



**Final Report**

**CAEQRO Report, FY10-11**

**San Bernardino**

**Conducted on**

**November 3-5, 2010**



## ❖TABLE OF CONTENTS❖

<b>Introduction</b> .....	4
<b>FY10-11 Review Findings</b> .....	5
Status of FY09-10 Review Recommendations.....	5
Changes in the MHP Environment and within the MHP .....	8
Performance & Quality Management Key Components .....	12
<b>Current Medi-Cal Claims Data for Managing Services</b> .....	18
Race/Ethnicity of Medi-Cal Eligibles and Beneficiaries Served .....	18
Penetration Rates and Approved Claim Dollars per Beneficiary .....	21
Medi-Cal Approved Claims History .....	24
Medi-Cal Denied Claims History .....	24
High Cost Beneficiaries.....	25
<b>Performance Measurement</b> .....	27
<b>Consumer and Family Member Focus Groups</b> .....	27
<b>Performance Improvement Project Validation</b> .....	32
Clinical PIP .....	32
Non-Clinical PIP .....	34
<b>Information Systems Review</b> .....	38
<b>Site Review Process Barriers</b> .....	42
<b>Conclusions</b> .....	42
Strengths .....	42
Opportunities for Improvement.....	43
Recommendations .....	43
<b>Attachments</b> .....	46
A. Attachment – Review Agenda.....	46
B. Attachment – Review Participants.....	50
C. Attachment – Approved Claims Source Data.....	54
D. Attachment – Medi-Cal Approved Claims Worksheets .....	56
E. Attachment – CAEQRO PIP Validation Tools .....	72
F. Attachment – MHP PIPs Submitted .....	81

## ❖ INTRODUCTION ❖

### BACKGROUND AND METHODOLOGY

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 fiscal year 2010–11 (FY10–11) findings of an external quality review of the San Bernardino County mental health plan (MHP) by the California External Quality Review Organization (CAEQRO), a division of APS Healthcare, from November 3 to November 5, 2010.

The CAEQRO review draws upon prior year’s findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP’s approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for Key Components associated with the four domains: quality, access, timeliness, and outcomes. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups and other stakeholders serve to inform the evaluation within these domains. Detailed definitions for each of the review criterion can be found on the CAEQRO Website [www.caeqro.com](http://www.caeqro.com)
- Analysis of Medi-Cal Approved Claims data
- Two active Performance Improvement Projects (PIPs) – one clinical and one non-clinical – to include the state-required PIP focused on EPSDT youth and another PIP of the MHP’s selection
- Three 90-minute focus groups with beneficiaries and family members
- Information Systems Capabilities Assessment (ISCA) V7

## ❖ FY10–11 REVIEW FINDINGS ❖

### STATUS OF FY09-10 REVIEW RECOMMENDATIONS

In the FY09-10 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY09-10 site visit, CAEQRO and MHP staff discussed the status of those FY08-09 recommendations, which are summarized below.

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### ASSIGNMENT OF RATINGS

- Fully addressed – The issue may still require ongoing attention and improvement, but activities may reflect that the MHP has either:
  - resolved the identified issue
  - initiated strategies over the past year that suggest the MHP is nearing resolution or significant improvement
  - accomplished as much as the organization could reasonably do in the last year
- Partially addressed – Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed – The MHP performed no meaningful activities to address the recommendation or associated issues.

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### KEY RECOMMENDATIONS FROM FY09–10

- Continue to monitor penetration rates, compare to estimated prevalence of mental illness in the community, and address barriers to access and engagement, particularly for underserved populations such as Asian/Pacific Islanders and Hispanics:
 

<input checked="" type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
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- Penetration rates are reviewed on an ongoing basis to assess and plan for community mental health needs. Each year, targeted goals are included in the MHP's business plan, which contains specific outreach-related goals for system achievement. The MHP presented analyses in many settings during the review, including sessions on disparities, access and retention, quality, and outcomes.

- The Office of Cultural Competence and Ethnic Services (OCCES) reviews penetration rates as compared to estimated prevalence in mental health issues in San Bernardino County. In 2009, the MHP began an Access Study for three target populations in the community - African American, Asian/Pacific Islanders (Vietnamese,) and Latinos; the study population consisted of 539 consumers and non-consumers. The resulting Action Plan includes over 70 recommendations for implementation and is discussed in further detail later in this report.
- MHP and contract provider staff reported numerous cultural competence trainings, and informants were well-versed on the many different aspects and definitions of culture. Of particular note, the MHP conducted a training titled “Uno Momento Por Favor” to assist support staff and Spanish-speaking consumers overcome language related barriers during initial contact. The training was developed in response to quality management test calls which demonstrated problems with dropped calls and general confusion; anecdotal reports indicate significant improvement.
- Continue to monitor the impact of process changes to determine whether the needs of foster care youth are being adequately addressed and that any improvements are sustained:
  - Fully addressed
  - Partially addressed
  - Not addressed

The MHP utilizes multiple strategies to increase access to services for foster children. The following strategies will continue to be monitored for sustainability as the MHP continues its collaboration with San Bernardino Child and Family Services (CFS) and explores additional efforts to increase access:

- The MHP continues to use the Universal Referral Form (URF) that was collaboratively developed by DBH and CFS to initiate referrals to the MHP, as well as the “Reference Workbook for CFS Staff” that was designed to assist CFS staff identify the most appropriate referral program. Since June 2009, the workbook has been presented at 36 different meetings with CFS staff or foster parents.
- CFS and DBH staff meet regularly, both at the programmatic meetings to address broad issues and at the direct service level to focus on the needs of specific children and youth.
- Through the MHSA Prevention and Early Intervention (PEI) programs, MHP clinical staff are available for consultation and attendance at Team Decision Meetings (TDMs) which address pressing needs of existing foster children or those being considered for entry. The MHP has increased this level of collaboration; during FY09-10 DBH clinical staff attended 100 TDMs, and in July and August of FY10-11 there had already been 53 TDMs attended by DBH staff.
- Several additional programs address the mental health needs of foster children but are not reflected in Medi-Cal claims data.

- In collaboration with juvenile justice, the MHP operates a Forensic Adolescent Services Team (FAST) which provides mental health services to detained youth. During FY09-10, FAST provided services to 3,716 of the 4,409 youth that were detained in the county. None of these services were billed to Medi-Cal.
  - CFS contracts for mental health services for foster youth that are independent of Medi-Cal. In FY09-10, CFS facilitated the provision of mental health services to 923 children and youth, and to 2,142 families and parents.
- Address the increasing Medi-Cal revenue shortfall caused by not being able to submit claims for Medicare/Medi-Cal eligible beneficiaries because of unresolved statewide policy issues:
- Fully addressed                       Partially addressed                       Not addressed
- The MHP implemented SD/MC Phase II as of Feb 1, 2010 and is now successfully producing Phase II claims on a monthly basis, which includes Medicare claiming.
  - Claim volume and revenue are equal to or exceed levels from SD/MC Phase I targets.
  - The MHP continues to collaborate with vendors, DMH, and other counties to further stabilize and make routine this complex implementation.
  - Due to the implementation of SD/MC Phase II, traditional SD/MC Phase I error rates are not suitable for comparison. The MHP has maintained a historically low error rate. However, during the first period of implementation, errors were due to several factors associated with aligning State, software vendors and county systems. This coordination is proceeding well.
- Increase attention to issues of service capacity and timeliness, particularly for access to psychiatric services. Share workflow processes and timeliness data across sites, and examine processes for opportunities for improvement:
- Fully addressed                       Partially addressed                       Not addressed
- Timelines and access issues are being addressed on several different levels, from global system reform to localized operational issues addressing wait times at the clinic level.
  - The MHP emphasized, and several independent focus groups validated, that a system of Crisis Walk In Centers (CWIC) combined with regular walk-in access for urgent needs is in place and fully operational. Additionally, a mobile Community Crisis Response Teams is operating in all districts of the County on a 24-hour, seven-days-per-week basis; clients with urgent needs can be seen at any time.
  - The following are three examples of MHP efforts to monitor wait times:
    - The Dashboard report, which is completed quarterly and shared department-wide and in numerous venues, details various timeliness measurements. Over the past four quarters, 85% of consumers (30,502) were seen within 1-14 days of

- their registration for routine appointment requests, with 7% being seen within 15-29 days and approximately 7% within 30-60 days.
- In August 2010, the Research and Evaluation (R&E) unit, in consultation with Quality Management Action Committee (QMAC), completed a psychiatrist appointment tracking analysis on a pilot basis. This pilot effort is expected to expand throughout the system and be reviewed on a quarterly basis. The first version of the new report shows a wide range in wait times, from 3.6 days to 62 days. Each clinic in the pilot used the data to evaluate possible strategies to shorten psychiatry wait times, and immediate action was taken to address staffing shortages at the clinic with the longest waits.
  - Also initiated in August, the department is beginning to review data generated out of the scheduler as related to overall appointments and no-shows.
- Provide more access and training to program managers who continue to need more access and training on how to use reports as management tools:
    - Fully addressed       Partially addressed       Not addressed
  - R&E staff have conducted group meetings and met individually with Program Managers to provide technical assistance and better understand data needs of programs as well as how they use existing reports. Training has included use of specific critical reports such as volume by reporting unit, clinic case load listings, detail reports on open episodes and a key report on weekly revenue goals by reporting unit.
  - The Dashboard is discussed on a regular basis at the QMAC meetings, an open forum for all staff to give feedback on the report, quality of the data, important indicators, and additional information needed.
  - Despite these efforts, there remains a need to continuously publicize and educate the community of users. New reports and innovative technology will continue to be produced; without an assertive outreach to staff, these valuable resources will not be optimally used.

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## CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

Changes since the last CAEQRO review, identified as having a significant effect on service provision or management of those services are discussed below. This section emphasizes systemic changes that affect access, timeliness, quality, and outcomes, including those changes that provide context to areas discussed later in this report.

- The MHP Director was appointed Interim Director for Public Health, filling both roles, Director of DBH and DPH concurrently. Additionally, the department hired a new Assistant Director.
- The MHP is in the middle of a multi-year, strategically planned transformation of the service delivery system; between 200 and 300 staff and stakeholders have been involved in planning this shift. Initial stages included a redesign of existing key processes to simultaneously address fiscal solvency and a more effective promotion of individual wellness and recovery for consumers, from initial access to appropriate “discharge” into the community. Leadership meets weekly to address these issues; meaningful commitment and progress was evident through document review, informant interviews, and site reviewer observations.
- The MHP implemented Project Impact, a benefits assistance project aimed at increasing benefits acquisition for eligible consumers. Piloted in Upland as a team approach that involved intra-agency collaborations, a dedicated team successfully assisted 177 out of 447 clinic consumers in obtaining benefits. After in depth analysis of staffing patterns and outcomes, the MHP plans to roll out the project department-wide.
- The MHP received the Bright Ideas Award from Harvard for its collaboration with law enforcement and other agencies in its community crisis services available in the High Desert area.
- As part of its cultural competence efforts, the MHP conducts outreach to diverse communities, works with community leaders, and attends such forums as city council meetings, local faith-based services, and community meetings.
  1. Leadership provided examples of successfully returning to communities where relationships with the MHP have historically been broken. Examples of some of the communities where the MHP has actively addressed stigma and behavioral health needs include African American and Latino communities, geographically diverse cultures, military culture, and the deaf and hard of hearing community.
  2. The MHP recently revised its Cultural Competence Plan, in which it identified strategies to reduce disparities, including:
    - Full Service Partnerships targeting underserved and inappropriately served populations, particularly within the African American population
    - Monthly community meetings with several different cultural groups

- Two-tiered interpreter training, for both the interpreter and the staff requesting interpretation
  - “Uno Momento Por Favor” training
  - Institute Elevate: provision of infrastructure development training to small ethnic-specific agencies
  - Development of Promotor training, including culture-based syndromes, in Spanish
  - Exploration possibility of a holistic campus under Innovations planning, to bring healers of all types under one roof
- The MHP provided a Behavioral Health 101 training for community members to support the development of new partnerships by providing tangible, logistical support; over 100 representatives from the community showed.
  - The MHP continues to value workforce development and succession planning. The Internal Leadership Development Academy was scheduled to begin early 2011, in which non-management staff are selected to participate in training to further the leadership skills of this cohort. The MHP partnered with Loma Linda University, utilizing evidence based leadership principles and conducting focus groups of over 600 MHP and provider staff about their perceptions on necessary elements of good leadership.
  - The MHP received the following National Association of Counties achievement awards in 2010:
    1. Assisting and Guiding Consumers to Self-Sufficiency program
    2. Improving the Social, Developmental, Cognitive, Emotional and Behavioral Functioning of Children (Ages 0-5)
    3. License Exam Prep Program: Known as LEEP, this program provides clinical licensing test study materials to pre-licensed staff, including online classes, seminars and books.
    4. CWIC (“Quick”) 24-Hour Crisis Walk-In Centers for Urgent Behavioral Health: The Crisis Walk-In Centers provide urgent mental health services to persons of all ages who are experiencing a mental health crisis. Crisis intervention, case management, medication evaluations, referrals and crisis stabilization are some of the services offered at these locations. Three centers are strategically located in the county, in Victorville, the Morongo Basin and Rialto.
      - The CWIC reports a 96% hospital diversion rate.
      - Same-day medication access is available

- Average discharge time from the CWIC is five to seven hours
- 5. Department of Behavioral Health's Law Enforcement Performs Social Work Electronically: The Crisis Intervention Team Information Technology System provides secure electronic collaboration between law enforcement and Behavioral Health to track outcomes of mental health crisis calls and provide clinical follow-up services to those in need.
- Through the Healthy Homes project, the MHP screens every child who is brought into Foster Care services to determine additional needs, such as academic, health, mental health, and provides recommendations to the Department of Child and Family Services. In the past year, the MHP screened over 800 children through this program.
- Services for Transitional Age Youth (TAY) are expanding.
  1. A 14-bed crisis residential facility is scheduled to open in 2011.
  2. The TAY program will be moving to a building three times its current size.
  3. All 325 Full Service Partnership (FSP) slots are currently full and there are waiting lists. However, each center reportedly provides drop-in services as needed.
  4. There are 55 TAY consumers in MHP-involved supported housing programs.
  5. The MHP has four facilities available to support pregnant and parenting TAY consumers.
- The MHP has increased participation with County-Wide Departments such as Public Health, Health and Human Services, Department of Aging, and Arrowhead Regional Medical Center (San Bernardino's Public Hospital) with regards to systems planning for healthcare reform.
  1. Included in this effort was the opening of a county provider-integrated health clinic similar to the Holt clinic, which has been highlighted in previous CAEQRO reports.
  2. Key MHP staff are meeting with the Inland Empire (primary care providers) to improve transfer/linkages for consumers.
  3. The MHP has established a referral tracking mechanism with the local Federally Qualified Health Centers (FQHCs), to which 100-130 consumers are referred monthly; however, clinical staff report consumer acuity is currently so high that the perception is few FQHC referrals are made.

## PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CAEQRO's overarching principle for review emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management – an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies which support system needs – are discussed below.

### Quality

CAEQRO identifies the following components of an organization that is dedicated to the overall quality services. Effective quality improvement activities and data-driven decision making requires strong collaboration among staff, including consumer/family member staff, working in information systems, data analysis, executive management and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Figure 1. Quality					
Component		Present	Partial	Not Present	Not Rated
1A	A current strategic plan/initiatives drives the service delivery system	X			
1B	Quality management and performance improvement are organizational priorities	X			
1C	Data is used to inform management and guide decisions	X			
1D	Investment in information technology infrastructure is a priority	X			
1E	Integrity of Medi-Cal claim process, including determination of beneficiary eligibility and timely claims submission	X			
1F	Effective communication from MHP administration	X			
1G	Stakeholder input and involvement in system planning and implementation	X			
1H	Consumers and family members are employed in key roles throughout the system	X			

Issues associated with the components identified above include:

- The MHP Strategic Plan includes detailed, measurable goals with actual, target, and estimated results.
- The Quality Improvement Performance Plan (QIPP) includes baseline measurements for each objective. Eight key areas are identified in the QIPP, including access, beneficiary satisfaction, continuity of care, and integration with physical health care.
- The QMAC oversees 12 workgroups that correspond to QIPP key areas, cultural competence, co-occurring disorders, and QI/documentation and review; workgroups are led by Section Chiefs who are ultimately responsible for the implementation, evaluation, and management of the workgroup goals as they pertain to the overall QIPP. Both QMAC and workgroup membership include a diverse cross-section of MHP leadership, staff, contract agencies, and consumers.
- The MHP continues efforts to ensure effective communication throughout the system:
  1. Clinical staff report QI information is disseminated well
  2. The MHP distributes some minutes and agendas, as well as the MHSA CSS Plan Update, in both English and Spanish.
- Staff, consumers, and family members demonstrated consistently high morale and commitment to the service delivery system throughout the site review.
- Consumer employment opportunities have grown substantially in the past few years. Peer Family Advocates (PFAs) are integrally involved in the clubhouses and hold varied roles throughout the MHP, including being on the management team. Full and part time positions are available, as is a meaningful career ladder.

## Access

CAEQRO identifies the following components as representative of a broad service delivery system which provides access to consumers and family members. Examining capacity, penetrations rates, cultural competency, integration and collaboration of services with other providers form the foundation of access to and delivery of quality services.

Figure 2. Access					
Component		Present	Partial	Not Present	Not Rated
2A	Service accessibility and availability are reflective of cultural competence principles and practices	X			
2B	Manages and adapts its capacity to meet service needs	X			
2C	Penetration Rates are used to monitor and improve access	X			
2D	Integration and/or collaboration with community based services	X			

Issues associated with the components identified above include:

- Several QI Workgroups monitor the accessibility and cultural competence of services throughout the delivery system. Examples of workgroup activities addressing these areas include:
  1. Monitoring the appointment system through test calls and “secret shoppers”
  2. Identifying areas of improvement as identified through consumer feedback
  3. Proposing short- and long-term solutions
  4. Conducting outreach activities to underserved and minority populations
  5. Monitoring the implementation of cultural competence plan goals
- The OCCES-sponsored Access study, described at the beginning of this report, began in 2009 and was completed in 2010. The project was implemented in four strategic phases: focus groups, surveys, secondary data analysis of DBH client dataset, and key informant interviews. The three racial/ethnic cohorts were subdivided into two groups – consumers and non-consumers – to evaluate individuals’ and groups’ understanding of mental health services and barriers.
- One of the QI Workgroups is dedicated to monitoring the service delivery capacity of the MHP. Tasks include providing information regarding the current type, number, and geographic distribution of mental health services in the system and monitoring overall capacity. The workgroup participates in county planning purposes to identify expanded service populations, makes

program recommendations based on capacity indicators, and works with R&E to distribute information to program managers and the QMAC.

**Timeliness**

CAEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Figure 3. Timeliness					
Component		Present	Partial	Not Present	Not Rated
3A	Tracks and trends access data from initial contact to first appointment	X			
3B	Tracks and trends access data from initial contact to first psychiatric appointment	X			
3C	Tracks and trends access data for timely appointments for urgent conditions	X			
3D	Has a mechanism to assure timely access (within 7 days) to follow up appointments after hospitalization			X	
3E	Tracks and trends No Shows and implements quality improvement activities to improve overall timeliness to services	X			

Issues associated with the components identified above include:

- The MHP-established timeliness standard for initial appointments is 14 days from the initial request until the first face to face appointment. Currently the MHP conducts test calls to determine relative availability of appointments, and that data is presented to the QIPP. Actual system-wide timeliness data is available and should reported regularly, whereas test call data, while useful, is a reflection of the effectiveness of access but not a valid measurement for actual wait times to be seen for care.
- At the time of the review, the MHP was in the beginning stages of analyzing wait times to psychiatry, including detailed chart review to determine reasons for delays. Preliminary analysis revealed staffing problems in an outlying clinic; the Medical Director re-deployed staff, and re-measurement data was pending. Staff report that it may take six to eight weeks to see a

- psychiatrist; however, staff also reported that consumers with an urgent need to see a psychiatrist are seen the same day. This perception was confirmed by multiple informants onsite.
- The MHP measures timeliness data for urgent appointments through test calls and utilization of crisis walk-in clinics; calls are logged on paper. Data reported shows the MHP meets its 24-hour response time goal, and on site review informants validated this measure is maintained and continues.
  - The MHP does not currently measure the timeliness from hospital discharge to first outpatient appointment, but rather it measures the timeliness from consumer request for outpatient appointment upon self-identifying that they were recently discharged from inpatient services.
    1. At the time of the review, the MHP standard was that providers were to offer an appointment within 14 days of a consumer requesting an appointment and identifying that they had been released from the hospital.
    2. There was no formal mechanism in place to track or notify outpatient services about consumer discharges from inpatient services, nor to assure post-discharge follow-up within a specified period of time.
    3. While some clinics report receiving pre-discharge notice from hospital staff, thus allowing scheduled follow-up appointments to be provided the consumer at discharge, others report “a high proportion of discharges have no follow-up at all.”
  - The MHP is testing and validating their Appointment tracking data which will improve the no-show data integrity, a concern addressed by the MHP.

## Outcomes

CAEQRO identifies the following components as essential elements of producing measurable outcomes for beneficiaries and the service delivery system. Evidence of consumer run programs, viable performance improvement projects, consumer satisfaction surveys and measuring functional outcomes are methods to evaluate the effectiveness of a service delivery system as well as identifying and promoting necessary improvement activities to increase overall quality and promote recovery for consumers and family members.

Figure 4. Outcomes					
Component		Present	Partial	Not Present	Not Rated
4A	Consumer run and or consumer driven programs	X			
4B	Measures functional outcomes of consumers served	X			
4C	Clinical PIP is active and ongoing			X	
4D	Clinical PIP shows post-intervention results			X	
4E	Non-Clinical PIP is active and ongoing	X			
4F	Non-Clinical PIP shows post-intervention results			X	
4G	Utilizes information from DMH/POQI Satisfaction Surveys	X			
4H	Utilizes information from Consumer Satisfaction Surveys		X		

Issues associated with the components identified above include:

- The MHP has an impressive array of consumer-run and consumer-driven programs. There are approximately 12 clubhouses located throughout the county, all but four of which are MHP-run. These programs provide an excellent example of MHP commitment to wellness and recovery principles.
- The MHP developed a level of care assessment tool, based on the LOCUS. There is a proposed treatment structure, but it was not yet in place at the time of the review.
- The MHP last issued the POQI in May 2009, which was the last time DMH distributed the surveys. The MHP looked at carefully selected items and has compared items over many measurement periods. Each site that has consumers responding is provided a report, and individual programs implement changes based on feedback from the report within the last review period. The MHP plans to continue working with the state on the administration of the POQI surveys, in addition to county specific surveys.
- In response to the cessation of administering the POQI survey, the MHP created and distributed a Life Satisfaction Survey. The MHP is currently

- establishing baseline measures for this survey to be used for comparison in future measurement periods.
- The MHP conducts consumer satisfaction focus groups twice annually; the most recent focus group results were being analyzed at the time of the review. Results are distributed to managers.

