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FY 2019-20
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SACRAMENTO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 27 – 29, 2019

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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) 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 State Medicaid Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also takes into account the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2018-19 findings of an EQR of the Sacramento MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Large

MHP Region — Central

MHP Location — Sacramento

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 23,775

MHP Threshold Language(s) — Spanish, Russian, Vietnamese, Hmong, Cantonese, Arabic

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of the MHP's Electronic Health Records (EHR), Information Technology (IT), claims, outcomes, and other reporting systems and methodologies for calculating PMs.

Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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[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.

[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 inform the evaluation of the 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, FY 2018-19

In this section, the status of last year's (FY 2018-19) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2018-19 Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2019-20 site visit, CalEQRO reviewed the status of those FY 2018-19 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY 2018-19

PIP Recommendations

Recommendation 1: As Per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.

Status: Met

- The MHP presented two PIPs completed on June 30, 2019 for review by CalEQRO. Both are rated as active in the past year.

Recommendation 2: Clinical PIP: Restate study question to include a metric for "improving consumer wellbeing" and redefine how the study question is stated for both clarity and to ensure quantifiable results. The Mental Health Urgent Care Clinic (MHUCC) changes in protocol make it necessary for the MHP to review both indicators and interventions for their usefulness in measuring change. Redesign the indicators and interventions to address the MHUCC changes in protocol. Consult with EQRO early and often during the PIP formulation.

Status: Met

- The MHP restated the study question to be both clear and quantifiable.

- Indicators were added to facilitate the measurement of change.
- Interventions were adjusted October 15, 2018 to affect accurate engagement with the indicators.
- PIP scorings can be viewed in Attachment E, PIP Validation Tools and in the Performance Improvement Project Validation of this report.

Recommendation 3: Non-clinical PIP: Restate the study question to include quantifiable goals. Investigate and resolve problems that are barriers to retrieving valid data. Complete any changes and/or additions to indicators and interventions. Begin interventions and collect data at least quarterly. Consult with EQRO early and often during the PIP formulation.

Status: Partially Met

- The study question was revised to include quantifiable goals. However, there was no percent of improvement listed as a goal.
- Changes were made effective October 15, 2018 that made identification of those beneficiaries seeking treatment who were candidates for Medication Bridge, as well as the ability to track these referrals, easier and documented. This eliminated the barrier opening a beneficiary to services while offering Med Bridge services.
- The MHP added indicators and interventions to increase ability to report the outcomes of the PIP.
- An issue effecting the PIP was that opening a beneficiary to services while offering Med Bridge was confusing to the beneficiary.
- This PIP was completed with a plan to re-evaluate the potential population that might be candidates for early access to psychiatric medication evaluation.
- PIP scorings can be viewed in Attachment E, PIP Validation Tools and in the Performance Improvement Project Validation of this report.

Access Recommendations

Recommendation 4: Research factors contributing to approximately 33 percent of all beneficiaries authorized to services being discharged without receiving a service.

Status: Partially Met

- MHP brought this issue for discussion to various provider meetings and forums to attempt to determine factors contributing to beneficiaries not engaging in services with the MHP following authorization for services. The MHP reports that they were only able to find anecdotal provider information and hypothesize reasons for lack of engagement.

- Steps have been taken to minimize the number of beneficiaries who are discharged without receiving a service through outreach and engagement efforts. The MHP tracks this using engagement, no-shows, and cancelation codes in the scheduling input. One outreach and engagement effort is conducted by the Community Care Teams, who connects with beneficiaries prior to their first appointment to provide connection and encouragement to attend their assessment appointment.

- Community care teams are in place to connect upon referral to first appointments.

- The system was changed regarding post discharge from hospital appointments. The beneficiary is now asked by the hospital discharge staff to sign whether they are interested, not interested in services, or receiving services from another entity as part the discharge planning process with the beneficiary. This allows the MHP to better track no-shows for post discharge appointments.

Timeliness Recommendations

Recommendation 5: Per IN 18-011, redefine timeliness standard from initial contact to first offered appointment to ten business days.

Status: Met

- The MHP updated the FY 2018-19 Quality Improvement (QI) Work Plan timeliness standard definition from initial contact to first offered appointment to 14 calendar days (10 business days).

Recommendation 6: Establish a PIP to improve the timeliness standard and adherence rates to the standard for treatment of urgent conditions.

Status: Met

- The MHP is designing a PIP using the Avatar Scheduler for appointments linking clients to services following inpatient hospitalization starting FY 2019-20. The PIP will include both Adult and Children's Providers.

- This PIP is an amended PIP from last year, which previously planned to use the Avatar Scheduler to increase timeliness to first service. Following the IN 18-011 the MHP decided that PIP was unnecessary as a benchmark is set.

Recommendation 7: Per IN 18-011, redefine timeliness standard from initial contact to first offered psychiatric appointment to 15 business days.

Status: Met

- The MHP updated the FY 2018-19 QI Work Plan timeliness standard definition from initial contact to first offered psychiatric appointment 21 calendar days (15 business days).

Recommendation 8: Design and implement a system to measure timeliness of first request to first offered psychiatric appointment for children and youth services.

Status: Partially Met

- The MHP is exploring a change in authorization policy that would allow tracking of first request for psychiatric services to first psychiatric appointment.
- The discussion was put on hold until the posting of DHCS IN 19-026 "Authorization of Specialty Mental Health Services" to reduce the possibility that any significant changes in practice would conflict with DHCS directives.

Quality Recommendations

Recommendation 9: Implement training and supervise clinicians to accurately document co-occurring diagnoses. Administer pre and post-tests of knowledge on co-occurring diagnoses as part of training and ongoing supervision process.

Status: Partially Met

- The MHP updated the Co-Occurring Disorders Assessment (CODA) to mirror the Diagnostic Statistical Manual of Mental Disorders Fifth Edition (DSM 5) substance use disorders diagnostic criteria. This allows the provider to determine the severity of the substance use, which leads to better identification of a diagnosis and subsequent referral for treatment.
- CODA criteria have been updated in the MHP Documentation Training and is discussed as part of the Utilization Review Committee, which includes Quality Management representation from County Operated and Contracted Providers.
- In addition, the topic was discussed with Executive Directors to identity perceived concerns regarding documenting co-occurring diagnosis.
- No specific training with pre and post tests have occurred at the time of the onsite CalEQRO review.
- Therefore, no specific changes in COD numbers or percentages are currently available.

Recommendation 10: Increase staff training and monitor data entry for network provider claims in order to reduce errors, increase timeliness, and lower number of denials.

Status: Met

- Training for staff who enter data for Network providers, as well as new staff being onboarded who will perform this task, has been increased for improving timeliness and accuracy for data entered on the providers' behalf.

Recommendation 11: Develop a system to address the issue of the MHP receiving data on beneficiaries seen by contracted providers of physical and mental health services at the jail. Ensure that the MHP Navigator at the jail has information of beneficiaries incarcerated to assist jail clinical staff.

Status: Partially Met

- A meeting with Correctional Health, Primary Care and Department of Health Services (DHS) Department of Technology (DTECH) took place on June 17, 2019 to initiate EHR communication/integration discussions.
- Until the change is implemented the Triage Navigator communicates with the Correctional Health discharge planner and documents in Avatar.

Beneficiary Outcomes Recommendations

Recommendation 12: Incorporate outcomes measures for Child and Adolescent Needs and Strengths – 50 (CANS-50) into the Avatar documentation flow and begin to report enterprise level outcomes. Research outcomes measures that will allow aggregate reporting for adult consumers.

Status: Partially Met

- CANS-50 was implemented in October 2018; an annual report will be generated in October of 2019.
- Prior to the CANS-50 implementation, an Annual Report was done every year based on outcomes from the Sacramento County CANS.
- Adult outcomes, Adult Needs and Strengths Assessment (ANSA), will be piloted in two new programs in FY 2019-20. Based on positive findings from the pilot, the ANSA will be implemented throughout the Adult System.

Recommendation 13: Research the opportunity to create a contract standardized defined career ladder for peer employees incorporated into contract provider programs. *(This recommendation is a carry-over from FY 2017-18 and FY 2018-19.)*

Status: Partially Met

- The research was completed by comparing the various contracts and discussing this issue with contract providers.
- Next steps include that the Division of Behavioral Health Services (BHS) is now working with Human Resources (HR) to create county positions for peer employees that would include a career ladder. This would demonstrate a model for contract providers.
- The county has a centralized job creation system. A study was approved; however, creation of the study will take three to six months. This will involve creation of class specifications and development of an outline for civil service and

union involved to approve. Following this, the Board of Supervisors would have to agree.

- Following this, the exam process can be created. This is projected to be a six to nine months process.
- If successful, the MHP plans to hire managerial level initially and empower them to participate in the creation of the full program.
- At the time of the onsite review this project was still conceptual in nature.

Foster Care Recommendations

Recommendation 14: Ensure that all workflows are in place and execute any new memorandums of understanding (MOUs) needed to ensure appropriate exchange of information in a timely manner that ensures the change in structure for oversight of the work with Katie A. designated subclass children to include foster care children between all involved agencies is effective.

Status: Partially Met

- Methods for effectively exchanging information between Child Protective Services (CPS) and the MHP continues to be discussed through cross system meetings at the management level for both the client level and system level data. Currently there are practical workflows happening to exchange data monthly and an MOU per AB 2083 is pending.

Recommendation 15: Investigate reasons for low average cost per beneficiary (ACB) for foster care beneficiaries. Design and implement plan to increase penetration rate to more closely reflect large county averages for this demographic.

Status: Met

- After cross system discussions, Child Welfare and the Division agreed to have MH staff conduct the CANS-50 for unlinked CPS youth. This will provide mental health (MH) staff with information on youth's needs for youth who formerly would not have been involved with MH.

Recommendation 16: Research opportunities to track follow up services within the EHR system after foster care beneficiaries have stepped down to a lower level of care (LOC).

Status: Partially Met

- With the Children's System Redesign, youth involved with the foster care system will continue with the same provider regardless of the LOC.
- If they wish to receive services through their managed care provider (MCP), the MHP will provide linkage using the bi-directional managed care plan referral process.

- Methods to exchange and provide follow up data are an ongoing discussion point for MCP and MHP collaboration meetings.

Information Systems Recommendations

Recommendation 17: Appropriately staff the MHP's IT Department. This includes:

- A Director of Information Technology who will report to the MHP Director, with electronic health record leadership experience and membership in the Executive Committee, who will bring coherence to the MHP's investment in technology.
- A clinical informaticist with a clinical background.
- A person with knowledge of and experience with standards-based healthcare data exchange integration.
- A healthcare data manager, ideally one with knowledge of data architecture and high-level database administrator skills.

Status: Partially Met

- The Quality Management Manager has been identified as the clinical informaticist.
- The Avatar Manager has been identified as the person with knowledge of and experience with standards-based healthcare data exchange integration.
- The Research and Performance Outcomes Manager has been identified as the healthcare data manager.
- This does not incorporate any additional staff.
- In Sacramento County, Department of Technology is a separate Department from the Department of Health Services with its own Director.

Recommendation 18: Establish a formal Avatar Help Desk supported by software to enable tracking and reporting on help desk calls.

Status: Not Met

- There is no specialized help desk software solution purchased for tracking purposes, but a formal help desk process is in place which tracks email requests and responses.
- The desk procedure/workflow was discussed during the EQRO session related to Avatar/IT.
- No reports were submitted to CalEQRO supporting any new tracking system.

Recommendation 19: Implement Avatar Scheduler at all MHP sites and make its use mandatory for all clinicians, including psychiatrists.

Status: Partially Met

- The Avatar Scheduler has been piloted in both the Children's and Adult Systems for initial assessment appointment for outpatient services using a PIP study.
- The Scheduler proved successful within the Children's System but added to the timeliness issues in the Adult System.
- The use of the Avatar Scheduler for appointments following an inpatient hospital stay will be tested using a PIP currently being designed, and then will be implemented system wide.
- No research has been done to date on how to utilize the Avatar Scheduler in the Adult System without increasing time to service.

Structure and Operations Recommendations

Recommendation 20: Utilize the current non-clinical PIP process as an opportunity to begin moving towards universal use of Avatar Scheduler by MHP and contract providers.

Status: Partially Met

- With the implementation of the new CSI Assessment Record requirements outlined in DHCS IN 19-020, the MHP will discontinue the use of the Avatar Scheduler for all appointments other than requests following an inpatient hospital stay. The form developed by Netsmart for Avatar will allow the MHP to track the elements and provide the required reporting structure to DHCS.

Recommendation 21: Update Quality Management (QM) Documentation Training to reflect the MHP direction to accurately reflect the data regarding co-occurring disorders. This is both a data reporting issue and a clinical assessment issue that can be strengthened in documentation training and Avatar training for instruction of data entry.

