Performance of the Sacramento County Mental Health System

Prepared by the Sacramento County Mental Health Board March 2021

Approved by the Sacramento County Mental Health Board

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Executive Summary

The purpose of this report is to comply with the Sacramento County Mental Health Board's (MHB) statutory mandate pursuant to Welfare and Institutions Code Section 5604.2(a)(5) to submit an annual report to the governing body on the needs and performance of the county's mental health system.

While we do not have data to provide an accurate estimation of the need for mental health services for Medi-Cal beneficiaries in the county, this year's report discusses relevant information from the California Health Interview Survey, a statewide survey on Californians' health needs that includes representative data for all 58 California counties. The results of this survey show that in Sacramento County of all Adults who needed behavioral health care services 62.3% received them, and less than half of African American, Asian, and Latino Adults needing behavioral health services received them.

With regard to timeliness, the Department of Health Care Services sets benchmarks of seven, fourteen, and thirty calendar days for various types of outpatient services. These benchmarks include time from request for service to first outpatient appointments, time from assessment to first outpatient psychiatric service, and time from acute hospital discharge to first outpatient appointment and first outpatient psychiatric service. Behavioral Health Services (BHS) is out of compliance with those benchmarks for most of its services for the majority of children and youth and adults that it serves. This lack of compliance is detrimental to those clients. The BHS has taken steps to improve timeliness by initiating new assessment procedures.

Recommendations: The MHB will continue to monitor the timeliness of access to services through CY 2020 and CY 2021. The BHS should continue to explore administrative alternatives to improve timeliness. The BHS should research innovative ways to improve timeliness in counties that have been successful in addressing that problem. The Board of Supervisors should consider increasing funding to the BHS to support implementation of those innovations.

The Dignity Health Behavioral Health Crisis Services Collaborative (BHCSC) began operating in September 2019 and serves clients who would benefit from mental health and crisis stabilization services. The program has an expressed goal of minimizing the time being on an involuntary 5150 hold. The project also includes a staffed Resource Center on site, which provides direct linkages to aftercare and social support services to ensure the presence of a continuum and coordination of care.

Preliminary data for clients who were admitted to the Dignity BHCSC between January and March 2020 show that during this period, a total of 230 clients were admitted to the BHCSC, for a total of 270 admissions. Most of clients served admitted to the BHCSC during the quarter were admitted on a voluntary legal status. Similar percentages of clients were discharged to the community, regardless of whether they were admitted voluntarily or not. The program is intended to link clients to services at discharge, which is emphasized by the onsite Resource Center of the program's design. Therefore, the low number of clients with referrals data and the high percentage of clients not linked with an

outpatient provider 30 days after discharge is concerning. Additionally, some of the reported demographic information was incomplete. Specifically, gender identity was reported as “Unknown or Declined to State” for all of the participants, and sexual orientation was reported as “Unknown” for approximately 96% of participants.

Recommendations: The BHS should identify and address any barriers to making referrals and linkages to outpatient providers for clients participating in this program. The BHS should ensure that participant demographic data, and documentation of referrals and linkages is complete in the data system for all participating clients. The BHS should ensure the documentation includes reasons why referrals were not made when applicable.

Regarding capacity, from FY 2008-09 to the Current Year, the BHS has had a fluctuating funding history. In FY 2009-10, it had a significant funding reduction that took years to recover from. While there have been recent budget increases, these increases have insufficient to address the county’s inadequate capacity of services. In several recent years the budget increases were exceeded by the rate of inflation. The BHS’s Average Cost per Beneficiary (ACB) is lower than that for Large Counties and Statewide rates.

Recommendation: The Board of Supervisors should work to increase the funding of the Division of Behavioral Health Services so it has greater capacity to provide services by:

- **Maximizing the allocation of County General Funds to the Division of Behavioral Health Services**
- **Working through its lobbyist and the California State Association of Counties to advocate for more funding for community behavioral health services in the State budget, including realignment funds and Medi-Cal**

Penetration Rates decreased between calendar year 2017 and calendar year 2018, with some variation among age and racial groups.

Recommendation: The BHS should investigate the causes of the decrease in penetration rates for 0 to 5 year olds, 6 to 17 year olds, African Americans and clients who identify as belonging to Other racial groups.

There is relative consistency in retention rates across most race, sex, and age groups.

No Recommendation.

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

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

Introduction

The purpose of this report is to comply with the Mental Health Board's (MHB) statutory mandate pursuant to Welfare and Institutions Code Section 5604.2(a)(5) to submit an annual report to the governing body on the needs and performance of the county's mental health system.

Methodology

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

Needs of the County's Mental Health System
- ✓ California Health Interview Survey data via Be Healthy Sacramento Community Dashboard

Outpatient Services
- Timeliness
  - ✓ Benchmark Report, CY 2019

Crisis Services
- ✓ Sacramento County Behavioral Health Services. Dignity Health Behavioral Health Crisis Services Collaborative Fiscal Year 2019-2020, Quarter 3 (January – March 2020).

Capacity of Services
- ✓ Behavior Health Concepts, Inc. FY 19-20. Medi-Cal Specialty Mental Health External Quality Review, Sacramento MHP Final Report. Prepared for California Department of Health Care Services.

Penetration Rates
- ✓ BHS Research Evaluation Performance Outcomes

Retention Rates
- ✓ BHS Research Evaluation Performance Outcomes

Human Resources
- ✓ Sacramento County Mental Health. 2019 Human Resources Survey

Background

Demographics

Sacramento County has an estimated population of 1,550,000 people. As reported in Table 1 on the next page, the Sacramento County BHS served 30,201 persons in FY 2018-19. Of those 30,201 persons, 26,075 were served by Medi-Cal during that same period. The table below breaks down clients served by age, gender, ethnicity, and race.

Table 1: Unduplicated Clients Served in Sacramento County, FY 2018-19

	All Served (N=30,201)		Medi-Cal Beneficiaries Only (N=26,075)	
Age	N	%	N	%
0-15	7,433	24.6%	7,218	27.7%
16-25	5,163	17.1%	4,427	17.0%
26-59	14,484	48.0%	11,934	45.8%
60+	3,104	10.3%	2,495	9.6%
Unknown	17	0.1%	1	0.0%
Gender	N	%	N	%
Female	15,710	52.0%	13,722	52.6%
Male	14,472	47.9%	12,349	47.4%
Unknown	19	0.1%	4	0.0%
Ethnicity	N	%	N	%
Hispanic/Latino	5,956	19.7%	5,365	20.6%
Not Hispanic/Latino	15,941	52.8%	14,291	54.8%
Unknown/Not Reported	8,304	27.5%	6,419	24.6%
Race	N	%	N	%
American Indian/Alaska Native	470	1.6%	383	1.5%
Asian/Pacific Islander	1,951	6.5%	1,622	6.2%
Black/African-American	6,449	21.4%	5,693	21.8%
Multi-Ethnic	1,514	5.0%	1,377	5.3%
White	10,485	34.7%	9,072	34.8%
Other Race	4,372	14.5%	4,106	15.7%
Unknown/Not Reported	4,960	16.4%	3,822	14.7%
Primary Language	N	%	N	%
Arabic	131	0.4%	116	0.4%
Cantonese	66	0.2%	66	0.3%
English	25,706	85.1%	22,295	85.5%
Hmong	267	0.9%	262	1.0%
Other/Non-English	620	2.1%	561	2.2%
Russian	241	0.8%	236	0.9%
Spanish	1,430	4.7%	1,321	5.1%
Vietnamese	194	0.6%	189	0.7%
Unknown/Not Reported	1546	5.1%	1029	3.9%

