

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

# STATEWIDE REPORT

FY2007 (July 1, 2006 - June 30, 2007)

VOLUME I OF II



PRESENTED TO

**CALIFORNIA**

**DEPARTMENT OF MENTAL HEALTH**



# Year Three





**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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## CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

### **Executive Summary**

California's Medicaid program – Medi-Cal – is administered by the California Department of Health Services (DHS). 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 DHS 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) 2007 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 two recommendations
3. Conduct individualized MHP site reviews that draw upon three years of quantitative findings
4. Explore each MHP's success in developing consumer-focused programs that support wellness, recovery and resiliency.

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 many 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 work process.

## 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. While Section 1 provides a detailed overview of the 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 to pay for the changes in mental health, social and health services. This dramatic change to a decentralized system had both financial and organizational implications.
  - 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.
  - While California's diverse population necessitated the creation of a decentralized system, this change created an environment in which counties became siloed – viewing themselves as separate and distinct entities. Decentralization also precipitated the creation of several strong, highly organized professional alliances to support collaboration in this environment – including the California Mental Health Director's Association (CMHDA) and the California Institute of Mental Health (CiMH).
- **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 funding mechanism is a one percent tax on annual incomes over one million dollars. The most current state budget projects several billion dollars in MHSA funds for three fiscal years. 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, it also has rendered an already complex regulatory environment even more daunting. Three leadership entities have come together to address often over-lapping statutory responsibilities for driving statewide quality and outcomes accountability for MHSA-funded programs:

- DMH – which provides leadership of California's mental health system and ensures through partnerships the availability of effective, efficient, culturally competent services

- California Mental Health Planning Council – which through federal and state statute, provides oversight of the public mental health system
- Mental Health Services Oversight and Accountability Commission – which oversees the implementation of MHPSA

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. Because of these challenges, many MHPs are ambivalent about the EQR process and view CAEQRO as “yet another compliance audit” with neither financial incentives nor consequences.

### Work process enhancements in FY07

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

- **Expanded data analytic capacity.** Our data analytic capacity expanded greatly during year three. We were not only able to present Calendar Year (CY) 2005 Medi-Cal approved claims data to all MHPs as part of the pre-site process, but also to compare that data against system-wide averages (i.e., region, state and two specifically identified MHPs). This information shaped the targeted focus of the site review process – from the notification packet through to the final report. We generated a variety of worksheets that provided data to the review team and MHP, including:
  - Penetration rates and approved claims per beneficiary – by age, gender, ethnicity, eligibility category and service type
  - Retention rates – overall and for foster care youth
  - Approved claims per beneficiary by provider/legal entity
  - High-cost beneficiaries
  - Denied claims
  - Penetration rates and approved claims for two underserved populations – women and Latinos
- **Extensive database improvements.** To increase our ability to perform quantitative analyses, we enhanced our database capabilities in two key areas:
  - Improved our ability to capture findings from the Information System Capabilities Assessment (ISCA) surveys (as described in Section 2.3)

- Built a sophisticated database that allowed us to capture major findings from our site review reports, including Performance Improvement Project (PIP) scores, and MHP strengths, opportunities for improvement and recommendations
- **Increased the scope, specificity and duration of site interviews.** Our year one and year two findings and recommendations, combined with our increased data analytic capabilities, enabled us to identify staff who could best address key programmatic or clinical areas. This information also enabled us to increase the number of stakeholder interviews, particularly contract providers and underserved populations. To accommodate these interviews, we increased the number of calendar and person days per site visit for many MHPs.

## Organizational Assessment and Structure Performance

In year three, mental health plans (MHPs) continued to face the challenges that we observed during the previous two years – with the additional demands of implementing programs funded by the Mental Health Services Act (MHSA). These demands continued to have a considerable influence on MHP priorities during FY07 and how they allocated resources for this year’s site review process. This section begins with a discussion on the environment in which MHPs continue to operate, since it provides an important context for all of our site review findings. We then structure our organization assessment based on major priorities for FY07:

- **Section 2.2 – Site Review Findings**
  - *Follow-up to the recommendations in our year two 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 were rated either “fully” or “partially addressed” in FY07.
  - *Consumer involvement in service delivery and recovery-oriented programming.* We observed a gradual improvement in this area from FY06 to FY07 – largely related to programmatic improvements associated with MHSA initiatives.
  - *FY07 focus 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.
- **Section 2.3 Health information systems review**
  - *Information Systems Capabilities Assessment (ISCA) V6.1.* The ISCA findings that follow in this section were produced from information contained in the improved ISCA database, which now stores three full years of MHP IS information. As we discuss in “Trends in Key Areas,” the most striking change

from FY06 to FY07 is the record number of new system implementations – particularly among small-rural and small counties.

Also included in this section is a summary of our findings related to Performance Improvement Projects (PIPs), which continue to be the most challenging aspect of the review process for nearly every MHP and which are significantly affected by lack of resources and experience.

## Technical Assistance and Training

Unlike a traditional external quality review organization (EQRO), CAEQRO has consistently sought opportunities to provide each mental health plan (MHP) with technical assistance that promote performance improvement. We learned that technical assistance during the site visit has limitations: only those staff members who participate in the process benefit from such assistance; and the subject matter is limited to the site visit agenda. In addition, the site review process is not conducive to developing skills that require repetition over time.

In Section 3, we discuss how we have addressed these limitations through providing a broad spectrum of technical assistance to four specific audiences:

- **Individual MHPs** – integrated with all three phases of the site review process
- **Outreach, training and education** – provided to MHPs, public mental health system stakeholders, and key leaders and organizations
- **Group training** – targeted to all MHPs and in collaboration with leaders in the public mental health system
- **Small counties** – focused on issues unique to MHPs in specific geographies

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.

## Performance Measurement Analysis

In year two, California External Quality Review Organization (CAEQRO) and California Department of Mental Health (DMH) considered several options for the performance measure (PM) analysis and, after an extensive analytic process, selected “cost per unduplicated beneficiary served.” For year three, 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 year two 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.

In Attachment 3 we include a graphic display of Med-Cal penetration rates and approved claim amount per beneficiary served based on standard methodologies.

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 disparities in access, cost and the types of services received by different groups of beneficiaries. Summarized below are our key performance measurement findings for FY07 based on our analysis of CY06 approved claims – which we compared to CY05 approved claims:

- 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 CY06)
- Fewer resource dollars were spent on older adults than on beneficiaries in other age groups

In addition, we noted that an increase in Therapeutic Behavioral Services appears to have influenced the cost per unduplicated beneficiary served for 6 to 17 year-old beneficiaries.

## Other Statewide Data Findings

Our objective in Section 5 was to provide a detailed analysis of California's public mental health system by:

- Employing a methodology for analyzing penetration rates different from one commonly used to determine how effectively a health plan is serving its respective community:
  - The demographic and ethnic landscape of communities in California is quite varied – perhaps the most diverse in the nation. In Attachment 3 we include map that suggest this diversity by simply displaying population distributions throughout the state. The adjustments for demographic and ethnic variations within each MHP have a significant effect on penetration rates. For example, San Benito MHP has an unadjusted overall penetration rate of 7.79 percent and a penetration rate adjusted by ethnicity of 10.04 percent.
  - We also adjusted penetration rates by eliminating those beneficiaries with a limited number of services – a methodology that reflects current research on service utilization in the public sector. For example, Monterey MHP shows a 3.59 percent overall penetration rate after excluding consumers with three or fewer services. However, the adjusted penetration rate by ethnicity increases to 5.06 percent.
- Presenting new data from a technical assistance project conducted by CAEQRO and the California Institute of Mental Health (CiMH) in cooperation with the County Mental Health Directors' Association (CMHDA) for the Small Counties Emergency Resource Pool (SCERP). This project applied the core principles of disease management:
  - Unplanned services, such as hospital-based emergency services or inpatient admissions are disruptive to the beneficiary's life, as well as costly to the MHP.
  - Unplanned services are generally not a desired modality for effectively managing chronic illness.
  - Beneficiaries with an individual treatment plan and who receive a set of effective planned services should be less likely to need unplanned services.
- Addressing retention rates for foster care beneficiaries – since stakeholders in the public mental health system have grave concerns about the service delivery system for this population. Of note, the high retention rate for this beneficiary population (over 50 percent with 15 or more services) remained stable over a two-year period. In addition, the data suggest a slight decrease in the beneficiary

population and an apparently greater decrease in the number of beneficiaries served.

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. 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

In compiling the exemplary practices highlighted in Section 6, we were struck by the ability of MHPs in varying geographic regions, with diverse demographics and often with limited resources, to develop innovative consumer-focused programs or to improve administrative processes – sometimes dramatically – by working collaboratively and cross functionally.

Listed below are highlights of the programmatic and administrative areas featured in Section 6:

- **Web site technologies** – Alameda MHP
- **Cultural competence in service delivery** – Orange MHP
- **Outreach to/analysis of underserved populations** – MHPs in Mono and San Benito counties, and San Mateo MHP
- **Primary and mental health care integration** – MHPs in Marin and Fresno counties
- **Information system implementations** – MHPs in Los Angeles and Solano counties
- **Claims payment processes** – Placer/Sierra MHP
- **Delivery system model (open access)** – San Bernardino MHP

In addition to the exemplary practice summaries presented in Section 6, we would also like to acknowledge several MHPs that are engaged in noteworthy practices or in activities specific to their operations: Kern MHP's implementation of its Anasazi information technology platform; San Diego MHP's Community Services and Support matrix; and Santa Clara MHP's physician spreadsheet to support medication management.

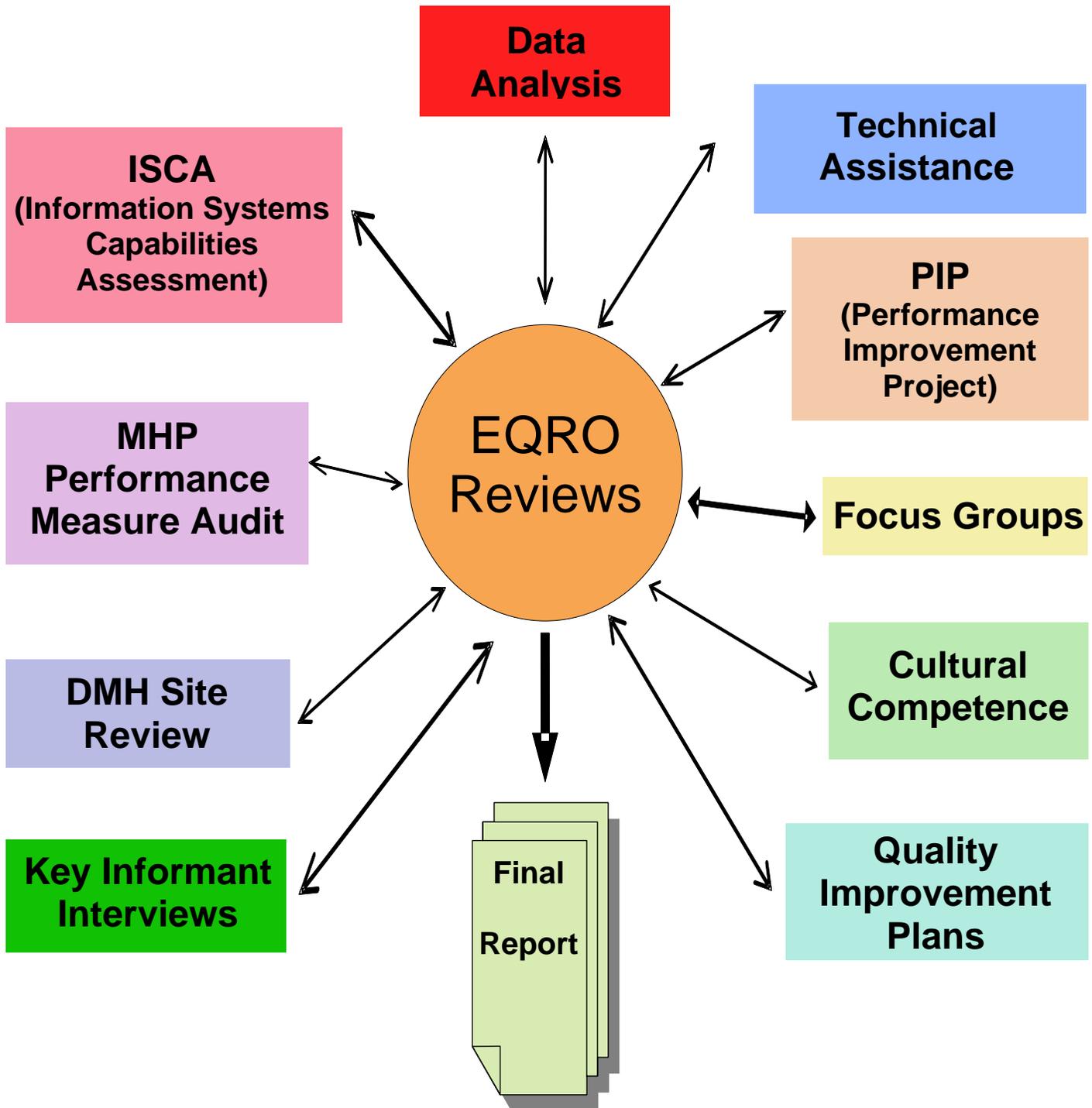
## Trends in Key Areas

As discussed in Section 7, we have systematically observed what we believe to be dominant themes within California's public mental health system – for the past three years. In previous years' statewide reports, we chose to discuss themes versus trends – pending a minimum of three years' observations and quantitative data on a specific area.

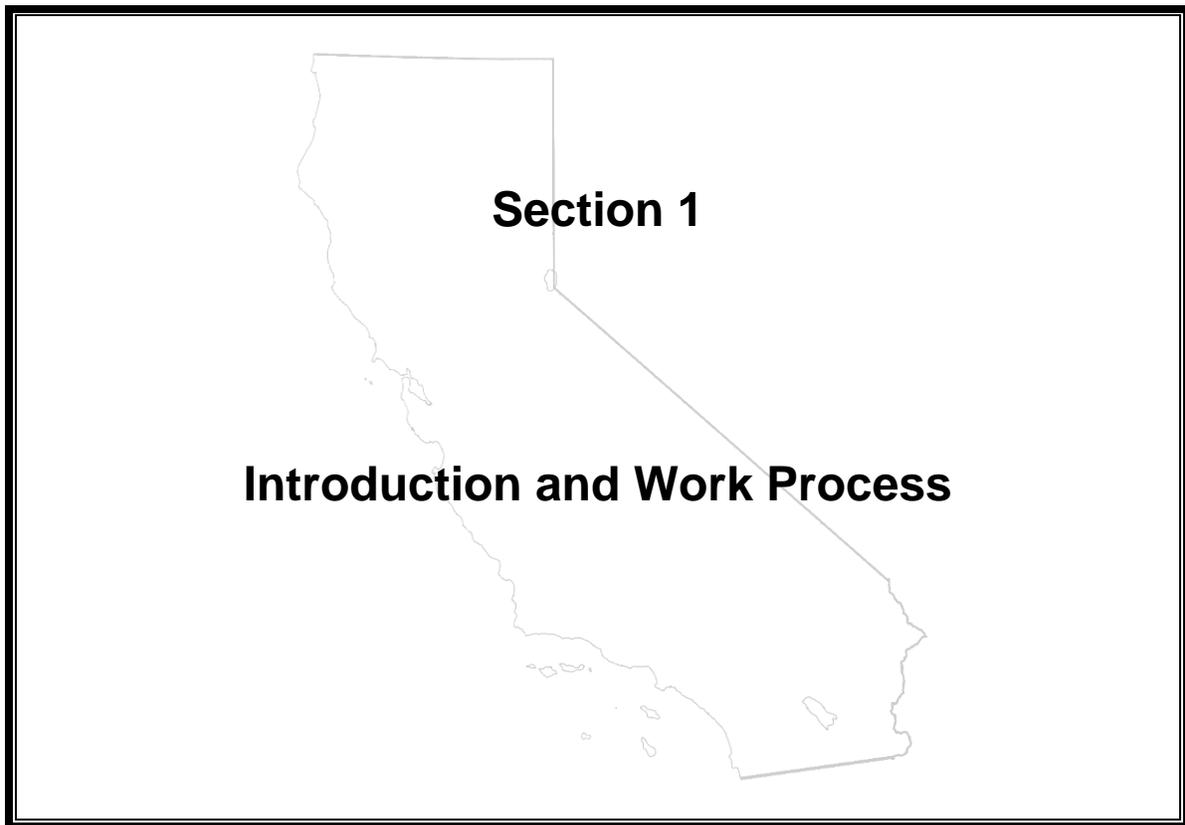
Having aggregated a substantial body of such information over three years, we can now identify trends within key areas. For each positive trend we also note in our discussions corresponding issues to identify possible areas of intervention for both MHPs and the California Department of Mental Health. We expect that FY08 will continue and hopefully accelerate these positive trends and where appropriate implement system changes to address service disparities for specific populations:

- **Trend #1: New delivery system models are beginning to increase access.** Some MHPs are developing new models to facilitate ease of access to mental health services. However, access to psychiatric services remains limited.
- **Trend #2: Female and Hispanic beneficiaries appear 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: MHPs are beginning to access and use data to drive performance management.** We saw a strong positive trend in the system's overall access to and use of data as reflected in CAEQRO reviewers' observations and recommendations.
- **Trend #4: MHPs are searching for or implementing new information systems in record numbers.** This trend suggests an unprecedented level of change within the core information system infrastructure for California's public mental health system.
- **Trend #5: MHPs are beginning to implement consumer-focused programs.** This trend appears to be largely tied to the implementation of programs funded by the Mental Health Services Act and not always integrated with other initiatives.
- **Trend #6: Strong leadership can manage through environmental challenges.** However, the performance of a number MHPs suffered because of poor management and leadership skills.

### 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 Services (DHS). 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 DHS 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 managed care 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. 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 are all important in providing a context not only for this section but also for our full report.

In this section, we provide a brief history of California's public mental health system and the current landscape. We then describe the EQRO process, which has evolved from years one and two – 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.

## Section 1.2: Background

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 1990's 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:

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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 MHP and Sutter/Yuba MHP).

- **The late 1950's and the 1960's.** 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 1970's and the 1980's.** In Fiscal Year (FY) 1973-1974, the state legislature required that all counties have a mental health program. However, during the 1970's and well into the 1980's, 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:
  - *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 1970's 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.
  - *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 1990's 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:

- *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.
- *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.
- *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.
- *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.
- **2000's 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:
  - *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 (FY2007-2008).
  - *EPSDT services.* In FY2002-03, 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.

- *AB 3632*. By FY 2001-02, 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 FY2002-03 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 1990's, 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:
  - 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.
  - 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.
  - 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 FY2005-2006 budget.
  - 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 MHPA 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 MHPA programs. With already complex and partially redundant compliance audits and quality reviews of MHPs and other county programs, the addition of MHPA-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

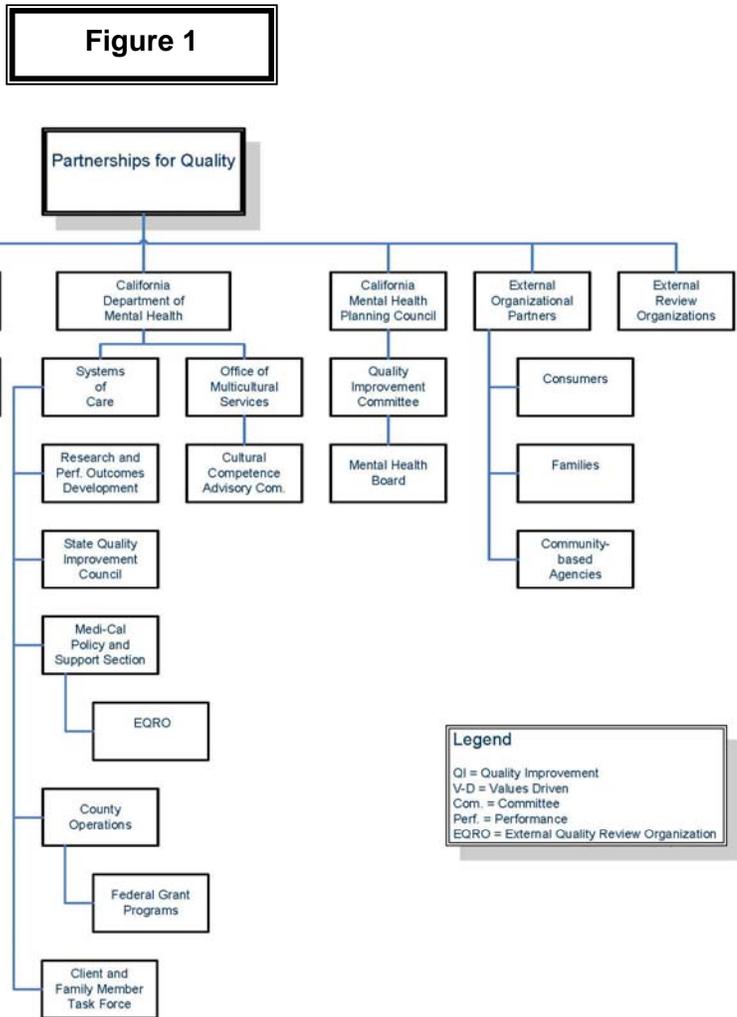
DMH “views accountability and quality improvement as critical components in achieving its mission (Mayberg S, 2004-05).” The following entities all play an important role in conducting fiscal, administrative and service oversight of California's public mental health system:

- 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 1990’s. 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

### **Section 1.3: External Quality Review Process**

During year three, 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 three 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 EQR process by standardizing core evaluation measures across the public mental health system, while focusing on the access, timeliness and quality of services that each MHP provides to its beneficiaries.

As in previous years, the review team included CAEQRO staff and senior consultants with clinical and information systems (IS) expertise. Also remaining unchanged since our first year was the overall site review structure, which consisted of three phases: pre-site, site and post-site. However, as we highlight below, our review strategies and areas of emphasis were even more targeted and in-depth than in years one and two:

- **Expanded data analytic capacity.** Our data analytic capacity expanded greatly during year three. We were not only able to present Calendar Year (CY) 2005 approved claims data to all MHPs as part of the pre-site process, but also to compare that data against system-wide averages (i.e., region, state and two specifically identified MHPs). This information shaped the targeted focus of the site review process – from the notification packet through to the final report. We generated a variety of worksheets that provided data to the review team and MHP, including:
  - Penetration rates and approved claims per beneficiary – by age, gender, ethnicity, eligibility category and service type
  - Retention rates – overall and for foster care youth
  - Approved claims per beneficiary by provider/legal entity
  - High-cost beneficiaries
  - Denied claims
  - Penetration rates and approved claims per beneficiary for two underserved populations – women and Latinos
- **Extensive database improvements.** To increase our ability to perform quantitative analyses, we enhanced our database capabilities in two key areas:
  - Improved our ability to capture findings from the Information System Capabilities Assessment (ISCA) surveys (as described in Section 2.3)
  - Built a sophisticated database that allowed us to capture major findings from our site review reports, including Performance Improvement Project (PIP) scores, and MHP strengths, challenges and recommendations
- **Increased the scope, specificity and duration of site interviews.** Our year one and year two findings and recommendations, combined with our increased data analytic capabilities, enabled us to identify staff who could best address key programmatic or clinical areas. This information also enabled us to increase the number of stakeholder interviews, particularly with contract providers and underserved populations. To accommodate these interviews, we increased the number of calendar and person days per site visit for many MHPs.

Rather than describing each of the three phases of our site review process, we emphasize in this section how our processes evolved and improved in FY07. Our year one and year two statewide reports, which contain detailed discussions on our general site review process, are available on our Web site at [www.caeqro.com](http://www.caeqro.com).

## Pre-Site Review Process

The pre-site review process for FY07 evolved from and improved upon the process established in year two. We initiated year three processes in the spring of year two to develop with each MHP a proposed schedule well in advance of the site visit. Our goal was to review each MHP approximately 12 months from its prior review date – and we successfully met that goal within no more than two month's variance.

Pre-site activities included notifying the MHP of the upcoming review, assisting the MHP in its preparation for the review, and reviewing MHP approved claims data and documents to prepare for the site visit. Below we offer a brief description of the notification process, emphasizing those activities that we added or improved in year three:

### Notification packet overview

As in year two, the lead reviewer sent each MHP director and QI coordinator an electronic copy of a notification letter and instructive materials to assist the MHP in its preparation. The notification packet, a sample of which is included in Attachment 4, consisted of the following documents:

- Notification Letter
- Consumer/Family Member Focus Group Guidelines
- Road Map to a PIP
- PIP Outline via Road Map
- PIP Validation Tool
- ISCA V6.1
- Approved Claims for CY05
- Demographics charts

As has become our practice, we requested in the notification letter that the MHP provide – prior to the site visit – certain documents that were updated from the previous year (i.e., strategic initiatives, organizational chart[s]), current QIC and cultural competence committee meeting minutes, QI work plan and evaluation, surveys and PIPs. This strategy has enabled us to prioritize site visit discussions based on progress – or lack thereof – in specific areas.

All notification letters included two areas for review:

- General areas that we addressed in all FY07 reviews, including:
  - MHP's strategic initiatives
  - Progress on addressing CAEQRO FY06 recommendations or other improvements
  - Examples of data or reports used to guide performance management
  - Changes or milestones in QI processes
  - ISCA V6.1
  - Wellness/recovery and cultural competence

- MHP-specific areas of review based on our FY06 findings and recommendations. The notification letter identified MHP-specific issues to be addressed through targeted staff/contractor interviews, as well as consumer/family member focus groups.

### Notification packet materials/request for materials

We highlight below those documents in the notification packet that we updated and improved for our FY07 annual review:

- **Performance Improvement Projects.** PIPs continued to be the most challenging aspect of the review process for nearly every MHP. We continued to assess our own strategies for facilitating PIP development. We had received positive feedback regarding the ease of use of the “Road Map to a PIP” that we developed in year two. We therefore used this document as a foundation for revising both the validation tool and the PIP submission document. We sent the PIP validation tool with the notification materials, so that MHPs could become familiar with the scoring criteria as they examined their PIPs. In Section 3 of this report, we discuss how we used these documents as training materials.
- **CY05 Medi-Cal approved claims data.** Our data analytic capacity expanded greatly during year three, allowing us to analyze and present Medi-Cal data using comparative analytical techniques. As in year two, the notification packet included statewide MHP claims and demographic data to provide a context for discussion. This information is included in Attachment 5. We used CY05 approved claims data as part of the pre-site and site review processes. We revised the worksheet format to include more detailed breakdowns by service type and ethnicity. A sample of this worksheet is included in Attachment 6. We also created foster care utilization worksheets for selected MHPs. An example of this worksheet is included in Attachment 7. We discuss our findings in Sections 4 and 5 of this report.

### CAEQRO staff preparation

Our pre-site meeting, held approximately one week prior to a site visit, continued in year three as a mechanism for coordinating the site review team, identifying review priorities, and obtaining input from the CAEQRO staff who would not be participating in the review. This meeting covered approved claims data, PIPs and other documents submitted by the MHP.

In addition, CAEQRO developed consistent and detailed guidance as illustrated in the internal site review template and consumer/family focus group questions – both of which are included in Attachment 8. These documents, which are highlighted below, were designed to guide the review team rather than serve as a rigid protocol:

- **A site review template.** CAEQRO highlighted those areas that we generally found needed improvement across all MHPs:
  - Strategic planning
  - Use of data from various sources to manage the MHP’s performance

- Collaboration between staffs in programs, management, QI, and IS to ensure that relevant and timely data are available
- **Consumer/family member focus groups questions.** CAEQRO created questionnaires specific to each MHP and specific to each group (e.g., Latinos, self-help center participants, consumers with co-occurring disorders, etc.).

Also included in Attachment 8 is a sample review agenda which offered guidance on key areas for discussion.

## Site Review Process

Our approach in year three was to focus on areas in which the MHPs applied data-driven decision-making and performance management. We also looked at changes in business or clinical practices that affected the experiences of beneficiaries in terms of timeliness, access, quality and outcomes since the previous review. Specific major changes to this year's site review process are highlighted below:

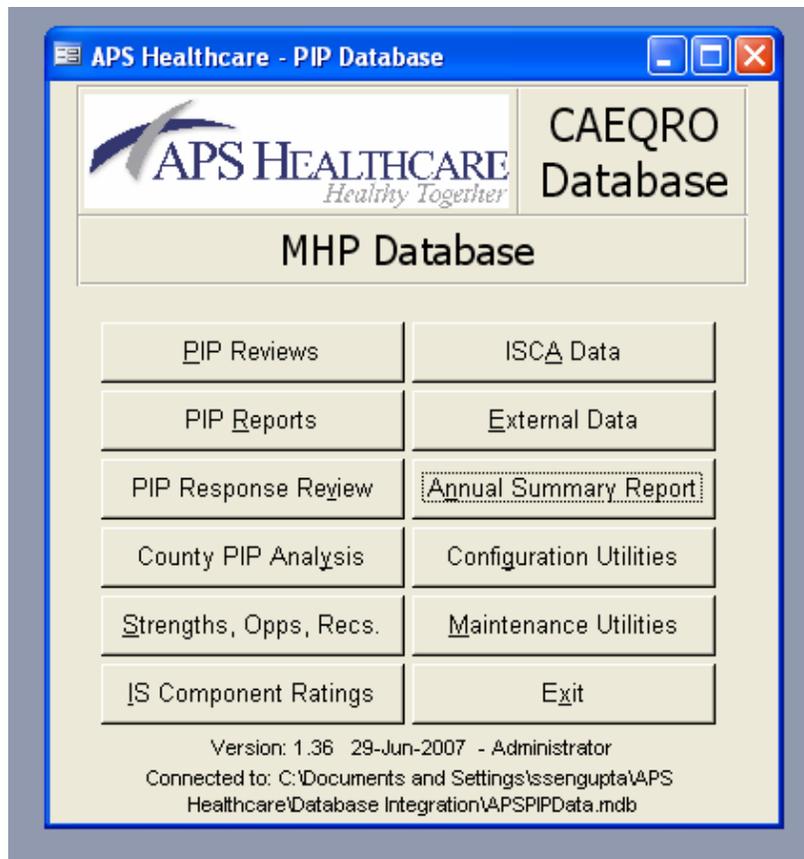
- **Increased overall site visit and “person” days.** In previous years' site reviews, we gathered baseline data – primarily from central administrative staff and to some extent from program staff. During year three, we built on this foundation and added the analysis of Medi-Cal claims data to observe key performance indicators. As a consequence of this focused approach, we recognized the need to expand – rather than compress – the site visit process, as well as the number of people participating. Below we list the guidelines we applied in scheduling our site reviews:
  - Very small/rural MHPs – one day
  - Small MHPs – one-two day(s)
  - Medium MHPs – two days
  - Large MHPs – three days
  - Los Angeles – four days

Overall, in comparing year two and year three, we increased our site visit days by 18 percent and our person days by 7 percent.

- **Developed a sophisticated database to capture major findings, including:**
  - PIP data – MHP's PIP topics, results from the validation tool scores, and the comments included in the MHP reports on elements rated as “partially met” or “not met”
  - MHP report data – strengths, opportunities and recommendations identified in each report and classified by “access”, “timeliness”, “outcomes”, “quality”, “IS” or “other”

Below is a screenshot of the database menu:

**Figure 2**



- Used approved claims data to focus discussion.** We began each review with an intensive performance management session to explore how the MHP measures success or areas requiring improvement. We specified that the entire management team, as well as other key staff and stakeholders, participate in this session. Included in this session was a detailed discussion of the MHP's approved claims data. To support the approved claims worksheet, we created a three-page document that highlighted key indicators (e.g., penetration rates, approved claims per beneficiary served) and compared them to those for the region, state, comparable MHPs and similar-sized counties.

We also continued to use each MHP's approved claims data to identify important issues such as penetration rates by age and ethnicity. Attachment 6 provides a sample of such data for Contra Costa MHP. Since foster care is such a critical issue, we also provided MHP-specific foster care data, as illustrated by Attachment 7, which includes approved claims data for foster care beneficiaries in the San Francisco MHP. Data findings directed our requests for focus groups that reflected specific demographic and ethnic populations. We conducted focus groups aimed at foster care youth and/or parents, transition age youth, Latinos, Southeast Asians, older adults, and parents of youth in services. We also

requested that the MHP schedule focus groups at locations that are familiar to and accessible for the participants.

Data from our year two review also shaped common discussions for all or most MHPs. For example, statewide disparities in access and service delivery to both female and Latino beneficiaries precipitated programmatic discussions throughout the state.

- **Facilitated shared discussion of MHP reports.** MHPs have begun to use the approved claims data that CAEQRO generates. We also encouraged discussion of those reports that the MHP either generates or can readily access. This discussion enabled MHP staff to educate each other about internal reports and, as appropriate, disseminate and use them throughout the organization. It also illustrated how MHPs could better use data from their own IS to support performance management.
- **Added participation by specific staff.** In year one and to some extent in year two, we generally did not specify who needed to participate in a session – with the exception of line staff and first-line supervisor interviews. Part of our “baseline development” approach included noting the MHP’s selection of those staff whom they viewed as relevant to the specific issues. We found that many key individuals – and consequently key areas – were absent from the review process. For example:
  - Often consumers were not included in projects directly affecting them.
  - Psychiatrists were not typically involved in projects regarding no-show rates to psychiatric appointments.
  - IS or data analytic staff was not always included in QI discussions.

In year three, we specified that the performance management session required all members of the senior management team, key staff and other stakeholders such as consumers and family members. For PIP discussions, we specified inclusion of the MHP’s PIP committee and other staff involved in PIP interventions, as well as the senior management team.

- **Increased depth of discussions.** By requesting that specific individuals participate in the review process, we were able to facilitate more in-depth conversations. As compared to last year, we met with an increased number of MHPs’ IS implementation teams to discuss their progress with new systems. These discussions were accompanied by a hands-on demonstration of core processes (consumer registration, service entry and claim production) by clinical and clerical users, which in turn facilitated a more intensive review of who uses the IS and for what activities. Approved claims data also served as the foundation for in-depth discussion of issues such as penetration rates, hospitalization rates and service inequities. These discussions focused on what MHP processes might contribute to problems and how the MHP is attempting to measure and ameliorate them.

- **Added visits to MHP, contract agencies and other sites.** In year three, we increased site visits to locations other than the MHP's centralized administrative offices. Based upon our year two review, we specified certain programs and/or sites whose staff members had the most knowledge of and day-to-day experience with specific review areas.
  - Using approved claims we identified:
    - Particular programs that served high-risk or underserved populations
    - The largest contract providers in the service area, especially if we had not reviewed that provider in previous years
  - We identified Federally Qualified Health Centers (FQHCs), since one of our goals was to facilitate relationships between the MHP and primary care providers. Since FQHCs have the option to provide mental health and other services (including substance abuse treatment) onsite or through another provider, their relationships with MHPs were not necessarily contractual and therefore did not necessarily require coordination.
  - We specified particular sites for consumer/family focus groups or staff interviews, including consumer-friendly locations such as wellness centers, clubhouses, drop-in centers or other service delivery sites. Since outlying areas of counties often represent potential barriers to access, we traveled to those areas to have discussions with consumers, families and staff. We also emphasized holding focus groups at service sites in underserved communities, since their respective populations often experience barriers to access.
- **Increased numbers and specificity of consumer/family member focus groups.** We continued to request consumer/family member focus groups that targeted issues previously identified as significant or problematic for the MHP. For example:
  - *Access:* One MHP had access barriers for beneficiaries living in an outlying rural area. The review team requested a focus group at that outlying location.
  - *Timeliness:* Another MHP had long wait times for intake assessments and psychiatry appointments. We requested a focus group of individuals who initiated services within the past year to better understand their experiences.

## Post-Site Review Process

Established in the first two years of our contract, the post-site process continued to be effective in year three. Approximately one week after the site visit, the site visit team and other staff and consultants participated in a post-site meeting to discuss significant findings. This meeting continued to include the participation of our psychiatric consultant who is expert in reviewing PIPs. The entire team reviewed the application of the PIP validation tool, discussed reasons why elements were or were not met, and made recommendations for PIP improvement. Team discussions continued to be important in promoting inter-rater reliability.

We provided a draft report to the MHP and requested feedback on this draft within 15 days. This process allowed MHPs to identify any areas warranting additional clarification. Sometimes this process required extensive follow-up – including discussion and written statements clarifying CAEQRO's impressions – prior to distributing the final report.

### Site review report template

The CAEQRO report in year three was designed to increase displays of quantitative data and specific rating scales. While narrative discussion is important, we continued our efforts to quantify issues in a meaningful way. The report template is included in Attachment 9.

We found that the report template developed in year two served as a solid foundation for our year three report. Major changes to the template involved consolidating some of the narrative and expanding the displays of data. The improvements to the report from last year are listed below.

- **Delivery system performance management.** This section reflects the themes underlying the reviews:
  - Strategic emphasis – including the MHP's strategic initiatives and other priorities
  - Significant delivery system changes since the last review
  - Utilization of data for performance improvement
- **Medi-Cal claims data for managing services.** This section includes the following data tables, all newly developed for this year's report format:
  - CY05 approved claims data – comparing the MHP's data against the region, MHPs of a similar size and statewide summary data:
    - Overall – penetration rate and average approved claims per beneficiary served
    - Foster care youth – penetration rate and average approved claims per beneficiary served
    - Hispanics – penetration rate and average approved claims per beneficiary served
    - Any other demographic issues warranting highlighting
  - CY05 Medi-Cal eligibility and approved claims from comparable counties – comparing key elements with two MHPs identified by the MHP as comparable.
  - Retention rates – identifying the number and percent of beneficiaries receiving a particular number of services, compared against statewide averages and range of MHPs.
  - Medi-Cal claims history – identification of beneficiaries served, penetration rates, and approved claims for the three prior fiscal years.

- Medi-Cal denied claims information – the percentage of denied claims for the MHP, compared with the range of all MHPs and the two comparable MHPs
- **Performance measurement results.** The two elements identified as performance measures in last year’s statewide report compared:
  - The MHP’s relative penetration rates for Hispanics versus Whites and for Females versus Males
  - The MHP’s relative approved claims per beneficiary served for Hispanics versus Whites and for Females versus Males

The table also included the data for the statewide average and the two MHPs that the MHP identified as comparable.

- **Performance Improvement Project validation.** This section and the summary table within this section were revised to reflect the new validation tool.
- **Recommendations.** We organized recommendations by domains: access, timeliness, quality, outcomes and IS. We also listed priority recommendations within each domain.
- **Attachments.** We included a list of the participants, the review agenda, data provided to the MHP, detailed PIP validation tool and the PIPs that were submitted by the MHP.

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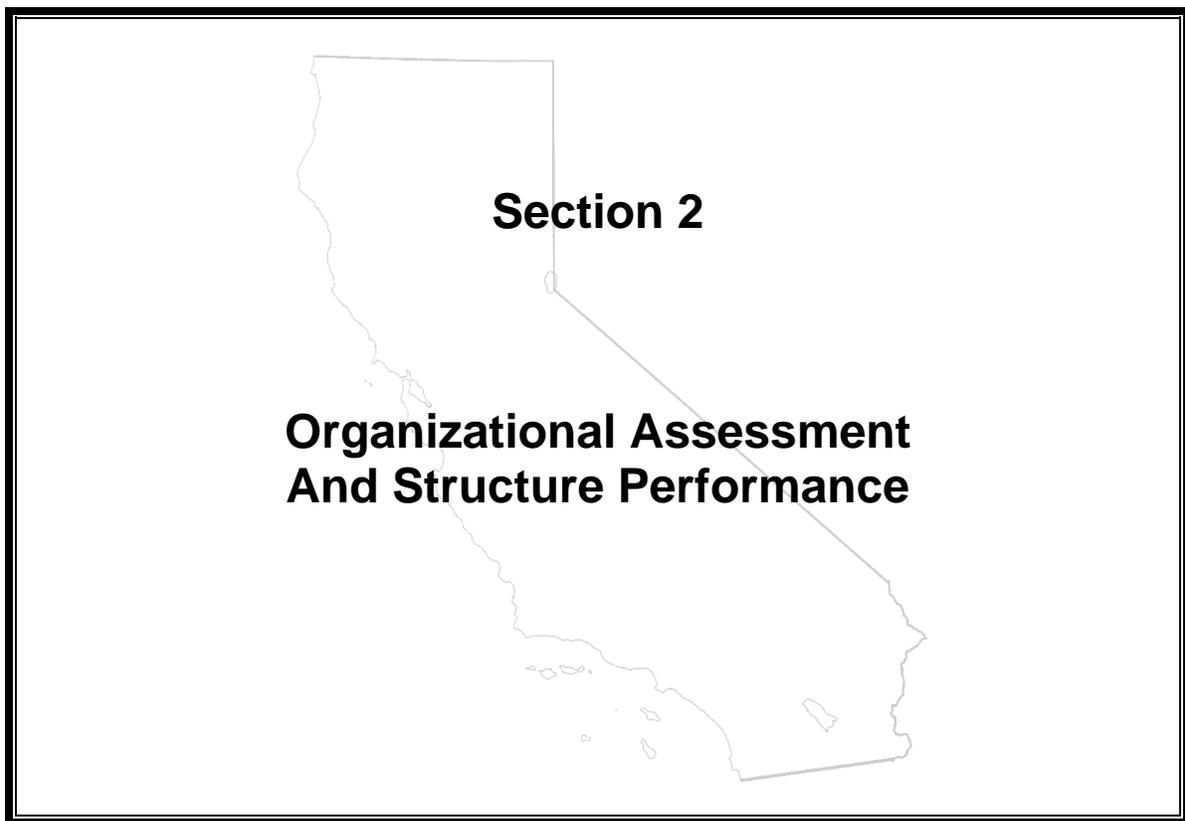
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**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 2.1: Overview

California External Quality Review Organization (CAEQRO) observed that in year three, mental health plans (MHPs) continued to face the challenges that we observed during the previous two years – with the additional demands of implementing programs funded by the Mental Health Services Act (MHSA). These demands continued to have a considerable influence on MHP priorities and how they allocated resources for this year's site review process. This section begins with a discussion on the environment in which MHPs continue to operate, since it provides an important context for all of our site review findings. We then structure our organizational assessment based on major priorities for Fiscal Year (FY) 2007:

- **Section 2.2 – Site Review Findings**
  - *Follow-up to the recommendations in our year two 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.
  - *Consumer involvement in service delivery and recovery-oriented programming.* We observed a gradual improvement in this area from FY06 to FY07 – largely related to programmatic improvements associated with MHSA initiatives.
  - *Focus on performance management.* As in previous years, we highlighted strengths, challenges and recommendations that address the need for data-driven decision-making.
- **Section 2.3 Health information systems review**
  - *Information Systems Capabilities Assessment (ISCA) V6.1.* The ISCA findings that follow in this section were produced from information contained in the improved ISCA database, which now stores three full years of MHP information systems (IS) data.

Also included in this section is a summary of our findings related to Performance Improvement Projects (PIPs), which continued to be the most challenging aspect of the review process for nearly every MHP and significantly affected by conflicting demands.

## Section 2.2: Site Review Findings

In year one, 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 because of MHSA's comprehensive planning process. In year three, most MHPs were beginning to implement new MHSA-funded programs, which provided many opportunities for innovation. However, MHSA-related activities not only continued to be a priority for many MHPs (minimizing their focus on CAEQRO-related activities), but also began to create a new set of challenges within the public mental health system. These

challenges, among others highlighted below, provide an important context for our FY07 site review findings.

## Environmental Considerations

Statewide, we observed the following:

- **Financial paradox.** Most MHPs were still enjoying the promise of increased funding and expanded services for some populations through MHPSA, while simultaneously tackling budget problems affecting both Medi-Cal and indigent programs. In fact, many MHPs found that MHPSA funding was inadequate to stem budgetary crises that had been building over time. As we discussed in Section 1, 50 percent of MHPSA funding must be spent on full service partnerships within the next two years, and these funds can not be diverted to pay for unbudgeted or under-budgeted programs/services. As a consequence:
  - Services to the indigent have been reduced or eliminated in many MHPs.
  - While MHPs were developing high-cost MHPSA-funded programs for small numbers of consumers, they were simultaneously grappling with strategies to deal with much larger numbers of consumers whom they were already having difficulty serving.
  - As two separate funding streams, Medi-Cal and MHPSA each carry a myriad of different compliance requirements. The demands of these different revenue sources have also created parallel delivery systems – often creating stress and confusion for MHP staff, consumers, families and communities.
- **Workforce development challenges.** Despite approved MHPSA plans and funding, many MHPs faced challenges in moving forward with program implementation, particularly in hiring new staff. Recruitment of bilingual and/or bicultural clinical staff was especially difficult since nearby MHPs and contract providers often had the same small pool of qualified applicants. Workforce issues affected MHPs' priorities and many were unable to devote resources to QI activities – even those MHPs with long histories of strong QI programs.
- **Conflicting priorities.** After three years of CAEQRO reviews, many MHPs understood the importance of determining whether outcomes were in line with resource allocation – despite their lack of staff to collect or analyze outcomes data. In addition, the MHPSA planning process had primed most counties for recognizing the importance of incorporating stakeholder input and data for strategic management. However, for many MHPs, the CAEQRO review became a lower priority than in previous years because of conflicting priorities. As we highlight in Section 1, MHPs now undergo a substantial number of audits annually, which carry financial penalties – and are currently facing even more oversight and accountability because of MHPSA compliance requirements. This reality drove MHPs to assign valuable staff resources to meeting mandates linked to funding, rather than to improving clinical outcomes and the overall delivery system.

## MHP Response to Year Two Recommendations

Follow-up to our year two recommendations was a major focus of our site review process. As we discuss in Section 1, we highlighted key areas in each MHP's notification letter and devoted a significant portion of the site visit to addressing the MHP's response to the recommendations in our FY06 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 to the five to eight FY06 recommendations. To support each rating, the corresponding recommendation included a summary of the MHP's responses – discussions, activities and plans or lack thereof.
- **MHP summaries.** As in our year one and year two 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 FY06 report and the status rating for each recommendation. These findings are based on an aggregate analysis of the status of the 168 recommendations, three from each of the 56 MHP summaries.

### Definition of ratings

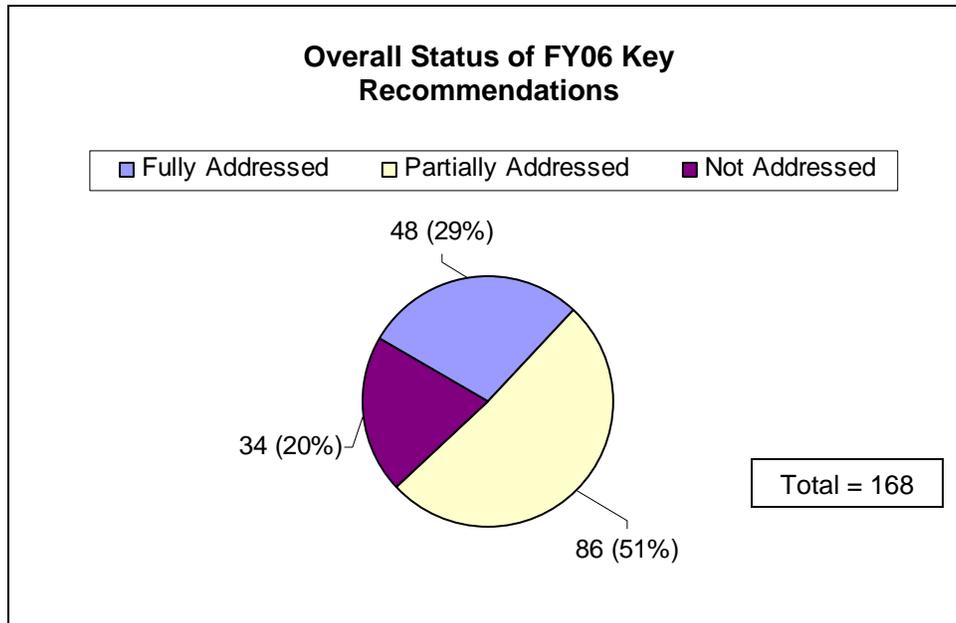
Consistent with our process in year two, we were interested in assessing whether the MHP had addressed the issue and agreed on a response, regardless of whether staff had followed our specific recommendation. This approach guided our rating system, which we summarize below:

- **“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:
  - If the MHP initiated a very limited number of activities during the year toward the long-term solution of a complex issue
  - If the MHP implemented a partial solution to a concrete issue that could reasonably be resolved within a year
  - 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 FY06 recommendations

Figure 2.1 below displays the status of FY06 recommendations for all MHPs, as determined in our FY07 reviews. Overall, we found that most MHPs initiated at least some activity to address our recommendations. Even many MHPs without active QI programs reported that the issues we identified in our reports were valid and warranted attention.

**Figure 2.1**

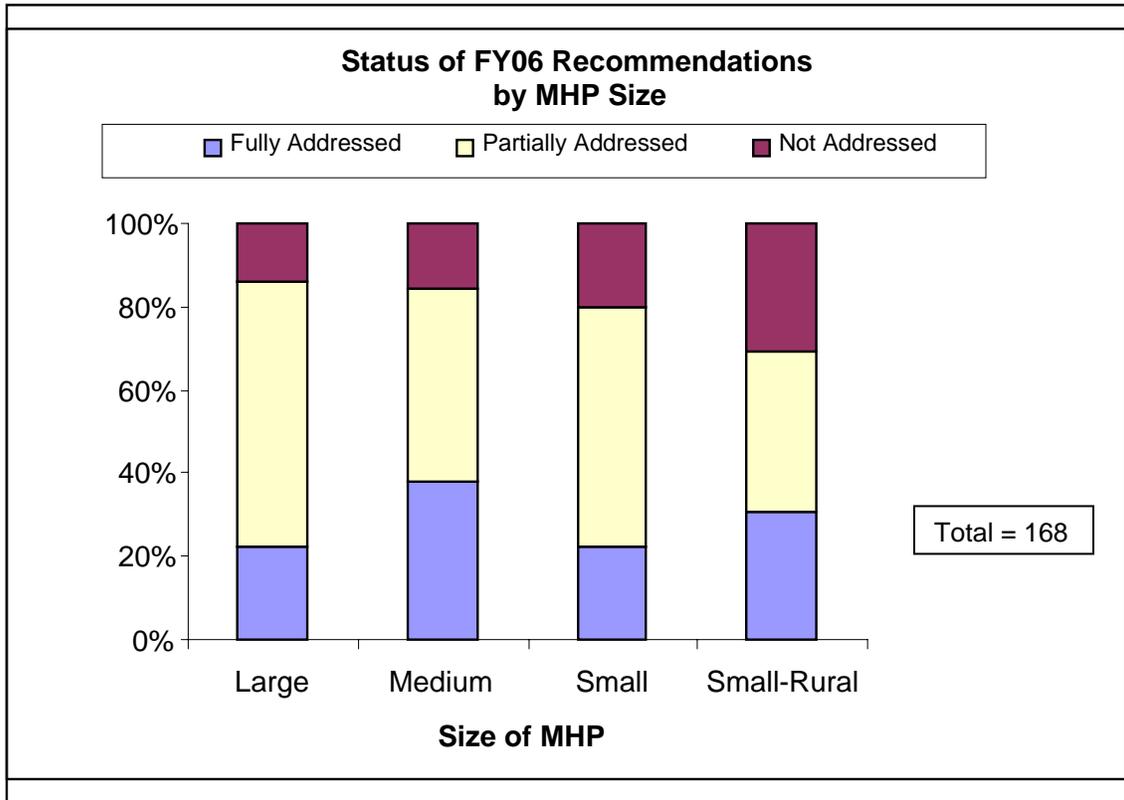


MHPs addressed a greater number of recommendations this year than they did last year:

- Eighty percent of the top three recommendations were rated either “fully” or “partially addressed.”
- Only one MHP received a rating of “not addressed” for all three recommendations.
- Most MHPs (84 percent) fully or partially addressed two or more recommendations.
- Thirty-one MHPs (more than 50 percent) had at least one recommendation rated “fully addressed.” Similarly, more than 50 percent of all MHPs either fully or partially addressed all three recommendations.

Figure 2.2 below illustrates the variable success among MHPs in different size categories in addressing CAEQRO’s year two recommendations.

**Figure 2.2**



Though small-rural MHPs fully addressed a greater percentage of recommendations than did small and large MHPs, small-rural MHPs also had the greatest percentage of recommendations that were not addressed at all. Of the 34 recommendations statewide that were rated “not addressed,” 39 percent of them pertained to small-rural MHPs. Resource availability in the smaller MHPs clearly affected their ability to respond to recommendations. Medium-sized MHPs had the highest percentage (38 percent) of recommendations rated “fully addressed.” However, large MHPs partially addressed 80 percent of their recommendations. Large MHPs appeared to have more difficulty implementing changes than MHPs in other size categories. One possible explanation is that large systems are more resistant and/or complex to change than are smaller systems.

Categories of FY06 recommendations

We organized our FY06 priority recommendations into six major categories, which are listed in the table below in descending order of frequency. The table also indicates the overall frequency of recommendations in MHP summaries, as well as the number that were rated “fully,” “partially,” or “not addressed.” As indicated, MHPs addressed most categories of recommendations to varying degrees. We found, however, that the type of

recommendation and the MHP size were the key factors in an MHP's success in responding to CAEQRO's FY06 recommendations.

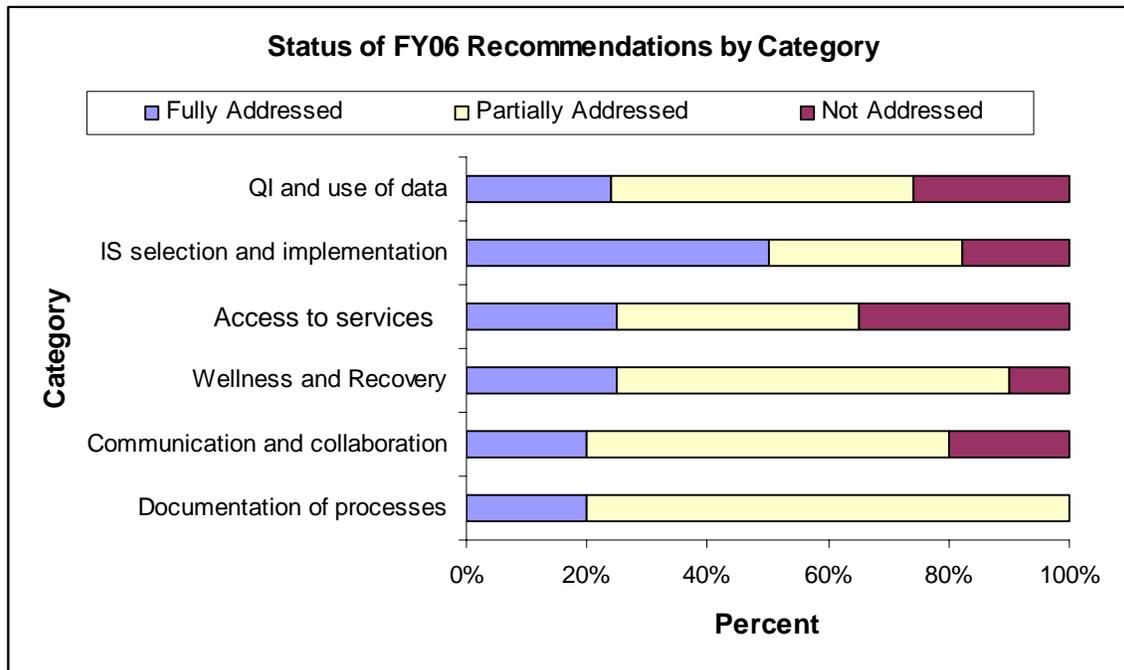
Over 90 percent of the 168 top recommendations fell into one of the six categories shown in Figure 2.3. These 154 recommendations form the basis for Figures 2.3 and 2.4 and related discussion. The remaining 14 recommendations revealed no discernible pattern and therefore are not included.

**Figure 2.3**

<b>Status of FY06 Recommendations by Category</b>				
<b>Recommendation Category</b>	<b>Fully Addressed</b>	<b>Partially Addressed</b>	<b>Not Addressed</b>	<b>Total of Category</b>
Quality improvement and the use of data	13	28	14	55
Information system selection and implementation	17	11	6	34
Access to services, including access to underserved populations	5	8	7	20
Wellness and recovery, including consumer employment	5	13	2	20
Communication and collaboration	3	9	3	15
Documentation of business processes	2	8	0	10

Figure 2.4 below presents another illustration of the status of last year's recommendations in each category across all MHPs. For instance, recommendations in the category "access to services" had the highest percentage of "not addressed" ratings. "IS selection and implementation" had the highest percentage of recommendations that were rated "fully addressed."

**Figure 2.4**



The following discussion provides further analysis of each category of recommendations.

### Quality improvement and data-related issues

One third of all recommendations were associated directly with QI and the use of data. More recommendations in this area were rated either "fully" or "partially addressed" than recommendations in the other five categories.

Within the high-level category displayed in Figure 2.4, MHPs had variable success in addressing specific types of QI recommendations:

- Use of data for quality improvement.** Consistent with our approach since year one, our most common recommendation involved the use of data for QI – accessing data, improving analytic skills and developing objective goals. Forty percent of QI-related recommendations focused on enhancing data utilization within QI processes, and 75 percent of these recommendations were rated either "fully" or "partially addressed."
- Prioritizing activities and resource allocation.** Recommendations associated with allocating resources to QI activities and work groups appeared in more than

50 percent of small and small-rural MHP reports. Yet very few of these MHPs addressed this recommendation. Establishing work groups appeared to be most difficult for small and small-rural MHPs given their limited resources. They also had particular difficulty in forming work groups to identify and implement PIPs. Other MHPs had many activities listed in their QI work plans, but the priorities for assigning resources were unclear, and only a few of the activities were truly QI-focused.

- **Broadening stakeholder involvement.** Recommendations focusing on the need to increase participation of MHP staff, consumers, family members and/or contract providers in QI activities appeared most often for large and medium-sized MHPs, and all were at least rated “partially addressed.”

Statewide, MHPs increased their efforts to engage consumers in Quality Improvement Committee (QIC) membership. Some were more successful than others at actually maintaining the continued involvement of consumers. While most MHPs attempted to recruit consumers, they failed to initiate strategies to educate and engage consumers in QI activities; consequently, consumer participation in this area was often minimal and sporadic. In many cases, this recommendation focused on increasing staff and contract provider inclusion in QI processes. Even in some MHPs with well-developed QI programs, staff reported a lack of awareness of key initiatives and contract providers were sometimes not involved at all.

### Information system selection and implementation

The category with the second largest number of recommendations focused on IS replacement, with 82 percent of the recommendations rated “fully” and/or “partially addressed.” As discussed throughout this report, most MHPs are dealing with replacing aging IS platforms. Recommendations focused on the Request for Proposal (RFP) process, project management, implementation plans and data archiving strategies. Section 2.3 includes an in-depth discussion of our findings in this area.

### Access to services

The category with the third largest number of recommendations focused on three areas:

- Analysis of low or declining penetration rates
- Outreach to and engagement of under-represented age and ethnic populations, particularly Latinos
- Assessment of service volume and capacity

Each of these areas covered a variety of access issues, including:

- Timeliness of initiation of services
- Psychiatrist accessibility
- Penetration rates for specific sub-populations
- Ease of access for underserved populations

### Wellness and recovery

Twenty recommendations for 19 MHPs addressed wellness/recovery and consumer employment. Our reports for small and small-rural MHPs contained 13 of the 20 recommendations in this category – and 93 percent of these recommendations had at a rating of “partially” or “fully” addressed. Given MHSA’s emphasis on consumer-driven services, these issues were largely addressed in the context of MHSA program development and implementation. Only two large MHPs received this recommendation as a priority recommendation, suggesting that large MHPs were already promoting recovery principles and beginning to develop consumer-driven and consumer-run wellness programs.

### Communication and collaboration

The majority of recommendations associated with communication (73 percent) were included in our reports to medium and large MHPs. Recommendations that emphasized the role of and relationship with contract providers appeared in more than 50 percent of the communication-related recommendations. MHPs generally tried to facilitate communication throughout staff, consumers, contract providers and communities, as well as to involve these same stakeholders in program planning. Follow up on this recommendation was often tied to MHSA-related activities.

### Documentation of business processes

All ten recommendations associated with documenting business processes were addressed. The frequency of these recommendations was divided evenly between medium/large MHPs and small/small-rural MHPs. Two of the small-rural MHPs fully addressed these recommendations by documenting workflows and cross-training staff. This is particularly important in very small MHPs where knowledge can rest solely with a single staff person.

## MHP Progress with Wellness and Recovery-Focused Programs

We devoted a significant portion of our site visit to discussing the MHP’s progress in developing and/or implementing programs that support wellness and recovery. 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 consumers and family members who participate in the delivery system
- Site visits to wellness or self-help centers
- Focus groups with consumers and family members

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 who are either employed by or volunteering within the MHP or a contract provider. Our findings were very similar in FY06 and in FY07 – although we significantly increased the number of interviews that we conducted this year:

- Consumer and family member employees perceived mixed reactions from the clinical staff and had varying degrees of success in establishing relationships with them.
- Consumers frequently lacked training or other support to do their jobs and in some cases were in positions where job descriptions were neither available in writing nor verbally clarified. They did anticipate receiving training and support through MHPSA programs.
- Consumers involved in MHPSA planning and other committees throughout the system often felt that they were not truly respected as equal members. In contrast, consumers involved in wellness centers felt that they were leaders and decision-makers.
- Most consumers felt that recovery concepts were progressing throughout the systems, but they did not have the same perception of success as did administrators and clinical staff.

### Wellness or self-help center site visits

The proliferation of wellness, drop-in and/or self-help centers, generally supported by MHPSA funding, was a positive change over the past year. The degree of development of these programs varied tremendously. Some had only very recently opened their doors and were in the process of developing services. In less developed programs, consumers seemed exclusively to work or craft projects and watch television. In those that were fully operational, consumers appeared to be participating in groups and meaningful activities. Many described their involvement in determining the kinds of services available at the centers, and they felt they were developing skills for employment within the MHP or within other areas of the community. Few centers were consumer-run, although that appeared to be the goal for most.

### Consumer and family member focus groups

Individuals who receive the services continue to provide among the most valuable feedback during the site visit process. As in previous years, MHPs varied in their success in organizing consumer and family member focus groups. Some claimed that it was difficult or nearly impossible to convene groups of eight to 10 consumers who met the demographics that we specified in our notification letter. For most MHPs, this activity was highly successful, as we were able to conduct groups averaging eight participants.

We tried to obtain input from consumers who could speak to a variety of issues – including ease of access to services, outreach and engagement for under-represented groups, contract providers, psychiatric services and consumer/family member involvement. While some participants had dramatically positive or negative perceptions of the services, most participants were able to speak to both strengths and weaknesses within the service delivery systems.

To obtain this broad input, CAEQRO conducted 86 focus groups that consisted of 663 consumers and family members. The participants were 57 percent female and 43 percent male. Listed below is an analysis of focus group locations – which illustrate both our emphasis on accessible service sites and the importance of contract providers:

- The largest majority (59 percent) of groups were held at MHP facilities, although often not the central administrative offices.
- 20 percent of the focus groups were held at contract provider sites.
- An additional 14 percent of the focus groups were conducted at wellness or self-help centers, which were often operated by contract providers.

Seventy-two percent of the participants were consumers, with the balance family members. Just over half of the participants appeared Caucasian and over a quarter Hispanic. Interpreters, most frequently Spanish, assisted in 25 percent of the consumer/family member focus groups conducted. As detailed below in Figure 2.5, forty-three of the groups (50 percent) emphasized a particular demographic and/or ethnic population.

Figure 2.5

Demographic/Ethnic Distribution for Focus Groups		
Specified Emphasis	Number	Percent of groups
Hispanic	17	20%
Transition age youth	11	13%
Co-occurring Substance Abuse and Mental Health	5	6%
Foster care (youth or caregivers)	5	6%
Older adults	2	2%
Asian Americans	2	2%
African Americans	1	1%

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

The major concern of consumers and families interviewed focused on various aspects of access:

- **Psychiatry and medications.** The most frequently identified concern for consumers and family members was long wait times for obtaining initial

appointments with psychiatrists. Many reported waiting three to four months before an evaluation and the provision of medications. Related concerns included frequent turnover of psychiatry staff, which subsequently resulted in undesired medication changes. Telepsychiatry was well-received by consumers when it was available.

- **Job skills training, housing, and other non-traditional treatment.** Adult consumers and parents of older youth often requested job skills training and reported either a scarcity of such programs or difficulty obtaining entry into them. Participants relayed many positives regarding drop-in centers, self-help centers and life skills classes, often requesting an additional number of groups and activities at these centers. More volunteer consumer-run or peer-support services, including “warm lines” and other networks for support, were also frequently noted. Safe and stable housing was a concern statewide.
- **Services after routine business hours.** Employed consumers and family members or those who needed assistance with transportation frequently identified the need for weekend and evening services. A similar need was expressed by those participants who emphasized that their crises occurred “after business hours.” In particular, families felt that because crisis services were not responsive, they reluctantly relied upon local law enforcement rather than mental health staff.
- **Support for families.** Many groups were unfamiliar with the National Alliance on Mental Illness or other resources for education and support. Family members, despite being a key support system, were often not a part of the services provided to their loved ones.

## FY07 MHP 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,” “information systems” or “other.” In Figure 2.6 below, we display how frequently we cited a strength or opportunity in each domain.

**Figure 2.6**

Key Evaluation Domains		
Domain	Strengths	Opportunities
Access	37	33
Timeliness	2	5
Outcomes	12	22
Quality	79	57
Information Systems	38	45
Other	0	6

In aggregating our findings for this report, we analyzed the specific strengths and opportunities in each of these domains to determine how they matched up with the more detailed categories for our FY06 strengths and opportunities. We were not surprised to find that although the frequency varied from FY06 to FY07, the categories were still quite valid. Our FY07 findings on strengths and opportunities are displayed in Figure 2.7 below:

Figure 2.7

FY07 Strengths and Opportunities			
Category	Strengths	Opportunities	Total by Category
1. Quality management and use of data	29	43	72
2. Access and disparities in access	33	34	67
3. Information Systems – use, resources, implementations	26	31	57
4. Leadership, including MHP communication and collaboration	39	10	49
5. Wellness & Recovery	25	17	42
6. Workforce	2	14	16
7. Business processes	2	12	14
8. Other (training, programs, EBPs)	12	7	19
<b>TOTAL</b>	<b>168</b>	<b>168</b>	<b>336</b>

Below we provide a discussion on the strengths and opportunities in the eight categories listed in Figure 2.7.

- **Quality management and use of data.** As in FY06, QI and data utilization issues was the most frequently noted opportunity comprising 60 percent of the total for this category. This broad category encompasses the following issues associated with quality and performance management:
  - *The ability to use available data.* As the largest area within this category, a data analytic capacity was cited in 12 strengths and 12 opportunities. Approximately 66 percent of the opportunities were noted in reports for small or small-rural MHPs for which lack of skills development was the core issue.
  - *Staff allocation and commitment to quality improvement.* The next largest sub-category, this area was noted as an opportunity in all MHPs but was predominant in small and small-rural MHPs. A number of MHPs demonstrated an inability to conduct basic QI monitoring, generally because QI staff were focused on MHSA, chart reviews and other compliance activities. For six MHPs this issue was noted as a strength because staff were either added to the QI unit or demonstrated enhanced analytic skills.

- *Prioritizing quality improvement projects.* The other major sub-category involved developing a clear QI work plan, as well as identifying a small number of key indicators to monitor and improve. This category included recommendations regarding incorporating organizational, programmatic, and cultural competence goals within the QI infrastructure. Only a few MHPs demonstrated the ability to routinely monitor outcomes to promote QI, whereas this activity was stated as an opportunity in over 30 percent of the MHPs.
- **Access to services.** Both a strength and an opportunity, access to services – including disparities in penetration rates – is the second most frequently cited issue. More frequently identified as an issue in FY07 than in FY06, access to services was cited as a strength for only three large MHPs.

