	\$4,185
African-American	36,945	4,246	\$16,365,325	11.49%	\$3,854	10.14%	\$4,802	9.94%	\$4,748
Asian/Pacific Islander	36,218	1,977	\$4,334,415	5.46%	\$2,192	4.54%	\$3,173	4.45%	\$3,197
Native American	1,423	238	\$854,008	16.73%	\$3,588	13.16%	\$4,825	10.86%	\$5,070
Other	31,328	2,772	\$10,083,726	8.85%	\$3,638	9.45%	\$4,962	9.56%	\$5,425
ELIGIBILITY CATEGORIES									
Disabled	69,279	15,076	\$48,830,556	21.76%	\$3,239	20.24%	\$4,328	19.89%	\$4,443
Foster Care	4,618	3,038	\$17,852,003	65.79%	\$5,876	53.12%	\$6,709	55.25%	\$7,054
Other Child	163,779	8,635	\$27,306,109	5.27%	\$3,162	3.87%	\$3,670	3.94%	\$4,196
Family Adult	61,543	4,088	\$5,558,652	6.64%	\$1,360	4.93%	\$1,774	4.49%	\$1,968
Other Adult	73,389	802	\$1,659,830	1.09%	\$2,070	0.97%	\$2,806	0.93%	\$2,827
SERVICE CATEGORIES									
24 Hours Services	367,173	2,844	\$19,719,351	0.77%	\$6,934	0.53%	\$8,400	0.47%	\$8,338
23 Hours Services	367,173	1,018	\$894,382	0.28%	\$879	0.50%	\$1,803	0.32%	\$1,679
Day Treatment	367,173	1,453	\$14,359,356	0.40%	\$9,883	0.14%	\$11,546	0.13%	\$11,245
Linkage/Brokerage	367,173	6,933	\$6,911,050	1.89%	\$997	2.79%	\$951	2.73%	\$878
Outpatient Services	367,173	24,080	\$40,624,709	6.56%	\$1,687	5.11%	\$2,502	5.10%	\$2,848
TBS	367,173	222	\$2,096,076	0.06%	\$9,442	0.07%	\$12,705	0.06%	\$15,377
Medication Support	367,173	18,746	\$16,602,228	5.11%	\$886	3.70%	\$1,038	3.35%	\$1,151

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 474,093

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY07

Number of Services Approved per Beneficiary Served	SAN DIEGO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	2,195	7.20	7.20	8.76	8.76	2.18	17.92
2 services	1,933	6.34	13.53	6.42	15.18	0.00	14.20
3 services	2,149	7.05	20.58	5.28	20.46	0.00	10.49
4 services	2,007	6.58	27.16	4.92	25.39	2.51	9.53
5 - 15 services	10,817	35.46	62.62	32.56	57.95	20.10	73.33
> 15 services	11,402	37.38	100.00	42.05	100.00	6.67	61.89

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 5/22/2008; Inpatient Consolidation approved claims as of 5/22/2008

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 07

Foster Care



Date Prepared:	June 23, 2008 / 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:	May 22, 2008, May 22, 2008, and May 15, 2008 - 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									
	4,618	3,038	\$17,852,003	65.79%	\$5,876	53.12%	\$6,709	55.25%	\$7,054
AGE GROUP									
0-5	1,376	655	\$762,402	47.60%	\$1,164	28.81%	\$3,060	27.65%	\$3,430
6+	3,242	2,383	\$17,089,600	73.50%	\$7,171	61.76%	\$7,314	64.34%	\$7,567
GENDER									
Female	2,255	1,472	\$8,231,556	65.28%	\$5,592	51.97%	\$6,515	52.65%	\$6,779
Male	2,363	1,566	\$9,620,447	66.27%	\$6,143	54.21%	\$6,884	57.72%	\$7,292
RACE/ETHNICITY									
White	1,445	969	\$6,402,236	67.06%	\$6,607	55.56%	\$6,880	52.69%	\$7,395
Hispanic	1,850	1,181	\$5,732,116	63.84%	\$4,854	50.12%	\$5,560	56.49%	\$5,950

	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	1,020	679	\$4,697,646	66.57%	\$6,918	52.71%	\$7,874	57.23%	\$7,587
Asian/Pacific Islander	147	116	\$429,077	78.91%	\$3,699	54.18%	\$5,959	58.03%	\$5,815
Native American	102	46	\$235,710	45.10%	\$5,124	52.84%	\$4,912	48.27%	\$6,275
Other	57	47	\$355,216	82.46%	\$7,558	86.14%	\$9,846	118.28%	\$9,990
SERVICE CATEGORIES									
24 Hours Services	4,618	118	\$479,586	2.56%	\$4,064	1.94%	\$7,508	1.89%	\$8,081
23 Hours Services	4,618	65	\$44,020	1.41%	\$677	1.50%	\$1,338	1.00%	\$1,323
Day Treatment	4,618	729	\$8,458,468	15.79%	\$11,603	3.98%	\$14,453	3.60%	\$14,052
Linkage/Brokerage	4,618	637	\$607,359	13.79%	\$953	23.61%	\$1,270	24.62%	\$1,060
Outpatient Services	4,618	2,672	\$5,835,584	57.86%	\$2,184	49.57%	\$4,013	52.22%	\$4,540
TBS	4,618	79	\$869,477	1.71%	\$11,006	2.41%	\$12,913	2.19%	\$14,730
Medication Support	4,618	1,183	\$1,557,508	25.62%	\$1,317	17.31%	\$1,280	18.76%	\$1,445

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 6,683

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY07

Foster Care

Number of Services Approved per Beneficiary Served	SAN DIEGO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	82	2.70	2.70	6.61	6.61	0.00	25.00
2 services	119	3.92	6.62	4.86	11.48	0.00	13.64
3 services	374	12.31	18.93	4.66	16.13	0.00	12.67
4 services	304	10.01	28.93	4.20	20.33	0.00	10.01
5 - 15 services	639	21.03	49.97	25.19	45.52	9.89	60.00
> 15 services	1,520	50.03	100.00	54.48	100.00	10.00	81.68

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 5/22/2008; Inpatient Consolidation approved claims as of 5/22/2008

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 07

Transition Age Youth (Age 16-25)



