Kings County: Data Notebook 2014

for California

Mental Health Boards and Commissions

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Prepared by California Mental Health Planning Council, in collaboration with: California Association of Mental Health Boards/Commissions, and APS Healthcare/EQRO

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Date: April 20, 2014

To: Chairpersons and/or Directors



Local Mental Health Boards and Commissions

From: California Mental Health Planning Council

Subject: **Instructions for Data Notebook 2014**

We ask that this report be prepared by the MH Board or Commission members. You are the most important resources for identifying program strengths and needs in your community.

On the first page, please fill in the requested information for your county websites:

* Department of Behavioral Health/ Mental Health
* Public reports about your county’s MH services.

Please send a copy of the filled-in first page to the Planning Council along with your final report which contains your answers to the questions in the Data Notebook. Please submit your report within 60 days by email to:

[DataNotebook@cmhpc.ca.gov](mailto:DataNotebook@cmhpc.ca.gov).

Or, you may mail a printed copy of your report to:

* Data Notebook Project
* California Mental Health Planning Council
* 1501 Capitol Avenue, MS 2706
* P.O. Box 997413 Sacramento, CA 95899-7413

Please examine the enclosed information, which will help you discuss the questions in the Data Notebook. We provide examples of recent mental health data for your county. In some figures, the term “MHP” is used to refer to your county’s Mental Health Plan.

Some data comes from APS Healthcare/EQRO, which gave permission to use their figures and tables, prepared for review of each county’s Medi-Cal Specialty Mental Health services. Data in this packet came from the following review cycle:

\_\_X\_\_ Fiscal Year 2013 -- 2014: <http://caeqro.com/webx/.ee85675/>

\_\_\_\_\_ Fiscal Year 2012 -- 2013: <http://caeqro.com/webx/.ee851c3/>

For some questions, you will need to consult your local county Quality Improvement Coordinator, and/or Mental Health Director. If you are not able to address all of the questions, just answer the ones you can.

Thank you for your participation in the Data Notebook Project.

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County Name: **Kings** Population (2013): 150,479

Website for County Department of Mental Health (MH) or Behavioral Health:

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Website for Local County MH Data and Reports:

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Website for local MH Board/Commission Meeting Announcements and Reports:

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Specialty MH Data from review Year 2013-2014: <http://caeqro.com/webx/.ee85675>

Total number of persons receiving Medi-Cal in your county (2012): 47,391

Average number Medi-Cal eligible persons per month: 38,114

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 51.8 %

Adults, ages 18-59: 38.9 %

Adults, Ages 60 and Over: 9.3 %

Total persons with SMI[[1]](#footnote-1) or SED[[2]](#footnote-2) who received Specialty MH services (2012): 1,820

Percent of Specialty MH service recipients who were:

Children 0-17: 35.5 %

Adults 18-59: 57.6 %

Adults 60 and Over: 6.9 %

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INTRODUCTION: Purpose, Goals, and Data Resources

This Data Notebook has been developed for the use by the local mental health (MH) boards and commissions by a yearlong workgroup comprised of members from:

* California Mental Health Planning Council (CMHPC)
* California Association of Local Mental Health Boards and Commissions (CALMHB/C)
* APS Healthcare/ EQRO (External Quality Review Organization)

Our plan is for the Data Notebook to meet these goals:

* assist local boards to meet their mandates to review the local county mental health systems, identify unmet needs, and recommend improvements.
* provide a professional format for submitting reports to their local Board of Supervisors, and/or their county Director of Mental Health Services.
* function as an educational tool for local boards, whose members have varying levels of skills, frequent turnover, and need ‘refresher’ training about using data.
* help the CMHPC fulfill its mandates to review and report on the public mental health system in California, which also helps provide evidence for advocacy.

Data reporting drives policy, and policy drives funding for programs. But the data must be both recent and available to the public, or else it is not useful. So, the CMHPC will provide examples of local data from current public reports. We focus on two broad areas: (1) evaluation of program performance, and (2) indicators of client outcomes.