Strengths in this area for all MHPs included:

- High penetration rates, either overall or for various sub-groups (36 percent)
- Timely access to appointments, including triage, intake or psychiatry (12 percent)
- Services designed to enhance access for under-served groups, including Latinos, Southeast Asians, TAY, and foster care youth (12 percent)
- Integration of services enabling ease of access for co-occurring mental health and substance use disorders (6 percent)

Of significance, access was consistently noted as a strength for those MHPs that employed drop in or other open access models.

Almost all opportunities in this area were associated with low penetration rates and other indicators of barriers to access. Low rates of penetration and retention for Latino beneficiaries was most commonly cited (21 percent), followed by complex admission processes (21 percent), and difficulty accessing services from outlying areas (10 percent). This last issue, although discussed frequently during reviews, was often too specific to be listed in the top three recommendations. As frequently noted in consumer and family member focus groups, access to psychiatric services and retention of psychiatric staff presented a widespread barrier. Despite acknowledged recruitment problems, many MHPs resisted considering tele-psychiatry to promote access to medications.

- **Information systems and information system resources.** This area was the third most frequently noted, almost equally represented as a strength and an opportunity. In 15 MHPs, the IS staff skills, knowledge or collaborative approach with QI staff were identified as strengths – representing over 50 percent of the strengths in this area. The balance identified the MHP's implementation of a new IS as a strength.

For 77 percent of the opportunities, the issue centered on IS-related resources – either the lack of staff to support the IS or to access (or assist in accessing) data and reports. These issues were identified in MHPs of all sizes.

- **Leadership, including communication and collaboration.** This category emerged as significant and was identified as a strength in 80 percent of the citations. In 20 percent of the MHPs, the leadership style and strategies were cited as positively affecting staff morale. We noted a marked increase in MHP's efforts and success in communicating within its own department and among other county and community agencies. Small and small-rural MHPs were noted as having strong collaboration with other entities. As a weakness, lack of collaboration was most common among large MHPs. The few MHPs for which this area was noted as a strength tended to maintain this orientation from year to year.

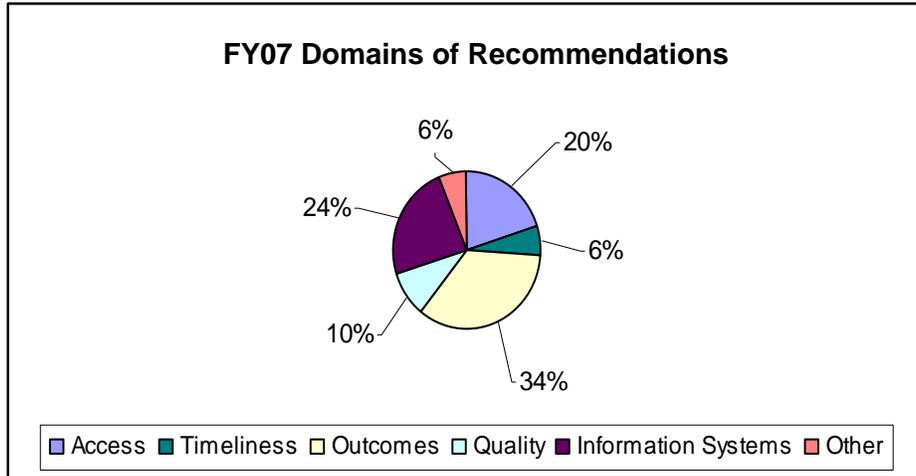
When we noted the issue of leadership specifically, it was generally identified as a strength. The aspect of leadership that was frequently captured as a workforce issue was staff retention and morale. We found that it was more feasible to identify the areas that weak leadership were affecting and commenting on those specific areas rather than the leadership itself.

- **Wellness and recovery.** This area was frequently cited by all CAEQRO reviewers and was noted as a strength in 60 percent of our citations. Topics included: wellness centers, consumer-driven or consumer-run programs, consumer and family member involvement in MHP processes, and consumer or family member employment. Wellness-related programs or activities were usually identified as a strength. This area was cited in a disproportionate number of medium-sized MHPs.
- **Workforce.** Fourteen of the 16 items associated with workforce addressed workforce opportunities. Present as a priority problem area in 25 percent of MHPs, these issues included low staff morale and difficulties with recruitment and retention of staff. Recruitment and retention of bilingual, bicultural staff were dominant issues throughout the state.
- **Business processes.** This category included denial rates, low reimbursement, business practice assessments, and policies and procedures. Of the 14 references, 12 were "opportunities for improvement." Issues associated with business process were prevalent in small and small-rural MHPs.

## FY07 Recommendations

In response to the strengths and opportunities cited in Figure 2.6, we made a number of recommendations within each MHP report. Five key recommendations – a total of 280 recommendations – were extracted from each report and included in the MHP summaries that comprise Volume II of this report. Figure 2.8 below displays the percent of recommendations in the domains of "access," "timeliness," "outcomes," "quality," "information systems" and "other."

**Figure 2.8**



Over 80 percent of MHPs had recommendations associated with quality and performance management processes. Sixty-three percent of MHPs had one or more priority recommendation regarding access to services. Ongoing issues associated with IS implementations warranted recommendations as well.

As we did in analyzing specific strengths and opportunities, we organized our recommendations according to the more detailed categories in our FY06 report – which are displayed in Figure 2.3. Again, we were not surprised to find that although the frequency varied from FY06 to FY07, the categories were still quite valid. Our FY07 recommendations are displayed below:

**Figure 2.9**

<b>FY07 Recommendations</b>	
<b>Category</b>	<b>Number</b>
Quality management and use of data	74
Timely access and disparities in access	60
Information systems – use, resources, and implementations	45
Wellness and recovery	33
Business processes	19
Leadership, including MHP communication and collaboration	18
Workforce	13
Other	13
<b>TOTAL</b>	<b>277</b>

## Section 2.2.1: Performance Improvement Projects

Consistent with year two, each MHP was required to have two active and ongoing PIPs available for review, one clinical, the other non-clinical. While we enhanced the process for FY07, the overall review procedure was as it had been in each of the previous years. As we describe in Section 1.3 and in Section 3.2, we asked each MHP to submit PIPs on a form that we modeled after our “Road Map to a PIP” – the training tool we had developed in year two. In addition we revised the evaluation tool to provide more specific detail about the activities covered under each of the evaluation elements required by the Centers for Medicare & Medicaid Services. Our intent was to increase the concrete feedback we provided to the MHPs to assist them in developing their PIPs. The tool also identified the 13 “key elements” of a PIP – which in effect comprised the critical path to completing any successful PIP.

On the following pages, we include the following categories in describing our findings:

- Total PIP activity
- PIP descriptive data: status, content area, specialty population, domain
- PIP evaluation tool scoring: key variables
- By MHP size as relevant
- In comparison to last year when relevant

As our findings suggest, PIPs remained the most difficult and confusing part of the review for most MHPs, just as they had been in years two and one. However, we did observe some significant positive changes during year three, as discussed below.

### Total Performance Improvement Project activity

In year two the maximum number of PIPs for review was 110. Because Alpine and Solano MHPs were in their first year of review, each was required to complete only one PIP instead of one clinical and one non-clinical PIP. In year three, the total possible number of PIPs was 112.

Although the number of evaluation categories increased in year three, a reasonable comparison is still possible. As Figure 2.10 illustrates, this year significantly more PIPs qualified as “active/ongoing” or “completed” with a corresponding increase in the percentage: in year two 43 percent of PIPs were active, increasing in year three to 54 percent.

**Figure 2.10**

<b>PIP Status – FY07</b>					
<b>FY07</b>				<b>FY06</b>	
<b>PIP Status</b>	<b>Clinical</b>	<b>Non-Clinical</b>	<b>Total</b>	<b>PIP Status</b>	<b>Count</b>
Completed	1	0	1	Active	47
Active	31	28	59		
Concept/Design	7	7	14	Concept/ Little Activity/ None	63
Little/No Activity	6	8	14		
None	11	13	24		
<b>Total</b>	<b>56</b>	<b>56</b>	<b>112</b>		<b>110</b>

Even more positive than the increased number of active PIPs is the reduction in the number of MHPs who presented no PIPs for review. Figure 2.11 shows the distribution for FY07 of MHPs with two, one and no PIP(s). In FY06, 28 MHPs had no PIPs as compared to only six in FY07.

**Figure 2.11**

<b>Overall PIP Count – FY07</b>	
<b>Count of MHPs with:</b>	<b>Count</b>
Two PIPs	38
One PIP	12
No PIP	6
<b>Total</b>	<b>56</b>

Not surprisingly, the number of active PIPs varied by county size. Small-rural and small MHPs have major challenges in managing the PIP process. Resources, data, technology limitations and limited numbers of consumers all contributed to their difficulties in considering, planning and executing the necessary tasks for a reasonable PIP. However, by year three most small and small-rural MHPs also understood that federal regulations require their participation regardless of their challenges. As described in Section 3, during year three SCERP members decided to collaborate in developing one or preferably two PIP(s). At the time of their reviews, a number of MHPs were involved in that planning process. Consequently, some who were waiting for the SCERP PIP had only one active PIP eligible for review.

Figure 2.12 shows the differences in the status of PIPs between small-rural and small MHPs in comparison to medium and large MHPs. (For these tables, Los Angeles is included in “large” since its numbers do not overly influence the totals.)

**Figure 2.12**

<b>PIP Count by MHP Size – FY07</b>					
<b>Count of MHPs with:</b>	<b>Small-Rural</b>	<b>Small</b>	<b>Medium</b>	<b>Large</b>	<b>Total</b>
Two PIPs	8	7	11	12	38
One PIP	3	6	2	1	12
No PIP	3	2	1	0	6
<b>Total</b>	<b>14</b>	<b>15</b>	<b>14</b>	<b>13</b>	<b>56</b>

### Performance Improvement Project descriptions

This year we assigned each active PIP available for review (N = 88) to one of a list of content areas derived from our analysis of last year's PIP topics. We will continue to refine and modify our categories as a result of this year's results. Figure 2.13 shows the content categories in descending order according to frequency and MHP size.

**Figure 2.13**

<b>PIP Descriptive Category by MHP Size – FY07</b>						
<b>Descriptive Category</b>	<b>Small-Rural</b>	<b>Small</b>	<b>Medium</b>	<b>Large</b>	<b>Total</b>	<b>Percent</b>
Improved Diagnosis or Treatment Processes	9	8	7	9	33	38%
Co-occurring Disorders	0	0	4	5	9	10%
Use of Acute or Inpatient Services	3	4	1	1	9	10%
Business Process Improvement	1	1	5	1	8	9%
Psychiatrist/Medication Appointment	2	2	1	2	7	8%
Retention	1	2	1	3	7	8%
Physical Health Care	0	1	3	1	5	6%
Other	3	2	2	3	10	11%
<b>Total</b>	<b>19</b>	<b>20</b>	<b>24</b>	<b>25</b>	<b>88</b>	<b>100%</b>

As Figure 2.14 illustrates, the majority of PIP categories apply across all size groups. However, small-rural and small MHPs had no PIPs on co-occurring disorders and appeared to concentrate their efforts on acute and inpatient services more than did medium and large MHPs.

In year three we also began identifying PIPs by their target population. Although we were not able to characterize all PIPs in this manner, some patterns emerged. We will continue to review and refine these categories. Figure 5 shows that MHPs targeted PIPs for adult populations to a much greater extent than for children or youth.

Figure 2.14

PIP Target Populations – FY07		
PIP Specialty Population	Specialty Population Number	Percent
Adult/Older Adult	32	37%
All Populations	24	27%
Transitional Age Youth/Foster Care	10	11%
Other Age Group	2	2%
Latino/Hispanic	1	1%
Other	19	22%
Total	88	100%

Finally, we attempted to assign each PIP to its predominant domain of access, timeliness, quality or outcomes. These key areas of our review enable us to identify strengths, opportunities and recommendations. While access overlaps with timeliness and quality with outcomes, we attempted to identify the domain that best fits each PIP. Figure 2.15 shows the initial spread of domains for year three PIPs. We will continue to evaluate whether this rating is valid, reliable and useful.

Figure 2.15

PIP Domain by MHP Size – FY07						
PIP Domain	Small-Rural	Small	Medium	Large	Total	Percent
Access	10	4	7	7	28	32%
Quality of Care	5	4	7	11	27	31%
Outcomes	3	9	9	3	24	27%
Timeliness	1	3	1	4	9	10%
					88	100%

#### Performance Improvement Project evaluation tool

The new evaluation tool for year three consisted of 44 ratings – 13 of which are considered “key variables.” Meeting all 13 key variables is essential for a PIP to be successful. We describe the use of this tool in Sections 1.3 and 3.2 and include a blank evaluation tool as Attachment 11. Attachment 12 shows the scores for each of the 44 items for all 88 PIPs that were scored.

Our discussion in this section concentrates on the scores of the 13 key variables only. Figure 2.16, the Key Criteria Rating summary, displays these scores.

**Figure 2.16**

Key Criteria Ratings – FY07						
Section Label	Section No	Question No	Question Text	Met/Partially Met	Not Met	Total
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

The descending numbers under “met/partial” suggest a learning curve that involves the following:

- Accurate identification of an important area of study has been a strength of the MHPs since year one. It requires experience and programmatic skills. It does not necessarily require a data base or baseline measures.
- An adequate and well-defined study question does require a more precise definition and benefits from concrete data to assist in developing that definition as well as to define a concrete outcome that can be demonstrated. Developing a precise study question goes well beyond a more conceptual definition about “improvement.” Lack of data hinders this process.

The ability to identify the study population also increased (as illustrated by the improvement in scores), since the ability to define characteristics of a consumer group need not depend on access to quantitative data. In addition, definitions of specific indicators have improved; however many MHPs’ skills at establishing defined

connections among indicators, data elements and interventions need additional development.

Lower scores on data analyses and results reflect that relatively few PIPs have continued long enough to reach that stage of activity. Many MHPs discarded their original PIPs and selected new projects once or even twice as their understanding of PIP requirements continues to increase.

## Section 2.3: Analysis of Health Information Systems

CAEQRO is responsible for the independent review of the health IS at each MHP in the state. Although the ISCA survey is mandated by Centers for Medicare & Medicaid Services (CMS), the model federal protocol serves only to provide guidance on the intent, process and purpose of a health information systems review.

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. By posing standard questions the ISCA survey assists CAEQRO in assessing the extent to which an MHP is capable of producing valid encounter data<sup>2</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 is therefore the foundation of our IS review.

Since year one, we have made a number of improvements to the survey that reflect both our increased experience with California's complex public behavioral health system and our continued commitment to respond to stakeholder input. Over the past two years, the evolving public behavioral health environment was changed by advances in information technology (IT). For example, some MHPs:

- Incorporated features of electronic health records into their behavioral health IS applications
- Implemented at least a precursor to an electronic health record

Access to consumer diagnostic history within the IS – for physical health and co-occurring disorders (COD) – was recognized as important to effective care. CAEQRO adapted by adjusting our IS review process and refining the foundational tool, the ISCA survey – a process that began in year two and was completed at the beginning of year three.

On the following pages, we summarize the evolution of the ISCA survey, recap the CAEQRO IS review process, and highlight our FY07 ISCA findings.

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<sup>2</sup> "For the purposes of this report, an encounter refers to the electronic record of a service provided to an 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.

## CAEQRO Information Systems Review Process and Tools

The CAEQRO IS review process, which has remained consistent since our year one statewide review, has included these four consecutive activities:

- **Step One** involves the collection of standard information about each MHP's IS by having the MHP complete an ISCA. The survey includes requests for information and documents from the MHP. A checklist at the end of the ISCA summarizes the required information.
- **Step Two** involves a review of the completed ISCA 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 or are knowledgeable about administrative or delivery system processes. The purpose of the interviews is to gather additional information to assess the integrity of the MHP's IS.
- **Step Four** produces an analysis of the findings from both the ISCA and the follow-up discussions with MHP staff. CAEQRO includes a summary of the findings in the IS section of the site review report we provide to each MHP. In the report, we address the MHP's ability to collect and use data to support business operations, conduct quality assessment initiatives and measure QI efforts. We also consider the ability of the MHP's IS to support the overall goal of quality management in providing mental health services to beneficiaries.

### Evolution of the CAEQRO ISCA

While the overall IS review process has remained constant, specific aspects evolved over time as we gained additional knowledge and experience – and responded to changes in the local and national landscape. For example, over the last few years, health care organizations nationwide are emphasizing electronic health records. In response, CAEQRO now includes queries about the MHP's progress in adopting an electronic health record. Since the ISCA is the foundation of our information gathering activities, it too has changed.

- **Year one.** CAEQRO used the federal protocol (Appendix Z Information Systems Capabilities Assessment for Managed Care Organizations and Pre-Paid Health Plans) as the basis for development of a California focused ISCA. During year one, we created several iterations of the ISCA as we refined the survey, although we collected the same basic set of information throughout the year.
- **Year two.** We streamlined the ISCA process for those MHPs that had completed a full ISCA during the previous year. With the help of DMH and several stakeholders, we developed an abbreviated "Information Systems Review Supplemental Questionnaire." MHPs that completed a full ISCA in year one were only required to complete the questionnaire in year two. Thus, during year two, 39 MHPs completed ISCA V5.7, while 17 MHPs completed the supplemental questionnaire. Our goal at the end of year two was to create a new standard ISCA survey for all MHPs in year three.

## Current ISCA V6.1

Prior to the end of FY06, CAEQRO developed ISCA V6.1 with input from the California Mental Health Director's Association (CMHDA) and its IT committee, representatives of many MHPs of various sizes and geographic locations, and experience gained from an Orange County pilot for the original supplemental questionnaire. This version incorporates the best and most useful portions of the original ISCA and the supplemental questionnaire, and was accepted by the California Department of Mental Health (DMH) as the official ISCA survey for FY07. Notification packets distributed during May 2006 for July reviews included the new ISCA V6.1. Thus, during year three every MHP completed a common ISCA survey.

ISCA V6.1 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 IS manager to answer questions within the document and returned as a completed survey to the CAEQRO. However, the ISCA is not confined to IS or IT 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 13.

- **Section A – General information**  
In this section, we establish the status of the current IS, modules included in the IS, top priorities of the IS department, makeup of system 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 with regard to timeliness and accuracy of data entry, system table maintenance, training capacity, access to and analysis of data, communication with system 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 considerations around 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 improvements

From 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 IS 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 questions as possible and appropriate.

In year three, in addition to creating an improved, standardized ISCA, CAEQRO rewrote the corresponding ISCA database. The database stores MHP responses to many of the quantitative and qualitative elements from the ISCA survey. The new database not only stores new data elements collected using ISCA V6.1, but also enables us to more readily retrieve data for reporting purposes. For selected data elements, the ISCA database now stores three full years of MHP IS information. The ISCA findings that follow in the section below were produced from information contained in the improved ISCA database.

### Information Systems Findings

CAEQRO currently has three full years of detailed information, as listed below, on all 56 MHPs' IS:

- Types of IS that MHPs use
- How long MHPs have used their respective IS
- How MHPs use their IS to collect data
- The quantity and quality of data collected by MHP staff
- How MHPs report data to internal and external customers
- What specific MHP staff uses the IS
- Which MHPs are planning to move from a legacy system
- Which MHPs are in various stages of implementing a new IS

Because of this substantial database of historical information, we were able in year three not only to analyze our current findings, but also to identify the following:

- Changes over time for items routinely collected over the last two to three years
- Findings for new items collected for the first time with ISCA V6.1

In the tables and charts that follow, we present our ISCA findings for year three.

**Information systems vendors and products**

As illustrated by Figure 2.17 below, the number of vendors has not changed

The vendor slate remains stable – but the proportion of MHPs per vendor is changing. Movement toward electronic health records may draw more vendors to California.

substantially since year two. However, there has been a slight change in the number of MHPs each vendor supports. This transition will escalate over the coming years, as more MHPs move to acquire and implement new systems. In addition, efforts by DMH to release a request for information (RFI) to support MHP acquisition of electronic health records may result in an increased number of vendors entering the California marketplace. However, building a public behavioral health

IS that responds to unique California billing and reporting requirements is a daunting effort, as the FY07 exit of one player with two installations suggests.

**Figure 2.17**

<b>Current MHP Information Systems by Vendor and County Size</b>								
<b>Vendors and Products</b>	<b>Small</b>		<b>Medium</b>		<b>Large</b>		<b>Total</b>	
	FY06	FY07	FY06	FY07	FY06	FY07	FY06	FY07
Anasazi	0	2	0	0	0	1	0	3
Cerner	0	0	0	0	1	1	1	1
Echo CD/RM	1	1	0	0	0	0	1	1
Echo INSYST	11	10	10	10	6	6	27	26
Echo ShareCare	1	1	2	0	0	0	3	1
HSD Diamond	0	0	1	1	1	1	2	2
InfoMC eCura	0	0	4	4	5	5	9	9
Locally developed system	2	1	3	4	1	5	6	10
Netsmart Avatar	3	3	1	1	0	0	4	4
NetSmart InfoScriber	2	1	0	0	0	0	2	1
NetSmart CMHC	10	10	1	1	0	0	11	11
NetSmart CSM	0	0	0	0	1	2	1	2
Platton Technologies Clinician's Gateway	0	0	2	2	0	1	2	3
Qualifacts/CalCIS	1	0	0	0	1	0	2	0
Sierra Integrated Systems	0	0	0	0	1	1	1	1
UniCare Profiler	0	0	0	0	1	1	1	1
Total	31	29	24	25	18	24	73	76

Note: Several MHPs recorded use of multiple systems for different IS functionalities.

Most noteworthy in the figure above is the following:

- Entry of Anasazi into the California marketplace with three MHPs using their system in FY07 – an increase from none in FY06
- Exit of Qualifacts/CalCIS, declining from two to zero since FY06 – following the vendor’s decision to end development of the product

- Increased use of locally developed systems, especially by the large MHPs

**Selection and implementation of new information systems**

The number of MHPs actively searching for or transitioning to a new IS has increased substantially since year two. As expected, the number of MHPs with no plans or a vague interest in a new system is extremely low. These findings displayed in Figure 2.18 clearly suggest an unprecedented level of change with the core IS infrastructure for California’s public mental health system – which can have significant consequences.

MHPs are searching for or implementing replacement IS in unprecedented numbers. Implementations skyrocketed from 5 percent of MHPs in FY06 to 30 percent in FY07, with small counties in the vanguard.

**Figure 2.18**

<b>New Information System Status</b>				
	<b>FY06</b>		<b>FY07</b>	
	<b>Number</b>	<b>Percent</b>	<b>Number</b>	<b>Percent</b>
No plans for new information system	9	16%	5	9%
Considering new information system	8	14%	4	7%
Actively searching for new information system	11	20%	17	30%
New IS selected, not implemented	19	34%	7	13%
Implementation in progress	3	5%	17	30%
Extended implementation	6	11%	-	-
New system in place	-	-	6	11%
<b>Total</b>	<b>56</b>	<b>100%</b>	<b>56</b>	<b>100%</b>

Note: “Extended implementation,” a separate category in FY06 was recorded as “new system in place” or “implementation in progress” in FY07. “No plans for new IS” last year included some newly installed systems that fit the new category “New system in place.”

Major changes underway in IS search and selection activity are evident in the figure above comparing FY06 and FY07 activity.

In FY07 we found that:

- Fewer MHPs with “no plans” for IS change or “considering”. Many of the MHPs in this status last year have moved into an active status

- Many more MHPs in an active search effort, which may mean releasing an RFP or contract negotiations with a potential vendor
- Fewer MHPs in a “selected, not implemented” status, reflecting the many small counties that moved to an implementation phase in FY07
- An impressive increase in MHPs implementing a new IS, from 5 percent in FY06 to 30 percent in FY07

Both the selection and implementation of new systems are extremely demanding on MHP organizational resources. A core IS implementation draws on resources within every area of the MHP: administrative, financial, support and – for the first time – clinical. Most MHPs will be challenged to simultaneously maintain their legacy system at a high standard, while also giving full attention to the set-up and testing of their new system. In a similar fashion DMH will be challenged to provide support to MHPs bringing up their new systems, particularly as each MHP seeks to test their new systems.

Small counties are in the vanguard of the movement – with 13 MHPs in an implementation phase during FY07. Medium counties moved from passive to active search efforts in the past year – with eight MHPs now actively searching versus only three last year. Figures for large counties may reflect the length of time from initial search efforts to implementation in large organizations, as numbers in each category have barely changed from FY06 to FY07.

In this information-hungry environment, vendor-associated user groups continue to flourish. DMH information sharing meetings, CMHDA IT meetings, and MHPA technical work groups are all methods that MHPs are using to learn about features, challenges, successes and failures of new systems.

### Implementations in progress

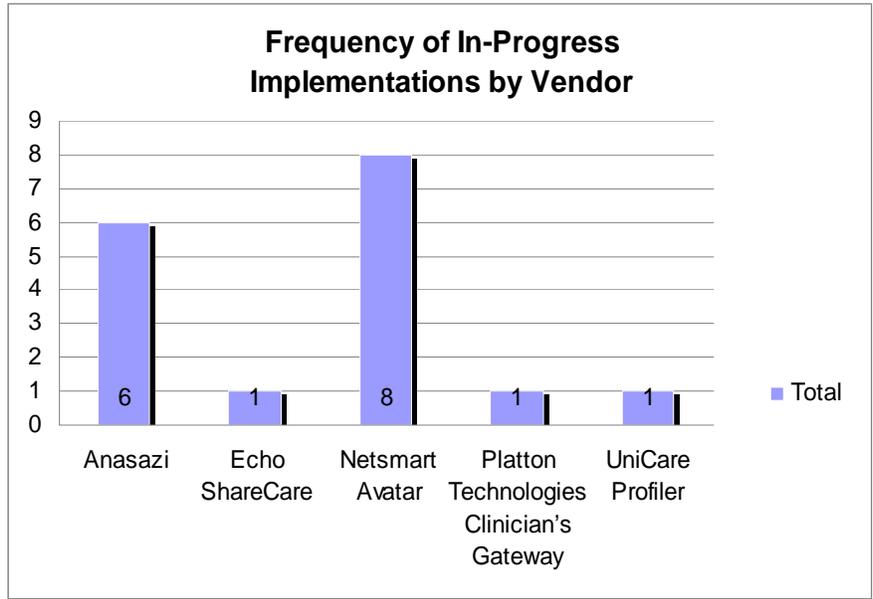
Almost 30 percent of MHPs are actively implementing a new IS, primarily in small counties. Two vendors account for 14 of the 17 implementations, potentially straining vendor capacity to adequately staff and support the projects.

As noted above, FY07 saw an unprecedented number of new IS implementations. Sixteen MHPs were in some form of IS implementation as FY07 ended – an increase from only three in FY06. This number includes implementations in 13 small counties. The figure below shows implementations in progress by vendor in FY07. One medium county is implementing two new applications simultaneously, thus Figure 2.19 below shows 17 total implementations for 16 MHPs.

Anasazi and Netsmart Avatar systems have made substantial inroads in small counties this year, with 14 implementations between them. Two additional MHPs (not reflected in statistics below) were planning to begin implementation at the close of the fiscal year, both with Netsmart Avatar, which would increase their county total to 10. This large increase in the number of implementations per vendor in a short period of time has implications for vendor capacity to adequately staff and support implementations. The majority of MHPs in implementation are converting from Echo’s InSyst application. Thus, the display of MHP’s IS by vendor (Figure 2.17 above) will show significant change in the number of MHPs supported by each vendor. Long-standing user groups

established under the prior vendor will continue to meet regularly for mutual support and assistance, but with a new vendor.

**Figure 2.19**



Selection of key software modules

Figure 2.20 below represents modules identified by MHPs as features desired in new systems. These statistics were only collected for the 29 MHPs in Figure 2.18 designated as:

In contrast to previous years, an increased number of MHPs are moving towards the acquisition of clinically oriented products in addition to standard modules, such as billing and reporting.

- New IS selected, not implemented (seven)
- Implementation in progress (16)
- New system in place (six)

In Figure 2.20, implementation activity in many small counties is evident by higher numbers, due partially to vendor coordinated installations.

MHPs continue to demand standard modules such as billing and Client and Service Information (CSI) reporting in new systems, each selected by 24 MHPs, along with MHSA reporting noted by 22 MHPs. However, a move toward the acquisition of more clinically oriented products is also evident in these statistics – with 22 MHPs designating appointment scheduling and electronic health records as required modules.

**Figure 2.20**

<b>New System Modules</b>				
<b>Desired Module</b>	<b>Small</b>	<b>Medium</b>	<b>Large</b>	<b>Total</b>
Practice Management	18	2	3	23
Appointment Scheduling	17	2	3	22
Medication Tracking	9	2	3	14
Managed Care	13	3	3	19
Electronic Health Records	17	2	3	22
Billing	19	2	3	24
State CSI Reporting	19	2	3	24
MHSA Reporting	18	2	2	22
Staff Credentialing	9	2	2	13
Grievances Appeals	3	0	0	3
Master Patient Index	15	3	2	20
Data Warehouse	9	0	0	9
Other	1	2	0	3

Most MHPs have internal IS staff who operate their systems. While stable since FY06, the number of vendor-operated IS may decline in the future, as MHPs seek to control their IS and their data.

Entity operating the information system

MHPs are operating many more separate applications now than in prior years to address deficiencies in functionality in legacy systems. In some cases, MHPs are operating both the legacy and new IS simultaneously to bridge the gap until the new system is fully functional.

As Figure 2.21 suggests, there is a shift away from vendor-operated systems to ones operated by the MHP, the Health Agency or the County IS staff. In the majority of cases, internal MHP staff operates the systems. In every case except “Vendor IS” and “Other,” the number of systems has grown substantially. “Vendor-operated” systems have remained at the same number since last year.

**Figure 2.21**

<b>Entity Operating the Information System</b>								
	<b>Small</b>		<b>Medium</b>		<b>Large</b>		<b>Total</b>	
	<b>FY06</b>	<b>FY07</b>	<b>FY06</b>	<b>FY07</b>	<b>FY06</b>	<b>FY07</b>	<b>FY06</b>	<b>FY07</b>
MHP Information Systems	8	7	12	21	8	14	28	42
Health Agency Information Systems	0	1	0	1	1	9	1	11
County Information Systems	2	2	0	3	2	6	4	11
Vendor Information Systems	18	20	2	1	1	0	21	21
Other	1	0	0	0	0	0	1	0

Data analysis capacity

The need for timely and meaningful data to support decision-making is long-standing and remains largely unmet – particularly in small counties which show a decline in this capacity over the past three years.

Figure 2.22 shows the number of data analysts by MHP size over three years. The need for timely and meaningful data to support decision-making is long-standing, and remains largely unmet. One quarter of MHPs report that they do not have staff capable of generating ad hoc reports from the core IS.

**Figure 2.22**

MHPs with Staff Data Analysis												
	Small			Medium			Large			Total		
	FY05	FY06	FY07	FY05	FY06	FY07	FY05	FY06	FY07	FY05	FY06	FY07
No	4	10	13	2	1	1	0	0	0	6	11	14
Yes	24	20	16	10	13	13	12	12	13	46	45	42

This lack of analytic capacity is very critical in small counties, evident in Figure 2.22 which shows an increasing number of “No” responses over the years. Medium and large counties have routinely retained data analysts, though probably not as many as needed to support the MHPs’ need for optimal operational and business analysis.

Perhaps this situation has contributed to greater activity toward purchasing new systems by small counties. A significant difference in newer IS (as opposed to legacy systems) is the introduction of improved, simpler tools for extracting and reporting data. This moves the data analytic capacity from technical staff to a broader group of users – a feature widely appreciated by users of new systems.

Information systems component ratings – statewide

During FY06 reviews, we began rating MHP IS based on ten key criteria – each of which had scores of “met,” “partially met,” “not met” and “not reviewed.” Figure 2.23 below

Data analysis/reporting showed the greatest need for improvement – with two components scoring consistently low: demonstrated capacity to support business analysis and access to data via standard and ad hoc reports.

displays information gathered from completed ISCA surveys and during site visits. Figure 2.24 graphically illustrates that despite tremendous variation among MHPs in this area, they share a striking number of common challenges and strengths.

<b>Figure 2.23</b>
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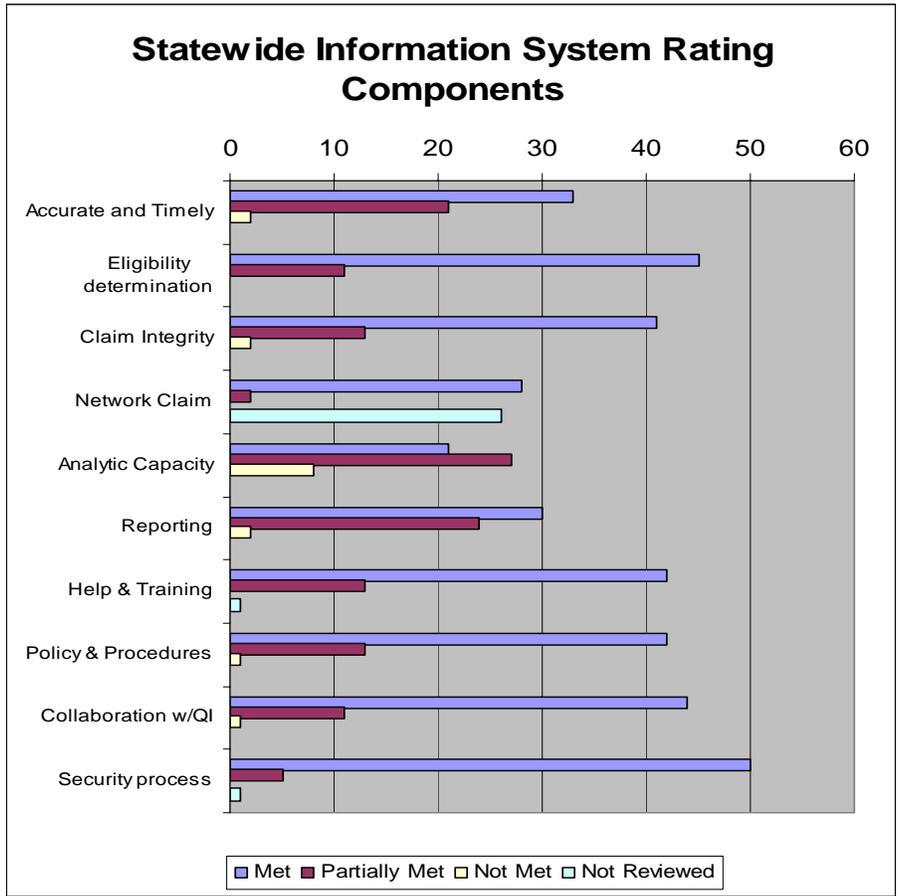
<b>Information Systems Component Ratings Statewide</b>				
<b>Component</b>	<b>Rating</b>			
	<b>Met</b>	<b>Partially Met</b>	<b>Not Met</b>	<b>Not Reviewed</b>
Accurate, consistent and timely data collection and entry	33	21	2	0
Procedures to determine a beneficiary's eligibility status	45	11	0	0
Integrity of Medi-Cal claim production process	41	13	2	0
Complete, reliable authorization and claims adjudication processes for network providers, including timely and accurate payment	28	2	0	26
Demonstrated capability to support business analysis and data analytic activities	21	27	8	0
Access to data via standard and ad hoc reports	30	24	2	0
Information systems training program and help desk support	42	13	0	1
Information systems/fiscal policies and procedures documented and distributed	42	13	1	0
Collaboration between quality improvement and IS departments	44	11	1	0
Documented data security and back-up procedures	50	5	0	1
<b>Total</b>	<b>376</b>	<b>140</b>	<b>16</b>	<b>28</b>

Not surprisingly, Figure 2.23 shows that data analysis and reporting show the greatest need for improvement. The two lowest rated components within these two areas were:

- Demonstrated capacity to support business analysis and data analytic activities – only 38 percent of MHPs were rated “met.” This component also ranked highest in percentage of “not met,” with 14 percent of MHPs assessed this rating. This component was new in FY07.
- Access to data via standard and ad hoc reports – only 54 percent of MHPs scored “met.” This component also scored low last year, with only 46 percent of MHPs achieving a score of “met.”

As illustrated in Figure 2.24 below, MHPs – regardless of size – share many strengths and challenges in how effectively their respective IS meet organizational and users’ needs.

**Figure 2.24**



As Figure 2.24 illustrates, only 33 MHPs (59 percent of all) fully met the most basic component of any practice management system: Accurate, consistent and timely data collection and entry. This area showed little improvement over last year’s results in which 61 percent of MHPs scored “met.”

Common reasons for low scores in this area were:

- Inconsistent data entry practices by various staff
- Few on-screen edits to catch errors immediately
- Data entry timelines that meet billing requirements but not the clinical need for real time information

This area is particularly critical as MHPs move to electronic health records in which the data do not simply reflect a billing record, but a picture of care provided. One basic area

that needs improvement is expedited data entry. Many MHPs require service information to be entered within 10-15 days following the month of service. This time frame means that a service encounter on April 2 may be entered anytime until May 15 to be considered timely.

Other statistics of note in Figure 2.24 are:

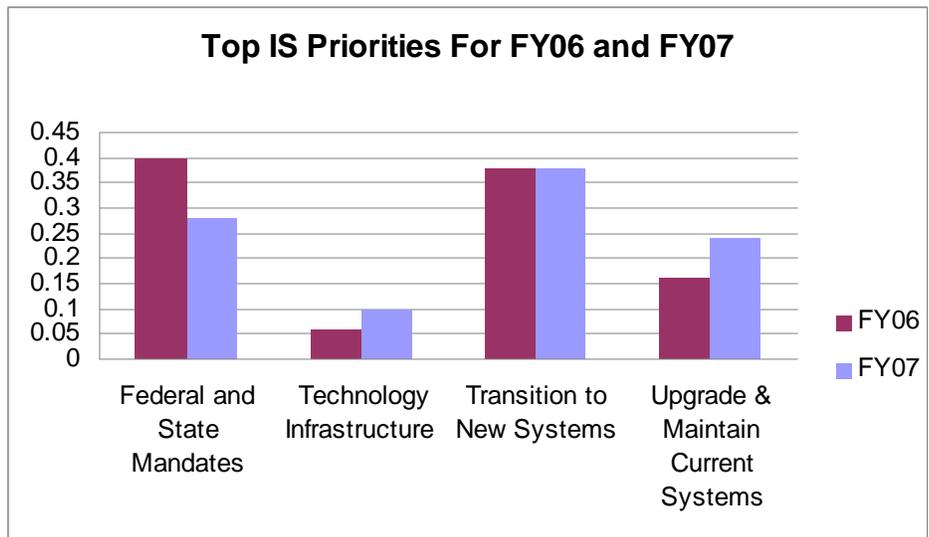
- Seventy three percent of MHPs fully met standards for integrity of Medi-Cal claim production process. However, 27 percent only “partially met” or did not meet standards for claiming, error correction and payment posting for the primary source of revenue. One factor in failing to meet this standard was a high Medi-Cal claims denial rate. Attachment 14 includes a detailed report by MHP of Medi-Cal Denied Claims Analysis.
- As last year, MHPs excelled in documenting data security and back-up procedures – with 89 percent of MHPs achieving a rating of “met.”
- Also similar to last year, claims processing and payment for network providers was the component most frequently “not reviewed” usually due to very low claim volume.

Each MHP’s rating for all components is included in its respective annual site review report. The individual MHP ratings are also included in the MHP summaries that comprise Volume II of the statewide report.

Top priorities of information systems departments

As displayed in Figure 2.25 below, the main categories of priorities within MHP IS departments were consistent with last year’s findings:

**Figure 2.25**



Each of the areas displayed in Figure 2.25 is described below:

- **Transition to new systems.** As in FY06, many MHP's are actively working to transition to new systems. Transition to a new IS includes activities such as RFP development, vendor selection and implementation. Interestingly, this category accounts for 38 percent of all top priorities in both FY06 and FY07. A more detailed analysis shows two interesting shifts:
  - Whereas FY05 to FY06 showed an increase in IS search and selection, active implementations increased dramatically from FY06 to FY07.
  - Movement toward acquiring or implementing an electronic health record accounted for about 40 percent of priorities in this category in FY07, whereas last year, few MHP's specifically noted activities focusing on new clinical systems as top priorities.
- **Federal and state mandates.** All MHPs face continuous change in federal and state reporting requirements. The number of priorities in this category declined slightly from FY06, when HIPAA claiming requirements dominated the IS landscape. This year, the focus is on NPI, MHSA, CSI, and preparing for "void and replace" functionality, which replaces the current Medi-Cal error correction process.
- **Upgrade and maintain current systems.** The increased attention to upgrading and maintaining current systems accurately reflects the need for MHPs to continue to run legacy systems to perform core business activities, even if they are considering or planning to implement a new system.
- **Technology infrastructure.** MHPs now recognize that technology upgrades are a continuous annual activity. The change from 6 percent of top priorities last year to 10 percent in FY07 reflects greater IT analysis concurrent with transition to a new system.

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

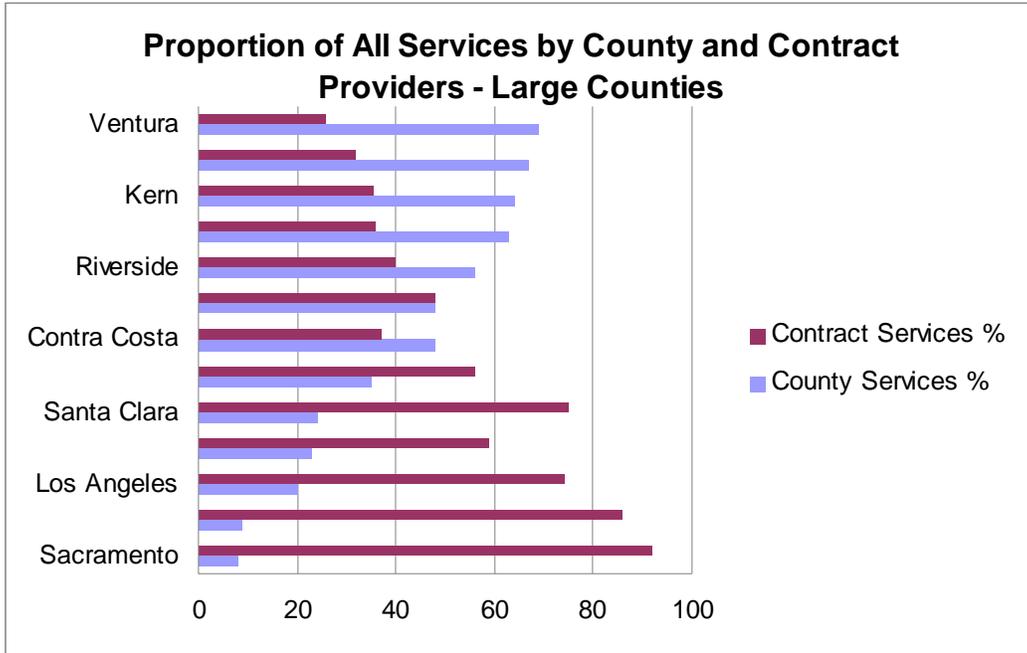
Figures 2.26 through 2.28 below display the relative proportion of services provided by county-operated and contract providers in large, medium and small counties. These figures clearly illustrate the wide variation in service delivery among MHPs by county size. For example,

- Contract providers are prevalent in larger and more urban counties.
- Fewer contract provider opportunities exist in smaller and more rural counties. (except Alpine, Kings, and Tuolumne MHPs)
- Network providers continue to perform a relatively small proportion of services, ranging from none in many counties to a high of 18 percent in San Diego County, 15 percent in Contra Costa and 13 percent in Mendocino.

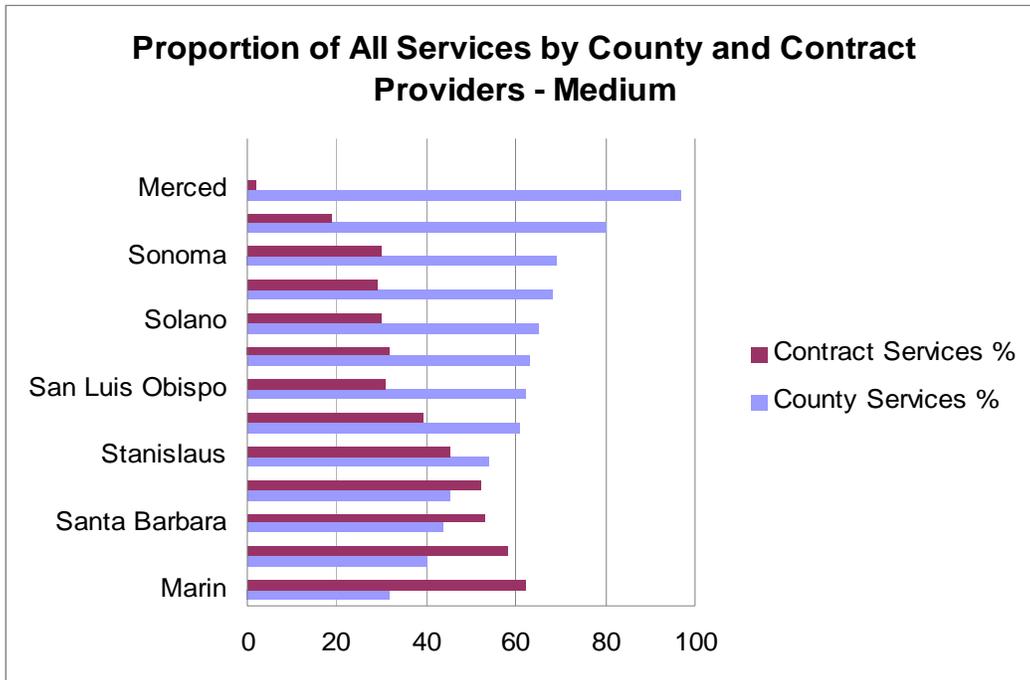
One possible reason for the growth of contract providers in large counties (and to a lesser extent in medium counties) is the implementation of MHSA-funded programs

which have expanded the type of services that counties could offer with Medi-Cal funding alone.

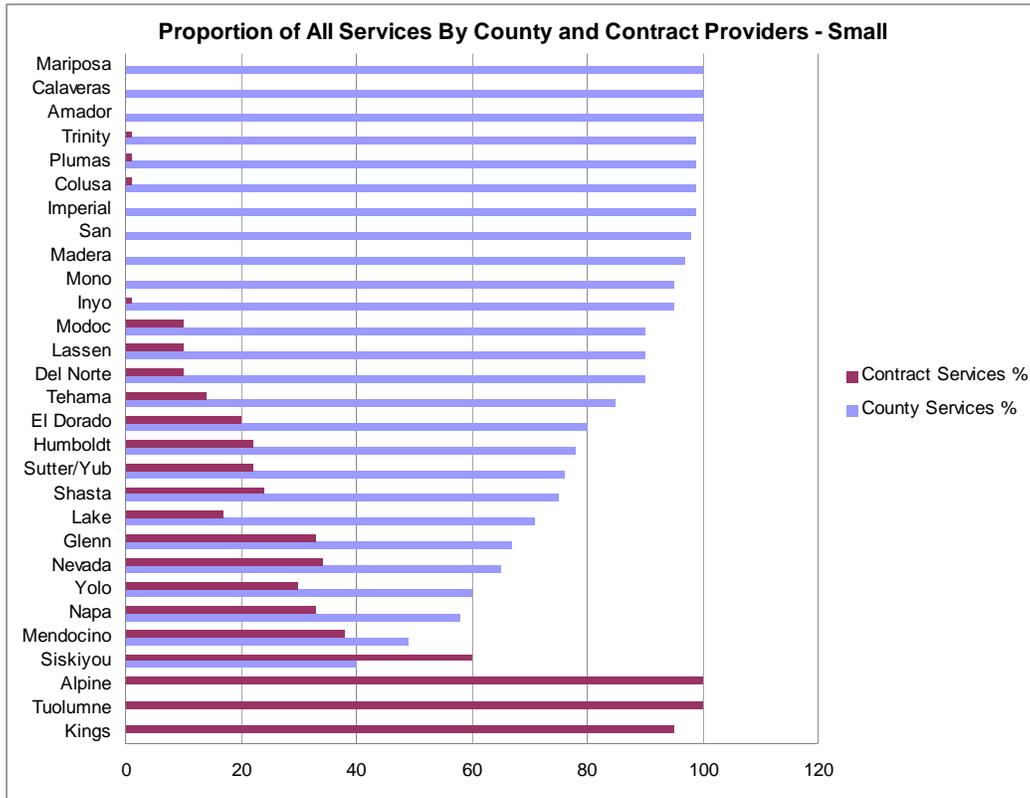
**Figure 2.26**



**Figure 2.27**



**Figure 2.28**



Consumers with co-occurring disorders

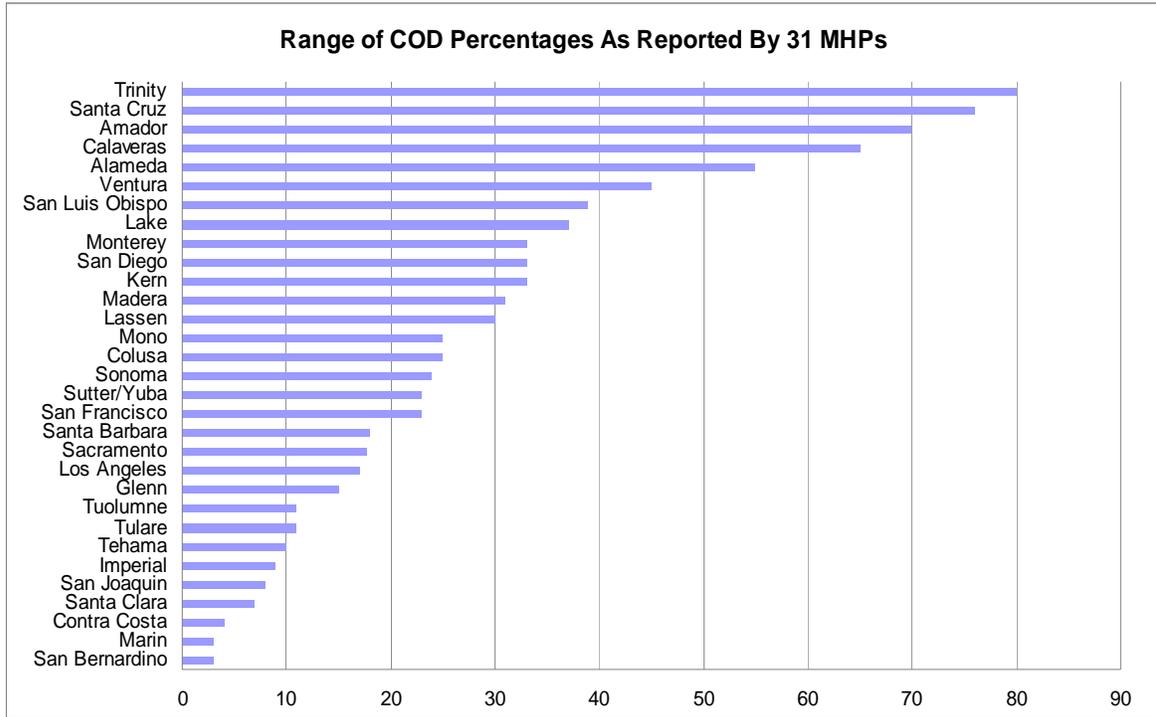
To support the growing effort to appropriately address the needs of consumers with co-occurring disorders (COD), we added questions in ISCA V6.1 related to the ability of MHPs to track these consumers through their information systems. In the ISCA, we ask:

- 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 2.29 provides a breakdown of responses. Forty-eight out of 56 MHPs responded “yes” to the question whether their IS captures COD. However, when asked the percentage, 17 MHPs left the item blank. Of the remaining MHPS that did provide a figure, the number ranged from three percent for Marin MHP and San Bernardino MHP to 80 percent in Trinity MHP and 76 percent in Santa Cruz MHP. This limited and questionable data reflects:

- Misunderstanding of how to determine COD from the IS
- Lack of analytic capacity to determine COD
- A belief that MHPs are “prohibited” from analyzing COD data
- The perception that COD information entered in an official database will lead to denial of services and/or billing

**Figure 2.29**



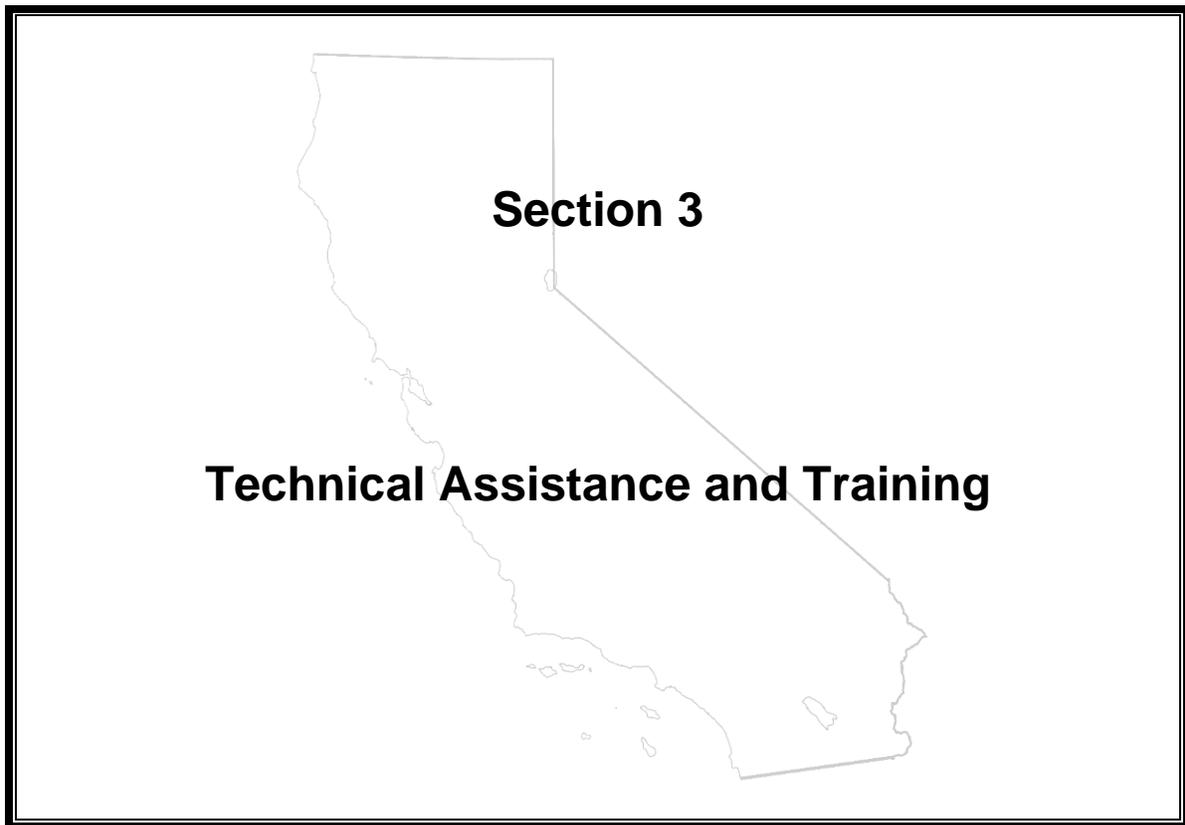
Integrity of diagnosis information

A new question in ISCA V6.1 relates to the integrity of diagnostic information in the core IS, 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.

Not surprisingly, only 26 out of 56 MHPs responded yes, they maintain diagnostic history. Most legacy systems only capture diagnoses associated with a single episode. If the diagnosis changes within the episode, the historical diagnosis is erased. In the past, the physical medical record was viewed as the repository of all clinical information. Clinical information that was entered into the IS was limited to the data elements required for billing or state reporting. However, as the need for an automated clinical record has emerged, new systems are responding by maintaining a full history of diagnoses as they change over time.

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 3.1: Overview

Unlike a traditional external quality review organization (EQRO), CAEQRO has consistently sought opportunities to provide each mental health plan (MHP) with technical assistance that promoted performance improvement. We learned that technical assistance during the site visit has limitations: only those staff members who participate in the process benefit from such assistance; and the subject matter is limited to the site visit agenda. In addition, the site review process is not conducive to developing skills that require repetition over time.

In this section, we discuss how we have addressed these limitations through providing a broad spectrum of technical assistance to four specific audiences:

- **Individual MHPs** – integrated with the site review process
- **Outreach, training and education** – provided to MHPs, public mental health system stakeholders, and key leaders and organizations
- **Group training** – targeted to all MHPs and in collaboration with leaders in the public mental health system
- **Small counties** – focused on issues unique to MHPs in specific geographies

For a calendar of our activities during year three of our contract, please refer to Attachment 15.

## Section 3.2: Individual Mental Health Plan Technical Assistance

During year three and consistent with our first two contract years, CAEQRO offered all 56 MHPs a wide variety of direct technical assistance, often beginning the day an MHP received the initial notification packet and frequently extending throughout all three phases of the review process. Across all three review years, staff members at some MHPs were highly receptive to using these services; others took little or no advantage of the technical assistance that CAEQRO offered.

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.

Highlighted below is the technical assistance that we provided during the three phases of our site review process.

## Pre-site Visit Technical Assistance

Each successive review year, CAEQRO has increased the technical assistance offered to MHPs *in advance of* the site visit. Our objective has consistently been to ensure that MHP staff participating in the site review process understood the requirements and had the proper tools to succeed. As in previous years, our pre-site visit technical assistance has involved both the dissemination of materials and consultative discussions.

### Training materials

As described in Section 1.3, CAEQRO provided MHPs with several documents to assist them in planning for their reviews. This year the documents that CAEQRO developed for this purpose included:

- **Enhanced notification letter and packet.** CAEQRO updated the notification letter and supporting documents to assist the MHP in better planning for the site visit. In addition to detailing the site visit focus, the notification letter listed specific documents that the MHP needed to complete and forward to us in advance of the site visit. For example, we asked that the MHP submit reports used to measure quality, outcomes, timeliness and access.
- **Performance Improvement Project outline via the “road map.”** In previous years, we recommended a format for MHPs to use in submitting information about their Performance Improvement Project (PIP) study questions and/or design. This year, we required a specific format because, in the past, many MHPs submitted a narrative that often omitted key information – either because they did not have the information or they did not know to include it. By requiring that the MHP answer a number of questions about the PIP, we hoped to help them improve their study design(s). To maintain consistency, we used the “Road Map to a PIP” as the basis for the required format, since most MHPs responded favorably to this method of conceptualizing PIP development.
- **PIP validation tool.** We revised and expanded the validation tool to include 44 elements. The increased specificity in the tool was intended to guide MHPs in providing the level of detail associated with a well-developed PIP. Our reviewers were also able to use these same elements as scoring criteria and identify those areas in the study design and/or methodology that needed improvement.

### Consultative discussions

Following the MHP’s receipt of notification materials (sent sixty days prior to the site visit), the lead reviewer initiated the technical assistance process by calling or e-mailing the contact person. Our intent at this phase was to clarify review priorities and develop an agenda that would enable the reviewers and the MHP to hold meaningful discussions regarding targeted issues. We provided the MHP staff with guidance on preparing for the various sessions of the review – sometimes holding conference calls with many representatives from the MHP staff. An MHP’s failure to participate in the pre-site review process generally resulted in poor MHP preparedness.

Despite CAEQRO's attempts over the past three years, some MHPs continued to participate minimally or not at all in pre-site technical assistance. For some of those MHPs, the lack of up-front coordination affected the overall quality of the review – including difficulties in identifying and submitting the requested documentation, obtaining the participation of the appropriate staff and contractors, and organizing the requested consumer/family member focus groups. Even in the third year of the EQRO process, some MHPs had difficulty in organizing for the review, others did not submit the requested documents, and some still failed to develop even one PIP for review.

When we received an MHP's documents prior to the site visit, we had the time to consult with our complete team of staff and consultants – even those who were not involved in that particular site visit. Offering a wealth of experience, our staff and consultants have backgrounds in various aspects of service delivery and management in private and public mental health systems. Based on the issues that surfaced in the MHP's documents, we were able to incorporate the appropriate perspectives to the site visit – including psychology, cultural competence, public health, psychiatry, public administration, consumer and family member experiences, pharmacy, nursing, social work, information systems (IS), and research. Several of our consultants are former MHP directors. Their familiarity with the demands on MHP staff and management continues to assist us in understanding an MHP's challenges and opportunities.

#### Performance Improvement Project assistance

MHPs continue to benefit from the experience of our specialty consultants. With regard to PIPs, we have available an expert physician reviewer, who is credentialed by the National Committee for Quality Assurance. As in year two, he reviewed all PIPs and provided consultation and specific feedback to our staff.

Some MHPs, as we requested, submitted PIPs early in the process, enabling CAEQRO staff to provide preliminary feedback prior to the site visit. These discussions enabled the lead reviewer to work individually with those MHP staff members who were coordinating the PIP processes. We also learned the status of the PIP(s) and potential barriers to discussing PIPs during the site visit. Common barriers to PIP development included the lack of management, staff and/or inter-departmental support, the lack of an important skill, gaps in knowledge, and/or inadequate resources. Such deficits are best addressed one-on-one with staff or within a private setting. Sometimes discussions enabled the MHP staff to “lay the issues on the table,” so that the review team could adjust its strategies. This type of advance planning paved the way for more productive PIP discussions during the site visit.

Unfortunately, some MHPs submitted their PIPs very late in the pre-site review process, which prevented the review team from having any discussions with appropriate MHP staff in advance of the site visit. Sometimes PIPs were submitted as late as the day prior to the site visit, which significantly hampered our ability to provide meaningful feedback onsite. Often a late PIP was less than adequate and typically little more than a rehash of material submitted in previous years. As a result, some MHPs perceived the feedback in the written report as “surprising” and/or negative as it was more thorough than the discussion that occurred during the site visit.

## Site Visit Technical Assistance

A consultative approach has been the cornerstone of our review strategy. While conducting the review in compliance with regulatory guidelines, we used our questions and the subsequent discussion as vehicles for providing technical assistance in several key areas:

- **Assisting with information systems capabilities.** Our IS site visit strategy included assisting MHPs with using approved claims data and information from their internal IS resources to compile data reports. In addition, many MHPs posed questions on how they could replicate reports similar to our approved claims reports from their own systems. While Section 2.3 details our health IS review process, we highlight below examples of IS technical assistance:
  - How to count (and how we counted) Medi-Cal eligibles or foster care eligibles, and reasons for discrepancies between our approved claims data and the MHP's data
  - How to extract data to support PIPs and other important performance management activities
  - How to establish co-occurring disorders counts
  - Best sources for specific data elements (overall penetration rate, type of services, etc.)
  - Counting unique Medi-Cal beneficiaries served (by legal entity and/or service type) for cost report settlement negotiations
  - Strategies for cleaning up demographic data prior to system conversion – the clinical value of converting a full set of data
  - Data archival strategies
  - Health Insurance Portability and Accountability Act 837/835 claims
  - Request for Proposal planning/development
  - Tools for looking up Medi-Cal eligibility
- **Modeling data-driven inquiry to promote performance management.** We used CY05 approved claims data (see Attachment 6 as an example) to identify potential areas for improvement in the MHP. We facilitated discussions on the MHP's operations to surface potential causes for patterns present in the claims data. In many of these discussions – particularly for medium and small MHPs – MHP staff continued to learn how to use aggregate information to understand internal processes and consumer needs. Our informal impression is that these MHPs continued to view this discussion as an added value of the ERQO process. One indication is that MHP staff not only reviewed this year's materials but also understood them

Examples of data-driven inquiries include:

- *Retention of beneficiaries for more than the first one or two sessions.* This data supported discussions about the MHP's intake processes, engagement at the point of assessment, and access to psychiatric medication services. In contrast, higher than average retention (i.e., more than 15 services) resulted in discussions about the MHP's philosophy and methods to promote consumer-driven, recovery-oriented services.
- *Low penetration rates by ethnicity (often Latinos or Asians), age (youth, transition age youth, or older adults), or gender (usually females).* This data supported discussions on system access, barriers to access, cultural competence, and demographic-specific outreach and engagement to reach underserved populations.
- *Potentially undesirable utilization patterns.* Many MHPs demonstrated high penetration rates for African Americans yet low retention in services; some had higher than average inpatient utilization rates and lower than average outpatient services. These data led to discussions regarding admission practices, community resources available to support lower levels of care, as well as staff and community training on wellness principles.

In Sections 4 and 5, we provide both statewide and MHP-specific data in these and other key areas that directed our discussions.

- **Assisting in Performance Improvement Project development.** PIPs are an important although single indication of an MHP's ability to develop and implement an analytic activity with quantifiable outcome measures. As in year one, most MHPs identified PIPs as the area of greatest need for technical assistance. This need increased in year two, when the California Department of Mental Health (DMH) required that every MHP develop both one clinical PIP and one non-clinical PIP and that each be "active and ongoing."

The year one requirement was to have one PIP at least in the conceptual stage. During year two and continuing in year three, some MHPs still needed assistance just identifying an appropriate topic for a PIP. Others had identified topics but still had little data in their systems for performance measurement. For these MHPs, the site review team explored potential sources of additional data and strategies for design and analysis. In a small number of reviews, the MHPs had two well-developed PIPs that did not require significant assistance. Our PIP findings are included in Section 2.2.1.

While PIPs were in various stages of development statewide, CAEQRO review teams typically devoted significant time during the site visit to teaching the MHP to:

- Examine existing data that could support a PIP
- Develop a strong study question regarding an identified problem

- Identify baseline information and project meaningful numerical indicators to answer study questions
- Consider potential interventions geared to improving an identified problem
- Target concrete and measurable goals for realistic and meaningful improvement

At the wrap-up session during each review, we invited all MHPs to contact us throughout the year regarding their planned PIP activities or any other areas in which they needed our input or assistance. After the conclusion of the year's review activities, a number of MHPs have continued to maintain close contact with CAEQRO, particularly for ongoing assistance with PIP activities. In these situations, we held a conference call with MHP staff or PIP committee and covered many of the same issues that we review during the site visit. Many MHPs have also maintained contact with CAEQRO to discuss data and related issues about penetration and/or service utilization.

### Performance improvement through collaboration

As summarized below, CAEQRO has consistently supported collaborative activities that involve sharing knowledge, experience and, when appropriate, resources to improve service activity:

- **Promoting collaboration with other MHPs.** We also continued to promote collaboration by sharing approved claims data among MHPs. We began this process in year two by asking MHPs to identify two MHPs that they view as comparable. Our intent was to encourage discussions on what the differences in data might suggest, particularly regarding similarities and differences in delivery systems. Following these discussions, we hoped that the MHP would then contact the comparable MHPs to inquire about their approved claims data and/or service patterns and the possible causes for such similarities and differences – especially when the other MHP's data reflected more desirable patterns. The similarities in data were particularly meaningful for small counties, as they often perceive themselves as having unique challenges.
- **Promoting collaboration with contract providers.** During past reviews, we noted that many county-contracted providers possess a wealth of experience, knowledge and skills that would benefit the MHP. For instance, many contract providers have long histories of grant funding to support rehabilitative services to promote wellness and recovery. Other contract providers utilize electronic health records that monitor consumer outcomes. Based on past experience, we requested that specific providers participate in the site visit and/or we visited their offices. We encouraged both the MHP and contract providers to share resources. Unfortunately many contract providers continued to report exclusion from processes and the lack of a real partnership with MHPs.

## Post-site visit technical assistance

Within a week of each site visit, CAEQRO convened a post-site visit meeting to discuss review findings and recommend verbal and written feedback to the MHP. Participants included the site visit team, other CAEQRO staff and consultants. The lead reviewer conveyed to the MHP salient aspects of these meetings through phone calls and e-mail correspondence, or in the site visit report.

A regular task for this meeting was to review and reach agreement on scoring the PIPs submitted by the MHPs. Team discussions throughout the scoring process included alternative approaches for the PIP, such as suggestions for improved study questions, clearer indicators and additional interventions. Ideas on how to improve PIPs – whether provided during the site visit or generated during the post-site visit conference – were communicated to the MHP through follow up phone conversations, e-mail correspondence, and/or as part of the written site review report.

