

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

Committee Members Present: Elaine Robinson-Frank, Lucy Johns, John Pescetti, Barbara Marquez, Barbara Mendenhal, Terri Shaw, and Ellen Wu.

Committee Members Present by Phone: Alyce Adams, Alex Chen, Michael Cousineau, Mary Giammona, Hattie Hanley, Paul Kurtin, Ed Mendoza, Matthew Meyer, Ulfat Shaikh, Sonya Vasquez, and Aaron Zaheer.

MRMIB Staff Present: Dianne Ehrke, Muhammad Nawaz, Shelley Rouillard, Mary Watanabe, Rachelle Weiss, and Aiming Zhai.

### **1. Welcome and Introductions**

Ms. Rouillard called the meeting to order with introductions.

Ms. Ehrke stated that a new subscriber parent member, Ann Taylor, has joined the ACQ. She will not be able to be on all the calls, but will be working off-line with MRMIB. Ms. Rouillard will look at having an ACQ meeting in the Bay Area, so she could be present at a meeting.

### **2. Review of Minutes from August 26, 2010 Meeting**

Ms. Rouillard called for the review and approval of the August meeting minutes. The minutes were approved.

### **3. 2010-11 Budget Update**

Mr. Nawaz updated the committee on the HFP budget. The HFP budget for 2010-11 is \$1.37 billion, \$139 million in general funds, \$853 million in federal funds, and \$386 million in special funds.

MRMIB projects year end enrollment of 964,864, an increase of 55,216 subscribers or 6.1 % over the current year.

The budget assumes the following:

- No changes in benefits, premiums, or co-payments.
- The managed care organization (MCO) fee established by AB 1422 will provide up to \$136.3 million in 2010-11.
- Implementation of certain CHIPRA requirements will add new positions and state operating funds.

Ms. Rouillard added MRMIB was approved for new CHIPRA and PCIP positions and that MRMIB will implement the requirements within this federal fiscal year.

Ms. Johns and Ms. Shaw brought up the issue of “meaningful use” and what that data may contribute to quality improvement efforts. They noted that providers may be

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

concerned if MRMIB is asking for something that is not part of the “meaningful use” requirements that providers must meet in order to get incentive payments to help them pay for the technology needed to implement Electronic Health Records and other data tracking systems. They suggested MRMIB work closely with Medi-Cal on this. Ms. Shaw noted that having a connection to Health IT is quality work.

Ms. Shaw asked about enrollment and outreach activities. Ms. Rouillard answered there is a campaign that will promote the Health-e-app electronic application, and MRMIB is trying to get funding to support that.

#### **4. HFP Updates**

##### **a. Quality Strategy and External Quality Review Organization (EQRO)**

Mr. Nawaz informed the committee that CHIPRA mandates the following Managed Care Standards:

- Quality Strategy and External Quality Review Organization
- Encounter and claims data for health and dental plans
- Consumer Assessment of Healthcare Providers and Systems(CAHPS) survey
- Application of Prospective Payment Systems to CHIP services provided by FQHCs and RHCs

MRMIB has contracted with Mercer to help develop the quality strategy and the EQRO solicitation and evaluation criteria. Ms. Rouillard noted Mercer will be talking to the plans, ACQ members, other stakeholders, and Medi-Cal to develop a solicitation and establish evaluation criteria for EQRO.

##### **b. Encounter Data**

Mr. Nawaz stated that CHIPRA 2009 requires that managed care organizations participating in CHIP must provide the state with encounter and claims data. The data will be used in MRMIB’s quality assessment and improvement strategy. Both health and dental plans will submit encounter data. MRMIB has been working with Maximus to develop the encounter and claims database. Some health plans have already started submitting test data. MRMIB is expecting all other plans will submit data in 2011. Budget trailer bill language will allow MRMIB to collect encounter data from plans back to January 2006.

