



Final Report

**Mental Health and Substance Abuse Services
Provided by Health Plans Participating in the
Healthy Families Program**

Submitted by

APS Healthcare, Inc. and San José State University

to

The California Managed Risk Medical Insurance Board

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❖ ACKNOWLEDGEMENTS ❖

This report summarizes the findings of a multi-method study about the mental health and substance abuse services provided by California's Healthy Families Program (HFP), the federally-sponsored low-cost Children's Health Insurance Program (CHIP) for children and adolescents. During the study period from July 1, 2008 to June 30, 2010, APS Healthcare, Inc. (APS) and San José State University (SJSU) worked collaboratively to plan and implement the study with the California Managed Risk Medical Insurance Board (MRMIB) and the twenty-one health plans that provide the HFP services.

This study was funded by Mental Health Services Act funding. The study team and MRMIB wish to thank the staff of health plans that participated in planning the study and submitted several documents and data reports. In addition, some health plans graciously agreed to host the study team to participate in key informant interviews. The active participation of health plan staff in planning the study, collecting data, and recruiting focus group participants was critical to the progress of the study. Their attention to detail and quick responses to our follow-up queries made this large task possible.

We also wish to thank the parents and youth who participated in focus groups and phone calls to share their perspectives and personal stories, while describing their experiences with HFP mental health and substance abuse services. We very much appreciate the time they contributed and the insights they provided.

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❖ EXECUTIVE SUMMARY ❖

INTRODUCTION AND BACKGROUND

This study was initiated by California's Managed Risk Medical Insurance Board (MRMIB) to evaluate mental health and substance abuse (MH/SA) services of California's Healthy Families Program (HFP), the federally-sponsored low-cost Children's Health Insurance Program (CHIP) for children ages 18 and younger. During the study period from July 1, 2008 to June 30, 2010, APS Healthcare, Inc. (APS) and San José State University (SJSU) worked collaboratively to plan and implement the study with MRMIB and the twenty-one health plans that provide the HFP services.

MRMIB received funding for two studies. Phase I, funded by the California Endowment, consisted of an evaluation of Serious Emotional Disturbance (SED) services provided to HFP members through county mental health programs. The focus of the evaluation was to determine whether HFP subscribers were receiving adequate SED treatment services. The adequacy of coordination of SED services between plans and counties was also included in the evaluation. Phases II and III, funded by Mental Health Service Act Funds, evaluated the mental health services and substance abuse treatment provided by health plans. The focus of this evaluation was to determine whether there are barriers to mental health and substance abuse services provided by the health plans and options for reducing those barriers.

HFP benefits for plan-provided mental health services include up to 20 days per year of outpatient services, and up to 30 days per year for psychiatric inpatient care. HFP also includes services for children with a serious emotional disturbance (SED) condition, as defined in Welfare and Institutions Code Section 5600.3(a)(2). Mental health services for SED conditions are provided by county mental health departments¹ for eligible children. This study focuses mainly on plan-provided mental health services for conditions other than SED². Plan-provided mental health services for non-SED conditions are administered in a variety of ways: (1) the health plan has mental health providers within its network; (2) the health plan contracts with an external organization such as a managed behavioral health organization; or (3) the plan contracts with local county mental health agencies.

¹ California's 58 counties administer their own mental health programs. Some counties have integrated mental health and substance abuse services under one "behavioral health" department, while others continue to operate separate mental health and substance abuse treatment systems. For ease of presentation in this report we will refer to such services as "mental health" or "substance abuse" services.

² Primary care and mental health parity was not in effect at the time this report was prepared. Parity for mental health and primary care services became effective July 1, 2010.

A primary reason for initiating the study was the low utilization of plan-provided MH/SA services among HFP subscribers. There are no systematic studies of other states' CHIP programs, especially in regard to the utilization of MH/SA services. In comparison to other states, benchmarking studies and recent analyses of Medicaid data show that California lags behind in the utilization of MH/SA services despite the high need of those eligible beneficiaries. There has yet to be a comprehensive analysis of utilization of plan-provided services, and there is also a continuing need for organizational research on the structure and process of service provision under CHIP in a population like California's, which has a high degree of ethnic diversity.

METHODOLOGIES

This study utilized multiple methods of data collection and analysis. The project included four components:

- Document Review—plans were asked to submit up to 55 policies, procedures and brochures in response to a request by the research team.
- Data Request—a set of aggregate data reports were requested from health plans in the areas of inpatient and outpatient mental health services, inpatient and outpatient substance abuse services, and pharmacy, using data from the benefit year 2007–2008.
- Key Informant Interviews—interviews were conducted with staff, administrators, and providers of representative health plans.
- Subscriber Focus Groups—four regionally-based focus groups and individual phone calls were held with subscribers who used mental health services.

FINDINGS

Subscriber utilization of plan-provided mental health services

Mental health utilization rates

- The average mental health inpatient utilization rate³ for children was .09%. The rates range from .01% (CenCal Health) to .22% (LA Care).

³ Utilization rates for all services were calculated as the ratio of those served divided by the number eligible to be served, from enrollment data for the benefit year 2007–2008 provided by Maximus, the state's vendor for managing HFP enrollment.

- The average mental health outpatient utilization rate was 1.79%, with a range of .07% (Care 1st) to 3.98% (Kaiser).

There are not currently any state or federal benchmarks for mental health care service utilization rates. Without such benchmarks, interpreting HFP mental health service utilization rates is difficult. The closest comparison for HFP outpatient mental health services are the utilization rates from existing studies of publicly funded mental health services. The average outpatient utilization rate for HFP is far below the rates from most Medicaid programs, which range from 5.89% to 13% in California and elsewhere. The plans whose rates exceeded the HFP average (1.79%) included CalOptima (2.14%), Community Health Group (2.28%), Health Net (1.90%), Health Plan of San Joaquin (2.08%), Kaiser Foundation Health Plan (3.98%), and San Francisco Health Plan (3.70%).

Mental health utilization rates by plan and subscriber characteristics

Other findings from the analysis of data submitted by the plans include:

- Outpatient rates for **provider networks** directly managed by plans exceeded those for plans whose mental health services are provided by county mental health agencies. Plans subcontracting to managed behavioral health organizations (MBHOs) showed the lowest outpatient utilization rates of all three types of provider networks. There was no relationship between plan size and MH service utilization.
- Mental health outpatient utilization rates differed by **age of child**. Children aged 6–12 were the highest users of outpatient care. Older adolescent age groups (13–15 and 16–19) showed lower use of services. Children aged 0–5 had the lowest service rates.
- The analysis of mental health outpatient service rates by **ethnicity of the child** was complicated by inconsistencies in the plans' coding of the child's ethnicity (especially in regards to "Other" and "Other Asian" categories). In this analysis, those ethnic groups whose subscribers appeared to have outpatient utilization rates higher than the overall average (1.79%) were African-American, Amerasian, Hispanic/Latino, Native American, Other Asian, White, and Other. With the exception of the Amerasian and the Other Asian categories, most Asian ethnic groups appeared to be more underserved than other ethnicities.
- The analysis of outpatient utilization rates of service use by **parent's primary language** showed utilization rates for those who spoke Cantonese, Farsi, Russian, English and Mandarin exceeded the average utilization rate for outpatient care. Those categorized as "other" language also had higher than

- average outpatient rates. Tagalog speakers had the highest inpatient rates, followed by Vietnamese and Cantonese speakers.
- **The most typical mental health diagnosis among HFP members is Attention Deficit Hyperactivity Disorder (ADHD).** The second and third most common diagnoses are Depressive Disorders and Anxiety Disorders, respectively. The rate of diagnosis in males with ADHD is higher than that of females in HFP. These findings are consistent with recent national surveys of common psychiatric diagnoses for children.
 - **41% more males than females used outpatient services.** This may be related to the finding that children with the diagnosis of ADHD had higher treatment rates than of any other diagnosis. Behavioral symptoms associated with ADHD are more noticeable to teachers and parents and often more disruptive to classrooms than symptoms related to depression or anxiety.

Pharmacy: Prescriptions for mental health in HFP

Given the growth of the use of medications in treating mental health conditions in psychiatric practice, this study sought to gather available data about the extent to which mental health medications are prescribed to HFP subscribers. In the data request, plans were asked to submit information on the rates of prescription use by age, and the most commonly prescribed medications by diagnostic category.

The distribution of psychoactive medications prescribed by subscriber age

The pattern of prescriptions made for treatment of mental health conditions by age is very similar to the use of outpatient services by age—the 6-12 age group had the highest amount of prescriptions of psychoactive medications. Prescriptions of psychoactive medications were lower for the adolescent groups (13–15 and 16–19), which paralleled these groups' lower outpatient utilization rates relative to the 6-12 age group. If adolescents are stopping treatment prematurely or are not provided opportunities for outpatient access, this would be reflected in both the utilization of outpatient visits as well as the use of psychoactive medications.

Commonly prescribed medications

HFP medication practice patterns seem consistent with those in the wider practice community, although even in the wider practice community some medications are being used despite the the lack of evidence justifying their use for children.

Substance abuse treatment

Overall numbers for substance abuse treatment utilization were extremely low. Only .07% (437 out of 852,000) of enrolled subscribers used outpatient care, and only 13 children and

youth used inpatient care. Over two-thirds (68.43%) of HFP members receiving outpatient care were enrolled in Kaiser.

Coordination of care: Primary care, service authorization, and screening

Primary care

Most plans submitted documentation addressing coordination of care between primary care and behavioral health, but there was variation in the amount of detail used to describe the procedures and processes.

- While documents from plans that subcontracted with Managed Behavioral Healthcare Organizations (MBHOs) mentioned the importance of coordinating care, they lacked detail about exactly how the coordination should work. An exception was the submission by Care 1st (CompCare) which provided a comprehensive outline of opportunities for coordination between behavioral health and primary care in the areas of information sharing, diagnosis, treatment, use of medications, and preventive programs, among others.
- There were other good examples of policies outlining roles and responsibilities in referral processes, tracking of referral success, and follow-up care from primary care and behavioral health services. These included the policies and procedures from Health Net, LA Care Health Plan, and Santa Clara Family Health Plan.
- CalOptima reported on a recently completed pilot program of primary care screening initiatives, which involves dissemination of new instruments to primary care providers and training. The pilot may provide a good model for the implementation of systems to ensure high use of multi-dimensional screening instruments in primary care, as well as their use in directing appropriate referrals to behavioral health care.
- Kaiser Foundation Health Plan is unique among the plans in its group model—the use of one provider group (The Permanente Medical Group) to provide all primary care and specialty health services, including mental health and substance abuse care. As described by key informants from various plans, the strength of Kaiser’s model is the ability of a primary care doctor to efficiently refer subscribers to specialty services such as mental health.

Standardized child/adolescent screening and assessment tools

A variety of documents were submitted addressing plans' use of child/adolescent screening and assessment tools. Further recommendations on developing or adapting a uniform set of screening instruments are addressed in the Recommendations section of this report.

- *Instruments developed for use in primary care offices:* of these instruments, the Pediatric Symptom Checklist (used by CalOptima) has been tested as valid and reliable and provides a cutoff score indicating the need for referral to mental health services. Five plans also reported using the California "Staying Healthy" Assessment (Individual Health Education Behavior Questionnaire).
- *In-depth mental health and/or substance abuse assessments:* six plans reported using the ALERT Wellness Assessment, developed for use by the Optum MBHO.
- *County- or Plan-developed assessment instruments and forms:* various in-depth assessment forms, developed by county mental health agencies, regional health plans, and Kaiser, were also submitted.

Authorization of treatment

Twelve plans (57%) mentioned procedures to authorize or pre-approve treatment.

- MBHOs submitted the most detailed procedures and information-gathering procedures.
- Parents' experience with MBHO authorization procedures appears to have an impact on access to services. The standard procedures for MBHOs, such as the requirement for the member to call the MBHO to locate a network provider, may be more of a problem for the HFP population than others for whom the MBHOs provide administrative services.

Use of additional benefits beyond maximum—Extension of benefits

Only five plans (24%) specifically addressed extension of benefits beyond the plan maximum.

- Most plans do not track HFP benefits for purposes of administering extensions.
- A few plans reported conversion ratios of inpatient to other levels of care (e.g., one inpatient day for two days residential treatment, three days of day treatment, or four outpatient visits). However, these substitutions and conversions rarely occur.

- For substance abuse treatment, Kaiser described its chemical dependency program as a basic medical benefit with no maximum limitations on clinically indicated services.
- Key informants pointed to limitations in HFP's substance abuse treatment benefits that provide only detoxification and outpatient care--limited options for adolescents with substance use problems. In addition, they emphasized that in general there is a shortage of providers and programs for adolescent substance abusers.

Administrative services and provider management

Use of behavioral health companies

- Eleven health plans (52%) subcontract or delegate the management of mental health and substance abuse services to specialty MBHOs.

MBHOs supply a provider network of behavioral health clinicians and group practices; claims processing; care management (utilization management and case review); and member services.

- Seven plans (33%) subcontract or delegate the provision of plan-provided mental health services to county mental health departments.
- Kaiser contracts with its Permanente Medical Group.
- CalOptima contracts with regional Independent Practice Associations.
- Community Health Group contracts with a local private practice group.

Provider credentialing

All plans submitted policies and procedures or some material indicating criteria for credentialing behavioral health providers. These procedures outlined the process of reviewing and approving providers' qualifications for membership in a provider network.

- All plans make use of national databases to confirm board certification, licensure status, and criminal sanctions, among other data. Plans also organize internal committees to review and approve the provider's network status.
- With the exception of Kaiser's procedure for the clinical privileging of addiction-specialist physicians, there was no material submitted indicating criteria for credentialing of substance abuse providers, aside from application questions for chemical dependency facility programs (such as detoxification, residential, partial day treatment and intensive outpatient).

Overlap of providers for plan-provided benefits and SED services

- According to key informants in the seven plans that contract or delegate plan-provided services to county mental health departments, those counties' clinicians are used to provide both plan-provided services and treatment of SED.

Monitoring quality

Policies and procedures for monitoring quality and outcomes

While the majority of plans submitted policies and procedures related to quality and outcome monitoring, the extent of detail varied.

- Those plans with the most comprehensive policies and procedures (from MBHOs) did not specifically mention HFP.
- The least comprehensive plans were submitted by county health plans, though they tended to include county-wide quality improvement activities related to the counties' priority target populations.
- Very few plans addressed collecting data about direct client outcomes.
- Only half of the plans submitted documentation showing they track time to first appointment after a MH/SA referral, an important quality indicator for access to care.

Quality of interpreting services

Fifteen plans submitted documentation concerning quality of interpreting services. The documentation submitted appeared to be general to all health services (including mental health and substance abuse services).

- Eleven plans (52%) submitted documentation regarding monitoring the accuracy of interpretation and subscriber satisfaction with the accuracy of interpreters.
- Four plans (19%) submitted sample satisfaction instruments or question items specifically addressing evaluation and improvement of interpreting services.

Complaints and grievances

Member satisfaction is an important part of monitoring quality of care. Since little is known about the extent of complaints and grievances among HFP subscribers related to mental health care, plans were asked to submit problem resolution and grievance policies and procedures. Plans were also asked to submit the “number of total overall logged HFP problems and grievances in the 2007-2008 benefit year plus the number related to mental health and substance abuse services” (see Appendix 4, Document Request Letter and Checklist, “Member Services” section). Table 6 lists the exact numbers of complaints and grievances. The general findings are:

- The behavioral health-related complaints are quite small in number.
- The complaint and grievance policies and procedures of only three health plans specifically address HFP.
- From the submitted documentation it appeared that all plans’ member complaint/grievance policies are comprehensive and most likely compliant with California’s mandated member complaint and grievance policies. However, a more in-depth analysis would be required to match each procedure with federal and California laws.
- Two plans (Kaiser and Central Coast Alliance) did not submit any information regarding complaints.
- Fourteen plans’ reports (67%) differentiated complaints related to MH/SA services versus other healthcare-related complaints, or simply reported the number of MH/SA complaints.

The parents’ perspective

Service access issues were addressed from the perspectives of parent participants in focus groups. These parents were recruited by Health Net (Los Angeles area), CalOptima (Orange County), Health Plan of San Joaquin (San Joaquin County), and Anthem Blue Cross (Riverside County) from lists of children who used mental health services during the 2007–2008 benefit year. Three on-site focus groups were held with a total participation of thirteen parents and youth. Another eleven parents were interviewed by phone. The on-site focus groups included parents who were primary Spanish speakers. Bilingual Spanish/English interpreters were provided for all focus groups. One focus group also included an interpreter for a Vietnamese-speaking parent. Phone call interviews were conducted in English or Spanish. The focus group interview sampling report is included as Appendix 8. Findings were organized under themes that characterized parents’ responses in the focus groups.

Identifying the problem and seeking treatment

Parents remembered noticing problems with their children very early. They mentioned the difficulties in convincing others that they were seeing something wrong. Often teachers and school personnel were the most likely people to notice behavioral problems for the first time outside of the home.

The role of the primary care physician

Early contacts with the primary care physician can be either very effective or frustrating for a parent noticing problems. Parents described the doctor as someone very trusted. Those doctors were especially valued who empathized with the parent, who validated the parent's concern, and who presented concrete options (such as a referral to a psychologist). On the other hand, when primary care doctors recommend medications early in the process, many parents view this as a response of convenience by doctors rather than a recommendation made after careful assessment. The recommendation of medications is a very sensitive issue, as indicated by the number of times parents addressed it spontaneously in the interviews.

The first appointments

Some parents experienced a delay of months before finally getting an appointment with a mental health clinician. For some parents the first few sessions were successful if they found "the right person." There is a steep learning curve for parents new to the mental health treatment system. More than once, parents described having to learn the system on their own—how mental health professionals make decisions, becoming assertive in order to meet their child's needs, understanding U.S. laws regarding confidentiality, and navigating administrative procedures.

Administrative procedures in accessing care

It is almost impossible for parents to separate administrative procedures from decision making about treatment, the latter being the most important issue for the parent unless the administrative procedures form an obstacle. In the early stages of seeking help, some parents reported calling three phone numbers before getting to the right person. When language is an issue this makes a complicated process of engagement in treatment even more burdensome.

Ensuring follow up care

Ensuring that follow up care occurs after the first session is critical to engaging parents and children in treatment. Parents new to the mental health system cannot be expected to know how to effectively ensure that follow up care is provided. Some plans make an effort to track the success of the referral to make sure subscribers have a first appointment, although most only track this retrospectively with the use of utilization reports.

Culture, language and stigma

In the focus groups we encountered cultural differences in the extent to which parents understand the mental health system. Language barriers made understanding the diagnostic and treatment planning issues even more difficult, even with an interpreter present.

Parents tend to prefer clinicians who speak the same primary language, though there was no evidence in the focus groups that there were difficulties in obtaining interpretation, either with a bilingual provider, an in-person interpreting professional, or the use of a language line. However, since the focus groups mainly included parents from urban areas, the experience of parents from rural areas may have been underrepresented. While stigma can discourage the use of services, most parents in the focus groups overcame it and learned to become assertive advocates for their children.

Parents' recommendations

In response to the question "What would you recommend we do in the community to help other parents get help for their children?" parents recommended the following:

- Education about the mental health process.
- Use of the school as a venue for educating parents about emotional problems and when to seek treatment.
- Delivery of mental health services at the school site.
- Offer parent support groups.

Regarding HFP in general, parents were generally very appreciative of having the health coverage and services available.

Cultural and linguistic proficiency

Plans were asked to submit various documents about providers, including lists of languages spoken by behavioral health providers and information about interpreters and the training they receive.

Multicultural characteristics of contracted providers

Of the information submitted, we were able to use provider language data from all but six health plans. Only eight plans submitted provider lists showing ethnicity.

After English, Spanish was the top language spoken among providers. The percentage of providers who speak Spanish ranges from 4.7% (Alameda Alliance) to 48.0% (Health Plan of San Mateo—county staff). The average percentage of providers who speak Spanish among the 16 plans that submitted provider ethnicity data is 11.4%. Three plans—Health Plan of San Mateo, LA Care Health Plan, and Blue Shield—had ratios of Spanish-speaking subscribers to Spanish-speaking providers exceeding the average ratio (2.9%). French is the second most-spoken language in eight plans.

Use of interpreters

Plans submitted information on their internal staff interpreters and externally contracted interpreters and interpreting services. This information pertained to general health plan services, not only to mental health or substance abuse services. The number of internal staff ranges from 12 in a county health plan to over 1,000 in a private statewide plan. Almost all plans use some type of external language line for interpreting services. Some national and international interpreting vendors are reported to have the capacity to handle 200 languages.

Training of interpreters

In the subsection *Training of Interpreters*, on page 59, examples are given of training programs for interpreters. Sixteen plans (76%) submitted either a document about training internal interpreters, training external subcontracted interpreters, or policies about how the plan monitors the quality of such services.

Challenges for health plans working with interpreters

Key informants consistently reported that they were satisfied with the interpreting alternatives available in the respective health plans, MBHOs, or provider organizations. The key informants we interviewed were unaware of any problems in the effectiveness of the interpreting infrastructure.

Data issues and limitations

Data sharing and data management issues remain for health plans, counties and providers. These limitations affected the validity of some findings in this report, and they continue to impact how well we can understand the performance of health plans. The following are areas most affected by data limitations:

- *Service data incompatibility*: plans vary in the type of service level data collected and in the type and number of databases used to collect service data; some plans rely on “paid claims” or claims data (post-service post-payment) data while others use “encounter” data (date of admission, type of service, number of visits in a given timeframe).

- *Demographic data inconsistencies*: variability in codes used to report race/ethnicity.
- *Pharmacy—coding and reporting*: variability in data reporting, coding or drug classification, and mixed ability to link prescriptions with diagnosis or service type.

RECOMMENDATIONS

Recommendations were made in six priority areas.

- ❖ ***Improve interface between primary care and behavioral health.***
 - *Require use of screening instruments and adapt or develop uniform tools*
 - *Improve processes of making referrals to behavioral health*
 - *Document tracking of follow up care*
 - *Share health records*

- ❖ ***Improve screening, access and treatment engagement.***
 - *Address needs of 0-5 age group by establishing screening, treatment options, and specialized providers*
 - *Address needs of adolescents by studying characteristics of the group and surveying providers, parents and subscribers*
 - *Address administrative barriers*

- ❖ ***Improve provision of substance abuse services.***
 - *Conduct statewide study*
 - *Health plans connect with community*
 - *Health plans screen for substance abuse specialists*

- ❖ ***Improve the tracking of quality and outcome data.***
 - *Disseminate and implement best practices in data sharing*
 - *Improve data capacity and validity*
 - *Study pharmacy data issues and quality*
 - *Health plans educate parents and providers about decision making*
 - *Improve tracking and standardize reporting of complaints*
 - *Include HFP subscribers in quality studies*

- ❖ ***Implement targeted outreach strategies.***
 - *Outreach in communities and neighborhoods*
 - *Outreach in schools*
 - *Use data to improve awareness and outreach*

- ❖ ***Increase parental support and education.***
 - *Educate parents about mental health care process*
 - *Create parent support groups*
 - *Recruit and train parent mentors*
 - *Conduct focus groups for monitoring quality of care*

❖ INTRODUCTION AND BACKGROUND ❖

California's Managed Risk Medical Insurance Board (MRMIB) initiated this study through a solicitation process. The solicitation requested an evaluation of mental health and substance abuse services provided by health plans, as Phase II and Phase III of a comprehensive examination of the provision of mental health and substance abuse services in the Healthy Families Program (HFP).

Phase I looked at services and referral processes for children with serious emotional disturbance (SED), which require coordination with, and services from, county mental health departments⁴ (Hughes, Kreger, Ng, & Brewster, 2006). The report made a number of recommendations to MRMIB concerning the SED carve-out. The recommendations included, but were not limited to the following:

- Creation of a state-wide forum for increasing the understanding of health plans and county mental health departments about issues related to referrals, assessment and treatment.
- Ensuring that both county mental health depts. and health plans have dedicated HFP SED liaisons.
- Clarifying within the model MOU between health plans and counties which entity is responsible for services if the county capacity is insufficient to provide services.
- Emphasizing the importance of early mental and behavioral health screening for all children and periodic repeat screening for high risk children through the currently available screening tools.
- Designing and adopting easy to use referral systems for providers and families so that screened children who warrant health plan or county mental health department assessments have a clear path to the next step in the assessment process.
- Building the interagency collaboration necessary to have operationally efficient systems of referral and treatment and facilitate primary care providers' involvement in these systems.
- Continuing to track and report the number of referrals from health plans to county mental health departments so as to monitor trends in referrals and health plans' involvement in SED identification and treatment.

⁴ California's 58 counties administer their own mental health programs. Some counties have integrated mental health and substance abuse services under one "behavioral health" department, while others continue to operate separate mental health and substance abuse treatment systems. For ease of presentation in this report we will refer to such services as "mental health" or "substance abuse" services.

In April 2007, MRMIB convened a mental health workgroup comprised of HFP plan and county mental health liaisons, MRMIB staff, County Mental Health Directors Association (CMHDA) staff, and Department of Mental Health (DMH) staff. The workgroup continues to meet quarterly. MRMIB uses the workgroup's expertise to identify best practices in the coordination and provision of care to children with SED as well as the provision of mental health and substance abuse services provided by the HFP health plans.

Phase II and Phase III were focused on mental health and substance abuse (MH/SA) services provided by the HFP participating plans. APS proposed a multi-method approach that included the following:

- Evaluate the provision of mental health (MH) and substance abuse (SA) services through available data.
- Assess quality monitoring of services by health plans.
- Evaluate plan processes and policies relating to subscriber access to services.
- Describe the current cultural and linguistic proficiency of health plans and providers; evaluate plan processes and policies relating to plans' and plan subcontractors' cultural and linguistic proficiency as related to mental health and substance abuse services.
- Convene five focus groups representing the urban, rural, coastal, and special populations of the state, which would include one focus group of Spanish-speaking only subscribers.
- Obtain information from plan subscribers via focus groups.
- Review, evaluate, and assess health plan materials and subscriber correspondence related to mental health and substance abuse services.
- Review health plan materials related to communication with subscribers related to outreach, plan forms, and other materials.

MRMIB awarded the contract to APS. The evaluation team consisted of analysts and managers from APS's Sacramento office (Sheila Baler, Ph.D., Michael Reiter, Pharm. D., and Saumitra SenGupta, Ph.D., Project Directors; Esperanza Calderon, Project Coordinator) with subcontracted research services from San José State University (Edward Cohen, Ph.D., Principal Investigator; Gerardo Salinas and Karen Parsons, Student Researchers).

BACKGROUND OF THE HFP MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

As California's federally sponsored low-cost Children's Health Insurance Program (CHIP) for children and adolescents up to age 19, HFP offers comprehensive health, dental and vision benefits. Benefits for mental health services include up to 20 days per year of outpatient

services, and up to 30 days per year for psychiatric inpatient care. SED services⁵ are not predetermined but depend on determinations of medical necessity for care, as assessed by mental health departments.

Substance abuse services include inpatient services for detoxification (as medically appropriate to remove toxic substances from the system), and up to 20 outpatient visits per year. These benefits comprise the plan-provided services for MH and SA care—in contrast to the SED benefit, which allows extended services provided at the discretion of county mental health departments for eligible children.

The project was undertaken between July 1, 2008 and June 30, 2010. The data collection period was from July 1, 2007 to June 30, 2008. Eight months following the beginning of this evaluation, major federal legislation, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), was passed which impacted children's health insurance and mental health and substance abuse services parity. CHIPRA is the primary source of funding for HFP. The reauthorization allowed children enrolled in HFP to access comprehensive health, dental and vision care, including requiring states to implement the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008.

The mental health and substance use disorder parity requirements of the Wellstone/Domenici Act are being implemented in the HFP effective October 1, 2010. There will be no limitations on inpatient stays or outpatient visits for either mental health or substance use disorder treatment. There will also be no difference in cost sharing between mental health and substance use disorder treatment and medical/surgical treatment.

This context is important as this evaluation pre-dates key legislation action affecting mental health and substance abuse services parity.

Twenty-one health plans provided services to HFP subscribers during the study period 2007-2008. The relationships between the plans and behavioral health providers are varied. Some plans use county behavioral health departments as the provider "network," some use behavioral health providers that subcontract to local independent practice associations; while others subcontract with large national managed care companies that provide administrative services, such as provider networks and utilization management of care.

⁵ For purposes of this report, "SED services" refers to the SED "carve out," whereby services are provided by county mental health departments for those children and youth who are assessed as seriously emotionally disturbed, as defined in the State of California Welfare and Institutions Code Section 5600.3(a)(2). The other defined benefits provided by health plans covered in this report will be identified as "plan-provided services." Both types of care are included in the HFP.

Table 1 (see Appendix 1) summarizes the HFP plans, along with the entity that provides the mental health services.

UTILIZATION OF HFP MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BY CHILDREN AND ADOLESCENTS

In initial conversations, the study team and MRMIB staff concluded that a primary reason for initiating the study was the low utilization of plan-provided mental health services among HFP subscribers.

In a recent report using data submitted by the plans, MRMIB concluded that mental health utilization from 2004 to 2007 was very low – approximately 3% of subscribers received a non-SED mental health service over each of the three years (California Managed Risk Medical Insurance Board, 2009).

Some plans' service use rates were lower than 1%. Kaiser and the San Francisco Health Plan had the highest mental health care service utilization rates at 10% and almost 5% rates, respectively, from 2006 through 2007.

SYSTEMATIC STUDIES OF CHILDREN'S MENTAL HEALTH SERVICE USE

There are no systematic studies of the utilization of mental health and substance abuse services in states' CHIP programs.

