Measuring Mental Health Disparities

A Roadmap & Recommendations for Implementation of the Mental Health Equity Act (AB 470, 2017)

California Pan-Ethnic Health Network

This Page Intentionally Left Blank

Table of Contents

Acknowledgements — 4

Introduction — 6

Methodology — 8

Data Collection — 9
Background — 9
Recommendations — 10

Data Reporting — 13
Background — 13
Recommendations — 13

Quality Measures — 16
Background — 16
Recommendations — 16
STRUCTURAL
Phase I — 19
Phase II — 20
PROCESS
Phase I — 21
Phase II — 22
OUTCOMES
Phase I — 23
Phase II — 23

Appendix A: Data Sources — 24

Appendix B: Definitions — 27

References — 28

ACKNOWLEDGEMENTS

We would like to express our sincere appreciation to the stakeholders who volunteered their time and expertise to this work. We would like to pay special thanks to:

- Assemblymember Dr. Joaquin Arambula, for his leadership in setting policies that highlight the importance of health equity and for authoring Assembly Bill (AB) 470;
- Dionne Maxwell, PhD, Department of Health Care Services (DHCS), for spearheading the implementation of AB 470;
- The California Health Care Foundation, for their participation and financial support of this work; and
- Health Management Associates (HMA) for their work coordinating and facilitating the Advisory Committee and their work developing this report.

Advisory Committee Members

Ignatius Bau, Healthcare Consultant

Lindsay Erickson, MSPH, Director, Value Based P4P Program, Integrated Healthcare Association

Len Finocchio, Consultant, Blue Sky Consulting

Sergio Aguilar-Gaxiola, MD, PhD, Director, UC Davis Center for Reducing Health Disparities

Margarita Pereyda, MD, Chief Medical Officer and Chief Medical Information Officer, LA County DHS-Correctional Health Services

Saumitra SenGupta, PhD, Executive Director, Behavioral Health Concepts - CalEQRO

Martha Shumway, PhD, UCSF, Associate Professor and Researcher, Department of Psychiatry

Catherine Teare, MPP, Associate Director, High-Value Care, California Healthcare Foundation

Key Informants

Debbie Innes-Gomberg, PhD, Deputy Director, LA Department of Mental Health

Clayton Chau, MD, Institute for Mental Health and Wellness St Joseph Hoag Health System, Regional Executive Medical Director

Hendry Ton, MD, MS, UC Davis, Interim Associate Vice Chancellor for Diversity & Inclusion

CPEHN Staff

Kiran Savage-Sangwan, MPA, Health Integration Policy Director, CPEHN

Cary Sanders, MPP, Director of Policy Analysis, CPEHN

HMA Staff

Jeffrey Ring, PhD, Los Angeles, CA

Helena Whitney, MSW, Phoenix, AZ

Katie Martino, MPH, CPH, Los Angeles, CA

About CPEHN

The California Pan-Ethnic Health Network (CPEHN) is a statewide multicultural health advocacy organization that works to ensure all Californians have access to quality health care and can live healthy lives. We gather the strength of communities of color to build a united and powerful voice for health equity. For more information, visit cpehn.org.

INTRODUCTION

We know that health care coverage and access alone do not guarantee a reduction of disparities or improve health outcomes. Quality of care and the cultural appropriateness of care are critical components of ensuring health equity. In California, where the majority of residents are from communities of color and over 200 different languages are spoken, culturally and linguistically appropriate services are particularly important. The importance of quality measurements that identify inequity in health outcomes and access to services is gaining recognition by healthcare providers and payers as a tool to reduce disparities and improve health outcomes in physical health. These types of quality measures are equally important in mental health services, where early intervention is known to be effective. Without these types of measures, the prevalence of inappropriate treatment or no treatment will remain, particularly for racial, ethnic, and linguistic minority populations, as well as other disenfranchised groups.

Overview of AB 470

California has been engaged in several efforts to improve data collection and public reporting of mental health utilization and outcomes. These included the Performance Outcomes System (POS) that is required by state law to report on children's mental health and a broader POS reporting also on adult mental health, which is required by Centers for Medicare and Medicaid Services (CMS). However, prior to the passage of Assembly Bill (AB) 470, California had no requirement in state law for consistent and standardized statewide reporting on disparities in access to or quality of Specialty Mental Health Services (SMHS). Because of misaligned standards in the current reporting system, the Department of Health Care Services (DHCS) and Mental Health Plans (MHPs) do not have consistent or reliable data to inform the development of meaningful quality improvement measures for disparity reduction efforts.

To address these issues, AB 470 "(statute)" was proposed in 2017 by Assemblymember Dr. Joaquin Arambula (D-Fresno) to mandate that DHCS update the performance and outcome reporting system on mental health outcomes and utilization for beneficiaries receiving SMHS in order to focus the POS on disparities. While the statute's reporting requirements include all beneficiaries, DHCS already reports much of the data for children (up to age 21). Therefore, the requirements primarily apply to services provided to adults. The statute requires the reporting system to include data collected by county-operated MHPs on utilization, timely access, language access, and quality.

Recognizing DHCS' limited resources and the need to avoid redundancy, the statute does not create a "new" system but instead builds upon the current performance outcomes reports for SMHS. By leveraging existing data collected by counties and the state, the statute aspires to develop a data system that can be the basis for providing quality, culturally informed, linguistically competent, and accessible SMHS for all eligible beneficiaries.

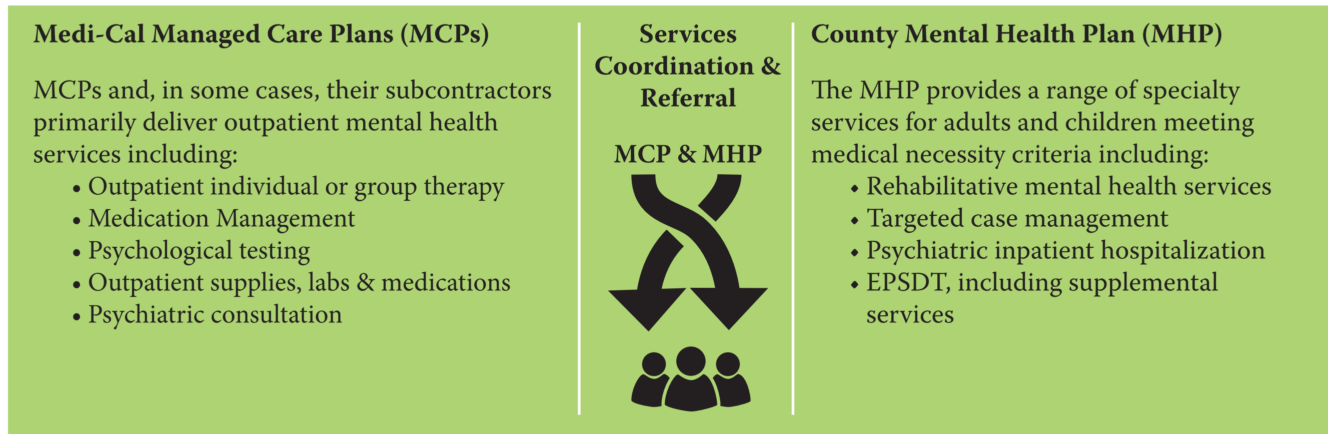
The statute requires stratification of data by age, sex, gender identity, race, ethnicity, primary language, sexual orientation, and any other data elements for which there is peer-reviewed evidence to assess performance outcomes related to mental health disparities. Additional stratification by these demographics will allow DHCS and MHPs to develop strategies to reduce mental health disparities.[i] Using existing data, stratified at the statewide and county levels, we can understand county performance and outcomes among minorities with regard to:

