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FY 2018–19
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SACRAMENTO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 21 – 23, 2018

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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

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

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

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

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

MHP Information

MHP Size — Large

MHP Region — Central

MHP Location — Sacramento

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 22,943

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

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

*Note: During onsite review, MHP informed CalEQRO that Arabic is a newly added threshold language authorized by DHCS.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

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

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2017-18 Review of Recommendations

In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY 2017-18

Recommendation 1: Complete implementation of Medicare Part B claim processing within the next nine months.

Status: Partially Met

- The MHP did not implement Medicare Part B claim processing.
- The change from contracted IT employees to county IT employees and the change in third party administrator for Medicare Part B claims processing were both disruptive.
- The MHP reports that it has readied their EHR system to bill beneficiaries for their share of cost and/or Uniform Method of Determining Ability to Pay (UMDAP) responsibilities. This is a requirement of Medicare claiming.
- Quality Management (QM) continues to assist practitioners with Medicare enrollment in preparation for claiming for services.
- Due to the lack of ability to claim Medicare Part B, the MHP is not capturing the revenue.

Recommendation 2: Explore strategies to eliminate current constraints on the use of data. Consider establishing a data warehouse to improve data analysis and reporting.

Status: Not Met

- The MHP states that there is no funding in the current budget for this project.
- The MHP will try to add funding to the Netsmart agreement when it is renewed in July 2019.
- No progress in this area is anticipated this FY.

Recommendation 3: Develop strategies and plans to electronically exchange data between the MHP's Avatar system and contract provider EHR.

Status: Not Met

- There was a kick-off meeting for this project in October 2017, but the project has since been put on hold because resources dedicated to the project are no longer available.
- The MHP is exploring the use of vendor resources to restart this project.
- The MHP is also exploring "interoperability options," by which they mean Health Information Exchange (HIE). Care Equality would be utilized to exchange information with system partner outside of the contracted provider system (i.e., hospitals, primary care, etc.) but has no bearing on interoperability with contracted providers with their own EHR.

Recommendation 4: Expand methods of informing consumer peer employees of the defined career ladder along with how to advance in job opportunities. Provide consumer employee group activities as ways to connect with each other.

Status: Partially Met

- The MHP's did not describe an expansion of methods to inform consumer peer employees of the defined career ladder.
- In the past year, the MHP has distributed information and materials for the Workforce Information Support and Education University (WISE U) run by Northern California Mental Health America (NorCal MHA). WISE U conducts a Peer Support Training Academy that not only provides training in recovery principles and development of skills that are key to successful employment, but also assists in seeking employment or volunteer opportunities upon graduation. The county also sponsors the Annual NorCal MHA Peer Empowerment Conference which brings together beneficiaries, peer employees and guest speakers to increase the collaboration and knowledge base within the mental health community.

- The recommendation of expanding methods of informing consumer peer employees of the defined career ladder is challenging in Sacramento County due to the multiple providers involved.
- Contract providers, who deliver 90.5 percent of the services in this MHP, each have their own approach to incorporating peer employees into their programs, with defined career path for those with lived experience. Those career paths are communicated within the provider structure. The county does not have a designated position for a beneficiary with lived experience.

PERFORMANCE MEASUREMENT

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

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a calendar year (CY).
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

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

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

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[4] Public Information Links to SB 1291 Specific Data Requirements:
1. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx
2. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

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

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

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

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity Sacramento MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	140,900	25.2%	7,467	32.5%
Latino/Hispanic	128,686	23.0%	3,765	16.4%
African-American	85,432	15.3%	4,391	19.1%
Asian/Pacific Islander	78,944	14.1%	1,320	5.8%
Native American	3,927	0.7%	236	1.0%
Other	121,538	21.7%	5,764	25.1%
Total	**559,425**	**100%**	**22,943**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

Penetration Rates and Approved Claims per Beneficiary

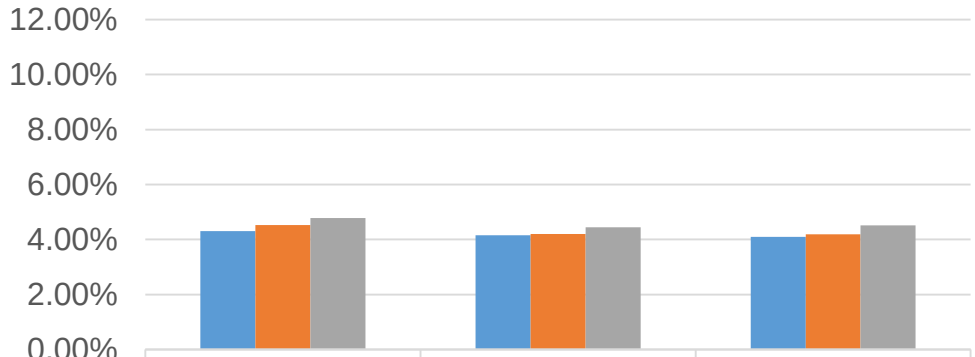
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA Penetration Rate and Approved Claims per Beneficiary.

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

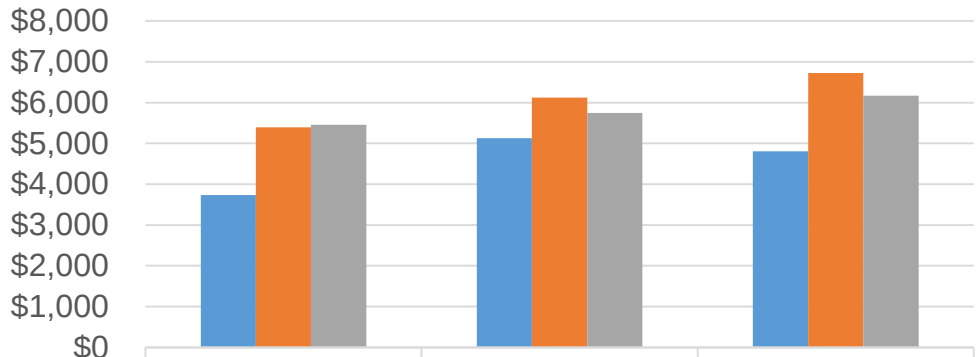
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1A. Overall Penetration Rates
Sacramento MHP



	CY 2015	CY 2016	CY 2017
MHP	4.31%	4.16%	4.10%
Large	4.53%	4.20%	4.19%
State	4.78%	4.44%	4.52%

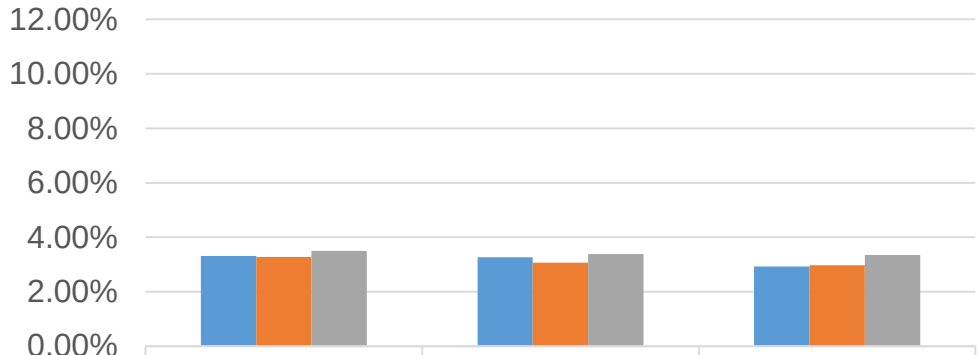
Figure 1B. Overall ACB
Sacramento MHP



	CY 2015	CY 2016	CY 2017
MHP	$3,735	$5,126	$4,805
Large	$5,393	$6,121	$6,723
State	$5,458	$5,746	$6,170

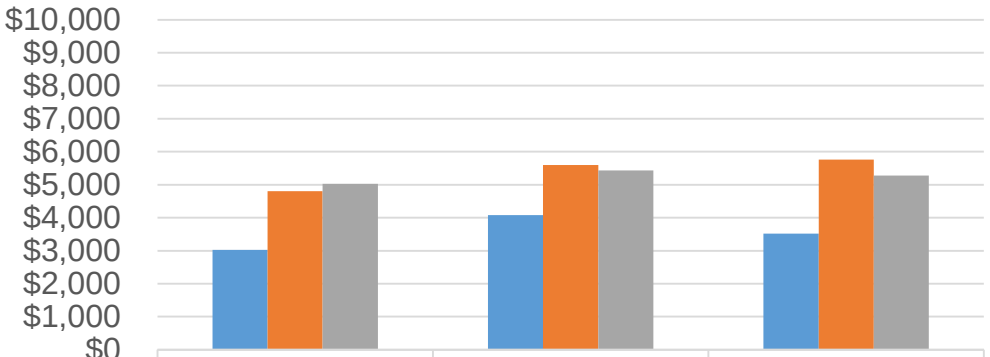
Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
Sacramento MHP



	CY 2015	CY 2016	CY 2017
MHP	3.31%	3.27%	2.93%
Large	3.28%	3.07%	2.97%
State	3.50%	3.38%	3.35%

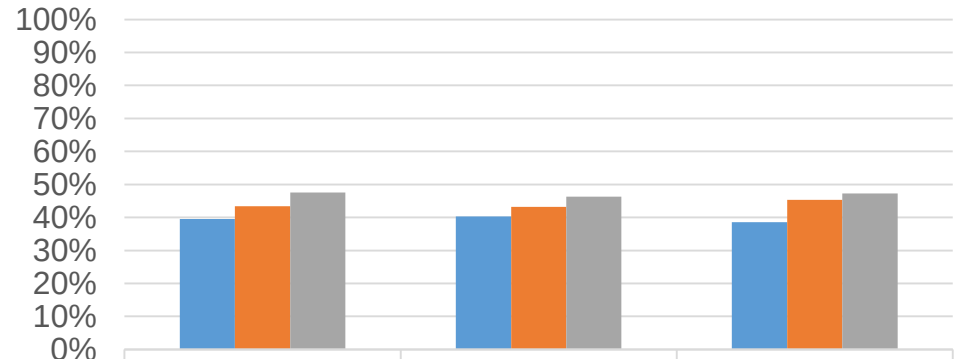
Figure 2B. Latino/Hispanic ACB
Sacramento MHP



	CY 2015	CY 2016	CY 2017
MHP	$3,026	$4,083	$3,519
Large	$4,804	$5,599	$5,758
State	$5,029	$5,430	$5,278