We recognize that each county has a unique population, resources, strengths, and needs. Thus, there is no single perfect data source to answer all the important questions one might ask about mental health services. However, the following data resources will help board members answer questions in this Data Notebook:

* experience and opinions of the local mental health board members
* recent reports about county MH programs from APS Healthcare/EQRO
* data you request from your county QI Coordinator and/or Mental Health Director (because CMHPC does not have that data, and it’s not in other public reports)
* client outcomes data provided by California Institute of Mental Health (CiMH) in their analysis of the most recent Consumer Perception Survey.

Some of our data comes from APS Healthcare/EQRO, which kindly gave permission to use their figures and tables, prepared for review of each county’s Medi-Cal Specialty Mental Health services. Those reviews are at: [www.CAEQRO.com](http://www.CAEQRO.com). You may find the full-length EQRO reports helpful because they summarize key programs and quality improvement efforts for each county. They also describe strengths, opportunities for improvement, and changes in mental health programs since the last year.

Understanding changes in local programs can help consumers because of the massive re-organization of mental health services statewide. Some changes have been confusing to clients. The old state Department of Mental Health was eliminated in 2012 and many functions were moved to the Department of Health Care Services. Other changes due to federal health care reform and the Affordable Care Act affect how mental health services are provided, funded, and linked to primary health care or substance use treatment. Also, local counties have adjusted to major challenges.

Remember, this report is about your community, and what you and your stakeholders choose to discuss. Examining the data can indeed “Tell a Human Story.” But quantitative data (numbers) provides only part of the picture, for example:

* measures of whether the quality of program services improve over time
* whether more people from different groups are receiving services
* how many clients got physical healthcare or needed substance use treatment.

The other part of the story gives human context to the numbers. Such qualitative data (narrative, descriptions, or stories) tells more of the story, because we can:

* describe special programs targeted for outreach to specific groups
* examine how the programs are actually implementing their goals
* list concrete steps that are taken to improve services, and
* tell what is being done to increase client engagement with continued treatment.

We hope this project contributes to ongoing quality improvement (QI) in mental health services. We seek constant improvement in our approach to quality because:

* needs change over time,
* all human endeavors are by nature imperfect,
* creativity gives rise to new ideas, and
* we can share examples of successful programs to help other communities.

One question is whether local boards are permitted to provide additional information, besides that requested in this Notebook. We always welcome supplemental reports about successful projects, or which the county administration uses to inform the public. Any additional reports may be attached in an “Appendix,” with the website address (if available). However, we emphasize such extra reports are not required.

Thank you for participating in this project. We hope this Data Notebook serves as a springboard for your discussion about all areas of the mental health system, not just those topics highlighted by our questions.

TREATING THE WHOLE PERSON:

Integrating Behavioral and Physical Health Care

Studies have shown that individuals with serious mental illness die, on average, 25 years earlier than the general population.  This information makes improving the physical health of clients of great importance and should be a goal of county mental health departments along with providing effective and appropriate mental health services.  Coordination of care for mental health, substance abuse and physical health is one way of accomplishing the goal.

The California Mental Health Planning Council does not have any data to provide to show how your county’s programs connect clients of mental health services with necessary physical health care. We ask that the local mental health board request information from your county mental health department for any data on numbers (or percent) of total mental health clients who are referred to, or connected with, physical health providers to assess, treat and monitor physical health issues.

If your county has data on numbers or percentages of clients who are also receiving physical health care, please include it in your Data Notebook you submit to the Council.

\_\_\_ Check here if your county does not have such data or information.

