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# FY 2023-24
# MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

## SACRAMENTO DRAFT REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

**California Department of Health Care Services (DHCS)**

Review Dates:

**August 8-10, 2023**

# TABLE OF CONTENTS


**EXECUTIVE SUMMARY ..... 6**

MHP INFORMATION ..... 6

SUMMARY OF FINDINGS ..... 6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS ..... 7

**INTRODUCTION ..... 9**

BASIS OF THE EXTERNAL QUALITY REVIEW ..... 9

REVIEW METHODOLOGY ..... 9

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE ..... 11

**MHP CHANGES AND INITIATIVES ..... 12**

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS ..... 12

SIGNIFICANT CHANGES AND INITIATIVES ..... 12

**RESPONSE TO FY 2022-23 RECOMMENDATIONS ..... 13**

**ACCESS TO CARE ..... 16**

ACCESSING SERVICES FROM THE MHP ..... 16

NETWORK ADEQUACY ..... 17

ACCESS KEY COMPONENTS ..... 18

ACCESS PERFORMANCE MEASURES ..... 19

IMPACT OF ACCESS FINDINGS ..... 31

**TIMELINESS OF CARE ..... 32**

TIMELINESS KEY COMPONENTS ..... 32

TIMELINESS PERFORMANCE MEASURES ..... 33

IMPACT OF TIMELINESS FINDINGS ..... 37

**QUALITY OF CARE ..... 38**

QUALITY IN THE MHP ..... 38

QUALITY KEY COMPONENTS ..... 38

QUALITY PERFORMANCE MEASURES ..... 40

IMPACT OF QUALITY FINDINGS ..... 46

**PERFORMANCE IMPROVEMENT PROJECT VALIDATION ..... 47**

CLINICAL PIP ..... 47

NON-CLINICAL PIP ..... 48

**INFORMATION SYSTEMS ..... 51**

INFORMATION SYSTEMS IN THE MHP ..... 51

INFORMATION SYSTEMS KEY COMPONENTS ..... 52
INFORMATION SYSTEMS PERFORMANCE MEASURES ..... 53
IMPACT OF INFORMATION SYSTEMS FINDINGS ..... 55
**VALIDATION OF MEMBER PERCEPTIONS OF CARE ..... 56**
CONSUMER PERCEPTION SURVEYS ..... 56
PLAN MEMBER/FAMILY FOCUS GROUPS ..... 56
SUMMARY OF MEMBER FEEDBACK FINDINGS ..... 58
**CONCLUSIONS ..... 59**
STRENGTHS ..... 59
OPPORTUNITIES FOR IMPROVEMENT ..... 59
RECOMMENDATIONS ..... 60
**EXTERNAL QUALITY REVIEW BARRIERS ..... 61**
**ATTACHMENTS ..... 62**
ATTACHMENT A: REVIEW AGENDA ..... 63
ATTACHMENT B: REVIEW PARTICIPANTS ..... 64
ATTACHMENT C: PIP VALIDATION TOOL SUMMARY ..... 68
ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE ..... 74
ATTACHMENT E: CALEQRO APPROVED CLAIMS DEFINITIONS ..... 75

# LIST OF FIGURES

Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022 ..... 22
Figure 2: MHP PR by Race/Ethnicity, CY 2020-22 ..... 23
Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22 ..... 23
Figure 4: Overall PR, CY 2020-22 ..... 24
Figure 5: Overall AACM, CY 2020-22 ..... 25
Figure 6: Hispanic/Latino PR, CY 2020-22 ..... 25
Figure 7: Hispanic/Latino AACM, CY 2020-22 ..... 26
Figure 8: Asian/Pacific Islander PR, CY 2020-22 ..... 26
Figure 9: Asian/Pacific Islander AACM, CY 2020-22 ..... 27
Figure 10: Foster Care PR, CY 2020-22 ..... 27
Figure 11: Foster Care AACM, CY 2020-22 ..... 28
Figure 12: Wait Times to First Service and First Psychiatry Service ..... 35
Figure 13: Wait Times for Urgent Services ..... 35
Figure 14: Percent of Services that Met Timeliness Standards ..... 36
Figure 15: Retention of Sacramento MHP Members Served, CY 2022 ..... 40
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022 ..... 41
Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022 ..... 42
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22 ..... 44
Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22 ..... 44
Figure 20: Members and Approved Claims by Claim Category, CY 2022 ..... 46

# LIST OF TABLES

Table A: Summary of Response to Recommendations ..... 6
Table B: Summary of Key Components ..... 6
Table C: Summary of PIP Submissions ..... 7
Table D: Summary of Plan Member/Family Focus Groups ..... 7
Table 1A: Sacramento MHP Alternative Access Standards, FY 2022-23 ..... 17
Table 1B: Sacramento MHP Out-of-Network Access, FY 2022-23 ..... 17
Table 2: Access Key Components ..... 18
Table 3: Sacramento MHP Annual Members Served and Total Approved Claims, CY 2020-22 ..... 19
Table 4: Sacramento MHP Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022 ..... 20
Table 5: Threshold Language of Sacramento MHP Medi-Cal Members Served in CY 2022 ..... 20
Table 6: Sacramento Medi-Cal Expansion (ACA) PR and AACM, CY 2022 ..... 21
Table 7: Sacramento MHP PR of Members Served by Race/Ethnicity, CY 2022 ..... 21
Table 8: Services Delivered by the Sacramento MHP to Adults ..... 29
Table 9: Services Delivered by the Sacramento MHP to Youth in Foster Care ..... 30
Table 10: Timeliness Key Components ..... 32
Table 11: FY 2023-24 Sacramento MHP Assessment of Timely Access ..... 34
Table 12: Quality Key Components ..... 39
Table 13: Sacramento MHP Psychiatric Inpatient Utilization, CY 2020-22 ..... 43

Table 14: Sacramento MHP High-Cost Members (Greater than $30,000), CY 2020-2245
Table 15: Sacramento MHP Medium- and Low-Cost Members, CY 2022 ..... 46
Table 16: Contract Provider Transmission of Information to Sacramento MHP EHR.... 52
Table 17: IS Infrastructure Key Components ..... 53
Table 18: Summary of Sacramento MHP Short-Doyle/Medi-Cal Claims, CY 2022..... 54
Table 19: Summary of Sacramento MHP Denied Claims by Reason Code, CY 2022 .. 54
Table A1: CalEQRO Review Agenda ..... 63
Table B1: Participants Representing the MHP and its Partners ..... 65
Table C1: Overall Validation and Reporting of Clinical PIP Results ..... 68
Table C2: Overall Validation and Reporting of Non-Clinical PIP Results ..... 71

# EXECUTIVE SUMMARY

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

## MHP INFORMATION

**Review Type** – Virtual

**Date of Review** – August 8-10, 2023

**MHP Size** – Large

**MHP Region** – Central

## SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

### Table A: Summary of Response to Recommendations

| # of FY 2022-23 EQR Recommendations | # Fully Addressed | # Partially Addressed | # Not Addressed |
|---|---|---|---|
| 5 | 3 | 2 | 0 |

### Table B: Summary of Key Components

| Summary of Key Components | Number of Items Rated | # Met | # Partial | # Not Met |
|---|---|---|---|---|
| Access to Care | 4 | 4 | 0 | 0 |
| Timeliness of Care | 6 | 2 | 3 | 1 |
| Quality of Care | 10 | 6 | 4 | 0 |
| Information Systems (IS) | 6 | 5 | 1 | 0 |
| **TOTAL** | **26** | **17** | **8** | **1** |

### Table C: Summary of PIP Submissions

| Title | Type | Start Date | Phase | Confidence Validation Rating |
|---|---|---|---|---|
| Racial Equity Action Plans (REAPs) | Clinical | 01/2022 | Concluded | Low |
| Admissions at Provider Site – Timeliness to Service Post-Assessment | Non-Clinical | 01/2022 | Concluded | Low |

### Table D: Summary of Plan Member/Family Focus Groups

| Focus Group # | Focus Group Type | # of Participants |
|---|---|---|
| 1 | ☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other | 6 |
| 2 | ☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other | 9 |
| 3 | ☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other | 2 |

## SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP currently supports 310 units of permanent supportive housing and provides wraparound services for supportive bridge housing.
- The MHP expanded their Community Outreach, Recovery and Empowerment (CORE) programs to serve 11 wellness centers and outpatient services in areas of specific identified populations.
- The MHP embarked on an ambitious roll-out of the new Electronic Health Record (EHR) SmartCare, providing numerous training courses and post roll-out technical assistance (TA.)
- The MHP has created a peer ladder to accommodate 44 new peer and peer certified work force positions.
- Working with the Workforce Education and Training (WET) Central Region, the MHP enhanced their ability to retain staffing positions by approving 125 awards for student loan repayment.

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

- The MHP is in the process of transitioning over to a new website. The current website lacks ease of maneuverability, crisis numbers, and consistent program and resource messaging.

- The MHP does not have a real-time EHR database that can be used for generating reports that they determine are necessary. Additionally, some SmartCare EHR users continue to have challenges using and understanding the policies and procedures of accessing and reporting data in the system.
- The MHP does not report standard percentages to identify no-show rates for psychiatrists and clinicians.
- The MHP does not accurately track the timeliness data for the first offered non-urgent psychiatry appointment.
- Calls to the Access line may go unanswered and/or not returned when individuals are seeking services.

Recommendations for improvement based upon this review include:

- Engage user and staff input when remodeling the current website; prominently display crisis access and 988 numbers, and how to access the Mental Health Urgent Care Clinic (MHUCC).
- Research and implement a project to gain access to a complete SmartCare database that is refreshed nightly and could be used for the MHP's distinct reporting needs. Assure that training meets the needs of those staff who use the EHR for reporting.
- Identify and implement acceptable standard percentages for clinical and psychiatrist no-show rates; and accurately report these rates.
- Provide reporting on all first offered non-urgent psychiatry appointment to monitor wait times.
- Examine staffing and responsiveness at the 24-hour Access line.

# INTRODUCTION

## BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

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

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

This report presents the FY 2023-24 findings of the EQR for Sacramento County MHP by BHC, conducted as a virtual review on August 8-10, 2023.

## REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY) 2022 and FY 2022-23, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

## HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

# MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

## ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the COVID-19 pandemic. The MHP continues to be impacted by staff shortages and vacancy rates of 40 percent overall.

## SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP implemented the California Mental Health Services Authority (CalMHSA) SmartCare Semi-Statewide EHR effective July 1, 2023.
- The MHP developed and implemented a new Level of Intensity Screening Tool (LIST) to screen and support referral and linkage to select Full-Service Partnership (FSP) programs.
- Caller identification will now display the County phone numbers as a way of addressing barriers to services for members who may not answer calls with blocked numbers.
- The MHP implemented a soft launch of the Community Wellness Response Team (CWRT).
- The MHP increased its Certified Peer staff positions across the system of care.

# RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

**Addressed** is assigned when the identified issue has been resolved.

**Partially Addressed** is assigned when the MHP has either:

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

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

Recommendations from FY 2022-23

**Recommendation 1:** Develop and implement a system to accurately track and report urgent service requests, including requests that do not require prior authorization and for beneficiaries who request urgent services but who do not follow up with the referral to MHUCC, and ensure data is accurate when reporting.

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP defines urgent appointments as admissions to the MHUCC and those with a mental health service within 48 hours of admission. The MHP tracked and reported on this collection for FY 2022-23.
- The MHP does not track individuals that chose not to walk into the MHUCC once referred. There currently is no mechanism to identify those individuals that are not receiving urgent services once referred to the MHUCC. This is a metric that the MHP is encouraged to track.

**Recommendation 2:** Develop and implement a system to accurately track and report no shows for psychiatrists and/or clinicians other than psychiatrists and ensure data integrity from Contractor providers.

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP uses existing no show and cancelation service codes and separates out the codes by practitioner.
- The MHP increased reminders to provider to use the no show and cancelation code during documentation training, UR Committee meeting, and provider director meetings and saw an increase in utilization.
- To be fully met the MHP needs to identify a standard no show rate to accurately report findings. A new recommendation will be assigned to address this finding.

**Recommendation 3:** Expand outcome goals within the Quality Improvement Work Plan (QIWP), to include the impact on beneficiaries when compliance percentage goals are achieved.

(This recommendation was continued from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP added beneficiary impact statements to each of the goals in the Quality Improvement Work Plan.

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

(This recommendation was continued from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP sought to address this recommendation in TA with CalEQRO.
- The MHP reviewed the recommendation and updated the PIP document to follow the assigned format.

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

(This recommendation was continued from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- A Learning Management System (LMS) was implemented for cultural competency training. If contracted providers conducted their own cultural competence training, they provided the MHP with a list of staff to identify those who have taken the training.
- A LMS was also created by CalMHSA for the implementation of the semi-statewide EHR. This system tracks all staff who have taken the training and

allows for the MHP to identify the number of staff who have completed the training.

- Compliance and HIPAA Act trainings are tracked through the site certification process and reviewed during the onsite portion of certification.

# ACCESS TO CARE

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

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

## ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 6 percent of services were delivered by county-operated/staffed clinics and sites, and 94 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 77 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff; members may request services through the Access Line as well as through walk-in to clinics and MHUCC. Additional service requests may come through navigator programs like the Community Support Team (CST). The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. Urgent service requests are immediately referred to the MHUCC or emergency department. The MHP deploys some Access clinicians with the homeless encampment teams, but the majority are in the call center. Certain programs do their own admissions based on the population they serve but these are mostly crisis response programs.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 4,711 adult members, 5,708 youth members, and 539 older adult members across 2 county-operated sites and 59 contractor-operated sites. Among those served, 1,351 members received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

## NETWORK ADEQUACY

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

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

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

### Table 1A: Sacramento MHP Alternative Access Standards, FY 2022-23

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

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

### Table 1B: Sacramento MHP Out-of-Network Access, FY 2022-23

| **Out-of-Network (OON) Access** | |
|---|---|
| The MHP was required to provide OON access due to time or distance requirements | ☐ Yes ☒ No |
| **OON Details** | |
| **Contracts with OON Providers** | |
| Does the MHP have existing contracts with OON providers? | ☐ Yes ☒ No |
| Contracting status: | ☐ The MHP is in the process of establishing contracts with OON providers<br>☒ The MHP does not have plans to establish contracts with OON providers |

| OON Access for Members | |
|---|---|
| The MHP ensures OON access for members in the following manner: | ☐ The MHP has existing contracts with OON providers<br>☒ Other: If the MHP is unable to meet the time and distance standards and there is a request to receive services from an OON provider, the MHP will pursue a single case agreement contract with the provider as long as they meet the DHCS MHP contract requirements. |

## ACCESS KEY COMPONENTS

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

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

### Table 2: Access Key Components

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

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

- The MHP increased their telehealth services in languages other than English by 87 percent since the previous EQR.
- The MHP completed the Behavioral Health Racial Equity Collaborative (BHREC) pilot in partnership with the African American/Black/African Descent (AA/B/AD) communities and is expanding the BHREC to work with the Latino/Latinx populations.
- The MHP launched the CWRT to work with law enforcement for bidirectional referrals.

