



Sacramento County
Mental Health Plan
Quality Improvement Program
Annual Work Plan Report

FY 2005/2006 - FY 2006/2007

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INTRODUCTION

The following report covers the activities conducted within Sacramento County's Mental Health Plan (MHP) addressing the annual work plan for Fiscal Year 2006-07. Fiscal Year 05-06 information is utilized wherever possible to provide the reader a two year view of changes as a comparison point. The Mental Health Plan's Quality Management (QM) efforts have adjusted to incorporate ongoing program design and service changes into the annual progress report. The MHP has had to adjust to federal and state level changes. Thus this report compares available data where possible, and provides references to appropriate MHP Research and Evaluation reports or Cultural Competence Plan Updates for more detailed information. The intent is to provide the reader information that is tracked over time in various core areas of the MHP. Each area has summary comments and findings.

This report is divided into the following areas:

- I. Utilization of Services and Penetration Rates
- II. Capacity and Availability of Services
- III. Accessibility/Timeliness/Satisfaction
- IV. Effectiveness of Care/Clinical Issues
- V. Utilization Review/Utilization Management
- VI. Coordination of Care with Physical Health
- VII. Cultural Competency, Training and Education

SUMMARY OF REPORT

In 2006-07, the Mental Health Plan undertook numerous quality management and quality improvement activities incorporated into its Annual Work Plan. Many of these activities resulted in other initiatives within the MHP at program and administrative levels. This included Performance Improvement Projects and efforts to track issues and changes over time. Below are some highlights of information detailed information in this report:

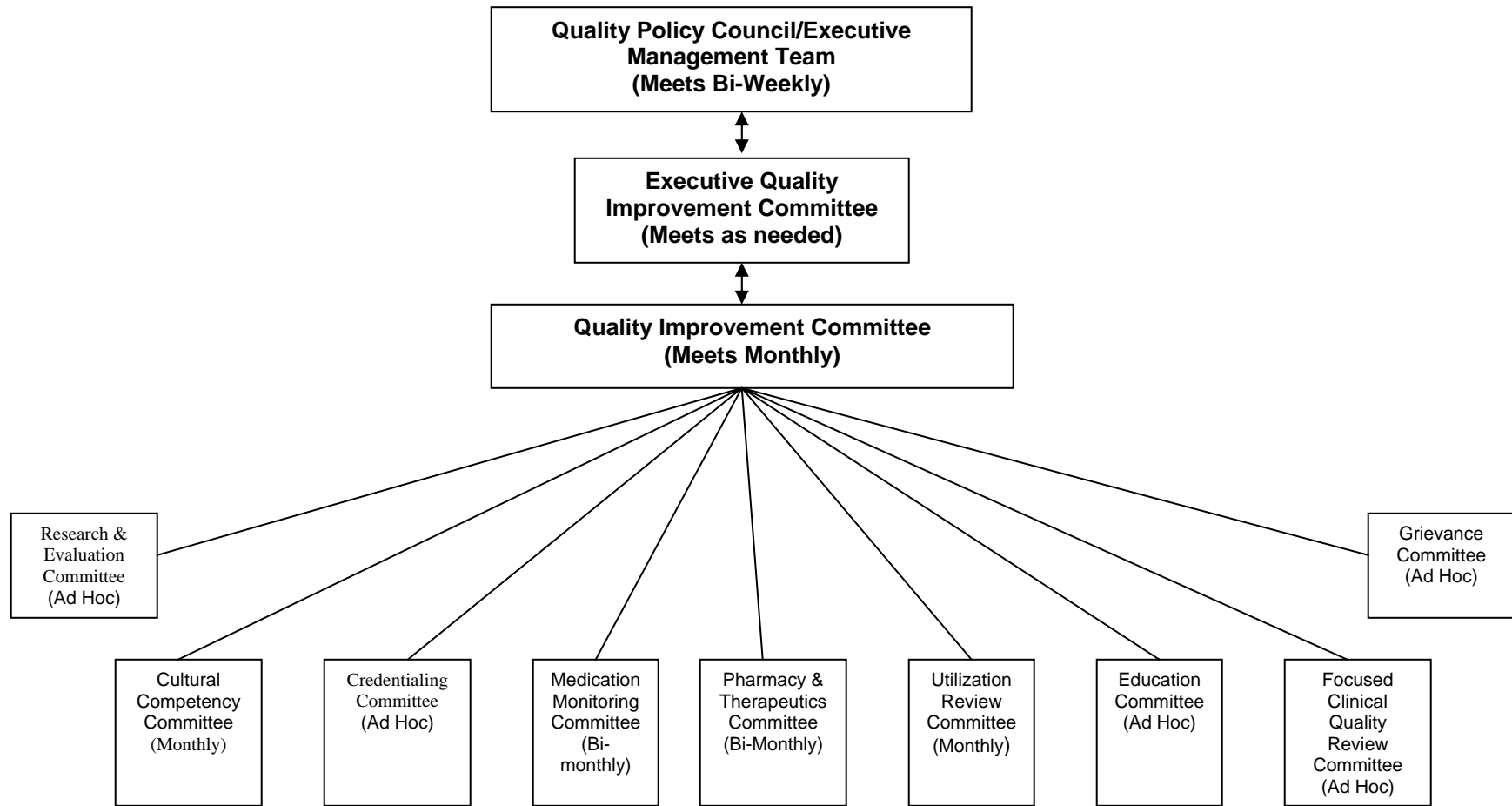
- 91 organizational provider sites delivered services to MHP clients across Sacramento County. This reflected a geographic vast area of service. With the development of Mental Health Services Act (MHSA) programs and continued efforts at flexible service delivery by both children's and adult providers, the MHP demonstrated significant efforts to reach out to clients and families in a variety of community settings. During 2006, it was also notable that the MHP added a provider with a specialty in delivery services to the deaf community.
- The MHP developed a "Dashboard" to monitor access and timeliness of service delivery. Data collected in this dashboard informed and monitored acute care, acute care return rates and timeliness of service. The MHP continued to be challenged in meeting the demand for services. Medication appointments were a special challenge within the outpatient adult system.
- The MHP penetration rate remained stable over time. There were 32,971 unduplicated clients served in 2006-07 out of 269,647 Medi-Cal eligibles equating to a 12.2% penetration rate. With five threshold languages and a community with significant linguistic and cultural diversity, the MHP continues to monitor and refine strategies for improvement of disparities.

- The MHP maintained a responsive problem resolution/beneficiary protection system and met its response time obligations in this area. Grievances were handled in a satisfactory and timely manner and reflected greater number of difficulties in the adult system of care. The primary areas of difficulty mirror the shortages relating to physician availability and medication appointments noted in the dashboard. Test calls to the points of access to the MHP in threshold languages continued to check for linguistic and afterhours access to the system.
- Satisfaction with the MHP services was measured through numerous reports gathering a variety of perspectives by recipients and providers of services. Data in these reports suggested that satisfaction in many domains remains relatively stable over time.
- The MHP continued to provide a variety of trainings for service staff across its provider and county operated system. 4340 attendees benefited from the MHP's training efforts. 994 received trainings focused on consumer recovery principles.
- 2178 attendees benefited from training specifically focusing on increasing cultural competency skills. Sacramento County was chosen as one of four California sites to pilot the California Brief Multicultural Scale (CBMCS) training, the first brief cultural competence self-report scale and training modules developed in collaboration with academia and select county mental health organizations.
- The MHP maintained a central point of authorization for community based mental health services. It complied with obligations to issue timely Notices of Action for any denials or reduction in services, at its Access Teams and/or other applicable points of authorization.
- The MHP conducted many utilization reviews, peer reviews, monitoring reviews across its service system. In FY 2006-07, a total of 4259 charts were reviewed across all parts of the care continuum (over 13%). This number did not include targeted reviews by contract agencies, contract monitors or other special oversight activities which reflected a robust utilization review/peer review, oversight effort. It was noted that Early Periodic Screening, Diagnosis and Treatment (EPSDT) external audits took place approximately every month during this fiscal year. Data collected in these reviews provided service providers feedback to improve documentation and clinical practices. The MHP also was able to improve training and develop new forms to streamline documentation requirements, review processes, as a result of findings in this area.
- The Pharmacy & Therapeutics Committee and Medication Monitoring Committees continued to provide critical input and oversight for medication practices and medication practice guidelines. The Medication Monitoring Committee reviewed 1468 charts across providers for polypharmacy issues, medication guidelines and laboratory work. In all cases feedback was provided to providers of services.
- Increased coordination of care and improving client services remained the focus of all clinical reviews and new programming. A physical health complication with mental health conditions and lack of physical health resources for adult clients was noted as an important pattern in clinical chart reviews where deaths occurred.

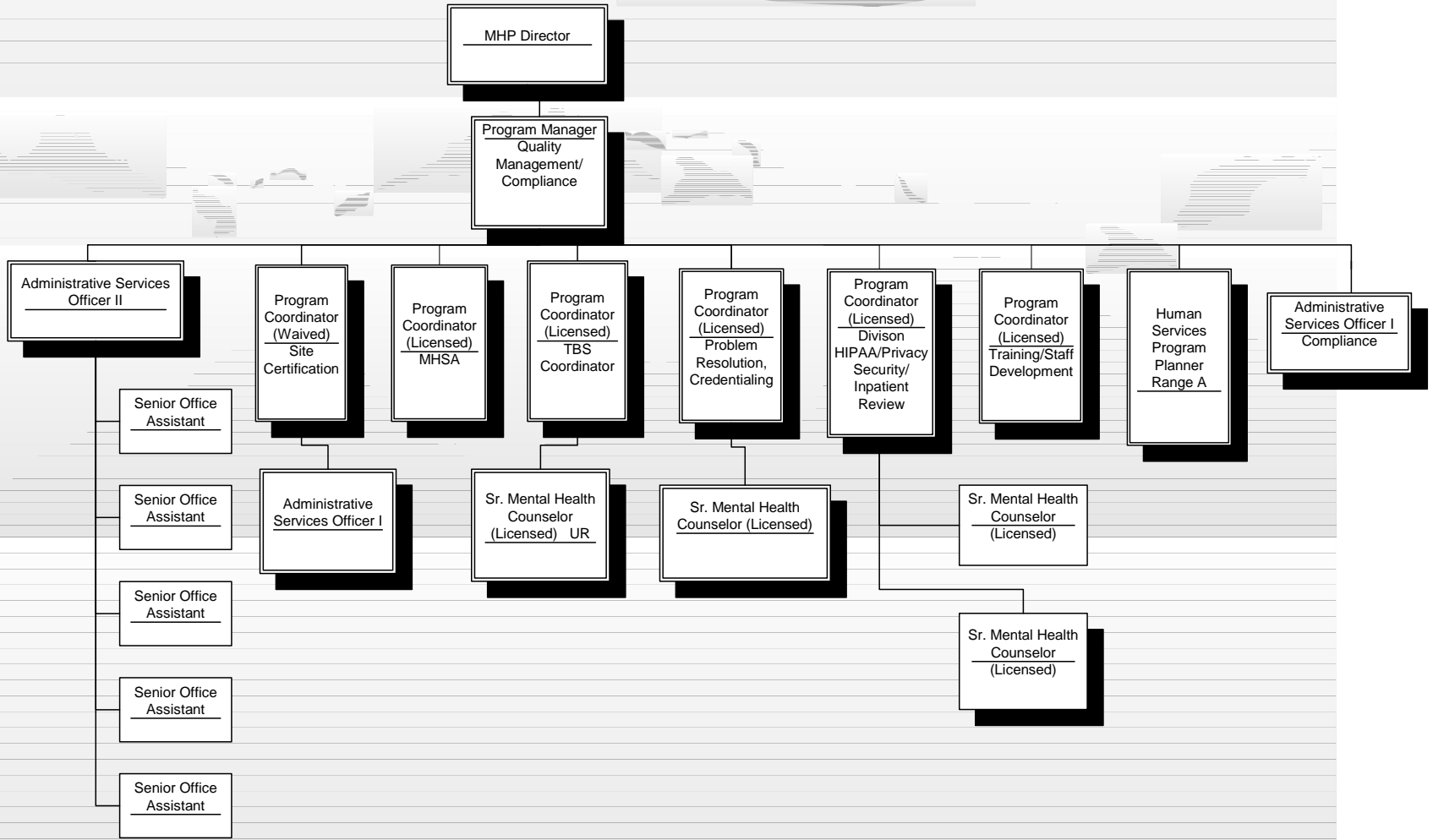
QUALITY MANAGEMENT ORGANIZATION AND STRUCTURE

The Quality Improvement Policy Council guides the Mental Health Plan's Quality Improvement processes. The Policy Council also functions as the Executive Management Team for the Mental Health Division. A subgroup of members of the Policy Council serves as the Executive Quality Improvement Committee and provides higher level of review and guidance on behalf of the Policy Council. The MHP's Quality Improvement Committee (QIC) is chaired by the MHP's Quality Management Manager. The QIC meets on a monthly basis and maintains minutes of its deliberations. It includes representatives of the Contract Provider system, County Program Monitoring unit, Access Teams, Research and Evaluation, Quality Management, Cultural Competence, Psychiatry and Pharmacy representatives, Consumer and Family Member representatives. The QIC structure is the umbrella for standing subcommittees, adhoc subcommittees and/or workgroups that are developed to meet the changing needs of the MHP. Subcommittees report to the monthly Quality Improvement Committee where information is reviewed and comments are received from all parts of the system. These deliberations result in approval, new initiatives, and recommendations for new directions and constitute a critical communication forum for the MHP.

QUALITY IMPROVEMENT STRUCTURE 2006-2007



MHP QUALITY MANAGEMENT SERVICES ORGANIZATIONAL CHART 2007



I. RETENTION & PENETRATION RATES

Retention Rates FY 2005-2006

Adults

- ❖ Clients admitted between July 1, 2005 and June 30, 2006
- ❖ General Outpatient – 3 service dates* within 6 months
- ❖ Intensive Programs – 3 service dates* within 1 month

*Service dates were used instead of service events because many clients receive several service events in a day.