Status: Met

- The QM Documentation Training was updated to provide direction regarding the accurate entry of co-occurring data elements after discussion, review and approval through utilization review (UR), the Quality Improvement Committee (QIC) and Executive Committees.
- This will be monitored to detect changes in the reporting and diagnosing of co-occurring disorders.

Recommendation 22: Complete the implementation of electronic laboratory orders and results.

Status: Partially Met

- A significant issue related to billing to the lab was discovered during the initial testing phase of electronic laboratory orders and results.
- The MHP has been working with the vendor to rectify the problem. There has been a fix identified and testing is currently in process.
- Barring any additional issues, the implementation should begin during the first quarter of FY 2019-20.

Recommendation 23: Complete the implementation of Medicare Part B claims processing. Please refer to IN 2011-04 and IN 2009-09. *(This recommendation is a carry-over from FY 2017-18 and FY 2018-19.)*

- The MHP currently cannot bill Medicare Part B which would increase revenue and provide the option to bill State Drug Medi-Cal (SDMC) for dually covered beneficiaries (i.e. Medi-Medi eligibles).
- Increased revenue would offer an opportunity to enhance service provisions for beneficiaries.

Status: Met

- Completed. Billing for Medicare Part B began with July 2019 claims.

Recommendation 24: Reassess in 2019 budget planning the MHP's ability to explore strategies to eliminate current constraints on the use of data. Consider establishing a data warehouse to improve data analysis and reporting capabilities. *(This recommendation is a carry-over from FY 2017-18 and FY 2018-19.)*

- Funding was not provided in the FY 2018 -19 budget for this project. This is the single known obstacle to addressing this recommendation.
- The MHP plans to recommend funding to the Netsmart agreement when it is renewed in July 2019 to enable this project.

Status: Met

- CalEQRO is eliminating this recommendation due to the fact both sub-bullets are not achievable currently.

PERFORMANCE MEASUREMENT

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

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent 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 (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following.
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Sacramento MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	130,017	24.0%	7,887	33.2%
Latino/Hispanic	123,714	22.8%	4,230	17.8%
African-American	81,353	15.0%	4,577	19.3%
Asian/Pacific Islander	75,110	13.8%	1,363	5.7%
Native American	3,617	0.7%	247	1.0%
Other	128,959	23.8%	5,471	23.0%
Total	**542,768**	**100%**	**23,775**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

Penetration Rates and Approved Claims per Beneficiary

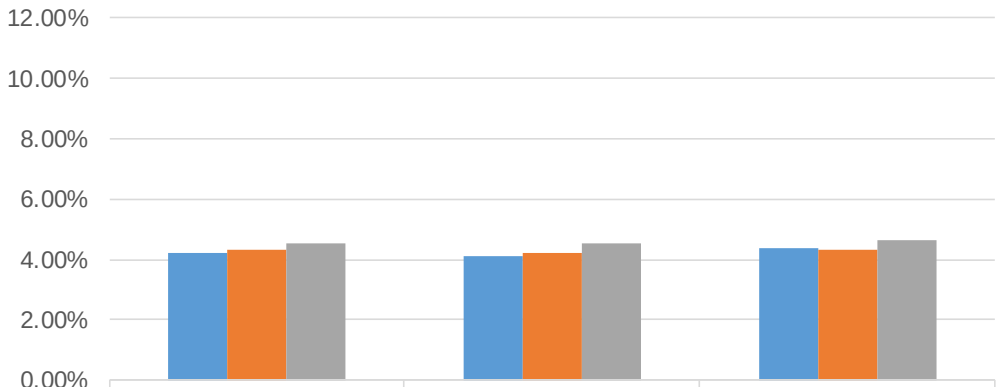
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2018. See Table C1 for the CY 2018 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Sacramento MHP uses the same method used by CalEQRO.

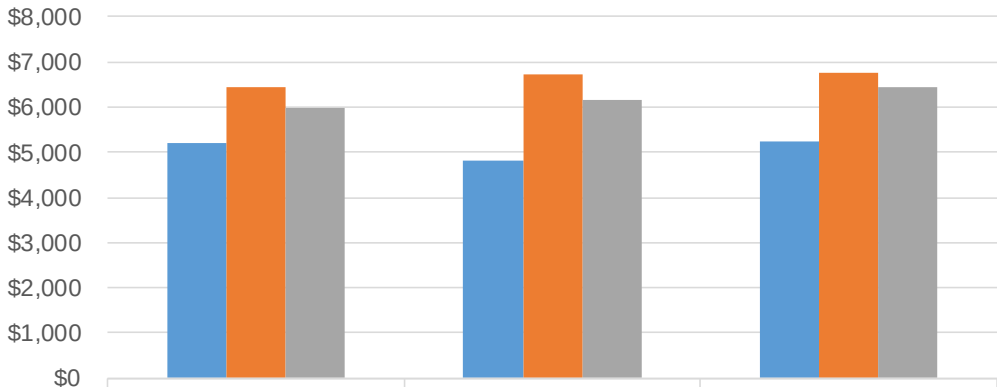
Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1A. Overall Penetration Rates
Sacramento MHP



	CY 2016	CY 2017	CY 2018
MHP	4.21%	4.10%	4.38%
Large	4.30%	4.19%	4.31%
State	4.53%	4.52%	4.66%

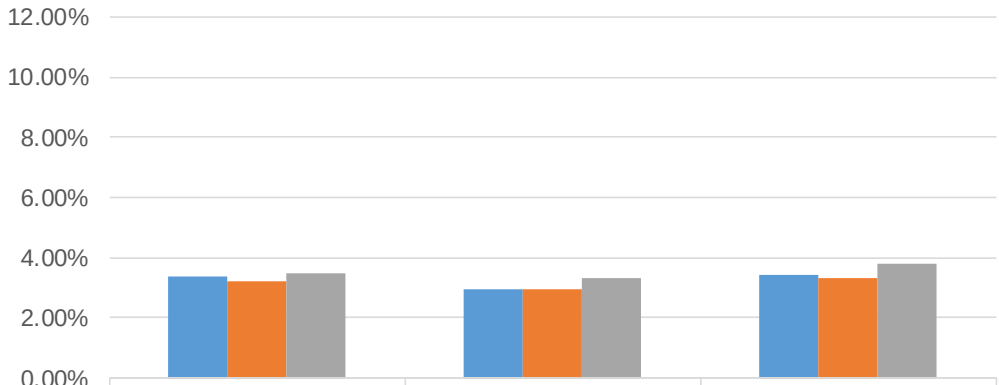
Figure 1B. Overall ACB
Sacramento MHP



	CY 2016	CY 2017	CY 2018
MHP	$5,201	$4,805	$5,224
Large	$6,430	$6,723	$6,750
State	$5,978	$6,170	$6,454

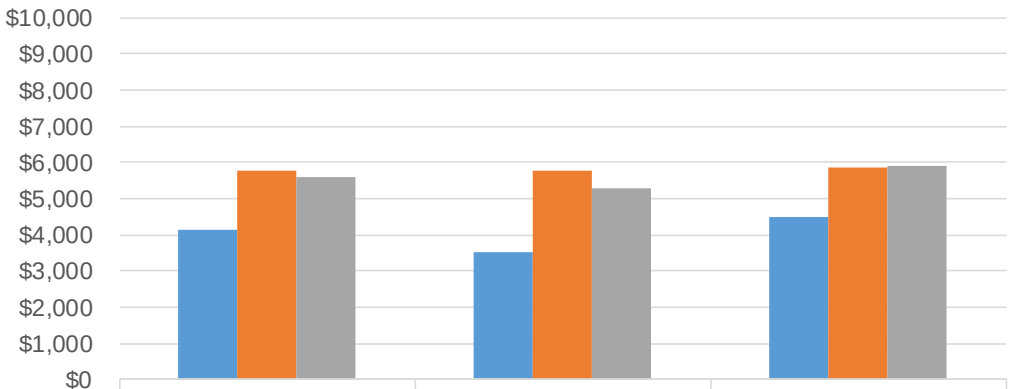
Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
Sacramento MHP



	CY 2016	CY 2017	CY 2018
MHP	3.36%	2.93%	3.42%
Large	3.21%	2.97%	3.33%
State	3.51%	3.35%	3.78%

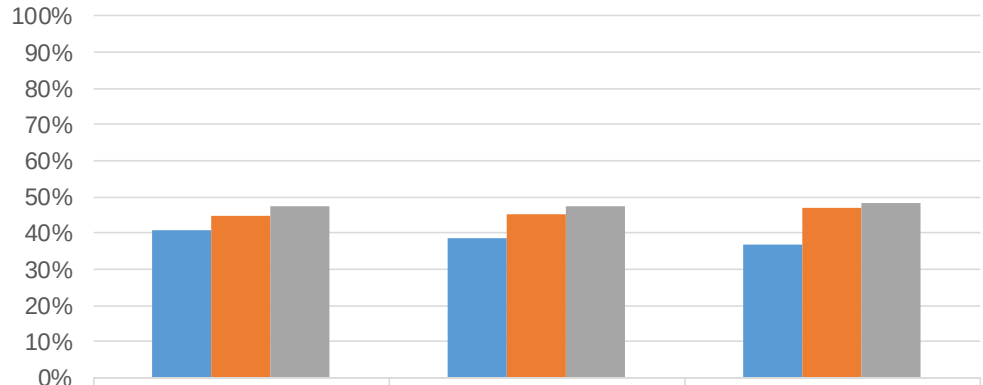
Figure 2B. Latino/Hispanic ACB
Sacramento MHP



	CY 2016	CY 2017	CY 2018
MHP	$4,157	$3,519	$4,480
Large	$5,785	$5,758	$5,884
State	$5,588	$5,278	$5,904

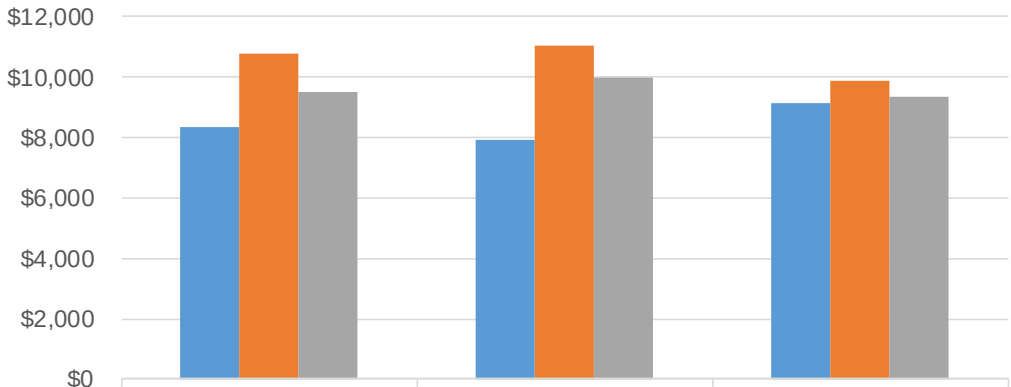
Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A. FC Penetration Rates
Sacramento MHP



	CY 2016	CY 2017	CY 2018
MHP	40.72%	38.58%	36.72%
Large	44.78%	45.37%	46.87%
State	47.48%	47.28%	48.41%

Figure 3B. FC ACB
Sacramento MHP



	CY 2016	CY 2017	CY 2018
MHP	$8,335	$7,906	$9,157
Large	$10,805	$11,064	$9,895
State	$9,521	$9,962	$9,340

High-Cost Beneficiaries

Table 2 provides the three-year summary (CY 2016-18) MHP HCBs and compares the statewide data for HCBs for CY 2018 with the MHP's data for CY 2018, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2. High-Cost Beneficiaries
Sacramento MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2018	23,164	618,977	3.74%	$57,725	$1,337,141,530	33.47%
MHP	CY 2018	505	23,775	2.12%	$51,348	$25,930,552	20.88%
	CY 2017	397	22,943	1.73%	$49,882	$19,802,985	17.96%
	CY 2016	568	23,784	2.39%	$50,368	$28,609,277	23.13%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2016-18) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

