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

FY 2004/2005 - FY 2005/2006

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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 2005-06. Fiscal Year 04-05 information is utilized wherever possible to provide the reader a two year view of changes as a comparison point. With continued regulatory changes and planning and development of the Mental Health Services Act, QM efforts have adjusted to incorporate those developments 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 Update 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.

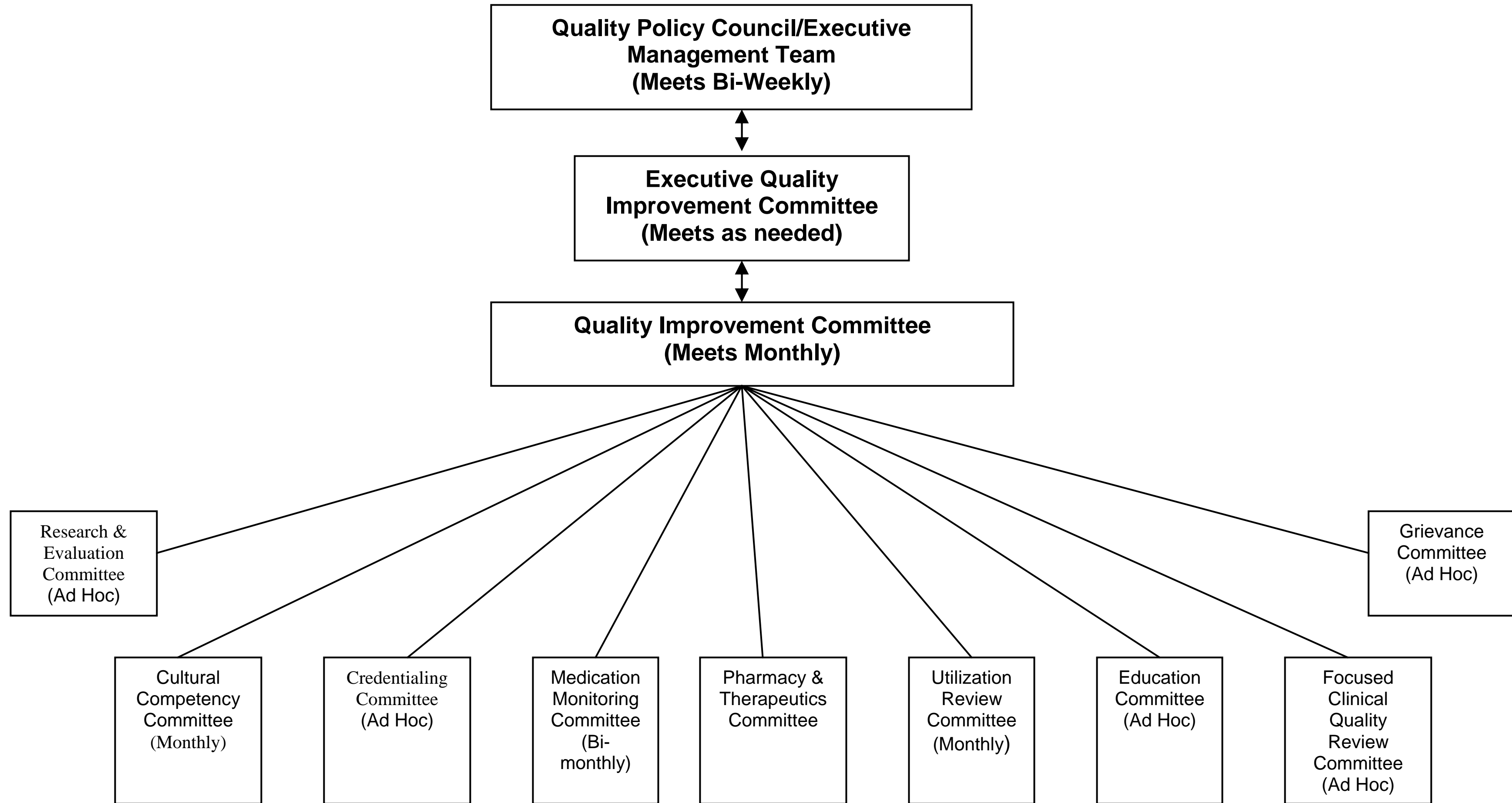
This report is divided into the following areas:

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

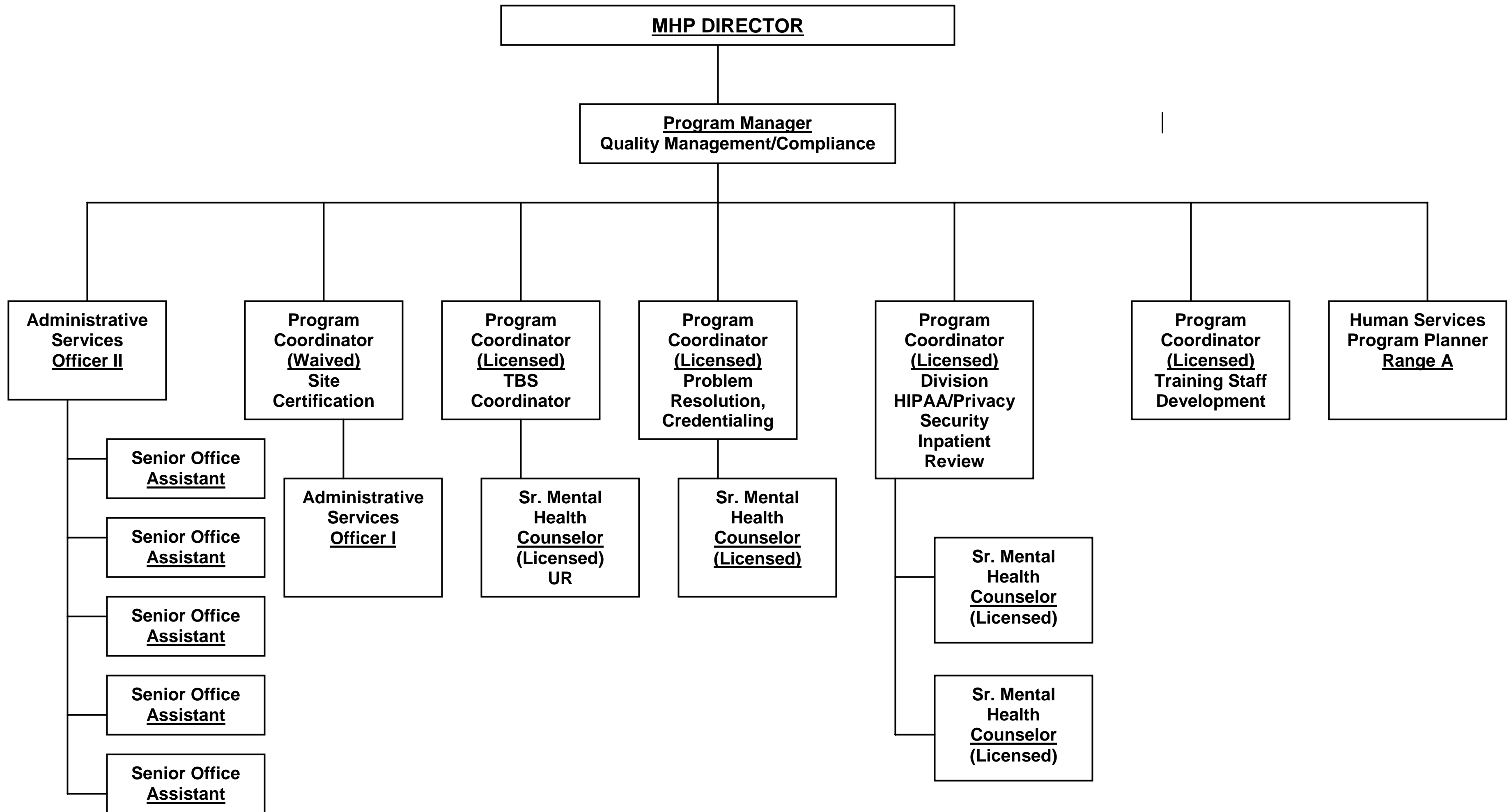
QUALITY MANAGEMENT ORGANIZATION AND STRUCTURE

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 and the Mental Health Board. 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



MHP QUALITY MANAGEMENT SERVICES ORGANIZATIONAL CHART FOR 2004-05 & 2005-06



Data Obtained from Mental Health's MIS System (CATS)

Retention Rates

FY 2004-2005

Adults

Definition of Retention Rate: Adult clients who had their first non-crisis out-patient visit during the fiscal year, and had at least 2 more outpatient visits in the following six month period.

	All Clients (N=5,687)		Clients Retained (N=4,931)		Retention Rate
Characteristic	N	%	N	%	%
Total	5,687		4,931		86.7
Ethnicity					
Caucasian	3,069	54.0	2,633	53.4	85.8
Hispanic	610	10.7	533	10.8	87.4
African American	1,089	19.1	968	19.6	88.9
Chinese	18	0.3	16	0.3	88.9
Vietnamese	55	1.0	51	1.0	92.7
Lao	26	0.5	25	0.5	96.2
Cambodian	16	0.3	13	0.3	81.3
Hmong	90	1.6	83	1.7	92.2
Mien	20	0.4	20	0.4	100.0
Multi-Ethnic	129	2.3	115	2.3	89.1
Other	694	12.2	474	9.6	68.3
Primary Language					
English	5,056	88.9	4,388	89.0	86.8
Spanish	173	3.0	132	2.7	76.3
Russian	35	0.6	32	0.6	91.4
Hmong	99	1.7	88	1.8	88.9
Vietnamese	46	0.8	44	0.9	95.7
Cantonese	9	0.2	9	0.2	100.0
Mien	26	0.5	24	0.5	92.3
Lao	16	0.3	16	0.3	100.0
Cambodian	4	0.1	4	0.1	100.0
Other	223	3.9	194	3.9	87.0
Gender					
Male	2,054	36.1	1,822	36.9	88.7
Female	3,632	63.9	3,108	63.0	85.6
Unknown	1	<0.1	1	<0.1	100.0

Characteristic	All Clients (N=5,687)		Clients Retained (N=4,931)		Retention Rate
	N	%	N	%	%
Diagnosis					
Psychotic	1,186	20.9	1,067	21.6	90.0
Bipolar	1,471	25.9	1,343	27.2	91.3
Depressive	2,055	36.1	1,827	37.1	88.9
Anxiety	330	5.8	286	5.8	86.7
Adjustment	215	3.8	146	3.0	67.9
Other (v-codes, deferred, etc.)	386	6.8	227	4.6	58.8
Unknown	44	0.8	35		79.5

Children

Definition of Retention Rate: Young clients who had their first non-crisis out-patient visit during the fiscal year, and had at least 2 more outpatient visits in the following three month period.

