

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION  
**STATEWIDE REPORT YEAR FOUR**  
*FY07-08 (July 1, 2007 - June 30, 2008)*  
**VOLUME I OF II**



PRESENTED TO  
**CALIFORNIA**  
**DEPARTMENT OF MENTAL HEALTH**



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**Year Four**





**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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560 J Street  
Suite #390  
Sacramento, CA 95814  
(916) 266-2578  
1-800-305-3720 ext. 2578





**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

**Table of Contents**

**Executive Summary..... 11**

**Section 1.....23**  
**Introduction and Work Process**

    Section 1.1: Overview..... 25

    Section 1.2: Background ..... 25

    Section 1.3: External Quality Review Process ..... 32

    Section 1.4: Technical Assistance, Training and Education..... 35

**Section 2.....39**  
**Organizational Assessment**

    Section 2.1: Overview..... 41

    Section 2.2: Site Review Findings ..... 41

        Section 2.2.1: Performance Improvement Projects ..... 58

    Section 2.3: Analysis of Health Information Systems ..... 65

**Section 3.....81**  
**Performance Measures Analysis**

    Section 3.1: Overview..... 83

    Section 3.2: Statewide Considerations..... 84

    Section 3.3: Cost Per Beneficiary Served – Gender ..... 87

    Section 3.4: Cost Per Beneficiary Served – Age ..... 88

    Section 3.5: Cost Per Beneficiary Served – Race/Ethnicity ..... 91

    Section 3.6: Service Delivery Patterns ..... 92

    Section 3.7: High-cost Beneficiaries..... 103

    Section 3.8: Foster Care Analysis ..... 105

**Section 4..... 111**  
**Exemplary Practices and Other Models**

    Section 4.1: Overview..... 113

    Section 4.2: Exemplary Practices..... 114

**Section 5..... 131**  
**Trends in Key Areas**

    Section 5.1: Overview..... 133

    Section 5.2: Trends in Key Areas ..... 134





**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

**Table of Attachments**

**Attachment 1**  
Glossary ..... 145

**Attachment 2**  
MHP Size Categories for FY07-08 Statewide Report..... 149

**Attachment 3**  
Geographic Information Systems Maps ..... 155

**Attachment 4**  
Background and Quality Initiatives ..... 165

**Attachment 5**  
Review of Claims Processes for the Short-Doyle/Medi-Cal Programs..... 177

**Attachment 6**  
California Department of Mental Health Mental Health Services Act  
Performance Audit..... 183

**Attachment 7**  
Sample Notification Packet..... 189

**Attachment 8**  
San Bernardino Mental Health Plan Approved Claims Data CY07 ..... 209

**Attachment 9**  
Site Visit Activities Guidelines ..... 221

**Attachment 10**  
Sample Report Format ..... 231

**Attachment 11**  
Activities Calendar..... 269

**Attachment 12**  
CAEQRO Data Exchange and Security Protocols ..... 283

**Attachment 13**  
Performance Improvement Project Protocol..... 289

**Attachment 14**  
PIP Analyses ..... 297

**Attachment 15**  
Information Systems Capabilities Assessment V6.1 ..... 301

**Attachment 16**  
Denied Claims Analysis..... 331

**Attachment 17**  
Claim/Demographic Data CY07 ..... 335

**Attachment 18**  
Performance Measures Analysis..... 341

**Attachment 19**  
Los Angeles MHP Moving from Data to Investigation and Action ..... 351

**Attachment 20**  
Madera MHP Hope House Brochure..... 361

**Attachment 21**  
Riverside MHP Career Ladder Job Descriptions..... 383

**Attachment 22**  
San Bernardino MHP Milestones on the Road to Integrated Health Care ..... 401





## CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

### **Acknowledgements**

#### **APS Healthcare, California External Quality Review Organization**

Sheila Baler, Ph.D., MPH, Executive Director  
Carol Borden-Gomez, MBA, Senior Analyst  
Lisa Farrell, Data Analyst  
Samantha Fusselman, LCSW, Lead Reviewer  
Elizabeth Harris, RN, MSN, CNS, Lead Reviewer  
David Larimer, LPC, CADC, Lead Reviewer  
Jerry Marks, Senior Analyst  
Rowena Nery, MA, Lead Reviewer  
Michael Reiter, Pharm.D., Administrative Director  
Saumitra SenGupta, Ph.D., Information Systems Director  
Sandra Sinz, LCSW, Site Review Director  
Bill Ullom, Senior Analyst  
Mary Valentinsen, Administrative Assistant  
Hui Zhang, Ph.D., Reporting Manager

#### **APS Healthcare, Massachusetts External Quality Review Organization**

Alison A. Ready, MBA, CEBS Executive Director  
Nicole Clowes, Technical Writer/Analyst

#### **Consultants**

Caryl J. Miller, MA, CJM Consulting, San Geronimo, CA  
Alison S. Britton, Consulting/Design Services, Oakland, CA





## CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

### **Executive Summary**

California's Medicaid program – Medi-Cal – is administered by the California Department of Health Care Services (DHCS). The Medi-Cal mental health managed care program is carved out of the medical benefits and administered by the Department of Mental Health (DMH) via an Interagency Agreement with DHCS and waivers approved by the Centers for Medicare & Medicaid Services (CMS) under Section 1915(b) of the Social Security Act. Through the 1915(b) waiver, California may operate a statewide system of individual mental health plans (MHPs) in each county – i.e., the mental health managed care program. County mental health departments operate the MHP for Medi-Cal recipients and also serve as the safety net for uninsured consumers.

California External Quality Review Organization (CAEQRO), a division of APS Healthcare, was engaged by DMH to conduct a series of data analytic and systems reviews as part of the CMS-mandated external quality review (EQR) of Medicaid managed care programs. Beginning with the first year of our contract, CAEQRO established core work processes that we have continued to enhance each year – building on the experience that we gained during the previous year's review. Consistent with last year's objectives, our Fiscal Year (FY) 07-08 EQR activities focused on four overarching objectives:

1. Continue to support data-driven decision making to help MHPs improve business processes, clinical operations and programmatic initiatives
2. Follow up on the status of our year three recommendations
3. Conduct individualized MHP site reviews that draw upon four years of quantitative findings
4. Explore each MHP's success in developing consumer-focused programs that support wellness, recovery and resilience.

The following narrative summarizes how we met these objectives within a public mental health environment that continues to present both unique challenges and opportunities. Attachment 1 includes a glossary for the acronyms that appear throughout this statewide report. Attachment 2 explains the MHP size categorizes that we used in aggregating our findings.

### **Introduction and Work Process**

A discussion of the public mental health environment in California provides an important context for understanding the challenges faced by an EQRO and, significantly, by the MHPs that have many conflicting priorities. Immediately following this brief environmental overview, we highlight our FY07-08 work process — including a brief

discussion on the technical assistance, education and training that our staff has provided to MHPs and other stakeholders since our first contract year.

### California's public mental health environment

Over the last 50 years, California's public mental health system has evolved into a comprehensive array of programs and services supported by a variety of complex local, state and federal funding streams. These challenges have recently been exacerbated by the state's budget crisis — which remains unresolved as of this report's August 31 publication date. According to Governor Arnold Schwarzenegger's May revision to the FY08-09 budget, California faces a \$17.2 billion dollar deficit and a potential 10 percent across-the-board cut — including Medi-Cal payments — and an additional \$627 million in reductions to health and human services. Operating without a budget as of July 1, 2008, the legislature continues to debate about how to close the gap between projected revenues and an historic deficit.

While Section 1 in combination with Attachment 4 provide a detailed overview of the complex history of California's public mental health system, the following two events are largely responsible for creating the environment in which CAEQRO operates today:

- **Realignment in the 1990's.** California's public mental health system experienced one of the most significant changes in the past several decades when in 1991 the Legislature enacted the Bronzan-McCorquodale Act, referred to as realignment. This legislation shifted program and funding responsibilities from the state to counties, adjusted cost-sharing ratios, and provided counties with a dedicated revenue stream — Short-Doyle/Medi-Cal (SD/MC) funds — to pay for the changes in mental health, social and health services. This dramatic change into a decentralized system had both financial and organizational implications.
  - o *Impact on MHPs* — Because of the funding mechanism, counties acquired increased management and service delivery responsibility without commensurate revenue. Realignment did create a number of fiscal advantages, including the ability to roll over funds year-to-year and the elimination of competition with entitlement programs for State General Funds.
  - o *Impact on DMH and DHCS* — Realignment has created administrative challenges that were articulated last December in a report by the California Department of Finance, Office of Audits and Evaluations (Finance) on "fiscal processes involved in the payment of local assistance claims for the SD/MC Program." Finance found deficiencies in program governance, information technology, claim processing and cost settlements and audits. DMH and DHCS were praised for taking "positive steps by conducting internal studies and convening special workshops and committees to define problems and identify solutions." In its response letter, DMH committed to use the audit as "a guiding document to support [its] collective management efforts" to respond to the specific recommendations in all identified problem areas.

- **Mental Health Services Act (MHSA).** Passed in 2004, MHSA has as its overarching objective to transform the public mental health system into one that focuses on consumer wellness, recovery and resilience. The legislation focuses on developing a broad spectrum of prevention, early intervention and other programs, as well as infrastructure support, to engage underserved populations and promote the recovery of individuals with mental illness. While MHSA provides tremendous opportunities for creative programming (and we feature examples of such programming in Section 4), it also has rendered an already complex regulatory environment even more daunting. The funding mechanism is a one percent tax on annual incomes over one million dollars. Given today's struggling economy, funding for MHSA is projected to decrease by \$172.2 million in the current year and \$105.2 million in the budget year, for total estimates of \$1.6 billion in FY07-08 and \$1.7 billion in FY08-09.

MHSA has also created another administrative task for an already over-burdened DMH — which is responsible for reviewing and approving each county's Three-Year Program and Expenditure Plan in partnership with the Mental Health Services Oversight and Accountability Commission. DMH is also responsible for the dispersal of funding. The program has been called to task by Finance in a recent audit report that found deficiencies in the program's development and implementation, plan review and approval, and fund distribution processes. In its response letter, DMH committed to working "successfully with [its] partners to streamline [its] processes, clarify roles and responsibilities and improve the approval of county Plans and the distribution of needed funds to local mental health plans."

When APS Healthcare initiated the EQRO contract in 2004, the state's public mental health system was seriously under-funded, experiencing increased stakeholder pressure, struggling with already complex compliance requirements, and poised for a promised system transformation through MHSA. As a consequence of this environment, many MHPs were initially ambivalent about the EQR process and viewed CAEQRO as "yet another compliance audit" with neither financial incentives nor consequences.

However, over our four contract years we experienced a sea change as our staff built new relationships and strengthened long-standing relationships throughout the public mental health system. DMH, the counties and leadership organizations such as the California Mental Health Directors Association (CMHDA), now turn to us for data analyses and technical assistance in support of their efforts to address the many challenges highlighted in Section 1.

### Work process enhancements in FY07-08

Consistent with previous years, CAEQRO conducted a large-scale programmatic, clinical and systems review of 56 MHPs throughout California. The overarching principle driving our EQR process has remained consistent over the past four years — use data to guide decisions regarding quality and performance improvement. However, with each successive year, we have been able to bring increased value to the review process by standardizing core evaluation measures, while focusing on the access to, as well as timeliness and quality of, the services that each MHP provides to its beneficiaries.

Our years one, two and three statewide reports, which contain detailed discussions on our core site review processes, are available on our Web site at [www.caegro.com](http://www.caegro.com). Highlighted below are the key process improvements specific to FY07-08:

- **Conducted collaborative quality reviews.** At the suggestion of Kern MHP, CAEQRO and the Commission on Accreditation of Rehabilitation Facilities (CARF) worked collaboratively during year four to conduct a joint EQR and CARF reaccreditation review.
- **Added two new areas for intensive review:**
  - *Prescribing practices.* We requested that MHPs provide their guidelines for monitoring medication prescribing practices, since clear and detailed documentation can help to mitigate the disruption caused by a frequent turnover in psychiatrists.
  - *Evidence-based practices.* We requested that MHPs provide any mechanisms for evaluating outcomes and/or fidelity to evidence-based practices (EBPs). Since a number of MHPs are implementing or plan to implement EBPs, assessing the thoroughness of training on and adherence to a variety of EBP-prescribed activities are becoming increasingly important components of our EQR process.

### Technical assistance, education and training

Unlike a traditional EQRO, CAEQRO has consistently sought opportunities to provide each MHP with technical assistance that promotes performance improvement. Consistent with previous years, we participated in a wide variety of technical assistance, education and training activities with individual MHPs, DMH and other key stakeholders, as well as providing ongoing internal professional development for both CAEQRO staff and our program's consumer/family member consultants who continue to work with us on site reviews.

We continually explore opportunities to extend the limited reach of the kind of technical assistance that we provide to individual MHPs during the site visit process. To that end, we added two new multi-county projects to the one we had initiated in year three:

- **Small County Emergency Risk Pool.** In year three we along with the California Institute of Mental Health (CiMH) and CMHDA worked to implement the Small County Emergency Risk Pool (SCERP) Performance Improvement Project (PIP) on reducing inpatient rehospitalization rates — now called SCERP Cohort 1. To date 17 of the 18 counties that initially signed up for this PIP are active and ongoing participants in this collaborative process. For those counties unable to meet the deadline for submitting baseline data and thus participate in this PIP, we also supported the start of SCERP Cohort 2.
- **California Department of Mental Health's Performance Improvement Project.** As part of the state's severe budget cutbacks, DMH was faced with legislative mandates to reduce funding required from State General Fund appropriations. One means to this end was to require additional authorizations

for children and adolescents enrolled in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs. CMHDA made a counter proposal to implement a statewide PIP on high-cost consumers to improve quality, while reducing administrative redundancy and duplicative services. DMH and the Legislature agreed to support this process, which is now in an early stage of implementation. To assist DMH with evaluating this initiative, CAEQRO has performed an in-depth analysis of EPDST data and assisted in training participants to begin the process. Currently initial CAEQRO data analyses are posted on the special DMH EPSDT Web site devoted to this special PIP: [http://www.dmh.ca.gov/Services\\_and\\_Programs/Medi\\_Cal/EPSDT\\_Statewide\\_PIP.asp](http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/EPSDT_Statewide_PIP.asp).

In our simultaneous roles as both quality reviewers and providers of technical assistance, we have been careful to avoid a perceived conflict of interest. Instead, we have conducted our review in a consultative manner, and we applied this perspective throughout the review year. By sharing MHPs' successes, promoting quality management skill building and proposing alternative solutions to issues, we have been able to balance providing technical assistance with conducting thorough and objective external quality reviews.

## Organizational Assessment and Structure Performance

In year four, MHPs continued to face most of the same challenges that we observed during the previous three years. However, some MHPs have responded in creative ways to address these challenges, while others have not been able effectively to move beyond the status quo. In particular, MHSA funding and program development have produced mixed results in beginning to effect system transformation:

- **Service capacity.** Some MHPs have creatively used MHSA funds to increase access for underserved populations by developing programs that support wellness, recovery and resilience. Others have not been successful in using this infusion of flexible funding to expand service capacity.
- **Data and performance management.** While most MHPs acknowledge the importance of using data for performance management, many have only begun to collect data on such basic indicators as timeliness of service delivery. In some cases, MHPs have viewed MHSA-required reports as a substitute for a system-wide focus on outcomes monitoring and evaluation.

These themes are evident throughout our findings which — as listed below — reflect our site review priorities:

- **Section 2.2 – Site Review Findings**
  - *Follow-up to the recommendations in our year three MHP reports.* Overall, we found that most MHPs initiated at least some activity to address our recommendations. Even many MHPs without active quality improvement (QI) programs reported that the issues we identified in our reports were valid and warranted attention. For example, 80 percent of

the priority recommendations from FY06-07 were rated either “fully” or “partially addressed” in FY07-08.

- o *Continued focus on performance management.* As in previous years, we highlighted strengths, opportunities for improvement and recommendations that address the need for data-driven decision-making. Lack of access — especially to reliable psychiatric services — continues to be a significant problem that affects the overall quality of the delivery system.
  - o *Consumer involvement in service delivery and recovery-oriented programming.* We observed a gradual improvement in this area from FY06-07 to FY07-08 — largely related to MHSA-funded programmatic initiatives. Because of the importance of this area, our findings contain several discussions on consumer-focused programming.
- **Section 2.3 Health information systems review**
    - o *Information Systems Capabilities Assessment (ISCA) V6.1.* The ISCA findings that are included in this section were produced from information extracted from our sophisticated ISCA database, which now stores multiple years of MHP information systems data. As we discuss in “Trends in Key Areas,” over the past three years many MHPs have been engaged in information systems activity — largely related to implementations — with mixed results.

Also included in this section is a summary of our findings related to PIPs, which also showed mixed results over previous years — with progress somewhat confined to the SCERP PIP on rehospitalizations. The results for other PIPs were highly variable — including the successful development of a second PIP by SCERP participants.

## Performance Measures Analysis

In year two, CAEQRO and DMH considered several options for the performance measures (PM) analysis and, after an extensive analytic process, selected “cost per unduplicated beneficiary served.” For years three and four, we built on our base analysis of cost per unduplicated beneficiary served to identify any changes from previous year’s findings. We also added a number of specific penetration rates (as highlighted in Section 5) as additional informative elements.

To increase our understanding and evaluation of the service delivery system, CAEQRO focused our analysis to:

1. Determine if key variables such as gender, ethnicity and age contribute to understanding service delivery patterns
2. Identify the most striking differences among various groups
3. Highlight consistencies and changes from prior year studies

4. Stimulate discussions by stakeholders about whether these patterns necessitate further review and study

As in our previous year's report, we included a simple ratio to illustrate how penetration rates and average cost per beneficiary compare among different populations:

- "Penetration rate ratio" is a ratio of the penetration rate of one demographic or ethnic group to another. A ratio of 1.0 reflects an equitable penetration rate based upon the beneficiary population. The further the value is from 1.0, the greater is the disparity.
- "Average payment ratio" is a ratio of the average payment for one demographic or ethnic group to another. Again, a value of 1.0 reflects parity. The further the value is from 1.0, the greater is the disparity.

However, this picture of services provided to individuals reflects only those beneficiaries who have entered the mental health system of care. Understanding barriers to initial access to the service system is also extremely important. Although the data we have available can only provide a partial picture of the delivery system, our findings are still valuable in providing stakeholders with useful information on areas that call for review and potential intervention by individual MHPs.

Our analysis indicated notable and highly consistent disparities in access, cost and the types of services received by different groups of beneficiaries. Summarized below are our key performance measure findings for FY07-08 based on our comparative analysis of claims data from CY05, CY06 and CY07:

- Female beneficiaries were still less likely to be served than male beneficiaries
- Hispanic beneficiaries were still less likely to be served than white beneficiaries
- Fewer resource dollars were spent on female beneficiaries than on male beneficiaries
- Fewer resource dollars were spent on Hispanic beneficiaries than on White beneficiaries (although the gap in spending narrowed from CY05 to CY07)
- Fewer resource dollars were spent on older adults than on beneficiaries in other age groups
- Over the past three years, the total percentage of Medi-Cal dollars supporting high-cost beneficiaries continues to increase (with a high of 26 percent in CY07)
- With a few exceptions, data for the foster care beneficiary population has remained unchanged from CY05 to CY07

The demographic and ethnic landscape of communities in California is quite varied — perhaps the most diverse in the nation. In Attachment 3 we include maps that suggest this diversity by simply displaying population distributions throughout the state. A detailed understanding of these findings, as well as performance measure analyses, can

only be gained by each MHP's evaluation of its own data, which we post on our Web site ([www.caeqro.com](http://www.caeqro.com)). This information can then be useful for local planning and evaluation of service delivery — especially regarding efforts to improve services to specific sub-populations.

## Exemplary Practices

Consistent with our approach in previous years, we wanted to acknowledge those MHPs that had recently implemented practices or processes with great promise to improve clinical or administrative operations. In particular, we chose examples that appear to be replicable either in whole or in part by other MHPs. Section 4 includes summaries of the following Exemplary Practices and Processes, as well as Noteworthy initiatives that warranted recognition:

- **Exemplary Practices and Processes** — implemented or improved in FY07-08 and have either demonstrated or have great promise to achieve measurable results:
  - *Kern MHP*, which we first identified in our FY06-07 Statewide Report for its noteworthy implementation of the Anasazi information technology system
  - *Los Angeles MHP*, whose Strategies for Total Accountability and Total Success process emphasizes management collaboration, scrutiny and oversight
  - *Madera MHP*, which leveraged both MHSA funds and a strong contract provider relationship to implement an unusually well-developed wellness center
  - *Riverside MHP*, which developed a comprehensive career ladder for consumer employees
- **Noteworthy Practices and Processes** — implemented or improved in FY07-08 and demonstrate initiatives that other MHPs may adopt for system-wide improvements:
  - *Humboldt MHP*, which has a coordinated effort to evaluate a number of EBPs
  - *San Bernardino MHP*, which has implemented the first stage of a comprehensive initiative to integrate all health care services
  - *Santa Clara MHP*, whose consumer health screening initiative reflects cost data and integrates mental and physical health services
  - *Stanislaus MHP*, which has a unique consumer-operated “warm line”

We were also struck by the ability of MHPs in varying geographic regions, with diverse demographics and often with limited resources, to work collaboratively and — in many

cases — cross functionally, to implement notable initiatives in the areas of wellness- and recovery-oriented programs. Additional examples of these initiatives are discussed in Section 2.

## Trends in Key Areas

As discussed in Section 5, we have systematically observed what we believe to be dominant themes within California's public mental health system. In last year's statewide report, we were first able to begin discussing trends because we had collected a minimum of three years' observations and quantitative data on a specific issue. Having aggregated a substantial body of such information now over four years, we can further explore the following trends within key areas:

- **Trend #1: Access remains limited despite alternative service models.** While new delivery system models continue to emerge, many consumers are still denied access for a variety of reasons. In particular, access to psychiatric services remains limited.
- **Trend #2: Female and Hispanic beneficiaries continue to be underserved by the public mental health system.** When compared to White male beneficiaries, female and Hispanic beneficiaries access the system less frequently.
- **Trend #3: Use of data for quality management shows little progress.** The collaboration of small counties on the SCERP PIP is an important exception.
- **Trend #4: MHPs continue to make major changes and investment in information systems.** However, all MHPs will not have new information systems operational for several more years — potentially delaying or hampering the implementation of key system-wide initiatives.
- **Trend #5: MHPs continue to emphasize wellness, recovery and resilience.** However, key initiatives such as consumer/family member employment are limited to the mental health system.
- **Trend #6: Strong leadership continues to have a significant impact on MHP performance.** Overall workforce development remains a major area for continued improvement.

## Year Five Priorities

In addition to those activities we have conducted since our first year, CAEQRO has the following priorities for our year five review:

- **To support ongoing collaborative performance improvement projects.**
  - As mentioned previously, we will not only be continuing the PIP — SCERP Cohort 1, but working with an additional 18 MHPs — both large and small — on the SCERP Cohort 2 PIP. CiMH and CMHDA are co-collaborators in these activities.

- o As also mentioned previously, we will continue working with DMH and CMHDA on a statewide PIP to review services to high cost children and adolescents receiving services through Early Periodic Screening Diagnosis and Treatment (EPSDT) Medi-Cal funding.
- o Ongoing since year three, CAEQRO has been participating with the California Mental Health Care Management Program (CaIMEND) project that concentrates on the use of pharmacy data for improvement in care.
- **To continue using our data resources and data analytic capabilities in assisting MHPs with continued performance management.**
  - o We plan to develop predictive modeling data analyses for program planning and identification of high-risk individuals.
  - o We now have five years of qualitative and quantitative data and results to inform our findings and system-wide recommendations.

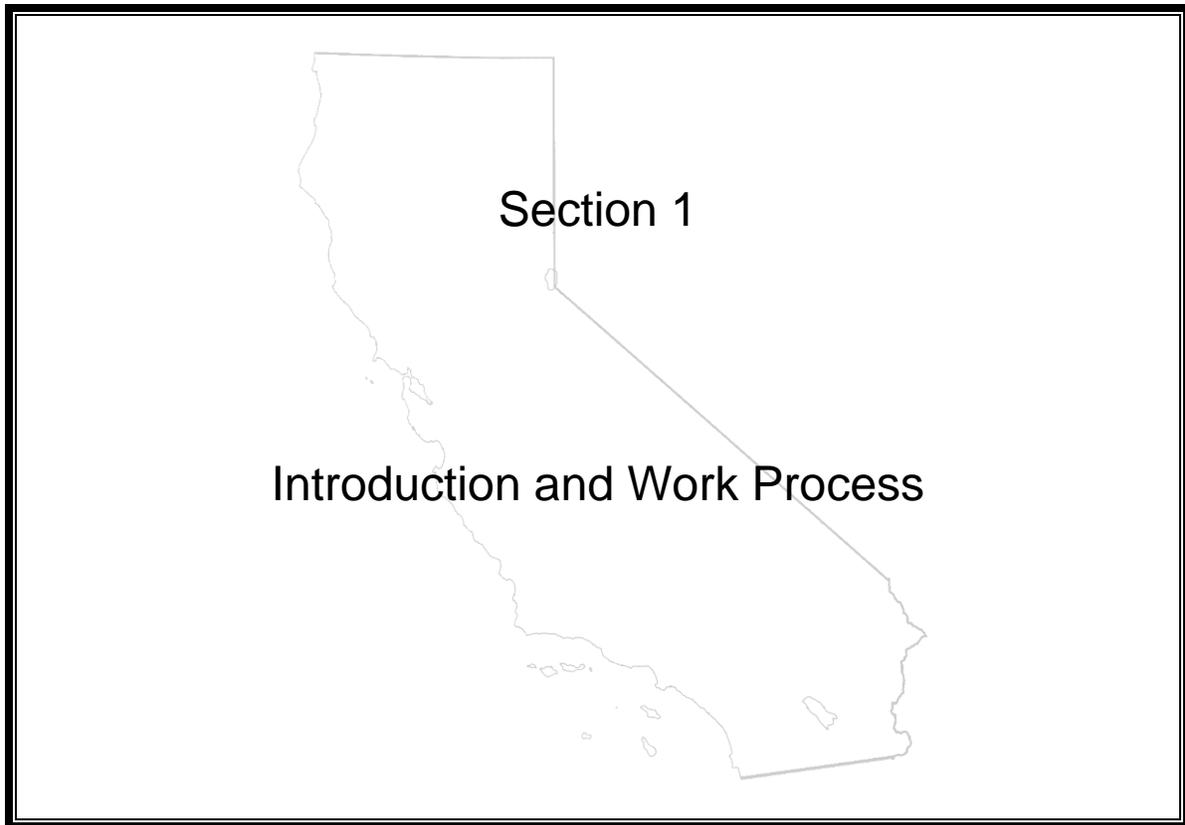
These initiatives reflect the collaborative relationships we have developed with DMH and leadership organizations such as CiMH, CMHDA and CaIMEND. They also reflect the evolutionary process of familiarizing a variety of stakeholders with the EQRO process and its potential value to support system transformation.

### CAEQRO Activities





**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 1.1: Overview

California's Medicaid program — Medi-Cal — is administered by the California Department of Health Care Services (DHCS). The Medi-Cal mental health managed care program is carved out of the medical benefits and administered by the Department of Mental Health (DMH) via an Interagency Agreement with DHCS and waivers approved by the Centers for Medicare & Medicaid Services (CMS) under Section 1915(b) of the Social Security Act. California External Quality Review Organization (CAEQRO), a division of APS Healthcare, was engaged by DMH to conduct a series of data analytic and systems reviews as part of the CMS-mandated external quality review (EQR) of Medicaid programs.

Through the 1915(b) waiver, California may operate a statewide system of individual mental health plans (MHPs) in each county — i.e., the mental health managed care program. County mental health departments operate the MHP for Medi-Cal recipients and also serve as the safety net for non-Medi-Cal indigent consumers. Different from models operated by states across the country, California's public mental health system presented and still presents a unique set of challenges for an EQRO.

In our Year Three Statewide Report, we included a comprehensive overview of the system's evolution into 56 MHPs<sup>1</sup> that serve a highly diverse consumer population, the funding that supports this decentralized community-based model, and its myriad and highly varied infrastructure challenges. We also summarized DMH's various mental health quality improvement (QI) initiatives over the past decade. That information is included in Attachment 4 for reference.

In this section, we provide updates to key infrastructure challenges and system-transformation initiatives — within the context of the state's most serious budget crisis since 1991. We then briefly highlight the EQRO process, which has evolved over our past four contract years — both in response to our increased understanding of this unique and complex system, as well as to an ever-changing political, financial and legislative environment. We also discuss the various technical assistance, education and training activities that are specific to year four. Previous years' reports, which include detailed discussions of the EQRO process and our ongoing technical assistance, education and training activities, are available on line at [www.caegro.com](http://www.caegro.com).

## Section 1.2: Background

According to the California Mental Health Directors Association (CMHDA), California lapsed from the nation's leader in community mental health development and civil rights for persons with mental illness into “decades of funding instability and program confusion” until the 1990's when the state “regained its preeminence in public mental health.” Some stakeholders might argue that California continues to experience varying degrees of success in implementing a “system transformation” and others worry that the mental health system “may be headed for crisis.”<sup>2</sup>

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<sup>1</sup> California has 58 counties; however, Placer and Sierra Counties and Sutter and Yuba Counties have merged to form two MHPs (i.e., Placer/Sierra and Sutter/Yuba).

<sup>2</sup> Lauer, G. *California's Mental Health System May Be Headed for Crisis*, California Healthline, April 14, 2008.

Below we highlight the ongoing infrastructure challenges faced by California's public mental health system and how those challenges have increased the complexity for an EQRO operating in this environment.

## A Complex and Evolving System

The passage of the Short-Doyle Act in 1957 created California's community mental health system by providing matching state funds for counties and cities to provide mental health services. Federal funding of public mental health services — known as Short-Doyle/Medi-Cal (SD/MC) did not begin until the 1970s and failed to offset the next 20 years of financial pressures produced by tax cuts and inflation, which reduced state allocations to counties for human services, and federal "entitlement" programs, which forced counties to dip into their shrinking coffers for these so-called unfunded or inadequately funded mandates

About 17 years ago, the state faced a budget crisis that precipitated a restructuring of the public mental health system without the necessary infrastructure support for either its administration or oversight. As of Fiscal Year (FY) 08-09, the state again faces a budget crisis compounded by a fractured infrastructure and the increased demands of implementing Proposition 63, known as the Mental Health Services Act (MHSA). While the California public mental health system is the product of many complex economic, demographic and political influences over the past 50 years (as summarized in Attachment 4), the following three factors are key to understanding the current environmental landscape. They are also key to understanding the challenges faced by DMH in its various oversight and administrative capacities.

### Program and funding realignment

In 1991, California faced a \$14.3 billion deficit. Mental health funding, which was then subject to annual legislative appropriation, was jeopardized by this statewide fiscal crisis. The Legislature responded by enacting the *Bronzan-McCorquodale Act*, referred to as *Realignment*. It shifted program and funding responsibilities to counties, adjusted cost-sharing ratios, and provided counties a dedicated revenue stream to pay for these changes in mental health, social and health services. Dedicated revenues from a half-cent increase in the state sales tax and the vehicle license fee were to cover the shifts in program costs. State oversight was to focus increasingly on outcomes and performance-based measures.

From 1995 to 1998, the state consolidated the two Medi-Cal mental health funding streams — SD/MC and fee-for-service/Medi-Cal (FFS/MC) — and carved out specialty mental health services from the rest of Medi-Cal managed care. County mental health departments were given the "first right of refusal" to be the MHP for the county. At that time, only two counties declined (although both today are the MHPs for their beneficiaries). The carve-out program operates under a Federal Freedom of Choice Waiver. Specialty mental health care (i.e., requiring a specialized provider) is provided by MHPs, while general mental health services are under the direct purview of DHCS, either through its managed care plans or through the FFS/MC system.

Over time, realignment has created both challenges and opportunities for the counties (as we discuss later on in this section). A recent audit of claims processes for the SD/MC Program points out the administrative challenges faced by DMH in providing timely payments to MHPs and its quality improvement initiatives in this area.

On December 31, 2007, the California Department of Finance, Office of Audits and Evaluations (Finance) issued a report on DMH's "fiscal processes involved in the payment of local assistance claims for the SD/MC Program" and included recommendations for "streamlining and improving the payment process." The audit was initiated by DMH in response to legislative and other stakeholder concerns over late payments to MHPs. A copy of the report's executive summary is included as Attachment 5.

Briefly, Finance found DMH lacking in the following areas:

- **Program governance** — which was described as "fragmented, decentralized, and ineffective." "Intradepartmental barriers between DMH and DHCS have impaired both organizations' abilities to centrally govern and make the mission-critical changes needed to improve operations."
- **Information technology** — which has "systems used to process claims...at grave risk of failure...[that are contributing] to significant payment delays." "Delays in the implementation of a replacement for the primary system raise concerns about whether such replacement has been a priority."
- **Claim processing** — which is characterized as "inefficient, slow, and poorly controlled." "Serious flaws in the design and operation of the process significantly impair DMH's and DHCS's ability to effectively manage the payment function."
- **Cost settlement and audits** — which are "not timely." MHP reports may contain errors that are not discovered until "years later... precluding timely and accurate expenditure forecasting."

DMH and DHCS were praised for taking "positive steps by conducting internal studies and convening special workshops and committees to define problems and identify solutions." In its response letter to Finance, DMH committed to use the audit as "a guiding document to support our collective management efforts" to respond to the specific recommendations in all identified problem areas.

### Implementation of the Mental Health Services Act

Passed in 2004 and enacted on January 1, 2005, MHSA has as its overarching objective to transform the public mental health system into one that focuses on consumer wellness, recovery and resilience. The funding mechanism is a one percent tax on incomes over one million dollars. The program focuses a broad spectrum of prevention, early intervention and other services, as well as infrastructure support for engagement of underserved populations and programs that promote recovery of individuals with mental illness.

MHSA funding has and continues to support consumer involvement in service delivery and recovery-oriented programming. However, the state's implementation of the program has been called to task by Finance in a recent performance audit. The executive summary of that audit is included as Attachment 6. As suggested above, DMH's infrastructure challenges pre-dated the added responsibilities of overseeing a unique system transformation initiative.

DMH is responsible for reviewing and approving each county's Three-Year Program and Expenditure Plan (Plan), which consists of three parts:

- Services for adults and children (referred to by DMH as Community Services and Supports [CSS])
- Workforce Education and Training (WET)
- Capital Facilities and Technology Needs (CAPTECH)
- Prevention and Early Intervention (PEI)

The responsibility for reviewing Plan components is split between DMH and the Mental Health Services Oversight and Accountability Commission (OAC) — which was established by the MHSA to oversee specific program components and funding, while referring county performance issues to DMH.

The audit report — which incorporates input from MHSA program, policy, and accounting staff, the OAC, the CMHDA, and the California Institute for Mental Health (CiMH) — had the following key findings:

- **Development and Implementation Process.** DMH does not have an overall plan for the development and implementation of the MHSA. Further, only the CSS component is fully implemented and its “review and approval process is cumbersome and lengthy.”
- **Plan Review and Approval Process.** While consistent with the MHSA, the process is “cumbersome and lengthy,” as well as “inflexible.” The audit report does acknowledge that with each milestone in MHSA, DMH staff have been “dedicated and enthusiastic,” and “continue to increase efficiency and effectiveness.” However, the audit report directs DMH to achieve greater efficiencies in reviewing the remaining component plans.
- **Fund Distribution Process.** The audit report describes fund distributions to the counties as “untimely.” As of March 31, 2008, “approximately \$3.2 billion has been collected and \$2.9 billion has been allocated for county use. Of the \$2.9 billion allocation, \$1 billion has been approved for distribution but only \$726 million has been distributed to counties.” Despite recent improvements by DMH that allows for increased cash flow to the counties, the audit report notes that delays in payment continue, since the process remains flawed.

In its response letter, DMH committed to working “successfully with [its] partners to streamline [its] processes, clarify roles and responsibilities and improve the approval of county Plans and the distribution of needed funds to local mental health plans.

Last year an issues memo (dated June 5, 2007) recapped that DMH, California Mental Health Planning Council (CMHPC), and the OAC have overlapping statutory responsibilities for driving statewide quality and outcomes accountability for MHSA-funded programs. They are potentially generating duplication in reporting and paperwork requirements imposed on county mental health departments — both in operating MHPs and in delivering services for indigent populations:

To increase coordination and decrease the likelihood of duplication of requirements, representatives from these three government partners, along with county mental health departments and community-based agencies, have proposed an Evaluation Group that is described in Attachment 4.

### The state's budget crisis

According to Governor Schwarzenegger's May revision to the FY08-09 budget, California faces a \$17.2 billion deficit — although, at “press time” for this report, various estimates of the “actual” budget deficit are still under discussion. To address this budget gap and end the year with a reserve of \$2 billion, the May revision includes a 10 percent across-the-board reduction and an additional \$627 million in reductions to health and human services programs.<sup>3</sup> The majority of cuts to the DMH are proposed in community mental health programs.<sup>4</sup>

- **Early and Periodic Screening, Diagnosis and Treatment.** Over the years, the state has owed counties as much as over \$243 million in mandated reimbursement for specialty mental health services, commonly referred to as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The original budget proposed a total reduction in EPSDT of \$6.7 million in the current year, and a \$46 million reduction in the 2008-09 budget year. Presently, the current year reflects a net increase of \$131.1 million and the budget year reflects a net increase of \$31 million. Previous iterations of the budget had required prior authorization of day treatment services that exceed six months; however, this proposed requirement was replaced by a mandated Performance Improvement Project on EPSDT services.
- **Medi-Cal Mental Health Managed Care.** As discussed above, timely processing of claims is already a challenge because of infrastructure flaws. Now, the administration is proposing to purposely delay \$200 million in payment to the counties for their MHPs (i.e., from July to September) for cash flow purposes. A comparable delay is proposed for \$92 million in EPSDT payment. The original budget called for a 10 percent across-the-board reduction in both the current year (\$8.2 in the State General Fund [SGF]) and the budget year (\$23.8 million in SGF).
- **Mental Health Services Act Funding.** Given today's struggling economy funding for MHSA is projected to decrease over previous estimates by \$177.2 million in the current year, and \$105.2 million in the budget year, for total estimates of \$1.6 billion in FY07-08 and \$1.7 billion in FY08-09.

<sup>3</sup> <http://www.ebudget.ca.gov/Revised/BudgetSummary/INT/8867191.html>

<sup>4</sup> This analysis was provided by Patricia Ryan, executive director of the California Community Mental Health Directors Association.

- **AB 3632 (Services to special education students).** In 1984, the Legislature enacted AB 3632, which included mental health treatment for all children less than 22 years of age. These services are a federal entitlement resulting from the 1975 Individuals with Disabilities Education Act – which was to be financed by the state’s categorical funds. This year’s budget does not include any reductions or changes to funding this federally mandated program — although historically funding has not kept pace with service costs.
- **Department of Mental Health Administration.** Despite Finance’s findings regarding infrastructure challenges — including inadequate and outdated information technology, DMH administration funding is projected to decrease by \$722,000 in the current year and by \$1.95 million in the budget year. However, quality improvement initiatives are ongoing — as most recently illustrated by the California administrative experts who have joined DMH and are charged with its reorganization to promote collaboration and accountability. Serving in key roles are Chief Deputy Director Elaine Bush, who is leading the reorganization initiative, and Special Projects Manager Sean Tracy, who is an expert in state finance.

The state’s budget crisis — which is affecting the public mental health system statewide — is causing some counties, such as Santa Cruz, to cut up to 20 percent of core programs that are not funded by MHPSA and rely on realignment dollars.

## An EQRO in Today’s Mental Health System

California’s public mental system has evolved from a simple one with state-local matching funds to one that includes state general funds, dozens of categorical funds, and federal matching funds to support a myriad of services. With realignment in the 1990s, California’s public mental system experienced one of the most significant changes in the past several decades. Counties acquired increased management and service delivery responsibility without commensurate funding support. Consequently, when APS Healthcare initiated the EQRO contract in 2004, the state’s public mental health system was seriously under-funded, experiencing increased stakeholder pressure, struggling with already complex compliance requirements, and poised for a promised system transformation through MHPSA.

While many MHPs had viewed MHPSA as providing relief to stretched budgets, that has not been the case according to Patricia Ryan, executive director of CMHDA. “Lots of counties are having to reduce services or close clinics and hospitals because of eroding funding...It’s partly due to Medi-Cal contractions, but not entirely...The state is having a hard time paying counties on time, that’s hard on everyone, but it makes things particularly difficult for small counties that don’t have the ability to borrow money.”<sup>5</sup>

Summarized below are some of the high-level challenges that the system continues to face and the implications for the CAEQRO:

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<sup>5</sup> Lauer, *op. cit.*

- **Siloed organizations.** The diversity of California’s population, in terms of population density, ethnic make-up and socio-economic conditions, necessitated the creation of the decentralized system that was created by realignment and exists today. The creation of several strong, highly organized professional alliances emerged to support collaboration in a decentralized environment, including the CMHDA and the nationally regarded CiMH. However, decentralization also created an environment in which each county system had become siloed and viewed itself as different and separate from other counties in the state. This entrenched perception created barriers to cross-county collaboration in addressing many of the system’s shared challenges, particularly among small counties.
- **Financing.** The mental health system’s funding sources today are primarily a mix of realignment funds (derived from the SGF), Medi-Cal Federal Financial Participation (FFP), categorical funds and most recently MHSA. A reduction in realignment funds and decreased spending in Medi-Cal funding could dramatically alter the relative proportion of these funding sources.
  - o Despite its fiscal advantages, realignment’s funding mechanism is inherently flawed. When the economy is weak as it is today, a host of issues create the need for increased mental health services, while the primary funding for these services — license and sales tax revenues — decreases. The governor’s repeal of the vehicle license fee increases in 2004 created additional shortfalls.
  - o FFP has fluctuated over time and many counties have had to use an increasing proportion of their realignment funds to draw the federal Medi-Cal match for mandated or entitlement programs. As noted previously in this section, DMH is having difficulty processing and paying these claims efficiently because of process inefficiencies and outdated information technology. And now MHPs are facing a 10 percent across-the-board cut in these funds. Legislation has been introduced SB1349 would require the State Controller’s Office to reimburse local governments for mental health services within 90 days of the receipt of a reimbursement claim by DMH. The measure also requires interest on late payments.<sup>6</sup>
  - o Categorical programs, such as EPSDT or those provided under AB 3632, continue to place administrative and financial pressures on counties. This year’s proposed budget for EPSDT would eliminate the Cost of Living Allowance (COLA) for the state mandate allowance (SMA) for providers, while funding for AB 3632 remains unchanged, including \$69 million through the Individuals with Disabilities Education Act, \$52 million in SGF and money through the SB 90 mandate reimburse process.
  - o Funding from MHSA, while still projected to bring several billion dollars of revenue over the next two fiscal years, has been affected by the economic downturn. Many counties have successfully implemented what is known as Full Service Partnerships (FSPs), which include a range of

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<sup>6</sup> Lauer, *op. cit.*

services and supports — some of which are not reimbursed under Medi-Cal. In addition, 50 percent of MHPA funding must be spent on FSPs within the next two years, and these funds cannot be diverted to pay for other unbudgeted or under-budgeted programs/services.

With already complex and partially redundant compliance audits and quality reviews of MHPs and other county programs, the addition of MHPA-related oversight initiatives apparently may result in counties' undergoing up to 12 site visits each year. However, despite these administrative burdens, MHPs no longer view the EQRO as "simply another compliance audit."

CAEQRO has experienced a genuine sea change in many MHPs' perception of the EQRO process, as our staff has built new relationships and strengthened long-standing relationships throughout the public mental health system. DMH, the counties and leadership organizations such as CMHDA, now turn to us for data analyses and technical assistance (as highlighted in Section 3) in support of their efforts to address the challenges articulated above. In Section 2.2, we address our system-wide findings in greater detail.

## Section 1.3: External Quality Review Process

During year four, CAEQRO conducted programmatic, clinical and information systems reviews of 56 MHPs throughout California. Our overarching principle during the process was the continued focus on the use of data to guide decisions regarding quality and performance improvement. Of the 56 reviews, 55 included a site review by a team of CAEQRO staff and consultants; each team included a consumer/family member representative. The review of Alpine MHP consisted of a document/phone review. With approximately 1,200 residents, Alpine is the smallest county in the state and key MHP staff remained on long-term medical leave during the month scheduled for the review.

After three years of refining the EQRO process to reflect input from MHPs throughout the system, the CAEQRO pre-site, site and post-site review process remained essentially the same as in year three. A detailed description can be found in pages 28–37 in our Year Three Statewide Report, which is available on our Web site at [www.caeqro.com](http://www.caeqro.com). The following is a brief summary of that process, along with one significant enhancement that helped one MHP address often duplicative and sometimes inconsistent mandated quality reviews from different organizations.

- **Conduct collaborative quality reviews.** At the suggestion of Kern MHP, CAEQRO and the Commission on Accreditation of Rehabilitation Facilities (CARF) worked collaboratively to conduct a joint year four EQR and CARF reaccreditation review. A national accrediting body, CARF includes the following description on its Web site ([www.carf.org](http://www.carf.org)):
  - o CARF is a "private, not-for-profit organization that promotes quality rehabilitation services. It does this by establishing standards of quality for organizations to use as guidelines in developing and offering their programs or services to consumers. CARF uses the standards to

determine how well an organization is serving its consumers and how it can improve.”

Kern MHP, CARF and CAEQRO viewed this collaboration as an opportunity to understand and learn from each others’ processes while maintaining the integrity of each discrete quality review process. We are exploring other such opportunities to help streamline review processes and reduce some of the daunting administrative demands that are associated with these processes.

- **Review scheduling process.** CAEQRO staff developed an initial schedule in January and February of year three. Although the goal is an annual review for each MHP, our practical objective is to ensure no more than 14 months and no less than 10 months between reviews. In February and March staff consulted with each MHP and issued a draft schedule by the third week of March. We finalized the schedule and posted it on our Web site by the middle of April. During the year, we stayed flexible as necessary to adjust review dates for a small number of MHPs, including Kern MHP to accommodate our collaboration with CARF.
- **Pre-site review process.** At least 60 days prior to the site review, the lead reviewer sent each MHP director and QI manager a notification packet that included a notification letter listing the documents required in advance of the site review. Attachment 7 includes a sample notification packet, which included a mix of MHP-specific documents and standardized documents such as the current version of the Information Systems Capability Assessment (ISCA) V6.1 for the MHP to update. For example:
  - o Each MHP received instructions on the specific demographics and/or targeted areas for consumer/family focus group(s). These areas reflected consumer/family focus groups feedback requiring follow-up from the prior year, as well as input from the MHP staff that particular consumer services or MHP sites warrant specific attention.
  - o Each MHP received a report detailing its claims data for CY07, a sample of which is included in Attachment 8.
  - o We requested that the MHP simply make any amendments to its prior year’s ISCA survey tool.
  - o Templates, such as the basic notification letter, were available on our Web site by July 2007, so that any MHP could review them several months prior to its scheduled review date.

We also requested that each MHP provide two new items in year four: its guidelines for monitoring medication prescribing practices and any tracking or evaluation of outcomes and/or fidelity to evidence-based practices (EBPs).

Our reasons are as follows:

- o **Prescribing practices.** Many MHPs experience frequent turnover of psychiatrists and some use a number of temporary physicians. A consistent complaint from consumers has been frequent changes in medication as psychiatrists changed. Strong medication practice guidelines can somewhat mitigate the disruption caused by frequent turnover.
- o **Evidence-based practices.** A number of MHPs identified one of their strategic initiatives was to implement a number of key EBPs. However, intensive training and ongoing review of actual adherence to EBP-required activities appeared to be less common.

The CAEQRO lead reviewer with the assistance of the team's senior analyst worked with the MHP's contact, generally the QI manager or director, to develop the actual agenda for the review. A sample agenda is located in Attachment 9, along with other site visit activities guidelines.

- **Site review process.** Our site review approach was consistent with that of year three and had the following two primary goals:
  - o Follow-up on issues identified in the prior year
  - o Evaluate issues affecting access, timeliness, outcomes and quality

We conducted site reviews over the course of one to four days, depending upon the size of the county and the complexity of the MHP's information systems. We began each review with a session focusing on significant performance management issues and requested broad MHP representation and participation. We continued to schedule a variety of small group interviews with MHP staff representing a wide variety of functions.

- **Post-site review process.** The site review was followed by a CAEQRO team meeting and an extensive process to write a report that conveyed findings from various team members and included the most significant issues. A template that formed the basis of each MHP report is included in Attachment 10. As in prior years, we submitted a draft report to the MHP and DMH, providing the MHP with a two-week time frame to respond with any feedback or concerns. When an MHP responded with questions, our team carefully evaluated each issue prior to issuing the final report and a memo explaining why changes were or were not made to the draft.

## Section 1.4: Technical Assistance, Training and Education

During year four we continued to emphasize and expand our training, education and technical assistance activities while maintaining the resources — such as the CAEQRO Web site ([www.caegro.com](http://www.caegro.com)) — that we had developed in previous years for MHPs and other stakeholders. In this section we concentrate on initiatives specific to year four and only briefly describe those that continued essentially as before. Our ongoing training, education and technical assistance activities are described in detail on pages 81-91 in our Year Three Report, which is available on our Web site. For a calendar displaying our overall year-four activities, please refer to Attachment 11.

### Outreach, Education and Training

CAEQRO continued to participate in wide variety of outreach, education and training activities — examples of which are included below:

- **Participation in professional associations' committees, conferences and educational meetings.** These included:
  - o California Quality Improvement Committee (CalQIC)
  - o CMHDA's Systems Committee
  - o California Primary Care Association (CPCA)'s Mental Health Taskforce

In addition, the CiMH's California Mental Health Care Management Program (CalMEND) developed a collaborative Performance Improvement Project (PIP) sub-committee. In addition to regular attendance at PIP subcommittee meetings and review of CalMEND's materials, we also made several educational presentations specific to the development of PIPs.

- **Collaboration with the California Department of Mental Health.** In year four, DMH requested that we participate regularly in a new task force on claims management processes — an important issue in DMH's reorganization and restructuring. At these task force meetings, we provided data analyses and provided technical assistance based on our four years of close attention to the functionality of MHPs' and DMH's information systems and their respective business processes.
- **Increased stakeholder access to CAEQRO information.** In contrast to previous years in which we hosted an annual presentation on our statewide findings in both Northern and Southern California locations, we presented our Year Three Report findings through a webinar that we publicized to multiple stakeholders. The format greatly increased stakeholder access to our data as it was attended by over 115 individuals who rated the webinar an average of 4.11 on a 5 point scale. We also continued to maintain the CAEQRO Web site, which by the end of year four had 904 individuals registered. Monthly hits ranged from 659 to 3,922.

- **Internal organizational trainings.** CAEQRO staff and consultants continued to receive training that included educational sessions incorporated into administrative meetings, as well as participation in special webinars offered by outside training organizations. We also called upon the expertise of the APS Healthcare staff in diverse programs throughout our organization. These subject-matter experts provided “author in the room” presentations as well as information on a variety of topics. We also recruited new consumer/family consultants and provided training sessions for them and for those who continued to work with us on reviews.
- **Individual Mental Health Plan technical assistance.** CAEQRO staff continued to offer individual MHPs a variety of tools, resources and technical assistance prior to, during and after the site review consistent with previous years. And as in previous years, MHPs varied in the thoroughness of their preparation, involvement and follow-up in the site review, as illustrated below:
  - o As an example of an uncooperative MHP, one MHP director made it clear that he had no time for any review, had done no preparation, and would not allow any of the staff to participate. However, due to contacts with other key parts of the health community, our team was able to gather key information on the status of services in the county as well as to speak with the director.
  - o In contrast, a number of MHPs provided detailed follow-up documentation and discussion of our previous year’s recommendations. They reviewed the data we provided with interest, requested our reactions to key issues, and improved their use of data over the previous year — particularly their emphasis on quality improvement — and accomplished excellent progress with their PIPs.

While an EQRO can accomplish important work with an individual MHP (and we provided extensive individualized technical assistance), our major focus in year four was to collaborate with CiMH and CMHDA, as well as with DMH on the development of joint learning opportunities for groups of MHPs.

## Multi-County Collaborative Groups

During year four we participated in three multi-county projects to design and implement PIPs. The initial development of the Small Counties Emergency Risk Pool (SCERP) PIP on reducing inpatient rehospitalization rates is described in detail in our Year Three Report. This PIP, now called SCERP Cohort 1, was active throughout year four and — because of its success — a similar project was initiated during the latter part of this fiscal year. As a result of these projects, DMH elected to develop and implement a statewide PIP this past spring and required that each MHP participate. We describe each of these three PIPs in this section.

### Small Counties Emergency Risk Pool Cohort 1

Almost every Monday, SCERP members participated in a telephone conference to review data, discuss project ideas, and determine indicators — which led to the design

of a collaborative PIP. The number of MHP participants on each call varied from seven to 15, although 17 MHPs were officially participating in this PIP. In addition to MHP representatives, the Deputy Director of CMHDA and a CiMH senior training associate jointly facilitated the discussion and up to three CAEQRO staff participated regularly. We provided data, technical assistance on the use of that data, and feedback on the adequacy of the PIP design and processes.

While the project was largely successful, it had a slow start because of several challenges, which are listed below:

- **Inexperience with data.** CAEQRO technical assistance on the data — what it meant and how to use it — proceeded slowly during the first several months. Because most small MHPs lacked resources and access to data, participants lacked experience reviewing data from their own systems. They also had little previous exposure to data from other MHPs.
- **Turnover in participants.** While the participants were a relatively stable group, the group did experience turnover which necessitated integrating new participants into the learning process.
- **Inexperience with cross-county collaboration.** Openly sharing data was new to the MHP experience — regardless of county size. Initially, some MHPs viewed the exercise as punitive — particularly if their data showed areas warranting improvement.

Over time, however, two key individuals — each from smaller MHPs — assumed leadership of the group, and the level of knowledge and engagement by other members increased rapidly. Members began to see the inherent value and expanded application of data analysis. Although small organizations serving relative small numbers of consumers, these MHPs found that the group's data led them to find within their own data trends that they previously had not identified. Within the group, findings began to be viewed through an objective lens; individuals ceased to view themselves as “on the spot” or data as illustrative of “good” or “bad” MHP services and systems. Instead, the group began to see opportunities for quality improvement.

CMHDA support and participation was crucial since this organization is the official statewide representative of all MHPs. CiMH involvement (supported by a contract with DMH) represented a neutral training entity and the CiMH associate had significant history with the group. CAEQRO staff also provided input to keep the discussion on track but did not join in sessions or discussion as the group began to develop the details of a specific PIP. We built a rapport with the group that extended our relationship well beyond that of an EQRO, which is typically viewed as “unknown generic reviewers” who “show up once a year.” As the group became more knowledgeable about data and more cooperative with each other, we were able to decrease our active participation.

During the fall of 2007 (FY07-08), SCERP Cohort 1 developed a joint data base which was managed by CMHDA. All MHPs who wished to join Cohort 1 were required to sign up and provide their baseline data by December 1, 2007 to be eligible to receive credit for an active and ongoing PIP — including those MHPs reviewed by CAEQRO before the deadline. Eighteen MHPs signed up and provided data — 17 MHPs were still involved in the PIP when the first quarter of post-intervention results were due. We

developed guidelines so that CAEQRO could score a combined PIP for all 17 participating MHPs.

### Small Counties Emergency Risk Pool Cohort 2

During the implementation of SCERP Cohort 1, many MHPs indicated that while they had wanted to join the PIP, they were unable to meet the deadline for submitting baseline data. To address this problem, SCERP members decided on an “open enrollment” model that reopened the PIP to new members during specific timeframes. Over FY08-09, data from Cohort 2 will be tracked separately but according to the same indicators and in an identical data base.

During May and June of 2008, additional Monday conference calls were scheduled for all MHPs considering participation. Many additional MHPs participated in these calls, including very large MHPs that are not members of SCERP. Although CMHDA, CIMH and CAEQRO representatives participated, the two small county leaders, who emerged during the SCERP Cohort 1 project, facilitated the calls and oriented participants to the PIP conference call process and data elements. Atypical of EQROs or other statewide performance improvement initiatives, their leadership has the potential to continue as a positive consequence of the PIP process.

### DMH-sponsored statewide Performance Improvement Project

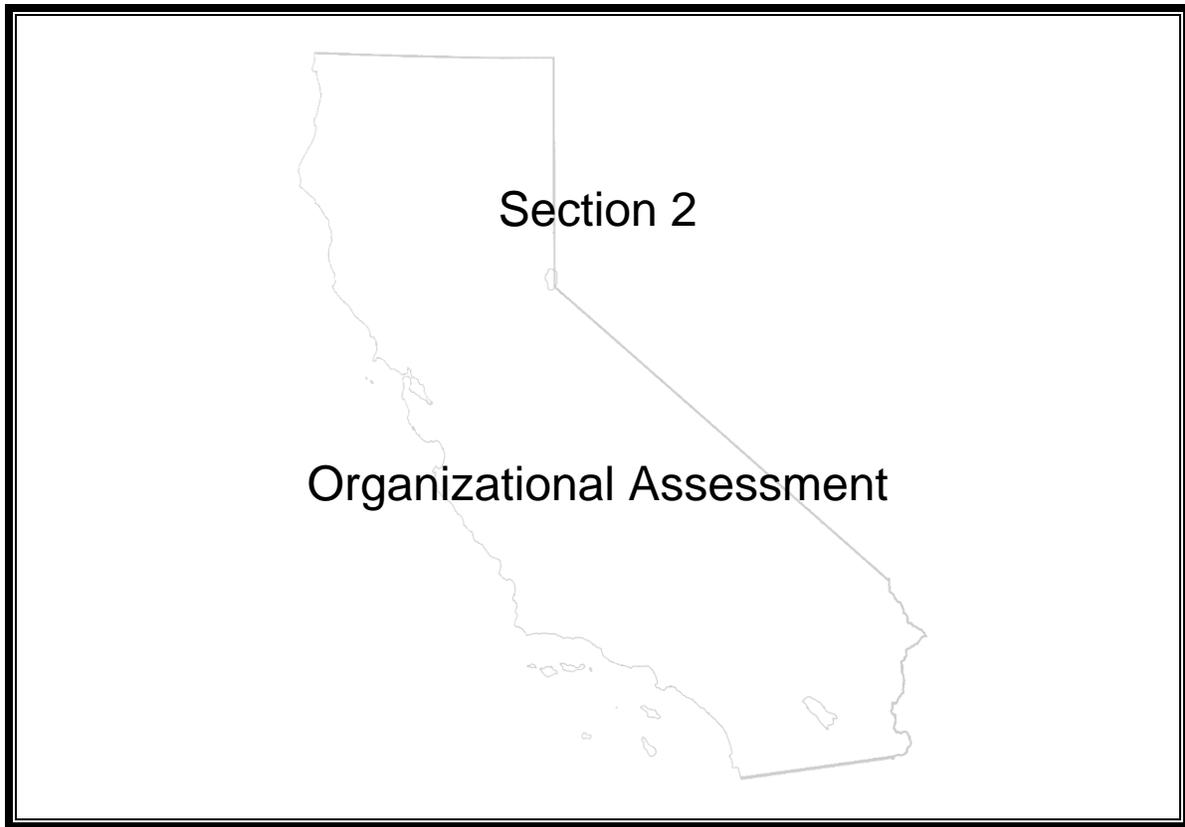
As part of the severe state budget shortfall reported in Section 1.2, DMH was faced with legislative mandates to reduce funding required from SGF appropriations. DMH staff initially considered and discussed with CMHDA its intent to require additional state authorization for day treatment services provided to a small group of children and adolescents through the EPSDT programs.

CMHDA made a counter proposal that DMH agreed to adopt. Rather than establish a set of state-authorization steps to provide specific services, CMHDA proposed that the state and county participants develop a PIP to reduce redundancy, increase coordination and improve services with a defined group of individuals who are consistently high-cost consumers. CAEQRO looked at the distribution of overall funds to the EPSDT population which showed a high concentration of individuals with the lowest costs for services and very few individuals showing costs much higher than average. DMH reviewed a broad data set on many of these same individuals and identified service patterns that included continuous use of crisis intervention, as well as a comparably disproportionate high use of other services.

CAEQRO staff has been very active in providing data analyses, feedback on possible projects and participation in training activities, as well as in planning sessions in preparation for this statewide PIP to be implemented in FY08-09.

As this PIP rolls out we will continue to give feedback to DMH and other stakeholders as they plan the actual PIP structure and activities. During year five we will expand our support of this statewide PIP by continuing to provide data analyses, technical assistance and support to the collaborative MHP/provider groups that emerge as work groups.

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 2.1: Overview

California External Quality Review Organization (CAEQRO) observed that in year four, Mental Health Plans (MHPs) continued to face many of the same challenges that we observed during the previous three years — with some significant differences in their ability to use Mental Health Services Act (MHSA) funds to initiate genuine system transformation. This section begins with a brief overview of two key areas in our findings: the initial impact of MHSA-funded programs on service capacity; and the public mental health system's relative success in employing data to manage and improve performance. We then structure our organizational assessment based on major priorities for FY07-08 — which were each informed by these key areas:

- **Section 2.2 – Site Review Findings**
  - *Follow-up to the recommendations in our year three (FY06-07) MHP reports.* Over time, we have seen significant progress across all MHPs in improving their processes and/or systems. However, issues specific to access and data-driven performance remain system-wide challenges.
  - *Analysis of FY07-08 strengths, challenges and recommendations.* As in previous years, we focused on the effective use of data for performance management and consumer involvement in service delivery and recovery-oriented programming.
  - *Evaluation of the system's wellness, recovery and resilience initiatives.* While we observed a gradual improvement in this area since we initiated our contract — largely related to programmatic improvements associated with MHSA initiatives — MHPs still have significant work ahead to achieve system transformation.
- **Section 2.3 Health information systems review**
  - *Information Systems Capabilities Assessment V6.1.* The Information Systems Capabilities Assessment (ISCA) findings that follow in this section were produced from information contained in CAEQRO's ISCA database, which now stores four years of MHP information systems data.

Also included in this section is a summary of our findings related to Performance Improvement Projects (PIPs), which showed notable progress over previous years — particularly MHPs participating in the Small County Emergency Risk Pool (SCERP) clinical PIP on reducing rehospitalizations. Other PIP results were highly variable, especially with regard to whether SCERP participants developed a second PIP.

## Section 2.2: Site Review Findings

CAEQRO has a keen understanding of the challenges faced by MHPs and how those challenges have affected each MHP's ability to address the findings of a rigorous external quality review process. In year one of our contract, many MHPs were struggling with financial difficulties but most had plans for stabilization and were optimistic that MHSA funding would assist with their long-term goals. In year two, MHPs began to divert

resources from almost all departments and staff to lead or participate in MHSA's comprehensive planning process. In year three, most MHPs were beginning to implement new MHSA-funded programs, which provided many opportunities for innovation but also began to create a new set of challenges.

During this year's site review process, CAEQRO observed that most MHPs continued to struggle with many of the same challenges — which were (and continue to be) compounded by the state's FY08-09 budget crisis as we discussed in Section 1. However, some MHPs have responded in quite creative ways to address these challenges and respond to our findings, while others have not been able effectively to move beyond the status quo:

- **Service capacity.** In year four, MHSA-funded full service partnerships (FSPs) were implemented by almost all counties. Many MHPs have consumer-run and/or consumer-staffed wellness centers. In some instances, MHPs simply used MHSA funding to retool existing programs and have been relatively unsuccessful in expanding overall service capacity. Other MHPs, in response to funding crises, had relied on their wellness centers as the preferred mode of outpatient service delivery — whether clinically appropriate or not — in conjunction with medication services. Others have used MHSA funds to develop specific programs, such as those for older adults or mobile crisis units, in strategically filling key gaps in service.
- **Data and performance management.** While most MHPs acknowledge the importance of using data for performance management, many have only begun collecting data on basic performance indicators such as timeliness of service delivery. Those MHPs that do use data for performance management tend to focus on collecting and reviewing productivity data exclusively and have not extended this kind of analysis to other areas of their operations. In particular, the monitoring of consumer outcomes as a measure of organizational success is essentially absent. While MHPs do submit outcomes data to the Department of Mental Health (DMH) on MHSA-funded programs, these data represent only a small sub-set of MHP consumers. Almost all MHPs still lack a formal system-wide structure for tracking and analyzing processes, efficiencies, and outcomes throughout the service system. Consequently, the overall evaluation of the delivery system — including the impact of MHSA — remains unmeasured.

In Section 5, we discuss how these key findings emerge as trends in a number of key areas. In this section, we provide a closer look at MHPs' abilities to respond to our year three recommendations and summarize our findings in the key areas of our site review process.

## Review of Year Three Recommendations

As in prior years, follow-up to our year three recommendations continued to be a major focus of our site review process. While we almost always included more than three recommendations in an MHP report, we have typically focused on the top three recommendations in aggregating our findings for our statewide report. As we discussed in Section 1, we highlighted key areas in each MHP's notification letter for follow-up and devoted a significant portion of the site visit to addressing the MHP's response to the

recommendations in our year three FY06-07 report. In compiling these findings, we used two source documents:

- **Individual MHP reports.** We devoted the first section of our reports to rating the MHP's responses the FY06-07 recommendations — approximately five per MHP report. To support each rating, the corresponding recommendation included a summary of the MHP's responses — discussions, activities and plans — or the absence of any progress.
- **MHP summaries.** As in our prior statewide reports, we include 56 MHP summaries in Volume II — each of which is a consolidation of the individual MHP reports. Each MHP summary extracts the top three recommendations from the MHP's FY06-07 report and the status rating for each recommendation. These findings are based on an aggregate analysis of the status of 168 recommendations — three from each of the 56 MHP summaries.

### Definition of ratings

Consistent with our approach in previous years, we focused on assessing whether the MHP had addressed the issue and internally had agreed on a response — regardless of whether staff had followed our specific recommendation in addressing the problem area. This approach guided our rating system, which has remained largely consistent over time and is summarized below:

- **“Fully addressed.”** We rated a recommendation as “fully addressed” if the MHP took action that appeared to resolve or achieve significant progress towards resolving an identified issue. Since we did not expect MHPs to resolve complex issues in one year, a rating of “fully addressed” indicated that the MHP had employed a number of meaningful activities directed at the issue.
- **“Not addressed.”** If the MHP did not respond to problems or recommendations in any way, we assigned a rating of “not addressed.”
- **“Partially Addressed.”** This rating reflects a number of considerations:
  - o If the MHP initiated a very limited number of activities during the year toward the long-term solution of a complex issue
  - o If the MHP implemented a partial solution to a concrete issue that could reasonably be resolved within a year
  - o If the MHP discussed a problem and had developed a detailed action plan but had not actually implemented any changes (i.e., “awarded credit” for an attempt to initiate change)

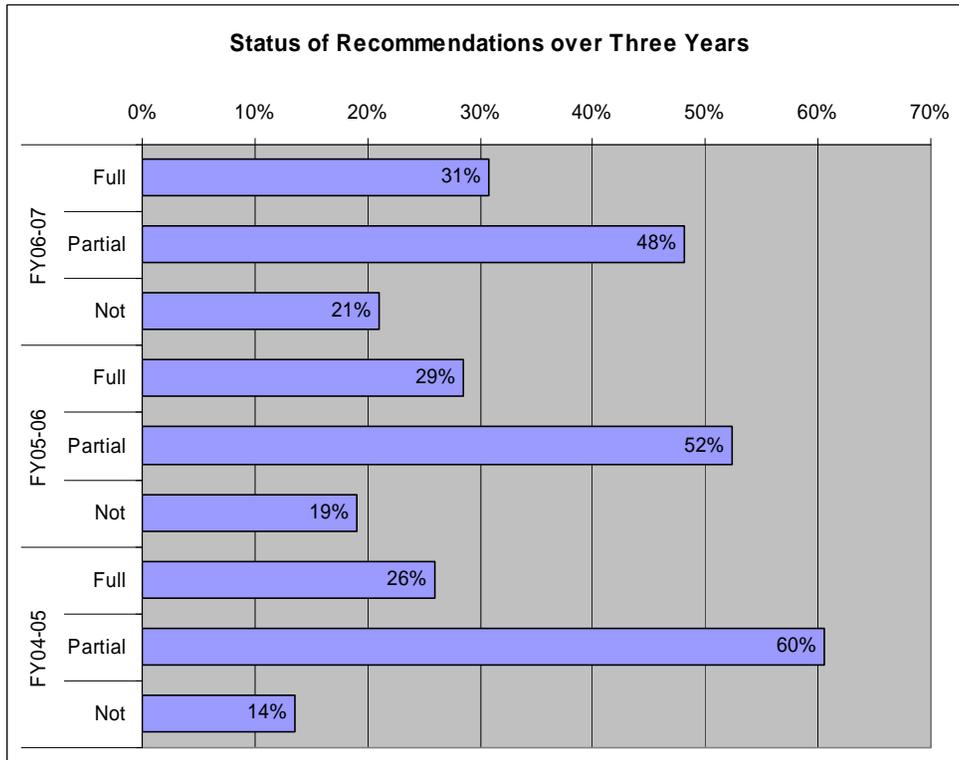
### Status of recommendations

Figure 2.1 below displays the status of FY06-07 recommendations for all MHPs based on our FY07-08 site reviews. It also compares three years of data since follow up on the prior year's recommendations began in year two of our contract. As noted below, each

successive year fewer recommendations received a rating of “partially addressed,” while the number of recommendations with the ratings —“fully addressed” and “not addressed” — both increased slightly.

The status of recommendations has trended over three years as presented in Figure 2.1 for a number of reasons. For example, the relatively high number of “partially addressed” ratings during the second year of our contract is in part attributable to our willingness to credit an MHP with the most basic efforts. In years three and four, however, as a result of our experience, we made a more stringent assessment than we did previously.

**Figure 2.1**



Categories of FY06-07 recommendations

In previous reports we organized priority recommendations into seven major categories, which are listed in the table below in descending order of frequency. These recommendations served as areas of focus during site visits and form the basis of our discussion in this section.

Figure 2.2 compares the overall frequency of CAEQRO's recommendations over a three-year period. Our FY07-08 recommendations are displayed later in this section and have been extracted from this year's 56 MHP summaries. These MHP summaries comprise Volume II of our Year Four Statewide Report and reflect data extracted from individual MHP FY07-08 reports. The fiscal year reflects the year that we actually made our recommendations and our follow-up occurred in the subsequent fiscal year.

**Figure 2.2**

<b>Three-Year Comparison of Recommendations</b>			
<b>Category</b>	<b>FY 06-07</b>	<b>FY 05-06</b>	<b>FY 04-05</b>
	<b>Number</b>	<b>Number</b>	<b>Number</b>
Timely access and disparities in access	46	20	15
Quality management and use of data	45	55	42
Information systems – use, resources, and implementations	21	34	39
Wellness, recovery and resilience	17	20	24
Business processes	12	10	21
Leadership, including MHP communication and collaboration	15	15	12
Workforce	11	*	*
Other	1	14	9
<b>TOTAL</b>	<b>168</b>	<b>168</b>	<b>162**</b>

\* We did not identify Workforce as a discrete category until year three of our site reviews.

\*\* Year one of our contract (FY 04-05), included reviews of 54 MHPs — totaling 162 priority recommendations. Each subsequent year, we reviewed 56 MHPs and made 168 priority recommendations.

Immediately following Figure 2.2, Figures 2.3 and 2.4 display the status of our FY06-07 recommendations based on our findings during our FY07-08 site review process.