How does the HFP experience compare with service use in other Children's Health Insurance Programs (CHIPs)? Unfortunately, there are no systematic studies of other CHIP programs, so comparison to service use in community studies, Medicaid and the private sector (employer-based and individually purchased private insurance) may be useful, though limited in comparability. There are few recent studies; however, four studies may be relevant for comparison to HFP:

- A national benchmarking study of Medicaid and mental health authority services for children and adolescents (Dougherty Management Associates, 2005).
- A California study of the impact on children's Medicaid (Medi-Cal) services by expansion of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program (Snowden, Masland, Wallace, Fawley-King, & Cuellar, 2008).
- Recent findings by the National Survey of America's Families (NSAF) (Howell, 2004). The NSAF was a survey of households that included the health care needs and service utilization of children.

- California’s Medi-Cal “paid claims” for children’s mental health services in 2008 (APS Healthcare, Inc, 2008). These data were collected from a statewide database of services provided by county mental health plans.

Figure 1 provides a summary of the findings from these studies.

Figure 1. Summary of Utilization Rates from Four National Studies

<i>Study</i>	<i>Sample</i>	<i>Utilization Rate⁶</i>
National Benchmarking Study (Medicaid and publicly funded services)	20 states (including California)	2% - 16%
Impact of EPSDT (Medicaid) Expansion	58 counties in California	Increase from 1.29% in 1992 to 3.91% by 2001
NSAF survey (Various types of funding)	National sample of households	Medicaid: 13% Other insurance: 8.2% ⁷ Uninsured: 4.5%
APS Healthcare, 2008 (Medicaid)	Specialty mental health Medi-Cal approved claims data from all 58 counties in California	5.89%

As shown in these studies, California’s low utilization rates in HFP indicate unmet need. The prevalence of mental disorders in children and adolescents in the general population has in some studies been measured as high as 37% (although not all may need treatment at any given time). The prevalence of SED in children may be as high as 13% (Costello, Mustillo, Erkanli, Keeler, & Angold (2003).

There is evidence of higher prevalence and severity of mental health problems for both undiagnosed and diagnosed children whose families’ income qualify them for either Medicaid or CHIP, compared to those with higher incomes (Howell, 2004).

⁶ The number of children receiving a Medicaid-funded mental health service divided by the number of children enrolled in Medicaid.

⁷ Utilization rates for “Other insurance” and “Uninsured” are computed as the ratio of service users to the total of those with either other insurance or estimates of those who are uninsured.

What factors influence the use of mental health services by children and adolescents?

Research literature includes the following factors—parental attitudes about their children’s mental health problems and the value of treatment, culturally-based attitudes, availability and capacity of providers, and seriousness of the child’s problem (including coercive pressures from schools)—amongst others (U.S. Department of Health and Human Services, 2001; Owens et al., 2002).

The authors are not aware of any available studies on utilization of mental health and substance abuse services specifically provided by CHIP programs. There has yet to be a comprehensive analysis of utilization of plan-provided services, and there is also a continuing need for organizational research on the structure and process of service provision in a population like California’s, which has a high degree of ethnic diversity. As of February, 2010, over 51% of HFP enrolled subscribers were Latino (California Managed Risk Medical Insurance Board, 2010). The environment in which HFP subscribers are served may be quite different than the private health insurance or Medicaid health environments.

The study team and MRMIB hypothesized that, considering the ethnic distribution of HFP subscribers, a combination of factors may be responsible for the current low rates of service use:

- cultural pre-dispositional factors of parents and communities;
- cultural competence and capacity of providers;
- ability of primary care practitioners to screen and refer to mental health services as needed;
- extent and cultural appropriateness of outreach and education, specifically about mental health and substance abuse problems and treatment alternatives; and
- administrative processes and procedures for accessing care.

The methodologies of the project were designed to address these various alternative explanations.

❖ METHODOLOGIES ❖

PROJECT COMPONENTS

This study utilized multiple methods of data collection and analysis. The project included four components:

- Document Review—plans were asked to submit up to 55 policies, procedures and brochures in response to a request included as Appendix 4.
- Data Request—a set of aggregate data reports was requested from health plans in the areas of inpatient and outpatient mental health services, inpatient and outpatient substance abuse services, and pharmacy, using data from the benefit year 2007–2008. The Data Request and introductory letter are included as Appendix 5.
- Key Informant Interviews—interviews were conducted with staff, administrators, and providers of a representative sample of health plans. A summary of the key informant interview sites is included as Appendix 6. An interview protocol for the key informant interviews is included as Appendix 7.
- Subscriber Focus Groups—four regionally-based focus groups and individual phone calls were held with subscribers who used mental health services. The focus group interview sampling report is included as Appendix 8. A focus group interview protocol is included as Appendix 9.

Table 2 (see Appendix 1) shows the distribution of all survey items received, sorted from the smallest to the highest percentage of health plans responding.

More detailed information about the methodologies for each component is included as Appendix 2. HFP enrollment and demographic data by health plan are shown in Appendix 3.

PROTECTION OF RESEARCH PARTICIPANTS

The project was approved by the San José State University’s Institutional Review Board. The approval covered informed consent forms and protocols for all components of the project. In addition, the protection of project data was stipulated in the business agreement between MRMIB and APS. Materials from the key informant interviews and focus groups—such as the researcher’s notes, contact logs, and signed informed consents—were protected as required by federal and state guidelines for the management of private health information.

❖ FINDINGS ❖

Key Findings

- ❖ The use of outpatient services in HFP remains lower than the national average.
- ❖ Services for 0–5 year olds are especially underutilized.
- ❖ Children aged 6-12 use the most mental health services, but service use drops dramatically for the older adolescent age groups
- ❖ The use of substance abuse services is negligible in all but two health plans—contributing factors include inadequate benefits and provider capacity.
- ❖ Parents experience barriers in access to care, despite the availability of bilingual personnel and interpreting services.
- ❖ Primary care is a very important gateway to mental health and substance abuse services.
- ❖ Trends in the use of psychiatric medications for HFP children match practice patterns in the general psychiatric community.
- ❖ The most common mental health diagnosis among HFP subscribers is ADHD.
- ❖ Accessing initial care is difficult for some parents new to mental health care
- ❖ There remain data problems that pose a barrier to a complete understanding of the utilization of services and prescribed medications

SUBSCRIBER UTILIZATION OF PLAN-PROVIDED SERVICES

Overall average utilization rates

The overall utilization rates by health plan for inpatient and outpatient MH care are shown in Table 3 (see Appendix 1).

From the data provided by health plans for this study, the overall average inpatient admission rate was .09%. The rates range from .01% (CenCal Health) to .22% (LA Care). It is difficult to interpret these rates—are they too low or high? There are no national benchmark standards for inpatient admissions for children and adolescents. Can inpatient rates be compared across health plans? Comparisons between health plans would not be useful at this time, due to variations in provider and hospital capacity.

High inpatient rates may indicate adequate responsiveness to crisis needs, whereas they may also indicate gaps in provider capacity for outpatient care, where inpatient facilities pick up the slack. Low inpatient rates may indicate a lack of hospital capacity or timely screening, or they may imply that there are adequate outpatient resources to respond to children with higher needs without the need for hospitalization. Interpreting these rates can only be done within the context of each health plan's provider capacity and its geographic presence.

Outpatient utilization rates averaged 1.79%, far below national rates from other public mental health and Medicaid programs.

The outpatient utilization rates averaged 1.79%, with a range of .07% (Care 1st) to 3.98% (Kaiser)⁸. This rate is far below the rates from benchmarking studies in public mental health systems, and below most Medicaid programs. However, as in the previous mental health utilization data on plan-provided services collected by MRMIB (California Managed Risk Medical Insurance Board, 2009), there is much variation among plans. The plans whose rates exceeded the average (1.79%) included CalOptima, Community Health Group, Health Net, Health Plan of San Joaquin, Kaiser, and San Francisco Health Plan.

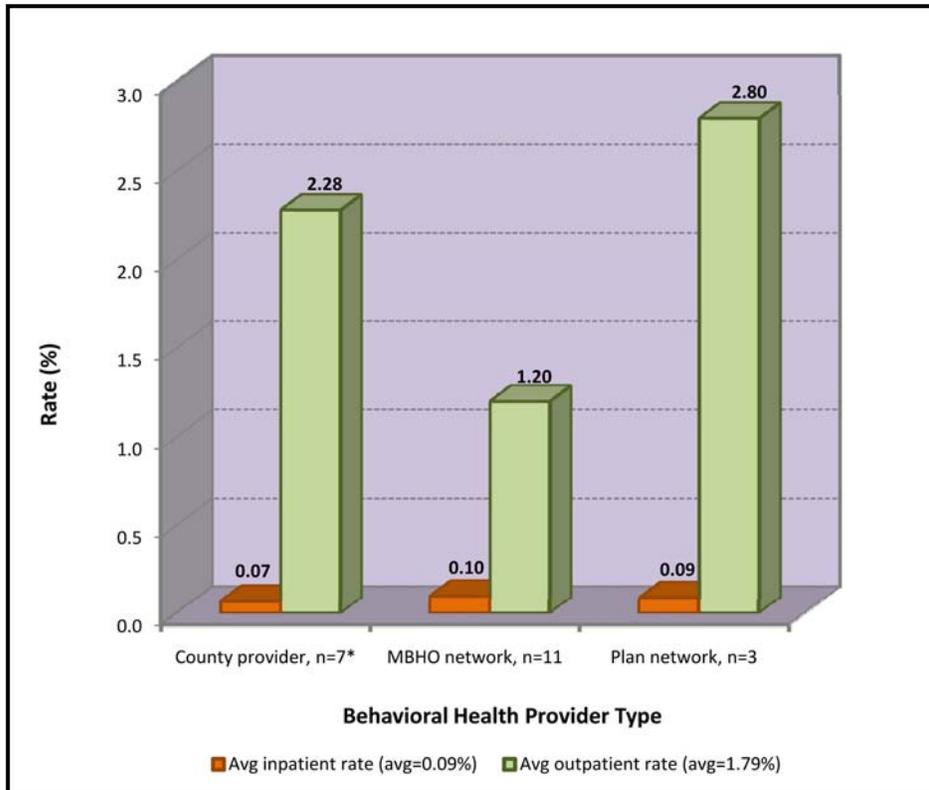
Utilization rates by plan characteristics—Provider network and size of plan

Can the differences in organizational structure of health plans (such as the type of provider network) be related to the utilization of mental health services? Figure 2 shows the distribution of outpatient and inpatient rates by type of behavioral health provider network, categorized for this analysis as county provider (plans that utilize county mental health agencies or county contracted providers), MBHOs (plans that subcontract or delegate provider management to MBHO companies), or plan network (plans that manage their own networks or subcontract directly with community providers).

The inpatient rates were very similar for all three types of providers. Plan networks showed the highest outpatient utilization rates, followed by county networks and then MBHOs. The outpatient utilization rates differed the most when comparing MBHO and plan networks. Testing the assumption that plans with larger enrollment also have more provider capacity, we found no significant correlation between the enrollment size of the health plan and outpatient utilization rates (not shown in Figure 2). More detailed analysis of provider capacity was beyond the scope of this project. In addition, since we did not have access to subscriber level data with zip code or other geographic markers, an analysis of rural versus urban experience was not possible.

⁸ These rates are lower than those reported on the use of any mental health service in 2004-2005 by the plans to MRMIB (California Managed Risk Medical Insurance Board, 2009). There may be differences in how services were counted and data reported. See page 59, "Data Limitations and Issues."

Figure 2. Comparison of 2007–2008 Inpatient and Outpatient Utilization Rates by Type of Behavioral Health Provider



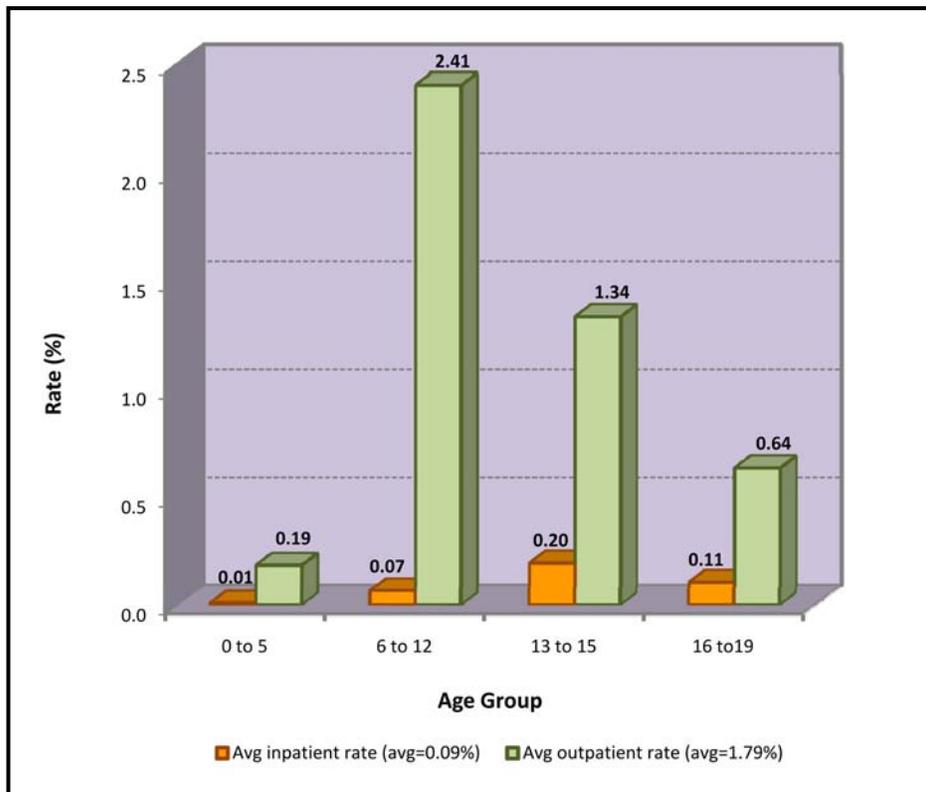
*Note: Kern Family Health Care did not provide outpatient data

Utilization rates by age

To understand differences in service use, the plans were asked to break down utilization data by age group. For purposes of this study, the predetermined age groups were

- 0 to 5
- 6 to 12
- 13 to 15
- 16 to 19

Figure 3 shows the utilization rates for inpatient and outpatient utilization by age group. Children aged 6–12 were clearly the highest users of outpatient care, which can be expected since most children’s learning, cognitive and behavioral problems are first noticed at that age as they begin attending school and progress towards middle school. It is surprising, however, that the outpatient rates decrease by about half for each subsequent adolescent age group, while inpatient rates increased. This may indicate that continuity of care is a problem for older children.

Figure 3. Inpatient and Outpatient Utilization Rates by Age, 2007–2008

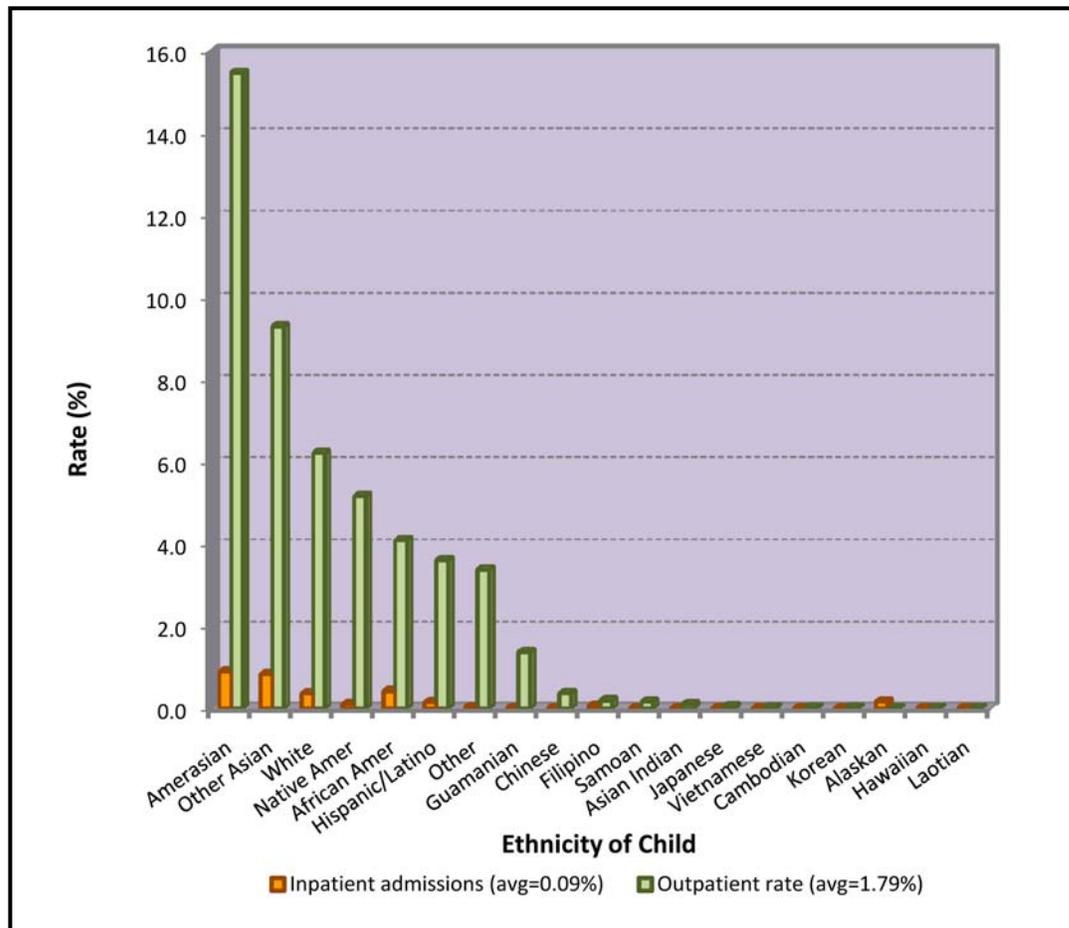
An alternative explanation is that the older children and adolescents who continue to have difficult psychological problems are referred to counties for SED treatment services, and are thus no longer receiving the plan-provided services. We cannot confirm this with the available data; however, a previous MRMIB report indicates that of treated children and adolescents, older children and adolescent age groups have higher rates of SED treatment (California Managed Risk Medical Insurance Board, 2009). It should also be noted that SED referrals are low in general based on the findings of the UCSF study cited previously (Hughes et al., 2006), so referral to SED services is not a likely explanation for the dropoff in treatment rates for adolescents. In addition, 0–5 year olds and their parents are not without psychological problems of their own, and the low rate of outpatient utilization may indicate the need for better outreach, screening, diagnosis and treatment of the unique developmental problems for this age group.

Utilization rates by ethnicity

To understand differences in service use by ethnicity, plans were asked to sort utilization rates by ethnicity categories, which were taken from the suggested categories in the HFP enrollment application (“ethnicity of child”). The distribution of inpatient and outpatient service use by ethnicity of the child is shown in Appendix 1, Table 4.

In order to see the distribution more clearly, Figure 4 shows these data sorted in descending order by outpatient treatment rates. The Amerasian category had the highest treatment rates, influenced primarily by high rates of services for CalOptima’s subscribers, who self-identified as Amerasian (39 out of an enrolled 55 used outpatient services). Those ethnic groups whose subscribers had outpatient rates higher than the overall average of 1.79% were African American, Amerasian, Hispanic/Latino, Native American, Other Asian, White, and Other.

Figure 4. Inpatient and Outpatient Utilization Rates by Child’s Ethnicity, Sorted in Descending Order of Outpatient Rates, 2007–2008



The coding of “ethnicity” was problematic for many health plans. See the section “Data Issues and Limitations” for specific problems in how ethnicity is coded and reported by the plans.

HFP subscribers served as a percent of HFP enrollment by race/ethnicity

In studies of health service disparities, comparisons of the proportion of enrollees served by race/ethnic category are useful to assess the service experiences of various race/ethnic groups.⁹

Ratios of the number of outpatient service users to those enrolled were calculated for each ethnicity category. The distribution is shown in Figure 5 below, which is sorted by largest to smallest ratio. The smaller the percentage, the greater the disparity between those served vs. those enrolled. Refer to Table 4 in Appendix 1 for mental health utilization rates by race/ethnicity.

Figure 5. Ratio of Ethnicity Served to Ethnicity Enrolled, 2007–2008

<i>Ethnicity of child</i>	<i>Number of outpatient users</i>	<i>Enrolled subscribers</i>	<i>Ratio of served to enrolled</i>
Alaska Native	16	45	35.56%
White	4,230	91,578	4.62%
Other Asian	645	16,999	3.79%
Black/African American	541	18,893	2.86%
Native American Indian	54	2,442	2.21%
Unknown or Not Given ¹⁰	3,481	166,751	2.09%
Amerasian	47	2,595	1.81%
Hispanic/Latino	6,567	479,471	1.37%
Guamanian	2	172	1.16%
Cambodian	5	2,034	0.25%

Continued on next page

⁹ Ideally, the comparison of service users to some measure of need, such as the proportion of people who are estimated to have a mental disorder, is typically done in disparities studies when such information is available, since this would adjust for differences in need between ethnicity groups. This information was not available for use in this study.

¹⁰ This category represents a merging of two categories in the services and enrollment data—“Other/Unknown” and “Not Given.” For the “Not Given” data, the number of service users far exceeded the number of enrolled, pointing to a data problem with either the enrollment data, service data from plans, or both.

<i>Ethnicity of child</i>	<i>Number of outpatient users</i>	<i>Enrolled subscribers</i>	<i>Ratio of served to enrolled</i>
Japanese	1	585	0.17%
Samoan	1	585	0.17%
Asian Indian	4	6,513	0.06%
Filipino	5	9,981	0.05%
Vietnamese	6	16,577	0.04%
Korean	4	10,926	0.04%
Chinese	8	24,504	0.03%
Hawaiian	0	336	0.00%
Laotian	0	956	0.00%

Monitoring ratios of service users to enrollment would be a useful measure of improvements in addressing disparities by ethnicity.

Asian ethnicities are more underserved than other ethnicities (with the exception of “Other Asian,” a category that contains a significant number of outpatient users). From the data reports it was not possible to understand which ethnic groups were included in this category.¹¹ (This would be important to clarify, since, for example, the San Francisco Health Plan reported an outpatient utilization rate of 3.28% for the “Other Asian” category.)

It is difficult to interpret this table since there is no standard “cut off” for these ratios that would indicate an appropriately served group; however, differences between groups are apparent, and ongoing monitoring of the ratios of service users to enrollment would be a useful measure of improvements in addressing disparities by ethnicity.

Utilization rates by parent’s primary language

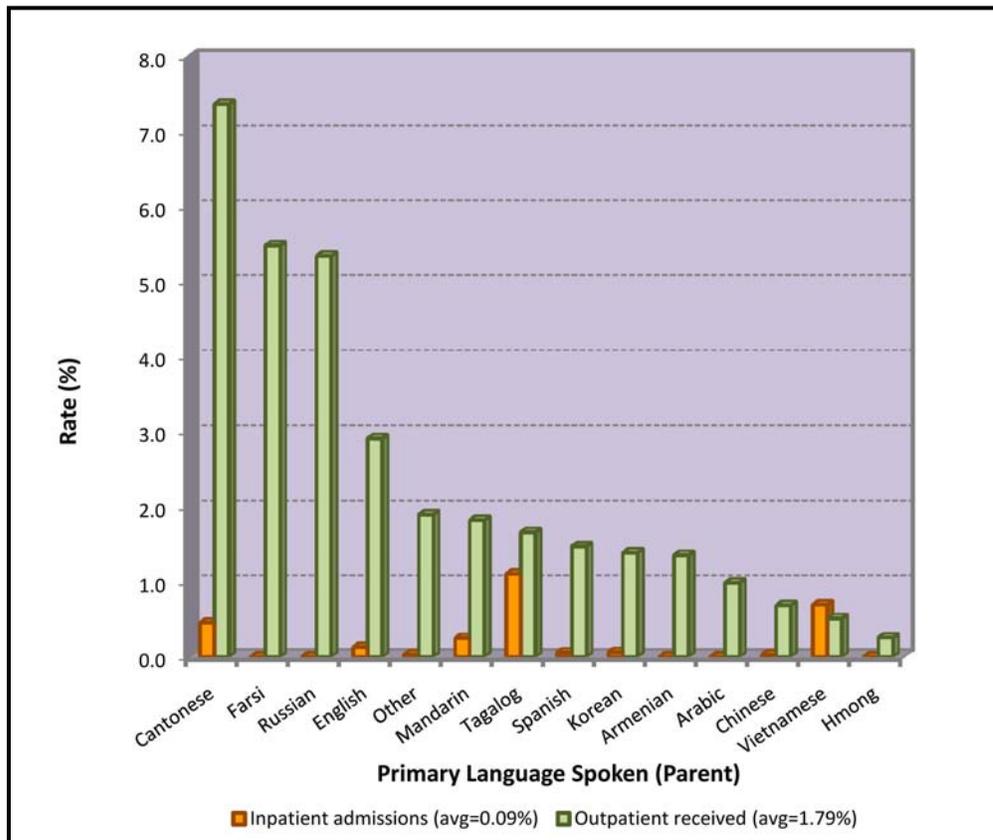
As with the analysis of service use by ethnicity, the comparison of service rates by primary language spoken (by parent) is important for understanding the impact of language spoken on access to and engagement in services.

Average utilization rates by parent’s primary language spoken are shown in Figure 6. Patterns indicated in Table 5 (see Appendix 1) are more clearly shown in Figure 6, which

¹¹ When all Asian and Pacific Islander groups are combined into one group, the ratio of served to enrolled is 0.63%, quite low relative to other ethnic groups.

displays both inpatient and outpatient rates sorted by descending order of outpatient rate. Cantonese speakers¹² were the most represented of users of outpatient care. Cantonese, Farsi, Russian, English and Mandarin speakers’ utilization rates in outpatient care exceeded the average overall rate of outpatient care reported above (1.79%). Subscribers who wrote in “Other” (or were categorized as such by health plans or providers) also exceeded the average outpatient utilization penetration rate. Tagalog speakers had the highest inpatient utilization rate 1.11%), followed by Vietnamese (0.70%) and Cantonese speakers (0.46%).

Figure 6. Inpatient and Outpatient Utilization Rates by Parent Primary Language, Sorted in Descending Order of Outpatient Utilization Rate, 2007–2008



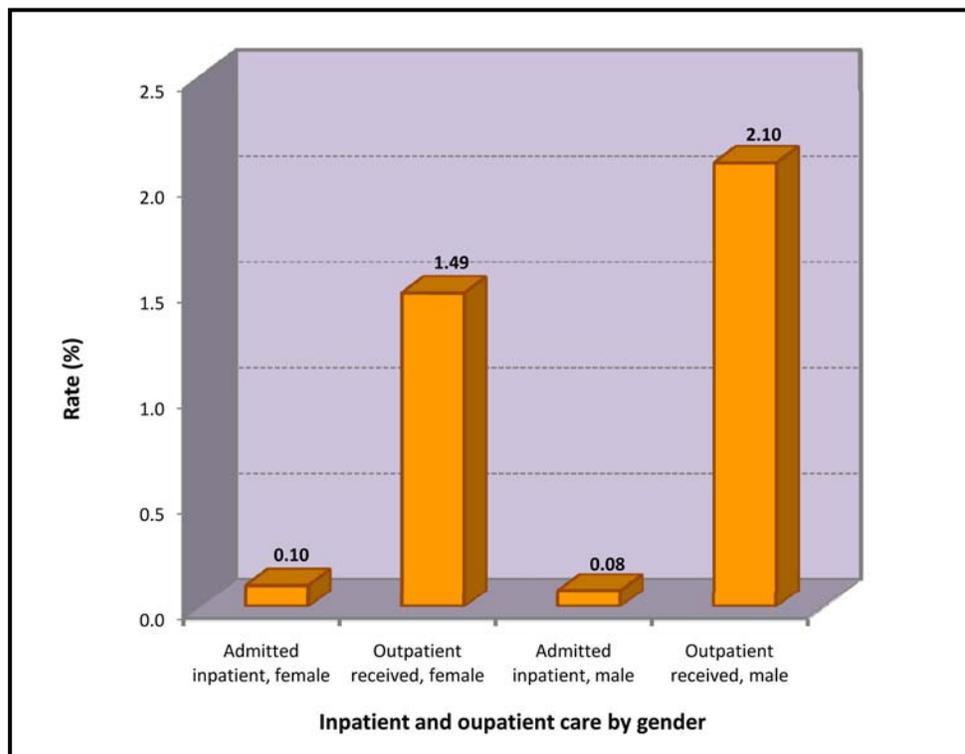
¹² The data on parent’s primary language were organized by health plans and Maximus, based on responses to the application question “What language do you want us to speak to you in?” and subscribers wrote in their answers on the application form. Responses included Chinese, Cantonese and Mandarin. We left the categories as is, without combining Mandarin and Cantonese into the “Chinese” category.

Utilization rates by gender

Differences in HFP mental health utilization rates by gender

The distribution of those admitted as inpatients and those receiving outpatient services by gender is shown in Figure 7. Slightly more females were admitted to inpatient hospitals, whereas 41% more males than females had at least one outpatient visit. The predominance of males in treatment may have to do with their higher rates of ADHD (in some studies, as high as nine times more than girls, Barkley, 2005), although prevalence research on other disorders—such as conduct and oppositional defiant disorders, depression, and learning disorders—show little difference between school-age boys and girls. The unique aspects of how these disorders are manifested in the HFP population are worth exploring to explain gender differences in outpatient service use.

Figure 7. Inpatient and Outpatient Utilization Rates by Gender, 2007–2008



Diagnosis in HFP: Common Mental Health Diagnoses and Utilization Rates

The most common psychiatric diagnoses reported by HFP health plans for children being treated (most common; second most common; etc.) are listed in order as follows¹³:

- *Most common diagnosis*: Attention Deficit Hyperactivity Disorder (ADHD) and other behavioral disorders (reported by 14 plans)
- *Second most common diagnosis*: Anxiety disorders (reported by 7 plans)
- *Third most common diagnosis*: Depressive disorders (reported by 6 plans)

This finding is consistent with recent national surveys of common psychiatric diagnoses for children (U.S. Department of Health and Human Services—National Institutes of Health, 2009). The predominance of the diagnosis of ADHD/behavioral disorders in boys, as previous research suggests (Reid et al., 2000), may also explain their higher outpatient utilization rates since the behavioral symptoms associated with ADHD are more noticeable to teachers and parents and often more disruptive to classrooms than symptoms related to depression or anxiety.