Date Prepared:	June 20, 2008 / 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:	May 22, 2008, May 22, 2008, and May 15, 2008 - 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									
	49,737	4,538	\$20,431,673	9.12%	\$4,502	6.96%	\$5,255	6.94%	\$5,559
AGE GROUP									
16-17	16,071	2,020	\$11,083,243	12.57%	\$5,487	10.17%	\$6,137	10.35%	\$6,492
18-21	20,509	1,566	\$6,428,838	7.64%	\$4,105	5.81%	\$4,811	5.81%	\$5,045
22-25	13,158	952	\$2,919,593	7.24%	\$3,067	5.29%	\$4,197	4.92%	\$4,333
GENDER									
Female	31,407	2,401	\$9,503,088	7.64%	\$3,958	5.70%	\$4,877	5.59%	\$5,166
Male	18,331	2,137	\$10,928,585	11.66%	\$5,114	9.10%	\$5,655	9.13%	\$5,949
RACE/ETHNICITY									
White	10,235	1,612	\$7,010,755	15.75%	\$4,349	12.69%	\$5,157	13.31%	\$5,541

	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
Hispanic	26,211	1,723	\$7,159,249	6.57%	\$4,155	4.38%	\$4,615	4.31%	\$5,098
African-American	6,279	680	\$3,436,386	10.83%	\$5,054	10.57%	\$5,688	10.27%	\$5,760
Asian/Pacific Islander	3,596	159	\$908,513	4.42%	\$5,714	3.46%	\$5,868	3.57%	\$5,659
Native American	240	37	\$185,293	15.42%	\$5,008	11.66%	\$6,607	11.20%	\$6,392
Other	3,180	327	\$1,731,476	10.28%	\$5,295	10.92%	\$7,007	12.17%	\$7,694
ELIGIBILITY CATEGORIES									
Disabled	5,626	1,388	\$6,222,799	24.67%	\$4,483	21.55%	\$6,119	22.34%	\$6,229
Foster Care	837	708	\$5,644,995	84.59%	\$7,973	70.36%	\$7,865	76.67%	\$7,581
Other Child	14,426	1,442	\$5,354,536	10.00%	\$3,713	7.49%	\$4,131	7.77%	\$4,630
Family Adult	21,040	1,056	\$2,319,203	5.02%	\$2,196	3.97%	\$2,523	4.02%	\$2,872
Other Adult	7,984	262	\$890,140	3.28%	\$3,397	2.20%	\$3,653	2.07%	\$3,957
SERVICE CATEGORIES									
24 Hours Services	49,737	526	\$3,160,945	1.06%	\$6,009	0.84%	\$7,682	0.76%	\$7,820
23 Hours Services	49,737	218	\$176,694	0.44%	\$811	0.76%	\$1,587	0.50%	\$1,506
Day Treatment	49,737	527	\$5,495,909	1.06%	\$10,429	0.29%	\$11,956	0.27%	\$12,101
Linkage/Brokerage	49,737	966	\$1,327,829	1.94%	\$1,375	2.89%	\$1,229	3.05%	\$1,052
Outpatient Services	49,737	3,734	\$7,775,468	7.51%	\$2,082	5.83%	\$2,965	6.05%	\$3,415
TBS	49,737	27	\$241,128	0.05%	\$8,931	0.11%	\$11,892	0.09%	\$13,462
Medication Support	49,737	2,565	\$2,253,700	5.16%	\$879	3.33%	\$1,020	3.12%	\$1,160

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 74,514

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY07

Transition Age Youth (Age 16-25)

Number of Services Approved per Beneficiary Served	SAN DIEGO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	351	7.73	7.73	10.10	10.10	2.07	27.36
2 services	289	6.37	14.10	6.88	16.99	0.00	20.16
3 services	284	6.26	20.36	5.45	22.44	0.00	12.59
4 services	260	5.73	26.09	4.61	27.05	1.59	8.11
5 - 15 services	1,436	31.64	57.73	28.96	56.01	16.67	43.48
> 15 services	1,918	42.27	100.00	43.99	100.00	13.51	65.43

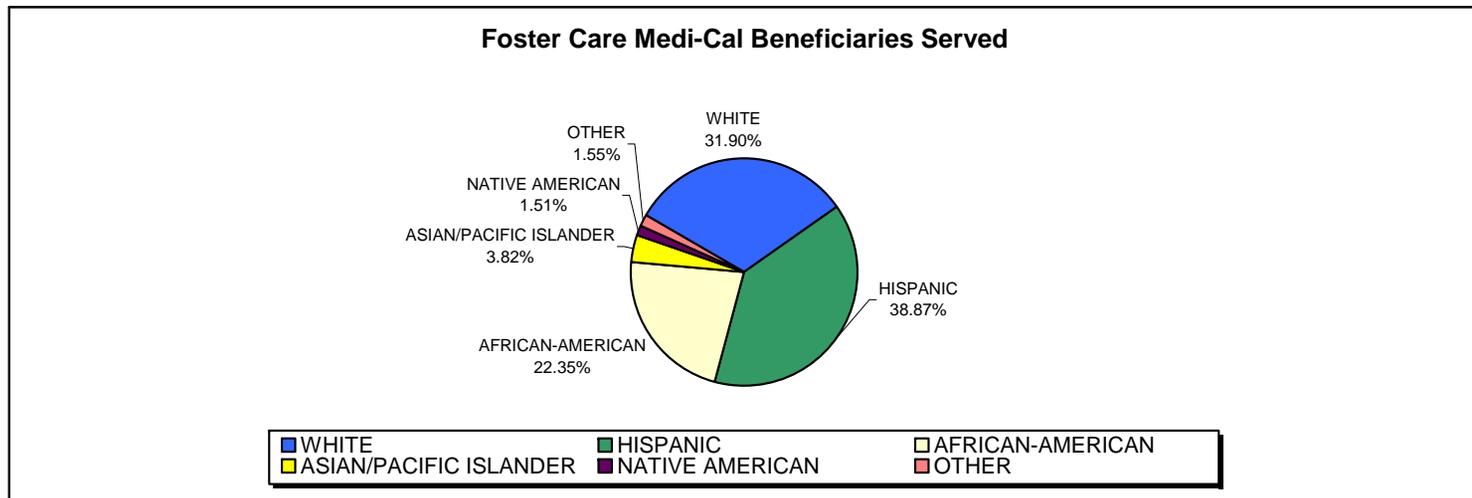
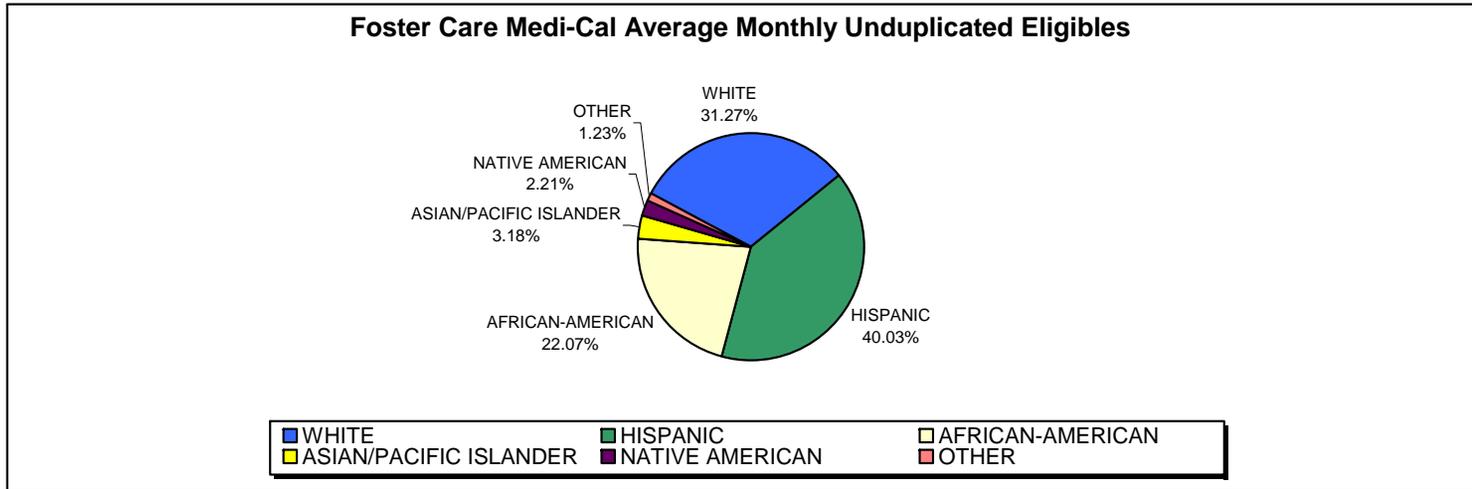
Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 5/22/2008; Inpatient Consolidation approved claims as of 5/22/2008