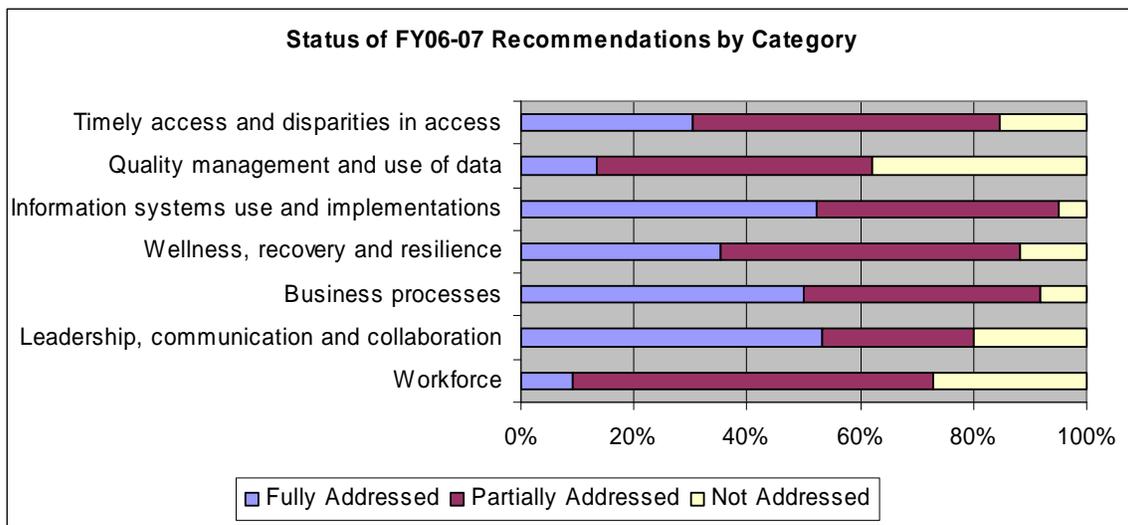
Figure 2.3 below presents the status of FY06-07 recommendations in each category across all MHPs as determined in our year four review (FY07-08):

**Figure 2.3**

<b>Status of FY06-07 Recommendations</b>			
<b>Category</b>	<b>Fully Addressed</b>	<b>Partially Addressed</b>	<b>Not Addressed</b>
	<b>Number</b>	<b>Number</b>	<b>Number</b>
Timely access and disparities in access	14	25	7
Quality management and use of data	6	22	17
Information systems – use, resources, and implementations	11	9	1
Wellness, recovery and resilience	6	9	2
Business processes	6	5	1
Leadership, including MHP communication and collaboration	8	4	3
Workforce	1	7	3
<b>TOTAL</b>	<b>52</b>	<b>81</b>	<b>34</b>

Figure 2.4 below presents a different display of the data that we present above in Figure 2.3. By displaying color-coded percentages, we can highlight those areas that continue to require attention across all MHPs. Each of these categories is then detailed on the following pages:

**Figure 2.4**



### Timely access and disparities in access

In FY06-07, we made 46 recommendations in 34 MHPs (60 percent of all MHPs) regarding issues of access. The increase in access-related recommendations over a three-year period, however, does not suggest that barriers regarding access were not as significant in prior years. Instead, several factors — listed below — increased our awareness of and focus on many MHPs' failure to identify and/or address access barriers.

- **Awareness through claims data.** In year two, DMH provided CAEQRO with access to two and three years of approved claims data. Statewide trends began to suggest significant access disparities among specific demographic and ethnic groups (e.g., older adults and Hispanics).
- **Focus through data reporting.** In prior years, we included some access-related recommendations in the category of quality and data use to emphasize the need for performance management systems that monitored the timeliness of access. Based on our analysis of statewide trends over the past two years, we were able to become more increasingly specific in our recommendations. Instead of recommending the use of data for performance management overall, we suggested that MHPs use data to manage the basic areas of timeliness and access. More recently, we fine-tuned our recommendations to address the following specific issues related to access.

Listed below are the areas specific to our FY06-07 site review and our findings during FY07-08:

- **Access for underserved populations.** Sixteen MHPs partially or fully addressed 16 recommendations related to underserved populations — including foster care, older adults, Latinos and other ethnic groups.
- **Service availability — including co-occurring disorders, psychiatry and other services.** Twenty recommendations in 17 MHPs focused on their capacity — often the lack thereof — to provide specific services. Delayed and inadequate access, particularly for psychiatric/medication providers, was a significant issue. While MHPs need to analyze demand relative to service availability to address this issue, they rarely performed a true capacity analysis. Instead MHPs generally made efforts to increase access and services through MHSA funds. This approach typically did not produce an adequate resolution for improving access to specific services, such as psychiatric follow up or medication management.
- **Long wait times.** We made recommendations to 11 MHPs that they reduce lengthy wait times — generally related to service capacity as well as lack of movement through the stages of service, creating high drop-out rates. Four of the 11 MHPs did not address this issue. Most MHPs do not regularly and consistently calculate wait times or track drop-out numbers. Some MHPs only measure timeliness for specific periods of time — and at best once or twice a year.

### Quality management and use of data

In year three, we made 45 recommendations regarding quality management processes and the use of data for decision making. Overall this area had both the highest actual number and the highest percentage of recommendations rated “not addressed.”

Most recommendations require that MHPs use data for performance management. Inadequate use of data as a specific category is, therefore, underrepresented because we only quantify it in this area. Many of these recommendations also emphasized the need for the MHP management to promote data use through example, as well as the need to dedicate resources and train staff. This recommendation specifically focused on developing data analytic skills, using and distributing data and reports, and creating effective quality management processes.

Below we highlight specific recommendations in this category:

- **Develop or expand data analytic skills.** Twelve MHP reports listed this recommendation, which was rated as “not addressed” in four. The lack of data analytic skills as well as the failure to identify this skill as a staffing priority has a huge impact on other areas within this category and contributed to the high percentage of recommendations rated “not addressed.”
- **Use data to measure quality indicators.** This recommendation included a variety of issues around identifying data and methods for measuring and monitoring performance through the use of those data. Most often this recommendation was partially addressed — as MHPs were beginning to demonstrate data use within the Quality Improvement (QI) Work Plan, QI Committee or management initiatives.
- **Develop and distribute reports to stakeholders.** Of the nine recommendations in this area, three were left unaddressed by large MHPs.
- **Analyze approved claims.** Of eleven MHPs in which we noted that the approved claims data suggested possible systemic problems, only one MHP fully addressed this issue. Six MHPs did not address the issue at all.

### Information systems

All 20 MHPs either fully or partially addressed priority information systems recommendations, which focused on implementations. Only one recommendation in this area was not addressed at all. The status of these recommendations is listed below:

Section 2.3 of this report details activities regarding information systems and implementations over the past year and across several years.

### Wellness, recovery and resilience

Passed in 2004, MHSA has as its overarching objective to transform the public mental health system into one that focuses on consumer wellness, recovery and resilience. Given the importance of this priority area, we provide additional discussion immediately

following our analysis of strengths and opportunities. Overall, we made recommendations to 17 MHPs regarding wellness, recovery and resilience during our FY06-07 site review. Only two small-rural MHPs did not address this issue. The status of these recommendations is listed below:

Far fewer MHPs had wellness, recovery and resilience as a priority recommendation than they did in previous years — largely because of the operation of MHSA-funded programs:

- **Recovery-oriented practices.** MHSA has supported the implementation of clinical practice based upon recovery principles. Our recommendations regarding recovery suggested that MHPs were now trying to apply these principles and practices throughout the system — rather than concentrating on a single wellness center or program. MHPs were attempting to do that but often with difficulty and much more still to be done.
- **Consumer and family employment.** MHPs expanded the hiring of consumers into positions within the MHP and required the same of contract providers over the past year. Some MHPs had just started to hire consumers— in part due to staffing FSPs and wellness centers, as well as to increase parent partner staffing.
- **Consumer and family involvement in system planning and development.** Our recommendations emphasized system-wide consumer and family involvement in productive MHP roles. While beginning to involve consumers in QI committees, MHPs need to improve consumer and family member education so that they can fully participate in these and other forums. Consumers are still infrequently represented on executive and other management teams.

### Business processes

Eleven MHPs (representing 12 total recommendations) successfully addressed business process-related recommendations. These recommendations included restructuring and/or documenting business processes, as well as staff training in this area. Recommendations in this category focused on specific operations that supported the fiscal strength of the organization — especially an efficient and accurate claiming process. High rates of claims denials or unusually low approved claim figures typically triggered recommendations in this area.

### Leadership, including MHP communication and collaboration

In our FY06-07 recommendations, we referred to leadership's role in establishing and maintaining communication throughout the MHP — including all levels of staff, contract providers and other stakeholders. We focused on how open and ongoing communication can support effective collaborations designed to promote comprehensive and coordinated services. MHPs typically only partially addressed these recommendations. The three MHPs that did not respond to recommendations regarding collaboration were small-rural MHPs.

## Workforce

Eleven recommendations related to a variety of workforce issues. Only one MHP fully addressed this recommendation, and over one-quarter of the recommendations in this area were not addressed at all.

Workforce recommendations addressed at least one of the following issues:

- Recruitment, especially psychiatrists and bilingual/bicultural staff
- Retention
- Staff morale
- Staff training

Issues of recruitment and retention, particularly of psychiatrists, dominated this category, as in previous years' reports. This year the shortages in these key positions— while still affected by high salaries for psychiatrists in the prison system — were largely due to low salaries in the mental health system. However, Riverside and Los Angeles MHPs worked with their respective county human resources department to increase salary levels and successfully recruit additional psychiatrists. Some MHPs addressed this problem through telemedicine.

In our year three recommendations, we also began to directly address issues of staff morale — noting the effect of the work environment on staff's ability to provide strength-based, recovery-oriented services.

In prior years' reports, workforce issues were generally included in our discussion of system capacity, program development or training. The implementation of many new MHSA programs generated new staff positions, staffing needs and consequently workforce issues. Traditional services felt the impact of these programs, as well, and the need for specific types of workforce development became more prominent.

## Year Four Key Evaluation Domains — Strengths and Opportunities for Improvement

At the end of each MHP report, we consolidated strengths and opportunities for improvement (opportunities) into the following key areas: “access,” “timeliness,” “outcomes,” “quality” or “information systems.” In Figure 2.5 below, we display how frequently we cited a strength or opportunity in each domain in our FY07-08 reports:

**Figure 2.5**

<b>Key Evaluation Domains</b>		
<b>Domain</b>	<b>Strengths</b>	<b>Opportunities</b>
Access	37	21
Timeliness	6	24
Outcomes	10	18
Quality	71	63
Information Systems	44	41

In aggregating our findings for our statewide report, we analyzed strengths and opportunities in the more specific categories listed below:

Figure 2.6

Key Issues – Strengths and Opportunities			
Category	Strengths	Opportunities	Total by Category
1 Timely access and disparities in access	30	45	75
2 Information Systems – use, resources, implementations	28	29	57
3 Quality management and use of data	17	38	55
4 Wellness, recovery and resilience	20	17	37
5 Collaboration & Communication	20	14	34
6 Business processes	9	13	22
7 Leadership	18	3	21
8 Workforce	13	6	19
9 Other (training, programs, EBPs)	13	2	15
TOTAL	168	167	335

In generating our year four findings, we became increasingly aware of leadership as essential to maintaining and improving overall MHP functioning, despite regulatory or environmental barriers. Similarly, workforce development has emerged as a significant management issue — addressing the recruitment and retention of qualified staff, as well as creating a work environment that is welcoming to both staff and consumers. However, the top five categories above represent 77 percent of the key issues discussed further below.

- **Timely access and disparities in access.** This year we emphasized various components of access throughout our reviews. More frequently cited as an opportunity than as a strength, this area accounts for 22 percent of the key issues, which are listed in order of decreasing frequency:
  - o Timeliness to services
  - o Access to underserved groups
  - o Penetration rates
  - o Service provision in the field or other locations that facilitate ease of access
- **Information systems — use, resources and implementations.** MHPs' information systems account for 17 percent of the key issues. Issues in this area mostly address MHPs' information system planning or actual implementation and system use. A small number of MHPs were not considering a new information system despite managing an aging system with limited usefulness. Their reasons

included: relative satisfaction with their “billing system,” more important organizational priorities, and a lack of funding to support a new information system and information technology infrastructure. Some had pended a new system implementation until they could assess the success of vendor products that other MHPs had implemented. Section 2.3 provides detailed information on our FY07-08 analysis of information systems across all MHPs.

- **Quality management and use of data.** The use of data to inform decisions and manage performance accounts for 16 percent of the key issues. More frequently cited as an opportunity than as a strength, this category includes the ongoing challenges that MHPs face due to failure to allocate any or enough resources to maintaining an adequate data analytic capacity:
  - o Many MHPs see the implementation of their new information system as a replacement for data analytic skills. However, mid-implementation, most do not know what data elements they intend to draw from that system.
  - o Some MHPs have demonstrated the use of data to manage the delivery system — a small number of MHPs are models in this area.
  - o Other MHPs that have demonstrated the skills and have data have not been able to use data for performance improvement.
- **Wellness, recovery and resilience.** Representing 11 percent of the key issues, this category was more frequently cited as a strength than as an opportunity. We did note that recovery as an organizational value and focus was lacking in many MHPs. However, in other MHPs, great progress was made in implementing wellness centers, creating consumer positions – some with civil service benefits – and promoting peer counselors to develop a life outside of the mental health system.

Progress in this area is exemplified through:

- o Development and expansion of wellness centers
- o Increased numbers of consumers receiving wellness center services
- o Increased numbers of consumer and family member employees, including access to and/or involvement with senior leadership
- o Focused improvement in clinical staff skills promoting recovery

Areas of opportunities for improvement often included:

- o Consumer and family member participation limited to specific and small numbers of committees or programs
- o Inadequate orientation, training and ongoing supervision/support for consumer employees working in the mental health system

- o Expansion of consumer employment within the mental health system, but less progress in supporting the transition to employment in the community
- o Use of wellness centers as an initial referral and substitute for individual clinical services

A detailed discussion on MHPs' overall progress related to wellness, recovery and resilience immediately follows in this section.

- **Collaboration and Communication.** Collaboration and communication represent 10 percent of the key issues, slightly more frequently noted as a strength than as an opportunity. These issues included:
  - o Communication throughout the MHP
  - o Communication with contract providers
  - o Collaboration with other county agencies
  - o Collaboration with health providers
  - o Collaboration with other non-mental health providers

Communication regarding information systems implementation was also a frequently noted issue, with some MHPs more successful than others at engaging providers. Only once was communication listed as a strength — suggesting a system-wide need to improve collaborative practices and processes.

## Wellness-, Recovery- and Resilience-focused Programs

We continued to devote a significant portion of our site visit to discussing the MHP's progress in developing and/or implementing programs that support wellness, recovery and resilience. These discussions not only explored service delivery, but also addressed the MHP's success in engaging consumers in program activities and promoting them into leadership roles. In addition to interviewing MHP administration, staff and contract providers, we found that the following activities provided significant findings in this area:

- Interviews with consumer and family member employees — most of whom held positions designated for consumers or family members
- Site visits to wellness or self-help centers
- Focus groups with consumers and family members who are receiving services

Each of these areas is discussed below.

### Consumer/family member volunteers and employees

In most MHPs, we were able to conduct small- or large-group interviews with consumers and family members, either employees or volunteers within the MHP or a contract provider. Some, generally small MHPs, had hired consumer employees for the first time and we were able to add their perspective to our interviews.

Consumer and family member employees were typically able to provide accurate perceptions about the status of implementing recovery-focused services in a system — particularly when viewed in conjunction with other findings. These employees live and work in “the two worlds” of service providers and consumers. With some exceptions, findings are quite consistent with last year’s discussions with these employees.

Of note and as described in Section 4, Riverside MHP has developed a career ladder for consumer employees that not only involves increasingly level of responsibility and direct service within this track, but also has potential to lead to management positions in any department in the system. Other examples — that illustrate varying degrees of success — are listed below:

- Consumer employees were often employed in wellness centers such as Placer/Sierra’s Welcome Center, but they were not necessarily in leadership or decision-making roles.
- Consumers and family employees generally saw significant progress and felt hope that the service delivery system would continue to become more consumer-driven and recovery-oriented over time. They also generally did not perceive the same degree of success in this area as reported by administrators and clinical staff.
- Consumer and family member employees experienced varying degrees of success in establishing relationships with other employees, particularly professional clinical staff. While not universally an issue, many consumer employees were willing to endure sometimes harsh work environments to maintain what they felt was an important employment experience.
- Consumer employees frequently lacked training or other support. Last year, many had anticipated additional training through MHSA, but real orientation and training were not the norm, despite MHSA funding. In some instances, consumers had no understanding of their roles — despite their efforts to seek clarification.
- Roles and responsibilities held by consumer and family employees varied tremendously throughout the state, and sometimes within the larger MHP systems as well. While not a comprehensive list, some examples include:
  - o Napa MHP has employed a consumer and a family member to conduct outreach and engagement to the monolingual Spanish speaking communities.
  - o Calaveras MHP has hired five consumers to outreach to target groups.
  - o Orange MHP hired a consumer employee to organize and supervise the other consumer and family member employees.

- o Tehama and Riverside MHPs engaged consumer employees on their management teams — roles typically include being a liaison between leadership and the consumer community.
- o San Bernardino MHP assigned a consumer employee mental health worker to each children’s crisis response team.
- o Glenn and Butte MHPs’ consumer youth mentors participate through peer support and committees, as well as organize community events.

### Wellness center site visits

Wellness centers of various types continued to open throughout the system – including small counties. In Section 4, we highlight Madera MHP’s Hope House which is an excellent example of a small MHP’s partnership with a contractor and judicious use of MHSA funds. In fact, programs identified as “wellness centers” were almost always funded through MHSA and varied greatly throughout the state. A wellness center could include a variety of professional mental health services as well as other non-mental health partner providers — some providing services also billed to Medi-Cal. Other centers were much less traditional in their provision of services and focused more on skill development, education, and employment. Programs still remain, though identified as wellness centers, which appeared to be more “day treatment light,” void of an atmosphere of recovery and consumer success.

### Consumer and family member focus groups

Individuals who receive the services continue to provide among the most valuable sources of information regarding the quality of services. To obtain this broad input, CAEQRO conducted 89 focus groups with 713 participants. List below is key demographic information:

- Sixty-nine percent of the participants were consumers and the balance was comprised of family members.
- Overall the participants were 62 percent female and 38 percent male.
- Based on observation only, fifty-two percent of the participants appeared to be Caucasian and 30 percent appeared to be Hispanic.
- Interpreters, most frequently Spanish-speaking, assisted in 22 percent of the consumer/family member focus groups.

As detailed below in Figure 2.7, sixty-three of the groups (71 percent) were designed to gain feedback from a specific age and/or ethnic population.

<b>Figure 2.7</b>
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<b>Demographic/Ethnic Distribution for Focus Groups</b>		
<b>Specified Emphasis</b>	<b>Number</b>	<b>Percent of groups</b>
Hispanic	20	22%
Foster care (youth or caregivers)	11	12%
Co-occurring Substance Abuse and Mental Health	9	10%
Asian Americans	7	8%
Transition age youth	6	7%
Older adults	5	6%
Other underserved ethnic groups	5	6%
<b>TOTAL</b>	<b>63</b>	<b>71%</b>

Interpreters were provided for participants speaking Cambodian, Cantonese, Hmong, Mandarin, Vietnamese and Spanish.

In addition to demographics/ethnicity, we also conducted groups based upon the types of services received, which included:

- Initiated services within the past year
- Received inpatient or other acute services
- Participated in wellness centers or other recovery oriented programming
- Participated in group activities
- Received services for co-occurring substance abuse and mental health issues

We attempted to ensure that a focus group did not overly represent MHSA FSP members, as these consumers represent a small percentage of an MHP's consumer population with whom their experience is rarely consistent. Members of focus groups with FSP member participation expressed a great deal of satisfaction with their services. Often, this created awkward feelings for other group participants who had great difficulty accessing such services because they did not meet the FSP threshold for inclusion.

The major concern of consumers and families interviewed focused on the following issues related to access:

- Timely access to assessments and psychiatry
- Responsive crisis services
- Safe and stable housing
- Meaningful employment
- Transportation to services or services closer to home
- More time with mental health providers
- More information about available services
- Involvement of family and other significant support in their services

## Year Four Recommendations

As in prior years, at the end of each MHP report, we list recommendations that correspond to the key issues. We began this section with a table that displayed a three-year comparison of recommendations. In Figure 2.8, we add this year's recommendations which will serve as the foundation for each MHP review in our year five reviews. In Section 5, we discuss how our FY07-08 recommendations in conjunction with our full set of findings support our assessment of system-wide trends.

**Figure 2.8**

<b>Four-Year Comparison of Recommendations</b>				
<b>Category</b>	<b>FY 07-08</b>	<b>FY 06-07</b>	<b>FY 05-06</b>	<b>FY 04-05</b>
	<b>Number</b>	<b>Number</b>	<b>Number</b>	<b>Number</b>
Timely access and disparities in access	36	46	20	15
Quality management and use of data	42	45	55	42
Information systems – use, resources, and implementations	34	21	34	39
Wellness, recovery and resilience	15	17	20	24
Business processes	11	12	10	21
Leadership, including MHP communication and collaboration	15	15	15	12
Workforce	14	11	*	*
Other	1	1	14	9
<b>TOTAL</b>	<b>168</b>	<b>168</b>	<b>168</b>	<b>162**</b>

## Section 2.2.1: Performance Improvement Projects

As in our year two and year three reviews, in FY07-08 each MHP was required to have two active and ongoing PIPs available for review — one clinical and one non-clinical. As in year three, we required each MHP to submit PIPs on a form that we modeled after our “Road Map to a PIP,” the training tool we developed in year two. In addition we revised the evaluation tool in year three to provide more specific detail about the activities covered under each of the evaluation elements required by the Centers for Medicare & Medicaid Services (CMS).

Our intent was to increase the concrete feedback we provided to MHPs to assist them in developing their PIPs. The evaluation tool also identified the 13 “key elements” of a PIP — which in effect comprised the critical path to designing, implementing, and completing any successful PIP. While we enhanced the process for gathering PIP data since our first-year review, our overall methodology — and priorities — have remained consistent over time.

In this section, we include the following categories in describing our PIP findings:

- Total PIP activity
- PIP descriptive data — status, content area, specialty population and domain
- PIP evaluation tool scoring — 13 key elements
- PIP submission by MHP size
- Year-to-year comparisons (as available since many MHPs have not developed PIPs)

As our findings suggest, MHPs have demonstrated significant progress in developing and implementing PIPs, particularly the seventeen MHPs participating in the SCERP clinical PIP on reducing rehospitalizations. Other PIP results were highly variable, especially with regard to whether SCERP participants developed a second PIP.

### Overall Performance Improvement Project Activity

In year four the maximum number of PIPs for review was 112 — which reflects the requirement of two PIPs for 56 MHPs. We reviewed and scored each of the 85 PIPs (76 percent of the possible total) we received. Because we applied the same evaluation tool in years three and four, we now have available a two-year comparison for PIPs rated with the same tool. In addition, in Figure 2.9 we also include data from year two in which we used a slightly different validation tool. However, while in year three we improved the descriptions of some of the elements within the validation tool, the set of 13 key elements has remained unchanged since year two of our contract. In year one, few MHPs had active PIPs or even those fully developed in concept.

As illustrated in Figure 2.9 the 85 PIPs we received and considered applicable for scoring, 58 were active and/or completed during the review period (FY07-08), 20 were still in a conceptual or early design phase, and seven had been developed in a prior year with minimal activity in the review year. In addition, a number of MHPs simply discontinued PIPs (without completing them), formed a new concept, and then neither finalized a specific design nor initiated any activity. If a PIP had completely languished over the review period, we did not count it — despite its submission by the MHP — and

instead recorded “none,” because essentially the MHP has failed to demonstrate any activity or analysis since the prior year’s review. Indeed, a few MHPs did submit their prior year PIPs without having done anything since our last review.

**Figure 2.9**

PIP Status Over Three Years			
PIP Status	FY07-08 Count	FY06-07 Count	FY05-06* Count
Completed	4	1	Active 47
Active	54	59	
Concept/Design	20	14	Concept/Little Activity/None 63
Little Activity	7	14	
None	27	24	
<b>TOTAL</b>	<b>112</b>	<b>112</b>	<b>110</b>

\*Initial PIP data base was more general — thus we can’t separate the categories

Figure 2.10 shows little change over the past two years in the number of MHPs submitting PIPs. In FY07-08, seven MHPs — one more MHP than in the year prior — failed to present a viable PIP. This data does not specify whether the same MHPs are represented in a given category from one year to the next.

**Figure 2.10**

Overall PIP Count Over Two Years		
Count of MHPs with:	FY07-08	FY06-07
Two PIPs	36	38
One PIP	13	12
No PIP	7	6
<b>Total MHPs</b>	<b>56</b>	<b>56</b>

Figure 2.11 below provides greater detail than does Figure 2.10, defining the number of PIPs submitted by MHP size over the past two years. Here is a summary of our findings:

- Large MHPs continued their level of performance from the previous year with all but one at least developing a concept or designing a PIP.
- Small MHPs showed improvement with two-thirds of this group submitting two PIPs in FY07-08, an increase from less than 50 percent in FY06-07. This

improvement reflects the seventeen small and small-rural MHPs participating in the SCERP rehospitalization PIP and their having more clinical PIPs overall.

- In both years, with one exception, MHPs that failed to submit PIPs were small or small-rural MHPs. CAEQRO generally recommended that these MHPs consider participating in the SCERP re-hospitalization PIP in order to at least participate in one PIP.
- Medium and small-rural MHPs showed a decline in the number that submitted two PIPs, and an increase in the number submitting only one PIP.

Figure 2.11

PIP Count by MHP Size										
Count of MHPs with:	Small-Rural		Small		Medium		Large		Total	
	FY07-08	FY06-07	FY07-08	FY06-07	FY07-08	FY06-07	FY07-08	FY06-07	FY07-08	FY06-07
Two PIPs	5	8	10	7	9	11	12	12	36	38
One PIP	6	3	2	6	4	2	1	1	13	12
No PIP	3	3	3	2	1	1	0	0	7	6
Total MHPs	14	14	15	15	14	14	13	13	56	56

Figure 2.12 below displays PIP categories by MHP size for the past two fiscal years. Our findings in several key categories are summarized below:

- **Use of Acute or Inpatient Services.** In year four, we found an increase in the number of PIPs that focused on use of inpatient and other acute services (n=24). While largely attributed to the 17 MHPs that participated in the SCERP PIP, 10 large MHPs also designed PIPs in this study area. In the prior fiscal year, only nine PIPs focused on the use of acute or inpatient services. Last year's most frequent area of study — improved diagnostic or treatment processes — was second this year.
- **Co-occurring disorders.** The number of PIPs focused on co-occurring substance abuse and mental health treatment decreased by one-third from FY06-07 to FY07-08. While six PIPs on this topic were still in progress — and one was successfully completed with improved consumer outcomes — other MHPs found this PIP topic to be difficult to implement. Factors contributing to their difficulty include: processes that did not promote accurate data recording; unreliable diagnostic data; poor collaboration between mental health and alcohol/drug programs; and limited clinician confidence in this skill area. Developing and/or improving services to this large population remains an area requiring increased attention statewide.

- Psychiatrist/Medication Appointment.** Though still a problem area throughout the state (as noted in Section 2.2), only two PIPs this year chose to focus on improving access to psychiatry, compared to seven PIPs in the prior year. Some MHPs reported that they simply lacked the ability to have an effect on this problem, while others initiated telemedicine or added nursing staff to deal with this workforce issue.

Figure 2.12

PIP Descriptive Category by MHP Size							
Descriptive Category	Fiscal Year	MHP Size				Total	Percent
		Small-Rural	Small	Medium	Large		
Use of Acute or Inpatient Services	07-08	10	8	2	4	24	28%
	06-07	3	4	1	1	9	10%
Improved diagnosis or treatment processes	07-08	1	6	5	11	23	27%
	06-07	9	8	7	9	33	38%
Business process improvement	07-08	2	2	3	2	9	11%
	06-07	1	1	5	1	8	9%
Co-occurring disorders	07-08	0	0	5	1	6	7%
	06-07	0	0	4	5	9	10%
Physical Health Care	07-08	0	2	2	0	4	5%
	06-07	0	1	3	1	5	6%
Psychiatrist/Medication Appointment	07-08	0	1	1	0	2	2%
	06-07	2	2	1	2	7	8%
Retention	07-08	0	0	0	2	2	2%
	06-07	1	2	1	3	7	8%
Wellness, recovery and resilience	07-08	0	0	0	1	1	1%
	06-07	0	0	0	0	0	0%
Other	07-08	3	3	4	4	14	16%
	06-07	3	2	2	3	10	11%
TOTAL	07-08	16	22	22	25	85	100%
	06-07	19	20	24	25	88	100%

Figure 2.13 below illustrates demographic information for the consumer population included in PIPs. Our data are based on the MHPs' definition of the study population

receiving interventions targeted for improvement. Based on directives from the CMS, MHPs will need to examine different issues affecting different groups of consumers:

- Forty-one percent (n=35) of the PIPs focused on the adult population, an increase from the year prior.
- Fifteen percent of the PIPs (n=13) were designed to apply to the entire MHP population.

When feasible by study design and/or resources, we encouraged MHPs to include as large a population as possible over the stages of the project, preferably the entire population affected – in order to promote better outcomes for more consumers.

**Figure 2.13**

<b>PIP Target Populations Over Two Years</b>		
<b>Target Population</b>	<b>Count</b>	
	<b>FY07-08</b>	<b>FY06-07</b>
All Population	13	24
Adult	35	32
Older Adult	4	
Transitional Age Youth/Foster Care	4	10
Children/Youth	8	
Other Age Group	2	2
Latino/Hispanic	3	1
Other	16	19
<b>TOTAL</b>	<b>85</b>	<b>88</b>

Figure 2.14 below categorizes the 85 PIPs by the CMS-defined domains of access, timeliness, quality and outcomes. Fewer MHPs this year than did last year addressed issues of access, timeliness and quality of care. The significant increase in PIPs categorized as “outcomes” reflects the 17 MHPs participating in the SCERP re-hospitalization project.

**Figure 2.14**

<b>PIP Domain Over Two Years</b>		
<b>PIP Domain</b>	<b>Count</b>	
	<b>FY07-08</b>	<b>FY06-07</b>
Access	20	28
Timeliness	4	9
Quality of Care	17	27
Outcomes	44	24
<b>TOTAL</b>	<b>85</b>	<b>88</b>

## Performance Improvement Project Evaluation Tool

The PIP evaluation tool that CAEQRO developed for use in year three was also used by our review team in year four. It consists of 44 ratings — 13 of which are considered “key elements.” Meeting all 13 key elements is required for a PIP to be evaluated as successful — i.e., fully developed, well implemented, and findings analyzed. In Attachment 14, we display the data for each of the 44 items for all 85 PIPs that were scored with the evaluation tool.

Our discussion in this section concentrates on the scores of the 13 key items in the PIP validation tool and is followed by Figure 2.15, the Key Criteria Rating summary, which displays these scores. These 13 key criteria cover the design, implementation and analysis phases of a PIP. The items that rate improvement are not included within the key criteria. Our decision was to emphasize the process of data examination as critical to PIP development because these skills are critical to performance improvement irrespective of the specific “project.” Thus while PIP outcomes are indeed important, our thinking was to reward MHPs who successfully demonstrated appropriate intervention and analytic strategies — since these strategies demonstrate skills that should not be confined to the narrow parameters of a single project.

### Overview of findings

In tabulating our findings, we consolidated the categories, “met” and “partially met.” “Partially met” usually meant either: 1) the item was aligned with the MHP’s intent, but the study design would benefit from the suggested improvements, or 2) the item would be considered as met with minor modifications or clarification. In all cases, we explained why we rated an item as anything other than “met” and offered suggestions in the “comments” section of the tool.

In general, we found a gradual decline in the number of key criteria rated as “met” or “partially met” as a PIP evolved from conceptual to implementation stages:

- **Initial stage of development — study design:** 70 to 80 percent of MHPs identified an appropriate study topic, study question, indicators and study population.
- **Subsequent stages of development:** fewer MHPs were successful in moving their PIPs beyond the study question as illustrated by the significant decrease in percentages for “met/partially met” in the areas of data collection strategies, application of interventions and analysis of results. Only 30 PIPs (35 percent of the PIPs we evaluated) had conducted an analysis of their post-intervention results.

We rated an element as “not met” for the following reasons:

- The stage of applying interventions or analyzing results had not been implemented or
- The analysis was conducted inaccurately or with a substantially poor design.

### Summary of results for key indicators

In Attachment 14, we include a table that lists FY07-08 PIP findings, which we summarize below in Figure 2.15:

- Progress in PIP design criteria.** Overall, MHPs appear to be making progress — especially in the early to mid-stages of PIP development. Approximately 75 percent of the PIPs “met/partially met” the criteria of clearly defined study indicators — increasing from approximately 50 percent of the FY06-07 PIPs. The MHPs also demonstrated an increase in successfully defining the study questions, correctly identifying the study population, performing data collection, and developing appropriate intervention and implementation strategies.
- Notable improvement in implementation/analysis.** While the percentages are lower for these criteria than for design criteria, the number of PIPs meeting data analysis and results interpretation showed significant improvement in FY07-08. This year 35 percent of the PIPs “met” or “partially met” these criteria, which is an increase from just over 20 percent of the PIPs in FY06-07.

Clearly, PIPs have improved significantly since our year one review — particularly in data analysis and results interpretation. MHPs could achieve further improvement in these areas by simply implementing PIPs all year long. Many initiate PIPs during the months prior to the CAEQRO review — the timing produces a PIP that could not have produced results yet at the time of the review.

**Figure 2.15**

Key Criteria Rating for FY07-08				
Category	Question	Met/Partially Met	Not Met	Total
Study Topic	1.5	68	17	85
Study Question Definition	2.1	64	21	85
	2.4	62	23	85
Clearly Defined Study Indicators	3.1	66	19	85
	3.2	60	25	85
	3.3	62	23	85
	3.4	62	23	85
Correctly Identified Study Population	4.1	63	22	85
Accurate/Complete Data Collection	6.3	50	35	85
Appropriate Intervention and Improvement Strategies	7.1	57	28	85

## Section 2.3: Analysis of Health Information Systems

CMS has determined that a complete evaluation of an MHP's systems capabilities is an essential component in assessing how effectively and efficiently an MHP manages the health care of its beneficiaries. CAEQRO is responsible for the independent review of the health information systems of each MHP in California. As part of this process, CMS also mandates administration of an ISCA each year at each MHP. However, the model federal protocol serves only to provide guidance on the intent, process and purpose of a health information systems review, allowing an EQRO to tailor the survey to individual state Medicaid environments.

By posing standard questions, the ISCA survey assists CAEQRO in assessing the extent to which an MHP is capable of collecting and reporting valid encounter data<sup>7</sup>, performance measures and other data necessary to support quality assessment and improvement, as well as manage the care delivered to its beneficiaries. The ISCA survey has been therefore the foundation of our information systems review. In year one of our contract, CAEQRO developed a California- and mental-health-specific ISCA. Over the past three years, we have worked with stakeholders to develop an increasingly sophisticated survey — one that reflects our enhanced experience with California's complex public behavioral health system, our continued commitment to respond to stakeholder input, and significant advances in the development and implementation of electronic health records in the behavioral health arena.

The full history and evolution of the CAEQRO-developed ISCA survey is described in our Year Two and Year Three Statewide Reports to DMH. These reports are available on the CAEQRO Web site — [www.caeqro.com](http://www.caeqro.com).

### CAEQRO Information Systems Review Process and Tools

Summarized below are our now standardized processes for conducting information system reviews and analyzing the data that we collect.

#### Information systems review process

The CAEQRO information systems review process, which has remained consistent since our year one statewide review, includes these four consecutive activities:

- **Step One** involves the collection of standard information about each MHP's information systems by having the MHP complete an ISCA. In FY07-08, all MHPs used the ISCA V6.1 survey in collecting data for their information systems reviews. The survey includes requests for information and documents from the MHP. A checklist at the end of the ISCA summarizes the required information.

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<sup>7</sup> "For the purposes of this report, an encounter refers to the electronic record of a service provided to a managed care organization/pre-paid inpatient health plans — i.e., an MHP — enrollee by both institutional and practitioner providers (regardless of how the provider was paid) when the service would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provides substantially the same type of information that is found on a claim form (e.g., UB-92 or CMS 1500), but not necessarily in the same format." – Validating Encounter Data, CMS Protocol, p. 2, May 2002.

- **Step Two** involves a review of the completed ISCA V6.1 and associated documents by CAEQRO reviewers in advance of the site visit.
- **Step Three** consists of a series of in-person and telephone interviews and discussion with MHP staff members who completed the ISCA V6.1 or are knowledgeable about administrative or delivery system processes. We also meet with clerical and clinical staff who use the information systems routinely in the course of their work. These interviews enable us to assess the integrity of the MHP's information systems processes and technology.
- **Step Four** produces an analysis of the findings from both the ISCA V6.1 and the follow-up discussions with MHP staff. CAEQRO summarizes our findings in the information systems section of each MHP's site review report, which address the MHP's ability to collect and use data to support business operations, conduct quality assessment initiatives and measure QI efforts in providing mental health services to beneficiaries.

### ISCA V6.1 survey

Since the ISCA V6.1 has remained stable over the last two years, MHPs were advised to use their FY06-07 ISCA V6.1 as a baseline, and simply highlight changes and additions applicable to year four. For most MHPs, the process of updating year four data greatly facilitated their response to the ISCA survey.

The ISCA is a 24-page document divided into six sections, with multiple questions in each section. The ISCA is designed to be completed by the MHP's information systems manager to answer questions within the document and returned as a completed survey to the CAEQRO. However, the ISCA is not confined to information systems or information technology issues. The document also delves into financial, business and clinical areas; thus, it commonly requires participation by staff members from these areas to fully respond to questions. Main section headers of ISCA V6.1 are shown below. The full document appears in Attachment 15.

- **Section A — General information**  
In this section, we establish the status of the current modules included in the information systems, top priorities of the information systems department, makeup of information systems users, relative percentage of Medi-Cal versus non-Medi-Cal services provided, percentage of county-operated programs versus contract agencies and network providers, and future system changes.
- **Section B — Data collection and processing**  
This section includes questions concerning policies and procedures specific to the timeliness and accuracy of data entry, system table maintenance, training capacity, access to and analysis of data, and communication with information systems users.
- **Section C — Medi-Cal claims processing information**  
Policies and procedures surrounding the Medi-Cal claim process are the focus of this section, including eligibility discovery, payment processing and denials.

- **Section D — Incoming claims processing**  
Here we collect information about the many MHPs who operate a managed care unit or otherwise assess eligibility, authorize care, manage a network of external providers, and process and pay claims.
- **Section E — Information systems security and controls**  
Security issues relevant to any health information system are addressed here, including consideration of the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- **Section F — Additional documentation requirements**  
This section specifically identifies documents for the MHP to submit to CAEQRO prior to the site review.

### ISCA database

Beginning in our first contract year, CAEQRO recognized the importance of storing data gathered from the ISCA. However, when we defined the California-specific ISCA for our first-year review, we designed questions primarily for text-based answers. This design served our early intentions to gather baseline information about an MHP's information systems processes; however, we recognized the inherent difficulties in storing qualitative data and measuring it over time. Thus, as we refined and standardized the ISCA, we substituted quantitative and categorical questions where possible and appropriate.

In year three, along with creating a standardized ISCA V6.1, CAEQRO rewrote the corresponding ISCA database and converted it to a module of a larger database that stores data used to produce the MHP summaries. The ISCA module stores MHP responses to many of the quantitative and qualitative elements from the ISCA survey, and supports improved access to data for reporting purposes. For selected data elements, the ISCA database now stores four full years of every MHP's information systems data. The figures that follow were produced from information contained in the CAEQRO ISCA database.

## Information Systems Findings

CAEQRO currently maintains four years of detailed information, as listed below, on all 56 MHPs' information systems:

- Types of information systems that MHPs use
- How long MHPs have used their respective information systems
- The quantity and quality of data collected by MHP staff
- How MHPs report data to internal and external customers
- What specific MHP staff use the information systems
- Which MHPs are planning to replace a legacy system
- Which MHPs are implementing a new information systems
- The extent of progress toward an electronic health record

In the tables and charts that follow, we present our ISCA findings for year four. Please note: not all data elements include four years.

### Information systems vendors and products

Vendors have grown market share by attracting groups of small counties — enabling them to receive added value previously afforded to large counties.

As in prior years, a few vendors dominate the public behavioral healthcare information system market in California. In FY07-08, Anasazi, Echo and Netsmart accounted for over 60 percent of all systems, including secondary and locally developed systems. These same vendors account for almost 90 percent of core Behavioral Health Information Systems used for Medi-Cal billing and mandated state reporting in

California counties. Figure 2.16 below shows the number of small, medium and large counties using each system in FY07-08, as well as the total number of counties per vendor in FY05-06 and FY06-07.

A major shift in leading vendors has occurred over the last several years. Once dominant Echo Systems has steadily declined in the number of customer counties, despite its introduction of the more technologically advanced ShareCare which was designed to replace the legacy InSyst product.

In contrast, another long-standing vendor in the California environment, Netsmart Technologies, appears to be continuing to attract customers to its new Avatar system, moving from four to 13 customers in the last year. The new (to California) vendor, Anasazi went from zero presence in FY05-06 to eight county customers in FY07-08. As illustrated in Figure 2.16, the majority of movement in information systems in FY07-08 continues to be in small MHPs. Both Netsmart and Anasazi expanded their market shares by attracting small MHPs, mostly through group purchases.

In the last three fiscal years, three vendors serviced a single California county, all large — Cerner in Orange, Sierra Systems in Los Angeles, and UNI/CARE in Santa Clara. MHPs with multi-county vendors benefit from robust user groups, shared funding of upgrades and stronger advocacy. These benefits are generally not provided by vendors that serve a single customer.

Figure 2.16

Current MHP Information Systems by Vendor and County Size*						
Vendors + Products	Small	Medium	Large	Total FY07-08	Total FY06-07	Total FY05-06
Anasazi	7	0	1	8	3	0
Cerner	0	0	1	1	1	1
Echo CD/RM	0	0	0	0	1	1
Echo INSYST	4	9	6	19	26	27
Echo ShareCare	1	1	0	2	1	3
HSD Diamond	0	1	1	2	2	2
InfoMC eCura	0	4	5	9	9	9
Locally developed system	3	3	7	13	10	6
Netsmart Avatar	11	2	0	13	4	4
Netsmart InfoScriber	2	0	0	2	1	2
Netsmart CMHC	7	1	0	8	11	11
Netsmart CSM	0	0	2	2	2	1
Platton Clinician Gateway	0	2	1	3	3	2
Qualifacts/CalCIS	0	0	0	0	0	2
Sierra Integrated Systems	0	0	1	1	1	1
UNI/CARE Profiler	0	0	1	1	1	1
<b>TOTAL</b>	<b>35</b>	<b>23</b>	<b>26</b>	<b>84</b>	<b>76</b>	<b>73</b>

\* Several MHPs have multiple systems

### Selection and implementation of new information systems

The key difference in new system implementations from previous years is the acquisition of systems with clinical components.

Over the past three years, MHPs have been extraordinarily active in the search, selection, and implementation of new core information systems. Figure 2.17 displays the status of each MHP in the continuum of activity related to acquisition of a new information system – from “No plans for a new system” to “New system in place,” and how the status has changed since FY05-06.

A summary of our findings is listed below:

- The number of MHPs with no plans to look for a replacement system has dropped by more than half — from nine in FY05-06 to four in FY07-08. These remaining four MHPs are all Netsmart CMHC customers.

- In combination, the number of MHPs that are either “Considering a new information system” or “Actively searching for a new information system” has remained relatively stable, with a combined number of 19, 21 and 20 in the last three fiscal years. These combined categories comprise 35 percent of all MHPs in FY07-08, reflecting the large number of MHPs that are still assessing which vendor systems are best suited to California mental health requirements and/or determining funding sources to replace aging systems and technology. A full 70 percent of MHPs (14 out of 20) in these two categories are long time Echo InSyst customers. Of the remaining six, three of the MHPs now operate locally developed systems, two are Netsmart CSM system users, and the last is a single-MHP vendor operating in Los Angeles.
- The number of MHPs with “New information system selected” decreased substantially from 19 in FY05-06 to three in FY07-08. This change is attributed to the large number of small counties that selected the Netsmart Avatar system in FY05-06 and have been implementing those systems over the past two years.
- “Implementations in progress” represent both “new” implementations started in year four in addition to many “extended” implementations that started during years two and three. The majority of MHPs in “Implementation in progress” in FY07-08 are small counties that selected the Netsmart Avatar system in FY05-06, reflecting the long timeline for implementing new systems. Two vendors/products account for all current implementations — Netsmart Avatar and Anasazi.
- The days of the behavioral health information system’s primary use as a billing instrument are numbered. The key difference in new system implementations from previous years is the acquisition of systems with clinical components. This brings a whole new class of system users into the equation, often requiring intensive training in using computers and other technical tools and extending the length of the implementation project. Currently, 39 percent of MHPs are in the midst of implementing a new system, signaling a huge flux in the overall behavioral health information system landscape over the last several years.
- The seven MHPs with a “New system in place” represent the early adopters. MHPs in this category selected a diverse set of vendors: two — Netsmart Avatar, two — Echo ShareCare, one — Anasazi, one — Cerner and one — UNI/CARE.

Figure 2.17

New Information System Status						
	FY05-06		FY06-07		FY07-08	
	Number	Percent	Number	Percent	Number	Percent
No plans for new information system	9	16%	5	9%	4	7%
Considering new information system	8	14%	4	7%	6	11%
Actively searching for new information system	11	20%	17	30%	14	25%
New information systems selected, not implemented	19	34%	7	13%	3	5%
Implementation in progress	9	16%	17	30%	22	39%
New system in place	0	0%	0	0%	7	13%
TOTAL	56		50		56	

### Information systems component ratings — statewide

Many MHPs continue to view service entries as “billing data” versus valuable clinical information. Most also consistently fail to use data to support business analyses.

During FY05-06 reviews, we began rating MHP information systems based on ten key criteria. The information systems were rated as “met,” “partially met,” “not met” and “not reviewed” on each of these criteria. Figures 2.18 and 2.19 display a statewide summary of this information gathered from completed ISCA surveys and interviews conducted during site visits. Figure 2.18 shows the number of

MHPs who scored “met” for each component over a three year period. Figure 2.19 displays a more detailed summary of these ratings specifically for FY07-08. Individual MHP ratings for FY07-08 are included in Volume II of this Statewide Report. Key findings displayed in these tables are highlighted below:

- Failure of timeliness and consistency of data entry.** The number of MHPs achieving “accurate, consistent and timely data collection and entry” has remained at 33 for three consecutive years. This means that 23 MHPs only partially met this requirement or did not meet it at all. Two key points of failure are “timeliness” and “consistency” of data entry across programs. Far too many MHPs continue to regard a service entry as a billing record instead of a piece of valuable clinical information. Therefore, they use Medi-Cal billing timelines as a guide in formulating policies for service data entry. In many MHPs, services are entered to the system more than a month after the date provided. This lag time is especially true for contract providers, who often do not have direct system access and need to fax or hand-deliver service slips to the county for data entry.

As systems transition to electronic clinical records, we anticipate that an increased number of MHPs will meet this requirement in the future. However, MHPs will need to provide greater system access to contract providers to meet this requirement.

- **A decline in three categories.**
  - o “Integrity of Medi-Cal claim production process.” MHP performance declined slightly in this rating,” with 38 MHPs attaining a “met” versus 41 in the previous two years. Inability to meet HIPAA claim standards and high Medi-Cal claim denial rates were the main contributors to low scores in this area.
  - o “Access to data via standard and ad hoc reports.” The rating suffered the significant drop — from 30 MHPs scoring “met” in FY05-06 to just 22 in FY07-08. This decline may be due to the implementation of many new systems, which have fewer standard reports available at startup than did the legacy systems.
  - o “Demonstrated capability to support business analysis.” While this area edged up slightly from FY06-07, it remains one of the two most difficult areas of competency for MHPs, along with “Access to data.” In FY07-08, 45 percent of the “not met” (10 out of 22) and 43 percent of “partially met” (51 of 120) scores for all components were in these two categories.

CAEQRO added two new components in FY07-08 pertaining to contract providers. Because they were added during the fiscal year, they were not reviewed in many MHPs, as displayed in Figure 2.19.

Medi-Cal denied claims rate is one indicator of an effective claims production operation — with a low denial percentage suggesting a high rate of accuracy in initial claims submissions. Also, denied claims rate can be an important and useful measure of an MHP’s success in testing and implementing a new information system. In rating the integrity of an MHP’s Medi-Cal claims process, a persistently high Medi-Cal denial rate over several years was one factor in our scoring the component as “not met” — which may have contributed to the statewide decline cited above.

Attachment 16 (Denied Claims Analyses) shows the percentage of denied Medi-Cal claims for each MHP over three fiscal years, along with their statewide ranking. The first ranking represents the highest denial percentage and #56 is the lowest denial percentage. The analysis clearly shows that most counties maintain similar denial rates and ranking over time. Santa Clara and Amador have consistently sustained the highest denial rates, while Siskiyou and Sonoma have maintained the lowest denial rates. A review of MHPs with high variance in ranking over three years reveals some of the activity that may impact a change in denial rates:

- Alameda improved from rank #16 in FY04-05 to #45 in FY06-07. The unusual spike in FY04-05 is likely related to the conversion to a HIPAA-compliant Medi-Cal claims system. This conversion also generated renewed focus on improving internal processes contributing to denials.

- Del Norte moved from a two-year pattern of low denial rates (rank #49 and #52) to rank #18 in FY06-07. This change coincided with the implementation of a new information system.
- Napa showed the largest one-year improvement — moving from rank #2 in FY05-06 to #50 in FY06-07. During FY05-06, two separate claim files were denied during the conversion from a proprietary format to the HIPAA-compliant format. The claims were subsequently re-submitted with valid claim identification numbers and approved.

**Figure 2.18**

Statewide Information System Components – “Met” Over Three Years			
Component	FY 05-06	FY 06-07	FY 07-08
Accurate, consistent and timely data collection and entry	33	33	33
Procedures to determine a beneficiary's eligibility status	45	46	51
Integrity of Medi-Cal claim production process	41	41	38
Complete, reliable authorization and claims adjudication processes for network providers, including timely and accurate payment	28	27	N/A
Demonstrated capability to support business analysis and data analytic activities	21	20	23
Access to data via standard and ad hoc reports	30	29	22
Information systems training program and help desk support	42	41	45
Information systems/fiscal policies and procedures documented and distributed	42	42	47
Collaboration between quality improvement and information systems departments	44	43	46
Documented data security and back-up procedures	50	50	53

Figure 2.19

Statewide Information System Component Ratings – FY07-08				
Component	Met	Partially Met	Not Met	Not Reviewed
Accurate, consistent and timely data collection and entry	33	19	3	1
Procedures to determine a beneficiary's eligibility status	51	5	0	0
Integrity of Medi-Cal claim production process	38	15	3	0
Complete and reliable authorization processes for contract providers	24	3	0	29
Complete and reliable claims adjudication for contract providers, including timely and accurate payment	21	7	2	26
Demonstrated capability to support business analysis and data analytic activities	23	25	6	2
Access to data via standard and ad hoc reports	22	26	4	4
Information systems training program and help desk support	45	7	1	3
Information systems/fiscal policies and procedures documented and distributed	47	5	1	3
Collaboration between quality improvement and information systems departments	46	6	2	2
Documented data security and back-up procedures	53	2	0	1

### Proportion of all services by county, contract and network providers

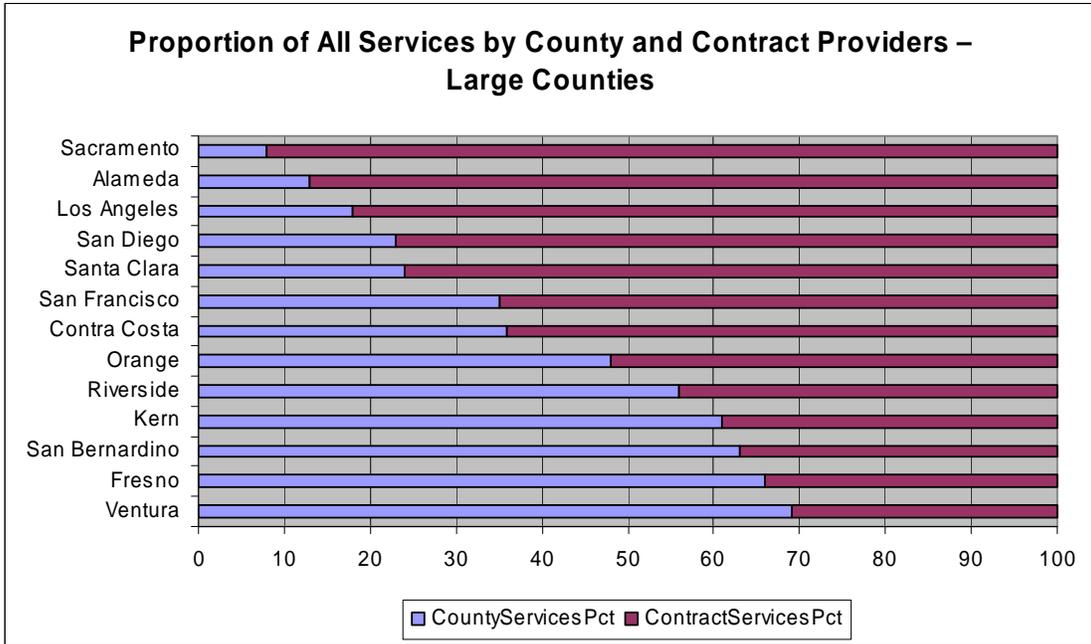
Small MHPs continue to have the lowest percentage of contract providers — suggesting an ongoing scarcity of resources to supplement county-delivered services.

Figures 2.20 to 2.22 below display the relative proportion of services provided by county-operated and contract providers in large, medium and small counties. In each figure, the MHP with the lowest percentage of services provided by county-operated programs appears first and the MHP with the highest percentage of services provided by county-operated programs appears last.

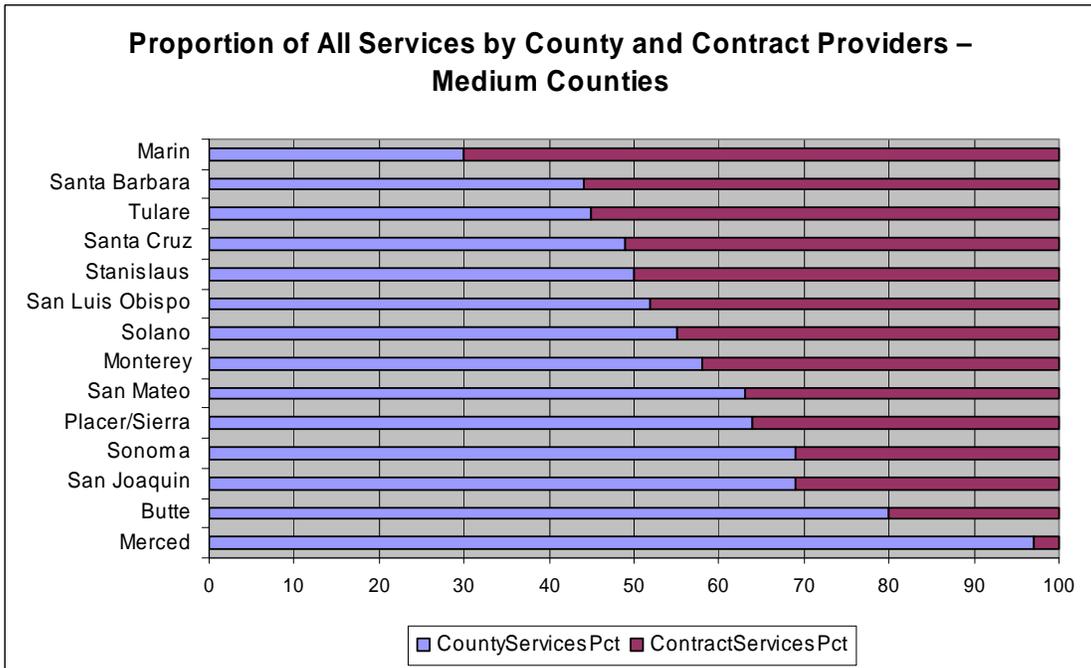
These figures, which are summarized below, clearly illustrate the wide variation in service delivery among MHPs by county size and location. Contract providers are more available in larger and urban locales, and may have very limited presence in smaller and more remote locations.

- As shown in Figure 2.20, in large counties overall, the majority of services are provided by contract providers. In three large MHPs, including Los Angeles, contract providers render over 80 percent of all services. In eight out of 13 large MHPs, contractors provide over 50 percent of services.
- Figure 2.21 shows a more equal distribution of services provided by county and contract providers in medium counties — with more counties providing half or less than half of their services through contract providers.
- Figure 2.22 displays the mix of county-operated services compared to services provided by contractors in small and small-rural counties. This figure contrasts sharply from Figure 2.20 for large counties. With the exception of three small counties (Alpine, Kings and Tuolumne) in which 100 percent of services are rendered by contract providers and a relatively equal mix for a few counties, the majority offer 75 to 98 percent of their services through county-operated programs.

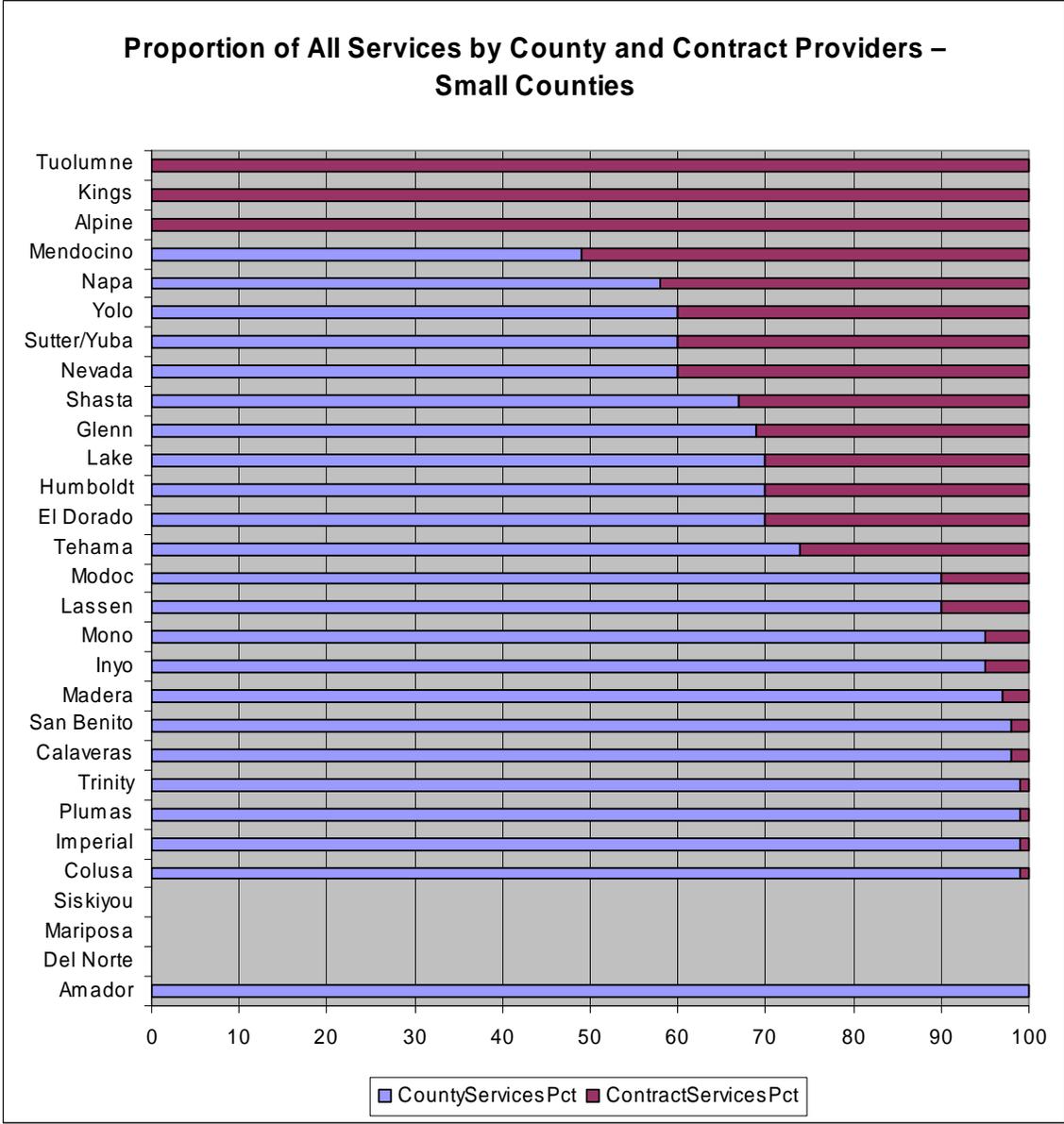
**Figure 2.20**



**Figure 2.21**



**Figure 2.22**



*Note: Three small-rural MHPs (Del Norte, Mariposa and Siskiyou) were unable to provide this breakdown, thus are listed in Figure 2.21 without corresponding bars to show the county versus contract provided service mixture.*

### Consumers with co-occurring disorders

MHPs are still unable to record accurate information on consumers with co-occurring disorders — in part due to continued misperceptions about eligibility issues.

To support growing efforts to address the needs of consumers with co-occurring disorders (COD), ISCA V6.1 contains questions related to the ability of MHPs to track these consumers through their information systems.

In the ISCA, we ask:

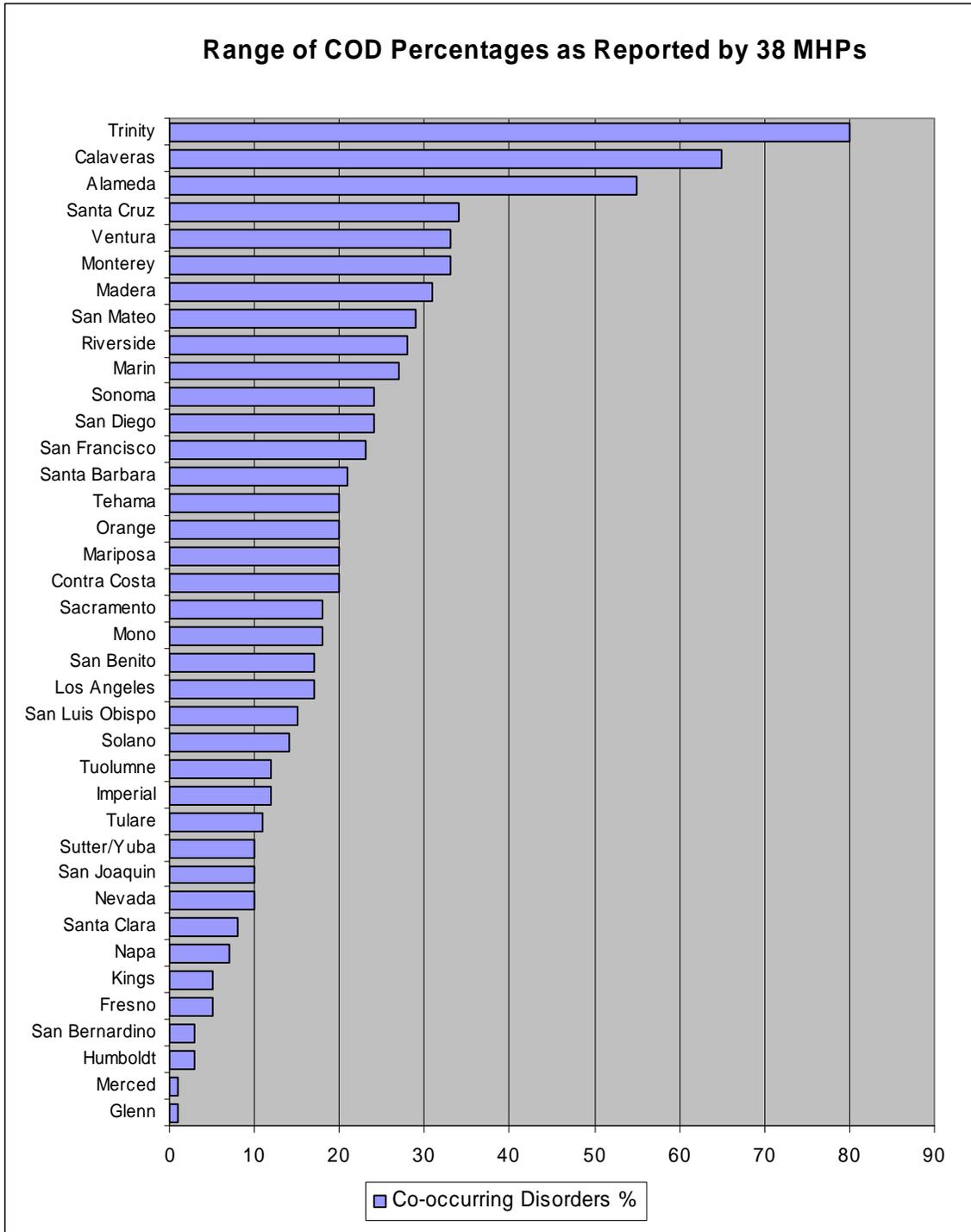
- Does your information system capture co-occurring mental health and substance abuse diagnoses for active consumers? Yes or No.
- If “yes,” what is the percentage of active consumers with COD?

Figure 2.23 provides a breakdown of responses by MHP. Forty-four out of 56 MHPs stated that the information system captures COD information; however, six of those were not able to provide the COD percentage (Amador, El Dorado, Kern, Modoc, Siskiyou and Yolo). Of the 38 that did provide a COD percentage, the number ranged from one percent in Glenn and Merced to 80 percent in Trinity. Among MHPs serving significant number of beneficiaries, Alameda recorded 55 percent COD while the next highest, Santa Cruz, indicated 34 percent. The median was 18 percent, well below the commonly acknowledged range of 40 to 60 percent.

Overall, Figure 2.23 displays a comparable pattern to the FY06-07 data. However, several individual MHPs appear to have made an effort to accurately capture and/or report COD information this year. For example, Santa Cruz reported 76 percent last year and 34 percent this year, while Marin reported 3 percent last year and 27 percent this year.

Clearly, MHPs still need significant improvement to accurately capture and report critical COD information in their information systems. As in FY06-07, misperceptions abound about the eligibility implications of recording substance use diagnoses in the mental health information system. Several MHPs performed studies comparing substance use diagnoses recorded in hardcopy medical charts versus the information systems. In all cases, the studies showed a greater number of substance use diagnoses in the medical chart than in the information system. In addition, many information systems do not offer an easy method of consistently recording and obtaining COD information.

**Figure 2.23**



### Integrity of diagnosis information

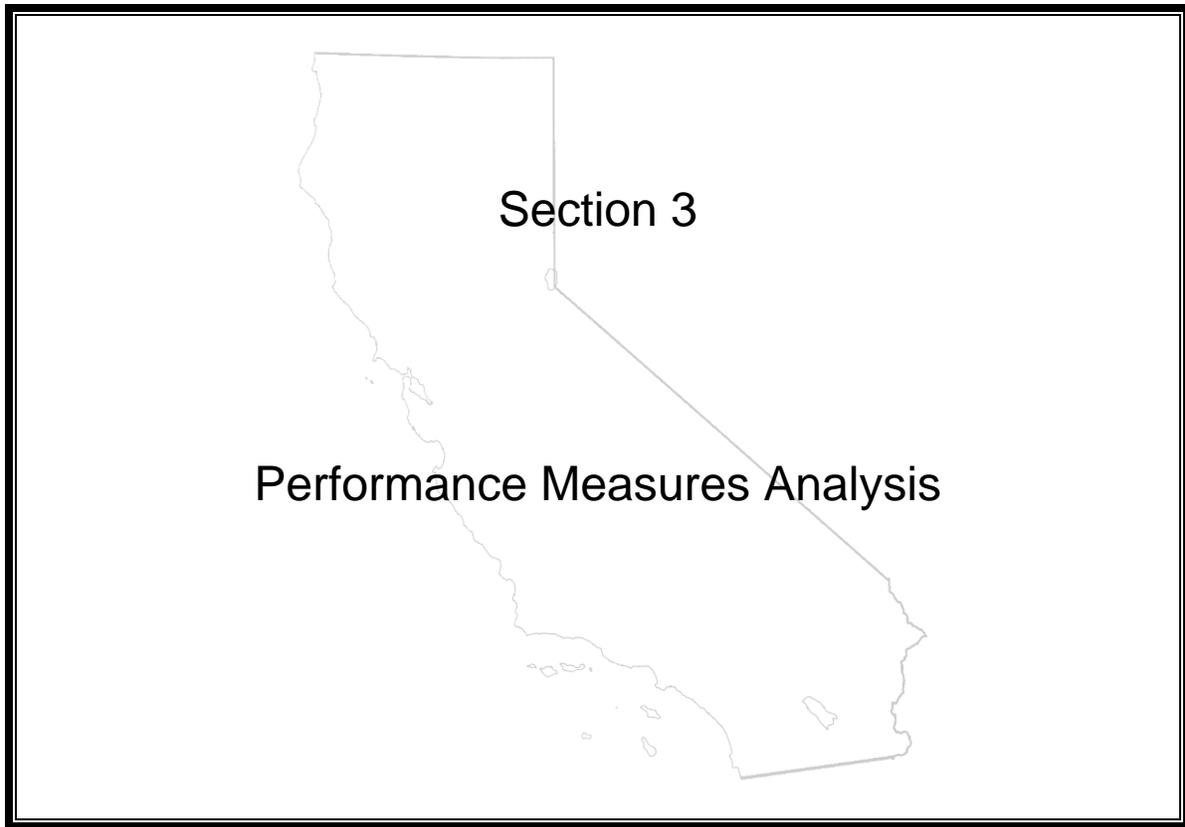
As MHPs implement new information systems, they will be able to track diagnoses as they change over time.

A question in ISCA V6.1 relates to the integrity of diagnostic information in the core information systems, especially as a diagnosis changes over time. In the ISCA we ask:

- Does your information system maintain a history of diagnoses as they change over time during an episode of care? Yes or No.

In FY06-07, only 26 MHPs responded Yes. This year, 35 MHPs responded Yes. We attribute this improvement to the implementation of newer systems in several counties in the last year. Many older legacy systems do not capture and store a client's diagnosis as it changes over time, while newer systems that are more clinically oriented include this key function.

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION





## Section 3.1: Overview

In year four, California External Quality Review Organization (CAEQRO) continued the performance measure (PM) analysis of “cost per unduplicated beneficiary served” that we began two years ago using Calendar Year (CY) 2005 data. We now have three calendar years of data for analysis of cost per unduplicated beneficiary served to determine significant changes over time. We also present a number of specific penetration rates as additional informative elements.

With the baseline analysis that we completed in year two we are able to analyze and compare approved claims data for CY05, CY06 and CY07 from the following sources:<sup>8</sup>

- CY05 — Short-Doyle/Medi-Cal (SD/MC) approved claims as of February 2007; Inpatient Consolidation (IPC) approved claims as of March 2007; and Medi-Cal Eligibility Data System (MED) Monthly Extract File (MMEF) data as of April 2006
- CY06 — SD/MC approved claims as of October 2007; IPC approved claims as of November 2007; and MMEF data as of April 2007
- CY07 — SD/MC approved claims as of May 2008; IPC approved claims as of May 2008; and MMEF data as of April 2008

### Performance Measures Analysis Goals

In this section, we review important non-clinical demographic variables to help analyze and understand cost and service patterns. To increase understanding and evaluation of the service delivery system, CAEQRO focused our analysis to:

1. Determine if key variables such as gender, age and ethnicity contribute to understanding service delivery patterns
2. Identify the most striking differences among various groups
3. Highlight consistencies and changes from prior year studies
4. Stimulate discussions by stakeholders about whether these patterns necessitate further review and study

As in our year two and year three reports, we include a simple ratio to illustrate how penetration rates and average cost per beneficiary compare among different populations:

- “Penetration rate ratio” is a ratio of one demographic or ethnic group to another. A ratio of 1.0 reflects an equitable penetration rate based upon the beneficiary population. The further the value is from 1.0, the greater the disparity.
- “Average payment ratio” is a ratio of the average payment per beneficiary served for one demographic or ethnic group to another. Again, a ratio of 1.0 reflects an

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<sup>8</sup> All figures in Section 3 reflect these sets of data.

equitable penetration rate based upon the beneficiary population. The further the value is from 1.0, the greater the disparity.

The data presented in this section refers to Medi-Cal beneficiaries only; non-Medi-Cal beneficiaries are not represented in graphs and tables. Although the data we have available can therefore only provide a partial picture of the delivery system, our findings are still valuable in providing stakeholders with useful information on areas that call for review and potential intervention by individual MHPs. The patterns that we have identified suggest questions around the types and intensity of services received by specific groups of beneficiaries. Patterns of service and retention in the system will vary across groups of beneficiaries who enter the mental health system.

In the remainder of this section, we discuss the impact of Los Angeles MHP data on our findings and then present PM analyses using the following variables: gender, age, race/ethnicity and service delivery patterns. Variation in these patterns by demographics and ethnicity may warrant further investigation by individual MHPs. We will post individual MHP data on our Web site ([www.caegro.com](http://www.caegro.com)) so that this information will be available for local review.

## Section 3.2: Statewide Considerations

Three high-level findings are important to consider in reviewing the data in this report:

- **Median versus the mean.** The median (i.e., the cost in the mid-point of the distribution) and mean (i.e., average cost) are significantly different. This disparity indicates that the distribution of overall services is largely skewed toward the lower end of both cost and number of services per person.
- **Impact of Los Angeles MHP.** Because the Los Angeles MHP represents 30 percent of beneficiaries served, its data can skew certain findings. Consequently, we display some data both with and without Los Angeles – i.e., California No Los Angeles (CANOLA).
- **Consumer Price Index Adjustment.** Approved claims payments are adjusted by the consumer price index (CPI) when comparing dollar amounts across calendar years. Attachment 18.1 contains a detailed description of our methodology. Attachment 18.2 displays companion figures that are “Not adjusted for CPI,” as well as side by side comparison figures for select service modalities by ethnicity.