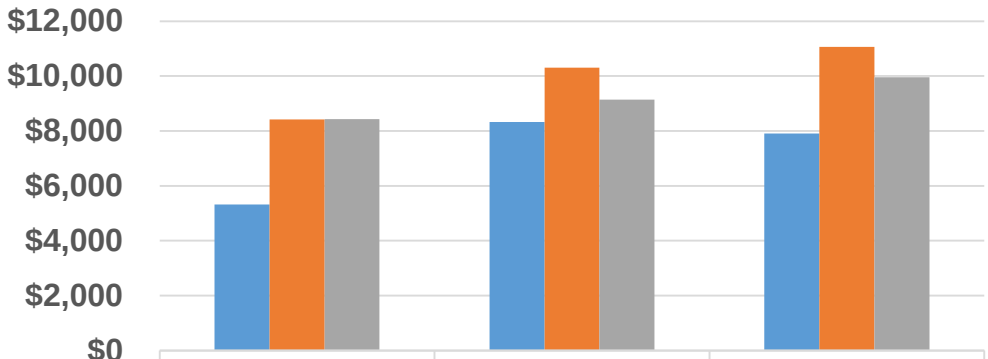
Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A. FC Penetration Rates
Sacramento MHP



	CY 2015	CY 2016	CY 2017
MHP	39.57%	40.27%	38.58%
Large	43.42%	43.22%	45.37%
State	47.52%	46.26%	47.28%

Figure 3B. FC ACB
Sacramento MHP



	CY 2015	CY 2016	CY 2017
MHP	$5,318	$8,321	$7,906
Large	$8,425	$10,301	$11,064
State	$8,432	$9,147	$9,962

High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP's data for CY 2017, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2. High-Cost Beneficiaries
Sacramento MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2017	21,522	611,795	3.52%	$54,563	$1,174,305,701	31.11%
MHP	CY 2017	397	22,943	1.73%	$49,882	$19,802,985	17.96%
	CY 2016	551	23,501	2.34%	$50,085	$27,596,969	22.91%
	CY 2015	337	23,466	1.44%	$46,645	$15,719,287	17.94%

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

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-2017) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS. Sacramento County has three free-standing psychiatric hospitals in the county which provide inpatient services that are not reimbursed by Medi-Cal. The utilization and cost for those IMD excluded services to Medi-Cal beneficiaries are not represented in this data. Therefore, this data only speaks to MHP inpatient psychiatric hospitalization in Medi-Cal eligible facilities and does not reflect the true costs expenditures for inpatient services by Sacramento County**.**

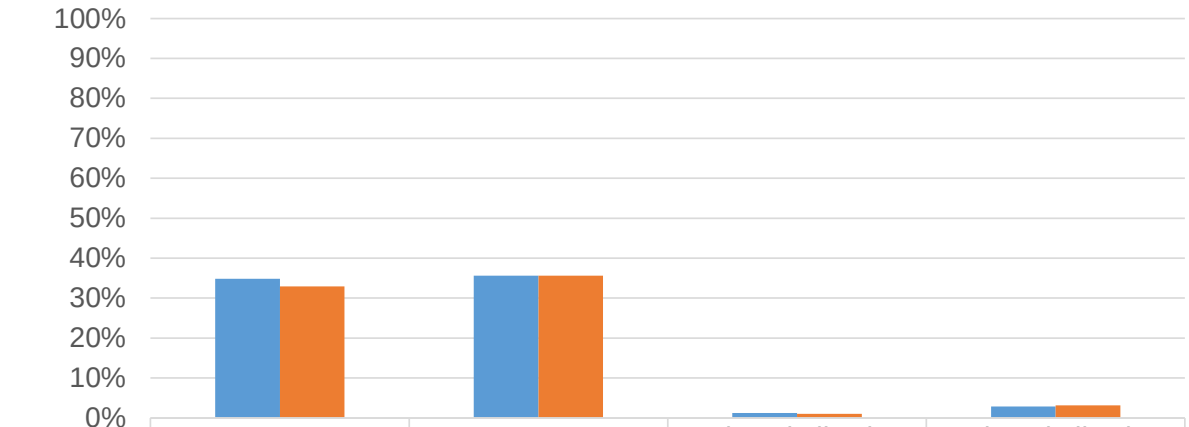
Table 3. Psychiatric Inpatient Utilization - Sacramento MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	1,835	3,851	9.24	$10,668	$19,575,081
CY 2016	1,856	3,975	9.73	$12,431	$23,071,408
CY 2015	1,750	3,758	9.47	$7,773	$13,602,050

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

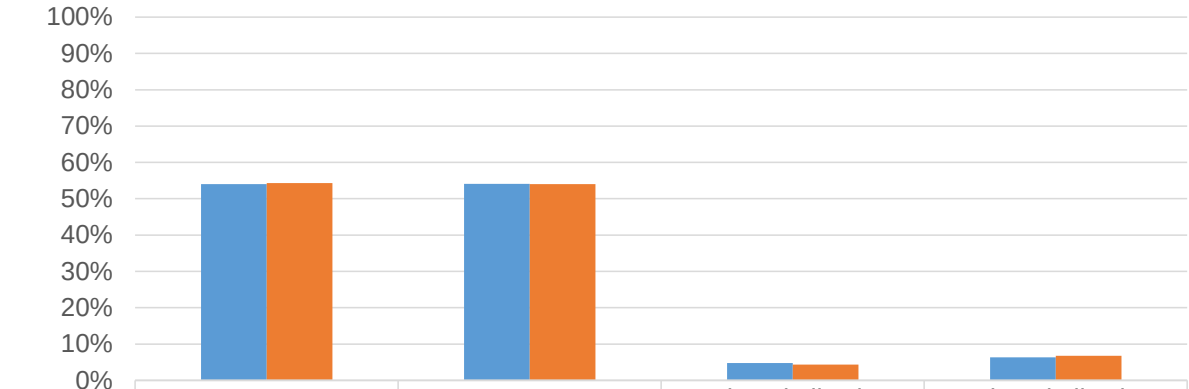
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	35%	36%	1%	3%
CY 2017	33%	36%	1%	3%

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



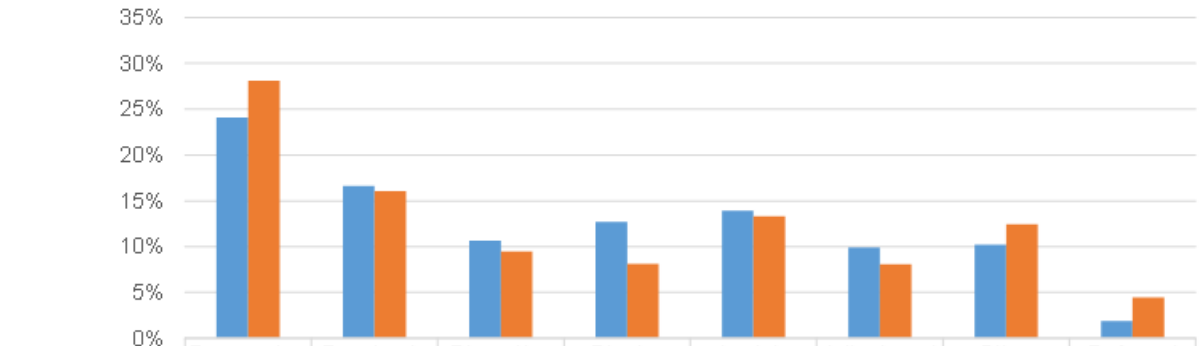
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	54%	54%	5%	6%
CY 2017	54%	54%	4%	7%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

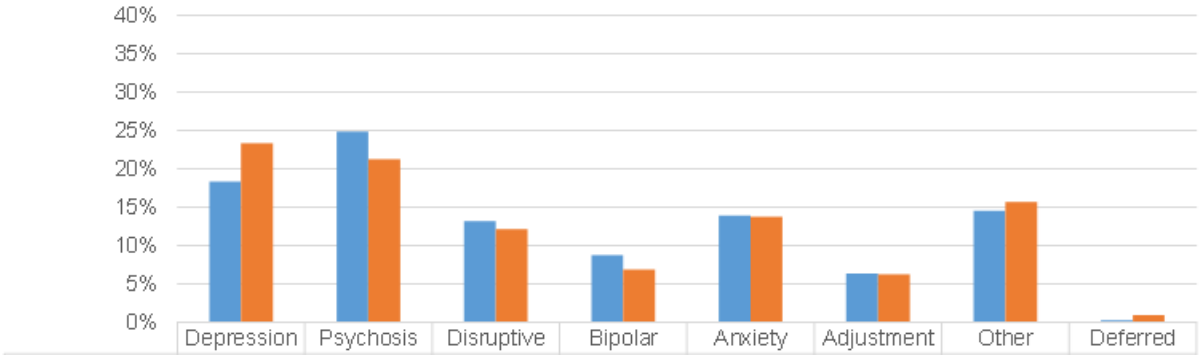
MHP self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 21 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Sacramento MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	24%	17%	11%	13%	14%	10%	10%	2%
State CY 2017	28%	16%	9%	8%	13%	8%	12%	4%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	18%	25%	13%	9%	14%	6%	15%	0%
State CY 2017	23%	21%	12%	7%	14%	6%	16%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Sacramento MHP PIPs Identified for Validation

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

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

Table 4: PIPs Submitted by Sacramento MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improve Timely Access
Non-clinical PIP	1	Uniform scheduling system using an electronic scheduling tool

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

[5] *2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.*

Table 5: PIP Validation Review					
				Item Rating	
Step	PIP Section	Validation Item		Clinical	Non-clinical
1	Selected Study Topics	1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	NR
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	NR
		1.4	All enrolled populations	NR	NR
2	Study Question	2.1	Clearly stated	NR	NR
3	Study Population	3.1	Clear definition of study population	NR	NR
		3.2	Inclusion of the entire study population	NR	NR
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	NR
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	NR
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NR
		5.2	Valid sampling techniques that protected against bias were employed	NR	NR
		5.3	Sample contained sufficient number of enrollees	NR	NR
6	Data Collection Procedures	6.1	Clear specification of data	NR	NR
		6.2	Clear specification of sources of data	NR	NR
		6.3	Systematic collection of reliable and valid data for the study population	NR	NR
		6.4	Plan for consistent and accurate data collection	NR	NR
		6.5	Prospective data analysis plan including contingencies	NR	NR
		6.6	Qualified data collection personnel	NR	NR

7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	NR
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	NR
		8.2	PIP results and findings presented clearly and accurately	NR	NR
		8.3	Threats to comparability, internal and external validity	NR	NR
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	NR
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	NR
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	NR
		9.3	Improvement in performance linked to the PIP	NR	NR
		9.4	Statistical evidence of true improvement	NR	NR
		9.5	Sustained improvement demonstrated through repeated measures	NR	NR

Table 6 provides a summary of the PIP validation review.

