Behavioral Health Concepts, Inc.
info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SACRAMENTO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 10-12, 2022

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, Sacramento may be used to identify the Sacramento County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type— Virtual

Date of Review— August 10-12, 2022

MHP Size — Large

MHP Region — Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	2	1	2

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	4	0	2
Quality of Care	10	8	2	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**21**	**3**	**2**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
“Racial Equity Action plans”	Clinical	01/2022	First Remeasurement	Low
“Admissions at Provider Site”	Non-Clinical	01/2022	Implementation	Low

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	11
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	10

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP utilizes Peer Navigator staff in the Emergency Departments
- The MHP negotiated a pay increase for MHP and Contract staff and created a county-approved multi-step employment ladder for persons with lived mental health experience.
- Ten out-patient clinics and Wellness Centers will be opened under the Community Outreach Recovery Empowerment (CORE).
- The MHP expanded the Urgent Care walk-in services to 24-hour, 7-day a week.
- The MHP provided a mental health support phone line for Ukrainian language immigrants who have been displaced and impacted by the war in Ukraine.

The MHP was found to have notable opportunities for improvement in the following areas:

- Urgent request service data is not accurately tracked on their submitted Assessment of Timely Access.
- Though the MHP is able to track and report no-show data through the use of service codes, accurate reporting is dependent on the entry done by direct service staff. There remains a need to improve the consistency in documentation requirements.
- The MHP identifies compliance goals and expectations on their Quality Improvement Work Plan (QIWP), however, it is unclear if the obtained outcome made an impact to the beneficiary experience.

- Both the Clinical and non-clinical PIP present design and structure flaws.
- The MHP tracks all participants that attend trainings offered, however, the MHP does not track if the contractors are sending all necessary staff. This has led to a reported gap in training within the contractor staff.

Recommendations for improvement based upon this review include:

- Develop and implement a system to accurately track and report urgent service requests. (This recommendation is a carry-over from FY 2021-22.)
- Develop and implement a system to accurately track and report no shows for psychiatrists and/or clinicians other than psychiatrists and ensure data integrity from Contractor providers. (This recommendation is a carry-over from FY 2021-22.)
- Expand on outcome goals within the QIWP, to include the impact on beneficiaries when compliance percentage goals are achieved.
- Restructure both the clinical and non-clinical PIP plans to follow the assigned format; to include clinical or non-clinical goals, flow, and identified variables with corresponding performance measure outcomes.
- Ensure contract agencies are providing MHP required or mandated trainings to all impacted staff.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, representing 58 counties, to provide specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal MHP. DHCS contracts with Behavioral Health Concepts, Inc., (BHC) the CalEQRO to review and evaluate the care provided to the Medi-Cal beneficiaries.

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill 1291 (Section 14717.5 of the Welfare and Institutions Code Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2022-23 findings of the EQR for Sacramento County MHP by BHC, conducted as a virtual review on August 10-12, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File; Short-Doyle/Medi-Cal (SDMC) approved claims; and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening Diagnosis and Treatment, FC, transitional age youth, and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during/after the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP continues to see a significant decline in staff retention and faces continued challenges in hiring replacement staff, while also serving the expanding needs of immigrant communities from countries in political strife, including those from Afghanistan and the Ukraine. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- Ukrainian Phone Support line has been established to provide emotional support to the large number of Ukrainians who are living in Sacramento County and who are concerned about their family and friends who are in Ukraine.
- MHP is recruiting staff to provide for the new 24-hour 7-day a week Call Center and Crisis Response Team.
- MHP is implementing Assisted Outpatient Treatment (AOT) and Forensic Behavioral Health Full Service Partnerships (FSP) in Sacramento County. AOT will include a county operated engagement team and contracted services provision. FSP is a partnership with the Criminal Justice Support Program.
- MHP is expanding hours of operation in their existing walk-in Mental Health Urgent Care clinic (MHUCC) to 24/7.
- Ten clinics and Wellness Centers will be opened under the CORE project to address mental health needs in underserved communities. Chosen contractors will identify specific outreach activities to engage the community of need.
- In collaboration with Probation, Public Defender and the Courts launched a new Justice Diversion Treatment Resource Center for misdemeanor mental health diversion clients.
- A new BHS Probation Mental Health Team was created in 2021 to expand behavioral health screening, assessment, and referral services to address the mental health needs of youth in the Juvenile Justice system.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

- What was not addressed
- EQRO's recommendation to have item fully met
- Barriers (if applicable)
- Reason the recommendation is discontinued despite not being fully met

Recommendations from FY 2021-22

Recommendation 1: Continue work in Cultural Competency and QI Committees to reduce barriers to access for FC, Latino/Hispanic, and Asian/Pacific Islander (API) beneficiaries and implement ways to increase outreach.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP created Quality Individual positions within the mental health and Child Welfare System to complete independent assessments, coordinate with the child family teams and determine proper level of care (LOC).
- Tailored outreach material was created for the Cantonese speaking community. The MHP reported an increased need for Cantonese interpretation that coincided with the release of the material.
- The MHP continues to work to identify the needs of all diverse communities yet continues to see a decline of Spanish speaking beneficiaries.

Recommendation 2: Research and implement strategies to support recruitment and retention in collaboration with contracted agencies.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP attended five outreach events to encourage applications for employment within the County and contracted agencies.
- The MHP entered negotiations with the union to increase pay for staff and contracted agencies. Pay was increased by 16 percent for clinicians and 10 percent for crisis response.
- The MHP worked with County Human Resources (HR) to allow for interviews and a warm follow-up by staff for potential employees when at County sanctioned job fairs.

Recommendation 3: Develop and implement a system to accurately track and report urgent service requests, including requests that do not require prior authorization and for beneficiaries who request urgent services but who do not follow up with the referral to MHUCC.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Urgent care timeliness data is tracked two ways. From calls to the Access Team to the first service at the assigned provider site, and from the time client walks into the MHUCC to the time they are first seen by direct service provider staff at the MHUCC.
- All requests for Urgent services that come into the Access Team are notified that they can walk into the MHUCC for a same day appointment.
- Data for reporting remains inconsistent and data integrity is questionable.
- The MHP does not accurately track and report services on their Assessment of Timely Access.
- The MHP is encouraged to seek timely and accurate data from Contractors.

Recommendation 4: Develop and implement a system to accurately track and report no-shows for psychiatrists and/or clinicians other than psychiatrists.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP is able to track and report no-show data through the use of service codes. Accurate reporting is dependent on the data entry done by direct service staff.
- The MHP currently has neither a standard for no-shows for psychiatrists and/or clinicians other than psychiatrists. Average no-show rate for psychiatrists is

under-reported showing 0.9 percent for children, 1.3 percent for FC and 4.4 percent for adults.

- Conversations between BHS administration and contracted providers is focused on strategies to improve consistency in documentation.
- The MHP recognizes that it does not have accurate reporting of no-show data from the contract providers, and consequently, cannot accurately determine caseload size and capacity. The MHP has offered repeated trainings and continues to report low compliance of accurate reporting among contract providers.
- The MHP is recommended to enforce the expectation of tracking no-show data within their contractor base.

Recommendation 5: Select and implement a LOC tool for universal use across the system of care.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP continues to use the Level of Care Utilization System (LOCUS) when identifying the appropriate LOC for the beneficiary.
- The MHP has selected the Adult Needs and Strengths Assessment (ANSA) as the LOC tool for improved LOC identification. The MHP has initiated contact with Praed, the creators of the tool, though the MHP has not moved forward with implementing a systemwide adult LOC tool.
- The recommendation is not carried over as the MHP is continuing to work with Praed institute, and is contracted with California Mental Health Services Authority (CalMHSA) to pilot the chosen standardized LOC tool.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or beneficiaries) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which beneficiaries live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Eighty organizational provider sites, as part of thirty-nine legal entities, delivered services to MHP beneficiaries across Sacramento County. This spread reflected a vast geographic area of service, and includes services delivered in clinic, field-based, residential, and inpatient settings. Regardless of payment source, approximately 6.17 percent of services were delivered by county operated/staffed clinics and sites, and 93.83 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 79.13 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Urgent service requests are immediately referred to the Sacramento County Mental Health Urgent Care or the emergency room. The MHP deploys some Access clinicians with the homeless encampment teams, but the majority are in the call center. Certain programs do their own admissions based on the population they serve but these are mostly crisis response programs.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 14,010 adult beneficiaries, 9,138 youth beneficiaries, and 2,305 older adult beneficiaries across 2 county-operated sites and 57 contractor-operated sites. Among those served, 722 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B below.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual BHIN.

For Sacramento County, the time and distance requirements are 15 miles and 30 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2021-22

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	☐ Yes ☒ No

- The MHP met all time and distance standards and was not required to submit an AAS request.

Table 1B: MHP OON, FY 2021-22

Out-of-Network (OON) Access		
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No	
OON Details		
Contracts with OON Providers		
Does the MHP have existing contracts with OON providers?	☐ Yes ☒ No	
Contracting status:	☐ The MHP is in the process of establishing contracts with OON providers ☒ The MHP does not have plans to establish contracts with OON providers	
OON Access for Beneficiaries		
The MHP ensures OON access for beneficiaries in the following manner:	☐ The MHP has existing contracts with OON providers ☒ Other: If the MHP is unable to meet the time and distance standards and there is a request to receive services from an OON provider, the MHP will pursue a single case agreement contract with the provider as long as they meet the DHCS MHP contract requirements.	

Because the MHP can provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access services via out-of-network (OON) provider.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Strengths and opportunities associated with the access components identified above include:

- The MHP created the capacity for 24-hour, 7-day a week Urgent Care walk-in clinic for immediate and emergent mental health needs.
- The MHP offers services in the seven threshold languages as well as emergent languages such as Dari and Ukrainian.
- Four organizations were identified to operate ten new CORE programs. Each program will include both a Community Wellness Center and flexible outpatient programs.
- The MHP created a centralized system to track and coordinate referrals. Key informants mentioned hiring challenges and turnover, which may affect the ability for new staff to identify the appropriate Contractor to send the referral.
- Access information on the MHP website is not easy to maneuver. It is difficult to quickly locate the crisis and warm-line, and suicide prevention hotline numbers.
- Key informants have identified languages other than English have a longer wait time before first appointment, and no knowledge of transportation options to reach their appointments.
- Staff retention and limited hiring remain a strain on the system both within the MHP and contract agencies. The MHP was able to work within their HR department to increase wages to become more competitive, but still face a challenging job market and competition for employees.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rate, and Average Approved Claims per Beneficiary

The following information provides details on Medi-Cal eligibles and beneficiaries served by age, race/ethnicity, and threshold language.

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the MHP's PR is comparable to the statewide average (3.79 percent vs. 3.85 percent) while the approved claims per beneficiary is approximately 19 percent lower than the statewide average ($5,267 vs. $6,496).

The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	592,920	22,455	3.79%	$118,273,432	$5,267
CY 2020	548,757	23,228	4.23%	$142,584,335	$6,138
CY 2019	536,431	23,842	4.44%	$120,527,841	$5,055

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	64,795	674	1.04%	1.29%	1.59%
Ages 6-17	139,618	7,364	5.27%	4.65%	5.20%
Ages 18-20	29,064	1,177	4.05%	3.66%	4.02%
Ages 21+	305,532	12,297	4.02%	3.73%	4.07%
Ages 65+	53,914	943	1.75%	1.52%	1.77%
Total	**592,920**	**22,455**	**3.79%**	**3.47%**	**3.85%**

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Arabic	109	0.49%
Cantonese	79	0.36%
Farsi	67	0.30%
Hmong	182	0.83%
Russian	219	0.99%
Spanish	1,738	7.88%
Vietnamese	178	0.81%
Total Threshold Languages	2,572	11.66%

- 11.66% of all beneficiaries served represent threshold language categories.
- Sacramento had seven threshold languages with Spanish speakers comprising the largest of the seven language groups. There were 1,738 beneficiaries served by the MHP who identified Spanish as a preferred language, 7.88 percent of the beneficiaries served by the MHP.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

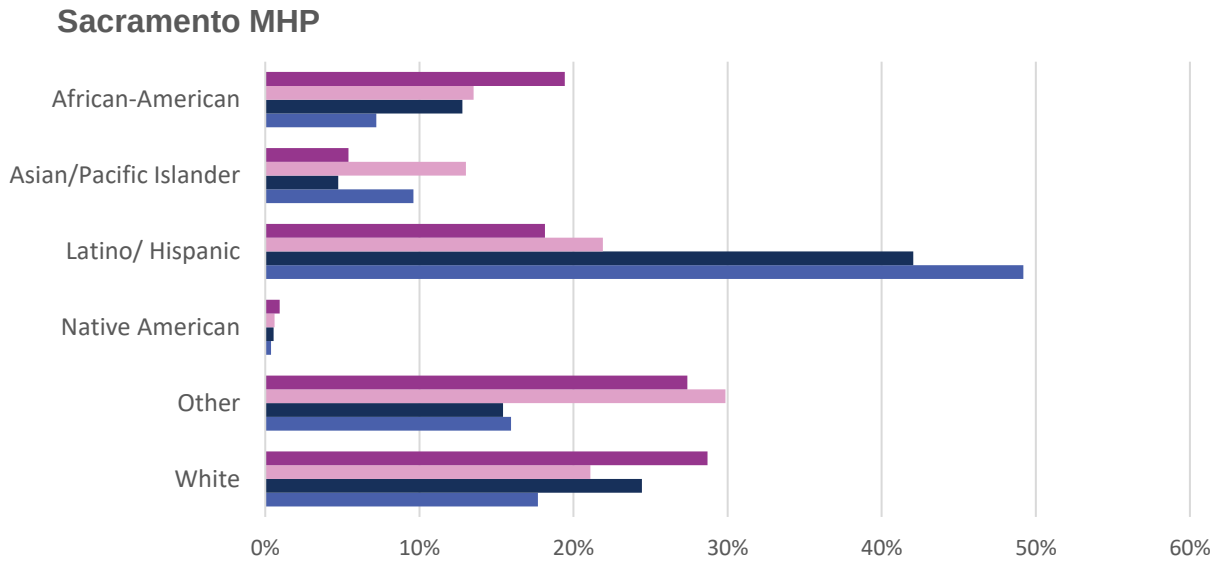
Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB for ACA
MHP	171,661	5,102	2.97%	$21,586,680	$4,231
Large	2,153,582	62,972	2.92%	$387,366,612	$6,151
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The MHP's ACA approved claims per beneficiary is approximately 25 percent lower than the statewide average ($4,231 vs. $5,677) and approximately 31 percent lower than the large county average ($4,231 vs. $6,151).
- The MHP's PR for this group is comparable to the large county average (2.97 percent vs. 2.92 percent) and approximately 10 percent less than the statewide average (2.97 percent vs. 3.31 percent).