**1)  Please describe any efforts in your county to improve the physical health of clients.**

* **Each time that a client meets with the nurse or the psychiatrist a brief health exam takes place. This typically consists of taking weight, blood pressure and sometimes temperature. This data is recorded in the progress note. Both nurses and doctors routinely review lab results.**
* **Our doctors continually offer to consult with primary care physicians regarding the integration of health concerns with mental health concerns.**
* **When one of our clients is admitted to the local emergency room our doctors routinely consult with the E.R. doctor.**
* **When relevant, our nurses provide clients with information regarding maintaining good health. That information may include education and consultation of diet, weight, exercise and managing chronic diseases.**
* **We contract with a licensed pharmacist who provides our Medication Monitoring committee with consultation and chart reviews related to drug interactions and best practices.**

**2)  How does your county address wellness programs to engage and motivate clients to take charge of improving their physical health?**

* **Our doctors and nurses routinely educate and consult with clients regarding caring for and maintaining good health.**
* **Topics related to healthy living are routinely provided to clients as part of our Oak Wellness Center programing.**
* **Therapist and Case Managers will counsel with and encourage their clients on issues related to good health.**

Examples:

* Exercise
* Nutrition
* Healthy cooking
* Stress management
* Quitting smoking
* Managing chronic disease
* Maintaining social connectedness

#### NEW CLIENTS: One Measure of Access

One way to evaluate the quality of mental health services outreach is to measure how many clients receive services who have never been part of the service system before (“brand new” clients). Another measure is how many clients return for services after a period of time with no services (“new” clients).

The California Mental Health Planning Council is exploring how each county mental health department defines “new” clients, and how a client is labelled when they return for additional services. This information is important in determining whether your county has a “revolving door,” that is, clients who are in and out of mental health services repeatedly. This data is one indicator of the success of your county’s programs in closing cases appropriately and providing adequate discharge planning to clients.

This data is not currently reported by the counties to the state. The Council does not have data to provide to you. This information should be requested from your county mental health department.

\_\_\_\_ Check here if your county does not have this information.

**3. How does your county define 'new' client for those individuals who have previously received services, but who have not received services for a while? (e.g., 6 months, 12 months, 2 years?)**

* **If it has been 6 months from the date of the most recent discharge to the date of the current admission, the client is considered a ‘new’ client for all practical purposes.**

**4.  Please provide any data your county has on the number of 'new' clients last year.  And if you have it, how many of those new clients were brand new clients?  You may need to ask your county mental health department for this data.**

* **Our system’s report writing capabilities are unable to distinguish between “new” clients “brand new” clients. Doing so would require a labor intensive process done by hand.**

**From January 1, 2013 through Dec 30, 2013 Kings View admitted 4318 consumers into treatment.**

# new children/youth  (0-17 yrs)  **1214**

of these, how many (or %) are ‘brand new’ clients \_\_\_\_\_

# new adults (18-59 yrs) **2834**

of these, how many (or %) are ‘brand new’ clients \_\_\_\_\_

# new older adults  (60+ yrs) **270**

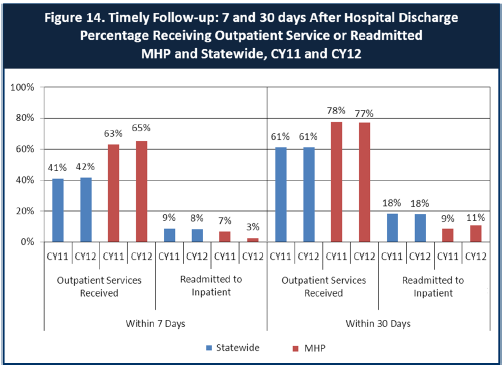
of these, how many (or %) are ‘brand new’ clients \_\_\_\_\_

REDUCING RE-HOSPITALIZATION: Access to Follow-up Care

Sometimes, an individual experiences acute symptoms of mental illness or substance abuse which can result in a brief stay in an acute care hospital.  Receiving follow-up services after discharge from a short-term (3-14 day) hospitalization can be critical to preventing a return to the hospital.