Figures 3.1, 3.2 and 3.3 present three years of data for cost per beneficiary served — comparing statewide, CANOLA and Los Angeles MHP data. These data indicate the relative influence of Los Angeles remained stable over the last three years.

- Figures 3.1, 3.2 and 3.3 indicate the following regarding the total number of eligible beneficiaries and total beneficiaries served:
  - o The statewide total of eligible beneficiaries increased slightly in CY07 from the prior year by 53,726 or 0.8 percent, while the statewide total

beneficiaries served decreased by 3,121 or 0.7 percent less than in CY06. In CY06, the eligible beneficiaries decreased marginally by 0.4 percent from the prior year while the beneficiaries served decreased by 1.1 percent less than in CY05. The beneficiaries served statewide decreased by 1.8 percent in CY07 from CY05.

- o The total eligible beneficiaries in Los Angeles show continual decrease by 54,815 from CY05 to CY06 and by 35,826 from CY06 to CY07 — a 3.7 percent decrease from CY05 to CY07. However, the total beneficiaries served in Los Angeles decreased in CY07 from CY05 by only 0.6 percent.
- o The total eligible beneficiaries for CANOLA show continual increase by 27,478 from CY05 to CY06 and 89,552 from CY06 to CY07 — a 2.7 percent increase from CY05 to CY07. However, the total beneficiaries served for CANOLA decreased in CY07 from CY05 by 2.3 percent.
- Figures 3.1, 3.2 and 3.3 indicate the following regarding costs per unduplicated beneficiary:
  - o In CY07, the average cost per unduplicated beneficiary served statewide (including Los Angeles) is \$4,148, which is consistent with this cost in CY06 and in CY05.
  - o The average cost per unduplicated beneficiary for Los Angeles alone is \$4,577, which is consistent with this cost in CY06 and in CY05. CANOLA demonstrated a similar trend in CY07 with the average cost per unduplicated beneficiary of \$3,961, consistent with this cost in CY06 and in CY05.
  - o When Los Angeles MHP data are included, the statewide mean remained in CY07 (as in CY05 and CY06) higher than that for CANOLA data. Therefore, the mean with Los Angeles included in the data is not the most accurate point of comparison for the vast majority of MHPs.

**Figure 3.1**

<b>Cost Per Beneficiary Served - Statewide/CANOLA CY05</b>							
	<b>Total Medi-Cal Eligibles</b>	<b>Percent of Medi-Cal Eligibles</b>	<b>Total Beneficiaries Served</b>	<b>Percent of Beneficiaries Served</b>	<b>Median - Cost Per Beneficiary Served</b>	<b>Average - Cost Per Beneficiary Served</b>	<b>Standard Deviation - Cost Per Beneficiary Served</b>
Statewide	6,810,962	100%	430,877	100%	\$1,346	\$4,045	\$8,396
CA No LA	4,353,453	64%	302,116	70%	\$1,287	\$3,866	\$8,301
Los Angeles	2,457,509	36%	128,761	30%	\$1,515	\$4,465	\$8,601

Source: SD/MC approved claims as of February 2007, IPC approved claims as of March 2007 and MMEF data as of April 2006

Figure 3.2

<b>Cost Per Beneficiary Served - Statewide/CANOLA CY06</b>							
	<b>Total Medi-Cal Eligibles</b>	<b>Percent of Medi-Cal Eligibles</b>	<b>Total Beneficiaries Served</b>	<b>Percent of Beneficiaries Served</b>	<b>Median - Cost Per Beneficiary Served</b>	<b>Average - Cost Per Beneficiary Served</b>	<b>Standard Deviation - Cost Per Beneficiary Served</b>
Statewide	6,783,625	100%	426,158	100%	\$1,415	\$4,158	\$8,537
CA No LA	4,380,931	65%	297,839	70%	\$1,326	\$3,964	\$8,460
Los Angeles	2,402,694	35%	128,319	30%	\$1,663	\$4,608	\$8,696

Source: SD/MC approved claims as of October, 2007, IPC approved claims as of November 2007 and MMEF as of April 2007

Note: CY06 dollars adjusted to CY05 dollars using California CPI

Figure 3.3

<b>Cost Per Beneficiary Served - Statewide/CANOLA CY07</b>							
	<b>Total Medi-Cal Eligibles</b>	<b>Percent of Medi-Cal Eligibles</b>	<b>Total Beneficiaries Served</b>	<b>Percent of Beneficiaries Served</b>	<b>Median - Cost Per Beneficiary Served</b>	<b>Average - Cost Per Beneficiary Served</b>	<b>Standard Deviation - Cost Per Beneficiary Served</b>
Statewide	6,837,351	100%	423,037	100%	\$1,425	\$4,148	\$8,430
CA No LA	4,470,483	65%	295,061	70%	\$1,315	\$3,961	\$8,415
Los Angeles	2,366,868	35%	127,976	30%	\$1,731	\$4,577	\$8,451

Source: SD/MC approved claims as of May 2008, IPC approved claims as of May 2008 and MMEF as of April 2008

Note: CY07 dollars adjusted to CY05 dollars using California CPI

### Section 3.3: Cost Per Beneficiary Served – Gender

Statewide data continue to indicate a disparity in cost per beneficiary served between male and female beneficiaries.

Figure 3.4 presents a statewide analysis of the count, average payments and penetration data by gender for CY05 through CY07. Data are consistent over the three-year period:

- The penetration rate for male beneficiaries is higher than for female beneficiaries in each of the last three years.
- The average payment for male beneficiaries continues to exceed that for female beneficiaries.

Statewide data continues to indicate a significant disparity based on gender. The female penetration rate ratio in CY07 was 0.82 — that is, for every 100 male beneficiaries served, 82 female beneficiaries were served. This disparity was also reflected in the average payment for female versus male beneficiaries, with females receiving 77 cents per \$1.00 for males.

**Figure 3.4**

Statewide Comparison of Beneficiary Count, Average Payment and Penetration Ratios by Gender						
	Count of Beneficiaries Served		Average Payment Per Beneficiary Served		Ratio of Females vs. Males	
	Female	Male	Female	Male	Penetration Rate	Average Payment
CY05	223,630	203,348	\$3,501	\$4,563	0.83	0.77
CY06	222,869	203,289	\$3,781	\$4,912	0.83	0.77
CY07	220,260	202,777	\$3,892	\$5,058	0.82	0.77

### Section 3.4: Cost Per Beneficiary Served – Age

Cost per beneficiary for most age groups continued to increase over three years regardless of county size.

Figure 3.5 below shows the statewide comparison of cost per beneficiary served according to age. Cost per beneficiary served in this category increased slightly from CY05 to CY07. The relative position of each age group over the time period remains constant. In CY06 we had noted a potential shift in costs to children and youth. The group of zero to five years notes an increase from

CY05 to CY07 of \$170 or 5.5 percent. The age group with the highest cost per beneficiary, six through 17 years, also had a modest increase for CY05 to CY07 of \$208 or four percent. The group with the smallest cost per beneficiary, 60 years or older, had the largest percentage increase from CY05 to CY07 of \$137 or 5.7 percent. This same group also represented the largest increase from CY06 to CY07 of \$98 or four percent. (We examine the 60 and older group in further detail below.) The most stable group is 18 through 59 years, for which costs remain virtually unchanged.

**Figure 3.5**

Statewide Comparison of Cost Per Beneficiary Served by Age			
Age Group	Average Payment CY05	Average Payment CY06	Average Payment CY07
0-5	\$3,099	\$3,261	\$3,269
6-17	\$5,209	\$5,425	\$5,417
18-59	\$3,581	\$3,643	\$3,619
60+	\$2,384	\$2,423	\$2,521

Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figure 3.6 below displays the relationship of age to cost per beneficiary by county size. Cost per beneficiary served displays high variability by county size for different age groups. However, costs for most age groups continued to increase over the period regardless of county size — up to \$2,100 or 36.4 percent for ages six through 17 years for small-rural MHP size for CY05 through CY07. While some MHPs experienced decreases during this timeframe for each age group, they were not very significant in

number and percentage — with the exception of the “very large” category (i.e., Los Angeles), showing \$341 or 7.9 percent less for the zero through five years age group.

**Figure 3.6**

<b>A Comparison of Cost Per Beneficiary Served by Age and MHP Size</b>				
<b>Age Group</b>	<b>MHP Size</b>	<b>Average Payment CY05</b>	<b>Average Payment CY06</b>	<b>Average Payment CY07</b>
0-5	Small-Rural	\$2,915	\$2,952	\$3,534
	Small	\$2,005	\$2,394	\$2,251
	Medium	\$2,901	\$3,177	\$3,418
	Large	\$2,730	\$2,835	\$2,962
	Very Large (Los Angeles)	\$4,291	\$4,384	\$3,950
6-17	Small-Rural	\$5,767	\$6,723	\$7,867
	Small	\$3,948	\$4,542	\$4,081
	Medium	\$5,050	\$5,304	\$5,450
	Large	\$4,633	\$4,838	\$4,944
	Very Large (Los Angeles)	\$6,292	\$6,381	\$6,178
18-59	Small-Rural	\$3,076	\$3,073	\$3,212
	Small	\$2,885	\$3,068	\$2,706
	Medium	\$4,150	\$4,323	\$4,225
	Large	\$3,582	\$3,525	\$3,501
	Very Large (Los Angeles)	\$3,485	\$3,661	\$3,748
60+	Small-Rural	\$3,059	\$2,913	\$2,967
	Small	\$2,565	\$2,705	\$2,505
	Medium	\$3,251	\$3,469	\$3,502
	Large	\$2,444	\$2,364	\$2,491
	Very Large (Los Angeles)	\$1,901	\$2,023	\$2,155

Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figures 3.7 and 3.8 are different displays of the same data and illustrate cost per beneficiary aged 60 years or older by county size. Costs from CY05 to CY07 rose regardless of county size — from “small-rural” to “very large” (i.e., Los Angeles). However, the largest increases for this timeframe were demonstrated in the “medium” and “very large” counties — with 16 percent and 22 percent, respectively. As the figures below reflect, the medium MHP size group represents the highest cost per beneficiary

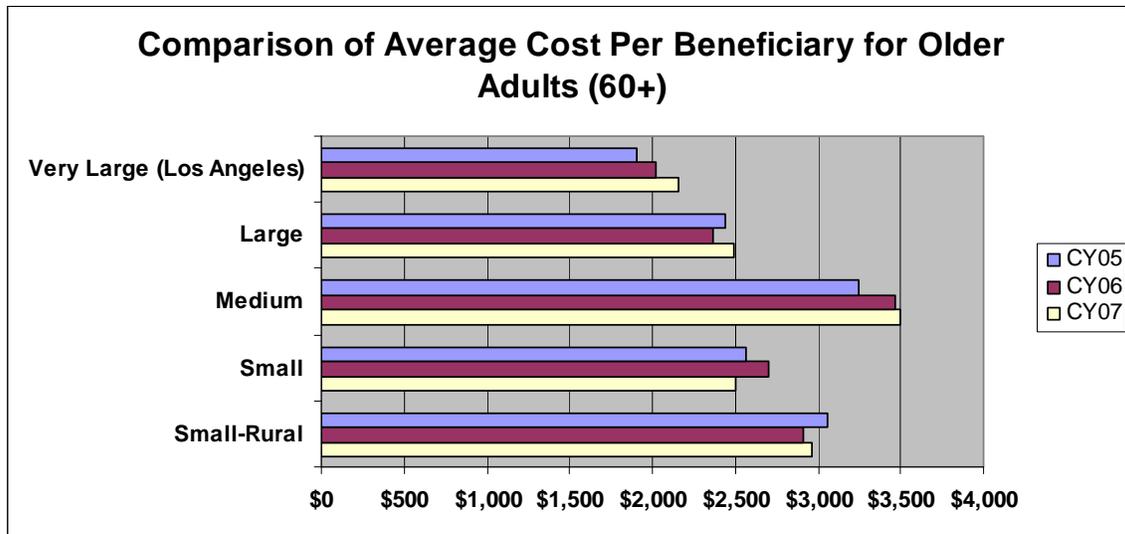
age 60 years or older for three years running — \$3,251 in CY05, \$3,604 in CY06 and \$3,758 in CY07.

**Figure 3.7**

<b>Cost Per Beneficiary Age 60+ by County Size</b>			
<b>MHP Size</b>	<b>CY05</b>	<b>CY06</b>	<b>CY07</b>
Small-Rural	\$3,059	\$2,913	\$2,967
Small	\$2,565	\$2,705	\$2,505
Medium	\$3,251	\$3,469	\$3,502
Large	\$2,444	\$2,364	\$2,491
Very Large (Los Angeles)	\$1,901	\$2,023	\$2,155

Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

**Figure 3.8**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

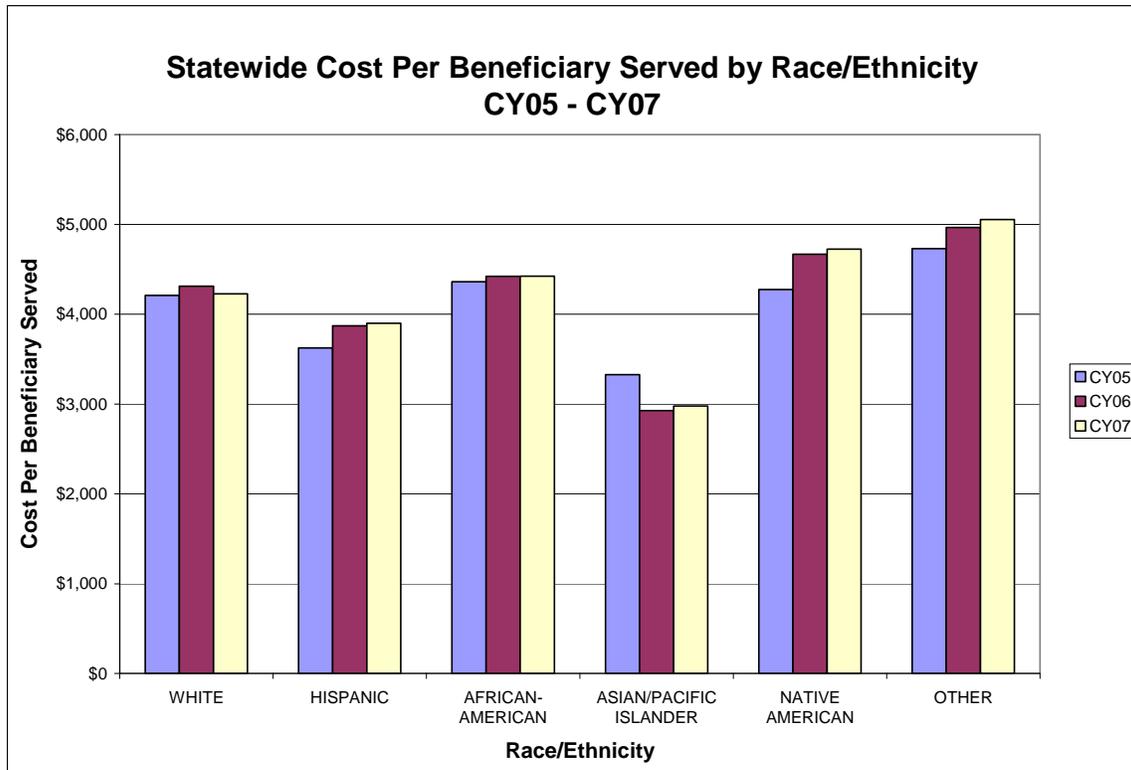
### Section 3.5: Cost Per Beneficiary Served – Race/Ethnicity

Only Asian/Pacific Islander beneficiaries, who have the lowest cost per beneficiary for three years, show a decrease in cost per beneficiary from CY05-CY07.

Cost per beneficiary served over the last three years shows consistent variation across race/ethnic groups, but little fluctuation within a specific group. As illustrated in Figure 3.9 below, statewide the cost per beneficiary has slowly but steadily increased for Hispanics, Native American and Other populations. The amount has remained

relatively stable for Whites and African Americans. However, only the Asian/Pacific Islander population shows a marked decrease in cost per beneficiary from CY05 to CY07. The Asian/Pacific Islander population also had the lowest cost per beneficiary for three consecutive years.

**Figure 3.9**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figure 3.10 below presents a more detailed statewide analysis of the count, average payments and penetration data comparing Hispanic and White populations for CY05 through CY07. We can draw two conclusions from the data:

- The penetration rate for White beneficiaries is markedly higher than for Hispanic beneficiaries over each of the last three years.

- The average payment for White beneficiaries continues to exceed that for Hispanic beneficiaries; however unlike gender the gap is narrowing.

Statewide data continues to indicate a substantial disparity based on race/ethnicity. The Hispanic penetration rate ratio in CY07 was 0.28 — that is, for every 100 White beneficiaries served, 28 Hispanic beneficiaries were served. This disparity was also reflected in the average payment for Hispanic versus White beneficiaries, with Hispanics receiving 92 cents per every \$1.00 for Whites. In CY07, the average payment for White beneficiaries exceeded the average payment for Hispanic beneficiaries by \$351. While significant, this difference shows less disparity than exhibited in previous years — a difference of \$459 in CY07 and \$577 in CY05.

**Figure 3.10**

Statewide Comparison of Beneficiary Count, Average Payment and Penetration Ratios by Race/Ethnicity						
	Count of Beneficiaries Served		Average Payment Per Beneficiary Served		Ratio of Hispanic vs. White	
	Hispanic	White	Hispanic	White	Penetration Rate	Average Payment
CY05	109,751	179,501	\$3,601	\$4,178	0.25	0.86
CY06	116,712	172,849	\$4,022	\$4,481	0.26	0.90
CY07	120,591	164,717	\$4,185	\$4,536	0.28	0.92

### Section 3.6: Service Delivery Patterns

Three calendar years of data show consistent disparities in service delivery patterns based on ethnicity and gender.

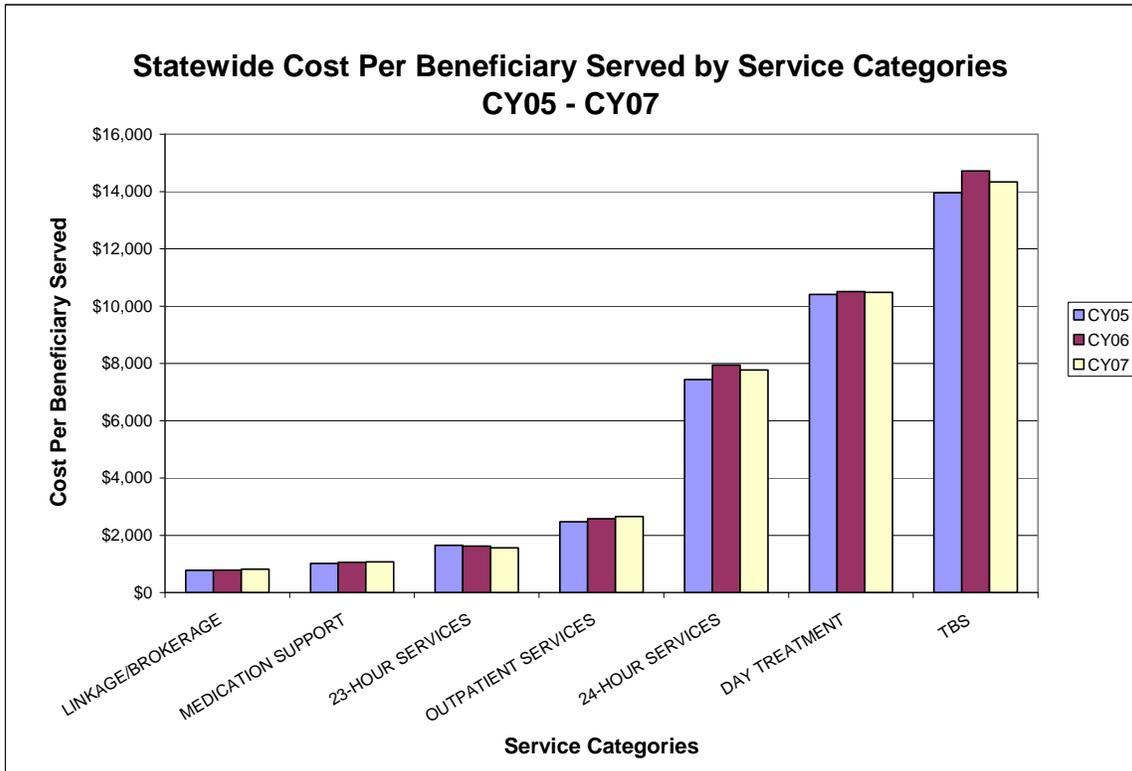
CAEQRO examined statewide cost per beneficiary by various service categories over a three year period. We used the following categories as defined by SD/MC — combining mental health service modes and service functions:

- 24-hour services — local hospital inpatient, hospital administrative days, psychiatric health facilities, adult crisis residential, adult residential and professional inpatient visits
- 23-hour services and crisis stabilization
- Day treatment
- Linkage/brokerage
- Outpatient services — mental health services and crisis intervention (often used for an unplanned outpatient contact)

- Therapeutic Behavioral Services (TBS)
- Medication support

As is clear in Figure 3.11, the statewide cost per beneficiary has remained stable within most service categories from CY05 through CY07. However, both 24-hour services and TBS show a slight spike during CY06.

**Figure 3.11**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

### Statewide Service Patterns: Gender

Figures 3.12 and 3.13 below show service patterns statewide and CANOLA by gender for CY07. As we had noted in CY05 and CY06, both average and median payments per beneficiary are greater for male than for female beneficiaries for each service category — indicating male beneficiaries continue to receive more services of each type than do female beneficiaries. Male and female beneficiaries continued largely similar utilization patterns as in prior years for both the most frequently utilized services (i.e., outpatient) and high-cost services (i.e., 24-hour, 23-hour and day treatment).

**Figure 3.12**

Statewide Service Patterns by Gender CY07								
Service Activity	FEMALE				MALE			
	Total Beneficiaries Served	Average Payment per Beneficiary	Median Payment per Beneficiary	Average Payment Standard Deviation	Total Beneficiaries Served	Average Payment per Beneficiary	Median Payment per Beneficiary	Average Payment Standard Deviation
24 HOUR SERVICES ***	16,599	\$7,694	\$3,750	\$11,044	15,818	\$9,014	\$4,673	\$11,930
23 HOUR SERVICES ***	10,863	\$1,528	\$1,082	\$2,021	10,753	\$1,831	\$1,323	\$2,656
DAY TREATMENT***	3,394	\$10,359	\$6,530	\$10,809	5,217	\$11,822	\$8,300	\$11,181
LINKAGE/BROKERAGE ***	93,855	\$819	\$256	\$1,821	92,594	\$939	\$298	\$1,959
OUTPATIENT SERVICES ***	179,405	\$2,524	\$896	\$4,957	169,606	\$3,192	\$1,207	\$5,890
TBS **	1,379	\$14,267	\$9,478	\$15,877	2,385	\$16,019	\$11,123	\$16,722
MEDICATION SUPPORT ***	120,352	\$1,077	\$676	\$1,599	108,723	\$1,233	\$758	\$1,754

\*\*\* p<0.0001, \*\* p<0.01 for differences in average payment per beneficiary between male and female.  
 Note: Represents a duplicate population

**Figure 3.13**

CANOLA Service Patterns by Gender CY07								
Service Activity	FEMALE				MALE			
	Total Beneficiaries Served	Average Payment per Beneficiary	Median Payment per Beneficiary	Average Payment Standard Deviation	Total Beneficiaries Served	Average Payment per Beneficiary	Median Payment per Beneficiary	Average Payment Standard Deviation
24 HOUR SERVICES ***	11,509	\$7,733	\$3,777	\$11,003	10,630	\$8,801	\$4,740	\$11,447
23 HOUR SERVICES ***	9,016	\$1,577	\$1,069	\$2,149	8,709	\$1,939	\$1,324	\$2,884
DAY TREATMENT***	2,357	\$10,081	\$6,037	\$11,052	3,667	\$11,788	\$8,256	\$11,337
LINKAGE/BROKERAGE ***	65,289	\$874	\$263	\$1,936	63,905	\$1,024	\$322	\$2,104
OUTPATIENT SERVICES ***	123,893	\$2,371	\$839	\$5,066	113,683	\$2,950	\$1,096	\$5,892
TBS **	971	\$13,982	\$9,361	\$16,062	1,638	\$14,278	\$9,760	\$15,237
MEDICATION SUPPORT ***	87,473	\$1,052	\$652	\$1,507	76,547	\$1,217	\$740	\$1,738

Note: Represents a duplicate population

## Statewide Service Patterns: Race/Ethnicity

CAEQRO performed an analysis of each type of service received by beneficiary race/ethnicity over the past three years. Our objective was not only to compare groups by average cost per beneficiary, but also to begin to identify noteworthy changes over time by service category. With three years of data shown in these analyses, some trends are starting to emerge. In CY07:

- Hispanic beneficiaries sustain the lowest average cost per beneficiary in three service categories: 24 hour, 23 hour, linkage/brokerage.
- Asian/Pacific Islander beneficiaries sustain the lowest average cost per beneficiary in three service categories: day treatment, outpatient, medication support.
- African American beneficiaries sustain the lowest average cost per beneficiary in one service category: TBS.
- Beneficiaries defined as “Other” sustain the highest average cost per beneficiary in all service categories except medication support, where Native Americans receive the highest cost per beneficiary.

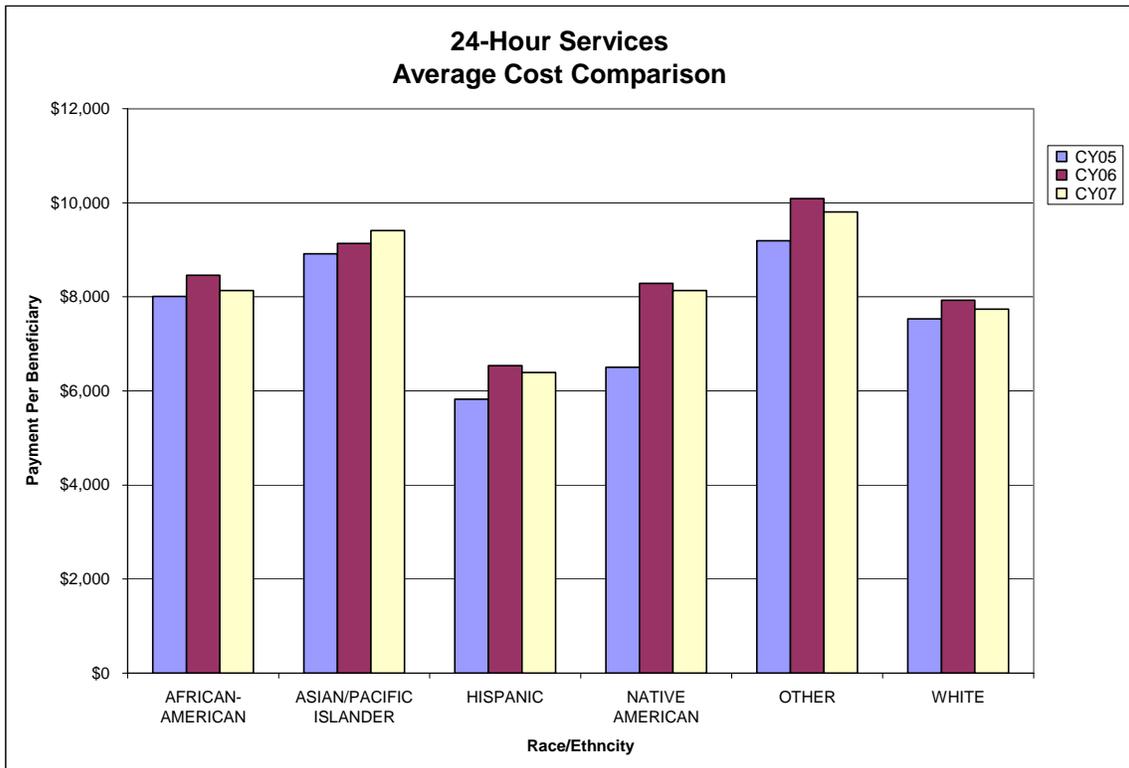
For three consecutive years:

- Asian/Pacific Islander beneficiaries have had the lowest cost per beneficiary for medication support, while Native American beneficiaries have had the highest cost.
- Hispanic beneficiaries have the lowest cost per beneficiary for 24-hour services, 23-hour services and linkage/brokerage.

The following figures display these findings.

Figure 3.14 below shows that 24-hour services remained relatively unchanged in CY07 and that all ethnic groups continued to exceed the average cost (i.e., cost per beneficiary) of Hispanic beneficiaries, which was \$6,394. The “Other” population continued to have the highest average cost of 24-hour services for CY07 (\$9,805), followed by the Asian/Pacific Islander beneficiary group (\$9,409). The Native American beneficiary group showed the greatest increase in cost per beneficiary served for 24-hour services from CY05 through CY07.

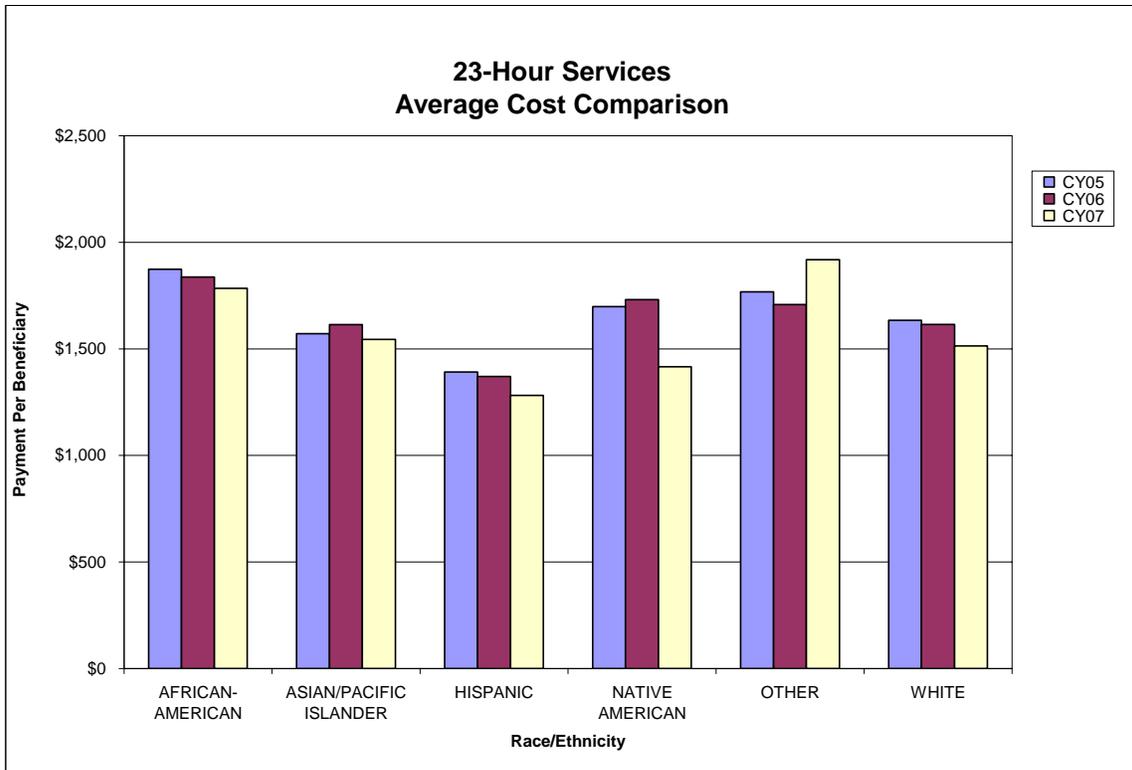
**Figure 3.14**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figure 3.15 below shows that the cost of 23-hour services declined in CY07 from CY06 for five of the six beneficiary groups: African-American, Asian/Pacific Islander, Hispanic, Native American and White. The largest decrease in average cost (i.e., cost per beneficiary) was apparent in the Native American beneficiary group, which dropped from \$1,731 in CY06 to \$1,416 in CY07. As with 24-hour services, the Hispanic beneficiary population also trended from CY05 to CY07 as the group having the lowest average cost for 23-hour services, which fell to \$1,282 in CY07. Conversely, the group labeled “Other,” who showed the highest average cost per beneficiary in CY07 among all six groups, represented the sole population to show an increase, from \$1,707 in CY06 to \$1,919 in CY07.

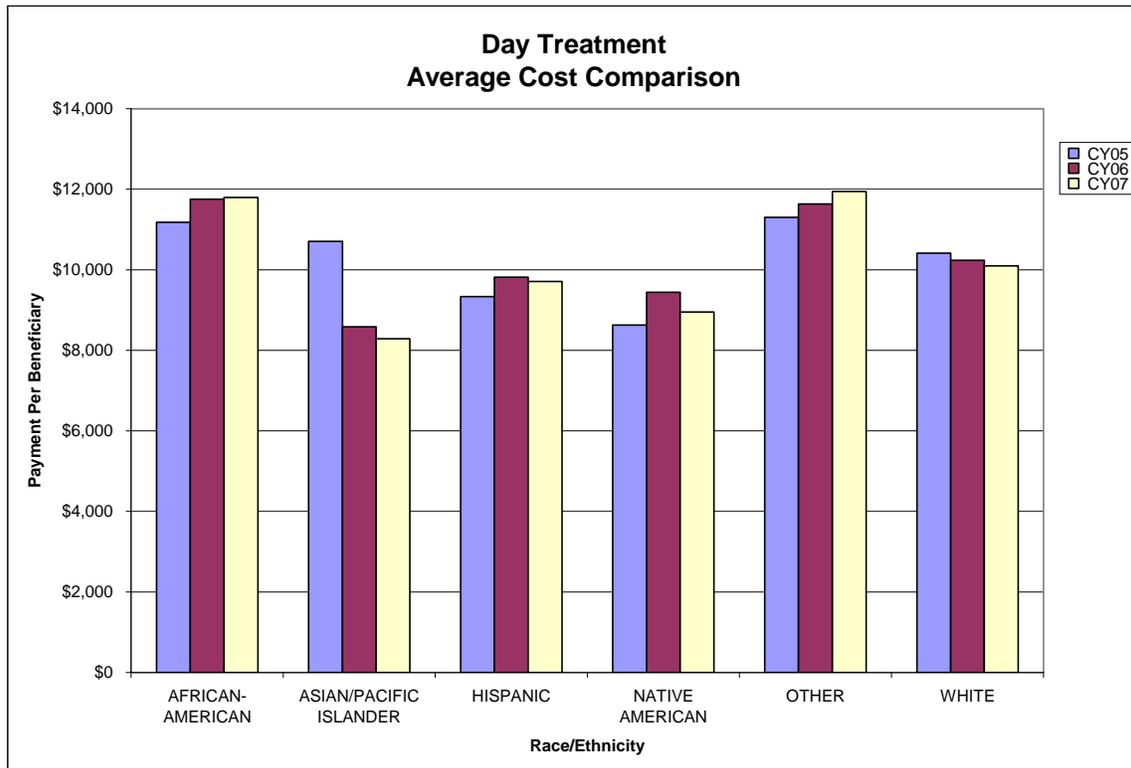
**Figure 3.15**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figure 3.16 below displays average cost of service for day treatment. These costs remained relatively the same in CY07 from CY06 for all groups. In CY07, the “Other” population received the highest average cost of \$11,949, followed closely by the African-American beneficiary population at \$11,798. Average costs for the Asian/Pacific Islander and Native American beneficiary groups dropped just slightly in CY07 from CY06. The Asian/Pacific Islander beneficiary group had the lowest average cost of day treatment of \$8,286.

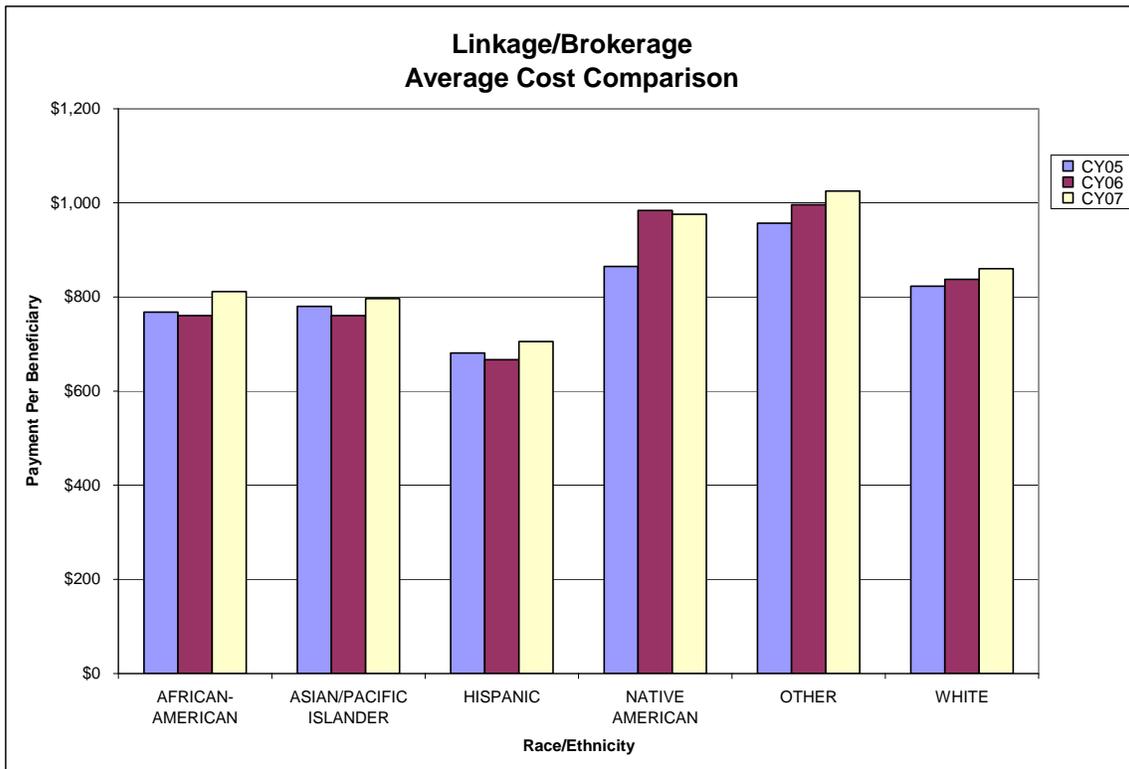
**Figure 3.16**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figure 3.17 below shows the average cost comparison for linkage/brokerage. Average costs were up in CY07 from CY06 for five of the six populations. The greatest increase appears in the African-American beneficiary group, which rose from \$760 to \$812. The “Other” group continued to have in CY07 the highest average cost of \$1,025, followed by the Native American group with an average cost of \$976. The Native American beneficiary group was the only group to note a decrease in CY07 from CY06, which was very slight. Consistent with 24-hour and 23-hour services, the Hispanic group received the lowest average cost in CY07 of \$705.

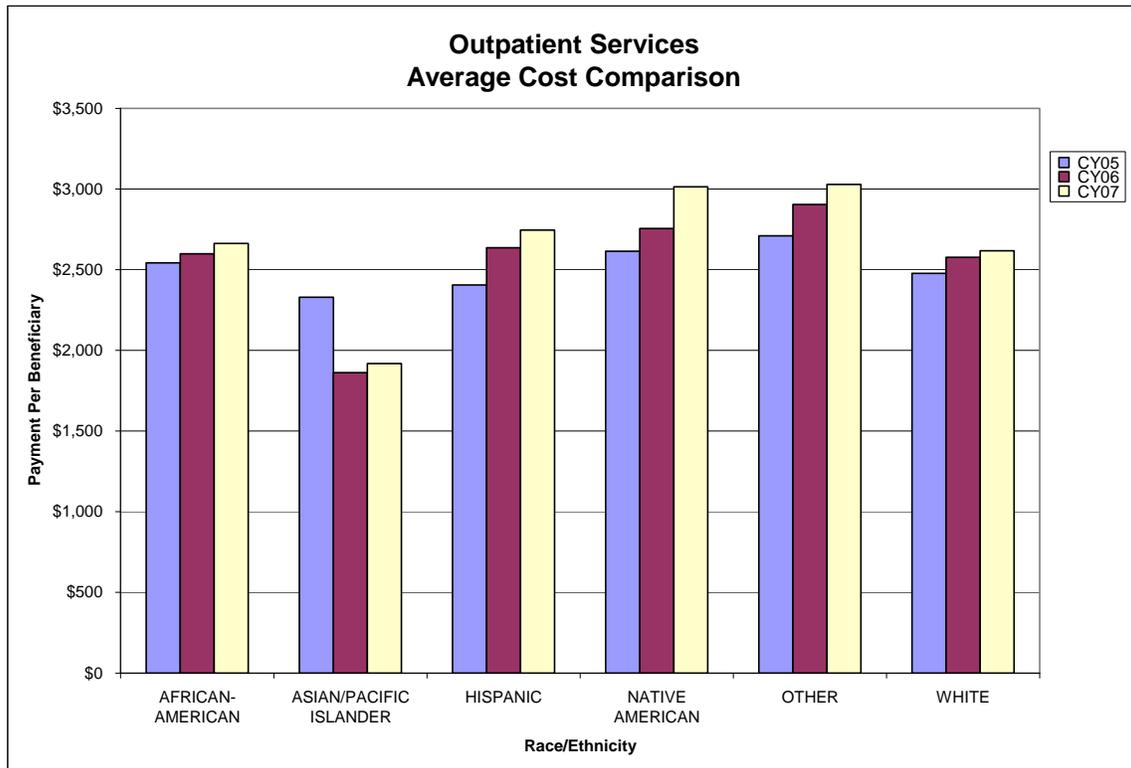
**Figure 3.17**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figure 3.18 below illustrates the average cost comparison among ethnic groups for outpatient services. The average cost rose in CY07 from CY06 for each group, with the greatest increases in the Hispanic, Native American, and Other beneficiary groups. The Other and Native American beneficiary populations also represented in CY07 the highest average costs for outpatient services of \$3,029 and \$3,014, respectively. As in CY05 and CY06, the Asian/Pacific Islander beneficiary population had the lowest average cost — \$1,918 — for outpatient services.

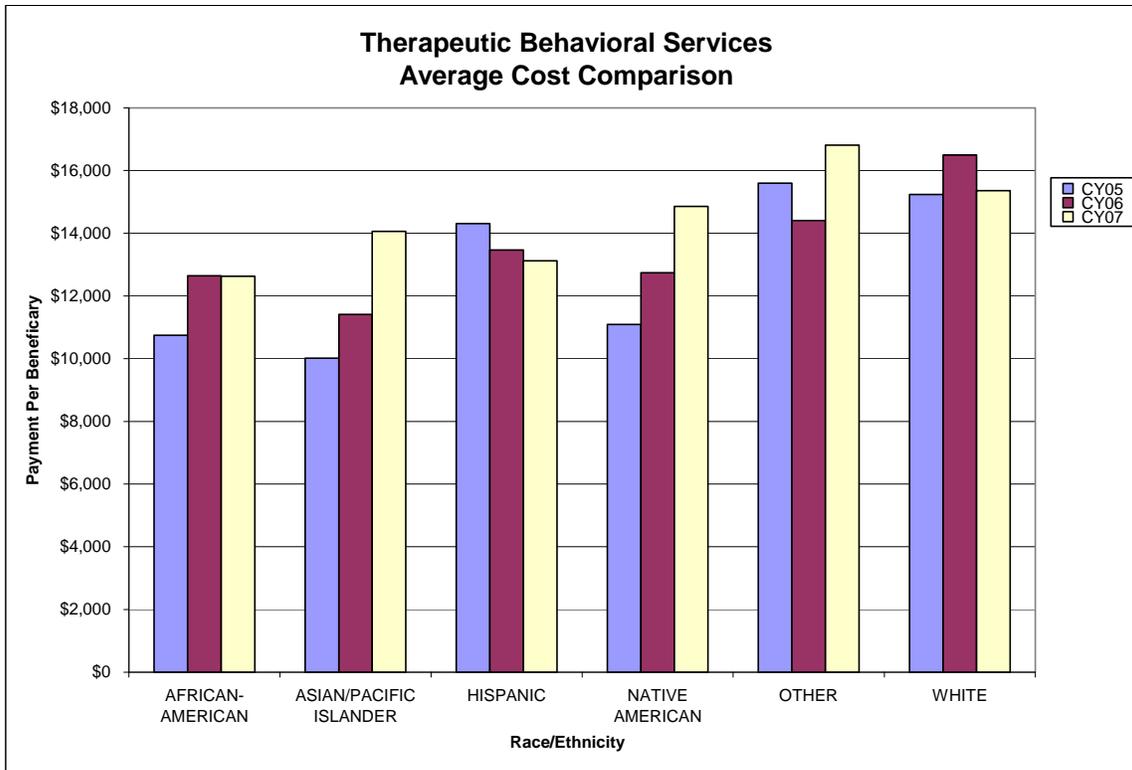
**Figure 3.18**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figure 3.19 below displays the average cost comparison for TBS. The average cost rose in CY07 from CY06 for three beneficiary groups: Asian/Pacific Islander, Native American, and Other. The White beneficiary population showed a decrease from \$16,497 in CY06 to \$15,359 in CY07. Despite this decrease, however, the White population continued to have in CY07 a higher average cost (i.e., cost per beneficiary) than the remaining group. The only exception is the “Other” population, which received services averaging \$16,811 in CY07. The Asian/Pacific Islander and Native American beneficiary groups rose in average cost continuously from CY05 to CY07 with average costs in CY07 over \$14,000 for each group. The African-American and Hispanic beneficiary populations show the most stability, especially from CY06 to CY07.

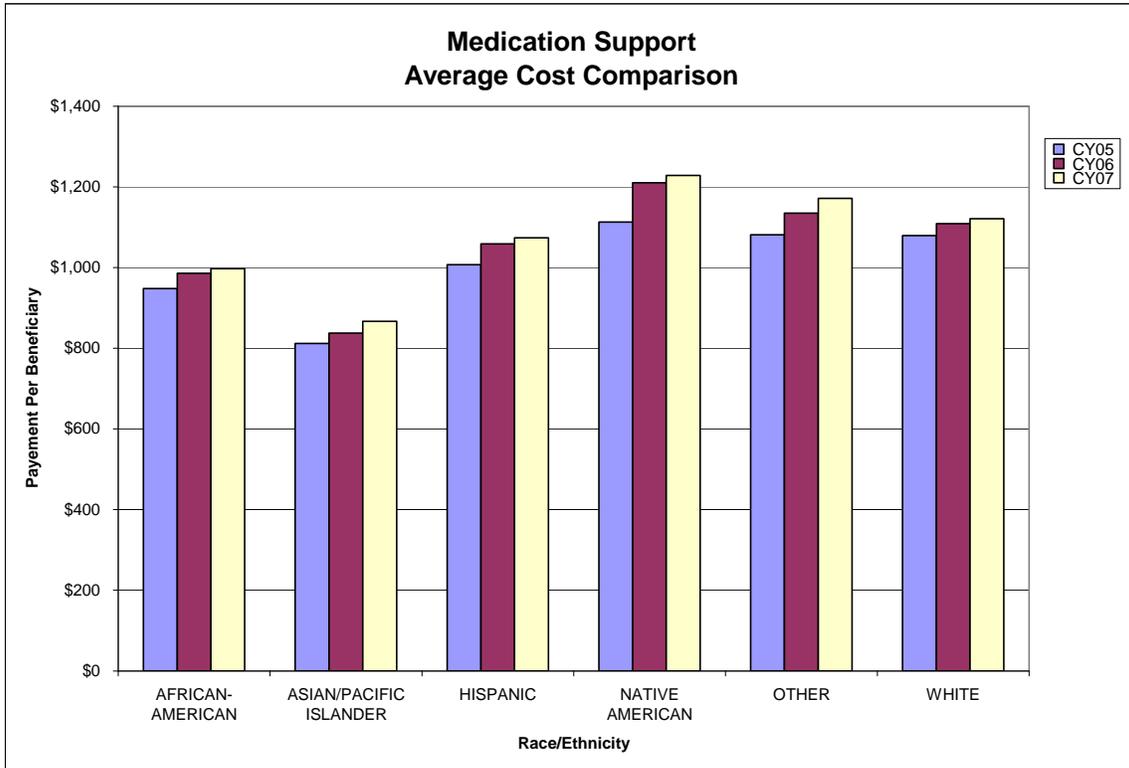
**Figure 3.19**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

Figure 3.20 below shows the average cost comparison for medication support. Average costs (i.e., cost per beneficiary) for this service rose for each group from CY05 and CY06 costs. The Native American beneficiary group continued to have in CY07 the highest average cost of \$1,228, while the Asian/Pacific Islander beneficiary group continued to have the lowest average cost of \$867.

**Figure 3.20**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

### Section 3.7: High-cost Beneficiaries

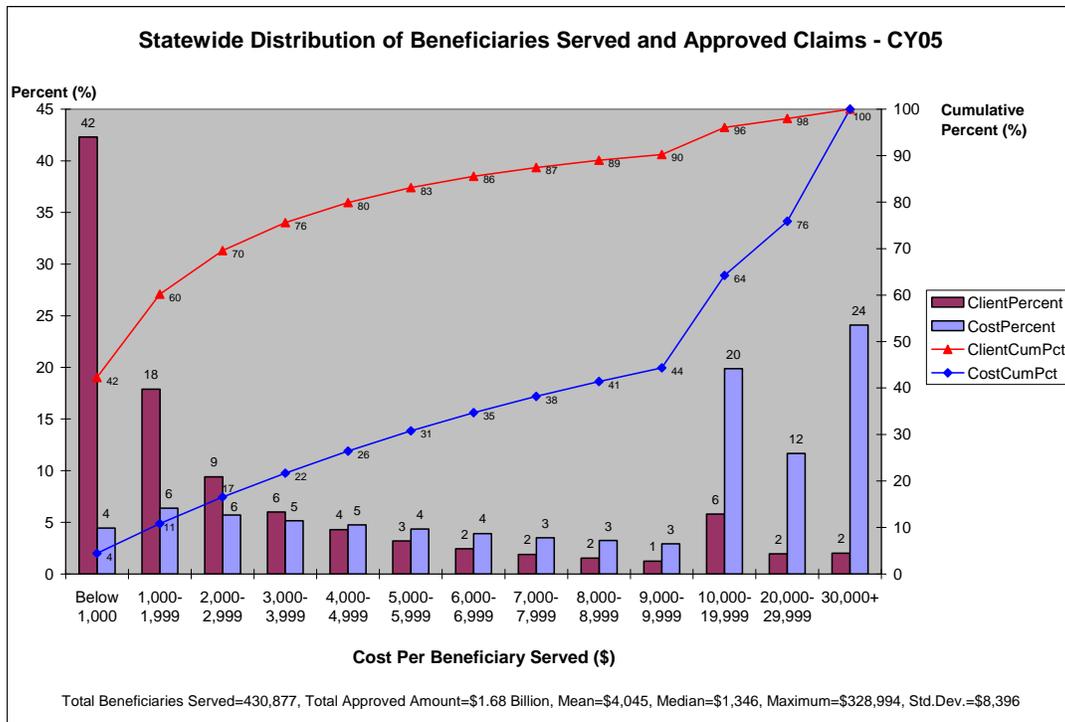
Over the past three years, the total percentage of Medi-Cal dollars supporting high-cost beneficiaries has steadily increased and based on CY07 claims is 26 percent.

As part of an analysis of service utilization, CAEQRO compiled claims data to identify the number and percentage of Medi-Cal beneficiaries statewide who received a disproportionately high dollar amount of services. A stable pattern over the last three calendar years of data reviewed shows that roughly two percent of the

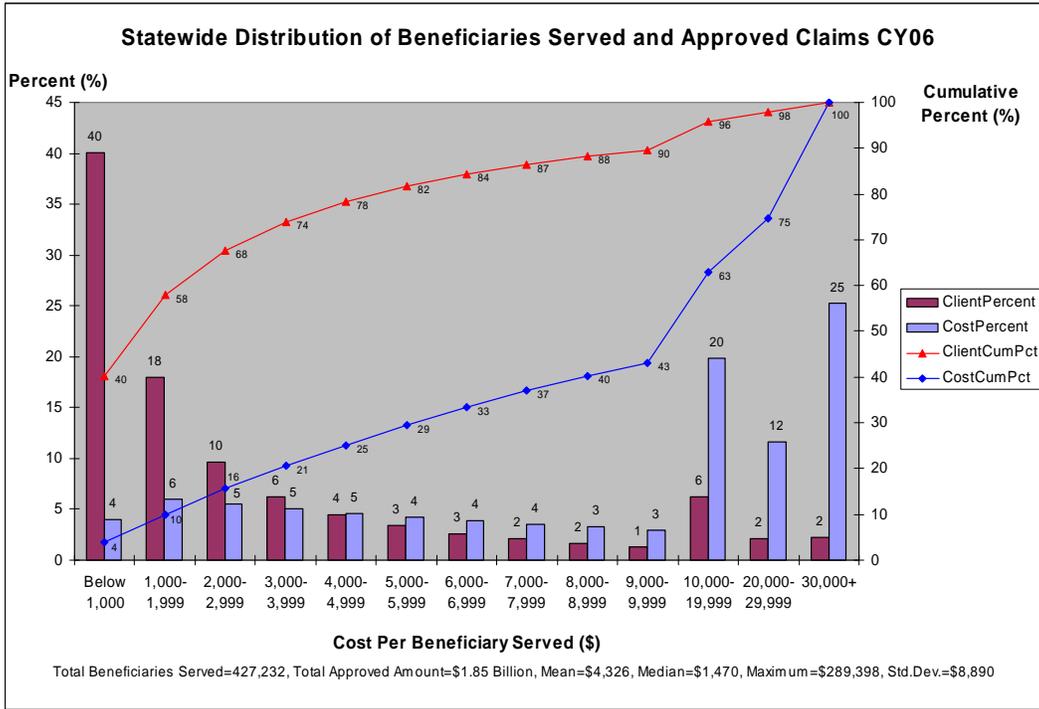
beneficiaries served accounted for one-quarter of the Medi-Cal expenditures. For purposes of this analysis, CAEQRO defined “high cost beneficiaries” as those whose services met or exceeded \$30,000 in the calendar year examined – this figure represents roughly three standard deviations from the average cost per beneficiary statewide.

Figures 3.21, 3.22 and 3.23 below illustrate the consistency from CY05 to CY07 in the number and costs of high-cost beneficiaries. Statewide, the trend appears to be slowly worsening — in CY05 24 percent of total Medi-Cal dollars supported two percent of beneficiaries consuming over \$30,000. In CY06 25 percent of the dollars supported high-cost beneficiaries and in CY07 the figure grew to 26 percent.

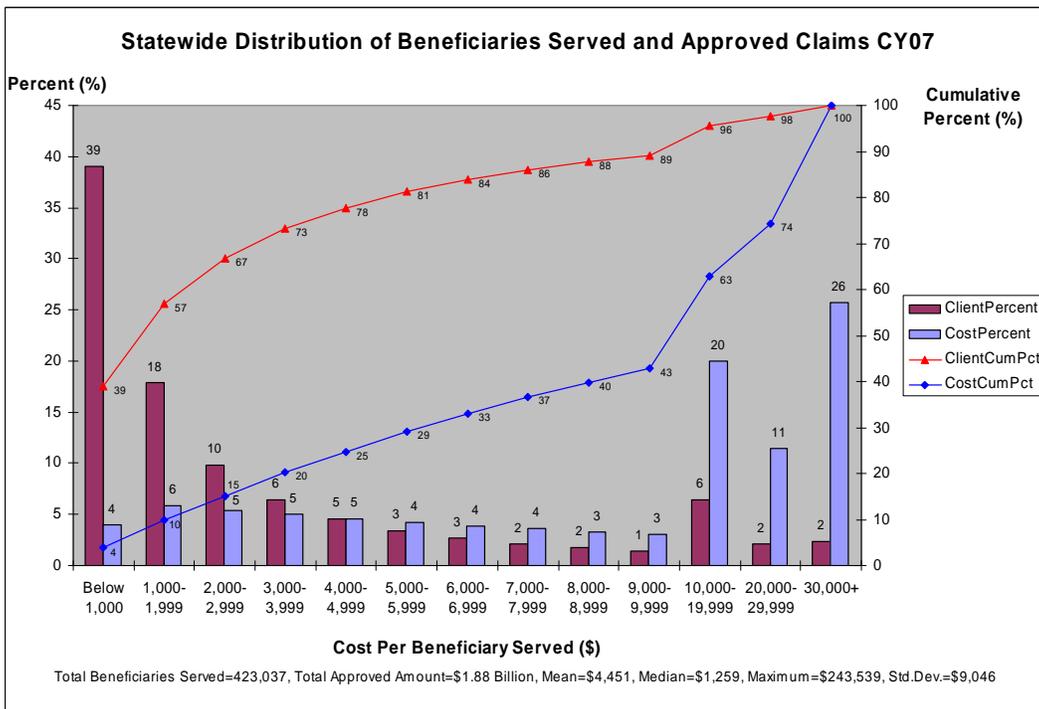
**Figure 3.21**



**Figure 3.22**



**Figure 3.23**



## Section 3.8: Foster Care Analysis

With a few exceptions, data for the foster care beneficiary population has remained unchanged from CY05 to CY07.

While foster care beneficiaries do not represent a significant percent of the eligible population (averaging only about 80,000 in recent years), they are one of the most high-risk populations in the state. Consequently, over the past three years, CAEQRO has performed an analysis of foster care beneficiaries to encourage MHPs to design programs that can best reach and

benefit this high-priority group.

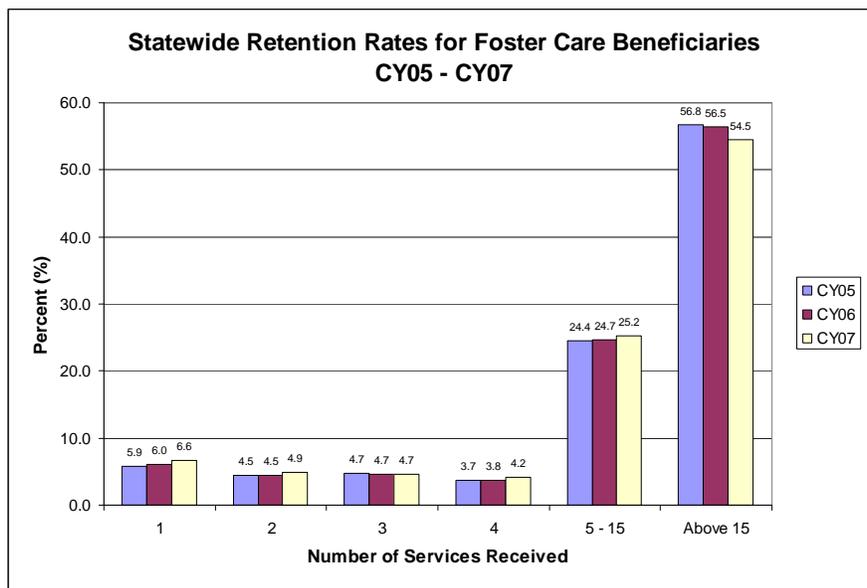
For this year’s statewide report, we performed a comparative analysis building on our FY06-07 analyses to identify any changes from CY05 and CY06 to CY07. We did not expect significant change from previous years’ findings and indeed noted that patterns remained unchanged. Of note when considering utilization trends for this population, the statewide foster care beneficiaries have shown a slow but steady decline: from 81,468 in CY05 to 78,833 in CY06 to 75,874 in CY07 — a decrease of 5,594 beneficiaries or 6.9 percent from CY05 to CY07.

In the remainder of this section, we analyze several measures of foster care beneficiary access, statewide and by race/ethnic group.

### Retention Analysis

Figure 3.24 below illustrates that the percentage of foster care beneficiaries receiving more than 15 services declined slightly from CY05 to CY06 to CY07, but has remained over 50 percent each year. The second largest group again in CY07 received between five and 15 services. These figures indicate overall a consistent pattern of retention in the three-year period.

**Figure 3.24**

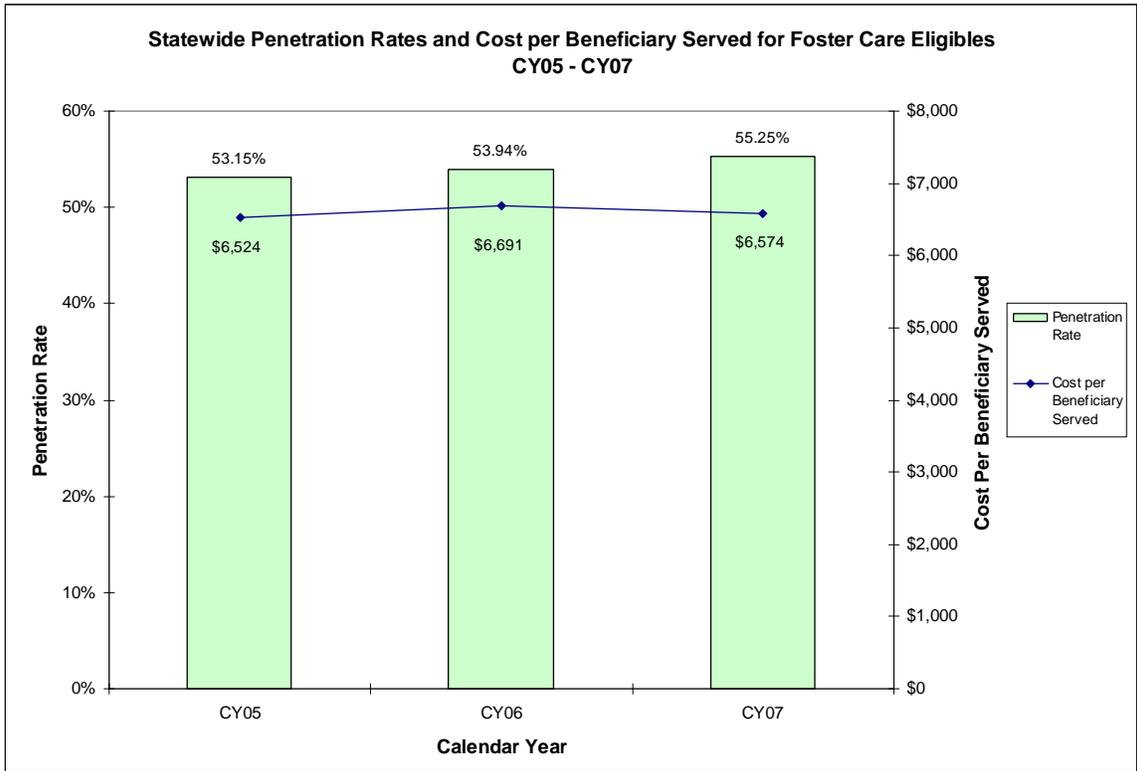


### Penetration Rate and Cost Per Beneficiary

Figure 3.25 below shows the overall stability of statewide penetration for foster care beneficiaries from CY05 through CY07. The total number of beneficiaries served in CY07 was 41,923, a decrease from 42,525 in CY06 and from 43,299 in CY05. The overall decrease in foster care beneficiaries served in CY07 from CY05 was 1,376 beneficiaries or 3.2 percent — notably higher than the 1.8 percent decrease in statewide total beneficiaries served in CY07 from CY05.

Figure 3.25 also illustrates that the cost per beneficiary on a statewide basis remained largely stable in CY07 at \$6,574.

**Figure 3.25**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI

### Race/Ethnicity

Figure 3.26 below displays relative stability statewide for eligible foster care beneficiaries by race/ethnicity, but notes reductions for some groups in CY07 from CY05. Whites represented the most significant decrease in eligible beneficiaries of 5,352 or 11.9 percent and African-Americans also showed a notable decrease of 1,241 or 8.7 percent.

**Figure 3.26**

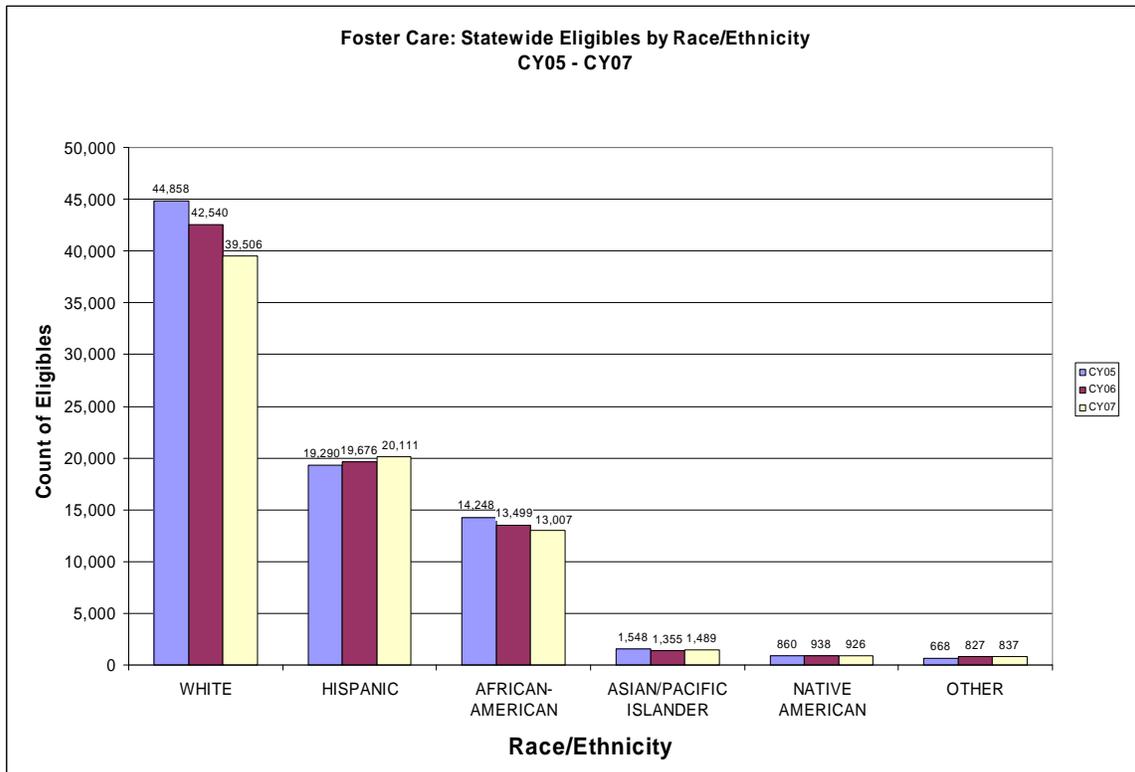
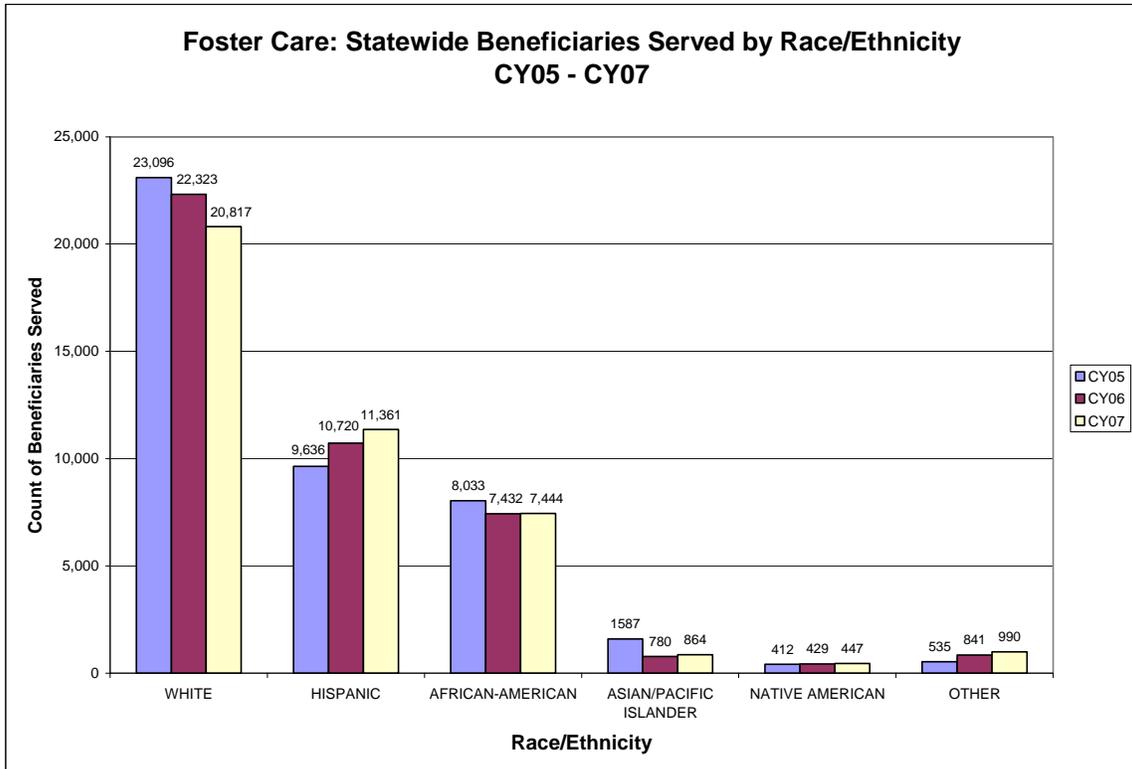


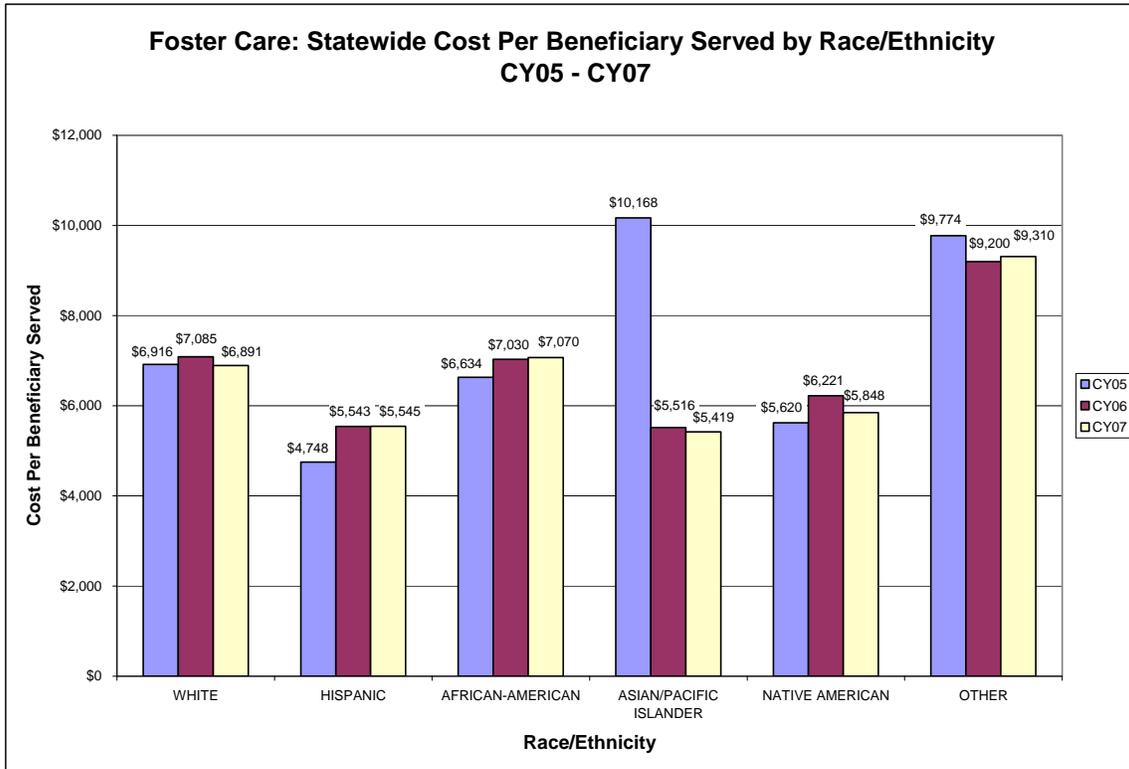
Figure 3.27 below shows that the patterns of beneficiaries served by ethnic group is largely consistent with that of the eligible beneficiaries displayed in Figure 3.26, with the exception of the relatively small Asian/Pacific Islander beneficiary group. This group decreased by 59 beneficiaries or 3.8 percent in CY07 from CY05. However, the beneficiaries served for this group had a substantial decrease for that same timeframe – 723 fewer beneficiaries or 45.6 percent.

