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

Fiscal Year 2014-2015

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INTRODUCTION

The following report covers the activities conducted within Sacramento County's Mental Health Plan (MHP) addressing the annual work plan for Fiscal Year 2014-2015. Fiscal Year 2013-2014 information is utilized wherever possible to provide the reader a two year view of changes as a comparison point. The Mental Health Plan's Quality Management (QM) efforts have adjusted to incorporate ongoing program design and service changes into the annual progress report. The MHP has had to adjust to federal and state level changes. Thus this report compares available data where possible, and provides references to appropriate MHP Research and Evaluation reports or Cultural Competence Plan Updates for more detailed information. The intent is to provide the reader information that is tracked over time in various core areas of the MHP. Each area has summary comments and findings.

This report is divided into the following areas:

I. Access, Accessibility, Monitoring Service Capacity
II. Penetration and Retention
III. Monitoring Beneficiary Satisfaction
IV. Effectiveness of Care/Clinical Issues
V. Continuity and Coordination of Care
VI. Cultural Competency, Education and Training

SUMMARY OF REPORT

In FY 2014-2015, the Mental Health Plan undertook numerous quality management and quality improvement activities incorporated into its Annual Work Plan. Many of these activities resulted in other initiatives within the MHP at program and administrative levels. These activities included Performance Improvement Projects and efforts to track issues and changes over time. Below are some highlights of information detailed information in this report:

- Eighty-two (82) organizational provider sites, as part of forty-three (43) legal entities, delivered services to MHP clients across Sacramento County. This spread reflected a vast geographic area of service, and includes services delivered in clinic, field based, residential, and inpatient settings.

- There were 28,734 unduplicated clients in all modes of services, served in FY 2014-2015, compared to 27,041 unduplicated clients in all modes of services in FY 2013-14.

- With five threshold languages and a community with significant linguistic and cultural diversity, the MHP continues to monitor and refine strategies for improvement of disparities.

- The MHP maintained a responsive problem resolution/beneficiary protection system and met its response time obligations in this area. Grievances were handled in a satisfactory and timely manner and reflected greater number of difficulties in the adult system of care.

- The MHP continued to provide a variety of trainings for service staff across its provider and county operated system. 1719 attendees benefited from the MHP's clinical and technical support trainings.

- 9,518 attendees attended trainings held specifically on increasing cultural competency skills.

- 635 attendees attended Avatar trainings and technical support forums.

- The MHP maintained a central point of authorization for community based mental health services. It complied with obligations to issue timely Notices of Action for any denials or reduction in services, at its Access Teams and/or other applicable points of authorization.

- The MHP conducted utilization reviews, peer reviews, and monitoring reviews across its service system. In FY 2014-2015 a total of 5,253 charts were reviewed across all parts of the care continuum. This number did not include internal targeted reviews by contract agencies, contract monitors or other special oversight activities which reflected a robust utilization review/peer review, and oversight effort.

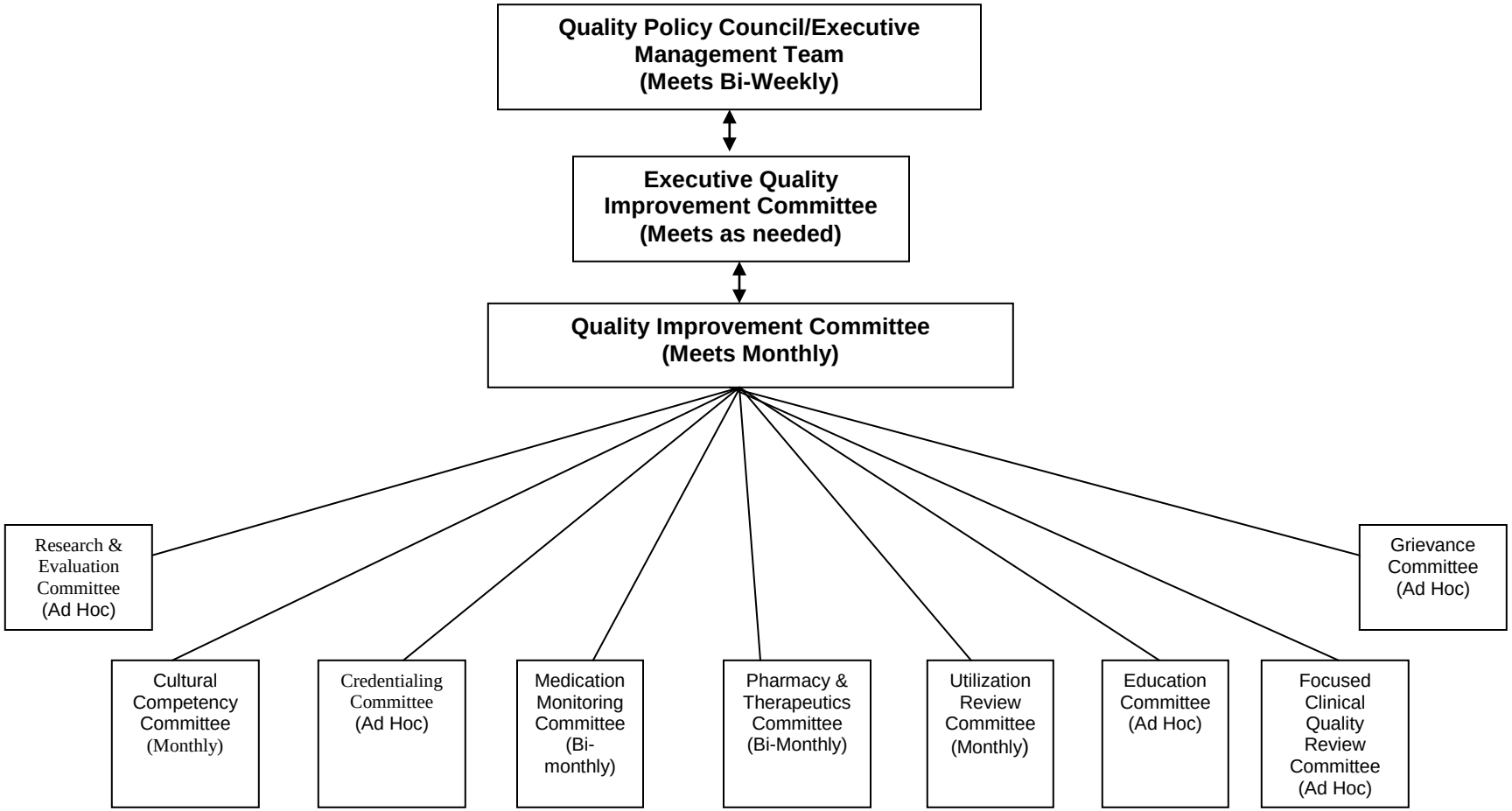
- The Pharmacy & Therapeutics Committee and Medication Monitoring Committees continued to provide critical input and oversight for medication practices and medication practice guidelines. The Medication Monitoring Committee reviewed 1,185 charts across providers for polypharmacy issues, medication guidelines and laboratory work. In all cases feedback was provided to providers of services.

- Increased coordination of care and improving client services remained the focus of all clinical reviews; new programming, documentation revisions, and development of the Electronic Health Record. The MHP continued efforts at increasing physical care coordination and access for adults by implementing the Sacramento County Performance Improvement Project, “Improvements in Primary Care Access and Treatment for Adults with Serious Mental Illness” countywide, with the expectation that all adult and children’s providers will document PCP contact information into the electronic health record. Coordination of care was also the focus of the Sacramento County Performance Improvement Project, “Increasing Collaboration Between Mental Health (MH) and Child Protective Services (CPS).”

QUALITY MANAGEMENT ORGANIZATION AND STRUCTURE

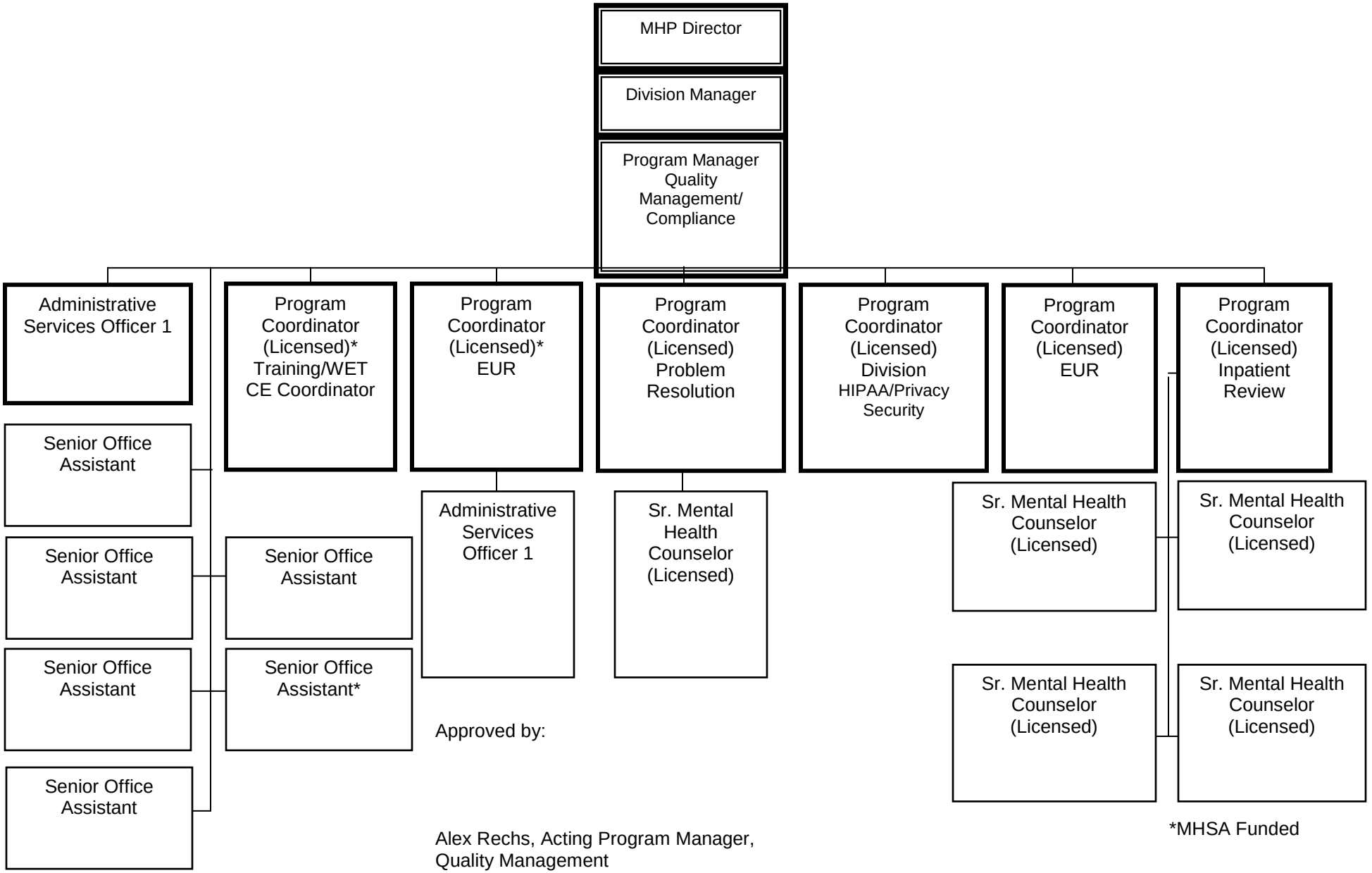
The Quality Improvement Policy Council guides the Mental Health Plan's Quality Improvement processes. The Policy Council also functions as the Executive Management Team for the Mental Health Division. A subgroup of members of the Policy Council serves as the Executive Quality Improvement Committee and provides higher level of review and guidance on behalf of the Policy Council. The MHP's Quality Improvement Committee (QIC) is chaired by the MHP's Quality Management Manager. The QIC meets on a monthly basis and maintains minutes of its deliberations. It includes representatives of the Contract Provider system, County Program Monitoring unit, Access Teams, Research and Evaluation, Quality Management, Cultural Competence, Psychiatry and Pharmacy representatives, Consumer and Family Member representatives. The QIC structure is the umbrella for standing subcommittees, adhoc subcommittees and/or workgroups that are developed to meet the changing needs of the MHP. Subcommittees report to the monthly Quality Improvement Committee where information is reviewed and comments are received from all parts of the system. These deliberations result in approval, new initiatives, and recommendations for new directions and constitute a critical communication forum for the MHP.

QUALITY IMPROVEMENT STRUCTURE 2013-2014



Additional Ad Hoc committees are authorized by QIC as needed.

MHP QUALITY MANAGEMENT SERVICES ~ ORGANIZATIONAL CHART ~ 6/30/15



Approved by:

Alex Rechs, Acting Program Manager,
Quality Management
Quality Management/Compliance

*MHSA Funded

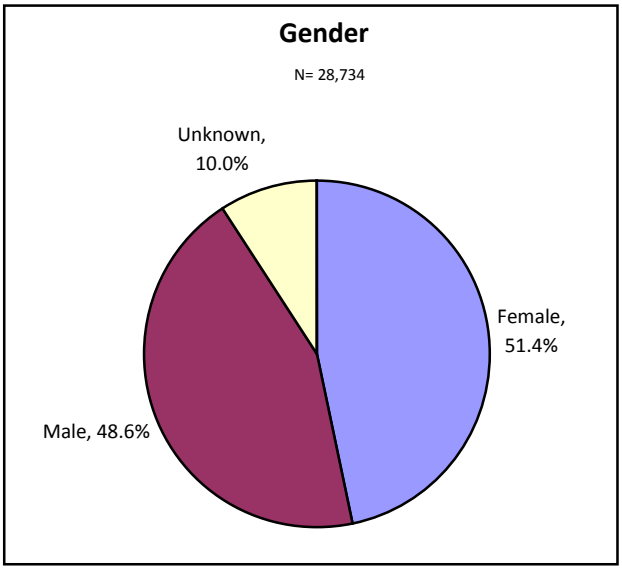
I. ACCESS, ACCESSIBILITY, MONITORING SERVICE CAPACITY

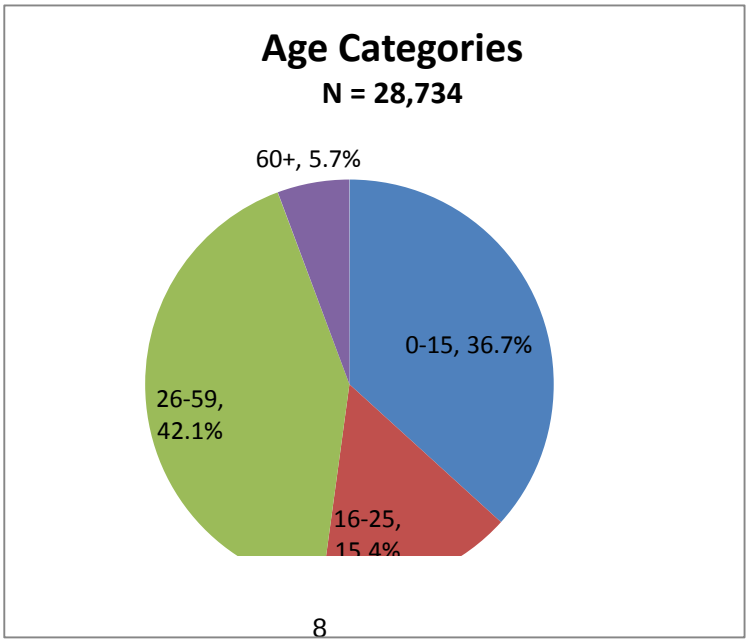
Access, accessibility and monitoring of service capacity occurs at several key points in the MHP.

- Demographic information is collected and reviewed to understand who is receiving services in the MHP.
- The number and location of organizational providers and sites are monitored and analyzed against beneficiary numbers and location.
- Test calls to the 24/7 access line are performed to test the accessibility and responsiveness of the system.
- Time to first appointments are tracked and monitored to evaluate timely access to services.

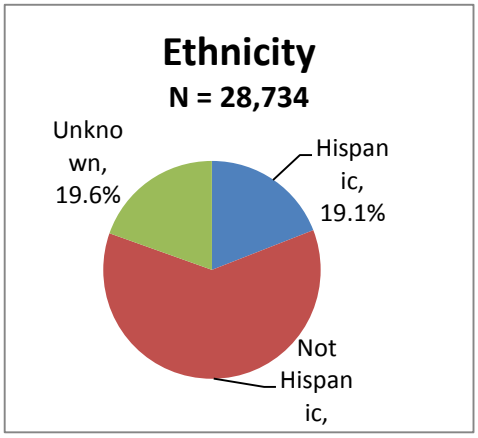
A. Demographics

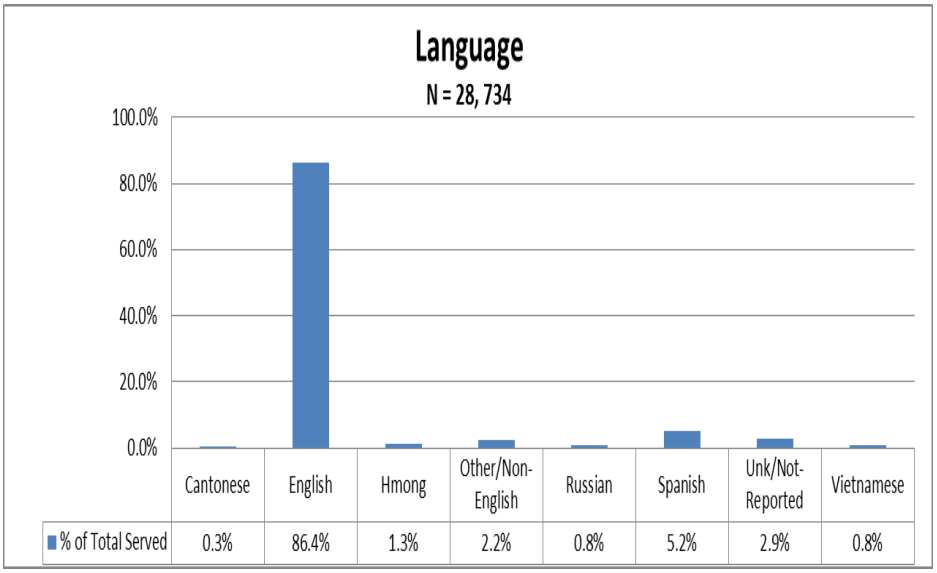
The Sacramento County Mental Health Plan provided specialty mental health services, including inpatient, crisis, and outpatient services to 28,734 individuals in FY14-15. The following five (5) charts illustrate the demographics of individuals served in the Sacramento County MHP in FY14-15.

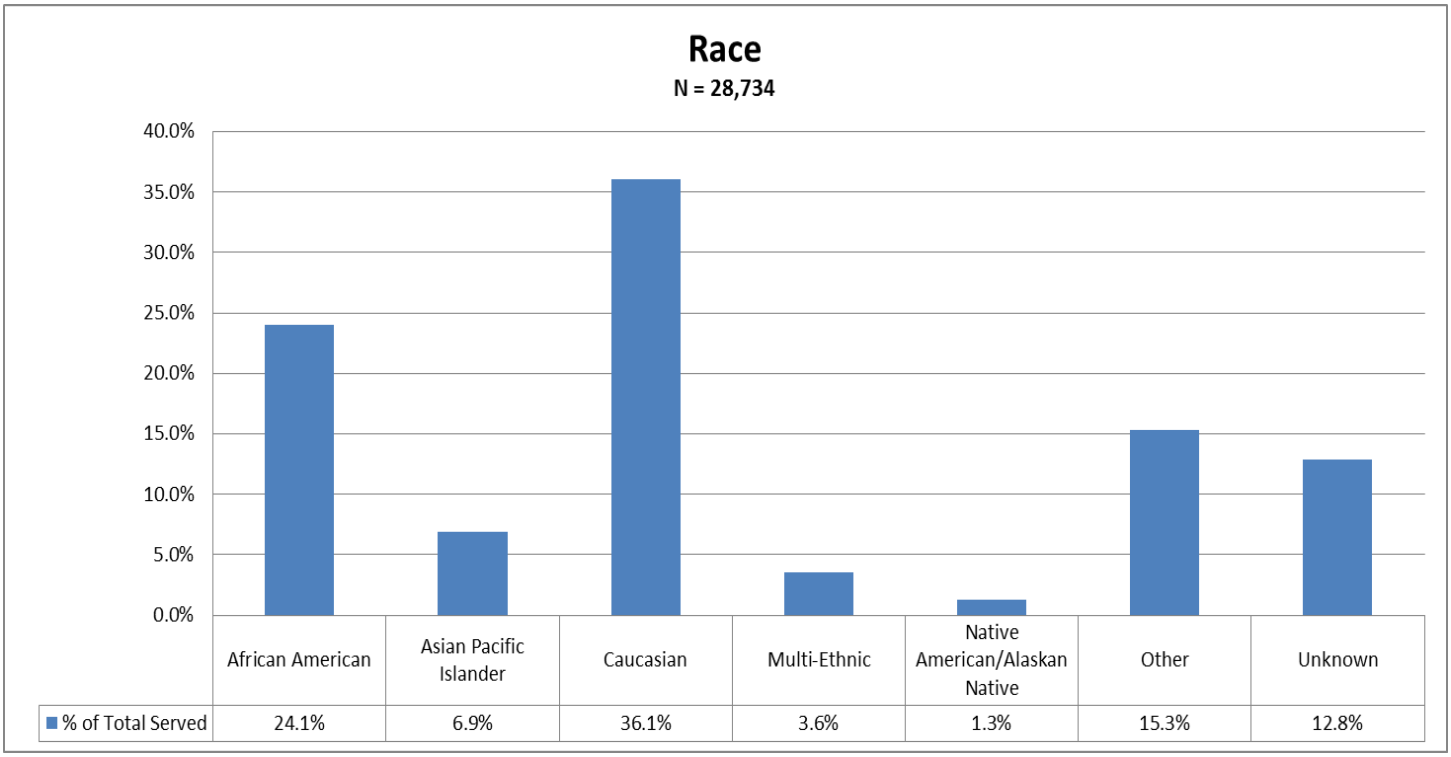




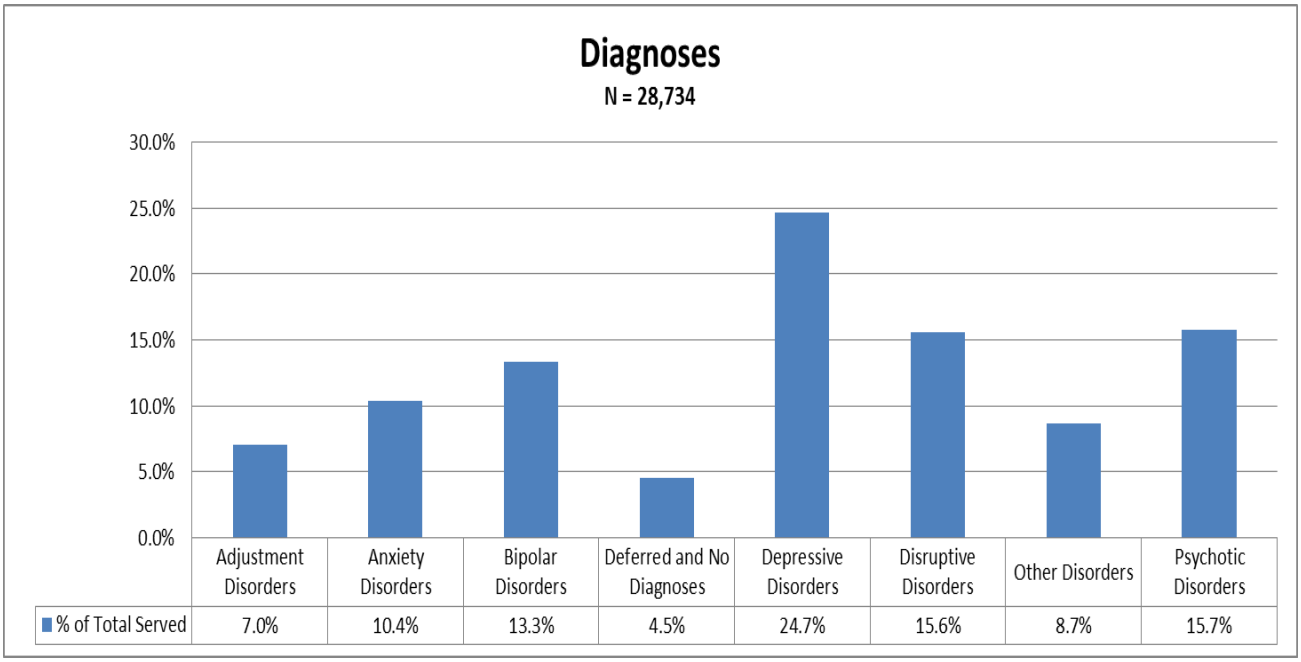
Approximately 64% of clients served in FY14-15 reported a race other than White and nearly 14% reported preferred language other than English. This reflects the diversity of clients served in FY14-15. Additionally, 19% of clients reported being of Hispanic origin.







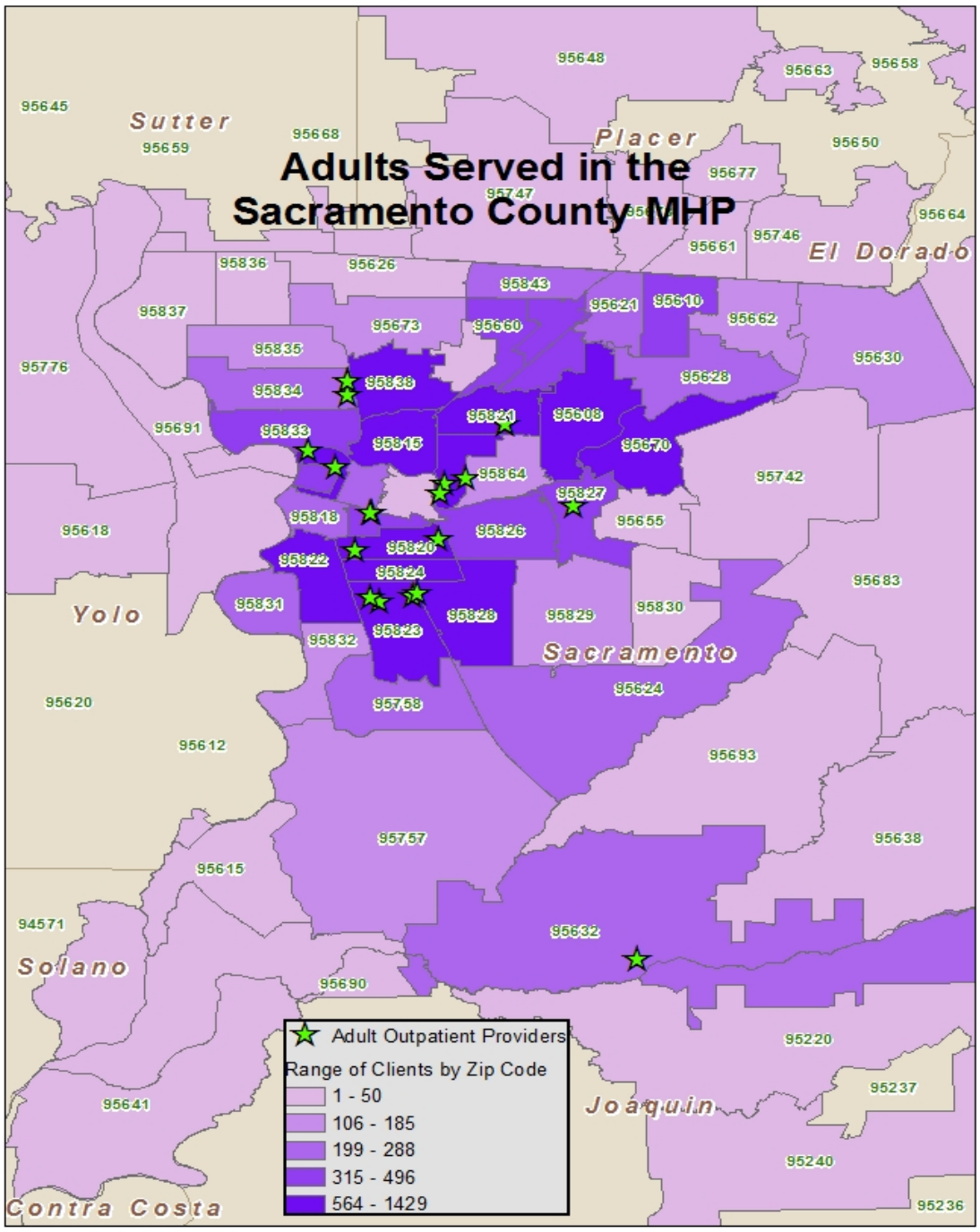
Mood disorders (Bipolar and Depressive Disorders) account for the highest percent of diagnoses, 38%, with Disruptive Disorders (15.6%) and Psychotic Disorders (15.7%) the 2nd highest.

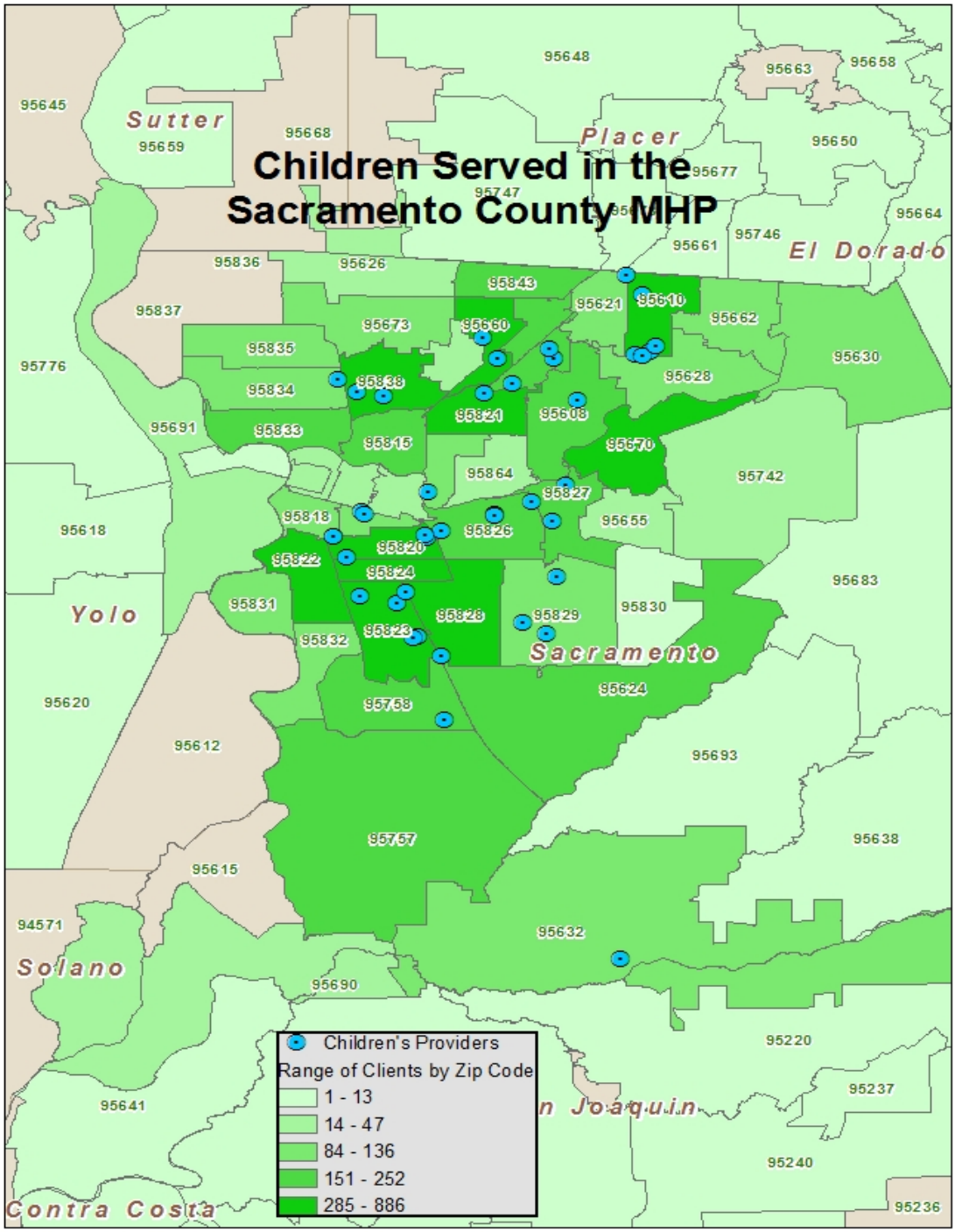


B. Capacity and Availability: Organizational Providers and Network Providers

Sacramento County is a county that is spread over a large geographic region and includes multiple cultural and ethnic populations living across all areas. The most recent State Department of Health Care Services data indicates that Sacramento County has five threshold languages (Spanish, Russian, Vietnamese, Chinese, Hmong) with a variety of other languages below the threshold definition. The MHP, through its Medi-Cal and grant funded programs has both built a geographically centered service system and given providers flexibility to work across these physical locations or sites. These locations may be clinics, the community, or in-home settings. The Children's system of care works in school settings, community settings, in the home and in clinics demonstrating a great deal of flexible delivery capability.