## ❖ CURRENT MEDI-CAL CLAIMS DATA FOR MANAGING SERVICES ❖

Information to support the tables and graphs, labeled as Figures 5 through 18, is derived from four source files containing statewide data. A description of the source of data and summary reports of Medi-Cal approved claims data – overall, foster care, and transition age youth – follow as an attachment. The MHP was also referred to the CAEQRO Website at [www.caeqro.com](http://www.caeqro.com) for additional claims data useful for comparisons and analyses.

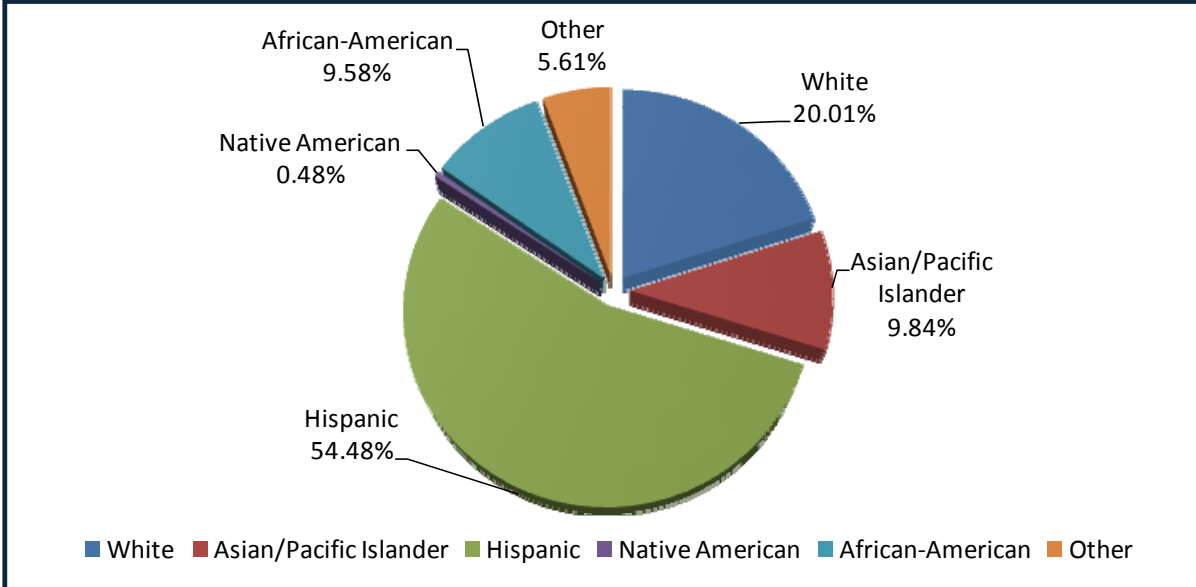
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### RACE/ETHNICITY OF MEDI-CAL ELIGIBLES AND BENEFICIARIES SERVED

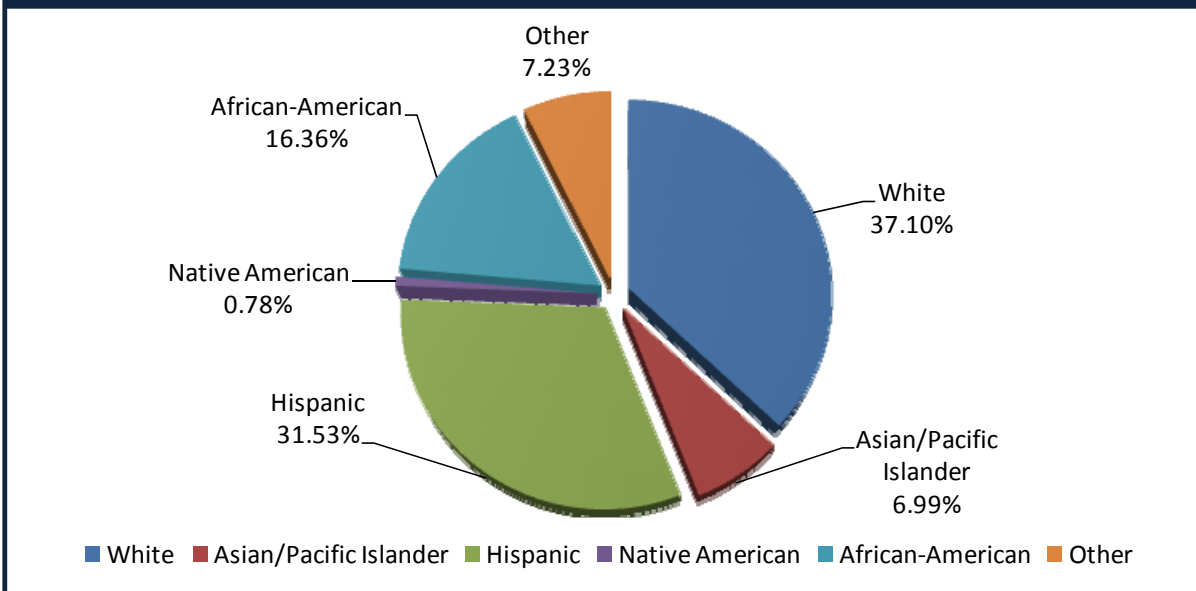
The following figures show the ethnicities of Medi-Cal eligibles compared to those who received services in CY09. Charts which mirror each other would reflect equal access based upon ethnicity, in which the pool of beneficiaries served matches the Medi-Cal community at large.

Figure 5 shows the ethnic breakdown of Medi-Cal eligibles statewide, followed by those who received at least one mental health service in CY09. Figure 6 shows the same information for the MHP's eligibles and beneficiaries served. Similar figures for the foster care and TAY populations are included in Attachment D following the MHP's approved claims worksheets.

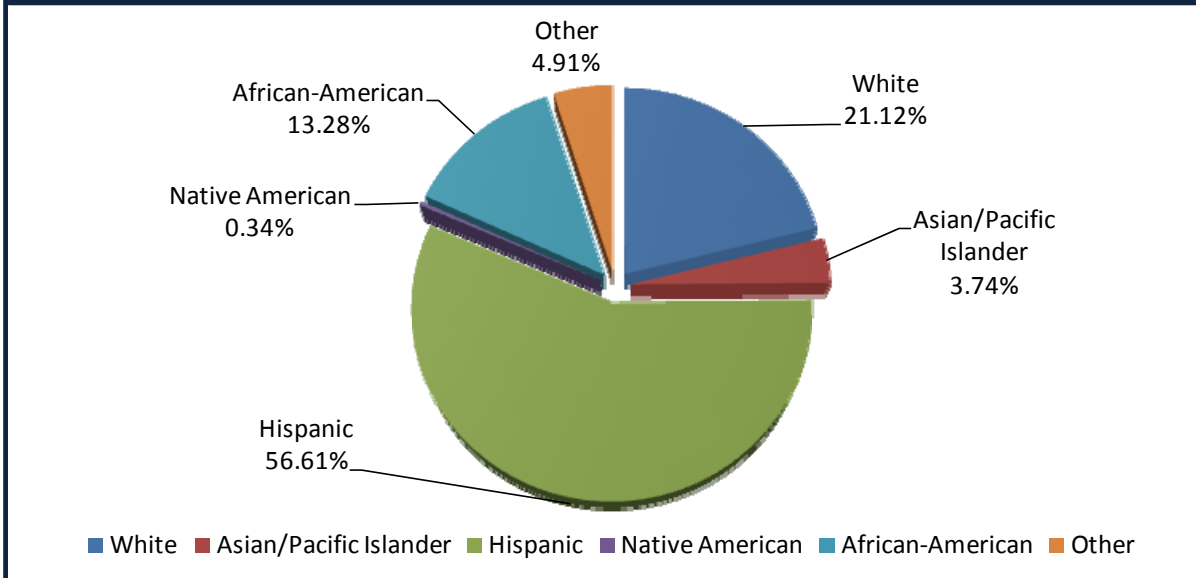
**Figure 5a. CY09 Statewide Medi-Cal Average Monthly Unduplicated Eligibles Served, by Race/Ethnicity**



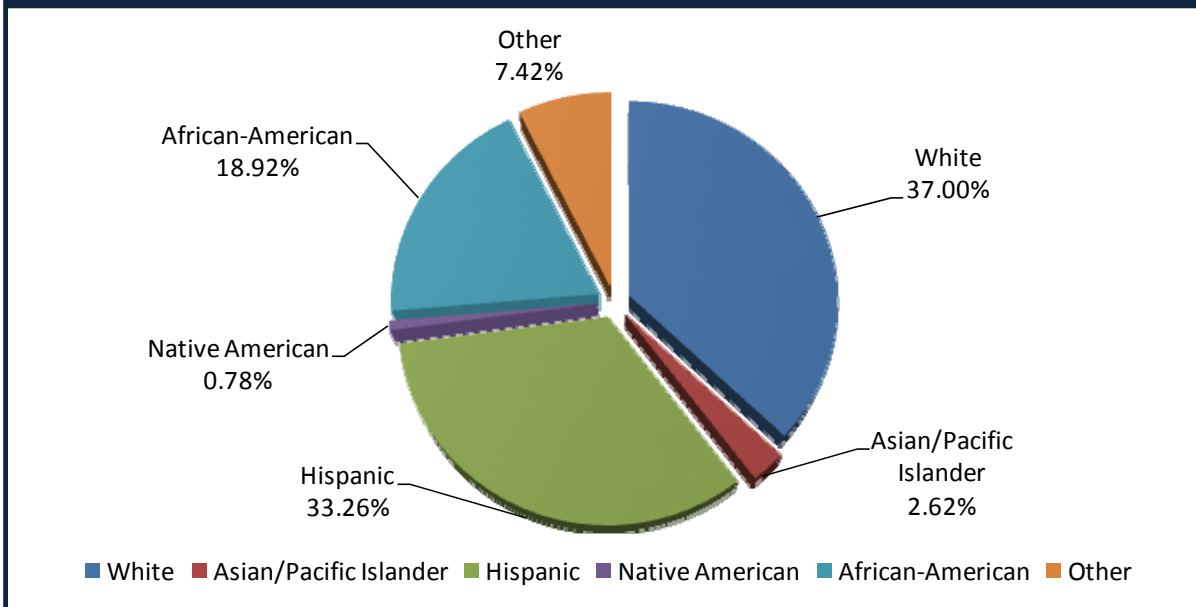
**Figure 5b. CY09 Statewide Medi-Cal Beneficiaries Served, by Race/Ethnicity**



**Figure 6a. CY09 MHP Medi-Cal Average Monthly Unduplicated Eligibles Served, by Race/Ethnicity**



**Figure 6b. CY09 MHP Beneficiaries Served, by Race/Ethnicity**



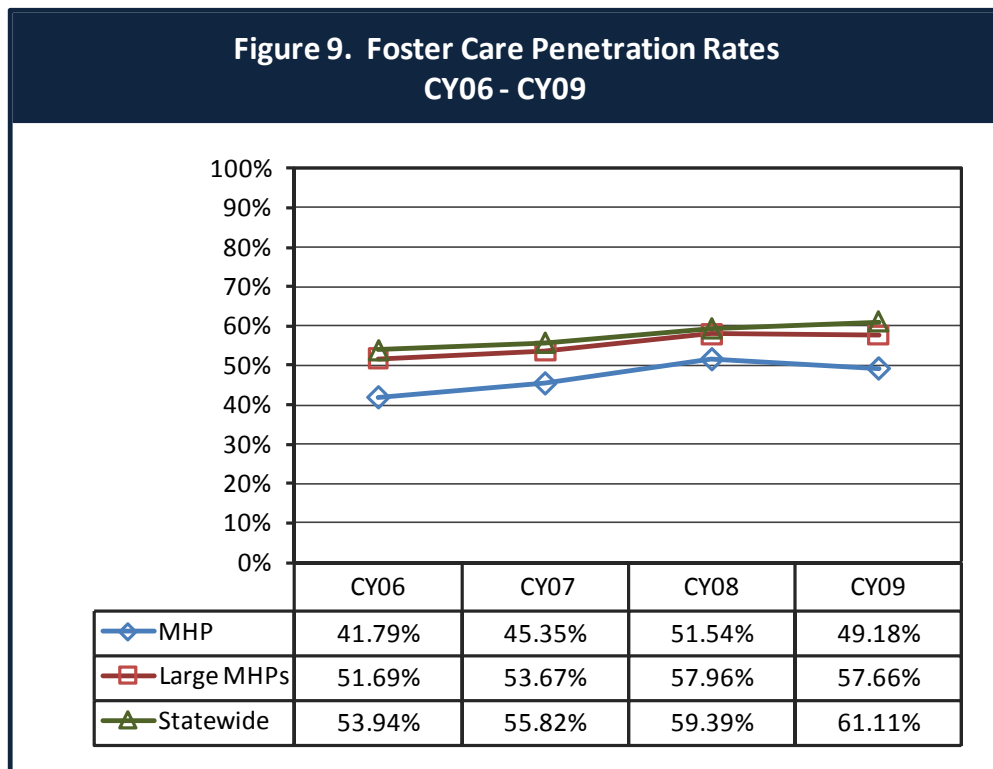
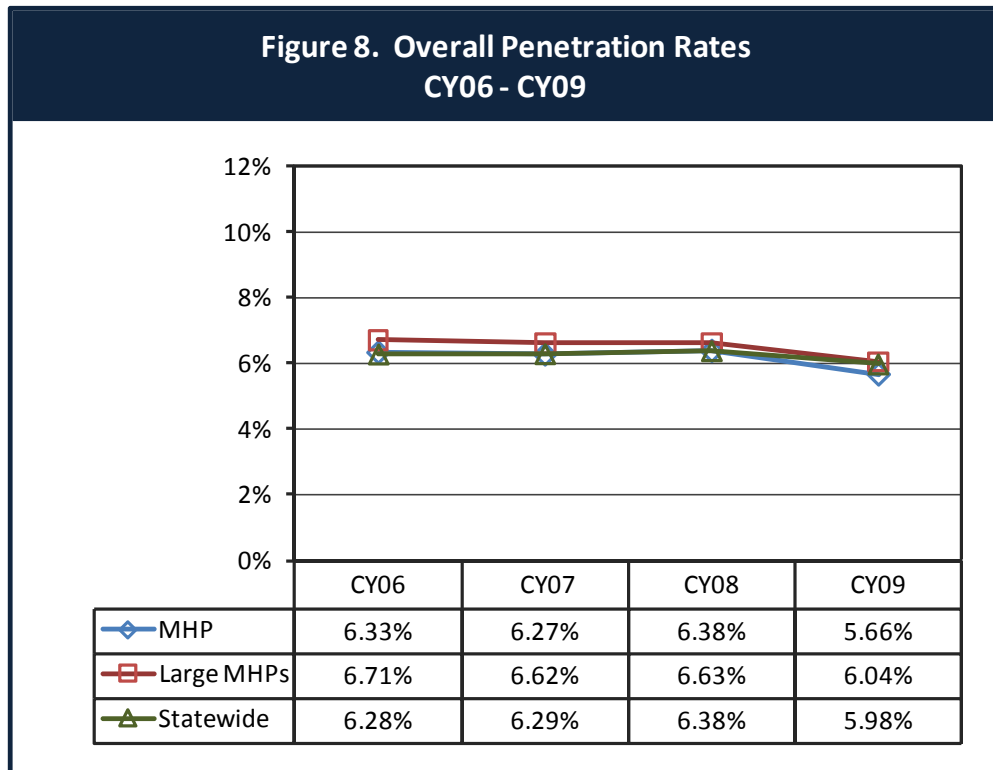
## PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Rankings, where included, are based upon 56 MHPs, where number 1 indicates the highest rate or dollar figure and number 56 indicates the lowest rate or dollar figure.

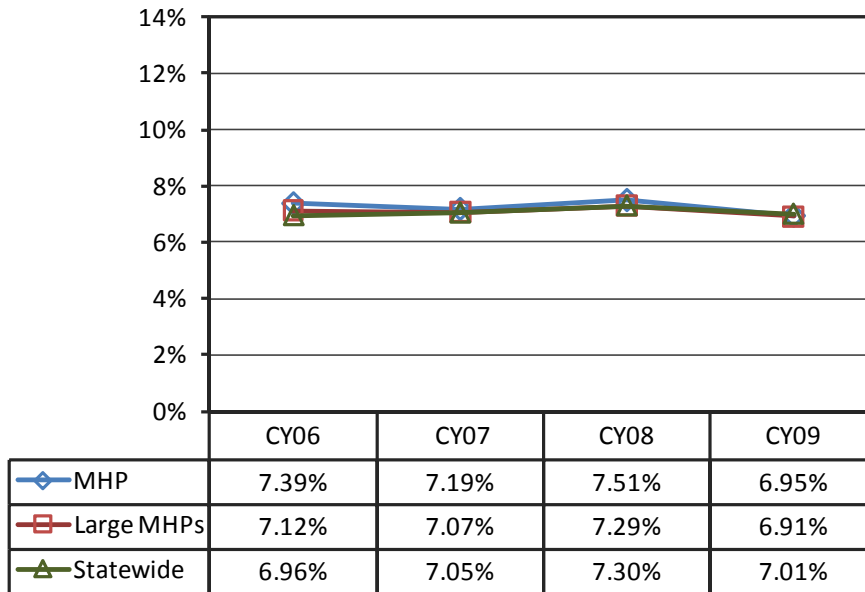
Figure 7 displays key elements from the approved claims reports for the MHP, MHPs of similar size (large, medium, small, or small-rural), and the state.

Figure 7. CY09 Medi-Cal Approved Claims Data				
Element	MHP	Rank	Large MHPs	Statewide
Total approved claims	\$75,736,845	N/A	N/A	\$2,113,209,089
Average number of eligibles per month	443,681	N/A	N/A	7,381,253
Number of beneficiaries served	25,111	N/A	N/A	441,682
Penetration rate	5.66%	42	6.04%	5.98%
Approved claims per beneficiary Served	\$3,016	44	\$4,335	\$4,784
Penetration rate – Foster care	49.18%	39	57.66%	61.11%
Approved claims per beneficiary served – Foster care	\$4,681	39	\$7,287	\$7,619
Penetration rate – TAY	6.95%	37	6.91%	7.01%
Approved claims per beneficiary served – TAY	\$3,543	44	\$5,461	\$5,966
Penetration rate – Hispanic	3.33%	30	3.43%	3.46%
Approved claims per beneficiary served – Hispanic	\$2,914	38	\$3,933	\$4,580

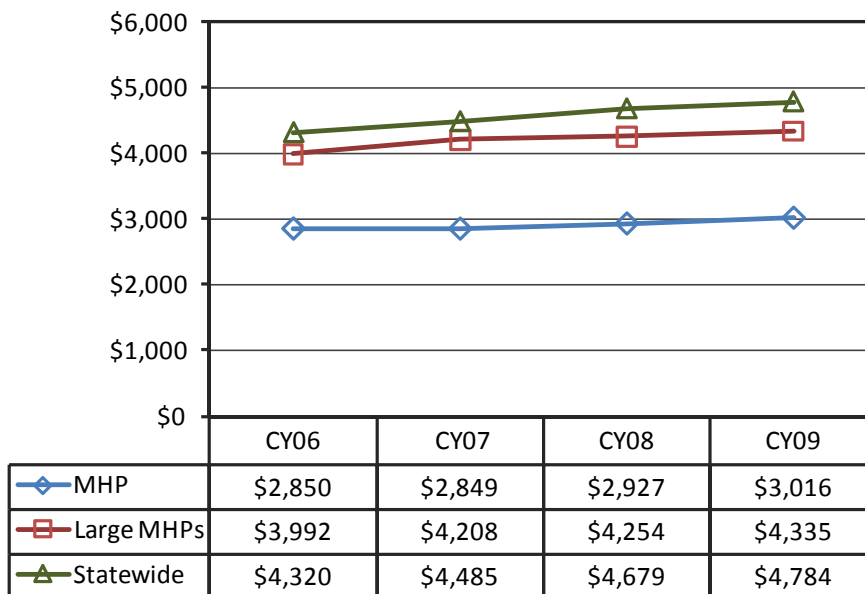
Figures 8 through 11 highlight four year trends for penetration rates and average approved claims.



**Figure 10. Transition Age Youth Penetration Rates  
CY06 - CY09**



**Figure 11. Average Approved Claims per Beneficiary Served  
CY06 - CY09**



## MEDI-CAL APPROVED CLAIMS HISTORY

The table below provides trend line information from the MHP's Medi-Cal eligibility and approved claims files from the last five fiscal years. The dollar figures are not adjusted for inflation.

Figure 12. Medi-Cal Eligibility and Claims Trend Line Analysis							
Fiscal Year	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate		Total Approved Claims	Approved Claims per Beneficiary Served per Year	
			%	Rank		\$	Rank
FY08-09	427,061	25,836	6.05%	40	\$77,074,433	\$2,983	47
FY07-08	393,460	24,430	6.21%	40	\$70,461,778	\$2,884	44
FY06-07	372,478	22,882	6.14%	40	\$63,387,566	\$2,770	44
FY05-06	377,678	24,077	6.38%	40	\$67,289,098	\$2,795	42
FY04-05	378,702	25,100	6.63%	40	\$64,142,448	\$2,555	43

## MEDI-CAL DENIED CLAIMS HISTORY

Denied claims information appears in Figure 13. These are denials in Medi-Cal claims processing, not the result of disallowances or chart audits, and the rates do not reflect claims that may have been resubmitted and approved. Denial rate rank 1 is the highest percentage of denied claims; rank 56 is the lowest percentage of denied claims.