**Figure 3.27**



Cost per beneficiary served by race/ethnicity largely replicated the statewide increase from CY05 to CY07, as shown in Figure 3.28 below. Asian/Pacific Islander beneficiaries are again in this category a notable exception — with cost per beneficiary having dropped \$4,749 or 46.7 percent in a two-year period.

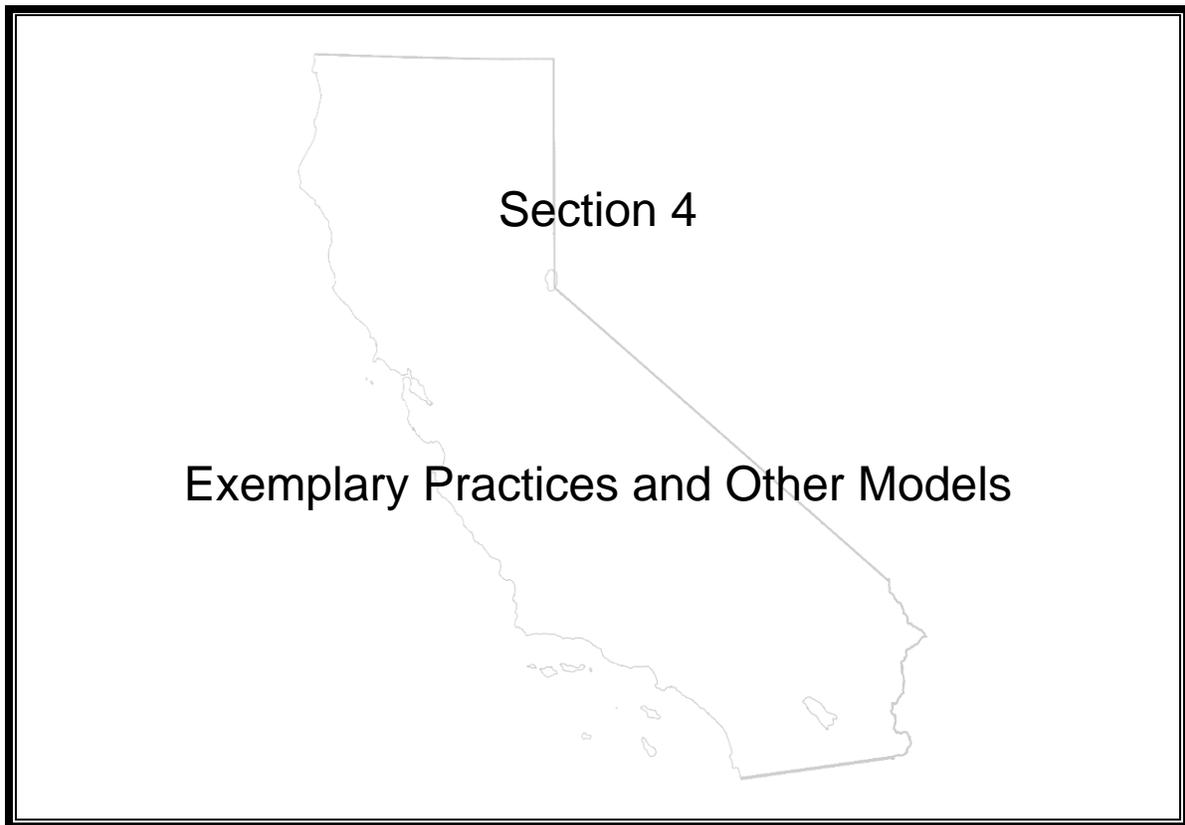
**Figure 3.28**



Note: CY06 and CY07 dollars adjusted to CY05 dollars using California CPI



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 4.1: Overview

In previous years, we broadly defined exemplary practices to acknowledge MHPs for initiatives showing great potential to improve their service delivery system. Consistent with our approach in previous years, we wanted to continue acknowledging MHPs that had recently implemented practices or processes with great promise to improve clinical or administrative operations. In particular, we chose examples that appear to be replicable either in whole or in part by other MHPs.

To accomplish these objectives, we have identified both Exemplary Practices and Processes, as well as Noteworthy initiatives that warranted recognition:

- **Exemplary Practices and Processes** — implemented or improved in FY07-08 and have either demonstrated or have great promise to achieve measurable results:
  - *Kern MHP*, which we identified in our FY06-07 Statewide Report for a noteworthy implementation of the Anasazi information technology system
  - *Los Angeles MHP*, whose Strategies for Total Accountability and Total Success process that emphasizes management collaboration, scrutiny and oversight
  - *Madera MHP*, which leveraged both MHSA funds and a strong contract provider relationship
  - *Riverside MHP*, which has a unique career ladder for consumer employees
  
- **Noteworthy Practices and Processes** — implemented or improved in FY07-08 and demonstrate initiatives that other MHPs may adopt for system-wide improvements:
  - *Humboldt MHP*, which has a coordinated effort to evaluate a number of evidence-based practices (EBPs)<sup>9</sup>
  - *San Bernardino MHP*, which has implemented the first stage of a comprehensive initiative to integrate all health care services
  - *Santa Clara MHP*, whose consumer health screening initiative reflects cost data and integrates mental and physical health services
  - *Stanislaus MHP*, which has a unique consumer-operated “warm line”

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<sup>9</sup> Each EBP has its own set of fidelity and outcomes measures, which are not addressed in this summary. We do want to acknowledge Humboldt MHP's fine efforts in implementing these research-backed models.

We were also struck by the ability of MHPs in varying geographic regions, with diverse demographics and often with limited resources, to work collaboratively and — in many cases — cross functionally, to implement notable initiatives in two key areas:

- **Wellness and recovery-oriented programs.** In addition to Madera and Riverside MHPs, other MHPs used Mental Health Services Act (MHSA) funds to promote consumer involvement in service delivery and recovery-oriented programming. Section 2.2 features examples of these MHPs.
- **Data-driven performance management.** As discussed in Sections 2 and 3, the Small County Emergency Risk Pool clinical Performance Improvement Project on reducing rehospitalizations brought together 17 small counties and could produce performance improvements based on data analysis. As we also discuss in Section 2, other MHPs were beginning to demonstrate data use within their Quality Improvement (QI) Work Plan, QI Committee or management initiatives.

The following pages include a variety of model programs and processes in alphabetical order for ease of reference.

## Section 4.2: Exemplary Practices

The following pages include descriptions of the eight model practices and processes that we have identified for our FY07-08 Statewide Report.

**Noteworthy Process****Humboldt MHP*****Quality Improvement Process  
for Evidence-based Practices*****Overview**

Humboldt Mental Health Plan (MHP), which is part of an integrated county Department of Health and Human Services (DHHS), has implemented a process for monitoring and improving the quality of evidence-based practices (EBPs). This cross-functional process combines the collection and regular review of

the demographics and outcomes for each EBP and development of a feedback loop for program change and improvement. The process emerged following the implementation of four EBPs by Children, Youth & Family Services and the initiation of data collecting and reporting by DHHS's Research & Evaluation Unit. Through the identifying, collecting, analyzing and reviewing data for each EBP, the MHP has been able to monitor and improve their process for admitting and treating participants throughout EBP programs.

**Benefits**

- Facilitates system-wide integration of clinical data which promotes cross-functional communication and coordination among treatment partners
- Provides a regular and ongoing forum for improving access to and the quality of research-backed mental health models
- Reduces silos of information and integrates programs through the improved management and linkage of data
- Strengthens relationships among partners and ability to respond to collaborative grant proposals requiring outcomes data

**Background**

During CAEQRO's FY06-07 site review, we learned that DHHS — which includes Mental Health, Social Services and Health departments — had developed a Research & Evaluation Unit to collect EBP data, track fidelity to the EBP model, and report outcomes. Humboldt is the smallest county to dedicate a unit to data collection and analysis, as well as to produce outcomes reports for EBPs. This unit identified appropriate measures for each of the EBPs that the Mental Health Branch had implemented in Children, Youth and Family Services. Staff had begun to create databases for collecting outcomes data and had published a preliminary report on consumer demographics for the Aggression Replacement Therapy (ART) program.

In FY07-08, the MHP continued to expand what has become a cross-functional, data-driven quality improvement process by forming a monthly EBP committee. The MHP also had published outcome reports for Incredible Years, Parent Child Interactive Therapy, ART, and Functional Family Therapy.

The EBP committee includes directors of mental health, public health, and social services, team leads for the four EBPs, members of the Research & Evaluation Unit and assistant directors from multiple divisions, including quality improvement, compliance, fiscal, and information systems. Its members are charged with monitoring outcomes and resolving implementation and reporting issues. The data – which are communicated to stakeholders through the EBP Committee and stakeholder meetings – are used to improve access to and the delivery of EBPs. The committee reviews monthly data reports for each EBP, and quarterly updates of the Outcome Reports. The MHP shares the outcomes data with system stakeholders through regular stakeholder meetings. The MHP plans to expand sharing of outcome reports to education partners and the broader community.

**Exemplary Practice****Kern MHP*****Continuous Quality Improvement*****Overview**

In July 2006 Kern Mental Health Plan (MHP) implemented a new system called Anasazi, through its vendor, Anasazi Software. Six months later in January 2007, the MHP determined Medi-Cal revenue had decreased by over 20 percent — reflecting both a drop in number of claims processed and reimbursement for submitted claims. The MHP leadership, a cross-functional team from across the agency, and Anasazi senior management and subject area experts subsequently initiated a formal analysis to determine potential causes for the decline in volume and revenue. The MHP not only gained a full understanding of why Medi-Cal claims revenue decreased but also initiated a series of corrective actions. In addition and, of significance, the claims data were used by management as a performance management tool — in the areas of information system and service delivery. Most of the process improvement activities described in this summary were completed by February 2008. The eligibility determination and system performance initiatives remain active and ongoing.

**Benefits**

- Reduced the shortfall of Medi-Cal claim dollars for FY06-07 from over 20 percent to two percent — resulting in millions of dollars in revenue recovery
- Prompted an increased focus on productivity — include management training and data-driven performance management
- Identified the need for increased staff training which has the potential to reduce user error and increase staff's ability to take responsibility for the quality of their documentation
- Processes were put in place to monitor network performance, which has improved significantly

**Background**

In July 2006 Kern MHP implemented a new system – called Anasazi. Six months later in January 2007, the MHP determined that Medi-Cal claims revenue for FY06-07 was more than 20 percent less than collected in FY05-06 — reflecting both fewer Medi-Cal claims processed and a decrease in revenue. Both Kern MHP and Anasazi senior management staff formed a work group that same month, with overall leadership provided by Kern's deputy director of administration and fiscal services. By August 2007, Kern participants included senior management, the technology services manager, and supervisors from accounting, billing, and data management. Anasazi participants included senior management staff and subject matter experts.

The work group conducted two analyses that compared the number of services, service duration, and service categories from the legacy system to data from the new Anasazi system to determine the extent of the problem:

- **Legacy system data. January 2006 to Anasazi data — January 2007.** Determined that the number of services performed decreased by about 15 percent and the claim dollars decreased about two percent.
- **Legacy system data. June 2006 to Anasazi data — June 2007.** Determined that the number of services performed decreased by 24 percent, and claim dollars decreased by 33 percent.

The work group was then tasked with troubleshooting three potential root causes for the problem: were fewer services being provided, were services being performed but not entered into Anasazi, or had errors occurred in claims production after data entry:

### Analyses and actions

- **Claim Lag Time.** Kern's FY06-07 approved claims processed during the fiscal year by the California Department of Mental Health (DMH) were \$43M. Between August 2007 and January 2008 an additional \$9M of FY06-07 claims were processed by Kern. *Due to complexity of the billing function, as well as staff turnover, the MHP provided advanced training to billing staff, which was completed in June 2007.*
- **Compared system data to paper charts.** This analysis found that case management and individual counseling accounted for the greatest decrease in services. This analysis prompted an increased focus on productivity. *Clinical administrators received a two-day training that focused on the use of reporting tools to monitor productivity. Managers now conduct weekly productivity reviews with supervisors and report to the management team at least monthly.*
- **Workflow analysis of suspended services.** The backlog of suspended services at its peak was over \$3.8M. The MHP, with significant assistance from Anasazi, performed a workflow analysis of suspended services. *After a modified process was implemented in July 2007, backlogged services decreased to less than \$100K by December 2007.*
- **Eligibility analysis.** The work group reviewed the new system's software algorithms and eligibility processing and determined three areas for improvement — Healthy Family eligibility, share of cost and multiple aid codes. *As of spring 2008, Anasazi installed system updates to correct these problems.*
- **System performance analysis.** This issue was addressed from several directions, as slow response and/or intermittent connection failures generally stem from multiple root causes: monitored the network for data bottlenecks and intermittent delays; tuned Citrix configurations; updated or replaced router and/or switches at some locations; upgraded the application database server memory, operating system, and disk capacity; collaborated with the telephone company to identify and improve data transmission; worked with a large provider to create an encrypted link between the provider's and county's wide area networks. *The network is now monitored 24/7 and network performance data are reported to management staff — producing significant improvement in network performance.*

**Exemplary Process****Los Angeles MHP*****Data-driven Performance Indicators and Management Process*****Overview**

In FY07-08, Los Angeles County Department of Mental Health (LACDMH) fully implemented STATS (Strategies for Total Accountability and Total Success) as the formal operational structure for data-driven performance indicators and management tools. Planning began in early FY06-07 with a cross-functional team within LACDMH. STATS utilizes a model similar to one first used by the New York Police Department and subsequently adopted by several municipalities and jurisdictions throughout the country. This model holds managers accountable using data that reflects both program-specific and department-wide outcomes and targeted goals. It holds great promise to have a positive impact on client outcomes, as well as operational efficiencies.

**Benefits**

- A culture-shift that emphasizes management collaboration, scrutiny and oversight to ensure the delivery of high-quality, appropriate and cost-effective mental health services
- Improvement in overall timeliness, quality and consistency of data across facilities/programs
- Enhanced claims revenue — reflecting improvements in:
  - o Direct service percentages
  - o Timeliness of data entry

**Background**

In early FY06-07, representatives from several bureaus and divisions within the LACDMH formed a group charged with developing and refining data-driven performance indicators and management tools. After seeing STATS in action in the LAC Department of Public Social Services (DPSS), LACDMH committed to adopting the model to guide these efforts. In May 2007, LACDMH introduced STATS as its formal operational structure.

**Increased authority and accountability**

The STATS process involves structured monthly meetings that are chaired by the chief deputy director, with active participation by the Executive Management Team (EMT), which consists of the LACDMH's director, assistant director, medical director, LACDMH deputy directors, district chiefs, and program heads. During the meetings, which are scheduled months in advance, the EMT reviews performance data that is presented by program managers. As needed, the program manager and the EMT discuss specific action plans to improve performance, and program managers commit to implementing these improvements. Follow-up is an integral part of the process, with program-specific reports provided to measure performance improvement over time.

During the first year of the program's implementation, STATS indicators have emphasized maximizing the commitment of staff resources to:

- Providing direct services to clients
- Supporting consumer access to healthcare and related benefits
- Assuring efficiency in business operations that support the delivery of services

As such, data analysis has focused on the following criteria to measure performance:

- Direct services – Staff time spent on direct clinical services as a percentage of total time
- Benefit establishment – Percentage of clients with benefits, and referred for benefits
- Claim lag time – Percentage of claims entered within 14 days of date of service

For each metric, data is aggregated at the department level, by service area and by individual program. Programs are measured against specific targets, which are established by LACDMH, as well as against their peers. Over time, plans are to increase the number of data elements that will be tracked and reviewed during the monthly meetings. For example, the EMT recently proposed a measurement to assess claiming success rate. In addition, efforts are underway to develop measures for evaluating the effectiveness of administrative areas such as human resources and information technology.

### Education on data-driven performance management

Education, as well as accountability, is an important part of the STATS process.

- **Intensive technical support.** A technical support team is available to provide intensive, on-site assistance to troubleshoot information technology problems and to help programs generate statistics for self-assessment over time.
- **Formal training sessions.** Monthly operations meetings that are attended by program heads include formal trainings on a variety of topics, including:
  - o How to understand and use data
  - o A review of STATS-related performance indicators
  - o The presentation and application of various management tools to improve performance
- **STATS Web site.** LACDMH also established a STATS website for managers to access both generic and program-specific STATS information and reports.
- **Help desk.** A special network e-mail address was created for staff and managers to use in submitting data and report-related questions. Any concern about the quality or accuracy of data is thoroughly investigated. Depending on the finding, consultation is provided to explain the source of data and/or the report is refined to more accurately reflect the intent.

Additional information on the STATS process is included in Attachment 19.

**Exemplary Practice****Madera Mental Health Plan*****Hope House —  
A Collaborative  
Management Model*****Overview**

Hope House began enrolling members in late FY06-07 and has developed into a thriving program over the past fiscal year. It serves as an excellent example of how a small county effectively used Mental Health Services Act (MHSA) dollars and a community partnership to provide a collaborative management model in a

recovery center that consistently exceeded membership projections. Membership in FY07-08 doubled over the prior year and exceeded the program's annual membership goal by over 150 percent. It is operated by Turning Point of Central California, Inc., through a contract from Madera County Mental Health with funding from MHSA and the county general fund. In FY07-08, the program inspired a consumer-developed and consumer-run drop-in center for the homeless in cooperation with a local church. The MHP supported the idea but was not requested to provide any resources to this additional program.

**Benefits**

- Established strong community linkages to expand the breadth of services and supports offered to consumers
- Developed volunteer, part-time, and full-time positions for consumers to assume increased level of responsibility in direct service
- Fostered the development a “spin-off program” developed and run by consumers to help homeless individuals (some of whom have a mental illness).

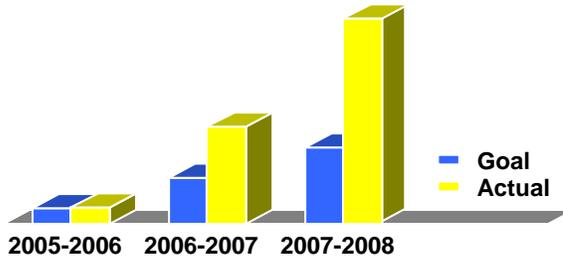
**Background**

According to Hope House Program Director Tim Gallemore, M.Div., CPRP, “the success of Hope House rests a great deal on the collaboration between Turning Point and Madera County Behavioral Health Services. Even though we are contracted and not county employees, we work very well together.” As an example, an employment developer who works for the Madera County Behavioral Health Services (MCBHS) and an MCBHS employee who offers a health program are located onsite at Hope House.

Enrollment statistics, services and supports, and consumer employment are also impressive. Included in Attachment 20 is a Hope House brochure, which includes information on programs and community linkages (i.e., mental health programs, community organizations, government agencies and local businesses), as well as related policies and procedures. Hope House staff members have presented workshops on peer-run recovery centers at the CASRA Conference in Southern California and the CLIENT FORUM in Sacramento. Hope House was also highlighted at the April meeting of the California Mental Health Directors Association in Sacramento as a successful program funded by MHSA.

Continued growth<sup>10</sup>

Hope House’s enrollment goals vs. actual enrollment are listed below and displayed below:



Fiscal Year	Goal	Actual
FY05-06	30 unique individuals	See note
FY06-07	90 unique individuals	191 unique individuals
FY07-08	150 unique individuals	403 unique individuals

*Note: Due to construction delays, there are not any official members for FY05-06; however, 32 consumers participated in the stakeholder planning process*

Services and supports

Hope House provides county-wide transportation from the outlying areas and a full array of services, including:

- Peer Support Groups
- Consumer Employment Opportunities
- Socialization Skills/Activities
- Life Skills Instruction
- Addiction Recovery Groups
- Computer Lab
- Laundry Facilities
- Showers
- WARMLINE – Phone Support
- Spanish-Speaking Staff
- Cooking Classes
- Outreach Services in the cities of Chowchilla and Oakhurst

Consumer employment and empowerment

To date the program employs several staff, including two full-time managers (an educator and a community-oriented minister), two full-time consumer employees, and five part-time consumer employees with flexible schedules. The two management staff are purposefully not mental health professionals to ensure that the program does not become a treatment focused. Members answer phones, lead activities and plan events. Some members receive community service credit if they have court-required service. The center also has two graduate student interns, who have motivated consumers to consider returning to college.

In addition to consumer employees at Hope House, the program has been successful in generating consumer positions in other MCBHS departments. A consumer employee is a member of the Madera County Mentally Ill Offender Crime Reduction program team — which works with youth in the juvenile justice system. Most recently, members of Hope House developed a satellite program based on their assessment that the homeless (some of whom have a mental illness) had specific and sometimes unique needs. These consumers who either were homeless themselves or had been homeless started this new program because they wanted to “give back” to the community that had helped them. One of the satellite program’s projects is a neighborhood clean-up to demonstrate to the community that the homeless are contributors. They also use the church space for people to socialize during the day — especially those hours when shelters are closed.

<sup>10</sup> Source: Hope Annual Report: FY07-08

**Exemplary Practice****Riverside MHP*****Consumer/Family Member  
Career Ladder*****Overview**

Over the past two years, the Riverside MHP has implemented a successful career ladder for consumer/family member employment — with major accomplishments in FY07-08. During this fiscal year, the MHP initiated the planning process, hiring a former county human

resources (HR) director as a consultant to address various needs related to creating consumer job opportunities. CAEQRO's consumer/family member focus group data and our site visit observations all indicate that this program is a great success. Through this program, the MHP has hired a substantial number of consumer/family members in positions at all levels throughout the organization, while providing ongoing training and support for meaningful career development. Attachment 21 includes job descriptions for these positions.

**Benefits**

- Increased consumer/family member employees from 12 FTEs to 61.5 FTEs representing 68 full- and part-time positions — including three management positions that are part of the executive team
- Implemented positions throughout the MHP — including support services, clinical services, and management — creating both meaningful employment and career development opportunities
- Fully integrated consumers into the organization — since every manager now supervises at least one peer specialist — successfully addressing the stigma associated with mental illness

**Background**

In early FY06-07, Riverside MHP undertook a massive consumer and family member employment initiative to bolster its wellness and recovery efforts. The preparation for this initiative, which was partially funded by a Mental Health Services Act grant, included hiring a former county HR director as consultant to help the MHP address the challenges of creating consumer job opportunities — including defining job requirements and incorporating the consumer/family member experience. The consultant also helped the MHP develop the presentation that gained the plan's approval by the county board of supervisors.

In brief, the career ladder includes a peer specialist trainee, peer specialist, senior peer specialist, and mental peer policy and planning specialist. The last "step" in the career ladder is part of the management team. The support services position — Community service assistant (CSA) — is open to all applicants and is distinct from the career ladder.

## Lessons learned

Hiring for the MHP is centralized at the county level. In addition to the HR consultant, the MHP director of research and quality improvement praised the county-level HR manager who served as an effective liaison between the MHP and the county HR department. The HR consultant and county HR representative advised the MHP on applying HR law when working with consumers — particularly in dealing with arrest histories and occupational health issues. The MHP’s willingness to share information about a variety of special considerations could help other MHPs develop a similar program. Several of these considerations are highlighted below:

- **Recruitment/job descriptions**
  - An employer can require that experience includes receiving mental health services, but by law this experience cannot be verified. Therefore, this experience is based on trust between the employer and employee.
  - HR law protects consumers as any applicant with a health-related issue — i.e., can the organization make reasonable accommodations.
  - The MHP needed to create job descriptions that extended beyond support services and provided opportunities for consumer employees to work directly with consumers receiving mental health treatment.
- **Extensive and ongoing training**
  - *The existing workforce* — Training of and intensive support for clinical staff and supervisors was required prior to, during, and after hiring a consumer employee to incorporate the peer specialist role into direct consumer care.
  - *The new peer specialists* — New training helped peer specialists understand the power of their own experiences and learn concepts of recovery. Trainings also clarified roles of clinicians and peer specialists — providing supervisors additional guidance in HR issues. Consumer employees also have regular planning and training sessions with managers who are employed in the highest “step” of the career ladder.
- **Performance management and employment opportunities**
  - The probationary period for new employees had to be extended from six months to one year to enable new employees to address timeliness and/or literacy issues (which, in particular, were initially underestimated).
  - The MHP is currently providing flexible scheduling that enables consumer employees with a bachelor’s degree to work half-time and attend school half-time for a master’s degree and a clinical license. After completing the advanced degree program, consumers can apply for management vacancies that match their experience, degrees and licensure. Planning is underway to extend this program to those without a bachelor’s degree.

**Noteworthy Process****San Bernardino MHP*****Integrated Healthcare Initiative*****Overview**

In August of 2007, San Bernardino MHP formed a work group to assess how to improve the integration of mental health and physical health care delivery. During the CAEQRO site visit in October 2007, the MHP had a clearly articulated vision and specific plans for integrating physical and mental health care. The MHP has done an excellent job in developing a road map for achieving truly integrated healthcare delivery and, as such, we view this initiative as a noteworthy process for further discussion and follow up during our FY08-09 site review. It has also taken preliminary steps to integrate medical and mental health care by embedding mental health staff in a primary care clinic.

**Benefits**

- Potential to transform healthcare delivery, including:
  - o Improved outcomes for consumers
  - o Improved contract provider communications and strengthen relationships
  - o Enhanced interagency collaboration
  - o Increased efficiency in resource utilization
- Potential to serve as model for other MHPs given the level of detailed planning and clear articulation of what is required to achieve a successful implementation

**Background**

During our FY07-08 site visit, San Bernardino provided our review team with “Milestones on The Road to Integrated Health Care,” a plan that outlines the process to integrate healthcare services — included as Attachment 22.

The San Bernardino plan consists of a three-staged implementation of integrated healthcare. The stages are related and interdependent:

- **Stage 1** — Creating primary care integrated health clinics.
- **Stage 2** — Co-locating and integrating clinics
- **Stage 3** — Integrating siloed health agencies or departments into a single cohesive healthcare delivery system

**Stage 1 progress**

As of August 2008, San Bernardino MHP had accomplished the following tactics in creating primary care integrated health clinics:

- **August 2007:** Formed a health integration team whose executive members include the Director of Behavioral Health, Director of Public Health, and hospital.

CEO. The “boots-on-the-ground” team members include the Assistant Director of Public Health, Behavioral Health senior manager, and Behavioral Health clinic manager. The integration team meets every two weeks to review and discuss current developments and plan future strategies.

- **September 2007:** Hired a Spanish-speaking mental health clinician, case manager and clinic manager. The mental health clinician and case manager are embedded in a primary care clinic to serve the county’s chronic care population. As of August 2008, over 100 referrals for service have been made by the clinician and case manager.
- **September – November 2007:** Participated in Web cast sponsored by the California Institute of Mental Health (CiMH). The topic was integrated behavioral health care and various MHPs presented information on their current and pending integrated health care initiatives. In addition to San Bernardino, the following counties participated in the Web cast: San Diego, San Mateo, Shasta and Stanislaus.
- **February 2008:** Attended CiMH sponsored integrated health care conference – established new contact and planned future site visits.
- **February – May 2008:** Hired a CiMH-recommended consultant to gather and present information on integrated health care policy, planning and funding initiatives.

In addition to these activities, staff from the MHP conducted numerous “boots-on-the-ground” site visits from August 2007 to gather a variety of information:

- Tulare — knowledge and understanding of integrated health care model
- Ventura — financing an integrated health care model
- Riverside — providing primary care through a public health Federally Qualified Health Center (FQHC)
- Golden Valley — successfully operating central valley FQHC
- Stanislaus — information on the county’s application for an FQHC look-alike license

### Immediate next steps

The county hospital currently contracts with a provider through the County Medical Services Program to serve Medically Indigent Adult (MIA) population. The contracted provider has applied to the state for Medi-Cal license to operate as a primary care clinic to serve self-pay and MIA consumers. Other key steps underway for Stage 1 include:

- Embedding mental health professionals in primary care clinics
- Developing cost projections for integrating mental health, primary care and public health

**Noteworthy Process****Santa Clara MHP*****Consumer Health Screening*****Overview**

In July of 2007, Santa Clara MHP in partnership with Santa Clara Valley Medical Center (SCVMC) — the county public hospital and a Federally Qualified Health Center (FQHC) — initiated the Mental Health Specialty Clinic (MHSCA) a pilot consumer health screening program. The program received formal approval in December 2007. The key goals of the MHSCA are to improve consumers' overall health by linking them with primary health care, while reducing the need for expensive emergency room services and the cost of psychotropic medications. During the program's first year, the benchmark of success is to have screened and medically triaged 900 consumers and initiated linkage to primary care services. While primarily focused on implantation during the first year, the program has great promise to meet its short- and long-term goals. It also is an excellent example of how a county has strategically used Mental Health Services Act funding to fill gaps in service.

**Benefits**

By linking consumers to PCPs, the SCVMC and the MHP hopes to:

- Help consumers engage with medical care and prevent/reduce emergency room visits
- Link consumers to health benefits (i.e., Medi-Cal or hospital insurance for consumers who are 200 percent below the Federal Poverty Level<sup>11</sup>) that provide access to a PCP, while decreasing co-pays for physical health care and psychotropic medications
- Support consumer compliance with psychotropic medication regimens
- Educate consumers on health issues/ importance of accessing care
- Educate and train consumers, staff and physicians regarding the connection between mental health outcomes and medical outcomes

**Background**

Anticipating the impact of the state's budget crisis (including reduced Medi-Cal reimbursement), the SCVMC in collaboration with Santa Clara MHP recognized that consumer co-pays for treatment and pharmacy bills would likely increase and create an access barrier for an already vulnerable and underserved population. The program started as a pilot project under the direction of the MHP in July 2007, initially targeting consumers receiving the highest-cost psychotropic medications. In December 2007

<sup>11</sup> The program staff also plan to assist consumers with securing Social Security Insurance benefits and have purchased software to help this process.

SCVMC Pharmacy Services formally approved the program through an attestation process.

### Identification, triage and referral

The MHP's Decision Support Team (DST) cross referenced INVISION, the SCVMC system, UNI/CARE, the county system and pharmacy dispensing and produced a list of consumers that had high emergency room use, very poor physical health, and lacked a primary care physician (and therefore regular medical care).<sup>12</sup> The initial contact to schedule the medical assessment is made by MHSAC staff through the consumers' MHP case managers. Appointments occur at the MHP clinics concurrent with the consumers' scheduled mental health or psychiatric appointments. MHSAC staff currently rotates at eight mental health clinics and plan to extend the services to all clinics in the future.

Consumers receive a comprehensive medical assessment completed by MHSAC staff using the MHSAC Health Assessment tool. The assessment tool was developed by the MHP which integrated those used by Kaiser Permanente and Stanford University, as well as other standard assessment tools. If vitals indicate the need for immediate medical care, the consumer is transported to SCVMC's emergency room or its urgent care center. Otherwise, the consumer is given an appointment with a PCP. The MHSAC staff informs the consumer case manager of the PCP appointment. Prior to the PCP appointment MHSAC staff provide a reminder call to the consumer and an e-mail reminder to the case manager of the scheduled appointment. Depending on the consumer's level of functioning, program staff will either provide referrals to dental and eye care (covered by Medi-Cal) or transport them directly to these providers.

To help eliminate access barriers, MHSAC has Spanish and Vietnamese speaking capacity and, when necessary, utilizes bilingual staff from other programs to assist in the health screening and triage process that occurs at the MHP mental health clinics. Providing this service at the consumers' MHP mental health clinics eases transportation hardships and increases engagement. The location also decreases some of the consumers' fear about having the appointment at the MHSAC office which is housed next to Emergency Psychiatric Services.

### Lessons learned

The MHASC staff quickly implemented process improvement in several areas to increase engagement. For example, staff quickly started to make reminder calls to consumers regarding their screening and primary care appointments. They also recognized the need for education and training of consumers, staff and physicians regarding the connection between mental health outcomes and medical outcomes. MHASC staff recently provided this kind of training to emergency room staff at SCVMC. MHASC staff also has received training on pharmacotherapy to familiarize them with the different medications that are typically prescribed to consumers. MHASC staff is also addressing the challenges of using three different data systems and associated data integrity. For example, a consumer identified in one database may no longer be receiving care in the county.

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<sup>12</sup> Consumers who initially seek treatment through Emergency Psychiatric Services are not currently prioritized for enrollment in the program, because they are linked to a psychiatrist and are already receiving follow up.

**Noteworthy Practice****Stanislaus MHP*****Consumer-operated  
Warm Line*****Overview**

Stanislaus County Recovery and Behavioral Health Services (Stanislaus County RBHS), the mental health plan (MHP), has successfully implemented a volunteer-operated Warm Line that functions as the primary contact between callers and all Mental Health Plan (MHP) services. The Warm Line operates on a 24/7

basis and is staffed by 15 volunteers — mostly consumers but some family members — with two volunteers available to answer calls at all times. Over 95 percent of the calls do not require a clinical intervention and are managed by the volunteers. Stanislaus County RBHS's consumer-operated Warm Line is unique among the MHPs that we reviewed in FY07-08 and has found a creative strategy for maximizing limited clinical resources, while providing consumers with direct service opportunities.

**Benefits**

- Callers can receive peer support, preserving limited clinical resources to those in crisis
- Early intervention — such as providing information on basic services such as housing and benefits referrals — helps to avoid the escalation of issues because basic needs go unmet
- Volunteers operating the service receive valuable training, including basic counseling skills — skills that could help with employment opportunities over time

**Background**

Stanislaus County Recovery and Behavioral Health Services initiated a Warm Line as part of its Mental Health Services Act (MHSA) implementation. The Warm Line is staffed by volunteers, most of whom are consumers although some are family members. All behavioral health calls to the toll-free access line and all calls to the direct crisis line are screened by the Warm Line 24 hours-a-day, seven days a week. Listed below are highlights of how the program works and summary utilization data:

- **Hiring and staffing.** The MHP has a large referral base for volunteers, including its Wellness Center and many contract providers — including the United Way. Warm Line volunteers follow the same thorough screening process as do other MHP volunteers, including undergoing background checks, and receiving identification cards through human resources. A total of 15 volunteers staff the warm line, and two volunteers are “on” at any given time.
- **Training.** After volunteers are assigned to the Warm Line they receive extensive training in a variety of settings on topics specific to their roles and functions on this team. Through a combination of on-the-job training, classroom exercises, role play, 1:1 and vignettes, volunteers are trained in crisis intervention, listening

skills and basic client advocacy training by MHP staff and are supervised through a contract with Turning Point, which is responsible for quality assurance and record-keeping activities.

- **Triage process.** During regular business hours, Warm Line volunteers answer calls and forward them to the MHP if the call requires a clinical intervention. Otherwise, callers can speak directly with peer operators about matters not requiring the attention of a clinician or case manager. Warm Line volunteers are able to provide referral information on community resources and may direct callers to other agencies regarding housing, benefits application, etc. After hours, the Warm Line volunteers answer crisis calls, deal directly with matters of a non-urgent nature, and forward to on-call clinical staff those calls requiring a professional intervention.
- **Utilization statistics.** Five percent of the callers are in crisis, 15 percent require peer support, and the remaining 80 percent need service information or referrals. Crisis calls are transferred to a clinician; the remaining calls are handled by the warm line volunteers. Monthly call volume has ranged from a low of 12 to a high of 193 calls per month — based on data that is recorded in a call log.

### Challenges/Lessons Learned

- Administrative
  - The initial telephone system did not provide for caller ID — a feature that is necessary to assure that emergency situations are triaged in a safe and effective manner. The MHP later installed a phone system with this capability.
- Resources
  - The MHP needs to maintain updated information on services in the community — assuring that contract information, hours of operation and agency locations are current and easily accessible to warm line volunteers.
- Training
  - Volunteers require (and received) training on the use of the phones — including working with the language line.
  - Volunteers require (and are receiving) ongoing interactions with staff, as well as supervisors, and refresher training to assure that they understand the difference between crisis calls that need to be referred to clinical staff and those requiring only peer support.

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 5.1: Overview

Over the past three years, California External Quality Review Organization (CAEQRO) has systematically observed what we believe to be dominant themes within California's public mental health system. Below is a summary of the process we employed in identifying these themes:

- **Year one.** We identified seven system-wide themes predominantly through extensive reviews of the narrative portions of 54 mental health plan (MHP) summaries.<sup>13</sup>
- **Year two.** Using our year one findings as a knowledge base, we performed the following additional analyses to determine which themes were still applicable and which themes no longer had system-wide importance:
  - o Analyzed two years of approved claims data from Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation Claims (IPC) files
  - o Reviewed either Information Systems Capabilities Assessment (ISCA) V5.7L or the Information Systems Review Supplemental Questionnaire for all 56 MHPs
  - o Gathered MHP-specific data based on highly targeted reviews
  - o Conducted formal trainings to address specific needs that were shared among groups of MHPs
- **Year three.** A distinguishing feature of our FY06-07 statewide report is our ability to perform sophisticated quantitative analyses through increased functionality in our databases. We provide numerous examples of these analyses throughout this report. We also had the significant advantage of the following activities:
  - o Gathered three years' data on each Mental Health Plan (MHP) from highly targeted reviews
  - o Collected information from an increased number of stakeholders in FY07, including remote MHP sites, contract providers, and consumers and family members
  - o Updated SD/MC and IPC data to include CY06
  - o Reviewed a common ISCA V6.1 for all 56 MHPs
  - o Conducted highly targeted trainings to address persistent challenges shared by specific groups of MHPs

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<sup>13</sup> Solano County did not opt into the public mental health system until our second contract year. We also had limited information from Alpine MHP.

- **Year four.** Our FY07-08 statewide report reflects our ability to perform quantitative analyses through increasingly sophisticated databases and new software applications. We provide numerous examples of these analyses throughout this report. We also had the significant advantage of the following activities:
  - o Gathered four years' data on each MHP from highly targeted reviews
  - o Collected multiple years' information from an increased number of stakeholders, including remote MHP sites, contract providers, and consumers and family members
  - o Updated SD/MC and IPC data to include CY05-CY07
  - o Reviewed several years' data from ISCA V6.1 for all 56 MHPs
  - o Supported two collaborative multi-county Performance Improvement Projects (PIPS)

In last year's statewide reports, we were able to begin discussing trends because we had collected a minimum of three years' observations and quantitative data on a specific issue. Having aggregated a substantial body of such information over four years, we can further explore trends within key areas.

## Section 5.2: Trends in Key Areas

In year four we saw the same four key areas that we had begun to observe as emerging trends in year three:

- **Access** — especially an MHP's ability to reduce wait times and other measures of timeliness (which was the most frequently cited opportunity for improvement in year four)
- **Service delivery** — which showed continued disparities within specific populations
- **Quality management and use of data** — an area of uneven performance in which some MHPs showed continued improvement, whereas others remained "stuck"
- **Information systems** – an area with significant activity since year two

Three points are important to consider in reviewing our discussion on trends:

1. As our report suggests, while MHPs share many strengths and opportunities, California's public mental health system is highly diverse in demographics and ethnicity, as well as in resources. Consequently, the trends that we identify will not apply to all 56 MHPs – but rather suggest a pattern among a high number of MHPs or groupings of MHPs (e.g., small-rural).

2. We recognize that MHPs face highly complex organizational and environmental challenges — as discussed in Section 1 and in Attachment 4. Consequently, the issues underlying some of the trends we identify are not simple to resolve and will continue to require a variety of activities over time.
3. We have made a number of observations we can consider a trend since we have at least three years of information. For example, the funds spent on Hispanic beneficiaries versus White beneficiaries have slowly and steadily increased over three years.

### Access: continued barriers – some progress

During year four the broad concept of “access” continued to rank first in the number of

**Trend #1: Many MHPs were successful in continuing or introducing new delivery system models.**

However, many consumers are still denied access for a variety of reasons. With some significant exceptions, access to psychiatric services remains particularly limited.

observations and recommendations made by CAEQRO reviewers. Because access is a broad concept, we focused our review priorities on areas such as “timeliness” that MHPs can more easily address than other very complex issues such as those we highlight in Section 1 and in Attachment 4 (e.g., inadequate matching State General Funds, unfunded mandates, etc.).

With some exceptions, individuals and families must apply to an MHP or community provider for publicly funded mental health

services. Many studies on the process for gaining access to health care show a direct correlation between the difficulty in accessing services and who enters and remains in the system. We address in the following section the disparity in services to particular groups. For this discussion, we focus on the ease or difficulty with which an individual can obtain services.

During year one, we noted a number of MHPs had long-standing difficulties in timely access as measured by a long wait from the initial request to the first appointment. Others had excessively long wait times for essential services, especially psychiatric evaluations and follow-up appointments. While many MHPs reported staff layoffs and work force reductions in both years one and two, it appeared to us that other important factors contributed to delays in access and consumers dropping out during the initial process.

In our year two report we described some factors, including internal barriers — most of which we again observed during our year three site visits. As in year two, many staff regretted these difficulties and continued their traditional efforts to remedy them. In year three we did note some exceptions to “business as usual” as some MHPs developed different models of service delivery in an attempt to reduce barriers to entry. In year four MHPs continued to employ new approaches to engaging a variety of populations; however many MHPs remained unsuccessful in improving access and achieving a timely intake process — especially for adults — and were unable to remedy long wait times. Delays at each successive stage of the process to gain access to services resulted in a high dropout rate. And many consumers who did gain initial access were often referred to outside community services immediately following the initial screening process.

Models to promote entry included the following:

- **Walk-in services.** A number of MHPs established hours and sites in which no appointment was necessary to initiate services. Some MHPs implemented this model at one site; others provided only screening services on a walk-in basis. During year four, while some MHPs continue to move to this model, those employing it struggled to manage the volume. Very few MHPs reported as their goal improving non-urgent access for individuals to less than seven business days. Only Orange MHP successfully analyzed data and considered staff/consumer perceptions in changing processes to meet their goal of providing non-urgent services in five days.
- **Co-location with other human services agencies.** The initial flow of MHSA funds accelerated MHP efforts to provide access and coordinated services in new or non-traditional locations. Improved coordination with Federally Qualified Health Centers (FQHCs), rural health clinics and Native American health services continued. Some attempts at coordination and transfer of beneficiaries were either stalled or blocked, especially as MHPs experienced core service budget cuts and staff in both systems expressed discomfort and anxiety about the process.
- **Collaborative programs for older adults.** Funding from the Mental Health Services Act (MHSA) enabled some MHPs to improve or initiate programs for older adults. We also continued to note additional outreach and services in schools and other county departments such as social services. MHPs began to establish programs with the adult criminal justice system, while continuing to work with juvenile justice.
- **New populations and sites.** Examples of innovative approaches to reach new or underserved populations include:
  - Tulare MHP — Peer support “buddies” are outreaching to residents of locked Institutions of Mental Disease (IMD) and engaging them in recovery-focused activities.
  - Colusa MHP — Staff members are providing educational groups and other services at migrant labor camps.
  - Sutter/Yuba MHP — Various groups are targeting services for specific and typically underserved populations. For example, a father’s group attracts male family members, while bi-lingual, bi-cultural staff provides outreach and engagement teams for Hmong, Asian Indians and Latinos.
  - Los Angeles MHP — To engage long-term homeless individuals in housing and services, the MHP launched Project 50, which involves collaborating with the County Administrator’s Office, the Departments of housing, vocational rehabilitation, and public health, as well as city council staff.

- o Los Angeles MHP — A pilot program is designed to engage families at the initiation of services that are sought by adults.
- o Glenn MHP— Management publishes a regular “report card” on services to a variety of community groups and individuals.

Despite these creative and effective initiatives, barriers to access continue. Below we note a few of the issues and some activities that could improve access or timeliness:

- **Evening and weekend access by county-operated services.** Contractors have historically offered off-hours for those MHPs in which they provide a significant percentage of services. Small-rural and small MHPs operate most services directly and tend to follow “normal business hours.” This system continued in year four and significantly hinders access to the system for those individuals who have conflicts with work schedules, child care needs and/or difficulty with transportation.
- **Telemedicine or physician extenders with prescribing capability.** Access to a psychiatric evaluation is measured by weeks and even months in some MHPs. Some MHPs have an even longer wait time for rescheduling an appointment or scheduling a second appointment. While consumer/family focus groups continued to point to a lack of timeliness and frequent turnover in psychiatric staff as an ongoing problem, a number of MHPs did adopt telemedicine in at least for some programs. Kern MHP is notable in that it provides telemedicine in 23 locations. Riverside MHP and Santa Cruz MHP, as well as Los Angeles MHP, made significant changes in their policies for employing psychiatrists (e.g., increased salaries, conducted marketing outreach, added a specialized “welcoming program,” etc).
- **Reduction in intake complexity.** In both our year two and year three reports, we commented on a multi-step time-consuming intake processes in many MHPs. During our year four site reviews, we observed that these practices and the resulting delays continued in a notable number of MHPs — often despite workforce reductions that should have made streamlining intake processes (to offset the reduction in staff) a high priority. For many MHPs we mapped how the intake process clearly created delays and caused consumers to simply drop out of the system. However, many MHPs persisted in employing an overly complex intake process, perhaps feeling they would be overwhelmed by the volume of demand by eliminating these implicit barriers.

Disparities in service delivery**Trend #2: Female and Hispanic beneficiaries continue to be underserved by the public mental health system.**

When compared to White male beneficiaries, female and Hispanic beneficiaries access the system less frequently.

During year one, we became aware of differences in the average dollars approved for Medi-Cal services to different groups of beneficiaries. In year two, we performed various detailed analyses of these differences as part of the performance measure process mandated by the Centers for Medicare & Medicaid Services.

Consistent with the past three years, we found the following during our site reviews in FY07-08:

- Female and Hispanic beneficiaries showed lower penetration rates than for male and White beneficiaries.
- In CY05 for every dollar spent on a White beneficiary, 86 cents was spent on a Hispanic beneficiary. In CY06 and CY07 the ratios increased to 90 and 92 cents, respectively. However, for female beneficiaries the ratio remained at 77 cents to every dollar spent on male beneficiaries during the past three years.
- The disparity in cost for both Hispanic and female beneficiaries occurred in most of the seven service modalities in addition to the total. These data are discussed in Section 3. This disparity is particularly of note since commercial populations show that a greater percentage of females seek and receive access to mental health services.

Quality management and use of data: mixed results**Trend #3: Use of data for quality management shows little progress.**

The collaboration of small counties on the SCERP Performance Improvement Project is an important exception.

The use of data to drive performance management has been a major focus of our EQRO activities in each of our four review years. In contrast to years one and two but similar to year three, quality management and use of data was no longer the area most frequently cited by CAEQRO. However, it still ranked second and only six of the previous year's 45 recommendations were rated fully addressed.

- In year one, we identified MHPs as “siloe organizations,” with limited internal communications among important groups such as quality improvement (QI), technology, program management and cultural competence, as well as the staff involved in planning for programs funded through MHSA. Access to data in many MHPs was nonexistent and quality activities were entirely devoted to compliance.

- In year two, compliance continued to represent the major QI activity. However, data became more accessible in an increased number of organizations and, as a result, collaboration between quality management and technology staff increased. MHSA planning activities accelerated interest in and training about data, especially community population and prevalence data necessary to develop plans for new programs.
- In years two and three, as we had recommended, cultural competence activities became integral components of an overall QI structure within many MHPs. An increased number of new QI work plans and updates to existing plans included timelines and other measurable objectives.
- In year three, use of data moved to number two in the list of strengths identified in each report, even though it still ranked as the number one opportunity for improvement, especially for small-rural and small MHPs.
- In year four, small and small-rural MHPs had implemented or were implementing new information systems; however often they continued to use the systems only for billing and business processes — lacking staff capability and/or time to use the new clinical functionality.

### Continued challenges with data analytic skills

Despite increased availability of and intention to use data, many MHPs still struggled to understand what their data represented, how to formulate questions to investigate the data's meaning, and how to identify data elements that may be relevant to key questions. The lack of data analytic skills was particularly evident in many MHPs' ongoing inability to formulate and/or implement PIPs. Some MHPs worked diligently on their PIPs but had failed to consider data essential to their success.

Lack of data and activities to measure beneficiary outcomes continued throughout the system. While a lack of staff resources contributed to this issue, the most significant factor was a lack of systems support. MHPs almost always chose to implement billing as the first priority in moving to a new system. Since those initial implementations often took longer than planned, installation of the program/clinical modules had not occurred for many sites. Therefore, outcomes measurement remains difficult and labor intensive — requiring special chart reviews, manual data collection or survey administration. Small county SCERP participants did develop a uniform data base — an excellent achievement. However, often participants collected and maintained their data manually.

As discussed in Section 2.3, year four data from Information Systems Capabilities Assessment (ISCA) surveys indicated that data analysis and reporting remain the weakest functional areas for information systems. Two new survey questions indicated that less than 50 percent of the MHP's current systems retain clinical diagnosis history. Systems also seem to vary in their reliability and accuracy in identifying co-occurring disorders (COD). These two areas — clinical diagnoses and COD — represent basic and important clinical variables that are vital in monitoring and measuring outcomes. Although most key clinical and administrative staff now understand the importance of such data, until new systems are operational and understood, they can not really act on that knowledge.

**Trend #4: MHPs continue to make major changes and investment in information systems.**

However, all MHPs will not have new information systems operational for several more years.

The ongoing implementation of new information systems continues to be a key area of importance. In years one and two, we observed that MHPs were focused on maintaining legacy systems while considering new systems. However, in year three, we observed a significant increase in planning for and implementing new information systems.

In year four, we continued to see experienced and competent staff wresting maximum functionality from legacy systems — with great success — while, in some cases, concurrently leading the implementation process for the new system. Some MHPs that had struggled with problematic and long implementations showed improved processes and user-friendly functions in year four. Los Angeles MHP is a notable example of an MHP making enormous progress in the area of information systems in the last two years. Even in year four, the upgraded infrastructure had produced significant improvements in the system’s ability to produce easily accessible data that staff could use for planning and program management.

While many MHPs are now including clinical staff in their implementation planning and processes, they tend not to include contract providers although they represent a long-term “user group” in medium and large MHPs (and are involved in small MHPs as well). The costs providers bear as a result of inefficiencies and redundant information systems are as costly to service delivery as are similar issues experienced by the MHPs.

MHPs continue to review and investigate the major information systems available to the market. Since year four ISCA data indicate that 35 percent of the MHPs are still assessing new information system products, it appears all MHPs will not have installed complete new information systems until at least FY10-11.

Wellness and recovery: continued evolution

**Trend #5: MHPs continue to emphasize wellness, recovery and resilience.**

However, key initiatives such as consumer/family member employment are concentrated within the mental health system.

During year one, MHPs did little more than discuss wellness and recovery, and rarely mentioned resilience for youth/adolescent populations. In year two, many MHPs viewed these concepts as the exclusive domain of MHSA-related activities. In addition, we noted some efforts to increase consumer/family participation in QI and other MHP processes/programs. We were able to schedule just a handful of consumer/family employee groups in both years, since these staff did not exist within the MHP. In some

large MHPs contract providers did employ this specialized workforce.

In year four, we were able to schedule a consumer/family member staff focus group in almost all but some of the small or small-rural MHPs:

- **Vocational training and job opportunities.** In year four, formal pre-vocational training and opportunities were highly concentrated in preparing individuals, generally adults, for work within the mental health system. MHPSA regulations seem to have been interpreted to require this exclusivity, although this excludes individuals who wish to volunteer or work, but also do not wish to provide mental health services as a career. This also excludes many adolescents and Transitional Age Youth (TAY), some of whom do want to volunteer within the system; others, however, actively wish to move on with their lives, go to school, and gain employment. While programs are available, the energy and activities of the system are primarily focused on internal work.
- **Wellness centers.** A number of wellness centers continued to open, many of which were thriving and very positively received by consumers. However, while wellness centers employed consumers or at least provided volunteer opportunities, they were not typically managed by consumers. As we noted last year some MHPs used these programs as an alternative to clinical or other services for a variety of reasons, including lack of capacity and reduction in funding. Instead of providing a period of regular contact with a clinician prior to a wellness center referral, individuals were referred directly from the access or intake process. A very typical treatment plan now consists of medication support and wellness center participation with a clinician nominally active to update the annual plan. While some wellness centers have systematically increased staff and resources proportionate to the number of participants, others cannot afford to do so.

Wellness centers vary in structure and organization. MHPs operate some of these programs and often co-locate them at clinical sites to increase billing opportunities and flexible use of staff. Other MHPs have established contracts with providers who are often experienced in managing such programs. Typically, contracted programs are not co-located with the MHP or other health care locations within the county system. Programming within the wellness centers varies as some emphasize socialization and leisure activities, while others focus on pre-vocational and skill-building services. In addition, some wellness centers are open only to consumers receiving mental health services, while others are open at specific times to the community at large.

- **Consumer/family member employment opportunities.** MHPs all had at least one part-time consumer or family member volunteer or paid employee. As in year three, employees were typically enthusiastic about their opportunities and eager to provide meaningful support in their new roles. Consistent with last year, however, in most MHPs they were not clear about their roles, described themselves as “second class citizens” and felt enormously responsible to serve as “models” for other consumers. These sentiments were more prevalent among consumer staff employed by MHPs as opposed to contractors. Consumer employees who had been part of the system for a number of years generally retained their sense of responsibility and dedication and often reported good relationships with their supervisors. They were also more likely to express continued difficulties in being accepted by some staff and requested more opportunities for peer support and further training. Section 4 described Riverside

MHP's career ladder as an exemplary practice since it involves a comprehensive program that other MHPs may wish to adopt in whole or part.

- **Consumer/family member involvement in system transformation.** As reported last year, not many MHPs involved consumers or families in management, QI programming or in meaningful advisory roles that have the potential to reshape the delivery system to support wellness, recovery and resilience.

### Leadership and culture: organizational variables

#### **Trend #6: Strong leadership continues to have a significant impact on MHP performance.**

Overall workforce development remains a major area for continued improvement.

The importance of leadership and management skills has continued as a dominant theme since our year two site visit. In every location with strong leadership, the MHP had made progress in key areas regardless of environmental challenges. Such directors and managers described environmental difficulties as part of their reality rather than as reasons for any lack of progress.

While strong leadership is a broad category, we found that open lines of internal communication and external collaboration were differentiating characteristics in many MHPs that were able to overcome common environmental challenges.

- **Strong communication with stakeholders.** Internal communication was important for line staff and supervisory morale. In staff focus groups we often asked them to tell us what the organization's major priorities for the year were. In many MHPs, staff either did not know of had different ideas. We found that when staff understood and could articulate management's organizational priorities, in general staff morale was more positive. Contractors also valued regular communication, especially about changes in processes and information system plans as well as budget constraints.
- **Collaboration with other entities.**
  - o MHSA planning appeared to have successfully moved MHPs as a whole into more interaction with community groups. Several MHPs as well as the California County Mental Health Directors (CMHDA) revised their organizational mission and vision from a service delivery orientation to that of being a partner with the community to improve functionality and quality of life.
  - o Conscious of their challenges in managing EQRO regulations, small counties combined forces to discuss and plan collaborative PIPs. Counties have had a tradition of strong teamwork in managing outside

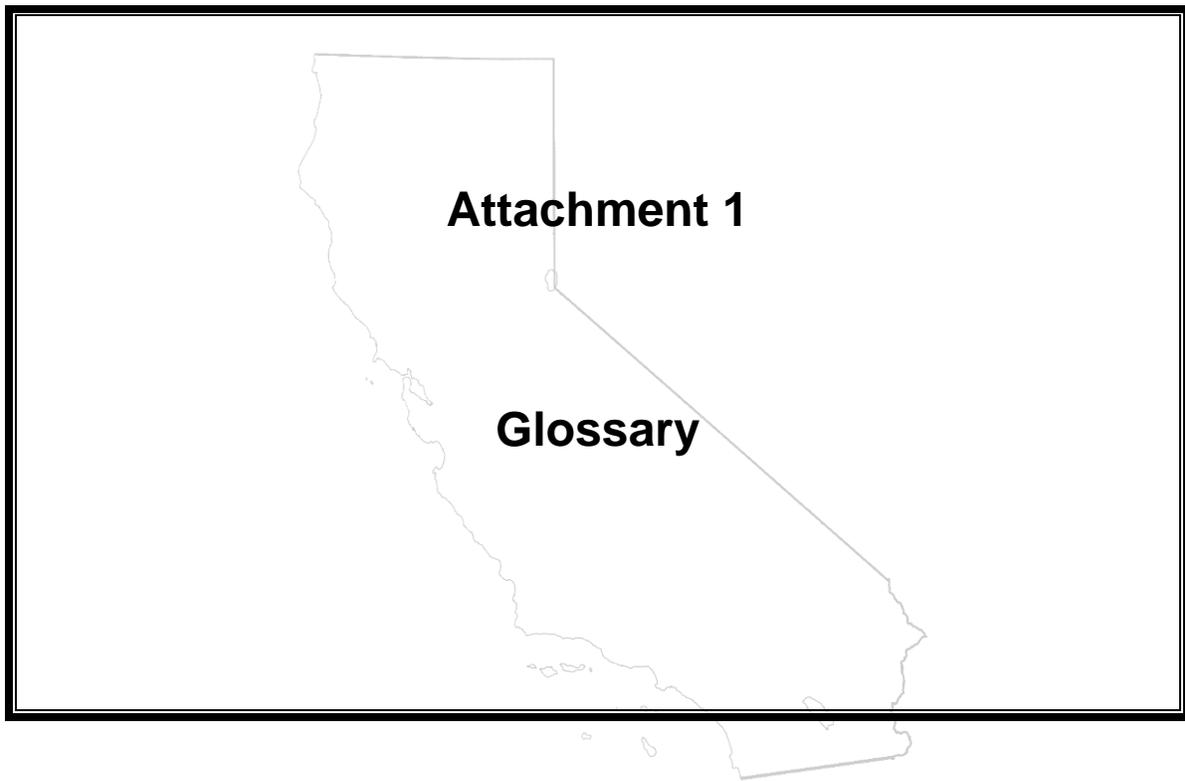
forces such as DMH and the legislature, but less of an orientation toward collaborative programming.

- o An increased number of MHPs attempted or established cooperative relationships with various health clinics. While some relationships have progressed, others have not. Since coordination and integration between behavioral health and physical health services are so crucial, the rocky nature of some relationships will require attention in the future. Both systems view themselves as significantly overloaded and underfunded, especially with California's cut in already low national Medi-Cal rates. Health clinics and plans describe what they consider "dumping" of individuals seeking mental health services who are refused by the MHP. Similarly, MHPs often consider health clinics unresponsive as they reach out to seek physical health and dental care for their beneficiaries. MHPA's Primary and Early Intervention funding stream may be a vehicle to help resolve this situation.

In our year two report we described FY05-06 as "A Year of Transition" — one in which MHPs were planning for major changes in programs, data and technology supports, and most importantly, in culture. In that same vein, we view FY06-07 as "The Year Changes Begin," as reflected in the trends we have highlighted in this section. While less elegant as a phrase, we view FY07-08 as "The Year of the Glass Half Full and Half Empty" — which suggests that the public mental health system has locations and initiatives characterized by progress and innovation and others with stagnation and persisting difficulties.



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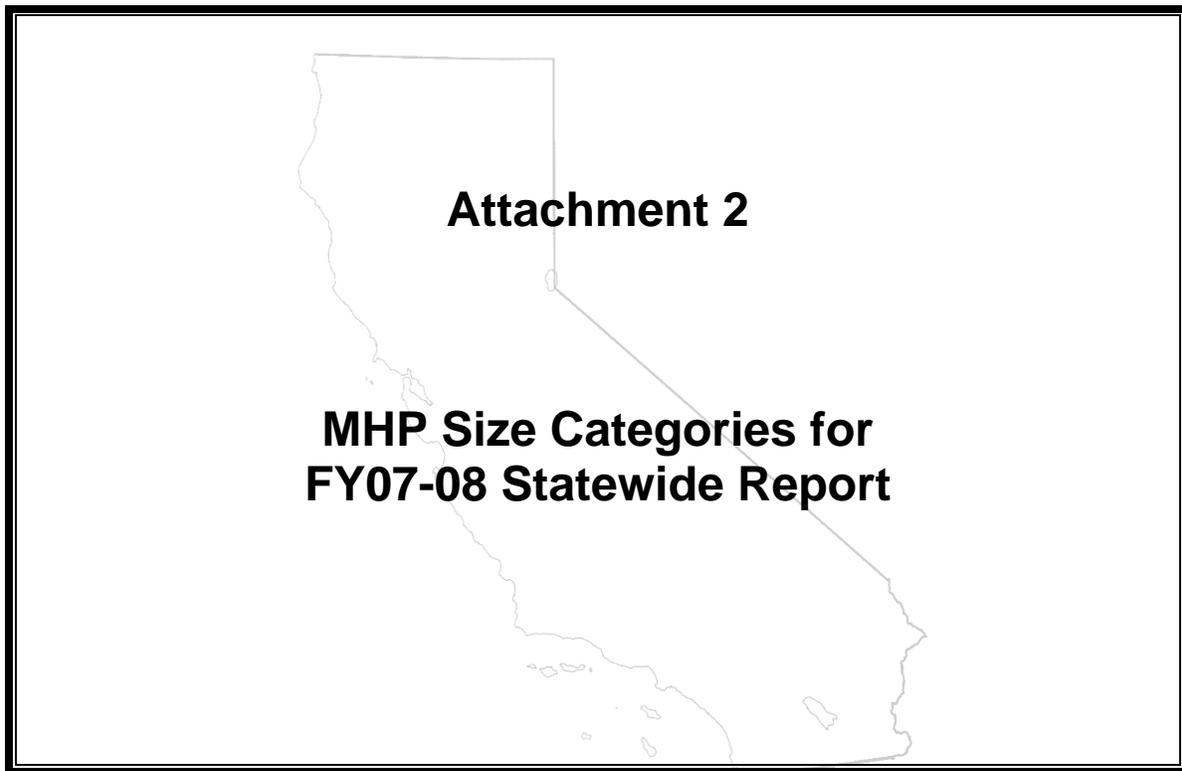
## GLOSSARY

Definition	
Beneficiary	Person covered by Medi-Cal insurance for medical/mental health and specific substance abuse services
Consumer	Person not covered by Medi-Cal insurance or the general term for those receiving services

Acronym	Meaning
AOD	Alcohol and Other Drugs
ASOC	Adult Systems of Care
CalMEND	California Mental Health Care Program
CalQIC	California Quality Improvement Committee
CARF	Commission on Accreditation of Rehabilitation Facilities
CBO	Community based organization
CaMH	California Institute of Mental Health
CMHDA	California Mental Health Directors Association
CMHPC	California Mental Health Planning Council
CMS	Centers for Medicare and Medicaid
COD	Co-Occurring Disorders
COLA	Cost of Living Allowance
CPCA	California Primary Care Association
CSI	Client Service Information
CSOC	Children's System of Care
CWS	Child Welfare System
DMH	Department of Mental Health Services
EBP	Evidence Based Practice
ECR	Error Correction Report
EOB	Explanation Of Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
FFP	Medi-Cal Federal Financial Participation
FFS/MC	Fee-for-Service Medi-Cal
FSP	Full Service Partnership
FTE	Full-time Equivalent
HIPAA	Health Insurance Portability and Accountability Act
IDDT	Integrated Dual Diagnosis Treatment
IMD	Institution for Mental Disease
IS	Information Systems
ISCA	Information Systems Capability Assessment
IT	Information Technology
LPS (Conservatorship)	Lanterman, Petris and Short
MH	Mental Health
MHP	Mental Health Plan

<b>GLOSSARY</b>	
MHSA	Mental Health Services Act
MMEF	Monthly Medi-Cal Eligibility Extract File
OAC	Mental Health Services Oversight and Accountability Commission
OASOC	Older Adult Systems Of Care
PDSA	Plan, Do, Study, Act
PIP	Performance Improvement Project
QI	Quality Improvement
QIC	Quality Improvement Committee
SAM	Statewide Approved Maximum (rate amount)
SCERP	Small County Emergency Risk Pool
SD/MC	Short-Doyle/Medi-Cal
SGF	State General Fund
SMA	State Mandate Allowance
SOC	Systems of Care
TAY	Transition Age Youth
UMDAP	Uniform Method of Determining Ability to Pay

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## MHP Size Categories for FY07-08 Data Analysis

In performing data analysis for the FY07-08 Statewide Report, CAEQRO categorized mental health plans (MHPs) by two different sets of size categories:

1. **Five size categories** — data on Medi-Cal beneficiaries, consumers or services: Most of the data analysis discussed in the annual report and displayed in the attachments reflects five size groupings: small-rural, small, medium, large, and very large. These categories are based on county population figures from the California, Department of Finance, E-1City/County Population Estimates, as of January 2008:

Group Size	County Population
Small-Rural	<54,999
Small	55,000 to 199,999
Medium	200,000 to 749,999
Large	750,000 to 3,999,999
Very Large	>4,000,000

With literally millions of records, five categories enable a substantial sample size in each category for meaningful analysis, such as revealing statistically significant trends. When appropriate, we extracted Los Angeles from our data set and analyzed California Not Los Angeles (CANOLA) only.

2. **Three size categories** — health information systems survey data. In Section 2.3, FY07-08 Analysis of Health Information Systems, the figures are based on a relatively small number — 56 MHPs. In analyzing data collected from Information Systems Capabilities Assessment V6.1, we combined the categories "small" and "small-rural." In addition, Los Angeles results are contained in the "large" category. If we use five size categories, the results are diluted and the frequencies in each cell are very low. For example, the very large category (Los Angeles) would always have one. Therefore, five categories parse a relatively small data set into such a granular level that identifying themes or trends is not possible.

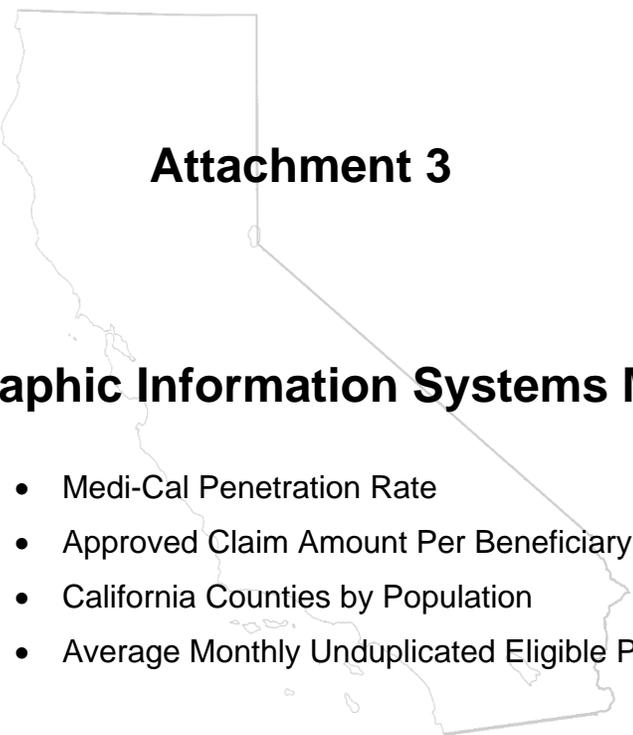
On the following page, we include a table displaying a cross walk that lists each MHP and its associated size category.