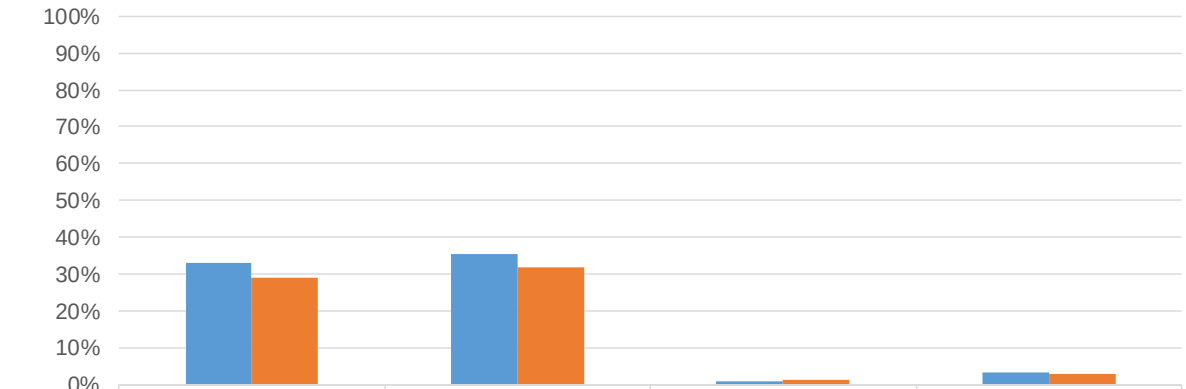
Table 3. Psychiatric Inpatient Utilization - Sacramento MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	1,919	3,604	19.52	$11,724	$22,499,113
CY 2017	1,835	3,851	9.24	$10,668	$19,575,081
CY 2016	1,856	3,975	9.73	$12,431	$23,071,408

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

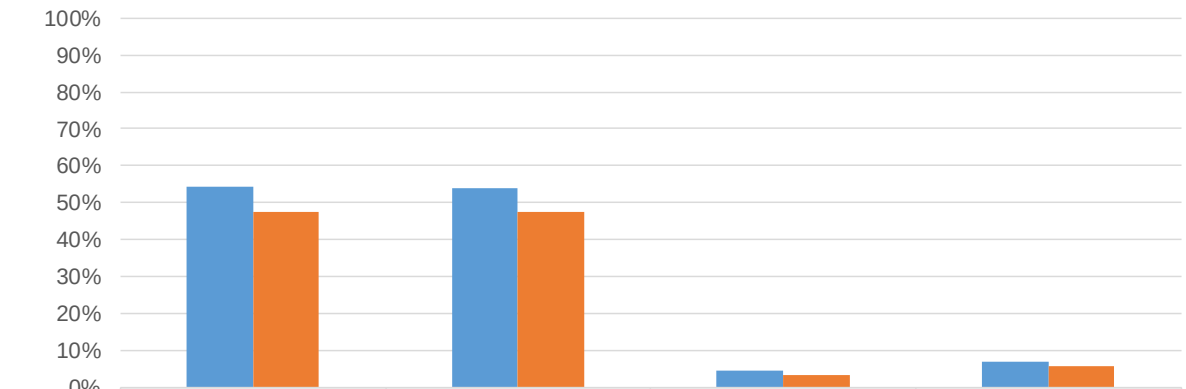
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
Sacramento MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	33%	36%	1%	3%
CY 2018	29%	32%	1%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
Sacramento MHP



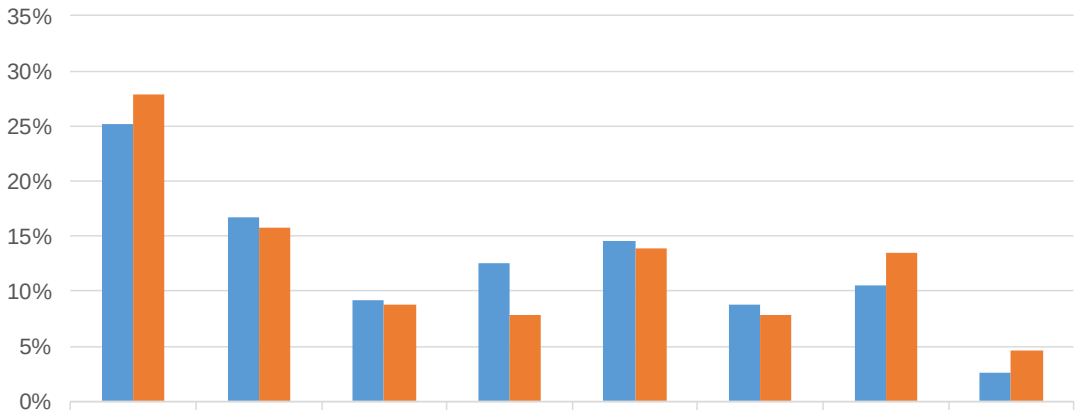
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	54%	54%	4%	7%
CY 2018	47%	48%	3%	6%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2018.

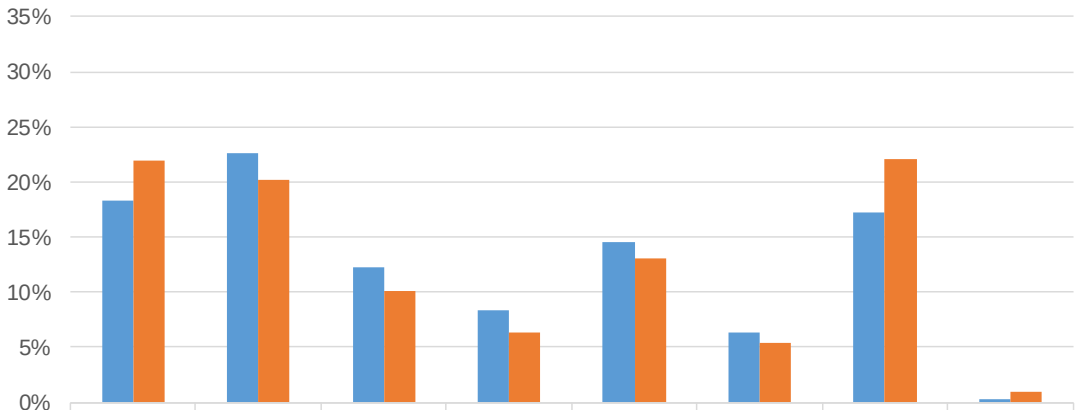
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 20 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Sacramento MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	25%	17%	9%	13%	15%	9%	10%	3%
State CY 2018	28%	16%	9%	8%	14%	8%	14%	5%

Figure 5B. Diagnostic Categories, Total Approved Claims
Sacramento MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	18%	23%	12%	8%	15%	6%	17%	0%
State CY 2018	22%	20%	10%	6%	13%	5%	22%	1%

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." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Sacramento MHP PIPs Identified for Validation

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

Table 4 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 4: PIPs Submitted by Sacramento MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improving Timely Access
Non-clinical PIP	1	Uniform Scheduling System Using an Electronic Scheduling Tool.

Clinical PIP— Improving Timely Access

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

"Does having a Medication Bridge Program with strategies for coordination of care, both initial and long term, increase consumer engagement, and timeliness to medication services, therefore decrease the use of mental health crisis services?"

Date PIP began: July 2017

End date: June 2019

Status of PIP: Completed

[5] 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.

The goal of the PIP was to reduce barriers and time to first psychiatric appointment by using the Medication Bridge Program for individuals who are unlinked and served at the MHUCC. By providing psychiatric services until the beneficiary can have their first face-to-face with the outpatient provider psychiatrist, the MHP hypothesizes that there should be a decrease in hospital/urgent care/emergency room use and an increase in engagement in outpatient services.

The MHP decided to discontinue the PIP due to decreased referrals to the Medication Bridge overall. They found that throughout the entire PIP, the Medication Bridge was only able to serve 128 people since July 1, 2018 to June 30, 2019. The Medication Bridge served an average of 15 people per month during the initial measurement period (December 1, 2017 through June 30, 2018). The MHUCC served an average of 333 people per month during the initial measurement (December 1, 2017 through June 30, 2018). The Medication Bridge served an average of four people per month during the re-measurement period (second quarter of fiscal year 18/19). The MHUCC served an average of 360 people per month during the re-measurement period (October 1, 2018 through December 31, 2019). Although the final data did not meet all performance indicator goals set out in the PIP, there was significant improvement in timeliness from request to psychiatric service at the Medication Bridge and an increase in client engagement in the Medication Bridge Program.

Suggestions to improve the PIP: The PIP Study Question would have benefited from inclusion of a goal number or percentages of beneficiaries who experienced earlier psychiatry appointments and engagement as well as a decrease in use of mental health crisis services.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of discussion of the completed PIP and areas that could be improved, to include the above-mentioned issues with the Study Question. It was also noted that it was problematic for the study that the process for access changed during the time of the PIP study.

Possible new clinical PIP topics were discussed. The MHP is currently considering looking at the clinical outcomes using a Strengths Model recovery tool and ANSA as an outcome tool.

The MHP was encouraged to avail themselves of TA early and often in the development of this new PIP.

Non-clinical PIP—Uniform Scheduling System Using an Electronic Scheduling Tool

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

"Does using the Avatar Scheduler to capture the first offered appointment at the point of authorization improve timeliness to first appointment and decrease the number of no shows and cancels, whereby improving client satisfaction and engagement to services?"

Date PIP began: February 2018; ended and amended January 2019 due to Final Rule timeliness requirements.

End date: June 2019

Status of PIP: Completed

The PIP is reviewed as originally designed, although it ended early and is going to be an amendment to the PIP presented last year which was a PIP with the goal to have the MHP Access Team schedule MHP beneficiaries with their initial appointment using a uniform electronic scheduling system among two selected adult providers for the study. The intent was to decrease no-show rates among adult beneficiaries by eliminating delays in obtaining an initial appointment with the provider. It was expected that this would result in improved timeliness to first appointments. Due to DHCS's new mandate on reporting timeliness, utilizing the scheduler for tracking and monitoring the first offered appointment is no longer necessary and would place an extra burden on the providers. The amendment to this PIP will entail changing the target population of the study while still utilizing the electronic scheduler.

The purpose of the amended PIP is to have the MHP Access Team schedule beneficiaries with an outpatient appointment at the time of discharge from a psychiatric hospital. The intent is to inform the beneficiary of a scheduled time and date for a follow up appointment at the time of discharge as opposed to a beneficiary waiting for a call back days after discharge to schedule a follow up appointment. The goal would be to improve timely access to follow up appointments and decrease beneficiary no-shows, as well as improve engagement and linkages to the MHP.

Suggestions to improve the PIP: The MHP wrote the amended PIP which is not yet active into the PIP submission. The amended PIP will need to be presented next EQRO review as free standing without information of previous PIP. This will be, for all intents and purposes, a new PIP.

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

The TA provided to the MHP by CalEQRO consisted of recommending that the MHP separate the original PIP out from the amended PIP to avoid confusion. Consult with the EQRO early and often during the development and implementation of the PIP.

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	PM	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	PM	PM
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 states, 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	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
		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	M	M
		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	NM
		8.2	PIP results and findings presented clearly and accurately	M	NM
		8.3	Threats to comparability, internal and external validity	PM	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	NM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	NM
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	NM
		9.3	Improvement in performance linked to the PIP	PM	NM
		9.4	Statistical evidence of true improvement	PM	NM
		9.5	Sustained improvement demonstrated through repeated measures	UTD	NM

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	19	14
Number Partially Met	5	1
Number Not Met	0	8
Unable to Determine	1	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Ratings ((#M*2) +(#PM))/(AP*2)	**86%**	**58%**

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its 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 Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

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

Table 7 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, and IT staff for the past four-year period. For comparative purposes, we have included similar size MHPs and statewide average IT budgets per year for prior three-year periods.

Table 7: Budget Dedicated to Supporting IT Operations				
	FY 2019-20	**FY 2018-19**	**FY 2017-18**	**FY 2016-17**
Sacramento	2.00%	1.37%	2.24%	1.90%
Large MHP Group	N/A	2.70%	2.88%	2.72%
Statewide	N/A	3.40%	3.30%	3.40%

The budget determination process for information system operations is:

- ☐ Under MHP control
- ☐ Allocated to or managed by another County department
- ☒ Combination of MHP control and another County department or Agency

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	8.17%

Table 8: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
Contract providers	90.97%
Network providers	0.86%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Table 9 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 9: Contract Providers Transmission of Beneficiary Information to MHP EHR System		
Type of Input Method	**Percent Used**	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	90%	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	N/A	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	N/A	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	5%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	5%	Daily
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	N/A	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of county-operated sites currently operational: -0-
- Number of contract provider sites currently operational: 1

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☐ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☒ To serve special populations (i.e. children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries

- Telehealth services are available with English speaking practitioners (not including the use of interpreters or language line).
- Telehealth services limited to beneficiaries served in the early psychosis program that have difficulty attending appointments due to symptoms or transportation issues.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

Fiscal Year	IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
2019-20	9	2	0	1
2018-19	6	2	6	3
2017-18	11	2	0	2

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	8	0	0	1
2018-19	8	0	0	1
2017-18	11	0	0	0

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

- As noted in Table10, three additional IT FTE positions were added during the year, with no staff retirement or transfers being reported.
- The nine FTE technology positions support 1570 healthcare professional staff, including contract providers, a support-to-staff ratio of approximately 1/175.

