

**Continuous System Improvement Committee**  
**AGENDA**  
**Wednesday, January 15**  
**Kona Kai Resort**  
**1551 Shelter Island Dr.**  
**San Diego, CA 92106**  
**1:30 p.m. to 5:00 p.m.**  
**Coronado Conference Room**

Notice: All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

| <b>Time</b> | <b>Topic</b>   | <b>Tab</b> |
|-------------|--|------------|
| 1:30 pm     | Planning Council Members Issue Requests  |            |
| 1:35 pm     | Welcome and Introductions<br><i>Patricia Bennett, PhD, Chair</i><br><i>Susan Morris Wilson, Vice-Chair</i>   |            |
| 1:40 pm     | Review and Approve October Minutes   | <b>A</b>   |
| 1:45 pm     | Discussion: Data Notebook Review and Update<br><i>Susan Morris Wilson, Linda Dickerson, PhD</i>  | <b>B</b>   |
| 2:45 pm     | Break  |            |
| 3:00 pm     | Panel Presentation: AB 114 Implementation – San Diego<br><i>Invited: Tasha Arneson, PhD, Riverside County Local Planning Agency; Cheryl Rode, PhD, Clinical Director, San Diego Center for Children; Mara Madrigal-Weiss, San Diego County Office of Education</i> | <b>C</b>   |
| 4:30 pm     | Public Comment   |            |
| 4:45 p.m.   | Evaluate Meeting/Develop Agenda for Next Meeting<br><i>Patricia Bennett, PhD, Chair</i><br><i>Susan Wilson, Vice-Chair</i>   |            |

**COMMITTEE MEMBERS**

|                              |                 |                   |
|------------------------------|-----------------|-------------------|
| Patricia Bennett, PhD, Chair | Karen Hart      | Monica Nepomuceno |
| Susan Wilson, Vice-Chair     | Celeste Hunter  | Jeff Riel         |
| Adrienne Cedro-Hament        | Carmen Lee      | Walter Shwe       |
| Amy Eargle                   | Lorraine Flores | Bill Wilson       |



## PROPOSED MEETING GROUND RULES

- Show up, be on time, be prepared
- Leave outside concerns outside
- Listen respectfully and appreciatively
- Speak to the question or issue, not in response to a person
- No side talk
- Be open-minded and objective: be informed by your expertise - decide based on evidence
- Practice active listening
- Be brief, stay on point; no speech making
- Say what you think, not what others think
- Respect confidentiality
- Allow the facilitator to 'direct speaking traffic'
- Cell phones and pagers on silent.



# Continuous System Improvement Committee Charter

## Overview

The California Mental Health Planning Council (CMHPC) is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Governor and the Legislature on priority issues and participate in statewide planning.

## Purpose

The purpose of the Continuous System Improvement Committee is to monitor, review, evaluate, and recommend improvements in the delivery of services in the public mental health system in California. By highlighting and recognizing outstanding service delivery programs, it is hoped that effective care can be duplicated and shared throughout the State of California.

The CSI will consider programs across the lifespan, incorporation of cultural competence in all programs, fiscal impacts on service delivery, legislative issues affecting programs, and other issues that may require attention as they occur.

## Mandate

**5772.** The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

- (a) To advocate for effective, quality mental health programs.
- (b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.
- (c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:
  - (1) To review and approve the performance outcome measures.
  - (2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.
  - (3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.
  - (4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.

(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.

*(This is only a partial list of all the CMHPC's mandates)*

## Guiding Principles

Committee policy and strategy recommendations should reflect and strive to address the following priorities:

- 1) Focus on improved outcomes for clients and their families.
- 2) Best practices and continuous quality improvement
- 3) Culture and linguistic competence
- 4) Promotes a client/family/parent driven system
- 5) Reduces stigma and discrimination
- 6) Emphasize the inclusion of all ages across the life-span
- 7) Aimed to reduce mental health disparities
- 8) Promote total health integration

The committee is made up of a chair-person, vice chair-person, and members. Currently, the committee consists of the following members.

## Continuous System Improvement

| Name                    |
|-------------------------|
| Patricia Bennett Chair  |
| Susan Wilson Vice-Chair |
| Adrienne Cedro-Hament   |
| Amy Eargle              |
| Lorraine Flores         |
| Karen Hart              |
| Celeste Hunter          |
| Carmen Lee              |
| Monica Nepomuceno       |
| Jeff Riel               |
| Walter Shwe             |
| Bill Wilson             |

INFORMATION

TAB SECTION:           A

  X   ACTION REQUIRED:

DATE OF MEETING: 01/16/14

Approve minutes from the October 2013 Meeting

DATE MATERIAL

PREPARED BY: Dorman

PREPARED: 12/13/13

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AGENDA ITEM: Approval of the Minutes of the October 2013 Meeting

ENCLOSURES:     •   October CSI 2013 Minutes

OTHER MATERIAL RELATED TO ITEM:

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ISSUE:



## **Continuous System Improvement Committee**

Meeting Highlights

October 16, 2013

Red Lion Woodlake

500 Leisure Lane, Sacramento, CA 95815

1:30 p.m. to 5:00 p.m.

### **Committee Members Present**

Patricia Bennett, PhD, Chairperson

Susan Wilson

Celeste Hunter

Patricia Santillanes

Monica Nepomuceno

Walter Shwe

Lorraine Flores

Bill Wilson

Adrienne Cedro-Hament

Karen Hart

Amy Eargle

### **Staff**

Linda Dickerson, PhD

Michael Gardner

Jane Adcock, EO

Laura Leonelli

### **Others Present**

Renay Bradley, PhD, MHSOAC

Beryl Nielson, Napa RiHB, CALMHBC

Michael Reiter, APS-CAEQRO

Karyn Bates, Ventura County MHB

Debra Allen, Kings Co., CALMHBC

May Farr, SBBHC, CALMHBC

Patricia Bennett, Chairperson, welcomed members. Committee members and guests introduced themselves. New CSI Committee staff, L. Leonelli, introduced herself and her background.

### **Review and Approve Minutes: June 16, 2013**

#### **Presentation: MHSOAC Evaluation Activities**

Dr. Renay Bradley presented a Powerpoint summary of the recent evaluation studies and the Master Plan developed by the OAC over the past year. A copy of the presentation slides was distributed. The purpose of the presentation was to inform CSI members about what evaluation projects the OAC is working on; how the OAC is implementing the Evaluation Master Plan; and how the evaluation results will be used to promote system improvement.

Performance monitoring is conducted both externally and internally. External monitoring is ongoing through several OAC evaluation contracts which include studies of existing County data collection and reporting systems (DCR, CSI, MHSA components). The UCLA contract includes an evaluation work group which is studying how to refine or improve the methods of calculating the 12 priority indicators. Their report is due in March, 2014 at which point UCLA will hand over monitoring to OAC staff. Internal monitoring includes developing a process for adding indicators, which can be incorporated from other work groups. OAC requests CMHPC collaboration with this.

Comments:

- How can data inconsistencies among Counties be corrected? *Answer:* The difficulty in systems that we already have is that the technology is very old, legacy systems that can't be easily amended. We can build new systems; whoever is doing this should look outside of our state to find existing solutions.
- Much MH policy has been developed using old data. We should know what happened last year, we should go forward from there. Priorities from 5 years ago may have changed.
- Current system needs to be preserved to maintain claims, billing, etc. State is notorious for investing in unworkable IT systems.
- We should not be hopeless; we should be encouraged by the example of several local communities who are working on ways to share data among different systems: schools, counties, etc. Some counties are able to generate their own data reports to inform their local policies.
- We need more momentum at the State level to pull all the county data reports together.
- How are we going to share the data, with whom, in what format so that it's timely, understandable, meaningful and can be used to impact policy?
- State should require a small number of things that all counties report in the same way. Among individual providers there should be some flexibility
- Standardized measures lead to comparisons between counties and they are not happy about that – however, those doing well should be able to teach others how to be successful. Unfortunately, counties are afraid that data will be used punitively and there will be some financial consequence to getting a negative performance report.

**Work Plan Review and Evaluation framework:**

Handout was reviewed by members.