Figure 13. Medi-Cal Denied Claims Information					
Fiscal Year	MHP Denied Claims Amount	MHP Denial Rate	MHP Denial Rate Rank	Statewide Median	Statewide Range
FY08-09	\$2,177,673	2.91%	35	3.86%	0.41% - 29.87%
FY07-08	\$2,374,123	3.69%	33	4.91%	0.23% - 25.89%
FY06-07	\$974,580	1.70%	43	3.55%	0.23% - 18.18%
FY05-06	\$1,375,930	2.34%	35	3.02%	0.57% - 22.69%
FY04-05	\$1,317,195	2.20%	39	3.24%	0% - 36.78%

Review of Medi-Cal approved claims data, displayed in Figures 5 through 13 in Section III-C above, reflect the following issues that relate to quality and access to services:

- Overall penetration rates (PR) are comparable to other large MHPs and statewide figures, while the average approved claims per beneficiary served (ACB) are significantly lower.
- PR data, as noted in Figure 5, continues to reveal disparities for Asian/Pacific, African-American, and Hispanic beneficiaries. The MHP demonstrated a number of outreach efforts for each of these groups.
- Overall Medi-Cal PR, as noted in Figure 8, are consistent with other large MHP's and also reflect the slight decline seen on a statewide basis. Rapidly growing beneficiary numbers, a reflection of the current recession, is likely driving down the overall PR.
- Medi-Cal approved claims data indicates a slight reduction in the CY-06-CY09 PR. However, specific MHP program efforts to address the needs of TAY beneficiaries should provide redress to this decline.
- Foster Care PR have not yet begun to rise, based on CY09 data. Current efforts discussed earlier in this report are expected to reflect increased PR in CY10 and CY11.
- Denied claims: This MHP has had historically low Medi-Cal error rates. The MHP is actively working with DMH and Vendors to complete the implementation of Short-Doyle Medi-Cal II (SDMCII). This is a major undertaking that has required intense effort by MHP staff. IT, Fiscal and R&E have all focused their efforts to complete this complex implementation.

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## HIGH-COST BENEFICIARIES

As part of an analysis of service utilization, CAEQRO compiled claims data to identify the number and percentage of beneficiaries within each MHP and the state for whom a disproportionately high dollar amount of services were claimed and approved. A stable pattern over the last three calendar years of data reviewed shows that statewide, roughly 2% of the beneficiaries served accounted for one-quarter of the Medi-Cal expenditures. The percentage of beneficiaries meeting the high cost definition has increased in each of the four years analyzed. For purposes of this analysis, CAEQRO defined "high cost beneficiaries" as those whose services met or exceeded \$30,000 in the calendar year examined—this figure represents roughly three standard deviations from the average cost per beneficiary statewide.

<b>Figure 14. High-Cost Beneficiaries (greater than \$30,000 per beneficiary)</b>						
	MHP Beneficiaries Served			Approved Claims		
	# HCB	# Served	%	Average per HCB	Total Claims for HCB	% of total claims
Statewide CY09	10,919	441,682	2.47%	\$48,892	\$533,854,301	25.26%
MHP CY09	289	25,111	1.15%	\$45,044	\$13,017,828	17.19%
MHP CY08	214	25,780	0.83%	\$44,109	\$9,439,240	12.51%
MHP CY07	196	23,822	0.82%	\$44,910	\$8,802,308	12.97%
MHP CY06	189	23,464	0.81%	\$48,141	\$9,098,644	13.61%

CAEQRO also analyzed claims data for beneficiaries receiving \$20,000 to \$30,000 in services per year. Statewide, this population also represents a small percentage of beneficiaries for which a disproportionately high amount of Medi-Cal dollars is claimed. Statewide in CY09, 37.43% of the approved Medi-Cal claims funded 4.87% of the beneficiaries served when this second tier of high cost beneficiaries is included. For the MHP, 28% of the approved Medi-Cal claims funded 2.5% of the beneficiaries served. This information is also depicted in pie charts in Attachment D.

- As reflected above, the MHP High Cost Beneficiaries are trending upward. Overall numbers and percentages of beneficiaries served and total claims amounts and percentage of total claims have risen steadily over the past few years, with a sizable increase between CY08–CY09.
- As noted in the Appendix D bar chart, the MHP has consistently had lower percentages of clients in the >15 service group. Similarly, the number of clients with 1, 2 or 3 services has tended to be higher than the State averages. Such data suggest retention of clients requires scrutiny by the MHP's R&E unit, examining such issues as dropout rates and no shows. Both of these data items can now be tracked with the newly installed appointment tracking system.

## ❖ PERFORMANCE MEASUREMENT ❖

Each year CAEQRO is required to work in consultation with DMH to identify a performance measurement (PM) which will apply to all MHPs – submitted to DMH within the annual report due on August 31, 2011. These measures will be identified in consultation with DMH for inclusion in this year's annual report.

## ❖ CONSUMER AND FAMILY MEMBER FOCUS GROUPS ❖

### FOCUS GROUPS SPECIFIC TO THE MHP

CAEQRO conducted three 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CAEQRO requested focus groups as follows:

1. A culturally diverse group of adult consumers who have initiated services within the past twelve months.
2. A culturally diverse group of family members of children/youth who receive services through the MHP.
3. A third focus group to be mutually determined by the MHP and the Lead Reviewer prior to the review.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to services, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CAEQRO provided gift certificates to thank the consumers and family members for their participation.

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### CONSUMER/FAMILY MEMBER FOCUS GROUP 1

The first focus group was held at the MHP offices. While CAEQRO requested a culturally diverse group, the MHP organized a group of all African American participants. Six individuals participated in the focus group, including three men and three women. All but one participant described timely responses to their requests for services and prompt access to seeing a psychiatrist, some seeing a doctor on the day they presented in crisis. Wait time to see a

therapist was typically between one to two months. Participants offered many examples of receiving recovery-oriented care through the MHP, including participation of family members in their treatment, assistance paying for medication, and coordination between psychiatrist and primary care physician; every participant expressed a sense of hope and the availability of help for the future. However, none of the participants was aware of any of the clubhouses or opportunities to participate on MHP decision-making committees. Additionally, none participated in any form of group therapy.

Participants offered the following suggestions for improvements:

- Increase community outreach and education about mental illness
- Increase interaction between the MHP and local churches and community centers in the greater San Bernardino area
- Increase accessibility and promote that medication and therapy services are indeed available for those who need them

**Figure 15. Consumer/Family Member Focus Group 1**

Number/Type of Participants	
Consumer Only	2
Consumer and Family Member	
Family Member of Adult	4
Family Member of Child	
Family Member of Adult & Child	
Total Participants	6

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	
Adult (approx 25-59)	6
Older Adult (approx 60 and older)	

Preferred Languages	
English	6

Estimated Race/Ethnicity	
African American	6

Gender	
Male	3
Female	3

Interpreter used for focus group 1:  No  Yes

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## **CONSUMER/FAMILY MEMBER FOCUS GROUP 2 - VICTORVILLE**

This group was held at the Victorville clinic, with eight participants of varied ages and ethnicities. All participants described receiving services from a psychiatrist. Individuals were seen by their psychiatrist mostly monthly, but a couple of individuals saw their psychiatrist every six or eight weeks. Most of the participants were full service partnership members - some saw a therapist weekly or more often. Others did not have services beyond their psychiatrist. Some saw case managers at the Clubhouse or participated in services at the Clubhouse. Most were also Clubhouse participants though individuals felt that their services with the psychiatrist and therapist were the most useful of all services received.

Participants expressed feeling that services have improved over time, generally due to changes in providers. They also described being “hopeful” that their mental illness will improve, though they were not necessarily in agreement with the term “recovery.” None of the individuals reported being on committees or involved in other decision-making venues at the MHP, nor had they been invited to participate.

Family member participation was not a large theme for the group members, though one of the participants discussed the value of having had family therapy sessions when needed. Others did not necessarily seem to want to have family members involved. People felt that they were involved and in charge of their care. One participant noted an example of doing better and having requested on his own to taper off a particular medication.

The group was very satisfied with services and had no major recommendations to offer for improvement.

**Figure 15. Consumer/Family Member Focus Group 2**

Number/Type of Participants	
Consumer Only	6
Consumer and Family Member	2
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)	6
Older Adult (approx 60 and older)	2

Preferred Languages	
English	8

Estimated Race/Ethnicity	
Caucasian	4
Hispanic/Latino	3
African American	1

Gender	
Male	6
Female	2

Interpreter used for focus group 2:  No  Yes

**CONSUMER/FAMILY MEMBER FOCUS GROUP 3**

This group was held at the South Coast Children’s Society in Ontario; a county contracting agency. There were eight parent participants of both Caucasian and Hispanic ethnicity, all with an adolescent son (or foster son) between the age of 14 and 17 years old being served in the Wraparound program by the agency. One participant was solely Spanish speaking, and an interpreter was provided. Another participant also had her two adolescent daughters enrolled in the Wraparound program.

All participants described receiving family Wraparound services from the agency on a weekly basis for anywhere from 2 months to at least a year. At least once per week, and in some cases two times per week, the adolescent was seen at the family home by their service provider. Weekly, the family also had an at-home family meeting, and the parent partners had weekly, if not every few days, contact with the children’s mothers/foster mothers. Only two of the adolescents were receiving psychotropic medication; both caretakers reported problems with psychiatrist access when concerns of side-effects or intervention inefficacy arose. In one case, the mother has reverted to private health insurance to obtain psychiatric care for her son as she

has been awaiting County psychiatric services of any kind since her initial intake nine weeks ago.

Overall, the participants reported that the Wraparound services have greatly improved the problems they and their child/foster child have experienced. People cited various program components or factors that have lead to this improvement, such as, the frequency and intensity of services, the child finding commonalities between themselves and other children in the program, the support the program staff provided (especially the parent partners), and the rewards for small successes and change for the children built into the program. The consensus was that the program held participants accountable; provided adaptability, accessible, and problem-solving staff; was consistently and appropriately structured; and emphasized parenting parameters. The program also offered children some access to anger management, drug and alcohol, and school counseling groups.

The participants' biggest concern was not with the program, nor the actual Wraparound services themselves, but with initial service access and referral to services as controlled by the juvenile court system, including probation. Generally, mothers reported either a denial of services repeatedly or a lack of program information provision as their child progressed through the justice and/or school systems. In nearly all cases, referral to Wraparound services did not occur until the parent advocated tirelessly to school and police officials, begged the judge or probation officer for help, the child had a number of repeated juvenile hall incarcerations, getting progressively more serious, or faced juvenile placement.

In sum, the group was very satisfied with services and had the following recommendations to offer for improvement.

- A focus on earlier intervention through the juvenile justice system; allowing access to this service sooner in the downhill trajectory of problem adolescents.
- An effort by the county to improve consumer awareness of these services at traditional schools, not just at nontraditional or continuation schools.
- Increased publicity of all the services and components that comprise the Wraparound program.

**Figure 15. Consumer/Family Member Focus Group 3**

Number/Type of Participants	
Consumer Only	
Consumer and Family Member	
Family Member of Adult	
Family Member of Child	8
Family Member of Adult & Child	
Total Participants	8

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	1
Adult (approx 25-59)	7
Older Adult (approx 60 and older)	

Preferred Languages	
English	7
Spanish	1

Estimated Race/Ethnicity	
Caucasian	3
Latino/Hispanic	4
Biracial – Caucasian/Hispanic	1

Gender	
Male	0
Female	8

Interpreter used for focus group 3:  No  Yes Spanish

**◆ PERFORMANCE IMPROVEMENT PROJECT VALIDATION ◆**

**CLINICAL PIP**

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

For Strategy 1: “Will intensive case management services in the form of a Full Service Partnership reduce the likelihood of rehospitalization and/or the number of hospital days used by clients who are high utilizers of hospital services?”

For Strategy 2: “Does an immediate post-hospitalization follow-up intervention have an effect on the rehospitalization rates of those who were recently discharged from inpatient care at the County Behavioral Health Unit?”

Year PIP began: September 2008

Status of PIP:

Active and ongoing

- Completed  
 Inactive, developed and completed in a prior year  
 Concept only, not yet active  
 No PIP submitted

The MHP completed its re-hospitalization PIP during the FY09-10 review period and was credited for the active participation in the prior year FY09-10 CAEQRO report. The review team also discussed possible ways to take some of the benefits learned from that project and initiate other quality improvement activities.

Two new PIP ideas were discussed onsite, including a PIP pertaining to Project Impact, discussed earlier in the report, and the implementation of Laura's Law. While there are clear performance improvement opportunities with Project Impact, a PIP for the purposes of the CAEQRO review must include Medi-Cal beneficiaries. As the MHP embarks on implementing Laura's Law, there are five consumers identified for intervention, which makes for too small a study population to be considered for a PIP.

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either “met,” “partial,” “not met,” or “not applicable.” Because the MHP does not have an active clinical PIP, all items are rated as “not met” for purposes of analysis.

Thirteen of the 44 criteria are identified as “key elements” indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 16. Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
2	The study question identifies the problem targeted for improvement			X
3	The study question is answerable/demonstrable			X
4	The indicators are clearly defined, objective, and measurable			X
5	The indicators are designed to answer the study question			X

<b>Figure 16. Clinical PIP Validation Review—Summary of Key Elements</b>				
Step	Key Elements	Present	Partial	Not Met
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
7	The indicators each have accessible data that can be collected			X
8	The study population is accurately and completely defined			X
9	The data methodology outlines a defined and systematic process			X
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes			X
11	The analyses and study results are conducted according to the data analyses plan in the study design			X
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			X
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			X
<b>Totals for 13 key criteria</b>				<b>13</b>

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIPs as submitted by the MHP are included in an attachment to this report. If the MHP did not submit any PIPs, the requested format for PIP submission is included.

## NON-CLINICAL PIP

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

“Will implementing a screening tool to assess the needs of an EPSDT client who has received \$3,000 of outpatient specialty mental health services within one (1) calendar month since July 1, 2008; and, facilitating a referral, if needed, to a specialty program to assure an appropriate level of care coordination is provided for the child or youth result in a significant increase in the percentage of children and youth receiving consistent

mental health services, as defined as not experiencing an increase of \$1,500 or more of services in one month followed by a decrease of \$1,500 or more of services in the next month?"

Year PIP began: October 2008

Status of PIP:

- Active and ongoing
- Completed
- Inactive, developed in a prior year
- Concept only, not yet active
- No PIP submitted

This PIP is a continuation of the statewide EPSDT PIP; please refer to the FY09-10 CAEQRO report for additional background information. The MHP had an initial study population of approximately 600 children. During the first four to five months, the PIP committee reviewed many variables, including geographic location, diagnosis, gender, and utilization trends, but found no identifiable trends for purpose of study.

In the next phase, the MHP chose to look at children who at one time were receiving a substantial amount of services and then virtually none. After conducting chart reviews and detailed analysis, the PIP committee found that among children with highly coordinated care, relatively few (9%) had this pattern. Conversely, of those children without highly coordinated care, 44% (nearly 100 youth) demonstrated the pattern of extremely high utilization followed by virtually no services.

The MHP determined that every child who is not in highly coordinated care and who meets the \$3,000 threshold in one month (for reasons other than being enrolled in a highly coordinated program) is part of the PIP study population. New children are identified and added to the population monthly, after which a structured telephone interview with the family occurs to determine eligibility for TBS, SART, or "Success First," an "early wrap-around" program funded through MHSA, that is not linked with CFS. These three programs become potential interventions for the study population.

The MHP has encountered challenges obtaining necessary eligibility information, having to pull information from three different databases. Furthermore, only approximately 40% of the families are receiving the initial screening call. Onsite discussion included the following recommendations from CAEQRO reviewers:

- Identify which approaches are and are not working, and modify accordingly
- Include rate of connectivity as a process measure
- Include the following indicators
  - Was an initial connection with the family made?

- o Did the family connect to a highly coordinated service?

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either “met,” “partial,” “not met,” or “not applicable.” Relevant details of these issues and recommendations are included within the comments of the PIP validation tool.

Thirteen of the 44 criteria are identified as “key elements” indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

<b>Figure 17. Non-Clinical PIP Validation Review—Summary of Key Elements</b>				
Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
2	The study question identifies the problem targeted for improvement	X		
3	The study question is answerable/demonstrable	X		
4	The indicators are clearly defined, objective, and measurable		X	
5	The indicators are designed to answer the study question	X		
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same		X	
7	The indicators each have accessible data that can be collected	X		
8	The study population is accurately and completely defined	X		
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X		
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes	X		
11	The analyses and study results are conducted according to the data analyses plan in the study design			X

<b>Figure 17. Non-Clinical PIP Validation Review—Summary of Key Elements</b>				
Step	Key Elements	Present	Partial	Not Met
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			X
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			X
<b>Totals for 13 key criteria</b>		<b>8</b>	<b>2</b>	<b>3</b>

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIPs as submitted by the MHP are included in an attachment to this report. If the MHP did not submit any PIPs, the requested format for PIP submission is included.

## ❖ 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 7.0, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

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### CURRENT OPERATIONS

- The IT, Research and Evaluation and Fiscal staff have all worked together to successfully begin billing (and receive payments) from the Short /Doyle Medi-Cal II system. While not fully completed (on a Statewide basis), the MHP has made good progress and is currently billing at rates comparable with the prior system.
- A much needed appointment tracking system was deployed county-wide. The extent of use and the integrity of the data is currently being evaluated. This system will offer a rich source of data for analysis of access and timeliness.
- The data warehouse project is on schedule with installed hardware. SAS Institute training is ongoing for MHP staff. The training plan provides for excellent cross training and should allow the MHP to successfully manage the data warehouse and the associated data analyses.
- Several projects to upgrade the hardware infrastructure are underway.
- Cross training of staff is noted and is an excellent redundancy for the security and reliability of the system.
- The BMHIS RFI is complete and ready for distribution with the year.

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### MAJOR CHANGES SINCE LAST YEAR

- The Research and Evaluation Dashboard Web portal is operational and staff are receiving training on this tool.
- Several Online/ Web base applications have been installed including
  - MHP Operation Center website for displaying emergency information

- Integrated Health Referral System to track client referrals
- Pre assessment screening/ Initial Contact Log
- SSI system to support staff helping consumers become eligible for SSI (Project Impact, discussed earlier in this report)

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## PRIORITIES FOR THE COMING YEAR

- Stabilize SD/MC Phase II environment and maximize revenue.
- A major activity will be the release of the MHP's RFI to help select a suitable EHR application; the approximate release date is January, 2011.
- The major elements of the data warehouse/data mining project should be completed and MHP staff will be operating the warehouse by 9/11.
- Continue the deployment of server, desktop upgrades.
- The EHR vendor will be selected by the end of 2011.

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## OTHER SIGNIFICANT ISSUES

- The data warehouse project and associated dashboard reports represent a significant step towards making all data used by DBH more accessible for decision makers. This is a major information infrastructure construction project that will allow analysis of a wide variety sources and systems to be organized and analyzed. The data warehouse is designed to adapt to change (such as the new EHR,) yet will have the capacity to store the many years of valuable data from legacy systems. The data warehouse will be key to allowing program management and executive staff to make data-informed decisions.
- The current IT shop has created several excellent web solutions to directly support MHP programs, of special note is the R&E Dashboard and the SSI Application support module. For an organization of this size, innovative work can be lost unless staff time is continuously devoted to training (selling) new solutions. The recent R&E training on reports is a fine example of what needs to be done, but it should be an ongoing activity highlighting each year's new products and solutions. Absent such ongoing internal sales work, many staff may not learn of critical resources that are available.

- The IT department has the capacity to organize and track complex tasks. The SSI application is a good example. Staff should consider similar ways that the computer can be used to assist overburdened staff. For example, the various medical assistance programs for medications for indigent clients are complicated and time consuming. Information Technology support for such a task would be welcome.

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, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

**Figure 18. Current Systems/Applications**

System/Application	Function	Vendor/Supplier	Years Used	Operated By
InSyst V9.1 A	Practice Management	ECHO	18	IT staff
Ecura	Managed Care	Infomc	11	IT staff
SpectraSoft	Appointment Tracking	Spectrasoft6	2	IT staff

**ELECTRONIC HEALTH RECORD STATUS**

See the table below for a listing of EHR functionality currently in widespread use at the MHP.

**Figure 19. Current EHR Functionality**

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments				X	
Document imaging				X	
Electronic signature-client				X	
Electronic signature-provider				X	
Laboratory results				X	
Outcomes				X	

Figure 19. Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Prescriptions				X	
Progress notes				X	
Treatment plans				X	

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- The MHP completed an RFI for system replacement in February, 2009. State funding for the BHMS project was received August 10, 2009. The release of the RFI has been on hold while the MHP completed core workflow and business process re-engineering in advance of the RFI release. Additionally, the work load associated with the installation of Short/Doyle Phase II has delayed the release of the RFI. The MHP is carefully watching the experiences of other MHP's all of whom face the need to replace their legacy systems. The MHP intends to learn from their sister MHP's implementation successes and failures.
- The current project plan calls for the RFI to be released in early 2011. The vendor will be selected by end of the year.
- During this interim period, the county continues to maintain their legacy system which performs all key billing functions.
- As a large county the MHP may use this period before the implementation to survey their staff. The extent of computer literacy necessary to use an EHR will need to be assessed. This is a 100% survey. Many staff will be prepared for the new system. However, it is critical to identify training needs now before training on the new system occurs.

## ❖ SITE REVIEW PROCESS BARRIERS ❖

The following conditions significantly affected CAEQRO's ability to prepare for and/or conduct a comprehensive review:

- There were no barriers affecting the preparation or the activities of this review.

## ❖ CONCLUSIONS ❖

During the FY10-11 annual review, CAEQRO found strengths in the MHP's programs, practices, or 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.