<b>Mental Health Plans and Size Categories</b>		
<b>Mental Health Plan</b>	<b>Three Categories</b>	<b>Five Categories</b>
Alameda	Large	Large
Alpine	Small	Small-Rural
Amador	Small	Small-Rural
Butte	Medium	Medium
Calaveras	Small	Small-Rural
Colusa	Small	Small-Rural
Contra Costa	Large	Large
Del Norte	Small	Small-Rural
El Dorado	Small	Small
Fresno	Large	Large
Glenn	Small	Small-Rural
Humboldt	Small	Small
Imperial	Small	Small
Inyo	Small	Small-Rural
Kern	Large	Large
Kings	Small	Small
Lake	Small	Small
Lassen	Small	Small-Rural
Los Angeles	Large	Very Large
Madera	Small	Small
Marin	Medium	Medium
Mariposa	Small	Small-Rural
Mendocino	Small	Small
Merced	Medium	Medium
Modoc	Small	Small-Rural
Mono	Small	Small-Rural
Monterey	Medium	Medium
Napa	Small	Small
Nevada	Small	Small
Orange	Large	Large
Placer/Sierra	Medium	Medium
Plumas	Small	Small-Rural
Riverside	Large	Large
Sacramento	Large	Large
San Benito	Small	Small
San Bernardino	Large	Large
San Diego	Large	Large
San Francisco	Large	Large
San Joaquin	Medium	Medium

<b>Mental Health Plans and Size Categories</b>		
<b>Mental Health Plan</b>	<b>Three Categories</b>	<b>Five Categories</b>
San Luis Obispo	Medium	Medium
San Mateo	Medium	Medium
Santa Barbara	Medium	Medium
Santa Clara	Large	Large
Santa Cruz	Medium	Medium
Shasta	Small	Small
Siskiyou	Small	Small-Rural
Solano	Medium	Medium
Sonoma	Medium	Medium
Stanislaus	Medium	Medium
Sutter/Yuba	Small	Small
Tehama	Small	Small
Trinity	Small	Small-Rural
Tulare	Medium	Medium
Tuolumne	Small	Small
Ventura	Large	Large
Yolo	Small	Small



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**Attachment 3**

**Geographic Information Systems Maps**

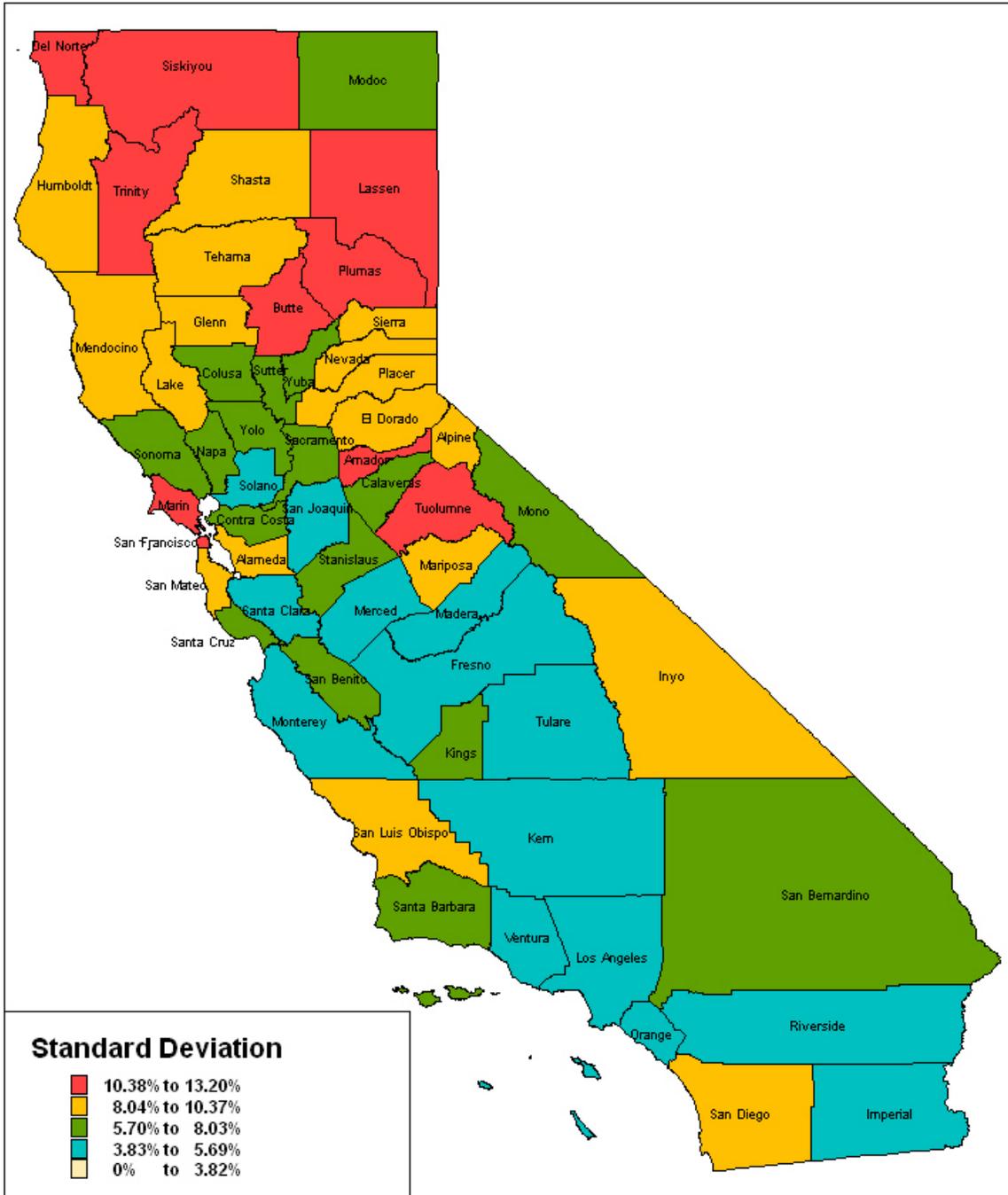
- Medi-Cal Penetration Rate
- Approved Claim Amount Per Beneficiary Served
- California Counties by Population
- Average Monthly Unduplicated Eligible Persons



# Medi-Cal Penetration Rate

## Medi-Cal Approved Claims - Calendar Year 2007

Statewide Average Penetration Rate - 6.19%



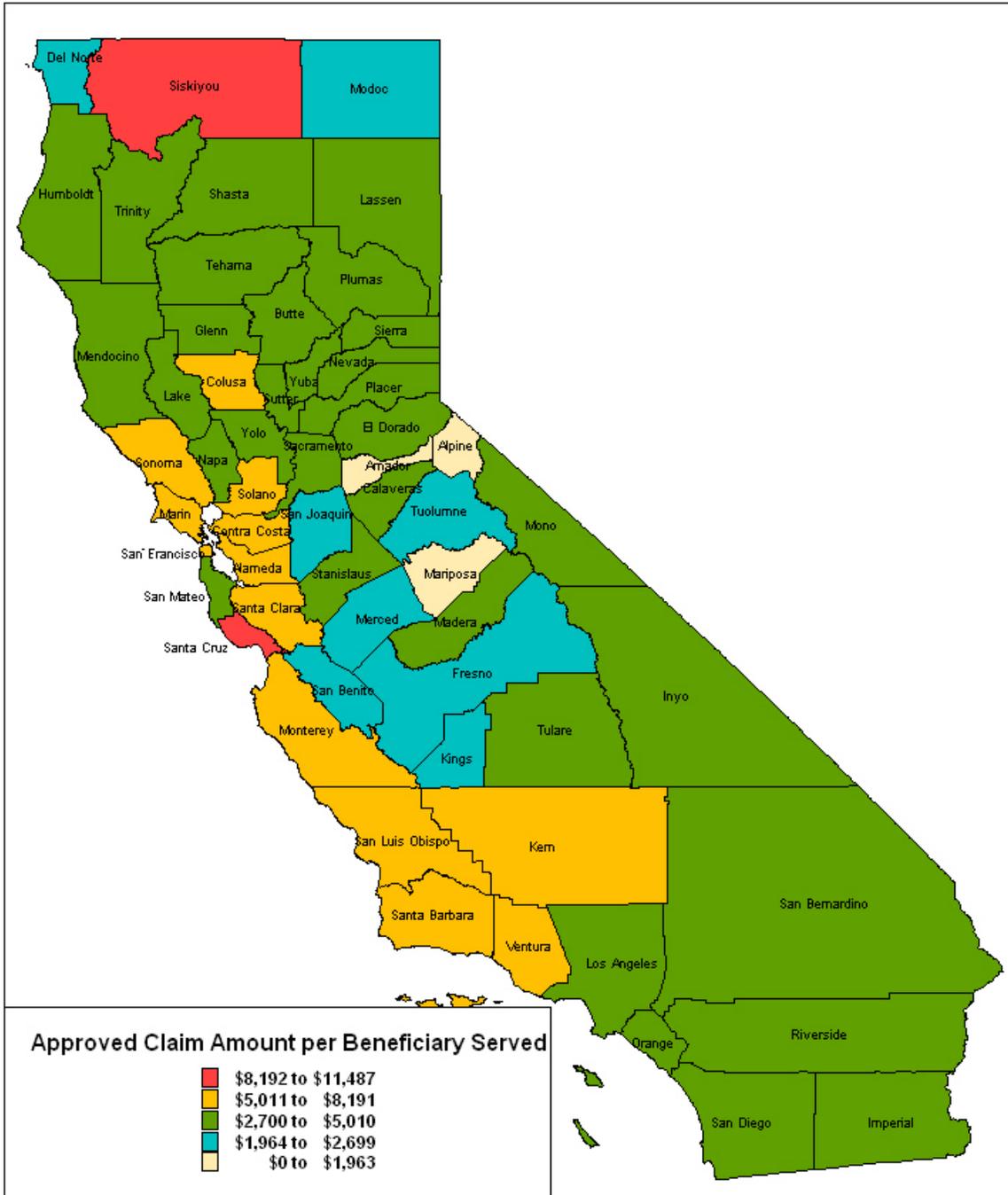
Source: Short-Doyle/Medi-Cal approved claims as of May 22, 2008; Inpatient Consolidated approved claims as of March 22, 2008  
 Prepared by: APS Healthcare CAEQRO, August 2008



# Approved Claim Amount Per Beneficiary Served

## Approved Claims - Calendar Year 2007

Statewide Average Claim Amount Per Beneficiary Served - \$4,451

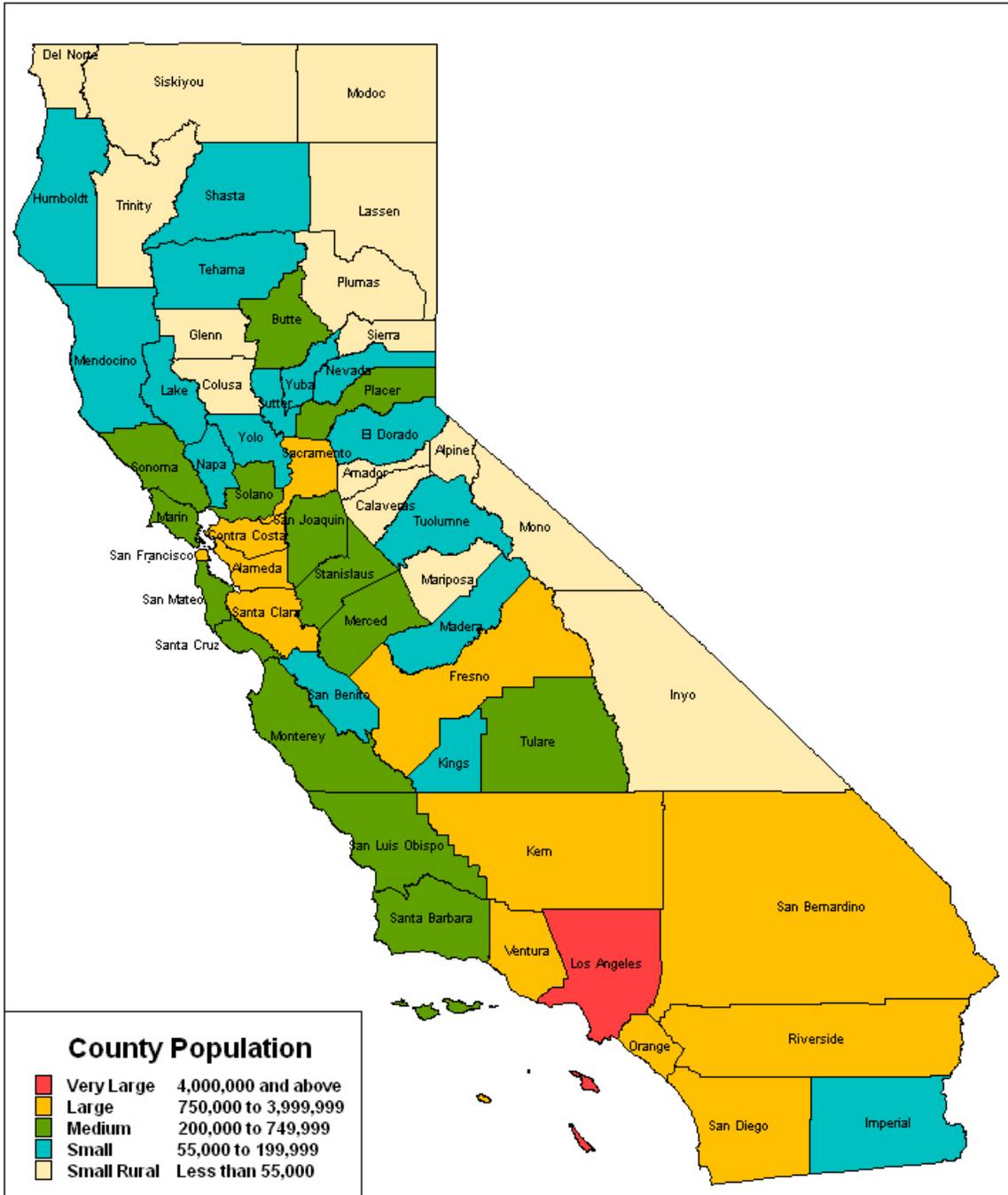


Data source: Short-Doyl/Medi-Cal approved claims as of May 22, 2008; Inpatient Consolidated approved claims as of May 22, 2008  
 Prepared by: APS Healthcare/CAEQR0, August 2008



# California Counties By Population January 2007

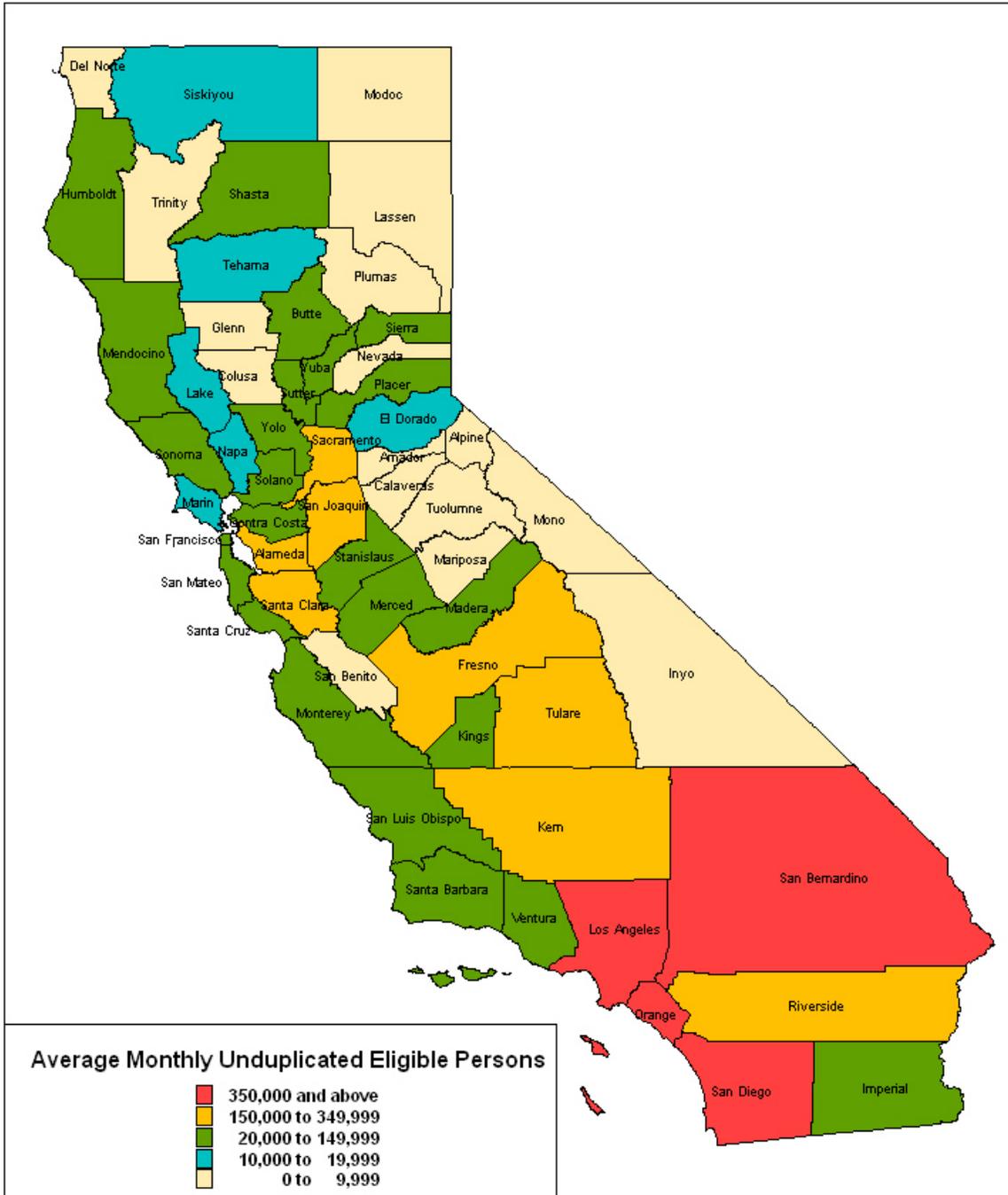
California Department of Finance - Demographic Research Unit, Table E-1 (as of May 2008)



Data source: California Department of Finance - Demographic Research Unit, Table E-1 (as of May 2008)  
Prepared by: APS Healthcare CAEQRO, August 2008



## Average Monthly Unduplicated Eligible Persons Medi-Cal Approved Claims - Calendar Year 2007



Source: Short-Doyle/Medi-Cal approved claims as of May 22, 2008; Inpatient Consolidated approved claims as of May 22, 2008  
 Prepared by: APS Healthcare CAEQRO, August 2008



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Background and Quality Initiatives<sup>14</sup>

According to the California Mental Health Director's Association (CMHDA), California lapsed from the nation's leader in community mental health development and civil rights for persons with mental illness into "decades of funding instability and program confusion" until the 1990s when the state "regained its preeminence in public mental health." Other stakeholders might argue that California has had varying degrees of success in implementing a number of changes to regain that preeminent position. Below we highlight the unique evolutionary path of the California public mental health system and the implicit challenges for an EQRO operating in this environment.

### The Evolution of a Unique System

Over the past 50 years, several significant events, as described below, have created California's complex and unique community mental health environment – characterized until very recently by successive budget cuts for human services and education coupled with increased demands on county-managed systems:

- **The late 1950s and the 1960s.** These two decades marked the beginnings of California's community mental health system, financed primarily through state funding and the implementation of the state's Medicaid program, which initially primarily focused on physical health care:
  - *Short Doyle Act.* In 1957, the passage of the Short-Doyle Act replaced large, state institutions with county-operated, local mental health programs. Under Short-Doyle, the state provided matching funds to counties and cities for the delivery of mental health services to their residents.
  - *Medi-Cal – California's Medicaid.* In 1966 California passed legislation establishing the California Medical Assistance Program (known as Medi-Cal), which primarily covered physical health care and some fee-for-service (FFS) mental health treatment.
  - *Community Mental Health Act.* In 1969, the California Community Mental Health Act increased the Short-Doyle funding ratio to 90 percent state/10 percent county funds when counties with populations over 100,000 were required to provide mental health services.
- **The 1970s and the 1980s.** In Fiscal Year (FY) 1973-1974, the state legislature required that all counties have a mental health program. However, during the 1970s and well into the 1980s, state allocations to counties for human services were severely diminished due to tax cuts and inflation, while federal "entitlement" programs – or so-called unfunded or inadequately funded mandates — created an additional fiscal burden:

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<sup>14</sup> This overview was first published in CAEQRO's Year Three Statewide Report. Please refer to Section 1.2 of the Year Four Statewide Report for updates.

- o *Proposition 13*. In 1978, the passage of “Prop 13” capped property taxes, reducing them by an average of 57 percent. Federal funding of Short-Doyle mental health programs — Short-Doyle/Medi-Cal (SD/MC) — did not begin until the early 1970s and did not offset the reduction in state monies. In 1987, for example, 68 percent of county Short-Doyle mental health expenditures were covered by the State General Fund (SGF), 12 percent by the federal government, 10 percent by the counties, and 10 percent by fees and insurance.
- o *AB 3632*. In 1984, the Legislature enacted AB 3632, which included mental health treatment for all children less than 22 years of age. These services are a federal entitlement resulting from the 1975 Individuals with Disabilities Education Act — which was to be financed by the state’s categorical funds.
- **The 1990s and realignment.** In 1991, California faced a \$14.3 billion deficit. Mental health funding, which was subject to annual legislative appropriation, was jeopardized by this statewide fiscal crisis. The Legislature responded by enacting the *Bronzan-McCorquodale Act*, referred to as *realignment*. It shifted program and funding responsibilities to counties, adjusted cost-sharing ratios, and provided counties with a dedicated revenue stream to pay for these changes in mental health, social and health services. Dedicated revenues from a half-cent increase in the state sales tax and the vehicle license fee were to cover the shifts in program costs. State oversight was to focus increasingly on outcomes and performance-based measures. Other significant events during the decade include the following:
  - o *Rehabilitation Option*. In 1993, a Medicaid State Amendment added services under the Rehabilitation Option to SD/MC benefits and greatly increased counties’ ability to increase their reimbursement for services through Medi-Cal funds.
  - o *Federal funding consolidation and managed mental health care*. From 1995 to 1998, the state consolidated the two Medi-Cal mental health funding streams — SD/MC and FFS/MC — and carved out specialty mental health services from the rest of Medi-Cal managed care. County mental health departments were given the “first right of refusal” to be the MHP for the county. At that time, only two counties declined (although both today are the MHPs for their beneficiaries). The carve-out program operates under a Federal Freedom of Choice Waiver. Specialty mental health care (i.e., requiring a specialist) is provided by MHPs, while general mental health services are under the direct purview of DHS either through its managed care plans or through the FFS/MC system.
  - o *Early and Periodic Screening, Diagnosis and Treatment*. A lawsuit against the state in 1995 resulted in the expansion of Medi-Cal services to Medi-Cal beneficiaries less than 21 years of age who need specialty mental health services, *whether or not such services are covered under the Medicaid State Plan*. As a result of the settlement, the state agreed to provide state general funds to counties as the match for these expanded

specialty mental health services, commonly referred to as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

- o *Therapeutic Behavioral Services*. Another lawsuit against the state, filed in 1998, resulted in the approval of a new EPSDT supplemental specialty mental health service for the Medi-Cal program. This new benefit is called Therapeutic Behavioral Services (TBS). Since these services were not included in the original realigned services, new state general funds were allocated to provide MHPs a match for these services as well.
- **2000s and budget cuts**. Until very recently — with the passage of Proposition 63, which became known the Mental Health Service Act (MHSA) — counties continued to experience increased budget cuts, cost shifting and unfunded or under-funded federal mandates:
  - o *AB 34/2034*. In 1999 a pilot program provided outreach and comprehensive services to homeless adults with severe mental illness. The Integrated Services for Homeless Adults, expanded to the majority of counties, is a categorical program that was funded through the SGF. After successive budget cuts, the program was eliminated in the most recent draft state budget (FY07-08).
  - o *EPSDT services*. In FY02-03, a 10 percent county share of cost was imposed by the administration for EPSDT services above a baseline expenditure level. These funds, together with realignment funds, may be used as the state Medicaid match for claiming federal matching funds.
  - o *AB 3632*. By FY01-02, the annual categorical allocation to counties for AB 3632 services had grown to \$12 million:
    - Because the costs to provide these services — at least \$100 million statewide — far exceeded the categorical allocation, counties were reimbursed for their additional costs through the SB 90 state mandate reimbursement process. Passed in 1972, SB 90 required the state to reimburse local governments for the costs of new programs or increased levels of service mandated by the state.
    - In the FY02-03 budget, all categorical funding for AB 3632 services was eliminated, and counties were told that they could receive all of their funding through the reimbursement process for unfunded mandates. However, the budget also suspended mandate reimbursements for local governments. In subsequent budgets, the Legislature ultimately approved funding but not enough to finance these mandated services.

## An EQRO in Today's Mental Health System

California's public mental health system has evolved from a simple one with state-local matching funds to one that includes state general funds, dozens of categorical funds, and federal matching funds to support a myriad of services. With realignment in the

1990s, California's public mental health system experienced one of the most significant changes in the past several decades. Counties acquired increased management and service delivery responsibility without commensurate funding support.

MHSA, which was passed in 2004, has as its overarching objective to transform the public mental health system into one that focuses on consumer wellness, recovery and resilience. The funding mechanism is a one percent tax on incomes over one million dollars. The most current state budget projects several billion dollars in MHSA funds for three fiscal years. The program focuses a broad spectrum of prevention, early intervention and other services, as well as infrastructure support for engagement of underserved populations and programs that promote recovery of individuals with mental illness.

Consequently, when APS Healthcare initiated the EQRO contract in 2004, the state's public mental health system was seriously under-funded, experiencing increased stakeholder pressure, struggling with already complex compliance requirements, and poised for a promised system transformation through MHSA. Summarized below are some of the high-level challenges that the system continues to face and the implications for CAEQRO, which many MHPs still view as "yet another compliance audit" with neither financial incentives nor consequences:

- **System-wide organizational culture.** The diversity of California's population, in terms of population density, ethnic make-up and socio-economic conditions, necessitated the creation of the decentralized system that was created by realignment and exists today. The creation of several strong, highly organized professional alliances emerged to support collaboration in a decentralized environment, including the CMHDA and the nationally regarded California Institute of Mental Health (CiMH). However, decentralization also created an environment in which each county system had become siloed and viewed itself as different and separate from other counties in the state. This entrenched perception created barriers to cross-county collaboration in addressing many of the system's shared challenges, particularly among small counties. In Section 3, we discuss how this year, CAEQRO has begun to overcome some of these barriers by promoting collaboration among counties.
- **Financing.** The mental health system's funding sources today are primarily a mix of realignment funds, Medi-Cal Federal Financial Participation (FFP), categorical funds and most recently MHSA:
  - o Realignment has certainly provided counties with a number of fiscal advantages, including the ability to roll over funds year-to-year and the elimination of competition with entitlement programs for state general funds. Passed as a legislative initiative, Realignment made available dedicated state funding based on sales tax and license fees according to population. However, this funding mechanism has an inherent flaw. When the economy is weak, a host of issues create the need for increased mental health services, while the primary funding for these services — license and sales tax revenues — decreases. The reduction of the vehicle license fees by the governor in 2004 created additional short falls.

- o Medi-Cal, a jointly funded state/local and federal program, represents the second largest revenue source for county mental health programs and has had a “mixed” impact on mental health services financing since realignment. FFP has fluctuated over time and many counties have had to use an increasing proportion of their realignment funds to draw the federal Medi-Cal match for mandated or entitlement programs. Various cuts in the most recent draft state budget follow the elimination of previous years’ Cost of Living Adjustment increases.
- o For budget shortfalls in categorical funds, counties have eliminated programs or for mandates they must dip into county general funds or reserves. Funding for AB 2034 appears to have been eliminated, leaving an entire population without a program that had proven effective in reducing hospitalization, the number of days spent in jail, and the number of days spent homeless. The state still owes counties over \$243 million in mandated reimbursement for EPSDT, although this funding is proposed in the most current version of the budget, and other cost settlements from previous years. AB 3632 shortfalls persist, as the current budget proposes funding levels equal to that included in the FY05-06 budget.
- o Funding from MHSA is projected to bring several billion dollars of revenue over three fiscal years. Many counties have started to implement what is known as Full Service Partnerships (FSPs), which will provide a range of services and supports that are not reimbursed under Medi-Cal. However, MHSA funding will still only reflect 17 percent of the overall budget. In addition, 50 percent of MHSA funding must be spent on FSPs within the next two years, and these funds can not be diverted to pay for other unbudgeted or under-budgeted programs/services.

Despite the anticipated influx of MHSA revenues, most MHPs are still grappling with serious budget shortfalls, are dedicating resources to those compliance activities that have financial implications and, most recently, are focused on implementing MHSA programs. With already complex and partially redundant compliance audits and quality reviews of MHPs and other county programs, the addition of MHSA-related oversight initiatives may result in counties’ undergoing up to 12 site visits each year. In this environment, many MHPs still view the EQRO process as another compliance exercise that diverts resources and neither produces nor preserves revenue. In Section 2.2, we address these and other findings in greater detail.

## Department of Mental Health Quality Initiatives

DMH “views accountability and quality improvement as critical components in achieving its mission (Mayberg S, 2004-05).” The following entities all play an important role in conducting fiscal, administrative and service oversight of California’s public mental health system:

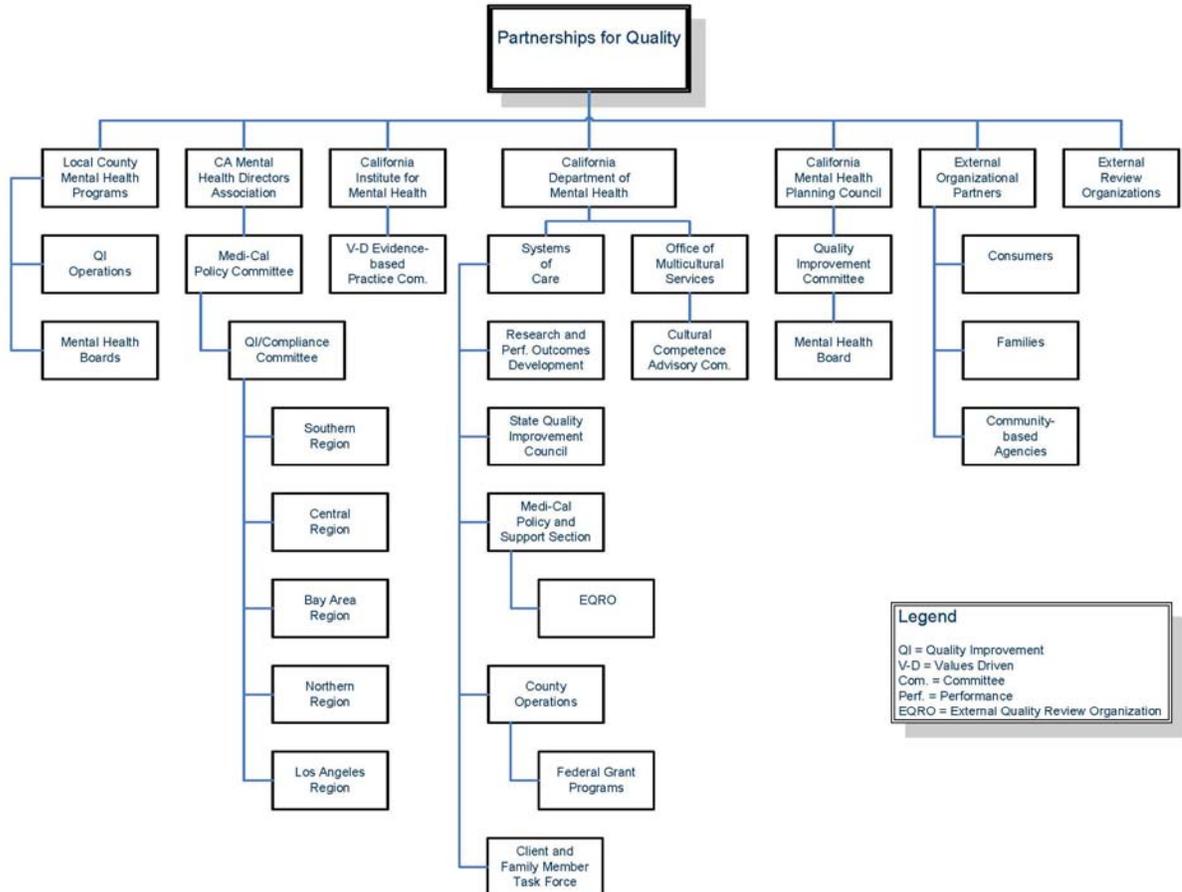
- DMH Performance Outcomes and Quality Improvement (POQI), Medi-Cal Oversight, and County Policy and Operations Units
- Fiscal auditors
- Performance Measurement Advisory Committee

- State Quality Improvement Council (SQIC)
- California Mental Health Planning Council (CMHPC)
- Local (county) Mental Health Boards and Commissions

A number of these entities have regulatory/statutory oversight of MHPs and other county mental health services. Following the implementation of MHPA, county mental health departments are facing potentially duplicative reporting and paperwork requirements – which is a key factor in preventing MHPs from addressing the quality improvement (QI) requirements mandated by CMS and implementing CAEQRO's QI-related recommendations.

Partnerships for quality

California's statewide QI systems involve multiple stakeholders and dozens of major entities. The organization chart below lists the Partnerships for Quality that are detailed in a 2005 white paper developed by CMHPC.



Within the statewide QI system, DMH has primary responsibility for oversight of quality and outcomes for MHPs — a role that was defined during realignment in the 1990s. Chapter 93, Statutes of 2000, recognized SQIC into law and directed it “to establish and measure indicators of access and to provide the information needed to improve the care provided in California’s public mental health system.” Established in 1999, SQIC historically has met four to six times per year.

After a lengthy process of evaluating various performance measures, SQIC adopted various indicators within four domains – Structure, Access, Process and Outcomes. Subsequently, DMH has proposed and implemented a variety of special studies within the public mental health system that supports each of these performance measures. These same domains are also consistent with the overarching objectives of the performance measurements that the DMH directs CAEQRO to apply as part of the annual review process.

### The impact of the Mental Health Services Act

A recent issues memo (June 5, 2007) recapped how three entities have emerged with often over-lapping statutory responsibilities for driving statewide quality and outcomes accountability for MHSA-funded programs. These three entities, listed below, also are potentially generating duplication in reporting and paperwork requirements imposed on county mental health departments — both in operating MHPs and in delivering services for indigent populations:

- DMH, which provides leadership of California’s mental health system and ensures through partnerships the availability of effective, efficient, culturally competent services.
- CMHPC, which through federal and state statute, provides oversight of the public mental health system.
- Mental Health Services Oversight and Accountability Commission (MHSOAC), which oversees the implementation of MHSA, includes “redirecting the state’s mental health system towards transformation such that all mental health activities and programs stress prevention, early intervention, wellness, recovery and resilience.”

To increase coordination and decrease the likelihood of duplication of requirements, representatives from these three government partners, along with county mental health departments and community-based agencies, have proposed an Evaluation Group to achieve five goals:

1. To use MHSA funding to transform the entire mental health system
2. To achieve integration of performance measurement for the MHSA with performance measurement for the entire public mental health system
3. To measure outcomes, to promote QI, and to communicate the results to the multiple audiences to which the public mental health system is accountable

4. To decrease duplication and overlap among the DMH, the CMHPC and the MHSOAC in performance measurement and accountability
5. To simplify reporting requirements for county mental health departments and community-based agencies

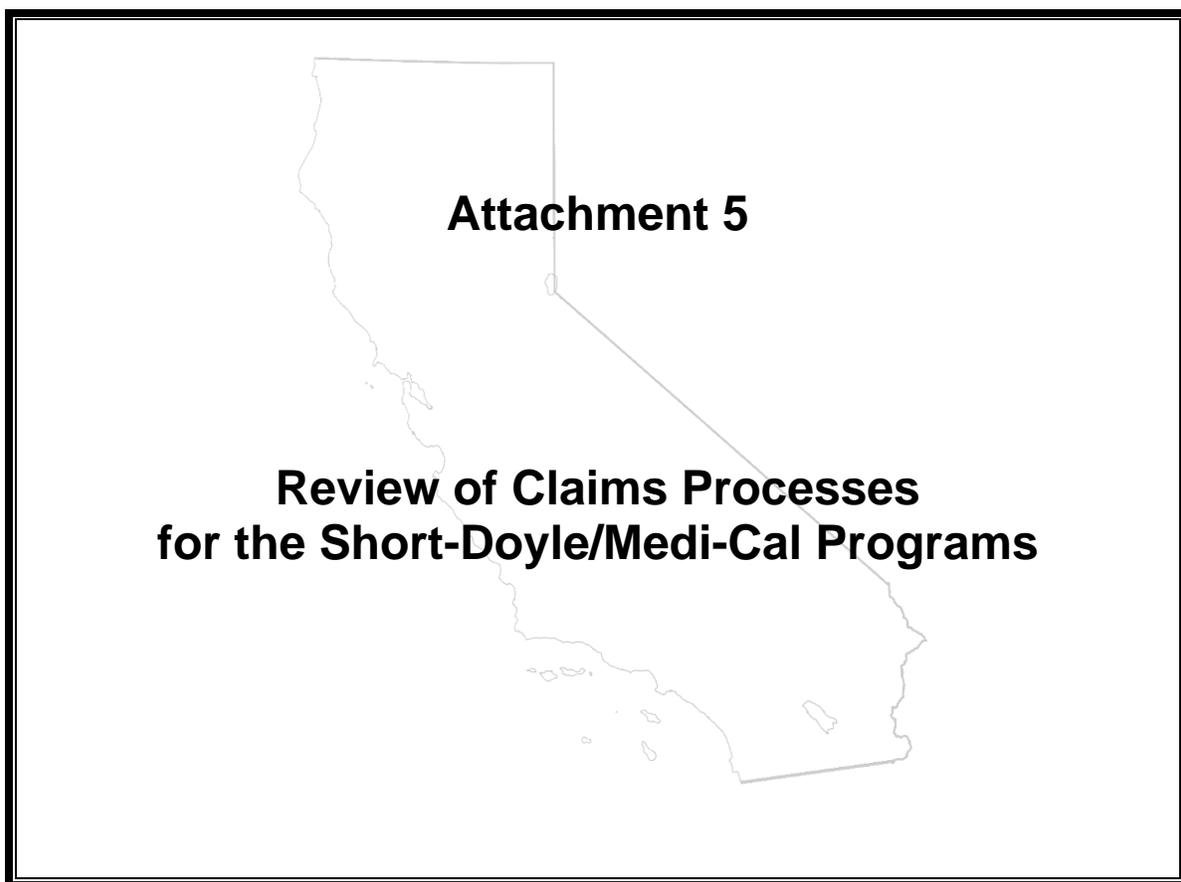
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For the full report go to: <http://www.dmh.cahwnet.gov/Reports/Legislative/ab328-data.asp>
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**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





A SPECIAL REVIEW

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Report on the California  
Department of Mental Health

Review of Claims Processes for  
Short-Doyle/Medi-Cal  
Programs

Prepared By:  
Office of State Audits and Evaluations  
Department of Finance

074440119

November 2007

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<sup>1</sup> This attachment includes an excerpt of this report. The complete report can be found on the Department of Finance Web site: [http://www.dof.ca.gov/osae/audit\\_reports/](http://www.dof.ca.gov/osae/audit_reports/)

## TABLE OF CONTENTS

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Executive Summary .....	1
Background, Scope, and Methodology.....	3
Observations and Recommendations.....	5
Conclusion .....	18
Exhibit 1—Description of Programs and Processes .....	19
Exhibit 2—Glossary of Acronyms and Terms .....	24
Exhibit 3—Process Flow Diagram .....	27
Response.....	29

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## EXECUTIVE SUMMARY

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In response to legislative and other stakeholders' concerns over late payments to Mental Health Plans (MHPs), the California Department of Mental Health (DMH) requested that the Department of Finance, Office of State Audits and Evaluations (Finance), review DMH's fiscal processes involved in the payment of local assistance claims for the Short-Doyle/Medi-Cal (SD/MC) Program, and make recommendations for streamlining and improving the payment processes.

The review confirmed that MHPs are not paid timely, and determined that the most far-reaching and mission critical weaknesses are program governance and the continued use of defective and outdated information systems. Most of the payment delays (and several of the observations in this report) stem from these over-arching deficiencies. DMH can better expedite payments to MHPs by improving governance, replacing defective systems, and eliminating inefficient manual processes. The following observations of the claims processes were identified, and the proposed recommendations, if implemented, would improve the SD/MC payment processes.

**Program Governance.** Governance over the SD/MC Program is fragmented, decentralized, and ineffective. Moreover, intradepartmental barriers between DMH and the Department of Health Care Services (DHCS) have impaired both organizations' ability to centrally govern and make the mission-critical changes needed to improve operations. The review found that:

- Communication and coordination between DMH and DHCS is poor.
- Performance benchmarks for critical claims processing functions do not exist.
- There is no single individual or unit with oversight responsibility for the SD/MC Program.
- A risk management process is not in place to identify threats to the SD/MC Program.

It is recommended that DMH and DHCS improve governance processes to ensure effective communication, coordination, and management of the SD/MC Program.

**Information Technology.** The various information technology systems used to process claims are at grave risk of failure, and contribute to significant payment delays. Moreover, delays in the implementation of a replacement for the primary system raise concerns about whether such replacement has been a high priority.

- Chief among these systems is the SD/MC System used by both DMH and DHCS to review and approve SD/MC Program claims. The review found that the SD/MC System is outdated and not compliant with the Health Insurance Portability and Accountability Act (HIPAA), and requires a cumbersome translation program to process claims. DHCS is responsible for system replacement, which is in progress but behind schedule. Further, DMH has not required MHPs to fully implement the electronic claims submission standards mandated by HIPAA which will impair any new system's effectiveness.
- Additional subsidiary systems that support the SD/MC System were also found to be deficient:
  - The HIPAA Translator has limited memory and cannot handle the current volume of claims, and as a result, is unreliable and at risk of failure. Until DHCS replaces the SD/MC System, claims processing will continue to rely on the HIPAA Translator.
  - The Access 97 Database used by DMH to process MHP claims has a history of

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significant errors and periods of non operation. Substantial state resources have been expended to repair and maintain the system.

- o The Invoice Processing System (IPS) used by DMH to create federal financial participation (FFP) invoices lacks sufficient controls over invoice creation and modification and may be unable to prevent duplicate payments.

DMH acknowledges the above systems weaknesses and has been working with DHCS on solutions, but progress has been slow. It is recommended that DHCS and DMH make systems replacement the top priority.

The review also determined that the lack of coordinated responsibility and a formal resolution process has impaired timely action on information technology issues.

**Claims Processing.** The current claims process is inefficient, slow, and poorly controlled. Serious flaws in the design and operation of the process significantly impair DMH's and DHCS's ability to effectively manage the payment function. The review found that:

- A key flaw is the bifurcated payment of state general fund (SGF) and FFP funds, whereby separate State Controller's Office (SCO) warrants are issued for the SGF and FFP portions of claimed amounts. Best practices require these funds to be combined in one payment.
- The calculation of SGF and FFP reimbursement amounts requires labor-intensive manual and semi-automated processes that can take up to a month to complete. Full automation of the reimbursement calculation process would correct this weakness.
- DMH's process of "invoicing" DHCS for the FFP due requires extensive effort by both departments to process, reconcile, and correct invoices. The process should be eliminated and replaced with an automated solution that utilizes information from the SD/MC System.
- Accounting and reporting systems do not provide timely, complete, and accurate information from which to effectively monitor and control SD/MC funds.
- DMH is at continued risk of overbilling the federal government because Early and Periodic Screening, Diagnosis and Treatment (EPSDT) claims are still included in Beneficiary Services for billing purposes, which may allow the errors to reoccur.
- Claims processing times should be improved. A limited sample revealed that the average processing times were 96 days for SGF and 109 days for FFP claims.

**Cost Settlements and Audits.** The cost settlement process is not timely. MHP-reported amounts may contain errors that are not discovered until the cost reports are audited years later, precluding timely and accurate expenditure forecasting. The review determined that:

- The cost settlement process is needlessly prolonged to include a small number of "good cause waivers" that result in no material difference in the total reported costs.
- Audits were not completed timely and the audit planning process could be improved.

DMH has already taken positive steps by conducting internal studies and convening special workgroups and committees to define problems and identify solutions. To further enhance these efforts, DMH and DHCS should develop a plan to address the observations and recommendations noted in this report.

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**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





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PERFORMANCE AUDIT

California Department of Mental Health  
Mental Health Services Act

Prepared By:  
Office of State Audits and Evaluations  
Department of Finance

084440075DPR

May 2008

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<sup>1</sup> This attachment includes an excerpt of this report. The complete report can be found on the Department of Finance Web site: [http://www.dof.ca.gov/osae/audit\\_reports/](http://www.dof.ca.gov/osae/audit_reports/)

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## TABLE OF CONTENTS

Executive Summary .....	iii
Background, Objectives, Scope, and Methodology .....	1
Results and Recommendations .....	7
Appendix 1: Plan Review Process Flow Diagrams .....	16
Appendix 2: Web-Based Survey Results of County Mental Health Directors .....	19

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## EXECUTIVE SUMMARY

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The Mental Health Services Act (MHSA) was enacted January 1, 2005 to provide counties additional resources to expand mental health services offered in their communities. The MHSA requires the Department of Mental Health (DMH) to review and approve each county's *Three-Year Program and Expenditure Plan* (Plan). Pursuant to the 2007-08 Budget Act and an interagency agreement with DMH, the Department of Finance, Office of State Audits and Evaluations, conducted a performance audit of DMH's Plan review and approval process.

An overall documented plan for the development and implementation of the MHSA does not exist. At present, only the Community Services and Supports<sup>1</sup> (CSS) component is fully implemented; therefore, distributions and services for other components have been limited resulting in the perceived notion that the intent of the MHSA is not being adequately met. The CSS Plan review and approval process is consistent with the MHSA, but it is cumbersome and lengthy. Additionally, fund distributions to the counties have been untimely. As of March 31, 2008, approximately \$3.2 billion has been collected and \$2.9 billion has been allocated for county use. Of the \$2.9 billion allocation, \$1 billion has been approved for distribution but only \$726 million has been distributed to the counties.

### Development and Implementation Process

Although DMH has diligently worked to implement the MHSA, a documented plan of the MHSA development and implementation does not exist resulting in a staggered implementation of components, delayed issuance of component guidelines, and fund distribution not in compliance with the MHSA. In addition, entities involved lack effective communication and coordination, and roles and responsibilities are not clearly defined and communicated.

To improve the development and implementation process and comply with the MHSA, DMH should: (1) create a strategic development and implementation plan which addresses component integration, performance measures, and program monitoring efforts, (2) promote effective communication and coordination among entities involved in the MHSA by engaging all relevant parties in policy development, standardizing common processes, and developing communication protocol, and (3) develop regulation to define the roles and responsibilities of each entity involved in the MHSA.

### Plan Review and Approval Process

DMH staff have been dedicated and enthusiastic throughout the MHSA development and implementation resulting in program efficiencies with the Plan review and approval process. However, DMH's application of the CSS component guidelines is strict and inflexible. The guidelines include repetitive and redundant information requests and create a labor intensive process requiring extensive administrative tasks at both DMH and the counties. DMH should review and revise guidelines and their application to provide for flexibility and customization. More reliance should be placed on the counties' expertise and the counties should be held accountable for their Plans.

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<sup>1</sup> Services for adults and children is commonly referred to by DMH as Community Services and Supports (CSS).

The CSS Plan review process is also lengthy and inefficient. The CSS Plan and Augmentation Plan reviews are not completed within the established time frames. Additionally, lack of established deadlines for the counties' submission of additional requested or missing information delays the process for indefinite lengths of time. For the Prevention and Early Intervention Plans, DMH uses the same review tool as the Mental Health Services Oversight and Accountability Commission (OAC) even though each entity has different review responsibilities. To improve review efficiency, DMH should establish and enforce deadlines for the submittal of additional information from counties. DMH should ensure that the use of the OAC's PEI review tool will enable it to meet its review obligations.

#### **Fund Distribution Process**

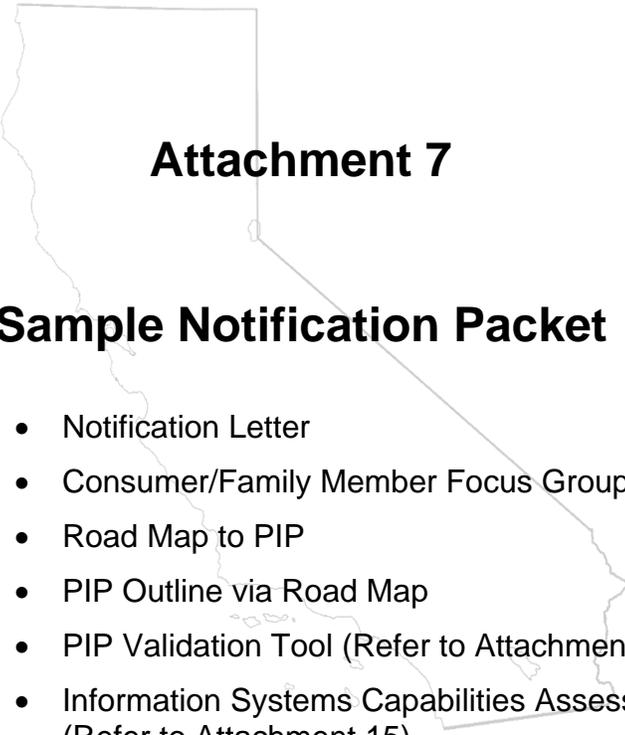
The DMH recently implemented improvements to the fund distribution process: (1) the MHSa contract process was changed to an Agreement process, which reduced the time required to process payments; (2) a source document verification form was created to verify the accuracy of fund distributions; (3) the fund allocation methodology was changed from accrual basis to cash basis which enables DMH to ensure sufficient funds are available to support the required fiscal year MHSa funding levels, and, DMH now advances 75 percent of the counties' approved Plan amounts to increase cash flow (4).

Despite these changes, the fund distribution process still needs improvement. Specifically, the process to notify the DMH Accounting Unit to issue payment is cumbersome and inefficient. To improve its operations, DMH should develop a formal payment authorization form for use when notifying DMH's Accounting Unit to schedule payments. Further, DMH should ensure policies and procedures are in place to require the prompt processing of county distributions.

DMH should develop a plan to address the observations and recommendations noted in this report. Implementing our recommendations will enable DMH to fulfill the intent of the MHSa and allow counties to readily implement programs and services to effectively treat and support the mentally ill.

For additional information related to the observations discussed above, see the *Results and Recommendations* section of the report. Various appendices were prepared for informational purposes.

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 7**

**Sample Notification Packet**

- Notification Letter
- Consumer/Family Member Focus Group Guidelines
- Road Map to PIP
- PIP Outline via Road Map
- PIP Validation Tool (Refer to Attachment 13)
- Information Systems Capabilities Assessment V6.1 (Refer to Attachment 15)
- Approved Claims Data (Refer to Attachment 8)





California EQRO  
560 J Street, Suite 390  
Sacramento, CA 95814

Date

Name

Mental/Behavioral Health Director

Name County Mental/Behavioral Health

Address

Address

Dear < Mr. /Ms. /Dr.>:

APS Healthcare is looking forward to the fourth year external quality review site meeting with the <Name> County Mental Health Plan (MHP) <on/from Date(s)>, from X a.m. – X p.m.

The designated review team will include the following APS staff members:

- Name, Lead Reviewer
- Name, Information Systems Reviewer
- Name, Consumer/Family Member Consultant
- An additional CAEQRO reviewer < if applicable, name(s) if known >

The CAEQRO review continues as an evaluative process of the overall service delivery system as it relates to organization and structure, quality improvement, performance management, business practices and progress towards strategic goals over the past year. Discussions will focus on the MHP's utilization of data, specific reports and activities designed to manage and improve the access, timeliness, quality, and outcomes of services. The list of requested MHP documentation is included with this letter; these documents will provide the basis for much of the review discussion.

This year's review will emphasize the following issues from the FY06-07 review of the MHP that include:

(Identify approximately five issues/recommendations from last year's report.)

- Issue
- Issue

As part of the process, CAEQRO reviews Medi-Cal approved claims data for each MHP, which will be discussed on-site as it applies to the various review components described above. A copy of these data is attached.

The review will also include < one/two/three > 90-minute consumer/family member focus group<s > with 8 to 10 participants. Please organize the focus group(s) according to the following criteria:

1. < Identify criteria here for each specific focus group, including specification for whether particular ethnic, language, or age groups are being sought. >
2. < Identify criteria here for each specific focus group, including specification for whether particular ethnic, language, or age groups are being sought. >
3. < Identify criteria here for each specific focus group, including specification for whether particular ethnic, language, or age groups are being sought. >

The CAEQRO Lead Reviewer will develop a detailed agenda with the designated MHP contact so that involved participants can appropriately plan their time. This process will occur upon CAEQRO's receipt and review of the requested documentation and confirmation of the date(s)/times(s) of the consumer/family member focus group(s), which should avoid being scheduled during the first morning of the review. Please inform the Lead Reviewer if the consumer/family member focus group(s) will be held off-site, if interpreters will be involved, and how much transportation time to allow. In addition, please confirm the availability of two meeting rooms that can accommodate the MHP and APS staffs conducting simultaneous review activities, as well as a room that can accommodate a consumer/family member focus group of up to twelve individuals.

Please discuss with the Lead Reviewer the detailed list of planned participants for each scheduled session so that the appropriate individuals are included in each component of the review. The various activities will require the participation of the following individuals:

- Executive Leadership
- Information Systems
- Finance, Billing, and Operations
- Quality Improvement, Data Analysis, and Research
- Key line staff and supervisors within direct clinical and psychiatric/medical services
- Consumers and family members employed by the MHP
- < approximate number of providers > organizational contract providers
- Other key organizations involved in collaboration with the MHP

The staff person who will be coordinating this review is requested to contact the Lead Reviewer directly at < number > or [name@apshealthcare.com](mailto:name@apshealthcare.com) by <DATE> so that we may begin discussing and planning the review.

Sincerely,

Name

CAEQRO Lead Reviewer

< Delete Blue individuals not involved in the review: >

cc: Sheila Baler, Executive Director, CAEQRO  
Rita McCabe, DMH Medi-Cal Policy and Support  
Sophie Cabrera, DMH Medi-Cal Policy and Support  
Jennifer Bianchi, DMH Medi-Cal Policy and Support  
Linda Okupe, DMH Medi-Cal Policy and Support  
Michael Reiter, Administrative Director, CAEQRO  
Sandra Sinz, Site Review Director, CAEQRO  
Saumitra SenGupta, Director of Information Systems, CAEQRO  
[Carol Borden-Gomez, Senior Systems Analyst, CAEQRO](#)  
[Bill Ullom, Senior Systems Analyst, CAEQRO](#)  
[Jerry Marks, Senior Systems Analyst, CAEQRO](#)  
[Hui Zhang, Reporting Manager, CAEQRO](#)  
[Lisa Farrell, Data Analyst, CAEQRO](#)  
[Dennis Louis, Information Systems Consultant, CAEQRO](#)  
[Beverly McGuffin, Lead Reviewer Consultant](#)  
[Rudy Lopez, Lead Reviewer Consultant](#)  
Bob Martinez, Consultant in Cultural Competence  
[Name](#), Consumer/Family Member Consultant  
[Name](#), MHP QI Coordinator  
[Name](#), MHP IT/IS Manager

Attachments:

Pre-Review Documentation List  
Consumer/Family Member Focus Group Guidelines  
[ISCA V6.1 – last year's ISCA is included for updating](#)  
PIP Outline with Road Map – for use to submit PIPs  
Road Map to a PIP  
CAEQRO PIP Validation Tool  
Approved Claims Data – All beneficiaries, TAY, foster care  
MHP Beneficiary Demographics





## **Pre-Review Documentation List**

Since the review will be specifically tailored to each MHP, it is important that the following items are submitted to the Lead Reviewer at ([name@apshealthcare.com](mailto:name@apshealthcare.com)) by < Date in approx 30 days >:

### **Please submit the following current MHP documents:**

- 1) MHP organizational chart(s)
- 2) Quality Improvement Work Plan and latest QI Work Plan Evaluation, including any related data and reports
- 3) Quality Improvement Committee and Cultural Competence Committee meeting minutes since the last review
- 4) The following only if they have been revised or updated since the last CAEQRO review:
  - a) Cultural Competence Plan
  - b) Two counties the MHP uses for comparison and the rationale for the selection
  - c) The MHP's mission and/or vision statement

### **Please develop and submit the following additional documents:**

- 5) A list of the current MHP strategic initiatives and a summary of the status of last year's initiatives
- 6) A summary document briefly describing significant changes within the service delivery system over the past year, including but not limited to:
  - a) Achievements in reducing racial, ethnic, cultural and linguistic disparities
  - b) Changes resulting from MHSA-related experiences
- 7) Key documents (which may include samples of working documents, reports, or forms) that depict the MHP's achievements in performance management associated with access, timeliness, outcomes, and/or other quality areas, including but not necessarily limited, to protocols for:
  - a) Timeliness of service provision – from request to first appointment and first psychiatry appointment; from hospital discharge to psychiatry appointment
  - b) Evaluation of evidence based practices
  - c) Medication prescribing guidelines and monitoring practices
  - d) Effectiveness of changes resulting from cultural competence, wellness/recovery, or other training programs

- 8) An update of last year's submitted ISCA V6.1, which is attached for your reference – please note updates in “track changes” or in a distinguishing colored font <OR> The completed ISCA V6.1 attached
- 9) Performance Improvement Projects:
  - a) Two current PIPs – one clinical and one non-clinical – submitted in the “PIP Outline with Road Map”
  - b) A summary of the status of any PIPs discontinued since last year's review.



## **Consumer/Family Member Focus Group Guidelines**

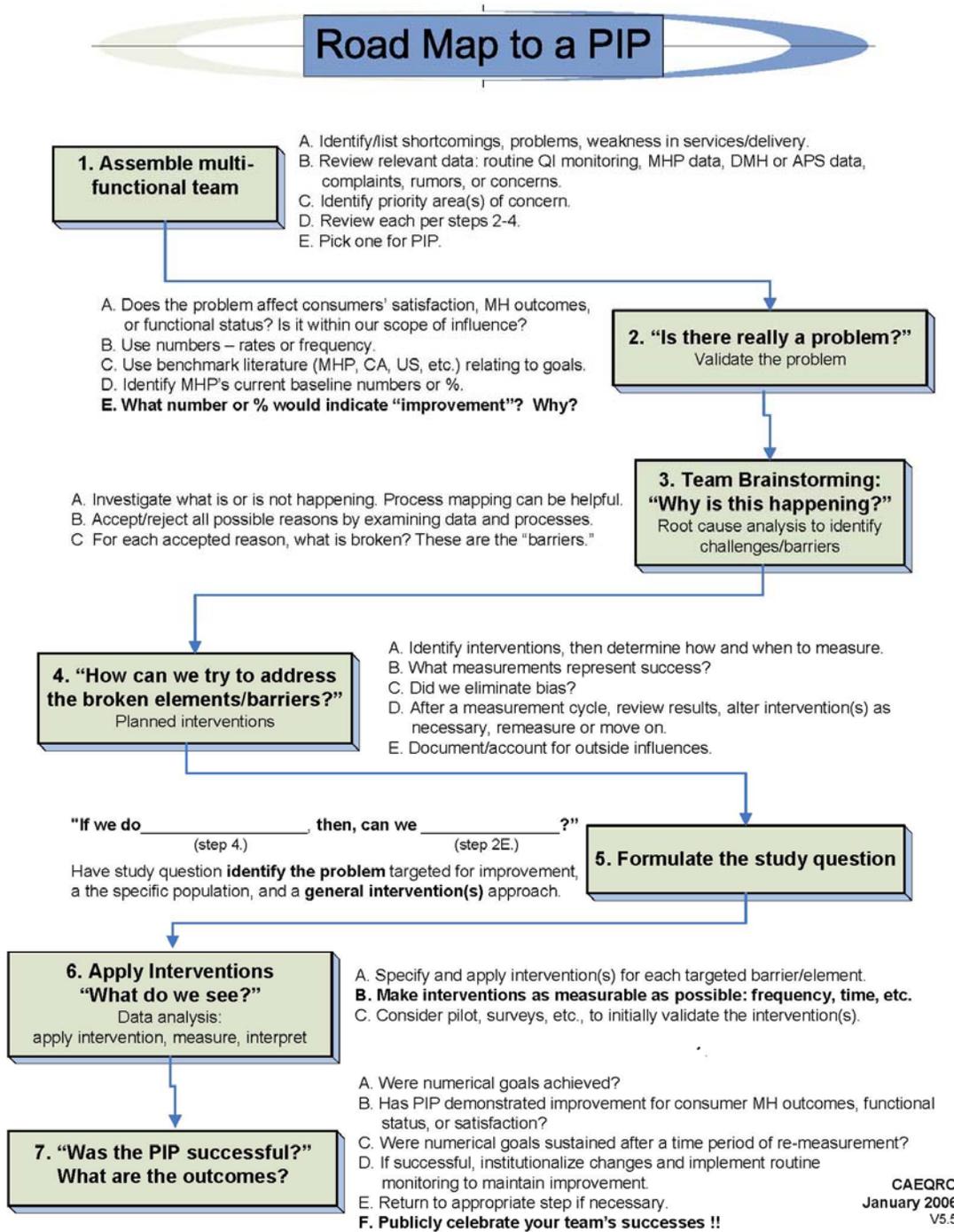
The Consumer/Family Member Focus Group is an important component of the CAEQRO Site Review process. Obtaining feedback from those who are receiving services from the MHP provides significant information regarding quality of care.

The Notification Letter identifies the demographic parameters of the focus group(s). In addition, the following guidelines apply to all focus groups. The MHP's review coordinator should be familiar with all of the items below, taking responsibility for all pre-planning logistics of the focus groups. Any contract provider who is sponsoring a group should have a full understanding of these logistical issues and should coordinate the specifics with the MHP prior to the site review. Direct any questions or suggested changes to the Lead Reviewer prior to the site review.

1. The focus group participants should not include:
  - Consumer/family member employees, advocates, Mental Health Board members, or any participants who represent the MHP in an official capacity
  - Staff members or other stakeholders who want to observe or participate
  - More than one individual from the same family within the same focus group (e.g., spouses, parent and child)
  - Participants who participated in previous CAEQRO consumer/family member focus groups
2. Schedule the group(s) at a time and location that is convenient for consumers and family members, though not on the morning of the first review day. Discuss the time and location with the Lead Reviewer so that travel time is built into the agenda. Consider additional strategies that can improve focus group attendance by:
  - Offering snacks, lunch, and/or transportation to participants
  - Posting signs in the waiting areas inviting participants to sign up to attend
  - Coordinating with the staff and/or consumer self-help programs to enlist participants
3. Inform potential participants of the purpose of the 90 minute focus group – specifically that APS is an external review organization and not affiliated with the county or DMH, and that the group is being conducted in order to solicit comments about their experiences with the mental health system. The distinction between the focus group and group therapy should be clear prior to the group.
4. Invite enough individuals so that there are 8 to 10 participants in each focus group. (Many MHPs invite 14-16 people to assure attendance of 8-10.) CAEQRO will provide 10 gift cards for each focus group, but the MHP should be prepared

with additional gift cards if there are more than 10 participants. Please do not advertise these \$20 gift cards as a mechanism for recruiting participants.

5. Advise the Lead Reviewer if monolingual participants are expected so that interpreter needs can be addressed. Limit each focus group to a single non-English language.







**California EQRO**  
560 J Street, Suite 390  
Sacramento, CA 95814

**This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that CAEQRO is required to use in evaluating PIPs. The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP.**

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

**CAEQRO PIP Outline via Road Map**

MHP:  
Date PIP Began:  
Title of PIP:  
Clinical or Non-Clinical:

Assemble multi-functional team

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

**“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.

**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?

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

Describe Cause/Barrier	Briefly describe data examined to validate the barrier

**Formulate the study question**

4. State the study question.  
This should be a single question in 1-2 sentences which specifically identifies the problem that the interventions are targeted to improve.
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?
  
- 9. 

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

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

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

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

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1					
2					
3					
4					
5					

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

**Table C - Interventions**

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1			
2			
3			
4			
5			
6			
7			

**Apply Interventions: “What do we see?”**  
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.
12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.
13. Describe the plan for data analysis. Include contingencies for untoward results.
14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.
15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?
16. Present objective data results for each performance indicator. Use Table D and attach supporting data as tables, charts, or graphs.

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

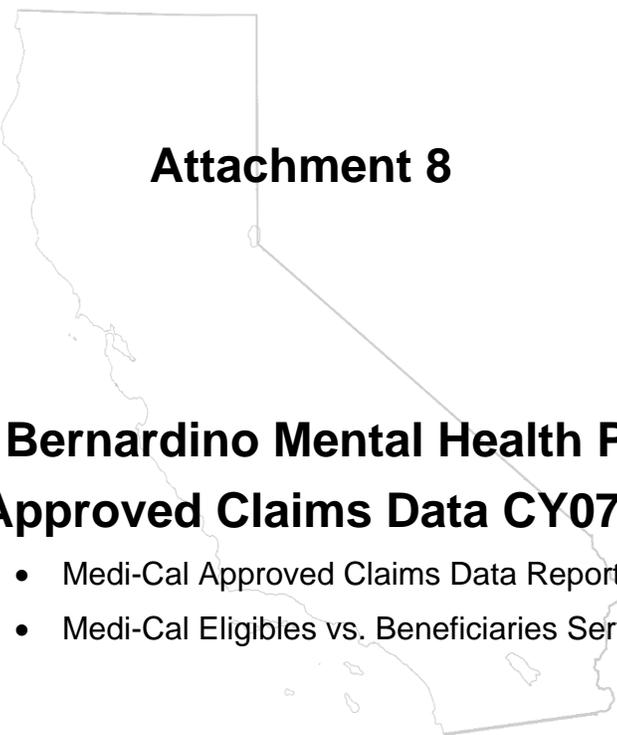
Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/denominator)	% improvement achieved

**“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?

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 8**

**San Bernardino Mental Health Plan  
Approved Claims Data CY07**

- Medi-Cal Approved Claims Data Report
- Medi-Cal Eligibles vs. Beneficiaries Served Chart



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



Date Prepared:	June 18, 2008 / Version 1.0
Prepared by:	Hui Zhang, AP S Healthcare / CAEORO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	May 22, 2008, May 22, 2008, and May 15, 2008 - Note (3)

	SAN BERNARDINO				LARGE			STATEWIDE		
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate
<b>TOTAL</b>	380,043	23,559	\$66,966,028	6.20%	\$2,842	6.52%	\$4,155	6.19%	\$4,451	6.19%
<b>AGE GROUP</b>										
0-5	82,902	735	\$1,596,101	0.89%	\$2,172	1.46%	\$3,178	1.31%	\$3,508	1.31%
6-17	120,475	8,621	\$29,875,179	7.16%	\$3,465	7.78%	\$5,305	7.71%	\$5,813	7.71%
18-59	133,370	13,026	\$33,346,624	9.77%	\$2,560	9.55%	\$3,757	8.70%	\$3,863	8.70%
60+	43,297	1,177	\$2,148,123	2.72%	\$1,825	3.52%	\$2,673	3.34%	\$2,705	3.34%
<b>GENDER</b>										
Female	217,474	12,501	\$32,838,040	5.75%	\$2,627	6.03%	\$3,640	5.67%	\$3,892	5.67%
Male	162,570	11,058	\$34,127,988	6.80%	\$3,086	7.16%	\$4,730	6.86%	\$5,058	6.86%
<b>RACE/ETHNICITY</b>										
White	87,849	9,594	\$27,715,361	10.92%	\$2,889	12.08%	\$4,180	11.84%	\$4,536	11.84%
Hispanic	204,996	6,933	\$19,295,831	3.38%	\$2,783	3.48%	\$3,725	3.29%	\$4,185	3.29%
African-American	54,057	4,364	\$11,849,505	8.11%	\$2,703	10.14%	\$4,802	9.94%	\$4,748	9.94%
Asian/Pacific Islander	15,646	637	\$1,340,058	4.07%	\$2,104	4.54%	\$3,173	4.45%	\$3,197	4.45%
Native American	1,578	213	\$720,100	13.50%	\$3,381	13.16%	\$4,825	10.86%	\$5,070	10.86%
Other	15,919	1,798	\$6,045,173	11.29%	\$3,362	9.45%	\$4,862	9.56%	\$5,425	9.56%

	SAN BERNARDINO				LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate
<b>ELIGIBILITY CATEGORIES</b>								
Disabled	60,695	11,025	\$31,325,530	18.16%	\$2,841	20.24%	\$4,328	19.89%
Foster Care	4,920	2,208	\$9,489,482	44.88%	\$4,298	53.12%	\$6,709	55.25%
Other Child	189,167	6,148	\$17,166,798	3.25%	\$2,792	3.87%	\$3,670	3.94%
Family Adult	72,178	4,293	\$7,594,375	5.95%	\$1,769	4.93%	\$1,774	4.49%
Other Adult	56,901	504	\$1,389,844	0.89%	\$2,758	0.97%	\$2,806	0.93%
<b>SERVICE CATEGORIES</b>								
24 Hours Services	380,043	2,491	\$14,047,325	0.66%	\$5,639	0.53%	\$8,400	0.47%
23 Hours Services	380,043	586	\$919,478	0.15%	\$1,569	0.50%	\$1,803	0.32%
Day Treatment	380,043	119	\$1,095,679	0.03%	\$9,207	0.14%	\$11,546	0.13%
Linkage/Brokerage	380,043	5,996	\$2,150,366	1.58%	\$359	2.79%	\$951	2.73%
Outpatient Services	380,043	18,405	\$33,104,539	4.84%	\$1,799	5.11%	\$2,502	5.10%
TBS	380,043	91	\$1,147,625	0.02%	\$12,611	0.07%	\$12,705	0.06%
Medication Support	380,043	14,500	\$14,501,015	3.82%	\$1,000	3.70%	\$1,038	3.35%

Footnotes:

- 1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs
- 2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding
- 3 - The most recent processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report
- 4 - County total number of yearly unduplicated Medi-Cal eligibles is 507,967

**SAN BERNARDINO County MHP Medi-Cal Services Retention Rates CY07**

Number of Services Approved per Beneficiary Served	SAN BERNARDINO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	2,165	9.19	9.19	8.76	8.76	2.18	17.92
2 services	2,067	8.77	17.96	6.42	15.18	0.00	14.20
3 services	1,632	6.93	24.89	5.28	20.46	0.00	10.49
4 services	1,387	5.89	30.78	4.92	25.39	2.51	9.53
5 - 15 services	9,631	40.88	71.66	32.56	57.95	20.10	73.33
> 15 services	6,677	28.34	100.00	42.05	100.00	6.67	61.89

Prepared by APS Healthcare / CAEQRO

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

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

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

Foster Care



Date Prepared:	June 23, 2008 / Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	May 22, 2008, May 22, 2008, and May 15, 2008 - Note (3)

	SAN BERNARDINO				LARGE			STATEWIDE		
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	
<b>TOTAL</b>	4,920	2,208	\$9,489,482	44.86%	\$4,296	53.12%	\$6,709	55.25%	\$7,054	
<b>AGE GROUP</b>										
0-5	1,193	233	\$566,011	19.53%	\$2,429	28.81%	\$3,060	27.65%	\$3,430	
6+	3,727	1,975	\$8,923,471	52.99%	\$4,518	61.76%	\$7,314	64.34%	\$7,567	
<b>GENDER</b>										
Female	2,372	938	\$3,671,763	39.54%	\$3,914	51.97%	\$6,515	52.65%	\$6,779	
Male	2,548	1,270	\$5,817,699	49.84%	\$4,581	54.21%	\$6,884	57.72%	\$7,292	
<b>RACE/ETHNICITY</b>										
White	1,729	813	\$3,849,378	47.02%	\$4,735	55.56%	\$6,880	52.69%	\$7,395	
Hispanic	1,824	777	\$3,011,611	42.60%	\$3,876	50.12%	\$5,560	56.49%	\$5,950	
African-American	1,270	562	\$2,347,151	44.25%	\$4,176	52.71%	\$7,874	57.23%	\$7,587	
Asian/Pacific Islander	35	10	\$18,291	28.57%	\$1,829	54.18%	\$5,959	58.03%	\$5,815	
Native American	35	21	\$141,547	60.00%	\$6,740	52.84%	\$4,912	48.27%	\$6,275	
Other	28	25	\$121,503	89.29%	\$4,860	86.14%	\$9,846	118.26%	\$9,990	

	SAN BERNARDINO				LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate
<b>SERVICE CATEGORIES</b>								
24 Hours Services	4,920	141	\$1,159,458	2.87%	\$8,223	1.94%	\$7,508	1.89%
23 Hours Services	4,920	65	\$125,223	1.32%	\$1,927	1.50%	\$1,338	1.00%
Day Treatment	4,920	59	\$529,110	1.20%	\$8,968	3.98%	\$14,453	3.60%
Linkage/Brokerage	4,920	531	\$188,954	10.79%	\$356	23.61%	\$1,270	24.62%
Outpatient Services	4,920	2,033	\$6,145,117	41.32%	\$3,023	49.57%	\$4,013	52.22%
TBS	4,920	33	\$414,541	0.67%	\$12,562	2.41%	\$12,913	2.19%
Medication Support	4,920	907	\$927,060	18.43%	\$1,022	17.31%	\$1,280	18.76%

Footnotes:

- 1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs
- 2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding
- 3 - The most recent processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report
- 4 - County total number of yearly unduplicated Medi-Cal eligibles is 6,883

**SAN BERNARDINO County MHP Medi-Cal Services Retention Rates CY07**  
**Foster Care**

Number of Services Approved per Beneficiary Served	SAN BERNARDINO				STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %	
1 service	180	8.15	8.15	6.61	6.61	0.00	25.00	
2 services	197	8.92	17.07	4.86	11.48	0.00	13.64	
3 services	194	8.79	25.86	4.66	16.13	0.00	12.67	
4 services	107	4.85	30.71	4.20	20.33	0.00	10.01	
5 - 15 services	648	29.35	60.05	25.19	45.52	9.89	60.00	
> 15 services	882	39.95	100.00	54.48	100.00	10.00	81.68	

Prepared by APS Healthcare / CAEQRO

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

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

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

**Transition Age Youth (Age 16-25)**



Date Prepared:	June 20, 2008 / Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	May 22, 2008, May 22, 2008, and May 15, 2008 - Note (3)

	SAN BERNARDINO			LARGE			STATEWIDE		
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
<b>TOTAL</b>	56,293	3,987	\$13,861,770	7.10%	\$3,468	6.96%	\$5,255	6.94%	\$5,559
<b>AGE GROUP</b>									
16-17	18,002	1,667	\$6,678,021	9.37%	\$3,959	10.17%	\$6,137	10.35%	\$6,492
18-21	22,302	1,367	\$4,560,650	6.22%	\$3,288	5.81%	\$4,811	5.81%	\$5,045
22-25	15,990	923	\$2,623,100	5.77%	\$2,842	5.29%	\$4,197	4.92%	\$4,333
<b>GENDER</b>									
Female	35,815	1,957	\$6,287,151	5.46%	\$3,213	5.70%	\$4,877	5.59%	\$5,166
Male	20,479	2,040	\$7,574,619	9.96%	\$3,713	9.10%	\$5,655	9.13%	\$5,949
<b>RACE/ETHNICITY</b>									
White	12,761	1,519	\$5,315,706	11.90%	\$3,499	12.69%	\$5,157	13.31%	\$5,541
Hispanic	30,976	1,391	\$4,971,902	4.49%	\$3,574	4.38%	\$4,615	4.31%	\$5,098
African-American	9,574	823	\$2,493,615	8.60%	\$3,030	10.57%	\$5,688	10.27%	\$5,760
Asian/Pacific Islander	1,679	49	\$145,768	2.92%	\$2,975	3.46%	\$5,868	3.57%	\$5,659
Native American	258	40	\$165,638	15.50%	\$4,646	11.66%	\$6,607	11.20%	\$6,392
Other	1,044	175	\$748,941	16.76%	\$4,280	10.92%	\$7,007	12.17%	\$7,694

	SAN BERNARDINO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
<b>ELIGIBILITY CATEGORIES</b>									
Disabled	6,747	1,352	\$5,056,627	20.04%	\$3,740	21.55%	\$6,119	22.34%	\$6,229
Foster Care	970	615	\$2,958,145	63.40%	\$4,810	70.36%	\$7,865	76.67%	\$7,581
Other Child	15,706	987	\$3,054,956	6.28%	\$3,085	7.49%	\$4,131	7.77%	\$4,630
Family Adult	25,614	1,032	\$2,054,441	4.03%	\$1,991	3.97%	\$2,523	4.02%	\$2,872
Other Adult	7,533	183	\$737,801	2.43%	\$4,031	2.20%	\$3,653	2.07%	\$3,957
<b>SERVICE CATEGORIES</b>									
24 Hours Services	56,293	714	\$3,936,425	1.27%	\$5,513	0.84%	\$7,682	0.76%	\$7,820
23 Hours Services	56,293	179	\$281,958	0.32%	\$1,575	0.76%	\$1,587	0.50%	\$1,506
Day Treatment	56,293	56	\$509,603	0.10%	\$9,100	0.29%	\$11,956	0.27%	\$12,101
Linkage/Brokerage	56,293	891	\$374,218	1.58%	\$420	2.89%	\$1,229	3.05%	\$1,052
Outpatient Services	56,293	3,409	\$6,358,954	6.06%	\$1,865	5.83%	\$2,965	6.05%	\$3,415
TBS	56,293	21	\$247,553	0.04%	\$11,788	0.11%	\$11,892	0.09%	\$13,462
Medication Support	56,293	2,251	\$2,153,059	4.00%	\$956	3.33%	\$1,020	3.12%	\$1,160

Footnotes:

- 1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs
- 2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding
- 3 - The most recent processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report
- 4 - County total number of yearly unduplicated Medi-Cal eligibles is 86,410

**SAN BERNARDINO County MHP Medi-Cal Services Retention Rates CY07  
Transition Age Youth (Age 16-25)**

Number of Services Approved per Beneficiary Served	SAN BERNARDINO				STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %	
1 service	375	9.38	9.38	10.10	10.10	2.07	27.36	
2 services	407	10.18	19.56	6.88	16.99	0.00	20.16	
3 services	331	8.28	27.85	5.45	22.44	0.00	12.59	
4 services	257	6.43	34.28	4.61	27.05	1.59	8.11	
5 - 15 services	1,476	36.93	71.20	28.96	56.01	16.67	43.48	
> 15 services	1,151	28.80	100.00	43.99	100.00	13.51	65.43	

Prepared by APS Healthcare / CAEQRO

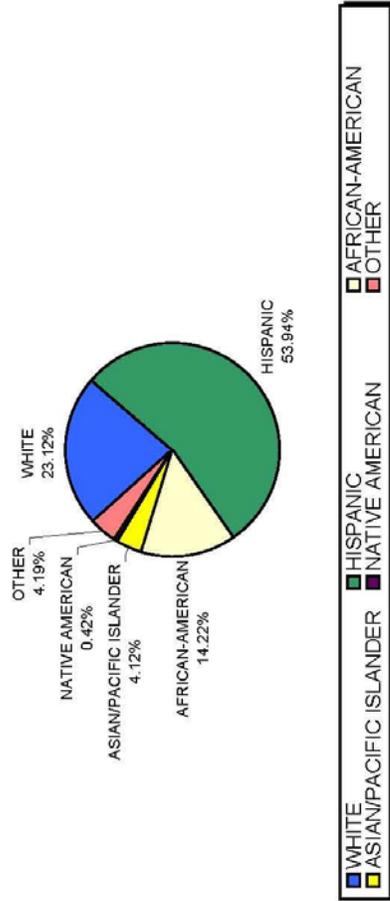
Source: Short-Doyle/Medi-Cal approved claims as of 5/22/2008; Inpatient Consolidation approved claims as of 5/22/2008

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

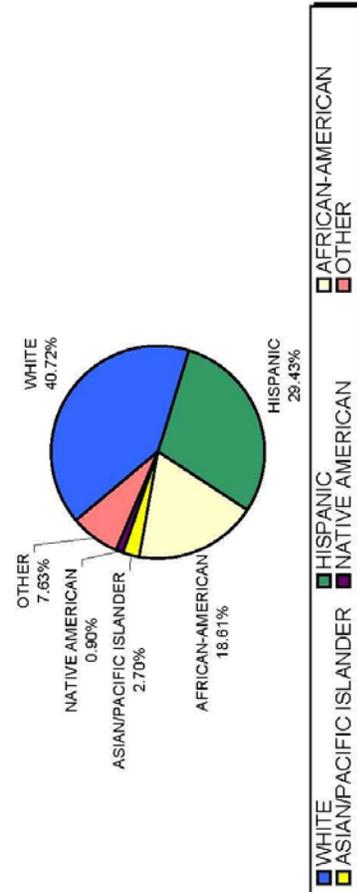
# San Bernardino Medi-Cal Eligibles vs. Beneficiaries Served

DMH Approved Claims Calendar Year 2007

Medi-Cal Average Monthly Unduplicated Eligibles

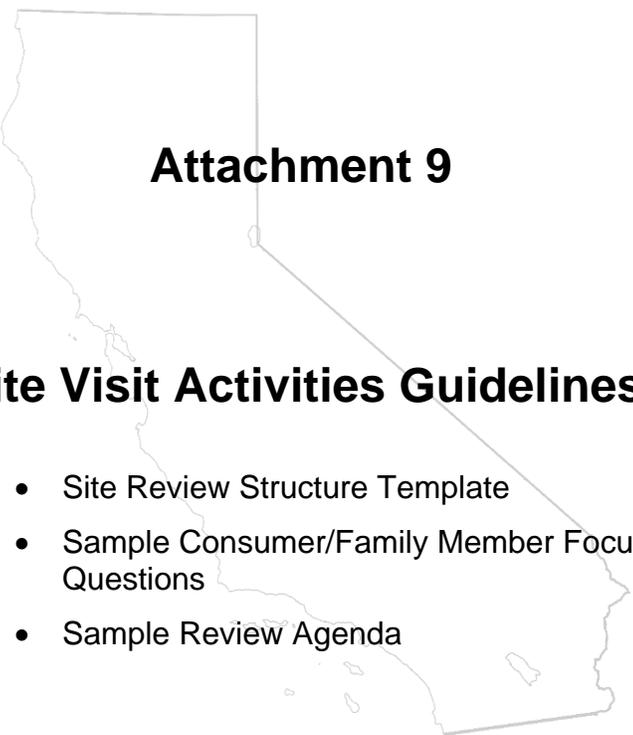


Medi-Cal Beneficiaries Served



Prepared by APS Healthcare CAEQRO  
 Source: Short-Doyle/Medi-Cal approved claims as of October 2007; Inpatient Consolidated approved claims as of November 2007

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 9**

**Site Visit Activities Guidelines**

- Site Review Structure Template
- Sample Consumer/Family Member Focus Group Questions
- Sample Review Agenda



## **MHP Review Structure Template**

**Total served:**

**Total budget:**

**# FTE in positions:**

**% services at the County:**

### **Introductory Session**

1. Introductions – sign-in sheets
2. EQRO federal regulations of managed care entities – annual quality review of each MHP
  - Special attention to issues of access, timeliness, outcomes, and quality
3. CAEQRO review priorities and strategies
  - Review of quality processes and use of data to support those processes
  - Review documentation and conduct interviews with key individuals – staff, c/fm, providers
  - Come back together at the end for a brief wrap-up, describe plan for report/etc
4. Year Three priorities include following up on previously identified issues and identifying growth in areas of data-driven performance management.
  - Revised documents to guide this process:
    - 1) Specify documents relevant to each MHP in the notification letter
    - 2) Updated ISCA 6.1
    - 3) To help MHPs with PIPs: Road Map and Outline with Road Map
    - 4) Revised PIP Validation Tool to be more clear and specific
    - 5) Revised our approved claims format and will continue to do so
  - Focusing on more opportunities to do technical assistance/training in group environments
  - Increasing the ways in which we use the data available to us – more analysis by ethnic group, gender, foster care, retention – emphasizing comparisons where feasible

Issues identified in the MHP's notification letter:

<Specify the 5-6 items from the notification letter>

## **Strategic Initiatives & Changes in the MHP**

- How has MHSA supported your strategies?
- How have changes in the MHP been for the positive or perhaps not?
- Major initiatives identified from MHP documentation:  
[< Specify the initiatives provided by the MHP. Identify for each the related goals, strategies, measurements, status >](#)

## **Last Year's Report Recommendations**

- Our goal is to encourage improvement in problem areas, whether or not the chosen methods were the ones we recommended. Did any new processes or improvements occur that resulted from the review, the report, or the data we brought?
- Was there anything about the report that was helpful?
- Which recommendations were more meaningful versus didn't seem important?
- What was done to address areas needing improvement?
- MHP's specific recommendations for discussion and rating:  
[< Specify the most important recommendations from the FY06-07 MHP Report >](#)

## **Follow-up issues from last year or from document review**

- Identify any other areas from last year's report or this year's document review that require clarification or discussion.

