ESTABLISHMENT OF QUALITY INDICATORS FOR CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

A Report to the Legislature
in Response to
Chapter 93, Statutes of 2000

Department of Mental Health
Stephen W. Mayberg, Ph.D.
Director

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REPORT TO THE LEGISLATURE

ESTABLISHMENT OF QUALITY INDICATORS FOR CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

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EXECUTIVE SUMMARY

Chapter 93, Statutes of 2000, an omnibus Health Trailer Bill to the Budget Act of 2000, recognized the Quality Improvement Committee (QIC) in law and directed it to "establish and measure indicators of access and quality to provide the information needed to continuously improve the care provided in California's public mental health system." Further, the Department of Mental Health (DMH) was directed to report on the development of these indicators by March 1, 2001. This report presents the performance measurement indicators developed by DMH and the QIC.

The QIC was administratively established within DMH in Fiscal Year 1998/99. It was an outgrowth of the Department's federal waiver to consolidate specialty mental health services, both inpatient and outpatient, and deliver those services at the local level through county-based mental health plans. Actual meetings of officially designated QIC members began in May 1999. The QIC has been meeting four to six times per year.

Prior to the legislative mandate in Chapter 93, DMH and the QIC had begun to review data with the goal of identifying key processes and improving performance in the delivery of quality mental health care. In its deliberations, the QIC had already adopted the performance measurement terminology used by the American College of Mental Health Administrators (ACMHA). While this varies slightly from the terminology used in Chapter 93, the content is virtually the same.

In determining what indicators to select as part of the performance measurement system, the QIC judged possible indicators against a variety of criteria:

- Meaningfulness for users.
- Applicability to an issue of importance for stakeholders.
- Availability of data in the California mental health system.
- Reliability of data obtained.
- Compatibility with California programs and priorities.
- Potential for California performance goals and comparison with national benchmarks.
- Similar measures found to be useful in other states and managed care companies.
- Similar measures found to be useful in other performance measurement systems.
- Restricted number of indicators initially.

Using these criteria as a guide along with the legislative requirements of Chapter 93, the QIC has adopted indicators within each of four domains – Structure, Access, Process, and Outcomes.

In their deliberations on performance indicators, the QIC and DMH came to the realization that there are many critical aspects of service delivery for which data sources are not readily available. Such concerns require special study to determine if they can be measured and if so, what benchmarks of performance are desirable. A variety of special studies have been identified in each of three domains – Structure, Access and Process. It is anticipated that the scope of a special study would continue to be refined as investigation continues.

The table on the next page summarizes the indicators and special studies that will be pursued. A more complete explanation of each can be found in the body of this report.

The QIC and DMH will focus on these performance indicators and special studies for at least the next year in order to establish baselines, identify trends, and develop a fuller understanding of the current quality of care being delivered in the public mental health system. In time, indicators may need to change to more fully reflect this increasing sophistication. On the national level, there continues to be a growing concern for quality measurement that may result in additional federal requirements related to state quality monitoring and external quality review. This preliminary set of indicators and special studies will position the QIC and DMH to adapt and develop as circumstances require while helping to improve the quality of care delivered in the California public mental health system.

Summary of Performance Measurement Indicators and Special Studies

DOMAIN	INDICATORS	SPECIAL STUDIES
Structure	Total Cost of Services per Client Type of Service	Structural Elements of Mental Health Plans (MHPs) Content Analysis of Annual Mental Health Quality Improvement Work Plans Client/Family Member Input and Involvement
Access	Penetration Rate EPSDT Penetration Rate Retention Rate in Routine, Outpatient Services for New Clients Follow-up Care After Inpatient Discharge Average Length of Time Between Inpatient Discharge and Next Contact Average Length of Time Between First Contact and Second Contact for New Patients for Routine, Outpatient Services Perception of Availability of Services – Caregiver/Youth, Adult/Older Adult	Timeliness of Services Underutilization of Mental Health Services - Latino Populations
Process	Consumer Perception of Involvement in Treatment Decisions - Adults/Older Adults Consumer Perception of Satisfaction - Adults/Older Adults Caregiver Perception of Satisfaction – Caregiver/Youth	Rehospitalization Involuntary Admission to Inpatient Facilities Fair Hearings Focus Groups Utilization of Inpatient Services - African American Populations
Outcomes	Consumer Perception of Improvement in Functioning - Adults/Older Adults Perception of Improvement in Functioning and Symptom Reduction - Youth Consumer Perception of Symptom Reduction - Adults/Older Adults	

REPORT TO THE LEGISLATURE

ESTABLISHMENT OF QUALITY INDICATORS FOR CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

ISSUE STATEMENT

This document is a report to the Legislature as required by Chapter 93, Statutes of 2000, which contains the following language:

> *"The department, in consultation with the Quality Improvement Committee…shall establish and measure indicators of access and quality to provide the information needed to continuously improve the care provided in California's public mental health system.*
>
> *The department, in consultation with the Quality Improvement Committee shall include specific indicators in all the following areas:*
> *(1) Structure.*
> *(2) Process, including access to care, appropriateness of care, and the cost effectiveness of care.*
> *(3) Outcomes.*
>
> *…The department shall report to the legislative budget committees on the status of the efforts in Section 5614 (Welfare and Institutions Code) and this section by March 1, 2001. The report shall include presentation of the… indicators developed pursuant to this section or barriers encountered in their development."*

This report presents the indicators of Structure, Access, Process and Outcome established by the Department of Mental Health working with the QIC. It also provides detailed information on additional Quality Special Studies the Department and the QIC will pursue.

BACKGROUND

Performance measurement is increasingly recognized as a critical element in assessing efficiency, cost-effectiveness and accountability in health care. As the costs of delivering quality health and mental health care rise on both the state and national levels, the importance of performance measurement increases. As currently used, performance measurement means the quantitative assessment of health and human services processes and outcomes. In general, indicators of quality care are identified, benchmarks are established, data is collected and performance against the indicators is measured.

California's concern and interest in continuous quality improvement and measuring system performance is consistent with system accountability goals established in realignment legislation and historically supported by DMH and the California Mental Health Planning Council (CMHPC). Appendix I. provides detail on other recent performance outcome activities of DMH and CMHPC.

The implementation and operation of the Medi-Cal mental health managed care program in California, operating under a federal 1915(b) Freedom of Choice Waiver, has been the subject of ongoing review by state and federal policymakers and stakeholder groups. Of particular interest has been the Department's ability to continuously improve this program. Toward this end, the Department established the QIC in early 1999 to identify various system performance indicators to be monitored over time and to develop special quality improvement studies focused on the Medi-Cal mental health managed care program. Appendix II. contains the Mission Statement of the QIC and a roster of the current membership.

With the passage of Chapter 93, Statutes of 2000, an omnibus Health Trailer Bill to the Budget Act of 2000, the QIC is now established in statute. This legislation also directed DMH and the QIC to establish performance indicators in all of the following areas: Structure, Process (including access to care, appropriateness of care and cost effectiveness of care), and Outcomes. This charge applied to care delivered in the Medi-Cal mental health managed care program specifically and also to the entire public mental health system.

In addition to the indicators that have been selected, DMH and the QIC identified critical elements of the mental health care system that need special study. The goal is to create additional performance measurement indicators that reflect California programs.

