# Performance of the Sacramento County Mental Health System

## Prepared by the Sacramento County Mental Health Board October 2019

Approved by the Sacramento County Mental Health Board

Table of Contents

Executive Summary ..... 3
Methodology ..... 8
Background ..... 9
Demographics ..... 9
Revenue ..... 12
Mental Health Services ..... 13
Outpatient Services ..... 14
Timeliness of Mental Health Services ..... 14
Client Satisfaction ..... 18
Crisis Services ..... 31
Mental Health Treatment Center Intake Stabilization Unit ..... 31
Mobile Crisis Support Teams ..... 32
Mental Health Triage Navigator Program ..... 35
Inpatient Services ..... 37
Mental Health Services Act ..... 39
Full Service Partnerships ..... 39
Capacity of Services ..... 42
Penetration Rates ..... 43
Retention Rates ..... 46
Human Resources ..... 46
Gender ..... 47
Race ..... 48
Language ..... 49
Appendix A ..... 50
Appendix B ..... 52
Appendix C ..... 54
Appendix D ..... 58
Appendix E ..... 61
Bibliography ..... 63

## Executive Summary

The purpose of this report is to comply with the Sacramento County Mental Health Board's (MHB) statutory mandate pursuant to Welfare and Institutions Code Section 5604.2(a)(5) to submit an annual report to the governing body on the needs and performance of the county's mental health system. This report does not include an analysis of needs because a community-wide needs assessment is not available.

Outpatient Services

Timeliness of Services

The Department of Health Care Services (DHCS) sets benchmarks of seven, fourteen, and thirty calendar days for various types of outpatient services. These benchmarks include time from request for service to first outpatient appointments, time from assessment to first outpatient psychiatric service, and time from acute hospital discharge to first outpatient appointment and first outpatient psychiatric service. The DBHS is out of compliance with those benchmarks for most of its services for the majority of children and youth and adults that it serves. This lack of compliance is detrimental to those clients[*]. The DBHS has taken steps to improve timeliness by initiating Performance Improvement Projects (PIPS) to test both clinical and administrative strategies. In November 2017, the Board of Supervisors increased funding for mental health service by $44 million over 3 years, which has increased service capacity. It should improve timeliness of services.

Recommendation: The DBHS should investigate the reasons for the deterioration in the timeliness of services from the first two quarters to the fourth quarter for Benchmark (BM)4 and BM5 for Children and Adults, and BM6 for Adults.

Recommendation: The MHB will continue to monitor the timeliness of access to services through Calendar Year (CY) 2018 and CY 2019 to see if efforts by the DBHS, including PIPs and budget increases, have improved timeliness. If no improvement is seen, the MHB will consider what further steps are necessary to improve timeliness.

Client Satisfaction

According to the November 2018 report, Adult and Older Adult consumers are satisfied with the following Domains:

- Access[†]
- Quality and Appropriateness
- Participation in Treatment Planning
- Outcomes of Services
- Functioning
- Social Connectedness
- General Life Satisfaction

[*] The report uses "client," "consumer" when discussing the Consumer Perception of Care Survey and other DBHS reports that use that term, "beneficiary" when referring to clients served by the Medi-Cal program, and "partner" when referring to clients in Mental Health Services Act Full Service Partnerships.

[†] This Domain consists of six items, only one of which relates to timeliness.

There are problems with the percent of Adults agreeing with the satisfaction scores for individual items. The scores need significant improvement for 3 of the 8 items in the Outcomes of Service Domain.

For Older Adults, the percent agreeing with the satisfaction scores needs to improve for 1 of the 6 items in the Access Domain. The scores need to improve for 1 of the 9 items in the Quality and Appropriateness Domain. The percent agreeing needs to improve significantly for 3 out of 8 items in the Outcomes of Services Domain. For the Functioning Domain, 3 out of 5 items need improvement. For the Social Connectedness Domain, all items need significant improvement.

Caregivers and Youth are satisfied with all domains. However, for some items there are problems with the percent of Youth agreeing with their satisfaction scores. The percent agreeing needs significant improvement for 2 of the 6 of the items in the Outcome of Services Domain. The percent agreeing needs significant improvement for 1 of the 5 items in the Functioning Domain and needs improvement in the other 3 items.

The reason that agreement with satisfaction scores is important is that these items represent aspects of the Recovery Model. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Working Definition of Recovery, Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Adults and Older Adult consumers are satisfied with Quality of Life Domain. In November 2018, the percent agreeing with their satisfaction scores is below 50% for most domains, so that result has room for improvement.

Recommendation: The DBHS needs to find a new strategy beyond adding items to its Quality Management Program Annual Work Plan to work on increasing the percent of consumers who agree with their satisfaction scores. It also needs to make sure it addresses Items 2 and 3 for Caregivers and Youth and Item 6 for Older Adults.

Recommendation: The DBHS should establish benchmarks for the percent agreeing with satisfaction scores for the Adult Domain Outcomes of Services and for the Older Adults Domains Access, Quality and Appropriateness, Outcomes of Services, and Social Connectedness.

Crisis Services

Mental Health Treatment Center Intake Stabilization Unit

For Inpatient Services, 66.3% of adults were discharged to that setting. For children, 33.7% were discharged to that setting. Over 30% of adults and children served by the Intake Stabilization Unit (ISU) were linked to outpatient services after their crisis, which is a positive outcome for continuity of care. We are unable to comment on recidivism rates due to lack of benchmarks. The number of Crisis Residential beds has increased from 12 in the mid- 1990's to 42, and the capacity is planned to increase by another 30

beds. With that increased capacity, the proportion of crisis visits discharged to Crisis Residential settings should increase.

No Recommendation

### Mobile Crisis Support Teams

The Mobile Support Crisis Teams (MCST) provide a high level of service, screening nearly 90% of referrals received. They provided linkages to mental health services, natural supports, and a variety of community services. In addition, they provide many more services to clients and family members than the routine police response to a crisis call. Hospitalizations before and after contact with the MCST decreased only slightly. Emergency room visits before and after contact with the MCST decreased to a greater extent. However, a significant difference exists between the rates for clients linked to outpatient services and rates for unlinked clients. The rates for unlinked clients did increase significantly, which would indicate that the linkage to outpatient services provided by the MCST was effective in reducing hospitalization. In addition to quantitative measures of the program's success, such as rehospitalization rates, both clients and family members served by the MCSTs experience many qualitative benefits. For example, clients experience less stress when offered the opportunity to interact with a mental health clinician, and families are offered additional support.

Recommendation: DBHS staff should investigate the factors that contribute to the differences between teams that have rate reductions and those that have rate increases to improve the success of the program.

Recommendation: Research Evaluation and Performance Outcomes should evaluate the timelines postdischarge for rehospitalization measures associated with the MCST Program.

### Mental Health Triage Navigator Program

The Mental Health Triage Navigator Program has shown success in multiple areas. In FY 17/18, it reduced inpatient hospitalizations for clients linked to outpatient programs by a third. Referrals from emergency rooms to the Mental Health Treatment Center Intake Stabilization Unit were reduced by more than half. Nearly all clients referred to outpatient programs received services within 30 days. Over 50% of clients screened had contact with a Peer Navigators, and that contact occurred within 5.5 days after initial screening. Clients were referred to a variety of essential services, including Respite, Benefits Acquisition, Medical and Health Services, and Drug and Alcohol Support. There are many other benefits to clients who encountered the Navigators at the Jail and collaborative courts.

No Recommendation

## Inpatient Services

In FY 17/18, 2,999 unduplicated adults accounted for 4,882 psychiatric admissions. Some adults had more than one admission. The overall 30-day recidivism rate for adults

in FY 17/18 was 20.4%, which is consistent with the rate in the literature for persons with mood disorders and schizophrenia. The 30-day recidivism rate for children is 9.7%. We cannot comment on this rate, due to lack of a benchmark. Some of the 30-day recidivism rates for adults by gender and race exceed 20%. The factors that contribute to those elevated rated should be investigated.

Recommendation: The DBHS Cultural Competence Committee should study the race/ethnicity and gender recidivism rates that exceed 20% and make recommendations that would reduce them.

## Mental Health Services Act

### Full Service Partnerships

The Mental Health Services Act (MHSA) Full Services Partnerships (FSPs) had excellent results for all its outcome measures except Employment. It is positive that the FSPs were able to maintain the employment for the partners who began the program employed, but securing new employment for just 2.5% of partners needs significant improvement. One of the major dimensions of SAMHSA's Working Definition of Recovery is that clients must have purpose in their lives—meaningful daily activities, such as a job, school, volunteerism, family caretaking or creative endeavors and the income and resources to participate in society.

Recommendation: The DBHS must work with FSP providers to increase their emphasis on providing vocational services to partners.

### Capacity of Services

From FY 2008/09 to the Current Year, the DBHS has had a fluctuating funding history. In the early years, it had a significant funding reduction that took years to recover from. In addition, funding increases in 4 out of the 11 years were exceeded by the rate of inflation. In recent years, there have been budget increases. But, these increases have been insufficient to address the county's inadequate capacity of services. The DBHS's Average Cost per Beneficiary (ACB) is consistently lower than that for Large Counties[‡] and Statewide rates. The External Quality Review Organization (EQRO) has concluded in its analysis that resources are inadequate to meet beneficiary needs and detrimental to the quality of care. According to the EQRO report, contract providers do not have sufficient resources to keep up with the cost of doing business and that their salaries have become progressively less competitive, leading to high staff turnover.

Recommendation: The Sacramento County Board of Supervisors should continue to increase the DBHS's budget to increase its capacity to provide services until its ACB approaches that of Large Counties or the Statewide average.

[‡] Sacramento County is classified as a Large County.

Recommendation: Contract providers should be given a sufficient cost of living increase to account for the increased cost of doing business and the need for adequate salaries to retain qualified staff.

Penetration Rates

The penetration rates among age groups for CY 2016 and CY 2017 pose no cause for concern except for the decrease in the rate between CY 2016 and CY 2017 for 0-5 year olds. By gender, the penetration rate for males exceeds that for females in CY 2017. Changes in the penetration rates for Asian/Pacific Islanders and Hispanics between CY 2016 and CY 2017 result from anomalies in the data for Medi-Cal Eligible Beneficiaries.

Recommendation: The DBHS should investigate the causes of the decrease in penetration rates for 0-5 year olds and the difference in the penetration rates for females and males.

Retention Rates

Summary

Retention rates show no significant differences by race, sex, or age. There are no differences by language except that the retention rate for the Arabic language is lower.

No Recommendation

Human Resources

The DBHS has a diverse staff in terms of race/ethnicity, language capability, and consumer family member representation among direct service staff. However, imbalances still exist when current staffing levels are compared to the Medi-Cal beneficiary population in the gender, race/ethnicity, and threshold languages of the consumers.

Recommendation

The DBHS should strive in its recruitment efforts to ameliorate the imbalances that exist in its representation of staff by gender, race/ethnicity, and threshold languages.

The purpose of this report is to comply with the MHB's statutory mandate pursuant to Welfare and Institutions Code Section 5604.2(a)(5) to submit an annual report to the governing body on the needs and performance of the county's mental health system. This report does not include an analysis of needs because a community-wide needs assessment is not available.

**Methodology**

The data for this report was obtained from Sacramento County Division of Behavioral Health Services (DBHS) Research Evaluation Performance Outcomes. We would like to thank the staff for their availability, cooperation, and willingness to answer our questions. We would also like to thank the DBHS program staff for their help.

The sources for the various sections of the report are provided below:

Outpatient Services

- Timeliness
  - ✓ Benchmark Report, CY 2017
- Client Satisfaction
  - ✓ Mental Health Consumer Perception Survey, May 2017 Collection Period
  - ✓ Mental Health Consumer Perception Survey, November 2017 Collection Period
  - ✓ Mental Health Consumer Perception Survey, May 2018 Collection Period
  - ✓ Mental Health Consumer Perception Survey, November 2018 Collection Period

Crisis Services

- Mental Health Treatment Center Intake Stabilization Unit
  - ✓ Crisis Visits, Inpatient Hospital Admissions, and Recidivism, Fiscal Year (FY) 2017-18
- Mobile Crisis Support Teams
  - ✓ Mobile Crisis Support Team Annual Report, FY 17/18
- Mental Health Triage Navigator Program
  - ✓ Mental Health Triage Navigator Program Annual Report. FY 17/18

Inpatient Services

- ✓ Crisis Visits, Inpatient Hospital Admissions, and Recidivism, FY 2017-18

Mental Health Services Act

- Full Service Partnerships
  - ✓ Mental Health Services Act Full Service Partnership Program Performance Indicator Report, FY 16/17

Capacity of Services

- ✓ Behavior Health Concepts, Inc. FY 18-19. Medi-Cal Specialty Mental Health External Quality Review, Sacramento MHP Final Report. Prepared for California Department of Health Care Services.

Penetration Rates
- ✓ DBHS Research Evaluation Performance Outcomes

Retention Rates
- ✓ DBHS Research Evaluation Performance Outcomes

Human Resources
- ✓ Sacramento County Mental Health. December 2018. 2018 Human Resources Survey

## Background

### Demographics

Sacramento County has an estimated population of 1,530,000 people. As reported in Table 1 on the next page, the Sacramento County DBHS served 29,833 persons in FY 2017-18. Of those 29,833 persons, 25,266 were served by Medi-Cal during that same period. The table breaks down clients served by age, gender, ethnicity, and race.

Table 1: Unduplicated Clients Served in Sacramento County, FY 2017-18

| | All Served (N=29,833) | | Medi-Cal Beneficiaries Only (N=25,468) | |
|---|---|---|---|---|
| **Age** | **N** | **%** | **N** | **%** |
| 0-15 | 8,340 | 28.0% | 8,100 | 31.8% |
| 16-25 | 4,878 | 16.4% | 4,097 | 16.1% |
| 26-59 | 14,059 | 47.1% | 11,267 | 44.2% |
| 60+ | 2,538 | 8.5% | 2,004 | 7.9% |
| Unknown | 18 | 0.1% | 0 | 0.0% |
| **Gender** | **N** | **%** | **N** | **%** |
| Female | 15,111 | 50.7% | 13,133 | 51.6% |
| Male | 14,698 | 49.3% | 12,327 | 48.4% |
| Unknown | 24 | 0.1% | 8 | 0.0% |
| **Ethnicity** | **N** | **%** | **N** | **%** |
| Hispanic/Latino | 6,135 | 20.6% | 5,494 | 21.6% |
| Not Hispanic/Latino | 18,614 | 62.4% | 16,325 | 64.1% |
| Unknown/Not Reported | 5,084 | 17.0% | 3,649 | 14.3% |
| **Race** | **N** | **%** | **N** | **%** |
| Alaskan Native | 459 | 1.5% | 361 | 1.4% |
| Asian/Pacific Islander | 2,036 | 6.8% | 1,814 | 7.1% |
| Black/African-American | 6,737 | 22.6% | 5,809 | 22.8% |
| Multi-Ethnic | 1,366 | 4.6% | 1,268 | 5.0% |
| White | 1,1029 | 37.0% | 9,418 | 37.0% |
| Other Race | 4,455 | 14.9% | 4,041 | 15.9% |
| Unknown/Not Reported | 3,751 | 12.6% | 2,757 | 10.8% |
| **Primary Language** | N | % | N | % |
| Arabic | 119 | .04% | 101 | 0.4% |
| Cantonese | 67 | .02% | 63 | 0.2% |
| English | 25,586 | 85.8% | 21,897 | 86.1% |
| Hmong | 292 | 1.0% | 283 | 1.1% |
| Other/Non-English | 627 | 2.1% | 559 | 2.2% |
| Russian | 242 | 0.8% | 233 | 0.9% |
| Spanish | 1,528 | 5.1% | 1,412 | 5.6% |
| Vietnamese | 195 | 0.7% | 190 | 0.7% |

Source: Sacramento County Division of Behavioral Health Services

The following pie charts display the percentage break down of clients by age, race, and primary language for all clients served.

Figure 1: Total Clients Percentage by Age

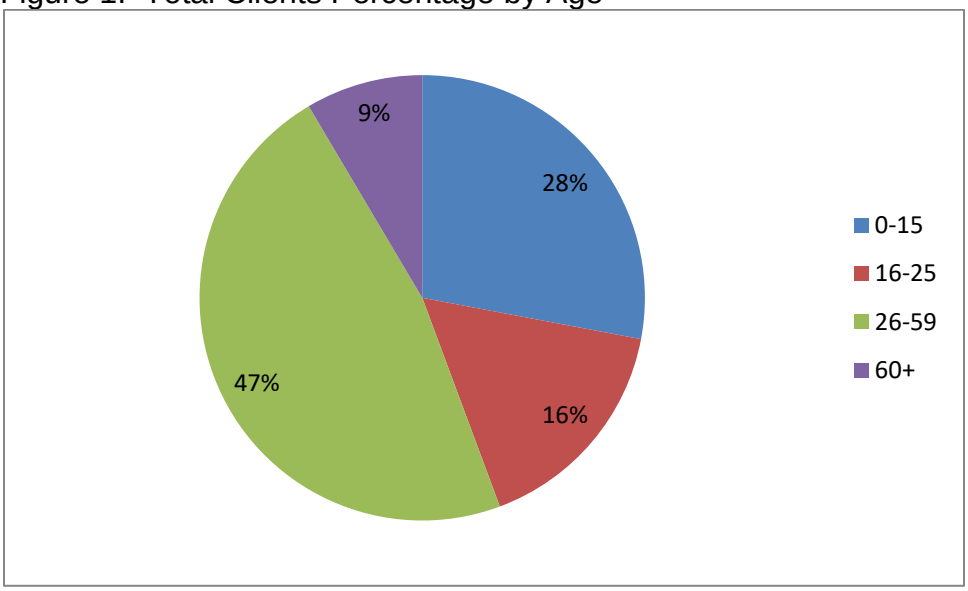



Figure 2: Total Clients Percentage by Race

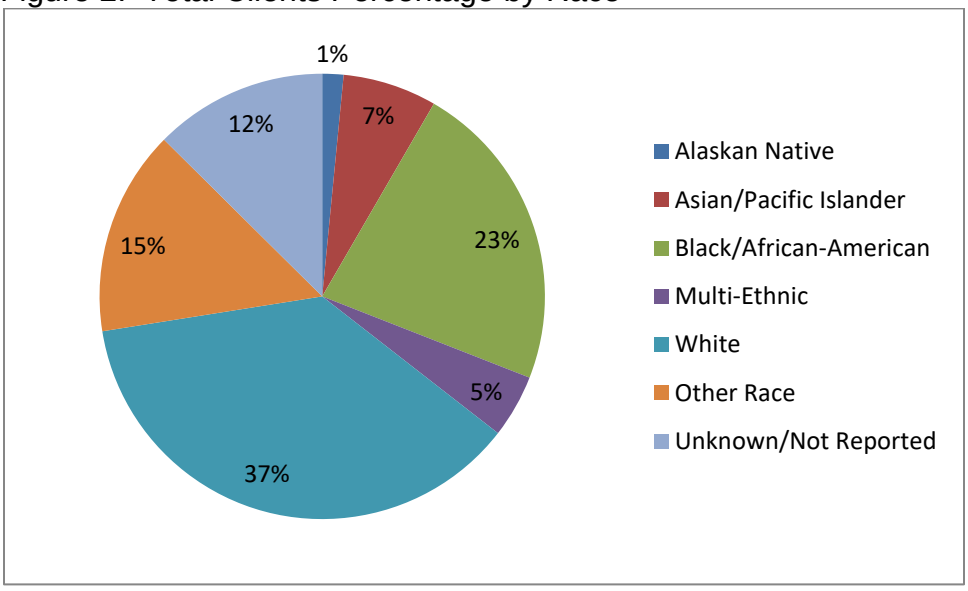
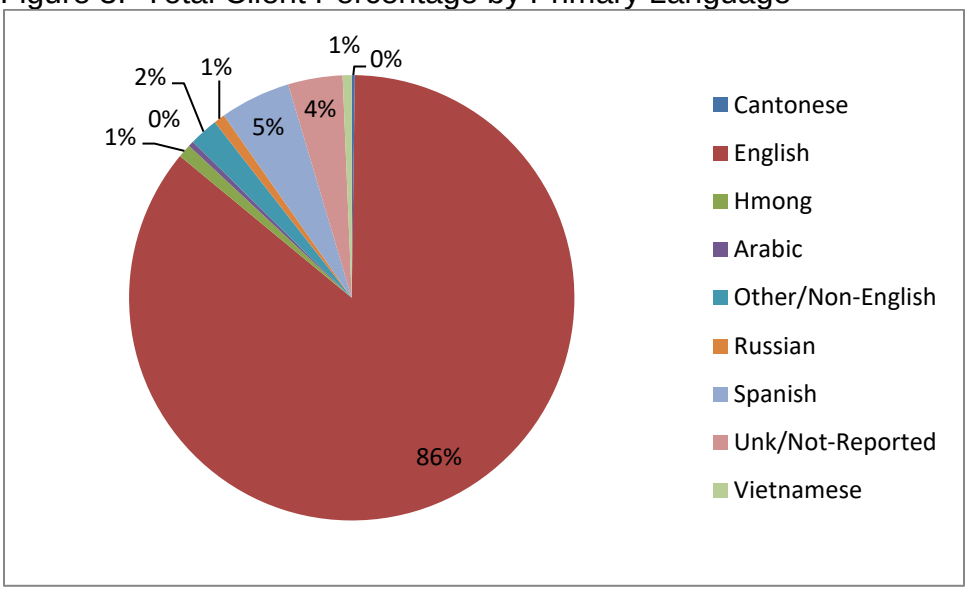


Figure 3: Total Client Percentage by Primary Language




## Revenue

The DBHS received approximately $300 million to provide mental health services in FY 2018-19. Table 2 below provides the revenue sources.