(See Appendix II for list of FY 14-15 service sites. Names with "*" in Appendix II are excluded from the numbers reported, as these are non-Medi-Cal programs.)


Adults Served in the Sacramento County MHP
Sutter
Placer
El Dorado
Yolo
Sacramento
Solano
Contra Costa
Joaquin
95645
95659
95668
95648
95663
95658
95650
95677
95747
95664
95746
95661
95836
95626
95843
95621
95610
95662
95837
95673
95660
95630
95835
95776
95834
95838
95628
95691
95833
95824
95608
95815
95670
95864
95742
95827
95818
95655
95618
95826
95820
95822
95824
95683
95831
95828
95829
95830
95832
95823
95620
95758
95624
95612
95693
95757
95638
95615
94571
95632
95690
95220
95237
95641
95240
95236
Adult Outpatient Providers
Range of Clients by Zip Code
1 - 50
106 - 185
199 - 288
315 - 496
564 - 1429


Children Served in the Sacramento County MHP
Sutter
Placer
El Dorado
Yolo
Sacramento
Solano
Contra Costa
n Joaquin
95648
95663
95658
95645
95659
95668
95650
95677
95747
95664
95661
95746
95836
95626
95843
95621
95610
95662
95837
95673
95660
95630
95835
95776
95628
95834
95838
95821
95608
95691
95833
95815
95670
95864
95742
95827
95818
95655
95618
95826
95820
95822
95824
95683
95831
95828
95829
95830
95832
95823
95624
95620
95758
95612
95693
95757
95638
95615
94571
95632
95690
95220
95641
95237
95240
95236
Children's Providers
Range of Clients by Zip Code
1 - 13
14 - 47
84 - 136
151 - 252
285 - 886

Data on organizational providers and service delivery sites is monitored and analyzed to ensure that the MHP maintains geographic distribution of service delivery sites across the County care system to ensure appropriate access to services. Organizational providers working in multiple community settings in addition to their geographically listed provider sites primarily drive the Sacramento County MHP service delivery system. Therefore, any movement of a physical service sites continues to be balanced with field based service delivery.

The table below provides data on the number of Organizational and Network Providers as well as the number of organizational service sites in the MHP during FY 2013-2014 and FY 2014-2015. In FY 2014-2015, there was a decrease in the number of organizational legal entities but an increase in the number of organization physical sites. Sme providers moved their location while other providers increased their number of physical locations in addition to providing services out in the community. This was a positive change from FY 13-14 when we had a decrease in physical sites.

The primary reason for the change in the number of legal entities is due to the decrease of service contracts with Out-of-County Providers. The contracting with Out-of-County providers continues to fluctuate based on the need of the children being served. Out of County services are not reflected fully due to the nature of placements and single, emergency agreements that the County executes to ensure that its beneficiaries are served across county jurisdiction. Special contracts and payment processes occur when clients are placed outside of the existing provider system or in another county. This is especially the case with Children's programs.

Enrolled network providers (ENP) remained at 2 for the FY14-15 period. The MHP continues to rely on organizational providers to provide services as these contractors have historically had the ability to provide more flexible services than traditional clinic based enrolled network providers.

Type of Provider Contracts

Organizational	FY 2013-2014	FY 2014-2015
Legal Entities	48	43
Physical Sites	79	82
Increase/(Decrease) from prior year (physical sites)	-3	3
Network Providers		
Individual Providers	2	2
Physical Sites (inpatient)	6	6
Increase/(Decrease) from prior year	(0)	(0)

Geographic Distribution of Sites

Organizational Service Sites by Region	FY 2013-2014	FY 2014-2015
North	7	5
South	16	18
East	38	41
West	2	4
Out of County	16	13
Total	**79**	**82**

C. Test Calls and Training

As part of the efforts to test the accessibility to services and responsiveness of the system, Quality Management and Cultural Competence staff conducted test calls to all established Access entry points to the system. A total of **104** calls were made in FY 2014 - 2015 as compared to **59** in FY 2013-2014. The calls were made in multiple languages including but not limited to the threshold languages in addition to English. Calls were placed to the ACCESS TEAM as well as the Sacramento County Mental Health Treatment Center Intensive Services Unit for the After Hours Access Line.

Following the test calls, training and feedback was given to all providers seeking to improve cultural sensitivity and linguistic competency in fielding business hour and after-hour calls. The Access Line Roll-over training was completed with all staff working at the Intensive Services Unit (ISU) responsible for this line in the Treatment Center **5** times, and 3 times with the adult and Child Access teams. Quality Management in consultation with Cultural Competence is planning to continue providing "After Hours Line Trainings" in addition to an "Ongoing Staff Orientation" in the use of language line access services for non-English speakers to improve the MHP quality of services

The MHP has found an increasing comfort level on the part of staff to respond to non-English speakers over the phone language lines. The MHP continues its efforts to recruit bilingual staff at the entry point to the system. Additionally to improve access for Deaf clients, 10 test calls were placed to adult, child, and family Access teams as a follow-up to training for staff at these facilities on appropriate etiquette when communicating with the deaf community and hands-on training over appropriate use of TTY and California relay services.

D. Timeliness to Service

Timeliness to service has been a focus of improvement for the MHS over the last year. Interventions have been put in place to both accurately measure and improve timeliness for our clients. We currently have one Performance Improvement Projects (PIPs) focused on access and timeliness to services and are in the planning stages of another PIP to address the issue. Along with the PIPS, many other efforts are being made to address timely access to outpatient services. The next work plan report will detail the outcome of our local efforts.

BM1 - Opened to OP Provider by Access to First OP Face-to-Face Service (*Target = 14 days)										
	1st Quarter CY		2nd Quarter CY		3rd Quarter CY		4th Quarter CY		Annual Average	
Benchmark 1 Summary	Children N=2068	Adults N=884	Children N=2137	Adults N=763	Children N=2188	Adults N=793	Children N=1677	Adults N=633	**Children N=8070**	**Adults N=3073**
Average # of Days to Service	28.3	42.6	21.5	34.7	18.1	40.9	19.5	35.9	**21.9**	**38.5**
Percent Meeting Target *(*Target is 10 business days, but the calculations are based on calendar days.)*	32.4%	13.0%	49.2%	28.2%	52.7%	16.3%	49.1%	26.5%	**45.8%**	**20.4%**
BM2 - Opened to OP Provider by Access to First OP Psychiatric Service (Target = 28 days) Adults Only										
	1st Quarter CY		2nd Quarter CY		3rd Quarter CY		4th Quarter CY		Annual Average	
Benchmark 2 Summary	Children N/A	Adults N=640	Children N/A	Adults N=500	Children N/A	Adults N=472	Children N=422	Adults N=329	**Children N/A**	**Adults N=1941**
Average # of Days to Service	N/A	69.4	N/A	60.6	N/A	61.6	52.7	53.9	**N/A**	**61.4**
Percent Meeting Target	N/A	14.7%	N/A	27.8%	N/A	22.7%	38.6%	34.0%	**N/A**	**23.3%**
BM3 - First Face-to-Face OP Service to Second OP Non-Psychiatric Face-to-Face Service (*Target = 30 days)										
	1st Quarter CY		2nd Quarter CY		3rd Quarter CY		4th Quarter CY		Annual Average	
Benchmark 3 Summary	Children N=1947	Adults N=607	Children N=1968	Adults N=516	Children N=2028	Adults N=575	Children N=1587	Adults N=473	**Children N=7530**	**Adults N=2171**
Average # of Days to Service	10.3	24.3	10.7	20.7	10.7	20.4	10.8	20.8	**10.6**	**21.6**
Percent Meeting Target *(*Target is 20 business days, but the calculations are based on calendar days.)*	95.7%	74.1%	95.2%	78.9%	94.3%	79.0%	95.8%	76.5%	**95.2%**	**77.1%**
BM4 - Acute Hospital Discharge to First OP Psychiatric Service (*Target = 30 days)										
	1st Quarter CY		2nd Quarter CY		3rd Quarter CY		4th Quarter CY		Annual Average	
Benchmark 4 Summary	Children N=130	Adults N=443	Children N=151	Adults N=398	Children N=154	Adults N=470	Children N=154	Adults N=353	**Children N=589**	**Adults N=1664**
Average # of Days to Service	19.2	25.1	14.9	26.4	13.6	31.5	14.5	24.2	**15.6**	**26.8**
Percent Meeting Target *(*Target is 20 business days, but the calculations are based on calendar days.)*	80.8%	72.7%	84.1%	71.6%	85.7%	62.8%	83.8%	74.8%	**83.7%**	**70.1%**
BM5 - Acute Hospital Discharge to First OP Face-to-Face Service (*Target = 7 days)										
	1st Quarter CY		2nd Quarter CY		3rd Quarter CY		4th Quarter CY		Annual Average	
Benchmark 5 Summary	Children N=154	Adults N=510	Children N=184	Adults N=547	Children N=182	Adults N=616	Children N=173	Adults N=559	**Children N=693**	**Adults N=2232**
Average # of Days to Service	10.6	15.4	8.6	18.6	6.2	20.1	9.5	20.5	**8.7**	**18.7**
Percent Meeting Target *(*Target is 5 business days, but the calculations ar based on calendar days.)*	60.4%	50.4%	73.4%	49.5%	76.9%	47.2%	76.3%	48.5%	**72.2%**	**48.8%**

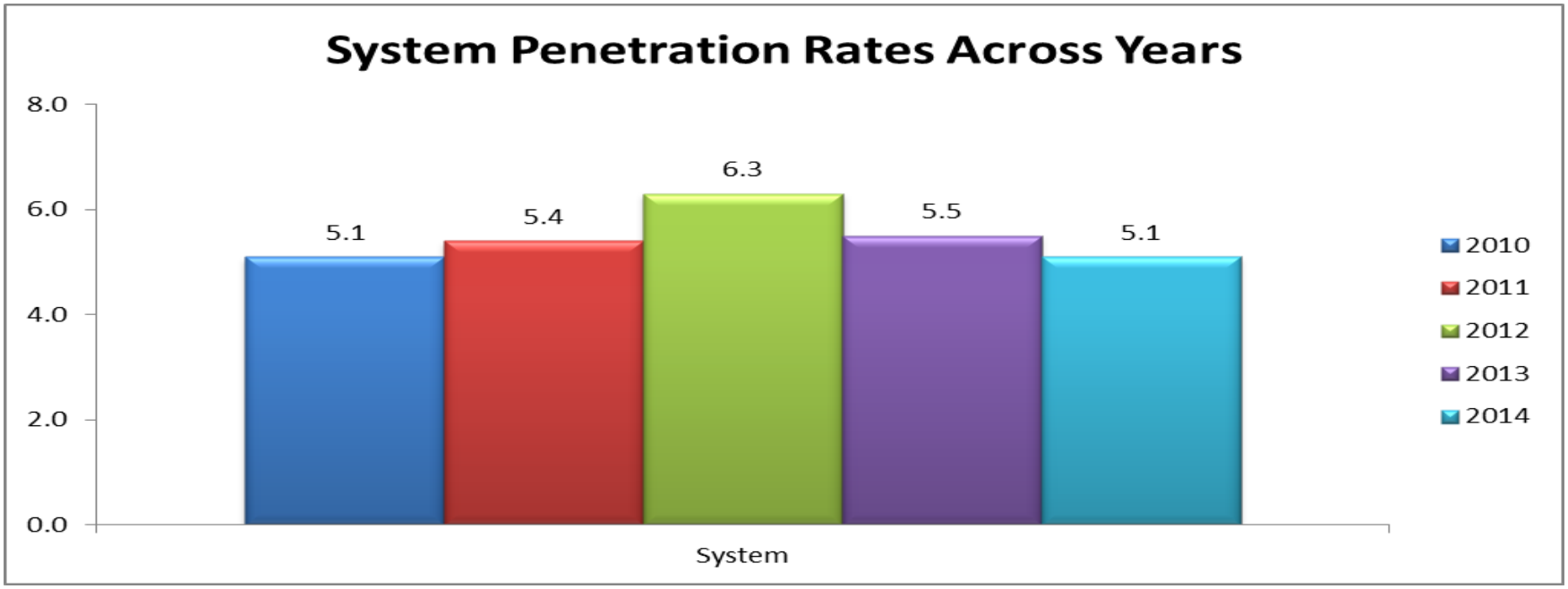
II. PENETRATION AND RETENTION

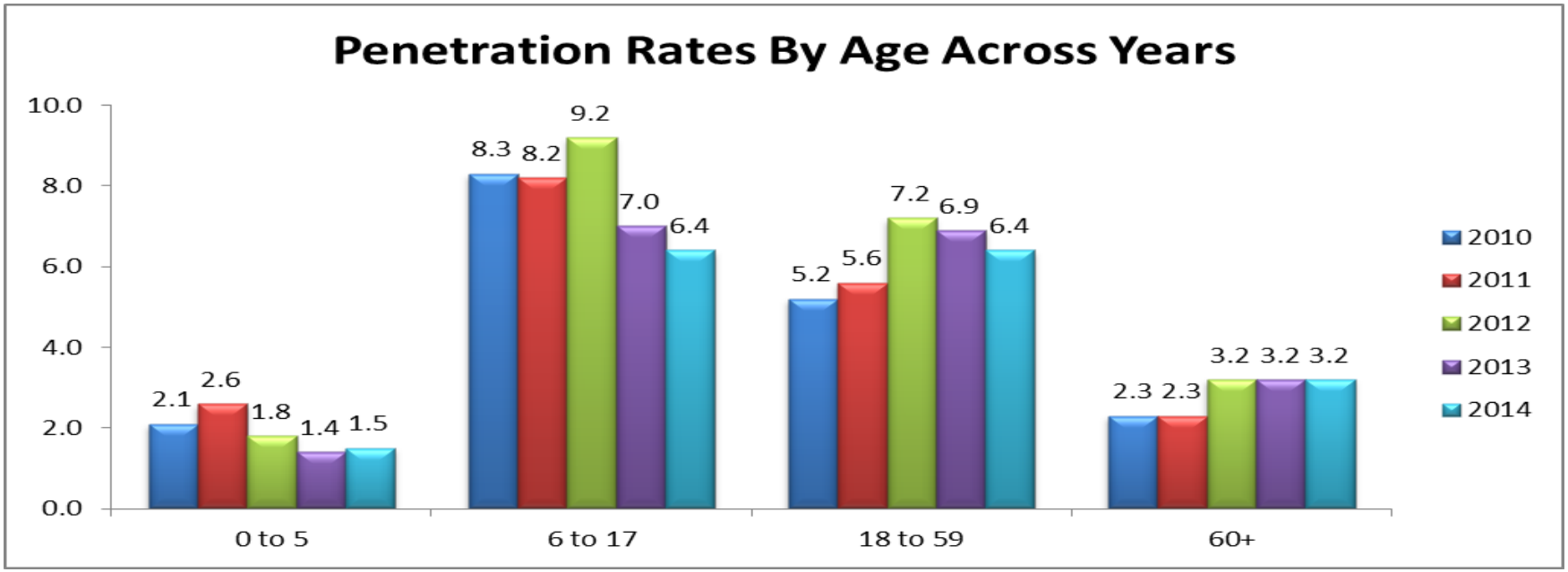
A. Penetration

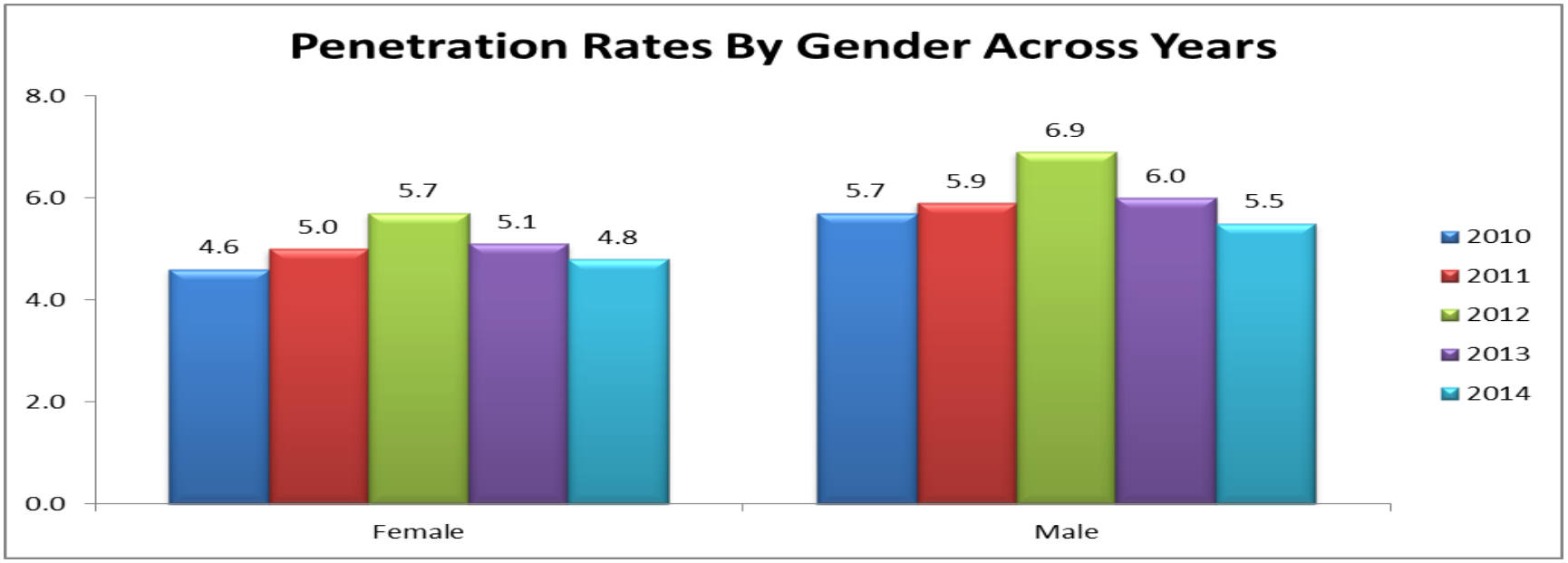
Penetration rates decreased slightly from Calendar Year (CY) 2013 to CY 2014, from 5.5 to 5.1, representing an overall decrease of 7.3%. The Medi-Cal beneficiary population continues to increase at a higher rate than those served in the County mental health system. The penetration rate herein only represents clients served within the Sacramento County Mental Health Plan. As a result of the Affordable Care Act (ACA), Medi-Cal beneficiaries have the ability to receive mental health services through their Geographic Managed Care plans (GMCs) as opposed to the County Mental Health Plan. Because of this the Medi-Cal penetration rate in this report may be under-represented, as it doesn't account for Medi-Cal beneficiaries served in the managed care plans.

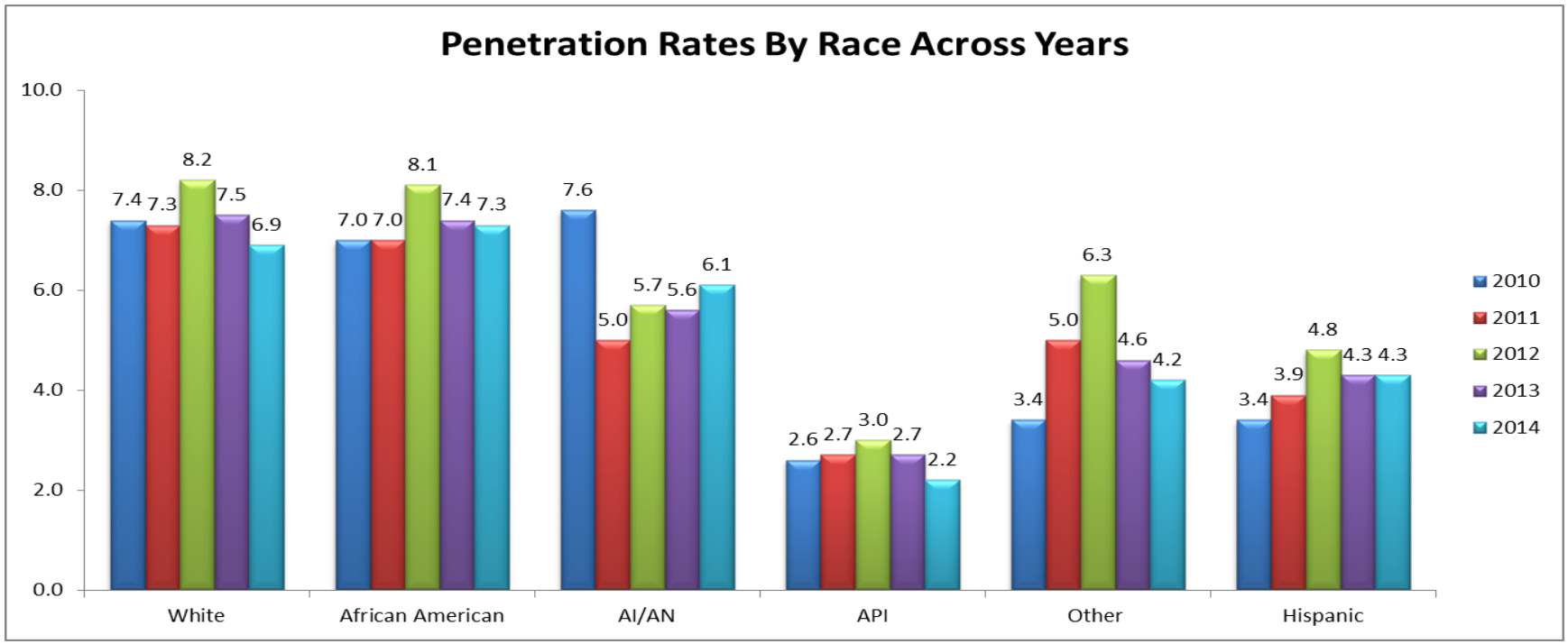
Penetration CY 2013 and 2014		Calendar Year 2013					Calendar Year 2014					
		A		B		B/A	A		B		B/A	
		Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (Undup)		Medi-Cal Penetration Rates	Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (Undup)		Medi-Cal Penetration Rates	Percent Change From CY13 to CY14
		N	%	N	%	%	N	%	N	%	%	%
Age Group	0 to 5	63,883	17.7%	907	4.5%	1.4%	68,908	17.1%	1,011	4.9%	1.5%	7.1%
	6 to 17	109,448	30.3%	7,711	38.7%	7.0%	123,220	30.5%	7,855	37.9%	6.4%	-9.8%
	18 to 59	143,854	39.8%	9,900	49.6%	6.9%	162,903	40.4%	10,362	49.9%	6.4%	-7.2%
	60+	44,462	12.3%	1,426	7.2%	3.2%	48,316	12.0%	1,524	7.3%	3.2%	0.0%
	Total	361,647	100.0%	19,944	100.0%	5.5%	403,347	100.0%	20,752	100.0%	5.1%	-7.3%
		N	%	N	%	%	N	%	N	%	%	%
Gender	Female	200,121	55.3%	10,267	51.5%	5.1%	222,117	55.1%	10,749	51.8%	4.8%	-5.9%
	Male	161,525	44.7%	9,633	48.3%	6.0%	181,229	44.9%	9,991	48.1%	5.5%	-8.3%
	Unknown	1	-	44	0.2%	-	1	0.0%	12	0.1%	-	-
	Total	361,647	100.0%	19,944	100.0%	5.5%	403,347	100.0%	20,752	100.0%	5.1%	-7.3%
		N	%	N	%	%	N	%	N	%	%	%
Race	White	94,656	26.2%	7,069	35.4%	7.5%	104,315	25.9%	7,229	34.8%	6.9%	-8.0%
	African American	65,361	18.1%	4,847	24.3%	7.4%	68,367	16.9%	4,980	24.0%	7.3%	-1.4%
	American Indian/Alaskan Native	3,060	0.8%	170	0.9%	5.6%	3,123	0.8%	190	0.9%	6.1%	8.9%
	Asian/Pacific Islander	55,771	15.4%	1,525	7.6%	2.7%	67,493	16.7%	1,490	7.2%	2.2%	-18.5%
	Other	54,691	15.1%	2,512	12.6%	4.6%	65,396	16.2%	2,776	13.4%	4.2%	-8.7%
	Hispanic	88,108	24.4%	3,821	19.2%	4.3%	94,653	23.5%	4,087	19.7%	4.3%	0.0%
	Total	361,647	100.0%	19,944	100.0%	5.5%	403,347	100.0%	20,752	100.0%	5.1%	-7.3%

Medi-Cal eligible beneficiary numbers are based on data received from EQRO. Medi-Cal eligible beneficiary data for language not available for CY 2014.


System Penetration Rates Across Years
8.0
6.0
4.0
2.0
0.0
5.1
5.4
6.3
5.5
5.1
System
2010
2011
2012
2013
2014


Penetration Rates By Age Across Years
10.0
8.0
6.0
4.0
2.0
0.0
2.1
2.6
1.8
1.4
1.5
8.3
8.2
9.2
7.0
6.4
5.2
5.6
7.2
6.9
6.4
2.3
2.3
3.2
3.2
3.2
0 to 5
6 to 17
18 to 59
60+
2010
2011
2012
2013
2014


Penetration Rates By Gender Across Years
8.0
6.0
4.0
2.0
0.0
4.6
5.0
5.7
5.1
4.8
5.7
5.9
6.9
6.0
5.5
Female
Male
2010
2011
2012
2013
2014


Penetration Rates By Race Across Years
10.0
8.0
6.0
4.0
2.0
0.0
7.4 7.3 8.2 7.5 6.9
7.0 7.0 8.1 7.4 7.3
7.6 5.0 5.7 5.6 6.1
2.6 2.7 3.0 2.7 2.2
3.4 5.0 6.3 4.6 4.2
3.4 3.9 4.8 4.3 4.3
White
African American
AI/AN
API
Other
Hispanic
2010
2011
2012
2013
2014

B. Retention

Retention rate is defined as the percent of new and returning clients that receive their 3rd outpatient, face to fact visit withing 60 days of their 2st face to face visit. The tables presented on the following 2 pages provided numbers and percents pertaining to the MHP rentention rates.

- The overall retention rate for FY 14-15 was 60.5%, up from 44.2% in FY 13-14. This represents a 36.9% increase in retention.
- The retention rate for Medi-Cal beneficiaries is slightly higher, at 64.3%, representing a 39.5% increase from FY 13-14.
- Retention rates for children (0-17) of any race/ethnicity are relatively high for both the Medi-Cal and total system (89%-91%). Retention rates for the adult population is significantly lower across all race/ethnicity categories, with a range of 35%-50% (Medi-Cal and total system)
- Males are retained at a higher rate than females across both the Medi-Cal (68.5%, 60.3%, respectively) and total system (65.9%, 55.6%, respectively)

Retention		A		B		C		D		D/C	(B-D)/(A-C)	B/A
FY14-15		All New & Returning Clients Admitted FY 14-15		All New & Returning Admitted w/ 3rd F2F w/ 60 Days		New and Returning Medi-Cal Admitted FY 14-15		New & Returning Medi-Cal Admitted w/ 3rd F2F w/60 Days		New & Returning Medi-Cal Retention Rate	200% FPL Retention Rate	Total System Retention Rate
		N	%	N	%	N	%	N	%	%	%	%
Race (0-17.9)	API	183	3.2%	166	3.3%	183	3.2%	166	3.4%	90.7%	100.0%	90.7%
	Black	1210	20.9%	1081	21.8%	1202	20.8%	1075	21.8%	89.4%	75.0%	89.3%
	Hispanic	1625	28.0%	1492	30.1%	1617	28.0%	1485	30.0%	91.8%	87.5%	91.8%
	Nat-Amer	45	0.8%	40	0.8%	45	0.8%	40	0.8%	88.9%	100.0%	88.9%
	White	1275	22.0%	1143	23.0%	1269	22.0%	1139	23.0%	89.8%	66.7%	89.6%
	Other/Unk*	1459	25.2%	1037	20.9%	1453	25.2%	1037	21.0%	71.4%	0.0%	71.1%
Race (≥18)	API	277	5.2%	124	7.1%	220	5.1%	110	7.2%	50.0%	24.6%	44.8%
	Black	1047	19.8%	455	26.0%	857	20.0%	405	26.6%	47.3%	26.3%	43.5%
	Hispanic	577	10.9%	246	14.0%	467	10.9%	219	14.4%	46.9%	24.5%	42.6%
	Nat-Amer	57	1.1%	20	1.1%	41	1.0%	19	1.2%	46.3%	6.3%	35.1%
	White	1738	32.9%	616	35.2%	1382	32.3%	527	34.6%	38.1%	25.0%	35.4%
	Other/Unk*	1592	30.1%	290	16.6%	1315	30.7%	245	16.1%	18.6%	16.2%	18.2%
Age	0-17.9	5797	52.3%	4959	73.9%	5769	57.4%	4942	76.4%	85.7%	60.7%	85.5%
	≥ 18	5288	47.7%	1751	26.1%	4282	42.6%	1525	23.6%	35.6%	22.5%	33.1%
Sex	Male	5277	47.6%	3479	51.8%	4944	49.2%	3385	52.3%	68.5%	28.2%	65.9%
	Female	5800	52.3%	3226	48.1%	5101	50.8%	3078	47.6%	60.3%	21.2%	55.6%
	Other/Unk*	8	0.1%	5	0.1%	6	0.1%	4	0.1%	66.7%	50.0%	62.5%
Language	English	9392	84.7%	5799	86.4%	8502	84.6%	5584	86.3%	65.7%	24.2%	61.7%
	Spanish	748	6.7%	623	9.3%	716	7.1%	613	9.5%	85.6%	31.3%	83.3%
	Russian	29	0.3%	16	0.2%	26	0.3%	16	0.2%	61.5%	0.0%	55.2%
	Hmong	46	0.4%	33	0.5%	38	0.4%	28	0.4%	73.7%	62.5%	71.7%
	Vietnamese	39	0.4%	26	0.4%	35	0.3%	24	0.4%	68.6%	50.0%	66.7%
	Cantonese	16	0.1%	12	0.2%	16	0.2%	12	0.2%	75.0%	100.0%	75.0%
	Other/Unk*	815	7.4%	201	3.0%	718	7.1%	190	2.9%	26.5%	11.3%	24.7%
TOTAL		**11,085**	100.0%	**6,710**	100.0%	**10,051**	100.0%	**6467**	100.0%	64.3%	23.5%	60.5%

Retention Comparison Between Years		New & Returning Medi-Cal Retention Rate			Total System Retention Rate		
		%			%		
		FY13-14	FY 14-15	% change	FY13-14	FY 14-15	% change
Ethnicity (0-17.9)	API	64.2	90.7	41.3	64.1	90.7	41.5
	Black	62.0	89.4	44.2	62	89.3	44.0
	Hispanic	67.2	91.8	36.6	67.2	91.8	36.6
	Nat-Amer	70.9	88.9	25.4	70.9	88.9	25.4
	White	66.0	89.8	36.1	66.2	89.6	35.3
	Other/Unk*	29.9	71.4	138.8	30.1	71.1	136.2
Ethnicity (≥18)	API	46.8	50.0	6.8	49.8	44.8	-10.0
	Black	34.3	47.3	37.9	35	43.5	24.3
	Hispanic	37.8	46.9	24.1	38.6	42.6	10.4
	Nat-Amer	45.7	46.3	1.3	46.5	35.1	-24.5
	White	33.5	38.1	13.7	33.7	35.4	5.0
	Other/Unk*	12.2	18.6	52.5	12.5	18.2	45.6
Age	0-17.9	57.2	85.7	49.8	57.3	85.5	49.2
	≥ 18	28.8	35.6	23.6	28.8	33.1	14.9
Sex	Male	49.6	68.5	38.1	47.4	65.9	39.0
	Female	42.8	60.3	40.9	41.2	55.6	35.0
	Other/Unk*	30.0	66.7	122.3	25	62.5	150.0
Language	English	46.3	65.7	41.9	44.5	61.7	38.7
	Spanish	61.4	85.6	39.4	60.2	83.3	38.4
	Russian	40.7	61.5	51.1	38.7	55.2	42.6
	Hmong	51.0	73.7	44.5	52.9	71.7	35.5
	Vietnamese	70.6	68.6	-2.8	76	66.7	-12.2
	Cantonese	66.7	75.0	12.4	63.6	75.0	17.9
	Other/Unk*	19.9	26.5	33.2	19.3	24.7	28.0
TOTAL		**46.1**	**64.3**	**39.5**	**44.2**	**60.5**	**36.9**

III. MONITORING BENEFICIARY SATISFACTION

The MHP tracks and monitors beneficiary satisfacation through a variety of activities which include a robust beneficiary protection/problem resolution process, consumer perception survey and numerous other satisfaction survey's for individual programs and services.