Because of the nature and amount of quality improvement activity that DMH and the QIC have undertaken, it was determined that the QIC would need to spin off smaller QIC workgroups and also rely on the expertise in existing DMH advisory committees. This has been a successful strategy to date. It allows access to a greater range of expertise and offers a more flexible structure capable of reacting to issues in a more prompt and detailed manner than would be possible for the QIC

acting as a whole. QIC quality activities are currently being leveraged and supported by the following groups:

- QIC Inpatient Treatment Review Workgroup
- QIC Performance Indicator Workgroup
- QIC Outpatient Services Workgroup (Proposed)
- DMH Compliance Advisory Committee
- DMH Client and Family Member Task Force
- DMH Cultural Competence Advisory Committee

OBJECTIVE

The objective of this report is to provide the Legislature with detailed information about the Performance Measurement Indicators and Special Studies developed by DMH and the QIC in accordance with Chapter 93, Statutes of 2000.

STUDY METHODOLOGY

While there are a number of national efforts to develop mental health performance measures for states, there are not yet any standard measures that can be readily adopted. Neither is there agreement on a common terminology to use in performance measurement. In addition California, like other states, maintains unique data systems that influence the selection of indicators. This section of the report will discuss the following: definitions, data sources for indicators, criteria for indicator selection and performance indicators and special studies established.

Definition of Terms

The QIC had begun work on developing performance indicators prior to the passage of Chapter 93. Developing a common language about indicators and measures was a critical first step. The Committee determined during its May 2000 meeting that it would adopt the terminology used by the American College of Mental Health Administrators (ACHMA). While this usage is slightly different than that used in Chapter 93, the same content is present. Appendix III. provides a crosswalk between the legislative language and the ACHMA terminology.

For purposes of this report and understanding the performance measures identified by DMH and the QIC, these critical terms are defined:

<u>Domain</u> – Describes a global category of things within which to identify indicators. Within the world of quality measurement, four domains are generally recognized: structure, access, process and outcomes.

<u>Structure</u> - The domain that addresses the resources and tools (human, physical, and organizational) that are needed to provide good quality care.

Access – The domain that addresses how consumers and family members get into care.

Process – The domain that describes what happens during service provision. The term “appropriateness” is often used interchangeably with “process.”

Outcomes – The domain that investigates the results of service.

Indicators - Variables used to point to program quality or performance.

Measures - Specific instruments or data elements used to quantify or calibrate an indicator.

For example, one nearly universal indicator in national performance measurement systems is Penetration Rate. This is a numerical description of the number of individuals who have received services. The measure of Penetration Rate is a percentage of total population served, obtained by dividing the number of individuals who have received services by the number of individuals who are eligible to receive services. This indicator is within the Access Domain.

Data Sources

Recognizing that there are inherent limitations in current databases, and that these may limit the choice of quality indicators, the QIC commenced work using existing data. Data is pivotal to measurement and performance indicators must be linked to reliable, high quality data sources. Data sources influence both the indicators that can be measured and the populations for whom the indicators can be measured. For example, Medi-Cal mental health paid claims and eligibility databases are excellent data sources for measuring the penetration rate among Medi-Cal eligible individuals but they do not measure the penetration rates among the population ineligible for Medi-Cal.

For the QIC performance measurement system, all the indicators rely principally on one or more of the following data sources:

Client and Services Information System (CSI) - CSI is DMH’s most current and comprehensive database. It replaced the Client Data System and the Institute for Mental Disease Reporting. Almost all persons served in county mental health treatment programs must be reported to the CSI system. This includes both Medi-Cal and non-Medi-Cal clients and persons served by the private practitioners that were formerly in the Fee-For-Service system. The CSI system contains the necessary information to meet state and federal reporting requirements for client-based information regarding persons served by mental health programs. By linking CSI data with county cost reports, cost calculations for clients and services can be obtained.

Medi-Cal Paid Claims – Data describing Medi-Cal clients and services are obtained from three claiming sources depending upon the time period for which data is sought: the Short-Doyle/Medi-Cal Approved Claims File, the Fee-For-Service Paid Claims File and the Inpatient Consolidation Paid Claims File. Due to the nature of the mental health managed care programs in San Mateo, Santa Barbara and Solano counties, data from these counties is excluded from all Medi-Cal data. The Medi-Cal data also does not include many clients that are receiving Medicare services or receiving both Medi-Cal and Medicare services when Medicare pays in full.

It should be noted that race/ethnicity data for indicators using Medi-Cal paid claims data as the data source is based on the code in the Department of Health Services Medi-Cal Eligibility Data System (MEDS) file. This file limits categories to White, Black and Other for persons in the Disabled Aid Code group. Thus the "Other" category is somewhat undefined and probably over-represented.

Performance Outcome System – The California Performance Outcome System is a comprehensive set of testing instruments designed to collect outcome information on specific age groups of clients – Children/Youth, Adults and Older Adults. Instruments vary by age group and are administered at the local level. Data is submitted to DMH on a semi-annual basis. Performance outcome data is not available for all mental health clients, but rather for a group of targeted clients who are generally considered to be the more high service, long term, and costly clients. The table below summarizes the target populations for whom data is/will be available in the Performance Outcome System.

PERFORMANCE OUTCOME SYSTEM		
AGE GROUP	DEFINITION OF TARGET POPULATION	IMPLEMENTATION STATUS
Children/Youth	Youth who are less than 18 years of age and who have received (or are expected to receive) services for 60 days or longer, excluding children receiving medication only services and children receiving services from private providers.	Implemented in April 1998
Adults	Adults with serious mental illness, ages 18 through 59, receiving (or expected to receive) public mental health services for 60 days or longer.	Implemented in July 1999
Older Adults	Adults with serious mental illness, ages 60 and above, receiving (or expected to receive) public mental health services for 60 days or longer.	Currently in Pilot Testing

As can be noted, data from the performance outcome system for clients of any age group who are not receiving services in the public mental health system for at least 60 days is not available. It is assumed that those clients experiencing the greatest difficulties relating to their mental illnesses and who therefore constitute those requiring the greatest proportion of staff, programmatic and financial resources, will remain in the mental health system longer. Thus the Performance Outcome System is designed to measure outcomes for individuals with more serious and persistent mental illness. See Appendix IV for information on the Performance Outcome System testing instruments used as data sources for the quality indicators.

Criteria for Selection of Indicators

Because performance measurement is staff-intensive and data-intensive, it is imperative to select indicators that will yield the most information for continuous quality improvement. In addition, while indicators selected must be appropriate for California's mental health programs it is also desirable to use indicators that will allow comparison and analysis against performance in other states and nationally. Finally, attention must be paid to the comprehensive set of indicators developed by the California Mental Health Planning Council and used as the basis for the Performance Outcome System.

DMH and the QIC developed a list of criteria against which proposed indicators were compared before inclusion in the indicator set. These are shown below:

Criteria for Selecting Indicators

Applies to an issue of importance for stakeholders.

Meaningful for users.

Availability of data in the California mental health system.

Reliability of data obtained.

Potential for California performance goals and comparison with national benchmarks.

Compatibility with California programs and priorities.

Similar measures useful in other states, managed care companies.

Similar measures appear in other performance measurement systems.

Restricted number of indicators initially.

Special Studies

The ideal performance indicator is one for which complete, reliable data can be collected and analyzed and the result of the analysis can be assessed against some identified performance goal or benchmark. The QIC has noted that such data is lacking for many critical variables in mental health care delivery systems. One example of this is rehospitalization. An independent assessment of the California Mental Health Managed Care Waiver Program by I.D.E.A. Consulting in 1999 identified an increase in rehospitalization rates among mental health clients at the same time as inpatient admissions in general were on a downward trend. This can be interpreted in a number of different ways:

- Does it mean that clients are released from inpatient facilities before they are completely stabilized?
- Does it mean that there are no placements available for lower levels of care and the client is readmitted as a result?
- Does it mean that case managers are monitoring clients closely and readmitting them before the situation can deteriorate?
- Does it mean all of these things?
- Does it mean the same thing in every county?