Source: Sacramento County Division of Behavioral Health Services

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

Figure 1: Total Clients Percentage by Age

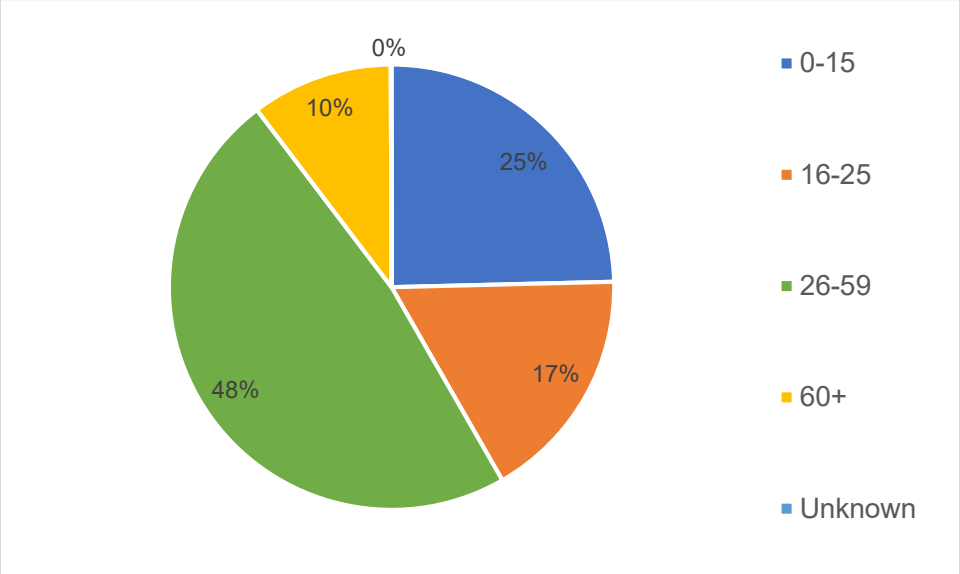


Figure 2: Total Clients Percentage by Race

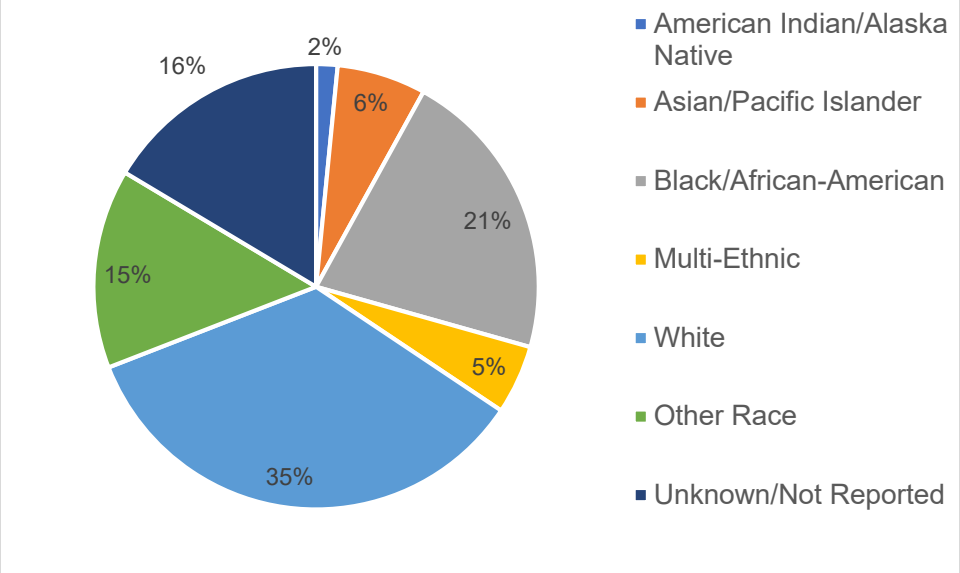
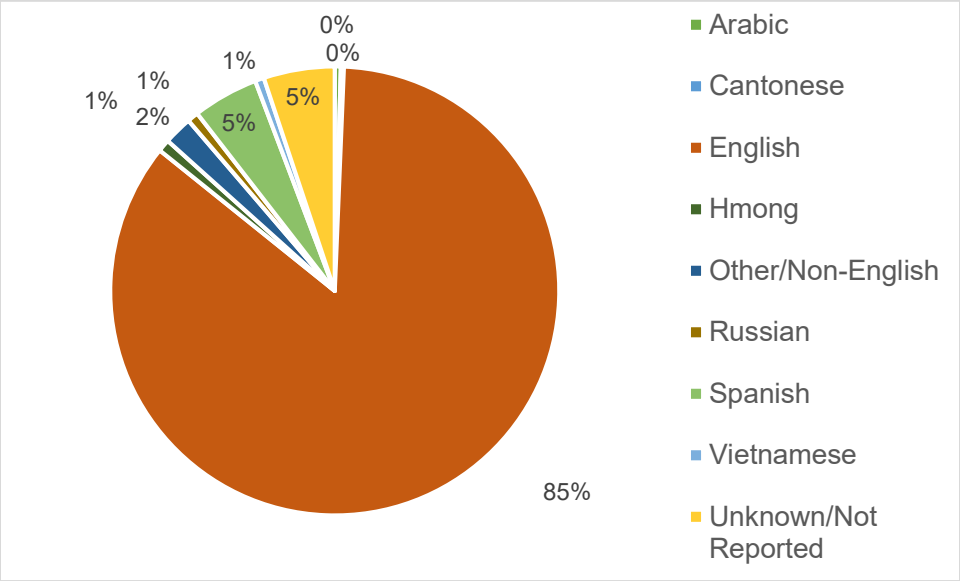


Figure 3: Total Client Percentage by Primary Language



Revenue

The BHS received approximately $354 million to provide mental health services in FY 2019-20. Table 2 below provides the revenue sources.

Table 2: Revenue Sources, FY 2019-20

Revenue Source	Revenue (in millions)
Realignment	$108.97
Medi-Cal (Federal Financial Participation)	$72.94
Medi-Cal Admin	$3.89
Mental Health Service Act	$136.97
County General Fund	$18.47
SB 82 Mental Health Wellness Grant	$1.80
SAMHSA	$3.66
CalWorks	$3.37
System Partner Funding (interdepartmental)	$3.93
Total	$354.00

Source: Sacramento County Division of Behavioral Health Services

Legend

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

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

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

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

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

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

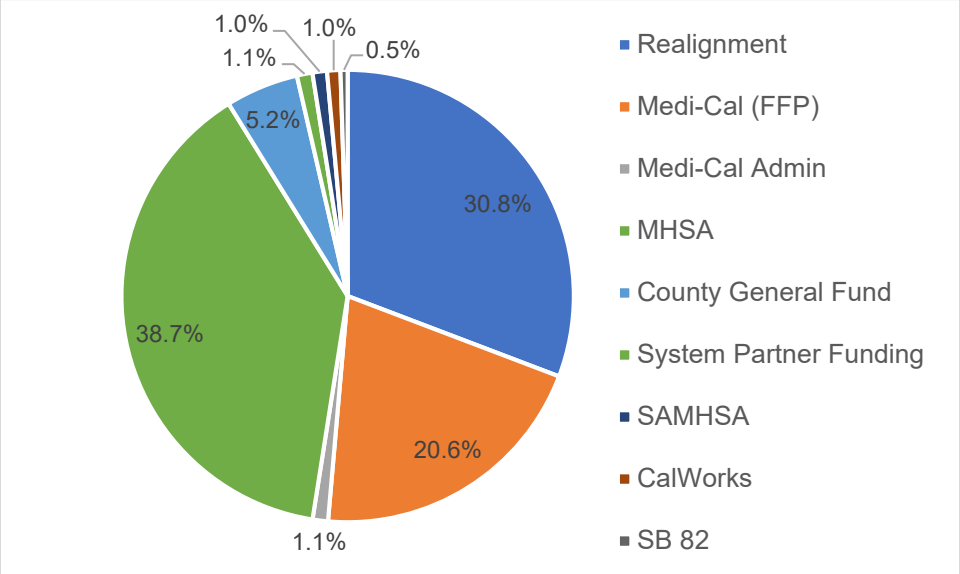
SAMHSA: a block grant provided by the federal SAMHSA for services to individuals with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness, or who are at imminent risk of homelessness

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

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

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

Figure 4: Revenue Source by Percentage



Mental Health Services

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

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

Mission: The Sacramento County MHP will:

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

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

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

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

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

Needs of the County's Mental Health System

BHS provides mental health services primarily through the Sacramento County Mental Health Plan (MHP), which is the portion of the county mental health system that serves Medi-Cal beneficiaries. An accurate estimation of the need for mental health services in the county would provide that data for Medi-Cal beneficiaries; however, those data are not available.