- Access to care (including timely access to services, waiting time to assessment, and waiting time to first appointment);

- Language capacity and language access;
- Quality; and
- Utilization and penetration.

Finally, the statute requires DHCS and stakeholders to add to the POS metrics that capture a similar scope of data regarding mental health services obtained through Medi-Cal managed care plans, beginning in 2019, and to develop recommendations for quality improvement and disparities reduction efforts based on the reported data.

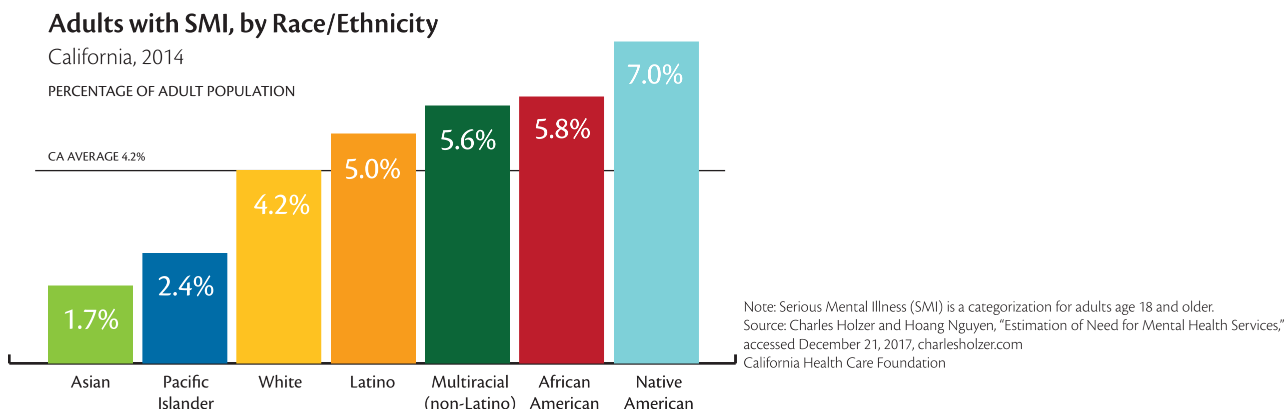
California's Public Mental Health System



California operates a "carve-out" system of services for mental healthcare for Medi-Cal beneficiaries. Adults with serious mental illness (SMI) and children are entitled to receive services from county-operated MHPs, which are authorized under a federal 1915(b) SMHS Consolidation waiver. These beneficiaries still receive all physical health care from their Medi-Cal managed care plan (or fee-for-service Medi-Cal, in limited cases). Medi-Cal managed care health plans are, as of 2014, responsible for providing outpatient mental health services to their members, including individual and group therapy, medication management, and psychiatric consultation.

Despite the major investments and tremendous progress made to provide the residents of California with coverage for mental health services and substance use disorders, significant barriers to accessing care remain, including gaps in coverage, workforce adequacy (lack of diversity and shortages), affordability, and systemic discriminatory practices.

Disparities in Mental Health Services



Note: Serious Mental Illness (SMI) is a categorization for adults age 18 and older.
Source: Charles Holzer and Hoang Nguyen, "Estimation of Need for Mental Health Services," accessed December 21, 2017, charlesholzer.com
California Health Care Foundation

Approximately 4% of adult Californians are diagnosed and living with SMI. However, Latino, African American, Native American, and multi-racial adults have rates of SMI above the state average.[ii] For Medi-Cal beneficiaries (and others) who meet the diagnostic and medical necessity criteria, county-operated MHPs are required to meet state and federal requirements and provide medically necessary, culturally competent care. MHPs must provide oral interpreter services in threshold languages at key points of contact, maintain a 24/7 toll-free access line in all languages spoken by beneficiaries, and provide timely access to services. Despite these requirements, Asian/Pacific Islander and Latino adults consistently have lower mental health penetration rates, or less access to specialty mental health services, than the state average.[iii]

It has become increasingly evident that consistent and reliable measurement of performance and outcomes in the delivery of mental health services and substance use disorder treatment is imperative if we want to address the stigmatization and discrimination these populations face. Additionally, without measures that provide performance and outcome data, the challenges of integrating physical and mental health will persist and the ability to create policies and interventions that address inequities in the mental health system will remain elusive.

METHODOLOGY

Reforming the California mental health delivery system's reporting and data collection infrastructure to improve the quality of care, uncover health disparities, and create equity in mental health requires input from a broad constituency. Accordingly, following the passage of the statute, CPEHN convened an Advisory Committee of behavioral health and health care experts to develop recommendations for the DHCS to consider during their stakeholder engagement process.

To ensure the recommendations are actionable, realistic, and meaningful, the Advisory Committee reviewed DHCS' existing data and quality measures, as well as metrics that highlight and/or measure disparities and are recommended by nationally recognized healthcare experts. These included the CMS Core Set of Behavioral Health Measures for Medicaid-Eligible Adults, data required for External Quality Review Organizations (EQRO) validation and compliance with network adequacy rules, the current Performance Outcomes Adult SMHS Report and the Medi-Cal Managed Care Dashboard.

Based on this analysis, the Advisory Committee identified data elements that the state performance and outcome reporting system on mental health should include to further the work of tracking mental health disparities and achieving health equity. These recommendations include both data points that can be reported on now, without changing the practices of counties or health plans, as well as a roadmap for the future.

In addition to a review of data, the Advisory Committee also considered information obtained through interviews with selected subject matter experts who understand the current landscape of performance and quality metrics in California and could provide insight on challenges and opportunities related to data collection and reporting for SMHS. These key informants also directed the Advisory Committee to additional performance measures and datasets to consider, such as those currently in use by health plans that are participating in state and national pilot programs such as the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, the Health Homes for Patients with Complex Needs Initiative, and the Whole Person Care (WPC) Program.