ADULT OUTPATIENT PROGRAMS					
Characteristic	All Clients (N=4,632)		Clients Retained (N=3,869)		Retention Rate
	N	%	N	%	%
Total	4632		3869		83.5
Ethnicity					
White	2459	53.1	2088	54.0	84.9
Black	887	19.1	736	19.0	83.0
Hispanic	487	10.5	389	10.1	79.9
Multi-Ethnic	156	3.4	135	3.5	86.5
Other Asian/Pacific Islander	181	3.9	147	3.8	81.2
Hmong	97	2.1	79	2.0	81.4
Native American	52	1.1	50	1.3	96.2
Vietnamese	42	0.9	36	0.9	85.7
Russian	21	0.5	13	0.3	61.9
Chinese	15	0.3	11	0.3	73.3
Other	227	4.9	180	4.7	79.3
Unknown/Not Reported	8	0.2	5	0.1	62.5
Primary Language					
English	4124	89.0	3465	89.6	84.0
Spanish	157	3.4	124	3.2	79.0
Cantonese	8	0.2	6	0.2	75.0
Hmong	103	2.2	85	2.2	82.5
Russian	28	0.6	19	0.5	67.9
Vietnamese	35	0.8	31	0.8	88.6
Other	126	2.7	105	2.7	83.3
Unknown/Not Reported	51	1.1	34	0.9	66.7
Gender					
Male	2970	64.1	2430	62.8	81.8
Female	1661	35.9	1438	37.2	86.6
Unknown	1	<0.1	1	<0.1	100.0
Diagnosis					
Psychotic	737	15.9	652	16.9	88.5
Bipolar	1530	33.0	1334	34.5	87.2
Depressive	1743	37.6	1433	37.0	82.2
Anxiety	260	5.6	198	5.1	76.2
Adjustment	131	2.8	84	2.2	64.1

Other (v-codes, deferred, etc.)	229	0.4	168	4.3	73.4
Unknown/Not Reported	2	0.0	0	0.0	0.0

ADULT INTENSIVE PROGRAMS					
Characteristic	All Clients (N=242)		Clients Retained (N=209)		Retention Rate
	N	%	N	%	%
Total	242		209		86.4
Ethnicity					
White	124	51.2	108	51.7	87.1
Black	63	26.0	53	25.4	84.1
Hispanic	19	7.9	14	6.7	73.7
Multi-Ethnic	3	1.2	3	1.4	100.0
Other Asian/Pacific Islander	8	3.3	6	2.9	75.0
Vietnamese	4	1.7	4	1.9	100.0
Chinese	2	0.8	2	1.0	100.0
Russian	2	0.8	2	1.0	100.0
Other	7	2.9	7	3.3	100.0
Unknown/Not Reported	10	4.1	10	4.8	100.0
Primary Language					
English	236	97.5	203	97.1	86.0
Spanish	1	0.4	1	0.5	100.0
Hmong	1	0.4	1	0.5	100.0
Russian	1	0.4	1	0.5	100.0
Vietnamese	1	0.4	1	0.5	100.0
Other	1	0.4	1	0.5	100.0
Unknown/Not Reported	1	0.4	1	0.5	100.0
Gender					
Male	127	52.5	109	52.2	85.8
Female	115	47.5	100	47.8	87.0
Diagnosis					
Psychotic	148	61.2	130	62.2	87.8
Bipolar	63	26.0	51	24.4	81.0
Depressive	17	7.0	15	7.2	88.2
Other (v-codes, deferred, etc.)	14	5.8	13	6.2	92.9

Children

- ❖ Clients admitted between July 1, 2005 and June 30, 2006
- ❖ General Outpatient – 5 service dates* within 3 months
- ❖ Intensive Programs – 5 service dates* within 1 month

*Service dates were used instead of service events because many clients receive several service events in a day.

CHILD OUTPATIENT PROGRAMS					
Characteristic	All Clients (N=5,535)		Clients Retained (N=4,892)		Retention Rate
	N	%	N	%	%
Total	5,535		4,892		88.4
Ethnicity					
White	1928	34.8	1718	35.1	89.1
Black	1478	26.7	1289	26.3	87.2
Hispanic	1029	18.6	915	18.7	88.9
Multi-Ethnic	595	10.7	534	10.9	89.7
Other Asian/Pacific Islander	134	2.4	122	2.5	91.0
Hmong	58	1.0	52	1.1	89.7
Native American	41	0.7	35	0.7	85.4
Vietnamese	29	0.5	24	0.5	82.8
Chinese	10	0.2	9	0.2	90.0
Russian	8	0.1	7	0.1	87.5
Other	221	4.0	183	3.7	82.8
Unknown/Not Reported	4	0.1	4	0.1	100.0
Primary Language					
English	5063	91.5	4480	91.6	88.5
Spanish	366	6.6	325	6.6	88.8
Hmong	28	0.5	23	0.5	82.1
Vietnamese	13	0.2	8	0.2	61.5
Cantonese	6	0.1	5	0.1	83.3
Russian	4	0.1	4	0.1	100.0
Other	32	0.6	27	0.6	84.4
Unknown/Not Reported	23	0.4	20	0.4	87.0
Gender					
Male	3064	55.4	2709	55.4	88.4
Female	2471	44.6	2183	44.6	88.3
Diagnosis					
Psychotic	81	1.5	74	1.5	91.4
Bipolar	302	5.5	278	5.7	92.1
Depressive	819	14.8	735	15.0	89.7
Anxiety	781	14.1	723	14.8	92.6
Adjustment	1176	21.2	1014	20.7	86.2
ADHD	673	12.2	619	12.7	92.0
Disruptive Behavior	814	14.7	726	14.8	89.2
Other Childhood Disorders	552	10.0	453	9.3	82.1
Other (v-codes, deferred, etc.)	337	6.1	270	5.5	80.1

CHILD INTENSIVE PROGRAMS					
Characteristic	All Clients (N=502)		Clients Retained (N=400)		Retention Rate
	N	%	N	%	%
Total	502		400		79.7
Ethnicity					
White	225	44.8	177	44.3	78.7
Black	137	27.3	108	27.0	78.8
Hispanic	69	13.7	55	13.8	79.7
Multi-Ethnic	42	8.4	33	8.3	78.6
Other Asian/Pacific Islander	10	2.0	9	2.3	90.0
Native American	4	0.8	4	1.0	100.0
Vietnamese	3	0.6	3	0.8	100.0
Russian	1	0.2	1	0.3	100.0
Other	11	2.2	10	2.5	90.9
Primary Language					
English	490	97.6	389	97.3	79.4
Spanish	10	2.0	9	2.3	90.0
Russian	1	0.2	1	0.3	100.0
Other	1	0.2	1	0.3	100.0
Gender					
Male	289	57.6	229	57.2	79.2
Female	213	42.4	171	42.8	80.3
Diagnosis					
Psychotic	22	4.4	17	4.3	77.3
Bipolar	68	13.5	60	15.0	88.2
Depressive	95	18.9	75	18.8	78.9
Anxiety	79	15.7	64	16.0	81.0
Adjustment	20	4.0	18	4.5	90.0
ADHD	82	16.3	68	17.0	82.9
Disruptive Behavior	91	18.1	59	14.8	64.8
Other Childhood Disorders	22	4.4	18	4.5	81.8
Other (v-codes, deferred, etc.)	23	4.6	21	5.3	91.3

**Retention Rates
FY 2006-2007**

Adults

- ❖ Clients admitted between July 1, 2006 and June 30, 2007
- ❖ Only counted clients that received a face to face mental health service
- ❖ General Outpatient – 3 service dates* within 6 months
- ❖ Intensive Programs – 3 service dates* within 1 month

*Service dates were used instead of service events because many clients receive several service events in a day.

ADULT OUTPATIENT PROGRAMS					
Characteristic	All Clients (N=4,671)		Clients Retained (N=2,836)		Retention Rate
	N	%	N	%	%
Total	4671		2836		60.7
Ethnicity					
White	2222	47.6	1411	49.8	63.5
Black	875	18.7	469	16.5	53.6
Hispanic	698	14.9	416	14.7	59.6
Multi-Ethnic	212	4.5	130	4.6	61.3
Other Asian/Pacific Islander	137	2.9	91	3.2	66.4
Hmong	87	1.9	60	2.1	69.0
Native American	45	1.0	23	0.8	51.1
Vietnamese	65	1.4	50	1.8	76.9
Russian	30	0.6	25	0.9	83.3
Chinese	20	0.4	12	0.4	60.0
Other	151	3.2	92	3.2	60.9
Unknown/Not Reported	129	2.8	57	2.0	44.2
Primary Language					
English	3942	84.4	2407	84.9	61.1
Spanish	394	8.4	195	6.9	49.5
Cantonese	3	0.1	2	0.1	66.7
Hmong	80	1.7	54	1.9	67.5
Russian	43	0.9	32	1.1	74.4
Vietnamese	49	1.0	37	1.3	75.5
Other	135	2.9	97	3.4	71.9
Unknown/Not Reported	25	0.5	12	0.4	48.0
Gender					
Male	1711	36.6	1057	37.3	61.8
Female	2960	63.4	1779	62.7	60.1
Diagnosis					
Psychotic	751	16.1	498	17.6	66.3
Bipolar	1469	31.4	937	33.0	63.8
Depressive	1852	39.6	1106	39.0	59.7
Anxiety	262	5.6	150	5.3	57.3
Adjustment	118	2.5	51	1.8	43.2
Other (v-codes, deferred, etc.)	197	4.2	84	3.0	42.6
Unknown/Not Reported	22	0.5	10	0.4	45.5

ADULT INTENSIVE PROGRAMS					
Characteristic	All Clients (N=209)		Clients Retained (N=150)		Retention Rate
	N	%	N	%	%
Total	209		150		71.8
Ethnicity					
White	99	47.4	70	46.7	70.7
Black	51	24.4	39	26.0	76.5
Hispanic	25	12.0	17	11.3	68.0
Multi-Ethnic	12	5.7	7	4.7	58.3
Other Asian/Pacific Islander	9	4.3	8	5.3	88.9
Native American	1	0.5	0	0.0	0.0
Vietnamese	1	0.5	1	0.7	100.0
Chinese	1	0.5	1	0.7	100.0
Hmong	1	0.5	1	0.7	100.0
Russian	2	1.0	1	0.7	50.0
Other	7	3.3	5	3.3	71.4
Primary Language					
English	199	95.2	142	94.7	71.4
Spanish	3	1.4	2	1.3	66.7
Hmong	2	1.0	2	1.3	100.0
Russian	2	1.0	1	0.7	50.0
Other	3	1.4	3	2.0	100.0
Gender					
Male	96	45.9	70	46.7	72.9
Female	113	54.1	80	53.3	70.8
Diagnosis					
Psychotic	144	68.9	106	70.7	73.6
Bipolar	46	22.0	30	20.0	65.2
Depressive	12	5.7	10	6.7	83.3
Other (v-codes, deferred, etc.)	7	3.3	4	2.7	57.1

Children

- ❖ Clients admitted between July 1, 2006 and June 30, 2007
- ❖ Only counted clients that received a face to face mental health service
- ❖ General Outpatient – 5 service dates* within 3 months
- ❖ Intensive Programs – 5 service dates* within 1 month

*Service dates were used instead of service events because many clients receive several service events in a day.

CHILD OUTPATIENT PROGRAMS					
Characteristic	All Clients (N=5,242)		Clients Retained (N=3,812)		Retention Rate
	N	%	N	%	%
Total	5,242		3,812		72.7
Ethnicity					
White	1645	31.4	1234	32.4	75.0
Black	1314	25.1	895	23.5	68.1
Hispanic	1476	28.2	1105	29.0	74.9
Multi-Ethnic	421	8.0	319	8.4	75.8
Other Asian/Pacific Islander	78	1.5	52	1.4	66.7
Hmong	55	1.0	44	1.2	80.0
Native American	28	0.5	19	0.5	67.9
Vietnamese	21	0.4	14	0.4	66.7
Chinese	13	0.2	7	0.2	53.8
Russian	2	0.0	0	0.0	0.0
Other	100	1.9	66	1.7	66.7
Unknown/Not Reported	105	2.0	67	1.8	63.8
Primary Language					
English	4692	89.5	3401	89.2	72.5
Spanish	447	8.5	335	8.8	74.9
Cantonese	10	0.2	4	0.1	40.0
Hmong	34	0.6	26	0.7	76.5
Russian	1	0.0	0	0.0	0.0
Vietnamese	5	0.1	3	0.1	60.0
Other	29	0.6	25	0.7	86.2
Unknown/Not Reported	24	0.5	18	0.5	75.0
Gender					
Male	2906	55.4	2104	55.2	72.4
Female	2336	44.6	1708	44.8	73.1
Diagnosis					
Psychotic	54	1.0	33	0.9	61.1
Bipolar	284	5.4	210	5.5	73.9
Depressive	713	13.6	531	13.9	74.5
Anxiety	802	15.3	622	16.3	77.6
Adjustment	1163	22.2	852	22.4	73.3
ADHD	662	12.6	512	13.4	77.3
Disruptive Behavior	800	15.3	582	15.3	72.8
Other Childhood Disorders	516	9.8	316	8.3	61.2
Other (v-codes, deferred, etc.)	235	4.5	144	3.8	61.3
Unknown/Not Reported	13	0.2	10	0.3	76.9

CHILD INTENSIVE PROGRAMS					
Characteristic	All Clients (N=551)		Clients Retained (N=276)		Retention Rate
	N	%	N	%	%
Total	551		273		50.1
Ethnicity					
White	196	35.6	101	36.6	51.5
Black	154	27.9	66	23.9	42.9
Hispanic	118	21.4	64	23.2	54.2
Multi-Ethnic	61	11.1	35	12.7	57.4
Other Asian/Pacific Islander	4	0.7	0	0.0	0.0
Hmong	5	0.9	3	1.1	60.0
Native American	1	0.2	0	0.0	0.0
Vietnamese	1	0.2	0	0.0	0.0
Chinese	1	0.2	1	0.4	100.0
Other	7	1.3	3	1.1	42.9
Unknown	3	0.5	3	1.1	100.0
Primary Language					
English	535	97.1	272	98.6	50.8
Spanish	11	2.0	2	0.7	18.2
Cantonese	1	0.2	0	0.0	0.0
Hmong	1	0.2	0	0.0	0.0
Other	2	0.4	1	0.4	50.0
Unknown/Not Reported	1	0.2	1	0.4	100.0
Gender					
Male	338	61.3	157	56.9	46.4
Female	213	38.7	119	43.1	55.9
Diagnosis					
Psychotic	18	3.3	8	2.9	44.4
Bipolar	94	17.1	56	20.3	59.6
Depressive	71	12.9	30	10.9	42.3
Anxiety	78	14.2	40	14.5	51.3
Adjustment	26	4.7	13	4.7	50.0
ADHD	96	17.4	57	20.7	59.4
Disruptive Behavior	90	16.3	46	16.7	51.1
Other Childhood Disorders	46	8.3	11	4.0	23.9
Other (v-codes, deferred, etc.)	32	5.8	15	5.4	46.9

The table below compares adult outpatient FY 05/06 retention rates with FY 06/07 rates.