Table 7: PR of MHP and State Beneficiaries Served by Race/Ethnicity CY2021

Race/Ethnicity	# MHP Served	# MHP Eligibles	PR MHP	PR State
African-American	4,364	80,207	5.44%	6.83%
Asian/Pacific Islander	1,212	77,156	1.57%	1.90%
Latino/Hispanic	4,074	129,839	3.14%	3.29%
Native American	209	3,604	5.80%	5.58%
Other	6,151	177,044	3.47%	3.72%
White	6,445	125,072	5.15%	5.32%
Total	**22,455**	**592,922**	**3.79%**	**3.85%**

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

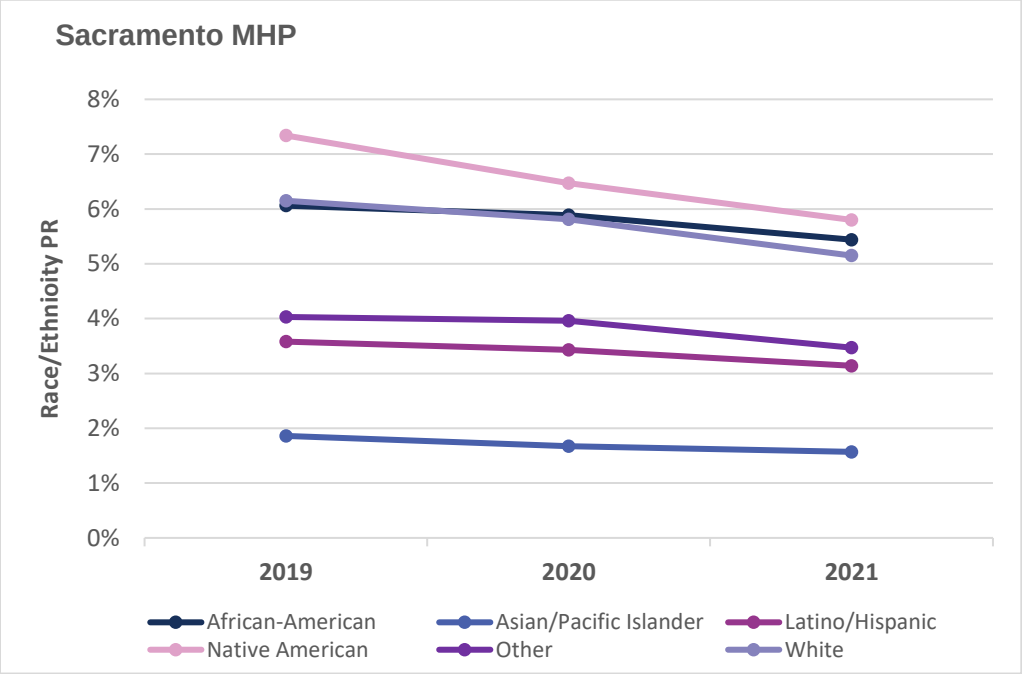


	White	Other	Native American	Latino/ Hispanic	Asian/Pacific Islander	African-American
MHP % Served	29%	27%	1%	18%	5%	19%
MHP % Eligibles	21%	30%	1%	22%	13%	14%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- Sacramento served 22,455 unique beneficiaries in CY 2021. Their eligible population was largely comprised of Other beneficiaries with this group comprising 30 percent of the eligible population and 27 percent of those served. Hispanic/Latino and White beneficiaries comprised the next largest race/ethnicity groups with Hispanic/Latino beneficiaries comprising 22 percent of the eligible population and 18 percent of those served, and White beneficiaries comprising 21 percent of the eligible population and 29 percent of those served.

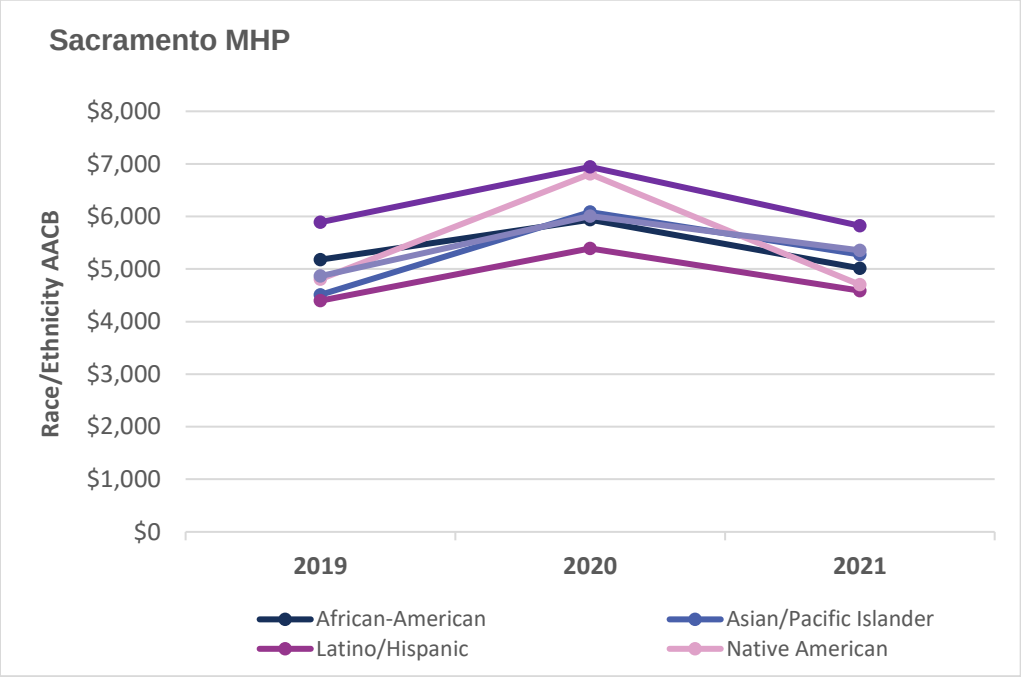
- Asian/Pacific Islander (API) beneficiaries comprised 13 percent of the eligible population and five percent of those served. The disproportionality between the percentage of the API eligible population and the percentage of those served indicates that this population may be underserved.

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



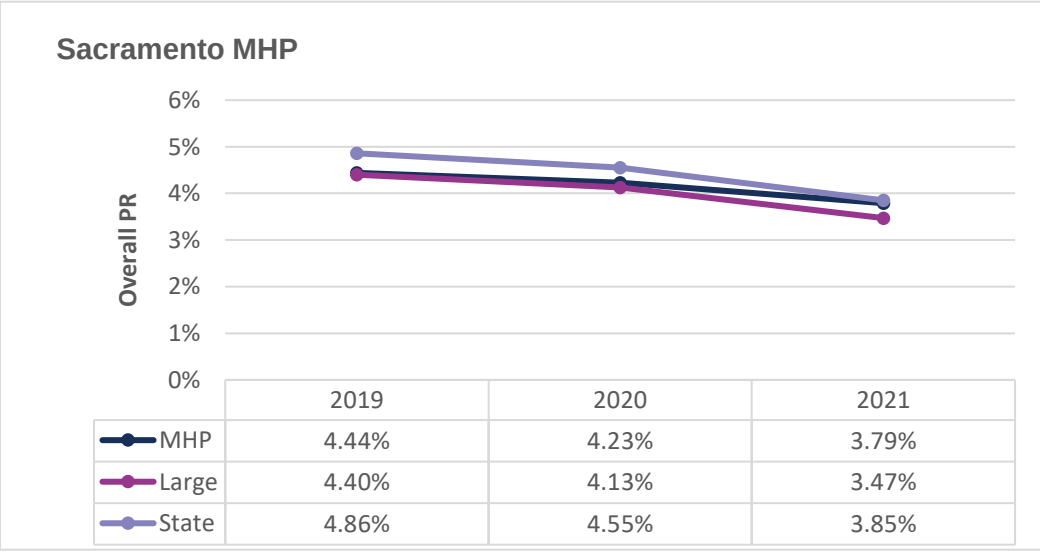
- A general trend of declining PR can be seen from CY 2019 to CY 2021 with API and Latino/Hispanic populations having lower PR across all three years when compared to other subgroups.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21



- With the exception of "Other" which saw an increase in AACB each year from CY 2019 to CY 2021, AACB saw only minor variations during this period.
- White beneficiaries with an increase in AACB in CY 2020 when compared to CY 2019 and CY 2021. While the cause for the CY 2020 increase was not identified, an increase in high-cost White beneficiaries in CY 2020 would impact overall AACB.

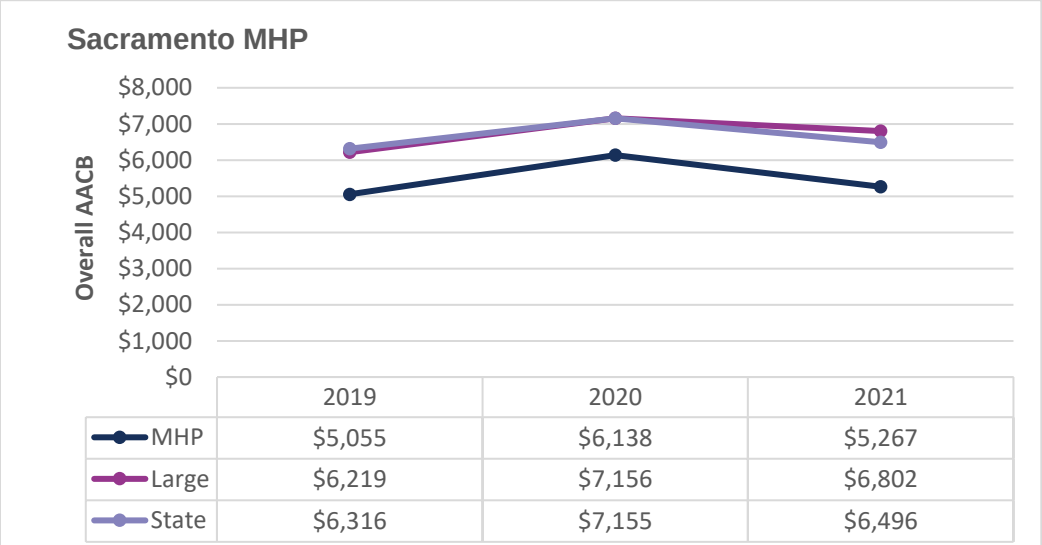
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.44%	4.23%	3.79%
Large	4.40%	4.13%	3.47%
State	4.86%	4.55%	3.85%

- PRs for statewide, large county and Sacramento declined similarly each year from CY 2019 to CY 2021.