Table 2: Revenue Sources, FY 2018-19

| Revenue Source | Revenue (in millions) |
|---|---|
| Realignment | $109 |
| Medi-Cal (Federal Financial Participation) | $68 |
| Medi-Cal Admin | $5.9 |
| Mental Health Service Act | $91 |
| County General Fund | $21 |
| SB 82 Mental Health Wellness Grant | $1.1 |
| SAMHSA | $3.3 |
| CalWorks | $3.35 |
| System Partner Funding (interdepartmental) | $3.5 |
| Total | $306.15 |

Source: Sacramento County Division of Behavioral Health Services

Legend

Realignment: a process whereby State Sales Tax and Vehicle License Fees are transferred to the county level to fund mental health services

Medi-Cal (Federal Financial Participation): the name of California's version of the federal Medicaid program that funds mental health services for low-income persons

Medi-Cal Admin: the portion of Medi-Cal funds allocated to pay for the administrative costs associated with managing the Medi-Cal program

Mental Health Services Act: the act created by Proposition 63 in 2004 creating a 1% tax on incomes over $1 million to fund mental health services

County General Fund: funds received from the County of Sacramento derived from local taxes, permit fees, etc. Allocated by the County Executive for general operating functions of County agencies

SB 82 Mental Health Wellness Grant: competitive grant program designated for the purpose of developing mental health crisis support programs

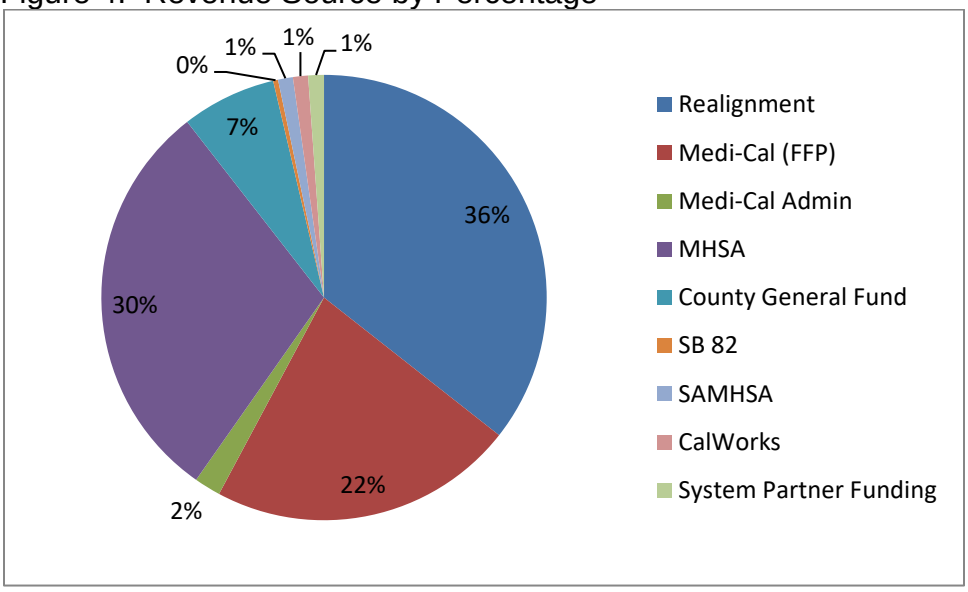
SAMHSA: a block grant provided by the federal SAMHSA for services to individuals with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness, or who are at imminent risk of homelessness

CalWorks: a public assistance program that provides cash aid and services to eligible families that have children in the home.

System Partner Funding (inter-departmental): inter-departmental transfers to leverage funding for services with other county departments, such as Child Protective Services, Probation, and CalWorks

Figure 4 below provides a pie chart that displays the revenue sources by percentage.

Figure 4: Revenue Source by Percentage




### Mental Health Services

The Sacramento County Mental Health Plan (MHP), which is the portion of the county mental health system that serves Medi-Cal beneficiaries, has the following Vision, Mission, and Values:

**Vision:** The Sacramento County MHP is committed to providing beneficiaries the necessary services and supports to attain and maintain the most dignified life existence possible.

**Mission:** The Sacramento County MHP will:

- Assist adults with mental illness and children/youth with emotional disturbance by providing services and supports to maximize their quality of life in the community
- Sustain and enhance a public mental health system that supports Recovery of adults with mental illness and children/youth with emotional disturbance
- Eliminate mental health disparities for all cultural, ethnic, and racial groups

**Values:** All individuals have a basic human right to be treated with dignity and respect; Inclusion of the beneficiary, family, and community support system in the individual treatment and system planning processes is critical to quality outcomes; Effective communication and respect for the relationship between individuals, families, and providers are essential for successful outcomes; Treatment should always be delivered in the most appropriate and least restrictive environment and level of care; The treatment process is strength based; Beneficiary choice will be honored within available resources.

The County of Sacramento provides or arranges and pays for the following medically necessary covered Specialty Mental Health Services (SMHS) to beneficiaries of Sacramento County:

1) Mental health services;
2) Medication support services;
3) Day treatment intensive;
4) Day rehabilitation;
5) Crisis intervention;
6) Crisis stabilization;
7) Adult residential treatment services;
8) Crisis residential treatment services;
9) Psychiatric health facility services;
10) Intensive Care Coordination (for beneficiaries under the age of 21);
11) Intensive Home Based Services (for beneficiaries under the age of 21);
12) Therapeutic Behavioral Services (for beneficiaries under the age of 21);
13) Therapeutic Foster Care (for beneficiaries under the age of 21);
14) Psychiatric Inpatient Hospital Services; and
15) Targeted Case Management.

The MHP provides 9% of the services through its county-operated clinics, and 91% of the services are delivered by contract providers.

## Outpatient Services

### Timeliness of Mental Health Services

The Department of Health Care Services (DHCS) sets benchmarks of seven, fourteen, and thirty calendar days for various types of outpatient services. These benchmarks are established in the Medicaid Managed Care Final Rule: Network Adequacy Standards, July 19, 2017. The DBHS is out of compliance in meeting those

benchmarks for most of its services for the majority of children and youth and adults that it serves. This lack of compliance is detrimental to those clients. The results for those benchmarks for CY 2017 that relate directly to client care are summarized below. (BM2 and BM7 are not discussed.) The results for all the benchmarks are provided in Table 13 in Appendix A

BM1: Time from Request for Service to First Outpatient (OP) Appointment (Target = 14 calendar days)

Average Number of Days from Request for Services to First OP Appointment

Children: First Two Quarters—Approximately 31 days with less than 20% of children meeting this benchmark; Last Two Quarters—Approximately 23 days with slightly more than 30% meeting the benchmark

Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data

Adults: First Quarter—Approximately 35 days with less than 20% meeting the benchmark; Last Two Quarters—29 days with less than 30% meeting the benchmark

*Significantly out of compliance for children and adults. Average Number of Days from Request to First OP Appointment and Percent meeting that benchmark improved between First Two Quarters and Second Two quarters because the Average Number of Days from Request for Services to Authorization decreased significantly for all populations*

BM3: Urgent Service Request Opened to OP Provider by Access to First OP Appointment (Target = 7 calendar days)

Children: First Two Quarters—21 days with under 13% meeting the benchmark; Second Two Quarters—Approximately 20 days with 5% meeting the benchmark in the Third Quarter and 8% meeting the benchmark in the Fourth Quarter

Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data

Adults: First Two Quarters—Approximately 27 days with 5% meeting the benchmark; Last Two Quarters—Approximately 32 days with 5% meeting the benchmark in the Third Quarter and 8% meeting the benchmark in the Fourth Quarter

*Significantly out of compliance for children and adults. There is no improvement between the First Two Quarters and the Second Two Quarters. This lack of compliance is especially problematic because this measure relates to the urgent need for services. For this measure the term "Urgent" is defined by the MHP.*

BM4: OP Assessment to First OP Psychiatric Service (Target = 30 calendar days)

Children: First Two Quarters: Approximately 50 days with 40% meeting this benchmark; Third Quarter—45 days with 40% meeting the benchmark; Fourth Quarter—98 days with 6.5% meeting the benchmark

Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data

Adults: Approximately 40 days with 40% meeting the benchmark; Third Quarter—38 days with 44% meeting the benchmark; Fourth Quarter—61 days with 28% meeting the benchmark

*Significantly out of compliance for children and adults with a marked deterioration in performance in the Fourth Quarter.*

BM5: Acute Hospital Discharge to First OP Service (Target = 7 calendar days)

Children: First Two Quarters—12 days with 60% meeting the benchmark; Third Quarter—14 days with 62% meeting the benchmark; Fourth Quarter—20 days with 53% meeting the benchmark

Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data

Adults: Approximately 22 days with 43% meeting the benchmark; Third Quarter—19 days with 48% meeting the benchmark; Fourth Quarter 35 days with 35% meeting the benchmark

*For children, out of compliance with more than a majority meeting the benchmark, but performance deteriorates in the Fourth Quarter*

*For adults, significantly out of compliance with performance deteriorating in Fourth Quarter*

BM6: Acute Hospital Discharge to First OP Psychiatric Service (Target = 30 calendar days)

Children: First Two Quarters—22 days with 76% meeting the benchmark; Last Two Quarters—Approximately 27 days with approximately 70% meeting the benchmark

Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data:

Adults: Approximately 30 days with approximately 60% meeting the benchmark; Third Quarter—26 days with 70% meeting the benchmark; Fourth Quarter 44 days with 58% meeting the benchmark

*For children, in compliance for three-quarters of the children served*

*For adults, in compliance for nearly three-quarters of the adults served with performance deteriorating in the Fourth Quarter*

Lack of timeliness has an adverse impact on client's health. Inability to see an outpatient provider or case manager can result in a lack of support or referral to needed community services. Lack of timely access to psychiatric services can result in not obtaining needed medications. These effects can lead to worsening of symptoms, increased use of crisis services, risk of homelessness, risk of incarceration, and increased cost to the mental health system and physical health care system.

The DBHS has taken some steps to improve timeliness. The DBHS has initiated both Clinical and Non-Clinical Performance Improvement Projects (PIP) in Fiscal Year 18/19. A PIP is a focused effort to improve specific administrative or clinical performance in order to improve access to and quality of Specialty Mental Health Services. A Non-Clinical PIP focuses on administrative processes. A PIP is part of the external quality review process of MHPs, which takes place annually. As required by Title 42, Code of Federal Regulations, Part 438, Subpart E, the Department of Health Care Services contracts with an External Quality Review Organization (EQRO). The EQRO conducts reviews of MHPs to analyze and evaluate information related to quality, timeliness, and

access to SMHS provided by California's 56 MHPs and/or their subcontractors to Medi-Cal beneficiaries. California EQRO for the Medi-Cal SMHS Program is Behavioral Health Concepts (BHC), Inc.

Clinical PIP: Med Bridge--Improving Timely Access

The plan is to utilize a portion of the APSS Clinic as a Medication Bridge Program for individuals who are unlinked to the MHP and receive a service at the Mental Health Urgent Care Clinic. The goal is to decrease hospital/urgent care/emergency room use and increase timeliness and engagement in outpatient services by providing psychiatric services until beneficiaries can have their first face-to-face meeting with the outpatient provider psychiatrist.

Non-Clinical PIP: Avatar Scheduler--Uniform Scheduling System Using an Electronic Scheduling Tool

The goal of the PIP is to have the MHP Access Team schedule MHP beneficiaries with their initial appointment using a uniform electronic scheduling system among selected adult providers. The intent is to decrease no-show rates among adult beneficiaries by eliminating delays in obtaining an initial appointment with the provider. The expectation is that this will result in improved timeliness to first appointments.

In November 2017, the Sacramento County Board of Supervisors approved dedicating $44 million in MHSA funding over the next three fiscal years to fund additional mental health treatment services to the Adult System of Care for individuals with serious mental illness who are homeless or at risk of becoming homelessness. As a result of this funding, the following expanded capacity resulted:

- Full Service Partnership—100 slots
- Regional Support Teams—100 slots

New programs were also created:

- New Adult Outpatient Program—500 slots
- New Full Service Partnership--200 slots

In FY 2018-19, the DBHS also implemented a redesign of the Children's System of Care. Goals of the redesign include improving timely access to services by reducing distance parameters to services; increasing service capacity; enhancing the quality of trauma informed and culturally responsive services; and increasing collaboration with child-serving systems and organizations, such as schools, juvenile justice, child welfare, and health care. The redesigned service system will include fifteen service sites that will be geographically distributed throughout Sacramento County. The quality of services will be enhanced by adding the Flexible Integrated Treatment (FIT) service delivery model to the traditional outpatient model. FIT is an integrated approach that addresses the multi-systemic needs of children and families and provides services anywhere in the community, including home, school, office, or other sites.

Summary

The Department of Health Care Services (DHCS) sets benchmarks of seven, fourteen, and thirty calendar days for various types of outpatient services. These benchmarks include time from request for service to first outpatient appointments, time from assessment to first outpatient psychiatric service, and time from acute hospital discharge to first outpatient appointment and first outpatient psychiatric service. The DBHS is out of compliance with those benchmarks for most of its services for the majority of children and youth and adults that it serves. This lack of compliance is detrimental to those clients. The DBHS has taken steps to improve timeliness by initiating PIPs to test both clinical and administrative strategies. In November 2017, the Board of Supervisors increased funding for mental health service by $44 million over 3 years, which has increased service capacity. It should improve timeliness of services.

Recommendation: The DBHS should investigate the reasons for the deterioration in the timeliness of services from the first two quarters to the fourth quarter for Benchmark (BM) 4 and BM5 for Children and Adults, and BM6 for Adults.

Recommendation: The MHB will continue to monitor the timeliness of access to services through CY 2018 and CY 2019 to see if efforts by the DBHS, including PIPs and budget increases, have improved timeliness. If no improvement is seen, the MHB will consider what further steps are necessary to improve timeliness.

## Client Satisfaction

This section of the report uses data collected in the November 2018 Mental Health Consumer Perception Survey administration. Data is also reported for the May 2017, November 2017, and May 2018 reporting periods for purposes of comparison. This report focuses on satisfaction with services received within the Sacramento County MHP Outpatient Services. As stated in the November 2018 Mental Health Consumer Perception of Care report, the goal of this survey is to collect data for reporting on the federally determined National Outcome Measures (NOMs). Reporting on these NOMs is required by the SAMHSA, and receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data. Counties are required to conduct the survey and submit data per §3530.40 of Title 9 of the California Code of Regulations.

Response Rate for Reporting Periods

As stated in the November 2018 Mental Health Consumer Perception of Care Survey report, the DBHS encourages its mental health providers to reach a response rate of at least 75%. Response rate (Column B/A in Table 3 below) is calculated by dividing the number of surveys received (whether or not they were fully completed) by the unduplicated number of clients receiving face-to-face services during the collection period. (The number of clients receiving face-to-face services was determined by the number of clients who received at least one of the several Treatment Codes and did not have “Phone” or “Telehealth” in Place of Service.) The completion rate (C/B) is

determined by dividing the number of surveys completed by the total number of surveys received. The completion rate for the current survey period remained the same from the previous period for Older Adults but decreased for Adults, Caregivers, and Youth. The percentage of consumers reflected (C/A) is determined by dividing the number of surveys completed by the total number of consumers served. The percentage of Adult consumers reflected increased from previous reporting periods, while the percentage of Older Adults, Caregivers, and Youth consumers decreased.

Table 3: Response Rate, Completion Rate, and Consumers Reflected for Consumer Perception Surveys

| | A | B | C | B/A | C/B | C/A |
|---|---|---|---|---|---|---|
| | **Consumers Served (N)** | **Surveys Received (N)** | **Completed Surveys (N)** | **Response Rate (%)** | **Completion Rate (%)** | **Consumers Reflected (%)** |
| **Adults – Nov 2018** | 2048 | 1302 | 804 | 64 | 62 | 39 |
| **May 2018** | 2213 | 1201 | 829 | 54 | 69 | 37 |
| **November 2017** | 2145 | 1471 | 955 | 69 | 65 | 45 |
| **May 2017** | 2197 | 1419 | 976 | 65 | 69 | 44 |
| **Older Adults – Nov 2018** | 445 | 159 | 82 | 36 | 52 | 18 |
| **May 2018** | 446 | 128 | 75 | 29 | 59 | 17 |
| **November 2017** | 426 | 128 | 74 | 30 | 58 | 17 |
| **May 2017** | 386 | 142 | 82 | 37 | 58 | 21 |
| **Caregivers – Nov 2018** | 2689 | 2347 | 1047 | 87 | 45 | 39 |
| **May 2018** | 2907 | 2154 | 1144 | 74 | 53 | 39 |
| **November 2017** | 2689 | 1781 | 922 | 66 | 52 | 34 |
| **May 2017** | 2722 | 1711 | 1031 | 63 | 60 | 38 |
| **Youth – Nov 2018** | 1433 | 1116 | 740 | 78 | 66 | 52 |
| **May 2018** | 1196 | 1087 | 705 | 91 | 65 | 59 |
| **November 2017** | 1360 | 869 | 558 | 64 | 64 | 41 |
| **May 2017** | 1320 | 820 | 601 | 62 | 73 | 46 |

Source: Mental Health Consumer Perception Survey—November 2018 Collection Period, Sacramento County Division of Behavioral Health Services

Items with Performance Improvement Goals

The DBHS has targeted three items on the perception survey for Adults and Older Adult and three different items for Caregivers and Youth as on-going performance improvement goals within the Quality Management Improvement Plan. These items are displayed on Table 4 below.