Characteristic	All Clients (N=7,040)		Clients Retained (N=5,996)		Retention Rate
	N	%	N	%	%
Total	7,040		5,996		85.2
Ethnicity					
Caucasian	2,782	39.5	2,328	38.8	83.7
Hispanic	1,142	16.2	934	15.6	81.8
African American	2,010	28.6	1,787	29.8	88.9
Chinese	6	0.1	6	0.1	100.0
Vietnamese	29	0.4	21	0.4	72.4
Lao	18	0.3	12	0.2	66.7
Cambodian	3	<0.1	2	<0.1	66.7
Hmong	42	0.6	32	0.5	76.2
Mien	17	0.2	14	0.2	82.4
Multi-Ethnic	684	9.7	599	10.0	87.6
Other	307	4.4	261	4.4	85.0

	All Clients (N=7,040)		Clients Retained (N=5,996)		Retention Rate
Characteristic	N	%	N	%	%
Primary Language					
English	6,565	93.3	5,657	94.3	86.2
Spanish	383	5.4	261	4.4	68.1
Russian	8	0.1	7	0.1	87.5
Hmong	17	0.2	14	0.2	82.4
Vietnamese	12	0.2	8	0.1	66.7
Cantonese	4	0.1	4	0.1	100.0
Mien	5	0.1	5	0.1	100.0
Lao	4	0.1	2	<0.1	50.0
Cambodian	1	<0.1	1	<0.1	100.0
Other	41	0.6	37	0.6	90.2
Gender					
Male	4,055	57.6	3,375	56.3	83.2
Female	2,985	42.4	2,621	43.7	87.8
Diagnosis					
Psychotic	95	1.3	69	1.2	72.6
Bipolar	343	4.9	265	4.4	77.3
Depressive	1,018	14.5	848	14.1	83.3
Anxiety	1,005	14.3	864	14.4	86.0
Adjustment	1,427	20.3	1,302	21.7	91.2
ADHD	904	12.8	741	12.4	82.0
Disruptive Behavior	1,181	16.8	1,007	16.8	85.3
Other Childhood DO	660	9.4	573	9.6	86.8
Other (v-codes, deferred, etc.)	396	5.6	322	5.4	81.3
Unknown	11	0.2	5	0.1	45.5

Data Obtained from Mental Health's MIS System (CATS)

Retention Rates

FY 2005-2006

Adults

Definition of Retention Rate: Adult clients who had their first non-crisis out-patient visit during the fiscal year, and had at least 2 more outpatient visits in the following six month period.

	All Clients (N=4,980)		Clients Retained (N=4,357)		Retention Rate
Characteristic	N	%	N	%	%
Total	4,980		4,357		87.5
Ethnicity					
Caucasian	2,638	53.0	2,329	53.5	88.3
Hispanic	561	11.3	480	11.0	85.6
African American	973	19.5	853	19.6	87.7
Chinese	17	0.3	15	0.3	88.2
Vietnamese	42	0.8	38	0.9	90.5
Lao	36	0.7	34	0.8	94.4
Cambodian	15	0.3	14	0.3	93.3
Hmong	93	1.9	78	1.8	83.9
Mien	22	0.4	19	0.4	86.4
Multi-Ethnic	122	2.4	104	2.4	85.2
Other	438	8.8	376	8.6	85.8
Unknown	23	0.5	17	0.4	73.9
Primary Language					
English	4,424	88.8	3,888	89.2	87.9
Spanish	171	3.4	136	3.1	79.5
Russian	30	0.6	22	0.5	73.3
Hmong	103	2.1	88	2.0	85.4
Vietnamese	31	0.6	30	0.7	96.8
Cantonese	11	0.2	10	0.2	90.9
Mien	20	0.4	18	0.4	90.0
Lao	28	0.6	27	0.6	96.4
Cambodian	7	0.1	6	0.1	85.7
Other	155	3.1	132	3.0	85.2
Gender					
Female	3,156	63.4	2,714	62.3	86.0
Male	1,824	36.6	1,643	37.7	90.1

Characteristic	All Clients (N=4,980)		Clients Retained (N=4,357)		Retention Rate
	N	%	N	%	%
Diagnosis					
Psychotic	882	17.7	801	18.4	90.8
Bipolar	1,392	28.0	1,262	29.0	90.7
Depressive	1,845	37.0	1,606	36.9	87.0
Anxiety	301	6.0	243	5.6	80.7
Adjustment	164	3.3	119	2.7	72.6
Other (v-codes, deferred, etc.)	283	5.7	233	5.3	82.3
Unknown	113	2.3	93	2.1	82.3

Children

Definition of Retention Rate: Young clients who had their first non-crisis out-patient visit during the fiscal year, and had at least 2 more outpatient visits in the following three month period.

Characteristic	All Clients (N=6,673)		Clients Retained (N=6,265)		Retention Rate
	N	%	N	%	%
Total	6,673		6,265		93.9
Ethnicity					
Caucasian	2,427	36.4	2,260	36.1	93.1
Hispanic	1,254	18.8	1,191	19.0	95.0
African American	1,778	26.6	1,670	26.7	93.9
Chinese	6	0.1	6	0.1	100.0
Vietnamese	39	0.6	36	0.6	92.3
Lao	23	0.3	23	0.4	100.0
Cambodian	10	0.1	10	0.2	100.0
Hmong	52	0.8	50	0.8	96.2
Mien	18	0.3	17	0.3	94.4
Multi-Ethnic	655	9.8	626	10.0	95.6
Other	404	6.1	372	5.9	92.1
Unknown	7	0.1	4	0.1	57.1

Characteristic	All Clients (N=6,673)		Clients Retained (N=6,265)		Retention Rate
	N	%	N	%	%
Primary Language					
English	6,123	91.8	5,753	91.8	94.0
Spanish	438	6.6	406	6.5	92.7
Russian	6	0.1	6	0.1	100.0
Hmong	22	0.3	21	0.3	95.5
Vietnamese	12	0.2	10	0.2	83.3
Cantonese	6	0.1	6	0.1	100.0
Mien	7	0.1	7	0.1	100.0
Lao	6	0.1	6	0.1	100.0
Other	53	0.8	50	0.8	94.3
Gender					
Male	3,776	56.6	3,550	56.7	94.0
Female	2,897	43.4	2,715	43.3	93.7
Diagnosis					
Psychotic	96	1.4	90	1.4	93.8
Bipolar	341	5.1	317	5.1	93.0
Depressive	953	14.3	887	14.2	93.1
Anxiety	881	13.2	832	13.3	94.4
Adjustment	1,466	22.0	1,385	22.1	94.5
ADHD	760	11.4	729	11.6	95.9
Disruptive Behavior	1,088	16.3	1,039	16.6	95.5
Other Childhood DO	660	9.9	607	9.7	92.0
Other (v-codes, deferred, etc.)	394	5.9	348	5.6	88.3
Unknown	34	0.5	31	0.5	91.2

RETENTION RATE COMPARISONS

The tables below compare FY 04-05 retention rates with FY 05-06 rates.

Adults

	Retention Rate *FY 04-05*	Retention Rate *FY 05-06*	Percent Change (+/-)
	%	%	
Total	86.7	87.5	+0.9%
Ethnicity			
Caucasian	85.8	88.3	+2.9%
Hispanic	87.4	85.6	-2.1%
African American	88.9	87.7	-1.3%
Chinese	88.9	88.2	-0.8%
Vietnamese	92.7	90.5	-2.4%
Lao	96.2	94.4	-1.9%
Cambodian	81.3	93.3	14.8%
Hmong	92.2	83.9	-9.0%
Mien	100.0	86.4	-13.6%
Multi-Ethnic	89.1	85.2	-4.4%
Other	68.3	85.8	+25.6%
Unknown	---	73.9	N/A
Primary Language			
English	86.8	87.9	+1.3%
Spanish	76.3	79.5	+4.2%
Russian	91.4	73.3	-19.8%
Hmong	88.9	85.4	-3.9%
Vietnamese	95.7	96.8	+1.1%
Cantonese	100.0	90.9	-9.1%
Mien	92.3	90.0	-2.5%
Lao	100.0	96.4	-3.6%
Cambodian	100.0	85.7	-14.3%
Other	87.0	85.2	-2.1%
Gender			
Male	88.7	86.0	-3.0%
Female	85.6	90.1	+5.3%
Unknown	100.0	---	N/A

	Retention Rate *FY 04-05*	Retention Rate *FY 05-06*	Percent Change (+/-)
	%	%	
Diagnosis			
Psychotic	90.0	90.8	+0.9%
Bipolar	91.3	90.7	-0.7%
Depressive	88.9	87.0	-2.1%
Anxiety	86.7	80.7	-6.9%
Adjustment	67.9	72.6	+6.9%
Other (v-codes, deferred, etc.)	58.8	82.3	+40.0%
Unknown	79.5	82.3	+3.5%

Children

	Retention Rate *FY 04-05*	Retention Rate *FY 05-06*	Percent Change (+/-)
	%	%	
Total	85.2	93.9	+10.2%
Ethnicity			
Caucasian	83.7	93.1	+11.2%
Hispanic	81.8	95.0	+16.1%
African American	88.9	93.9	+5.6%
Chinese	100.0	100.0	0.0%
Vietnamese	72.4	92.3	+27.5%
Lao	66.7	100.0	+49.9%
Cambodian	66.7	100.0	+49.9%
Hmong	76.2	96.2	+26.2%
Mien	82.4	94.4	+14.6%
Multi-Ethnic	87.6	95.6	+9.1%
Other	85.0	92.1	+8.4%
Unknown	---	57.1	N/A

	Retention Rate *FY 04-05*	Retention Rate *FY 05-06*	Percent Change (+/-)
	%	%	
Primary Language			
English	86.2	94.0	+9.0%
Spanish	68.1	92.7	+36.1%
Russian	87.5	100.0	+14.3%
Hmong	82.4	95.5	+15.9%
Vietnamese	66.7	83.3	+24.9%
Cantonese	100.0	100.0	0.0%
Mien	100.0	100.0	0.0%
Lao	50.0	100.0	+100.0%
Cambodian	100.0	94.3	-5.7%
Other	90.2	94.0	+4.2%
Gender			
Male	83.2	94.0	+13.0%
Female	87.8	93.7	+6.7%
Diagnosis			
Psychotic	72.6	93.8	+29.2%
Bipolar	77.3	93.0	+20.3%
Depressive	83.3	93.1	+11.8%
Anxiety	86.0	94.4	+9.8%
Adjustment	91.2	94.5	+3.6%
ADHD	82.0	95.9	+17.0%
Disruptive Behavior	85.3	95.5	+12.0%
Other Childhood DO	86.8	92.0	+6.0%
Other (v-codes, deferred, etc.)	81.3	88.3	+8.6%
Unknown	45.5	91.2	+100.4%

Penetration Rates
Fiscal Years 2004-2005 and 2005-2006

Definition of Penetration Rate: The percentage of Medi-Cal eligibles served by the Mental Health Plan.

	Number Unduplicated Clients Served July 1, 2004 to June 30, 2005	Number of Medi-Cal Eligibles, January 2005	***Penetration Rate***	Number Unduplicated Clients Served July 1, 2005 to June 30, 2006	Number of Medi-Cal Eligibles, January 2006	***Penetration Rate***	**Absolute Change**
Total	31,911	267,860	***11.9***	32,376	277,791	***11.7***	-0.3
Gender							
Male	16,189	116,144	***13.9***	16,654	120,055	***13.9***	0.0
Female	15,712	151,716	***10.4***	15,717	157,736	***10.0***	-0.4
Unknown	10	0	-	5	0	-	
Age							
0-15	9,461	116,049	***8.2***	9,681	119,442	***8.1***	-0.1
16-25	5,791	41,087	***14.1***	6,019	43,142	***14.0***	-0.1
26-60	15,357	79,799	***19.2***	15,296	83,473	***18.3***	-0.9
61+	1,302	30,925	***4.2***	1,380	31,734	***4.3***	.01
Race							
Am Native/Indian	218	1,411	***15.5***	230	1,774	***13.0***	-2.5
Amerasian	35	50	***70.0***	35	44	***79.5***	9.5
Asian /PI	876	46,114	***1.9***	978	19,337	***5.1***	3.2
Black	7,377	51,170	***14.4***	7,455	52,816	***14.1***	-0.3
Cambodian	68	3,053	***2.2***	73	1,394	***5.2***	3.0
Chinese	135	3,949	***3.4***	144	4,837	***3.0***	-0.4
Filipino	194	2,238	***8.7***	213	2,887	***7.4***	-1.3
Guamanian	11	134	***8.2***	13	128	***10.2***	1.9
Hawaiian	11	128	***8.6***	20	255	***7.8***	-0.8
Hispanic	4,130	35,240	***11.7***	4,454	64,565	***6.9***	-4.8
Other/Unknown	3,561	28,807	***12.4***	3,651	42,094	***8.7***	-3.7
Samoan	13	497	***2.6***	13	517	***2.5***	-0.1
Vietnamese	318	7,479	***4.3***	330	7,931	***4.2***	-0.1
White	14,964	87,590	***17.1***	14,767	79,212	***18.6***	1.6
Language							
Cambodian	42	738	***5.7***	39	597	***6.5***	0.8
Cantonese	72	4,139	***1.7***	78	4,416	***1.8***	0.0
English	28,650	150,352	***19.1***	28,916	164,770	***17.5***	-1.5
Hmong	360	10,054	***3.6***	381	11,267	***3.4***	-0.2
Lao	145	1,437	***10.1***	160	1,617	***9.9***	-0.2
Mien	179	2,344	***7.6***	180	2,399	***7.5***	-0.1
Other/Unknown	686	41,095	***1.7***	712	28,151	***2.5***	0.9
Russian	225	18,257	***1.2***	206	18,970	***1.1***	-0.1
Spanish	1,304	32,587	***4.0***	1,463	38,240	***3.8***	-0.2
Vietnamese	248	6,857	***3.6***	241	7,364	***3.3***	-0.3