Chair P. Bennett: Hold off on review for now, we are scheduled to make a presentation to the full Council tomorrow, we should discuss this first. State audit report found that the PC was out of compliance with its mandates, as well as the OAC and DMH. Chair P. Bennett reported that yesterday there was a meeting between EO Adcock and representatives of OAC and DHCS, to discuss collaboration in sharing and evaluation of data. We need to come up with an evaluation plan, something that maps our mandates and what we as a Council should do to address that. Some on the CSI Committee have been working the past few months on a framework (handout). On second page there is a plan for an evaluation work group, to identify process, data sources, and timelines. We should be following a standard set of indicators that are already agreed and established. Domains are: Education/Employment, Homelessness/Housing, Justice Involvement, Family/Youth/Client perception of wellbeing, and New clients (increased access). We should present the plan to the full Council and get approval, at tomorrow's meeting.

Regarding the Work Plan, what does the CSI committee do, or has done? There is a need to partner with other groups due to the lack of resources. The work plan includes working with the Mental Health Boards locally, through the Data Notebook. We hope to release a final report with findings and recommendations. Also the oversight mandates include holding more public meetings, conducting on-site visits, and surveying counties on specific topics, which we have done. We have done some review/comment on reports by other entities. However, according to the Audit report this has not been enough.

- Questions: A. Cedro-Hament asked who was at the meeting yesterday? *Answer:* high-level DHCS staff, the Planning Council Chair, Gail Nickerson and the EO, with Renay B. and Richard Van Horn of OAC. Will these be ongoing meetings? Yes. The attendees will report at the Executive Committee meeting and to the full Council.
- L. Dickerson noted that the CSI committee could do short, focused topical reports on specific issues of stakeholder and policy maker interest; [Senator Steinberg's consultant] Diane Van Maren uses our reports and they are useful for informing the public. CSI committee can make the OAC and other evaluation reports more understandable for our members and MH Boards.
- L. Dickerson and EO J. Adcock went to meet with Bay area Mental Health boards in mid-September, to introduce the Data Notebook. MHB members had concerns about the lack of data about institutionalization, conservatorship, excessive medications use. What are the data sources regarding state hospitals? OSHPD? We need to seek out not just those concerned with Medi-Cal funded services. Often the data for involuntary confinement are not stored or sorted at the County where the patient lives, only by hospital location.
- Members were handed the new draft work plan in a separate packet today; some said it was not enough time to review this new version. Chair P. Bennett asked what would it take to accomplish this plan, within the current resources and time frame? She had asked to include the kind of thinking we had done about goals and assumptions, but this is definitely a draft and a work in progress.
- Comments: A. Cedro-Hament said these are wonderful tasks, if we could realize them it would give the Council some 'teeth' in implementing our mandates, and create more visibility and accountability for the PC. Our reports should be more widely distributed. Will the plan require more meetings? More conference calls? How effective are the conference calls? Chair P. Bennett reminded the committee of the limited staff capacity and resources – how can we get more? Have we ever asked for more?
- S. Wilson said we could use more of the volunteer time on the Committee, as well as staff, that there are resources in the group, talents that can be leveraged. Chair P. Bennett said that the small groups meet often, the whole group needs to work together more. There is a lot of trust in the subcommittees to do the work that needs to be done.
- Ideas for the San Diego meeting, CSI will present to the whole Council: Trauma-Informed care (ACES – Adverse Childhood Experiences) – Susan Wilson has a presentation. AB 114 / 3632 Transfer, should we have a panel from school districts and other stakeholders in San Diego? Celeste can assist with finding presenters. Interest in both these topics: Subcommittee formed of Lorraine Flores, Susan Wilson, Celeste Hunter and Monica Nepomuceno. L. Flores agreed to chair. Staff will need to coordinate tasks.

**Discussion: MHSOAC Master Plan:**

Chair P. Bennett stated that there had been a plan to do section review; 2 monthly phone calls occurred, but not much Committee participation. Walter Shwe participated on both calls. It was concluded that the Master Plan is done. There is not much opportunity for input at this point. CSI should report out that the Master Plan was reviewed, and that the Committee hopes to continue the dialogue with OAC as new evaluation projects are developed.

### **Update on the Data Notebook:**

S. Wilson reported that the anticipated time frame for completion will not be met, it will take until the end of this year and will be implemented next year. The premise is to present a framework to the Mental Health Boards and ask them questions; they can insert their own data or will be directed to sources to find the data. The first Module concerns access. The format is shorter, simpler and educational. Different counties have varied needs due to population, sophistication, services available. The goal is to complete the draft, will need more input and participation in phone calls.

- Comment: there are several ongoing conference call schedules, this is confusing. (eg, CSI calls on 4<sup>th</sup> Friday, Data Notebook calls on Thursday, Evaluation committee meets 3<sup>rd</sup> Friday) Staff should identify the call in the subject line of the email. Former CSI staff had calls calendared, new staff should send updated schedule to members. Phone meeting notices should be sent out 2 weeks in advance.
- Chair P. Bennett asked if the draft Notebook will be available to all for review? S. Wilson answered yes, members should check for clarity, ask how easily this could be used in your county.
- L. Dickerson requested feedback on the language, how technical it is or how to achieve more user clarity. She has completed the introduction and most of Module 1. Module 2 is in development. She is waiting for data to be analyzed. CiMH is analyzing the Consumer Participation Survey (should be completed by December). She will send out a re-formatted draft 1 – 2 weeks before the next Data Notebook call.
- S. Wilson asked about process: should the Committee approve the Data Notebook? Is it necessary to take a vote? Chair P. Bennett answered that the Subcommittee should review and send recommendations to the CSI Committee, which will present to the full Council.

### **Evaluate Meeting / Develop Agenda for Next Meeting:**

Quarterly Meeting in San Diego – the Notebook is a priority (draft will be finished by January). We need a subcommittee to plan an agenda and arrange for presenters on the topic of ACEs - Trauma Informed care. Also to plan a panel on how schools are coping / handling the changes of the AB 114 / AB 3632 Transition. There are different experiences for parents, schools, contractors. Include SELPAS, invite representatives from contrasting counties.

Members reported that the meeting was informative, and “hopeful”. The audit report will give momentum to the work and problems will be addressed. Members liked having R. Bradley presentation, there were good handouts. Others said they are supportive of the collaboration between OAC and CMHPC. One member expressed interest in a subcommittee for Spirituality.

Michael Gardner reminded members of the pre- and post-meeting conference calls, they are an opportunity to ask questions, review notes, etc. He will send an e-mail 7 – 10 days prior to call; members approve of this idea.



**Continuous System Improvement Committee**  
**CSI CC Meeting Highlights**  
**November 22, 2013**  
**9 a.m. to 10 a.m.**

**Members Present**

**Pat Bennett, Chairperson**  
**Susan Wilson, Vice-Chairperson**  
**Walter Shwe**  
**Celeste Hunter**  
**Pat Santillanes**  
**Carmen Lee**  
**Lorraine Flores**  
**Bill Wilson**  
**Jeff Riel**

**Staff**

**Laura Leonelli**  
**Linda Dickerson, PhD**  
**Jane Adcock, Executive Officer**  
**Tamara Jones, Manager**

**Discussion: January Quarterly Meeting agenda**

- Time Frame: we will have from 1:30 – 5 pm on Wednesday for the CSI Committee meeting, and again on Thursday for the Presentation to the full Council, 3.5 hrs each day. The Committee meeting agenda will include an update on the Data Notebook and a panel discussion on AB 114 as it has been implemented in San Diego and Riverside counties. The CSI Committee presentation to the General Session will include a presentation on Trauma-Informed Care.

**Discussion: Data Notebook progress update**

- Vice-Chair Susan Wilson and Linda Dickerson reported to the Committee about their recent meeting and changes made to the format of the Data Notebook, based on the desired outcomes of having the Notebook be more useful to the Mental Health Boards and easier for them to prepare. They have proposed separating the guidance and the questions to MHB into two separate sections. Members agreed that sounded like a good approach. Chair Pat Bennett thanked the Data Notebook committee for all their work on this document, especially S. Wilson for her leadership.
- It was suggested that the report on the Data Notebook would be presented to the full Council on Friday morning, when members of the CALMHBC will be attending. Members agreed that this would be a good plan, the report will take about 45 minutes. Protocol question – are we seeking Council approval for the Notebook at this session? Answer: No, we are just providing an update on what the Committee has produced so far. (Goal #1 on the CSI Committee Work Plan).