Table 4: Items with Performance Goals for Adults, Older Adults, Caregivers and Youth

| Item # | Question | May 2017 | | Nov 2017 | | May 2018 | | Nov 2018 | |
|---|---|---|---|---|---|---|---|---|---|
| | | % | # | % | # | % | # | % | # |
| Adults | | N=976 | | N=955 | | N=829 | | N=804 | |
| 6 | Staff returned my calls within 24 hours | 77 | 4.16 | 75 | 4.12 | 75 | 4.09 | 72 | 4.09 |
| 17 | I, not staff decided my treatment goals | 74 | 4.11 | 74 | 4.12 | 74 | 4.09 | 76 | 4.09 |
| 20 | I was encouraged to use consumer-run programs | 78 | 4.21 | 78 | 4.23 | 79 | 4.23 | 78 | 4.18 |
| | | | | | | | | | |
| Older Adults | | N=82 | | N=74 | | N=75 | | N=82 | |
| 6 | Staff returned my calls within 24 hours | 71 | 4.05 | 78 | 4.34 | 68 | 3.90 | 74 | 4.08 |
| 17 | I, not staff decided my treatment goals | 66 | 3.88 | 86 | 4.36 | 59 | 3.76 | 68 | 4.05 |
| 20 | I was encouraged to use consumer-run programs | 54 | 3.95 | 62 | 3.93 | 43 | 3.70 | 48 | 3.74 |
| | | | | | | | | | |
| Caregivers | | | | | | | | | |
| | | N=1,031 | | N=922 | | N=1,144 | | N=1,047 | |
| 3 | I helped choose my treatment goals | 90 | 4.39 | 90 | 4.43 | 88 | 4.43 | 89 | 4.38 |
| 2 | I helped choose my services | 85 | 4.27 | 85 | 4.33 | 87 | 4.39 | 85 | 4.30 |
| 11 | I got as much help as I needed | 81 | 4.23 | 79 | 4.26 | 79 | 4.28 | 80 | 4.27 |
| | | | | | | | | | |
| Youth | | N=601 | | N=558 | | N=705 | | N=740 | |
| 3 | I helped choose my treatment goals | 87 | 4.24 | 87 | 4.25 | 84 | 4.20 | 86 | 4.23 |
| 2 | I helped choose my services | 71 | 3.89 | 74 | 3.92 | 72 | 3.90 | 74 | 3.96 |
| 11 | I got as much help as I needed | 77 | 4.11 | 76 | 4.10 | 76 | 4.08 | 77 | 4.15 |

Note %=Percent Agree #=Average Score

Having these items as Performance Goals in the Quality Management Improvement Plan has not proven to be effective. They have been Performance Goals at least since FY 2015-16, the oldest date available on the DBHS website. Furthermore, Item 2 for Caregivers "I helped choose my services," Item 3 for Caregivers "I helped choose my treatment goals," and Item 6 for Older Adults, "Staff returned my calls within 24 hours," have never been included as Performance Goals despite being listed as such in the Consumer Perception of Care reports.

Overall Satisfaction Outcomes: Adults and Older Adults

As stated in the November 2018 Mental Health Consumer Perception of Care report, overall for the November 2018 reporting period, consumers are satisfied with the services they receive in the Sacramento County MHP-Outpatient Services. The data represented in Table 5 below illustrates average scores for the seven domains measured. Each domain has several items scored on a five-point Domain: 1=Strongly

Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree. Higher scores reflect higher levels of satisfaction, and consumers are considered "Satisfied" in a domain if their average scores were greater than 3.50. On average, consumers are satisfied in all domains, with the highest satisfaction in Quality & Appropriateness, Participation in Treatment Planning, and General Satisfaction for Adults and Older Adults.

Table 5: Overall Satisfaction Outcomes for Adults and Older Adults

| | November 2018 | | | | May 2018 | | | |
|---|---|---|---|---|---|---|---|---|
| | Adult (N=804) | | Older Adult (N=82) | | Adult (N=829) | | Older Adult (N=75) | |
| **Domain** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** |
| Access | 80 | 4.17 | 74 | 4.15 | 79 | 4.18 | 73 | 3.96 |
| Quality & Appropriateness | 84 | 4.22 | 82 | 4.10 | 86 | 4.25 | 73 | 3.98 |
| Participation in Treatment Planning (PIT) | 77 | 4.19 | 72 | 4.20 | 75 | 4.17 | 63 | 3.90 |
| Outcomes of Services | 59 | 3.78 | 52 | 3.73 | 59 | 3.81 | 63 | 3.67 |
| Functioning | 61 | 3.76 | 55 | 3.72 | 62 | 3.80 | 57 | 3.63 |
| Social Connectedness | 55 | 3.76 | 50 | 3.70 | 58 | 3.87 | 48 | 3.66 |
| General Satisfaction | 85 | 4.30 | 80 | 4.34 | 86 | 4.31 | 76 | 4.06 |
| **Overall Average** | **81** | **4.03** | **82** | **3.98** | **81** | **4.06** | **69** | **3.85** |

Source: Mental Health Consumer Perception Survey—November 2018 Collection Period, Sacramento County Division of Behavioral Health Services

### Item Analysis

Items from the various Domains that make up the Consumer Perception Survey were analyzed for the May 2017, November 2017, May 2018, and November 2018 periods to see if any specific performance problems had trends over time. The results are provided in Table 6, and the items are grouped by Domain for each target population. All the items have Average Scores that met the 3.50 Average Score reflecting satisfaction with the item. The problem area is in the Percent Agree where an insufficient percentage of consumers agree with their satisfaction scores on some items.

### Criteria for Evaluative Terms

In conducting the Item Analysis, each item is evaluated. The following evaluations are used with the criteria for those terms:

- Percent agreeing needing improvement—60% and above
- Percent agreeing needing significant improvement—59% and below

- Percent agreeing slightly increasing during last reporting period—5 percentage point increase
- Percent agreeing increased during last reporting period—8-10 percentage point increase

The question is how much should the percent agreeing with satisfaction scores increase. The DBHS has set a benchmark of 70% for percent agreeing with satisfaction scores for the Perception of Functioning Domain in its Quality Management Program Annual Work Plan for FY 18/19. Thus, Items 30, 31, and 32 for Older Adults should increase to that level. For the others Domains—Outcomes of Services for Adults; and Access, Quality and Appropriateness, Outcomes of Services, and Social Connectedness for Older Adults—the DBHS should establish benchmarks.

Adults

For Item 25 from the Outcome of Services Domain, “I am better in social situations,” the percent agreeing was consistent across all reporting periods and needs significant improvement to promote socialization in keeping with the SAMHSA Working Definition on Recovery (hereafter referred to as the Recovery Model) major dimension of Community. The Community dimension states that consumers need relationships and social networks that provide support, friendship, love, and hope.

For Item 26 from the Outcomes of Services Domain, “I do better in school and/or work,” the percent agreeing is consistent over time and needs significant improvement. This item is important because of the high unemployment rate for consumers. The unemployment for consumers in California is 90 percent (NAMI, 2014). Providers should be making vocational services a top priority. This item also related to one of the dimensions of Recovery that consumers should have meaningful daily activities, such as a job, school, or volunteerism.

For Item 28 from the Outcomes of Services Domain, “My symptoms are not bothering me as much,” the percent agreeing is consistent over time and needs significant improvement. This item is important because experiencing too many symptoms of mental illness can interfere with functioning in daily life. This item also relates to the Recovery dimension of health and overcoming or managing one’s disease or symptoms.

Older Adults

For Item 9 from the Access Domain, “I was able to see a psychiatrist when I wanted,” the percent agreeing decreased over time but and increased slightly in the last reporting period. Improvement is needed to promote access to services for good medication management.

For Item 15 from the Quality and Appropriateness Domain, “Staff told me what side-effects to watch for,” the percent agreeing decreased over time. This item needs improvement because it is important to monitor side-effects and ensure medication compliance.

For Item 23 from the Outcomes of Services Domain, “I am better able to deal with a crisis,” the percent agreeing decreased over time and increased in the last reporting period. It needs improvement. This skill is needed to implement the Recovery Model principle that self-determination and self-direction empowers consumers and provides resources to gain or regain control over their lives.

For Item 24 from the Outcome of Services Domain, “I am getting along better with my family,” the percent agreeing is consistent over time and needs improvement. This item relates to the Recovery Principle that Recovery is supported through relationships and social networks. It is especially important for older adults because adequate family support can prevent unnecessary institutionalization.

For Item 25 from the Outcome of Services Domain, “I am better in social situations,” the percent agreeing decreased over time and increased slightly in the last reporting period. This item needs improvement. It is important to promoting socialization in keeping with the Recovery Model major dimension of Community. The Community dimension states that consumers need relationships and social networks that provide support, friendship, love, and hope.

For Item 28 from the Outcome of Service Domain, “My symptoms are not bothering me as much,” the percent agreeing decreased over time. It needs improvement. It is important because experiencing too many symptoms of mental illness can interfere with functioning in daily life.

For Item 30 from the Functioning Domain, “I am better able to take care of my needs,” the percent agreeing decreased over time. This item needs improvement. This skill is needed to implement the Recovery Model principle that self-determination and self-direction empowers consumers and provides resources to gain or regain control over their lives.

For Item 31 from the Functioning Domain, “I am better able to handle things when they go wrong,” the percent agreeing decreased over time and increased in the last reporting period. It needs improvement. This skill is needed to implement the Recovery Model principle that self-determination and self-direction empowers consumers and provides resources to gain or regain control over their lives.

For Item 32 from the Functioning Domain,” I am better able to do things that I want to do,” the percent agreeing decreased overtime and needs improvement. This item is important to the Recovery Model principle that self-determination and self-direction are the foundation for Recovery as individuals define their own life goals and design their unique paths towards these goals.

For Item 33 from the Social Connectedness Domain, “I am happy with the friendships I have,” the percent agreeing decreased over time and needs significant improvement. This item relates to the Recovery Model principle that Recovery is supported through relationships and social networks.

For Item 34 from the Social Connectedness Domain, “I have people with whom I can do enjoyable things,” the percent agreeing decreased over time and needs significant improvement. This item relates to the Recovery Model principle that Recovery is supported through relationships and social networks.

For Item 35 from the Social Connectedness Domain, “I feel I belong to the community,” the percent agreeing decreased over time and needs significant improvement. Communities are important in the Recovery Model. They have the responsibility to provide opportunity and resources to address discrimination and to foster social inclusion and Recovery.

For Item 36 from the Social Connectedness Domain, “In a crisis, I would have the support I need from a friend or family member,” the percent agreeing decreased over time and increased slightly in the last reporting period. It needs significant improvement. This item relates to the Recovery Principle that recovery is supported through relationships and social networks.

Table 6: Item Analysis from Selected Domains for Adults and Older Adults

| Item # | Question | May 2017 | | Nov 2017 | | May 2018 | | Nov 2018 | |
|---|---|---|---|---|---|---|---|---|---|
| | | % | # | % | # | % | # | % | # |
| **Adults** | | N=976 | | N=955 | | N=829 | | N=804 | |
| Outcomes of Services Domain | | | | | | | | | |
| 25 | I am better in social situations | 54 | 3.70 | 55 | 3.72 | 57 | 3.75 | 56 | 3.72 |
| 26 | I do better in school and/or work | 37 | 3.55 | 42 | 3.69 | 42 | 3.66 | 41 | 3.61 |
| 28 | My symptoms are not bothering me as much | 51 | 3.54 | 56 | 3.66 | 56 | 3.65 | 53 | 3.58 |
| | | | | | | | | | |
| **Older Adults** | | N=82 | | N=74 | | N=75 | | N=82 | |
| Access Domain | | | | | | | | | |
| 9 | I was able to see a psychiatrist when I wanted | 74 | 4.01 | 81 | 4.24 | 65 | 3.86 | 70 | 4.03 |
| Quality and Appropriateness Domain | | | | | | | | | |
| 15 | Staff told me what side-effects to watch for | 71 | 3.98 | 76 | 4.09 | 71 | 3.99 | 68 | 4.07 |
| Outcome of Services Domain | | | | | | | | | |
| 23 | I am better able to deal with a crisis | 70 | 3.94 | 72 | 4.10 | 53 | 3.64 | 63 | 3.85 |
| 24 | I am getting along better with my family | 62 | 3.97 | 62 | 4.06 | 53 | 3.64 | 61 | 3.81 |
| 25 | I am better in social situations | 62 | 3.78 | 70 | 4.08 | 55 | 3.59 | 60 | 3.52 |
| 28 | My symptoms are not bothering me as much | 62 | 3.79 | 68 | 3.87 | 53 | 3.59 | 51 | 3.55 |
| Functioning Domain | | | | | | | | | |
| 30 | I am better able to take care of my needs | 70 | 3.94 | 73 | 4.10 | 56 | 3.63 | 60 | 3.82 |
| 31 | I am better able to handle things when they go wrong | 62 | 3.83 | 68 | 3.99 | 53 | 3.61 | 61 | 3.85 |
| 32 | I am better able to do things that I want to do | 65 | 3.87 | 69 | 3.91 | 56 | 3.65 | 60 | 3.74 |
| Social Connectedness | | | | | | | | | |
| 33 | I am happy with the friendships I have | 70 | 3.96 | 69 | 4.03 | 56 | 3.66 | 55 | 3.69 |
| 34 | I have people with whom I can do enjoyable things | 65 | 3.89 | 58 | 3.85 | 55 | 3.62 | 48 | 3.56 |
| 35 | I feel I belong to the community | 67 | 3.87 | 61 | 3.92 | 53 | 3.70 | 46 | 3.61 |
| 36 | In a crisis, I would have the support I need from friend or family member | 62 | 3.85 | 64 | 3.98 | 52 | 3.62 | 66 | 3.92 |

Note %=Percent Agree #=Average Score

Overall Satisfaction Outcomes: Caregivers and Youth

On average, Caregivers and Youth are satisfied with all domains with highest satisfaction scores in Access, Cultural Sensitivity, and General Satisfaction as displayed in Table 7 below.

Table 7: Overall Satisfaction Outcomes for Caregivers and Youth

| | November 2018 | | | | May 2018 | | | |
|---|---|---|---|---|---|---|---|---|
| | Caregiver (N=1047) | | Youth (N=740) | | Caregiver (N=1144) | | Youth (N=705) | |
| **Domain** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** |
| Access | 91 | 4.49 | 82 | 4.26 | 90 | 4.50 | 79 | 4.19 |
| Cultural Sensitivity | 97 | 4.64 | 93 | 4.46 | 96 | 4.66 | 92 | 4.39 |
| Participation in Treatment Planning (PIT) | 92 | 4.39 | 85 | 4.16 | 92 | 4.44 | 83 | 4.12 |
| Outcomes of Services | 61 | 3.79 | 61 | 3.78 | 62 | 3.85 | 61 | 3.77 |
| Functioning | 65 | 3.83 | 68 | 3.83 | 65 | 3.87 | 67 | 3.81 |
| Social Connectedness | 87 | 4.29 | 78 | 4.10 | 85 | 4.32 | 80 | 4.11 |
| General Satisfaction | 89 | 4.41 | 87 | 4.25 | 89 | 4.44 | 83 | 4.19 |
| **Overall Average** | **92** | **4.27** | **89** | **4.13** | **92** | **4.30** | **86** | **4.09** |

Source: Mental Health Consumer Perception Survey—November 2018 Collection Period, Sacramento County Division of Behavioral Health Services

Item Analysis

Table 8 below shows the items for which Youth had low percent agreeing with satisfaction scores.

For Item 19 from the Outcome of Services Domain, “I am doing better in school and/ or work,” the percent agreeing is consistent over time and needs improvement. School is an important performance domain for youth. This item is related to one of the dimensions of Recovery that consumers should have meaningful daily activities, such as a job, school, or volunteerism.

For Item 21 from the Outcomes of Services Domain, “I am satisfied with our family life right now’” the percent agreeing is consistent over time and is in need of significant improvement. This item related to the Recovery Principle that Recovery is supported through relationships and social networks.

For Item 17 from the Functioning Domain, “I am getting along better with family members,” the percent agreeing is consistent over time and needs improvement. This

item related to the Recovery Principle that Recovery is supported through relationships and social networks.

For Item 18 from the Functioning Domain, “I get along better with friends and other people,” is consistent over time and needs improvement. This item relates to the Recovery Model principle that Recovery is supported through relationships and social networks.

For Item 20 from the Functioning Domain, “I am better able to cope when things go wrong,” the percent agreeing is consistent over time and needs improvement. This skill is needed to implement the Recovery Model principle that self-determination and self-direction empowers consumers and provides resources to gain or regain control over their lives.

For Item 22 from the Functioning Domain, “I am better able to do things I want to do,” the percent agreeing is consistent over time and needs improvement. This item supports the Recovery principle that self-determination and self-direction are the foundation for Recovery as individuals define their goals and design their unique paths toward those goals

Table 8: Item Analysis from Selected Domains for Youth

| Item # | Question | May 2017 | | Nov 2017 | | May 2018 | | Nov 2018 | |
|---|---|---|---|---|---|---|---|---|---|
| | | % | # | % | # | % | # | % | # |
| **Youth** | | N=601 | | N=558 | | N=705 | | N=740 | |
| Outcomes of Services | | | | | | | | | |
| 19 | I am doing better in school and/ or work | 63 | 3.74 | 64 | 3.74 | 60 | 3.77 | 60 | 3.76 |
| 21 | I am satisfied with our family life right now | 60 | 3.62 | 56 | 3.57 | 59 | 3.83 | 56 | 3.62 |
| | | | | | | | | | |
| Functioning | | | | | | | | | |
| 17 | I am getting along better with family members | 63 | 3.72 | 61 | 3.67 | 61 | 3.71 | 60 | 3.71 |
| 18 | I get along better with friends and other people | 71 | 3.91 | 69 | 3.88 | 66 | 3.86 | 69 | 3.89 |
| 20 | I am better able to cope when things go wrong | 68 | 3.83 | 64 | 3.73 | 66 | 3.80 | 68 | 3.85 |
| 22 | I am better able to do things I want to do | 67 | 3.80 | 65 | 3.72 | 68 | 3.84 | 68 | 3.84 |

Note %=Percent Agree #=Average Score

Quality of Life Outcomes: Adults and Older Adults

As stated in the November 2018 Mental Health Consumer Perception of Care Survey report, the Adult and Older Adult surveys include a Quality of Life section of questions. The questions are grouped into domains similar to the Satisfaction with Services portion and are scored on a seven-point Domain: 1=Terrible, 2=Unhappy, 3=Mostly Dissatisfied, 4=Mixed, 5=Mostly Satisfied, 6=Pleased, 7=Delighted. Higher scores reflect higher levels of satisfaction, and consumers are considered "Satisfied" in a domain if their average scores were greater than 4.50. Overall for the November 2018 reporting period, Adults and Older Adults are slightly less than satisfied with their Quality of Life. Both Adults and Older Adults are the least satisfied in the Health Domain. In addition, the percent of Adults and Older Adults that agree with the Average Score for both November 2018 is below 50% for most domains, so that result has room for improvement. The results are displayed in Table 9 below.