## **Performance Management**

- What reports do you use to measure performance?
- Which reports let you know how you are doing in terms of your strategic initiatives or other goals?
- Which reports are most meaningful for daily operations?
- What data do you provide to staff, contractors, consumers, etc?
- How did any of your own data guide your MHSA process? Did this process assist you in determining other ways to use data to guide management and development in other programs?

## **Performance Improvement Projects**

- How are your QI processes set up to foster identification of potential PIPs?
- Are your PIP topics significant enough to stimulate interest and receive the necessary attention and resources it requires to be successful?
- Do the PIPs represent different aspects of the MHP?
- Refer to PIP Validation Tool as appropriate.

## **Issues from approved claims data**

- Identify any outliers or changes in approved claims data for the MHP
- What are the MHP's impressions or hypotheses regarding the approved claims data?
- Specific emphasis on performance measures:
  - Latino penetration and approved claims
  - Gender penetration and approved claims

## **Wrap-Up**

- Closure
- Thank you for the preparation
- Preliminary themes or observations from the review
- Identify any outstanding documentation
- Will likely e-mail regarding any "loose ends" – things I didn't have time to ask, neglected to ask, or need clarification on
- Describe report process - Feedback from you regarding the draft
- Valuable items to include in the report from MHP's perspective
- Available for technical assistance
- Check out the website



## **Consumer/Family Member Focus Group Questions**

**Prior to asking questions:**

1. Explain purpose of EQRO.
2. Review confidentiality and collect signed participation forms.
3. Encourage interaction. We will not ask everybody every question. Answer those that are relevant to you.
4. This group will end in 90 minutes.

**Ask those questions deemed appropriate to the group. Adjust questions based upon information content as well.**

**Ask participants to introduce themselves – first name, programs they are involved in, how long they have received services in this County's system.**

1. How did you get invited to this focus group?
2. What services do you receive that are the most helpful to you? (Are you able to receive services in your preferred language?)
3. Do you receive services that help you with “real life” problems like dealing with your bills, living on your own, finishing school, or getting a job? What goals are most important for you, and how do your services help you get there?
4. Do you feel like you can “recover” from the problems that brought you here for services? How would you know if you achieved that?
5. Do you participate in any groups? Are there other kinds of groups that you think would help you that aren't offered? Do you know about opportunities to help others as a volunteer or even getting paid?
6. If you want your family involved, how does your provider include your family in ways that helps you?
7. Often people are afraid to ask for help. When you first asked for help here, did the staff help make you feel comfortable? Is there more that they can do to encourage others to come in when they need help?
8. How easy or difficult is to get an appointment with a psychiatrist? How satisfied are you with these services? Does your psychiatrist also work with your primary care doctor to make sure that the medications they both prescribe work together?
9. **What would you do if you felt that the staff person working with you wasn't a good fit for you?**
10. **What do you recommend for improving services?**



## Madera County MHP CAEQRO Site Review Agenda

14277 Road 28, Suite A, Madera

March 6, 2008

Time	Activities		
9:00 – 12:00	<p style="text-align: center;"><b><u>Performance Management</u></b> <b>Access, Timeliness, Outcomes, and Quality</b></p> <ul style="list-style-type: none"> <li>• Introductions of participants</li> <li>• Overview of review intent</li> <li>• Significant MHP changes in past year</li> <li>• Strategic initiatives – progress &amp; plans</li> <li>• Last Year's CAEQRO Recommendations</li> <li>• Performance improvement measurements utilized to assess access, timeliness, outcomes, and quality</li> <li>• Examples of MHP reports used for to manage performance and decisions</li> <li>• CAEQRO approved claims data</li> </ul> <p>Participants – those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions – including but not limited to:</p> <ul style="list-style-type: none"> <li>○ MHP Director, senior management team, and other managers/senior staff in: fiscal, programs, IS, medical, QI, research</li> <li>○ Involved consumer and family member representatives</li> </ul>		
12:00 – 1:00	APS Staff – Working Lunch		
1:00 – 2:30	<p style="text-align: center;"><b>Consumer/Family Member Focus Group</b></p> <p style="text-align: center;">8-10 individuals per notification letter &amp; MHP/CAEQRO discussion</p>	<p style="text-align: center;"><b><u>Site Visit – Homeless Helping the Community</u></b></p> <p style="text-align: center;">Visit to consumer-run, community-based program</p>	<p style="text-align: center;"><b><u>ISCA Update, Medi-Cal Claims and Billing Issues</u></b></p> <ul style="list-style-type: none"> <li>• Changes since year three review</li> <li>• Top IS priorities this year</li> <li>• Data access for managers, users</li> <li>• Medi-Cal claim, ECR, EOB processes</li> <li>• Denied claims reports and related processes</li> <li>• New policies and procedures since last review</li> </ul>
2:30 – 3:00	Travel		
3:00 – 4:30	<p style="text-align: center;"><b><u>Consumer/Family Member Focus Group</u></b></p> <p style="text-align: center;">8-10 individuals per notification letter &amp; MHP/CAEQRO discussion</p>	<p style="text-align: center;"><b><u>Clinical Supervisors Group Interview</u></b></p> <p style="text-align: center;">4-6 clinical supervisors (all peers) representing various programs and geographical sites</p>	<p style="text-align: center;"><b><u>3:30 – 4:30</u></b></p> <p style="text-align: center;"><b><u>MHP Site Visit for IS Review – Oakhurst</u></b></p> <p style="text-align: center;">Meet with 1-2 support staff and 1-2 clinical staff to discuss the Anasazi implementation</p>
4:30 – 5:00	Travel		

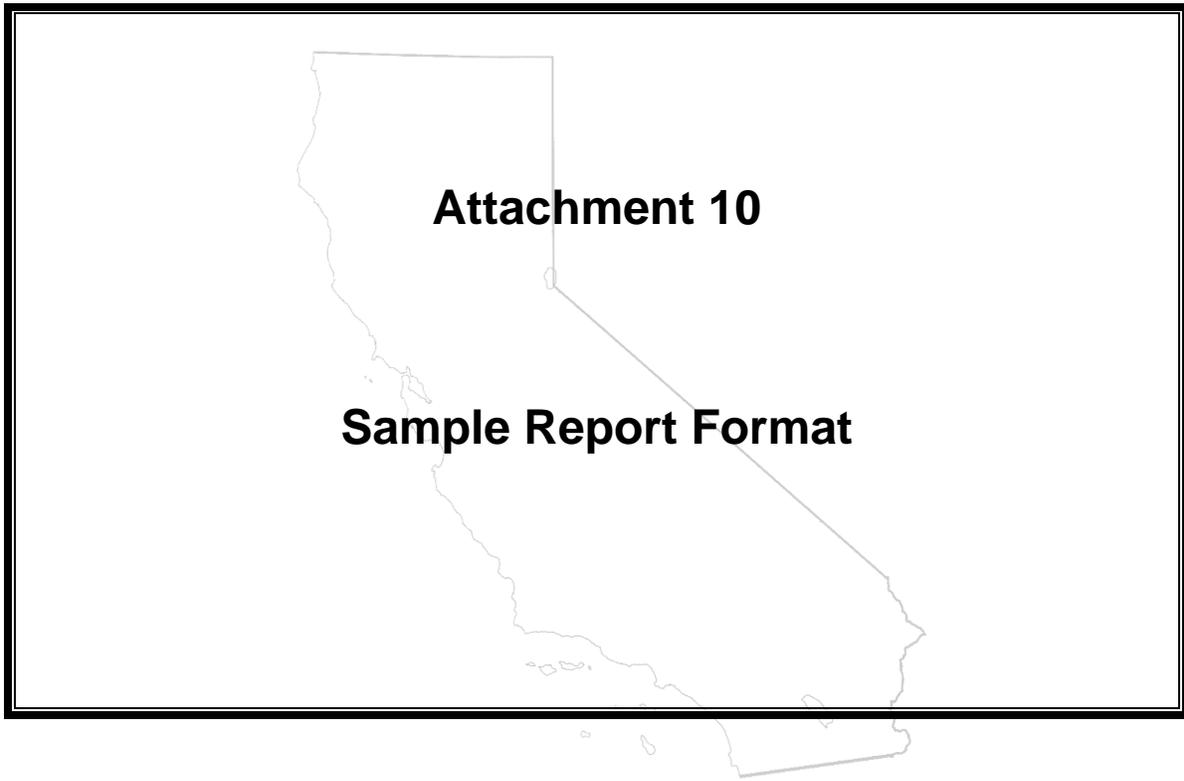
## Madera County MHP CAEQRO Site Review Agenda

March 7, 2008

Time	Activities		
9:00 – 10:00	<p style="text-align: center;"><b>Quality Improvement Committee and Cultural Competence Committee</b> <b><u>(Include any involved IS Staff, Research, and/or Data Analysts)</u></b></p> <p style="text-align: center;"><b>please include the most involved individuals regardless of status</b></p> <ul style="list-style-type: none"> <li>• Review of data and goals for quality measures and operations</li> <li>• Initiatives, activities and projects</li> </ul>		
10:00 – 11:30	<p style="text-align: center;"><b><u>Performance Improvement Projects</u></b></p> <p>Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans</p> <p>Participants should be those involved in the development and implementation of PIPs, including, but not necessarily limited to: PIP committee, MHP Director, other senior managers or key staff</p>	<p style="text-align: center;"><b><u>10:30 – 11:30</u></b> <b><u>Local FQHC Visit to</u></b> <b><u>Camerena Health Center</u></b></p> <ul style="list-style-type: none"> <li>• Discussion of coordination of care</li> <li>• Referral processes with MHP</li> <li>• Information sharing with MHP</li> <li>• Mental health services provided</li> </ul>	
11:30 – 12:30	<p style="text-align: center;"><b>Consumer Employees – at Hope House</b></p> <p>Consumers employed within the system, not necessarily only those employed at Hope House</p>	<p style="text-align: center;"><b><u>Clinical Line Staff Group Interview</u></b></p> <p>Clinical staff involved in crisis, access, intake, assessments (various ways of entry into the system)</p>	<p style="text-align: center;"><b><u>11:45 – 12:30</u></b> <b><u>Anasazi</u></b> <b><u>Implementation Team</u></b></p> <p>Should include <u>clinical and support staff</u> from various clinics as well as IS, Compliance, and Data Management Staff</p>
12:30 – 1:30	APS Lunch & Staff Meeting		
1:30 – 2:00	<p style="text-align: center;"><b><u>Wrap-Up Session</u></b></p> <ul style="list-style-type: none"> <li>• Closing the review with discussion of some preliminary themes and issues</li> <li>• CAEQRO next steps after the review</li> </ul>		

Check out our website at [www.caeqro.com](http://www.caeqro.com)

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**







## California External Quality Review Organization

**< Name > County MHP**  
**< Dates of Review >**

### Introduction and Scope

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

This report presents the fourth year findings of an external quality review of the < Name > County mental health plan (MHP) by the California External Quality Review Organization (CAEQRO), a division of APS Healthcare, < from/on date to date >. CAEQRO customized this year's review based upon last year's review findings, with the intent to examine and include findings on the following areas:

- Changes, progress, or milestones in the MHP's approach to performance management, including: the organization and structure of the overall service delivery system, business practices, quality improvement, and progress toward strategic goals
- Utilization of data, specific reports, and activities designed to manage and improve access, timeliness, quality, and outcomes of services
- Strategies to decrease disparities in service delivery to diverse populations
- Implementation of wellness/recovery and other best practices throughout the system
- Information Systems Capabilities Assessment V6.1 (ISCA)
- Two current Performance Improvement Projects (PIPs) — a clinical and a non-clinical
- Interviews with key clinical, administrative, information systems, and clerical/data entry staffs within the service delivery system
- <#> 90-minute focus group(s) with beneficiaries and family members

The review agenda and the list of participants follow the report as Attachments A and B. A description of the source of data for Tables and Figures 1 through 15 follows as Attachment C. The Medi-Cal approved claims data summary and any other data CAEQRO provided to the MHP follow as Attachment D. The detailed results from applying the PIP validation tool and the MHP's PIPs as submitted follow as Attachments E and F respectively.

## Review Findings for Fiscal Year 2007-2008

### Status of Fiscal Year 2006-2007 Recommendations

In the FY06-07 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY07-08 site visit, CAEQRO and MHP staff discussed the status of those FY06-07 recommendations, summarized below.

The ratings are assigned as follows:

- ◇ Fully addressed – The issue may still require ongoing attention and improvement, but activities reflect either a) resolution of the identified issue, b) the initiation of strategies over the past year that suggest the MHP is nearing resolution or improvement, and/or c) judged to be as much as the organization could reasonably do and accomplish in the last year.
  - ◇ Partially addressed – Either a) the MHP has made clear plans and is in the early stages of initiating activities to address the recommendation, or b) a situation where some of the related issues were addressed, but others were not.
  - ◇ Not addressed – The MHP performed no meaningful activities to address the recommendation.
- < List issue followed by colon: >
 

<input type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
--	--	--

    - < Text here if no bullets >
    - < Text here if bullets >
  - < List issue followed by colon: >
 

<input type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
--	--	--

    - < Text here if no bullets >
    - < Text here if bullets >
  - < List issue followed by colon: >
 

<input type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
--	--	--

    - < Text here if no bullets >
    - < Text here if bullets >
  - < List issue followed by colon: >
 

<input type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
--	--	--

    - < Text here if no bullets >
    - < Text here if bullets >

## Changes in the MHP Environment

CAEQRO views changes in the MHP environment as those external events having a significant effect on the quality of the overall service delivery system since the last review. These changes have the potential to affect an MHP's business practices, strategic planning, and program development during the new fiscal year and over the long term.

For the MHP, significant events include the following:

< Include those **external** events having a significant effect on the quality of the overall service delivery system or organization since the last review. Not – change in director, not MHSA, not a minor to moderate budget deficit. >

- There were no significant external events affecting the MHP. <OR>
- < Issue >
- < Issue >

## Delivery System Performance Management

### Strategic emphasis

< Write a brief summary of strategic initiatives or other MHP priorities – usually completed by lead reviewer only. >

The MHP presented the following strategic initiatives: < Adjust lead-in as appropriate >

- < Issue >
- < Issue >

Discussion regarding the status of last year's initiatives included:

- < Issue >
- < Issue >

### Significant delivery system changes since the last review

- < change >
- < change >

### Utilization of data for performance improvement

CAEQRO emphasizes the analysis of data as a key tool for performance management, paying particular attention to data used to monitor and improve access and timeliness of services as well as quality of care.

The MHP presented the data and/or reports it uses to manage performance. Discussion of the use of data includes: [< Amend as appropriate for intro to this section >](#)

- [< Issue >](#)
- [< Issue >](#)

## Current Medi-Cal Claims Data for Managing Services

### Source of data for Figures 1 through 15

Information to support the tables and graphs, labeled as Figures 1 through 15, is derived from four source files containing statewide data. A description of the source of data follows in Attachment C.

### Current Medi-Cal approved claims data

CAEQRO provided the MHP with three summary reports of Medi-Cal approved claims data – overall, foster care, and transition age youth – which follow as Attachment D. [< If applicable; if not, delete the next sentence: >](#) CAEQRO provided additional data related to [< contract provider utilization, retention, etc. – specify for the MHP any extra drill-downs that were provided >](#), which also follow in Attachment D. The MHP was also referred to the CAEQRO Website for additional approved claims data useful for comparisons and additional analyses.

Figure 1 displays key elements from the approved claims reports for the MHP, MHPs of similar size (large, medium, small, or small-rural), and the statewide average.

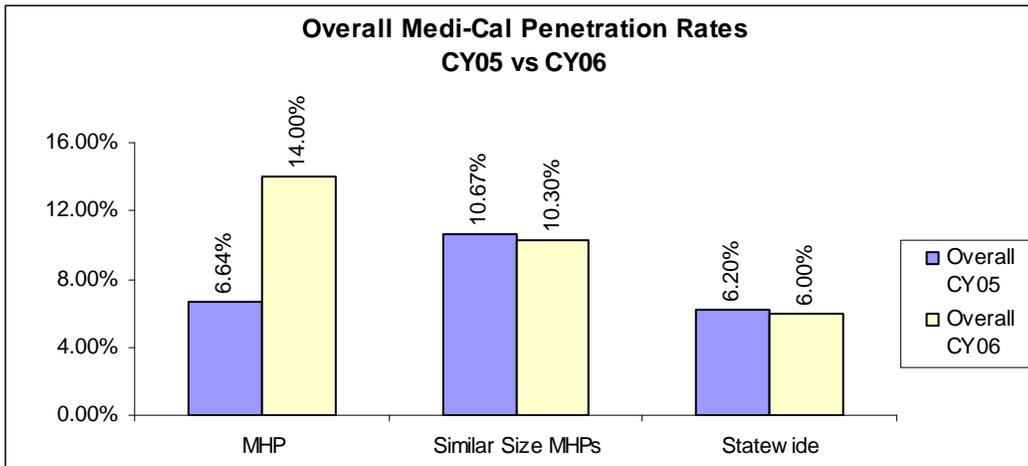
**Figure 1 – CY2006 Medi-Cal Approved Claims Data**

Element	MHP	Similar Size MHPs < Size >	Statewide
Total approved claims per year	\$XXX	\$XXX	\$1,672,091,078
Average number of eligibles per month	XXX	XXX	6,783,625
Number of beneficiaries served per year	XXX	XXX	406,679
Penetration rate	XXX%	XXX%	6.00%
Approved claims per beneficiary served per year	\$XXX	\$XXX	\$4,112
Penetration rate – Foster care	XXX%	XXX%	51.37%
Approved claims per beneficiary served per year – Foster care	\$XXX	\$XXX	\$6,782

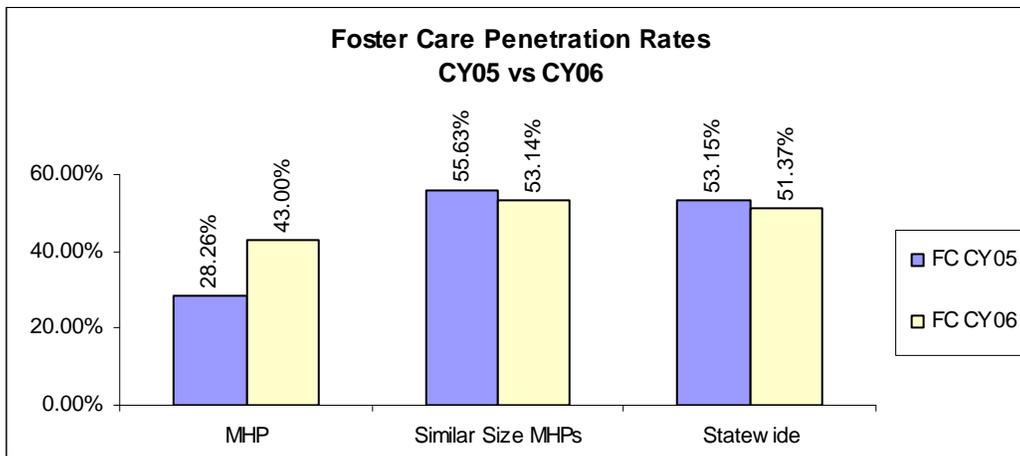
Element	MHP	Similar Size MHPs < Size >	Statewide
Penetration rate – TAY	XXX%	XXX%	6.63%
Approved claims per beneficiary served – TAY	\$XXX	\$XXX	\$5,078

Figures 2 through 4 display penetration rates – overall, foster care youth, and transition age youth. Both CY05 and CY06 are included to depict changes over time.

**Figure 2**



**Figure 3**



**Figure 4**

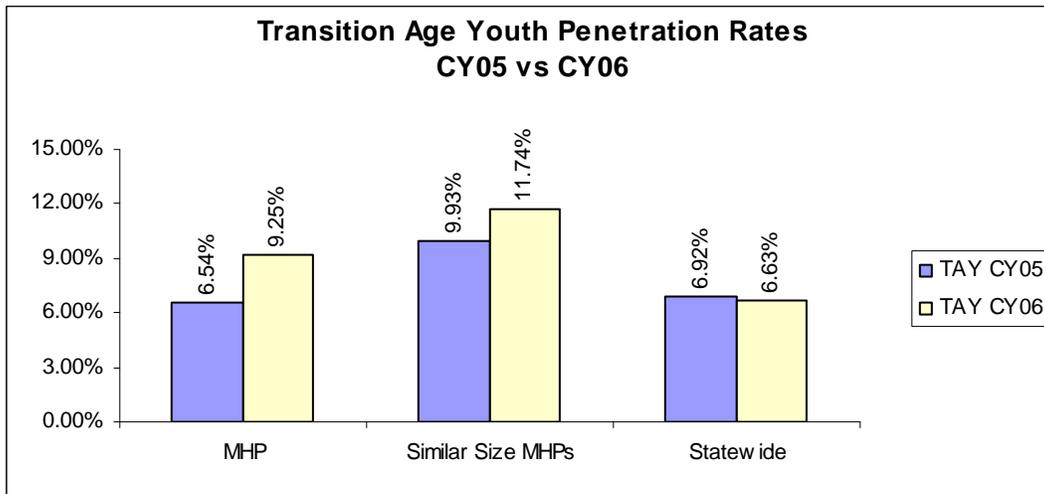
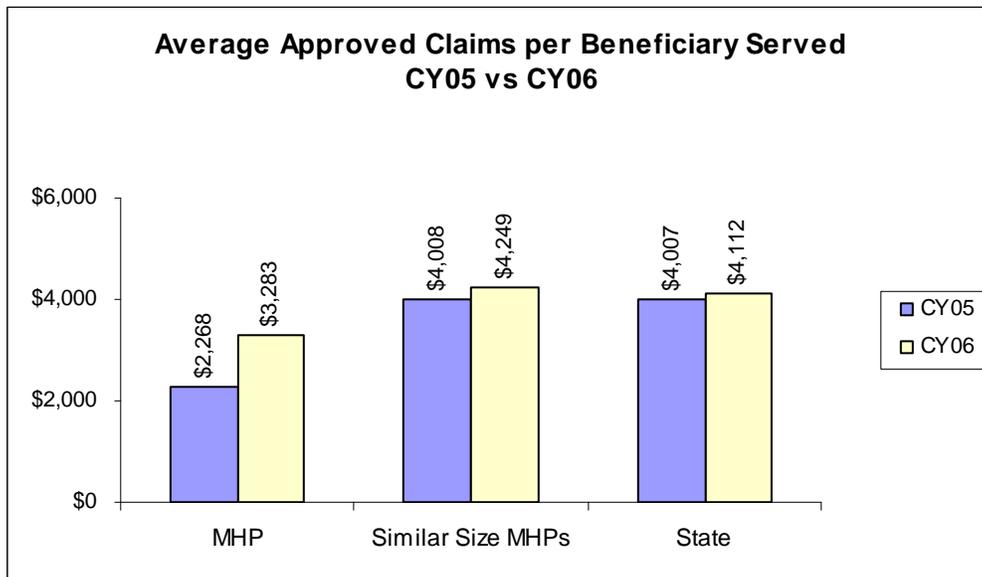


Figure 5 below displays the MHP's average approved claims per beneficiary served for CY05 and CY06, as well as for similar size MHPs and the statewide average.

**Figure 5**



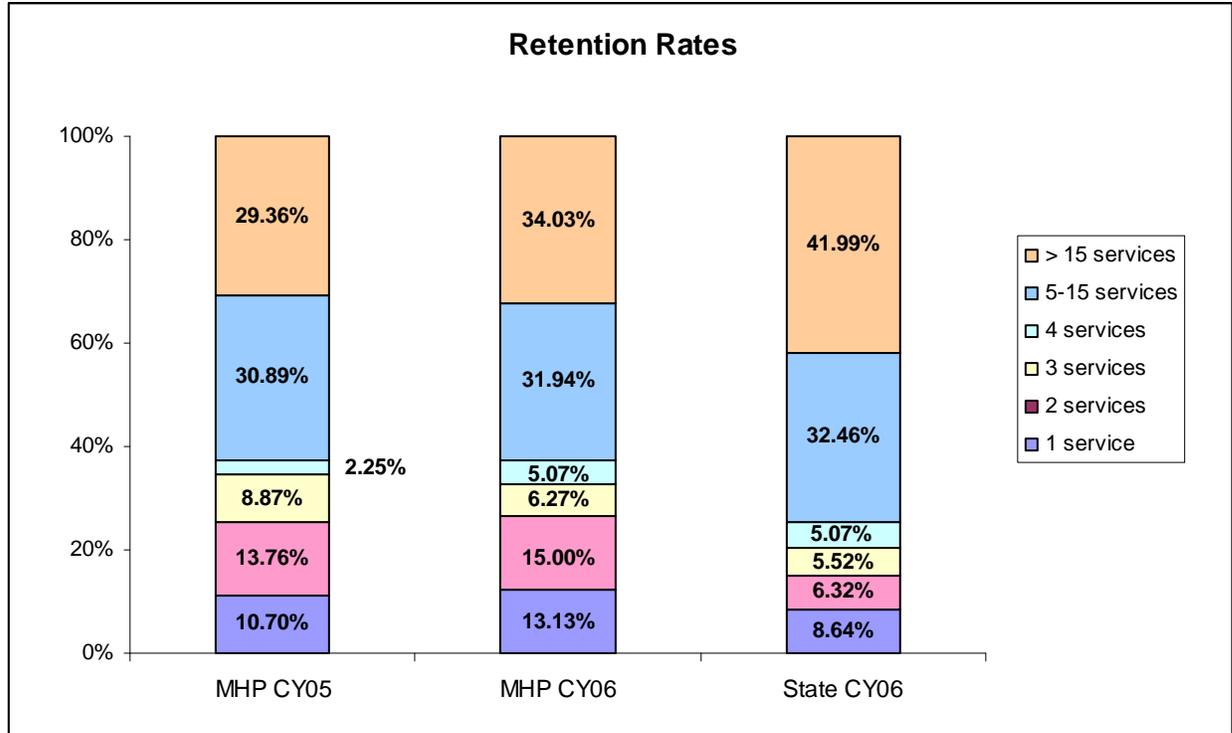
Review of Medi-Cal approved claims data, summarized in the table and figures above, included the following issues that relate to quality and access to services:

- < Issue >
- < Issue >

**Retention Rates**

Figure 6 displays the MHP’s CY05 and CY06 Medi-Cal approved claims data showing retention rates – the percentage of beneficiaries who received the specified number of services during each annual period. Statewide data for CY06 is also presented for comparison. Figure 7 follows, depicting the raw numbers of beneficiaries who received the specified number of services, as well as the average amount of approved claims for each category for the MHP and the state.

**Figure 6**



**Figure 7 – CY2006 Retention Rates**

Number of Services Approved per Beneficiary Served	MHP Number of beneficiaries served	MHP \$ per beneficiary served	Statewide \$ per beneficiary served
1 service	XXX	\$ XXX	\$229
2 services	XXX	\$ XXX	\$358
3 services	XXX	\$ XXX	\$484
4 services	XXX	\$ XXX	\$600
5 – 15 services	XXX	\$ XXX	\$1,228
> 15 services	XXX	\$ XXX	\$8,605

Review of the retention data included the following issues:

- < Insert relevant text >
- < Insert relevant text >

**Adjusted Penetration Rates**

Because different MHPs may have very different demographic distributions in their Medi-Cal beneficiary populations, the overall penetration rate can mask disparities in MHP penetration rates by race/ethnicity. Penetration rates can be adjusted or standardized using a common standard population, in this case, the statewide Medi-Cal population. A factor-adjusted penetration rate for each MHP helps eliminate or account for the confounding effects caused by differing MHP demographic compositions.

Penetration rates are also influenced by the number of services received by each beneficiary, a measure of the retention rate for each MHP. Without adjusting for retention, MHPs with a higher proportion of beneficiaries receiving fewer services are likely to have higher penetration rates than those providing more services per beneficiary. Therefore, exclusion of beneficiaries with a low number of service encounters can also produce another perspective on penetration rates and access.

In Figure 8 below, penetration rates reflect the following:

- Mathematical adjustment for the race/ethnicity of the MHP’s beneficiary population based upon the statewide beneficiary population
- Exclusion of beneficiaries receiving only one service
- Exclusion of beneficiaries receiving three or fewer services

A rank of 1 is the highest penetration rate; a rank of 56 is the lowest penetration rate.

**Figure 8 – CY2006 Adjusted Penetration Rates**

Adjusted Penetration Rates	MHP	Rank
Penetration rate – adjusted by race/ethnicity	XXX%	X
Penetration rate – adjusted by retention (single service removed)	XXX%	X
Penetration rate – adjusted by retention (3 or fewer services removed)	XXX%	X
Penetration Rate – not adjusted	XXX%	X

Review of adjusted penetration rates for the MHP includes:

- <text>
- <text>

**High Cost Beneficiaries**

As part of an analysis of service utilization, CAEQRO compiled claims data to identify the number and percentage of beneficiaries within each MHP and the state for whom a disproportionately high dollar amount of services were claimed and approved. In both CY05 and CY06 statewide, fewer than 2% of the beneficiaries served accounted for nearly one-quarter of the Medi-Cal expenditures. For purposes of this analysis, CAEQRO defined “high cost beneficiaries” as those whose services met or exceeded \$30,000 in the calendar year examined – this figure represents roughly three standard deviations from the average cost per beneficiary statewide. This pattern was stable from CY05 to CY06.

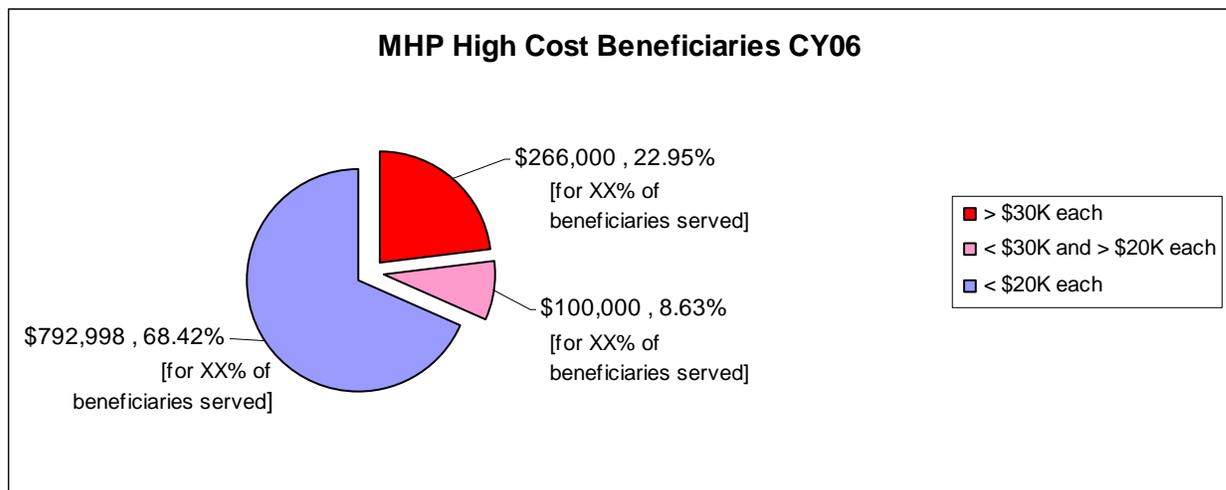
**Figure 9 – High Cost Beneficiaries (greater than \$30,000 per beneficiary)**

	MHP Beneficiaries Served			Approved Claims		
	# HCB	# Served	%	Average per HCB	Total Claims for HCB	% of total claims
<b>Statewide CY06</b>	8,109	406,679	1.99%	\$48,193	\$390,793,612	23.37%
<b>MHP CY06</b>	XX	XXX	XXX%	\$XXX	\$XXXX	XXX%
<b>MHP CY05</b>	XX	XXX	XXX%	\$XXX	\$XXXX	XXX%

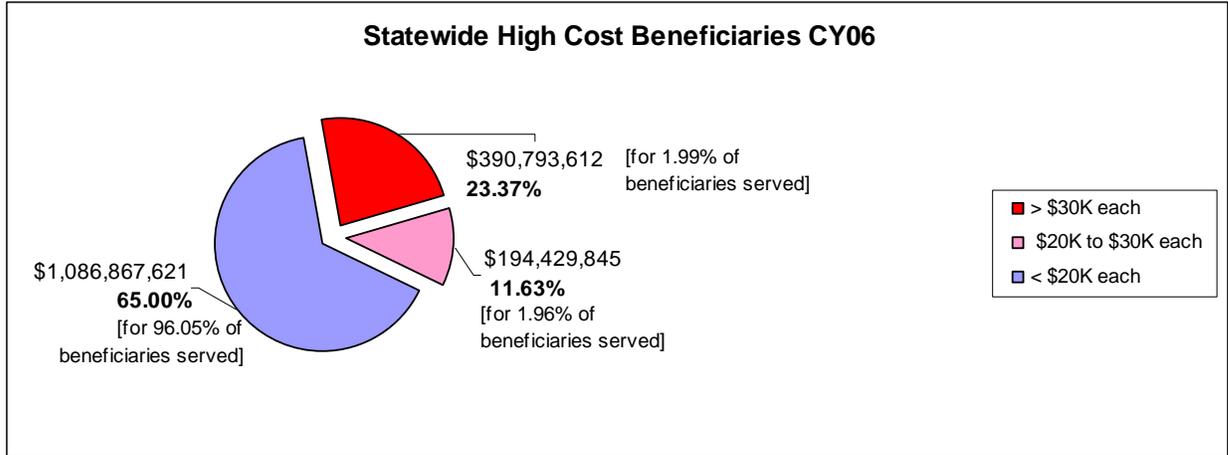
As an additional analysis, beneficiaries receiving \$20,000 to \$30,000 in services per year are identified in the charts below as a second level of high cost beneficiaries. Statewide, this population also represents a small percentage of beneficiaries for which a disproportionately high amount of Medi-Cal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

Statewide, 35% of the approved Medi-Cal claims funded less than 4% of the beneficiaries served. For the MHP, XX% < Add the percent dollars for both small pieces of the pie > of the approved Medi-Cal claims funded XX% < Add the percent beneficiaries for both small pieces of the pie > of the beneficiaries served. This information is depicted in the figures 10 and 11, first for the MHP and then for the state.

**Figure 10**



**Figure 11**



Review of the above high cost beneficiary data included:

- < Insert relevant text >
- < Insert relevant text >

Medi-Cal claims history

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

**Figure 12 – Medi-Cal Eligibility and Claims Trend Line Analysis**

Fiscal Year	Average Number Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate		Total Approved Claims	Approved Claims per Beneficiary Served per Year	
			%	Rank		\$	Rank
FY05-06	XXX	XXX	X.XX%	X	\$XXX	\$XXX	X
FY04-05	XXX	XXX	X.XX%	X	\$XXX	\$XXX	X
FY03-04	XXX	XXX	X.XX%	X	\$XXX	\$XXX	X
FY02-03	XXX	XXX	X.XX%	X	\$XXX	\$XXX	X

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

- < Insert relevant text >
- < Insert relevant text >

## Medi-Cal Denied Claims History

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

**Figure 13 – Medi-Cal Denied Claims Information**

Fiscal Year	MHP Denied Claims Amount	MHP Denial Rate	MHP Denial Rate Rank	Statewide Median	Statewide Range
FY06-07	\$XXX,XXX	XX%	X	3.55%	0.23% - 18.18%
FY05-06	\$XXX,XXX	XX%	X	6.32%	1.18% - 37.57%
FY04-05	\$XXX,XXX	XX%	X	3.24%	0% - 36.78%
FY03-04	\$XXX,XXX	XX%	X	3.82%	0% - 30.11%

Discussion of Medi-Cal denied claims included:

- [< Any relevant text regarding the above table >](#)

## Performance Measurement Results

In the Performance Measurement (PM) analysis last year, CAEQRO analyzed penetration rates and approved Medi-Cal claims for females versus males and Hispanics versus Whites and discovered significant disparities in both populations. CAEQRO continued this analysis in year three and noted the following patterns:

- The relative access and the average approved claims for female beneficiaries were lower than for males. These disparities are equal to those identified in last year's CY05 data.
- The relative access and the average approved claims for Hispanic beneficiaries were lower than for White beneficiaries. These disparities are slightly less than those identified in the CY05 data.

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

Below, for each variable (Hispanic/White and female/male), two ratios are calculated to depict relative access and relative approved claims. Figure 14 reflects approved claims data and penetration rates between Hispanic and White beneficiaries. This penetration rate ratio is calculated by dividing the Hispanic penetration rate by the White penetration rate, resulting in a ratio that depicts the relative access for Hispanics when compared to Whites. The approved claims ratio is calculated by dividing the average approved claims

for Hispanics by the average approved claims for Whites. Similar calculations follow in Figure 15 for female to male beneficiaries.

For all elements, ratios depict the following:

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

**Figure 14 – CY2006 Performance Measurement Results – Hispanic versus White**

	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY06	110,938	3.08%	166,242	11.82%	\$3,884	\$4,270	.26	.91
MHP CY06	XXX	XX%	XXX	XX%	\$XXXX	\$XXX	.XX	.XX
MHP CY05	XXX	XX%	XXX	XX%	\$XXXX	\$XXX	.XX	.XX

**Figure 15 – CY2006 Performance Measurement Results – Female versus Male**

	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Female versus Male for	
	Female		Male		Female	Male	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY06	212,660	5.51%	194,019	6.64%	\$3,597	\$4,675	.83	.77
MHP CY06	XXX	XX%	XXX	XX%	\$XXXX	\$XXX	.XX	.XX
MHP CY05	XXX	XX%	XXX	XX%	\$XXXX	\$XXX	.XX	.XX

Discussion of the performance measurement data included:

- < Any relevant text regarding the above table >
- < Any relevant text regarding the above table >

## Consumer/Family Member Focus Group(s)

CAEQRO conducted < one/two/three > 90-minute focus group<s> with consumers and family members during the site review of the MHP. As part of the pre-site planning process, the following focus groups were requested:

1. <Summary of group requested >
2. <Summary of group requested >
3. <Summary of group requested >

< The focus group was held at – if more than one group, instead include this information under the header for the specific group. > The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to services, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CAEQRO provided gift certificates to thank the consumers and family members for their participation.

### Consumer/Family Member Focus Group 1 – < delete this header if only one focus group >

< Describe significant focus group findings, including where the group was held >

**Figure 16 – Consumer/Family Member Focus Group <1 >**

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

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

Preferred Languages	
< List all that apply >	
< Delete unused rows >	

Estimated Race/Ethnicity	
< List all that apply >	

Gender	
Male	
Female	

Interpreter used for focus group 1:  No  Yes Language(s): >

### Consumer/Family Member Focus Group 2

< Delete section if only one focus group and renumber all tables to follow >

< Describe significant focus group findings, including where the group was held >

**Figure 17– Consumer/Family Member Focus Group 2**

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

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

Preferred Languages	
< List all that apply >	
< Delete unused rows >	

Estimated Race/Ethnicity	
< List all that apply >	

Gender	
Male	
Female	

Interpreter used for focus group 2:  No  Yes < Language(s): >

## Performance Improvement Project Validation

### Clinical PIP validation

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

“< Study Question > “

Year PIP began:

Status of PIP:

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

< Write 1-2 paragraphs summarizing the PIP to include: >

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either “met,” “partial,” “not met,” or “not applicable.”

< Include one of the two sentences:

Relevant details of these issues and recommendations are included within the comments of the PIP validation tool. The summary total scores for this tool are:

Met:

Partially Met:

Not Met:

Not Applicable:

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

Thirteen of the 44 criteria are identified as “key elements” indicating areas that are critical to the success of a PIP. Results for the key criteria are included in the table below.

**Figure 18 – Clinical PIP Validation Review – Summary of Key Elements**

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

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

and non-clinical PIPs submitted by the MHP. < Followed by one of the following sentences, if applicable, amended if necessary depending upon what/how the MHP submitted: > Because the MHP did not submit the PIP in the requested format, CAEQRO's format is also included. < OR > The MHP did not submit a clinical PIP; therefore, the requested format follows in Attachment F.

#### Non-clinical PIP validation

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

“< Study Question > “

Year PIP began:

Status of PIP:

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

< Write 1-2 paragraphs summarizing the PIP to include: >

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either “met,” “partial,” “not met,” or “not applicable.”

< Include one of the two sentences:

Relevant details of these issues and recommendations are included within the comments of the PIP validation tool. The summary total scores for this tool are:

Met:

Partially Met:

Not Met:

Not Applicable:

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

**Figure 19 – Non-Clinical PIP Validation Review – Summary of Key Elements**

Step	Key Criteria	Met	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			
2	The study question identifies the problem targeted for improvement			
3	The study question is answerable/demonstrable			
4	The indicators are clearly defined, objective, and measurable			
5	The indicators are designed to answer the study question			

Step	Key Criteria	Met	Partial	Not Met
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			
7	The indicators each have accessible data that can be collected			
8	The study population is accurately and completely defined			
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data			
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes			
11	The analyses and study results are conducted according to the data analyses plan in the study design			
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			
<b>Totals for 13 key criteria</b>				

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. Attachment F includes the clinical and non-clinical PIPs submitted by the MHP. < Followed by one of the following sentences, if applicable, amended if necessary depending upon what/how the MHP submitted: > Because the MHP did not submit the PIP in the requested format, CAEQRO's format is also included. < OR > The MHP did not submit a non-clinical PIP; therefore, the requested format follows in Attachment F.

Additional PIPs completed or discontinued since the last review  
 If the PIPs from last year continued as PIPs for this year, then delete this section.

Status of last year's clinical PIP:

- Discontinued because <enter reasons>
- Completed, and plans for monitoring sustained improvement include <enter >
- None submitted last year

< Include any recommendations regarding last year's clinical PIP or aspects that warrant continued attention even if not as a PIP.>

Status of last year's non-clinical PIP:

- Discontinued because <enter reasons>
- Completed, and plans for monitoring sustained improvement include <enter >
- None submitted last year

< Include any recommendations regarding last year's non-clinical PIP or aspects that warrant continued attention even if not as a PIP.>

## Information Systems Review

Knowledge of the capabilities of an MHP’s information system is essential to evaluate the MHP’s capacity to manage the health care of its beneficiaries. CAEQRO used the written response to standard questions posed in the California-specific ISCA Version 6.1, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

### MHP information systems overview

< Provide a brief summary emphasizing differences from last year. Do not repeat last year’s issues. – 1 page maximum – of MHP current IS operations and status.>

The table below lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

**Figure 20 – Current Systems/Applications**

System/Application	Function	Vendor/Supplier	Years Used	Operated By

### Plans for information systems change

< Provide a brief summary of any MHP plans for system replacement, or significant changes they plan to make in current review period. Include discussion of plans outlined in last year’s CAEQRO review – what actions were taken, current status >

### Clinical and programmatic functionality

< Describe the MHP’s progress toward adopting an electronic health record, especially in the area of treatment plans, outcomes, etc. >

### System component findings

The following table displays a list of information system components assessed by CAEQRO during the FY07-08 review, along with a rating for each separate component and the rating from the FY06-07 review.

**Figure 21 – Review of Information System Components**

COMPONENT	Rating				FY 06-07 Rating
	Met	Partially Met	Not Met	Not Reviewed	
Accurate, consistent and timely data collection and entry					Met
Procedures to determine a beneficiary's eligibility status					Not Met
Integrity of Medi-Cal claim production process					Partial
Complete and reliable authorization processes for contract providers					New in FY07-08
Complete and reliable claims adjudication for contract providers, including timely and accurate payment					New in FY07-08
Demonstrated capability to support business analysis and data analytic activities					< etc >
Access to data via standard and ad hoc reports					
Information systems training program and help desk support					
Information systems/fiscal policies and procedures documented and distributed					
Collaboration between quality improvement and IS departments					
Documented data security and back-up procedures					

Specific information system component findings

Components rated “Partially Met,” “Not Met,” or “Not Reviewed” are explained below. In addition, some components rated as “Met” may be included if they were deemed exemplary practices. Ratings that have significantly changed from last year's report are also explained.

<List the component and the rating on a line (both underlined), followed by your explanation on the next line. For example:

- Access to data via standard and ad hoc reports – Partially Met  
Moderately detailed explanation of why it was scored this way follows here.
- Documented data security and back-up procedures – Met/Exemplary  
Moderately detailed explanation of why it was exemplary follows here.

## Site Review Process Barriers

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

- [< Issue >](#)
- [< Issue >](#)

## Conclusions: Strengths and Opportunities for Improvement

During the FY07-08 annual review, CAEQRO found strengths in the MHP's programs, practices, and information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CAEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access and timeliness of services and improving the quality of care.

### Strengths

Specify, if appropriate, whether new strengths were identified or the status or previously identified strengths.

1.  [< Strength >](#)  
 [\[Access, Timeliness, Quality, Outcomes, Information Systems, Other: \]](#)
2.  [< Strength >](#)  
 [\[Access, Timeliness, Quality, Outcomes, Information Systems, Other: \]](#)
3.  [< Strength >](#)  
 [\[Access, Timeliness, Quality, Outcomes, Information Systems, Other: \]](#)

### Opportunities for Improvement

1.  [< Opportunity >](#)  
 [\[Access, Timeliness, Quality, Outcomes, Information Systems, Other: \]](#)
2.  [< Opportunity >](#)  
 [\[Access, Timeliness, Quality, Outcomes, Information Systems, Other: \]](#)
3.  [< Opportunity >](#)  
 [\[Access, Timeliness, Quality, Outcomes, Information Systems, Other: \]](#)

## Recommendations

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

1. < Recommendation >  
[Access, Timeliness, Quality, Outcomes, Information Systems, Other: ]
2. < Recommendation >  
[Access, Timeliness, Quality, Outcomes, Information Systems, Other: ]
3. < Recommendation >  
[Access, Timeliness, Quality, Outcomes, Information Systems, Other: ]
4. < Recommendation >  
[Access, Timeliness, Quality, Outcomes, Information Systems, Other: ]
5. < Recommendation >  
[Access, Timeliness, Quality, Outcomes, Information Systems, Other: ]

## **Attachments**

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Source Data: Figures 1 through 15

Attachment D: Data Provided to MHP

Attachment E: CAEQRO PIP Validation Tools

Attachment F: MHP PIP Summaries Submitted

# **Attachment A**

## **Review Agenda**

< Insert Review Agenda >

# **Attachment B**

## **Review Participants**

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

< List staff: First Name then Last Name, Job Title – no credentials/degrees >

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

< List staff >

Additional CAEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and, ultimately, in the recommendations within this report.

## **Attachment C**

### **Source Data: Figures 1 through 15**

### Source of data for Figures 1 through 15

- Source Files: Information to support Figures 1 through 15 is derived from four source files containing statewide data:
  - Short-Doyle/Medi-Cal approved claims (SD/MC) from the Department of Mental Health
  - Short-Doyle/Medi-Cal denied claims (SD/MC–D) from the Department of Mental Health
  - Inpatient Consolidation claims (IPC) from the Department of Health Services (originating from Electronic Data Systems, the California Fiscal Intermediary)
  - Monthly MEDS Extract Files (MMEF) from the Department of Health Services
  
- Selection Criteria:
  - Claims for Medi-Cal beneficiaries for whom the MHP is the “County of Fiscal Responsibility” are included, even when the beneficiary was served by another MHP
  - Beneficiaries with aid codes eligible for SD/MC program funding are included
  - See “Medi-Cal Approved Claims Definitions” in Attachment D for more detailed criteria
  
- Process Date: This is the date DMH provides files to CAEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2005 file with a DMH process date of July 10, 2006 includes claims with service dates between January 1 and December 31, 2005 processed by DMH through June 30, 2006.
  - CY2006 includes SD/MC approved claims with process date October 2007 and IPC process date November 2007
  - CY2005 includes SD/MC approved claims with process date July 10, 2006 and IPC process date July 13, 2006
  - FY04-05 includes SD/MC and IPC approved claims with process date April 14, 2006
  - FY03-04 includes SD/MC and IPC approved claims with process date October 7, 2005
  - FY02-03 includes SD/MC and IPC approved claims as of final reconciliation
  - FY06-07 denied claims includes SD/MC claims (not IPC claims) denied between July 1, 2006 and June 30, 2007 (without regard to service date) with process date September 25, 2007. Same methodology is used for prior years.
  - Most recent MMEF includes Medi-Cal eligibility for April 2007 and 15 prior months
  
- Data Definitions: Selected elements displayed in Figures 1 through 15 are defined below.
  - Penetration rate – The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of the Medi-Cal eligibles over a 12-month period.

- Approved claims per beneficiary served per year – The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year

# **Attachment D**

## **Data Provided to MHP**

< Insert data and Demographics charts – 3 of each >

**Attachment E:**  
**CAEQRO PIP Validation Tools**

< Insert PIP validation tools – Remove CAEQRO PIP Validation Tool label and the legend >

PIP Category	Descriptive Category	Target Population
Access	Business process improvement	Older Adult
Timeliness	Co-occurring disorders	Transitional Age Youth
Quality of Care	Psychiatrist / Med Appointment	Other Age Group (specify)
Outcomes	Improved diagnosis or treatment processes	Foster Care
	Physical Health Care	Latino/Hispanic
	Recovery and Wellness	African American
	Retention	Asian American
	Use of Acute or Inpatient Services	Other Racial/Ethnic Group (specify)
	Other	Combination of Two/More Above (specify)
		Other (specify)
		All Population

**Attachment F:**  
**MHP PIPs Submitted**

The following pages include the PIPs as submitted by the MHP. When the MHP did not submit any PIPs, or did not submit its PIPs in the requested format, the requested format alone is included.

Please click on the Adobe icon below:

[< Admin staff will convert the MHP's PIPs to PDF](#)

If the “PIP Outline with Road Map” needs to be included because the MHP did not use that format or did not submit PIPs, attach the PDF file called [“Attachment F PIP Format Sample.”](#)

Remove this page for the Final Report. >

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





July 2007				
Monday	Tuesday	Wednesday	Thursday	Friday
2	3	4	5	6
9	10	11	12	13
Lake MHP Review	Colusa MHP Review	Monterey MHP Review		
SCERP PIP		Glenn MHP Review		
16	17	18	19	20
SCERP PIP				CMHDA IT
23	24	25	26	27
SCERP PIP				
30	31			
Tehama MHP Review				
SCERP PIP				

<b>August 2007</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
		<b>1</b>	<b>2</b>	<b>3</b>
		Humboldt MHP Review		
<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
SCERP PIP				
<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>
SCERP PIP		Mendocino MHP Review		
<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>
SCERP PIP		Sonoma MHP Review		
<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>	<b>31</b>
SCERP PIP		Del Norte MHP Review		

<b>September 2007</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>
SCERP PIP	San Diego MHP Review			
	Tulare MHP Review		Kings MHP Review	
<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>
SCERP PIP			Solano MHP Review	
ANNUAL REPORT WEBCAST				
<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>
SCERP PIP		Santa Cruz MHP Review		CMHDA IT

<b>October 2007</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
SCERP PIP	Alameda MHP Review			
	LBHI Latino Conference			
			Shasta MHP Review	
<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>
SCERP PIP	San Bernardino MHP Review			
<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>
SCERP PIP	Sacramento MHP Review			CMHDA IT
		Western Users of SAS Software		
<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>
SCERP PIP				
<b>29</b>	<b>30</b>	<b>31</b>		
SCERP PIP				
Napa MHP Review				
Cultural Competence Summit				

<b>November 2007</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
			1	2
5	6	7	8	9
SCERP PIP	San Luis Obispo MHP Review			
12	13	14	15	16
SCERP PIP		Yolo MHP Review		
			Calaveras MHP Review	
19	20	21	22	23
SCERP PIP				
San Benito MHP Review				
26	27	28	29	30
SCERP PIP		Fresno MHP Review		
			Santa Barbara MHP Review	

<b>December 2007</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
SCERP PIP	Contra Costa MHP Review			
<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>
Butte MHP Review		Ventura MHP Review		
Marin MHP Review				
SCERP PIP				
<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>
SCERP PIP				CMHDA IT
<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>
<b>31</b>				

January 2008				
Monday	Tuesday	Wednesday	Thursday	Friday
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
	Riverside MHP Review			
		Planning Council		
21	22	23	24	25
	San Joaquin MHP Review			
28	29	30	31	
	Orange MHP Review			

<b>February 2008</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
				<b>1</b>
<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
		CiMH Policy Forum – Primary Care		
<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>
NRI 18 <sup>th</sup> Annual NASMHPD				
	Nevada MHP Review			
	Sutter/Yuba MHP Review			
<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>
	San Mateo MHP Review			
		El Dorado MHP Review		
		Kern MHP Review		
<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>
Santa Clara MHP Review			CAEQRO Staff Meeting	

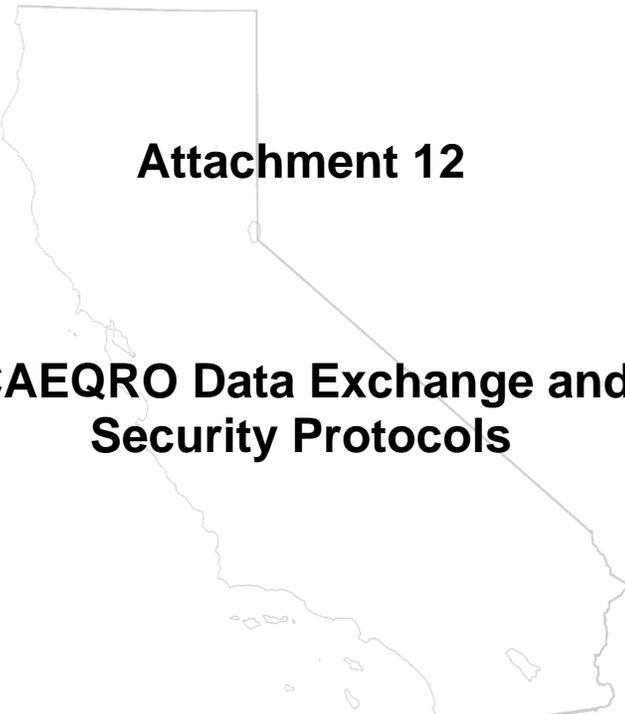
<b>March 2008</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
		Mariposa MHP Review	Madera MHP Review	
			Placer/Sierra MHP Review	
<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>
			ACMHA – Santa Fe	
<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>
	San Francisco MHP Review			
		Merced MHP Review		
<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>
	Claims TF	CalQIC		
<b>31</b>				

<b>April 2008</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
			Stanislaus MHP Review	
<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>
		CIMH IT		
<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>
			Plumas MHP Review	
<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>
Alpine MHP Call	Siskiyou MHP Review	Lassen MHP Review	Trinity MHP Review	
<b>28</b>	<b>29</b>	<b>30</b>		

<b>May 2008</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
			1	2
5	6	7	8	9
Los Angeles MHP Review				Amador MHP Review
			Tuolumne MHP Review	
12	13	14	15	16
Claims TF	Mono MHP Review	Inyo MHP Review		
19	20	21	22	23
SCERP PIP	Imperial MHP Review	Modoc MHP Review	CalMEND PIP Call	
26	27	28	29	30
		CAEQRO Annual Retreat		

June 2008				
Monday	Tuesday	Wednesday	Thursday	Friday
2	3	4	5	6
SCERP PIP				EPSDT PIP
9	10	11	12	13
Claims TF			Emily Q Special Master	
16	17	18	19	20
SCERP PIP			EPSDT PIP	
23	24	25	26	27
EPSDT PIP			CalMEND Call	
SCERP PIP				
30	31			
EPSDT PIP				

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 12**

**CAEQRO Data Exchange and  
Security Protocols**



## CAEQRO Data Exchange and Security Protocols

### CAEQRO Source Data Files

For our FY07-08 review, the California Department of Mental Health (DMH) has continued to provide CAEQRO access to eligibility and approved claims for source data through the following secure process that we jointly developed during FY04-05:

- DMH placed source data files, which have been compressed and password protected, on one of its secure servers.
- CAEQRO was granted access permission (username and password) by DMH to this secure server.
- An authorized CAEQRO analyst was then able to log-on to the DMH secure server and download the source files to a CAEQRO secure server.
- The source files were uncompressed by using the same password assigned by DMH when they compressed the file. Uncompressed source files were stored as “text format files.”

Using this process, CAEQRO continues to have access to the following source data files for data analysis purposes:

- **Inpatient Consolidation Claims Files (IPC).** These files are transferred from Electronic Data Systems (EDS), the California fiscal intermediary for Medicaid, to the DMH. These monthly files are created by EDS as part of its claims adjudication process, and are located at the Health and Human Services Data Center (HHSDC). The monthly files contain paid and denied claims processed during the respective month.

CAEQRO has created an historical file of approved and denied IPC records processed since July 2003 to current file creation date. At present, CAEQRO receives refreshed IPC data at least twice a year.

- **Short-Doyle/Medi-Cal Approved Claims Files (SD/MC).** Located at HHSDC, these files are generated by DHS during the process of adjudicating the SD/MC claims. The DMH IT unit downloads these files to its SAS server, after changing the COBOL high values to spaces. The files contain approved claims data, which are subject to year-end cost report settlement.

The SD/MC file contains adjudicated approved claims during a fiscal year. CAEQRO has successfully loaded historical SD/MC data for prior fiscal years. For partial fiscal year data, DHS generates a cumulative fiscal year-to-date file. With this processing strategy SD/MC files typically contain claims for more than one fiscal year. DHS processing ignores when the actual date the service was.

To date, CAEQRO has uploaded SD/MC files for the following fiscal years:

- FY01-02
- FY02-03
- FY03-04
- FY04-05
- FY05-06
- FY06-07
- FY07-08 (DMH process date May 22, 2008)
- **MEDS Monthly Extract File (MMEF).** The MMEF files are produced by DHS using the Medi-Cal Eligibility Data System (MEDS). A DMH copy of these files resides in the HHSDC. The file is created on the last Friday of the month and the current data refers to the beneficiaries' eligibility status on that date. At the end of each month, the file is prepared for the upcoming month. The file contains 16 months of eligibility data for each eligible beneficiary—including the current upcoming month, plus the 15 most recent months. For example, the file created in May 2006 would contain the following months of eligibility data: Current upcoming (June 2006), May 2006, April 2006, March 2006, February 2006, January 2006, December 2005, November 2005, October 2005, September 2005, August 2005, July 2005, June 2005, May 2005, April 2005 and March 2005. The MMEF that DMH provides to CAEQRO is refreshed about three times per year.
- **Short-Doyle/Medi-Cal Denied Claims File (SDMCD).** Short-Doyle/Medi-Cal Denied Claims Files (SDMCD). Located at HHSDC, these files are generated by DHS during the process of adjudicating the SD/MC claims. The DMH IT unit downloads these files to its SAS server, after changing the COBOL high values to spaces. Currently the SDMCD fiscal-year-to-date file is refreshed four times per year.
- **Provider File (PF).** The PF file is produced by DMH using the statewide Provider and Legal Entity File that the department maintains. The PF file contains provider demographic and services information for all authorized SD/MC providers. At present, CAEQRO receives refreshed PF data at least twice a year.

## CAEQRO Server Environment

Below we review how we configured our information systems environment during our first contract year to support our ability to analyze data. Because this configuration provided us with regular and secure access to data — including maintaining the security of PHI — it was unchanged for our FY07-08 review:

- **Server file configuration.** The CAEQRO server contains the following three main folders (also called directories) for storing the source data files. This strategy permits CAEQRO to maintain three copies of the same file to independently validate data at the file or field levels among the three different folders or directories:

- o **The import folder** contains the original, unaltered version of the source data files that are down loaded from the DMH server. Import folder files are stored in “text” formats.
- o **The SAS folder** contains SAS-generated data and work files. SAS files are stored in SAS-readable formats. SAS is the software application used by DMH for data analysis.
- o **The SQL folder** contains Microsoft-SQL database tables. SQL tables are stored in SQL-readable data formats.

- **CAEQRO master files**

Since the source data files that DMH provides CAEQRO only contain field “values,” no descriptive labels are included. It was determined that it was necessary to produce master tables for certain key fields. These master tables contain all valid codes for the appropriate table and corresponding label. The source information for the tables was the data records layout and field definitions/descriptions produced by DHS and DMH:

Name	Source
• Race	• DMH recodes MEDS codes for reporting purposes
• Language	• From MEDS
• Gender	• From MEDS and SD/MC
• County	• From MEDS, SD/MC and IPC
• Service Mode	• From SD/MC and IPC
• Service Function Code	• From SD/MC and IPC
• Aid Code	• From MEDS, SD/MC and IPC
• Cross Over Indicator	• From SD/MC and IPC
• Claim Paid Status	• From SD/MC and IPC
• Denial Reason	• From SD/MC and IPC
• Override Code Indicator	• From SD/MC and IPC

- **CAEQRO application software**

The following application software is used to process, manipulate and analyze data:

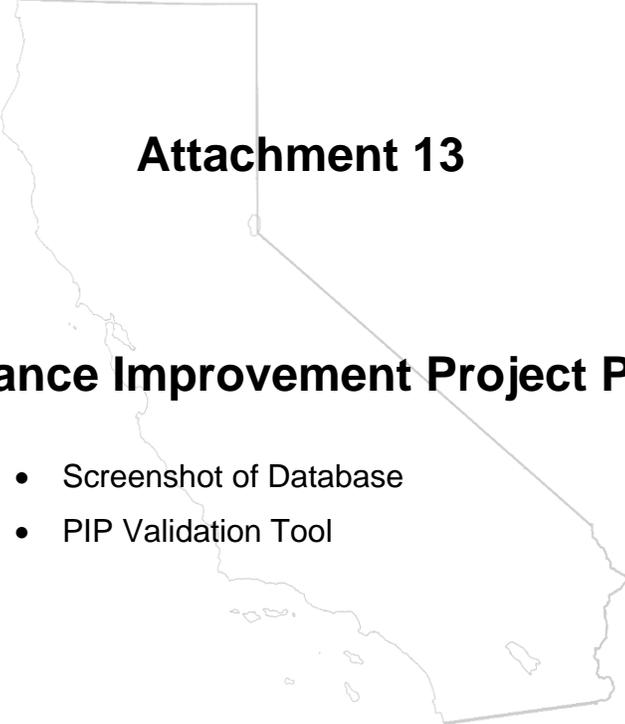
Software	Description
• SAS	• Statistical analysis software
• SPSS	• Statistical analysis software
• Data Transformation Services	• Software that manages SQL files
• Transact-SQL	• Programming language used to extract data from SQL database files
• Excel	• Software that reads SAS/SQL

- **CAEQRO data quality assurance processes:**

Quality assurance validation of the data occurs at two key intervals in the transfer and load processes. The transfer process moves files from the secure DMH server to CAEQRO server. CAEQRO has in place procedures to validate that the file transfer process was successfully completed. The load processes validates the loading of data files entirely within the CAEQRO Server environment. The validation process is done at the field level for the three primary data source files.

- **CAEQRO data security.** Information in the CAEQRO server includes many data files that contain PHI. All data are stored on secure servers in Brookfield, Wisconsin and are maintained under strict HIPAA-compliant security. In addition, CAEQRO staff with access to the server environment is carefully limited to only those individuals with adequate expertise and a specific need to access this sensitive information. To further protect this information, no PHI is stored on local PCs.