**Discussion: ACEs Presentation to Council General Session**

- S. Wilson would like to do a presentation that will include audience participation via ‘clickers’. Members think this is a good idea, the format would be engaging. The equipment is expensive and there will be only 50, so audience members would not be able to participate. How long would this take? S. Wilson says she can be flexible as

needed. Members agreed to give her one hour for the presentation, leaving 2.5 hours for other presenters.

- Including a 15 minute break, and ½ hr for questions, this would leave about 20 minutes each for 4 presenters. Committee members would like to review materials and power point presentations beforehand.
- L. Leonelli has received recommendations for service providers at Rady Children's Hospital and United Pan-Asian Community (UPAC). Chair P. Bennett asked if these agencies are connected to the County Mental Health system at all, the Council is concerned mainly with oversight of the public MH system. Celeste Hunter verified that these agencies receive MHSA funds through the County and will send L. Leonelli the contact information for the County Trauma Care Team.
- EO Jane Adcock asked about the focus of this presentation, and what the Committee wants to do with the information? Chair P. Bennett responded that this is a relevant topic that is being emphasized at the Federal level. This is a concept that is transforming mental health service delivery and impacts the child welfare system, the juvenile justice system, treatment of substance abuse and domestic violence. There are policy implications at both the Federal and State levels.
- It was mentioned that Goal #2 of the CSI Work Plan includes identifying best practices and making recommendations for treatment of childhood trauma. Chair P. Bennett requested an issue report parallel to the one prepared for AB 109. EO J. Adcock suggested that the Council could highlight emerging programs around the state that are employing best practices in trauma-informed care, and compile into a report that we could share with diverse stakeholders. The Planning Council can also make recommendations to the OAC and CMHDA based on these findings. Chair P. Bennett and other Members agreed.

### **Discussion: AB 114 presentation to CSI Committee**

- EO J. Adcock mentioned that both the full Council and the CSI Committee have heard presentations from the CA Dept. of Education; at this meeting we should hear input from family members as well as school district personnel. She suggested that this topic be covered again in Irvine at the April meeting, to hear from diverse areas around the State. After hearing different perspectives, staff can compile recommendations that can be reported by Summer, 2014. Members agreed that this would be useful and meaningful. (Goal #3 of the CSI Work Plan.)
- Monica Nepomuceno has volunteered to contact her friend Ms. Mara Madrigal-Weiss from the San Diego County Office of Education. L. Leonelli has received referrals of Dr. Cheryl Rode, Clinical Director of the San Diego Center for Children, and Donna Marto, CEO of the Family and Youth Roundtable, who would be able to contact family members of children receiving services. Riverside County SELPA was also contacted, and their Mental Health Case Manager, Dr. Tasha Arneson, would be able to attend.
- Questions on this topic have already been suggested by Committee members. Staff will finalize questions to ask these presenters. We will have about 2 hours for this panel discussion at the Committee meeting.

### **Information Item: MHSOAC conference calls on Performance Indicators**

- Chair P. Bennett asked about this, what are the details? L. Dickerson responded that the OAC is working on changing the calculations, and the definitions, of performance indicators used to evaluate effectiveness of mental health services. The calls will be held on two Mondays in December, we don't have the call-in information as yet. We will forward this information to all Council members when we receive it. Will the OAC seek Council approval after they draft these measures? Yes, they are required to do so.
- EO J. Adcock stated that it would be important to have staff listen in on these calls, but that it is also important for Council members to participate in this process. Chair P. Bennett remarked that anyone who calls in is representing themselves and not the Council.

### **Next Steps and Future Agenda Items:**

- Next In-Between meeting/conference call is scheduled for the 4<sup>th</sup> Friday in December, which is right after Christmas. It was decided that this call should be cancelled. Staff will inform Members.
- Warmest Holiday Wishes!



## Data Notebook Workgroup Meeting Notes

October 10, 2013  
9 A.M to 10:00 A.M.

### **Members Present:**

Susan Wilson, Chair  
Karen Hart  
John Pearson  
Monica Nepomuceno  
Beryl Nielson

### **Staff Present:**

Jane Adcock, EO  
Linda Dickerson, PhD  
Laura Leonelli

### **Others Present:**

Michael Reiter, APS Healthcare CAEQRO

### **Links to reports discussed:**

**Monterey County MH Report:** (Excellent linkage of figures/graphs to clear, simple questions, designed for general public understanding, as well as for policy makers).

[http://www.mtyhd.org/QI/images/stories/QI\\_Doc\\_2/08012013FInalDraft.pdf](http://www.mtyhd.org/QI/images/stories/QI_Doc_2/08012013FInalDraft.pdf)

### **Humboldt Trends Report: Integrated Progress & Trends Report, June 2012**

<http://www.caeqro.com/webx/.ce85417/>

**Napa County Report:** (The Community Health report below contains a section on behavioral health).

[Napa County Comprehensive Community Health Assessment \(145 pages\)](#)

### **San Mateo County Report:**

(A different style, relies on Excel Workbook spreadsheets, click on the individual county name)

<http://www.caeqro.com/webx/Examples%20and%20Materials/Dashboard%20Reports/>

### **CAEQRO Webinar October 29, 2013:**

**Race/Ethnicity and Other Demographic Disparities Observed in Medi-Cal Mental Health Data**

Please see front page at [www.caeqro.com](http://www.caeqro.com) and click on the “flyer” for specifics.

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Chair Wilson welcomed all to the meeting.

### **Review and Approve Minutes from Prior Meeting**

Notes from last meeting on August 8<sup>th</sup> were approved (moved – BN, seconded – MN, passed)

### **Discussion of Data Notebook:**

- Susan Wilson: Tehama County is used just as an example for Notebook development and editing. In the final product, there will be separate Notebooks prepared for each county. This project addresses the Planning Council mandates, and the ability of a County to comply with reporting requirements though their needs and abilities are different. It has been a difficult task.

## General comments –

- Beryl Nielson: Linda has done a great job. Monica Nepomuceno agrees, the introduction is helpful.
- Karen Hart: Counties are disparate in size, and there is much turnover in Mental Health Board membership.
- Linda Dickerson will try to streamline text while retaining the precision needed. Questions in the topic headings can be confused with the actual questions that MHBs are being asked to answer. The model for this format is the Monterey County IQ 2012 report (see link above). LD will forward to CALMHB. She would like feedback from the MHB members on the text and content of the Notebook.
- Mike Reiter announced the EQRO webinar on MH Disparities on 10/29, there is limited attendance capacity due to cost.
- LD – Not all of the Modules in the Table of Contents will necessarily be completed, due to length and complexity involved. We do not want the process to be too burdensome for MHBs.
- Let us start our discussion with Module 1. Access is most important of parameters – timeliness of first encounter, appointment. Different Counties measure this in different ways. Is there another more accurate way to measure this? When writing the summary report of the MHB reports, LD can group data by different measures used by different counties. Data can still be meaningful and the discussion may lead to a more standardized definition in the future.
- John Pearson: How does it affect the timeliness measure when clients don't show for follow-up appts? What practical methods can be used to reduce no-shows?
- SW: This is also an issue for medical appointments. Counties should be able to define the measures most meaningful to them. They will then be more involved in the process.
- LD: New clients are also defined differently by county. Some use 6 month time lapse, others 12 months, others may use a different basis.
- MR: Some counties measure by program enrollment.
- SW: If new clients are measured after coming back after a certain number of months, is this measure also used for children?
- MR: There is no standard definition as yet. That is one reason why this Notebook is a good project – it will bring awareness and discussion to these questions.
- Monica Nepomuceno: Is the goal to streamline definitions?
- MR: Perhaps standardized definitions are not the best use of resources.
- LD: The Notebook report by the Planning Council can break out, or group data, by similar Counties' measures and the result can still be useful.
- SW: It will be good to know the range of definitions being used.
- KH: There has been no state-level leadership on this issue. Data sources have been inadequate in the past, and there was not enough training.
- LD: Access to outpatient services is related to hospitalizations. One statewide EQRO project was to evaluate the most effective ways to prevent re-hospitalization. One strategy is to schedule meds support within the first 7 days after discharge.
- JP: Mental Health clients who are in jail need a post-release process to get them back into outpatient services. It would be good to have data on this, to support the policy.
- MR: Humboldt County does a meds reconciliation, regarding what was given before and during hospitalization, to prepare patients for discharge with correct medications. (see link above)
- SW: What other issues do members want to address at this meeting?