The chart below shows the percentage of people discharged in your county who received at least one service within 7 days of discharge. Also shown is the percentage of those same people who were readmitted to the hospital.  The chart also shows the same information for receiving services and being readmitted to the hospital within 30 days.  Red indicates the numbers for your county and the blue indicates the percentage for the state of California.

**Kings County**:



**6.  Looking at the chart, is your county doing better or worse than the state?  Discuss why (e.g., your county has programming available that specifically ensures a warm handoff for follow-up services).**

**YES. Kings County is doing better than the Statewide Average. Kings County MH Services provider is partnered with the Behavioral Health Recovery Support Coordinators (RSC’s). While providing case management for clients they provide for:**

* **Early re-engagement before a partner decompensates and needs to be hospitalized.**
* **Our partners are involved in Enrichment classes and Pride classes on a monthly basis which keep them connected to the case manager which also allows for them to be monitored in an informal way and partners trust that they can re-engage in services more readily.**
* **RCS’s make wellness checks (visits and phone calls) to clients that are no longer actively engaged in services and step in to re-engage when needed to avoid complete decompensation and re-hospitalization.**

**7. Do you have any suggestions on how your county can improve follow-up and reduce re-hospitalizations?**

**Currently Kings County uses Recovery Support Coordinators and Strength Based Assessment Program as well as Peer Specialist for continued client support and follow-up. Other options are:**

* **Ombudsmen program**
* **Peer Support Program modeled after Stanislaus County.**

**8. What are the three most significant barriers to service access? Examples:**

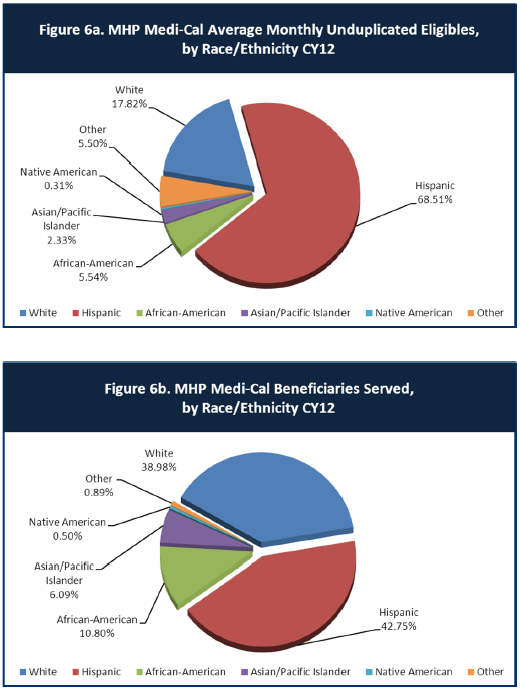
* **Transportation**
* **Child care**
* **Language barriers or lack of interpreters**
* **Specific cultural issues**
* **Too few child or adult therapists**
* **Lack of psychiatrists or tele-psychiatry services**
* **Delays in service**
* **Restrictive time window to schedule an appointment**
* **Kings County is highly rural and transportation is a significant barrier.**
* **Our threshold language is Spanish and we are in need of licensed LCSW’s and MFT’s.**
* **Delays in service caused by high demand and not enough licensed therapist.**
* **The need for pediatric psychiatrist.**
* **Availability of evening hours for services.**

##### ACCESS BY UNSERVED AND UNDER-SERVED COMMUNITIES

One goal of the Mental Health Services Act (MHSA) is to reach unserved and underserved communities, especially communities of color. The MHSA promotes outreach to engage these communities in services. If individuals and families in these communities are not accessing services, then we may need to explore new ways of reaching them. Or, we may need to change our programs to meet their mental health needs in ways that better complement their culture.

From data the counties report to the state, we can see how many individuals living in your county are eligible for Medi-Cal, and of those individuals, how many received mental health services. Are you serving the Medi-Cal clients who need your services?