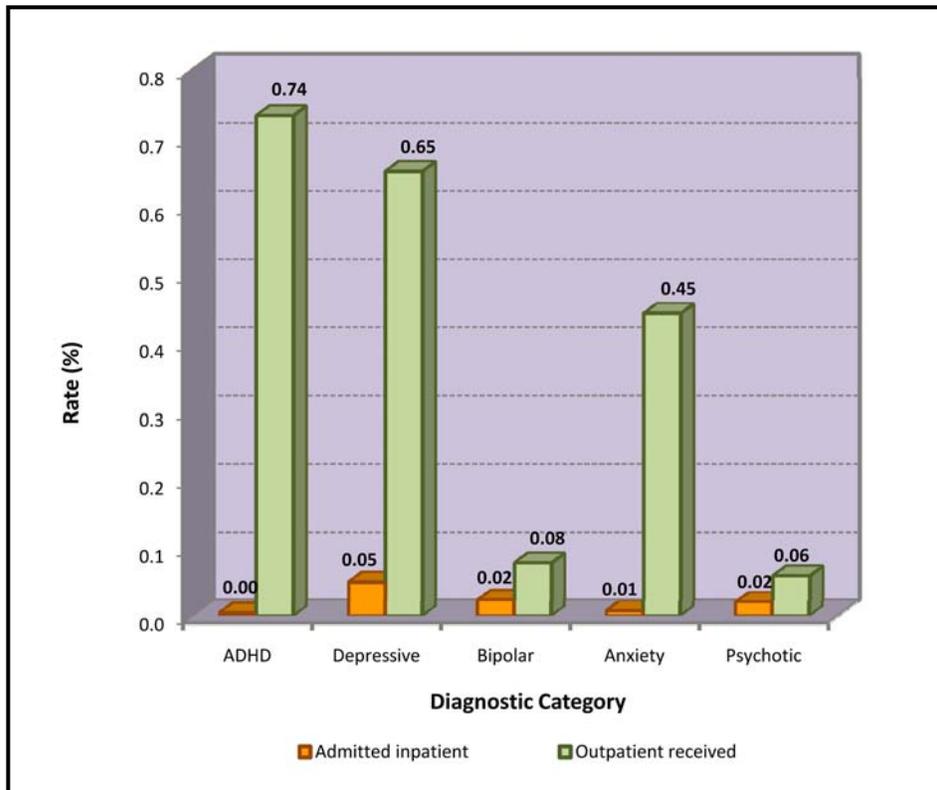
Mental health service utilization rates by diagnostic category

Health plans reported inpatient and outpatient utilization rates by diagnostic category. The diagnostic categories were organized as follows:

- ADHD diagnosis, including conduct or behavioral disorders
- Depressive disorders
- Bipolar disorders
- Anxiety disorders, including stress disorders
- Psychotic disorders

Figure 8 shows the distribution of inpatient and outpatient utilization rates by diagnostic category, relative to the health plans' total enrollment. Not surprisingly, the highest utilization rate was for children in outpatient care with an ADHD or behavioral diagnosis, followed by those with a depressive disorder, and then anxiety disorder.

¹³ These diagnostic categories are consistent with both the Diagnostic Statistical Manual of Mental Disorders (DSM-IV-TR) as well as the International Classification of Diseases (ICD-9). See the "Data Issues and Limitations" section for a summary of the data limitations and data sources reported by the health plans.

Figure 8. Inpatient and Outpatient Utilization Rates by Diagnostic Category, 2007–2008

Pharmacy: Medication use in HFP

Given the growth of the use of medications in psychiatric practice, this study sought to gather available data about medication use in HFP for children and adolescents. In the data request component, plans were asked the following questions about the use of psychoactive medications during the benefit year 2007–2008:

- The distribution of prescribed medication by age
- The most commonly prescribed medications by diagnostic category

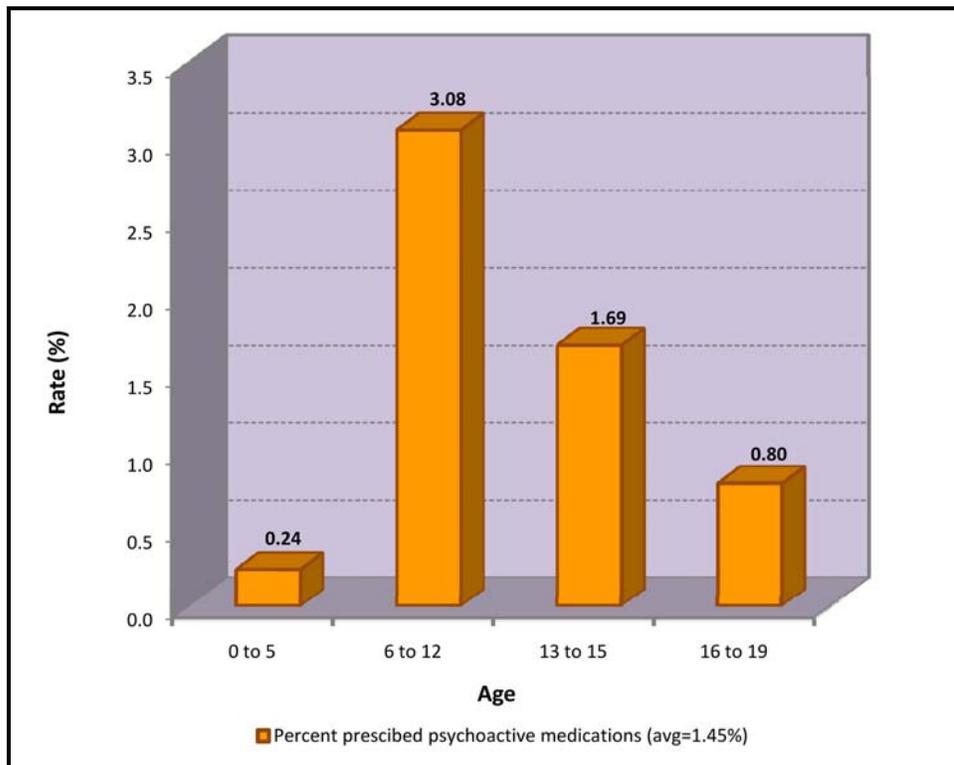
Medication prescribed by member age

Figure 9 shows the utilization rates of medication prescriptions by age group¹⁴. The pattern is very similar to the use of outpatient services by age—the 6–12 age group had the highest amount of prescribed medications. The age groups for adolescents (ages 13–15 and 16–

¹⁴ Utilization rates were calculated by the number of children reported to have been prescribed psychoactive medications for each age group, divided by the number of enrolled children for each age group.

19) showed lower rates, similar to the patterns of rates in outpatient care. If adolescents are stopping treatment prematurely or are not provided opportunities for outpatient access, this would be reflected in both the utilization of outpatient visits as well as the use of psychoactive medications.

Figure 9. Psychoactive Prescription by Age, 2007–2008



Frequently prescribed medications for mental health treatment

Figure 10 shows the most frequently prescribed medications by mental health diagnostic category. For the most part, the drug classifications reported match the diagnostic categories for which the medication was prescribed. It should be noted, however, that the clinical trials for using psychoactive medications for depression in children are still in the early stages (Antonuccio, 2008), although the Academy of Child and Adolescent Psychiatry has concluded that fluoxetine in combination with Cognitive Behavioral Therapy is effective and safe based on experimental trials (American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, n.d.).

Figure 10. Most Frequently Prescribed Medications by Diagnostic Category, 2007–2008

<i>Diagnostic category</i>	<i>Most commonly used medications/ Classification (% of plans reporting)</i>	<i>Second most commonly used medications/ Classification (% of plans reporting)</i>
ADHD	<ul style="list-style-type: none"> • Concerta, Metadate, Methylphenidate, Ritalin (Methylphenidate)/ Psychostimulant (76%) • Risperdal (Risperidone)/ Antipsychotic (48%) 	<ul style="list-style-type: none"> • Adderall (Amphetamine)/ Psychostimulant (48%) • Strattera (Atomoxetine)/ Psychostimulant (24%)
Depressive disorders	<ul style="list-style-type: none"> • Prozac (Fluoxetine)/ Antidepressant (48%) • Zoloft (Sertraline)/ Antidepressant (14%) 	<ul style="list-style-type: none"> • Prozac (Fluoxetine)/ Antidepressant (19%) • Zoloft (Sertraline)/ Antidepressant (19%)
Anxiety disorders	<ul style="list-style-type: none"> • Prozac (Fluoxetine)/ Antidepressant (19%) • Ativan (Lorazepam)/ Benzodiazapine (19%) 	<ul style="list-style-type: none"> • Ativan (Lorazepam)/ Benzodiazapine (14%) • Zoloft (Sertraline)/ Antidepressant (14%)
Bipolar disorders	<ul style="list-style-type: none"> • Abilify (Aripiprazole)/ Antipsychotic (14%) • Prozac (Fluoxetine)/ Antidepressant (14%) • Lithium/ Mood stabilizer (14%) • Risperdal (Risperidone)/ Antipsychotic (14%) 	<ul style="list-style-type: none"> • Celexa (Citalopram)/ Antidepressant (10%) • Eskalith (Lithium)/ Mood stabilizer (10%)
Psychotic disorders	<ul style="list-style-type: none"> • Risperdal (Risperidone)/ Antipsychotic (48%) • Abilify (Aripiprazole)/ Antipsychotic (19%) 	<ul style="list-style-type: none"> • Abilify (Aripiprazole)/ Antipsychotic (19%) • Seroquel (Quetiapine)/ Antipsychotic (14%)

As for the use of Risperdal for ADHD, as of 2009 there was little evidence of its effectiveness despite its widespread use with children (Thomson, Maltezos, Paliokosta, & Xenitidis, 2009), while the evidence of effectiveness is strong for the use of psychostimulants for children and adolescents, in combination with cognitive coping strategies. The diagnosis of bipolar disorder is increasingly being used for pediatric populations, and most practitioners use

a combination of mood stabilizers and psychotherapy for children and adolescents with this diagnosis (McClellan et al., 2006).

In summary, these medication practice patterns seem consistent with those in the wider practice community, although even in the wider practice community some medications are being used despite the lack of evidence justifying their use for children.

Substance abuse treatment

Only 0.07% of HFP enrollees utilized outpatient substance abuse treatment in 2007-2008. Two plans provided the majority (88%) of these services—Kaiser (68%) and CalOptima (20%).

The numbers on substance abuse treatment utilization in HFP were extremely low overall. Only thirteen children and youth used inpatient, and 437 used outpatient substance abuse services in the study year 2007–2008. To put this number in perspective, 437 represents only 0.07% of the 852,000 enrolled in HFP during the study year. The numbers were not distributed evenly among the plans. Kaiser was responsible for 299 of those utilizing outpatient care, and the next highest utilization was for CalOptima, with 86 outpatient users.

These two plans accounted for 88% of HFP members treated for substance use disorders. See the “Discussion—Implications of Findings” section regarding the implications of low utilization of substance abuse treatment.

COORDINATION OF CARE: PRIMARY CARE, SERVICE AUTHORIZATION AND SCREENING

This section covers three main areas: (a) coordination between physical and behavioral healthcare, (b) authorization (or pre-approval) of treatment and (c) standardized screening and assessment instruments. Documents from HFP health plans, and information obtained from focus groups and key informant interviews were used to assess health plans in each of these three areas.

Coordination between physical and behavioral healthcare

Fourteen out of 21 plans (67%) addressed coordination between primary care and behavioral health care. All but one of these plans submitted actual referral forms for MH/SA services, and all fourteen submitted consent forms for sharing information between primary care and behavioral health providers. These plans addressed procedures related to referral and follow up to MH/SA services from primary care, although the amount of detail used to describe the procedures varied.

Health Net submitted an example of a referral form to MH/SA services. The form can be used by primary care providers and allows for the documentation of relevant information for

continuity of care that might be known by the primary care provider, such as demographic information, known MH or SA diagnoses, current medications, and date of last well-child exam. This form can serve as a model for referral communication from primary care to mental health services.

LA Care Health Plan's Coordination of Care Tracking forms (presumably meant to be placed in the patient's medical record) allow providers to track contacts between primary care and behavioral health clinicians.

The seven plans subcontracting with Optum MBHO (Alameda Alliance, Blue Shield, CenCal Health, Central California Alliance for Health, Inland Empire Health Plan, LA Care Health Plan, and Ventura County Health Plan) submitted Optum's general policies concerning care coordination. While Optum's policies mentioned the importance of coordinating care with primary care they lacked detail about exactly how the coordination should work. Other managed care companies participating in the key informant interviews reported having similarly underdeveloped primary care coordination activities. One MBHO example is an exception. Care 1st Health Plan submitted a policy (attached as Appendix 10) from Comprehensive Behavioral Care, Inc. (CompCare), which outlined a comprehensive list of opportunities for coordination between behavioral health and primary care in the areas of information sharing, diagnosis, treatment, use of medications, and preventive programs, among others.

Eighteen plans (86%) submitted procedures (if not detailed forms) about the referral process for MH/SA services. Santa Clara Family Health Plan submitted a procedure briefly outlining roles and responsibilities of primary care and county behavioral health staff. Doctors are notified of their responsibility for treating members' mental health care through the Provider Services Department, a Provider Manual, Provider Newsletters, and during training and staff orientation sessions. Community Health Group's procedures for "Referral and Prior Authorization System" contain specific follow-up tracking after a referral from primary care to behavioral health.

Kaiser's integrated model of care improves and increases coordination between primary care services and behavioral care health services, which may explain Kaiser's high utilization rates for mental health care.

Kaiser is unique among the plans in its group model—the use of one provider group (The Permanente Medical Group) to provide all primary care and specialty health services, including mental health and substance abuse services. As key informants described, the strength of Kaiser's model is the ability of a primary care doctor to efficiently refer subscribers to specialty services such as mental health. Key informants within and outside of Kaiser, in fact, pointed to that aspect of the model as a primary explanation of why Kaiser's utilization rates for mental health care are higher than those of other plans. CalOptima, in our key informant interview with their

representatives, was the only plan that discussed considering ways to emulate this model by assigning social workers to primary care offices.

In the informants' view, organizational and physical proximity of primary care providers to behavioral health care providers is very important, as are organizational procedures that have institutionalized multi-dimensional screening, efficient information sharing, referral processes, follow-up tracking, and quality improvement studies aimed at these coordination activities.

Authorization of treatment

Twelve plans made mention of authorization procedures in their submitted documents. (For the purposes of this report, the terms "authorization" and "pre-approval" are used interchangeably.) For example, CompCare—the MBHO for Health Net, Molina Healthcare, and Care 1st—submitted a procedure outlining the steps taken to authorize outpatient care to network providers, as well as authorization of an unspecified number of units for inpatient or other higher level of care "through the next scheduled review date." Included in the submission were the types of information collected by administrative intake and care management staff to support this decision process.

In the key informant interviews we obtained more detail about some plans' pre-approval and authorization processes. We interviewed two plans that subcontract or delegate utilization management to MBHOs (Anthem Blue Cross and Health Net). The MBHO representatives at the interviews described their intake and pre-approval procedures. The MBHOs operate centralized telephone response units that take calls from subscribers, collect intake information about their needs, and then refer the caller to a network provider in the caller's geographic location. Pre-approval of 3 or 5 sessions is then communicated to the caller and/or the provider by phone and in writing. The provider then sees the child and family, and sends in a request for more sessions that includes a summary of the assessment and treatment plan. These requests are rarely denied.

Key informants consistently reported that the purpose of treatment plan reviews (some of which are phone-based) is to track the results of the assessment and facilitate a referral to county mental health departments for SED treatment, if appropriate. These reviews, which are otherwise similar to those for subscribers in the companies' other lines of business, provide a method of monitoring quality of care by reviewing the provider's treatment plan to ensure that the treatment interventions match the diagnosis and that the treatment is appropriate.

When asked if the HFP callers were in some way different from those in other lines of business, such as commercial/employer-provided health benefits, one health plan's key informants (clinicians from intake and care management units) characterized HFP callers as having higher levels of need, and also more often externally coerced into seeking care for a

child—for example, “The school told me to get help”—than typical subscribers from an employer-based insurance plan, who call to access the benefit they know they are entitled to. Not all key informants from other plans shared this perception—some did not perceive any difference between HFP subscribers and others, except for the predominance of Spanish speakers in HFP.

Most informants confirmed, however, that handling HFP clients takes more time due to the need to screen for SED and coordinate those referrals with county mental health departments. Otherwise, from the key informants’ perspective, HFP subscribers are not managed any differently than those with other types of health care coverage.

Parents’ experience with MBHO authorization procedures appears to have an impact on access to services. From the parents’ perspective, it seemed that authorization of services was one of the administrative procedures that, among others, cumulatively seemed to make it more difficult for HFP parents who were new to mental health treatment (as well as non- or limited-English speakers) understand how to access care. Yet we found no indication in the plans’ documentation or the perception of key informants that there are rigid administrative procedures that required prior authorization, and subsequent denial of care if such authorization was not obtained. Key informants consistently reported that the intent was to allow for decentralized access in situations where county or community HFP providers were available to everyone, or in the case of managed networks, flexible procedures to authorize care for licensed non-network providers.

It could be that the standard procedures for MBHOs, such as the requirement that the member call the MBHO to locate a network provider, may be a greater problem for the HFP population than for others whom the MBHOs provide administrative services.

For the most part, plans allow subscribers to access behavioral health outpatient services without requiring approval by the primary care physician. However, as shown below in the section describing the results of the parents’ focus groups, the primary care doctor is viewed by parents as a gateway to mental health treatment. As reported by informants, hospital days are obviously more closely monitored, by written policy and practice. Policies generally allow for a grace period of 24–48 hours for emergency admissions without prior approval.

One southern California parent we interviewed used psychiatric hospitalization for her child. As the approved hospital was too far away, the parent was pleased with the health plan’s responsiveness in approving the transfer of the child to a non-network hospital closer to home, although she had to spend much time on the phone negotiating with the health plan and the two hospitals in order to confirm approval for the transfer. The parent remarked “You have to get aware about these things very fast.”

Use of additional MH/SA services beyond maximum, and procedures for extension of mental health benefits¹⁵

Health plans were asked to submit documentation of their policies and procedures regarding benefit extension beyond plan maximum. While ten plans submitted a document to address this item, close review of the documents showed that only five plans (24%) specifically addressed extension of benefits for HFP. Central Coast Alliance (MHN) submitted a general procedure to consider benefit extension for all lines of business, including either MH or SA services, if available to the plan member. Blue Shield submitted a document (in response to another document request question) showing the conversion ratios of inpatient to “residential” and “PHP” (partial hospitalization), but the documentation did not directly address procedures to extend the outpatient benefit. CalOptima and Community Health Group also submitted an HFP procedure allowing for the substitution of one inpatient day for either two days of residential treatment, three days of day treatment, or four outpatient visits. According to key informants from various plans, these substitutions and conversions rarely occur.

Kaiser submitted a note discussing Kaiser’s general approach to SA treatment. To quote the partial written response for this item, Kaiser “considers the treatment of chemical dependency to be an essential component within the continuum of quality health care.” Kaiser’s Chemical Dependency Recovery Program is regarded as a basic medical benefit with no maximum limitations on clinically indicated services. Therefore, it is not possible for a Kaiser member to exhaust their outpatient chemical dependency benefit. Kaiser has found this to be an effective approach to treatment that decreases the likelihood of acute care readmissions and other medical complications.

HFP substance abuse benefit may be of limited use for adolescents with substance abuse problems, as there are no benefits for residential or day treatment, only outpatient or acute detoxification.

Not all key informants’ health plans were as accommodating for substance abuse treatment. One psychologist with a managed care company felt that the HFP substance abuse benefit was not very useful, since there are no benefits for residential or day treatment, only outpatient or acute detoxification—limited options for adolescents with substance use problems. The clinician reported that, according to research, detoxification is rarely needed for children and most adolescents, and that outpatient treatment alone has limited value to treat substance use problems. Other informants pointed to a lack of provider capacity to treat substance-abusing adolescents. One parent in our focus groups described being seen initially for the parent’s concerns about his son’s use of drugs; however, it appeared that the clinician may have shifted the care to a mental

¹⁵ Note—the study period and preparation of this report occurred prior to the implementation of physical and mental health parity.

health focus as treatment progressed. Few other parents addressed drug and alcohol concerns in the focus groups.

Standardized child/adolescent screening and assessment tools

Health plans were asked to submit mental health or substance abuse tools used for screening, well-child and well-adolescent protocols, and in-depth mental health assessments.¹⁶ Two plans (Community Health Group and Kern Family Health Care) did not submit any documents for these items. The other plans submitted a variety of documents at all levels of complexity, from brief one-page intake screening forms to complex multi-dimensional assessments. The submitted instruments fell into the following main categories, all relevant to children and adolescents:

- Screening instruments developed for use in primary care offices. Examples included:
 1. **Pediatric Symptom Checklist (CalOptima)**—a validated, 45-item scored questionnaire of behavioral and emotional symptoms. CalOptima also uses a set of well-care screening instruments (each of which includes a short checklist of developmental/behavioral items).
 2. **California “Staying Healthy” Assessment (Individual Health Education Behavior Questionnaire) used in five, or 4%, of HFP plans**—a set of age-related multi-dimensional health screening tools that includes risk indicators in the areas of home safety (e.g., “Does your home have a working smoke detector?”), child/youth safety, depression and anxiety, adolescent smoking habits, substance abuse, and sexual safety/health.
 3. **Kaiser’s set of developmental screening tools** (up to 24 months of age) and teen well-being questionnaire.
 4. **Santa Clara Family Health Plan’s set of well-being forms** for use from early childhood to age 21 which includes an anticipatory guidance checklist for health behaviors and emotional/behavioral indicators.

Of the primary care instruments submitted, the Pediatric Symptom Checklist is the only one that has been tested as valid and reliable (Jelinek, 1999), as far as this study’s authors are aware. In contrast to other primary care instruments, this instrument also provides a cutoff score indicating the need for referral to mental health services.

¹⁶ While the words “screening” and “assessment” are often used interchangeably (even in the instruments we reviewed), we refer to screening as a brief process to identify an illness or problem, while an assessment is considered more in depth and diagnostic in nature, often administered by a professional whose scope of practice is specific to the focus of the assessment, such as a licensed mental health professional.

- Screening instruments or protocols used by MBHOs or MH clinic settings
 1. Various intake questionnaires or screening protocols from MBHOs which include questions about presenting problems and treatment preferences.
 2. Intake forms from some county mental health departments which include demographic information, presenting problems, and brief treatment history.

- In-depth mental health and/or substance abuse assessments
 1. The ALERT Wellness Assessment (six, or 3.5% of plans)—a brief tool (developed for use by plans subcontracting with Optum MBHO) to identify level of emotional distress, functioning and substance use. It was designed for use in weekly psychotherapy to track outcomes, indicators for premature termination of treatment, and risk of danger to self. The ALERT instrument has undergone significant validity and reliability testing (Brown & Jones, 2005). (An example of the ALERT form is attached as Appendix 12, made available for this report with permission from the Ventura County Health Plan.)
 2. County mental health assessment instruments (four, or 19% of HFP plans)—in-depth assessments developed locally, covering Medi-Cal and County Mental Health Plan requirements, as well as mental status, presenting problems, developmental history, family relations/system, medical history summary, and substance use history, among other dimensions.
 3. Other mental health and substance abuse assessment instruments developed by non-county plans (such as Kaiser and Molina Healthcare).

In addition, two plans (Santa Clara Family Health Plan and Anthem Blue Cross) submitted recommendations for preventive pediatric health care adapted from those of the American Academy of Pediatrics and the U.S. Preventive Services Task Force. (The American Academy of Pediatrics guidelines include schedules for developmental and autism screening, psychosocial/behavioral assessment, and alcohol/drug use assessment, among others.)

In our key informant interviews, CalOptima shared a recent screening pilot project, which involves dissemination of their well-being screening instruments to primary care providers and training. The instruments include behavioral health, developmental, and well-child items in one form. Doctors receive \$100 per form for completing and faxing the form back to CalOptima. So far the response was reported to have been very positive. The CalOptima screening pilot may provide a good model for the implementation of systems to ensure high use of multi-dimensional screening instruments in primary care, as well as their use in directing appropriate referrals to behavioral health care. (A copy of the procedures for the screening pilot is included as Appendix 11.)

Further recommendations on developing or adapting a uniform set of screening instruments are addressed in the recommendations section of this report.

ADMINISTRATIVE SERVICES AND PROVIDER MANAGEMENT

Use of behavioral health companies

Eleven HFP health plans subcontract or delegate the management of mental health and substance abuse services to specialty managed behavioral health organizations.

As shown in Table 1 (see Appendix 1), eleven health plans (52% of HFP participating plans) subcontract or delegate the management of mental health and substance abuse services to specialty managed behavioral health organizations (MBHOs). The MBHOs provide fee-for-service administrative services for the HFP program. According to documents and information received from key informants, these services include:

- *Provider network.* The MBHOs develop a provider network that is made available to subscribers. One MBHO key informant explained that while the network is made available as a “preferred provider network,” if an HFP subscriber was in treatment with a non-network provider and requested HFP benefits, the treatment would be authorized as long as the provider met the basic credentialing standards and criteria. The provider network consists mainly of licensed mental health or substance abuse clinicians with masters, doctoral or medical degree level of training.
- *Claims processing.* Claims from providers are processed and paid according to the MBHO’s negotiated rates. The subscriber is not charged more than the HFP benefit-defined copayment. (One parent reported that she was initially charged full fee for the first few sessions; however, a few phone calls to the health plan resolved the problem.)
- *Intake.* Toll-free calls are taken from subscribers wishing to locate a provider. The intake specialist (licensed or non-licensed mental health staff) determines the caller’s need for treatment, the level of urgency, and the caller’s preferences for provider language capacity, geographic accessibility, and clinical specialty (such as trauma, family therapy, attention deficit disorders, grieving, etc.).
- *Care management.* Care managers are licensed mental health clinicians who provide utilization management and case review. In one MBHO interviewed, all HFP calls are routed directly to care management clinicians who take the initial information, find a provider, and track the provider’s assessment.
- *Member services.* The MBHOs’ member services staff has electronic access to HFP enrollment and benefit information, in order to answer questions and make necessary referrals to the appropriate MBHO staff.

Of the remaining ten plans,

- Seven plans (33%) subcontract or delegate the provision of plan-provided mental health services to county mental health departments.
- Kaiser contracts with The Permanente Medical Group.
- CalOptima contracts with regional Independent Practice Associations.
- Community Health Group contracts with a local private practice group.

Professional standards for MH/SA providers

Plans had no specific credentialing criteria for substance abuse providers, with the exception of Kaiser.

Plans were asked to submit procedures for credentialing and privileging mental health and substance abuse providers. “Credentialing” refers to the process of reviewing and approving providers’ qualifications for membership in a provider network. “Providers” typically include physicians, registered nurses and clinical nurse specialists, clinical psychologists, licensed social workers, and licensed marriage and family therapists. The credentialing process entails gathering providers’ resumes, licensure status, physicians’ medical board certifications, work history, professional liability insurance policies, and attestations about criminal misconduct, sanctions and investigations, among other items. The process also typically includes checking national databases to confirm licensing status, criminal investigations, and medical board specialties. “Clinical privileging” is a term used by most plans to indicate the further approval of provider specialty areas as supported by documentation, certificates, or other information relevant to the specific provider’s professional scope of practice.

All plans submitted either a policy/procedure for credentialing providers, sections of a provider manual, or an application form that indicates the criteria for credentialing.¹⁷ All plans mentioned an internal committee that reviews provider network applicants. Plans subcontracting with MBHOs submitted those companies’ credentialing procedures, since the MBHO companies manage those plans’ provider networks. Almost all plans submitted separate procedures and application forms for individual clinical providers and facilities.

Based on the documents submitted, the criteria and information requested from provider applicants appeared to be similar for all plans. Plans mentioned using national

¹⁷ As shown in Table 2 (see Appendix 1), the inventory of responses to survey items 21a, 21b, 22a and 22b related to provider credentialing does not show 100% response. However, these survey requests may have been viewed as redundant by the health plans. In many cases, documents submitted under one item could also have applied to other items. All plans responded to at least one of these items.

databases to confirm board certification and license status. Site visits to individual providers and facilities were not specifically addressed, except briefly mentioned in Optum's policies ("...facility must meet...site visit standards..."). Health Net, however, provided a comprehensive checklist and rating scale for a provider site visit evaluation. This checklist includes items related to the physical premises (e.g. "services provided in a professional office"), protection of treatment records, standards for treatment record contents, and office statistics such as average wait time and "emergency appointments available."

The formal credentialing policies (and in a few cases, application forms) for individual practitioners that were submitted routinely included a specialty category of "substance abuse" among other clinical specialty areas. However, we could not find evidence in any of the provider credentialing documents of criteria specific to substance abuse treatment, such as specialized training or certifications. The only exception was Kaiser's "Request for Clinical Privileges" for its Department of Psychiatry, Clinical Service of Addiction Medicine. Kaiser's clinical privileging procedures address minimum criteria for physicians working in ambulatory or inpatient addiction treatment settings.

Some plans submitted application forms for psychiatric hospital facilities applying for facility network status. Those applications included questions about chemical dependency programs—such as detox, inpatient, residential, partial day treatment and intensive outpatient.

Overlap of providers for plan-provided benefits and SED services

Based on information from the key informant interviews and document review, in the seven plans that contract or delegate services to county mental health departments, those clinicians are used to provide both plan-provided and SED benefit services. In most if not all of these counties, children and adolescents with SED might be provided separate services through organized systems of care with specialized clinical staffing and programs. However, individual clinicians in county systems may also be called on to provide services to children with SED.

