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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SACRAMENTO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

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TABLE OF CONTENTS

List of Tables 4

List of Figures 5

INTRODUCTION 6
MHP Information 6
Validation of Performance Measures 7
Performance Improvement Projects 7
MHP Health Information System Capabilities 7
Network Adequacy 7
Validation of State and MHP Beneficiary Satisfaction Surveys 8
Review of Recommendations and Assessment of MHP Strengths and Opportunities 8

PRIOR YEAR REVIEW FINDINGS, FY 2019-20 10
Status of FY 2019-20 Review of Recommendations 10
Recommendations from FY 2019-20 10

PERFORMANCE MEASURES 18
Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure 20
Total Beneficiaries Served 21
Penetration Rates and Approved Claims per Beneficiary 22
Diagnostic Categories 26
High-Cost Beneficiaries 27
Psychiatric Inpatient Utilization 27
Post-Psychiatric Inpatient Follow-Up and Rehospitalization 28

PERFORMANCE IMPROVEMENT PROJECT VALIDATION 29
Sacramento MHP PIPs Identified for Validation 29
Clinical PIP 29
Non-clinical PIP 38

INFORMATION SYSTEMS REVIEW 43
Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP 43
Summary of Technology and Data Analytical Staffing 45
Summary of User Support and EHR Training 46
Availability and Use of Telehealth Services 48
Telehealth Services Delivered by Contract Providers 49
Current MHP Operations 50
The MHP's Priorities for the Coming Year 51

Major Changes since Prior Year 52
Other Areas for Improvement 55
Plans for Information Systems Change 55
MHP EHR Status 55
The list of the IS priorities for the coming year has ten projects for 11 IT full-time equivalents (FTEs). The MHP also purchases resources, including staff time, from the vendor to assist in completing priority items. Progress toward priorities is dependent on any change in priorities or DHCS mandates/requirements, as well as COVID-19 pandemic conditions. Contract Provider EHR Functionality and Services 56
Personal Health Record (PHR) 58
Medi-Cal Claims Processing 59

NETWORK ADEQUACY 61
Network Adequacy Certification Tool Data Submitted in April 2020 61
Findings 62
Provider NPI and Taxonomy Codes – Technical Assistance 62

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S) 63
CFM Focus Group One 63
CFM Focus Group Two 65
CFM Focus Group Three 67

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS 69
Access to Care 69
Timeliness of Services 71
Quality of Care 73
Beneficiary Progress/Outcomes 75
Structure and Operations 76

SUMMARY OF FINDINGS 78
MHP Environment – Changes, Strengths and Opportunities 78
FY 2020-21 Recommendations 82

SITE REVIEW PROCESS BARRIERS 83

ATTACHMENTS 84
Attachment A—On-site Review Agenda 85
Attachment B—Review Participants 87
Attachment C—Approved Claims Source Data 92
Attachment D—List of Commonly Used Acronyms 93

LIST OF TABLES

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity 21
Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language 22
Table 3: High-Cost Beneficiaries CY 2017-19 27
Table 4: Psychiatric Inpatient Utilization CY 2017-19 27
Table 5 : PIPs Submitted by Sacramento MHP 29
Table 6: General PIP Information – Clinical PIP 29
Table 7: Improvement Strategies or Interventions – Clinical PIP 30
Table 8: Performance Measures and Results – Clinical PIP 30
Table 9: General PIP Information – Non-Clinical PIP 38
Table 10: Improvement Strategies or Interventions – Non-Clinical PIP 39
Table 11: Performance Measures and Results – Non-Clinical PIP 39
Table 12: Budget Dedicated to Supporting IT Operations 43
Table 13: Business Operations 44
Table 14: Distribution of Services by Type of Provider 44
Table 15: Technology Staff 45
Table 16: Data Analytical Staff 45
Table 17: Count of Individuals with EHR Access 46
Table 18: Ratio of IT Staff to EHR User with Log-on Authority 47
Table 19: Additional Information on EHR User Support 47
Table 20: New Users' EHR Support 47
Table 21: Ongoing Support for the EHR Users 48
Table 22: Summary of MHP Telehealth Services 48
Table 23: Contract Providers Delivering Telehealth Services 50
Table 24: Primary EHR Systems/Applications 50
Table 25: EHR Functionality 55
Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR 57
Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission 58
Table 28: PHR Functionalities 58
Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims 59
Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial 60
Table 31: NPI and Taxonomy Code Exceptions 62
Table 32: Focus Group One Description and Findings 63
Table 33: Focus Group Two Description and Findings 65
Table 34: Focus Group Three Description and Findings 67

Table 35: Access to Care Components 69
Table 36: Timeliness of Services Components 71
Table 37: Quality of Care Components 73
Table 38: Beneficiary Progress/Outcomes Components 75
Table A1: EQRO Review Sessions 85
Table B1: Participants Representing the MHP 88
Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB 92
Table C2: CY 2019 Distribution of Beneficiaries by ACB Range 92
Table D1: List of Commonly Used Acronyms 93

LIST OF FIGURES

Figure 1: Overall Penetration Rates CY 2017-19 23
Figure 2: Overall ACB CY 2017-19 23
Figure 3: Latino/Hispanic Penetration Rates CY 2017-19 24
Figure 4: Latino/Hispanic ACB CY 2017-19 24
Figure 5: FC Penetration Rates CY 2017-19 25
Figure 6: FC ACB CY 2017-19 25
Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019 26
Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019 26
Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19 28
Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19 28

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 access, timeliness, and quality of 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 considers 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) 2020-21 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) 2019 — 23,842

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

CalEQRO obtained the MHP threshold language information from the DHCS Information Notice (IN) 13-09.

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.

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed AB 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and INs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard (AAS)

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS IN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS will review these forms to determine if the provider networks met required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services to youth and adults. If these standards are not met, DHCS will require the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, these will be reviewed by CalEQRO as part of their annual quality review process with a structured protocol to assess access and timeliness and validation of the AAS and any plan of correction or improvement of the services to Medi-Cal recipients living in the zip codes requiring an AAS.

CalEQRO reviews the NACT provider files, maps of clinics closest to the AAS zip codes, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the MHP shall develop and propose an AAS plan, and access to any alternative providers who might become Medi-Cal certified for the MHP. The MHP shall submit a plan of correction addressing the needs to meet the AAS.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO will review grievance and complaint log reports, facilitate beneficiary focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

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:

- 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 five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. 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.calegro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 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.

Recommendations from FY 2019-20

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 submitted two active PIPs this year.

Recommendation 2: Design and implement a clinical PIP with results reported not less than quarterly.

Status: Met

- The MHP is in process of a PIP study "Improving Access, Engagement and Satisfaction Through Telehealth Services".

- The service utilization data are collected and reviewed quarterly.
- The survey data are to be collected after closing the survey on 8/21/2020.

Recommendation 3: Continue the non-clinical PIP as amended to ensure an active PIP with results reported not less than quarterly.

Status: Met

- The MHP ended the non-clinical PIP "Uniform Scheduling System Using an Electronic Scheduling Tool" in December 2019.
- The MHP initiated a new non-clinical PIP "Timeliness to First Outpatient Assessment After Inpatient Discharge" in January 2020.
- The new PIP is active with results reported in real time and reviewed quarterly.

Recommendation 4: Contact EQRO early and often in the development of the PIPs.

Status: Met

- The MHP requested and received PIP telephonic technical assistance (TA) twice during the review cycle.
- EQRO encourages the MHP to be available to receive technical TA early and often in the development of PIPs.

Access Recommendations

Recommendation 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.)

Status: Partially Met

- The MHP did not state a baseline for beneficiaries authorized for service who are then discharged without receiving services nor did they state if any change had been made in the rate of discharge without receiving services as a result of their efforts.
- The use of the Pre-Admit feature in Avatar is under review for implementation for the referrals from the inpatient hospitals.
- The MHP determined that a large portion (not specifically quantified) of the beneficiaries discharged without receiving any services are those

discharged from local hospitals, some of whom have insurance other than Medi-Cal.

- The MHP stated that their non-clinical PIP focused on engaging beneficiaries who are discharged from the hospital and do not have prior engagement with the MHP. The problem statement did not clarify if only unlinked beneficiaries showed the pattern of discharge without a subsequent service and did not state whether the PIP had shown any impact on the rate of discharge without service.

Recommendation 6: Continue to research and implement solutions to the recruitment and retention of psychiatric providers.

Status: Partially Met

- The main barrier to psychiatrist recruitment was stated as the inability to compete with the pay and benefits offered by Kaiser and other managed care plans.

- The MHP is reviewing other enticements and has not considered if there might be a way to close the gap enough to make a difference.

- The MHP's response did not provide a statement or data that indicated if their research has led to improvements in this area such as reduced time to initial psychiatric appointments.

- The MHP has encouraged contract providers to contract for telehealth services and COVID-19 protocols have made telehealth the only mechanism for routine medication services. The MHP did not indicate how well this was working, insofar as access and timeliness.

- The MHP's partnership with University of California (UC) Davis was identified as a continuing "avenue of opportunity for recruiting from residents," and "residents often find employment at the contracted provider sites post training at the Mental Health Treatment Center (MHTC), which increases the pool of potential psychiatric staff." While this information is encouraging, it would have been more valuable if the MHP had quantified the number of psychiatrists recruited under this program as well as the impact on the length of time to first psychiatric appointment.

- There is a cost to the MHP and beneficiaries to being unable to deliver timely quality services; a cost benefit analysis may be useful.

Timeliness Recommendations

Recommendation 7: Explore possible reasons for the standard of timeliness for first offered psychiatric appointment being met only 37.7 percent of the time.

Status: Partially Met

- The MHP stated that currently it had no way to track the time from request to first offered psychiatric appointment.
- The MHP is currently measuring timeliness from the first clinical service (i.e., intake appointment) to psychiatry services when requested utilizing telehealth.
- CalEQRO notes that other MHPs using Avatar are able to track this measure using the Avatar Scheduler module.

Recommendation 8: Continue to research solutions for psychiatry timeliness to service.

Status: Partially Met

- As in the response to Recommendation 7, the MHP referenced inability to track time to first appointment. The Avatar Scheduler was proposed to the MHP as a solution with proven success.
- The relationship of the no-show and cancellation non-billable codes to this recommendation was unclear.
- Telehealth has been implemented since COVID-19, but it has yet to be determined if it has impacted timeliness of psychiatry services.

Quality Recommendations

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

Status: Not Met

- The MHP did not track the outcomes of EBPs for individual and program levels. The MHP has the capacity to identify when a program is using an EBP or when an EBP is used with an individual client, however, fidelity measures still need to be included in Avatar to track efficacy of EBPs.

Beneficiary Outcomes Recommendations

Recommendation 10: Continue the work necessary to initiate a standardized defined career ladder for peer employees in direct county programs.