Table 9: Quality of Life Outcomes for Adults and Older Adults

| | **November 2018** | | | | **May 2018** | | | |
|---|---|---|---|---|---|---|---|---|
| | **Adult (N=773)*** | | **Older Adult (N=75)*** | | **Adult (N=774)*** | | **Older Adult (N=69)*** | |
| **Domain** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** | **% Agree** | **Avg. Score** |
| General Life | 40 | 4.31 | 48 | 4.47 | 46 | 4.53 | 48 | 4.49 |
| Living Situation | 53 | 4.59 | 60 | 4.83 | 53 | 4.64 | 52 | 4.71 |
| Daily Activities & Functioning | 43 | 4.49 | 38 | 4.38 | 45 | 4.60 | 44 | 4.44 |
| Family | 46 | 4.59 | 48 | 4.66 | 45 | 4.56 | 43 | 4.61 |
| Social Relations | 43 | 4.53 | 39 | 4.27 | 46 | 4.61 | 43 | 4.42 |
| Safety | 56 | 4.68 | 54 | 4.81 | 55 | 4.66 | 53 | 4.73 |
| Health | 37 | 4.11 | 34 | 4.07 | 41 | 4.22 | 43 | 4.15 |
| **Overall Average** | **46** | **4.47** | **41** | **4.47** | **47** | **4.55** | **47** | **4.48** |

**Not all clients answered the Quality of Life questions.*

Source: Mental Health Consumer Perception Survey—November 2018 Collection Period, Sacramento County Division of Behavioral Health Services

Summary

According to the November 2018 report, Adult and Older Adult consumers are satisfied with the following Domains:

- Access
- Quality and Appropriateness
- Participation in Treatment Planning

- Outcomes of Services
- Functioning
- Social Connectedness
- General Life Satisfaction

There are problems with the percent of Adults agreeing with the satisfaction scores for individual items. The scores need significant improvement for 3 of the 8 items in the Outcomes of Service Domain.

For Older Adults, the percent agreeing with the satisfaction scores needs to improve for 1 of the 6 items in the Access Domain. The scores need to improve for 1 of the 9 items in the Quality and Appropriateness Domain. The percent agreeing needs to improve significantly for 3 out of 8 items in the Outcomes of Services Domain. For the Functioning Domain, 3 out of 5 items need improvement. For the Social Connectedness Domain, all items need significant improvement.

Caregivers and Youth are satisfied with all domains. However, for some items there are problems with the percent of Youth agreeing with their satisfaction scores. The percent agreeing needs significant improvement for 2 of the 6 of the items in the Outcome of Services Domain. The percent agreeing needs significant improvement for 1 of the 5 items in the Functioning Domain and needs improvement in the other 3 items.

The reason that agreement with satisfaction scores is important is that these items represent aspects of the Recovery Model. According to SAMHSA's Working Definition of Recovery, Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Adults and Older Adult consumers are satisfied with Quality of Life Domain. In November 2018, the percent agreeing with their satisfaction scores is below 50% for most domains, so that result has room for improvement.

Recommendation: The DBHS needs to find a new strategy beyond adding items to its Quality Management Program Annual Work Plan to work on increasing the percent of consumers who agree with their satisfaction scores. It also needs make sure it addresses Items 2 and 3 for Caregivers and Youth and Item 6 for Older Adults.

Recommendation: The DBHS should establish benchmarks for the percent agreeing with satisfaction scores for the Adult Domain Outcomes of Services and for the Older Adults Domains Access, Quality and Appropriateness, Outcomes of Services, and Social Connectedness.

## Crisis Services

### Mental Health Treatment Center Intake Stabilization Unit

The Intake Stabilization Unit (ISU) is certified as a 23-hour crisis stabilization unit and designated as a 5150 facility. A 5150 facility is where a person can be placed on an involuntary psychiatric hold. The main goals for the ISU are to:

- Provide crisis stabilization for clients in psychiatric crisis
- Reduce wait time for clients in the Emergency Department (ED)
- Assist/consult with EDs on clinical matters on Sacramento County clients, offering info re: treatment, dispositions, etc
- Refer clients in crisis who are not linked to outpatient providers to services
- Assist callers in crisis, offering resources, services, and other emergent psychiatric needs

The ISU receives patient referrals from EDs, Sacramento County Main Jail, Mobile Crisis Support Teams, via the Law Enforcement Consult Line, the Mental Health Urgent Care Clinic, Public Guardian's office, sub-acute secure settings, via the Intensive Placement Team, or other County-operated or contracted clinics. Patients/clients are on various kinds of legal holds (California Welfare & Institutions Codes 5150, 5250, 5270, Temporary-Conservatorship, Conservatorship, or Murphy's). Clients may also come in on a voluntary status.

The ISU serves individuals of all ages. Per regulatory standards clients (minors and adults) may stay on ISU for a period of 23 hours and 59 minutes. Minors under 18 years of age receive crisis stabilization services and then are discharged or diverted to other services. Minors are not hospitalized at the Mental Health Treatment Center (MHTC) inpatient facility. Adults receive crisis stabilization services and may be either discharged from the ISU, diverted to another facility, or admitted to the MHTC inpatient facility.

Outcome Data for FY 2017/18

Consumers' Linked to Outpatient Provider after Crisis Visit
Adults (N=1,176) 33.2%
Children (N=214) 33.2%

Recidivism (return to ISU)
Adults (N=1542 consumers)
30-Day—9.9%
90-Day—8.9%

Children (N=329 consumers)
30-Day—6.6%
90-Day—4.1%

Proportion of Crisis Visits Discharged to the Community, Inpatient, and Crisis Residential Settings
Adults

Inpatient: 66.3%
Community: 31.5%
Crisis Residential: 2.2%

Children
Inpatient: 33.7%
Community: 66.3%

Summary
For Inpatient Services, 66.3% of adults were discharged to that setting. For children, 33.7% were discharged to that setting. Over 30% of adults and children served by the ISU were linked to outpatient services after their crisis, which is a positive outcome for continuity of care. We are unable to comment on recidivism rates due to lack of benchmarks. The number of Crisis Residential beds has increased from 12 in the mid-1990's to 42, and the capacity is planned to increase by another 30 beds. With that increased capacity, the proportion of crisis visits discharged to Crisis Residential settings should increase.

No Recommendation

MCST Success Story

The MCST Officer and Counselor responded to a call for services for an adult individual living at a room and board who sent a suicidal message to his mother.

When the MCST arrived on the scene, the individual was in the passenger seat of his mother's car breathing heavily, crying, and rocking back and forth. The MCST Counselor was able to engage the individual using active listening and validation while also providing crisis mental health intervention services. The individual was eventually able to engage in deep breathing and identify other coping skills to manage his anxiety in the moment. He was then able to regulate enough to effectively communicate to the MCST regarding his current stressors to begin participating in safety planning and follow-up service planning.

Through the planning process, he was able to identify support systems, triggers, coping skills, as well as his current service provider. The MCST Counselor contacted the service provider to coordinate care and develop a follow-up support plan that included the individual, his mother, and the provider. As a result, this individual was able to stay in the community with increased support from the family and the provider

**Mobile Crisis Support Teams**

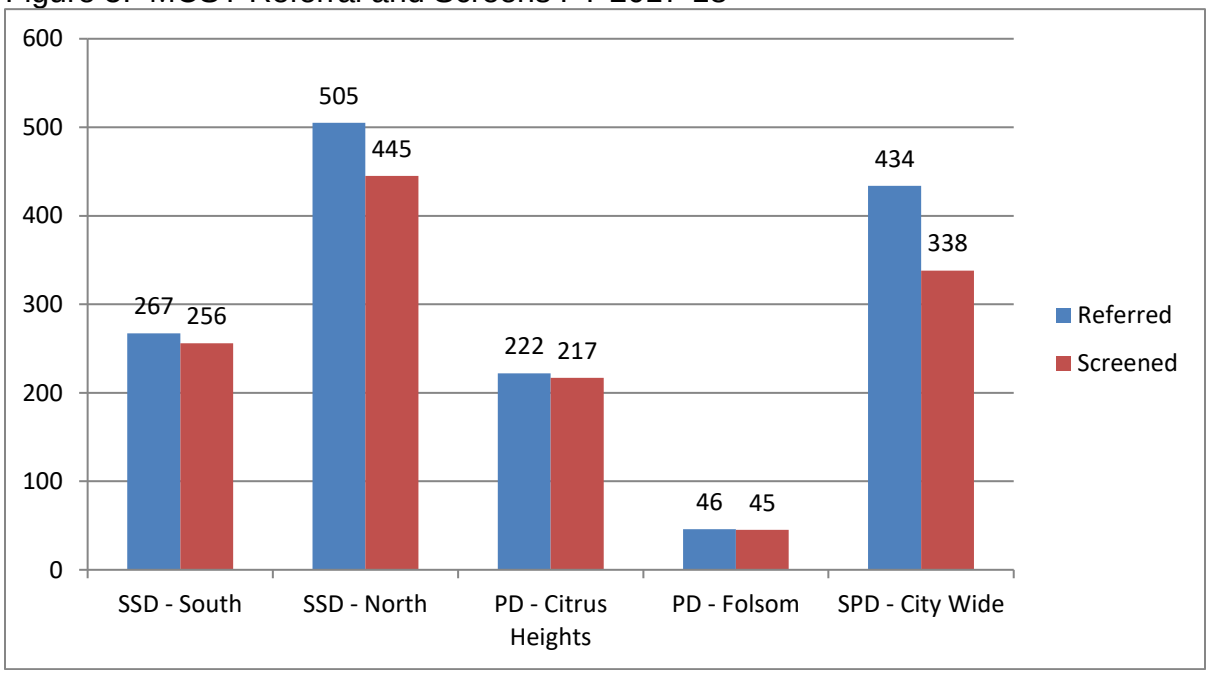
As stated in the Mobile Crisis Support Team report, the MCSTs are a collaboration between the DBHS and Law Enforcement to respond together to emergency calls for individuals experiencing a mental health crisis with the objective of mitigating the crises in the community. The program serves diverse individuals, regardless of demographic characteristics, housing, or insurance status. The teams consist of a Law Enforcement Officer, a Mental Health Counselor, and a Peer Specialist. Once a mental health crisis call is received that could benefit from a mental health intervention, a DBHS Senior Mental Health Counselor and an assigned Officer/Deputy are dispatched to respond to the crisis. The MCST ride-a-long, first response model allows utilization of skills and expertise from both law enforcement and behavioral health to increase diversion of individuals from unnecessary incarceration or hospitalization.

MCST interventions may include the following services: crisis intervention and de-escalation, risk assessments, mental health and substance use assessments, brief medical clearances, 5150 applications, mobilizing linked providers or natural supports,

referrals to mental health and/or alcohol and drug treatment, and referrals to follow-up care via a peer professional to support individuals in accessing care. Teams are assigned to six specific areas of Sacramento County: Sacramento County Sheriff Department (SSD) South; SSD North, Sacramento Police Department, Citrus Heights Police Department, Folsom Police Department; and Elk Grove Police Department.

In FY 17/18, the MCST received 1,474 referrals, which resulted in 1,301 clients screened (88.3%). Most of the teams screened over 95% of their referrals as displayed in Figure 5. Table 14 in Appendix B provides all the dispositions and referrals for 1,552 clients for the MCST teams in FY 17/18. For all the teams combined, 34.7% of the clients declined support. Appointments were scheduled with providers for 17.5%. 13.7% of the clients were referred to hospital emergency rooms (primary psychiatric). A variety of other dispositions in the 1 and 2 percent range can be viewed in Appendix B.

Figure 5: MCST Referral and Screens FY 2017-18




Source: Mobile Crisis Support Team Annual Report, FY 17/18; Sacramento County Division of Behavioral Health Services; Research Evaluation and Performance Outcomes

Table 15 in Appendix B provides the reasons for discharge from the MCST program for 1,286 clients in FY 17/18. 38.4% of clients declined or refused services. For clients already in the County mental health system, the MCST helped them engage with their provider in 27.4% of the cases. The whereabouts were unknown for 9.9% of the clients. Clients were linked for services to a county MHP provider for the first time in 7.1% of the cases. Clients did not meet the definition of medical necessity in 5.1% of the cases. Clients were helped toward wellness with resources other than mental health services in 4.1% of the cases. These resources included In Home Supportive Services, NAMI, community leisure and other support groups, food and clothing, and housing navigators. For discharge reasons below 4%, see Appendix B.

All MCST discharges in the fiscal year were analyzed to determine the effect of the program on inpatient hospitalizations for clients before their screening and after their discharge from the program. Only screened clients who were discharged in FY 17/18 were included. For clients linked to outpatient services, they were hospitalized at a rate of 23.4% within 90 days before screening (N=312). Within 90 days after discharge, they were hospitalized at a rate of 23.1%, a reduction of 1.4%. For clients who were not linked to outpatient services, they were hospitalized at a rate of 4.6% within 90 days before screening (N=911). Within 90 days after discharge they were hospitalized at a rate of 7.1%, an increase of 54.8%.

ED visits were estimated based on the number of client referrals to the MHTC-ISU from the EDs across Sacramento County. Data from the MHTC referral logs were used as a proxy to estimate ED visits by MCST clients. Only screened clients who were discharged in FY 17/18 were included in this analysis. Clients linked to outpatient services were hospitalized at a rate of 20.5% within 90 days before screening (N=312). Within 90 days after discharge, they were hospitalized at a rate of 19.6%, a reduction of 4.7%. Clients who were not linked to outpatient services were hospitalized at a rate of 6.7% within 90 days before screening N=911). Within 90 days after discharge, they were hospitalized at a rate of 8.5%, an increase of 26.2%.

MCSTs differed in their rate changes for Psychiatric Hospitalizations Before and After Program Contact and for emergency room visits before and after MCST program contact. For two teams, the rates increased for clients both linked and unlinked to outpatient services. Staff have indicated that measurement timelines for the MCST program may need adjustment to 30 days post discharge for rehospitalization rates. The measurement timelines for FY 17-18 for rehospitalization is 90 days post discharge before and after contact with the MCST. For the emergency room, it is within 90 days before and after contact with the MCST. This period of time may be too long, given the goal of the program to assist with ameliorating crisis in the moment with referral to follow-up services and supports to the peer counselors – therefore, allowing too many factors beyond the control of the MCST to intervene.

Other Benefits of the Program

Having mental health clinicians on the MCSTs has many benefits. Having a mental health counselor involved produces a more nuanced response than a police officer alone, which can provide a less stressful experience for the individual in crisis. MCST Counselors can offer alternatives to inpatient hospitalization, such as engaging natural supports and open outpatient providers for safety planning as well as crisis residential services. MCST Counselors can also provide clients with resource options, including referring to the Triage Navigator Program (TNP) for ongoing support with linkage and navigation to needed follow-up services.

MCST Counselors are also a resource to family members, describing next steps in the crisis response process and providing them with information about how to get support, what questions to ask, how to advocate for their family member, and how to get involved in their family member’s treatment, if appropriate.

MCSTs have also been useful in hostage situations where the expertise of both behavioral health and law enforcement personnel can benefit the situation. MCST Counselors can provide consultation to law enforcement regarding mental health as well as direct intervention in situations when counselors can be perceived as less threatening than law enforcement.

Summary

The MCSTs provide a high level of service, screening nearly 90% of referrals received. They provided linkages to mental health services, natural supports, and a variety of community services. In addition, they provide more services to clients and family members than the routine police response to a crisis call. Hospitalizations before and after contact with the MCST decreased only slightly. Referrals from EDs to the MHTC ISU before and after contact with the MCST decreased to a greater extent. However, a significant difference exists between the rates for clients linked to outpatient services and rates for unlinked clients. The rates for unlinked clients did increase significantly, which would indicate that the linkage to outpatient services provided by the MCST was effective in reducing hospitalization. In addition to quantitative measures of the program's success, such as rehospitalization rates, both clients and family members served by the MCSTs experience many qualitative benefits. For example, clients experience less stress when offered the opportunity to interact with a mental health clinician, and families are offered additional support.

Recommendation: DBHS staff should investigate the factors that contribute to the differences between teams that have rate reductions and those that have rate increases to improve the success of the program.

Recommendation: Research Evaluation and Performance Outcomes should evaluate the timelines postdischarge for rehospitalization measures associated with the MCST Program.

Triage Navigator Success Story

A 55 year old male experiencing mental health symptoms was referred to the Triage Navigator Program after being admitted to the emergency department and then ICU as a result of his third overdose of insulin within the past year. Prior to this hospital admission, he was experiencing homelessness, using a power chair, and did not have access to food or shelter. After being discharged from the hospital, the Navigator coordinated with the individual on a plan to address his ongoing health needs and was able to assist him in finding housing and linked him to a Primary Care Physician as well as a Mental Health Provider. The Navigator also supported him in securing bus passes, a cell phone and legal services all the while providing him with encouragement and emotional support throughout services. During his time with the Navigator Program, he was able to stabilize physically and emotionally by addressing his basic needs, allowing him to link and benefit from ongoing care in the community – and in time became a house leader at his Room and Board.

**Mental Health Triage Navigator Program**

As stated in the Mental Health Triage Navigator report, the objective of the TNP is to reduce unnecessary incarceration and inpatient psychiatric hospitalizations of

individuals experiencing a mental health crisis in Sacramento County. Navigators are located in six Sacramento County EDs, (University of California, Davis Medical Center, Sutter Medical Center, Mercy General, Mercy San Juan, Methodist, and Kaiser South), the Loaves and Fishes campus with a focus on the homeless population, and the Main Jail with a focus on "Quicks" (clients incarcerated for 6-12 hours). Triage Navigators work in tandem with Peer Navigators who are deployed upon client discharge to support aftercare when indicated. Navigators can continue support up to 60 days after the first face-to-face meetings with clients experiencing a mental health crisis.

In FY 17/18, a total of 2,492 persons were referred to the TNP. The TNP screened at least 65% of referrals at most hospitals, with a low of 18% at the Main Jail and a high of 93% at Loaves and Fishes. Table 16 in Appendix C reports the referrals and screening for each team.

Clients screened by the TNP are referred to a Peer Navigator to further help engage and refer them to appropriate services. Table 17 in Appendix C indicates the percentage of clients referred to the Peer Navigators and the time it takes the Peers to make their first contact. Approximately 59% of all clients screened had contact with a Peer Navigator. On average, peer support engages with clients 5.5 days after the initial screening and assessment with the TNP.

Clients had a variety of dispositions and referrals as a result of contact with the TNP. In FY 2017/18, Mental Health Respite Services was the disposition for 15.9% of the clients; 10.1% declined support; 6.2% were helped with Benefits Acquisitions; 6.2% were referred to Medical or Health Services; and 5.9% were referred to Drug and Alcohol Support Services. See Table 18 in Appendix C for additional Dispositions and Referrals.

There were 1,064 unduplicated clients discharged from the program in FY 17/18. Of the clients who were admitted to a new outpatient program (OP), approximately 96.4% received at least one service within 30 days of admission in the OP program. By 90 days of admission, this proportion increased to 97.5% for linked clients. Alternatively, 2.5% of clients who were admitted to an OP program had not yet received a service by 90 days after linkage.

Data were analyzed according to outpatient linkage status. Within 90 days of discharge from the TNP, inpatient hospitalizations for FY 2017/18 decreased before and after participation in the program for clients linked to outpatient services. Only screened clients who were discharged in FY 17/18 were included. For clients linked to outpatient services, clients were hospitalized at a rate of 18.9% 90 days prior to their TNP screening and at a rate of 29.8% at 90 days after discharge, a 36.7% reduction (N=265). Unlinked clients also had reduced hospitalizations from 14.5% 90 days before their screen to 7.8% 90 days after being discharged from the program, a 46.6% reduction (N=811).

ED visits were estimated based on the client referrals from the ED to the MHTC-ISU; as such, not all ED visits for FY 17/18 were included in the analysis. Only screened clients who were discharged in FY 17/18 were included in analysis. Data from the MHTC ISU referral logs was used to examine this outcome. The percentage of referrals from EDs

to the MHTC ISUs across Sacramento County were reduced to 18.5% within 90 days after discharge compared to 37.7% 90 days prior to their TNP screening, a 51.0% reduction (N=265). Unlinked clients also had reduced hospitalizations, from 21.6% 90 days before their screen to 10.0% 90 days after being discharged from the program, a 53.7% reduction (N=811).

Recidivism was defined as any readmission to the TNP within 30 and 60 days of discharge from the program. The overall recidivism rate for FY17/18 was 3.1% at 30 days and 5.6% at 60 days.