Diagnosis By Age Group

Children 17 years and younger

	FY04-05		FY05-06			
	N	%	N	%	Percent Change	Absolute Change
Adjustment	2047	17.3	2227	17.8	3.1	0.5
Anxiety	573	4.8	594	4.8	-1.7	-0.1
Attention Deficit	1495	12.6	1407	11.3	-10.8	-1.4
Bipolar	532	4.5	522	4.2	-7.0	-0.3
Deferred	190	1.6	190	1.5	-5.2	-0.1
Depressive	1643	13.9	1605	12.9	-7.4	-1.0
Disruptive Behavior	1782	15.1	2151	17.2	14.4	2.2
Other	1200	10.1	1596	12.8	26.1	2.6
Other Childhood	893	7.5	905	7.2	-3.9	-0.3
Psychotic	100	0.8	108	0.9	2.4	0.0
PTSD	951	8.0	861	6.9	-14.2	-1.1
Schizoaffective	26	0.2	25	0.2	-8.9	0.0
Substance Related	404	3.4	297	2.4	-30.3	-1.0
Total	11836	100	12488	100		

Adults 18 years and older

	FY04-05		FY05-06			
	N	%	N	%	Percent Change	Absolute Change
Adjustment	848	4.0	711	3.5	-13.5	-0.5
Anxiety	421	2.0	386	1.9	-5.4	-0.1
Bipolar	4551	21.6	4503	22.1	2.1	0.5
Deferred	2086	9.9	1837	9.0	-9.1	-0.9
Dementia	97	0.5	93	0.5	-1.0	0.0
Depressive	5940	28.2	5807	28.5	0.9	0.3
Other	578	2.7	667	3.3	19.1	0.5
Psychotic	3356	16.0	3331	16.3	2.5	0.4
PTSD	424	2.0	385	1.9	-6.3	-0.1
Schizoaffective	1701	8.1	1644	8.1	-0.2	0.0
Substance Abuse	1032	4.9	1013	5.0	1.3	0.1
Total	21034	100.0	20377	100.0		

Comments and Findings:

Retention Rates: The tables on pages 9-14 present information on the number of clients served and the corresponding retention rates for Adults and Children in Fiscal Years 2004-2005 and 2005-2006. Client utilization data were drawn from the MHP Information System. Data indicate that the MHP has been successful in maintaining a stable retention rate for adults between the two fiscal years (page 12). On the other hand, the MHP has successfully increased the retention rates for children by 10% (page 13).

Retention data are also presented in terms of gender, ethnicity, primary language and diagnosis. For adults, the MHP has been successful in increasing the retention of Cambodian clients (by ethnicity), although there has been a decrease in the ability to retain clients from some populations either by ethnicity (Hmong and Mien) or by language (Cantonese, Cambodian, and Russian).

Different patterns are found in the retention rates of children. Specifically, retention rates have increased by both ethnicity (Latino, Vietnamese, Lao, Cambodian, Hmong and Mien) and language (Spanish, Vietnamese, Lao, Hmong, and Russian).

Penetration Rates: The tables on page 15 and 16 present information on the number of clients served and the corresponding penetration rates in Fiscal Years 2004-2005 and 2005-2006. 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 maintaining the overall penetration rate during the two fiscal years.

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 increased somewhat for Amerasians, Asian or Pacific Islanders, and Cambodians, but decreased for Hispanics and "Other/Unknowns." These data are difficult to interpret for a number of reasons. First, regarding Amerasian, the penetration rate has increased almost 10%. However, with only 50 of 267,000 and 44 of 277,000 Medi-Cal eligibles identifying as Amerasian, the data is of questionable reliability. Second, and more important, there appears to be an issue with the Medi-Cal eligibility data in January 2006. For example, it is unlikely that the number of eligible Asian/Pacific Islanders dropped from 46,000 to 19,000 in one year. Changes of a similar magnitude are found with Cambodians, Hispanics, and "Other/Unknowns." We hypothesize that the data issues are associated with the implementation of a new data system by the Sacramento County Department of Human Assistance where data for Medi-Cal eligibles is gathered, and have been investigating the matter.

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 2004/2005**	**FY 2005/2006**
Legal Entities	33	35
Physical Sites	78	92
Increase/(Decrease) from prior year (physical sites)	(5)	14
Network Providers		
Individual Providers	33	20
Physical Sites	N/A	N/A
Increase/(Decrease) from prior year	2	-13

Geographic Distribution of Sites

Organizational Service Sites by Region	**FY 2004/2005**	**FY 2005/2006**
North	8	9
South	16	18
East	33	39
West	10	14
Out of County	11	12
Total	**78**	**92**

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.

(See **Appendix II** or list of FY05-06 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. Opportunities for growth resulted in a significant increase in service sites across regions (78 in FY04-05 to 92 in FY05-06). 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 substantially from 33 to 20 from FY04-05 to FY05-06. 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.

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. Thirty nine calls were made in FY05-06 compared to twenty-six calls in FY04-05. 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.

B. Linkage to First Appointments

A second area monitored was the timeliness of service delivery. The chart below compares two years of data on time from referral point at the Access Team or Inpatient Stay to Outpatient service.

Average Wait Time For Intake Appointments: FY 2004-2005 and FY 2005-2006

Outpatient Services	Average Time From Inpatient Referral To Intake Appointments		Average Time From Routine ACCESS Referral To Intake Appointments	
	FY 04-05	FY 05-06	FY 04-05	FY 05-06
Adult Outpatient #1	4 days	8 days	14 days	18 days
Adult Outpatient #2	3 days	4 days	4 days	43 days
Adult Outpatient #3	3 days	5 days	6 days	22 days
Adult Outpatient #4	12 days	24 days	38 days	47 days

<u>Comments:</u>

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. Average times at the four large outpatient providers reflect that wait times have increased but the average remains under the 30 days of discharge.

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 this client 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.

<u>Findings:</u>

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.

The average referral wait times for intake appointments fall within the expected standard for clients coming from the inpatient setting for both FY 04-05 and FY 05-06. However, this information does not capture when clients missed appointments, go to other parts of the system

to get psychiatric refills and fall outside the data collected for this report. The MHP is acutely aware of the lack of capacity to meet the demand on the adult system of care.

For routine outpatient referrals, the average time for the initial linkage to the outpatient system increased at all RST Providers. Routine outpatient referrals fall at the lower end of the priority list and typically have greater wait for service.

C. Beneficiary Protection/Problem Resolution Information

FY04-05 and FY05-06 incorporate regulatory changes that became effective July 1, 2004. These changes are important to note when understanding data relating to grievances and problem resolution processes. The most significant changes are the following:

- Informal levels of complaints were left to the MHP providers. Effective 2004-05, MHPs were required to track only one level of Grievance. Sacramento County chose to continue involving its contract providers in resolving problems at the lowest level including tracking and addressing provider specific issues. In FY04-05, providers submitted a Summary /Analysis Report.
- Effective FY04-05, the Grievance process no longer has an appeal process. The problem resolution decision by the MHP is final. The Appeal starts after the conclusion of the MHP action and has both a Standard and Expedited Process.
- Effective FY04-05, clients must exhaust the MHP's problem resolution process completely before a State Fair Hearing is filed. The decision of the Administrative Law Judge in the State Fair Hearing is final. There is no additional appeal process beyond the State Fair Hearing.

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.

Sacramento County Mental Health Plan
Annual Problem Resolution Summary/Analysis Report

Category	Adults		Children		Total	
	04-05	05-06	04-05	05-06	04-05	05-06
Grievances	129	342	12	15	141	357
Standard Appeal	0	1	7	2	7	3
Expedited Appeal	0	0	0	0	0	0
Fair Hearings	5	1	4	2	9	3
Total	**134**	**344**	**23**	**19**	**157**	**363**

Comments:

The majority of the Adult grievances involved change of provider requests. The majority of those requests involved clients returning to services and wanting to return to their previous provider despite their location. The client preference for a specific provider is honored

whenever possible. While it appears that grievances have increased substantially, in fact, this increase also reflects providers giving the MHP grievance line for clients to independently access to address small and large concerns. The MHP tracks all calls it receives in this category.

Medication issues remain the most significant of client grievances in the Adult System of Care. The most common issues related to timely follow-up appointments with the psychiatrist. Shortages of psychiatrist time are a national and statewide problem and Sacramento County faces this challenge as well. This shortage has resulted in unrealistic demands on the provider's ability to provide adequate psychiatrist support. This is compounded by a high "no show" rate for psychiatrist appointments, which intersects difficulties with re-scheduling appointments. The resulting cause has been significant client dissatisfaction.

The majority of issues in the Children's system relate to confusion around changes in levels of care. "Step down" from a higher level of care was the most common area of complaint. Problem resolution staff found that the step down was clinically appropriate but the caregiver comfort in the step-down in service was difficult to navigate as this placed greater responsibility with the caregiver. For example, outpatient services are far less intensive than Intensive Focus Programs. Once a client achieves goals that permit step-down in service level, worries about their ability to sustain at the outpatient level result in grievances. Child issues primarily concerned parent/caregiver needs and not necessarily those of the client.

Standard Appeals involved the lack of documentation for the level of care requested and were resolved appropriately when investigated by Problem Resolution staff. The MHP had no requests for Expedited Appeals. All State Fair Hearings (SFH) were resolved in favor of the MHP and the total numbers are too small to speak to any trends. The significant drop in the number of SFH requests can best be explained by the change in the regulations. A client must exhaust the MHP problem resolution process before filing for a SFH. Problem resolution staff can generally resolve an issue to the satisfaction of the client and avoid a SFH. The SFH heard over the past year were not jurisdictional issues for the administrative law judge and were therefore, dismissed.

Provider Annual Problem Resolution Summary/Analysis Report

July 1, 2005 – June 30, 2006

Issue Category	Adults		Children		Total	
	04-05	05-06	04-05	05-06	04-05	05-06
Quality of Care	74	43	115	8	189	51
Confidentiality	11	1	6	1	17	2
ACCESS		0		2		2
Change of Provider*		186		0		186
Facility Operations	47		16		63	
Other		112				112
Total	**132**	**342**	**137**	**11**	**269**	**353**

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

Comments:

Starting in FY04-05, contract providers have tracked client feedback, dissatisfaction and informal complaints at the program level. Contract providers submit a Provider Summary Analysis Report which indicates the number of issues in a given category, analyzes the areas of concern and develops corrective strategies at the agency level.