Status: Met

- A standardized career ladder of three positions for peer employees in directly operated county programs has been developed through Personnel Services.
- The position was sent to and vetted by the Civil Service Commission (CSC) Executive Officer on August 14, 2020 for final review and approval. This information was not yet available at the time of the review.

Recommendation 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.)

Status: Not Met

- The creation of peer employee levels/job classifications among contract providers is one of the projects adversely affected by COVID-19 restrictions, however the information is available to the county to be collated.
-

Recommendation 12: Report Child and Adolescent Needs and Strengths (CANS)-50 data on both an individual and aggregate by program level on a quarterly basis.

Status: Met

- CANS-50 reports that allow providers to assess individual progress over time, as well as by program, are in Avatar.

Foster Care Recommendations

Recommendation 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.)

Status: Met

- Currently the Children's Division Manager receives monthly placement data from Child Protective Services (CPS) as well as a monthly "match" of CPS youth served by the MHP.
- Efforts to make additional modifications of current exchanges of information are pending Assembly Bill (AB) 2083 implementation.
- The Access Line provides real time notifications to providers as part of the beneficiary assignment information when the social worker is known to them. An email is also sent to the social worker, if known, as notification of the assigned mental health organizational provider.
- CPS has a mental health liaison who providers can contact if they need to find the child/youth's social worker or to provide support when a quick linkage or response is needed.
- There is progress, but real-time exchange of and access to information should be the goal.

Recommendation 14: Complete development of manual for child and family teams (CFTs) and ensure collaborative training of all agencies involved in CFTs to ensure consistency in delivery of CFTs.

Status: Partially Met

- CFT manual has been drafted and is in final approval process.
- There was no mention of collaborative training in the response.

Information Systems Recommendations

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

Status: Partially Met

- An Access database has been established to track support calls and emails. The database is used to track issues, look for trends in order to

determine additional user training needs, and determine volume of support requests to inform staffing needs. The data tracked include date/time of call; name of caller; and caller's program.

i. Date / Time of support call or email
ii. Name of user requesting support
iii. Program the users is calling from
iv. Avatar Support staff who handled to request
v. Specific issue

- The Avatar Help Desk is available to all providers, both County Operated and Contracted, to provide TA for issues related to functionality with the Avatar EHR, which is web based and therefore not under the DTech purview. The Access Database used to track Avatar Help Desk calls is able to capture calls from all providers.

- Avatar Help Desk employees also serve as Avatar trainers. The employees have assigned times to be on the Avatar Help Desk, and it is unclear whether the staffing is adequate to user demand..

Recommendation 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.

Status: Partially Met

- The purchase of Microsoft Power BI has been approved to do further data analysis and build dashboards. Implementation is in process through the Department of Technology (DTech).

- A new IT analyst was hired to help support Avatar and begin creating additional efficiencies around data extraction and creating reports.

- Implementation of ScriptLink is scheduled for this year, pending any competing priorities. ScriptLink is intended to create efficiencies for the end user and to support compliance issues.

Structure and Operations Recommendations

Recommendation 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.

Status: Met

- The recognition that telehealth services is as an opportunity for people who might otherwise face a long commute is important, both as a hiring strategy and a retention strategy.
- Through Behavioral Health Services (BHS) participation in the Central Regional Partnership, there is a plan to use available Workforce Education and Training (WET) funding to recruit, hire, and retain staff who are reflective of the linguistic and cultural diversity of the community.
- The MHP also plans to explore ways of intentionally recruiting staff from culturally and linguistically diverse backgrounds through more informal networks using plan-do-study-act (PDSA) cycles.
- The county has expanded its use of social media sites (e.g., Glassdoor) to post positions and current job opportunities. Historically, positions were only posted on the county personnel website.
- While the MHP believes that more individuals are aware of available positions, nothing was reported that indicated a quantifiable improvement.

PERFORMANCE MEASURES

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]

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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:

- 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.
- 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).

- 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.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

- 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: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Sacramento MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	123,919	23.1%	7,619	32.0%
Latino/Hispanic	121,301	22.6%	4,340	18.2%
African-American	80,018	14.9%	4,851	20.3%
Asian/Pacific Islander	73,606	13.7%	1,366	5.7%
Native American	3,622	0.7%	266	1.1%
Other	133,967	25.0%	5,400	22.6%
Total	**536,431**	**100%**	**23,842**	**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.

Table 2 provides details on beneficiaries served by threshold language identified in DHCS Information Notice 13-09. The MHP also recognizes Arabic as a sixth threshold language, based on more recent Medi-Cal eligibility data.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Sacramento MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	1,826	7.7%
Russian	242	1.0%
Vietnamese	213	0.9%
Cantonese	91	0.4%
Hmong	237	1.0%
Other Languages	21,233	89.1%
Total	**23,842**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

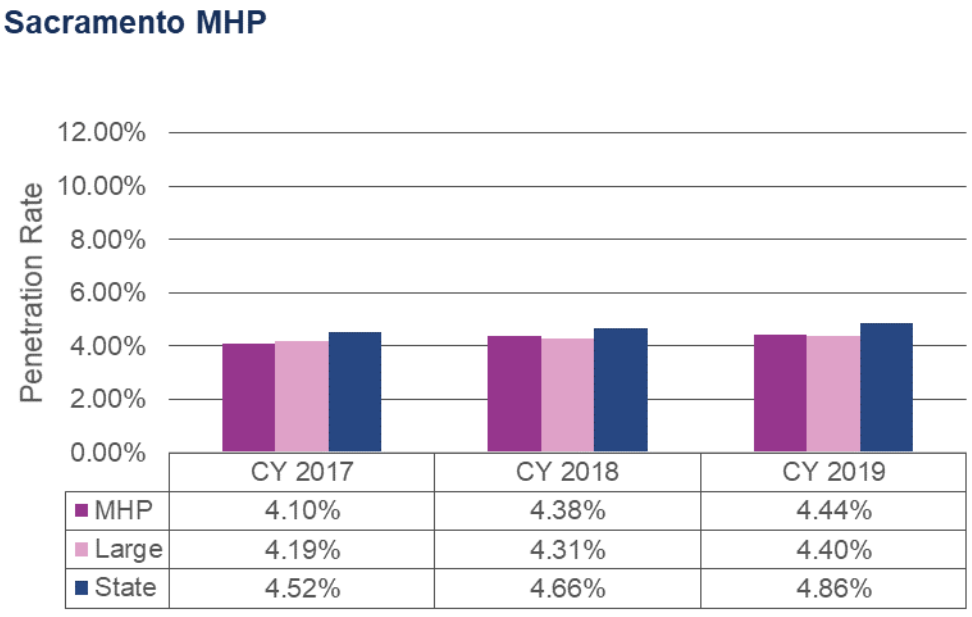
Penetration Rates and Approved Claims per Beneficiary

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 2019. See Table C1 for the CY 2018 ACA penetration rate and ACB.

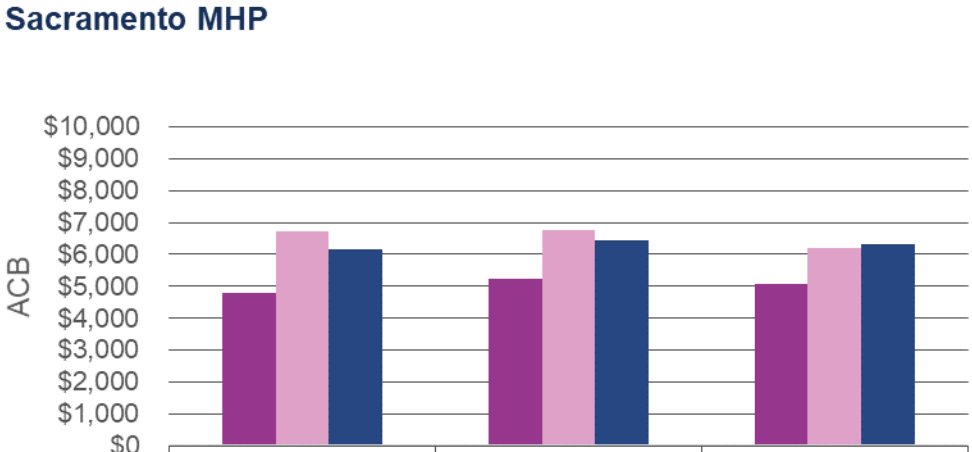
Regarding the calculation of penetration rates, the Sacramento MHP uses a different method than that used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	4.10%	4.38%	4.44%
Large	4.19%	4.31%	4.40%
State	4.52%	4.66%	4.86%

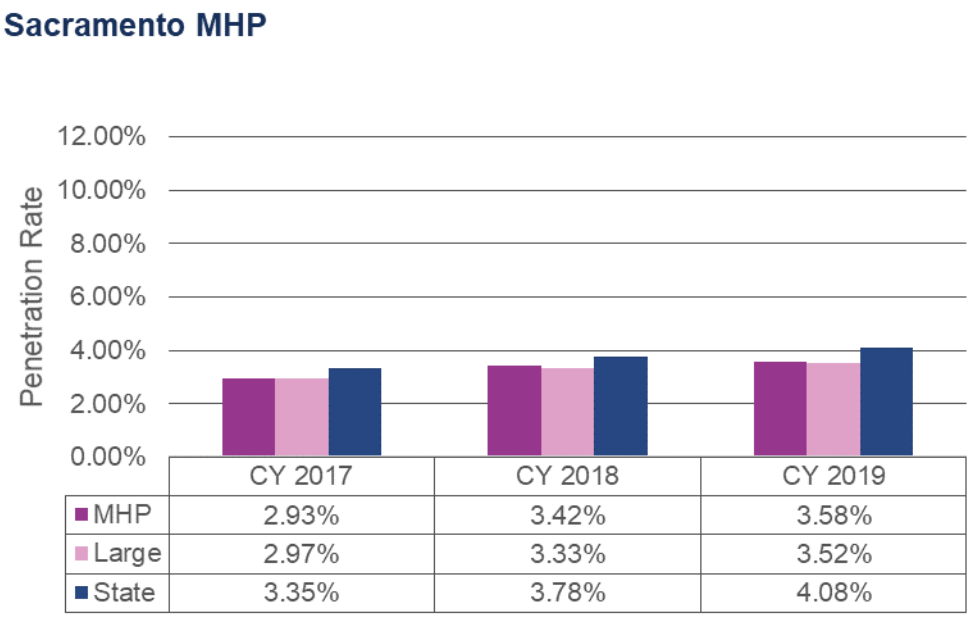
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,805	$5,224	$5,055
Large	$6,723	$6,750	$6,219
State	$6,170	$6,454	$6,316