When determining which measures to recommend to DHCS, special consideration was given to measures

that were (1) developed by nationally-recognized organizations such as the National Committee for Quality Assurance (NCQA) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Consortium, (2) are endorsed by the National Quality Forum (NQF), (3) are widely used by other states, (4) and/or are cited in the literature as "disparity-sensitive," meaning that the measurements help to identify inequities in health outcomes and access to services.[iv]

Per the requirements of the statute, the Advisory Committee organized its measure recommendations into two phases:

1) Those that are currently available from county mental health plans or the state and should be included in the initial POS reports ("Phase I").

2) Those that could be added to county reporting systems and/or may be available from Medi-Cal managed care plans and should be included in future POS reports ("Phase II").

DATA COLLECTION

Background

Performance Outcomes Adult Specialty Mental Health Services Report

DHCS SMHS county mental health programs collect client-level service utilization data about California's county mental health programs beneficiaries, which is reported on a monthly basis to the Client & Service Information (CSI) and the Data Collection Reporting (DCR) System. The data is summarized at the state level and reported to DHCS management and staff, MHPs, other state agencies, federal agencies, the Legislature, and other interested groups and individuals.

DHCS' annual Performance Outcomes Adult Specialty Mental Health Services Report provides statewide aggregate data and county-specific data that measures the effectiveness of adult specialty mental health services.[v] Today these reports provide information on the initial indicators that were developed for the POS and focus on adults 21 and older who are receiving SMHS based on approved claims for Medi-Cal eligible beneficiaries. The POS report includes:

- Demographics of this population by age, gender, and race/ethnicity;
- Utilization of services reports shown in dollars and by services delivered in increments of time; and
- Two types of penetration information: (1) a point-in-time view of adults arriving, exiting, and continuing services over a two-year period and (2) a view over the past four years of the time to stepdown services following inpatient discharge.

These data elements are responsive to a requirement of the 1915(b) placed by CMS to address concerns about access to and quality of SMHS. The adult POS is required by CMS to be produced annually.

California EQRO for Medi-Cal Specialty Mental Health Services

Federal regulations require states that contract with Medicaid Managed Care Organizations (MCO) or Prepaid Inpatient Health Plans (PIHP), such as the county-operated MHPs in California, to conduct an External Quality Review (EQR) of each entity. States can perform EQR tasks directly or they can contract with an independent External Quality Review Organization (EQRO) to conduct the external quality review

of aggregated information on quality, timeliness, and access to healthcare services provided by an MCO or PIHP, or their contractors. DHCS currently contracts with Behavioral Health Concepts, Inc. to conduct the CalEQRO[vi] for Medi-Cal Specialty Mental Health Services, which includes validation of various performance measures pertaining to utilization and quality, as well as an analysis of consumer perceptions, workforce adequacy, data collection and validation processes, and performance improvement plans pertaining to access, timeliness and outcomes.

Consumer Experience Data Collection

County MHPs currently collect consumer experience data using the California Institute of Behavioral Health Solution's (CIBHS) California Consumer Perception Survey (CCPS). This survey obtains information about beneficiary satisfaction with services and self-evaluated mental health outcomes. It is administered twice a year using a convenience sample methodology. Surveys are distributed at clinic locations in May and November of each year and beneficiaries are offered the opportunity to complete the survey. The survey is made available in seven languages – English, Spanish, Chinese, Russian, Vietnamese, Tagalog, and Hmong. The EQRO also collects consumer experience data through focus groups with both beneficiaries and their family members By contrast, Medi-Cal health plans rely largely on the CAHPS®, which also results in data about beneficiary satisfaction with health care services and self-reported health outcomes. CAHPs is administered every three years using a random sample methodology. CAHPS is only administered in in English and Spanish. Additionally, some consumer experience data are collected outside the delivery system, capturing the experiences of beneficiaries served by all types of health plans offered across the state, including but not limited to Medi-Cal, as well as the experiences of consumers who are not accessing services. The largest health survey of this type is the annual telephone survey, the California Health Interview Survey (CHIS), administered by the University of California, Los Angeles (UCLA). Through CHIS, UCLA collects a wealth of data on the demographics, health behaviors, health conditions, healthcare utilization, and consumer experiences from a representative sample of approximately 20,000 California residents. While CHIS data are helpful in understanding the mental healthcare needs and access to care of Californians, the target sample is not large enough to capture disparities between various racial, ethnic, and linguistic minority populations who are enrolled in county-operated MHPs.

Recommendations

The Advisory Committee reviewed the data and quality measures collected by DHCS from the county-operated MHPs and the Medi-Cal health plans and developed recommendations to stratify data elements by demographic factors and to implement reporting on metrics in each of the key areas identified by the statute:

- Access and utilization;
- Quality and outcomes; and
- Disparities.

Recommendation #1: Standardized Demographic Data Elements

The Advisory Committee supports DHCS' ongoing efforts by the Chief Medical Officer to create an expanded and standardized demographic data set. While we recognize that this is a project that goes far beyond the statute's mandate, we suggest that streamlined data collection will be useful to this effort for the following indicators:

- Age
- Sex
- Gender Identity
- Race
- Ethnicity
- Primary language written
- Primary language spoken
- Sexual orientation

We recommend that the state's demographic data set be consistent across all public programs and mirror the standards set forth in the U.S Department Of Health And Human Services [Implementation Guidance On Data Collection Standards For Race, Ethnicity, Sex, Primary Language, And Disability Status].[vii]

Recommendation #2: Develop Best Practice Guidelines for the Collection of Data & Model Training Guidelines for the Collection of Race, Ethnicity, Primary Language, and Other Demographic Data

Consistently collecting accurate demographic data is a critical component of identifying, understanding and ultimately eliminating health disparities. According to the National Academies of Sciences, Engineering, and Medicine's Report Brief *Capturing Social and Behavioral Domains and Measures in Electronic Health Records, Phase 2,* standardizing social and behavioral data collection and measurement "can provide crucial information about factors that influence health and the effectiveness of treatment."[viii] Therefore, accurately documenting the demographic characteristics of county MHP beneficiaries is important in order to inform providers of the cultural factors that influence the patient-provider relationship and the care plan, likely resulting in better communication and improving patients' health outcomes.

The Advisory Committee recommends a multi-pronged approach to facilitate standardization in the collection of patient demographic data:

- DHCS should partner with subject matter experts to identify, customize, and adopt best practices for the collection of race, ethnicity, language preference (spoken and written), gender identity, and sexual orientation demographic data, and incorporate these guidelines into the administrative requirements for county-operated MHPs, as well as managed care delivery systems across the department.
- DHCS should partner with subject matter experts to develop a model program to train county staff responsible for the collection of race, ethnicity, language preference (spoken and written), gender identity, and sexual orientation demographic data.
- DHCS should require or incentivize the collection of self-reported demographic data, the gold standard for demographic data collection.
- DHCS could consider providing financial incentives for plans that meet a benchmark rate of self-reported demographic data collection.