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

Clinical PIP— Improve Timely Access

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

Date PIP began: NA

Projected End date: NA

Status of PIP: Concept only, not yet active (not rated)

The goal of the PIP is to reduce barriers and time to first psychiatric appointment by using the Med Bridge Program for individuals who are unlinked and served at the Mental Health Urgent Care Clinic (MHUCC). By providing psychiatric services until the beneficiary can have their first face-to-face with the outpatient provider psychiatrist there should be a decrease in hospital/urgent care/emergency room use and an increase in engagement in outpatient services.

Suggestions to improve the PIP:

The MHP reported discovery of process “glitches” that require further investigation to improve referral and engagement experience for beneficiaries. PIP team meetings were held to resolve these issues and determine updates to the order of the interventions. CalEQRO suggests that the MHP schedule TA once the interventions have been updated to provide guidance to ensure a successful outcome.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of a recommendation that the study question be rewritten to include quantifiable goals. The MHP reported discovery of process “glitches” that require further investigation while examining data intended to help identify interventions. There are now meetings of the PIP team to resolve these issues. CalEQRO suggested that the MHP schedule TA once the interventions and the process to gather data are corrected to ensure a working PIP is in process.

The PIP needs to become active by correcting issues that have interfered with collecting data from interventions and collecting and reporting data not less than quarterly.

The MHP was further encouraged to consult with EQRO early and often during PIP formulation.

Non-clinical PIP—Uniform scheduling system using an electronic scheduling tool

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

Date PIP began: NA

Projected End date:

Status of PIP: Concept only, not yet active (not rated)

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

The PIP builds on previous and current efforts to address timeliness to service by implementing a mechanism within the EHR that allows the MHP to measure the full spectrum of timely access to service, from the initial request for service to the time the MHP authorizes services, to the time of first offered appointment, to the time to first completed face to face appointment.

Suggestions to improve the PIP:

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

The TA provided to the MHP by CalEQRO consisted of a recommendation to restate the study question to include quantifiable goals. The MHP reported challenges related to implementation of a new function in the EHR. The MHP conducted PIP team meetings to determine issues and provided site-specific technical assistance to providers. With the provision of the TA interventions were not disrupted and data

collection continued. CalEQRO suggests that the MHP schedule TA once the first reporting period data is available to ensure a successful outcome.

The MHP was further encouraged to consult with EQRO early and often during PIP formulation.

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

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

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 1.37 percent.

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

Table 7 shows the percentage of services provided by type of service provider.

Table 7: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	8.51%
Contract providers	90.5%
Network providers	0.99%
Total	**100%**

Table 8 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System

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

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☐ Yes ☒ No ☐ In pilot phase

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 9.

Table 9: Technology Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
6	2	6	3

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

Table 10: Data Analytical Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
8	0	0	1

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

- Table 9, the MHP currently has a 50 percent IT staff vacancy rate. Even with zero vacancies, this MHP would be severely challenged to make effective use of the technology it already has, let alone taking on new projects.
- Chronic challenges in the availability and quality of data from the MHP's EHR creates obstacles in determining the adequacy of data analytic staffing.

Current Operations

- The MHP currently employs 6.5 FTEs to support 1573 MHP Avatar users, including contract providers, a support-to-user ratio of 1/242. There are an additional 3 FTEs authorized, but not yet filled. Although the MHP lacks help desk software there is an established help desk process of triaging the calls/emails and assigning to the appropriate person to address. All emails are kept and archived. If one of the 6.5 employees are unable to resolve the issue, then a process is in place to open a ticket with the vendor for additional assistance.
- The ISCA lists five local user groups, all led by the same person. More often these local user groups are led by leaders in each area addressed, not the same individual. In this MHP, while one person has been identified as the lead

facilitator, subject matter experts are included in the creation of the agenda, presentations, and assisting with leading the forum discussions.

Table 11 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 11: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar	Practice Management (CalPM)	Netsmart	9	Netsmart
Avatar	Clinical Workstation (CWS)	Netsmart	7	Netsmart
Order Connect	e-Prescribing	Netsmart	1	Netsmart
Order Connect	Lab Order Exchange	Netsmart	1	Netsmart

The MHP's Priorities for the Coming Year

- Medicare Part B Implementation
- Electronic Lab Orders
- Provider integration
- Interoperability with system partners
- Personal Health Record planning

Major Changes Since Prior Year

- Electronic Lab Order pilot for Quest Labs.
- PIP Scheduler to capture first offered appointment in the adult system of care using the scheduler.
- Transition from outside contractors to County staff for training, support, system maintenance and implementation.

Other Areas of Improvement

- Of the MHP's five priorities for the coming year, four were priorities carried over from last year. The one priority from last year that is not on the list (Complete the implementation of the CarePOV mobile module from Netsmart) is not listed among the achievements of the past year. The CarePOV mobile module was not implemented and will not be carried forward because of resource limitations and other, higher priority, initiatives.
- The electronic laboratory order entry and results reporting pilot has been put on hold because of resource constraints and system functionality that impacts clinician workload and quality of care. The MHP is working with the vendor to resolve the functionality issues.
- What is labelled as the "PIP Scheduler" is the Avatar Scheduling module implemented in a subset of clinics. Given existing issues with the accuracy and completeness of timeliness data in this MHP, Avatar Scheduler should be a priority at all MHP sites.
- The MHP is not ready for Personal Health Record (PHR) and they do not have the resources to support it. The MHP needs to ensure that its Avatar implementation is working effectively for clinicians before committing resources to implementing PHR.

Plans for Information Systems Change

- There are no plans to replace the current system

Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12: EHR Functionality

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

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Level of Care/Level of Service	Netsmart	X			
Outcomes		X			
Prescriptions (eRx)		X			
Progress Notes		X			
Referral Management				X	
Treatment Plans		X			
Summary Totals for EHR Functionality:					
FY 18-19 Summary Totals for EHR Functionality:		8	1	3	
FY 17-18 Summary Totals for EHR Functionality:		8	0	4	
FY 16-17 Summary Totals for EHR Functionality:		8	1	1	

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

- In EQRO sessions with clinicians, when asked what they would like to see change, the first response was, “Improve Avatar.” The clinicians do not see it as an effective tool that makes their work more efficient. That needs to be corrected if the MHP is going to get full value from Avatar. EQRO recommends that the MHP survey clinicians for clarity on what does not work for them. Efficiency in the utilization of Avatar results from standardization of use of the tool.

- There was limited progress in improving the EHR over the past year. The electronic laboratory order entry and results reporting pilot has been put on hold because of resource constraints and system functionality that impacts clinician workload and quality of care. The MHP is working with the vendor to resolve the functionality issues.

- Document imaging was reported to be highly unreliable. There were reports of frequent downtime for the module as well as lost documents. It was described as a problem known to the vendor and the local Avatar support team, but one that has been awaiting a resolution for some time.

- Statements were made that Avatar cannot handle Evidenced Based Practice (EBP) documentation, referral processes, or the incorporation of outcomes tools.

This is the perception of clinicians using the system. All of these are done in other counties. Whether this represents a lack of deep expertise in Avatar or merely miscommunication to the end-users was unclear.

- MHP staff reported that when the new MHUCC opened, it used paper forms because the necessary forms were not yet created in Avatar. Leadership was aware of the Avatar workload and decided to pilot with paper forms. Leadership reported that this was not a workload issue, and that the paper forms were used to determine what data elements and workflow would be needed for the urgent care setting. They also reported that when a beneficiary is linked to a provider after receiving services from the MHUCC, the provider can request documents from MHUCC for continuity of care. However, clinicians in other programs who may see someone after an MHUCC visit will not have access to the information from that visit in Avatar. Also, the data from the initial rollout of the MHUCC will not be available for analysis and reporting unless it is entered manually into a stand-alone database.

Personal Health Record (PHR)

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

☐ Yes ☐ In Test Phase ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Dimension Reports (used with assistance of a consultant)

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☐ Clearinghouse

Note: The MHP does not currently submit Medicare Part B claims.

Table 13 summarizes the MHP's SDMC claims.

Table 13. Summary of CY 2017 Short Doyle/Medi-Cal Claims Sacramento MHP							
Number Submitted	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Claim Adjustments**	**Dollars Approved**
647,652	$107,827,694	**20,206**	$3,457,487	3.21%	$104,370,207	$4,830,813	$99,539,394
Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2017 was **2.73 percent.**							

Table 14 summarizes the top three reasons for claim denial.

Table 14. Summary of CY 2017 Top Three Reasons for Claim Denial Sacramento MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed prior to submission of claim.	10,707	$1,805,505	52%
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	5,251	$931,586	27%
Beneficiary not eligible. Or emergency services or pregnancy indicator must be "Y" for aid code.	2,254	$341,097	10%
TOTAL	20,206	$3,457,487	NA
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with reason "Medicare or Other Health Coverage must be billed prior to submission of claim" are generally re-billable within the State guidelines. For this MHP, that only applies to claims denied for Other Health Coverage because the MHP does not currently claim to Medicare.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

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

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

Consumer/Family Member Focus Group One

CalEQRO requested a culturally diverse group of adult participants, both high and low utilizers of services, who are mostly new clients who have initiated/utilized services within the past 12 months, including non-English speaking participants. The group included all female participants, Hmong speaking, of Asian ethnicity. They all identified as consumers. The focus group was held at 7171 Bowling Drive, Suite 300, Sacramento, CA 95823

Number of participants: 14

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

- Referral to mental health services came through a medical doctor to the MHP's program that included a Hmong speaking clinician.
- Initial assessment included medication assessment and referral to a Hmong speaking clinician.
- Most new beneficiaries felt that initial experiences were positive and there were no system barriers to accessing treatment.
- The only barrier to accessing treatment noted in the group was hesitation on the consumer's part due to cultural and language issues.

Participants' general comments regarding service delivery included the following:

- Most participants found the services they receive helpful.
- All agreed that the medications (all prescribed medications) and having someone to talk to about their problems (clinical therapy) were the most helpful parts of services they receive.

- Several participants reported ongoing physical pain and possibly somatic issues. These are addressed by their primary care doctor and not the psychiatrist.
- All participants see a psychiatrist with an interpreter on regular basis (frequency dependent on need) and have twice a month group session with a Hmong speaking clinician.
- Participants agreed that being home alone is the most challenging time for them. Group activities are welcome as a respite from depression.

Participants' recommendations for improving care included the following:

- The hiring of a Hmong speaking Community Health Worker would be useful. It would be nice to have someone to talk with other than the interpreter who leaves immediately after the session.
- All like their current psychiatrist, although using an interpreter is sometimes difficult.
- The participants agreed that they would like group outings organized by the clinic. It would be good to get outside and not be at home alone.