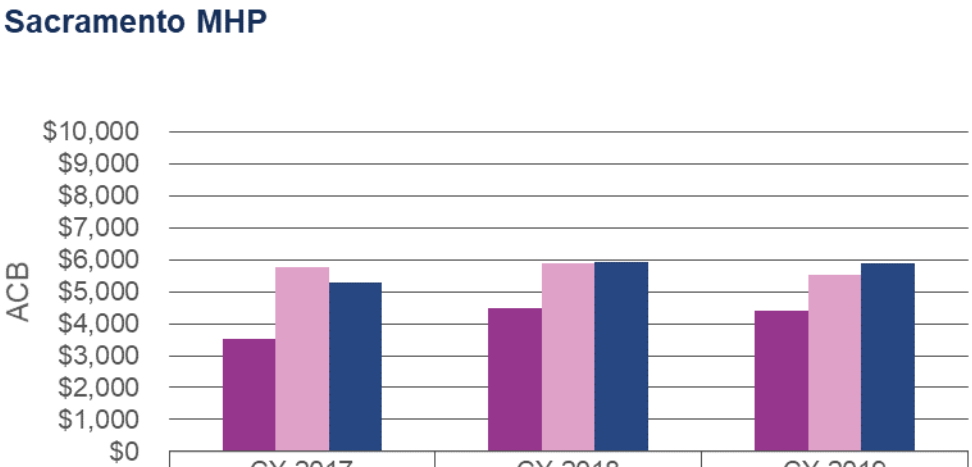
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	2.93%	3.42%	3.58%
Large	2.97%	3.33%	3.52%
State	3.35%	3.78%	4.08%

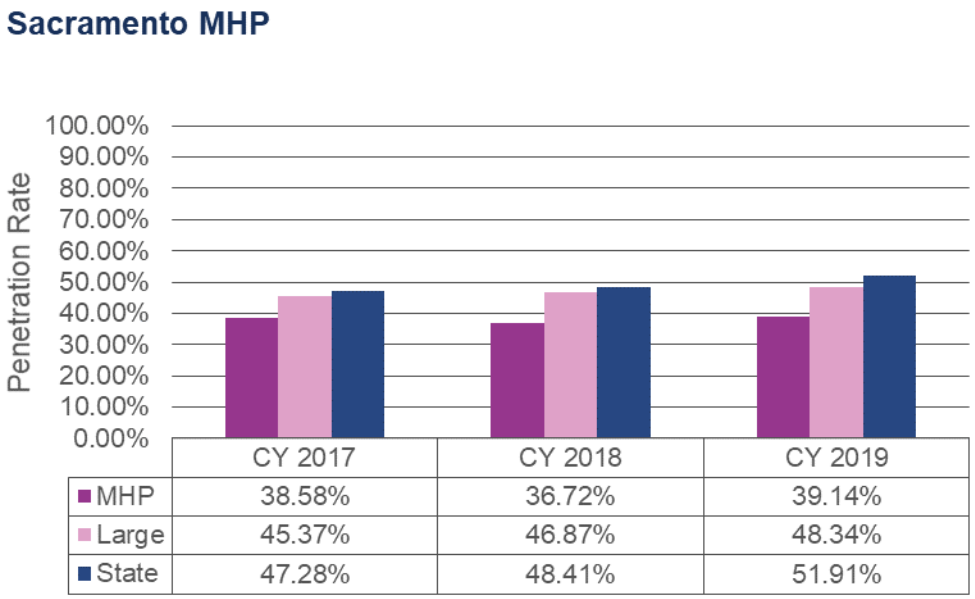
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,519	$4,480	$4,398
Large	$5,758	$5,884	$5,523
State	$5,278	$5,904	$5,869

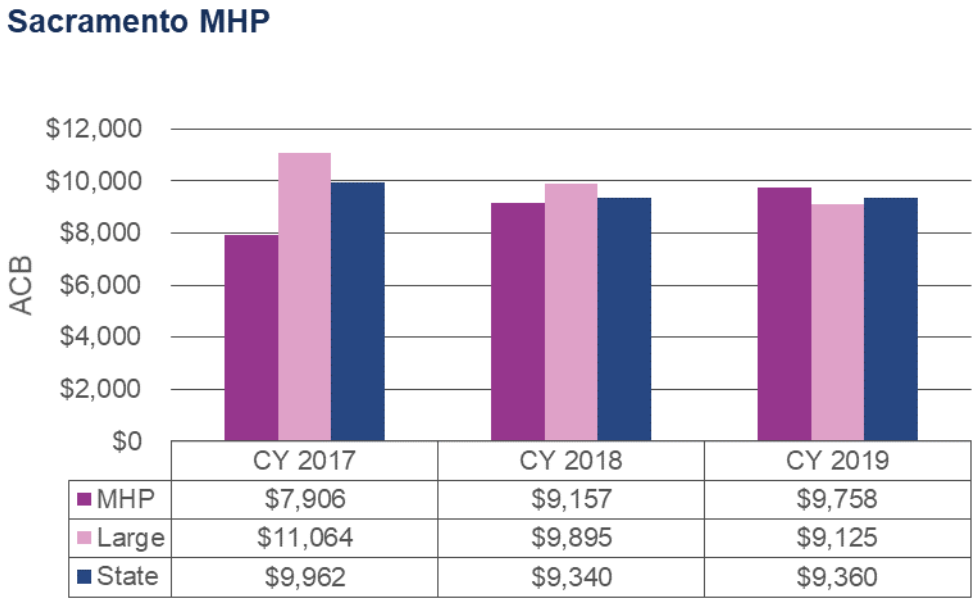
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	38.58%	36.72%	39.14%
Large	45.37%	46.87%	48.34%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

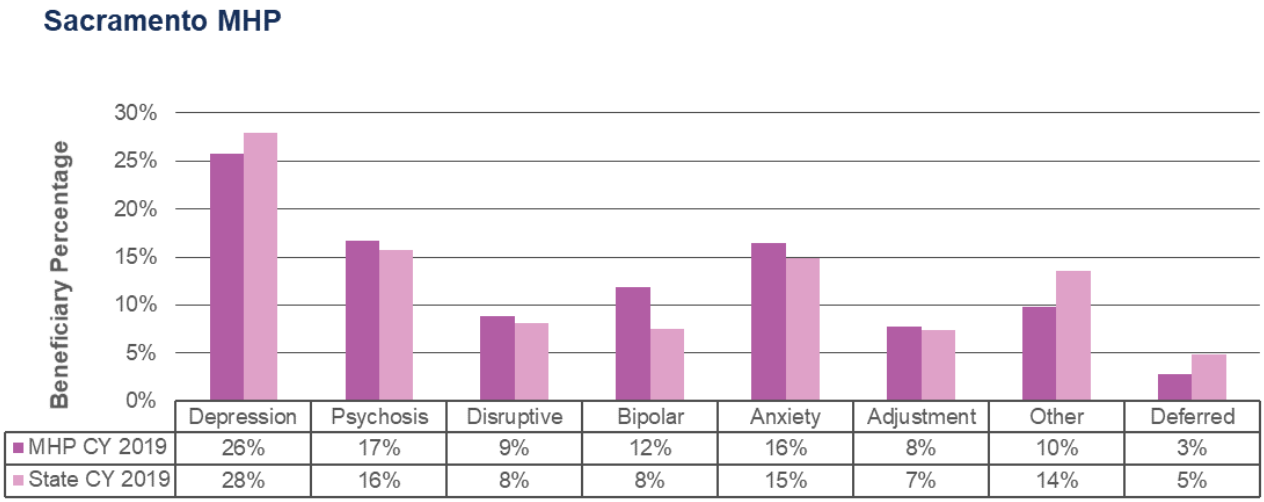


	CY 2017	CY 2018	CY 2019
MHP	$7,906	$9,157	$9,758
Large	$11,064	$9,895	$9,125
State	$9,962	$9,340	$9,360

Diagnostic Categories

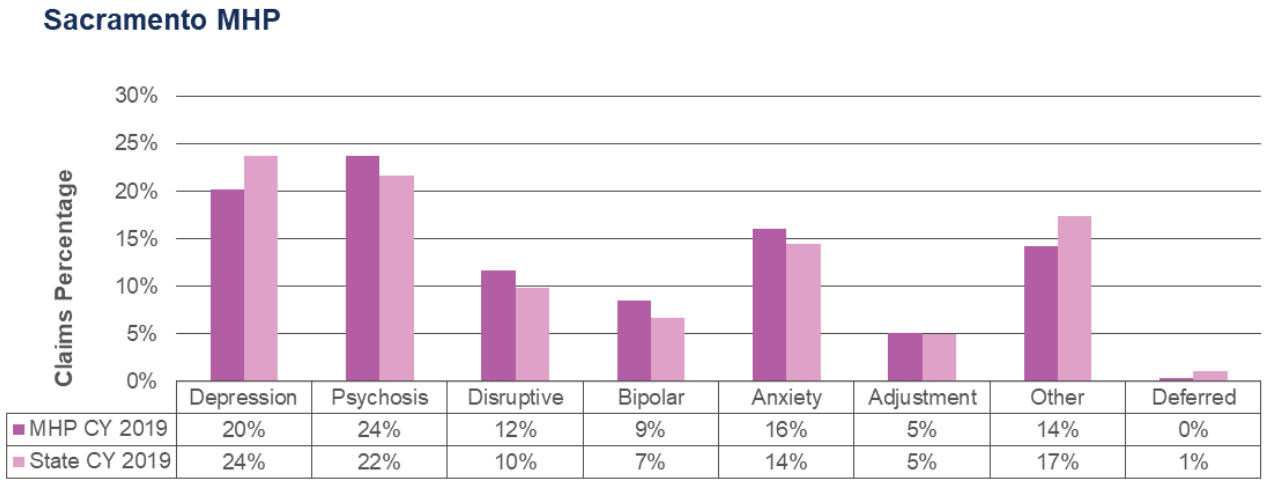
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	26%	17%	9%	12%	16%	8%	10%	3%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	20%	24%	12%	9%	16%	5%	14%	0%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Sacramento MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	478	23,842	2.00%	$48,398	$23,134,369	19.19%
	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%

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 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