Recommendation #3: Consistently Collect Consumer Experience Data

Understanding health and healthcare needs from the consumer's perspective and experience is necessary to uncover factors that influence physical and mental health outcomes and understand the factors that influence how the consumer uses (or doesn't use) healthcare services to address physical and mental health issues. An example of a measure set for consumer perspectives is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Experience of Care and Health Outcomes (ECHO) Survey, which asks health plan enrollees about their experiences with behavioral healthcare and services. The ECHO survey is a widely accepted tool, used to improve the quality of mental health and substance abuse services, evaluate and monitor the quality of behavioral healthcare organizations, and hold providers accountable through public reporting.[ix]

Today, the process of collecting data on consumer experience is highly fragmented and data are inconsistently reported across data sources.

The Advisory Committee recommends that DHCS:

- Conduct the California Consumer Perception Survey (CCPS) using a random sampling methodology, and oversample racial, ethnic, and linguistic populations that have historically been underserved. Make the CCPS available in the threshold languages of each county, at a minimum.
- Modify the CCPS to align with the CAHPS® Experience of Care and Health Outcomes (ECHO) Survey for behavioral health. Both surveys are largely based on the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, but the CAHPS ECHO can be used to evaluate the mental health services offered through Medi-Cal managed care plans in addition to MHPs, and can be compared across state Medicaid programs.
- Translate the CAHPS ECHO into all Medi-Cal threshold languages and validate for use in inpatient psychiatry settings in accordance with AHRQ requirements.[x]

Recommendation #4: Data Sharing & Integration

Identifying and reducing disparities in California's public mental health system requires the state to align, connect and present data collected by various state and county agencies. These include but are not limited to:

- County-operated MHPs,
- Medi-Cal health plans,
- Substance use disorder treatment organized delivery systems,
- California Department of Public Health (CDPH),
- California Department of Social Services (CDSS),
- California Department of Corrections & Rehabilitation (CDCR), and
- County jail medical services.

An example of cross department data sharing that may be effective in bettering care coordination is the Foster Care Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Performance Outcomes Systems report. This is a joint effort of DHCS and CDSS to report on mental health access and outcomes for children in California's child welfare system.

The Advisory Committee recommends that DHCS convene a workgroup comprised of academic institutions, philanthropic organizations, and private sector expert data analysts to develop an actionable and cost-effective strategic plan to align and integrate public program data that will:

- Identify disparities in the state healthcare system.
- Align data on quality and performance measures.
- Identify opportunities to collect data that will measure disparities in structural, outcome, and performance measures.
- Identify structural, process, and outcome measures that will improve the health status for racial, ethnic, linguistic minority populations, and other disenfranchised groups.
- Facilitate a culture of continuous quality improvement that is benchmarked against other states.

DATA REPORTING

Background

DHCS is required by federal regulation to develop and implement an annual Quality Strategy, which includes quality measurements, goals, and focus areas. Beginning July 1, 2018, the Quality Strategy must incorporate all managed care delivery systems, including Medi-Cal managed care plans, MHPs, Drug Medi-Cal Organized Delivery Systems, and Dental managed care plans. In the draft 2018 Quality Strategy released to the public,[xi] DHCS proposes to utilize metrics and data from the POS for MHPs.

Since 2014, DHCS has published the Managed Care Performance Dashboard, which provides quarterly updates to Medi-Cal managed care enrollment, service utilization, and plan HEDIS Aggregated Quality Factor Scores (AQFS). This report includes data on the utilization of Medi-Cal managed care plan mental health services, by beneficiary aid code, race, age, and gender. In 2015, DHCS began publishing the POS reports, discussed above, to capture similar information related to SMHS. Keeping in mind that maintaining beneficiary privacy and adhering to the rules governing collection, maintenance, use, and dissemination of personally identifiable information is critical, the POS reports could be modified so that the information these reports provide is more useful and actionable and furthers the state's goal of improving outcomes for beneficiaries as well as improving program performance and system functionality. There is also an opportunity to leverage data and quality related measures that the state and counties currently collect but do not report. Incorporating these additional data into the POS reports will enhance the state's ability to measure quality through structural, process, and outcome measurements.

Recommendations

Recommendation #1: Further Stratify Data In Order to Identify Disparities

The Advisory Committee recommends that DHCS expand the set of data reported in in the POS report as follows:

- Expand the stratification of the AGE DEMOGRAPHIC CATEGORY. Currently the adult age groups are consolidated in a way that masks the onset and progression of mental illness. For example, there is a marked increase in prevalence of psychotic disorder between the ages of 15

-17 and Schizophrenia usually begins in the age range of 15 – 35.[xii] To better understand where to invest resources for the identification and early intervention of mental illness we recommend the age demographic categories report on adults between the ages of 19 and 26. Additionally, we recommend an age band of adults 55 – 65 and adults 65+ to identify Alzheimer's disease and dementia in older beneficiaries.

- Expand the stratification of the PENETRATION RATES FOR SMHS VISITS. Currently the penetration rate summary consolidates SMHS visit into two categories: (1) Adults with at least one SMHS visit and (2) Adults with five or more SMHS visits.

A more detailed penetration rate report will provide valuable information that identifies disparities in access to and /or the delivery of mental health services. For example, if there is a high prevalence of beneficiaries in a specific ethnic or racial group who receive only one SMHS visit, it may be due to a lack of interpreter services or language access. To understand where there are disparities in access to care, we recommend the penetration rate report stratify SMHS visits by service type (crisis intervention, mental health service, crisis stabilization etc.) by number of visits instead of an aggregated number of minutes. For example:

SERVICE TYPE	ONE VISIT	TWO VISITS	THREE VISITS	FOUR VISITS	FIVE+ VISITS
Case Management					
Mental Health Service					
Crisis Intervention					
Medication Support					
Full Day Rehabilitation					
In Patient Hospitalization					

Additionally, the current POS report stratifies the penetration rate by age, race and gender only for adults with five or more SMHS visits. The Advisory Committee recommends that this same data be reported for adults with at least one SMHS visit.