ADULT OUTPATIENT PROGRAMS			
	Retention Rate FY 05/06	Retention Rate FY 06/07	Percent Change (+/-)
Total	83.5	60.7	-27.3
Ethnicity			
White	84.9	63.5	-25.2
Black	83.0	53.6	-35.4
Hispanic	79.9	59.6	-25.4
Multi-Ethnic	86.5	61.3	-29.1
Other Asian/Pacific Islander	81.2	66.4	-18.2
Hmong	81.4	69.0	-15.2
Native American	96.2	51.1	-46.9
Vietnamese	85.7	76.9	-10.3
Russian	61.9	83.3	34.6
Chinese	73.3	60.0	-18.1
Other	79.3	60.9	-23.2
Unknown/Not Reported	62.5	44.2	-29.3
Primary Language			
English	84.0	61.1	-27.3
Spanish	79.0	49.5	-37.3
Cantonese	75.0	66.7	-11.1
Hmong	82.5	67.5	-18.2
Russian	67.9	74.4	9.6
Vietnamese	88.6	75.5	-14.8
Other	83.3	71.9	-13.7
Unknown/Not Reported	66.7	48.0	-28.0
Gender			
Male	81.8	61.8	-24.4
Female	86.6	60.1	-30.6
Unknown	100.0		-100.0
Diagnosis			
Psychotic	88.5	66.3	-25.1
Bipolar	87.2	63.8	-26.8
Depressive	82.2	59.7	-27.4
Anxiety	76.2	57.3	-24.8
Adjustment	64.1	43.2	-32.6
Other (v-codes, deferred, etc.)	73.4	42.6	-42.0
Unknown/Not Reported	0.0	45.5	N/A

The table below compares adult intensive FY 05/06 retention rates with FY 06/07 rates.

ADULT INTENSIVE PROGRAMS			
	Retention Rate FY 05/06	Retention Rate FY 06/07	Percent Change (+/-)
Total	86.4	71.8	-16.9
Ethnicity			
White	87.1	70.7	-18.8
Black	84.1	76.5	-9.0
Hispanic	73.7	68.0	-7.7
Multi-Ethnic	100.0	58.3	-41.7
Other Asian/Pacific Islander	75.0	88.9	18.5
Native American	---	0.0	N/A
Vietnamese	100.0	100.0	0.0
Chinese	100.0	100.0	0.0
Hmong	---	100.0	N/A
Russian	100.0	50.0	-50.0
Other	100.0	71.4	-28.6
Primary Language			
English	86.0	71.4	-17.0
Spanish	100.0	66.7	-33.3
Hmong	100.0	100.0	0.0
Russian	100.0	50.0	-50.0
Vietnamese	100.0	---	N/A
Other	100.0	100.0	0.0
Unknown/Not Reported	100.0	---	N/A
Gender			
Male	85.5	72.9	-14.7
Female	87.0	70.8	-18.6
Diagnosis			
Psychotic	87.8	73.6	-16.2
Bipolar	81.0	65.2	-19.5
Depressive	88.2	83.3	-5.6
Other (v-codes, deferred, etc.)	92.9	57.1	-38.5

The table below compares children's outpatient FY 05/06 retention rates with FY 06/07 rates.

CHILD OUTPATIENT PROGRAMS			
	Retention Rate FY 05/06	Retention Rate FY 06/07	Percent Change (+/-)
Total	88.4	72.7	-17.8
Ethnicity			
White	89.1	75.0	-15.8
Black	87.2	68.1	-21.9
Hispanic	88.9	74.9	-15.7
Multi-Ethnic	89.7	75.8	-15.5
Other Asian/Pacific Islander	91.0	66.7	-26.7
Hmong	89.7	80.0	-10.8
Native American	85.4	67.9	-20.5
Vietnamese	82.8	66.7	-19.4
Chinese	90.0	53.8	-40.2
Russian	87.5	0.0	-100.0
Other	82.8	66.7	-19.4
Unknown/Not Reported	100.0	63.8	-36.2
Primary Language			
English	88.5	72.5	-18.1
Spanish	88.8	74.9	-15.7
Hmong	82.1	76.5	-6.8
Vietnamese	61.5	60.0	-2.4
Cantonese	83.3	40.0	-52.0
Russian	100.0	0.0	-100.0
Other	84.4	86.2	2.1
Unknown/Not Reported	87.0	75.0	-13.8
Gender			
Male	88.4	72.4	-18.1
Female	88.3	73.1	-17.2
Diagnosis			
Psychotic	91.4	61.1	-33.2
Bipolar	92.1	73.9	-19.8
Depressive	89.7	74.5	-16.9
Anxiety	92.6	77.6	-16.2
Adjustment	86.2	73.3	-15.0
ADHD	92.0	77.3	-16.0
Disruptive Behavior	89.2	72.8	-18.4
Other Childhood Disorders	82.1	61.2	-25.5
Other (v-codes, deferred, etc.)	80.1	61.3	-23.5
Unknown/Not Reported	---	76.9	N/A

The table below compares children's intensive FY 05/06 retention rates with FY 06/07 rates.

CHILD INTENSIVE PROGRAMS			
	Retention Rate FY 05/06	Retention Rate FY 06/07	Percent Change (+/-)
Total	79.7	50.1	-37.1%
Ethnicity			
White	78.7	51.5	-34.6
Black	78.8	42.9	-45.6
Hispanic	79.7	54.2	-32.0
Multi-Ethnic	78.9	57.4	-27.2
Other Asian/Pacific Islander	90.0	0.0	-100.0
Hmong	---	60.0	N/A
Native American	100.0	0.0	-100.0
Vietnamese	100.0	0.0	-100.0
Chinese	---	100.0	N/A
Russian	100.0	---	N/A
Other	90.9	42.9	-52.8
Unknown	---	100.0	N/A
Primary Language			
English	79.4	50.8	-36.0
Spanish	90.0	18.2	-79.8
Cantonese	---	0.0	N/A
Hmong	---	0.0	N/A
Russian	100.0	---	N/A
Other	100.0	50.0	-50.0
Unknown/Not Reported	---	100.0	N/A
Gender			
Male	79.2	46.4	-41.4
Female	80.3	55.9	-30.4
Diagnosis			
Psychotic	77.3	44.4	-42.6
Bipolar	88.2	59.6	-32.4
Depressive	78.9	42.3	-46.4
Anxiety	81.0	51.3	-36.7
Adjustment	90.0	50.0	-44.4
ADHD	82.9	59.4	-28.3
Disruptive Behavior	64.8	51.1	-21.1
Other Childhood Disorders	81.8	23.9	-70.8
Other (v-codes, deferred, etc.)	91.3	46.9	-48.6

Penetration Rates
Fiscal Years 2005-2006 and 2006-2007

Definition of Penetration Rate: The percentage of Medi-Cal eligibles served by the Mental Health Plan. *Note: Race data is presented based on Sacramento County (Department of Human Assistance) Medi-cal reporting methodology. The "Asian/Pacific Islander" category includes Asian Indian, Japanese, Korean, Laotian, Mien, Other Asian/Pacific Islander. The "other" category includes Former Soviet, Hmong, Multi-Race, Unknown/Not Reported, and Other.*

	Number Unduplicated Clients Served July 1, 2005 to June 30, 2006	Number of Medi-Cal Eligibles, January, 2006	Penetration Rate	Number Unduplicated Clients Served July 1, 2006 to June 30, 2007	Number of Medi-Cal Eligibles, January, 2007	Penetration Rate	Absolute Change
Totals	32,376	277,791	11.7	32,971	269,647	12.2	0.6
Gender							
Male	16,654	120,055	13.9	16931	116622	14.5	0.6
Female	15,717	157,736	10.0	16030	153025	10.5	0.5
Unknown	5	0	-	10	0	-	0.0
Age							
0-15	9681	119,442	8.1	9492	115,393	8.2	0.1
16-25	6,019	43,142	14.0	6191	41,679	14.9	0.9
26-60	15,296	83,473	18.3	15794	80,455	19.6	1.3
61+	1,380	31,734	4.3	1494	32,120	4.7	0.3
Race							
AmNative/Indian	230	1,774	13.0	265	1,796	14.8	1.8
Amerasian	35	44	79.5	23	43	53.5	-26.1
Asian/PI	978	19,337	5.1	960	17,315	5.5	0.5
Black	7,455	52,816	14.1	7,430	52,203	14.2	0.1
Cambodian	73	1,394	5.2	78	971	8.0	2.8
Chinese	144	4,837	3.0	147	4,862	3.0	0.0
Filipino	213	2,887	7.4	189	2,898	6.5	-0.9
Guamanian	13	128	10.2	10	142	7.0	-3.1
Hawaiian	20	255	7.8	22	288	7.6	-0.2
Hispanic	4,454	64,565	6.9	3,884	64,839	6.0	-0.9
Other/Unknown	3,651	42,094	8.7	5,463	40,869	13.4	4.7
Samoan	13	517	2.5	12	527	2.3	-0.2
Vietnamese	330	7,931	4.2	358	7,531	4.8	0.6
White	14,767	79,212	18.6	14,130	75,406	18.7	0.1
Language							
Cambodian	39	597	6.5	46	523	8.8	2.3
Cantonese	78	4,416	1.8	68	4,484	1.5	-0.2
English	28,916	164,770	17.5	29,111	162,365	17.9	0.4
Hmong	381	11,267	3.4	425	10,546	4.0	0.6
Lao	160	1,617	9.9	163	1,481	11.0	1.1
Mien	180	2,399	7.5	196	2,123	9.2	1.7
Other/Unknown	712	28,151	2.5	667	26,161	2.5	0.0
Russian	206	18,970	1.1	210	16,512	1.3	0.2
Spanish	1,463	38,240	3.8	1,799	38,348	4.7	0.9
Vietnamese	241	7,364	3.3	286	7,104	4.0	0.8

Diagnosis By Age Group

Children 17 years and younger

	FY05-06		FY06-07		Percent Change	Absolute Change
	N	%	N	%		
Adjustment	2227	17.9	2111	17.2	-3.9	-0.7
Anxiety	594	4.8	600	4.9	2.1	0.1
Attention Deficit	1407	11.3	1414	11.5	1.8	0.2
Bipolar	522	4.2	573	4.7	11.9	0.5
Deferred	95	0.8	111	0.9	12.5	0.1
Depressive	1605	12.9	1440	11.7	-9.3	-1.2
Disruptive Behavior	2151	17.3	1931	15.7	-9.2	-1.6
Other	1632	13.1	1941	15.8	20.6	2.7
Other Childhood	905	7.3	920	7.5	2.7	0.2
Psychotic	108	0.9	101	0.8	-11.1	-0.1
PTSD	861	6.9	902	7.4	7.2	0.5
Schizoaffective	25	0.2	12	0.1	-50.0	-0.1
Substance Related	297	2.4	205	1.7	-29.2	-0.7
Total	12429	100	12261	100.0		

Adults 18 years and older

	FY05-06		FY06-07		Percent Change	Absolute Change
	N	%	N	%		
Adjustment	711	3.6	703	3.5	-2.8	-0.1
Anxiety	386	2.0	440	2.2	10.0	0.2
Bipolar	4503	23.1	4933	24.4	5.6	1.3
Deferred	931	4.8	752	3.7	-22.9	-1.1
Dementia	103	0.5	101	0.5	0.0	0.0
Depressive	5807	29.8	6031	29.9	0.3	0.1
Other	675	3.5	755	3.7	5.7	0.2
Psychotic	3331	17.1	3289	16.3	-4.7	-0.8
PTSD	385	2.0	450	2.2	10.0	0.2
Schizoaffective	1644	8.4	1777	8.8	4.8	0.4
Substance Related	1017	5.2	956	4.7	-9.6	-0.5
Total	19,493	100.0	20187	100.0	0.0	0.0

Comments and Findings:

Retention Rates: The tables on pages 6-17 present information on the number of clients served and the corresponding retention rates for Adults and Children in Fiscal Years 2005-2006 and 2006-2007. The data are further categorized in terms of whether the outpatient service was considered intensive or not. Client utilization data were drawn from the MHP Information System. Although the data indicate that the MHP has evidenced lower levels of retention from 05-06 to 06-07, the data also demonstrate the unintended consequences of making a positive change in the recording of data. Specifically, in FY 06-07, providers began to indicate if services were provided over the phone, in the office, at home, etc. Therefore, we were able to define retention rate as including only those services that were delivered face-to-face (i.e., non phone). Because this field was not available in the FY05-06 data, the comparatively higher

retention rate likely reflects phone services being counted. It is, therefore, difficult to determine the meaning of the 06-07 data since there is no like comparison.

Penetration Rates: The tables on page 18 and 19 present information on the number of clients served and the corresponding penetration rates in Fiscal Years 2005-2006 and 2006-2007. Client utilization data were drawn from the MHP Information System, while the number of Medi-Cal Eligibles was provided to the MHP from the State Department of Social Services. Data on the "Total" line indicates that the MHP has been successful in slightly increasing the overall penetration rate during the two fiscal years by just over 4%.

Penetration data are also presented in terms of gender, age, race, and primary language. The data indicate that penetration rates maintain stability regardless of gender, age, or primary language. In terms of race, penetration rates decreased substantially for Amerasians. This finding is difficult to interpret because less than 50 of the 270,000 Medi-Cal eligibles identify as Amerasian, and very small changes in relatively small numbers become magnified. The absolute change is of questionable reliability.

Because no data regarding the diagnostic breakdown exists for Medi-Cal Eligibles, diagnosis data only reflect utilization. The data indicate here also that the diagnostic profile of clients in the MHP has remained relatively stable over the two fiscal years.

II. CAPACITY AND AVAILABILITY

Type of Provider Contracts

Organizational	FY 2005/2006	FY 2006/2007
Legal Entities	35	37
Physical Sites	92	92
Increase/(Decrease) from prior year (physical sites)	14	0
Network Providers		
Individual Providers	20	18
Physical Sites	N/A	N/A
Increase/(Decrease) from prior year	-13	-2

Geographic Distribution of Sites

Organizational Service Sites by Region	FY 2005/2006	FY 2006/2007
North	9	9
South	18	17
East	39	39
West	14	14
Out of County	12	12
Total	92	91

Comments:

Sacramento County is a county that is spread over a large geographic region and includes multiple cultural and ethnic populations living across all areas. The most recent State Department of Mental Health data indicates that Sacramento County has five threshold languages (Spanish, Russian, Vietnamese, Chinese, Hmong) with a variety of other languages below the threshold definition. The MHP, through its MediCal and grant funded programs has built both a geographically centered service system and given providers flexibility to work across these physical locations or sites. These locations may be clinics, the community or in-home settings. An example in the adult system of this flexibility is the highly successful AB2034 homeless programs for adult mentally ill clients where services are provided across the county. The Children's system of care works in school settings, community settings, in the home and in clinics demonstrating a great deal of flexible delivery capability. As the fiscal year ended five new Mental Health Service Act programs were implemented. These new programs, which

include three full service partnerships, add to this flexibility by providing services in the community and home. These MHSA programs started with sites in existing programs.

(See Appendix II or list of FY06-07 service sites. Bolded names in Appendix II are excluded from the numbers reported, as these are non-MediCal programs.)

Findings:

The Work Plan objective was to maintain geographic distribution of service delivery sites across the County care system. There was minimal change in service sites across regions for the period (92 in FY05-06 to 91 in FY06-07). Organizational providers working in multiple community settings in addition to their geographically listed provider sites primarily drive the Sacramento County MHP service delivery system. Therefore, these changes reflect efforts to provide services closer to where clients live reducing transportation barriers to service. Out of County services are not reflected fully due to the nature of placements and single, emergency agreements that the County executes to ensure that its beneficiaries are served across county jurisdiction. Special contracts and payment processes occur when clients are placed outside of the existing provider system or in another county. This is especially the case with Children's programs.