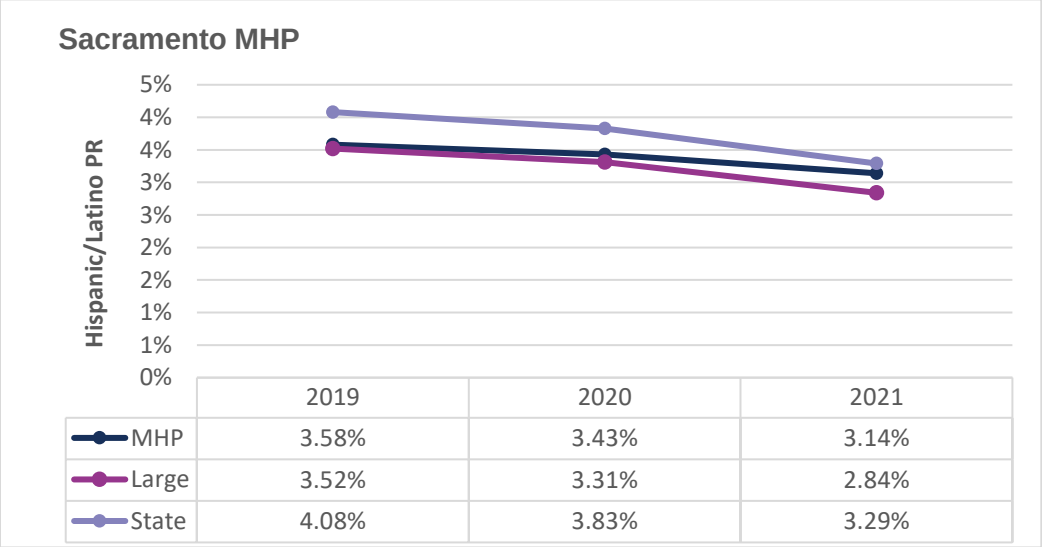
Figure 5: Overall AACB CY 2019-2021



	2019	2020	2021
MHP	$5,055	$6,138	$5,267
Large	$6,219	$7,156	$6,802
State	$6,316	$7,155	$6,496

- Billing rates impacted by the COVID-19 pandemic likely had an impact on the AACB increase seen from CY 2019 to CY 2020.

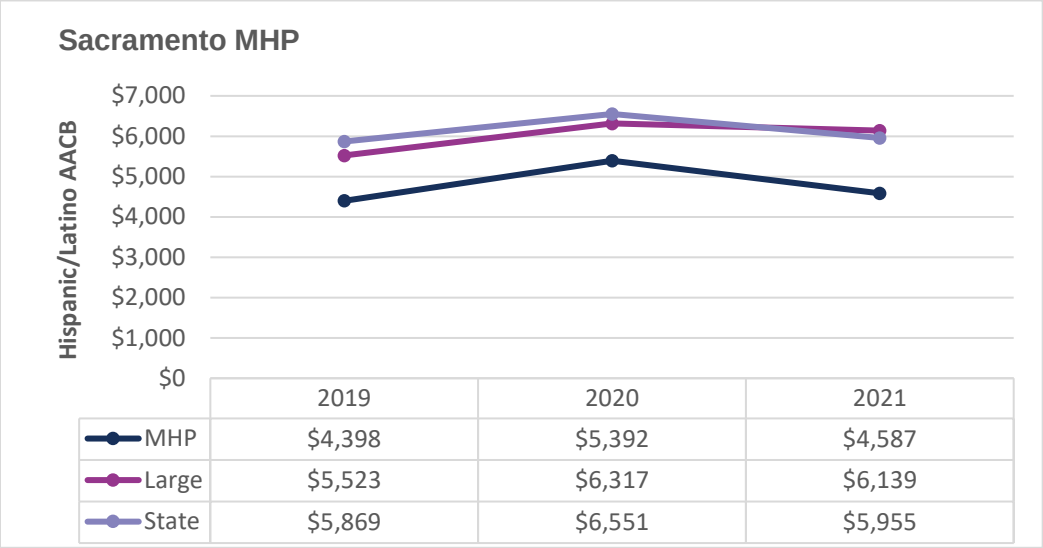
Figure 6: Hispanic/Latino PR CY 2019-2021



	2019	2020	2021
MHP	3.58%	3.43%	3.14%
Large	3.52%	3.31%	2.84%
State	4.08%	3.83%	3.29%

- Hispanic/Latino PR for statewide, large county and Sacramento declined each year from CY 2019 to CY 2021.

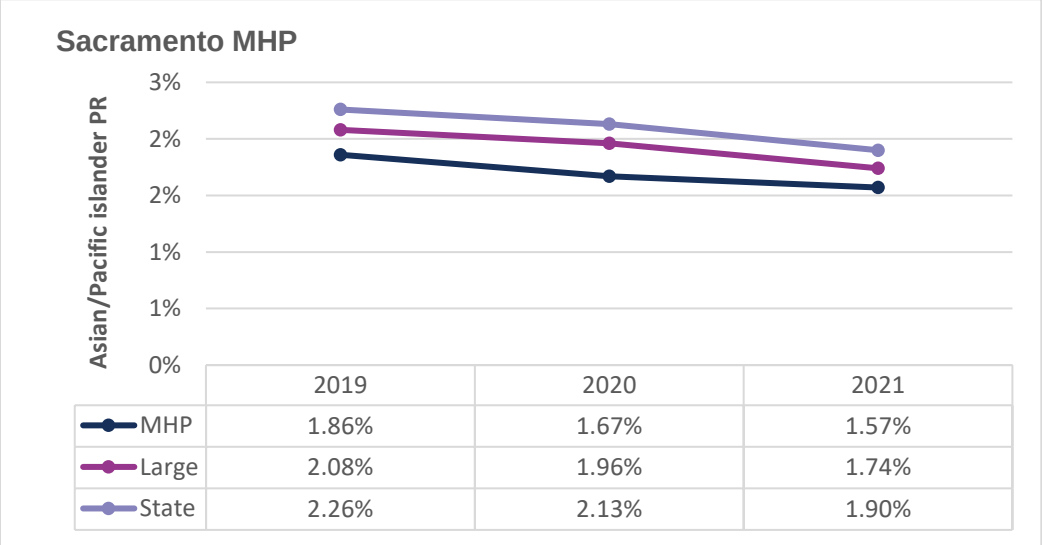
Figure 7: Hispanic/Latino AACB CY 2019-2021



	2019	2020	2021
MHP	$4,398	$5,392	$4,587
Large	$5,523	$6,317	$6,139
State	$5,869	$6,551	$5,955

- Billing rates impacted by the COVID-19 pandemic likely had an impact on the AACB increase seen from CY 2019 to CY 2020. Sacramento's Hispanic/Latino AACB was lower than that of the statewide and large county averages across all three years.

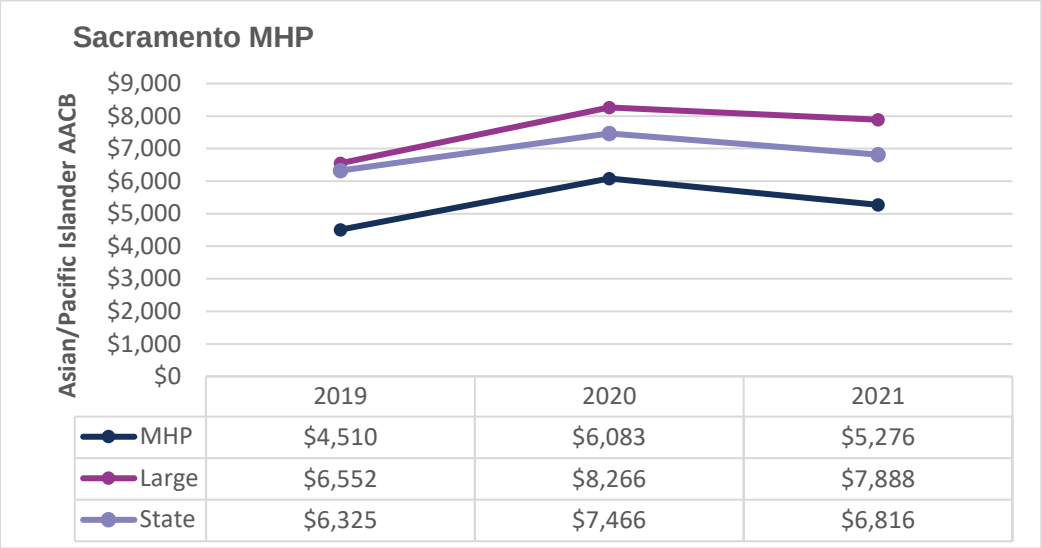
Figure 8: Asian/Pacific Islander PR CY 2019-2021



	2019	2020	2021
MHP	1.86%	1.67%	1.57%
Large	2.08%	1.96%	1.74%
State	2.26%	2.13%	1.90%

- API PR for statewide, large county and Sacramento declined each year from CY 2019 to CY 2021.

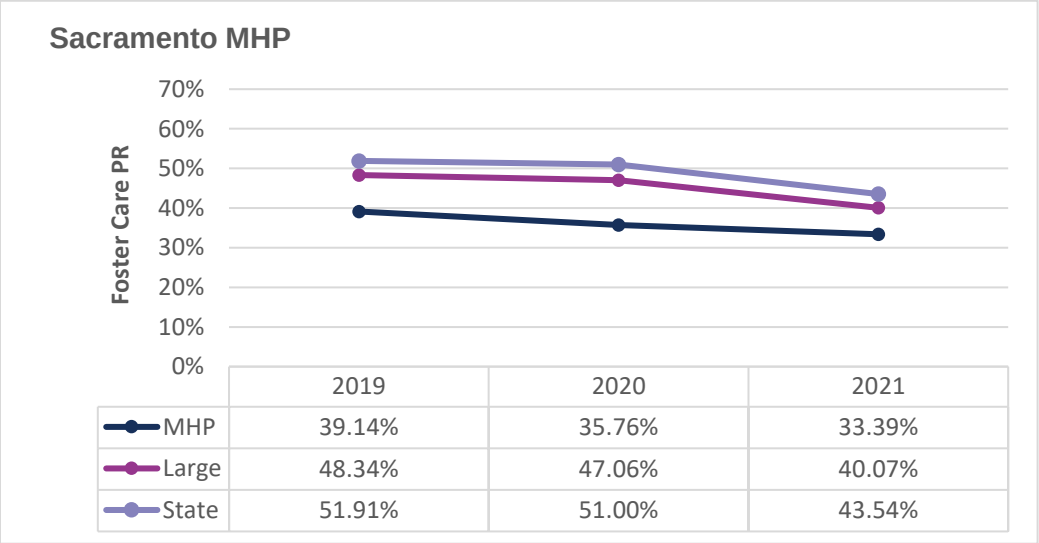
Figure 9: Asian/Pacific Islander AACB CY 2019-2021



	2019	2020	2021
MHP	$4,510	$6,083	$5,276
Large	$6,552	$8,266	$7,888
State	$6,325	$7,466	$6,816

- COVID-19 rates likely had an impact on the AACB increase from seen CY 2019 to CY 2020.
- Sacramento's API PR and average approved claims per beneficiary were lower than that of the statewide and large county averages across all three years.

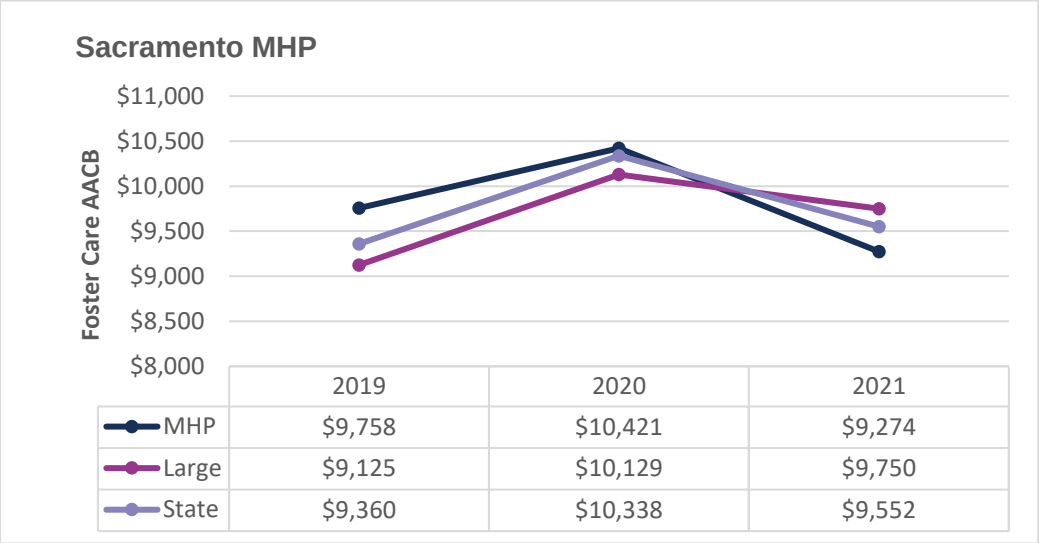
Figure 10: Foster Care PR CY 2019-2021



	2019	2020	2021
MHP	39.14%	35.76%	33.39%
Large	48.34%	47.06%	40.07%
State	51.91%	51.00%	43.54%

- While Sacramento's FC PRs were lower than both the large county and statewide averages from CY2019 to CY 2021, PR for statewide, large county, and Sacramento declined each year from CY 2019 to CY 2021. Sacramento's FC PRs were lower than statewide and large county averages across all three years.