Interpreter used for focus group one: Yes Language: Hmong

Consumer/Family Member Focus Group Two

CalEQRO requested a culturally diverse group of parents/foster parents/caregivers of child/youth beneficiaries, both high and low utilizers of services, who are mostly new clients who have initiated/utilized services within the past 12 months, including non-English speaking participants. The group included eight females and one male participants, both bilingual and monolingual Spanish speaking, and were a mix of Hispanic/Latino, Caucasian/White, and African American/Black ethnicities. They all identified as family members of consumers. The focus group was held at Stanford Youth Solutions, 8912 Volunteer Lane, Sacramento, CA 95811.

Number of participants: Ten

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

- Some participants reported that accessing services was difficult due to the school, pediatrician or other referral sources not understanding the problem their child was exhibiting as meeting the criteria of a mental health diagnosis.
- Several participants were unclear of the type of services or where they came from that their child was receiving. They were unclear of differences in clinicians,

case managers or other providers the child was receiving as well as how decisions were made for level of service.

Participants' general comments regarding service delivery included the following:

- Several participants reported they are greatly helped by the services they receive.
- Some participants reported that they felt the schools lack understanding of what their child needs and are incapable of providing appropriate services.

Participants' recommendations for improving care included the following:

- Hire more Spanish speaking psychiatrists to shorten wait times.
- Pediatricians that are more educated on children's mental health issues.

Interpreter used for focus group two: Yes Language: Spanish

Consumer/Family Member Focus Group Three

CalEQRO requested a culturally diverse group of transitional age youth (TAY) beneficiaries, both high and low utilizers of services who are mostly new clients who have initiated/used services within the past 12 months, including non-English speaking participants. The group included four female and six male participants, English speaking, and were a mix of Hispanic/Latino, Caucasian/White, African American/Black, Asian American/Pacific Islander, and mixed ethnicities. They all identified as TAY consumers. The focus group was held at 410 S St., Sacramento, CA 95811.

Number of participants: Ten

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

- Services were accessed in a reasonable timeframe once referred or requested.
- All four find the services meet their needs and are satisfied with the new TAY Full Service Partnership (FSP) program.

Participants' general comments regarding service delivery included the following:

- Most of the participants see a clinical therapist on a regular basis, with frequency depending on need.
- Several participants see a psychiatrist for medication at present and all report having been on medication in the past.

- Some participants receive family therapy and find it useful, while others decline it due to risks of disclosing information.
- All participants agree that their need for an appointment outside of regular schedule is responded to more quickly if they use text than if they leave a voicemail.
- The participants reported negative experiences with crisis hospitalizations that included problems with discharge planning.
- The participants agreed that they were involved in their treatment planning and ongoing care.
- Several participants are employed outside of the MHP, and all have volunteered with various TAY programs. None of the participants have received any information about possible employment in the FSP.
- The FSP provides a monthly schedule of groups and activities available.

Participants' recommendations for improving care included the following:

- The participants find leaving a voicemail after hours and waiting for a call back less than helpful. They would like a live person to talk with if they are having issues.
- A caseworker or someone to assist them with life challenges (e.g. getting identification cards, applying for Social Security, finding housing) would greatly improve recovery for the participants.
- All the participants found the services from the MHP helpful and would recommend them to others.

Interpreter used for focus group three: No Language(s): NA

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are described below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 15: Access to Care Components		
Component		**Quality Rating**
1A	Service accessibility and availability reflective of cultural competence principles and practices	M
The MHP has a Cultural Competency Plan, and they analyze data to assess the cultural, ethnic, racial, and linguistic needs of its beneficiaries. The MHP has a variety of new innovations addressing cultural disparity to include eight funded navigators in three middle schools, mostly over 18-year-old TAY peers, who are available during school hours for youth and educators at selected schools with at risk youth. The MHP implemented two contracts addressing the needs of the target group of Commercially Sexually Exploited Children and Youth (CSEC). The scope of work is to create engagement teams that provide effective outreach and engagement strategies, crisis intervention, and services to children and youth that have been CSEC identified. The MHP continues to provide accessibility in language of choice and provides services in six threshold languages as well as English. The Consumer Family Member Employee group noted difficulties in access for specific cultural and linguistic groups (e.g. Hmong, Arabic) that are referred by their cultural organizations, but are unclear in understanding what services are available.		
1B	Manages and adapts its capacity to meet beneficiary service needs	M
Work continues the implementation of the Continuum of Care Reform (CCR). Open enrollment for both Short Term Residential Therapeutic Programs (STRTP) and		

Table 15: Access to Care Components		
Component		**Quality Rating**
Therapeutic Foster Care (TFC) are posted on the Sacramento County Department of Human Services (DHS) Contractor Bidding Opportunities webpage. Two new Mobile Crisis Teams are scheduled to be added in the North and Elk Grove parts of the county. This brings the total of six teams throughout the county in collaboration with law enforcement. The impact of the MHP changes to programs made to address disparities is compromised by chronic staff turnover issues and a substantial overall gap between available resources and the level of need in the community. The MHP continues to work towards improvement in timeliness to services.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP has developed and maintained collaborative relationships with a broad range of community organizations. Examples include: The Homeless Expansion Initiative is a collaboration with the City of Sacramento and aligned with the Whole Person Care framework; this program will be implemented across the Adult System of Care (ASOC) within the year. The success of outreach efforts and partnerships in the community includes that Sacramento County has prioritized the expansion of the Mobile Crisis Teams – two new teams will be added in the North and Elk Grove areas and are due to begin in Fall 2018. The Community Support Team plans to hire additional staff to increase the flexibility of response to the community.		

Timeliness of Services

As shown in Table 16, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to mental health services. This ensures successful engagement with beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first offered appointment	NM
The MHP does not track the time from initial contact to first offered appointment, per their Timeliness Self-Assessment. Both current PIPS being developed by the MHP address timeliness of access.		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
The MHP does not currently have an effective means to measure the time of identification of the need for a psychiatrist for a child/youth consumer. Initial referral date has been difficult for the MHP to standardize. The standard is 30 days, with adults meeting this 38.8 percent of the time, children 27.6 percent and FC 21.7 percent.		
2C	Tracks and trends access data for timely appointments for urgent conditions	PM
The standard for the MHP is seven days, with adults meeting this standard 5.6% of the time, children 15.5% and FC 9.7%. The mean is 29.5 days for adults, 20.5 days for children and 20 for foster care, per the Timeliness Self-Assessment. The MHUCC reports that they link the beneficiary to another provider and leave the chart open for three days for follow up to ensure engagement.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	M
The MHP has a standard of seven days (complying with HEDIS standard), with adults meeting this standard 51.3% of the time, children 42.46%, and 33.3% for FC. The MHP tracks appointments, however, per support staff work with consumers upon discharge, there is a capacity issue that makes timeliness to appointments post discharge difficult.		
2E	Tracks and trends data on rehospitalizations	M
The MHP continues to track hospital readmissions within 30 days with a goal of not exceeding 15%. The data is available for the three local private hospitals, two local Psychiatric Health Facilities (PHFs), and the Sacramento County Mental Health Treatment Center (MHTC) inpatient unit. FY 17-18 data shows readmission rate for adults 20.4% and for children 9.7%. FC data is unavailable for this benchmark.		
2F	Tracks and trends no-shows	PM
The MHP does not track separate information for no-shows to psychiatrist versus other clinicians but does separate client no show from clinician cancellation. No-show rates for 4th Quarter CY 17 was adults 10.4%, children 14.1percent and 8.6 percent		

Table 16: Timeliness of Services Components	
Component	**Quality Rating**
for FC. Consumers interviewed reported that there were providers that did not show up due to staff turnover issues. There is no data to measure this for frequency of this problem.	

Quality of Care

In Table 17, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 17: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
The MHP operates with a current Quality Improvement Performance Plan (QIPP), supported by QIPP minutes and the evaluation of the previous year's plan. The minutes are notable in the information which is communicated, enabling readers to understand and track the improvement activities of the department. The MHP presented regular Quality Improvement (QI) minutes, a Quality Improvement work plan, and an evaluation of the prior year activities in a standardized format inclusive of the goals, objectives, results, and follow-up activities. The MHUCC opened November 2017. The MHUCC has been incorporated into the MHP service continuum to provide walk-in services to individuals of all ages who are experiencing a mental health and/or co-occurring substance abuse crisis		
3B	Data used to inform management and guide decisions	PM
While the MHP endeavors to utilize data to inform management and guide program decisions, QI workplan goals are not typically time specific or measurable per se. As has been previously stated, resources to aggregate quality data to inform management is limited. However, the MHP utilize does Research and Evaluation staff		

to aggregate data for the QI Work Plan as well as provide reports to the Contract Monitors, Program Managers, and Division Managers for monitoring and resource allocation decisions. Staff interviewed reported limited ability to create reports in Avatar. Reports can be requested, go on a list, and are addressed in priority order as resources are available. If ongoing data needs are identified, then scheduled reports can be created and run to the requester's specifications.

Contractor CFM employees report using Avatar to track employment outcomes.

3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	PM

Stakeholders report that communication has improved in the past year; however, there is still an issue of receiving a decision of change with limited information on why that decision was made and its significance. Line staff reported that they received information on a regular basis and could convey information to their supervisors and managers to convey to leadership. They are not invited to be involved in any committees (i.e., QM, QI) to collaborate on improving quality of care. Consumer/Family Members report that they take surveys throughout the year and believe they have input into services.

3D	Evidence of a systematic clinical continuum of care	M

The MHP continuum of care includes 90 contracted and county-operated service providers delivering services across the spectrum from prevention and early intervention, early childhood, outpatient services, crisis intervention and stabilization, residential services, wellness and recovery centers, and inpatient psychiatric hospitalization.

A TAY FSP opened October 2017. The program targets TAY who meet at least one of the following criteria: homeless or at risk of homelessness, aging out of the child mental health system, involved in or aging out of the child welfare system, involved in or aging out of the juvenile/criminal justice system, at risk of involuntary psychiatric hospitalization or institutionalization, experiencing a first episode of a serious mental illness, in or recently discharged from an acute care setting, or other at-risk populations with identified mental health needs.

The MHUCC opened in November 2017 and filled a gap in the continuum of care. The clinic staff provides triage, assessment, and referrals for qualifying services and resource to those individuals that are not currently linked to services. For those that have been linked to outpatient services the clinic staff will provide urgent care services and communicate treatment with primary provider.