## Section 3.3: Outreach, Training and Education

Since year one, CAEQRO has sought opportunities to work in group forums that enabled MHPs to share ideas and gain a perspective on the statewide public mental health system. Critical to our ability to provide such opportunities is an ongoing involvement in key professional organizations and with key opinion leaders who have a significant impact on the public mental health system. We summarize both areas of collaboration and consultation below.

### Organization Collaboration

CAEQRO has continued to prioritize participation in a variety of organizations throughout the year to be available for group oriented technical assistance and to continue building collaborative relationships with key leaders and organizations. We either attended or collaborated on one or more presentations at the following events:

- CAEQRO year two report presentations in both northern and southern California
- Annual California Institute for Mental Health (CIMH) information technologies conference
- State Quality Improvement Committee (SQIC) meeting
- California Mental Health Director's Association (CMHDA) IS committee meetings
- Medi-Cal Policy committee meetings (a sub-committee of CMHDA)
- CIMH's California Mental Health Care Management Program (CalMEND) project
- Mental Health Services Act training and informational meetings
- California Quality Improvement Committee (CalQIC)
- California Primary Care Association notices and activities

### Web Site Resources

Recognizing that many MHPs would benefit from the same information, CAEQRO developed the Web site, [www.caegro.com](http://www.caegro.com), in year one as a forum for broadly disseminating information and continued to enhance it in year two as a venue for shared information. By year three, there were 808 registered users (June 30, 2007). Monthly hits

to the site ranged from a low of 807 to a high of 2,235 – not including CAEQRO staff and consultants. Links within the CAEQRO Web site that visitors most frequently accessed included: EQRO Calendars, Performance Improvement Projects and Review Preparation.

With MHP permission, CAEQRO posted a range of MHP-produced documents to provide examples to assist other MHPs, such as PIPs, ISCA surveys, and cultural competence and quality improvement (QI) work plans. CAEQRO is committed to encouraging MHPs to share resources, knowledge and skills, and this Web site is one venue for doing so. Examples of other information available on the Web site include:

- Links to other useful Web sites
- Tools for statistical analysis
- Interesting publications related to data analysis, research, practices, cultural competence, and other quality related issues
- CAEQRO documents:
  - Sample notification packet
  - Site review report format
  - Year two statewide report and power point presentation
  - MHP site review schedule
  - Staff contact information

## Group Training Workshops

CAEQRO provided or participated in training sessions aimed at addressing issues that would help all MHPs learn about or enhance common performance improvement initiatives. These training sessions included the following:

- **Consumer and family member CAEQRO peer reviewer quarterly meetings.** We continued to conduct quarterly telephone conference calls to provide ongoing training to our consumer and family member consultants. Because these consultants receive the majority of their training during an orientation site review, this forum was important for sharing questions, ideas and recommendations among the nearly twenty consultants and lead reviewers.
- **CaIMEND.** CIMH's CaIMEND project is designed to affect changes in how psychiatric services are provided throughout the mental health system. A part of the CaIMEND project has included inviting several counties to join the CaIMEND project and develop a number of PIPs that are related to this area. These counties are: Alameda, El Dorado, Fresno, Marin, Orange, Stanislaus and Tehama. The Department of Health Services (DHS) has also invested staff resources into this project, since Medi-Cal funds psychiatric medications. CAEQRO has provided consultative support so that the collaborative could achieve its goals and develop PIPs that would meet the review criteria. We participated in two presentations for the CaIMEND participants – one focused on

root cause analysis and other QI techniques, and another focused on our Road Map to a PIP.

We participated in the review of the initial analysis of data regarding beneficiaries who were prescribed anti-psychotic medications. This area is currently the focus of the CalMEND project and PIP. The participating MHPs are beginning with the examination of polypharmacy prescribing practices and then will analyze other prescribing practices by examining DHS pharmacy data. Support of this project has required several meetings between CAEQRO, DHS, DMH and CiMH staff, as well as some individual MHPs.

We also worked in collaboration with CiMH and CMHDA to plan and present a series of workshops on specific PIP areas. In the following section, we focus on our collaboration specific to small counties.

## **Section 3.4: Technical Assistance: Small Counties**

The expectation to fulfill all of the federal requirements of a managed care plan continues present challenges for the small counties. In this section, we summarize the consequences of these challenges and then highlight how we have encouraged collaboration among small counties – given their limitations in staff and financial resources.

### **Performance Improvement Barriers**

The difficulties that MHPs have with their PIPs symbolize their struggles on many levels. Listed below are examples of small MHPs' barriers to conducting meaningful performance improvement activities:

- Concentration on quality assurance and compliance activities, often excluding a performance improvement focus
- Isolation and lack of awareness of how other MHPs address similar issues
- Inadequate technological systems to support data collection, compilation and analysis
- History of thinking that a small organization does not require data to understand the system
- Lack of skill base to design an on-going system of measuring improvement or a structured PIP
- Few staff resources to form multi-functional committees or to work with community stakeholders and other county departments to bring various disciplines together, broadening knowledge, skills and perspectives
- A single staff person devoted, sometimes only part-time, to QI activities

A number of small MHPs voiced concerns about how PIPs and other performance improvement activities drain the system of staff resources. Small MHPs often viewed as unnecessary those activities that are an important part of managed care system oversight and formal performance review. These included: evaluating service patterns for high-cost consumers; analyzing outcomes compared to service utilization; and monitoring patterns of entry, length of stay, and exit from services. The small MHPs that did view these analyses as valuable often reported lacking the skills or technology to manage their systems effectively – and had not developed alternate ways to collect and/or retrieve necessary data for such activities.

## A Launching Pad for Collaboration: Small County Emergency Risk Pool

While many small MHPs acknowledged that collaboration could help them to achieve some system-intensive objectives, most still reported that demands on their time restricted them from engaging in collaborative activities. A notable exception is the Small County Emergency Risk Pool (SCERP), which has been our most productive vehicle for supporting such MHP collaboration.

The State of California set aside funds for a self-insurance risk pool for small counties as defined in the California Welfare and Institutions Code Section 5778(j)(1)(D). The self-insurance risk pool reimburses small county mental health plans for the costs of acute inpatient psychiatric services as approved by participating counties. The self-insurance risk pool also provides funding for participating small counties' training and development needs. SCERP therefore was already organized and considered important by the small counties.

Managing inpatient services effectively and efficiently is a particularly difficult activity for small counties, few of which have inpatient units within the county or even adjacent to it. The director and deputy director of CMHDA therefore identified this issue as a potential platform for small county collaboration. Both were aware of our data capabilities and interest in technical assistance and approached us to work with them in addressing this issue.

In collaboration with CiMH and CMHDA, several of our staff led a full-day workshop using inpatient data analyses specifically developed for this purpose on the SCERP counties who wished to participate. We provided summary data by admission and readmission for each county as well as the overall group of counties. However to illustrate the reality that the data actually provided into lives of real people, we used a random sampling of hospitalizations in a particular month's approved claims and displayed the services that were – or were not provided – to individual beneficiaries in the months prior to and after the hospitalization. Displaying these data provided a basis for MHPs to use available data to understand how the service system affected the outcomes of real, although de-identified, people. We hoped to demonstrate how the MHPs could and should use these kinds of analyses routinely, as well as how PIPs emerge from routine analysis. Additional information on this workshop and our data analyses are included in Section 5.

As areas of significant clinical and fiscal concern, hospitalizations and rehospitalizations have brought these MHPs together to obtain data and address underlying issues.

CAEQRO's role is to provide one type of data, offer training on how to use that data, and facilitate discussions about how other data and information could meet PIP requirements. Additionally, because small MHPs have a relatively small number of consumers for monitoring outcomes, we promoted collaborative activity by advising the MHPs to view the entirety of SCERP MHP populations as the study populations for their shared PIP.

Investing our resources in support of this group's PIP development achieved two objectives:

- Enabled small MHPs to participate in and learn from a data-driven PIP process despite having very small numbers of beneficiaries involved
- Required participating MHPs to identify similarities in their processes that enable them to work collaboratively and cooperatively

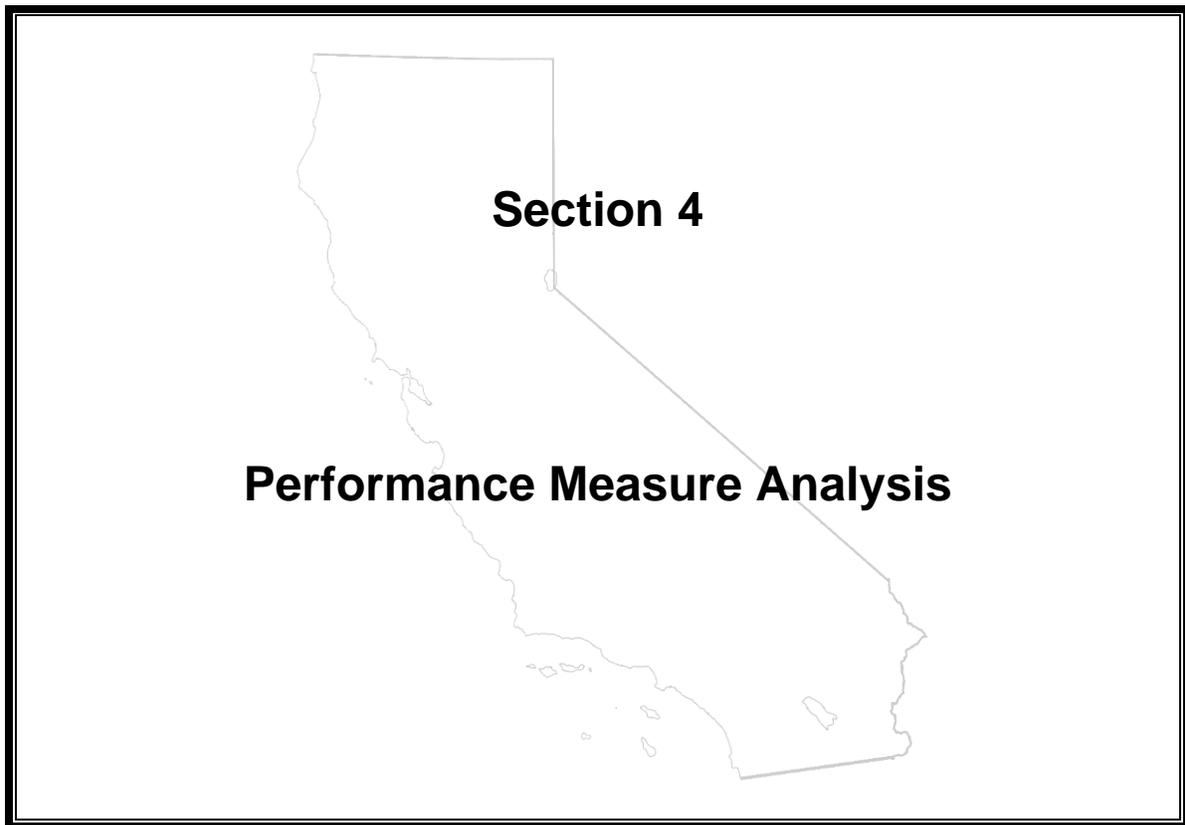
Emerging from this collaborative are two potential projects that could be jointly developed and scaled to the needs of small counties:

- **PIP development – reducing hospitalizations and rehospitalizations.** We provided relevant data to all of the participating MHPs and participated routinely in planning meetings with CiMH and CMHDA as well as conference calls with all of the participating entities.
- **Usage pattern analysis – planned and unplanned services.** At the end of year three, we began working with MHPs to redefine how they classify services to better understand how well they are managing care to promote wellness, resiliency and recovery. This process includes:
  - Selecting specific data elements to capture services that in turn are reclassified as a disease management “package of services.” These new classifications consist of planned interventions and consumer activity.
  - Identifying data elements to capture unplanned services, which include high intensity services such as emergency, crisis or inpatient services and are not considered part of managing care successfully?
  - Defining consumers (including both Medi-Cal and non-Medical recipients) as connected or “active” in the system or not “active” in the system.

We are currently providing data specific to these classifications to engage MHPs in working through assumptions that drive all data-based projects. At the time of this report, the MHPs are interested in identifying the issues that may be involved in higher than “ideal” rates of unplanned services to consumers already involved or “active” in the service system.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 4.1: Overview

In year two, California External Quality Review Organization (CAEQRO) and California Department of Mental Health (DMH) considered several options for the performance measure (PM) analysis and, after an extensive analytic process, selected “cost per unduplicated beneficiary served.” For year three, we built on our base analysis of cost per unduplicated beneficiary served to identify any changes in previous years’ findings. We also included a number of specific penetration rates as additional informative elements. With the baseline analysis that we gained in year two we were also able to analyze and compare approved claims data for Calendar Year (CY) 2005 and CY06 from the following sources:<sup>3</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 February 2007; IPC approved claims as of March 2007; and MMEF data as of April 2007

The exceptions are the ratios for penetration rates and the cost per beneficiary served for male/female and Hispanic/White beneficiaries:

- CY05 – SD/MC approved claims as of July 10, 2006; IPC approved claims as of July 13, 2006; and MMEF data as of April 2006

### Performance Measurement Analysis Goals

As part of our year two PM analysis, DMH requested that CAEQRO review important non-clinical demographic variables to help analyze and understand cost and service patterns. To increase our understanding and evaluation of the service delivery system, CAEQRO focused our analysis to:

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

As in our year two 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

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<sup>3</sup> All figures in Section 4 reflect these sets of data.

- 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 per beneficiary served 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.<sup>4</sup>

The picture of services provided to individuals reflects only those Medi-Cal beneficiaries who have entered the mental health system of care. Understanding barriers to initial access to the service system is extremely important in addressing these questions. For example, because of different funding levels, mental health plans (MHPs) have varying abilities to match the Federal Financial Participation portion of Medi-Cal reimbursement. The differences across MHPs in turn affect the funds available to support the array of services to the Medi-Cal eligible population within a particular county.

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, ethnicity and service delivery patterns. Variation in these patterns by demographics and ethnicity may warrant further investigation by individual MHPs.

## Section 4.2: Statewide Considerations

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

- **Median versus the mean.** The median (the cost in the mid-point of the distribution) and mean (average cost) are typically significantly different. This disparity indicates that the distribution of overall services is highly 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).

Figure 4.1 and Figure 4.2 present two years of data for cost per beneficiary served – comparing statewide, CANOLA and Los Angeles MHP data. In comparing CY05 and CY06 data, we found that the relative influence of Los Angeles remained stable. However, each figure shows the importance of CANOLA in understanding some statewide measurements. Please note CY06 amounts have not been adjusted for inflation.

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<sup>4</sup> Throughout Section 4, the terms “average payment per beneficiary” and “average cost per beneficiary” are used interchangeably. Both refer to the calculation of total approved claims divided by the total number of beneficiaries served.

- Figures 4.1 and 4.2 indicate that the total number of eligible beneficiaries, as well as beneficiaries served, decreased in CY06. While the reduction in eligible beneficiaries statewide was only 27,337 or 0.4 percent, the number of those served in CY06 was 5.6 percent less than in CY05. CANOLA figures show a 6 percent reduction.<sup>5</sup>
- Figure 4.2 indicates the following:
  - In CY06 the average cost for unduplicated beneficiary served statewide is \$4,112 (including Los Angeles).
  - In CY06 the average cost per unduplicated beneficiary for Los Angeles alone is \$4,638 while the same cost for CANOLA is \$3,882.

Considering statewide figures without considering the influence of Los Angeles MHP data could lead to incorrect conclusions. As displayed in the figures below, when Los Angeles MHP data are included, the statewide mean is higher than that for CANOLA data. Therefore the mean with Los Angeles included in the data is not the most accurate yardstick for the vast majority of the MHPs.

**Figure 4.1**

Cost Per Beneficiary Served - Statewide/CANOLA CY05							
	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost per Beneficiary Served	Average - Cost Per Beneficiary Served	Standard Deviation - Cost Per Beneficiary Served
Statewide	6,810,962	100%	430,877	100%	\$1,346	\$4,045	\$8,396
CANOLA	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

**Figure 4.2**

Cost Per Beneficiary Served - Statewide/CANOLA CY06							
	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost per Beneficiary Served	Average - Cost Per Beneficiary Served	Standard Deviation - Cost Per Beneficiary Served
Statewide	6,783,625	100%	406,679	100%	\$1,411	\$4,112	\$8,354
CANOLA	4,380,931	65%	283,323	70%	\$1,315	\$3,882	\$8,203
Los Angeles	2,402,694	35%	123,356	30%	\$1,691	\$4,638	\$8,669

<sup>5</sup> These percentages might change as additional claims are analyzed for CY06.

### Section 4.3: Cost Per Unduplicated Beneficiary Served – Gender

If this pattern remains stable for a third year, do penetration rates and average payment for male and female beneficiaries deserve attention? If not, why not?

Figure 4.3 presents a statewide analysis of the count, average payments and penetration data by gender for CY05 and CY06. Statewide all data across these two years are extremely consistent:

- The penetration rate for male beneficiaries is higher than for female beneficiaries.
- The average payment for male beneficiaries continues to exceed that for female beneficiaries.

The CY06 data indicates that overall female beneficiaries were less likely to be served than male beneficiaries. Fewer resource dollars were spent on women than on men. The data show that female beneficiaries had a penetration rate ratio of .83; in other words, for every 100 male beneficiaries served, 83 female beneficiaries were served. Similarly and noteworthy is the fact that Medi-Cal average payments for female beneficiaries was 77 cents for each \$1.00 for male beneficiaries. Each figure illustrates but does not explain the apparent consistent and considerable disparity based on gender across the state.

**Figure 4.3**

Statewide Comparison of Beneficiary Count, Average Payment and Penetration Ratios by Gender						
Beneficiary County	Count of Beneficiary Served		Average Payment Per Beneficiary Served		Ratio of Female vs. Male for	
	Female	Male	Female	Male	Penetration Rate	Average Payment
<b>CY05 STATEWIDE</b>	223,630	203,348	\$3,501	\$4,563	0.83	<b>0.77</b>
<b>CY06 STATEWIDE</b>	212,660	194,019	\$3,597	\$4,675	0.83	<b>0.77</b>

In Attachment 16, we display the ratio of penetration rates and cost per beneficiaries for female to male beneficiaries for CY05 and CY06 for all 56 MHPs. While statewide penetration rate ratios and average payment ratios remain constant for two years, some individual MHPs' data show a different pattern. Since the variability occurs mainly with smaller MHPs, the general stability of these ratios across other MHPs is of note.

## Section 4.4: Cost Per Unduplicated Beneficiary Served – Age

Is the rise in costs in the 6 to 17 year-old age group due to the increased use of Therapeutic Behavioral Services, the modality with the highest cost in the state?

Figure 4.4 illustrates the changes from CY05 to CY06 for average payments by age groups. Increases for the two age groups – 0 to 5 years and 6 to 17 years – are offset by small decreases for adults (ages 18 to 59) and older adults (age 60+). A high-level analysis might suggest that a shift in costs is occurring – i.e.,

MHPs are beginning to spend more money on children and youth than on adults and older adults. In fact, increases in both the use of Therapeutic Behavioral Services (TBS) and the cost for TBS in the 6 to 17 year-old age group likely account for at least part of the overall increase in average payments for the two youngest age groups.

TBS continued to be the most expensive service modality per person in CY06 (\$14,934) as it was in CY05 (\$13,951). Total payments increased in CY06 to \$49,236,227 from \$43,792,934 in CY05 although persons served increased by only 158 (3139 to 3297). The relative position of each age group, however, remains constant. Further, older adults continue to receive the lowest average payment per beneficiary, which is about half of that for the 6 to 17 years age group (which receives the highest average cost per beneficiary served).

**Figure 4.4**

Statewide Comparison of Cost Per Beneficiary by Age		
Age Group	Average Payment CY05	Average Payment CY06
0-5	\$3,099	\$3,290
6-17	\$5,209	\$5,452
18-59	\$3,581	\$3,547
60+	\$2,384	\$2,336

While these data do not yet suggest a trend, the consistency across MHPs in the apparent reduction in services to older adults is worth exploring.

Figures 4.5 and 4.6 display the relationship of age to cost per beneficiary by the size of counties. Since the mix of services is sometimes quite varied according to the size of the MHP and the population it serves, county size may have a significant impact on the cost per beneficiary served. However, the overall pattern revealed at the statewide level generally holds true irrespective of MHP size. For example, in

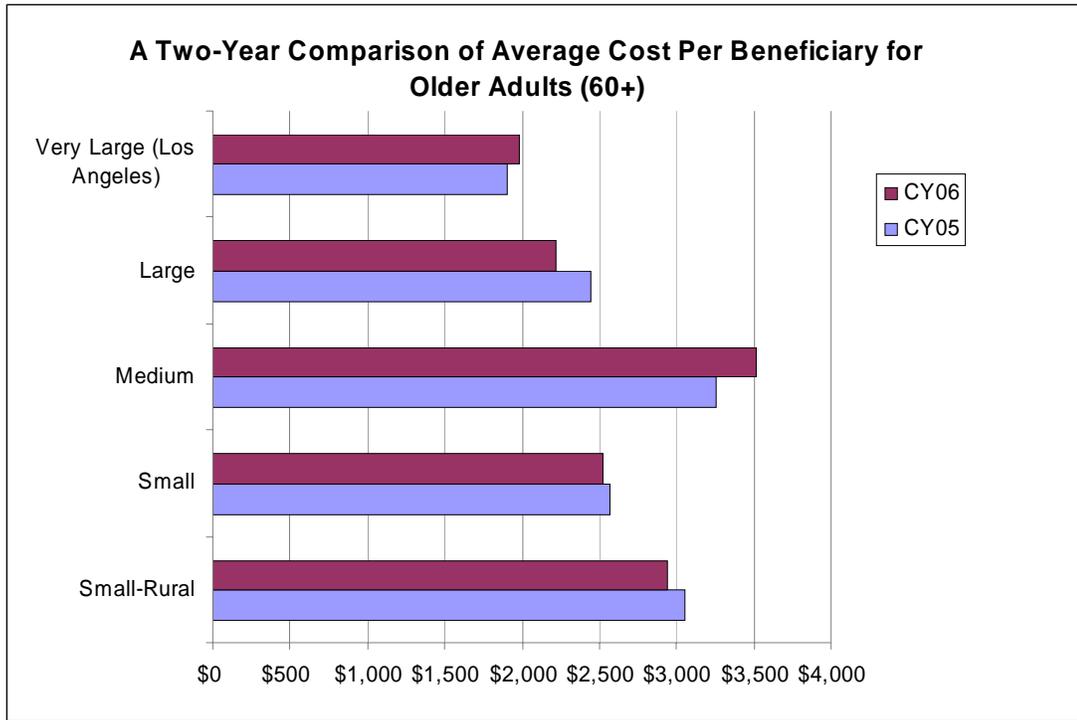
the 6-17 years age group the average payment increased for MHPs of every size from

CY05 to CY06. With the exception of small-rural MHPs, cost per beneficiary ages 0-5 years also increased. For older adults the average payment per beneficiary declined for every county size with the exception of medium and very large (Los Angeles MHP).

**Figure 4.5**

<b>A Comparison of Cost per Beneficiary Served by Age and Region</b>			
<b>Age Group</b>	<b>MHP Size</b>	<b>Average Payment CY05</b>	<b>Average Payment CY06</b>
0-5	Small-Rural	\$2,915	\$2,866
	Small	\$2,005	\$2,498
	Medium	\$2,901	\$3,286
	Large	\$2,730	\$2,827
	Very Large (Los Angeles)	\$4,291	\$4,420
6-17	Small-Rural	\$5,767	\$6,684
	Small	\$3,948	\$4,463
	Medium	\$5,050	\$5,320
	Large	\$4,633	\$4,796
	Very Large (Los Angeles)	\$6,292	\$6,508
18-59	Small-Rural	\$3,076	\$3,100
	Small	\$2,885	\$2,960
	Medium	\$4,150	\$4,307
	Large	\$3,582	\$3,370
	Very Large (Los Angeles)	\$3,485	\$3,621
60+	Small-Rural	\$3,059	\$2,937
	Small	\$2,565	\$2,526
	Medium	\$3,251	\$3,514
	Large	\$2,444	\$2,219
	Very Large (Los Angeles)	\$1,901	\$1,987

**Figure 4.6**



### Section 4.5: Cost Per Beneficiary Served – Ethnicity

Will the reduction in the gap in the amount spent on Hispanic and White beneficiaries continue to close?

CAEQRO’s analysis included a review of data over a two-year period to evaluate the parity of payments and penetration rates between Hispanic and White beneficiaries. In Attachment 16 we include a table displaying both statewide and detailed information at the MHP level:

- Penetration rates.** Statewide the relative penetration ratios for Hispanic and White beneficiaries remained constant from CY05 to CY06: the low parity of a .26 penetration ratio in CY06 is essentially the same as the .25 penetration ratio for CY05. Individual MHP and statewide penetration rates are consistent for White and Hispanic beneficiaries and show very little difference from CY05 to CY06 data.
- Average payment.** Average payment per beneficiary for Hispanic and White beneficiaries show a slight increase for both groups when comparing data for CY05 and CY06 statewide. The ratio for average payments indicates that the average disparity in payment for Hispanic beneficiaries in relation to White beneficiaries has decreased somewhat from CY05 to CY06 – moving from .86 to .91 statewide. However, as Attachment 16 shows, individual MHP data are not always consistent with the statewide pattern. For example, in El Dorado,

Humboldt, and Madera MHPs (in both CY05 and in CY06), the average payments for Hispanic beneficiaries exceeded those for White beneficiaries. As another illustration of the diversity of these data, San Bernardino MHP shows ratios for Hispanic and White beneficiaries that indicate nearly equal average payments for both groups. Although comparative data from two years does not yet indicate a trend, we will repeat these analyses in year four (adjusted for inflation).

## Section 4.6: Service Delivery Patterns

CAEQRO examined service delivery patterns by gender and ethnicity by applying the following categories, which combine mental health service modes and service functions as defined by Medi-Cal:

- 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)
- TBS
- Medication support

### Statewide Service Patterns: Gender

Figures 4.7 and 4.8 show service patterns by gender for both statewide and CANOLA in CY06. Both analyses display the same results. Over each and every service category, average and median payments per beneficiary are greater for male than for female beneficiaries just as CY05 data indicated. These figures indicate male beneficiaries are receiving more services of each type. These findings provide a detailed view of the higher total cost per male beneficiary served discussed earlier in this section.

Figure 4.7

Statewide Service Patterns by Gender CY06						
Data Type	Gender	Service Activity	Total Beneficiaries Served	Average Payment per Beneficiary	Median Payment per Beneficiary	Average Payment Standard Deviation
Statewide	FEMALES	24 HOURS SERVICES	16,571	\$7,216	\$3,709	\$10,020
Statewide	MALES	24 HOURS SERVICES	15,612	\$8,181	\$4,275	\$10,865
Statewide	FEMALES	23 HOURS SERVICES	9,801	\$1,467	\$1,042	\$1,993
Statewide	MALES	23 HOURS SERVICES	9,982	\$1,759	\$1,279	\$2,363
Statewide	FEMALES	DAY TREATMENT	3,831	\$9,751	\$6,551	\$10,070
Statewide	MALES	DAY TREATMENT	5,622	\$11,165	\$7,823	\$10,737
Statewide	FEMALES	LINKAGE/BROKERAGE	94,109	\$735	\$236	\$1,682
Statewide	MALES	LINKAGE/BROKERAGE	91,296	\$845	\$273	\$1,778
Statewide	FEMALES	OUTPATIENT SERVICES	171,473	\$2,295	\$820	\$4,494
Statewide	MALES	OUTPATIENT SERVICES	160,852	\$2,928	\$1,099	\$5,343
Statewide	FEMALES	TBS	1,211	\$14,139	\$8,865	\$16,613
Statewide	MALES	TBS	2,086	\$15,395	\$9,999	\$16,959
Statewide	FEMALES	MEDICATION SUPPORT	118,221	\$972	\$611	\$1,380
Statewide	MALES	MEDICATION SUPPORT	105,671	\$1,116	\$686	\$1,589

Figure 4.8

California No Los Angeles (CANOLA) Service Patterns by Gender CY06						
Data Type	Gender	Service Activity	Total Beneficiaries Served	Average Payment per Beneficiary	Median Payment per Beneficiary	Average Payment Standard Deviation
CA No LA	FEMALES	24 HOURS SERVICES	11,248	\$7,197	\$3,800	\$9,891
CA No LA	MALES	24 HOURS SERVICES	10,352	\$8,131	\$4,414	\$10,253
CA No LA	FEMALES	23 HOURS SERVICES	8,070	\$1,533	\$1,057	\$2,127
CA No LA	MALES	23 HOURS SERVICES	8,194	\$1,857	\$1,284	\$2,513
CA No LA	FEMALES	DAY TREATMENT	2,546	\$9,229	\$5,676	\$10,292
CA No LA	MALES	DAY TREATMENT	3,701	\$10,967	\$7,345	\$10,855
CA No LA	FEMALES	LINKAGE/BROKERAGE	65,638	\$795	\$248	\$1,813
CA No LA	MALES	LINKAGE/BROKERAGE	63,202	\$917	\$293	\$1,908
CA No LA	FEMALES	OUTPATIENT SERVICES	118,126	\$2,133	\$779	\$4,541
CA No LA	MALES	OUTPATIENT SERVICES	107,589	\$2,680	\$1,005	\$5,341
CA No LA	FEMALES	TBS	813	\$12,089	\$7,855	\$14,996
CA No LA	MALES	TBS	1,408	\$12,998	\$8,610	\$14,874
CA No LA	FEMALES	MEDICATION SUPPORT	85,718	\$960	\$592	\$1,355
CA No LA	MALES	MEDICATION SUPPORT	74,011	\$1,112	\$676	\$1,592

### Statewide Service Patterns: Ethnicity

CAEQEO performed an analysis of each type of service by ethnicity over the past two years. Our objective was not only to compare ethnic groups by average cost per beneficiary, but also to begin to identify noteworthy changes over time. Since only two years are shown in these analyses, any statement of trend would be premature. As we conduct further analysis in FY08 and, in future years, we will be better able to determine if any trends emerge.

The following series of figures displays these findings.

**Figure 4.9**

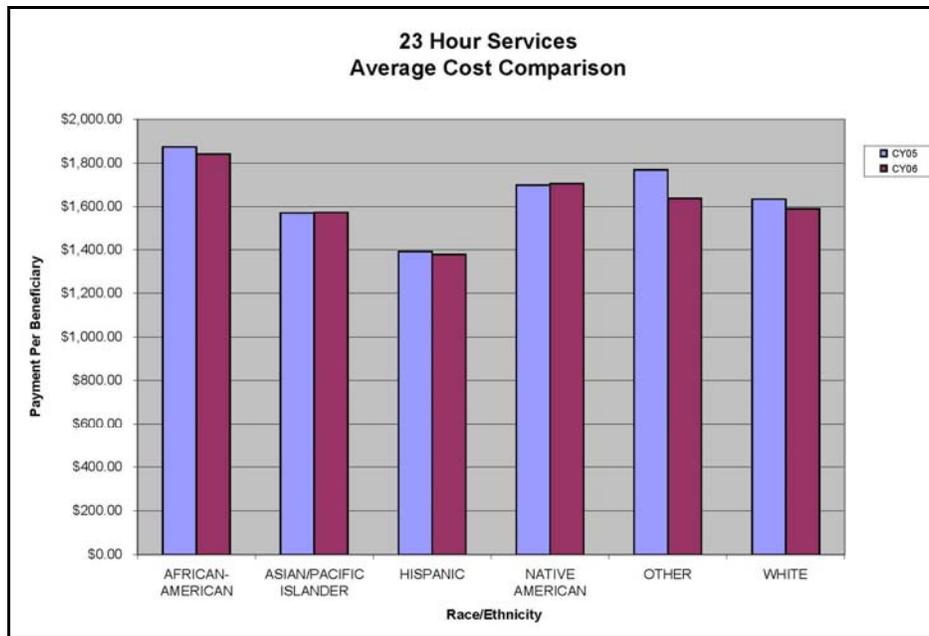
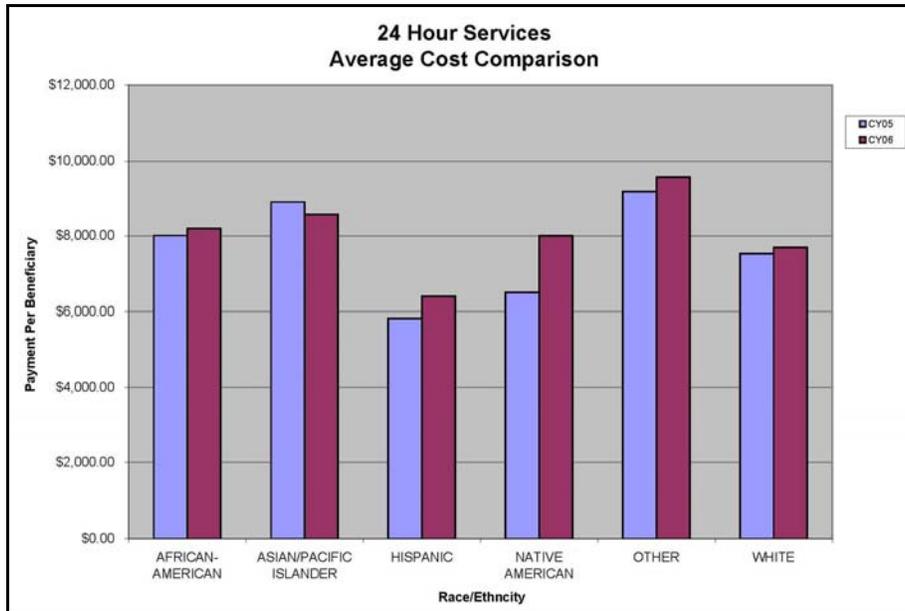


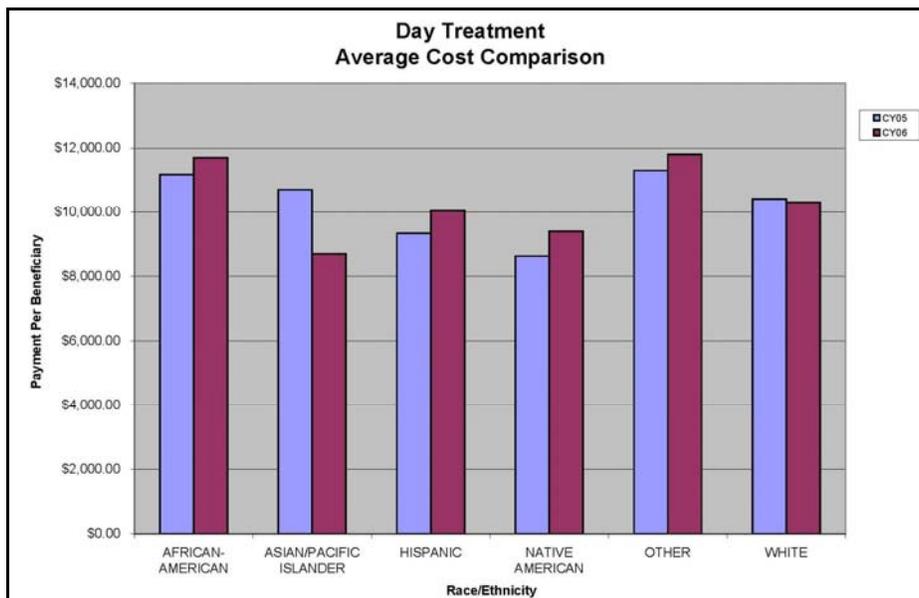
Figure 4.9 above displays average payments for beneficiaries for 23-hour services. This graph illustrates that Hispanic beneficiaries received lower average cost for these services, while African American beneficiaries received services with the highest average costs per beneficiary.

**Figure 4.10**



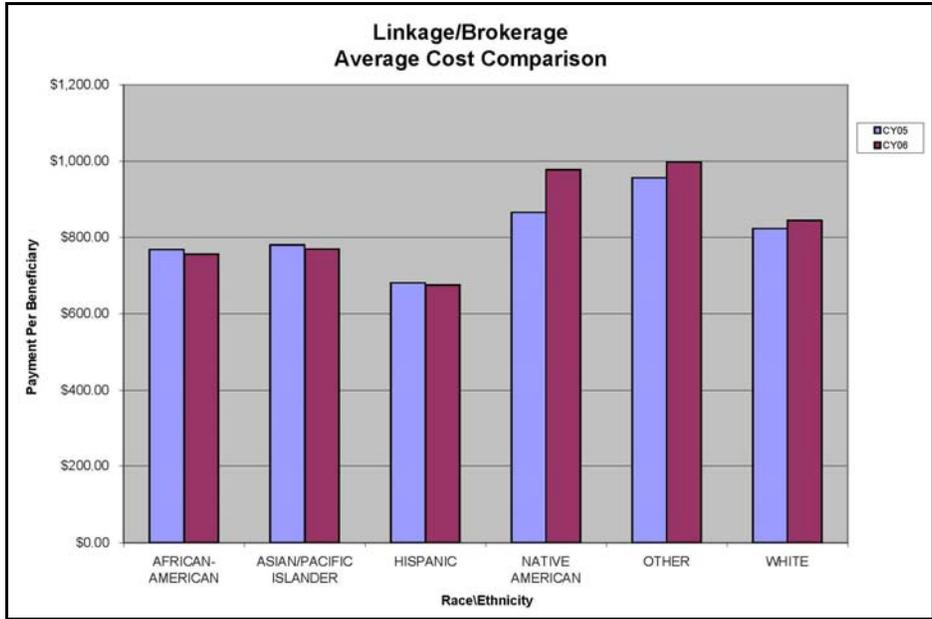
For 24-hour services, Figure 4.10 above indicates that virtually all ethnic categories exceed the average cost of Hispanic beneficiaries. Asian/Pacific Islander and African American beneficiaries receive the greatest average cost per beneficiary. The figure also indicates a noteworthy increase in service costs for Native American beneficiaries from CY05 to CY06. Other ethnic groups show little change.

**Figure 4.11**



Day treatment average cost of service for beneficiaries are displayed in Figure 4.11 above. This graph shows an increase for each ethnic group with the exception of White and Asian/Pacific Islander beneficiaries. African American beneficiaries and individuals in the category “Other” have the highest average payment per beneficiary.

**Figure 4.12**



In Figure 4.12 above, Linkage/Brokerage shows the greatest increases from CY05 to CY06 for Native American beneficiaries, while Hispanic beneficiaries received comparable amounts for both years, but remain the ethnic group with lowest average cost in this comparison.

**Figure 4.13**

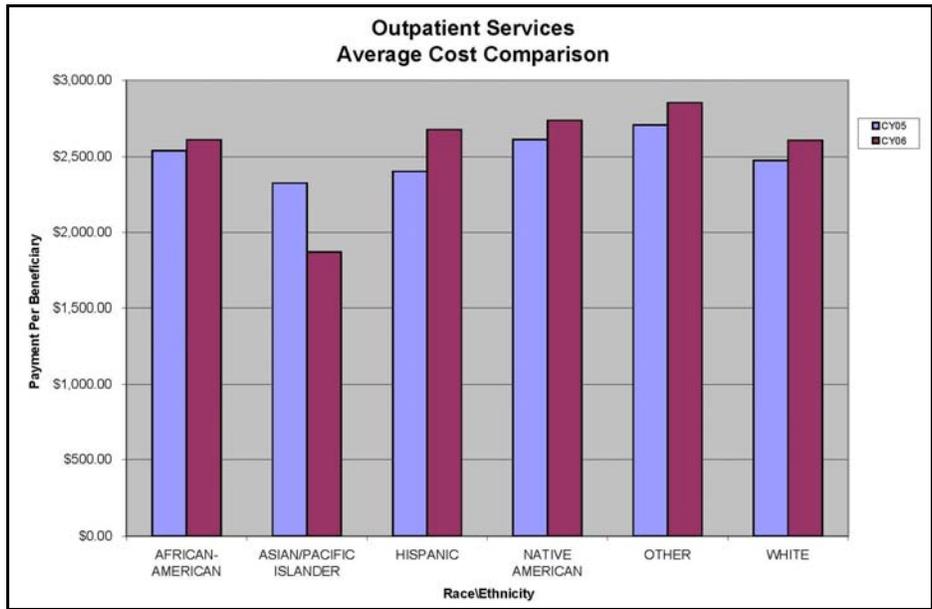


Figure 4.13 above illustrates that outpatient services approach or exceed \$2,500 for virtually all ethnic groups with the exception of Asian/Pacific Islander beneficiaries. Here Hispanic beneficiaries display statistics comparable to other groups and slightly higher than White beneficiaries, a difference from CY05 data in which these data for Hispanic beneficiaries were lower than Whites. The dollar levels increased from CY05 to CY06 for every group with the exception of Asian/Pacific Islander beneficiaries.

**Figure 4.14**

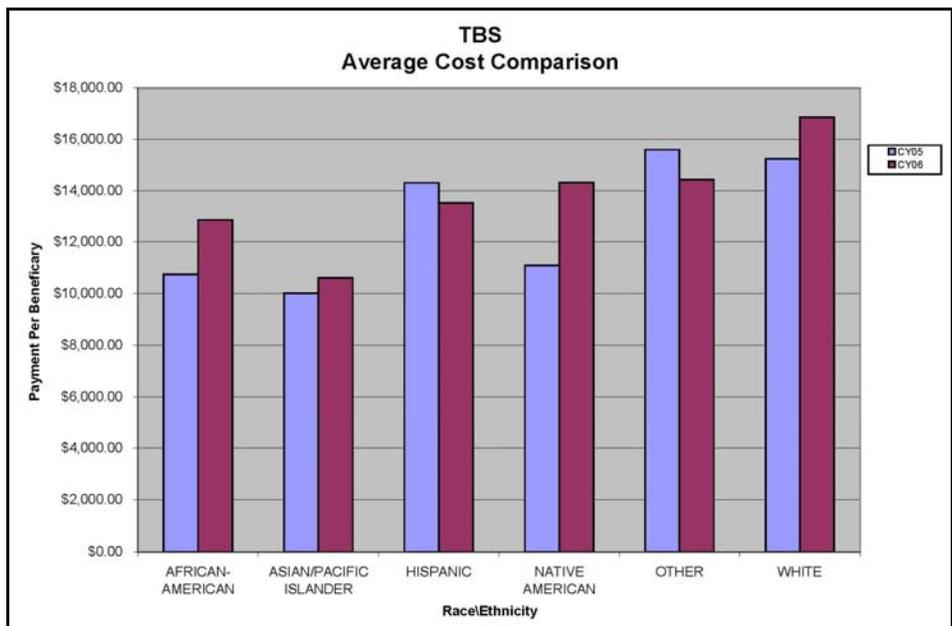
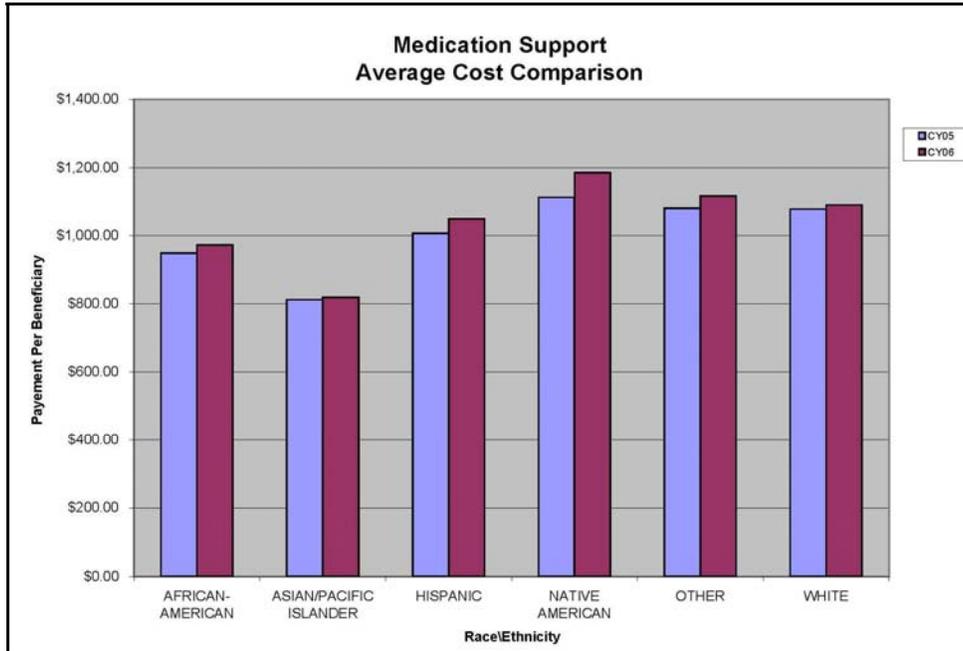


Figure 4.14 above shows strong increases in TBS from CY05 to CY06 for Native American beneficiaries, as well as increases for African American and White beneficiaries. White beneficiaries reflect the greatest average cost per beneficiary.

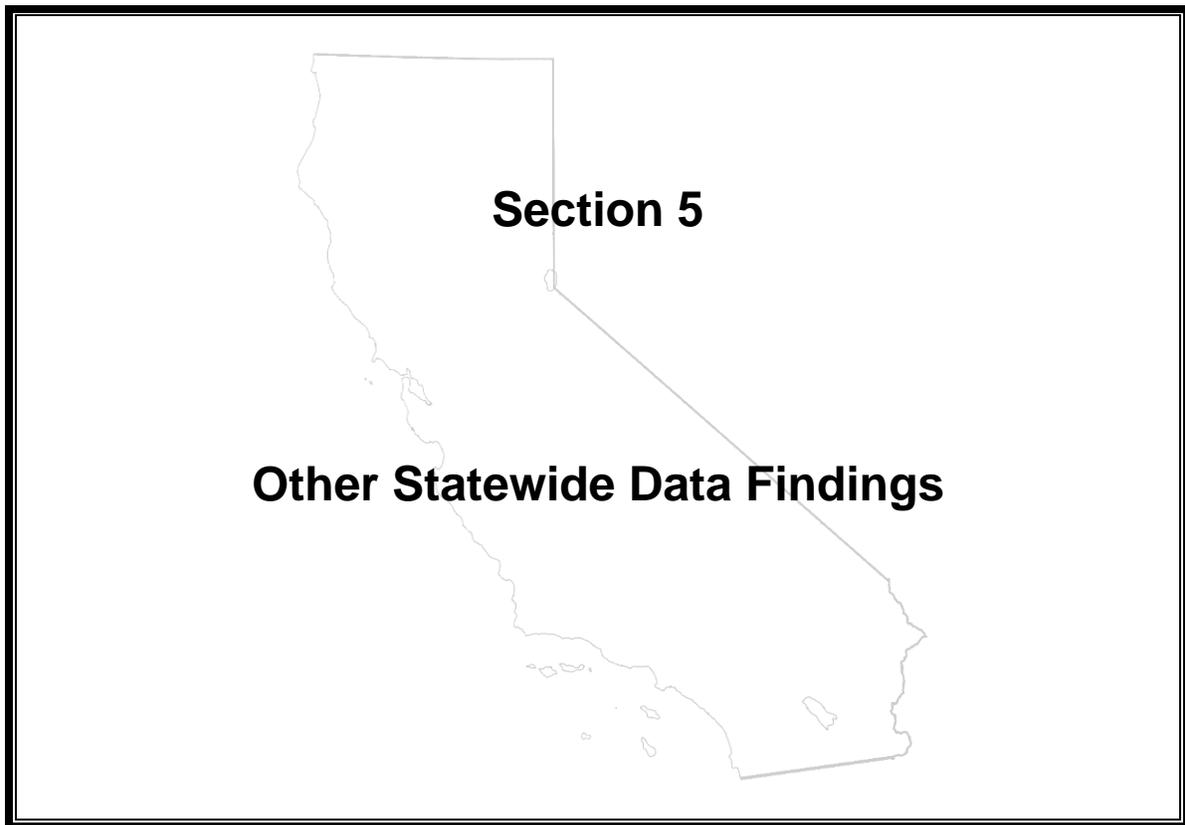
**Figure 4.15**



Average costs for medication support services (Figure 4.15 above) are highest for Native Americans with increases from CY05 to CY06 for virtually every ethnic group. The greatest increase per ethnic group is also shown for Native American beneficiaries. Asian/Pacific Islander beneficiaries show the lowest average cost for medication support.

The figures throughout this section illustrate how MHPs can use claims data to evaluate how they are serving various demographic and ethnic groups and whether services are delivered in an equitable and appropriate manner. Our intent is that this information generates interest, discussion, and further study leading to service delivery improvement at individual MHPs.

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 5.1: Overview

In Section 4, California External Quality Review Organization (CAEQRO) analyzed two important measures of the state's public mental health system's efficacy and equity in serving various demographic and ethnic populations: penetration rate and cost per beneficiary, updating the analysis we reported in our year two annual report. These data revealed what appear to be significant disparities in the services that different populations receive throughout the state.

As we suggested in Section 4, retention rates – or the number of visits a beneficiary receives – are an important measure of access in combination with penetration rates, which alone can present an incomplete picture of service utilization. In this section<sup>6</sup> our objective was to provide a more detailed analysis of California's public mental health system by:

- Providing a methodology for analyzing penetration rates that is different from one commonly used to determine how effectively a health plan is serving its respective community
- Highlighting new data from a technical assistance project conducted by CAEQRO and the California Institute of Mental Health (CiMH) in cooperation with the County Mental Health Directors' Association (CMHDA) for the Small Counties Emergency Resource Pool (SCERP)
- Addressing retention rates for foster care beneficiaries – since stakeholders in the public mental health system have grave concerns about the service delivery system for this population

## Section 5.2: Adjusted Penetration Rates

MHPs throughout California have adopted penetration rates as a key indicator of access for various populations they serve. The commonly applied formula for determining penetration rate is displayed below:

- $(\text{numerator/number of served beneficiaries}) \div (\text{denominator/number of eligible beneficiaries}) = \text{Penetration Rate}$

We believe that this formula is problematic for two reasons:

1. **The methodology for calculating the numerator.** In contrast to many purchasers of service, the California Department of Mental Health (DMH) calculates the numerator by including all beneficiaries with at least one service in a year rather than adjusting for the number of months of eligibility – or member months. A member month is a calculation that reflects the actual number of members eligible per month.

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<sup>6</sup> Source data in this section are Short-Doyle/Medi-Cal and Inpatient Consolidation approved claims extracted at different times up to March 2007.

- 2. **The diversity of California’s beneficiaries.** In certain circumstances, this formula may be overly simple. The demographic and ethnic landscape of communities and counties in California is quite varied – perhaps the most diverse in the nation. Therefore, the total size of a county, its ethnic make-up, and the age and gender distributions are all critical variables in developing a complete picture of this important measure of access to care.

Over the past three years, CAEQRO has examined MHP penetration rates, drawing on the collective analytic experience of public sector and private sector managed care plans. In year three, we present findings that reflect a more detailed approach to calculating penetration rates and provide interesting comparisons across MHPs. This section provides only a few examples of such analyses. Following the release of the FY07 Statewide Report by DMH, access to Microsoft® Excel spreadsheet versions of the data will be available at [www.caegro.com](http://www.caegro.com).

### Adjusted Penetration Rates – Age, Gender and Ethnicity

Figure 5.1 below displays two fictional examples – each of which illustrates how the traditional method for calculating penetration rates can be somewhat misleading by failing to disclose a more detailed picture.

- In example 1, MHP X and MHP Y have the same overall penetration rate of six percent. However, the penetration rate for Hispanic beneficiaries is dramatically different; MHP X shows three percent and MHP Y shows only one percent.
- In example 2, two MHPs with identical penetration rates for Hispanic beneficiaries of three percent have different overall penetration rates. In each example the different total and Hispanic beneficiary population sizes of each MHP influences the statistics.

**Figure 5.1**

Examples Illustrating The Rationale for Adjusting Penetration Rates								
Example 1	MHPs with the same overall penetration rates masking the disparities in penetration rates by race/ethnicity							
	MHP X Penetration Rate	MHP Y Penetration Rate	MHP X Eligible Count	Percentage	MHP Y Eligible Count	Percentage	MHP X Beneficiary Served	MHP Y Beneficiary Served
White	7%	8%	10,000	83%	5,000	71%	670	400
Hispanic	3%	1%	2,000	17%	2,000	29%	50	20
Overall	6%	6%	12,000		7,000		720	420
Example 2	MHPs with the same penetration rate distribution by race/ethnicity but different overall penetration rates							
	MHP X Penetration Rate	MHP Y Penetration Rate	MHP X Eligible Count	Percentage	MHP Y Eligible Count	Percentage	MHP X Beneficiary Served	MHP Y Beneficiary Served
White	10%	10%	6,700	77%	4,000	83%	670	400
Hispanic	3%	3%	2,000	23%	800	17%	50	20
Overall	8%	9%	8,700		4,800		720	420

These two examples display the limitations of calculating penetration rates using the most basic formula described above. One way to improve the simple formula is to use statistical procedures that adjust for key demographic variables within California's Medi-Cal beneficiary population. Attachment 17 further explains our rationale and methods for adjusting penetration rates and the formula we used to calculate the adjusted rate.

Attachment 17 also presents penetration data for CY06 illustrating the impact of adjustments for gender, age and ethnicity for every MHP. The table includes ranking, where 'one' is the highest value and 56 is lowest. Our findings indicate that adjustments for gender and age have little impact. However, a comparison of overall penetration rate with the adjusted ethnic penetration often shows significant differences. For example, San Benito MHP has an unadjusted overall penetration rate of 7.79 percent and a penetration rate adjusted by ethnicity of 10.04 percent. Using the unadjusted penetration rate, San Benito MHP's overall ranking is 24; however, its ranking based on an adjusted penetration rate for ethnicity is six.

### Adjusted Penetration Rates – Retention

A continuing dialogue with MHP staff and a review of current research on service utilization in public sector settings suggest that penetration rates can also be adjusted by eliminating clients who receive few services. For most MHPs, except for beneficiaries in acute crisis, the screening and formal intake process may account for one to five of the initial billable services. In addition consumers may withdraw or discontinue services for many reasons. Therefore another view of the penetration rate is to eliminate clients with three or fewer services from the pool of beneficiaries served. Attachment 17 also displays adjusted penetration rates by MHP when clients with three or fewer services are removed from the numerator.

For example, Monterey MHP shows a 3.59 percent overall penetration rate when eliminating consumers with three or fewer services. However, the adjusted ethnic penetration increases to 5.06 percent. These data are particularly interesting since the shifts in penetration rates are not consistent. For some MHPs, excluding consumers with three or fewer services results in increased penetration rates for the ethnic penetration rate; however, for other MHPs there is a dramatic decline in the ethnic penetration rate.

A detailed understanding of these results can only be gained by each MHP's evaluation of its own data. This information can then be useful for local planning and evaluation of service delivery, especially regarding efforts to gain insight into and improve services to specific sub-populations.

### Section 5.3: Small County Emergency Risk Pool Project

In Section 3, we describe the technical assistance project for SCERP that was offered by CAEQRO in partnership with CMHDA and CiMH. CMHDA initially approached CAEQRO on behalf of SCERP counties to assist in data collection and analysis for inpatient admissions. Together with CMHDA and CiMH, CAEQRO offered the following specific technical assistance to help MHPs in SCERP counties gain a better understanding of how well they are managing care to promote wellness, resiliency and recovery.

## Admission and Readmission Analysis

Understanding inpatient admissions is key to an MHP's ability to effectively manage resources. Most small MHPs not only have limited (if any) access to data analysts but also have too few consumers for formal quantitative projects. While inpatient admissions always present disruptions for beneficiaries, those beneficiaries served by small MHPs are usually hospitalized outside their county of residence causing even more distress. Because of the highly disruptive impact of hospitalizations on beneficiaries – particularly in small counties – as well as the high cost of these services, CAEQRO analyzed Medi-Cal approved claims data to study key service patterns that precede and follow inpatient admissions.

As part of the SCERP technical assistance process, with the assistance of CiMH and CMHDA, CAEQRO conducted a seminar for MHP clinical managers and administrators. To begin the dialogue, CAEQRO used a novel presentation of data to help participants better understand and use service pattern data contained within Medi-Cal approved claims files, as described below:

1. The CAEQRO data analyst selected a random sample of 20 beneficiaries from among those who had received one or more inpatient hospital days during May 2005 – which was chosen as the “index month” or original data point. Because May is almost mid-way through the calendar year, it is possible to display a significant amount of data both before and after it for that calendar year.
2. Each of the beneficiaries in the sample was de-identified and given an alias to convey the point that the data reflected a “real person” who was in the service delivery system and to track the services that he or she did or did not receive.
3. CAEQRO then analyzed the services provided in each month of CY05 for these 20 beneficiaries. Figure 5.2 offers three examples of beneficiaries who were followed in this manner and shows how this display allows anyone viewing the data to easily see “what happened” to each person and ask questions such as:
  - What types of services might help prevent admissions?
  - What types of services typically follow admissions?
  - What patterns are associated with readmissions?

**Figure 5.2**

Three Cases from SCERP Sample With Index Admissions During May 2005																
Name	Demographics	Service Category	Total Service	CY 2005												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
<i>Fred</i>	<i>43, M, White</i>	CRISIS	1													
		Index INPATIENT	1					1								
		INPATIENT	8									8				
		MEDICATION SUPPORT	55	4	5	2	4	12	8		8	4	8			
		MH SERVICES	32				1	4	6		16	2	3			
<i>Gail</i>	<i>25, F, White</i>	CRISIS	22	5		1	1	1	7				1	4	2	
		Index INPATIENT	2					2								
		LINKAGE/BROKERAGE	3	1			1	3							1	
		MEDICATION SUPPORT	8	2				3	1					1		1
		MH SERVICES	70	5		1	2	3			10		14	33	5	
<i>Henry</i>	<i>31, M, White</i>	CRISIS	10			3		4			1	2				
		Index INPATIENT	3					3								
		INPATIENT	12			7					5					
		LINKAGE/BROKERAGE	3			2							1			
		MEDICATION SUPPORT	6			6										
MH SERVICES	4			2	1						1					

For example, Figure 5.2 above shows that consumer “Fred” had one inpatient day in May 2005. His service pattern shows no linkage services and a subsequent re-hospitalization for eight days in August. Consumer “Henry” had no services following his three-day hospital stay in May and was subsequently re-hospitalized for five days in July. Seminar participants found these sample data to be quite interesting.

This display of data helps to illustrate a very practical use of data. Attachment 18 presents the full sample of 20 cases used in the SCERP workshop. As a follow-up to the workshop, CAEQRO performed more extensive analysis for all MHPs as illustrated in Attachment 18. This follow-up analysis allows each MHP to see the costs and volume of services their clients received before and after the indexed inpatient admission.

### Planned/Unplanned Services Analysis

CAEQRO applied the following core principles of disease management to approach the planned/unplanned services analysis – the next component of the SCERP technical assistance project:

- Unplanned services such as hospital-based emergency services or inpatient admissions are disruptive to the beneficiary’s life and place in the community as well as costly to the MHP.
- Unplanned services are generally not a desired modality for effectively managing chronic illness.

- Beneficiaries who have an individual treatment plan and receive a set of effective planned services should be less likely to need unplanned services.

The first round of data provided by CAEQRO applied the following assumptions about planned versus unplanned services and active versus inactive beneficiaries.

- **Planned vs. unplanned services.** Planned services are less intense and typically associated with a treatment plan. Unplanned services are expensive, more intense, and more confining, and therefore more disruptive to daily living.
- **Active vs. inactive consumers:** Active consumers have received a specific number of planned services within a specific time frame. This level of service activity suggests that they are receiving those services as part of a formal treatment plan. Inactive consumers have not received planned services in the same time frame and are likely not to be engaged with the delivery system.

These sets of definitions are consistent with two common measures of successful disease management: reduced hospitalization and reduced use of emergency services. CAEQRO, CiMH and CMHDA staff initiated discussions with some of the SCERP counties to review these data. These discussions stimulated questions about the original data assumptions underlying our findings.

Below we review the data that we originally presented to the SCERP counties. Our goal is to finalize data assumptions in early FY08, so that the collaborative group can move forward in studying/analyzing key service variables through a collaborative project.

### Initial data discussions

To develop the initial set of data, CAEQRO used four designated index months as shown in Figure 5.3 below to identify those clients receiving unplanned services in that month. Each client was then classified according to whether he/she was active or inactive. An “active client” was defined as a client receiving four or more planned services during the previous 90 days. The mean percent of active clients statewide who received unplanned services is between 44 percent and 47 percent in each of the sample data sets. However, most of the samples show a very wide range from 0 percent to 100 percent for specific MHPs, thus presenting opportunities for intervention.

**Figure 5.3**

Statewide Percentages of Active Clients Who Received Unplanned Services in Index Month								
Index Month	Client Total	Client Active	Client Inactive	Client Active Percentage				
				Mean	Median	Minimum	Maximum	
Jul. 2005	6,979	3,157	3,822	45%	50%	0%	100%	
Nov. 2005	6,771	3,204	3,567	47%	53%	24%	100%	
Jul. 2006	6,258	2,867	3,391	46%	50%	0%	100%	
Nov. 2006	4,179	1,819	2,360	44%	45%	0%	100%	

As Attachment 19 illustrates, SCERP MHPs represent small counties with smaller, more variable numbers than MHPs in larger counties; however, the four samples in Figure 5.3 illustrate that some MHPs are consistently above average in their percentages of hospitalized active beneficiaries.

Although SCERP counties are those working on these concepts actively, these analyses are relevant as measures for all MHPs. Attachment 19 shows a very wide range of percentages of active clients who received any unplanned service in the index month of July 2005. Kings MHP and Madera MHP exhibit higher rates of 75 percent and 73 percent, respectively. The statewide percentage is 45 percent. Consequently, reducing unplanned services for active clients should be a common goal for all MHPs. The data analysis illustrated for SCERP counties can help all counties measure and evaluate progress towards such a goal.

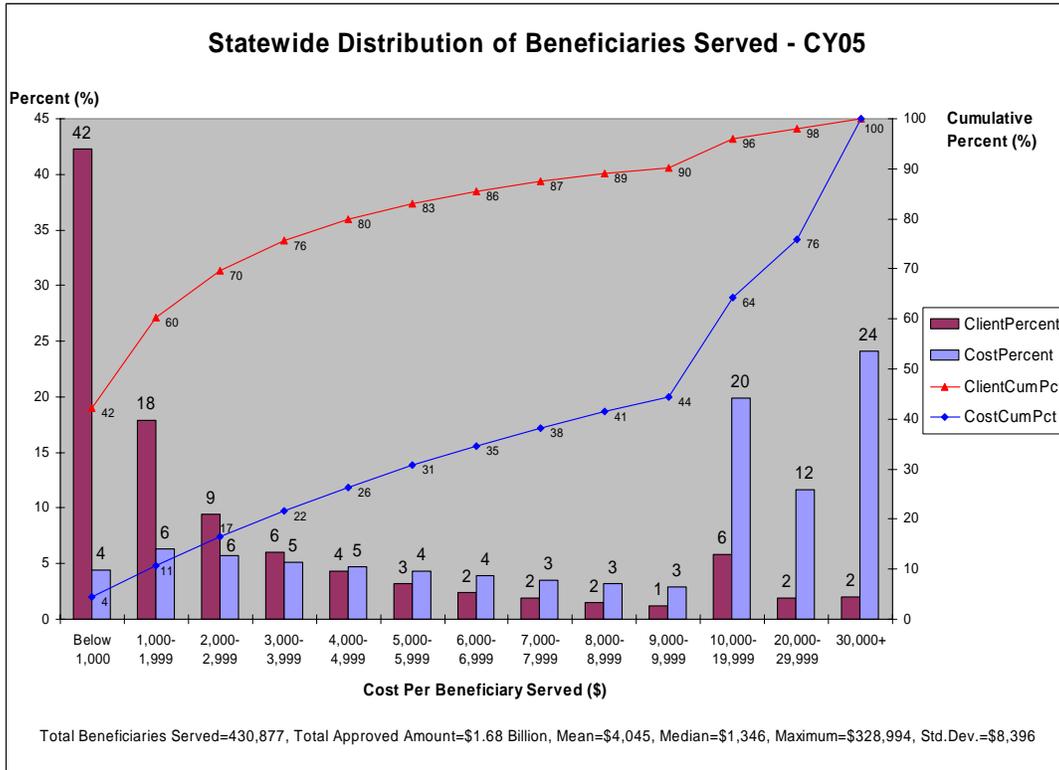
## Section 5.4: High-cost Beneficiaries

All MHPs managing Medi-Cal resources for their communities are concerned with how they can best allocate limited resources. As discussed above, using planned services to avoid high-cost unplanned services can be a valuable strategy. Figures 5.4 (CY05) and 5.5 (CY06) – both follow below – illustrate that the number and cost of “high-cost beneficiaries” over two years are consistent.

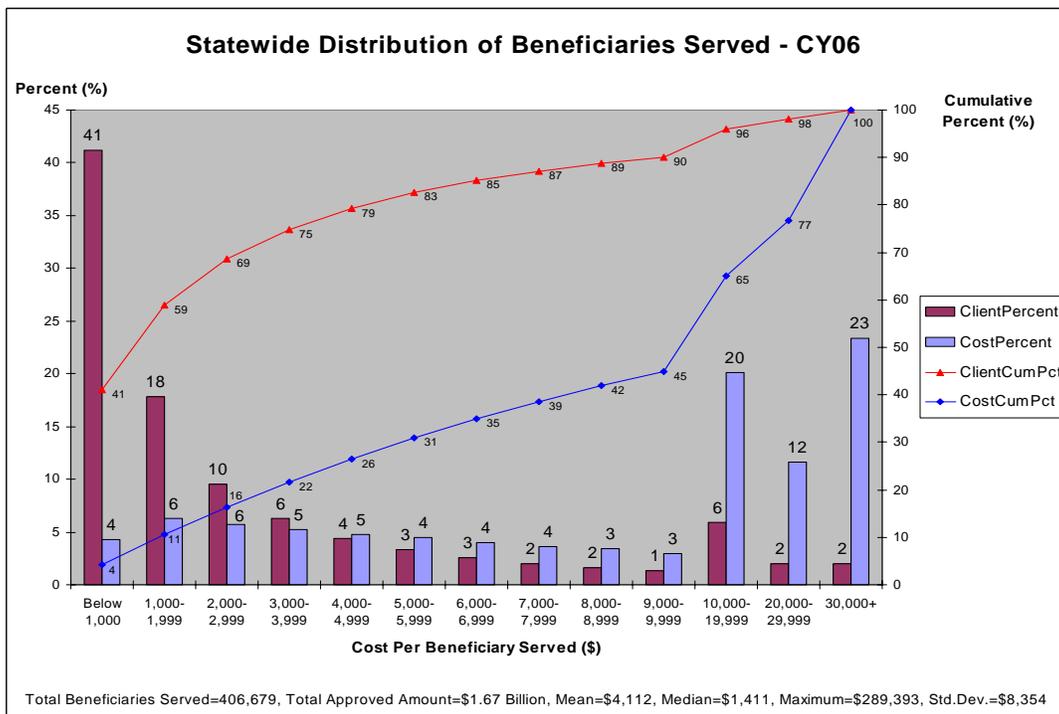
For both years, the graphs illustrate how a small number of beneficiaries receive a very large percentage of the cost of service. For example, in Figure 5.5, a small 10 percent of clients received over \$10,000 in services in CY06. In that same year, only two percent of beneficiaries received 23 percent of the total service costs. While the figures have not been adjusted for the annual cost of living, the consistency between the two years is likely to remain.

These data represent a starting point for analysis and a useful platform for program planning and evaluation. It may be possible, for example, to work with consumers who are receiving lower cost and fewer unplanned services to avoid disruptive and costly unplanned services such as acute inpatient stays. Similarly, by analyzing which consumers are in the high-cost groups (shown in these figures), MHPs may be able to initiate more thoughtful planning. In future analyses, CAEQRO will pursue such questions and share our results with MHPs.

