FY 16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Sacramento

Conducted on

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SACRAMENTO MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—19,996
- MHP Threshold Languages—Cantonese, Hmong, Russian, Spanish, Vietnamese
- MHP Size—Large
- MHP Region—Central
- MHP Location—Sacramento
- MHP County Seat—Sacramento

Introduction

Sacramento is a large-sized, central region county that includes the city of Sacramento. It is one of the most diverse counties in California, with Sacramento being the most diverse large city in the United Sates. The MHP headquarters are in Sacramento. Service delivery is provided utilizing 95 organizational providers and 57 legal entities.

During the FY 16-17 review, CalEQRO found the following overall significant changes, efforts and opportunities related to Access, Timeliness, Quality and Outcomes of MHP and its contractor services. Further details and findings from EQRO mandated activities are provided in the rest of the report.

Access

The MHP experiences capacity challenges, some which appear to be a result of the ACA influx of beneficiaries. During the past year the MHP increased contract provider contracts so as to be able to provide both more services and serve more clients. Sacramento delivers 92% of its services through contract providers. Outreach and services are targeted to the five threshold cultural and language sub-populations throughout the county. Sacramento has four health plans (soon to be six) and this creates a potential for significant confusion on where and how to access services from the consumer perspective.

Timeliness

The MHP struggles with timeliness and service engagement. The Clinical PIP endeavors to address timeliness and engagement as measured by client satisfaction. The Non Clinical PIP attempts to increase timeliness by allowing the ACCESS Team, through the use of the EHR scheduler tool, to offer an appointment during initial call requesting services.

Quality

The MHP has made progress on several indicators of quality throughout the continuum of care, yet some challenges remain. A Wellness and Recovery Model is present in all Systems of Care (SOC) in the MHP. The Co-Occurring Court addresses the increasing number of mentally ill defendants who also have substance use disorders. However, the transition from Specialty Mental Health to a

Moderate or Mild level of care with Geographic Managed Care Providers has had its challenges for maintaining timely access and integration of services.

Outcomes

Consumer voice is included through the Consumer Perception Survey data that are included in the MHP's Annual Dashboard Report. The Katie A Foster children program evaluates success placement/stable school placement and family reunification.

INTRODUCTION

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of Managed Care services. CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid Managed Care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

The State of California Department of Health Care Services (DHCS) contracts with fifty-six (56) county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year 2016-2017 (FY 16-17) findings of an EQR of the Sacramento (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **eight (8) Mandatory Performance Measures** (PM) as defined by DHCS. The eight performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.

- Count of TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs) during the 12 months preceding the review; Sacramento MHP submitted two PIPs for validation through the EQRO review. The PIP(s) are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES[3]

Utilizing the Information Systems Capabilities Assessment (ISCA) protocol, the EQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirement for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included review of the MHP's reporting systems and methodologies for calculating Performance Measures (PM).

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

The EQRO examined available consumer satisfaction surveys conducted by DHCS, the MHP or its subcontractors.

CalEQRO also conducted three 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

(5) KEY COMPONENTS, SIGNIFICANT CHANGES, ASSESSMENT OF STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT, RECOMMENDATIONS

The CalEQRO review draws upon prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

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[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for Key Components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders serve to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY15-16

In this section we discuss the status of last year's (FY15-16) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

In the FY15-16 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY16-17 site visit, CalEQRO and MHP staff discussed the status of those FY15-16 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
  - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY15-16

- Recommendation #1: Investigate communications and collaboration with Geographic Managed Care (GMC) to serve Medi-Cal beneficiaries with "mild" to "moderate" mental health impairments, as well as receive referral from them of "seriously mentally ill" (SMI) beneficiaries.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP is a member of the monthly local GMC meetings. Sacramento is a GMC county with four (soon to be six) GMC plans, primary care clinics, providers and multiple health stakeholders.
- The MHP also attends the GMC Coalition Meeting, hosted by Molina. Multiple system partners provide pertinent updates such as DHCS, Sacramento DHHS Primary Care and the MHP, Health Care Options, Department of Human Assistance, California Regional Center and the Managed Care Plans.
- The MHP is actively reviewing screening and referral tools with the intent to establish a single tool for Sacramento.
- The MHP is reviewing level of care tool used in other counties to establish a single tool for Sacramento.
- An Operational Guide developed in collaboration between MHP and the GMC's is pending final approval by the GMC's. This tool was developed with key contact information for the purpose of assisting MHP and GMC providers in their coordination of care efforts.

- Recommendation #2: Implement Medicare Part B production billing as soon as practical.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- Prior to billing Medicare Part B, Sacramento County must implement client billing for share of cost, Uniform Method of Determining Ability to Pay (UMDAP)/self-pay and co-pay.
- There are several activities that the MHP has worked on in the past year to prepare for implementing Medicare Part B billing:
  - Set up and test EHR system data clean up, development of client billing
  - Development of Quality Management and Fiscal policies and procedures relating to client billing.
  - Development of FAQs for providers and clients regarding client billing.
  - In November 2015 all providers were notified of change in billing procedures and anticipated client billing.
  - In November/December 2015 a letter was mailed to MHP clients informing them of an upcoming change in billing procedures and providing assurances that the change would not impact the services they are currently receiving.
  - The MHP met with Medicare representative to discuss on-line registration of clinicians and staff into the Medicare system. QM continues to track clinician registration and provide technical assistance to providers/clinicians as needed.

        - ▷ Development of training material for providers and staff involved in client billing.
    - It is currently projected that client billing will be implemented in January 2017 and the MHP will begin Medicare Part B billing shortly thereafter.

- Recommendation #3: Explore ways to implement flexibility in the centralized Access Unit function and staffing to improve access and timeliness.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

    - The MHP has initiated a variety of activities to improve the centralized Access functions and staffing in the past two years.
    - In August of 2015, the MHP began cross training child and adult clinical activities. At this time all staff and new hires are able to process any request that comes through Access regardless of age of person for whom services are requested.
    - The Access clinical staff starting in April 2016, began using the call center feature, which allows for tracking of volume and provides data to improve processes.
    - The MHP has begun a Non-Clinical PIP which will utilize electronically scheduling appointments for consumers during their initial contact with Access to improve timeliness to initial appointment.

- Recommendation #4: Explore further opportunities to improve access and timeliness, such as mobile crisis teams to local law enforcement, peer navigator program to improve linkage with hospital and outpatient services, and Community Care Team to support the four regional service support teams.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

    - Mobile Crisis Team Expansion: The addition of two additional teams to serve a broader area of Sacramento and increase the number of individuals served is pending approval by the Board of Supervisors. This expansion, due to be completed in this fiscal year, will include two additional Senior Mental Health Clinicians and three additional peer staff.
    - The new respite programs provide immediate access and supports. This includes Gender Health Center, TLCS Crisis Respite Center (serves all ages), Saint John's Program for Real Change, Turning Point Abiding Hope, Wind Youth Services, Capital Adoptive Families Alliance, Del Oro Caregiver Resource Center, Sacramento LGBT Community Center and Church for All.
    - The MHP facilitates a monthly Inpatient Outpatient Care Coordination meeting. The meeting includes representations from acute psychiatric hospital staff, outpatient community service providers, Consumer and Family Advocates and MHP Access Team and Quality Management Team staff. The purpose of the

meeting is to provide a forum to discuss care coordination and methods to streamline access to services.

- The current Clinical PIP is tracking the implementation and impact of the Community Care Teams (CCT) on access and timeliness to services at Regional Support Teams (RST) Outpatient Programs.
- Four new Crisis Residential Programs increase capacity from 12 to 72 beds. There is a special focus on co-occurring, Transitional Aged Youth (TAY) populations and a Rapid Response program to assist with the Emergency Department overcrowding.

- Recommendation #5: Complete implementation of the full spectrum of timeliness data elements including tracking "no-shows" and cancellations, tracking time to urgent services, and tracking time of first offered appointment.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - No-show data has been incorporated into the MHP quarterly timeliness reports.
  - Additional codes to define "no-show" have been added to the EHR. There are now codes for client no-show, staff no-show, client cancellation and staff cancellation.
  - Urgent requests are tracked on the service request and have been incorporated into the MHP quarterly timeliness reports.
  - The MHP developed a PIP that includes a process for first offered appointment. Upon completion of this PIP and following any adjustments needed, the use of the scheduler tool in the EHR will be rolled out into the system for the Access Team to utilize when consumer first contacts requesting services.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality, including those changes that provide context to areas discussed later in this report.

- Access to Care
  - Through California Health Facilities Financing Authority (CHFFA) funding, Turning Point Community Programs (TPCP) has created a new Crisis Residential Program in Rio Linda. This will expand the number of crisis residential beds in Sacramento County from 12 to 27. The program is expected to open for services to clients in August 2016, pending final certification.
  - Operated by Transitional Living and Community Support Inc. (TLCS), Triage Navigator Program provides triage, recovery-focused crisis intervention, peer

support, system navigation services, and linkages to community services and supports. This program serves all ages experiencing a mental health crisis. Triage/Peer Navigators provide services at Sacramento County Main Jail, Loaves and Fishes Campus, some local hospitals and emergency rooms. There are plans for more points of access at local hospital Emergency Departments.