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

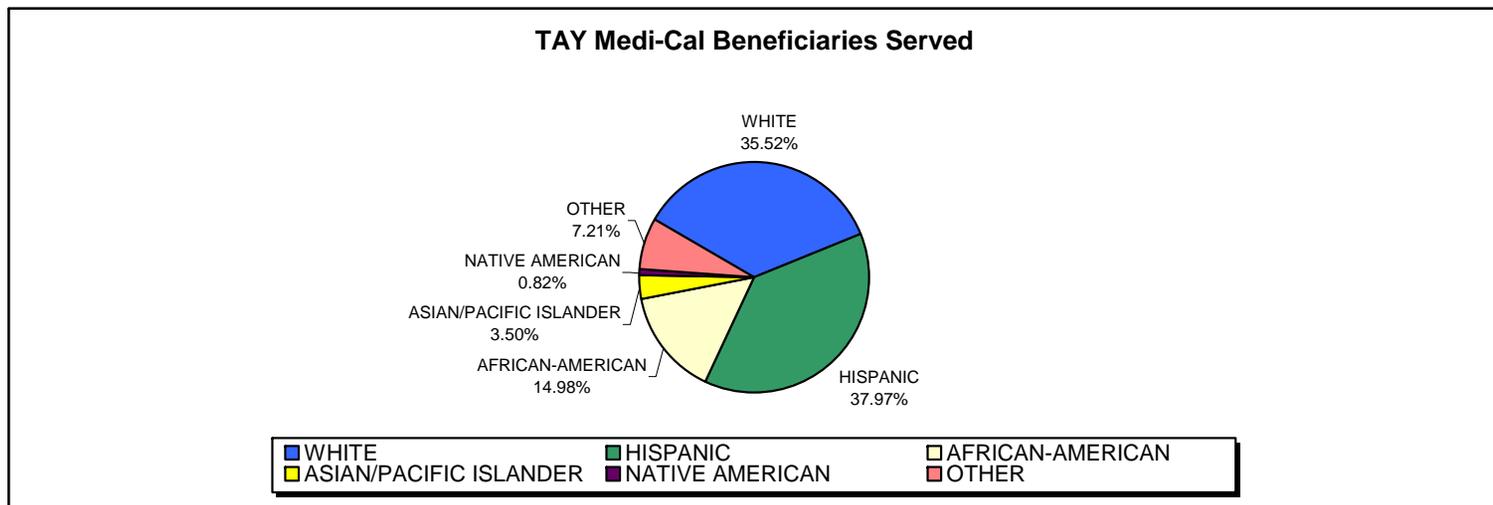
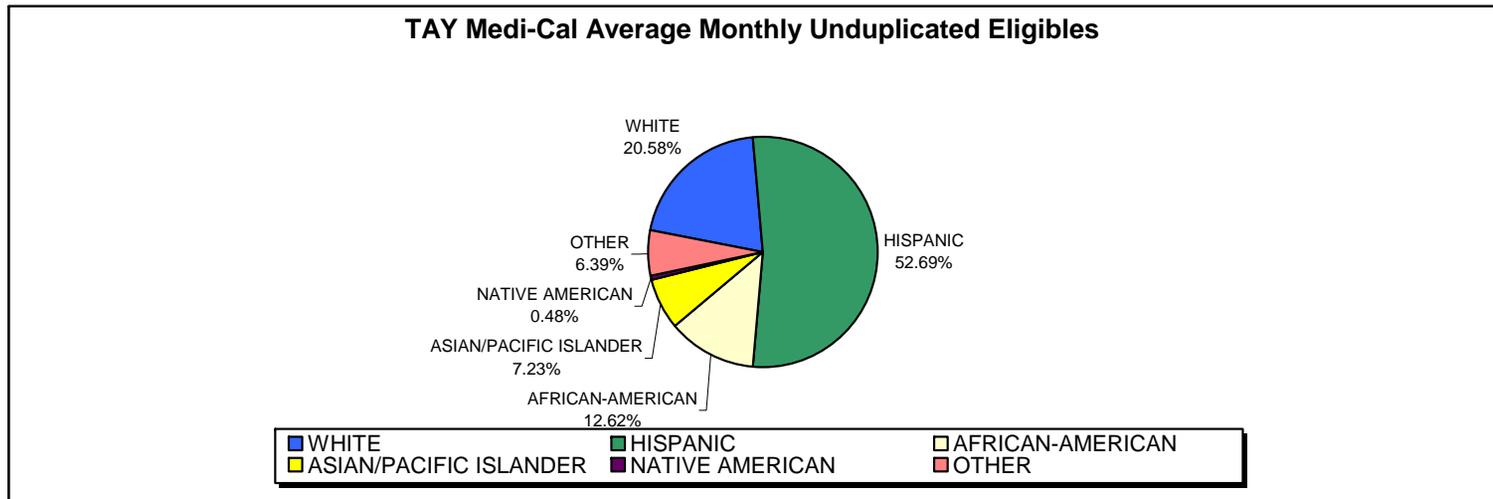
San Diego Foster Care Medi-Cal Eligibles vs. Foster Care Beneficiaries Served