**Figure 5.4**



**Figure 5.5**



## Section 5.5: Foster Care Analysis

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. Consequently, CAEQRO performed an analysis of foster care beneficiaries to help each MHP design services that can best reach and benefit this high-priority group.

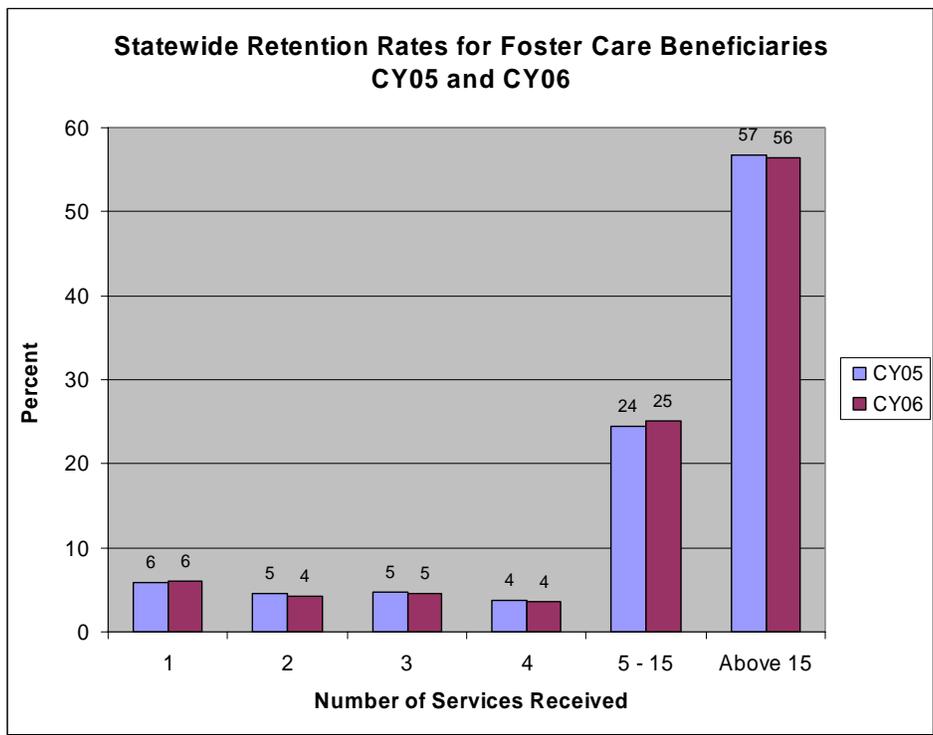
Building on year two, we performed a comparative analysis to identify any changes from CY05 to CY06. While we did not expect dramatic changes from our year two findings, we noted that most patterns remained unchanged. The statewide foster care beneficiary population did decline slightly: the total number of beneficiaries for CY05 was 81,472 and for CY06 was 78,525 – a decrease of 2,947 beneficiaries or 3.6 percent. In addition, our analysis surfaced shifting in statewide patterns for foster care beneficiaries by ethnicity.

In the remainder of this section, we analyze several measures of foster care beneficiary access – both statewide and within specific ethnic groups.

### Retention Analysis

Figure 5.6 below shows that in each calendar year (CY05 and CY06), the percentage of foster care beneficiaries receiving high levels of service (over 15) remained over 50 percent. The next largest group received 5-15 services. This analysis indicates an unchanged pattern of retention over a two-year period.

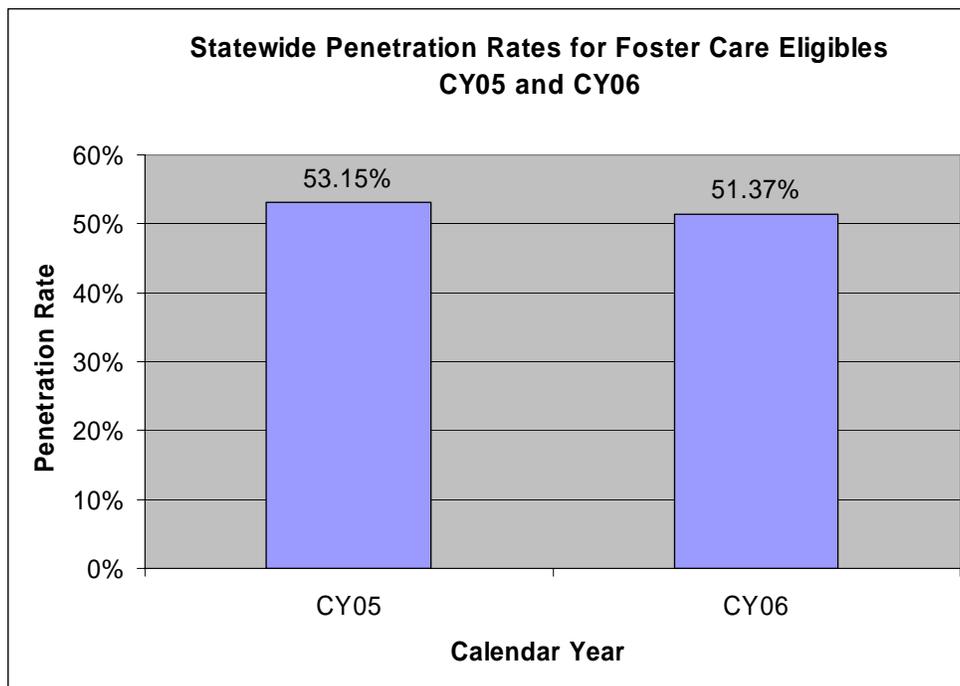
**Figure 5.6**



## Penetration Rate

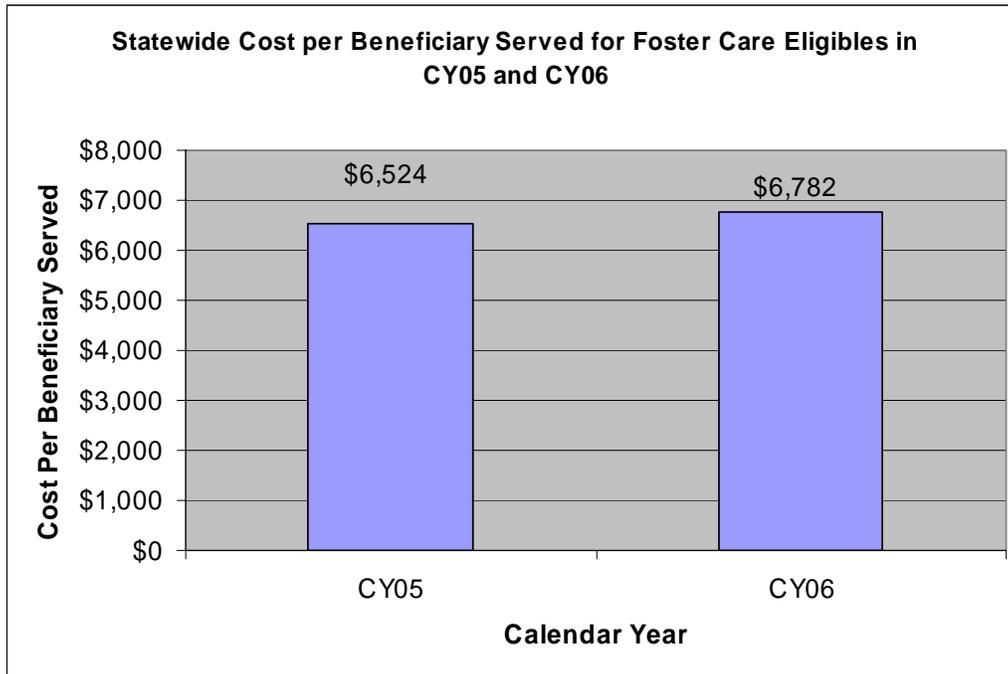
Figure 5.7 illustrates the relative stability of statewide penetration for foster care beneficiaries for CY05 and CY06. However, the actual numbers underlying the percentages are important to consider. The number of foster care beneficiaries served for CY05 was 43,299 and for CY06 was 39,963 – a decrease of 3,336 beneficiaries or 7.7 percent. This reduction is higher than the 3.6 percent decrease in the beneficiary population in CY06 compared to CY05. A slight decline cannot be considered a trend, but continued analysis will be important in future years to assess whether penetration levels remain high.

**Figure 5.7**



## Cost per Beneficiary

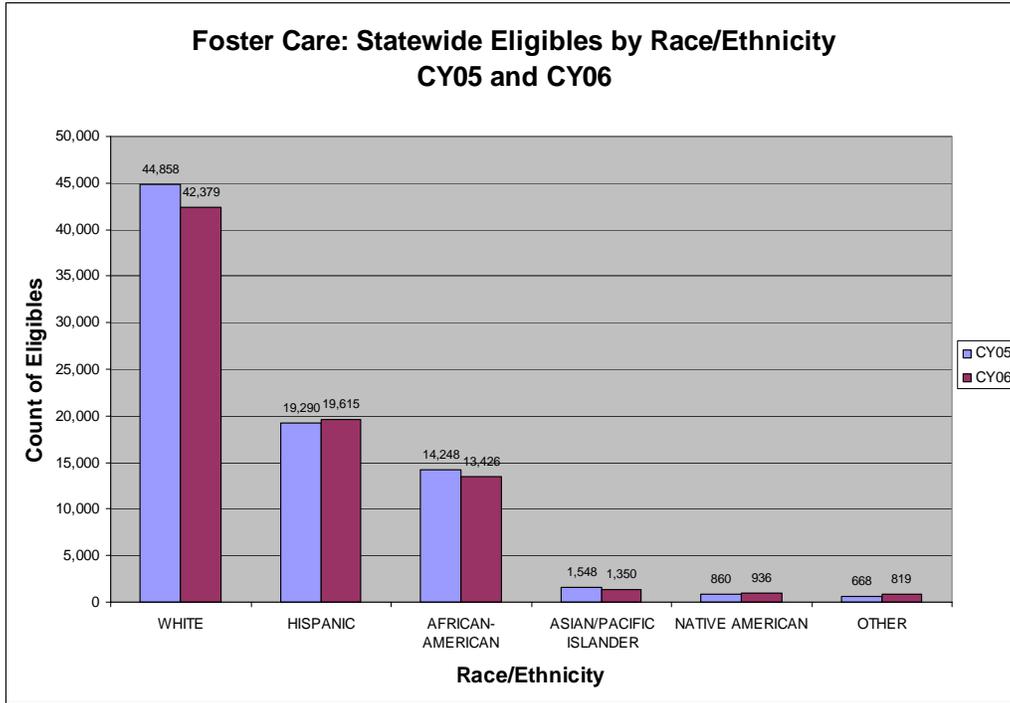
Cost per beneficiary on a statewide basis remains relatively stable with a slight upward movement in CY06, as illustrated by Figure 5.8 below. As with the cost data included in Section 4, these figures are not adjusted for inflation.

**Figure 5.8**

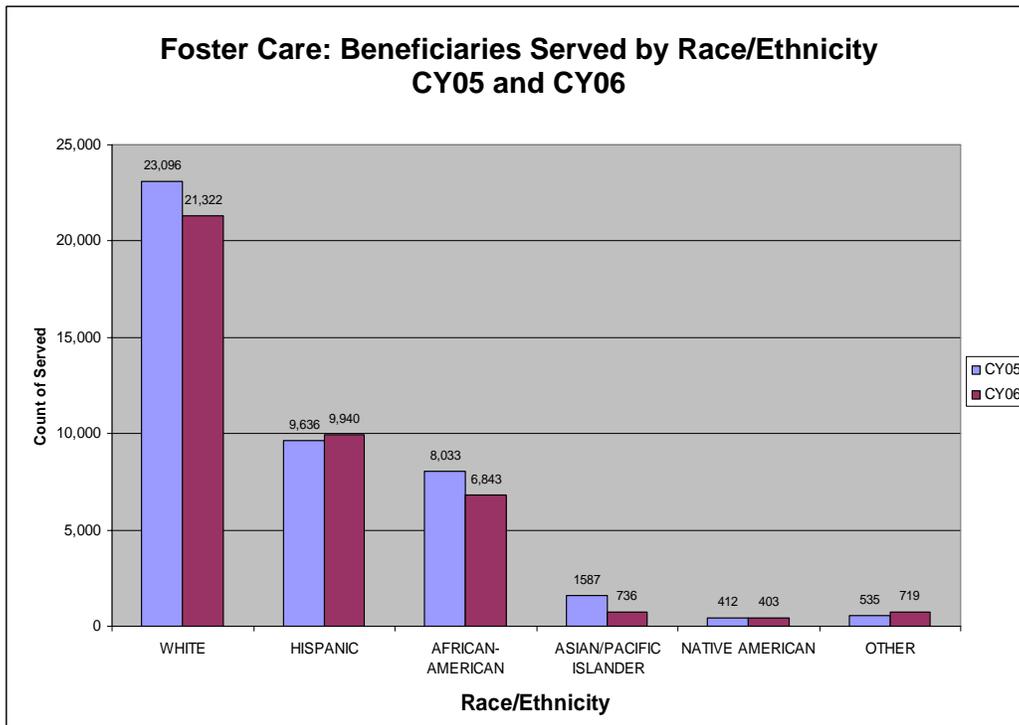
## Ethnicity

Our findings on foster care beneficiaries by ethnicity showed relative stability in the number of eligible beneficiaries by ethnicity (Figure 5.9) but also indicated potentially significant reductions in the number of African-American and Asian/Pacific Islander beneficiaries served as displayed in Figure 5.10.

**Figure 5.9**

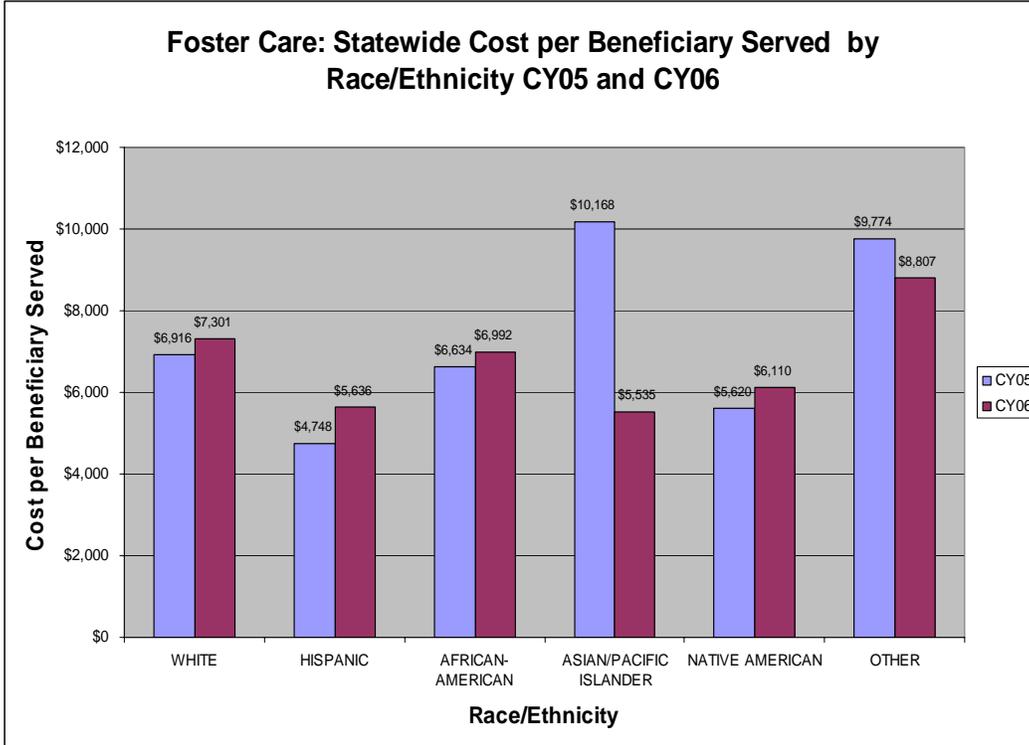


**Figure 5.10**



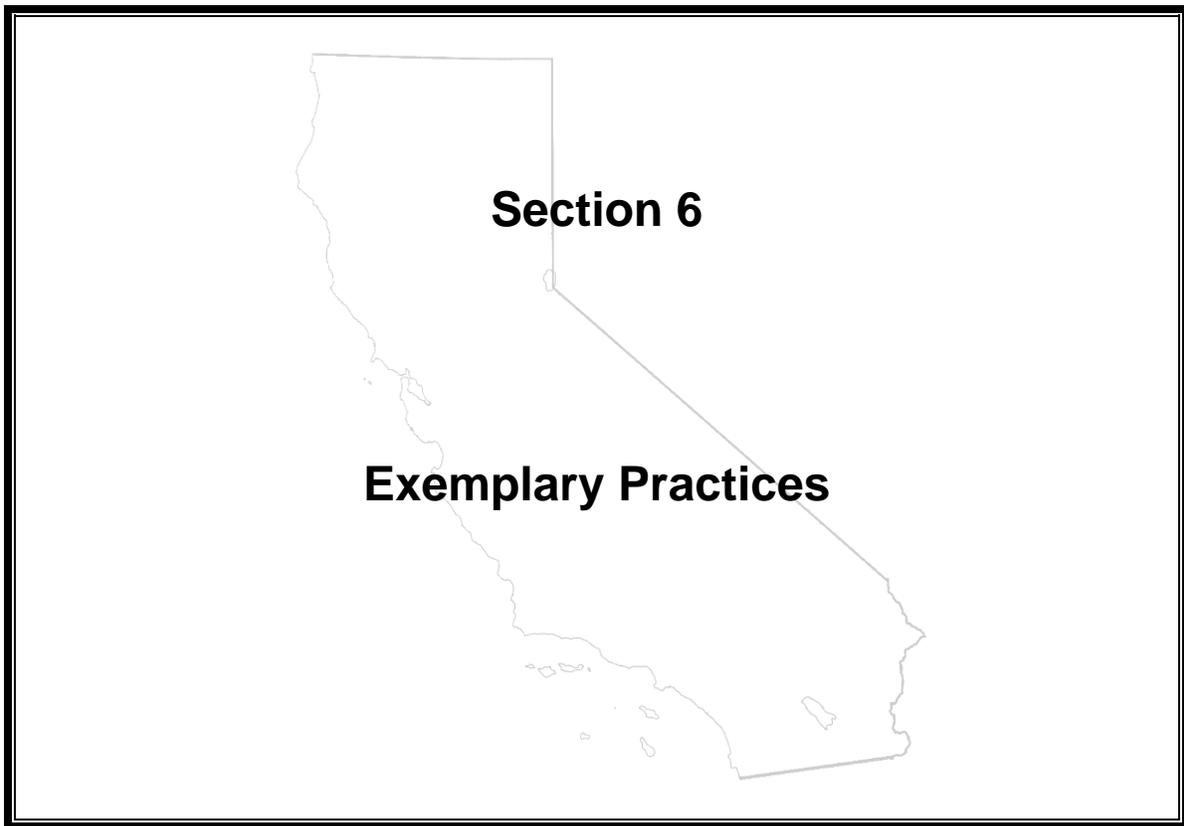
Cost per beneficiary served by ethnicity largely replicated the slight increase statewide from CY05 to CY06, as shown in Figure 5.11. Asian/Pacific Islander beneficiaries experienced a large reduction in cost per beneficiary served.

**Figure 5.11**





**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 6.1: Overview

In Section 2, we indicate that almost all mental health plans (MHPs) initiated at least some activity to address our recommendations from year two – and in some instances – from year one. These findings suggest that the CAEQRO process has helped raise awareness among all MHPs of the importance of working collaboratively within the MHP, within the community and across counties in developing creative solutions to delivery system challenges. We also believe that our emphasis on analyzing readily available approved claims data has helped to highlight quality improvement initiatives and illustrate the value of data.

In compiling the exemplary practices highlighted in this section, we were struck by the ability of MHPs in varying geographic regions, with diverse demographics and often with limited resources, to develop innovative consumer-focused programs or to improve administrative processes – sometimes dramatically – by working collaboratively and cross functionally.

Listed below are highlights of the programmatic and administrative areas featured in this section:

- **Web site technologies** – Alameda MHP
- **Cultural competence in service delivery** – Orange MHP
- **Outreach to/analysis of underserved populations** – MHPs in Mono and San Benito counties, and San Mateo MHP
- **Primary and mental health care integration** – MHPs in Marin and Fresno counties
- **Information system implementations** – MHPs in Los Angeles and Solano counties
- **Claims payment processes** – Placer/Sierra MHP
- **Delivery system model (open access)** – San Bernardino MHP

In addition to the exemplary practice summaries that follow, we would also like to acknowledge several MHPs that are engaged in noteworthy practices or in activities specific to their operations: Kern MHP's implementation of its Anasazi information technology platform; San Diego MHP's Community Services and Support matrix; and Santa Clara MHP's physician spreadsheet to support medication management.



## Section 6.2: Exemplary Practices

### Exemplary Practice #1

#### Alameda MHP

#### *Improved communication through Internet technologies*

### Overview

Alameda MHP employs Internet technologies to improve communication between MHP staff and contract providers and provide useful information to all stakeholders. Today the MHP operates the following Web sites:

- An Intranet for Alameda County Behavioral Health Care Services (BHCS) staff
- A public Web site that offers a broad spectrum of information to consumers, family members and other stakeholders
- A provider Web site that offers a centralized source of timely, accurate information to these important partners in care

Alameda MHP also has a very effective help desk that supports all of these Web sites.

In addition, Alameda County offers a Network of Care for Behavioral Health Web site that provides information to consumers and family members. (The county also offers a second Network of Care Web site for older adults.) The California Department of Mental Health has made this resource available to all counties through funding under the Mental Health Services Act.

### Benefits

- Improved staff and contractor productivity, as well as improved contractor relations, through:
  - Easy-to-access policies, procedures, forms, resources and other materials
  - Fewer errors caused by staff use of using out-of-date information
  - Increased access to help desk resources
- More informed consumers and family members, including
  - Access to advocacy tools
  - Information about available services
  - A provider resource search tool, which allows consumers to specify the kind of services they need by city, gender, age and type of service desired

### Background

In 1998, the MHP's information systems (IS) department launched an Intranet Web site for BHCS staff. Secure and intended for internal use only, the Intranet today provides access to most policies and procedures, as well as clinical and administrative forms, including an IS services request for the help desk. In August 2002, the MHP launched a public Web site that was built with commonly used and relatively inexpensive Internet technology. This first public Web site ([www.acbhcs.org](http://www.acbhcs.org)) was developed to inform the

public and providers about Health Insurance Portability and Accountability Act (HIPAA) rules and regulations. Today, in addition to its Intranet, the MHP offers access to three Web sites for its stakeholders:

- **A greatly improved public site** ([www.acbhcs.org](http://www.acbhcs.org)). The MHP has greatly improved its original public site over the last five years, creating a comprehensive portal with information such as calendars of events, provider resource directories, training materials, announcements, external links, etc. It also offers a great deal of information about available services, patient rights, the Mental Health Board, contracting opportunities for providers, etc.
- **A provider-only Web site.** Formerly accessed through the public Web site, this provider-only resource offers a variety of information and useful tools, including: quality assurance policies; procedures and forms; client data collection forms; IS service request forms; other downloadable forms, reports and screens for collecting data to meet reporting requirements for full service partnership programs funded through MHSA. This Web site is especially helpful to this MHP because of its large contract provider network, which delivers approximately 85 percent of its direct services.
- **Network of Care for Behavioral Health –** <http://alameda.networkofcare.org/mh/home/index.cfm>. Alameda County offers a public Network of Care for Behavioral Health Web site, providing another useful option for consumers and family members, and for those seeking care. It provides information about mental health services, laws and related news, as well as communication tools and other features. DMH made this site available to all counties through funding under the MHSA. Alameda County staff works with Trilogy Integrated Resources LLC, creator of the Network of Care Web sites, to maintain up-to-date program listings.

Except for the Network of Care for Behavioral Health Web site, the on-going operation and continued improvement of these Web sites are provided by the MHP's IS staff, with guidance and participation from executive leadership. The MHP offers training and technical support through a centralized IS Support and Operations unit that has six FTEs (full-time equivalents) and includes a help desk comprised of an additional four FTEs. Overall, the unit supports up to 3,500 users and fields 700-800 calls per month for assistance on a variety of routine and complex problems. The help desk is a well-regarded resource with its staff described by MHP staff and contractors as very friendly, knowledgeable and supportive – both for Web-site-related questions and all other critical IS applications.

**Exemplary Practice #2****Fresno MHP*****Primary and mental health  
care integration*****Overview**

Fresno MHP and Sequoia Community Health Center, a local Federally Qualified Health Center (FQHC) within the largest metropolitan area of the county, successfully collaborated to create a “warm hand off” of consumers who were “stable enough” to receive community-based behavioral health services at the FQHC

(or other primary care provider). The MHP Director attributes much of the success of this project to a commitment by each agency’s leadership to working in partnership, as well as a shared focus on quality of care – in other words, doing what best serves the consumer. Based on the success of this initial effort, the MHP is currently entering into an additional memorandum of understanding (MOU) with Valley Health Team, another FQHC that serves consumers in outlying rural communities in the county.

**Benefits**

- Facilitated the coordination of service planning for consumers with acute medical and psychiatric needs
- Enabled the MHP and the FQHC to allocate resources appropriately and provide the appropriate level of care to consumers in their community
- Actively engaged consumers in their service planning – providing choice and control regarding their participation in the new process

**Background**

During August 2006, Fresno MHP and Sequoia Community Health Center, an FQHC within the largest metropolitan area of the county began meeting to address the primary and mental health care needs of consumers in their community. The FQHC had obtained a state grant that funded a psychiatrist and clinical behavioral health staff to provide services to the homeless. Simultaneously, the MHP was examining its target population and scope of services. A key objective of these meetings was to define mechanisms for a “warm hand off” for those MHP consumers who were “stable enough” to receive community-based behavioral health services at the FQHC.

The MHP’s administrative, medical and clinical staffs worked with the FQHC staff to develop MOU and formalized the following:

1. The referral process for MHP clients into the FQHC for primary care consultation and management
2. The referral process for FQHC clients into the MHP for consultation from behavioral health care specialists
3. Criteria for “stepping down” those MHP consumers whose care could be managed at the FQHC level of services

This exemplary practice focuses on the third of these objectives.

### The “criteria”

The MHP elected to rely on the medical judgment of its medical staff and provide guidelines for its clinical and medical staff, including identifying those consumers who:

- Require medication-management only
- Have not had any recent medication changes
- Have not had recent acute episodes

Significantly, consumers are empowered to have a choice in their treatment plan. Only consumers who agree to the transfer participate in these services.

### The process

The “warm hand off” is coordinated by two project managers – one from the MHP and the other from the FQHC. Support staff arrange for appropriate releases, appointments and medical record copying. All potential consumers are tracked from referral through the first contact at the FQHC. Potentially eligible consumers who miss appointments are given referrals by phone and/or mail. Interpreter services are specifically coordinated on an “as needed” basis.

Project leads meet weekly, or more often, if needed, and monthly with management and supervisory staffs from both agencies. The executive management staff from both agencies meets quarterly and both report that on-going communication has proven useful in ensuring the appropriate level/intensity of care for individual consumers, as well as in refining organizational processes.

### Results to date

The initially targeted goal was the successful transition of a maximum of five consumers per month to allow both the MHP and the FQHC staff to review and modify the process. During the first five months of 2007, 21 consumers were transferred from the MHP to the FQHC, while another 116 consumers were also transitioned from the MHP to other primary care providers of their choosing.

**Exemplary Practice #3****Los Angeles MHP*****Work flow analysis for  
replacement information  
system*****Overview**

The Los Angeles County Department of Mental Health (LACDMH) developed a comprehensive work flow analysis and documentation process prior to issuing a Request for Proposal (RFP) for a replacement system – known as Integrated Behavioral Health Information System (IBHIS).

This process provided LACDMH (the Los Angeles mental health plan) with up-to-date written documentation of the existing system's major clinical and business functions and assisted with communications among the many interested stakeholder groups. It also provided baseline information from which to review and streamline many outmoded processes, an important activity planned to occur concurrently with system selection and implementation. Such work flow documents are critical to any successful information system (IS) vendor selection and implementation. LACDMH anticipates releasing the RFP in September or October 2007.

**Benefits**

- Having documented work flows prior to the start of the RFP development enabled LACDMH to understand the needs that exist within specific operations and create an RFP that is responsive to those needs. It will also assist in identifying the vendor/product that best satisfies clearly defined requirements.
- Content area experts produced comprehensive and accurate work flow documentation – both as a resource for the RFP development process and as a reference point throughout all project phases.
- The work flows assisted LACDMH staff in developing clear and concise technical requirement questions and scenarios, which will help vendors more accurately formulate technical responses. The work flows will also be an integral tool used by staff in evaluating RFPs.
- The work flows assisted with communications to various interested stakeholder groups on a very complex topic.

**Background**

Most MHPs installed their current systems more than ten years ago and since then have made significant enhancements to software and work flow functionality. However, very few MHPs have taken the time and devoted staff resources to documenting current core business and clinical activities prior to developing an RFP's technical requirements for a new information technology (IT) system and vendor.

LACDMH recognized the need for a comprehensive mental health IS with robust clinical functionality. Internal department planning work for IBHIS began in July 2005. The goal of the IBHIS project is to obtain and implement a proven commercial off-the-shelf software solution that will integrate and automate numerous clinical and administrative

operations, as well as transition county-operated clinics from existing paper-based records to an electronic health record.

The formal public kick-off occurred in June 2006; the finished work flows were presented to LACDMH stakeholders at a Workflow Playback Session on February 8, 2007; and on March 12, 2007, LACDMH presented an overview of the process at the Statewide Information Sharing on Technology Projects and Efforts, a conference sponsored by the California Department of Mental Health.

### Specification – a critical phase in the process

The IBHIS project has three significant phases – specification, selection and implementation. This exemplary practice describes one of the work activities within the specification phase – documenting work flow functions prior to producing the RFP for a new IT system. It was essential to have the core activities of the current system and related business practices documented for future reference. To provide valuable information for the RFP development of technical requirements, LACDMH initiated a work flow documentation process, which allowed all stakeholders to better understand how programs operate and the needs that exist within these operations.

The work flows provided logical representation of seven core business and two administrative functions and included the key steps, decisions and outputs involved in a particular function. Staff members with content area expertise were assigned to work groups to develop, review and revise the workflows relevant to that content area. The work groups were also responsible for identifying and providing the actual forms, documents, reports and tracking mechanisms that were a part of the related workflow.

To obtain this snapshot of departmental operations, numerous work group sessions were conducted between August and November 2006, and the final work flows were released in February 2007. As a result of these efforts, a set of core operational categories was identified. Those operational categories include: referral in, screening, authorization, intake, service delivery, billing and closure. The work groups produced a total of sixty-nine work flows – each of which fits into one of the identified operational categories. LACDMH anticipates releasing the RFP in September or October 2007.

**Exemplary Practice #4****Marin MHP*****Integration of mental health  
and primary care*****Overview**

Marin Community Clinic (MCC), a Federally Qualified Health Center (FQHC), and Community Mental Health System Clinic (CMHSC) recognized delivery systems problems affecting consumers who were at high risk for co-morbid mental health and medical illnesses.

Located on the same campus, MCC and CMHSC created an innovative “Dual Clinic” to address both sets of health care needs in one location, during one visit and through an integrated treatment plan. This innovative and effective program currently serves 200-300 active consumers and has been highly successful in mitigating many of the issues associated with providing care to this high-risk population.

**Benefits**

- Integrated service planning for consumers with co-morbid mental and medical health conditions – greatly reducing the likelihood of an adverse medication reaction
- Early intervention for consumers who are at high-risk for co-morbid mental health and medical illness – potentially improving treatment outcomes
- Increased identification and referral of MHP consumers from other community linkages, such as housing authority programs that serve those who are homeless
- Increased consumer participation in achieving improved health and wellness objectives (e.g., diabetes management, smoking cessation, etc.)

**Background**

Located on the same campus, staff from both MCC and CMHSC – the Marin County mental health plan (MHP) – identified delivery systems problems that were affecting consumers – some of whom were clients at both facilities. MCC staff requested assistance from the MHP in dealing with consumers with behaviors that proved problematic for clinic staff and other clients in the waiting room. The MHP staff identified groups of consumers who were at high risk for co-morbid mental health and medical illnesses, many of whom had histories of homelessness and substance abuse.

Many MCC clients were already assigned to MHP case managers; however, MHP staff did not consistently know which consumers needed medical care or were MCC clients who required follow up. Collaboration between one MHP nurse practitioner (NP) and one FQHC primary care physician (PCP) resulted in the formation of a Dual Clinic to address both sets of health care needs in one setting. After signing a memorandum of understanding, the MHP and MCC implemented a regularly scheduled clinic at the end of 2002.

Initially the FQHC provided a PCP and a medical assistant, and the MHP provided a NP – each of whom devoted two hours a week to a jointly conducted clinic in a medical examination room in the MHP medication clinic. Currently, one PCP spends a total of 12 hours a week on site and is joined by one of five NPs assigned to mental health teams who identify MCC clients for referral into the Dual Clinic.

Today, all consumers have an assigned MHP case manager, MHP clinical team and NP – all of whom meet regularly. In addition, case managers identify and refer consumers from other community linkages, such as a housing authority programs that serve those who are homeless. Goals and interventions are incorporated into one client plan so all involved are aware of consumer-driven health care objectives, which most commonly are related to smoking, weight, diabetes, or a host of post-hospital health care needs. In addition, since the consumer sees both his/her PCP and mental health provider on the same day, each provider reviews the chart for prescription drugs, thus minimizing adverse drug reactions due to medication interactions.

As a further example of integration, while each provider separately bills his/her respective clinic payors, chart documentation – including progress notes – is accessible to both clinics. (Respective funding streams process claims in the usual manner.)

### Results

The Dual Clinic currently serves 200-300 active consumers who generally return every three months unless more frequent monitoring is indicated. While consumers can schedule appointments, the Dual Clinic regularly accommodates consumers on a walk-in basis.

**Exemplary Practice #5****Mono MHP*****Creative outreach increases Latino awareness of services*****Overview**

To increase utilization by the Latino community, Mono MHP recognized the need to develop a creative outreach program that could de-stigmatize mental health services. After conducting consumer focus groups, the MHP, along with the county Department of Public Health (DPH) and county Office of Education

(COE), developed an outreach program that involved offering English language classes at the community-based wellness center that is jointly operated by DPH and the MHP.

**Benefits**

- Enhanced outreach in a non-threatening environment to potential consumers of mental health services
- Increased participation in wellness center activities by Latino community members, as well as bringing them English-language skills training
- Reduced stigma and fear of clinical professionals – i.e., gained community’s trust of “government” staff (a key objective of the project)

**Background**

In 2006 Mono MHP recognized that to increase utilization of its services by the Latino community it would first need to devise creative outreach strategies that de-stigmatized mental health care. The initial step was to convene consumer focus groups to understand some of the barriers to access and to develop creative solutions to overcome them. Applying the feedback from these focus groups, the MHP developed a plan to increase the numbers of people referred for MHP services by offering community members English language skills.

Staff from the MHP, DPH and COE worked collaboratively to develop an English as a Second Language (ESL) curriculum that could teach adults to read and speak English, while simultaneously learning about good health practices for themselves and their families. Materials supporting this program are included in Attachment 20. Since the target population was adults (the majority of whom work multiple jobs), the project team assumed that many would likely have child care needs, come to a class after business hours, and not have the opportunity to eat dinner. To address these needs, the project team scheduled classes from 6:00 p.m. – 8:00 p.m. and provided child care and light meals. In addition, children are welcome and have participated in the class. Participants are free to attend regularly or as their schedules or needs dictate.

The COE instructor salary is paid by funds from a Mental Health Services Act grant. The COE and MHP staffs are paid their usual salaries since their work schedule is adjusted to provide coverage for the classes. Although classes were initially offered once a week, the MHP added a second night and now plans to accommodate increased demand by offering classes three times weekly. On a given night, approximately 10-15 people

participate, and recently, more than 25 people attended a farewell celebration for an instructor.

### Results to date

Targeted to involve all Latinos in the community, currently active MHP consumers are welcome to participate. From March-June 2007, there were 135 unduplicated participants, and the MHP has data to support that 240 people registered and attended classes, thus reflecting that many people return for additional sessions. MHP staff feels very good about having direct involvement with so many people who can then pass along to family and community members their positive experiences with ESL instructors. Since these instructors are also mental and medical health care staff, the course provides an opportunity for the community to have a positive, non-threatening experience with providers who are employed by government agencies.

**Exemplary Practice #6****Orange MHP*****Consumer and staff surveys  
for improved cultural  
competence*****Overview**

Orange MHP wanted not only to meet continuing education requirements through its training program, but more importantly to determine the program's actual effectiveness in improving cultural competence. In addition to a clinic-based consumer survey, the MHP

recently administered an online Zoomerang survey to staff and contract providers. The findings of this survey revealed important areas for improvement in cultural competence trainings.

**Benefits**

- Formalized regularly scheduled opportunities to obtain consumers' feedback
- Provided an objective and anonymous method to assess staff's knowledge and capabilities
- Enabled program planning to address specifically identified consumer and staff needs

**Background**

The MHP employs a full-time training coordinator to organize and track all training activities. For many years, the MHP has administered pre- and post-training tests. Although this practice was sufficient to meet continuing education requirements, the MHP recognized that these tools did not necessarily measure the effectiveness of the instruction – particularly in the area of cultural competence.

To help ensure that staff training resulted in improved outcomes, the MHP instituted two surveys.

1. **Consumer survey.** Since 2002, the MHP has distributed this survey annually at each clinic site and referred to the findings in developing cultural competence trainings. The survey obtains information from consumers about ease of access, degree of comfort, level of respect, and availability of materials in consumers' languages. Historically, individual clinics have utilized the findings for quality improvement and performance improvement projects. For example, the MHP now provides consumers with additional written materials in threshold languages. A copy of this survey is included in Attachment 21.
2. **Staff and provider survey.** During June 2006, the MHP electronically distributed a new Cultural Competence Self-Assessment survey to 871 behavioral health staff and providers. The MHP used Zoomerang, an online survey company with cost-effective, easy-to-use, flexible products. To encourage participation (which was voluntary and anonymous), MHP administrative staff included a cover letter requesting input and sent periodic reminders throughout July 2006. Although the

survey took approximately 20 minutes to complete, the rate of return was an excellent 62.5 percent. The results from 544 staff who responded now comprise baseline data for future trainings. A copy of the Zoomerang survey is included in Attachment 21.

Some findings were surprising and important to the MHP. For example:

- Contract staff expressed less discomfort with diversity in comparison to county staff.
- A small but significant percentage of staff believes that a direct relationship exists between someone's ability to speak English and their educational level.
- Almost three quarters of respondents utilized consumer family members when interpretation was needed – although the MHP promoted salary differentials and direct recruitment of interpreters.

MHP management is reviewing these findings to determine appropriate training initiatives to respond to the findings and mitigate these issues. The MHP also plans to distribute the Zoomerang survey every six months to assess the effectiveness of trainings geared to address these and similar issues.

**Exemplary Practice #7****Placer/Sierra MHP*****Quality improvement project  
to improve claims payment*****Overview**

Over the past year, Placer/Sierra MHP greatly improved its turnaround time for processing and paying claims to its contract providers. The MHP first identified the problem following a very low rate of provider satisfaction in an annual survey by the Children's System of Care and feedback from the provider association. To address this issue, the MHP initiated a process improvement initiative, which it soon formalized and monitored as a quality improvement (QI) project. As a result, the MHP reduced the claims receipt/payment cycle to less than 16 days, more than a 50 percent reduction from prior experience and greatly improved contract provider satisfaction.

**Benefits**

- Greatly improved turnaround time for processing and paying contract provider claims – from a high of 90-120 days (average of 30+) to less than 16 days
- Increased provider satisfaction rates – from a low of 49 percent to the current 78 percent
- Improved contract provider relations – for an MHP that utilizes contract providers for 25 percent of its services.

**Background**

The MHP recognized the need to reduce claims payment after conducting its annual survey of providers in 2006. The survey found that 49 percent of the contracted providers expressed dissatisfaction with payment turnaround time on claims. Prompt payment is a key factor in the MHP's ability to attract and maintain a network of qualified providers in what is already an inadequate system of funding for behavioral health services. The MHP relies on contracted providers as an invaluable part of a diversified service delivery system, so it was important to address the issue of payment timeliness.

**Work group findings**

In early 2006, a work group composed of MHP staff involved in claims processing began analyzing existing policies and procedures. Using available data from the claims processing system and logs, they learned that the average number of days between claim receipt and payment had been as high as 90-120 days and often over 30 days in recent years. This delay was surprising since Placer County had previously consolidated functions within several related health and human service agencies to achieve greater efficiencies.

In mid-2006, after identifying obstacles in the current system, the MHP implemented a more streamlined process largely by automating what had been a manual process as summarized below:

- Claims files were previously created by duplicative entry of information into the MHP's managed care database and the Placer Auditor-Controller's accounts payable system.
- Claim files are now automatically extracted from the managed care database by MHP staff and processed directly by the accounts payable system without redundant data entry and staff effort.
- After adding the necessary accounting codes, staff can now automatically transmit the completed claims file to the Auditor-Controller's check-writing system.

A similar interface will be developed when the new managed care system implementation is completed. The current workflow reduces repetition and duplication of effort, centralizes the flow of documents, and standardizes processing steps. Another improvement was made in staff coverage through increased cross-training in the various administrative and financial control tasks performed by claims processing and payment staff.

### Results

To measure the effectiveness of its efforts, the MHP conducted follow-up surveys with its contracted providers. The most recent survey indicates that nearly 78 percent of the accounts payable unit's customers rate performance as excellent or above average, demonstrating a much higher satisfaction with claims processing times. This example illustrates staff collaboration on a successful process improvement project, one which helps ensure providers are available and willing to serve the MHP's consumers.

**Exemplary Practice #8****San Benito MHP*****Community partnership for  
Latino older adult outreach*****Overview**

San Benito Mental Health Plan (MHP) recognized that few older adults in the county – especially Latinos – were receiving mental health services. Utilizing a unique approach to reach Latino older adults, the MHP placed behavioral health clinicians in a popular local senior center. While the program is still in its

early stages, MHP staff members are becoming more accepted and trusted by the older adults who visit the senior center. In fact, some are beginning to stop by the clinician's office "for a chat." This program is fully embraced by the senior center director, as well as center staff, who work collaboratively with on-site behavioral health staff.

**Benefits**

- Demonstrates that mental health outreach and education can be conducted in a non-threatening manner in a community setting
- Addresses reluctance of Latino older adults to seek mental health services and/or information in a traditional clinic-based setting due to stigma
- Provides senior center staff with valuable training to recognize signs and symptoms of mental health problems in older adults

**Background**

In early 2006 San Benito MHP reviewed demographic and service data to support anecdotal evidence that few older adults were receiving mental health care. The data also revealed specifically low penetration rates for Latino older adults. Analysis of Medi-Cal data and census data combined with local MIS service statistics provided a 10-year picture of penetration rates for older adults. These statistics were compared with DMH prevalence estimates for older adults, clearly demonstrating the need for improving access to older adults, particularly Latinos.

Based on these data, the MHP decided to outreach into the community and contacted an established, well-attended senior center located downtown. The shared objective was to determine strategies for providing access to mental health services to older adults who visited the senior center. All agreed on the importance of mental health staff slowly integrating into the center to gain trust. As a measure of success, older adults who use the center are starting to "come by the office for a chat."

Listed below are highlights of activities that are supporting this unique outreach program:

- Developed a referral form for senior center staff to use in identifying signs of mental health issues
- Scheduled office hours when the senior center is well-attended

- Have private office space, so behavioral health can see older adults onsite at the senior center
- Co-facilitate with senior center staff two ongoing support groups for caregivers (one English, one Spanish speaking)

In addition, MHP case managers accompany senior center staff on home visits and to deliver Meals on Wheels to older adults in need. These visits provide case managers with an opportunity to conduct assessments for mental health needs. In addition, MHP clinical staff is developing an on-site training on understanding signs and symptoms of depression (and other diagnoses) for senior center staff and older adults.

**Exemplary Practice #9****San Bernardino MHP*****Improved access with Service First “walk-in” model*****Overview**

San Bernardino MHP implemented a “walk-in” model – called Service First – to reduce average waiting time for a clinical screening appointment and address the concurrent problem of “no-shows.” When the initial walk-in model failed to produce satisfactory improvements, the MHP developed a non-

clinical Performance Improvement Project (PIP) to study the problem and implement a system redesign initiative – known as Service First. After the redesign, the MHP not only saw an increased number of consumers, but dramatically decreased wait time by implementing a number of key process changes including: utilizing a “duty officer” to coordinate variations in demand and capacity; providing immediate translation services; and modifying administrative work flows.

**Benefits**

- Within twelve to fifteen months:
  - The MHP served 1,017 persons – or 38 percent more consumers than through the old system.
  - Consumers experienced a mean internal wait time of less than two hours – a dramatic reduction from several visits over three weeks for a financial assessment, clinical assessment and psycho-social assessment.
- Consumer satisfaction with the current system is an average of 84 percent
- Staff morale improved (according to anecdotal information)

**Background**

Recognizing that distance and lack of transportation were creating access barriers for consumers and families, San Bernardino MHP implemented an unscheduled appointment or walk-in model to facilitate access to all major sites. When the initial implementation of this model began in early 2006, the average waiting time for a clinical screening appointment was three weeks; no-show rates ranged from 16.7 percent to 55.8 percent. While 737 consumers accessed services during the new system’s first month of operation, the processes in place could not accommodate the increased volume.

Committed to facilitating access for consumers in need of services, the MHP continued to measure outcomes and provide opportunities for consumer feedback on the effectiveness of the walk-in model. Subsequent complaints about prolonged clinic wait times triggered further MHP research and additional investigation into models to facilitate improved flow and reduced internal delays.

**A model Performance Improvement Project**

In June 2006, the MHP initiated a non-clinical Performance Improvement Project (PIP) to study and improve the existing walk-in model. Victor Valley is a hub for rural health care

in a fast-growing, geographically broad, “high desert” region, which is approximately an hour from the main population areas of San Bernardino County. Several staff volunteered to learn rapid process improvement techniques and became Redesign Team Advocates (RTA) who analyzed new consumers’ experiences and developed baseline data about the “cycle time” of the initial visit. “Cycle time” begins when the consumer signs in for an initial visit and ends when the consumer leaves the clinic with either a referral for non-MHP services or an appointment for a follow-up MHP visit (i.e., measured from time-in to time-out).

In the pre-redesign phase of the Service First initiative, RTAs – with clipboards and stopwatches in hand – followed and timed the steps and processes that consumers experienced during triage, intake, screening, assessment and referral. They also included the times to obtain and provide translation services. RTAs collected baseline data over a three-week period and learned that total cycle times averaged 237 minutes, including two trips to the site. In a little under three months, the MHP developed a series of incremental redesign measures and was ready for the implementation phase.

The MHP implemented a series of incremental redesign measures to expedite administrative and clinical processes. Physical changes included: reformatting the waiting area for greater comfort and privacy; including play space for children; using walkie-talkies to facilitate communication among staff facilitating these processes with consumers; and moving business machines to reduce the steps for the fiscal intake processes. Clinical assessment was facilitated by adding back-up or “duty officer” staffing to assist with intake, referrals, and/or translation services. (Face-to-face visits with a psychiatrist, when clinically indicated, are now provided at the time of the visit, although they were not included in the initial baseline measurements.)

Four post-redesign cycle times were measured since the official implementation date of October 2006. As of July 2007, the two-day cycle time average of 237 minutes has been reduced to two hours in one day, with the most recent average of 99 minutes. While recognizing the value of baseline satisfaction surveys, the MHP still viewed consumer feedback as critical. Based on post-implementation surveys, consumers reported mean Service First approval scores of 84 percent.

### Future improvements

The MHP is currently considering the next phases of redesign development. Two additional geographic locations are under consideration and the expansion includes the utilization of the RTAs to “champion” the methodologies and to serve as mentors and direct support for the new locations.

**Exemplary Practice #10****San Mateo MHP*****Tracking engagement data for quality improvement*****Overview**

Using fiscal year data, San Mateo MHP created a Strategic Planning Data Book (Data Book) that provides in-depth information on which beneficiaries are served by the MHP, what type of service they are receiving, and how effectively these services are meeting the needs of targeted populations. The MHP widely

distributes the Data Book within county departments, contract provider organizations and concerned consumer groups. Reports in the Data Book include LOCUS (Level of Care Utilization System) client and service characteristics, and special studies.

**Benefits**

- Provides initiation and engagement data that are complementary to penetration rates as defined by the California Department of Mental Health and allow for an examination of access to services in a more descriptive approach.
- Offers another methodology for analyzing the parity of services to specific underserved ethnic populations

**Background**

In our year two statewide report, we acknowledged this MHP's Strategic Planning Data Book and Extract (Data Book) process as an Exemplary Practice. Begun in 2003, the Data Book was instrumental in developing functionality specifications for the selection of a new information system and is now the overall repository for data elements pertaining to the whole system, including contracted providers.

In the second year of publishing its Data Book, San Mateo MHP greatly expanded the section on initiation and engagement data which are complementary to penetration rate data. These data are more descriptive than penetration rates alone, because they consider different aspects of client retention within a service. As defined by the MHP, the "initiation standard" requires that the second visit occurs within 14 days from the first visit. The "engagement standard" is met if a client has a third or fourth visit within 30 days, and if four visits occur within 44 days.

The MHP uses initiation and engagement standards as one measure of how effectively different client populations are served. Client population characteristics include ethnicity, diagnosis, age, and LOCUS levels that indicate level of functioning. The analysis includes a three-year comparison of data – which is available on [www.caeqro.com](http://www.caeqro.com).



**Exemplary Practice #11****Solano MHP*****Information systems work flow  
and gap analysis*****Overview**

Solano County Health and Social Services Department (SCHSSD) successfully conducted a comprehensive analysis for defining the requirements for a new information system (IS). By forming stakeholder work groups, SCHSSD was able to determine the needs for its divisions

of mental health and substance abuse – effectively using staff resources and gaining cross-functional consensus.

**Benefits**

- A process that is easily replicated by counties of all sizes – particularly small counties
- A process is that cost-effective – utilizing work groups that were managed by one IS Analyst on a part-time basis

**Background**

During FY06 SCHSSD initiated a comprehensive process for determining the requirements for a new information system (IS). The county formed work groups representing mental health, substance abuse and managed care. The work groups represented clinical and business units and were structured as follows:

- Included administrative, clinical (including a psychiatrist) and clerical staff
- Had between 10 and 30 members
- Comprised of members who were identified by administrators, supervisors and the IS project coordinator as problem solvers

Where appropriate, sub-workgroups were formed.

Each workgroup used the Request for Proposal (RFP) developed by the California Behavioral Services (CBS) Coalition as a guideline. The CBS coalition, a group of 21 counties organized by the California Institute of Mental Health, has been working together since 2003 to evaluate, select and implement behavioral health information systems to meet the administrative, billing, clinical, managed care and reporting requirements of their counties. After reviewing and discussing the relevant sections of RFP, the work groups drafted requirements and workflow gap analysis documents.

After meeting to review and edit the draft documents, the work groups created a final Requirements Analysis and Work Flow Gap Analysis. These documents were then reviewed and approved by a steering committee consisting of the county administrator, chief information officer, chief financial officer, and the directors of mental health and

substance abuse services. The county later expanded the project to include public health services and added a public health addendum.

The project has been referred to the Board of Supervisors for funding in the FY08 budget. The county has hired a project manager who will produce a request for proposal or request for information based on the work groups' findings and documentation.

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## Section 7.1: Overview

Over the past three years, we have 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>7</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:
  - Analyzed three years of approved claims data from Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation Claims (IPC) files
  - Reviewed either Information Systems Capabilities Assessment (ISCA) V5.L or the Information Systems Review Supplemental Questionnaire for all 56 MHPs
  - Gathered MHP-specific data based on highly targeted reviews
  - Conducted formal trainings to address specific needs that were shared among groups of MHPs
- **Year three.** A distinguishing feature of our FY07 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:
  - Gathered three year's MHP-specific data from highly targeted reviews
  - Collected information from an increased number of stakeholders in FY07, including remote MHP sites, contract providers and consumers and family members
  - Updated SD/MC and IPC data to include CY06
  - Reviewed a common ISCA V6.1 for all 56 MHPs
  - Conducted highly targeted trainings to address persistent challenges shared by specific groups of MHPs

In previous years' statewide reports, we chose to discuss themes versus trends – pending a minimum of three years' observations and quantitative data on a specific

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<sup>7</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.

issue. Having aggregated a substantial body of such information over three years, we can now identify trends within key areas.

## Section 7.2: Trends in Key Areas

We have identified four key areas in which we are beginning to observe the emergence of trends.

- **Access** – most frequently cited by CAEQRO as needing improvement
- **Service delivery** – disparities within specific populations
- **Quality management and use of data** – significant advances across most MHPs
- **Information systems** – significant activity in the area of implementations

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. Consequently, the issues underlying some of the trends we identify are not simple to resolve and will require a variety of activities over time.
3. Throughout our FY07 report and consistent with previous years, we have made a number of observations we can not consider a trend until we have at least three years of information. For example, as noted in Section 5, we observed a slight reduction in penetration rates for Foster Care beneficiaries coupled with fewer individuals served – which might be cause for concern and as such warrants continued monitoring by the MHP.

### Access: continued barriers – some progress

During year three, the broad concept of “access” ranked first in the number of 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 issues such as those we highlight in Section 1 (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 (often successful) to reduce barriers to entry.

**Trend #1: New delivery system models are beginning to increase access.**

Some MHPs are developing new models to facilitate ease of access to mental health services. However, access to psychiatric services remains limited.

New 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. However, few MHPs offered psychiatric services through this model,

although some MHPs did allow for flexibility in psychiatric schedules to accommodate walk-in clients. The most extensive multi-faceted effort to provide immediate services is illustrated by San Bernardino MHP whose “exemplary practice” we described in Section 6.

- **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. Examples include Federally Qualified Health Centers (FQHCs), Native American health services and senior citizen centers. For Marin MHP “co-locating” extended into the creation of a “dual clinic” that integrates planning for consumers with co-morbid mental and medical health issues – an exemplary practice that we highlight in Section 6. We also noted additional outreach to schools and other county departments such as social services. Some MHPs began to use newly formed wellness or drop-in centers to provide access to individuals they were unable to serve. We comment further on these activities in the discussion of wellness and recovery later in this section.

In addition, we only noted a few of the following 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.” Merced MHP is a significant exception since it provides regular psychiatric services on Saturdays – a schedule that is particularly helpful to Southeast Asian beneficiaries many of whom have limited flexibility due to their work schedules.
- **Telemedicine or physician extenders with prescribing capability.** Access to a psychiatric evaluation is measured by weeks and even months in some MHPs. An additional group of MHPs has an even longer wait time for rescheduling an appointment or scheduling a second appointment. Despite this chronic barrier to access and service, we saw no serious attention or attempts to modifying psychiatric service delivery. In fact, many MHPs appeared to have a negative bias about telemedicine.
- **Reduction in intake complexity.** In our year two report we described a multi-step time-consuming intake processes in many MHPs. These practices and the resulting delays continue in a notable number of MHPs, often despite continuing staff reductions that should prompt the need for streamlining intake processes.

### Disparities in service delivery

**Trend #2: Female and Hispanic beneficiaries appear 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. As first reported in year two, we found the following in year three:

- 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. For female beneficiaries the ratio was 77cents to every dollar for spent on male beneficiaries.
- The disparity in cost for both Hispanic and female beneficiaries occurred in each of the seven service modalities in addition to the total. These data are discussed in Section 4.

Repeating these analyses for year three performance measures, we found a decrease in the disparity in spending for Hispanic beneficiaries as compared to White beneficiaries. Spending for Hispanic beneficiaries increased to 91cents for each dollar spent on White

beneficiaries. Although most modalities of service continued to show the same disparity as in previous years, CY06 outpatient cost per Hispanic beneficiary served was equal to or slightly higher than for White beneficiaries.

Since these data represent only two years, we view this shift in spending as promising rather than an actual positive trend. Providing greater access to Hispanic beneficiaries and other underserved groups has been a statewide and MHP priority for a number of years. Next year's data will include an increased number of programs partially funded by MHSA dollars and perhaps access for underserved populations will continue to improve.

For female beneficiaries, however, the CY06 ratio remained at 77 cents for each dollar spent for male beneficiaries. Women comprise a higher percentage of the older adult age group which is also an MHSA priority. Whether additional older females served through MHSA will alter this disparity is questionable.

A few MHPs have implemented creative outreach programs for underserved populations, including MHPs in Mono and San Benito Counties – as demonstrated by their respective exemplary practices in Section 6.

### Quality management and use of data: significant advances

#### **Trend #3: MHPs are beginning to access and use data to drive performance management.**

We saw a strong positive trend in the system's overall access to and use of data as reflected in CAEQRO reviewers' observations and recommendations.

In contrast to years one and two, quality management and use of data was no longer the area most frequently cited by CAEQRO reviewers in their recommendations as needing improvement. We saw a strong positive trend in the system's overall Access to and use of data as reflected in CAEQRO reviewers' observations and recommendations. However, it still ranked second in these evaluation categories – indicating that it will remain an area of focus in the future.

### Increased use of data for performance management

The use of data to drive performance management has been a major focus of our EQRO activities in each of our three review years.

- 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 competency as well as the staff involved in planning for programs funded through the Mental Health Services Act (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 quality improvement (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.

“An emphasis on data driven decision-making...is slowly permeating the service delivery system.” This quote from an individual MHP report actually characterizes many of the MHPs at the end of year three. Recommendations for a few MHPs actually suggested they simplify and prioritize the abundance of detailed data they produced and shared since staff and others felt overwhelmed by the detail.

### 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 Performance Improvement Projects (PIPs). Some MHPs worked diligently on but had failed to consider data essential to the success of their projects.

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. Outcomes measurement remains difficult and labor intensive since special chart reviews, data collection or survey administration would be necessary.

In year three a number of clinical staff and contract providers commented that management did not respond to their request for available data and internal reports. Although officially categorized as an “opportunity for improvement,” the emergence of this complaint actually represents significant progress. We have not yet determined whether this is particularly associated with MHPs using newly installed clinical applications in which clinicians are able to enter more programmatic and client related data.

As discussed in Section 2.3, year three data from Information Systems Capabilities Assessment (ISCA) surveys indicated that data analysis and reporting remain the weakest functional areas for IS in current use. Two new ISCA questions in year three 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 particularly important in monitoring and measuring outcomes. Although most key staff now understands the importance of such data, analysis of clinical and outcome data may lag until new IS are operational.

Information systems: sharp increase in implementations**Trend #4: MHPs are searching for or implementing new information systems in record numbers.**

This trend suggests an unprecedented level of change within the core information system infrastructure for California's public mental health system.

IS 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 (IS).

We continued to see significant strengths for MHPs with experienced competent staff wresting maximum functionality from legacy

systems while, in some cases, concurrently leading the implementation process for the new system. Some MHPs who had struggled with problematic long implementations of new systems showed improved processes and user-friendly functions in year three. Many MHPs still planning for new systems had expanded their planning or implementation processes to include clinical staff and less frequently, contract providers.

More small-rural and small MHPs were actively implementing new IS than were any other group. These MHPs have historically had the least access to and experience with data-driven decision making. Consequently, while their new systems will increase their access to data, they will also require the development of staff support resources and analytic capabilities.

New system planning still continued for a number of medium and large MHPs. Some issued RFPs, but budget constraints and lack of clarity about new requirements slowed their selection and implementation processes. Notable planning processes include both Los Angeles and Solano MHPs as illustrated by their respective exemplary practices in Section 6.

Lack of appropriate resources for implementations and continued difficulties with business processes represented major challenges for a smaller group of MHPs than in years one and two.

Wellness and recovery: notable improvements**Trend #5: MHPs are beginning to implement consumer-focused programs.**

This trend appears to be largely tied to the implementation of programs funded by the Mental Health Services Act and not always integrated with other initiatives.

During year one, MHPs did little more than discuss wellness and recovery, and rarely mentioned resiliency for youth/adolescent populations. In year two, many MHPs viewed these concepts as the exclusive domain of MHSA-related activities. We also observed some training and program plans that were part of an MHP's existing programmatic initiatives. In addition, we noted some efforts to increase consumer/family participation in QI and other MHP processes/programs.

During our year three site visits, we continued to emphasize wellness and recovery efforts. Many MHPs discussed activities that they characterized as “consumer-focused” or “wellness – and recovery-focused.” However actual programming varied widely throughout the state, as noted below:

- **Vocational training and job opportunities.** Often formal pre-vocational training and opportunities were still lacking despite their importance for consumers and families – including parents of adolescent and transition age youth. In fact, these areas ranked as one of the two most important priorities for consumers and families.
- **Wellness centers.** A number of wellness centers had opened, 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. In addition, despite a clear enthusiasm and support for wellness centers, some MHPs had started to use these programs as an alternative to clinical or other services for a variety of reasons including lack of capacity and reduction in funding. Consequently, wellness center staff in some MHPs were already feeling overwhelmed.
- **Consumer/family employment opportunities.** Many MHPs had begun to employ more consumers/family members than in the past. We were able to conduct consumer/family employee focus groups or interviews in many more MHPs than in previous years. New employees were typically enthusiastic about their opportunities and eager to provide meaningful support in their new roles. Often, however, 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 MHP programs. Consumers often felt that clinical staff in these programs were confused and/or ambivalent about how to engage them in the system. Consumers employed in separate official “consumer directed” programs or sites were less apt to express this set of concerns.

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.

- **Consumer/family involvement in system transformation.** Few 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 resiliency. Small-rural and small MHPs tended to be more successful in this area, while medium and large MHPs had a number of “opportunities for improvement.”

Of greatest concern, however, few MHP managers described a process for integrating these concepts into their service system or articulated a detailed vision of what transformation means. At least ten MHPs were still simply discussing their plans to

introduce wellness, recovery and resiliency. And importantly, for a large number of MHPs, these concepts are equated with “an MHSA program.”

### Leadership and culture: organizational variables

**Trend #6: Strong leadership can manage through environmental challenges.**

However, the performance of a number of MHPs suffered because of poor management and leadership skills.

The importance of leadership and management skills emerged during our year two site visits. 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. These leaders were also concerned about the need to integrate MHSA-funded programs across the entire service system and were concerned about the

apparent separation between Medi-Cal and MHSA transformation principles.

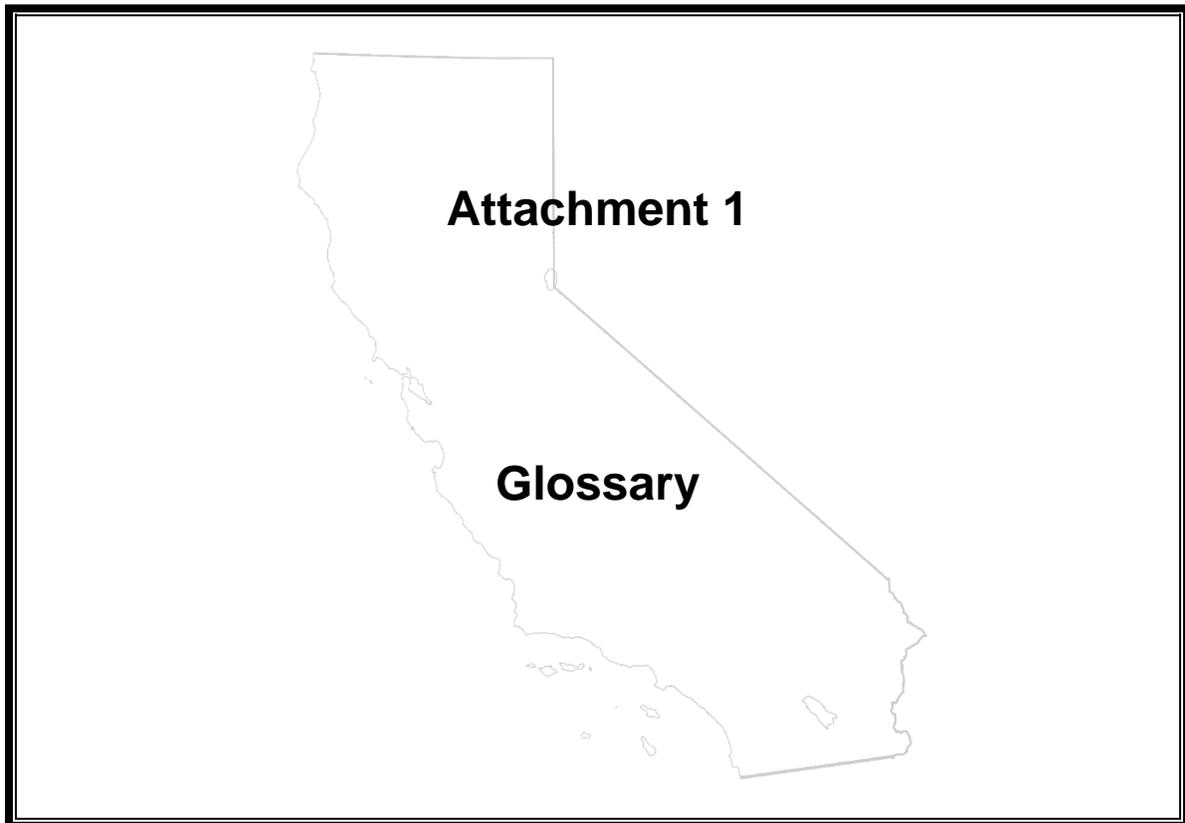
While strong leadership is a broad category, we found that open lines of communication and collaboration were differentiating characteristics in many MHPs that were able to overcome common environmental challenges.

- **Strong communication with stakeholders.** Internal communication was important for line staff and supervisory morale. In some cases, new leadership had instituted communication vehicles which ranged from newsletters to intranet communications to staff advisory groups. Contractors also valued regular communication, especially about changes in processes and information system plans. Alameda MHP has been particularly successful in using Internet technology to facilitate communication, as illustrated by its exemplary practice in Section 6.
- **Collaboration with other entities.** Collaboration appeared to increase as a strength but more commonly among small and small-rural MHPs than for large and medium MHPs. For example, conscious of their challenges in managing EQRO regulations, small counties combined forces to discuss and plan collaborative PIPs. Since this group is trending toward improved technology functionality, their collaboration is particularly encouraging. Other examples of collaboration included:
  - An increased number of MHPs established cooperative relationships with various health clinics – a marked increase from our year one and year two reviews.
  - Collaboration also extended to county departments as well as to contract providers.

In our year two report we described FY06 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 FY07 as “The Year Changes Begin,” as reflected in the promising trends we have highlighted in this section. For each of

these we also note corresponding issues to identify possible areas of intervention for both MHPs and the California Department of Mental Health. We expect that FY08 will continue and hopefully accelerate these positive trends.