MONITORING QUALITY

Policies and procedures for monitoring quality and outcomes

The majority of plans (16, or 76%) submitted policies and procedures related to quality and outcome monitoring.

While most plans (71%) also submitted procedures or reports listing specific MH/SA quality measures, the extent of detail varied. Some submitted comprehensive plans that included multiple domains of quality (e.g., access, population enrollment studies, timeliness to care, network availability, enrollee satisfaction, complaints, provider satisfaction, utilization

management, special clinical outcome studies, and coordination between primary care and behavioral health providers, among other measures).

The most comprehensive quality improvement (QI) descriptions were submitted by the Optum MBHO plans; however, there was no specific mention of HFP in those documents. The least comprehensive, addressing only one or a few domains, were those from county health plans, although one county health plan submitted an annual report showing evaluation findings in multiple areas of access and utilization management for mental health services.

While the quality improvement plans of MBHOs were the most comprehensive, there was no information about the extent to which HFP subscribers were sampled in their QI studies.

There was evidence in the available documentation from only a few of the MBHO plans that direct client outcomes (e.g., reduction in depression symptoms, reduced substance use) are being monitored. It should be noted that the comprehensive QI plans seemed to address many of the behavioral health plans' lines of business (e.g., employee-based behavioral health and Medicaid). However, with the exception of Community Health Group's QI documents, Healthy Families is not mentioned specifically; thus the extent to which the QI indicators are effectively applied to HFP (with the exception of member complaints—see below) is unclear from the available

documentation. The county health plans' documents generally described the mental health agencies' county-wide quality improvement activities related to the counties' priority target populations (such as Medi-Cal beneficiaries, those in crisis or needing emergency care, Full Service Partnership groups covered by the MHSA, etc.).

Only half of the plans submitted documentation showing they track time to first appointment after a MH/SA referral.

Only half of the plans submitted documentation showing they track time to first appointment after a MH/SA referral. This is an important quality indicator for access to care (Hermann, 2005). However, all plans made mention of timeliness standards for responding to various levels of need. Those plans subcontracting with Optum submitted the same policy, indicating a goal of 6 hours to appointment for an "emergent" case, 48 hours to an urgent appointment, and 10 days to a routine appointment. Others were very similar. The metrics of one county health plan's QI document were less

specific about routine visits and instead listed time to an ACCESS Team screening (3 days) after initial phone contact, and time to triage a client in crisis to crisis staff and psychiatrists.

Quality of interpreter services

We asked plans to submit documentation regarding monitoring the accuracy of interpretation and subscriber satisfaction with the accuracy of interpreters. The documentation

submitted appeared to be general to all health services (including mental health and substance abuse services).

Eleven plans (52%) submitted documents for this section. Two plans submitted the previous Cultural and Linguistic survey report to MRMIB. Six plans did not address this section. The remaining plans submitted survey instruments or procedures with sample questions about subscribers' experience with interpreting services. Examples include:

- Care 1st survey of member satisfaction with interpreting services.
- Kaiser recently added questions to the general member satisfaction survey relating to language assistance.
- Molina Healthcare submitted a comprehensive "Interpreter Evaluation Form."
- Anthem Blue Cross utilizes survey and group needs assessment data to monitor, evaluate and improve their Cultural and Linguistics Program.

Complaints and grievances

Behavioral health-related complaints or grievances are quite small in number and there is a need for standardized data collection and reporting.

Member satisfaction is an important part of monitoring quality of care. Since little is known about the extent of complaints and grievances among HFP subscribers related to mental health care, plans were asked to submit problem resolution and grievance policies and procedures "general to health plan," as well as a report of all complaints and grievances during 2007–2008. Plans were also asked to differentiate complaints and grievances specifically related to mental health and substance abuse care.

A review of the member complaint/grievance policies and procedures showed some variation in the extent to which the plans addressed HFP specifically. Fourteen plans submitted documents that referenced HFP as one "line of business" covered by the policy. Three plans—CalOptima, Community Health Group, and Ventura County Health Plan—submitted HFP-specific documents. The remaining plans (mostly the Optum/UBH/PBH subcontracted plans and a few county health plans) submitted the company- or county-wide policy and procedure that did not mention HFP. Despite these differences, it appeared that all plans' member complaint/grievance policies are comprehensive and most likely compliant with California's mandated member complaint and grievance policies. However, a more in-depth analysis would be required to match each procedure with federal and California laws.

Two plans (Kaiser and Central Coast Alliance) did not submit a member complaint/grievance report. Of the 19 plans that submitted member complaint/grievance

reports, 14 plans' reports differentiated complaints related to MH/SA services versus other healthcare-related complaints, or simply reported the number of MH/SA complaints. These are shown in Table 6 (see Appendix 1). The behavioral health-related complaints are quite small in number. One key informant characterized HFP subscribers as "not complaining" as much as members in other lines of business.

As can be seen in Table 6, it would be very difficult to summarize the number of overall MH/SA complaints and grievances for all plans. There is a need for standardized data collection and reporting of mental health and substance abuse treatment-related complaints and grievances.

THE PARENTS' PERSPECTIVES

This section will cover service access issues from the perspectives of parent participants in focus groups. Despite the fact that a focus group is by nature a small sample, such groups can be very helpful in understanding the experience of accessing and engaging in care from the parents' perspectives.

These parents were recruited by Health Net (Los Angeles area), CalOptima (Orange County), Health Plan of San Joaquin (San Joaquin County), and Anthem Blue Cross (Riverside County) from lists of children who used mental health services during the 2007–2008 benefit year. Three on-site focus groups were held with a total participation of thirteen parents and youth. Another eleven parents were interviewed by phone. The on-site focus groups included parents who were primary Spanish speakers. Bilingual Spanish/English Interpreters were provided for all focus groups. One focus group also included an interpreter for a Vietnamese-speaking parent. Phone call interviews were conducted in English or Spanish. The focus group interview sampling report is included as Appendix 8. Findings were organized under themes that characterized parents' responses in the focus groups.

There are several important points of access that can influence the perception of treatment effectiveness by parents. They are:

- the suggestion or recommendation that the parent seek treatment for their child;
- initial attempts to learn about treatment alternatives;
- finding a clinician;
- completion of an assessment; and
- negotiating the ongoing treatment strategy.

All of these areas were addressed by parents in the focus groups, and there are barriers associated with each of them. In order for parents to address the questions posed in the focus groups (see Attachment 7), some of them went into detail about the history of their experience that began well before becoming eligible for HFP.

Identifying the problem and seeking treatment

Many parents in the groups remembered noticing problems with their children very early. One parent reported:

I called because when my daughter was between two to three and a half years old we noticed she had some attention deficit problems. I noticed something was wrong and I took her to the doctor (we had Kaiser at the time). I just felt something was wrong. I took her to see a counselor; I was so mad because the psychologist said I needed to learn to be a parent. I didn't think so.

Other parents also mentioned the difficulties in convincing others that they were seeing something wrong, even as, at the time, they themselves were unsure. Ambivalent or dismissive responses from providers had the effect of discouraging the parent, and later making the parent all the more persistent. Some focus group participants wondered aloud if other less knowledgeable parents might instead have become discouraged and given up, only to see the problems become much worse later.

At the other extreme, some early signs of a problem were communicated externally. Teachers and school personnel were the most likely people to notice behavioral problems for the first time outside the home. For those parents who had no previous exposure to the mental health treatment process, the school can be a major support or a frustrating barrier in the process of getting their child help. Some cultures may view teachers as authority figures, so teachers' recommendations have an important impact, although over time the focus group participants learned to question the school system's responses.

I think it has a lot to do with counselors. When I asked the school about my son, they said he was immature. They didn't want to give me a referral to get him tested. I think schools need more training; they can just refer and maybe it is that he is just immature, but at least give him the evaluation so you can have peace of mind. I had to wait so long because the school just thinks he's immature.

For some children's emotional or behavioral problems, the parent's interactions with the school regarding noticeable behaviors are just the beginning of a long process. Another Spanish-speaking parent talked about her battle over several years to get assistance from the school district.

I know a lot. I have time to go to the school. I always send him to the school and they return him to the house because of the behavior. I tell them if he needs one-on-one attention, they need to provide it.

Parents in a few of the focus groups spent much time giving each other advice about dealing with schools, especially when trying to get the child evaluated for SED to qualify for special education services.

The role of the primary care physician

Early contacts with the primary care physician can also be either very effective or frustrating for a parent noticing problems:

My child, when he was 3 years old, he had a very explosive temperament. The doctor kept asking what the problem was. I would explain to the doctor that it was a behavior problem. The doctor didn't want to refer him to a psychiatrist and just wanted to give him medicine. I said no. I felt he needed an evaluation first. I went for help at school.

Those doctors were especially valued who empathized with the parent, validated the parent's concern, and presented concrete options (such as a referral to a psychologist).

The importance of the primary care physician's role came up many times in all focus groups. Parents described the doctor as someone very trusted. Those doctors were especially valued who empathized with the parent, who validated the parent's concern, and who presented concrete options (such as a referral to a psychologist). On the other hand, when primary care doctors recommend medications early in the process, many parents view this as a response of convenience by doctors rather than a recommendation made after careful assessment. The recommendation of medications is a very sensitive issue, as indicated by the number of times parents addressed it spontaneously in the interviews. From their perspective, the explanation given by clinicians is often too abrupt. Parents feel that clinicians assume that they are more prepared to accept the recommendation than they really are. If this is the case, then despite the cultural pressure to accept authority figures' advice without question, parents will either ignore the advice, find another provider whose advice is more consistent with the parent's wishes, or agree at the time but not follow through.

The first appointments

Some parents experienced a delay of months before finally getting an appointment with a mental health clinician.

...my son was diagnosed with ADHD...his pediatrician asked [a provider] to do an assessment, months and months after he was diagnosed. I had to wait for five months to get an appointment after his evaluation...and the school didn't want to have him tested with their credentials so I had to write a letter to the board of the city (sic), it took almost two years [to get the school to consider an SED evaluation].

Another parent:

I was told, after I go to the referral, that there was a very long wait list, like 3-4 months. The receptionist I talked to said I need to call the insurance company.

A third example:

When they diagnosed my son with ADD, the doctor, the pediatrician, sent him to mental health but they didn't accept him because they said he didn't qualify (this was when he was 7). When his behavior was worse, they sent him to mental health and they accepted him.

Not all parents remembered having so much difficulty, and reported very positive results when calling on the health plan to assist in finding a practitioner. "Once I got the right person, things happened very fast." Sometimes the first referral does not work and a parent may have initiated several attempts at assessments.

My son went to therapy maybe a year, when he was between 4 and 5. But it was difficult because interns would see him, not actual psychologists but people studying to be psychologists. My daughter is with another health plan and they give her another referral and I could put my son with the same doctor. But in June last year was the last appointment and they haven't called back again to set another appointment.

Children who switch back and forth between HFP and Medi-Cal may experience problems with continuity of care.

The discontinuity of providers may be a special problem for children who shift back and forth from Medi-Cal to HFP. One such parent reported, "After I had to leave Healthy Families, my Medi-Cal doctor didn't do the changes the other doctor wanted, even though I explained that the changes were working."

There is a steep learning curve for parents new to the mental health treatment system. More than once, parents described having to learn the system on their own, especially in the following areas:

- *Professionals disagree.* Three clinicians may have three different diagnoses and treatment strategies. Also, for people used to having a single treatment response to a physical symptom, the fact that mental health problems might

require multiple treatment alternatives (e.g., medications, individual psychotherapy, and family therapy) is difficult to accept at first.

- *Assertiveness.* Due to the variety of professional responses, parents have to learn to be assertive and persistent (“*Insista, insista, insista!*”).
- *Cultural differences.* Parents may not understand relevant laws and regulations, such as mandated child abuse reporting by primary care and mental health professionals. (Also, there are misperceptions—some parents said that they had heard stories about parents losing custody of their children as a result of getting them into mental health treatment.)
- *Administrative procedures.* Parents need to make many phone calls to find clinicians, make appointments, reiterate the treatment history and need for the visit, obtain approval for sessions, and understand the HFP benefit.

Administrative procedures in accessing care

Regarding the interface between administrative procedures and the perception of treatment effectiveness, a parent remarked:

Of the five [phone numbers given for mental health clinicians] only 2 called back. They only gave me 20 sessions and only gave me medication. I called to get more sessions. They said no. They said maybe she needs medication. I said no, I don't want to give her medication. They gave her five more sessions. They said maybe another [clinician] can work well again. They gave me five more numbers. One called back.

In the early stages of help seeking, some parents reported calling numerous phone numbers before getting to the right person.

Earlier in this report it was mentioned that the authorization/pre-approval process was meant to be transparent to parents. The just-quoted example illustrates the importance of this, since it is almost impossible for parents to separate administrative procedures from decision making about treatment, the latter being the most important issue for the parent unless the administrative procedures form an obstacle. In the early stages of help seeking, some parents reported calling at least three phone numbers before getting to the right person. A parent remembered being completely confused upon being asked to call the toll-free number for the managed care company. When language is an issue this makes a complicated process of engagement in treatment even more burdensome.

Ensuring follow-up care

Ensuring that follow up care occurs after the first session is critical to engaging parents and children in treatment. We asked about this in all key informant site visits and phone

conversations¹⁸. One informant from an MBHO thought that the follow up tracking for HFP subscribers was not very thorough. Some plans make an effort to track the success of the referral to make sure subscribers have a first appointment, though some only track this retrospectively with the use of utilization reports. One regional health plan in particular, Health Plan of San Joaquin, devotes considerable energy to subscribers who call the plan for a mental health referral by county provider and makes sure the subscriber is engaged in the assessment, especially for high risk or urgent-need cases.

Culture, language and stigma

The stigma of a mental health problem was a recurring theme in all focus groups.

We encountered cultural differences in the extent to which parents understand the mental health system and whether to get care. A first generation Southeast Asian parent described the following scenario:

My son also stopped taking the medication. Up to now, I don't know what his diagnosis is. Ever since then I don't go to any other doctor. His academics are at an average, like C's, but he has a really bad temper and everybody has to please him, whatever he wants everybody has to give it to him. I'm not sure if it's Autism or he's just being a bad child. I don't know how to get him to see a doctor because he says he doesn't have anything wrong with him.

A Spanish-speaking parent talked about her experience with an English-speaking psychiatrist using an interpreter. The psychiatrist was recommending medication, and the mother wondered whether or not the psychiatrist really understood her concerns about medications due to the language barrier. Since her English comprehension was not very good, she could never be sure of the accuracy of the interpreter. Especially in one focus group consisting of all Spanish-speaking parents, there was general agreement that the language barrier made understanding the mental health treatment process more difficult. (We did not ask, nor did parents remark, on the effectiveness of the various language lines used by health plans and some provider organizations. We also never heard that there were difficulties in obtaining interpretation, either with a bilingual provider, an in-person interpreting professional, or the use of a language line.) Another parent said "I always look for Latino doctors. They just seem to understand my problem better."

¹⁸ In the data request we also tried to collect information on the timely first appointment after referral to treatment, however due to the variation in how health plans collect this information (some not at all), and also due to problems in how we asked the question, the data were not useable.

Still another Spanish-speaking parent seemed to have been affected by a combination of cultural stigma and her fears about her son's dependence, when she talked about her older adolescent. Her son had been to treatment for depression, and stopped. Later he asked to return to treatment.

Sometimes the doctors don't want to listen to you, just want to listen to the child. My son didn't speak until he was three years old. They want attention; they're bored. The teacher talked to me. That's the behavior part. I had the option of putting my son on medication and I didn't. One counselor told me that her brother grew up using medications, and now he's a teacher and still taking the medication. The other person didn't take medication and he was fine. My son, when he gets in trouble, says he wants to see the counselor. I say no, you don't want to become dependent on the counselor. You only get coverage until you're 19; you can't always have it.

Since the parents were recruited from those receiving services in 2007–2008, many parents had the perspective of having completed a full course of treatment, while others had very brief treatment encounters. One parent, accompanied by her 17 year old son, had overall positive thoughts about the entire treatment experience that took place over two years. The son is still in treatment for depression, and has a good relationship with his therapist. He informed the group about the challenges of being in treatment and how that affects his peer relationships. ("I only tell certain friends I'm getting treatment. The others won't understand.")

In fact, the stigma of a mental health problem was a recurring theme in all focus groups. While the stigma of mental illness affected parents' initial reaction to feedback from teachers or treating professionals, one parent commented that despite that initial reaction, she learned that getting what her child needs is much more important than what other people think. Some participants knew of other parents who were at that early stage—the child has serious problems but the parent is too afraid or reluctant to seek help.

Parents' recommendations

Parents recommend closer work with the schools in educating other parents and school personnel about mental health issues.

We asked all parents "What would you recommend we do in the community to help other parents get help for their children?" Education about the mental health process was the most frequently cited suggestion—helping parents understand how to navigate the system during the first contacts with health plans or providers.

Parents also strongly recommended the school as an important site for education of students, health clinic workers, teachers, and parents. The education should focus on HFP

benefits, but also on mental health issues and when to seek a referral. Also, mental health services delivered at the school would be very helpful. One parent described a recent history of frequent school changes for her son who has behavioral problems. “My son has been to different schools; my daughter has been to six different schools. The schools can’t find a good program for her.” Having treatment at the site where problems are first identified would make the process go more smoothly.

Many parents commented that the focus group provided an opportunity they never had before—a chance to talk to other parents with similar problems. At some points during the focus groups, parents had strong emotional reactions as they talked about their children’s problems. At the end of some of the groups, parents could be seen exchanging phone numbers and continuing to provide information about their experiences—clinicians they liked, whom to call at the health plan for information, how to deal with the school, medications to avoid and those that helped, etc.

Regarding HFP in general, parents were quick to say how much they appreciate having the program (“I honestly don’t know what I would have done without it”).

CULTURAL AND LINGUISTIC PROFICIENCY

To better understand the capacity of the health plans to provide culturally sensitive and competent services, health plans were asked to submit the following information:

- Mental health and substance provider lists including languages spoken
- Information about the use of internal staff interpreters as well as externally contracted interpreters or interpreting services
- Information about the training provided to interpreters, especially training to prepare them to work in behavioral health settings

Multicultural characteristics of contracted providers

The percentage of providers who speak Spanish ranges from 4.7% (Alameda Alliance) to 48% (Health Plan of San Mateo).

Out of the twenty-one health plans, Kaiser and Kern Family Health Care did not submit provider information. In a cover letter response, Kaiser explained that almost all MH/SA services are provided within an integrated delivery system that relies on contracts with Kaiser Foundation Hospitals and The Permanente Medical Group, rather than contracts with a behavioral health provider network. A profile of the provider staff in these large contracted groups was not provided. One private non-profit plan, Community Health Group, submitted a list of behavioral health providers from the member

handbook, a list of one group's (Psycare) bilingual clinicians, and a list of clinicians associated with the group Psychiatric Centers of San Diego (PCSD). Neither the member handbook list nor PCSD list included information on ethnicity or language spoken. The Psycare list consisted of 20 clinicians and languages spoken by them. We were not able to determine percentages of this plan's provider network who spoke other languages from these sources of information.

We were able to use provider language data from all but six health plans. Only eight plans submitted provider lists showing ethnicity (the seven plans using the Optum MBHO network and Anthem Blue Cross).

The available provider lists were analyzed by counting the top languages spoken. There were two complications in analyzing the provider lists. The first complication involved disaggregating the statewide lists from the Optum network, which we sorted by county and then analyzed each Optum health plan by county covered. The other complication had to do with the presentation of data. Most lists showed multiple languages, either in the same spreadsheet cell or in multiple spreadsheet columns. Table 7 (see Appendix 1) shows a summary of the distribution of the top three languages spoken by providers in each health plan that submitted such information.

Spanish was the top language spoken by plan providers; French was the second most-spoken language in eight plans.

For all the plans that reported provider language, Spanish was the top language spoken. The percentage of providers who speak Spanish ranges from 4.7% (Alameda Alliance) to 48% (Health Plan of San Mateo, using county staff). The average percentage of providers who speak Spanish among all 16 plans that submitted analyzable data is 11.43%.¹⁹ Plans at or above average percentages of Spanish-speaking providers are Molina Healthcare, Health Net, Care 1st, Contra Costa Health Plan, and Health Plan of San Mateo. French is the second most-spoken language in eight plans. Other second most-spoken languages include Chinese (Mandarin or Cantonese), German, Hindi, Italian, Tagalog and Hebrew.

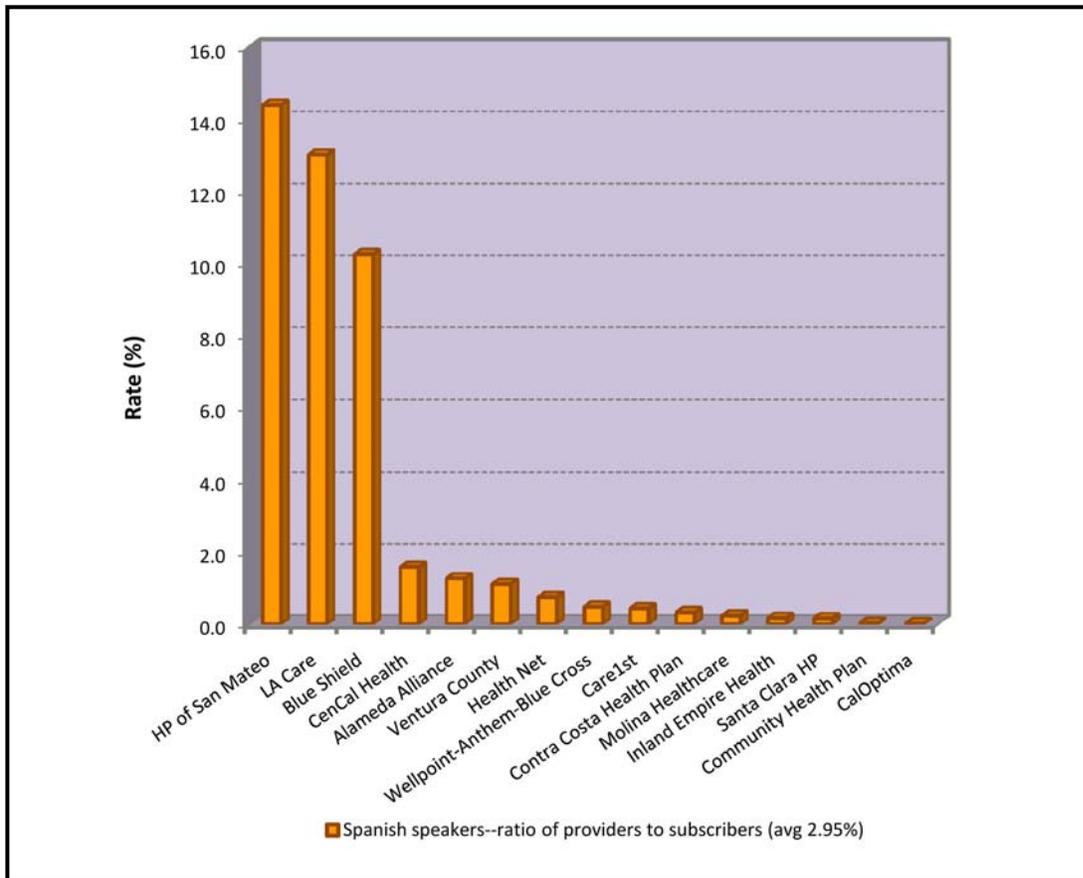
Comparison of provider language to member language

To further understand the distribution of Spanish-speaking providers in relation to the enrollment of Spanish-speaking subscribers, we computed the ratio of providers speaking Spanish as the first language spoken to the enrollment data for the parent's preferred language as Spanish (see footnote 12 on page 31 regarding the source of language data). Figure 11 shows the distribution of these ratios by health plan, sorted in descending order. The average ratio over the fifteen plans that submitted complete provider data was 2.95%. Three plans—Health

¹⁹ When Health Plan of San Mateo's 48% is removed, the average distribution of Spanish-speaking providers among the remaining 15 plans is 9%.

Plan of San Mateo, LA Care Health Plan, and Blue Shield—had ratios exceeding this average. While there is no standard threshold for ratios of provider languages to those of members, such an analysis may be useful for ongoing monitoring of changes in the balance of provider language capacity.

Figure 11. Ratio of Spanish-Speaking Providers to Spanish-Speaking Subscribers



Use of interpreters

Table 8 (see Appendix 1) presents a summary of each health plan’s response for external/subcontracted interpreters, internal interpreters and bilingual staff.

Almost all plans use some type of external language line for interpreting services. (These services are regularly used, as reported in key informant interviews.) There were twelve different companies listed. Some larger plans subcontract with as many as four different interpreting services. Some national and international vendors are reported to have the capacity to handle 200 languages.

Fifteen of the 21 plans (71.4%) listed internal staff hired specifically to be interpreters, or bilingual staff who are called into service to interpret. The number of these staff ranges from 12 in a county health plan to over 1,000 in a statewide health plan.

Training of interpreters

Sixteen plans (76%) submitted either a document about training internal interpreters, training external subcontracted interpreters, or policies about how the plan monitors the quality of such services²⁰. Many plans use a certification service to screen or identify staff who can provide interpreting services. For example, CenCal Health uses PreVisor, a company that provides language certification, to test and certify its Spanish-speaking bilingual staff. PreVisor administers a validated test that provides an accurate assessment of how well a person speaks Spanish and understands spoken Spanish.

Although Health Plan of San Joaquin did not submit a report on the number of bilingual staff and interpreters, the plan submitted the agenda for training in “Interpreting in Health Settings: Basic Strategies to Improve Communication and Patient Understanding.” While this training seems to have been targeted to health care workers in general, the agenda provides a good overview of the general competencies required for clinical interpreting and useful for behavioral health interpreters.

Kaiser submitted a description of its training for Qualified Bilingual Staff (QBS). The training is aimed at providing a variety of techniques and strategies for the QBS to work effectively in medical settings. Analyzing and applying techniques of effective communication in cross-cultural encounters is emphasized.

Challenges for health plans working with interpreters

Key informants consistently reported that they were satisfied with the interpreting alternatives available in the respective health plans, MBHOs, or provider organizations. In those site visits attended by MBHO clinical staff, we were especially interested in whether they saw gaps in the provider network by language, since those staff are charged with matching subscribers to providers, and there were no major gaps reported. The key informants we interviewed were unaware of any problems in the effectiveness of the interpreting infrastructure.

²⁰ The five plans that did not submit any of these documents are The Alameda Alliance for Health, Blue Shield, Health Plan of San Mateo, LA Care, and the San Francisco Health Plan.

DATA ISSUES AND LIMITATIONS

There remain data sharing and data management issues for health plans, counties and providers. For the data used to respond to the data request, the following issues were raised regarding the information submitted by the health plans:

Diagnosis—Coding and reporting

- 17 plans used ICD-9 classification for reporting diagnoses
- Four plans either used DSM-IV, or a similar system that was not identified in the response
- The different diagnostic systems do not pose a serious problem for reporting. There exists enough concurrence between ICD-9 and the DSM-IV to allow for cross-plan analyses of diagnosis.

Service data incompatibility

- Most plans used “paid claims” data to report service utilization rates, while four used “encounter” data, leading to a question about the comparability of the service data among plans, since there may be differences comparing the number of encounters reported with the number of successfully paid services
- Some plans noted that they needed to access multiple systems to respond to the data request, even for the outpatient utilization reports. Some plans have multiple systems containing client information separate from service data, requiring analysts to link separate systems to report utilization rates on services by age, ethnicity, and other demographic information.
- Substance abuse information was unavailable for the Kern Family Health Care plan and San Francisco Health Plan. Health Net reported that subscribers calling for substance abuse services were referred to mental health services. Providers for Health Plan of San Joaquin assigned substance use/abuse as secondary diagnoses under the primary mental health diagnosis.

Demographic data inconsistencies

- Some plans reported that their categories of ethnicity, age and language spoken were different from the way the researchers organized the data request, leading to inconsistency of response among plans.
- Blue Shield reported using the Data Request spreadsheet category of “Other” for Caucasian, rather than the available “White” category.

- The following plans reported limitations in reporting ethnicity and language spoken:
 - CenCal Health
 - Inland Empire Health Plan
 - Alameda Alliance for Health
 - LA Care (and Community Health Plan’s LA Care subcontract)

Pharmacy—Drug classification and reporting differences

Pharmacy data were especially problematic:

- The plans provided a mix of brand and generic names that had to be cross-matched; in some instances the “top two” were the same drug, reported twice. This was also true for the same drug with different dosages reported twice (e.g. Ritalin 5mg, Ritalin 10mg).
- While not evident in the Methodologies section of the Data Request, plans appeared to have differed about how drugs were classified, e.g. drug classes vs. categories from the National Drug Code (NDC).
- CenCal Health found inconsistencies and missing data from its third-party vendor managing pharmacy data.
- Inland Empire Health Plan noted problems sorting service users by diagnosis with pharmacy data and instead reported users by drug classification.
- For Ventura County Health Plan’s 54 service users, a manual process was used to conduct case reviews for pharmacy utilization.
- It is unclear whether the pharmacy data came from prescribers’ orders or prescriptions’ claims (i.e., whether the prescription was actually picked up by subscriber).

❖ KEY INFORMANT PERSPECTIVES ❖

We asked health plan respondents to interpret the utilization rates as reported in the preceding sections of this MRMIB report. All agreed the utilization rates were low in general. Explanations included:

- The traditions and stigma in some cultural groups that are at odds with the recognition of diagnosable mental illness and the use of formal services.
- Resource gaps as a result of budget cuts in county behavioral health departments. This not only affects how many people can access care in county clinics, but also results in reductions of community resources in general.
- The HFP population's high utilization of primary care services rather than specialty behavioral health services may be one factor affecting utilization rates. The most common theme in all key informant site visits and interviews was the importance of primary care as a potential gateway to behavioral health services so that if the linkages can be improved between primary care and behavioral health services, access to services would also improve.
- A view shared by some informants (not all) that HFP members delay treatment, and thus when treatment occurs the situation is more serious.