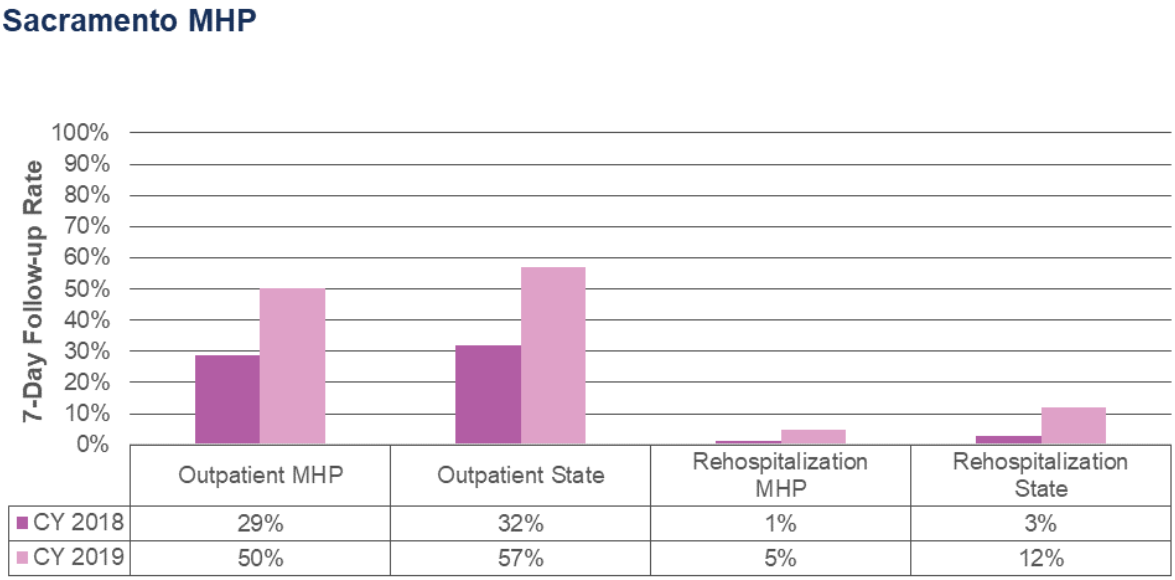
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Sacramento MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	1,540	2,857	10.28	7.80	$11,265	$10,535	$17,347,981
CY 2018	1,919	3,604	19.52	7.63	$11,724	$9,772	$22,499,113
CY 2017	1,835	3,851	9.24	7.36	$10,668	$9,737	$19,575,081

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

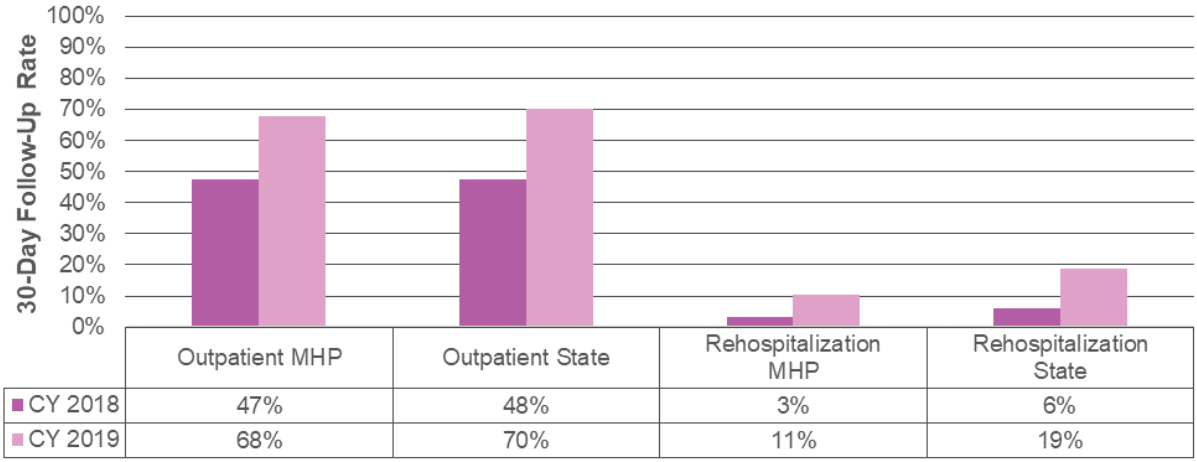
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	29%	32%	1%	3%
CY 2019	50%	57%	5%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	47%	48%	3%	6%
CY 2019	68%	70%	11%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

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 5 : PIPs Submitted by Sacramento MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Improving Access, Engagement and Satisfaction Through Telehealth Services
Non-Clinical	1	Timeliness to First Outpatient Assessment After Inpatient Discharge

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Sacramento
PIP Title	Improving Access, Engagement and Satisfaction Through Telehealth Services
PIP Aim Statement	Will providing telehealth services from office to beneficiary's home improve engagement, access, and satisfaction of services, while decreasing no-shows and cancelations during a 3-month period?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	Sacramento
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17) * ☐ Adults only (age 18 and above) ☒ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): All MHP beneficiaries receiving outpatient services via telehealth.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Members are encouraged to access services through telehealth. • The MHP implemented a survey to assess beneficiaries' experience with technology using their own devices.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • The MHP provided assistance to providers to facilitate access and delivery of telehealth services.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): • The MHP has implemented telehealth as the frontline access to services during the COVID-19 restrictions.

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Change in service delivery (duration by service type)	6/5 2020	Average Duration of Services Per beneficiary: C = Children/ youth A = Adults Case Management Brokerage: C = 85.3 A = 72.4 Crisis Intervention: C = 1.8 A = 3.2 Medication Services: C = 22.9 A = 49.6 Mental Health: C = 659.9 A = 359.5 Peer Services: C = .06 A = 20.1 Engagement: C = 0.6 A = 6.3	7/21 2020 ☒ n/a*	Average Duration of Services Per beneficiary: Case Manage-ment Brokerage: C = 122.7 A =79.1 Crisis Intervention: C = 2.7 A = 3.6 Medication Services: C = 19.1 A = 51.5 Mental Health: C = 551.7 A = 262.7 Peer Services: C = 0.3 A = 10.4 Engagement: C = 2.5 A = 4.5	☐ Yes ☒ No	☒ Yes ☒ No p-value: ☒ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Change in service delivery (frequency by service type)		Average Number of Services Per beneficiary: Case Management Brokerage: C = 2.0 A = 2.0 Crisis Intervention: C = 0.4 A = 0.1 Medication Services: C = 0.47 A = 1.6 Mental Health: C = 8.54 A = 4.5 Peer Services: C = 0.3 A = 0.7 Engagement: C = 0.1 A = 0.2	☒ n/a*	Average Number of Services Per beneficiary: Case Management Brokerage: C = 4.0 A = 2.6 Crisis Intervention: C = 0.1 A = 0.1 Medication Services: C = 0.4 A = 1.6 Mental Health: C = 10.3 A = 4.5 Peer Services: C = 0.0 A = 0.4 Engagement: C = 0.2 A = 0.2	☐ Yes ☐ No	☒ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Change in no shows		Average Number of No Shows Per beneficiary C = 0.63 A = 0.5	☒ n/a*	Average Number of No Shows Per beneficiary C = 0.64 A = 0.2	☐ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Change in cancellations		Average Number of Cancellations Per beneficiary C = 1.15 A = 0.5	☒ n/a*		☒ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Beneficiary satisfaction with telehealth	Pend-ing survey results	Number of beneficiaries who agreed or strongly agreed to the survey questions (Satisfaction/ future use section) divided by the total number of beneficiaries	☒ n/a*	Pending survey results	☐ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
		who completed this section				
Beneficiary satisfaction with access to care	Pend-ing survey results	Number of beneficiaries who agreed or strongly agreed to the survey questions (Access to Care section) divided by the total number of beneficiaries who completed this section.	☒ n/a*	Pending survey results	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Beneficiary satisfaction with use of system	Pend-ing survey results	Number of beneficiaries who agreed or strongly agreed to the survey questions (Use of System section) divided by the total number of beneficiaries who completed this section.	☒ n/a*	Pending survey results	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Beneficiary satisfaction with service provider interaction	Pend-ing survey results	Number of staff who agreed or strongly agreed to the survey questions (Service Provider Interaction section) divided by the total number of staff who completed this section.	☒ n/a*	Pending survey results	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Staff satisfaction with telehealth	Pend-ing survey results	Number of staff who agreed or strongly agreed to the survey questions (Satisfaction/ future use section) divided by the total number of staff who completed this section.	☒ n/a*	Pending survey results	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Staff satisfaction with access to care	Pend-ing survey results	Number of staff who agreed or strongly agreed to the survey	☒ n/a*	Pending survey results	☐ Yes ☒ No	☐ Yes ☒ No p-value:

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
		questions (Access to Care section) divided by the total number of staff who completed this section.				☐ <.01 ☐ <.05 Other (specify):
Staff satisfaction with use of system	Pend-ing survey results	Number of staff who agreed or strongly agreed to the survey questions (Use of System section) divided by the total number of staff who completed this section	☒ n/a*	Pending survey results	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Staff satisfaction with service provider interaction	Pend-ing survey results	Number of staff who agreed or strongly agreed to the survey questions (Service Provider Interaction section) divided by the total	☒ n/a*	Pending survey results	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
		number of staff who completed this section				

Was the PIP validated? ☒ Yes ☐ No

Validation phase:

☐ PIP submitted for approval
☐ Planning phase
☒ Implementation phase
☐ Baseline year
☐ First remeasurement
☐ Second remeasurement
☐ Other (specify):

Validation rating:

☐ High confidence
☒ Moderate confidence
☐ Low confidence
☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

CalEQRO recommends continuation of the PIP during the COVID-19 pandemic, while telehealth is first line service delivery option. The surveys that are in process need to be tracked and results updated at least quarterly.

The technical assistance (TA) provided to the MHP by CalEQRO consisted of:

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
TA provided included discussion of the need to compare service delivery across the system of care as it relates to before COVID-19 and telehealth services presently, during COVID-19. The MHP agrees to engage in ongoing TA for this PIP not less than quarterly.						

*PIP is in planning and implementation phase if n/a is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Sacramento
PIP Title	Timeliness to First Outpatient Assessment After Inpatient Discharge
PIP Aim Statement	"Will utilizing the Adult Psychiatric Support Services (APSS) program as an assessment center and providing appointments prior to or at the time the beneficiary discharges from the hospital increase the follow up to hospitalization intake appointments from 34.7 percent to 50 percent?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17) * ☒ Adults only (age 18 and above)	

MHP Name	Sacramento
☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The study population will include all adult (18 and older) unlinked Medi-Cal beneficiaries discharged from one of three acute psychiatric facilities or one of three psychiatric health facilities (PHF) and who were subsequently admitted to outpatient services in the MHP. Note: unlinked is defined as not receiving services from an outpatient provider within the MHP at the time of inpatient hospital admission	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Immediate follow-up outpatient appointments upon inpatient discharge.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Timeliness to 1st assessment	CY 2019				☒ Yes ☐ No	☒ Yes ☐ No

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
appointment after inpatient hospital discharge (unlinked beneficiaries) Number of beneficiaries receiving follow-up outpatient appointment within 7 days of inpatient discharge NQF #0576			☒ n/a* PIP is in Planning or implementation phase, results not available			p-value: ☐ <.01 ☐ <.05 Other (specify):
No-shows to prior to first appointment	CY 2019		☒ n/a* PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Cancellations prior to first appointments	CY 2019		☒ n/a* PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
			☐ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?				☒ Yes	☐ No	
Validation phase: ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):						
Validation rating:						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: The MHP did not report any direct beneficiary input to the PIP. Add beneficiary input as is possible. Report rates for unlinked and linked separately. Disaggregate linked from unlinked clients who are engaging in post inpatient discharge services. Baseline data needs to be reported.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: Include beneficiary input to the PIP. Measure PIP results at least quarterly. CalEQRO will follow-up with TA for this PIP at least quarterly this year.						