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### STRENGTHS

1. The MHP serves as a model to others with its strong leadership and a solid commitment to quality improvement:
  - Leadership effectively maintains a simultaneous focus on fiscal solvency and the promotion of wellness and recovery principles system wide.
  - The Internal Leadership Development Academy and the License Exam Prep Program support professional development and long term succession planning for the organization.
  - Cultural competence is an organizational priority, evidenced by an active, dedicated team and committee.
  - Staff, consumers, and family members demonstrated consistently high morale and commitment to the service delivery system throughout the site review.  
[Quality, Other: Wellness and Recovery]
2. The MHP successfully implemented the Project Impact pilot and is preparing to expand to other locations. IS and clinical staff collaborated in documenting the process. This type of computer assist can be expanded to other complex tasks.  
[Quality, Information Systems]

3. Consumer employment opportunities have grown substantially in the past few years. PFAs are integrally involved in the clubhouses and hold varied roles throughout the MHP. Full and part time positions are available, as is a meaningful career ladder.  
[Quality, Other: Wellness and Recovery]
4. IS staff and Research and Evaluation staff have prepared an excellent data dashboard.  
[Quality, Information Systems]

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## OPPORTUNITIES FOR IMPROVEMENT

1. While the MHP has set a 14-day standard for timeliness to outpatient appointments after a hospitalization, the methodology for tracking this data does not accurately capture the wait times from discharge to outpatient appointment.  
[Timeliness]
2. With the installation of the new EHR, the current standard of seven business days for data entry is outdated. As the EHR is deployed, much of the claims data will be captured by clinicians rather than data entry personnel, and services will be integrated with progress notes.  
[Information Systems]
3. While the MHP makes effort to inform staff of new IS infrastructure improvements, not all staff may be aware of the capabilities.  
[Information Systems]

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## RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the review process, identified as an issue of access, timeliness, outcomes, quality, information systems, or others that apply:

1. Revise the methodology for tracking timeliness to post-hospital outpatient appointments so that timeliness data captures time from date of discharge rather than date the consumer requests an appointment. Evaluate current discharge planning protocol to determine if it supports such tracking.  
[Timeliness]
2. Revise the current standard of seven business days for data entry to be congruent with the new EHR.  
[Information Systems]

3. Survey all staff to determine computer literacy and readiness to use the impending EHR. Deploy training resources indicated.  
[Information Systems]
4. Ensure all technology advancements and innovative improvements are disseminated throughout the organization. This activity should be a continuous quality improvement effort. Without such an effort, many new system features may go unused.  
[Information Systems]
5. Increase efforts to recruit and involve consumers and family members as system stakeholders.  
[Quality, Other: Wellness and Recovery ]

 **ATTACHMENTS** 

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: Data Provided to the MHP

Attachment E: CAEQRO PIP Validation Tools

Attachment F: MHP PIP Summaries Submitted

***A. Attachment—Review Agenda***

Agenda – Day 1: Wednesday, November 3, 2010		
<p><b>Time: 9:00 am – 12:00 pm</b></p> <p><b>ENTRANCE INTERVIEW/PERFORMANCE MANAGEMENT – MHP ACCOMPLISHMENTS REGARDING QUALITY ACCESS, TIMELINESS, OUTCOMES, AND QUALITY</b></p> <ul style="list-style-type: none"> <li>• Introductions of participants</li> <li>• Overview of review intent</li> <li>• Significant MHP changes in past year</li> <li>• Strategic initiatives – progress &amp; plans</li> <li>• Last Year’s CAEQRO Recommendations</li> <li>• Performance improvement measurements utilized to assess access, timeliness, outcomes, and quality</li> <li>• Examples of MHP reports used for to manage performance and decisions</li> <li>• CAEQRO approved claims data</li> </ul> <p><b>Location: DBH Training Institute - 1950 S. Sunwest Lane, Ste 200, San Bernardino</b>  <b>Contact: Dina Jaramillo (909) 252-4017</b>      <b>Reviewer(s): All</b></p>		
<p><b>12:00 pm – 1:00 pm</b>      <b>APS Staff – Working Lunch</b></p>		
<p><b>Time: 1:00 pm – 2:15 pm</b></p> <p><b>MHP OR CONTRACT PROVIDERS CLINICAL SUPERVISORS GROUP INTERVIEW</b></p> <ul style="list-style-type: none"> <li>• Group interview</li> </ul> <p><b>Location: DBH Admin 268 W. Hospitality Ln, San Bern., Conference Room: #457</b>  <b>Contact: La Shon Brown (909) 382-3149</b>  <b>Reviewer(s): SF</b></p>	<p><b>Time: 1:00 pm – 2:30 pm</b></p> <p><b>IS MANAGER/KEY IS STAFF GROUP INTERVIEW</b></p> <ul style="list-style-type: none"> <li>• Review and discuss ISCA</li> <li>• FY 2010/11 CAEQRO information technology recommendation</li> </ul> <p><b>Location: DBH Admin 268 W. Hospitality Lane, San Bern., Conference Room: #433</b>  <b>Contact: Melissa Jones (909) 382-3101</b>  <b>Reviewer(s): MG</b></p>	<p><b>Time: 1:00 pm – 2:30 pm</b></p> <p><b>CONSUMER EMPLOYEE/VOLUNTEER GROUP INTERVIEW</b></p> <ul style="list-style-type: none"> <li>• Group Interview</li> <li>• Held at wellness or self-help center if possible.</li> </ul> <p><b>Location: DBH Training Institute, 1950 S. Sunwest Ln, Ste 200, San Bern, Conf Rm</b>  <b>Contact: Dina Jaramillo (909) 252-4017</b>  <b>Reviewer(s): TS, SS</b></p>
<p><b>Time: 2:30 pm – 3:45 pm</b></p> <p><b>MHP OR CONTRACT PROVIDER CLINICAL LINE STAFF GROUP INTERVIEW</b></p> <ul style="list-style-type: none"> <li>• Group interview</li> </ul> <p><b>Location: DBH Admin 268 W. Hospitality Lane, San Bern., Conference Room: #457</b>  <b>Contact: La Shon Brown (909) 382-3149</b>  <b>Reviewer(s): SF</b></p>	<p><b>Time: 2:45 pm – 3:45 pm</b></p> <p><b>FISCAL/BILLING/FINANCE GROUP INTERVIEW – SD/MC CLAIMS PROCESSING</b></p> <ul style="list-style-type: none"> <li>• Medi-Cal claim, ECR, EOB processes</li> <li>• Denied claims reports and related processes</li> <li>• New policies and procedures since last review</li> </ul> <p><b>Location: DBH Admin 268 W. Hospitality Lane, San Bern., Conference Room: #433</b>  <b>Contact: Melissa Jones (909) 382-3101</b>  <b>Reviewer(s): MG</b></p>	<p><b>Time: 3:00 pm – 4:30 pm</b></p> <p><b>CONSUMER/FAMILY MEMBER FOCUS GROUP INTERVIEW</b></p> <ul style="list-style-type: none"> <li>• Group Interview</li> <li>• 8-10 participants as specified in the notification letter</li> <li>• African American Consumer Family Members</li> </ul> <p><b>Location: DBH Training Institute, 1950 S. Sunwest Lane, Ste 200, San Bern.</b>  <b>Contact: Jennifer Gonzalez (909) 252-4004</b>  <b>Reviewer(s): TS, SS</b></p>
<p><b>Time: 4:00 pm – 5:00 pm</b></p> <p><b>MHP OR CONTRACT PROVIDER SITE VISIT - ARROWHEAD MEDICAL REGIONAL CENTER (ARMC) DIVERSION (PSYCHIATRIC TRIAGE DIVERSION PROGRAM)</b></p> <ul style="list-style-type: none"> <li>• Tour</li> </ul> <p><b>Location: ARMC 400 N. Pepper Ave. Colton, 92324</b>  <b>Contact: Paula Rutten (909) 873-4491</b>  <b>Reviewer(s): SF, MG</b></p>		

Agenda – Day 2: Thursday, November 4, 2010		
Travel Time: 8:00 am - 9:00 am		
<b>Time: 9:00 am – 10:00 am</b>		<b>Time: 9:00 am – 10:00 am</b>
<b>MHP OR CONTRACT PROVIDER SITE VISIT HIGH DESERT CRISIS WALK IN CENTER (CWIC)</b>		<b>MHP KEY SUPPORT/ OPERATIONS STAFF FOR GROUP INTERVIEW</b>
<ul style="list-style-type: none"> <li>Group interview</li> </ul> <b>Location: HD CWIC 16460 Victor Street Victorville, 92395</b>		<ul style="list-style-type: none"> <li>Group Interview</li> </ul> <b>Location: DBH Training Institute, 1950 S. Sunwest Ln. Ste. 200, San Bern.</b>
<b>Contact: Sandra Kopp (760) 694-6237</b>		<b>Contact: Kamisha Ford (909) 252-4063</b>
<b>Reviewer(s): SS, TD</b>		<b>Reviewer(s): MG</b>
Travel Time: 10:00 – 10:30		Travel Time: 9:15 am - 10:15 am
<b>Time: 10:30 am – 11:45 pm</b>		<b>Time: 10:15 am – 11:15 am</b>
<b>CONSUMER/FAMILY MEMBER FOCUS GROUP INTERVIEW</b>		<b>WELLNESS/SELF-HELP CENTER SITE VISIT - AMAZING PLACE</b>
<ul style="list-style-type: none"> <li>Group interview</li> <li>Full Service Partnership (FSP)</li> </ul>		<ul style="list-style-type: none"> <li>Informal discussion/or tour on either side of a focus group</li> </ul>
<b>Location: Victor Valley Behavioral Health, 12625 Hesperia Rd., Victorville, 92392</b>		<b>Location: 934 N. Mountain Ave. Suite C, Upland, 91786</b>
<b>Contact: Patty Medina/Kevin Lee (760) 245-6719/(760) 955-1777</b>		<b>Contact: David Miller (909) 579-8157</b>
<b>Reviewer(s): TD, SF</b>		<b>Reviewer(s): SS</b>
Travel Time: 11:45 am – 12:45 pm		Travel Time: 12:00 pm – 12:45 pm
<b>Time: 12:45 pm – 1:45 pm</b>		<b>Time: 10:30 am – 12:30 pm</b>
<b>PERFORMANCE IMPROVEMENT PROJECTS</b>		<b>MHP OR CONTRACT PROVIDER SITE VISIT - IS</b>
<ul style="list-style-type: none"> <li>Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans</li> </ul>		<ul style="list-style-type: none"> <li>Hands on review of IS.\</li> <li>Data Warehouse Project Presentation</li> <li>PASS Database</li> <li>Benefits Assistance Database</li> <li>Quantative Analysis Software Overview</li> </ul>
<b>Location: DBH Training Institute 1950 S. Sunwest Ln. Ste. 200 San Bern., Conf Room: Suoi</b>		<b>Location: DBH Admin, 268 W. Hospitality Lane, San Bern., Conference Rm: #215</b>
		<b>Contact: Tammy Dickey (909) 382-3112</b>
		<b>Reviewer(s): MG</b>
Travel Time: 11:45 am – 12:45 pm		
Travel Time: 12:00 pm – 12:45 pm		
Time: 12:45 pm – 1:45 pm		
<b>Time: 1:45 pm – 3:15 pm</b>		<b>Time: 1:45 pm – 3:15 pm</b>
<b>PERFORMANCE IMPROVEMENT PROJECTS</b>		<b>CONTRACT PROVIDER GROUP INTERVIEW</b>
<ul style="list-style-type: none"> <li>Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans</li> </ul>		<ul style="list-style-type: none"> <li>Group interview</li> </ul>
<b>Location: DBH Training Institute 1950 S. Sunwest Ln. Ste. 200 San Bern., Conf Room: Suoi</b>		<b>Location: DBH Training Institute 1950 S. Sunwest Ln. Ste. 200 San Bern, Conf Rm: Agasga</b>
Travel Time: 11:45 am – 12:45 pm		Travel Time: 12:00 pm – 12:45 pm
<b>Time: 3:30 pm – 5:00 pm</b>		<b>Time: 3:30 pm – 5:00 pm</b>
<b>CONSUMER/FAMILY MEMBER FOCUS GROUP INTERVIEW</b>		<b>KEY QIC MEMBERS GROUP INTERVIEW</b>
<ul style="list-style-type: none"> <li>Group interview</li> <li>Family Member of Children Receiving Services</li> </ul>		<ul style="list-style-type: none"> <li>Group interview</li> </ul>
<b>Location: South Coast 721 Nevada Street, Suite #209, Redlands</b>		<b>Location: DBH Training Institute, 1950 S. Sunwest Ln. Ste. 200, San Bern, Rm: Suoi</b>
<b>Contact: Jennifer Gonzalez (909) 252-4004</b>		<b>Contact: Victoria Hall (909) 252-4010</b>
<b>Reviewer(s): SS, TD</b>		<b>Reviewer(s): SF, MG</b>



***B. Attachment—Review Participants***

## CAEQRO REVIEWERS

Samantha Fusselman, LCSW, Lead Reviewer  
Michael Gorodezky, PhD, Information Systems Reviewer Consultant  
Tilda De Wolfe, Consumer/Family Member Consultant  
Sandra Sinz, LCSW, Director of Operations, CAEQRO  
Mila Green, PhD, Reviewer

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.

## SITES OF MHP REVIEW

CAEQRO staff visited the locations of the following county-operated and contract providers:

### County provider sites

San Bernardino County Department of Behavioral Health Administration Offices

### Contract provider organizations

Amazing Place  
934 N. Mountain Ave., Suite C, Upland, 91786

Arrowhead Medical Regional Center Diversion (Psychiatric Triage Diversion Program)  
400 N. Pepper Ave. Colton, 92324

High Desert Crisis Walk-In Center (CWIC)  
16460 Victor Street Victorville, 92395

Holt Clinic Community Crisis Response Team – West Valley  
1647 E. Holt Blvd., Ontario

**PARTICIPANTS REPRESENTING THE MHP**

Alicia Goding, Office Assistant, Mental Health Services-Operations  
Allan Rowland, MHP Director  
Ana Astrande, Staff Member, Behavioral Health-Performance Management  
Andre Bossieux, Staff Member, Behavioral Health  
Andy Ruchy, Staff Member, Quality Improvement  
Arelis Martinez, Volunteer, Behavioral Health  
Armando Ontiveros, Staff Member, Families First  
Barbara Rose, Volunteer, Behavioral Health  
Bill Cramer, Staff Member, Information Systems  
Bob Sudol, Supervisor, Behavioral Health  
CaSonya Thomas, Staff Member, Behavioral Health-Performance Management  
Cheryl Long, Staff Member, Behavioral Health-Performance Management  
Chuck Cobb, Analyst, Information Systems  
Cindy Messer, Staff Member, Behavioral Health  
Claire Karp, Contract Provider, Behavioral Health  
Cynthia Eurbow, Supervisor, Behavioral Health  
Dan Peters, Staff Member, Holt Clinic  
David Denkers, Staff Member, Behavioral Health  
David Miller, Volunteer, Behavioral Health  
Diane Waters, Provider, Mental Health Services  
Dianne Sceranka, Staff Member, Holt Clinic  
Domingo Rodriquez, Supervisor, Behavioral Health  
Doris Turner, Staff Member, Behavioral Health  
Doris Melara, Staff Member, Behavioral Health-Performance Management  
Edward Deyon, Staff Member, Behavioral Health-Performance Management  
Gary Hubbard, Contract Provider, Behavioral Health  
Gary Atkins, Staff Member, Behavioral Health  
Jason Hill, Analyst, Information Systems  
Jatin Dalal, Staff Member, Behavioral Health-Performance Management  
Jeanette Gervantes, Provider, Mental Health Services  
Jill Smith, Staff Member, Quality Improvement  
Jim Jackson, Volunteer, Behavioral Health  
Jim Granger, Staff Member, Information Systems  
Joni Kincer, Volunteer, Behavioral Health  
Jose Herrera, Staff Member, Holt Clinic  
Julie Hovivian, Contract Provider, Quality Improvement  
Keith Harris, Staff Member, Behavioral Health Services-PIP Projects  
Keith Haigh, Staff Member, Behavioral Health  
Kevin Lee, Supervisor, Behavioral Health

Kimberly Ligon, Provider, Mental Health Services  
Kimberly Robinson, Provider, Mental Health Services  
Lauretta Ross, Staff Member, Behavioral Health-Performance Management  
Lisa McGinnis, Contract Provider, Behavioral Health  
Maggie Caceres, Office Assistant, Mental Health Services-Operations  
Margarita Pacini, Office Assistant, Mental Health Services-Operations  
Mariana Ruffolo, Staff Member, Behavioral Health-Performance Management  
Marina Espinosa, Coordinator, Ethics & Compliance  
Mark Thomas, Clinical Supervisor, Quality Management  
May Farr, Staff Member, Behavioral Health-Performance Management  
Melissa Zaili, Provider, Mental Health Services  
Michael Day, Information Technology, Behavioral Health-Performance Management  
Michael Knight, Staff Member, Behavioral Health-Performance Management  
Michael Oliver, Program Manager, Behavioral Health  
Michelle Fleming, Office Assistant, Mental Health Services-Operations  
Michelle Dusick, Staff Member, Behavioral Health-Performance Management  
Mike Schaefer, Staff Member, Behavioral Health-Performance Management  
Milagros Bran, Office Assistant, Mental Health Services-Operations  
Norma Lopez, Office Assistant, Mental Health Services-Operations  
Pamela Garcia, Staff Member, Information Systems  
Paula Rutten, Staff Member, Behavioral Health Services-PIP Projects  
Paula Quijano, Contract Provider, Behavioral Health  
Rebecca Gehlke-Baez, Supervisor, Behavioral Health  
Rebecca Risper, Office Assistant, Mental Health Services-Operations  
Richard Hernandez, Volunteer, Behavioral Health  
Robert Jeske, Volunteer, Behavioral Health  
Robert Dotson, Volunteer, Behavioral Health  
Ron Smith, Psychiatrist, Behavioral Health  
Sarah Erberhardt-Rios, Quality Improvement Manager  
Sarah Rushbrook, Contract Provider, Behavioral Health  
Sonja Gautreaux, Provider, Mental Health Services  
Stephanie Canani, Provider, Mental Health Services  
Stephen Thorpe, Contract Provider, Behavioral Health  
Susan Davis, Supervisor, Behavioral Health  
Tanya Bratton, Staff Member, Behavioral Health-Performance Management  
Terri Franklin, Program Manager, Behavioral Health  
Timothy Hougan, Manager, Children's Behavioral Health  
Veronica Kelley, Staff Member, Behavioral Health-Performance Management  
Veronica Camacho, Staff Member, Holt Clinic  
Yolanda Romero, Office Assistant, Mental Health Services-Operations

***C. Attachment—Approved Claims Source Data***

- **Source:** Data in Figures 5 through 14 and Appendix D is derived from four statewide source files:
  - Short-Doyle/Medi-Cal approved claims (SD/MC) from the Department of Mental Health (DMH)
  - 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 via DMH (originating from Electronic Data Systems, the Medi-Cal Fiscal Intermediary)
  - Monthly MEDS Extract Files (MMEF) from the Department of Health Services via DMH
- **Selection Criteria:**
  - Medi-Cal beneficiaries for whom the MHP is the “County of Fiscal Responsibility” are included, even when the beneficiary was served by another MHP
  - Medi-Cal beneficiaries with aid codes eligible for SD/MC program funding are included
- **Process Date:** The date DMH processes files for 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 CY2008 file with a DMH process date of April 28, 2009 includes claims with service dates between January 1 and December 31, 2008 processed by DMH through March 2009.
  - CY2009 includes SD/MC and IPC approved claims with process date April 2010
  - CY2008 includes SD/MC and IPC approved claims with process date December 2009
  - CY2007 includes SD/MC and IPC approved claims with process date April 2009
  - CY2006 includes SD/MC approved claims with process date October 2007 and IPC process date November 2007
  - CY2005 includes SD/MC and IPC approved claims with process date July 2006
  - FY08-09 includes SD/MC and IPC approved claims with process date December 2009
  - FY07-08 includes SD/MC and IPC approved claims with process date April 2009
  - FY06-07 includes SD/MC and IPC approved claims with process date May 2008
  - FY05-06 includes SD/MC and IPC approved claims with process date October 2007
  - FY04-05 includes SD/MC and IPC approved claims with process date April 2006
  - FY03-04 includes SD/MC and IPC approved claims with process date October 2005
  - FY02-03 includes SD/MC and IPC approved claims as of final reconciliation
  - FY08-09 denials include SD/MC claims (not IPC claims) processed between July 1, 2008 and June 30, 2009 (without regard to service date) with process date November 2009. Same methodology is used for prior years.
  - Most recent MMEF includes Medi-Cal eligibility for April 2010 and 15 prior months
- **Data Definitions:** Selected elements displayed in many figures within this report 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 Medi-Cal eligibles over a 12-month period.
  - Approved claims per beneficiary served per year – The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year
- **MHP Size:** Categories are based upon DMH definitions by county population.
  - Small-Rural MHPs = Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Plumas, Siskiyou, Trinity
  - Small MHPs = El Dorado, Humboldt, Imperial, Kings, Lake, Madera, Mendocino, Napa, Nevada, San Benito, Shasta, Sutter/Yuba, Tehama, Tuolumne, Yolo
  - Medium MHPs = Butte, Marin, Merced, Monterey, Placer/Sierra, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare
  - Large MHPs = Alameda, Contra Costa, Fresno, Kern, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Ventura
  - Los Angeles’ statistics are excluded from size comparisons, but are included in statewide data.