Figure 11 Foster Care AACB CY 2019-2021



	2019	2020	2021
MHP	$9,758	$10,421	$9,274
Large	$9,125	$10,129	$9,750
State	$9,360	$10,338	$9,552

- Billing rates impacted by the COVID-19 pandemic likely had an impact on the AACB increase seen from CY 2019 to CY 2020. Sacramento's AACB is comparable to statewide and large county averages.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 14,419				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	440	3.1%	10	7	10.8%	14	8
Inpatient Admin	≤11	-	-	-	0.4%	16	7
Psychiatric Health Facility	393	2.7%	18	12	1.0%	16	8
Residential	≤11	-	-	-	0.3%	93	73
Crisis Residential	349	2.4%	22	23	1.9%	20	14
Per Minute Services							
Crisis Stabilization	925	6.4%	1,453	1,200	9.7%	1,463	1,200
Crisis Intervention	1,310	9.1%	127	79	11.1%	240	150
Medication Support	9,789	67.9%	272	188	60.4%	255	165
Mental Health Services	11,672	80.9%	688	359	62.9%	763	334
Targeted Case Management	8,155	56.6%	312	109	35.7%	377	128

- Sacramento shows more adults receiving targeted case management (TCM), medication support (MS) and mental health services (MHS) than statewide. However, the average units are lower for those who receive TCM and MHS, and slightly higher for those who receive MS.
- Psychiatric Health Facility (PHF) use is higher in Sacramento as they have added more Medi-Cal billable PHF facilities. Inpatient facility use is difficult to compare statewide as Sacramento uses a number of large IMD- (Institutes for Mental Disease) excluded facilities.
- While Sacramento appears to rely upon crisis residential, in general, it does not appear to place beneficiaries in residential facilities that bill to SD/MC.

Table 9: Services Delivered by the MHP to Youth in Foster Care

Service Category	MHP N = 929				Statewide N=33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	58	6.2%	15	9	4.5%	13	8
Inpatient Admin	≤11	-	-	-	≤11	6	4
Psychiatric Health Facility	≤11	-	-	-	0.2%	25	9
Residential	≤11	-	-	-	≤11	140	140
Crisis Residential	≤11	-	-	-	0.1%	16	12
Full Day Intensive	≤11	-	-	-	0.2%	452	360
Full Day Rehab	≤11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	18	1.9%	971	1,080	2.3%	1,354	1,200
Crisis Intervention	71	7.6%	248	124	6.7%	388	195
Medication Support	344	37.0%	355	270	28.5%	338	232
TBS	58	6.2%	2,304	1,616	3.8%	3,648	2,095
Therapeutic FC (TFC)	≤11	-	-	-	0.1%	1,056	585
Intensive Home Based Services	382	41.1%	821	388	38.6%	1,193	445
Intensive Care Coordination (ICC)	131	14.1%	1,002	532	19.9%	1,996	1,146
Katie-A-Like	≤11	-	-	-	0.2%	837	435
Mental Health Services	895	96.3%	1,414	922	95.7%	1,583	987
Case Management	656	70.6%	441	200	32.7%	308	114

- Sacramento's FC PR is relatively lower than statewide, and of those receiving SMHS, Sacramento shows more foster youth receiving inpatient care and for longer average lengths of stay. Additionally, more foster youth receive medication support and significantly more TCM.
- While the MHP shows high rates of TCM, it has relatively low rates of ICC; this may represent lack of comprehensive child/family team treatment planning, or it could be a function of coding such collaboration as TCM instead of ICC.
- There have been no significant changes to TFC and open enrollment continues.

IMPACT OF ACCESS FINDINGS

- The MHP has begun to implement many of the current and upcoming CalAIM protocols. They have prepared by hiring new staff, holding monthly meetings with managed care providers to discuss authorizations, data exchange and billing differences. The MHP is streamlining documentation as they prepare for payment reform.
- The MHP has opened several new Access points for beneficiaries to access services and resources. The MHP stated challenges in filling staffing positions which key informants suggest leads to confusion as to appropriate referrals to services. As reported referrals, at times, are based on proximity to beneficiary verses actual services provided.
- Overall and subgroup penetration rates for Sacramento, statewide and large county averages declined each year from CY 2019 to CY 2021.
- There were 1,738 beneficiaries served by the MHP who identified Spanish as a preferred language, 7.88 percent of the beneficiaries served by the MHP indicating a notable population of monolingual Spanish speaking beneficiaries.
- Hispanic/Latino beneficiaries comprising 22 percent of the eligible population and 18 percent of those served. The Hispanic/Latino population, both English and non-English speaking, should be a continued focus for outreach and engagement.
- API beneficiaries compressed 13 percent of the eligible population and five percent of those served. The disproportionality between the percentage of the API eligible population and the percentage of those served indicates that this population may be underserved and offers the MHP an opportunity for additional outreach to API populations.

TIMELINESS OF CARE

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

Each Timeliness Component is comprised of individual subcomponents, which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Not Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Not Met

Strengths and opportunities associated with the timeliness components identified above include:

- The MHP tracks numerous elements to guide program design and structure.
- Readmission rates are reported as lower than the statewide average. The MHP works diligently with beneficiaries to reduce readmission rates.

- The MHP continues to face challenges when reporting data metrics on the Assessment of Timely Access. FC numbers on First Non-Urgent Service remains under-reported, Non-Urgent Psychiatry was not tracked during the reporting period and No-Show rates are under-reported.
- The MHP reported challenges and lack of consistency acquiring the necessary reporting numbers from the numerous Contractors.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Counties are also expected to submit the source data used to prepare these calculations. This is particularly relevant to data validation for the additional statewide focused study on timeliness that BHC is conducting.

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of CY 2021. This data represented the entire system of care. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows.

Claims data for timely access to post-hospital care and readmissions are discussed in the Quality of Care section.

Table 11: FY 2021-22 MHP Assessment of Timely Access

MHP			
Timeliness Measure	**Average**	**Standard[2]**	**% That Meet Standard**
First Non-Urgent Appointment Offered	5.3 Days	10-Business Days*	83.7%
First Non-Urgent Service Rendered	5.4 Days	10 days**	84.7%
First Non-Urgent Psychiatry Appointment Offered	***	15-Business Days*	***
First Non-Urgent Psychiatry Service Rendered	29 Days	15 days**	25%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	9.9 Hours	48-Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	12.2 Days	7 Days**	37.1%
No-Show Rate – Psychiatry	2.7%	****	n/a
No-Show Rate – Clinicians	1.2%	****	n/a

* DHCS-defined timeliness standard as per BHIN 21-023 and 22-033

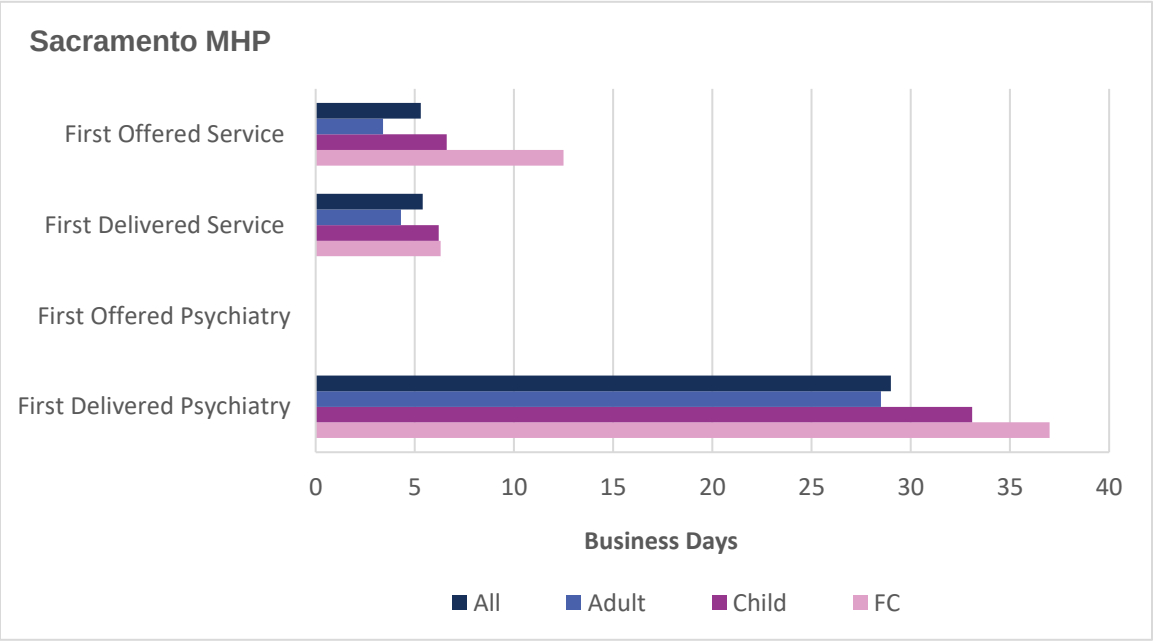
MHP-defined timeliness standards

*** MHP did not report data for this measure

**** The MHP does not set a standard for this measure

[2] DHCS-defined standards, unless otherwise noted.

Figure 12: Wait Times to First Service and First Psychiatry Service



- "First offered psychiatry" service is not tracked by the MHP.

Figure 13: Wait Times for Urgent Services

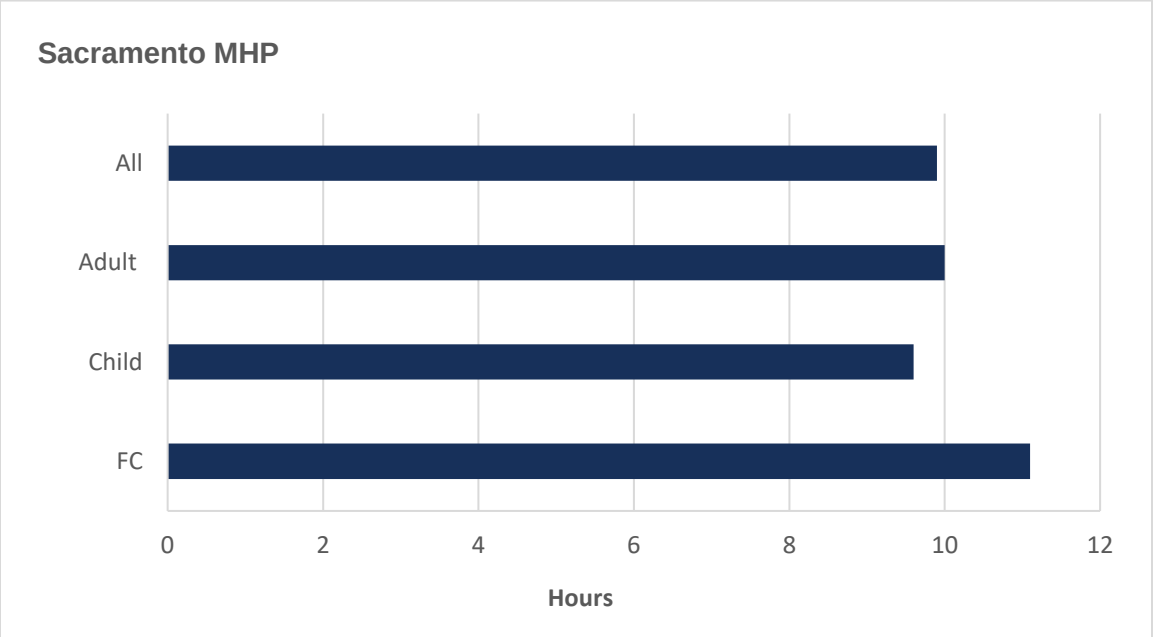
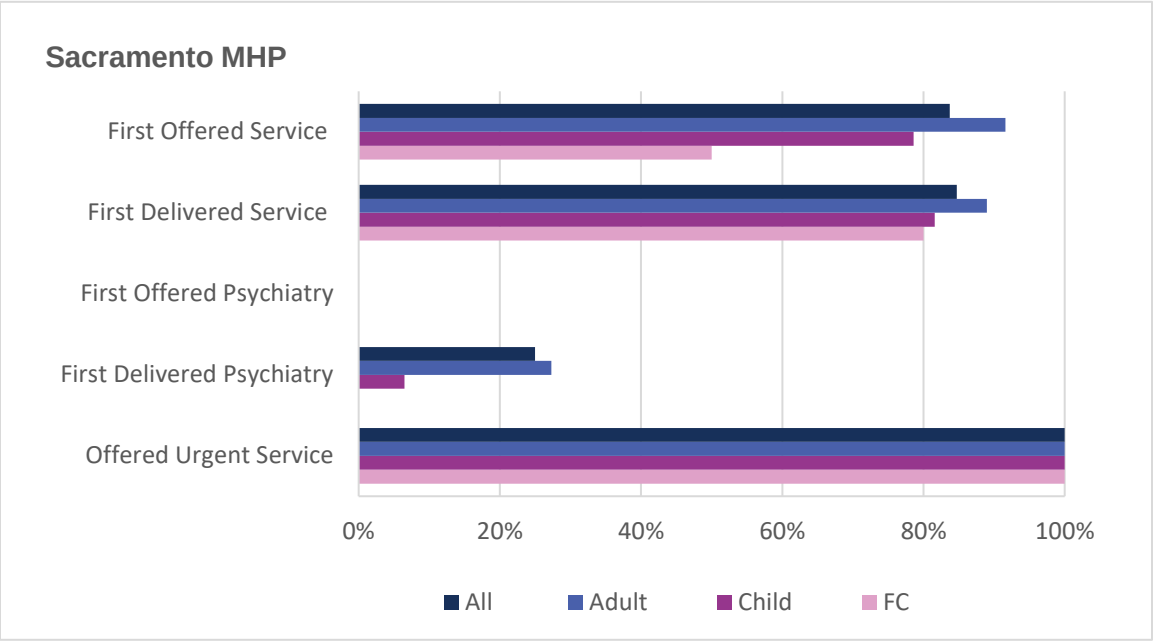


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent when a beneficiary walks into a clinic or Urgent Care clinic, they receive their first service. Contract providers figure out the best way to offer same day services.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined "urgent services" for purposes of the ATA as a "condition is such that the beneficiary faces an imminent and serious threat to his or her health …" and/or "the normal time frame for the decision-making process would be detrimental to the beneficiary's life or health or could jeopardize the beneficiary's ability to regain maximum function." There were reportedly 4,049 urgent service requests with a reported actual wait time to services for the overall population at an average of 9.9 hours.
- Timely access to psychiatry may be defined by the County MHP. The process as well as the definitions and tracking may differ for adults and children. The MHP has defined psychiatry access in the submission as measured from the first determination of clinical need for both adults and children.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked with an average rate of 2.7% for psychiatry and 1.2% for non-psychiatry staff. This represents an unusually low no-show rate that suggests that it may not represent the entire data set.