Ms. Rouillard stated expectations are that all the plans will submit their data in an 837 format, but some of the Medi-Cal managed care plans aren’t able to do so yet. Maximus will accept health plan data in both the 837 and DHCS flat file format.

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

Dr. Pescetti asked if there is any language in the trailer bill that would allow those providers using the electronic health records to share that data with us. Ms. Rouillard replied not to her knowledge, but the same providers in HFP are working with Medi-Cal IT and other programs, and there might be some impact here.

Ms. Hanley noted that preventing hospital-acquired infections is a high priority in California.

**c. Community Provider Plan / Premium Discount Project**

Mr. Nawaz stated each year MRMIB designates a Community Provider Plan (CPP) from each county based on the number of Traditional & Safety Net (T&SN) providers in their network. We have 3 issues with the current CPP process. First, it is a very complicated process. Second, there are some data integrity issues. Third, how can we include quality designation in the process? MRMIB contracted with a consultant, who met with the plans and others, to help us figure out a new process that would include quality. We got push back from the plans, especially the smaller ones, who don't want to change the current system. They do not want to be compared to the statewide plans, which they feel is not a fair comparison.

Ms. Johns asked if it is okay from a policy and quality perspective that the smaller plans push back. Ms. Rouillard answered that it is not just because the smaller plans pushed back, but there is no good way to figure out how to incorporate quality into the CPP formula because of how HEDIS scores are measured and reported by the different plans. For example, Health Plan of San Mateo doesn't want to be compared to Anthem Blue Cross statewide. They want to be compared to Anthem in San Mateo County. Some of the plans have expressed concern about being the default CPP. The plans feel like they do not get enough money to enroll the people who choose their plan, much less the added enrollment of the defaults.

For now, the CPP process will remain unchanged.

Dr. Giammona stated HFP kids are healthier but cost more than Medi-Cal Kids. She said Medi-Cal providers are capitated, whereas HFP reimburses on a Fee-For-Service basis.

Dr. Giammona suggested asking the plans if they want to be the CPP. Would they choose to do so? Ms. Watanabe explained the plans have a choice whether or not to participate. The challenge is there is a lot of negotiating about coverage and rates. Six months down the road, the plans may quit participating, choose not to cover a county, or cover only a portion of the county.

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

Ms. Rouillard confirmed the structure and basis on which we determine the CPP is crumbling, but MRMIB hasn't figured out how to fix it. Dr. Giammona suggested that when a plan is designated the CPP, it should agree not to change the coverage area throughout the rest of the contract.

Mr. Nawaz noted that encounter data could be used instead of Medi-Cal data for this purpose.

**d. California Children Services (CCS) Pilot Projects**

Dr. Kurtin explained over the past year there have been two parallel processes going on regarding the CCS Program. The first is that every five years the CCS program does a self-assessment of how it has performed in the previous five years and develops a strategic plan for the next five years. David Maxwell-Jolly has been looking at a redesign of CCS, because the program structure is unsustainable going forward. The cost is rising faster than the enrollment. In August, the Department of Health Care Services (DHCS) put out a draft RFP to get responses to the four CCS pilot models. The four models are the Expanded Primary Care Case Management, a provider-driven Accountable Care Organization (ACO), a specialty health plan which carves out the CCS kids, and a Medi-Cal Managed Care Plan that would expand to include CCS conditions.

State responses to questions are expected. The biggest questions were around financial risk. The ACO, for example, carries a fair amount of financial risk, but there were no details in the draft about how the providers would be paid. The final RFP will be out on December 1<sup>st</sup>, and responses are due in March. The DHCS wants to see if all four models can be tested. They hope to test with enough kids to see if there are differences and which one works better at maintaining and improving quality while holding down cost. They would also like to see projects from Southern as well as Northern California, because the regions are so different.