***D. Attachment—  
Medi-Cal Approved Claims Worksheets and Additional  
Tables***

## Medi-Cal Approved Claims Data for SAN BERNARDINO County MHP Calendar Year 09

Date Prepared:	05/12/2010, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	04/14/2010, 04/20/2010, and 04/07/2010 - Note (3)

	SAN BERNARDINO				LARGE		STATEWIDE		
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
<b>TOTAL</b>									
	443,681	25,111	\$75,736,845	5.66%	\$3,016	6.04%	\$4,335	5.98%	\$4,784
<b>AGE GROUP</b>									
0-5	95,957	882	\$2,873,588	0.92%	\$3,258	1.47%	\$3,654	1.46%	\$3,886
6-17	138,825	9,489	\$35,150,507	6.84%	\$3,704	7.44%	\$5,647	7.71%	\$6,316
18-59	161,737	13,507	\$35,039,648	8.35%	\$2,594	8.47%	\$3,753	8.03%	\$4,057
60+	47,162	1,233	\$2,673,102	2.61%	\$2,168	3.46%	\$3,062	3.41%	\$3,174
<b>GENDER</b>									
Female	251,035	13,086	\$35,858,111	5.21%	\$2,740	5.57%	\$3,790	5.46%	\$4,213
Male	192,646	12,025	\$39,878,734	6.24%	\$3,316	6.66%	\$4,927	6.67%	\$5,391
<b>RACE/ETHNICITY</b>									
White	93,689	9,292	\$29,023,822	9.92%	\$3,124	11.17%	\$4,290	11.09%	\$4,894
Hispanic	251,186	8,352	\$24,334,187	3.33%	\$2,914	3.43%	\$3,933	3.46%	\$4,580
African-American	58,922	4,750	\$13,903,360	8.06%	\$2,927	10.10%	\$5,296	10.22%	\$5,218
Asian/Pacific Islander	16,613	659	\$1,406,142	3.97%	\$2,134	4.27%	\$3,328	4.25%	\$3,493

	SAN BERNARDINO				LARGE		STATEWIDE		
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Native American	1,491	195	\$743,574	13.08%	\$3,813	11.38%	\$4,661	9.80%	\$5,120
Other	21,781	1,863	\$6,325,760	8.55%	\$3,395	7.46%	\$4,882	7.71%	\$5,344
<b>ELIGIBILITY CATEGORIES</b>									
Disabled	64,572	11,211	\$35,549,112	17.36%	\$3,171	18.94%	\$4,434	18.93%	\$4,710
Foster Care	4,384	2,156	\$10,091,486	49.18%	\$4,681	57.66%	\$7,287	61.11%	\$7,619
Other Child	220,502	7,202	\$21,758,730	3.27%	\$3,021	3.84%	\$4,042	4.06%	\$4,661
Family Adult	93,432	4,604	\$6,902,029	4.93%	\$1,499	4.38%	\$1,881	4.21%	\$2,239
Other Adult	65,212	555	\$1,435,488	0.85%	\$2,586	0.96%	\$3,205	0.96%	\$3,324
<b>SERVICE CATEGORIES</b>									
24 Hours Services	443,681	2,603	\$15,686,110	0.59%	\$6,026	0.48%	\$8,026	0.46%	\$8,248
23 Hours Services	443,681	929	\$1,075,429	0.21%	\$1,158	0.44%	\$1,677	0.31%	\$1,601
Day Treatment	443,681	136	\$1,352,715	0.03%	\$9,946	0.12%	\$10,712	0.10%	\$11,632
Linkage/Brokerage	443,681	4,916	\$2,479,529	1.11%	\$504	2.46%	\$1,004	2.61%	\$898
Outpatient Services	443,681	19,383	\$38,663,317	4.37%	\$1,995	4.83%	\$2,774	5.00%	\$3,228
TBS	443,681	176	\$2,852,026	0.04%	\$16,205	0.08%	\$12,173	0.06%	\$13,830
Medication Support	443,681	15,328	\$13,627,720	3.45%	\$889	3.34%	\$1,032	3.19%	\$1,212

## 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 574,726

### SAN BERNARDINO County MHP Medi-Cal Services Retention Rates CY09

Overall							
Number of Services Approved per Beneficiary Served	SAN BERNARDINO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
<b>1 service</b>	2,604	10.37	10.37	8.88	8.88	0.00	19.70
<b>2 services</b>	2,455	9.78	20.15	6.24	15.11	3.60	17.61
<b>3 services</b>	1,924	7.66	27.81	5.46	20.58	0.00	10.75
<b>4 services</b>	1,654	6.59	34.40	4.87	25.45	2.04	10.45
<b>5 - 15 services</b>	9,918	39.50	73.89	32.24	57.69	20.08	46.67
<b>&gt; 15 services</b>	6,556	26.11	100.00	42.31	100.00	11.34	61.48

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 04/14/2010; Inpatient Consolidation approved claims as of 04/20/2010

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

## Medi-Cal Approved Claims Data for SAN BERNARDINO County MHP Calendar Year 09 FOSTER CARE

Date Prepared:	05/13/2010, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	04/14/2010, 04/20/2010, and 04/07/2010 - Note (3)

	SAN BERNARDINO				LARGE		STATEWIDE		
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
<b>TOTAL</b>									
	4,384	2,156	\$10,091,486	49.18%	\$4,681	57.66%	\$7,287	61.11%	\$7,619
<b>AGE GROUP</b>									
0-5	1,039	248	\$878,396	23.87%	\$3,542	33.44%	\$3,532	37.16%	\$3,521
6+	3,345	1,908	\$9,213,090	57.04%	\$4,829	66.07%	\$7,947	69.07%	\$8,351
<b>GENDER</b>									
Female	2,149	939	\$4,247,545	43.69%	\$4,523	56.22%	\$7,041	58.77%	\$7,361
Male	2,235	1,217	\$5,843,941	54.45%	\$4,802	59.04%	\$7,511	63.35%	\$7,847
<b>RACE/ETHNICITY</b>									
White	1,369	734	\$3,865,271	53.62%	\$5,266	62.00%	\$7,374	58.99%	\$8,606
Hispanic	1,721	825	\$3,519,221	47.94%	\$4,266	54.79%	\$5,926	64.19%	\$5,808
African-American	1,176	533	\$2,426,248	45.32%	\$4,552	57.33%	\$8,747	61.77%	\$8,046

	SAN BERNARDINO					LARGE		STATEWIDE		
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	
Asian/Pacific Islander	27	11	\$53,116	40.74%	\$4,829	62.67%	\$7,750	62.05%	\$7,390	
Native American	27	9	\$27,964	33.33%	\$3,107	49.25%	\$5,863	46.37%	\$6,371	
Other	67	44	\$199,666	65.67%	\$4,538	55.67%	\$9,722	71.14%	\$8,718	
<b>SERVICE CATEGORIES</b>										
24 Hours Services	4,384	104	\$755,797	2.37%	\$7,267	2.03%	\$7,115	2.22%	\$8,147	
23 Hours Services	4,384	51	\$45,568	1.16%	\$893	1.70%	\$1,200	1.19%	\$1,225	
Day Treatment	4,384	53	\$633,710	1.21%	\$11,957	4.46%	\$10,892	3.57%	\$12,014	
Linkage/Brokerage	4,384	383	\$263,824	8.74%	\$689	25.62%	\$1,339	28.84%	\$1,024	
Outpatient Services	4,384	2,011	\$6,848,190	45.87%	\$3,405	54.43%	\$4,773	58.37%	\$5,229	
TBS	4,384	44	\$740,149	1.00%	\$16,822	3.10%	\$12,279	2.77%	\$13,415	
Medication Support	4,384	856	\$804,248	19.53%	\$940	18.44%	\$1,243	20.01%	\$1,563	

Footnotes:

- 1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs
- 2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding
- 3 - The most recent processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report
- 4 - County total number of yearly unduplicated Medi-Cal eligibles is 6,053

### SAN BERNARDINO County MHP Medi-Cal Services Retention Rates CY09

Foster Care							
Number of Services Approved per Beneficiary Served	SAN BERNARDINO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
<b>1 service</b>	178	8.26	8.26	6.31	6.31	0.00	22.90
<b>2 services</b>	292	13.54	21.80	4.97	11.28	0.00	16.67
<b>3 services</b>	116	5.38	27.18	4.85	16.14	0.00	16.32
<b>4 services</b>	81	3.76	30.94	3.53	19.66	0.00	22.22
<b>5 - 15 services</b>	626	29.04	59.97	24.86	44.52	12.50	52.38
<b>&gt; 15 services</b>	863	40.03	100.00	55.48	100.00	22.22	76.38

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 04/14/2010; Inpatient Consolidation approved claims as of 04/20/2010

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

## Medi-Cal Approved Claims Data for SAN BERNARDINO County MHP Calendar Year 09 TRANSITION AGE YOUTH (Age 16-25)

Date Prepared:	05/13/2010, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	04/14/2010, 04/20/2010, and 04/07/2010 - Note (3)

	SAN BERNARDINO				LARGE		STATEWIDE		
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
<b>TOTAL</b>	68,954	4,792	\$16,980,345	6.95%	\$3,543	6.91%	\$5,461	7.01%	\$5,966
<b>AGE GROUP</b>									
16-17	21,442	1,968	\$9,041,732	9.18%	\$4,594	9.93%	\$6,455	10.21%	\$7,023
18-21	28,758	1,828	\$5,101,002	6.36%	\$2,790	6.02%	\$4,958	6.13%	\$5,469
22-25	18,754	996	\$2,837,611	5.31%	\$2,849	5.00%	\$4,262	4.83%	\$4,469
<b>GENDER</b>									
Female	42,667	2,339	\$7,955,062	5.48%	\$3,401	5.66%	\$5,098	5.74%	\$5,618
Male	26,287	2,453	\$9,025,283	9.33%	\$3,679	8.86%	\$5,826	8.96%	\$6,306
<b>RACE/ETHNICITY</b>									
White	14,322	1,602	\$6,148,275	11.19%	\$3,838	11.87%	\$5,376	12.72%	\$6,173
Hispanic	39,873	1,815	\$6,299,618	4.55%	\$3,471	4.61%	\$4,839	4.70%	\$5,525
African-American	10,987	1,012	\$3,084,082	9.21%	\$3,048	11.05%	\$6,170	10.92%	\$6,199
Asian/Pacific Islander	1,757	64	\$285,364	3.64%	\$4,459	3.60%	\$5,881	3.64%	\$5,853

	SAN BERNARDINO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Native American	257	40	\$157,830	15.56%	\$3,946	11.78%	\$6,672	10.06%	\$6,812
Other	1,760	259	\$1,005,175	14.72%	\$3,881	9.09%	\$6,560	9.21%	\$7,128
<b>ELIGIBILITY CATEGORIES</b>									
Disabled	7,232	1,587	\$6,110,999	21.94%	\$3,851	21.39%	\$6,470	22.24%	\$6,767
Foster Care	958	651	\$3,492,912	67.95%	\$5,365	75.12%	\$8,071	81.84%	\$8,275
Other Child	19,168	1,198	\$4,253,841	6.25%	\$3,551	7.52%	\$4,507	7.88%	\$5,064
Family Adult	33,619	1,289	\$2,360,357	3.83%	\$1,831	3.94%	\$2,823	4.21%	\$3,306
Other Adult	8,208	246	\$762,236	3.00%	\$3,099	2.60%	\$3,834	2.46%	\$4,253
<b>SERVICE CATEGORIES</b>									
24 Hours Services	68,954	827	\$4,239,164	1.20%	\$5,126	0.83%	\$7,088	0.77%	\$7,292
23 Hours Services	68,954	239	\$241,859	0.35%	\$1,012	0.70%	\$1,435	0.49%	\$1,430
Day Treatment	68,954	70	\$711,260	0.10%	\$10,161	0.24%	\$10,866	0.21%	\$12,256
Linkage/Brokerage	68,954	961	\$541,969	1.39%	\$564	2.78%	\$1,305	3.06%	\$1,067
Outpatient Services	68,954	4,029	\$8,278,298	5.84%	\$2,055	5.87%	\$3,364	6.18%	\$3,953
TBS	68,954	52	\$732,424	0.08%	\$14,085	0.14%	\$10,912	0.11%	\$11,402
Medication Support	68,954	2,693	\$2,235,372	3.91%	\$830	3.22%	\$1,031	3.15%	\$1,248

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 102,776

### SAN BERNARDINO County MHP Medi-Cal Services Retention Rates CY09

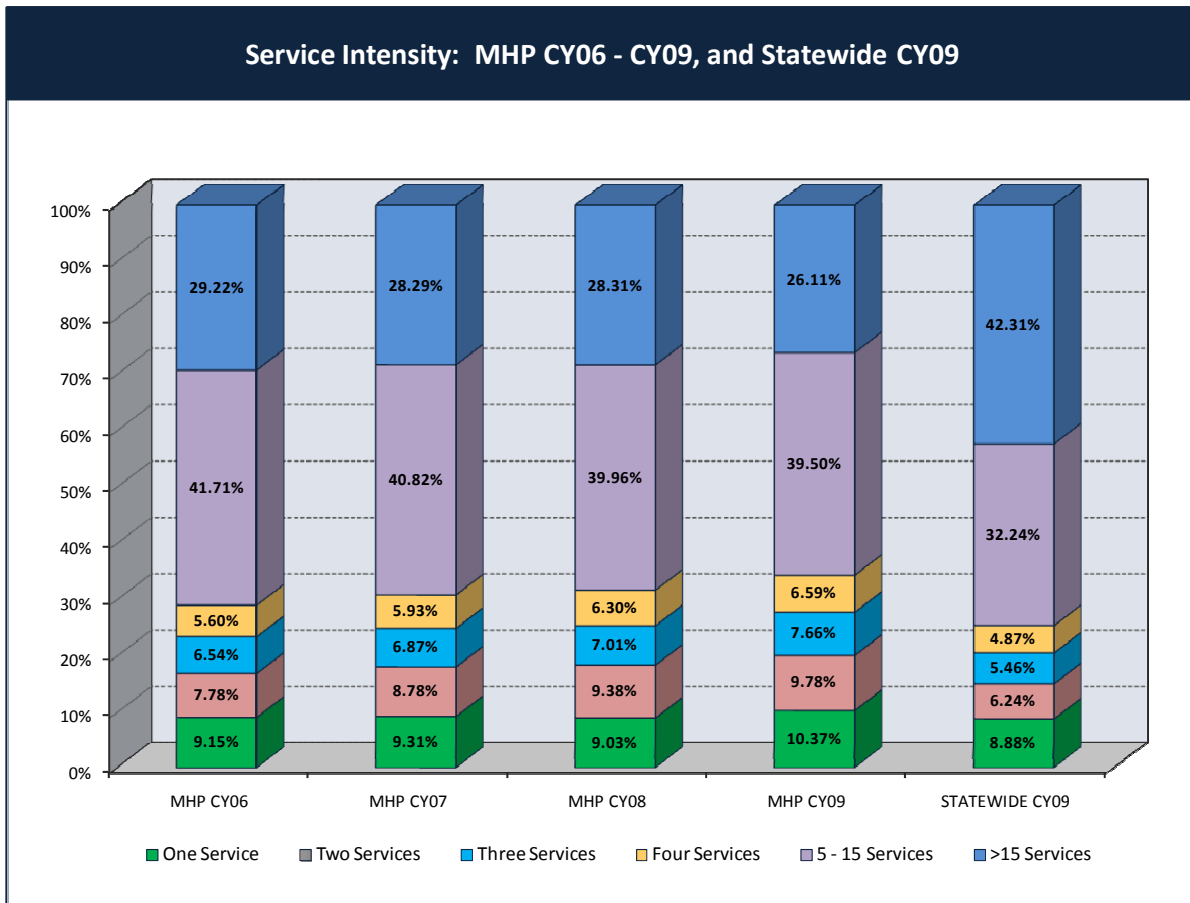
Transition Age Youth (Age 16-25)							
Number of Services Approved per Beneficiary Served	SAN BERNARDINO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
<b>1 service</b>	557	11.62	11.62	9.99	9.99	0.00	24.86
<b>2 services</b>	510	10.64	22.27	6.74	16.73	0.00	20.25
<b>3 services</b>	360	7.51	29.78	5.24	21.96	0.00	10.17
<b>4 services</b>	320	6.68	36.46	4.73	26.69	0.00	20.34
<b>5 - 15 services</b>	1,762	36.77	73.23	28.35	55.04	19.39	100.00
<b>&gt; 15 services</b>	1,283	26.77	100.00	44.96	100.00	0.00	61.77

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 04/14/2010; Inpatient Consolidation approved claims as of 04/20/2010

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

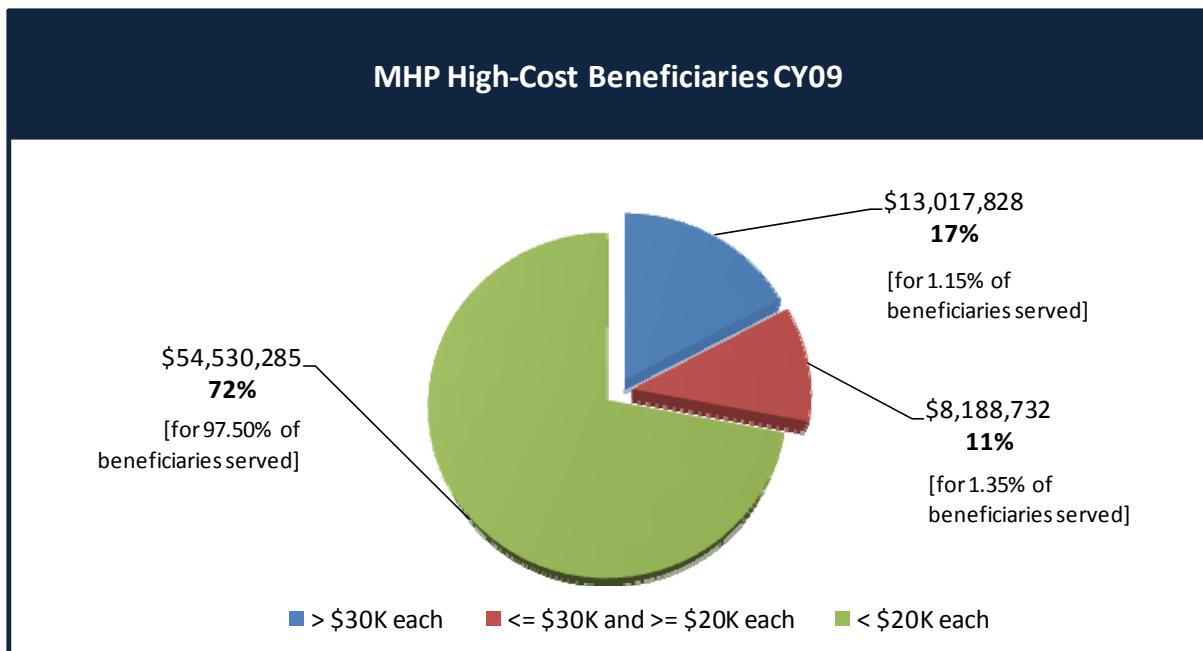
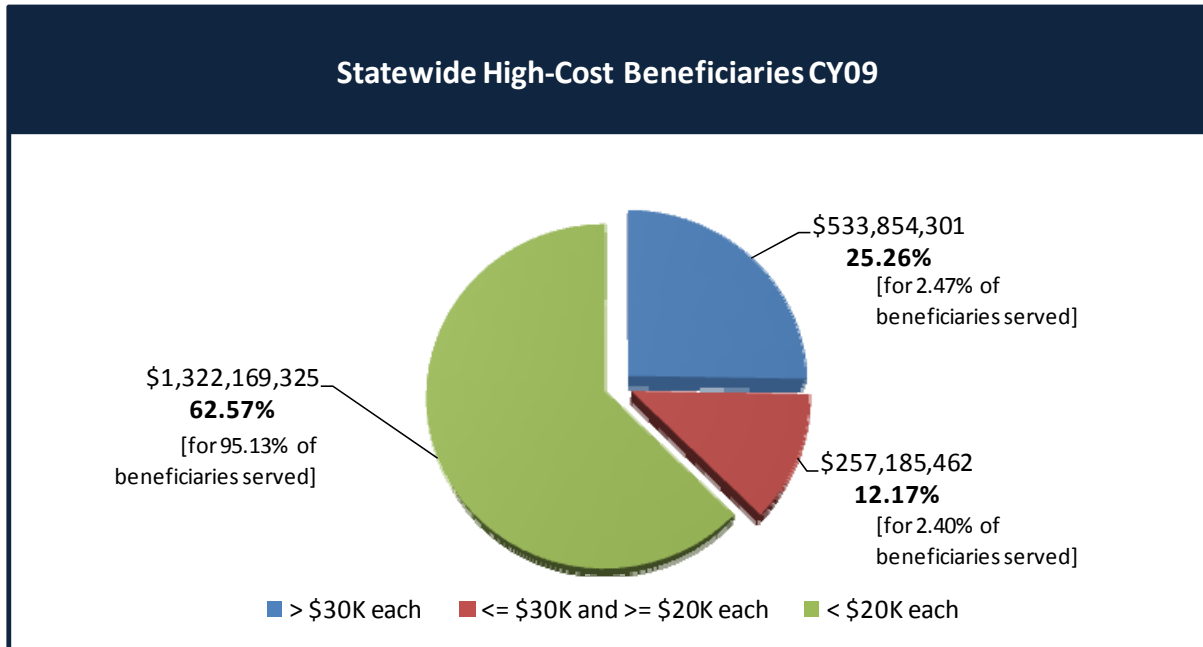
## Retention Rates



**CY2009 Retention Rates with Average Approved Claims per Category**

Number of Services Approved per Beneficiary Served	MHP Number of beneficiaries served	MHP \$ per beneficiary served	Statewide \$ per beneficiary served
<b>1 service</b>	2,604	\$234	\$281
<b>2 services</b>	2,455	\$431	\$434
<b>3 services</b>	1,924	\$526	\$564
<b>4 services</b>	1,654	\$679	\$696
<b>5 – 15 services</b>	9,918	\$1,423	\$1,440
<b>&gt; 15 services</b>	6,556	\$8,820	\$9,934

## High Cost Beneficiaries CY09



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## EXAMINATION OF DISPARITIES

Statewide disparities remain for Hispanic and female beneficiaries:

- The relative access and the average approved claims for Hispanic beneficiaries were lower than for White beneficiaries. Over the past four years of data, these disparities decreased slightly – approaching parity in approved claims but a continued remarkable disparity in access.
- The relative access and the average approved claims for female beneficiaries were lower than for males. These disparities have remained stable over the last four years.

For each variable (Hispanic/White and female/male), two ratios are calculated to depict relative access and relative approved claims. The first figure compares approved claims data and penetration rates between Hispanic and White beneficiaries. This penetration rate ratio is calculated by dividing the Hispanic penetration rate by the White penetration rate, resulting in a ratio that depicts the relative access for Hispanics when compared to Whites. The approved claims ratio is calculated by dividing the average approved claims for Hispanics by the average approved claims for Whites. Similar calculations follow in the second figure for female to male beneficiaries.