The suggested categories for the Provider Summary Analysis Report were: Quality of Care, Confidentiality, Facility Operations, and Other. Change of Provider was added for the 2005-06 reporting period. In November, 2004, Quality Management issued a memo to the Adult providers indicating they were responsible for managing client requests to remain at their agency despite the fact that they no longer reside in their catchment area. The decision was made to support client preference over geographic location wherever this option was possible. Providers generally manage the client requests to change a service provider or psychiatrist within their agency.

Findings:

Over the past two years, the salient issues of concern relate to medication issues and communication between clients and provider staff. Medication issues are a result of the physician shortage in the Adult System of Care. The Adult System of Care remains impacted with capacity issues. Demographic growth in the Sacramento area has multiplied demand for services. Demand remains significantly greater than the system capacity at every entry point of the adult system. This has resulted in client dissatisfaction. The Child System of Care, with multiple levels of care and overlapping services, finds clarifying expectations challenging. The Adult System of Care, as impacted as it is, experiences an equal challenge to avoid miscommunication and unclear expectations of the services they provide. Noteworthy are the provider efforts made to identify issues raised by clients and continued efforts to provide quality services within limited resources. Problem resolution efforts are measured by client satisfaction. This is a time intensive Quality Management task and remains a priority across the MHP.

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

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. **Appendix IIIA & IIIB** detail the work done in both fiscal years to select a Clinical and Non-Clinical PIP. The Clinical PIP selected addresses quality of care for clients with substance use/abuse co-occurring disorders. Multiple study questions were developed with the long-term goal of systematically evaluating and improving care for this target group of clients. This is a multi-year effort. The Non-Clinical PIP selected relates to increasing the quality of care to underserved population groups in Sacramento County through the Cultural Competence Consultation Service (CCCS).

In addition to these two PIPs, the MHP intends to deliberate and address findings from the completed Latino Access Study (see separate report).

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 FY03-04 and FY04-05, 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 have been refined in FY05-06. 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.

Findings:

Review of FY04-05 and FY05-06 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. For Major Depression Medication Guidelines, adherence decreased from 90% to 86%. For schizophrenia, adherence decreased from 91% to 83%. 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	
	04-05	05-06	04-05	05-06
Major Depression	79	71	71 (90%)	25 (86%)
Schizophrenia	23	21	21 (91%)	5 (83%)

*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 FY04-05 and FY05-06 Adverse Incident and reported death information received by Quality Management.

	FY 04-05	FY 05-06	(+/-)
Adult	181	164	-17
Child	50	36	-14
Total	231	200	-31

Reported Deaths	FY 04-05	FY 05-06	(+/-)
MEDICAL CAUSES PER CORONER'S REPORT	29	29	0
SUICIDE	03	01	-2
UNKNOWN OR *PENDING CORONER'S REPORT	35	23	-12
TOTAL DEATH CASES	67 (43%)	53 (54%)	-14

** Coroner's report may or may not be applicable for all reported deaths.*

Comments:

There was an overall decrease of 31 adverse incident reports from FY04-05 to FY05-06. Adult reports decreased by 17, children's reports decreased by 14. 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. Out of a total 67 deaths (FY04-05) and 53 (FY05-06), medical causes remain the same (29) in each year. In FY04-05, this amounted to 43% of deaths; in FY05-06, it reflected 54% of deaths. Suicides declined from 3 to 1. Deaths due to unknown causes or pending a coroner's report declined from 35 to 23.

Feedback regarding corrective actions or acceptability of care was provided to service providers following reviews. 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. This hypothesis is supported by the two years of data that reflects 29 deaths each year involved medical causes. Reporting of adverse incidents continues to reflect appropriate internal quality oversight by the MHP's contractors.

Findings:

There is an overall decrease in 31 adverse incident reports from FY04-05 to FY05-06. 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 FY04-05 and FY05-06 medication review information:

	FY 2004/2005	FY 2005/2006
Charts Reviewed		
Adult Program	704	686
Children's Program	285	288
Treatment Center Inpatient/Crisis	292/149	269/153
Jails	116	105
TOTAL Charts Reviewed	**1546**	**1501**
Number of Corrective Actions		
Adult Program	7	5
Children's Program	18	13
Treatment Center-Inpatient/Crisis	10/8	5/0
Jail	0	1
Total Corrective Actions	**43**	**24**

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 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 FY04-05 and FY05-06 remain similar. Corrective actions spread across adult and children's providers demonstrating that the feedback loop from the Medication Monitoring efforts is reaching all service providers. Corrective actions have decreased from 43 to 24 in this period reflecting greater adherence to community standard of practice. 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 County 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 23,210 clients [9,368 Children / 13,842 Adults] served between July 1, 2004 and June 30, 2005. Hence, the minimum number of charts that should have been reviewed in Fiscal year 2005-2006 was 1,160 (5%).

In fiscal year 2005-2006, a total of 3,353 (14.4%) non-duplicated charts were reviewed (1,131 externally, and 2,222 internally). Of the 1,131 externally reviewed charts, 307 were Adult charts, 824 were Children's charts. *

The projected goal for FY 2006 – 2007 is to review a minimum of 1,605 charts (146 per month excluding December) to meet our 5% requirement. The goal is based on 31,713 clients being served in FY 2005-2006 [11,670 Children / 20,043 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 2005-2006 period, 100% of all inpatient cases (n=679) were retrospectively reviewed and authorized for payment and documentation standards. In addition, a total of 131 charts were reviewed for documentation and care practices at the county jail. Quality Management serves as the external review process for jail psychiatric services.

**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 2005/2006

AREAS OF REVIEW	**FY 04/05**		**FY 05/06**	
Total Number of Clients Served (previous fiscal year)	24,489		23,210	
Adults	14,247		13,842	
Children	10,242		9,368	
# of Clients constituting 5% of Total	1,224		1,160	
Total # of Clients reviewed	**2,775**	**11.3%**	**3, 353**	**14.4%**
Non Duplicate Charts Reviewed	**FY 04/05**		**FY 05/06**	
External Adults (County UR)	290		307	
External Children (County UR)	642		824	
External Total (County UR)	932		1,131	
Internal Total (Within Agencies)	1,843		2,222	
Total # of Clients reviewed	**2,775**		**3,353**	
External Duplicate* Charts Reviewed	**FY 04/05**		**FY 05/06**	
Adult County UR	467	28.7%	563	31.4%
Children's County UR	490	30.1%	610	34.0%
Children's Intensive County UR	673	41.3%	619	34.5%
Total Duplicate Charts Reviewed	1,630	100%	1,792	100%
**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".*				
Medical Necessity and Diagnosis	**FY 04/05**		**FY 05/06**	
Medical Necessity not met	42	2.6%	11	.6%
No ICD-9 code	100	6.1%	45	2.5%
Primary Diagnosis Missing			24	1.3%
Treatment Planning	**FY 04/05**		**FY 05/06**	
No ACP	59	3.6%	38	2.1%
No R&R	21	1.3%	44	2.5%
Incomplete ACP/R&R	131	8.0%	233	13%
No AMSP	42	2.6%	97	5.4%
Incomplete AMSP	129	7.9%	112	6.3%
Goals Not Measurable/Quantifiable	133	8.2%	82	4.6%
Goals, Symptoms, Diagnosis, & Interventions Incongruent	76	4.7%	87	4.9%
Risk Factors & Special Status Situation not addressed	20	1.2%	42	2.3%
No Client Signature on ACP/R&R/w/o explanation	71	4.4%	69	3.9%
No Caregiver/Significant Support Persons' Signature on ACP/R&R	8	0.5%	44	2.5%
Staff signature/co-signature/title missing from plan	28	1.7%	61	3.4%
No indication of Coordination of Care	84	5.2%	52	2.9%

Progress Notes	**FY 04/05**		**FY 05/06**	

Missing Progress Notes (billed to CATS but not in chart)	370	22.7%	343	19.1%
Over billing (i.e Duplicate billing, excessive billing)	97	6.0%	71	4.0%
Using Incorrect Billing Codes	66	4.0%	66	3.7%
Group Billing Formula Errors	50	3.0%	9	.5%
Billed during a lockout	9	.55%	7	.4%
Billed non-billable service	45	2.8%	48	2.7%
Billed for Transportation	1	.06%	2	.1%
Billed for No-Show	3	.18%	1	.06%
Staff Signature/Co-Signature/Title Missing or Late	29	1.8%	33	1.8%
Staff operated outside their scope of practice	27	1.7%	11	0.6%
General Billing & Documentation Errors **	126	7.7%	224	12.5%
***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.*				
ACCESS Authorization	**FY 04/05**		**FY 05/06**	
No current MSO was found in the chart	56	3.4%	61	3.4%
Authorization Dates on ACP/R&R were missing or incorrect	60	3.7%	72	4.0%
Billed outside of Authorization period	19	1.2%	3	.2%
Missing Documentation	**FY 04/05**		**FY 05/06**	
HQ/HQ Update was Missing	147	9.0%	165	9.2%
CDS Missing	58	3.6%	48	2.7%
Consents Missing (I.e. Informed Consent; Medication Consent; HIPAA forms)	51	3.1%	56	3.1%
Miscellaneous Findings	**FY 04/05**		**FY 05/06**	
Member Handbook/Problem resolution/Guide not given/reviewed	189	11.6%	53	3.0%
No Linkage to physical health or other service	2	.12%	18	1.0%
Breaches of Confidentiality	1	.06%	14	.8%
Inpatient Hospital Reviews	**FY 04/05**		**FY 05/06**	
MediCal Adults	32		42	
MediCal Children	503		492	
MediCal Total	535		534	
Short Doyle	72		145	
Jail Psychiatric Services Chart Review	**FY 04/05**		**FY 05/06**	
Inpatient	66		56	
Outpatient	66		75	
Total	**132**		**131**	

(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 04-05, Quality Management utilized existing data to set baseline measures for improvement in four areas with information collected at County Utilization Review. In FY05-06, improvements were seen in three of the four areas listed below:

1) Reduction in percentage of cases without an ICD-9 code: FY 04-05 Baseline Measure: 6.1%; FY 05-06: 2.5%; Acceptable Error rate = 0%

2) Reduction of percentages of Missing Notes: FY04-05 Baseline Measure: 22.7%; FY 05-06: 19.1%; Acceptable Error rate = 0%

3) Missing, Incomplete or Late Health Questionnaire Updates: FY04-05 Baseline Measure: 9.0% ; FY 05-06: 9.2%. Acceptable Error rate = 0%.

4) Reduction in failure to provide clients with problem resolution information: from baseline FY 04-05 11.6% to FY 05-06: 3.0%. 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 2005-06, the Adult Access Team sent 11 Notices of Actions for denial of services. The Children’s Access Team issued 198 Notices of Actions. See **Appendix IV** 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 04-05	**FY 05-06**
NOA-A		
Adult	9	11
Child	28	16
NOA-B		
Adult	2	60
Child	170	110
NOA-C		
Adult-Inpatient	62	28
Child-Inpatient	13	8
NOA-D (Delayed Grievance)		
Adult	0	0
Child	0	0
Total NOA’s Issued	**294**	**267**

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 waivered 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 have decreased In FY05-06. NOA-C notices to inpatient hospitals for adult hospital professional services also increased in the first year of the requirement but have decreased in FY05-06. 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 05-06, the Adult Access Team received 193 referrals for mental health services from Primary Care. In FY04-05, 329 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 FY04-05, data relating to additional outreach efforts to increase linkages with Alcohol and Other Drugs (ADS) began to be collected by the Adult Access Team. In FY05-06, 57 referrals were received from ADS sources. 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

The MHP places great importance and value in providing education and training in all aspects of clinical, documentation and service delivery. This occurs at Quality Management, through Cultural Competence, and at provider sites and programs. A separate Cultural Competence Plan Update was submitted to the State Department of Mental Health in September 2003 detailing training efforts made specifically in that area. It is believed that contract providers and program administration conduct many trainings of note, which are not captured in this report. Training is a continuous work in progress an ongoing effort. The MHP Quality Management Work Plan and the Cultural Competence Plan goals have emphasized as part of the provider level work plans Training priorities reflected in annual work plan goals were the following areas:

1. To 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.

2. To continue incorporation of cultural competency skill sets within all training and education opportunities.

3. To continue development and delivery of curriculum training for paraprofessionals. Such training shall incorporate a cultural framework to core skill areas that includes, but is not limited to: orientation for new employees; confidentiality, ethics and boundaries; diagnosis and the mental status exam; treatment and service planning; wellness, strength-based and recovery focus with inclusion and involvement of consumer, family and other support systems.