*PIP is in planning and implementation phase if n/a is checked.

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 responses 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 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Sacramento	2.00%	2.00%	1.37%	2.24%
Large MHP Group	n/a	2.81%	2.59%	2.88%
Statewide	n/a	3.58%	3.35%	3.34%

- Two percent of budget devoted to IT is simply inadequate when using a complex system such at Netsmart's Avatar. It requires constant monitoring, frequent updates and upgrades, and skilled resources to make timely effective use of its full capabilities.

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

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the MHP uses an ASP model to host EHR system which provides 24-hour operational support.	☐ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☐ Yes	☒ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☐ Yes	☐ No

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	7.36%
Contract providers	91.94%
Network providers	.69%
Total	**100%***

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

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 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	11	2	0	0
2019-20	9	2	0	1
2018-19	6	2	6	3

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	9	1	0	0
2019-20	8	0	0	1
2018-19	8	0	0	1

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

- While the number of IT employees has increased to 11, it still appears to be inadequate. Contract providers stated that reports requested and agreed upon with the MHP may take as much as two years to arrive. The MHP does not appear to be getting full value from its investment in Netsmart's Avatar EHR.

- While information technology is not a part of the MHP's organizational chart, the Avatar steering committee provides the structure for MHP leadership and subject matter experts, along with DTech, to determine IT projects and assignments. This is under the direction of the Avatar manager.DTech reporting structure does not directly report to the MHP Director. However, there is a long-established, process to prioritize issues and projects identified by the Avatar steering committee. The EQRO observes that the MHP continues to view Avatar as a utility rather than a strategic tool.
- .
- In Table 13, Business Operations, the MHP did not respond to the last item on cyber resiliency training.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by MHP and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	118	222	340
Clinical Healthcare Professional	429	1203	1632
Clinical Peer Specialist	0	66	66
Quality Improvement	38	*	38
Total	585	1491	2076

* We do not currently have a user role specific to contract provider QM

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not

include IT staff time spent on end user support, infrastructure maintenance, training, and other activities .

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Large MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	11	37.85
Total EHR Users Supported by IT (Source: Table 17)	2,076	2,084
Ratio of IT Staff to EHR Users	1:188	1:55

- A ratio of 1:188 versus the large MHP average of 1:55 suggests, consistent with comments made about budget and the place of IT in the organization, an MHP seriously deficient in IT resources compared to its peers. This cannot but have a negative impact on the MHP's ability to achieve its goals.

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☐ Yes	☒ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☐	☐	☒
Screen workflow and navigation	☐	☐	☐	☒

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	40
Number of county-operated telehealth sites	2
Number of contract providers' telehealth sites	38
Total number of beneficiaries served via telehealth during the last 12 months	3,912
Adults	1,256
Children/Youth	2,443
Older Adults	213
Total Number of telehealth encounters (services) provided during the last 12 months:	25,183

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
☒	To support NA time and distance standards
☒	To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- The MHP, in response to the COVID-19 pandemic, expanded their telehealth service capability from a small pilot to implementation across the organization in a matter of weeks. It is an impressive accomplishment, more so because of the difficult circumstances.
- Even with telehealth fully implemented, the MHP continues to have issues with timely access to psychiatrists. They do not have enough psychiatrists.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☒	Arabic	☐	Armenian	☐	Cambodian
☒	Cantonese	☐	Farsi	☒	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☒	Russian	☒	Spanish	☐	Tagalog
☒	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
All contracted outpatient providers are using telehealth for all MHP beneficiaries.	38

Current MHP Operations

- The MHP continues to use ASP model to support Avatar EHR with IS vendor hosting and provides 24/7 operations.
- The MHP also continues to maintain and use “Report copy” of Avatar data for reporting purposes.

Table 24 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 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Avatar	Practice Management	Netsmart	11	Netsmart
Avatar	Clinical Workstation (CWS)	Netsmart	9	Netsmart
Order Connect	e-Prescribing	Netsmart	9	Netsmart
Order Connect	Laboratory Orders and Results	Netsmart	3	Netsmart
Avatar	RAD	Netsmart	11	MHP
Avatar	Appointment Scheduling	Netsmart	11	Netsmart
Avatar	CareFabric	Netsmart	0*	Netsmart

*Avatar CareFabric is being implemented but is not yet in production use.

The MHP's Priorities for the Coming Year

- MHSA Innovation (INN) 4: Multi-County full-service partnership (FSP) INN Collaborative: Six counties launched the Multi-County FSP Innovation Project to leverage their collective resources and experiences to transform how FSP data are used to continuously innovate and improve FSP services.

- MHSA INN 5: Forensic Behavioral Health Multi-System Teams: This proposed project will serve justice-involved, Medi-Cal eligible individuals, 18 years and older, experiencing serious mental illness with significant functional impairment.

- Mobile Community Support Team (MCST) Expansion: adding six additional teams (11 total). The plan is to expand existing partnerships with police and sheriff and to add new partnerships with Galt, Rancho Cordova, and Metro Fire.

- Community Support Team (CST) Expansion: adding five additional clinicians to better support the community as well as respond to referrals from the law enforcement partners, when a clinician/peer follow-up is recommended.

- 15-bed transitional age youth (TAY) Crisis Residential Program (CRP) opening in Fall 2020.

- Additional 15-bed Adult Crisis Residential Program opening in Fall 2020.

- Preparing to release a request for application (RFA) for Therapeutic Behavioral Services (TBS).

- Planning to apply for California Health Facility Financing Authority grant (CHFFA) related to family respite services.

- Planning to implement trauma-informed culturally responsive therapy Program focused on African American/Black community.

- Working with San Juan Unified School District to re-establish an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) contract for school based mental health services.

- Providing EBP training to become certified to provide Parent Child (PC) Care services. PC Care is a practice that non-clinical staff can also implement.

- Expanding Homeless Access support: The MHP is hiring a second clinician to support local shelters and homeless encampments in assessing and linking to mental health and substance use treatment.

- Prevention and Early Intervention (PEI) Trauma Informed Wellness Program for the African American/Black Community

The MHP's list of priorities for the coming year did not include IT projects. The list of IT projects from the ISCA is provided below.

- Interoperability (CareQuality/Care Connect Inbox)
- Go live with complete Clinical Work Station (CWS) for ADS providers
- Additional billing automation (837/835) all payors
- Implementation of eMAR and Order Entry (MHTC)
- Safety Plan
- Preparation for new EHR Platform (NX)
- New Web-Based Service Request Form
- Electronic Lab Orders (Quest Labs)
- Provider Integration
- myHealthPointe Client Portal

Major Changes since Prior Year

- Supporting Community Connections Suicide Prevention Program to serve Arabic-speaking community members. Received Board of Supervisor's approval to contract for this in July 2020.

- Implemented a new FSP, Telecare ARISE, in February 2020. Serving 200 individuals who are at risk of homelessness or who are experiencing homelessness.

- Implemented an Adult Residential Treatment pool: July 2020

- Implemented an Augmented Board & Care pool: July 2020

- Implemented Adult Needs Strengths Assessment (ANSA): July 2020

- Implemented Strengths Model EBP: July 2020

- Created a homeless indicator in Avatar to better track homeless data: November 2019
- Hired a Homeless Access Clinician: Community-based, conducting assessments at shelter sites and linking individuals to mental health and substance use treatment.
- Shifted the Sacramento Police Department Mobile Community Support Team from a ride along model to a “Response Model” utilizing the Community Support Team clinician and peer to provide follow-up support post law enforcement contact.
- Hiring and onboarding additional Senior mental health counselors to be co-located with CWS to support CFT meetings, CANS completions, consultation, and eventually short-term mental health services/interventions. Four of five new positions for this team have been filled for a total of nine of ten FTEs employed.
- Pilot with juvenile court services to include a .2FTE Senior mental health counselor (SrMHC) on the front-end of the juvenile court process to screen, briefly assess and link to needed mental health services.Telework implemented across the system.
- The Source expanded to serve all youth and caregivers up to age 26.
- Re-procurement and implementation of refreshed Wraparound programming.
- Redesigned Flexible Integrated Treatment (FIT) contracts have resources to provide housing assistance to families that are homeless or at risk of homelessness.
- Youth Help Network (YHN), funded by Mental Health Services Act (MHSA) Oversight and Accountability Commission (MHSOAC) and Homeless Mentally Ill Outreach and Treatment (HMIOT) grants, expanded online presences and collaborations with community-based organizations (CBO) and increased outreach in response to COVID-19 pandemic.
- Implemented use of ANSA in TAY FSP programs.
- Infused additional MHSA funding into PEI respite/suicide prevention programs to expand services and address data collection needs.

The MHP’s list of changes did not include IT projects, so that information is provided below.

- Electronic Prescribing of Controlled Substances (EPCS).

- CalOMS reporting converted to Avatar from legacy system.
- Virtual Learning (end-user training) – rewrite of all training courses to support virtual learning.
- Implementation of service import for providers with their own EHR.
- Updated and/or implemented Strengths Assessment, and ANSA.
- Implementation of Housing Plan IT role.

Other Areas for Improvement

- CalEQRO continues to support that a data warehouse solution would be a useful benefit which the MHP should continue to explore. The MHP will be challenged to implement state mandated 274 project requirements within Avatar. It would also provide additional data analytics to support clinic operations and programmatic decisions that support timeliness and access to services. Inconsistency of information occurred within the ISCA and the Assessment of Timely Access, and between the Assessment of Timely Access and the Sacramento Benchmarks CAL Yr 2019.

Plans for Information Systems Change

- No plans to replace current system (in place more than five years).

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

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

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Outcomes	Netsmart/ Avatar	☒	☐	☐	☐
Prescriptions (eRx)	Netsmart/ Avatar	☒	☐	☐	☐
Progress Notes	Netsmart/ Avatar	☒	☐	☐	☐
Referral Management		☒	☐	☐	☐
Treatment Plans	Netsmart/ Avatar	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		11	0	1	0
FY 2019-20 Summary Totals for EHR Functionality:		8	1	3	0
FY 2018-19 Summary Totals for EHR Functionality:		8	1	3	0

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

- The MHP has not yet implemented Alerts functionality.