- The website lacks easily accessible information and navigation of programming, wellness centers, and crisis response and services.
- Key informants have identified that calls to the Access line go unanswered and upon leaving a message to request a return a call, the call is often not returned by staff.

## ACCESS PERFORMANCE MEASURES

### Members Served, Penetration Rates, and Average Approved Claims per Member Served

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

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with an average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, beneficiaries may be experiencing more challenges accessing mental health services in Sacramento County than seen statewide.

**Table 3: Sacramento MHP Annual Members Served and Total Approved Claims, CY 2020-22**

| Year | Total Members Eligible | # of Members Served | MHP PR | Total Approved Claims | AACM |
|---|---|---|---|---|---|
| CY 2022 | 634,909 | 21,817 | 3.44% | $135,778,583 | $6,224 |
| CY 2021 | 592,920 | 24,552 | 4.14% | $146,137,014 | $5,952 |
| CY 2020 | 548,757 | 23,228 | 4.23% | $142,584,335 | $6,138 |

Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- PR has declined each year between CY 2020 and CY 2022.
- The number of eligible members increased over 15 percent between CY 2020 and CY 2022, while the number of members served has decreased by 6 percent.

- In CY 2022, the MHP's AACM was about 84 percent of the statewide average.

### Table 4: Sacramento MHP Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

| Age Groups | Total Members Eligible | # of Members Served | MHP PR | County Size Group PR | Statewide PR |
|---|---|---|---|---|---|
| Ages 0-5 | 65,607 | 564 | 0.86% | 1.50% | 1.82% |
| Ages 6-17 | 147,093 | 7,124 | 4.84% | 5.01% | 5.65% |
| Ages 18-20 | 31,485 | 1,218 | 3.87% | 3.66% | 3.97% |
| Ages 21-64 | 332,418 | 11,992 | 3.61% | 3.73% | 4.03% |
| Ages 65+ | 58,307 | 919 | 1.58% | 1.64% | 1.86% |
| **Total** | **634,909** | **21,817** | **3.44%** | **3.60%** | **3.96%** |

Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The MHP's PR is lower than other large counties for all age groups other than Ages 18-20.
- The MHP's PR is lower than the statewide rate in all age categories.

### Table 5: Threshold Language of Sacramento MHP Medi-Cal Members Served in CY 2022

| Threshold Language | # Members Served | % of Members Served |
|---|---|---|
| Spanish | 1,680 | 7.88% |
| Russian | 217 | 1.02% |
| Hmong | 179 | 0.84% |
| Vietnamese | 135 | 0.63% |
| Arabic | 92 | 0.43% |
| Cantonese | 74 | 0.35% |
| Farsi | 57 | 0.27% |
| **Members Served in Threshold Languages** | **2,434** | **11.42%** |
| Threshold language source: Open Data per BHIN 20-070 | | |

- Sacramento had seven threshold languages, demonstrating the wide cultural diversity within the county. Spanish speakers comprised the largest of the seven language groups. There were 1,680 beneficiaries, 7.88 percent of members served, who identified Spanish as their preferred language.

### Table 6: Sacramento Medi-Cal Expansion (ACA) PR and AACM, CY 2022

| Entity | Total ACA Eligibles | Total ACA Members Served | MHP ACA PR | ACA Total Approved Claims | ACA AACM |
|---|---|---|---|---|---|
| MHP | 190,459 | 5,279 | 2.77% | $26,658,950 | $5,050 |
| Large | 2,530,000 | 76,457 | 3.02% | $535,657,742 | $7,006 |
| Statewide | 4,830,000 | 164,980 | 3.41% | $1,051,087,580 | $6,371 |

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This pattern holds true in Sacramento. The MHP's 2.77 percent ACA PR is lower than its overall 3.44 percent PR. Likewise the $5,050 ACA AACM is lower than the MHP's $6,224 AACM.

The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total members served. Table 7 and Figures 1-9 compare the MHP's data with MHPs of similar size and the statewide average.

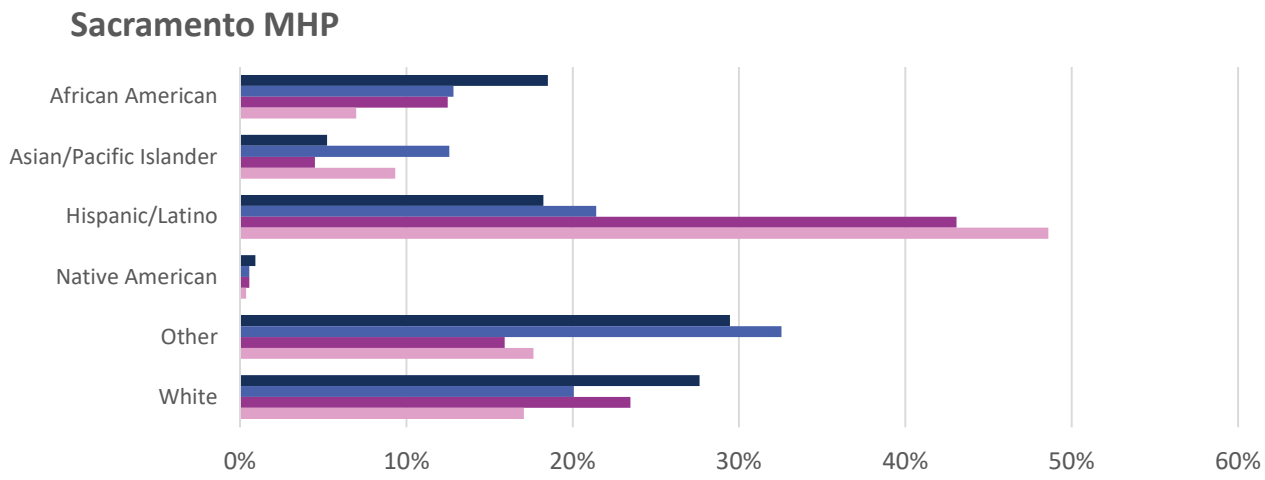
### Table 7: Sacramento MHP PR of Members Served by Race/Ethnicity, CY 2022

| Race/Ethnicity | Total Members Eligible | # of Members Served | MHP PR | Statewide PR |
|---|---|---|---|---|
| African American | 81,429 | 4,037 | 4.96% | 7.08% |
| Asian/Pacific Islander | 79,867 | 1,142 | 1.43% | 1.91% |
| Hispanic/Latino | 135,960 | 3,981 | 2.93% | 3.51% |
| Native American | 3,572 | 201 | 5.63% | 5.94% |
| Other | 206,699 | 6,428 | 3.11% | 3.57% |
| White | 127,384 | 6,028 | 4.73% | 5.45% |
| **Total** | **634,911** | **21,817** | **3.44%** | **3.96%** |

Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The MHP's PRs by race/ethnicity are lower than the statewide PRs for all races/ethnicities.
- The Hispanic/Latino population makes up the second largest racial/ethnic group of annual eligibles in the county and has one of the lowest PRs.

### Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022

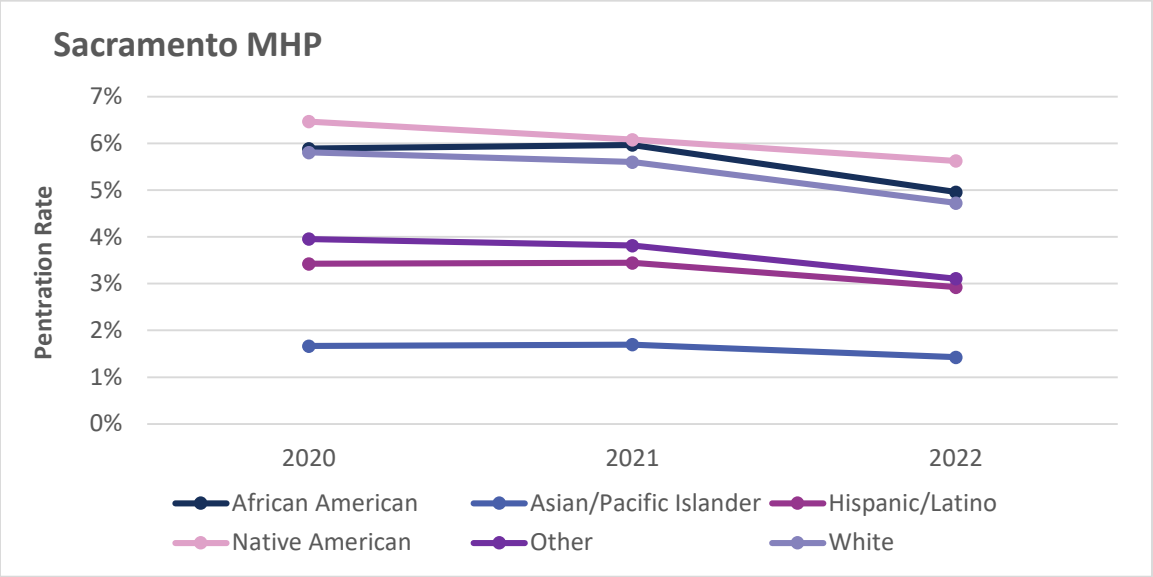



| | White | Other | Native American | Hispanic/Latino | Asian/Pacific Islander | African American |
|---|---|---|---|---|---|---|
| MHP % Served | 28% | 29% | 1% | 18% | 5% | 19% |
| MHP % Eligible | 20% | 33% | 1% | 21% | 13% | 13% |
| State % Served | 23% | 16% | 0.55% | 43% | 4% | 12% |
| State % Eligibles | 17% | 18% | 0.37% | 49% | 9% | 7% |

- Similar to statewide, there are higher percentages of African American, Native American and White members who received services than their total proportion of the Medi-Cal population. In contrast, a lower percentage of Asian/Pacific Islander, Hispanic/Latino and Other members received services compared to their proportion of eligible members.
- Other and White members were proportionally the largest racial/ethnic categories receiving services. Other, Hispanic/Latino and Whites made up the largest racial/ethnic categories in the MHP's Medi-Cal population.

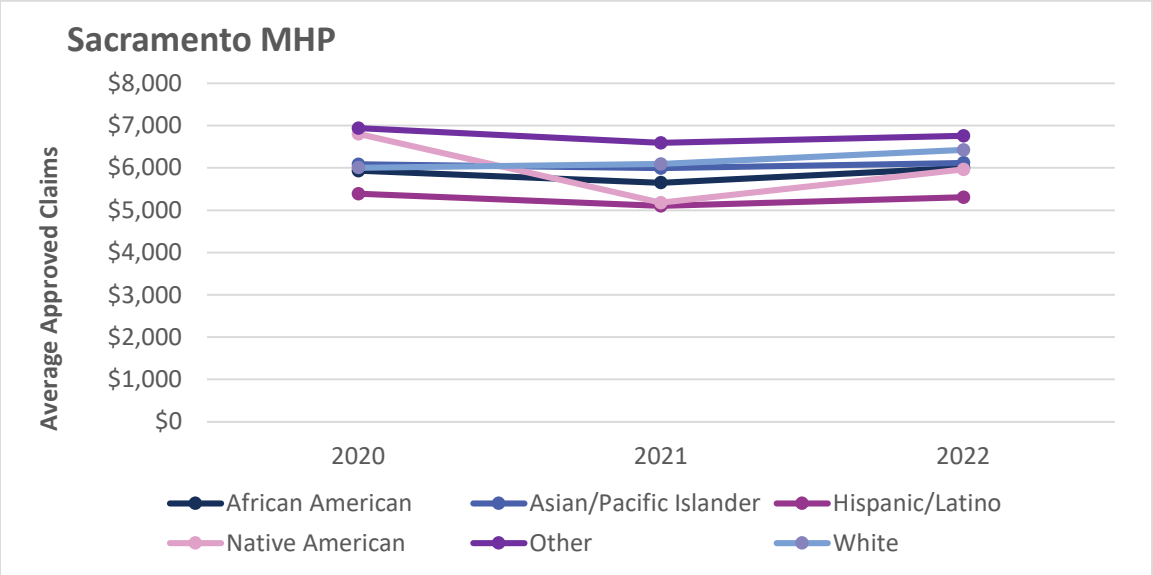
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

### Figure 2: MHP PR by Race/Ethnicity, CY 2020-22




- For the last three years, there have been three clusters of PRs by race/ethnicity. Native American, African American and Whites consistently had the highest PRs. Other and Hispanic/Latinos have been in the middle cluster, and Asian/Pacific Islanders have consistently had the lowest PRs between CY 2020 and CY 2022.
- PRs for all racial/ethnic groups have been trending down between CY 2020 and CY 2022.

### Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22

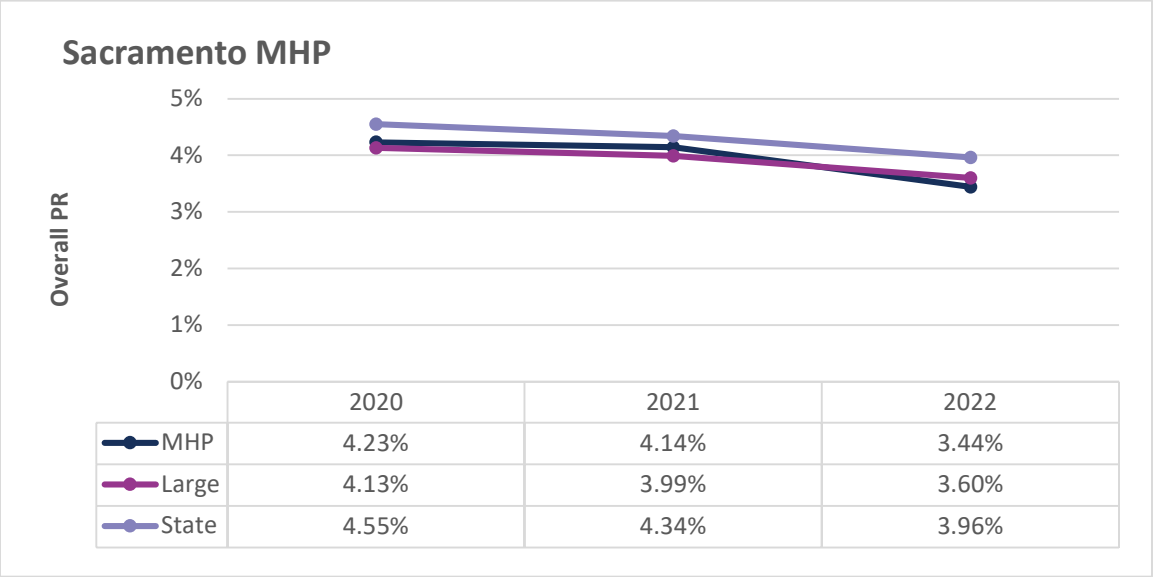



- Except for Native American members, AACMs between CY 2020 and CY 2022 have been quite stable. Those identifying as Other have the highest AACM,

followed by White, Asian/Pacific Islander, then African American members. Hispanic/Latinos have had the lowest AACM in all three CYs.