Although rehospitalization rate data is available for analysis, the critical question is to determine what the data means and what rate of rehospitalization is most clinically appropriate for which mental health clients.

Because these and other questions don't always lend themselves to the disciplines of performance measurement but are nonetheless important, DMH and the QIC identified an additional category of quality improvement activities called special studies. A special study is distinguished by the fact that additional research and analysis will be required before a performance indicator can be articulated. These special studies will be undertaken along with the analysis of the performance indicators. In fact, DMH and the QIC have identified special studies in most of the same domains for which indicators have been developed. As envisioned, data collected for performance indicators and that collected in the course of a special study will supplement each other.

FINDINGS

Indicators

Indicators were formulated for four different domains: Structure, Access, Process and Outcomes. Each indicator will be discussed in this section of the report – including the measure prescribed, the numerator and denominator for calculations, the data source to be used and a brief discussion. In most cases, the data source permits analysis by age, gender, diagnosis, aid code and race/ethnicity for counties, regions and statewide.

Some indicators are calculated separately for the total universe of clients eligible for public mental health care and for the Medi-Cal population. This allows an enhanced understanding of the data but also documents performance for state and federal oversight agencies. However when a measure requires using a value for the total persons eligible for public mental health services a methodological challenge arises. It will be difficult to determine what constitutes the total population of persons in California eligible for services in the public mental health sector. Because of the difficulty of this task, this part of the indicators is likely to take longer to implement.

It should be noted that the data sources for all these indicators speak to the population that has successfully entered the public mental health service system. There is little data available about the characteristics of potential clients who are not able to access services.

A summary of the indicators is shown on the next page.

Summary of Performance Measurement Indicators by Domain

DOMAIN	INDICATORS
1. Structure	1.A. Total Cost of Services per Client 1.B. Type of Service
2. Access	2.A. Penetration Rate 2.B. EPSDT Penetration Rate 2.C. Retention Rate in Routine, Outpatient Services for New Clients 2.D. Follow-up Care After Inpatient Discharge 2.E. Average Length of Time Between Inpatient Discharge and Next Contact 2.F. Average Length of Time Between First Contact and Second Contact for New Patients for Routine, Outpatient Services 2. G., H. Perception of Availability of Services – Caregiver/Youth, Adult/Older Adult
3. Process	3.A. Consumer Perception of Involvement in Treatment Decisions - Adults/Older Adults 3.B. Consumer Perception of Satisfaction - Adults/Older Adults 3.C. Caregiver Perception of Satisfaction – Caregiver/Youth
4. Outcomes	4.A. Consumer Perception of Improvement in Functioning - Adults/Older Adults 4.B. Perception of Improvement in Functioning and Symptom Reduction - Youth 4.C. Consumer Perception of Symptom Reduction - Adults/Older Adults

1. STRUCTURE DOMAIN INDICATORS

STRUCTURE INDICATOR A. TOTAL COST OF SERVICES PER CLIENT

Rationale for Inclusion

Cost is useful baseline data for purposes of interpreting the meaning of other indicators, particularly access and utilization. It is also helpful in tracking trends in spending over time for individual counties and between counties and regions. The QIC anticipates that national data may also be available for comparative purposes since this is an indicator being studied in the federal Substance Abuse Mental Health Services Administration (SAMHSA) Sixteen State Indicator Pilot Grant Project currently underway.

Measure*	Numerator/Denominator	Data Source
1.) Amount spent for mental health treatment services: a.) Per client, and b.) Per total eligibles.	1.) Total population of mental health clients: Numerator – Total amount paid for mental health treatment services from CSI and county cost reports. Denominator – a.) Total unduplicated annual clients and b.) Total unduplicated persons eligible for public mental health services.	1.) CSI and county cost reports
2.) Claims paid or approved for mental health treatment services: a.) Per Medi-Cal client, and b.) Per total Medi-Cal eligible.	2.) Medi-Cal population of clients: Numerator – Total claims paid and approved. Denominator – a.) Total unduplicated Medi-Cal annual clients and b.) Average monthly Medi-Cal eligible persons.	2.) Medi-Cal paid claims and eligibility files

*Data for these measures can be analyzed by age, gender, diagnosis, aid code and race/ethnicity for counties, regions, and statewide.

STRUCTURE INDICATOR B. TYPE OF SERVICE

Rationale for Inclusion

These calculations are particularly useful because they add the element of service utilization to information about costs. This indicator could as easily be included in the Access or Process domains since it provides a picture helpful in understanding those domains. Similar calculations were used by I.D.E.A. Consulting in the independent assessment and were found to be comprehensive summaries of types of service, utilization and cost.

Measure*	Numerator/Denominator	Data Source
Types and costs of services provided (24-Hour Services, Day Services, Outpatient Services) including: a.) Cost per unit of service; b.) Average units of service per client by type of service; c.) Percent of clients utilizing services by type and d.) Cost per client by type of service for services delivered during a fiscal year (including outpatient and inpatient services). These calculations will be made for 1.) The total population of public mental health clients, and 2.) For all Medi-Cal clients.	1.) Total population of mental health clients: Numerators – Units of each service and total amount paid for mental health treatment services. Denominators – a.) Total units and b.) Total paid by service for clients. 2.) Medi-Cal population of clients: Numerators – Units of service and total claims paid or approved for Medi-Cal clients Denominators – a.)Total units and b.) Total paid by Medi-Cal service for Medi-Cal clients.	1.) CSI and county cost reports: 2.) Medi-Cal paid claims.

*Data for these measures can be analyzed by age, gender, diagnosis, aid code and race/ethnicity for counties, regions, and statewide.

2. ACCESS DOMAIN INDICATORS

ACCESS INDICATOR A. PENETRATION RATE

Rationale for Inclusion

This indicator addresses the very fundamental issue of whether or not clients are receiving services. It is also very helpful in understanding cost and type of service data. This is a nearly universal indicator among most proposed or functioning performance measurement systems. Data should eventually be widely available at the state and national levels for comparative purpose (Sixteen State Study). It is also helpful in tracking trends in spending over time for individual counties and between counties and regions. DMH has county Medi-Cal penetration rates dating from FY1993/94.

Measure*	Numerator/Denominator	Data Source
Penetration Rate will be calculated for persons who receive one or more mental health treatment services in a year. The measures will be analyzed for the: 1.) Total population eligible for public mental health services and 2.) Total eligible Medi-Cal clients.	1.) Total population of mental health clients: Numerator – Total number of clients receiving services Denominator – Total unduplicated persons eligible to receive public mental health services 2.) Medi-Cal population of clients: Numerator – Total number of clients receiving services Denominator – Total number of persons eligible to receive Medi-Cal services	1.) CSI 2.) Medi-Cal paid claims and eligibility files

*Data can be analyzed by age, gender, diagnosis, aid code, and race/ethnicity for counties, regions and statewide.

ACCESS INDICATOR B. EARLY PERIODIC, SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PENETRATION RATE

Rationale for Inclusion

This is another Penetration Rate as in Access Indicator A. but this indicator is intended to look at utilization of a specific kind of services. DMH is already using EPSDT penetration rates to try to determine appropriate levels of EPSDT service provision in various counties. EPSDT is particularly critical because it is the principal source of funding for services for children and youth (under age 21). Increasing the provision of EPSDT services has been a priority for DMH for several years. This will assist the Department in determining what progress has been made in expanding these services.