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





## GLOSSARY

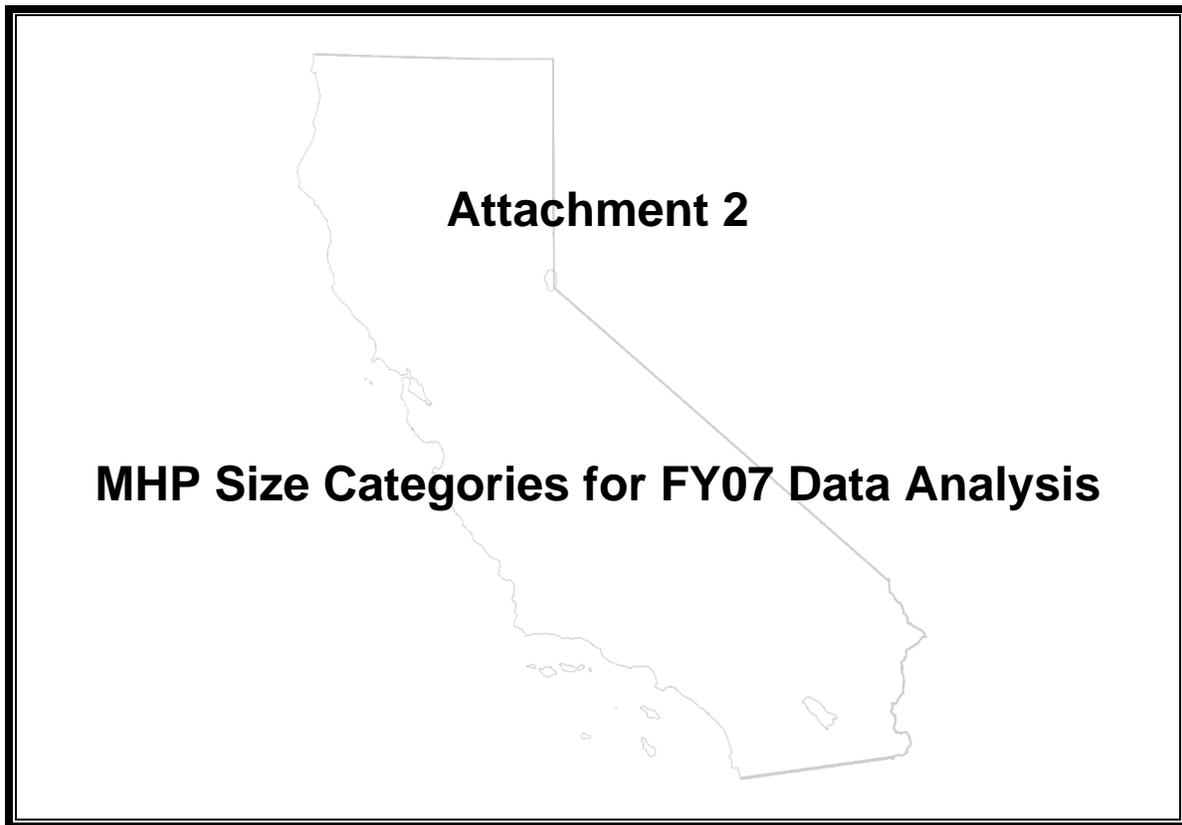
Definition	
Beneficiary	Person covered by Medi-Cal insurance for medical/mental health and specific substance abuse services
Consumer	Person not covered by Medi-Cal insurance or the general term for those receiving services

Acronym	Meaning
AOD	Alcohol and Other Drugs
ASOC	Adult Systems of Care
CalMEND	California Mental Health Disease Management
CBO	Community based organization
CIMH	California Institute of Mental Health
CMHDA	California Mental Health Directors Association
COD	Co-Occurring Disorders
CSI	Client Service Information
CSOC	Children's System of Care
CWS	Child Welfare System
DMH	Department of Mental Health
EBP	Evidence Based Practice
ECR	Error Correction Report
EOB	Explanation Of Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
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
IT	Information Technology
LPS (Conservatorship)	Lanterman, Petris and Short
MH	Mental Health
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MMEF	Monthly Medi-Cal Eligibility Extract File
OASOC	Older Adult Systems Of Care
PDSA	Plan, Do, Study, Act
PIP	Performance Improvement Project
QI	Quality Improvement
QIC	Quality Improvement Committee
SCERP	Small County Emergency Risk Pool
SMA	Statewide Approved Maximum (rate amount)
SD/MC	Short-Doyle/Medi-Cal

**GLOSSARY**

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 Data Analysis

In performing data analysis for the FY07 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 2006:

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 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.

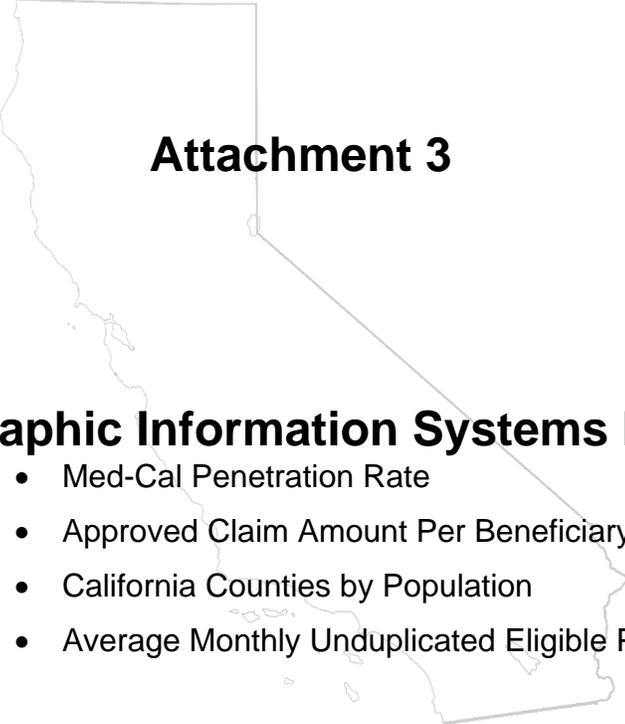
On the following page, we include a table displaying a cross walk that lists each MHP and its associated size category.

<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

<b>Mental Health Plans and Size Categories</b>		
<b>Mental Health Plan</b>	<b>Three Categories</b>	<b>Five Categories</b>
San Joaquin	Medium	Medium
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



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 3**

**Geographic Information Systems Maps**

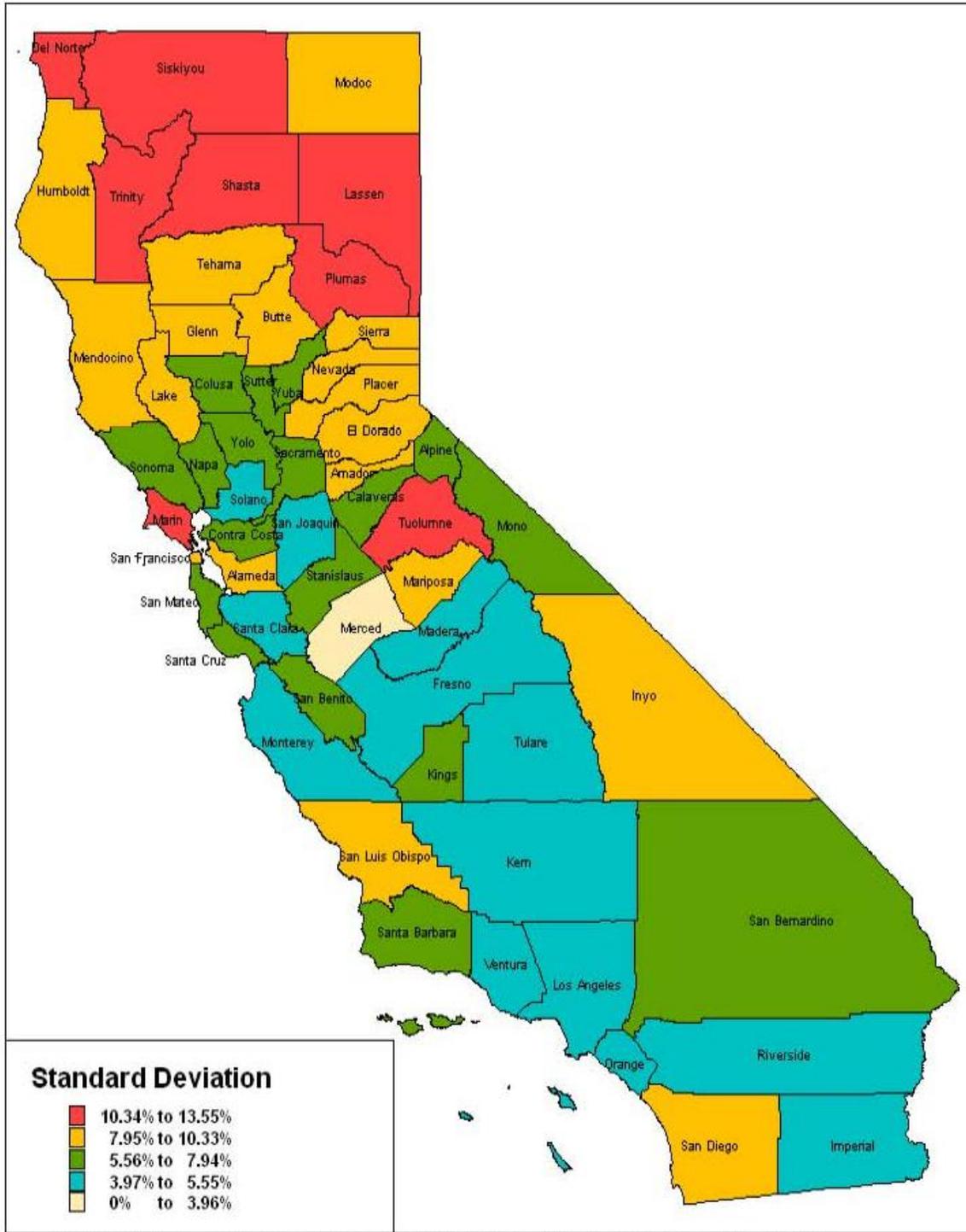
- Med-Cal Penetration Rate
- Approved Claim Amount Per Beneficiary Served
- California Counties by Population
- Average Monthly Unduplicated Eligible Persons



# Medi-Cal Penetration Rate

## Approved Claims - Calendar Year 2006

Statewide Average Penetration Rate - 6.00%

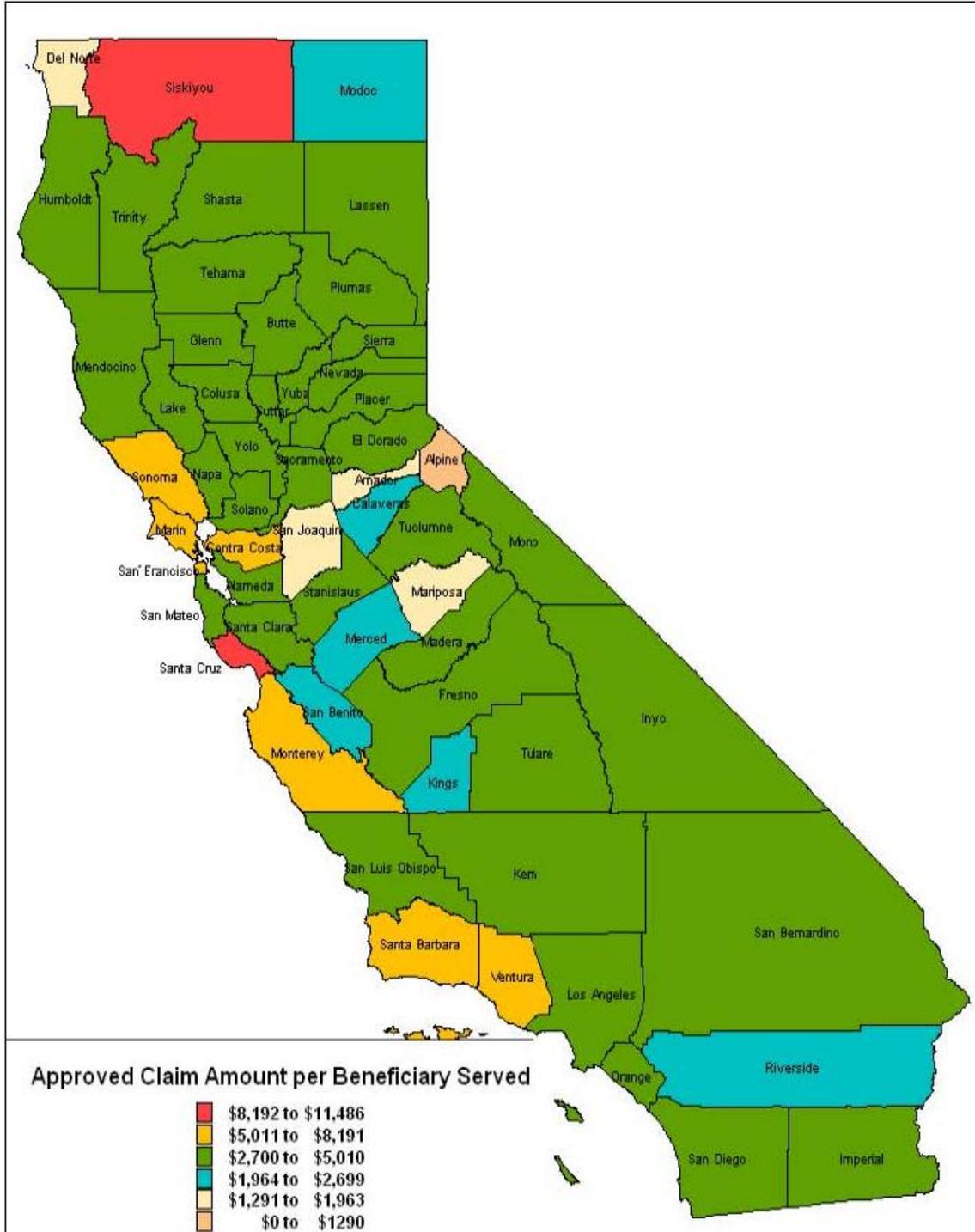


Source: Short-Doyle/Medi-Cal approved claims as of February 16, 2007; Inpatient Consolidated approved claims as of March 19, 2007

# Approved Claim Amount Per Beneficiary Served

## Approved Claims - Calendar Year 2006

Statewide Average Claim Amount Per Beneficiary Served - \$4,112



Data source: Short-Doyle/Medi-Cal approved claims as of February 16, 2007; Inpatient Consolidated approved claims as of March 19, 2007.

# California Counties By Population

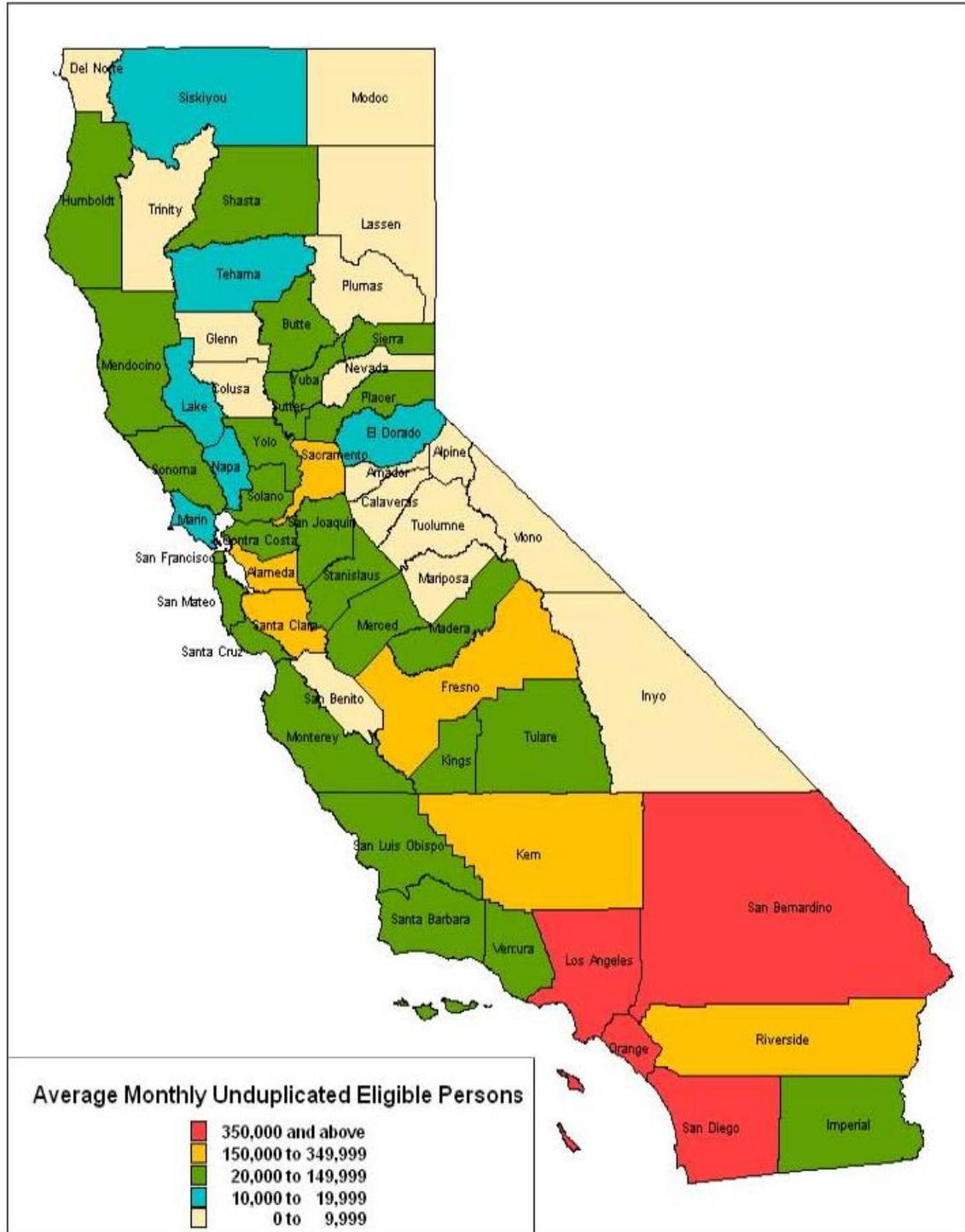
## January 2006

California Department of Finance - Demographic Research Unit, Table E-1 (as of May 2007)



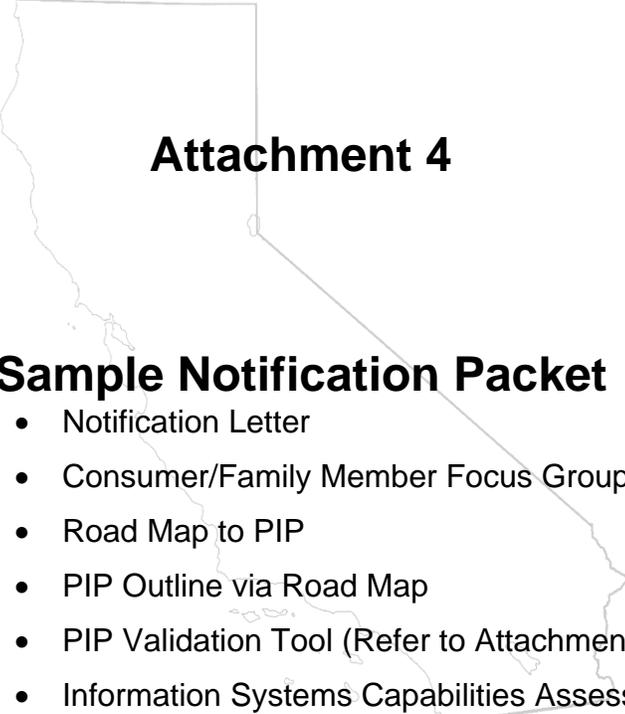
Data source: California Department of Finance - Demographic Research Unit, Table E-1 (as of May 2007)

# Average Monthly Unduplicated Eligible Persons Approved Claims - Calendar Year 2006



Source: Short-Doyle/Medi-Cal approved claims as of February 16, 2007; Inpatient Consolidated approved claims as of March 19, 2007

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 4**

**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 11)
- Information Systems Capabilities Assessment V6.1 (Refer to Attachment 13)
- Approved Claims Data (Refer to Attachment 6)
- Demographic Charts (Refer to Attachment 5)





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

The FY 06-07 reviews are customized according to the findings of the last CAEQRO review, and will include an evaluative process of the overall service delivery system as it relates to business practices and performance management. CAEQRO will review the following issues/recommendations based upon the < Name > MHP FY 05-06 CAEQRO review and report:

(Include approximately five issues from last year's report.)

- A review of ...
- 

In addition to those specific issues outlined above, the review includes the following components:

1. The new Information System Capabilities Assessment V6.1. CAEQRO revised the ISCA with stakeholder input and approval by DMH
2. Two active and ongoing Performance Improvement Projects (PIPs) – one clinical and one non-clinical

3. The MHP's utilization of data designed to support decision-making, including the use, if any, of the data provided by CAEQRO at the last review
4. At least three MHP changes initiated or reinforced from the last CAEQRO review
5. Any changes, progress, or milestones in quality improvement processes and activities since the last review – with emphasis on processes for measuring and improving timely access to care and consumer outcomes
6. Wellness and recovery principles throughout the system
7. Interviews with key staff from clinical services, administration, quality improvement, research and analysis, information systems, and clerical/data entry
8. < One/two/three > 90-minute consumer/family member focus < group/groups > with a minimum of 8 and a maximum of 10 participants. Please refer to the attached Focus Group Guidelines and organize the focus group(s) according to the following criteria:
  - < Identify criteria here for each focus group. >
  -

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 are attached.

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. This includes the various activities requiring 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

CAEQRO reviews a variety of documents in planning for the site review. If any of these documents are not available electronically, please discuss with the Lead Reviewer an alternate medium for submission.

Please submit the following to the Lead Reviewer at ([name@apshealthcare.com](mailto:name@apshealthcare.com)) by < Date in approx 30 days >:

1. The completed ISCA V6.1 attached
2. Two active and ongoing PIPs – one clinical and one non-clinical – submitted using the format “PIP Outline with Road Map” attached. CAEQRO created this document to assist the MHPs in submitting PIPs that describe all of the elements required by the CAEQRO PIP Validation Tool, also attached for your reference.
3. The current Quality Improvement Work Plan and the most recent report evaluating the QI Work Plan
4. Quality Improvement Committee (or equivalent) meeting minutes since the last review

5. Cultural Competence Committee (or equivalent) meeting minutes since the last review
6. A copy of the Cultural Competence Plan and/or Latino Access Study if either of these documents have been revised since the last review
7. A list of cultural competence and wellness/recovery training that occurred since the last review and any scheduled upcoming training
8. A list of beneficiary and/or staff surveys conducted since the last review. For at least one survey, provide the survey tool, a summary of the results, and discussion of any activities resulting from these results.
9. A detailed MHP organizational chart
10. Two counties the MHP uses for comparison and the rationale for the selection
11. The MHP's current mission or vision statement
12. A list of the current MHP strategic initiatives
13. < Additional documents requested for this MHP, if applicable >

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). 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 inform the Lead Reviewer if the consumer/family member focus group(s) will be held off-site and how much transportation time to allow.

Please advise the staff person who will be coordinating this review 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  
Anne Murray, DMH Medi-Cal Policy and Support  
Sophie Cabrera, DMH Medi-Cal Policy and Support  
Mike Reiter, Administrative Director, CAEQRO  
Sandra Sinz, Site Review Team 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, Review Consultant](#)  
[Rudy Lopez, Review Consultant](#)

Bob Martinez, Consultant in Cultural Competence  
[Name](#), Consumer/Family Member Consultant  
[Name](#), MHP QI Coordinator  
[Name](#), MHP IT/IS Manager

Attachments:

ISCA V6.1  
PIP Outline with Road Map – for use to submit PIPs  
Road Map to a PIP  
CAEQRO PIP Validation Tool  
Consumer/Family Member Focus Group Guidelines  
Approved Claims Data



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

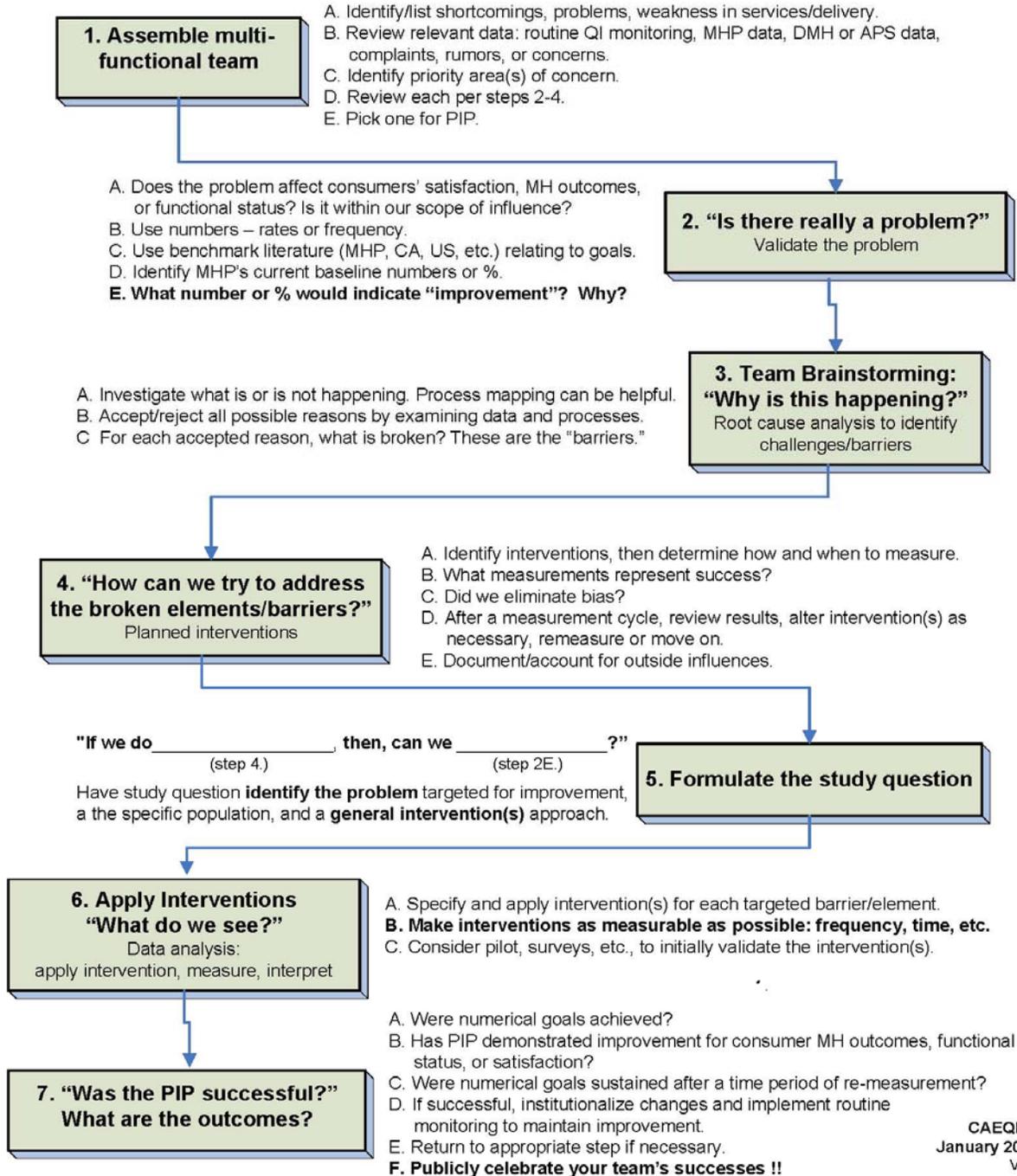
The Consumer/Family Member Focus Group is an important component of the CAEQRO Site Review process. Obtaining feedback from those who are receiving services from the MHP provides significant information regarding quality of care. The focus group(s) will be led by a CAEQRO Consumer/Family Member Consultant with a CAEQRO Site Reviewer participating as a recorder.

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 familiarize him or herself with all of the items below, taking full 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
  - More than one individual from the same family within the same focus group (e.g., spouses, parent/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. 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
  - Coordinating with the clinical staff and 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 a minimum of 8, and no more than 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 gift cards as a mechanism for recruiting participants.
5. Advise the Lead Reviewer if mono-lingual participants are expected in the group so that interpreter needs can be addressed. Limit each focus group so that no more than one language requires an interpreter within a single focus group. If the MHP would like to have an additional focus group to reach multiple threshold language groups, this can be explored with the Lead Reviewer prior to the site review.

# Road Map to a PIP







**CAEQRO PIP Outline via Road Map**

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.

**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
Lack of post-hospitalization substance abuse (SA) linkages	Retrospective review of all adults readmitted for acute psychiatric hospitalizations to Nurses' Hospital within 30 days of initial discharge in FY 05. 16% of those with co-occurring SA issues had planned linkage for substance abuse counseling upon prior discharge

## Formulate the study question

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

4. **State the study question.**  
This should be a single question in 1-2 sentences which specifically identifies the problem that the interventions are targeted to improve.
5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.
6. Describe the population to be included in the PIP, including the number of beneficiaries.
7. Describe how the population is being identified for the collection of data.
8.
  - a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?
  - b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

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

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

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

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

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

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

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

**Table C - Interventions**

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
#1	Education of Hospital and case management staffs, which includes: <ul style="list-style-type: none"> <li>• Review of existing referral protocols with Hospital &amp; case management staff.</li> <li>• Initiation of procedure to assess for referrals, prior to discharge, when discharge instructions are shared with consumers</li> <li>• Monitoring of targeted readmissions for linkages and provide feedbacks to management every two weeks</li> </ul>	Issues associated with staff knowledge and behaviors: <ul style="list-style-type: none"> <li>• Lack of staff knowledge about existing protocols</li> <li>• Lack of staff understanding about expectations</li> <li>• Lack of staff adherence to existing protocols</li> <li>• Lack of planned linkage for SA counseling</li> </ul>	9/1/05 – 2/28/06
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 indicator. Use Table D and attach supporting data as tables, charts, or graphs.

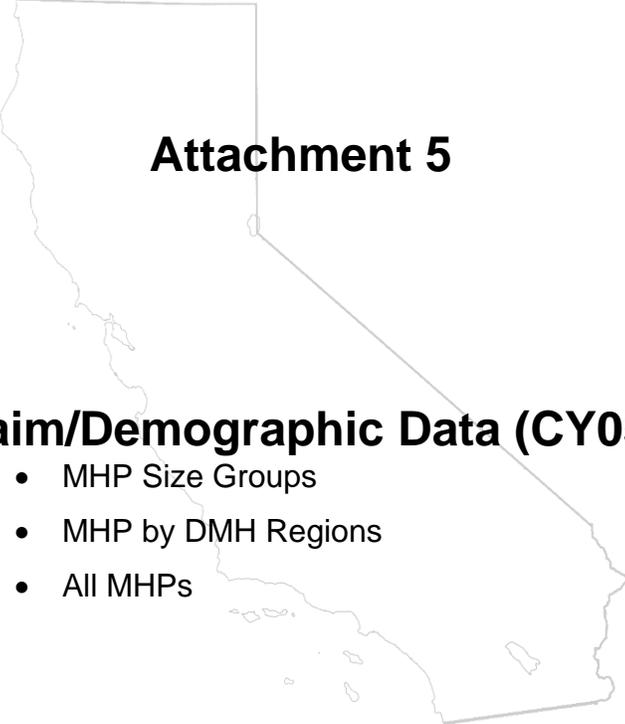
**Table D - Table of Results for Each Indicator and Each Measurement Period**

Describe indicator	Date of baseline measurement	Baseline measurement (numerator/denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/denominator)	% improvement achieved
Example: # 1	7/1/05	6 adults with readmissions had addressed SA linkages <hr/> 37 unduplicated adults with unplanned readmissions with identified SA issues 6 / 37 = 16% had planned linkage	32% ( 100% improvement )	#1: 9/1/05 – 2/28/06	3/1/06, retrospective for same 6-month period	6 adults with unplanned readmissions had addressed SA linkages <hr/> 16 unduplicated adults with unplanned readmissions with identified SA issues 6/16 = 38% had planned linkage	> 100% improvement

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

17. Describe issues associated with data analysis:
  - a. Data cycles clearly identify when measurements occur.
  - b. Statistical significance
  - c. Are there any factors that influence comparability of the initial and repeat measures?
  - d. Are there any factors that threaten the internal or the external validity?
18. To what extent was the PIP successful? Describe any follow-up activities and their success.
19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?
20. Does data analysis demonstrate an improvement in processes or client outcomes?
21. Describe the “face validity” – how the improvement appears to be the result of the PIP intervention(s).
22. Describe statistical evidence that supports that the improvement is true improvement.
23. Was the improvement sustained over repeated measurements over comparable time periods?

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 5**

**Claim/Demographic Data (CY05)**

- MHP Size Groups
- MHP by DMH Regions
- All MHPs



<b>MHP Size Groups</b>									
MHP Size Groups	No. MHPs	Ave. Month Elig.	Beneficiaries	Penetration Rate	Approved Claims	Ave Monthly	Ave Benefit	Population	Per 100 Eligible
Small-Rural	14	59,426	6,120	10.30%	\$26,002,831	\$438	\$4,249	340,713	17.4
Small	15	356,861	27,653	7.75%	\$94,841,792	\$266	\$3,430	1,862,346	19.2
Medium	14	971,763	58,967	6.07%	\$267,988,162	\$276	\$4,545	5,631,851	17.3
Large	12	2,992,883	190,583	6.37%	\$711,109,740	\$238	\$3,731	19,102,336	15.7
Very Large	1	2,402,694	123,356	5.13%	\$572,148,553	\$238	\$4,638	10,257,994	23.4
<b>Total</b>	<b>56</b>	<b>6,783,650</b>	<b>406,679</b>	<b>6.00%</b>	<b>\$1,672,091,078</b>	<b>\$246</b>	<b>\$4,112</b>	<b>37,195,240</b>	<b>18.2</b>

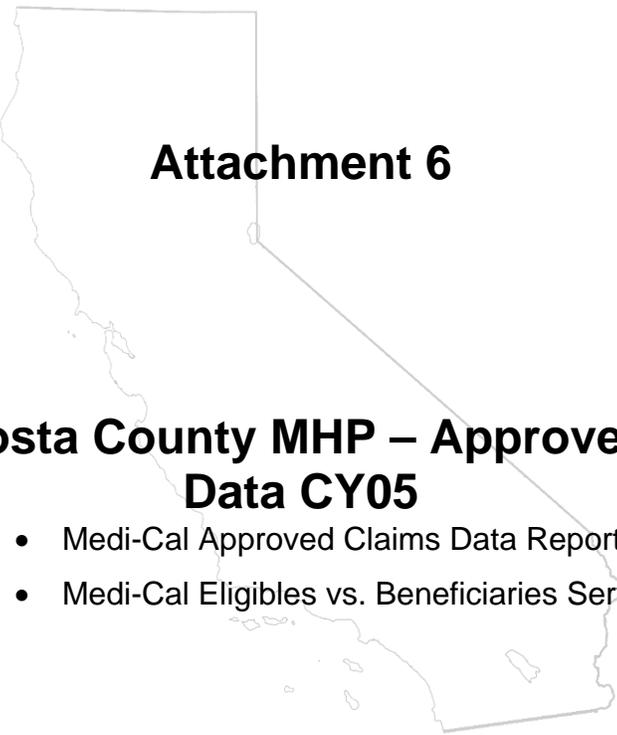
<b>MHP by DMH Regions</b>									
MHP Regions	No. MHPs	Ave. Month Elig.	Beneficiaries	Penetration Rate	Approved Claims	Ave Monthly	Ave Benefit	Population	Per 100 Eligible
Bay Area	12	1,041,290	74,499	7.15%	\$392,812,954	\$5,273	\$377	7,877,451	13.2
Central	18	1,241,110	72,020	5.80%	\$227,600,443	\$3,160	\$183	5,451,880	22.8
Los Angeles	1	2,402,694	123,356	5.13%	\$572,148,553	\$4,638	\$238	10,257,994	23.4
Southern	9	1,879,329	115,121	6.13%	\$390,853,587	\$3,395	\$208	12,543,041	15.0
Superior	16	219,227	21,663	9.89%	\$88,675,540	\$4,090	\$404	1,064,874	20.6
<b>Statewide</b>	<b>56</b>	<b>6,783,650</b>	<b>406,679</b>	<b>6.00%</b>	<b>\$1,672,091,078</b>	<b>\$4,112</b>	<b>\$246</b>	<b>37,195,240</b>	<b>18.2</b>



All Mental Health Plans																		
County	County Size	Region	Average Monthly Unduplicated Eligibles	Unduplicated Count of Beneficiaries Served	Penetration Rate	Approved Claims as of March 2007	Average Monthly Approved Claims Undup Eligibles	Approved Unduplicated Beneficiaries Served	Rank - Penetration Rate	Rank - Unduplicated Beneficiaries Served	Rank - Approved Claims Undup Eligibles	County Population (Jan 2006)	Rank - County Population (Jan 2006)	Federal Poverty Level (2002)	Rank - Medi-Cal (Jan 2006) *	Rank - Medi-Cal Eligible as % of 2006 County Pop	Medi-Cal Eligible Per 100 2006 County Pop	Threshold Languages Oct 2006
Alameda	Large	Bay Area	226,233	18,919	8.19%	\$84,834,037	\$375	\$4,881	25	15	14	1,509,981	7	9	32	15.0	9.7%	4
Alpine	Small/Rural	Central	180	31	1.71%	\$12,714	\$71	\$398	28	56	56	1,238	56	56	35	14.5	15.6%	0
Amador	Small/Rural	Central	3,616	331	9.16%	\$476,231	\$132	\$1,439	16	54	53	38,142	45	49	50	9.5	9.4%	1
Butte	Medium	Superior	47,917	4,706	9.82%	\$20,750,127	\$433	\$4,409	13	46	46	216,981	27	24	47	22.2	16.4%	2
Calaveras	Small/Rural	Central	5,145	390	7.56%	\$1,036,071	\$201	\$2,657	30	48	39	46,623	44	47	47	11.3	9.7%	0
Colusa	Small/Rural	Superior	4,944	392	6.78%	\$3,283	\$222	\$3,283	38	36	37	21,501	49	48	14	23.0	13.2%	1
Contra Costa	Large	Bay Area	119,613	8,922	7.46%	\$45,414,518	\$380	\$5,090	33	9	13	1,030,732	9	14	45	11.6	6.7%	1
Del Norte	Small/Rural	Superior	6,033	904	11.25%	\$1,271,405	\$158	\$1,466	6	55	46	29,025	47	43	5	27.7	21.1%	1
El Dorado	Small	Central	15,478	1,493	9.65%	\$4,301,898	\$279	\$2,881	15	45	27	176,837	30	37	54	8.7	7.1%	1
Fresno	Large	Central	279,029	13,410	4.91%	\$36,624,269	\$134	\$2,731	51	41	51	899,872	10	7	2	30.3	21.0%	2
Glenn	Small/Rural	Superior	7,034	626	6.90%	\$2,481,228	\$353	\$3,964	18	23	18	28,475	48	45	8	24.7	15.4%	1
Humboldt	Small	Superior	27,013	2,757	10.21%	\$13,453,693	\$498	\$4,880	10	11	8	131,990	36	32	21	20.6	15.5%	0
Imperial	Small	Southern	49,741	2,601	5.23%	\$8,178,981	\$164	\$3,145	47	38	45	167,026	31	23	4	29.8	21.9%	1
Inyo	Small/Rural	Superior	3,172	312	9.84%	\$1,058,770	\$326	\$3,913	12	36	21	18,976	51	50	27	17.3	9.9%	1
Ken	Large	Southern	206,233	11,345	5.50%	\$39,481,868	\$191	\$3,480	43	30	41	779,490	13	6	6	26.5	18.3%	1
Kings	Small	Central	32,522	2,104	6.47%	\$4,313,627	\$133	\$2,050	39	51	52	148,073	33	29	20	22.0	19.6%	1
Lake	Small	Superior	15,529	1,345	8.66%	\$5,119,911	\$330	\$3,806	21	27	20	63,737	39	36	9	24.4	15.6%	1
Lassen	Small/Rural	Superior	5,887	723	13.42%	\$3,043,772	\$565	\$4,210	2	22	5	35,607	46	46	30	15.2	16.9%	1
Los Angeles	Very Large	Los Angeles	2,402,684	123,356	5.13%	\$572,148,553	\$238	\$4,658	50	12	36	10,257,594	1	1	13	23.4	17.3%	12
Madera	Small	Central	37,842	1,228	4.85%	\$5,979,462	\$142	\$2,943	52	39	49	145,198	34	26	7	26.1	20.5%	1
Marin	Medium	Bay Area	18,493	2,208	11.94%	\$11,342,777	\$613	\$5,137	5	7	3	253,818	25	35	56	7.3	6.8%	1
Mariposa	Small/Rural	Central	2,655	263	10.17%	\$426,991	\$165	\$4,620	11	53	44	16,200	52	53	38	14.2	11.7%	0
Mendocino	Small	Superior	21,556	1,884	8.74%	\$8,614,444	\$400	\$4,572	20	16	12	89,834	38	34	10	24.0	14.6%	1
Mendocino	Medium	Central	79,807	2,932	3.97%	\$7,270,094	\$99	\$2,480	56	48	55	246,114	26	18	3	30.0	18.8%	2
Modoc	Small/Rural	Superior	2,229	197	8.84%	\$427,547	\$192	\$2,170	19	50	40	9,715	55	54	16	22.9	16.9%	1
Monterey	Small/Rural	Central	1,277	98	7.67%	\$316,991	\$248	\$3,236	29	37	32	13,842	54	55	51	9.2	8.1%	1
Monterey	Medium	Bay Area	75,609	3,430	4.54%	\$21,019,164	\$278	\$6,128	54	4	22	423,048	18	17	26	17.9	13.3%	1
Napa	Small	Bay Area	13,932	1,088	7.81%	\$5,031,290	\$361	\$4,624	26	14	17	134,524	35	39	49	10.4	7.0%	1
Nevada	Small	Superior	8,813	742	8.42%	\$2,474,313	\$281	\$3,359	23	34	25	99,392	37	41	53	8.9	7.6%	1
Orange	Large	Southern	381,456	19,841	5.19%	\$67,681,617	\$151	\$2,837	49	40	48	3,071,824	2	2	43	12.4	10.2%	2
Orange/Sierra	Medium	Central	24,617	2,354	9.72%	\$9,154,308	\$372	\$3,524	14	26	15	320,991	22	22	33	9.5	7.8	5.5%
Plumas	Small/Rural	Superior	2,769	311	11.23%	\$1,877,964	\$498	\$4,431	7	17	8	21,142	50	52	40	13.1	9.8%	0
Riverside	Large	Southern	298,989	16,137	5.40%	\$41,657,093	\$139	\$2,575	44	47	50	1,966,607	5	5	30	15.2	12.9%	1
Sacramento	Large	Central	282,839	19,389	6.85%	\$74,152,390	\$262	\$3,928	37	25	30	1,387,771	8	6	23	20.4	12.7%	5
San Benito	Small	Bay Area	8,435	657	7.79%	\$1,499,719	\$178	\$2,281	27	49	42	57,513	41	42	34	14.7	8.8%	1
San Bernardino	Large	Southern	370,787	22,823	6.10%	\$62,854,034	\$170	\$2,762	41	43	43	1,993,963	4	3	25	18.6	15.7%	1
San Diego	Large	Southern	355,248	29,644	8.26%	\$102,696,965	\$287	\$3,463	24	32	24	3,064,113	3	4	44	11.7	10.9%	4
San Francisco	Large	Bay Area	129,219	13,288	10.25%	\$77,859,482	\$603	\$5,856	9	5	4	800,099	12	13	29	16.2	10.7%	4
San Joaquin	Medium	Central	148,692	7,880	5.30%	\$14,902,624	\$100	\$1,891	45	52	54	688,259	15	11	17	22.2	14.2%	2
San Luis Obispo	Medium	Southern	30,464	2,624	8.61%	\$11,166,757	\$366	\$4,266	22	19	16	262,594	23	30	45	11.6	10.7%	1
San Mateo	Medium	Bay Area	66,527	4,963	7.45%	\$20,909,405	\$314	\$4,221	34	21	22	726,536	14	20	52	9.2	5.9%	1
Santa Barbara	Medium	Southern	70,888	5,194	7.35%	\$39,966,137	\$564	\$7,899	35	3	6	419,369	21	19	28	16.9	12.4%	1
Santa Clara	Large	Bay Area	235,748	12,863	5.29%	\$60,706,290	\$260	\$4,910	46	10	31	1,780,449	6	8	40	13.1	7.8%	5
Santa Cruz	Medium	Bay Area	37,798	2,823	7.47%	\$32,424,023	\$868	\$11,486	31	1	2	261,385	24	27	35	14.5	10.6%	1
Shasta	Small	Superior	37,113	3,009	10.53%	\$10,911,745	\$294	\$2,791	8	42	23	179,835	29	28	21	20.6	13.4%	0
Shasta	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	n/a
Stanislaus	Small/Rural	Superior	10,183	1,269	12.46%	\$11,529,564	\$132	\$9,086	3	2	1	45,877	43	40	17	22.2	15.6%	1
Sutter	Medium	Bay Area	60,102	3,194	5.21%	\$14,496,800	\$241	\$4,626	48	13	35	421,642	19	21	37	14.3	7.9%	1
Sonoma	Medium	Bay Area	51,551	3,104	6.02%	\$17,275,470	\$335	\$5,567	42	6	19	478,222	17	22	48	10.8	7.5%	1
Stanislaus	Medium	Central	118,226	7,230	6.12%	\$24,167,547	\$204	\$3,643	40	33	38	513,441	16	15	14	23.0	13.8%	1
Sutter/Yuba	Small	Central	38,421	2,869	7.47%	\$10,489,992	\$273	\$3,565	31	28	29	160,867	32	25	12	23.9	13.0%	1
Tehama	Small	Superior	14,657	1,316	8.96%	\$3,617,553	\$247	\$2,749	17	44	33	60,979	40	38	10	24.0	16.3%	1
Trinity	Small/Rural	Superior	2,878	347	12.06%	\$1,465,675	\$511	\$4,235	4	20	7	14,108	53	51	23	20.4	16.1%	0
Tulare	Medium	Central	147,058	6,955	4.32%	\$23,119,931	\$157	\$3,698	55	29	47	420,131	20	12	1	35.0	22.5%	1
Tuolumne	Small	Southern	7,426	1,016	13.55%	\$3,486,065	\$449	\$3,465	1	31	30	57,039	42	44	10	12.1%	9.0%	0
Tulare	Large	Southern	112,493	5,302	4.71%	\$27,168,136	\$242	\$5,124	53	8	34	817,315	11	16	39	13.8	9.0%	1
Yuba	Small	Central	28,440	2,654	7.22%	\$7,971,159	\$280	\$3,881	36	24	26	190,500	28	31	33	14.9	11.3%	2
Yuba	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	n/a
State Wide	State Wide	State Wide	6,763,650	406,679	6.00%	\$1,672,091,078	\$246	\$4,112	n/a	n/a	n/a	37,185,240	n/a	n/a	n/a	18.2	n/a	13



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 6**

**Contra Costa County MHP – Approved Claims  
Data CY05**

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



Medi-Cal Approved Claims Data for CONTRA COSTA County MHP Calendar Year 2005



Date Prepared:	January 18, 2007 / Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
DMH Data Process Dates:	July 10, 2006, July 13, 2006, and April 6, 2006 - Note (3)

	CONTRA COSTA				BAY AREA		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>TOTAL</b>	114,548	9,534	\$49,939,237	8.32%	\$5,238	7.54%	\$5,271	6.27%	\$4,007
<b>AGE GROUP</b>									
0-15	46,953	3,092	\$19,335,066	6.59%	\$6,253	4.83%	\$6,262	4.54%	\$4,822
16-25	16,678	1,739	\$10,893,961	10.43%	\$6,264	7.80%	\$6,738	6.92%	\$4,902
26-59	32,799	4,211	\$18,054,944	12.84%	\$4,288	13.38%	\$4,843	10.24%	\$3,400
60+	18,119	492	\$1,655,266	2.72%	\$3,364	4.08%	\$3,064	3.28%	\$2,340
<b>GENDER</b>									
Female	66,798	5,193	\$22,332,660	7.77%	\$4,301	6.93%	\$4,482	5.77%	\$3,501
Male	47,747	4,341	\$27,606,577	9.09%	\$6,359	8.36%	\$6,148	6.92%	\$4,563
<b>RACE/ETHNICITY</b>									
White	28,266	4,020	\$20,592,299	14.22%	\$5,122	14.67%	\$5,527	12.30%	\$4,178
Hispanic	39,507	1,348	\$6,234,298	3.41%	\$4,625	3.06%	\$4,454	3.07%	\$3,601
African-American	26,723	2,960	\$15,779,092	11.08%	\$5,331	12.75%	\$5,575	10.08%	\$4,305
Asian/Pacific Islander	12,671	821	\$4,545,019	6.48%	\$5,536	5.70%	\$4,810	5.21%	\$3,301
Native American	308	67	\$516,038	21.75%	\$7,702	14.95%	\$5,460	11.66%	\$4,177
Other	7,074	318	\$2,272,491	4.50%	\$7,146	7.22%	\$5,794	7.79%	\$4,646

	CONTRA COSTA					BAY AREA		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	22,189	4,513	\$26,389,952	20.34%	\$5,848	24.47%	\$5,592	20.98%	\$4,090
Foster Care	1,756	1,087	\$6,733,194	61.90%	\$6,194	56.11%	\$8,895	53.15%	\$6,524
Other Child	47,577	2,587	\$12,794,454	5.44%	\$4,946	3.98%	\$4,338	3.80%	\$3,626
Family Adult	20,126	1,453	\$2,575,390	7.22%	\$1,772	5.41%	\$1,917	4.51%	\$1,634
Other Adult	24,078	314	\$1,446,247	1.30%	\$4,606	1.29%	\$3,163	1.01%	\$2,507
<b>SERVICE CATEGORIES</b>									
24 Hours Services	114,548	823	\$9,450,206	0.72%	\$11,483	0.67%	\$10,117	0.52%	\$7,206
23 Hours Services	114,548	1,224	\$2,345,433	1.07%	\$1,916	0.80%	\$2,032	0.33%	\$1,631
Day Treatment	114,548	528	\$5,899,946	0.46%	\$11,174	0.32%	\$10,825	0.16%	\$10,368
Linkage/Brokerage	114,548	2,281	\$2,036,608	1.99%	\$893	3.67%	\$1,001	3.05%	\$781
Outpatient Services	114,548	9,360	\$28,446,392	8.17%	\$3,039	7.15%	\$3,302	6.01%	\$2,694
TBS	114,548	208	\$1,760,653	0.18%	\$8,465	0.07%	\$9,776	0.05%	\$13,908
<b>FOSTER CARE</b>									
24 Hours Services	1,756	33	\$373,384	1.88%	\$11,315	1.95%	\$8,438	1.99%	\$6,856
23 Hours Services	1,756	44	\$83,391	2.51%	\$1,895	1.51%	\$1,465	1.04%	\$1,313
Day Treatment	1,756	96	\$1,446,366	5.47%	\$15,066	6.02%	\$14,961	4.35%	\$12,906
Linkage/Brokerage	1,756	254	\$288,254	14.46%	\$1,135	27.21%	\$1,361	28.32%	\$975
Outpatient Services	1,756	1,082	\$3,355,332	61.62%	\$3,101	54.60%	\$5,887	51.83%	\$4,326
TBS	1,756	131	\$1,186,468	7.46%	\$9,057	3.34%	\$9,564	1.81%	\$13,139
<b>SERVICE CATEGORIES BY RACE/ETHNICITY</b>									
<b>23 Hours Services</b>									
White	28,266	582	\$1,123,174	2.06%	\$1,930	1.70%	\$1,999	0.65%	\$1,612
Hispanic	39,507	143	\$258,755	0.36%	\$1,809	0.26%	\$1,674	0.12%	\$1,374
African-American	26,723	401	\$785,445	1.50%	\$1,959	1.77%	\$2,254	0.82%	\$1,858
Asian/Pacific Islander	12,671	66	\$118,148	0.52%	\$1,790	0.37%	\$1,866	0.21%	\$1,552
Native American	308	13	\$29,578	4.22%	\$2,275	2.17%	\$2,435	0.77%	\$1,715
Other	7,074	19	\$30,333	0.27%	\$1,596	0.51%	\$1,991	0.34%	\$1,681

CONTRA COSTA							BAY AREA		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>24 Hours Services</b>										
White	28,266	393	\$4,340,733	1.39%	\$11,045	1.49%	\$10,207	1.10%	\$7,300	1.10%
Hispanic	39,507	96	\$1,327,858	0.24%	\$13,832	0.23%	\$8,488	0.22%	\$5,654	0.22%
African-American	26,723	248	\$2,662,316	0.93%	\$10,735	1.20%	\$9,672	0.99%	\$7,776	0.99%
Asian/Pacific Islander	12,671	51	\$659,407	0.40%	\$12,930	0.33%	\$12,325	0.28%	\$8,694	0.28%
Native American	308	10	\$124,580	3.25%	\$12,458	1.42%	\$10,943	1.07%	\$6,149	1.07%
Other	7,074	25	\$335,311	0.35%	\$13,412	0.67%	\$11,503	0.73%	\$8,777	0.73%
<b>Day Treatment</b>										
White	28,266	193	\$2,243,177	0.68%	\$11,623	0.66%	\$9,080	0.34%	\$10,382	0.34%
Hispanic	39,507	63	\$589,724	0.16%	\$9,361	0.10%	\$10,686	0.06%	\$9,337	0.06%
African-American	26,723	219	\$2,524,383	0.82%	\$11,527	0.72%	\$12,859	0.34%	\$11,096	0.34%
Asian/Pacific Islander	12,671	32	\$240,385	0.25%	\$7,512	0.15%	\$11,613	0.07%	\$10,608	0.07%
Native American	308	4	\$23,893	1.30%	\$5,973	0.66%	\$4,250	0.33%	\$8,692	0.33%
Other	7,074	17	\$278,384	0.24%	\$16,376	0.18%	\$11,203	0.15%	\$11,233	0.15%
<b>Linkage/Brokerage</b>										
White	28,266	993	\$839,003	3.51%	\$845	7.41%	\$1,046	6.04%	\$824	6.04%
Hispanic	39,507	285	\$236,256	0.72%	\$829	1.60%	\$895	1.56%	\$682	1.56%
African-American	26,723	757	\$652,569	2.83%	\$862	5.51%	\$998	4.82%	\$768	4.82%
Asian/Pacific Islander	12,671	167	\$214,877	1.32%	\$1,287	2.85%	\$954	2.35%	\$760	2.35%
Native American	308	20	\$14,859	6.49%	\$743	6.93%	\$1,047	5.51%	\$867	5.51%
Other	7,074	59	\$79,043	0.83%	\$1,340	3.24%	\$1,162	3.49%	\$956	3.49%
<b>Outpatient Services</b>										
White	28,266	3,959	\$11,381,242	14.01%	\$2,875	13.96%	\$3,467	11.83%	\$2,762	11.83%
Hispanic	39,507	1,334	\$3,835,820	3.38%	\$2,875	2.89%	\$2,983	2.94%	\$2,642	2.94%
African-American	26,723	2,893	\$8,829,617	10.83%	\$3,052	11.97%	\$3,328	9.54%	\$2,706	9.54%
Asian/Pacific Islander	12,671	809	\$3,079,987	6.38%	\$3,807	5.49%	\$3,198	5.06%	\$2,264	5.06%
Native American	308	67	\$262,589	21.75%	\$3,919	13.96%	\$3,374	11.10%	\$2,893	11.10%
Other	7,074	298	\$1,057,137	4.21%	\$3,547	6.61%	\$3,269	7.30%	\$2,854	7.30%

	CONTRA COSTA				BAY AREA		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>TBS</b>								
White	28,266	92	\$921,067	0.33%	\$10,012	0.12%	\$11,018	0.10%
Hispanic	39,507	20	\$192,749	0.05%	\$9,637	0.03%	\$10,831	0.02%
African-American	26,723	78	\$492,111	0.29%	\$6,309	0.17%	\$7,464	0.09%
Asian/Pacific Islander	12,671	9	\$62,798	0.07%	\$6,978	0.04%	\$10,895	0.02%
Native American	308	3	\$34,042	0.97%	\$11,347	0.12%	\$10,394	0.05%
Other	7,074	6	\$57,886	0.08%	\$9,648	0.03%	\$13,193	0.04%

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 144,122

**CONTRA COSTA County MHP Medi-Cal Services Retention Rates CY05**

Number of Services Approved per Beneficiary Served	Contra Costa				Range		
	# of beneficiaries	%	Cumulative %	Statewide %	Minimum %	Maximum %	
1 service	737	7.73	7.73	8.66	2.05	25.00	
2 services	646	6.78	14.51	6.33	2.99	13.72	
3 services	549	5.76	20.26	5.39	1.84	11.76	
4 services	526	5.52	25.78	4.82	2.24	17.65	
5 - 15 services	2,930	30.73	56.51	31.87	20.07	41.49	
> 15 services	4,146	43.49	100.00	42.92	11.76	61.55	

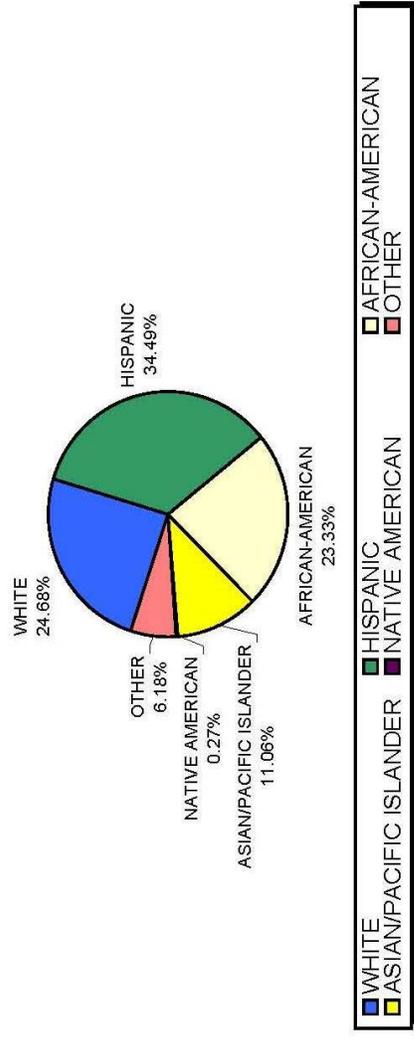
Source: Short-Doyle/Medi-Cal approved claims as of July 10, 2006; Inpatient Consolidation approved claims as of July 13, 2006.

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

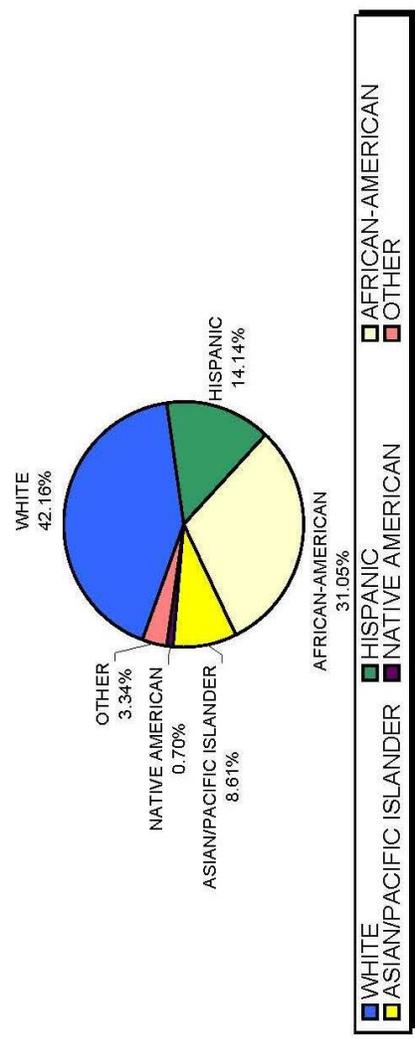
# Contra Costa Medi-Cal Eligibles vs. Beneficiaries Served

DMH Approved Claims Calendar Year 2005

Medi-Cal Average Monthly Unduplicated Eligibles

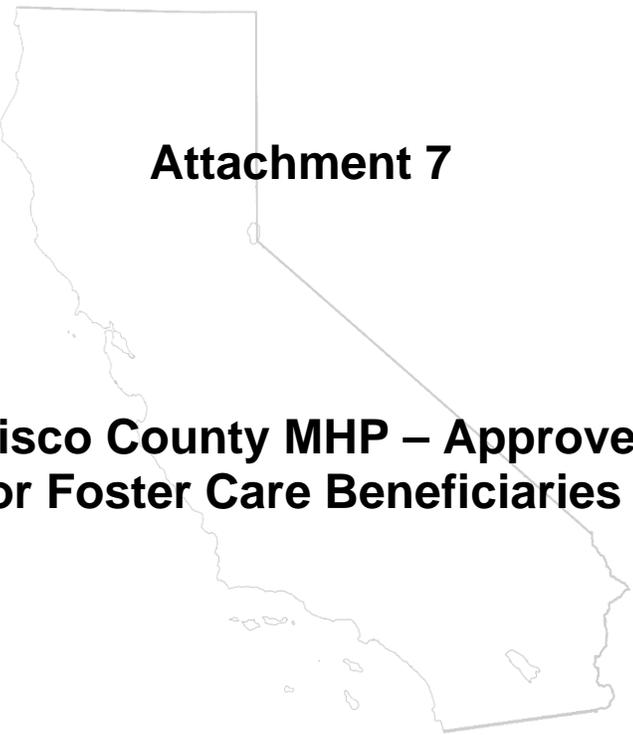


Medi-Cal Beneficiaries Served



Source: Short-Doyle/Medi-Cal approved claims as of July 10, 2006; Inpatient Consolidated approved claims as of July 13, 2006

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 7**

**San Francisco County MHP – Approved Claims  
Data for Foster Care Beneficiaries FY05**





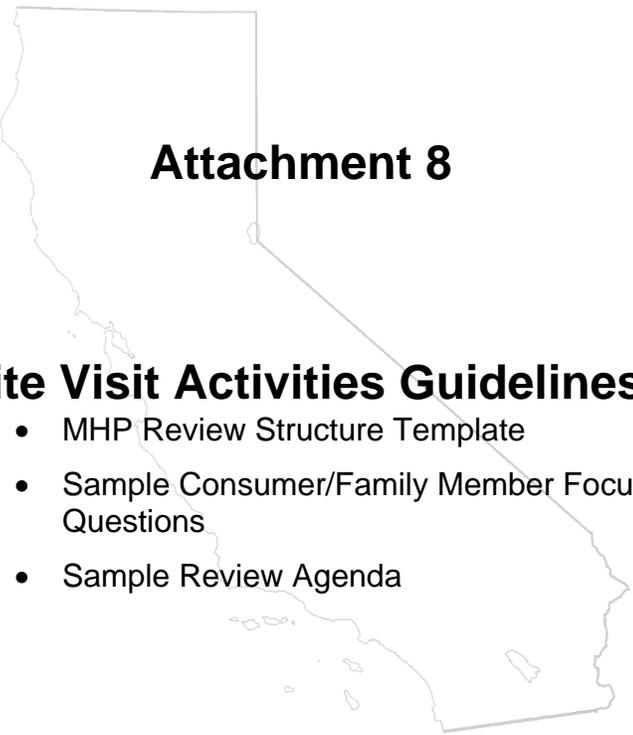
**Medi-Cal Approved Claims Data - Foster Care Beneficiaries  
for San Francisco County MHP  
Fiscal Year 04-05**

Date Prepared: February 26, 2007  
Prepared by: Hui Zhang, APS Healthcare/CAEQRO  
Information Source: DMH Approved Claims Summary Data  
DMH Process Date: December 23, 2005

	S A N F R A N C I S C O C O U N T Y D A T A				B A Y A R E A D A T A					
	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Medi-Cal Beneficiaries Served	Approved Amount	Penetration Rate	Average Monthly Approved Claims Undup Eligibles	Approved Claims Per Unduplicated Beneficiary Served	Penetration Rate	Average Monthly Approved Claims Undup Eligibles	Approved Claims Per Unduplicated Beneficiary Served
<b>San Francisco - MHP TOTAL</b>	<b>149,918</b>	<b>126,836</b>	<b>14,407</b>	<b>\$87,835,906</b>	<b>11.36%</b>	<b>\$693</b>	<b>\$6,097</b>	<b>7.19%</b>	<b>\$382</b>	<b>\$5,319</b>
<b>San Francisco - Other Child</b>	<b>25,095</b>	<b>19,116</b>	<b>551</b>	<b>\$1,633,340</b>	<b>2.88%</b>	<b>\$85</b>	<b>\$2,964</b>	<b>2.04%</b>	<b>\$75</b>	<b>\$3,681</b>
<b>San Francisco - Foster Care</b>	<b>2,861</b>	<b>2,289</b>	<b>951</b>	<b>\$5,602,287</b>	<b>41.55%</b>	<b>\$2,447</b>	<b>\$5,891</b>	<b>53.11%</b>	<b>\$4,680</b>	<b>\$8,812</b>
<b>Race/Ethnicity</b>										
WHITE	276	214	94	\$655,111	43.93%	\$3,061	\$6,969	57.72%	\$5,139	\$8,902
HISPANIC	361	260	99	\$337,006	38.08%	\$1,296	\$3,404	40.01%	\$2,952	\$7,380
AFRICAN-AMERICAN	1,967	1,626	669	\$4,109,501	41.14%	\$2,527	\$6,143	50.80%	\$4,353	\$8,568
ASIAN/PACIFIC ISLANDER	233	175	84	\$446,412	48.00%	\$2,551	\$5,314	114.90%	\$13,821	\$12,028
NATIVE AMERICAN	9	7	4	\$15,251	57.14%	\$2,179	\$3,813	45.88%	\$2,730	\$5,949
OTHER	15	7	1	\$39,005	14.29%	\$5,572	\$39,005	36.84%	\$3,860	\$10,477
<b>Total</b>	<b>2,861</b>	<b>2,289</b>	<b>951</b>	<b>\$5,602,287</b>	<b>41.55%</b>	<b>\$2,447</b>	<b>\$5,891</b>	<b>53.11%</b>	<b>\$4,680</b>	<b>\$8,812</b>
<b>Gender</b>										
FEMALES	1,362	1,108	441	\$2,110,434	39.60%	\$1,905	\$4,786	52.55%	\$4,483	\$8,531
MALES	1,499	1,181	510	\$3,491,853	43.18%	\$2,957	\$6,847	53.63%	\$4,863	\$9,068
<b>Total</b>	<b>2,861</b>	<b>2,289</b>	<b>951</b>	<b>\$5,602,287</b>	<b>41.55%</b>	<b>\$2,447</b>	<b>\$5,891</b>	<b>53.11%</b>	<b>\$4,680</b>	<b>\$8,812</b>
<b>Age Groups</b>										
0-17	2,659	2,198	920	\$5,436,975	41.86%	\$2,474	\$5,910	56.52%	\$5,791	\$10,247
18-20	202	92	31	\$165,312	33.70%	\$1,797	\$5,333	44.20%	\$3,316	\$7,503
<b>Total</b>	<b>2,861</b>	<b>2,289</b>	<b>951</b>	<b>\$5,602,287</b>	<b>41.55%</b>	<b>\$2,447</b>	<b>\$5,891</b>	<b>53.11%</b>	<b>\$4,680</b>	<b>\$8,812</b>
<b>Age Groups by Gender</b>										
0-17 - Females	1,269	1,065	427	\$2,003,333	40.09%	\$1,881	\$4,692	52.71%	\$4,501	\$8,538
0-17 - Males	1,390	1,133	493	\$3,433,640	43.51%	\$3,031	\$6,965	54.15%	\$4,949	\$9,140
18-20 - Females	93	44	14	\$107,100	31.82%	\$2,434	\$7,650	48.61%	\$4,052	\$8,335
18-20 - Males	109	48	17	\$58,213	35.42%	\$1,213	\$3,424	40.25%	\$2,657	\$6,601
<b>Total</b>	<b>2,861</b>	<b>2,289</b>	<b>951</b>	<b>\$5,602,287</b>	<b>41.55%</b>	<b>\$2,447</b>	<b>\$5,891</b>	<b>53.11%</b>	<b>\$4,680</b>	<b>\$8,812</b>
<b>Service Activity</b>										
INPATIENT	2,861	2,289	39	\$258,614	1.70%	\$113	\$6,631	2.01%	\$135	\$6,699
DAY TX	2,861	2,289	68	\$1,196,196	2.97%	\$523	\$17,591	5.65%	\$850	\$15,046
LINKAGE/BROKERAGE	2,861	2,289	483	\$208,290	21.10%	\$91	\$431	25.75%	\$342	\$1,329
MH SERVICES	2,861	2,289	916	\$3,143,369	40.02%	\$1,373	\$3,432	49.92%	\$2,818	\$5,645
TBS	2,861	2,289	53	\$409,439	2.32%	\$179	\$7,725	3.19%	\$268	\$8,425
MEDICATION SUPPORT	2,861	2,289	226	\$249,542	9.87%	\$109	\$1,104	13.89%	\$184	\$1,326
CRISIS	2,861	2,289	76	\$128,500	3.32%	\$56	\$1,691	5.82%	\$82	\$1,410
<b>Totals</b>	<b>2,861</b>	<b>2,289</b>	<b>951</b>	<b>\$5,602,287</b>	<b>41.55%</b>	<b>\$2,447</b>	<b>\$5,891</b>	<b>53.11%</b>	<b>\$4,680</b>	<b>\$8,812</b>



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 8**

**Site Visit Activities Guidelines**

- MHP 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**

- Introductions – sign-in sheets
- EQRO federal regulations of managed care entities – annual quality review of each MHP
  - Special attention to issues of access, timeliness, outcomes, and quality
- 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
- 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 V6.1
    - 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 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 and daily operations?
- Which reports let you know how you are doing in terms of your strategic initiatives or other goals?
- 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

## **Staff and Provider Interviews and Field Visits**

Identify questions based upon issues identified from last year's report, this year's document review, and/or this year's review so far.