Current Operations

- The MHP periodically conducts User Forums to obtain end-users input. The last forum was held July 2019.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 12: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Avatar	Practice Management (CalPM)	Netsmart	10	Netsmart
Avatar	Clinical Workstation (CWS)	Netsmart	8	Netsmart
Avatar	RAD	Netsmart	10	Netsmart

Table 12: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Avatar	Appointment Scheduler	Netsmart	10	Netsmart
Order Connect	e-Prescribing	Netsmart	2	Netsmart
Order Connect	Lab Order Exchange	Netsmart	2	Netsmart
Avatar	Care Fabric	Netsmart	>1	Netsmart

The MHP's Priorities for the Coming Year

- Implement Electronic Lab Orders (Quest Labs).
- Implement Interoperability using (CareQuality / CareConnect Inbox).
- Convert CalOMS State reporting - from legacy system to Avatar.
- Implement Electronic Prescribing Controlled Substances (EPCS).
- Support Provider Integration.
- Implement myHealthPointe - Client Portal.
- Timely implement CSI Assessment transactions to support DHCS IN 19-020 data capture and state reporting requirements.

Major Changes since Prior Year

- Implementation of DMC-ODS Demonstration Waiver project.
- Implement Medicare Part B claiming.
- Re-design and implement Electronic Service Request system.
- Implement Speech to Text solution (MModal).
- Complete system updates to support State Mandated Data Reporting for CANS, PSC-35 and Timeliness tracking and reporting.

Other Areas for Improvement

- Lack of data warehouse that supports advanced data analytical conditions continues to hamper the MHP ability to effectively use Avatar EHR clinical data.

- Clinicians continue to not see Avatar as an effective tool that makes their work more efficient.
- Challenges in the availability and quality of data from the MHP's EHR creates obstacles in determining the adequacy of data analytic staff to conduct comprehensive analysis of services by provider for year-over-year comparative results to assess network capacity given the diversity of the Medi-Cal beneficiary population
- The MHP lacks help desk software application to track and monitor support activities. There is an established help desk process to triage calls/emails and to assign to the appropriate person to address but does not provide dashboards or management reports to monitor overall effectiveness of the support.
- The MHP continues to allow contract providers to use and submit paper documents for data entry input, or scanning, into Avatar. While the number of paper forms is limited, and document volume is unknown, this process is labor-intensive and prone to data entry errors.

Plans for Information Systems Change

- The MHP has no plans to replace current system – in place for more than five years.

Current EHR Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts				X	
Assessments	Netsmart	X			
Care Coordination				X	
Document Imaging/ Storage	Netsmart	X			
Electronic Signature—MHP Beneficiary	Topaz/Netsmart	X			
Laboratory results (eLab)	Netsmart		X		
Level of Care/Level of Service	Netsmart	X			

Table 13: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Outcomes	Netsmart	X			
Prescriptions (eRx)	Netsmart	X			
Progress Notes	Netsmart	X			
Referral Management				X	
Treatment Plans	Netsmart	X			
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		8	1	3	0
FY 2018-19 Summary Totals for EHR Functionality:*		8	1	3	0
FY 2017-18 Summary Totals for EHR Functionality:		8	0	4	0

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

Progress and issues associated with implementing an EHR over the past year are summarized below:

- As noted in Table 13, Summary Totals for EHR Functionality: there continues to be limited progress to improve EHR functionality over the past three fiscal years.
- While elements on the list have not been implemented, the Avatar Team has provided workflow analysis, hands on technical assistance with new and existing programs, and worked with providers to determine improvements (customized widgets, consoles, bundles, etc.) for front line staff efficiencies.
- The electronic laboratory order entry and results project is active, the MHP is working with the vendor (QUEST Labs) to resolve functionality issues.
- Release of Information (ROI) documents, supported by electronic signature functionality, remains a “work-in-progress” that will significantly reduce clinicians’ time and effort to share beneficiary information with other authorized healthcare provides.

Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

☐ Yes ☐ In Test Phase ☒ No

If no, provide the expected implementation timeline.

☐ Within 6 months	☒ Within the next year
☐ Within the next two years	☐ Longer than 2 years

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Dimension Reports

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

- The MHP went live with submitting Part B claims to Medicare fiscal intermediary beginning July 2019.

Table 14 summarizes the MHP's SDMC claims.

Table 14. Summary of CY 2018 Short Doyle/Medi-Cal Claims Sacramento MHP							
Service Month	**Number Submitted**	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Dollars Approved**
TOTAL	**691,230**	**$121,085,647**	**21,816**	**$4,152,683**	**3.43%**	**$116,932,964**	**$110,527,839**
JAN18	57,408	$9,762,990	1,741	$284,982	2.92%	$9,478,008	$9,077,279
FEB18	53,002	$9,105,367	1,660	$284,818	3.13%	$8,820,549	$8,424,471
MAR18	58,193	$9,916,661	1,733	$298,633	3.01%	$9,618,028	$9,188,778
APR18	57,459	$9,823,321	1,864	$368,669	3.75%	$9,454,652	$8,957,844
MAY18	58,481	$9,962,432	1,865	$345,074	3.46%	$9,617,358	$9,132,028
JUN18	51,035	$8,841,016	1,701	$340,339	3.85%	$8,500,677	$8,037,679
JUL18	50,763	$8,966,833	1,622	$429,128	4.79%	$8,537,705	$7,868,545
AUG18	104,943	$18,256,153	3,098	$559,728	3.07%	$17,696,425	$16,770,886
SEP18	49,361	$9,025,242	1,586	$298,496	3.31%	$8,726,746	$8,179,807
OCT18	56,986	$10,328,605	1,834	$367,792	3.56%	$9,960,813	$9,305,925
NOV18	49,060	$8,980,165	1,554	$290,256	3.23%	$8,689,909	$8,170,864
DEC18	44,539	$8,116,862	1,558	$284,769	3.51%	$7,832,093	$7,413,733
Includes services provided during CY 2018 with the most recent DHCS claim processing date of June 7, 2019. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2018 was **3.25 percent.**							

Table 15 summarizes the top three reasons for claim denial.

Table 15. Summary of CY 2018 Top Three Reasons for Claim Denial Sacramento MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed before submission of claim.	12,129	$2,246,665	54%
Payment denied - prior processing information incorrect. Void/replacement condition.	4,791	$952,474	23%
Beneficiary not eligible, or emergency services or pregnancy indicator must be "Y" for this aid code.	3,279	$514,296	12%
TOTAL	21,816	$4,152,683	N/A
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

Some of the CY 2018 denied claim transactions with reason description "Medicare or Other Health Coverage must be billed before submission of claim" maybe re-billable as the MHP went live with Part B claims processing July 2019.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted three 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested three focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

CFM Focus Group One

Cal EQRO requested a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months, including non-English speaking beneficiaries. The group was consistent with that requested by CalEQRO, with a mix of young adult, adult, and older adult participants. The group was held at Visions Unlimited, 6833 Stockton Boulevard, Suite 485, Sacramento CA 95823.

Number of participants: 12

The four participants who entered services within the past year described their experiences as the following:

- New beneficiaries agreed that response to request for services was timely.
- Participants report that they are receiving useful services that include groups.

Participants' general comments regarding service delivery included the following:

- All participants have a therapist.
- Three participants have case managers. Two participate in groups.
- Several of the participants have psychiatrists.
- Five reported that they have unpleasant side-effects from their medications and can discuss this with the psychiatrist.
- Several participants reported that when waiting for an appointment, they are often taken to the room for the appointment and then must wait lengthy periods of time (length of time unspecified).

- A few participants were unhappy that their case managers change frequently.
- All participants know what to do if they experience a mental health crisis. Five people had experienced a crisis in the past year and reported being able to access services.
- Several participants reported they have accessed transportation assistance.
- Most information is received through therapists, brochures and fliers in the lobby and at times from mailings.
- All participants agree that they are involved in their treatment planning.
- Most of the participants report having a wellness and recovery plan.
- Several are involved in the National Alliance on Mental Illness (NAMI) and go to a wellness center.
- Most of the participants have primary care providers, and several are aware that their doctors are in contact with their psychiatrists.
- Only one person reported receiving any information about employment services.

Participants' recommendations for improving care included the following:

- More interpreters would be helpful. Sometimes the MHP must cancel an appointment because of no available interpreter. It can take 15 days to a month to reschedule. It was noted that the MHP calls or texts to notify the client in this case.
- More Spanish speaking therapists are needed.
- It would be helpful to have more groups available to help deal with stigma.

Interpreter used for focus group one: Yes Language(s): Spanish

CFM Focus Group Two

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months, including non-English speaking beneficiaries. The group was consistent with that requested by CalEQRO, with a mix of adult and older adult participants, all female and of Hispanic/Latino ethnicity. The group was held at La Familia, 3301 37th Avenue, Sacramento, CA 95824

Number of participants: 11

The four participants who entered services within the past year described their experiences as the following:

- There were no issues accessing services; some were referred by the school and some from family doctors.
- All report that their children are improving with services.

Participants' general comments regarding service delivery included the following:

- Most of the participants' children receive services in school.
- Several children also receive in-home services.
- Four receive services in Spanish and seven receive services in English.
- Five participants reported that their children see a psychiatrist.
- All children of this group have a therapist.
- All receive services in the summer, and five families receive this service in-home.
- All agreed they are involved in treatment planning for their children.
- Several participants are part of a parent support group, and one stated she was also receiving mental health services.
- The majority reported that if therapists cancel appointments they are immediately rescheduled, and if they need to cancel, they can quickly reschedule.

Participants' recommendations for improving care included the following:

- All participants expressed gratitude for the services they receive. Comments were about things that were positive.
- All services have asked parents for input on how to improve services. Specifically, La Familia has a monthly feedback meeting.
- The participants were particularly impressed that Jennifer Newsom (Governor Newsom's wife) came to a program to ask how services could improve.
- Changes in services in past year mean more services and offerings with no changes in quality of services.

Interpreter used for focus group two: Yes Language(s): Spanish

CFM Focus Group Three

CalEQRO requested a culturally diverse group of transitional age youth (TAY) beneficiaries, both high and low utilizers of services who are mostly new clients who have initiated/used services within the past 12 months, including non-English speaking beneficiaries. The group was consistent with that requested by CalEQRO, with a mixture of under 18, young adult (18-24) and one adult (25). The group was of mixed ethnicity and all English speaking. The group was held at Capital Star, 401 S Street, Sacramento, CA. 95811

Number of participants: Nine initially; however, one left because s/he thought there would be housing assistance. Eight filled out demographic forms.

The four participants who entered services within the past year described their experiences as the following:

- All found services easy to access; some came through the process of seeking housing through county resources.
- All reported having therapists and being in groups.
- All participants reported finding services is easy because there are many programs to choose from.
- Some participants experienced difficulty obtaining supplies and bus passes. (What supplies was not specified.)
- Several participants were aware of, and some have utilized, CalWorks.
- Some, but not the majority, of participants have a primary care provider. They were unaware of communication between psychiatrist and the primary care doctor.
- Four participants reported that their parents are involved in their treatment and have permission to contact their primary care doctor.

Participants' general comments regarding service delivery included the following:

- Four participants in treatment more than a year at Capital Star and are aware of resources through that treatment program. Others did not know about services until their interview when requesting services.
- Housing is a major issue to all participants; four currently have permanent or semi-permanent housing. Others couch-surf or live with family. None are currently living on the street.

Participants' recommendations for improving care included the following:

- Need more focus on mental health services, not just referring to other resources.

- Beneficiaries need more support to find work and/or transportation.
- More service sites are needed in different geographic locations.
- Improvement is needed in physical spaces, larger more comfortable and welcoming rooms and lobbies.