- LD: Penetration rates measure fairness of access. Pie charts compare County and Statewide data for general population, children, foster care, and transition age youth. Trends over time can measure penetration rates. These can go up or down independent of total numbers of eligible people. In the past (Workbook 2010) the rates were based on Holzer's estimate of need, weighted by economic and social factors, using national surveys.
- BN: What are barriers to access in each county? Can we use this in the discussion?
- LD: Each county should assess this for its own situation. Discussion of barriers should be moved to the same section of Notebook as penetration rates.  
Retention rates measure client engagement in services. MHBs want to know what kinds of services people receive. Tables are in EQRO Appendix D, p. 19.
- SW: There are 10 minutes remaining, is there any particular section that members want to review?
- LD: The section on Integrated Healthcare starts on p. 32. We ask open-ended questions about how Counties are trying to improve the physical wellness of mental health consumers. Counties report various activities as measures of health/dental health improvement.
- SW: This topic is interesting and compelling. It draws counties into the discussion.
- LD: The example is taken from Tehama County. Should the Optional question set on p. 35 be eliminated?  
Another important issue is the co-occurrence of Substance Use Disorders. Some Counties measure this. Many other counties don't have effective means of measurement or tracking. They use estimates from service provider information. LD tried to find estimates from other sources, but there is inconsistent data reported from different sources. Most counties rely on self-reporting.
- BN: This is a good issue for MHBs to discuss.
- SW: This is an important issue. Many local Mental Health departments and boards are being combined with Alcohol/Drug boards.
- BN: CALMHB are doing a survey for feedback about this. It happens mainly for financial reasons. It seems better for the stakeholder process to have more involvement.
- SW: The Data Notebook will be reviewed at the CSI committee meeting next week. Please review the document and provide more thoughts and input.
- LD would like written comments via email. They are very helpful.

No public comment.

Meeting adjourned at 10:00 am



## **Data Notebook Workgroup Meeting Notes**

December 12, 2013  
9 A.M to 10:30 A.M.

### **Members Present:**

Susan Wilson, Chair  
Karen Hart  
John Pearson  
Monica Nepomuceno  
Beryl Nielson  
Cary Martin  
Lorraine Flores  
Herman DeBose, PhD

### **Staff Present:**

Tamara Jones  
Linda Dickerson, PhD  
Laura Leonelli

Chair Wilson welcomed all to the meeting.

### **Review and Approve Minutes from Prior Meeting**

Notes from last meeting on October 10<sup>th</sup> were approved as written.

### **Discussion of Data Notebook:**

(Note: there was no discussion on the agenda item for Guide and Overview.)

Chair Wilson opened the discussion by emphasizing that there was still much modification needed to the draft of the Data Notebook document that Linda Dickerson had sent out the previous day. Some questions should be eliminated, some should be re-phrased, and the format should be re-organized. She led the members through a question-by-question review. It was agreed that not all suggestions made would be included in the final draft, although everyone's comments would be heard and recognized.

There was a discussion of what County-specific data should be included. As part of the Overview, LD intends to include a page of demographic questions at the beginning of the notebook. It was emphasized that the statistical information requested be simple and relevant to the discussion questions. Counties should have ready access to most of the data required. What is the time frame for Counties to supply this information? It was decided that 60 days was sufficient time, representing 2 monthly meetings of the Mental Health Boards/Commissions.

A discussion followed about the capacity of MHBs, who are by statute composed of 50% consumers and family members, and who are all volunteers, to research the data needed for the Notebook. It is anticipated that some of the data questions will be answered by County staff, and it is not the intention of this exercise to have County staff complete the Notebook. Questions are meant as discussion items to bring awareness to the MHB members about topics that they should know to better represent their constituents. It was recommended that the data items (statistics, charts, graphs) be presented first for each question, then have follow up questions for the MHB members to answer. This would ensure MHB input, and would emphasize the importance of their role.

SW does not think that LD should provide all the EQRO data for each County on the Notebook. She thinks that MHB as consumer representatives should build relationships with their County staff. The Notebook should be clear about what data is requested and where to find it, and MHB members should be responsible for obtaining it. Other members thought that this would be too time consuming for volunteer members, and that LD should provide the statistics just to ensure consistency, in case Counties measure data differently.

Starting with the first question, it was suggested that before discussing the strengths of the County programs the MHB should list what the existing programs are. After a review of all the questions, and discussion about the most important elements to include, meeting participants agreed on this outline:

Major Theme/Topic Areas for Data Notebook Question Items:

- Overview: Behavioral Health in your County  
What are the existing MH programs? Strengths? Examples of successful programs?  
Do any of these programs focus on underserved or special needs groups?  
Suggestion: choose 3—5 programs to discuss, perhaps broken down by primary targeted age group.  
MHB/C members: suggestions regarding unmet needs or improvements in services?
- Integrated Health Care: Treating the Whole Person  
Coordinating MH and Substance Use Treatment for Dual Diagnoses Clients  
How many (or what percent of) clients need services in both systems? How is this determined? How are they provided linkages to needed services?  
What MH/SUD Services or Programs exist in your county? Describe any gaps/unmet needs?  
Linking clients to Primary Health Care: client #s or per cent, if available, and how measured; describe processes/programs to link MH clients to primary care  
Wellness Programs: MH client activities or skills to maintain health
- Access to Services  
How many new MH clients? (and how is this defined?) New clients by age group: Seniors, Adults, Children<18, TAY (16-25). [Note: put data first, then the related questions or discussions].  
Wait time to first appointment for services: how defined and measured?  
MH program steps to manage resources and improve timely access to care?  
Is there timely access to follow-up services ( $\leq 7$  days,  $\leq 30$  days) following a MH hospitalization? How does that relate to percentages of clients who are re-hospitalized ( $\leq 7$  days,  $\leq 30$  days) following hospital discharge?  
What strategies used by county MH programs to link clients to services following either a MH hospitalization or a post-crisis stabilization episode?
- What are major barriers for access to care in your county? Choose 3 – 5 examples of the most significant for clients in your community.

- Potential Disparities in Access to Services by Race/Ethnicity
  - Overview of pie chart data: local data by race/ethnicity
  - Focus area: Hispanic groups
  - General question on role of language and culture in MH services
  - Any suggestions to improve client engagement in continuing MH services
  
- Potential disparities in service by age (or special needs) group: Include Access issues, target group-specific programs, and critical needs
  - Older Adult MH clients
  - Children’s MH
  - Foster Children MH services, retention rates
  - TAY MH clients services, retention rates

Relevant to the county statistics pages, subsequent discussion later in the meeting considered requesting basic data about total numbers of MH hospital admissions, regardless of type of facility; possibly, moving the request for summary data about “New MH Clients” to these County Statistics pages; and maybe including homelessness estimates, but only if discussed in the body of the Data Notebook. Final form and content of county statistics pages will be reviewed and decided later.

LD stated that she will make these revisions and will send out the document as soon as possible for further review. The Data Notebook update is on the agenda for the Continuous System Improvement Committee meeting at the Planning Council Meeting in San Diego on January 15<sup>th</sup> (1:30 – 5 pm). Workgroup members requested phone access for the meeting, since some can’t attend in person. Staff agree, and assure group that this will be provided.

**Public Comment:**

Dr. DeBose mentioned that he heard a radio report that California would be awarded \$100 million for mental health and substance abuse programs. He asked if anyone had more information about that. He asked if there is any County formula for allocating funds, and is concerned that stakeholders should have some input into how the funds are spent locally. Staff may have received an announcement of the Federal funding through email, and will forward any news to workgroup members.



**X** INFORMATION

**TAB SECTION: A**

**\_\_\_ ACTION REQUIRED:** None

**DATE OF MEETING: 1/15/14**

**PREPARED BY:** Leonelli

**DATE MATERIAL  
PREPARED: 12/13/13**

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**AGENDA ITEM:** Data Notebook Review and Update

**ENCLOSURES:**

- Revised Data Notebook Questions for Mental Health Boards/Commissions (Will be distributed at the meeting)

**OTHER MATERIAL RELATED TO ITEM:** None

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**ISSUE:**

The Planning Council is assisting County Mental Health Boards and Commissions to engage in oversight and accountability for their local Mental Health Plans by providing this tool. The Data Notebook is intended to help CALMHB/C members identify and compile useful and relevant information for the specific community mental health needs in their county. The version of the Data Notebook enclosed here has been updated and revised since the last Continuous System Improvement Committee review in October. Committee members can review and submit suggestions for further improvement. This document is one of the deliverables under the CSI Work Plan.