DMH Approved Claims Calendar Year 2007



San Diego TAY Medi-Cal Eligibles vs. TAY Beneficiaries Served

DMH Approved Claims Calendar Year 2007



Attachment E:
CAEQRO PIP Validation Tools

FY 08-09 Review of: San Diego

Clinical Non-Clinical

PIP Title: EPSDT

Date PIP Began: November 2008

Date PIP Completed (if applicable):

PIP Category: Access Timeliness Quality Outcomes Other

Descriptive Category: Clinical Process Improvement

Target Population: Children receiving more than \$3000 per month in services for at least three months

The MHP did not submit an active Clinical PIP. All elements are rated as “not met” for purposes of analysis.

Step		Rating			
		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	
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:		0	0	5	0
2	Study Question Definition <i>The written study question:</i>				
2.1	Identifies the problem targeted for improvement			X	
2.2	Includes the specific population to be addressed			X	
2.3	Includes a general approach to interventions			X	
2.4	Is answerable/demonstrable			X	
2.5	Is within the MHP’s scope of influence	0	0	X	0
Totals for Step 2:		0	0	5	0

Step		Rating			
		Met	Partial	Not Met	N/A
3	Clearly Defined Study Indicators <i>The study indicators:</i>				
3.1	Are clearly defined, objective, and measurable			X	
3.2	Are designed to answer the study question			X	
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X	
3.4	Have accessible data that can be collected for each indicator			X	
3.5	Utilize existing baseline data that demonstrate the current status for each indicator			X	
3.6	Identify relevant benchmarks for each indicator			X	
3.7	Identify a specific, measurable goal(s) for each indicator			X	
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	
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	5	0
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	

Step		Rating			
		Met	Partial	Not Met	N/A
Totals for Step 6:		0	0	5	0
7	Appropriate Intervention and Improvement Strategies <i>The planned/implemented intervention(s) for improvement:</i>				
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	4	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	
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		4	
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

FY 08-09 Review of: San Diego

Clinical Non-Clinical

PIP Title: Improving Consumer Satisfaction

Date PIP Began: November 2008

Date PIP Completed (if applicable):

PIP Category: Access Timeliness Quality Outcomes Other

Descriptive Category: Business Process Improvement

Target Population: All

The MHP did not submit an active Non-Clinical PIP. All elements are rated as “not met” for purposes of analysis.

Step		Rating			
		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	
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:		0	0	5	0
2	Study Question Definition <i>The written study question:</i>				
2.1	Identifies the problem targeted for improvement			X	
2.2	Includes the specific population to be addressed			X	
2.3	Includes a general approach to interventions			X	
2.4	Is answerable/demonstrable			X	
2.5	Is within the MHP’s scope of influence	0	0	X	0
Totals for Step 2:		0	0	5	0

Step		Rating			
		Met	Partial	Not Met	N/A
3	Clearly Defined Study Indicators <i>The study indicators:</i>				
3.1	Are clearly defined, objective, and measurable			X	
3.2	Are designed to answer the study question			X	
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X	
3.4	Have accessible data that can be collected for each indicator			X	
3.5	Utilize existing baseline data that demonstrate the current status for each indicator			X	
3.6	Identify relevant benchmarks for each indicator			X	
3.7	Identify a specific, measurable goal(s) for each indicator			X	
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	
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	5	0
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	

Step		Rating			
		Met	Partial	Not Met	N/A
Totals for Step 6:		0	0	5	0
7	Appropriate Intervention and Improvement Strategies <i>The planned/implemented intervention(s) for improvement:</i>				
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	4	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	
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		4	
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

Attachment F:
MHP PIPs Submitted



California EQRO

560 J Street, Suite 390
Sacramento, CA 95814

This outline is a compilation of the “Road Map to a PIP” and the PIP Validation Tool that CAEQRO is required to use 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.

If the MHP is submitting a PIP that was previously submitted, please ensure that this document reflects and emphasizes the work completed over the past year.

CAEQRO PIP Outline via Road Map

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.

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

MHP: The EPSDT Stakeholder Committee includes the Assistant Deputy Director of Children's Mental Health (Lead), CMH Chief Psychiatrist, and representatives from Special Ed, Children’s Emergency Screening Unit, QI, Client/Family Liaison, Youth rep, CWS, Children’s Hospital Research Center, and contract provider representatives

“Is there really a problem?”

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

Statewide: Approved EPSDT claims data for FY 2006-07 shows that the 3% of EPSDT clients with the highest average monthly claims account for 25.5% of total annual EPSDT spending. While it is reasonable to expect that this highest-cost-of-service cohort includes clients with severe conditions that justify higher average monthly costs, a review of client specific services received by a sample drawn from this cohort often include a complex pattern of use that raises questions about service levels, array of services, possible gaps in service, and multi-system involvement. Studies identified by the Department of Mental Health suggest of other pediatric health care system highest-cost-of-service cohorts suggest that the cost and complexity of these EPSDT services could indicate a need for improved coordination, enhanced capacity, and other improvements to ensure that each client 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: The data from DMH regarding approved EPSDT claims data for FY 2006-07 revealed that approximately 5% of EPSDT clients in San Diego County received \$3000 of paid mental health services within a one month period (738 children and youth). Utilizing the names of the clients identified in the data the EPSDT Stakeholder Committee reviewed patterns of service utilization to ascertain any potential problems in use of service levels, array of services, possible gaps in service, or gaps in multi-system involvement.