SB 208 is the legislation authorizing the pilot project and these four models. The Medicaid waiver, that changes the way services are provided for Medicaid children, should be signed tomorrow. The provider community is nervous because of the financial risk. Many providers have provided for the specialty needs associated with the condition, but you need to add primary care, mental health, and other costs. The care models want a robust medical home model as proposed by the American Academy of Pediatrics. Thorough and complete care coordination is nice but not being delivered today. What would be the added cost for providing those services? Primary and specialty care would love to be able to do these things, but are unable because of the cost of additional staff, and they don't know how to fit it in their already busy days. CCS will likely undergo some dramatic changes.

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

Dr. Cousineau acknowledged the ACO model is in the early stages of development. There is concern how the Safety Net providers are going to fit into this. It's not clear what the federal regulations are going to be for them, and how they will be applied to the special populations.

Dr. Kurtin said Medi-Cal is recommending a size of about 5,000 patients to test the ACO, but most providers are afraid to go that high without the financial model. There really are no blueprints to follow.

Dr. Chen asked if either Dr. Kurtin or Dr. Cousineau were involved with Paul Wise's project to evaluate CCS data. The project provides data on restructuring CCS. Dr. Kurtin stated Mr. Wise was given a lot of data, and his task is to develop a baseline cost model to reduce primary care costs. Medicaid is working by a baseline, and if the projection for the next year is under that, then there are savings.

Dr. Chen asked if Mr. Wise's results would affect the way the model is formulated. Dr. Kurtin replied it would affect how the financial model rolls out. There is talk about holding providers harmless for maybe two years. Dr. Chen stated Mr. Wise plans to get the results out by December or January so that the upcoming decisions will be data driven.

Ms. Johns stated that when the HMO Act was first passed, 5,000 patients was the minimum size for a viable HMO. That number turned out to be ridiculously low. Dr. Kurtin stated the 5,000 Medicaid number includes all types of people including the very ill and fairly healthy but elderly. To take 5,000 sick kids is very problematic. Dr. Giammona added in some counties there aren't 5,000 kids. To balance things, you have to have low risk CCS kids, as well as healthy kids.

Dr. Kurtin continued saying health plans submitted letters of interest for the managed care CCS pilot. There is a disconnect between case management, because CCS has always been at another site managing kids for their specialty conditions and not getting information back in a timely manner to the PCP.

Dr. Kurtin hopes that CCS will integrate with the plan like a specialty plan within a plan. This way the CCS staff and provider staff can work on kids simultaneously, so the whole child can be managed. The most exciting thing we're looking at is the child dictating case management and not the condition.

Dr. Pescetti asked how many children are in CCS and what's the annual cost of the program now? Dr. Kurtin answered that CCS spends \$600 million in NICU care, and the overall budget was between \$1.1 and \$1.2 billion per year.

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

**5. Health Care Reform Update**

Ms. Rouillard confirmed the Pre-existing Condition Insurance Plan (PCIP) started on Monday. PCIP is temporary insurance for people who have a pre-existing condition which excludes them from being able to buy private insurance. So far over 1,000 applications and 500 subscribers are signed up. Maximus sent out 6,000 applications to people who expressed interest in the program. Once subscribers have signed up, they can access a website called myPCIP. They can check on their explanation of benefits, status of a claim, or eligibility status. The website for PCIP is <http://www.pcip.ca.gov>.

Dr. Cousineau questioned whether people who are currently enrolled in MRMIP, the high risk pool, can switch to the new Pre-existing Insurance Condition Plan. Ms. Rouillard answered they cannot. Federal law states they have to be without insurance for six months.

Ms. Rouillard continued to say there is no average premium as premiums are based on age and where a person lives. The premium range is from \$500-\$1,200 per month. Premiums are not subsidized. There is one PCIP PPO Network. The company who administers the plan is a Third Party Administrator (TPA) called Health Now Administrative Services (HNAS). HNAS is based in Pennsylvania and has subcontracts with the PPO network, the pharmacy benefits manager, and the utilization review company.