Measure*	Numerator/Denominator	Data Source
The measure is the percent of the eligible EPSDT population who receive one or more mental health treatment services in a year.	Numerator – Number of persons receiving at least one billable EPSDT service in a year. Denominator – Total number of persons eligible for EPSDT services.	Medi-Cal paid claims and eligibility files

*Data can be analyzed by age, gender, diagnosis, aid code, and race/ethnicity for counties, regions and statewide.

ACCESS INDICATOR C. RETENTION RATE IN ROUTINE, OUTPATIENT SERVICES FOR NEW CLIENTS

Rationale for Inclusion

This measure is a helpful companion to understanding penetration rates. High penetration rates are less impressive in a system if clients are not then retained in service for some period of time. Retention rates may also signal issues related to cultural competence if data shows that specific race/ethnic groups exhibit lower retention rates than others. Crisis intervention services are not included as a treatment service for this calculation because the intended focus is on outpatient follow-up after an initial visit. Since analysis will be done on a fiscal year basis, specifying new clients increases the accuracy of the calculation.

Measure*	Numerator/Denominator	Data Source
This measure will track the trend of new clients who receive 1-10 or more follow-up outpatient treatment services (not including crisis intervention) for a one year period. It will be calculated for the: 1.) Total population eligible for public mental health services and 2.) Total Medi-Cal eligible population.	1.) Total population of mental health clients: Numerator – Number of unduplicated clients receiving 1-10 or more follow-up outpatient treatment services in one year (not including crisis intervention). Denominator – Total number of unduplicated clients initially entering service at the beginning of the measurement period. 2.) Medi-Cal population of clients: Numerator – Number of unduplicated Medi-Cal clients receiving 1-10 or more follow-up outpatient treatment services in one year (not including crisis intervention). Denominator – Total number of unduplicated Medi-Cal clients initially entering service at the beginning of the measurement period.	1.) CSI 2.) Medi-Cal paid claims

*Data can be analyzed by age, gender, diagnosis, aid code and race/ethnicity, for counties, regions and statewide.

ACCESS INDICATOR D. FOLLOW-UP CARE AFTER INPATIENT DISCHARGE

Rationale for Inclusion

This is an important measure for purposes of determining if clients are linked with community-based services after hospital discharge. This is commonly thought to be a reason for subsequent rehospitalizations. The numerator is qualified in three different ways in an effort to characterize the nature of the follow-up service more clearly. National data should be available eventually since this is an indicator included in the Sixteen State Indicator Study. It will also be useful to compare and contrast this information with other indicators and with the special study on rehospitalization.

Measure*	Numerator/Denominator	Data Source
Percent of clients who receive care within 7 days of discharge: a.) Not including inpatient services, b.) Not including inpatient and crisis services, and c.) Not including inpatient, crisis and brokerage services. This will be calculated for the: 1.) Total population of public mental health clients and 2.) Total Medi-Cal clients.	1.) Total population of mental health clients: Numerator – Number of unduplicated clients who received care within 7 days of discharge. This numerator would be modified in three ways for three different calculations based on the type of follow-up service -- not including inpatient service, not including inpatient and crisis services and not including inpatient, crisis and brokerage services. Denominator – Total number of inpatient discharges for total unduplicated clients.	1.) CSI
	2.) Medi-Cal population of clients: Numerator – Number of unduplicated Medi-Cal clients who received care within 7 days of discharge. This numerator would be modified in three ways for three different calculations based on the type of follow-up service -- not including inpatient service, not including inpatient and crisis services and not including inpatient, crisis and brokerage services. Denominator – Total number of inpatient discharges for unduplicated Medi-Cal clients.	2.) Medi-Cal paid claims

*Data can be analyzed by age, gender, diagnosis, aid code and race/ethnicity for counties, regions and statewide.

ACCESS INDICATOR E. AVERAGE LENGTH OF TIME BETWEEN INPATIENT DISCHARGE AND NEXT CONTACT

Rationale for Inclusion

This indicator is closely related to Access Indicator D. Follow-up After Inpatient Discharge. The goal is to determine on average how long it takes to receive the next contact after a discharge. The numerator is qualified in three different ways in an effort to characterize the nature of the follow-up service more clearly. The term "contact " is used to indicate any service. It will also be useful to compare and contrast this information with other indicators and with the special study on rehospitalization.

Measure*	Numerator/Denominator	Data Source
Average length of time for clients between inpatient discharge and next contact a.) Not including inpatient services, b.) Not including inpatient and crisis services, and c.) Not including inpatient, crisis and brokerage services. This will be calculated for the: 1.) Total population of public mental health clients and 2.) Total Medi-Cal clients.	1.) Total population of mental health clients: Numerator – Total length of time for persons discharged from inpatient care between inpatient discharge and the next contact. This numerator would be modified in three ways for three different calculations based on the type of follow-up service -- not including inpatient service, not including inpatient and crisis services and not including inpatient, crisis and brokerage services. Denominator – Total number of inpatient discharges for unduplicated clients. 2.) Medi-Cal population of clients: Numerator – Total length of time for Medi-Cal clients discharged from inpatient care between inpatient discharge and the next contact. This numerator would be modified in three ways for three different calculations based on the type of follow-up service -- not including inpatient service, not including inpatient and crisis services and not including inpatient, crisis and brokerage services. Denominator – Total number of inpatient discharges for unduplicated Medi-Cal clients.	1.) CSI 2.) Medi-Cal paid claims

*Data can be analyzed by age, gender, diagnosis, aid code and race/ethnicity for counties, regions and statewide.

ACCESS INDICATOR F. AVERAGE LENGTH OF TIME BETWEEN FIRST CONTACT AND SECOND CONTACT FOR NEW PATIENTS FOR ROUTINE, OUTPATIENT SERVICES

Rationale for Inclusion

The intent of this indicator is to determine the timeliness of the delivery of routine, outpatient services. This is a significant concern for the QIC, reflected by the fact that both an indicator and a special study were developed to ferret out timeliness information. Most of the data required for the Timeliness special study will have to be collected in some way other than directly accessing a database. This element of timeliness is the only one for which a database is immediately available. The QIC felt that whatever timeliness data can be generated should be incorporated into an indicator. Contact in this context means any service. Since analysis will be done on a fiscal year basis, specifying new clients increases the accuracy of the calculation.

Measure*	Numerator/Denominator	Data Source
Average length of time between first contact and second contact for new clients for routine, outpatient services. This will be calculated for the: 1.) Total population of public mental health clients and 2.) Total Medi-Cal clients.	1.) Total population of mental health clients: Numerator – Total length of time between first and second contacts for new clients for routine, outpatient services. Denominator – Total number of new, unduplicated clients receiving routine, outpatient services. 2.) Medi-Cal Population of Clients Numerator - Total length of time between first and second contacts for new Medi-Cal clients for routine, outpatient services Denominator – Total number of new, unduplicated Medi-Cal clients receiving routine, outpatient services.	1.) CSI 2.) Medi-Cal paid claims

*Data can be analyzed by age, gender, diagnosis, aid code and race/ethnicity for counties, regions and statewide.

ACCESS INDICATOR G CAREGIVER PERCEPTION OF AVAILABILITY OF SERVICES (YOUTH)

Rationale for Inclusion

The CSQ-8 is one of the testing instruments in the Children and Youth Performance Outcome Project. It is intended to gather data on customer satisfaction with services rendered from the parent's perspective. The specific items indicated relate to availability of care. The target population for children and youth participating in the performance outcomes testing is mental health clients (under 18) who will/have received services for 60 days or longer (excludes those who receive medication support services and those who receive services exclusively from the MHPs' provider network).