For all elements, ratios depict the following:

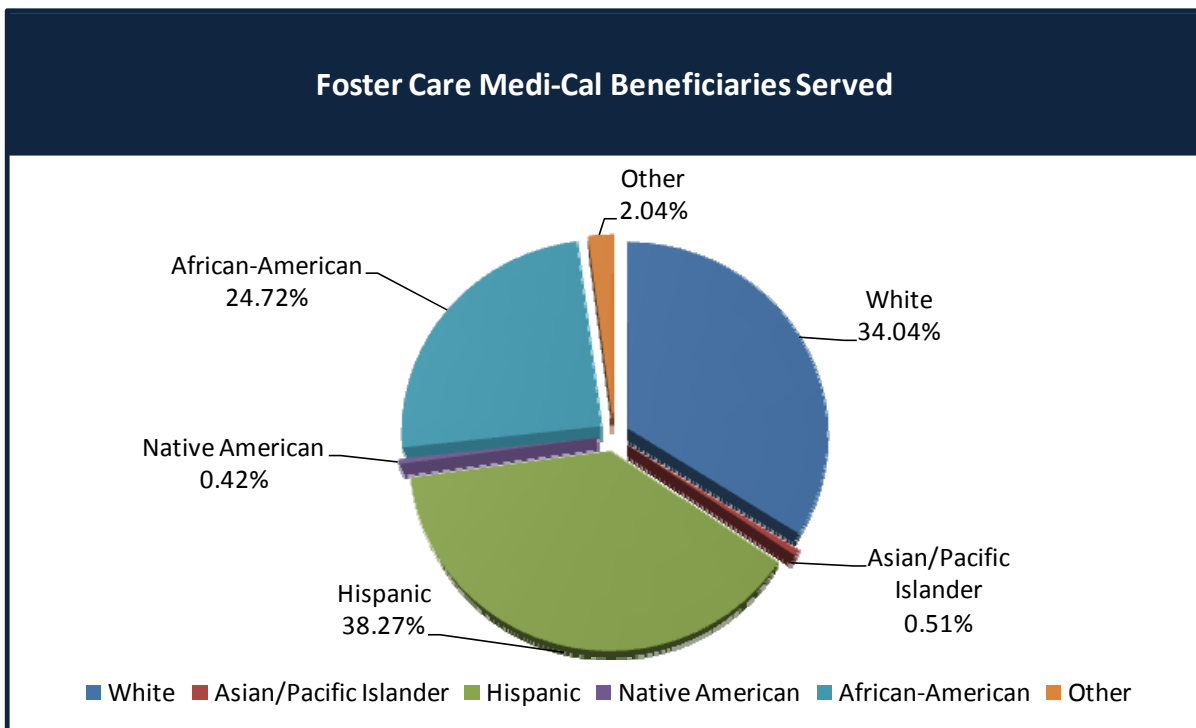
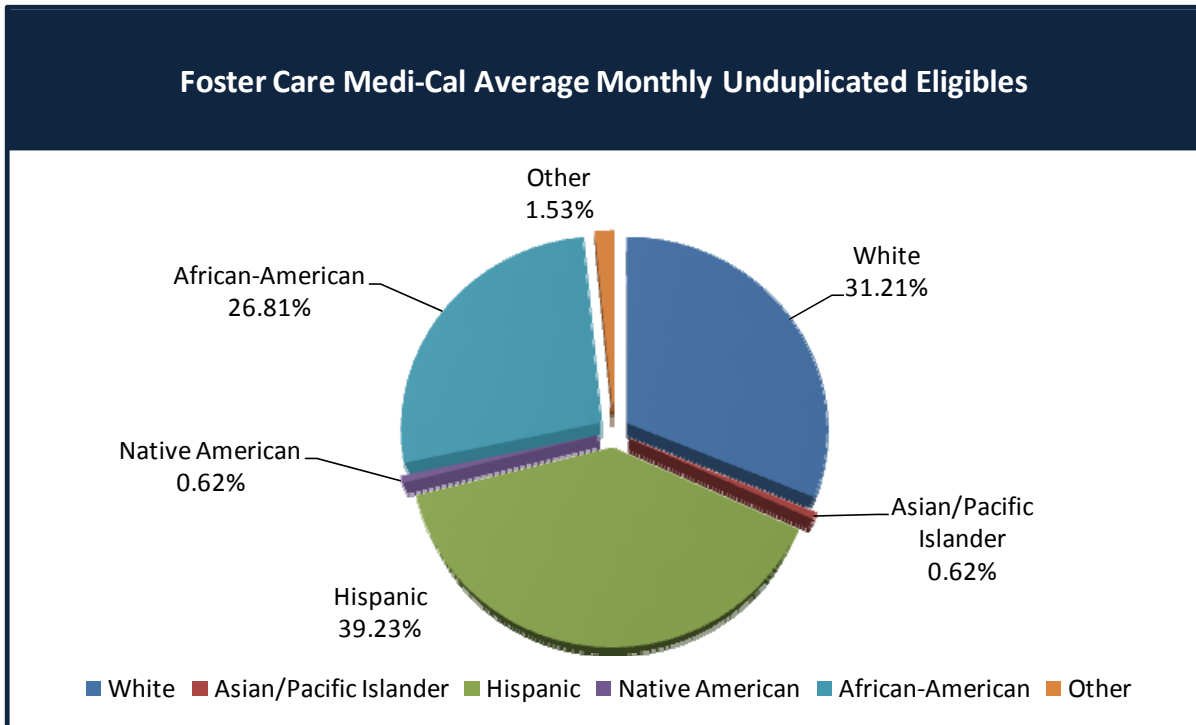
- 1.0 = parity between the two elements compared
- Less than 1.0 = disparity for Hispanics or females
- Greater than 1.0 = no disparity for Hispanics or females. A ratio of greater than one indicates higher penetration or approved claims for Hispanics when compared to Whites or for females when compared to males.

Examination of Disparities—Hispanic versus White								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
<b>Statewide CY09</b>	139,264	3.46%	163,864	11.09%	\$4,580	\$4,894	.31	.94
<b>MHP CY09</b>	8,352	3.33%	9,292	9.92%	\$2,914	\$3,124	.34	.93
<b>MHP CY08</b>	8,147	3.65%	10,089	11.36%	\$2,845	\$2,914	.32	.98
<b>MHP CY07</b>	7,018	3.42%	9,674	11.01%	\$2,788	\$2,890	.31	.96
<b>MHP CY06</b>	6,572	3.39%	9,934	10.96%	\$2,736	\$2,846	.31	.96

Examination of Disparities—Female versus Male								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Female versus Male for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
<b>Statewide CY09</b>	227,299	5.46%	214,383	6.67%	\$4,213	\$5,391	.82	.78
<b>MHP CY09</b>	13,086	5.21%	12,025	6.24%	\$2,740	\$3,316	.84	.83
<b>MHP CY08</b>	13,595	5.90%	12,185	7.01%	\$2,653	\$3,232	.84	.82
<b>MHP CY07</b>	12,638	5.81%	11,184	6.88%	\$2,634	\$3,093	.84	.85
<b>MHP CY06</b>	12,397	5.84%	11,067	6.98%	\$2,679	\$3,042	.84	.88

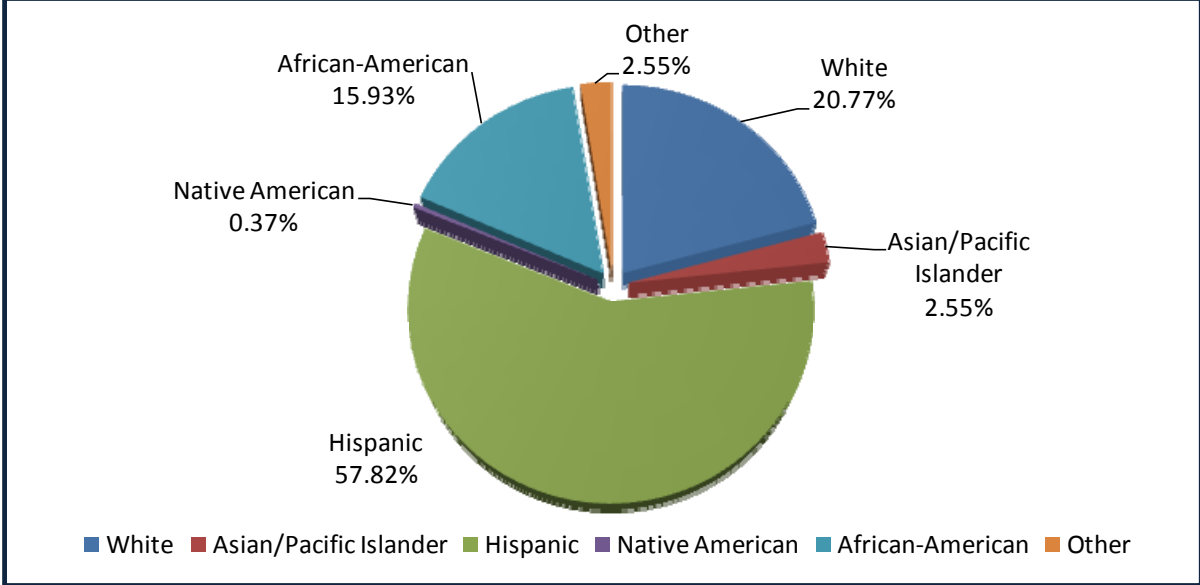
## MHP Foster Care Medi-Cal Eligibles vs. Foster Care Beneficiaries Served

DMH Approved Claims Calendar Year 2009

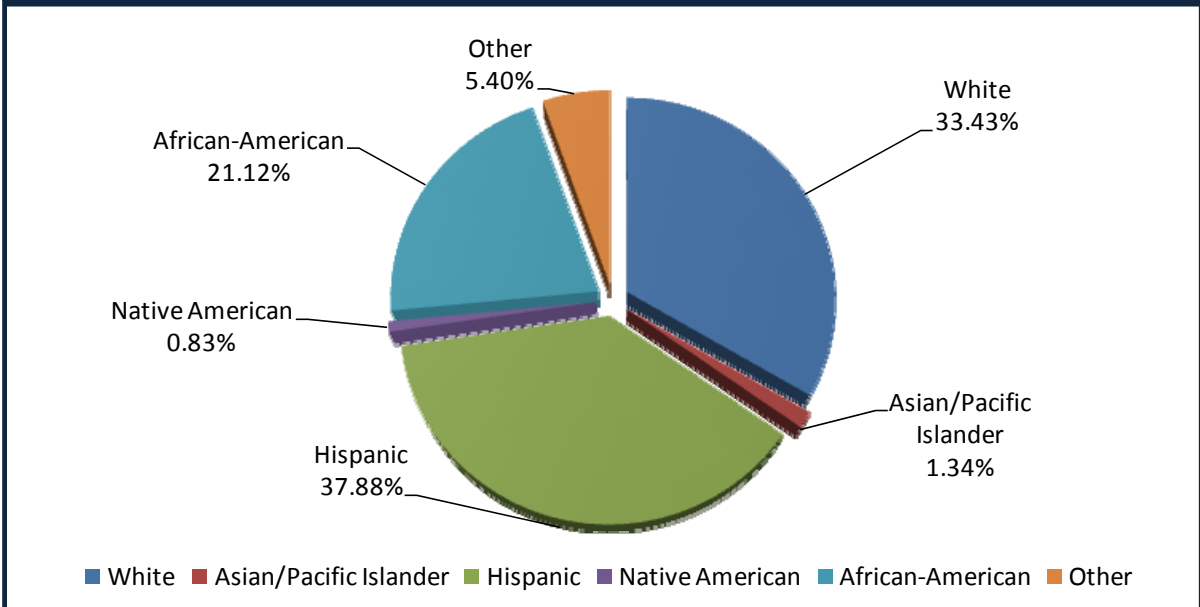


## MHP TAY Medi-Cal Eligibles vs. TAY Beneficiaries Served DMH Approved Claims Calendar Year 2009

### TAY Medi-Cal Average Monthly Unduplicated Eligibles



### TAY Medi-Cal Beneficiaries Served



***E. Attachment—PIP Validation Tool***

**The MHP did not submit a Clinical PIP. All elements are rated as “not met” for purposes of analysis.**

Step		Rating						
		Met	Partial	Not Met	N/A			
<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			X				
1.2	Was selected following data collection and analysis of data that supports the identified problem			X				
1.3	Addresses key aspects of care and services			X				
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs			X				
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X				
<b>Totals for Step 1:</b>		<b>0</b>	<b>0</b>	<b>5</b>	<b>0</b>			
<b>2</b>	<b>Study Question Definition</b> <i>The written study question:</i>							
2.1	Identifies the problem targeted for improvement			X				
2.2	Includes the specific population to be addressed			X				
2.3	Includes a general approach to interventions			X				
2.4	Is answerable/demonstrable			X				
2.5	Is within the MHP’s scope of influence	0	0	X	0			
<b>Totals for Step 2:</b>		<b>0</b>	<b>0</b>	<b>5</b>	<b>0</b>			
<b>3</b>	<b>Clearly Defined Study Indicators</b> <i>The study indicators:</i>							
3.1	Are clearly defined, objective, and measurable			X				
3.2	Are designed to answer the study question			X				
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			X				
3.4	Have accessible data that can be collected for each indicator			X				
3.5	Utilize existing baseline data that demonstrate the current status for each indicator			X				
3.6	Identify relevant benchmarks for each indicator			X				
3.7	Identify a specific, measurable goal(s) for each indicator			X				
<b>Totals for Step 3:</b>		<b>0</b>	<b>0</b>	<b>7</b>	<b>0</b>			

Step		Rating			
		Met	Partial	Not Met	N/A
<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			X	
4.2	Included a data collection approach that captures all consumers for whom the study question applies			X	
<b>Totals for Step 4:</b>		<b>0</b>	<b>0</b>	<b>2</b>	<b>0</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			X	
5.2	Identify the sample size			X	
5.3	Specify the confidence interval to be used			X	
5.4	Specify the acceptable margin of error			X	
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population			X	
<b>Totals for Step 5:</b>		<b>0</b>	<b>0</b>	<b>5</b>	<b>0</b>
<b>6</b>	<b>Accurate/Complete Data Collection</b> <i>The data techniques:</i>				
6.1	Identify the data elements to be collected			X	
6.2	Specify the sources of data			X	
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data			X	
6.4	Provides a timeline for the collection of baseline and remeasurement data			X	
6.5	Identify qualified personnel to collect the data			X	
<b>Totals for Step 6:</b>		<b>0</b>	<b>0</b>	<b>5</b>	<b>0</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			X	
7.2	Have the potential to be applied system wide to induce significant change			X	
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			X	
7.4	Are standardized and monitored when an intervention is successful			X	
<b>Totals for Step 7:</b>		<b>0</b>	<b>0</b>	<b>4</b>	<b>0</b>
<b>8</b>	<b>Analyses of Data and Interpretation of Study Results</b> <i>The data analyses and study results:</i>				

Step		Rating			
		Met	Partial	Not Met	N/A
8.1	Are conducted according to the data analyses plan in the study design			X	
8.2	Identify factors that may threaten internal or external validity			X	
8.3	Are presented in an accurate, clear, and easily understood fashion			X	
8.4	Identify initial measurement and remeasurement of study indicators			X	
8.5	Identify statistical differences between initial measurement and remeasurement			X	
8.6	Include the interpretation of findings and the extent to which the study was successful			X	
<b>Totals for Step 8:</b>		<b>0</b>	<b>0</b>	<b>6</b>	<b>0</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			X	
9.2	Documented quantitative improvement in processes or outcomes of care			X	
9.3	Improvement appearing to be the result of the planned interventions(s)			X	
9.4	Statistical evidence for improvement			X	
<b>Totals for Step 9:</b>		<b>0</b>		<b>4</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			X	
<b>Totals for Step 10:</b>		<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>

**FY 10-11 Review of: San Bernardino**

Clinical     Non-Clinical

**PIP Title: EPSDT**

**Date PIP Began: October 2008**

**Date PIP Completed (if applicable):**

**PIP Category:**     Access                       Timeliness                       Quality                       Outcomes                       Other

**Descriptive Category: processes of care**

**Target Population: youth**

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
<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	X				
1.2	Was selected following data collection and analysis of data that supports the identified problem	X				
1.3	Addresses key aspects of care and services	X				
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs	X				Includes all eligible youth based upon the MHP's problem definition.
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X				
<b>Totals for Step 1:</b>		<b>5</b>	<b>0</b>	<b>0</b>	<b>0</b>	

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
<b>2</b>	<b>Study Question Definition</b> <i>The written study question:</i>					
2.1	Identifies the problem targeted for improvement	X				
2.2	Includes the specific population to be addressed	X				
2.3	Includes a general approach to interventions	X				
2.4	Is answerable/demonstrable	X				
2.5	Is within the MHP's scope of influence	X				
<b>Totals for Step 2:</b>		<b>5</b>				
<b>3</b>	<b>Clearly Defined Study Indicators</b> <i>The study indicators:</i>					
3.1	Are clearly defined, objective, and measurable		X			The PIP would be strengthened by inclusion of an indicator that shows improved client outcome occurring as a result of more consistent service delivery.
3.2	Are designed to answer the study question	X				
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		X			It is possible that variation in service pattern is based upon consumer need.
3.4	Have accessible data that can be collected for each indicator	X				For the existing indicator as defined.
3.5	Utilize existing baseline data that demonstrate the current status for each indicator	X				For the existing indicator as defined.
3.6	Identify relevant benchmarks for each indicator			X		
3.7	Identify a specific, measurable goal(s) for each indicator	X				For the existing indicator as defined.
<b>Totals for Step 3:</b>		<b>4</b>	<b>2</b>	<b>1</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	X				
4.2	Included a data collection approach that captures all consumers for whom the study question applies	X				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
<b>Totals for Step 4:</b>		<b>2</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				X	
5.2	Identify the sample size				X	
5.3	Specify the confidence interval to be used				X	
5.4	Specify the acceptable margin of error				X	
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population				X	
<b>Totals for Step 5:</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>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	X				
6.2	Specify the sources of data	X				
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X				
6.4	Provides a timeline for the collection of baseline and remeasurement data	X				
6.5	Identify qualified personnel to collect the data	X				
<b>Totals for Step 6:</b>		<b>5</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	X				
7.2	Have the potential to be applied system wide to induce significant change	X				
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			X		
7.4	Are standardized and monitored when an			X		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	intervention is successful					
<b>Totals for Step 7:</b>		<b>2</b>	<b>0</b>	<b>2</b>	<b>0</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			X		There are no findings yet.
8.2	Identify factors that may threaten internal or external validity			X		
8.3	Are presented in an accurate, clear, and easily understood fashion			X		
8.4	Identify initial measurement and remeasurement of study indicators			X		
8.5	Identify statistical differences between initial measurement and remeasurement			X		
8.6	Include the interpretation of findings and the extent to which the study was successful			X		
<b>Totals for Step 8:</b>				<b>6</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			X		
9.2	Documented quantitative improvement in processes or outcomes of care			X		
9.3	Improvement appearing to be the result of the planned interventions(s)			X		
9.4	Statistical evidence for improvement			X		
<b>Totals for Step 9:</b>				<b>4</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			X		

Step		Rating				Comments/Recommendations
		<i>Met</i>	Partial	Not Met	N/A	
<b>Totals for Step 10:</b>				1		

***F. Attachment—MHP PIPs Submitted***



**California EQRO**

560 J Street, Suite 390  
Sacramento, CA 95814

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

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

## **CAEQRO PIP Outline via Road Map**

**MHP:**

**Date PIP Began: September 15, 2008**

**Title of PIP: Acute Psychiatric Hospital Recidivism Reduction**

**Clinical or Non-Clinical: Clinical**

**Assemble multi-functional team**

1. Describe the stakeholders who are involved in developing and implementing this PIP.
  - II. The San Bernardino County Department of Behavioral Health Quality Management Unit is the coordinating body for this project. The Research and Evaluation team has been involved as well as other staff members to include, but not limited to, clerical assistants and staff analysts. The development of the clinical aspects of the project has been assigned to a Team Leader, a Program Manager

Implementation of Strategy 1 is being done done by the Telecare Corporation Members Assertive Positive Solutions program (MAPS) staff including clinicians, case managers, program managers and administration. This implementation is ongoing as of this date (09/13/2010).

Implementation of Strategy 2 has been completed. Implementation was done by case managers and clinicians. Data analysis and write up was completed by an MSW intern as a research project.

**“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.
  - ✓ **Priority for MHP:** In reviewing the department’s data, it was found that psychiatric rehospitalization is problematic. Data is available to document the number of hospital visits (to include Psychiatric Emergency Room “seen and released” visits, Psychiatric Triage Diversion Visits, and hospital admissions). Data can also be obtained as to the number of hospital days used by a particular client within the past 12 months. This data was collected by the DBH Research and Evaluation department using internal data bases as well as the TAR log for hospital admissions.  
In fiscal year 07/08, 116 unique clients had six or more inpatient hospitalizations, using 5,359 total bed days (14.33% of all bed days). This means that 2.83% of the DBH’s clients used a disproportionate 14.33% of total bed days.  
Additionally, in FY 08/09, 109 unique clients had six or more inpatient hospitalizations, using 5,198 total bed days. This means that 2.63% of all clients used 14.62% of the hospital bed days..  
Furthermore, in FY 09/10, 123 unique clients had six or more inpatient hospitalizations, using 4,848 total bed days. This means that 2.67% of all clients used 14.69% of all hospital bed days.
  - ✓ **MHP’s scope of influence:** The MHP can provide (or arrange to be provided) case management services to our recently discharged clients. These services were utilized during strategy 2 for a variety of services including screening for at-risk clients for rehospitalization, reinforcing the discharge plan, encouraging outpatient compliance, and making additional referrals as deemed necessary.

- ✓ For strategy 2, intensive case management services are being provided in the form a Full Service Partnership to accomplish all of the above, plus the needed case management services necessary to obtain and maintain stability for the client in the community.
- ✓ **Consumer population—the severely and persistently mentally ill:** Acute hospitalization impacts client’s and their families’ lives. Hospitalization can be disruptive and traumatic to some clients. Enabling clients to remain in the community and receive the necessary services at the outpatient level promotes the ideology of recovery.

For the purposes of the project only adult (over age 18) clients have been included.

**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?

Strategy 2, which was implemented by DBH staff, included screening questions that helped identify the barriers and/or causes of rehospitalization. A comprehensive literature review was conducted, and several factors are associated with repeat rehospitalizations. These factors include poor medication adherence, the length of hospital stays, the client’s legal status (voluntary or involuntary) upon admission to the hospital, client demographic characteristics, and the continuity of care between inpatient and outpatient treatment.