One public health plan with an admittedly weak relationship to one of the counties it serves pointed out how crucial it is that county behavioral health departments are organized to respond to HFP subscribers and to the health plan. This includes problems in data flow between the county and the health plan, a problem echoed by other key informants in obtaining data from provider groups, IPAs (Individual Practice Associations), etc.

Informants also had explanations for why some plans have higher utilization rates than others. Representatives from both Kaiser and other health plans explain Kaiser's higher rates as a function of its integrated model, as explained earlier in this report. CalOptima staff reported wanting to emulate aspects of that model by somehow finding a way to assign social work providers to primary care clinics.

One informant suggested that another explanation for Kaiser's higher utilization rates may be data-related—that Kaiser counts primary care visits that are mental health related in addition to visits to behavioral health clinicians, whereas other health plans count only behavioral health clinician services. (We confirmed this with Kaiser—primary care visits that involve a mental health diagnosis were indeed counted. However Kaiser estimates that these visits amount to only 16% of total mental health visits, insufficient to explain the high utilization rate.)

Informants from the San Francisco Health Plan, also with a higher than average utilization rate, explained that the county implemented Healthy Families in the context of the county's public health needs; i.e., to address underserved or unserved populations. Therefore, they ascribe their higher service use to intensive, culturally relevant outreach efforts.

❖ DISCUSSION ❖

IMPLICATIONS OF FINDINGS

The challenge in this study was to integrate the various types of data in order to provide the context, possible explanations, and recommended strategies for improving the access and utilization of mental health and substance abuse services. Some of the findings have clear implications, while others may be harder to interpret at this time in order to provide any useful recommendations. It should also be noted that physical and mental health parity, to be implemented on July 1, 2010, will address some of the issues related to benefit limitations. The issues raised in this section, however, would still be relevant since they address factors beyond benefit limitations.

Of the findings, the following stand out as having clear-cut, immediate implications:

- The role of primary care in the facilitation and provision of behavioral health services is extremely important. Parents place high value in primary care doctors' opinions—they are seen as gateway providers even when the health plan's policy allows parents to access mental health services directly without primary care referral. Much behavioral healthcare occurs in the primary care office. In the context of HFP, many see the strength of the integrated healthcare model as conducive to the coordination of care between primary care and behavioral health. This applies to adequate screening of behavioral problems in primary care, referral processes, tracking of follow up, and shared health records.
- The substance abuse benefit is significantly more underutilized than mental health; only 437 out of over 800,000 subscribers used SA outpatient services in the benefit year. Explanations include:
 - lack of awareness of the benefit among subscribers;
 - lack of treatment capacity for appropriate, age-related services;
 - limitations in the benefit that disallow residential or partial day programs; and
 - the possible tendency of mental health providers to establish a mental health diagnosis as primary for billing purposes and relegate substance use problems, even when a primary concern, as a secondary diagnosis that is not reported.

- Parents still face barriers in getting help for their children, once they surmount the powerful cultural and stigmatizing aspects of dealing with a mental health problem. Despite the best efforts to streamline administrative procedures, parents still experience challenges—especially for those who are new to the mental health system and/or who are non-or limited-English speaking—in navigating their way to a successful treatment experience. Once the parent becomes convinced that the child needs to be assessed, there are unacceptable delays in finding a clinician and getting an appointment. In addition, the lower utilization of outpatient services in MBHO plans may indicate barriers related to the administrative procedures required to access care (such as obtaining prior authorization or having providers request more sessions). While the data in this study cannot confirm this, it is worthy of further study.

Once the parent becomes convinced that the child needs to be assessed, there are unacceptable delays in finding a clinician and getting an appointment.

The resilience shown by the parents in the focus groups was impressive. The lesson from them was how complicated it can be to care for a child with emotional and behavioral problems, since the parent must often interact with the school, numerous treatment providers, and occasionally, health plan staff. On the positive side, access to adequate interpreter services and bilingual clinicians did not seem to be very problematic for focus group parents. However, since all of the focus group parents live in urban areas, the experience of rural subscribers and their access to adequate bilingual providers and interpreting services might not have been represented in the study.

- While health plans are tracking member satisfaction and complaints, some plans cannot disaggregate data about member phone calls and complaints related to behavioral health. In addition, plans involving MBHOs especially, while having comprehensive quality management policies and procedures, did not seem to sufficiently target HFP in quality studies. Because HFP enrollment is small relative to the MBHOs' other insured groups, HFP subscribers may be underrepresented and their voices may not be heard in those plans' quality studies.
- The analysis of the distribution of services by age group was very informative. The 0-5 age group is the least served of any other group, the use of services was highest for 6-12 year olds, and adolescent age groups (13-16 and 17-19) used fewer services. In other reports older age groups were shown to have higher rates of treatment for SED, although from the available data it could not be confirmed that the higher SED treatment rates affect rates of plan-provided services.

- The data limitations in service reporting are serious enough to call into question current utilization reports, especially for understanding service use by subscriber demographics such as ethnicity and language spoken. There is a need for uniform reporting standards as well as health plan-focused improvements in data management and reporting.
- The barriers to reporting are especially apparent in pharmacy data. Such barriers would make it difficult to obtain a clear understanding of pharmacy utilization, which would be important for quality and safety studies. In addition, the high sensitivity and cautiousness expressed by parents about medications warrants focused attention on the pharmacy experience of HFP subscribers, a topic that is larger than the scope of the current study.

❖ RECOMMENDATIONS ❖

Key Recommendations

- ❖ **Improve interface between primary care and mental health**
- ❖ **Improve screening, access and treatment engagement**
- ❖ **Improve provision and documentation of substance abuse services**
- ❖ **Improve the tracking of quality and outcome data**
- ❖ **Implement targeted outreach strategies**
- ❖ **Increase parent support and education**

IMPROVE INTERFACE BETWEEN PRIMARY CARE AND MENTAL HEALTH

The following recommendations address the importance of the primary care interface with mental health services.

MRMIB can further direct health plans to show evidence of integration of primary care and behavioral health services, especially in the areas of **screening, referral processes, tracking of follow up, and shared health records**. Alternative strategies for doing this include contractual requirements describing the health plans' approach to each of these areas; or a more detailed study of health plan processes in these areas, with a plan for improvement when appropriate.

- Health plans can improve **screening in primary care** by requiring use of screening instruments, training physicians and ancillary physician staff in the proper administration of instruments, and training physicians in the use of such data during brief well care or symptom-based visits. MRMIB can engage health plans, providers and researchers to identify the most recent evidence-based screening instruments that contain items related to emotional/behavioral indicators that would point to referral for further mental health and substance abuse assessment. The process of developing or adapting a uniform set of screening instruments would involve building consensus among health plan and provider representatives and a more in-depth review of the existing research than was possible in this project.
- **Referral processes** refer to the documentation of referrals from primary care to behavioral health, such that the physician and office staff are familiar with the behavioral health network of providers and procedures to enable successful referrals, such as assisting subscribers in calling MBHOs and educating subscribers new to mental health services in how to access care.

- **Documented tracking of follow up** is very important since that establishes communication between primary care and behavioral health providers and also closes the loop of the referral process.
- **Sharing health records**, to the extent allowed by state and federal privacy laws, including HIPAA statutes, enables the seamless transfer of care and continuity of care so that both primary and behavioral health providers are aware of important information that could lead to successful outcomes. The current trend towards electronic health records and personal health records should further enable and justify efforts in improving communication. The direct involvement of the health plan in taking a strong leadership role in facilitating these efforts will most likely lead to their successful implementation.

IMPROVE SCREENING, ACCESS AND TREATMENT ENGAGEMENT

While the scope of this study did not include a thorough analysis of provider capacity, the findings pointed to some specific areas requiring improvements in access to care.

Addressing the 0–5 age group

- Establish screening, treatment options, and specialized providers for the 0–5 age group.
- Such a focus would also result in a more educated and informed parent so that the parent can be enlisted as a treatment partner earlier in the life span of the family.
- Establishing a system of care for this age group may require efforts to educate health plan staff, primary care, and behavioral health providers since the care of this age group is a growing, but still nascent specialty area.

Addressing adolescent needs

- Health plans can conduct data studies to determine the characteristics of those adolescents and families who discontinue treatment prior to a predetermined threshold (such as five outpatient sessions), as well as the characteristics of youth who after being hospitalized return to outpatient treatment in a timely way.
- Providers can be surveyed about their explanation of the drop-off in adolescent service use, i.e., to what extent do parents or youth refuse further appointments?

- Parents should be surveyed as well—especially those new to mental health services who might assume more active outreach by providers and defer making follow-up appointments on their own.
- Plan subscribers should be surveyed about the needs of their youth and the results should be shared with contracted MBHOs and providers. Such surveys can include existing instruments such as the Consumer Satisfaction Surveys (CAHPS) with additional questions addressing adolescent needs, or the Young Adult Health Care Survey (YAHCS). Collaborative processes between providers and the health plan can be explored. For example, early termination of treatment can trigger a review by health plan staff that might result in family-specific follow up. Cultural issues most likely play an important role, as different cultures (e.g. Southeast Asian, Latino) have different expectations about the development of adolescent independence and family responsibility, and the relationship of these factors to help-seeking. Further training of the provider community would be helpful in this area.

Address Potential Problems Related to Administrative Protocols

- Each health plan can conduct a study of its internal procedures for facilitating access to care, as well as the flow of access experienced by the subscriber. MBHOs should review pre-authorization procedures and facilitate initial contacts from HFP subscribers so that they are efficiently referred to providers.

IMPROVE PROVISION OF SUBSTANCE ABUSE SERVICES

Gaps in substance abuse utilization are cause for concern and at odds with the national prevalence of substance abuse problems in older children and adolescents.

- At the state level, MRMIB can conduct a study of the feasibility for changing the substance abuse benefit to include evidence-based modes of limited residential programs and partial day treatment. Such a study would include estimates of expected utilization and a cost-benefit analysis to assess the impact of benefit scenarios on overall program cost. Such a study can also include a survey administered by MRMIB or the health plans of sampled enrolled families focusing on parents' and youths' perceived need for a focus on alcohol use, illicit drugs, and treatment alternatives.
- Health plans can explore the need for substance abuse treatment in partnership with their provider communities. To what extent do providers see youth with primary substance abuse problems? How are these cases

generally handled in traditional psychotherapy visits? What alternatives would providers recommend? For adolescents with co-occurring SA and MH problems, how do providers prioritize treatment approaches?

- The study found that the health plans' credentialing criteria for substance abuse providers were very weak, with the exception of Kaiser's criteria for physicians working in addiction treatment settings. Health plans, their contracted IPAs, MBHOs, and provider organizations can improve the recruitment and screening of substance abuse specialists from all professional categories that might include, for example, documented experience in outpatient and residential treatment substance abuse modalities, knowledge of co-occurring disorders and the existing treatment approaches, and certifications of specialized training and internship hours, among other criteria.

IMPROVE THE TRACKING OF QUALITY AND OUTCOME DATA

Address data-sharing issues

MRMIB can assess whether or not subscriber data can transfer seamlessly between the HFP plan, their subcontracted behavioral health providers, and participating county mental health departments. Best practices in data sharing can be disseminated and implemented.

Improve data capacity and validity

While this study did not include a comprehensive analysis of data capacity, data limitations surfaced as health plans organized their responses to the Data Request component. The following are recommended:

- Health plans can engage in an analysis of the flow of data between providers and health plan staff and develop an improvement plan.
- The reliability of data (e.g., how services are coded and aggregated for reports) can be made more consistent. MRMIB can engage with health plans in the standardization of data reporting, leading to more accurate overall utilization and performance reports.
- Tracking time to first appointment after referral is a very important indicator of access to care. MRMIB can require health plans to track this information and report performance to MRMIB on a regular basis.

Address pharmacy data issues and quality

MRMIB can initiate focused mental health pharmacy studies aimed at gaining a better understanding of pharmacy utilization, improving standardization of reporting, and improving the pharmacy data management capacity at the health plan or provider level.

Given the parents' concerns about medications, health plans can educate both parents and providers about how to engage parents in decision making, so that confusion and conflict can be minimized. Formal education campaigns for parents would also heighten their awareness of current practices and the benefits and risks of medications.

Improve ability to track complaints

Improving the ability to track complaints, grievances and problems is related to two issues:

- The ability to differentiate problems reported by subscribers related to mental health services vs. those reported about other healthcare or administrative issues.
- The need to standardize reporting so that the subscribers' experience with mental health and substance abuse services can be compared across all plans.

MRMIB can develop a standardized reporting format related to complaints, grievances and problems. Plans can be required to implement the format, which may require them to adjust data systems and allow for the differentiation of problems related to mental health and substance abuse services and their resolution.

Include HFP subscribers in quality studies

MRMIB can require plans (and their providers and MBHOs) to implement quality studies that specifically include HFP subscribers. Given the findings of this report, activities that target improvements in the initiation and engagement phases of treatment would be very useful to monitor improvements in access to care. In addition, the HFP subscribers should also be included in safety and utilization studies of medications, studies of quality of care relative to diagnosis and treatment plan, and studies of improvements in outcomes as a result of care.

IMPLEMENT TARGETED OUTREACH STRATEGIES

The study found excellent examples of culturally-specific outreach materials submitted by health plans. However improvements can be made in the following areas:

Successful outreach occurs at the community and neighborhood level

- Newsletters and brochures sent to enrolled subscribers that contain information about stress, depression, violence, etc. are important but must be used in conjunction with more intensive efforts locally.
- Health plans can engage local providers with offices in underserved neighborhoods. These providers can be expected to know more about their communities' cultural barriers and stigmatizing reactions to mental illness, as well as the strategies to successfully engage parents and youth in mental health and substance abuse treatment. They would also be familiar with the networks of informal helping that often are used in place of, or as a gateway to, formal treatment services.
- Health plans can also work in collaboration with local county mental health departments, which have already been engaged in community needs assessments as part of the Mental Health Service Act activities. Approaches might include town hall meetings in neighborhoods, the engagement of community leaders, locally targeted media campaigns, and provider-based educational presentations to the community on child and adolescent mental health issues.

Schools are potential sites for outreach, problem identification, and treatment

- Schools serve as an important environment in which children's problems are identified. As recommended by the parent study participants, health plans and provider organizations can engage targeted schools in the community to improve the dissemination of information about behavioral health services offered in HFP as well as information about mental health and substance abuse issues. Specifically, school health clinic staff and administrators should become knowledgeable about referral processes for HFP subscribers.

Use data to improve awareness and outreach

MRMIB can intensify the awareness of a focus on mental health and substance abuse service use by developing reports for the public that provide updates on the use of services. Simple charts can be included in subscriber materials, such as newsletters showing how many subscribers use mental health services (by age, and by ethnicity). This may help confirm to subscribers that mental health services are available and being used by others.

INCREASE PARENT SUPPORT AND EDUCATION

To address the challenges faced by parents, especially those new to mental health services and non- or limited-English speaking subscribers, the following are recommended:

- Health plans, MBHOs, county providers, and plan-contracted providers can improve the education of subscribers at those critical times during the initiation of treatment. Such education should assume that the caller is new to mental health services, and provide an orientation about what to expect when calling for referrals, making an appointment with a specific provider, attending the first session, and the typical procedures of the assessment process (such as information required of parents, the role of various mental health professionals, and the HFP benefits available for assessment and subsequent treatment).
- In addition to the community-based outreach strategies discussed above, health plans can conduct neighborhood-based educational meetings to acquaint the community with mental health issues and the HFP services available.
- This study's parent participants valued the opportunity to meet together and discuss shared concerns. Health plans can encourage providers to utilize this powerful strategy so that parents can learn from each other and become more engaged, educated "consumers" of behavioral health services for their children. Parent support groups can also be initiated at the health plan level.
- Health plans should identify and recruit parents interested in helping others new to the system by providing mentoring and advice.
- In addition to these support groups, ongoing focus groups administered by the plans would give plan managers direct information about quality of care from the perspective of parents.

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TABLES

Table 1. HFP Health Plans

Health Plan	Mental health services provided by:
Alameda Alliance for Health	Contracted providers of Optum/United Behavioral Health, a managed care company ²¹
Anthem Blue Cross	Contracted providers of WellPoint Behavioral Health, a managed care company
Blue Shield	Contracted providers of Optum/United Behavioral Health, a managed care company
CalOptima	Contracted behavioral health providers of regional independent practice associations, groups of physicians independent of the health plan
Care 1 st Health Plan	Contracted providers of CompCare Behavioral Health, a managed care company
CenCal Health	Contracted providers of Optum/United Behavioral Health, a managed care company
Central California Alliance for Health	Contracted providers of Optum/United Behavioral Health, a managed care company
Community Health Group	Contract with private practice group (Psychiatric Centers at San Diego)
Community Health Plan	Subcontracts with LA Care, LA Dept. of Mental Health, and Health Net for behavioral health services
Contra Costa Health Plan	Individual hospitals and providers contracted through county behavioral health
Health Net	Contracted providers of MHN, a managed care company
Health Plan of San Joaquin	Contracted providers and county staff of San Joaquin and Stanislaus behavioral health departments
Health Plan of San Mateo	County behavioral health staff
Inland Empire Health Plan	Contracted providers of Optum/United Behavioral Health, a managed care company
Kaiser Foundation Health Plan	Contracted providers of The Permanente Medical Group
Kern Family Health Care	Contracted providers and county-run clinics of the Kern County Mental Health Department
LA Care Health Plan	Contracted providers of Optum/United Behavioral Health, a managed care company
Molina Healthcare	Contracted providers of CompCare Behavioral Health, a managed care company
San Francisco Health Plan	County behavioral health staff and contracted providers
Santa Clara Family Health Plan	County behavioral health staff and contracted providers
Ventura County Health Plan	Contracted providers of Optum/United Behavioral Health, a managed care company

²¹ The Optum group includes United Behavioral Health and Pacificare Behavioral Health.

Table 2. Distribution of Documents Received, Sorted from Smallest to Largest Percentage of Documents Submitted

Survey item number	Request	Percentage of total plans (N=21) submitting document
39	Policies and procedures regarding behavioral health training for in-house interpreters	10%
4	Descriptions of media communications on education about MH or SA problems, or accessing HFP benefits Media communications include radio, TV or newspaper spots educating the public about mental illness or substance abuse treatment.	14%
40	Policies and procedures regarding behavioral health training for subcontracted interpreters	14%
47	Other policies and procedures related to MH/SA	19%
1	Announcements, flyers	24%
15	Substance abuse in-depth assessment instrument used or mandated by health plan	24%
25	Policies and procedures on training requirements for contracted behavioral health providers about HFP benefits	24%
48	Other health education materials related to MH/SA	29%
31	Number of health plan staff who provide behavioral healthcare services and languages spoken by each	33%
33	Number of health plan interpreters with behavioral health training and languages spoken by each	33%
49	Other trainings to providers about mental health and substance abuse assessment or treatment	33%
18	Other documentation of liaison or joint planning activities between behavioral health and physical health care providers Such as: · Meeting minutes · Description of committee conferences · Description of case conferences	38%
34	Number of interpreters engaged by subcontracted network providers and languages spoken	38%
38	Policies related to any training requirements for interpreters engaged by subcontractors	38%
2	General brochures about HFP benefits mentioning accessing MH and SA care	43%

Table 2. Distribution of Documents Received, Sorted from Smallest to Largest Percentage of Documents Submitted

Survey item number	Request	Percentage of total plans (N=21) submitting document
22b–Network	Specific credentialing/privileging policies and procedures, if any, for mental health providers, including application forms	43%
24a–Internal	List and demographics of staff and contracted behavioral health providers in health plan, by <ul style="list-style-type: none"> · Ethnicity · Language · Gender · Treat serious emotional disturbance (SED) 	43%
3	Specific educational brochures about MH and/or SA problems, and accessing HFP services	48%
12	Mental health in-depth assessment instrument used or mandated by health plan	48%
20	Policies and procedures regarding substance abuse benefit extension beyond plan maximum	48%
23b–Network	Specific credentialing/privileging policies and procedures, if any, for substance abuse providers (individual providers and organizations), including application forms	48%
28a	Number of on-call (contracted, non-hired) individuals available to provide language interpreting and languages spoken by each	48%
5	Other material related to education about MH or SA problems, or how to access MH or SA HFP services	52%
6	Example of referral form given to member to access provider Materials may include: <ul style="list-style-type: none"> · List of eligible providers · Referral to specific provider · Appointment slip 	52%
10	Protocols for Well Child Visits for MH/SA	52%
11	Protocols for Adolescent Well Care visits for MH/SA	52%
24b–External	List and demographics of staff and contracted behavioral health providers in health plan, by <ul style="list-style-type: none"> · Ethnicity · Language · Gender · Treat serious emotional disturbance (SED) 	52%
37	Training curricula (including who conducts trainings) and frequency for in-house interpreters	52%

Table 2. Distribution of Documents Received, Sorted from Smallest to Largest Percentage of Documents Submitted

Survey item number	Request	Percentage of total plans (N=21) submitting document
23a–Internal	Specific credentialing/privileging policies and procedures, if any, for substance abuse providers (individual providers and organizations), including application forms	57%
28b	If subcontracted, name of organization and number of interpreters and languages spoken by each	57%
29	Number of interpreters hired internally by the health plan, languages spoken by each, and a list of job title(s) used for them	57%
36	Policies and procedures for subcontracted provider network interpreters, including requirements for: <ul style="list-style-type: none"> · Certification · Types of continuous training · Frequency of continuous training 	57%
17	Health assessment tool	62%
21b–Network subcontracted	Policies and procedures regarding provider credentialing/privileging requirements for individual and organizational providers, including application forms	62%
22a–Internal	Specific credentialing/privileging policies and procedures, if any, for mental health providers, including application forms	62%
41	Documents (i.e. follow-up surveys) and policies and procedures regarding how health plan monitors accuracy of interpretations, member satisfaction with interpreters and comprehension	67%
46	Policies and procedures on time to first appointment after MH/SA referral	67%
35	Policies and procedures for in-house interpreters Including requirements for: <ul style="list-style-type: none"> · Certification · Types of continuous training · Frequency of continuous training 	71%
45	List of quality and outcome measurements for MH and/or SA	71%
9	Mental health or substance abuse screening tool used at intake, if any	76%
13	Substance abuse screening tool used at intake	76%
14	Criteria for referral to internal or external specialty substance abuse treatment services	76%

Table 2. Distribution of Documents Received, Sorted from Smallest to Largest Percentage of Documents Submitted

Survey item number	Request	Percentage of total plans (N=21) submitting document
16b–Contracted provider	Policies and procedures regarding coordination of behavioral health and physical health care with PCP	76%
19	Other training material for providers related to the coordination of mental health and physical health care	76%
44	Policies and procedures related to quality and outcome monitoring reports for MH and/or SA	76%
16a–Internal Health Plan Staff	Policies and procedures regarding coordination of behavioral health and physical health care with PCP	81%
27	Demographics of monthly averages of HFP enrollees and MH/SA service users in health plan, by <ul style="list-style-type: none"> · Age · Ethnicity · Language · Gender 	81%
30	Number of subcontracted interpreters and languages spoken by each	81%
32	Number of network providers who provide behavioral healthcare services and languages spoken by each	81%
7	Policy and procedures for criteria and process for screening and/or assessing MH and SA problems	86%
21a–Internal	Policies and procedures regarding provider credentialing/privileging requirements for individual and organizational providers, including application forms	86%
8	General intake screening forms for children and youth	90%
26	List of network providers identified by MH and SA	90%
43	Number of total overall logged HFP problems and grievances in the 2007–2008 benefit year plus the number related to mental health and substance abuse services	90%
42	Problem resolution and grievance policy and procedures, general to health plan	100%

Table 3. Utilization of Inpatient and Outpatient Mental Health Care, 2007–08

Health Plan	Number admitted to inpatient	Penetration rate, ²² admitted to inpatient	Number receiving outpatient services	Penetration rate, received outpatient	2006-2007 Overall penetration rates for comparison
Anthem Blue Cross	347	0.10%	5509	1.66%	2.68%
Alameda Alliance for Health	8	0.10%	76	0.97%	0.07%
Blue Shield	45	0.11%	828	1.93%	2.79%
CalOptima	28	0.09%	698	2.14%	1.98%
Care 1 st Health Plan	6	0.06%	7	0.07%	0.09%
CenCal Health	3	0.01%	22	0.93%	0.09%
Central California Alliance for Health	3	0.09%	38	1.19%	2.15%
Community Health Group	25	0.10%	574	2.28%	1.97%
Community Health Plan	14	0.07%	285	1.44%	0.5%
Contra Costa Health Plan	3	0.09%	137	3.92%	1.19%
Health Net	125	0.11%	2226	1.90%	2.04%
Health Plan of San Joaquin	3	0.03%	204	2.08%	0.23%
Health Plan of San Mateo	3	0.09%	63	1.79%	1.09%
Inland Empire Health Plan	66	0.14%	66	1.18%	1.72%
Kaiser Foundation Health Plan	93	0.08%	4688	3.98%	10.15%
Kern Family Health Care	9	0.07%	Not reported	Not reported	0.27%
LA Care Health Plan	8	0.22%	12	0.33%	Included in Community Health Group
Molina Healthcare	20	0.06%	484	1.37%	2.99%
San Francisco Health Plan	3	0.05%	229	3.70%	4.92%
Santa Clara Family Health Plan	11	0.07%	110	0.73%	1.13%
Ventura County Health Plan	4	0.13%	52	1.65%	1.46%
TOTAL	827	0.09%	16,308	1.79%	3.32%

²² Penetration rates based on HFP enrollment data from 2007-08.

Table 4. Inpatient and Outpatient Utilization, by Child's Ethnicity, 2007–2008

Ethnicity of child	Average inpatient admission rate	Average outpatient received rate
African American	0.43%	4.11%
Alaskan	0.17%	0.00%
Amerasian	0.91%	15.49%
Asian Indian	0.00%	0.11%
Cambodian	0.00%	0.03%
Chinese	0.00%	0.37%
Filipino	0.07%	0.20%
Guamanian	0.00%	1.39%
Hawaiian	0.00%	0.00%
Hispanic/Latino	0.15%	3.63%
Japanese	0.00%	0.06%
Korean	0.00%	0.03%
Laotian	0.00%	0.00%
Native American	0.11%	5.18%
Other Asian	0.85%	9.31%
Samoan	0.00%	0.17%
Vietnamese	0.01%	0.04%
White	0.37%	6.23%
Other	0.04%	3.39%

Table 5. Inpatient and Outpatient Utilization by Parent's Primary Language Spoken, Sorted Alphabetically by Language, 2007–2008

Parent's primary language spoken	Inpatient admissions	Outpatient received
Arabic	0.00%	0.99%
Armenian	0.00%	1.36%
Cantonese	0.46%	7.37%
Chinese	0.03%	0.69%
English	0.13%	2.91%
Farsi	0.00%	5.48%
Hmong	0.00%	0.26%
Korean	0.06%	1.39%
Mandarin	0.25%	1.83%
Other	0.03%	1.90%
Russian	0.00%	5.34%
Spanish	0.06%	1.48%
Tagalog	1.11%	1.67%
Vietnamese	0.70%	0.52%

Table 6. Number of MH/SA Appeals, Complaints, or Grievances from Total, 2007-2008

Health Plan	Number of MH/SA appeals, complaints or grievances	Overall number of appeals, complaints or grievances	Percentage of mental health appeals, complaints or grievances
Alameda Alliance for Health	3	Not reported	Not reported
Anthem Blue Cross	94	1,376	6.8%
Blue Shield	3	Not reported	Not reported
CalOptima	0	100	0%
Care 1 st Health Plan	5	432	0.01%
CenCal Health	0	Not reported	Not reported
Central California Alliance for Health	Not reported	Not reported	Not reported
Community Health Group	0	27	0%
Community Health Plan	Not reported	189	Not reported
Contra Costa Health Plan	0	3	0%
Health Net	11	Not reported	Not reported
Health Plan of San Joaquin	Not reported	Not reported	Not reported
Health Plan of San Mateo	1	4	25%
Inland Empire Health Plan	2 appeals 2 grievances	28 appeals 34 grievances	7% appeals 6% grievances
Kaiser Foundation Health Plan	Not reported	Not reported	Not reported
Kern Family Health Care	6	12	50%
LA Care Health Plan	Not reported	114	Not reported
Molina Healthcare	0	45	0%
San Francisco Health Plan	0	9	0%
Santa Clara Family Health Plan	1	16	6%
Ventura County Health Plan	0	3	0%

Table 7. Distribution of Top Three Languages Spoken by MH/SA Providers, by Health Plan

Health Plan	Total number of providers	#1 language spoken (% of total)	#2 language spoken (% of total)	#3 language spoken (% of total)
Alameda Alliance for Health	934	4.7% Spanish	2.7% French	1.6% German
Anthem Blue Cross	8,429	8% Spanish	1% French	1% Tagalog
Blue Shield	15,439	8% Spanish	2% French	1% Hindi
CalOptima	53	6% Spanish	4% Hindi	9% Other
Care 1 st Health Plan	235	13% Spanish	3% Cantonese	8% Other
CenCal Health	399	6.5% Spanish	1.7% French	1.5% Russian
Central California Alliance for Health	Not provided	Not provided	Not provided	Not provided
Community Health Group	93	Not provided ²³	Not provided	Not provided
Community Health Plan	41	8% Spanish	5% Mandarin	5% Other
Contra Costa Health Plan	51	16% Spanish	12% Other	
Health Net	2,939	11.8% Spanish	1.3% Hindi	1% Tagalog
Health Plan of San Joaquin	32	Not provided	Not provided	Not provided
Health Plan of San Mateo	345 (staff with valid language data)	48% Spanish	9% French	7% Tagalog
Inland Empire Health Plan	990	4.7% Spanish	2.7% French	1.6% German
Kaiser Foundation Health Plan	Not provided	Not provided	Not provided	Not provided
Kern Family Health Care	Not provided	Not provided	Not provided	Not provided
LA Care Health Plan	3,590	8.4% Spanish	2.1% Hebrew	1.9% French
Molina Healthcare — Behavioral Health Associates	210	11% Spanish	2.9% French	2.4% Tagalog
— CompCare	194	15% Spanish	2.6% Italian	Other
San Francisco Health Plan	Not provided	Not provided	Not provided	Not provided
Santa Clara Family Health Plan	148	9% Spanish	6% Chinese	3% Hindi
Ventura County Health Plan	366	7.3% Spanish	1.6% French	< 0.5% German

²³ Community Health Group submitted lists for its two contracted provider groups. The list with the majority of providers (those in the Psychiatric Centers of San Diego) did not contain ethnicity or language information.