Interpreter used for focus group three: No Language(s): n/a

PERFORMANCE AND 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 Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

Access to Care

Table 16 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries 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 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
1A	Service Access and Availability	14	12
The MHP has information on its website that includes a toggle that allows the reader to choose language (English, Spanish, Chinese, Vietnamese, Tagalog, Russian, Hindi). While the website is under the auspices of the County, the MHP monitors usage and accessibility. The MHP maintains an up-to-date provider directory available for referrals. The beneficiaries' experiences with the 24/7 access line is monitored and tracked for reports of efficacy. There is also a 24/7 mobile response system for foster youth, former foster youth and their caregivers that launched in June 219 called "The Source". There is a beneficiary operated warm line Monday – Friday 9:00 a.m. – 5:00 p.m. where callers can obtain information on services. The MHUCC is available for urgent mental health (MH) and /or co-occurring substance use disorder (SUD) Monday – Friday from 10:00 a.m. – 10:00 p.m. and holidays 10:00 a.m. – 6:00 p.m. support during a crisis through several community-based programs. Crisis triage support is provided via phone, in-person, and a secured website. Interventions may include in the moment support, mediation, follow-up support, information and referrals, and linkage to outpatient mental health services through various community services. The MHP conducted a PIP to address the ongoing issue of timely access to first psychiatric appointment.			
1B	Capacity Management	10	5

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
The MHP conducted a PIP to address capacity through utilization of a uniform scheduling system using an electronic scheduling tool (Avatar Scheduler). In response to last year's recommendation that the MHP investigate the reason 33 percent of beneficiaries who receive authorization for services discharge without receiving services, the MHP brought this issue for discussion to various provider meetings and forums to attempt to determine factors contributing to beneficiaries not engaging in services with the MHP following authorization for services. Results were inconclusive. The MHP has taken steps to minimize the number of beneficiaries who are discharged without receiving a service through outreach and engagement efforts. The MHP tracks this using engagement, no-shows, and cancelation codes in the scheduling input. Outreach and engagement efforts utilized were not specified during the EQRO onsite review. The MHP continues to lack program capacity to service beneficiary demand for services. Given the diversity of this county, the MHP encourages hiring bilingual/bicultural staff who speak one of the six threshold languages. Service is provided to all beneficiaries by bilingual/bicultural staff or through the use of an interpreter. Community care teams are in place to connect upon referral to first appointments. The system was changed regarding post discharge from hospital appointments. The beneficiary is now asked by the hospital discharge staff to sign whether they are interested in services, not interested in services, or receiving services from another entity as part of the discharge planning process with the beneficiary. This allows the MHP to better track no-shows for post discharge appointments.			
1C	Integration and Collaboration	24	22
The MHP is integrated and maintains collaborative relationships with multiple programs, partnering agencies and community-based organizations. Examples validated during the onsite review include Sacramento County schools, Consulate of Mexico, Whole Person Care Network aligned with the Homeless Expansion Initiative in collaboration with the City of Sacramento, Law Enforcement Agencies, Collaborative Courts, Probation and Child Welfare Services, Department of Human Assistance (DHA) Housing Authority, Primary Care Providers, Hospitals, SUD programs, Public Health, Managed Care Organizations, Faith-Based Organizations, Department of Rehabilitation and Employment Support. There are barriers in some instances due to a lack of enough contract providers and MHP direct services staff to fully utilize collaborative organizations.			

Timeliness of Services

As shown in Table 17, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
2A	First Offered Appointment	16	13
Per Information Notice (IN) 18-011, the MHP updated the FY2018-19 QI Work Plan timeliness standard definition from initial contact to first offered appointment to 14 calendar days (10 business days) as of July 1, 2019. The MHP tracks and reports this quarterly, to include looking at average and median times, percentage of times the standard is met, and the range, therefore this data was unavailable during CalEQRO onsite review.			
2B	Assessment Follow-up and Routine Appointments	8	8
The MHP offers timely services to beneficiaries and consistently tracks and reports quarterly routine and follow-up appointment data. This data is reported separately for children, adult, older adults and FC beneficiaries in addition to the aggregate data. The MHP initiates performance improvement activities with time limited goals when the DHCS standard and CCR timely access to routine mental health care standards are not consistently met. Currently, the MHP is planning a system change that implements changes for the access team to enhance engagement to first kept appointment and lowers no-shows.			
2C	First Offered Psychiatry Appointment	12	10
The MHP completed a PIP last year to address timeliness to initial psychiatry appointment. The MHP continues to recruit and work to solve psychiatry capacity issues. Per IN 18-011, the MHP has a timeliness standard of 15 business days. The MHP met the standard 37.7 percent overall, with a mean of 52.1 percent. The standard was met for adults 41.7 percent, with a mean of 41.9; for children 27 percent, with a mean of 62.3 percent; and for FC 38.5 percent with a mean of 37.6 percent.			
2D	Timely Appointments for Urgent Conditions	18	12
Per IN 18-011, the MHP does a timeliness standard of 48 hours for urgent conditions that do not require preauthorization and 96 hours for conditions requiring			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
preauthorization. The timeliness for urgent conditions formerly was measured in days. The MHP did not produce data for this new standard at the time of the onsite review.			
2E	Timely Access to Follow-up Appointments after Hospitalization	8	5
The MHP sets the standard as the seven days HEDIS standard for hospital post discharge appointments; however, this is not consistently met. The MHP tracks the overall number of inpatient discharged beneficiaries who receive a follow-up care encounter within seven days, and meets the standard overall 50.8 percent, with a mean of 20.2 percent. Adults meet the standard 48.3 percent of the time, with a mean of 24.8 percent; children 61.1 percent of the time, with a mean of 15.6 percent; and FC meet the standard 63.8 percent, with a mean of 33.1 percent.			
2F	Tracks and Trends Data on Rehospitalizations	6	4
The MHP routinely tracks and trends rehospitalization data within 30 days of discharge. The data presented was for a six months basis and is not part of the MHP's benchmarks. Only the first half of FY 2018-19 data was complete at the time of the onsite review. The MHP noted they had previously not tracked this measure for FC. The total number of hospital admissions for the first six months of the FY was 2,747, with 480 (17.4 percent) being readmitted within 30 days. Adult admissions were 2,549, with 468 or 18.4 percent readmitted; children admissions were 198 with 12 (6.1 percent) readmitted. Readmissions are known to be heavily weighted by discharges that are not linked to services.			
2G	Tracks and Trends No-Shows	10	6
The MHP produced a list of reports that they track no-shows by staff or beneficiary. MHP Benchmark data related to No Shows/Cancellations was provided to CalEQRO prior to on site review. Contract providers produce regular reports in some form of excel spreadsheet to track by clinician. Providers use their own EHRs to track and identify no-shows. Providers use their own EHRs to track and identify no-shows.			

Quality of Care

In Table 18, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 18: Quality of Care Components			
Component		**Maximum Possible**	**MHP Score**
3A	Beneficiary Needs are Matched to the Continuum of Care	12	8
The MHP presented a schematic diagram of the service continuum for both adult and children systems of care. There is a system within the EHR that can provide reports that facilitates matching of beneficiary needs with appropriate service level. The MHP continuum of care includes approximately 90 contracted and county-operated service providers delivering services across the spectrum from prevention and early intervention, early childhood, outpatient services, crisis intervention and stabilization, residential services, wellness and recovery centers, and inpatient psychiatric hospitalization. The issue of approximately 33 percent of those authorized for being discharged without receiving a service has yet to be resolved. The MHP does not yet have a plan in place to discern which beneficiaries or why this is occurring. The MHP continues encourage providers to utilize the newly added engagement codes to support data gathering and analysis. Once a year's worth of data has been gathered the MHP will work on a plan to address and discern which beneficiaries and why this is occurring."			
3B	Quality Improvement Plan	10	10
The MHP has a current QI plan, inclusive of prior year's findings and results. It contains measurable goals and objectives with quarterly progress included. The plan includes analysis of disparity in services by site, region, and population served. The meeting minutes are notable in the information communicated, enabling readers to understand and track the improvement activities of the department. The MHP provided the annual evaluation of the effectiveness of the QI activities in the work plan.			
3C	Quality Management Structure	14	14
The MHP has a designated Quality Management (QM) unit that effectively interfaces with other units within the MHP. The MHP has a designated QI Coordinator, and additional QI staff (e.g., analysts), adequate to perform quality management functions. The MHP presented evidence of a direct line of communication between the QI coordinator, QI staff and leadership. The QIC includes representative membership of the entire system of care (SOC), including contract providers, beneficiaries and family members. The QM functions include data extraction and analysis pertaining to access, timeliness, quality and outcomes. These findings are shared with leadership and throughout the MHP SOC.			

3D	QM Reports Act as a Change Agent in the System	10	8
Utilization Review (UR) committee looks at QI across the board and the QM reports are utilized for decision making on program and performance improvement. These reports guide the performance improvement activities, to include selection of Plan-Do-Study-Act (PDSA) and PIP topics. The MHP provided examples of successful outcomes for several of these activities. However, recent PIPs that were to address capacity have had limited success.			
3E	Medication Management	12	12
QI meeting minutes provide information of ongoing medication monitoring and oversite. The MHP follows standard practices of care regarding medication management through the systems of care, to include contract agency providers. The MHP tracks and monitors FC medications in alignment with SB 1291 requirements. Examples of both adult and child treatment outcomes and HEDIS reporting were also submitted to CalEQRO.			

Beneficiary Progress/Outcomes

In Table 19, CalEQRO identifies the components of an organization that is dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 19: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	16
The MHP currently uses the Level of Care Utilization System (LOCUS) tool for adults, with plans to convert to the ANSA this year. The MHP adopted the CANS-50 for all children and youth programs. Both adult and children and youth tools are used consistently, at the beginning of treatment, and as appropriate to the tool including at exit from treatment. Outcomes are tracked for beneficiary outcomes in order to discern any gaps among subpopulations and identify groups in need of quality improvement in service delivery. These reports are shared with management, clinical staff, and contract providers.			
4B	Beneficiary Perceptions	10	10
The MHP administers the DHCS Consumer Perception Survey (CPS) each year. The results are compared with previous years. Pertinent findings are shared with leadership, the Mental Health Board, MHP staff, contract providers, beneficiaries and			

the general public through the county website. The MHP also administers its own surveys to various programs and holds focus groups of those receiving services. QM utilizes all survey information as part of the decision process for programmatic changes to improve quality in services. All beneficiaries interviewed reported completing a survey within the past year. An example is the MHUCC Satisfaction Survey given to beneficiaries who receive their services. One question that it asks is where the beneficiary would have gone if not to MHUCC, and 15 percent respond to the ER. This points to effective diversion.			
4C	Supporting Beneficiaries through Wellness and Recovery	4	3
The MHP has enriched and functional peer-run and peer-driven programs. MHP has a robust Wellness Recovery Action Program (WRAP) imbedded in the SOC. Beneficiaries and family advocates participate in management team meetings on a regular basis. Career opportunities for peers and family members within the MHP are limited to contract provider organizations, however the MHP is currently researching feasibility of creating direct hire position descriptions and slots for lived-experience employees.			

Structure and Operations

In Table 20, CalEQRO identifies the structural and operational components of an organization that is facilitates access, timeliness, quality, and beneficiary outcomes.

Table 20: Structure and Operations Components			
Component		**Quality Rating**	
5A	Capability and Capacity of the MHP	30	25
Sacramento has a robust array of continuum of services. The MHP provided documentation of the various services in the SOC. The MHP produced a schematic diagram of the service continuum for both the adult and children systems of care. Psychiatry capacity continues to be an access to services issue.			
5B	Network Adequacy	18	18
The MHP utilizes an array of adjunct services delivery options. They met all DHCS requirements of the Final Rule for Network Adequacy for the current year.			
5C	Subcontracts/Contract Providers	16	16

The MHP includes contract providers in overall program development, planning and performance improvement activities. The MHP produced evidence of collaborative relationships with contract providers which was verified in the Community-Based Services Agencies Session during the CalEQRO onsite review.			
5D	Stakeholder Engagement	12	10
The MHP includes multiple levels of stakeholders in program planning, committees, and management meetings. This includes, supervisors, managers, contract providers, beneficiaries, family advocates, and community-based organizations. NAMI is active within the MHP's SOC as an advocate and participant in specific meetings.			
5E	Peer Employment	8	5
All designated peer positions are currently within contracted provider agencies. The MHP is currently researching the feasibility of creating a direct hire position description and slots for lived-experience employees. (See Response to Recommendations 13.)			
5F	Peer-Run Programs	10	10
The MHP has peer-run and peer-driven programs with a majority of the employees being peers and/or family members. These programs are dispersed throughout the geographic areas of the county. The beneficiaries are informed of these programs by therapists, case managers, fliers on bulletin boards and in their intake packets. This information is also available on the MHP county website, but few beneficiaries reported that they ever utilized this site. The MHP tracks and reports the utilization of peer-run programs.			
5G	Cultural Competency	12	10
The MHP has a Cultural Competency Plan (CCP), and they track and report data to assess the cultural, ethnic, racial, and linguistic needs of its beneficiaries with regards to access, timeliness, quality, and outcomes of services. The CCP documents strategies identified and resources employed to meet these needs of the beneficiaries. The Cultural Competency Committee (CCC) evaluates strategies and resources utilized and reports this in the CCP. The CCC meets monthly. The Ethnic Services Manager sits on the QI Committee and reports directly to the MHP Director as part of the executive team. The MHP provided documentation and examples of coordination between the CCP and QI committee's work plan, activities and evaluation. The MHP continues to provide accessibility in language of choice and provides services in the beneficiary's language of choice, which may include one of the six threshold languages as well as English. Recruitment and retention of clinical staff with cultural and linguistic competency in languages other than English continues to be a challenge for the MHP due to the competitive job market in this region.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2019-20 review of Sacramento MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- The MHP conducted a PIP to address timely access to first psychiatric appointment.
- The MHP is working to minimize the number of beneficiaries who are discharged without receiving a service through outreach and engagement efforts. The MHP tracks this using engagement, no-shows, and cancelation codes in the scheduling input.
- The system for post discharge appointment access was changed. The beneficiary is now asked by the hospital discharge staff to sign whether they are interested, not interested in services, or receiving services from another entity as part of the discharge planning process with the beneficiary at the time of discharge.