Recommendation #2: Update the POS Report Format by Including Secondary and Tertiary Data Stratification

The POS currently only reports singular stratification, or stratification of data by one beneficiary demographic or utilization data point at a time, which hampers the state's ability to identify disparities in:

- Access to care, including timely access to services, waiting time to assessment, and waiting time to first appointment;
- Language capacity and language access;
- Quality; and
- Utilization and penetration

The Advisory Committee recommends DHCS, in consultation with stakeholders, update the POS report demographic data so that the data is stratified by at least two categories, in addition to singular stratification for key data. For example:

FY 19-20		
Age	Female	Male
15-21	x	x
21 – 30	x	x
31 – 40	x	x
41 – 50	x	x
51 – 60	x	x
61 – 65+	x	x
Total	xx	xx

FY 19-20		
Race	Female	Male
Alaskan Native or American Indian	x	x
Asian or Pacific Islander	x	x
Black	x	x
White	x	x
Unknown	x	x
Total	xx	xx

FY 19-20						
Race	Age	Age	Age	Age	Age	Age
	15-21	21 – 30	31-40	41-50	51-60	61 - 65
Alaskan Native or American Indian	x	x	x	x	x	x
Asian or Pacific Islander	x	x	x	x	x	x
Black	x	x	x	x	x	x
White	x	x	x	x	x	x
Unknown	x	x	x	x	x	x
Total	xx	xx	x	xx	xx	xx

Recommendation #3: Cross Reference MHP Beneficiary Data with MCP Service Utilization

Since California currently operates a carve-out system of mental health care, Medi-Cal beneficiaries with serious mental illness receive physical health services from one delivery system – Medi-Cal managed care – and mental health services from another delivery system – MHPs. However, individuals with serious mental illness require coordinated physical health care in order to address co-occurring physical health conditions and appropriately monitor the use of psychiatric medication, among other issues. In order to adequately gauge quality of care for Medi-Cal beneficiaries with serious mental illness, DHCS needs to develop a more comprehensive plan for monitoring quality across managed care delivery systems. One key factor in doing this is the ability to track MHP beneficiaries in the Medi-Cal managed care delivery system.

The Advisory Committee recommends that DHCS:

- Develop a mechanism to identify MHP beneficiaries, or those diagnosed with a serious mental illness, in their Medi-Cal managed care plan. This will allow Medi-Cal managed care plan data to stratify utilization, HEDIS measures, and other data by SMI and assess the physical health care being provided to MHP beneficiaries.
- Incorporate quality measures that draw upon data from Medi-Cal managed care plans into the POS so that it is possible to evaluate the full picture of care and outcomes for the population.

QUALITY MEASURES

Background

The importance of quality measurement is increasingly recognized in healthcare as a tool to reduce disparities and advance equity. Quality measurement is equally important in mental health care, where early intervention for mental illness and substance use is effective, but inappropriate treatment is prevalent. Historically, quality measures for behavioral health have been limited, and measuring performance and outcomes has been challenging, particularly related to integrated care.

The Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services (HHS) to identify and publish a core set of healthcare quality measures for adult Medicaid enrollees and, in Section 2701 of the ACA, the Secretary is required to issue annual updates to the Adult Core Set. CMCS worked with the National Quality Forum's (NQF) Measures Application Partnership (MAP) to review the Adult Core Set and to identify ways to improve it. Through this work, CMCS identified a set of behavioral health measures that they identified as the Core Set of Behavioral Health Measures for Medicaid and CHIP, which states can voluntarily report to CMS. The updated November 2017 guidance issued by CMCS discusses the need to promote alignment of quality measurements. The guidance states that "[P]art of implementing an effective quality measures reporting program is to periodically reassess the measures that comprise it since many factors, such as changes in clinical guidelines and experiences with reporting and performance rates, may warrant modifying the measure set[xiii]."

DHCS currently receives reports from the Medi-Cal managed care plans on seven of the eleven Adult Core Set behavioral health measures for Medicaid and CHIP but does not receive reports on these measures from the county Mental Health Plans.[xiv] Furthermore, the managed care plan data is not incorporated into the POS, and thus that report fails to provide a complete representation of mental healthcare for Medi-Cal beneficiaries.

Recommendations

County Mental Health Plans Quality Improvement Recommendations

The Advisory Committee's quality improvement recommendations are focused on updating the POS reports and the EQRO Reports to include quality measures collected and reported to DHCS by Medi-Cal health plans. Incorporating these data will further facilitate identification of health disparities and lead to quality improvement efforts that achieve health equity. The Advisory Committee is recommending that DHCS focus on three domains of quality measures:

- ***Structural measurements*** that provide a sense of a healthcare system and/or provider's capacity, systems, and processes to provide high-quality care.

- ***Process measurements*** that indicate what a health system and/or provider does to maintain or improve health. These measures can be for healthy people or people with a diagnosed health condition and usually reflect generally accepted recommendations for clinical practice (i.e., U.S. Preventive Services Task Force Guidelines). And,

- ***Outcome measurements*** that reflect the healthcare system or provider's impact through the delivery of service(s) or intervention(s) on the patient's health status.

A guiding principle for the development of quality measures must be that county-operated MHPs and the Medi-Cal health plans be required to share data for beneficiaries' utilization of mental health services and the utilization of physical health/medical services for reporting purposes. The integration of these data is critical for a patient-centered approach to care delivery, which is the first step in eliminating health disparities. This should focus on incorporating existing DHCS data that are collected but not currently published in California, specifically data that are (1) designed to identify patient and/or system behaviors that are known to lead to, or exacerbate chronic health conditions and, (2) improve the overall health of individuals with a mental health diagnosis who also have a chronic condition.

The specific quality measure recommendations in the section that follows are divided into two phases.

***Phase I* measures are based on available data for specialty mental health services that the department can publish, by December 31, 2018, in a revised performance outcomes system reports.**

***Phase II* measures are recommendations from subject matter experts for statewide quality improvement and reduction in mental health disparities that can be incorporated into the performance outcomes system report after January 1, 2019.**

This Page Intentionally Left Blank

Recommendation #1: Disparity-Sensitive Structural Quality Measures

The recommended structural quality measures are intended to provide DHCS insight into the county's capacity, systems, and processes to provide culturally responsive, quality care. These should be incorporated into the POS in Phase I and Phase II.

This section provides a broad selection of structural measurements to further assess quality and the reduction of health disparities that can be considered as the state makes changes to the data collection and reporting system. These measures are adopted from nationally recognized recommendations and are considered best practice.