Two additional Mobile Crisis Teams (MCTs) will be added to service in the North and Elk Grove areas of the county beginning in Fall 2018. This bring the total to six MCTs. Each team composition includes a law enforcement officer and county mental health

clinician who ride together in the law enforcement vehicle, as well as a peer who is also part of the team.		
3E	Evidence of beneficiary and family member employment in key roles throughout the system	M
All peer employee positions exist in contract provider organizations. Three consumer/family members sit in Executive Team meetings. Consumer and family advocates participate in management team meetings on a regular basis. Peers are involved in MCT services. Knowledge of career opportunities within the MHP system appeared limited, and peer employees present at the on-site meeting were unaware of career opportunities for advancement.		
3F	Beneficiary run and/or beneficiary driven programs exist to enhance wellness and recovery	M
The wellness and recovery centers are beneficiary run and beneficiary driven. Expanded contracts provide for increase in services to the homeless and for peer crisis respite support. Peer partners assist with discharge planning, coordinate care, and support various wellness and recovery behavior that promote self-determination		
3G	Measures clinical and/or functional outcomes of consumers served	M
The MHP and its contract providers utilize Child and Adolescent Needs and Strengths (CANS) (and are implementing CANS-50), Level of Care Utilization System (LOCUS), Consumer Perception Survey (CPS) and other satisfaction surveys for feedback from consumers on needs, satisfaction, and level of care (LOC).		
3H	Utilizes information from Consumer Satisfaction Surveys	M
The bi-annual Consumer Perception Survey continues to be conducted and data reported. Aggregate beneficiary responses are compared for trending patterns. Stakeholders interviewed were aware of completing this and other intermittent surveys through the year.		

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of Sacramento MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities and Recommendations

PIP Status

Clinical PIP Status: Concept only, not yet active (not rated)

Non-clinical PIP Status: Concept only, not yet active (not rated)

Recommendations:

- As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.
- Clinical PIP: Restate study question to include a metric for "improving consumer wellbeing" and redefine how study question is stated for both clarity and to ensure quantifiable results. The Mental Health Urgent Care Clinic (MHUCC) changes in protocol make it necessary for the MHP to review both indicators and interventions for their usefulness in measuring change. Redesign the indicators and interventions to address the MHUCC changes in protocol. Consult with EQRO early and often during the PIP formulation.
- Non-clinical PIP: Restate the study question to include quantifiable goals. Investigate and resolve problems that are barriers to retrieving valid data. Complete any changes and/or additions to indicators and interventions. Began interventions and collect data at least quarterly. Consult with EQRO early and often during the PIP formulation.

Access to Care

Changes within the past year:

- The MHUCC opened in November 2017 and filled a gap in the continuum of care. The clinic staff provides triage, assessment, and referrals for qualifying services and resource to those individuals that are not currently linked to services. For those that have been linked to outpatient services the clinic staff will provide urgent care services and communicate treatment with primary provider.
- Two new contracts were executed addressing the needs of Commercially Sexually Exploited Children and Youth (CSEC).
- A Transition Age Youth Full Service Partnership (TAY FSP) program opened in October 2017.

- Two new MCSTs are scheduled to be added within the quarter in the North and Elk Grove parts of the county.

Strengths:

- There has been a significant expansion of services for people with mental illness who are homeless or at risk of being homeless. In November 2017, the Board approved $44,000,000 over three years to fund mental health treatment services and supports. Some funds have been allocated to expand existing programs in FY18-19 while other funds are in the procurement process with the goal of improving quality of care and outreach to the mentally ill homeless population.

- The MHP will gather data from the school district that utilizes MHP navigators to track the number of connections and linkages to the mental health system and resources in the community.

- The MHP makes changes to programs to address identified disparities.

Opportunities for Improvement:

- Overall penetration rates and Average Cost per Beneficiary (ACB) have both been below other large counties and the State for the last three years.

- The MHP reports that, for the fourth quarter of CY 2017, 38.9 percent of adults who were authorized for services were discharged without receiving a service. For children it was 25.5 percent; for foster care it was 34.5 percent. There is no comparable data for other large counties or the state, but in a county with a clear capacity issue, that level of consumers leaving without receiving services is a concern.

- Roughly a third of consumers authorized for services leave the MHP without receiving a service, basic timeliness goals are met only 30 percent of the time. The timeliness goal for urgent services, seven days where most MHPs have a two-day goal for urgent appointments, is met only 8 percent of the time for adults, 16.8 percent of the time for children, and 28.6 percent of the time for foster care.

- Contract providers report carrying caseloads as much as twice the number in their original contract with no increase in funding and they do this while dealing with a chronic high turnover rate in qualified employees. The MHP is in a crisis of inadequate resources to meet beneficiary needs.

- The impact of the MHP changes made to address disparities is compromised by chronic staff turnover issues and a substantial overall gap between available resources and the level of need in the community.

Recommendations:

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

Timeliness of Services

Changes within the past year:

- The MHP has introduced the Avatar Scheduler module in two Adult Regional Support Teams (RSTs) provider clinics as part of a PIP to improve timeliness.
- Both the clinical and non-clinical PIPs this year address timeliness to services.

Strengths:

- The MHP continues to address timeliness issues in an ongoing effort to increase timeliness to first and ongoing services. The current PIPs are examples of this.

Opportunities for Improvement:

- The MHP does not track the time from initial contact to first offered appointment, per their Timeliness Self-Assessment. Per DHCS Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) 18-011, the state requirement is ten business days.
- The MHP-reported timeliness data for urgent conditions show very low adherence to its own standards.
- The MHP standard for timeliness from initial contact to first offered psychiatric appointment is 30 days. Per IN 18-011, the state requirement is 15 days.
- The MHP does not have a system in place for children and youth services to measure timeliness from first request to first offered psychiatric appointment.

Recommendations:

- Per IN 18-011, redefine timeliness standard from initial contact to first offered appointment to ten business days.
- Establish a PIP to improve timeliness standard and adherence rates to the standard for treatment of urgent conditions.
- Per IN 18-011, redefine timeliness standard from initial contact to first offered psychiatric appointment to 15 days.
- Design and implement system to measure timeliness of first request to first offered psychiatric appointment for children and youth services.

Quality of Care

Changes within the past year:

- High cost beneficiaries (HCB) as a percentage of total beneficiaries was 3.52 percent at the state level and 1.73 percent for the Sacramento MHP, down from

2.34 percent the previous year. ACB for HCB beneficiaries was 8.6 percent below the state average.

- Inpatient psychiatric admissions were down 3 percent from last year, but the ACB for inpatients was down 14 percent. Average length of stay was also lower by approximately half a day. These three results combined may be indicators of progress in addressing the MHP's relatively high inpatient costs. It is important to note that while admission for Medi-Cal reimbursed inpatient psychiatric services have gone down, this does not include the cost for the IMD excluded hospitals where Medi-Cal beneficiaries receive inpatient psychiatric care. Those costs have increased but are not captured in Medi-Cal claims data.

- Whether broken down by age, gender, race/ethnicity, or eligibility category, for CY 2017, Sacramento's ACB was below both the state and other large MHPs. beneficiaries. That was true for service categories as well, with one exception. Sacramento's ACB for inpatient services was higher than the state by 13.5 percent and higher than other large counties as well.

- The figures for CY 2017 are similar to CY 2016. In CY 2016, Sacramento overall ACB was 10.8 percent below the state, and even more below other large counties. In CY 2017, the MHP was 8.3 percent below the state ACB and, again, even more also below the ACB of other large counties. In CY 2016, the MHP's ACB for inpatient was 39.0 percent higher than the statewide average.

- There are identified staff from Jail Psychiatric Services with direct access to Avatar. Current access allows these users to run Diagnosis and Movement History reports to see if the individual is known to the MHP and/or currently linked to an outpatient provider. There is also a MHP Navigator at the jail with access to Avatar that can assist when they know a MHP client is in the jail. The MHP does not receive data on MHP consumers seen by the contracted provider of physical and mental health services at the jail but can coordinate with Jail Services to obtain records for continuity of care purposes.

- The MHP's self-reported percentage of beneficiaries served with co-occurring diagnoses (i.e., substance abuse and mental health) diagnoses is 21 percent. In sessions with clinicians there was a consensus that this number substantially under-reports co-occurring diagnoses. Clinicians reported that a past practice of not formally documenting co-occurring diagnoses thinking they were doing the beneficiary a favor, needs to change. Clinicians acknowledged that the culture needs to change for this to occur. The advent of the Drug Medi-Cal Waiver may encourage a rapid adjustment in practice.

Strengths:

- Continuum of care was evident in the MHP to include prevention and early intervention, early childhood mental health services, outpatient service, crisis intervention and stabilization, residential service, and inpatient psychiatric hospitalization.

Opportunities for Improvement:

- With consistently lower ACB than other large counties and the state for all categories of service except inpatient, where the Sacramento ACB is substantially higher, there is a question of whether beneficiary needs are not being met at lower levels of care and that is then driving inpatient utilization. The other possibility is that people in inpatient care are not being moved to lower levels of care efficiently and timely because of congestion at those levels of care. The MHP's penetration rate for inpatient is below the rate for the state and other large counties; however it is important to note the penetration data does not include the three freestanding IMD excluded hospitals in the County, which would increase the penetration rates as most of the MHP's beneficiaries are served in these hospitals. This may suggest that the number of inpatient stays is not driving inpatient costs, but rather the severity of those cases and/or the difficulty in finding appropriate stepdown placements from inpatient, or both, are driving inpatient costs. The average length of stay is over nine days, which is high compared to other counties. In either case, it is money going to inpatient while other service categories appear to be underfunded relative to the demand.

- Contracted providers stated that the gap between MHP capacity and demand for MHP services has reached a point where it is directly affecting the quality of care. This is, at its root, a financial issue. Contract providers have not had a rate increase in many years, but costs continue to rise for rent and other necessities of doing business, and the salaries they can offer employees have become progressively less competitive over the years.

- Network providers make up only .99 percent of the MHP claims. Of those, twenty-three percent of network provider claims were denied in CY 2017. The MHP does the data entry for these claims. The source of the problem was stated as late data entry and input errors (which may speak to the level of training).

- There is a need to train, encourage, and supervise clinicians to accurately document co-occurring diagnoses.

- Level of Care Tools were not mentioned in any session, nor were the participants in groups familiar with outcome tools used to assess Level of Service (LOS) or LOC that would be appropriate for an individual beneficiary. While Level of Care Tools are used by the MHP this indicates that additional education for provider staff is necessary to equate the LOCUS with the determination of LOS/LOC.

Recommendations:

- Implement training and supervise clinicians to accurately document co-occurring diagnoses. Administer pre and posttests of knowledge on co-occurring diagnoses as part of training and ongoing supervision process.