Other Benefits of the Program

The TNP provides a number of other benefits for clients. At EDs, it provides a safety net either by engaging clients with their existing outpatient providers or by linking clients to new outpatient providers for those without follow-up services in place. It also helps with the transition to the community for clients who are discharged. It helps navigate clients to their first outpatient appointment, including ensuring transportation. Because the Triage Navigator can provide navigation and support services for clients up to 60 days, they can provide other support services to address barriers until linked to outpatient services, such as assistance with picking up medication, helping apply for housing, and assisting clients re-instate or apply for benefits. They are also useful for clients who are discharging from Jail, including for those who may be eligible for collaborative courts, such as Mental Health Court—as they are able to meet with clients in the lobby when needed in order to ensure clients follow up with essential services, such as making it to their first outpatient appointment, accessing the food bank, or receiving benefits.

Summary

The TNP has shown success in multiple areas. In FY 17/18, it reduced inpatient hospitalizations for clients linked to outpatient programs by a third. Referrals from emergency rooms to the MHTC ISU were reduced by more than half. Nearly all clients referred to outpatient programs received services within 30 days. Over 50% of clients screened had contact with a Peer Navigators, and that contact occurred within 5.5 days after initial screening. Clients were referred to a variety of essential services, including Respite, Benefits Acquisition, Medical and Health Services, and Drug and Alcohol Support. There are many other benefits to clients who encountered the Navigators at the Jail and collaborative courts.

No Recommendation

**Inpatient Services**

Inpatient services in Sacramento are provided at:

- Sacramento County MHTC
- Crestwood Behavioral Health—Psychiatric Health Facilities, Carmichael/Sacramento (Crestwood PHF)
- Heritage Oaks Hospital

- Sierra Vista Hospital
- Sutter Center for Psychiatry

Only the MHTC and the Crestwood facilities serve adult clients exclusively while Heritage Oaks, Sierra Vista, and Sutter serve both children and adults.

In FY 2017/18, 2,999 unduplicated Adults were admitted to psychiatric hospitals for a total of 4,882 admissions. Some Adults had more than one admission. The mean length of stay was 12.6 days; the median length of stay was 8 days; and the range was 0-312 days. For children, 375 individuals had 487 admissions. The mean length of stay was 6.5 days; the median length of stay was 6 days; and range was 0-41 days

In Table 10 on the next page, the reported overall recidivism rate for Adults for FY 17/18 is 20.4%. The 30-day recidivism rate for persons with mood disorders is 15% and for person with schizophrenia, 22.4% (Heslin & Weiss, May 2015). Thus, the Adult Inpatient 30-day recidivism rate of 20.4% is consistent with that for persons with serious mental illnesses. The 30-day recidivism rate for children is 9.7%. We are unable to comment on that recidivism rate due to lack of a benchmark.

Notable differences exist in the 30-day recidivism rates by race and gender that exceed the 20.4% overall recidivism rate for Adults. Multi-race females had a recidivism rate of 25.4%. For males, the rates exceeded 20.4% for over half of the races:

- AI/AN—40.6%
- Black—26.3%
- Multi-Race—30.9%
- White—23.9%

Summary

If FY 17/18, 2,999 unduplicated Adults accounted for 4,882 psychiatric admissions. The overall 30-day recidivism rate for adults in FY 17/18 was 20.4%, which is consistent with the rate in the literature for persons with mood disorders and schizophrenia. The 30-day recidivism rate for children is 9.7%. We cannot comment on this rate, due to lack of a benchmark. Some of the 30-day recidivism rates for adults by gender and race exceed 20%. The factors that contribute to those elevated rated should be investigated.

Recommendation: The DBHS Cultural Competence Committee should study the race/ethnicity and gender recidivism rates that exceed 20% and make recommendations that would reduce them.

Table 10: Adult Mean Length of Stay and Recidivism Rates by Race and Gender

| Race | Mean LOS of Readmits (Days) | Female | | | | Male | | | | Overall | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A | B | (B/F) | (B/A) | C | D | (D/F) | (D/C) | E | F | (F/E) |
| | | Total Admits | # Within 30 Days | % of Readmits Within Racial Groups | Recidivism Rate | Total Admits | # Within 30 Days | % of Readmits Within Racial Groups | Recidivism Rate | Total Admits | # Within 30 Days | Recidivism Rate |
| AI/AN[1] | 12.1 | 28 | 3 | 18.8% | 10.7% | 32 | 13 | 81.3% | 40.6% | 60 | 16 | 26.7% |
| A/PI[2] | 17.8 | 148 | 31 | 50.0% | 20.9% | 160 | 31 | 50.0% | 19.4% | 308 | 62 | 20.1% |
| Black | 15.2 | 485 | 102 | 34.2% | 21.0% | 745 | 196 | 65.8% | 26.3% | 1230 | 298 | 24.2% |
| Multi-Race | 11.4 | 71 | 18 | 46.2% | 25.4% | 68 | 21 | 53.8% | 30.9% | 139 | 39 | 28.1% |
| Other | 12.1 | 197 | 38 | 37.3% | 19.3% | 295 | 64 | 62.7% | 21.7% | 492 | 102 | 20.7% |
| White | 14.4 | 853 | 151 | 37.8% | 17.7% | 1036 | 248 | 62.2% | 23.9% | 1889 | 399 | 21.1% |
| Unknown | 9.8 | 339 | 35 | 44.3% | 10.3% | 425 | 44 | 55.7% | 10.4% | 764 | 79 | 10.3% |
| Overall | 14.1 | 2121 | 378 | 38.0% | 17.8% | 2761 | 617 | 62.0% | 22.3% | 4882 | 995 | 20.4% |

Source: Division of Behavioral Health Services Crisis Visits, Inpatient Hospital Admissions, and Recidivism, FY 2017-2018

1. AI/AN=American Indian/Alaska Native
2. A/PI=Asian/Pacific Islander

## Mental Health Services Act

In 2004, California voters approved Prop 63, and the MHSA was enacted in 2005 by placing a one percent tax on incomes above $1 million. It provided the first opportunity in many years to expand county mental health programs for all populations: children, transition-age youth, adults, older adults, families, and most especially, the un- and under-served. It was also designed to provide a wide range of prevention, early intervention, and treatment services, including the necessary infrastructure, technology, and enhancement of the mental health workforce to support it. Prop 63 began as approximately 10% of the entire public mental health budget; it now comprises approximately 24%. Between FY 2004/05 and FY 2014/15, the MHSA generated $14.7 billion.

### Full Service Partnerships

Partners Served

During FY 16/17, 1,889 unduplicated partners were served in Full Service Partnerships (FSP). For the 321 partners that were discharged during the FY, the average length of stay was 2.9 years. In the Child age group, the average length of stay was 2.2 years, while in the Transition Age Youth (TAY) age group, the average length of stay was 1.8 years. As for the Adult age group, the average length of stay was 3.3 years, and Older Adults had the longest length of stay at 4.1 years.

Demographics

*Age*
Of total partners served, the majority were Adults, making up more than half (61.6%, 1164) of the total served, followed by Older Adults at 15.6% (295). The Child age group made up 8.4% (159) and the TAY age group represented 14.3% (271).

*Gender*
Overall, more men were served (52.8%, 997) than women (47.2%, 891). Under one percent of partners had no gender listed (0.05%, 1).

*Race/Ethnicity*
Sacramento County's FSPs served partners from many different racial backgrounds. Nearly one-third (37.5%, 709) of partners reported their race as White/Caucasian. Just over 26% (26.5%, 500) reported their race as Black/African American. Other prevalent race categories included Hmong (4.9%, 92) and Vietnamese (4.0%, 76).

Race and ethnicity are distinguished separately in that ethnic categories are broad groups for which people identify with Hispanic or Non-Hispanic. Approximately 13% (12.9%, 244) of partners reported they were "Hispanic."

*Preferred Language*
Partners served in the 7 FSPs speak a variety of languages, and the county provides services in their preferred language. The top language utilized by partners is English at 84.4% (1,596). The second most utilized language is Hmong at 4.2% (79) followed by Vietnamese at 3.0% (56).

*Primary Diagnosis*
The top primary diagnosis for partners was schizoaffective disorder, affecting 25.5%, (482) of consumers, followed by Major Depressive disorders at 19.3% (365).

*Co-Occurring Substance Use*
Approximately 30% (29.8%, 563) of partners reported having a co-occurring substance use disorder at the time this report was prepared. Of the partners with a co-occurring disorder, 48.3% (272) reported receiving substance abuse services.

Outcomes over Time: FY 2016/17 Compared to Baseline

*Homelessness*
In the FY, 107 (5.7%) partners experienced being homeless. These partners had a combined 163 homelessness occurrences. The 107 partners accrued 5,714 homeless days with an average of 35 homeless days per occurrence. The percent change in homeless days between baseline and after one year of services in an FSP showed a 90.8% decline.

*ED Visits for Psychiatric and Physical Reasons*
In the FY, 23.9% (451) unduplicated partners had a total of 1,108 visits to the ED. Over half (54.2%, 633) of the ED visits were for psychiatric reasons. A total of 475 (42.8%) were for physical health reasons. The percent change in mental health ED visits

between baseline and after one year of services in an FSP showed a 67.9% decline. The percent change in medical ED visits between baseline and after one year of services in an FSP showed a 74.8% decline.

*Psychiatric Hospitalizations*
For the FY, 288 (15.4%) unduplicated partners accounted for 597 psychiatric hospitalizations. The percent change in psychiatric hospitalizations between baseline and after one year of services in an FSP showed a 59.6% decline.

*Arrests*
In the FY, 6.4% (121) partners were arrested for a total of 237 arrests. Most arrests occurring in the "26-59 age group" with 61.6% (146) of all arrests, followed by the "16-25 age group" at 17.3% (41). The percent change in arrests for all groups who completed one year of services in an FSP showed a 60.1% decline.

*Incarcerations*
There were 161 (8.5%) unduplicated partners incarcerated for a total of 270 incarcerations. The age group with the largest number of incarcerations during the FY was the "26-59" age group with 138 (51.1%) incarcerations. A total of 6,211 days were spent in a justice placement. The percent change in days incarcerated for partners who completed one year of services showed a 53% decline.

*Suspensions and Expulsions*
The FSP's served a total of 146 (7.7%) school aged children during the FY. Of those, 11 partners had a total of 16 suspensions. One partner was expelled. The majority (91.8%) were able to maintain good status in schools.

*Employment*
While receiving services in an FSP, 359 (19%) partners indicated employment as a goal. Of those, the FSPs assisted 9 (2.5%) partners to secure employment and 47 (13%) partners to maintain their employment, for a total of 56 (15.6%) partners employed at the end of the FY.

Summary

The MHSA FSPs had excellent results for all its outcome measures except Employment. It is positive that the FSPs were able to maintain the employment for the partners who began the program employed, but securing new employment for just 2.5% of partners needs significant improvement. One of the major dimensions of SAMHSA's Working Definition of Recovery is that clients must have purpose in their lives—meaningful daily activities, such as a job, school, volunteerism, family caretaking or creative endeavors and the income and resources to participate in society.

Recommendation: The DBHS must work with FSP providers to increase their emphasis on providing vocational services to partners.

## Capacity of Services

From FY 2008/09 up to the Current Year, the DBHS has had a fluctuating funding history as displayed in Table 11 below. In FY 2009/10, it incurred a 10.5% budget reduction. It was not until FY 2014-15 when there was a 14.3% increase that the budget increases made up for that reduction. Since that time, the budget has increased, except in FY 2017-18 when it decreased 1.4%. Also, the budget increases have not kept up with inflation in 4 out of the 11 years.

Table 11: Percent Change in Mental Health Budgets from Prior Year Compared to the Rate of US Inflation

| Fiscal Year | Total Mental Health Budget | Percent Change from Prior Year | US Inflation Rate |
|---|---|---|---|
| 2008-09 | $204,153,788 | Base | 2.7% |
| 2009-10 | $182,631,189 | -10.5% | 1.5% |
| 2010-11 | $188,419,517 | 3.2% | 3% |
| 2011-12 | $190,734,669 | 1.2% | 1.7% |
| 2012-13 | $192,344,489 | 0.8% | 1.5% |
| 2013-14 | $194,115,598 | 0.9% | 0.8% |
| 2014-15 | $221,894,585 | 14.3% | 0.7% |
| 2015-16 | $249,583,248 | 12.5% | 2.1% |
| 2016-17 | $267,912,434 | 7.3% | 2.1% |
| 2017-18 | $264,043,571 | -1.4% | 2.1% |
| Current Year | $308,810,135 | 17.% | 1.6% |

Source: Total Mental Health Budget—Division of Behavioral Health Services
Inflation Rate: Retrieved on July 18, 2019 from https://www.usinflationcalculator.com/inflation/current-inflation-rates/

Despite the budget increases in recent years, the DBHS budget is still under capacity to provide the necessary service level for clients. The timeliness data in the Outpatient Services section of the report demonstrates that problem. With more capacity to provide services, more providers of mental health services would be available for appointments.

Contractors have received some COLAs. In FY 2016/17, Adult and Children outpatient providers received a 2% COLA to address Audit Readiness and Fiscal Management Capacity Building. In FY 2018/19, Medi-Cal and non-Medi-Cal providers received a 2% COLA.

However, contract providers report carrying caseloads as much as twice the number in their original contracts, and they do this while dealing with a chronic high turnover rate in qualified employees (Behavior Health Concepts, Inc. FY 18/19). According to the EQRO, the DBHS is in a crisis of inadequate resources to meet beneficiary needs (Behavior Health Concepts, Inc. FY 18/19). Contracted providers told the EQRO during their FY 18/19 Annual Review that the gap between Mental Health Plan capacity and demand for services has reached a point where it is directly affecting the quality of care. According to the EQRO, this is, at its root, a financial issue. Contractors' costs continue

to rise for rent and other necessities of doing business, and the salaries they can offer employees have become progressively less competitive over the years. (Behavior Health Concepts, Inc. FY 18/19).

Another way to measure the problem with capacity to provide services is to look at our Average Cost per Beneficiary (ACB) compared to Large Counties and Statewide rates as displayed in Table 19 in Appendix D. The DBHS's Total ACB for CY 2017 was $4,805 compared with the ACB for Large Counties of $6,723, a difference of $1,918. Sacramento is categorized as a Large County by the EQRO. The ACB Statewide Rate was $6,170, producing a difference of $1,365. No matter how the ACB is analyzed--by age group, gender, race/ethnicity, eligibility category, or service category—the DBHS ACB is lower than that of the Large Counties or Statewide Rates.

Summary

From FY 2008/09 to the Current Year, the DBHS has had a fluctuating funding history. In FY 2009-10, it had a significant funding reduction that took years to recover from. In addition, funding increases in 4 out of the 11 years were exceeded by the rate of inflation. In recent years, there have been budget increases. But, these increases have insufficient to address the county's inadequate capacity of services. The DBHS's ACB is consistently lower than that for Large Counties and Statewide rates. The EQRO has concluded in its analysis that resources are inadequate to meet beneficiary needs and detrimental to the quality of care. According to the EQRO report, contract providers do not have sufficient resources to keep up with the cost of doing business and that their salaries have become progressively less competitive, leading to high staff turnover.

Recommendation: The Sacramento County Board of Supervisors should continue to increase the DBHS's budget to increase its capacity to provide services until its ACB approaches that of Large Counties or the Statewide average.

Recommendation: Contract providers should be given a sufficient cost of living increase to account for the increased cost of doing business and the need for adequate salaries to retain qualified staff.

## Penetration Rates

Penetration rates are provided in Table 12 below. There are some differences in the penetration rates to note. The penetration rates for children 0-5 decreased 20% between CY 2016 and CY 2017 going from 5.7% to 4.3%. On a positive note, the penetration rate for 18-59 year olds increased 10% during that time period, going from 4.7% to 5.2%. In CY 2017, the penetration rate for males exceeded that for females with the rate for males of 5.3% and that for females of 2.6%. However, mental health problems affect women and men equally (Recovery Across Mental Health) so that factor cannot account for the difference.

Differences exist in the penetration rates for two racial groups, but these differences are a result of anomalies in the data. The Asian/Pacific Islander penetration rate increased

by 48.9%, but this increase is a result of an artificial decrease in the number of Medi-Cal Eligible Beneficiaries of over 33,000 beneficiaries. The Hispanic penetration rate decreased by 12.9%, but this decrease is a result of an artificial increase in the number of Medi-Cal Eligible Beneficiaries of nearly 20,000 beneficiaries.

Summary

The penetration rates among age groups for CY 2016 and CY 2017 pose no cause for concern except for the decrease in the rate between CY 2016 and CY 2017 for 0-5 year olds. By gender, the penetration rate for males exceeds that for females in CY 2017. Changes in the penetration rates for Asian/Pacific Islanders and Hispanics between CY 2016 and CY 2017 result from anomalies in the data for Medi-Cal Eligible Beneficiaries.

Recommendation: The DBHS should investigate the causes of the decrease in penetration rates for 0-5 year olds and the difference in the penetration rates for females and males.

Table 12: Penetration Rates CY 2016, CY 2017

| Penetration Rates | | Calendar Year 2016 | | | | | Calendar Year 2017 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A | | B | | B/A | A | | B | | B/A | |
| | | Medi-Cal Eligible Beneficiaries | | Medi-Cal Clients (Undup) | | Medi-Cal Penetration Rates | Medi-Cal Eligible Beneficiaries | | Medi-Cal Clients (Undup) | | Medi-Cal Penetration Rates | Percent Change between CY 2016 and CY 2017 |
| | | N | % | N | % | % | N | % | N | % | % | % |
| Age Group | 0 to 5 | 72,266 | 12.8% | 1,555 | 5.7% | 2.2% | 69,886 | 12.5% | 1,203 | 4.3% | 1.7% | -20.0% |
| | 6 to 17 | 134,120 | 23.7% | 9,967 | 36.5% | 7.4% | 133,236 | 23.8% | 9,737 | 34.7% | 7.3% | -1.7% |
| | 18 to 59 | 293,755 | 52.0% | 13,894 | 50.9% | 4.7% | 288,999 | 51.7% | 15,070 | 53.7% | 5.2% | 10.2% |
| | 60+ | 65,086 | 11.5% | 1,894 | 6.9% | 2.9% | 67,305 | 12.0% | 2,075 | 7.4% | 3.1% | 5.9% |
| | Total | 565,227 | 100.0% | 27,310 | 100.0% | 4.8% | 559,426 | 100.0% | 28,085 | 100.0% | 5.0% | 3.9% |
| | | N | % | N | % | % | N | % | N | % | % | |
| Gender | Female | 298,366 | 52.8% | 14,261 | 52.2% | 4.8% | 296,052 | 52.9% | 14,523 | 51.7% | 4.9% | 2.6% |
| | Male | 266,860 | 47.2% | 13,039 | 47.7% | 4.9% | 263,373 | 47.1% | 13,553 | 48.3% | 5.1% | 5.3% |
| | Unknown | ---- | ---- | 10 | 0.0% | N/A | ---- | | 9 | 0.0% | N/A | N/A |
| | Total | 565,226 | 100.0% | 27,310 | 100.0% | 4.8% | 559,425 | 100.0% | 28,085 | 100.0% | 5.0% | 3.9% |
| | | N | % | N | % | % | N | % | N | % | % | |
| Race | White | 149,383 | 26.4% | 8,766 | 32.1% | 5.9% | 140,900 | 25.2% | 8,927 | 31.8% | 6.3% | 8.0% |
| | African American | 89,118 | 15.8% | 6,037 | 22.1% | 6.8% | 85,432 | 15.3% | 6,174 | 22.0% | 7.2% | 6.7% |
| | American Indian/Alaskan Native | 4,290 | 0.8% | 264 | 1.0% | 6.2% | 3,927 | 0.7% | 286 | 1.0% | 7.3% | 18.3% |
| | Asian/Pacific Islander | 112,185 | 19.8% | 1,706 | 6.2% | 1.5% | 78,944 | 14.1% | 1,788 | 6.4% | 2.3% | 48.9% |
| | Other | 101,461 | 18.0% | 4,837 | 17.7% | 4.8% | 121,538 | 21.7% | 5,036 | 17.9% | 4.1% | -13.1% |
| | Hispanic | 108,792 | 19.2% | 5,700 | 20.9% | 5.2% | 128,686 | 23.0% | 5,874 | 20.9% | 4.6% | -12.9% |
| | Total | 565,229 | 100.0% | 27,310 | 100.0% | 4.8% | 559,427 | 100.0% | 28,085 | 100.0% | 5.0% | 3.9% |

## Retention Rates

The retention rates for FY 2017/18 are displayed in Table 20 in Appendix E. They show no significant differences by race, sex, or age. The retention rates by language do not show any significant differences except that the retention rate is lower for the Arabic language. This difference is probably accounted for by the fact that it is the most recent threshold language to be added. The rate will probably increase as the language capability in the service system increases over time.