What is available are data from the California Health Interview Survey (CHIS). The CHIS is the largest state health survey in the nation. More than 20,000 Californians are interviewed each year. It is a web and telephone survey that asks questions on a wide range of health topics. CHIS is conducted on a continuous basis allowing the survey to generate timely one-year estimates. CHIS provides representative data on all 58 counties in California and provides a detailed picture of the health and health care needs of California's large and diverse population. CHIS data would include primarily individuals covered by employer-based and private health insurance. SB 855, which was passed this year, will require parity for behavioral health services in private insurance policies, and should improve access to behavioral health services for those privately insured. The survey asks about "Adults Needing and Receiving Behavioral Health Care Services." To obtain this information, it asks questions about whether subjects needed to see professionals because they had problems with their mental health and whether they had seen a physician or various types of mental health professionals in the past 12 months. Overall, in Sacramento County 62.3% of Adults needing behavioral health care services received them. Table 3 breaks this percentage down by age, gender, and race/ethnicity.

Table 3: Adults Needing and Receiving Behavioral Health Care, FY 2017-18

Age	%
18-24	49.1
25-44	58.8
45-64	77.8
65+	78.5
Gender	%
Female	66.7
Male	56.4
Race/Ethnicity	%
African American	43.1
Asian	43.5
Latino	53.8
Two or More Races	49.9
White	73.4

Source: Sacramento County, Be Healthy Sacramento, Measurement Period 2017-18

Of all these data, the race/ethnicity data for minority populations is probably the closest to representing the Medi-Cal eligible population because minority populations tend to be lower income and, therefore, more likely to be eligible for Medi-Cal than the white population. These data show that less than half of African American, Asian, and Latino Adults needing behavioral health services received them.

Outpatient Services

Timeliness of Mental Health Services

The Department of Health Care Services (DHCS) sets benchmarks of seven, fourteen, and thirty calendar days for various types of outpatient services. These benchmarks are established in the Medicaid Managed Care Final Rule: Network Adequacy Standards, July 19, 2017. BHS is out of compliance in meeting those benchmarks for most of its services for the majority of children and youth and adults that it serves. This lack of compliance is detrimental to those clients. The results for those benchmarks for CY 2019 that relate directly to client care are summarized below. (BM2 and BM7 are not discussed.) The results for all the benchmarks are provided in Table 6 in Appendix A.

BM1: Time from Request for Service to First Outpatient (OP) Appointment (Target = 14 calendar days)
Average Number of Days from Request for Services to First OP Appointment
Children: First Two Quarters—Approximately 27 days with 25% of children meeting this benchmark; Last Two Quarters—Approximately 22 days with 32% meeting the benchmark
Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data
Adults: First Quarter—Approximately 32 days with 15% meeting the benchmark; Last Two Quarters—Approximately 28 days with 24% meeting the benchmark
Significantly out of compliance for children and adults.

BM3: Urgent Service Request Opened to OP Provider by Access to First OP Appointment (Target = 7 calendar days)
Children: First Two Quarters—Approximately 21 days with 13% meeting the benchmark; Third Quarter—19 days with 15% meeting the benchmark; Fourth Quarter—21 days with 44% meeting the benchmark
Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data
Adults: First Two Quarters—Approximately 30 days with 6% meeting the benchmark; Third Quarter—25 days with 8% meeting the benchmark; Fourth Quarter—25 days with 32% meeting the benchmark
Significantly out of compliance for children and adults. However, there was improvement in the percent in compliance with the benchmark between the Third and Fourth Quarters for both children and adults. Overall, however, lack of compliance is especially problematic because this measure relates to the urgent need for services.

For this measure Urgency Indicators are defined by the MHP in Policy and Procedure 02-03 as:

- From Intake Stabilization Unit
- From a psychiatric inpatient unit
- Current suicidal or homicidal ideation
- Imminent risk of placement/housing loss due to a mental illness
- Recent trauma

- Clinical judgment

BM4: OP Assessment to First OP Psychiatric Service (Target = 30 calendar days)
Children: First Two Quarters: Approximately 100 days with 20% meeting this benchmark; Third Quarter—72 days with 23% meeting the benchmark; Fourth Quarter—48 days with 29% meeting the benchmark. This benchmark is somewhat misleading because children do not usually request an OP Psychiatric Service immediately after OP Assessment. Thus, the number of days does not really represent a delay in receiving services.
Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data
Adults: First Two Quarters—Approximately 55 days with 37% meeting the benchmark; Last Two Quarters—Approximately 54 days with 22% meeting the benchmark;
Significantly out of compliance for children and adults

BM5: Acute Hospital Discharge to First OP Service (Target = 7 calendar days)
Children: First Two Quarters—Approximately 16 days with 55% meeting the benchmark; Last Two Quarters—21 days with 45% meeting the benchmark
Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data
Adults: Approximately 45 days with 39% meeting the benchmark; Third Quarter—42 days with 30% meeting the benchmark; Fourth Quarter—28 days with 31% meeting the benchmark
For children, out of compliance with more than a majority meeting the benchmark in the First Two Quarters and slightly less than a majority meeting the benchmark in the Last Two Quarters
For adults, significantly out of compliance with the number of days decreasing in the Fourth Quarter

BM6: Acute Hospital Discharge to First OP Psychiatric Service (Target = 30 calendar days)
Children: First Two Quarters—Approximately 45 days with 55% meeting the benchmark; Last Two Quarters—Approximately 21 days with approximately 80% meeting the benchmark
Foster Youth: number of youth available for this benchmark is too small for meaningful results; see Appendix A for the data:
Adults: First Quarter—70 days with 49% meeting the benchmark; Second Quarter—55 days with 53% meeting the benchmark; Third Quarter—41 days with 57% meeting the benchmark; Fourth Quarter—29 days with 68% meeting the benchmark
For children, in compliance for 80% of the children served by the Last Two Quarters
For adults, out compliance for number of days for first three quarters; in compliance for number of days for Fourth Quarter with two-thirds meeting the benchmark

Overall, BHS compliance with timeliness benchmarks was unchanged from performance in Calendar Year 2017.

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

BHS has taken some steps to improve timeliness. Since April 2020, Senior Mental Health Counselors at Access have been providing the first part of the assessment process over the phone, which has streamlined the time between service requests and the first service. Access is the phone line that potential clients call to request service from BHS. Before this change, the average time to first service was 30 days. Since the start of this new procedure and the end of August 2020, 1,113 Adults were assessed with 587 followed up with outpatient treatment. The average time for Adults to receive an Access assessment was 1.4 days, with 19.1 days to outpatient treatment. Similarly, 1,101 Children were assessed during that time period with 620 followed up with outpatient treatment. The average time for Children to receive an Access assessment was 2 days, with 13.5 days to outpatient treatment.

Summary
The DHCS sets benchmarks of seven, fourteen, and thirty calendar days for various types of outpatient services. These benchmarks include time from request for service to first outpatient appointments, time from assessment to first outpatient psychiatric service, and time from acute hospital discharge to first outpatient appointment and first outpatient psychiatric service. BHS is out of compliance with those benchmarks for most of its services for the majority of children and youth and adults that it serves. This lack of compliance is detrimental to those clients. The BHS has taken steps to improve timeliness by initiating new assessment procedures.