# TEHAMA COUNTY: DATA NOTEBOOK 2013

## FOR CALIFORNIA

### MENTAL HEALTH BOARDS AND COMMISSIONS



*Prepared by California Mental Health Planning Council, in collaboration with:  
California Association of Mental Health Boards/Commissions, and APS Healthcare/EQRO*

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## **Overview: First, Tell us about Behavioral Health in Your Community**

### 1. What are the MH programs in your county?

- a. Please provide some examples of successful MH programs in your county that seem to make a difference in people's lives. Suggestion: choose three to five examples, and list age groups targeted. (Feel free to select programs regardless of funding sources: i.e., MHSA, public—private partnerships, schools, FQHCs,<sup>1</sup> and county MH programs, etc).
- b. Do any of these programs include the use of Wellness and Recovery Perspectives<sup>2</sup> ?
- c. Do any programs focus on underserved, minorities, or special needs populations? (Suggestion: choose three to five examples most relevant to your community). Examples could include any of the following:

|                          |                                       |
|--------------------------|---------------------------------------|
| racial/ethnic minorities | pregnant women                        |
| children                 | elderly                               |
| TAY                      | disabled                              |
| LGBT/Q                   | homeless                              |
| foster youth             | dual diagnosis (MH and substance use) |
| tribal youth             | jail inmates                          |
| veterans                 | recently released offenders           |

[Leave space for text by MHB members].

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<sup>1</sup> FQHCs = Federally Qualified Health Centers

<sup>2</sup> Examples can be found in the CiMH Final Report, June 2013, for those counties participating in: "Advancing Recovery Practices: A Breakthrough Series Collaborative." Similar programs may be offered soon in other counties. Please check with your local MH/BH director for more information.

2. With respect to delivery of MH services, do you have suggestions regarding any of the following:

- a. specific unmet needs (or gaps in services),
- b. new programs,
- c. improvements to, or better coordination of, existing services,
- d. improvements in access or outreach, or
- e. access to MH services in other language(s) ?

[Leave space for text by MHB members].

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### **Coordinating MH and Substance Use Treatment for Dual Diagnosis Clients:**

3. To what extent is substance use among MH clients an issue in your county?  
How does your county MH program measure the number of MH clients which also have a substance use problem?
  - a. If so, what percent are believed to have dual diagnoses for both MH and substance use (alcohol or drugs)?
  - b. How do your MH programs (and/or substance abuse programs) address this issue? What steps does your county take to connect MH clients with any needed substance use treatment?
  - c. What programs for substance use treatment are you aware of in your local community? Which programs have a reputation for good success in helping people to recover?
  - d. In your opinion, what factors do you think lead to successful recovery from substance use problems?

[Leave space for text by MHB members].

## **Treating the Whole Person: Integrating Behavioral and Physical Health Care**

“Individuals living with serious mental illness (SMI) die, on average, 25 years earlier than the general population.... This is a serious public health crisis for state mental health agencies.”<sup>3</sup>

Improving the physical health of clients with serious mental illness (SMI) is a national goal. The goal is better coordination of care for mental health, substance use treatment, and physical health. One helpful example for small counties can be found in the Performance Improvement Project of Tehama County,<sup>4</sup> as part of a Learning Collaborative sponsored by CiMH.<sup>5</sup>

To answer this question, you may need to seek information from your county Quality Improvement (QI) coordinator or MH director.

4. Does your county measure how many clients have seen a primary care physician or nurse practitioner in last year?
  - a. If available, please provide data (numbers, percent of total MH clients).
  - b. Describe MH program efforts to link clients to physical health care providers.

[Leave space for text from MHB members]

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<sup>3</sup> National Association of State Mental Health Directors, 2006. Cited in: “SCCI Final Report: Small Counties Care Integration”. June 2013, CiMH. This report describes the results of a Collaborative Learning Initiative in which 14 small counties participated.

<sup>4</sup> For details, see page 27, and pp. 77-80 (Appendix F), of the 2012-13 EQRO report for the Tehama County MHP, at [www.caeqro.com](http://www.caeqro.com).

<sup>5</sup> Other counties have recently participated in similar “Care Integration Collaboratives” sponsored by CiMH (for examples, see CIC Final Report, June 2013, CiMH). Please check with your local county for information about recent, or planned future, participation in care integration learning projects.

5. How does your county address wellness programs to engage and motivate MH clients to take charge of improving their physical health?

Examples of wellness programs could include classes or activities for:

- exercise
- nutrition
- healthy cooking
- stress management
- quitting smoking
- maintaining social connectedness
- managing chronic diseases (such as diabetes or high blood pressure).

[Leave space for text by MHB members]

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## System Performance Indicators

### Access: New Clients

Most counties choose to define new clients as those not seen within the prior 6 months, but some may choose to count those not seen in the prior 12 months.

This data should be available from your local QI Coordinator or MH Director. These data refer to any MH clients within the CSI/DCR<sup>6</sup> or other local MH data systems.

6. How many children and adult clients are “new” clients? That is, those who have not received MH services within the prior 6 months? What do these numbers and the way they are defined tell you about your MH program?

New Adult Clients (age 18 and older), Number: \_\_\_\_

% of All Adult Clients: \_\_\_\_

Time frame (months) for definition of New Adult Client: \_\_\_\_

New Clients, Children & Youth, (aged 0-17), Number: \_\_\_\_

% of All Child & Youth Clients: \_\_\_\_

Time frame (months) for definition of New Client: \_\_\_\_

New Clients, Transition Age Youth (TAY)<sup>7</sup>, (aged 16-25), Number: \_\_\_\_

% of All Child & Youth Clients: \_\_\_\_

Time frame (months) for definition of New Client: \_\_\_\_

[Leave space for text from MHB members]

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<sup>6</sup> CSI and DCR refer to the DHCS data systems (formerly DMH) for all MH clients reported by the counties to the state. CSI = Client Services Information. DCR = Data Collection and Reporting system for Full Service Partnership (FSP) client outcomes.

<sup>7</sup> TAY clients represent a subset of children (ages 16-17) combined with a subset of adults (aged 18-25).

**Access: Wait time for appointments**

Wait time for appointments may be one of the most critical issues for individuals or families with a member who experiences a mental health crisis.

Please examine the Timeliness data and discussion in the section of your county EQRO report labeled “Access.”<sup>8</sup> That section will provide some of the data requested below.

7. How does your county set goals and monitor wait time to appointments? What are those goals? How often are the goals met? What are the average wait times? Do they monitor and report these values separately for children’s services? Please report your numbers in the formatted table below and then discuss.

| Type of Appointment  | Goal (days) | % Goal Achieved | Average Time (days) |
|----------------------|-------------|-----------------|---------------------|
| New Patient, Adult   | ___         | ___             | ___                 |
| New Patient, Child   | ___         | ___             | ___                 |
| Urgent Care/Crisis   | ___         | ___             | ___                 |
| Post-Hospitalization | ___         | ___             | ___                 |

Source: Your County’s MH Plan Data on Access

[Leave space for text from MHB members, to discuss above data and issues.]

8. What type of service does your county define as the “first appointment” provided after the initial request for mental health services?

[Leave space for text from MHB members]

<sup>8</sup> Note that the “Access to Appointment” data is **not** audited by the EQRO. This section of the report only conveys what the county MHP reports to the EQRO. However, for the year 2013-14 review, the EQRO will begin to ask the county MHPs to provide the data they used to determine their timeliness measures.

9. What is your opinion about the best way to define measures of “time-to-first-appointment?”

- Should timeliness be a measure of the time from first contact with the MHP (via phone or in person) to the first treatment/assessment visit?
- Should the first visit be counted if it's just filling out financial forms?
- Should “orientation” group attendance be counted as the first visit?
- Should the first visit designation only apply to face-to-face encounters with a person licensed to provide MH services (similar to the Medicare definition)?

[Leave space for text from MHB members]

10. What are examples of steps taken by your MH program to improve timely access to care? How have these steps been implemented ?