- Timeliness of Services
    - Regional Support Teams (RST), who serve adults, have implemented Community Care Teams (CCT) to enhance engagement and timely access to RSTs using culturally and linguistically competent services.
    - The MHP has developed a Non-Clinical PIP, currently active, to address electronically scheduling appointments for consumers during their initial contact with the Access Team in order to decrease the wait time of first offered appointment.
- Quality of Care
    - The Sacramento Superior Court received a Judicial Council of California Recidivism Reduction grant to more effectively address the increasing number of mentally ill defendants who also have a substance use disorder cycling through the courts and jails. The newly formed co-occurring Mental Health court (COMHC) is a collaboration between the Sacramento Superior Court, Public Defender's Office (PD), District Attorney's Office (DA), Sacramento County Department of Health and Human Services (Division of Behavioral Health Services and Alcohol and Drug Treatment Services), and the Probation Department's Adult Community Corrections Division.
    - The Board of Supervisors (BOS) authorized expansion of the Juvenile Justice Diversion Treatment Program. This Full Service Partnership (FSP) expansion supports the diversion of youth into mental health treatment to avoid formal probation involvement when possible and to remain in their homes, schools and communities. These diversion services also support collaborative initiatives currently underway with Probation and Child Welfare partners. Examples include the Crossover Youth Practice Model and Title IV-E Waiver goals.
    - The BOS approved using MHSA Prevention and Early Intervention (PEI) funds to sustain an additional five crisis respite programs through June 30, 2017. This means that for Sacramento County, with the six programs already approved for sustainability, there are 11 operational crisis respite programs.
    - In May, 2015, the hours of operation of the pilot Law Enforcement Consultation Line extended their hours from 8 a.m. – 4 p.m. Monday – Friday to 8 a.m. to 8 p.m. Monday to Friday, allowing further ISU staff triage and disposition recommendations involving individuals with experiencing a mental health crisis.
- Consumer Outcomes

- The two-phase SMART Medical Clearance Pilot began Phase 2 in May 2016. This is a collaborative effort among UC Davis Medical Center's ER and the local inpatient psychiatric hospitals to streamline the medical clearance process for patients with prior mental health issues who would unlikely benefit from laboratory testing prior to their admission to inpatient psychiatric hospitalization.
- The BOS authorization of increased capacity at the TLCS New Direction FSP supports the provision of mental health service to an additional 64 homeless clients on an annual basis.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following PMs as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

TOTAL BENEFICIARIES SERVED

Table 1 provides detail on beneficiaries served by race/ethnicity.

Table 1—Sacramento MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	107,779	6,863
Hispanic	94,815	3,269
African-American	70,073	4,418
Asian/Pacific Islander	75,755	1,571
Native American	3,173	226
Other	72,079	3,649
Total	423,673	19,996

**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

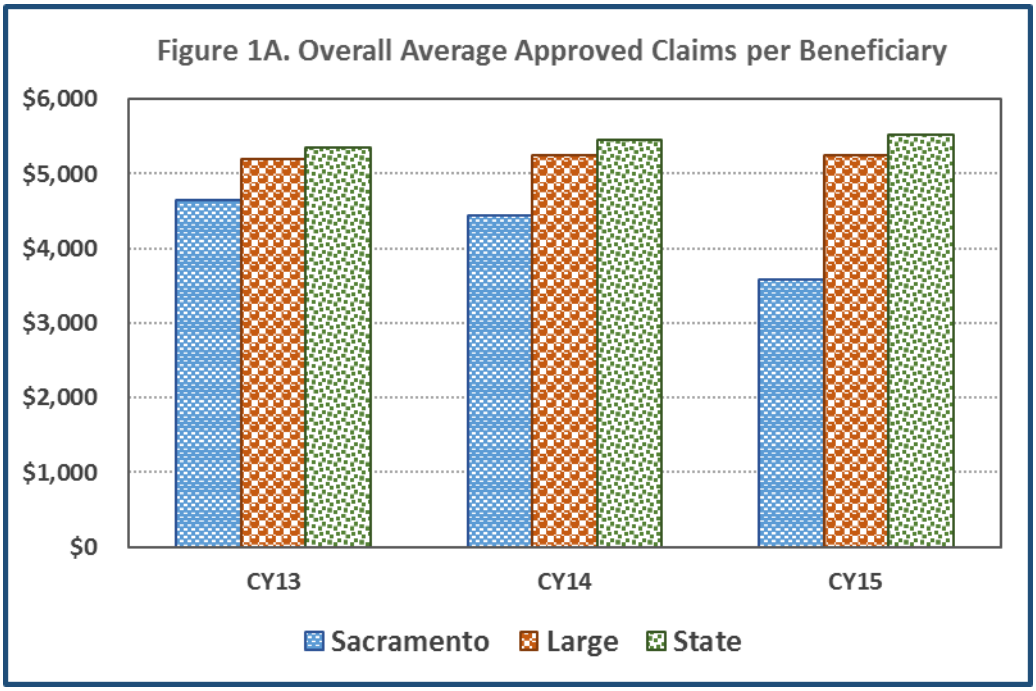
Regarding calculation of penetration rates, the Sacramento MHP:

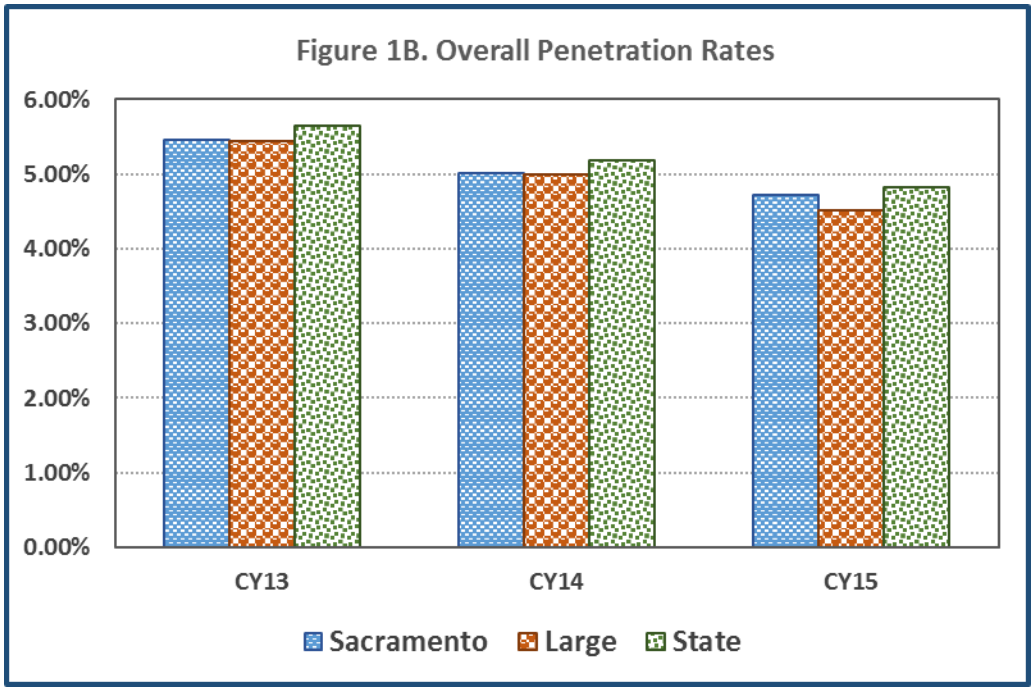
☐ Uses the same method as used by the EQRO

☒ Uses a different method: EQRO data is used to determine unduplicated Medi-Cal beneficiaries. An unduplicated count of all Medi-Cal eligible consumers regardless of claim status or mode of service is used to determine beneficiaries served.

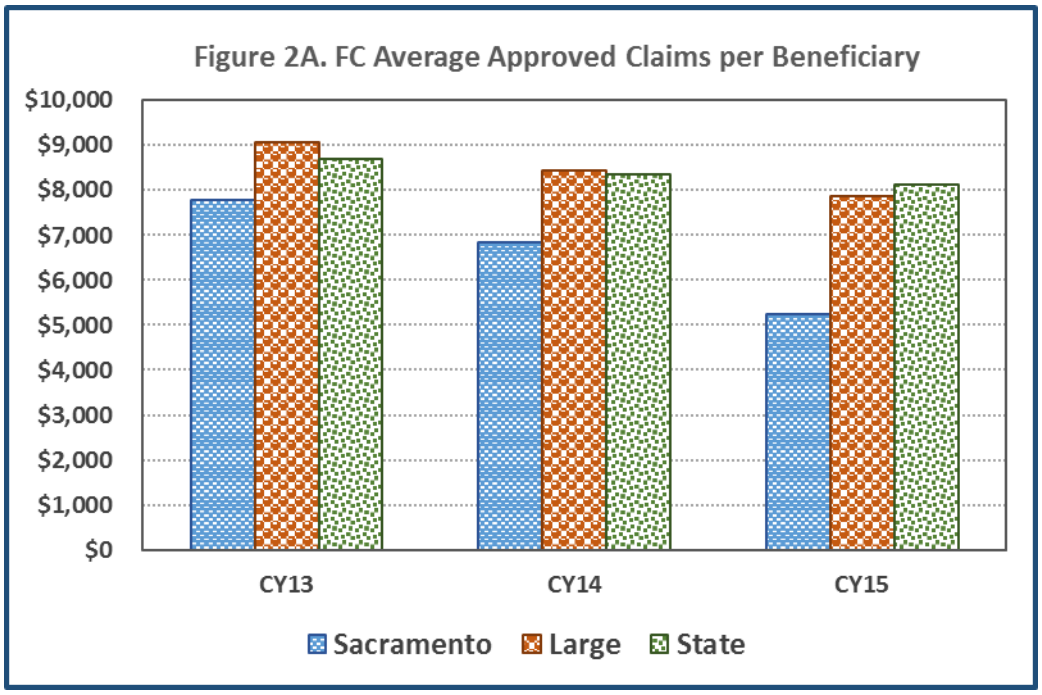
☐ Does not calculate its' penetration rate.