A. Beneficiary Protection/Problem Resolution

The MHP has a system in place that provides all clients and providers a mechanism for the resolution of grievances and appeals. The MHP strives to address all concerns about services in a sensitive, timely and culturally competent manner. Clients rights are protected at all stages of the grievance and appeal process. Quality Management services (QM) is responsible for monitoring member dissatisfaction and provider concerns, privacy issues, grievances, appeals and State hearings.

Definitions

Grievance: A grievance is any expression of dissatisfaction about any matter other than an Action regarding mental health services offered through the MHP.

Standard Appeal: An Appeal is a request to review an Action taken by the MHP. An Action occurs when the MHP does any of the following: denies or limits authorization of a requested service, including the type or level of service; reduces, suspends, or terminates a previously authorized service; denies, in whole or part, payment for a service; fails to provide services in a timely manner, as determined by the MHP, or fails to act within the timeframes for disposition of grievances, the resolution of standard appeals or the resolution of expedited appeals.

Expedited Appeal: An Expedited Appeal is a request to review an Action when using the Standard Appeal resolution process could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

State Fair Hearing: A State Fair Hearing is a formal hearing conducted by the State Department of Social Services to review the decision made by the MHP regarding a Standard or Expedited Appeal.

The following table provides a comparison of the number of Grievances,Appeals and Fair Hearings for Fiscal Years 13-14 to 14-15. The number of of Appeals and Fair Hearings decreased in FY14-15, however the number of Grievances increased significantly. The MHP chooses to capture and report on all change of provider requests regardless of whether a beneficiary expresses a concern/dissatisfaction. This results in a higher number of grievances than what is reported to the California Department of Healthcare Services (DHCS). The number of grievances compared to the number of individuals served in the MHP is approximately 2%, or 2 out of every 100 clients filed a grievance in FY2014-2015.

Sacramento County Mental Health Plan						
Annual Problem Resolution Summary/Analysis Report						
Category	**Adults**		**Children**		**Total**	
	FY13-14	**FY14-15**	**FY13-14**	**FY14-15**	**FY13-14**	**FY14-15**
Grievances	405	**617**	8	**28**	413	**645**
Standard Appeal	12	**8**	0	**0**	12	**8**
Expedited Appeal	0	**1**	0	**0**	0	**1**
Fair Hearings	6	**3**	1	**0**	7	**3**
Total	**423**	**627**	**9**	**28**	**423**	**657**

Grievance Issues

The table below reflects the Race of the clients that submitted grievances in FY14-15. The highest percent of grievances were submitted by clients reporting white as their race (48.2%), followed by clients reporting black as their race (28.1%). These numbers are proportionate to the racial breakdown of clients served in the MHP in FY14-15; where clients reporting White and Black as their race represent the largest racial groups served in the MHP. These percents are similar to the previous fiscal year with the majority of grievance issues being brought forth by individuals within the White and Black populations and the fewest grievance issues being brought forth by those within the individual Asian, American Indian, Former Soviet, and other ethnic populations.

The MHP continues to strive to identify the unique needs of our beneficiaries in order to provide services that are culturally sensitive and appropriate to promote optimal well-being.

FY 14/15 Grievances by Race/Ethnicity Total: 645					
Ethnicity	**# of Grievances**	**% of Total**	**Ethnicity**	**# of Grievances**	**% of Total**
White	303	48.2	American Indian	10	1.6
Unknown	32	5.6	Asian Native	1	0.2
Other	7	1.1	Black	180	28.1
Vietnamese	6	0.9	Chinese	6	0.9
Filipino	6	0.9	Former Soviet	7	1.1
Japanese	1	0.2	Hmong	6	0.9
Multiple	7	1.1	Laotian	1	0.2
Asian Indian	6	0.9	Mien	3	0.5
Other Asian/Pacific Islander	5	0.8	Spanish/Hispanic	57	8.8

The FY14/15 Grievance By Category Summary and Details tables that follow provide a categorical look at the types of grievances submitted (summary) and a more detailed look at reasons within each category (detail).

The main issue categories presented remain the same as last year; however, the subcategories within each issue category have been changed to reflect the new reporting requirements of the Department of Health Care Services (DHCS).

Adults represent 617 of the 645 (96%) grievance issues reported above to the MHP during fiscal year 14-15. Children represent 28 of the 645 (4%) grievance issues reported above to the MHP for attention during fiscal year 14-15. This is an increase of about 2% from the previous fiscal year.

This increase is largely due to the Child and Family ACCESS Team referring grievance issues to the MHP Member Services Office for resolution rather than resolving grievance issues at the ACCESS level.

Change of Provider

The majority of grievance issues reported to the MHP for attention during fiscal year 14-15 remains Change of Provider requests 58% (374/645).

The Adult System of Care, 97% (362/374) comprise the majority of Change of Provider requests submitted for consideration. The MHP adult system is organized primarily around geographic boundaries and assigns members to their treating agency based upon where they live within the County. By assigning individuals based upon their geographic location, members are able to transport themselves to appointments using private vehicles or public transportation with greater ease and convenience. The majority of requests to change from one agency to another, 86% (322/374), is due to a client moving to another area within the County and wanting to transfer to an agency closer to the new residence, or because transportation issues make another agency more convenient. 7% (26/374) of members requested a change in provider due to dissatisfaction with services provided by staff and/or believing that their individual mental health needs were not being met. 3% (11/374) of Change of Provider requests were based upon an individual client transitioning from the child to adult system of care or from a higher/lower level of care, or from a homeless program to a Regional Support Team (RST). The remaining 15 or 4% of members requested a Change of Provider due to requests for specific staff or services, or better access to sooner appointments, etc. The MHP grants a member's preference whenever possible.

Children represent 12 of the 374 Change of Provider Requests above or 3%. Within the Children's System of Care, members are assigned to agencies by the ACCESS Team based upon level of care needed, availability of needed services, and geographic location. The reasons for change of provider requests did not yield a specific trend. Reasons noted include: behavior of staff, requests for an increase in the level of services provided, transition to adult system of care, and unmet mental health needs that included specific treatment interventions and member preference based upon location or past experience.

Quality of Care:

Quality of Care issues comprised 91/645 or 14% of the total grievance issues. Treatment concerns, including concerns regarding medication and medical support staff, comprise the majority of grievances lodged within this area, 78% (71/91). Members expressed concern that their treatment plans were not being followed resulting in a lack of progress towards goals, specific services such as therapy or desired medications were not being provided, and concerns regarding follow-up appointments were most commonly expressed. 12% (11/91) of grievances in this category were related to the perception that staff were rude and/or communicated poorly, and the remaining 9% (8/91) were for various concerns, i.e. disability forms, cultural concerns, housing, etc.

Children represented 9 of the 91 Quality of Care issues discussed above, or 10%. Among the grievances filed on behalf of children, 7/91 or 8% involved treatment concerns regarding: dissatisfaction with treatment interventions, medication concerns, or the level of care either ending prematurely or not believed to be the appropriate level of care by the parent(s). The remaining 2 issues in this category 2/91 or 2% are varied and include: CPS report filing, perception that staff was rude in their communication or discriminatory in their treatment decisions.

Access:

Access issues comprised 21% (137/645) of grievance issues. 133 (133/137) or 97% of Access issues were filed by adults. 61% (84/137) of Access issues were the result of delays obtaining return telephone calls from the receiving agency to schedule an Intake appointment or to schedule a follow-

up appointment with staff. 31% (43/137) of Access grievances were because a member's case was closed to the MHP as a result of the member not actively participating in services and the client wanted to be re-opened, or the client was ineligible for the services requested, mainly, a request for a higher level of care than initially authorized to, etc. The remaining 7% (10/137) of grievances were due to the MHP not offering a desired service at a specific provider site, i.e. therapy, field based services, intensive services, etc.

Children represented (4/137) or 3% of the Access issues filed above. Issues included: appointment scheduling delays, case closure due to lack of participation in services, and requests for intensive services for a special needs child or a higher level of care than the child qualified for.

Other

The category of other represents cases brought forth by members of the MHP, but do not directly involve the provision of a mental health service, or they were brought forth by individuals that were not open to the MHP and did not involve a MHP agency. The most common issues in this category involved cases that were not within the jurisdiction of the MHP, 34% (14/41). These issues were against non-MHP agencies, such as CPS, DHA, SSI, or private hospitals or organizations. 22% (9/41) of issues were miscellaneous and had no clear pattern of issues. These issues addressed forms, lost property, peer behaviors, physical environment of agencies, etc. 15% (6/41) of issues were requests for copies of one's medical record or requests to have something amended within the record, and the remaining 29% (12/41) regarded housing or financial issues. Members in this category contacted the MHP seeking assistance with housing, case management for Shelter Plus Care, or assistance paying housing costs.

Children represented 2 of the above 41 issues within this category (2/41) or 5%. Issues involved CPS and DHA.

FY 14/15 Grievances By Category: Summary

Issue Category Grievances	Adults FY13-14	Adults FY14-15	Children FY13-14	Children FY14-15	Total FY13-14	Total FY14-15
Access	18	**133**	0	**4**	18	**137**
Change of Provider	216	**362**	1	**12**	217	**374**
Quality of Care	139	**82**	5	**9**	144	**91**
Confidentiality	0	**1**	0	**1**	0	**2**
Other	32	**39**	2	**2**	34	**41**
Conlan vs Bonta	0	**0**	0	**0**	0	**0**
Totals	405	**617**	8	**28**	413	**645**

FY 14/15 Grievances By Category: Detail

Change of Provider	#	Comments
Relocation/Transportation	322	Majority moved and wanted an agency closer to home or requested an agency based upon transportation needs.
System of care/level of care	11	Clients moving from child to adult system of care, homeless services to RST, or requests for a higher/lower level of care
Dissatisfaction with Services	26	Client dissatisfied with staff, prescribing decisions of MD, or believing their needs aren't being met.
Specific service/staff	7	Client request specific provider due to past positive experience.
Other	8	Miscellaneous: housing, better access to appointments or coordination of services,etc.

FY 14/15 Grievances By Category: Detail		
Quality of Care, N=91	**#**	**Comments**
Treatment concerns	36	Client dissatisfied with care being provided, i.e. Treatment plan not being followed, lack of therapy or other desired services,
Psychiatrist/Medication	35	Client dissatisfied with medication prescribed/or denied, length of appointment, disagreement with diagnosis given.
Staff Behavior	11	Client report staff is rude, unprofessional in behavior
Other	9	Housing, forms, timeliness of appointments, cultural, etc.
Access, N=137	**#**	**Comments**
Accessibility	43	Case closed due to lack of engagement in services, transportation, ineligible for services, etc..
Availability	10	Lack of desired services, i.e. therapy, field based services, intensive services, Shelter Plus Care, etc.
Timeliness to Intake/ Appointments	84	Time to Initial Intake or follow-up appointment at agency or from hospital.
Other, N=41	**#**	**Comments**
HIPAA	6	Requests for records or record amendments or client belief PHI shared.
Housing/Financial Issues	12	Client need help securing housing, case management for Shelter Plus Care, or assistance paying for housing costs.
No MHP Jurisdiction	14	Caller closed to MHP, non-MHP agency grievance issues, CPS,
Miscellaneous	9	No clear pattern. Various issues including: forms, lost property, peer behaviors, physical environment of agency, court orders, CPS, medical, etc.

Appeal Issues:

During fiscal year 14-15, there were (8) Standard Appeals brought to the attention of the MHP, which represents 1% (8/657) of problem resolution issues. All Appeals were filed by adults. Zero (0) Appeals were filed on behalf of children. Seven (7) of the (8) Appeals were the result of the member receiving a Notice of Action denying services within the MHP due to not meeting the criteria for Specialty Mental Health Services. Two (2) of these (7) individuals were later determined to qualify for Specialty Mental Health Services within the MHP and were assigned to a MHP agency for care. Five (5) of the (7) were determined not to meet the required criteria for MHP services and were referred to a provider in the community to address their mental health needs. One (1) individual filed a Standard Appeal due to receiving a Notice of Action indicating that part, or all, of an inpatient hospitalization would not be paid. After discussion with MHP staff, this individual withdrew the Appeal request.

There was (1) Expedited Appeal request regarding a member that lost funding and feared being unable to pay for medical, housing, and mental health needs. This was determined by the MHP not to meet the criteria of an Expedited Appeal and was treated as a grievance.

State Fair Hearings:

In order to file a State Fair Hearing members must first exhaust the Appeal process within the MHP. Given this, the (3) State Fair Hearing requests were also cases counted in the Appeal section above. All State Fair Hearing cases involved adults. Zero (0) involved children. Two (2) of the (3) State Fair Hearing requests were due to the MHP determining that the individuals did not meet the necessary criteria to receive mental health services from the MHP. One of the cases resulted in a denial by the

Administrative Law Judge and the other case was the responsibility of another county and was routed appropriately. The third State Fair Hearing case was in response to an individual receiving a Notice of Action indicating that part, or all, of an inpatient hospital stay was being denied by the MHP. After the MHP explained the Notice of Action to the member, and it was understood that the individual was not responsible for payment, the individual withdrew the hearing request.

B. Satisfaction Reports

Sacramento County MHP complies with §3530.40 of Title 9 of the California Code of Regulations which requires counties to conduct a semiannual consumer perception survey that collects clients'/families' perceptions of quality and results of services provided. The survey instrument and collection period is defined by the California Department of Healthcare Services.

The MHP monitors satisfaction from a variety of perspectives in order to ensure that service is being offered in a timely and appropriate fashion. Survey findings are shared with the Quality Improvement Committee, the Executive Leadership including consumer/family advocates, and Clinical directors/managers at contract and county provider sites to discuss results and provide input into strategies that address quality, access and service provision in the MHP.

The Division has set a goal of receiving a survey from 75% of the consumers served during the survey distribution time period. During FY14-15, the Consumer Perception survey was collected two times (November 2014, May 2015). The response rates for both of these collection periods was 65%.

Overall, consumers were satisfied with the services they received in the Sacramento County MHP-Outpatient Services during FY14-15. The data represented in the table illustrates average scores for the seven domains measured. Each domain has several items scored on a five-point scale: 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree. Higher scores reflect higher levels of satisfaction, and consumers are considered “Satisfied” in a domain if their average scores were greater than 3.50. The four types of surveys have the same domains, although the items in each domain differ between Adult/Older Adult and Caregiver/Youth (See Addendum for full survey items and ratings). On average, consumers are satisfied in all domains, with the highest satisfaction in Quality & Appropriateness, Participation in Treatment Planning, and General Satisfaction for Adult/Older Adult and Access, Cultural Sensitivity and General Satisfaction for Youth/Caregivers

OVERALL SATISFACTION OUTCOMES								
	May 2015				November 2014			
	Adult (N=958)		Older Adult (N=79)		Adult (N=955)		Older Adult (N=95)	
Domain	% Agree	Avg. Score	% Agree	Avg. Score	% Agree	Avg. Score	% Agree	Avg. Score
Access	79	4.09	80	4.05	82	4.21	80	4.15
Quality & Appropriateness	83	4.14	82	4.10	87	4.28	87	4.15
Participation in Treatment Planning (PIT)	75	4.12	72	4.03	79	4.25	72	4.12
Outcomes of Services	59	3.70	66	3.85	63	3.85	63	3.87
Functioning	58	3.66	62	3.78	62	3.79	63	3.85
Social Connectedness	56	3.71	58	3.79	59	3.85	68	3.99
General Satisfaction	84	4.22	90	4.30	90	4.42	91	4.32
Overall Average	**78**	**3.95**	**86**	**4.01**	**83**	**4.10**	**78**	**4.05**

OVERALL SATISFACTION OUTCOMES								
	May 2015				November 2014			
	Caregiver (N=1282)		Youth (N=705)		Caregiver (N=1483)		Youth (N=839)	
Domain	% Agree	Avg. Score	% Agree	Avg. Score	% Agree	Avg. Score	% Agree	Avg. Score
Access	89	4.41	79	4.19	89	4.43	79	4.15
Cultural Sensitivity	95	4.60	92	4.41	96	4.58	92	4.38
Participation in Treatment Planning (PIT)	91	4.36	80	4.05	90	4.33	80	4.03
Outcomes of Services	59	3.74	67	3.86	59	3.76	62	3.77
Functioning	63	3.77	72	3.90	63	3.78	67	3.81
Social Connectedness	86	4.26	84	4.15	85	4.26	80	4.13
General Satisfaction	88	4.36	85	4.22	88	4.35	83	4.18
Overall Average	**92**	**4.22**	**89**	**4.12**	**92**	**4.22**	**88**	**4.07**

While consumers are satisfied with the services they receive in the Sacramento County MHP-Outpatient Services; the MHP has targeted three items on the consumer perception survey as on-going performance improvement goals within the Quality Management Improvement Plan. These items are listed in the table below. The data presented in the table illustrates the percent of consumers that agree or strongly agree with the item and the average score for each item. Each item is rated on a five point scale: 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree. Higher scores reflect higher levels of satisfaction, and consumers are considered "Satisfied" with an item if their average score is greater than 3.50.

With the exception of 20 for Older Adults, Adults and Older Adult satisfaction scores decreased slightly from November 2014 to the May 2015 collection period. Youth average satisfaction scores increased in all domains from November 2014 to May 2015, while Cargiver average scores decreased. We will continue to monitor satisfaction scores in the upcoming collection periods.

Adult and Older Adult					
Adult		November 2014 (N=955)		May 2015 (N=958)	
Item #	*Definition of Items*	*Percent Agree*	*Average Score*	*Percent Agree*	*Average Score*
6	Staff returned my phone calls within 24 hours	74	4.12	74	4.10
17	I, not staff, decided my treatment goals.	74	4.14	72	4.01
20	I was encouraged to use consumer run programs.	77	4.21	74	4.06
Older Adult		November 2014 (N=95)		May 2015 (N=79)	
Item #	*Definition of Items*	*Percent Agree*	*Average Score*	*Percent Agree*	*Average Score*
6	Staff returned my phone calls within 24 hours	76	4.07	75	4.01
17	I, not staff, decided my treatment goals.	74	4.01	71	3.83
20	I was encouraged to use consumer run programs.	56	3.91	52	3.98

Youth and Caregiver					
Youth		November 2014 (N=839)		May 2015 (N=705)	
Item #	*Definition of Items*	*Percent Agree*	*Average Score*	*Percent Agree*	*Average Score*
3	I helped choose my treatment goals.	83	4.13	82	4.15
2	I helped choose my services.	61	3.72	66	3.77
11	I got as much help as I needed.	75	4.01	76	4.10

Caregiver		November 2014 (N=1,483)		May 2015 (N=1282)	
Item #	*Definition of Items*	*Percent Agree*	*Average Score*	*Percent Agree*	*Average Score*
3	I helped choose my treatment goals.	87	4.30	82	4.15
2	I helped choose my services.	83	4.22	66	3.77
11	I got as much help as I needed.	77	4.16	76	4.10

IV. EFFECTIVENESS OF CARE/CLINICAL ISSUES

The MHP has initiated a variety of programmatic and oversight efforts to continuously monitor the effectiveness of care and underlying clinical reviews. These activities are conducted through the Performance Improvement Projects (PIP), selected Clinical Practice Guidelines as well as through retrospective reviews of Adverse Incident Reviews and Medication Monitoring Reviews.

A. Medication Monitoring Reviews

Charts across adult and children's providers are reviewed and monitored for medication practices on a monthly schedule. Feedback is provided to providers on any area of concern identified by the medication monitoring reviews.

The Medication Monitoring Committee reviewed a variety of Adult and Children's program charts and provided timely feedback to providers. Close attention was given to review of charts of clients served at the MHTC inpatient unit, as well as to poly-pharmacy issues, reviews of treatment guidelines and laboratory work. Laboratory guidelines and panels were developed to aid physicians in ordering labs. The Pharmacy & Therapeutics Committee has taken an active role in enhancing communication between Medical Directors and the clinics in analyzing the findings of the medication monitoring efforts.

The table that follows provides information on the number of charts reviewed and the number corrective actions as a result of the chart reviews. The number of charts reviewed in FY14-15 decreased by 27 compared to FY13-14. There were two main issues that contributed to the increase of corrective actions for both the Adult and Children's programs. First, it was discovered that there were technical difficulties between the Avatar system and the Order Connect system regarding allergy tracking. This appears to have contributed to the increase in corrective actions related to documentation of allergies. Second, the practice of scanning the Infomed Consents into the EHR has not been consistent across all programs which has lead to

the increase of corrective actions related to the evidence of documentation of informed consents. Both areas are currently being addressed in the Pharmacy & Therapeutics Committee through discussing best practices regarding documentation of allergies in the EHR and revising the Informed Consent Policy and Proceedure.The main reason for the decrease in the number of corrective actions for the Mental Health Treatment Center charts is due to a change in business practices that require the nurses to review the charts daily to ensure that the informed consents have been completed and are in the chart.

	FY 2013-2014	FY 2014-2015
Charts Reviewed		
Adult Program	719	696
Children's Program	412	379
Treatment Center Inpatient	143	110
TOTAL Charts Reviewed	**1274**	**1185**
Number of Corrective Actions		
Adult Program	5	15
Children's Program	3	11
Treatment Center-Inpatient	45	10
Total Corrective Actions	**56**	**36**

B. Medication Practice Guidelines

Medication Practice Guidelines were selected as the MHP makes efforts to develop a clinical decision tree across all adult mental health providers. Since FY05-06, the Pharmacy & Therapeutics Committee and the Medication Monitoring Committees of the QIC have worked to develop, test, retest and implement Medication Practice Guidelines for Depression, Schizophrenia, and Bipolar Disorder. These guidelines are reviewed and refined annually. The MHP continues to dedicate significant attention to developing guidelines for prescribing practices across the large provider system and the clinical implications of their use. These efforts remain an important priority for effectiveness and quality of care.

The Pharmacy & Therapeutics Committee within the Quality Improvement Committee brings psychiatrists together on a bi-monthly basis to review, discuss and comment on the medication practice guidelines. Training, new information and updates are disseminated effectively through this committee.

C. Adverse Incident Reviews

Contract providers throughout the system submit Adverse Incident Reports to the MHP, both to Program Monitors and to Quality Management, whenever a sentinel incident occurs. A sentinel incident involves a client or a staff person and includes: death (for e.g. suicide or homicide), suicidal attempt, sexual harassment, infractions of patient's rights, serious medication side effects, likelihood of litigation, possibility of media coverage, falsification of professional credentials, and facility fire. Quality Management reviews all these reports. The Executive Committee reviews all reports of suicide or death when the cause is undetermined, and reports that suggests a trend or pattern of issues of concern. If, at any level of review, there is noted a need for improvement, feedback is given to the provider either through a meeting and/or in writing with a request for a plan of correction. All actions are tracked, reviewed and monitored by the Manager of Quality Management on behalf of the Executive Committee of the Quality Improvement Committee.

Below is the FY13-14and FY14-15 Adverse Incident and reported death information received by Quality Management. There was a decrease in number of Adverse Incident Reports from FY13-14 to FY 14-15. Adult reports decreased by 7 and Child reports decreased by 3, totaling an overall decrease of 10 reports. The Quality Management Program Manager reviewed all reports. The number of deaths reported during the period decreased by 3. The Quality Improvement Committee's Executive Committee reviewed all instances where deaths occurred from medical/psychiatric as well as the effectiveness of clinical /community care perspective. Reported deaths by natural cause remained the same in FY14-15 as FY13-14. Suicides reported in Adverse Incident Reports increased from 2 to 6 during the period. Deaths due to unknown causes decreased from 41 to 34 from FY 13-14 and FY 14-15.

Feedback regarding corrective actions or whether care provided was within community standards was evaluated for quality assurance purposes. The greatest challenge for clients with medical and psychiatric issues is the difficulty in accessing timely preventive care for health conditions. This is particularly significant with the highest number of deaths occurring with clients ages 46-59. Reporting and follow-up of adverse incidents continues to reflect appropriate internal quality oversight by the MHP's contractors.

Adverse incident reports span many different types of occurrences in the community care continuum. While suicide is confirmed in few cases, unknown causes and pending coroner's reports remain a significant number of reports. This again reflects the difficulty in conclusive information regarding client deaths in the community. During the past two years, the MHP has worked on a performance improvement project to improve the collaboration between the physical and mental health providers and link clients to a primary care provider. The MHP continues to review possible factors to develop preventive programs in the community that strengthen collaboration to benefit clients and do whatever is possible to prevent untimely deaths.

MHP ADVERSE INCIDENT REPORTING

	FY 13-14	FY 14 - 15	+/-
Adult	132	125	-7
Child	69	66	-3
Total	201	191	-10

QUALITY IMPROVEMENT COMMITTEE
INFORMATION RELATED TO DEATHS REPORTED TO MHP

		FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 14 - 15
CAUSE OF DEATH	Natural	09	37	44	44
	Suicide	09	01	02	6
	Unknown	62	41	41	34
AGE	0-17	02	00	02	1
	18-24	01	02	01	1
	25-45	16	11	13	7
	46-59	35	37	41	42
	60+	26	29	30	33

DIAGNOSIS	Major Depression	20	16	23	17
	Bipolar	31	23	16	22
	Schizophrenia	28	39	43	39
	Other	01	01	05	6
PROGRAM	RST's	46	45	60	43
	Homeless	01	04	01	7
	Intensive	15	14	23	26
	Other	18	16	03	8
TOTALS		**80**	**79**	**87**	84

V. Utilization Review/Utilization Management

A. Utilization Review

The Mental Health Plan's (MHP) Utilization Review activities are performed by the MHP Utilization Review Committee (URC). In previous years, the URC conducted two reviews each month (e.g. Adults and Children's Review) as well as on-going focused reviews of specific types of services when warranted based on clinical or programmatic need. Quality Management directed reviews are referred to as "External Reviews." An electronic utilization review process (EUR) was developed and implemented effective October 16, 2014. The county operated and contract providers conduct monthly internal reviews and submit monthly minutes to the MHP's Quality Management unit. County operated and Contract providers' reviews are referred to in the report as "Internal Reviews." Some special reviews are for technical assistance to assist new providers, and others are conducted for quality improvement or compliance purposes. These reviews maintained compliance with the MHP UR responsibilities. There are three tools utilized depending on the review: a EUR tool to focus on Mode 15 Outpatient Mental Health Services, a EUR to focus on TBS services, and a EUR to focus on Day Treatment/Day Rehab Services.

Quality Management has also implemented increased oversight for Out-of-County Providers. Quality Management in coordination with the MHP Contract Monitor conducts a quarterly review using a quality assurance process of a minimum of 5% of the Out-of-County clients served. The provider is expected to complete appropriate corrections on any of the reportable items that are found during the review. The numbers from these reviews are counted in the "External Reviews" numbers. This expands oversight of care for children placed out of Sacramento County.

Quality Management and Contract Monitoring staff has also been conducting on site reviews of providers who do not utilize Avatar Clinical Workstation (CWS) as their EHR. These contract providers receive feedback on corrections and are expected to ensure corrections to errors are completed and upon request submit a Plan of Correction within 30 days of receipt of the report. Providers utilize the information for internal training to improve delivery and documentation of clinical services. For the purpose of this report, the numbers from these site reviews are reported under "External Reviews."

Quality Management staff developed the Electronic Utilization Review (EUR) utilizing Avatar and included additional types of review into the UR processes. Utilizing the report functionality in Avatar, Quality Management staff has been able to pull information such as the missing CSI report and as needed the timeliness of progress notes, timeliness of assessment and client plan completion, and data indicating missing pieces of information for billing purposes. This

information has also been reported back to the provider so that these items can be corrected, when appropriate.

In addition to outpatient reviews, Quality Management staff also review charts for services provided in the inpatient setting, excluding the Mental Health Treatment Center (MHTC) Psychiatric Health Facility (PHF) which conducts its own reviews, and at the Jail psychiatric services. In the 2014-2015 period, 100% of all inpatient cases (n= 1,748) were retrospectively reviewed and authorized for payment and documentation standards. Quality Management serves as the external review process for Jail Psychiatric Services, where a total of 99 charts were reviewed for documentation and care practices at the County Jail site.

The URC's goal is to review a minimum of 5% of the total number of non-duplicated clients open to the system. Current fiscal year chart review projections are based on the number of clients registered in the MHP's client tracking system (AVATAR) the previous fiscal year.

According to the MHP's AVATAR Electronic Health Record (EHR) there were 28,734 unduplicated clinical records (12,509 Children and 16,222 Adults served) between **July 1, 2014 and June 30, 2015**. Based on this total, the minimum number of charts to be reviewed in Fiscal Year 2014-2015 was **1,437 (5%)**; however the MHP exceeded the minimum standard and reviewed charts on 11.9% of all clients opened to the system.

The purpose of the Utilization Review Process is to:

- Evaluate the medical necessity of services rendered to clients
- Verify that claims are substantiated by the medical record
- Evaluate the quality of care provided
- Complete corrective actions related to recommendations and/or findings, and
- Recommend appropriate system-wide training and documentation changes

The following table provides information related to the chart reviews and compares FY2013-1014 to FY2014-2015.