Measure	Numerator/Denominator	Data Source
Percent of caregiver responses to Client Satisfaction Questionnaire (CSQ-8) survey questions (items 2,3,5) about availability of services for youth.	Numerator – Survey respondents whose average CSQ-8 score on items 2,3, and 5 were 3 or above. Denominator – Total number of CSQ-8 surveys.	CSQ-8 performance outcome data

*Data can be analyzed by age, gender, diagnosis and race/ethnicity for counties, regions and statewide.

ACCESS INDICATOR H. CONSUMER PERCEPTION OF AVAILABILITY OF SERVICES (ADULTS/OLDER ADULTS)

Rationale for Inclusion

The Mental Health Statistics Improvement Program (MHSIP) survey is a widely used and highly regarded testing instrument developed at the national level with substantial participation from consumers. Various items on the MHSIP survey relate to different aspects of client satisfaction. The MHSIP survey is a critical element in the Adult and Older Adults Performance Outcome Project.

In this indicator, the focus is on the Access Subscale of the MHSIP, composed of survey items 4-8 and 19. The highest possible rating for either a subscale or for an individual item is a score of 5. The target population for adults and older adults participating in the Performance Outcome Project is mental health adult and older adult clients who will/have received services for 60 days or longer (excludes those who receive medication support services only and those who receive services exclusively from the MHPs' provider network.) Older Adult performance outcome pilot tests currently in progress may result in a different definition of the Older Adult target group.

Measure	Numerator/Denominator	Data Source
Average Mental Health Statistics Improvement Project (MHSIP) Consumer Survey Access Subscale responses (items 4-8, 19) of 3.6 or above from adults and older adults.	Numerator – MHSIP Survey respondents whose average MHSIP subscale scores are 3.6 or above. Denominator – Total number of MHSIP surveys.	MHSIP performance outcome data

*Data can be analyzed by age, gender, diagnosis and race/ethnicity for counties, regions and statewide.

3. PROCESS DOMAIN INDICATORS

PROCESS INDICATOR A. CONSUMER PERCEPTION OF INVOLVEMENT IN TREATMENT DECISIONS (ADULTS/OLDER ADULTS)

Rationale for Inclusion
See Rationale section for Access Indicator H (page 22). MHSIP Survey items 17 and 18 relate to client satisfaction with involvement in treatment decisions. The highest possible rating is a score of 5 on these items.

Measure*	Numerator/Denominator	Data Source
Percent of adult and older adult clients indicating a score of 4 or above on MHSIP Consumer Survey items 17,18.	Numerator – Adult and Older Adult Survey respondents scoring MHSIP survey items 17 and 18 at 4 or above. Denominator – Total number of MHSIP surveys.	MHSIP performance outcome data

*Data can be analyzed by age, gender, diagnosis, race/ethnicity for counties, regions and statewide.

PROCESS INDICATOR B. CONSUMER PERCEPTION OF SATISFACTION

Rationale for Inclusion
See Rationale section for Access Indicator H (page 22). Survey items 1-3 comprise the Satisfaction Subscale of the MHSIP Consumer survey instrument. The highest possible score on these items is a score of 5.

Measure*	Numerator/Denominator	Data Source
Average MHSIP Consumer Survey Satisfaction Subscale responses (items 1-3) of 3.6 or above from adults and older adults.	Numerator – MHSIP Survey respondents whose average MHSIP subscale scores are 3.6 or above. Denominator – Total number of MHSIP surveys.	MHSIP performance outcome data

*Data can be analyzed by age, gender, diagnosis and race/ethnicity for counties, regions and statewide.

PROCESS INDICATOR C. CAREGIVER PERCEPTION OF SATISFACTION (YOUTH)

Rationale for Inclusion

The CSQ-8 is one of the testing instruments in the Children and Youth Performance Outcome Project. It is intended to gather data on customer satisfaction with services rendered from the parent's perspective. The specific items indicated here relate to satisfaction with care. The highest possible score would be a score of 5.

The target population for children and youth participating in the performance outcomes testing is mental health clients (under 18) who will/have received services for 60 days or longer (excludes those who receive medication support services only and those who receive services exclusively from the MHPs' provider network).

Measure*	Numerator/Denominator	Data Source
Percent of caregiver responses to survey questions about satisfaction will be examined.	Numerator – Survey respondents who average CSQ-8 score on item 7 and whose total CSQ-8 scores were 3 or above. Denominator – Total number of CSQ-8 surveys.	CSQ-8 performance outcome data

*Data can be analyzed by age, gender, diagnosis and race/ethnicity for counties, regions and statewide.

4. OUTCOME DOMAIN INDICATORS

OUTCOME INDICATOR A. CONSUMER PERCEPTION OF IMPROVEMENT IN FUNCTIONING (ADULTS/OLDER ADULTS)

Rationale for Inclusion

See Rationale section for Access Indicator H (page 22). MHSIP Survey items 20-25 comprise the Outcome Subscale of the MHSIP Consumer survey instrument. The highest possible score on these items would be a score of 5.

Measure*	Numerator/Denominator	Data Source
Average MHSIP Survey Outcome Subscale responses (items 20-25) of 3.6 or above from adults and older adults.	Numerator – MHSIP Survey respondents whose average MHSIP subscale scores are 3.6 or above. Denominator – Total number of MHSIP surveys.	MHSIP performance outcome data

*Data can be analyzed by age, gender, diagnosis and race/ethnicity for counties, regions and statewide.

OUTCOME INDICATOR B. PERCEPTION OF IMPROVEMENT IN FUNCTIONING AND SYMPTOM REDUCTION (YOUTH)

Rationale for Inclusion

This indicator uses data from three different performance outcome instruments to ascertain the degree to which clinicians, parents/caregivers and the youth themselves perceive improvement in functioning and symptom reduction. The Children/Youth Performance Outcome system is undergoing changes as a result of pilot tests. This indicator will be adapted as necessary to reflect the data available from the testing instruments.

Measure*	Numerator/Denominator	Data Source
Two scores over a period of time from: 1. Clinician, 2. Parent/caregiver and 3. Youth, all of which gauge perceptions of the youth's functioning and symptom reduction.	Numerators 1. Number of youth with positive reliable change ratings from clinicians. 2. Number of youth with positive reliable change ratings from parents/caregivers. 3. Number of youth who identify positive reliable change ratings in themselves. Denominators Total number of: 1.CAFAS surveys (clinicians) 2. CBCL surveys (parents/caregivers) 3. YSR surveys (youth)	CAFAS (total score) CBCL YSR

*Data can be analyzed by age, gender, diagnosis and race/ethnicity for counties, regions and statewide.

OUTCOME INDICATOR C. CONSUMER PERCEPTION OF SYMPTOM REDUCTION (ADULTS/OLDER ADULTS)

Rationale for Inclusion

See Rationale section for Access Indicator H (page 22). MHSIP Survey item 26 relates to client satisfaction with symptom reduction. The highest possible score on this item would be a score of 5.

Measure*	Numerator/Denominator	Data Source
Percent of adult and older adult clients indicating a score of 4 or above on MHSIP Consumer Survey item 26.	Numerator – Adult and Older Adult MHSIP Survey respondents scoring MHSIP survey item 26 at 4 or above. Denominator – Total number of MHSIP surveys.	MHSIP performance outcome data

*Data can be analyzed by age, gender, diagnosis and race/ethnicity for counties, regions and statewide.