4. To continue to expand the resource list of trainers across cultures and disciplines, and disseminate information from a master training calendar through monthly posting on MHP's website and regular distribution to the provider community.

5. To utilize a variety of training and educational opportunities to enhance the array of culturally competent skill sets and community interfaces for mental health and partner agencies.

Comments:

All five areas of planned activities FY05-06 workplan were addressed in the training provided. Mandated access points to the system received annual and periodic training/consultation. Numerous training sessions of an informational and technical nature incorporated cultural competency skill sets, core skills, and other technical and clinical training. Quality Management staff, Research and Evaluation and Cultural Competence/Ethnic Services staff provide a wide range of training related to providing MHP services. Examples are: an Orientation to the Mental Health Plan, Children's and Adult's Documentation Training Level I and II, Internal Utilization Review, Performance Outcomes, Problem Resolution, Medi-Cal Billing/Treatment Codes, Site Certification, Credentialing, Compliance and Managed Care Regulatory Changes and Advance Medical Directives. All these trainings assist providers in documenting and providing appropriate care to MHP clients.

A wide range of training designed to enhance clinical assessment, intervention, and treatment skills of direct service staff is included in this report. Of note, cultural competency trainings have included administrators and other staff as well to reach clinical and non-clinical staff. New trainers and community resource list of trainers and training opportunities are also distributed to MHP providers on an ongoing basis.

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

Special trainings of note in FY 05-06: In addition to continuing the special offerings that the MHP sponsors, the following areas are highlight some comparable training efforts.

NAME OF TRAINING	TARGET AUDIENCE	NUMBER OF ATTENDEES	
		2004/2005	**2005/2006**
▶ **Medi-Cal Technical Support and Clinical Training**	Adult and Children providers, county staff	**2901**	**3482**
▶ **Cultural Competency Training**	Adult and Children providers, county staff	**2,558**	**2724**
▶ **Documentation Training** Includes Chart Documentation, Medi-Cal Billing/Treatment Codes, Utilization Review, Balancing Clinical Care and Compliance, Day Program Provider Training, and Infant Toddler Assessment Client Plan	Adult and Children's direct service and supervisory staff	**570**	**501**
▶ **Managed Care Regulatory Changes** Includes Compliance Training, Beneficiary Protection, Problem Resolution, Advance Medical Directives	Adult and Children's direct service and supervisory staff	**125**	**118**
▶ **Core Skills Training**	Entry level paraprofessional staff in the Adult system	**139**	**157**
▶ **5150 Certification Training**	Professionals throughout Children's and Adults systems, as well as hospital emergency room and mobile crisis staff	**131**	**98**
▶ **HIPAA Privacy & Security**	Mandated County Staff	**566**	**67**
▶ **Co-Occurring Disorders Case Conferences and Training Opportunities**	Child and Adult Providers, County staff and partnering agencies	**169**	**428**
▶ **Client Service Information (CSI)**	Adult and Children's Service Staff	**NA**	**294**

Findings:

Total attendance numbers for training increased in FY05-06 from 2901 to 3475. Cultural competency focused training also increased from 2558 to 2724. This reflects the MHP's continued commitment to provide targeted training to improve staff ability to delivery quality services to clients and families. Selected topics included in the following chart illustrate the types of core training that have been offered to staff within the Mental Health Plan. For a complete list of training, please refer to "Mental Health Sponsored Trainings" document in the **Appendix V.**

Among important training efforts offered by the Division of Mental Health:

- MHP Orientation for the Mental Health Services Act (MHSA) planning process;
- Training for all clinical and administrative staff in the implementation of the new Client Service Information (CSI) data sheet. This involved training staff who are responsible for entering the billing information into the electronic data system, in addition to clinical staff, so they are aware of the information required as well as any procedural elements;
- Continued training for implementation of the SacPort PsychoSocial Rehabilitation Recovery classes for staff implementers and Consumers;
- Multiple and expanded opportunities for CIMH webcasts hosted by the MHP on Evidence Based Practices, Medicare Part D, MHSA, and consumer/family education;
- Co-Occurring Disorders Case Conferences were held monthly for both the Adult and Children's System of Care – facilitators include mental health and alcohol/drug staff;
- CPS and APS Mandated Reporter Training to improve and maintain risk assessment and mandated reporting skills in clinical staff;
- A conference entitled "Co-Occurring Disorders: Clinical Dilemmas in Assessment and Treatment" training, targeting consumers, mental health providers and providers from alcohol and drug services programs. The MHP remains committed to increasing skills in staff to provide co-occuring treatment as needed by clients and families.
- 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 been seen significant growth and opportunity for the MHP providers to receive timely responses to their inquiries, and additional consultation as needed. The e-communication and technical assistance also supported the MHPs EPSDT providers through a large number of audits. Targeted technical assistance has been provided to assist MHP providers in clinical documentation areas;
- Additional co-sponsorship of topics and events of interest to MHP service providers include *Trading Secrets*, an annual conference collaborative with UCDMC, probation, CPS, mental health, alcohol/drug services and other invested parties; *Consumer Speaks Conference* is sponsored by the Mental Health Association and targets consumers and family members

with mental health providers; *Lesbian, Gay, Bi-Sexual, Transgender (LGBT) Cultural Competency Training*, co-sponsored with a mental health provider;

- Elements of cultural competence are an integral aspect of all MHP trainings, and expansion of cultural competence related trainings is on-going.

ACKNOWLEDGMENTS

The MHP depends on the efforts of Providers, Contract Monitors, Access Teams, County Administration and many support staff. This report acknowledges the special efforts of members of the Quality Management, Cultural Competency and Research and Evaluation Units for their contribution.

Appendix I

QUALITY MANAGEMENT
PROGRAM

ANNUAL WORK PLAN
July 1, 2005 to June 30, 2006

SCOPE	**OBJECTIVES**	***PLANNED ACTIVITY***	**RESPONSIBLE PARTY**	**DUE DATE**
1. Capacity/ Availability	**Preserve capacity of service delivery by:** **Number:** • Increase penetration rate of underserved population by 1.5 percentage points.	• Penetration rate comparative data analysis.	QM, Research & Evaluation, Ethnic Service Staff	Report to QIC July 31, 2006
	Type: • Maintain an array of services through (as of June 30, 2005) through a variety of contracts with organizational and enrolled network service providers. • Maintain number of culturally and linguistically competent network and organizational providers.	• Continue to diversify contracts with organizational and network providers. • Use annual Human Resource survey to monitor progress	Adult & Children's Program, QM & Ethnic Services Staff	
	Geographic distribution: • Maintain service delivery sites across county care system.	• Ensure availability of one or more service delivery sites in each service region.	Adult & Children's Program, QM & Ethnic Services Staff	

SCOPE	**OBJECTIVES**	***PLANNED ACTIVITY***	**RESPONSIBLE PARTY**	**DUE DATE**
1. Capacity/ Availability (continued)	**Preserve existing and continue to develop capacity to serve:** • Unserved and underserved consumers representing language and cultural makeup of the community.	• Compile annual statistics on the number served • Analysis of Cultural Competence Data Collection	Adult & Children's Program, QM, Research & Evaluation and Ethnic Services Staff	Report to QIC due August 2006
2.Accessibility	• Assess and remove barriers for participation of under-represented populations.	• Formulate and analyze gap between penetration rate and population data, and develop strategies for system response.	Access, QM, Research & Evaluation, Ethnic Services	Report to QIC annually.
		• Analyze retention rates annually to determine changes relative to system's Cultural Competence goals.	QM, Research & Evaluation, Ethnic Services	Report to QIC by July 31, 2006
	• Monitor responsiveness of 24-hour telephone access to meet statewide standard for timeliness, responsiveness and cultural competence.	• Quality Management to conduct year round tests of 24 hour call line and MHP follow-up system.	Access & QM	Report to QIC annually
	• Establish mechanisms to monitor access to mental health services.	• Analysis of complaints regarding timeliness.	Program & QM Staff	Report to QIC by July 31, 2006

SCOPE	**OBJECTIVES**	***PLANNED ACTIVITY***	**RESPONSIBLE PARTY**	**DUE DATE**
2.Accessibility **(continued)**	For routine mental health appointments, members will be seen within 30 days of discharge from inpatient hospitalization or crisis unit	• *Collect data, analyze, and provide system feedback. Provide information through targeted program specific reports*	Program, Research & Evaluation, QM	Periodic Reports to QIC
	Ensure consumer satisfaction • Monitor and assess consumer satisfaction. • Inform providers/practitioners of family member satisfaction.	• Administer and analyze State required satisfaction surveys. • Analysis of satisfaction data and ACCESS satisfaction survey data. • Continue to track & trend grievances and Fair Hearings. • Publish satisfaction survey results system wide.	Practitioners/ Providers & QM Research & Evaluation	Annual Report to QIC by July 31, 2006 Same as above Report annually to QIC and publish system-wide.

4. Effectiveness of Care/ Clinical Issues	**To ensure safe, effective, efficient member services.** **Latino Access Study:** • Analyze findings of Latino Access Study completed in FY04-05.	• Develop strategies to address findings of LAS through LAS Committee with community and provider input.	QM, Program & Ethnic Service	Periodic Report to QIC
SCOPE	**OBJECTIVES**	**PLANNED ACTIVITIES**	**RESPONSIBLE PARTY**	**DUE DATE**
4. Effectiveness of Care/ Clinical Issues (continued)	• Identify potential occurrences of poor quality care.	• Continue QIC Executive Committee Review of adverse incidents, identifying issues, including cultural competence considerations, requesting and reviewing plans of correction.	EQIC and appropriate QIC sub-committees	Report as needed to QIC
	• Outcome measures will evaluate for system change and recommend appropriate response strategy.	• Monthly clinical chart reviews, which can identify potential occurrence of poor quality with feedback given to providers. Track corrections and apply information to improve system training.	QM/UR subcommittee on UR	Ongoing
		• Analysis of complaint, grievance, and fair hearings with concomitant monitoring of correction when appropriate.	QM	Report to QIC as needed
		• Use data from all QI/outcome studies, reviews, to identify priorities for and barriers to improvement.	Program Staff and Research and Evaluations	Report to QIC on studies throughout the year
	• Study, analyze and continuously improve medication monitoring and medication practices in Child and Adult system.	• Continue improvements in criteria for medication monitoring for outpatient clinics.	Medication Monitoring Committee & QM	Report on progress to QIC at semi-annual intervals
		• Use practice guidelines developed by Pharmacy and Therapeutics Committee for	P&T Committee	

		schizophrenia and depression. • Focused reports on medication issues by Child and Adult Medical Director led projects.		
SCOPE	**OBJECTIVES**	**PLANNED ACTIVITIES**	**RESPONSIBLE PARTY**	**DUE DATE**
5. Continuity and coordination of care with physical Health Care Providers	**Continuity and coordination with Physical Health Care** • Ensure continuity of care coordination with physical health providers. • Monitor Provider Appeals	• Analyze information from targeted reviews of data relating to physical health/mental health coordination of care. • Analyze information from focused project regarding impact of physical health issues on reported deaths of adult mental health clients. • Continue effort to complete MOU as required with physical healthcare providers.	Adult ACCESS and QM Staff Adult Program	Annual Report to QIC Periodic & Annual Report to QIC
6. **Cultural Competence**	• Ensure access through representation consistent with number of Managed Care beneficiaries. • Ensure that culturally competent & linguistically proficient staff renders services. Outcomes will be equivalent to recipients of services in general.	• Continue to track/trend utilization rates across ethnic groups. • Analyze utilization rates by: age, diagnosis, gender, ethnicity, and primary language. • Track/trend satisfaction through translated surveys. Compare to level of satisfaction of MHP members in general. (As of 2004, only English and Spanish available) MHP will assess feasibility of collecting data in all threshold languages	Research & Evaluation and Ethnic Services Staff Research & Evaluation and Ethnic Services Staff	**Annual report to QIC** **Annual report to QIC**