Summary

Retention rates show no significant differences by race, sex, or age. There are no differences by language except that the retention rate for the Arabic language is lower.

No Recommendation

## Human Resources

As stated in the 2018 Human Resources Survey report, the Cultural Competence Plan Requirements, (CCPR) Modification (2010), issued by the Department of Mental Health (DMH) in DMH Information Notice No. 10-17 states that counties are required to collect demographic information and language capabilities of staff, volunteers, and any committee members who participate in serving individuals throughout the entire County Mental Health System. The purpose of the surveys is to assess demographic and linguistic information for those who provide services in the county to determine whether it is reflective of the diversity of the community as a whole. The information collected focuses on staff ethnicity, language proficiencies, consumer/family member status, gender, sexual orientation, disability, and veteran status (Sacramento County Mental Health. December 2018).

- A total of 1,454 staff responded to at least one question on the survey

- Of all unduplicated staff surveyed, 496 (34.1%) indicated speaking a language other than English. For those who spoke one language other than English, the majority spoke Spanish (43.1%) followed by Hmong at 7.3%. 19.0% of staff indicated speaking more than one language other than English.

- 19.1% of staff self-identify as being of Hispanic ethnicity.

- 44.8% of staff self-identified as Caucasian, 14.2.% as African American, 8.2% as Multi-ethnic, 3.6% as Filipino, 2.1% as Other Asian, and 2.1% as Hmong, 1.7 % as Asian Indian, 1.4 % as Chinese, and 7.8% as “Other”.

- 71.7% of the staff identify as being female and 24.3% as male.

- 35.3% self-identify as a family member of a consumer, 19.5% of staff self-identify as a consumer of Mental Health Services, while 9.2% of staff self-reported that they live with a disability and 2.3% currently serve or have served in the US Military.

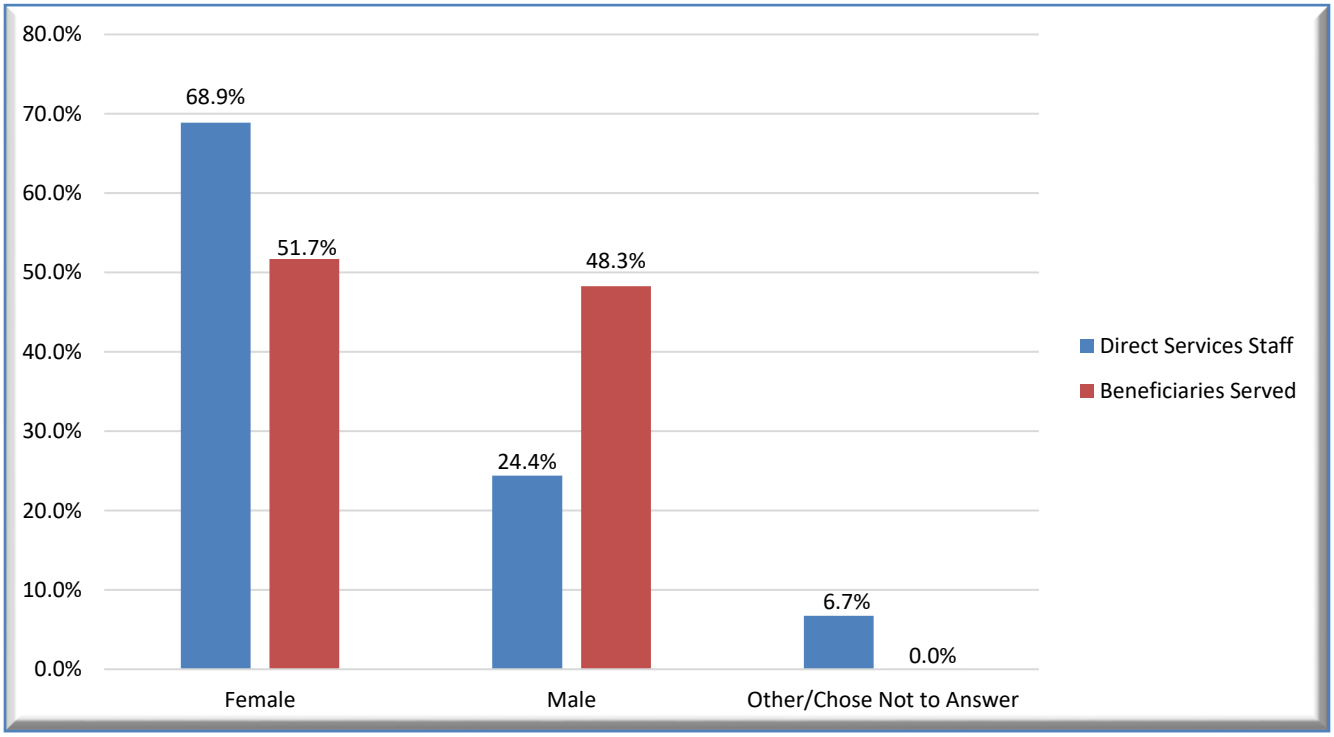
- 21.4% of direct service staff self-identify as a consumer of Mental Health Services, while 35.5% self-identify as having a family member who is a consumer of Mental Health Services

- 78.8% of the staff self-identified as being heterosexual/straight, 2.7% as lesbian, 2.8% as bisexual, 1.7 % as gay, 1.1% pansexual, and 0.7% as queer, 0.4% other, 0.2% as questioning, 0.1 as asexual, and 11.5% choose not to answer the question.

**Gender**

As indicated in Figure 6 below, males are underrepresented in direct service staff compared to the number of females served in the system

Figure 6: Direct Services Staff Compared to Medi-Cal MHP Beneficiaries by Gender

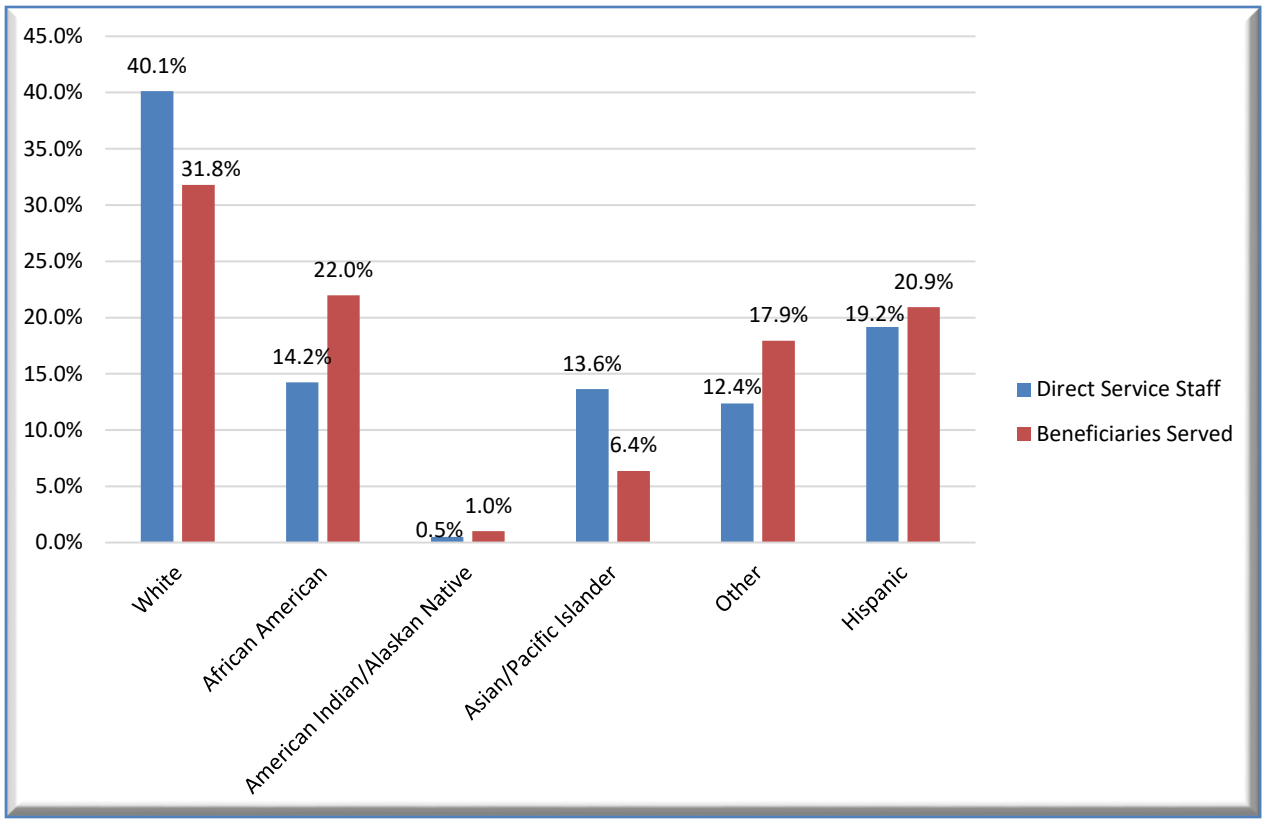



Source: Sacramento County Mental Health 2018 Human Resources Survey, December 2018

**Race**

African Americans are underrepresented compared to the number of African American clients served, while Caucasian and Asian/Pacific Islander direct service staff are overrepresented. Hispanic and American Indian/Alaska Native direct service staff represent the population served as displayed in the Figure 7 below.

Figure 7: Direct Services Staff Compared to Medi-Cal Beneficiaries by Race




Source: Sacramento County Mental Health 2018 Human Resources Survey, December 2018

### Language

While the MHP has a wide variety of languages spoken by staff, the percent who speak the Sacramento County threshold languages is lower that the beneficiaries served as displayed in Figure 8 below.

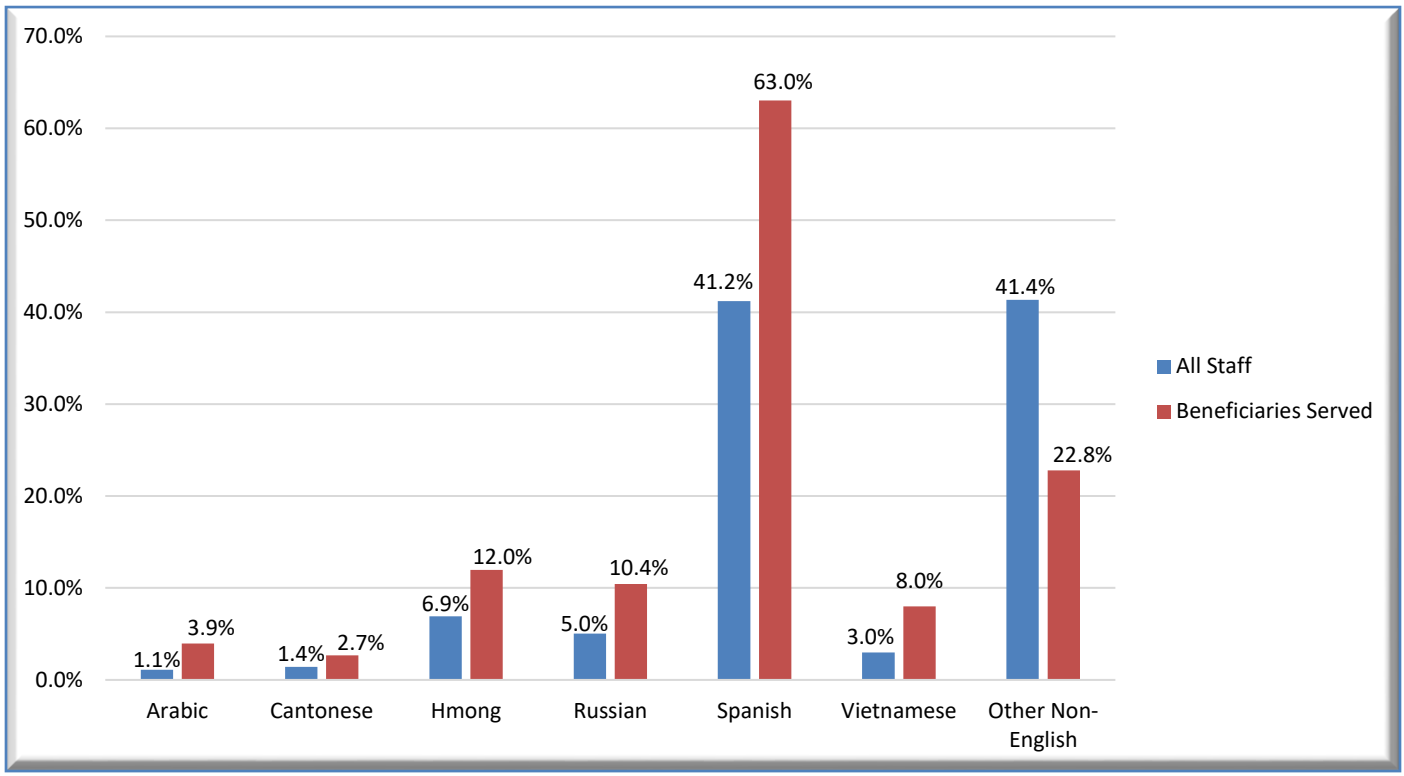



Figure 8: Languages Spoken by Staff Compared to Medi-Cal MHP Beneficiaries Primary Language

Summary

The DBHS has a diverse staff in terms of race/ethnicity, language capability, and consumer/family member representation among direct service staff. However, imbalances still exist when current staffing levels are compared to the Medi-Cal beneficiary population in the gender, race/ethnicity, and threshold languages of the consumers.

Recommendation

The DBHS should strive in its recruitment efforts to ameliorate the imbalances that exist in its representation of staff by gender, race/ethnicity, and threshold languages.

# Appendix A

Table 13: Benchmark Report on Timeliness, CY 2017

| BM1 - From Request for Services to First OP Appointment (Target = 14 days) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st Quarter CY 17 | | | 2nd Quarter CY 17 | | | 3rd Quarter CY 17 | | | 4th Quarter CY 17 | | |
| | Children N=1,404 | Foster Youth N=90 | Adults N=600 | Children N=1,176 | Foster Youth N=74 | Adults N=504 | Children N=1,240 | Foster Youth N=67 | Adults N=641 | Children N=1,340 | Foster Youth N=35 | Adults N=594 |
| **Benchmark 1A Summary** | | | | | | | | | | | | |
| **Average # of Days from Request for Services to Authorization** | 11.4 | 10.1 | 9.3 | 12.5 | 11.6 | 9.5 | 3.4 | 2.9 | 2.7 | 4.1 | 4.0 | 3.2 |
| **Benchmark 1B Summary** | | | | | | | | | | | | |
| **Average # of Days from Authorization of Services to First Face to Face Appointment** | 18.3 | 21.0 | 24.0 | 19.9 | 22.9 | 27.1 | 18.5 | 15.7 | 26.5 | 20.2 | 23.1 | 25.6 |
| **Benchmark 1 Overall Summary** | | | | | | | | | | | | |
| **Average # of Days from Request for Services to First Outpatient Appointment** | 29.7 | 31.1 | 33.3 | 32.5 | 33.7 | 36.6 | 21.9 | 18.6 | 29.1 | 24.2 | 27.1 | 28.7 |
| **Percent Meeting Target** | 19.7% | 25.6% | 20.3% | 15.9% | 31.1% | 18.9% | 38.1% | 44.8% | 24.2% | 31.3% | 19.5% | 30.8% |
| **BM2 - Admitted to OP Provider and Discharged Without Having an Outpatient Service** | | | | | | | | | | | | |
| | **1st Quarter CY 17** | | | **2nd Quarter CY 17** | | | **3rd Quarter CY 17** | | | **4th Quarter CY 17** | | |
| **Benchmark 2 Summary** | Children N=1,583 | Foster Youth N=92 | Adults N=890 | Children N=1,709 | Foster Youth N=81 | Adults N=1,028 | Children N=1,692 | Foster Youth N=96 | Adults N=1,112 | Children N=1,862 | Foster Youth N=58 | Adults N=991 |
| **Number of Admissions that were Discharged without having a service** | 409 | 25 | 308 | 514 | 15 | 426 | 412 | 26 | 399 | 475 | 20 | 385 |
| **Percentage of Admissions that were Discharged without having a service** | 21.6% | 27.2% | 30.0% | 30.1% | 18.5% | 41.4% | 24.3% | 27.1 | 35.9% | 25.5% | 34.5% | 38.9% |
| **BM3 - Urgent Service Request, opened to OP Provider by Access to First OP Appointment (Target = 7 days)** | | | | | | | | | | | | |
| | **1st Quarter CY 17** | | | **2nd Quarter CY 17** | | | **3rd Quarter CY 17** | | | **4th Quarter CY 17** | | |
| **Benchmark 3 Summary** | Children N=262 | Foster Youth N=20 | Adults N=266 | Children N=218 | Foster Youth N=7 | Adults N=249 | Children N=252 | Foster Youth N=6 | Adults N=258 | Children N=352 | Foster Youth N=14 | Adults N=247 |
| **Benchmark 3A Summary** | | | | | | | | | | | | |
| **Average # of Days from Request for Services to Authorization** | 5.7 | 4.5 | 3.7 | 5.9 | 7.0 | 3.6 | 2.5 | 2.6 | 1.7 | 3.8 | 4.9 | 2.4 |
| **Benchmark 3B Summary** | | | | | | | | | | | | |
| **Average # of Days from Authorization of Services to First Outpatient Appointment** | 15.0 | 21.5 | 22.3 | 15.4 | 11.0 | 25.2 | 14.3 | 11.8 | 26.4 | 19.6 | 16.8 | 32.7 |
| **Benchmark 3 Overall Summary** | | | | | | | | | | | | |
| **Average # of Days from Request for Services to First Outpatient Appointment** | 20.7 | 25.9 | 26.1 | 21.3 | 18.0 | 28.7 | 16.8 | 14.5 | 28.1 | 23.3 | 21.6 | 35.1 |
| **Percent Meeting Target** | 12.2% | 10.0% | 4.9% | 13.8% | 0% | 4.0% | 19.0% | 0% | 5.4% | 16.8% | 28.6% | 8.1% |