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



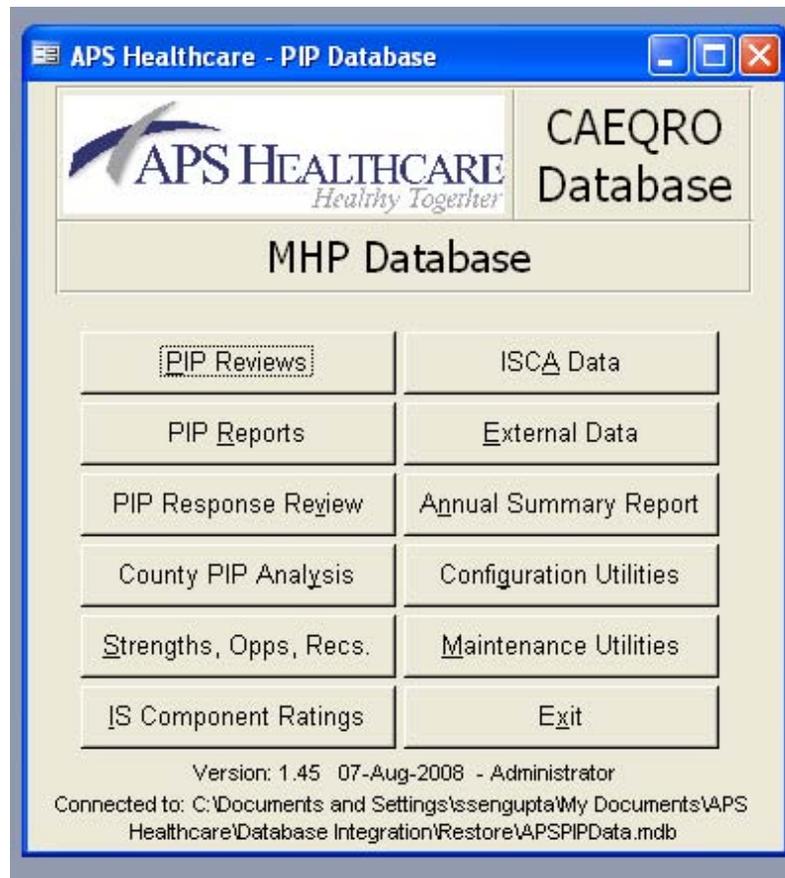
**Attachment 13**

**Performance Improvement Project Protocol**

- Screenshot of Database
- PIP Validation Tool



## Screenshot of Database





### CAEQRO PIP Validation Tool

FY 07-08 Review of: <MHP>  Clinical  Non-Clinical

PIP Title: <Enter brief phrase to identify PIP >

Date PIP Began:

Date PIP Completed (if applicable):

PIP Category:  Access  Timeliness  Quality  Outcomes  Other

Descriptive Category:

Target Population:

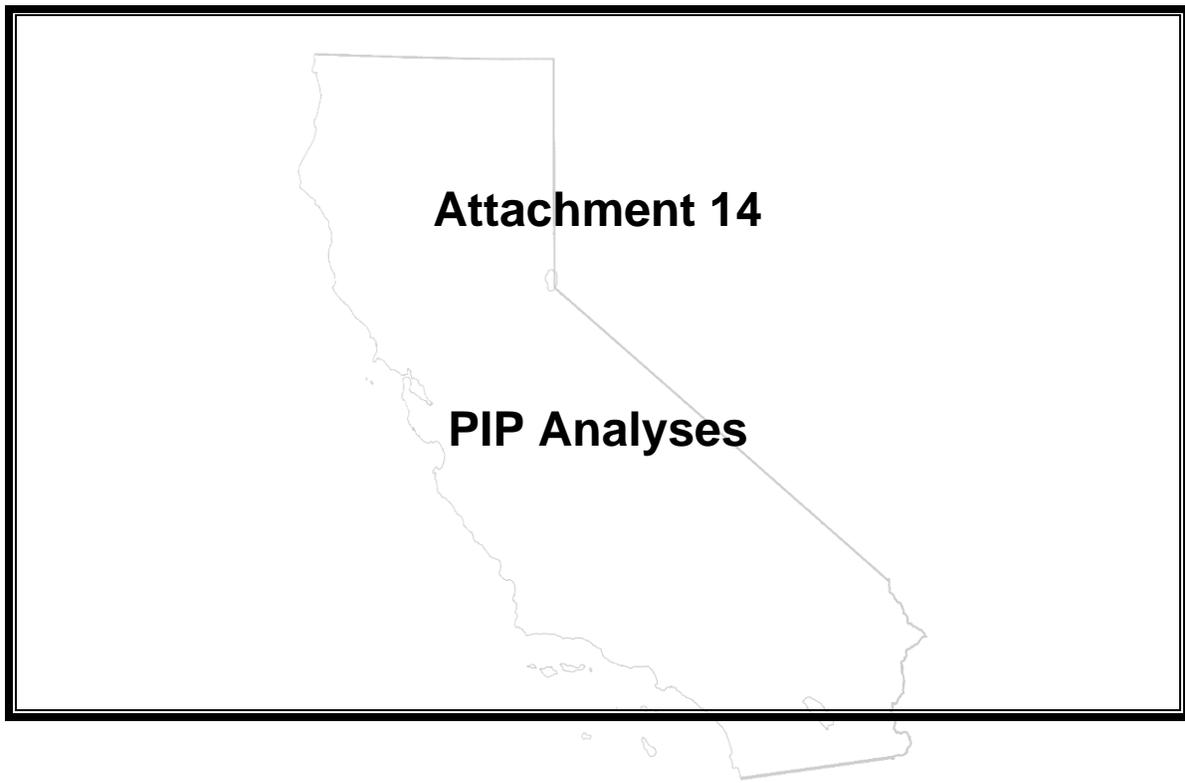
Step	Rating	Comments/Recommendations		
		Met	Partial	Not Met
<b>1</b>				N/A
<b>Study topic</b> <i>The study topic:</i>				
1.1				
1.2				
1.3				
1.4				
1.5				
<b>Totals for Step 1:</b>				
<b>Total of 1 key criteria for Step 1:</b>				

Step	Study Question Definition <i>The written study question:</i>	Rating			Comments/Recommendations
		Met	Partial	Not Met	
<b>2</b>	<b>Study Question Definition</b> <i>The written study question:</i>				
2.1	Identifies the problem targeted for improvement				
2.2	Includes the specific population to be addressed				
2.3	Includes a general approach to interventions				
2.4	Is answerable/demonstrable				
2.5	Is within the MHP's scope of influence				
<b>Totals for Step 2:</b>					
<b>Total of 2 key criteria for Step 2:</b>					
<b>3</b>	<b>Clearly Defined Study Indicators</b> <i>The study indicators:</i>				
3.1	Are clearly defined, objective, and measurable				
3.2	Are designed to answer the study question				
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same				
3.4	Have accessible data that can be collected for each indicator				
3.5	Utilize existing baseline data that demonstrate the current status for each indicator				
3.6	Identify relevant benchmarks for each indicator				
3.7	Identify a specific, measurable goal(s) for each indicator				
<b>Totals for Step 3:</b>					
<b>Total of 4 key criteria for Step 3:</b>					
<b>4</b>	<b>Correctly Identified Study Population</b> <i>The method for identifying the study population:</i>				
4.1	Is accurately and completely defined				
4.2	Included a data collection approach that captures all consumers for whom the study question applies				
<b>Totals for Step 4:</b>					

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
<b>Total of 1 key criteria for Step 4:</b>				
<b>5</b>	<b>Use of Valid Sampling Techniques</b> <i>The sampling techniques:</i>			N/A
5.1	Consider the true or estimated frequency of occurrence in the population			
5.2	Identify the sample size			
5.3	Specify the confidence interval to be used			
5.4	Specify the acceptable margin of error			
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population			
<b>Totals for Step 5:</b>				
<b>6</b>	<b>Accurate/Complete Data Collection</b> <i>The data techniques:</i>			
6.1	Identify the data elements to be collected			
6.2	Specify the sources of data			
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data			
6.4	Provides a timeline for the collection of baseline and remeasurement data			
6.5	Identify qualified personnel to collect the data			
<b>Totals for Step 6:</b>				
<b>Total of 1 key criteria for Step 6:</b>				
<b>7</b>	<b>Appropriate Intervention and Improvement Strategies</b> <i>The planned/implemented intervention(s) for improvement:</i>			
7.1	Are related to causes/barriers identified through data analyses and QI processes			
7.2	Have the potential to be applied system wide to induce significant change			
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			
7.4	Are standardized and monitored when an intervention is successful			
<b>Totals for Step 7:</b>				

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
<b>Total of 1 key criteria for Step 7:</b>				N/A
<b>8</b>	<b>Analyses of Data and Interpretation of Study Results</b> <i>The data analyses and study results:</i>			
8.1	Are conducted according to the data analyses plan in the study design			
8.2	Identify factors that may threaten internal or external validity			
8.3	Are presented in an accurate, clear, and easily understood fashion			
8.4	Identify initial measurement and remeasurement of study indicators			
8.5	Identify statistical differences between initial measurement and remeasurement			
8.6	Include the interpretation of findings and the extent to which the study was successful			
<b>Totals for Step 8:</b>				
<b>Total of 3 key criteria for Step 8:</b>				
<b>9</b>	<b>Improvement Achieved</b> <i>There is evidence for true improvement based on:</i>			
9.1	A consistent baseline and remeasurement methodology			
9.2	Documented quantitative improvement in processes or outcomes of care			
9.3	Improvement appearing to be the result of the planned interventions(s)			
9.4	Statistical evidence for improvement			
<b>Totals for Step 9:</b>				
<b>10</b>	<b>Sustained Improvement Achieved</b> <i>There is evidence for sustained improvement based on:</i>			
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			
<b>Totals for Step 10:</b>				

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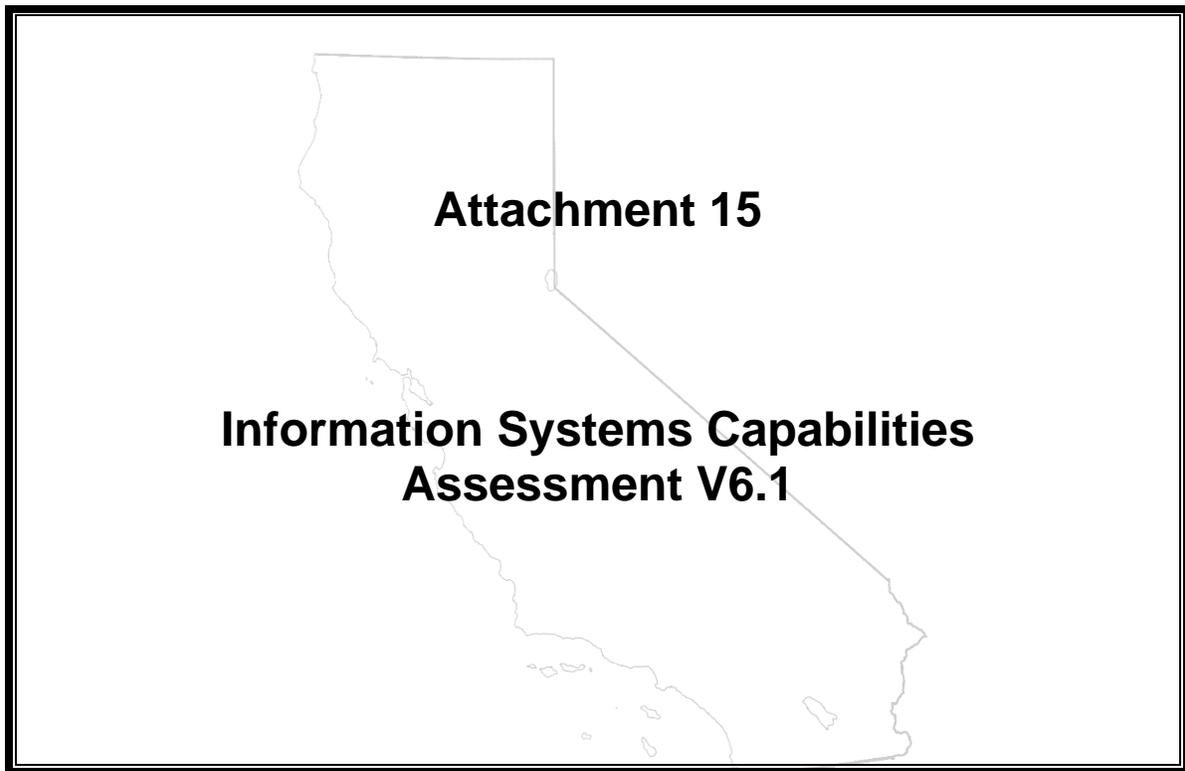




<b>PIP Key Criteria Ratings FY07-08</b>						
<b>Section Label</b>	<b>Section No</b>	<b>Question No</b>	<b>Question Text</b>	<b>Met/ Partially Met</b>	<b>Not Met</b>	<b>Total</b>
Study Topic	1	5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction or related processes of care designed to improve the same.	61	27	88
Study Question Definition	2	1	Identifies the problem targeted for improvement.	54	34	88
	2	4	Is answerable/demonstrable	53	35	88
Clearly Defined Study Indicators	3	1	Are well defined, objective and measurable	49	39	88
	3	2	Are designed to answer the study question.	44	44	88
	3	3	Are identified to measure changes designed to improve consumer mental health outcomes functional status, satisfaction, or related processes of care designed to improve	43	45	88
	3	4	Have accessible data that can be collected for each indicator.	51	37	88
Correctly Identified Study Population	4	1	Is accurately and completely defined.	54	34	88
Accurate/Complete Data Collection	6	3	Outline a defined and systematic process that consistently and accurately collects baseline and re-measurement data.	33	55	88
Appropriate Intervention and Improvement Strategies	7	1	Are related to causes/barriers identified through the data analyses and QI process.	33	55	88
Data Analysis and Study Results Interpretation	8	1	Are conducted according to the data analyses plan in the study design.	18	70	88
	8	3	Are presented in an accurate, clear, and easily understood fashion.	23	65	88
	8	6	Including the interpretation of findings and the extent to which the study was successful.	22	66	88



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





# Information Systems Capabilities Assessment

## (ISCA)

### California Mental Health Plans

#### **FY07-08**

Version 6.1

August 2, 2006

*This document was produced by the California EQRO in collaboration with the California Department of Mental Health and California MHP stakeholders.*



# Information Systems Capabilities Assessment (ISCA)

## FY07-08

### California Mental Health Plans

#### General Information

*This information systems capabilities assessment pertains to the collection and processing of data for Medi-Cal. In many situations, this may be no different from how a Mental Health Plan (MHP) collects and processes commercial insurance or Medicare data. However, if your MHP manages Medi-Cal data differently than commercial or other data, please answer the questions only as they relate to Medi-Cal beneficiaries and Medi-Cal data.*

- *Please insert your responses after each of the following questions. If information is not available, please indicate that in your response. Do not create documents or results expressly for this review. Be as concise as possible in your responses.*
- *If you provide any attachments or documents with protected health information (“PHI”), please redact or remove such information.*
- *Return an electronic copy of the completed assessment, along with documents requested in section F, to CAEQRO for review by [REDACTED]*

#### Contact Information

Insert MHP identification information below. The contact name should be the person completing or coordinating the completion of this assessment.

<i>MHP Name:</i>	█
<i>ISCA contact name and title:</i>	█
<i>Mailing address:</i>	█
<i>Phone number:</i>	█
<i>Fax number:</i>	█
<i>E-mail address:</i>	█
<i>Identify primary person who participated in completion of the ISCA (name, title):</i>	█ █ █
<i>Date assessment completed:</i>	█

*Note: This document is based on Appendix Z of the External Quality Review Activity Protocols developed by the Department of Health and Human Services Centers for Medicare and Medicaid Services (Final Protocol, Version 1.0, May 1, 2002). It was developed and refined by the California EQRO in collaboration with the California Department of Mental Health and California MHP stakeholders.*

## ISCA OVERVIEW

### PURPOSE of the Information System Capabilities Assessment (ISCA)

Knowledge of the capabilities of a Mental Health Plan (MHP) information system is essential to evaluate effectively and efficiently the MHP's capacity to manage the health care of its beneficiaries. The purpose of this assessment is to specify the desired capabilities of the MHP's Information System (IS) and to pose standard questions to be used to assess the strength of a MHP with respect to these capabilities. This will assist an External Quality Review Organization (EQRO) to assess the extent to which an MHP's information system is capable of producing valid encounter data<sup>1</sup>, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its beneficiaries.

If a prior assessment has been completed by private sector accreditation or performance measures validation, and the information gathered is the same as or consistent with what is described in this assessment, it may not be necessary to repeat this assessment process. However, information from a previously conducted assessment must be accessible to EQRO reviewers.

<sup>1</sup> "For the purposes of this protocol, an encounter refers to the electronic record of a service provided to an MCO/PIHP [MHP] enrollee by both institutional and practitioner providers (regardless of how the provider was paid) when the service would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provides substantially the same type of information that is found on a claim form (e.g., UB-92 or CMS 1500), but not necessarily in the same format." – Validating Encounter Data, CMS Protocol, P. 2, May 2002.

## OVERVIEW of the Assessment Process

Assessment of the MHP's information system(s) is a process of four consecutive activities.

**Step one** involves the collection of standard information about each MHP's information system. This is accomplished by having the MHP complete an *Information System Capabilities Assessment (ISCA) for California Mental Health Plans*. The ISCA is an information collection tool provided to the MHP and developed by the EQRO in cooperation with California stakeholders and the California Department of Mental Health. The California Department of Mental Health defined the time frame in which it expects the MHP to complete and return the tool. Data will be recorded on the tool by the MHP. Documents from the MHP are also requested through the tool and are summarized on the checklist at the end of this assessment tool. These are to be attached to the tool and should be identified as applicable to the numbered item on the tool (e.g., 1.4, or 2.2.3).

**Step two** involves a review of the completed ISCA by the EQRO reviewers. Materials submitted by the MHP will be reviewed in advance of a site visit.

**Step three** involves a series of onsite and telephone interviews, and discussion with key MHP staff members who completed the ISCA as well as other knowledgeable MHP staff members. These discussions will focus on various elements of the ISCA. The purpose of the interviews is to gather additional information to assess the integrity of the MHP's information system.

**Step Four** will produce an analysis of the findings from both the ISCA and the follow-up discussions with the MHP staff. A summary report of the interviews, as well as the completed ISCA document, will be included in an information systems section of the EQRO report. The report will discuss the ability of the MHP to use its information system and to analyze its data to conduct quality assessment and improvement initiatives. Further, the report will consider the ability of the MHP information system to support the management and delivery of mental health care to its beneficiaries.

### INSTRUCTIONS:

Please complete the following ISCA questions. For any questions that you believe do not apply to your MHP, please mark the item as "N/A." For any ISCA survey question, you may attach existing documents which provide an answer. For example, if you have current policy and procedure documents that address a particular item, you may attach and reference these materials.

**Please complete this survey using Microsoft Word. You may supply your answers in the areas indicated by tabbing through the fields.**

**Section A – General Information**

1. List the top priorities for your MHP's IS department at the present time.

█
█
█
█
█

2. How are mental health services delivered?

**Note:** For clarification, Contract Providers are typically groups of providers and agencies, many with long-standing contractual relationships with counties that deliver services on behalf of an MHP and bill for their services through the MHP's Short-Doyle/Medi-Cal system. These are also known as organizational contract providers. They are required to submit cost reports to the MHP and are subject to audits. They are not staffed with county employees, as county-run programs typically are. Contract providers do not include the former Medi-Cal fee-for-service providers (often referred to as network providers) who receive authorizations to provide services and whose claims are paid or denied by the MHP's managed care division/unit.

Of the total number of services provided, approximately what percentage is provided by:

	Distribution
County-operated/staffed clinics	█ %
Contract providers	█ %
Network providers	█ %
	100%

Of the total number of services provided, approximately what percentage is claimed to Medi-Cal:

	Medi-Cal	Non-Medi-Cal	Total
County-operated/staffed clinics	█ %	█ %	100%
Contract providers	█ %	█ %	100%
Network providers	█ %	█ %	100%

3. Provide approximate annual revenues/budgets for the following:

	Medi-Cal	Non-Medi-Cal	Total
County-operated/staffed clinics	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]
Contract providers	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]
Network providers	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]
Total	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]

4. Please estimate the number of staff that use your current information system:

Type of Staff	Estimated Number of Staff
MHP Support/Clerical	[REDACTED]
MHP Administrative	[REDACTED]
MHP Clinical	[REDACTED]
MHP Quality Improvement	[REDACTED]
Contract Provider Support/Clerical	[REDACTED]
Contract Provider Administrative	[REDACTED]
Contract Provider Clinical	[REDACTED]
Contract Provider Quality Improvement	[REDACTED]

5. Describe the primary information systems currently in use.

The following several pages allow for a description of up to four of the most critical and commonly used information systems. For clarification, certain terms used in this part are defined below:

Practice Management – Supports basic data collection and processing activities for common clinic/program operations such as new consumer registrations, consumer look-ups, admissions and discharges, diagnoses, services provided, and routine reporting for management needs such as caseload lists, productivity reports, and other day-to-day needs.

Medication Tracking – Includes history of medications prescribed by the MHP and/or externally prescribed medications, including over-the-counter drugs.

Managed Care – Supports the processes involved in authorizing services, receipt and adjudication of claims from network (formerly fee-for-service) providers, remittance advices, and related reporting and provider notifications.

Electronic Health Records – Clinical records stored in electronic form as all or part of a consumer’s file/chart and referenced by providers and others involved in direct treatment or related activities. This may include documentation such as

assessments, treatment plans, progress notes, allergy information, lab results, and prescribed medications. It may also include electronic signatures.

Master Patient Index – The function to search and locate patients using an index mechanism. The index synchronizes key patient demographic data including name, gender, social security number, date of birth and mother’s name. The synchronization of data is crucial to sharing information across systems.

**Current information system 1:**

Name of product: [REDACTED]	Name of vendor/supplier: [REDACTED]
When was it implemented? (An estimate is acceptable)    Month: [REDACTED]    Year: [REDACTED]	

What are its functions? (Check all that currently are used)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) [REDACTED]		

Who provides software application support?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

What type of Short-Doyle/Medi-Cal claims does it currently produce?

<input type="checkbox"/> SD/MC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> No claims or N/A
--	------------------------------------	---

Does this system interface or exchange data with other systems? If so, please list them.

[REDACTED]

**Current information system 2:**

Name of product: [REDACTED]	Name of vendor/supplier: [REDACTED]
When was it implemented? (An estimate is acceptable)    Month: [REDACTED]    Year: [REDACTED]	

What are its functions? (Check all that currently are used)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) [REDACTED]		

Who provides software application support?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

What type of Short-Doyle/Medi-Cal claims does it currently produce?

<input type="checkbox"/> SD/MC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> No claims or N/A
--	------------------------------------	---

Does this system interface or exchange data with other systems? If so, please list them.

[REDACTED]

**Current information system 3:**

Name of product: [REDACTED]	Name of vendor/supplier: [REDACTED]
When was it implemented? (An estimate is acceptable)    Month: [REDACTED]    Year: [REDACTED]	

What are its functions? (Check all that currently are used)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) [REDACTED]		

Who provides software application support?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

What type of Short-Doyle/Medi-Cal claims does it currently produce?

<input type="checkbox"/> SD/MC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> No claims or N/A
--	------------------------------------	---

Does this system interface or exchange data with other systems? If so, please list them.

[REDACTED]

**Current information system 4:**

Name of product: [REDACTED]	Name of vendor/supplier: [REDACTED]
When was it implemented? (An estimate is acceptable)    Month: [REDACTED]    Year: [REDACTED]	

What are its functions? (Check all that currently are used)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) [REDACTED]		

Who provides software application support?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

What type of Short-Doyle/Medi-Cal claims does it currently produce?

<input type="checkbox"/> SD/MC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> No claims or N/A
--	------------------------------------	---

Does this system interface or exchange data with other systems? If so, please list them.

[REDACTED]

6. Selection and Implementation of a new Information System:

Mark the box that best describes your status today and respond to the associated questions.

<input type="checkbox"/>	A) No plans to replace current system
<input type="checkbox"/>	B) Considering a new system
	What are the obstacles? <div style="background-color: #cccccc; width: 50px; height: 15px; margin-top: 5px;"></div>
<input type="checkbox"/>	C) Actively searching for a new system
	What steps have you taken? <div style="background-color: #cccccc; width: 50px; height: 15px; margin-top: 5px;"></div> When will you make a selection? <div style="background-color: #cccccc; width: 50px; height: 15px; margin-top: 5px;"></div>
<input type="checkbox"/>	D) New system selected, not yet in implementation phase
	What system/vendor was selected? <div style="background-color: #cccccc; width: 50px; height: 15px; margin-top: 5px;"></div> Projected start date <div style="background-color: #cccccc; width: 50px; height: 15px; margin-left: 100px;"></div> Go live date <div style="background-color: #cccccc; width: 50px; height: 15px; margin-left: 100px;"></div> Projected end date <div style="background-color: #cccccc; width: 50px; height: 15px; margin-left: 100px;"></div> Please attach your project plan.
<input type="checkbox"/>	E) Implementation in progress
	What system/vendor was selected? <div style="background-color: #cccccc; width: 50px; height: 15px; margin-top: 5px;"></div> Implementation start date <div style="background-color: #cccccc; width: 50px; height: 15px; margin-left: 100px;"></div> Go live date <div style="background-color: #cccccc; width: 50px; height: 15px; margin-left: 100px;"></div> Projected end date <div style="background-color: #cccccc; width: 50px; height: 15px; margin-left: 100px;"></div> Please attach your project plan.

7. Implementation of a new Information System

**If you marked box D, or E in 6 above, complete the following questions. Otherwise, skip to Section B.**

7.1. Describe any strategies or safeguards you plan to use to ensure timely and accurate continuation of Medi-Cal claims and CSI reporting during the transition to a new system.

7.2. If you are converting/transferring data from a legacy system, describe your conversion strategy, such as what general types of data will be transferred to the new system and what data will be left behind or archived.

7.3. Will the new system support conversion of the existing consumer identifier as the primary consumer identifier?

Yes  No

7.3.1. If No, describe how the new system will assign a unique identifier (you may identify the number as the consumer ID, patient ID, medical record number, unit record number) to new consumers.

7.4. Describe what features exist in the new system to prevent two or more unique identifiers being assigned to the same consumer by mistake (“duplicate charts”).

7.5. Specify key modules included in the system:

What are its functions? (Check all that are currently planned)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) <span style="background-color: #cccccc; display: inline-block; width: 50px; height: 15px;"></span>		

7.6. What departments/agencies will use the system? (Check all that apply)

<input type="checkbox"/> Mental Health
<input type="checkbox"/> Mental Health Contract Providers
<input type="checkbox"/> Alcohol and Drug
<input type="checkbox"/> Public Health
<input type="checkbox"/> Hospital

### ***Section B – Data Collection and Processing***

#### **Policy and Procedures**

1. Do you have a policy and procedure that specifies the timeliness of data entered into the system?

Yes  No

1.1. If Yes, describe your recent experience using any available data collected on timeliness.

<div style="background-color: #cccccc; width: 50px; height: 15px;"></div>
---

2. Do you have a policy and procedures specifying the degree of accuracy required for data entered into the IS?

Yes  No

2.1. If Yes, describe your recent experience using any available data collected on data accuracy.

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3. Does your MHP perform periodic verification of data in the IS compared to the medical record, such as ethnicity, language, birth date, and gender?

Yes  No

3.1. If Yes, please provide a description of your current policy and procedure or a report of a past data validity review.

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4. Do you have a policy and procedures for detection and reporting of fraud?

Yes  No

4.1. If Yes, describe your procedures to monitor for fraud.

5. Describe any recent audit findings and recommendations. This may include EPSDT audits, Medi-Cal audits, independent county initiated IS or other audits, OIG audits, and others.

**System Table Maintenance**

6. On a periodic basis, key system tables that control data validations, enforce business rules, and control rates in your information system must be reviewed and updated. What is your process for management of these tables?

6.1. Are these tables maintained by (check all that apply):

- MHP Staff
- Health Agency Staff (“Umbrella” health agency)
- County IS Staff
- Vendor Staff

7. Who is responsible for authorizing and implementing the following system activities?

Activity	Who authorizes? (Staff name/title or committee/workgroup)	Who implements? (Staff name/title or committee/workgroup)
Establishes new providers/reporting units/cost centers	<input type="text"/>	<input type="text"/>
Determines allowable services for a provider/RU/CC	<input type="text"/>	<input type="text"/>
Establishes or decides changes to billing rates	<input type="text"/>	<input type="text"/>
Determines information system UR rules	<input type="text"/>	<input type="text"/>
Determines assignments of payer types to services	<input type="text"/>	<input type="text"/>
Determines staff billing rights/restrictions	<input type="text"/>	<input type="text"/>

Activity	Who authorizes? (Staff name/title or committee/workgroup)	Who implements? (Staff name/title or committee/workgroup)
Determines level of access to information system	█	█
Terminates or expires access to information system	█	█

**Staff Credentialing**

8. Who ensures proper staff/provider credentialing in your organization for the following groups of providers?

County-operated/staffed clinics	█
Contract providers	█
Network (formerly fee-for-service) providers	█

9. Are staff credentials entered into your information system and used to validate appropriate Medi-Cal billing by qualified/authorized staff?

Yes  No

**Staff Training and Work Experience**

10. Does your MHP have a training program for users of your information system?

Yes  No

10.1. If Yes, please check all that apply.

	Classroom	On-the-Job	One-On-One Trainer	New Hires Only
Clerical/Support Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality Improvement Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Program Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Billing/Fiscal Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managed Care Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Describe your training program for users of your information system. Indicate whether you have dedicated or assigned trainers and whether you maintain formal records of this training. If available, include a list of training offerings and frequency, or a sample of a recent calendar of classes.

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12. What is your technology staff turnover rate since the last EQRO review?

Number of IS Staff	Number - New Hires	Number - Retired, Transferred, Terminated

**Access to and analysis of data**

13. Who is the person(s) most responsible for analyzing data from your information system? Describe the working relationship between this person(s) and your QI unit. If there is no such person, please state "NONE."

Staff Name/Title	Organization/Dept/Division	Describe relationship to QI unit or "None"
█	█	█
█	█	█
█	█	█

14. Considering the reports and data available from your information system, list the major users of this information (such as billing department, program clerical staff, QI unit, management, program supervisors, etc).

█
█
█

15. Does your information system capture co-occurring mental health and substance abuse diagnoses for active consumers?

Yes  No

15.1. If Yes, what is the percent of active consumers with co-occurring diagnoses?

█%

16. Does your information system maintain a history of diagnoses, as they are changed over time during an episode of care?

Yes  No

**Staff/Contract Provider Communications**

17. Does your MHP have User Groups or other forums for the staff to discuss information system issues and share knowledge, tips, and concerns?

Please complete all that apply	Meeting frequency (weekly, monthly, quarterly, as needed)	Who chairs meetings? (name and title)	Meeting minutes? (Yes/No)
Clerical User Group			
Clinical User Group			
Financial User Group			
Contract Providers			
IS Vendor Group			
Other			

18. How does your organization know if changes are required for your information system in order to meet requirements of the State Medi-Cal Program?

19. How are required State and local policy changes communicated to the staff or vendor responsible for implementing the policy change in the information system?

20. Does your organization use a Web server, intranet server, shared network folders/files, content management software, or other technology to communicate policy, procedures, and information among MHP and contract provider staffs?

Yes  No

20.1 If Yes, briefly describe how this is used and managed. Include examples of information communicated.

**Other Processing Information**

21. Describe how new consumers are assigned a unique identifier (you may identify this number as the consumer ID, patient ID, medical record number, unit record number).

22. Describe how you monitor missed appointments (“no-shows”) and provide a brief report or any available data regarding your rate of missed appointments.

23. Does your MHP track grievances and appeals?

Yes  No

23.1 If Yes, is it automated or manual?

<input type="checkbox"/>	Automated – Integrated into primary information system
<input type="checkbox"/>	Automated – Separate system
<input type="checkbox"/>	Manual
	Please describe: <input style="width: 100px;" type="text"/>

24. How does your MHP plan to address MHSA reporting requirements for Full Service Partnerships?

<input type="checkbox"/>	Integrate into primary information system, by vendor or in-house staff
<input type="checkbox"/>	Use separate on-line system developed by DMH
<input type="checkbox"/>	Use separate system developed by in-house staff
<input type="checkbox"/>	Use separate system developed by vendor
<input type="checkbox"/>	Have not decided

**Section C - Medi-Cal Claims Processing**

1. Who in your organization is authorized to sign the MH1982A attestation statement for meeting the State Medi-Cal claiming regulatory requirements?  
(Identify all persons who have authority)

Name: <input style="width: 50px;" type="text"/>	Title: <input style="width: 50px;" type="text"/>
Name: <input style="width: 50px;" type="text"/>	Title: <input style="width: 50px;" type="text"/>
Name: <input style="width: 50px;" type="text"/>	Title: <input style="width: 50px;" type="text"/>
Name: <input style="width: 50px;" type="text"/>	Title: <input style="width: 50px;" type="text"/>

2. Indicate normal cycle for submitting current fiscal year Medi-Cal claim files to DMH.

Monthly  More than 1x month  Weekly  Daily  Other

3. Provide a high-level diagram depicting your monthly operations activity to prepare a Medi-Cal claim. Note the steps your staff takes to produce the claim for submission to DMH.

4. If your IS vendor controls some part of the claim cycle, describe the Medi-Cal claim activities performed by your information system vendor.

5. Does your MHP use a standard review process for claims before submission?

Yes  No

5.1. If yes, please describe the claims review process. What criteria are used to ensure that a claim is accurate before submission to DMH?

6. Briefly describe your strategy to implement the National Provider Identifier (NPI), as required by HIPAA.

7. Please describe how beneficiaries' Medi-Cal eligibility is stored and updated within your system in order to trigger Medi-Cal claims. Include whether automated matches to the State's MMEF file are performed for the purpose of mass updates to multiple consumers.

8. What Medi-Cal eligibility sources does your MHP use to determine monthly eligibility? Check all that apply

<input type="checkbox"/>	IS Inquiry/Retrieval from MEDS	<input type="checkbox"/>	POS devices
<input type="checkbox"/>	MEDS terminal (standalone)	<input type="checkbox"/>	AEVS
<input type="checkbox"/>	MEDS terminal (integrated with IS)	<input type="checkbox"/>	Web based search
<input type="checkbox"/>	MMEF	<input type="checkbox"/>	FAME
<input type="checkbox"/>	Eligibility verification using 270/271 transactions	<input type="checkbox"/>	Other: <input style="width: 50px; height: 15px;" type="text"/>

9. When checking Medi-Cal eligibility, does your system permit storing of eligibility information – such as verification code (EVC), county of eligibility, aid code of eligibility, share of cost information?

Yes  No

9.1. If Yes, identify which of these fields are stored and describe if a user needs to enter this information manually, or if the process is automated (system does it).

10. Does your MHP use the information system to create ad hoc reports on Medi-Cal claims and eligibility data?

Yes  No

10.1 If Yes, please indicate the software reporting tools used by your staff and include a brief description of a recent ad hoc report.

11. Describe your most critical reports for managing your Medi-Cal claims and eligibility data.

12. Do you currently employ staff members to extract data and/or produce reports regarding Medi-Cal claims or eligibility information?

Yes  No

13. Please describe your MHP's policy and procedure and timeline for reviewing the Error Correction Report (ECR).

14. Please describe your MHP's policy and procedure for reviewing the Medi-Cal Explanation of Benefits (EOB or 835) that is returned to the MHP.

15. What percent of Medi-Cal claims were denied during:

FY 2004	<input type="text"/> %	FY 2005	<input type="text"/> %
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### ***Section D – Incoming Claims Processing***

Note: "Network providers" (commonly known as fee-for-service providers or managed care network providers) may submit claims to the MHP with the expectation of payment. Network providers do not submit a cost report to the MHP.

1. Beginning with receipt of a Medi-Cal claim in-house, provide a diagram of the claim handling, logging, and processes to adjudicate and pay claims.

2. How is Medi-Cal eligibility verified for incoming claims?

3. How are claims paid to network providers billed to Short-Doyle/Medi-Cal?

4. Have any recent system changes influenced, even temporarily, the quality and/or completeness of the Medi-Cal claims data that are collected? If so, how and when?

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5. What claim form does the MHP accept from network providers?

<input type="checkbox"/>	CMS 1500	
<input type="checkbox"/>	UB-92	
<input type="checkbox"/>	837I	
<input type="checkbox"/>	837P	
<input type="checkbox"/>	MHP specific form (describe):	

6. Please indicate which code sets are required by your MHP on claims received from network providers.

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Outpatient Diagnosis	Outpatient Procedure
ICD-9-CM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPT-4		<input type="checkbox"/>		<input type="checkbox"/>
HCPCS		<input type="checkbox"/>		<input type="checkbox"/>
UB Revenue Code		<input type="checkbox"/>		<input type="checkbox"/>
DSM-IV-TR	<input type="checkbox"/>		<input type="checkbox"/>	
MHP Internal Code	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Please indicate whether you require the following data elements on claims submitted by network providers.

Data Elements	Yes or No	
Patient Gender	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient DOB/Age	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diagnosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Procedure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
First date of service	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Last date of service	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Financial Responsibility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider Specialty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MHP consumer identification number	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Place of service	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. How does your MHP monitor the accuracy and productivity of individual staff members who have responsibility for adjudicating incoming Medi-Cal claims from network providers?

9. What is the average length of time between claim receipt and payment to network provider? (An estimate is acceptable.)

10. Does your MHP maintain provider profiles in your information system?

Yes  No

- 10.1. If Yes, please describe what provider information is maintained in the provider profile database (e.g., languages spoken, special accessibility for individuals with special health care needs).

11. Please describe how network provider directories are updated, how frequently, and who has “update” authority.

12. Does your MHP use a manual or an automated system to process incoming claims, and adjudicate and pay claims?

Manual  Automated  Combination of Both

**If you marked either “Automated” or “Combination of Both,” complete the following questions. Otherwise, skip to Section E.**

13. What percent of claims are received electronically?  %

14. What percent of claims are auto adjudicated?  %

15. How are the fee schedule and network provider compensation rules maintained in your IS to assure proper claims payment by your MHP? Who has “update” authority?

16. Does the system generate a remittance advice (e.g., EOB)?

Yes  No

16.1. If Yes, does your system generate a HIPAA transaction for the remittance advice?

Yes  No

17. Does the system generate an authorization advice (i.e., letter)?

Yes  No

17.1. If Yes, does your system generate a HIPAA transaction for the authorization letter?

Yes  No

### **Section E – Information Systems Security and Controls**

1. Please describe the frequency of back-ups that are required to protect your primary Medi-Cal information systems and data. Where is the back-up media stored?

2. Describe the controls used to assure that all Medi-Cal direct services are entered into the system (e.g., control numbers, daily audits, and/or service activity logs).

3. Please describe your policy and procedure for password control on your Medi-Cal system(s). For example, how often do you require passwords to be changed?

4. Please describe the provisions in place for physical security of the computer system(s) and manual files. Highlight provisions that address current HIPAA security requirements.

4.1. Premises

4.2. Documents

4.3. Computer room/server room

4.4. Workstation access and levels of security

5. Describe how your MHP manages access for users. Do you use templates to standardize user access? If so, describe the levels of access for both MHP and contract provider staffs.

6. Describe your procedures to remove/disable access for terminated users. Explain the process for both MHP and contract provider staffs. Include frequency it is done for both groups of users.

### **Section F – Additional Documentation**

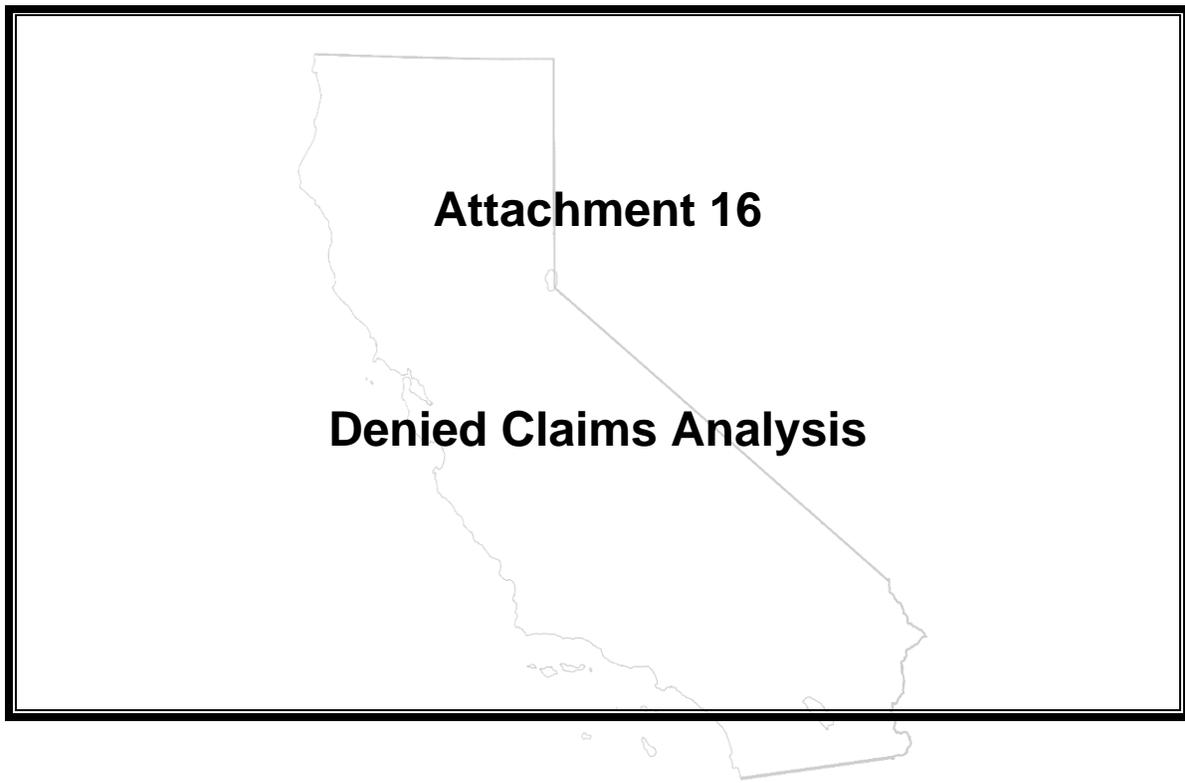
1. Please provide the documentation listed in the table below. Documentation may be submitted electronically or by hardcopy. Label documents as shown under the “Requested Documents” column.

<b>Requested Documents</b>	<b>Description</b>
A. Organizational chart	The chart should make clear the relationship among key individuals/departments responsible for information management.
B. County-operated programs and clinics	A list of those who can bill Medi-Cal, including name, address, and type of program (i.e., outpatient, day treatment, residential, and inpatient).
C. Contract providers	A list of those who can bill Medi-Cal, including name, address, and type of program (i.e., outpatient, day treatment, residential, and inpatient).
D. Procedures to monitor accuracy and timeliness of data collection	Provide copies of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers that address standards for data collection accuracy and timeliness.
E. Procedures to determine consumer/beneficiary eligibility status	Provide copies of the current policies and procedures, desk procedures, and/or written instructions to the staff and providers that describe how to determine consumer/beneficiary eligibility status.
F. Procedures to produce Medi-Cal claims and review error/denied claims	Provide copies of the current policies and procedures, operations manual, flowchart, calendar, and/or written instructions that document production of the Medi-Cal claim and resolving error/denied claims.
G. Procedures to monitor timeliness of claims processing and payments to network providers	Provide copies of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers that describe standards for monitoring timely claims processing/payment.
H. Procedures for the following topics: new user authorization, disable user accounts, password standards, data security standards, unattended computers, electronic security audits.	Provide a copy of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers for these activities.

Requested Documents	Description
I. Prior Internal Audits	If you have recently done an internal audit of your Medi-Cal claims submissions or your Medi-Cal claims adjudication from network providers, please attach a copy for review.
J. Ethnicity/race, language code translations	Provide a cross-reference list or table showing what codes are used internally by the staff on source documents for data entry and how they are translated into valid codes for Medi-Cal claims and CSI reporting.
K. Crosswalk from locally used service/procedure codes to CPT/HCPCS codes used in the Medi-Cal claim.	Provide a crosswalk for mapping codes used to record services to codes used to bill Medi-Cal. Include those used by network providers.
L. Index of your Reports Manual	If available, provide a list of all current vendor-supplied and internally developed reports and report titles. Do not include ad hoc reports developed to meet temporary or one-time needs.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

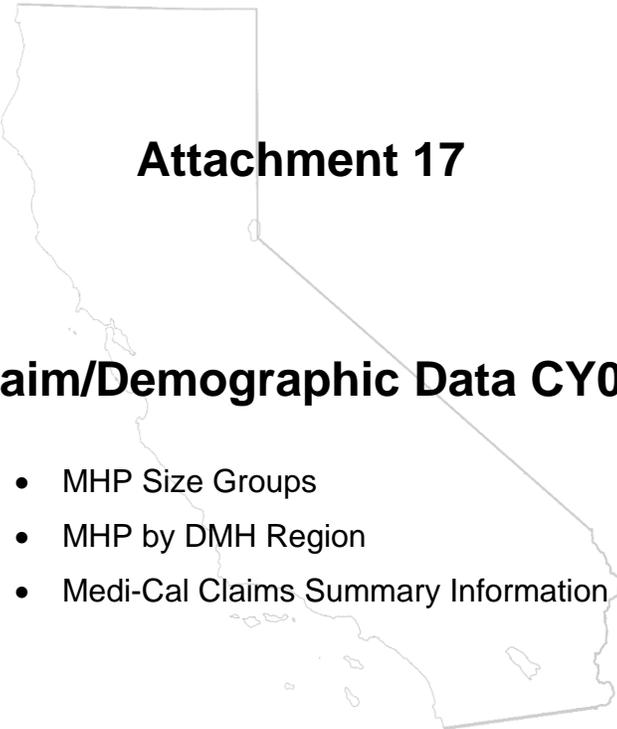




Denied Claims Analyses						
MHP	FY06-07 Statewide Rank	FY06-07 % Denied	FY05-06 Statewide Rank	FY05-06 % Denied	FY04-05 Statewide Rank	FY04-05 % Denied
Alameda	45	1.66%	33	2.34%	16	6.94%
Alpine	1	18.18%	4	14.71%	56	0.00%
Amador	4	12.95%	3	14.77%	2	21.67%
Butte	21	4.70%	15	6.84%	11	8.65%
Calaveras	27	3.63%	20	4.54%	17	6.59%
Colusa	34	2.72%	26	3.52%	26	3.47%
Contra Costa	23	4.20%	29	2.96%	14	7.24%
Del Norte	18	5.16%	49	0.98%	52	0.88%
El Dorado	19	4.95%	39	1.41%	34	2.47%
Fresno	25	3.90%	11	9.51%	33	2.59%
Glenn	28	3.61%	28	3.07%	29	3.18%
Humboldt	39	2.04%	24	3.77%	24	3.65%
Imperial	31	2.88%	27	3.49%	19	6.22%
Inyo	15	5.64%	18	5.53%	7	11.34%
Kern	32	2.85%	44	1.17%	46	1.40%
Kings	46	1.32%	37	1.81%	32	2.64%
Lake	6	10.99%	14	7.10%	10	9.35%
Lassen	11	7.09%	6	12.67%	5	12.84%
Los Angeles	12	6.17%	8	10.84%	3	17.60%
Madera	16	5.55%	46	1.08%	31	2.71%
Marin	42	1.73%	52	0.88%	53	0.86%
Mariposa	29	3.48%	16	6.71%	15	7.09%
Mendocino	10	8.35%	17	5.85%	13	7.25%
Merced	20	4.89%	9	9.85%	22	4.72%
Modoc	30	3.10%	42	1.25%	49	1.32%
Mono	24	3.98%	5	12.93%	9	9.38%
Monterey	14	5.65%	23	3.84%	30	3.11%
Napa	50	1.01%	2	17.46%	21	5.10%
Nevada	5	11.30%	10	9.54%	27	3.42%
Orange	13	5.90%	19	4.83%	12	8.31%
Placer/Sierra	22	4.49%	25	3.53%	28	3.29%
Plumas	35	2.39%	35	2.24%	36	2.36%
Riverside	36	2.28%	30	2.82%	38	2.23%
Sacramento	17	5.51%	21	4.39%	37	2.25%
San Benito	3	15.03%	7	11.54%	4	15.71%
San Bernardino	43	1.70%	33	2.34%	39	2.20%
San Diego	47	1.30%	41	1.26%	47	1.35%
San Francisco	40	1.82%	31	2.49%	44	1.53%
San Joaquin	26	3.67%	40	1.32%	40	2.11%
San Luis Obispo	54	0.45%	48	1.01%	49	1.32%
San Mateo	48	1.21%	45	1.09%	18	6.38%
Santa Barbara	41	1.74%	36	2.01%	35	2.46%
Santa Clara	2	15.12%	1	22.69%	1	36.78%
Santa Cruz	8	8.80%	12	9.34%	8	10.23%
Shasta	53	0.46%	53	0.78%	48	1.34%
Siskiyou	56	0.23%	56	0.57%	54	0.81%
Solano	43	1.70%	49	0.98%	41	1.97%
Sonoma	52	0.83%	55	0.60%	55	0.76%
Stanislaus	33	2.82%	32	2.48%	42	1.78%
Sutter/Yuba	51	0.92%	46	1.08%	51	0.92%
Tehama	38	2.20%	22	4.33%	20	5.69%
Trinity	49	1.13%	51	0.97%	23	4.03%
Tulare	7	8.97%	38	1.62%	45	1.48%
Tuolumne	55	0.32%	54	0.75%	43	1.59%
Ventura	37	2.23%	43	1.22%	25	3.56%
Yolo	9	8.53%	13	7.75%	6	11.97%
Statewide Median		3.55%		3.02%		3.24%
Statewide Range		0.23% to 18.18%		0.57% to 22.69%		0.0% to 36.78%



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 17**

**Claim/Demographic Data CY07**

- MHP Size Groups
- MHP by DMH Region
- Medi-Cal Claims Summary Information CY07



**MHP Size Groups**

MHP Size Groups	Number MHPs	Average Monthly Eligibles	Beneficiaries Served	Penetration Rate	Approved Claims	Average Benefit	Average Benefit per Eligible	Population	Eligibles Per 100/Population
Small-Rural	14	59,586	6,341	10.64%	\$32,144,517	\$5,069	\$539	342,446	17.4
Small	15	361,959	28,034	7.75%	\$94,782,176	\$3,381	\$262	1,910,245	18.9
Medium	14	992,212	61,535	6.20%	\$299,853,920	\$4,873	\$302	5,760,417	17.2
Large	12	3,056,728	199,151	6.52%	\$827,558,721	\$4,155	\$271	19,672,504	15.5
Very Large	1	2,366,868	127,976	5.41%	\$628,525,927	\$4,911	\$266	10,363,850	22.8
<b>Total</b>	<b>56</b>	<b>6,837,351</b>	<b>423,037</b>	<b>6.19%</b>	<b>\$1,882,865,260</b>	<b>\$4,451</b>	<b>\$275</b>	<b>38,049,462</b>	<b>18.0</b>

**MHP by DMH Regions**

DMH Regions	Number MHPs	Average Monthly Eligibles	Beneficiaries Served	Penetration Rate	Approved Claims	Average Benefit	Average Benefit per Eligible	Population	Eligibles Per 100/Population
Bay Area	12	1,056,378	79,481	7.52%	\$466,049,916	\$5,864	\$441	8,053,932	13.1
Central	18	1,266,015	73,753	5.83%	\$251,701,782	\$3,413	\$199	5,620,533	22.5
Los Angeles	1	2,366,868	127,976	5.41%	\$628,525,927	\$4,911	\$266	10,363,850	22.8
Southern	9	1,928,362	119,725	6.21%	\$440,450,218	\$3,679	\$228	12,934,867	14.9
Superior	16	219,729	22,102	10.06%	\$96,137,417	\$4,350	\$438	1,076,280	20.4
<b>Statewide</b>	<b>56</b>	<b>6,837,351</b>	<b>423,037</b>	<b>6.19%</b>	<b>\$1,882,865,260</b>	<b>\$4,451</b>	<b>\$275</b>	<b>38,049,462</b>	<b>18.0</b>

Prepared by APS Healthcare / CA EQRO  
 Data source: Short-Doyle/Medi-Cal approved claims as of May 22, 2008; Inpatient Consolidated approved claims as of May 22, 2008

Medi-Cal Claims Summary Information  
for CY07  
All Mental Health Plans

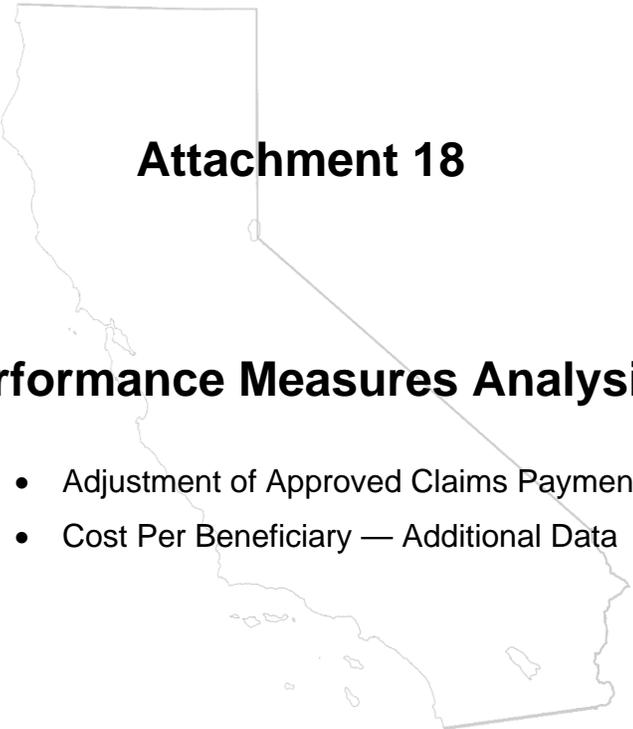
MHP Name	Region	MHP Size	Average Number of Eligibles	Number of Beneficiaries Served	Penetration Rate	Approved Claims as of May 2008	Approved Claims per Beneficiary Served	Approved Claims per Eligible	Rank - Penetration Rate	Rank - Approved Claims per Beneficiary Served	Rank - Approved Claims per Eligible	County Population (Jan 2008)	Rank - County Population	Rank - Medi-Cal Eligibles (2008)	Rank - Medi-Cal Eligibles as % of 2008 County Pop	Medi-Cal Eligibles Per 100 2008 County Pop	Federal Poverty Level (2002)	Number of Threshold Languages Oct 2006
Alameda	Bay Area	Large	227,258	19,421	8.55%	\$101,540,666	\$5,238	\$447	22	11	12	1,543,000	7	9	32	14.7	9.7%	4
Alpine	Central	Small-Rural	161	15	9.32%	\$18,139	\$1,208	\$113	19	56	55	1,222	56	56	35	13.2	15.6%	0
Amador	Central	Small-Rural	3,669	391	10.65%	\$844,344	\$1,048	\$176	9	55	48	37,343	45	49	50	9.7	9.4%	0
Butte	Superior	Medium	47,684	4,852	10.38%	\$22,610,535	\$4,586	\$474	10	21	9	220,407	27	24	17	21.6	19.4%	2
Calaveras	Central	Small-Rural	5,335	402	7.54%	\$1,189,100	\$2,958	\$223	33	41	40	48,127	43	47	47	11.6	9.7%	1
Colusa	Superior	Small-Rural	4,828	387	8.02%	\$2,150,415	\$8,557	\$445	27	9	13	21,910	49	48	14	22.0	13.2%	1
Contra Costa	Bay Area	Large	121,805	9,314	7.65%	\$49,890,855	\$5,357	\$410	32	10	15	1,051,674	9	14	45	11.6	6.7%	1
Del Norte	Superior	Small-Rural	8,053	1,046	12.98%	\$2,505,178	\$2,395	\$311	2	49	28	29,418	47	43	5	27.4	21.1%	1
El Dorado	Central	Small	15,761	1,486	9.43%	\$4,361,335	\$2,935	\$277	17	42	36	179,722	30	36	54	8.8	7.1%	1
Fresno	Central	Large	281,331	13,032	4.63%	\$34,919,576	\$2,680	\$174	54	47	53	831,088	10	7	2	30.2	21.0%	2
Glenn	Superior	Small-Rural	6,972	566	8.11%	\$2,927,749	\$4,966	\$420	23	16	14	29,195	48	45	8	23.9	15.4%	1
Humboldt	Superior	Small	26,852	2,732	10.17%	\$12,098,108	\$4,428	\$451	11	24	10	132,821	36	32	21	20.2	15.5%	0
Imperial	Southern	Small	50,862	2,887	5.67%	\$9,830,981	\$3,405	\$193	44	34	43	176,158	31	23	4	28.9	21.9%	1
Inyo	Superior	Small-Rural	3,293	315	9.57%	\$654,045	\$3,029	\$290	15	40	30	32,900	52	50	27	18.1	9.9%	1
Kern	Southern	Large	209,435	11,805	5.64%	\$59,415,407	\$5,033	\$284	45	14	32	817,517	13	10	6	25.6	18.3%	1
Kings	Central	Small	33,034	2,147	6.50%	\$4,233,377	\$1,972	\$138	39	53	52	154,434	33	29	20	21.4	19.6%	1
Lake	Superior	Small	15,735	1,496	9.51%	\$5,063,576	\$3,398	\$233	16	35	24	64,059	39	37	9	24.8	15.8%	1
Lassen	Superior	Small-Rural	5,351	692	12.93%	\$2,736,621	\$3,955	\$511	3	28	7	35,757	46	46	30	15.0	19.9%	1
Los Angeles	Los Angeles	Very Large	2,366,868	127,976	5.41%	\$628,525,927	\$4,911	\$266	49	18	38	10,963,890	1	1	13	22.8	17.3%	12
Madera	Central	Small	38,449	1,845	4.80%	\$5,879,356	\$3,165	\$153	53	38	50	150,887	34	27	7	25.5	20.5%	1
Marin	Bay Area	Medium	19,148	2,118	11.06%	\$10,625,110	\$5,017	\$555	7	15	5	257,406	25	35	56	7.4	6.8%	1
Mariposa	Central	Small-Rural	2,592	247	9.68%	\$465,689	\$1,885	\$162	13	54	45	18,406	51	53	38	13.9	11.7%	0
Mendocino	Superior	Small	21,411	1,752	8.18%	\$7,965,676	\$4,543	\$372	26	22	18	90,163	38	34	10	23.7	14.6%	1
Merced	Central	Medium	74,242	2,849	3.84%	\$6,494,619	\$2,280	\$87	56	51	56	255,250	26	18	3	29.1	18.8%	2
Modoc	Superior	Small-Rural	2,178	169	7.76%	\$387,905	\$2,291	\$178	31	50	46	9,702	55	54	16	22.4	18.9%	1
Mono	Central	Small-Rural	1,296	85	6.56%	\$422,714	\$4,973	\$326	38	17	23	13,769	54	55	51	9.4	8.1%	1
Monterey	Bay Area	Medium	76,561	3,957	5.17%	\$27,204,373	\$6,875	\$355	51	4	19	428,549	20	17	26	17.9	13.3%	1
Napa	Bay Area	Small	14,021	1,100	7.85%	\$3,866,888	\$3,006	\$263	29	31	33	136,704	35	39	49	10.3	7.0%	1
Nevada	Superior	Small	9,049	798	8.76%	\$3,041,424	\$3,835	\$396	21	29	22	99,186	37	41	53	9.1	7.6%	1
Orange	Southern	Large	383,930	20,340	5.30%	\$67,118,393	\$3,300	\$175	50	37	49	3,121,251	3	2	43	12.3	10.2%	2
Placer/Sierra	Central	Medium	25,764	2,413	9.37%	\$9,612,498	\$3,984	\$373	18	27	17	336,781	22	33	55	7.7	5.5%	1
Plumas	Superior	Small-Rural	2,766	332	12.00%	\$1,544,559	\$4,652	\$558	4	19	4	20,917	50	52	40	13.2	9.8%	0
Riverside	Southern	Large	315,668	17,182	5.44%	\$48,082,140	\$2,788	\$152	48	45	51	2,068,322	4	5	30	15.1	12.9%	1
Sacramento	Central	Large	265,373	20,826	7.23%	\$30,814,912	\$4,403	\$318	36	25	25	1,424,415	8	6	23	20.0	12.7%	5
San Benito	Bay Area	Small	8,554	671	7.84%	\$1,726,627	\$2,573	\$202	30	48	42	57,784	41	42	34	14.8	8.8%	1
San Bernardino	Southern	Large	380,043	23,559	6.20%	\$66,966,028	\$2,842	\$176	40	44	47	2,055,766	5	3	25	18.5	15.7%	1
San Diego	Southern	Large	367,173	30,503	8.31%	\$101,207,150	\$3,318	\$276	24	36	37	3,146,274	2	4	44	11.7	10.9%	4
San Francisco	Bay Area	Large	129,225	14,163	10.96%	\$89,095,131	\$6,291	\$689	8	5	3	824,525	12	13	29	15.7	10.7%	4
San Joaquin	Central	Medium	152,144	8,362	5.50%	\$18,546,482	\$2,118	\$122	47	52	54	685,690	15	11	17	22.2	14.2%	2
San Luis Obispo	Southern	Medium	31,251	2,751	8.80%	\$4,070,540	\$5,145	\$450	20	12	11	269,337	23	30	45	11.6	10.7%	1
San Mateo	Bay Area	Medium	67,664	5,563	8.22%	\$25,764,809	\$4,631	\$351	25	20	16	739,469	14	20	52	9.2	5.9%	1
Santa Barbara	Southern	Medium	72,752	5,017	6.90%	\$39,241,539	\$7,822	\$539	47	3	6	428,855	19	19	28	17.0	12.4%	1
Santa Clara	Bay Area	Large	238,339	13,525	5.67%	\$33,990,432	\$6,710	\$352	33	6	21	1,837,075	6	8	40	13.0	7.8%	4
Sanita Cruz	Bay Area	Medium	39,238	3,107	7.92%	\$35,954,756	\$11,572	\$916	28	1	2	266,519	24	26	35	14.7	10.6%	1
Shasta	Superior	Small	37,240	3,711	9.97%	\$11,669,238	\$3,144	\$313	12	39	26	182,236	29	28	21	20.4	13.4%	0
Sierra (see Placer)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0
Siskiyou	Superior	Small-Rural	10,210	1,248	13.20%	\$14,736,985	\$10,932	\$1,443	1	2	1	45,971	41	40	17	22.2	15.6%	1
Solano	Bay Area	Medium	61,642	3,472	5.63%	\$17,509,780	\$5,043	\$284	46	13	31	426,757	21	21	37	14.4	7.9%	1
Sonoma	Bay Area	Medium	52,927	3,070	5.80%	\$18,780,479	\$6,117	\$355	42	7	20	484,470	17	22	48	10.9	7.5%	1
Stanislaus	Central	Medium	119,882	7,071	5.90%	\$24,894,056	\$3,521	\$298	41	32	41	525,903	16	15	14	22.8	13.8%	1

Medi-Cal Claims Summary Information  
for CY07  
All Mental Health Plans

MHP Name	Region	MHP Size	Average Number of Eligibles	Number of Beneficiaries Served	Penetration Rate	Approved Claims as of May 2008	Approved Claims per Beneficiary Served	Approved Claims per Eligible	Rank - Penetration Rate	Rank - Approved Claims per Beneficiary Served	Rank - Approved Claims per Eligible	County Population (Jan 2009)	Rank - County Population	Rank - Medi-Cal Eligibles (2009)	Rank - Medi-Cal Eligibles as % of 2008 County Pop	Medi-Cal Eligibles Per 100 2008 County Pop	Federal Poverty Level (2002)	Number of Threshold Languages Oct 2006
Sutter/Yuba	Central	Small	39,370	2,959	7.52%	\$11,081,507	\$3,745	\$281	34	30	34	167,807	32	25	12	23.5	13.0%	1
Tehama	Superior	Small	15,188	1,495	9.85%	\$4,274,330	\$2,918	\$281	14	43	35	82,419	40	38	10	24.3	16.3%	1
Trinity	Superior	Small-Rural	2,927	326	11.14%	\$1,461,775	\$4,484	\$499	6	23	8	13,966	53	51	23	21.0	16.1%	0
Tulare	Central	Medium	151,320	6,833	4.52%	\$28,544,333	\$4,177	\$189	55	26	44	435,254	18	12	1	34.8	22.5%	1
Tuolumne	Central	Small	7,968	653	11.58%	\$2,301,805	\$2,698	\$312	5	46	27	56,769	42	44	42	13.0	12.1%	0
Ventura	Southern	Large	117,151	5,681	4.85%	\$4,518,041	\$8,076	\$295	52	8	29	831,587	11	16	39	14.1	9.0%	1
Yolo	Central	Small	28,972	2,136	7.37%	\$7,277,940	\$3,407	\$251	35	33	39	199,066	28	31	33	14.6	11.3%	2
Yuba (see Sutter)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	17.8%	0
<b>Statewide</b>	<b>66MHPs</b>		<b>6,837,351</b>	<b>423,037</b>	<b>6.19%</b>	<b>\$1,882,895,260</b>	<b>\$4,451</b>	<b>\$275</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>	<b>38,049,482</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>	<b>18.0</b>	<b>n/a</b>	<b>14</b>



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 18**

**Performance Measures Analysis**

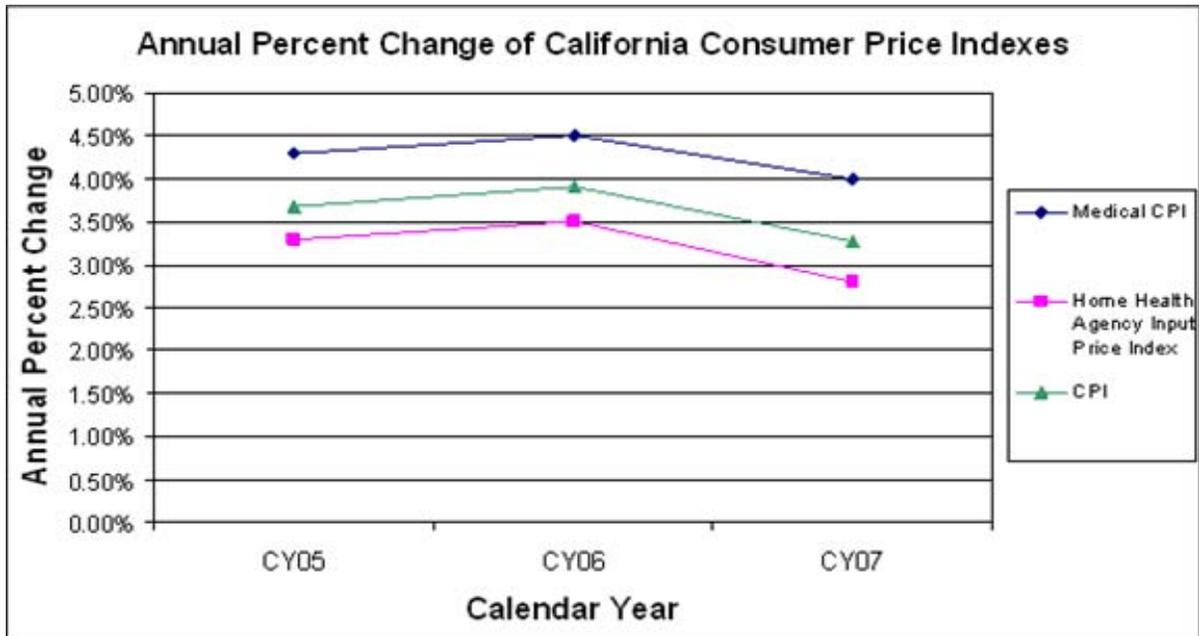
- Adjustment of Approved Claims Payments for Inflation
- Cost Per Beneficiary — Additional Data



## Adjustment of Approved Claims Payments for Inflation

CAEQRO adjusted the statewide approved claims payments by the consumer price index (CPI) when comparing approved claims payments across calendar years, where indicated. We used the California CPI annual percent changes for calendar years 2007 and 2006 to deflate these years' dollar amounts to 2005 dollars.

CAEQRO chose not to use the medical component of CPI (MCPI) for these adjustments as the current literature indicates that MCPI overestimates medical sector price inflation due to its methodological issues. California Department of Mental Health (DMH) only applies MCPI to the annual price adjustment for hospital acute inpatient services. DMH does apply the home health agency input price index (HHAIFI) to the annual price increases for all non-hospital services. However, HHAIFI is lower than CPI. Therefore, using CPI as a medical deflator can avoid over-adjustment by using MCPI or under-adjustment by using HHAIFI.