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
<p>Medication adherence            Poor adherence leads to rehospitalization</p>	<p>Abas, M., Vanderpyl, J., Le Prou, T., Kydd, R., Emery, B., &amp; Foliaki, S. A. (2003). Psychiatric hospitalization: Reasons for admission and alternatives to admission in South Auckland, New Zealand. <i>Australian and New Zealand Journal of Psychiatry</i>, 37, 620-625. Retrieved August 15, 2008 from Academic Search Premier Database.</p> <p>Weiden, P. J., Kozma, C., Grogg, M., &amp; Locklear, J. (2004). Partial compliance and risk of rehospitalization among California Medicaid patients with schizophrenia. <i>Psychiatric Services</i>, 55(8), 886-891. Retrieved August 17, 2008 from Psychiatryonline Database.</p>
<p>Length of index hospitalization            Too short hospital stays lead to rehospitalization            Longer hospital stays lead to rehospitalization            (literature is inconsistent)</p>	<p>Kolbasovsky, A., Reich, L. &amp; Futterman, R. (2007). Predicting future hospital utilization for mental health conditions. <i>The Journal of Behavioral Health Services &amp; Research</i>, 34(1), 34-42. Retrieved May 26, 2008 from: Academic Search Premier Database.</p> <p>Segal, S. P., Akutsu, P. D., &amp; Watson, M. A. (2002). Involuntary return to a psychiatric emergency service within twelve months. <i>Social Work in Health Care</i>, 35(½), 591-603. Retrieved June 5, 2008 from Academic Search Premier Database.</p>
<p>Legal status            Those who are involuntarily hospitalized tend to be rehospitalized more often</p>	<p>Segal, S. P., Akutsu, P. D., &amp; Watson, M. A. (2002). Involuntary return to a psychiatric emergency service within twelve months. <i>Social Work in Health Care</i>, 35(½), 591-603. Retrieved June 5, 2008 from Academic Search Premier Database.</p>
<p>Client demographic characteristics            Rehospitalization is influenced by diagnosis, older age, single marital status, ethnicity, living situation</p>	<p>Kolbasovsky, A., Reich, L. &amp; Futterman, R. (2007). Predicting future hospital utilization for mental health conditions. <i>The Journal of Behavioral Health Services &amp; Research</i>, 34(1), 34-42. Retrieved May 26, 2008 from: Academic Search Premier Database.</p> <p>Montgomery, P. &amp; Kirkpatrick, H. (2002). Understanding those who seek frequent psychiatric hospitalizations. <i>Archives of Psychiatric Nursing</i>, 16(1), 16-24. Retrieved June 5, 2008 from Academic Search Premier Database.</p>

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
	Yamada, M. M., Korman, M., & Hughes, C. W. (2000). Predicting rehospitalization of persons with severe mental illness. <i>Journal of Rehabilitation</i> , 66(2), 32-39. Retrieved August 19, 2008 from Wilson Web Database.
<p>Continuity of care between inpatient and outpatient treatment</p> <p>Rehospitalization is avoided most often when inpatient and outpatient systems work together rather than on parallel tracks</p>	<p>Cuffel, B., Held, M., &amp; Goldman, W. (2002). Predictive models and the effectiveness of strategies for 72 improving outpatient follow-up under managed care. <i>Psychiatric Services</i>; 53(11): 1438-1443. Retrieved August 27, 2008 from Psychiatryonline Database.</p> <p>Kanter, J. S. (1991). Integrating case management and psychiatric hospitalization. <i>Health &amp; Social Work</i>, 16(1), 34-42. Retrieved on December 6, 2008 from Academic Search Premier Database.</p> <p>Kolbasovsky, A., Reich, L. &amp; Futterman, R. (2007). Predicting future hospital utilization for mental health conditions. <i>The Journal of Behavioral Health Services &amp; Research</i>, 34(1), 34-42. Retrieved May 26, 2008 from: Academic Search Premier Database.</p> <p>Nelson, E. A., Maruish, M. E., &amp; Axler, J. L. (2000). Effects of discharge planning and compliance with outpatient appointments on readmission rates. <i>Psychiatric Services</i>, 52(7), 885-889. Retrieved August 17, 2008 from Psychiatryonline Database.</p>

**Formulate the study question**

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

For Strategy 1: Will intensive case management services in the form of a Full Service Partnership reduce the likelihood of rehospitalization and/or the number of hospital days used by clients who are high utilizers of hospital services?

For Strategy 2: Does an immediate post-hospitalization follow-up intervention have an effect on the rehospitalization rates of those who were recently discharged from inpatient care at the County Behavioral Health Unit?

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

For the purposes of this study the focus is only the adult (over age 18) population. This study focuses on the severely and persistently mentally ill in San Bernardino County. For Strategy 2, a sample was taken for the pilot project, as the population of all patients who were recently discharged from inpatient care is too large for the purpose of this pilot project.

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

The population included in Strategy 1 is adult clients who are high users of hospital services and at risk of rehospitalization without intensive community based interventions. There are currently 51 clients included in the program with a maximum of 60 clients to be included into the program as they are identified as being able to benefit and willing to cooperate with the program

The sample for Strategy 2 included 144 adult clients who had been recently discharged from the County inpatient psychiatric unit during the months of December 2008 and January 2009. A total of 73 clients were randomly assigned to the experimental group and 71 to the control group. The population consists of severely and persistently mentally ill adults in San Bernardino County. A sample was taken for the pilot project, as the population of all patients who were recently discharged from inpatient care is too large for the scope of this pilot project.

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

The clients assigned to the MAPS program (Strategy 1) are identified through case managers working with inpatient clients. Referrals are made through the DBH gatekeeper and then to the Telecare Corporation. Telecare is responsible for compiling the outcome data for these clients and long term data compilation is still underway.

For Strategy 2, all patients discharged from the County Behavioral Health Unit from December 1, 2008-January 31, 2009 who were not discharged to locked placement were included in the sample.

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

Sampling was done only in Strategy 2. A random sampling was done on a monthly basis of all clients discharged from the County inpatient program. This sample population was then randomly assigned to either the experimental group or the control group.

An explanatory classical experiment design with random assignment to experimental and control groups was utilized. All clients discharged from the County inpatient program were randomly assigned to control or experimental groups.

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

There are currently 51 clients assigned to Strategy 1 with a maximum of 60 to be assigned.

There were 144 clients included in Strategy 2 (73 in the experimental group and 71 in the control group). This number allowed for statistical analysis of the data.

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

Planned interventions

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

9. a) Why were these performance indicators selected?

Performance indicators for both strategies focus on the rehospitalization data. Additionally, in Strategy 2 the length of hospital stay as measured in days on subsequent hospital readmissions was measured. These performance indicators were selected based on a review of rehospitalization literature and on anecdotal evidence collected from case managers and clinicians working with this population.

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

The recovery model is a logical successor to deinstitutionalization and the community mental health model which emphasizes optimal client functioning in the community. The performance indicators selected are reflective of this model.

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

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	Number of hospitalizations in a 3 month period			1.6 (average) Range = 0 – 26 hospitalizations	reduction in # hospitalization
2	Number of days hospitalized on each hospitalization			6.4 (average) Range = 1 -49 hospital days	reduction in # hospital days
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	Referral to a full service partnership program	Targeting those clients who require maximum support in order to remain in the community	Ongoing
2	Case management follow up within 72 hours of discharge from the County inpatient psychiatric unit	Targeting clients post-discharge to encourage outpatient follow-up, educate, provide referrals, and screen for “at-risk” symptoms requiring additional follow-up	Dec. 4, 2008 through February 10, 2009
3			
4			
5			

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

**Apply Interventions: “What do we see?”**

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

For the completed intervention, data collected included date intervention was applied, client identification number, data collectors identifier, number of previous admissions over the past year, reason for index admission, legal status upon admission, number of hospital days during index admission, discharge diagnoses, demographics to include age, gender, ethnicity, marital status, presence of co-occurring disorder, employment status, city of residence and insurance status, medication adherence since discharge, living situation, type of residence, previous outpatient treatment, planned outpatient follow-up, and recommendations for follow-up.

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.

Existing data for our Information System was utilized along with information for the discharging hospital completed on discharge of the client as well as information obtained during the intervention on the intervention survey tool.

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

Data analysis for Strategy 2 included simple numbers and percentages for demographic and diagnostic data. A chi-square test for independence, a Mann-Whitney U test, a two-way between-groups analysis of variance studies were also applied as described in the attachment.

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

Department of Behavioral Health staff employed by the Psychiatric Triage Diversion team were responsible for application of the intervention as well as data collection. This included case managers and clinicians. The data analysis was completed by a MSW intern student (also employee) who completed the PIP pilot project as a research thesis.

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?

Data analysis demonstrated that the intervention had impact on rehospitalizations. However, the question still remains as to the reason for the rehospitalizations which may result in a third strategy for the PIP project.

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

The statistical analysis demonstrated that there was a significance in the reduction of hospital visits and the number of days of subsequent hospital visits to a moderate degree. The sample size was small and precludes a meaningful measurement in terms of percentage of improvement achieved.

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

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/denominator)	% improvement achieved
<b>THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS</b>							
Number of hospitalizations in a 3 month period	<i>90 days pre-date of index hospitalization</i>	1.6 (average) Range = 0-26	<i>10% reduction in # of hospitalizations</i>	<i>12-4-09 through 2-10-09</i>	<i>90 days post discharge from index hospitalization</i>	<i>.5 (average) Range = 0-4</i>	
Number of days hospitalized on	<i>90 days pre-index hospitalization</i>	6.4 (average) Range = 1-49 days	<i>10% reduction in # hospital days</i>		<i>90 days post discharge from index</i>	<i>1.9 (average) Range = 0-24</i>	

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/denominator)	Goal for % improvement	Intervention applied & dates applied			
each hospitalization					<i>hospitalizations</i>		

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

17. Describe issues associated with data analysis:

As both projects target only a small population of the entire client population data analysis can only be applied to those clients included in the samples. It is theorized that the same results would be demonstrated if the resources were available to apply the interventions to all clients.

- a. Data cycles clearly identify when measurements occur.  
In Strategy 2 measurements of hospital admissions were taken for the 3 months prior to the intervention and for the 3 months post-intervention of telephonic case management.
- b. Statistical significance  
Statistical significant was demonstrated as described in #22 below.

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

no

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

no

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

Strategy 1 is still in process of application and results are still pending. Antedotal data indicates that the interventions are resulting in reduced hospitalizations and reduction in numbers of days spent in the hospital on subsequent admissions.

Strategy 2 demonstrated that the follow-up intervention was successful. It was found that those in the intervention group were rehospitalized less than those in the control group, and that when those in the intervention group were rehospitalized, they spent less time in the hospital.

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?

Data has not yet been compared system wide for these projects as each targeted just a few of the total number of clients hospitalized throughout the system.

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

In Strategy 2 data analysis did demonstrate an improvement in process as well as client outcomes. Process was improved when continuity of care between outpatient and inpatient systems was improved. Client outcomes were improved in that the intervention reduced hospital readmissions and number of days spent in the hospital.

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

Validity of the improvement is seen when comparing the experimental group who received the intervention with the outcomes of those clients included in the control group. It was found that those in the intervention group were

rehospitalized less than those in the control group, and that when those in the intervention group were rehospitalized, they spent less time in the hospital.

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

A Mann-Whitney  $U$  test revealed a significant difference in the rehospitalization rates of the experimental ( $Md=.00$ ,  $n=73$ ) and control ( $Md=.00$ ,  $n=71$ ) groups,  $U=2177.5$ ,  $z=-1.999$ ,  $p=.046$ ,  $r=0.2$  (small to medium effect). Those who received the follow-up intervention were rehospitalized significantly less than those who did not.

A second Mann-Whitney  $U$  test also revealed a significant difference in the total number of days spent in the hospital if rehospitalized for the experimental ( $Md=.00$ ,  $n=73$ ) and control ( $Md=.00$ ,  $n=71$ ) groups,  $U=2117.5$ ,  $z=-2.275$ ,  $p=.023$ ,  $r=0.2$  (small to medium effect). Those who received the follow-up intervention, if they returned to the hospital, spent less time hospitalized than those who did not.

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

As Strategy 2 was a pilot project repeated measurements have not been done.



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

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

### **CAEQRO PIP Outline via Road Map**

**MHP:** County of San Bernardino Department of Behavioral Health  
**Date PIP Began:** October 2008  
**Title of PIP:** EPSDT PIP  
**Clinical or Non-Clinical:** Administrative

**Assemble multi-functional team**

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

**Statewide:** The stakeholders involved include California Mental Health Directors Association (CMHDA), Department of Mental Health (DMH), Mental Health Plan (MHP) Contract Providers, the California Mental Health Directors Association, the County Welfare Directors Association, the California Council of Community Mental Health Agencies, and the California Alliance of Child and Family Services.

**MHP:** The stakeholders involved include the County of San Bernardino Department of Behavioral Health (DBH), local contracted EPSDT providers, local psychiatric hospitals, and the Department of Mental Health (DMH)

**“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.

**Statewide:** Approved EPSDT claims data for FY 2006-07 shows that the 3% of EPSDT clients with the highest average monthly claims account for 25.5% of total annual EPSDT spending. While it is reasonable to expect that this highest-cost-of-service cohort includes clients with severe conditions that justify higher average monthly costs, a review of client specific services received by a sample drawn from this cohort often include a complex pattern of use that raises questions about service levels, array of services, possible gaps in service, and multi-system involvement. Studies identified by the Department of Mental Health suggest of other pediatric health care system highest-cost-of-service cohorts suggest that the cost and complexity of these EPSDT services could indicate a need for improved coordination, enhanced capacity, and other improvements to ensure that each client is receiving services that are indicated, effective, and efficient, at the levels being provided. DMH has consulted with representatives from the California Mental Health Directors Association, the County Welfare Directors Association, the California Council of Community Mental Health Agencies, and the California Alliance of Child and Family Services on the concepts of this proposal as they relate to addressing quality, effectiveness and efficiency of service delivery to children.

**MHP: Define local problem – Refer to data examined (include as an attachment if too detailed to dd here). If Criterion B, include the MHP’s initial dollar threshold for study population inclusion.**

The locally identified problem relates to the coordination of services, in that some high-needs EPSDT clients receive services from a variety of providers without sufficient coordination of those services provided. High-needs EPSDT clients require complex coordination of frequent services and, as such, often include monthly costs in excess of \$3,000. Provision of services within such highly coordinated programs is needed more now as other options for meeting the needs of some children and youth become increasingly unavailable (e.g., no state hospital resources, fewer RCL 14 group homes). To meet the needs of this population, the availability of highly coordinated programs for high-needs EPSDT clients has increased over the past several years. Geographic barriers (i.e., San Bernardino is the largest county in continuous 48

States) were overcome in February 2006 when SB163 wraparound became available throughout the county. Funding and socio-economic barriers were overcome in October 2007 with the implementation of Success First (i.e., MHSA Full-Service Partnership) programs for children and youth. In addition to these programs, Therapeutic Behavioral Services (TBS) continues to be increasingly available for EPSDT clients in a variety of settings. However, some high-needs EPSDT clients are not gaining access to these programs in their various locales, and are attempting to meet their mental health needs through various providers without a high degree of care coordination.

DBH EPSDT service data for FY 2006-07 indicates that 3% of EPSDT clients with the highest average monthly claims account for 31% of the total annual EPSDT spending, indicating a similar pattern for San Bernardino County. EPSDT Claims for this 3% population are comprised of multiple types of services: 36% of the services in FY06-07 were for individual therapy; 18% were for psychiatric hospitalizations; 10% were for assessment; and 9% were for collateral services. The remainder of the claim constitutes various services with no one service accounting for more than 8% of the total. EPSDT services for FY08-09 indicate a similar distribution of services. Evaluation of the EPSDT services for FY08-09 indicate that beneficiaries enrolled in coordinated programs (e.g., wraparound, TBS, or intensive case management) received more consistent services as indicated by changes in the amount of services between months. 44% of the clients not enrolled in an identified program experienced dramatic increases and decreases of services in two sequential months, while only 9% of the clients enrolled in a coordinated program experienced a similar fluctuation of services provided. Services provided to clients receiving \$3,000 of services in a month need to be more coordinated to ensure consistency of care.

**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?

**Statewide:** EPSDT claims data used in developing this proposal consists of FY 2006-07 approved claims data received as of March 2008; the most current EPSDT claims data available at this time. The Medi-Cal claims file for this period included claims for ~183,892 clients totaling ~ \$949,967,324. MHPs, in collaboration with their providers, are responsible for the identification and collection of relevant data such as clinical data derived from chart reviews, billing/reporting data, treatment service factors, etc., and continuing data exchange and reporting to the Department of Mental Health to inform, measure and continuously improve services to children and their families.

**Table 1**  
**Distribution of Approved Claims for EPSDT**  
 SFY 2006-07 Year Claims to date (Includes SGF, FFP, County Share funds)

<b>Service</b>	<b>Approved \$</b>	<b>% Total</b>
PHF	\$2,745,896	0.29%
Adult Crisis Residential	\$725,573	0.08%
Adult Residential	\$1,919,066	0.20%
Crisis Stabilization	\$5,574,531	0.59%
Day Tmt Intensive Half Day	\$5,601,497	0.59%
Day Tmt Intensive Full Day	\$49,610,477	5.22%
Day Tmt Rehabilitative Half Day	\$1,175,263	0.12%
Day Tmt Rehabilitative Full Day	\$27,372,551	2.88%
Targeted Case Management	\$69,504,927	7.32%
Mental Health Services	\$637,266,489	67.08%
Collateral Services		
Assessments		
Plan Development		
Individual Services		
Group Services		
Rehabilitation		
Professional In-patient Visit		
Therapeutic Behavior Services	\$54,744,405	5.76%
Medication Support	\$79,440,321	8.36%
Crisis Intervention	\$14,295,328	1.50%
<b>EPSDT Total</b>	<b>\$949,976,324</b>	<b>100.00%</b>

Table 2 displays standard analytic metrics for the expenditure data as well as a distribution of clients' average monthly claims by quartiles. For purposes of this proposal, the DMH elected to set a cut-off point at the 97<sup>th</sup> percentile. This is the point at which 97 percent of the clients have an average monthly service cost below \$3,000 and 3 percent have an average monthly cost for services equal to or greater than \$3,000. Average monthly cost data was arrived at using only months during which a client received services for which an approved claim was submitted. The highest 3% group was found to represent 5,518 clients.

**Table 2**  
**Monthly EPSDT Approved Claims Metrics**

Monthly	Values	Quartiles	
		Quartile	Estimate
Number	183,892	100.00%	\$24,188
Mean	\$742	99.00%	\$4,693
Std Dev	\$935	95.00%	\$2,313
Median	\$489	90.00%	\$1,535
Mode	\$313	75.00%	\$850
IQR	\$596	50.00%	\$489
		25.00%	\$254
		10.00%	\$120
		5.00%	\$78
		1.00%	\$40
		0.00%	\$1

Table 3 provides a breakdown of expenditures by the number of months of service for the 5,518 clients. These 3 percent of the total EPSDT caseload were found to have received services costing \$242,277,620, or 25.5 percent of the total 2006-07 annual expenditures.

**Table 3**  
**Approved Annual Claims per Client**  
**Where Monthly Claims are Equal To or Greater Than \$3,000**  
**per month**  
(For months in which Claims Were Submitted)

Months Pd Svc	Frequency	All \$
All	5518	\$242,277,620
1	185	\$830,647
2	194	\$1,688,992
3	206	\$2,831,905
4	231	\$4,168,661
5	215	\$4,877,961
6	247	\$6,421,969
7	220	\$6,633,899

8	259	\$9,561,421
9	323	\$13,410,002
10	382	\$17,594,196
11	515	\$26,934,757
12	2541	\$147,323,204

This quality improvement proposal is supported by a study of pediatric high health care service users. The study discusses that high-cost children use services of numerous types delivered in multiple venues, and concludes that “providing care coordination throughout the entire health care system is important to address both the cost and the quality aspects of health care for the most costly children”. The study further concludes that “clinicians should review regularly the extent of care coordination that they provide for their high-need and high-cost patients, especially preteens and adolescents” and that “targeted programs to decrease expenditures for those with the greatest costs have the potential to save future health care dollars.”(Liptak, GS et al. Short-term Persistence of High Health Care Costs in a Nationally Representative Sample of Children. PEDIATRICS Vol. 118 No. 4 October 2006).

MHP 3a) Describe MHP issues associated with locally defined problem and patterns. What data supports the MHP’s interpretation of the problems and reasons for the problems? Does the data suggest other problems as well? What other evidence within the MHP’s system provide additional support to the MHP’s interpretation of the data?

EPSDT service data used in developing this proposal consists of FY 2006-07, FY2007-08, and FY2008-09 claims data available through April, 2009. This represents the most current EPSDT service data available at this time. For these time periods, the number of clients served and total amounts are as follows:

FY2006-07:	10,789	\$43,457,418.47
FY2007-08	11,894	\$51,284,510.25
FY2008-09 (YTD)	11,847	\$49,722,808.53

Demographics for the population served through EPSDT services are listed in Table 4

**Table 4**  
**Demographic for EPSDT population by Fiscal Year**

	<b>FY06-07</b>	<b>FY07-08</b>	<b>FY08-09 (YTD)</b>
Male	62%	61%	61%
Female	38%	39%	39%
Age			
0-5	9%	10%	8%
6-12	41%	40%	39%
13-17	47%	44%	45%
18+	3%	6%	8%
Ethnicity			
Asian	1%	1%	1%
Black	18%	18%	19%
Latino	34%	33%	34%
White	38%	36%	35%
Other	2%	4%	5%
Unknown	6%	7%	5%

Table 5 includes detailed information on the specific services included in each time period

<b>Table 5</b>						
<b>Distribution of EPSDT for San Bernardino County</b>						
	<b>FY 2006-07</b>		<b>FY2007-08</b>		<b>FY2008-09 YTD {5/4/09}</b>	
<b>Service</b>	<b>Cost</b>	<b>% Total</b>	<b>Cost</b>	<b>% Total</b>	<b>Cost</b>	<b>% Total</b>
Assess & Eval	\$4,424,674.25	10.18%	\$5,216,707.70	10.17%	\$4,528,420.47	9.11%
Case Management	\$1,312,294.79	3.02%	\$1,042,968.57	2.03%	\$1,377,324.19	2.77%
Collateral	\$4,090,467.81	9.41%	\$5,511,446.89	10.75%	\$6,139,768.08	12.35%
Crisis Intervention	\$886,632.67	2.04%	\$1,678,341.78	3.27%	\$2,411,099.79	4.85%
Day Treatment	\$353,934.36	0.81%	\$289,520.49	0.56%	\$470,047.89	1.18%
Group Therapy	\$597,356.50	1.37%	\$653,639.07	1.27%	\$587,891.49	1.18%
Hospitalization	\$7,761,282.30	17.86%	\$8,120,435.89	15.83%	\$5,957,888.48	11.98%
Individual Therapy	\$15,851,139.10	36.48%	\$20,021,634.49	39.04%	\$18,612,065.03	37.43%
Medication Support Services	\$4,191,397.99	9.64%	\$4,517,125.85	8.81%	\$4,124,067.39	8.29%
Plan Development	\$2,261,058.26	5.20%	\$2,243,666.58	4.37%	\$2,605,456.32	5.24%
Psychological Testing	\$92,615.04	0.21%	\$73,274.35	0.14%	\$48,052.71	0.10%
Therapeutic Behavioral Services	\$1,634,565.40	3.76%	\$1,915,748.59	3.74%	\$2,860,726.69	5.75%
<b>TOTALS</b>	<b>\$43,457,418.47</b>	<b>100.00%</b>	<b>\$51,284,510.25</b>	<b>100.00%</b>	<b>\$49,722,808.53</b>	<b>100.00%</b>

The initial group of beneficiaries identified by APS as being part of the highest 3% group totaled 491. Of these, 401 were enrolled in programs considered to demonstrate a high degree of coordination of services and intended to meet the complex mental health needs of the seriously emotional disturbed children and youth considered to be "high-needs." In San Bernardino County programs considered to be highly coordinated include the following:

Full Service Partnerships: There are several different FSP programs serving children and youth in San Bernardino County. These include:

SB163 Wraparound: Wards and Dependents of the court are provided wraparound services throughout the county by five contract agencies as authorized by the Interagency Placement Committee.