The EPSDT Stakeholder Committee agreed with the DMH position that while it is reasonable to expect that this highest-cost-of-service cohort includes clients with severe conditions which does justify higher average monthly costs, an evaluation of the quality, effectiveness and efficiency of service delivery to children receiving this level of services is warranted. The results of this evaluation will potentially lead to a plan to develop systemwide improvements to ensure that each client receiving this level of services is receiving services that are indicated, effective, and efficient.

Team Brainstorming: “Why is this happening?”

Root cause analysis to identify challenges/barriers

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

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

Table 1
Distribution of Approved Claims for EPSDT

SFY 2006-07 Year Claims to date (Includes SGF, FFP, County Share funds)

Service	Approved \$	% Total
PHF	\$2,745,896	0.29%
Adult Crisis Residential	\$725,573	0.08%
Adult Residential	\$1,919,066	0.20%
Crisis Stabilization	\$5,574,531	0.59%
Day Tmt Intensive Half Day	\$5,601,497	0.59%
Day Tmt Intensive Full Day	\$49,610,477	5.22%
Day Tmt Rehabilitative Half Day	\$1,175,263	0.12%
Day Tmt Rehabilitative Full Day	\$27,372,551	2.88%
Targeted Case Management	\$69,504,927	7.32%
Mental Health Services	\$637,266,489	67.08%
Collateral Services		
Assessments		
Plan Development		
Individual Services		

Group Services Rehabilitation Professional In-patient Visit		
Therapeutic Behavior Services	\$54,744,405	5.76%
Medication Support	\$79,440,321	8.36%
Crisis Intervention	\$14,295,328	1.50%
<hr/> EPSDT Total	<hr/> \$949,976,324	<hr/> 100.00%

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

Table 2
Monthly EPSDT Approved Claims Metrics

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

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

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

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

This quality improvement proposal is supported by a study of pediatric high health care service users. The study discusses that high-cost children use services of numerous types delivered in multiple venues, and concludes that “providing care coordination throughout the entire health care system is important to address both the cost and the quality aspects of health care for the most costly children”. The study further concludes that “clinicians should review regularly the extent of care coordination that they provide for their high-need and high-cost patients, especially preteens and adolescents” and that “targeted programs to decrease expenditures for those with the greatest costs have the potential to save future health care dollars.”(Liptak, GS et al. Short-term Persistence of High Health Care Costs in a Nationally Representative Sample of Children. PEDIATRICS Vol. 118 No. 4 October 2006).

MHP- SDCMH used the EPSDT claims data of FY 2006-07 based on approved claims data received as of March 2008. In addition, the EPSDT PIP Stakeholder Committee asked for an analysis of service provided, demographics of clients including primary diagnosis, comparison to overall CMHS population, and information about service use by this group from the previous FY. The data helps to establish patterns of service utilization as well at defining some possible indicators which may be used to help define an intervention. (See attached data)

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

MHP- SDCMHS is still evaluating the possible causes for receiving \$3000 of service for 3 months ore more in a year period. The following is a short list of possible causes:

Table A – List of Possible Causes/Barriers:

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Children may not need the level of services they are receiving	
Children may be receiving too much service	
Children may be receiving this level of service because the service they need is not available	

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 implement activities such as, but not limited to: improved utilization management, care coordination activities, data collection, review and validation, 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: The MHP is still in the process of developing the final study question. As an initial step SDCMH will evaluate if kids who receive \$3000 or more per month for 3 months within a fiscal year are receiving appropriate level of services. This initial step will allow the EPSDT PIP Stakeholder Committee to determine if there is a problem within our scope of influence that needs to be addressed. Once we have identified a problem, the Committee will formulate an intervention and finalize the study question.

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

The EPSDT PIP Stakeholder committee has determined that they will focus their efforts on the children and youth using \$3000 or more of mental service for 3 months during a one year period.

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

The children and youth using \$3000 or more of mental service for 3 months during a one year period.

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

Data collected about service utilization will be for the entire population of children and youth using \$3000 or more of mental service for 3 months during a one year period.

Data collected by medical record review will be based on a random sample.

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

Sampling technique to be identified

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

The sample size will be statistically significant. The total population is estimated to be 350 clients, and therefore the sample size will be 50 to 70 clients for the medical record review.

“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 EPSDT Stakeholder Committee has not identified indicators. All further questions beyond this point are not applicable at this time.

- 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					
2					
3					
4					
5					

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			
2			
3			
4			
5			
6			
7			

Apply Interventions: “What do we see?”

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.
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.
13. Describe the plan for data analysis. Include contingencies for untoward results.
14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.
15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?