Calendar Year	CY05	CY06	CY07
California Medical Component of Consumer Price Index Change	4.30%	4.50%	4.00%
California Home Health Agency Input Price Index Change	3.30%	3.50%	2.80%
California Consumer Price Index Change	3.68%	3.90%	3.28%

**Attachment 18  
Glossary**

CANOLA – Indicates statistics on California without Los Angeles (CA no LA)

Cost Per Beneficiary – Same as Approved Claims Per Beneficiary

CPI – Consumer Price Index

IPC – Inpatient Consolidation Claims

MMEF – MEDS Monthly Extract Files

MEDS – Medi-Cal Eligibility Data System

SD/MC – Short-Doyle/Medi-Cal

TBS – Therapeutic Behavioral Services

## Cost Per Beneficiary — Additional Data

<b>Cost Per Beneficiary Served - Statewide/CANOLA CY05 Not Adjusted for CPI</b>							
	<b>Total Medi-Cal Eligibles</b>	<b>Percent of Medi-Cal Eligibles</b>	<b>Total Beneficiaries Served</b>	<b>Percent of Beneficiaries Served</b>	<b>Median - Cost Per Beneficiary Served</b>	<b>Average - Cost Per Beneficiary Served</b>	<b>Standard Deviation - Cost Per Beneficiary Served</b>
Statewide	6,810,962	100%	430,877	100%	\$1,346	\$4,045	\$8,396
CA No LA	4,353,453	64%	302,116	70%	\$1,287	\$3,866	\$8,301
Los Angeles	2,457,509	36%	128,761	30%	\$1,515	\$4,465	\$8,601

Source: SD/MC approved claims as of February 2007, IPC approved claims as of March 2007 and MMEF data as of April 2006

<b>Cost Per Beneficiary Served - Statewide/CANOLA CY06 Not Adjusted for CPI</b>							
	<b>Total Medi-Cal Eligibles</b>	<b>Percent of Medi-Cal Eligibles</b>	<b>Total Beneficiaries Served</b>	<b>Percent of Beneficiaries Served</b>	<b>Median - Cost Per Beneficiary Served</b>	<b>Average - Cost Per Beneficiary Served</b>	<b>Standard Deviation - Cost Per Beneficiary Served</b>
Statewide	6,783,625	100%	426,158	100%	\$1,470	\$4,320	\$8,870
CA No LA	4,380,931	65%	297,839	70%	\$1,378	\$4,119	\$8,790
Los Angeles	2,402,694	35%	128,319	30%	\$1,728	\$4,788	\$9,035

Source: SD/MC approved claims as of October, 2007, IPC approved claims as of November, 2007, and MMEF as of April, 2007

<b>Cost Per Beneficiary Served - Statewide/CANOLA CY07 Not Adjusted for CPI</b>							
	<b>Total Medi-Cal Eligibles</b>	<b>Percent of Medi-Cal Eligibles</b>	<b>Total Beneficiaries Served</b>	<b>Percent of Beneficiaries Served</b>	<b>Median - Cost Per Beneficiary Served</b>	<b>Average - Cost Per Beneficiary Served</b>	<b>Standard Deviation - Cost Per Beneficiary Served</b>
Statewide	6,837,351	100%	423,037	100%	\$1,529	\$4,451	\$9,046
CA No LA	4,470,483	65%	295,061	70%	\$1,411	\$4,251	\$9,030
Los Angeles	2,366,868	35%	127,976	30%	\$1,857	\$4,911	\$9,069

Source: SD/MC approved claims as of May, 2008, IPC approved claims as of May, 2008, and MMEF as of April, 2008

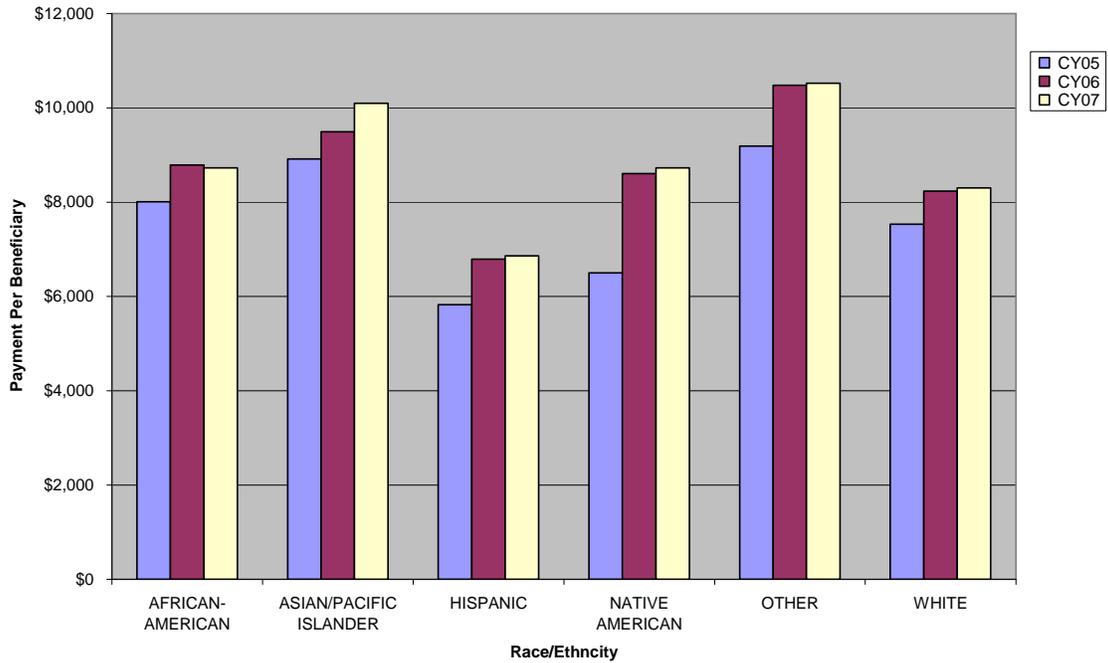
**Statewide Comparison of  
Cost Per Beneficiary Served by Age  
Not Adjusted for CPI**

Age Group	CY05	CY06	CY07
0-5	\$3,099	\$3,388	\$3,508
6-17	\$5,209	\$5,637	\$5,813
18-59	\$3,581	\$3,785	\$3,883
60+	\$2,384	\$2,518	\$2,705

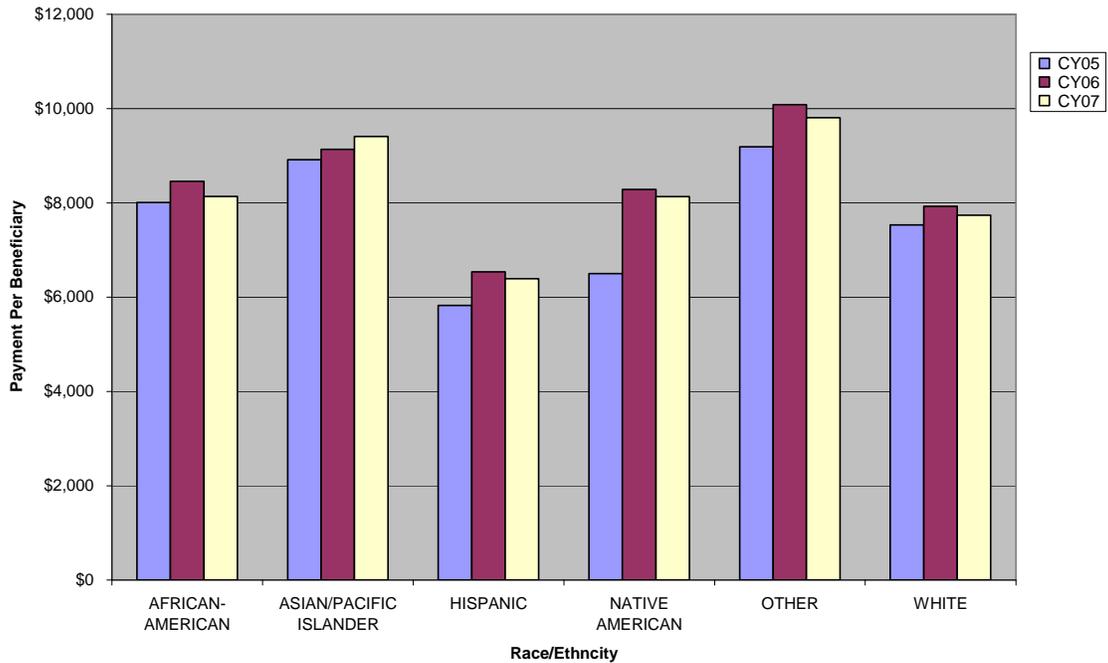
**A Comparison of Cost Per Beneficiary  
Served by Age and MHP Size  
Not Adjusted for CPI**

Age Group	MHP Size	CY05	CY06	CY07
0-5	Small-Rural	\$2,915	\$3,067	\$3,792
	Small	\$2,005	\$2,487	\$2,416
	Medium	\$2,901	\$3,301	\$3,668
	Large	\$2,730	\$2,946	\$3,178
	Very Large (Los Angeles)	\$4,291	\$4,555	\$4,239
6-17	Small-Rural	\$5,767	\$6,985	\$8,442
	Small	\$3,948	\$4,719	\$4,379
	Medium	\$5,050	\$5,511	\$5,848
	Large	\$4,633	\$5,027	\$5,305
	Very Large (Los Angeles)	\$6,292	\$6,630	\$6,629
18-59	Small-Rural	\$3,076	\$3,193	\$3,447
	Small	\$2,885	\$3,188	\$2,904
	Medium	\$4,150	\$4,492	\$4,534
	Large	\$3,582	\$3,662	\$3,757
	Very Large (Los Angeles)	\$3,485	\$3,804	\$4,022
60+	Small-Rural	\$3,059	\$3,027	\$3,184
	Small	\$2,565	\$2,811	\$2,688
	Medium	\$3,251	\$3,604	\$3,758
	Large	\$2,444	\$2,456	\$2,673
	Very Large (Los Angeles)	\$1,901	\$2,102	\$2,313

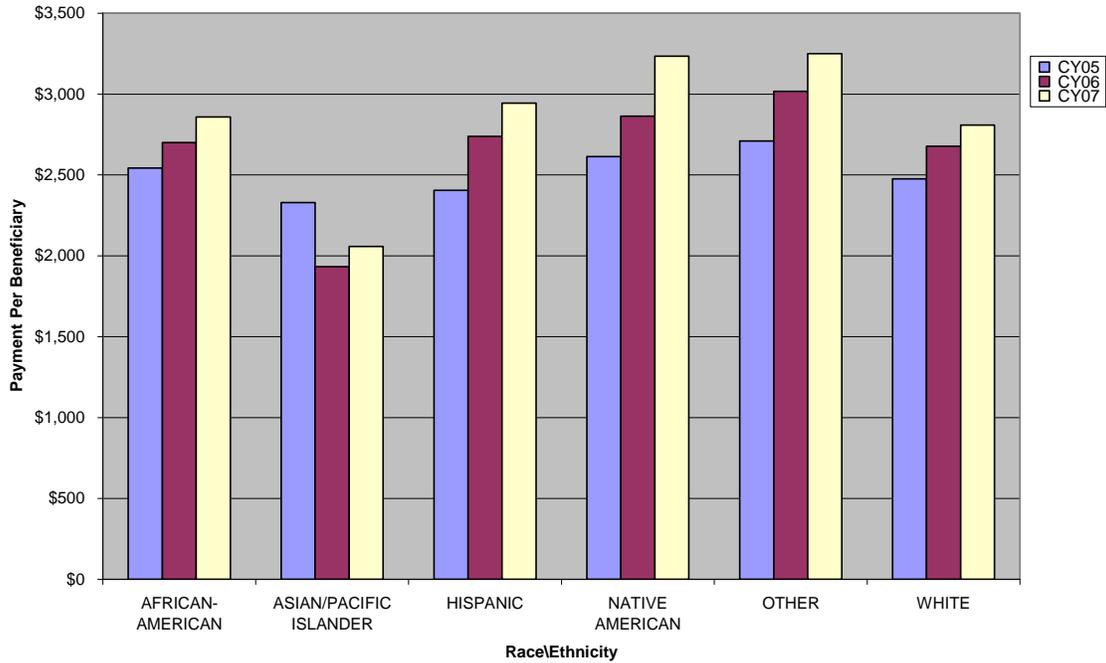
**Cost Per Beneficiary by Ethnicity - CY05-07  
24 Hour Services - Not Adjusted for CPI**



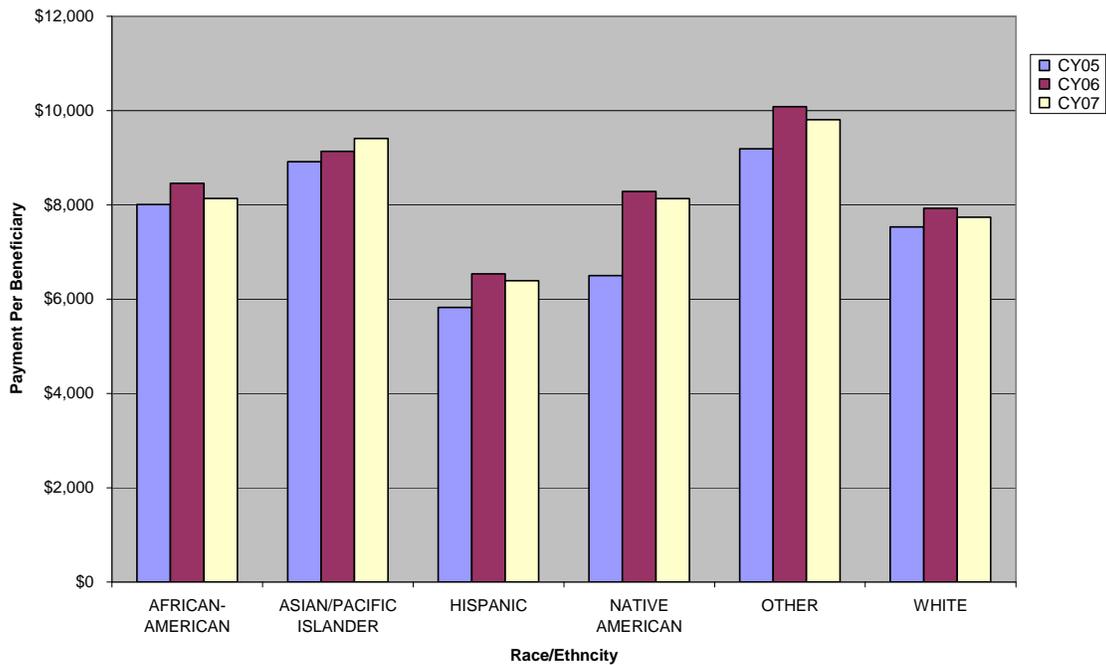
**Cost Per Beneficiary by Ethnicity - CY05-07  
24 Hour Services - CPI Adjusted**



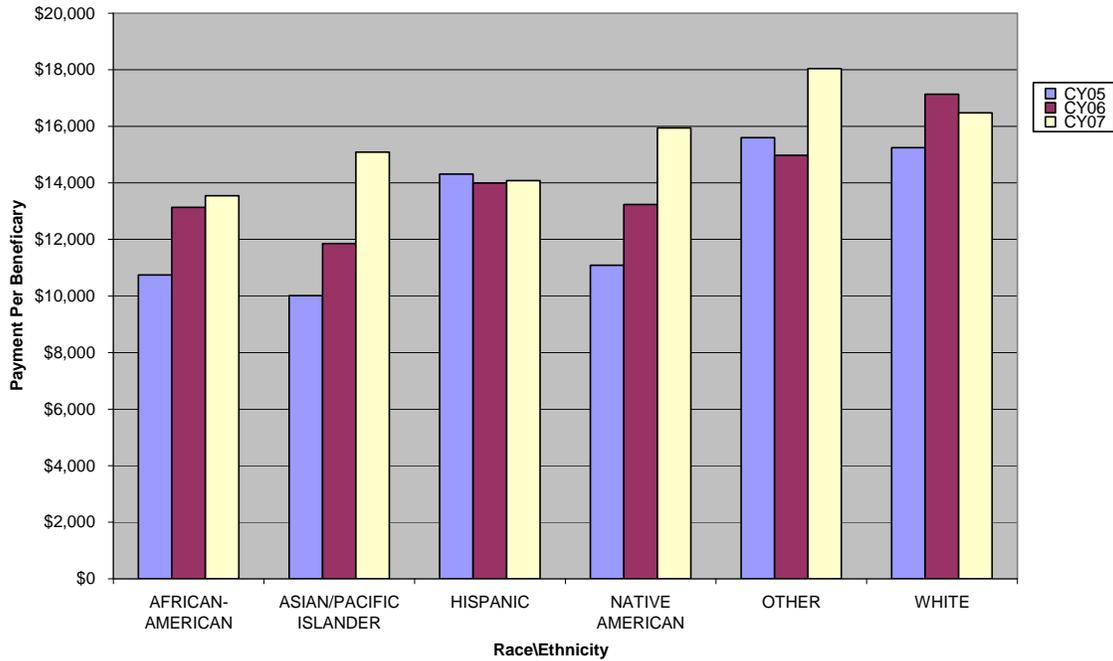
**Cost Per Beneficiary by Ethnicity - CY05-07  
Outpatient Services - Not Adjusted for CPI**



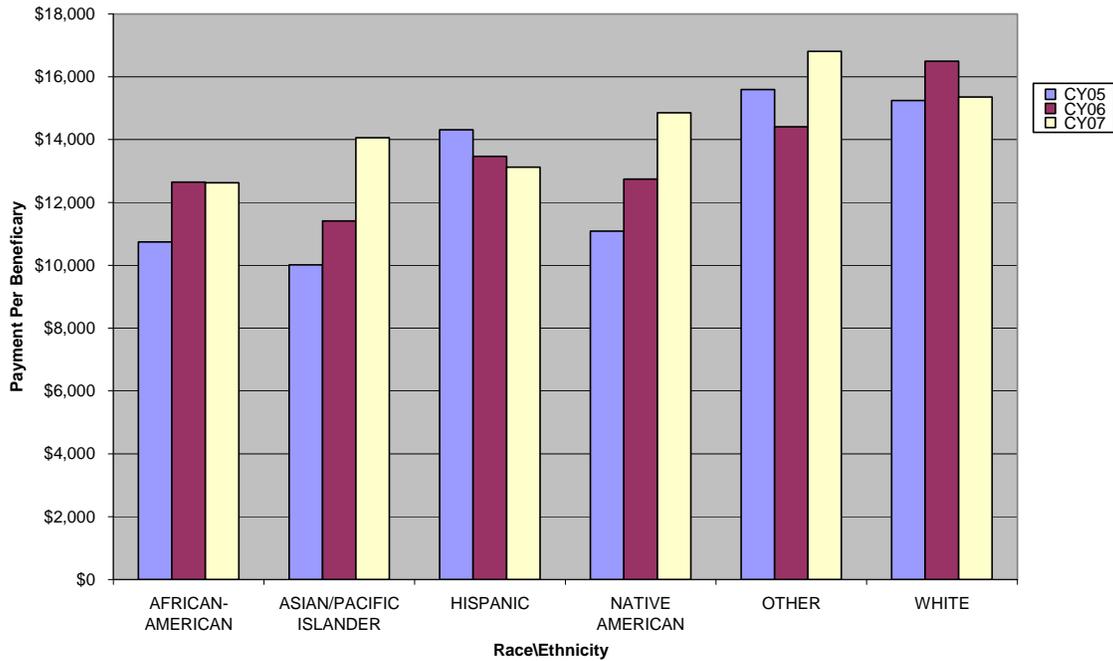
**Cost Per Beneficiary by Ethnicity - CY05-07  
24 Hour Services - CPI Adjusted**

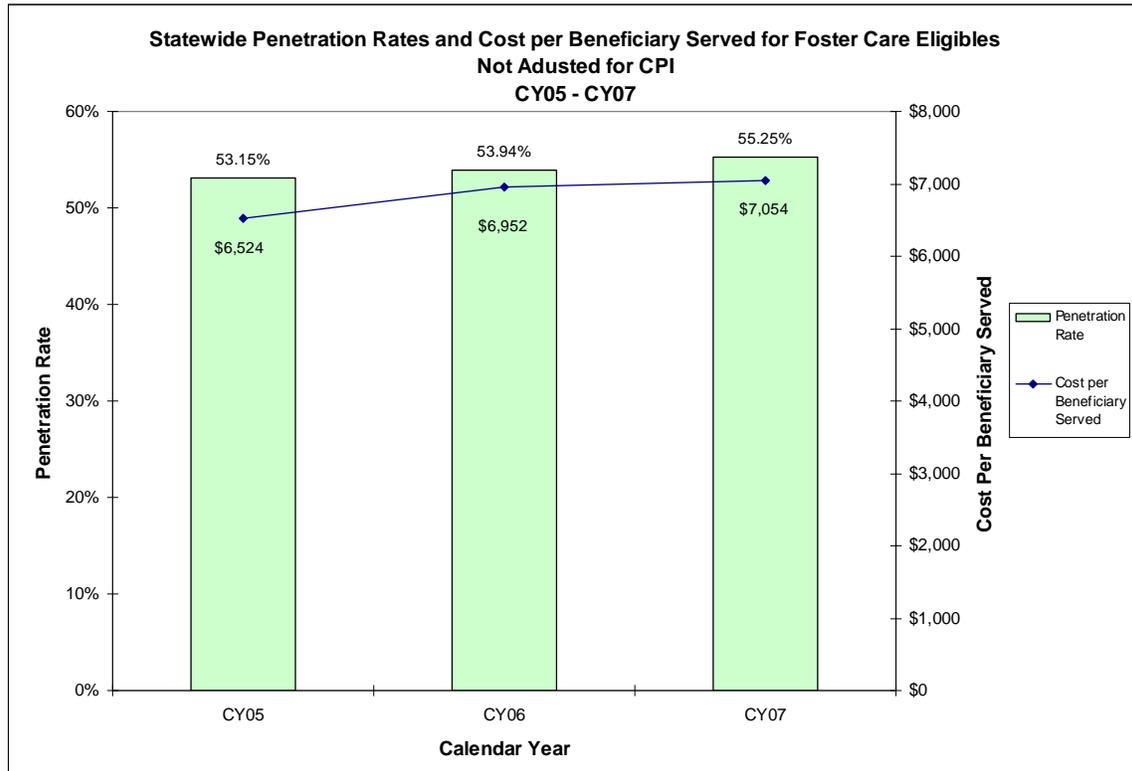


**Cost Per Beneficiary by Ethnicity - CY05-07  
TBS - Not Adjusted for CPI**



**Cost Per Beneficiary by Ethnicity - CY05-07  
TBS - CPI Adjusted**







**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

**Attachment 19**

**Los Angeles MHP  
Moving from Data to Investigation and Action**



# **5.6**

## **STATS**

### **Moving from Data to Investigation and Action**



## Assessing Low Total DS% (& Lag Time)

- Are people submitting UofS logs, COS forms and MAA forms in a timely manner?
- Is this data being entered in a timely manner?
- Are forms being lost or delayed between the rendering provider and billing staff?
- Other things you've explored?

## Strategies for timely (and accurate)

### submission of data

- Use supervisors to monitor daily submission (e.g., co-sign UofS)
  - If possible, best to use existing mechanisms instead of creating new paperwork to track workflow.
- Share or flex support staff
  - Using volunteers to free support staff
- Use temporary employees
- Use RMD if approaching 6 month mark on billing
- Other strategies you have used?

## Assessing Low Individual DS%

- Is staff member making effective use of time?
- Do they have a lot of cancellations?
- Does timecard accurately include sick, vacation, training, etc.?
- Is staff member documenting and billing for all billable services?  
Procedure code training needed?
- Are there clinic or departmental issues/activities that impede direct service delivery?
- Does this individual submit UofS in a timely manner (and filled out properly and completely)?
- Is there anything procedural occurring in billing department that could account for a data entry lag for this particular rendering provider?
- Other questions you ask or obstacles you've seen?

## Addressing low individual DS%

- Take a problem solving approach
- Be empathic but clear on the importance relative to:
  - Assisting/providing services to clients
  - Generating revenue needed to maintain directly-operated programs and staff
  - Documenting services for legal and audit protection
- Keep records/notes of your meeting
- Don't fear the grievance
- Try not to frame this as an area of concern only among DMH Administration (i.e., "downtown")
  - Model the mindset that this is important to all DMH employees and the Department as a whole
- Reinforce progress
- Other strategies you have used or lessons learned?

## Assessing Benefits Establishment Activity

- Is it a priority?
- Is oversight someone's responsibility?
- When and by whom is benefit status assessed?  
Any tracking of B.E. candidates?
- Do staff know what to do?
- Is 1002 completion monitored?
- Do some staff take "philosophical exception" to such activity?
- What sort of assistance is provided to clients?
- Other questions you ask or barriers you encounter?

## Available Assistance for Benefits Establishment Activity

- Benefits Establishment workflow is included in your packet
- The Revenue Management Division can provide managers with a list of clients at their site whose claims are CGF-only
- RMD staff can visit provider sites to help identify clients who may be eligible for benefits
- Other things that would help?



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

**Attachment 20**

**Madera MHP  
Hope House Brochure**



# Hope House of Madera County



**.....a partnership bringing hope  
in the midst of struggle.**



**Madera County Behavioral Health Services**

117 North R Street, Suite 101, Madera, CA 93637  
(559) 675-7926

Janice Melton, LCSW, Director

Debby Estes, LCSW, Asst. Director

Debbie DiNoto, LMFT, Division Manager/Contract Manager

**Turning Point of Central California, Inc.**

PO Box 7447, Visalia, CA 93290-7447

J. Jeff Fly, M.A., CEO	<a href="mailto:tpinceceo@aol.com">tpinceceo@aol.com</a>	(559) 732-8086, Ext. 115
Ray Banks, M.P.A., COO	<a href="mailto:tpoccred1@aol.com">tpoccred1@aol.com</a>	(559) 732-8086, Ext. 140
Walt Lunsford, LCSW, M.P.A., COO	<a href="mailto:tpoccwl@aol.com">tpoccwl@aol.com</a>	(559) 732-8086, Ext. 119
Dennis Reid, LCSW, Regional Director	<a href="mailto:tpdjr@aol.com">tpdjr@aol.com</a>	(559) 237-0846, Ext.11

**Hope House of Madera County**

117 North R Street, Suite 103, Madera, CA 93637  
(559) 664-9021 fax (559) 664-9027

Tim Gallemore, M.Div., Program Director [timtphh@sbcglobal.net](mailto:timtphh@sbcglobal.net)

Alfonso Lopez, B.A., Day Resource Coor. [alfonsotphh@sbcglobal.net](mailto:alfonsotphh@sbcglobal.net)

Program Assistants

Esther Capuchino, A.A., Admin. Asst.  
Gwen Palmer, Outreach Coor.  
Lori Nieto, Recording Secretary  
John Pacheco, WRAP and SMART Coor.

William Gustin, B.A.  
Josie Wynn  
Meg Swan  
Maria Elena Medina  
Lonnie Upton

### **Hope House Committee**

This committee is comprised of both MCBHS Staff and Turning Point Staff and offer guidance and direction to the operations of Hope House. Currently on the committee are:

#### **Madera County Behavior Health**

Janice Melton, LCSW, Director  
Debbie Estes, LCSW, Asst Director  
Debbie DiNoto, LMFT, Div. Manager  
Greg Gregson, LMFT, Div. Manager  
Diana Solano, B.A., Caseworker  
David Weikel, M.S.W., MHSA Coordinator  
Carol Powroznik, RHIT, Patient Rights Adv.

#### **Turning Point/Hope House**

Tim Gallemore, M.Div., Program Director  
Alfonso Lopez, B.A., Day Resource Coor.  
Esther Capuchino, A.A., Admin. Asst.  
Gwen Palmer, Outreach Coor.  
John Pacheco, Program Assistant

### **Hope House Management Staff**

#### **Program Assistant I**

##### Requirements

1. Completion of MCBHS *Let's Talk Careers* or equivalent.
2. Pass required screenings.

#### **Program Assistant II**

##### Requirements

1. Served for a minimum of one year as Program Assistant I.
2. During the time employed as a Program Assistant I, one must have completed a minimum of 60 hours of training in Psychosocial Rehabilitation through CASRA or similar training (individual and/or group personal therapy may be counted for up to 30 hours of this requirement).
3. Completed a minimum of 200 hours of peer leadership in a combination of the following areas:
  - Facilitate a Peer Support Group.
  - Serve as a chairperson on a peer planning team.
  - Co-facilitate a group or project with a MCBHS staff person or other public agency.
4. Pass the exam for Program Assistant II (Exam will be either written or oral and consisting of questions concerning the operations of Hope House and basic principles in Psychosocial Rehabilitation.)

**Program Assistant III**

## Requirements

1. Served for a minimum of six months as Program Assistant II.
2. During the time employed as a Program Assistant II, one must have completed an additional 60 hours of training in Psychosocial Rehabilitation through CASRA or similar training (individual and/or group personal therapy may be counted for up to 30 hours of this requirement).
3. Completed a minimum of 30 hours of Health and Wellness/Psychosocial Rehabilitation leadership in the following areas:
  - Co-facilitate a group or project with a MCBHS staff person or other mental health professional. (This group or project must be preapproved.)
  - Research, prepare, and present an educational workshop on one or more elements of Psychosocial Rehabilitation.
4. Take and pass the USPRA/CASRA exam to be a Certified Psychiatric Rehabilitation Practitioner CPRP.

**Program Assistant Duty Assignments**

- *Administrative Assistant*
- *Outreach Coordinator*
- *Recording Secretary*
- *WRAP Coordinator*
- *MIOCRE Liaison*
- *Peer Group Leadership*
- *Operational Duties:  
Receptionist, Pantry,  
Common Room,  
Cleaning, Patio  
Supervision, Outreach*

**Day Resource Coordinator**

## Requirements

1. AA Degree or two years experience in field of work.

**Program Director**

## Requirements

1. BA Degree, Master's preferred.
2. Two years experience working in the field.

**MCBHS Staff at Hope House** – we have an open door for all MCBHS staff to participate in Hope House Activities along with visiting their clients. In addition to this, the following positions have an office at Hope House:

- Patient Rights Advocate
- MCBHS Caseworker
- MHSA Coordinator

**Monthly/Weekly Schedule** – The monthly schedule is adjusted each month to accommodate the interests and need of our members. A copy of the April Schedule is attached.

**Annual Calendar** – The annual calendar is completed each fall. A copy of the 2008 Calendar is attached.

**Membership** – Membership is opened to all residents of Madera County who currently or in the past have had a case with MCBHS. Individual exceptions may be made by the Program Director. Day Passes are available for individuals who are visiting or are inquiring about services at MCBHS.

**Town Hall Meeting/Birthday Celebration** – This is a monthly meeting held with members, Hope House Staff, and MCBHS Staff. Following the meeting we have a lunch and cake in honor of those who had a birthday during the month.

**Services** – At Hope House members have use of laundry facilities, showers, computers with internet access, kitchen, and TV room.

**Pantry & Hope House Points** – Points are earned by all members for participation in groups and activities. Points can be exchanged for food, toiletries, and trips. Members can also bring food to cook and/or eat. There is a McDonalds, Taco Bell, Deli, Subway, and various stores within two blocks.

**Groups** – Groups are planned and developed based on the interest of members. Almost all groups are peer led but a few are coordinated by MCBHS Staff. Some of the groups are:

- *Lets Talk Coffee,*
- *Healing the Past*
- *Coping with Depression*
- *Current Events*
- *SMART*
- *Take a Trip with Us*
- *Trip up the Mountain*
- *Game Wars*
- *Academic Challenge*
- *Computer Classes*
- *Conflict Resolution*
- *Healing from Within*
- *Culturas y Depression (Spanish)*
- *Lets Watch a Movie*
- *Reaching Your Full Potential*
- *Well Travelled Paths (MCBHS)*
- *Members Only Topics*
- *History of Mental Health*
- *Jumpstart Your Health (MCBHS)*
- *Assert Yourself*
- *Personal Empowerment*
- *Anger Management*

*Hope House has other activities throughout the year: Martin Luther King Family Day, Super Bowl Sunday, Valentine's Day Lunch, St. Patrick's Day, Easter Family Picnic, April Fools Day Talent Show, Cinco de Mayo Lunch, NAMI Walk - Fresno, That 50's Party, Native American Heritage Day, Hope House Anniversary, Thanksgiving Day Meal, and Christmas Family Holiday Party.*

*Additionally, Hope House provides classes for training purposes: Victim Services Certification, CPR & First Aid Certification, CASRA Training and Sexual Harassment in the Workplace.*

**Partnerships** – Hope House works to form partnerships with those in the community.

Hope House maintains a working relationship with existing Behavioral Health Programs including: Madera Counseling Center, Oakhurst Counseling Center, Chowchilla Counseling Center, Mentally Ill Offender Crime Reduction (MIOCR) Program, MCBHS Supportive Employment Program, MHSA TAY Programs, MHSA Adult Programs, and the MHSA Older Adult Programs.

Hope House maintains a relationship with the following community organizations: NAMI, Center for Independent Living, Workforce Connection, Hospice, Madera Action Committee, Fresno/Madera Continuum of Care, Victim Services Center of Madera County, Fresno/Madera Red Cross, Madera Food Pantry, Madera Rescue Mission, HHtC (Homeless Helping the Community), Griffin Hall Soup Kitchen, Open Up Your Heart, St. Vincent de Paul, LOVE Inc., Mission Madera, Salvation Army, St. Joachim's Church, Yosemite Christian Center, Madera Lutheran Church, and Madera Ministerial Association.

Hope House maintains a relationship with the following governmental agencies: Madera County Agencies, City of Madera, Madera Transportation Agencies, Madera Unified School District, Madera Adult School, Madera Police Department, Probation and Parole.

Additionally, Hope House maintains a relationship with the following businesses who offer support for our members: Blockbuster, Martinizing Cleaners, Donut House, Pistoresi Ambulance, and Madera Tribune.

## **Hope House of Madera County Membership Rights, Responsibilities, and Policies**

### **PARTICIPANT RIGHTS**

- You have the right to access Hope House and its activities and to participate (at the level with which you are comfortable) in services, workshops, classes, and events
- You have the right to be treated with dignity and respect by staff, volunteers, and members
- You have the right to be informed about, and involved in, any decisions, events, policies or conditions that may affect your participation at Hope House
- You have the right to expect a safe, supportive environment
- You have the right to request a mediation meeting with any staff member, volunteer or participant with whom you have difficulty
- You have the right to expect any information you share will be treated respectfully by staff and volunteers
- You have the right to ask questions concerning Hope House, its activities or policies that confuse you
- You have the right to expect punctuality from staff who have set appointments with you
- You have the right to grieve any decision you feel is unfair

### **PARTICIPANT RESPONSIBILITIES**

- To follow Hope House policies
- To be actively and constructively working towards Wellness and Recovery
- To treat staff, volunteers, other participants, Hope House space and materials with dignity and respect
- To communicate your expectations about how you would like to engage in activities
- To voice your concerns in a respectful manner, using the appropriate forums
- To use the grievance procedure in the appropriate manner



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4/9/2008

1

To promote a safe and comfortable environment at Hope House, we ask that all participants comply with the following policies. There are two categories of policies, each with its own set of consequences for non-compliance: Health and Safety Policies (immediate suspension) and Program Rules (non-immediate suspension).

### **HEALTH & SAFETY POLICIES (Immediate Suspension)**

#### **ONE YEAR SUSPENSION**

1. We do not allow acts of violence, fighting, or weapons. Any type of physical violence, fighting, use of weapons, or use of Hope House or personal materials as weapons is not allowed.

#### **6 MONTH SUSPENSION**

2. We do not allow threats of violence. In an effort to keep our programs safe from intimidation, we do not allow physical or verbal threats of violence, the threat of the use of weapons; or the threat of the use of Hope House materials as weapons. Additionally, self-abuse is not allowed.
3. We do not allow destruction, alteration or theft of agency, staff, or participant property. In respect of all staff and participants, we ask that participants do not destroy, alter, or remove any items from Hope House that do not belong to them.
4. We do not allow sale or trafficking of drugs or alcohol on the premises. In an effort to make this a safe space, selling drugs, promotion of drug use, and drug trafficking is not allowed. This includes the front sidewalks and area around Hope House.

#### **ONE MONTH SUSPENSION (1<sup>ST</sup> OFFENSE), TWO MONTH SUSPENSION (2<sup>ND</sup> OFFENSE), THREE MONTH SUSPENSION FOR ADDITIONAL OFFENSES**

5. We do not allow derogatory language or behaviors. All members, volunteers and staff have the right to be treated with respect. Therefore, disrespectful behavior will not be tolerated. This includes, but is not limited to, teasing, put downs, rude comments, and hate messages (including those that are racist, homophobic, sexist, transphobic, or directed at a specific cultural or religious group or at persons with disabilities).
6. We do not allow the use or possession of drugs or alcohol on the premises. Using drugs and alcohol on the premises is not allowed. Smoking cigarettes inside the buildings is also prohibited.
7. We do not allow sexual harassment or other sexual behavior. In an effort to create a safe emotional environment, Hope House does not tolerate sexual harassment. Therefore, leering; making sexual gestures; displaying sexually suggestive objects or pictures; making or using derogatory comments, epithets, slurs or jokes; making verbal or physical sexual advances; or verbal abuse of a sexual nature is not allowed. Additionally, sexual behavior, including self-stimulation, exposure of one's genitals, or sexual behavior with another participant is not allowed.
8. We do not allow sexually exploitative or discriminatory behavior, messages or materials at Hope House. Although Hope House recognizes that censorship is a serious issue, certain restrictions exist to maintain the emotional safety of the agency environment. Therefore, artwork, writing, magazines, or other material containing sexually exploitive material or hate messages (including those that are racist, sexist, homophobic, transphobic, material directed at a specific cultural or religious group or persons with disabilities or are otherwise threatening to a specific group or individual) will be asked to be removed from display if an individual or group in a program finds it physically or emotionally threatening.
9. We do not allow continuous disruptive behavior. In respect of fellow participants and staff, we ask that you not engage in behavior that is continually disruptive to the program or environment.

#### **UNTIL PROBLEM RESOLVED**

10. We do not allow loitering within a one-block radius of Hope House and/or our programs. We ask that anyone wishing to access our services refrain from loitering and to respect the property and rights of our neighbors.

4/9/2008

2

**PROGRAM POLICIES (non-immediate suspension)**

11. Participants must wear appropriate clothing at all times, including shoes and shirts.
12. Participants cannot reserve chairs. Once you leave your seat, someone else is permitted to sit in it.
13. Hope House is not responsible for items that are lost or stolen. Please do not leave belongings unattended. Hope House does not have the space to store personal belongings. Items left overnight will be discarded.
14. Members are not allowed in the staff offices or to use the staff phone without prior approval.
15. Only approved volunteers are allowed to sit at the front desk.
16. There is a 5-minute time limit for the bathroom; for extended use of the bathroom (i.e. Shower), please notify staff, and arrangements can be made for longer time.
17. Members are not permitted to urinate or defecate in places other than the toilet.
18. Men are not allowed in the women's bathroom without staff permission and women are not allowed in the men's bathroom without staff permission.
19. There is a 5-minute time limit for all participant phone calls; for extended business phone calls, please notify staff, and arrangements can be made for longer phone time.
20. Hope House is a group space that hosts various program activities. Participants are asked to keep noise levels to a minimum. Loud talking, yelling, excessive noise, is not allowed.
21. Members are asked to clean up after themselves at all times.
22. Members are not permitted in the food pantry or other unauthorized areas without prior approval.
23. All members have an equal status with one another, regardless of how long they have been coming to Hope House. No member has authority over another. Intimidation will not be tolerated.
24. Members using the Computer Lab and/or personal computers must follow posted rules and guidelines.

**APPEAL PROCESS**

If you are suspended from Hope House and do not agree that the suspension was appropriate, you have the right to appeal your suspension and have a hearing with program management. There are two types of suspensions: immediate and non-immediate.

If your suspension is in the **IMMEDIATE SUSPENSION** category:

1. You must leave Hope House immediately.
2. If you are not issued a written notice at the time of the suspension, you may return the next working day to receive your paperwork. You will not be able to access Hope House for any other reason than to retrieve your paperwork.
3. You must request an appeal within 3 working days from the written suspension or lose your right to appeal.
4. To request a hearing, you may talk to the program staff. They will set up an appointment for you.

If your suspension is in the **NON-IMMEDIATE SUSPENSION** category:

1. You will receive a verbal warning the first time that you break a rule in this category. If you break the same rule again, you will be given a written warning. If you break the same rule again, you will be given a written suspension of services letter.
2. You must request an appeal within 3 working days from the written suspension or lose your right to appeal.
3. To request a hearing, you may talk to the staff at the Center. They will set up an appointment for you.

- There are three possible outcomes to your hearing: 1) You may have the suspension of services overturned and you may return to the Center immediately; 2) you may have a reduction in the length of time you are denied access to the Center; or 3) you may have no change to the length of the suspension. In cases of an immediate suspension, you will be asked to meet with staff before re-entering Hope House to clear up any issues that may remain as a result of your suspension from Hope House.

#### **PROCEDURE TO FILE A COMPLAINT OR GRIEVANCE**

Occasionally, conflicts arise between participants, with staff or volunteers, or around policies in the programs of Hope House. While in most instances these can be mediated quickly, in certain instances one must employ the grievance procedure. This is the process to guide that procedure. MCBHS Staff may be invited to participate in the procedure by the member and/or Hope House Administration.

- **Step One:** Attempt to mediate the situation on your own – *respectfully and calmly* - with the person(s) with whom you are experiencing difficulty.
- **Step Two:** If the situation involves another program participant or volunteer, present your grievance verbally to a trusted staff member. *If the situation involves a staff person, please skip to Step Three.* The staff member will then attempt to mediate the situation by hearing both sides of the argument, and problem-solving with both parties to attempt a resolution. If the behavior being discussed is in violation of program or agency policy, it is possible that the resolution will include a denial of services for a period of time. If it is not possible to fulfill this step, skip to Step three, although be prepared to support your decision to skip this step.
- **Step Three:** Present your grievance verbally to the Program Director in the same manner as Step Two. In some instances, it will be necessary to make an appointment to present your grievance, although all attempts will be made to guarantee you an appointment within 3 working days of your request. You have the right to bring an advocate to this meeting if you feel it is necessary, although you must inform the Program Manager of this decision.
- **Step Four:** If you are able, present your grievance in writing to the Program Director either in a letter form or using the Grievance Form provided. If you would like assistance in filling out the form, please ask a staff person or MCBHS Staff Person. The Program Director will respond to your grievance in writing within 7 days (except in the case of vacations or other extended leave). If you cannot present your grievance in writing, you may request to schedule a meeting to present your grievance verbally. If the solution reached is not satisfactory, you must repeat this step at least once before moving to Step Five. It is not possible to skip this step, although if you cannot present your grievance in writing, you may request to schedule a meeting to present your grievance verbally.
- **Step Five:** Present your grievance in writing to Madera County Behavioral Health Services. It is under MCBHS's discretion to respond to you in writing or to arrange a meeting, although it is appropriate for you to request your desired response. If you cannot present your grievance in writing, you may request to schedule a meeting to present your grievance verbally. MCBHS will respond to your grievance within 7 days (except in the case of vacations or other extended leave). If appropriate, MCBHS may choose to arrange a meeting with you, your advocate if appropriate, and the Program Director.

*(The above document is subject to change by Turning Point of Central California and Madera County Behavioral Health Services.)*

## **ANNUAL GOLDEN HOUSE AWARDS**

### Hope House's Annual Achievement Awards

The **GOLD HOUSE AWARDS** will be given annually to honor achieve and growth. The **GOLDEN HOUSE AWARDS** will have four categories: **EMPLOYMENT, EDUCATION, COMMUNITY SERVICE, and COMMUNITY RECOGNITION.**

#### **THE GOLDEN HOUSE AWARD for EMPLOYMENT SUCCESS**

- This award is given to HH Members who have gained regular employment after a period of unemployment.

#### **THE GOLDEN HOUSE AWARD for EDUCATION SUCCESS**

**Hope House Members** are eligible for this award if he/she meets one or more of the following criteria:

- 1) Enrolled and currently attending a program of study toward a designated goal such as GED, HS Diploma, Professional Certification, or College Degree.
- 2) Have completed a course of study and have received a GED, HS Diploma, Professional Certificate, or Degree within the past 12 months.
- 3) Other Education Success as recommended by the Awards Committee.

**Hope House Staff** and **MCBHS Staff** are eligible for this award if he/she meets one or more of the following criteria:

- 1) Has completed a course of study which results in a Certificate or Degree that will directly benefit consumers of mental health services within the past 12 months.
- 2) Has taken the exam and has been credentialed as a *Certified Psychiatric Rehabilitation Practitioner* (CPRP) through the US Psychiatric Rehabilitation Association/CASRA within the past 12 months.
- 3) Has completed Licensure as LCSW, LMFT or other Mental Health Professional within the past 12 months.

#### **THE GOLDEN HOUSE AWARD for COMMUNITY SERVICE**

**Hope House Members** are eligible for this award if he/she has completed a minimum of 25 volunteer hours during the prior 12 months at an approved Community Service Organization other than Hope House.

**Community Members** are eligible for this award if he/she has completed a minimum of 25 volunteer hours at Hope House during the past 12 months. Mandatory community service hours cannot be counted for this award.

#### **THE GOLDEN HOUSE AWARD for COMMUNITY RECOGNITION**

This award is presented to individuals, organizations, churches, and businesses that have offered special support to MCBHS, Hope House, and/or its members during the past 12 months.

**NOMINATION PROCESS**

Hope House Members, MCBHS Staff, and Madera County Residents may make nominations for the GOLDEN HOUSE AWARDS. Individuals may nominate themselves or be nominated by others.

The Awards Committee will review all Nominations and will recommend who should receive the awards. These recommendations will be presented to the Director of Madera County Behavior Health for final approval.

The Awards Committee will be comprised of the following members:

- Program Director of Hope House, Chairperson
- 1 Hope House Staff person (chosen by staff)
- 2 Hope House Members (chosen by Hope House Membership)
- 2 MCBHS Staff (appointed by Mental Health Director)
- 1 Mental Health Board Member (chosen by MHB)

**AWARD CEREMONY**

The GOLDEN HOUSE AWARDS will be presented at a public ceremony at a time and place to best accommodate the recipients and their families. A reception should follow the event.

The Golden House Awards may be presented during the Annual Anniversary Celebration of Hope House in October.



# HOPE HOUSE

## April Weekly Calendar

117 North R Street, Suite 103, Madera CA 93637

	Monday	Tuesday	Wednesday	Thursday	Friday
9:00	<b>Good Morning Hope House</b>				
9:30	Beautifying the Neighborhood	Lets Talk Coffee	Lets Talk Coffee	Lets Talk Coffee	Lets Talk Coffee
10:00	Healing from Within	Well Traveled Paths & Current Events	Healing from Within	Personal Empowerment	Reaching Your Full Potential
10:30					
11:00	Conflict Resolution Techniques	Reaching Your Full potential	Members Only Topics	Current Events	Getting Through The Weekend
11:30					
12:00	S.M.A.R.T. Recovery	Healing from Within	Staff Meeting Begins	Assert Yourself	Current Events
12:30			Jumpstart Your Health		
1:00	Culturas y Depression (Spanish Group)	Let's Watch A Movie	Staff Meeting Ends	Let's Watch A Movie	Academic Challenge
1:30			Current Events		
2:00	Current Events	Projects	Take a Trip with Us	Free Time	Individual Computer Lessons
2:30					
3:00	<b>Free Time</b>	Projects	Take a Trip with Us	Free Time	Individual Computer Lessons
3:30					
4:00					
4:30					
5:00	<b>Good Night, see you tomorrow.</b>				

### MARK YOUR CALENDAR

Tuesday, April 1st – 2<sup>nd</sup> Annual Talent Show  
 Thursday, April 24th – Town Hall Meeting and Birthday Celebration

April is “Men’s Health Issues” at Hope House—  
 Various men’s health topics will be discussed throughout the month

Phone: (559) 664-9021

Fax: (559) 664-9027

## HOPE HOUSE

### Activity Calendar 2008

**January**     *Diet and Vitamins Awareness*

Tuesday 1     New Years Day (Closed)  
 Monday 21     Martin Luther King Family Day  
 Thursday 31     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**February**     *High Blood Pressure Awareness*

Sunday 3     Super Bowl Sunday  
 Tuesday 5     Mardi Gras Party  
 Thursday 14     Valentine's Day Lunch  
 Monday 18     President's Day (Closed)  
 Thursday 28     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**March**     *Women's Health Issues*

Monday 17     St. Patrick's Day/  
                        Easter Family Picnic  
 Sunday 23     Easter  
 Thursday 27     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**April**     *Men's Health Issues*

Tuesday 1     April Fools Day Talent Show  
 Thursday 24     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**May**     *Mental Illness Awareness*

Thursday 1     May Day & Western Barn Dance  
 Monday 5     Cinco de Mayo Lunch  
 Saturday 10     NAMI Walk - Fresno  
 Sunday 11     Mother's Day  
 Monday 26     Memorial Day (Closed)  
 Thursday 29     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**June**     *Skin Cancer Awareness*

Sunday 15     Father's Day  
 Thursday 19     That 70's Party  
 Thursday 26     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**July**     *Eating Natural and Healthy*

Friday 4     Independence Day (Closed)  
 Thursday 17     Summer Carnival/Family Day  
 Thursday 31     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**August**     *Psych Meds and Side Effects*

Thursday 14     Hope House BEIJING Olympics  
 Thursday 28     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**September**     *Diet and Obesity Awareness*

Monday 1     Labor Day (Closed)  
 Thursday 18     Native American Heritage Day  
 Thursday 25     Town Hall Meeting 11am  
                        Birthday Celebration 12noon

**October**     *Breast Cancer Awareness*

Sunday 26     Hope House 2<sup>nd</sup> Anniversary  
 Thursday 30     Town Hall Meeting 11am  
                        Birthday Celebration 12noon  
 Friday 31     Halloween Party

**November**     *Diabetes Awareness*

Thursday 20     Town Hall Meeting 11am  
                        Birthday Celebration 12noon  
 Tuesday 25     HH Thanksgiving Meal  
 Thursday 27     Thanksgiving Day (Closed)

**December**     *HIV/AIDS Awareness*

Monday 1     AIDS Awareness Day  
 Thursday 18     Town Hall Meeting 11am  
                        Birthday Celebration 12noon  
 Monday 22     Family Holiday Party  
 Thursday 25     Christmas Day (Closed)



\* All activities are subject to change.

SERVING THE HEART OF CALIFORNIA SINCE 1892



# MADERA Tribune

WWW.MADERATRIBUNE.COM

WEDNESDAY, MAY 14, 2007

Monday, May 14, 2007

## Mental Health Month:

# Hope House works for community's health

By Ramona Frances  
THE MADERA TRIBUNE

With an influx of funding since the passing of Mental Health Proposition 63, eight new programs have been planned or implemented in Madera County. One program includes a staff and peer supported mental health center called "Hope House" in the Behavioral Health Building at 117 R Street in Madera.

Hope House Program Director Tim Gallimore said he and Resource Coordinator Allison Lopez cultivate an open door policy at the center, which opened in September.

"Sometimes I am able to get my administrative duties done by 5 pm, and sometimes I don't get started until five. It's because people come first. If people need to talk, that's what we do," Gallimore said.

"Twelve staff members are employed at Hope House. When Gallimore, Lopez and Director, Janice Melton were asked if they shared any per-

sonal safety concerns working with high-risk populations, Melton said, "Most people with mental issues are not acting out violently; the ones that don't come here are more of a concern."

When the Hope House opened, it was expected to serve less than 60 people, but clients have exceeded 168. Gallimore said people showing up at Hope House are working on personal issues.

"My fear is (regarding) the ones who have needs and are not coming to us, the ones not seeking our services," he said.

"The Hope House provides peer support staff. At certain stages of recovery, consumers can reach out to others to share experiences, support and hope," he said.

Lopez and other staff believe the most valuable service Hope House provides Madera County is family and support, a place where people can develop a sense of community and reduce isolation. Community Board Member

Jan Stutzman said she has worked in the mental health field since 1983 and thought she could offer some direction in terms of advocacy, so she sat in on the mental health steering committee in the county.

The board reviews everything the department does and makes recommendations, Stutzman said.

"The biggest hurdles for people facing mental challenges is the stigma associated with mental illness. Green Palmer said it was easier to admit she was a drug addict than to say she was suffering from mental illness.

Palmer has recovered from depression and is now employed by Madera County to work with vulnerable populations in the area of Behavioral Health.

The problem of stigma and mental health is so great, a statewide anti-stigma campaign is being planned now for the future. Madera County provides

mental health services to 2,500 people, and a consumer survey has been launched by Behavioral Health to gather public comment from those who have used services. The comments will be accepted up until the next board meeting on June 6.

Contact Nancy Gorney at 675-7650 or visit their Web site at <http://www.maderacounty.com/mentalhealth/services.html> for information.

Hope House can be contacted at 664-9021 or 673-3508 for additional mental health related resources.

A directory of services lists services such as mental health counseling, adult alcohol and drug prevention, youth programs, and wellness empowerment networks that include Chowchilla, Madera and the foothill areas of Madera County. Transportation is available to pick up people from eastern Madera County and Chowchilla.

# HHtC

Homeless Helping the Community

## MISSION STATEMENT

**Homeless Helping The Community** is a group of homeless people who believe that in order to help ourselves overcome homelessness it is necessary to build ties to the greater community in which we find ourselves, to show that we want to be contributing members of that community.

Too often the homeless are portrayed as users of the system, takers of community services who give nothing back to the community. It is our fervent hope that we can begin to change that portrait by acting together to enrich the community in which we live through simple but meaningful action.

# HHtC

Homeless Helping the Community

Vol. 1, #14

## NEWSLETTER

Well, the Walk-A-Mile-In-Her-Shoes event is now history. The walk for Victims Services, part of the Madera Action Committee, Raised over \$5,000 in donations to help in the fight against domestic and child abuse. The Hope House/HHtC team accounted for over \$600 of that amount. After walking in high heels, 4 inch heels at that, we have a tremendous amount of admiration and respect for women who do this everyday. HHtC was proud that they could be a part of this worthy event.

HHtC has been meeting with Max Rodriquez of the Board of Supervisors to discuss the Fresno River Cleanup (Part 2). We have chosen April 30<sup>th</sup> as the date for the clean-up. Last year's effort was a rousing success and we hope that this year's effort will be even bigger and better. Supervisor Rodriquez deserves a lot of credit for the clean-up effort, both last years and the current effort. We hope to have a hamburger cook-out for those who help in this year's effort. So mark April 30<sup>th</sup> on your calendar and plan to make the river clean-up a part of your plans.

On April 15<sup>th</sup> the Griffin Hall Drop-in Center will be closing for the summer. In the 3 and one half months that we have been open, we attracted over 6,000 visitors. We offered movies, books and magazines, games of all kinds to play. Most days we offered some kind of food and snacks and, of course, all the coffee that one could drink. St. Joachim's parish, Father Larry and Denise Bondurant deserve much of the credit for making the drop-in center a reality. From moment one they were committed to making this happen and were more than gracious in their encouragement and support. The Drop-in will open as a cooling center on days when the temperature hits 100 degrees or higher. We hope to be open again next November with even

more services. Thank you to all those who helped, in little and big ways, make the drop-in a success.

There will be no HHtC Spotlight this issue, but it will return in issue #15.

QUOTE:

“The simple truth is that at their core social problems, such as homelessness and drug addiction, reflect a radical breakdown in fundamental human relationships (love, compassion, understanding and mercy), and any attempt to prevent socially dysfunctional behaviors requires a strengthening of those spiritual relationships in the day-today life of individuals, families, neighborhoods, institutions, and ultimately the whole human community”

-Abe Maslow-

e-mail address: [hhtc-madera@hotmail.com](mailto:hhtc-madera@hotmail.com).

Phone: (559) 664-9021

Fax: (559)664-9027

# Tribune

Thursday, September 27, 2007

## Homeless service organization works on setting city projects

By June Woods  
THE MADERA TRIBUNE

A new Madera organization, Homeless Helping the Community (HHHC), came up with a couple of projects it would like to pursue in advance of Hunger and Homelessness Awareness Week in November. A decision is expected to be made at its next meeting in two weeks.

At its first meeting Wednesday, the group solicited input from those attending concerning what projects they felt would best "enrich the community." Many were there to support the group's effort. "I was shocked to see all the people that started coming in,"



City and County government officials, homeless and other community members gathered for the first Homeless Helping the Community (HHHC) meeting at Griffin Hall, Wednesday.

said organizer and founder Ron Glasel. "As first it looked like nobody was coming and we were going to be here talking to ourselves, then every year

started showing up at once." Glasel, along with fellow organizers Vernon Price and Dan Lyons, kept attendees on

SEE MADERA PAGE 18

## Homeless

CONTINUED FROM PAGE 18

topic and they came away with two possible projects: a river cleanup and assisting the graffiti abatement team. Officer Durbin Llorren, of Madera Police Department is the one who suggested that the group consider working with the local graffiti abatement team.

"We had actually discussed helping with the graffiti," Glasel said. But, he added, they didn't want to step on other organizations already doing abatement.

Llorren assured them that there was enough graffiti to go around and the abatement team would welcome the extra help. It was agreed they would discuss this as an additional project.

Madera County Supervisor Mark Rodriguez, District 3, suggested the cleanup of the river, which he hoped could be accomplished before the rains come.

Rodriguez who had met with men and women at the breakfast held at Griffin Hall, noted that the number attending the breakfast was considerable and that it would be good if some of them could be recruited to take part in projects with HHHC. "Imagine the impact that many people would have," Ro-

driguez said, "seeing all of us there working together."

One of the goals of the group is to show that the homeless can make positive contributions to the community.

The majority of those present were not from the homeless community but from city and county government. Several representatives expressed an interest to not only attend the next meeting but to work along with HHHC to organize and take part in the projects.

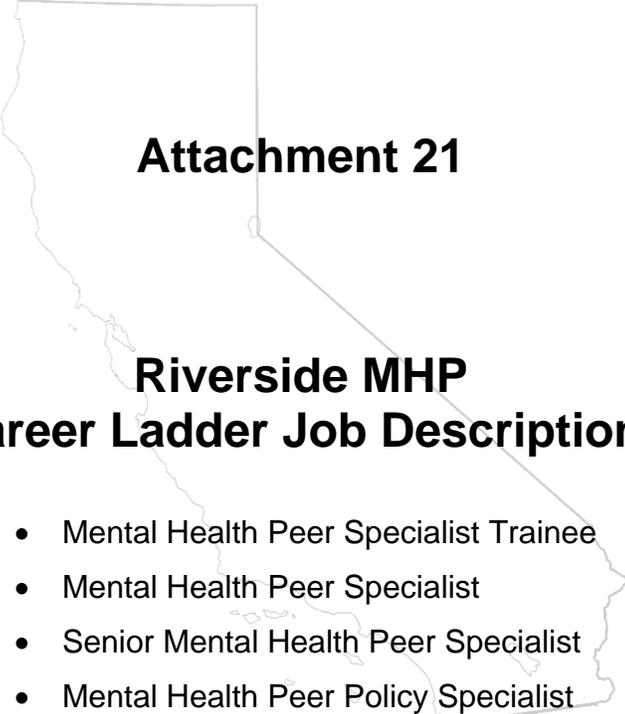
Organizers say that there are about a dozen homeless individuals that have expressed a serious desire to be involved. Glasel said the National Homeless Coalition put the number of homeless in Madera County at 600.

"The face of homelessness is changing," he said. "About 25 percent have jobs that they go to every day."

He also noted that there has been an increase in the number of single mothers and seniors that find themselves homeless simply because they have been squeezed out of the housing market.

To those who wanted to discuss politics, Glasel reminded them that they did not want to become involved in politics, their only goal was the betterment of the community.

***Hope House of Madera County***  
*117 North "R" Street*  
*Madera, CA 93637*  
  
*(559) 664-9021*



**Attachment 21**

**Riverside MHP  
Career Ladder Job Descriptions**

- Mental Health Peer Specialist Trainee
- Mental Health Peer Specialist
- Senior Mental Health Peer Specialist
- Mental Health Peer Policy Specialist



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Employment Job Descriptions

### Job Descriptions

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Class Title: MENTAL HEALTH PEER SPECIALIST TRAINEE

Class Code: 79725

Salary: \$12.46 - \$16.65 hourly  
 \$996.52 - \$1,331.98 biweekly  
 \$2,159.13 - \$2,885.97 monthly  
 \$25,909.52 - \$34,631.58 annually

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Description	Benefits
<p>Under close supervision, provide information, support and assistance and advocacy for consumers and/or caregivers/family members of consumers of mental health services and to provide feedback and perspective to the mental health system relative to the impact and effectiveness of the services provided and to do other work as required.</p> <p>This is the entry and trainee level class in the Mental Health Peer Specialist series. Incumbents are expected to promote to the journey level position of Mental Health Peer Specialist upon meeting the minimum qualifications and with satisfactory work performance.</p> <p>Incumbents in this class report to either a program supervisor or a regional manager; team with mental health professionals in the provision of consumer treatment, directly assist consumers and families/caregivers in the utilization of appropriate community resources, provide education and information to consumers and the community; and provide a unique consumer perspective to the mental health team.</p> <p>Incumbents in this class provide basic information, training, support, encouragement, advocacy, service effectiveness assessment and related services in order to assist the consumer and family/caregiver in coping with immediate situations. The consumer and family/caregiver perspective is provided in the development of programs and services and in formulation of treatment strategies. Incumbents of</p>	

this class do not attempt to modify or change the consumer's personality structure. Classes in this series differ from those in the Clinical Therapist series in that the latter, due to advanced education and experience, use independent judgment in making diagnoses, developing treatment plans, and providing a wide range and variety of mental health services including psychotherapy. This series differs from the Behavioral Health Specialist series in that the latter does not require the unique experience of having been the recipient or having been closely associated with the direct recipient of mental health services.

**Examples Of Essential Duties:**

- In a training capacity; informs, trains, supports and empowers consumers and families/caregivers who directly or indirectly receive mental health services.
- Communicates, represents and promotes the consumer and families/caregivers' perspective within the mental health system.
- Facilitates self-help groups for consumers, youth, family members and caregivers.
- Attends and participates in special events, conferences, workshops and trainings within the mental health system and in the community.
- Develops activities, programs and resources which support consumers and family/caregivers in achieving their goals.
- Supports the appropriate recognition, acceptance and understanding of social and cultural factors in the provision of mental health services.
- Develops effective working relationships with agencies and organizations to advocate for consumer and family/caregiver empowerment.
- Helps prepare and support clients and families/caregivers at case staffings and at a variety of formal and informal hearings.
- Helps consumers and those who support them to articulate their needs.
- Focuses on and is sensitive to consumer and family/caregiver satisfaction with the services received and general satisfaction with mental health services.
- Assists and promotes consumers and those who support them in support networks and activities.
- Documents all activities as required.

**Recruiting Guidelines:**

Experience: Depending on the assignment, current or previous experience as a consumer of mental health services or as a family member/caregiver of a former or current mental health consumer.

Knowledge of: The basic needs and difficulties faced by ethnically diverse consumers, caregivers and families of mental health consumers; the public and/or private agency services available for families, children and adults with serious mental health needs, such as schools, social services and other systems.

Ability to: Learn the basic principles of the mental health system and effectively work within the system; represent and advocate for the consumer perspective within the community and mental health system; understand the cultural and social factors affecting behavior patterns; effectively communicate the workings of the mental health system to service consumers, parents, family members and caregivers; establish and maintain working relationships with a wide range of community agencies and organizations; obtain and record accurate information for case documentation and other reports.

**Other Requirements:**

License/Certificate: Possession of a valid California Driver's License may be required.

**Pre-Employment:**

All employment offers are contingent upon successful completion of both a pre-employment physical exam, including a drug/alcohol test, and a criminal background investigation, which involves fingerprinting. (A felony or misdemeanor conviction may disqualify the applicant from County employment).

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Employment Job Descriptions

### Job Descriptions

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Class Title: MENTAL HEALTH PEER SPECIALIST

Class Code: 79726

Salary: \$14.66 - \$19.61 hourly  
 \$1,172.70 - \$1,568.77 biweekly  
 \$2,540.84 - \$3,399.00 monthly  
 \$30,490.10 - \$40,787.97 annually

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Description	Benefits
<p>Under direction, provide information, support and assistance and advocacy for recipients, and/or caregivers/family members of consumers of mental health services and to provide feedback and perspective to the mental health system relative to the impact and effectiveness of the services provided and to do other work as required.</p> <p>Incumbents in this class perform the full journey level scope of assignments in the Mental Health Peer Specialist series and report to either a program supervisor or a regional manager; team with mental health professionals in the provision of consumer treatment, directly assist consumers and families/caregivers in the utilization of appropriate community resources, provide education and information to consumers and the community; and provide a unique consumer perspective to the mental health team.</p> <p>Incumbents in this class provide a full range of information, training, support, encouragement, advocacy, service effectiveness assessment and related services in order to assist the consumer and family/caregiver in coping with immediate situations. The consumer and family/caregiver perspective is provided in the development of programs and services and in formulation of treatment strategies. Incumbents of this class do not attempt to modify or change the consumer's personality structure. Classes in this series differ from those in the Clinical Therapist series in that the latter, due to advanced education and experience, use independent judgment in making diagnoses, developing</p>	

treatment plans, and providing a wide range and variety of mental health services including psychotherapy. This series differs from the Behavioral Health Specialist series in that the latter provides general counseling, initial assessment and case management. In contrast, this series provides information and assistance based on the unique perspective of being a recipient of or having been closely associated with the direct receipt of mental health services.

**Examples Of Essential Duties:**

- Informs, trains, supports and empowers consumers and families/caregivers who directly or indirectly receive mental health services.
- Communicates, represents and promotes the consumer and families/caregivers' perspective within the mental health system.
- Facilitates self-help groups for clients, youth, family members and caregivers.
- Attends and participates in special events, conferences, workshops and trainings within the mental health system and in the community.
- Develops activities, programs and resources which support consumers and family/caregivers in achieving their goals.
- Supports the appropriate recognition, acceptance and understanding of social and cultural factors in the provision of mental health services.
- Develops effective working relationships with agencies and organizations to advocate for consumer and family/caregiver empowerment.
- Helps prepare and support clients and families/caregivers at case staffings and at a variety of formal and informal hearings.
- Helps consumers and those who support them to articulate their needs.
- Focuses on and is sensitive to consumer and family/caregiver satisfaction with the services received and general satisfaction with mental health services.
- Assists and promotes consumers and those who support them in support networks and activities.
- Documents all activities as required.

**Recruiting Guidelines:**

Experience: Depending on the assignment, current or previous experience as a consumer of mental health services or as a family member/caregiver of a former or current mental health consumer.

AND

One year as a Mental Health Peer Specialist Trainee or one year of experience equivalent to the Mental Health Peer Specialist Trainee.

Knowledge of: The needs and difficulties faced by ethnically diverse consumers , caregivers/ families of mental health consumers; the public and/or private agency services available for families, children and adults with serious mental health needs, such as schools, social services and other systems; the self-help and consumer oriented treatment models; and methods to effectively communicate with consumers, family/caregivers, the community and the mental health treatment team.

Ability to: Understand the principles of the mental health system and effectively work within the system; effectively represent and advocate for the consumer perspective within the community and mental health system; understand and articulate the cultural and social factors affecting behavior patterns; effectively communicate the workings of the mental health system to service consumers, parents, family members and caregivers; establish and maintain strong working relationships with a wide range of community agencies and organizations; obtain and record accurate information for case documentation and other reports.

**Other Requirements:**

License/Certificate: Possession of a valid California Driver's License may be required.

**Pre-Employment:**

All employment offers are contingent upon successful completion of both a pre-employment physical exam, including a drug/alcohol test, and a criminal background investigation, which involves fingerprinting. (A felony or misdemeanor conviction may disqualify the applicant from County employment).

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Employment Job Descriptions

### Job Descriptions

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Class Title: SENIOR MENTAL HEALTH PEER SPECIALIST

Class Code: 79727

Salary: \$18.31 - \$24.50 hourly  
 \$1,464.79 - \$1,960.06 biweekly  
 \$3,173.72 - \$4,246.79 monthly  
 \$38,084.59 - \$50,961.46 annually

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Description	Benefits
<p>Under direction, to provide the highest level of information, support and assistance and advocacy for consumers and/or caregivers/family members of consumers of mental health services and to provide feedback and perspective to the mental health system relative to the impact and effectiveness of the services provided; provide specialized training and work direction to other peer specialists and to do other work as required.</p> <p>Incumbents in this advanced level class perform the highest level of assignments in the Mental Health Peer Specialist series and report directly to either a regional manager or Peer Policy and Planning Specialist; team with mental health professionals in the provision of consumer treatment, directly assist consumers and families/caregivers in the utilization of appropriate community resources, provide education and information to consumers and the community; provide a unique consumer perspective to the mental health team; and may act in a lead capacity.</p> <p>Incumbents in this class provide a full range of information, training, support, encouragement, advocacy, service effectiveness assessment and related services in order to assist the consumer and family/caregiver in coping with immediate situations. The consumer and family/caregiver perspective is provided in the development of programs and services and in formulation of treatment strategies. Incumbents of this class do not attempt to modify or change the consumer's personality structure. Classes in this</p>	

series differ from those in the Clinical Therapist series in that the latter, due to advanced education and experience, use independent judgment in making diagnoses, developing treatment plans, and providing a wide range and variety of mental health services including psychotherapy. This series differs from the Behavioral Health Specialist series in that the latter does not require the unique experience of having been the recipient or having been closely associated with the direct recipient of mental health services.

**Examples Of Essential Duties:**

- Acts as a resource person for and assists in the training, work assignment and supervision of other peer specialists.
- Provides guidance and leadership in the solution of the most complex consumer service and case related situations.
- Informs, trains, supports and empowers consumers and families/caregivers who directly or indirectly receive mental health services.
- Communicates, represents and promotes the consumer and families/caregivers' perspective within the mental health system.
- Develops and facilitates self-help groups for consumers, youth, family members and caregivers.
- Attends, participates and takes a leadership role in special events, conferences, workshops and trainings within the mental health system and in the community.
- Develops and promotes activities, programs and resources which support consumers and family/caregivers in achieving their goals.
- Supports the appropriate recognition, acceptance and understanding of social and cultural factors in the provision of mental health services.
- Develops effective personal and departmental working relationships with agencies and organizations to advocate for consumer and family/caregiver empowerment.
- Helps prepare and support consumers and families/caregivers at case staffings and at a variety of formal and informal hearings.
- Helps consumers and those who support them to articulate their needs.
- Focuses on and is sensitive to consumer and family/caregiver satisfaction with the services received and general satisfaction with mental health services and investigates the most sensitive complaints.
- Assists and promotes consumers and those who support

<p>them in support networks and activities.</p> <ul style="list-style-type: none"> <li>• Documents all activities as required.</li> </ul>
<p><b>Recruiting Guidelines:</b></p> <p>Experience: Depending on the assignment, current or previous experience as a consumer of mental health services or as a family member/caregiver of a former or current mental health consumer.</p> <p>AND</p> <p>One year of experience as a Mental Health Peer Specialist or two years of experience equivalent to the Mental Health Peer Specialist.</p> <p>Knowledge of: The basic principles and practices of leadership and training; the needs and difficulties faced by clients, caregivers and families of mental health consumers; the public and/or private agency services available for families, children and adults with serious mental health needs, such as schools, social services and other systems; the self-help and consumer oriented treatment models; methods to effectively communicate with consumers, family/caretakers, the community and the mental health treatment team and</p> <p>Ability to: Act in a lead capacity; understand the principles of the mental health system and effectively work within the system; effectively represent and advocate for the consumer perspective within the community and mental health system; understand and articulate the cultural and social factors affecting behavior patterns; effectively communicate the workings of the mental health system to service consumers, parents, family members and caregivers; develop and maintain strong working relationships with a wide range of community agencies and organizations; obtain and record accurate information for case documentation and other reports.</p>
<p><b>Other Requirements:</b></p> <p>License/Certificate: Possession of a valid California Driver's License may be required.</p>
<p><b>Pre-Employment:</b></p> <p>All employment offers are contingent upon successful completion of both a pre-employment physical exam, including a drug/alcohol test, and a criminal background investigation, which involves fingerprinting. (A felony or misdemeanor conviction may disqualify the applicant from County employment).</p>

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**Employment** **Job Descriptions**

## Job Descriptions

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**Class Title:** MENTAL HEALTH PEER POLICY AND PLANNING SPECIALIST

**Class Code:** 79728

**Salary:** \$22.03 - \$28.66 hourly  
 \$1,762.12 - \$2,292.62 biweekly  
 \$3,817.93 - \$4,967.35 monthly  
 \$45,815.12 - \$59,608.22 annually

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Description	Benefits
<p>Under general direction, to plan, coordinate and advocate for programs, activities and services which support an ethnically diverse population of consumers and families/caregivers in receiving from the mental health system the full scope of services they require; to make ongoing policy and program recommendations based on the special needs of consumers and/or families/caregivers; to functionally supervise specialized programs for consumers and families/caregivers; to make policy and operational recommendations to the highest levels of mental health administration; and to do other work as required.</p> <p>Incumbents of this classification report to the Director of Mental Health or his designee and are primarily responsible for understanding the needs and perspective of consumers and families/caregivers, focusing on the barriers to care, and providing that unique perspective to mental health administration. Duties include communicating, developing, organizing, facilitating, coordinating and advocating for programs, services and activities designed around the special identified needs of consumers and those who care for them. The classification is further characterized by special project assignments, by its functional countywide responsibility for consumer directed programs and services and by its responsibility for representing the department of mental health at statewide and national activities relative to consumer oriented services.</p> <p><b>Examples Of Essential Duties:</b></p>	

- Understands, articulates and advocates for the consumer and family/caregiver perspective in policies, procedures and practices within the department of mental health.
- Makes consumer and family/caregiver oriented recommendations to mental health administration on current and proposed policies, programs and procedures.
- Develops and implements strategies aimed at meeting the needs of consumers and family/caregivers for information, education, support and empowerment.
- Develops and administers programs for the improvement of consumer relations, consumer satisfaction and understanding of "consumer culture".
- Coordinates the oversight and/or supervision of consumers and family/caregivers in the provision of mental health services and program design and development.
- Monitors consumer and family/caregiver complaints, concerns and issues regarding access to and satisfaction with services and peer assistance in solving problems.
- Participates in the analysis of current and proposed State and Federal legislation as it impacts department programs and corresponds with State liaisons for the application and implementation of legislative changes.
- Develops partnerships with diverse community and State and local consumer/caregiver groups, including advocacy, self-help, family alliances and parent groups.
- Supports the appropriate recognition, acceptance and understanding of social and cultural factors in the provision of mental health services.
- Plans, develops and implements consumer and family/caregiver related training and human resource development projects.
- Represents the department at local, statewide and federal task forces, workshops, conferences and meetings.
- Partners with other county agencies such as Probation, Department of Social Services, the Office of Education and school districts to facilitate services to consumers and families/caregivers.
- Undertakes other related special projects as assigned and compiles a variety of reports.

**Recruiting Guidelines:**

Experience: Current or previous experience as a consumer, direct family member/caregiver of a mental health consumer.

AND

One year of experience as or comparable to the Mental Health Senior Peer Specialist in a California County Department of Mental/Behavioral Health.

OR

One year of experience comparable to the Mental Health Peer Policy and Planning Specialist.

Knowledge of: The needs and difficulties faced by consumers and families/caregivers of mental health consumers; the concepts of self-help, peer support and recovery model; familiarity with the mental health consumer movement; basic program development and management techniques; basic training and development techniques; public and/or private agency services available for consumers of mental health services; basic principles of individual, group and community behavior and sensitivity to multicultural issues.

Ability to: Communicate the consumer experience and perspective at all levels within the mental health system and the community; assist to establish policies and procedures that support the treatment and other needs of consumers and families/caregivers; establish and maintain effective working relationships with diverse groups, including mental health consumers, consumer/family organizations, family members, caregivers, treatment staff, other county departments and community organizations; investigate and assess complaints and work to solve problems; prepare and deliver group presentations and training; effectively establish and maintain good relations with a range of social and ethnic groups; and communicate effectively in oral and written form, preparing formal reports, brochures and documents.

**Other Requirements:**

All employment offers are contingent upon successful completion of both a pre-employment physical exam, including a drug/alcohol test, and a criminal background investigation, which involves fingerprinting. (A felony or misdemeanor conviction may disqualify the applicant from County employment).

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**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 22**

**San Bernardino MHP  
Milestones on the Road to  
Integrated Health Care**





County of San Bernardino  
**Milestones**  
ON

**The Road to Integrated Health Care**

		LEVEL OF INTEGRATION				
		FRAGMENTED	LINKAGE	COLLABORATION	COORDINATION	INTEGRATION
<b>ADMINISTRATION</b>	Siloed	Siloed governing boards & site-specific administrators. Informal policies permit linkage to other providers.	Siloed	Siloed governing boards, site-specific administrator communication and collaboration	Coordinating directives issued as policy from governing boards mandating business process coordination.	Single, unified administrative structure and governing board at the multi-site and single-site levels.
<b>PHYSICAL LOCATION</b>	Unplanned, separate	Separate with relationships between providers within close proximity, possible transportation provided.	Siloed	Separate with Curbside Consultation: i.e. Providers visit each other's sites to provide onsite services.	Providers "outstationed" permanently to other provider's site.	Collocated, full service behavioral health services at same site.
<b>PLANNING</b>	Siloed		Siloed	Cross communication as courtesy to collaborators	Cross communication with plan modifications to optimize impacts	Multiple agency integrated stakeholder involvement, planned interdependency.
<b>FUNDING</b>	Siloed		Siloed	Startup grants fostering interagency collaboration with funds distributed to multiple agencies.	Persisting funds requiring integrated / coordinated intervention strategies. (possible e.g. MHSA Prevention and Early Intervention Funding)	Shared / Blended funding and resources, including categorical grants, persisting revenue sources (Federal, state and local). Special payor relationships supporting integration.
<b>INFORMATION SHARING</b>	By ad hoc request for information to be released	By ad hoc request for information to be released	By ad hoc request for information to be released	Ad hoc with pre-defined protocols	Standardized by policy to overcome operational and legal barriers. De-identified data across agency boundaries.	Standardized, fluid, "seamless" transmission of paper-based and electronic data across agency boundaries. Unified data systems.
<b>INTERAGENCY RELATIONS</b>	Non-existent to highly tenuous	Informal, cordial	Informal, cordial	Semi-formalized by verbal agreement between parties/agencies.	Moderately formalized, some joint protocols, coordinated processes	(1) Single Agency or (2) Highly formalized by MOU or written agreement. Unity: vision, values, processes, & goals.
<b>SERVICE DELIVERY</b>	Siloed	Ad hoc referral to known providers; business processes unrelated, at times conflicting.		Cross referral, consultation.	Cross assessment and referral, consultation, ad hoc interdisciplinary treatment teams.	Integrated business processes: Cross assessment, referral, treatment planning, interventions, and outcome monitoring.
<b>PROFESSIONAL PARADIGM / CULTURE</b>	Exclusive professional boundaries, adherence to rigid scope-of-practice, moderate to serious professional narcissism.	Recognizes personal professional limitations, passively respects / values other disciplines and areas of expertise as contributory.	Highly values cross-disciplinary expertise. Recognizes occasional ascendent value in other disciplines. Actively collaborates with other disciplines.	Highly values cross-disciplinary expertise. Familiar with extra-disciplinary construal of illness/wellness. Actively coordinates treatment.	Extensive cross-disciplinary training. Has an integrated, whole person conception of illness / wellness. Open-minded, non-parochial perspective.	