Success First Wraparound: Serving seriously emotionally disturbed children, meeting medical necessity criteria, who do not do not meet all the admission criteria for SB163 Wraparound, but are considered at risk for hospitalization, homelessness, or dropping out of school, may be enrolled in this wraparound-style program. These services are provided throughout the county by six contract agencies.

Transitional Age Youth (TAY): Serving seriously emotionally disturbed youth by providing coordinated and comprehensive support and direct services in the community and at the One Stop TAY Centers. These services are provided throughout the county by five contract agencies.

TBS: These intensive one-to-one services are provided throughout the county by three contract agencies.

Screening, Assessment, Referral and Treatment (SART): Services provided in collaboration with First 5 to meet the needs of the 0-5 population. These services are provided by three contract agencies in the Central Valley, West Valley, and High Desert Regions of the county.

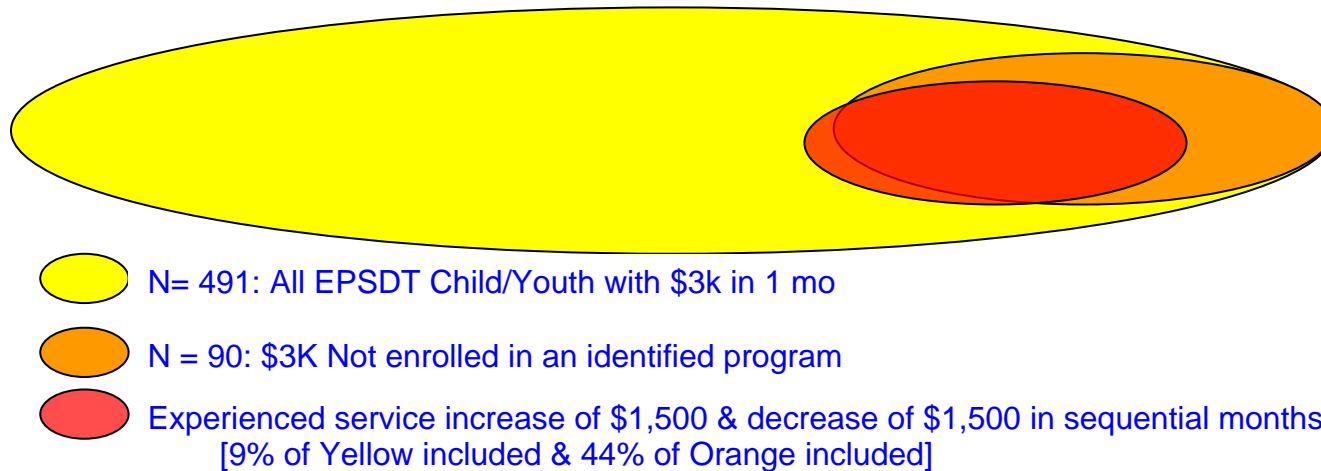
Centralized Children's Intensive Case Management (CCICMS): DBH's County-wide unit responsible for coordinating mental health services for severely emotionally disturbed children in residential placement. This includes AB2726 residential services.

Day Treatment: Highly structured day program provided within the context of residential placement.

Preliminary review of month-by-month patterns of the cost of services provided to the beneficiaries included by APS appeared to indicate that those enrolled in a highly coordinated program were provided services in a more consistent manner than beneficiaries not enrolled in one of the aforementioned programs. This was particularly evident by a higher occurrence of dramatic fluctuations between amounts of services provided to clients in two sequential months. The committee postulated that there could be a problem for these high-needs clients in receiving needed services consistently, and these perceived rapid fluctuations of services were signs of inconsistent access. Following multiple efforts to quantify "dramatic fluctuations", it was determined that a review of

the pattern of services for increased services in one month by \$1,500 or more for a monthly total in excess of \$3,000, followed by decreases in cost of services of \$1,500 or more in the next month might be more instructive. Using this operational definition of “dramatic fluctuations” it was found that 9% of the children enrolled in a highly coordinated program experienced a dramatic increase and decrease in service while 44% of the clients not enrolled in one of these programs had this experience.

Pictorial display of the breakdown of the original beneficiaries identified by APS



The demographics for this group of the highest 3% clients not enrolled in a highly coordinated program are contained in Table 7. FY08-09 data for the entire EPSDT population are repeated for easy comparison.

**Table 7**  
**Demographic comparison of Study Group & Entire EPSDT population**

	Study Group FY08-09 (YTD -4/30/09)	Total EPSDT FY08-09 (YTD – 5/4/09)
Male	53%	61%
Female	47%	39%
Age		
0-5	7%	8%
6-12	30%	39%
13-17	52%	45%
18+	11%	8%
Ethnicity		

Asian	2%	1%
Black	13%	19%
Hispanic	44%	34%
White	35%	35%
Unknown	5%	5%
Other	1%	6%
FosterCare	37%	45%
Hospitalized	44%	

Additionally, upon reviewing the services provided to these 90 clients, the following findings emerged:

- 69% were involved in care through 2 or more providers during a 3 months period
- 35% were provided the same type of service by two different care providers within the same month
- Diagnostic Breakdown is as follows:
  - Major Depressive Disorder 20%
  - Bipolar 19%
  - Mood Disorder – Other 17%
  - ADHD 16%
  - Conduct Disorder 9%
  - Psychotic Disorder 7%
  - Anxiety Disorder 4%
  - Adjustment Disorder 2%
  - Other Qualifying Diagnoses 5%

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
Geographic	San Bernardino County is the largest contiguous county in terms of land mass in the entire Continental US; further, 50% of the initial study group reside in the Desert Mountain Region of the county which covers vast amounts of desolate space.
Impact of lack of clarity on service definition for Case Management	Recent confusion regarding a more limited definition of Case Management services appears to have resulted in a decrease of coordination of services for children and youth served by multiple providers.

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Budget	Recent and current budget issues have negatively impacted the availability of funding for oversight services that may be provided to high-needs children and youth outside of highly coordinated programs
Cultural	Study group demographics indicate a 10% higher representation for Hispanics than in the total demographics for the entire serviced EPSDT population. This high penetration rate more accurately reflects the cultural composition of San Bernardino County, but there may be other reasons why Hispanic youth and children are more represented in the study group.
Transient Nature	Multiple regional factors and economical climate impact families, causing them to move frequently and affecting their ability to consistently provide care to their children and youth.
Limited Access to Coordination of Care	44% of high needs clients not enrolled in a highly coordinated program experience dramatic increases and decreases in outpatient services, whereas only 9% of high needs clients enrolled in these programs experience this shift.
Technological	There is not a current method to identify children with high needs in real time, which is partially a technological barrier.

**Formulate the study question**

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

**Statewide:** Will implementing activities such as, but not limited to: improved utilization management, care coordination activities, data collection, review and validation, and a focus on the outcomes of interventions lead to enhanced quality, effectiveness and/or efficiency of service delivery to children receiving EPSDT funded mental health services?

**MHP:** State the local study question which includes the problems as defined by the MHP and MHP's general approach to addressing the associated causes/barriers.

Will:

- implementing a screening tool to assess the needs of an EPSDT client who has received \$3,000 of outpatient specialty mental health services within one (1) calendar month since July 1, 2008; and ,
- facilitating a referral, if needed, to a specialty program to assure an appropriate level of care coordination is provided for the child or youth

Result in:

- a significant increase in the percentage of children and youth receiving consistent mental health services, as defined as not experiencing an increase of \$1,500 or more of services in one month followed by a decrease of \$1,500 or more of services in the next month;

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

Yes

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

Medi-Cal beneficiaries under the age of 21 who have received \$3,000 of outpatient services within 1 calendar month since 7/1/08, and who are not enrolled in a MHP program identified as including a high level of care

coordination. Included beneficiaries will be exited from the EPSDT PIP should they reach the age of 21 or move outside of San Bernardino County. The number of beneficiaries participating in the PIP will vary over time; beneficiaries exiting the PIP will impact this number, and beneficiaries newly identified and enrolled in the PIP during FY09-10 will increase this number. At the time of implementation (i.e., 9/28/09) there were 142 individuals included in the PIP.

7. Describe how the population is being identified for the collection of data.  
Initial summary review and ongoing monthly review of outpatient mental health services provided to Medi-Cal beneficiaries, as contained in county computer system (SIMON), which identifies all Medi-Cal beneficiaries meeting criteria identified in #6.

8. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?  
N/A – Sampling technique is not being used.

b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?  
The initial number of beneficiaries identified within the PIP were 90, as of 12/30/08. Beneficiaries were enrolled in the PIP as they met the criteria and disenrolled as they moved out of the area or aged out of EPSDT services. During the course of the PIP 151 additional beneficiaries have been enrolled at various times for a total of 241 being enrolled in the PIP at some point since 12/30/08. Also over the course of the PIP 107 beneficiaries were disenrolled from the PIP in compliance with disenrollment standards.

Since the performance indicator selected requires at least two months of measurement, up to a 12 month period of time (i.e., Sept 2009 through Aug 2010) was utilized. Over this period there were a total of 181 beneficiaries who were active in the PIP for a significant period of time (i.e., 4 months or more) that they were included in the sample.

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

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

9. a) Why were these performance indicators selected?

The indicator of high fluctuation of services provided was included as this appears to be indicative of a child or youth not receiving needed mental health services in an appropriately consistent manner. Children and youth experiencing such dramatic changes in the level of services received are less likely to benefit from mental health services.

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

A decrease in the percentage of children and youth who experience dramatic fluctuation in the reception of mental health services will indicate a change in the process of care since more children will participate in services consistently across months. More consistent participation in services, including an appropriate termination of services, will facilitate fewer disruptions to school experiences and other aspects of daily living.

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

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	Percentage of Children or Youth, not enrolled in an identified program, who experience sequential increase and decrease of \$1,500 of outpatient services in span of two sequential months	Number of Children and Youth in PIP meeting this criteria	Total Number of Children and Youth in PIP	44%	10%

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.

**Interventions should be logically connected to barriers/issues identified as causes associated with the problems affecting the study population.**

**Table C - Interventions**

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	<p>DBH Staff shall attempt to contact, via phone, guardians for children and youth identified as meeting PIP enrollment criteria. Once contacted, staff shall conduct a short structured interview designed to assess level of current need and identify appropriate referrals. (See Appendix #1 for copy of structured interview)</p> <p>Based upon phone interview results staff shall identify appropriate level of care coordination needed for child/youth and make referrals to programs as appropriate.</p>	Limited access to coordination of care	9/28/09
2	Identification of children/youth who have met PIP inclusionary criteria within one (1) month of receiving \$3,000 or more of services. Identification will result in prompting for Intervention #1 to be provided for identified child/youth.	Technological & Limited access to coordination of Care	10/1/09
3	Identification of children/youth who are included in the PIP, but who have been determined to not need a referral to a “highly coordinated” program; however, then receive \$3,000 of outpatient services within a subsequent month. Identification will result in prompting for Intervention #1 to be provided to child/youth	Technological & Limited access to coordination of Care	10/1/09

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

11. Describe the data to be collected.
- Dollar amount of services received by enrollees per calendar month
  - Binomial indication if enrolled child/youth has experienced an increase of \$1,500 or more of outpatient services in one month followed by a decrease of \$1,500 or more of outpatient services the next month since 10/1/09 or since month child/youth is identified as an EPSDT PIP member, which ever date is more recent.

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. **Describe how the MHP will collect data for all individuals for whom the study question applies.**

Archived client, episode, service and cost data will be extracted from existing data systems that already track and manage such information. Most queries operate on an SQL mirror database that is refreshed weekly from the transactional data system used by clinics and providers.

13. Describe the plan for data analysis. Include contingencies for untoward results. **What processes will the MHP have in place to ensure that the intervention is applied as intended? How will that be measured?**

Following extraction of service, episode, client and other necessary data from the existing tables, staff from the Research and Evaluation section will assist PIP sponsor in the analyses necessary to determine clients' appropriate category, and to determine costs of services by type.

Completion of the structured interview and subsequent referrals will be recorded in tracking system that includes reminder flags to ensure this is completed in a timely manner. Same tracking system with indicate the referrals, if any, that were made at that time. Measuring if intervention is applied as intended will be completed by calculating the percentage of surveys that are completed in a timely manner. The goal is for structured interviews and referrals for currently identified PIP enrollees to be completed within 30 days. For those beneficiaries enrolled in the

PIP after 10/1/09, the goal is for the structured interview and referrals to be made within 14 days of identification of child/youth as PIP participant; goal is for 95% of all surveys to be completed within this 14 day time period.

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

Staff who evaluate client need and provide services will serve as the base data collectors. These consist of case managers, clinicians and psychiatrists. Due to their positions, they will have received training on such data collection, and the clinic supervisors have systems in place to ensure accurate, timely, and complete data collection.

Data collection, as related to compiling the fiscal amount of services provided to individuals to identify future enrollees in the PIP and to compile information about beneficiaries once enrolled in the PIP, shall be conducted by staff within the Research & Evaluation Unit of DBH.

Data collection, as related to the implementation of the PIP shall be as follows:

Contacting guardians and conducting structured interviews shall be conducted by clinical staff and parent partners within one of the following programs: Community Crisis Response Team (CCRT), Centralized Children's Intensive Case Management Services (CCICMS), or Juvenile Court Behavioral Health Services (JCBHS).

Facilitation of appropriate referrals shall be conducted by clinical staff and parent partners as follows: For dependents or wards, JCBHS staff will facilitate referrals; for all other children and youth, CCICMS staff will facilitate referrals.

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? **What might be next steps in the EPSDT PIP?**

The concept of implementing this PIP was relatively simple:

1. Identify youth receiving \$3,000 in a month of services while not enrolled in highly coordinate programs,
2. Contact the youth and family to provide information and facilitate referrals to appropriate services, and
3. Thereby attempt to ensure more consistent access to services.

The intent was to decrease the level of inconsistency of mental health services received by these youth. Based upon previous reviews of all beneficiaries who received \$3,000 of services within a month, those not enrolled in a highly coordinated program experience inconsistent services much more frequently.

The implementation of this PIP is complicated by the difficulties of getting timely and accurate information. In regards to the identification of youth to enroll in the PIP, the required technical processes needed to successfully identify this youth and obtain contact information is an example of the difficulties faced with multiple systems with limited compatibility. The difficulty of needing information from multiple systems for individual beneficiaries is one reason why SBCDBH has been working on developing a data warehouse and automated report system. Although not yet available, the contract for development and implementation of this system was awarded and approved by the San Bernardino County Board of Supervisors on 9/1/10. However, this PIP was attempting to pull timely information from multiple systems without the aid of this type of system, and this resulted in multiple obstacles that required more resources to overcome than were consistently available. In short, we were not able to identify youth to be enrolled in the PIP more often than once every three or four months.

The information obtained through the complex process of consolidating information from different systems appeared to be very accurate in regards to the amount of services billed; however, during the PIP implementation it was learned that the contact information contained in these systems was not consistently accurate. The design of the intervention (i.e., structured interview via phone) was intended to be an efficient and effective means of reaching the youth and family. Only slightly more than half of the families could be provided the intervention due to the remaining families not having accurate phone contact information. This is believed to be due to a combination of computer databases not being maintained by the providers, families not consistently providing information about changes in phone numbers, and the more transitory nature of cell phone numbers in our current socio-economic climate.

Given the technical difficulties in identifying the youth to be enrolled in the PIP in a timely manner and the difficulties of providing the intervention to the youth once identified, the implementation of this PIP is being extended for two years and additional resources are being allocated to facilitate a consistent implementation. In addition to staff resources, the specific issues identified through this process will be incorporated into the development of the data mining system and this PIP will be considered for a potential pilot project for the data warehouse and automated report system.

The description of the indicators, intervention and staff involved in the PIP contained in this document continue to be accurate, as the additional resources will all come from within the programs mentioned. The re-measurement period is changed to be completed by 7/1/2012. Additionally, upon the suggestion of outside reviewers, the possible inclusion of a more traditional indicator of well being (e.g., number of hospitalizations) will be explored for inclusion.

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

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

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/denominator)	% improvement achieved
<b>THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS</b>							
Binomial indication if enrolled child/youth has experienced an increase of \$1,500 or more of outpatient services in one month followed by a decrease of \$1,500 or more of outpatient services the next month since 10/1/09 or since month child/youth is identified as an EPSDT PIP member, which ever date is more recent.	4/30/09	<u>40/90 = 44%</u>	34%, so that only 10% of PIP study meets this criteria	9/28/09	7/1/2012	Not Completed	Not Completed

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

17. Describe issues associated with data analysis:  
**Not Completed:**
- a. Data cycles clearly identify when measurements occur. **Not Completed:**
  - b. Statistical significance **Not Completed**
  - c. Are there any factors that influence comparability of the initial and repeat measures? **Not Completed: Potential influences identified to date include: (1) Substantial increase in departmental efforts to facilitate access to some specialty mental health programs (e.g., TBS) create a different climate from period of initial measurement (i.e., 7/1/07 through 12/31/08) and current time period.**
  - d. Are there any factors that threaten the internal or the external validity? **The internal validity of this PIP is the degree to which there is certainty that contacting the family, conducting the screening interview, and providing appropriate referrals impacted access to mental health services. There are several threats to the internal validity of this PIP: (1) One potential impact is the substantial efforts that are being made by the department to increase access to specialty mental health services in general. This is helping more direct service providers provide access to these programs prior to the intervention of the PIP. (2) The low rate of having accurate contact information may suggest a demographic difference between families who were able to be contacted (i.e., who had consistent phone numbers) and families who were not able to be contacted (i.e., who did not have consistent phone numbers).**
18. To what extent was the PIP successful? Describe any follow-up activities and their success.  
**Not Completed**
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?  
**Not Completed**
20. Does data analysis demonstrate an improvement in processes or client outcomes?  
**Not Completed**
21. Describe the “face validity” – how the improvement appears to be the result of the PIP intervention(s).

**Not Completed**

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

**Not Completed**

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

**Not Completed**

Attachment #1:  
EPSDT PIP Service Intervention – Structured Interview

EPSDT PIP Service Follow Up Form

"Hello. My name is \_\_\_\_\_. I am a (staff member, clinician) for Department of Behavioral Health of San Bernardino County. We are following up on children who have received services in the past. How is \_\_\_\_\_ doing lately?"

- 1. Does this child still reside within San Bernardino County? Yes No
2. Is this child currently Medi-Cal eligible? Yes No
3. How is the child doing in the following areas? Family Good Fair Poor School Good Fair Poor Community Good Fair Poor Self-Care Good Fair Poor

SART PROGRAM CRITERIA- (SART is a program that includes screening, diagnosis and treatment services for children ages 0-5.)

SART Referral-If the child is 0-5 and yes to 1 & 2 and "Poor" in one of the above.

TBS PROGRAM CRITERIA - (Therapeutic Behavioral Services is an intensive, one-on-one, short-term outpatient treatment intervention targeting specific behaviors. These services take place in the home.)

- 4. Is the child placed in or at risk for being placed in a group home level 12 or above? Yes No
5. Has the child had at least one psychiatric hospitalization in the past 24 months or is currently at risk for a hospitalization? Yes No
6. Has your child received Therapeutic Behavioral Services (TBS) services in the past? Yes No

TBS Referral-If yes to 1 & 2 AND Yes to 4 or 5 or 6.

SB 163-WRAPAROUND PROGRAM CRITERIA-(The Wraparound process provides individualized, comprehensive, community-based services and supports to children and adolescents with serious emotional and/or behavioral disturbances.)

- 7. Is the child a Dependent, Ward or AB2726? Yes No
8. Is the child at risk of being placed in a group home RCL 10-14 or being transitioned out of this group home. Yes No
9. Does the child have a parent, relative, legal guardian, or caregiver who would agree to actively participate in the Wraparound process. Yes No

SB 163 Wrap Referral-If Yes to all of the above 7, 8 and 9.

SUCCESS FIRST CRITERIA- (Success First is an early wraparound program to provide services by keeping children in the lowest level possible.)

- 10. Is the child age 0 to 15.5. Yes No
11. Does the child display impairment in two areas --- a) school, b) family, c) community or d) self-care.
12. Is the child at risk of removal from home or has been impaired 6 months. Yes No
13. Does the child display a) psychotic, b) suicidal or c) violent symptoms. Yes No

Success First Referral-If Yes to 10 AND either 11, 12, or 13.

"Your child may meet criteria for (please circle) SART, Therapeutic Behavioral Services (TBS), Wraparound Services, or Success First. Would you consider a referral to this program?" If yes, "Would it be okay for me to have the program call you? Thank you. A staff member will call you within a week."

OTHER SERVICES- If the child does not meet criteria for the above programs---

"Would you like your child to receive outpatient services at a clinic? Please call our Access Unit at 1-888-743-1478." "Thank you."

DISPOSITION

DECLINED--(Please Circle) SART/ TBS/ Wrap/ Success First/ Outpatient Services is refused by \_\_\_\_\_ or is not available because \_\_\_\_\_

FINAL STEP-- Please circle the referral program (or none) and fax this form to JCBHS fax (909) 387-7402, phone (909) 387-7406 and to the CCICMS Liaison fax (909) 421-9411, phone (909) 421-9300.

- SART
TBS
SB 163 WRAPAROUND
SUCCESS FIRST
ACCESS UNIT
RETURN TO PREVIOUSLY ATTENDED PROGRAM
OTHER
None

Simon Number
Consenting Caregiver Name
Phone Number
Date
Printed Name of DBH Staff Member
Signature of DBH Staff Member

Child's Name
DOB