- Native Americans had one of the highest AACMs in CY 2020, one of the lowest in CY 2021, and their PR in CY 2022 was around the middle of the range. There are a relatively low number of Native Americans served, less than one percent of all members served, which can factor into large variations in AACM from year to year due to outliers having an outsized impact on the mean.

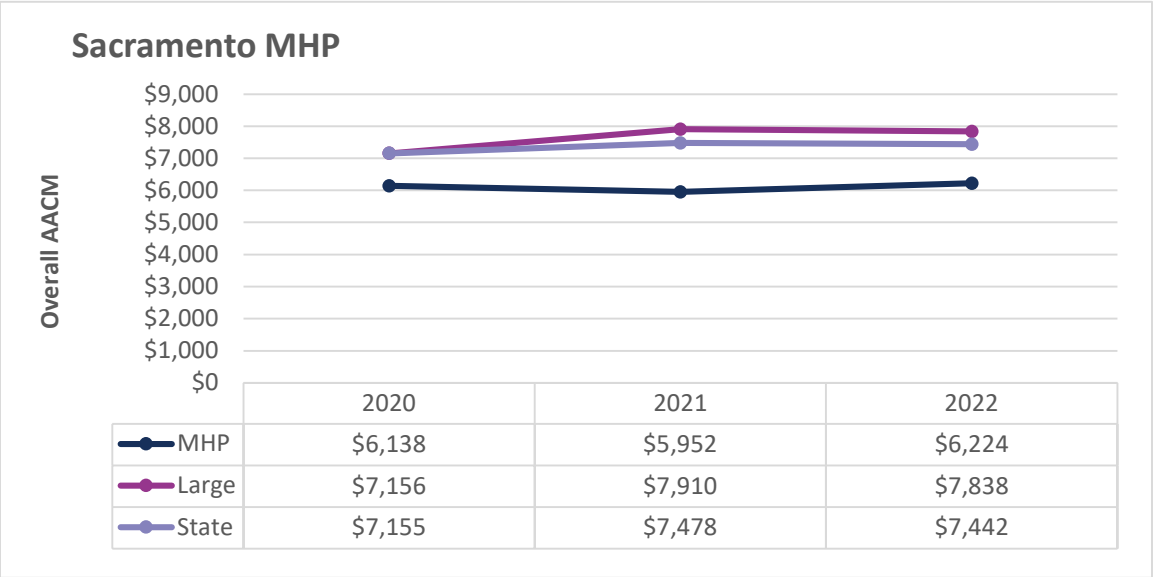
**Figure 4: Overall PR, CY 2020-22**




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| MHP | 4.23% | 4.14% | 3.44% |
| Large | 4.13% | 3.99% | 3.60% |
| State | 4.55% | 4.34% | 3.96% |

- Similar to trends statewide and in other large counties, the MHP's PR has been declining between CY 2020 and CY 2022.
- The MHP and other large county PRs have been very similar between CY 2020 and CY 2022 and have been a little lower than the statewide rates.

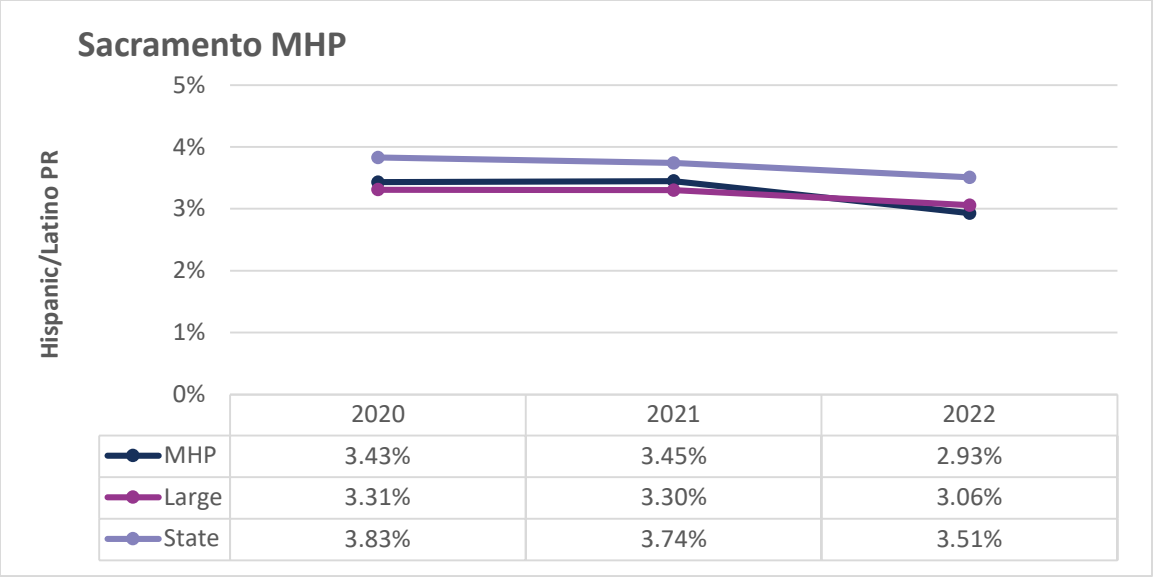
### Figure 5: Overall AACM, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| MHP | $6,138 | $5,952 | $6,224 |
| Large | $7,156 | $7,910 | $7,838 |
| State | $7,155 | $7,478 | $7,442 |

- The MHP's AACM has been consistently lower than the state and other large counties between CY 2020 and CY 2022. It has been close to $6,000 for the last three years.

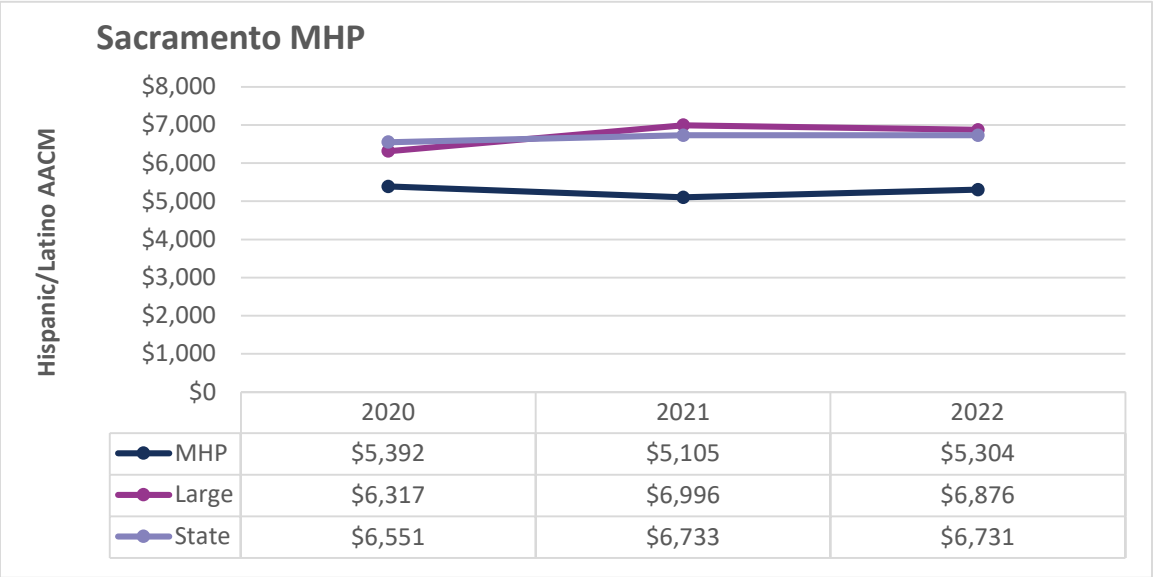
### Figure 6: Hispanic/Latino PR, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| MHP | 3.43% | 3.45% | 2.93% |
| Large | 3.31% | 3.30% | 3.06% |
| State | 3.83% | 3.74% | 3.51% |

- Similar to the overall PR, the MHP and other large county Hispanic/Latino PRs have been very similar between CY 2020 and CY 2022 and have been a little lower than the statewide rates.

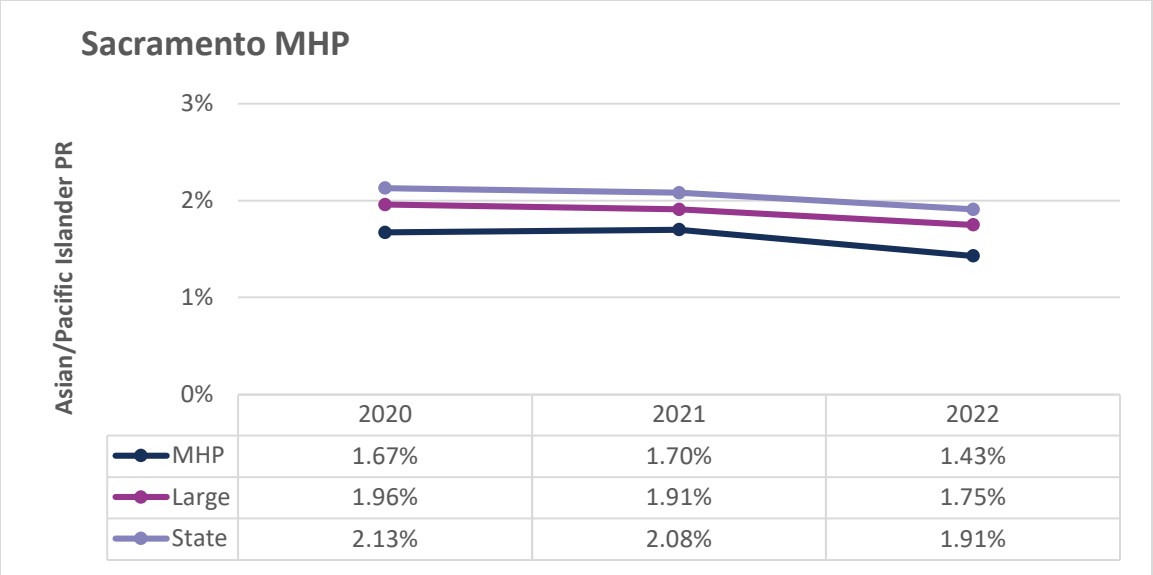
### Figure 7: Hispanic/Latino AACM, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| MHP | $5,392 | $5,105 | $5,304 |
| Large | $6,317 | $6,996 | $6,876 |
| State | $6,551 | $6,733 | $6,731 |

- Similar to the overall AACM, the Hispanic/Latino AACM continues to be lower than other large counties and the overall state average. It has been close to $5,300 for the last three years in the MHP; lower than the overall $6,224 average statewide.

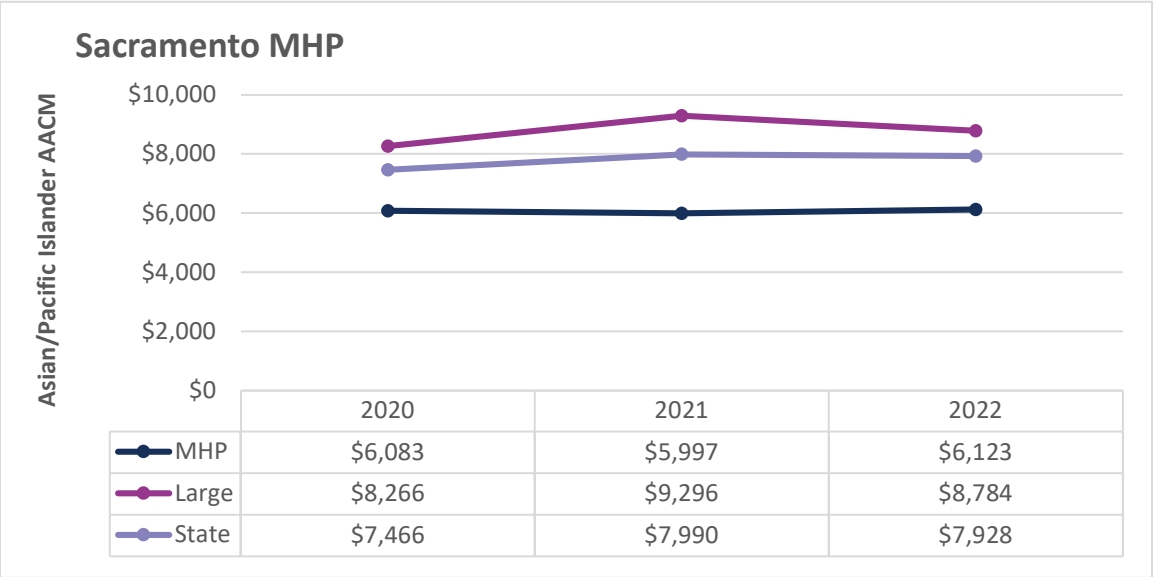
### Figure 8: Asian/Pacific Islander PR, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| MHP | 1.67% | 1.70% | 1.43% |
| Large | 1.96% | 1.91% | 1.75% |
| State | 2.13% | 2.08% | 1.91% |

- The Asian/Pacific Islander PR has been slightly lower than the statewide PR and other large-sized MHP rates from CY 2020 to CY 2022. It continues to trend downward.

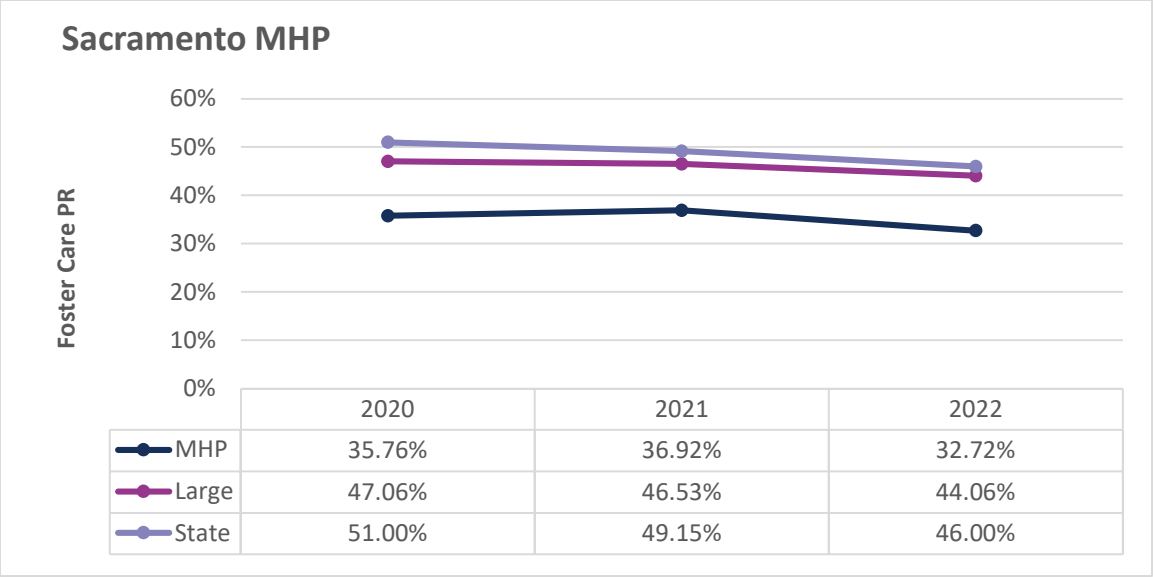
### Figure 9: Asian/Pacific Islander AACM, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| MHP | $6,083 | $5,997 | $6,123 |
| Large | $8,266 | $9,296 | $8,784 |
| State | $7,466 | $7,990 | $7,928 |

- Similar to the overall AACM, the Asian/Pacific Islander AACM continues to be lower than other large counties and the overall state average. At about $6,000 it is very similar to the MHP's overall AACM.