Strengths:

- Community care teams are in place to connect upon referral to first appointments as an effort to assist in access and engagement.
- The MHP has six Mobile Crisis units in various geographic areas of the county.

Opportunities for Improvement:

- The MHP has not succeeded in addressing the issue of approximately 33 percent of all beneficiaries authorized to services being discharged without receiving a service.
- Psychiatry capacity continues to be an issue.

Timeliness of Services

Changes within the Past Year:

- The MHP made changes in timeliness standards to be compliant with IN 18-011, this includes a standard of 14 calendar (10 business) days from initial contact to first offered appointment, and a standard of first offered psychiatric appointment to 15 business days.

Strengths:

- The MHP continues to work to increase psychiatry capacity through recruitment and retention, including telemedicine resources.
- Use of Avatar Scheduler has improved timeliness and capacity in the Children's System of Care (CSOC).

Opportunities for Improvement:

- The MHP only meets the standard for first offered psychiatric appointment 37.7 percent of the time.
- Utilizing Avatar Scheduler for adult services scheduling has resulted in a longer wait period to services.
- Time to first offered psychiatric appointment and first kept continues to be an issue across the SOC.

Quality of Care

Changes within the Past Year:

- The MHP updated the Co-Occurring Disorders Assessment (CODA) to mirror the DSM-5 substance use disorders diagnostic criteria. This change was discussed with Executive Directors of contracted agencies to identify any concerns regarding documenting co-occurring disorders.
- The MHP is creating its tenth community specialized suicide prevention program within the Arabic speaking community in Sacramento County. This is an example of community-based organizations collaboration with the MHP.

Strengths:

- The change in the CODA to mirror the DSM-5 facilitates the provider in determining the severity of substance use, leading to more accurate diagnosis and referral for treatment for substance use disorders. CODA criteria have been updated in the MHP Documentation Training and are discussed as part of the Utilization Review Committee, which includes QM representation from county operated and contracted providers.
- The MHP has a robust continuum of care including prevention and early intervention, early childhood mental health services, TAY services, outpatient services, crisis intervention and stabilization, mobile crisis response in

collaboration with law enforcement, residential services, and inpatient psychiatric hospitalization.

Opportunities for Improvement:

- While the MHP utilizes various evidence-based practices (EBPs), trainings are not regularly scheduled and oversight of fidelity to the models is not tracked individually or for specific programs.

Beneficiary Outcomes

Changes within the Past Year:

- CANS-50 was implemented in October 2018, and an annual report is due to be generated in October 2019.
- ANSA will be piloted in two new programs FY2019-20. Based on positive findings from the pilot, ANSA will be implemented throughout the adult system of care (ASOC).

Strengths:

- The MHP has implemented CANS-50 across the CSOC and has assisted Child Welfare Services (CWS) in implementing CANS-50.
- The MHUCC gives every client who comes through the clinic a satisfaction survey when they leave.

Opportunities for Improvement:

- Development of a career ladder for peer employees has completed the background research phase, also involving contracts and contract providers, to be followed up with the help of County Human Resources (HR) for the creation of direct hire positions that include a career ladder.
- CANS-50 data is only reported on yearly.

Foster Care

Changes within the Past Year:

- The MHP is tracking and reviewing all SB 1291 criteria for internal use.
- The MHP has implemented a 24/7 call center with mobile response capability for FC and former FC youth and caregivers.
- The MHP entered into contract with three agencies for Short Term Residential Therapeutic Programs (STRTPs) and one agency for Therapeutic Foster Care (TFC).

- The MHP participates in an Interagency Placement Committee (IPC) to review placements and moves related to STRTPs. IPC includes an MOU and collaboration between Behavioral Health Services (BHS), CPS, probation, the regional center and local school districts to come to decisions of consensus on placement decisions. Currently this committee meets weekly, with possibility of twice weekly as needs grow.

Strengths:

- The MHP has six families who are in the process of being vetted as TFC families.
- Contracted providers for FC agree that the CSOC redesign improved collaboration between mental health and child welfare services.

Opportunities for Improvement:

- Methods for effectively exchanging information between CPS and the MHP continues to be discussed through cross-system meetings at the management level for both client level and system level data.
- CPS now implements Child and Family Team (CFT) meetings and the MHP participates in those CFTs. The MHP is developing a curriculum that will create more consistency in the delivery of CFTs.

Information Systems

Changes within the Past Year:

- Increase technology staffing was achieved and no staff turnover issues noted.

Strengths:

- None noted.

Opportunities for Improvement:

- The MHP does not have a specialized help desk software solution for tracking and reporting help desk calls. However, the MHP reports that a formal help desk process is in place which tracks email requests and responses.
- A data warehouse is not fiscally feasible currently and would not necessarily increase efficiencies as Sacramento County's software and database are hosted by the vendor; therefore, the MHP needs to focus on creating more robust reporting workarounds with IT staff for the current constraints on the use of data.

Structure and Operations

Changes within the Past Year:

- The redesign of the CSOC served multiple purposes, including better geographic distribution of clinics, gave all programs the ability to provide low to high intensity services, all programs have the ability to provide Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS), and a distribution of funding to allow all providers to invest in EBPs.

- The MHP has expanded their crisis continuum of care, including now having six mobile support teams and working with the Sacramento Police Department, County Sheriffs, as well as Elk Grove, Folsom, Citrus Heights Police Department and others. This is not a billable service, nor does it count for Network Adequacy, but one the MHP believes it is essential.

- A new Director of DBHS has been in position for six months.

Strengths:

- The MHP continues to search for successful ways to recruit and retain clinical staff.

- The redesign of the CSOC means that children and youth do not have to move to a different provider when service needs change, including ICC or IHBS.

Opportunities for Improvement:

- The county hiring process for County Operated Programs is lengthy and valuable time and candidates are lost during the process, especially for the recruitment of psychiatrists.

FY 2019-20 Recommendations

PIP Status

- 1. As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.
- 2. Design and implement a clinical PIP with results reported not less than quarterly.
- 3. Continue the non-clinical PIP as amended to ensure an active PIP with results reported not less than quarterly.
- 4. Contact EQRO early and often in the development of the PIPs.

Access to Care

- 5. Continue to work to understand the issue of beneficiaries authorized to services who are discharged without receiving a service. *(This recommendation is a carry-over from FY 2018-19.)*
- 6. Continue to research and implement solutions to the recruitment and retention of psychiatric providers.

Timeliness of Services

- 7. Explore possible reasons for the standard of timeliness for first offered psychiatric appointment being met only 37.7 percent of the time.
- 8. Continue to research solutions for psychiatry timeliness to service.

Quality of Care

9. Design and implement tracking of outcomes of Evidence Based Practices (EBP) for individual and program levels. Assess how fidelity to the model is be ensured and if inadequate remediate this issue. Report not less than quarterly to the Quality Improvement Committee (QIC).

Beneficiary Outcomes.

- 10. Continue the work necessary to initiate a standardized defined career ladder for peer employees in direct county programs.
- 11. Following the successful implementation of county peer employees with a defined career ladder, proceed with research of creating a contract standardized defined career ladder for peer employees incorporated into contract provider programs. *(This recommendation is a carry-over from FY 2018-19.)*

- 12. Report CANS-50 data on both an individual and aggregate by program level on a quarterly basis.

Foster Care

- 13. Ensure that all workflows are in place and execute any new memorandums of understanding (MOUs) needed to affect the appropriate exchange of information in a timely manner that ensures the change in structure for oversight of the work with Katie A. designated subclass children, to include FC children, between all involved agencies is effective. *(This recommendation is a carry-over from FY 2018-19.)*

- 14. Complete development of manual for CFTs and ensure collaborative training of all agencies involved in CFTs to ensure consistency in delivery of CFTs.

Information Systems

- 15. Establish a formal IT Help Desk supported by software to enable tracking and reporting on help desk calls.

- 16. Focus on workarounds for the current constraints on the use of data to use advanced data analytical tools to improve data analyses and reporting capabilities, and dashboards for end user use.

Structure and Operations

- 17. Given that parts of the hiring process, specifically the time required for a successful hire, are out of the MHP's control, research ways to expand the recruitment process. This might include utilizing more students in internship positions, and creating opportunities and enticement for them to be regular staff upon obtaining their respective licenses.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, either individually or in combination with other sessions.

Table A1—EQRO Review Sessions - Sacramento MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employee/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Forensics and Law Enforcement Group Interview
Community-Based Services Agencies Group Interview
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth

Table A1—EQRO Review Sessions - Sacramento MHP
Wellness Center Site Visit
Contract Provider Site Visit
Crisis Stabilization/Psychiatric Health Facility Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Lynda Hutchens, NCC, LMFT, Lead Quality Reviewer
Laurence Smith, LCSW, Quality Reviewer
Bill Ullom, Chief Information Systems Reviewer
Mark Refowitz, Information Systems Reviewer
Lisa Farrell, Information Systems Reviewer
Tilda DeWolfe, Consumer/Family Member Consultant
Alycia Martens, BHC Director of Business Operations

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 in preparing the recommendations within this report.

Sites of MHP Review

MHP Sites

Sacramento Health Services Administration>
7001A East Parkway>
Sacramento, CA 95823

El Hogar Guest House
600 Bercut Drive
Sacramento, CA 95811

Mental Health Urgent Care Clinic (MHUCC)
2130 Stockton Boulevard, Building 300
Sacramento, CA 95817

Access Call Center
3331 Power Inn Road
Sacramento, CA 95826

Contract Provider Sites

Visions Unlimited
6833 Stockton Boulevard, Suite 485
Sacramento, CA 95823

Dignity Health Medical Foundation Children's Center
6615 Valley Hi Drive, Suite A
Sacramento, CA 95823

Stanford Youth Solutions
8912 Volunteer Lane
Sacramento, CA 95826

La Familia Counseling Center, Inc.
3301 37th Avenue
Sacramento, CA 95824

Capital Star Behavioral Health
401 S Street
Sacramento, CA 95811

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Alfaro	Miguel	Clinician	El Hogar
Alqarwani	Latika	Program Director	TLCS
Asare	Mary Ann	Pharmacist	Sacramento County – Department of Health Services
Ayala	Gustavo	Peer Employee	Consumers Self Help – Wellness and Recovery Center
Bader	Sandena	Youth and Family Advocate Liaison	Nor Cal Mental Health America
Banh	Amy	Senior Mental Health Counselo0r	Access - Sacramento County Behavioral Health
Barney	Robin	Family Advocate Liaison	Nor Cal Mental Health America
Bates	Andrew	Detective	Folsom Police Department
Bennett	Deborah	Director of Flexible Integrated Treatment	Stanford Youth Solutions
Borja	Erlinda	Senior Mental Health Counselor	Access - Sacramento County Behavioral Health
Brown	Grainger	Clinical Supervisor	Dignity Health
Brown	Lawrence	Judge	County of Sacramento – Superior Court of California
Cagle	Christian	Family Partner Manager	Stanford Youth Solutions
Cation	Amber	Lead Clinician	Visions Unlimited Inc
Cervantes	Jesus	Program Coordinator – Adult Services	Sacramento County Behavioral Health
Child	Jon	Pharmacist	Sacramento County – Department of Health Services
Collette	Sara	Program Director	Human Resource Consultant (HRC)