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

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

Beneficiary Outcomes

Changes within the past year:

- The MHP has started using the CANS-50 outcomes tool with children.
- The MHP decided to wait for guidance from DHCS before choosing and implementing further outcomes tools for adults.

Strengths:

- Consumers reported that they were involved in treatment planning and ongoing services decisions.
- Wellness and recovery centers in the county are beneficiary run and beneficiary driven. These facilitate ongoing opportunities for independence for the beneficiaries involved.
- The MHP distributed information and materials for the Workforce Information Support and Education University (WISE U). WISE U conducts a Peer Support Training Academy that not only provides training in recovery principles and development of skills that are key to successful employment, but also assists in seeking employment or volunteer opportunities upon graduation. The county also sponsors the Annual NorCal MHA Peer Empowerment Conference which brings together consumers, peer employees and guest speakers to increase the collaboration and knowledge base within the mental health community.

Opportunities for Improvement:

- The MHP does not have the ability to do enterprise level outcomes reporting. As a first step, they need to incorporate outcomes measures into the Avatar documentation flow where it then becomes available for reporting.
- The MHP does not have a defined career ladder that is consistent within all contract providers who incorporate peer employees into their programs.

Recommendations:

- Incorporate outcomes measures for CANS-50 into the Avatar documentation flow and begin to report enterprise level outcomes. Research outcomes measures that will allow aggregate reporting for adult consumers.
- Research the opportunity to create a contract standardized defined career ladder for peer employees incorporated into contract provider programs.

Foster Care

Changes:

- The Department of Health and Human Services (DHHS) split into two departments, with Behavioral Health Services overseen by the Department of Health Services (DHS), and Child Welfare Services overseen by the Department of Child, Family and Adult Services (DFACS). This creates a different structure for oversight of the work with Katie A.-designated subclass eligible children, which includes foster care children.
- Behavioral Health Services (BHS) participates in cross system meetings to address the implementation of the Continuum of Care Reform (CCR). BHS is participating in the review of Short Term Residential Therapeutic Program (STRTP) statements led by Child Protective Services (CPS) and Probation.
- There are currently open enrollment requests posted for bids for STRTPs and TFCs.

Strengths:

- The MHP has an effective working relationship with Child Welfare Services and Probation.
- There are seven incubator leads in Sacramento County to improve outreach to minority communities. CPS has created Cultural Brokers to assist families in moving through the Child Welfare System (CWS), and to support engagement with CPS social workers.

Opportunities for Improvement:

- The ACB for foster care is 20.6 percent below the state ACB and 28.5 percent below the ACB in other large counties. In the absence of compelling outcomes data showing better outcomes at this lower cost, this difference very likely represents a lower LOS for foster care consumers in this MHP. This needs to be investigated and, if confirmed, corrected.
- The MHP reports that they have no ability to track if services are received after foster care beneficiaries have stepped down to a lower LOC.

Recommendations:

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

- Investigate reasons for low ACB for foster care beneficiaries. Design and implement plan to increase penetration rate to more closely reflect large county averages for this demographic.
- Research opportunities to track follow up services within the EHR system after foster care beneficiaries have stepped down to a lower LOC.

Information Systems

Changes within the past year:

- County employees replaced contracted IT resources during this planned transition year. This was disruptive of some efforts in progress and there is limited progress to show for the year as a result.
- There were few other significant changes in the past year. While the MHP changed from contracted IT resources to county employees, they are currently at a 37 percent vacancy rate for IT employees. At that staffing level, this MHP is challenged just to handle day-to-day operations and user support. They simply do not have the resources to take on projects that will move the organization forward. Even fully staffed, taking on any one of their current priorities may be all they can manage.

Strengths:

- The MHP has invested in an EHR, Netsmart Avatar, which can support an organization of its size and complexity.
- The MHP IT employees encountered during the review appeared capable and dedicated. There just weren't enough of them at the right levels.

Opportunities for Improvement:

- Strategies to eliminate constraints on the use of data by use of a data warehouse was not possible in the past year.
- The MHP was unable to develop strategies and did not have resources plans to electronically exchange data between the MHP's Avatar system and contract provider's EHR.
- The current Avatar implementation appears to be incomplete and not optimally set up for this MHP. There are functions within the Avatar system (i.e., referrals and scheduling) that are not being fully utilized. There were statements from MHP staff that Avatar cannot support certain functions, to include integrating EBP documentation, that are being used effectively in other counties. This is frustrating the MHP's employees and contractors, impacting the timeliness and quality of care, impacting the quality of the MHP's data, and likely costing the MHP money.

- The MHP does not have adequate IT resources, even if its current FTEs are filled. The MHP is not getting their full value for their investment in Avatar and they are likely losing revenue as well. Number of resources is certainly part of it, but there are also key skill sets missing. Ideally, the MHP should add:
    - A clinical informaticist: This is ideally a working clinician (part time) who is expert in the Avatar Clinicians Workstation (CWS), and knowledgeable about Practice Management (Cal-PM) and Avatar billing and claims processing.
    - A person with knowledge of and experience with standards-based healthcare data exchange and integration.
    - A healthcare data manager, ideally one with knowledge of data architecture and high-level database administrator skills.
    - A Director of Information Technology who will report to the MHP Director, with electronic health record leadership experience and membership in the Executive Committee, to bring coherence to the MHP's investment in technology.
    - A Director of Information Technology, with electronic health record leadership experience, reporting to the MHP Director and with membership in the Executive Committee to bring realistic planning and coherence to the MHP's investment in technology.
- The MHP appears to be doing the bulk of its reporting directly from Avatar and a few stand-alone databases. Avatar is a care delivery and management tool. It is not optimized for data reporting purposes, particularly enterprise level longitudinal reporting. That is a job for a data warehouse. Ultimately, to improve the quality of its reporting, the MHP will need to implement a data warehouse. It can be designed from scratch (a long and difficult project), purchased as a framework from vendors like Oracle, or purchased from healthcare specific vendors such as Netsmart. The MHP does not have the resources to take this on unless it addresses the staffing recommendations above.
- Modern healthcare delivery is becoming progressively more dependent upon electronic health information exchange to coordinate care across organizations and types of healthcare to the ultimate benefit of the beneficiary. The MHP has no current strategy nor the resources to execute such a project should they identify a strategy. This is an opportunity to improve the efficiency of operations, improve the quality and timeliness of data, and ultimately improve outcomes for MHP beneficiaries.

Recommendations:

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

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

- Establish a formal IT Help Desk supported by software to enable tracking and reporting on help desk calls.
- Implement Avatar Scheduler at all MHP sites and make its use mandatory for all clinicians, including psychiatrists.

Structure and Operations

Changes within the past year:

- The Department of Health and Human Services (DHHS) split into two departments, with Behavioral Health Services going to the new Department of Health Services (DHS).
- The MHP changed from contracted IT resources to county employees.

Strengths:

- The MHUCC opened November 2017. The MHUCC has been incorporated into the MHP service continuum to provide walk-in services to individuals of all ages who are experiencing a mental health and/or co-occurring substance abuse crisis.

Opportunities for Improvement:

- Not all MHP clinicians use the Avatar Scheduler module and while the introduction of Scheduler as part of the non-clinical PIP is a reasonable first step, the needed goal would be universal use of Scheduler by clinicians in the MHP and the contract providers (unless their EHRs are integrated with the MHP's Avatar).
- It was stated by participants in more than one session that the demand for services greatly exceeds current capacity. This is exacerbated by chronic resource shortages because local salaries are not approximately competitive in the regional market. This holds true for clinical and IT resources.
- The MHP did not implement Medicare Part B claim processing.

- The MHP's self-reported percentage of beneficiaries served with co-occurring diagnoses (i.e., substance abuse and mental health) diagnoses is 21 percent. The MHP acknowledges problems with tracking co-occurring disorders.
- The electronic laboratory order entry and results reporting pilot has been put on hold because of resource constraints and system functionality that impacts clinician workload and quality of care. The MHP is working with the vendor to resolve the functionality issues.
- The MHP was unable to explore strategies to eliminate current constraints on the use of data in this past year. Budget constraints presented barriers to find and implement solutions to constraints of use of data.

Recommendations:

- Utilize the current non-clinical PIP process as an opportunity to begin moving towards universal use of Avatar Scheduler by MHP and contract providers.
- Complete the implementation of Medicare Part B claims processing. Please refer to IN 2011-04 and IN 2009-09. (This recommendation is a carry-over from FY 2017-18.)
- Update QM Documentation Training to reflect the MHP direction to accurately reflect the data regarding co-occurring disorders. This is both a data reporting issue and a clinical assessment issue that can be strengthened in Documentation training and Avatar training for instruction of data entry
- Complete the implementation of electronic laboratory orders and results.
- Reassess in 2019 budget the MHP's ability to explore strategies to eliminate current constraints on the use of data. Consider establishing a data warehouse to improve data analysis and reporting capabilities. (This recommendation is a carry-over from FY 2017-18.)

Summary of Recommendations

FY 2018-19 Recommendations:

- Research factors contributing to approximately 33 percent of all beneficiaries authorized to services being discharged without receiving a service.
- Per IN 18-011, redefine timeliness standard from initial contact to first offered appointment to ten business days.
- Establish a PIP to improve timeliness standard and adherence rates to the standard for treatment of urgent conditions.
- Per IN 18-011, redefine timeliness standard from initial contact to first offered psychiatric appointment to 15 days.
- Design and implement system to measure timeliness of first request to first offered psychiatric appointment for children and youth services.
- Clinical PIP: Restate study question to include a metric for “improving consumer wellbeing” and redefine how study question is stated for both clarity and to ensure quantifiable results. The Mental Health Urgent Care Clinic (MHUCC) changes in protocol make it necessary for the MHP to review both indicators and interventions for their usefulness in measuring change. Redesign the indicators and interventions to address the MHUCC changes in protocol. Consult with EQRO early and often during the PIP formulation.
- Non-clinical PIP: Restate the study question to include quantifiable goals. Investigate and resolve problems that are barriers to retrieving valid data. Complete any changes and/or additions to indicators and interventions. Began interventions and collect data at least quarterly. Consult with EQRO early and often during the PIP formulation.

FY 2018-19 Foster Care Recommendations:

- Ensure that all workflows are in place and execute any new MOUs needed to ensure appropriate exchange of information in a timely manner for the oversight of the work with Katie A. designated subclass children, to include foster care children, between all involved agencies.
- Investigate reasons for low ACB for foster care beneficiaries. Design and implement a plan to increase this penetration rate to more closely reflect large county averages for this demographic.
- Research opportunities to track follow up services within the EHR system after foster care beneficiaries have stepped down to a lower LOC.
- Implement training to accurately document co-occurring diagnoses. Include adult learning principles of practice activities to facilitate learning. Include this issue

within the Utilization Review Committee to bring this need to the Provider QA representatives for oversight.