Structural: Phase I

PHASE I - RECOMMENDED STRUCTURAL MEASURES	SOURCE	AB 470 Data Element
% of visits that comply with time and distance measures from network adequacy rules based on county population size as follows: • Rural Counties: 60 miles or 90 minutes from the beneficiary's residence • Small Counties: 45 miles or 75 minutes from the beneficiary's residence • Medium Counties: 30 miles or 60 minutes from the beneficiary's residence • Large Counties: 15 miles or 30 minutes from the beneficiary's residence	Client Information System	Access
Time from initial request to the first appointment kept	HEDIS CalEQRO	Access
Does the office provide services in the evenings/weekends or alternative visits (i.e., online)?	HEDIS	Access
Services were available at times that were good for me	MHSIP	Access
I was able to see a psychiatrist when I wanted to.	MHSIP	Access
Were the services you received provided in the language that you prefer?	DHCS MHSIP Adult Consumer Perception Survey PRIME	Language Access
Staff were sensitive to my cultural background (race, religion, language, etc.)	DHCS Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Perception Survey	Quality
Time (mean) to step-down services following inpatient discharge *and* Time (median) to step-down services following inpatient discharge	DHCS Performance Outcomes System for Medi-Cal SMHS	Quality
Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team	WPC Pilot HEDIS	Quality
Consumer and family run/driven programs to enhance wellness and recovery	CalEQRO MHP Annual Review	Quality
Housing status, referral to and receipt of housing services, referral to and receipt of supportive housing	WPC Variant Measures (3)	Quality
Percent using Controlled Substance Utilization Review and Evaluation System (CURES) prescribing practices for opioids	Controlled Substance Utilization Review and Evaluation System	Quality
Combine two measures: track no-show rates for psychiatry and other clinical appointments	CalEQRO MHP Self-Assessment of Timely Access	Quality
Has the beneficiary been asked by a doctor or other health provider if there are things that make it hard to take care of the beneficiary's health	CAHPS Adult Medicaid Health Plan Survey (not specific to mental health)	Quality

Structural: Phase II

PHASE II - RECOMMENDED STRUCTURAL MEASURES	SOURCE	AB 470 Data Element
Percent of adult patients who reported how often they get treatment quickly	CAHPS-ECHO	Access
Mental illness HCBS CAHPS measure (5 of 19): Transportation to medical appointments	CMS	Access
Usual place for care: "Is there a place that you USUALLY go to when you are sick or need advice about your health?"	NHIS	Access
Provider explained things in a way that was easy to understand	CAHPS	Quality
HBIPS-7 post-discharge continuing care plan transmitted to next level of care provider upon discharge	The Joint Commission	Quality
Providers using trauma informed approaches.	NBHQF	Quality
Communication between provider, Medi-Cal managed care plans and MHPs	WPC PRIME Reports	Quality
% of patients with SMI whose primary care record shows documentation of communication between primary care clinician and mental health clinician; % of patients with SMI whose MHP record shows documentation of communication between mental health clinician and primary care clinician	N/A	Quality
IT system must capture social, psychological, and behavioral information	ONC IT criteria	Quality
Clinical decision support technology	ONC IT criteria	Quality
Percent of providers using an EHR that tracks patients by diagnosis	N/A	Quality

Recommendation #2: Disparity-Sensitive Process Quality Measures

The recommended process measures are intended to indicate what a county does to reduce disparities and improve health for racial, ethnic, linguistic populations, and other disenfranchised populations. For example, data on medication management and the utilization of physical and behavioral health services should be used to inform how we manage patient care and how we distribute resources to ensure our most vulnerable populations are not subjected to disparate care. These measures are adopted from nationally recognized recommendations for culturally responsive best practices and/or clinical best practices for individuals with mental health issues or substance use disorder.

This section provides a broad selection of process measurements to further assess quality and the reduction of health disparities that can be considered as the state makes changes to the data collection and reporting system. These measures are adopted from nationally recognized recommendations and are considered best practice.

Process: Phase I

PHASE I - RECOMMENDED PROCESS MEASURES:	SOURCE	AB 470 Data Element
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	CMS Core BH Measure PRIME	Quality
Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates	Client Information System	Quality
Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	CMS Core Measure NCQF	Quality
Antidepressant Medication Management	CMS Core BH Measure NCQA PRIME	Quality
Mental Illness Depression Screening by Primary Care Providers: Adults	HIW	Quality
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	2018 Core Set of Behavioral Health Measures for Medicaid and CHIP NCQA	Quality
Comprehensive Diabetes Care • Eye Exam (Retinal) Performed • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attention for Nephropathy Blood pressure control (<140/90 mm Hg)	HEDIS, DHCS Managed Care EAS Measures-Full-Scope Medi-Cal Managed Care Health Plans PRIME	Quality
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	CMS Core BH Measure HEDIS	Quality
Medical Assistance With Smoking and Tobacco Use Cessation (MSC-AD)	CMS Adult BH Core NCQA	Quality
Mental health, SUD, and trauma diagnosis recorded	County Mental Health CSI Database	Utilization/Penetration
S-29.0 Axis I Primary	County Mental Health CSI Database	Utilization/Penetration
S-30.0 Additional Axis I Diagnosis	County Mental Health CSI Database	Utilization/Penetration
S-31.0 Axis II Diagnosis	County Mental Health CSI Database	Utilization/Penetration
S-32.0 Axis II Primary	County Mental Health CSI Database	Utilization/Penetration
S-33.0 Additional Axis II Diagnosis	County Mental Health CSI Database	Utilization/Penetration
S-34.0 General Medical Condition Summary Code	County Mental Health CSI Database	Utilization/Penetration
S-35.0 General Medical Condition Diagnosis	County Mental Health CSI Database	Utilization/Penetration
S-37.0 Substance Abuse/Dependence	County Mental Health CSI Database	Utilization/Penetration
S-38.0 Substance Abuse/Dependence Diagnosis	County Mental Health CSI Database	Utilization/Penetration
S-36.0 Axis-V/GAF Rating	County Mental Health CSI Database	Utilization/Penetration
S-26.0 Trauma	County Mental Health CSI Database	Utilization/Penetration

Process: Phase II

PHASE II - - RECOMMENDED PROCESS MEASURES	SOURCE	AB 470 Data Element
Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit	CMS MN Community Measurement QPS PRIME	Quality
Use of Screening, brief intervention, and referral for treatment for alcohol misuse	NBHQF PRIME	Quality
Percent using Controlled Substance Utilization Review and Evaluation System (CURES) prescribing practices for opioids		Quality
Adult depression in primary care: percentage of perinatal patients with documentation of screening for major depression or persistent depressive disorder using PHQ-9	ICSI	Quality
Percent of providers receiving ongoing training on the use of established screening tools, such as SBIRT, PQH, etc.		Quality
Major depressive disorder (MDD): percentage of patients aged 18 years and older with a diagnosis of MDD who have a depression severity classification and who receive, at a minimum, treatment appropriate to their depression severity classification at the most recent visit during the measurement period	APA; PCPI	Quality
In the past month, how many times have you been arrested for any crime?	MHSIP	Quality
Adherence to antipsychotic medications for individuals with schizophrenia: percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period	NCQA	Utilization
Mental Illness Adherence to Antipsychotic Medications for Individuals with Schizophrenia	QPS, NQF	Utilization
Mental Illness Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	QPS, NQF	Utilization

Recommendation #3: Disparity-Sensitive Outcome Quality Measures

The recommended outcome measures are intended to reflect the impact of health care service or interventions on the health status racial, ethnic, linguistic populations, and other disenfranchised groups. These measures are reported in the state of California or they are adopted from nationally recognized recommendations for culturally responsive best practices and/or clinical best practices for individuals with mental health issues or substance use disorder.