## **Wrap-Up**

- Closure
- Thank you for the preparation
- Preliminary themes or observations from the review
- Identify any outstanding documentation
- Describe post-site and report process, including from the MHP regarding the draft
- Any valuable items to include in the report from MHP's perspective
- Available for technical assistance
- Check out the website



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

- Identify those questions relevant to this review
- Adapt questions as appropriate for the MHP or participants & skip questions not relevant
- Add questions based upon the last year's report, document review, or findings so far

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 group?
2. What services do you receive that are the most helpful to you?
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?
4. What goals are most important for you, and how do your services help you get there?
5. Do you have hope that you can "recover" from the problems that brought you here for services? How would you know if you achieved that?
6. Do you participate in any groups? Are there other kinds of groups that you think would help you that aren't offered?
7. Do you know about opportunities to help others as a peer volunteer or an employee?
8. If you want your family involved, how does your provider include your family in ways that helps you?
9. Often people are afraid to ask for help. When you first asked for help here, did the staff help make you feel comfortable?
10. Is there more that they can do to encourage others to come in when they need help?
11. How easy or difficult is to get an appointment with a psychiatrist? How satisfied are you with these services?
12. Does your psychiatrist also work with your primary care doctor to make sure that the medications they both prescribe work together?
13. If you need help for mental health and substance use problems, how are those services provided?
14. What would you do if you felt that the staff person working with you wasn't a good fit?
15. What do you recommend for improving services here?



## Sample Review Agenda

### Day One

Time	CAEQRO Activities	
<b>9:00 – 12:00</b>  break at approx 10:30	<b><u>Performance Management</u></b>	
	<ul style="list-style-type: none"> <li>• Introductions of review participants</li> <li>• CAEQRO overview of review intent</li> <li>• MHP significant changes over the past year</li> <li>• MHP current strategic initiatives</li> <li>• CAEQRO report recommendations</li> <li>• MHP use of data to support decision-making, planning, and assessing the effectiveness of services and procedures – including data access, analysis, interpretation, and plans of action</li> </ul> <p>Include 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, Deputy Directors, Division Managers, and other relevant senior staff in: fiscal, clinical, IS, medical, QI, or research</li> <li>• Involved consumer and family member representatives</li> </ul>	
<b>12:00 – 1:00</b>	APS Staff Lunch (On-Site)	
<b>1:00 – 2:00</b>	<b><u>Performance Management – continued</u></b>	
	<ul style="list-style-type: none"> <li>• Performance improvement measurements used to support decision-making, planning, and assessing the effectiveness of services and procedures – including data access, analysis, interpretation, and plans of action</li> <li>• Discussion of CAEQRO claims data</li> <li>• Sharing of data with stakeholders</li> </ul>	
<b>2:15 – 3:45</b>	<b><u>Information System Enhancements</u></b>	
<b>3:45 – 5:00</b>		<b><u>Reports Committee</u></b>
<b>7:00 – 8:30</b>	<b><u>Consumer/Family Member Focus Group (Latino consumers &amp; family members)</u></b>	

**Day Two**

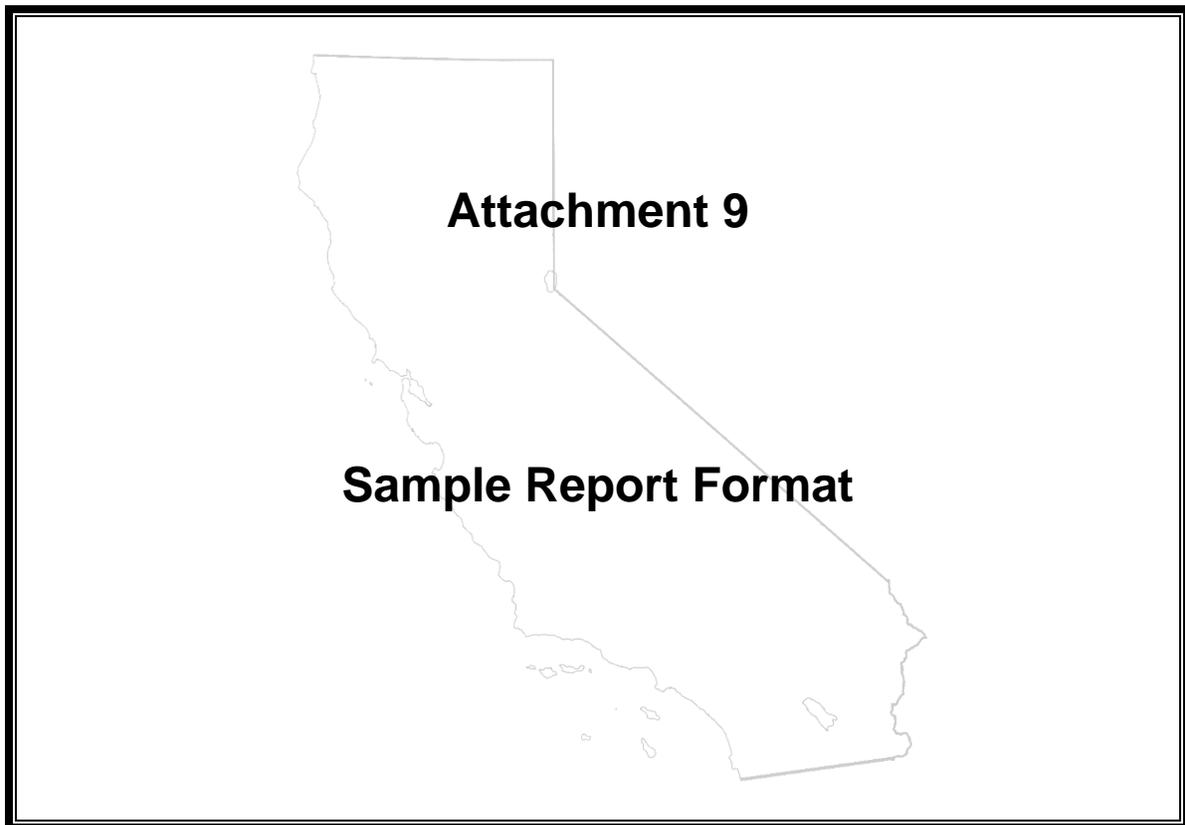
<b>Time</b>	<b>CAEQRO Activities</b>		
<b>9:00 – 10:30</b>	<b><u>Wellness &amp; Recovery implementation</u></b>	<b><u>Contract Provider Site Visit</u></b> Operations/Support and Clinical staff	
	Travel		
<b>11:00 – 12:00</b>	<b><u>MHP Clinical Line Staff</u></b> 8-10 participants representing various programs	<b><u>Consumer Employee Group Interview</u></b> 6-8 consumers who are employed within the MHP and/or contract providers	<b><u>ISCA Group Interview</u></b>
<b>12:00 – 1:00</b>	APS Staff Lunch (Off-Site)		
	Travel		
<b>1:30 – 3:00</b>	<b><u>MHP Providers Clinical Supervisors Group Interview</u></b> 8-10 mid-level managers representing various programs	<b><u>1:00 – 2:30 Adult Consumer Focus Group</u></b>	<b><u>SD/MC Claims Processing</u></b> To include Auditor/Controller staff and other MHP staff involved in claims processing
	Travel		
<b>3:45– 5:00</b>		<b><u>MHP Provider Visit</u></b>	
<b>6:00 – 7:30</b>	<b><u>Family Member Focus Group</u></b> <b><u>(Family Members of Adult and Child Consumers)</u></b>		

**Day Three**

<b>Time</b>	<b>CAEQRO Activities</b>	
9:00 – 10:30	<p align="center"><b><u>Contract Provider Site Visit</u></b></p> <p align="center">Administration, support, and clinical Staff</p>	
Travel		
11:00 – 12:30	<p 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:</p> <ul style="list-style-type: none"> <li>○ PIP committee</li> <li>○ Directors, Division Managers, or involved Supervisors</li> </ul>	<p align="center"><b><u>Contract Provider Site Visit</u></b></p> <p align="center">Operations/Support and Clinical Staff</p>
12:30 – 1:30	APS Staff Lunch (On-Site)	
1:30 – 2:30	<p align="center"><b><u>QI/IS/Research Analyst Group Interview</u></b></p> <p align="center">Interface, collaborative projects, and strategies for data management</p>	
2:30 – 2:45	APS Staff Meeting	
2:45 – 3:15	<p align="center"><b><u>Wrap-Up</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>	



**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 third 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, emphasizing the MHP's approach to strategic planning and performance management.

Consistent with this approach, CAEQRO's intent is to include findings on the following areas:

- Any changes, progress, or milestones in the MHP's approach to performance management – including the overall service delivery system, business practices, and quality improvement processes
- Information Systems Capabilities Assessment V6.1 (ISCA)
- Two current Performance Improvement Projects (PIPs) — one clinical and one non-clinical
- Implementation of wellness and recovery practices throughout the system
- Interviews with key MHP clinical, administrative, information systems, and clerical/data entry staffs and, where appropriate, contract provider staffs
- <#> 90-minute focus group(s) with beneficiaries and family members

The review agenda and the list of participants follow the body of the report as Attachments A and B. A description of the source of data for Tables 1 through 7 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 2006-2007

### Status of Fiscal Year 2005-2006 Recommendations

In the FY05-06 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY06-07 site visit, CAEQRO and MHP staffs discussed the status of the FY05-06 recommendations summarized below:

- < List issue followed by colon: >
  - Fully addressed       Partially addressed       Not addressed
  - < Text here if no bullets >
  - < Text here if bullets >
  
- < List issue followed by colon: >
  - Fully addressed       Partially addressed       Not addressed
  - < Text here if no bullets >
  - < Text here if bullets >
  
- < List issue followed by colon: >
  - Fully addressed       Partially addressed       Not addressed
  - < Text here if no bullets >
  - < Text here if bullets >
  
- < List issue followed by colon: >
  - Fully addressed       Partially addressed       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:

- < Issue 1 >
- < Issue 2 >

## Delivery System Performance Management

### Strategic emphasis

- < Issue >
- < Issue >
- < Issue >
- < Issue >

### Significant delivery system changes since the last review

- < change >
- < 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 these reports included the following issues:

- < Issue >
- < Issue >
- < Issue >
- < Issue >

## Medi-Cal Claims Data for Managing Services

### Source of data for Tables 1 – 7

Information to support Tables 1 through 7 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 a summary report of Medi-Cal approved claims data that follows as Attachment D. Table 1 displays key elements from this report. In each ranked category, rank 1 is the highest value; rank 56 is the lowest value. < If applicable; if not, delete the next sentence: > CAEQRO provided additional data related to < foster care approved claims, contract provider utilization, retention, etc. – specify for the MHP any extra drill-downs that were provided >, which also follow in Attachment D.

**Table 1 – CY2006 Medi-Cal Approved Claims Data**

Element	< insert MHP name >	< insert region >	MHPs of Similar Size - < insert size >	Statewide	Rank Out of 56 MHPs Reviewed
Penetration rate	XX%	XX%	XX%	XX%	X
Approved claims per beneficiary served per year	\$XX	\$XX	\$XX	\$XX	X
Approved claims per eligible per year	\$XX	\$XX	\$XX	\$XX	X
Penetration rate – Foster care	XX%	XX%	XX%	XX%	N/A
Approved claims per beneficiary served per year – Foster care	\$XX	\$XX	\$XX	\$XX	N/A
Delete if not used	\$XX	\$XX	\$XX	\$XX	X
Delete if not used	\$XX	\$XX	\$XX	\$XX	X

As part of the pre-site process, CAEQRO asked the MHP to identify two other counties that it deems to be useful for comparison purposes – identified for similarities in treatment philosophy, organizational structure, region, size, demographics, or other relevant characteristics. The table below includes elements from Medi-Cal approved claims data for the MHP and the two other identified MHPs.

**Table 2 – CY2006 Medi-Cal Eligibility and Claims Information from Comparable Counties**

Element	< insert MHP name >	< insert other MHP name >	< insert other MHP name >
Average number of eligibles per month	X	X	X
Number of beneficiaries served per year	X	X	X
Penetration rate	XX%	XX%	XX%
Penetration rate – Rank	X	X	X
Approved claims per year	\$XX	\$XX	\$XX

Element	< insert MHP name >	< insert other MHP name >	< insert other MHP name>
Approved claims per eligible per year	\$XX	\$XX	\$XX
Approved claims per eligible per year – Rank	X	X	X
Approved claims per beneficiary served per year	\$XX	\$XX	\$XX
Approved claims per beneficiary served per year – Rank	X	X	X
Penetration rate – Foster care	XX%	XX%	XX%
Approved claims per beneficiary served per year – Foster care	\$XX	\$XX	\$XX
Delete if not used	X	X	X

Review of Medi-Cal approved claims data included the following issues that may reflect access to services and quality:

- < Issue >
- < Issue >
- < Issue >
- < Issue >

The table below includes CY2005 Medi-Cal approved claims data showing number and the percentage of beneficiaries who received the number of services indicated in the first column. These data are compared with the statewide rates and the range of all MHPs.

**Table 3 – CY2005 Retention Rates**

Number of Services Approved per Beneficiary Served	< insert MHP name >			Statewide %	Range	
	# of beneficiaries	%	Cumulative %		Minimum %	Maximum %
1 service				8.66	2.05	25.00
2 services				6.33	2.99	13.72
3 services				5.39	1.84	11.76
4 services				4.82	2.24	17.65
5 - 15 services				31.87	20.07	41.49
> 15 services				42.92	11.76	61.55

Review of the retention data included the following issues:

- < 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.

**Table 4 – Medi-Cal Eligibility and Claims Trend Line Analysis**

Fiscal Year	Average Number Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate	Approved Claims	Approved Claims per Eligible per Year	Approved Claims per Beneficiary Served per Year
FY04-05	X	X	XX%	\$XX	\$XX	\$XX
FY03-04	X	X	XX%	\$XX	\$XX	\$XX
FY02-03	X	X	XX%	\$XX	\$XX	\$XX

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

- < Insert relevant text >
- < Insert relevant text >

Medi-Cal denied claims information appears in the following table. These are denials in Medi-Cal claims processing, not the result of disallowances or chart audits. Denial rate rank 1 is the highest percentage of denied claims; rank 56 is the lowest percentage of denied claims.

**Table 5 – Medi-Cal Denied Claims Information**

Fiscal Year	MHP Denial Rate	Denial Rate Rank	Statewide Median	Statewide Range	< other MHP name > Denial Rate	< other MHP name > Denial Rate
FY05-06	XX%	X	6.32%	1.18% - 37.57%	XX%	XX%
FY04-05	XX%	X	3.24%	0% - 36.78%	XX%	XX%
FY03-04	XX%	X	3.82%	0% - 30.11%	XX%	XX%

Discussion of Medi-Cal denied claims included: < Delete this if N/A >

- < Any relevant text regarding the above table >

## Performance Measurement Results

As the Performance Measurement for Year Two, CAEQRO analyzed a number of demographic and service activity variables associated with the average dollar amount of Medi-Cal approved claims per beneficiary served during calendar year 2005. Statewide data showed that the average dollar amount discrepancy among various populations was especially noteworthy in two groups.

- The dollar amount approved for female Medi-Cal beneficiaries was lower than for males.
- The dollar amount approved for Hispanic/Latino Medi-Cal beneficiaries was lower than for Whites.

The tables below show the results of these analyses for the MHP, comparing the MHP results with statewide and MHP identified comparison county/MHP averages and ratios. Table 6 reflects approved claims data and a ratio of penetration rates between Hispanics and Whites. This ratio takes into consideration the overall percentage of the MHP's Hispanic Medi-Cal eligibles as well as the percentage of Hispanic Medi-Cal beneficiaries that received services during the year. Similar calculations follow in Table 7 for Female to Male Medi-Cal beneficiaries.

**Table 6 – CY2005 Performance Measurement Results – Hispanic/Latino versus White**

	Number of Beneficiaries Served per Year		Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic	White	Hispanic	White	Penetration Rates	Approved Claims
< MHP >						
State	109,751	179,501	\$3,601	\$4,178	.25	.86
< other MHP >						
< other MHP >						

**Table 7 – CY2005 Performance Measurement Results – Female versus Male**

	Number of Beneficiaries Served per Year		Approved Claims per Beneficiary Served per Year		Ratio of Female versus Male for	
	Female	Male	Female	Male	Penetration Rates	Approved Claims
< MHP >						
State	223,630	203,348	\$3,501	\$4,563	.83	.77
< other MHP >						
< other MHP >						

Discussion of the performance measurement data included:

- < Any relevant text regarding the above table >

## Consumer/Family Member Focus Group(s)

CAEQRO conducted < one/two/three > 90-minute focus < group/groups > with consumers and family members during the site review of the MHP. < The focus group was held at – if more than one group, include this information below under the header. > The focus group questions emphasized the availability of timely access to services, recovery, peer support, cultural competence, improved outcomes, <and> consumer and family member involvement, < etc., based upon MHP >. 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 >

**Table 8 – 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 >

< Repeat above tables for additional focus groups >

## Performance Improvement Project Validation

### Clinical PIP validation

The MHP presented its study question for the clinical PIP as follows:

“< Study Question > “

< Describe the current status of the PIP, including salient information regarding the PIP >

Attachment F includes PIPs submitted by the MHP. < Followed by one of the following sentences, amended if necessary depending upon what/how the MHP submitted > Because the MHP submitted a clinical PIP in a different format, attachment F also includes the requested format. < OR > However, the MHP did not submit a clinical PIP. The requested format follows as Attachment F.

CAEQRO's discussions with the MHP staff included activities to date regarding the PIP, plans for the PIP, and technical assistance to improve this PIP. Relevant details of these issues and recommendations are included within the comments of the PIP validation tool that follows as Attachment E. CAEQRO applied the PIP validation tool to all PIPs, rating each of the 44 individual elements as either “met,” “partial,” “not met,” or “not applicable.” These elements reflect ten categories with the results summarized in the table below.

**Table 9 – Clinical PIP Validation Review Results Summary**

Step		Individual Criteria				Key Criteria	
		Met	Partial	Not Met	N/A	Met	Total Possible
1	Study topic						1
2	Study question definition						2
3	Clearly defined study indicators						4
4	Correctly identified study population						1
5	Use of valid sampling techniques					N/A	0
6	Use of reliable data collection processes						1
7	Appropriate intervention/improvement strategies						1
8	Analysis of data and interpretation of study results						3
9	Creation of a plan for real improvement					N/A	0
10	Achievement of sustained improvement					N/A	0
	Total of 44 criteria						<b>13</b>

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve its PIP.

#### Non-clinical PIP validation

The MHP presented its study question for the non-clinical PIP as follows:

“< Study Question > “

< Describe the current status of the PIP, including salient information regarding the PIP >

Attachment F includes PIPs submitted by the MHP. < Followed by one of the following sentences, amended if necessary depending upon what/how the MHP submitted > Because the MHP submitted a non-clinical PIP in a different format, attachment F also includes the requested format. < OR > However, the MHP did not submit a non-clinical PIP. The requested format follows as Attachment F.

CAEQRO’s discussions with the MHP staff included activities to date regarding the PIP, plans for the PIP, and technical assistance to improve this PIP. Relevant details of these issues and recommendations are included within the comments of the PIP validation tool that follows as Attachment E. CAEQRO applied the PIP validation tool to all PIPs, rating each of the 44 individual elements as either “met,” “partial,” “not met,” or “not applicable.” These elements reflect ten categories with the results summarized in the table below.

**Table 10 – Non-Clinical PIP Validation Review Results Summary**

Step		Individual Criteria				Key Criteria	
		Met	Partial	Not Met	N/A	Met	Total Possible
1	Study topic						1
2	Study question definition						2
3	Clearly defined study indicators						4
4	Correctly identified study population						1
5	Use of valid sampling techniques					N/A	0
6	Use of reliable data collection processes						1
7	Appropriate intervention/improvement strategies						1
8	Analysis of data and interpretation of study results						3
9	Creation of a plan for real improvement					N/A	0
10	Achievement of sustained improvement					N/A	0
	Total of 44 criteria						<b>13</b>

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve its PIP.

Additional PIPs completed or discontinued since the last review

< Delete section if n/a or amend as needed to describe the status of other PIPs. >

In addition to the two PIPs described above, the MHP also completed its PIP on < topic >. < Describe plan for monitoring sustained improvement and any recommendations in that regard.>

In addition to the two PIPs described above, the MHP discontinued its PIP on < topic > because < describe general issues >. < Include any 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 – 1 page maximum – of MHP current IS operations and status. Discuss the MHP's stated priorities in the ISCA and how they are responding.>

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.

**Table 11 – Current Systems/Applications**

<b>System/Application</b>	<b>Function</b>	<b>Vendor/Supplier</b>	<b>Years Used</b>	<b>Operated By</b>

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 FY06-07 review, along with a rating for each separate component and the rating from the FY05-06 review.

**Table 13 – Review of Information System Components**

Component	Rating				FY 05-06 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, reliable authorization and claims adjudication processes for network providers, including timely and accurate payment					< etc. >
Demonstrated capability to support business analysis and data analytic activities					New in FY06-07
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

< In addition to describing this year's rating, review how scoring compares to last year; include comment if improved, same, deteriorated. If there are no items to explain here (i.e., all are Met, none are exemplary, no status changes from last year) then remove this section and header. >

< Items marked as Partially Met, Not Met, or Not Reviewed must be explained here. If you only provide explanations for these categories, use this sentence as the lead-in and delete the other below. > Components rated "Partially Met," "Not Met," or "Not Reviewed" are explained below. Ratings that have significantly changed from last year's report are also explained.

< Optionally, you may provide narrative on any exemplary practices that you have categorized as Met. If you do, use this as your lead-in, and delete the other above. > Components rated “Partially Met,” “Not Met,” or “Not Reviewed” are explained below. In addition, some components rated as “Met” are included because they were exemplary practices observed during the course of the review. 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 >

## Site Review Process Barriers

CAEQRO considered the following issue(s) significant in affecting the ability to conduct a comprehensive review:

- < Issue >
- < Issue >

## Conclusions: Strengths and Opportunities for Improvement

During the FY06-07 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

- < Strength >
- < Strength >
- < Strength >

### Opportunities for Improvement

- < Opportunity >
- < Opportunity >
- < Opportunity >

## Recommendations

The following recommendations are in response to the opportunities for improvement identified during the review process:

< In general, address all of the opportunities in the recommendations. Note where strengths can be leveraged to address the opportunities..>

- < Recommendation >

## Attachments

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Source Data: Tables 1 through 7

Attachment D: Data Provided to MHP

Attachment E: CAEQRO PIP Validation Tools

Attachment F: MHP PIP Summaries Submitted

# **Attachment A**

## **Review Agenda**

## &lt; Insert Review Agenda &gt;

- Remove MHP name from the top off the agenda.
- If it was a one-day review, remove the date from the top of the agenda
- Adjust bulleting that may have shifted during the cut and paste
- In most cases, formatting with the session title in Bold and the supporting information in regular font, perhaps 10 point looks the clearest.

# **Attachment B**

## **Review Participants**

The following participants represented the MHP – and where applicable, contract providers and other stakeholders – during the review:

< 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: Tables 1 – 7**

Source of data for Tables 1 – 7

- **Source Files:** Information to support Tables 1 through 7 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
  
- **DMH Process Date:** The “DMH process date” is the date DMH provides claim 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.
  - 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
  - FY05-06 denied claims includes SD/MC claims with process date July 11, 2006
  - Most recent MMEF includes Medi-Cal eligibility for April 2006 and 15 prior months
  
- **Data Definitions:** Selected elements displayed in Tables 1 through 7 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 eligible per year – The annual dollar amount of approved claims divided by the average number of Medi-Cal eligibles per month
  - 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 tables and demographics charts >

**Attachment E:**  
**CAEQRO PIP Validation Tools**

**One Validation Tool follows, though each MHP report includes two (clinical & non-clinical)**

**FY 06-07 Review of: <MHP>**  Clinical  Non-Clinical

**PIP Title/Topic: <Enter brief phrase to identify PIP >**

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
<b>1</b>	<b>Study topic</b>			
	<i>The study topic:</i>			N/A
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations			
1.2	Was selected following data collection and analysis of data that supports the identified problem			
1.3	Addresses key aspects of care and services			
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs			
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			
<b>Totals for Step 1:</b>				
<b>Total of 1 key criterion for Step 1:</b>				
<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			

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
2.4	Is answerable/demonstrable			N/A
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 well 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>				
<b>Total of 1 key criterion for Step 4:</b>				

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
<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 criterion 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			

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
7.4	Are standardized and monitored when an intervention is successful			N/A
<b>Totals for Step 7:</b>				
<b>Total of 1 key criterion for Step 7:</b>				
<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 intervention(s)			
9.4	Statistical evidence for improvement			
<b>Totals for Step 9:</b>				

Step	Rating			Comments/Recommendations
	Met	Partial	Not Met	
10	<b>Sustained Improvement Achieved</b> <i>There is evidence for sustained improvement based on:</i>			
<b>Totals for Step 10:</b>				

**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:

[< Convert the MHP's PIPs to PDF and insert. Also insert the PIP Format Sample if the MHP did not submit PIPs or did not use the requested format. >](#)

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 10**

**CAEQRO Data Exchange and Security Protocols**



## CAEQRO Data Exchange and Security Protocols

### CAEQRO Source Data Files

For our FY07 review, 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 FY05:

- 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 (SDMC).** Located at HHSDC, these files are generated by DHS during the process of adjudicating the SDMC 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 SDMC file contains adjudicated approved claims during a fiscal year. CAEQRO has successfully loaded historical SDMC data for prior fiscal years. For partial fiscal year data, DHS generates a cumulative fiscal year-to-date file. With this processing strategy SDMC 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 SDMC files for the following fiscal years:

- FY01-FY02
- FY02-FY03
- FY03-FY04
- FY04-FY05
- FY05-FY06
- FY06-FY07 (DMH process date March 31, 2007)
- **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 SDMC 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 SDMC 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 (IS) 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 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:

- **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.
  - **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.
  - **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 SDMC
• County	• From MEDS, SDMC and IPC
• Service Mode	• From SDMC and IPC
• Service Function Code	• From SDMC and IPC
• Aid Code	• From MEDS, SDMC and IPC
• Cross Over Indicator	• From SDMC and IPC
• Claim Paid Status	• From SDMC and IPC
• Denial Reason	• From SDMC and IPC
• Override Code Indicator	• From SDMC and IPC

- **CAEQRO application software**

The following application software is used to process, manipulate and analyze data:

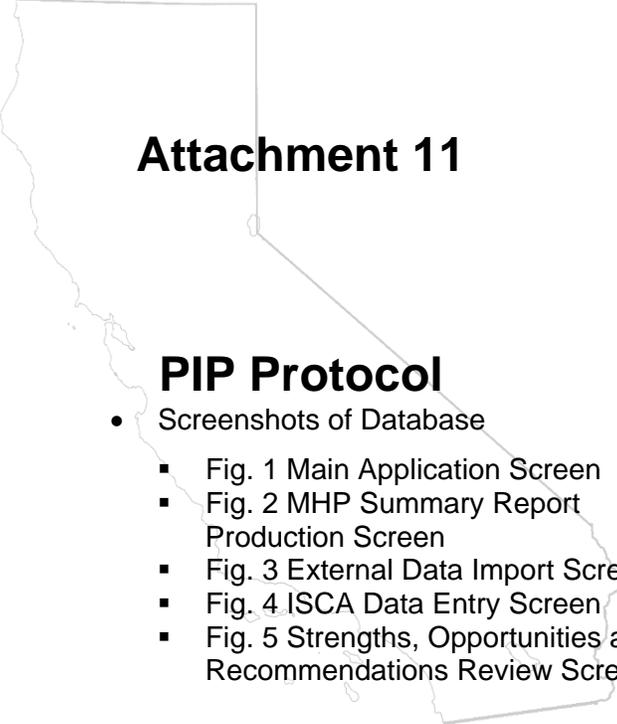
<b>Software</b>	<b>Description</b>
<ul style="list-style-type: none"> <li>• SAS</li> <li>• SPSS</li> </ul>	<ul style="list-style-type: none"> <li>• Statistical analysis software</li> <li>• Statistical analysis software</li> </ul>
<ul style="list-style-type: none"> <li>• Data Transformation Services</li> </ul>	<ul style="list-style-type: none"> <li>• Software that manages SQL files</li> </ul>
<ul style="list-style-type: none"> <li>• Transact-SQL</li> </ul>	<ul style="list-style-type: none"> <li>• Programming language used to extract data from SQL database files</li> </ul>
<ul style="list-style-type: none"> <li>• Excel</li> </ul>	<ul style="list-style-type: none"> <li>• Software that reads SAS/SQL</li> </ul>

- **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.

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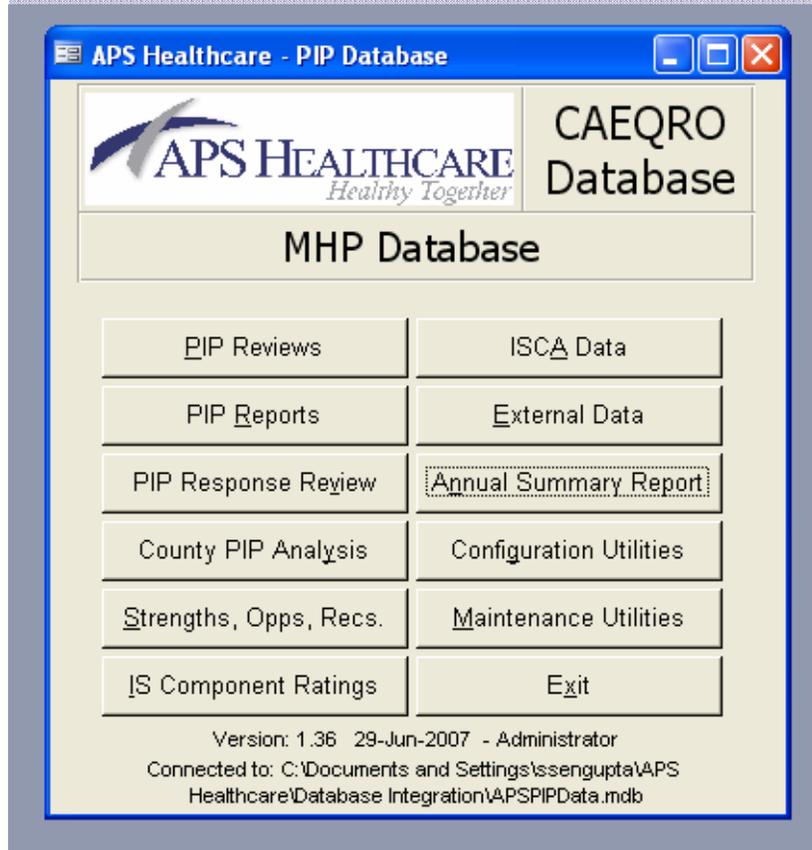
**Attachment 11**

**PIP Protocol**

- Screenshots of Database
  - Fig. 1 Main Application Screen
  - Fig. 2 MHP Summary Report Production Screen
  - Fig. 3 External Data Import Screen
  - Fig. 4 ISCA Data Entry Screen
  - Fig. 5 Strengths, Opportunities and Recommendations Review Screen
- PIP Validation Tool



**Fig. 1 – Main Application Screen**



**Fig. 2- MHP Summary Report  
Production Screen**

The screenshot shows a software window titled "Annual MHP Summary Report" with a blue title bar and standard window controls (minimize, maximize, close). The main area is a light beige form with the following elements:

- County:** A dropdown menu with "Inyo" selected.
- Fiscal Year:** A dropdown menu with "06-07" selected. To its right is a button labeled "Customize Footer".
- Calendar Year:** A dropdown menu with "2005" selected. To its right is a button labeled "QA Data".
- Include Footnotes:** A checked checkbox.
- Page Number Prefix:** A text input field containing "MHP -".
- Starting Page Number:** A text input field containing "1".
- Page Footer Text:** A text input field containing "Statewide Report Year Three".
- Document Date:** A text input field containing "28-Jun-2007".
- Buttons:** At the bottom, there are three buttons: "Print", "Preview", and "Close".

**Fig. 3 – External Data Import Screen**

The screenshot shows a software window titled "External Data Loading". At the top, it prompts the user to "Select an Excel Spreadsheet file." with a "Select File" button. Below this, the "Selected File:" field contains the path "C:\Documents and Settings\ssengupta\APS Healthcare\Database Integrator". A list of "Worksheets:" includes "Deleted Rows", "MHP Foster Care", "County Size Foster Care", "Region Foster Care", and "Statewide Foster Care".

There are three tabs: "County Information" (selected), "County Size Information", and "County Region Information". The "County Information" tab contains a section titled "Specify the cells to be loaded into the database." with the following fields:

- Worksheet: County Size Foster Care (dropdown)
- Row: [ ] Column: [ ]
- County: [ ]
- Calendar Year: 2005 (dropdown)
- Approved Penetration Rate: [ ] Rank: [ ]
- Penetration Rate Foster Care: [ ] Rank: [ ]
- Penetration Rate Hispanic/Latino: [ ] Rank: [ ]
- Fiscal Year: 07-08 (dropdown)
- Denial Rate: [ ] Rank: [ ]
- Review Period: Start [ ] End: [ ]
- Expected No. of Counties: 61

At the bottom of the window, there are five buttons: "Load County", "Enter State", "View Calendar", "View Fiscal", and "Close".

**Fig. 4 – ISCA Data Entry Screen**

**County ISCA Information**

Fiscal Year: 06-07 County: Monterey

Priorities and Products | **Medi-Cal % and Revenues** | Current IS Products | Miscellaneous

Percent Services Claimed to Medi-Cal:

	Medi-Cal	Non-Medi-Cal
County Operated Clinics:	<input type="text"/>	100.00%
Contract Providers:	<input type="text"/>	100.00%
Network Providers:	<input type="text"/>	100.00%

Revenues:

	Medi-Cal	Non-Medi-Cal	Total
County MediCal:	<input type="text"/>	<input type="text"/>	\$0
Contract MediCal:	<input type="text"/>	<input type="text"/>	\$0
Network MediCal:	<input type="text"/>	<input type="text"/>	\$0
Total:	\$0	\$0	\$0

Delete Close

**Fig. 5 – Strengths, Opportunities and Recommendations Review screen**

County	Type	Date Created	Title
Stanislaus	Strength	18-May-07	The availability of walk-in services for medication support, especia
Stanislaus	Strength	18-May-07	Foster care penetration is higher than the region and the state ave
Stanislaus	Strength	18-May-07	The MHP has great diversity among staff members and many bilin
Stanislaus	Strength	18-May-07	There is good use of web-based technology that provides access t
Stanislaus	Strength	18-May-07	The core group of IS staff are highly competent and experienced.
Stanislaus	Opportunity	18-May-07	Participants in the review expressed concern regarding access to i
Stanislaus	Opportunity	18-May-07	Retention of key technology staff members and the hiring and trait
Stanislaus	Opportunity	18-May-07	The absence of some key staff members due to illness in the past
Stanislaus	Opportunity	18-May-07	The uncertainty regarding the inpatient psychiatric facility affects p
Stanislaus	Opportunity	18-May-07	The closure of regional clinic services and Common Ground consu
Stanislaus	Recommendation	18-May-07	Conduct contingency planning regarding possible psychiatric inpati
Stanislaus	Recommendation	18-May-07	For meaningful improvement to occur as a result of performance i
Stanislaus	Recommendation	18-May-07	As consumer and family members often represent different intere-
Stanislaus	Recommendation	18-May-07	Determine whether the closing of particular programs has negativ
Stanislaus	Recommendation	18-May-07	Determine the whether API population is underserved and their b:

### Fig. 6 – PIP Report Production Screen

**APS Healthcare - P.I.P. Database**

County:

Fiscal Year:

PIP Category:

MHP Clinical:

PIP Description:

Report Type:

- Landscape Orientation
- Portrait Orientation
  - Include Review Notes
- Summary Report

Report Heading:

### CAEQRO PIP Validation Tool

Clinical  Non-Clinical

FY 06-07 Review of: <MHP>

PIP Title/Topic: <Enter brief phrase to identify PIP >

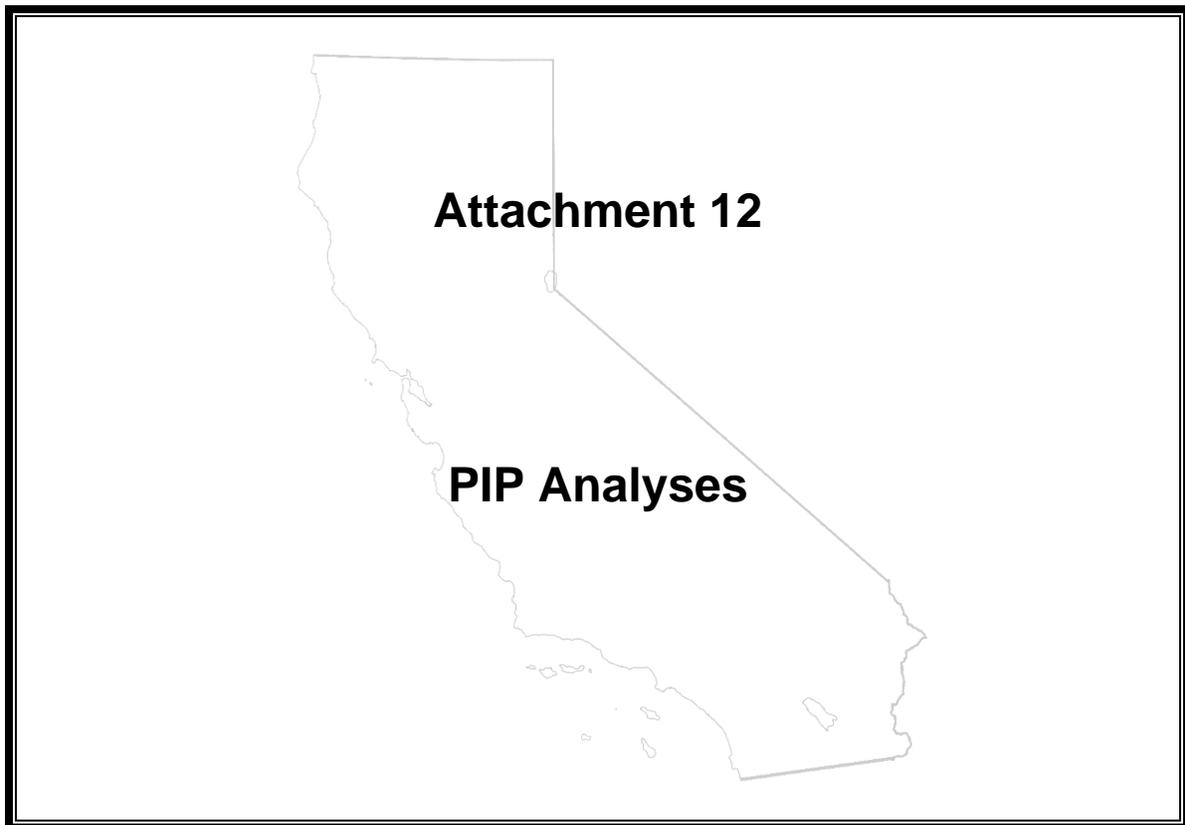
Step		Rating			Comments/Recommendations
		Met	Partial	Not Met	
<b>1</b>	<b>Study topic</b> <i>The study topic:</i>				
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations				
1.2	Was selected following data collection and analysis of data that supports the identified problem				
1.3	Addresses key aspects of care and services				
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs				
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same				
<b>Totals for Step 1:</b>					
<b>Total of 1 key criteria for Step 1:</b>					
<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				

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
<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 well 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>				
<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>			
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			

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
5.4	Specify the acceptable margin of error			N/A
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 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 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>				
<b>Total of 1 key criteria for Step 7:</b>				
<b>8 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			

Step	Comments/Recommendations	Rating		
		Met	Partial	Not Met
8.2	Identify factors that may threaten internal or external validity			N/A
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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PIP Analyses										
Section Label	Section No	Question No	Question Text	Met	Partially Met	Not Met	Total	Average Met	Average Partially Met	Average Not Met
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.	34	27	27	88	34	27	27
Study Question Definition	2	1	Identifies the problem targeted for improvement.	31	23	34	88	33.5	20	34.5
	2	4	Is answerable/demonstratable.	36	17	35	88			
Clearly Defined Study Indicators	3	1	Are well defined, objective and measurable	16	33	39	88	18	28.75	41.25
	3	2	Are designed to answer the study question.	21	23	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	15	28	45	88			
	3	4	Have accessible data that can be collected for each indicator.	20	31	37	88			
Correctly Identified Study Population	4	1	Is accurately and completely defined.	31	23	34	88	31	23	34
Accurate/Complete Data Collection	6	3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data.	8	25	55	88	8	25	55
Appropriate Intervention and Improvement Strategies	7	1	Are related to causes/barriers identified through the data analyses and QI process.	15	18	55	88	15	18	55
Data Analyses and Study Results Interpretation	8	1	Are conducted according to the data analyses plan in the study design.	8	10	70	88	7.3	13.7	67.0
	8	3	Are presented in an accurate, clear, and easily understood fashion.	8	15	65	88			
	8	6	Including the interpretation of findings and the extent to which the study was successful.	6	16	66	88			



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





# Information Systems Capabilities Assessment

## (ISCA)

### California Mental Health Plans

#### **FY 2007**

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)

## FY2007

### 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 (Desired Deadline Date Here)*

#### Contact Information

Insert MHP identification information below. The contact name should be the person completing or coordinating the completion of this assessment.

*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.*

<i>MHP Name:</i>	<span style="background-color: #cccccc;">APS fills in here</span>
<i>ISCA contact name and title:</i>	<span style="background-color: #cccccc;"> </span>
<i>Mailing address:</i>	<span style="background-color: #cccccc;"> </span>
<i>Phone number:</i>	<span style="background-color: #cccccc;"> </span>
<i>Fax number:</i>	<span style="background-color: #cccccc;"> </span>
<i>E-mail address:</i>	<span style="background-color: #cccccc;"> </span>
<i>Identify primary person who participated in completion of the ISCA (name, title):</i>	<span style="background-color: #cccccc;"> </span> <span style="background-color: #cccccc;"> </span> <span style="background-color: #cccccc;"> </span>
<i>Date assessment completed:</i>	<span style="background-color: #cccccc;"> </span>

## 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>8</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.

### 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.

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<sup>8</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.

**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	█ %
Total	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"/> SDMC 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"/> SDMC 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"/> SDMC 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"/> SDMC 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 <span style="float: right;"><div style="background-color: #cccccc; width: 50px; height: 15px;"></div></span>
	Go live date <span style="float: right;"><div style="background-color: #cccccc; width: 50px; height: 15px;"></div></span>
	Projected end date <span style="float: right;"><div style="background-color: #cccccc; width: 50px; height: 15px;"></div></span>
	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 <span style="float: right;"><div style="background-color: #cccccc; width: 50px; height: 15px;"></div></span>
	Go live date <span style="float: right;"><div style="background-color: #cccccc; width: 50px; height: 15px;"></div></span>
	Projected end date <span style="float: right;"><div style="background-color: #cccccc; width: 50px; height: 15px;"></div></span>
	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) <input type="text"/>		

## 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.

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.

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.

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	█	█
Determines allowable services for a provider/RU/CC	█	█
Establishes or decides changes to billing rates	█	█
Determines information system UR rules	█	█
Determines assignments of payer types to services	█	█
Determines staff billing rights/restrictions	█	█
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	<input type="checkbox"/>
Contract providers	<input type="checkbox"/>
Network (formerly fee-for-service) providers	<input type="checkbox"/>

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.

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 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 type="text"/>	Title: <input type="text"/>
Name: <input type="text"/>	Title: <input type="text"/>
Name: <input type="text"/>	Title: <input type="text"/>
Name: <input type="text"/>	Title: <input 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: <span style="background-color: #cccccc; display: inline-block; width: 50px; height: 1em;"></span>

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	%	FY 2005	%
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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?

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	<b>Yes or No</b>	
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.

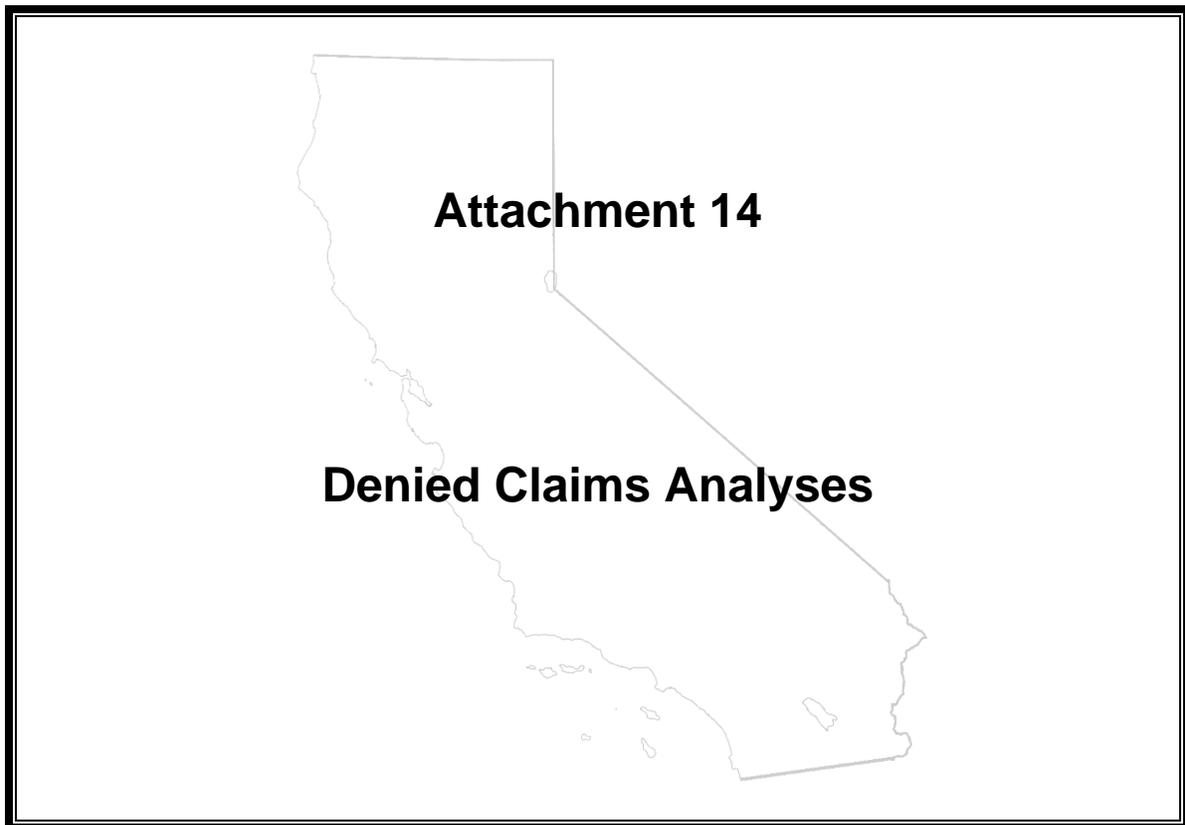
**Section F – Additional Documentation**

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.

Requested Documents	<i>Description</i>
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.
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									
County	Statewide Rank	% Denied	HIPAA Approved Claims	HIPAA Denied Claims	HIPAA Total Claims	Non-HIPAA Approved Claims	Non-HIPAA Denied Claims	Non-HIPAA Total Claims	Grand Total
Santa Clara	1	37.57%	\$36,490,993	\$24,566,532	\$61,057,525	\$66,516,779	\$37,414,833	\$103,931,611	\$164,989,136
Napa	2	30.20%	\$4,215,832	\$1,795,907	\$6,011,739	\$1,259	\$28,538	\$29,797	\$6,041,536
Amador	3	26.44%	\$384,280	\$114,707	\$498,987	\$0	\$23,436	\$23,436	\$522,423
Alpine	4	25.65%				\$15,929	\$5,495	\$21,425	\$21,425
Lassen	5	23.58%				\$3,151,270	\$972,345	\$4,123,615	\$4,123,615
Mono	6	23.32%	\$237,130	\$72,122	\$309,251	\$0	\$0	\$0	\$309,251
San Benito	7	22.10%	\$1,626,587	\$461,544	\$2,088,131	\$0	\$0	\$0	\$2,088,131
Los Angeles	8	20.45%	\$560,816,442	\$117,642,914	\$678,459,356	\$76,325,384	\$46,114,312	\$122,439,696	\$800,899,052
Merced	9	18.00%	\$5,604,070	\$1,101,739	\$6,705,809	\$1,111,048	\$371,851	\$1,482,900	\$8,188,708
Fresno	10	17.67%	\$44,083,149	\$8,888,299	\$52,971,448	\$340,402	\$644,916	\$985,318	\$53,956,766
Nevada	11	17.52%	\$2,456,369	\$521,663	\$2,978,031	\$0	\$0	\$0	\$2,978,031
Santa Cruz	12	17.12%				\$34,345,823	\$7,095,290	\$41,441,114	\$41,441,114
Yolo	13	14.39%				\$7,399,241	\$1,243,294	\$8,642,535	\$8,642,535
Lake	14	14.03%				\$3,844,236	\$627,568	\$4,471,804	\$4,471,804
Butte	15	13.52%	\$10,119,680	\$1,434,129	\$11,553,809	\$12,589,277	\$2,115,154	\$14,704,431	\$26,258,240
Mariposa	16	13.33%				\$359,611	\$55,299	\$414,909	\$414,909
Mendocino	17	12.57%				\$7,707,453	\$1,107,817	\$8,815,270	\$8,815,270
Orange	18	11.39%	\$17,056,304	\$2,574,883	\$19,631,187	\$39,631,896	\$4,710,138	\$44,342,035	\$63,973,222
Inyo	19	10.54%	\$384,076	\$47,185	\$431,261	\$708,139	\$81,484	\$789,623	\$1,220,884
Humboldt	20	9.92%				\$12,946,599	\$1,425,536	\$14,372,134	\$14,372,134
Sacramento	21	9.19%	\$85,595,899	\$8,664,217	\$94,260,117	\$0	\$0	\$0	\$94,260,117
Calaveras	22	9.05%	\$815,738	\$79,870	\$895,608	\$0	\$1,337	\$1,337	\$896,945
Tehama	23	8.46%	\$3,573,987	\$330,146	\$3,904,132	\$0	\$0	\$0	\$3,904,132
Monterey	24	7.45%	\$9,248,775	\$179,264	\$9,428,040	\$14,525,758	\$1,734,286	\$16,260,044	\$25,688,084
Colusa	25	7.29%	\$839,689	\$66,071	\$905,760	\$0	\$0	\$0	\$905,760
Imperial	26	7.06%				\$9,028,746	\$685,349	\$9,714,095	\$9,714,095
Placer	27	6.83%				\$10,833,375	\$793,968	\$11,627,363	\$11,627,363
Contra Costa	28	6.66%	\$5,809,572	\$62,966	\$5,872,538	\$58,261,646	\$4,511,444	\$62,773,090	\$68,645,628
Glenn	29	5.98%	\$2,525,227	\$160,691	\$2,685,919	\$0	\$0	\$0	\$2,685,919
Riverside	30	5.55%	\$39,938,270	\$2,344,554	\$42,282,824	\$131	\$706	\$837	\$42,283,662
Stanislaus	31	5.28%	\$23,683,548	\$721,707	\$24,405,255	\$4,829,972	\$868,937	\$5,698,909	\$30,104,163
San Francisco	32	5.03%	\$111,844,467	\$5,917,500	\$117,581,967	\$0	\$0	\$0	\$117,581,967
Plumas	33	4.90%				\$1,421,678	\$73,269	\$1,494,947	\$1,494,947
Alameda	34	4.77%				\$88,252,959	\$4,419,229	\$92,672,188	\$92,672,188
San Bernardino	35	4.64%	\$33,830,191	\$743,315	\$34,573,506	\$23,539,994	\$2,047,785	\$25,587,778	\$60,161,284
Santa Barbara	36	4.41%	\$34,455,920	\$1,040,467	\$35,496,387	\$3,472,110	\$710,085	\$4,182,195	\$39,678,582
Tulare	37	4.14%				\$22,207,689	\$958,865	\$23,166,555	\$23,166,555
Kings	38	3.57%				\$4,418,743	\$163,779	\$4,582,522	\$4,582,522
El Dorado	39	2.81%	\$4,656,315	\$126,751	\$4,783,066	\$992	\$7,877	\$8,869	\$4,791,935
San Joaquin	40	2.75%	\$7,728,072	\$97,034	\$7,825,106	\$11,633,948	\$449,572	\$12,083,520	\$19,908,626
San Diego	41	2.72%	\$101,631,726	\$2,480,390	\$104,112,117	\$86,178	\$365,559	\$451,737	\$104,563,854
Modoc	42	2.47%	\$329,662	\$8,339	\$338,000	\$0	\$0	\$0	\$338,000
Ventura	43	2.44%				\$35,257,932	\$881,558	\$36,139,490	\$36,139,490
Kern	44	2.41%	\$54,253,307	\$1,309,870	\$55,563,178	\$104,947	\$34,120	\$139,067	\$55,702,245
San Mateo	45	2.19%	\$17,717,752	\$395,777	\$18,113,529	\$871	\$689	\$1,560	\$18,115,089
Madera	46	2.18%				\$4,716,697	\$105,324	\$4,822,021	\$4,822,021
Sutter/Yuba	46	2.18%	\$10,445,778	\$216,374	\$10,662,152	\$2,867	\$15,989	\$18,855	\$10,681,008
Del Norte	48	2.07%	\$1,837,748	\$38,822	\$1,876,571	\$0	\$0	\$0	\$1,876,571
San Luis Obispo	49	2.01%				\$13,881,724	\$284,630	\$14,166,354	\$14,166,354
Trinity	50	1.98%				\$1,307,496	\$26,435	\$1,333,931	\$1,333,931
Solano	51	1.95%	\$18,983,948	\$358,721	\$19,342,670	\$6,917	\$18,885	\$25,803	\$19,368,472
Marin	52	1.79%	\$9,233,333	\$158,040	\$9,391,373	\$2,898,411	\$62,850	\$2,961,260	\$12,352,633
Shasta	53	1.58%				\$10,440,763	\$167,733	\$10,608,496	\$10,608,496
Tuolumne	54	1.49%				\$2,654,850	\$40,117	\$2,694,967	\$2,694,967
Sonoma	55	1.22%	\$15,165,692	\$186,958	\$15,352,650	\$1,919	\$254	\$2,173	\$15,354,823
Siskiyou	56	1.18%				\$11,271,123	\$134,282	\$11,405,405	\$11,405,405
Sierra	n/a	n/a	no claims data			\$0	\$0	\$0	\$0
Yuba	n/a	n/a	in Sutter/Yuba						
Statewide Median		6.32%	\$1,277,419,529	\$184,909,467	\$1,462,328,996	\$602,054,782	\$123,602,239	\$725,657,020	\$2,187,986,016
HIPAA vs. Proprietary					66.83%			33.17%	
Statewide Range	1.18% - 37.57%								



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**





### Activities Calendars (July 2006 – June 2007)

July 2006				
Mon	Tue	Wed	Thu	Fri
3	4	5	6	7
10	11	12	13	14
CIMH Coordination Mtg.	Colusa MHP Review	Glenn MHP Review	Lake MHP Review	
	Tehama MHP Review	CMHDA Medi-Cal Policy		
17	18	19	20	21
CSI/DIG Workshop			Consumer/Family Member Consultant	CMHDA IT
24	25	26	27	28
31				

August 2006				
Mon	Tue	Wed	Thu	Fri
	1	2	3	4
		Monterey MHP Review		
7	8	9	10	11
	Rita McCabe and Mike Borunda - DMH	Solano MHP Review		
14	15	16	17	18
				CMHDA IT
21	22	23	24	25
		Humboldt MHP Review		
		Napa MHP Review		
28	29	30	31	

### Activities Calendars (July 2006 – June 2007)

September 2006				
Mon	Tue	Wed	Thu	Fri
				1
4	5	6	7	8
			SCERP	
11	12	13	14	15
	Sonoma MHP Review			Staff Mtg. with APS VP Cheryl Collins
18	19	20	21	22
Tulare MHP Review			Kings MHP Review	
		Medi-Cal Policy		SF Foster Care
25	26	27	28	29
Butte MHP Review				
	Alameda MHP Review			
			Shasta MHP Review	

October 2006				
Mon	Tue	Wed	Thu	Fri
2	3	4	5	6
				Annual Report Presentation – Riverside
9	10	11	12	13
	San Bernardino MHP Review			
		Santa Cruz MHP Review		
			Mendocino MHP Review	
16	17	18	19	20
	Annual Report Presentation – Sac	Stanislaus MHP Review		
23	24	25	26	27
		San Luis Obispo MHP Review		
30	31			

### Activities Calendars (July 2006 – June 2007)

November 2006				
Mon	Tue	Wed	Thu	Fri
		1	2	3
		San Diego MHP Review		CMHDA IT
6	7 Del Norte MHP Review	8	9	10
13	14	15	16	17
	Sacramento MHP Review		Santa Barbara MHP Review	
		Compliance Advisory Committee		
20	21	22	23	24
27	28	29	30	

December 2006				
Mon	Tue	Wed	Thu	Fri
				1
4	5 Calaveras MHP Review	6	7 Amador MHP Review SCERP	8
11	12	13	14	15
		Fresno MHP Review		CMHDA IT
		Marin MHP Review		
18	19	20	21	22
25	26	27	28	29 CalMEND – Cecil Lynch MD

### Activities Calendars (July 2006 – June 2007)

January 2007				
Mon	Tue	Wed	Thu	Fri
1	2	3	4	5
			SQIC	
8	9	10	11	12
	CalMEND	Yolo MHP Review		
		San Benito MHP Review		
15	16	17	18	19
	San Joaquin MHP Review			
	Contra Costa MHP Review			
22	23	24	25	26
		Orange MHP Review		
29	30	31		
		Ventura MHP Review		

February 2007				
Mon	Tue	Wed	Thu	Fri
			1	2
			Ventura MHP Review	
5	6	7	8	9
CalMEND		CalMEND Policy	Madera MHP Review	
12	13	14	15	16
	Riverside MHP Review			
	San Mateo MHP Review			
19	20	21	22	23
		Kern MHP Review		
	Santa Clara MHP Review			
26	27	28		
SCERP				

### Activities Calendars (July 2006 – June 2007)

March 2007				
Mon	Tue	Wed	Thu	Fri
			1	2
5	6	7	8	9 Nevada MHP Review
12	13 Imperial MHP Review Sutter/Yuba MHP Review	14	15	16
		San Francisco MHP Review		
19	20	21	22	23
		CALQIC		
26	27	28	29	30

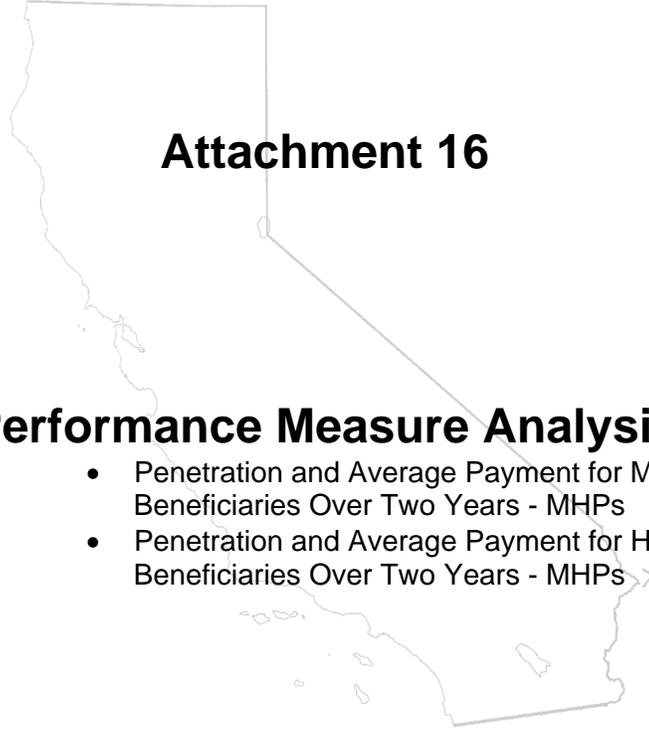
April 2007				
Mon	Tue	Wed	Thu	Fri
2	3	4	5	6
	Los Angeles MHP Review			
		Placer/Sierra MHP Review		
9	10	11	12	13
		CIMH Data Conference		CalMEND
				SCERP
16	17 El Dorado MHP Review DMH Recovery Charting	18	19	20
23 SCERP PIP	24	25	26	27
		Mariposa MHP Review		Rapid Process Improvement
		Sophie Cabrera, DMH	Ergonomic Training	
		Network for the Improvement of Addiction Treatment Summit		
30				

### Activities Calendars (July 2006 – June 2007)

May 2007				
Mon	Tue	Wed	Thu	Fri
	1 Lassen MHP Review Modoc MHP Review	2	3 Plumas MHP Review Siskiyou MHP Review	4 Petris Conference
7	8	9	10 MHSA Technology	11 Tuolumne MHP Review
14	15 Mono MHP Review National Council Teleconference	16 Alpine MHP Review	17 Inyo MHP Review	18 CMHDA IT
21	22 Trinity MHP Review Corporate Compliance Training	23	24	25
28	29	30	31	

June 2007				
Mon	Tue	Wed	Thu	Fri
				1
4	5	6	7	8 Merced MHP Review
11	12	13	14	15 CalMEND CMHDA IT
18	19 SCERP Planned/ Unplanned Health Disparities	20	21	22
25	26	27 SCERP Webcast	28	29

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 16**

**Performance Measure Analysis**

- Penetration and Average Payment for Male vs. Female Beneficiaries Over Two Years - MHPs
- Penetration and Average Payment for Hispanic vs. White Beneficiaries Over Two Years - MHPs



### A Comparison of Penetration and Cost Ratios for Female vs. Male Beneficiaries over Two Years

Beneficiary County	Ratio of Females vs. Males				Average Payment Per Beneficiary			
	Penetration Rate CY05	Penetration Rate CY06	Average Payment CY05	Average Payment CY06	Female	Male	Female	Male
					CY05		CY06	
ALAMEDA	0.88	0.88	0.68	0.65	\$3,773	\$5,558	\$3,698	\$5,649
ALPINE	1.56	0.97	4.00	1.67	\$3,017	\$753	\$1,098	\$655
AMADOR	0.87	1.03	1.01	1.20	\$1,283	\$1,268	\$1,544	\$1,290
BUTTE	0.90	0.87	0.83	0.82	\$3,609	\$4,366	\$4,000	\$4,858
CALAVERAS	1.13	1.03	0.78	0.78	\$1,905	\$2,433	\$2,367	\$3,043
COLUSA	1.30	1.24	0.92	0.78	\$2,194	\$2,389	\$2,964	\$3,786
CONTRA COSTA	0.86	0.85	0.68	0.67	\$4,301	\$6,359	\$4,161	\$6,201
DEL NORTE	1.02	1.09	0.95	0.90	\$1,819	\$1,908	\$1,343	\$1,490
EL DORADO	0.85	1.01	0.85	0.74	\$2,502	\$2,935	\$2,513	\$3,377
FRESNO	1.00	0.92	0.80	0.80	\$2,663	\$3,349	\$2,449	\$3,059
GLENN	1.18	1.27	0.83	0.63	\$3,455	\$4,178	\$3,259	\$5,145
HUMBOLDT	0.90	0.91	1.05	0.92	\$4,239	\$4,030	\$4,694	\$5,088
IMPERIAL	0.64	0.61	0.82	0.82	\$2,815	\$3,437	\$2,796	\$3,416
INYO	0.90	0.84	0.85	0.76	\$3,274	\$3,873	\$2,884	\$3,771
KERN	0.80	0.82	1.00	0.99	\$4,169	\$4,184	\$3,464	\$3,496
KINGS	0.93	0.92	0.96	0.94	\$2,052	\$2,136	\$1,994	\$2,117
LAKE	1.01	1.05	0.91	0.93	\$2,914	\$3,205	\$3,689	\$3,962
LASSEN	1.11	1.05	0.83	0.86	\$3,934	\$4,768	\$3,944	\$4,568
LOS ANGELES	0.77	0.77	0.76	0.78	\$3,849	\$5,049	\$4,067	\$5,217
MADERA	1.07	1.01	0.91	0.88	\$2,372	\$2,615	\$2,778	\$3,147
MARIN	0.88	0.87	0.70	0.75	\$4,470	\$6,374	\$4,435	\$5,949
MARIPOSA	0.90	1.00	0.71	0.87	\$1,381	\$1,934	\$1,518	\$1,755
MENDOCINO	1.10	1.14	0.58	0.65	\$3,153	\$5,447	\$3,740	\$5,758
MERCED	1.05	1.05	0.75	0.84	\$2,053	\$2,731	\$2,287	\$2,732
MODOC	1.51	1.18	1.55	0.91	\$2,246	\$1,450	\$2,086	\$2,296
MONO	0.79	1.03	1.56	0.87	\$3,618	\$2,318	\$3,052	\$3,489
MONTEREY	0.86	0.82	0.81	0.80	\$5,833	\$7,174	\$5,459	\$6,846
NAPA	0.92	0.88	0.72	0.67	\$3,801	\$5,306	\$3,761	\$5,609
NEVADA	0.93	0.85	0.73	0.62	\$3,250	\$4,468	\$2,597	\$4,179
ORANGE	0.87	0.86	0.81	0.80	\$2,509	\$3,103	\$2,636	\$3,282
PLACER	0.97	0.95	0.65	0.63	\$3,783	\$5,841	\$3,050	\$4,860
PLUMAS	0.94	0.97	0.65	0.93	\$3,420	\$5,299	\$4,283	\$4,628
RIVERSIDE	0.82	0.83	0.82	0.80	\$2,236	\$2,735	\$2,311	\$2,872
SACRAMENTO	0.86	0.85	0.78	0.79	\$3,663	\$4,713	\$3,408	\$4,297
SAN BENITO	0.96	1.06	0.78	0.83	\$1,851	\$2,378	\$2,106	\$2,546
SAN BERNARDINO	0.83	0.84	0.87	0.87	\$2,379	\$2,731	\$2,606	\$2,980