The list of the IS priorities for the coming year has ten projects for 11 IT full-time equivalents (FTEs). The MHP also purchases resources, including staff time, from the vendor to assist in completing priority items. Progress toward priorities is dependent on any change in priorities or DHCS mandates/requirements, as well as COVID-19 pandemic conditions. Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 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 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	90%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	10%	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Not used

The rest of this section is applicable: ☒ Yes ☐ No

Some contract providers have EHR systems which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission

EHR Vendor	Product	Count of Providers Supported
Netsmart	TIER	2
Netsmart	MyEvolve	1
Netsmart	Avatar	1
Welligent	Welligent	1
Cerner	Millennium	1

Personal Health Record (PHR)

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

☐ Yes ☒ No ☐ Implementation Phase

n/a

Expected implementation timeline:

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

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No

PHR Functionality	Status	
View list of current medications through portal.	☐ Yes	☒ No
Have ability to both send/receive secure Text Messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

X	Dimension Reports application
☐	Web-based application, including the MHP EHR system, supported by vendor or ASP staff
☐	Web-based application, supported by MHP or DMC staff
☐	Local SQL database, supported by MHP/Health/County staff
☐	Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

Sacramento MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**657,504**	**$122,815,723**	**23,810**	**$4,321,622**	**3.40%**	**$118,494,101**	**$111,640,256**
JAN19	61,341	$11,351,838	2,499	$515,041	4.34%	$10,836,797	$10,052,033
FEB19	55,024	$9,922,006	2,080	$398,126	3.86%	$9,523,880	$8,898,292
MAR19	59,172	$10,910,199	2,169	$417,638	3.69%	$10,492,561	$9,780,083
APR19	59,152	$10,737,416	2,239	$405,449	3.64%	$10,331,967	$9,638,537
MAY19	58,605	$10,775,344	2,480	$461,812	4.11%	$10,313,532	$9,653,141
JUN19	51,598	$9,472,155	2,254	$450,758	4.54%	$9,021,397	$8,397,723
JUL19	53,562	$9,989,600	1,001	$204,706	2.01%	$9,784,894	$9,333,773
AUG19	54,021	$10,473,719	3,371	$448,233	4.10%	$10,025,486	$9,357,167
SEP19	52,518	$10,227,248	3,048	$412,877	3.88%	$9,814,371	$9,148,797
OCT19	56,721	$10,747,919	945	$206,291	1.88%	$10,541,628	$10,190,454
NOV19	48,144	$9,341,702	854	$213,103	2.23%	$9,128,599	$8,796,683
DEC19	47,646	$8,866,578	870	$187,589	2.07%	$8,678,989	$8,393,574

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five 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.	7,611	$1,433,801	33%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	5,032	$924,707	21%
Service line is a duplicate and a repeat service procedure code modifier not present.	2,152	$560,642	13%
NPI, Type 2 credentialing data missing, incomplete, or invalid.	4,784	$507,170	12%
Beneficiary not eligible.	2,937	$469,022	11%
Total	23,810	$4,321,622	NA

The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.

- Denied claim transactions with reason “Medicare or Other Health Coverage must be billed before submission of claim” and “ICD-10 diagnoses codes or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid” are generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Sacramento, the time and distance requirements are 30 minutes and 15 miles for mental health services, and 30 minutes and 15 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted three consumer and family member focus groups, six stakeholder interviews, three staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	6
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	14
NPI Type 1 number reported is associated with two or more providers	2
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	0
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	2

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

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held on the virtual platform Zoom.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Three
Interpreter used	Yes If yes, specify language: Spanish
Summary of the main findings of the focus group: (1-3 sentences per area).	
Access - new beneficiaries	All three beneficiaries who had initiated services in the past 12 months reported no issues in accessing services. The range of time was from a few days to one month.

Topic	Description
Access – overall	COVID-19 restrictions have changed the way services are accessed. Previously, pamphlets were available in different languages at outpatient settings, but now communication and services are virtual, and this makes it more difficult to be aware of resources.
Timeliness	All participants reported they had timely access to services, including now during COVID-19. Participants receive texts or reminder calls.
Urgent care and resource support	None of the participants in the groups had heard of the Acute Care Center (crisis center). Only one had used any extra care between appointments.
Quality	Most of the participants had seen their treatment plans. One person reported having a Wellness Recovery Action Plan (WRAP). Participants noted that contact with therapists, case managers, and others involved in their treatment was by telephone or virtual platform since COVID-19 began.
Peer employment	Most participants had employment services available to them. Transitional Community Opportunities for Recovery and Engagement (TCORE) has an employment specialist, but that person has stopped providing services because of COVID-19 restrictions.
Structure and operations	The local Clubhouse cancelled activities due to COVID-19 restrictions. One participant was previously on the Sacramento MHSA steering committee and the Sacramento Mental Health Board.
Recommendations from this focus group	• Increase the number of staff who are fluent in Spanish. • All participants agreed that more groups would be useful, especially during this time when in-person services are not generally available.
Any best practices or innovations (optional)	• None noted.

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of TAY who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held on the virtual platform Zoom.
Total number of participants	Four
Number of participants who initiated services during the previous 12 months	Two
Interpreter used	No
Summary of the main findings of the focus group:	
Access - new beneficiaries	The two participants who had initiated services in the past 12 months reported no issues in accessing services. The time ranged from two weeks to one month. Both were satisfied with the process involved in accessing services.
Access – overall	One participant entered treatment after aging out of FC. Some participants had transportation provided and others did not have this benefit.
Timeliness	All participants reported they had timely access to services, including now during COVID-19. All saw a therapist on a weekly basis and psychiatrists as needed. All were offered family therapy, and all had declined. This continues now that services are virtual.
Urgent care and resource support	Information on urgent care and available resources were sparse. Only one participant reported being given phone numbers and a contact list of resources, including the crisis line. Only one participant knew about the warm line.
Quality	All participants had seen and received their treatment plans. Only one participant had a WRAP plan. The others had not heard about WRAP plans before this group. Participants agreed that information on medications was given when prescribed, but there was no follow-up. One participant

Topic	Description
	stated that it did not feel like medication was negotiable, but rather a requirement. With COVID-19, services switched to the Zoom virtual platform or phone calls. None of the participants thought this was a problem, other than one participant who had technical issues with access to services. No one in the group had heard about a quality improvement committee.
Peer employment	One participant had been offered employment assistance. None of the participants have received any information about job services.
Structure and operations	Wellness centers are closed at this time due to COVID-19 restrictions. None of the participants have served on committees or groups to improve services.
Recommendations from this focus group	• One participant wanted psychiatrists that were more understanding regarding beneficiaries not wanting to take medication. • Some participants asked if there could be more information about what services are available. This includes advertisements and flyers regarding available services.
Any best practices or innovations (optional)	• None noted.

CFM Focus Group Three

Table 34: Focus Group Three Description and Findings

Topic	Description
Focus group type	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. The group was consistent with that requested by CalEQRO. The focus group was held on the virtual platform Zoom.
Total number of participants	15
Number of participants who initiated services during the previous 12 months	Ten
Interpreter used	Yes If yes, specify language: Spanish
Summary of the main findings of the focus group:	
Access - new beneficiaries	The ten participants who had initiated services in the past 12 months reported no issues in accessing services. Schools and CPS were two major sources of referrals. Some services were school-based and other were in-home before COVID-19 restrictions.
Access – overall	Participants agreed that transportation was not an issue, neither before COVID-19 restrictions nor currently. Many reported that they now have virtual platform video sessions.
Timeliness	All participants reported they had timely access to services, including during COVID-19. Half of the participants have regular appointments with therapists and/or psychiatrists.
Urgent care and resource support	All participants reported having information on where to go during a crisis. Some reported they could call their therapists, and other would use the crisis line.
Quality	All participants were involved in their treatment planning. In most cases, their primary care doctors and psychiatrists do not communicate with each other. Some participants use the county website to find resources for mental health, while

Topic	Description
	others reported getting information from their therapists. Information is readily available in Spanish. The participants note that they missed home visits during this time of COVID-19 restrictions, especially those who do not have Internet access.
Peer employment	Participants were aware of peer employment assistance availability. Participants recounted their experience being helped with a resume and a job search.
Structure and operations	None of the participants were aware of any committees, programs, or other activities that they could be involved in to improve services. Many of the participants reported that as caregivers they were able to give input and were provided an overview of their child's progress and ways that they could be involved.
Recommendations from this focus group	• The participants would like home visits to restart as soon as it is possible to do so. • The participants would like more reports on what is working with their child and information on the course of treatment.
Any best practices or innovations (optional)	• None noted.

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.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 35 lists the components that CalEQRO considers representative of a broad service delivery system in providing 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 35: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
The MHP has in place various avenues to make the initial access for mental health services in Sacramento County simple, including telehealth and telephone services while COVID-19 restrictions continue. The MHP section of the Sacramento Department of Health website includes multiple ways the beneficiary can access resources and services during COVID-19 restrictions. This includes how to access the mental health Access Team, including medical providers; presumptive transfer Medi-Cal (AB 1299) information; PEI and MH respite service providers, the "Hope Cooperative's Peer Navigators" support line; a support line for youth and caregivers; a consumer-operated warm line; a community support team for referral to community resources; MH Crisis Triage Services; Mental Health Urgent Care Clinic (MHUCC); and a local 24-hour suicide prevention hotline. The Access Team uses a call center program through the county CISCO phone system to track and monitor number of calls, wait times, dropped calls, and referrals. Since the COVID-19 stay-at-home order was enacted, the Access clinicians and administrative staff have transitioned to working remotely. The Call Center reports			

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td colspan="4">allow the supervisors to provide oversite to ensure customer services standards are met.</td></tr>
<tr><td>1B</td><td>Capacity Management</td><td>10</td><td>9</td></tr>
<tr><td colspan="4">Cultural, ethnic, racial, and linguistic needs and disparities along with penetration rates are tracked and reported in the Sacramento County Cultural Competence Plan Report and the Quality Assessment and Performance Improvement (QAPI) Work Plan Report.
The children’s system of care (CSOC) contract monitors have a weekly census call with children’s outpatient Flexible Integrated treatment (FIT) providers to assess caseloads and productivity at all service locations with the intent to help referral flow decisions.</td></tr>
<tr><td>1C</td><td>Integration and Collaboration</td><td>24</td><td>24</td></tr>
<tr><td colspan="4">Unlike many counties, the MHP does not report any chronic problems coordinating services with managed care organizations. The MHP participates in a regional meeting hosted by the California Hospital Association to collaborate and address local patient flow/placement issues. Since the start of the pandemic, emergency rooms, hospitals, and inpatient facilities have been meeting to problem solve at both the local, regional, and state level.
The MHP participates in a quarterly coalition meeting with representatives from primary care providers/clinics. The MCPs facilitate/host the meeting.
The MHP’s TAY program coordinator attends, by phone, monthly Commercially and Sexually Exploitation of Children (CSEC) meeting led by CWS and that includes Public Health, BHS, and Alta Regional Center). Other community providers attend as appropriate/needed.
The MHP has recently increased its resources embedded in CPS and working with law enforcement. The MHP is involved in the following meetings with law enforcement/criminal justice partners:
o Quarterly Task Force Meeting together with the Mobile Crisis Support Team (MCST).
o Monthly meetings between BHS MCST and LE partners individually.
o Weekly court multi-disciplinary team Meetings (Mental Health Court Judge, Public Defenders, District Attorney, Probation, Provider Representatives, and BHS Representatives).
o Monthly and quarterly meetings with the Probation Adult Day Reporting Centers (ADRC)/Intake partners.
o Collaborative Court Provider Meeting, which includes the Court’s Administrative Liaison</td></tr>
</table>

Component	Maximum Possible	MHP Score
The MHP participates in the Quarterly memorandums of understanding (MOU) meeting with the five MCP. o A Coordination of Care Guide is used to reach out when processes or client specific needs arise. This guide was made available to EQRO as support documentation.		