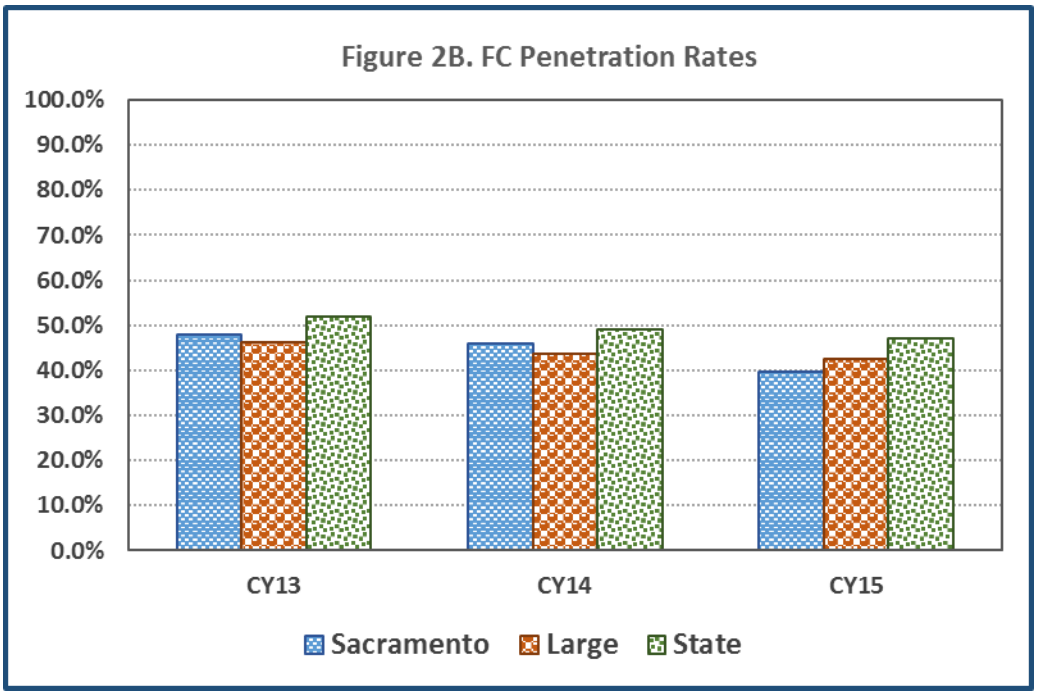
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



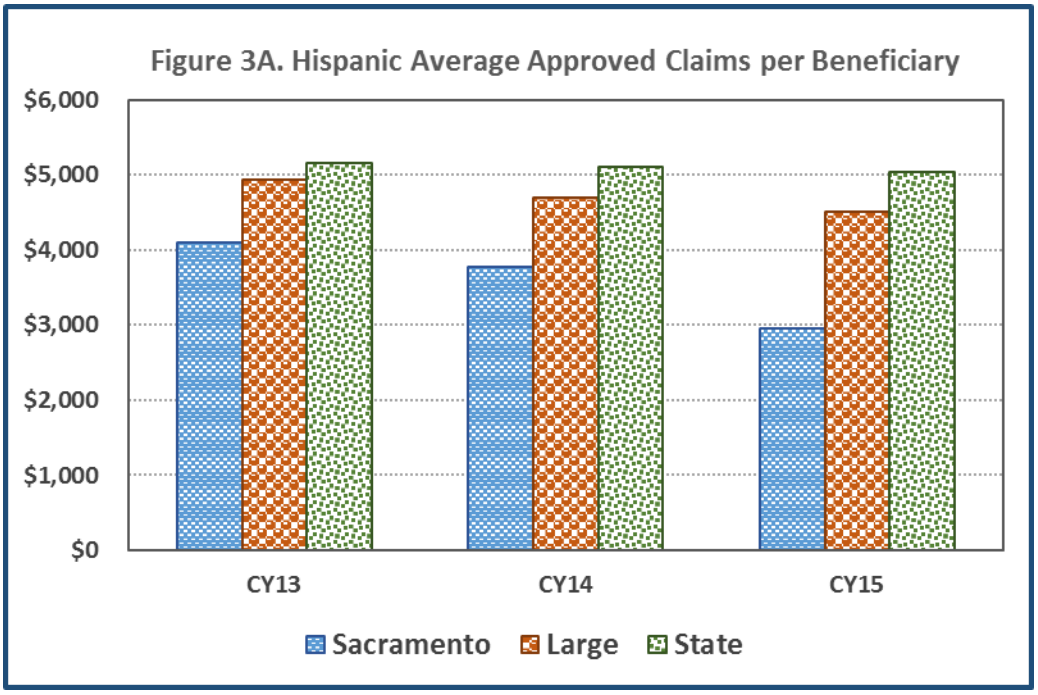


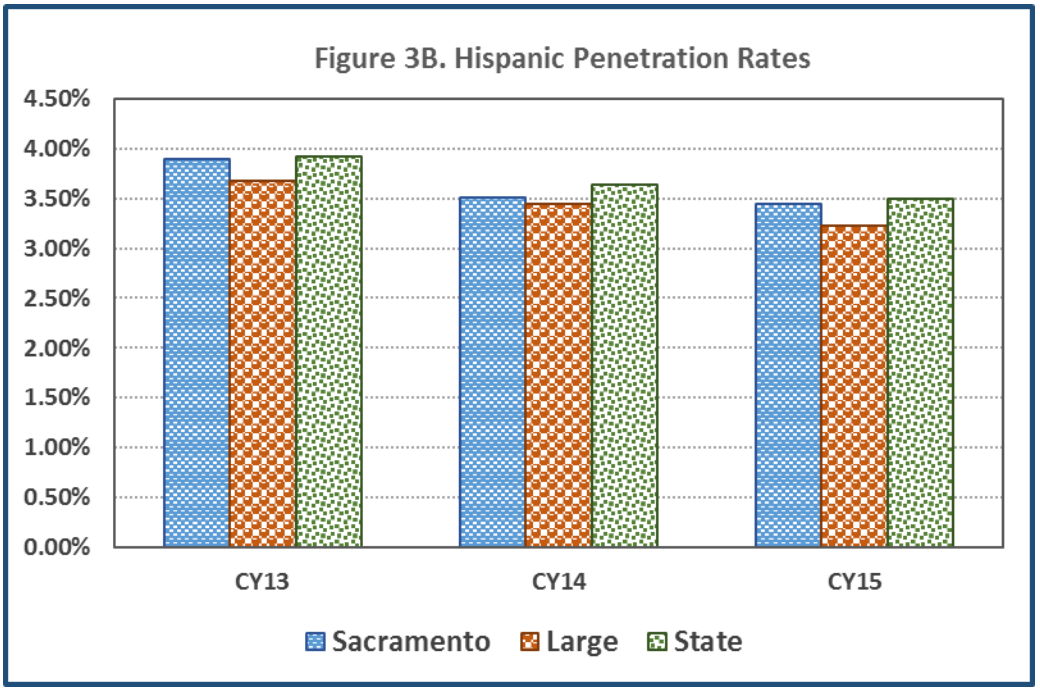
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





Figures 3A and 3B show 3-year trends of the MHP's Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





HIGH-COST BENEFICIARIES

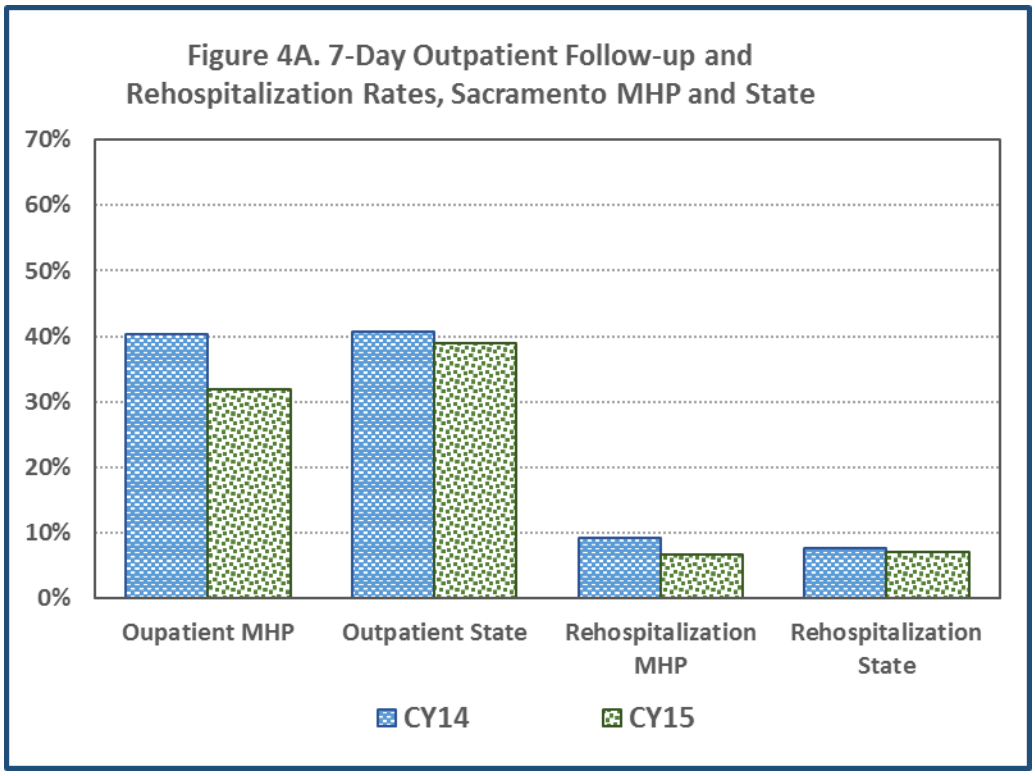
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than $30,000 in a year.

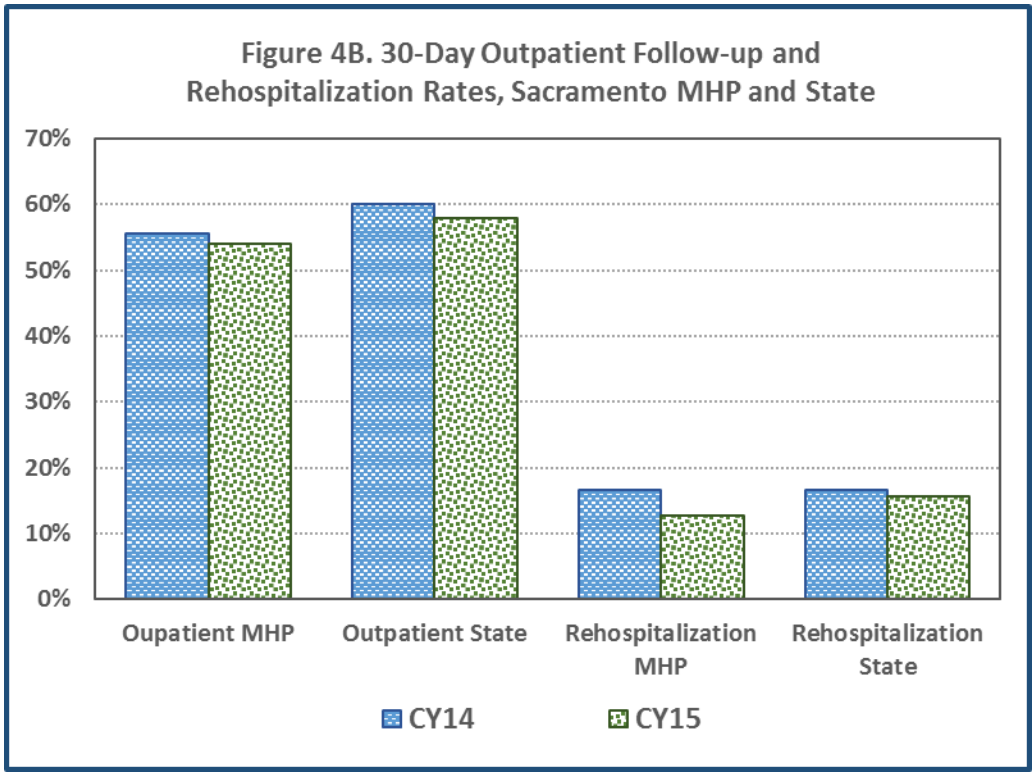
Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
Sacramento	CY15	241	19,995	1.21%	$44,562	$10,739,322	14.98%
	CY14	250	20,151	1.24%	$42,987	$10,746,759	12.74%
	CY13	326	19,746	1.65%	$45,084	$14,697,284	16.01%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY14 and CY15.