SCOPE	**OBJECTIVES**	**PLANNED ACTIVITIES**	**RESPONSIBLE PARTY**	**DUE DATE**
6. Cultural Competence (continued)	Ensure agency progression towards cultural competency.	Analyze self-assessment data and compare with the general ethnic representation against the general MHP member population	Research & Evaluation and Ethnic Services Staff	**Same as above Sept. 2006**
7. Training/ Education	• Enhance skill level through education.	• Continue incorporation of cultural competency skill sets within all training/education opportunities. • 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.	QM, Program & Ethnic Services QM & Program Staff QM Staff & Ethnic Services QM & Ethnic Services	**Report back by July 30, 2006** **Ongoing** **Same as above**
SCOPE	**OBJECTIVES**	**PLANNED ACTIVITIES**	**RESPONSIBLE**	

			PARTY	DUE DATE
7. Training/ Education (continued)		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 & Ethnic Services	**Annual Report** **Ongoing**
8. Performance Improvement Projects	**Performance Improvement Projects**	MHP will evaluate preliminary findings on Performance Improvement Projects (PIP) established in FY 04-05. One project will be clinical and another project will be non-clinical.	QM, Ethnic Services, Research and Evaluation Staff	**Periodic Progress Report to QIC**

APPENDIX II

SACRAMENTO COUNTY MHP PROVIDERS 2005-2006 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)
Turning Point Community Programs (A) (2)

East Area:

Another Choice Another Chance (C)
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)
Jewish Family Service of Sacramento (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)
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)
Child and Family Institute (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)
UC Davis Medical Center Child Protection (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)
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 (A)

Sacramento County
Clinical Performance Improvement Project

Quality of Care for Clients With Substance Use/Abuse Co-Occurring Disorders

Assemble multi-functional team

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

The MHP assembled the multi-functional team in November of 2005. During the months of December, January, and February, the team engaged in brainstorming and planning activities, which culminate in the data presented in this report. The multi-functional team was a workgroup of the Quality Improvement Committee, and included the Ethnic services manager; Quality improvement manager; R&E manager; Medical Directors; Contracted providers administration and clinical supervisors (adult and children); County provider administration, line staff and clinical supervisors (adult and children); QM staff; R&E staff; contract monitors and consumer and family member representatives.

"Is there really a problem?"

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

The Division of Mental Health began focusing on the low rates of reporting of co-occurring disorders approximately 10 years ago. One of the first salient instances of underreporting was documented in 1997 and was based on data from our children's system

of care. At that time, all of our children's outpatient programs were utilizing the CAFAS (a clinician rating of child and youth impairment), the CBCL (a caregiver rating of child and youth behavioral problems), and the YSR (a youth self-rating of behavioral problems). What particularly caught our attention was the fact that on the CBCL and YSR, relatively high rates of substance use were being reported by the youth and their caregivers. In stark contrast, clinician ratings indicated that only 6% of 1350 youth were reported as having moderate or severe levels of impairment with respect to substance abuse – and this included nicotine use! At that time, we had several possible explanations including: the CAFAS may not be sensitive enough to detect substance abuse issues; clinical training in the area of identification of substance abuse issues may be inadequate; or clients and caregivers may be unwilling to report substance abuse issues to the clinician but may be willing to indicate the issue on a self-report instrument.

Other data also pointed to low rates of substance use/abuse reporting across many programs in Sacramento. For example, we noted that the rate of substance use/abuse in our adult outpatient population was only 13%. Clients who were discharged from an acute psychiatric hospitalization and no-showed their first outpatient appointment were diagnosed with substance use/abuse issues only 14% of the time. CalWORKs clients, those who are not seriously emotionally disturbed, but who are unable to work because of their alcohol, drug, and mental health issues, were only diagnosed with substance use/abuse issues 16% of the time. Finally, outpatient data previously reported to the EQRO showed that in 2004, only 2.8% of youth, 17% of adults aged 18-59 and 4.4% of adults aged 60 and older were dually diagnosed. Of course, all of these data are viewed in the context of SAMHSA data which indicate that 23% of adults with serious mental illness have co-occurring substance abuse disorders. We consider this to be an issue that relates to all consumers receiving services within our MHP.

It is generally recognized and accepted that clients with both psychiatric and substance abuse issues have a more complex and difficult road to recovery than those struggling with only one of those issues. Treating co-occurring disorders is recognized as a best practice and is hypothesized to result in positive outcomes for clients (e.g., better quality of life, increased community tenure). Dr. Kenneth Minkoff, for example, has identified the *Comprehensive, Continuous, Integrated System of Care Model (CCISC)* for organizing services for individuals with co-occurring psychiatric and substance disorders. The model includes integrated treatment as part of a set of best practices, and specifies that co-occurring disorders be treated as primary, and that primary diagnosis-specific treatment be integrated into the treatment plan.

Adopting and implementing fully integrated treatment, however, can be a challenging task. Many potential barriers exist including: client willingness to disclose information; system philosophy; practitioner knowledge and experience in identifying co-occurring disorders; practitioner beliefs about acceptable billing diagnoses; negative and contradictory Medi-Cal audit experiences; practitioner knowledge and experience in developing treatment plans for co-occurring disorders; and practitioner knowledge and experience in implementing treatment interventions for co-occurring disorders. All of these factors are at least in part, under the influence of the MHP.

The MHP has a series of study questions we would like to address, although the current project is limited to the first, very complex question. The long term goal is to systematically evaluate the impact our efforts have made on the quality of care for clients with substance use/abuse co-occurring disorders. The series of questions is outlined below.

1. ***Can we increase the rate of documentation of substance use/abuse in administrative data?***
2. When substance use/abuse issues are diagnosed, are they addressed in the treatment plan?
3. When substance use/abuse issues are diagnosed and addressed in the treatment plan, is the plan following best practices and of high quality?
4. When substance use/abuse issues are diagnosed and addressed in a high quality treatment plan, are there more positive client outcomes than in other cases?

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

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

The multi-functional team that assembled to tackle this issue participated in a series of brainstorming sessions to help develop hypotheses concerning the low rates of documented dual diagnoses in our administrative data. In the first session, the team talked about the AB2034 program that we knew had higher rates of dual diagnosis. We compared data from two organizational providers that had 3 programs with differing levels of intensity (AB2034, intensive outpatient services, and regular outpatient services). The data showed that the rates of dual diagnosis decreased with the intensity of services – they were 53%, 22%, and 10% respectively. Understanding that the populations served by each program might also differ somewhat, the team hypothesized that something about the actual practices in the different levels of intensity might also differ.

The following is a list of possibilities generated by the team over several meetings. These four have been condensed/combined from an original list of more than twenty.

(1) Clients are not disclosing/sharing information about their substance abuse issues (due to embarrassment, fear, lack of trust, denial, etc).

(2) Clinicians are not recognizing substance abuse issues in their clients (due to fear, lack of time, lack of training, personal experience).

(3) Clinicians are recognizing substance abuse issues, but are not documenting the diagnosis in clinical assessments (due to fear, lack of time, beliefs about acceptable billing diagnoses, knowledge of treatment planning, etc).

(4) Clinicians are recognizing and documenting substance abuse issues, but the information is not being entered into the administrative data (a data entry problem).

In order to determine the validity of these possibilities, we have taken the following steps (#1 to #3 are completed and we are in process with #4):

(1) Nine focus groups were conducted (four with line staff and five with clients) to ask a series of questions about experience with dual diagnosis issues, level of comfort with the issues, knowledge of resources available in the community, and factors that affect its disclosure, documentation, etc. Because of our interest in intensity of service, we talked to staff and clients from both AB2034 programs as well as regular outpatient programs. A summary of the focus groups and the focus group questions is attached (Attachment 1). In essence, however, the common finding from both staff and clients was that talking about dual diagnosis issues in the context of treatment felt comfortable and beneficial after the client and service provider had an opportunity to build rapport and trust. Prior to the establishment of a relationship, there was fear about losing SSI/other benefits, having Child Protective Services called, as well as other negative repercussions. No clients reported a negative outcome after having shared their substance abuse issues with clinician or doctor. The findings were similar regardless of intensity of service.

(2) Medical Directors of the major adult out-patient clinics participated in a questionnaire designed to understand the factors that might impact their making a substance abuse diagnosis or referral for the clients. A summary of the findings along with the questionnaire is attached (Attachment 2). In general, the psychiatrists acknowledge that they do not always give a dual diagnosis to those they suspect as having substance abuse issues. Barriers to making a diagnosis and/or referring a client to AOD services reported by the physicians primarily dealt with knowledge of services available in community and access of services for patients.

(3) Utilization Review information was used to specifically address whether client substance use information indicated substance abuse or neglect, and if it did, whether a substance abuse/dependence diagnosis was reflected in the assessment. In addition, if there was a substance abuse/dependence diagnosis, we determined whether there was an appropriate goal in the Treatment Plan (Attachment 3). The data show that in those cases where service providers note evidence of current substance abuse or dependence, they fail to indicate a substance abuse diagnosis in about 1/3 of cases.

(4) A chart review will be performed to determine the frequency with which a substance abuse diagnosis appears in the chart, but is not reflected in the information system.

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

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Lack of post-hospitalization substance abuse (SA) linkages	Retrospective review of all adults readmitted for acute psychiatric hospitalizations to Nurses' Hospital within 30 days of initial discharge in FY 05. 16% of those with co-occurring SA issues had planned linkage for substance abuse counseling upon prior discharge
Lack of client trust of service coordinators	Clients and line staff agree that clients are less likely to share issues regarding substance abuse/dependence until rapport and trust have been developed.
Lack of knowledge of system resources for referral	Psychiatrists view lack of AOD resources as a barrier to diagnosis (because don't know where to refer)
Lack of time in psychiatrist assessment	Psychiatrists feel they don't have sufficient time to assess and refer appropriately for dual diagnosis issues – acute psychiatric issues have to take precedence
Lack of access (time, location, existence) of Treatment programs	Clients, line staff and psychiatrists agree that there are not sufficient system resources for dually diagnosed clients. Therefore, it is difficult to develop an appropriate treatment plan, so it is best to not include it in the diagnosis
Lack of accurately reflecting dual diagnosis assessment information in clinical documentation	There is room for improvement in the accuracy of documentation from service coordinators

The MHP will formulate the study question after completing the chart review to determine the frequency with which a substance abuse diagnosis appears in the chart, but is not reflected in the information system.

Formulate the study question

Example: If we improve care coordination and linkages, then can we reduce the number and percent of adults with unplanned re-admissions for acute psychiatric hospitalizations within 30 days of discharge?

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

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

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

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

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

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

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

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

9. a) Why were these indicators selected?