Timeliness of Services

As shown in Table 36, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 36: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	12
The MHP has a standard of ten business days in compliance with this state timeliness metric as per IN 18-011. They meet this standard 100 percent of the time overall, including adults, children, and FC. Timeliness data were not separated for adults and older adults. Time to first offered and first kept appointment is defaulted to the date and time of the call, as that is when the Access Line employee delivers the brief assessment, rather than at first accepted and kept appointment.			
2B	First Offered Psychiatry Appointment	12	10
The MHP's standard from initial request to first offered psychiatry appointment is 15 days per IN 18-011. The standard was met 97.7 percent of the time overall, 98 percent for adults, 96.2 percent for children, and 100 percent for FC. Reported timeliness data for this metric did not separate adults and older adults. The data are part of a timeliness assessment the MHP provided post review and takes into account new ways to track this data.			
2C	Timely Appointments for Urgent Conditions	18	9
The DHCS standard for length of time from service request for urgent appointment to actual encounter is 48 hours for appointments that do not require prior authorization and 96 hours for appointments that require prior authorization.			

Component		Maximum Possible	MHP Score
The MHP is determining the method to track these requests. With the implementation of the MHUCC, all calls for urgent or crisis services are directed to the MHUCC. The MHUCC also serves walk-in beneficiaries and those who are brought by law enforcement. Reported timeliness data for this metric was not reported. The 96-hour standard for urgent appointments requiring an authorization does not apply because the MHP does not require authorization for urgent requests for services.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	10
The MHP's standard for follow-up post psychiatric hospitalization is the HEDIS standard of seven days. The standard was met 71.8 percent of the time overall, 70.7 percent for adults, 83.6 percent for children, and 88.9 for FC. The 7-day standard for post-hospital follow-up appointments was met 71.8 percent of the time overall in FY 2019-20. The EQRO Performance Measure for CY 2019 shows a rate of 50 percent for 7-day follow-up, which was an improvement from CY 2018 (at 29 percent). It is unclear why these two reports are inconsistent. There has clearly been a significant improvement in this measure. Reported timeliness data for this metric did not separate adults and older adults.			
2E	Psychiatric Inpatient Rehospitalizations	6	5
The MHP reported a re-hospitalization rate of 22 percent based on the MHP's CY 2019 data. The EQRO Performance Measures reports a re-hospitalization rate of 11 percent. It is unclear why the two reports are so different. EQRO queried the MHP if the 22 percent might reflect all subsequent hospitalizations versus 11 being only the first re-hospitalization. The MHP reported a rehospitalization rate for adults at 23.3 percent, for children at 2.5 percent, and for FC at 30 percent. Reported timeliness data for this metric did not separate adults and older adults.			
2F	Tracks and Trends No-Shows	10	5
The MHP does not track no-shows/cancellations separately for clinicians and psychiatrists. The Assessment of Timely Access does not indicate whether the information reported was for the entire system or just directly operated providers. The MHP reports a no-show rate of less than 0.1 percent. The Sacramento Benchmarks document for CY 2019 shows no-show rates between 7.6 percent and 13.3 percent depending on the age group of the beneficiaries. It is unclear why these two measures are so different. Reported timeliness data for this metric did not separate adults and older adults.			

Quality of Care

In Table 37, CalEQRO identifies the components of an organization that are 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 37: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The MHP has a cultural competency plan (CCP). 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 QIC 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 QIC work plan, activities, and evaluation. The MHP provides services in the beneficiary's language of choice, which includes one of the six threshold languages as well as English. During COVID-19 restrictions, the MHP offers language of choice during virtual services with language proficient providers or interpreters.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP recently updated the Level of Care Utilization System (LOCUS) in their policies and procedures. The Intensive Placement Team (IPT) uses LOCUS for intensive outpatient and subacute level of care (LOC). Within the MHP an Access to Service Request for a change in LOC is submitted with the use of LOCUS. Between the MHP and MCP providers, a Bi-lateral Referral Process policy and procedure and LOC tool are used. The MHP is in the process finalizing a children/youth tool for change in LOC. Finding a step-down placement post discharge from hospitalization was reported as challenging for the MHP, more because of difficulty finding an appropriate living arrangement for the beneficiary rather than to meeting their clinical needs. Placement difficulty for such beneficiaries contributed to a hospital LOS longer than most other large counties. Most beneficiaries interviewed reported that they are involved in developing their own treatment plans.			
3C	Quality Improvement Plan	10	10

Component		Maximum Possible	MHP Score
The MHP completes a QI workplan with the previous year's findings. Goals are measurable and contain objectives. The plan includes an analysis of disparities in services and identifies underserved populations. QIC minutes were provided to EQRO. The MHP produces an annual evaluation of the effectiveness of the QI work plan.			
3D	Quality Management Structure	14	12
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 QM 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 Research, Evaluation, and Performance Outcomes unit functions include data extraction and analysis pertaining to access, timeliness, quality, and outcomes. These findings are shared with leadership and throughout the MHP SOC..			
3E	QM Reports Act as a Change Agent in the System	10	8
During this review, few of the QM reports focused on outcomes. They reported work in progress, discussions, and intentions, but not measurable progress in most cases. COVID-19 and resulting need to reprioritize work has resulted in some emergency shifts in priorities. Line staff, from different contract providers, endorsed participation in QM and other system planning. The staff involved would like more training and understanding of the requirements of QM. Most were involved in chart reviews. The QIC meets quarterly and, every month, the MHP holds system improvement meetings. The QI workplan is revised quarterly and the MHP reviews service delivery goals, PIPs, chart review summaries, analysis of all grievances, appeals, medication monitoring, and provider analysis. The MHP has not adopted a formal change management practice. Utilization review 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.			
3F	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			

Component	Maximum Possible	MHP Score
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 38, CalEQRO identifies the components of an organization that are 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 38: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	16
The MHP currently uses the LOCUS for adults, with plans to convert to the ANSA delayed due to issues with the COVID-19. The MHP utilizes the CANS-50 for all children and youth programs. Both adult and youth outcome tools are used consistently, at the beginning of treatment, at exit from treatment, and as appropriate. Beneficiary outcomes are tracked in order to discern any gaps among subpopulations and identify groups in need of QI in service delivery. These outcome reports are shared with management, clinical staff, and contract providers.			
4B	Beneficiary Perceptions	10	8
The MHP obtains beneficiary feedback through the Consumer Perception Survey, the MHSA stakeholder feedback process, and its own targeted surveys. Results are posted on the MHP's website and discussed at the MH Advisory Board meeting. During the consumer/family member focus groups, no one reported having any feedback information from the surveys they had taken in the past year.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	10
Wellness centers are closed to in-person visits due to COVID-19 restrictions. The MHP has enriched and functional peer-run and peer-driven programs, especially through contracted providers (e.g., Cal Voices).			

Structure and Operations

In Table 39, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 39: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	30
Sacramento has a robust array of continuum of services. The MHP provided documentation of the various services in the SOC. The MHP effectively implemented telework across the system for employees during COVID-19 restrictions. Providers have been resilient in pivoting to telephone and telehealth services for all but emergency and crisis services requiring onsite staff. Capacity has been maintained through this pandemic thus far. The MHP assisted providers in finding technology and equipment to pivot to telehealth delivery of services.			
5B	Network Enhancements	18	18
The MHP utilizes a variety of adjunct services delivery options. The MHP met all time and distance standards and did not require any adjunct providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries. In response to COVID-19, the MHP rapidly transitioned to providing services through telehealth, including contract providers. The MHP's approach to services is holistic and whole-person based. Staff reported connecting beneficiaries with resources that they need—housing, substance use disorders (SUD) services, and educational programs. Due to COVID-19, they are also working to get clients thermometers and other materials. The MHP has and continues to deploy field-based staff where necessary during the pandemic.			
5C	Subcontracts/Contract Providers	16	16
At the beginning of the pandemic, the MHP director initiated weekly meetings with contract providers to keep them informed and to collaborate on problems they were facing. Among the results of these meetings, changes were made to CBO contracts that improved CBO cash flow.			
5D	Stakeholder Engagement	12	12

Component		Maximum Possible	MHP Score
The MHP includes multiple levels of stakeholders in program planning, committees, and management meetings. This includes, supervisors, managers, line staff, contract providers, beneficiaries, family advocates, and community-based organizations. National Alliance on Mental Illness (NAMI) is active within the MHP's SOC, as an advocate and participant in specific meetings.			
5E	Peer Employment	8	6
The work to create direct hire position descriptions and slots for employees with lived experience is in the final phases of development. This is one of the projects that has been adversely affected by COVID-19 issues.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Sacramento MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- There are multiple entry points to the system in terms of "Access to Care" and the Access Line is just one of them. In this past year the Access Team was redesigned to include the start of the Assessment process by capturing the required elements to determine medical necessity, diagnosis, and assign to the appropriate contracted provider. The MHP expanded its telehealth service capability across the system, including directly operated and contracted providers.

Strengths:

- In response to the COVID-19 pandemic, the MHP expanded its telehealth service capability from a small pilot to implementation across the system in a matter of weeks. It is an impressive accomplishment, more so because of the difficult circumstances.

Opportunities for Improvement:

- None noted.

Timeliness of Services

Changes within the Past Year:

- Time to first offered and first kept appointment of beneficiaries calling the Access Line is defaulted to the date and time of the call as that is when the Access Line employee delivers the brief assessment.

Strengths:

- The MHP has increased timeliness to services with the implementation of telehealth. They report fewer cancelations and no-shows using this technology.