Recommendations: The MHB will continue to monitor the timeliness of access to services through CY 2020 and CY 2021. The BHS should continue to explore administrative alternatives to improve timeliness. The BHS should research innovative ways to improve timeliness in counties that have been successful in addressing that problem. The Board of Supervisors should consider increasing funding to the BHS to support implementation of those innovations.

Crisis Services

Dignity Health Behavioral Health Crisis Services Collaborative

The Dignity Health Behavioral Health Crisis Services Collaborative (BHCSC) serves individuals eighteen years of age and older for up to 23 hours when they present to Dignity Health's Mercy San Juan Emergency Department, experiencing a mental health crisis, are medically stabilized, and would benefit from mental health and crisis stabilization services. The program has an expressed goal of minimizing the time being on an involuntary 5150 hold. The project also includes a staffed Resource Center on site, which provides direct linkages to aftercare and social support services to ensure the presence of a continuum and coordination of care. The program began operating in September 2019.

Data and results are preliminary and available for clients who were admitted to the program between January and March 2020. During this period, a total of 230 clients were admitted to the BHCSC, for a total of 270 admissions. The number of admissions is greater than the number of unduplicated clients admitted, because some clients had more than one admission during the quarter.

- Clients served ranged in age from 18 to 78 years old.
- Over 60% of clients served were white and approximately 56% were male.
- Sixty-two percent (61.7%) of unduplicated BHCSC clients reported their housing status as housed, while 23% reported being homeless. The balance had an unknown housing status or were at risk for homelessness.
- Major depressive disorders (24%), schizophrenia spectrum disorders (24%), other (or unknown) substance use disorder (14%), bipolar disorder (9%), and unspecified anxiety disorder (6%) were the leading diagnoses among those in the program during the quarter.
- 72% of clients admitted to the BHCSC during the quarter were admitted on a voluntary legal status.
- Similar percentages of clients were discharged to the community, regardless of whether they were admitted voluntarily or not.
    - Of clients admitted to the BHCSC on a voluntary status, approximately 89% were discharged to the community. Of these clients, 13% returned to the BHCSC for a subsequent admission within 30 days of discharge.
    - Of those admitted to the BHCSC on a 72-hour hold, 87% were discharged to the community, and 7% returned to the BHCSC within 30 days for a subsequent admission.
- Of the 269 BHCSC discharges, there were 260 Discharge Summaries recorded into the County's electronic record system. However, only 10% of those contained

notations about referrals made during the quarter and most of those referrals were made to the client's current outpatient provider.

- Of 230 unduplicated individuals admitted to the BHCSC program, 36% were already linked with an outpatient service provider. Six percent were linked to outpatient providers at discharge via Dignity's referral team, and another 14% were linked to outpatient services within 30 days of their discharge.

Tables 7, 8, and 9 in Appendix B show demographic data for the participants, and more detailed information on diagnoses and housing status.

Summary

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Recommendation: The BHS should identify and address any barriers to making referrals and linkages to outpatient providers for clients participating in this program. The BHS should ensure that participant demographic data, and documentation of referrals and linkages is complete in the data system for all participating clients. The BHS should ensure the documentation includes reasons why referrals were not made when applicable.

Capacity of Services

From FY 2008-09 up to the Current Year, the BHS has had a fluctuating funding history as displayed in Table 4 below. In FY 2009-10, the Division incurred a 10.5% budget reduction. In FY 2014-15, there was a 14.3% increase in the budget that made up for that reduction. Since that time, the budget has increased, except in FY 2017-18 when it decreased by 1.4%.

Notably, budget increases have not kept up with inflation in 4 out of 11 years for which comparison data is available.

Table 4: Percent Change in Mental Health Budgets from Prior Year Compared to the Rate of US Inflation

Fiscal Year	Total Mental Health Budget	Percent Change from Prior Year	US Inflation Rate
2008-09	$204,153,788	Base	2.7%
2009-10	$182,631,189	-10.5%	1.5%
2010-11	$188,419,517	3.2%	3%
2011-12	$190,734,669	1.2%	1.7%
2012-13	$192,344,489	0.8%	1.5%
2013-14	$194,115,598	0.9%	0.8%
2014-15	$221,894,585	14.3%	0.7%
2015-16	$249,583,248	12.5%	2.1%
2016-17	$267,912,434	7.3%	2.1%
2017-18	$264,043,571	-1.4%	1.9%
2018-19	$308,810,135	17.%	2.3
2019-20	$354,000,000	14.6%	1.2

Source: Total Mental Health Budget—Division of Behavioral Health Services
Inflation Rate: Retrieved on December 8, 2020 from
https://www.usinflationcalculator.com/inflation/current-inflation-rates/.
Note: inflation rates calendar year rates as of December, except 2020, which is as of October.

Despite the budget increases in recent years, the BHS budget remains under capacity to provide the necessary service level for clients. The timeliness data in the Outpatient Services section of the report demonstrates that problem. The capacity issue has also been discussed with the External Quality Review Organization (EQRO)[1], and the 2019-20 report noted that the "MHP continues to lack program capacity to service beneficiary demand for services."

Another metric of capacity to provide services is Sacramento County's Average Cost per Beneficiary (ACB) compared to the ACB of other counties. Sacramento is categorized as

[1] The EQRO conducts reviews of MHPs to analyze and evaluate information related to quality, timeliness, and access to SMHS provided by California's 56 MHPs and/or their subcontractors to Medi-Cal beneficiaries. California EQRO for the Medi-Cal SMHS Program is Behavioral Health Concepts (BHC), Inc.

a Large County by the EQRO. As shown in Table 10 in Appendix C, the ACB for different categories of services is generally lower for Sacramento County than for Large Counties. For example, the BHS's ACB for CY 2019 for Residential Services was $6,571 compared to $9,312 for Large Counties, a difference of $2,741, or 41.7%. Similarly, the ACB for Case Management was $615 for Sacramento County compared to $1,013 for Large Counties, a difference of $398, or 64.7%.

Summary
From FY 2008-09 to the Current Year, the BHS has had a fluctuating funding history. In FY 2009-10, it had a significant funding reduction that took years to recover from. While there have been recent budget increases, these increases have insufficient to address the county's inadequate capacity of services. In several recent years the budget increases exceeded by the rate of inflation. The BHS's ACB is lower than that for Large Counties and Statewide rates.

Recommendation: The Board of Supervisors should work to increase the funding of the Division of Behavioral Health Services so it has greater capacity to provide services by:

- Maximizing the allocation of County General Funds to the Division of Behavioral Health Services
- Working through its lobbyist and the California State Association of Counties to advocate for more funding for community behavioral health services in the State budget, including realignment funds and Medi-Cal

Penetration Rates

Penetration rates are provided in Table 5 below. The overall penetration rate decreased between 2017 and 2018 by 5.0% to 4.8%, a decrease of 4%. The rate decrease was consistent across all age groups with the exception of adults over 60, where the rate increased from 3.1% to 3.2%, an increase of 3.2%. The penetration rates for clients under 18 showed the largest decreases: the rate for 0 to 5-year olds decreased by 11.8%, and the rate for 6 to 17-year olds decreased by 6.8%. While the penetration rates for both males and females decreased between 2017 and 2018, the rate for females decreased more (decreases of 1.9% and 4.1%, respectively).

There were also differences in how the penetration rates changed across racial groups, between 2017 and 2018, with some groups experiencing rate increases, some groups experiencing rate decreases, and some groups remaining the same. Specifically, increases were observed in the penetration rates for Whites (6.3% increase) and American Indian/Alaskan Natives (5.5% increase). The rates did not change for Asian/Pacific Islanders and Hispanics. The penetration rates decreased for African Americans (6.3% decrease) and clients in Other races (22% decrease). The decreases

Summary

The overall penetration rates decreased between CY 2017 and 2018, with some variation among age and racial groups.