IMPACT OF TIMELINESS FINDINGS

- The MHP does not accurately count, report, and trend No Shows. The data does not offer the MHP the ability to improve Timeliness without accurate collection and reporting by all providers.
- Data in the Assessment of Timely Access report is challenging to report, due to the numerous IMD exclusion facilities that provide psychiatric in-patient services.
- The MHP will be changing Electronic Health Record (EHR) as it moves to the required elements of tracking and trending timeliness data requirement through CalAIM.
- The MHP is currently piloting the new Assessment Screening Tool as provided by DHCS in preparation for CalAIM requirements.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to beneficiaries. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

In the MHP, the Quality Improvement Policy Council guides the Mental Health Plan's QI processes. The Policy Council also functions as the Executive Management Team for the Mental Health Division. In the MHP, the responsibility for QI is under the Quality Management team, which consists of 27 positions. Within QM, lies the positions of compliance, QI and data collection and analysis. QM is a structure throughout the MHP and quality improvements are brought forth by contractors and staff then elevated to QM topics for discussion.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QIWP workplan, and the annual evaluation of the QIWP workplan. The QIC, comprised of representatives of the MHP, the Drug Medi-Cal Organized Delivery System (DMC-ODS), contract providers, and beneficiaries and family members, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met 10 times. Of the 20 identified FY 2021-22 QAPI workplan goals, the MHP met or addressed all goals. Below are some highlights provided by the MHP of information detailed in the report.

- Through the ten CORE clinics, mental health services will be provided in geographically diverse locations that best represent the community needs.
- The MHP continues to maintain a multi-tiered crisis service continuum.
- Timeliness to first Non-Urgent service within the benchmark of ten business days, increased in adult services from 84.3 percent in review FY 2021-22 to 91.6 percent in FY 2022-23.
- The MHP identifies compliance and service-related goals. By not drilling down to beneficiary level impact outcomes, it is challenging to determine trends within the individual or larger aggregate group of children or adults receiving clinical services.

The MHP utilizes the following LOC tool: LOCUS, ANSA, Pediatric Symptom Checklist (PSC-35), and Child and Adolescent Needs and Strengths (CANS). The MHP reports aggregated data on a systems level basis. The LOCUS is used with individual

beneficiaries when working on treatment planning. The MHP does not currently aggregate PSC-35 data.

The MHP utilizes the following outcomes tools: CANS, PSC-35, ANSA and LOCUS.

The CANS is used to track improved outcomes including, Caregiver Resource and Needs, Risk Behaviors, Life Domain Functioning, Cultural Factors, Strengths and transition to adulthood and Child Behavioral/Emotional Needs and trauma.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

Each Quality Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

Strengths and opportunities associated with the quality components identified above include:

- The MHP is trending on target for all aspects and expectations of CalAIM implementation.
- The MHP negotiated with their HR department to increase employee and Contractor pay, and created a County Peer employment ladder, including supervisory positions.
- The MHP focuses in-depth on cultural and racial equity and outreach effort throughout the numerous threshold languages within the community, and identifies, in partnership with stakeholders, appropriate services.
- The challenge the MHP faces with the numerous threshold languages is the ability to consistently inform the various communities of services. Key informants within the Spanish speaking community were not aware of transportation options or crisis line information, as compared to key informants who were English speaking.
- The MHP and Contractors provide numerous trainings with the expectation of the transfer of knowledge from the trainings. Key informants relayed not knowing about trainings within the current EHR and how to prepare for upcoming CalAIM requirements. Neither the MHP nor Contractors consistently track for training compliance with staff or within the contract management discussions.
- The MHP does track but does not trend the following HEDIS measures as required by WIC Section 14717.5:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD).
    - The Use of Multiple Concurrent Psychotropic Medications for Children and Adolescents (HEDIS APC).
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
    - The Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented in the approved claims:

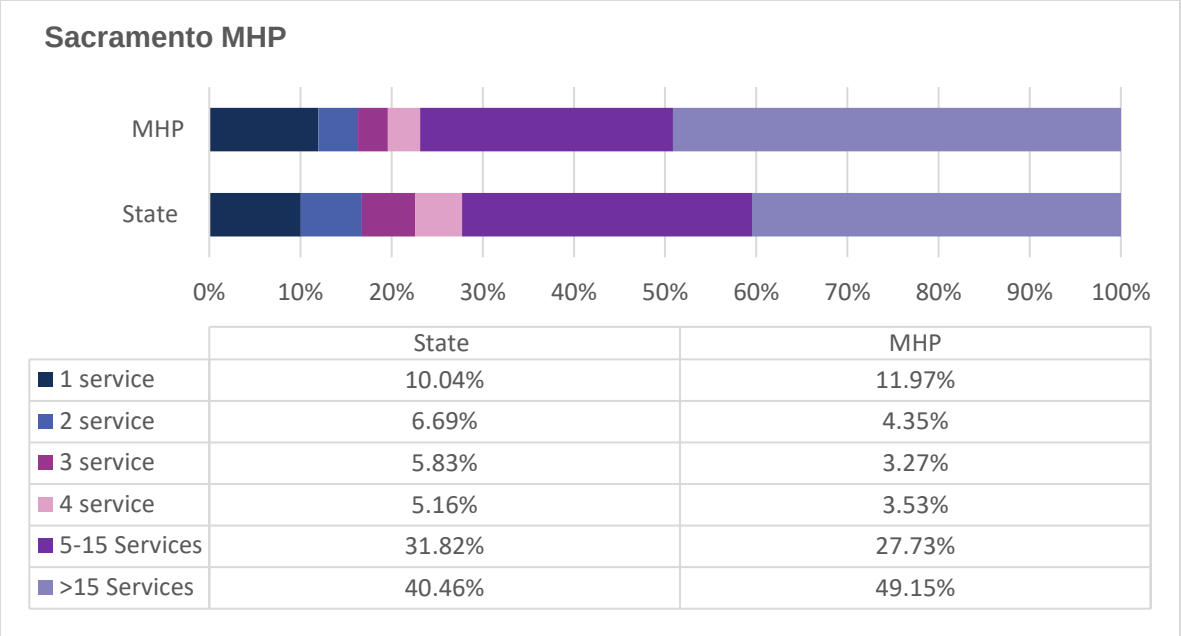
- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates

- High-Cost Beneficiaries (HCB)

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.04%	11.97%
2 service	6.69%	4.35%
3 service	5.83%	3.27%
4 service	5.16%	3.53%
5-15 Services	31.82%	27.73%
>15 Services	40.46%	49.15%

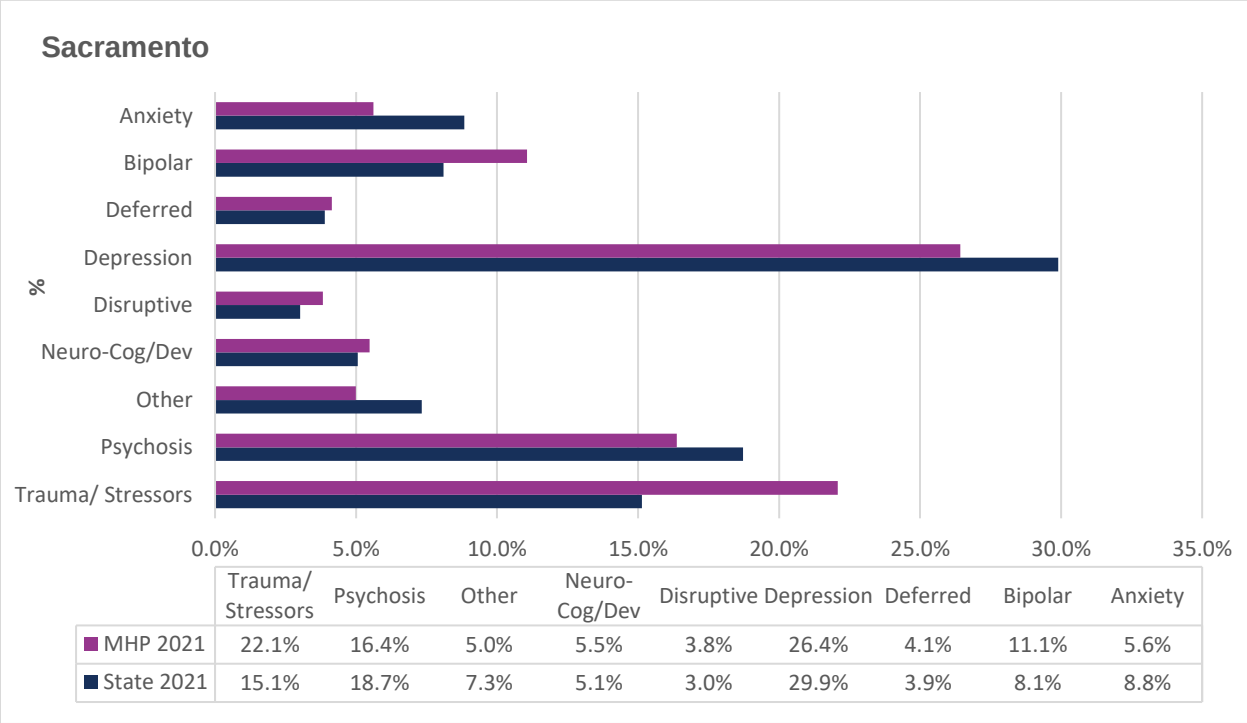
- The MHP provided more than 15 services to almost half (49.15 percent) of its beneficiaries, approximately 21 percent greater than the 40.46 percent statewide average.
- No retention disparity was observed for Hispanic/Latino and API beneficiaries when compared to Sacramento's overall retention data. The Hispanic/Latino beneficiary one service average was 12.64 percent and 50.61 percent received more than 15 services. The API beneficiary one service average was 8.5 percent and 47.47 percent received more than 15 services. FC youth had the highest percentage of greater than 15 services, 62.22%.
- Considering the PR and overall engagement patterns, outliers might require drill-down into the retention data for subpopulations.

