



CHAIRPERSON  
John Black

EXECUTIVE OFFICER  
Jane Adcock

June 27, 2012

CalDuals.Org  
c/o Department of Health Care Services  
Attn: Rollin Ives  
1600 Capitol Ave  
Sacramento, CA 95814

Dear Mr. Ives:

Thank you for this opportunity to provide input on the identification and evaluation of quality metrics to be included in the Dual Eligible Demonstration Project. The California Mental Health Planning Council (Council) has been a long-standing advocate for a system of accountability and continuous quality improvement based on program evaluation, and we are happy for this opportunity to weigh in on this essential issue. The Council is a majority consumer and family member advisory body mandated in federal and state statute to provide oversight of the public mental health system, advocate for individuals and families across the life span living with serious mental illnesses or serious emotional disturbance. In addition to advocating for program evaluation, we also strongly promote a culturally competent mental health system that is wellness and recovery based and inclusive of stakeholders.

A large percentage of the dual eligible population has behavioral health issues, and many live with serious mental illness. The "Faces of Medicaid III" (October 2009) reports that, when pharmacy data is included in their research, the investigators found that *"psychiatric illness is represented in three of the top five most prevalent pairs of diseases, or dyads, among the highest-cost 5% of Medicaid-only beneficiaries with disabilities"* and that 49% of Medicaid beneficiaries with disabilities have a psychiatric condition (52% of dual eligibles).

The Council is concerned that the metrics in current consideration do not include enough indicators on mental health and substance use services. Moreover, they do not reflect the attitude or perspective of an individual consumer's satisfaction based on choice, accessibility, or follow-up to treatment. For example, the prescription drug metric queries on drug education, courteous treatment, and cost information, but does not ask about whether the prescription needed was covered under the formulary, or whether refills for chronic mental health issues were easy to obtain or required a separate office visit, evaluation, and prescription. We are also concerned at the lack of any shared accountability metrics for county behavioral health plan carve outs.

The majority of the indicators emphasize physical health indicators, and/or appear to be based on complaints rather than successes. We support measuring improvement of health status for those with mental health and substance use issues – a very important potential outcome of these demonstration projects. We also support and appreciate the suggestions of the four pilot counties to use existing data collection sources to monitor benchmarks such as reduction in psychiatric bed days, ER visits, and re-admits.

At a minimum, the Council would respectfully suggest that for the first year, the metrics should query on:

- Whether the plans demonstrated a continuum of substance abuse and mental health rehabilitative services which are sufficient to serve the percentage of serious mentally ill clients enrolled in the demonstration projects.

The Planning Council recently participated in a workgroup to develop reporting requirements for the Mental Health Services Act and the projected Integrated Plan.

It developed a crosswalk of indicators and measurements across the life span using existing data sources collected by the DMH and DHCS that counties already used. The outcomes are sourced from Data Collection & Reporting (DCR), the Client Services and Information System (CSI), the Youth Satisfaction Survey (YSS) and the YSS-Family (YSS-F), and lastly, the Mental Health Statistics Improvement Program (MHSIP). We would recommend consulting this crosswalk to obtain indicators that are very important to the mental health community.

The Planning Council agrees with our colleagues at the California Mental Health Directors Association on the need for shared accountability mentioned earlier, and supports their suggestion for some type of performance and incentive metric that would promote coordinated care for emergency and pharmacy services. Additionally, we observe that the “Faces of Medicaid III” study gained a much more thorough understanding of the prevalence and needs of the Medicaid population by studying the pharmacy records. There may be some application for that in the Dual Eligibles demonstration project as well. We also support the comments of the California Council of Community Mental Health Agencies (CCCMHA), particularly in regard to the usefulness of the criteria that are measured (i.e., hospital days & readmission rates, social supports, continuity of care with periodic follow-ups beyond 30 days, etc.).

We regret that time does not permit as thorough a response as we feel this important topic deserves. However, we appreciate this opportunity to comment on what we’ve seen, and to reinforce the importance of pertinent metrics. Consumer choice and person directed care are high priorities in any system reform. Given more time we could search for a metric that would be appropriate to assess progress in these important areas. We are optimistic that your experts might be able to suggest something that could accomplish this goal.

We look forward to seeing what metrics are finally decided upon, and appreciate and welcome the opportunity to provide additional input. If you have any questions, please contact our Executive Officer, Jane Adcock at [jane.adcock@dmh.ca.gov](mailto:jane.adcock@dmh.ca.gov) or by phone at (916) 651-3803.

Cordially,

A handwritten signature in black ink that reads "John Black". The signature is written in a cursive, flowing style.

John Black, Chair  
California Mental Health Planning Council

Attn: Performance Indicators for Evaluating the Mental Health System