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
DeCoursey	Sara	TBS Clinical Program Manager	Stanford Youth Solutions
DeOcampo	Maria	Program Planner - Research, Evaluation and Performance Outcomes	Sacramento County Behavioral Health
Eskow	Genelle	Chief Executive Officer	El Hogar
Fakhri	David	Psychiatrist	Human Resource Consultant (HRC)
Ferry	Katherine	Consumer Advocate Liaison	Nor Cal Mental Health America
Garza	Dionna	Clinician	Child and Adolescent Psychiatric Services (CAPS)
Gillette	Robert	Senior Accounting Manager	Sacramento County – Department of Health Services
Glamben	Lilyane	M.Ed., Project Manager	On Track Consulting
Glassman	Roxanne	Peer Employee	UC Davis - EDAPT
Gonsalves	Manuel	Supervising Probation Officer	Sacramento County Probation Department
Graham	Jenny	Quality Improvement Manager	Stanford Youth Solutions
Green	Sheri	Program Manager – Children's Services	Sacramento County Behavioral Health
Gregory	Kelly	Youth Advocate	Capital star Community Services
Guerrero	Marissa	Clinical Supervisor	Stars Behavioral Health Group
Guillen	Felipe	Peer Employee	Sacramento County Behavioral Health – Community Support Team
Gulley	Sillas	Program Manager, Mental Health Treatment Center	Sacramento County Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Harmon	Lisa	Program Planner - Research, Evaluation and Performance Outcomes	Sacramento County Behavioral Health
Hawkins	Pamela	Program Planner – Quality Management	Sacramento County Behavioral Health
Haynes	Carter	Executive Director	Dignity Health
Hayward	Audred	Clinical Director	TPCP Mental Health Urgent Care Clinic
Heck	Jennifer	Lead Family Partner	Stanford Youth Solutions
Heintz	Laura	Chief Executive Officer	Stanford Youth Solutions
Horn	Lisa	Program Coordinator – CPS/MH Team	Sacramento County Behavioral Health
Horst	Robert	Medical Director, Children's Services	Sacramento County Behavioral Health
Hullett	Joseph	Medical Director, Behavioral Health	Molina Health Care
Hussain	Iffat	Program Director	Mental Health Urgent Care Clinic Sacramento County Behavioral Health
Hussain	Zohair	Peer Employee	Sacramento County Behavioral Health – APSS
Hyppolite	Paul	Supervisor, Care Management	Molina Health Care
Ibarra	Melony	Administrative Officer 2	Sacramento County Behavioral Health
Irizarry	Christina	Program Coordinator – Program	Sacramento County Behavioral Health
Island	Lorenzo	Clinician	Terkensha
Jacobs	Melissa	Division Manager – Children's Services	Sacramento County Behavioral Health
Janoska	Holly	Program Coordinator	Sacramento County Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Kantner	James	Program Coordinator – Quality Management	Sacramento County Behavioral Health
Kelly	Stephanie	Program Manager – Adult Services	Sacramento County Behavioral Health
Kelly-Levin	Guadalupe	Clinician	Uplift Family Services
Kesserling	Rob	Health Program Manager	Access - Sacramento County Behavioral Health
Keune	Lynn	Clinical Supervisor	La Familia
Lewis	Sevina	Program Planner – Research, Evaluation and Performance Outcomes	Sacramento County Behavioral Health
Lloyd	Melissa	Deputy Director – CFAS	Sacramento County Department of Child, Adult and Family Services
Madariaga	Anthony	Division Manager - Mental Health Treatment Center	Sacramento County Behavioral Health
Mancina	Richard	Psychiatrist	Stanford Youth Solutions
McClure	Erin	Mental Health Program Coordinator	Access - Sacramento County Behavioral Health
Mendez	Gibran	Director of Quality Improvement	Stanford Youth Solutions
Mitchell	Ann	Administrative Services Officer – Avatar Training & Support/DBHS Billing	Sacramento County Behavioral Health
Moore	Darlene	Program Coordinator – Cultural Competence and Ethnic Services	Sacramento County Behavioral Health
Morgan	Kayla	Family Service Coordinator	Stanford Youth Solutions

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Nakamura	Mary	Program Manager – Cultural Competence and Ethnic Services	Sacramento County Behavioral Health
Nateghi	Maryam	Program Manager	Consumers Self Help – Wellness and Recovery Center
Ortiz	Mary	Peer Employee	UC Davis - EDAPT
Owen	Kestrel	Peer Employee	Turning Point Community Programs
Pai	Dean	Lieutenant	Sacramento County Sheriff's Department
Panyala	Anantha	Program Manager, Mental Health Treatment Center	Sacramento County Behavioral Health
Pastor	Dara		El Hogar Guest House
Perkins	Ernest	Program Coach	Stanford Youth Solutions
Preszler	Eric	Program Coordinator – Children's Services	Sacramento County Behavioral Health
Quinley	Matthew	Health Program Manager	Sacramento County Behavioral Health
Quist	Ryan	Deputy Director – Division of Behavioral Health	Sacramento County Behavioral Health
Ranes	Leanne	Assistant Program Director	Turning Point
Rechs	Alex	Program Manager – Quality Management	Sacramento County Behavioral Health
Reed	Rolanda	Program Coordinator – Quality Management	Sacramento County Behavioral Health
Reiman	Jennifer	Program Coordinator	Sacramento County Behavioral Health
Richards	Belyn	Peer Employee	Consumers Self Help - Wellness and Recovery Center
Richards	Jason	Program Planner	Sacramento County Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Rickards	Kris	Clinical Supervisor	Sacramento Children's Home
Robitz	Rachel	Assistant Medical Director	Mental Health Urgent Care Clinic
Rodriguez	Lupita	Program Administrator	Health Education Council
Rodriguez	Jacqueline	Coordinator, Student Services & Health Support	Sacramento City Unified School District
Rowlett	Al	Chief Executive Officer	Turning Point Community Programs
Sawyer	John	Information Technology Analysist II	Sacramento County – Department of Health Services
Scates-Gonzalez	Mindy	Human Resources Manager	Sacramento County Behavioral Health
Schallert	Janae	Clinician	Capital Star
Seide	Xiomara	Clinician	Uplift Family Services
Sharma	Pooja	Peer Employee	River Oak Center for Children
Shaw III	Vernell		Health Net
Shebesta	Jennifer	Program Director	Stanford Youth Solutions
Sheridan	Merrett		Aenta
Stanton	Meghan	Executive Director	Consumers Self Help – Wellness and Recovery Center
Stuto	Becky	Clinician	El Hogar
Synnott	Tiffanie	Public Defender	Sacramento County – Office of the Public Defender
Taylor	Shannan	Regional Director of Operations	Telecare
Thompson	Alondra	Behavioral Health Director	One Community Health
Thurmond	Howard	Peer Support Specialist	TPCP Mental Health Urgent Care Clinic

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Udy	Roland	Chief Operations Manager	River Oak Center for Children
Walshaw	Laura	Clinical Program Manager	Stanford Youth Solutions
Ware	Meka	Youth Advocate	Dignity Health
Waxvik	Nina	Service Provider	Hoe Cooperative RST
Weaver	Kelli	Division Manager – Adult Services	Sacramento County Behavioral Health
Wiley	Karly	Regional Administrator	Stars Behavioral Health Group
Williams	Dawn	Program Manager – Research, Evaluation and Performance Outcomes	Sacramento County Behavioral Health
Winistorfer	Katie	Wraparound Facilitator	Stanford Youth Solutions
Wirtz	Danielle	Clinical Supervisor	Telecare
Wright	Melanie	Clinician	River Oak Center for Children
Xiong	Glenn	Medical Director, Adult Services	Sacramento County Behavioral Health
Xiong	Cindy	Program Director	El Hogar Guest House
Zakhary	Jane Ann	Division Manager – Administration, Planning and Outcomes	Sacramento County Behavioral Health

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Sacramento MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,807,829	152,568	4.01%	$832,986,475	$5,460
Large	1,833,373	69,835	3.81%	$406,057,927	$5,815
MHP	141,487	3,931	2.78%	$16,543,618	$4,209

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

Table C2. CY 2018 Distribution of Beneficiaries by ACB Cost Band
Sacramento MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	22,628	95.18%	93.16%	$82,753,110	$3,657	$3,802	66.63%	54.88%
>$20K - $30K	642	2.70%	3.10%	$15,513,981	$24,165	$24,272	12.49%	11.65%
>$30K	505	2.12%	3.74%	$25,930,552	$51,348	$57,725	20.88%	33.47%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms	
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Sacramento	
PIP Title: Improving Timely Access	
Start Date: 07/01/17 **Completion Date:** 06/30/19 **Projected Study Period**: 24 Months **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review** 08/27-29/19 **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 ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of the PIP was to reduce barriers and time to first psychiatric appointment by using the Medication Bridge Program for individuals who are unlinked and served at the MHUCC. By providing psychiatric services until the beneficiary can have their first face-to-face with the outpatient provider	

psychiatrist, the MHP hypothesizes that there should be a decrease in hospital/urgent care/emergency room use and an increase in engagement in outpatient services.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Topic was selected due to historical data noting long wait times for linkage to ongoing outpatient MH services. Timeliness to first psychiatric appointment is a historically known issue. After opening of MHUCC in November 2017, there was concern that delay of engagement and direct service with psychiatrist following MHUCC service, would result in additional crisis or beneficiaries dropping out of services. Neither last year, nor this year, were there beneficiaries listed as part of the multi-functional team.

1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP's benchmark to first outpatient appointment is ten business days. However, as shown in Table 1 (Graphs 1 – 2), for adult consumers served at the Regional Support Teams (RSTs), the average number of days from request for outpatient services to first outpatient appointment in FY 2015-16 was 32.2 days, and in FY 2016-17 was 31.5 days. Additionally, the average number of days from intake (Assessment) to first psychiatric service for FY 2015-16 was 87.1, and in FY 2016-17 was 114.0 days.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Med Bridge program serves adults 18 years and older, who were unlinked to the MHP prior to their visit at the MHUCC. This population will be compared to the Adult consumers 18 years and older who requested services through traditional means (i.e., the Access Team).

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Med Bridge program serves adults 18 years and older, who were unlinked to the MHP prior to their visit at the MHUCC.
Totals		**3** Met **4** Partially Met **0** Not Met **0** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* "Does having a Med Bridge Program with strategies for coordination of care, both initial and long term, increase consumer engagement and timeliness to medication services, therefore decrease the use of mental health crisis services?"	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study question would be strengthened if there was a percentage goal for decrease in use of mental health crisis services.
Totals		**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other Previously unlinked prior to MHUCC visit	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Med Bridge program serves adults 18 years and older, who were unlinked to the MHP prior to their visit at the MHUCC. This population will be compared to the adult beneficiaries 18 years and older who requested services through traditional means (i.e. the Access Team).

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators

4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Timeliness from request to psychiatric service at Med Bridge program 2. No show and cancellations rates prior to first Med Bridge appointment 3. Percentage of referred Med Bridge consumers that have an intake appointment at the RST 4. Percent of referred Med Bridge consumers that receive engagement services prior to their first face to face RST appointment 5A. Percent of referred Med Bridge clients hospitalized while waiting for their first RST appointment (includes clients that eventually received RST services and clients who never showed for services) 5B. Percent of referred Med Bridge consumers that received crisis services (Intake Stabilization Unit (ISU), inpatient hospitalization, Sacramento County mobile crisis, and TLCS-Navigator) while waiting for their first medication appointment (includes clients that eventually received RST services and clients who never showed for services) 6. Percent of Med Bridge consumers that are discharged from an RST and never make it to their first RST appointment 7. Percent of clients that are discharged from Med Bridge and never make it to their first Med Bridge appointment	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

8A. Percent of clients that have had a Med Bridge psychiatric service and are re-admitted to the MHUCC within 30 days of their MHUCC discharge. 8B. Percent of clients that have had a Med Bridge psychiatric service and are re-admitted to the MHUCC within 90 days of their MHUCC discharge. 9A. Percent of clients who had a Med Bridge psychiatric service and were admitted to a higher level of service (ISU, inpatient hospitalization, Sacramento County mobile crisis, and TLCS-Navigator) within 30 days of their MHUCC discharge. 9B Percent of clients who had a Med Bridge psychiatric service and were admitted to a higher level of service (ISU, inpatient hospitalization, Sacramento County mobile crisis, and TLCS-Navigator) within 30 days of their Med Bridge psychiatric service. 10. Percent of clients who had a Med Bridge psychiatric service and had a first follow-up RST psychiatric service within 30 days of their Med Bridge psychiatric service.		

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The hypothesis is that early access to psychiatric care and medications increases the percent of positive treatment outcomes and increased wellness and recovery.
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**0** Met **0** Partially Met 0 Not Met **3** NA **0** UTD	
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Service authorization and utilization data was used to determine engagement and timeliness to services. Other information collected included demographics, Medication Bridge admissions and discharges, and psychiatric hospitalization data.
6.2 Did the study design clearly specify the sources of data? *Sources of data:*	☒ Met ☐ Partially Met ☐ Not Met	

☐ Member ☐ Claims ☐ Provider ☒ Other: Utilization data	☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data scheduled to be analyzed and reported comparing results from the first six months after PIP implementation with results one year after implementation. The Program Planner assigned to the PIP extracted data from MHP's EHR. Data was extracted based on the indicators outlined in this PIP.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☒ Medical record abstraction tool ☒ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All information for the PIP is captured in the EHR and available for reporting purposes.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Program Planner assigned to the PIP extracted data from MHP's EHR. Data was extracted based on the indicators outlined in this PIP. Results and trends are reviewed as part of a standing agenda item in the PIP Steering Committee meeting to determine whether the interventions set forth are providing the intended results. Interventions to be adjusted as necessary.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Pamela Hawkins Title: Program Coordinator Role: Facilitator *Other team members:* Names: no names given.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Research Evaluation and Performance Outcomes (REPO) Program Manager oversees the monthly data extraction and reporting by her staff. Staff is comprised of Program Planners who specialize in data collection, analysis, and reporting.
	Totals	**6** Met **0** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies

7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *July 1, 2017 – October 14, 2018:* 1. Face to face authorization of RST and Med Bridge Services with consumer is at MHUCC. 2. Written document providing outpatient provider information and Med Bridge information with next appointment information while at MHUCC. 3. Coordination of care between Med Bridge and the assigned outpatient provider. 4. RST engages consumer by telephone with three days of referral. 5. APSS/Med Bridge engages consumer by telephone within 48 hours of referral. 6. Develop a Satisfaction Survey for Med Bridge Services. *Updated Interventions (Effective October 15, 2018):* 1. MHUCC will submit a service request for authorization of RST while consumer is at the Urgent Care Clinic or within 72 hours. 2. MHUCC will provide outpatient provider information to the consumer while at the Urgent Care Clinic. 3. RST engages consumer by telephone within 3 days of referral	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	During the analysis of the first reporting period (December 2017 – June 2018) a number of unanticipated barriers presented themselves which resulted in a change in the authorization and referral process. The following items were the issues identified for analysis and discussion: 1. It was determined that the current practice of authorizing the client to both the RST and the Medication Bridge program at the initial referral from Urgent care was causing some confusion for clients. By receiving initial intake calls from both programs, it was unclear to the client who was to be their primary provider. 2. With the MHUCC providing a 30-day supply of medications upon discharge, the clients often did not attend their initial intake appointment with the Medication Bridge Program. 3. When the client attended the RST orientation, they were often able to schedule a psychiatric appointment and therefore did not need the Medication Bridge Program services. It is important to note that the PIP continued with the original interventions and process until the changes were approved and a start date was established. However, it took six to seven months to identify the barrier and if more frequently analyzed, this barrier could have been identified and dealt with sooner.