Recommendation: The BHS should investigate the causes of the decrease in penetration rates for 0 to 5 year olds, 6 to 17 year olds, African Americans and clients who identify as belonging to Other racial groups.

Table 5: Penetration Rates CY 2017, CY 2018

Penetration Rates		Calendar Year 2017					Calendar Year 2018					
		A		B		B/A	A		B		B/A	
		Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (Undup)		Medi-Cal Penetration Rates	Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (Undup)		Medi-Cal Penetration Rates	Percent Change between CY 2017 and CY 2018
		N	%	N	%	%	N	%	N	%	%	%
Age Group	0 to 5	69,886	12.5%	1,203	4.3%	1.7%	67,166	12.4%	994	3.8%	1.5%	-11.8%
	6 to 17	133,236	23.8%	9,737	34.7%	7.3%	129,650	23.9%	8,805	33.6%	6.8%	-6.8%
	18 to 59	288,999	51.7%	15,070	53.7%	5.2%	277,033	51.0%	14,261	54.4%	5.1%	-1.9%
	60+	67,305	12.0%	2,075	7.4%	3.1%	68,920	12.7%	2,176	8.3%	3.2%	3.2%
	Total	559,426	100.0%	28,085	100.0%	5.0%	542,769	100.0%	26,236	100.0%	4.8%	-4.0%
		N	%	N	%	%	N	%	N	%	%	
Gender	Female	296,052	52.9%	14,523	51.7%	4.9%	287,591	53.0%	13,577	51.7%	4.7%	-4.1%
	Male	263,373	47.1%	13,553	48.3%	5.1%	255,178	47.0%	12,655	48.2%	5.0%	-1.9%
	Unknown	----		9	0.0%	N/A	----		4	0.0%	N/A	N/A
	Total	559,425	100.0%	28,085	100.0%	5.0%	542,769	100.0%	26,236	100.0%	4.8%	-4.0%
		N	%	N	%	%	N	%	N	%	%	
Race	White	140,900	25.2%	8,927	31.8%	6.3%	130,017	24.0%	8,696	33.1%	6.7%	6.3%
	African American	85,432	15.3%	6,174	22.0%	7.2%	81,353	15.0%	5,650	21.5%	6.9%	-4.2%
	American Indian/Alaskan Native	3,927	0.7%	286	1.0%	7.3%	3,617	0.7%	278	1.1%	7.7%	5.5%
	Asian/Pacific Islander	78,944	14.1%	1,788	6.4%	2.3%	75,110	13.8%	1,759	6.7%	2.3%	0.0%
	Other	121,538	21.7%	5,036	17.9%	4.1%	128,959	23.8%	4,134	15.8%	3.2%	-22.0%
	Hispanic	128,686	23.0%	5,874	20.9%	4.6%	123,714	22.8%	5,719	21.8%	4.6%	0.0%
	Total	559,427	100.0%	28,085	100.0%	5.0%	542,770	100.0%	26,236	100.0%	4.8%	-4.0%

Retention Rates

The retention rates for FY 2018-19 are displayed in Table 11 in Appendix D. There is relative consistency in retention rates across most race, sex, and age groups with a couple of exceptions. The retention rates for clients under 18 in the White group, and clients 18 or over in the Asian/Pacific islander were higher than the rates for other racial groups within their respective age categories at the greater than 15 services mark. The data also show that the rate for these group were lower at the 1 service mark, indicating there may be some factors contributing to retention at this early point. The retention rate for the Arabic language is lower and there are no other notable differences by language.

No Recommendation

Human Resources

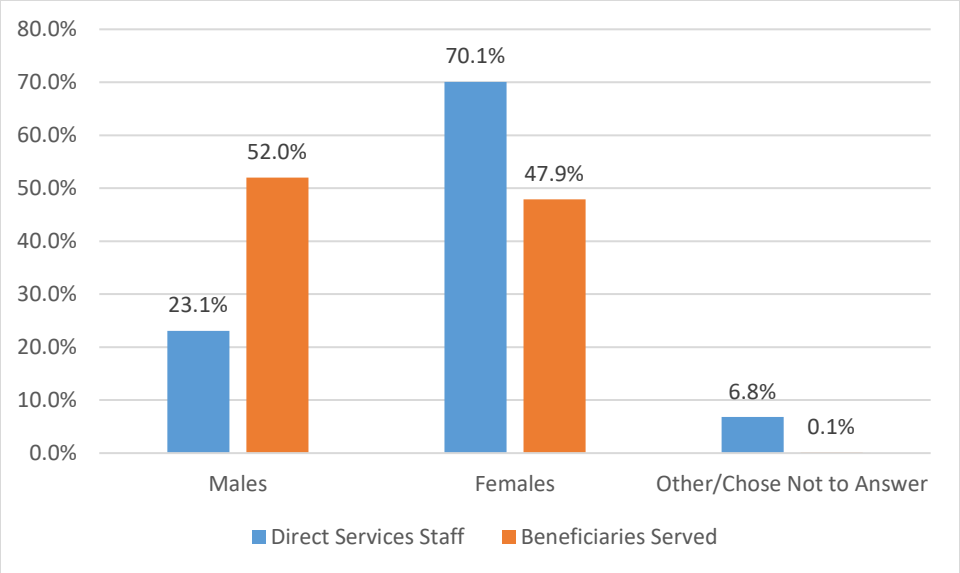
As stated in the 2019 Human Resources Survey report, counties are required to collect demographic information and language capabilities of staff, volunteers, and any committee members who participate in serving individuals throughout the entire County Mental Health System. The purpose of the surveys is to assess demographic and linguistic information for those who provide services in the county to determine whether it is reflective of the diversity of the community as a whole. The information collected focuses on staff ethnicity, language proficiencies, consumer/family member status, gender, sexual orientation, disability, and veteran status. According to the survey:

- A total of 1,239 staff responded to at least one question.
- Of all staff surveyed, 400 (32.3%) staff indicated speaking a language other than English. A majority who spoke one language other than English spoke Spanish (39.0%) followed by Hmong at just over 7% (7.5%).
- 36.3% self-identify as a family member of a consumer, 20.6% of staff self-identify as a consumer of Mental Health Services, while 10.4% of staff self-reported that they live with a disability and 2.8% currently serve or have served in the US Military.
- 73.8% of the staff self-identified as being heterosexual/straight, 4.7% as bisexual, 2.7% as lesbian, 2.3% as queer, 1.9 % as gay, 1.2% pansexual, 0.6 as asexual, 0.6% as other, 0.2% as questioning and 12.0% choose not to answer the question.
- 27.3% of direct service staff self-identify as a consumer of Mental Health Services, while 43.7% self-identify as having a family member who is a consumer of Mental Health Services.

Gender

As indicated in Figure 5 below, males are underrepresented in direct service staff, compared to the number of males served in the system.