16. Present objective data results for each performance indicator. 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							

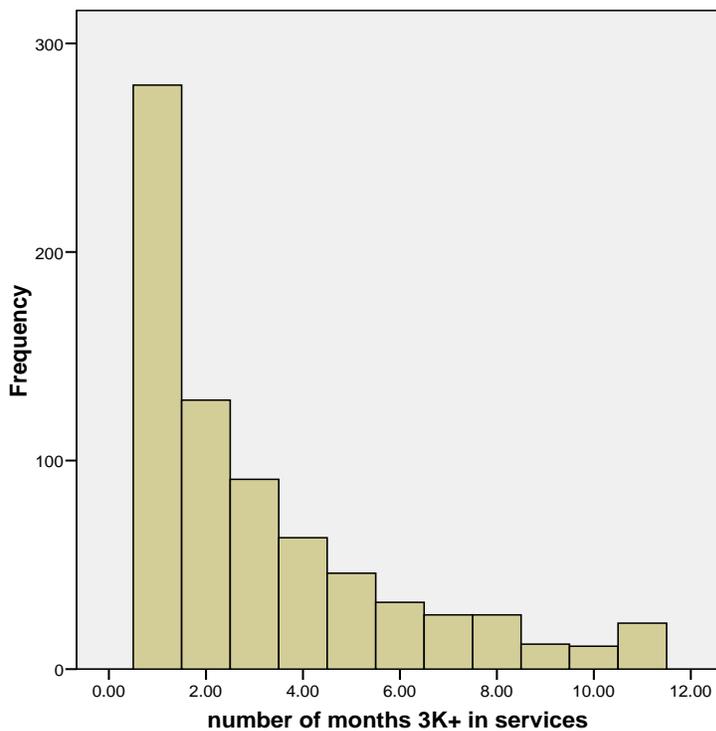
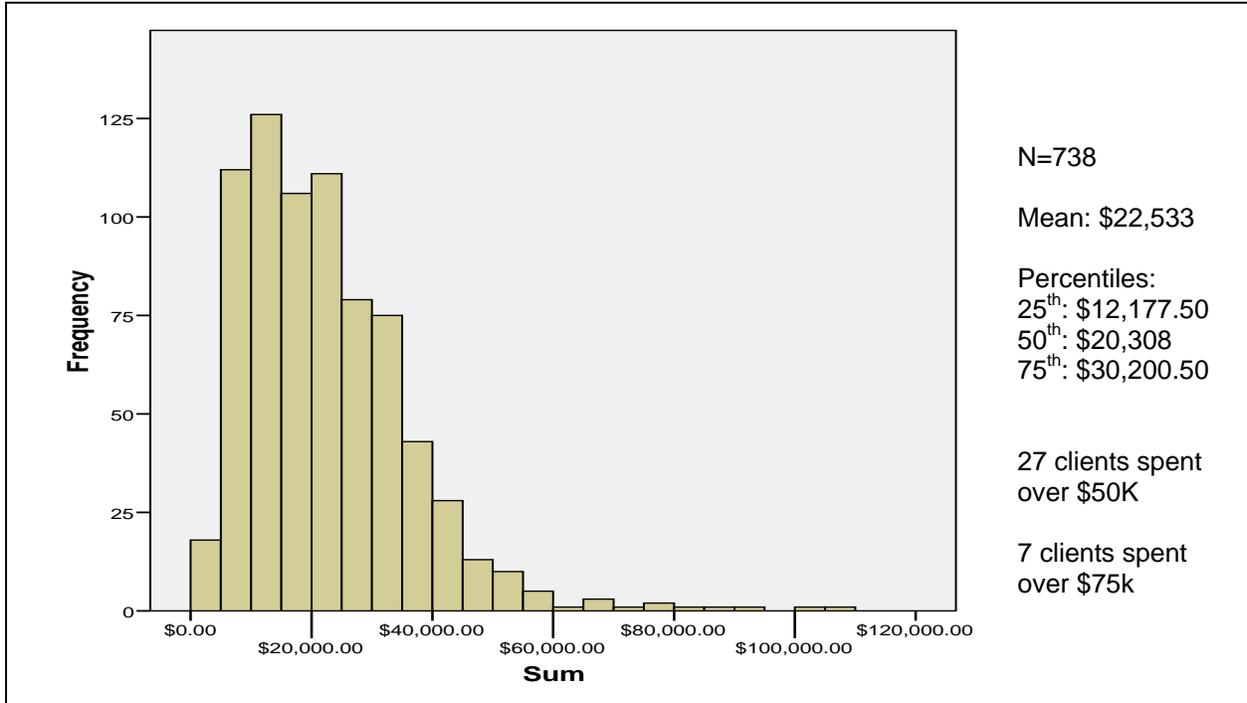
“Was the PIP successful?” What are the outcomes?

17. Describe issues associated with data analysis:
- a. Data cycles clearly identify when measurements occur.
 - b. Statistical significance

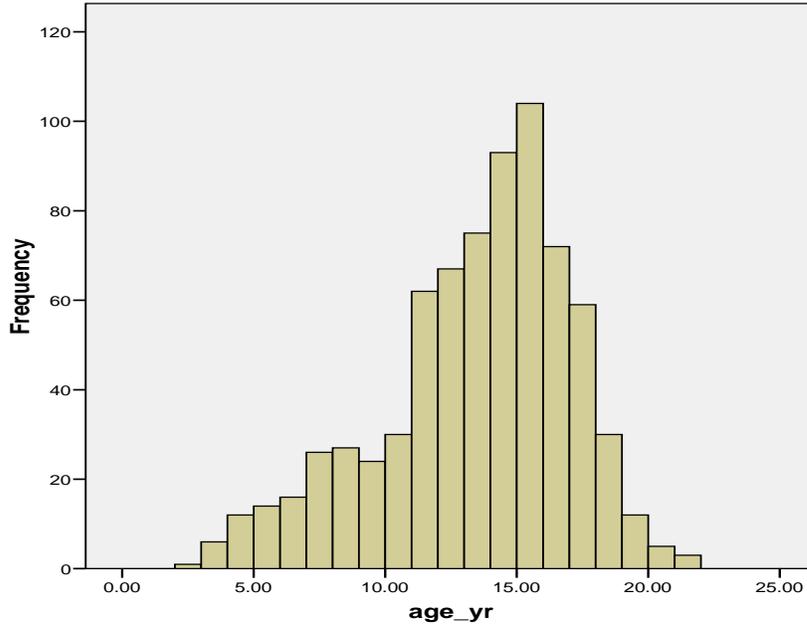
- c. Are there any factors that influence comparability of the initial and repeat measures?
 - d. Are there any factors that threaten the internal or the external validity?
18. To what extent was the PIP successful? Describe any follow-up activities and their success.
 19. Describe how the methodology 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?

Analyses of EPSDT PIP Sample – 3K+ in expenditures in 1+ months in FY0708

Report prepared by the Child & Adolescent Services Research Center (CASRC) – Jennifer Rolls Reutz and Bill Ganger



Overall Sample description



Age:

Mean: 13.4 yrs

Median: 14.1 yrs

Range:
2.7 – 21.41 yrs

33 youth (4.5%)
were less than 6

50 youth (6.8%)
were ages 18+

Gender: 36.4% Female, 63.2% Male

Race/Ethnicity:

Hispanic:	37.4%
White:	31.4%
African-American:	19.8%
Asian/Pacific Islander:	2.3%
Native American:	0.4%
Other:	1.6%
Missing:	7.0%

Types of Services used (updated with service use from 11/2008 download)

Outpatient:	66.0%
Case management:	48.4%
Day Treatment:	61.8%
TBS:	25.7%
ESU:	19.1%
Inpatient:	19.4%

Primary Diagnosis:

ADHD:	19.7%
Opp / Conduct:	22.7%
Depressive:	19.1%
Bipolar:	11.1%
Anxiety:	7.1%
Adjustment:	11.1%
Schizophrenia:	1.2%
Other:	4.4%
Excluded:	3.6%

Dual diagnosis (including other factors field): 6.6%

Comparison to overall CMHS population:

- Higher percentage White, African-American
- Higher percentage English speaking
- Bipolar diagnosis more common, but most common dx is still oppositional/conduct disorders
- More likely to use all types of services, and to user more minutes of services
- More likely to use inpatient services, but did not use more inpatient days, or have longer lengths of stay, than other youth

FY0607 Service Use by PIP sample

- Same basic patterns as above
- Multiple service users – more likely to use Short Doyle and FFS, as opposed to using just one.
- More likely to have received JFS or Spectrum services in FY0607.
- More like to have received services from another public sector in FY0607 – CWS, Special Ed, Probation.
- Alcohol and Drug Services involvement is not significant.