UTILIZATION REVIEW ANNUAL REPORT FINDINGS 2014/2015

AREAS OF REVIEW	FY 13/14	FY 14/15
Total Number of Unduplicated Clients in AVATAR	27,041	28,734
Adults	15,537	12,509
Children	11,504	16,222
# of Clients constituting 5% of Total	1,352	1,437
Total # of Clients reviewed	**2,332**	**3,406**
Non Duplicate Charts Reviewed	**FY 13/14**	**FY 14/15**
External Adults (QM/County UR)	0	57
External Children (QM/County UR)	33	215
External Total (QM/County UR)	33	272
Internal Total (Within Agencies)	2,299	3,134
Total # of Clients reviewed	**2,332**	**3,406**
External Duplicate* Charts Reviewed	**FY 13/14**	**FY 14/15**
Adult County UR	0	0
Children's County UR	0	0
Total Duplicate Charts Reviewed	0	0

**Duplicate Charts: If a client is enrolled in more than one agency, each agency's chart would be reviewed (i.e. example if a client is receiving services from five agencies, all five charts would be reviewed at the external UR and potentially result in five different McFloop reports to each agency). For the purpose of this report, more than one chart associated with the same client is considered a "duplicate".*

ADULT/CHILD COMBINED EXTERNAL UR COMPARISON BY FISCAL YEAR 13/14 & 14/15

Medical Necessity and Diagnosis	FY 13/14	N=33	FY 14/15	N=272
	N	%	N	%
Medical Necessity not met	0	0.0%	9	3.3%
No ICD-9 code in at least one clinical/medical document	0	0.0%	2	0.8%
Primary Diagnosis Missing in at least one clinical/medical document	1	3.0%	2	0.8%
Treatment Planning	**FY 13/14**		**FY 14/15**	
	N	%	N	%
No ACP/ACA (Core Assessment)	1	3.0%	16	5.9%
No R&R (Core Assessment)	0	0.0%	16	5.9%
Incomplete ACP/ACA/R&R (Core Assessment)	3	9.1%	18	6.7%
No AMSP (MSP)	3	9.1%	26	9.6%
Incomplete AMSP (MSP)	0	0.0%	26	9.6%
No Client and/or Caregiver signature on MSP	3	9.1%	21	7.8%
Goals Not Measurable/Quantifiable	1	3.0%	12	4.5%
Goals, Symptoms, Diagnosis, & Interventions Incongruent	1	3.0%	5	1.9%
Risk Factors & Special Status Situation not addressed	0	0.0%	17	6.3%
No Client Signature on ACP/R&R/Client Plan w/o explanation	2	6.1%	14	5.2%
No Caregiver/Significant Support Persons' Signature on ACP/R&R/Client Plan	3	9.1%	10	3.7%
Staff signature/co-signature/title missing from plan	0	0.0%	0	0%
No indication of Coordination of Care	2	6.1%	1	0.4%

ADULT/CHILD COMBINED EXTERNAL UR COMPARISON BY FY 13/14 & 14/15 (CONTINUED)

Progress Notes	FY 13/14	N=33	FY 14/15	N=272
	N	%	N	%
Missing Progress Notes (billed to AVATAR but not in chart)	0	0.0%	0	0.0%
Over billing (i.e. excessive billing; insufficient documentation)	9	9.1%	8	3.0%
Using Incorrect Billing Codes	3	3.0%	21	7.8%
Billed during a lockout	0	0.0%	1	0.4%
Billed non-billable service	0	0.0%	6	2.3%
Staff Signature/Co-Signature/Title Missing or Late	0	0.0%	0	0.0%
Staff operated outside their scope of practice	0	0.0%	3	1.2%

***I.e. Data entry error; unclear billing; incorrect date; 2nd staff not justified; incomplete progress note; billing not substantiated by note; no Clinical Intro note; etc.*

ACCESS Authorization	FY 13/14		FY 14/15	
	N	%	N	%
No current Managed Care Authorization was found in the chart	0	0.0%	NA	NA
Authorization Dates on ACP/R&R (Core Assessment) were missing or incorrect	0	0.0%	NA	NA
Billed outside of Authorization period	0	0.0%	0	0.0%

Missing Documentation	FY 13/14		FY 14/15	
	N	%	N	%
HQ/HQ Update was Missing	1	3.0%	35	12.9%
Client Data Sheet Initial or Updated Missing	0	0.0%	13	4.8%
Consents Incomplete or Missing (I.e. Informed Consent; Medication Consent; HIPAA forms)	4	12.1%	62	22.8%

Miscellaneous Findings	FY 13/14		FY 14/15	
	N	%	N	%
No Linkage to physical health or other service	4	12.1%	21	10%
Breaches of Confidentiality	0	0.0%	5	1.9%

Targeted Outpatient RST Chart Review	FY 13/14	FY 14/15
Adult System of Care	145	0

Inpatient Hospital Reviews	FY 13/14	FY 14/15
MediCal Adults (Includes Charts Reviewed from IMD Project)	954	2132
MediCal Children	743	576
MediCal Total	**1697**	**2708**
Short Doyle	51	

Other Psychiatric Services Chart Review	FY 13/14	FY 14/15
Jail Inpatient	29	37
Jail Outpatient	59	62
Total	**88**	**99**

Due to limitations of the data tracking system and other data gathering difficulties, the above information is only applicable to the External Reviews (County UR). It does not include detailed information from Internal Reviews conducted by providers.

Comments:

On-going reviews are one method of monitoring care, along with providing feedback to improve the quality of service delivery and identifying training needs. Documentation training by MHP staff will incorporate UR findings that suggest areas for improvement. Most findings in a review fall into three major categories: Disallowance (due to over-billing or insufficient documentation to support billing); Compliance (a chart did not comply with State and/or Federal regulations); or Quality of Care (corrective action would improve quality of care to the client/family).

Significant observations are noted below regarding the UR review data presented above:

- The External UR meetings were reinstated in October 2014. External UR was cancelled beginning May 2013 for a time period due to the county focusing on implementing Electronic UR using the Avatar Clinical Workstation (CWS) system. Therefore, FY 2013 – 2014 the External UR data is significantly low.
- 100% of Avatar users have obtained client signatures on all MSP's. Out of the providers not using Avatar as their electronic health record 5.2 % of the children's charts were found with no client signatures on the MSP. These providers were using the previous AMSP document which does not have a designated spot for the client to sign. Therefore, they are not held to this standard until they adopt the updated MSP document.
- The data indicates a significantly high amount of missing "Consents Incomplete or Missing (I.e. Informed Consent; Medication Consent; HIPAA forms)" A factor that may skew the data is that within the External Review Tool consent documents are sectioned out as separate tool items. As an example, if the provider completed all but one of the above documents then the data would still reflect that there is a missing consent.
- The section, "No Current Care Authorization" was found in the chart was not a question that was within the external UR tool during FY 2014-2015 given that this information is found on a widget in Avatar under the chart view screen, Therefore, it is marked "NA."
- The section, "Authorization Dates on ACP/R&R were missing or incorrect" was not a question within the external UR tool during FY 2014-2015 given that the information is not documented on the Core Assessment document. The Core Assessment/ Updated Core Assessment is the Avatar version of the ACP/R&R.
- The section, "Billed outside of Authorization period" was not a question that was within the External UR tool during FY 2014-2015.

Findings:

In **FY 2014-2015 a total of 272 charts** were reviewed externally by the County UR committee. A total of **3,134** were reviewed internally by MHP providers. The combined total of external and internal reviews **(3,406 or 11.9% of MHP unduplicated clients)** easily exceeds the 5% goal A total of **5,253 cases** were reviewed across all parts of the MHP system of care. This total includes inpatient hospital reviews, reviews of Jail Psychiatric chart review. This total does not include targeted reviews by program monitors or other Executive QI processes to oversight client care.

The annual plan goal was to track two areas using benchmark data. Quality Management utilized existing data to set baseline measures for improvement in areas with information collected at County Utilization Review. It is important to remember that these findings are based on External UR numbers, and in FY 13-14, the sample size of External UR is very small

compared to previous fiscal years. Therefore, the data in the findings appears significantly skewed. In FY 14-15, the following findings in these areas were:

1) Decrease in "No client signature or explanation": FY 10-11: 5%; FY 11-12: 7%; FY 12-13: 5%; FY 13-14: 6.1% (2/33); FY 14-15: 5.2% (14/272). Acceptable Error rate = 0%.

2) Continuing to be in 100% compliance for "Missing Progress Notes": FY 10-11: 25%; FY 11-12: 32%; FY 12-13: 30%; FY 13-14: 0% (0/33); FY14-15: 0% (0/272) Acceptable Error rate = 0%
Note: It should be noted that for providers who utilize Avatar as their EHR, progress notes generate the claim. However, it is possible for providers who submit their claims, such as the Out-of-County providers or providers who use their own EHR, to still have missing progress notes, and this is an item for review during the UR process for those providers.

For providers utilizing the MHP's Avatar Clinical Workstation (CWS), this system is supporting documentation efficiency by reducing duplication of information and linking the claiming system and clinical record. It should be noted that the external reviews were conducted at providers who do not utilize Avatar as their EHR. The areas that are in need of ongoing training involve utilizing the appropriate service codes when documenting, completing the initial health questionnaire and updated health questionnaire, ensuring that signatures are gathered on client plans, obtaining consents and HIPAA forms, and completion of all necessary forms in a timely manner. All areas identified in UR will be the focus of training in the MHP.

Utilization Management:

The MHP's Utilization Management is conducted at select administrative control points. The Adult Access Team and the Child & Family Access Team provide centralized entry points to the MHP service system. Private local Inpatient Hospitalization is reviewed concurrently and private Out of County Inpatient hospitalization is reviewed retrospectively and authorized through Quality Management by a unit of licensed staff. Problem resolution staff as part of resolution of issues brought to their attention also reviews utilization of services from this unique role. Utilization management takes place from the vantage point of authorization, satisfaction, and provider appeals.

The Access Teams are comprised of licensed or "waivered/registered" mental health staff, which authorizes treatment based on the clinical information available. Authorizations are based on Medical Necessity criteria. Written notices are sent to Medi-Cal beneficiaries for any denial, reduction or termination of service or denial of payment. Notices of Action (NOAs) are required to be sent whenever such actions are taken by the MHP. (See Appendix III for definition of reasons to issue a NOA.)

The MHP provides consistent authorization since standardized authorizations are packaged for the appropriate designated level of care. For instance, a client requiring the services of an adult outpatient program is authorized for one year of treatment. A child receiving standard outpatient services is authorized for one year of treatment in a children's program. Re-authorization and Reassessment is required for additional services. Length of authorization is established by the MHP service standards.

Timeliness of urgent care is not an issue, since the MHP does not require preauthorization for urgent care services.

In FY14-15 the MHP has complied with the managed care regulations and provided consistent authorizations. Licensed and waivered staff authorized or denied services. The MHP notifies members when services are denied, reduced, or terminated. No delays occurred in resolution of grievances or appeals within the required timeline. Inpatient hospital Notices of Action are a result of retrospective chart reviews and/or concurrent review. The issuing of a NOA is delineated by regulation. NOA-As, sent to individuals requesting services in the adult system increased slightly from 475 to 489. NOA-C notices to local inpatient hospitals for adult and child hospital professional services and/or inpatient stay denied days increased.

It is noted that no NOA-D for delayed problem resolution activities were needed as all issues were addressed within the required timeframes.

The MHP complied with its obligation to issue appropriate Notices of Action when required.

Notice of Actions		
	FY 13-14	**FY 14-15**
NOA-A		
Adult	475	489
Child	11	15
NOA-B		
Adult	0	0
Child	7	0
NOA-C		
Adult-Inpatient	4	6
Child-Inpatient	15	39
NOA-D		
Adult	0	0
Child	0	0
Total NOA's Issued	491	549

VI. CONTINUITY AND COORDINATION OF CARE

Continuity and coordination of care was addressed in both of the Performance Improvement Projects during FY 13/14 and FY 14/15.

See attachment/Appendix V: CAEQRO PIP Outline via Road Map – Sacramento County MHP, 2013-2014 PIP Update.
The MHP continues implementation of this Adult Performance Improvement Project (PIP). As a result of this PIP, standards and performance measures have been written into all outpatient contracts. All adult and children's providers are required to document the clients primary care provider contact information into the electronic health record as evidence of coordination of care. Benchmarks, indicating the percent with a PCP documented in the electrocinic health recored, have been established in all contracts with the expectation of a percent increase overtime.

See attachment/Appendix VI: CAEQRO PIP Outline via Road Map – Sacramento County MHP, 2013-2014 PIP Update: Increasing Collaboration Between Mental Health (MH) and Child Protective Services (CPS)

In March of 2013, Sacramento County's Mental Health Plan (MHP) and Child Protective Services (CPS) began the planning process for implementation of the Katie A. Settlement Agreement. The process was guided by the Core Practice Model developed by the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS). In the Core Practice Model the elements of focus were Teaming, Trauma-Informed Practice, Practice Components, and Services. During the planning meetings and stakeholder information gathering activities it became increasingly clear that the success of the Katie A. implementation would be dependent on the teaming process between families, youth, Mental Health Providers, and CPS. It was decided that the MHP would use Katie A. implementation planning to determine which elements would result in an increase in teaming and have the potential to influence outcomes for children, youth and families. After reviewing current teaming practices and identifying barriers, challenges and strengths the PIP committee agreed to the following PIP question:

Does applying a standard set of expectations for involvement and coordination with Child Protective Services (CPS) in Intensive Care Coordination-Child and Family Teams (ICC-CFT) result in better outcomes for children/youth and their families?

VII. CULTURAL COMPETENCE, EDUCATION AND TRAINING

NAME OF TRAINING	TARGET AUDIENCE	NUMBER OF ATTENDEES	
		2013/2014	2014/2015
Medi-Cal Technical Support and Clinical Training Totals **(Includes Medi-Cal Eligibility, UMDAP, & CPT Code numbers)** **(Cultural Competency and Avatar numbers are not included)**	Adult and Children Mental Health providers, county staff	**2055**	**1,719**
Cultural Competency Training Totals Includes but not limited to basic as well as more advanced cultural competence training including Cultural Competence Foundational Training, Utilization CBMCS, "Integrating Core Principles of Cultural Competence into Service Delivery", "Use of Interpreters in MH Settings", and training that explore the impact of culture on the wellness and recovery process.	Adult and Children Mental Health providers, Community partners Stakeholders County staff	**9327**	**9,518**
Consumer Recovery & SacPORT (Psychosocial Options for Recovery Training) Includes "Consumer Speaks Conference"; Group Facilitator Workshop-Wellness, Recovery, Peer Support; WRAP (Wellness and Recovery Action Plan) training; psychosocial rehabilitation training with group implementation.	Adult Mental Health provider service staff and Consumers	**370**	**275**
Co-Occurring Disorders Case Conferences and Alcohol and Drug Treatment Initiative Series	Children and Adult Mental Health providers, Alcohol & Drug Division providers, county staff and partnering agencies	**400**	**127**
Documentation Training Including Chart Documentation, Billing/Service Codes, Staff Qualifications, and Site Certification	Adult and Children's Mental Health direct service and supervisory staff	**215**	**225**

Other Clinical Training Mental Health First Aid Training, Use of CANS in Treatment Process, Mental Health Aging Conference	Adult and Children Mental Health providers, county staff and community partners	**844**	**845**
Managed Care Regulatory Changes Includes Compliance Training Program and Beneficiary Protection: Problem Resolution/Advance Medical Directives	Adult and Children's Mental Health direct service and supervisory staff	**71**	**86**
AVATAR Training and Technical Assistance	Adult and Children's Mental Health service Staff	**770**	**635**
LOCUS Training Level of Care Utilization System Training	Adult Mental Health providers	**81**	**71**
5150 Certification Training Overview of the LPS Act, patient's rights, confidentiality, completing the 5150 application, and other relevant issues related to 5150 authority	Child and Adult Mental Health providers, hospital designated staff	**74**	**90**

Findings:

Total attendance numbers for Medi-Cal Technical Support and Clinical trainings offered within the Mental Health Plan was 1719 for FY14-15. This is a decrease from 2055 in FY 13/14 which is due to the system wide implementation of CPT Code training that took place in April and May of 2014.

The MHP provided training for its IT system - Avatar in FY14-15. This included monthly forums (Clinical and Practice Management), Drop-in sessions, a basic "Avatar 101" training, and Advanced Billing training. Providers using the Avatar Clinician Workstation (CWS) for documentation of clinical services also participated in CWS training during the year. 635 individual attendees benefited from Avatar trainings and forums in the 2014-2015 FY. In addition to noted trainings, the MHP maintains an email and telephone support line for both IT and documentation questions.

In FY14-15, the MHP continued several ongoing training initiatives:

- Cultural competence is a key aspect of all MHP trainings, and expansion of knowledge and related skills in this area are an on-going target of trainings. The Cultural Competence Plan requires that all training conducted throughout the system incorporate cultural competence and includes a training plan to ensure that all service delivery staff receive training incorporating material from all the of modules of the California Brief Multicultural Scale training. Focused cultural competence training tailored to the needs of the diverse workforce is conducted by the county and contract provider agencies. Cultural Competence training for the system increased from 9,327 in FY 2013-14 to 9,518 in FY 2014-15.

  ****** Over the last several years through a variety of prevention and early intervention programs, community based organizations have been offering more trainings to members of the community they serve. Therefore this number includes both the number of staff working in a mental health program as well as community members/public.

- 275 attendees received training focusing on building recovery skills in the 2014-2015 FY. These included the annual Consumer Speaks conference involving consumers and Wellness/Recovery Action Plan (WRAP) training alongside the SacPORT (PsychoSocial Rehabilitation Training) modules.

- Quality Management offers 5150 Certification training to providers in the Mental Health Plan and community hospitals, which certifies Designees authorized to write 5150 applications. 90 attendees were trained in 5150 Certification or Re-Certification classes during the 2014/2015 FY.

- Sacramento County's law enforcement training initiative continued into the 2014/2015 FY by providing the Mental Health for Crisis Responders as part of the Sacramento County Sheriff Department's Advanced Officer Training (AOT) program. The 2-hour course is presented by a mental health team comprised of consumers, family members and mental health professional educators. The participants of the AOT class include not only sworn officers and communication center staff but can include retired officers from the Sheriff's Department, Police Force, and California Highway Patrol. The decision to continue to include the Mental Health Update as part of the AOT schedule was to re-enforce the need to increase positive outcomes for individuals and families who are experiencing mental health challenges. During the period 7/1/2014 through 12/30/2014, sixteen (16) scheduled trainings were completed and approximately 336 officers were trained through this Advanced Officer Training (AOT) period.

- Mental Health First Aid Mental Health First Aid (MHFA) is an evidenced-based program, which uses adult learning principles and role-playing to demonstrate how those in the community who do not have a mental health background can assess a mental health crisis and provide initial help until appropriate professional help can be obtained. The training also addresses risk factors and warning signs of specific mental health conditions like anxiety, depression, schizophrenia, bipolar disorder, and substance abuse. The trainings are offered free to the community on a monthly basis to provide education about mental health conditions and to provide resources and skills that the general public can use in their interactions with individuals who may experience mental health issues. During the 2014-2015 FY the Mental Health First Aid for Youth (YMHFA) curriculum was included as part of the schedule on a quarterly basis to offer those who work with and support youth who may be experiencing the onset of a mental health condition or crisis related to a mental health condition. The goal for YMHFA is to provide adults who work with youth the skills and resources to engage and link youth and families to prevention and early intervention programs. In 2014-2015 Sacramento County provided 11 MHFA courses and provided certification to 217 participants as well as providing 3 YMHFA courses and provided certification to 53 participants.

- Technical support offered through the DHHS-Mental Health web page has expanded and supplemented the face to face documentation training provided by MHP, with the QM Information link. This area has been seen significant growth and opportunity for the MHP providers to receive timely responses to inquiries, and additional consultation as needed. Targeted technical assistance has been provided to assist MHP providers in clinical documentation areas when necessary and applicable.

- The Compliance Program training continues for county and provider staff, and a refresher course has been developed that attendees can take on-line, including an exam.

ACKNOWLEDGMENTS

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

APPENDIX I

QUALITY MANAGEMENT
PROGRAM
ANNUAL WORK PLAN
July 1, 2014 to June 30, 2015

SCOPE	**OBJECTIVES**	*PLANNED ACTIVITY*	**RESPONSIBLE PARTY**	**DUE DATE**
1. Cultural Competence (Reference: 2010 Cultural Competence Plan Goals –	1. Increase the retention rates of un-served, underserved and inappropriately served populations to ensure rates overall are at least 53%, for adults are at least 50% and children are at least 77% over a 1 year period.	• Continue to track and measure retention rates in accordance with Reducing Disparities Learning Collaborative (RDLC) definitions	MHP Team (Research & Evaluations (REPO) and Ethnic Services	Annual Report to Cultural Competence Committee (CCC) and QIC
		• Evaluate methodology to track and measure retention rates to be inclusive of all consumers served in OP programs		
		• Track/trend utilization rates by: age, gender, race, ethnicity, and preferred language.	Same as above	
	2. Increase the penetration rate in un-served/underserved populations by 1.5% over previous year as measured for • Race and ethnicity • Language • Age • Gender			Annual Report to Cultural Competence Committee (CCC) and QIC
		• Refine mechanisms to track/measure PEI activities by age, gender, race, ethnicity and language.	Same as above	
	3. Increase the utilization of mental health services by monitoring participation in the activities of PEI projects.			Same as above
		• Utilize administrative data to calculate costs.	REPO and Ethnic Services Staff	
	4. Monitor cost of service by race/ethnicity to determine disparities.			
		• Complete the annual Human Resources Survey and analyze findings	REPO and Ethnic Services Staff	Report to Cultural Competence Committee and QIC by June

	5. Increase the percentage of direct service staff by 5% annually to reflect the racial, ethnic, cultural and linguistic makeup of the county until the proportion of direct service staff equals the proportion of Medi-Cal beneficiaries and 200% of poverty population. 6. Determine whether client outcomes are equivalent regardless of ethnic group or primary language 7. Ensure MHP progress in the delivery of culturally competent services through the biennial completion and analysis of a system-wide Cultural Competence Agency Self-Assessment. 8. Ensure agency progression towards cultural competency.	• Track/trend satisfaction through translated surveys and/or analyze by primary language of consumers. Compare to level of satisfaction of MHP members in general. • Collect self-assessment data and measure progress based on information • Continue incorporation of cultural competency skill sets within all training/education opportunities. • Administer California Brief Multicultural Competence Scale (CBMCS) to service delivery and supervisory staff and provide CBMCS training modules across the system. • Provide Mental Health Interpreter training for interpreter staff and providers who use interpreters.	REPO and Ethnic Services Staff Cultural Competence/ Ethnic Services Staff and MHP Training Committee Same as Above	2015 Annual report to CCC and QIC Periodic report to CCC Periodic report to CCC and QIC Same as Above
2.Access, Accessibility, Monitoring Service Capacity	1. Monitor benchmarks tracking timely and appropriate access to mental health services by race, ethnicity and language.	• First request for service at provider point of access (opening episode at provider) to first engagement by provider: a. Children – 10 business days (14 calendar days) b. Adults – 10 business days (14 calendar days) • First request for at provider point of access (opening episode at provider) to first	MHP REPO Team/Ethic Services	Periodic Report to QIC and CCC

		psychiatric appointment, if required: a. Children – N/A b. Adults – 28 calendar days • Time between provider intake (first face-to-face visit) and second non-psychiatric face-to-face contact: a. Children – 20 business days (30 calendar days) b. Adults – 20 business days (30 calendar days) • Average length of time from hospital discharge to first psychiatric appointment: a. Children – 20 business days (30 calendar days) b. Adults – 20 business days (30 calendar days) • Length of time from hospital discharge to first non-psychiatric face-to-face contact for clients already in outpatient services: a. Children – 5 business days (7 calendar days) b. Adults – 5 business days (7 calendar days) • Quarterly analysis of time-to-service indicators in specific programmatic areas		
	2. Maintain service delivery sites across county care system through a variety of contracts with organizational and enrolled network providers	• Annual report on changes in numbers of organizational and enrolled network providers from previous year	QM	Annual Report to QIC & CCC
	3. Monitor responsiveness of 24-hour telephone access to meet statewide standard for timeliness, responsiveness and cultural competence.	• Quality Management to conduct year round tests of 24 hour call line and MHP follow-up system.	QM/Ethnic Services staff	Report back to QIC and CCC
	4. Monitor MHP organizational capacity	• Track number of contracts (hospitals, outpatients and enrolled network	QM	Reports to QIC

		providers)		
3. Monitoring Beneficiary Satisfaction Provider	1. Evaluate, monitor and assess consumer satisfaction 2. Monitor Problem Resolution process.	• Administer and analyze State required and local/program specific satisfaction surveys. Analysis includes examination of disparities by race, ethnicity and language. • Develop appropriate system wide recovery tool survey and pilot test for adult programs. • Inform providers/practitioners of results through publication of satisfaction survey results system wide. • Track and analyze provider level complaint, grievance process with concomitant correct plans • Track, trend and analyze beneficiary grievance and State Fair Hearing actions. Include type, ethnicity, race, and language as part of this tracking.	REPO QM	Semi-Annual Report to QIC and CCC Annual report to QIC and CCC
4. Effectiveness of Care/ Clinical Issues	1. Identify and analyze quality of care across all age groups across MHP providers	• Develop quality assurance measures in AVATAR reports to establish data measurement for MHP service system • Continue to monitor quarterly targeted reports to check use of specific AVATAR options to record care (e.g. Use of Client Resources to record primary care or other	Avatar Team QM/REPO/ Program	Periodic report as needed to QIC

		supports in Avatar system) • Identify specific reports to develop monitoring and rapid feedback loop across system • Continue QIC Executive Committee Review of adverse incidents, identifying issues, cultural competence considerations to include ethnicity, requesting and reviewing plans of correction.	Executive QIC and appropriate QI committees and CCC	Annual Report to QIC& CCC

	2. Evaluate information produced through monthly adult and child clinical chart reviews.
	3. Study, analyze and continuously improve medication monitoring and medication practices in Child and Adult system.
	4. Monitor use of Child and Adolescent Needs and Strengths (CANS) as part of clinical assessment and treatment planning
	5. Develop implementation plan for the use of Adult Needs and Strengths (ANSA) for system wide outcome measures for adult programs
	6. Implement Katie A. protocols and data tracking
	7. Implement system wide monitoring of the electronic
		• Implement targeted chart review at provider site to verify medical necessity for continuation of mental health services.
		• Reduction in error rates in the following categories:
		  • Reduce missing data and error rates in Client Service Information (CSI) reporting to 4%. (system wide & provider level)
		  • No Client/Caregiver Signature on Plan without explanation (FY08-09 1.3%; FY09-10: 2.3%, FY10-11; 5%, FY 11-12; 6.7 %, FY 12-13; 5.4% (Acceptable Error rate: 0%).
		• Continue improvements in criteria for medication monitoring for outpatient clinics.
		• Use practice guidelines developed by Pharmacy and Therapeutics Committee for schizophrenia, bipolar disorders, depressive disorders and ADHD.
		• Continue to monitor the effectiveness of the CANS data and targeted trauma modules.
			QM/UR Committee
			QM/REPO/UR Committee
			QIC/ Medication Monitoring Committee
			QIC/ P&T Committee
				Annual report to QIC
				Annual report to QIC
				Report to QIC as needed
				Report on progress to QIC at semi-annual intervals

	medical record AVATAR Clinical Workstation	• Select components of the implementation of the ANSA and train and pilot test • Continue the implementation plan including identifiers, data fields, treatment codes, and protocols to track Katie A. members. • Implement clinical documentation and train clinical and administrative staff. • Develop and implement an electronic clinical utilization review system.	QM/Children's Program/REPO Adult Program/QM QM/ACCESS/ Child Program AVATAR Team Same as Above	Report back to QIC Report back to QIC Report back to QIC Same as Above
5. Continuity and coordination of care with physical health and other human services agencies	1. Evaluate continuity and coordination with physical health care 2. Evaluate coordination of care with CPS in regards to Foster Care youth	• Explore methods of tracking care coordination between GMC PCP and Behavioral Health Care. • Develop quality assurance measures in AVATAR reports to establish data measurement for MHP service system • Monitor referrals and evaluate Primary Care/Behavioral Health coordinated services. Include type, ethnicity, race, and language as part of tracking of referrals. • Child PIP	QM/REPO/Adult Program/ Behavioral Health collaboration QM/Program QM/Child Program/Cultural Competence	Periodic & Annual Report to QIC Periodic & Annual Report to QIC
6. Training/ Education	1. Utilize Mental Health Services Act (MHSA) principles to enhance skill level through education at all levels of MHP.	• Continue implementation of MHP WET Training Plan based on community input and MHP prioritization.	MHP Training Committee	Annual Report to QIC

		• Develop and implement curriculum for integrating cultural competency and wellness, recovery and resiliency principles for different levels and types of providers and stakeholders.	Ethnic Services; MHP Training Committee	Periodic reports to QIC
		• Refine system wide implementation of trauma informed and trauma specific trainings to address all ages and cultural groups served by the MHP.	MHP Team, CCC & Training Committee	Periodic Report to QIC and CCC
		• Utilize training/educational opportunities to include methods to enhance the array of culturally competent skill sets and community interfaces for mental health and partner agencies.	Same as above	Annual QIC and CCC Report
		• Conduct at least one workshop on consumer culture with trainers to include consumer/youth/parent/caregiver/family perspective on mental illness.	Same as above	Same as above
		• Conduct at least annual in-house training/consultation to MHP's mandated key points of contact to ensure competence in meeting the access needs of diverse communities.	QM and Ethnic Services	Same as above
		• Continue expansion and targeted implementation of MH training for law enforcement and first responders within and outside of the mental health provider community	MHSA Training Partnership Team, MHP Training Team	Annual QIC Report
		• Explore training opportunities to provide a continuum of crisis intervention trainings to address all age groups and a variety of service specific issues to enhance crisis intervention competency skills across MHP services.	Same as above	Same as above

APPENDIX II

SACRAMENTO COUNTY MHP PROVIDERS 2014-2015

ORGANIZATIONAL CONTRACT PROVIDERS

North Area:

Martin's Achievement Place (C)
Terkensha Associates (C)
Turning Point Community Programs (A)(2)
WellSpace Health (formerly The Effort, Inc.) (C)

South Area:

Child & Family Institute (C)
Consumer Self Help/WRC-S (A)
Dignity Medical Foundation (C)
*Hmong Women's Heritage Association (A)
Milhous Children's Services (C) (4)
River Oak Center for Children, Inc. (C)(2)
Sacramento County-APSS Bowling (A)
Sierra Vista Hospital (A) (C)
Turning Point Community Programs (A) (C) (4)
Visions Unlimited, Inc. (A) (C) (2)
WellSpace Health (formerly The Effort, Inc.) (C)

East Area:

Another Choice Another Chance (C)
Asian Pacific Community Counseling - TWC (A) (C)
BHC Heritage Oaks (A)(C)
Child & Family Institute (C)
Children's Receiving Home (C)
Consumer Self Help/WRC-N (A)
Crestwood Sacramento PHF (A)
Cross Creek Family Counseling, Inc. (C)
Dignity Medical Foundation (C)
El Hogar, Inc. (Sierra Elder Wellness) (A)
EMQ/Families First, Inc. (C)
La Familia Counseling Center, Inc. (C)
Human Resource Consultants (A) (2)
*Mental Health America of Northern California (A)
Quality Group Homes, Inc. (C) (3)
Paradise Oaks (C) (4)
River Oak Center for Children, Inc. (C) (3)
Sacramento Children's Home (C) (3)
Sacramento County (A) (C) (5)

- *Mental Health Treatment Center
- Intake Stabilization Unit
- Child & Adolescent Psychiatric Services
- Adult Psychiatric Support Services

San Juan Unified School District (C)
Sierra Forever Families (C)
Stanford Youth Solutions (C)
Sutter Center for Psychiatry (A)(C)
Telecare, Inc. - SOAR (A)
Terkensha Associates (C)
Terra Nova Counseling (C)
Transitional Living & Community Support (A)
UC Davis Medical Center CAARE (C)
UC Davis Medical Center SacEDAPT (C)

West Area:

El Hogar, Inc. (A) (2)
Terra Nova Counseling Center (C)
River Oak Center for Children (C)

Out of County Children's Providers:

Crestwood Bridge Program (Bakersfield) (A)
Counseling4Kids (Burbank) (C)
Edgewood Residential Treatment Center (S.F., CA) (C)
EMQFF (Davis) (C)
Fred Finch Youth Center (Oakland) (C)
Milhous Children's Services (Nevada City, CA) (C)
St. Helena Hospital (Vallejo) (C)
Summitview Child Treatment Center (Placerville, CA) (C)
Victor Treatment Centers, Inc. (Lodi; Redding; San Bernardino; Santa Rosa, CA) (C) (4)
Willow Glen Care Center (HOSP-Yuba City) (C)

Note: Quality Management maintains a separate list of Enrolled Network Providers.