Figure 5: Direct Services Staff Compared to Medi-Cal MHP Beneficiaries by Gender

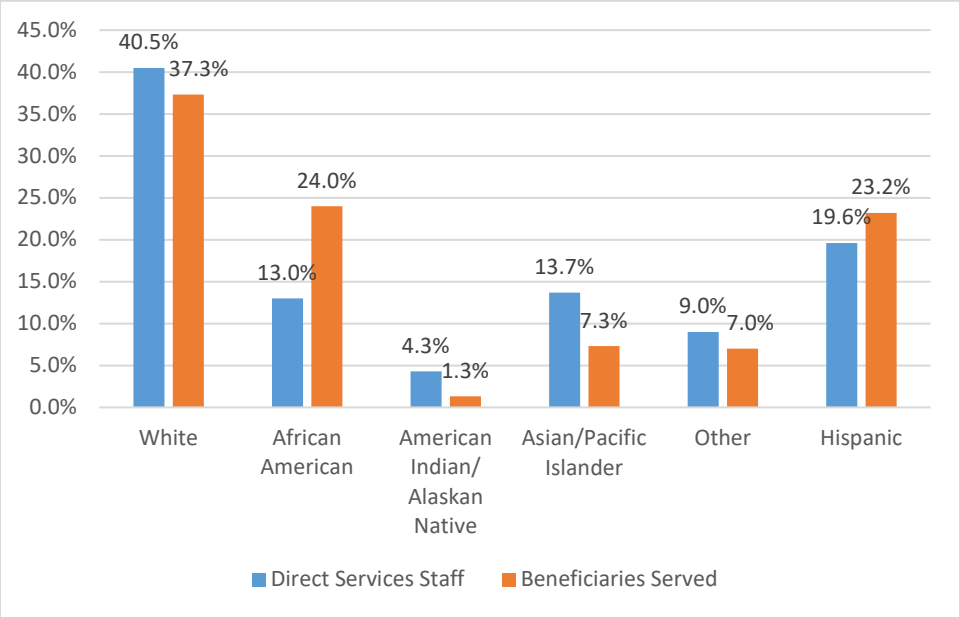


Source: Sacramento County Mental Health 2019 Human Resources Survey, October 2019

Race

African Americans and Other Direct Service Staff are underrepresented, compared to the number of African American clients served, while White and Asian/Pacific Islander Direct Service Staff are overrepresented as displayed in the Figure 6 below.

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

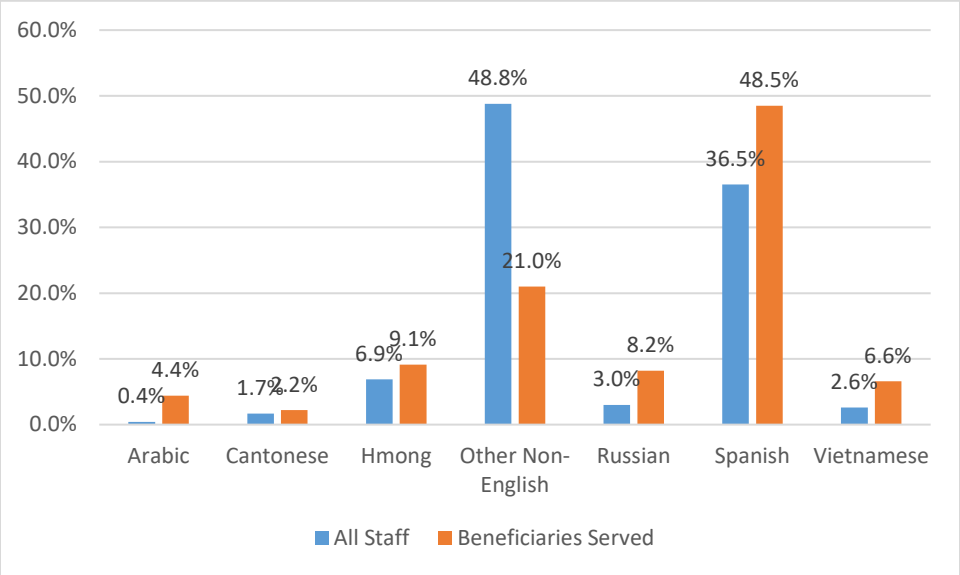


Source: Sacramento County Mental Health 2019 Human Resources Survey, October 2019

Language

A wide variety of languages are spoken by staff, and the percent who speak the Sacramento County threshold languages is lower than the beneficiaries served, with the exception of “Other Non English” languages.

Figure 7: Languages Spoken by Staff Compared to Medi-Cal MHP Beneficiaries Primary



Source: Sacramento County Mental Health 2019 Human Resources Survey, October 2019

Summary

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

Recommendation

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

Appendix A

Table 6: Benchmark Report on Timeliness, CY 2019

BM1 - From Request for Services to First OP Appointment (Target = 14 days)												
	1st Quarter CY 2019			2nd Quarter CY 2019			3rd Quarter CY 2019			4th Quarter CY 2019		
	Children N=663	Foster Youth N=72	Adults N=422	Children N=1173	Foster Youth N=155	Adults N=718	Children N=983	Foster Youth N=98	Adults N=783	Children N=1032	Foster Youth N=98	Adults N=689
Benchmark 1A Summary												
Average # of Days from Request for Services to Authorization	4.5	4.9	3.5	4.4	5.2	3.5	3.2	3.3	2.8	3.8	4.2	2.9
Benchmark 1B Summary												
Average # of Days from Authorization of Services to First Face to Face Appointment	23.9	26.2	28.9	21.3	22.1	28.9	17.7	21.4	24.9	20.8	24.6	25.4
Benchmark 1 Overall Summary												
Average # of Days from Request for Services to First Outpatient Appointment	28.5	31.1	32.4	25.8	27.4	32.4	20.9	24.7	27.7	24.6	28.9	28.3
Percent Meeting Target	23.2%	20.8%	17.1%	27.8%	23.2%	13.9%	37.4%	32.7%	25.5%	28.2%	22.4%	23.2%
BM3 - Urgent Service Request, opened to OP Provider by Access to First OP Appointment (Target = 7 days)												
	1st Quarter CY 2019			2nd Quarter CY 2019			3rd Quarter CY 2019			4th Quarter CY 2019		
Benchmark 3 Summary	Children N=246	Foster Youth N=23	Adults N=206	Children N=310	Foster Youth N=25	Adults N=350	Children N=201	Foster Youth N=11	Adults N=356	Children N=251	Foster Youth N=14	Adults N=307
Benchmark 3A Summary												
Average # of Days from Request for Services to Authorization	2.9	1.2	2.0	3.2	1.2	2.2	2.4	2.4	1.7	2.7	5.2	1.8
Benchmark 3B Summary												
Average # of Days from Authorization of Services to First Outpatient Appointment	17.4	15.7	27.3	18.5	17.3	28.0	16.8	27.5	23.6	18.5	19.6	23.5
Benchmark 3 Overall Summary												
Average # of Days from Request for Services to First Outpatient Appointment	20.3	16.9	29.3	21.7	18.5	30.2	19.2	29.8	25.4	21.3	24.9	25.3
Percent Meeting Target	14.2%	17.4%	6.3%	12.3%	24.0%	6.0%	15.4%	9.0%	8.1%	43.8%	35.7%	31.9%
BM4 - OP Assessment to First OP Psychiatric Service (Target = 30 days)												
	1st Quarter CY 2019			2nd Quarter CY 2019			3rd Quarter CY 2019			4th Quarter CY 2019		
Benchmark 4 Summary	Children N=128	Foster Youth N=11	Adults N=293	Children N=180	Foster Youth N=23	Adults N=475	Children N=162	Foster Youth N=18	Adults N=496	Children N=107	Foster Youth N=8	Adults N=313
Average # of Days to Service	95.3	121.5	55.9	104.2	97.6	55.4	72.7	85.9	58.7	48.4	25.3	50.1
Percent Meeting Target	22.7%	27.3%	42.7%	21.1%	26.1%	32.4%	22.8%	27.8%	24.2%	29.0%	62.5%	19.5%
Note: Children's numbers are typically higher because children are rarely assessed for medication services at the first outpatient assessment												