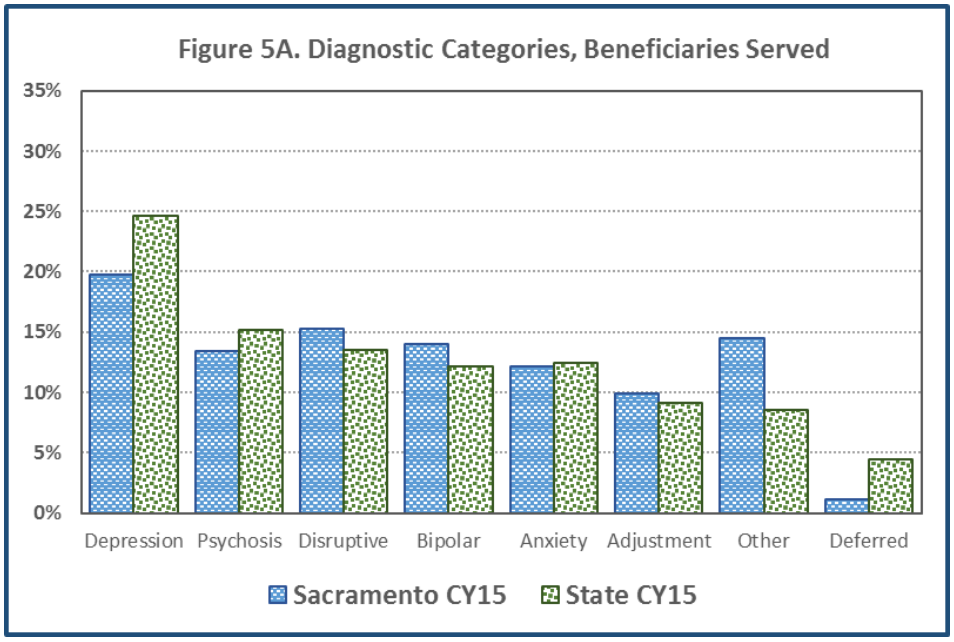


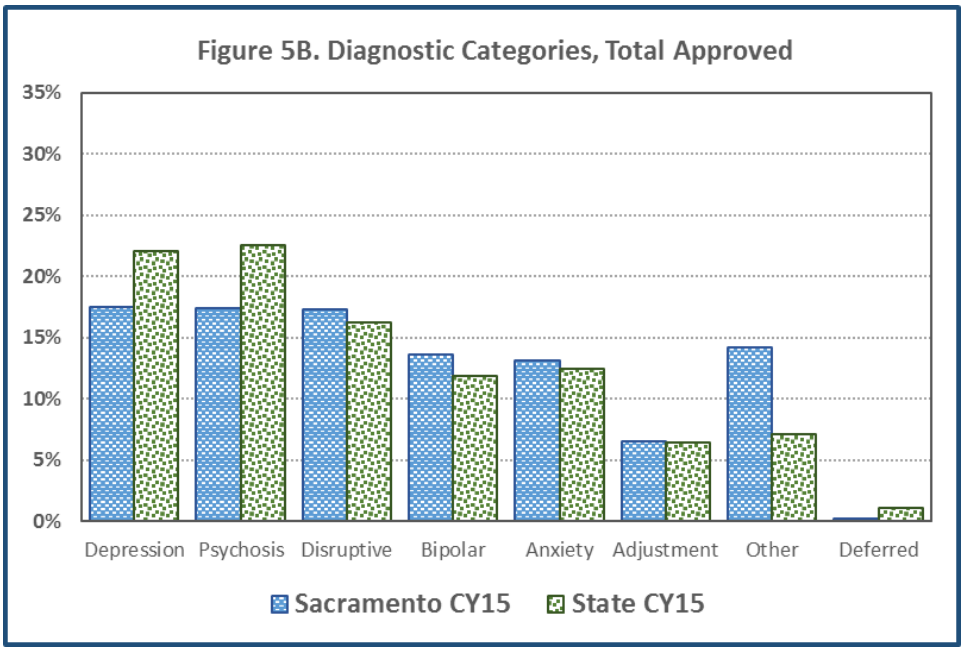


DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY15.

- MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 27.0%





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Due to technical difficulties during the SDMC claims adjudication processing, approximately 42,000 claims were approved for zero dollars. As a result the approved claims dollars used to calculate Figures 1A, 2A, 3A and Table 2 underreports average approved claims per beneficiary for CY15.

- The overall penetration rate has decreased from 5.64% for CY13 to 4.72% for CY15. This is similar to the statewide trend.
- The MHP's had a comparatively low percent of High Cost Beneficiaries (HCB) receiving more than $30,000 in services compared to the statewide average (1.21% versus 2.86% statewide). The resulting lower percent of total claims for HCB (14.98% versus 26.96% statewide) as well as the MHP's higher percentage of beneficiaries with total claims less than $20,000 (74.83% versus 61.20%), as shown in Table C2, were likely a contributing factor in the relatively low average approved claims rate.

- Timeliness of Services
  - Although the percent of MHP follow up visits were slightly less than the statewide averages for the 7-day and 30-day measures, the MHP rehospitalization rates remain below the statewide averages.
- Quality of Care
  - The MHP percentages of services by diagnostic category are lower than the statewide averages for depression and psychosis, but higher for disruptive, bipolar, and other. The rates for anxiety and adjustment are very close to the statewide averages.
  - The percent of claim amounts by diagnostic category follow the percentage of occurrence fairly closely.
  - The comparatively lower rates of services and expenditures for the major disorders of depression and psychosis raise some concern that that individuals in those categories may be underserved.
  - The MHP's relatively low percentage and average claims for HCB, as compared to the statewide averages, are indicators of effective interventions for seriously impaired beneficiaries.
- Consumer Outcomes
  - Performance measure data for consumer outcomes was not evaluated.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2015.

SACRAMENTO MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed and validated two MHP submitted PIPs as shown below.

Table 3A—PIPs Submitted

PIPs for Validation	# of PIPS	PIP Titles
Clinical PIP	1	Improving Timely Access to Outpatient Services
Non-Clinical PIP	1	Implementing a Streamlined E-Scheduling Tool to Increase Timeliness to 1st Offered Appointment

Table 3B lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

Table 3B—PIP Validation Review

Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M

[4] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

Table 3B—PIP Validation Review					
				Item Rating*	
Step	PIP Section	Validation Item		Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	n/a	UTD
		5.2	Valid sampling techniques that protected against bias were employed	n/a	UTD
		5.3	Sample contained sufficient number of enrollees	n/a	UTD
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	PM
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	PM	PM
		6.6	Qualified data collection personnel	M	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	M	n/a
		8.2	PIP results and findings presented clearly and accurately	PM	n/a
		8.3	Threats to comparability, internal and external validity	PM	n/a
		8.4	Interpretation of results indicating the success of the PIP and follow-up	PM	n/a
9	Validity of Improvement	9.1	Consistent methodology throughout the study	PM	n/a
		9.2	Documented, quantitative improvement in processes or outcomes of care	PM	n/a

Table 3B—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		9.3	Improvement in performance linked to the PIP	PM	n/a
		9.4	Statistical evidence of true improvement	PM	n/a
		9.5	Sustained improvement demonstrated through repeated measures.	PM	n/a

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine*

Table 3C gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 3C—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	16	14
Number Partially Met	9	2
Number Not Met	0	3
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	19
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	82%	78.95%

CLINICAL PIP—IMPROVING TIMELY ACCESS TO OUTPATIENT SERVICES

The MHP presented its study question for the clinical PIP as follows:

- "Does creating a Care Coordination Team with strategies to engage and provide timely access to outpatient services increase overall client satisfaction?"
- Date PIP began: July, 2015
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

The Sacramento MHP has historically struggled with timeliness and service engagement. This PIP attempts to address and correct these issues. Review of timeliness data provided enough information to demonstrate that timeliness to services is a current issue for Sacramento County MHP. It was also recognized that timeliness to service is impacted by numerous barriers including capacity, staff shortages, and lack of engagement prior to services. During Fiscal year 2015-2016 the PIP committee met quarterly and updates to the Performance Indicators were reviewed. Barriers noted in implementation included: Difficulty hiring and fully staffing the Community Care Teams until October 2015; Consumers discharged from the hospital prior to contact were more difficult to engage; New referrals continued to increase at all RSTs which impacted staff availability; Increased referrals and engagement of consumers impacted timeliness to medication appointments due to lack of additional doctor availability. Adjustments and new interventions as a result of identifying barriers were implemented July 1, 2016. The MHP has decided to continue the PIP for another year to assess the results of these Interventions. Interventions added or changed: 1) Intervention #4 adjusted time for CCT staff to call consumer within 6 days of access opening episode. 2) Intervention # 12 changed protocol that instead of consumer receiving a letter confirming an appointment and asking them to call RST staff that they will receive a letter confirming appointment and CCT staff will call consumer. It is hoped these two changes will increase effectiveness and positive outcome of this PIP.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of the offer to discuss how to track data with new interventions, redesign interventions, and analyze results in a useful manner. An ongoing TA plan between EQRO reviews was discussed.