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of

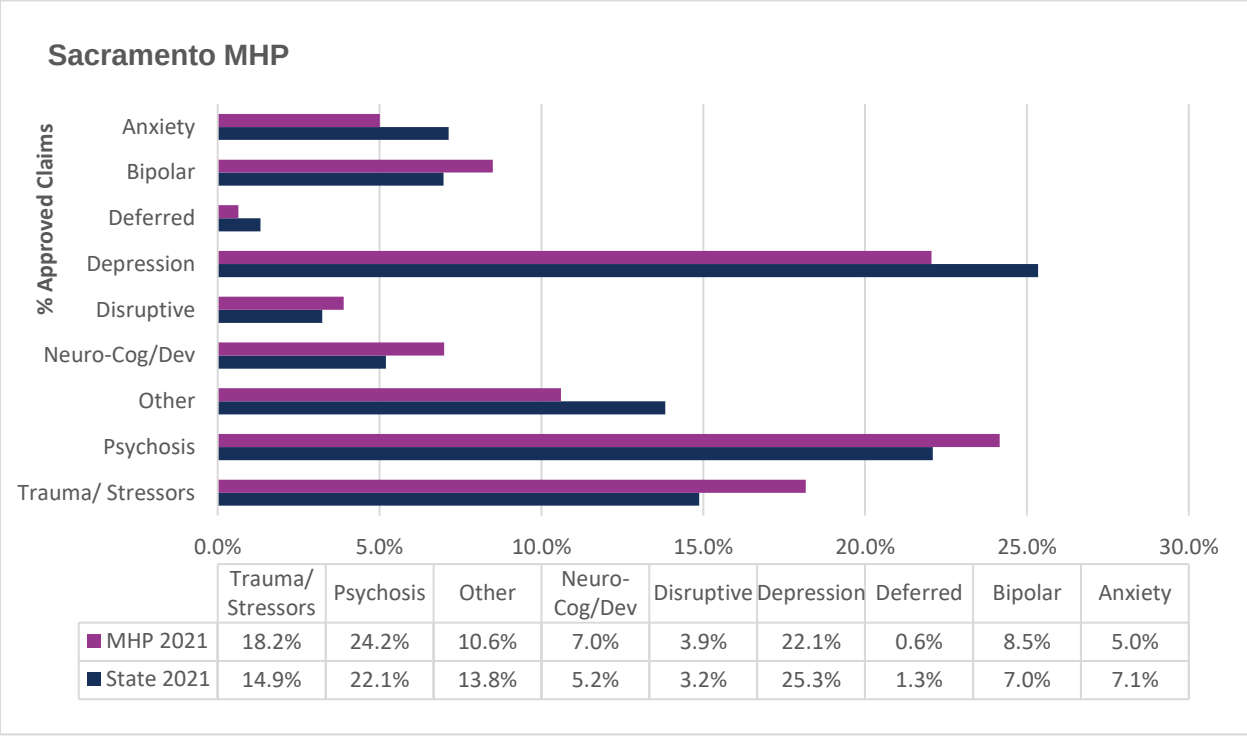
delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	22.1%	16.4%	5.0%	5.5%	3.8%	26.4%	4.1%	11.1%	5.6%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	18.2%	24.2%	10.6%	7.0%	3.9%	22.1%	0.6%	8.5%	5.0%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- Approximately 65 percent of beneficiaries had one of three diagnoses: depression disorders (26.5 percent), trauma/stressor related disorders (21.7 percent), psychosis (16.6 percent). While comparatively fewer beneficiaries are diagnosed with a psychotic disorder compared to statewide, the MHP allocates more of its claimed dollars to psychotic disorders.
- Sacramento had a higher percentage of trauma/stressor related disorders (21.7 percent vs. 14.9 percent) and bipolar disorders (11.2 percent vs. 7.6 percent) and a lower percentage of anxiety disorders (5.6 percent vs. 8.8 percent) when compared to statewide averages. Approved claims dollars were reasonably aligned with the distribution of services by diagnosis.

Psychiatric Inpatient Services

The following figure provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay.

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	1,441	2,518	10.37	8.79	$12,318	$12,052	$17,750,558
CY 2020	1,518	2,687	10.90	8.68	$12,432	$11,814	$18,872,005
CY 2019	1,540	2,857	10.28	7.63	$11,265	$10,212	$17,347,981

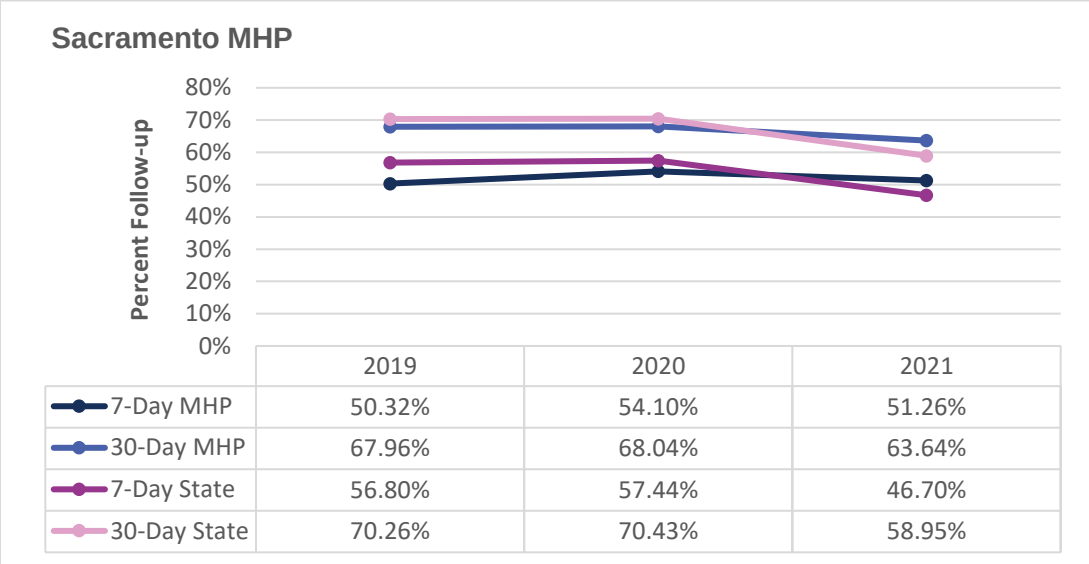
- Because the MHP relies upon large facilities subject to the IMD exclusion, the approved claims data set represents a subset of all hospitalizations. The MHP reported in its ATA submission 5,324 inpatient admissions, indicating that the above inpatient data reflects 47% of the MHP's hospitalization admissions.
- The inpatient LOS remained stable from CY 2019 to CY 2021 and remained greater than the statewide average in CY 2021 (10.37 days vs. 8.37 days).

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

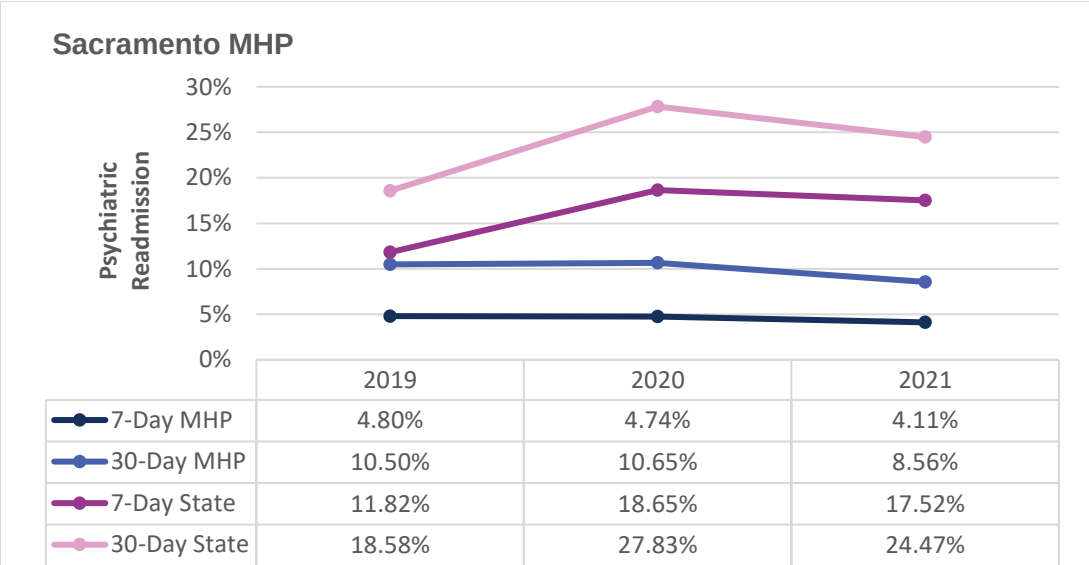
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	50.32%	54.10%	51.26%
30-Day MHP	67.96%	68.04%	63.64%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	4.80%	4.74%	4.11%
30-Day MHP	10.50%	10.65%	8.56%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The 7-day post psychiatric inpatient follow-up rate remained stable from CY 2019 to CY 2021 and was greater than the statewide average in CY 2021 (51.26 percent vs. 46.70 percent).
- The 30-day follow-up rate declined from CY 2020 to CY 2021 (68.04 percent vs. 63.64 percent) and was above the statewide average in CY 2021 (63.64 percent vs. 58.95 percent). The MHP reports its 30-day follow-up at 37.1 percent. This may suggest that the Medi-Cal facilities have stronger performance in linking to post-discharge services.
- The 7-day psychiatric readmission rate remained stable from CY 2019 to CY 2021 and was significantly lower than the statewide average in CY 2021 (4.11

percent vs. 17.52 percent). The MHP similarly reports its 7-day readmission rate at 4.2 percent.

- The 30-day psychiatric readmission rate decreased from CY 2020 to CY 2021 (10.65 percent vs. 8.56 percent) and was significantly lower than the statewide average in CY 2021 (8.56 percent vs. 24.47 percent). Using the entire inpatient data set, the MHP reports its 30-day readmission rate at 19.4 percent.

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCBs may disproportionately occupy treatment slots that may prevent access to levels of care by other beneficiaries. HCB percentage of total claims, when compared with the HCB count percentage, provides a subset of the beneficiary population that warrants close utilization review, both for appropriateness of LOC and expected outcomes.

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $6,496, the median amount is just $2,928.

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	494	22,455	2.20%	$47,015	$40,173
	CY 2020	644	23,228	2.77%	$49,305	$41,364
	CY 2019	478	23,842	2.00%	$48,398	$40,031

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	596	2.66%	$14,327,839	11.89%	$24,019	$23,502
Low Cost (Less than $20K)	21,357	95.14%	$80,528,883	64.41%	$3,648	$2,307

The number of high-cost beneficiaries declined from CY 2020 to CY 2021 (644 vs. 494) and the percent of high-cost beneficiaries also declined during this period 2.77 percent vs. 2.20). The percent of high-cost beneficiaries in CY 2021 was approximately 36 percent lower than the statewide average (2.20 percent vs. 3.46 percent) and the average approved claims dollars per high-cost beneficiaries was 12 percent lower than the statewide average ($47,015 vs. $53,476). Twenty percent of Sacramento's approved claims dollars served 2.2 percent of their beneficiaries.

Figure 20: Proportion of Beneficiary Count by Claim Amount Grouping CY 2021

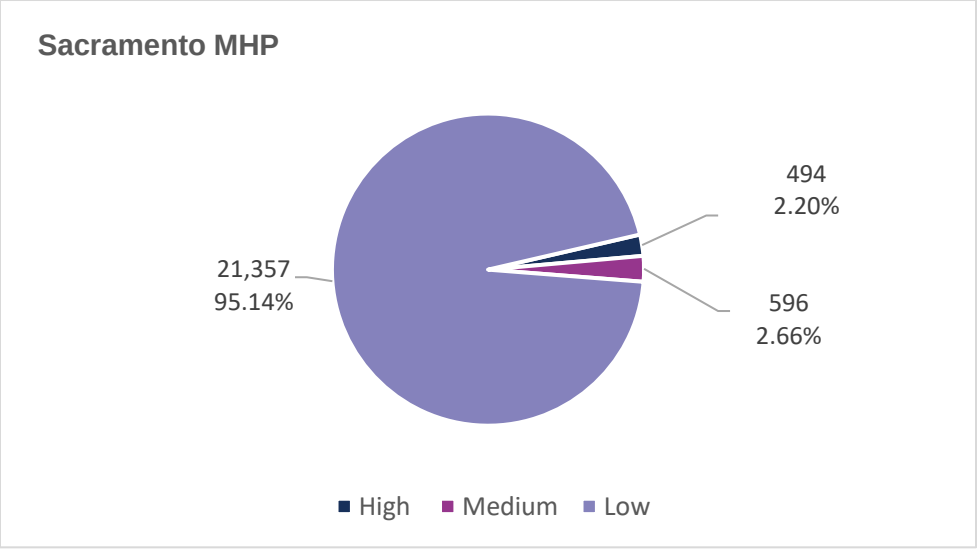
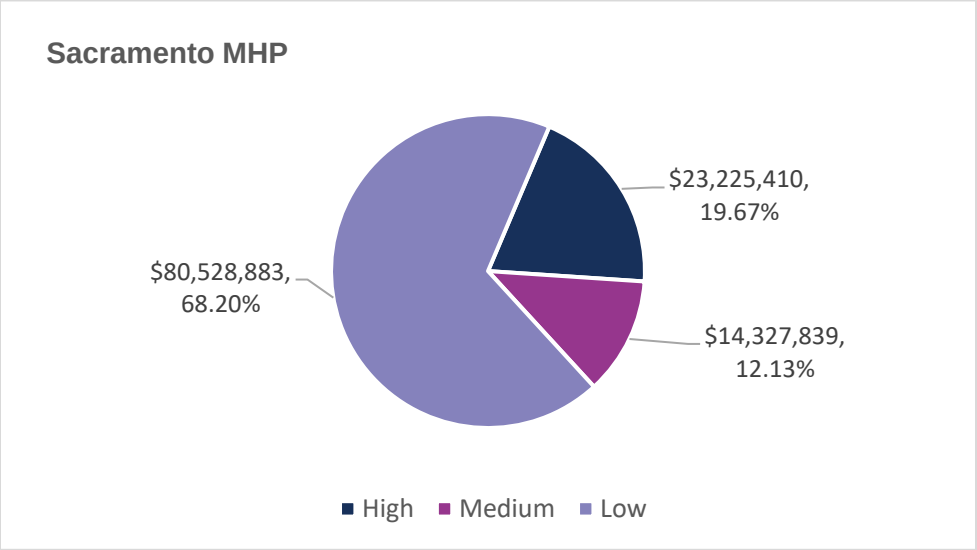


Figure 21: Approved Claims by Cost Type CY 2021



IMPACT OF QUALITY FINDINGS

- Approximately 65 percent of beneficiaries have one of three diagnoses: depression disorders (26.5 percent), trauma/stressor related disorders (21.7 percent), psychosis (16.6 percent).
- The MHP provided more than 15 services to almost half (49.15 percent) of its beneficiaries. No disparity was observed among Latino/Hispanic or API beneficiaries receiving greater than 15 services.
- The MHP is adapting Quality services to provide the necessary staffing to support CalAIM.
- The MHP is also proactively involved in Peer Certification, to prepare the Peer workforce to bill services rendered.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[3] and 457.1240(b)[4]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Appendix C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: "Racial Equity Action Plans"

Date Started: 01/2022

Aim Statement: "How will training improve the clinical outcomes? MHP will increase the retention of clients by 10% by training staff in racial equity training. By equipping staff with appropriate clinical language tailored to the priority population."