| BM4 - OP Assessment to First OP Psychiatric Service (Target = 30 days) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st Quarter CY 17 | | | 2nd Quarter CY 17 | | | 3rd Quarter CY 17 | | | 4th Quarter CY 17 | | |
| Benchmark 4 Summary | Children N=139 | Foster Youth N=4 | Adults N=364 | Children* N=164 | Foster Youth N=6 | Adults N=310 | Children* N=194 | Foster Youth N=10 | Adults N=445 | Children* N=168 | Foster Youth N=4 | Adults N=371 |
| Average # of Days to Service | 52.6 | 73.8 | 41.2 | 47.3 | 27.3 | 38.1 | 44.9 | 49.5 | 38.1 | 97.9 | 71.3 | 60.6 |
| Percent Meeting Target | 30.2% | 0.0% | 42.3% | 33.5% | 66.7% | 41.6% | 40.2% | 20.0% | 43.6% | 6.5% | 0.0% | 27.8% |
| Note: Children's numbers are typically higher because children are rarely assessed for medication services at the first outpatient assessment | | | | | | | | | | | | |
| **BM5 - Acute Hospital Discharge to First OP Service (Target = 7 days)** | | | | | | | | | | | | |
| | 1st Quarter CY 17 | | | 2nd Quarter CY 17 | | | 3rd Quarter CY 17 | | | 4th Quarter CY 17 | | |
| Benchmark 5 Summary | Children N=133 | Foster Youth N=1 | Adults N=462 | Children N=146 | Foster Youth N=2 | Adults N=600 | Children N=143 | Foster Youth N=0 | Adults N=647 | Children N=153 | Foster Youth N=1 | Adults N=486 |
| Average # of Days to Service | 11.0 | 27.0 | 20.2 | 12.4 | 0 | 23.5 | 13.6 | n/a | 18.7 | 20.3 | 52 | 34.6 |
| Percent Meeting Target | 60.5% | 0.0% | 43.2% | 65.1% | 100.0% | 43.2% | 62.2% | n/a | 47.8% | 52.9% | 0.0% | 35.2% |
| **BM6 - Acute Hospital Discharge to First OP Psychiatric Service (Target = 30 days)** | | | | | | | | | | | | |
| | 1st Quarter CY 17 | | | 2nd Quarter CY 17 | | | 3rd Quarter CY 17 | | | 4th Quarter CY 17 | | |
| Benchmark 6 Summary | Children N=102 | Foster Youth N=1 | Adults N=371 | Children N=96 | Foster Youth N=0 | Adults N=398 | Children N=97 | Foster Youth N=1 | Adults N=459 | Children N=129 | Foster Youth N=2 | Adults N=370 |
| Average # of Days to Service | 21.7 | 26.0 | 29.5 | 22.8 | n/a | 32.6 | 24.9 | n/a | 25.7 | 28 | 80.0 | 44 |
| Percent Meeting Target | 76.4% | 100.0% | 66.3% | 76.0% | n/a | 62.6% | 74.2% | n/a | 70.2% | 67.4% | 50.0% | 58.1% |
| **BM7 - Opened to Psychiatric Testing Provider by Access to First Psychiatric Testing Service (Target = 14 days)** | | | | | | | | | | | | |
| | 1st Quarter CY 17 | | | 2nd Quarter CY 17 | | | 3rd Quarter CY 17 | | | 4th Quarter CY 17 | | |
| Benchmark 7 Summary | Children N=19 | Foster Youth N=1 | | Children N=13 | Foster Youth N=0 | | Children N=16 | Foster Youth N=0 | | Children N=17 | Foster Youth N=0 | |
| Benchmark 7A Summary | | | | | | | | | | | | |
| Average # of Days from Request for Services to Authorization | 7.4 | 0 | | 2.4 | n/a | | 2.0 | n/a | | 5.4 | n/a | |
| Benchmark 7B Summary | | | | | | | | | | | | |
| Average # of Days from Authorization of Services to | 12.1 | 29.0 | | 31.8 | n/a | | 23.1 | n/a | | 7.8 | n/a | |
| Benchmark 7 Overall Summary | | | | | | | | | | | | |
| Average # of Days from Request for Services to First Psych Testing Service | 19.6 | 29.0 | | 34.2 | n/a | | 25.1 | n/a | | 13.1 | n/a | |
| Percent Meeting Target | 58.0% | 0.0% | | 7.7% | n/a | | 31.3% | n/a | | 64.7% | n/a | |

## Appendix B

Table 14: MCST Dispositions and Referrals, FY 17/18

| Referrals and Dispositions | SSD - South | | SSD - North | | SPD - Citrus Heights | | SPD - Folsom | | SPD - City Wide | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Declined Support | 83 | 25.0% | 302 | 68.0% | 59 | 21.8% | 10 | 17.5% | 85 | 19.0% | 539 | 34.7% |
| Scheduled Appt with Current Provider | 76 | 22.9% | 55 | 12.4% | 64 | 23.6% | 12 | 21.1% | 64 | 14.3% | 271 | 17.5% |
| Hospital/ER (primary psychiatric) | 63 | 19.0% | 29 | 6.5% | 22 | 8.1% | 4 | 7.0% | 95 | 21.2% | 213 | 13.7% |
| Other | 35 | 10.5% | 14 | 3.2% | 51 | 18.8% | 19 | 33.3% | 18 | 4.0% | 137 | 8.8% |
| Managed Care Plan Kaiser | 7 | 2.1% | 0 | 0.0% | 11 | 4.1% | 3 | 5.3% | 21 | 4.7% | 42 | 2.7% |
| Linked to MHP (New Referral) | 11 | 3.3% | 13 | 2.9% | 9 | 3.3% | 0 | 0.0% | 5 | 1.1% | 38 | 2.4% |
| Hospital/ER (primary medical) | 10 | 3.0% | 7 | 1.6% | 8 | 3.0% | 0 | 0.0% | 8 | 1.8% | 33 | 2.1% |
| Jail | 1 | 0.3% | 6 | 1.4% | 6 | 2.2% | 0 | 0.0% | 20 | 4.5% | 33 | 2.1% |
| Family/Parent Support Services | 7 | 2.1% | 0 | 0.0% | 10 | 3.7% | 3 | 5.3% | 6 | 1.3% | 26 | 1.7% |
| Concrete Needs (food, clothing, showers) | 2 | 0.6% | 0 | 0.0% | 0 | 0.0% | 1 | 1.8% | 22 | 4.9% | 25 | 1.6% |
| Housing Resources | 4 | 1.2% | 2 | 0.5% | 5 | 1.8% | 1 | 1.8% | 13 | 2.9% | 25 | 1.6% |
| Natural Supports Links | 4 | 1.2% | 0 | 0.0% | 3 | 1.1% | 2 | 3.5% | 15 | 3.3% | 24 | 1.5% |
| Homeless Entry Point | 5 | 1.5% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 15 | 3.3% | 20 | 1.3% |
| Mental Health Respite Services | 1 | 0.3% | 4 | 0.9% | 3 | 1.1% | 0 | 0.0% | 7 | 1.6% | 15 | 1.0% |
| VA Resources | 6 | 1.8% | 1 | 0.2% | 0 | 0.0% | 0 | 0.0% | 7 | 1.6% | 14 | 0.9% |
| Medical or Health Resources | 3 | 0.9% | 5 | 1.1% | 1 | 0.4% | 0 | 0.0% | 4 | 0.9% | 13 | 0.8% |
| Detox | 1 | 0.3% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 11 | 2.5% | 12 | 0.8% |
| Alta Regional Services | 2 | 0.6% | 1 | 0.2% | 5 | 1.8% | 0 | 0.0% | 3 | 0.7% | 11 | 0.7% |
| Drug and Alcohol Support Services | 2 | 0.6% | 2 | 0.5% | 4 | 1.5% | 1 | 1.8% | 2 | 0.4% | 11 | 0.7% |
| Domestic Violence Resources | 0 | 0.0% | 0 | 0.0% | 7 | 2.6% | 0 | 0.0% | 1 | 0.2% | 8 | 0.5% |
| Document/Personal ID | 0 | 0.0% | 0 | 0.0% | 1 | 0.4% | 0 | 0.0% | 6 | 1.3% | 7 | 0.5% |
| Senior Services | 0 | 0.0% | 0 | 0.0% | 1 | 0.4% | 0 | 0.0% | 5 | 1.1% | 6 | 0.4% |
| Community Support Group | 2 | 0.6% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 3 | 0.7% | 5 | 0.3% |
| Benefits Acquisition | 1 | 0.3% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 3 | 0.7% | 4 | 0.3% |
| Referral to ADS System of Care | 0 | 0.0% | 1 | 0.2% | 0 | 0.0% | 1 | 1.8% | 2 | 0.4% | 4 | 0.3% |
| Crisis Residential | 0 | 0.0% | 1 | 0.2% | 0 | 0.0% | 0 | 0.0% | 2 | 0.4% | 3 | 0.2% |
| Private Pay/Private Ins. MH Services | 2 | 0.6% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 0.2% | 3 | 0.2% |
| Crisis Nursery | 0 | 0.0% | 0 | 0.0% | 1 | 0.4% | 0 | 0.0% | 1 | 0.2% | 2 | 0.1% |
| Culturally-Relevant Organization/Service | 2 | 0.6% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 0.1% |
| Employment/Voc./ Education | 2 | 0.6% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 0.1% |
| Legal Services | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 0.4% | 2 | 0.1% |
| Shelter | 0 | 0.0% | 1 | 0.2% | 0 | 0.0% | 0 | 0.0% | 1 | 0.2% | 2 | 0.1% |
| Total | 332 | 100.0% | 444 | 100.0% | 271 | 100.0% | 57 | 100.0% | 448 | 100.0% | 1552 | 100.0% |

Source: Mobile Crisis Support Team Annual Report, FY 17/18; Sacramento County Division of Behavioral Health Services; Research Evaluation and Performance Outcomes

Table 15: MCST Discharge Reasons, FY 17/18

| Discharge Reason | SSD - South | | SSD - North | | PD - Citrus Heights | | PD - Folsom | | SPD - City Wide | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Client refused/declined services | 64 | 26.6% | 264 | 60.1% | 53 | 25.9% | 10 | 23.8% | 103 | 28.7% | 494 | 38.4% |
| Client is receiving services elsewhere - transfer | 104 | 43.2% | 4 | 0.9% | 93 | 45.4% | 16 | 38.1% | 135 | 37.6% | 352 | 27.4% |
| Client's whereabouts unknown | 8 | 3.3% | 43 | 9.8% | 13 | 6.3% | 3 | 7.1% | 60 | 16.7% | 127 | 9.9% |
| Client is receiving services elsewhere - step up | 2 | 0.8% | 85 | 19.4% | 1 | 0.5% | 0 | 0.0% | 3 | 0.8% | 91 | 7.1% |
| Client does not meet medical necessity | 40 | 16.6% | 9 | 2.1% | 11 | 5.4% | 6 | 14.3% | 0 | 0.0% | 66 | 5.1% |
| Client has completed services | 11 | 4.6% | 6 | 1.4% | 11 | 5.4% | 1 | 2.4% | 24 | 6.7% | 53 | 4.1% |
| Other | 1 | 0.4% | 15 | 3.4% | 22 | 10.7% | 5 | 11.9% | 2 | 0.6% | 45 | 3.5% |
| Referred to GMC - Kaiser | 7 | 2.9% | 1 | 0.2% | 0 | 0.0% | 0 | 0.0% | 22 | 6.1% | 30 | 2.3% |
| Client moved out of Sacramento County | 3 | 1.2% | 11 | 2.5% | 1 | 0.5% | 0 | 0.0% | 8 | 2.2% | 23 | 1.8% |
| Client is deceased | 1 | 0.4% | 1 | 0.2% | 0 | 0.0% | 1 | 2.4% | 0 | 0.0% | 3 | 0.2% |
| Referred to GMC - Blue Cross | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 0.3% | 1 | 0.1% |
| Referred to GMC - Molina | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 0.3% | 1 | 0.1% |
| Total | 241 | 100.0% | 439 | 100.0% | 205 | 100.0% | 42 | 100.0% | 359 | 100.0% | 1286 | 100.0% |

Source: Mobile Crisis Support Team Annual Report, FY 17/18; Sacramento County Division Behavioral Health Services; Research Evaluation and Performance Outcomes

Note: the discharge data depicts all discharges in the fiscal year regardless of when a client was screened.

Discharge Notes:

- **"Client has completed services"** –This selection is chosen when we have linked individual to resources that will help individual toward wellness but is not an identified Mental Health resource. As a result of Mobile support, if an individual has been linked to things such as IHSS, NAMI, community leisure or support groups, food or clothing resources, Housing navigators etc. this selection applies.
- **"Client is receiving services elsewhere – transfer"** –This selection is used when and individual is already open to a County Mental Health Plan provider and MCST supports them in engaging that provider.
- **"Referred to GMC"** – Client is known to be linked to GMC and we have supported them to connect or reconnect with someone in the network. This selection would include PCP (on-going medication support). GMC linked when individual has mild-to-moderate impairment/non-included diagnosis.
- **"Other"** – This selection is utilized when an individual that has received services from MCST is incarcerated.

## Appendix C

Table 16: Mental Health Triage Navigator Program—Number Referred and Screened, FY 2017/18

| Team | FY 17/18 (July 2017-June 2018) | | |
|---|---|---|---|
| | Number Referred | Number Screened | % Referred that were Screened |
| Kaiser South | 317 | 125 | 39.4% |
| Loaves & Fishes | 147 | 136 | 92.5% |
| Main Jail | 1034 | 183 | 17.7% |
| Mercy General | 78 | 62 | 79.5% |
| Mercy San Juan | 430 | 279 | 64.9% |
| Methodist | 237 | 101 | 42.6% |
| Sutter General | 124 | 86 | 69.4% |
| UCD | 125 | 87 | 69.6% |
| Total | 2492 | 1059 | 42.5% |

Source: DBHS Mental Health Triage Navigator Program Annual Report, FY 2017-18

Table 17: Mental Health Triage Navigator Program Linkage to Peer Navigators, FY 2017/18

| Team | Total Screened | Number with a Peer Service | % with a Peer Service | Average Time in Days Between Screen and Peer Service | Range of Time between Screen and Peer Service |
|---|---|---|---|---|---|
| Kaiser South | 125 | 118 | 94.4% | 0.3 Days | 0 to 14 Days |
| Main Jail | 183 | 86 | 47.0% | 7.2 Days | 0 to 59 Days |
| Mercy General | 62 | 28 | 45.2% | 9.4 Days | 1 to 59 Days |
| Mercy San Juan | 279 | 151 | 54.1% | 7.2 Days | 0 to 47 Days |
| Methodist | 101 | 60 | 59.4% | 6.4 Days | 0 to 29 Days |
| Sutter General | 86 | 54 | 62.8% | 5.4 Days | 0 to 20 Days |
| UCD | 87 | 48 | 55.2% | 6.6 Days | 1 to 28 Days |
| Total | 923 | 545 | 59.0% | 5.5 Days | 0 to 59 Days |

Source: DBHS Mental Health Triage Navigator Program Annual Report, FY 2017-18

Table 18: Mental Health Triage Navigator Program—Service Referrals/Dispositions, FY 2017/18

| Service Referrals/Dispositions | Kaiser South | | Loaves & Fishes | | Main Jail | | Mercy General | | Mercy San Juan | | Methodist | | Sutter General | | UCD | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| Mental Health Respite Services | 46 | 18.4% | 42 | 7.4% | 93 | 18.6% | 21 | 13.1% | 104 | 20.5% | 18 | 10.8% | 28 | 17.0% | 48 | 23.8% | 400 | 15.9% |
| Other | 57 | 22.8% | 11 | 1.9% | 86 | 17.2% | 26 | 16.3% | 118 | 23.2% | 30 | 18.0% | 20 | 12.1% | 33 | 16.3% | 381 | 15.1% |
| Declined Support | 35 | 14.0% | 19 | 3.3% | 39 | 7.8% | 22 | 13.8% | 76 | 15.0% | 24 | 14.4% | 25 | 15.2% | 14 | 6.9% | 254 | 10.1% |
| Benefits Acquistion | 17 | 6.8% | 43 | 7.5% | 32 | 6.4% | 12 | 7.5% | 18 | 3.5% | 15 | 9.0% | 11 | 6.7% | 8 | 4.0% | 156 | 6.2% |
| Medical or Health Resources | 17 | 6.8% | 33 | 5.8% | 24 | 4.8% | 8 | 5.0% | 35 | 6.9% | 9 | 5.4% | 11 | 6.7% | 18 | 8.9% | 155 | 6.1% |
| Drug and Alcohol Support Services | 10 | 4.0% | 25 | 4.4% | 58 | 11.6% | 7 | 4.4% | 21 | 4.1% | 10 | 6.0% | 9 | 5.5% | 8 | 4.0% | 148 | 5.9% |
| Housing Resources | 6 | 2.4% | 40 | 7.0% | 22 | 4.4% | 9 | 5.6% | 16 | 3.1% | 9 | 5.4% | 11 | 6.7% | 9 | 4.5% | 122 | 4.8% |
| Homeless Entry Point | 1 | 0.4% | 80 | 14.0% | 7 | 1.4% | 2 | 1.3% | 3 | 0.6% | 3 | 1.8% | 5 | 3.0% | 4 | 2.0% | 105 | 4.2% |
| Document/Personal ID | 11 | 4.4% | 26 | 4.6% | 22 | 4.4% | 7 | 4.4% | 12 | 2.4% | 7 | 4.2% | 7 | 4.2% | 8 | 4.0% | 100 | 4.0% |
| Linked to MHP(New Referral) | 12 | 4.8% | 18 | 3.2% | 11 | 2.2% | 10 | 6.3% | 26 | 5.1% | 7 | 4.2% | 6 | 3.6% | 9 | 4.5% | 99 | 3.9% |
| Scheduled Appt with Current Provider | 5 | 2.0% | 30 | 5.3% | 10 | 2.0% | 7 | 4.4% | 17 | 3.3% | 5 | 3.0% | 6 | 3.6% | 10 | 5.0% | 90 | 3.6% |
| Shelter | 4 | 1.6% | 45 | 7.9% | 9 | 1.8% | 4 | 2.5% | 5 | 1.0% | 5 | 3.0% | 4 | 2.4% | 4 | 2.0% | 80 | 3.2% |
| Concrete Needs(food, clothing, showers) | 4 | 1.6% | 47 | 8.2% | 13 | 2.6% | 0 | 0.0% | 5 | 1.0% | 4 | 2.4% | 2 | 1.2% | 3 | 1.5% | 78 | 3.1% |
| Employment/Voc./Education | 4 | 1.6% | 14 | 2.5% | 4 | 0.8% | 4 | 2.5% | 7 | 1.4% | 4 | 2.4% | 4 | 2.4% | 3 | 1.5% | 44 | 1.7% |
| Community Support Group | 3 | 1.2% | 9 | 1.6% | 4 | 0.8% | 5 | 3.1% | 7 | 1.4% | 5 | 3.0% | 1 | 0.6% | 2 | 1.0% | 36 | 1.4% |
| Managed Care Plan | 8 | 3.2% | 4 | 0.7% | 3 | 0.6% | 2 | 1.3% | 13 | 2.6% | 1 | 0.6% | 2 | 1.2% | 1 | 0.5% | 34 | 1.3% |
| Legal Services | 0 | 0.0% | 8 | 1.4% | 14 | 2.8% | 2 | 1.3% | 3 | 0.6% | 0 | 0.0% | 3 | 1.8% | 2 | 1.0% | 32 | 1.3% |
| Referral to ADS System of Care | 1 | 0.4% | 14 | 2.5% | 5 | 1.0% | 2 | 1.3% | 3 | 0.6% | 1 | 0.6% | 1 | 0.6% | 2 | 1.0% | 29 | 1.1% |
| Family/Parent Support Services | 4 | 1.6% | 7 | 1.2% | 5 | 1.0% | 4 | 2.5% | 1 | 0.2% | 1 | 0.6% | 1 | 0.6% | 0 | 0.0% | 23 | 0.9% |
| Hospital/ER(primary medical) | 0 | 0.0% | 10 | 1.8% | 2 | 0.4% | 1 | 0.6% | 3 | 0.6% | 2 | 1.2% | 3 | 1.8% | 2 | 1.0% | 23 | 0.9% |
| Hospital/ER(primary psychiatric) | 1 | 0.4% | 9 | 1.6% | 1 | 0.2% | 1 | 0.6% | 3 | 0.6% | 4 | 2.4% | 0 | 0.0% | 3 | 1.5% | 22 | 0.9% |