This section provides a selection of outcome measurements to further assess quality and the reduction of health disparities that can be considered as the state makes changes to the data collection and reporting system. These measures are adopted from nationally recognized recommendations and are considered best practice.

Outcome: Phase I

PHASE I – RECOMMENDED OUTCOME MEASURES	Source	AB 470 Data Element
DCR outcomes – education, employment, housing, incarceration, arrests	Data Collection Reporting System (DCR)	Quality
Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates	DHCS Performance Outcomes System for Medi-Cal SMHS; CalEQRO MHP Self-Assessment of Timely Access (mandatory for CalEQRO validation) CalEQRO MHP Annual Review	Quality
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	NCQA QPS 2018 Core Set of BH Measures for Medicaid & CHIP	Quality
Antidepressant medication management (effective acute phase treatment): percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 84 days (12 weeks)	NCQA	Quality
Behavioral health care patients' experiences: percentage of adult patients who rated how much improvement they perceived in themselves	AHRQ; CAHPS Consortium; Harvard Medical School CAHPS ECHO	Quality
Measures clinical and/or functional outcomes of consumers served	CalEQRO MHP Annual Review	Quality
Medical Assistance with Smoking and Tobacco Use Cessation	CMS Core BH Measure NCAQ; endorsed by NQF	Quality
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	CMS BH Core Measure	Quality
Ambulatory Care: • Outpatient Visits • Emergency Department visits (Adults)	DHCS Managed Care EAS Measures -Full-Scope Medi-Cal Managed Care Health Plans (not spec. to MH)	Quality
Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay	DHCS Performance Outcomes System for Medi-Cal SMHS; CalEQRO MHP Self-Assessment of Timely Access (mandatory for CalEQRO validation)	Utilization/Penetration

Outcome: Phase II

PHASE II – RECOMMENDED OUTCOME MEASURES:	Source	AB 470 Data Element
Adherence to antipsychotic medications for individuals with schizophrenia: percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period	NCQA	Quality
Objective measure of functional status improvement (consider implementation of the Milestone of Recovery Scale (MORS) by all county MHPs)		Quality
Behavioral health care patients' experiences: Percentage of adult patients who reported whether someone talked to them about including family or friends in their counseling or treatment	AHRQ; CAHPS Consortium; Harvard Medical School CAHPS ECHO	Quality
Implementation of the CAHPS-ECHO consumer perception survey by all county MHPs		Quality

APPENDIX A: DATA SOURCES

Achieving Health Equity: Closing the Gaps In Health Care Disparities, Interventions, And Research, Health Affairs 2016. Health Affairs is the leading journal of health policy thought and research founded in 1981 under the aegis of Project HOPE, a nonprofit international health education organization. Health Affairs explores health policy issues of current concern in domestic and international spheres. Its mission is to serve as a high-level, nonpartisan forum to promote analysis and discussion on improving health and health care, and to address such issues as cost, quality, and access.

Agency for Healthcare Research and Quality; CAHPS Consortium; Harvard Medical School. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. The goals of the CAHPS program are twofold (1) Develop standardized patient questionnaires that can be used to compare results across sponsors and over time and (2) Generate tools and resources that sponsors can use to produce understandable and usable comparative information for both consumers and health care providers.

AHRQ National Quality Measures Clearinghouse (NQMC). CMS regulations, published in January 2003, require that states which contract with Medicaid Managed Care Organizations (MCO) or Prepaid Inpatient Health Plans (PIHP) conduct an External Quality Review (EQR) of each entity.

American Psychiatric Association; Physician Consortium for Performance Improvement®. The All Measures Spreadsheet is a comprehensive collection of performance measures that pertain to mental health.

CAHPS Adult Medicaid Health Plan Survey. The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. It was designed to support consumers in assessing the performance of health plans and choosing the plans that best meet their needs. Health plans can also use the survey results to identify their strengths and weaknesses and target areas for improvement.

CalEQRO MHP Annual Review & MHP Self-Assessment of Timely Access. California Medicaid program External Quality Review Organization (EQRO) fiscal year 2016-2017 (FY 16-17) findings of an EQR of the MHP by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC)

California Health Interview Survey (CHIS). The California Health Interview Survey (CHIS) is the largest state health survey in the nation. It is a random-dial telephone survey that asks questions on a wide range of health topics. CHIS is conducted on a continuous basis allowing the survey to generate timely one-year estimates. CHIS provides representative data on all 58 counties in California and provides a detailed picture of the health and health care needs of California's large and diverse population.

Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. the National Institutes of Health, together with the Blue Shield of California Foundation, the California Healthcare Foundation, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services (CMS), the Lisa and John Pritzker Family Fund, the Robert Wood Johnson Foundation, the Substance Abuse and Mental Health Services Administration, and the Department of Veterans Affairs requested that the Institute of Medicine (IOM) convene a committee to conduct a two-phase study, first to identify social and behavioral domains that most strongly determine health, and then to evaluate the measures of those domains that can be used in EHRs.

Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services. The online Health Care Quality program at GW was developed to meet an emerging demand for quality and patient safety specialists who have the capacity and competence to grow and sustain a culture of continuous improvement at all levels and within every sector of the health care delivery system.

Center for Health Care Strategies (CHCS) Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons. As a nonpartisan organization, CHCS facilitates problem-solving exchanges and peer learning among a diverse range of health care stakeholders to improve access, integrate fragmented services, reduce avoidable expenditures, and link payment with quality.

CHCS Complex Care Program Development: A New Framework for Design and Evaluation, March 2017. Center for Healthcare Strategies.

County Mental Health Client & Service Information (CSI) Database. The CSI and the DCR Reporting Systems both collect client-level service utilization data about California's county mental health programs. Data are provided monthly by county mental health programs (MHPs) and summarized at the state level. The CSI System began on July 1,1998 and is the successor to the Client Data System (CDS).

CPEHN Landscape Report 2016 & CPEHN Mind, Body, Spirit: Advancing Mental Health and Substance Use Equity. CPEHN, a non-profit organization dedicated to promoting health equity by advocating for public policies and sufficient resources to address the health needs of communities of color.

California Reducing Disparities Project (CRDP) Strategic Plan, 2014. The former Department of Mental Health (DMH), with support from the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council (CMHPC), created a statewide policy initiative to identify solutions for historically unserved, underserved, and inappropriately served communities. Under the California Office of Health Equity, this statewide Prevention and Early Intervention effort, the California Reducing Disparities Project (CRDP), focuses on five populations: African Americans, Asians and Pacific Islanders (API), Latinos, Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ), Native Americans.

Medicare Consumer Assessment of Healthcare Providers and Systems Clinician & Group (CG-CAHPS) Adult 12-Month Survey. Agency for Healthcare Research and Quality's (AHRQ)

CAHPS – ECHO Health Plan Survey. Agency for Healthcare Research and Quality's (AHRQ)

National Healthcare Quality and Disparities Reports (QDR). Agency for Healthcare Research and Quality (AHRQ).