MRMIP is still administered by Anthem Blue Cross. If someone applies for PCIP, they have to fill out two applications (MRMIP and PCIP). If they are approved for both programs, they are asked to pick which program they want to enroll.

Ms. Marquez stated there's a website called <http://www.healthcare.ca.gov> which is the state's version of Federal Healthcare Reform. There is a wealth of information on the site and a link to the PCIP.

**6. Healthy Smiles – Healthy Families: Oral Health Quality Improvement Project**

Mr. Rouillard stated MRMIB received a grant from the California Healthcare Foundation (CHCF) to undertake an Oral Health Quality Improvement Project. The results of the HFP Dental Quality Report showed capitated plans performed significantly lower than open network dental plans. Now that there is requirement for HFP children go into a dental HMO for the first two years of enrollment in the program, MRMIB is particularly concerned that children are not getting services. MRMIB has contracted with the Center for Health Care Strategies (CHCS), who has a lot of experience nationally in doing oral health quality improvement.

The project kicked off with conference calls with the Oral Health Advisory Group. Dental plans are saying "we can't get the kids to come in," but the Advisory Group is

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

suggesting using schools, PCPs, and teaching lay people how to provide services such as fluoride varnish. The dental quality improvement project will occur in the current benefit year, and each of the plans will have a team of people working with CHCS and MRMIB. The focus is on early intervention, targeting the 0-6 year olds. Most parents don't think they need to take their kids to the dentist until after the first tooth comes in. However, the dentist should see children prior to getting their first tooth.

MRMIB and CHCS also had a conference call with the dental plans who will be working directly with CHCS. CHCS will be meeting with them on an individual basis to help them set up their quality improvement teams. The first meetings will occur in January.

The target geographic areas for the project are Los Angeles, San Luis Obispo, Santa Barbara, and Ventura counties. Other areas of focus are targeting children based on risk, reinforcing primary and secondary prevention, engaging primary care providers in oral health, and using scientific evidence to advance improvements. Other activities of the project are to help MRMIB develop contract amendments and a dental periodicity schedule. Ultimately, MRMIB wants a three year action plan for HFP. The foundation grant was approximately \$49,000 which will be matched with federal funds.

Ms. Shaw asked if MRMIB has any data on children reaching the dental benefit cap. She asked if this could be part of this quality improvement exercise and whether the encounter data includes dental data.

Ms. Rouillard stated MRMIB will get dental encounter data after the health plan data. MRMIB does not have any data about children reaching the cap. CMS has determined that the HFP dental benefits do not meet the definition of benchmark for CHIPRA, so MRMIB will have to get Secretary approval for the dental benefits. CMS has said that a cap is okay as long as there is a process for providing medically necessary dental services when the child reaches the cap. Some states use a prior authorization process once a child reaches the cap but still needs services to restore oral health function.

## **7. Evaluation of Mental Health and Substance Abuse Services Provided by HFP Health Plans**

Ms. Rouillard reported on the APS Healthcare evaluation of mental health and substance abuse services provided by HFP health plans. This evaluation is Phase II of a two-phase project. The first part was looking at services provided to kids with Serious Emotional Disturbances (SED) by the county, funded by the California Endowment and was completed in 2006.

This project looks at mental health and substance abuse treatment services provided by the plans. Utilization is very low compared to the national averages and compared to both Medicaid and the commercial market. Kaiser and San Francisco Health Plan have the highest utilization of mental health services. HFP plans provide these services in different ways. Some contract with county mental health departments, some contract

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

with private Managed Behavioral Health Organizations (MBHO), and some provide the services in-house. The outpatient mental health service utilization rates were the lowest in the private MBHOs.

Children 6-12 years old had the highest utilization of services. It falls off dramatically from 13-15, as well as in the 16-19 age groups. It appears as though the kids are dropping out of treatment at 13 years old. There is some concern about why that happens.