### A Comparison of Penetration and Cost Ratios for Female vs. Male Beneficiaries over Two Years

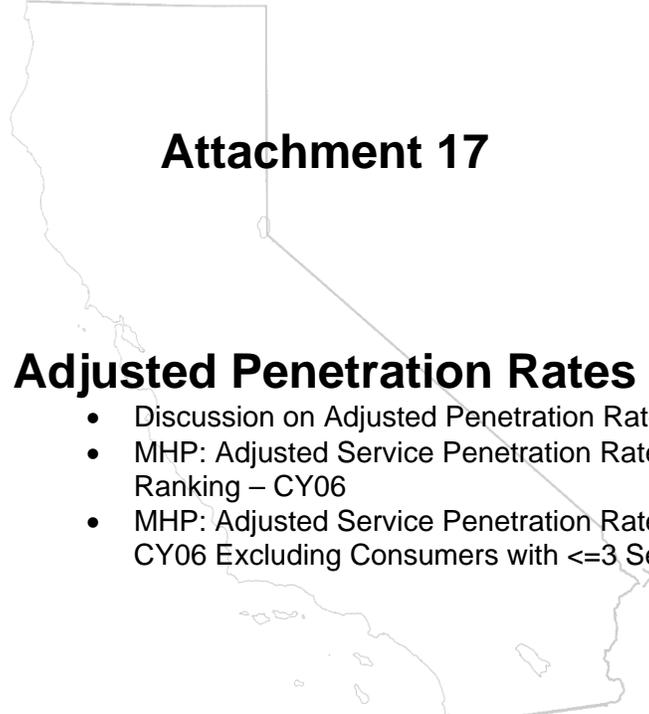
Beneficiary County	Ratio of Females vs. Males				Average Payment Per Beneficiary			
	Penetration Rate CY05	Penetration Rate CY06	Average Payment CY05	Average Payment CY06	Female	Male	Female	Male
					CY05		CY06	
SAN DIEGO	0.85	0.82	0.71	0.72	\$2,759	\$3,870	\$2,932	\$4,059
SAN FRANCISCO	0.75	0.75	0.76	0.75	\$5,170	\$6,835	\$4,975	\$6,654
SAN JOAQUIN	1.02	1.03	0.73	0.72	\$1,632	\$2,227	\$1,627	\$2,244
SAN LUIS OBISPO	0.86	0.86	0.63	0.64	\$3,245	\$5,124	\$3,382	\$5,270
SAN MATEO	0.88	0.88	0.85	0.81	\$2,430	\$2,847	\$3,820	\$4,722
SANTA BARBARA	0.83	0.82	0.86	0.82	\$6,443	\$7,470	\$6,959	\$8,501
SANTA CLARA	0.86	0.89	0.77	0.75	\$4,505	\$5,813	\$4,250	\$5,695
SANTA CRUZ	0.74	0.70	0.73	0.82	\$9,769	\$13,308	\$10,318	\$12,559
SHASTA	0.89	0.91	0.96	0.92	\$2,693	\$2,807	\$2,679	\$2,925
SIERRA	0.82	0.95	0.07	0.63	\$1,604	\$22,954	\$3,050	\$4,860
SISKIYOU	0.94	0.92	0.68	0.78	\$6,731	\$9,960	\$8,038	\$10,279
SOLANO	0.71	0.72	0.76	0.69	\$3,984	\$5,221	\$3,778	\$5,474
SONOMA	0.81	0.77	1.03	0.94	\$5,245	\$5,105	\$5,408	\$5,735
STANISLAUS	0.84	0.80	0.94	0.94	\$3,513	\$3,754	\$3,241	\$3,449
SUTTER/YUBA	1.02	1.03	0.72	0.71	\$3,038	\$4,214	\$3,095	\$4,377
TEHAMA	1.09	1.06	0.83	0.74	\$1,962	\$2,369	\$2,393	\$3,252
TRINITY	1.13	1.07	0.80	0.76	\$3,832	\$4,775	\$3,709	\$4,902
TULARE	0.78	0.80	0.92	0.87	\$3,231	\$3,508	\$3,390	\$3,882
TUOLUMNE	0.94	0.98	1.05	0.96	\$2,874	\$2,749	\$3,402	\$3,553
VENTURA	0.88	0.84	0.64	0.72	\$3,739	\$5,834	\$4,320	\$6,034
YOLO	0.99	1.02	0.85	0.83	\$3,504	\$4,118	\$3,563	\$4,303
<b>STATEWIDE</b>	<b>0.83</b>	<b>0.83</b>	<b>0.77</b>	<b>0.77</b>	<b>\$3,501</b>	<b>\$4,563</b>	<b>\$3,597</b>	<b>\$4,675</b>

## Comparison of Penetration and Average Payment Ratios for Hispanic vs. White Beneficiaries over Two Years

Beneficiary County	Ratio of Hispanic vs. White				Average Payment Per Beneficiary			
	Penetration Rate CY05	Penetration Rate CY06	Average Payment CY05	Average Payment CY06	Hispanic CY05	White	Hispanic CY06	White
ALAMEDA	0.27	0.26	0.90	0.94	\$3,810	\$4,254	\$4,188	\$4,434
ALPINE	0.00	1.96		0.32		\$5,537	\$277	\$871
AMADOR	0.49	0.48	0.96	1.04	\$1,198	\$1,253	\$1,460	\$1,407
BUTTE	0.34	0.37	0.88	0.82	\$3,626	\$4,131	\$3,746	\$4,597
CALAVERAS	0.46	0.37	0.45	0.65	\$969	\$2,139	\$1,793	\$2,747
COLUSA	0.21	0.21	0.60	1.21	\$1,643	\$2,744	\$3,721	\$3,071
CONTRA COSTA	0.24	0.27	0.90	0.95	\$4,625	\$5,122	\$4,461	\$4,705
DEL NORTE	0.41	0.33	0.83	1.46	\$1,597	\$1,931	\$2,056	\$1,405
EL DORADO	0.21	0.23	1.69	1.18	\$4,211	\$2,488	\$3,252	\$2,754
FRESNO	0.31	0.31	0.74	0.77	\$2,502	\$3,401	\$2,301	\$2,978
GLENN	0.27	0.27	0.99	1.24	\$3,731	\$3,779	\$4,607	\$3,707
HUMBOLDT	0.38	0.34	1.22	1.16	\$5,007	\$4,113	\$5,548	\$4,797
IMPERIAL	0.45	0.44	0.90	1.14	\$3,034	\$3,371	\$3,142	\$2,768
INYO	0.23	0.26	0.58	0.80	\$2,050	\$3,563	\$2,688	\$3,373
KERN	0.29	0.28	0.72	0.78	\$3,373	\$4,654	\$2,963	\$3,785
KINGS	0.30	0.31	0.72	0.68	\$1,748	\$2,418	\$1,660	\$2,439
LAKE	0.32	0.25	0.81	1.10	\$2,482	\$3,072	\$4,151	\$3,787
LASSEN	0.50	0.49	0.85	1.16	\$3,526	\$4,154	\$4,829	\$4,169
LOS ANGELES	0.22	0.23	0.85	0.86	\$4,287	\$5,019	\$4,458	\$5,155
MADERA	0.23	0.24	1.07	1.05	\$2,577	\$2,411	\$2,864	\$2,732
MARIN	0.22	0.20	0.58	0.51	\$3,282	\$5,695	\$2,947	\$5,742
MARIPOSA	0.39	0.36	0.46	0.23	\$682	\$1,485	\$393	\$1,689
MENDOCINO	0.19	0.23	0.95	1.08	\$3,692	\$3,885	\$4,607	\$4,250
MERCED	0.27	0.27	0.66	0.78	\$1,781	\$2,687	\$2,030	\$2,596
MODOC	0.28	0.24	1.32	0.91	\$2,397	\$1,822	\$1,936	\$2,127
MONO	0.09	0.10	0.61	0.56	\$2,058	\$3,362	\$1,739	\$3,101
MONTEREY	0.19	0.20	0.75	0.75	\$5,531	\$7,374	\$5,138	\$6,837
NAPA	0.15	0.18	0.79	0.79	\$3,415	\$4,336	\$3,561	\$4,482
NEVADA	0.23	0.30	0.66	1.74	\$2,210	\$3,347	\$5,253	\$3,021
ORANGE	0.24	0.24	0.92	0.90	\$2,909	\$3,175	\$3,100	\$3,440
PLACER	0.18	0.35	0.77	0.72	\$3,624	\$4,709	\$2,860	\$3,953
PLUMAS	0.48	0.49	0.48	0.60	\$2,069	\$4,302	\$2,663	\$4,442
RIVERSIDE	0.28	0.27	0.77	0.86	\$1,962	\$2,556	\$2,248	\$2,617
SACRAMENTO	0.24	0.39	0.69	1.00	\$2,970	\$4,282	\$3,834	\$3,816
SAN BENITO	0.40	0.37	0.90	0.67	\$1,918	\$2,129	\$1,823	\$2,712

<b>Comparison of Penetration and Average Payment Ratios for Hispanic vs. White Beneficiaries over Two Years</b>								
<b>Beneficiary County</b>	<b>Ratio of Hispanic vs. White</b>				<b>Average Payment Per Beneficiary</b>			
	<b>Penetration Rate CY05</b>	<b>Penetration Rate CY06</b>	<b>Average Payment CY05</b>	<b>Average Payment CY06</b>	<b>Hispanic CY05</b>	<b>White</b>	<b>Hispanic CY06</b>	<b>White</b>
SAN BERNARDINO	0.31	0.31	0.94	0.97	\$2,388	\$2,540	\$2,677	\$2,771
SAN DIEGO	0.36	0.36	0.97	1.02	\$3,162	\$3,267	\$3,480	\$3,402
SAN FRANCISCO	0.29	0.28	0.72	0.70	\$4,742	\$6,589	\$4,537	\$6,524
SAN JOAQUIN	0.26	0.27	0.90	0.94	\$1,912	\$2,130	\$2,020	\$2,145
SAN LUIS OBISPO	0.27	0.27	0.86	1.02	\$3,480	\$4,069	\$4,053	\$3,955
SAN MATEO	0.19	0.22	0.86	0.75	\$2,290	\$2,663	\$3,488	\$4,673
SANTA BARBARA	0.25	0.24	0.70	0.70	\$5,524	\$7,838	\$6,032	\$8,632
SANTA CLARA	0.17	0.22	0.93	1.29	\$4,931	\$5,279	\$6,506	\$5,028
SANTA CRUZ	0.16	0.30	0.77	0.87	\$8,746	\$11,397	\$10,246	\$11,813
SHASTA	0.53	0.53	0.78	0.85	\$2,204	\$2,843	\$2,403	\$2,814
SIERRA	0.95	0.35	0.03	0.72	\$376	\$14,100	\$2,860	\$3,953
SISKIYOU	0.46	0.40	0.84	1.04	\$6,670	\$7,940	\$9,636	\$9,247
SOLANO	0.19	0.24	0.86	0.96	\$4,002	\$4,643	\$4,274	\$4,468
SONOMA	0.18	0.17	0.69	0.69	\$3,740	\$5,390	\$4,055	\$5,856
STANISLAUS	0.31	0.32	0.81	0.86	\$2,981	\$3,681	\$2,867	\$3,338
SUTTER/YUBA	0.23	0.25	0.83	1.09	\$3,147	\$3,809	\$4,110	\$3,779
TEHAMA	0.23	0.27	0.80	0.77	\$1,621	\$2,033	\$2,130	\$2,766
TRINITY	0.64	0.59	0.93	1.02	\$3,820	\$4,093	\$4,308	\$4,236
TULARE	0.34	0.34	0.86	0.96	\$3,113	\$3,627	\$3,491	\$3,640
TUOLUMNE	0.80	0.67	0.92	0.86	\$2,573	\$2,808	\$2,930	\$3,413
VENTURA	0.19	0.18	0.93	0.94	\$4,303	\$4,623	\$4,717	\$4,995
YOLO	0.17	0.27	0.45	0.63	\$1,900	\$4,266	\$2,846	\$4,483
<b>STATEWIDE</b>	0.25	0.26	0.86	0.91	<b>\$3,601</b>	<b>\$4,178</b>	<b>\$3,884</b>	<b>\$4,270</b>

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 17**

**Adjusted Penetration Rates**

- Discussion on Adjusted Penetration Rates
- MHP: Adjusted Service Penetration Rates and Ranking – CY06
- MHP: Adjusted Service Penetration Rates and Ranking – CY06 Excluding Consumers with  $\leq 3$  Services



## Discussion on Adjusted Penetration Rates

In analyzing our findings (see Section 5) based on approved claims data for CY06, CAEQRO adjusted penetration rates by factors such as age, gender, race/ethnicity and retention rate. This attachment explains why this formula was critical to obtaining an accurate picture which beneficiaries are accessing the public mental health system and the amount of service they receive.

### Rationale for Adjusting Penetration Rates

Different MHPs may have very different demographic distributions in their Medi-Cal eligible populations. As a result, the overall penetration rate can mask disparities in MHP penetration rates by race/ethnicity, gender and age. For example, MHP A and B might show an equal penetration rates for White and Hispanic beneficiaries; however, if MHP A has a higher proportion of eligible Hispanic beneficiaries than does MHP B, the penetration rates do not disclose a disparity in access for Hispanic beneficiaries served by MHP A. In other words, the overall penetration rates should reflect the differences in population race/ethnicity compositions between the two MHPs. Penetration rates can be adjusted or standardized by using a common standard population, in this study, by the California Medi-Cal population. A factor-adjusted penetration rate for each MHP helps eliminate the confounding effects caused by MHP demographic compositions.

Penetration rates are also influenced by the number of services received by each beneficiary – which is a measure of the retention rate for each MHP. Without adjusting for retention, MHPs with a higher proportion of clients with fewer services are likely to have higher penetration rates than those providing more services per client. Therefore, penetration rates can also be adjusted for retention rates by excluding clients with a low number of service encounters. In Section 5, we include tables that display penetration rates reflecting the following adjustments: excluding those beneficiaries receiving only one service from the MHP; excluding clients with three or less service encounters.

### Methodology for Calculating Adjusted Penetration Rates

Let  $p_i$  be the MHP penetration rate for a particular factor or demographic group, such as for Whites or Hispanics;  $N_i$  the statewide number of Medi-Cal eligibles for the same demographic group; and  $i$  the number of categories within that demographic group, (for race/ethnicity,  $i=6$ ).

Then the factor-adjusted or standardized overall MHP penetration rate  $P'$  is:

$$P' = \frac{\sum N_i p_i}{\sum N_i}$$

The retention and factor-adjusted factor penetration rates are obtained by first subtracting the number of clients with only one or less than four services from the factor number of beneficiaries served. The next step is to calculate the retention-adjusted factor penetration rate. The final step is to apply the above formula to obtain the factor-adjusted MHP overall penetration rate.

In charts that immediately follow this narrative, the 56 California MHPs are ranked by the unadjusted overall penetration rates, factor-adjusted overall penetration rates, and the retention and factor-adjusted overall penetrations rates.

**MHP: Adjusted Service Penetration Rates and Ranking - CY06**

County Code	County Name	Region Name	County Size	County Penetration Rate UnAdjusted	Penetration Rate Adjusted By Age	Penetration Rate Adjusted By Gender	Penetration Rate Adjusted By Race	Rank of Penetration Rate Adjusted By Age	Penetration Rate Adjusted By Gender	Rank of Penetration Rate Adjusted By Gender	Penetration Rate Adjusted By Race	Rank of Penetration Rate Adjusted By Race	Rank of Penetration Rate Adjusted By Gender	Rank of Penetration Rate Adjusted By Race	Rank of Penetration Rate UnAdjusted
1	Alameda	Bay Area	Large	8.19%	8.27%	8.20%	7.44%	22	8.20%	25	7.44%	17	25	17	25
2	Alpine	Central	Small-Rural	7.78%	7.38%	7.78%	10.65%	32	7.78%	28	10.65%	3	28	3	28
3	Amador	Central	Small-Rural	9.15%	8.72%	9.15%	6.76%	17	9.15%	16	6.76%	27	16	27	16
4	Butte	Superior	Medium	9.82%	9.43%	9.80%	7.19%	14	9.80%	13	7.19%	20	20	20	13
5	Calaveras	Central	Small-Rural	7.58%	7.11%	7.58%	5.63%	35	7.58%	30	5.63%	44	30	44	30
6	Colusa	Superior	Small-Rural	6.78%	6.93%	6.79%	6.92%	37	6.79%	38	6.92%	24	38	24	38
7	Contra Costa	Bay Area	Large	7.46%	7.44%	7.48%	6.33%	31	7.44%	31	6.33%	34	31	34	33
8	Del Norte	Superior	Small-Rural	11.25%	10.40%	11.28%	8.53%	7	11.28%	6	8.53%	10	6	10	6
9	El Dorado	Central	Small	9.68%	9.37%	9.68%	6.48%	15	9.68%	15	6.48%	31	15	31	15
10	Fresno	Central	Large	4.91%	4.83%	4.91%	5.58%	51	4.91%	51	5.58%	45	51	45	51
11	Glenn	Superior	Small-Rural	8.90%	8.72%	8.90%	7.58%	16	8.90%	18	7.58%	16	18	16	18
12	Humboldt	Superior	Small	10.21%	9.56%	10.19%	6.90%	12	10.19%	10	6.90%	25	10	25	10
13	Imperial	Southern	Small	5.23%	5.33%	5.21%	6.45%	46	5.21%	48	6.45%	33	48	33	47
14	Inyo	Superior	Small-Rural	9.84%	9.70%	9.82%	6.95%	10	9.82%	12	6.95%	23	12	23	12
15	Kern	Southern	Large	5.50%	5.38%	5.49%	5.35%	44	5.49%	43	5.35%	44	43	49	43
16	Kings	Central	Small	6.47%	6.43%	6.47%	6.97%	39	6.47%	39	6.97%	22	39	22	39
17	Lake	Superior	Small	8.66%	8.15%	8.67%	5.09%	24	8.67%	21	5.09%	52	21	52	21
18	Lassen	Superior	Small-Rural	13.42%	12.57%	13.43%	9.11%	2	13.43%	2	9.11%	7	2	7	2
19	Los Angeles	Los Angeles	Large	5.13%	5.11%	5.14%	5.89%	49	5.14%	50	5.89%	41	50	41	50
20	Madera	Central	Small	4.83%	4.82%	4.83%	5.37%	52	4.83%	52	5.37%	48	52	48	52
21	Marin	Bay Area	Medium	11.94%	11.54%	11.94%	10.18%	4	11.94%	4	10.18%	5	5	5	5
22	Mariposa	Central	Small-Rural	10.17%	9.64%	10.17%	6.26%	11	10.17%	11	6.26%	11	11	36	11
23	Mendocino	Superior	Small	8.74%	8.31%	8.76%	7.01%	21	8.76%	20	7.01%	21	20	21	20
24	Merced	Central	Medium	3.97%	3.92%	3.98%	4.33%	56	3.98%	56	4.33%	55	56	55	56
25	Modoc	Superior	Small-Rural	8.84%	8.24%	8.85%	6.74%	23	8.85%	19	6.74%	28	19	28	19
26	Mono	Central	Small-Rural	7.67%	8.07%	7.67%	5.50%	26	7.67%	29	5.50%	47	29	47	29
27	Monterey	Bay Area	Medium	4.54%	4.57%	4.54%	6.30%	54	4.54%	54	6.30%	35	54	35	54
28	Napa	Bay Area	Small	7.81%	8.10%	7.81%	7.27%	25	7.81%	26	7.27%	18	26	18	26
29	Nevada	Superior	Small	8.42%	8.02%	8.43%	6.50%	27	8.43%	23	6.50%	30	23	30	23
30	Orange	Southern	Large	5.15%	5.36%	5.15%	5.91%	45	5.15%	49	5.91%	39	49	39	49
31	Placer/Sierra	Central	Medium	9.72%	9.56%	9.73%	6.47%	13	9.73%	14	6.47%	32	14	32	14
32	Plumas	Superior	Small-Rural	11.23%	10.68%	11.23%	7.67%	6	11.23%	7	7.67%	15	7	15	7
33	Riverside	Southern	Large	5.40%	5.68%	5.40%	5.25%	43	5.40%	44	5.25%	50	44	50	44
34	Sacramento	Central	Large	6.85%	6.60%	6.85%	5.95%	38	6.85%	37	5.95%	38	37	38	37
35	San Benito	Bay Area	Small	7.79%	7.92%	7.78%	10.04%	28	7.78%	27	10.04%	6	27	6	27
36	San Bernardino	Southern	Large	6.10%	6.15%	6.10%	5.79%	40	6.10%	41	5.79%	41	41	42	41
37	San Diego	Southern	Large	8.28%	8.56%	8.29%	7.90%	19	8.29%	24	7.90%	14	24	14	24
38	San Francisco	Bay Area	Large	10.29%	10.27%	10.22%	10.42%	8	10.22%	9	10.42%	4	9	4	9

**MHP: Adjusted Service Penetration Rates and Ranking - CY06**

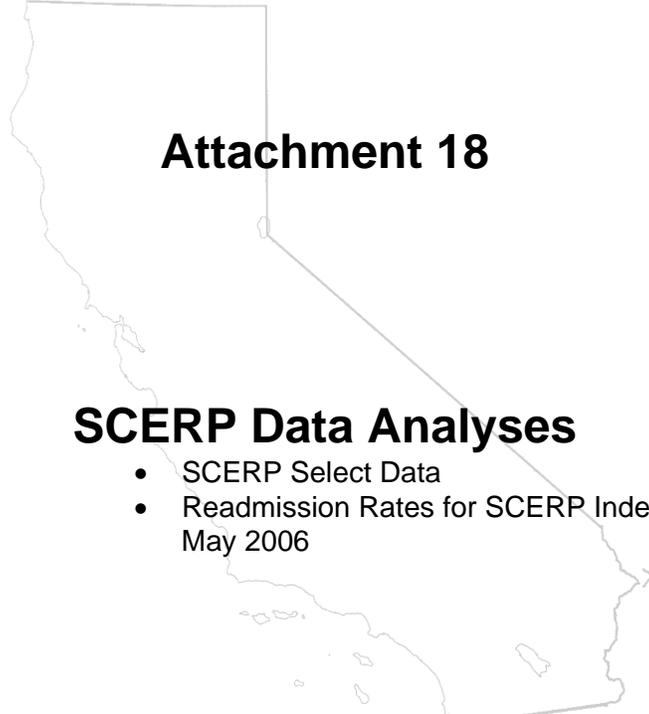
County Code	County Name	Region Name	County Size	County Penetration Rate UnAdjusted	Penetration Rate Adjusted By Age	Penetration Rate Adjusted By Gender	Penetration Rate Adjusted By Race	Rank of Penetration Rate Adjusted By Age	Rank of Penetration Rate Adjusted By Gender	Rank of Penetration Rate Adjusted By Race	Rank of Penetration Rate UnAdjusted
39	San Joaquin	Central	Medium	5.30%	5.23%	5.30%	4.98%	48	45	53	45
40	San Luis Obispo	Southern	Medium	8.61%	8.39%	8.61%	6.89%	20	22	26	22
41	San Mateo	Bay Area	Medium	7.45%	7.77%	7.46%	8.19%	29	33	12	34
42	Santa Barbara	Southern	Medium	7.33%	7.32%	7.33%	8.61%	33	35	9	35
43	Santa Clara	Bay Area	Large	5.29%	5.27%	5.29%	6.03%	47	46	37	46
44	Santa Cruz	Bay Area	Medium	7.47%	7.47%	7.46%	8.41%	30	34	11	31
45	Shasta	Superior	Small	10.53%	10.13%	10.53%	8.18%	9	8	13	8
47	Siskiyou	Superior	Small-Rural	12.46%	11.95%	12.44%	8.77%	3	3	8	3
48	Solano	Bay Area	Medium	5.21%	5.10%	5.24%	4.25%	50	47	56	48
49	Sonoma	Bay Area	Medium	6.02%	6.04%	6.03%	4.89%	41	42	54	42
50	Stanislaus	Central	Medium	6.12%	6.00%	6.11%	5.71%	42	40	43	40
51	Sutter/Yuba	Central	Small	7.47%	7.29%	7.47%	5.90%	34	32	40	32
52	Tehama	Superior	Small	8.98%	8.60%	8.98%	7.20%	18	17	19	17
53	Trinity	Superior	Small-Rural	12.06%	11.31%	12.07%	12.35%	5	4	2	4
54	Tulare	Central	Medium	4.32%	4.18%	4.30%	5.14%	55	55	51	55
55	Tuolumne	Central	Small	13.55%	13.08%	13.55%	12.44%	1	1	1	1
56	Ventura	Southern	Large	4.71%	4.79%	4.72%	5.53%	53	53	46	53
57	Yolo	Central	Small	7.22%	7.07%	7.22%	6.74%	36	36	29	36

**MHP: Adjusted Service Penetration Rates and Ranking - CY06  
Excluding Consumers With Three or Fewer Services**

County Code	County Name	Region Name	County Size	County Penetration Rate UnAdjusted	Penetration Rate Adjusted By Age	Penetration Rate Adjusted By Gender	Penetration Rate Adjusted By Race	Rank of Penetration Rate Adjusted By Age	Rank of Penetration Rate Adjusted By Gender	Rank of Penetration Rate Adjusted By Race	Rank of Penetration Rate UnAdjusted
1	Alameda	Bay Area	Large	6.14%	6.27%	6.15%	5.61%	29	28	20	29
2	Alpine	Central	Small-Rural	3.33%	3.08%	3.30%	0.90%	55	54	56	54
3	Amador	Central	Small-Rural	6.80%	6.44%	6.80%	5.17%	26	21	28	21
4	Butte	Superior	Medium	7.91%	7.65%	7.89%	5.88%	9	9	17	9
5	Calaveras	Central	Small-Rural	5.79%	5.43%	5.79%	4.03%	35	33	48	33
6	Colusa	Superior	Small-Rural	4.81%	4.93%	4.82%	5.29%	38	38	24	38
7	Contra Costa	Bay Area	Large	5.70%	5.72%	5.72%	4.88%	33	34	35	35
8	Del Norte	Superior	Small-Rural	7.59%	7.07%	7.61%	5.91%	14	11	16	12
9	El Dorado	Central	Small	7.26%	7.08%	7.26%	5.20%	13	13	27	13
10	Fresno	Central	Large	3.53%	3.47%	3.53%	4.03%	52	52	47	52
11	Glenn	Superior	Small-Rural	6.99%	6.87%	7.00%	5.98%	16	18	14	17
12	Humboldt	Superior	Small	7.79%	7.43%	7.77%	5.00%	11	10	31	10
13	Imperial	Southern	Small	4.48%	4.57%	4.46%	5.49%	41	41	21	41
14	Inyo	Superior	Small-Rural	7.16%	7.09%	7.14%	5.27%	12	15	25	15
15	Kern	Southern	Large	4.38%	4.30%	4.37%	4.30%	43	42	42	42
16	Kings	Central	Small	4.80%	4.77%	4.80%	5.22%	39	39	26	39
17	Lake	Superior	Small	6.99%	6.62%	6.99%	4.18%	22	19	45	18
18	Lassen	Superior	Small-Rural	10.45%	9.83%	10.45%	6.75%	4	4	10	4
19	Los Angeles	Los Angeles	Large	4.23%	4.20%	4.23%	4.85%	47	45	37	45
20	Madera	Central	Small	3.54%	3.52%	3.54%	4.00%	51	51	49	51
21	Marin	Bay Area	Medium	9.48%	9.17%	9.48%	8.08%	5	5	4	5
22	Mariposa	Central	Small-Rural	7.20%	6.82%	7.18%	3.54%	19	14	52	14
23	Mendocino	Superior	Small	6.99%	6.67%	7.00%	5.75%	20	17	18	19
24	Merced	Central	Medium	2.80%	2.77%	2.80%	3.06%	56	56	55	56
25	Modoc	Superior	Small-Rural	6.15%	5.72%	6.15%	3.72%	32	29	51	28
26	Mono	Central	Small-Rural	6.66%	7.02%	6.65%	4.87%	15	23	36	23
27	Monterey	Bay Area	Medium	3.59%	3.63%	3.59%	5.06%	50	50	30	50
28	Napa	Bay Area	Small	6.29%	6.54%	6.28%	5.95%	23	27	15	27
29	Nevada	Superior	Small	6.96%	6.66%	6.96%	5.42%	21	20	23	20
30	Orange	Southern	Large	4.06%	4.24%	4.06%	4.59%	45	46	39	46
31	Placer/Sierra	Central	Medium	7.60%	7.46%	7.60%	4.91%	10	12	34	11
32	Plumas	Superior	Small-Rural	8.92%	8.55%	8.93%	6.81%	7	6	9	6
33	Riverside	Southern	Large	4.01%	4.21%	4.01%	3.90%	46	48	50	48
34	Sacramento	Central	Large	5.70%	5.50%	5.70%	4.95%	34	35	32	34
35	San Benito	Bay Area	Small	5.93%	6.04%	5.92%	7.91%	30	32	5	32
36	San Bernardino	Southern	Large	4.64%	4.67%	4.64%	4.45%	40	40	41	40
37	San Diego	Southern	Large	6.60%	6.83%	6.61%	6.29%	18	24	13	24

MHP: Adjusted Service Penetration Rates and Ranking - CY06 Excluding Consumers With Three or Fewer Services											
County Code	County Name	Region Name	County Size	County Penetration Rate UnAdjusted	Penetration Rate Adjusted By Age	Penetration Rate Adjusted By Gender	Penetration Rate Adjusted By Race	Rank of Penetration Rate Adjusted By Age	Rank of Penetration Rate Adjusted By Gender	Rank of Penetration Rate Adjusted By Race	Rank of Penetration Rate UnAdjusted
38	San Francisco	Bay Area	Large	8.81%	8.81%	8.75%	8.82%	6	7	3	7
39	San Joaquin	Central	Medium	3.26%	3.21%	3.26%	3.09%	54	55	54	55
40	San Luis Obispo	Southern	Medium	7.01%	6.85%	7.02%	5.74%	17	16	19	16
41	San Mateo	Bay Area	Medium	6.13%	6.43%	6.14%	6.72%	27	30	11	30
42	Santa Barbara	Southern	Medium	6.43%	6.44%	6.43%	7.61%	25	25	7	25
43	Santa Clara	Bay Area	Large	4.37%	4.37%	4.37%	4.93%	42	43	33	43
44	Santa Cruz	Bay Area	Medium	6.35%	6.40%	6.35%	7.18%	28	26	8	26
45	Shasta	Superior	Small	8.24%	7.97%	8.24%	6.61%	8	8	12	8
47	Siskiyou	Superior	Small-Rural	10.51%	10.12%	10.48%	7.61%	3	3	6	3
48	Solano	Bay Area	Medium	4.03%	3.97%	4.06%	3.33%	48	47	53	47
49	Sonoma	Bay Area	Medium	5.21%	5.21%	5.22%	4.21%	37	37	44	37
50	Stanislaus	Central	Medium	4.35%	4.27%	4.35%	4.10%	44	44	46	44
51	Sutter/Yuba	Central	Small	5.97%	5.84%	5.98%	4.68%	31	31	38	31
52	Tehama	Superior	Small	6.77%	6.48%	6.77%	5.49%	24	22	22	22
53	Trinity	Superior	Small-Rural	10.91%	10.26%	10.93%	12.03%	2	2	1	2
54	Tulare	Central	Medium	3.52%	3.41%	3.50%	4.24%	53	53	43	53
55	Tuolumne	Central	Small	11.12%	10.77%	11.14%	9.86%	1	1	2	1
56	Ventura	Southern	Large	3.86%	3.93%	3.87%	4.57%	49	49	40	49
57	Yolo	Central	Small	5.43%	5.33%	5.43%	5.07%	36	36	29	36

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 18**

**SCERP Data Analyses**

- SCERP Select Data
- Readmission Rates for SCERP Index Clients – May 2006



### SCERP Select Data

Name*	Demographics	Service Category	Total Service Units	CY 2005													
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		
<b>Annie</b>	<b>59, F, White</b>	CRISIS	1					1									
		Index INPATIENT	5					5									
		LINKAGE/BROKERAGE	15	3			1				1	4	2	2	2		
		MEDICATION SUPPORT	19	3			4					6	1	2	3		
		MH SERVICES	23	8			4			1	4	2	1	1	2		
<b>Bob</b>	<b>42, M, White</b>	Index INPATIENT	9					9									
<b>Carol</b>	<b>32, F, White</b>	CRISIS	2					1	1								
		Index INPATIENT	18					18									
		INPATIENT	19						19								
		LINKAGE/BROKERAGE	33	1			1	1	4	8	5	7	4	2			
		MEDICATION SUPPORT	46						5	15	6	7	3	10			
		MH SERVICES	30					6	15	6	2						1
<b>Dave</b>	<b>61, M, White</b>	CRISIS	1					1									
		Index INPATIENT	6					6									
		LINKAGE/BROKERAGE	62		1	3	3	8	3	4	9	5	9	5	12		
		MEDICATION SUPPORT	17	1	1	1	1	1	1	1	1	1	4	1	4		
		MH SERVICES	6					6									
<b>Ed</b>	<b>52, M, White</b>	CRISIS	4					2		2							
		Index INPATIENT	2					2									
		INPATIENT	2							2							
		LINKAGE/BROKERAGE	1					1									
		MEDICATION SUPPORT	1					1									
		MH SERVICES	1					1									

\* No real names were used in this summary

Index INPATIENT = The inpatient episode that triggered inclusion in this dataset

### SCERP Select Data

Name*	Demographics	Service Category	Total Service Units	CY 2005												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Fred	43, M, White	CRISIS	1					1				1				
		Index INPATIENT	1													
		INPATIENT	8									8				
		MEDICATION SUPPORT	55	4	5	2	4	12	8		8	4	8			
		MH SERVICES	32			1	4	6		16	2	3				
Gail	25, F, White	CRISIS	22	5		1	1	1	7				1	4	2	
		Index INPATIENT	2					2								
		LINKAGE/BROKERAGE	3	1			1							1		
		MEDICATION SUPPORT	8	2			3	1					1		1	
		MH SERVICES	70	5		1	2			10			14	33	5	
Henry	31, M, White	CRISIS	10			3		4		1	2					
		Index INPATIENT	3					3								
		INPATIENT	12			7				5						
		LINKAGE/BROKERAGE	3			2					1					
		MEDICATION SUPPORT	6			6										
MH SERVICES	4			2	1					1						
Ike	41, M, White	CRISIS	4					2	1						1	
		Index INPATIENT	8					8								
		INPATIENT	2							2						
		LINKAGE/BROKERAGE	2					1	1							
		MEDICATION SUPPORT	26				3		3			4	3	3	5	3
		MH SERVICES	74	2	5	4	2	2	6	11	6	5	13	8	10	
		RESIDENTIAL	25	25												
Juan	43, M, Hispanic	CRISIS	12				1	2	1	6	1			1		
		Index INPATIENT	6					6								
		INPATIENT	84						8	7	24	6		39		
		LINKAGE/BROKERAGE	68				4	3	1	6	15			18	21	
		MEDICATION SUPPORT	38	1	2	2	8	5	9	4	5			2		
MH SERVICES	195				16	32	23	30	47	6	6	19	16			

\* No real names were used in this summary

Index INPATIENT = The inpatient episode that triggered inclusion in this dataset

### SCERP Select Data

Name*	Demographics	Service Category	Total Service Units	CY 2005												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
<b>Ken</b>	<b>22, M, White</b>	CRISIS	3	2					1							
		Index INPATIENT	4				4									
		LINKAGE/BROKERAGE	6	2			4									
		MEDICATION SUPPORT	32		3	5	1	8	2	1	3	3	3	3		
		MH SERVICES	98	9	14	6	4	21	12	3	6	12	6		5	
<b>Mario</b>	<b>17, M, White</b>	CRISIS	6				2	2					2			
		Index INPATIENT	9				9									
		INPATIENT	6				6									
		LINKAGE/BROKERAGE	96	9	2	9	14	11	6	2	2	10	8	11	12	
		MEDICATION SUPPORT	10	2		1		1		1			1	3	1	
		MH SERVICES	26				2	4						5	9	6
<b>Nick</b>	<b>42, M, White</b>	CRISIS	2					1			1					
		Index INPATIENT	8				8									
		LINKAGE/BROKERAGE	6				5				1					
		MEDICATION SUPPORT	1				1									
		MH SERVICES	4				4									
<b>Obi</b>	<b>50, M, White</b>	CRISIS	7				1	4	1		1					
		Index INPATIENT	6				6									
		LINKAGE/BROKERAGE	6	3			2				1					
		MEDICATION SUPPORT	29	1	2	1	1	10	4	1	3	2	2	1	1	
		MH SERVICES	31	1	2	1	2	10	6	2	4	1	1		1	
<b>Lenny</b>	<b>13, M, Asian/Pacific Islander</b>	CRISIS	2					2								
		Index INPATIENT	5				5									
		INPATIENT	5				5									
		LINKAGE/BROKERAGE	6				4	2								
		MH SERVICES	10				10									

\* No real names were used in this summary

Index INPATIENT = The inpatient episode that triggered inclusion in this dataset

### SCERP Select Data

Name*	Demographics	Service Category	Total Service Units	CY 2005											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<b>Peg</b>	<b>51, F, White</b>	Index INPATIENT	13					13							
		INPATIENT	13					13							
		LINKAGE/BROKERAGE	6		2	2		2							
		MEDICATION SUPPORT	10	4		4		2							
		MH SERVICES	10			2			4			2	2		
<b>Queeny</b>	<b>35, F, White</b>	CRISIS	3									1		2	
		Index INPATIENT	3					3							
		LINKAGE/BROKERAGE	9					4		1	2		1		1
		MEDICATION SUPPORT	43	1	2	9		5	1	5	2	3	4	4	7
<b>Rob</b>	<b>42, M, White</b>	CRISIS	2				1	1							
		Index INPATIENT	3					3							
		LINKAGE/BROKERAGE	3					3							
		MEDICATION SUPPORT	1						1						
<b>Sue</b>	<b>49, F, White</b>	CRISIS	1					1							
		Index INPATIENT	3					3							
		MEDICATION SUPPORT	35	3		4	6	4	2	6	5	1	1	2	1
		MH SERVICES	7					3		4					
<b>Tanya</b>	<b>59, F, Other</b>	CRISIS	1					1							
		Index INPATIENT	6					6							
		LINKAGE/BROKERAGE	13					6	3					2	2
		MEDICATION SUPPORT	27	5	1	4	2	2	2	1	3	1	3	1	2
		MH SERVICES	405	29	29	39	30	20	50	40	33	40	38	25	32

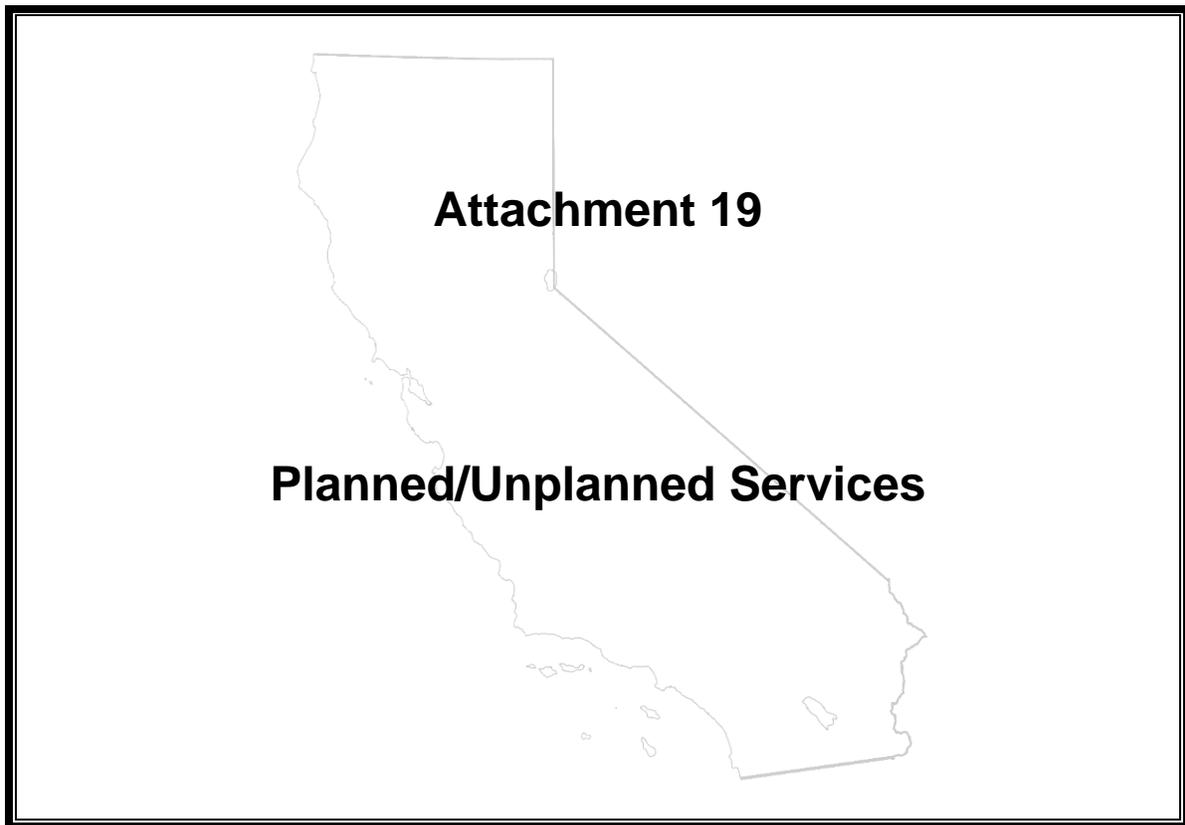
\* No real names were used in this summary

Index INPATIENT = The inpatient episode that triggered inclusion in this dataset

<b>Readmission Rates for SCERP Index Clients – May 2006</b>			
<b>County</b>	<b>Total Readmission</b>	<b>&gt;=1 Readmission Number</b>	<b>&gt;=1 Readmission Percent</b>
AMADOR	11	1	9.09%
BUTTE	267	101	37.83%
CALAVERAS	14	2	14.29%
COLUSA	7	4	57.14%
DEL NORTE	10	1	10%
EL DORADO	54	17	31.48%
GLENN	7	2	28.57%
HUMBOLDT	118	44	37.29%
IMPERIAL	55	15	27.27%
INYO	7	2	28.57%
KINGS	46	15	32.61%
LAKE	22	7	31.82%
LASSEN	7	1	14.29%
MADERA	32	8	25%
MARIPOSA	11	4	36.36%
MENDOCINO	46	10	21.74%
MERCED	168	68	40.48%
MODOC	4	1	25%
MONO	1	1	100%
NAPA	33	9	27.27%
NEVADA	19	6	31.58%
PLACER	101	31	30.69%
PLUMAS	7	2	28.57%
SAN BENITO	4	1	25%
SHASTA	51	13	25.49%
SIERRA	3	0	0%
SISKIYOU	14	3	21.43%
SUTTER/YUBA	106	53	50%
TEHAMA	10	2	20%
TRINITY	3	0	0%
TUOLUMNE	53	23	43.4%
YOLO	63	30	47.62%
<b>Total</b>	<b>1354</b>	<b>477</b>	<b>35.2%</b>



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

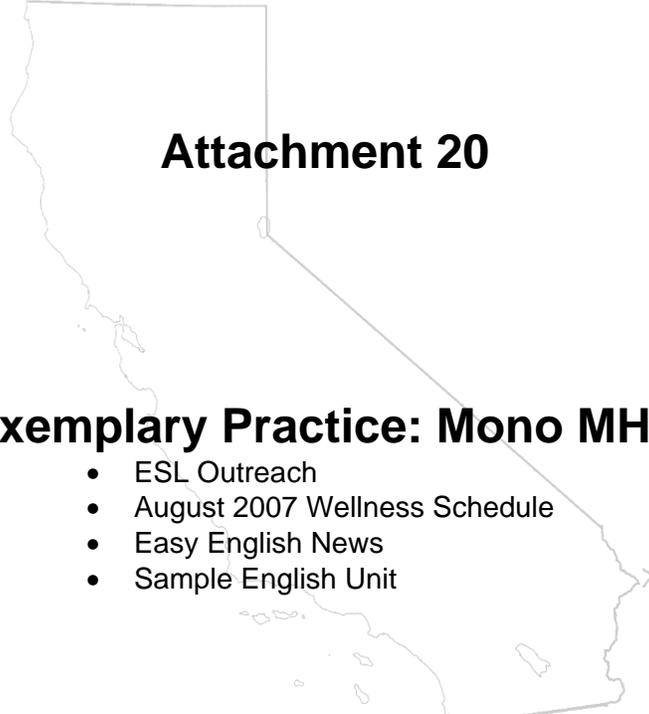




<b>Percentages of Active Clients (with Planned Services &gt;=4 from April through June CY05)</b>					
<b>County</b>	<b>SCERP County</b>	<b>Client Total</b>	<b>Client Active</b>	<b>Client Inactive</b>	<b>Client Active Percentage</b>
INYO	Yes	1	1	0	100%
LASSEN	Yes	1	1	0	100%
MARIPOSA	Yes	1	1	0	100%
TRINITY	Yes	1	1	0	100%
COLUSA	Yes	2	2	0	100%
KINGS	Yes	16	12	4	75%
MADERA	Yes	15	11	4	73%
CALAVERAS	Yes	3	2	1	67%
SHASTA	Yes	42	28	14	67%
IMPERIAL	Yes	17	11	6	65%
SANTA CRUZ	No	48	31	17	65%
MONTEREY	No	51	32	19	63%
SAN JOAQUIN	No	59	37	22	63%
SANTA BARBARA	No	49	30	19	61%
KERN	No	137	84	53	61%
PLACER/SIERRA	Yes	27	16	11	59%
TULARE	No	34	20	14	59%
NAPA	Yes	14	8	6	57%
SAN DIEGO	No	541	308	233	57%
LAKE	Yes	9	5	4	56%
SUTTER/YUBA	Yes	29	16	13	55%
SOLANO	No	31	17	14	55%
SONOMA	No	71	39	32	55%
YOLO	Yes	23	12	11	52%
MARIN	No	52	27	25	52%
SAN FRANCISCO	No	377	193	184	51%
NEVADA	Yes	2	1	1	50%
SISKIYOU	Yes	2	1	1	50%
EL DORADO	Yes	12	6	6	50%
STANISLAUS	No	137	66	71	48%
CONTRA COSTA	No	209	100	109	48%
BUTTE	Yes	70	33	37	47%
SAN BERNARDINO	No	367	170	197	46%
VENTURA	No	100	45	55	45%
SANTA CLARA	No	186	83	103	45%
<b>STATEWIDE</b>	<b>N/A</b>	<b>6,979</b>	<b>3,157</b>	<b>3,822</b>	<b>45%</b>
ALAMEDA	No	500	220	280	44%
MENDOCINO	Yes	12	5	7	42%
HUMBOLDT	Yes	60	25	35	42%
LOS ANGELES	No	2,135	874	1,261	41%

<b>Percentages of Active Clients (with Planned Services &gt;=4 from April through June CY05)</b>					
<b>County</b>	<b>SCERP County</b>	<b>Client Total</b>	<b>Client Active</b>	<b>Client Inactive</b>	<b>Client Active Percentage</b>
FRESNO	No	279	110	169	39%
RIVERSIDE	No	407	159	248	39%
TUOLUMNE	Yes	16	6	10	38%
SACRAMENTO	No	324	124	200	38%
MERCED	Yes	51	19	32	37%
SAN LUIS OBISPO	No	35	12	23	34%
TEHAMA	Yes	27	9	18	33%
ORANGE	No	294	98	196	33%
SAN MATEO	No	98	2	96	2%
AMADOR	Yes	1	0	1	0%
DEL NORTE	Yes	1	0	1	0%
PLUMAS	Yes	2	0	2	0%
GLENN	Yes	3	0	3	0%
ALPINE	Yes	0	0	0	
MODOC	Yes	0	0	0	
MONO	Yes	0	0	0	
SAN BENITO	Yes	0	0	0	

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



**Attachment 20**

**Exemplary Practice: Mono MHP**

- ESL Outreach
- August 2007 Wellness Schedule
- Easy English News
- Sample English Unit



### ESL Outreach at the Wellness Center:

1) ESL Advisory Board has been established with community members, Mono County Office of Ed Certificated ESL instructor; representative from Wild Iris (Domestic Violence/Child Abuse Prevention non-profit); representative from Mono County Mental Health. Public Health has been invited to participate.

2) Effective September, 2007, we will be offering both Beginner's, Intermediate, and Advanced classes in English. The Wellness Center will only be offering Beginning English. The Wellness Center will be offering three "semesters" of 16 weeks of instruction. At the end of the 16 weeks, participants who have actively participated in 50% or more of the scheduled classes will receive a Certificate of Participation. At the end of the 16 weeks, there will be three students chosen for the following awards:

- a) Most Improved Student
- b) Hardest Working Student
- c) Student with Best Attendance

The Certificates and Awards ceremony will be followed by a potluck with students and instructors (opportunity to apply new skills).

### 3) Curriculum:

Curriculum is based on:

- a) Interchange (3<sup>rd</sup> Ed.) which can be purchased at [esl.net](http://esl.net)  
(See attached PFD sample of Unit 1 – Beginners)
- b) Easy English Times – monthly newspaper written for ESL classes (See attached Word sample). This can be purchased at [www.easyenglishtimes.com](http://www.easyenglishtimes.com)
- c) Supplemental hand-outs from Ordonez, M. (2000). *English for Progress: Ingles para progresar: Guia de ingles conas explicaciones en espanol para el hispanohablante*. (4<sup>th</sup> ed.). Montebello, CA: Casa Blanca Press.
- d) SKIDMORE, Charles & DeFillipo, J, *Skill Sharpeners, Vol 3*. ISBN 0131929941
- e) We are also collecting additional ideas and hand-outs from internet resources:

[http://www.eslmonkeys.com/teacher/teaching\\_materials.php](http://www.eslmonkeys.com/teacher/teaching_materials.php)

<http://www.edhelper.com/listening.htm>

<http://www.eslsite.com/>

[http://esl.about.com/library/lessons/bl\\_guided\\_writing.htm](http://esl.about.com/library/lessons/bl_guided_writing.htm)

Instruction for the classes provided at the Wellness Center is shared by Paula Alvarez, LCSW, MHP Clinical Supervisor and another bilingual/bicultural professional community member so as to cover concepts regarding meeting basic needs and health & wellness

in the curriculum material. Outside speakers will be integrated into the curriculum to introduce specific wellness concepts; for example, a bilingual/bicultural member of the AA recovery community will speak.

Regarding, tracking our outreach efforts in numbers of individuals who have come into services after participating in ESL class(es): while we are establishing a frequency for tracking such data, we have known of at least one person who followed up after participating in an ESL class and requested MHP services. Also, we know of at least one MHP consumer and two AOD consumers who have elected to participate in the ESL classes. We hope to increase this cross over of participation and our ability to measure such outcomes. Also, we hope to find a way to track referrals that may be coming in from those who attend ESL to their friends/family members that request service with us.



# Sierra Wellness Center

A FREE service of Mono County Mental Health & Prop. 63

Join us Monday - Wednesday, and Friday 09:00 a.m. to 5:00 p.m.

Center Opens at 1:00 PM on Thursdays

94 Laurel Mountain Road, Suite 202, next to KMMT Radio

## AUGUST ACTIVITIES

- DAILY: *FREE Internet, pastries, coffee & conversation!!*
- MONDAYS: 9:00 - 10:30 Body Shop Gym Weight training (meet at body shop)  
 10:00 - 11:00 Effective Communication Class  
 12:00 - 1:00 Center Closed for Lunch  
 1:30 - 3:30 Computer Skills Workshop
- TUESDAYS: 9:30-12:00 Featured Movie  
 12:00 - 1:00 Center Closed for Lunch  
 6:00-8:00 pm English as a Second Language (ESL)
- WEDNESDAYS: 10:30-12:30 Yoga and Relaxation  
 10:30 - 12:00 Body Shop Gym Weight training (meet at body shop)  
 12:30 - 1:30 Center Closed for Lunch
- THURSDAYS: CENTER OPENS AT 1:00 PM  
 6:00-8:00pm English as a Second Language (ESL) @ Mono County  
 Office of Ed. - *CALL 934-0031 for directions*
- FRIDAYS: 9:00 - 12:00 Job / Interviewing Techniques (08/03/07 ONLY)  
 9:00-12:00 Watercolor Workshop - discover your inner artist!  
 (August 10, 17, 24, and 31 ONLY)  
 NO WOODTURNING WORKSHOP ON AUGUST 3, 2007  
 9:00-12:00 Woodturning Workshop - try something new...  
 12:00 - 1:00 Center Closed for Lunch  
 1:00-3:00 Yoga and Relaxation

**\*\* For additional information call (760) 934-3914 \*\***

**Located At: 94 Laurel Mountain Rd, Suite 202, next to KMMT  
 Radio (Corner of Laurel Mountain & Tavern Road)**





Click here for [sample newspaper in PDF format](#).

These samples come from *Easy English NEWS* for September, 1999.

Page 1: [Life in the U.S.](#): Making Schools Safe  
 Page 1: [Citizenship](#): Citizenship Day  
 Page 2 and 3: [Holiday pages](#): Labor Day  
 Page 4: [Editorial](#): Meet the people  
 Page 5: [This Is Your Page \(readers stories\)](#): Nine One One  
 Page 6: [Discover the U.S.A.](#): Immigrants and the United States  
 Page 7: [Ask Elizabeth](#): (The first story--"When I was nineteen years old. . .")  
 Page 8: [Crossword Puzzle](#)  
 Page 8: [Quiz](#): How well did you read?  
 Page 9: [Idioms page](#)  
 Page 9: [Funny Stuff](#)  
 Page 10: [Ask Jim about Sports](#): Women's soccer team  
 Page 10: [Culture Corner](#): Understanding movie ratings  
 Page 11: [Word Help Sample](#)

When you see a word that is **boldfaced**, and has a star (asterisk "\*") that tells you that the word is defined in Easy English in the [Word Help](#) section on page 11.

(Sample from September 1999 Easy English NEWS.)

## Life in the U.S.: Making schools safe

### Violence in schools

© Elizabeth Claire and Easy English NEWS, 1999

Last spring, there was bad news from a few schools in the U.S. Some students became very **violent\***. They brought guns and bombs to school. They killed their classmates. All Americans were **shocked\***.

### There were many questions

Everyone asked, "Why did such terrible things happen?"

The government wanted to know, too. **Congress\*** called many people to talk together in Washington, DC.

Congressmen and women talked to teachers, students, **psychologists\***, police, and **victims\*** of the violence.

The **lawmakers\*** asked many questions: What makes a person act violently? Who is selling guns to young people? How do children learn to make bombs? Why would teenage boys shoot their classmates? How can we **prevent\*** violence?

### **And there were many answers**

The **witnesses\*** gave different answers. They said that many things must change to make schools safe. Here are some of the things they said:

#### **Children's needs**

The family is very important in a child's life. Children need love and education from their parents. **Society\*** must help parents to be *good* parents.

Some children watch TV or play video games for many hours each day. They don't learn how to get along with other people. Children need more time with parents and other children, face-to-face. At school, there should be more social play, sports, and games for everyone, not just the best **athletes\***. Schools should have more guidance **counselors\***.

#### **We can all be kinder and gentler**

Parents and schools must teach **compassion\***. Groups of students are often very **cruel\*** to other students they don't like. They make fun of them and **harass\*** them.

Children need to learn that each human being is **valuable\***. Parents and schools must teach students to **accept\*** people who are different from themselves.

#### **Violence is "in the air that children breathe"**

The average child sees 37 acts of violence a day on TV! Children may learn that violence is fun. They may think that violence is an easy way to **solve\*** a problem.

People can ask the **entertainment industry\*** to create less violent TV shows, movies, music, and video games. Theaters can keep children out of "R-rated" movies. Parents can learn the rating systems for movies, TV shows, and games.

#### **Dangers of the Internet\***

The Internet is a powerful source of information. But it can be very dangerous for children. People have complete freedom on the Internet. There are **websites\*** where anyone may learn to make bombs. People with violent ideas talk with each other in "**chat rooms\***." Parents need to carefully **supervise\*** children who use the Internet.

#### **Too many guns**

The Constitution gives Americans the right to own guns. There are laws that say that children, criminals, and

mentally ill people cannot buy guns. Congress wants the police to make sure people obey these laws.

#### **Schools and courts must set clear limits**

Schools have rules. But often young people break the rules. Sometimes they are not **punished\***. Courts have also let young people go free after breaking the law. Then a young person cannot learn the **limits\*** for behavior. They cannot learn to be responsible for their actions. The rules must be clear. The punishment must be quick and fair. Children must know that people care what they do.

A **dress code\*** may help in some schools. Students may not be allowed to wear coats, baggy pants, or hats in school. More schools will ask students to wear uniforms.

#### **Schools may need more security\***

There will be more fences, security guards, and police around some schools this September.

Some schools will use a **metal detector\*** to check students as they come into the school building. Back packs may have to be made of clear plastic or see-through material.

At some schools, students will have to wear a photo ID.

TV cameras will be in halls, libraries, and cafeterias of some schools.

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(Sample from September 1999 Easy English NEWS.)

## **Citizenship: Citizenship Day**

© Elizabeth Claire and Easy English NEWS, 1999

September 17 is Citizenship Day.

It is a day that **honors\*** citizens. Citizens are people born in the U.S. or **naturalized\***. It is a day to think: What does citizenship mean? What rights do citizens have? What are citizens' **responsibilities\***?

This day was chosen because it is the birthday of the United States **Constitution\***. The Constitution is the basic plan for democratic government in the United States. It was signed on September 17, 1787.

The Constitution tells the rights of the citizens. Some of these are the freedom of speech, freedom of religion, and the freedom to get together in groups. People, newspapers, radio, TV, and the Internet, have the freedom to print or say what they want.

There can be good government only when there are good citizens. Citizens 18 years old and older have the right to vote. This is also one of the responsibilities of citizens.

There will be an election on Tuesday, November 2. Voters will choose some town, city, and state officials on this day. They will vote on public questions about spending money.

Citizens must register before they can vote. People who move or change their names must register again. In many states this must be done 30 days before the election.

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(Sample from September 1999 Easy English NEWS.)

## Holiday pages: Labor Day

© Elizabeth Claire and Easy English NEWS, 1999

Most American workers were extremely poor 100 years ago. They were paid very low wages. Their working conditions were full of danger. They often worked 12 or 14 hours a day. There were no **benefits\***. Workers could lose their jobs if they joined a **union\***.

In the early 1900s many children worked in **mines\*** and factories. They helped earn money for their families. There were no laws that said children must be in school.

Mary Harris Jones was a union **organizer\***. She knew that one worker had very little power against their employers. Workers could be powerful if they acted as a group. They had to get the public to see their terrible conditions. They had to change laws that hurt them.

She was a great speaker. Workers felt more powerful when they heard her. She was like a strong mother to them.

"Mother" Jones wrote about her work. These are her words:

"In the spring of 1903, I went to Kensington, Pennsylvania. Seventy-five thousand textile **workers\*** were on **strike\***. Ten thousand of them were little children. They were striking for more pay and shorter hours.

"Every day, little children came into union **headquarters\***. Some of them had only one hand, some with the thumb missing, some with their fingers off. They lost them in the machines they worked on. The children were small for their age, and **skinny\***.

"I asked the parents if they would let me have their children for a week. I promised to bring them back safe and sound.

"The boys and girls carried signs that said, "We want time to play." We marched through New Jersey and New York. We went to see President Theodore Roosevelt. The president would not see them.

But we had let everyone know about the **crime\*** of child labor."

Source: A People's History of the United States, 1492-Present by Howard Zinn

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(Sample from September 1999 Easy English NEWS.)

## Editorial: Meet the people

Welcome to all of our new readers. And welcome back to our regular readers.

This is *Easy English NEWS*' fourth year. Our purpose is to help you learn about life in the U.S. We hope you'll learn a lot of English, too.

I've been an ESL teacher for 32 years. I've written many books for people learning English. I like writing for a newspaper. All the information can be **up-to-date\*** and useful.

*Easy English NEWS* is a "two-way street." Readers can send in stories and ideas. That makes it different from a textbook.

I'd like you to meet the other people who work on your newspaper.

This is Ya-ping Liu. He's from China. He was a reader of the paper before he came to work here. He is our business manager.

George Rowland is our **copy editor\***. He was Managing Editor of The Free Press (New York). George helps us to stay 99.99% error-free.

Steve Jorgensen makes sure that everything in *Easy English NEWS* fits nicely on the page. He used to **design\*** books at Prentice Hall. He's our page designer.

Here's Tina Di Bella. She is our office manager. She enters customer information in our computer. She sends out the bills.

Do you like the **idioms\*** and other illustrations? Dave Nicholson is our artist. He was an art teacher in the Ridgewood Public Schools.

Did your paper get to you on time? Thank Fumie Fukushima. She (and sometimes her whole family) helps to count, stuff, and pack *Easy English NEWS* each month. She's from Japan.

Many readers asked for sports news. That's why we can "ask Jim" Simms questions about sports. Jim is a **walking encyclopedia\*** of sports.

There are a lot of volunteers too. One is Anna Eardley (she's my Mom). Another is Steve Pollack. (He helps when the computer **crashes\***.)

*Easy English NEWS* has many thousands of readers all across the United States and in eight foreign countries. More than a thousand classrooms use *Easy English NEWS* for reading, vocabulary building, conversation, and citizenship

preparation. It is the fastest-growing little newspaper in the ESL world!

We're **proud\*** of *Easy English NEWS*. But we always want to **improve\***. Please tell us your ideas to make the paper better and better.

*Elizabeth Claire*

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(Sample from September 1999 Easy English NEWS.)

## **This is Your Page (readers' stories): Nine One One**

My father came to visit us from China recently. One evening, he asked me how to make a call from here to China.

I told him to press 011 first, then press the country **code\***, the area code, and the telephone number he wanted to call.

After 5 minutes, the doorbell rang. I thought that was a little **strange\***. It was 9 o'clock in the evening. We were not expecting anyone to visit us. I opened the door. It was a policeman. He asked me **politely\***, "What happened?"

I was surprised. "Nothing," I said.

He said: "You just called 911." Then he asked, "Do you have children? May I see them for a minute?"

I understood that he thought I was beating my child. I asked my son to come out of his room. The policeman asked him: "Is every-thing OK?" My son **noded\*** with a smile. The policeman went out of the door and said, "Sorry. Have a nice night."

Suddenly I thought about my father. I ran into the bedroom. "Did you just make a phone call?" I asked him.

"Yes," he said. "I tried to call China. An American man answered the phone. I couldn't understand him, so I hung up."

I realized that my father must have pressed nine one one instead of zero one one.

I quickly ran out to catch the policeman. I shouted: " Please wait, please wait!" I caught him and explained about my father's mistake.

He smiled and laughed: "OK. Now he can easily remember the number. Tell him to call 911 when he has an **emergency\***."

Ya-ping Liu

Tenafly, NJ (China)

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(Sample from September 1999 Easy English NEWS.)

## Discover the U.S.A.-- People and Places



### Immigrants and the U.S.A.

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There are people in the U.S. from *hundreds* of different countries. Almost 9% of the people living in the U.S. today were born in another country. More than 800,000 new people come to live in the U.S. each year.

The states with the most immigrants are California, New York, Florida, Texas, New Jersey, Illinois, Washington, Virginia, Massachusetts, and Maryland. But every state has at least some newcomers.

#### Where are the immigrants from?

During the 1700s and 1800s, most immigrants came from England, Germany, and northern Europe. Africans were brought to America as **unwilling\*** immigrants.

Around 1900, people began to come from central and southern Europe. Jews and other Europeans came during the 1930s and the '40s

Starting in the '50s many Mexicans, and people from Central and South America came.

For the past 25 years, more people have come from Asia and the Middle East. Recently, people have started to come from Africa.

### **Why does the U.S. welcome immigrants?**

Immigrants help the United States in many ways:

Many immigrants have excellent **skills\*** needed in America. Other immigrants take difficult, dirty, or dangerous jobs that Americans do not want. Immigrants often work for lower pay. They are willing to work hard.

Immigrants increase the population. This makes more customers for people who sell things. Landlords rent apartments to immigrants, and builders build homes for them. There are more students for teachers, more patients for doctors. Some immigrants have money to start new businesses. This can create jobs for Americans.

Immigrants bring new ideas and new ways of looking at things. Most immigrants appreciate the freedom in the U.S. They are glad to be here. They make very good citizens.

### **How can someone immigrate to the U.S.?**

One way to immigrate is to have a **sponsor\***. This can be a family member. Or a sponsor can be an employer who needs someone with special skills.

The person must wait for an immigrant's visa from the American **embassy\*** in their country.

Some people may enter the country as **refugees\***. They were forced to leave their country because of war or **persecution\***.

There is also an immigration **lottery\***. It is for people from countries that do not send a lot of immigrants to the U.S. It is called the "**diversity\***" lottery.

Some **investors\*** who have enough money to start a large business in the U.S. are welcomed as immigrants.

### **Is there a limit to immigration?**

Yes. The number of immigrants that may come into the U.S. is set by law. This number changes each year. Each country has a limit, too. Some people wait many years to enter the U.S.

### **What about people who come without the proper visa?**

Many poor people come to the U.S. to find jobs. They hope that they can send money home to their hungry families.

The U.S. government makes it very difficult for them. It's against the law to **hire\*** a person who does not have permission to work in the U.S. People without legal visas can be **deported\***. Then they may not be allowed to come

back into the United States for a long time.

### How can an immigrant become a citizen?

- Enter the country legally.
- Live here 5 years (3 years in some cases); have a **clean record\*** and good **character\***.
- Fill out an application.
- Pay a **fee\*** of \$225 plus \$25 for fingerprinting.
- Take a test of English and American history and government.
- Take a **loyalty oath\***. Give up loyalty to one's **former\*** country.

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(Sample from September 1999 Easy English NEWS.)

## Ask Elizabeth

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Dear Elizabeth,

When I was nineteen years old, I was **arrested\*** for **shoplifting\***. I was shocked that I almost went to jail. I've never been in trouble again. Later, this crime was erased from my record. Now I found out I can lose my green card and never become a citizen. Is that true?

*Lazaro*

Dear Lazaro,

A person needs a **clean record\*** to get a green card or to become a citizen. Non-citizens can lose their green cards if they are found guilty of a crime.

In March 1999, the immigration court made a decision that affects many immigrants. It decided that it will "not **accept\* expungements\***" to change the **status\*** of persons with **minor\*** criminal records. The law says that **criminals\*** may not immigrate, they may not become **naturalized\*** citizens, and they may be **deported\***.

That means that your record may be clean for some purposes. But it may not be clean for immigration purposes.

You will need to get a copy of your police record to see what is in it. You will need help from an **attorney\***. The attorney should be an immigration **expert\***. Get this help before you go to any appointment with INS.

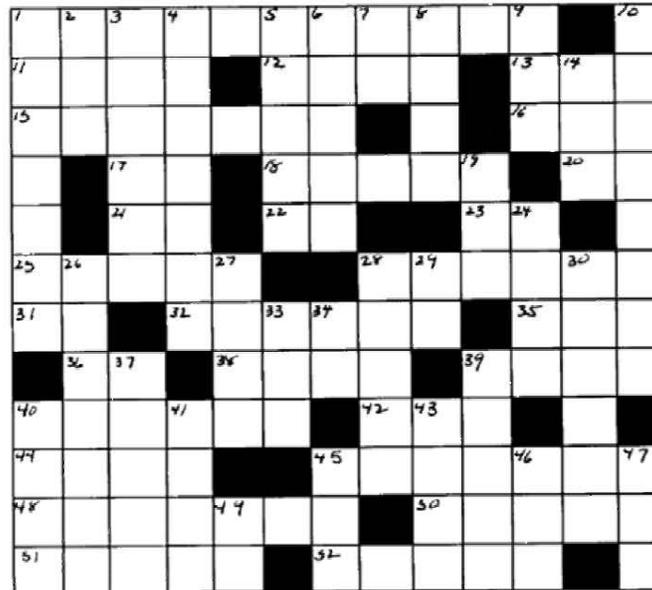
Your experience gives a warning for any other immigrant: Do not get into trouble with the law.

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(Sample from September 1999 Easy English NEWS.)