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

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

Table B – List of Indicators, Baselines, and Goals

#	Describe Indicator	Numerator	Denominator	Baseline for indicator	Goal
EX:	Unduplicated adults with identified SA issues with unplanned readmissions for acute psychiatric hospitalizations to Nurses' Hospital within 30 days of initial discharge	6 adults readmitted had planned SA linkages	37 unduplicated adults readmitted with identified SA issues	6 / 37 = 16% readmitted had planned linkages	32% of adults with unplanned readmissions will have planned SA linkages when appropriate. (an increase of 100%)
1					
2					
3					
4					
5					

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

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
#1	Education of Hospital and case management staffs, which includes: • Review of existing referral protocols with Hospital & case management staff. • Initiation of procedure to assess for referrals, prior to discharge, when discharge instructions are shared with consumers • Monitoring of targeted readmissions for linkages and provide feedbacks to management every two weeks	Issues associated with staff knowledge and behaviors: • Lack of staff knowledge about existing protocols • Lack of staff understanding about expectations • Lack of staff adherence to existing protocols • Lack of planned linkage for SA counseling	9/1/05 – 2/28/06
1			
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Apply Interventions: “What do we see?”
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

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

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

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

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

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

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

Describe indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
Example: # 1	7/1/05	6 adults with readmissions had addressed SA linkages 37 unduplicated adults with unplanned readmissions with identified SA issues 6 / 37 = 16% had planned linkage	32% (100% improvement)	#1: 9/1/05 – 2/28/06	3/1/06, retrospective for same 6-month period	6 adults with unplanned readmissions had addressed SA linkages 16 unduplicated adults with unplanned readmissions with identified SA issues 6/16 = 38% had planned linkage	> 100% improvement

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

17. Describe issues associated with data analysis:

    a. Data cycles clearly identify when measurements occur.

    b. Statistical significance

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

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

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

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

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

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

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

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

APPENDIX III (B)

Sacramento County
Non-Clinical Performance Improvement Project

Determining the Validity of Diagnosis Data in the Foster Care Medi-Cal Claim

Assemble multi-functional team

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

The MHP assembled the multifunctional team for the first time on June 19, 2006. The team included representatives from Children's Programs, TBS, Out of County Placement, Cultural Competence, Research & Evaluation, and Quality Management. Subsequent meetings included representatives of the IT and Fiscal units. A children's provider, consumer, and family member representative will also be added to the team in the near future.

"Is there really a problem?"

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

The Sacramento County team convened for the first time on June 19, 2006 and considered data provided by APS Healthcare on mental health services to foster care youth. The data set was comprised of information related to approved claims for FY04-05 for foster care beneficiaries. Although the data set presented several interesting issues for discussion, the primary one of focus for the team became the large proportion of unduplicated foster care eligibles that are categorized as having a "Deferred/Missing" Diagnosis

(22.6% or 1,020 youth). We were concerned about the high rate of "Deferred/Missing" Diagnoses primarily because of quality of care/clinical implications. Specifically, without the accurate assessment and identification of presenting problems and diagnoses, appropriate treatment planning is difficult.

The team immediately attempted to brainstorm reasons for the high rate of Deferred/Missing diagnoses and generated several ideas, including:

- Age of clients is young and there may be a reluctance on the part of clinicians to give a diagnosis
- If it is the start of service, there may not be a diagnosis yet
- There may be a failure to update the record in the data system at any later point when Deferred or Missing is resolved
- Some referrals are to establish whether there is need for services and may be assessed and found not to meet medical necessity, so there wouldn't be a diagnosis
- Clients closed after completing treatment with V71.09 closing diagnosis may be seen as last diagnosis given.
- What is included in Deferred: Psychotic Disorder NOS (not clarified after 6 months; Dysthmia?; Adjustment Disorder NOS; what else is included or not in this category.
- Data may be in physical record but not made it over to the electronic system.

One additional issue the team did consider, however, was that if the MHP had such high rates of Deferred/Missing diagnoses in foster care youth, that is was likely that the problem might be reflected elsewhere in our children's system as well. Therefore, the first action we undertook was to examine the rate of Deferred/Missing diagnoses in our children's system as a whole. Again, we reasoned that if the rate of Deferred/Missing diagnoses was over 20%, then appropriate treatment planning was less likely to be occurring for a substantial minority of our youth. The MHP believes this is a problem given that accurate clinical information and appropriate treatment planning impacts quality and continuity of care. This issue is especially important in the foster care population given that some children with multiple risk factors move frequently and accurate clinical records can facilitate or create barriers to their care. The MHP, however, sees the need for accurate diagnostic clinical records for all children as an important goal to document improvements, changes and continuity in care. Thus, this PIP can address the issue of valid diagnoses in the children and youth served by the MHP.

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

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

As stated above, the first action we undertook was to examine the rate of Deferred/Missing diagnoses in our children's system as a whole (see Attached excel document for data). The data we looked at was for Calendar Year 2005, and it reflected admission and discharge diagnoses for all children and youth served by the MHP. The highlighted lines of data in the attachment indicate what we would classify as a Deferred/Missing diagnosis. An examination of the data suggests that we do not see the proportionately large number of Deferred/Missing diagnoses evident in the Foster Care Eligible data supplied by APS. For example, of the 13,574 diagnoses across our whole child and youth outpatient population, only 904 (6.7%) would be classified as Deferred/Missing. While still a large number of Deferred/Missing diagnoses, the percentage is much less (6.7% versus 22.6%).

At this point, we have at least two issues to investigate in order to develop this PIP and the resultant study question.

(1) Although we have been unable to replicate either the number or percent of Deferred/Missing diagnoses, 904 is still a large number of youth for whom more accurate assessment and identification of presenting problems may be lacking. As the data indicate, however, the majority of these Deferred/Missing diagnoses exist at admission (5.0% at admission versus 1.7% at discharge). Therefore, the MHP needs to investigate whether they are accurate or require appropriate diagnostic reconciliation, or whether an intervention is needed to clinically update these diagnoses at a stage more helpful to the beneficiary. The MHP will search for understanding underlying factors in this Deferred/Missing Diagnosis area. For example: are there clusters of Deferred/Missing Diagnosis by age, program or agency? Are the charts accurate but the IT system not reflecting the changes? Is there an unplanned delay in completing assessments resulting in longer deferred diagnoses? Are the deferred diagnoses a result of referrals made only for diagnostic clarification purposes? Each query has clinical and continuity of care implications for the beneficiary of care within the MHP.

(2) The discrepancy between the data supplied by APS and that generated by the MHP remains an important concern. Consultation with an APS team helped to generate some hypotheses for the difference. These included:

- APS data was FY and MHP data was calendar year
- Possibility of differential classification of Deferred/Missing by APS and the MHP
- Youth served out of County are not reflected in MHP data, but they are in APS approved claims data

- When youth had multiple diagnoses during the FY, the diagnostic classification rule used by APS needed clarification.
- APS data reflected approved claims diagnoses while County data reflected admission and discharge diagnoses

Nonetheless, none of these issues seem sufficient to explain the discrepancy between the two datasets. Therefore, the APS and MHP teams began to take a look at the process the MHP utilizes to generate the Medi-Cal claim. Essentially, the Medi-Cal claim is generated using multiple steps:

1. Data are extracted from CATS (the MHP's IT system) into an Access database
2. The Access database is imported into Biztalk
3. Biztalk generates the 837 which is sent to DMH
4. DMH generates the EOB and 835, which indicate the claims that are approved.

APS has been using the Statewide EOB to generate the approved claims data that showed Sacramento to have 1,020 foster care youth with Deferred/Missing diagnoses. Thus, it is possible that somewhere between CATS and the Statewide EOB, the diagnosis data from Sacramento are being altered/corrupted. In order to investigate whether this is the case, we will use our EOB data from FY04-05 to attempt to duplicate the data supplied to us by APS. We won't get 100% duplication because our EOB does not contain the out-of-county beneficiaries, nor do we have the diagnostic classification rule used by APS in instances where youth have more than one diagnosis during the FY.

If we validate the EOB data, the MHP will embark on a series of steps to determine where in the process the diagnosis data are being altered from valid diagnoses. This is important to the MHP because in order to understand the service needs of foster youth, accurate diagnostic data is important. Planning programs for specific subsets of youth, determining the true cost of programs, as well as the cost-effectiveness of programs for youth with specific characteristics, will be unreliable if youth are not reflected accurately.

If we cannot validate the EOB data, we will continue to work with APS to determine the reason for the discrepancy. Paid claims data is utilized by a variety of stakeholders and evaluators for a variety of Statewide projects and cross-county comparative studies. Therefore, accuracy in this diagnostic area and an understanding of the assumptions underlying data sets is valued by the MHP. The MHP also sees the APS data sets as valuable in efforts to compare itself with other similar size counties across the State. Therefore this part of the non-clinical PIP may have the positive unintended consequence of improving our understanding of data transmission from the local to the State level.

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

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Lack of post-hospitalization substance abuse (SA) linkages	Retrospective review of all adults readmitted for acute psychiatric hospitalizations to Nurses' Hospital within 30 days of initial discharge in FY 05. 16% of those with co-occurring SA issues had planned linkage for substance abuse counseling upon prior discharge

Formulate the study question

Example: If we improve care coordination and linkages, then can we reduce the number and percent of adults with unplanned re-admissions for acute psychiatric hospitalizations within 30 days of discharge?

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

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

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

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

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

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

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

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

9. a) Why were these indicators selected?

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

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

Table B – List of Indicators, Baselines, and Goals

#	Describe Indicator	Numerator	Denominator	Baseline for indicator	Goal
EX:	Unduplicated adults with identified SA issues with unplanned readmissions for acute psychiatric hospitalizations to Nurses' Hospital within 30 days of initial discharge	6 adults readmitted had planned SA linkages	37 unduplicated adults readmitted with identified SA issues	6 / 37 = 16% readmitted had planned linkages	32% of adults with unplanned readmissions will have planned SA linkages when appropriate. (an increase of 100%)
1					
2					
3					
4					
5					

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

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
#1	Education of Hospital and case management staffs, which includes: • Review of existing referral protocols with Hospital & case management staff. • Initiation of procedure to assess for referrals, prior to discharge, when discharge instructions are shared with consumers • Monitoring of targeted readmissions for linkages and provide feedbacks to management every two weeks	Issues associated with staff knowledge and behaviors: • Lack of staff knowledge about existing protocols • Lack of staff understanding about expectations • Lack of staff adherence to existing protocols • Lack of planned linkage for SA counseling	9/1/05 – 2/28/06
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Apply Interventions: "What do we see?"