Table 8. Summary of Document Responses – Interpreters and Bilingual Staff

Health Plan	External/subcontracted interpreters	Internal interpreters	Bilingual staff
Alameda Alliance for Health	Language Line		12 bilingual staff (Spanish)
Anthem Blue Cross	—Language Line —Lexicon International		Over 1,000 bilingual staff (655 Spanish)
Blue Shield	Language Line	8	
CalOptima	21 contracted organizations for CalOptima and IPA groups		
Care 1 st Health Plan	Interpreters Unlimited (30 languages)		
CenCal Health		12 Spanish	
Central California Alliance for Health	—Tele-Interpreters —Commgap International —Sign Language Associates, Inc.		
Community Health Group	—Language Line		70% bilingual staff
Community Health Plan	—Life Signs (150 interpreters) —American Language Interpreters (1,850 interpreters, 200 languages)		40 bilingual staff (32 Spanish)
Contra Costa Health Plan	Various vendors, 100 languages		13 bilingual staff (8 Spanish)
Health Net	—TeleInterpreters (160 interpreters) —Commgap International (100 languages) —Sign Language Associates		776 bilingual staff (32 languages)
Health Plan of San Joaquin	Not provided	Not provided	Not provided
Health Plan of San Mateo	190 interpreter services delivered (Unclear in response if provided by external service or internal staff)		

Table 8. Summary of Document Responses – Interpreters and Bilingual Staff

Health Plan	External/subcontracted interpreters	Internal interpreters	Bilingual staff
Inland Empire Health Plan	—Language Line	13 Spanish	
Kaiser Foundation Health Plan	—Language Line —Language People (ASL)	Northern CA: 50 Southern CA: unspecified number of employed interpreters	“Qualified Bilingual Status Employees” Northern CA: 187 Southern CA: 2
Kern Family Health Care	Language Line		19 Bilingual staff (18 Spanish)
LA Care Health Plan Molina Healthcare	Language Line —Language Line —ISI	12 Spanish	127 Bilingual staff (121 Spanish)
San Francisco Health Plan	—Lam Do and Associates		
Santa Clara Family Health Plan	—Pacific Interpreters —Interpreters Unlimited		23 Bilingual staff (9 Spanish)
Ventura County Health Plan	—Language Line —Lourdes González Campbell and Associates		12 Bilingual staff

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METHODOLOGIES

Document Review

A survey instrument and cover letter were drafted and reviewed by MRMIB staff and discussed with health plan representatives. In January 2009, a request for policy and administration documents was sent to health plans. The request consisted of a cover letter and spreadsheet containing 55 items with which the plans were to indicate the availability of the specific document. The cover letter and document request checklist are included as Attachment 2. The plans were asked to attach the document, if available, and forward it to APS. The timeline for completion was six weeks from the date of the request.

The analysis of these documents consists of (a) a tally of those documents received, by health plan and in total, for each of the 55 items; (b) a review of documents; and (c) content and narrative analyses—consisting of counts of occurrences of specific items in available documents, counts and occurrences of key phrases within the documents, and overall narrative appraisal about the extent to which the document addresses the question. Exemplars will be cited in certain areas, although they are not meant to be exhaustive of all innovative or successful practices of the health plans.

Fifty-five items were requested from each plan, totaling 1,155 documents. A total of 644 separate documents were received, representing 56% of those requested. This count does not take into consideration that some documents cover more than one item in the survey, as was noted by the health plans in their spreadsheet responses. For example, a general policy and procedure document covering quality monitoring might also include member satisfaction, complaint resolution, HEDIS measures, access measures, monitoring the provider network, and other process indicators of quality.

Table 2 (see Appendix 1) shows the distribution of all survey items, sorted from the smallest to the highest percentage of health plans responding. The range for a positive item response—document available and submitted—was from only 10% of health plans (for the item “Policies and procedures regarding behavioral health training for in-house interpreters”) to 100% of health plans (for the item “Problem resolution and grievance policy and procedures, general to health plan”).

Data Review

Due to data-sharing restrictions we were unable to obtain subscriber-level service data from the health plans. The Scope of Work made allowances for alternative methods to analyze service utilization and some measures of continuity of care. Using data from the benefit year 2007–2008, a set of aggregate data reports was requested from health plans in the areas of inpatient and outpatient mental health services, inpatient and outpatient substance abuse services, and pharmacy. Several health plans participated in two conference calls to plan the data request and their comments were incorporated. The cover letter and final data request spreadsheet covering

over 1,940 variables were sent to health plans on July 18, 2009, and the timeline for response was August 31, 2009. The final cover letter and data request spreadsheet are included as Attachment 3.

For this report we prioritized the following analyses, based on the quality and completeness of data received and priorities for recommendations:

- Utilization of inpatient and outpatient services, by health plan and plan characteristics
- Utilization of inpatient and outpatient services by age
- Utilization of inpatient and outpatient services by ethnicity, including proportion served by ethnicity compared to proportion represented in enrollment
- Utilization of inpatient and outpatient services by parent's primary language
- Utilization of inpatient and outpatient services by gender
- Utilization of inpatient and outpatient services by diagnosis
- Medication use, by age
- Commonly used medications, by diagnostic category
- Overview of substance abuse treatment utilization

Key Informant Interviews

Interviews were set up with staff, administrators, and providers of representative health plans. We chose a combination of health plan types—for-profit, public, and regional health plans. Three health plans were visited on site, and three participated in conference calls. A variety of participants represented clinical Managed Behavioral Healthcare Organization (MBHO) staff, member services, administrators, and medical directors. The interview protocol included as Attachment 5 was sent to participants in advance of the scheduled interviews, along with the informed consent form for their participation.

Subscriber Focus Groups

Four health plans were enlisted to recruit participants for focus groups. Health plans were chosen based on geographic diversity, as well as the diversity of type of plan. Attachment 6 shows the focus group interview participant sampling for each health plan. Health plans reviewed historical records to identify potential participants who used any mental health services during the benefit year 2007–2008. The plans sent letters of invitation to potential participants, with a copy of the research informed consent form, and instructions to complete basic contact information and return the information to APS offices. The APS coordinator then arranged focus group logistics in coordination with the health plan.

Focus groups were designed to last up to an hour and a half. The interview protocol used in the groups is included as Attachment 7. The protocol was designed to address the parents' perspective of the quality of services they received and their perspectives on accessing care.



APPENDIX 3

**HFP ENROLLMENT AND DEMOGRAPHIC DATA
BY HEALTH PLAN, 2007–2008**

Evaluation of Mental Health and Substance Abuse Services Provided to Healthy Families Subscribers--
Data Request to Health Plans

	Plan Name	ALAMEDA ALLIANCE	ANTHEM BLUE CROSS - EPO	ANTHEM BLUE CROSS - HMO	BLUE SHIELD - HMO	CALOPTIMA	COMMUNITY HEALTH GROUP	COMMUNITY HEALTH PLAN	CONTRA COSTA HEALTH
Item #									
I	TOTAL PLAN ENROLLMENT:	7,862	199,507	132,460	34,827	32,557	25,197	19,799	3,493
	Monthly Average (Items II- V):	7,862	199,480	132,438	34,823	32,554	25,195	19,798	3,493
II	AGE GROUP								
A	0-5	1,297	42,605	25,812	6,553	6,461	4,673	2,297	784
B	6-12	1,449	35,206	24,674	6,477	5,888	4,776	4,364	592
C	13-15	1,667	38,758	28,010	7,178	5,928	4,980	5,416	555
D	16-19	3,449	82,938	53,964	14,619	14,279	10,768	7,722	1,562
		7,862	199,507	132,460	34,827	32,557	25,197	19,799	3,493
III	GENDER								
A	Female	3,819	97,219	63,940	16,889	15,823	12,211	9,807	1,721
B	Male	4,041	102,178	68,432	17,922	16,724	12,977	9,989	1,770
		7,860	199,397	132,372	34,811	32,546	25,188	19,796	3,491
IV	RACE/ETHNICITY								
A	Alaska Native	4	25	4	2		1		
B	Amerasian	30	642	485	131	55	38	18	14
C	Asian Indian	170	1,461	1,524	349	97	9	24	34
D	Black/African American	283	2,049	2,652	961	104	388	374	86
E	Cambodian	31	216	388	65	110	34	71	1
F	Chinese	1,532	1,988	7,593	1,696	142	121	541	34
G	Filipino	136	1,355	1,708	493	154	347	213	37
H	Guamanian	2	39	26	9	3	4	3	
I	Hawaiian	6	94	26	14	10	9	2	
J	Hispanic/Latino	3,420	112,387	63,446	15,573	21,726	19,141	14,441	2,200
K	Japanese	3	129	117	72	16	9	9	
L	Korean	45	2,314	4,879	1,152	576	36	179	10
M	Laotian	6	164	197	45	4	33	5	5
N	Native American Indian	13	1,323	183	61	11	28	11	4
O	Samoan	12	93	96	21	14	16	11	1
P	Vietnamese	269	2,277	2,172	782	3,412	285	188	18
Q	White	242	32,315	12,804	5,005	797	1,079	409	140
R	Other Asian	349	2,574	4,941	1,205	338	143	366	36
S	Other (Unknown)	1,299	37,653	28,896	7,104	4,931	3,438	2,908	866
T	Not Given	14	408	323	88	58	41	27	7
		7,863	199,507	132,460	34,827	32,557	25,198	19,799	3,494

Evaluation of Mental Health and Substance Abuse Services Provided to Healthy Families Subscribers--
Data Request to Health Plans

Plan Name	HEALTH NET	HEALTH PLAN SAN JOAQUIN	HEALTH PLAN SAN MATEO	INLAND EMPIRE HEALTH PLAN	KAISER PERMANENTE	KERN FAMILY HEALTH	L.A. CARE HEALTH PLAN	MOLINA	
Item #									
I	TOTAL PLAN ENROLLMENT:	116,397	9,805	3,519	48,637	117,808	12,112	3,669	35,377
	Monthly Average (Items II- V):	116,377	9,804	3,519	48,634	117,793	12,111	3,669	35,372
II	AGE GROUP								
A	0-5	24,200	1,806	755	9,529	23,475	2,252	798	7,270
B	6-12	20,769	1,785	589	8,849	21,155	2,218	636	6,402
C	13-15	22,938	1,889	586	9,167	24,450	2,443	677	6,993
D	16-19	48,489	4,325	1,589	21,092	48,729	5,199	1,558	14,712
		116,397	9,805	3,519	48,637	117,808	12,112	3,669	35,377
III	GENDER								
A	Female	56,550	4,820	1,678	23,835	57,088	5,827	1,815	17,175
B	Male	59,768	4,981	1,840	24,789	60,658	6,280	1,852	18,180
		116,317	9,801	3,518	48,624	117,746	12,107	3,667	35,356
IV	RACE/ETHNICITY								
A	Alaska Native				4	1			3
B	Amerasian	369	12	5	108	476	37	6	47
C	Asian Indian	677	163	27	78	1,492	77	16	34
D	Black/African American	2,937	203	32	1,193	6,143	222	91	637
E	Cambodian	385	123	3	54	339	42	5	45
F	Chinese	4,035	165	60	118	1,948	23	27	259
G	Filipino	1,378	218	224	210	2,328	194	60	344
H	Guamanian	24	1		4	33			13
I	Hawaiian	47	1	5	25	66	1	3	5
J	Hispanic/Latino	62,572	6,043	2,227	33,319	61,020	8,703	2,608	24,599
K	Japanese	101	4	2	12	73	4	4	19
L	Korean	872	5	4	75	521	9	37	83
M	Laotian	131	82		9	187	2	2	53
N	Native American Indian	194	27	2	60	283	30	1	46
O	Samoan	85	3	4	18	147	1	2	34
P	Vietnamese	2,779	77	7	159	994	17	13	275
Q	White	13,023	782	98	3,993	13,785	868	89	2,132
R	Other Asian	3,414	222	37	275	2,196	47	36	163
S	Other (Unknown)	23,091	1,654	774	8,839	25,519	1,818	662	6,497
T	Not Given	283	20	8	87	257	19	9	90
		116,397	9,806	3,520	48,637	117,809	12,115	3,671	35,377

Evaluation of Mental Health and Substance Abuse Services Provided to Healthy Families Subscribers--
Data Request to Health Plans

	Plan Name	SAN FRANCISCO HEALTH	CENCAL HEALTH	SANTA CLARA FAMILY HEALTH	CENTRAL COAST ALLIANCE	VENTURA COUNTY HEALTH	CARE 1ST HEALTH PLAN	BLUE SHIELD - EPO	HEALTH NET LIFE
Item #									
I	TOTAL PLAN ENROLLMENT:	6,188	2,357	15,079	3,185	3,150	10,053	8,027	855
	Monthly Average (Items II- V):	6,187	2,358	15,076	3,185	3,150	10,052	8,026	856
II	AGE GROUP								
A	0-5	911	616	3,145	837	607	1,828	1,793	199
B	6-12	1,247	384	2,462	474	578	1,857	1,344	141
C	13-15	1,591	410	2,525	538	674	1,844	1,460	145
D	16-19	2,438	948	6,946	1,337	1,292	4,524	3,431	370
		6,188	2,357	15,079	3,185	3,150	10,053	8,027	855
III	GENDER								
A	Female	3,022	1,149	7,304	1,532	1,522	5,047	3,800	402
B	Male	3,164	1,207	7,763	1,651	1,625	5,001	4,223	453
		6,186	2,356	15,067	3,183	3,147	10,048	8,023	855
IV	RACE/ETHNICITY								
A	Alaska Native							1	
B	Amerasian	5	3	22	14	2	2	67	8
C	Asian Indian	9	1	167	4	3	10	36	50
D	Black/African American	80	15	116	21	12	158	118	16
E	Cambodian	8	3	88	1		11	9	1
F	Chinese	3,651	4	395	12	5	104	50	2
G	Filipino	87	9	240	31	15	118	74	8
H	Guamanian			3	1	2		6	
I	Hawaiian			10	1		1	10	
J	Hispanic/Latino	947	1,650	8,355	2,263	2,545	7,470	2,536	281
K	Japanese	1	2	4	1		3	3	
L	Korean	7	3	51	3	3	30	33	
M	Laotian	2	3	12			3	10	2
N	Native American Indian	2	5	7	7	3		130	11
O	Samoan	8		7		1	3	9	1
P	Vietnamese	64	4	2,685	14	4	22	63	
Q	White	59	169	308	215	131	235	2,680	220
R	Other Asian	201	4	206	7	7	123	84	28
S	Other (Unknown)	1,045	482	2,377	586	412	1,743	2,089	228
T	Not Given	12	5	28	6	10	17	19	3
		6,188	2,360	15,079	3,187	3,153	10,055	8,027	857

Evaluation of Mental Health and Substance Abuse Services Provided to Healthy Families Subscribers--
Data Request to Health Plans

	Plan Name	ALAMEDA ALLIANCE	ANTHEM BLUE CROSS - EPO	ANTHEM BLUE CROSS - HMO	BLUE SHIELD - HMO	CALOPTIMA	COMMUNITY HEALTH GROUP	COMMUNITY HEALTH PLAN	CONTRA COSTA HEALTH
V	PRIMARY LANGUAGE SPOKEN OF PARENT/GUARDIAN								
A	English	2,454	102,300	62,863	20,516	6,679	6,822	5,749	840
B	Spanish	3,436	89,697	51,252	10,597	21,935	17,839	13,121	2,557
C	Chinese	1,352	1,611	7,039	1,657	64	80	458	23
D	Vietnamese	293	2,226	2,259	771	3,337	270	173	21
E	Korean	30	1,837	3,636	696	382	19	127	7
F	Russian	12	245	1,328	78	4	4	7	1
G	Cantonese	121	56	360	60	1	4	11	1
H	Farsi	9	157	734	76	22	8	13	6
I	Tagalog	19	114	169	43	16	72	28	3
J	Armenian		17	876	24			36	
K	Mandarin	24	80	225	64	1		9	1
L	Arabic	9	266	171	45	49	25	6	1
M	Hmong		79	274	23		1	5	
N	Not Given								
O	Other (Unknown)	103	825	1,272	180	67	54	58	31
		7,862	199,507	132,460	34,827	32,557	25,197	19,799	3,493

Evaluation of Mental Health and Substance Abuse Services Provided to Healthy Families Subscribers--
Data Request to Health Plans

	Plan Name	HEALTH NET	HEALTH PLAN SAN JOAQUIN	HEALTH PLAN SAN MATEO	INLAND EMPIRE HEALTH PLAN	KAISER PERMANENTE	KERN FAMILY HEALTH	L.A. CARE HEALTH PLAN	MOLINA
V	PRIMARY LANGUAGE SPOKEN OF PARENT/GUARDIAN								
A	English	60,719	4,249	941	20,334	68,541	5,015	1,254	12,084
B	Spanish	45,710	5,217	2,395	27,921	44,331	6,997	2,315	22,641
C	Chinese	4,353	143	42	44	1,343	3	16	155
D	Vietnamese	2,700	59	6	155	787	21	14	236
E	Korean	707		2	52	353	11	27	56
F	Russian	820		4	3	705		9	36
G	Cantonese	121	2	10	8	97		6	5
H	Farsi	107	5	2	9	111		1	14
I	Tagalog	119	14	81	15	302	22	2	37
J	Armenian	79				76		12	4
K	Mandarin	172		4	4	65	1	3	5
L	Arabic	86	6	11	25	136	7	1	20
M	Hmong	102	46			98			8
N	Not Given								
O	Other (Unknown)	602	63	21	67	863	37	11	79
		116,397	9,805	3,519	48,637	117,808	12,112	3,669	35,377

Evaluation of Mental Health and Substance Abuse Services Provided to Healthy Families Subscribers--
Data Request to Health Plans

Plan Name		SAN FRANCISCO HEALTH	CENCAL HEALTH	SANTA CLARA FAMILY HEALTH	CENTRAL COAST ALLIANCE	VENTURA COUNTY HEALTH	CARE 1ST HEALTH PLAN	BLUE SHIELD - EPO	HEALTH NET LIFE	
V	PRIMARY LANGUAGE SPOKEN OF PARENT/GUARDIAN									
	A	English	1,395	712	3,323	923	748	2,727	6,357	608
	B	Spanish	1,023	1,627	8,410	2,217	2,377	7,061	1,441	237
	C	Chinese	3,256	2	288	13	6	132	44	
	D	Vietnamese	64	2	2,748	8	7	17	65	
	E	Korean	3	5	43	2	3	26	21	
	F	Russian	7	1	3	1		2	10	2
	G	Cantonese	379		33	2		7	4	
	H	Farsi			27		3	2	16	
	I	Tagalog	15	3	42	14	2	14	16	
	J	Armenian						35		
	K	Mandarin	24		33			3	3	
	L	Arabic	5			2	2		2	
	M	Hmong		9					13	3
	N	Not Given			1					
O	Other (Unknown)	16	-3	129	4	2	28	35	5	
		6,188	2,357	15,079	3,185	3,150	10,053	8,027	855	

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APPENDIX 4

DOCUMENT REQUEST LETTER AND CHECKLIST



560 J Street, Suite 390 • Sacramento, CA 95814

www.apshealthcare.com

TO: Healthy Families Program Health Plan

FROM: Sheila Baler, Ph.D., M.P.H.
Executive Director
APS Healthcare
Sacramento Office

RE: Health Plan Request, Part I – Policy and Administration Documents, Benefit Year 2007-2008

Date: January 16, 2009

APS Healthcare is assisting the Managed Risk Medical Insurance Board (MRMIB) to evaluate the access, utilization and quality of mental health and substance abuse services provided by health plans participating in the Healthy Families Program (HFP). This is a restart of the project that was originally begun in 2008 by the Macias Consulting Group. The new timeframe for this project is November 1, 2008 to June 30, 2010. The documents and data to be evaluated are for the 2007-2008 Benefit Year.

The goal of this evaluation is to assess the delivery of basic mental health and substance abuse services provided by HFP plans and to identify and recommend to MRMIB the changes that are needed to improve the delivery of these services to HFP subscribers. As part of this evaluation, APS will assess the timeliness, quality, and access of the plans' mental health and substance abuse services, and the barriers to the same. MRMIB recently sent a more detailed scope of work to all the HFP plans. However, if you have questions about the objectives of the study, please contact Sarah Swaney of MRMIB. Throughout this project we will be asking for your suggestions and feedback. We appreciate your time in helping us to complete a thorough, accessible, and useful evaluation.

In order to complete our evaluation, we will be sending out two different requests for documents or data. Attached is our first request for policy and administration documents. The next request will be for utilization data. We understand that the HFP health plans are a diverse group; there are many different organizational structures among plans. Because of these differences there may be documents we request which your health plan does not have or which do not apply to your health plan. In these cases, please mark the "none" box. If you have questions about documents we are requesting, please contact Ms. Calderon.

Attached is a form requesting a variety of documents and information relevant to the Scope of Work contained in the MRMIB contract with APS Healthcare. Please review the form. It is an electronic document that includes document descriptions plus boxes to be checked indicating either that there are no documents specific to the particular item or that the relevant documents/information are attached. Electronic versions of documents are highly preferred; only send hard copy when absolutely necessary. Each item has a number and check box to indicate whether an electronic or hard copy version is sent. Please label each submission attachment with the corresponding item number from the form. We suggest either labeling each document or labeling the file name or file folder. Also, if one document meets the criteria for more than one category, please label the document with all of the corresponding item numbers.

In the request we ask for documents relating to cultural and linguistics responsiveness. We understand that plans may have recently submitted documents for the Cultural and Linguistics Survey to MRMIB. If that is the case, please make a note next to the item number so we can cross-reference your submissions (i.e. "☒ Previously Submitted, Policy #6090 Translation Services"). We will contact you if we have any questions.

Please provide the completed electronic form and electronic materials (by email attachment or CD) to Esperanza Calderon at ecalderon@apshealthcare.com by **Friday, February 27, 2009**. Send the few documents available only in hard copy or any documents on CD to APS Healthcare, Attn. Esperanza Calderon, 560 J. St., Ste. 390, Sacramento, CA 95814. Questions can also be addressed to Ms. Calderon either at the above email address or at 916.266.2579. Please note that some organizations have policies regarding the size of emails and attachments and may "block" some emails. You may need to "zip" the attachments or send the attachments with more than one email. Upon receipt of your documents, Ms. Calderon will contact you to confirm receipt. If you do not hear back from our office about receipt of documents, please contact us. If you have difficulties sending the electronic copies, please call for assistance to discuss alternate modes of electronic submission rather than resorting to paper copies.

We thank you in advance for your help with this, and we look forward to collaborating with you on this important project.

Sheila G. Baler, Ph.D., M.P.H.
Executive Director, CAEQRO
APS Healthcare

o 916.266.2571 m 916.704.2270
www.apshealthcare.com
www.caegro.com

cc Janette Lopez, Chief Deputy Director
Shelley Rouillard, Deputy Director, Benefits and Quality Monitoring Division
Ruth Jacobs, Assistant Deputy Director, Benefits and Quality Monitoring Division
Sarah Swaney, Benefits and Quality Monitoring Division

Evaluation of Mental Health and Substance Abuse Services Provided to Healthy Families Subscribers—Document Request to Health Plans

Member Materials and Brochures				
1	Announcements, Flyers	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
2	General brochures about HFP benefits mentioning accessing MH and SA care	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
3	Specific educational brochures about MH and/or SA problems, and accessing HFP services	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
4	<p>Descriptions of media communications on education about MH or SA problems, or accessing HFP benefits</p> <p>Media communications include radio, TV or newspaper spots educating the public about mental illness or substance abuse treatment.</p>	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
5	Other material related to education about MH or SA problems, or how to access MH or SA HFP services	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
Confirmation Material of MH/SA Referral &/Or Appointment				
6	<p>Example of referral form given to member to access provider</p> <p>Materials may include:</p> <ul style="list-style-type: none"> • List of eligible providers • Referral to specific provider • Appointment slip 	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted

Screening and Assessment				
7	Policy and procedures for criteria and process for screening and/or assessing MH and SA problems	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
8	General intake screening forms for children and youth	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
9	Mental health or substance abuse screening tool used at intake, if any	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
10	Protocols for Well Child Visits for MH/SA	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
11	Protocols for Adolescent Well Care visits for MH/SA	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
12	Mental health in-depth assessment instrument used or mandated by health plan	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
13	Substance abuse screening tool used at intake	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
14	Criteria for referral to internal or external specialty substance abuse treatment services	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
15	Substance abuse in-depth assessment instrument used or mandated by health plan	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted

Coordination of Care				
16a – Internal Health Plan Staff	Policies and procedures regarding coordination of behavioral health and physical health care with PCP	<input type="checkbox"/> Enclosed—internal health plan staff	<input type="checkbox"/> Electronic	<input type="checkbox"/> Previously Submitted
16b – Contracted provider		<input type="checkbox"/> None	<input type="checkbox"/> Hard Copy	
17	Health assessment tool	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
18	Other documentation of liaison or joint planning activities between behavioral health and physical health care providers Such as: <ul style="list-style-type: none"> • Meeting minutes • Description of committee conferences • Description of case conferences 	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
19	Other training material for providers related to the coordination of mental health and physical health care	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
20	Policies and procedures regarding substance abuse benefit extension beyond plan maximum	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted

Individual and Organizational Providers				
21a – Internal	Policies and procedures regarding provider credentialing/privileging requirements for individual and organizational providers, including application forms	<input type="checkbox"/> Enclosed—internal staff providers	<input type="checkbox"/> Electronic	<input type="checkbox"/> Previously Submitted
21b – Network subcontracted		<input type="checkbox"/> None	<input type="checkbox"/> Hard Copy	
		<input type="checkbox"/> Enclosed—network providers	<input type="checkbox"/> Electronic	<input type="checkbox"/> Previously Submitted
		<input type="checkbox"/> None—Network list unavailable	<input type="checkbox"/> Hard Copy	
		<input type="checkbox"/> None—Not applicable		
22a – Internal	Specific credentialing/privileging policies and procedures, if any, for mental health providers, including application forms	<input type="checkbox"/> Enclosed—internal staff providers	<input type="checkbox"/> Electronic	<input type="checkbox"/> Previously Submitted
22b – Network		<input type="checkbox"/> None	<input type="checkbox"/> Hard Copy	
		<input type="checkbox"/> None—Network list unavailable	<input type="checkbox"/> Electronic	<input type="checkbox"/> Previously Submitted
		<input type="checkbox"/> None—Not applicable	<input type="checkbox"/> Hard Copy	
23a – Internal	Specific credentialing/privileging policies and procedures, if any, for substance abuse providers (individual providers and organizations), including application forms	<input type="checkbox"/> Enclosed—internal staff providers	<input type="checkbox"/> Electronic	<input type="checkbox"/> Previously Submitted
23b – Network		<input type="checkbox"/> None	<input type="checkbox"/> Hard Copy	
		<input type="checkbox"/> Enclosed—network providers	<input type="checkbox"/> Electronic	<input type="checkbox"/> Previously Submitted
		<input type="checkbox"/> None	<input type="checkbox"/> Hard Copy	

24	List and demographics of staff and contracted behavioral health providers in health plan, by <ul style="list-style-type: none"> • Ethnicity • Language • Gender • Treat serious emotional disturbance (SED) 	<input type="checkbox"/> Enclosed—internal <input type="checkbox"/> None <input type="checkbox"/> Enclosed—external <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy <input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted <input type="checkbox"/> Previously Submitted
25	Policies and procedures on training requirements for contracted behavioral health providers about HFP benefits	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
26	List of network providers identified by MH and SA	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
Cultural and Linguistic Responsiveness				
27	Demographics of monthly averages of HFP enrollees <u>and</u> MH/SA service users in health plan, by <ul style="list-style-type: none"> • Age • Ethnicity • Language • Gender 	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
28a	Number of on-call (contracted, non-hired) individuals available to provide language interpreting and languages spoken by each	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
28b	If subcontracted, name of organization and number of interpreters and languages spoken by each	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
29	Number of interpreters hired internally by the health plan, languages spoken by each, and a list of job title(s) used for them	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted

30	Number of subcontracted interpreters and languages spoken by each	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
31	Number of health plan staff who provide behavioral healthcare services and languages spoken by each	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
32	Number of network providers who provide behavioral healthcare services and languages spoken by each	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
33	Number of health plan interpreters with behavioral health training and languages spoken by each	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
34	Number of interpreters engaged by subcontracted network providers and languages spoken	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
35	Policies and procedures for in-house interpreters Including requirements for: <ul style="list-style-type: none"> • Certification • Types of continuous training • Frequency of continuous training 	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
36	Policies and procedures for subcontracted provider network interpreters Including requirements for: <ul style="list-style-type: none"> • Certification • Types of continuous training • Frequency of continuous training 	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted

37	Training curricula (including who conducts trainings) and frequency for in-house interpreters	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
38	Policies related to any training requirements for interpreters engaged by subcontractors	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
39	Policies and procedures regarding behavioral health training for in-house interpreters	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
40	Policies and procedures regarding behavioral health training for subcontracted interpreters	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
41	Documents (i.e. follow-up surveys) and policies and procedures regarding how health plan monitors accuracy of interpretations, member satisfaction with interpreters and comprehension	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
Member Services				
42	Problem resolution and grievance policy and procedures, general to health plan	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
43	Number of total overall logged HFP problems and grievances in the 2007-2008 benefit year plus the number related to mental health and substance abuse services	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
Quality Monitoring and Quality Improvement				
44	Policies and procedures related to quality and outcome monitoring reports for MH and/or SA	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted

45	List of quality and outcome measurements for MH and/or SA	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
46	Policies and procedures on time to first appointment after MH/SA referral	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
Other				
47	Other policies and procedures related to MH/SA	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
48	Other health education materials related to MH/SA	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted
49	Other trainings to providers about mental health and substance abuse assessment or treatment	<input type="checkbox"/> Enclosed <input type="checkbox"/> None	<input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy	<input type="checkbox"/> Previously Submitted

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APPENDIX 5

DATA REQUEST LETTER AND SPREADSHEET



560 J Street, Suite 390 • Sacramento, CA 95814
www.apshealthcare.com

TO: Healthy Families Program Health Plan

FROM: Sheila Baler, Ph.D., M.P.H.
Executive Director
APS Healthcare
Sacramento Office

RE: Health Plan Request, Part II – Data Request, Benefit Year 2007-2008

Date: May 14, 2009

APS Healthcare is assisting the Managed Risk Medical Insurance Board (MRMIB) to evaluate the access, utilization and quality of mental health and substance abuse services provided by health plans participating in the Healthy Families Program (HFP). In this phase of our evaluation, we are requesting reports from your data that focus on utilization of plan provided mental health and substance abuse services and medications prescribed to HFP children. We are also requesting HFP enrollment and demographic data. The format of these reports will be presented in Microsoft Excel spreadsheets, which can also be used by you to respond to our request.