- Do these steps include efforts to reduce “no-shows” or fill empty time slots?
- For example, if tele-psychiatry hours are available, how many hours are used or actually filled each week?

[Leave space for text from MHB members]

## **Role of Access to Reduce Repeat MH Hospitalizations**

Examine the data figure below showing data for your county compared to the statewide averages. An important measure of access for patients released from the hospital is how soon they have a post-discharge follow-up appointment. Note the relationship, if any, of follow-up appointment wait time (7 days vs 30 days) on the goal to reduce re-hospitalizations within that first month after release.

[Insert EQRO Graph, Fig. 14]

[Leave space for text from MHB members]

11. In your county, consider the effect of post-discharge appointment wait time (7 days vs. 30 days) on the goal to reduce repeat hospitalizations within the first month after discharge.
  - a. What steps does your local MH program take to improve follow-up and continued care for clients after a hospitalization? (For example, what is the “hand-off” process from hospital staff to outpatient staff? Often, that could involve scheduling initial outpatient appointments).
  - b. Do they have similar strategies to help clients who received crisis stabilization or other crisis support services?
  - c. Do you have suggestions on how to improve access to care and follow-up after a MH-related hospitalization or crisis stabilization service?

[Leave space for text from MHB members]

## **Access: Barriers to Service**

12. In your county, what are the most significant barriers to service access experienced by MH clients and their families? Examples of some potential barriers might include:

- Transportation
- Child care
- Language issues or lack of translators
- Specific cultural Issues
- Too few child or adult therapists
- Lack of psychiatrist or tele-psychiatry services
- Delays getting evaluation for prescription
- Lack of means to access internet or e-mail
- Restrictive time window for scheduling appointments.

Suggestion: identify the three examples you believe to be most important to MH clients in your community.

[Leave space for text from MHB members]

## **Health Disparities and Fairness of Access**

In order to address basic questions about fairness of access to healthcare, researchers ask: Are people of all ages and race/ethnicity groups coming in for services, in numbers roughly similar to their proportion of total Medi-Cal clients?<sup>9</sup> To address that question, we examine demographic data for the state and for individual counties.

Statewide data for race/ethnicity: first, compare the percent of population for each group in the top figure (Medi-Cal beneficiaries) to the same group's percent in the next figure (recipients of MH services). Examine which groups receive a greater per cent of services (lower figure) compared to their percentage of the Medi-Cal population (top figure). [Insert 'Pie chart' Graphs from Figures 5a and 5b]

Next, compare the patterns you observed in those statewide data to the figures which follow, showing the data for your county. Examine each of the ethnic/racial demographic groups and compare to those groups who received MH services.

[Insert 'Pie Chart' Graphs from Figures 6a and 6b]

Based on your examination the data for your county, note which groups appear to receive a lower percent of services (bottom figure) compared to their percent of the Medi-Cal population (upper figure).

13. Which groups (if any) appear to be underserved? What outreach efforts are being made to minority groups in your community? What about non-English-speaking persons, homeless individuals, or other hard-to-reach populations?

[Leave space for text from MHB members]

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<sup>9</sup> Penetration Rates

## **Service Penetration Rates: Another Measure of MH Access**

This is just one measure of fairness in access to mental health services. However, penetration rates are one important standard performance indicator used by the state of California and some federal agencies.

The definition of penetration rate used in this Data Notebook is the same as the one used by the EQRO, because it is simple, easy to calculate, and much easier to understand than some other measures.<sup>10</sup> First, note the baseline value, then, look at how that measure changed over time. Such trends help give an indication of whether there is an improvement, over time, in access to services by different groups.

Next, we consider 4-year trends in penetration rate of the overall Med-Cal eligible population (adults + children) for this county.

[Insert Graph here: EQRO Figure 8].

14. How have these trends changed over time? Do you have any comments on what these trends might mean for local MH services? For example, are they increasing the total numbers of clients served over time?

[Leave space for text from MHB members]

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<sup>10</sup> Some MH board/commission members may have come across a different definition of penetration rates based on “Holzer” targets, which involved a complex statistical estimate of mental health needs in different populations. Those estimates included factors for poverty level, age, gender, race/ethnicity, and used census data from 2000, which are sadly outdated. We mention this problem because past reports from DMH, DHCS, and current reports from the MHSOAC use the Holzer estimates for reporting data from 2004 to 2012.

There is no easy or correct way to relate the EQRO penetration rates to the Holzer target numbers. One *could* try using the public health estimate that one-fifth of the population at any time may need mental health services. So, multiplying the EQRO penetration rates by five would give one a “rule of thumb” comparison to reports which use the Holzer targets. But that rule of thumb would not be strictly accurate. For one thing, the mental health needs of the Medi-Cal population are generally greater than those of the larger population

The important thing to remember is: first, choose one consistent measure (or definition). Take note of the baseline value. Then look at how that measure changed over time. Such trends give an indication of whether there is an improvement in access to healthcare services by different groups.

**Disparities in Access to Services by Race or Ethnicity:**

**Focus on Comparison of Hispanic to White Service Penetration Rates**

The following table examines service differences between Hispanic and White clients. The average claims paid per client is one indicator of relative fairness in access to services. The penetration rates shown are another measure of fairness of access to mental health services. Statewide, the approved claims per individual served are now similar for Hispanic and White clients. However, this indicator may be lagging in some counties. The penetration rate ratios are still much lower for Hispanics than for White eligible Medi-Cal recipients. Statewide, these rates for Hispanics are about one-third those for White Medi-Cal recipients. In some counties, these rates may be even lower. Please examine the most recent numbers for rates and ratios for your county (listed under MHP CY11) in the table below. Compare your county numbers to the average statewide numbers.

[Insert part of Figure D-9 here]

MH Plan Data from Tehama County, 2011.

| Figure D-9. Examination of Disparities—Hispanic versus White |  |       |          |        |   |         |                                    |                       |
|--|--|-------|----------|--------|---|---------|------------------------------------|-----------------------|
| Calendar Year  | Number of Beneficiaries Served & Penetration Rate per Year |       |          |        | Approved Claims per Beneficiary Served per Year |         | Ratio of Hispanic versus White for |                       |
|  | Hispanic   |       | White    |        | Hispanic  | White   | PR Ratio                           | Approved Claims Ratio |
|  | # Served   | PR %  | # Served | PR %   |   |         |                                    |                       |
| <b>Statewide CY11</b>  | 158,486  | 3.68% | 155,835  | 10.06% | \$4,706   | \$4,726 | .37                                | 1.00                  |
| <b>MHP CY11</b>  | 173  | 3.12% | 1,396    | 11.50% | \$1,947   | \$3,081 | .27                                | .63                   |

Language and culture can be critical factors to helping people engage in, and to continue, treatment. These may be key factors to help clients to gain initial access to care, especially for clients or parents of children whose primary language is not English. The numbers and cultural backgrounds of underserved populations vary considerably by county. A similar analysis may be done for other race/ethnicity groups by different counties, depending on their population and needs.

For reference, look at the data above, and also look back at the “pie chart” figures for your county shown earlier in this report, to consider other groups as well.

15. After examining the data, what do you think about the roles of language and culture for MH care in your community?

- a. Does your county measure time to access appointments for therapists who speak Spanish or other languages? How well do the medical translators do in assisting with sensitive MH services?
- b. What are specific program or service needs for some of the minority groups in your county (e.g., African-Americans, Asian/Pacific Islanders, Hispanics, or American Indian/Alaskan Natives, others)?

Suggestion: data sources might include local community organizations or churches, published reports, and your local QI coordinator or MH director.

- c. Can you provide suggestions to improve program content and outreach for minority groups in your county?

[Leave space for text from MHB members]

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## **Retention Rates: One Measure of Client Engagement in Services**

Why are these measures important? Research shows that, without sufficient time engaged in services, often few long-lasting improvements in behavioral health are seen.

Also, if the programs do not measure these rates, they could be unaware of how many clients only get one or two services but never come back to get the help they really need. Knowing these numbers helps the county staff figure out that improvements may be needed. But other efforts are required to determine the reasons why some clients receive fewer than 5 services and whether they still have unmet MH needs.