4. If RST medication support appointment provided by RST are not able to meet the medication need then the RST will submit a service request for Med Bridge services prior to the RST Provider Start Date. 5. RST will provide Med Bridge information to the consumer prior to the RST Provider Start Date. 6. APSS/Med Bridge engages consumer by telephone within 48 hours of authorization 7. Coordination of care between Med Bridge and the assigned outpatient provider.		
Totals		**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The Performance Indicators were tracked on a semi-annual basis and were reviewed at the bi-weekly PIP Committee Meetings. Service authorization, service utilization, admission, discharge and psychiatric hospitalization data were collected and analyzed using the same methodology each reporting period.

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: December 2017 – June 2018; October 2018 – December 2018 Indicate the statistical analysis used: _____n/a_____ Indicate the statistical significance level or confidence level if available/known: ____percent ___X___Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP was unable to complete any statistical analysis due to the small data set during the re-measurement period (28 Total Medication Bridge referrals with 12 receiving a Medication Bridge service).

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* The Medication Bridge was successful for the small number of beneficiaries that were enrolled and used the process as designed. However, due to the RST's ability to prioritize the referrals from the MHUCC the results were not as impactful to the identified target group. *Conclusions regarding the success of the interpretation:* The change in process in October 2018 may have threatened the internal and external validity of the outcomes *Recommendations for follow-up:* Although the MHP discontinued the PIP, the Medication Bridge will continue to offer appointments since there was data that demonstrated reduction to crisis/emergency services as well as timeliness to medication services for the number that was served. The MHP will re-evaluate the potential target group that may benefit from earlier access to medication services while being connected to their ongoing service provider. The PIP Committee reports that it has been beneficial for those who have received services from Medication Bridge. The Medication Bridge PIP Committee recommends the following expanded access to the Medication Bridge Program to include individuals who meet the following criteria	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals	**3** Met **1** Partially Met 0 Not Met **0** NA **0** UTD	

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Although there was a small N, there was improvement for those who were involved in the Medication Bridge service. The Medication Bridge was successful for the small number of beneficiaries that were enrolled and used the process as designed. However, due to the RST's ability to prioritize the referrals from the MHUCC the results were not as impactful to the identified target group
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☒ Fair ☐ High	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP was unable to complete any statistical analysis due to the small data set during the re-measurement period (28 Total Medication Bridge referrals with 12 receiving a Medication Bridge service). The change in process in October 2018 also may have threatened the internal and external validity of the outcomes.

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☒ Moderate ☐ Strong	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The Medication Bridge was successful for the small number of beneficiaries that were enrolled and used the process as designed. However, due to the RST's ability to prioritize the referrals from the MHUCC the results were not as impactful to the identified target group.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The MHP decided to discontinue the PIP due to decreased referrals to the Medication Bridge overall. They found that throughout the entire PIP, the Medication Bridge was only able to serve 128 people from July 1, 2018 to June 30, 2019. The Medication Bridge served an average of 15 people per month during the initial measurement period (December 1, 2017 through June 30, 2018). The MHUCC served an average of 333 people per month during the initial measurement (December 1, 2017 through June 30, 2018). The Medication Bridge served an average of 4 people per month during the re-measurement period (second quarter of fiscal year 18/19). The MHUCC served an average of 360 people per month during the re-measurement period (October 1, 2018 through December 31, 2019). Although the final data did not meet all performance indicator goals set out in the PIP, there was significant improvement in timeliness from request to psychiatric service at the Medication Bridge and an increase in client engagement in the Medication Bridge

Totals	**2** Met **2** Partially Met **0** Not Met **0** NA **1** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

Previous year's comments: Complete changes needed in the Study Question, Indicators, and Interventions to allow clarity in what is being measured. Proceed to collect and report data not less frequently than quarterly to ensure the PIP becomes active. Schedule TA with CalEQRO to assist in design and implementation of this PIP. These recommendations were addressed.

The PIP was ended due to the fact the MHP decided it no longer was needed.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS	
Recommendations: The PIP has been completed. The MHP needs to put a clinical PIP in place and begin intervention for this year. Contact EQRO early and often in the design of the PIP.	
Check one:	☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☒ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☐ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Sacramento	
PIP Title: Uniform Scheduling System Using an Electronic Scheduling Tool	
Start Date: 02/26/18 amended 01/01/19 **Completion Date:** 06/30/19 **Study Period**: 16 Months **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review:** 08/27-29/19 **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 ☐ No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The original goal of the PIP was to have the MHP Access Team schedule MHP beneficiaries with their initial appointment using a uniform electronic scheduling system among selected adult provider programs. The intent is to decrease no-show rates among adult beneficiaries by eliminating delays in obtaining an initial appointment with the provider. It was expected that this would result in	

improved timeliness to first appointments. Due to DHCS's new mandate on reporting timeliness, utilizing the scheduler for tracking and monitoring the first offered appointment is no longer necessary and would place an extra burden on the providers.

The amendment to this PIP (which will be the coming year non-clinical PIP) entails changing the target population of the study while still utilizing the electronic scheduler.

The purpose of the PIP is to have the MHP Access Team schedule beneficiaries with an outpatient appointment at the time of discharge from a psychiatric hospital. The intent is to inform the beneficiary of a scheduled time and date for a follow-up appointment at the time of discharge as opposed to a beneficiary waiting for a call back days after discharge to schedule a follow-up appointment. The goal would be to improve timely access to follow up appointments and decrease beneficiary no shows, as well as improve engagement and linkages to the MHP. However, the PIP as originally implemented is scored in this validation process.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments

1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP involved many stakeholders in the development and organization of this PIP. Members of the committee were selected based upon their experience and knowledge of the MHP system. The committee was comprised of MHP administrative staff from Quality Management (QM), Research, Evaluation, and Performance Outcomes (REPO), Avatar (Electronic Health Record), Access, Behavioral Health Services (BHS) Program, and Cultural Competence. It also involved direct care providers from the Adult system, Family Advocates, and Community members. The committee meetings were held bi-monthly and additional sub-committee meetings were held to delineate specific tasks and to ensure that various tasks were completed on schedule.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The topic of the original PIP was selected based on historic data on timeliness to services for outpatient. This was pointed out by EQRO, and the PIP was designed to address the initial time to service using a uniform electronic scheduling system. Due to DHCS mandating timeliness to first appointment as ten business days, this was no longer a useful PIP as the Scheduler actually increased wait times

Select the category for each PIP: *Non-clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions ☒ Process of accessing or delivering care		
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP addresses timeliness to first completed services, and number of no-shows and cancelations prior to first outpatient appointment. Additionally, the MHP wanted to address beneficiary satisfaction
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All adult beneficiaries referred authorized for services through the Access Team to the selected Regional Support Team (RST) providers.
	Totals	**4** Met **0** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* "Does using the Avatar Scheduler to capture the first offered appointment at the point of authorization improve timeliness to first appointment and decrease the number of no-shows and cancels, whereby improving client satisfaction and engagement to services?"	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Study question would be improved by adding a percent of improvement goal, as well as no-shows and cancelation targets. The MHP needs to operationalize "client satisfaction" and create an instrument to measure this outcome.
Totals		**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Entire adult population of individuals referred and authorized for services through the Access Team to the selected providers and does not utilize a sampling method.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Both RST sites selected for the PIP utilize the County's EHR (Avatar).
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1.Timeliness to first OP Face-to-Face Service at two distinct providers 2. Beneficiaries with no-shows/cancellations prior to first OP appointment 3. Timeliness from first contact to first offered and accepted appointment (scheduler data) 4. Beneficiary satisfaction for first OP appt. 5. Problem Resolution – grievance and appeals related to timeliness issues. 6. Engagement in Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators were drawn from long-standing county benchmarks. Indicator 6. Engagement in services is defined in the indicator as beneficiary that was opened for services with the provider.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary focused. ☐ Health Status ☐ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP postulates that engagement in initial services will lead to further engagement in services and satisfaction on the part of the client. This serves as a proxy for early wellness and recovery.
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**0** Met **0** Partially Met **0** Not Met **3** NA **0** UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The date of first offered appointment will be captured in the EHR along with no-show and cancellation data. Service authorization and utilization data will also be captured in the EHR and used to determine timeliness to services. Other data to be collected include provider admissions and discharges, and consumer demographic data. Data on the number of grievances submitted to beneficiary protection will also be collected and analyzed.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☒ Claims ☐ Provider ☒ Other: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The EHR and Beneficiary Protection access database are the instruments used to collect the data. County and Contract staff will be responsible for entering the data into the EHR.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The date of first offered appointment will be captured in the EHR along with no-show and cancellation data. Service authorization and utilization data will also be captured in the EHR and used to determine timeliness to services. Other data to be collected include provider admissions and discharges, and consumer demographic data. Data on the number of grievances submitted to beneficiary protection will also be collected and analyzed.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: Beneficiary Protection access database	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The EHR and Beneficiary Protection access database are the instruments used to collect the data. County and Contract staff will be responsible for entering the data into the EHR.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Appointment, no-show/cancellation data, service authorization, utilization data, and grievance data collected will be used to calculate baseline and repeated measures data for the performance indicators listed in Table A. of the PIP. Data will be analyzed by comparing results from baseline to PIP implementation with results one year after implementation, permeated with quarterly updates. Results and trends will be reviewed quarterly with the PIP Steering Committee meeting to determine whether interventions set forth are providing the intended results. Interventions will be adjusted, and training/coaching may be implemented as required.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Title: Role: *Other team members:* Names:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The REPO Program Manager oversees the monthly data extraction and reporting by designated staff. Staff is comprised of Program Planners who specialize in data collection, analysis and reporting.
	Totals	**6** Met **0** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Update "Scheduling Tool" curriculum, orientation, and training to ensure model fidelity and consistency of use across all sites Deliver Training to two sites Access utilizes the scheduler to schedule appointments while they have the beneficiary on the phone Provider utilizes the scheduler to ensure that there are appointment slots available for Access to schedule appointments for beneficiaries Provider reviews Avatar on daily basis to learn of newly scheduled beneficiaries Provider follows up with beneficiary to confirm appointment within 3 business days If beneficiary is hospitalized, Access schedules beneficiary appointment using the scheduler	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met **0** Partially Met 0 Not Met 0 UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not complete results or improvement achieved due to fact the PIP was ended.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Last two columns, “results (numerator/denominator) and % Improvement Achieved” were not completed due to fact the PIP was ended.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not complete results or improvement achieved due to fact the PIP was ended.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals	**0** Met **0 Partially** Met 4 Not Met **0** NA **0** UTD	

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not complete results or improvement achieved due to fact the PIP was ended.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☒ No	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not complete results or improvement achieved due to fact the PIP was ended.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☒ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not complete results or improvement achieved due to fact the PIP was ended.

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☒ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not complete results or improvement achieved due to fact the PIP was ended.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not complete results or improvement achieved due to fact the PIP was ended.
Totals	**0** Met **0** Partially Met **5** Not Met **0** NA **0** UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS	
Conclusions: Due to Final Rule timeliness criteria, the PIP was ended before originally planned or completed. An amended PIP that utilizes the scheduler but looks at post hospital discharge time to services is being designed.	
Recommendations: CalEQRO recommends that the MHP contact EQRO for TA early and often in the designing of the amended PIP.	
Check one:	☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time