We have set up a conference call to go over the request for any plans that have questions. The call is set for May 21 at 2pm.

The spreadsheet is attached as an electronic document. Please review the form. There is a worksheet with specific instructions. Worksheet 1 ("1 HFP Enrollment") is for HFP enrollment. At this time, you do not need to complete this worksheet. We expect to receive this data from another source. This data will allow us to analyze penetration rates using data from the other worksheets. Worksheet 2 ("2 MH Inpt") concerns inpatient hospital admissions and lengths of stay in psychiatric inpatient hospitals. Worksheet 3 ("3 MH Outpt") covers similar data from mental health (MH) outpatient visits. Worksheets 4 and 5 ("4 SA Inpt" and "5 SA Outpt") replicate the same information for substance abuse (SA) treatment. Worksheet 6 ("6 Pharmacy Data") concerns plan-prescribed psychoactive medications used for treatment of HFP members with mental health diagnoses. All data reports are requested for the July 2007 through June 2008 benefit year.

Using the spreadsheet for your responses is preferred. If you submit separate documents or reports, please label them according to the worksheet number. Please provide the completed electronic form and electronic materials (by email attachment or CD) to Esperanza Calderon at ecalderon@apshealthcare.com no later than **July 9, 2009**.

Send the few documents available only in hard copy or any documents on CD to APS Healthcare, Attn. Esperanza Calderon, 560 J St., Ste. 390, Sacramento, CA 95814. Questions can also be addressed to Ms. Calderon either at the above email address or at 916.266.2579. Please note that some organizations have policies regarding the size of emails and attachments and may "block" some emails. You may need to "zip" the attachments or send the attachments with more than one email. Upon receipt of your documents, Ms. Calderon will contact you to confirm receipt. If you do not hear back from our office about receipt of documents, please contact us. If you have difficulties sending the electronic copies, please call for assistance to discuss alternate modes of electronic submission rather than resorting to paper copies.

We thank you in advance for your help with this, and we look forward to collaborating with you on this important project.

Sheila G. Baler, Ph.D., M.P.H.
Executive Director, CAEQRO
APS Healthcare

o 916.266.2571 m 916.704.2270
www.apshealthcare.com
www.caeqro.com

cc Janette Lopez, Chief Deputy Director
Shelley Rouillard, Deputy Director, Benefits and Quality Monitoring Division
Ruth Jacobs, Assistant Deputy Director, Benefits and Quality Monitoring Division
Sarah Swaney, Benefits and Quality Monitoring Division

Health Plan Name:

Subcontractor Name(s) if applicable:

Preparer's Name and Title:

E-mail:

Phone #:

Data Request to Health Plans - Instruction Sheet

General Instructions: There are six worksheets in this document. Please summarize your data for the benefit year (BY) July 1, 2007 through June 30, 2008. Enter your report data in the space provided in this spreadsheet. If you do not have data for a specific cell, enter "Unk" or "Unknown" (also see below re: worksheet 7, "Your Methodology"). If you attach other documents, please label the documents according to the spreadsheet number and name and label all tables clearly according to the item of the spreadsheet (e.g. "Worksheet 3. No. of Members Referred for Outpatient MH Services").

Do not send any identifiable Patient Health Information (PHI).

Please complete the header information for each worksheet (Health Plan Name, etc.)

At this time, DO NOT COMPLETE Worksheet 1. This worksheet covers HFP Enrollment and Demographics. We will receive this information from another source.

Worksheets 2-5 cover services for mental health (MH) and substance abuse (SA). The worksheets are titled

- 2 MH Inpt
- 3 MH Outpt
- 4 SA Inpt
- 5 SA Outpt

Worksheet 6 covers pharmacy for mental health diagnoses, and you are asked to identify psychoactive medications used to treat members with psychiatric diagnoses. These medications may include, for example, CNS stimulants; anti-depressants; antipsychotics; atypical antipsychotics; misc. antipsychotic agents; phenoiazine antipsychotics; anxiolytics, sedatives and hypnotics; anticonvulsants (those typically used for psychiatric diagnoses).

Note: the services covered in these worksheets are for basic benefit services only--not those provided for children already determined to be SED for those SED conditions (i.e. those services provided by the county mental health agency).

When asked to identify members by MH or SA diagnoses, use the primary MH or SA diagnosis (i.e. first Axis I diagnosis). For emergency room visits when the primary diagnosis is MH or SA, report them in the MH or SA Outpatient worksheets.

In Worksheet 7, "Your Methodology", please briefly explain your methodology in the following areas: 1) Diagnostic system (ICD-9, DSM-IV, or other) used; 2) what type of services data you reported; 3) your method for reporting pharmacy data if different than instructions; 4) Other data limitations in your information system; and 5) Any other variance from the instructions in your reporting. You may state "refer to Methodology" for any items that cannot be completed in the worksheets.

Using the spreadsheet for your responses is preferred. If you submit separate documents or reports, please label them according to the worksheet number. Please provide the completed electronic form and electronic materials (by email attachment or CD) to Mike Reiter. The usual plan contact, Esperanza Calderon, will be on vacation from August 13-September 4. If you have questions during this time please contact Mr. Reiter by email or phone, at mreiter@apshealthcare.com, (916) 266-2572. If you have questions before August 13, Ms. Calderon can be reached at (916) 266-2579 or ecalderon@apshealthcare.com.

Mail correspondence can be sent to:

APS Healthcare
Mike Reiter
560 J. St., Ste, 390
Sacramento, CA 95814

Please respond to our survey request by August 31, 2009

STOP!
Do not complete.
We will receive data from another source.

Health Plan Name:
Preparer's Name and Title:
E-mail:
Phone #:

HFP Enrollment and Demographics	
Data for 2007-2008 Benefit Year (July 1, 2007 - June 30, 2008)	
Monthly Average	
Item #	Total no. of plan HFP members
I	TOTAL
II	AGE GROUP
A	0-5
B	6-12
C	13-15
D	16-18
III	GENDER
A	Female
B	Male
IV	ETHNICITY OF CHILD
A	Alaska Native
B	Amerasian
C	Asian Indian
D	Black/African American
E	Cambodian
F	Chinese
G	Filipino
H	Guamanian
I	Hawaiian
J	Hispanic/Latino
K	Japanese
L	Korean
M	Laotian
N	Native American Indian
O	Samoan
P	Vietnamese
Q	White

Do not complete this page.

R S T V A B C D E F G H I J K L M N O	Other Asian	
	Other	
	Unknown	
	PRIMARY SPOKEN LANGUAGE OF PARENT/GUARDIAN	
	English	
	Spanish	
	Chinese	
	Vietnamese	
	Korean	
	Russian	
	Cantonese	
	Farsi	
	Tagalog	
	Armenian	
	Mandarin	
	Arabic	
Hmong		
Not Given		
Other		

*****END OF REQUEST - 1 HFP Enrollment*****

STOP!
Do not complete.
We will receive data from another source.

Health Plan Name:

Behavioral Health Subcontractor Name(s) if applicable:

Preparer's Name and Title:

E-mail:

Phone #:

<p style="text-align: center;">Mental Health - Psychiatric Inpatient Services (Admitted to freestanding psychiatric hospital or psychiatric unit in a general acute care hospital) Data for 2007-2008 Benefit Year (BY) (July 1, 2007 - June 30, 2008)</p>											
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K
	No. of <i>un-duplicated</i> members who were admitted for MH inpatient in BY (first day of admit was in BY)	No. of total days of <i>all</i> members' MH inpatient admissions (first day admit in BY)	No. of un-duplicated members who had inpatient MH length of stay longer than 30 days for any admission in BY	No. of un-duplicated members who were hospitalized <u>and</u> have a co-occurring disorder (both mental health and substance abuse diagnoses)	No. of un-duplicated members who had: <i>only</i> 1 MH inpatient admission during the BY	No. of un-duplicated members who had: 2-4 MH inpatient admissions during the BY	No. of un-duplicated members who had: 5 or more MH inpatient admissions during BY	Of members having had at least one inpatient admission during BY (Column A), total number of members receiving subsequent MH outpatient care <i>during the BY</i>	For members in Column H, total number of days from hospital discharge to first outpatient visit <i>in the BY</i>	For members in Column H, what was the shortest delay (in number of days) between hospital discharge and first outpatient visit?	For members in Column H, what was the longest delay (in number of days) between hospital discharge and first outpatient visit?
Item #											
I	TOTAL										

II	AGE GROUP (Age at first admission in BY)											
A	0-5											
B	6-12											
C	13-15											
D	16-19											
III	GENDER											
A	Female											
B	Male											
IV	DIAGNOSTIC CATEGORY											
A	ADHD diagnosis (i.e. ADHD and ADHD Not Otherwise Specified) or other Conduct/ Oppositional Diagnosis											
B	Depressive disorders (excluding bipolar depressive disorders)											
C	Bipolar disorders											

D	Anxiety Disorder diagnosis (such as Panic, Phobia, Stress, Compulsive, & Anxiety Disorders)											
E	Psychotic Disorder diagnosis (such as Schizophrenia, Schizophreniform, Delusional, other Psychotic disorders)											
V	ETHNICITY OF CHILD											
A	Alaska Native											
B	Amerasian											
C	Asian Indian											
D	Black/African American											
E	Cambodian											
F	Chinese											
G	Filipino											
H	Guamanian											
I	Hawaiian											
J	Hispanic/Latino											
K	Japanese											

L	Korean											
M	Laotian											
N	Native American Indian											
O	Samoan											
P	Vietnamese											
Q	White											
R	Other Asian											
S	Other											
T	Unknown											
VI	PRIMARY SPOKEN LANGUAGE OF PARENT/GUARDIAN											
A	English											
B	Spanish											
C	Chinese											
D	Vietnamese											
E	Korean											
F	Russian											
G	Cantonese											
H	Farsi											
I	Tagalog											
J	Armenian											
K	Mandarin											
L	Arabic											
M	Hmong											
N	Not Given											
O	Other											
*****END OF REQUEST - 2 MH Inpatient*****												

Health Plan Name:

Behavioral Health Subcontractor Name(s) if applicable:

Preparer's Name and Title:

E-mail:

Phone #:

Mental Health - Outpatient Psychiatric or MH Services Data for 2007-2008 Benefit Year (BY) (July 1, 2007 - June 30, 2008)										
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J
	No. of <i>un-duplicated</i> members referred for outpatient MH services in BY	No. of un-duplicated members who received outpatient MH services	Total no. of visits for outpatient services for MH during BY	Number of un-duplicated members who received outpatient MH services <u>and</u> have a co-occurring disorder (both mental health and substance abuse diagnoses)	No. of un-duplicated members who had <i>only</i> 1 MH outpatient service during the BY	No. of un-duplicated members who received 2-4 MH outpatient services during the BY	No. of un-duplicated members who received 5 or more MH outpatient services during BY	No. of un-duplicated members who received more than 20 MH outpatient services in BY	For members in Column B, average no. of days from referral during BY to appointment for outpatient MH service during BY	Total number of outpatient visits involving family in BY (e.g. CPT codes 90846, 90847, or 90887 or other coding to indicate family or collateral session)
Item #										
I	TOTAL									

II	AGE GROUP (Age at first outpatient visit in BY)										
A	0-5										
B	6-12										
C	13-15										
D	16-19										
III	GENDER										
A	Female										
B	Male										
IV	DIAGNOSTIC CATEGORY										
A	ADHD diagnosis (i.e. ADHD and ADHD Not Otherwise Specified) or other Conduct/ Oppositional Diagnosis										
B	Depressive disorders (excluding bipolar depressive disorders)										
C	Bipolar disorders										
D	Anxiety Disorder diagnosis (such as Panic, Phobia, Stress, Compulsive, & Anxiety Disorders)										
E	Psychotic Disorder diagnosis (such as Schizophrenia, Schizophreniform, Delusional, other Psychotic disorders)										

V	ETHNICITY OF CHILD										
A	Alaska Native										
B	Amerasian										
C	Asian Indian										
D	Black/African American										
E	Cambodian										
F	Chinese										
G	Filipino										
H	Guamanian										
I	Hawaiian										
J	Hispanic/Latino										
K	Japanese										
L	Korean										
M	Laotian										
N	Native American Indian										
O	Samoan										
P	Vietnamese										
Q	White										
R	Other Asian										
S	Other										
T	Unknown										
VI	PRIMARY SPOKEN LANGUAGE OF PARENT/GUARDIAN										
A	English										
B	Spanish										
C	Chinese										
D	Vietnamese										
E	Korean										
F	Russian										
G	Cantonese										
H	Farsi										
I	Tagalog										

J	Armenian									
K	Mandarin									
L	Arabic									
M	Hmong									
N	Not Given									
O	Other									

*****END OF REQUEST - 3 MH Outpatient*****

Health Plan Name:

Subcontractor Name(s) if applicable:

Preparer's Name and Title:

E-mail:

Phone #:

Substance Abuse Services - Inpatient Services
(Admitted to a hospital for treatment of a primary diagnosis of substance abuse)
Data for 2007-2008 Benefit Year (BY) (July 1, 2007 - June 30, 2008)

	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K
	No. of <i>un-duplicated</i> members who were admitted for a primary SA diagnosis in BY	No. of total days of <i>all</i> members' SA inpatient admissions (first day admit in BY)	No. of un-duplicated members who had inpatient SA length of stay longer than 30 days for any admission in BY (first day admit in BY)	No. of un-duplicated members who were hospitalized and have a co-occurring disorder (both mental health and substance abuse diagnoses)	No. of un-duplicated members who had: only 1 SA inpatient admission during the BY	No. of un-duplicated members who had: 2-4 SA inpatient admissions during the BY	No. of un-duplicated members who had: 5 or more SA inpatient admissions during BY	Of members having had at least one inpatient admission during BY (Column A), total number of members receiving subsequent SA outpatient care during the BY	For members in Column H, total number of days from hospital discharge to first outpatient visit <i>in the BY</i>	For data in Column H, what was the shortest delay (in no. of days) between hospital discharge and first outpatient visit?	For data in Column H, what was the longest delay (in no. of days) between hospital discharge and first outpatient visit?
Item # I	TOTAL										

II	AGE GROUP (Age at first admission in BY)											
A	0-5											
B	6-12											
C	13-15											
D	16-19											
III	GENDER											
A	Female											
B	Male											
IV	ETHNICITY OF CHILD											
A	Alaska Native											
B	Amerasian											
C	Asian Indian											
D	Black/African American											
E	Cambodian											
F	Chinese											
G	Filipino											
H	Guamanian											
I	Hawaiian											
J	Hispanic/Latino											
K	Japanese											
L	Korean											
M	Laotian											
N	Native American Indian											
O	Samoan											
P	Vietnamese											
Q	White											
R	Other Asian											

S	Other											
T	Unknown											
V	PRIMARY SPOKEN LANGUAGE OF PARENT/GUARDIAN											
A	English											
B	Spanish											
C	Chinese											
D	Vietnamese											
E	Korean											
F	Russian											
G	Cantonese											
H	Farsi											
I	Tagalog											
J	Armenian											
K	Mandarin											
L	Arabic											
M	Hmong											
N	Not Given											
O	Other											

*****END OF REQUEST - 4 SA Inpatient*****

Health Plan Name:

Subcontractor Name(s) if applicable:

Preparer's Name and Title:

E-mail:

Phone #:

Substance Abuse Services - Outpatient Services Data for 2007-2008 Benefit Year (BY)										
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J
	No. of <i>un-duplicated</i> members referred for outpatient SA services	No. of un-duplicated members who received outpatient SA services	Total no. of visits members received outpatient services for SA	No. of members who received outpatient services <u>and</u> have a co-occurring disorder (both mental health and substance abuse diagnoses)	No. of un-duplicated members who had: only 1 SA outpatient service during the BY	No. of un-duplicated members who had: 2-4 SA outpatient services during the BY	No. of un-duplicated members who had: 5 or more SA outpatient services during BY	No. of un-duplicated members who had: More than 20 SA outpatient services in BY	Average no. of days from referral to appointment for outpatient SA service	Total number of outpatient visits involving family (e.g. CPT codes 90846, 90847, or 90887 or other coding to indicate family or collateral session)
Item # 1	TOTAL									

II	AGE GROUP (Age at first outpatient visit in BY)										
A	0-5										
B	6-12										
C	13-15										
D	16-19										
III	GENDER										
A	Female										
B	Male										
IV	ETHNICITY OF CHILD										
A	Alaska Native										
B	Amerasian										
C	Asian Indian										
D	Black/African American										
E	Cambodian										
F	Chinese										
G	Filipino										
H	Guamanian										
I	Hawaiian										
J	Hispanic/Latino										
K	Japanese										
L	Korean										
M	Laotian										
N	Native American Indian										
O	Samoaan										
P	Vietnamese										
Q	White										
R	Other Asian										

S	Other										
T	Unknown										
V	PRIMARY SPOKEN LANGUAGE OF PARENT/GUARDIAN										
A	English										
B	Spanish										
C	Chinese										
D	Vietnamese										
E	Korean										
F	Russian										
G	Cantonese										
H	Farsi										
I	Tagalog										
J	Armenian										
K	Mandarin										
L	Arabic										
M	Hmong										
N	Not Given										
O	Other										

*****END OF REQUEST - 5 SA Outpatient*****

Health Plan Name:

Subcontractor Name(s) if applicable:

Preparer's Name and Title:

E-mail:

Phone #:

**Pharmacy Data for MH Diagnoses
Data for 2007-2008 Benefit Year (BY)**

**Number of *unduplicated* members with a psychiatric diagnosis
and prescribed psychoactive medications (see General
Instructions).**

Item #

	AGE GROUP (Age at first prescription in BY)
I	0-5
II	6-12
A	13-15
B	16-19
III	GENDER
A	Female
B	Male
IV	ETHNICITY OF CHILD
A	Alaska Native
B	Amerasian
C	Asian Indian
D	Black/African American
E	Cambodian
F	Chinese
G	Filipino
H	Guamanian
I	Hawaiian
J	Hispanic/Latino
K	Japanese
L	Korean
M	Laotian
N	Native American Indian
O	Samoan
P	Vietnamese
Q	White
R	Other Asian
S	Other

T	Unknown
V	PRIMARY SPOKEN LANGUAGE OF PARENT/GUARDIAN
A	English
B	Spanish
C	Chinese
D	Vietnamese
E	Korean
F	Russian
G	Cantonese
H	Farsi
I	Tagalog
J	Armenian
K	Mandarin
L	Arabic
M	Hmong
N	Not Given
O	Other

VI	5 most common DSM IV diagnoses for HFP members (i.e. sort by primary MH diagnosis and report the top five most used diagnoses) in BY
A	1.
B	2.
C	3.
D	4.
E	5.

VII	Suggested methodology for VII - XII: Sort by MH diagnoses within category and then by psychoactive medication , and report the top 5 counted psychoactive medications for that category, in BY.
A	Top 5 prescriptions (medication name) related to ADHD diagnosis (i.e. ADHD and ADHD Not Otherwise Specified)
B	1.
C	2.
D	3.
E	4.
VIII	Top 5 prescriptions (medication name) related to any Depressive disorder diagnosis (excluding depressive cycle of bipolar disorder)

A	1.
B	2.
C	3.
D	4.
E	5.
IX	
Top 5 prescriptions (medication name) related to any Bipolar disorder diagnosis	
A	1.
B	2.
C	3.
D	4.
E	5.
X	
Top 5 prescriptions (medication name) related to any Anxiety Disorder diagnosis (such as Panic, Phobia, Stress, Compulsive, & Anxiety Disorders)	
A	1.
B	2.
C	3.
D	4.
E	5.
XI	
Top 5 prescriptions (medication name) related to any Psychotic Disorder diagnosis (such as Schizophrenia, Schizophreniform, Delusional, other Psychotic disorders)	
A	1.
B	2.
C	3.
D	4.
E	5.
XII	
Top 5 prescriptions (medication name) related to any other diagnosis not covered above (no need to list diagnoses)	
A	1.
B	2.
C	3.
D	4.
E	5.

*****END OF REQUEST - 6 Pharmacy*****

Health Plan Name:

Subcontractor Name(s) if applicable:

Preparer's Name and Title:

E-mail:

Phone #:

Methodology
1. Diagnoses Describe your methodology for identifying mental health and substance abuse diagnoses (e.g. ICD-9, DSM-IV-TR, or other system).
2. Service Data Describe what service data you reported (e.g. claims data, encounter data, authorized services, referred services, or other type).
3. Pharmacy (spreadsheet #6) If your methods for pulling medication data were different than those in the instructions, explain your methodology.
4. Other Data Limitations Please share any limitations of your information system in reporting these data, such as 1) limitations in database software or reporting tools; 2) inability to merge data from separate databases; 3) lack of specific types of service data; 4) technical staffing limitations, or other limitations.
5. Use this space to explain any other variations from the instructions or categories provided.

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KEY INFORMANT INTERVIEW SITES

	Health Plan	Mental health services provided by:	Date of Interview
1	Health Net	Contracted providers of MHN, a managed care company	02/28/10
2	CalOptima	Contracted behavioral health providers of regional independent practice associations	02/10/10
3	Health Plan of San Joaquin	Contracted providers and county staff of San Joaquin and Stanislaus behavioral health departments	02/17/10
4	San Francisco Health Plan	County behavioral health staff and contracted providers	03/11/10
5	Kaiser Foundation Health Plan	Staff model for all specialty services	03/18/10
6	Anthem Blue Cross	Contracted providers of WellPoint Behavioral Health, a managed care company	04/15/10

KEY INFORMANT INTERVIEW GUIDE

San José State University
Human Subjects – Institutional Review Board

“Evaluation of Mental Health (MH) and Substance Abuse (SA) Services Provided to Subscribers
Enrolled in the Healthy Families Program”

Key Informant Interview Domains

Methodology

Not all of these questions may be required for each health plan (nor would there likely be time to cover all these areas for each interview). We plan to assess the strengths and challenges of plans based on their documents they submitted and focus each interview on those priority areas.

- I. Contracts with Providers and Subcontracts with behavioral health care companies or county mental health departments
 - A. Describe the contracting process for MH/SA providers
 1. Are providers ever screened out of the network? If yes, what criteria or reasons are used that result in a provider being screened out?
 2. Nature and extensiveness of MH/SA providers in network. What criteria are used to credential or contract with MH/SA providers and facilities?
 3. What gaps do you have in provider network regarding expertise with special populations, ethnic groups, and problem areas?
 4. To what extent do you contract with county providers?
 5. What success in contracting have you experienced-what works well?
 6. What are the biggest challenges in contracting with these providers?
 - B. If the HP contracts with contracted behavioral health companies:
 1. Impact of sub-contracted MH/SA services overall
 - a) What success in contracting have you experienced - what works well?
 - b) What are the biggest challenges in contracting with these providers?
 2. How do you monitor your behavioral health company subcontract? (Routine reports, identification of issues, timely communication, etc) What quality indicators are used to determine effectiveness of subcontract?
 3. How satisfied are you with your work with the subcontracted company?
 4. What should be improved in their ability to respond to special populations, ethnic groups, and types of problems?
 5. For representatives of the contracted behavioral health company, as available, these additional questions would be addressed in addition to others listed:
 - a) What has been your company’s experience with the HFP plan and beneficiaries, compared to your other lines of business?

- b) What aspects of your administrative, data and clinical programs seem to fit well with HFP? What aspects do not fit so well? What changes/improvements would you like to see?
- c) If a beneficiary calls your Member Services number, how readily available is information about HFP benefits for MH/SA care? Do you have any data on how many calls are received about HFP?

II. Authorization and utilization management

- A. Describe the process the HP uses to authorize care
 - 1. Types of services requiring authorization vs. those not requiring authorization
 - 2. Staffing levels used to approve or authorize services
 - 3. Extent to which disputes with providers occur about approval process, and how they are generally resolved
 - 4. Summarize the system you use to monitor utilization of both MH and SA services, e.g. management reports, UM meetings or committee

III. Outreach and education to community

- A. What are the HP's strengths and challenges in access to MH/SA services for the communities served?
- B. (For local plans) What are the specific populations in your service area that are underserved? (For statewide plan representatives, if available) How do you assess and monitor which populations are underserved in local communities served by your plan?
- C. HFP MH/SA services rates are low for most plans compared to expected rates. What are your strategies for conducting outreach and education to underserved communities and increasing MH/SA services utilization?
- D. What are your recommendations for increasing access to MH/SA services for these populations?

IV. Monitoring quality of care in a multi-cultural context

- A. How does the HP monitor the ability of providers to provide culturally competent care?
- B. How does the HP monitor HFP members' satisfaction of MH/SA services they have received?
- C. Does the HP require cultural competence training of MH/SA providers? Is in-house training provided, or is it contracted out? If contracted, how is the training verified? What other types of training would be helpful?
- D. What strengths and challenges are there with your provider network in providing culturally competent care?

V. Coordination of Care

- A. Describe how your primary care and specialty medical providers screen HFP patients for potential MH/SA problems. Please identify the specific screening tools used. Identify strengths, challenges and needs in this area, such as a need for more primary care training, better screening tools, screening children at younger ages, etc.
- B. What is your appraisal of the plan's MH/SA providers' ability to catch, document and triage potential physical health problems for those in treatment?
- C. What is your assessment of the communication process between primary care and MH/SA providers? (Scale of 1-10?) How might this be improved?
- D. Describe the coordination between MH/SA service providers. What are your plan's strengths and challenges in this area? What are your recommendations for making improvements?
- E. Are there system barriers beyond the HPs control that are problematic?



APPENDIX 8

**FOCUS GROUP INTERVIEW PARTICIPANT
SAMPLING REPORT**

County – Health Plan	Number of Letters Sent to Members	Number of Member Responses	Language Preference		Members Attending Focus Groups	Members Participating in Phone Call Interviews	TOTALS
Los Angeles – Health Net	206	5	Spanish Engl./Span.	4 1	4 3 parents 1 youth*	2	6
Orange – CalOptima	310	11	Spanish English Engl./Viet. Vietnamese	6 3 1 1	6 5 parents 1 youth*	3	9
San Joaquin – Health Plan of San Joaquin	211	6	Spanish English	4 2	3 3 parents 0 youth	3	6
Riverside – Anthem Blue Cross	59	3	Spanish English	2 1	No focus group	3	3
TOTALS	786	25	Spanish English Vietnamese Engl./Span. Engl./Viet.	16 6 1 1 1	13	11	24

* Youth participating in the focus group did not send in a separate member response form. They attended with a parent who sent in a member response form.

Note: Santa Clara County was an additional focus group site. Originally Kaiser was asked to host a focus group in this county, but they declined. Santa Clara Family Health Plan also declined to participate.

Note: Spanish-speaking interpreters attended all focus groups. A Vietnamese-speaking interpreter also attended the CalOptima focus group.



APPENDIX 9

FOCUS GROUP INTERVIEW GUIDE

San José State University
Human Subjects – Institutional Review Board

“Evaluation of Mental Health and Substance Abuse Services Provided to Subscribers Enrolled in the Healthy Families Program”

Focus Group Interview Domains

Purpose

This document will outline the general topic areas for the focus groups with Healthy Families beneficiaries. These focus groups will be conducted using open-ended questions to allow for maximum participation. The order and exact language of the questions will be determined by the focus group leaders and participants.

A. Nature and types of services received

1. How was it determined that the child needed help - who suggested? Was the problem identified first by the provider? Was advice/help asked of anyone else? Was a teacher involved? etc.
2. Tell us about the services you or your child received for your child’s emotional or behavior issues
3. Tell us about the provider (psychiatrist, MFCC, psychologist, social worker)
4. Were they able to explain treatment, behavior and other topics in a way that helped you understand?
5. Did you have trust and confidence in the provider that they could help you and that they were interested in helping you /or your child?

B. Perceived quality of services

1. Did you think the services you received were of high quality?
2. What, if anything, would you like to see improved?
3. Did you feel that the providers at your health plan understood your needs and concerns?
4. Did you feel that the providers at your health plan understood your family, your background, culture, and your values?

C. Timeliness of services/Timeliness of scheduling an appointment

1. After you contacted your health plan get help, how long did it take to actually see a provider?
2. Were you satisfied with the amount of time it took to see a provider?

D. Barriers to services

1. What were some of the reasons that make it difficult for you to go to a mental health provider?
2. Were there any barriers to you getting help for your child?

3. What do most people in your family and your community think about getting help for emotional problems?
 4. Do you feel any differently now about that compared to before you started getting help?
 5. How easy or difficult was it to find out about Healthy Families benefits and services?
 6. Do you feel that the Healthy Families/Health Plan provides enough information about the services that allows people to know about mental health and substance abuse services?
- E. Suggestions for Healthy Families
1. What would you recommend that the Healthy Families program should do to make it easier to get help?