Let us consider how these rates are measured. We examine the total number of clients in each group who received:

- just one service,
- those who received 2, 3 or 4 services,
- those who received 5-15 services (which may be the range for at least “minimally adequate care”), and
- those who received more than 15 services in a year.<sup>11</sup>

For an examination of the total number of services received, see tables/figures listed below. Take note of the numbers of services for your county, the per cent of clients who fell into each group, and then compare to the statewide numbers.

[Insert EQRO Table from Appendix D, Overall Retention Rates]

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<sup>11</sup> Some members may wish to know more detail about the types of services provided. That level of detail is provided on page 2 of [Appendix D](#) for each individual county’s EQRO report. The data tables in Appendix D are highly informative and provide a much more complete picture for evaluation.

Tehama County MHP Medi-Cal Services: Overall Retention Rates CY11<sup>12</sup>

| Number of Services Approved per Beneficiary Served | TEHAMA             |       |              |
|--|--------------------|-------|--------------|
|  | # of beneficiaries | %     | Cumulative % |
| 1 service  | 144                | 8.44  | 8.44         |
| 2 services   | 219                | 12.84 | 21.28        |
| 3 services   | 177                | 10.38 | 31.65        |
| 4 services   | 95                 | 5.57  | 37.22        |
| 5 - 15 services                                    | 568                | 33.29 | 70.52        |
| > 15 services                                      | 503                | 29.48 | 100.00       |

16. What are some steps taken by your MHP to improve client engagement in care? For those clients receiving fewer than five services, what is your county doing to determine if those individuals need further MH care, and to re-engage them in treatment? Do you have suggestions to improve client engagement in continued MH services?

[Leave space for text from MHB members]

<sup>12</sup> Prepared by APS Healthcare/CAEQRO. Source: Short-Doyle/Medi-Cal approved claims as of 12/10/2012. Inpatient Consolidation approved claims as of 03/04/2013. Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services.

## Vulnerable Groups and Potential Disparities in Services by Age

### Older Adults

Next, examine the percent of MH clients in your county who are older adults, aged 60 and over. Consider how these numbers compare with statewide data.

[Insert numbers here from EQRO data tables at website: [www.caeqro.com](http://www.caeqro.com)]

Tehama county: 11.5% of Medi-Cal beneficiaries were adults 60 or older, but they represented only 8% of those who received MH services. The penetration rate for this age group = 6.14%.

That value is about half of the penetration rate of 12.9% for adults aged 18-59.

17. Regarding mental health services for older adults in your county:
  - a. Social isolation and difficulty traveling to appointments are just two examples of barriers to MH care for some older adults. What are other significant barriers to access and engagement in services?
  - b. Are you aware of any programs in your region to meet the MH needs of older adults?
  - c. What do you identify as the most critical behavioral health issues for older adults?

[Leave space for text by MHB members]

## **Children and Youth:**

Examine the data for children and youth. Note the percent of MH clients in your county who are children under 18. Consider how those numbers might compare with data for other counties of similar size, or to statewide numbers.

[Insert numbers here, calculated from EQRO data tables]

Tehama county: 45.4 % of Medi-Cal eligibles were children aged 0-17.

Children (aged 6-17) represented 27.2 % of all those who received MH services (S/D Medi-Cal).

For this group (ages 6-17), the penetration rate was 9.03% for Medi-Cal eligibles accessing MH services.

18. Regarding mental health services for children and youth in your county:

- a. What effects on access to MH services do you predict from the increased numbers of children eligible for Medi-Cal benefits in 2014 and beyond?<sup>13</sup>
- b. Do you have information about programs targeted for children or youth, or to assist parents whose children have MH needs?
- c. If data are available from your county: What percent of your county budget for MH is allocated for children and youth services? What are the major funding sources for these programs?
- d. What do you think are critical areas of unmet mental health needs?

[Leave space for text from MHB members. Answer may involve discussion of information from county QI coordinator or director of MH services, if available].

## **Foster children:**

<sup>13</sup> Some increases are due to transitioning children and families from low-income health plans, changes in certain managed care programs, and Medicaid expansion under the Affordable Care Act.

These represent an especially vulnerable group of children who have had exposure to abuse, neglect, or other trauma (e.g., loss of a parent). Many have significant mental health needs to help them cope with changes in their living arrangements, change in schools, loss of their siblings, friends, pets or other social support systems, and many other factors.

In the figure below, examine the race/ethnicity distribution for Foster Care children who are eligible for Medi-Cal in your county.

[Insert 'Pie chart' Graph, Fig. D-11]

Next, in the graph below, consider the race/ethnicity distribution for Foster Care children who received specialty MH services funded by Medi-Cal. Compare the figure below with the figure above, and examine the relative distributions of services received by race/ethnicity. Please note any apparent differences.

[Insert 'Pie chart' Graph, Fig. D-12]

Next, consider the following figure, and examine the trends for penetration rates for receipt of MH services by foster youth over recent years. Note how these rates have changed over time up to the present.

[Insert Graph: EQRO Fig. 9 Foster Care Penetration Rates]

Next, in the figure below, we consider retention rates for foster children, as one measure of the degree of engagement in MH services.<sup>14</sup> The data are grouped by numbers of services received, and the percentages of foster children who received those services.

[Insert Table from EQRO Appendix D]

Foster Children: Number of MH Services Received, CY11.

| Number of Services Approved per Beneficiary Served | TEHAMA             |       |              |
|--|--------------------|-------|--------------|
|  | # of beneficiaries | %     | Cumulative % |
| 1 service  | 5                  | 4.81  | 4.81         |
| 2 services   | 14                 | 13.46 | 18.27        |
| 3 services   | 7                  | 6.73  | 25.00        |
| 4 services   | 3                  | 2.88  | 27.88        |
| 5 - 15 services                                    | 31                 | 29.81 | 57.69        |
| > 15 services                                      | 44                 | 42.31 | 100.00       |

19. In terms of MH services for foster children and youth, the needs are complex and go far beyond the data shown above for access by race/ethnicity, service penetration rate trends over time, or the total number of services received. For your county, consider the following:

- a. Are there any local barriers to access and engagement in MH services for foster youth or children? (One example might be if the child changes schools or is moved several times to different home placements, making it

<sup>14</sup> For more detail regarding types of services received, locate the EQRO report for your county at [www.caeqro.com](http://www.caeqro.com). At the end of that report, look at Appendix D, to find the data tables for foster children.

- difficult to maintain continuity with one therapist). Are there specific needs with respect to the child's preferred language or culture?
- b. What special MH programs or services exist for foster children or youth? Do any of these programs involve perspectives based on the effects of trauma or other serious life events on child development?
  - c. Do you have recommendations for programs or services for foster children or youth based on critical needs in your local community?
  - d. Optional.<sup>15</sup> Consider discussing some current foster child/youth programs with one of the following groups or local agencies:
    - Department/Board of Education,
    - Department of Social Services (or Child Protective Services),
    - Department of Public Health (or Health & Human Services),
    - Juvenile Justice-related agencies (e.g. family court, probation), or
    - Health care provider (e.g. pediatriacian, pediatric nurse practitioner, or a licensed child therapist or psychiatrist).

[Leave space for text from MHB members]

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<sup>15</sup> This optional question is only for those MHB members who have extra time to invest. However, talking with different agencies with responsibility for child/youth services may provide greater depth to answers for parts (a), (b), and (c). Needs –and therefore programs-- may vary greatly for rural vs. urban counties.

## **Transition Age Youth (TAY) (ages 16-25)**

The needs of youth as they transition into adulthood are multi-faceted in terms of education, work/employment, and their evolving identity and personal relationships. . Some adult programs may have a TAY-focused component. Needs for substance use treatment may be a consideration, as well as linkages to primary health care, or referral to smoking cessation programs, if desired by the individual. Some TAY clients are former foster youth. Some of these youth may lack other community and social supports. In some counties, TAY individuals may be an under-counted (and therefore under-served) component of the homeless population.

[Insert 'Pie chart' Graph, EQRO Fig.D-13] Please examine figure below which shows the race/ethnicity distribution of TAY individuals who were eligible for Medi-Cal services. You may wish to compare this distribution to the "pie charts" earlier in this report regarding the overall race/ethnicity of Med-Cal eligible persons in your county, as there may be some important differences for TAY clients.

[Insert 'Pie chart' Graph, EQRO Fig.D-14] Next, in the figure below, consider the race/ethnicity distribution of TAY clients who received MH services. Compare to the previous figure of Medi-Cal eligible TAY clients. Note any major differences in the race/ethnicity of those TAY actually served compared to Medi-Cal eligible youth.