Specialized Providers – Non-Geographic

*UCD Jail Psych
*Sacramento County Juvenile Justice

(#) = Number of physical sites for specified provider in designed area
*** = Not a Medi-Cal provider**
(A) = Adults (C) = Children's

APPENDIX III

NOTICE OF ACTION (NOA)

Definitions:

NOA - A (Assessment) form is used when the MHP or its provider assesses a Medi-Cal beneficiary and determines that the beneficiary does not meet medical necessity criteria and no specialty mental health services will be provided.

NOA - B (Denial of Services) form is used when a provider requests payment authorization for a specialty mental health services and the MHP denies or modifies the provider's request and the beneficiary did not receive the service.

NOA - C (Post-Service Denials) form is used when a provider requests payment authorization for a specialty mental health service and the MHP denies or modifies the provider's request and the beneficiary not responsible for the cost of the service rendered but retrospectively denied or modified.

NOA - D (Delayed Grievance/Appeal Decision) form is used when the MHP does not provide the resolution of a grievance, appeal, or expedited appeal within the required timeframes.

NOA - E (Lack of Timely Services) is a form used when the MHP does not provide services in a timely manner according to their own standards for timely services.

APPENDIX IV

System-Wide Technical and Clinical Trainings
July 1, 2014-June 30, 2015

Date	#	TRAINING JULY '14-JUNE '15
7/10/2014	3	24/7 Access Line Training
5/11/2015	14	5150 Certification Training
1/12/2015	16	5150 Certification Training
9/8/2014	21	5150 Certification Training
3/9/2015	11	5150 Re-Certification Training
11/10/2014	8	5150 Re-Certification Training
7/14/2014	8	5150 Re-Certification Training
5/15/2015	12	5150 Train the Trainer
7/22/2014	9	Access Afterhours Test Calls
7/7/2014	6	Access Afterhours Test Calls
7/3/2014	15	Access Afterhours Test Calls
7/2/2014	14	Access Afterhours Test Calls
3/11/2015	21	Adult Documentation 1 Training
1/26/2015	12	Adult Documentation 1 Training
3/10/2015	21	Adult Documentation 2 Training
1/27/2015	9	Adult Documentation 2 Training
4/27/2015	16	APCC/TWC Technical Support
5/26/2015	38	APPS Technical Support Day I
6/16/2015	24	APPS Technical Support Day II
6/18/2015	9	CANS Training
4/9/2015	12	CANS Training
1/30/2015	12	CANS Training
10/2/2014	13	CANS Training
7/30/2014	13	CANS Training
6/2/2015	13	Child Documentation 1 Training
4/7/2015	14	Child Documentation 1 Training
2/3/2015	5	Child Documentation 1 Training
6/3/2015	10	Child Documentation 2 Training
4/8/2015	15	Child Documentation 2 Training
2/4/2015	4	Child Documentation 2 Training
1/13/2015	53	Communicating Effectively Through Compassionate Conversation (Listening & Speaking)
6/3/2015	9	Compliance Program Training
5/6/2015	3	Compliance Program Training
4/1/2015	5	Compliance Program Training
3/4/2015	3	Compliance Program Training
2/4/2015	7	Compliance Program Training
1/7/2015	4	Compliance Program Training
12/3/2014	4	Compliance Program Training
11/5/2014	6	Compliance Program Training
10/1/2014	7	Compliance Program Training
9/4/2014	0	Compliance Program Training
9/3/2014	2	Compliance Program Training
8/6/2014	8	Compliance Program Training

System-Wide Technical and Clinical Trainings
July 1, 2014-June 30, 2015

Date	#	TRAINING JULY '14-JUNE '15
7/8/2014	1	Compliance Program Training
7/8/2014	1	Compliance Program Training
7/2/2014	1	Compliance Program Training
7/2/2014	1	Compliance Program Training
6/26/2015	275	Consumer Speaks Conference Training
5/19/2015	49	CPT Service Code Training
5/18/2015	33	CPT Service Code Training
5/12/2015	19	CPT Service Code Training
5/8/2015	36	CPT Service Code Training
5/7/2015	15	CPT Service Code Training
5/5/2015	17	CPT Service Code Training
5/4/2015	21	CPT Service Code Training
4/30/2015	32	CPT Service Code Training
4/28/2015	30	CPT Service Code Training
4/13/2015	13	CPT Service Code Training
5/19/2015	73	CPT Service Code Webinar
5/18/2015	126	CPT Service Code Webinar
5/12/2015	44	CPT Service Code Webinar
5/8/2015	60	CPT Service Code Webinar
5/7/2015	22	CPT Service Code Webinar
5/5/2015	18	CPT Service Code Webinar
5/4/2015	22	CPT Service Code Webinar
4/30/2015	8	CPT Service Code Webinar
4/28/2015	17	CPT Service Code Webinar
4/20/2015	5	CPT Service Code Webinar
4/17/2015	12	CPT Service Code Webinar
4/13/2015	20	CPT Service Code Webinar
6/4/2015	40	Cultural Competence Foundational Training-Utilizing the California Brief Multicultural Competence Scale
6/3/2015	41	Cultural Competence Foundational Training-Utilizing the California Brief Multicultural Competence Scale
5/15/2015	38	Cultural Competence Foundational Training-Utilizing the California Brief Multicultural Competence Scale
5/14/2015	37	Cultural Competence Foundational Training-Utilizing the California Brief Multicultural Competence Scale
3/16/2015	35	Cultural Competence Foundational Training-Utilizing the California Brief Multicultural Competence Scale
1/28/2015	42	Cultural Competence Foundational Training-Utilizing the California Brief Multicultural Competence Scale
1/27/2015	43	Cultural Competence Foundational Training-Utilizing the California Brief Multicultural Competence Scale
8/6/2014	12	Documentation 1 (Adult) Training @ El Hogar RST
8/7/2014	11	Documentation 2 (Adult) Training @ El Hogar RST
10/10/2014	8	Documentation SacEDAPT and Service Code Training at UC Davis
10/16/2014	10	Documentation Training (Children)
9/18/2014	0	Documentation Training (Children)
7/17/2014	6	Documentation Training (Children)
8/19/2014	5	Documentation Training (Children) at WellSpace Part 1
10/21/2014	6	Documentation Training (Children) at WellSpace Part 2
9/16/2014	105	Latino Behavioral Health Week: Strength in Connections Training
6/11/2015	4	LOCUS Training

System-Wide Technical and Clinical Trainings
July 1, 2014-June 30, 2015

Date	#	TRAINING JULY '14-JUNE '15
4/24/2015	15	LOCUS Training
3/27/2015	14	LOCUS Training
3/6/2015	11	LOCUS Training
3/5/2015	16	LOCUS Training
2/6/2015	11	LOCUS Training
5/21/2015	3	Medi-Cal Eligibility Training
2/19/2015	2	Medi-Cal Eligibility Training
8/21/2014	0	Medi-Cal Eligibility Training
6/5/2015	16	Mental Health First Aid USA Training
6/4/2015	16	Mental Health First Aid USA Training
5/15/2015	21	Mental Health First Aid USA Training
5/14/2015	21	Mental Health First Aid USA Training
4/24/2015	21	Mental Health First Aid USA Training
4/23/2015	24	Mental Health First Aid USA Training
4/3/2015	15	Mental Health First Aid USA Training
4/2/2015	16	Mental Health First Aid USA Training
3/6/2015	22	Mental Health First Aid USA Training
3/5/2015	23	Mental Health First Aid USA Training
2/20/2015	15	Mental Health First Aid USA Training
2/19/2015	15	Mental Health First Aid USA Training
2/6/2015	18	Mental Health First Aid USA Training
2/5/2015	18	Mental Health First Aid USA Training
11/7/2014	17	Mental Health First Aid USA Training
11/6/2014	18	Mental Health First Aid USA Training
10/10/2014	22	Mental Health First Aid USA Training
10/9/2014	22	Mental Health First Aid USA Training
9/19/2014	20	Mental Health First Aid USA Training
9/18/2014	21	Mental Health First Aid USA Training
8/15/2014	22	Mental Health First Aid USA Training
8/14/2014	22	Mental Health First Aid USA Training
8/8/2014	16	Mental Health First Aid USA Training
8/7/2014	16	Mental Health First Aid USA Training
7/11/2014	20	Mental Health First Aid USA Training
7/10/2014	20	Mental Health First Aid USA Training
6/9/2015	44	Mental Health Interpreter Training
6/22/2015	9	MHSA Code Training
6/22/2015	2	MHSA Code Webinar
10/30/2014	222	Older Adults Conference: 34rd Annual Mental Health Aging Conference Training
10/29/2014	37	Preventable Diseases: Substance- Related & Addictive Disorders
4/9/2015	6	Problem Resolution/Advance Medical Directives Training
10/2/2014	5	Problem Resolution/Advance Medical Directives Training
7/10/2014	5	Problem Resolution/Advance Medical Directives Training
10/7/2014	27	Progress Notes & Service Codes Training
9/2/2014	4	Progress Notes & Service Codes Training

System-Wide Technical and Clinical Trainings
July 1, 2014-June 30, 2015

Date	#	TRAINING JULY '14-JUNE '15
8/5/2014	8	Progress Notes & Service Codes Training
4/9/2015	2	Site Certification Training
10/2/2014	2	Site Certification Training
5/21/2015	4	Staff Registration/Credentialing Training
2/19/2015	2	Staff Registration/Credentialing Training
8/21/2014	2	Staff Registration/Credentialing Training
1/21/2015	20	Turning Point ISA Technical Support
2/19/2015	3	U.M.D.A.P Training
5/28/2015	24	U.M.D.A.P. Training
5/21/2015	5	U.M.D.A.P. Training
8/21/2014	0	U.M.D.A.P. Training
4/29/2015	18	UMDAP

APPENDIX V

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

Regarding this PIP Submission Document:

- **This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that CAEQRO uses 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.**
- **You are not limited to the space in this document. It will expand, so feel free to use more room than appears to be provided, and include relevant attachments.**
- **Emphasize the work completed over the past year, if this is a multi-year PIP. A PIP that has not been active and was developed in a prior year may not receive "credit."**
- **PIPs generally should not last longer than roughly two years.**

CAEQRO PIP Outline via Road Map

MHP: *Sacramento County*
Date PIP Began: *October 19, 2012*
Title of PIP: *Changing the culture of Mental Health to increase coordination with Primary Care*
Clinical or Non-Clinical: *Non-Clinical*

Assemble multi-functional team

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

The Committee consisted of a cross section of administration, service provider and advocacy. Sequences of committee meetings were held as well as sub-committee meetings where specific tasks were the focus of attention. The Adult PIP Committee was comprised of representatives from: Mental Health Plan (MHP) Quality Management (QM), Research, Evaluation and Performance Outcomes (REPO), Adult Mental Health Programs, Cultural Competence, University of California at Davis (UCD), Contract Providers, Contract Monitors representatives and Family Advocates. The brainstorming activities to understand the gaps and needs of the system to frame this Adult PIP began with an Adult PIP Committee meeting on October 19, 2012 and have continued through a series of committee and sub-committee meetings, individual communications with members of Adult PIP Committee, as well as through the Adult System of Care Programs and Quality Improvement Committee (QIC) monthly meeting report process.

The Adult PIP Committee membership is as follows:

County Participants
Kathy Aposhian, RN, Program Manager Quality Management, Chair, QIC, Chair PIP Committee
Uma Zykofsky, LCSW, Deputy Director, Behavioral Health Services
Jesus Cervantes, Psy D. / LMFT, Mental Health Program Coordinator, Adult Mental Health Programs
Michelle Schuhmann, MPH, LCSW, Program Planner, Research, Evaluation and Performance Outcomes
Lisa Sabillo, Division Program Manager, REPO and QM
Jo Ann Johnson, LCSW, Cultural Competence Program Manager
Terry Nichols, LCSW, Mental Health Program Coordinator, Adult Mental Health Programs
Steve Ballanti, LCSW, Mental Health Program Coordinator, Adult Mental Health Programs
Bernice Zaborski, MHP, Mental Health Program Coordinator, Adult Mental Health Programs
Melody Boyle, LCSW, Senior Mental Health Counselor, Quality Management
Tiffany Greer, LCSW, Mental Health Program Coordinator, Quality Manager

Provider and Advocate Participation
Amanda Divine, LMFT, El Hogar - Adult Outpatient: Regional Support Team
Dan Gordon, MD, El Hogar - Adult Outpatient: Regional Support Team
Paul Heffner, ASW, El Hogar - Adult Outpatient: Regional Support Team
Marilyn Hillerman, Family Advocate- MHANCA
Paul Cecchettini, Ed. D Psychologist, Turning Point –Adult Outpatient: Regional Support Team
Alexis, Lyon, MFTI, Turning Point –Adult Outpatient: Regional Support Team
Lynn Place, MHRS, Human Resource Consultants-Adult OP: Regional Support Team
Marlyn Sepulveda, ASW, Human Resource Consultants -T-CORE-
Sherri Mikel, MHRS, and Human Resource Consultants-Adult Outpatient: Regional Support Team
Wendy Hoffman-Blank, LCSW, Visions Unlimited- Adult Outpatient: Regional Support Team
Cindy Lopez, ASW, Visions Unlimited- Adult Outpatient: Regional Support Team
Stephanie Kvasager, ASW, El Hogar- Adult Outpatient: Regional Support Team
Contributions from UCD Department of Psychiatry dually boarded medical team:
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"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 client population it affects.

There is sufficient literature demonstrating that mortality associated with severe mental illness is well known (Brown, 1997; Harris and Barraclough, 1998; Sahaert al., 2007). Individuals with severe mental illness are more likely to have physical co-morbidities, more likely to have physical health problems that are not being treated, and more physical co-morbidities are associated with worse mental health (Dixon et al., 1999). In May 2010, the State Department of Health Care Services (DCHS), the State Department of Mental Health (DMH) and the California Institute of Mental Health initiated a six-county pilot collaborative to improve the health of individuals with severe mental illness and co-occurring chronic medical disorders through more effective partnerships between mental health and primary care providers. Sacramento County's Primary Care and Behavioral Health Division was one of six counties in this pilot collaborative through the CALMEND project. The CALMEND project has also acknowledged that there is growing evidence that physical health problems are often caused and/or exacerbated by mental health problems.

Often these medical conditions are preventable chronic illnesses, such as asthma, diabetes, hypertension and cardiovascular diseases, which are made worse by lack of treatment and poor health habits. There are many factors that contribute to the poor physical health of people with SMI including lifestyle factors, medication side effects and disparities in healthcare. In a literature review published in the Journal of Psychopharmacology November 2010 (Lawrence and Kisely, 2010) the issues of physical co-morbidities and inequalities in medical treatment are attributed to a combination of factors including system issues, such as separation of mental health services from other medical services, healthcare provider issues including the pervasive stigma associated with mental illness, and consequences of mental illness and side effects of mental health treatment.

To address systemic barriers having to do with the separation of mental healthcare and physical healthcare a range of integrated models have been proposed (Vreeland, 2007). These include co-location of services, having staff from one service visit another on a regular basis, or appointing case managers to act as liaisons between mental health and physical healthcare providers. Griswold et al, (2005, 2008) found that nurse case managers were effective in increasing the percentage of patients with severe mental illness who were successfully linked to primary care services. In another study, the use of case managers as liaisons with primary care physicians was associated with significant improvements in the quality and outcomes of primary care (Druss et al., 2010). It is well known that the stigma surrounding mental health pervades all aspects of society, including the healthcare system. One issue in the reduced access to primary care for people with severe mental illness is that some practitioners regard people with severe mental illness as being difficult or disruptive. Most often primary care physicians receive little to no training in mental health issues and are ill-equipped to address mental health issues and behaviors. Sartorius (2007b) has suggested that a campaign to reduce stigma and discrimination within the entire healthcare sector should be a high priority in an effort to reduce stigma associated with mental illness in the population at large. Mental health case managers and psychiatrists working in partnership with primary care physicians also provides the opportunity to cross train both sectors and heighten awareness of both the mental and physical health needs of people with severe mental illness.

The importance of integrating mental health and primary care was acknowledged in 2003 with the release of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. One of many responses to this report was the establishment of the Primary Care/Mental Health Integration Workgroup, commonly referred to as the "Integration Workgroup". The

overall mission of the Integration workgroup is to improve the health of people with and at risk for mental illnesses through expanded access to integrated health care services. Evidence indicates that integrated care improves access to and service outcomes for persons with or at risk of mental illness. Integrated services help maintain mental wellness and prevent the occurrence of mental distress or the exacerbation of existing mental illnesses. Integrating mental health and physical health for persons with severe mental illness is not only a National need and priority, but is a local need as well.

During FY 2010-2011 The Sacramento County Department of Health and Human Services (DHHS), through its Primary Care Division and Behavioral Health Division, built up a multifaceted plan to increase the access to coordinated and/or integrated care for persons with mental illness and co-occurring physical health needs. While the MHP serves clients with specialty mental health needs, physical care falls outside the direct system of care. However, costs of this care or lack thereof impact mental health outcomes and general health outcomes for clients. Increased costs for either physical or mental health impacts community and client resources. The client populations affected by this PIP are Medi-Cal eligible adult clients meeting target population and being served in the Sacramento County MHP.

During FY 2011-12, 4,706 individuals were served in the Regional Support Team (RST) clinics in the MHP. Table 1 shows the number and percentage of the same clients who have one or more reported serious medical condition. Table 2 shows the number of clients reporting each medical condition and the percentage of total clients with each condition. The data highlights those serious medical conditions chosen for the focus of the last PIP as well as other conditions frequently effecting RST clients and affect their quality of life significantly.

Table 1

	Number	Percent
Clients with one medical condition	1,109	23.6%
Clients with two medical conditions	863	18.3%
Clients with or more three medical conditions	1,812	38.5%
No Medical Condition	393	8.4%
Not Reported	529	11.2%
Total	4,706	100.0%

The clients who receive services at the RST providers are experiencing many chronic medical conditions, most often hypertension and high cholesterol, followed by diabetes and chronic pain. Over 80% of clients have one or more medical condition. Additionally, almost 40% of clients have three or more medical conditions, 56.8% have two or more medical conditions and only 8.4% report having no medical condition.

Table 2

N=4,706	Number	Percentage
Arthritis	461	9.8%
Asthma	362	7.7%
Cardio/cardiovascular Disease	198	4.2%
Cerebrovascular Disease	34	0.7%
Cholesterol	971	20.6%
Chronic pain	647	13.7%
Diabetes	644	13.7%
Digestive Disorders	404	8.6%
Hypertension	1,249	26.5%
Liver disease	319	6.8%
Migraines	259	5.5%
No medical condition	393	8.4%
Obesity	438	9.3%
Other**	2,288	48.6%
Not Reported	529	11.2%

**Totals do not equal 100% due to clients reporting more than one medical condition*
***Other includes everything from cancer to sexually transmitted diseases*

Through the Quality Improvement Committee's Executive Committee, the Sacramento County MHP collects and reviews incident reports from mental health service providers for clients who have died. One purpose of these reports is to look at all instances where deaths correlate with medical and psychiatric causes, as well as the effectiveness of clinical and community perspective. During the last two Fiscal Years 2010-2012, the average age of MHP clients who were reported as deceased was 50.4 years. The vast majority, 74%, were between 25 and 59 years of age when they died. Additionally, 60.3% of these clients had one of the following serious medical conditions: asthma, high cholesterol, cardio-vascular disease, diabetes, high blood pressure, hepatitis or liver disease. This supports the need for closely coordinated physical and mental health treatment for the clients we serve.

During FY 2010-2011 the Sacramento MHP implemented a PIP as an attempt to address documentation issues related to co-occurring physical health issues. The PIP results were very successful primarily in terms of identifying and documenting PCP, medical condition and coordination of care/addressing medical condition in both the case record and electronic files. It brought a heightened awareness to provider staff and it became apparent through chart reviews and data extracts (from Avatar) that some of the PIP interventions had influenced non PIP chart and electronic file documentation. While a successful change in documentation process took place across RST providers that participated in the PIP, efforts to coordinate with the PCP fell short. Initial attempts at using a form to communicate with the PCP were not successful. Providers had difficulty getting the PCP to respond to the form or to return their calls. The majority of the coordination of care was obtaining release of information documents so that staff could discuss or obtain medical information from the PCP/PCP office. Follow up to medical care consisted of staff discussing medical issues and care with the client and encouraging and/or assisting the client in seeking care for their concerns. While these are worthwhile and beneficial to the client, the need to integrate care with the PCP is also important. The PIP committee has recognized the need for a culture shift in our MHP that incorporates physical health issues and begins to treat the "whole person".

Consequently, during EQRO exit interview, it was decided to establish a new Adult PIP Committee to develop and implement the 2012-2013 PIP to follow up and develop a PIP with new strategies to improve the coordination of care on behalf of the client between Mental Health and PCP's in the community with the ultimate goal of improving the overall health of our clients.

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?

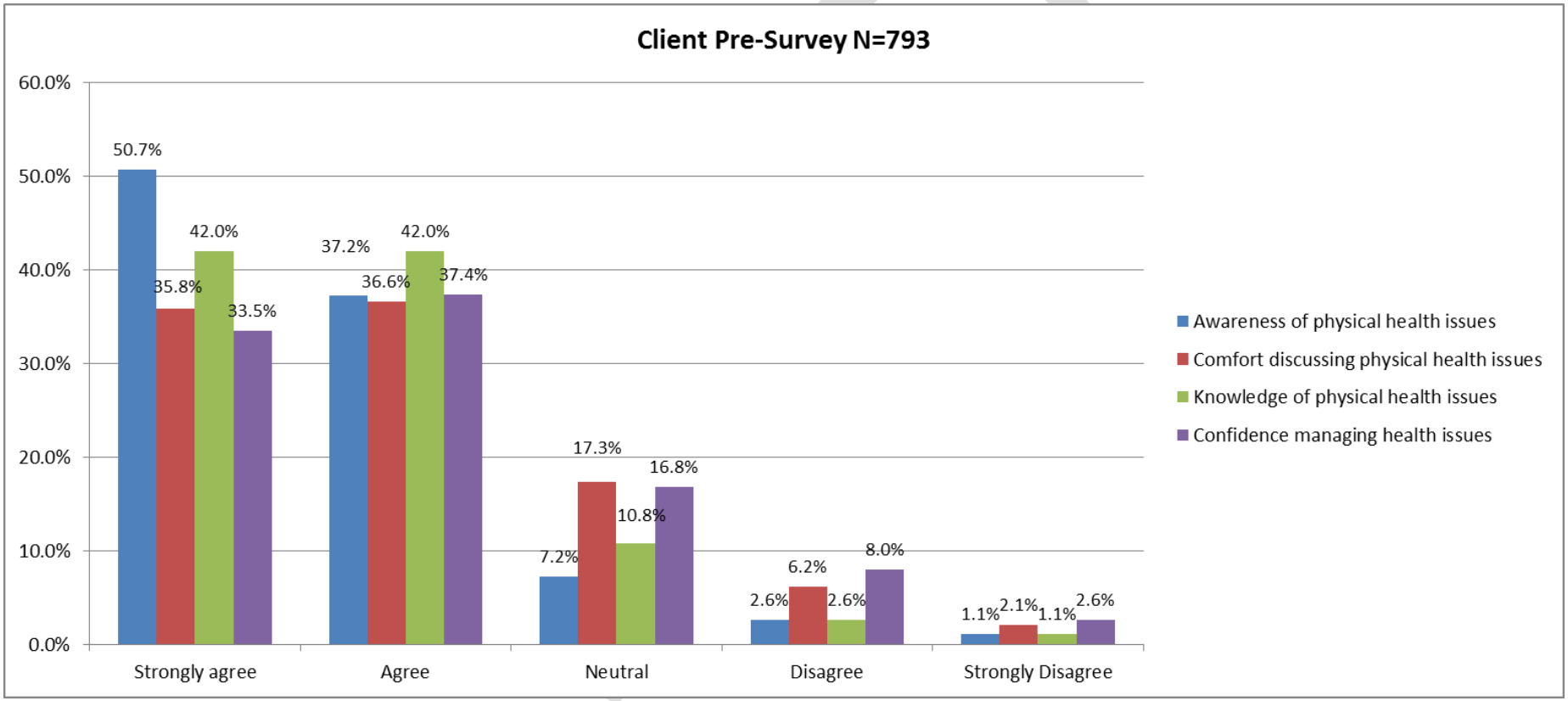
On October 19, 2012, the Adult PIP committee met to begin the planning and analysis for the 2012-13 PIP. Members of the committee represented a diverse mix of service providers, Quality Management staff, Research, Evaluation and Performance Outcome (REPO) staff, adult programs staff, adult mental health provider's staff and family advocate representation. Brainstorming on barriers/causes affecting integration of mental health services with primary care in the Sacramento County's mental health clients was completed and documented in meeting minutes. Following is the result of the brainstorming covering different areas that the committee recognized as existing barriers:

1. There is no effective working relationship/coordination between mental health and primary health care systems.
2. There is no system in place for communication, referral and follow-up between mental health and primary health care systems.
3. Mental health clients and mental health clinical staff have little to no training regarding how to approach medical doctors about medical conditions.
4. There is a need for qualified mental health staff available in the mental health clinics to educate clients and staff on different illnesses that co-occur with mental health conditions.
5. Primary Care Doctors have minimum training in mental health and don't feel comfortable treating mental health consumers.
6. There is no available supportive educational information (pamphlets, posters, magazines) in the mental health clinics to motivate/educate mental health clients regarding healthy life styles.
7. Lack of training for mental health staff about healthy lifestyle choices (nutrition, exercise, weight management, smoking cessation, etc.)
8. Lack of case consultation for either MDs, clinicians or other staff to support clients that are dealing with medical problems.
9. Lack of client knowledge about healthy lifestyle choices (nutrition, exercise, weight management, smoking cessation, etc.)
10. Client lack knowledge of symptom recognition and how to manage their symptoms.
11. Mental Health staff believes that physical health is not their responsibility.
12. Mental Health staff believes that physical health is not within their scope of practice.
13. Mental health clients do not feel comfortable discussing their physical health needs with mental health staff.

After the brainstorming, it was agreed that while last year's PIP was successful in changing a documentation process, additional efforts are needed in order to improve the coordination of care with the PCP. The goal of the current PIP is to change the culture of the RST clinics to include primary care, put systems for close coordination in place, and increase both staff and clients' awareness, knowledge and comfort around physical health issues.

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

In an effort to assess the existing culture around physical and mental health integration and verify the barriers identified in the brainstorming session a pre-post tool was developed for the PIP to collect baseline data. Clients at the RST clinics were asked to complete a survey during May of 2013 regarding their knowledge and awareness of physical health issues, their comfort level discussing physical health issues with their mental health provider and their confidence in managing their health issues. The graph below shows the results of the pre-survey by domain area. The specific questions for each domain can be seen in Table 3.



Nearly 30% of all clients are not confident in managing their health issues, and 25% are not comfortable discussing physical health issues with MH staff. When looking more closely at the responses to specific questions in each domain, 80% of clients report being comfortable discussing physical health issues with MH staff, but only 64% would like help with their physical health care issues from MH staff. This may be a result of the clients' perception of the role of the MH staff, or related to the fear or stigma and discrimination.

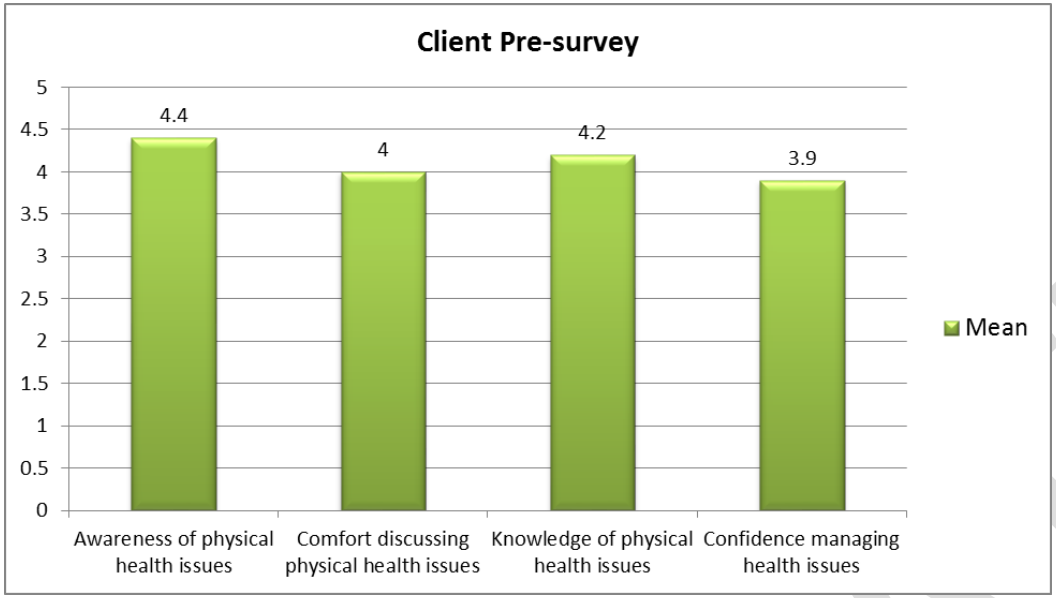
In the Confidence domain, 87% of clients go to the doctor when they have a physical health problem, while only 54% are able to manage their health problems on a daily basis. This speaks to the need for wellness education and assistance for clients, to enable them to take care of themselves.

The table below shows the survey results for each question as well as the mean scores for each question and domain.

Table 3-Client Pre-Survey Detail

N=793	Strongly Agree	% Strongly Agree	Agree	% Agree	Neutral	% Neutral	Disagree	% Disagree	Strongly Disagree	% Strongly Disagree	Mean Score
Awareness											***4.4***
Mental health symptoms can affect my physical health	363	45.8%	319	40.2%	58	7.3%	35	4.4%	11	1.4%	4.3
It is important to take care of both my physical health and mental health	487	61.4%	258	32.5%	26	3.3%	8	1.0%	6	0.8%	4.5
It is important to me that all my doctors/care providers talk to each other about my health and wellness	357	45.0%	308	38.8%	88	11.1%	20	2.5%	9	1.1%	4.3
Comfort											***4.0***
I feel comfortable discussing physical health problems with MH program staff	339	42.7%	296	37.3%	109	13.7%	29	3.7%	7	0.9%	4.2
I would like help from MH program staff concerning my physical health care	228	28.8%	285	35.9%	165	20.8%	69	8.7%	27	3.4%	3.8
Knowledge											***4.2***
I have a good understanding of my physical health issues	304	38.3%	313	39.5%	121	15.3%	30	3.8%	13	1.6%	4.1
I know when I have physical health symptoms that might mean I need to go to my medical doctor	362	45.6%	353	44.5%	50	6.3%	12	1.5%	5	0.6%	4.4
Confidence											***3.9***
I am able to manage my health problems and the affect they have over my daily life	164	20.7%	269	33.9%	206	26.0%	104	13.1%	32	4.0%	3.6
I go to my medical doctor when I have a physical health problem	367	46.3%	324	40.9%	61	7.7%	23	2.9%	9	1.1%	4.3

Below is a graph of the Mean scores in each domain.