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APPENDIX 10

**COMPREHENSIVE BEHAVIORAL CARE, INC.
POLICIES AND PROCEDURES—
CONTINUITY AND COORDINATION**

Comprehensive Behavioral Care, Inc Policies and Procedures

National

<i>Class:</i>	UM, QI, MS	<i>Issue Date:</i> 2/27/96
<i>Number:</i>	07.50.00	<i>Review Date:</i> 6/99,7/00, 7/01, 7/29/04, 07/29/05, 8/8/06,
<i>Department:</i>	Care Management Services, National Service Center	073107, 8/29/08
<i>Title:</i>	Continuity and Coordination - Between Behavioral Health- Other Behavioral Health Care Practitioners and Medical Care Practitioners/Providers	<i>Revise Date:</i> 4/97, 7/98 7/24/02, 12/15/2003, 07/29/05; 6/21/06; 8/28/06, 11/3/06
		<i>Page:</i> 156 of 162

Purpose: To outline the process for collaboration with relevant behavioral and medical delivery systems or primary care physicians to monitor and improve coordination among behavioral health and medical practitioners providing a member care and services. CompCare recognizes that behavioral and medical disorders can interact to affect an individual's health.

Policy: CompCare written policies, procedures and monitoring activities are in place to ensure the timely, effective and confidential exchange of patient information among the behavioral health care practitioners/providers and relevant medical practitioners or primary care physicians and/or other behavioral/medical delivery systems involved in a member's treatment.

Procedure:

1. CompCare collects data, at least annually, about the following opportunities for collaboration among participants in the member's behavioral and medical health care.
 - A. Exchange of information
 - I. Review of behavioral health practitioner treatment records to determine if behavioral health practitioners & PCP exchange information. (Random Record Reviews)
 - II. Assessment of communication between behavioral health and medical practitioners, including protection of privacy. (Random Record Reviews)
 - III. Review and assessment of communication between behavioral health practitioner and other behavioral health practitioners involved in the members care. (Random Record Reviews)
 - B. Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care
 - I. Data on the use of primary care guidelines for treating or making referrals for treatment of problems such as eating disorders, depression, postpartum depression, substance abuse or attention deficit disorder. (Available on the CompCare Web Site)
 - II. Results of HEDIS (Health Plan Employer Data and Information Set) antidepressant Medication Management measure (can also be used to monitor medication use) if available from medical health plan.
 - C. Appropriate uses of psychopharmacological medications
 - I. CompCare representation on, or structured input into, the MCO's (Managed Care Organization) pharmacy and therapeutics committee (or into the MCO's mechanism for decisions to approve use of psychopharmacological medications in individual situations) as allowed by the medical health plan.
 - II. When appropriate, Collaboration with an MCO or relevant medical delivery system in technology assessments to evaluate emerging psychopharmacological medications through the CompCare New Technology Committee. .
 - III. Analysis of pharmaceutical utilization data for appropriateness of the use of a psychopharmacological medication (when data is available from the medical health plan).
 - IV. Review of medical health plan formulary by CompCare Medical Directors with feedback to the medical plan.
 - D. Management of treatment access and follow-up for members with coexisting behavioral and medical disorders
 - I. Data on the frequency of behavioral health consultations for the organization's medical or surgical inpatients with secondary or tertiary mental health or substance abuse diagnoses
 - II. Pharmaceutical data (when available) on medication interactions to assess coordination of coexisting medical and behavioral problems

See Policy and Procedure Committee date and annual signature page for CompCare Regional, National and Board of Director revision and/or review and approval.

Comprehensive Behavioral Care, Inc Policies and Procedures

National

<i>Class:</i>	UM, QI, MS	<i>Issue Date:</i> 2/27/96
<i>Number:</i>	07.50.00	<i>Review Date:</i> 6/99,7/00, 7/01, 7/29/04, 07/29/05, 8/8/06,
<i>Department:</i>	Care Management Services, National Service Center	073107, 8/29/08
<i>Title:</i>	Continuity and Coordination - Between Behavioral Health- Other Behavioral Health Care Practitioners and Medical Care Practitioners/Providers	<i>Revise Date:</i> 4/97, 7/98 7/24/02, 12/15/2003, 07/29/05; 6/21/06; 8/28/06, 11/3/06
		<i>Page:</i> 157 of 162

- III. Standing procedures for UM review that includes assessment of co-morbidities as evidenced by Care Management (CM) Intake Form. Additionally, audits of CM documentation to ensure co-morbid identification and follow up with the medical health plan.
- E. Implementation of a primary or secondary preventive behavioral health program
 - Primary:
 - I. Educational programs to promote prevention of substance abuse
 - II. Parenting skill training
 - III. Nutritional and body image programs for adolescents
 - IV. Stress management programs
 - Secondary:
 - I. A program for ADHD (Attention-Deficit/Hyperactivity Disorder) screening for children in primary care settings
 - II. A program for screening for eating disorders in adolescent females in primary care setting
 - III. A program that provides behavioral health consultation for members hospitalized for targeted medical or surgical conditions that are known to be associated with behavioral complications or co-morbidities
 - IV. A program for conducting postpartum depression screening
2. CompCare will collaborate with partner Health Plans and primary care physicians to identify at least one opportunity to improve coordination of behavioral health care with general medical care. Local Quality Committees will coordinate with partner Health Plans to identify improvement opportunities. Selected opportunities will be presented for approval at Quality Committees and the Centralized Quality Advisory Council. Collaborative efforts will be documented and include:
 - I. Collaboration among CompCare, network practitioners, and the medical delivery system or primary care physicians
 - II. Quantitative and casual analysis of data to identify improvement opportunities
 - III. Identification and selection of at least one opportunity for improvement
3. CompCare will collaborate with its partner Health Plans or primary care physicians to take action to improve continuity and coordination of behavioral health care with general medical care. Local Quality Committees will coordinate with partner Health Plans to take actions on identified and selected improvement opportunities. Actions will be presented for approval at Quality Committees and the Centralized Quality Advisory Council.
4. CompCare requires that the providers share behavioral health information and coordinate care for all members receiving services, to the extent permitted by law and in accordance with the member's consent, when required. CompCare contractually requires every behavioral health provider contracted with CompCare, to ask and encourage members to sign a consent that permits release of substance abuse treatment.

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**CALOPTIMA—COMPREHENSIVE PREVENTIVE
SCREENING INITIATIVE**

Comprehensive Preventive Screening Initiative

Target Population: CalOptima Healthy Families Program members ages 2 to 17 years of age

Date of Service: Screening/s must be on or after January 1, 2010 and on or before June 30, 2010

Description: Providers will receive **\$100** for performing ALL of the following steps at the recommended annual well-care visit for each qualified CalOptima Healthy Families Program member.

STEP 1: SCREEN FOR DEVELOPMENTAL DELAY USING A STANDARDIZED DEVELOPMENTAL SCREENING TOOL

- Some examples of standardized developmental screening tools are the Parents' Evaluation of Developmental Status (PEDS), the Ages and Stages Questionnaire (ASQ), or the Denver Developmental Screening Test II (DDST-II).
- Hard copies of the PEDS materials will be sent to your office shortly for your convenience.

STEP 2: CALCULATE BMI PERCENTILE (Use the age-appropriate well-care form)

- In the "Nurse Intake" Section, add a note indicating the **date on which the BMI percentile was documented** and evidence of either of the following: **BMI percentile or BMI percentile plotted on age-growth chart.**
- Please see the document entitled "BMI for Children and Teens – Screening Reference Guide for Providers" for instructions on how to calculate BMI percentile. If plotting on age-growth chart, the chart must also be submitted.

STEP 3: COUNSEL FOR NUTRITION (Use the age-appropriate well-care form)

- In the "Assessment" and "Plan" Section, add a note indicating the **date** and **at least one of the following:**
 - Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
 - Checklist indicating nutrition was addressed
 - Counseling or referral for nutrition education
 - Member received educational materials on nutrition
 - Anticipatory guidance for nutrition

STEP 4: COUNSEL FOR PHYSICAL ACTIVITY (Use the age-appropriate well-care form)

- In the "Assessment" and "Plan" Section, add a note indicating the **date** and **at least one of the following:**
 - Discussion of current physical activity behaviors (e.g. exercise routine, participation in sports activities, exam for sports participation)
 - Checklist indicating physical activity was addressed
 - Counseling or referral for physical activity
 - Member received educational materials on physical activity
 - Anticipatory guidance for physical activity

STEP 5: MAIL/FAX THE FOLLOWING DOCUMENTS TO CALOPTIMA BY SEPTEMBER 30, 2010:

- 1) Member completed response form for a standardized developmental screening tool
- 2) Provider completed scoring/Interpretation form for a standardized developmental screening tool
- 3) Age-Appropriate Well-Care Form
- 4) Age-Growth Charts, if applicable

*If administering PEDS on-line, a hard copy of the PEDS tool is not required via mail/fax.

Mail Address: CalOptima, Medical Data Management
1120 West La Veta Ave., Orange, CA 92868

Attention: Quality Improvement Initiative

ALERT WELLNESS ASSESSMENT—YOUTH



Evaluation of Mental Health and Substance Abuse Services Provided by Health Plans in the Healthy Families Program

**Presented to MRMIB Board on
September 15, 2010**

**APS Healthcare, Inc and
San José State University**

Acknowledgements

- This study was funded by Mental Health Services Act funding
- The study team and MRMIB wish to thank:
 - The staff of health plans for their active participation
 - The parents and youth who participated in focus groups and phone calls for sharing their stories

Purpose and Scope of the Evaluation

Purpose:

Determine whether there are barriers to mental health (MH) and substance abuse (SA) services provided by the health plans and options for reducing those barriers

Note on Scope:

This evaluation's study period and completion of the final report occurred prior to the implementation of physical health/MH parity

Evaluation Phases

- Phase I covered SED services (UCSF study)
 - Emphasized the importance early mental and behavioral health screening
- Phases II and III covered plan-provided services (APS and SJSU study)
 - Emphasized barriers to MH and SA services

Background – Low Utilization of MH/SA Services

- MRMIB MH Services Utilization Report (2009)*
 - Average 3% utilization rate of plan-provided MH services
 - Below national averages for Medicaid, private, and uninsured access to MH services
- Kaiser and SF Health Plan have the highest utilization rates
- California's publicly-funded services have low MH utilization rates in general

*California Managed Risk Medical Insurance Board. (2009). *Mental Health Services Utilization in the Healthy Families Program, Fiscal Years 2004-05 through 2006-07.*

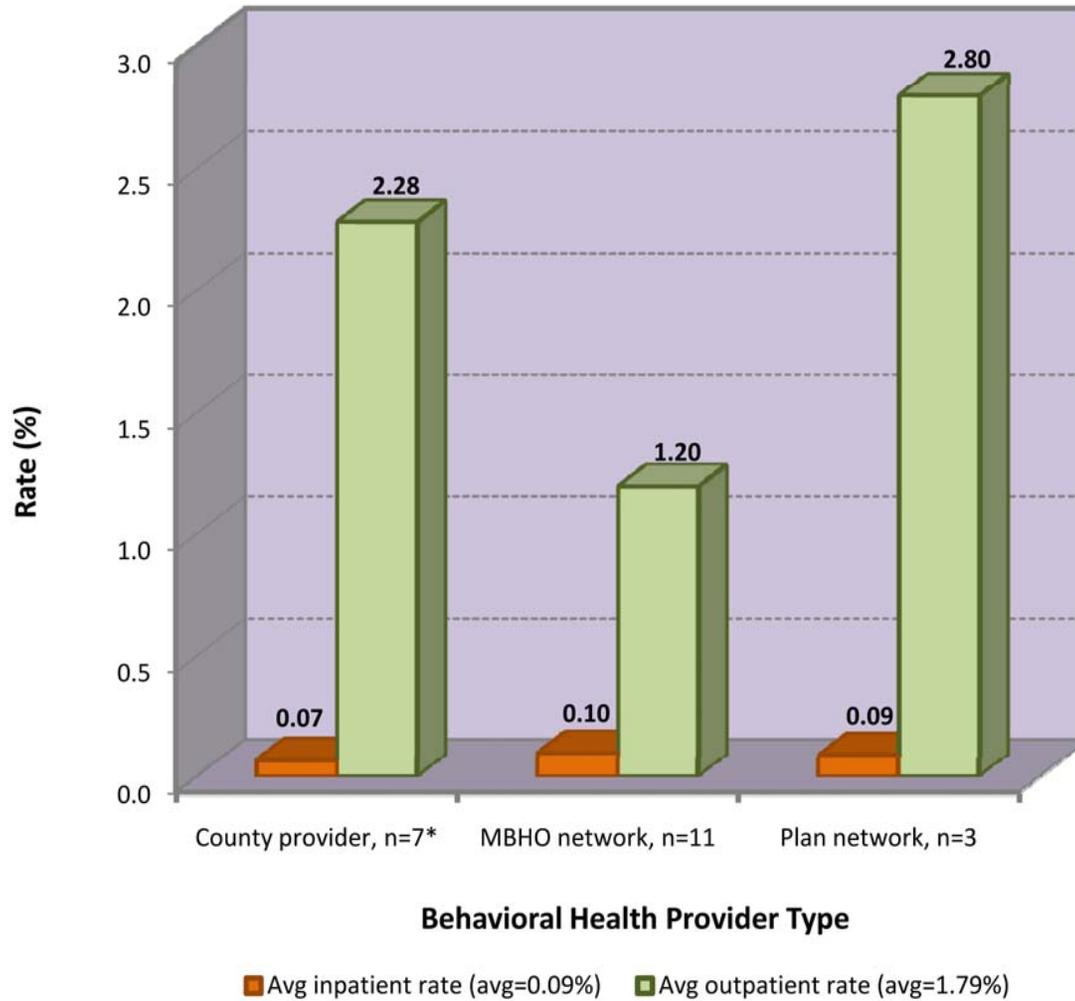
Methodology

- Document Review
- Data Request
- Key Informant Interviews
- Subscriber Focus Groups

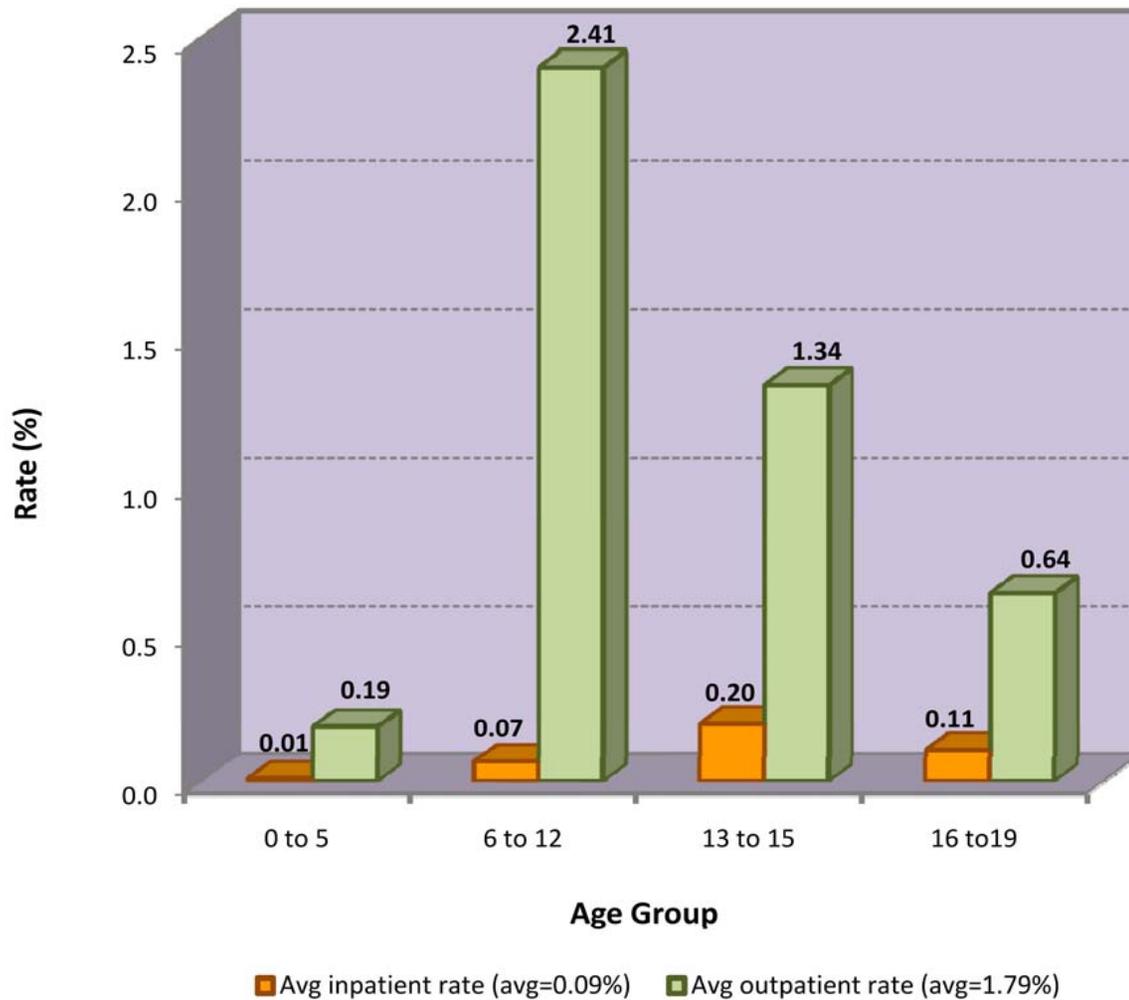
Key Findings: General MH/SA Service Utilization

- HFP outpatient service rates lower than the national average
 - Average HFP outpatient rate is 1.79%
- Outpatient rates lowest in 11 private MBHO plans
- There are difference in access by age groups
- There are differences in access among ethnic and linguistic groups

Key Findings: Service Use by Provider Network Type



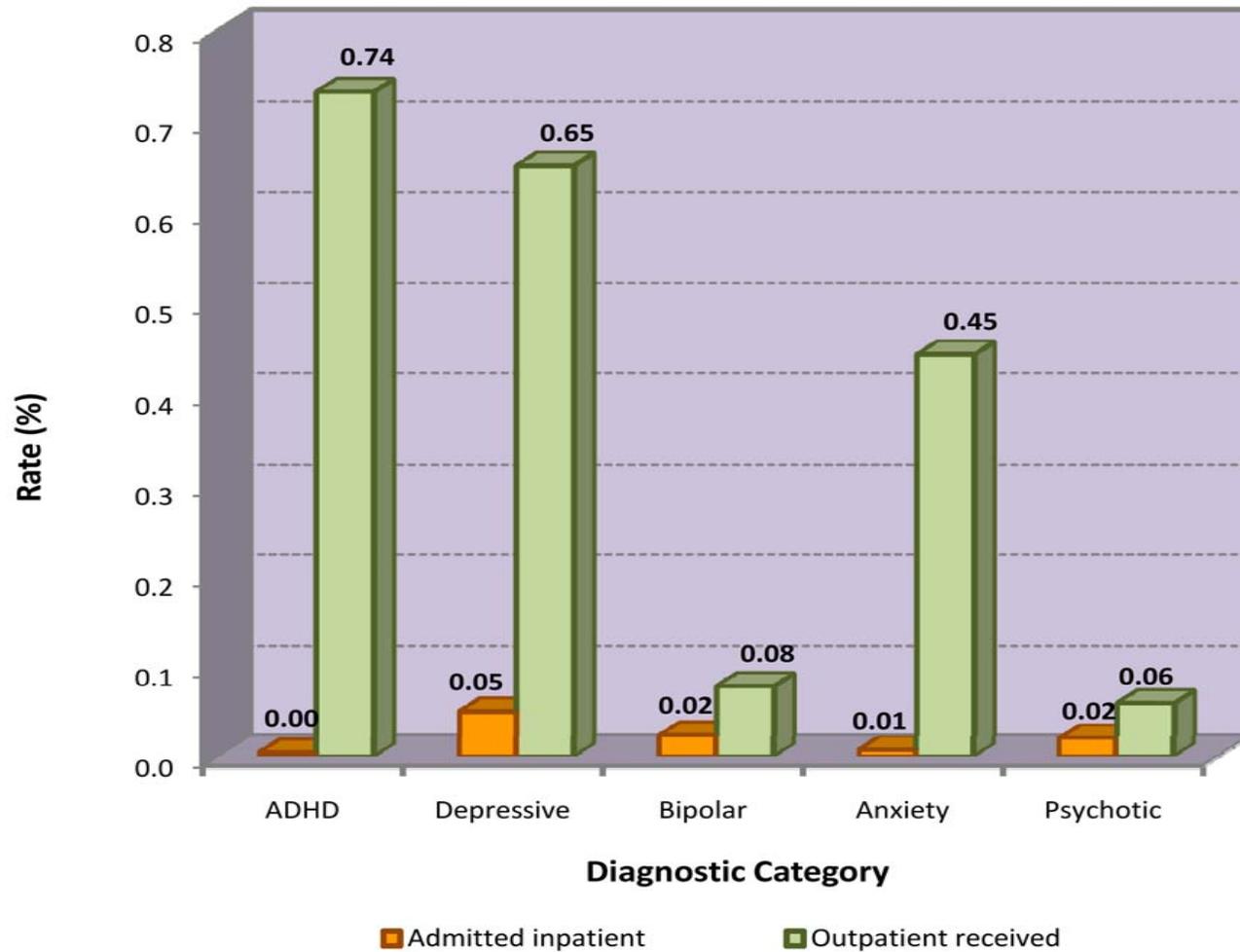
Key Findings: Service Use by Age Group



Key Findings: Substance Abuse Services

- Substance abuse utilization is low
 - Except Kaiser and CalOptima
 - 0.07% of HFP subscribers used outpatient SA services
- Possible factors:
 - Benefit structure
 - Provider capacity

Key Findings: MH Service Use by Diagnosis



Key Findings: Prescribed Medications

- Prescribing patterns very similar to general practice community
- Some medications used for purposes not supported by evidence, as in general psychiatric community

Major Findings: Coordination of Care – Primary Care Interface

- Primary care interface
 - Strongest in Kaiser
 - Weakest in MBHO plans (except Care 1st)
- Screening instruments reviewed
 - Pediatric Symptom Checklist (CalOptima) only one with validity and reliability testing
 - Promising practice: CalOptima pilot of procedures to increase screening compliance in primary care

Major Findings: Coordination of Care – Utilization Management

- Pre-authorization procedures
 - Health plan key informants viewed them as transparent and non-problematic
 - Parents with non- or limited-English or new to MH find them confusing
- No evidence of extension of benefits beyond plan maximum
 - Exception: Kaiser's substance abuse treatment

Major Findings: Behavioral Health Provider Networks

Type of Provider Network	Number of Plans
Managed Behavioral Health Organizations (MBHOs)	11
Delegated to county mental health departments	7
One medical group with mental health specialty	1 (Kaiser)
Local Independent Practice Associations (IPAs)	1 (CalOptima)
Local mental health practice group	1 (Community Health Group)

Major Findings: Provider Credentialing

- All plans have credentialing procedures for MH
- Only Kaiser provided substance abuse provider credentialing criteria (for addiction physicians)

Major Findings: Monitoring Quality

- Most plans do not mention HFP in QI policies & procedures
 - Exception: Community Health Group
- Only half of plans track time to first appointment
 - Health Plan of San Joaquin good example of follow up monitoring

Major Findings: Client Satisfaction

- Many good examples of monitoring satisfaction with interpreting services
- Very few MH/SA-related complaints & grievances
 - How to interpret this
 - Many plans can't differentiate MH/SA from general health complaints

Major Findings: Parents' Perspectives

- Importance of primary care as “gateway” to mental health services
- Cultural stigma and language barriers
- Administrative barriers to obtaining initial services
- Parents' recommendations
 - Outreach and education, especially in schools
 - Parent support

Overall, parents were very appreciative of HFP services.

Cultural and Linguistic Proficiency

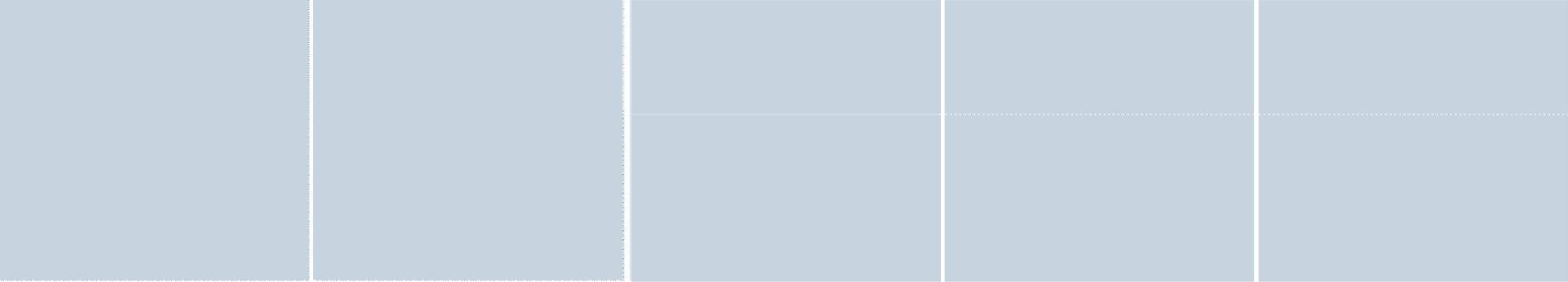
- MH providers who speak Spanish: 16%
- Good examples of interpreter “certification” and/or training (general to health services)
- All plans report using language lines
- Interpreting infrastructure seems adequate, but we don’t know rural families’ experience

Data Issues and Limitations

- Types of services data available
 - Claims vs. "paid claims" vs. encounters
- Multiple separate databases
 - Enrollment (demographic), services, pharmacy
- Inconsistencies in coding ethnicity
- Pharmacy coding and reporting
 - Brand vs. generic names
 - Drug classification
 - Doctors' orders vs. prescription claims

Recommendations

- Improve interface between primary care and MH
- Improve screening, access and treatment engagement
- Improve provision and documentation of SA services
- Improve the tracking of quality and outcome data
- Implement targeted outreach strategies
- Increase parent support and education



Project Study Team

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**APS Healthcare

California Institute for Mental Health

Date: September 15, 2010

To: Managed Risk Medical Insurance Board

From: Sandra Naylor Goodwin, PhD, MSW, President and CEO

The Managed Risk Medical Insurance Board is to be congratulated for initiating the study to evaluate mental health and substance abuse services of California's Healthy Families Program. The study report by APS Healthcare, Inc. and San Jose State University is informative and provides excellent recommendations.

We strongly support the recommendations to improve screening, assessment, treatment engagement and the development of stronger partnering between the health plans and the county specialty mental health systems. As we prepare for healthcare reform changes in 2014, the thoughtful bi-directional integration of services is critical. The California Institute for Mental Health (CIMH) has been working for the last year developing pilot partnerships between local primary care and specialty mental health with a focus on adults. In this process we, along with the pilot sites, are learning many lessons to improve the interface between primary care and specialty mental health. Simply making a referral is unlikely to result in the successful engagement of services. It is essential that the two services understand their mutual concerns and responsibility for the identified patient and family, and find ways to track and share data. The connection between physical needs and mental health needs is well-documented, and better health outcomes and cost containment cannot be achieved without bi-directional care.

CIMH has developed a report examining the business case for bi-directional integrated care. A two page summary is attached. The full report is available on our web site, www.cimh.org.

We urge you to look carefully at the recommendations of the APS/SJSU report. The lessons learned in our integration pilot projects support these recommendations.

The Business Case for Bidirectional Integrated Care: Mental Health and Substance Use Services in Primary Care Settings and Primary Care Services in Specialty Mental Health and Substance Use Settings

Problem Statement

- Depression is one of the top 10 conditions driving medical costs, ranking 7th in a national survey of employers. It is the greatest cause of productivity loss among workers.¹ People diagnosed with depression have nearly twice the annual health care costs of those without depression.² The cost burden to employers for workers with depression is estimated at \$6,000 per depressed worker per year.³
- 49% of Medicaid beneficiaries with disabilities have a psychiatric illness. 52% of those who have both Medicare and Medicaid have a psychiatric illness.⁴
- 11% of Californians in the fee for service Medi-Cal system have a serious mental illness. Healthcare spending for these individuals is 3.7 times greater than it is for all Medi-Cal fee-for-service enrollees—\$14,365 per person per year compared with \$3,914.⁵

Making the case still more compelling, a recent study has estimated that “if a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, \$5.4 million of healthcare savings could be achieved for each group of 100,000 insured members...the cost of doing nothing may exceed \$300 billion per year in the United States.”⁶

Without addressing the healthcare needs of persons with serious Mental Health/Substance Use (MH/SU) disorders and the MH/SU treatment needs of the whole population, it may be very difficult to achieve the three critical healthcare reform objectives articulated by the Institute for Healthcare Improvement’s Triple Aim:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of total healthcare⁷

Research has proven that prevention works, MH/SU treatment is effective, and people with MH/SU disorders can recover with effective care and supports.

Improve the health of the population

- People with type 2 diabetes have nearly double the risk of depression. Studies have shown depression in diabetic patients is associated with poor glycemic control, increased risk for complications, functional disability and overall higher healthcare costs. There are treatment protocols that can double the effectiveness of depression care resulting in improved physical functioning and decreased pain.⁸
- Care management focused on the health status of people with serious mental illnesses has been shown to significantly improve risk scores for cardiovascular disease.⁹
- Improving the health of those with SU conditions may well benefit the health of their family members—In the Kaiser Northern California system, family members of patients with SU disorders had greater healthcare costs and were more likely to be diagnosed with a number of medical conditions than family members of similar persons without a SU condition. In follow up studies, if the family member with a SU condition was abstinent at one year after treatment, the healthcare costs of family members went down to the level of the control group.¹⁰