Special Studies

The idea of special studies has evolved over the course of the last 18 months as DMH and the QIC gained familiarity with data and enhanced their understanding of quality improvement. Special studies initially were proposed to explore the significance of unexpected findings of the independent assessment of the Medi-Cal managed mental health care waiver reported in August 1999. The QIC has since identified additional areas of concern that have an impact upon quality mental health care delivery. Special studies allow investigation of critical elements of quality care for which data sources are not readily available. Some special studies will analyze information generated by current DMH program activities to shed light on issues related to quality concerns. The table below summarizes the Special Studies by Domain.

DOMAIN	SPECIAL STUDY
1. Structure	1.1 Structural Elements of Mental Health Plans (MHPs) 1.2 Content Analysis of Annual Mental Health Quality Improvement Work Plans 1.3 Client/Family Member Input and Involvement
2. Access	2.1 Timeliness of Services 2.2 Utilization of Mental Health Services - Latino Populations
3. Process	3.1 Rehospitalization 3.2 Involuntary Admission to Inpatient Facilities 3.3 Fair Hearings 3.4 Focus Groups 3.5 Utilization of Inpatient Service - African American Populations
4. Outcomes	To Be Determined

By definition, special studies are investigative in nature though as research proceeds, a performance measurement indicator could be generated. However, special studies are valuable activities in and of themselves, whether or not they result in a formal indicator, and provide opportunities to continuously improve care.

1. STRUCTURE DOMAIN SPECIAL STUDIES

STRUCTURE SPECIAL STUDY 1. – STRUCTURAL ELEMENTS OF MENTAL HEALTH PLANS

Focus
Study will review on-site review protocols to identify critical elements of mental health plan structure (e.g. problem resolution processes, Memorandums of Understanding with physical health care plans, etc.) that can impact the quality of care delivered. The next step will be to summarize data on the characteristics of all mental health plans in terms of these critical elements.

Rationale for Inclusion
This special study will provide descriptive data as a baseline for all indicators and special studies. The most recent complete fiscal year of on-site review protocols will be used because protocol content can vary from one fiscal year to the next, and the intent is to look at all mental health plans against a consistent set of standards.

Potential Data Source
Completed on-site protocols from previous fiscal year.

Assigned To
QIC staff, DMH compliance staff, other stakeholders to be identified

STRUCTURE SPECIAL STUDY 2. CONTENT ANALYSIS OF MENTAL HEALTH ANNUAL QUALITY IMPROVEMENT WORKPLANS

Focus
Study will review two required aspects of local QI activity: monitoring the service delivery capacity of the mental health plan; and monitoring the accessibility of services (routine and urgent services, after-hours care, responsiveness of 24 hour phone line, etc.).

Rationale for Inclusion
This special study will provide descriptive data as a baseline for all indicators and special studies. It will also help DMH and the QIC to understand the volume and scope of quality improvement activity occurring at the local level. This knowledge will help the QIC direct it's own quality activities in the most effective and efficient manner.

Potential Data Source
Mental Health Plan Implementation Plans.
Annual QI work plans for previous fiscal year.
Completed on-site review protocols from previous fiscal year.

Assigned to
QIC staff, DMH Training and Technical Assistance staff, other stakeholders to be identified

STRUCTURE SPECIAL STUDY 3. CLIENT/FAMILY MEMBER INPUT AND INVOLVEMENT IN MENTAL HEALTH PLANS

Focus
Study will focus on client and family member involvement in local mental health plan operations and state level operations including but not limited to planning, program operation, and quality improvement.

Rationale for Inclusion
It is generally accepted that the participation of clients and family members results in superior service delivery and outcomes. Recognizing this, DMH and the QIC place a high value on client and family member involvement. This special study will investigate and describe the degree to which clients and family members are involved in activities at the state and local level. This will serve as baseline data within which all of the indicators and special studies can be better understood.

Potential Data Source
Mental Health Plan Implementation Plans.
Annual QI work plans for previous fiscal year.
Completed on-site review protocols from previous fiscal year.

Assigned To
DMH Client and Family Member Task Force, other stakeholders to be identified.

2. ACCESS DOMAIN SPECIAL STUDIES

ACCESS SPECIAL STUDY 1. TIMELINESS OF SERVICES

Focus
For routine, outpatient services, the study will focus on time elapsed from first contact to first face-to-face appointment, and time elapsed from the identification of service need to time client receives recommended service.

Rationale for Inclusion
This study will investigate various aspects of timely delivery of services at the local level. Access Indicator F. will provide data on time between first and second contacts. Other parameters of timeliness are not readily available in a database and will have to be researched.

Potential Data Source
Mental Health Plan Implementation Plans.
Annual QI work plans for previous fiscal year.
Completed on-site review protocols from previous fiscal year.
Mental Health Plan logs.
Contacts with local QI coordinators.
MHSIP data
Retention Rate data
Chart reviews

Assigned To
Assignment held pending workgroup development

ACCESS SPECIAL STUDY 2. UTILIZATION OF MENTAL HEALTH SERVICES - LATINO POPULATIONS

Focus

For FY 97/98, the largest race/ethnic group eligible for Medi-Cal (other than Caucasian) was Latinos, which comprise 38% of the total eligibles. However, this group has the lowest utilization rate at 18 persons using mental health services out of every 1,000 persons eligible; this compares to a rate of 60 persons/1,000 for all clients and all ages. This equates to a penetration rate of 6% for all persons eligible for Medi-Cal and 1.9% for Latino eligible persons.

For persons beginning Medi-Cal services in 6/98 followed through 6/99 (excluding inpatient and crisis services), statewide more than 23% of Latino clients received no follow-up services after initial contact while the rate for all clients was 14%. This

disproportionate relationship also exists for Latinos in the Disabled and Foster Care aid codes.

Rationale for Inclusion

This is a critical special study that has a high priority in DMH and the QIC. The Independent Assessment showed substantial underutilization of services by Latino populations. Subsequent research on retention rates shows that Latino populations are also not retained in services after an initial contact. There is a critical need for quality improvement in this area. The goal will be to identify factors that are barriers to Latino involvement in the public mental health care system.

Potential Data Source

Medi-Cal paid claims
CSI

Assigned To

DMH Cultural Competence Advisory Committee, other stakeholders to be identified

3. PROCESS DOMAIN SPECIAL STUDIES

PROCESS SPECIAL STUDY 1. REHOSPITALIZATION

Focus
Between FY93/94 and FY98/99, although the total number of persons served in inpatient services statewide decreased by 867, the persons who were readmitted within 30 days increased by 860 or 26%.

Rationale for Inclusion
The Inpatient Treatment Review Workgroup has been working on this special study for six months. After a preliminary look at a variety of factors, it is now focusing on selected hypotheses and refining its research. A workplan outline for this special study can be found in Appendix V.

Potential Data Source
Medi-Cal paid claims
CSI

Assigned To
QIC Inpatient Treatment Review Workgroup, other stakeholders to be identified

PROCESS SPECIAL STUDY 2. INVOLUNTARY ADMISSIONS TO INPATIENT FACILITIES

Focus
Study will track the number of involuntary admissions to inpatient facilities from FY 90/91 to FY 98/99.

Rationale for Inclusion
DMH has identified involuntary admissions as an important quality concern. A DMH policy guidance will be issued to clarify the distinction between involuntary admissions and medical necessity for inpatient admissions. This study will track the changes in numbers of involuntary admissions in response to this guidance.

Potential Data Source
CSI
Involuntary Detention Reports
Office of Statewide Health Planning and Development Data

Assigned To
QIC Inpatient Treatment Review Workgroup, other stakeholders to be identified.