BM5 - Acute Hospital Discharge to First OP Service (Target = 7 days)												
	1st Quarter CY 2019			2nd Quarter CY 2019			3rd Quarter CY 2019			4th Quarter CY 2019		
Benchmark 5 Summary	Children N=93	Foster Youth N=14	Adults N=934	Children N=103	Foster Youth N=20	Adults N=840	Children N=69	Foster Youth N=15	Adults N=710	Children N=88	Foster Youth N=9	Adults N=629
Average # of Days to Service	14.6	17.4	43.6	17.8	27.2	47.1	23.4	43	41.7	19.5	22	27.9
Percent Meeting Target	57.0%	42.9%	40.1%	48.5%	40.0%	38.1%	49.3%	33.3%	30.1%	39.8%	44.4%	30.8%
BM6 - Acute Hospital Discharge to First OP Psychiatric Service (Target = 30 days)												
	1st Quarter CY 2019			2nd Quarter CY 2019			3rd Quarter CY 2019			4th Quarter CY 2019		
Benchmark 6 Summary	Children N=65	Foster Youth N=10	Adults N=635	Children N=73	Foster Youth N=12	Adults N=555	Children N=47	Foster Youth N=8	Adults N=511	Children N=55	Foster Youth N=8	Adults N=493
Average # of Days to Service	42.3	39.9	70.1	50.4	20.9	55.2	20.6	37.8	41.1	22.4	23.1	28.9
Percent Meeting Target	60.0%	50.0%	48.7%	49.3%	75.0%	52.6%	78.7%	50.0%	57.3%	80.0%	87.5%	65.3%
BM7 - Request for Psychiatric testing to to First Psychiatric Testing Service (Target = 14 days)												
	1st Quarter CY 2019			2nd Quarter CY 2019			3rd Quarter CY 2019			4th Quarter CY 2019		
Benchmark 7 Summary	Children N=16	Foster Youth N=2		Children N=6	Foster Youth N=0		Children N=15	Foster Youth N=1		Children N=14	Foster Youth N=2	
Benchmark 7A Summary												
Average # of Days from Request for Services to Authorization	4.5	6.5		2.8	N/A		5.1	7		3.4	3.5	
Benchmark 7B Summary												
Average # of Days from Authorization of Services to First Psych Testing Service	40.5	52		39	N/A		26.3	7		9.2	8.5	
Benchmark 7 Overall Summary												
Average # of Days from Request for Services to First Psych Testing Service	45.0	58.5		41.8	N/A		31.4	14		12.6	12	
Percent Meeting Target	31.2%	0%		66.7%	N/A		46.7%	100.0%		78.6%	50.0%	
BM8 - No Shows/Cancellations Prior to First Outpatient Appointment												
	1st Quarter CY 2019			2nd Quarter CY 2019			3rd Quarter CY 2019			4th Quarter CY 2019		
Benchmark 8 Summary	Children N=663	Foster Youth N=72	Adults N=422	Children N=1173	Foster Youth N=155	Adults N=718	Children N=983	Foster Youth N=98	Adults N=783	Children N=1032	Foster Youth N=98	Adults N=689
Number of Unduplicated Clients with No Shows/Cancellations Prior to First Outpatient Appt	60	7	42	96	8	79	74	13	96	80	8	61
Percentage of No Show/Cancellations Prior to First Outpatient Appt	9.0%	9.7%	10.0%	8.2%	5.2%	11.0%	7.5%	13.2%	12.3%	7.8%	8.2%	8.9%

BM9 - Number and Percent of No Shows/Cancellations for All OP Appointments												
	1st Quarter CY 2019			2nd Quarter CY 2019			3rd Quarter CY 2019			4th Quarter CY 2019		
Benchmark 9 Summary	Children N=46,437	Foster Youth N=10,160	Adults N=78,395	Children N=50,249	Foster Youth N=10,532	Adults N=76,183	Children N=53,889	Foster Youth N=10,954	Adults N=77,575	Children N=56,791	Foster Youth N=10,660	Adults N=75,893
Number of Services coded as No Shows/Cancellations	5450	776	7519	6668	908	8004	6854	959	8678	7110	969	8278
Client No Show/Cancel	*4754*	*672*	*7173*	*5973*	*805*	*7625*	*6174*	*839*	*8353*	*6306*	*863*	*7913*
Staff No Show/Cancel	*696*	*104*	*346*	*695*	*103*	*379*	*680*	*120*	*325*	*804*	*106*	*365*
Percent of Services coded as No Shows/Cancellations	11.7%	7.6%	9.6%	13.3%	8.6%	10.5%	12.7%	8.8%	11.2%	12.5%	9.1%	10.9%
Percent Client No Show/Cancel	*87.2%*	*86.6%*	*95.4%*	*89.6%*	*88.7%*	*95.3%*	*90.1%*	*87.5%*	*96.3%*	*88.7%*	*89.1%*	*95.6%*
Percent Staff No Show/Cancel	*12.8%*	*13.4%*	*4.6%*	*10.4%*	*11.3%*	*4.7%*	*9.9%*	*12.5%*	*3.7%*	*11.3%*	*10.9%*	*4.4%*

Appendix B

Table 7: Demographics of Unduplicated Clients Served at the Dignity Behavioral Health Program, January to March 2020

Demographics	Dignity BHCSC (N=230)		Dignity RC (N=197)		Unduplicated Total (N=233)	
	N	%	N	%	N	%
Age Group						
Children/Youth (0-15)	0	0.0%	0	0.0%	0	0.0%
TAY (16-25)	45	19.6%	38	19.3%	45	19.3%
Adults (26-59)	164	71.3%	142	72.1%	167	71.7%
Older Adults (60+)	21	9.1%	17	8.6%	21	9.0%
Unknown	0	0.0%	0	0.0%	0	0.0%
Ethnicity						
Hispanic or Latino	29	12.6%	23	11.7%	29	12.4%
Non-Hispanic/Non-Latino	163	70.9%	143	72.6%	164	70.4%
Unknown	38	16.5%	31	15.7%	40	17.2%
Race						
American Indian or Alaska Native	7	3.0%	5	2.5%	7	3.0%
Asian	6	2.6%	5	2.5%	6	2.6%
Asian Indian	2	0.9%	1	0.5%	2	0.9%
Black or African American	39	17.0%	37	18.8%	39	16.7%
Multi-Race	5	2.2%	5	2.5%	5	2.1%
Native Hawaiian or other Pacific Islander	4	1.7%	3	1.5%	4	1.7%
White	145	63.0%	123	62.4%	147	63.1%
Other	10	4.3%	7	3.6%	10	4.3%
Unknown	12	5.2%	11	5.6%	13	5.6%
Primary Language						
English	219	95.2%	191	97.0%	222	95.3%
Non-English	6	2.6%	3	1.5%	6	2.6%
Unknown	5	2.2%	3	1.5%	5	2.1%
Gender						
Male	129	56.1%	113	57.4%	131	56.2%
Female	101	43.9%	84	42.6%	102	43.8%
Unknown	0	0.0%	0	0.0%	0	0.0%

Demographics of Unduplicated Clients Served at the BHSCC, January to March 2020 (continued)

Demographics	Dignity BHCSC (N=230)		Dignity RC (N=197)		Unduplicated Total (N=233)	
	N	%	N	%	N	%
Gender Identity						
Agender	0	0.0%	0	0.0%	0	0.0%
Female	0	0.0%	0	0.0%	0	0.0%
Gender Fluid	0	0.0%	0	0.0%	0	0.0%
Gender Nonbinary	0	0.0%	0	0.0%	0	0.0%
Gender Queer	0	0.0%	0	0.0%	0	0.0%
Intersex	0	0.0%	0	0.0%	0	0.0%
Male	0	0.0%	0	0.0%	0	0.0%
Transexual	0	0.0%	0	0.0%	0	0.0%
Two Spirit	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	0	0.0%	0	0.0%
Questioning	0	0.0%	0	0.0%	0	0.0%
Unknown or Declined to State	230	100.0%	197	100.0%	233	100.0%
Sexual Orientation						
Asexual	0	0.0%	0	0.0%	0	0.0%
Bisexual	0	0.0%	0	0.0%	0	0.0%
Demisexual	0	0.0%	0	0.0%	0	0.0%
Fluid	0	0.0%	0	0.0%	0	0.0%
Graysexual	0	0.0%	0	0.0%	0	0.0%
Gay or Lesbian	1	0.4%	1	0.5%	1	0.4%
Heterosexual or Straight	8	3.5%	7	3.6%	8	3.4%
Pansexual	0	0.0%	0	0.0%	0	0.0%
Questioning or Unsure	0	0.0%	0	0.0%	0	0.0%
Queer	0	0.0%	0	0.0%	0	0.0%
Another Sexual Orientation	0	0.0%	0	0.0%	0	0.0%
Unknown	221	96.1%	189	95.9%	224	96.1%