NON-CLINICAL PIP—IMPLEMENTING A STREAMLINED E-SCHEDULING TOOL TO INCREASE TIMELINESS TO 1ST OFFERED APPOINTMENT

The MHP presented its study question for the Non-Clinical PIP as follows:

- "Will the practice of electronically scheduling appointments for consumers during their initial contact with the MHP decrease the wait time to first offered appointment and improve the likelihood that the consumer attends the initial appointment?"

- Date PIP began: February, 2016 designed with study begun July 1, 2016

- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ Submission determined not to be a PIP

  ☐ No PIP submitted

Prolonged wait times by consumers to access of care have been a problem and concern across Sacramento County MHP Systems of Care (SOCs). This PIP attempts to address this issue by allowing ACCESS Team, through the use of the EHR scheduler tool, to offer an appointment during initial call requesting services, and to notify the provider who needs to contact the perspective client within 24 hours. The interventions in this PIP aim at changing the current business process used to schedule first appointments through the use of the EHR Scheduling module.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of agreement between EQRO and MHP that follow up and update for purpose of technical assistance will occur quarterly as needed.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The Non-Clinical PIP has the goal of improving the way the MHP and its contract providers schedule first appointments when a consumer contacts the ACCESS Team. .
  - The Clinical PIP seeks to improve timely access to outpatient services due to the use of the Care Coordination Team (CCT)within the Regional Support Teams (RST)
- Timeliness of Services
  - The goal of the Non-Clinical PIP is to reduce consumer wait times to first appointment following service request through the ACCESS line.
  - The Clinical PIP examines the effect of a CCT within each RST insofar as reducing wait times to Outpatient Mental Health services.

- Quality of Care
    - Both PIPs attempt to address an issue cited in the that long wait times to access psychiatric services can attribute to worsening existing mental health problems..
    - Engagement, used as a proxy of quality, is measured in the Clinical PIP.
- Consumer Outcomes
    - The clinical PIP measures client satisfaction by scores on the General Satisfaction domain of the Consumer Perception Survey (CPS) for RST clients meeting Performance Indicator #1 (face to face service) and those who do not meet this Indicator.
    - The Non-Clinical PIP does not measure consumer satisfaction per se; however it does track and measure "Problem resolution – grievances related to timeliness" – Intervention #5 and "Engagement in Services" – Intervention #6 as proxies.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below.

Access to Care

As shown in Table 4, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 4—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	90+% of MHP's providers are contractors, inclusive of many culturally-specific providers - La Familia and River Oaks programs are examples of culturally competent service delivery. Six threshold languages addressed at ACCESS center along with translators/language line available as needed and for other languages. Working with incompetent to stand trial.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	During past year the MHP increased contract provider contracts to provide more services and serve more clients to address capacity issues.
1C	Integration and/or collaboration with community based services to improve access	FC	Sacramento County MHP has four Health Plans and nine local Emergency Departments in various hospitals with which they coordinate varying and complex access and timeliness issues. The Director and senior staff hold a monthly meeting to engage Plan leadership and hospital leadership to discuss important policy issues and directions such as Health Homes and Whole Person Care, but by design with four (soon to be six) health plans and those subcontracting to numerous medical groups there is potential for consumer and case manager confusion and fragmentation. Outreach and services are targeted to cultural and language sub-populations through the county.

**FC =Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

Timeliness of Services

As shown in Table 5, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 5—Timeliness of Services

Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	PC	Wait time from initial contact to first service is not tracked. A PIP has been initiated to allow tracking to first offered appointment. Wait times from opened to OP Provider by Access to first appointment standard is 14 days and CY2015 average is 17.1 for children and 37 for adults. Target met 51.2% of time for children and 28.1% for adults respectively.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP has difficulty tracking time to first psychiatric appointment because of fact that child/adolescent clients are not always assessed to have need of a psychiatrist at the start of services. Wait times from opened to OP Provider by Access to first psychiatric appointment standard is 28 days and CY2015 average is 57.1 for children and 56.2 for adults. Target is met 27.9% of time for children and 28.1% for adults respectively.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	Wait times for urgent conditions have been added to the Quarterly Benchmark Report. A 3 day goal has been established for referral to a provider for urgent conditions. In FY15/16 2nd Quarter average is 6 days for children and 4.3 days for adults; meeting target 48.4% of time for children and 64.9% for adults respectively. An "Urgent' checkbox has been added to the Service Request Form. Urgent request is defined as – Imminent risk of danger to self/danger to others/hospitalization or incarceration; hospital discharges.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	Follow up service post discharge from hospital is a 7 days standard. Average is below 30 days. In 2nd Quarter FY15/16 average is 12.5 for children and 22.9 for adults; meeting target 62% of time for children and 42% for adults.
2E	Tracks and trends data on re-hospitalizations	FC	The MHP continues to track hospital recidivism within 30 days. Recidivism rates for FY14/15 was16.8%, with 17.7% for adults and 9.4% for children respectively. 65% of these returned only one time to inpatient admission. The MHP does an extensive data analysis of hospital recidivism trends (i.e. tracking 30-day recidivism by

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
			hospital, age, race/ethnicity, total number of readmissions a year and total number of hospital days for readmission).
2F	Tracks and trends No Shows	FC	The MHP began tracking No-Shows in July 2015. Codes have been added for cancelations by staff and consumers. No- shows for 2nd Quarter FY15/16 were overall 14.9% for children and 13.2% for adults. Tracking is reported for adult and children but broken out separately for clinical and medical staff.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

Quality of Care

As shown in Table 6, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	PIPs are in process to address improvement in timeliness. Some contractors did not seem aware of the breath and diversity of activities in their areas, so more education is needed and perhaps special reports linked to their contract in key areas to further engage them.
3B	Data are used to inform management and guide decisions	FC	Staff reported use of CANS, LOCUS, POQI, ACES and Satisfaction Surveys. The MHP produces reports to include Quarterly Dashboard Summary Report; the Child and Adolescent Needs and Strength (CANS) Annual Report and others for use in program planning and development.
3C	Evidence of effective communication from MHP administration	FC	In a variety of staff focus group settings it was endorsed that they are aware of communications of standards and program changes etc. from administration.
3D	Evidence of stakeholder input and involvement in	FC	MHP staff, consumers and contractors all reported participation in a variety of MHP committees.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
	system planning and implementation		
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	91+% of the MHP's services are provided through contract providers who represent a broad spectrum of the county's community based organizations. The Triage/Peer Navigator and Community Care Teams (CCTs) within their Regional Services structure has helped in facilitating this complex system for clients.
3F	Evidence of a systematic clinical Continuum of Care	FC	The MHP uses CANS, AVS, LOCUS, POQI and other satisfaction surveys for feedback on client needs, satisfaction and Level of Care (LOC). The difficulty in timeliness of transition from Specialty Mental Health to a Moderate or Mild level of care due to capacity issues of the Managed Care entities creates barriers for some beneficiaries in accessing appropriate level of care.
3G	Evidence of individualized, client-driven treatment and recovery	FC	Wellness and recovery model is present and understood by staff and consumer/family members. More focus on this and understanding of the model by both staff and CFMs would be useful.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP values clearly promoted wellness and recovery and significant presence of family and consumers in programs, especially contractor programs. There was family and consumer education. Staff at a variety of locations felt even more would be beneficial.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	MHP has no designated CFM positions, however they are widely used within contractors' programs (90+% of services). Consumers endorsed consumer run and driven programs within the system of the MHP and contract providers.
3J	Measures clinical and/or functional outcomes of consumers served	FC	The Non-Clinical PIP addresses outcomes across the Systems of Care (SOCs). The Katie A Foster children program evaluates success placement/stable school placement and family reunification. The MHP is tracking successful levels of care in youth.
3K	Utilizes information from Consumer Satisfaction Surveys	FC	Consumer Perception Survey data continues to be included in the MHP's Annual Dashboard Report. Aggregate consumer responses are compared for most recent four years.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The Homepage of the MHPs website is in English only. Even though there are no legal requirements for translation of a website home page, the MHP provides enhanced language access on its webpage through the use of a translation program.
    - The MHP is aware of caseload demands and, at times, Access Call Center is asked to redirect referrals from providers that are over capacity to those providers with available capacity.
    - MHP staff are encouraged to document the problems they were having with case transfers to the health plan medical groups for medications and therapy for mild to moderate cases and share them with upper leadership within the MHP.
- Timeliness of Services
    - The MHP has developed a Non-Clinical PIP to address electronically scheduling appointments for consumers during their initial contact with the Access Team in order to decrease the wait time of first offered appointment.
    - The MHP has developed a Clinical PIP, currently active, to address providing timely access to outpatient services through engaging a Care Coordination Team within the Regional Support Teams to contact and facilitate intake appointments for consumers.
    - Clinical staff report some difficulty in obtaining inpatient admission/discharge status of their clients in a timely manner.
- Quality of Care
    - The MHP staff is made aware of access, timeliness, and quality issues via staff meetings, email and website.
    - Various contract provider consumer volunteer/employees stated they felt valued in their place of work, but lacked voice at the executive level.
    - There is a need for increased coordination and collaboration with key Federally Qualified Health Centers (FQHC) and Medi-Cal primary care clinics so they will take the referrals that are needing medication within timely standards.
- Consumer Outcomes
    - The Katie A foster children's program utilizes two domains as indicators of successful outcomes for clients: 1) Successful family reunification or foster care placement out of group homes, and 2) Stable school placement without need of special education placement.

- The issues with capacity of health plans in relation to accepting clients moved to the Moderate to Mild level of care (LOC) require coordination to ensure medication availability until first appointment at the new LOC provider.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted three 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested three focus groups with 8 to 10 participants each, the details of which can be found in each section below.

The Consumer/Family Member Focus Group is an important component of the CalEQRO Site Review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. There were ten participants in this group, nine women and one man. Eight participants were ages 25 – 59 and two were over 60 years of age. Seven participants preferred English language and three preferred Spanish. Participants self-identified race/ethnicity as three Caucasian, four Hispanic/Latino, two African American/Black and one as Asian American/Pacific Islander. Three were grandparents who had care responsibility/legal guardianship for one or more grandchild. One was in the process of adopting two foster children she had received when their mother/a friend lost custody of them. Six were parents of children or youth receiving services. This group was held at Turning Point FIT, 7245 E. Southgate Dive, Sacramento, CA 95823.