PROCESS SPECIAL STUDY 3. FAIR HEARINGS

Focus
Study will focus on trends in numbers of fair hearing filings over two most recent fiscal years and tabulate outcomes of those fair hearings.

Rationale for Inclusion
Last year the DMH Ombudsman Services Office researched the outcome of all mental health-related fair hearings that were filed and prepared a summary report. The QIC will follow the results of this report in the future to determine if there is a pattern of problems that have quality implications.

Potential Data Sources
DMH Ombudsman Office Fair Hearing logs and staff follow-up

Assigned To
DMH Training and Technical Assistance staff, other stakeholders to be identified

PROCESS SPECIAL STUDY 4. FOCUS GROUPS

Focus
Study will focus on feedback from all focus groups conducted in the previous fiscal year.

Rationale for Inclusion
DMH staff currently prepares a yearly summary report on the content of focus groups conducted at mental health plans over the course of the last year. The QIC will review the reports to determine if there is a pattern of problems that have quality implications. This will also provide descriptive data that will be helpful in understanding all other indicators and special studies.

Potential Data Source
Summary report on focus groups prepared by DMH staff with assistance from clients and family members who participated in focus groups during the year.

Assigned To
DMH Managed Care Implementation staff, DMH Training and Technical Assistance staff, other stakeholders to be identified

PROCESS SPECIAL STUDY 5. UTILIZATION OF INPATIENT SERVICES – AFRICAN-AMERICAN POPULATIONS

Focus

Between FY 93/94 and FY 97/98, there was a decrease in inpatient service utilization by the Caucasian race/ethnic group from 12,271 to 12,241. African Americans showed an increase in inpatient service utilization during the same time period from 3,806 to 5,202, - the largest increase for any race/ethnic group.

Between July-December 1993, there were 2,101 African American clients seen in inpatient services. Of these, 713 returned within six months – a 34% return rate. Between July-December 1997, there were 2,388 African Americans in inpatient services. Of these, 1,248 returned – a 52% return rate. This is the highest return rate for any race/ethnic group.

Rationale for Inclusion

This critical special study will look for quality-related factors that could be influencing the frequency of inpatient admissions for African-Americans. In its work on the Rehospitalization special study, the Inpatient Treatment Review Workgroup is already analyzing data to determine race/ethnic disparities. This will provide a springboard for this special study. Assistance from the DMH Cultural Competence Advisory Committee will probably be requested in order to bring additional resources to bear on this issue.

Potential Data Source

Medi-Cal paid claims
CSI

Assigned To

QIC Inpatient Treatment Review Workgroup, Cultural Competence Advisory Committee, other stakeholders to be identified

IMPLEMENTATION

It is the intent of DMH and the QIC to analyze data on all indicators and determine progress on all special studies during the course of the next calendar year. A Technical Appendix for each indicator and special study will be constructed as the QIC and staff proceed with their analysis. The Technical Appendix will define terms used in the indicators and specify all numerators and denominators for calculations. The work of the QIC and its workgroups will proceed as rapidly as staff and data generation resources allow. Throughout this period, the QIC will be making preliminary judgments about performance goals and benchmarks for each indicator. In addition, the QIC will turn its attention to the best means of communicating the progress and findings of its quality improvement activities to a broader audience. At least initially, this will include quarterly progress reports that will be disseminated in a variety of ways including the DMH website.

Workgroups will be formulated and dissolved as new issues arise or existing activities are completed. Membership on workgroups is subject to change in order to obtain technical expertise needed on a given subject. However, there will always be an emphasis on diversity and client and family member involvement.

CONCLUSIONS

The performance indicators and special studies detailed in this report are an excellent first step in defining and improving the quality of services delivered in the California public mental health system. DMH and the QIC anticipate the initiation of formal performance measurement as described in this report will also provide a basis for dialogue among stakeholders as other quality improvement activities are implemented in the future.

Appendices

“Establishment of Quality Indicators for California’s Public Mental Health System”

APPENDIX I.

Recent Performance Outcome Activities

RECENT PERFORMANCE OUTCOME ACTIVITY

In 1991, the Legislature enacted a statute that realigned the funding and program responsibility for mental health services. This replaced General Fund revenues with a share of the state sales tax as a means of funding county mental health services. Realignment gave counties greater autonomy to design their own service systems and greater flexibility in how they spent the funds. Realignment legislation also included a requirement that county mental health programs had to collect and report to the State performance outcome data on their clients.

In subsequent legislation, the California Mental Health Planning Council (CMHPC) was given the authority to review and approve all outcome measures and to use the data to review program performance annually. Additionally, the CMHPC is required to use the data to identify best practices in providing mental health services so that those services can be replicated in other counties.

Mental health boards and commissions (MHBC) are also given a role in the interpretation of their county's performance data. Welfare and Institutions Code Section 5602.2(a)(7) requires that MHBCs review and comment on the performance outcome data and communicate their findings to the CMHPC. CMHPC staff developed a workbook format to facilitate this reporting process by MHBCs. Each MHBC received a workbook with the county's performance outcome data. Once the CMHPC received all the workbooks, it prepared a statewide report.

The system to collect performance outcome data has evolved into a massive undertaking. Data are to be collected annually for all clients who receive services for more than 60 days. It is estimated that approximately 25,000 children and 185,000 adults and older adults fall into this category.

The performance outcomes testing and reporting is overseen by a collaboration of representatives from the CMHPC, DMH and county mental health programs. Implementation has been guided by defining a balance between necessary data and information to provide oversight and an administratively workable system that would not be too burdensome to county mental health programs.

APPENDIX II.

QIC Mission Statement and Roster

Mission Statement

State Quality Improvement Committee
Department of Mental Health

To assure a collaborative, accessible, responsive, efficient, and effective mental health system that is culturally competent, client and family oriented, and age appropriate by the implementation of quality improvement methodologies.

DEPARTMENT OF MENTAL HEALTH
QUALITY IMPROVEMENT COMMITTEE (QIC)
January 2001

Beverly Abbott
San Mateo County Mental Health
225 West 37th Avenue
San Mateo, CA 94403
(650) 851-8469
(650) 573-2544 (Work)
(650) 573-2841 Work Fax

Neal Adams
Medical Director
Santa Cruz County Mental Health
1400 Emeline
Santa Cruz, CA 95060
(831) 454-4543 (Work)
(831) 454-4883 (Work Fax)
Email: neal.adams@health.santa-cruz.co.ca.us

Carolyn Cooper
United Advocates for Children of CA
P.O. Box 8900
Emeryville, CA 94662
1124 54th Street
Oakland, CA 94608 (Home)
(510) 547-8754 (Home/Fax)
uacc@pacbell.net

Rachel Guerrero
DMH Office of Multicultural Services
1600 9th Street, Rm. 153
Sacramento, CA 95814
(916) 654-2323
(916) 654-3198 (Fax)
Email rguerrer@dmhhq.state.ca.us

Karen Hart
291 San Bernabe Drive
Monterey, CA 93940
(831) 373-3966 (Home)
(831) 373-2679 (Home Fax)
Email **khart@redshift.com**

Ann Heater
2600 Woodland Drive
Visalia, CA 93277
(559) 733-7655
(*51 For Fax)

Erma Kendrick
1512 Terrace Way
Bakersfield, CA 93304
(661) 322-0479 (Work)
(661) 322-1507 (Work Fax)
Email: E.Kendrick@msn.com