Table 8: Diagnoses of Clients Served at the BHSCC, January to March 2020

Primary Diagnosis	#	%
Academic or educational problem	1	0.2
Adjustment disorders	27	5.7
Alcohol use disorder	25	5.3
Amphetamine use disorder	6	1.3
Autism spectrum disorder	1	0.2
Bipolar disorder	43	9.1
Borderline personality disorder	2	0.4
Cannabis use disorder	1	0.2
Conduct disorder	1	0.2
Delusional disorder	2	0.4
Disruptive mood dysregulation disorder	1	0.2
Generalized anxiety disorder	2	0.4
Major depressive disorders	114	24.2
Malingering	1	0.2
Opioid use disorder	2	0.4
Other (or unknown) substance use disorder	68	14.4
Posttraumatic stress disorder	6	1.3
Schizoaffective disorder	12	2.5
Schizophrenia spectrum disorders	113	23.9
Unspecified anxiety disorder	28	5.9
Unspecified mental disorder	10	2.1
Unspecified personality disorder	5	1.1
Unspecified sedative-, hypnotic-, or anxiolytic-related disorder	1	0.2
Total	472	100.0

Table 9: Housing Status of Unduplicated Clients Served at the BHSCC, January to March 2020

Housing Status	#	%
Housed/No Imminent Risk of Homelessness	142	61.7
Imminent Risk for Homelessness	14	6.1
Literally Homeless-Chronic Homelessness	6	2.6
Literally Homeless-Not Chronic Homeless	47	20.4
Unknown / Not Reported	21	9.1
Total	**230**	100.0

Appendix C

Table 10: Average Cost per Beneficiary: BHS, Large County, and Statewide, Calendar Year 2019 by Service Category

	SACRAMENTO						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
SERVICE CATEGORIES											
Inpatient Services	536,431	1,540	$17,347,981	0.29%	$11,265		0.42%	$10,507		0.43%	$10,213
Residential Services	536,431	443	$2,910,757	0.08%	$6,571		0.11%	$9,312		0.08%	$9,735
Crisis Stabilization	536,431	1,559	$3,918,696	0.29%	$2,514		0.57%	$3,158		0.48%	$2,845
Day Treatment	536,431	10	$200,154	0.00%	$20,015		0.01%	$11,029		0.01%	$12,223
Case Management	536,431	16,145	$9,932,348	3.01%	$615		1.65%	$1,013		1.71%	$1,054
Mental Health Services	536,431	21,629	$58,769,918	4.03%	$2,717		3.50%	$3,526		4.00%	$3,756
Medication Support	536,431	14,202	$18,792,912	2.65%	$1,323		2.16%	$1,821		2.30%	$1,926
Crisis Intervention	536,431	2,215	$1,081,910	0.41%	$488		0.37%	$1,043		0.57%	$1,351
TBS	536,431	354	$2,195,441	0.07%	$6,202		0.07%	$9,097		0.06%	$10,969
Look-A-Like	536,431	5	$0	0.00%	$0		0.00%	$3,095		0.00%	$6,192
TFC	536,431	0	$0	0.00%	$0		0.00%	$22,542		0.00%	$16,748
IHBS	536,431	887	$2,279,908	0.17%	$2,570		0.11%	$4,449		0.14%	$5,373
ICC	536,431	1,803	$3,097,815	0.34%	$1,718		0.23%	$1,976		0.23%	$2,590

Source: Adapted from Behavioral Health Concepts / CalEQRO Medi-Cal Approved Claims Data for Sacramento County MHP Calendar Year 2019

Appendix D

Table 11: Retention Rates for FY 18/19

Sacramento County Mental Health Plan Retention - FY 18/19														
FY 18/19		Total Served	1 Service		2 Services		3 Services		4 Services		5 to 15 Services		>15 Services	
			N	%	N	%	N	%	N	%	N	%	N	%
Race (0-17.9)	API	359	40	11.1	30	8.4	25	7.0	21	5.8	128	35.7	115	32.0
	Black	2,118	269	12.7	186	8.8	112	5.3	81	3.8	643	30.4	827	39.0
	Hispanic	3,297	324	9.8	182	5.5	191	5.8	131	4.0	1,185	35.9	1,284	38.9
	Nat-Amer	81	10	12.3	3	3.7	5	6.2	1	1.2	30	37.0	32	39.5
	White	2,137	184	8.6	133	6.2	93	4.4	82	3.8	622	29.1	1,023	47.9
	Other	788	80	10.2	49	6.2	41	5.2	29	3.7	290	36.8	299	37.9
	Unk/NR	1,120	139	12.4	84	7.5	66	5.9	59	5.3	432	38.6	340	30.4
Race (≥18)	API	1,459	151	10.3	105	7.2	66	4.5	75	5.1	607	41.6	455	31.2
	Black	3,575	616	17.2	328	9.2	198	5.5	179	5.0	1,234	34.5	1,020	28.5
	Hispanic	2,551	431	16.9	240	9.4	181	7.1	120	4.7	876	34.3	703	27.6
	Nat-Amer	196	34	17.3	18	9.2	9	4.6	5	2.6	74	37.8	56	28.6
	White	6,662	1,196	18.0	593	8.9	362	5.4	281	4.2	2,383	35.8	1,847	27.7
	Other	898	172	19.2	84	9.4	48	5.3	50	5.6	329	36.6	215	23.9
	Unk/NR	1,705	567	33.3	249	14.6	128	7.5	127	7.4	467	27.4	167	9.8
Age	0-17.9	9,900	1,046	10.6	667	6.7	533	5.4	404	4.1	3,330	33.6	3,920	39.6
	≥ 18	17,046	3,167	18.6	1,617	9.5	992	5.8	837	4.9	5,970	35.0	4,463	26.2
Sex	Male	12,964	2,090	16.1	1,105	8.5	696	5.4	548	4.2	4,230	32.6	4,295	33.1
	Female	13,982	2,127	15.2	1,178	8.4	828	5.9	691	4.9	5,070	36.3	4,088	29.2
	Unk/NR	6	2	33.3	1	16.7	1	16.7	2	33.3	0	0.0	0	0.0
Language	English	23429	3,776	16.1	1,980	8.5	1,289	5.5	1,047	4.5	7,852	33.5	7,485	31.9
	Spanish	1401	139	9.9	97	6.9	90	6.4	55	3.9	572	40.8	448	32.0
	Russian	232	9	3.9	7	3.0	13	5.6	9	3.9	124	53.4	70	30.2
	Hmong	266	13	4.9	16	6.0	17	6.4	25	9.4	118	44.4	77	28.9
	Vietnamese	190	8	4.2	12	6.3	9	4.7	14	7.4	89	46.8	58	30.5
	Cantonese	68	3	4.4	5	7.4	1	1.5	3	4.4	22	32.4	34	50.0
	Arabic	132	15	11.4	15	11.4	5	3.8	8	6.1	73	55.3	16	12.1
	Other	579	47	8.1	41	7.1	42	7.3	34	5.9	286	49.4	129	22.3
	Unk/NR	655	209	31.9	111	16.9	59	9.0	46	7.0	164	25.0	66	10.1
TOTAL		**26,952**	**4,219**	**15.7**	**2,284**	**8.5**	**1,525**	**5.7**	**1,241**	**4.6**	**9,300**	**34.5**	**8,383**	**31.1**

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