Enrolled network providers decreased slightly from 20 to 18 from FY05-06 to FY06-07. This reflects the MHP's continued reliance on organizational providers to provide services as these contractors have historically had ability to provide more flexible services than traditional clinic based enrolled network providers. The MHP did add one specialized ENP provider for the deaf client community.

III. Accessibility/Timeliness/Satisfaction of Services

The MHP tracks accessibility to services through a variety of activities, conducted by Quality Management staff through test calls, as well as monitoring activities by Contract Monitors and the Access Teams. Four areas are listed in this report: test calls, linkage to first appointments and beneficiary protection/problem resolution information. A separate effort to evaluate client satisfaction is performed by Research and Evaluation staff conducting targeted satisfaction studies. A list of these surveys is provided in this report.

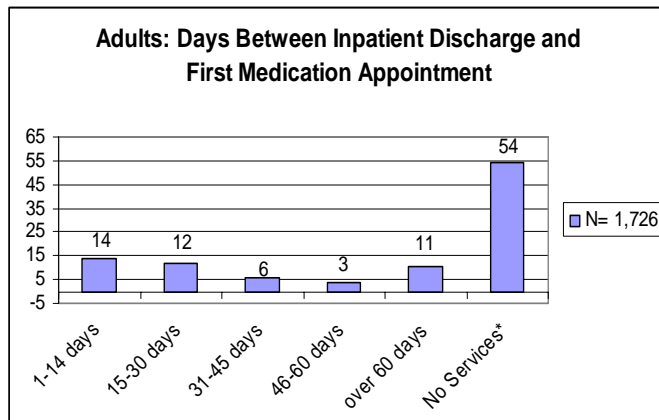
A. Test Calls and Training

As part of the efforts to test the accessibility to services and responsiveness of the system, Quality Management and Cultural Competence staff conducted test calls to all established Access entry points to the system. These test calls included the Mental Health Treatment Center Crisis Unit, the Adult Access Team and the Child and Family Access Teams. 34 calls were made in FY 06-07 compared to 39 calls in FY05-06. Calls for service were made in all the MHP's threshold languages. The threshold languages are Spanish, Hmong, Chinese, Russian and Vietnamese. Following the test calls, training and feedback was given to all providers seeking to improve cultural sensitivity and competency in fielding business hour and after-hour calls. The MHP has found an increasing comfort level on the part of staff to respond to non-English speakers with use of the AT&T Language line. The MHP continues its efforts to recruit bilingual staff at the entry point to the system.

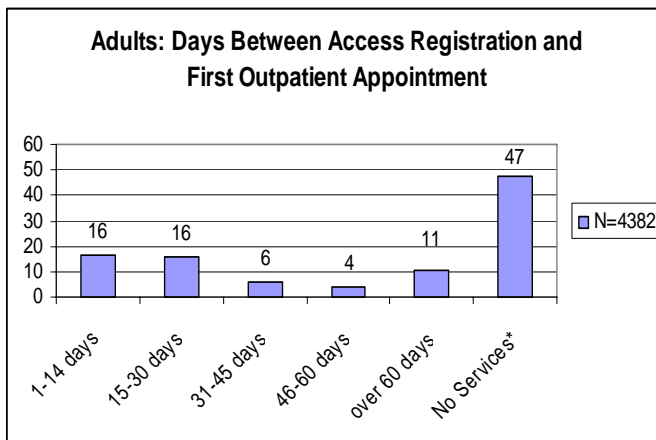
B. Access to Care

A second area monitored was access and timeliness of service delivery. The MHP has developed a “dashboard” to inform and monitor acute care, acute care return rates, and timeliness of service. This report is reviewed on a quarterly basis by the Quality Improvement Committee (QIC). The charts below show 2006-2007 data on time from referral point at the Access Team or Inpatient Stay to First Medication Service and First Outpatient Appointment.

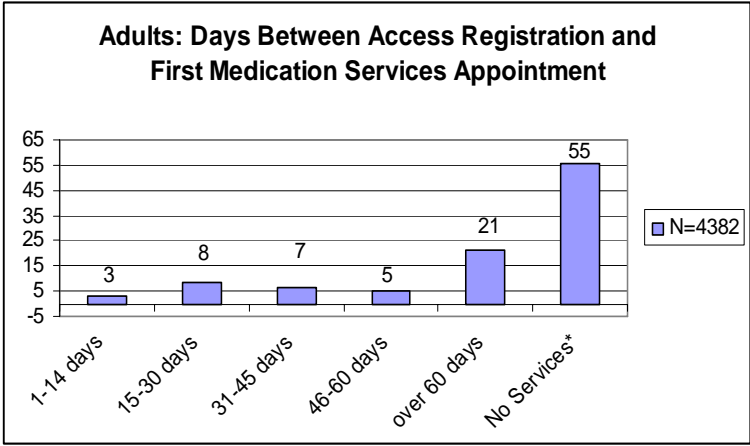
Adults:



- Most clients fall in the “No Services” category, wherein clients discharged from inpatient did not receive outpatient services as of September 30, 2007.
- For clients who did receive a medication service, the average number of days was 49.0 with a median of 28 days.

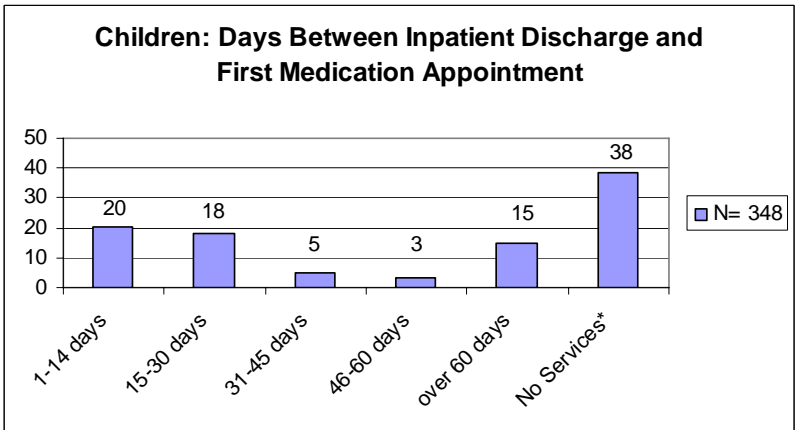


- Average number of days between Access registration and first outpatient was 47.2 days with a median of 23.

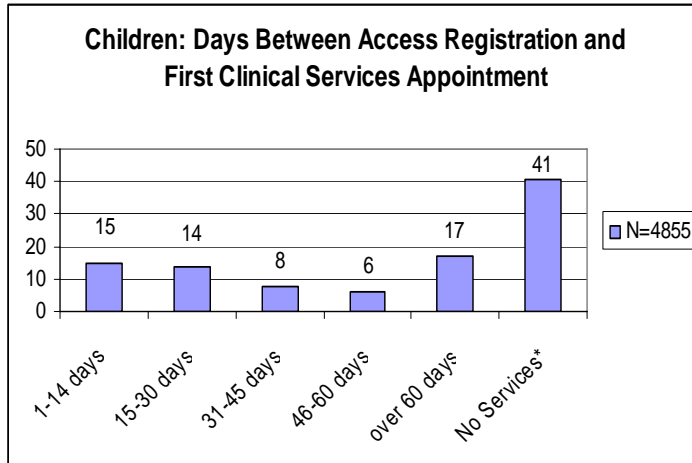


- Average number of days between Access registration and first medication appointment was 77.3 days with a median of 57 days.

Children:



- Average number of days between inpatient discharge and first medication appointment was 47.8 days with a median of 23 days.



- Average number of days between Access registration and first clinical appointment was 33 days with a median of 50 days.

Comments:

The MHP standard for linkage from inpatient care to outpatient care is for services to be initiated within 30 days of discharge from the psychiatric hospital. In the case of both adults and children, the median length of time to a medication appointment fell within that standard (28 days for adults and 23 days for children). The averages, however, did not (49 days for adults and 48 days for children).

At the close of the fiscal year, a new Mental Health Service Act (MHSA) program, Transitional Community Opportunities for Recovery and Engagement (TCORE), was opened with the function of providing transition psychiatric services to clients coming out of acute care settings. This program began providing intensive psychiatric services and serving as a “bridge” to the outpatient system in July, 2007.

This is the first time the MHP examined the time between registration with the Access Teams and first appointments. For adults, the data suggest that the average time to an intake appointment was 47 days with a median of 23. To see the psychiatrist for the first time, however, it took an average of 77 days (median of 57). The outpatient system continued to have significant difficulty in finding outpatient psychiatric coverage. Thus, it was possible to have service coordinators see clients within a reasonable timeframe but psychiatric evaluations were more difficult to schedule for these clients given competing demands for psychiatrist time.

There are times when appointments open up or are available due to cancellations sooner than planned or anticipated. Providers continue to make extraordinary efforts to rearrange schedules where possible to accommodate referrals and expedite care.

Findings:

Test calls have resulted in important training and improved skills at all entry points of the MHP. Access Teams and the after-hours clinical staff have increased their bilingual staff and comfort level in fielding non-English speaking requests for service.

C. Beneficiary Protection/Problem Resolution Information

The MHP Adult system is organized around geographic boundaries. While this system works to facilitate access through ease of location to clients served, unique reasons result in clients requesting to stay with the same provider. The MHP gives providers and the Access Teams appropriate latitude to consult, discuss and make exceptions for reasonable requests to stay with the same provider. Quality Management requires notification only for a Change of Provider driven by client request where an unusual circumstance is involved or a grievance needs to be considered.

Annual Problem Resolution Summary/Analysis Report						
Category	Adults		Children		Total	
	05-06	06-07	05-06	06-07	05-06	06-07
Grievances	342	313	15	15	357	328
Standard Appeal	1	0	2	3	3	3
Expedited Appeal	0	0	0	0	0	0
Fair Hearings	1	3	2	0	3	3
Total	344	316	19	18	363	334

Comments:

Grievances

Adult System of Care:

The majority of Adult grievances involved a change of provider. The majority of those requests involved clients returning to services and requesting to return to a previous provider despite their location. Transportation accounted for second most prevalent issue for requesting a change of provider. Dissatisfaction with services as the reason for requesting a new provider was the third most prevalent issue. Dissatisfaction issues ranged from general, nonspecific, to issues related to the physician prescribing practices. No trends were noted.

Medication issues remain the majority and most significant issue in the category, Quality of Care. The primary concern reported that the client would be out of medication before the scheduled medication appointment. This was the case for new clients into the system as well

as established clients with a provider. In some cases, the client had missed scheduled medication appointments but for a significant number of clients the next available medication appointment meant they would run out of medications.

Reports that the Personal Service Coordinator (PSC) does not return client calls in a timely manner (often reported to be 2 weeks if at all) was the second most often reported issue categorized as a Quality of Care issue. It is noted, that as a result of investigating these reports, the lack of a return phone call resulted in a medication issue. Clients, who were calling their PSC to schedule a medication appointment but were unable to reach them, reported various medication issues. These issues ranged from filling medications at local pharmacies to actually being out of medications.

Child System of Care

Grievances related to the Child System of Care were not significant to a specific issue. A few concerns were reported concerning the planned closure of a specific school program. Specific referrals to other programs had not been determined at that time. All children were referred prior to the closure of that program. Change of Provider requests reflected preference rather than dissatisfaction with a provider. Preference relate to geographic location, agency, and specific program choices expressed by parent or caregiver. The MHP tries to honor all requests or provide alternatives.

Appeals

The Child System of Care had three standard appeals. The appeals relate to services ending due to improvements made by the client resulting in the client no longer meeting criteria for ongoing services. Parents expressed concern that without services the improvements might not endure. Appropriate referrals were made to the satisfaction of client and family.

The sole Adult Appeal did not qualify as a reportable denial as it involved a client who was denied a requested medication by his psychiatrist. There were no expedited appeals.

State Fair Hearings

Three State Fair Hearing (SFH) were filed during 06-07 reporting period. Two of the filings were in response to a Notice of Action (NOA) issued by Adult Access as a result of a miscommunication between Adult Access and a provider. Both were resolved quickly without a SFH. One SFH request was heard by the Administrative Law Judge and was found to be “not a jurisdictional issue” and resolved in favor of the County.

Provider Annual Problem Resolution Summary/Analysis Report

July 1, 2006 – June 30, 2007

Issue Category	Adults		Children		Total	
	05-06	06-07	05-06	06-07	05-06	06-07
Quality of Care	43	77	8	5	51	82
Confidentiality	1	0	1	0	2	0
ACCESS	0	3	2	3	2	6
Change of Provider*	186	150	0	3	186	153
Facility Operations	0	0	0	0	0	0
Other	112	86	0	7	112	93
Total	342	316	11	18	353	334

* Requests are handled according to the MHP guidelines honoring the client preference of internal providers and managed appropriately by the provider

The MHP values providers' responsiveness to client feedback at the agency level. Each agency submits an annual report regarding areas that were resolved. The MHP compiles all informal reports in the above areas.

Comments:

The most common area of concern reported involved the issue of Quality of Care. The most prominent issues related to physician availability and delays in obtaining medications. Prolonged response time to return telephone calls, difficulty getting appointments, and length of wait time for appointments and access to services after hours was among the most significant complaints. Staff conduct and lack of communication or miscommunications were among other noteworthy issues.

Provider agencies are implementing strategies to improve the quality of services provided to their clients. Such actions include, but are not limited to: mandatory staff training targeting customer service, confidentiality, case management, and quick response to after hour's coverage; coaching and supervision of staff to improve communications between staff and clients; case staffings; hiring new staff, development of new policies and procedures; and increase the use of client and family advocates.

Findings:

The Adult System of Care remains seriously impacted with capacity issues and physician shortage issues. Despite limited resources, providers continue to explore alternative processes to provide quality services. In an effort to meet the ever increasing census demand, providers offer, whenever possible, physician appointments during evening and Saturday hours. The MHSA development of TCORE and other Full Service Partnership programs also addresses these impactation issues.

With Medicare D and other insurance related changes, clients and staff have had to learn new information and advocate more forcefully.

D. Satisfaction Reports

The MHP monitors satisfaction from a variety of perspectives in order to ensure that service is being offered in a timely and appropriate fashion. Reports are provided to the Quality Improvement Committee, which deliberates the results and provides input to the system.

Depending on the point of the system being addressed, reports are produced on a bi-annual, annual, semi-annual, quarterly, or monthly basis. The table below indicates the point of the system being assessed, the specific measure utilized, the frequency of reports back to the MHP, and the targeted respondents.