Opportunities for Improvement:

- The MHP's measurement for time to first service uses the brief assessment provided over the phone by the Access Team as the first clinical service. It is not clear that this is consistent with how DHCS would measure the time to first service. It also leaves open the question of timeliness to the next clinical appointment.
- Timely access to psychiatry services remains a challenge for the MHP.
- The MHP did not report timeliness for length of time from service request for urgent appointment to actual encounter. The MHP is determining the method to track these requests.
- Depending on the data source reviewed, there can be quite disparate numbers for the same timeliness measures, which are hard to understand.

Quality of Care

Changes within the Past Year:

- Both the 7-day and 30-day rehospitalization rates have improved substantially over last year's numbers.
- The MHP's current clinical PIP "Improving Access, Engagement and Satisfaction Through Telehealth Services" addresses quality of services during COVID-19.

Strengths:

- The MHP currently spends about 19 percent of its funding on HCBs. The statewide average is 29 percent. Whether this is because the MHP has found an exceptionally effective way to manage the care of its most challenging beneficiaries or is simply spending less on them is unclear.
- Line staff, from different contract providers, endorsed participation in the QM and other system planning.
- During COVID-19 restrictions, the MHP offers language of choice during virtual services with language proficient providers or interpreters.

Opportunities for Improvement:

- Finding a step-down placement for beneficiaries ready to discharge from hospitalization was reported as challenging. Delayed placement has contributed to a longer length of hospital stay than most other large counties.
- The non-clinical PIP addresses follow-up and engagement post-hospitalization to increase quality of services and promote best practice of engagement within seven days post discharge.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP re-procured and implemented refreshed Wraparound programming.

Strengths:

- Beneficiary outcomes are tracked to discern any gaps among subpopulations and identify groups in need of QI in service delivery.

Opportunities for Improvement:

- There appears to be little in the way of comprehensive MHP-level outcomes assessment.
- Beneficiaries interviewed reported they do not receive information regarding results of surveys that they complete.

Foster Care

Changes within the Past Year:

- Therapeutic Foster Care (TFC) was implemented in past year. At least two youth have been served to date.
- A CFT manual has been drafted and is in final approval process.

Strengths:

- The MHP has added resources, now at ten FTEs, to its staff assigned to work with CPS. This allows for more timely collaboration of the two entities.
- Two additional organizations have expressed interest in TFC.

Opportunities for Improvement:

- Discussions are underway related to improved data sharing between the MHP and Juvenile Probation.

Information Systems

Changes within the Past Year:

- Telework was implemented across the system at two directly operated sites and 38 CBO sites.
- EPCS was implemented.
- Virtual Learning (end-user training) – there was a rewrite of all training courses to support virtual learning.
- Implementation of service import for providers with their own EHR.
- Two FTE positions added to IT resources.

Strengths:

- The monthly Avatar user forum Combined Clinical Work Station (CWS) and Practice Management (PM) is available for contract providers.

Opportunities for Improvement:

- The MHP Information Systems are under-funded and under-staffed.

Structure and Operations

Changes within the Past Year:

- The MHP effectively implemented telework across the system for employees during COVID-19.
- Providers have been resilient in pivoting to telephone and telehealth services in all but emergency and crisis services requiring onsite staff.
- At the beginning of the COVID-19 crisis, the MHP director initiated weekly meetings with contract providers to keep them informed and to collaborate on problems they were facing.

Strengths:

- MHP leadership has a clear vision for the future of the organization. The open question is whether they will be able to access the IT resources to deliver it.
- Service delivery capacity has been maintained through the pandemic.

- The MHP assisted providers in finding technology and equipment to pivot to telehealth delivery of services.
- The Children's Medication Monitoring committee reviews and monitors compliance with prescribing standards and trends related to children prescribed psychotropic medications.

Opportunities for Improvement:

- The MHP's IT budget as a percentage of MHP budget is nearly a full percentage point below other large counties. Its ratio of IT employees to systems users is over three times higher than other large counties.

FY 2020-21 Recommendations

PIP Status

None noted.

Access to Care

None noted.

Timeliness of Services

Recommendation 1: Review with DHCS the method currently used to measure the time to first offered and first kept appointment, which has resulted in meeting the standard 100 percent of the time. Also review whether the time to the second clinical appointment is at or near 100 percent.

Recommendation 2: Continue efforts to recruit and retain adequate psychiatry coverage and measure progress in terms of full-time equivalents (FTEs) and time to first psychiatry appointment.

Recommendation 3: Begin to track and report no-shows separately for psychiatrists and clinicians. Disaggregate data for adults, older adults, children, and youth in foster care (FC).

Recommendation 4: Determine a methodology to track time to response for urgent conditions and implement. Track and report this data, disaggregating adults, older adults, children, and FC.

Quality of Care

None noted.

Beneficiary Outcomes

Recommendation 5: Implement a system to ensure that beneficiaries (especially those participating in surveys) receive information regarding outcomes of the surveys, including the Consumer Perception Survey (CPS).

Foster Care

None noted.

Information Systems

None noted.

Structure and Operations

None noted.

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible, such as site visits. All sessions were conducted via Zoom virtual platform.

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
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
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Clinical Directors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/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
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)

Sacramento
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Ewurama Shaw-Taylor, Quality Reviewer
Robert Greenless, Information Systems Reviewer
Walter Shwe, Consumer-Family Member Reviewer

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

All sessions for this review were conducted via Zoom and/or desk review of documentation.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Adams	Rolanda	Program Coordinator	Sacramento County Behavioral Health
Alhadi	Fatin	Clinical Director	Turning Point
Alison	Sweet	Clinical Director	RST
Bader	Sandena	Family and Youth Advocate Liaison	Cal Voices
Barajas	Socorro	Clinician	El Hogar
Barney	Robin	Family Advocate Liaison	Cal Voices
Blackman	Brandi	Clinical Director	Telecare
Borden	Denisha (Nina)	Peer Employee	Hope Cooperative
Byrd	Helen	Program Coordinator	Sacramento County Behavioral Health
Clothier	Laurie	CEO	River Oak
Cordova	Roberto	Clinical Director	Heartland
Deville	Lou	Peer Employee	Cal Voices
Eldridge	Chris	Mental Health Program Coordinator	Sacramento County Behavioral Health
Eskow	Genelle	CEO	El Hogar
Fortes	Mary Ann	Senior Accountant	Sacramento County Behavioral Health
Geniesse	Andrew	Peer Employee	Cal Voices
Gillette	Robert	Senior Accounting Manager	Sacramento County Behavioral Health
Green	Sheri	Program Manager - Children's Services	Sacramento County Behavioral Health
Hawkins	Pamela	Program Coordinator	Sacramento County Behavioral Health
Heggum	Kathleen		Turning Point
Hurst	Paulette	Senior Mental Health Counselo	Sacramento County Behavioral Health

Last Name	First Name	Position	Agency
Ibarra	Melony	Administrative Services Officer II	Sacramento County Behavioral Health
Jacobs	Melissa	Division Manager – Children's Services	Sacramento County Behavioral Health
Johansen	Erin	CEO	TLCS Hope Cooperative
Jones	Shelia	Peer Employee	Turning Point Community Programs
Jung	Betty	Clinician	River Oak
Kaur	Manpreet		Visions Unlimited
Kelly	Stephanie	Program Manager – Adult Services	Sacramento County Behavioral Health
Kenobi	Robbie		Hope Cooperative
Kesselring	Rob	Program Manager - Children's Services	Sacramento County Behavioral Health
Kucharew	Byron	Clinician	PSE2-Telecare
Kushida	Leslie	Clinician	Visions Unlimited
Ledesma	Cecilia	Clinician	La Familia Counseling Center
Leung	Julie	Acting Program Manager – MHSA	Sacramento County Behavioral Health
Lund	Erin	Clinician	Capital Star
Malroutu	Lakshmi	CEO	Asian Pacific Community Counseling
McCarty	Chris	COO	Sacramento Children's Home
McClure	Erin	Program Coordinator	Sacramento County Behavioral Health
Mitchell	Ann	Administrative Services Officer 3 – Avatar Training & Support/DBHS Billing	Sacramento County Behavioral Health

Last Name	First Name	Position	Agency
Mutinda	Peggy	Clinician	Dignity Health
Nakamura	Mary	Program Manager – Cultural Competence/Ethnic Services	Sacramento County Behavioral Health
Niedam	Tara	ED	UCD SacEDAPT
Owens	Whitney	Program Planner	Sacramento County Behavioral Health
Panyala	Anantha	Division Manager – Mental Health Treatment Center	Sacramento County Behavioral Health
Quinley	Matt	Program Manager - County Operated Services	Sacramento County Behavioral Health
Quist	Ryan	Deputy Director – Division of Behavioral Health	Sacramento County Behavioral Health
Rechs	Alex	Program Manager – Quality Management	Sacramento County Behavioral Health
Sawyer	John	IT Analyst II	Sacramento County Behavioral Health
Sellers	Lonyeua	Clinician	Stanford Youth Solutions
Soares	Brandon	Peer Employee	Telecare ARISE
Seng	Xiong		Capital Star Community Services
Towne	Shadya	Clinician	Hope Cooperative
Trumbull	Joshua	Clinician	Hope Cooperative
Umayam	Maria	Senior Accountant	Sacramento County Behavioral Health
Watters	Tricia	Mental Health Program Coordinator	Sacramento County Behavioral Health
Weaver	Kelli	Division Manager – Adult Services	Sacramento County Behavioral Health
Wiley	Karly	Regional Administrator	Capital Star

Last Name	First Name	Position	Agency
Wilkinson	Jeff	CEO	Heartland FIT
Williams	Dawn	Program Manager – Research, Evaluation and Performance Outcomes	Sacramento County Behavioral Health
Wilson	Kari	Sr. Administrative Analyst	Sacramento County Behavioral Health
Woolcott	John		Sacramento Children's Home
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 ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Sacramento MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Large	1,791,890	69,726	3.89%	$372,190,347	$5,338
MHP	143,489	4,992	3.48%	$19,031,942	$3,812

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 2019 Distribution of Beneficiaries by ACB Range

Sacramento MHP								
ACB Range	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	22,768	95.50%	93.31%	$83,065,633	$3,648	$3,998	68.92%	59.06%
>$20K - $30K	596	2.50%	3.20%	$14,327,839	$24,040	$24,251	11.89%	12.29%
>$30K	478	2.00%	3.49%	$23,134,369	$48,398	$51,883	19.19%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
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
CCBH	Community Care Behavioral Health
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIT	Crisis Intervention Team or Training
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSD	Community Services Division
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services

Acronym	Full Term
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
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
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
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay

Acronym	Full Term
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health 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
NA	Network Adequacy
n/a (alt)	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
ONA	Out-of-Network Access
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PM (alt)	Partially Met
QI	Quality Improvement

Acronym	Full Term
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration
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
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version