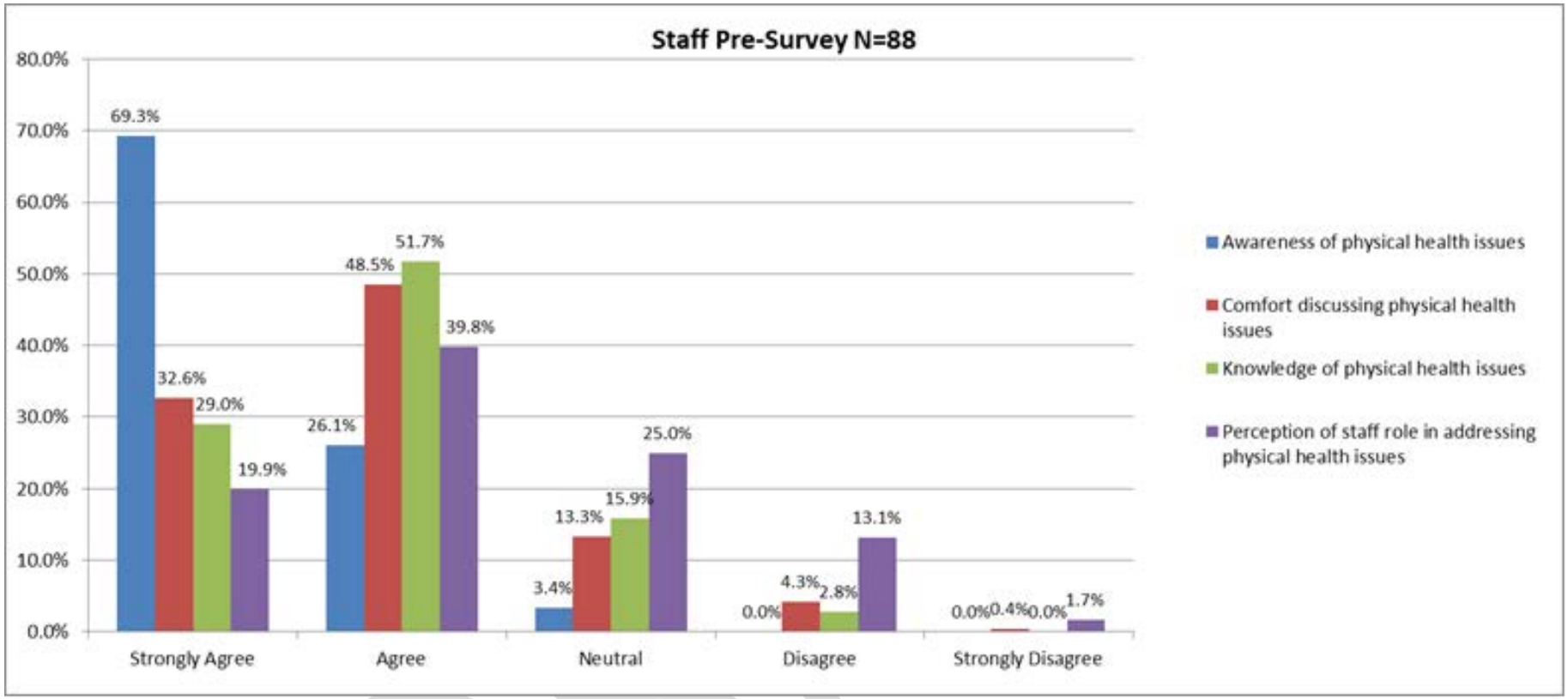
Clients were also asked to rate how they felt about their lives in general on a 7 point scale.

Table 4-Client Satisfaction and Well-being

	Terrible		Unhappy		Mostly Dissatisfied		Mixed		Mostly Satisfied		Pleased		Delighted		Mean Score
N=793	N	%	N	%	N	%	N	%	N	%	N	%	N	%	*Total: 4.0*
About your life in general?	46	5.8	100	12.6	59	7.4	265	33.4	153	19.3	100	12.6	50	6.3	*3.9*
Your health in general?	42	5.3	106	13.4	70	8.8	242	30.5	188	23.7	87	11.0	39	4.9	*3.9*
Your physical condition?	59	7.4	113	14.2	77	9.7	226	28.5	173	21.8	81	10.2	44	5.5	*4.0*
Your emotional well-being	71	9.0	118	14.9	59	7.4	245	30.9	139	17.5	92	11.6	47	5.9	*4.1*

The majority of clients report they have mixed feelings about their lives, physical health and emotional well-being. More than 25% feel mostly dissatisfied, unhappy or terrible in these areas. This is in contrast to clients' responses in the previous table around comfort, awareness and knowledge of physical health issues. The mean score in all domains in table 3 is between 3.9 and 4.4, on a scale from 1 to 5. In table 4 the mean score is 4.0, but this is closer to the midpoint of the seven point scale, indicating more mixed emotions rather than satisfaction with life in these areas. The data suggest that clients need additional education and assistance in managing their health conditions in order to feel better.

Similarly, staff were surveyed during May 2013 about their awareness, knowledge of and comfort discussing physical health care issues and their perception of their role in addressing the client's physical health care needs. Staff surveyed includes those who have direct client contact (MH service providers, doctors and nurses). The following graph contains the results of the staff pre-survey. The questions for each domain are specified in Table 5.

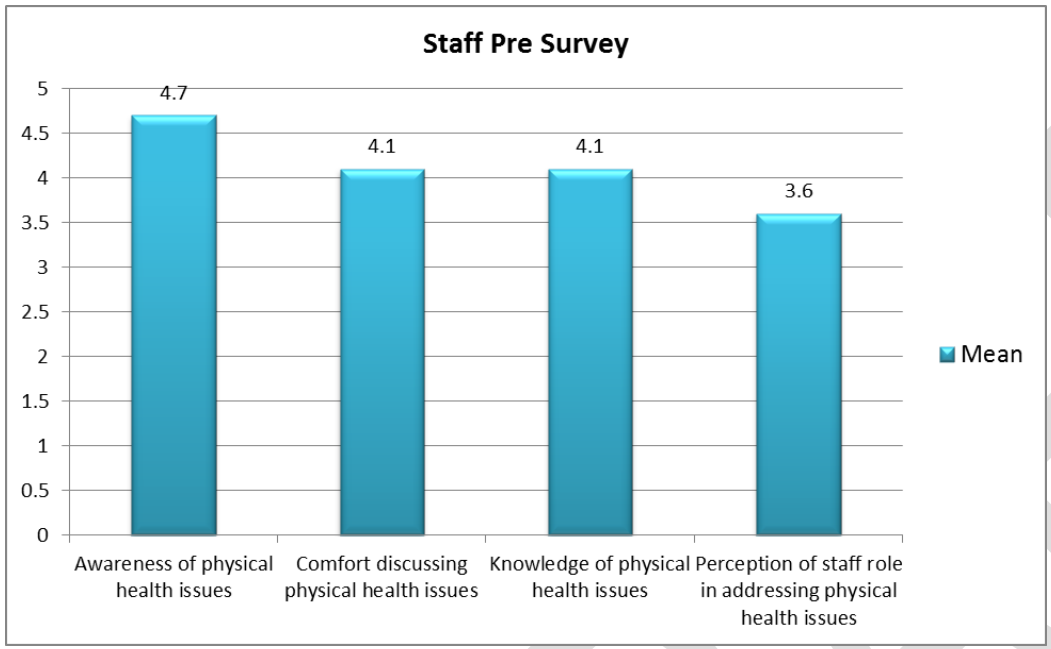


Although staff feel that they are well aware of the importance of physical health issues and 80% agree they are comfortable discussing and have knowledge about these issues, almost 40% of staff are neutral or do not perceive it to be in their scope to provide assistance with physical health care issues. This indicates a need to put systems in place which allow for close coordination between primary care clinics and mental health staff. Short of completely integrated teams, an increase in staff comfort level and confidence in dealing with primary care issues is valuable. In a truly integrated system we would expect to see a higher percentage of staff who strongly agree in the Comfort, Awareness and Staff Role domains.

Table 5-Staff Pre-Survey Detail

N=88	Strongly Agree	% Strongly Agree	Agree	% Agree	Neutral	% Neutral	Disagree	% Disagree	Strongly Disagree	% Strongly Disagree	Mean Score
Awareness											***4.7***
Physical health plays a vital role in mental health treatment	60	68.2%	24	27.3%	4	4.5%	0	0.0%	0	0.0%	4.6
It is important to integrate physical health and mental health care	62	70.5%	22	25.0%	2	2.3%	0	0.0%	0	0.0%	4.7
Comfort											***4.1***
I am able to assist consumers to talk with their primary care physician	28	31.8%	46	52.3%	7	8.0%	5	5.7%	0	0.0%	4.1
I have confidence in my ability/know how to teach consumers skills to enable them to take responsibility for their health	29	33.0%	41	46.6%	14	15.9%	4	4.5%	0	0.0%	4.1
I feel comfortable discussing physical health problems with consumers	29	33.0%	41	46.6%	14	15.9%	3	3.4%	1	1.1%	4.1
Knowledge											***4.1***
I have a good understanding of physical health issues	28	31.8%	47	53.4%	13	14.8%	0	0.0%	0	0.0%	4.2
I am able to recognize physical health symptoms that might indicate the need for a primary care appointment	23	26.1%	44	50.0%	15	17.0%	5	5.7%	0	0.0%	4.0
Staff role											***3.6***
It is easy to make a referral for a consumer to a primary care provider	16	18.2%	27	30.7%	25	28.4%	17	19.3%	2	2.3%	3.4
It is my responsibility to assist a consumer to follow-up with the primary care provider when the consumer has a medical or medication issue	19	21.6%	43	48.9%	19	21.6%	6	6.8%	1	1.1%	3.9

The graph below depicts the mean scores for the staff pre survey.



The mean score for the awareness domain is 4.7, while the mean for staff role is only 3.6, suggesting that although staff are aware of the importance of the integration of physical and mental health issues, they do not consider it a part of the mental health clinics' array of service delivery options. The data support the goal of the PIP, to change the culture of the RST clinics to improve the relationship between primary care and mental health at both the individual and system level.

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Clients lack knowledge about physical health issues	% of responses indicating Neutral or Disagree in the knowledge domain on the pre-survey
Clients are not comfortable discussing their physical health needs with mental health providers	% of responses indicating Neutral or Disagree in the comfort domain on the pre-survey
Clients are not confident in managing their physical health	% of responses indicating Neutral or Disagree in the confidence domain on the pre-survey
Staff lack knowledge about physical health conditions, symptoms and the interaction between mental health and physical health	% of responses indicating Neutral or Disagree in the knowledge domain on the pre-survey
Mental health Staff are not comfortable discussing physical health issues with clients	% of responses indicating Neutral or Disagree in the comfort domain on the pre-survey

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Mental health Staff do not perceive physical health issues a part of the mental health clinics' array of service delivery options	% of responses indicating Neutral or Disagree in the staff role domain on the pre-survey
Culture/systems are not in place that connect/integrate mental health and physical health care	None of the RSTs have systems in place to effectively coordinate with primary care

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/approach for improvement.
Will implementation of staff training on physical health issues, wellness groups for clients and establishment of collaboration with a primary health care provider result in increased coordination of care, leading to improved primary care access and treatment for mental health clients?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.
The PIP includes all beneficiaries for whom the question applies. All four RST's were chosen as the pilot population to test the interventions on a small scale. The intention is to determine the benefits of the interventions and apply successful interventions to the entire MHP.

6. Describe the population to be included in the PIP, including the number of beneficiaries.
The study population includes all clients receiving outpatient mental health services at all four RSTs. Currently there are approximately 4,289 clients open at the four RSTs.

7. Describe how the population is being identified for the collection of data.
All clients receiving outpatient mental health services at all the four RSTs will have the opportunity to complete the Consumer pre-post survey. All RST staff that are in a position where they have contact with clients for the purposes of delivering MH services (Personal Service Coordinators, Nurses, Doctors) will be asked to complete the Staff pre-post survey. Pre-Post data will also be collected from clients who attend health and wellness groups and staff who attend training geared to specific physical health issues.

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

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

"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 performance indicators were selected to support the hypothesis that implementation of staff training, wellness groups for clients and establishment of a collaboration between the four Regional Support Teams (RSTs) and a primary care provider will result in improved primary care access and treatment for mental health clients.

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 performance indicators measure factors associated with improved knowledge, confidence and awareness of physical health care issues and the connection with mental health. The indicators also measure changes in coordination of care, both of which will result in better mental and physical outcomes for clients.

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	Increase in staff knowledge of physical health care issues	Sum of staff scores for items in the knowledge domain on the survey	# of staff that respond to items in the knowledge domain in the survey multiplied by the number of questions in that domain	4.07	4.30
2	Increase in staff awareness regarding physical health care issues	Sum of staff scores for items in the awareness domain on the survey	# of staff that respond to items in the awareness domain in the survey multiplied by the number of questions in that domain	4.66	4.80
3	Increase in staff comfort level in counseling clients about physical health care issues	Sum of staff scores for items in the comfort domain on the survey	# of staff that respond to items in the comfort domain in the	4.09	4.30

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
			survey multiplied by the number of questions in that domain		
4	Increase in perception of staff role in addressing physical health care issues	Sum of staff scores for items in the staff role domain on the survey	# of staff that respond to items in the staff role domain in the survey multiplied by the number of questions in that domain	3.64	3.90
5	Increase in client knowledge of physical health issues	Sum of client scores for items in the knowledge domain on the survey	# of clients that respond to items in the knowledge domain on the survey multiplied by the number of questions in that domain	4.23	4.30
6	Increase in client awareness regarding physical health issues	Sum of client scores for items in the awareness domain on the survey	# of clients that respond to items in the awareness domain on the survey multiplied by the number of questions in that domain	4.35	4.50
7	Increase in client comfort level discussing physical health care issues with a mental health provider	Sum of client scores for items in the comfort domain on the survey	# of clients that respond to items in the comfort domain on the survey multiplied by the number of questions in that domain	4.00	4.10
8	Increase in client confidence in managing their health issues	Sum of client scores for items in the confidence domain on the survey	# of clients that respond to the confidence domain on the survey	3.93	4.00

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
			multiplied by the number of questions in that domain		
9	Increase in client satisfaction with their lives in general	Sum of client scores for items in the life satisfaction domain on the survey	# of clients that respond to the life satisfaction domain on the survey multiplied by the number of questions in that domain	4.04	4.50
10	Establishment of a collaboration between the RSTs and a primary care provider	# of Collaborations	# of RSTs	0%	100%
11* Newly added	Documentation of a Primary Care Provider in Avatar	# of clients with a PCP documented in Avatar			

10. <u>Use Table C to summarize interventions</u>. 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	RST staff training about physical health issues most common to clients	• Medical issues are not addressed/followed up by RST staff • Inability to recognize symptoms • Staff discomfort in discussing health issues with clients • Clients discomfort with discussing health issues with MH staff • Concern about scope of practice	4/1/2013
2	Provide physical health and wellness education for RST clients	• Clients are not aware of the importance of coordination of physical and MH care • Clients don't recognize physical health symptoms • Clients want to keep physical health and mental health issues separate	4/1/2013

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
		• Clients are not comfortable talking with PC provider	
3	Establish a letter of agreement with a primary health care health provider (documented process for linkage, collaborative relationship, liaison etc.)	• Lack of coordination of care following known PCP appointments • Lack of communication and trust between primary care and mental health providers	4/1/2013
4	Physical improvements to each RST that include health and wellness information and disease prevention in the form of brochures, posters and video presentations, which are easily accessible to clients	• Clients are not aware of the importance of coordination of physical and MH care • Clients don't recognize physical health symptoms • Clients want to keep physical health and mental health issues separate • Clients are not comfortable talking with PC provider	4/1/2013
5	Examples of samples provided for RST staff to guide documentation of medical issues in the progress note	• Staff perception of MH clinics' array of services • Lack of coordination of care following known PCP appointments • Staff discomfort in discussing health issues with clients	4/1/2013

Apply Interventions: "What do we see?"
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

Data regarding RST clients' knowledge, awareness and comfort discussing physical health issues, access to care and overall health and well-being will be collected. Demographic data including age, race, ethnicity and preferred language will also be captured. Before and after each client wellness group series, data will be collected about knowledge and attitudes regarding the physical health and disease prevention issues specific to the group. Wellness groups include topics such as: Nutrition, Smoking Cessation, Exercise and Wellness Groups.
Similarly, data will be collected from all relevant RST staff regarding their knowledge, awareness, comfort counseling clients about physical health issues and scope of practice. For each staff training data will be collected pre and post regarding the information presented, the benefits of the training and how training could be improved. Staff trainings include topics such as: COPD, Asthma, Hypertension and Smoking Cessation, and are usually completed in the same day.

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.

Data will be collected from Sacramento County's existing data information and billing system, Avatar. Additional data will be collected through surveys for RST clients and staff. Demographic data will be collected from Avatar, and data regarding RST clients' knowledge, awareness and

comfort discussing physical health issues, access to care and overall health and well-being will be collected using surveys. Clients will be asked to complete a voluntary survey one time during the month of March 2013 to obtain a baseline and once again in March 2014 to obtain follow-up data. Pre and Post surveys for those clients who attend wellness groups will used to gather data specific to each group. Staff data will be collected similarly, using surveys, in March 2013 and again in March 2014. Data regarding staff training will be collected through training surveys, and collected as training is implemented at each RST site.

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

Data will be reviewed periodically to ensure accuracy and adherence to the PIP requirements. Feedback regarding the accuracy and completeness of the data will be given to the RSTs and others involved in the project. After March 31, 2014, one year after baseline data were collected, the data will be analyzed against performance indicators to measure improvement.

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

RST staff including case managers, medical staff, office managers and front desk staff will collect data by asking clients to complete the voluntary surveys. The Research, Evaluation and Performance Outcome (REPO) staff responsible for collecting data from the agency and collecting data from the Avatar information system have at least a BA degree in Social Services or a related field and have been analyzing and reporting on data for the REPO unit for over 6 years.

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 collection and analysis occurred as planned. PIP implementation was monitored through meetings with the 4 RST providers and there was consistent communication regarding the successes and challenges involved with PIP activities. Data was examined for accuracy and validity on a bi-monthly basis.

A total of 793 clients and 88 staff completed the pre survey questionnaire in March 2013 and 593 clients and 88 staff completed the post survey questionnaire in March 2014. The pre and post surveys were analyzed in SPSS comparing the means in each domain and the differences in answers to each question. The result for each performance indicator was calculated using the baseline mean score for each domain and the corresponding post-test mean score. Client demographic information was not collected on the pre-post survey.

A total of 583 Pre-post training evaluations were collected for all staff trainings. These evaluations measured staff's perceived knowledge and comfort level with physical health issues before training compared to after training. The pre and post training evaluations were analyzed in SPSS comparing the means on each question.

Pre-post training evaluations for each client groups were collected however the numbers completed and submitted were very low and we were not able to utilize them in data analysis. The RST staff reported that it took a while to get the groups up and running and they were very small at first. Clients also had inconsistent attendance, dropped out or did not show for the last session, when the post survey was completed. Staff are making modifications to group in response to client feedback and have hopes that these modifications will lead to more consistent and higher attendance.

Additional data was collected which included:

- A chart review of a random sample of those clients with one or more co-morbid physical health conditions was completed on 122 clients receiving at least the median number of services (12) from an RST during the PIP time period. The chart review was designed to provide additional information on the efforts of staff to address clients' health status and connection with a primary care provider.

- o A focus group with staff at each RST was also completed in June 2014 to obtain additional feedback from staff about how the PIP interventions were helpful and/or challenging. Approximately 55 RST staff participated in the focus groups.

16. Present objective data results for each performance indicator. Use Table D and attach supporting data as tables, charts, or graphs.
Include the raw numbers that serve as numerator and denominator!

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
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
Increase in staff knowledge of physical health care issues	*March 2013*	*4.07 (713/175)*	*5.55% Increase (4.30)*	*RST staff training about physical health issues most common to clients *Physical improvements to each RST that include health and wellness information and disease prevention in the form of brochures, posters and video presentations, which are easily accessible to clients	*March 2014*	*4.15 (726/175)*	*1.81%*
Increase in staff awareness regarding physical health care issues	*March 2013*	*4.66 (812/174)*	*3.02% Increase (4.80)*	*RST staff training about physical health issues most common to clients *Physical improvements to each RST that include health and wellness	*March 2014*	*4.67 (817/175)*	*.24%*

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
				information and disease prevention			
Increase in staff comfort level in counseling clients about physical health care issues	*March 2013*	*4.09 (1072/262)*	*5.01% Increase (4.30)*	*RST staff training about physical health issues most common to clients *Physical improvements to each RST that include health and wellness information and disease	*March 2014*	*4.26 (1125/264)*	*4.07%*
Increase in perception of staff role in addressing physical health care issues	*March 2013*	*3.64 (636/175)*	*7.25% Increase (3.90)*	*RST staff training about physical health issues most common to clients *Examples of samples provided for RST staff to guide documentation of medical issues in the progress note	*March 2014*	*3.91 (689/176)*	*7.66%*
Increase in client knowledge of physical health issues	*March 2013*	*4.23 (6609/1563)*	*1.77% Increase (4.30)*	*Provide physical health and wellness education for RST clients *Physical improvements to each RST that include health and wellness information and disease prevention	*March 2014*	*4.25 (4907/1154)*	*.52%*
Increase in	*March 2013*	*4.35*	*3.43%*	*Provide	*March 2014*	*4.42*	*1.59%*

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
client awareness regarding physical health issues		*(10243/2353)*	*Increase (4.50)*	physical health and wellness education for RST clients *Physical improvements to each RST that include health and wellness information and disease prevention		*(7668/1735)*	
Increase in client comfort level discussing physical health care issues with a mental health provider	*March 2013*	*4.00 (6211/1554)*	*2.56% Increase (4.10)*	*Provide physical health and wellness education for RST clients *Physical improvements to each RST that include health and wellness information and disease prevention	*March 2014*	*4.01 (4544/1132)*	*.34%*
Increase in client confidence in managing their health issues	*March 2013*	*3.93 (6123/1559)*	*1.87% Increase (4.00)*	*Provide physical health and wellness education for RST clients *Physical improvements to each RST that include health and wellness information and disease prevention	*March 2014*	*3.95 (4531/1146)*	*.58%*
Increase in client satisfaction with their lives in general	*March 2013*	*4.04 (12484/3091)*	*11.39% Increase (4.50)*	*Provide physical health and wellness education for RST clients	*March 2014*	*3.84 (8747/2277)*	*-4.95%*

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
				*Physical improvements to each RST that include health and wellness information and disease prevention			
Establishment of a collaboration between the RSTs and a primary care provider	*March 2013*	*0 (0/4)*	*100% 4/4*	*Establish a letter of agreement with a primary health care health provider (documented process for linkage, collaborative relationship, liaison etc.)	*March 2014*	*75% (3/4)*	
** Has a Primary Care Provider	*January 2013*	*54.2% (2196/4051)*	*NA*	Training of RST staff to ask clients and document PCP information in Avatar	*May 2014*	*66.1% (2677/4051)*	*22%*

*** Newly added indicator*

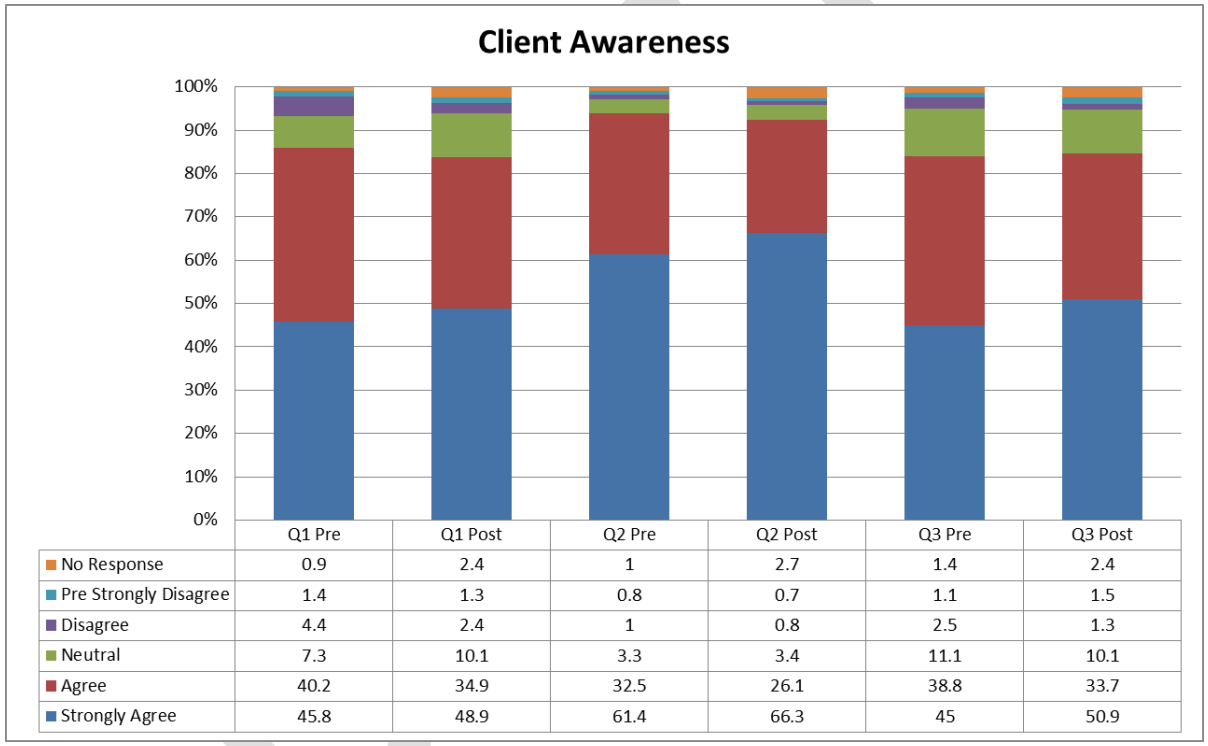
The PIP team anticipated that a shift in the culture of the RST clinics was going to be a gradual change and could be difficult to measure. The mean scores in all domains except one showed an increase, but most did not meet our goal % for improvement. The goal was achieved in the Staff Role domain, indicating that the interventions were helpful in expanding staffs' perception of their role to include physical health care issues. Additionally, the increases for the Client Awareness domain and the Staff Role domain were statistically significant at the .05 level. The baseline scores were 3.64 and above on a 5-point scale, and we hoped to see more of a % increase, but in some cases the baseline score was well over 4.0, making it difficult to achieve an increase. To measure the documentation of a PCP data was pulled from Avatar for all clients open to an RST provider on January 1, 2013. Prior to PIP interventions 2196 (54.2%) of these clients had a PCP noted in "Client Resources". After PIP interventions (as of May 31, 2014) 2677 (66.1%) of these clients had a PCP resulting in a 22% change from pre to post PIP intervention.

The graphs on pages that follow show the detail for each question included in the domains from the pre/post surveys distributed March 2013 and March 2014. The 100% stacked bar graphs allow for an easier interpretation of the movement from one point to another on the scale and between the time periods.

Performance Indicator: *Increase in client awareness regarding physical health issues*

Q1: Mental health symptoms can affect my physical health
Q2: It is important to take care of both my physical health and mental health
Q3: It is important to me that all my doctors talk to each other about my health and wellness

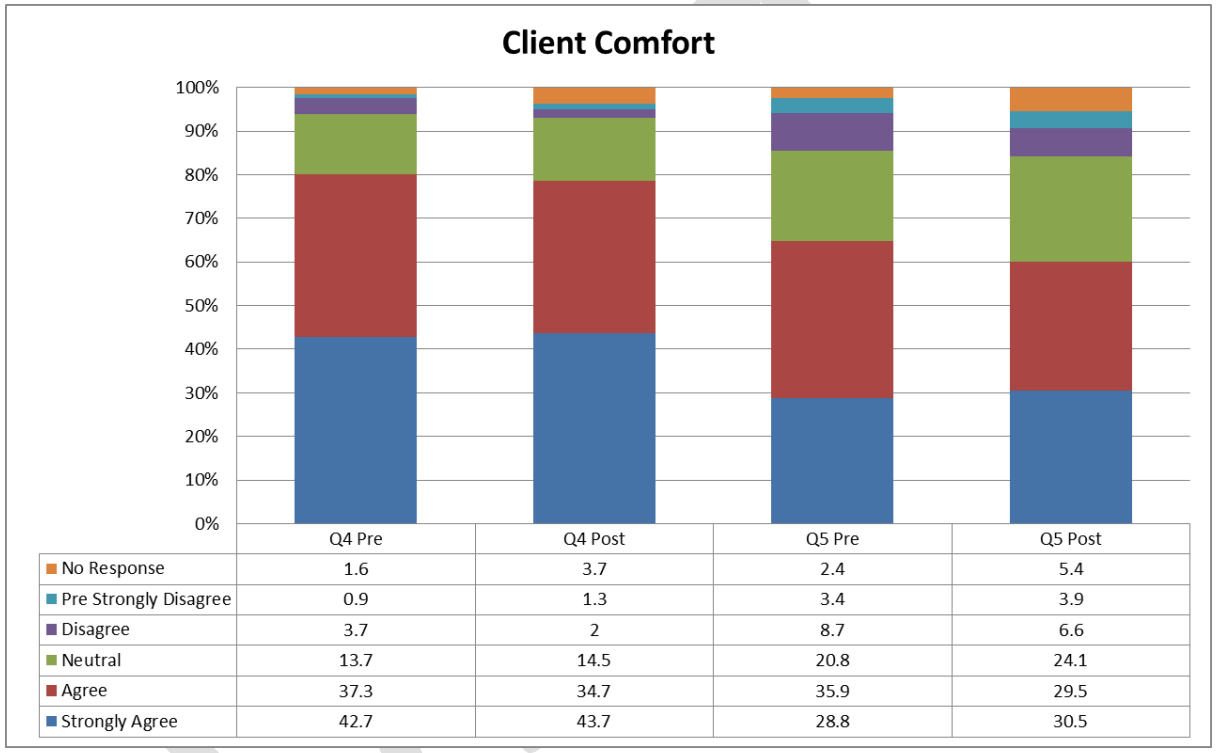
Overall this domain went from a mean of 4.35 to 4.42, and was statistically significant. In addition to calculating the mean we also looked at the percent change for each question. For all three questions the percent of clients who answered strongly agree on the pre survey increased on the post survey.



	Q1 Pre	Q1 Post	Q2 Pre	Q2 Post	Q3 Pre	Q3 Post
No Response	0.9	2.4	1	2.7	1.4	2.4
Pre Strongly Disagree	1.4	1.3	0.8	0.7	1.1	1.5
Disagree	4.4	2.4	1	0.8	2.5	1.3
Neutral	7.3	10.1	3.3	3.4	11.1	10.1
Agree	40.2	34.9	32.5	26.1	38.8	33.7
Strongly Agree	45.8	48.9	61.4	66.3	45	50.9

Performance Indicator: *Increase in client comfort level discussing physical health care issues with a mental health provider*
Q4: I feel comfortable discussing physical health problems with MH program staff
Q5: I would like help from MH program staff concerning my physical health care

Overall this domain showed only a slight increase, from a mean of 4.00 to 4.01. For this domain both the clients who initially agreed and disagreed decreased, while the clients who strongly agreed and disagreed increased slightly on the post survey.

