APS HEALTHCARE
Healthy Together
California EQRO
560 J Street, Suite 390
Sacramento, CA 95814

CAEQRO PIP Outline via Road Map – EPSDT PIP

MHP:
Date PIP Began:
Title of PIP:
Clinical or Non-Clinical:

- For May 22, 2009 submission, the MHP should complete the Road Map to reflect the study as it is designed thus far. All applicable items are in RED. If the MHP has not reached a certain point, please state "not completed" for that item.
- Aggregate data may be included as attachments to support the problem definition, barriers associated with the problems, and reasons for intervention selection.
- Submit via e-mail to Sandra Sinz at ssinz@apshealthcare.com no later than May 22, 2009.
- Also send a separate e-mail stating that the PIP has been e-mailed.

Assemble multi-functional team

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

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

MHP Level Committee: List local PIP committee members including their position and affiliation.

"Is there really a problem?"

2. Define the problem by describing the data reviewed and relevant benchmarks. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

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

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

Team Brainstorming: "Why is this happening?"

Root cause analysis to identify challenges/barriers

3. a) Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

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

Table 1
Distribution of Approved Claims for EPSDT

SFY 2006-07 Year Claims to date (Includes SGF, FFP, County Share funds)

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

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

Table 2
Monthly EPSDT Approved Claims Metrics

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

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

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

Months Pd Svc	**Frequency**	**All $**
All	5518	$242,277,620
1	185	$830,647
2	194	$1,688,992
3	206	$2,831,905

4	231	$4,168,661
5	215	$4,877,961
6	247	$6,421,969
7	220	$6,633,899
8	259	$9,561,421
9	323	$13,410,002
10	382	$17,594,196
11	515	$26,934,757
12	2541	$147,323,204

This quality improvement proposal is supported by a study of pediatric high health care service users. The study discusses that high-cost children use services of numerous types delivered in multiple venues, and concludes that "providing care coordination throughout the entire health care system is important to address both the cost and the quality aspects of health care for the most costly children". The study further concludes that "clinicians should review regularly the extent of care coordination that they provide for their high-need and high-cost patients, especially preteens and adolescents" and that "targeted programs to decrease expenditures for those with the greatest costs have the potential to save future health care dollars."(Liptak, GS et al. Short-term Persistence of High Health Care Costs in a Nationally Representative Sample of Children. PEDIATRICS Vol. 118 No. 4 October 2006). Historically, the growth in the EPSDT program has been driven by lawsuit activity that improved access to EPSDT funded services for children/youth and relied heavily on the clinical judgment of direct treatment providers. The state established a minimal requirement for utilization and quality management activities but has not historically required MHPs to conduct a focused review of EPSDT clients to establish that the array of services being provided to a child/youth is appropriate and that those services support the child/youth's desired treatment plan goals.

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

b) What are barriers/causes that require intervention? Use Table A, and attach as an appendix any charts, graphs, or tables to display the data (preferably in aggregate form). **Do not include PHI.**

Table A – List of Validated Causes/Barriers:

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 are targeted to improve.

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

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

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.
This PIP is required to include all beneficiaries for whom the study question applies unless there are clear, data-driven reasons for exclusion. Any exclusionary criteria must be carefully considered.

6. Describe the population to be included in the PIP, including the number of beneficiaries.
Exclusionary criteria are discouraged unless the MHP has clinically or programmatically driven reasons, supported by data, to create a study population that is smaller than those who meet the initial dollar threshold. Identify here the total clients who meet the dollar threshold, and for what time frame, as well as the number of clients to be included in the PIP.

7. Describe how the population is being identified for the collection of data.
Because there is an initial dollar criterion for consideration of inclusion, the MHP needs to identify the process by which youth meeting that dollar threshold will be identified on a monthly basis. In particular, describe how beneficiaries for FY08-09 were selected and how youth will be routinely added to the study population.

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

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

"How can we try to address the broken elements/barriers?"
Planned interventions

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

9. a) Why were these performance indicators selected?

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? **Indicators may not focus on the dollar threshold. Indicators should include raw numbers and also be represented as a percentage/rate.**

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

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

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1					
2					
3					
4					
5					

10. Use Table C to summarize interventions. In column 2, describe each intervention. Then, for each intervention, in column 3, identify the barriers/causes each intervention is designed to address. Do not cluster different interventions together. **Interventions should be logically connected to barriers/issues identified as causes associated with the problem affecting the study population.**

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1			
2			
3			
4			
5			
6			
7			

Apply Interventions: "What do we see?"

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why. **Describe how the MHP will collect data for all individuals for whom the study question applies.**

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

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

15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects? **What might be next steps in the EPSDT PIP?**

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

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

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							

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

17. Describe issues associated with data analysis:

    a. Data cycles clearly identify when measurements occur.

    b. Statistical significance

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

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

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

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?

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

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

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

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