Number of participants – 10

For the 3 participants *who entered services within the past year*, they described their experience as the following:

- The process of access to services was described as timely and none had encountered any barriers to access in services.
- All three participants described the services as useful and helpful to their children and the family as a whole.
- One participant stated transportation was sometimes an issue in receiving services. It was not always possible to make appointments when scheduled.

General comments regarding service delivery that were mentioned included the following:

- The participants reported that all of the children in question were receiving therapy and some were prescribed medication.
- None of the participants were receiving, nor aware of the option for therapy, for the parents/caretakers.
- The participants did endorse availability of parenting classes offered at CAPs. Six of the participants reported they had attended these classes and found them useful.
- All of the participants endorsed that they were able to obtain services in their preferred language and felt their specific culture was understood and appropriately addressed within the services they received.
- Two participants had children who had been hospitalized in the last year. Both described the service and information they received as a positive experience.
- None of the participants were familiar with NAMI or what it might offer for them.
- All participants were aware of, and a few had become involved in, various committees and/or opportunities to give feedback on services.

Recommendations for improving care included the following:

- Participants all agreed that there was a need for more providers and time slots for services.
- Several participants voiced concern that most appointment availability was during school hours, which disrupts the child's routine. They would like more appointment slots after regular school hours.
- The participants would like information provided in writing on the care available and what to expect for their children when they enter services.
- There was a request by the majority of participants for more support for the family as a whole unit.

Interpreter used for focus group 1: ☐ No ☒ Yes Language(s): Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

CalEQRO requested a culturally diverse group of adult beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. There were eleven participants in this group, seven women and three men and one participant who declined to state a gender. Ten participants identified as consumers and one as a consumer and family member. Nine participants were ages 25 – 59 and two were over 60 years of age. Ten participants preferred

English language and one identified on the demographic form as bilingual without stating any languages. Participants self-identified race/ethnicity as seven Caucasian, two Hispanic/Latino, one African American/Black and one as Native American. This group was held at Visions Unlimited, 6833 Stockton Blvd. Suite 485, Sacramento 95823.

Number of participants – 11

For the two participants *who entered services within the past year*, they described their experience as the following:

- The wait time from first request for services to first psychiatrist appointment was approximately three months.
- Both endorsed being involved in their own individualized care planning.

General comments regarding service delivery that were mentioned included the following:

- All participants see a psychiatrist, eight every four months, and three every three months.
- The participants agree they can see their psychiatrist sooner, if the need arises.
- The warm line 9 am to 5 pm Monday through Friday, as well as a respite center hotline, were both known to all participants as available for them to receive support.
- Only two participants stated that their primary care doctor had communication with their psychiatrist.
- TLCS was mentioned by several as very responsive to their needs.
- Ten participants have case managers, some of whom are peers, and almost all have individual therapists/clinicians.
- Nine participants attend groups which they find even more useful than individual therapy.
- Four participants spoke about having a Psychiatrist change (not by request) and sometimes more than once in the past year.
- Transportation is voiced as a problem for all the participants in accessing services.
- The new location of the Wellness Center in Lincoln Village is found to be difficult by most to access. For some participants it can take one light rail and three buses to get there.
- Several have attended advisory oversight and town hall meetings and have given input.
- Most state they have felt stigma in general of being homeless as well as from the police in the past year more than once.

Recommendations for improving care included the following:

- The majority of the participants would like better timeliness with psychiatrist turn-around of disability paperwork.
- The group all stated that services are more difficult to schedule this past year, and they would like an increase in contracted providers to expand capacity.
- The group agreed they would like better communication between the psychiatrist and primary care doctor, as well as only one blood test to serve for both.
- All would like better communication with provider offices and more availability of crisis stabilization.
- Housing is an issue and specifically the group would like general housing increases and handicap housing availability.
- All agreed more mental health services are needed for the many in the community who have no access at this time.
- The group endorsed that they would benefit from a clear description of the continuity of care within clinics and more peer support services to navigate same.

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

CalEQRO requested a third Consumer Family Member Focus Group as agreed with MHP. During the agenda building process, it was agreed that a non-English speaking group that did not have Spanish as a preferred language would be useful given the diversity of cultures and languages in Sacramento County. CalEQRO also requested at least three beneficiaries who have started services within the past year. There were 13 people in the group and 12 identified as consumers only. One person reported that she had a family member, an adult son, who also receives mental health services through the county. All participants receive psychiatric services to include medications. All were female and 12 were between 25 - 59 years of age and one was over 60 years old. Although some of the participants understood some English, all preferred Hmong language. Two participants reported they had begun services within the past year. This group was held at APSS Clinic, 2130 Stockton Blvd. Sacramento, CA 95817.

Number of participants – 13

For the two participants *who entered services within the past year*, they described their experience as the following:

- Both participants who had begun services within past year reported that they had been referred from either a friend or the Hmong Women's Association.

- Both participants expressed being satisfied with services that were culturally and linguistically comfortable to them.

General comments regarding service delivery that were mentioned included the following:

- There is one clinician who is Hmong, speaks their language and understands their culture. All participants remarked that he is their go-to person for information, crisis or whatever else they need.
- The participants reported that the interpreter services used in their psychiatric appointments was adequate in allowing them to be able to have conversations with their psychiatrist about their mental health and medication issues.
- The participants reported that at times it is somewhat difficult to get appointments for outpatient counseling as soon as they would like due to lack of Hmong speaking providers.
- All participants agreed they feel that they and their culture is respected in the services they receive.
- Many participants had been part of peer advisory groups that give feedback information to the provider and MHP regarding services offered.

Recommendations for improving care included the following:

- The participants agreed that more availability of clinicians who speak Hmong would help with access to services.
- Transportation is sometimes an issue for the majority of the participants in accessing services.
- All participants remarked that they were grateful for the services and in general did not feel there were any issues that were barriers to receiving services.

Interpreter used for focus group 1: ☐ No ☒ Yes Language(s): Hmong

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - At times transportation is an issue in accessing services.
  - Generally, participants felt that there were not enough appointments available.
- Timeliness of Services

- Participants sometimes find it difficult to make an appointment due to shortage of available time slots.
- The timeliness of first service following request seemed too long to some participants.
- Across the focus groups, consumers were aware of psychiatrist shortages and how that affects both appointment availability and medication refills.

- Quality of Care
  - Generally participants felt that the services delivered were useful in addressing the mental health issues that brought them to treatment.
  - Consumers were positive about the cultural competency in service delivery.
- Consumer Outcomes
  - The participants reported that they have opportunities to complete client satisfaction surveys to give input to treatment outcomes.
  - All three consumer family member groups were aware of opportunities to be a part of advisory oversight and/or town hall committees as well as various MHP committees.

INFORMATION SYSTEMS REVIEW

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. CalEQRO used the written response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

KEY ISCA INFORMATION PROVIDED BY THE MHP

The following information is self-reported by the MHP in the ISCA and/or the site review.

Table 8 shows the percentage of services provided by type of service provider:

Table 8—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	7.90%
Contract providers	91.73%
Network providers	.37%
Total	100%

- Percentage of total annual MHP budget is dedicated to support information technology operations: (includes hardware, network, software license, IT staff)

  1.9%

- Consumers have on-line access to their health records either through a Personal Health Record (PHR) feature provided within EHR or a consumer portal or a third-party PHR:

  ☐ Yes ☐ In Test/Pilot Phase ☒ No

- MHP currently provide services to consumers using an tele-psychiatry application:

  ☐ Yes ☐ In Test/Pilot Phase ☒ No

  - If yes, the number of remote sites currently operational:

    n/a

- MHP self-reported technology staff changes since the previous CalEQRO review (FTE):

Table 9 – Summary of Technology Staff Changes			
Number IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
9	1	2	0

- MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE):

Table 10 – Summary of Data Analytical Staff Changes			
Number Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
7	1	1	0

The following should be noted with regard to the above information:

- The MHP is moving towards internal consolidation of IS and billing staff. Current staffing is a combination of division, departmental and contract staff.
- Data analytics is done by Research, Evaluation and Performance Outcomes (REPO) unit and reports to Program Support Services Division Manager.

CURRENT OPERATIONS

- The MHP continues to utilize the Avatar Information System (Avatar) from NetSmart Technologies under an Application Services Provider (ASP) agreement for practice management (PM) and Clinician Work Station (CWS) for electronic health record functions.
- All but three outpatient contract providers utilize the MHP's Avatar system as their primary EHR. The remaining three providers submit weekly claims data and documentation. Planning has begun for providing electronic submission of claims for the remaining providers, but an implementation timeline has not been established.
- The MHP has hired an internal Avatar Manager and continues to utilize a contracted project manager to lead the Avatar implementation.

- The Intensive Placement Team (IPT) is now entering services into the EHR.
- The MHP has begun a project to provide further mobile connectivity through the use of the Avatar Care POV module. This requires touchscreen computers, which have not been purchased. A pilot of 16-19 users is planned for later this year.
- The MHP has licensed the MyHealthPoint personal health record (PHR) software from NetSmart. Implementation planning has begun, but the functional aspects to be implemented have not been determined.
- The MHP has a policy to complete new user training within 30 days of completion of credentialing. User training is offered weekly.

Table 11 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 11— Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar CWS	EHR	Netsmart Technologies	5	MHP/Netsmart Technologies
Avatar PM	Practice Management	Netsmart Technologies	7	MHP/Netsmart Technologies
Infoscriber/Order Connect	3-Prescribing	Netsmart Technologies	5	MHP/Netsmart Technologies

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans for information systems change.
- Current plans call for work to begin on the implementation of the Personal Health Record and provider EHR integration in the third quarter of FY16/17.

ELECTRONIC HEALTH RECORD STATUS

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Avatar	X			
Assessments	Avatar	X			
Document imaging/storage	Avatar	X			
Electronic signature—consumer	Topaz	X			
Laboratory results (eLab)				X	
Level of Care/Level of Service	Avatar	X			
Outcomes	CANS		X		
Prescriptions (eRx)	Avatar	X			
Progress notes	Avatar	X			
Treatment plans	Avatar	X			
Summary Totals for EHR Functionality		8	1	1	

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- Child outcomes are measured through the CANS report which is integrated into the EHR.
- The MHP is working with NetSmart, Quest, and LabCorp to implement electronic lab orders and results. Vendor testing is in place, but required functionality is not currently available.
- Consumer's Chart of Record for county-operated programs (self-reported by MHP):

  ☐ Paper ☐ Electronic ☒ Combination

MAJOR CHANGES SINCE LAST YEAR

- Implementation of ICD-10 diagnoses codes.
- Mental Health Navigator Implementation to allow for documents to be shared electronically Internal Release Development.
- IPT is now entering services into the EHR.
- The ability to share/release Avatar generated documentation to users in a different System for the purpose of coordination of care was implemented.