Source: DBHS Mental Health Triage Navigator Program Annual Report, FY 2017-18

Table 18 Continued

| Service Referrals/Dispositions | Kaiser South | | Loaves & Fishes | | Main Jail | | Mercy General | | Mercy San Juan | | Methodist | | Sutter General | | UCD | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| Jail | 0 | 0.0% | 5 | 0.9% | 12 | 2.4% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 0.6% | 1 | 0.5% | 19 | 0.8% |
| Natural Supports Links | 0 | 0.0% | 5 | 0.9% | 7 | 1.4% | 1 | 0.6% | 1 | 0.2% | 0 | 0.0% | 0 | 0.0% | 1 | 0.5% | 15 | 0.6% |
| Domestic Violence Resources | 2 | 0.8% | 8 | 1.4% | 3 | 0.6% | 0 | 0.0% | 1 | 0.2% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 14 | 0.6% |
| Detox | 0 | 0.0% | 1 | 0.2% | 4 | 0.8% | 0 | 0.0% | 2 | 0.4% | 2 | 1.2% | 1 | 0.6% | 2 | 1.0% | 12 | 0.5% |
| Private Pay/Private Ins. MH Services | 1 | 0.4% | 1 | 0.2% | 2 | 0.4% | 1 | 0.6% | 4 | 0.8% | 1 | 0.6% | 0 | 0.0% | 1 | 0.5% | 11 | 0.4% |
| Crisis Residential | 0 | 0.0% | 5 | 0.9% | 2 | 0.4% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 0.6% | 2 | 1.0% | 10 | 0.4% |
| Senior Services | 1 | 0.4% | 2 | 0.4% | 1 | 0.2% | 1 | 0.6% | 2 | 0.4% | 0 | 0.0% | 1 | 0.6% | 1 | 0.5% | 9 | 0.4% |
| Culturally-Relevant Organization/Service | 0 | 0.0% | 4 | 0.7% | 2 | 0.4% | 0 | 0.0% | 1 | 0.2% | 0 | 0.0% | 0 | 0.0% | 1 | 0.5% | 8 | 0.3% |
| VA Resources | 0 | 0.0% | 3 | 0.5% | 2 | 0.4% | 1 | 0.6% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 1.0% | 8 | 0.3% |
| Alta Regional Services | 0 | 0.0% | 0 | 0.0% | 1 | 0.2% | 0 | 0.0% | 1 | 0.2% | 0 | 0.0% | 1 | 0.6% | 0 | 0.0% | 3 | 0.1% |
| Crisis Nursery | 0 | 0.0% | 2 | 0.4% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 0.1% |
| Total | 250 | 100.0% | 570 | 100.0% | 500 | 100.0% | 160 | 100.0% | 508 | 100.0% | 167 | 100.0% | 165 | 100.0% | 202 | 100.0% | 2522 | 100.0% |

## Appendix D

Table 19: Medi-Cal Approved Claims Data for SACRAMENTO County MHP, Calendar Year 17


| | |
|---|---|
| Date Prepared: | 07/30/2018, Version 1.1 |
| Prepared by: | Rachel Phillips, BHC / CalEQRO |
| Data Sources: | DHCS Approved Claims and MMEF Data - Notes (1) and (2) |
| Data Process Dates: | 04/30/2018, 06/05/2018, and 04/01/2018 - Note (3) |

| | SACRAMENTO | | | | | LARGE | | STATEWIDE | |
|---|---|---|---|---|---|---|---|---|---|
| | Average Number of Eligibles per Month (4) | Number of Beneficiaries Served per Year | Approved Claims | Penetration Rate | Approved Claims per Beneficiary Served per Year | Penetration Rate | Approved Claims per Beneficiary Served per Year | Penetration Rate | Approved Claims per Beneficiary Served per Year |
| **TOTAL** | | | | | | | | | |
| | 559,425 | 22,943 | $110,236,384 | 4.10% | $4,805 | 4.19% | $6,723 | 4.52% | $6,170 |
| **AGE GROUP** | | | | | | | | | |
| 0-5 | 69,886 | 953 | $3,137,731 | 1.36% | $3,292 | 1.75% | $6,636 | 2.07% | $5,431 |
| 6-17 | 133,236 | 8,253 | $47,235,644 | 6.19% | $5,723 | 5.55% | $8,110 | 6.31% | $7,610 |
| 18-59 | 288,999 | 11,936 | $53,193,671 | 4.13% | $4,457 | 4.53% | $6,023 | 4.71% | $5,519 |
| 60 + | 67,305 | 1,801 | $6,669,337 | 2.68% | $3,703 | 2.55% | $5,806 | 2.78% | $4,900 |
| **GENDER** | | | | | | | | | |
| Female | 296,052 | 11,913 | $54,678,641 | 4.02% | $4,590 | 3.83% | $6,227 | 4.15% | $5,748 |
| Male | 263,373 | 11,030 | $55,557,743 | 4.19% | $5,037 | 4.60% | $7,201 | 4.96% | $6,577 |
| **RACE/ETHNICITY** | | | | | | | | | |
| White | 140,900 | 7,467 | $30,170,192 | 5.30% | $4,040 | 6.10% | $5,172 | 5.93% | $4,916 |
| Hispanic/Latino | 128,686 | 3,765 | $13,249,574 | 2.93% | $3,519 | 2.97% | $5,758 | 3.35% | $5,278 |
| African-American | 85,432 | 4,391 | $18,592,727 | 5.14% | $4,234 | 6.49% | $6,645 | 7.37% | $5,635 |
| Asian/Pacific Islander | 78,944 | 1,320 | $5,068,576 | 1.67% | $3,840 | 1.96% | $6,796 | 2.08% | $5,639 |
| Native American | 3,927 | 236 | $914,336 | 6.01% | $3,874 | 7.01% | $5,635 | 6.38% | $5,468 |
| Other | 121,538 | 5,764 | $42,240,979 | 4.74% | $7,328 | 6.19% | $10,103 | 7.23% | $9,948 |
| **ELIGIBILITY CATEGORIES** | | | | | | | | | |
| Disabled | 58,077 | 8,351 | $41,720,474 | 14.38% | $4,996 | 17.12% | $7,253 | 17.85% | $6,613 |
| Foster Care | 3,411 | 1,316 | $10,404,863 | 38.58% | $7,906 | 45.37% | $11,064 | 47.28% | $9,962 |

| | SACRAMENTO | | | | | LARGE | | STATEWIDE | |
|---|---|---|---|---|---|---|---|---|---|
| | Average Number of Eligibles per Month (4) | Number of Beneficiaries Served per Year | Approved Claims | Penetration Rate | Approved Claims per Beneficiary Served per Year | Penetration Rate | Approved Claims per Beneficiary Served per Year | Penetration Rate | Approved Claims per Beneficiary Served per Year |
| Other Child | 148,544 | 6,552 | $29,006,415 | 4.41% | $4,427 | 4.11% | $6,526 | 4.76% | $6,041 |
| Family Adult | 123,720 | 2,142 | $6,016,463 | 1.73% | $2,809 | 2.11% | $3,640 | 2.13% | $3,482 |
| Other Adult | 42,373 | 313 | $805,157 | 0.74% | $2,572 | 0.81% | $4,942 | 0.91% | $4,172 |
| MCHIP | 46,481 | 1,730 | $6,663,732 | 3.72% | $3,852 | 3.83% | $6,206 | 4.09% | $5,623 |
| ACA | 145,108 | 4,254 | $15,619,281 | 2.93% | $3,672 | 3.68% | $5,330 | 3.86% | $4,782 |
| **SERVICE CATEGORIES** | | | | | | | | | |
| Inpatient Services | 559,425 | 1,835 | $19,581,850 | 0.33% | $10,671 | 0.41% | $9,894 | 0.42% | $9,404 |
| Residential Services | 559,425 | 319 | $1,355,554 | 0.06% | $4,249 | 0.10% | $8,417 | 0.07% | $8,764 |
| Crisis Stabilization | 559,425 | 1,487 | $3,842,896 | 0.27% | $2,584 | 0.55% | $3,177 | 0.48% | $2,622 |
| Day Treatment | 559,425 | 24 | $256,091 | 0.00% | $10,670 | 0.02% | $10,294 | 0.01% | $11,254 |
| Case Management | 559,425 | 15,760 | $9,997,985 | 2.82% | $634 | 1.51% | $1,086 | 1.60% | $982 |
| Mental Health Services | 559,425 | 20,280 | $53,457,046 | 3.63% | $2,636 | 3.26% | $4,429 | 3.63% | $3,996 |
| Medication Support | 559,425 | 13,346 | $16,456,779 | 2.39% | $1,233 | 2.10% | $1,643 | 2.17% | $1,641 |
| Crisis Intervention | 559,425 | 1,997 | $981,200 | 0.36% | $491 | 0.37% | $1,100 | 0.53% | $1,361 |
| TBS | 559,425 | 366 | $2,589,309 | 0.07% | $7,075 | 0.07% | $9,875 | 0.06% | $10,887 |
| Katie-A ICC/IHBS | 559,425 | 630 | $1,717,675 | 0.11% | $2,726 | 0.14% | $5,274 | 0.14% | $6,481 |

Footnotes:

1 - Includes approved claims data on DHCS eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DHCS for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligible beneficiaries is 667,349

5 - Includes the Affordable Care Act Expansion Population

6 - Katie A 'look-alike' services are included with ICC and IHBS services.

7 - CY17 Race/Ethnicity data shows significant changes compared to CY16 for some MHPs. CalEQRO uses MMEF data for Race/Ethnicity, and recognizes MHP's do not have control over the quality or veracity of this data.

## Appendix E

Table 20: Retention Rates for FY 17/18

| Sacramento County Mental Health Plan<br>Retention FY 17/18 | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY 17/18 | | Total Served | 1 Service | | 2 Services | | 3 Services | | 4 Services | | 5 to 15 Services | | >15 Services | |
| | | | N | % | N | % | N | % | N | % | N | % | N | % |
| Race (0-17.9) | API | 322 | 16 | 5.0 | 20 | 6.2 | 14 | 4.3 | 12 | 3.7 | 97 | 30.1 | 163 | 50.6 |
| | Black | 1,890 | 132 | 7.0 | 121 | 6.4 | 79 | 4.2 | 68 | 3.6 | 538 | 28.5 | 952 | 50.4 |
| | Hispanic | 3,072 | 168 | 5.5 | 180 | 5.9 | 123 | 4.0 | 143 | 4.7 | 944 | 30.7 | 1,514 | 49.3 |
| | Nat-Amer | 74 | 5 | 6.8 | 5 | 6.8 | 4 | 5.4 | 4 | 5.4 | 20 | 27.0 | 36 | 48.6 |
| | White | 2,168 | 120 | 5.5 | 116 | 5.4 | 95 | 4.4 | 76 | 3.5 | 585 | 27.0 | 1,176 | 54.2 |
| | Other | 675 | 41 | 6.1 | 25 | 3.7 | 26 | 3.9 | 23 | 3.4 | 186 | 27.6 | 374 | 55.4 |
| | Unknown | 909 | 71 | 7.8 | 72 | 7.9 | 47 | 5.2 | 43 | 4.7 | 310 | 34.1 | 366 | 40.3 |
| Race (≥18) | API | 1,467 | 74 | 5.0 | 82 | 5.6 | 49 | 3.3 | 50 | 3.4 | 575 | 39.2 | 637 | 43.4 |
| | Black | 3,597 | 368 | 10.2 | 320 | 8.9 | 231 | 6.4 | 184 | 5.1 | 1,151 | 32.0 | 1,343 | 37.3 |
| | Hispanic | 2,503 | 250 | 10.0 | 253 | 10.1 | 176 | 7.0 | 116 | 4.6 | 785 | 31.4 | 923 | 36.9 |
| | Nat-Amer | 207 | 17 | 8.2 | 32 | 15.5 | 8 | 3.9 | 12 | 5.8 | 67 | 32.4 | 71 | 34.3 |
| | White | 6,860 | 675 | 9.8 | 630 | 9.2 | 472 | 6.9 | 302 | 4.4 | 2,442 | 35.6 | 2,339 | 34.1 |
| | Other | 795 | 59 | 7.4 | 59 | 7.4 | 50 | 6.3 | 53 | 6.7 | 300 | 37.7 | 274 | 34.5 |
| | Unknown | 1,811 | 369 | 20.4 | 239 | 13.2 | 191 | 10.5 | 129 | 7.1 | 568 | 31.4 | 315 | 17.4 |
| Age | 0-17.9 | 9,110 | 553 | 6.1 | 539 | 5.9 | 388 | 4.3 | 369 | 4.1 | 2,680 | 29.4 | 4,581 | 50.3 |
| | ≥ 18 | 17,240 | 1,812 | 10.5 | 1,615 | 9.4 | 1,178 | 6.8 | 845 | 4.9 | 5,888 | 34.2 | 5,902 | 34.2 |
| Sex | Male | 12,694 | 1,259 | 9.9 | 1,060 | 8.4 | 763 | 6.0 | 591 | 4.7 | 3,809 | 30.0 | 5,212 | 41.1 |
| | Female | 13,645 | 1,101 | 8.1 | 1,093 | 8.0 | 802 | 5.9 | 624 | 4.6 | 4,755 | 34.8 | 5,270 | 38.6 |
| | Other/Unk* | 11 | 4 | 36.4 | 1 | 9.1 | 1 | 9.1 | | 0.0 | 4 | 36.4 | 1 | 9.1 |
| Language | English | 22,703 | 2,049 | 9.0 | 1,884 | 8.3 | 1,375 | 6.1 | 1,039 | 4.6 | 7,210 | 31.8 | 9,146 | 40.3 |
| | Spanish | 1,450 | 89 | 6.1 | 93 | 6.4 | 71 | 4.9 | 77 | 5.3 | 474 | 32.7 | 646 | 44.6 |
| | Russian | 236 | 9 | 3.8 | 5 | 2.1 | 5 | 2.1 | 8 | 3.4 | 116 | 49.2 | 93 | 39.4 |
| | Hmong | 284 | 9 | 3.2 | 15 | 5.3 | 3 | 1.1 | 8 | 2.8 | 125 | 44.0 | 124 | 43.7 |
| | Vietnamese | 192 | 5 | 2.6 | 4 | 2.1 | 3 | 1.6 | 7 | 3.6 | 77 | 40.1 | 96 | 50.0 |
| | Cantonese | 63 | 0 | 0.0 | 3 | 4.8 | 1 | 1.6 | 1 | 1.6 | 23 | 36.5 | 35 | 55.6 |
| | Arabic | 117 | 4 | 3.4 | 11 | 9.4 | 9 | 7.7 | 1 | 0.9 | 59 | 50.4 | 33 | 28.2 |
| | Other | 581 | 27 | 4.6 | 22 | 3.8 | 25 | 4.3 | 27 | 4.6 | 283 | 48.7 | 197 | 33.9 |
| | Unknown | 724 | 172 | 23.8 | 117 | 16.2 | 74 | 10.2 | 47 | 6.5 | 201 | 27.8 | 113 | 15.6 |

## Bibliography

Behavior Health Concepts, Inc. FY 17-18. Medi-Cal Specialty Mental Health External Quality Review, Sacramento MHP Final Report. Prepared for California Department of Health Care Services. Retrieved May 29, 2019, from https://www.caleqro.com/mh-eqro#!mh-reports_and_summaries

Behavior Health Concepts, Inc. FY 18-19. Medi-Cal Specialty Mental Health External Quality Review, Sacramento MHP Final Report. Prepared for California Department of Health Care Services. Retrieved July 19, 2019, from https://www.caleqro.com/mh-eqro#!mh-reports_and_summaries

Division of Behavioral Health Services, Research Evaluation and Performance Outcomes. Mental Health Triage Navigator Program Annual Report, FY 2017/18.

Division of Behavioral Health Services, Research Evaluation and Performance Outcomes. Mobile Crisis Support Team Annual Report, FY 17/18.

Heslin, K. C., Weiss, A. J. (May 2015). Hospital readmissions involving psychiatric disorders, 2012. Statistical Brief #189. Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality. Retrieved on July 20, 2019 from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.jsp

NAMI. 2014. Mental Illness: NAMI Report Deplores 80 Percent Unemployment Rate; State Rates And Ranks Listed—Model Legislation Proposed. Retrieved on September 13, 2019 from https://www.nami.org/Press-Media/Press-Releases/2014/Mental-Illness-NAMI-Report-Deplores-80-Percent-Une

Sacramento County Behavioral Health Services. Research Evaluation and Performance Outcomes. Crisis Visits, Inpatient Hospital Admissions, and Recidivism, Fiscal Year 2017-18.

Sacramento County, Mental Health Service Act, Full Service Partnership Program Performance Indicator Report, FY 2019/17. Prepared by Alba Garcia, Planner Research Evaluation and Performance Outcomes.

Sacramento County Mental Health. December 2018. 2018 Human Resources Survey.

Recovery Across Mental Health, Gender Differences in Mental Health. Retrieved on July 20, 2019 from https://ramh.org/guide/gender-differences-in-mental-health

Sacramento County, Behavioral Health Services, Research Evaluation and Performance Outcomes, Lisa Harmon, Planner. Mental Health Consumer Perception Survey, May 2017 Collection Period.

Sacramento County, Behavioral Health Services, Research Evaluation and Performance Outcomes, Lisa Harmon, Planner. Mental Health Consumer Perception Survey, November 2017 Collection Period.

Sacramento County, Behavioral Health Services, Research Evaluation and Performance Outcomes, Lisa Harmon, Planner. Mental Health Consumer Perception Survey, May 2018 Collection Period.

Sacramento County, Behavioral Health Services, Research Evaluation and Performance Outcomes, Lisa Harmon, Planner. Mental Health Consumer Perception Survey, May 2017 Collection Period.

Sacramento County, Behavioral Health Services, Research Evaluation and Performance Outcomes, Lisa Harmon, Planner. Mental Health Consumer Perception Survey, November 2018 Collection Period.

Sacramento County Division of Behavioral Health Services. (Fiscal Year 2015-2016). Sacramento County Mental Health Plan Quality Improvement Program Annual Work Plan. Retrieved on July 20, 2019 from http://www.dhs.saccounty.net/BHS/Documents/Reports--Workplans/RT-QM-Program-Annual-Work-Plan-FY2015-16.pdf

Sacramento County Division of Behavioral Health Services. (Fiscal Year 2016-17). Sacramento County Mental Health Plan Quality Improvement Program Annual Work Plan. Retrieved on July 20, 2019 from file:///C:/Users/ann/Downloads/RT-QM-Program-Annual-Work-Plan-FY2016-17%20(1).pdf

Sacramento County Division of Behavioral Health Services. (Fiscal Year 2017-18). Sacramento County Mental Health Plan Quality Improvement Program Annual Work Plan. Retrieved on July 20, 2019 from file:///C:/Users/ann/Downloads/RT-QM-Program-Annual-Work-Plan-FY2017-18%20(1).pdf

Sacramento County Division of Behavioral Health Services. (Fiscal Year 2018-19). Sacramento County Mental Health Plan Quality Improvement Program Annual Work Plan. Retrieved on July 20, 2019 from file:///C:/Users/ann/Downloads/RT-QM-Program-Annual-Work-Plan-FY2018-19%20(1).pdf

Sacramento County Research Evaluation Performance Outcomes. Mental Health Services Act Full Service Partnership Program Performance Indicator Report, FY 16/17, Prepared by Alba Garcia, Planner.

SAMHSA's Working Definition of Recovery. Retrieved on July 20, 2019 from https://store.samhsa.gov/system/files/pep12-recdef.pdf.