Point of System	Measure	Report Frequency	Respondents
Points of Access	Access Team Satisfaction Survey	Annual	Clients interacting with the MHP Access Team
	CalWORKs Team	Quarterly	Clients receiving services from the CalWORKs Clinical Team
Acute Care	MERT (children's crisis services)	Monthly	Children and youth receiving crisis stabilization services
	Adult Crisis	Monthly	Adults receiving crisis stabilization services
	Adult Inpatient	Monthly	Adults who have been hospitalized
Outpatient Care	MHSIP	Semi-Annual	Adults receiving outpatient services
	YSS	Semi-Annual	Children and youth receiving outpatient services
	YSS-F	Semi-Annual	Caregivers of children and youth receiving outpatient services
Mental Health Services Providers	Organizational Contract Providers	Bi-Annual	Executive Directors and Clinical Directors of Organizational Contracted Providers
	Network Providers	Bi-Annual	Individually contracted network providers
	Hospitals	Bi-Annual	QM contact of Hospitals that contract with the MHP

The MHP has targeted three items on each of the Outpatient Care Satisfaction surveys (MHSIP, YSS and YSS-F) for improvement. The tables below present the data gathered in May 2006 (FY05-06) and May 2007 (FY06-07). The data suggests that although there have been relatively small increases/decreases in some of the items, satisfaction in these domains has remained relatively stable.

		May 2006 (N=1576)		May 2007 (N=1621)	
MHSIP -- Adults		% agree	Average Score	% agree	Average Score
	Staff returned my calls within 24 hours	74	3.95	74	3.94
	I, not staff, decided my treatment goals	73	3.95	73	3.95
	I was encouraged to use consumer run programs	76	4.03	75	4.01
		May 2006 (N=91)		May 2007 (N=98)	
MHSIP -- Older Adults		% agree	Average Score	% agree	Average Score
	Staff returned my calls within 24 hours	79	4.05	81	4.09
	I, not staff, decided my treatment goals	80	4.04	87	4.27
	I was encouraged to use consumer run programs	70	3.91	72	4.07

		May 2006 (N=1120)		May 2007 (N=1050)	
YSS		% agree	Average Score	% agree	Average Score
	I helped choose my treatment goals	79	3.85	80	3.98
	I helped choose my services	61	3.43	63	3.57
	I got as much help as I needed	72	3.84	75	3.97
		May 2006 (N=1787)		May 2007 (N=1822)	
YSS -- F		% agree	Average Score	% agree	Average Score
	I helped choose my treatment goals	91	4.29	87	4.18
	I helped choose my services	86	4.12	84	4.07
	I got as much help as I needed	77	4.09	75	4.04

IV. EFFECTIVENESS OF CARE/CLINICAL ISSUES

The MHP has initiated a variety of programmatic and oversight efforts to continuously monitor the effectiveness of care and underlying clinical reviews. These activities are conducted through the Performance Improvement Projects (PIP), selected Clinical Practice Guidelines as well as through retrospective reviews of Adverse Incident Reviews and Medication Monitoring Reviews.

A. Medication Practice Guidelines

Medication Practice Guidelines were selected as the MHP makes efforts to develop a clinical decision tree across all adult mental health providers. Over FY05-06 and FY06-07, the Pharmacy & Therapeutics Committee and the Medication Monitoring Committees of the QIC worked to develop, test, retest and implement Medication Practice Guidelines for Depression and Schizophrenia. These guidelines are reviewed and refined annually. The MHP continues to dedicate significant attention to developing guidelines for prescribing practices across the large provider system and the clinical implications of their use. These efforts remain an important priority for effectiveness and quality of care.

Comments:

The Pharmacy & Therapeutics Committee within the Quality Improvement Committee brings psychiatrists together on a bi-monthly basis to review, discuss and comment on the medication practice guidelines. Training, new information and updates are disseminated effectively through this committee.

Finding:

Review of FY05-06 and FY06-07 indicates that while adherence to the guidelines has decreased, this may also be reflective of client choice and involvement in medication decisions made by psychiatrists. In all reviews, a clinical feedback loop is in place to engage and inform psychiatrist providing the care of the medication monitoring findings.

	# of Charts Reviewed*		Adherence to Guideline	
	05-06	06-07	05-06	06-07
Major Depression	29	29	25	25
Schizophrenia	6	10	5	6

*Sample is a subset of the charts reviewed for medication monitoring with a focus on the diagnostic categories targeted for guidelines

B. Adverse Incident Reviews

Contract providers throughout the system submit Adverse Incident Reports to the MHP, both to Program Monitors and to Quality Management, whenever a sentinel incident occurs. A sentinel incident involves a client or a staff person and includes: death (for e.g. suicide or homicide), suicidal attempt, sexual harassment, infractions of patient's rights, serious medication side effects, likelihood of litigation, possibility of media coverage, falsification of professional credentials, and facility fire. Quality Management reviews all these reports. The Executive Committee reviews all reports of suicide or death when the cause is undetermined, and reports that suggests a trend or pattern of issues of concern. If, at any level of review, there is noted a need for improvement, feedback is given to the provider either through a meeting and/or in writing with a request for a plan of correction. All actions are tracked, reviewed and monitored by the Manager of Quality Management on behalf of the Executive Committee of the Quality Improvement Committee. Below is the FY05-06 and FY06-07 Adverse Incident and reported death information received by Quality Management.

	FY 05-06	FY 06-07	(+/-)
Adult	164	157	-7
Child	36	42	6
Total	200	199	-1

**QUALITY IMPROVEMENT COMMITTEE
INFORMATION RELATED TO DEATHS REPORTED TO MHP**

		FY 2004-2005	FY 2005-2006	FY 2006-2007
CAUSE OF DEATH	Natural	28	11	15
	Suicide	08	08	09
	Unknown	31	34	41
AGE				
	0-17	01	00	00
	18-24	02	00	00
	25-45	26	20	23
	46-59	28	25	30
	60+	10	08	12
DIAGNOSIS				
	Major Depression	11	16	17
	Bipolar	19	11	21
	Schizophrenia	28	23	26
	Other	09	03	01
PROGRAM				
	RST's	56	38	43
	Homeless	01	07	08
	Intensive	04	02	07
	Other	06	06	07
TOTALS		67	53	65

Comments:

Overall, there was very little change in number of Adverse Incident Reports from FY05-06 to FY06-07. Adult reports decreased by 7 while Child reports increased by 6. The Quality Management Program Manager reviewed all reports. The Quality Improvement Committee's Executive Committee reviewed all instances where deaths occurred from medical/psychiatric as well as clinical/community care perspective. Deaths by natural cause increased from 11 to 15 from FY05-06 to FY06-07. This represents a slight change in percentage for the period (21% of reported deaths in FY05-06 vs. 23% in FY06-07). Suicides increased by one from 8 to 9 during the period but dropped in percentage (15% of reported deaths for FY05-06 vs. 14% for FY06-07). Deaths due to unknown causes increased from 34 to 41.

Feedback regarding corrective actions or whether care provided was within community standards was evaluated for quality assurance purposes. The greatest challenge for clients with medical and psychiatric issues is the difficulty in accessing timely preventive care for health conditions. Adult incident reports have remained significant but it is noted that this is partly attributable to an increase in services being provided in the community by adult programs with homeless and intensive service clients. This flexible delivery has also resulted in increased knowledge of client difficulties in living independently in the community.

Executive QIC conducted a separate review to evaluate whether the increase in physical health complications and the lack of physical health resources was a significant contributor to this increase. Reporting of adverse incidents continues to reflect appropriate internal quality oversight by the MHP's contractors.

Findings:

Overall, adverse incident reporting from FY05-06 to FY06-07 decreased by one report. These reports span many different types of occurrences in the community care continuum and reflect caution taken by providers to report any areas of concern. In both years, medical causes remain significant as contributing factors to deaths. While suicide is confirmed in few cases, unknown causes and pending coroner's reports remain a significant number of reports. This again reflects the difficulty in conclusive information regarding client deaths in the community. The MHP continues to review possible factors to develop preventive programs in the community that strengthen collaboration to benefit clients and do whatever is possible to prevent untimely deaths.

C. Medication Monitoring Reviews

Charts across adult and children's providers are reviewed and monitored for medication practices on a monthly schedule. Feedback is provided to providers on any area of concern identified by the medication monitoring reviews. Below is the FY05-06 and FY06-07 medication review information:

	FY 2005-2006	FY 2006-2007
Charts Reviewed		
Adult Program	686	688
Children's Program	288	229
Treatment Center Inpatient/Crisis	269/153	287/153
Jails	105	111
TOTAL Charts Reviewed	1501	1468
Number of Corrective Actions		
Adult Program	5	9
Children's Program	13	13
Treatment Center-Inpatient/Crisis	5/0	11/1
Jail	1	3
Total Corrective Actions	24	37

Comments:

The Medication Monitoring Committee reviewed a variety of Adult and Children's program charts and provides timely feedback to providers. Close attention was given to review of charts of clients served at the Crisis Unit and follow-up at the MHTC inpatient care, as well as to polypharmacy issues, reviews of treatment guidelines and laboratory work. Laboratory guidelines and panels were developed to aid physicians in ordering labs. The Pharmacy & Therapeutics Committee has taken an active role in enhancing communication between Medical Directors and the clinics in analyzing the findings of the medication monitoring efforts.

Findings:

The number of charts reviewed in FY05-06 and FY06-07 remained the same range of sampling. Corrective actions spread across adult and children's providers demonstrating that the feedback loop from the Medication Monitoring efforts is reaching all service providers. There were slight increases in the number of corrective actions for adult services, the MHTC, and the Jail reviews. Corrective actions for Children care remained the same at 13. Dialogue and discussion on areas for improvement that is taking place at the Pharmacy & Therapeutics Committee is helpful to the system. Polypharmacy appears to be decreasing, which may be due to the increased implementation of the Medication Treatment Guidelines.

V. Utilization Review/Utilization Management

Utilization Review

The MHP's Utilization Review activities are performed by the MHP Utilization Review Committee (URC) and by contract providers conducting monthly internal reviews and submitting reports to Quality Management. The URC (referred to in the chart as "External" Review) conducts three reviews each month (e.g. Adults and Children's Review) as well as on-going focused reviews of specific types of services when warranted based on clinical or programmatic need. Contract providers' reviews are referred to in the chart as ("Internal" Review). Some special reviews are for technical assistance to assist new providers and others are conducted for quality improvement or compliance purposes. The URC provides feedback to contract providers through a feedback tool referred to as a Multiuse Complete Feedback Loop (i.e., the "McFloop".) Providers respond with corrections and utilize the information for internal training to improve their service delivery and record keeping of clinical services.

The purpose of the Utilization Review Process is to:

- Evaluate the medical necessity of services rendered to clients
- Verify that the services billed are substantiated by the medical record, and
- Evaluate the quality of care provided

Issues reviewed include collaboration, coordination of care, cultural/language accommodation, diagnostic consistency, appropriateness of care, and documentation of services.

The UR committee's goal is to review a minimum of 5% of the total number of non-duplicated clients open to the system. Projections of the amount of charts to be reviewed each year are based on the number of clients served the previous fiscal year.

According to the Client Activity and Tracking System (CATS), there were 31,713 clients [11670 Children / 20013 Adults] served between July 1, 2006 and June 30, 2007. Hence, the minimum number of charts that should have been reviewed in Fiscal year 2006-2007 was 1586 (5%).

In fiscal year 2006-2007, a total of 3,053 (9.63%) non-duplicated charts were reviewed (885 externally, and 2,168 internally). Of the 885 externally reviewed charts, 279 were Adult charts, 606 were Children's charts. *

The projected goal for FY 2007 - 2008 is to review a minimum of 1586 charts (144 per month excluding December) to meet our 5% requirement. The goal is based on 31,713 clients being served in FY 2006-2007 [11,670 Children / 20,013 Adults].

In addition to outpatient reviews, Quality Management staff also review charts for services provided in the inpatient setting and at the jail psychiatric services. In the 2006-2007 period, 100% of all inpatient cases (n=1022) were retrospectively reviewed and authorized for payment and documentation standards. At the Mental Health Treatment Center's Crisis Unit, 60 charts were reviewed. In addition, a total of 124 charts were reviewed for documentation and care practices at the county jail. Quality Management serves as the external review process for jail psychiatric services.

A total of 4259 cases were reviewed across all parts of MHP care (over 13%). This excludes targeted reviews by program monitors or other Executive QI processes to oversight client care.

**Additionally, internal reviews conducted by EPSDT providers account for significantly additional oversight activities. However, data is not available to quantify these efforts.*

UTILIZATION REVIEW ANNUAL REPORT FINDINGS 2006/2007

AREAS OF REVIEW	FY 05/06		FY 06/07	
Total Number of Registrants in CATS	23,210		31,713	
Adults	13,842		20,013	
Children	9,368		11,670	
# of Clients constituting 5% of Total	1,160		1586	
Total # of Clients reviewed	3,535	14.4%	3,053	9.63%
Non Duplicate Charts Reviewed	FY 05/06		FY 06/07	
External Adults (County UR)	307		279	
External Children (County UR)	824		606	
External Total (County UR)	1,131		885	
Internal Total (Within Agencies)	2,222		2,168	
Total # of Clients reviewed	3,353		3,053	
External Duplicate* Charts Reviewed	FY 05/06		FY 06/07	
Adult County UR	563	31.4%	411	31%
Children's County UR	1,229	69%	917	69%
Total Duplicate Charts Reviewed	1,792		1,328	100%
<i>*Duplicate Charts: If a client is enrolled in more than one agency, each agency's chart would be reviewed (i.e. example if a client is receiving services from five agencies, all five charts would be reviewed at the external UR and potentially result in five different McFloop reports to each agency). For the purpose of this report, more than one chart associated with the same client is considered a "duplicate".</i>				
Medical Necessity and Diagnosis	FY 05/06		FY 06/07	
Medical Necessity not met	11	.6%	23	1.7%
No ICD-9 code	45	2.5%	91	6.9%
Primary Diagnosis Missing	24	1.3%	33	2.5%
Treatment Planning	FY 05/06		FY 06/07	
No ACP	38	2.1%	25	1.9%
No R&R	44	2.5%	12	.9%
Incomplete ACP/R&R	233	13%	94	7.0%
No AMSP	97	5.4%	40	3.0%
Incomplete AMSP	112	6.3%	36	2.7%
Goals Not Measurable/Quantifiable	82	4.6%	115	8.7%
Goals, Symptoms, Diagnosis, & Interventions Incongruent	87	4.9%	76	5.7%
Risk Factors & Special Status Situation not addressed	42	2.3%	83	6.2%
No Client Signature on ACP/R&R/w/o explanation	69	3.9%	55	4.0%
No Caregiver/Significant Support Persons' Signature on ACP/R&R	44	2.5%	34	2.6%
Staff signature/co-signature/title missing from plan	61	3.4%	39	2.9%
No indication of Coordination of Care	52	2.9%	127	9.6%

Progress Notes	FY 05/06		FY 06/07	
Missing Progress Notes (billed to CATS but not in chart)	343	19.1%	315	23.7%
Over billing (i.e. Duplicate billing, excessive billing)	71	4.0%	64	4.8%
Using Incorrect Billing Codes	66	3.7%	58	4.4%
Group Billing Formula Errors	9	.5%	12	.90%
Billed during a lockout	7	.4%	3	.23%
Billed non-billable service	48	2.7%	46	3.5%
Billed for Transportation	2	.1%	2	.15%
Billed for No-Show	1	.06%	3	.23%
Staff Signature/Co-Signature/Title Missing or Late	33	1.8%	55	4.1%
Staff operated outside their scope of practice	11	0.6%	7	.53%
General Billing & Documentation Errors **	224	12.5%	340	25.6%
<i>**I.e. Data entry error; unclear billing; incorrect date; rubberstamped; 2nd staff not justified; incomplete progress note; billing not substantiated by note; no Clinical Intro note; No note every 4 hours at MHTC; etc.</i>				
ACCESS Authorization	FY 05/06		FY 06/07	
No current MSO was found in the chart	61	3.4%	44	3.3%
Authorization Dates on ACP/R&R were missing or incorrect	72	4.0%	89	6.7%
Billed outside of Authorization period	3	.2%	15	1.1%
Missing Documentation	FY 05/06		FY 06/07	
HQ/HQ Update was Missing	165	9.2%	48	3.6
CDS Missing	48	2.7%	33	2.5
Consents Missing (I.e. Informed Consent; Medication Consent; HIPAA forms)	56	3.1%	95	7.2
Miscellaneous Findings	FY 05/06		FY 06/07	
Member Handbook/Problem resolution/Guide not given/reviewed	53	3.0%	56	4.2
No Linkage to physical health or other service	18	1.0%	57	4.3
Breaches of Confidentiality	14	.8%	15	1.1
Inpatient Hospital Reviews	FY 05/06		FY 06/07	
MediCal Adults	42		126	
MediCal Children	492		530	
MediCal Total	534		656	
Short Doyle	145		366	
Other Psychiatric Services Chart Review	FY 05/06		FY 06/07	
MHTC Crisis Unit			60	
Jail Inpatient	56		61	
Jail Outpatient	75		63	
Total	131		184	

(Due to limitations of the data tracking system and other data gathering difficulties, the above information is only applicable to the External Reviews (County UR). It does not include Internal Reviews (conducted by providers).