- Development and distribution of clinical data element requirements to the three providers with their own EHR for Provider Integration planning purposes was completed.

PRIORITIES FOR THE COMING YEAR

- Continue to implement: Provider Integration and Personal Health Record projects.
- Initiate patient liability billing and Medicare Part B billing.
- Continue to implement Electronic Lab Orders and Results.
- Implementation of CarePOV mobile solution.

OTHER SIGNIFICANT ISSUES

- Clinicians indicate that they are frequently unware of hospital admissions and discharges of their clients in a timely manner.
- Although record sharing between providers capability was put in place last year, it is only being utilized by the Mobile Crisis Team and the Intake Stabilization Unit.
- Technical issues with the State claims processing resulted in a large number of claims being approved for zero dollars for nearly 7 months during FY15-16. The MHP held all claims for several months resulting in cash flow issues and plans to address the errors via the Cost Report.

MEDI-CAL CLAIMS PROCESSING

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☐ Monthly ☒ More than 1x month ☐ Weekly ☐ More than 1x weekly

- MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

Not Available

- Method used to submit Medicare Part B claims:

  ☐ Clearinghouse ☐ Electronic ☐ Paper

  - The MHP does not currently submit Medicare Part B claims. They are in the process to implement same. See Prior Year Recommendations and Priorities for Coming Year sections for additional information.

Table 13 - Sacramento MHP Summary of CY15 Processed SDMC Claims

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
520,148	$76,063,876	$4,605,545	6.05%	27,136	$71,458,331	$14,760,717	$56,697,614

Note: Includes services provided during CY15 with the most recent DHCS processing date of May 19,2016

Note 2: Due to technical difficulties during SDMC claims adjudication processing by the State, approximately 42,000 claims were approved for zero dollars. As a result Table 13, Gross Dollars Approved column understates the total dollars approved for CY15.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP produces an annual analysis of service penetration for a number of demographic characteristics including age, race and ethnicity.
- Timeliness of Services
  - The MHP has begun tracking timeliness data for contacts and referrals which have been identified as urgent.
  - The MHP still does not track wait times from initial contact or referral to first service.
- Consumer Outcomes
  - The MHP has both an annual report that aggregates CANs data pulled from the EHR to analyze performance as well as individual reports available in the EHR to assist staff with incorporating the CANs results into treatment planning.

SITE REVIEW PROCESS BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

- There were no barriers or conditions that significantly affected CalEQRO's ability to prepare for and/or conduct this review.

CONCLUSIONS

During the FY16-17 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - During past year the MHP increased contract provider contracts so as to be able to provide more services and serve more clients.
  - Outreach and services are targeted to cultural and language sub-populations throughout the county.
  - Beyond meeting all legal requirements for translation of documents, the MHP provides enhanced language access on its webpages using a translation program.
- Opportunities:
  - With four health plans (soon to be six) and nine local Emergency Departments in Sacramento County, there is potential for significant confusion about where and how to access services from the consumers' perspectives.

Timeliness of Services

- Strengths:
  - Both active PIPs address issues of timeliness.
  - Wait times for urgent conditions have been added to the Quarterly Benchmark Report. A three day goal has been established for referral to a provider for urgent conditions.
- Opportunities:
  - Wait time from initial contact with Access Team to first service is not tracked. A PIP has been initiated to allow tracking to first offered appointment.
  - Clinical staff report some difficulty in obtaining inpatient admission/discharge status of their clients. This effects timeliness in post discharge engagement and appointments.

- An "Urgent' checkbox has been added to the Service Request Form. Urgent request is defined as – Imminent risk of danger to self/danger to others/hospitalization or incarceration; hospital discharge.

Quality of Care

- Strengths:
  - A wellness and recovery model is present and seems to be understood by staff and consumer/family members.
  - Consumers/Family Members interviewed reported that they received culturally and linguistically competent services to address their needs.
- Opportunities:
  - Clinicians indicate that they are frequently not made aware of hospital admissions and discharges of their clients.
  - More focus on and further understanding of the Wellness and Recovery model by both staff and CFMs would be useful.

Consumer Outcomes

- Strengths:
  - Staff looks for and tracks successful family reunification or foster care placement out of group homes and stable school placement without need of special education placements in children's program.
  - The Non-Clinical PIP addresses outcomes across the Systems of Care (SOCs).
  - As indicators of successful outcomes for client, the Katie A. Program staff utilizes indicators of 1) success family reunification or foster care place out of group homes and 2) stable school placement without need of special education placement.
  - The MHP is tracking successful levels of care in youth.
- Opportunities:
  - The issues with capacity of the County health plans in relation to accepting clients moved to the Moderate to Mild level of care (LOC) require coordination to ensure medication availability until first appointment at the new LOC provider.
  - Transportation issues are cited by consumers and family members as barriers to positive outcomes in receiving adequate and frequent services.

RECOMMENDATIONS

- To facilitate integration of services and access to care for clients who have been "stepped down" in diagnoses to Mild or Moderate category, recommend that the MHP needs to collaborate with the MCOs to develop guidelines and business standards for access, referrals and timely appointments for referrals.

- Integration and collaboration efforts between primary care, mental health and substance use treatment for next year needs to be a priority for the MHP. Develop protocols which address steps to increase integration and promotes effective collaboration between all programs involved.

- Recommend that Sacramento BH and MCOs collaborate to create screening/referral form (not unlike the SMART Medical Clearance Pilot form) to measure access and timeliness of referrals. This would involve developing screen/referral form in collaboration with stakeholder partners and then developing a tracking process to monitor two way referrals. It would be useful to create a monthly summary of referrals which is shared with BH and MCO partners.

- Timeliness tracking for intakes is incomplete. Wait time from initial contact with Access Team to first service is not tracked. A PIP has been initiated to allow tracking to first offered appointment, however the MHP needs to track timeliness from initial contact until first appointment across SOCs.

- Develop a better system, such as through the EHR, to notify staff in a timely manner when their clients have been admitted or discharged from the hospital.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the MHP On-Site Review Agenda:

Sacramento County
MHP CalEQRO Agenda

Unless otherwise indicated, all conference rooms are located at MHP Main office at
7001A East Parkway, Sacramento, CA 95823

Day 1 **July 26, 2016**

Time	Activity Please note location of sessions		
9:00 am – 10:30 am	**Opening Session** • Introduction to BHC • MHP Team Introductions • Overview of review intent • Significant MHP Changes in past year • Highlights of MHP Current Initiatives • Response to Previous Year's Recommendations • CalEQRO Performance Measure Data **Participants:** Uma Zykofsky, Lisa Sabillo, Melissa Jacobs, JoAnn Johnson, Alex Rechs, Dawn Williams, Jane Ann LeBlanc, Dr. Robert Hales, Dr. Robert Horst, Steve Davidson, Matt Quinley, Andrea Crook, Blia Cha, Sandena Bader, Angela Chalmers, Anthony Madariaga, Ann Mitchell, Pamela Gardner, Shelly Kunker, Rolanda Reed-Anning **BHC EQRO Participants:** All **Location:** Conference Room 1		
10:30am – 10:45am	**Break**		
10:45 am – 12:15 pm	**Quality Management Activities** • Quality, Access, Timeliness, Outcomes • Use of data in past year. **Participants:** Lisa Sabillo, Dawn Williams, Alex Rechs, Pam Gardner, Rolanda Reed-Anning, JoAnn Johnson **BHC EQRO Participants:** LH, JM **Location:** Conf. Room 301	**Wellness & Recovery Center** **BHC EQRO Participants:** TdeW, **Location:** WRC - North 9719 Lincoln Village Dr. #300 Sacramento, CA 95827 **Site Point of Contact:** Michael Lane	**Acute Care Collaboration** • Overview of current process to transition from Acute Care to Follow-up care • Use of paper versus electronic forms • Availability and use of Health Information Exchange strategies. • Roll/function of System Navigator provider – acute care; patient follow-up care

Sacramento Agenda FINAL 7-20-2016

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, NCC, LMFT - Lead Quality Reviewer
Jerry Marks – Information Systems Reviewer
Bill Ullom – Chief Information Systems Reviewer
Rama Khalsa, PhD –Director, Drug MediCal EQRO
Tilda De Wolfe – Consumer/Family Member Consultant

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and, ultimately, in the recommendations within this report.

Sites of MHP Review

MHP SITES

7001 A East Parkway, Sacramento, CA 95823
Access Call Center, 3331 Power Inn Road, Sacramento, CA 95826

CONTRACT PROVIDER SITES

WRC – North, 9719 Lincoln Village Dr. #300, Sacramento, CA 95827
Turning Point FIT, 7245 E. Southgate Drive, Sacramento, CA 95823
River Oak Center for Children, 5445 Laurel Hills Drive, Sacramento, CA 95841
Visions Unlimited, 6833 Stockton Blvd., Suite 485, Sacramento, CA 95823
La Familia Counseling Center, 3301 37th Avenue, Sacramento, CA 95824
APSS Clinic, 2130 Stockton Blvd., Sacramento, CA 95817

Participants Representing the MHP

Name	Position	Agency
Alexandra Rechs	Acting Program Manager	BHS QM
Anantha Panyala	Crisis Director MHTC	DHHS BHS MHTC
Andrea Crook	Client Advocate Liaison	NorCal Mental Health America
Angela Chalmers	Budget Manger	BHS
Ann Mitchell	ASO III Avatar & Billing	BHS