- Develop a system to address the issue of the MHP receiving data on beneficiaries seen by contracted providers of physical and mental health services at the jail. Ensure that the MHP Navigator at the jail has information of beneficiaries incarcerated to assist jail clinical staff.
- Incorporate outcomes measures for CANS-50 into the Avatar documentation flow and begin to report enterprise level outcomes. Research outcomes measures that will allow aggregate reporting for adult consumers.
- Appropriately staff the MHP's IT Department. This includes:
    - A Director of Information Technology, who will, report to the MHP Director, with electronic health record leadership experience and membership in the Executive Committee, to bring coherence to the MHP's investment in technology.
    - A clinical informaticist with a clinical background.
    - A person with knowledge of and experience with standards-based healthcare data exchange integration.
    - A healthcare data manager, ideally one with knowledge of data architecture and high-level database administrator skills.
- Establish a formal IT Help Desk supported by software to enable tracking and reporting on help desk calls.
- Utilize the current non-clinical PIP process as an opportunity to begin moving towards universal use of Avatar Scheduler by the MHP and contract providers. Implement Avatar Scheduler at all MHP sites and make its use mandatory for all clinicians, including psychiatrists.
- Research the opportunity to create a contract standardized defined career ladder for peer employees incorporated into contract provider programs.

Carry-over and Follow-up Recommendations from FY2017-18:

- Complete the implementation of Medicare Part B claims processing. Please refer to IN 2011-04 and IN 2009-09. (This recommendation is a carry-over from FY 2017-18 and was also a recommendation in FY 2015 -16.)
    - The MHP currently cannot bill Medicare Part B which would increase revenue and provide the option to bill State Drug Medi-Cal (SDMC) for dually covered beneficiaries (i.e. Medi-Medi eligibles).
    - Increased revenue would offer an opportunity to enhance service provisions for beneficiaries.

- Reassess in 2019 budget planning the MHP's ability to explore strategies to eliminate current constraints on the use of data. Consider establishing a data warehouse to improve data analysis and reporting capabilities. (This recommendation is a carry-over from FY 2017-18.)
    - Funding was not provided in the FY 2018 -19 budget for this project. This is the single known obstacle to addressing this recommendation.
    - The MHP plans to recommend funding to the Netsmart agreement when it is renewed in July 2019 to enable this project.
- Research the opportunity to create a contract standardized defined career ladder for peer employees incorporated into contract provider programs. (This recommendation is a carry-over from FY 2017-18.)
    - The MHP will need to create a boilerplate contract clause to include how peer employees are incorporated into contract provider programs.
    - This needs to include opportunities for career advancement (i.e. a career ladder).

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: PIP Validation Tools

Attachment A—On-site Review Agenda

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

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

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

Attachment B—Review Participants

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Laysha Ostrow, Quality Reviewer Consultant
Robert Greenless, Information Systems Reviewer
Tilda DeWolfe, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Sites

Sacramento Health Services Administration
7001 East Parkway
Sacramento, CA 95828

Mental Health Urgent Care Clinic
2130 Stockton Blvd., Building 300
Sacramento, CA 95817

Contract Provider Sites

Consumer Self Help - Wellness and Recovery Center.
7171 Bowling Drive, Suite 300
Sacramento, CA 95823

Capital Start Behavioral Health
Transitional Age Youth Full Service Program
401 S. St.
Sacramento, CA 95811

Stanford Youth Solutions
8912 Volunteer Lane
Sacramento, CA 95826

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Asare	Mary-Ann	Pharmacist	Sacramento County Behavioral Health
Bader	Sandena	Family and Youth Advocate Liaison	NorCal Mental Health America
Baker	David	Chief Executive Officer	Sacramento Children's Home
Barney	Robin	Family Advocate Liaison	NorCal Mental Health America
Baumgardner	Robert	Clinician	Adult Psychiatric Support Services (APSS)
Bielz	Georgia	Program Manager	Crossroads Diversified
Bliss	Erin	Administrative Services Officer 2	Sacramento County Behavioral Health
Bosley	La Guana	Vocational Specialist	Telecare SOAR
Cervantez	Jesus	Program Coordinator	Sacramento County Behavioral Health
Churchill	Jennifer		Terra Nova
Collette	Sara	Program Director	Human Services Consultant (HRC)
Curran	Tom	Program Coordinator	El Hogar, Guest House
Czarnecki	David		Adult Psychiatric Support Services – Peer Program
DeOCamplo	Maria	Human Service Program Planner	Sacramento County Behavioral Health
Dr. Horst	Bob	County Medical Director – Children's Services	Sacramento County Behavioral Health
Dugan	Amy		UC Davis
Dziuk	Ed	Program Manager – Alcohol and Drug Services	Sacramento County Behavioral Health
Earle	Wendy	Clinical Director	El Hogar RST
Echeverria	Jessica	Clinician	El Hogar, Sierra Elder Wellness Program

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Eskow	Genelle	Chief Executive Officer	El Hogar
Fiaws	Caitlin	Youth Advocate	Nor Cal Mental Health America
Freeny	Katie	Program Director	El Hogar
Garcia	Alba	Human Services Program Planner	Sacramento County Behavioral Health
Garcia	Olivia		Nor Cal Mental Health America
Gilletts	Robert	Accounting Manager	Sacramento County Behavioral Health
Green	Sheri	Program Manager – Children's Services	Sacramento County Behavioral Health
Hawkins	Pamela	Program Coordinator	Sacramento County Behavioral Health
Hoang	Trang	Program Coordinator	Sacramento County Behavioral Health
Hunter	Timothy		Uplift Family Services
Ibarra	Melony	Administrative Services Officer 2	Sacramento County Behavioral Health
Iverson	Marintha	Health Program Manager	Sacramento County Behavioral Health
Jacobs	Melissa	Division Manager – Children's Services	Sacramento County Behavioral Health
Jensen	Amy	Program Director	Turning Point Community Programs (TPCP)
Kantner	James	Program Coordinator	Sacramento County Behavioral Health
Kelly	Stephanie	Program Manager – Adult Services	Sacramento County Behavioral Health
Knickerbocker	Tracey		TLCS
Kuhl	Melissa	Clinician	La Familia
Lane	Michael	Program Director	Consumers Self Help – Wellness and Recovery Center

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Leung	Julie	Acting Program Manager – MHSA	Sacramento County Behavioral Health
Lewis	Sevina	Human Services Program Planner	Sacramento County Behavioral Health
Madariaga	Anthony	Division Manager - Mental Health Treatment Center	Sacramento County Behavioral Health
Marrison	Matthew	Client Advocate Liaison	NorCal Mental Health America
McClure	Erin	Program Coordinator – Access Team	Sacramento County Behavioral Health
McGovern	Lauren	Clinician	Terkensha
Mendoza	Yesenia	Community Support Specialist	CST - Crossroads
Mitchell	Ann	Administrative Services Officer 3 – Avatar Training & Support/DBHS Billing	Sacramento County Behavioral Health
Moharam	Samira	Clinician	Human Resource Consultant (HRC)
Moore	Darlene	Program Coordinator	Sacramento County Behavioral Health
Nakamura	Mary	Program Manager – Cultural Competence/Ethnic Services	Sacramento County Behavioral Health
Nateghi	Maryam		Consumers Self Help – Wellness and Recovery Center
Pastor	Dara	Program Coordinator	El Hogar - RST
Pettengill	Michelle	Quality Improvement Manager	Terkensha
Pimentel	Alicia		Anthem
Provosnsha	Christina	Clinician	Child and Adolescent Psychiatric Services (CAPS)
Ransdell	Mary	Family Advocate	Dignity Health

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Rechs	Alex	Program Manager – Quality Management	Sacramento County Behavioral Health
Reed	Rolanda	Program Coordinator	Sacramento County Behavioral Health
Reid	Michael		Visions Unlimited
Richards	Belyn		Consumers Self Help – Wellness and Recovery Center
Roberts	Trevor	Clinician	El Hogar, RST
Rocha-Wyatt	Monica	Program Coordinator	Sacramento County Behavioral Health
Rodriguez	Yvette	Program Coordinator	Sacramento County Behavioral Health
Ross	Kateri	Behavioral Health Case Manager II – Anthem	Anthem Blue Cross
Sawyer	John	IT Analyst II	Sacramento County Behavioral Health
Sepulveda	Maryln	Program Director	TCore
Shaw III	Vernell		Health Net
Stanton	Meghan	Executive Officer	Consumers Self Help – Wellness and Recovery Center
Udy	Roland	Chief Operations Manager	River Oak Center for Children
Vang	Karen	Clinical Information and Quality Manager	River Oak Center for Children
Watters	Tricia	Program Coordinator – Child and Adolescent Psychiatric Services	Sacramento County Behavioral Health
Weaver	Kelli	Division Manager – Adult Services	Sacramento County Behavioral Health
Wilkinson	Jeff	Chief Executive Officer	Terkensha
Williams	Dawn	Program Manager – Research, Evaluation	Sacramento County Behavioral Health

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		and Performance Outcomes	
Zaborski	Bernice	Program Coordinator	Sacramento County Behavioral Health
Zykofsky	Uma	Behavioral Health Services Director	Sacramento County Behavioral Health

Attachment C—Approved Claims Source Data

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

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

Table C1. CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Sacramento MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,816,091	147,196	3.86%	$703,932,487	$4,782
Large	1,848,772	68,086	3.68%	$362,898,987	$5,330
MHP	145,083	4,254	2.93%	$15,619,281	$3,672

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

Table C2. CY 2017 Distribution of Beneficiaries by ACB Cost Band
Sacramento MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	22,020	95.98%	93.38%	$77,651,836	$3,526	$3,746	70.44%	56.69%
>$20K - $30K	526	2.29%	3.10%	$12,781,563	$24,300	$24,287	11.59%	12.19%
>$30K	397	1.73%	3.52%	$19,802,985	$49,882	$54,563	17.96%	31.11%

Attachment D—List of Commonly Used Acronyms

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

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

YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Sacramento	
PIP Title: Improving Timely Access	
Start Date: 07/01/18 **Completion Date**: TBD **Projected Study Period** (#of Months):12 **Completed**: Yes ☐ No ☐ **Date(s) of On-Site Review** (MM/DD/YY): 08/21-23/18 **Name of Reviewer**: Lynda Hutchens Robert Greenless	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established, and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of the PIP is to reduce barriers and time to first psychiatric appointment by using the Med Bridge Program for individuals who are unlinked and served at the Mental Health Urgent Care Clinic (MHUCC). By providing psychiatric services until the beneficiary can have their first face-to-face with the outpatient provider psychiatrist the MHP hypothesizes that there should be a decrease in hospital/urgent care/emergency room use and an increase in engagement in outpatient services.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Topic selected due to historical data noting long wait times for linkage to ongoing outpatient MH services. Timeliness to first psychiatric appointment is a historically known issue. After opening of MHUCC in November 2017, there was concern that delay of engagement and direct service with psychiatrist would result in additional crisis or consumers dropping out of services.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Sacramento County's Mental Health Plan (MHP) benchmark to 1st outpatient appointment is 10 days. However, as shown in Table 1 (Graphs 1 – 2), for adult consumers served at the RSTs, the average number of days from request for outpatient services to 1st outpatient appointment in FY 2015/16 was 32.2 days, and 31.5 days in FY 2016/17. Additionally, the average number of days from intake (Assessment) to 1st psychiatric service for FY 2015/16 was 87.1, and in FY 2016/17 was 114.0 days.

Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Med Bridge program serves adults 18 years and older, who were unlinked to the MHP prior to their visit at the MHUCC. This population will be compared to the Adult consumers 18 years and older who requested services through traditional means (i.e., the Access Team).
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other not linked to services	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All consumers who are 18 and older who are not linked to services and present at MHUCC.
	Totals	Met Partially Met Not Met UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* "Does having a Med Bridge Program with strategies for coordination of care, both initial and long term, increase consumer engagement, and timeliness to medication services, therefore improving consumer well-being?"	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The question would be more valuable if there were goal percentages. There needs to be a way to measure "improving consumer wellbeing" in the Study Question.
	Totals	Met Partially Met Not Met UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other not linked to services	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Med Bridge serves adults 18 years and older who were unlinked to the MHP prior to their visit to MHUCC. This population will be compared to the adult consumers 18 years and older who requested services through traditional means (i.e., the Access Team).
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	Met Partially Met Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Timeliness from request to psychiatric service at Med Bridge program 2. No show and cancellations rates prior to first Med Bridge appointment 3. Percentage of referred Med Bridge consumers that have an intake appointment at the RST 4. Percent of referred Med Bridge consumers that receive engagement services prior to their first face to face RST appointment 5. Percent of referred Med Bridge consumers that are hospitalized while waiting for their 1st RST appointment (includes consumers that eventually received RST services and consumers that never showed for services) 6. Percent of Med Bridge consumers that are discharged from an RST and never make it to their 1st RST appointment 7. Percent of clients that are discharged from Med Bridge and never make it to their 1st Med Bridge appointment 8. Percent of consumers that have had a Med Bridge psychiatric service and are re-admitted to the MHUCC within 30 days of their MHUCC discharge. 9. Percent of consumers that have had a Med Bridge psychiatric service and are admitted to a higher level of service (ISU and Inpatient) within 30 days of their MHUCC discharge. 10. Level of consumer satisfaction with timely Med Bridge services.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☐ No Are long-term outcomes implied? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	There is no data to evaluate this as yet.
	Totals	Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	There is no data to evaluate this as yet.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	There is no data to evaluate this as yet.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	There is no data to evaluate this as yet.
Totals	Met Partially Met Not Met NA UTD	
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	There is no data to evaluate this as yet.
6.2 Did the study design clearly specify the sources of data? *Sources of data:*	☐ Met ☐ Partially Met ☐ Not Met	

☐ Member ☐ Claims ☐ Provider ☒ Other: *Sources of data: authorization and utilization data, demographics, Med Bridge admissions and discharges, psychiatric hospitalization data, and consumer satisfaction.*	☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Program Planner assigned to the PIP will extract data from MHP's EHR. Data will be extracted based on the indicators outlines in this PIP.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	There is no data to evaluate this as yet.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	There is no data to evaluate this as yet.

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

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Face to face authorization of RST and Med Bridge Services with consumer is at MHUCC. 2. Written document providing outpatient provider information and Med Bridge information with next appointment information while at MHUCC. 3. Coordination of care between Med Bridge and the assigned outpatient provider. 4. RST engages consumer by telephone with three days of referral. 5. APSS/Med Bridge engages consumer by telephone within 48 hours of referral. 6. Develop a Satisfaction Survey for Med Bridge Services.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Interventions are being changed due to change in protocol at MHUCC.
	Totals	Met Partially Met Not Met UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	PIP is concept only. This information is not yet available.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	PIP is concept only. This information is not yet available.

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

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

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	PIP is concept only. This information is not yet available.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	PIP is concept only. This information is not yet available.
Totals	Met Partially Met Not Met NA UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	PIP is concept only. This information is not yet available.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Conclusions: PIP is concept only. This information is not yet available.
Recommendations: Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward. Complete changes needed in the Study Question, Indicators, and Interventions to allow clarity in what is being measured. Proceed to collect and report data not less frequently than quarterly to ensure the PIP becomes active. Schedule TA with CalEQRO to assist in design and implementation of this PIP.
Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19
NON-CLINICAL PIP

GENERAL INFORMATION

MHP: Sacramento

PIP Title: Uniform scheduling system using an electronic scheduling tool

Start Date:2/26/18

Completion Date: TBD

Projected Study Period: 12 Months

Completed: Yes ☐ No ☒

Date(s) of On-Site Review: 8/21 – 23/18

Name of Reviewer: Lynda Hutchens and Robert Greenless

Status of PIP (Only Active and ongoing, and completed PIPs are rated):

Rated

☐ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.

☒ Concept only, not yet active (interventions not started)

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish):

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

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	PIP committee included multi-functional MHP staff, and provider and advocate and community member participation.

1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CalEQRO FY 2013-14 site review recommended that the MHP improve timely access to system-wide services. Historically, there have been timeliness challenges evident in the MHP data. As discussion in different venues to include CalQIC conferences, DHCS webinars on Standards, Terms and Conditions for MHP contracts and various metric/outcome workgroups, the MHP recognized the need to re-evaluate both the calculation methodology and the initial appointment business process to determine the impact on timeliness to service. The PIP builds on previous and current efforts to address timeliness to service by implementing a mechanism within the EHR that allows the MHP to measure the full spectrum of timely access to service, from the initial request for service to the time the MHP authorizes services, to the time of first offered appointment, to the time to first completed face to face appointment.

Select the category for each PIP:

Non-clinical:

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition
☒ Process of accessing or delivering care
☐ High volume services
☐ High risk conditions

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP will test the Avatar scheduler functionality with the adult RST providers. Two adult providers with high volume of clients will participate in the PIP.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other two selected providers	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All adult RST clients of the two selected providers are included.
	Totals	Met Partially Met Not Met UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* "Does using the Avatar scheduler to capture the first offered appointment at the point of authorization improve timeliness to first appointment and decrease the number of no shows and cancels, whereby improving client satisfaction and engagement to services?"	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Study Question needs to ask quantifiable questions of how much improvement of timeliness to first appointment and how much decrease in number of no-shows and cancels.
	Totals	Met Partially Met Not Met UTD

STEP 3: Review the Identified Study Population						
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine					
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine					
	Totals	Met	Partially Met	Not Met	UTD	

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Timeliness to 1st OP Face-to-Face Service at two distinct providers 2. Beneficiaries with no-shows/cancellations prior to 1st OP appt. 3. Timeliness from 1st contact to 1st offered and accepted appointment (scheduler data) 4. Beneficiary satisfaction for 1st OP appt 5. Problem Resolution – grievances and appeals related to timeliness issues 6. Engagement in Services	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☐ No Are long-term outcomes implied? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	There is no data to evaluate this as yet.
	Totals	Met Partially Met Not Met UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	There is no data to evaluate this as yet.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	There is no data to evaluate this as yet.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	There is no data to evaluate this as yet.
Totals	Met Partially Met Not Met NA UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The date of first offered appointment will be captured in the EHR along with no-show and cancellation data. Service authorization and utilization data will also be captured in the EHR and used to determine timeliness to services. Other data to be collected include provider admissions and discharges, and consumer demographic data. Data on the number of grievances submitted to beneficiary protection will also be collected and analyzed.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☐ Other:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Except for data entered into the Scheduler option of the EHR, all other data being used in the analysis of this PIP has been collected/reported by MHP county and contract provider staff since implementation of the EHR (2009). The data to be collected is currently part of the established business processes and guided by policy and procedure.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The EHR and Beneficiary Protection access database are the instruments that will be used to collect the data. County and Contract staff will be responsible for entering the data into the EHR

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Except for data entered into the Scheduler option of the EHR, all other data being used in the analysis of this PIP has been collected/reported by MHP county and contract provider staff since implementation of the EHR (2009). The data to be collected is currently part of the established business processes and guided by policy and procedure.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Appointment, no-show/cancellation data, service authorization, utilization data, and grievance data collected will be used to calculate baseline and repeated measures data for the performance indicators listed in Table A. Data will be analyzed by comparing results from baseline to PIP implementation with results one year after implementation, permeated with quarterly updates. Results and trends will be reviewed quarterly with the PIP Steering Committee meeting to determine whether interventions set forth are providing the intended results. Interventions will be adjusted, and training/coaching may be implemented as required
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Rolanda Reed Title: Program Coordinator Role: Facilitator *Other team members:* Names:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	County and contract staff are responsible for entering data into the EHR.

	Totals	Met Partially Met Not Met UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Update "Scheduling Tool" curriculum, orientation, and training to ensure model fidelity and consistency of use across all sites 2. Deliver Training to 2 sites 3. Access utilizes the scheduler to schedule appointments while they have the beneficiary on the phone 4. Provider utilizes the scheduler to ensure that there are appointment slots available for Access to schedule appointments for beneficiaries 5. Provider reviews Avatar on daily basis to learn of newly scheduled beneficiaries 6. Provider follows up with beneficiary to confirm appointment within 3 business days 7. If beneficiary is hospitalized, Access schedules beneficiary appointment using the scheduler.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	PIP is concept only. This information is not yet available.
	Totals	Met Partially Met Not Met UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	PIP is concept only. This information is not yet available.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	PIP is concept only. This information is not yet available.

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

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

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	PIP is concept only. This information is not yet available. There is no data to evaluate this as yet.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	PIP is concept only. This information is not yet available. There is no data to evaluate this as yet.
Totals	Met Partially Met Not Met NA UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	PIP is concept only. This information is not yet available.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Conclusions: PIP is concept only. This information not yet available.
Recommendations: Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward. Rewrite Study Question to allow quantifiable outcomes. Proceed to collect and report data at least quarterly to ensure the PIP becomes active. Schedule TA with CalEQRO to assist in design and implementation of this PIP.
Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time