Comments:

On-going reviews are an effective method of monitoring quality of care and providing feedback to improve the quality of service delivery. Reviews have also identified areas for training needs. Training on the MHP Documentation Standards typically incorporates this information. Most findings in a review fall into three major categories: Disallowance (due to over-billing); Compliance (a chart did not comply with State and/or Federal regulations); or Quality of Care (corrective action would improve quality of care to the client/family).

Three significant observations are noted below regarding the data presented above:

- Some areas of review are too broad and data captured includes several elements of review. For example: Diagnosis Missing, Incomplete or Incorrect. There are too many variables to benchmark a measurable correction strategy.
- Due to the variability in the experience of reviewers conducting the reviews, some elements of data reported above are not truly measurable or reliable. Utilization Review feedback is only as valid or accurate as the reviewer who provided the feedback.
- The data is reflective of a small proportion of the total number of charts reviewed. This data has value because it comes from only the County facilitated UR where all reviewers have the same level of clinical qualifications in the MHP.
- The data regarding late Reassessments & Reauthorizations (R&Rs) is from a small sample and is not tied back to the Access authorization system. Thus, it may or may not reflect the actual practices in the system.

Findings:

In FY 05-06, Quality Management utilized existing data to set baseline measures for improvement in four areas with information collected at County Utilization Review. In FY06-07, improvements were seen in one of the four areas listed below:

- 1) Increase in percentage of cases without an ICD-9 code: FY 05-06 Baseline Measure: 2.5%; FY 06-07: 6.9%; Acceptable Error rate = 0%
Note: Most ICD-9 and DSM IV codes are the same. However, this increase may reflect a failure to document ICD-9 codes in all parts of the case record.
- 2) Increase in percentage of Missing Notes: FY 05-06 Baseline Measure: 19.1%; FY 06-07: 23.7%; Acceptable Error rate = 0%
Note: Late filing of notes into the case record not accounted by this increase.
- 3) Reduction in percentage of Missing, Incomplete or Late Health Questionnaire Updates: FY 05-06 Baseline Measure: 9.2%; FY 06-07: 3.6%. Acceptable Error rate = 0%.
- 4) Increase in percentage of cases with failure to provide clients with problem resolution information: from Baseline FY 05-06: 3.0%; FY 06-07: 4.2%. Acceptable Error rate = 0%.

Utilization Management:

The MHP's Utilization Management is conducted at selected administrative control points. The Adult Access Team and the Child & Family Access Team provide centralized entry points to the MHP service system. The Crisis Unit at the Mental Health Treatment Center (MHTC) also is an access point but does not require any pre-authorization. Inpatient hospitalization in the private hospitals is retrospectively reviewed and authorized through a unit of licensed staff embedded in the Quality Management. Problem resolution staff as part of resolution of issues brought to their attention also reviews utilization of services from this unique role. Utilization management takes place from the vantage point of authorization, satisfaction, and provider appeals.

The Access Teams are comprised of licensed or "waivered/registered" mental health staff, which authorizes treatment based on the clinical information available. Authorizations are based on Medical Necessity criteria. Written notices are sent to MediCal beneficiaries for any denial, reduction or termination of service or denial of payment. Notices of Action (NOAs) are required to be sent whenever such actions are taken by the MHP. Effective July 1, 2004, new managed care regulations required MHPs to utilize additional Notices of Action (NOA-C) for denial of payment, for timeliness of processing grievances (NOA-D), and timeliness of services (NOA-E) if the MHP has a standard of measuring such timeliness.

During Fiscal Year 2006-2007, the Adult Access Team sent 7 Notices of Actions for denial of services. The Children's Access Team issued 19 Notices of Actions. See Appendix III for description of Notice of Action (NOA.) The licensed Program Coordinators responsible for the Access Teams reviewed all denials before the action was taken.

Notice of Actions		
	FY 05-06	FY 06-07
NOA-A		
Adult	11	7
Child	16	19
NOA-B		
Adult	60	60
Child	110	99
NOA-C		
Adult-Inpatient	28	24
Child-Inpatient	8	12
NOA-D (Delayed Grievance)		
Adult	0	0
Child	0	0
Total NOA's Issued	267	221

Comments:

The MHP provides consistent authorization since standardized authorizations are packaged for the level of care. For instance, a client requiring the services of an adult outpatient program is authorized for one year of treatment. A child receiving standard outpatient services is authorized for one year of treatment in a Children's program. Reauthorization and Reassessment is required for additional services.

Timeliness of urgent care is not an issue, since the MHP does not require preauthorization for urgent care services.

The Quality Management Section of the Division of Mental Health has the responsibility for establishing policies and procedures concerning Utilization Management. These policies and procedures are communicated to providers in written form, and through the Quality Improvement Committee and provider meetings.

Findings:

The MHP has complied with the Managed Care regulations and provides consistent authorizations. Licensed and waived staff authorizes or denies services. The MHP notifies members when services are denied, reduced, or terminated. No delays occurred in resolution of grievances or appeals within the required timeline. The Children's System has a larger number of Notices of Action consistent with its larger size and levels of care. Inpatient hospital Notices of Action are a result of retrospective chart reviews, which occur after services are provided (post-service). The issuing of NOA is delineated by regulation. Significant increases in NOA-B for adult services were issued based on better understanding of the new requirements in FY04-05 but decreased in FY05-06. Numbers for NOA-B in FY06-07 remained nearly constant. NOA-C notices to inpatient hospitals for adult hospital professional services also increased in the first year of the requirement but decreased in FY05-06. In FY06-07 NOA-C notices decreased for Adults and increased for Children. It is noted that no NOA-D for delayed problem resolution activities were needed as all issues were addressed within the required timeframes.

VI. CONTINUITY AND COORDINATION OF CARE

Several efforts continue to expand and improve the continuity and coordination of care with physical health care providers. Geographic Managed Care (GMC) providers (Kaiser, Western Health Advantage, Health Net and Molina) provide services for many beneficiaries in Sacramento County. Efforts have continued to complete a Memorandum of Understanding between the MHP and each provider. A separate and important effort is also being made to recruit psychiatrists with training in family practice to provide more coordinated care for MHP clients.

Referrals tracked by the Adult Access Team track requests for service from primary care sources. In FY 06-07, the Adult Access Team received 188 referrals for mental health services from Primary Care. In FY05-06 193 referrals were received. While this appears to be a decrease in referrals, the location of dually board psychiatrists/internal medicine physicians has resulted in more access to psychiatric care at the Primary Care clinic reducing the referrals to Access. The increase also speaks to the outreach and education efforts by the MHP representative for appropriate referrals from partnering agencies. In FY06-07, only 3 referrals

were received from ADS services compared to the FY05-06 period when 57 referrals were received. This drop may reflect a large number of clients that do not identify where they were referred from. ADS issues frequently fall between physical health and mental health service systems. The Children's System has continued to work with pediatricians in the community to coordinate services and provide consultation. A pediatrician works through the Children and Adolescent Psychiatric Clinic (CAPS) to provide consultation for community primary care physicians when children step out of services with the MHP.

VII. CULTURAL COMPETENCE, EDUCATION AND TRAINING

Findings:

Total attendance numbers for Medi-Cal Technical Support and Clinical trainings offered within the Mental Health Plan increased significantly from 3482 for FY05-06 to 4340 for FY06-07. 2178 trainings were provided in the area of Cultural competency for the system in FY06-07. Elements of cultural competence are an integral aspect of all MHP trainings, and expansion of cultural competence knowledge and related skills are an on-going focal point.

Targeted training efforts offered by the Division of Mental Health in FY06-07 included the following:

- Numerous trainings, conferences and workshops focused on co-occurring (mental health and substance related issues) assessment, strategies and interventions, including a conference with nationally recognized trainers entitled "Changing the World: Developing Welcoming, Integrated Systems of Care", a conference with Mental Health and Alcohol and Drug Services entitled "A Shared Vision: Co-Occurring Recovery Empowerment", and "Integrating Mental Health and Substance Abuse Services". These trainings supported increased efforts towards cross training between mental health providers and alcohol and drug services programs;
- Co-Occurring Disorders Case Conferences were held monthly for both the Adult and Children's System of Care – facilitators include physicians partnering with mental health and alcohol and drug staff. A Co-Occurring Disorders Case Conference including domestic violence is held quarterly;
- SacPORT (PsychoSocial Rehabilitation Training) teaches staff implementers and Consumers rehabilitation skill building and group facilitation;
- Consumer focused training included the annual "Consumer Speaks Conference", "Group Facilitator Workshop: Wellness, Recovery and Peer Support", and "WRAP (Wellness and Recovery Action Plan) Training";
- Clinical and administrative staff received training in changes to the Client Service Information (CSI) data sheet, including staff responsible for entering billing information into the electronic

data system in addition to clinical staff, highlighting changes to requirements as well as procedural elements;

- CPS and APS Mandated Reporter Training was offered for the Adult and Children’s System of Care in addition to Alcohol and Drug Services staff in cross-training efforts, focusing on risk assessment and mandated reporting requirements;
- Co-sponsorship of topics and events of interest to MHP service providers included *Trading Secrets*, an annual conference collaborative with UCDMC, probation, CPS, mental health, alcohol and drug services and other invested parties;
- Additional specialized training included “Cognitive Behavioral Therapy” (CBT) sponsored by UCDMC for clinicians, “Problem Gambling and Older Adults” training offered through a state technical assistance program, “ADHD and Bipolar Disorders”, “Pediatric Mental Health for Primary Care Physicians”, “Psychological Testing 101”, “Diagnostic Classifications 0-3R”, and “Workplace Response to Domestic Violence” with various community partners;
- Technical support offered through the email system has expanded and supplemented the face to face Documentation Training provided by MHP, with the QM Information link. This area has seen significant growth and opportunity for the MHP providers to receive timely responses to their inquiries, and additional consultation as needed. It has also supported the EPSDT providers through the high volume of audits. Targeted technical assistance has been provided to assist MHP providers in clinical documentation areas;
- The Compliance Program training continues for county and provider staff, and a refresher course has been developed that attendees can take on-line, including an exam.

A list of the various training sessions can be found in the Appendix IV.

NAME OF TRAINING	TARGET AUDIENCE	NUMBER OF ATTENDEES	
		2005/2006	2006/2007
Medi-Cal Technical Support and Clinical Training Totals	Adult and Children Mental Health providers, county staff	3482	4340
Cultural Competency Training Totals Includes "Integrating Core Principles of Cultural Competence into Service Delivery" and "Use of Interpreters in MH Settings"	Adult and Children Mental Health providers, county staff	2724	2178
Consumer Recovery & SacPORT (Psychosocial Options for Recovery Training) Includes "Consumer Speaks Conference"; Group Facilitator Workshop-Wellness, Recovery, Peer Support; WRAP (Wellness and Recovery Action Plan) training; psychosocial rehabilitation training with group implementation.	Adult Mental Health provider service staff and Consumers	349 (SacPORT #'s only)	994
Co-Occurring Disorders Case Conferences and related Training, Conferences and Workshops	Children and Adult Mental Health providers, Alcohol & Drug Division providers, county staff and partnering agencies	428	936
Documentation Training Including Chart Documentation, Medi-Cal Billing/Treatment Codes, Utilization Review, Balancing Clinical Care and Compliance, Staff Qualifications, and Site Certification	Adult and Children's Mental Health direct service and supervisory staff	501	751
Other Clinical Training Including APS and CPS Mandated Reporter Training, CBT, ADHD and Bipolar Disorders, Problem Gambling and Older Adults, Workplace Response to Domestic Violence, Pediatric Mental Health for Primary Care Physicians, Psychological Testing 101, Trading Secrets Conference, Diagnostic Classification 0-3R, and various webcasts	Adult and Children Mental Health providers, county staff and community partners	New Category	704
Managed Care Regulatory Changes Includes Compliance Training Program and Beneficiary Protection: Problem Resolution/Advance Medical Directives	Adult and Children's Mental Health direct service and supervisory staff	118	466
CATS Training Update for Client Service Information (CSI) Data Changes	Adult and Children's Mental Health service Staff	294	175
Core Skills Training Series Includes Orientation to the Mental Health Plan, Confidentiality, Ethics and Boundaries, Risk Assessment, DSM-IV and Mental Status Exam, and Strength-Based Treatment/Service Planning	Paraprofessional staff from the Mental Health Adult System of Care	157	118
5150 Certification Training Overview of the LPS Act, patient's rights, confidentiality, completing the 5150 application, and other relevant issues related to 5150 authority	Child and Adult Mental Health providers, hospital emergency room staff, and mobile crisis team members	98	116