Name	Position	Agency
Anthony Madariaga	Division Manager Mental Health Treatment Center	Sacramento County DHHS/Behavioral Health
Anthony Urquiza	Director	UC Davis CAARE Center
Barbara Oleachea	Program Planner	CPS
Betty Knight	Clinical Program Manager	ROCC
Blanca Velacquez	Lead Clinician/CCT Lead	Visions Unlimited
Blia Cha	Adult Family Advocate	NorCal Mental Health America
Cassandra Cochron	Team Leader	TLCS
Cheryl Keenan	Senior Specialist Family-Youth Support	River Oak Center for Children
Christine Baker	MH Program Coordinator	Sacramento County BHS
Daniel Bojarano	Employment Specialist	TCORE
Daniel Gouveia	Program Services Clinician	River Oak Center for Children
Dawn Williams	Program Manager REPO	DHHS BHS
Debbie Mendez	Director	River Oak Center for Children
Diana White	Chief Operations Officer	Turning Point
Dionna Garza, LMFT	Senior Mental Health Counselor	CAPS
Erin McClure	Senior MH Counselor	Sacramento County Access
Esperanza Salazar	WRAP Facilitator	ROCC
Faith Patterson	Youth-Family Support Manager	River Oak Center for Children
Garland Feathers	Peer Navigator	TLCS
Gary Suits	EHR Administrator	River Oak Center for Children
Gina Mertz	Managing Clinical Supervisor	SJUSD
Gordon Richardson	Executive Director	Uplift Family Services
Grace Irvine	Program Services Clinician	River Oak Center for Children
Grainger Brown	Clinical Supervisor/Manager	Dignity Health
Helen Byrd	MH Program Coordinator	BHS Programs
Jennifer Baker	Program Director	Turning Point RST
Jennifer Reiman	Program Coordinator	DHHS Division of BH
Jessica Munoz	Service Coordinator, MHRS	HRC
Jesus Cervantes	MH Program Coordinator	Sacramento County
JoAnn Johnson	Program Manager Cultural Competence/WET	Sacramento County DHHS – Behavioral Health
Joshua Collver	Manager Social Work	Sutter Center for Psychiatry

Name	Position	Agency
Judy Foddrill, LMFT	Therapist	Sacramento Children's Home (SCH)
Justine Pap Rocki	Clinical Program Manager	River Oak Center for Children
Kacey Vencill	Consultant	DBHS
Karen Vang	Clinical Support Services Manager	River Oak Center for Children
Kathy Burlingame	MH Program Coordinator	Access
Kezzia Bullen	Clinical Director	Telecare SOAR
Laurie Clothier	CEO	River Oak Center for Children
Lisa Sabillo	Division Manager REPO, QM, Avatar	BHS
Lynn Place	Executive Director	Human Resources Consultants/ TCORE 7
Marge Hollingsworth	Health Information Supervisor	River Oak Center for Children
Maria DeOcampo	Program Planner	DHHS BHS
Marlyn Sepulveda	Program Director	TCORE
Mary Bush	Youth-Family Support Director	River Oak Center for Children
Mary Nakamura	Human Services Program Planner	DBHS
Matt Quinley	Program Manager	BHS
Max King	Youth Advocate	NorCal Mental Health America
Melissa Jacobs	Division Manager Child & Family	BHS
Michael Lane	Program Director	Consumer Self-Help Center
Michele O. Knight	Associate Director	UC Davis CAARE Center
Miranda Furie	Program Director RST	El Hogar
Nicole Hiu	Admin Associate III	DHMF
Pamela Gardner	Program Coordinator	BHS QM
Pamela Gardner	Program Coordinator BH QM	DHHS BHS
Pat George	Program Manager	SJUSD
Paul Nicora, ASW	Personal Service Coordinator	SEWP, El Hogar
Rob Kesselring	Program Coordinator	BHS Programs
Robert Baumgardner, LMFT	Senior Mental Health Counselor	APSS
Robert Gillette	Accounting Manager	DHHS
Robert Horst	Children's Medical Director	DHHS BHS
Robin Skalsky	Clinic Director	APSSC
Roland Udy	COO	River Oak Center for Children

Name	Position	Agency
Rolanda Reed	Program Coordinator	BHS
Rosemary Younts	Senior Director Behavioral Health Services	Dignity Health
Sandena Bader	Family & Youth Advocate	MHA BHS
Sara Collette	Clinical Director	HRC
Scott Becker	Director of Operations	River Oak Center for Children
Shelly Kunker	Program Coordinator QM	DHHS BHS
Sheri Green	Program Coordinator	Sacramento County
Sonny Iverson	Peer Navigator	TLCS
Stacy Small	Clinical Director	Crestwood American River
Stephen Davidson	Program Manager	BHS
Tara Arnaiz	MFTI	Sacramento Children's Home (SCH)
Tina Traxler	Division Director, FIT	River Oak Center for Children
Trang Hoang	Senior MH Counselor	Sacramento County Access
Tricia Watters	Program Coordinator	CAPS Sacramento County
Uma Zykofsky	Behavioral Health Director	DHHS BHS

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

Approved Claims Summaries are separately provided to the MHP in a HIPAA-compliant manner.

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands.

Table C1 shows the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal ACA Expansion Penetration Rate and Approved Claims per Beneficiary.

Table C1 - CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statwide	2,001,900	131,350	6.56%	$533,318,886	$4,060
Large	950,222	63,298	6.66%	$263,166,307	$4,158
Sacramento	76,821	3,182	4.14%	$10,224,706	$3,213

Table C2 shows the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under $20,000; $20,000 to $30,000, and those above $30,000.

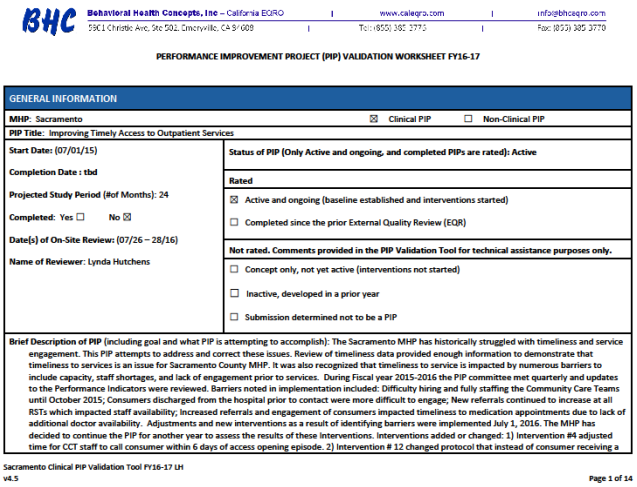
Table C2 - Sacramento MHP CY15 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
$0K - $20K	19,457	97.31%	94.46%	$53,663,808	$2,758	$3,553	74.83%	61.20%
>$20K - $30K	297	1.49%	2.67%	$7,308,698	$24,608	$24,306	10.19%	11.85%
>$30K	241	1.21%	2.86%	$10,739,322	$44,562	$51,635	14.98%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

Double click on the icons below to open the PIP Validation Tools:

Clinical PIP:



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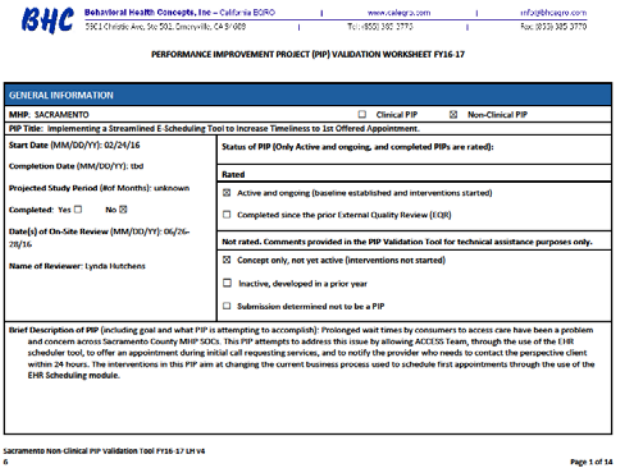
PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION	
MHP: Sacramento	☒ Clinical PIP ☐ Non-Clinical PIP
PIP Title: Improving Timely Access to Outpatient Services	
Start Date: (07/01/15) **Completion Date : tbd** **Projected Study Period (#of Months):** 24 **Completed:** Yes ☐ No ☒ **Date(s) of On-Site Review:** (07/26 – 28/16) **Name of Reviewer:** Lynda Hutchens	**Status of PIP (Only Active and ongoing, and completed PIPs are rated): Active** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The Sacramento MHP has historically struggled with timeliness and service engagement. This PIP attempts to address and correct these issues. Review of timeliness data provided enough information to demonstrate that timeliness to services is an issue for Sacramento County MHP. It was also recognized that timeliness to service is impacted by numerous barriers to include capacity, staff shortages, and lack of engagement prior to services. During Fiscal year 2015-2016 the PIP committee met quarterly and updates to the Performance Indicators were reviewed. Barriers noted in implementation included: Difficulty hiring and fully staffing the Community Care Teams until October 2015; Consumers discharged from the hospital prior to contact were more difficult to engage; New referrals continued to increase at all RSTs which impacted staff availability; Increased referrals and engagement of consumers impacted timeliness to medication appointments due to lack of additional doctor availability. Adjustments and new interventions as a result of identifying barriers were implemented July 1, 2016. The MHP has decided to continue the PIP for another year to assess the results of these interventions. Interventions added or changed: 1) Intervention #4 adjusted time for CCT staff to call consumer within 6 days of access opening episode. 2) Intervention # 12 changed protocol that instead of consumer receiving a	

Sacramento Clinical PIP Validation Tool FY16-17 LH v4.5 Page 1 of 14

Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION	
MHP: SACRAMENTO	☐ Clinical PIP ☒ Non-Clinical PIP
PIP Title: Implementing a Streamlined E-Scheduling Tool to Increase Timeliness to 1st Offered Appointment.	
Start Date (MM/DD/YY): 02/24/16 **Completion Date** (MM/DD/YY): tbd **Projected Study Period** (#of Months): unknown **Completed:** Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 06/26-28/16 **Name of Reviewer:** Lynda Hutchens	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP
Brief Description of PIP (including goal and what PIP is attempting to accomplish): Prolonged wait times by consumers to access care have been a problem and concern across Sacramento County MHP SOCs. This PIP attempts to address this issue by allowing ACCESS Team, through the use of the EHR scheduler tool, to offer an appointment during initial call requesting services, and to notify the provider who needs to contact the perspective client within 24 hours. The interventions in this PIP aim at changing the current business process used to schedule first appointments through the use of the EHR Scheduling module.	

Sacramento Non-Clinical PIP Validation Tool FY16-17 LH V4 6 Page 1 of 14