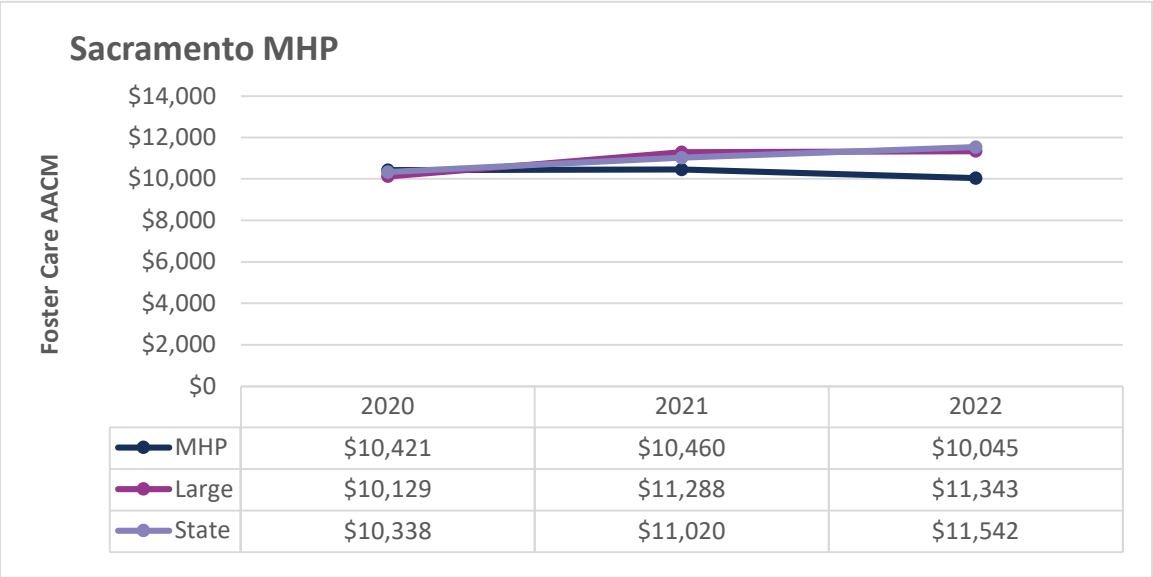
### Figure 10: Foster Care PR, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| MHP | 35.76% | 36.92% | 32.72% |
| Large | 47.06% | 46.53% | 44.06% |
| State | 51.00% | 49.15% | 46.00% |

- The MHP's FC PR is well below the statewide FC PR of 33 percent compared to 46 percent. The gap between statewide and the MHP's FC PR widened in CY 2022.

### Figure 11: Foster Care AACM, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| MHP | $10,421 | $10,460 | $10,045 |
| Large | $10,129 | $11,288 | $11,343 |
| State | $10,338 | $11,020 | $11,542 |

- Statewide FC AACM has increased each year for the past three years. The MHP's FC AACM has remained constant between CY 2020 and CY 2022, creating greater disparity between the statewide and MHP rates. The MHP's FC AACM was higher than the statewide rate in CY 2020. It was about 13 percent lower than statewide in CY 2022.
- While overall AACMs in the county are lower than average, the FC AACM is closer to other large counties and the statewide AACM for this group.

## Units of Service Delivered to Adults and Foster Youth

### Table 8: Services Delivered by the Sacramento MHP to Adults

| Service Category | MHP N = 14,130 | | | | Statewide N = 381,970 | | |
|---|---|---|---|---|---|---|---|
| | Members Served | % of Members Served | Average Units | Median Units | % of Members Served | Average Units | Median Units |
| **Per Day Services** | | | | | | | |
| Inpatient | 439 | 3.1% | 9.7 | 7.0 | 10.29% | 14 | 8 |
| Inpatient Admin | <11 | - | 17.3 | 16.0 | 0.41% | 26 | 10 |
| Psychiatric Health Facility | 487 | 3.4% | 18.9 | 12.0 | 1.19% | 16 | 8 |
| Residential | 11 | 0.1% | 71.0 | 23.0 | 0.33% | 114 | 84 |
| Crisis Residential | 416 | 2.9% | 24.4 | 27.0 | 1.92% | 23 | 15 |
| **Per Minute Services** | | | | | | | |
| Crisis Stabilization | 1,337 | 9.5% | 1,371 | 1,200 | 13.36% | 1,449 | 1,200 |
| Crisis Intervention | 1,314 | 9.3% | 139 | 89 | 12.21% | 236 | 144 |
| Medication Support | 9,954 | 70.4% | 329 | 200 | 59.75% | 298 | 190 |
| Mental Health Services | 10,677 | 75.6% | 814 | 374 | 62.71% | 832 | 329 |
| Targeted Case Management | 8,369 | 59.2% | 327 | 116 | 36.95% | 445 | 135 |

- The MHP's overall inpatient service utilization (inpatient and psychiatric health facility [PHF]), is lower than statewide, but it is difficult to compare as Sacramento uses several large Institutes for Mental Disease (IMD)-excluded facilities. PHF utilization alone at 3.4 percent is higher than the 1.19 percent statewide utilization rate, with a median of 12 days compared to 8 days statewide.
- Crisis residential utilization is about 50 percent higher than the statewide rate, and the median units billed is 27 days versus 15 days statewide.
- Crisis services are utilized by a lower percentage of member compared to statewide:
    - Crisis stabilization went up to 9.5 percent in CY 2022 compared to 7.6 percent in CY 2021. The statewide rate as 13.4 percent in CY 2022.
    - Crisis intervention at 9.3 percent of members served is also lower than the 12.2 percent statewide rate. Median units of crisis intervention are 89 in the MHP and 144 statewide.
- Non-crisis services are utilized by a higher percentage than seen statewide:

- Medication Support went up to 70.4 percent from 67.5 percent in CY 2021. Statewide the rate has been closer to 60 percent in both years.
- Mental Health Services came down from 81.2 percent in CY 2021 to 75.6 percent in CY 2022. It is still higher than the statewide rate of 62.7 percent.
- Targeted Case Management at 59.2 percent remains higher than the statewide 37.0 percent rate.

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

| Service Category | MHP N = 812 | | | | Statewide N = 33,243 | | |
|---|---|---|---|---|---|---|---|
| | Members Served | % of Members Served | Average Units | Median Units | % of Members Served | Average Units | Median Units |
| **Per Day Services** | | | | | | | |
| Inpatient | 23 | 2.8% | 12 | 8 | 4.5% | 12 | 8 |
| Inpatient Admin | 0 | 0.0% | 0 | 0 | 0.0% | 5 | 3 |
| Psychiatric Health Facility | <11 | - | 7 | 6 | 0.2% | 19 | 8 |
| Residential | 0 | 0.0% | 0 | 0 | 0.0% | 56 | 39 |
| Crisis Residential | <11 | - | 30 | 30 | 0.1% | 24 | 22 |
| Full Day Intensive | <11 | - | 855 | 855 | 0.2% | 673 | 435 |
| Full Day Rehab | 0 | 0.0% | 0 | 0 | 0.2% | 111 | 84 |
| **Per Minute Services** | | | | | | | |
| Crisis Stabilization | 13 | 1.6% | 1,688 | 1,080 | 3.1% | 1,166 | 1,095 |
| Crisis Intervention | 64 | 7.9% | 198 | 125 | 8.5% | 371 | 182 |
| Medication Support | 304 | 37.4% | 395 | 262 | 27.6% | 364 | 257 |
| TBS | 75 | 9.2% | 2,419 | 1,599 | 3.9% | 4,077 | 2,457 |
| Therapeutic FC | 0 | 0.0% | 0 | 0 | 0.1% | 911 | 495 |
| Intensive Home Based Services | 383 | 47.2% | 884 | 463 | 40.8% | 1,458 | 441 |
| Intensive Care Coordination | 136 | 16.7% | 1,380 | 681 | 19.5% | 2,440 | 1,334 |
| Katie-A-Like | <11 | - | 28 | 28 | 0.2% | 390 | 158 |
| Mental Health Services | 784 | 96.6% | 1,686 | 1,042 | 95.4% | 1,846 | 1,053 |
| Targeted Case Management | 623 | 76.7% | 446 | 179 | 35.8% | 307 | 118 |

- The number of FC members utilizing inpatient services came down from 58 to 23 in CY 2022, resulting in an inpatient utilization rate that is about half that of the statewide rate.
- Fewer FC members received crisis stabilization and crisis intervention services than statewide. They received slightly fewer minutes of crisis stabilization and substantially fewer minutes of crisis intervention.
- Over one-third of the MHP's FC members received medication support services compared to 27.6 percent statewide.
- The MHP's 9.2 percent of FC members receiving therapeutic behavioral services (TBS) is well above the 3.9 percent statewide rate. While the TBS utilization is higher than the statewide average, the median units for Sacramento members was 1,599 compared to 2,457 statewide. The MHP plans to expand TBS capacity by 25 percent in October 2023.
- Fewer FC members utilized Intensive Care Coordination (ICC) in the MHP than statewide, and they received less than half the median number of units compared to statewide. In contrast, over twice as many Sacramento FC members received Targeted Case Management (TCM) compared to statewide. They also received more units of TCM than statewide.

## IMPACT OF ACCESS FINDINGS

- The MHP may want to analyze the services delivered under TCM and ICC to ensure that comprehensive child/family team treatment planning is occurring and is coded correctly.
- The MHP is aware of the reduction in services to the Latino/Latinx population and will address this challenge within their BHREC.
- The MHP has implemented the CalAIM screening tool with success in identifying the appropriate initial service.
- Without an easy to maneuver website, the community is currently unable to quickly identify crisis numbers or possible mental health linkages.
- Key informants have identified a lack of response from the Access line with calls going unanswered or unreturned.

# TIMELINESS OF CARE

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

## TIMELINESS KEY COMPONENTS

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

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

**Table 10: Timeliness Key Components**

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

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

- To expand capacity, the MHP is releasing a request for application for a second MHUCC location in North Sacramento.

- The MHP did not accurately report first non-urgent psychiatry appointment offered. They reported that they always offered an appointment the same day it was requested but did not report the number of days to the appointment itself.
- The MHP defined urgent requests as any admission to the MHUCC, which resulted in the appearance of very little time to first offered urgent appointments reflected in their tracking. They do not track urgent appointments from any other sources, and so there is no non-crisis but urgent service tracking.
- The MHP's self-reported 7- and 30-day follow-up appointments after a psychiatric hospitalization were lower than seen in the claims data. This suggests that it is more difficult to follow-up with members who are hospitalized under non-Medi-Cal billable circumstances.
- The MHP has not established a standard percentage for the no-show rate of both clinicians and psychiatrists. Without this standard the MHP is unable to accurately identify the no-show rate performance.
- The MHP is unable to accurately identify FC members as Children's Protective Services needs to change the methodology of notifying the MHP of FC youth in or in need of services.

## TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of CY 2022. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care. The MHP did not accurately report first non-urgent psychiatry appointment offered. Also, no show rates appear unrealistically low due to the lack of comparison to a standard percentage rate.

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

### Table 11: FY 2023-24 Sacramento MHP Assessment of Timely Access

| Timeliness Measure | Average | Standard | % That Meet Standard |
|---|---|---|---|
| First Non-Urgent Appointment Offered | 13.9 Business Days | 10 Business Days* | 51.3% |
| First Non-Urgent Service Rendered | 18.8 Business Days | 10 Business Days** | 36.5% |
| First Non-Urgent Psychiatry Appointment Offered | *** | 15 Business Days* | *** |
| First Non-Urgent Psychiatry Service Rendered | 30.2 Business Days | 15 Business Days** | 25.6% |
| Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required | 0.7 Hours | 48 Hours* | 99.97% |
| Follow-Up Appointments after Psychiatric Hospitalization – 7 Days | 14.2 Days | 7 Calendar Days** | 25.1% |
| Follow-Up Appointments after Psychiatric Hospitalization – 30 Days | 14.2 Days | 30 Calendar Days | 35.6% |
| No-Show Rate – Psychiatry | 1.6% | n/a | n/a |
| No-Show Rate – Clinicians | 1.2% | n/a | n/a |