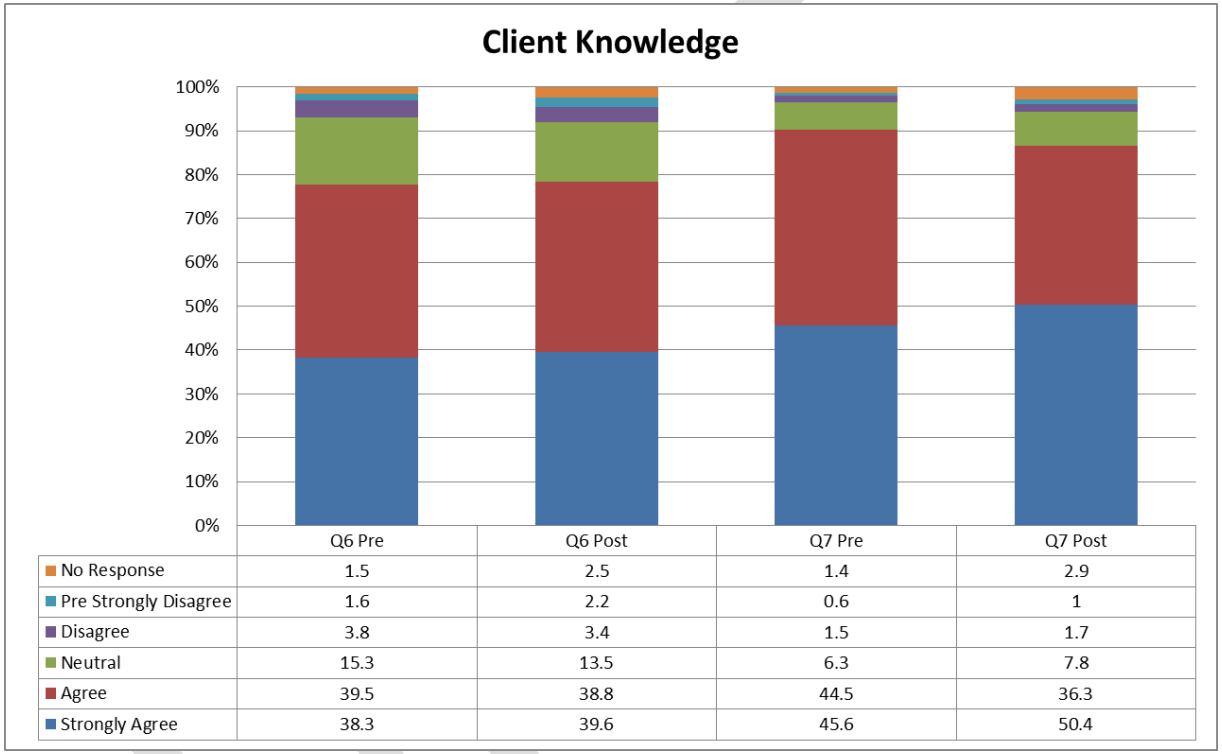


	Q4 Pre	Q4 Post	Q5 Pre	Q5 Post
No Response	1.6	3.7	2.4	5.4
Pre Strongly Disagree	0.9	1.3	3.4	3.9
Disagree	3.7	2	8.7	6.6
Neutral	13.7	14.5	20.8	24.1
Agree	37.3	34.7	35.9	29.5
Strongly Agree	42.7	43.7	28.8	30.5

Performance Indicator: *Increase in client knowledge of physical health issues*

Q6: I have a good understanding of my physical health issues
Q7: I know when I have physical health symptoms that might mean I need to go to my medical doctor

Overall this domain showed only a slight increase, from a mean of 4.23 to 4.25. The percentage of clients who strongly agreed increased for both question 6 and question 7.

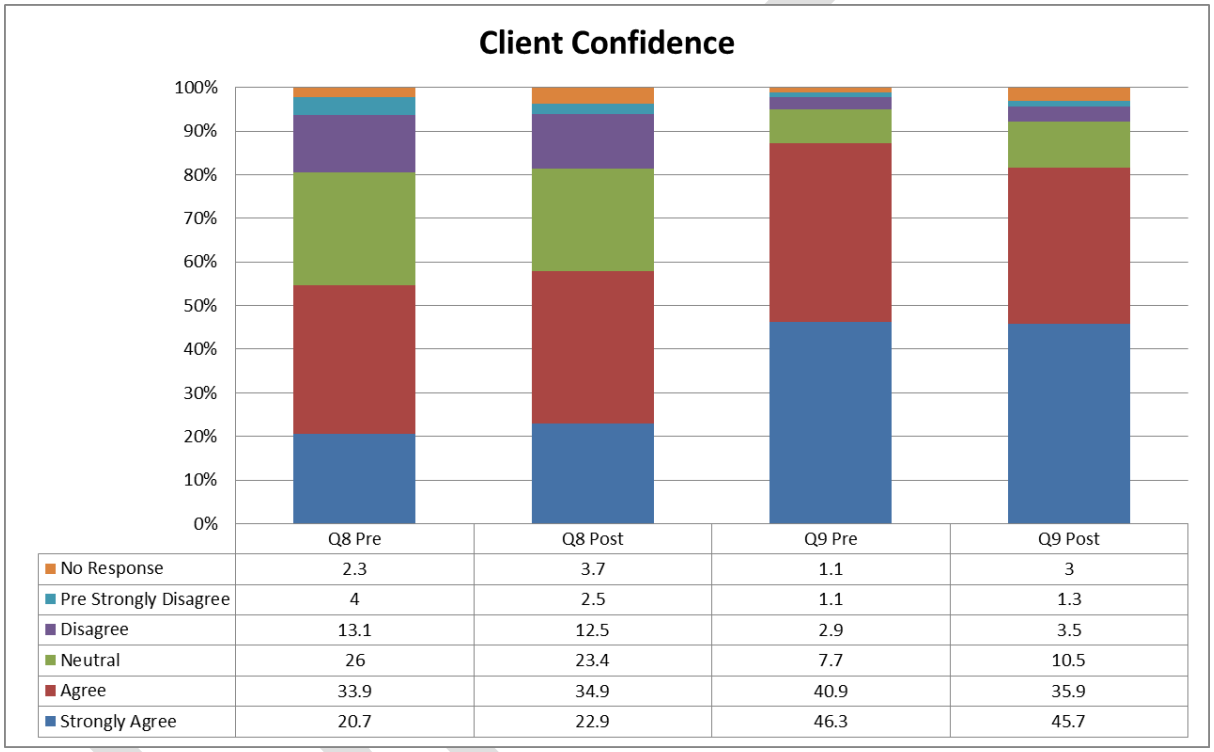


	Q6 Pre	Q6 Post	Q7 Pre	Q7 Post
No Response	1.5	2.5	1.4	2.9
Pre Strongly Disagree	1.6	2.2	0.6	1
Disagree	3.8	3.4	1.5	1.7
Neutral	15.3	13.5	6.3	7.8
Agree	39.5	38.8	44.5	36.3
Strongly Agree	38.3	39.6	45.6	50.4

Performance Indicator: *Increase in client confidence in managing their health issues*
Q8: I am able to manage my health problems and the affect they have over my daily life

Q9: I go to my medical doctor when I have a physical health problem

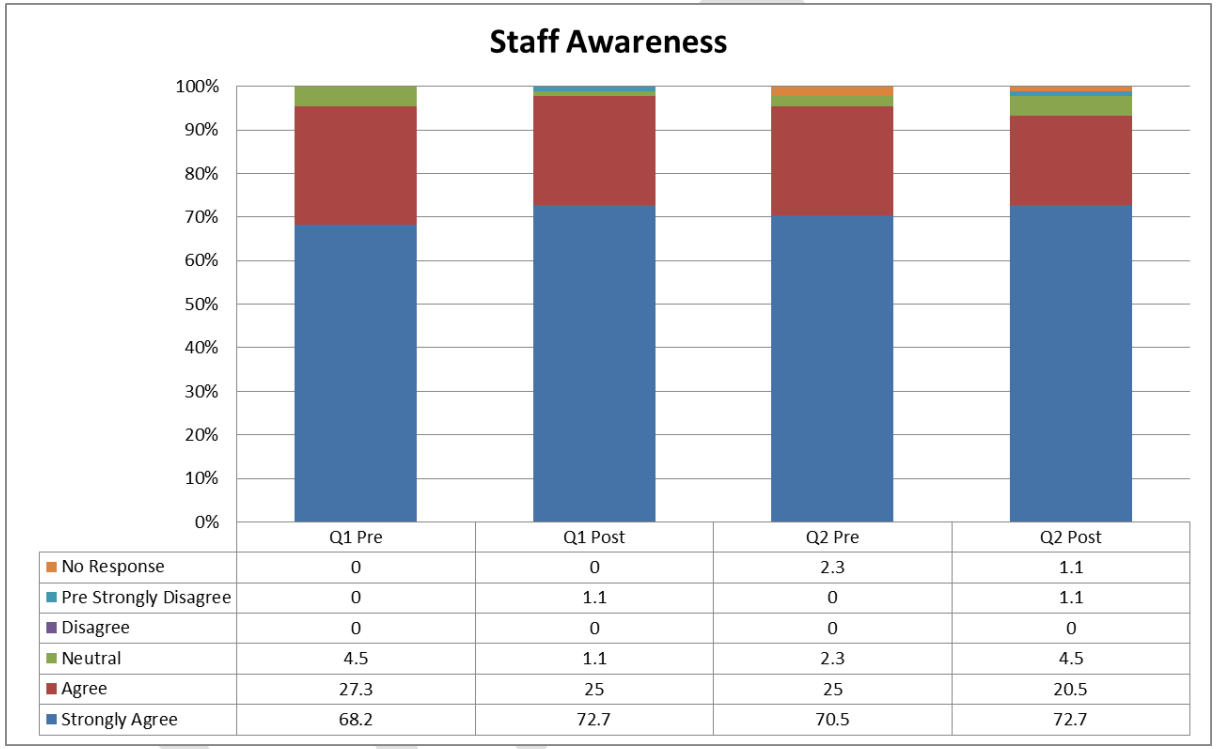
Overall this domain showed only a slight increase, from a mean of 3.93 to 3.95. From pre to post survey, the percentage of clients who agreed with question 8 increased, while fewer clients agreed with question 9.



	Q8 Pre	Q8 Post	Q9 Pre	Q9 Post
No Response	2.3	3.7	1.1	3
Pre Strongly Disagree	4	2.5	1.1	1.3
Disagree	13.1	12.5	2.9	3.5
Neutral	26	23.4	7.7	10.5
Agree	33.9	34.9	40.9	35.9
Strongly Agree	20.7	22.9	46.3	45.7

Performance Indicator: *Increase in staff awareness regarding physical health care issues*
Q1: Physical health plays a vital role in mental health treatment
Q2: It is important to integrate physical health and mental health care

Overall this domain showed a very slight increase, from a mean of 4.66 to 4.67. This domain had a very high pre survey mean score, and increased slightly for those who strongly agreed.

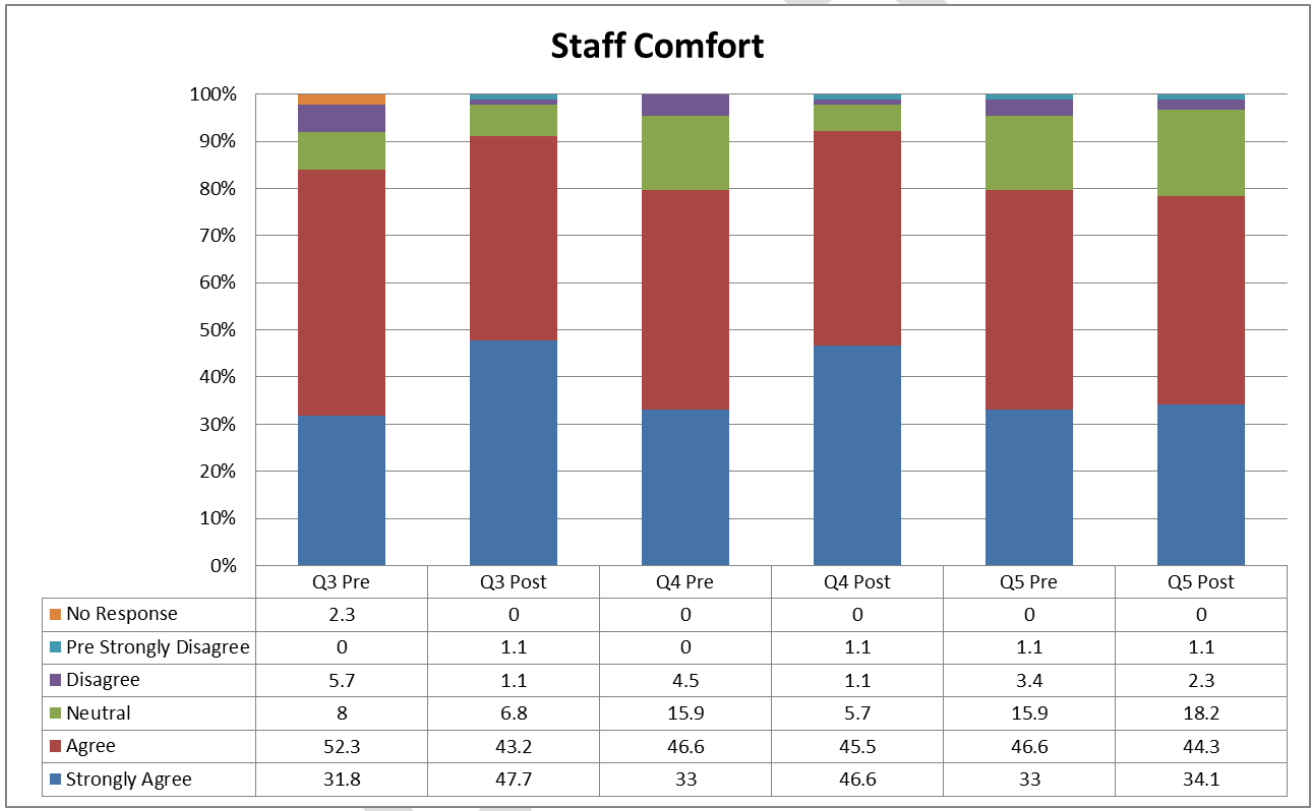


	Q1 Pre	Q1 Post	Q2 Pre	Q2 Post
No Response	0	0	2.3	1.1
Pre Strongly Disagree	0	1.1	0	1.1
Disagree	0	0	0	0
Neutral	4.5	1.1	2.3	4.5
Agree	27.3	25	25	20.5
Strongly Agree	68.2	72.7	70.5	72.7

Performance Indicator: *Increase in staff comfort level in counseling clients about physical health care issues*

Q3: I am able to assist consumers to talk with their primary care physician
Q4: I have confidence in my ability/know how to teach consumers skills to enable them to take responsibility for their health
Q5: I feel comfortable discussing physical health problems with consumers

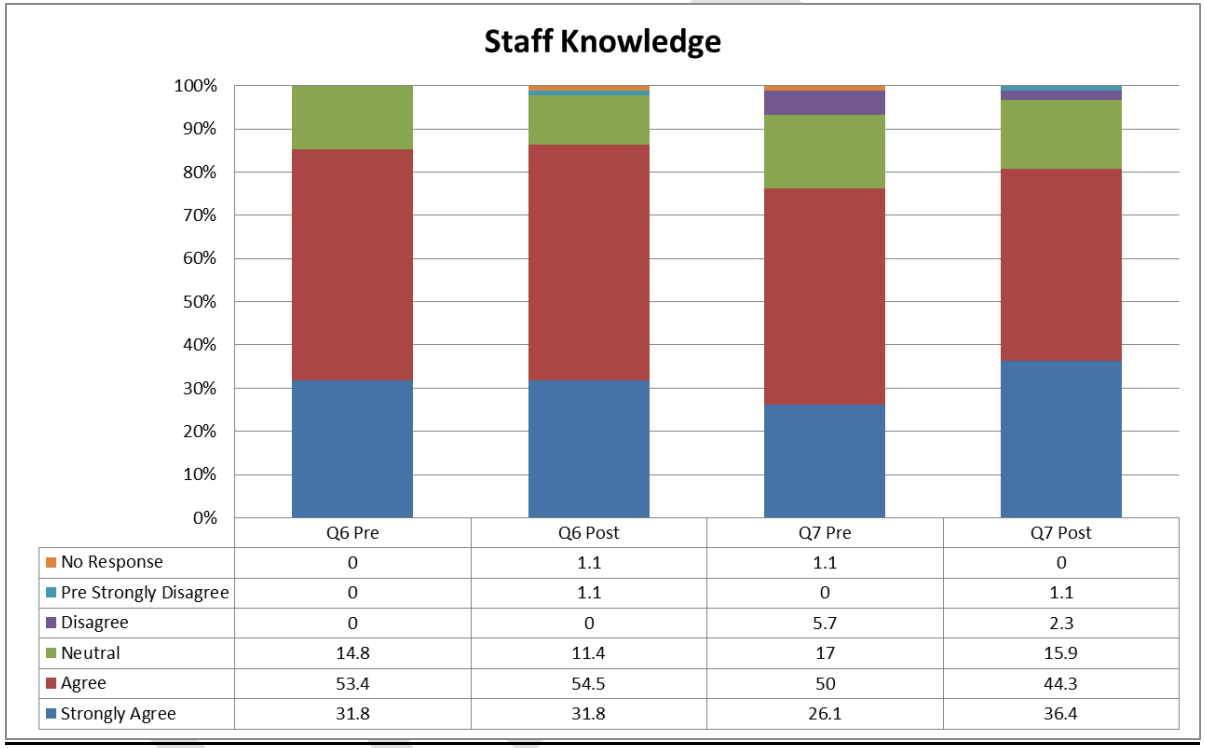
Overall this domain showed an increase, from a mean of 4.09 to 4.26. Staff comfort increased for questions 4 and 5 but decreased slightly for question 6.



	Q3 Pre	Q3 Post	Q4 Pre	Q4 Post	Q5 Pre	Q5 Post
No Response	2.3	0	0	0	0	0
Pre Strongly Disagree	0	1.1	0	1.1	1.1	1.1
Disagree	5.7	1.1	4.5	1.1	3.4	2.3
Neutral	8	6.8	15.9	5.7	15.9	18.2
Agree	52.3	43.2	46.6	45.5	46.6	44.3
Strongly Agree	31.8	47.7	33	46.6	33	34.1

Performance Indicator: *Increase in staff knowledge of physical health care issues*
Q6: I have a good understanding of physical health issues
Q7: I am able to recognize physical health symptoms that might indicate the need for a primary care appointment

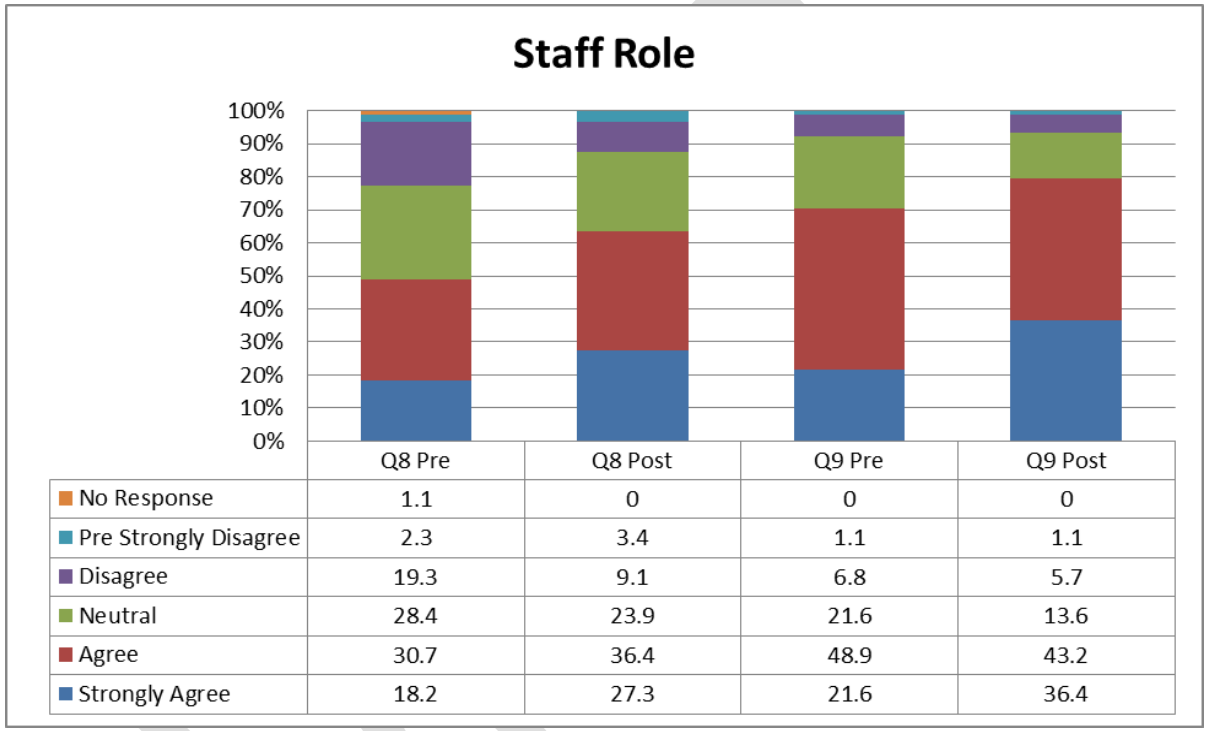
Overall this domain showed an increase, from a mean of 4.07 to 4.15. The percent of staff that agreed or strongly agreed to both questions increased from pre to post survey, more considerably for question 7.



	Q6 Pre	Q6 Post	Q7 Pre	Q7 Post
No Response	0	1.1	1.1	0
Pre Strongly Disagree	0	1.1	0	1.1
Disagree	0	0	5.7	2.3
Neutral	14.8	11.4	17	15.9
Agree	53.4	54.5	50	44.3
Strongly Agree	31.8	31.8	26.1	36.4

Performance Indicator: *Increase in perception of staff role in addressing physical health care issues*
Q8: It is easy to make a referral for a consumer to a primary care provider
Q9: It is my responsibility to assist a consumer to follow-up with the primary care provider when the consumer has a medical or medication issue

Overall this domain showed an increase, from a mean of 3.64 to 3.91 and was statistically significant. For both questions the percentage of staff that agreed or strongly agreed increased.



	Q8 Pre	Q8 Post	Q9 Pre	Q9 Post
No Response	1.1	0	0	0
Pre Strongly Disagree	2.3	3.4	1.1	1.1
Disagree	19.3	9.1	6.8	5.7
Neutral	28.4	23.9	21.6	13.6
Agree	30.7	36.4	48.9	43.2
Strongly Agree	18.2	27.3	21.6	36.4

Performance Indicator: Increase in client satisfaction with their lives in general

Please indicate how you feel:
Q1: About your life in general?
Q2: Your health in general?
Q3: Your physical condition?
Q4: Your emotional well-being?

Overall this domain had a decrease in mean score from 4.04 to 3.84, which was statistically significant. The percentage of clients who were mostly satisfied or pleased decreased from pre to post survey.

	Q1 Pre	Q1 Post	Q2 Pre	Q2 Post	Q3 Pre	Q3 Post	Q4 Pre	Q4 Post
No Response	2.6	3.3	2.4	4.6	2.7	3.9	2.8	4.4
Terrible	5.8	8.9	5.3	9.9	7.4	10.5	9	10.3
Unhappy	12.6	14.7	13.4	14.2	14.2	14.3	14.9	15.3
Mistly Dissatisfied	7.4	7.1	8.8	8.3	9.7	9.6	7.4	9.9
Mixed	33.4	32.7	30.5	29	28.5	29.7	30.9	30.5
Mostly Satisfied	19.3	15.3	23.7	19.2	21.8	18.4	17.5	14.3
Pleased	12.6	12.1	11	10.8	10.2	9.1	11.6	10.5
Delighted	6.3	5.9	4.9	4	5.5	4.6	5.9	4.7

The post survey asked clients and staff what helped make them more aware of the connection between physical and mental health. The results are contained in the following tables.

	Client Response N=593		Staff Response N=88	
	N	%	N	%
Learned from my own personal experience	290	48.9	49	55.7
Talking/interactions with RST staff (Client Only)	237	40.0	NA	NA
Learned from working with consumers (Staff Only)	NA	NA	55	62.5
Consulting with the medical staff (Staff Only)	NA	NA	65	73.9
The agency's emphasis on collaboration and coordination of care (Staff Only)	NA	NA	49	55.7
Information I learned from groups/training	164	27.7	59	67.0
Internet	121	20.4	46	52.3
Educational pamphlets	113	19.1	32	36.4
Other	61	10.3	16	18.2
Nothing	40	6.7	0	0.0
Health related posters	32	5.4	8	9.1

Staff found consultation with the dually boarded doctors, staff training and working with clients the most helpful activities. Clients were made more aware most often through learning from their personal experience and talking or interacting with RST staff. Staff found the educational pamphlets more helpful than did clients, and neither group was highly influenced by the health related posters.

Three of the four RSTs were able to make some progress in establishing collaboration with a primary health care provider. One RST has formalized a relationship with Sacramento Family Medical Clinic and has an agreement to share collateral information for clients they have in common. Another provider partnered with Wellspace, a primary care provider, to move in to their site and provide health care services to their clients. This arrangement worked out very well initially, especially because services were co-located. Unfortunately the nurse practitioner left Wellspace and they have been unable to fill the position. The third provider has developed a collaborative relationship with Sacramento Community Clinic and has been successful in referring medication only clients for transfer. The last RST has made numerous attempts to set up a meeting with Mercy Norwood Clinic but is not receiving return telephone calls. Despite the challenges in establishing a partnership with Mercy Norwood Clinic, this provider's psychiatrist has increased his attempts to coordinate with primary care on a case-by-case basis, emphasizing on those with much more complex medical needs.

The establishment of a collaboration between the RST's and a primary care provider proved to be challenging for most of the RSTs because of the following: inability to identify the staff person at the primary health clinic to coordinate with, difficulty helping client's navigate their medical benefits and clients are assigned to a large range of primary care providers and collaborating with one was not reaching the majority of clients.

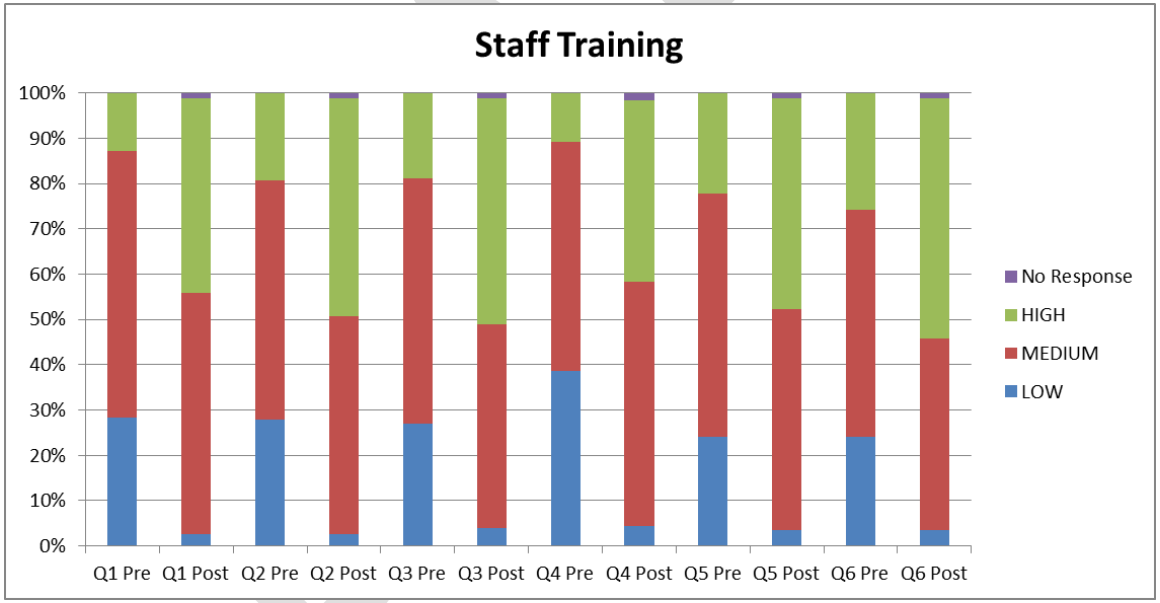
As indicated previously, the team anticipated that a shift in the culture of the RST clinics was going to be a gradual change and could be difficult to measure in performance indicators alone. For this reason, pre/post staff training evaluation, client chart review and focus group data was also analyzed to look for culture shifts in the RST that resulted from this PIP. Data from these additional data collection efforts is presented below.

Staff Training

The dually boarded doctors at each RST conducted 22 trainings on a variety of physical health issues for 130 unduplicated staff during the PIP timeframe. Training topics included: Cholesterol, Diabetes, Hep C, Smoking Cessation and Hypertension. Staff completed a pre and post-test for each training using the following scale: 1=Low, 2=Medium, 3=High. The following table depicts the mean scores for each question.

How would you rate your:	Pre	Post	Change
Q1 Overall knowledge base of the medical issues that will be covered in this training?	1.9	2.4	0.6
Q2 Ability to talk to consumers about the medical issues that will be covered in this training?	1.9	2.5	0.5
Q3 Comfort level assessing/providing services to consumers in relation to the topics of this training?	1.9	2.5	0.5
Q4 Ability to recognize symptoms of the medical issues that will be covered in this training?	1.7	2.4	0.6
Q5 Understanding of the possible interactions between physical health and mental health symptoms?	2.0	2.4	0.4
Q6 Confidence in talking to a primary health care provider on behalf of a consumer regarding medical issues that will be covered in this training?	2.0	2.5	0.5

The mean score for each question asked increased and was statistically significant at the .01 level. The graph below shows the change in scores from pre to post test for each question.



Staff was also asked “What was the most valuable thing you learned today”. In addition to comments regarding the cause, prevalence, treatment and prevention of the health condition, many comments were in reference to:

- The link between psychiatric medications and physical health conditions
- The correlation between mental health physical health symptoms and conditions
- The difference between LDL and HDL
- The difference between type 1 and type 2 diabetes

Chart Reviews

A chart review of a random sample of those clients with one or more co-morbid physical health conditions was completed on 122 clients receiving at least the median number of services (12) from an RST during the PIP time period. The following table shows the results of the chart review.

	N	%
The Clinical Introductory note mentions physical health care or connection with a PCP?	90	73.8
There are progress notes that speak to the client's physical health related conditions?	93	76.2
The progress notes clearly reflect the clients' physical health status?	56	45.9
How do the progress notes reflect the coordination of care?		
0- No acknowledgement of physical health condition	12	9.8
1- Reference to PCP or canned language	39	32.0
2- Documentation of clients' physical health status and related discussion, client going to see PCP, have appointment and follow up discussion	56	45.9
3- Support or assistance with physical health challenges, staff offers suggestions about things client can do to feel better, preventative measures, intensive case management, RST doc or staff contacting PCP	14	11.5
What did staff do to assist?		
Encourage client to make an appointment with PCP	64	52.5
Check in with client about health care issue/contact with PCP/appointment details	58	47.5
Help client call or link to PCP/appointment	18	14.8
Encourage preventative behavior	37	30.3
Get a release of information	43	35.2
Discuss labs with client	23	18.9
Communicate labs or other physical health info to PCP	15	12.3
Other	25	20.5

The majority of charts reviewed contained progress notes regarding the clients' physical health related conditions and efforts to coordinate care. The majority, 57.4%, of progress notes demonstrated coordination of care, by scoring a 2 or 3 on the above scale. About 50% documented staff efforts to encourage clients to make an appointment with PCP and check in with the client about health care issues and PCP appointment details.