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

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

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

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

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

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

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

Describe indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
Example: # 1	7/1/05	6 adults with readmissions had addressed SA linkages ——— 37 unduplicated adults with unplanned readmissions with identified SA issues 6 / 37 = 16% had planned linkage	32% (100% improvement)	#1: 9/1/05 – 2/28/06	3/1/06, retrospective for same 6-month period	6 adults with unplanned readmissions had addressed SA linkages ——— 16 unduplicated adults with unplanned readmissions with identified SA issues 6/16 = 38% had planned linkage	> 100% improvement

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

17. Describe issues associated with data analysis:

    e. Data cycles clearly identify when measurements occur.

    f. Statistical significance

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

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

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

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

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

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

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

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

APPENDIX IV

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 V

System-Wide Technical & Clinical Trainings		
July 1, 2005 - June 30, 2006		
DATE	**#**	**TRAINING JULY '05 - June '06**
9/1/2005	17	5150 Certification Training
1/9/2006	17	5150 Certification Training
5/8/2006	26	5150 Certification Training
8/11/2005	13	5150 Re-Certification Training
11/3/2005	6	5150 Re-Certification Training
3/13/2006	10	5150 Re-Certification Training
1/27/2006	9	5150 Train-the-Trainer Training
8/30/2005	38	Adult Protective Services Mandated Reporter Training
5/3/2006	10	Adult Protective Services Mandated Reporter Training
1/19/2006	20	After Hours Phone Calls Meeting/Training (Adult)
2/15/2006	5	After Hours Phone Calls Meeting/Training (Adult)
3/1/2006	16	After Hours Phone Calls Meeting/Training (Children)
1/30/2006	8	After Hours Phone Calls Meeting/Training (MHTC)
2/7/2006	9	After Hours Phone Calls Meeting/Training (MHTC)
3/22/2006	7	An Overview of Child and Adolescent Psychopharmacology
11/3/2005	12	Any Door is the Right Door Conference-Mental Health, AOD, Domestic Violence, CIMH
3/7/2006	50	Balancing Clinical Care & Compliance Issues (QM Technical Assistance (Adult) Training)
3/7/2006	87	Balancing Clinical Care & Compliance Issues (QM Technical Assistance (Child) Training)
11/1/2005	16	Child Protection Services Mandated Reporting Training
6/14/2006	44	Client Services Information (CSI) Data Collections Changes (Child & Adult) Training @ 11:00 am
6/15/2006	36	Client Services Information (CSI) Data Collections Changes (Child & Adult) Training @ 11:00 am
6/14/2006	41	Client Services Information (CSI) Data Collections Changes (Child & Adult) Training @ 8:30 am
6/15/2006	47	Client Services Information (CSI) Data Collections Changes (Child & Adult) Training @ 8:30 am
4/5/2006	9	Compliance Program Training

5/4/2006	22	Compliance Program Training
5/12/2006	28	Compliance Program Training
6/14/2006	12	Compliance Program Training
6/29/2006	31	Compliance Program Training
9/22/2005	**148**	**Consumer Speaks Conference**
8/1/2005	17	Co-Occurring Disorders Case Conferences Series (Adult)
10/3/2005	18	Co-Occurring Disorders Case Conferences Series (Adult)
11/7/2005	18	Co-Occurring Disorders Case Conferences Series (Adult)
12/5/2005	17	Co-Occurring Disorders Case Conferences Series (Adult)
3/6/2006	20	Co-Occurring Disorders Case Conferences Series (Adult)
4/3/2006	19	Co-Occurring Disorders Case Conferences Series (Adult)
5/1/2006	17	Co-Occurring Disorders Case Conferences Series (Adult)
6/5/2006	24	Co-Occurring Disorders Case Conferences Series (Adult)
9/21/2005	16	Co-Occurring Disorders Case Conferences Series (Youth)
2/15/2006	7	Co-Occurring Disorders Case Conferences Series (Youth)
3/15/2006	11	Co-Occurring Disorders Case Conferences Series (Youth)
4/19/2006	30	Co-Occurring Disorders Case Conferences Series (Youth)
6/21/2006	10	Co-Occurring Disorders Case Conferences Series (Youth)
9/20/2005	215	Co-Occurring Disorders: Clinical Dilemmas in Assessment and Treatment Training
1/26/2006	14	Core Skills Training Series - Confidentiality, Ethics and Boundaries
5/16/2006	6	Core Skills Training Series - Confidentiality, Ethics and Boundaries
9/20/2005	18	Core Skills Training Series - DSM IV and Mental Status Exam
3/23/2006	12	Core Skills Training Series - DSM IV and Mental Status Exam
7/20/2005	9	Core Skills Training Series - Orientation to the Mental Health Plan
10/19/2005	5	Core Skills Training Series - Orientation to the Mental Health Plan
1/18/2006	13	Core Skills Training Series - Orientation to the Mental Health Plan
4/6/2006	12	Core Skills Training Series - Orientation to the Mental Health Plan
8/16/2005	23	Core Skills Training Series - Risk Assessment
2/23/2006	13	Core Skills Training Series - Risk Assessment
6/14/2006	8	Core Skills Training Series - Risk Assessment

11/15/2005	16	Core Skills Training Series - Treatment/Service Planning
4/19/2006	8	Core Skills Training Series - Treatment/Service Planning
7/14/2005	2	Credentialing Training
10/20/2005	9	Credentialing Training
2/16/2006	4	Credentialing Training
7/7/2005	26	Day Program Provider Training
9/23/2005	47	Documentation 1 (Adult) & Performance Outcomes Training @ HRC
2/8/2006	17	Documentation 1 (Adult) & Performance Outcomes Training @ Northgate
5/10/2006	39	Documentation 1 (Adult) & Performance Outcomes Training @ Visions
7/19/2005	48	Documentation 1 (Child) & Performance Outcomes Training
10/18/2005	50	Documentation 1 (Child) & Performance Outcomes Training
1/9/2006	24	Documentation 1 (Child) & Performance Outcomes Training
4/12/2006	42	Documentation 1 (Child) & Performance Outcomes Training
9/30/2005	22	Documentation 2 (Adult) Training @ HRC
2/9/2006	17	Documentation 2 (Adult) Training @ Northgate
5/11/2006	34	Documentation 2 (Adult) Training @ Visions
7/20/2005	45	Documentation 2 (Child) Training
10/19/2005	38	Documentation 2 (Child) Training
1/11/2006	28	Documentation 2 (Child) Training
4/13/2006	37	Documentation 2 (Child) Training
10/7/2005	13	Documentation Training @ Cross Creek
9/23/2005	76	Facts About Adolescent Depression and Suicide: Science, Sense, and Non-Sense
11/21/2005	**18**	**Group Facilitator Workshop - Wellness, Recovery, Peer Support Training**
5/25/2006	8	Identification and Treatment in Children and Adolescents
12/1/2005	**64**	**Introduction To Wellness Recovery Action Plan (WRAP) Training**
9/13/2005	149	Latino Behavioral Health Week - Use of Psychotropic Medication with Latino Populations
6/30/2006	60	Lesbian, Gay, Bi-Sexual, Transgender (LGBT) Cultural Competency Training
7/6/2005	7	Medi-Cal Billing/Treatment Code Training
8/3/2005	5	Medi-Cal Billing/Treatment Code Training
10/5/2005	5	Medi-Cal Billing/Treatment Code Training

11/2/2005	15	Medi-Cal Billing/Treatment Code Training
2/1/2006	10	Medi-Cal Billing/Treatment Code Training
3/1/2006	7	Medi-Cal Billing/Treatment Code Training
4/5/2006	12	Medi-Cal Billing/Treatment Code Training
5/3/2006	4	Medi-Cal Billing/Treatment Code Training
6/7/2006	8	Medi-Cal Billing/Treatment Code Training
6/5/2006	10	MHSA Co-Occurring Disorders Training Planning
5/18/2006	66	Out of the Shadow @ The Crest
8/2/2005	1	Problem Resolution/Advance Medical Directives Training
11/1/2005	5	Problem Resolution/Advance Medical Directives Training
1/11/2006	3	Problem Resolution/Advance Medical Directives Training
4/12/2006	7	Problem Resolution/Advance Medical Directives Training
6/21/2006	11	Psychological Testing 101 Training
7/6/2005	**7**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
7/20/2005	**11**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
7/27/2005	**11**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
8/17/2005	**14**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
8/18/2005	**5**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
8/24/2005	**14**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
10/19/2005	**13**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
10/26/2005	**13**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
11/7/2005	**3**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
11/14/2005	**3**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
11/30/2005	**6**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
12/5/2005	**6**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
3/9/2006	**10**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
3/16/2006	**10**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
4/12/2006	**9**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
4/26/2006	**9**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**

5/25/2006	**4**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
5/26/2006	**4**	**SacPort - Advanced Implementer - Wellness, Recovery, Peer Support Training**
7/14/2005	**14**	**SacPort - Community Wide Liaison - Wellness, Recovery, Peer Support Training**
8/11/2005	**10**	**SacPort - Community Wide Liaison - Wellness, Recovery, Peer Support Training**
11/10/2005	**10**	**SacPort - Community Wide Liaison - Wellness, Recovery, Peer Support Training**
2/16/2006	**9**	**SacPort - Co-Occurring Disorders - Wellness, Recovery, Peer Support Training**
1/12/2006	**9**	**SacPort - How to Complete a Module - Wellness, Recovery, Peer Support Training**
9/8/2005	**9**	**SacPort - How to Properly Complete a Module - Wellness, Recovery, Peer Support Training**
7/8/2005	**1**	**SacPort - In-Vivo-Russian - Wellness, Recovery, Peer Support Training**
5/11/2006	**7**	**SacPort - Module Overview Recreation & Leisure - Wellness, Recovery, Peer Support Training**
6/8/2006	**6**	**SacPort - Orientation to Module Tracking Sheet - Wellness, Recovery, Peer Support Training**
10/13/2005	**13**	**SacPort - Pre & Post Test - Wellness, Recovery, Peer Support Training**
6/9/2006	**3**	**SacPort - Problem Solving - Wellness, Recovery, Peer Support Training**
7/13/2005	**4**	**SacPort - SAMM - Wellness, Recovery, Peer Support Training**
12/7/2005	**4**	**SacPort - SAMM - Wellness, Recovery, Peer Support Training**
2/1/2006	**21**	**SacPort - SAMM - Wellness, Recovery, Peer Support Training**
6/22/2006	**15**	**SacPort - SAMM - Wellness, Recovery, Peer Support Training**
6/1/2006	**2**	**SacPort - SAMM & Community Re-Entry Program - Wellness, Recovery, Peer Support Training**
12/14/2005	**5**	**SacPort - SAMM Booster - Wellness, Recovery, Peer Support Training**
4/13/2006	**7**	**SacPort - SAMM Overview - Wellness, Recovery, Peer Support Training**
6/2/2006	**7**	**SacPort - SAMM Practice Session - Wellness, Recovery, Peer Support Training**
6/19/2006	**30**	**SacPort - STARS Presentation - Wellness, Recovery, Peer Support Training**
3/9/2006	**11**	**SacPort - WRAP Overview - Wellness, Recovery, Peer Support Training**
4/5/2006	22	Safety In Numbers Case Conference
10/20/2005	6	Site Certification Training
2/16/2006	4	Site Certification Training
5/11/2006	3	Site Certification Training
10/20/2005	9	Staff Qualification/Credentialing Training
2/16/2006	4	Staff Qualification/Credentialing Training

5/11/2006	8	Staff Qualification/Credentialing Training
12/21/2005	9	Technical Assistance Training @ TLCS Passages
11/15/2005	470	Trading Secrets Training
8/16/2005	0	UMDAP and Medi-Cal Eligibility Training
10/18/2005	13	UMDAP and Medi-Cal Eligibility Training
2/7/2006	8	UMDAP and Medi-Cal Eligibility Training
5/16/2006	5	UMDAP and Medi-Cal Eligibility Training
9/20/2005	3	Utilization Review (Adult) Training
9/21/2005	13	Utilization Review (Child) Training
8/12/2005	15	Video Conference: MHSA Community Services and Supports Plan Requirements Training
1/23/2006	1	Video Conference: Statewide Family Advocate Roundtable Training
7/26/2005	**11**	**WebCast: CIMH MHSA: Employment in Recovery Training**
7/28/2005	**5**	**WebCast: CIMH MHSA: Employment in Recovery Training**
7/5/2005	**6**	**WebCast: Evidence Based & Promising Practices Training**
9/30/2005	3	WebCast: Medicare Part D Webcast Training
12/21/2005	1	WebCast: Medicare Part D Webcast Training
8/8/2005	5	WebCast: MHSA Intro to Regional Data Trainings
8/18/2005	0	WebCast: MHSA Selecting an Evidence Based Practice for Children Training
8/11/2005	0	WebCast: MHSA TAY Program Design Training
8/4/2005	4	WebCast: MHSA TAY Supported Education/Employment Training
9/13/2005	12	WebCast: SD/MC Claims Summary Report Training
3/29/2006	4	WebCast: TBS EPSDT Training
8/2/2005	**6**	**WebCast: MHSA Wellness and Recovery Overview**
8/9/2005	**0**	**WebCast: MHSA Wellness and Recovery: Evidence Based Training**
TOTAL	**3482**	