ADHD, depression, and anxiety disorders are the top three conditions for which HFP children are treated. The evaluators looked at medication prescribing patterns to see if they were similar to the community at large. The evaluators thought some medications were being used for purposes not supported by the evidence, but the data had some accuracy issues. This was self-reported aggregated data by the plans; individual level data was not available to the evaluators because of the California Medical Information Act.

The report contains many recommendations including the need to integrate primary care with mental health, substance abuse, identification of diagnosis, referral patterns, and access.

The evaluators interviewed key informants at the plans including line staff and people in the MBHOs. Plan and MBHO staff thought their preauthorization procedures were transparent and easy to use. However, parents in the focus groups said they had real barriers with it and found them to be confusing.

The evaluators collected data on grievances and complaints; it was interesting that a number of plans do not separate out complaints about mental health and substance abuse services from the rest of their complaints and grievances. This may be something for MRMIB to look at, but the numbers are small. Out of almost a million children last year, there were only 3,600 complaints and grievances, and only small portions of those were related to mental health and substance abuse.

The evaluators talked to about 24 parents in Southern California and the Central Valley. The parents stressed the importance of the PCP as the gateway to mental health services. Parents trust their child's doctor to help them figure out where to go and how to get services. There are cultural and language barriers to access mental health and substance abuse treatment services. There are administrative barriers such as of the prior authorizations. The parents believe there should be more outreach and education, particularly in the schools, since this is where kids are being identified as needing services. They also thought there should be more parent support.

Ms. Johns asked if the high use in Kaiser compared to other plans was directly because of the primary care interface where you would get identification of mental health problems. Ms. Rouillard responded it is also because someone can walk down the hall

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

after seeing the doctor and see a therapist. Patients don't have to leave or call another place to make an appointment.

Ms. Adams stated it would be good to have more information on how they went about identifying the different groups of diagnosis. It would be good to have more information about how the study was conducted so the comparisons between plans would be fair.

Dr. Zaheer shared a personal experience. In San Diego, the HFP mental health contractor does not accept the clinic's mental health providers. There are mental health providers at the clinic that HFP kids can't use. Instead, they have to be referred outside of the clinic. A lot of the time, patients are seen by the clinic's mental health providers, but the clinic cannot bill because those providers aren't contracted with the plan. That diagnosis, as well as the service, isn't being counted. Dr. Zaheer's clinic contracts with Community Health Group, Molina, and Care First.

**Action item:** Ms. Rouillard stated she would follow-up with Dr. Zaheer on this issue. This whole idea of integration with primary care is so important.

Mr. Mendoza added the carved-out behavioral health plans are the ones that seem to have the most issues around utilization. This is similar in the commercial plans. When you carve out mental health from the master plan, the data flow breaks down and the parent plan loses track of what is going on with the member.

Mr. Mendoza added that many mental health services are provided by the PCP, because the doctor doesn't know how to appropriately refer or doesn't feel comfortable referring his/her patient to the carve-out plan. What HPF would count as mental health services may be disguised as general primary care, so HFP could be losing a lot of data.

Dr. Giammona said there are a number of patients, because of cultural background or even age, who do not want to go to mental health in fear of being thought of as "crazy". A PCP may say "well the only way I can provide care is to do it myself." The child may be getting mental health services, but it does not show up in the data.

Ms. Rouillard held a conference call with the plans to talk about the recommendations. Inland Empire Health Plan decided they would bring all the mental health services in-house and not contract with the MBHO anymore. They made a big effort to contract with the providers. They screened the mental health providers about their willingness to coordinate care with the PCPs and their interest in serving children. They feel like they have a good network now; a more integrated model. They have done a lot of training with the PCPs on referring and screening. Ms. Rouillard said she is interested to see how that shows up in the data in a year or so.

CalOptima has been doing pilot projects with some of their primary care offices around integration of mental health screening along with the regular well child check-ups.

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

Ms. Rouillard asked how HFP might be able to better integrate primary care and behavioral health.