Penelope Knapp, Chair
Office of the DMH Director
1600 9th Street, Rm. 151
Sacramento, CA 95814
(916) 654-2309
(916) 654-3198
Email pknapp@dmhhq.state.ca.us

Steve Leoni
C/o San Francisco Mental Health Assoc.
1119 Market Street, Suite 200
San Francisco, CA 94103
(415) 241-2926 (Home)
(415) 241-2926 (Message)
(415) 241-2928 (MHA Fax)

Ruben Lozano
DMH Program Compliance
1600 9th Street, Rm. 250
Sacramento, CA 95814
(916) 654-3576 Work
(916) 654-6394 Work Fax
Email rlozano@dmhhq.state.ca.us

Maria Maceira
6610 B Surfside Way
Sacramento, CA 94831
(916) 392-9601 (Home)
(916) 441-2933 (Work)
Email **mariaem@jps.net**

Jay Mahler
18872 Center Street
Castro Valley, CA 94546
(510) 889-9163 (Home)
(925) 646-5783 (Work)
(925) 313-6449 (Work Fax)
Email jhm2646@excite.com

Susan Mandel
Pacific Clinics
909 S. Fair Oaks
Pasadena, CA 91105
(626) 798-7892 (Home)
(626) 795-8471 (Work)
(626) 578 – 1278 (Work Fax)
Email **slm42@pacbell.net**

Maria Mar
3235 Cobblestone Drive
Santa Rosa, CA 95404-1744
(707) 579-9931 (Home)
(707) 579-9921 (Home Fax)
(707) 570-3649 (Work)
Email **mariamar@neteze.com**

Joyce Ott-Havenner
P.O. Box 10
Junction City, CA 96048
(530) 623-3997 (Home Phone & Fax)
Email jott@tcoe.trinity.k12.ca.us

Anne Sippi Clinic
1800 Midvale Court
Bakersfield, CA 93309
(661) 871-9697 (Work)
(661) 871-1270 (Work Fax)
Email **Riversideranch@aol.com**
(Work)

Daphne Shaw
PO Box 690040
Stockton, CA 95269-0040
(209) 461-5170 (Work)
(209) 467-6513 (Work Fax)
(209) 952-2186 (Home)

Marvin Southard
Los Angeles County Mental Health
550 South Vermont
Los Angeles, CA 90020
(213) 738-4601 (Work)
(213) 386-1297 (Work Fax)
Email msouthar@cola.ca.us

Edward P. Walker
Marin County Community M H
20 N. San Pedro, Suite 2028
San Rafael, CA 94903
(415) 499-6769 (Work)
(415) 499 3791 (Work Fax)
Email: ewalker@marin.org

Darlene Prettyman

APPENDIX III.

Terminology Crosswalk

Domains for Quality Indicators

Terminology Comparison

Domains **Chapter 93, Statutes of 2000** **July 2000**	**Domains** **American College of Mental Health Administrators** **(Adopted by State Quality Improvement Committee in May 2000)**
1. Structure	1. Structure
2. Process, including: Access to Care Appropriateness of Care Cost Effectiveness of Care	2. Process (Appropriateness of Care) Note: Assessment of the Cost-Effectiveness of Care will be drawn from indicators in all four domains.
	3. Access
3. Outcomes	4. Outcomes

APPENDIX IV.

Selected Performance Outcome System Testing Instruments

Selected Instruments from California's Community Mental Health Performance System (Used as Data Sources in DMH/QIC Performance Indicators)

Children and Youth

- *Child and Adolescent Functional Assessment Scale for Ages 7-18 (CAFAS)*

A Clinician-rated scale which measures a client's functional levels for the domains of role performance in the school, at home, and in the community; behavior toward others; moods and self-harmful behavior; substance use, and thinking.

- *Child Behavior Checklist for Ages 4-18 (CBCL)*

A standardized assessment instrument which measures competencies and problems from the parent's perspective.

- *Youth Self Report for Ages 11-18 (YSR)*

A standardized assessment instrument which measures competencies and problems from the youth's perspective.

- *Client Satisfaction Questionnaire (CSQ-8)*

An eight item survey to measure consumer satisfaction with services received from the parent's perspective.

Adults and Older Adults

- *Mental Health Statistics Improvement Program Consumer Survey (MHSIP)*

A 26 item consumer survey that collects consumer perceptions of access to care, appropriateness of care, perceived outcomes of care, and satisfaction with services.

APPENDIX V.

Rehospitalization Special Study Outline

Rehospitalization Special Study Outline
Inpatient Treatment Review Workgroup

Focus of Study

Between FY93/94 and FY98/99, although the total number of persons served in inpatient services statewide decreased by 867, the persons who were readmitted within 30 days increased by 860 or 26%. (Source: Short-Doyle/Medi-Cal Approved Paid Claims File, Fee for Service Paid Claims File and Inpatient Consolidation Paid Claims File – Claims paid through January 2000.

Objective

The objectives of this Special Study are to: 1) analyze rehospitalization data; 2) investigate potential factors related increased rehospitalizations; 3) identify opportunities to improve care; and 4) remeasure to evaluate success and redirect efforts.

Methodology

The Special Study will be organized into three phases:

Phase One - Information Gathering
Phase Two - Directed Study of Specific Factors (identified in Phase One)
Phase Three - Convert Results of Study to Performance Measurement

Phase One – Information Gathering

A. General survey of rehospitatization data in relationship to the following parameters:

- Age of clients rehospitalized
- Diagnosis of clients rehospitalized
- Race/Ethnicity of clients rehospitalized
- Length of inpatient stay
- Rehospitalization and length of stay by selected characteristics (age, race/ethnicity, diagnosis
- Time to rehospitalization from initial admission by selected characteristics (age, race/ethnicity, diagnosis)
- Time elapsed between inpatient discharge and first outpatient contact

B. Detailed analysis of specific hypotheses in selected mental health plans (those with the lowest and the highest rates of rehospitalization (readmissions within 30-45 days). Necessary preliminary steps will include: 1) Identify the study mental health plans, 2) Review the data collected and studied under Phase One, Part A. for the study mental health plans identified.

Hypotheses for which data will be developed include:

- Relationship of acuity of illness to rehospitalization (also dual diagnoses)

    i. Review data for diagnoses from Medi-Cal claims (both initial and rehospitalizations – are there any differences?)

    ii. Review CSI data for multiple diagnoses

- Relationship between rehospitalization rates and substance abuse

    i. Review CSI data for incidence of substance abuse

    ii. Check the literature, including AB 34 grant applications.

- Availability of lower levels of care/community housing/family or caregiver support and their relationship to rehospitalization

    i. Utilization of case management services (discharge planning information to the degree it is possible to obtain – survey counties?)

    ii. Phone survey of counties on availability of lower levels of care (Need to develop list of standardized questions for this.)

    iii. Review Table H data for target counties.

    iv. County study of Administrative Days charges.

- Determine if these variables are significantly different for different race/ethnic groups and age groups

    i. Review all data gathered for differences across age and race/ethnic groups.

- Rehospitalization rates may be an indication of a more client-focused system.

    i. Client satisfaction (Applicable MHSIP data)

    ii. Cultural awareness/sensitivity

Phase Two – Directed Study of Specific Factors (identified in Phase One)

Work with a voluntary sample of counties to:

- Design appropriate interventions
- Collect and analyze data related to the interventions
- Suggest range of appropriate rehospitalization rates

Phase Three – Converting Results of Study to Performance Measurement

- Work with State QIC to develop indicators of rehospitalization for on-going monitoring.

- Work with State QIC to determine appropriate performance goals for the rehospitalization indicator(s) adopted.