**Kings County Data**:



**9. Is there a big difference between the race/ethnicity breakdown on the two charts? Do you feel that the group(s) that need services in your county are receiving services?**

**Yes there is a big difference. The data shows that all groups seeking services are receiving them at a rate almost double the eligible numbers except for Hispanic which was just explained. The shortage of licensed bi-lingual therapist plays a major part in the gap.**

**10. What outreach efforts are being made to reach minority groups in your community?**

**Our County is actively engaged in outreach and information dissemination. We use the Spanish radio and television as well as local billboards, newspapers and information booths at local events. This is done in all cities within the County.**

**11. Do you have suggestions for improving outreach to and/or programs for underserved groups?**

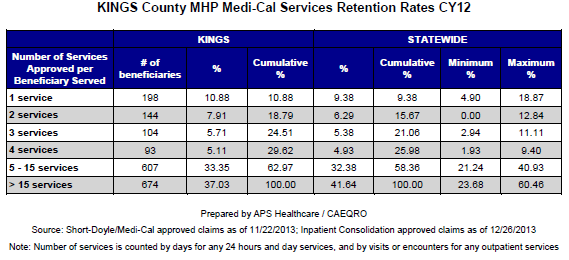
* **Continue to participate in rural city events.**
* **Training and stipend programs that help in recruiting bi-lingual/Spanish speaking Therapist.**
* **Continue supporting Workforce Education and Development to attract more of our own bi-lingual youth to be educated, trained and committed to staying in their community to work in the Mental Health / Substance Use field.**
* **More Therapists in the rural community.**
* **Integrated services between BH/MH services and Primary Care and reverse.**

##### CLIENT ENGAGEMENT IN SERVICES

One MHSA goal is to connect individuals to services they need to be successful. Clients who stop services too soon may not achieve much improvement, nor is it likely to last. So it is important to measure not only who comes in for treatment, but also how long they stay in services. Here we are considering individuals with high service needs, not someone who just needs a ‘tune-up.’ Although not every individual needs the same amount of services, research shows that when someone with severe mental illness continues to receive services over time, their chances of recovery increase.

Engagement in services, also called ‘retention rate’, is important to review. If individuals come in, receive only one or two services and never come back, it may mean the services were not appropriate, or that the individual did not feel welcome, or some other reason that should be explored. Again, we recognize that some individuals only need minimal services, but here we are looking at those with severe mental illness. Ultimately, the goal is to ensure they are getting needed services and are on the road to recovery. But we would not know that unless we look at how many services individuals received over time.

The chart below shows the number of Medi-Cal beneficiaries in your county who received 1, or 2, or 3, or 4, or 5, or more than15 mental health services during the year. For individuals experiencing severe mental illness, the more engaged they are in services, the greater the chance for lasting improvements in mental health.



**12. Do you think your county is doing a good job at keeping clients engaged in services? If yes, how? If not, why?**

**Yes, according to the data, the County is doing a good job; for the reasons reported about the reduction in re-hospitalizations. The relationship and use of Recovery Support Coordinators and Peer Supporters provides for quicker re-engagement and the use of the Strength Based model for case management appears to be making a difference.**

**13. For those clients receiving less than 5 services, what is your county doing to follow-up and re-engage those individuals for further mental health services?**

**It is not certain why clients with less than 5 services are disengaging. However the follow-up is done by Peer Support Specialist and Recovery Support Coordinators and they do a good job or re-engaging clients that have stopped services.**

**14. Looking at the previous chart of who is being served by race/ethnicity in your county, do you have any thoughts or ideas to share regarding your county’s engagement of underserved communities?**

**It is this Boards belief that our County services are good but that again the rural communities do have a transportation barrier and that because our County does have a problem recruiting bi-lingual/Spanish Licensed Therapists. However, the County is doing a lot to improve on that situation and continue to make great strides to servicing the underserved.**

CLIENT OUTCOMES: Consumer Perception Survey (August 2013)

Ultimately, the reason we provide mental health services is to help individuals manage their mental illness and to lead productive lives. We have selected two questions from the Consumer Perception Survey which capture this intention. One question is geared toward adults of any age, and the other is for children and youth under 18.