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

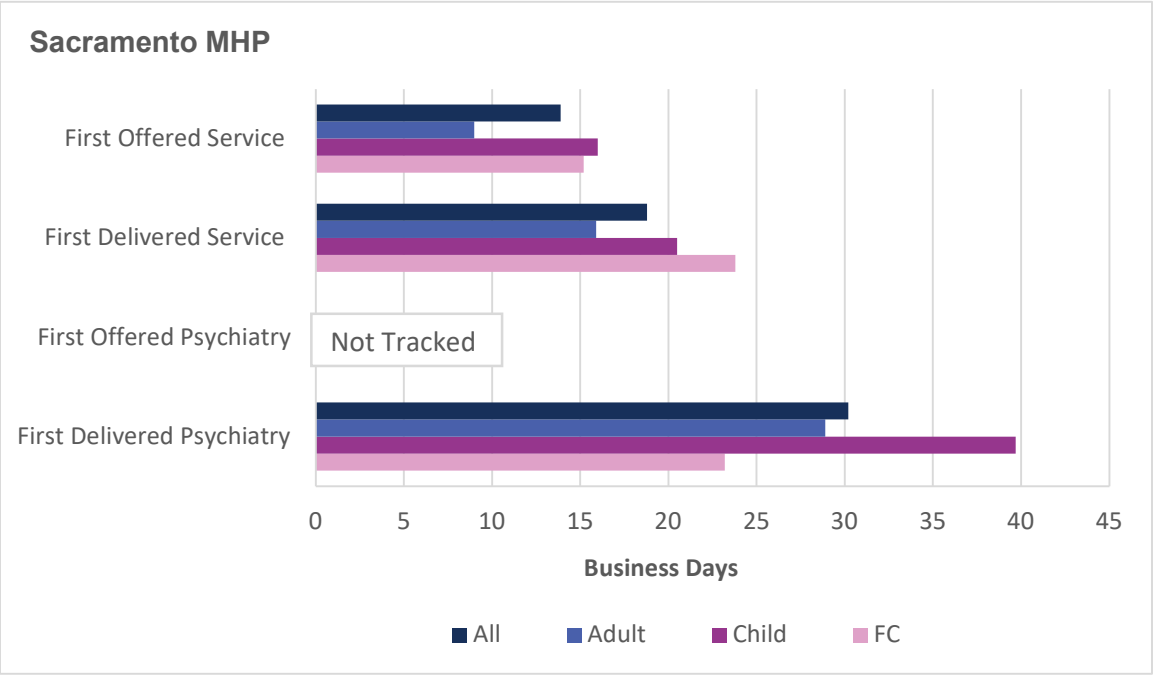
** MHP-defined timeliness standards

*** The MHP did not report data for this measure

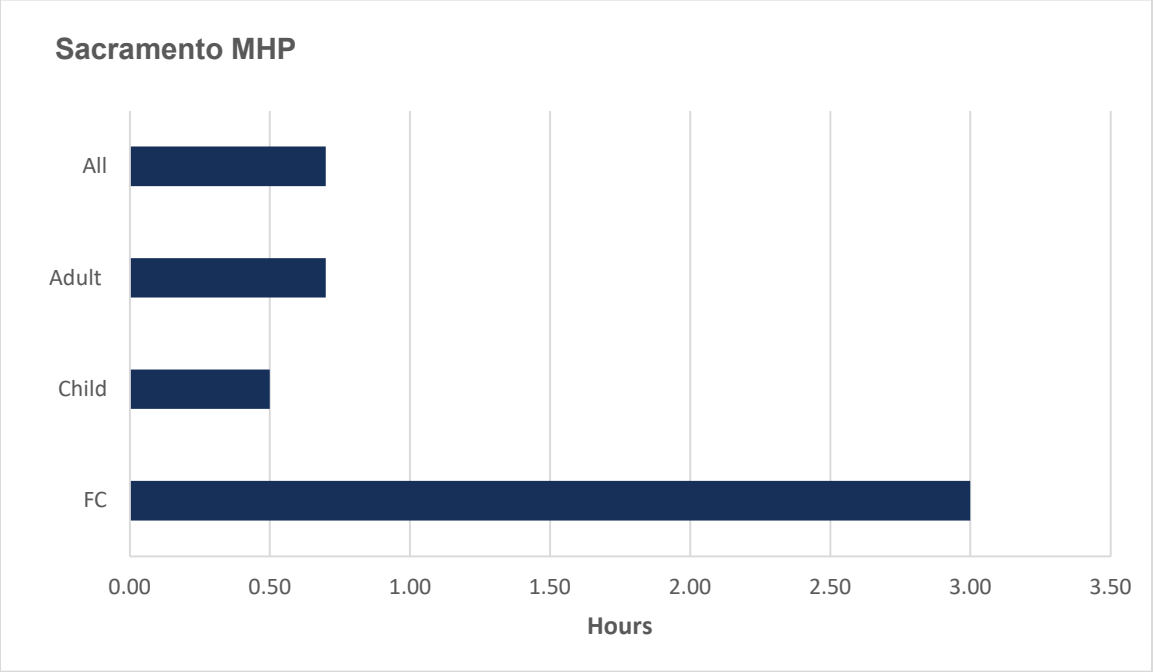
**** The MHP does not separately report urgent timeliness for services requiring prior authorization

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: CY 2022

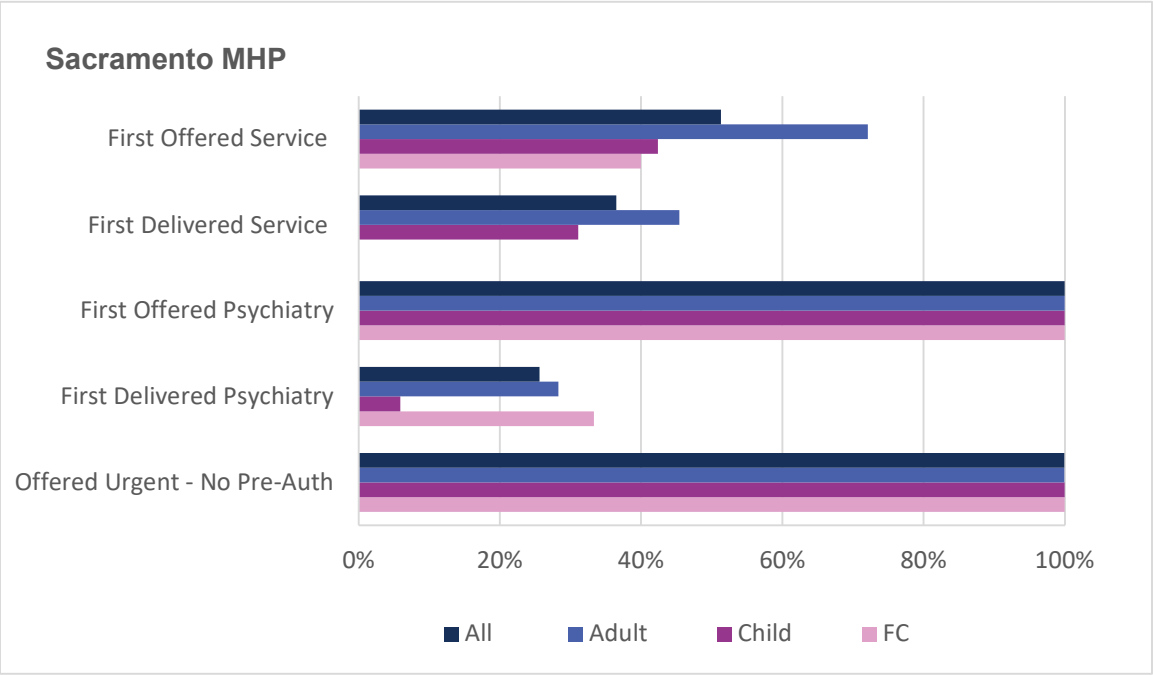
## Figure 12: Wait Times to First Service and First Psychiatry Service




## Figure 13: Wait Times for Urgent Services



### Figure 14: Percent of Services that Met Timeliness Standards




- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments and unscheduled, walk-in assessments.
- The MHP defined “urgent services” for purposes of the ATA as any admission to the MHUCC. There were reportedly 4,261 urgent service requests with a reported actual wait time to services for the overall population of 0.7 hours. The MHP does not offer urgent services that require pre-authorization separately.
- A 15-business day standard is expected for initial access to psychiatry, though the MHP may define when and how this is measured, and often MHP processes, definitions, and tracking may differ for adults and children. The MHP defines timeliness to first delivered/rendered psychiatry services as from the time an “assessment with Rx request” is entered into the EHR.
- The 10-business day first offered appointment standard is met 51.3 percent of the time, with an average of 13.9 days. The MHP’s 10-business day standard for first non-urgent service rendered is met 36.5 percent of the time with an average of 18.8 days. The MHP only meets their 15-business day standard for first non-urgent psychiatry service rendered 25.6 percent of the time, with an average over 6 weeks, 30.2 days.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 1.6 percent for psychiatrists and

1.2 percent for non-psychiatry clinical staff. These represent unusually low no-show rates that suggests it may not represent the entire data set.

## IMPACT OF TIMELINESS FINDINGS

- The average time to first rendered psychiatry appointment is twice the MHP's 15-day standard, resulting in beneficiaries being delayed in receiving medication support for their mental health conditions. This may have a trickle-down effect on other parts of the system, such as an increase in crisis or emergency department access due to the need for more immediate care which has been intensified by long outpatient wait times. With the data on first offered appointments also showing average times longer than DHCS standards, it would be beneficial for the MHP to continue exploring ways to address these metrics and evaluate whether identified solutions will improve timeliness and beneficiary outcomes.
- The MHP's current practice of not monitoring the members who request urgent services but who do not follow up with the referral to MHUCC may result in missed opportunities for engagement of high-risk members. Further exploration and possible modification of practices is warranted to ensure the needs of these beneficiaries are addressed.
- Without appropriate standards for tracking no-show rates, the MHP is unable to accurately report data or identify system or provider level improvements.

# QUALITY OF CARE

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

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

## QUALITY IN THE MHP

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

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of representatives of the MHP, the Drug Medi-Cal Organized Delivery System (DMC-ODS), contract providers, members, and family members, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met eight times. All data had not been aggregated and the MHP was evaluating the prior year's QAPI at the time of the review. Of note, is the addition of the impact to the member added to the updated workplan.

The MHP does not utilize a level of care (LOC) tool. The MHP is working on a project with John Lyons to provide definitions and guidance on the use of outcome tools as LOC. The MHP uses the LIST to identify appropriate referral and linkage levels.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35.)

## QUALITY KEY COMPONENTS

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

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

### Table 12: Quality Key Components

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

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

- The MHP has identified areas of member impacts within the QAPI workplan. Expanding on the member voices within these impacts will provide additional measurable outcomes.
- The MHP has a comprehensive continuum of care but does not currently leverage a LOC tool to collect and analyze data.
- Key informants have identified pay increases within contracted agencies that do not equitably address peer services, further expressing a perception that due to high clinician turnover the stable peers may be compensated less in order to increase salaries that attract a clinical workforce.
- The MHP has a comprehensive medical management system of reporting but does not aggregate the data to identify trends or areas of system improvements.
- The MHP does track but does not trend the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

## QUALITY PERFORMANCE MEASURES

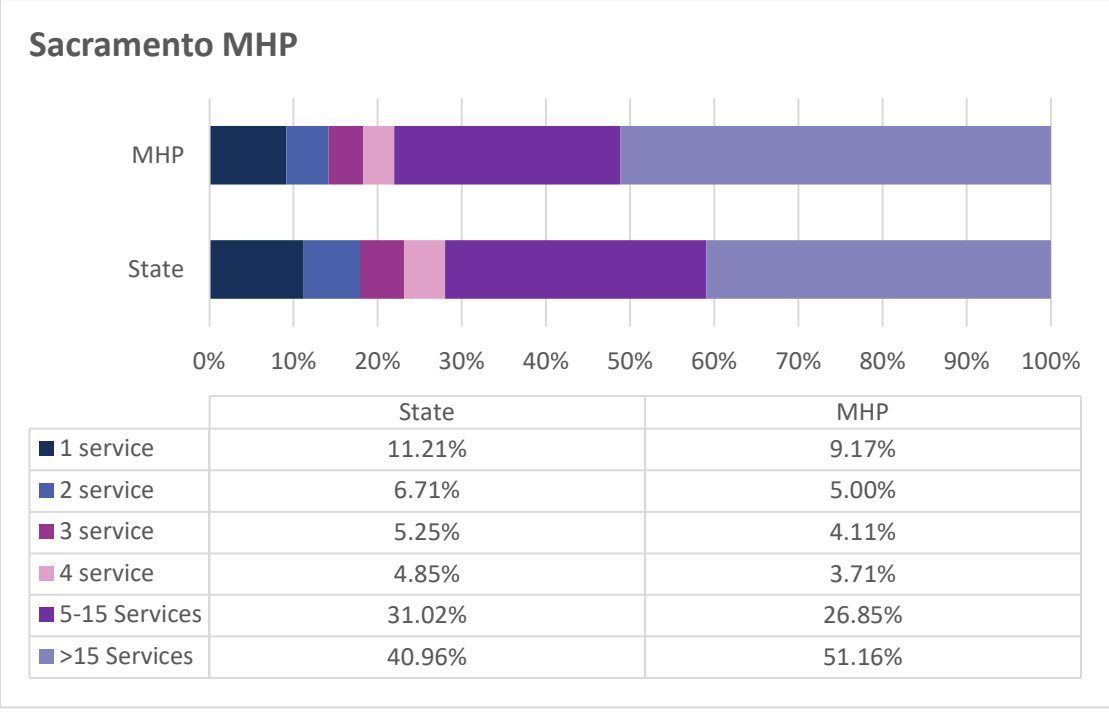
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

- Retention in Services
- Diagnosis of Members Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Members (HCM)

### Retention in Services

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

**Figure 15: Retention of Sacramento MHP Members Served, CY 2022**



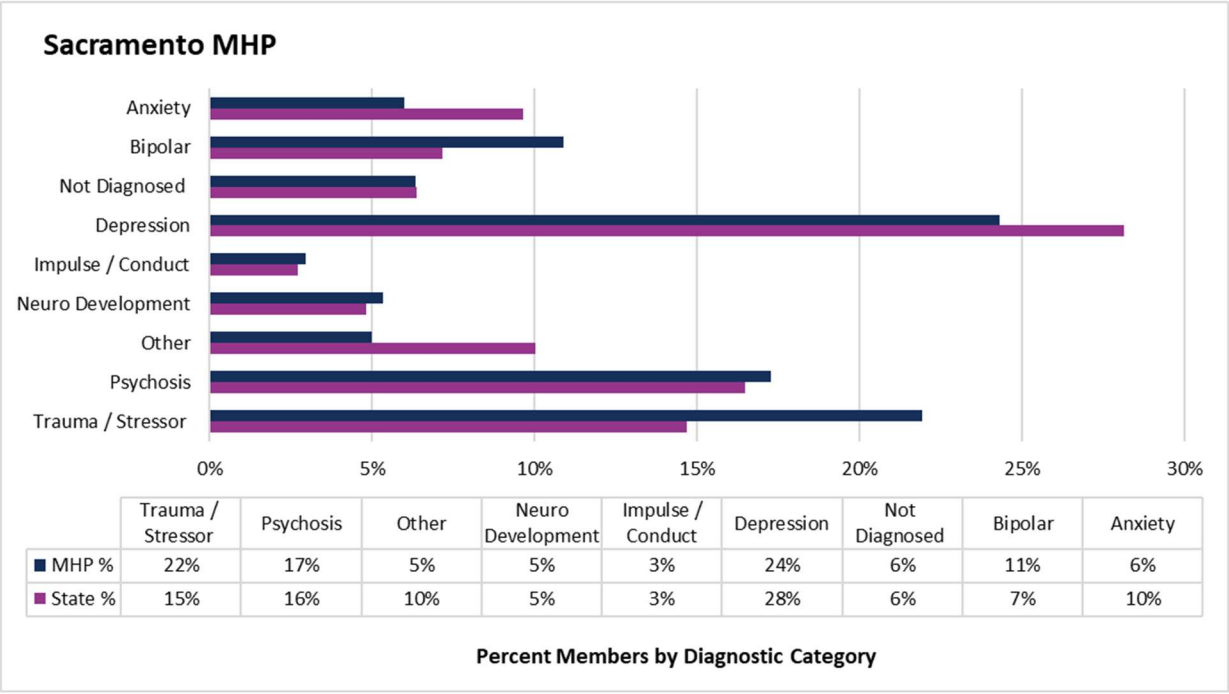

| | State | MHP |
|---|---|---|
| 1 service | 11.21% | 9.17% |
| 2 service | 6.71% | 5.00% |
| 3 service | 5.25% | 4.11% |
| 4 service | 4.85% | 3.71% |
| 5-15 Services | 31.02% | 26.85% |
| >15 Services | 40.96% | 51.16% |

- About one quarter of members received 1-4 services, another quarter received 5-15 services and a little over half received more than 15 services. Compared to statewide data, fewer members received 1-15 services. The percentage of MHP members receiving more than 15 services is 25 percent more than seen statewide.

## Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

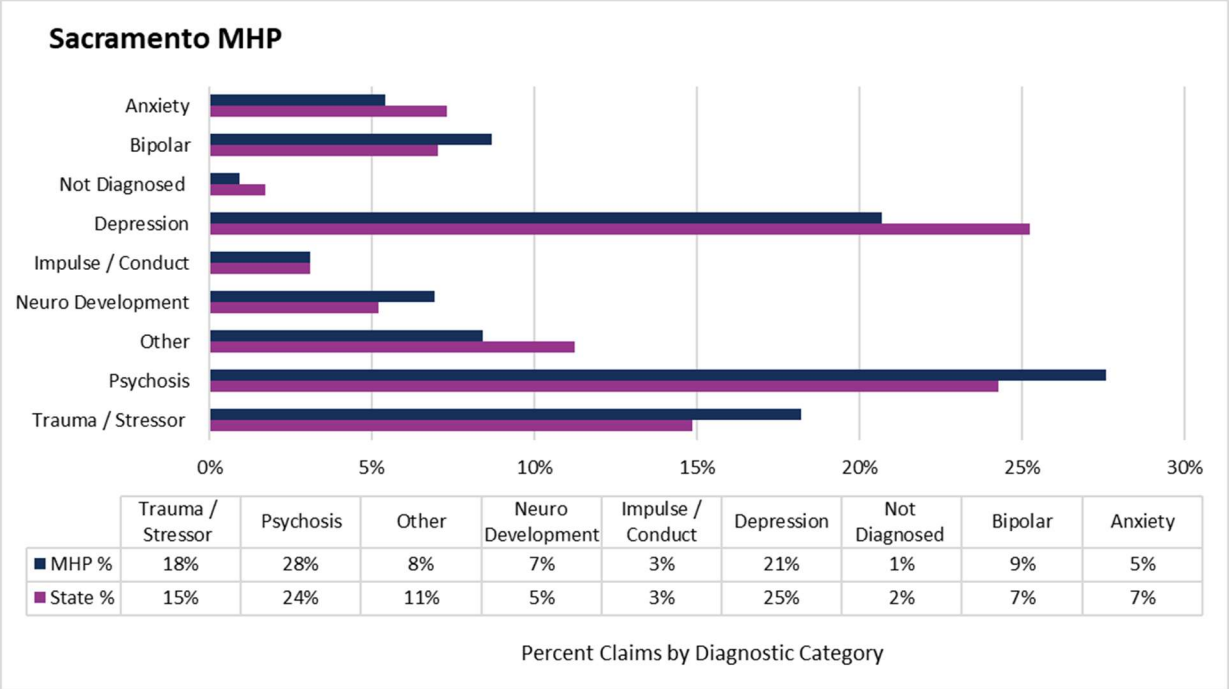
### Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022




| | Trauma / Stressor | Psychosis | Other | Neuro Development | Impulse / Conduct | Depression | Not Diagnosed | Bipolar | Anxiety |
|---|---|---|---|---|---|---|---|---|---|
| MHP % | 22% | 17% | 5% | 5% | 3% | 24% | 6% | 11% | 6% |
| State % | 15% | 16% | 10% | 5% | 3% | 28% | 6% | 7% | 10% |

- Depression, trauma/stressor related diagnoses, and psychosis are the most common diagnostic categories, collectively representing 63 percent of members.
- Trauma/stressor and bipolar diagnoses are each about 50 percent higher than statewide diagnostic rates.

### Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022




| | Trauma / Stressor | Psychosis | Other | Neuro Development | Impulse / Conduct | Depression | Not Diagnosed | Bipolar | Anxiety |
|---|---|---|---|---|---|---|---|---|---|
| MHP % | 18% | 28% | 8% | 7% | 3% | 21% | 1% | 9% | 5% |
| State % | 15% | 24% | 11% | 5% | 3% | 25% | 2% | 7% | 7% |

- Psychosis, depression, and trauma/stressor related diagnoses are the most prevalent diagnostic categories based on proportions of approved claims, collectively representing 67 percent of claims.
- Psychosis, trauma/stressor, and bipolar diagnoses represent a higher proportion of members than statewide. Depression and anxiety diagnostic rates are lower than those seen statewide.

## Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average length of stay (LOS). An issue with the programming produced previously published reports that displayed CY 2019-21 with an over-stated number of inpatient admissions. The unique number of Medi-Cal members served in inpatient did not change, but the number of admissions is now corrected; this report reflects the updated, generally reduced, number of admissions.

### Table 13: Sacramento MHP Psychiatric Inpatient Utilization, CY 2020-22

| Year | Unique Inpatient Medi-Cal Members | Total Medi-Cal Inpatient Admissions | Average Admissions per Member | MHP Average LOS in Days | Statewide Average LOS in Days | Inpatient MHP AACM | Inpatient Statewide AACM | Inpatient Total Approved Claims |
|---|---|---|---|---|---|---|---|---|
| CY 2022 | 1,323 | 1,635 | 1.24 | 11.58 | 8.45 | $14,167 | $12,763 | $18,742,934 |
| CY 2021 | 1,605 | 2,038 | 1.27 | 10.74 | 8.86 | $12,888 | $12,696 | $20,686,012 |
| CY 2020 | 1,518 | 1,911 | 1.26 | 10.90 | 8.68 | $12,432 | $11,814 | $18,872,005 |

- The number of hospitalized Medi-Cal members and Medi-Cal inpatient admissions came down in CY 2022 from CY 2021, while the MHP's inpatient AACM increased by 10 percent.
- The average LOS increased to 11.58 days, and the MHP continues to have a higher average LOS than the statewide average.
- Because the MHP relies upon large facilities subject to the IMD exclusion, the approved claims data set represents a subset of all hospitalizations. The MHP reported in its ATA submission 5,444 inpatient admissions, indicating that the above inpatient data reflects 40 percent of the MHP's hospitalization admissions.

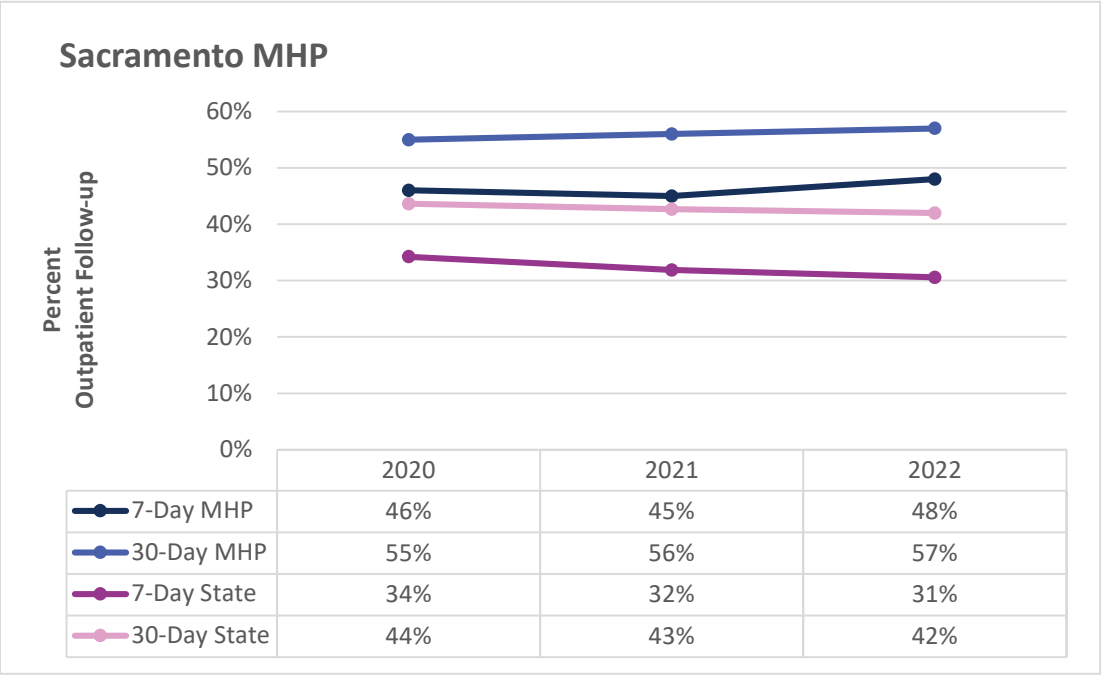
## Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

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

As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the corrected number of inpatient admissions.

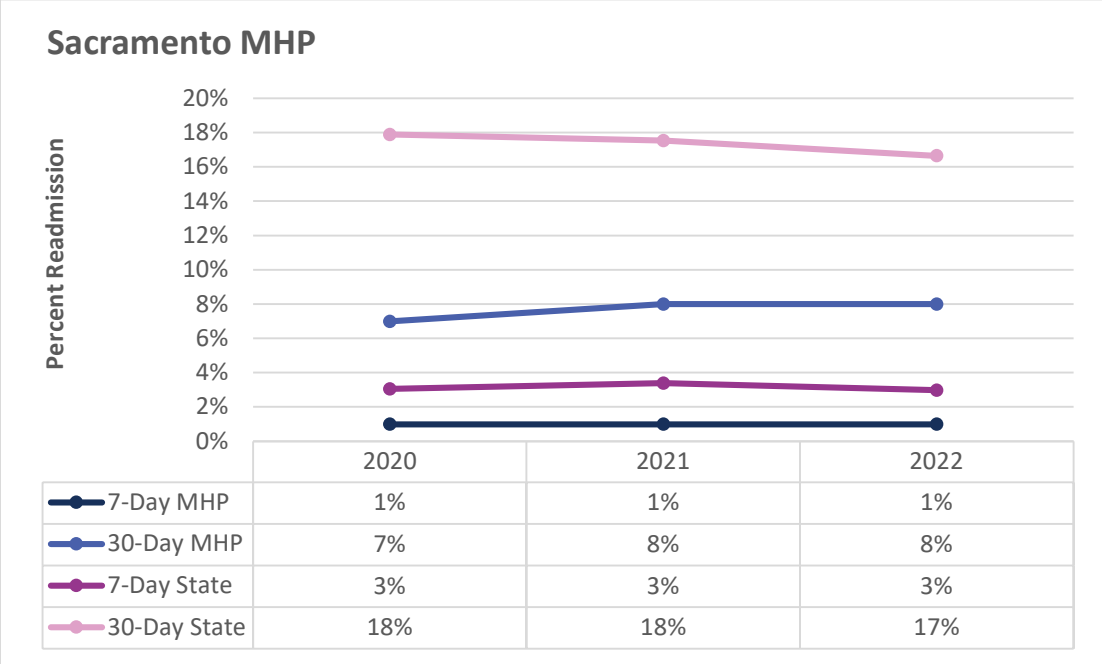
## Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| 7-Day MHP | 46% | 45% | 48% |
| 30-Day MHP | 55% | 56% | 57% |
| 7-Day State | 34% | 32% | 31% |
| 30-Day State | 44% | 43% | 42% |

- The 7- and 30-day post psychiatric inpatient follow-up rates remained stable from CY 2020 to CY 2022.

## Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22




| | 2020 | 2021 | 2022 |
|---|---|---|---|
| 7-Day MHP | 1% | 1% | 1% |
| 30-Day MHP | 7% | 8% | 8% |
| 7-Day State | 3% | 3% | 3% |
| 30-Day State | 18% | 18% | 17% |

- Across the three-year period, the MHP shows readmission rates significantly lower than statewide.

## High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Additionally, Table 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

### Table 14: Sacramento MHP High-Cost Members (Greater than $30,000), CY 2020-22

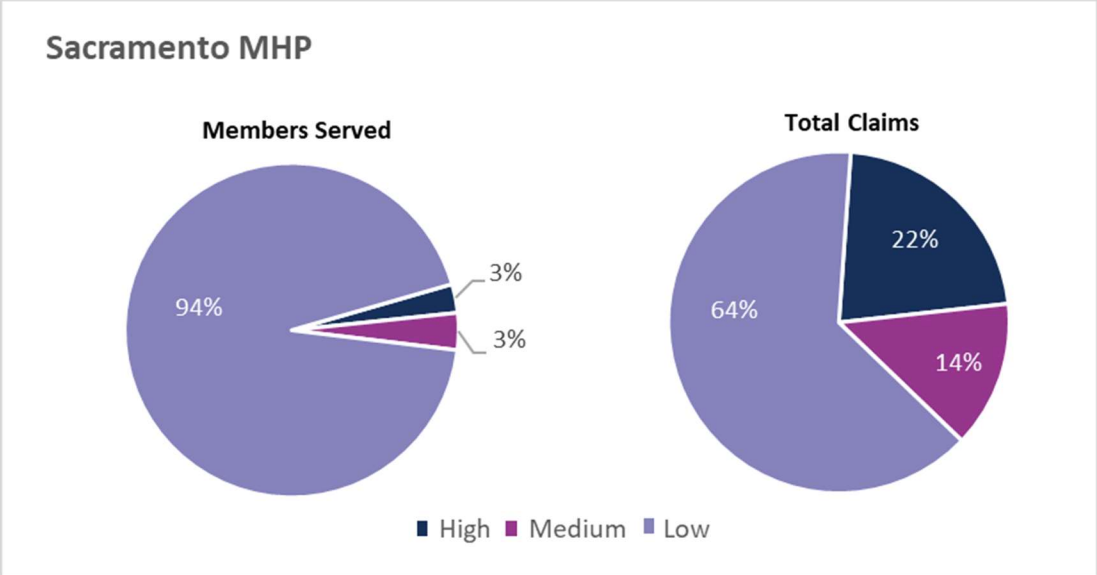
| Entity | Year | HCM Count | HCM % of Members Served | HCM % of Claims | HCM Approved Claims | Average Approved Claims per HCM | Median Approved Claims per HCM |
|---|---|---|---|---|---|---|---|
| **Statewide** | CY 2022 | 27,277 | 4.54% | 33.86% | $1,514,353,866 | $55,518 | $44,346 |
| **MHP** | CY 2022 | 605 | 2.77% | 22.13% | $30,049,822 | $49,669 | $40,214 |
| | CY 2021 | 710 | 2.89% | 23.86% | $34,863,039 | $49,103 | $41,247 |
| | CY 2020 | 644 | 2.77% | 22.27% | $31,752,324 | $49,305 | $41,364 |

- The MHP has a low percentage of members and claims that are in the HCM category. Low HCMs contribute to lower rates of AACM.