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APPENDIX I

QUALITY MANAGEMENT PROGRAM

ANNUAL WORK PLAN
July 1, 2006 to June 30, 2007

SCOPE	<u>OBJECTIVES</u>	PLANNED ACTIVITY	RESPONSIBLE PARTY	DUE DATE
1. Cultural Competence	<ul style="list-style-type: none"> • Evaluate changes in capacity of service delivery • Increase the penetration rate in underserved populations by 1.5% over previous year as measured for <ul style="list-style-type: none"> • ethnicity • language • age • <i>Increase the retention rate in underserved populations:</i> <ol style="list-style-type: none"> 1) Retention rates in all ethnic groups will be at least 53% over a two year period. 2) Retention rates by primary language for adult consumers will be retained by at least 50% over a two year period. 3) Retention rates by primary language for all children and youth will be retained by at least 77% over a two year period. 	<ul style="list-style-type: none"> • Track/trend utilization and penetration rates by: age, diagnosis, gender, ethnicity, and primary language. • <i>Adult Client Retention Rate:</i> Clients are considered “retained” if they had their first non-crisis outpatient visit during a fiscal year, and had at least two more outpatient visits in the following six month period. • <i>Child/Youth Retention Rate:</i> Clients are considered “retained” if they had their first non-crisis outpatient visit during a fiscal year, and had two more outpatient visits in the following four week period. • Complete the annual Human Resources Survey 	Research & Evaluation and Ethnic Services Staff	Annual report to QIC

<p>Cultural Competence Cont'd</p>	<ul style="list-style-type: none"> • Increase the percentage of direct service staff by 5% annually to reflect the racial and ethnic makeup of the communities speaking threshold languages until the proportion of direct service staff equals the proportion of Medi-Cal beneficiaries. • Determine whether client outcomes are equivalent regardless of ethnic group or primary language • Ensure MHP progress in the delivery of culturally competent services through the biennial completion and analysis of a system-wide Cultural Competence Agency Self Assessment. • Ensure agency progression towards cultural competency. 	<ul style="list-style-type: none"> • Track/trend satisfaction through translated surveys and/or analyze by primary language of consumers. Compare to level of satisfaction of MHP members in general. • Collect self-assessment data and set goals based on information • Continue incorporation of cultural competency skill sets within all training/education opportunities. 		
<p>2.Accessibility</p>	<ul style="list-style-type: none"> • Maintain service delivery sites across county care system through a variety of contracts with organizational and enrolled network providers • Monitor responsiveness of 24-hour telephone access to meet statewide standard for timeliness, responsiveness and cultural competence. • Establish mechanisms to monitor access to mental health services. 	<ul style="list-style-type: none"> • Annual report on changes in numbers of organizational and enrolled network providers from previous year • Quality Management to conduct year round tests of 24 hour call line and MHP follow-up system. • For appointments following inpatient services at MHTC, MHP standard of care is for clients to be seen by MD within 30 days of 	<p>QM</p> <p>Research & Evaluation, QM</p>	<p>Report to QIC by August 31, 2007</p> <p>Report to QIC by August</p>

<p>Accessibility Cont'd</p>		<p>discharge from inpatient hospitalization</p> <ul style="list-style-type: none"> • For appointments following inpatient services for clients under 18, MHP standard of care is for clients to be seen by MD within 30 days of discharge from inpatient hospitalization <p><i>Data to be Collected to Establish Standards for the Next Workplan</i></p> <ul style="list-style-type: none"> • For outpatient linkage to a Children's provider from the first Access Team contact to the first outpatient service in Children's. • For outpatient linkage to a Children's provider from the first Access Team contact to the first medication appointment in Children's. • For outpatient linkage to an Adult provider from the first Access Team contact to the first outpatient service in Adults. • For outpatient linkage to an Adult provider from the first Access Team contact to the first medication appointment in Adults. 		<p>31, 2007</p>
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<p>3. Satisfaction</p>	<p>Evaluate consumer satisfaction</p> <ul style="list-style-type: none"> • Monitor and assess consumer satisfaction. <ul style="list-style-type: none"> • Monitor Problem Resolution process. 	<ul style="list-style-type: none"> • Administer and analyze State required and local/program specific satisfaction surveys. • MHP goal for return of State required satisfaction surveys is 80% • MHP goal for consumer satisfaction is to target specific items on State required satisfaction surveys for improvement (see Attachments. Adults: Items 6, 17 and 20; Children: Items 2, 3, and 11) • Inform providers/practitioners of results through publication of satisfaction survey results system wide. • Track, trend and analyze grievance and State Fair Hearings. 	<p>Practitioners/ Providers & Research</p> <p>QM</p>	<p>Semi-Annual Report to QIC</p> <p>Annual report to QIC</p>
<p>4. Effectiveness of Care/ Clinical Issues</p>	<ul style="list-style-type: none"> • Identify potential occurrences of poor quality care. • Evaluate information produced through monthly adult and child clinical chart reviews. 	<ul style="list-style-type: none"> • Continue QIC Executive Committee Review of adverse incidents, identifying issues, including cultural competence considerations, requesting and reviewing plans of correction. • Reduce error rates in the following categories based on FY04-05 report: <ul style="list-style-type: none"> • No ICD-9 code (Baseline 6.1%; Acceptable Error Rate: 0%). • No Client/Caregiver Signature on Plan 	<p>EQIC and appropriate QIC sub-committees</p> <p>QM/UR subcommittee on UR</p>	<p>Report as needed to QIC</p> <p>Annual Report to QIC</p>

<p>4. Effectiveness of Care/ Clinical Issues (continued)</p>	<ul style="list-style-type: none"> Study, analyze and continuously improve medication monitoring and medication practices in Child and Adult system. 	<p>without explanation (Baseline 4.4%; Acceptable Error rate: 0%).</p> <ul style="list-style-type: none"> No indication of Coordination of Care (Baseline 5.2%; Acceptable Error Rate: 0%). Missing Notes for billed services (Baseline data: 22%; Acceptable Error Rate: 4%) <ul style="list-style-type: none"> Analysis of complaint, grievance, and fair hearings with concomitant monitoring of correction when appropriate. Continue improvements in criteria for medication monitoring for outpatient clinics. Use practice guidelines developed by Pharmacy and Therapeutics Committee for schizophrenia, bipolar disorders and depressive disorders. 	<p>QM</p> <p>Medication Monitoring Committee & QM</p> <p>P&T Committee</p>	<p>Report to QIC as needed</p> <p>Report on progress to QIC at semi-annual intervals</p>
<p>5. Continuity and coordination of care with Physical Health Care Providers</p>	<ul style="list-style-type: none"> Evaluate continuity and coordination with Physical Health Care (GMC) 	<ul style="list-style-type: none"> Analyze information from Adult and Child Access referral data relating to physical health/AOD/mental health coordination of care. Analyze referrals to physical health providers documented in clinical charts through UR process Analyze information from focused project regarding impact of physical health issues on reported deaths of adult mental health clients. 	<p>ACCESS and QM Staff</p> <p>QM</p> <p>QM & P&T</p>	<p>Annual Report to QIC</p> <p>Periodic & Annual Report to</p>

		<ul style="list-style-type: none"> Continue effort to complete MOU as required with all GMC providers. 	Adult Program	QIC
7. Training/Education	<ul style="list-style-type: none"> Enhance skill level through education. 	<ul style="list-style-type: none"> Conduct at least annual in-house training/consultation to MHP's mandated key points of contact to ensure competence in meeting the access needs of diverse communities. Conduct at least one workshop on consumer culture with trainers to include consumer/family perspective on mental illness. Continue development and delivery of curriculum training for MHP paraprofessional staff. Such training shall incorporate a cultural framework to core skill areas that include, but not limited to: Diagnosis and symptoms, mental health assessment and client service planning; inclusion and involvement of consumer and family and other support systems. Continue to expand resource list of trainers across cultures and disciplines and disseminate information of master calendar through monthly posting on MHP's website and regular distribution Utilize a variety of training/educational opportunities to enhance the array of culturally competent skill sets and community interfaces for mental health and partner agencies. 	QM, Program & Ethnic Services	Annual Report to QIC

8. Performance Improvement Projects	Performance Improvement Projects Report Progress on selected MHP Performance Improvement Projects	<ul style="list-style-type: none"> MHP will evaluate preliminary findings on Performance Improvement Projects (PIP) established in FY 04-05. 	QM, Ethnic Services, Research and Evaluation Staff	Periodic Progress Report to QIC
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APPENDIX II

SACRAMENTO COUNTY MHP PROVIDERS 2006-2007 Fiscal Year

ORGANIZATIONAL CONTRACT PROVIDERS

(A) = Adults (C) = Children's (M) Managed Care

North Area:

Cross Creek Family Counseling, Inc. (C)
San Juan Unified School District (C)
Stanford Home (C)
Terkensha Associates (C) (3)
The Effort, Inc. (C)
Turning Point Community Programs (A) (2)

East Area:

Another Choice Another Chance (C)
Asian Pacific Community Counseling (A)
BHC Heritage Oaks (C)
Catholic Social Service of Sacramento (A)
Charter Behavioral Health (C)
Children's Receiving Home (C)
Child & Family Institute (C) (1)
CHW Medical Foundation (A) (C) (3)
Consumer Self Help (A)
Crestwood Behavioral Health (A)
Eastfield Ming Quong (C)
El Hogar (A)
Eskaton Senior Connection (A)
Families First, Inc. (C)
Human Resource Consultants (A)
La Familia Counseling Center, Inc. (C)
Quality Group Homes, Inc. (C) (2)
River Oak Center for Children, Inc. (C) (4)
Sacramento Black Alcoholism Center (C)
Sacramento Children's Home (C) (2)
San Juan Unified School District (C) (2)
Sutter Counseling Center (C)
Terkensha Associates (C)
Terra Nova Counseling (C)
The Effort, Inc. (C) (2)
Turning Point Community Programs (C)
Transitional Living and Community Support (A)
UC Davis Medical Center Child Protection (C)
Volunteers of America (A)

(#) = Number of physical sites for specified provider in designed area
Bolded names are not included in statistics.

West Area:

Crossroads Rehabilitation Services (A)

CHW Medical Foundation (C)

El Hogar (A) (2)

Mental Health Association of Sacramento (A)

River Oak Center for Children, Inc. (C)

Sacramento Children's Home (C)

Sutter Center for Psychiatry (C)

Terkensha Associates (C) (2)

Terra Nova Counseling (C)

Transitional Living & Community Support (A)

Triad Family Services (C)

South Area:

Another Choice Another Chance (C)

Asian Pacific Community Counseling (A)

BHC – Sierra Vista (C)

CHW Medical Foundation (C)

Consumer Self Help (A)

Crestwood (A)

Milhous Children's Services (C) (4)

River Oak Center for Children, Inc. (C) (2)

Southeast Asian Assistance Center (A)

Terra Nova Counseling (C)

Turning Point Community Programs (A) (C) (4)

Visions Unlimited, Inc. (A) (C) (2)

Visions Unlimited, Inc. (Galt, CA) (A) (C) (2)

Out of County Children's Providers:

Charis Youth Center (Grass Valley, CA) (C)

Edgewood Residential Treatment Center (S.F., CA) (C)

Families First, Inc. (Davis, CA) (C)

Milhous Children's Services (Nevada City, CA) (C)

Seneca Residential & Day Treatment Center for children (Concord; S.F, Martinez) (C) (3)

Sequoia Psychiatric Center (Yuba City, CA)

Summitview Child Treatment Center (Placerville, CA) (C)

Victor Treatment Centers, Inc. (Lodi; Redding; San Bernardino; Santa Rosa, CA) (C) (4)

Note: Quality Management maintains a separate list of Enrolled Network Providers.

(#) = Number of physical sites for specified provider in designed area

Bolded names are not included in statistics.

Specialized Providers – Non-geographic

Catholic Social Services - Cal Works
Catholic Social Services – Managed Care (M)
Ethel's Daughters
Family Service Agency – Cal Works
Family Service Agency – Suicide Prevention
Family Service Agency – Managed Care (M)
Grace Home II
Green Pastures Guest Home
Jewish Family Services - Cal Works
Jewish Family Services – Managed Care (M)
Kimberly's Care Home
Mexican American Alcoholism Program (M)
New Horizon's Guest Home
Sacramento Chinese Community Counseling Center
St. Mary's Guest Home
St. Therese's #1 & #2
Sandy's Guest Home
Scottsdale Guest Home
Sungold Guest Home
Sutter Counseling Center – Cal Works
The Effort
Traditions Behavioral Health
UCD – Jail Psych
UCLA – SacPORT
Williams' Care home
Yolo Community Care Continuum

APPENDIX III

NOTICE OF ACTION (NOA)

Definitions:

NOA-A (Assessment) form is used when the MHP or its provider assesses a Medi-Cal beneficiary and determines that the beneficiary does not meet medical necessity criteria and no specialty mental health services will be provided.

NOA – B (Denial of Services) form is used when a provider requests payment authorization for a specialty mental health services and the MHP denies or modifies the provider's request and the beneficiary did not receive the service.

NOA – C (Post-Service Denials) form is used when a provider requests payment authorization for a specialty mental health service and the MHP denies or modifies the provider's request and the beneficiary not responsible for the cost of the service rendered but retrospectively denied or modified.

NOA – D (Delayed Grievance/Appeal Decision) form is used when the MHP does not provide the resolution of a grievance, appeal, or expedited appeal within the required timeframes.

NOA – E (Lack of Timely Services) is a form used when the MHP does not provide services in a timely manner according to their own standards for timely services.