Target Population: "The entire population of African American enrollees served by the six identified providers will be affected by this PIP. At the baseline year of FY 20/21, this number was 2,637. Their ages range from 3 to 96, with 53% women, and 47% men."

Status of PIP: The MHP's clinical PIP is in the first remeasurement phase.

Summary

The MHP in collaboration with the California Institute for Behavioral Health Solutions, facilitated the MHP Behavioral Health Racial Equity Collaborative (BHREC) beginning in

[3] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[4] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

November 2020. The intention of the BHREC was to use a targeted universalism approach to advance behavioral health equity for the African American/Black/of African Descent (AA/B/AD) communities within the MHP communities. Qualitative data from the BHREC Steering Committee and state level reports, was used to define and prioritize the BHREC racial equity program level goals. The goal of this PIP is to implement strategies identified in the Racial Equity Action Plans (REAPs) focused on the recruitment and retention of provider staff from the AA/B/AD community and increase the racial equity training for all provider staff.

The brand-new training aimed to make real changes, shown in the outcomes, on the inequalities within treatment, rather than the original training which aimed to help staff understand working with beneficiaries through a culturally competent lens. Variables were selected to measure any changes in the utilization of the service continuum, by looking at early disengagement and unsuccessful discharges within the AA/B/AD community.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: The challenge of the PIP as submitted, though equities in racial services is an excellent topic, is that it lacks clinical impact and outcomes. Training is not in itself a clinical outcome. The MHP has chosen a large population of all age groups, the PIP may better be served narrowing down the test population. The PIP does not have a target improvement rate and the interventions are not clinical in nature.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this clinical PIP including:

- The MHP is recommended to reword the PIP to follow the flow of the PIP Development Tool. There is definition and data drift, what are the goals, problems, barriers, interventions, variables (indicators), PMs (outcomes) and target improvement rate. And, how does that tie into the clinical impact on the beneficiary?
- When looking at racial equity outcomes, a smaller test population could be more meaningful when implementing a clinical goal.
- The MHP did engage in TA in January 2022, it is recommended the MHP seek out TA throughout the development and formation process of a PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: “Admissions at Provider Site”

Date Started: 07/2022

Aim Statement: “Does providing an option for beneficiaries to access services directly from the contracted provider improve or maintain the timeliness from request to first assessment appointment and then to first treatment appointment within 18 months?”

Target Population: “The study population will include children ages 3-18 in the MHP admitted to the four Outpatient providers who will be providing walk in services as part of the pilot. Pacific Clinics (previously Uplift Family Services), University of California, Davis Child and Adolescent Abuse Resource and Evaluation, La Familia Counseling Center, and Capital Star Community Services. In FY2020-21 there were 1,045 Beneficiaries who completed their First Assessment with La Familia-Flexible Integrated Treatment (FIT), Star-FIT, UCD-FIT, Uplift-FIT-Performance or Uplift-FIT-Tech Center.”

Status of PIP: The MHP’s non-clinical PIP is in the baseline year.

Summary

The PIP goal is to improve or maintain the timeliness from request for services to assessment and subsequently to first treatment appointment, by allowing beneficiaries to request services directly from the provider by phone call or walk-in services. The PIP variable is: Increase access opportunities by providing open drop-in hours at least two times per week, at five sites throughout the county. The PMs are 1) change in days between service request and initial assessment for beneficiaries utilizing the walk-in hours option 2) change in days between initial assessment and first treatment appointment for beneficiaries utilizing the walk-in hours option 3) change in the Percentage of beneficiaries who attend both the initial assessment AND the initial treatment appointment.

Four select providers, at five scattered sites, established weekly drop-in hours in which beneficiaries are permitted to request access to services in-person or by phone, complete an intake assessment, and establish an assigned clinician. Due to barriers such as staffing shortages and significant MHP changes, the PIP strategy went live on July 1, 2022. There was not enough time to do a remeasurement in this reporting period. Baseline data was presented as an average across all four identified providers, covering five service sites.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: The MHP has not adequately presented their goals, indictors and outcomes, though they have rich data the PIP will be collecting, the AIM statement lacks the measurable indictor the PIP is attempting to improve.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this non-clinical PIP including:

- Similar to the Clinical PIP above, the non-clinical PIP could use restructuring to follow the flow of the PIP Development Tool. There is definition and data drift,

what are the goals, problems, barriers, interventions, variables (indicators), PMs (outcomes) and target improvement rate.

- Rewording the AIM statement would clarify first treatment appointment is not within 18-months, but instead the course of the PIP is the full 18-months. And, within the AIM statement, what is the baseline the MHP is trying to improve?
- The MHP is recommended to provide a satisfaction survey to caregiver/family members of youth on their ability to access services of an urgent nature. Did the urgent access decrease the youth symptoms, did they receive services as stated in the Urgent protocol?
- The MHP is recommended to seek out TA earlier in the development process and throughout the formation of the PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/Avatar, which has been in use for 13 years. Currently, the MHP has selected a new system but is not yet in the implementation phase.

Approximately 3.2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). This is a decline from 4.12 percent reported in the prior year. The MHP attributes the budget decrease to COVID-19 related purchases made in the prior year to support staff who were working remotely. The budget determination process for IS operations is a combined process involving MHP control, Behavioral Health IS and County IS.

The MHP has 2,046 named users with log-on authority to the EHR, including approximately 581 county staff and 1,654 contractor staff. Support for the users is provided by 12 full-time equivalent (FTE) IS technology positions which support BHS, mental health and DMC-ODS. There is currently one vacancy, an IT Analyst. This position adds one FTE to IT staffing and will support the implementation of and provide ongoing support to the Wellness Crisis Call Center.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	90%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	10%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR. This functionality is expected to be implemented in the next two years.

Interoperability Support

The MHP is a member/participant in the Carequality interoperability framework which allows for the exchange of health information between health information networks. Carequality promotes interoperability with a common set of rules and technical standards. MHP professional staff can also use secure information exchange directly with service partners through secure email, and electronic consult. The MHP engages in electronic exchange of information with the following departments, agencies, and organizations: mental health contract providers, alcohol and drug contract providers, primary care providers and hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic

findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

Strengths and opportunities associated with the IS components identified above include:

- The MHP has selected the CalMHSA semi-statewide CalMHSA Streamline EHR as the replacement for the Avatar system. This project is not yet in the implementation phase.
- While an online IT training calendar is available to MHP and contract provider staff, multiple stakeholders reported being unaware of Avatar NX trainings until after the software upgrade went live.
- Twelve IT FTEs support BHS. There was an increase of one FTE in the past year. The new FTE will support the implementation of and provide ongoing support to the Wellness Crisis Call Center.
- The MHP does not have a data warehouse which replicates the Avatar system.
- Data analytics is provided by the Research and Evaluation unit which has eight FTEs. One new FTE will be added to support CalAIM reporting requirements. The position is in recruitment.
- Contract providers have full access to Avatar with 90 percent of services entered directly into Avatar by contract provider staff.
- The PSC-35 and the ACES were implemented in Avatar.
- Two-factor authentication to authorize user password changes is not supported.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the table below, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY21.

For the MHP, the chart indicates that a claims lag begins in November and likely represents approximately $22,000,000 in services not yet shown in the approved claims provided. While it appears that very few claims were processed in November and December, the MHP indicates that claims were submitted in a timely manner throughout the year.

Table 18: Summary of Monthly Approved and Denied Claims CY2021

Month	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	$11,272,952	$273,912	2.43%	$10,999,040
Feb	$11,325,115	$237,340	2.10%	$11,087,775
Mar	$13,364,828	$286,309	2.14%	$13,078,519
April	$12,176,647	$272,578	2.24%	$11,904,069
May	$11,105,080	$209,728	1.89%	$10,895,153
June	$11,574,350	$179,212	1.55%	$11,394,788
July	$9,972,845	$200,806	2.01%	$9,772,039
Aug	$10,138,106	$242,272	2.39%	$9,895,834
Sept	$9,733,116	$251,269	2.58%	$9,481,847
Oct	$8,794,876	$180,506	2.05%	$8,614,370
Nov	$170,159	$1,076	0.63%	$169,083
Dec	$865	$0	0.00%	$865
Total	**$109,628,939**	**$2,335,008**	**2.13%**	**$107,293,382**

Table 19: Summary of Denied Claims by Reason Code CY2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	3,817	$824,316	35.30%
Medicare Part B or Other Health Coverage must be billed before submission of claim	2,213	$584,966	25.05%
Beneficiary not eligible or non-covered charges	1,773	$405,502	17.37%
NPI related	466	$184,253	7.89%
Service line is a duplicate and a repeat service procedure code modifier not present	688	$178,994	7.67%
Other	495	$156,979	6.72%
Total Denied Claims	9,452	$2,335,010	100.00%
Overall Denied Claims Rate	2.13%		
Statewide Overall Denied Claims Rate	2.78%		

- Sacramento's claim denial rate for CY 2021 of 2.13 percent is lower than the statewide average, 2.78 percent.
- Claims with denial codes claim/service lacks information which is needed for adjudication, Medicare Part B or other health coverage must be billed prior to the submission of this claim, and NPI related are generally rebillable within State guidelines upon successful remediation of the reason for denial.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The Research and Evaluation team contains 12 FTEs which effectively support the reporting and analytic needs of the organization.
- The MHP's participation in the Carequality interoperability framework allows for the accurate and timely electronic exchange of health information between health information networks, including primary care providers and hospitals.
- The implementation of the PSC-35 and ACES into Avatar creates the opportunity for reporting and analysis of the data contained in these tools.
- The lack of knowledge of Avatar training opportunities is a barrier to full knowledge and use of the system by clinical contract provider and MHP staff.
- The MHP has selected a replacement system for Avatar but is not yet in the implementation phase. While a new EHR will provide the benefit of new and updated functionality, the MHP reported having over 300 ad hoc Avatar reports. The review of these reports to identify required reporting in the new system will be an important part of the design phase of this project.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP did not find the new format of the CPS to be beneficial for improving services this year. The new aggregated information did not break out providers individually as it has in past years. Contractors provided their own agency specific CPS. The Cultural Competency Committee recommended utilizing the voice of community peers to create beneficiary "friendly" clinics in the new CORE project.

CONSUMER FAMILY MEMBER FOCUS GROUPS

Consumer and family member (CFM) focus groups are an important component of the CalEQRO review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 8 to 10 participants each.

Family Member Focus Group One

CalEQRO requested CFM FG parameters; a diverse group of Spanish speaking caretakers who initiated services in the preceding 12 months. The focus group was held via Zoom and included ten participants; a Spanish language interpreter was used for this focus group. All caretakers/family members participating have a family member who receives clinical services from the MHP.

The overall voice of the key informants was very complementary of the MHP and Contracted services. One caregiver stated, "everything felt so well organized and taken care of that they uncovered my needs that I didn't know to ask for." Another mentioned the clinician visiting the youth at school, home, or the park, so the family would not miss their scheduled appointment.

It was reported services took approximately one month or more to receive an appointment due to waiting for a Spanish speaking clinician. It was further mentioned

only psychiatrist used interpreters as most services were provided in Spanish. The key informants did not know there were transportation options at their disposal. Often, they have had to cancel appointments when they did not have their own means of transportation. The key informants also reported not knowing what services they could use in a crisis. They did not know about the crisis line nor the support line for caregivers.

Recommendations from focus group participants included:

- To provide more male staff as it seemed some clinics had more females, as it was difficult for male beneficiaries to feel comfortable being transparent in sessions.
- Instructions for ease of use to obtain interpretation over the phone.

Consumer Member Focus Group Two

CalEQRO requested CFM FG parameters; a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via Zoom and included 11 participants. All consumers participating receive clinical services from the MHP.

Overall, the key informants did not raise any concerns and were very complimentary of staff, feeling a sense of hope, several even stating staff were “lifesavers.” Some key informants were receiving medication only services. All key informants acknowledged knowing how to access crisis services and most have used the provided transportation options. Many expressed their Primary Care Physician will collaborate with their clinician. The idea of exercise and yoga was the theme in most of the interactions. The key informants appreciated their ability to choose in-person services or telehealth services as needed to be successful in treatment.

Recommendations from focus group participants included:

- Two beneficiaries requested the Wellness Center South be left open.
- “Homeless are not all on the same level – always keep offering help and do not kick out of Wellness Centers.”
- “Help make the transition from Children services to Adult services easier.”