### Table 15: Sacramento MHP Medium- and Low-Cost Members, CY 2022

| Claims Range | # of Members Served | % of Members Served | Category Total Approved Claims | Category Total Approved Claims | Average Approved Claims per Member | Median Approved Claims per Member |
|---|---|---|---|---|---|---|
| Medium-Cost ($20K to $30K) | 780 | 3.58% | 13.94% | $18,924,173 | $24,262 | $23,842 |
| Low-Cost (Less than $20K) | 20,432 | 93.65% | 63.93% | $86,804,588 | $4,248 | $2,701 |

### Figure 20: Members and Approved Claims by Claim Category, CY 2022




- The MHP has more members in the low-cost category than statewide. While statewide nearly 92 percent of beneficiaries are “low-cost,” in the MHP 94 percent of members are considered low-cost, and they account for 64 percent of approved claims. Statewide, low-cost members represent 54 percent of approved claims.

## IMPACT OF QUALITY FINDINGS

- The MHP has consistently low Medi-Cal psychiatric hospital readmission rates, suggesting that inpatient care and follow-up strategies are working for their members who are hospitalized in Medi-Cal facilities.
- The MHP collects medication management and HEDIS measures. Aggregating the data and analyzing the results will assist in identifying trends and possible QIC or PIP interventions.

# PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

## CLINICAL PIP

### General Information

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

Date Started: 01/2022

Date Completed: 07/2023

Aim Statement: "Will implementing the recruitment/retention strategies and racial equity training identified in the Behavioral Health REAPs improve engagement, timely access, and retention of AA/B/AD over the next 18 months?"

Target Population: "The entire population of African American enrollees served by the six identified providers will be affected by this PIP. At the baseline year of FY 2020-21, this number was 2,637. Their ages range from 3 to 96, with 53 percent women, and 47 percent men."

Status of PIP: The MHP's clinical PIP is concluded.

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

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

### Summary

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

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

Results did not showcase what the MHP expected to achieve. In looking at the ANSA/CANS within treatment racial equity was not identified as an issue nor did members voice it as an issue. The data provided was inaccurately presented and overall, the PIP did not meet expectations.

### TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because the PIP continues to lack clinical impacts and outcomes. Data was not consistently tracked throughout the time periods and the overall “n” was very low and not statistically significant.

The MHP participated in one TA session in the year prior to the review.

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

- Ensure the AIM statement identifies a number or percentage of improvement.
- Ensure data collection is consistent and accurately reported.
- Ensure the PIP has a measurable clinical outcome component.

## NON-CLINICAL PIP

### General Information

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

Date Started: 01/2022

Date Completed: 07/2023

Aim Statement: “Will providing an option for beneficiaries under 18 years old to access services directly from the contracted provider improve the time between request to first assessment appointment and then to first treatment appointment by five percent throughout the 18 months of this project?”

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

Status of PIP: The MHP’s non-clinical PIP is concluded.

## Summary

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

Four select providers, at five scattered sites, established weekly drop-in hours in which beneficiaries are permitted to request access to services in-person or by phone, complete an intake assessment, and establish an assigned clinician. Due to barriers such as staffing shortages and significant MHP changes, the PIP strategy went live on July 1, 2022.

Results showed inconsistent data collection and reporting. It did seem the number of days between first contact and first assessment decreased, however, the data that showed number of days between first assessment and first clinical appointment was presented as zero days, which was an error in reporting. A reported challenge coincided with the CalAIM documentation reform roll-out, due to the new documentation standards and time needed to focus on the reform roll-out.

### TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: the MHP does not clearly articulate what is the five percent improvement, a low “n,” and data collection and reporting was inconsistent or inaccurate.

The MHP participated in one TA session in the year prior to the review.

Although the MHP has concluded this PIP, CalEQRO provided TA to the MHP in the form of recommendations for improvement of this non-clinical PIP, and largely for beginning their next PIPs:

- Ensure a clear and consistent plan when utilizing contracted agencies to collect and report on data.
- Ensure performance measures are clearly defined and documented.

# INFORMATION SYSTEMS

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

## INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system now used by the MHP is the Streamline SmartCare Semi-Statewide EHR, which was rolled out five weeks before the EQR. Currently, the MHP is actively implementing all components of the EHR.

Approximately 4.68 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). This is an increase from last year's 3.2 percent to support the SmartCare implementation. The budget determination process for IS operations is a combined process involving MHP and County IT.

The MHP has 1,822 named users with log-on authority to the EHR, including approximately 519 county staff and 1,303 contractor staff. Support for the users is provided by 12 full-time equivalent IS technology positions. Currently all positions are filled.

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

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

### Table 16: Contract Provider Transmission of Information to Sacramento MHP EHR

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

### Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not have a PHR in place. They plan to implement a SmartCare PHR within the next two years.

### Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/ organizations: MH contract providers, alcohol and drug contract providers, hospitals, and primary care providers.

## INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive member outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

### Table 17: IS Infrastructure Key Components

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

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

- The MHP does not have access to the complete, current SmartCare database for reporting purposes. They have access to the live database but cannot report from there due to potential negative performance impacts. The MHP does have access to a SmartCare QI data warehouse, but it is only updated once a month so does not meet their reporting needs.
- The MHP, in partnership with CalMHSA, had a well thought out plan to train and prepare users for the SmartCare implementation, including a learning management system, live training, and online videos that could be accessed repeatedly and as needed. However key informants indicated that some users continue to lack the skills to use the system correctly, and specific examples were provided of how incorrect data entry is impacting some of the timeliness tracking measures, for example.
- The MHP has a 2.05 percent denied claims rate which is lower than the 5.92 percent denial rate statewide.
- The MHP reduced the number of EHR users by 11 percent in the previous year due to vacancies and user clean-up in preparation for the SmartCare implementation, including removing users who had not accessed the system in 90 days. The MHP should review all offboarding procedures to ensure user access is removed immediately after staff leave their positions.

## INFORMATION SYSTEMS PERFORMANCE MEASURES

### Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

### Table 18: Summary of Sacramento MHP Short-Doyle/Medi-Cal Claims, CY 2022

| Month | # Claim Lines | Billed Amount | Denied Claims | % Denied Claims | Approved Claims |
|---|---|---|---|---|---|
| Jan | 55,107 | $10,732,489 | $237,832 | 1.18% | $10,494,657 |
| Feb | 53,364 | $10,556,773 | $255,582 | 1.25% | $10,301,191 |
| Mar | 62,269 | $12,858,025 | $247,068 | 1.03% | $12,610,957 |
| April | 54,759 | $11,666,683 | $191,625 | 0.95% | $11,475,058 |
| May | 54,380 | $11,672,257 | $205,260 | 1.01% | $11,466,997 |
| June | 52,061 | $10,880,009 | $195,818 | 1.06% | $10,684,191 |
| July | 48,532 | $9,913,033 | $203,076 | 1.19% | $9,709,957 |
| Aug | 55,654 | $10,990,661 | $283,204 | 1.42% | $10,707,457 |
| Sept | 51,861 | $10,430,713 | $273,149 | 1.34% | $10,157,564 |
| Oct | 50,625 | $10,565,519 | $214,993 | 1.04% | $10,350,526 |
| Nov | 44,592 | $9,467,203 | $182,521 | 0.91% | $9,284,682 |
| Dec | 42,262 | $8,973,513 | $146,593 | 0.82% | $8,826,920 |
| **Total** | **625,466** | **$128,706,878** | **$2,636,721** | **2.05%** | **$126,070,157** |

### Table 19: Summary of Sacramento MHP Denied Claims by Reason Code, CY 2022

| Denial Code Description | Number Denied | Dollars Denied | Percentage of Total Denied |
|---|---|---|---|
| Other healthcare coverage must be billed first | 3,213 | $846,483 | 32.10% |
| Medicare Part B must be billed before submission of claim | 2,761 | $745,994 | 28.29% |
| Beneficiary is not eligible or non-covered charges | 1,606 | $507,616 | 19.25% |
| Place of service incomplete or invalid | 95 | $165,260 | 6.27% |
| Service line is a duplicate and repeat service modifier is not present | 636 | $117,469 | 4.46% |
| Late claim submission | 356 | $116,041 | 4.40% |
| Other | 431 | $59,742 | 2.27% |
| Deactivated NPI | 62 | $45,842 | 1.74% |
| Service location NPI issue | 100 | $32,273 | 1.22% |
| **Total Denied Claims** | **9,260** | **$2,636,720** | **100.00%** |
| **Overall Denied Claims Rate** | **2.05%** | | |
| **Statewide Overall Denied Claims Rate** | **5.92%** | | |

- The MHP has a claims denial rate of 2.05 percent, as compared to a denial rate of 5.92 percent statewide.

## IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP does not have an up-to-date copy of the SmartCare EHR database that can be used for reporting purposes. Currently they are dependent on the vendor and CalMHSA to develop and implement reports and cannot create the reports they deem necessary to run their operations.
- Despite a well-organized training plan, there are deficiencies in users' use of the new SmartCare EHR that will impact all aspects of the data collected.
- The MHP reduced the number of user accounts with access to the EHR in preparation for the SmartCare implementation, purging inactive accounts from the system. The MHP should review all offboarding procedures to ensure user access is removed immediately after staff leave their positions.
- The MHP is not a member of an HIE. They are encouraged to explore regional HIE opportunities.

# VALIDATION OF MEMBER PERCEPTIONS OF CARE

## CONSUMER PERCEPTION SURVEYS

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

The MHP provides the required CPS to members. There is a low return of the CPS and currently the documentation that is returned to the MHP is unable to be aggregated and no longer identifies provider level data. The MHP does not find the current model of the required CPS to be useful in addressing member voice. Due to the numerous requirements placed on the members, the MHP does not feel it appropriate to create an additional and separate CPS in addition to the currently required document.

## PLAN MEMBER/FAMILY FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested three 90-minute focus groups with Plan members (MHP members) and/or their family, containing 10 to 12 participants each.

### Sacramento MHP Consumer Family Member Focus Group One

CalEQRO requested a diverse group of Black, Indigenous, and Persons of Color family members who initiated services in the preceding 12 months. The focus group was held virtually and included six participants. All family members participating have a family member who receives clinical services from the MHP.

Family members reported that despite calling the Access line many times, youth did not access services after hospitalization. At times it took a child up to three months to receive services. Family members felt it was more complicated than in the past to get their child into services. Schools were an essential starting point for identification and referral to services.

The family members did report a positive interaction with both the clinician and psychiatrist and feeling a sense of hope. In addition, families reported a positive experience with the crisis team and the ability to participate in treatment planning.

Recommendations from focus group participants included:

- For the providers to work on reducing turnover, possibly offering incentives to retain frontline staff.
- To improve overall access to care, referrals programs should be expedited with clear instructions on next steps in the process.

### Sacramento Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included nine participants. All consumers participating receive clinical services from the MHP.

Most members were participating in a crisis residential treatment program. It was stated that it could take 90 days to transition to a higher level of care such as an FSP. Most members expressed frustration in getting connected to ongoing services and all agreed that lack of housing was a significant issue in their recovery. They felt that “You need to know right questions to ask to get services.” Members agreed that housing is an issue.

Recommendations from focus group participants included:

- Collaborate care when multiple agencies are working with a single member. They experienced frustration and confusion when receiving services from more than one provider agency.
- Improve wait times to higher levels of care such as FSP.

### Sacramento Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of TAY who initiated services in the preceding 12 months. The focus group was held virtually and included two participants. All consumers participating receive clinical services from the MHP.

Due to the low number of participants, specific information is not included in this section of the report.

Recommendations from focus group participants included:

- “More outreach and groups.”
- More housing options are needed as TAY shelters have closed due to lack of funding, displacing the participants.

## SUMMARY OF MEMBER FEEDBACK FINDINGS

The overall feedback identifies challenges in Access. Calls are not returned; calls are not answered, and it may be difficult to get outpatient services. Across all groups lack of housing has been identified as an issue of recovery and moving to a lower level of care.

# CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

## STRENGTHS

1. The MHP currently supports 310 units of permanent supportive housing and provides wraparound services for supportive bridge housing. (Access, Timeliness, Quality)
2. The MHP expanded their CORE programs to serve 11 wellness centers and outpatient services in areas of specific identified populations. (Access, Timeliness, Quality)
3. The MHP embarked on an ambitious roll-out of the new EHR SmartCare, providing numerous trainings and post roll-out TA. (Quality, IS)
4. The MHP has created a Peer ladder to accommodate 44 new peer and peer certified work force positions. (Quality)
5. Working with the WET Central Region, the MHP enhanced their ability to retain staffing positions by approving 125 awards for student loan repayment. (Access, Timeliness, Quality)

## OPPORTUNITIES FOR IMPROVEMENT

1. The MHP is in the process of transitioning over to a new website. Key informants have reported not knowing the existence of a website. The current website lacks ease of maneuverability, crisis numbers prominently displayed, and consistent program and resource messaging. (Access, Quality)
2. The MHP does not have a real-time SmartCare EHR database that can be used for generating reports that they determine are necessary. Additionally, some EHR users continue to have challenges using and understanding the policies and procedures of accessing and reporting data in the SmartCare system. (Quality, IS)
3. The MHP does not report standard percentages to identify no-show rates for psychiatrists and clinicians; inaccurate tracking may lead to the inability to obtain the data needed for system-wide improvements. (Timeliness, Quality)
4. The MHP does not accurately track the timeliness data for first offered non-urgent psychiatry appointment, using the wait time to being offered an appointment versus the wait time to first offered appointment. (Timeliness)

5. Delays are reported at the Access Line with reports of calls not being answered or returned to individuals seeking services. (Access, Timeliness)

## RECOMMENDATIONS

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

1. Engage user input, such as members, family members, contractors, and staff, when remodeling the current website; prominently display crisis access and 988 numbers, and MHUCC hours and locations, and provide website information to all contractors and members. (Quality, IS)
2. Research and implement a project to gain access to a complete SmartCare database that is refreshed nightly and could be used for the MHP's distinct reporting needs. (Quality, IS)
3. Identify and implement acceptable standard percentages for clinical and psychiatrist no-show rates; and accurately report timeliness data with these rates. (Timeliness)
4. Reporting on all members, with the standard of 15 business days, First Offered Non-Urgent Psychiatry Appointment, as the time to the first appointment offered. (Timeliness)
5. Examine staffing and training associated with procedures for responsiveness at the Access line. Ensure that when members reach out for care that they receive a timely response with clear instructions on how to obtain services. (Access, Timeliness)

# EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2023-24 EQR.

# ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

## ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

### Table A1: CalEQRO Review Agenda

| CalEQRO Review Sessions – Sacramento MHP |
|---|
| Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations |
| Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care |
| Validation and Analysis of the MHP's PIPs |
| Validation and Analysis of the MHP's PMs |
| Validation and Analysis of the MHP's Network Adequacy |
| Validation and Analysis of the MHP's Health Information System |
| Validation and Analysis of Member Perceptions of Care |
| Validation of Findings for Pathways to MH Services (Katie A./CCR) |
| Consumer and Family Member Focus Group(s) |
| Clinical Line Staff Group Interview |
| Clinical Supervisors Group Interview |
| Use of Data to Support Program Operations |
| Cultural Competence / Healthcare Equity |
| Quality Management, Quality Improvement and System-wide Outcomes |
| Primary and Specialty Care Collaboration and Integration |
| Acute and Crisis Care Collaboration and Integration |
| Health Plan and MHP Collaboration Initiatives |
| Peer Employees/Parent Partner Group Interview |
| Peer Inclusion/Peer Employees within the System of Care |
| Contract Provider Group Interview – Clinical Management and Supervision |
| Information Systems Billing and Fiscal Interview |
| EHR Deployment |
| Telehealth |
| Closing Session – Final Questions and Next Steps |