APPENDIX IV

System-Wide Technical & Clinical Trainings

July 1, 2006 - June 30, 2007

DATE	#	TRAINING JULY '06 - June '07
5/14/2007	26	5150 Certification Training
2/21/2007	39	5150 Certification Training
9/11/2006	11	5150 Certification Training
7/10/2006	9	5150 Re-Certification Training
3/12/2007	22	5150 Re-Certification Training
11/13/2006	9	5150 Re-Certification Training
12/1/2006	105	A Shared Vision: Co-Occurring Recovery Empowerment
10/12/2006	31	Adolescent Substance Abuse and Mental Health Training Series
10/19/2006	30	Adolescent Substance Abuse and Mental Health Training Series
10/26/2006	27	Adolescent Substance Abuse and Mental Health Training Series
10/5/2006	31	Adolescent Substance Abuse and Mental Health Training Series
5/3/2007	37	Adult Protective Services Mandated Reporter Training
6/13/2007	12	Balancing Clinical Care & Compliance Issues - Adult
3/15/2007	12	Balancing Clinical Care & Compliance Issues - Adult
9/13/2006	42	Balancing Clinical Care & Compliance Issues - Adult
9/15/2006	45	Balancing Clinical Care & Compliance Issues - Children
6/13/2007	46	Balancing Clinical Care & Compliance Issues - Children
3/15/2007	52	Balancing Clinical Care & Compliance Issues - Children
7/11/2006	38	CATS Training Update for CSI Data Changes @ 1:00 pm
7/10/2006	18	CATS Training Update for CSI Data Changes @ 1:30 pm
7/10/2006	33	CATS Training Update for CSI Data Changes @ 10:30 am
7/11/2006	37	CATS Training Update for CSI Data Changes @ 3:00 pm
1/12/2007	76	Changing The World: Developing Welcoming, Integrated Systems of Care; A Forum for Managers, Administrator & Planners
8/7/2006	21	Client Services Information (CSI) Data Changes Make-up Training
8/4/2006	28	Client Services Information (CSI) Data Changes Make-up Training
10/17/2006	70	Cognitive Behavioral Therapy Part 1 (CBT) Training
7/11/2006	74	Cognitive Behavioral Therapy Part 1 Training
10/17/2006	75	Cognitive Behavioral Therapy Part 2 (CBT) Training
2/7/2007	15	Completing Zip Slips/Medi-Cal Billing/Treatment Code Training
6/6/2007	16	Completing Zip Slips/Medi-Cal Billing/Treatment Code Training
3/7/2007	4	Completing Zip Slips/Medi-Cal Billing/Treatment Code Training
5/2/2007	6	Completing Zip Slips/Medi-Cal Billing/Treatment Code Training
4/4/2007	4	Completing Zip Slips/Medi-Cal Billing/Treatment Code Training
7/13/2006	35	Compliance Program Training
2/6/2007	5	Compliance Program Training
5/7/2007	33	Compliance Program Training
11/16/2006	22	Compliance Program Training
11/6/2006	7	Compliance Program Training
5/30/2007	4	Compliance Program Training

DATE	#	TRAINING JULY '06 - June '07
7/10/2006	9	Compliance Program Training
11/21/2006	32	Compliance Program Training
5/2/2007	35	Compliance Program Training
4/14/2007	8	Compliance Program Training
2/5/2007	14	Compliance Program Training
11/15/2006	38	Compliance Program Training
11/9/2006	44	Compliance Program Training
10/25/2006	33	Compliance Program Training
10/6/2006	2	Compliance Program Training
9/18/2006	10	Compliance Program Training
9/26/2006	11	Compliance Program Training
4/26/2007	16	Compliance Program Training
6/28/2007	11	Compliance Program Training
11/8/2006	17	Compliance Program Training 1:00-2:30pm
10/11/2006	21	Compliance Program Training 2:00-3:30pm
11/8/2006	14	Compliance Program Training 3:00-4:30pm
10/11/2006	10	Compliance Program Training 3:30-5:00pm
3/29/2007	17	Compliance Program Training 7:30-9:00am
8/10/2006	160	Consumer Speaks Conference
7/31/2006	28	Co-Occurring Disorders & Domestic Violence Case Conference
11/6/2006	19	Co-Occurring Disorders & Domestic Violence Case Conference
4/9/2007	20	Co-Occurring Disorders & Domestic Violence Case Conference
4/2/2007	13	Co-Occurring Disorders Case Conferences Series (Adult)
8/7/2006	16	Co-Occurring Disorders Case Conferences Series (Adult)
11/6/2006	15	Co-Occurring Disorders Case Conferences Series (Adult)
3/5/2007	18	Co-Occurring Disorders Case Conferences Series (Adult)
2/5/2007	24	Co-Occurring Disorders Case Conferences Series (Adult)
5/7/2007	10	Co-Occurring Disorders Case Conferences Series (Adult)
6/4/2007	10	Co-Occurring Disorders Case Conferences Series (Adult)
10/2/2006	11	Co-Occurring Disorders Case Conferences Series (Adult)
12/4/2006	17	Co-Occurring Disorders Case Conferences Series (Adult)
5/16/2007	8	Co-Occurring Disorders Case Conferences Series (Youth)
2/1/2007	16	Co-Occurring Disorders Case Conferences Series (Youth)
3/20/2007	4	Co-Occurring Disorders Case Conferences Series (Youth)
10/17/2006	11	Co-Occurring Disorders Case Conferences Series (Youth)
9/20/2006	9	Co-Occurring Disorders Case Conferences Series (Youth)
11/15/2006	5	Co-Occurring Disorders Case Conferences Series (Youth)
6/20/2007	6	Co-Occurring Disorders Case Conferences Series (Youth)
7/19/2006	9	Co-Occurring Disorders Case Conferences Series (Youth)
8/16/2006	13	Co-Occurring Disorders Case Conferences Series (Youth)
2/27/2007	12	Core Skills Training Series - Confidentiality, Ethics and Boundaries
9/20/2006	8	Core Skills Training Series - Confidentiality, Ethics and Boundaries
4/18/2007	15	Core Skills Training Series - DSM IV and Mental Status Exam
11/15/2006	3	Core Skills Training Series - DSM IV and Mental Status Exam
7/19/2006	7	Core Skills Training Series - DSM IV and Mental Status Exam

DATE	#	TRAINING JULY '06 - June '07
7/12/2006	6	Core Skills Training Series - Orientation to the Mental Health Plan
1/17/2007	11	Core Skills Training Series - Orientation to the Mental Health Plan
10/11/2006	22	Core Skills Training Series - Orientation to the Mental Health Plan
10/4/2006	4	Core Skills Training Series - Risk Assessment
3/21/2007	13	Core Skills Training Series - Risk Assessment
8/16/2006	4	Core Skills Training Series - Treatment/Service Planning
5/16/2007	10	Core Skills Training Series - Treatment/Service Planning
12/5/2006	3	Core Skills Training Series - Treatment/Service Planning
11/6/2006	53	CPS - Child Protection Services Mandated Reporting Training
11/30/2006	48	Differentiating Between ADHD and Bipolar Disorder
8/9/2006	28	Documentation 1 (Adult) & Performance Outcomes Training @ El Hogar, RCCHP
11/15/2006	10	Documentation 1 (Adult) & Performance Outcomes Training @ HRC
2/8/2007	14	Documentation 1 (Adult) & Performance Outcomes Training @ Northgate
5/10/2007	11	Documentation 1 (Adult) & Performance Outcomes Training @ Visions
10/11/2006	45	Documentation 1 (Child) & Performance Outcomes Training
4/18/2007	27	Documentation 1 (Child) & Performance Outcomes Training
7/12/2006	45	Documentation 1 (Child) & Performance Outcomes Training
1/10/2007	19	Documentation 1 (Child) & Performance Outcomes Training
2/15/2007	13	Documentation 2 (Adult) & Performance Outcomes Training @ Northgate
5/11/2007	20	Documentation 2 (Adult) & Performance Outcomes Training @ Visions
8/10/2006	20	Documentation 2 (Adult) Training @ El Hogar, RCCHP
11/16/2006	10	Documentation 2 (Adult) Training @ HRC
1/18/2007	17	Documentation 2 (Child) & Performance Outcomes Training
4/20/2007	15	Documentation 2 (Child) & Performance Outcomes Training
11/1/2006	50	Documentation 2 (Child) Training
10/12/2006	50	Documentation 2 (Child) Training
7/14/2006	38	Documentation 2 (Child) Training
6/1/2007	74	Empower Co-Occurring Recovery Success
8/23/2006	15	Group Facilitator Workshop - Wellness, Recovery, Peer Support Training
9/13/2006	7	Group Facilitator Workshop - Wellness, Recovery, Peer Support Training
10/12/2006	60	Improving the Workplace Response to Domestic Violence
3/22/2007	45	Integrating Core Principles of Cultural Competence into Service Delivery - Matthew Mock, Ph.D.
1/12/2007	280	Integrating Mental Health and Substance Abuse Services
12/14/2006	15	Introduction To Wellness Recovery Action Plan (WRAP) Training
11/28/2006	15	Introduction To Wellness Recovery Action Plan (WRAP) Training
11/27/2006	15	Introduction To Wellness Recovery Action Plan (WRAP) Training
12/13/2006	15	Introduction To Wellness Recovery Action Plan (WRAP) Training
8/2/2006	6	Medi-Cal Billing/Treatment Code Training
11/1/2006	10	Medi-Cal Billing/Treatment Code Training
10/4/2006	15	Medi-Cal Billing/Treatment Code Training
3/22/2007	2	Pediatric MH for Primary Care Physicians - Early Identification of Psychotic Disorders
2/22/2007	7	Pediatric MH for Primary Care Physicians - Evaluation of Anxiety Disorders in the Pediatric Population
3/5/2007	30	Problem Gambling and Older Adults Training and Technical Assistance

DATE	#	TRAINING JULY '06 - June '07
5/18/2007	22	Problem Gambling and Older Adults Training and Technical Assistance
11/8/2006	0	Problem Resolution/Advance Medical Directives Training
8/9/2006	4	Problem Resolution/Advance Medical Directives Training
2/14/2007	10	Problem Resolution/Advance Medical Directives Training
5/9/2007	4	Problem Resolution/Advance Medical Directives Training
4/11/2007	35	Provider Training on the appropriate Use of Interpreters in Mental Health Settings
7/6/2006	53	Psychological Testing 101 Training
5/23/2007	6	SacPort - 7 Step Problem Solving Method Training @ Welcome Home House
7/13/2006	3	SacPort - Administering Pre and Post Tests Training @ TPISA, MHTC, Visions
7/19/2006	3	SacPort - Advanced Implementer Training @ ARBH
7/12/2006	3	SacPort - Advanced Implementer Training @ ARBH
11/29/2006	8	SacPort - Advanced Implementer Training @ ARBH, CSH-N, CSH-S
11/30/2006	8	SacPort - Advanced Implementer Training @ ARBH, CSH-N, CSH-S
2/26/2007	9	SacPort - Advanced Implementer Training @ El Hogar, TLCS, TP-ISA
2/27/2007	9	SacPort - Advanced Implementer Training @ El Hogar, TLCS, TP-ISA
1/17/2007	13	SacPort - Advanced Implementer Training @ JPS - Main Jail
1/23/2007	6	SacPort - Advanced Implementer Training @ JPS-Main Jail
8/30/2006	15	SacPort - Advanced Implementer Training @ MHTC, EDAPT, NGP, Crestwood Sac
5/17/2007	10	SacPort - Advanced Implementer Training @ MHTC, TLCS, TP-ISA, CSH-S, El Hogar
1/18/2007	13	SacPort - Advanced Implementer Training @ MHTC, ARBH, El Hogar, JPS - RCCC Staff
6/20/2007	9	SacPort - Advanced Implementer Training @ MHTC, TP-TISA, Crestwd Sac, CSH-South
7/17/2006	6	SacPort - Advanced Implementer Training @ TISA, TLCS, MHTC
7/13/2006	6	SacPort - Advanced Implementer Training @ TISA, TLCS, MHTC
11/20/2006	7	SacPort - Advanced Implementer Training @ TP-ISA, El Hogar, TLCS, ARBH
11/13/2006	7	SacPort - Advanced Implementer Training @ TP-ISA, El Hogar, TLCS, ARBH
1/10/2007	10	SacPort - Advanced Implementer Training @ TP-ISA/TISA
1/8/2007	10	SacPort - Advanced Implementer Training @ TP-ISA/TISA
3/2/2007	2	SacPort - Advanced Implementer Training @ Welcome Home House
3/1/2007	2	SacPort - Advanced Implementer Training @ Welcome Home House
5/9/2007	7	SacPort - Beginning a Module Training @ Welcom Home House
5/10/2007	8	SacPort - Completing a Module Training @ MHTC, TP-ISA, CSH-S, TLCS, New Horizons Crestwood Sac., El Hogar
2/28/2007	3	SacPort - Errorless Learning Training @ Visions
5/30/2007	6	SacPort - Errorless Learning Training @ Welcome Home House
4/24/2007	8	SacPort - Friendship & Intimacy Training @ TLCS, El Hogar
4/12/2007	8	SacPort - Leadership Qualities Training @ MHTC, NGP, Visions, TPISA, NH, HRC, Crestwood Sac.
2/8/2007	6	SacPort - Leadership Skills Training @ El Hogar, NGP, HRC, New Horizons
4/11/2007	2	SacPort - Medication Management Module Training @ Welcome Home House
8/24/2006	2	SacPort - Module Overview - CPR Training @ CSH-South
4/19/2007	4	SacPort - Module Update Training @ TLCS-MICA/Palmer
6/14/2007	5	SacPort - Obtaining Pre and Post Tests Training @ HRC, El Hogar, Crestwood Sac.

DATE	#	TRAINING JULY '06 - June '07
4/4/2007	21	SacPort - Overview /STARS Presentation Training @ MHTC
6/21/2007	20	SacPort - Overview Training @ ACT Providers
5/3/2007	20	SacPort - Overview Training @ Adult Access
4/18/2007	32	SacPort - Overview Training @ Children Access
1/25/2007	25	SacPort - Overview Training @ Crossroads
4/13/2007	5	SacPort - Overview Training @ El Dorado Co. MHTC Staff
4/20/2007	65	SacPort - Overview Training @ El Dorado, Yolo, San Joaquin, Placer, Butte, Stanislaus, Sutter-Yuba, Amador & Solano Counties
10/18/2006	19	SacPort - Overview Training @ El Hogar
1/24/2007	75	SacPort - Overview Training @ Sacramento County Children & Family Services
3/14/2007	2	SacPort - Overview Training @ Serna Village
4/3/2007	5	SacPort - Overview Training @ TLCS-Crisis Residential
11/9/2006	2	SacPort - Resource Management Refresher Training @ NGP, TP-ISA
8/18/2006	2	SacPort - Resource Management Refresher Training @ Northgate Point RST
6/27/2007	5	SacPort - Resource Management Training @ Welcome Home House
2/15/2007	7	SacPort - SAMM Training @ Crestwood Sac, TLCS, MHTC, JPS-RCCC
10/11/2006	9	SacPort - SAMM Training @ Crestwood Sac., EDAPT, NGP
3/7/2007	5	SacPort - SAMM Training @ JPS-Main Jail
7/24/2006	7	SacPort - SAMM Training @ TP-ISA, MHTC, NGP, TLCS, JPS
5/23/2007	150	SacPort - STARS DHHS Recognition Overview Event Training @ DHHS Staff
4/12/2007	5	SacPort - STARS Overview Training @ MHA
12/14/2006	5	SacPort - Tracking Group Member's Participation Training @ NGP, TP-ISA, Crestwood Sac, HRC, Visions
9/14/2006	8	SacPort - Understanding the Module Tracking Sheet Training @ MHTC, NGP, HRC, TP-ISA, CSH-N, New Horizons
8/23/2006	7	SacPort - Update / Filing Out An Att. Sheet Training @ Crestwood Sacramento
6/6/2007	22	SacPort - Updates Training @ MHTC
10/19/2006	2	Site Certification Training
4/9/2007	4	Site Certification Training
2/15/2007	2	Staff Qualification/Credentialing Training
10/19/2006	2	Staff Qualification/Credentialing Training
5/17/2007	3	Staff Qualification/Credentialing Training
6/18/2007	8	TBS CIMH Coaches Training (Train-the-Trainer)
10/26/2006	41	Trading Secrets Conference 2006
2/6/2007	9	UMDAP and Medi-Cal Eligibility Training
5/15/2007	6	UMDAP and Medi-Cal Eligibility Training
8/15/2006	6	UMDAP and Medi-Cal Eligibility Training
9/8/2006	95	Using the Diagnostic Classification: 0-3R Training
3/12/2007	5	WebCast: Illness Management and Recovery Training
3/5/2007	5	WebCast: Implementing Evidence Based Practices: Illness Management/Recovery Training
3/14/2007	6	WebCast: Program Integrity and Deficit Reduction Act Training
7/12/2006	13	WebCast: TBS Webcast Training CIMH

TOTAL 4335