Below are the data for responses by clients in your county to these two questions.

For general comparison, statewide reference data for various sized counties are shown in the tables on page 19.

The total numbers of surveys completed for Adults or Children/Youth in your county are shown separately in the tables below, under the heading “**Total**.”

Q1. Adults. As a direct result of the services I received, I deal more effectively with daily problems.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Total |
| Number of Responses | 0 | 4 | 37 | 87 | 96 | 224 |
| Percent of Responses | 0 % | 1.8 % | 16.5 % | 38.8 % | 42.9 % | 100.0 % |

Q2. Children/Youth. As a result of services my child and/or family received, my child is better at handling daily life.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Total |
| Number of Responses | 1 | 1 | 19 | 36 | 22 | 79 |
| Percent of Responses | 1.3 % | 1.3 % | 24.1 % | 45.6 % | 27.8 % | 100.0 % |

**15. Is the data consistent with your perception of the effectiveness of mental health services in your county?**

**The data is consistent based on the number of surveys collected. However the Board does recognize that the survey numbers are low.**

**16. Do you have any recommendations for improving effectiveness of services?**

**The County is in the midst of it’s new MHSA 3yr plan and is working with partnering agencies to do a community needs assessment. It is our belief that we will have a much better picture as to the effectiveness of past services (compared to the perception survey) as well as a clearer picture of what our community needs are.**

**17. Many counties experience very low numbers of surveys completed. Do you have suggestions to increase the response rate?**

* **We will explore the use of Volunteers to take surveys the next time.**
* **Take the surveys to the schools**
* **Because clients are not always seen often enough to get the survey, it may be better to have CMHPC provide for a longer survey collection period.**

**18. Lastly, but perhaps most important overall, with respect to delivery of services, do you have suggestions regarding any of the following:**

1. **Specific unmet needs or gaps in services**

**Licensed Therapists**

1. **Improvements to, or better coordination of, existing services**

**Extended services for Crisis**

**Extended services in the rural communities**

**Extended hours for services in rural communities**

1. **New programs that need to be implemented to serve individuals in your county**

**Funding for homeless that is not contingent on the homeless person having some type of income**

**Rapid Rehousing**

**<END>**

REFERENCE DATA: for general comparison with your county MHP results





**County Mental Health Plan Size:** Categories are based upon DHCS definitions by county population.

o Small‐Rural MHPs = Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Plumas, Siskiyou, Trinity

o Small MHPs = El Dorado, Humboldt, Imperial, Kings, Lake, Madera, Mendocino, Napa, Nevada, San Benito, Shasta, Sutter/Yuba, Tehama, Tuolumne

o Medium MHPs = Butte, Marin, Merced, Monterey, Placer/Sierra, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Yolo

o Large MHPs = Alameda, Contra Costa, Fresno, Kern, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Ventura

o Los Angeles’ statistics are excluded from size comparisons, but are included in statewide data.

Total Values (in Tables above) = include all statewide data received by CiMH for these survey items.

**REMINDER:**

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for the following year. We welcome your input.

**Please submit your Data Notebook report by email to:**

[**DataNotebook@CMHPC.CA.GOV**](mailto:DataNotebook@CMHPC.CA.GOV)

**Or, you may submit a printed copy by postal mail to:**

* **Data Notebook Project**
* **California Mental Health Planning Council**
* **1501 Capitol Avenue, MS 2706**
* **P.O. Box 997413**
* **Sacramento, CA 95899-7413**

For information, you may contact either email address above, or telephone:

(916) 449-5249, or

(916) 323-4501



1. Serious Mental Disorder, term used for adults 18 and older. [↑](#footnote-ref-1)
2. Severe Emotional Disorder, term used for children 17 and under. [↑](#footnote-ref-2)