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall key informants were very complimentary towards the services received through the MHP. Spanish speaking caretakers seemed to wait longer for services and did not know of provided services such as transportation and crisis/warm lines. English speaking beneficiaries seemed to know of those service and freely used them as needed. Some beneficiaries did not understand that the MHP is opening ten new Wellness Centers and thought they would be losing their ability to use a Wellness

Center. Communication within the current Wellness Centers may aid in the ease of anxiety at the loss of the current Wellness Center and assist in the transition to one of the new Wellness Centers.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP utilizes Peer Navigator staff in the Emergency Departments which offer in the moment resources, support and often prevents an admitted individual from being held on a 5150 application. (Access)

2. The MHP negotiated a pay increase for MHP and Contract staff with the HR and their Union. In addition, the HR department approved a multi-step employment ladder for persons with lived mental health experience. The recently appointed Mental Health Services Act Manager is an individual with mental health lived experience. (Quality)

3. Ten outpatient clinics with Wellness Centers will be opened under the CORE project to address mental health needs in underserved communities. Chosen Contractors will identify specific outreach activities to engage the community of need with resources and outpatient services. (Quality)

4. The MHP expanded the hours to 24-hours, 7-days a week, for mental health Urgent Care Walk-In services. (Access)

5. The MHP provided a mental health support phone line for Ukrainian language immigrants who have been displaced and impacted by the war in Ukraine and have been worried about their family members residing in Ukraine. (Access)

OPPORTUNITIES FOR IMPROVEMENT

1. Though the MHP is able to track and report no-show data through the use of service codes, accurate reporting is dependent on the entry done by direct service staff. There remains a need to improve the consistency in documentation requirements. (Timeliness)

2. The MHP does not consistently track no-show data from contract providers and therefore is unable to accurately determine caseload size and capacity. While the MHP does have a way to track no-shows through the use of service codes, continued training is needed to ensure accurate documentation by direct service staff. (Timeliness)

3. The MHP identifies compliance goals and expectations on their QIWP; however, it is unclear if the obtained outcome made an impact to the beneficiary experience, treatment, and recovery, based on the outcomes presented. (Quality)

4. Both the clinical and non-clinical PIP present design and structure flaws. Following the prescribed format of the Aim Statement, Variables, which tie into identified PMs would lead to a functioning format to identify cause and impact of the assigned PIP. (PIP)

5. The MHP identified several instances of training opportunities provided for Contractors as it pertains to, EHR, data input and/or reporting. Key informants stated not having knowledge of such trainings, thus impacting the MHP's ability to review or collect necessary data and is a barrier to full knowledge and use of the system by clinical staff. (Quality, IS)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve beneficiary outcomes:

1. Develop and implement a system to accurately track and report urgent service requests, including requests that do not require prior authorization and for beneficiaries who request urgent services but who do not follow up with the referral to MHUCC, and ensure data is accurate when reporting. (Timeliness) (This recommendation is a carry-over from FY 2021-22.)

2. Develop and implement a system to accurately track and report no shows for psychiatrists and/or clinicians other than psychiatrists and ensure data integrity from Contractor providers. (Timeliness) (This recommendation is a carry-over from FY 2021-22.)

3. Expand on outcome goals within the QIWP, to include the impact on beneficiaries when compliance percentage goals are achieved. (Quality)

4. Restructure both the clinical and non-clinical PIP plans to follow assigned format. Include clinical or non-clinical goals, flow, and identified variables with corresponding performance measure outcomes. (PIP)

5. Identify and implement a process for Contractors to track and report all staff attendance to mandatory training offered by the Contractor or MHP, with follow-up reports provided to the MHP to track Contractor compliance. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a public health emergency (PHE) exists. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions - Sacramento MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, Lead Quality Reviewer
Bill Walker, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Pamela Roach, Consumer Family Member

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Acosta	Nina	Division Manager – Forensic Services	Sacramento County Behavioral Health
Adams	Rolanda	Program Coordinator - QM	Sacramento County Behavioral Health
Adema	Jillian	Clinical Supervisor	Turning Point Community Programs
Andersen	Dana	Program Manager – CalAIM	Sacramento County Behavioral Health
Barker	Kathleen	Clinical Supervisor	Turning Point Community Programs
Barney	Robin	Adult Family Advocate Liaison	CalVoices
Bruno	Susannah	Clinical Supervisor	Hope Cooperative
Bryan	Regina	Clinical Supervisor	Capital Star
Burkett	Tara	Clinical Supervisor	Turning Point Community Programs
Cable	Nicole	Program Coordinator - QM	Sacramento County Behavioral Health
Crook	Andrea	Program Manager – MHSA	Sacramento County Behavioral Health
Du Plessis	Chanel	Peer Employee	Capital Star
Estrada	Alejandra	Clinical Supervisor	Turning Point Community Programs
Fawcett	Frank	Peer Employee	Sacramento County Behavioral Health
Gomez-Hernandez	Karen	Clinician	Telecare Corp.
Green	Sheri	Program Manager - Children's Services	Sacramento County Behavioral Health
Grosser	Jerri	Clinician	El Hogar

Last Name	First Name	Position	County or Contracted Agency
Hawkins	Pamela	Program Planner - QM	Sacramento County Behavioral Health
Hayes	Leslie	Peer Employee	
Housely	Andrea	Youth and Family Advocate Liaison	CalVoices
Hoyle	Lawanda	Clinical Supervisor	Telecare Corp.
Hunter	Sheree	Clinical Supervisor	Turning Point Community Programs
Ibarra	Melony	Administrative Services Officer 3 – Avatar Training & Support/DBHS Billing	Sacramento County Behavioral Health
Irizarry	Christina	Program Manager – Children's Services	Sacramento County Behavioral Health
Jimenez	Lindsay	Clinician	El Hogar
Keiner	Olivia	Clinician	Turning Point Community Programs
Kesselring	Robert	Program Manager – Children's Services	Sacramento County Behavioral Health
Kunker	Shelly	Program Coordinator, QM	Sacramento County Behavioral Health
Kwong	Evelyn	Clinical Supervisor	El Hogar
Lang	Star	Clinician	Capital Star Community Programs
Lee	Sora	Clinical Supervisor	Asian Pacific Community Counseling
Leung	Julie	Health Services Program Planner	Sacramento County Behavioral Health
Martinez	Andrea	Clinical Supervisor	El Hogar
McClure	Erin	Program Coordinator - QM	Sacramento County Behavioral Health
Nakamura	Mary	Program Manager – Cultural Competence/Ethnic Services	Sacramento County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Olito	Tiffany	Clinician	Stanford Sierra Youth and Families
Olivas	Teresa	Clinician	El Hogar
Olivera	Martin	Clinician	El Hogar
Owens	Whitney	Program Planner - QM	Sacramento County Behavioral Health
Panyala	Anantha	Division Manager – MHTC	Sacramento County Behavioral Health
Quinley	Matt	Program Manager – Children's Services	Sacramento County Behavioral Health
Quist	Ryan	Director of Behavioral Health	Sacramento County Behavioral Health
Rechs	Alex	Program Manager – Quality Management	Sacramento County Behavioral Health
Reiman	Jennifer	Program Coordinator, Crisis Continuum	Sacramento County Behavioral Health
Roberts	Victoria	Peer Employee	Hope Cooperative
Rosales	Jesse	Clinician	Stanford Sierra Youth and Families
Sawyer	John	IT Applications Analyst 2	Sacramento County Behavioral Health
Sellers	Lonyeua	Clinician	Stanford Sierra Youth and Families
Singleton	Kisha	Peer Employee	Turning Point Community Programs
Taylor	Eryca	Program Coordinator	Sacramento County Behavioral Health
Thompson	Alondra	Program Manager – Adult Services	Sacramento County Behavioral Health
Tidrick	Katie	Clinical Supervisor	Hope Cooperative

Last Name	First Name	Position	County or Contracted Agency
Valdez	Megan	Clinician	Stanford Sierra Youth and Families
Weaver	Kelli	Division Manager – Adult Services	Sacramento County Behavioral Health
Webb	Anthanita	Peer Employee	Sacramento County Behavioral Health
Welch	Lorin	Peer Employee	Capital Star
Williams	Dawn	Program Manager – Research, Evaluation, and Performance Outcomes	Sacramento County Behavioral Health
Williams	Allison	Program Manager – Adult Services	Sacramento County Behavioral Health
Wilson	Kari	Sr. Administrative Analyst	Sacramento County Behavioral Health
Woodberry	Angelina	Adult Consumer Advocate Liaison	CalVoices
Yang	Koua	Clinician	Asian Pacific Community Counseling
Zakhary	Jane Ann	Division Manager – Administration, Planning, and Outcomes	Sacramento County Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	As submitted, this Clinical PIP was found to have low confidence, because: The challenge of the PIP as submitted, though equities in racial services is an excellent topic, this PIP lacks clinical impact and outcomes. Training is not in itself a clinical outcome. The MHP has chosen a large population of all age groups, the PIP may better be served narrowing down the test population. The PIP does not have a target improvement rate and the interventions are not clinical in nature.
General PIP Information	
MHP/DMC-ODS Name: Sacramento	
PIP Title: "Racial Equity Action Plans"	
PIP Aim Statement: "How will training improve the clinical outcomes? MHP will increase the retention of clients by 10% by training staff in racial equity training. By equipping staff with appropriate clinical language tailored to the priority population."	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): "The entire population of African American enrollees served by the six identified providers will be affected by this PIP. At the baseline year of FY 20/21, this number was 2,637. Their ages range from 3 to 96, with 53% women, and 47% men."	

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): By providing culturally relevant and racial equitable services, members will increase the successful discharge rate.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Racial equity training for all provider staff will decrease member unsuccessful discharge rate.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): MHP facilitated the BHREC committee to a universalism approach to advanced behavioral health equity for the AA/B/AD communities.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of beneficiaries who disengage early.	FY 2019-20	N = 2,914 9.5%	☐ Not applicable—PIP is in Planning or implementation phase, results not available	N=183 21.9%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☒ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of beneficiaries who discharge unsuccessfully	FY 2019-20	N= 9,079 75%	☐ Not applicable—PIP is in Planning or implementation phase, results not available	N=419 67%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☒ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

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

EQRO recommendations for improvement of PIP:

- The MHP is recommended to reword the PIP to follow the flow of the PIP Development Tool. There is definition and data drift, what are the goals, problems, barriers, interventions, variables (indicators), PMs (outcomes) and target improvement rate. And, how does that tie into the clinical impact on the beneficiary.
- When looking at racial equity outcomes, a smaller test population could be more meaningful when implementing a clinical goal.
- The MHP did engage in TA in January 2022, it is recommended the MHP seek out TA throughout the development and formation process of a PIP.

Non-Clinical PIP

Attachment C1: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	As submitted, this non-clinical PIP was found to have low confidence, because: The MHP has not adequately presented their goals, indicators, and outcomes, though they have rich data the PIP will be collecting, the AIM statement lacks the measurable indictor the PIP is attempting to improve.

General PIP Information
MHP/DMC-ODS Name: Sacramento
PIP Title: "Admissions at Provider Site"
PIP Aim Statement: "Does providing an option for beneficiaries to access services directly from the contracted provider improve or maintain the timeliness from request to first assessment appointment and then to first treatment appointment within 18 months?"
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): "The study population will include children ages 3-18 in the MHP admitted to the four Outpatient providers who will be providing walk in services as part of the pilot. Pacific Clinics (previously Uplift Family Services), University of California, Davis Child and Adolescent Abuse Resource and Evaluation, La Familia Counseling Center, and Capital Star Community Services. In FY20/21 there were 1,045 Beneficiaries who completed their First Assessment with La Familia-FIT, Star-FIT, UCD-FIT, Uplift-FIT-Performance or Uplift-FIT-Tech Center."

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Members will be provided five sites as walk-in or urgent services. The member is responsible for follow through.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Four identified providers will provide walk-in/urgent services.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): MHP will refer members to five sites that allow walk-in/urgent services.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of days between first contact and first assessment.	>10 days	FY 2020-21	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of days between first assessment and first clinical appointment.	>7 days	FY 2020-21	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of beneficiaries who attended the first assessment appointment AND the first treatment appointment.	<75%	FY 2020-21	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

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

EQRO recommendations for improvement of PIP:

- Similar to the Clinical PIP, the non-Clinical PIP could use restructuring to follow the flow of the PIP Development Tool. There is definition and data drift, what are the goals, problems, barriers, interventions, variables (indicators), PMs (outcomes) and target improvement rate.
- Rewording the AIM statement would clarify first treatment appointment is not within 18-months, but instead the course of the PIP is the full 18-months. And within the AIM statement, what is the baseline the MHP is trying to improve.
- The MHP is recommended to provide a satisfaction survey to caregiver/family members of youth on their ability to access services in an urgent nature. Did the urgent access decrease the youth symptoms, did they receive services as stated in the Urgent protocol?
- The MHP is recommended to seek out TA earlier in the development process and throughout the formation of the PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, and PIP Validation Tool, are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM MHP DIRECTOR

The MHP experienced no barriers to participating in the EQR; therefore, no letter from the MHP Director is needed.