Ms. Johns clarified integrating primary care and mental health is considered the best practice. In the best of all worlds, this is what we want and will pay for. Ms. Rouillard stated we are talking about an exchange of information and also a proactive approach on the part of the PCP to make a referral and to follow-up.

Ms. Shaw added this is another area where HIT comes in. In the meaningful use requirements, there are provisions about putting in place decision support tools as part of the EHR. Automating screening tools are used when kids come in for well child care including tools for mental health. Based on the screening, the physician acts to refer or provide the care. Building those expectations into the meaningful use requirements is one way to go, or opting to do that as part of meaningful use requirements.

Mr. Meyer stated his clinic is looking at a measure of successful linkage and co-location. Knowing how formalized relationships are between primary care and behavioral health would be very helpful.

Dr. Zaheer commented at his clinic they have a psychologist that does mental health screenings for patients as they are waiting to be seen by their PCPs. If the patients need more, then they are scheduled for an additional appointment to see both the PCP and the psychologist at the same time. This is how some of the mental health data could be masked, because the providers are billing with the medical codes and not the mental health codes. HFP should allow billing of mental health services on the same day as medical services. This is one of the things preventing investment in mental health and primary care integration.

Ms. Giammona stated it is important for MRMIB to recognize the need for multiple models. In her county, there are only San Mateo Medical Center, a FQHC look-alike, and Ravenswood, FQHC. Everybody else is private practice. You need to have alternatives for private practice; San Mateo Health Plan out sources to county mental health. Doctors at the FQHC have tiny offices and wouldn't be able to have someone else come see patients there. It would be good to support the pediatricians who are truly interested in doing these screenings. Maybe MRMIB could get grant funding for training the PCPs. There needs to be different mechanisms to bring the kind of interface that is needed. It's important, but there's no way some private practitioners would be able to have an interface in their office given their space issues.

Ms. Wu added this issue isn't specific to mental health. The idea of the medical home cuts across issues, and it is a model that can be looked at as a whole team approach.

Ms. Robinson-Frank stated there is a big drop off when dealing with adults between assessment and referral and the contact with behavioral health. She did not know if it is the same with children's referrals.

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

Ms. Rouillard stated one of the findings from this study is the plans aren't tracking the time from the referral to the first appointment. Ms. Robinson-Frank said there's a big fall off even when the behavioral health provider reaches out to the member. A lot of rejections of services happen due to cultural issues or stigma. Ms. Rouillard added it could be the parents who are saying "oh, my child is fine, and there's nothing really wrong with him." Ms. Robinson-Frank did not know if keeping the treatment with the PCP helps, if that is better than nothing.

Mr. Meyer stated that integration really helps with on going care needs once mental health has successfully been treated. ADHD is a good example. His mental health clinic holds onto a lot of kids with ADHD that don't need services anymore, because they have been treated successfully. However, community providers don't want to take the kids into care. As a result, his clinic provides "meds only" which could easily be provided by primary care. Mental health providers need to deliver the best practice treatment, which is not feasible for a primary care provider to deliver, because it is too intensive.

Dr. Cousineau stated The California Endowment has funded integrated models, and one thing they found was a lot of the PCPs were reluctant to do the medication management.

Dr. Zaheer has a psychologist who comes in for a half day once a week and will see the patient together with the primary care doctor. Having these mental health resources available in the primary care makes a big difference. The repetitive patients who come in once a month to get medicine are taking time away from people that need to be evaluated, reevaluated, stabilized, or who cannot even get in. Patients who need mental health services have to wait to be seen as long as three months. The only practical way is to integrate mental health into primary care. The challenge for the plans and MRMIB is to figure out a way to make it so it's financially feasible for the providers to do it. In the long run, it ends up being cheaper. His clinic has a psychologist there two days a week and can have a patient seen by one within five days at most. Prior to integration, it took three months for the patient to be seen.