Clients above the 3k+ cutpoint for 3 or more months (44.6% of sample):

- In FY0708
 - Bipolar diagnosis more common (22%)
 - 74% used Day Treatment services
 - 31% used Day Treatment residential services
 - 41% used Day Treatment intensive services
 - 26% used inpatient services
 - 32% used TBS
 - 39% used wraparound services

- In FY0607
 - 53% had an active CWS case
 - 14% were open to Probation
 - 71% received Special Education services
 - 43% were classified as ED
 - 59% used Day Treatment services
 - 25% used Day Treatment residential services
 - 31% used Day Treatment intensive services
 - 32% used inpatient services
 - 22% used TBS
 - 29% used wraparound services

Clients above the 3k+ cutpoint for ONLY 1 month (37.9% of sample):

- In FY0708
 - 52% used Day Treatment services
 - 22% used Day Treatment residential services
 - 16% used Day Treatment intensive services
 - 13% used inpatient services
 - 16% used TBS
 - 17% used wraparound services

- In FY0607
 - 56% had an active CWS case
 - 16% were open to Probation
 - 68% received Special Education services
 - 30% were classified as ED
 - 38% used Day Treatment services
 - 25% used Day Treatment residential services
 - 31% used Day Treatment intensive services
 - 13% used inpatient services
 - 15% used TBS
 - 15% used wraparound services

Clients with NO Day Treatment Services – N=262 (35.5% of sample)

- 46.6% of the non Day Treatment sample used 3K+ in services in only 1 month during FY0708
- 30.9% used 3K+ in services in 3+ months during FY0708

- In FY0708
 - ADHD diagnosis more common (24%)
 - 13% used inpatient services
 - 37% used TBS
 - 35% used wraparound services

- In FY0607
 - 44% had an active CWS case
 - 7% were open to Probation
 - 65% received Special Education services
 - 29% were classified as ED
 - 15% used inpatient services
 - 16% used TBS
 - 21% used wraparound services

Clients using Day Treatment Residential Services – N=177 (24% of sample)

- 31.6% of the Day Treatment Residential sample used 3K+ in services in only 1 month during FY0708
- 55.4% used 3K+ in services in 3+ months during FY0708

- In FY0708
 - 28% African-American
 - 44% Female
 - 28% Oppositional/Conduct disorder, 26% Bipolar diagnosis
 - 29% used inpatient services
 - 25% used TBS
 - 16% used wraparound services

- In FY0607
 - 54% had an active CWS case
 - 14% were open to Probation
 - 67% received Special Education services
 - 36% were classified as ED
 - 22% used inpatient services
 - 18% used TBS
 - 21% used wraparound services

Sample: only clients who reach 3K cutpoint in 2+ months (N=428)

Age at first episode:

Mean = 7.9 years (+/- 3.45)

Overall system Mean = 9.0 years (+/- 4.60)

Episode count:

Mean = 19.54 (+/- 16.9)

Overall system Mean = 4.17 (+/- 6.12)

Episode count per year of service (for clients open at least one year):

Mean = 5.04 (+/- 5.37)

Overall system Mean = 1.76 (+/- 1.72)

First episode type (does not total to 100%, can have more than one episode open on same day, range 1-5):

FFS OP: 27%

RTC: 0%

OP clinic: 42%

OP school: 8%

CM: 4%

CM Therapy: 0%

TBS: 1%

Day Rehab: 7%

DT Intensive: 1%

DT Residential: 2%

DT Meds: 3%

Inpatient: 5%

Other: 9%

Missing mode: 5% (these are mostly pre INSYST episodes)

- In FY0708

- 23.1% used inpatient services
- 31.8% used TBS
- 38.3% used services from wrap program
- 50.9% used CM
- 17.1% day rehab
- 28.3% DT Residential
- 34.6% DT Intensive
- 67.3% Any DT
- 57.0% OP Clinic
- 63.6% OP School
- 38.8% Other
- 19.9% ESU
- 43.7% FFS OP
- 17.8% used MHSA services
- 35.0% received AB2726
- Note: Used significantly more (minutes or days) of every type of service except IP days

- In FY0607

- 53.2% had an active CWS case
- 12.9% were open to Probation
- 66.8% received Special Education services
 - 38.7% were classified as ED
- 30.8% used inpatient services
- 23.7% ESU
- 19.5% TBS
- 24.5% wraparound
- 16.6% Day Rehab
- 22.6% Day Residential
- 27.9% Day Intensive



California EQRO

560 J Street, Suite 390
Sacramento, CA 95814

This outline is a compilation of the “Road Map to a PIP” and the PIP Validation Tool that CAEQRO is required to use 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.

If the MHP is submitting a PIP that was previously submitted, please ensure that this document reflects and emphasizes the work completed over the past year.

CAEQRO PIP Outline via Road Map

MHP: San Diego County Behavioral Health
Date PIP Began: Nov 1, 2008
Title of PIP: Improving Client Satisfaction with Mental Health Services
Clinical or Non-Clinical: Non-Clinical

Assemble multi-functional team

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

Mental Health Administration: San Diego County Behavioral Health Clinical Director, Director of Quality Improvement, Quality Review Council, Health Services Research Center, Child and Adolescent Research Center, Program Monitors, County and Contract Mental Health Administration, and clients who fill out the twice annual client satisfaction surveys

“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.

Please note: This study is still in early developmental stages. The MHP would appreciate any suggestions for improving the study question, the study design, or the methodology for analyzing data.