Focus Groups

A total of 4 focus groups, one at each RST were completed to obtain additional feedback from staff about how the PIP interventions were helpful and/or challenging. Approximately 55 staff participated in the focus groups. The focus groups were completed in June 2014. The summary below reflects the answers that were provided by provider staff that participated in the focus groups.

What are some of the barriers to coordination of care with the PCP?

The barriers include lack of physical health care providers accepting a particular insurance, lack of contact and follow up between the PCP and MH provider, long wait times for clients to see a PCP, lack of time with the PCP during appointments with the client, a reluctance on the part of the PCP to treat MH clients, lack of appropriate interpreter services for LEP individuals, and client's refusal to see a PCP.

What would help you (the MH provider) to more easily coordinate with the PCP and discuss physical health with your clients?
Things that would be helpful include a contact person at each physical health care clinic who could help coordinate appointments and information sharing; more physical health care resources such as more clinics and PCPs; increased training to Personal Service Coordinators (PSCs) around insurances and coverage, particularly medication coverage; increased coordination between hospitals, PCPs, and MH; increased interpreter service availability at PCP clinics and offices; and an increased ability for more doctor-to-doctor communication.

As Sacramento County utilizes Avatar as our Electronic Medical Record system, we also took the opportunity to question participants regarding how Avatar has positively or negatively impacted their experience with the activities of the PIP:

How has Avatar helped and/or hindered this process?
Avatar has been helpful as a standard place to put client resources (contacts); it saves time pulling up the chart and finding phone numbers and contact information; information such as prescription history and medical history is easier to locate; and Avatar has made it easier to locate clients who have not yet been assigned a PCP.
Challenges with Avatar include that it sometimes does not work properly; it can take a long time to load and it "times out" a lot; it does not pre-populate prior information into client health questionnaire updates; and there have been problems with Order Connect not sending up the prescriptions.

When the PIP first began, there were trainings that occurred to help PSCs enhance their knowledge around physical health care conditions and wellness. The following question was asked in regard to the outcome of the surveys:

In March 2013, you were asked to complete a questionnaire (green survey) about your knowledge, comfort level, and attitude towards physical health and mental health integration. The resulting high scores of the survey indicated that staff overall felt very knowledgeable and comfortable with physical health issues. Do you feel that the trainings offered through this PIP have increased your knowledge and have helped you assist clients with their physical health needs? If so, can you provide examples of something you learned that you have applied to your work with clients?

Overall, the providers felt that the trainings did increase their knowledge. Providers shared a few examples:

- Greater awareness and reminder to follow up with physical health issues and with a PCP; focused on motivating clients and encouraging them to reach out to their PSC.
- There is more of an emphasis on prevention; PSCs encourage nutrition and wellness.
- Primary health has become a part of the conversation; a few years ago PSCs wouldn't feel comfortable bringing up the conversation.
- One individual expressed that with each training, they thought they knew the subject matter fairly well, until after the training was over and realized they didn't know the subjects as well as they had thought.
- PSCs believe MH care and primary care all ties together.

And finally, because the purpose of the PIP was to increase care coordination with a focus of improving health outcomes, the last two questions were aimed at the participants' thoughts on improvement of health outcomes and if there was a shift in culture to a focus of integrated healthcare.

What success stories have you had related to efforts to coordinate with the PCP or improved health outcomes for clients?

Overall, providers report success by seeing an increase in coordination between mental health and physical health care as well as an increased education for both clients and staff. Providers also shared a few "success stories" regarding client successes:

- PIP was very helpful. It has stopped clients from thinking we are the only doctor they have to take care of all their needs.
- A client was doing well on their own and was referred to Native American Health Center. They received a PCP and no longer needed services through MH.
- A client who had one time had an eating disorder was receiving services and the PSC say that the client was still not eating properly. The client was trying to lose weight by only eating one large meal a day. The client became diabetic. The PSC talked to the client about their symptoms and encouraged the client to talk with her PCP. The client is no longer diabetic.
- The smoking cessation group has a 100% success rate. The group served 25 clients. For example, one client switched from chewing Tobacco to non-nicotine chewing tobacco. Another client quit smoking and went on the patch.
- A client was struggling with constant ER visits. It was easier for the client to get to the ER instead of to a PCP. The client was given a bus pass so that they could easily visit the PCP instead of going to the ER.
- The clients in the nutrition group have poor physical health due to poor nutrition. The nutrition group has helped them make health changes. One client went from drinking 6 cans of soda a day to quitting drinking soda altogether after watching a sugar demonstration in the group. Another client is trying to cut out fast food after watching a fast food documentary in the group.
- The first smoking group was a huge success. All four participants in the group have quit smoking. The longest smoker of the group had previously smoked for 54 years. This particular participant has had improvements on their heart and lung capacity. They still have COPD and are still on oxygen however they now only have to wear the oxygen at night, instead of all the time.

Do you feel that as a result of the strategies laid out in the PIP that there has been a cultural shift in your program that has led to an increase in coordination of care and/or improved health outcomes for clients? Can you provide examples?

Overall, providers felt that there has been a cultural shift and pointed to examples of increased coordination between mental health and physical health care, increased client motivation to follow up with primary health care, and increased integrated care as evidence of this.
Examples include:

- **Increased coordination between mental health and physical health** (i.e.-MH programs have made an increased effort to coordinate care unless a client refuses; This includes increased documentation of such follow up; strong messages to keep all appointments made with PCPs; PSCs are more consistent on following through and following up on the client's PCP appointments; PSCs keep clients accountable to get to their PCP appointments; PSCs make sure that they ask clients if they have a PCP and if they have an appointment scheduled with said PCP. When clients show resistance, they are better able to explain why it's so important.) (Ex-all SacPort women must have a PCP before they are able to graduate.)

- **Increased client motivation to follow up with primary health care** (Since primary health is now being talked about, clients are becoming more motivated.; clients have an increased awareness that they need to seek help for physical health issues; ex-A long term client is now eating healthier and aware of their wellness. They now have a desire to live a longer life.)

- **Increased integrated care** (i.e.-physical and mental health was very separate before, it is no longer that way. Physical and mental health now go hand in hand.; there is increased awareness that physical health and mental health affect each other, example: chronic pain affects mental health; The first year of the PIP laid down the ground work, it is now engrained and it's a conversation that has to happen. It has become a part of the conversation that happens in a regular visit; The medical doctor on staff is in favor of the integration; When the PIP was first introduced, it started as just another thing to think about, there has been a shift and it is now seen as routine, even beneficial and enjoyable; there is more of a connection with PCPs who prescribe psych meds.)

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

a. Data cycles clearly identify when measurements occur.
Data was collected through voluntary client and staff surveys in March 2013 for baseline and one year later after PIP interventions were implemented, in March 2014. Data for staff training and client wellness groups was collected as groups occurred between March 2013 and June 2014. Chart reviews and the staff focus groups were completed in June 2014.

b. Statistical significance
Statistical significance was determined through analysis in SPSS. Variances between baseline data and follow up data was tested using an analysis of variance (ANOVA) and/or paired sample t-tests. Statistically significant differences were found in the Client Awareness, Staff Role and Client Satisfaction domains in Table D. The mean scores for all of the questions on the staff training pre-post survey were statistically significant.

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

The pre survey given to both clients and staff had averages of 3.6 or higher across all domains. We did not anticipate the averages to be so high on the pre-survey and it made it difficult to reach our goals for improvement on the post survey. It is believed that the idea of "you don't know what you don't know" may have come into play on the pre-survey. One possible factor that may have influenced the comparability of the pre and post surveys is the theory that some people may believe they have knowledge and awareness because they have been doing something for so long, but after they receive training or additional information they discover that that may not have known as much as they thought we did. In other words, "you don't know what you don't know".

Also, in order to maintain confidentiality and simplify the data collection, we did not include client ID numbers on the pre/post surveys, and therefore do not have a one to one match, which is a limitation to the study design. The post survey may contain clients who are fairly new to the clinics and may not have been exposed to the interventions for very long.

d. Are there any factors that threaten the internal or the external validity?
The RST providers reported that while staff feel they are knowledgeable and are comfortable talking to clients about physical health issues, they continue to have a fear of having conversations about these issues due to scope of practice concerns. This may explain the relatively high scores on the staff pre survey for knowledge and comfort domains. The questions about comfort may have been interpreted in a number of ways, as we didn't specifically define "comfort".

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

During the focus groups, RST staff indicated an increased comfort level in discussing physical health care conditions, assisting clients to gain knowledge about physical health care concerns and there has been an increase in care coordination. The focus groups also brought to light the successes clients had in increased identification and management of co-morbid health conditions. Staff also felt a shift in the culture of the RST clinics, one that included physical health concerns, overall health and wellness and treating the "whole person". The chart reviews indicated that attention is being paid to physical health issues and staff are addressing PCP visits and encouraging clients to make appointments.

Clients feel more cared for, more connected. There has been an increase in staff in client awareness and support for clients. Staff report an overall positive experience and have seen change as a result of this PIP. Staff reported that the PIP has helped clients see that their mental health doctor is not the only doctor that can help take care of their needs.

The RSTs plan to continue to provide trainings to staff and clients. They have received feedback from staff and clients on how to improve the groups and increase client participation.

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?
The survey distribution used in March 2013 was also used in March 2014: all clients that came in for services during the month were given the opportunity to complete the survey. The survey was distributed by front office staff and clients were asked to give honest answers to help improve their services. The staff survey was distributed during the staff meeting at each RST by the Clinical Supervisor/Director. The training surveys were distributed before and after each training at the time of the training.

20. Does data analysis demonstrate an improvement in processes or client outcomes?
Yes. The quantitative data analysis from both the client and staff pre-post surveys demonstrated an increase in means across all but one of the domains that were tested indicating an improvement in client and staff knowledge and awareness of physical health issues, their comfort

level discussing physical health issues with their mental health provider and their confidence in managing their health issues. Additionally data from staff trainings demonstrated a significant increase in staff knowledge and awareness around physical health issues. Three out of the four RSTs were able to set up some form of collaboration with a primary health provider and there was a 22% increase in the percent of clients with a primary health provider (54.2% pre PIP, 66.1% post PIP). The qualitative data obtained from the focus groups was the strongest indicator for improvement in client outcomes. There were countless success stories provided that demonstrated because of the PIP interventions client's health has improved. Some clients quit smoking, some went to the doctor for the first time, some resolved on-going health issues, and others lost weight and improved their eating habits.

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

The focus groups with staff were strong indicators demonstrating change in the culture of the RSTs is occurring. Staff indicated that both they and the clients are more confident and knowledgeable about physical health issues as they relate to mental health. The trainings have educated and motivated both clients and staff to make changes to their lifestyle and/or eating habits to improve their overall health.

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

While the goals for improvement were not met for most of the indicators, there were significant increases in the Client Awareness and Staff Role domains from pre to post PIP survey. This indicates a significantly higher awareness from clients that their mental health symptoms can affect their physical health, it is important to take are of both physical and mental health and it is important for doctors to talk to each and a greater perception of staff responsibility to assist clients with seeing a primary care provider when they have a medical or medication issue. Additionally there was statistical improvement seen as a result of providing training on a variety of medical issues to staff. The mean scores before training indicated that staff were in the low-medium category for overall knowledge about medical issues, ability to talk with clients about medical issues, ability to recognize symptoms, understanding of possible interactions between physical and mental health symptoms, and confidence in talking to a primary health care provider and after receiving training on the specific medical issues their scores showed a statistically significant increase to the medium-high level.

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

This was not a repeated measures project.

APPENDIX VI

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

Regarding this PIP Submission Document:

- **This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that CAEQRO uses 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.**
- **You are not limited to the space in this document. It will expand, so feel free to use more room than appears to be provided, and include relevant attachments.**
- **Emphasize the work completed over the past year, if this is a multi-year PIP. A PIP that has not been active and was developed in a prior year may not receive "credit."**
- **PIPs generally should not last longer than roughly two years.**

CAEQRO PIP Outline via Road Map

MHP: Sacramento County
Date PIP Began: March, 2014
Title of PIP: Increasing Collaboration Between Mental Health (MH) and Child Protective Services (CPS)
Clinical or Non-Clinical: Non-Clinical

Assemble multi-functional team

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

The Sacramento County Mental Health Plan (MHP) established a Children's PIP Committee to develop and implement this PIP. The core committee consisted of County staff representing Program Development and Support (PDS)/Children's Mental Health , Research, Evaluation and Performance Outcomes (REPO) , Office of Finance, Contracts and Administration (OFCA) and Quality Management (QM) . The in-development PIP was presented to representatives from the contracted provider community in a special Provider Input meeting and to members of the Children's Stakeholder Committee at their regular meeting. The input received at both of these venues is included. Additionally, representatives from the Provider Community providing Wraparound and Flexible Integrated Treatment (FIT) Services and from Sacramento County Child Protective Services (CPS) were invited to participate in the workgroup to direct the Performance Improvement Project.

County Participants

Susan Anderson – Human Services Supervisor, Child Protective Services
Kathy Aposhian, RN, Program Manager, Quality Management, Sponsor of the EPSDT PIP Committee
Edward Fernando – Human Services Program Specialist, Child Protective Services
Tiffany Greer, Program Coordinator, Quality Management
Lisa Harmon – Program Planner, Research & Evaluation
Melissa Jacobs, Program Manager, Children's Mental Health
Verronda Moore – Program Manager, Child Protective Services
Matthew Quinley – Program Manager, Children's Mental Health
Alex Rechs, Program Coordinator, Quality Management
Lisa Sabillo, Division Manager, Support Services – Quality Management, Research & Evaluation, and Avatar
Dawn Williams – Program Planner, Office of Finance, Contracts and Administration
Billee Willson – Program Planner, Children's Mental Health
Julie Zawodny – Program Planner, Office of Finance, Contracts and Administration

Provider and Advocate Participation

Kathy Bader – Youth Peer Mentor, Mental Health of America, Northern California
Sandena Bader – Family Advocate, Mental Health of America, Northern California
Deborah Bennett – Stanford Youth Solutions Faith Patterson – Youth Peer Mentor, River Oak Center for Children
Farrah Phillips – EMQ/Families First
Gordon Richardson – EMQ/ Families First
Roland Udy – River Oak Center for Children
Diana White – Turning Point

"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.

In March of 2013, Sacramento County's Mental Health Plan (MHP) and Child Protective Services (CPS) began the planning process for implementation of the Katie A. Settlement Agreement. The process was guided by the Core Practice Model developed by the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS). In the Core Practice Model the elements of focus were Teaming, Trauma-Informed Practice, Practice Components, and Services. During the planning meetings and stakeholder information gathering activities it became increasingly clear that the success of the Katie A. implementation would be dependent on the teaming process between families, youth, Mental Health Providers, and CPS. It was decided that the MHP would use Katie A. implementation planning to determine which elements would result in an increase in teaming and have the potential to influence outcomes for children, youth and families.

For the purpose of this PIP a useful definition of teaming is that it refers to, "a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable" (Katzenbach & Smith, 1993, p.112).

While reviewing research about teaming and collaboration, two models were reviewed; the Input-Process-Output (IPO) model (Hackman & Morris, 1975) and the Input-Mediator-Output-Input (IMOI) model (Ilgen et al., 2005). The traditional Input-Process-Output model, until recently, had been the most widely used template for research on team effectiveness (West, Borrill & Unsworth, 1998). The Wraparound model is a variant of this model. While this was an effective model in most organizations where teaming focused on a single, linear process, this did not directly apply to social service teaming. In more recent years, research has taken into account a broader range of variables in the group or teaming process. The alternative model, IMOI includes the mediational influences and the added input at the end acknowledging the cyclical causal feedback that is inherent in social service teaming approaches. This model also allows for growth over time. The IMOI model more closely resembles the Wraparound approach to teaming in that it looks at the Forming Stage (i.e. building of team cohesion and trust) as an element that is equal if not more important to the Functioning Stage (i.e. processing and decision making). It is important to note Wraparound outcomes include supportive and adaptive relationships, and some of those relationships will be those formed or strengthened between team members in the forming process. The experiences of participation on a cohesive team provides the basis for these relationships, as well as a model for family efforts to build similar adaptive and supportive relationships outside of the team context or after the team has concluded its work (Walker & Schutte, 2004).

During several of the Katie A. Sub-Committee Meetings, it became clear there were a number of barriers inhibiting a more effective teaming experience for children/youth, caregivers, mental health providers, CPS social workers, and other members of their team. It also became clear there was a need for clear and consistent roles, expectations, and outcome standards to be clarified as part of the Katie A. implementation process. Using the Wraparound model as a starting place made sense because contracted Wraparound providers were already using this model.

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?

Although formal and informal teaming has been in place since the implementation of Wraparound Services in 1999 and Flexible Integrated Treatment (FIT) in 2011 the MHP has had no structured method of tracking the attendance and content of the teaming meetings. Wraparound providers are expected to keep meeting minutes in a format that is consistent with Wraparound fidelity. As part of the development of this PIP, Wraparound providers submitted their meeting minute formats used as part of the current Child and Family Team (CFT) process, outlined in the Wraparound model. (See Attachment) Many of the FIT providers who also provide Wraparound services adopted the CFT model and use a similar format with their youth and families.

To determine the barriers/causes that might be contributing to the problem, the MHP first identified the current teaming strategies providers were using to identify, engage, and establish CFT's. Providers reported using the assessment period with the family and child/youth as the primary way to identify members of the CFT. Engagement and on-going communication with CFT members is primarily by phone, fax or scheduled face-to-face meetings. Secondly, the providers were asked to survey direct service staff to gather the following information:

1. What are the anticipated or known areas of concern for the children who meet the Subclass Criteria?
2. What elements are included in good coordination between CPS and MH? What describes a poor level of coordination?
3. Are there any concerns or potential barriers to coordination currently experienced or anticipated?

Of the four FIT and Wraparound Providers surveyed, three responded and their reported barriers are listed in the table

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

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Scheduling - Difficulty in coordination of schedules for consistent CFT meetings.	Provider feedback
Procedural barriers - (MH - receiving releases of authorizations and consents; CPS – communication from Access or providers when child/youth is linked to service)	Provider feedback
Expectations - Lack of clarity of roles in CFT interactions.	Provider feedback
Communication – Differences in terminology and definitions, limited understanding of concerns of either CPS or MH	Provider feedback

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

Formulate the study question

4. State the study question. This should be a single question in 1-2 sentences which specifically identifies the problem that the interventions/approach for improvement.

Does applying a standard set of expectations for involvement and coordination with Child Protective Services (CPS) in Intensive Care Coordination-Child and Family Teams (ICC-CFT) result in better outcomes for children/youth and their families?

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

No. While the implementation of the Katie A. Settlement includes youth and families receiving outpatient services as well as those who are receiving intensive level services provided by our Flexible Integrated Services (FIT), Wraparound, Full Service Partnerships (FSP), and Residentially Based Services (RBS) providers, we will be concentrating our efforts for this PIP on the children and youth who receive intensive level services and thereby meet the Subclass criteria. This decision was made because the children and youth who meet the Subclass Criteria are eligible for the Intensive Care Coordination (ICC) which is led by the Mental Health provider. In keeping with our scope of influence, it was determined the MHP would be able to inform and influence the policies, procedures, and practices of coordination of care if it is the Mental Health provider leading the ICC-CFT.

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

The number of children and youth meeting Subclass Criteria with open CPS and MH episodes from January 1 through June 30, 2014 period is 599. We will follow this same 599 children and youth over the course of a year once the Katie A settlement has been implemented starting July 1, 2014.

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

The population was identified using both the CPS and MH databases to find children and youth who had both open CPS and MH episodes in intensive level programs.

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

Sampling techniques were not used; we will look at all 599 children and youth that meet Subclass Criteria.

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

Study 1: N/A

Study 2:

"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. Why were these performance indicators selected?

Performance indicators were selected by determining what data could be collected that will give a good reading of improvement of outcomes for youth. The CANS assessment was rolled out to all providers by the July 1st Katie A implementation, so it is an assessment that is easily accessed and is reliable. It also addresses many aspects of outcomes that the ICC-CFT process is hoping of affect. The Reduction in Placement Changes and Reduction of Hospitalizations can be pulled from the CPS and MH databases and will give a good measure of improved outcomes. The ICC-CFT Satisfaction Survey that is being distributed at meetings will help us to learn if youth and caregivers are feeling more involved and better informed in the meetings.

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	Decrease in CANS Action Items for Caregiver Stability (CANS items: Supervision, Involvement,	403 youth meeting Subclass Criteria with a CANs assessment	158 Domain Action Items	39.2% with Action Items in Caregiver Stability	Statistically significant reduction in

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
	Social Resources, Family Stress and Residential Stability)				Action Items (p=.05)
2	Decrease in CANS Action Items for Youth Home Functioning (CANS items: Family, Living Situation, Social Functioning)	403 youth meeting Subclass Criteria with a CANs assessment	350 Domain Action Items	86.8% with Action Items in Youth Home Functioning	Statistically significant reduction in Action Items (p=.05)
3	Decrease in CANS Action Items for Youth School Functioning (CANS items: School Behavior, School Achievement, School Attendance)	403 youth meeting Subclass Criteria with a CANs assessment	275 Domain Action Items	68.2% with Action Items in Youth School Functioning	Statistically significant reduction in Action Items (p=.05)
4	Increase in CANS Action Items for Youth Strengths (CANS items: Family, Relationship Permanence, Resiliency)	403 youth meeting Subclass Criteria with a CANs assessment	783 Domain Action Items	194% with Action Items in Youth Strengths	Statistically significant increase in Action Items (p=.05)
5	Reduction in Placement Changes	599 youth meeting Subclass Criteria	401 Placement Changes	66.9% Placement Changes	Statistically significant decrease in Placement Changes (p=.05)
6	Reduction in Hospitalizations	599 youth meeting Subclass Criteria	20 Hospitalizations	3.3% Hospitalizations	Statistically significant decrease in Hospitalizations (p=.05)
7	Increase in ICC-CFT Satisfaction for Youth and Caregivers	33 Youth & 53 Caregivers with completed Satisfaction Surveys	6 Questions on a 5 point Likert Scale	4.42 Youth & 4.69 Caregiver Mean Satisfaction	Statistically significant increase in Satisfaction (p=.05)

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.

The interventions selected are directly related to the barriers that have had the most historical impact in creating effective teaming between children/youth, families, CPS and MH.

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	Utilization of CPS/MH Katie A. Steering Committee to discuss strategies to eliminate coordination barriers at systems level.	Procedural, Expectations	January 1, 2014

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
2	Implementing coordination expectations in contracts for Intensive Level Service Providers.	Expectations	July 1, 2014
3	Creation and implementation of ICC-CFT documentation standards to promote consistency between providers.	Expectations, Communication	July 1, 2014
4	Creation of Information Sharing Document to clarify roles of responsibility in coordination of care.	Procedural, Expectations	July 1, 2014
5	Combining CPS and MH in an Introduction to Katie A. Training that includes strategies for coordination.	Communication	July 1, 2014
6	Creating and distributing an ICC-CFT manual to providers who serve children and youth who meet the Subclass Criteria.	Expectations, Communication	July 1, 2014
7	Implementing MH Resource Fairs for CPS to share program details, services provided, and promote communication between systems.	Communication	August and September, 2014
8	Provide on-going shared training opportunities to promote understanding of viewpoints, increased communication, and shared vision between MH and CPS.	Communication	January 1, 2014 (on-going)

Apply Interventions: "What do we see?"
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

CANS assessments are collected and entered into the MH AVATAR database at Intake, every six months and at discharge. Hospitalization and Placement Change data are in the MH AVATAR database and the CPS CMS database respectively. This data is extracted by Research and Evaluation (REPO) Staff for analysis. The ICC-CFT Satisfaction Survey will be distributed by program staff to participating youth and caregivers at the end of each meeting and then will be turned in to County REPO Staff on a regular basis. ICC-CFT Attendance Sheets will also be turned into REPO on a regular basis. The Attendance Sheets will be used to validate the attendance of CPS SW in the ICC-CFT meetings. A chart review of Case Management progress notes and ICC-CFT progress notes will be completed by County QM Staff to verify the inclusion of CPS in coordination efforts outside of formal ICC-CFT meetings.

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

The method of data collection is primarily from MH AVATAR and CPS CMS databases, with the exception of the Satisfaction Surveys and Attendance Sheets, which will be sent in to REPO on a regular basis. We did use existing data, aside from the Satisfaction Survey and the new Attendance Sheet format which was developed entirely for this purpose and did not exist previously.

Below is an example of the Satisfaction Survey that was developed and implemented with the Youth and Caregivers:

Katie A
ICC-CFT Meeting Satisfaction Survey

Date of Meeting: _____ Client ID: _____

Evaluation completed by: _____ Youth____ Caregiver____

Date: _____ By phone_____ In person_____

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1-The meeting was at a convenient time for you.					
2-The meeting was at a convenient location for you.					
3-The team worked well together.					
4-I was satisfied with my Child and Family Team Meeting.					
5-There was a clear action plan at the end of the meeting.					
6-The next meeting was scheduled before the end of the meeting.					

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

At the end of one year following the implementation, REPO will pull the data from the various databases and collect the Satisfaction Surveys and enter the data into an Access database. All data will be analyzed using Access database and SPSS software. The data will be analyzed for statistically significant reductions in CANS needs, Placement Changes and Hospitalizations and statistically significant increases in CANS strengths and satisfaction.

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

The Research, Evaluation and Performance Outcome (REPO) staff are responsible for collecting the data from the agency and extracting Avatar information system data have at least a BA degree in Psychology, Social Services or other related fields and have been analyzing and reporting on data for the REPO unit for over seven years. The REPO staff has received continuous training on data analysis and performance outcomes. Quality Management staff will conduct the chart reviews and have at least a Master's degree in a field of clinical work and extensive experience in chart reviews.

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?

The data Analysis did occur mostly as planned for the CANS, Placement Changes and Hospitalization data since those data collection procedures were already in place and established. The collection of the Satisfaction Surveys and ICC-CFT Sign-In sheets did require some oversight to make sure all documents were being completed and submitted correctly. This required some auditing of the data and returning the feedback to the programs to increase proper completion. The analysis has not yet triggered any other QI projects, but could in the future.

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

Include the raw numbers that serve as numerator and denominator!

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
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
Decrease in CANS Action Items for Caregiver Stability (CANS items: Supervision, Involvement, Social Resources, Family Stress and Residential Stability)	July 2014	*403 youth meeting Subclass Criteria with a CANs assessment/158 Domain Action Items =* ***39.2% with Action Items in Caregiver Stability***	Statistically significant reduction in Action Items (p=.05)	*All Interventions (See Table C)*	July 2015	*403/155=* ***38.5% with Action Items in Caregiver Stability***	*1.8% decrease in Action Items* ***(p<.05)***
Decrease in CANS Action Items for Youth Home Functioning (CANS items: Family, Living Situation, Social Functioning)	July 2014	*403 youth meeting Subclass Criteria with a CANs assessment/350 Domain Action Items=* ***86.8% with Action Items in Youth Home Functioning***	Statistically significant reduction in Action Items (p=.05)	All Interventions (See Table C)	July 2015	*403/299=* ***74.2% with Action Items in Youth Home Functioning***	*14.5% decrease in Action Items* ***(p<.05)***
Decrease in CANS Action Items for Youth School Functioning (CANS items: School Behavior, School Achievement, School Attendance)	July 2014	*403 youth meeting Subclass Criteria with a CANs assessment/275 Domain Action Items=* ***68.2% with Action Items in Youth School Functioning***	Statistically significant reduction in Action Items (p=.05)	All Interventions (See Table C)	July 2015	*403/249=* ***61.8% with Action Items in Youth School Functioning***	*9.4% decrease in Action Items* ***(p<.05)***
Increase in CANS Action Items for Youth Strengths (CANS items: Family, Relationship Permanence, Resiliency)	July 2014	*403 youth meeting Subclass Criteria with a CANs assessment/783 Domain Action Items=* ***194% with Action Items in Youth Strengths***	Statistically significant increase in Action Items (p=.05)	All Interventions (See Table C)	July 2015	*403/843=* ***209% with Action Items in Youth Strengths***	*7.7% Increase in Action Items* ***(p<.05)***
Reduction in Placement Changes	July 2014	*599 youth meeting Subclass Criteria/401 Placement Changes=* ***66.9% Placement Changes***	Statistically significant decrease in Placement Changes (p=.05)	All Interventions (See Table C)	July 2015	*599/256=* ***42.7% Placement Changes***	*36.2% decrease in Placement Changes* ***(p<.05)***
Reduction in Hospitalizations	July 2014	*599 youth meeting Subclass Criteria/20 Hospitalizations=*	Statistically significant	All Interventions (See Table C)	July 2015	*599/17=* ***2.8%***	*15.1% decrease* ***(p<.05)***

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/	% improvement achieved
		3.3% Hospitalizations	decrease in Hospitalizations (p=.05)			***Hospitalizations***	
Increase in ICC-CFT Satisfaction for Youth and Caregivers	Sept & Oct 2014	*33 Youth& 53 Caregivers with completed surveys/4.42 & 4.69 Mean Satisfaction*	Statistically significant increase in Satisfaction (p=.05)	All Interventions (See Table C)	May & June 2015	*30 & 37/4.66 & 4.79 Mean Satisfaction*	*5.4% Youth and 2.1% Caregiver Increase* ***(p<.05))***

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

e. Data cycles clearly identify when measurements occur.

For the CANS, Placement Changes and Hospitalizations were collected for the same time period, one year apart (January through June 2014 and 2015). For the Surveys and Sign-In Sheets, these were implemented at a later time period, so the measurements occurred in the first two months the data was collected (September and October 2014) and then again in the two most recent months before the analysis (May and June 2015).

f. Statistical significance

Statistically significant reduction and increase in all CANS items was present, along with a significant reduction in placement changes, hospitalizations and a significant increase in both Youth and Caregiver satisfaction in the ICC-CFT meetings.

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

The same 599 youth were looked at for the CANS, Placement Changes and Hospitalization data, however for the Satisfaction Surveys we had to use all surveys completed for the four months of measurement regardless if they were the same youth since meeting schedules can vary.

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

Internal and External validity should be present for the CANS, Placement Changes and Hospitalization data. The validity of the Satisfaction Surveys could be influenced by who chose to complete the surveys versus who refused.

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

From the measurement of this data it seems that the PIP has been successful in every area. The increase in training, awareness and coordination between Child Protective Services and Mental Health is decreasing needs, placement changes and hospitalizations and increasing strengths and both youth and caregiver satisfaction in ICC-CFT meetings.

Some follow-up analysis was done on those youth whom we could identify as having multiple ICC-CFT meetings to see if those with more meetings improved more than those with just one identifiable meeting. Those youth (59 or 14% of the 403 youth with CANS data) improved more in three of the four CANS areas (Caregiver Stability-7.8% decrease vs. 1.8%, Youth Home Functioning-26.9% decrease vs. 14.5%, Youth School Functioning- 5.9% decrease vs. 9.4%, and Youth Strengths-36.3% increase vs. 7.7%). This analysis helps to confirm that an increase in ICC-CFT meetings will also improve Outcomes for the youth.

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 for both baseline and follow-up was pulled from the same sources and the same 599 youth were analyzed for both time periods for the CANS, Placement Changes and Hospitalizations. For the ICC-CFT Satisfaction Surveys, all completed surveys for the two time periods were analyzed.

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

Yes, all areas showed a statistically significant improvement in client outcomes and satisfaction.

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

The increase in training, awareness and coordination between Child Protective Services and Mental Health is helping youth and families to decrease their areas of needs and increase their strengths and satisfaction in the services.

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

All items were run through SPSS T-Tests and returned significance of less than .05.

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

This measurement was just completed, but we are hopeful that the cooperation between CPS and Mental Health will continue and will show even greater improvements over time.