# ATTACHMENT B: REVIEW PARTICIPANTS

## CalEQRO Reviewers

Kiran Sahota, Lead Quality Reviewer
Elaine Crandall, Quality Reviewer
Zena Jacobi, Information Systems Reviewer
Lisa Farrell, Information Systems Reviewer
Pamala Roach, Consumer/Family Member Reviewer

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

### Table B1: Participants Representing the MHP and its Partners

| Last Name | First Name | Position | County or Contracted Agency |
|---|---|---|---|
| **Acosta** | Nina | Division Manager – Forensic Services | Sacramento County Behavioral Health |
| **Alves** | Kathryn | Quality Manager | Pacific Clinics |
| **Amos** | Melissa | Clinical Staff | Turning Point Community Programs |
| **Armenta** | Jessie | Clinical Director | La Familia Counseling |
| **Band** | Mai | Peer Staff | El Hogar, Inc. |
| **Barker** | Kathleen | Clinical Supervisor | Turning Point Community Programs |
| **Barney** | Robin | Adult Family Advocate Liaison | CalVoices |
| **Bob** | Jennifer | Clinical Staff | Sacramento County Behavioral Health |
| **Burkett** | Tara | Clinical Staff | Turning Point Community Programs |
| **Cable** | Nicole | Program Manager – Forensics | Sacramento County Behavioral Health |
| **Cooper** | Riene | Peer Staff | Hope Cooperative |
| **Crook** | Andrea | Program Manager – MHSA | Sacramento County Behavioral Health |
| **Crossley** | Dakota | Peer Staff | Turning Point Community Programs |
| **Duthler** | Kristina | Health Program Planner | Sacramento County Behavioral Health |
| **Faux** | Valencia | Clinical Staff | Sacramento Children's Home |
| **Felsky** | Simone | Health Information Manager | Pacific Clinics |
| **Grant** | Janelle | Senior Account Manager | Sacramento County Behavioral Health |
| **Green** | Sheri | Division Manager – Children's Services | Sacramento County Behavioral Health |
| **Hahn** | Ralph | Clinical Staff | El Hogar, Inc. |
| **Hawkins** | Pamela | Program Planner - QM | Sacramento County Behavioral Health |
| **Hein** | Claudia | Clinical Supervisor | Capital Stars Community Services |

| Last Name | First Name | Position | County or Contracted Agency |
|---|---|---|---|
| **Her** | Pahoua | Program Planner - REPO | Sacramento County Behavioral Health |
| **Hicks** | Deborah | Director of Employee and Community Development | HeartLand Child and Family Services |
| **Housley** | Andrea | Youth and Family Advocate Liaison | CalVoices |
| **Hypolite** | Karissa | Program Planner - REPO | Sacramento County Behavioral Health |
| **Ibarra** | Melony | Administrative Services Officer - 3 | Sacramento County Behavioral Health |
| **Inderpreet** | Toor | Clinical Staff | River Oak Center for Children |
| **Irizarry** | Christina | Program Manager – Children's Services | Sacramento County Behavioral Health |
| **Jimenez** | Lindsey | Clinical Supervisor | El Hogar, Inc. |
| **Juarez** | Soph | Peer Staff | HeartLand Child and Family Services |
| **Kaplan** | Anna | Peer Staff | River Oak Center for Children |
| **Kesselring** | Robert | Program Manager – Children's Services | Sacramento County Behavioral Health |
| **Lee** | Sora | Clinical Supervisor | Asian Pacific Community Counseling |
| **Leung** | Julie | Health Services Program Planner | Sacramento County Behavioral Health |
| **Malenab** | Bethany | Clinical Supervisor | Asian Pacific Community Counseling |
| **Mann** | Monroe (Gerald) | Peer Staff | Hope Cooperative |
| **Marisa** | Ciani | Clinical Supervisor | Turning Point Community Programs |
| **McGriff** | Shelly (Michelle) | Peer Staff | El Hogar, Inc. |
| **Mendez** | Gibran | Director of Quality Improvement | Stanford Sierra Youth Solutions |
| **Nakamura** | Mary | Program Manager – Cultural Competence and Ethnic Services | Sacramento County Behavioral Health |

| Last Name | First Name | Position | County or Contracted Agency |
|---|---|---|---|
| **Owens** | Whitney | Program Planner - QM | Sacramento County Behavioral Health |
| **Panyala** | Anantha | Division Manager – MHTC | Sacramento County Behavioral Health |
| **Quinley** | Matt | Program Manager – Children's Services | Sacramento County Behavioral Health |
| **Quist** | Ryan | Director of Behavioral Health | Sacramento County Behavioral Health |
| **Rechs** | Alex | Program Manager – Quality Management | Sacramento County Behavioral Health |
| **Rickards** | Kris | Clinical Supervisor | Sacramento Children's Home |
| **Rocha-Wyatt** | Monica | Program Manager – Adult Services | Sacramento County Behavioral Health |
| **Ross** | Tory | Program Manager – Access | Sacramento County Behavioral Health |
| **Sawyer** | John | IT Applications Analysist | Sacramento County Behavioral Health |
| **Sebastian** | Dana | Program Manager – CalAIM | Sacramento County Behavioral Health |
| **Sloan** | Barton | Peer Staff | Hope Cooperative |
| **Swanton** | Jamie | Clinical Supervisor | River Oak Center for Children |
| **Taylor** | Eryca | Program Coordinator - Access Team | Sacramento County Behavioral Health |
| **Thomas** | Terrell | Strategic Initiative Officer | Stanford Sierra Youth Solutions |
| **Thompson** | Alondra | Program Manager – Adult Services | Sacramento County Behavioral Health |
| **Weaver** | Kelli | Deputy Director of Behavioral Health | Sacramento County Behavioral Health |
| **Williams** | Dawn | Program Manager – Research, Evaluation, and Performance Outcomes | Sacramento County Behavioral Health |
| **Williams** | Allison | Program Manager – Adult Services | Sacramento County Behavioral Health |
| **Zakhary** | Jane Ann | Division Manager – Administration, Planning, and Outcomes | Sacramento County Behavioral Health |

# ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

## Clinical PIP

### Table C1: Overall Validation and Reporting of Clinical PIP Results

| PIP Validation Rating (check one box) | Comments |
|---|---|
| ☐ High confidence<br>☐ Moderate confidence<br>☒ Low confidence<br>☐ No confidence | The PIP continues to lack clinical impacts and outcomes. Data was not consistently tracked through the time periods and the overall "n" was very low and not statistically significant. |

| General PIP Information |
|---|
| **MHP/DMC-ODS Name:** Sacramento |
| **PIP Title:** "Racial Equity Action Plans" |
| **PIP Aim Statement:** : "Will implementing the recruitment/retention strategies and racial equity training identified in the Behavioral Health REAPs improve engagement, timely access, and retention of AA/B/AD over the next 18 months?" |
| **Date Started:** 01/2022 |
| **Date Completed:** 07/2023 |
| **Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)**<br>☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic)<br>☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases)<br>☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic) |
| **Target age group (check one):**<br>☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children<br>*If PIP uses different age threshold for children, specify age range here: |
| **Target population description, such as specific diagnosis (please specify):** "The entire population of African American enrollees served by the six identified providers will be affected by this PIP. At the baseline year of FY 2020-21, this number was 2,637. Their ages range from 3 to 96 with 53 percent women, and 47 percent men." |

| General PIP Information | | | | | | |
|---|---|---|---|---|---|---|
| **Improvement Strategies or Interventions (Changes in the PIP)** | | | | | | |
| **Member-focused interventions** (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>By providing culturally relevant and racial equitable services, members will increase the successful discharge rate. | | | | | | |
| **Provider-focused interventions** (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>Racial equity training for all provider staff will decrease member unsuccessful discharge rate. | | | | | | |
| **MHP/DMC-ODS-focused interventions/system changes** (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):<br>MHP facilitated the BHREC committee to a universalism approach to advanced behavioral health equity for the AA/B/AD communities. | | | | | | |
| **PMs (be specific and indicate measure steward and National Quality Forum number if applicable):** | **Baseline year** | **Baseline sample size and rate** | **Most recent remeasurement year (if applicable)** | **Most recent remeasurement sample size and rate (if applicable)** | **Demonstrated performance improvement (Yes/No)** | **Statistically significant change in performance (Yes/No) Specify P-value** |
| Percentage of beneficiaries who disengage early. | *FY19/20* | *N = 2,914*<br>*9.5%* | ☐ Not applicable—PIP is in planning or implementation phase, results not available | *N = 143*<br>*34.3%* | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>P-value:<br>☐ <.01 ☐ <.05<br>Other: n/a |
| Percentage of beneficiaries who discharge unsuccessfully | *FY19/20* | *N= 9,079*<br>*75%* | ☐ Not applicable—PIP is in planning or implementation phase, results not available | *N= 510*<br>*70%* | ☒ Yes<br>☐ No | ☐ Yes ☐ No<br>P-value:<br>☐ <.01 ☐ <.05<br>Other: n/a |
| Percentage of change in cultural factors met on the CANS assessment from Initial to most recent assessments | *FY19/20* | *10%* | ☐ Not applicable—PIP is in planning or implementation phase, results not available | *1.9%* | ☒ Yes<br>☐ No | ☐ Yes ☐ No<br>P-value:<br>☐ <.01 ☐ <.05<br>Other :n/a |

| PMs (be specific and indicate measure steward and National Quality Forum number if applicable): | Baseline year | Baseline sample size and rate | Most recent remeasurement year (if applicable) | Most recent remeasurement sample size and rate (if applicable) | Demonstrated performance improvement (Yes/No) | Statistically significant change in performance (Yes/No) Specify P-value |
|---|---|---|---|---|---|---|
| Percentage of change in cultural factors met on the ANSA assessment from Initial to most recent assessments | *FY19/20* | *26%* | ☐ Not applicable—PIP is in planning or implementation phase, results not available | *20.4%* | ☒ Yes<br>☐ No | ☐ Yes ☐ No<br>P-value:<br>☐ <.01 ☐ <.05<br>Other :n/a |

**PIP Validation Information**

**Was the PIP validated?** ☒ Yes ☐ No

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

**Validation phase (check all that apply):**

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

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

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

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

**EQRO recommendations for improvement of PIP:**

- The MHP participated in one TA session during the review cycle.
- Ensure the AIM statement identifies a number or percentage of improvement.
- Ensure data collection is consistent and accurately reported.
- Ensure the PIP has a measurable clinical outcomes component.

## Non-Clinical PIP

### Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

| PIP Validation Rating (check one box) | Comments |
|---|---|
| ☐ High confidence<br>☐ Moderate confidence<br>☒ Low confidence<br>☐ No confidence | The MHP does not clearly articulate what the five percent improvement entails, a low "n," and data collection and reporting was inconsistent or inaccurate. |
| **General PIP Information** | |
| **MHP/DMC-ODS Name:** Sacramento | |
| **PIP Title:** "Admissions at Provider Site" | |
| **PIP Aim Statement:** "Will providing an option for beneficiaries under 18 years old to access services directly from the contracted provider improve the time between request to first assessment appointment and then to first treatment appointment by five percent throughout the 18 months of this project?" | |
| **Date Started:** 01/2022 | |
| **Date Completed:** 07/2023 | |
| **Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)**<br>☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic)<br>☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases)<br>☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic) | |
| **Target age group (check one):**<br>☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children<br>*If PIP uses different age threshold for children, specify age range here: | |
| **Target population description, such as specific diagnosis (please specify):** "All children in the MHP are affected by the problem. The three-leading diagnosis of the beneficiaries in the study population were: Disruptive behavior Disorder (44 percent), Disorder of infancy, childhood, or adolescence (41 percent) and Attention-Deficit/Hyperactivity Disorder of Combined Type or Predominantly Hyperactively-Impulsive Type (19 percent)." | |

| General PIP Information | | | | | | |
|---|---|---|---|---|---|---|
| **Improvement Strategies or Interventions (Changes in the PIP)** | | | | | | |
| **Member-focused interventions** (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>Members will be provided with five sites as walk-in or urgent services. The member is responsible for follow through. | | | | | | |
| **Provider-focused interventions** (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>Four identified providers will provide walk-in/urgent services. | | | | | | |
| **MHP/DMC-ODS-focused interventions/system changes** (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):<br>MHP will refer members to five sites that allow walk-in/urgent services. | | | | | | |
| **PMs (be specific and indicate measure steward and National Quality Forum number if applicable):** | **Baseline year** | **Baseline sample size and rate** | **Most recent remeasurement year (if applicable)** | **Most recent remeasurement sample size and rate (if applicable)** | **Demonstrated performance improvement (Yes/No)** | **Statistically significant change in performance (Yes/No) Specify P-value** |
| Number of days between first contact and first assessment. | *FY20/21* | 12.96 days | ☐ Not applicable—PIP is in planning or implementation phase, results not available | *N= 49*<br>*4.68 days* | ☒ Yes<br>☐ No | ☐ Yes ☐ No<br>P-value:<br>☐ <.01 ☐ <.05<br>Other: n/a |
| Number of days between first assessment and first clinical appointment. | *FY20/21* | 4.4 days | ☐ Not applicable—PIP is in planning or implementation phase, results not available | *N= 49*<br>*0 days* | ☒ Yes<br>☐ No | ☐ Yes ☐ No<br>P-value:<br>☐ <.01 ☐ <.05<br>Other: n/a |
| Percentage of beneficiaries who attended the first assessment appointment AND the first treatment appointment. | *FY20/21* | 67% | ☐ Not applicable—PIP is in planning or implementation phase, results not available | *N= 49*<br>*75.0%* | ☒ Yes<br>☐ No | ☐ Yes ☐ No<br>P-value:<br>☐ <.01 ☐ <.05<br>Other: n/a |

| PIP Validation Information |
|---|
| **Was the PIP validated?** ☒ Yes ☐ No<br>"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations. |
| **Validation phase (check all that apply):**<br>☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year<br>☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): concluded.<br>Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence<br>"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. |
| **EQRO recommendations for improvement of PIP:**<br>• The MHP participated in one TA session during the review cycle.<br>• Ensure a clear and consistent plan when utilizing contracted agencies to collect and report on data.<br>• Ensure performance measures are clearly defined and documented. |

## ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

## ATTACHMENT E: LETTER FROM THE MHP DIRECTOR

A letter from the Director was not required for this report.