Next, in the following graph, consider the trends in penetration rates for receipt of MH services by TAY clients over recent years. Note how these rates may have changed up to the present time (or most recent data available).

[Insert Graph, EQRO Fig.10]

Next, in the figure below, we consider retention rates for TAY, as one measure of the degree of engagement in MH services.<sup>16</sup> Because of their unique needs, this age range is one of the more challenging groups to reach and get involved in MH services. The data below are grouped by numbers of services received, and the percentages of TAY who received those services.

Insert EQRO Graph of Table from Appendix D].

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<sup>16</sup> For more detail about types of services, please find your county report at [www.caegro.com](http://www.caegro.com), and look at Appendix D, to find the data tables for MH services provided to TAY clients.

Transition Age Youth (Age 16-25): Number of MH Services Received, CY 2011.

| Number of Services Approved per Beneficiary Served | TEHAMA             |       |              |
|--|--------------------|-------|--------------|
|  | # of beneficiaries | %     | Cumulative % |
| 1 service  | 42                 | 11.93 | 11.93        |
| 2 services   | 57                 | 16.19 | 28.13        |
| 3 services   | 53                 | 15.06 | 43.18        |
| 4 services   | 22                 | 6.25  | 49.43        |
| 5 - 15 services                                    | 100                | 28.41 | 77.84        |
| > 15 services                                      | 78                 | 22.16 | 100.00       |

20. Regarding mental health services for transition-aged youth in your county:

a. Access: Who are the major race/ethnicity groups being served? How have the overall service penetration rates changed over time?

b. What does your MH program do to improve TAY client access to, and continued engagement in care? For example, are there peer counselors or specifically targeted youth programs?

c. Do you have suggestions to improve TAY clients' engagement in continuing MH services?

[Leave space for text from MHB members]

## **Client Outcomes: Are people getting better?**

Due to the recent re-organization of state agencies, there is not much current data for client outcomes and some aspects of mental health programs. Therefore, we are giving MHB/C members flexibility and several options in how they address this question.

Some counties collect and provide their own data regarding important areas of client outcomes, in order to evaluate the effectiveness of their programs. MHB/C members are highly encouraged to make use of such data resources or reports, if available. Other possible choices are listed below.

Please mark with an "X" the source of client outcomes data you chose to review.

- County-specific report from your local MH Director or QI coordinator
- Consumer Perception Survey (subset of questions related to client outcomes)
- Full Service Partnership data for your county (DCR dataset)
- County-level reports from MHSOAC (e.g., Consumer Services Support reports through 2010 by UCLA contract; reports for more recent years are expected in late 2014).
- Other: Please list or describe: \_\_\_\_\_.

21. Please examine and discuss data about client outcomes for improved function in these areas of daily life (as appropriate to age group: children, youth, adults, older adults):

- a. school attendance improved, or reduced school suspensions/expulsions
- b. ability to work improved (paid or unpaid, full or part-time)
- c. justice system involvement (encounters with police, numbers of arrests)
- d. housing situation (improved/unchanged, not homeless)
- e. client is better able to cope with problems of daily life

[Leave space for text from MHB members]

**Optional question (A) for discussion:**

How many CPS surveys were turned in for your county? How many were for: families of children, youth, adults, and older adults? Of those turned in, how many were filled out completely?

[Insert Data below, for the selected questionnaire items].

[Leave space for text by MHB members].

**Optional question (B) for discussion:**

Which CPS survey question items are most useful for your local MH board/commission to think about?

What conclusions, if any, do you have about the effectiveness of services received by those who answered the surveys?

What strategies do you recommend to increase participation in completing these surveys by more MH clients and families?

[Leave space for text by MHB members].

**<END>**

**X** INFORMATION

TAB SECTION: C

\_\_\_ ACTION REQUIRED:

DATE OF MEETING: 1/15/14

PREPARED BY: Leonelli

DATE MATERIAL  
PREPARED: 12/13/13

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**AGENDA ITEM:** Panel Presentation: AB 114 Implementation – San Diego

**ENCLOSURES:**

- PowerPoint: San Diego SELPA/CMH Contract Discussion
- Parent Survey: United Advocates for Children and Families

**OTHER MATERIAL RELATED TO ITEM:**

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**ISSUE:**

In June, the Continuous System Improvement Committee heard a presentation on AB 114, which mandated the transfer of special education students' mental health services from counties to school districts/Special Education Local Planning Areas (SELPA). Presenters represented the California Department of Education and the California Alliance of Child and Family Services. Today's presentation continues the discussion with an overview of how the transfer is being implemented locally in San Diego and Riverside Counties.



# *ABOUT SAN DIEGO*

- 42 SCHOOL DISTRICTS
- SIX SELPAS
  - 4 MULTI DISTRICT
    - EAST COUNTY
    - NORTH INLAND
    - NORTH COASTAL CONSORTIUM
    - SOUTH COUNTY
  - TWO SINGLE DISTRICTS:
    - POWAY UNIFIED
    - SAN DIEGO UNIFIED
- PUPILS SERVED:
  - 498,243 STUDENTS
  - 50,706 STUDENTS RECEIVING SPECIAL ED SERVICES





## Who Speaks for Our Children...In the Schools?

\*Required Question(s)

\* 1. Has your child/youth ever received mental health services as authorized by a written Individualized Education Plan (IEP) team agreement?

Yes

No

\* 2. Were you aware of the transition of AB 3632 to AB 114?

Yes

No

Comment:

500 characters left.

\* 3. Have you felt that your child/youth has not been properly assessed in all areas of his/her suspected disability?

Yes

No

Comment:

500 characters left.

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\* 4. Have any decisions or IEP team meetings been conducted without your involvement or approval? If yes, please explain.

Yes

No

Comment:

500 characters left.

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\* 5. Has your child/youth lost any mental health services as a result of the transition of AB3632 to AB114? If yes, please explain.

Yes

No

Comment:

500 characters left.

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\* 6. Have you felt that school personnel failed to provide correct or related mental health services during or after the transition? If yes, please explain.

Yes

No

Comment:

500 characters left.

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\* 7. Have you ever been told that any of the mental health services described in your child's IEP will not be provided to your child because funding for a specific type of service is no longer available?

Yes

No

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\* 8. Have school personnel cited changes in laws or state budget as a reason for specific changes this year to mental health services described in your child's IEP?

Yes

No

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\* 9. Have school personnel suggested to you that schools can no longer provide the support of a psychiatrist to prescribe, monitor, or adjust medication in connection with your child's school program?

Yes

No

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\* 10. Has your child's IEP team addressed, to your satisfaction, concerns you have had about changes occurring this year with regard to your child's mental health services?

If not, please explain.

Yes

No

Comment:

500 characters left.

- \* 11. Please rate on a scale of 1 (lowest) to 5 (highest), how satisfied you are with the effectiveness of school-related mental health services your child/youth has received.

| Very<br>dissatisfied | Somewhat<br>dissatisfied | No<br>opinion | Somewhat<br>satisfied | Very<br>satisfied |
|----------------------|--------------------------|---------------|-----------------------|-------------------|
|----------------------|--------------------------|---------------|-----------------------|-------------------|

Comment:

500 characters left.

- \* 12. Has your child been denied any mental health support service such as day treatment or family counseling, due to lack of Medi-Cal coverage?

Yes

No

Comment:

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- \* 13. Have you been asked to provide consent for the school district to bill Medi-Cal or other insurance for mental health services that are included on an IEP?

Yes

No

Comment:

500 characters left.

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\* 14. Does your child receive mental health services that require residential placement through his or her IEP?

Yes

No

Comment:

500 characters left.

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\* 15. Have you been told that your child could no longer have residential services due to a change in the law?

Yes

No

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16. UACF is looking for families with a child/youth that have an IEP who are willing to share their stories about accessing appropriate mental health care services and supports. These stories help us effectively demonstrate to state and federal lawmakers why access to mental health care support programs are critical for families. Additionally, these stories generate media attention to support the mission of UACF, empowering parents and families to be the voice for their child/youth at all levels of decision making. Please enter your information below if UACF may contact you regarding your responses to this survey.

First Name:

Last Name:

Home Phone:

Email Address:

emailaddress@xyz.com