## Crossword Puzzle

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### Across

1. A date on which something special happened in the past.
11. Twelve o'clock p.m.
12. Extremely
13. You \_\_ I are friends.
15. A person who swims
16. Not me
17. South America (abbreviation)
18. She or he helps sick people.
20. Washington, \_\_
21. A famous movie about an extraterrestrial

### Down

1. Replies to a question
2. At this time
3. Sounds
4. People who live in a prison
5. Something that happens
6. Run again
7. Senior (abbreviation)
8. Yeses; voting by voice
9. An expression of joy
10. What a teacher does
14. Move one's head to say yes

- 22. Tennessee (abbreviation)
- 23. Preposition (Sit \_\_\_ the table.)
- 25. Summer flowers
- 28. Run very fast
- 31. Spelling (abbreviation)
- 32. The one after the first one
- 35. To stop living
- 36. BE; It \_\_\_ September.
- 38. Type of bread in southern states:  
corn \_\_\_
- 39. Arms and \_\_\_
- 40. Makes a noise like a pig
- 42. Short name for Edith
- 44. AIUI
- 45. Not open to the public
- 48. A dangerous creature
- 50. A part of a poem
- 51. Finished
- 52. Very overweight
- 19. Sense organ for listening
- 24. Movement of the ocean
- 26. A thought or idea about something
- 27. The ninth month (abbreviation)
- 28. To look at someone in a negative way;  
to disapprove
- 29. Police Department (abbreviation)
- 30. Times of darkness
- 33. Companies (abbreviation)
- 34. Opposite of off
- 37. Something you can hear
- 39. Is alive
- 40. Not different
- 41. Go up
- 43. Enter a pool
- 45. For; taking the side of in an argument
- 46. BE; They \_\_\_ teachers.
- 47. A long, thin, snake-like fish
- 49. Touchdown (abbreviation)

**Answers to Crossword Puzzle**

A	N	N	I	V	E	R	S	A	R	Y	E
N	O	O	N	V	E	R	Y	A	N	D	
S	W	I	M	M	E	R	E	Y	O	U	
W	S	A	N	U	R	S	E	D	C		
E	E	T	T	N	A	T	A				
R	O	S	E	S	S	P	R	I	N	T	
S	P	S	E	C	O	N	D	D	I	E	
I	S	P	O	N	E	L	E	G	S		
S	N	O	R	T	S	E	D	I	H		
A	I	U	I	P	R	I	V	A	T	E	
M	O	N	S	T	E	R	V	E	R	S	E
E	N	D	E	D	O	B	E	S	E	L	

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(Sample from September 1999 Easy English NEWS.)

**QUIZ: How well did you read?**

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**MATCH**

Write the letter of the best meaning for each word.

- |                    |  |
|--------------------|--|
| ___ 1.compassion   | A. an act  |
| ___ 2.deed         | B. a person who lives in a place                           |
| ___ 3.diploma      | C.a favorite saying of a person or organization            |
| ___ 4.resident     | D.a feeling of understanding and sympathy                  |
| ___ 5.motto        | E.a paper that shows someone has graduated from a school   |
| ___ 6.labor        | F.a promise that something will work properly or not break |
| ___ 7.expert       | G.a person who is responsible for a young person           |
| ___ 8.financial    | H.a person who knows a lot about something                 |
| ___ 9.guarantee    | I.work   |
| ___ 10. guardian   | J.having to do with money                                  |
| ___ 11.shoplifting | K.a small fish   |
| ___ 12.double      | L.the edge of something                                    |
| ___ 13.limit       | M.two times something                                      |
| ___ 14.salary      | N.money that is earned by working                          |
| ___ 15.sardine     | O.taking things from a store without paying                |
| ___ 16.skinny      | P.a group of workers who act together                      |
| ___ 17.strike      | Q.very thin  |
| ___ 18.tuition     | R.something unsafe   |
| ___ 19.union       | S.the cost of instruction                                  |
| ___ 20.hazard      | T.stop working, in order to get better working conditions  |

Answers to Quiz			
1. D	6. I	11. O	16. Q
2. A	7. H	12. M	17. T
3. E	8. J	13. L	18. S
4. B	9. F	14. N	19. P
5. C	10. G	15. K	20. R

#### My Score

**20 correct: Expert!**  
**17-19 correct: Very Good!**  
**14-16 correct: Good**  
**8-13 correct: Not Bad**  
**0-7 correct: Atone!**

**Get the facts**

1. What may be some causes of school violence?
2. What is the purpose of Citizenship Day?
3. What is the purpose of the Constitution?
4. What do Americans do on Labor Day?
5. Why did children march to see the president in 1903?
6. What is the purpose of a labor union?
7. Why does the U. S. government welcome immigrants?
8. What states have the most immigrants?
9. What can happen to an immigrant who is arrested for a crime?
10. How can an immigrant become a citizen?
11. Why are many towns holding Y2K meetings?
12. How can a person pay for college expenses?
13. What are some rules for fire safety?
14. What do the movie ratings G, PG13, and R mean?

**Share your ideas**

1. What does your school do to prevent violence?
2. Do you think there should be laws against violent movies? Against carrying guns? Why or why not?
3. How can schools teach students to be compassionate?
4. How do movie ratings help you?
5. How much TV is OK for a child to watch? An adult? Why?
6. Do you think a college education is worth the years of study?

7. What things will you do this month to get ready for Y2K?
8. Have you ever had to call 911? Tell about it.
9. How is an American dentist different from a dentist in your native country?
10. Do you think the U.S. is right to have a limit on the number of immigrants that may come into the country? Why or why not?
11. Is soccer a popular sport for women in your country? Why or why not?
12. Have you ever had a dream come true? Tell about it.

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(Sample from September 1999 Easy English NEWS.)

## Idiom Corner

Illustrations by Dave Nicholson

Can you match these idioms with their meanings?



### Meanings

- A. a party; an invitation to people to visit on a certain day
- B. a leader in an organization
- C. a son who is similar to his father



\_\_\_ 3. a big wheel



\_\_\_ 4. an open house

D. a serious worry

E. many people crowded into a small space

F. a very small part of a large thing



\_\_\_ 5. the tip of the iceberg



\_\_\_ 6. packed like sardines in a can

Answers to Idiom Corner Quiz	
1. C	4. A
2. D	5. F
3. B	6. E

**Practice**

Write the correct forms of the idioms in the blank spaces.

- Ramon was unemployed. He did not know how he would pay his bills. He was two months behind on the rent. He could not sleep well because of the \_\_\_\_\_.
- The police caught a man stealing a car. but soon they learned it was just \_\_\_\_\_.
- Jerry became a policeman, just like his father. He's a real \_\_\_\_\_.
- Tessa is quiet as a mouse at home, but she's a \_\_\_\_\_ at her job. She's vice-president of the bank.
- The five o'clock bus was full of people \_\_\_\_\_.
- The Smiths have \_\_\_\_\_ on New Year's Day every year. Their friends and family drop over to visit and eat.

Answers to Practice
1. weight hanging over his head
2. the tip of the iceberg

3. chip off the old block
4. big wheel
5. packed like sardines in a can
6. an open house

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(Sample from September 1999 Easy English NEWS.)

## Funny Stuff

 <p><b>He:</b> I see spots in front of my eyes.</p> <p><b>She:</b> Have you seen a doctor?</p> <p><b>He:</b> No, only spots.</p>	<p>What is the longest word in the English Language?</p>  <p>Smiles. There is a mile between the first letter and the last letter.</p>
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(Sample from September 1999 Easy English NEWS.)

## Ask Jim about Sports: Women's soccer team

© Jim Simms and Easy English NEWS, 1999

Dear Jim,

What did you think of the American women winning the World Cup in Soccer this summer?

*Alejandra*

Dear Alejandra,

Exciting!

It was an outstanding national sports event. The level of competition was tremendous. The skill level was outstanding. The teamwork was powerful.

The drama was so high, I never thought "These are women playing." I thought "These are great **athletes\*** playing." Both teams were so good. The Chinese women were great. No one knew who would win until the last kick.

Ninety thousand people were at the stadium, including President Clinton. Millions of people around the world watched the game on TV.

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(Sample from September 1999 Easy English NEWS.)

## Culture Corner: Understanding movie ratings

### Movie and TV ratings

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**G:** General **audiences\***. This **rating\*** means that it is for the whole family. There is not a lot of **violence\***. There is no bad language. There are no sex scenes.

**PG:** This rating means that parents' **guidance\*** is needed. The movie may have some violence, brief sex scenes, and a small amount of bad language. Parents should read a review of the movie, and talk to adults who have seen it.

**PG-13:** This rating means that the movie is *not suitable\** for children under the age of 13. It may contain sex scenes, violence, and bad language.

**R:** This rating means that the movie is *restricted*. A person under 17 may not go into the theater without a parent or **guardian\***. The movie may contain a lot of sex, or a lot of violence or both. There may also be a lot of bad language.

**NR:** This means the movie is *not rated*. It is for adults over the age of 18 only. Contains a great deal of violence and/or sex.

### TV ratings

There is a rating system for TV programs, too. Most of the larger TV networks (ABC, CBS, NBC, Fox) use this

system.

**Y:** For children, all ages

**Y-7:** For children over 7 years

**G:** General audience (everyone OK)

**PG:** Parental guidance is needed. Watch the program with your children and decide.

**TV-14:** Not suitable for children under 14

**TV-M:** Mature audiences only (over 18)

In addition, the following letters tell why a program has an unsuitable rating.

**V**-violence; **S**-sex; **L**-vulgar language; **D**-dialogue (talk about sex or violence)

### **Video game ratings**

There are ratings on the package of video games.

**eC:** Early Childhood. OK for children 3 and older.

**E:** Everyone. Suitable for ages 6+. May have a small amount of violence, comic **mischief\***, or bad language.

**T:** Teen. Suitable for ages 13+. May contain violence, bad language, and sex scenes..

**M:** Mature. This is *not* suitable for children under 17. May have a lot of blood and violence and/or sex and bad language.

**A:** Adults only. Sex and violence. May not be sold or rented to anyone under 18.

**RP:** Rating Pending. It has not yet gotten a rating from the Entertainment Software Rating Board.

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(Sample from September 1999 Easy English NEWS.)

### **Word Help Sample**

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These words may have many meanings. We give only the meanings that are used in this issue of *Easy English NEWS*.

**arrest** *verb*. To put someone under the control of the police.

**athlete** *noun*. A person who is good at sports.

**attorney** *noun*. A lawyer.

**audience** *noun*. A group of people who listen to or watch a movie, show, lesson, etc.

**average** *noun*. The result of adding a list of numbers and dividing the total by the number of numbers in the list.

**benefit** *noun*. Something good; an extra value from work, in addition to a paycheck: pension, vacation time, health insurance, etc.

**broil** *verb*. To cook under a fire.

**clean record, to have a** *noun*. To have never committed a crime.

**code (area or country code)** *noun*. A special number used when making a phone call.

**compassion** *noun*. A feeling of understanding and sympathy for others.

**Congress** *noun*. The representatives and senators who make laws for the U.S.

**Constitution** *noun*. The basic laws of the U.S. government.

**copy editor** *noun*. A person who corrects errors made by writers.

**council** *noun*. A group of people who make decisions for a town or organization.

**county** *noun*. States are divided into counties. Counties are parts of a state.

**crash** *verb*. (Said of a computer) To stop working.

**credit report** *noun*. A statement about a person's history of paying bills and loans.

**crime** *noun*. An act against the law: murder, robbery, selling drugs, etc.

**criminal** *noun*. A person who does an illegal act.

**cruel** *adjective*. Causing great pain.

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# 6 My sister works downtown.

## 1 SNAPSHOT

- Listen and practice.

**Transportation in the U.S.**  
The Top Eight Ways to Get to Work

<input type="checkbox"/> 1. drive 	<input type="checkbox"/> 2. walk 	<input type="checkbox"/> 3. take the bus 	<input type="checkbox"/> 4. take the subway 
<input type="checkbox"/> 5. take the train 	<input type="checkbox"/> 6. ride a bike 	<input type="checkbox"/> 7. ride a motorcycle 	<input type="checkbox"/> 8. take a taxi/cab 

Source: U.S. Census Bureau

Check (✓) the kinds of transportation you use.  
What are some other kinds of transportation?

## 2 CONVERSATION Nice car!

- Listen and practice.

Ashley: Nice car, Jason! Is it yours?  
Jason: No, it's my sister's. She has a new job, and she drives to work.  
Ashley: Is her job here in the suburbs?  
Jason: No, it's downtown.  
Ashley: My parents work downtown, but they don't drive to work. They use public transportation.  
Jason: The bus or the train?  
Ashley: The train doesn't stop near our house, so they take the bus. It's really slow.  
Jason: That's too bad.



### 3 WORD POWER Family

**A** **Pair work** Complete the sentences about the Carter family. Then listen and check your answers.

- Anne is Paul's *wife*.
- Jason and Emily are their .....
- Paul is Anne's .....
- Jason is Anne's .....
- Emily is Paul's .....
- Jason is Emily's .....
- Emily is Jason's .....
- Paul and Anne are Jason's .....

kids = children  
mom = mother  
dad = father



**B** **Pair work** Tell your partner about your family.

“My mother’s name is Angela.  
David and Daniel are my brothers.”

### 4 GRAMMAR FOCUS

#### Simple present statements

- |  |                                    |
|--|------------------------------------|
| I <b>walk</b> to school.               | I <b>don't live</b> far from here. |
| You <b>ride</b> your bike to school.   | You <b>don't live</b> near here.   |
| He <b>works</b> near here.             | He <b>doesn't work</b> downtown.   |
| She <b>takes</b> the bus to work.      | She <b>doesn't drive</b> to work.  |
| We <b>live</b> with our parents.       | We <b>don't live</b> alone.        |
| They <b>use</b> public transportation. | They <b>don't need</b> a car.      |

**Contractions**  
don't = do not  
doesn't = does not

**A** Paul Carter is talking about his family. Complete the sentences with the correct verb forms. Then compare with a partner.

- My family and I *live* (live/lives) in the suburbs. My wife and I ..... (work/works) near here, so we ..... (walk/walks) to work. Our daughter Emily ..... (work/works) downtown, so she ..... (drive/drives) to work. Our son ..... (don't/doesn't) drive. He ..... (ride/rides) his bike to school.
- My parents ..... (live/lives) in the city. My mother ..... (take/takes) a train to work. My father is retired, so he ..... (don't/doesn't) work now. He also ..... (use/uses) public transportation, so they ..... (don't/doesn't) need a car.

### Simple present statements with irregular verbs

#### I/you/we/they

I **have** a bike.  
We **do** our homework every day.  
My parents **go** to work by bus.

#### he/she/it

My father **has** a car.  
My mother **does** a lot of work at home.  
The bus **goes** downtown.

**B** Ashley is talking about her family and her friend Jason. Complete the sentences. Then compare with a partner.

1. My parents *have* (have/has) a house in the suburbs. My mom and dad ..... (go/goes) downtown to work. My parents are very busy, so I ..... (do/does) a lot of work at home.
2. My brother doesn't live with us. He ..... (have/has) an apartment in the city. He ..... (go/goes) to school all day, and he ..... (do/does) office work at night.
3. I ..... (have/has) a new friend. His name is Jason. We ..... (go/goes) to the same school, and sometimes we ..... (do/does) our homework together.

**C Pair work** Tell your partner about your family.

"I have one brother and two sisters. They . . ."

## 5 PRONUNCIATION Third-person singular -s endings

Listen and practice. Notice the pronunciation of the -s endings.

<i>s</i> = /s/	<i>s</i> = /z/	(e) <i>s</i> = /ɪz/	irregular
take takes	go goes	dance dances	do does
walk walks	study studies	watch watches	have has

## 6 WHO IS IT?

**A** Write five sentences about you and your family. Write "Male" or "Female" on your paper, but not your name.

*(Female) I live with my parents. I have two sisters. My father works downtown. . . .*

**B Class activity** Put all the papers in a bag. Choose a paper and describe the writer. Your classmates guess the writer.

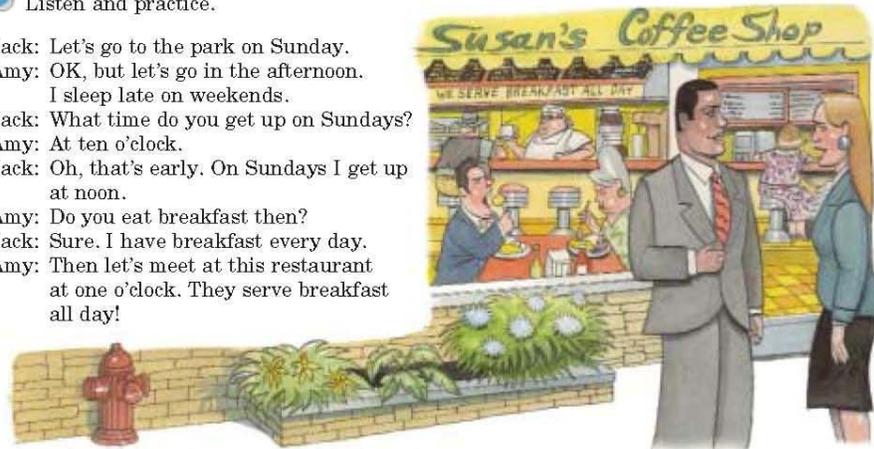
- A: She lives with her parents. She has two sisters. Her father works downtown. . . . Who is it?  
B: Michelle, is it you?  
C: No, it's not me. . . .



**7 CONVERSATION** *I get up at noon.*

Listen and practice.

Jack: Let's go to the park on Sunday.  
 Amy: OK, but let's go in the afternoon.  
 I sleep late on weekends.  
 Jack: What time do you get up on Sundays?  
 Amy: At ten o'clock.  
 Jack: Oh, that's early. On Sundays I get up  
 at noon.  
 Amy: Do you eat breakfast then?  
 Jack: Sure. I have breakfast every day.  
 Amy: Then let's meet at this restaurant  
 at one o'clock. They serve breakfast  
 all day!



**8 GRAMMAR FOCUS**

**Simple present questions**

Do you **get up** early?  
 No, I **get up** late.

Does he **have** lunch at noon?  
 No, he **eats** lunch at one o'clock.

Do they **drive** to work?  
 Yes, they **drive** to work every day.

What time do you **get up**?  
 At ten o'clock.

What time does he **have** lunch?  
 At one o'clock.

When do they **drive** to work?  
 Every day.

**A** Complete the questions with *do* or *does*. Then write four more questions.

1. ...*Do*... you get up early on weekdays?
2. What time ..... you go home?
3. .... your mother work?
4. How ..... your father get to work?
5. .... your parents read in the evening?
6. When ..... your parents shop?
7. Does ..... ?
8. What time ..... ?
9. Do ..... ?
10. When ..... ?

time expressions	
early	in the morning
late	in the afternoon
every day	in the evening
at 9:00	on Sundays
at noon/midnight	on weekends
at night	on weekdays

**B Pair work** Ask and answer the questions from part A. Use time expressions from the box.

A: Do you get up early on weekdays?  
 B: Yes, I do. I get up at seven o'clock.

**C** Unscramble the questions to complete the conversations. Then ask a partner the questions. Answer with your own information.

1. A: *Do you exercise every day* ..... ?  
(you every day exercise do)  
B: Yes, I exercise every day.
2. A: ..... ?  
(you what time lunch do eat)  
B: At 1:00 P.M.
3. A: ..... ?  
(at start does eight o'clock this class)  
B: No, this class starts at nine o'clock.
4. A: ..... ?  
(study you English do when)  
B: I study English in the evening.



**9 LISTENING Marsha's weekly routine**

**A** Listen to Marsha talk about her weekly routine. Check (✓) the days she does each thing.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
get up early	<input type="checkbox"/>						
go to work	<input type="checkbox"/>						
exercise	<input type="checkbox"/>						
see friends	<input type="checkbox"/>						
see family	<input type="checkbox"/>						

**B Group work** Tell your classmates about your weekly routine.

- A: I get up early on weekdays and Saturdays.  
But I sleep late on Sundays. . . .
- B: I get up early on weekdays, too.  
I get up at 6:00.
- C: Really? I get up late every day. . . .



**10 INTERCHANGE 6 Class survey**

Find out more about your classmates. Go to Interchange 6.

**11** **READING**

# What's your schedule like?

Look at the pictures and the labels. Who gets up early? Who gets up late?

Student reporter Mike Starr talks to people on the street about their schedules.



**Brittany Davis**  
College Student



**Joshua Burns**  
Web-site Designer



**Maya Black**  
Rock Musician

**Mike:** What's your schedule like?

**Brittany:** My classes start at 8:00 A.M., so I get up at 7:00 and take the bus to school.

**MS:** When do your classes end?

**BD:** They end at noon. Then I have a job at the library.

**MS:** So when do you study?

**BD:** My only time to study is in the evening, from eight until midnight.

**Mike:** What's your schedule like?

**Joshua:** Well, I get up at 6:30 A.M. and go for a run before breakfast.

**MS:** How do you go to work?

**JB:** I work at home. I start work at 8:00. Around 1:00, I take a lunch break.

**MS:** How late do you work?

**JB:** Sometimes I work all night to finish a project!

**Mike:** What's your schedule like?

**Maya:** I work at night. I go to work at 10:00 P.M., and I play until 3:00 A.M.

**MS:** What do you do after work?

**MB:** I have dinner. Then I take a taxi home.

**MS:** What time do you go to bed?

**MB:** I go to bed at 5:00 in the morning.

**A** Read the article. Then number the activities in each person's schedule from 1 to 5.

**Brittany Davis**

- ..... a. She goes to class.
- ..... b. She takes the bus.
- ..... c. She works.
- ..... d. She studies.
- ..... e. She gets up.

**Joshua Burns**

- ..... a. He has breakfast.
- ..... b. He starts work.
- ..... c. He eats lunch.
- ..... d. He gets up.
- ..... e. He goes for a run.

**Maya Black**

- ..... a. She has dinner.
- ..... b. She finishes work.
- ..... c. She goes to bed.
- ..... d. She goes to work.
- ..... e. She goes home.

**B** Write five sentences about your schedule. Are you an "early bird" or a "night owl"? Compare with a partner.

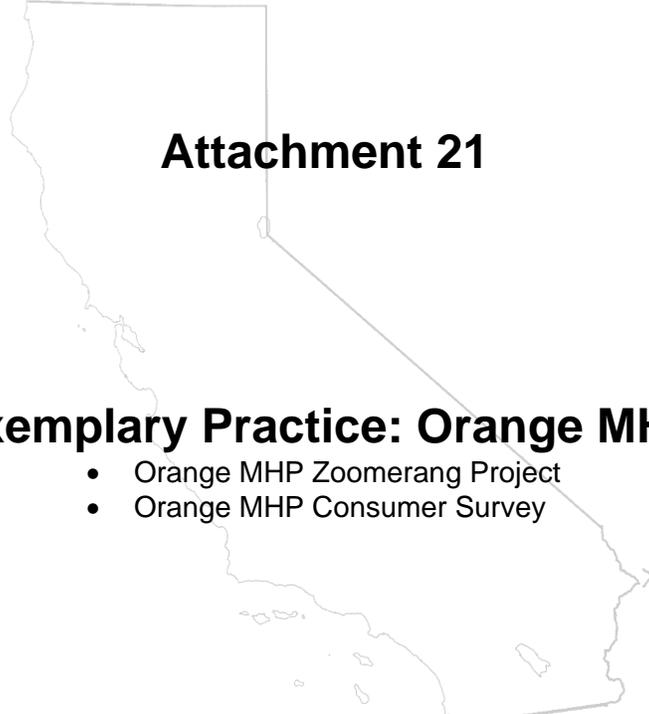


early bird



night owl

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 21**

**Exemplary Practice: Orange MHP**

- Orange MHP Zoomerang Project
- Orange MHP Consumer Survey





**Cultural Competence Self-Assessment in Behavioral Health Services**

An annual survey conducted by  
County of Orange Health Care Agency  
Behavioral Health Services  
Cultural Competency and Multiethnic Services

June 2007

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Report generated at MHSA Training Program. For questions/comments contact (714) 834-5403

**Introduction**

The Behavioral Health Services (BHS) of County of Orange Health Care Agency recently undertook an effort to identify the strengths, weaknesses and needs to become a more culturally competent organization. The BHS understands that cultural competence is a developmental process. Changes do not take place instantly and introduction of changes to the system is often difficult. A clear understanding of the current nature of cultural competence in BHS is thus imperative to identify the areas in need of change/improvement and further staff training. Thus, BHS believes that results of this study would serve as a baseline to measure the potential future changes in the system. The same survey will be conducted semiannually to identify if interventions introduced in between assessments have an effect on the cultural competency in BHS.

**Methodology**

- **Instrument:** 62-Item anonymous self-assessment questionnaire with four Likert scale response options:
  - 1=Never or almost never
  - 2=Sometimes
  - 3=Often
  - 4=Always or almost alwaysSkip item if question does not apply
- 
- **Sample:** 871 of BHS (County and Contract) staff members who had access to the on-line Essential Learning Training system. This was the best available method to reach the widest BHS audience.
- **Sample size (number of unduplicated staff who completed the questionnaire):** 540
- **Completion rate:**  $(544/871) * 100 = 62.5\%$
- **Length of time to complete the questionnaire:** 31-Calendar Days (05/01/07 to 05/31/07)
- **Method of delivery:** Zoomerang on-line questionnaire
- **Composition of the instrument:**
  - 7 items on demographics (labeled D1 to D7)
  - 10 items for clinicians only (labeled CL1 to CL10)
  - 40 items for all staff (labeled Q1 to Q40)
  - 5 validity items (labeled VL1 to VL5)

**Demographics of the respondents**

## D1. Employer:

County	465 (85.5%)
Contract	79 (14.5%)

## D2. Division

ADAS	124 (22.8%)
AMHS	156 (28.7%)
CYS	133 (24.4%)
Other	49 ( 9.0%)
Not specified	82 (15.1%)

## D6. Management vs. Non-management staff

Management	121 (22.2%)
Non-management	414 (76.1%)
Not specified	9 ( 1.7%)

## D7. Clinical vs. Non-Clinical staff

Clinical	302 (55.5%)
Non-Clinical	242 (44.5%)

## D5. Gender

Male	176 (32.4%)
Female	362 (66.5%)
Not specified	6 ( 1.1%)

## D3. Ethnicity

African-American	17 ( 3.1%)
Latino	117 (21.5%)
Vietnamese	31 ( 5.7%)
White	293 (53.9%)
Other/Mixed	65 (11.9%)
Not specified	21 ( 3.9%)

## D4. Bilingual pay status

Yes	155 (28.5%)
No	383 (70.4%)
Not specified	6 ( 1.1%)

**Factor and Reliability Analysis**

Through factor analysis, five distinct factors with high inter-item correlation were extracted<sup>1</sup> from the questionnaire. Analysis of mean scores of each of the five factors indicates that four of the five factors have a Cronbach's alpha coefficient of over 0.70. An alpha score of over 0.70 is generally indicative of a reliable evaluation tool.

Factor 1: Agency supports cultural competence	Mean
Q1 Agency promotes cultural competence	3.26
Q2 Committees reflect cultural competence	3.04
Q3 BHS provides translation	3.19
Q4 BHS services cultural competence	3.14
Q5 Diverse interns	2.92
Q6 Diverse clients participate	2.69
Q7 Diverse managers	2.83
Q8 Diverse clinical staff	3.16
Q9 Diverse support staff	3.21
Q10 P&P re culture	3.17
Q11 Interpreters evaluated	3.14
Q15 Interpretation available	3.04
Q24 BHS hiring is cultural competence	3.14
Q37 Approval for serving divers easy	3.23
Q39 BHS provides cultural training	3.12
<b>Item mean</b>	<b>3.09 (alpha 0.94)</b>
Factor 2: Attend/value cultural activities	Mean
Q22 Attend cultural functions	2.50
Q23 Attend Cultural Competency open house	1.76
Q26 Cultural competence trainings valuable	3.28
Q27 Cultural competence trainings useful	3.12
<b>Item mean</b>	<b>2.67 (alpha 0.70)</b>
Factor 3: Cultural competency practices by clinical staff	Mean
CL1 Reports at consumer level	3.59
CL2 Intervene with client slurs	3.41
CL3 Home visits - learn culture	3.35
CL7 Cultural competence is part of Treatment Plans	3.08
CL8 Aware of cultural competence EBT <sup>2</sup>	3.26
CL9 Understand how culture affects client symptoms	3.57
CL10 Understand cultural/MI attitudes	3.58
<b>Item mean</b>	<b>3.41 (alpha 0.83)</b>

<sup>1</sup> Using SPSS software. Extraction method: Principal component analysis. Rotation method: Oblimin with Kaiser Normalization

<sup>2</sup> Evidence Based Treatment

Factor 4: BHS environment reflects cultural competence	Mean
Q34 Report/notices culturally appropriate	3.30
Q35 Decor reflects culture	3.07
Q36 Brochures reflect culture	3.43
<b>Item mean</b>	<b>3.27 (alpha 0.74)</b>

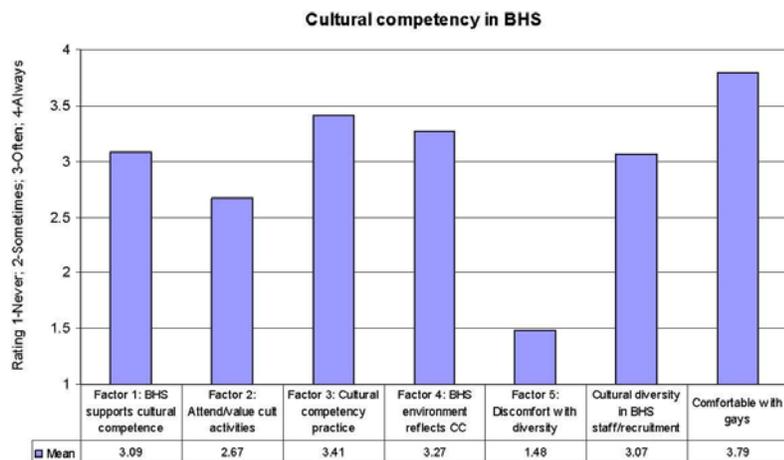
Factor 5: Discomfort with diversity	Mean
Q29 English/education relationship	1.71
Q30 Diversity causes problems	1.34
Q32 Bothered by foreign language	1.55
Q33 Uncomfortable with diversity	1.32
<b>Item mean</b>	<b>1.48 (alpha 0.61)</b>

**Cultural diversity in BHS staff and in the recruitment practices of BHS**

Items Q7, Q8, Q9 and Q24 together appear to measure the cultural diversity in BHS personnel and recruitment practices of BHS although they did not surface as a factor during factor analysis.

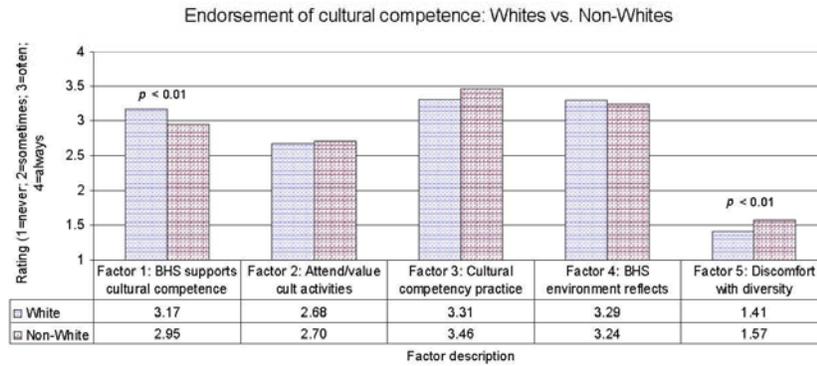
	Mean
Q7. BHS recruits culturally diverse managers/administrators	2.80
Q8. BHS recruits culturally diverse clinical staff	3.13
Q9. BHS recruits culturally diverse support staff	3.20
Q24. Personnel recruitment, hiring and retention practices of BHS demonstrate ethnic diversity/cultural competence	3.16
<b>Item mean</b>	<b>3.07</b>
<b>Cronbach's alpha</b>	<b>0.89</b>

**A graphical representation of mean staff ratings for the five factors and other closely related items**

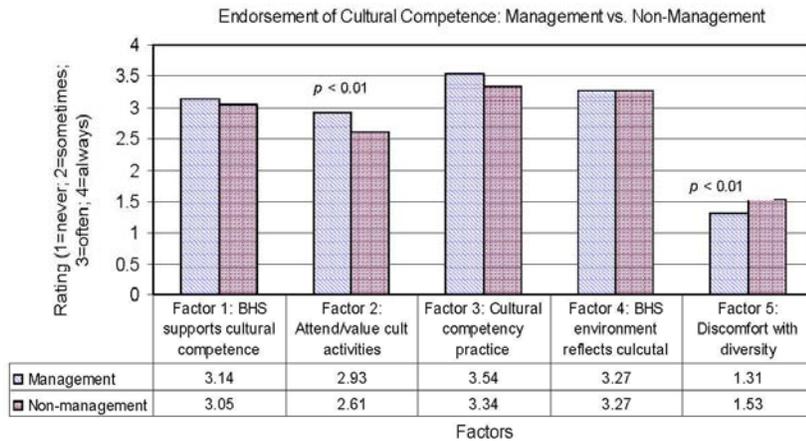


The cultural competency in BHS is shaped by at least five distinct areas as illustrated by the five extracted factors. The response pattern for three of the five factors significantly differed according to certain demographics.

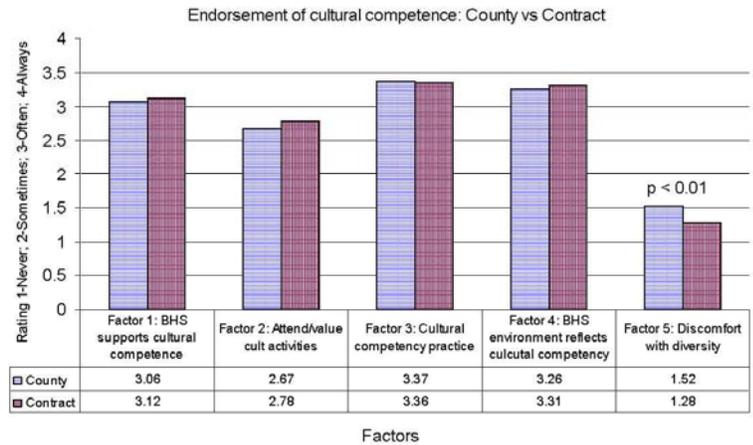
**Whites are more likely than non-Whites to believe that BHS supports cultural competence and have less discomfort with diversity.**



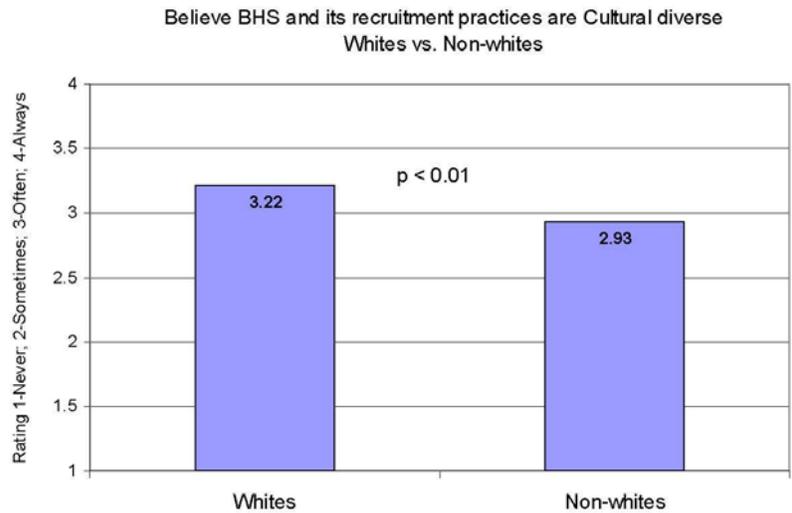
**Managers are more likely than non-managers to attend cultural activities and have less discomfort with diversity**



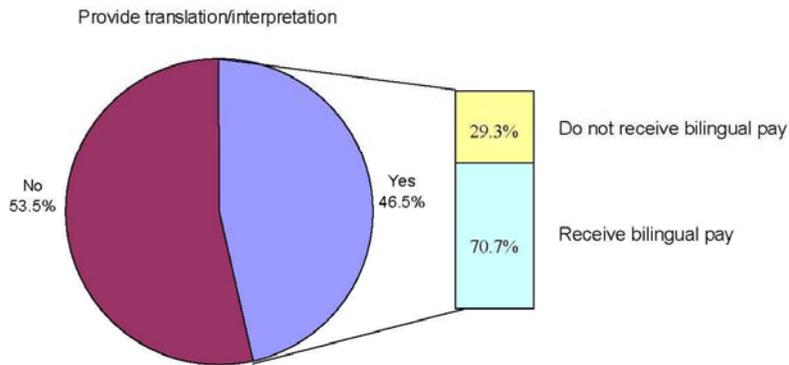
**Contract BHS staff show less discomfort with diversity than their County BHS counterparts**



**More Whites than non-Whites believe that BHS and its recruitment practices are culturally diverse**

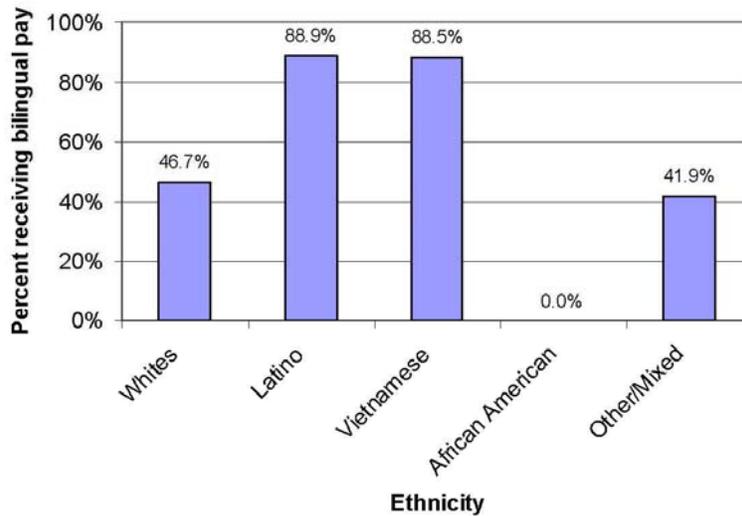


**Close to 50% of the BHS staff provide translation/interpretation services, and over two-thirds of them receive bilingual pay**

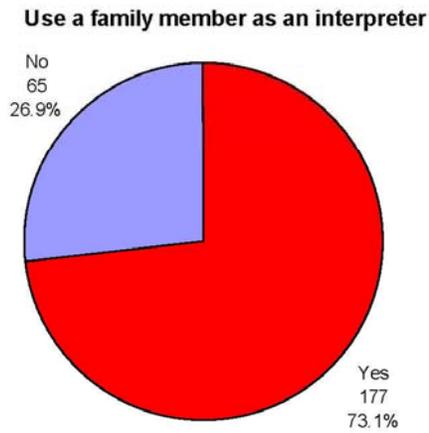


**Nearly 90% of Latinos and Vietnamese who provide translation/interpretation services receive bilingual pay**

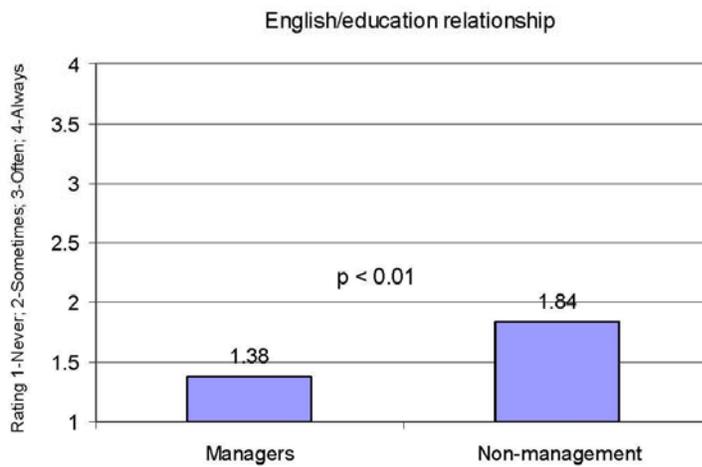
**Bilingual pay distribution according to ethnicity**



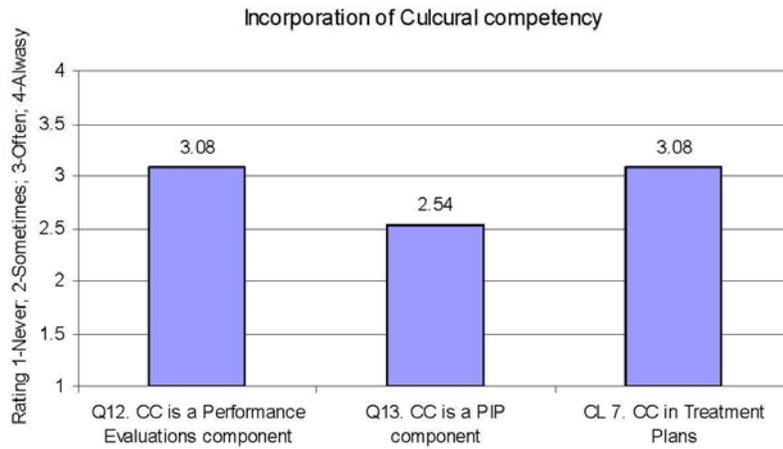
**Almost three-fourths of clinicians use a family member as an interpreter at least sometimes**



**More non-management BHS staff believe in a direct relationship between one's ability to speak English and his/her education level**



**Incorporation of cultural competency into employee evaluations and Treatment Plans written by clinicians**



**Summary**

Current BHS workforce, although fairly culturally diverse, is in need of improvement in various areas of cultural competency. Managers/supervisors should encourage and facilitate their staff to attend various cultural activities hosted by BHS. These activities should be centrally located to promote a wider BHS staff participation. Among all the ethnicities, Whites expressed less discomfort with diversity. They also believe that BHS supports cultural diversity and that its recruitment practices are culturally diverse. Contract BHS staff expressed less discomfort with diversity in comparison to County BHS staff.

Nearly 90% of staff who provide translation/interpretation services in a threshold language, receive bilingual pay. Despite this nominal financial compensation the use of a family member as an interpreter appears to be quite common among the clinicians suggesting that the availability of interpretation services might not be sufficient. This practice in itself raises many more questions regarding ethics and policy. There is a small but significant percentage of staff who believe a direct relationship exists between ones' ability to speak English and his/her educational level. The formatting of the question itself leads to additional questions. The speaking of English with an accent does not correlate with educational attainment other than when a child/person learned English- the age of English learning is what contributes to the degree of accent present- not intelligence or education. While it is true that English language acquisition and fluency are correlated with educational level, although in varying degrees that differ with both immigration history and language spoken at home. There is virtually no difference in 18-24 year olds who enroll in postsecondary education with regards to educational attainment, whether they spoke English at home or not. 11% of English only speakers and 10% of language minorities obtain a BA. Differences do persist for young adults who spoke Spanish at home- they were less likely than all other language minorities to have completed some college or received a BA. Additionally, the shorter ones time in the U.S, the less likely a person is to attend college regardless of language spoken. Studies have been done on refugee English skills which positively correlate to educational level. The refugee population in the U.S. is far less than the immigrant population, 100,000-150,000 compared to 700,000. Additional training and study should take place to determine the need for bilingual positions to meet the needs of monolingual consumers/families as well as to help staff better understand language regulations and the BHS policy and procedures regarding use of interpreters.

Thus, it is clear that the entire BHS is in need of additional training in cultural competency, and the future trainings should be targeted to the management and the non-management staff separately to address their respective weaknesses in cultural competency. Managers/supervisors should be encouraged and trained to incorporate cultural competency as a component of employee evaluations and performance incentive plans. This practice, in turn, might encourage the employees to have a greater appreciation for the cultural diversity/competency in the workplace.

**Mean score for each of the items on the questionnaire**

Item #	Item description	N	Mean
CL1	I take care to write reports or any other form of written communication in a style and at a level which clients, families, and other program participants will understand	280	3.58
CL2	In group therapy or other treatment situations, I intervene when clients use racial and ethnic slurs by helping them understand that certain words can hurt others	266	3.36
CL3	When I visit or provide services in a client's home or community, I learn about acceptable behaviors, courtesies, customs and expectations that characterize families of the specific cultures and ethnic groups I am serving	258	3.31
CL4	An interpreter is available to me when I see a client who only speaks a threshold language	253	3.01
CL5	When an interpreter is not available to me, I use a family member/friend as an interpreter	242	2.67
CL6	An interpreter is available to me when I treat clients using American Sign Language	214	2.23
CL7	I incorporate cultural competence into the Treatment Plans I write	257	3.08
CL8	I am aware of evidence of treatments that work effectively with people from diverse cultures	283	3.19
CL9	I understand how culture can affect the presentation of symptoms of clients I see	291	3.53
CL10	I am aware of culturally based attitudes toward mental illness and mental health services in the clients I see	289	3.55
Q1	Our agency provides resources required to promote cultural competence	519	3.16
Q2	Participants for advisory committees and councils reflect diverse cultural representation of Orange County	413	3.00
Q3	Our agency provides resources required for translational/ interpretational needs	511	3.15
Q4	Clinical services are routinely reviewed in terms of providing services to clients and their families in culturally competent ways	459	3.05
Q5	Students/interns/trainees are vigorously recruited from diverse cultures	427	2.94
Q6	Representatives of the diverse cultures who make up our client population actively participate in the planning and presentation of training activities	405	2.64

Q7	Our agency recruits culturally diverse managerial/administrative staff	461	2.83
Q8	Our agency recruits culturally diverse clinical staff	495	3.15
Q9	Our agency recruits culturally diverse support staff	498	3.19
Q10	Our agency has established Policies & Procedures to address personnel issues concerning culture/race/ethnicity/language	442	3.18
Q11	Interpreters/translators (i.e. staff receiving bilingual pay) are evaluated for their respective language proficiency	410	3.16
Q12	Cultural Competency is a component of my performance evaluation	458	3.08
Q13	My PIP/MPP goals involve a component related to cultural competence	424	2.54
Q14	My supervisor supports my desire to host and/or participate in cultural celebrations as long as they do not interfere with my work.	442	3.31
Q15	Translation and interpretation assistance are available to me when needed	463	3.09
Q16	I provide translation and/or interpretation services	458	1.98
Q17	I have observed/encountered behaviors that appear culturally insensitive or racially discriminative	497	3.19
Q18	When I observe other staff within my program engaging in behaviors that show cultural insensitivity, bias or prejudice, I bring it to their attention or otherwise intervene in an appropriate manner	432	2.68
Q19	I encounter interpersonal issues related to race/language/culture at work place	470	3.11
Q20	I am comfortable working with co-workers who are gay/lesbian	526	3.79
Q21	I can report culturally sensitive work related issues to my supervisor without the fear of retaliation	509	3.46
Q22	I attend cultural group functions (i.e. Cinco de Mayo) organized by Agency employees	481	2.51
Q23	I attend open house events hosted by HCA Cultural Competency department	479	1.73

Q24	Personnel recruitment, hiring, and retention practices of our agency demonstrate ethnic diversity and cultural competence	464	3.16
Q25	I seek guidance from others to make sure that important work related decisions I make are culturally competent	483	3.00
Q26	I can learn something valuable by attending cultural competency related trainings	511	3.28
Q27	Attending additional cultural competency related trainings will be useful to me	494	3.13
Q28	I feel it is inappropriate for HCA to provide services in languages other than English.	508	3.37
Q29	I believe there is a direct relationship between one's ability to speak English and his/her educational level	483	3.27
Q30	I believe individuals from diverse cultures/ethnicities are responsible for most of the social problems that exist today	489	3.66
Q31	I believe fluency in English should be a requirement for holding managerial/supervisory positions in our agency	508	2.01
Q32	It bothers me when I hear others speak in a language that I do not understand	506	3.44
Q33	I feel uncomfortable when I am around people from culturally diverse backgrounds	506	3.68
Q34	The reports, appointment notices, telephone message greetings, etc., which I use are culturally and linguistically appropriate for the populations I serve	484	3.28
Q35	Clinic notices and décor, such as pictures, posters, forms and other printed materials reflect the culture and ethnic backgrounds of the clients and families served by my program	453	3.06
Q36	Agency brochures, service descriptions, posters, policies and procedures, fact sheets, forms and other printed materials in clinic waiting rooms are available in threshold (Spanish & Vietnamese)languages	482	3.42
Q37	Obtaining approval from my supervisor(s) to initiate changes that will better serve clients from diverse cultures is easy	465	3.25
Q38	After hours voice mail system in my program contains an informative greeting in all threshold languages	398	2.51
Q39	Our Agency provides formal training to clinical staff on how to appropriately interact/communicate with clients from diverse cultures/ethnicities	467	3.07
Q40	Outreaching to ethnic/linguistic groups in the community takes place to recruit clients from diverse cultural backgrounds	399	2.93

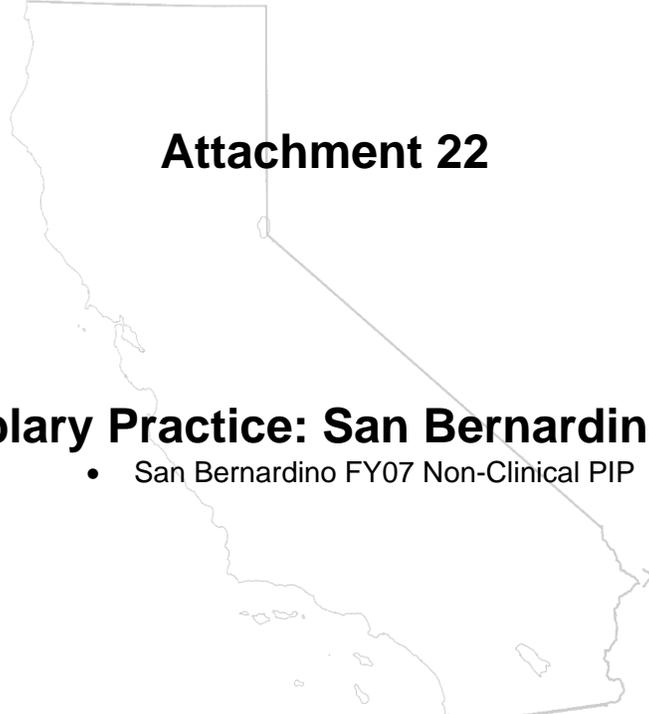
<b>Validity Items</b>		<b>N</b>	<b>%</b>
VL1	Our agency serves more than one ethnic group	512	77.9 % responded Never
VL2	I speak English well enough to converse with clients and co-workers	516	93.4% responded Always
VL3	Persons belonging to certain ethnic groups are not allowed to obtain services at this Agency.	491	92.7% responded Never
VL4	I attend the annual Blue Ribbon Diversity Celebration.	441	86.2% responded Never
VL5	There are no resources available for the clients seen by this Agency.	442	76.9% responded Never

**Demographics**

D1	Who is your employer?
D2	What division do you work for?
D3	What is your ethnicity? Caucasian/White, African-American, Latino, Vietnamese, Other Asian, Other-please specify
D4	Do you receive bilingual pay?
D5	What is your gender?
D6	Are you a manager/supervisor?
D7	Are you a clinician?

Legend: CL= items for Clinical staff only, VL=Validity items

**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**



**Attachment 22**

**Exemplary Practice: San Bernardino MHP**

- San Bernardino FY07 Non-Clinical PIP



## Performance Improvement Project

### Victor Valley Behavioral Health Center Wait Time Improvement Project

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

The stakeholders involved in this project represent concerned family members and clients, as well as DBH staff, who have voiced their concerns about the process of initial intake, as well as concerns about a lack of client focus, long wait times, and the requirement of multiple clinic visits prior to seeing a treatment staff member. Treatment staff and DBH Administrators have worked together to develop and implement this Performance Improvement Project with the help of the outside consulting agency The Coleman Associates.

The primary stakeholders in the project are the DBH Director, Assistant Director, Medical Director, Deputy Director and the Program Manager, Supervisors and treatment staff at the Victor Valley Behavioral Health Center, as well as clients and their family members.

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.

This project was developed because of growing concerns from clients, families, treatment staff and administrators about two things: the waiting period from the time a client enters the clinic to the time they would leave the clinic, as well as the need for multiple visits to complete the initial intake process. Pre-Redesign clients either waited in excess of two to four hours to be processed for an initial screening, or were to asked to make return visits to complete the Clinical Assessment in a separate visit. It is suspected that this delay of entry into treatment was contributing to the "no-show" rate seen from initial screening to intake.

Wait times for the first service are addressed in the MHP and the Redesign was geared to make that a more effective, timely, and satisfactory process for both the clinic staff and clients. The consumer populations affected by the Redesign would be an individual of any age who is requesting mental health services who meets medical necessity criteria as established by the State of California Medical regulations.

3. 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?

Baseline data were established via a period of preliminary observation and data collection regarding current processes for the four visit types: screening, intake, ADS, and doctor visits.

The purpose was to measure the “cycle time” for an initial screening prior to proposed Redesign changes. Cycle time is defined as the time between signing in for a service and the time leaving the clinic with either a referral or a follow-up appointment. Redesign Team Advocates (RTA’s) “shadowed” clients used in testing periods using stop watches from the time they entered the clinic until the time they left (time in, time out) in order to obtain data about wait times and client moves.

#### Pre-Redesign

The Pre-Redesign process represents the period of preliminary observation of current processes and data collection to gain a baseline of data and understanding of it. This process involved evaluation of screenings over a 3 week period in June 2006, during which prospective clients were either screened and referred to the community or screened and given follow-up appointments for both a Clinical Assessment (full intake).

Table 1 Baseline data collected Pre-redesign (Test 1 and 2)

Day	Number of Clients Seen	Type of Visit	Average Cycle Time
One	16	Screening and referral only- “first visit”	108 minutes
Two	7	Clinical assessment only “second visit”	113 minutes
Three	10	Screening and referral only	90 minutes
Four	3	Screening and referral only	51 minutes
Five	No clients entered triage during testing hours	N/A	N/A
Six	6	Clinical assessment only – “second visit”	210 minutes

The redesign process consisted of five phases:

1. Understand your current processes (observation and baseline data collection).
2. Redesign on paper: The team gathered knowledge of Redesign at Learning Session and created, on paper, a model they would test.
3. Rapid Redesign Testing: The team did a series of tests to try their model ideas, adjusting and changing based on findings of one test then testing again.
4. Trial Run: The best model from previous trials was then implemented. This is the model the team is currently working with.
5. Implementation clinic-wide.

Redesign tests implemented numerous logistical changes that included:

- Use of Walkie-Talkies to facilitate communication
- Moving of the POS machine
- Use of copier up front to expedite the F/I process
- Reducing the number of times a client is moved from one location to another in the intake process

- Addition of “back-up” or “duty officer” staff to assist with the intake process
- Provision of special functions, such as language translation or referral for ADS services.

Additional adjustments include expediting the Financial Interview (FI) call, improving confidentiality (which involved rearranging the lobby area, eliminating the sign-in log, and moving the FI out of the lobby area), and training with front desk staff to perform more as a team.

**Redesign In-Process** (refer to flip charts)

Time studies of various changes yielded the following results:

Redesign cycle times include a combined averaging of cycle times for all visits involving an initial request for service, including those who received a screening and referral only as well as those who received a combination of screening and Clinical Assessment (“combination” visit).

Data is separated out for those who received screening and intake for tests 9 and 10.

Table 2 Data collected during Redesign process

Day	Number of Clients Seen	Type of Visit	Average Cycle Time
One	No walk-in's	N/a	N/a
Two	8	Combination of “screening and referral only” visits and “screening/Clinical Assessment” visits	79 minutes
Three	3	Combination of “screening and referral only” visits and “screening/Clinical Assessment” visits	96 minutes
Four	13	Combination of “screening and referral only” visits and “screening/Clinical Assessment” visits	155 minutes
Five	No walk-in's	N/a	N/a
Six	7	Screening and referral only	115 minutes
	3 of 7	Screening and clinical assessments “Combo Visits”	141 minutes
Seven	8	Screening and referral only	84 minutes
	3 of 8	Screening and clinical assessments “Combo Visits”	140 minutes

*Note: Testing showed that the “combo” visit could be accomplished in the same amount of time that just the screening visit took. In other words, one visit could fulfill the requirements usually needing two visits to accomplish.*

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

Problem/Barrier	Data examined to validate the problem/barrier
Difficulty processing prospective new clients in an efficient manner without either excessive wait periods or the need for multiple return visits.	Testing established a “baseline” data, measuring the “cycle time” for an initial visit prior to proposed redesign changes:  “Cycle time” is defined as the time between signing in for an initial visit and the time leaving the clinic with either a referral or a follow-up appointment (time in, time out).

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.

“How can we accommodate initial requests for service on a Walk-In basis without either making the time between sign-in and departure from the clinic excessive or causing people to make multiple return visits for screening, Clinical Assessments, and first treatment visit?”

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

The PIP includes prospective mental health clients who presented at the walk-in clinic on the dates of the pre-testing and the days of “Redesign testing.”

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

The population was represented by 81 Walk-In Clinic consumers with initial requests for MH/ADS services over a 12 week period.

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

The data were gathered by the Redesign team through direct observations and timing of various components of a Walk-In Clinic visit by (81) prospective mental health clients over a 12 week period.

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

No sampling technique was employed; testing of proposed new procedures was scheduled on a random (convenient) basis and was comprised of any individual walking into the clinic seeking mental health services during the testing time frames.

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

See above. Tentative conclusions warrant more extensive testing of the model during the implementation phase.

9. Why were these indicators selected?

Table 3 Indicators, Baselines and Goals

#	Indicator	Numerator	Denominator	Baseline for indicator	Goal
1	Time between sign in to the clinic and time of departure from the clinic with follow up appt in hand	572	42 clients (number of clients seen)	13.6 minutes	10% improvement
2	Client Satisfaction with the way that that service is received by clients	24 client survey returned	20 client survey with positive feedback 4 with negative feedback	.83	20% improvement

In the initial phase of this project, the staff used these indicators to measure the effectiveness of the interventions.

Indicator 1 (time in, time out) measured the average cycle time from the point where the client signed in to the point when the client left with either a referral to another facility or follow up appointment. This indicated whether or not there was improvement on the wait time.

Indicator 2 (client satisfaction) was conducted Redesign phase to measure overall client satisfaction. The need for this was discovered during the Redesign process, so no Pre-Redesign satisfaction surveys (only verbal complaints) had been done.

These indicators were selected because they address the goals for the project and address the problems clients are dissatisfied with.

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

Reducing the cycle time (time spent by client in accessing services) will improve client satisfaction (due to clients receiving requested services the same day) and may improve outcomes from subsequent treatment, which can be measured at a later time when implementation takes place. Client surveys directly measured consumer satisfaction in those two areas.

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 4

Number Of Intervention	Specific Intervention	Barrier or cause intervention is designed to target	Dates Applied
1	Physical Plan Changes made to lobby and triage area	This intervention addressed the problem of flow, confidentiality, and client satisfaction	June 2006
2	Combine Intake and Screening process	The intervention addressed the excessive wait time and return visit problem for initial intake	June 2006
3	Create the children's play area	Created a play area for children while clients waited	June 2006
4	Technology relocation – make POS and copy machine more accessible	This intervention made Medi-Cal verification and copying more accessible for Office staff	In process

11. Describe the data to be collected.

The data is collected in two separate stages. Data has been collected before Redesign and during testing. The data is the measurement of average cycle time for initial visits and the number of clients seen within the period of testing hours.

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

The Redesign team, made up of Clinical staff and administrator, is responsible for collecting that data. This data will include:

- a. Pre-Redesign test duration (in hours)
- b. Rapid Redesign test duration (in hours)
- c. Number of care teams
- d. Total number of clinical hours
- e. Total number of clients seen
- f. Type of visit (Screening only or combo visit-screening and intake)
- g. Average Cycle Time (in minutes)

Baseline information was obtained initially from the DBH Information System (SIMON) before Pre-Redesign testing was initiated. This information was used to set up the Pre-Redesign, and can be used for comparative purposes at a later point. This PIP focused on comparing data from the Pre-Redesign and Redesign time frames.

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

The Redesign team will continue to measure, test, and evaluate the average cycle times and compare the changes from before, during redesign, and for the implementation process (beginning October 19, 2006). The first step in analysis will be to establish the range (min-max) and overall mean time of initial contact visits. When implementing the Redesign, the team will collect testimonials from both clients and staff to understand the overall impact of the project through further surveys to clients and staff. The RTA's are also holding weekly meetings with staff to facilitate feedback and training and to allow for further ideas and/or successful modifications of the process.

Untoward results of the Redesign could arise from poor collection of data or misinterpretation of data based on the collection method. This has not been a problem to this point due to the training that was provided by The Coleman Associates, an outside consultant group helping to improve the collection process. The Coleman Associates will continue to provide consultation during the implementation process.

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

The staff members that will be collecting data are the Redesign Team Advocates (RTA's), along with leadership from the DBH Administration, the DBH Desert/Mountain Management team, and The Coleman Associates; the consulting team assisting with the Redesign. DBH Desert/Mountain Manager/Supervisors selected the RTA's for their technical or functional expertise, problem solving, decision-making skills, and interpersonal skills. The RTA works directly with clinic staff to accomplish the goals of Redesign. The consulting group works directly with DBH Desert/Mountain management and the RTA's to provide support and suggest changes.

The DBH Desert/Mountain Management/Supervisors, the RTA's, and the Coleman Associates have been and will provide further information and data to the larger DBH Administration via scheduled meetings so Redesign can be considered for Department-wide implementation.

**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?**

In order to obtain accurate data, the RTA team appointed a designated observer that was positioned in the clinic to capture all movements (changes in location) the clients made. Total cycle times began when the clients entered the clinic to the time they exited the clinic. Other data

gathered included the separate cycle times for a screening only visit, for a same-day intake, total wait time (non-value time) and total time spent with a clinician (value time).

The analysis occurred as planned.

As a result, major physical changes to the clinic lobby and office area were made, with some changes still pending. Further changes to the screening/intake process were developed in order to streamline the process and reduce wait times and client moves. Improved results did occur as hoped.

Other QI focuses occurred. Seemingly long cycle times for “client wait time” triggered special data of average wait times for the client in different scenarios, such as averages of wait times in the lobby, for the FI process, and for paperwork completion times (non value times).

It also triggered the need for surveys of both staff and clients in order to obtain satisfaction and feedback information.

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

	Dates of Baseline Measurement	Baseline measurement (num / denom)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement (num / denom)	% improvement achieved
1	June 2006 Screening only Total cycle time and Intake only total cycle time	249min/ 29 cl.- Pre-Redesign screen only and 323 min/ 13 cl Pre-Design Intake only  **Done in 2 visits within 2 weeks**	10%	June-August 2006 Combined screening/intake	June – August 2006	611 min/ 39 cl. – combined screen /intake during testing  **Done in one day**	Client was able to complete in one day what used to take 2 days. Time spent at clinic reduced nearly 50%.
2	N/A Client satisfaction	0	20%	June – August 2006 Satisfaction Surveys	June- August 2006	56/47 47 positive 9 negative	84% approval rating

**17. Describe issues associated with data analysis:**

No Client satisfaction surveys were done Pre-Redesign.  
Client satisfaction rates were only obtained during the Redesign measurement period.

Data cycles clearly identify when measurements occur.

N/A

Statistical significance

N/A

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

Physical clinic changes to improve staff access, client comfort, and confidentiality were made, and received positive feedback from both populations.

The Combined screening/intake service was perceived by clients as more satisfactory and also reduced total cycle times by \_\_\_%.

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

N/A

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

The project is a "work in progress" and has been considered successful. Future implications look promising.

Part of the Redesign process has been to focus on the following areas: Reception, Triage, Intake, Alcohol and Drug Services, and Cultural Issues.

Some of the goals in the Reception area were to improve confidentiality, eliminate sign in sheets, improve Office Assistant multi-tasking, eliminate clutter, and create a play area in the lobby. In Triage, the plan was to combine screening and intake and complete the financial interview. Redesign also integrated the ADS component of the clinic, which reduced wait times, added a duty officer, and implemented the same day intake procedure for those services. It improved the communication between MII and ADS staff. An interpreter was provided as needed.

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?

Baseline methodology for Pre-Redesign and during Redesign were consistent for the measurement of wait times and total cycle times. However, there was no Pre-Redesign baseline measurement of client satisfaction besides the verbal complaints that had been previously received. Further Client Satisfaction surveys will be used as the implementation process occurs to see if further modifications are needed.

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

Data analysis demonstrates improvement in the process by confirming shorter wait times, eliminating the “no show” rate for the intake, and increasing client satisfaction. More time in the implementation phase is needed to determine if treatment was perceived by clients as more successful due to wait times and total cycle times having been reduced.

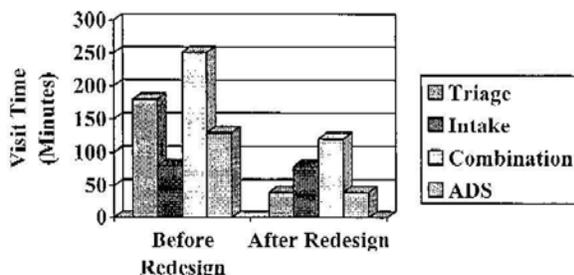
21. Describe the “face validity” – how the improvement appears to be the result of the PIP Intervention(s).

The intervention appears to have made a significant difference in the process from beginning to end. The PIP seems to have positive results as it shows in the data. Average cycle times have decreased from an average of 237 min in two days to an average of 120 minutes in one day.

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

Please see the charts below and refer to Post-redesign tables in question three.

**Rapid Re-Design Test Statistics**



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

The improvements have remained positive and further testing is being undertaken as more of the interventions are measured and completed during the implementation process. This project is still in its initial trial and error phase, and the RTA team is working closely with the Coleman Group consultants, DBH Administration, clinic staff, and clients to further evaluate the problems and implement new solutions.



**Baseline (Pre-Redesign) Data Sheet**  
**Victor Valley Behavioral Health Center**

**Productivity Data/No Show Rates/Other Data**

<u>Data Element</u>	<u>Pre-Redesign Average</u> (Last three months averaged per provider per hour)
Productivity (Intake Appts)	1.66 Consumers per hour 21.4% No-show rate
Productivity (Walk-In Visits)	1.3 Consumers per hour
Productivity (Doctor/Other Appts)	2.5 Adult Consumers per hour per provider 1.5 Child Consumers per hour per provider 16.7% No-show rate: Adult – 55.8% No-show rate: Child
Productivity (ADS Appts)	1.42 Consumers per hour per provider 27% No-show rate

<u>Other Data</u>	<u>Average</u>
Current average length of time between: * First visit (screening) and Intake appointment * Intake appointment and doctor/other appointment	* 2 days to 11 days * 36 days
Number of consumers sent flows to the Victor Valley Community Health Center during the month of April	100 consumers
Number of Emergency Team calls during the month of April	47 calls



**Baseline (Pre-Redesign) Data Sheet  
Victor Valley Behavioral Health Center**

Data Element	Pre-Redesign Average
<b>Cycle Time (Intake Appointments)</b> Average cycle time (in minutes) for Intake visits	3 Total Number of Consumers 136 Average Minutes
<b>Cycle Time (Walk-In Visits)</b> Average cycle time (in minutes) for Walk-In visits.	6 Total Number of Consumers 101 Average Minutes
<b>Cycle Time (Doctor/Other Appointments)</b> Average cycle time (in minutes) for Doctor/Other visits.	27 Total Number of Consumers 30 Average Minutes
<b>Cycle Time (ADS Screening Appointments)</b> Average cycle time (in minutes) for ADS visits.	17 Total Number of Consumers 97 Average Minutes

**GEMS Results Table**  
**Victor Valley Behavioral Health Center**  
**Area Of Focus: Triage Process**

	Baseline	Gem 1	Gem 2	Gem 3
<b>GEM Duration (in hours)</b>		7 hours	7 hours	7 hours
<b>Number of Staff Involved</b>		7	5	4
<b>Total # Clients Seen</b>		11	9	6
	Screening: 6 Intake: 3			
<b>Cycle Time Average Screening Visit</b>	101 minutes			
<b>Cycle Time Average Intake Visit</b>	136 minutes			
<b>Cycle Time Average Same Day Intakes (Combines Screening and Intake Visit on same day - one stop for clients)</b>		120 minutes	129 minutes	98 minutes