The results of the State mandated client satisfaction surveys have historically demonstrated that overall San Diego County clients are more satisfied with their mental health services than clients in other Southern California counties, and higher also than averages overall for the State. However members of the Quality Review Council, the Mental Health Board, and other stakeholders have expressed concern that the:

- Results of the surveys are not valued
- Results are not being used for quality improvement efforts
- Results are not expressing the full range of experiences of some clients in the system

This is priority for the MHP because these survey tools represent the voice of clients and their family members. Used appropriately measures can function as indicators to identify quality problems, provide insight into contributing problems, and guide efforts to improve care.

Developing a system based on quality improvement principles requires time, effort, commitment. It is within the MHP’s scope of influence to impact client satisfaction by setting quality improvement goals and specifying operational requirements which will affect client services.

This study could potentially impact any client of SDCMHS. Once the county has identified “lower than optimal” rates of satisfaction, and has identified the programs which are rated consistently lower, there can be interventions designed to mitigate the problems. Even clients who have higher rates of satisfaction may experience an improvement in the services they are receiving.

In addition to helping the MHP to utilize the client satisfaction data, this study will provide an opportunity for training on the use of quality improvement tools and methods for MH administration and will serve to further enhance the development of quality improvement environment.

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?

The data to be used for this study has been gathered over the last 4 cycles of Mandated State Surveys. SDCMHS has consistently demonstrated result that are higher than other southern California Counties and also higher than overall State averages. However there is a substantial amount of unexplained variance in the results for SDCMHS. We will begin this study sequentially. First we know we have unexplained a variance compared to other counties but don't know why. We will analyze causes of lower scores and identify best practices that are related to higher scores. Once we understand the variance we believe we can raise satisfaction levels by improving consistency internally we improve satisfaction overall.

In addition to utilizing the state mandated surveys, complaints that are collected by our client advocacy programs will be studied, as well as alternative methods of gathering data, such as client focus groups.

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

Causes/barriers still need to be identified. This will be one of the initial steps in this study. Listed below are possible causes and barriers

Table A – List of Possible Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Complexity of system	Supervision of contracts is diffused among a number of county and contract program monitor- each of whom has traditionally had their own approach to addressing quality concerns with programs
Challenges to developing a quality improvement system	MHP recognizes that training is required

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.

The MHP plans to study the unexplained variances in the results of the State mandated client satisfaction survey to identify why satisfaction scores are better in some settings and worse in others. The MHP will specifically focus on the administrative or operational factors that result in some scores being higher than others
5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.

This PIP attempts to include all beneficiaries for the study questions applies, however the methodology for sampling over a designated two-week limits the number of clients represented in the group. There are also some additional factors limiting responses from certain groups of clients, such as those experiencing a crisis, or those who may be too impaired to answer questions on the survey. The MHP will include additional sampling strategies to try to mitigate these types of limitations.
6. Describe the population to be included in the PIP, including the number of beneficiaries.

All child and adult clients who are served by a County or contracted organizational provider during the two week periods designated by the State for surveys.
7. Describe how the population is being identified for the collection of data.

All child and adult clients who are served by a County or contracted organizational provider during the two week periods designated by the State for surveys.
8.
 - a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

The sampling technique utilized is based on limited resources ns therefore we will utilize the mandated cycle as designated by the State for surveys. The MHP does understand that an organized approach to random sampling would be preferable
 - b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

The number of beneficiaries varies each survey period, but is a large enough sample size to render a fair interpretation

“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?

These performance data were selected because the MHP already has access to the data, which is collected utilizing standardized, psychometrically validated survey measure.

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

These performance data were selected because they are standardized, psychometrically validated survey measures for client satisfaction which is a strong indicator 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	MHSIP	MHSIP scores by program	MHSIP scores by system	Results over 4 survey periods	Reduction in standard deviations from the norm
		MHSIP scores by program	MHSIP scores by program historically	Results over 4 survey periods	Improvement of 3-5% within 1-2 years
2	Cal Qol	Cal Qol scores by program	Cal Qol scores by system	Results over 4 survey periods	Reduction in standard deviations from the norm
		Cal Qol scores by program	Cal Qol scores by program historically	Results over 4 survey periods	Improvement of 3-5% within 1-2 years
3	YSS- Youth	YSS- Youth scores by program	YSS- Youth scores by system	Results over 4 survey periods	Reduction in standard deviations from the norm

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
		YSS- Youth scores by program	YSS- Youth scores by program historically	Results over 4 survey periods	Improvement of 3-5% within 1-2 years
4	YSS- Family	YSS- Family scores by program	YSS- Family scores by system	Results over 4 survey periods	Reduction in standard deviations from the norm
		YSS- Family scores by program	YSS- Family scores by program historically	Results over 4 survey periods	Improvement of 3-5% within 1-2 years

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	Getting data in usable format	Reports must be easy to interpret and easy to access	NA
2	Bring a team together to analyze process for responding to MHSIP, CalQoI and YSS data and complaints	Lack of understanding of how to use the information Inconsistency of approach to interpreting data and to working with programs to resolve problems	NA
3	Select a specific process for Plan Do Study Act cycles with goal of reducing unexplained variance	Lack of process to define an intervention, and monitor the results	NA
4	Develop a system that routinely uses the data from MHSIP, CalQoI and YSS data and complaints to work with programs to spread best practices and minimize inter-program variance	Lack of process to define an intervention, and monitor the results	NA

Apply Interventions: “What do we see?”

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

Client Satisfaction ratings:

1. Identify programs that consistently perform in the top and bottom quartile on the MHSIP, Cal-QoI, and YSS
2. Determine if certain types of programs are more likely to have positive or negative satisfaction ratings
3. Examine program-level differences between the top and bottom performing programs

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

The adult and child/family state-mandated surveys, completed twice a year by all clients receiving services during the two week survey period, will be utilized to collect the data. Analyses will be conducted on the selected top and bottom quartile groups. We will not sure data from InSyst of Anasazi as client satisfaction data is not collected in those systems.

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

Basic analyses will be conducted to describe the two groups (type of program, region, client demographics, program size, etc) and conduct comparisons between the two groups. Analyses will be conducted in SPSS utilizing chi square and t tests where appropriate.

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

To be added.

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?

NA- still in the planning phases

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							
Program scores compared to baseline							
Program scores compared to system							

“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?