Ms. Shaw was interested in the parent recommendation and the connection to the schools as outreach and education. She would like to add a screening/assessment site. She wondered about leverage MRMIB has to encourage integration in school based care into the plans and provider networks which she supports to help with information exchange.

Dr. Chen asked if CHDP could help any in this regard, since he knows a lot of CHDP exams go on at schools. Ms. Rouillard stated this came up on the plan call, and someone had mentioned it being very difficult to get into schools. Mr. Meyer confirmed they work with about 40 L.A. schools, and delivering mental health services.

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

Ms. Shaw commented that the recommendation about parent support is excellent. She recommends MRMIB set up a "MyHFP" website and build in the education materials, outreach, and how to use your health plan to get services. Ms. Rouillard stated this would take resources and money.

Dr. Giammona asked if the plans include information when they mail out their premiums. Another place to put the information is in the EOC.

Ms. Johns asked if there is a difference between mental health for adults vs. mental health for children. Does the notion of integration change or should it change when dealing with adolescents who will have more opinions? Dr. Giammona thought there should be different approaches for younger children and adolescents.

Mr. Meyer stated the best example he's seen of integrated care was an adolescent clinic at Children's Hospital. Their adolescent clinic truly had an integrated mental health and primary care team. There was a warm hand off. There was co-training between primary care and mental health, and both worked together with families. It worked well; the mental health needs were very high and had a lot of interplay with the physical issues. He said the integration is more vital at the adolescent stage for developmental reasons than at the child stage, because teens have more autonomy getting themselves to and from the clinic.

Ms. Shaw noted in earlier conversations that utilization of care among adolescents is problematic and would like a focus on them. Mr. Nawaz asked if there is any study that has been done around what causes the decline in treatment of adolescents.

Dr. Zaheer said he would like plans to automatically initiate a process of contacting patients to give them chronic disease education when a patient gets asthma medication or other chronic disease medication. The patient would be less likely to use the emergency room. If the same thing can be done with mental health diagnosis, ICD-9 codes would come through the health plans like social problems, learning problems, developmentally delayed, depression, and ADHD.

Ms. Rouillard explained plans can also mine their pharmacy data for the types of medications kids are prescribed to identify, and reach out to see if they are getting their treatments. Inland Empire sponsored a youth summit with the schools and the county; they trained student leaders about mental health, suicide, and depression. Maybe those kids might see peers with this behavior and intervene. Ms. Shaw added there have been efforts around the country to do peer-to-peer counseling through social networking tools.

Ms. Robinson-Frank added at Health Net they have tried letters to members who show up in the pharmacy data with a new anti-depressant medicine. Interestingly, the commercial product has no impact, and doesn't seem to do anything, but Medicare seems to work. She didn't know if that will work with children. Dr. Zaheer commented

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of October 28, 2010**

that it would be more effective to have a case manager call the families. Written material is not effective. Ms. Rouillard asked Ms. Robinson-Frank if Health Net has tried this with the Medi-Cal population. Ms. Robinson-Frank answered no but Health Net just launched a social networking site.

Ms. Shaw added having the plan notify the PCP is the way to go.

Dr. Zaheer noted often medications aren't always prescribed by the primary care doctor, but rather through the emergency room as with the asthma patients. Children's Hospital sends him the records.

Ms. Rouillard stated that part of the quality strategy and the EQRO are performance improvement projects. This could become something to try within the program or with some subset of the plans.

Mr. Mendoza added the CHIS database has questions about "did your primary care doctor talk to you about mental health?" This data might provide insight into who is being screened and whether the Healthy Families experience is any different. Another idea might be to know how many mental health referrals are actually consummated.

Dr. Zaheer stated at his clinic the show-up rate for mental health is half of the show-up rate for medical health appointments. He thinks it is because it takes so long to get a mental health appointment.

Ms. Rouillard stated she wants the plans track the time from referral to the first appointment to find the no-show rate.

## **8. Next Meeting**

January 27, 2011 – 1:00pm to 4:00pm