National Association of State Mental Health Program Directors Research Institute, Inc. Inpatient Consumer Survey (ICS). Guideline Central is dedicated to providing healthcare professionals with evidence-based clinical decision-support tools that are current, practical, and easily accessible.

National Committee for Quality Assurance. The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

National Quality Forum A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. The National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare.

National Survey on Drug Use and Health (NSDUH). The National Survey on Drug Use and Health (NSDUH) is a nationwide study that provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States.

Office of the National Coordinator (ONC) Health IT Certification Criteria, 2015 Edition. The Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program is a voluntary certification program established by the Office of the National Coordinator for Health IT to provide for the certification of health IT standards, implementation specifications and certification criteria adopted by the Secretary. The ONC Health IT Certification Program supports the availability of certified health IT for its encouraged and required use under other federal, state and private programs.

SAMHSA National Behavioral Health Quality Framework (NBHQF). Using the NQS as a model, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed the National Behavioral Health Quality Framework (NBHQF).

Accountable Health Communities Health-Related Social Needs Screening Tool. The Center for Medicare and Medicaid Innovation (CMMI) Accountable Health Communities (AHC) health-related social needs screening tool created to use in the AHC Model. It is testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Medi-Cal Pay-for-Performance (P4P) Core Measure Set developed by the Integrated Healthcare Association (IHA).

Whole Person Care (WPC) Pilot Program Performance Metrics. WPC is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots will provide an option to a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Performance Measures. The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program is a five-year initiative under the Medi-Cal 2020 section 1115 waiver that builds upon the Delivery System Reform Incentive Payment (DSRIP) program established under the Bridge to Reform waiver. The goal of PRIME is to continue significant improvement in the way care is delivered through California's safety net hospital system to maximize health care value and to move toward alternative payment models (APMs), such as capitation and other risk-sharing arrangements.

APPENDIX B: DEFINITIONS

CDSS – California Department of Social Services[xv] **(CDSS).** California Department of Social Services' mission is to serve, aid, and protect needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence

Client & Service Information (CSI)[xvi] **Data System.** Collects client-level service utilization data about California's county mental health programs. Data are provided monthly by county mental health programs (MHPs) and summarized at the state level.

Consumer Assessment of Healthcare Providers and Systems[xvii] (CAHPS). CAHPS is an AHRQ program that began in 1995. Its purpose is to advance our scientific understanding of patient experience with health care. The acronym "CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

DHCS – Department of Health Care Services[xviii] **(DHCS).** DHCS provides Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care.

Healthcare Effectiveness Data and Information Set (HEDIS.) HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

Joint Commission[xix] An independent, not-for-profit organization, The Joint Commission accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Medi-Cal Specialty Mental Health Services (SMHS). The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act.

Medi-Cal Eligibility Data System (MEDS). The data system maintained by the DHCS that contains information on Medi-Cal eligibility including a beneficiary's county of responsibility.

Mental Health Services Oversight and Accountability Commission (MHSOAC). The role of the Mental Health Services Oversight and Accountability Commission (MHSOAC) is to oversee the implementation of the Mental Health Services Act (MHSA). The MHSOAC is also responsible for developing strategies to overcome stigma. At any time, the MHSOAC may advise the Governor or the Legislature on mental health policy.

PCPI. PCPI® is the multiple stakeholder community including providers, patients, professional societies, health plans, and vendors united for the advancement of measurement science, quality improvement and clinical registries.

Quality Positioning System (QPS). A web-based tool developed by the National Quality Forum (NQF) to help people select and use NQF-endorsed measures.

REFERENCES

i AB-470 Medi-Cal: specialty mental health services: performance outcome reports (2017-2018) (State of California, n.d.). Retrieved from https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201720180AB470

ii California Health Care Foundation. For Too Many, Care Not There. March 2018. Retrieved from https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf

iii Medi-Cal Speciality Mental Health External Quality Review FY16-17 Statewide Report. Prepared for the California Department of Health Care Services (DHCS) by Behavioral Health Concepts, Inc.

iv National Quality Forum. A roadmap for promoting health equity and eliminating disparities: the four I's for health equity: final report [Internet]. Washington (DC): NQF; 2017 Sep 14. Available for download from: https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx

v POS Measures Catalog, September 2016. Retrieved from http://www.dhcs.ca.gov/services/MH/Documents/POS_MeasuresCatalog_Sept2016.pdf

vi California EQRO for Medi-Cal Specialty Mental Health Services Website. http://www.caleqro.com/mh-eqro

vii U.S. Department Of Health And Human Services Implementation Guidance On Data Collection Standards For Race, Ethnicity, Sex, Primary Language, And Disability Status. Retrieved from https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

viii POS Measures Catalog, September 2016. Retrieved from http://www.dhcs.ca.gov/services/MH/Documents/POS_MeasuresCatalog_Sept2016.pdf

ix CAHPS Experience of Care & Health Outcomes (ECHO) Survey. Content last reviewed May 2018. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/cahps/surveys-guidance/echo/index.html

x https://www.ahrq.gov/cahps

xi California Department of Health Care Services. Medi-Cal Managed Care Quality Strategy Report Draft for Public Comment. March 28, 2018.

xii Kessler, R. C., Amminger, G. P., Aguilar Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: A review of recent literature. Current Opinion in Psychiatry, 20(4), 359–364. http://doi.org/10.1097/YCO.0b013e32816ebc8c

xiii CMS Informational Bulletin: 2018 Updates to the Child and Adult Core Health Care Quality Measurement Sets. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf

xiv Table 5-AD. Performance measures for Medicaid managed care plans that evaluate care provided to adults, as reported in External Quality Review (EQR) technical reports, 2016–2017 reporting cycle. Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

Agency for Healthcare Research and Quality. https://www.ahrq.gov/

American Psychological Associations. www.apa.org

xv California Department of Social Services. http://www.cdss.ca.gov/

UCLA Fielding School of Public Health, California Health Interview Survey. http://healthpolicy.ucla.edu/chis/Pages/default.aspx

xvi California Department of Health Services, Client & Service Information (CSI) and Data Collection Reporting (DCR) Systems. http://www.dhcs.ca.gov/services/MH/Pages/CountyMentalHealthClientServiceInformation(CSI)System.aspx

xvii Agency for Healthcare Research and Quality, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) https://www.ahrq.gov/cahps/about-cahps/index.html

xviii California Department of Healthcare Services. http://www.dhcs.ca.gov/Pages/default.aspx

xix The Joint Commission. https://www.jointcommission.org/

The National Committee for Quality Assurance. http://www.ncqa.org/homepage

CPEHN

California Pan-Ethnic Health Network

June 2018