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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

STANISLAUS MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 20 – 21, 2020

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INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Stanislaus MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Medium

MHP Region — Central

MHP Location — Modesto

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 7,546

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS MHSD Information Notice (IN) 13-09.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed AB 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and INs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard (AAS) and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS IN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS will review these forms to determine if the provider networks met required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services to youth and adults. If these standards are not met, DHCS will require the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, these will be reviewed by CalEQRO as part of their annual quality review process with a structured protocol to assess access and timeliness and validation of the AAS and any plan of correction or improvement of the services to Medi-Cal recipients living in the zip codes requiring an AAS.

CalEQRO reviews the NACT provider files, maps of clinics closest to the AAS zip codes, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the MHP shall develop and propose an AAS plan, and access to any alternative providers who might become Medi-Cal certified for the MHP. The MHP shall submit a plan of correction addressing the needs to meet the AAS.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO will review grievance and complaint log reports, facilitate beneficiary focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: Clinical PIP: Continue implementing interventions and measuring indicators, evaluating data measurement processes and interventions, and changing processes to address untoward results.

Status: Met

- Since the 2019 Mental Health EQRO review, the Clinical PIP, Children's Mobile Assessment Team (CMAT) PIP, continued to implement interventions, measure indicators, and evaluate data measurement processes and interventions.

- Due to COVID-19 restrictions of in-person services, the data collection was stopped the third quarter (March 2020) for the PIP analysis and summary.
- The data up until March 2020 reflected positive changes after implementing the interventions.

Recommendation 2: Clinical PIP: Add more specificity in describing data gained from beneficiary surveys and how that data will inform interventions.

Status: Met

- The Clinical PIP added more specificity in describing the data gained from the beneficiary surveys and how the data informed the interventions.
- The surveys are meant to provide Stanislaus Behavioral Health and Recovery Services (BHRS) with valuable data and feedback regarding the quality and ease of accessing assessment services.
- These surveys were reviewed monthly in the PIP committee to discuss any relevant information regarding practices of the CMAT team, provide stakeholder input, and provide a guide for potential changes or adjustments to make in the CMAT process.

Recommendation 3: Non-clinical PIP: Continue to gather information and develop and implement the data analysis plan.

Status: Met

- The PIP team continued to gather data, developed, and implemented the data analysis plan.
- The data comes from the CAGE (an acronym where each letter represents a specific question (cut, annoyed, guilty, eye-opener)), and the medical assessment team (MAT) staff complete the CAGE.
- MAT clinicians utilize the CAGE assessment, which is embedded into the Mental Health Comprehensive Assessment as a separate tab, to collect data.

Recommendation 4: Consult with CalEQRO for technical assistance (TA) early and often to address the needs identified in both PIPs through Quality Improvement (QI) processes.

Status: Met

- Following the FY2019-20 EQR, the PIP Committees received TA in October of 2019, August of 2020, and October of 2020 to discuss the

progress of the PIP, options for moving forward, and assistance with the new PIP submission tool.

- More frequent contact with BHC was not scheduled due to issues related to the holidays and the pandemic.
- Moving forward, the BHRS plans to reach out more frequently to BHC for PIP TA.

Access Recommendations

Recommendation 5: Continue to track the CMAT team to attain the set goal of 90 percent meeting the ten-day access standard.

Status: Met

- The CMAT is part of the Children's System of Care (CSOC) Quality Improvement Committee (QIC). The committee meets monthly and reviews the Medi-Cal Key Indicators tool and program specific data. One of the items on the CSOC QIC Work Plan is a focus on increasing the timeliness of child and adolescent assessments.
- The committee focuses on reviewing data and strategizing ways to meet the standard that Child/Adolescent beneficiaries have a scheduled assessment within ten business days of the initial request for services.
- The CMAT team monitored no-shows and cancellations, increased the assessment slots to meet the needs, and offered slots to assist with other programs in meeting the ten-day access standards when the data showed this was needed.
- A review of the first three quarters of FY 2019-20 shows that CMAT increased timeliness to 85 percent. The goal of 90 percent has not been attained; however, this is a significant improvement, and this will continue to be an area of focus.
- During COVID-19 there has been a significant decrease in referrals; the CMAT team has been meeting the goal of 90 percent of the ten-day access standard.

Timeliness Recommendations

Recommendation 6: Continue to evaluate the efficacy of changes made to improve utilization of psychiatric services to increase capacity (i.e. by altering scheduling practices to include e.g., double-booking, walk-in appointments, and/or scheduling at least one initial contact appointment daily to fill no-show

times). Track and trend results and continue to find any needed resolutions to this issue. (This is a follow-up recommendation from FY 2018-19.)

Status: Partially Met

- The current no-show rate for psychiatric evaluations remains at about 20 percent, per BHRS data, despite the recommended adjustments in scheduling. BHRS is considering a PIP with the goal of reducing no-shows. The plan is to review the data and create a meaningful goal.
- Another intervention the MHP is considering is to implement a list of clients who may be able to attend their evaluations on short notice when there is a cancellation. Historically there has not been such a list, as generally the psychiatric appointments for evaluations are within the required time frames.

Recommendation 7: Adopt the Network Adequacy Final Rule urgent request for services timeliness standard of 48 hours (instead of a standard in days).

Status: Met

- BHRS had been tracking, monitoring, and reporting the timeliness of urgent requests for services using the standard of two calendar days, rather than 48 hours.
- To change the criteria to measure hours versus days, it was necessary to revise the Request for Urgent Referral Form in the EHR to capture this data.
- Staff was alerted regarding the change to ensure the collection of the *time* of requests and *time* of services.
- This was completed in January 2020, and the data from that point forward reflects the 48-hour timeliness standard. Policy number 50.1.119, *Timely Access and Service Availability* reflects the 48-hour urgent request timeliness standard.

Quality Recommendations

Recommendation 8: Continue recruitment efforts to fill the five currently unfilled Information Technology (IT) positions to facilitate use of data for quality improvement (QI) and programmatic decisions.

Status: Met

- BHRS continued recruitment efforts and was able to recruit the Senior Software Developer Analyst and a Staff Services Coordinator (focusing on NACT and EHR).
- The Staff Services Analyst III position was filled for only a short period of time, and BHRS is now contracting two “embedded” developers from Stanislaus County Information Technology Central (ITC) for this position.
- Filling these positions has assisted the department to facilitate the use of data for QI and programmatic decisions.

Beneficiary Outcomes Recommendations

None.

Foster Care Recommendations

Recommendation 9: Continue Presumptive Transfer Single Point of Contact (SPOC) meetings with Behavioral Health Recovery Services (BHRS) CSOC program provider teams on Presumptive Transfer matters such as continuity of practice and training on internal processes for Presumptive Transfer cases.

Status: Met

- Prior to COVID-19 the SPOC met with BHRS/Child Welfare Program to talk specifically about Presumptive Transfer (PT) during the team meeting on the third Monday of each month.
- During COVID-19 the SPOC continues to work closely and has ongoing communication with the BHRS/Child Welfare PT Assessor. The SPOC resumed attending BHRS/Child Welfare team meeting starting September 22, 2020.
- The SPOC scheduled a PT 101 Training for the BHRS/Juvenile Justice Program on September 9, 2020 and for the Josie’s Treatment Team on September 8, 2020.
- The SPOC is part of the Children’s Assessment Team/Leaps and Bounds Program, attends the weekly meeting, and PT is one of the standing agenda items.
- PT is a standing agenda item for the following meetings:
    - Weekly CSOC Leadership meeting,

- Monthly Joint CSOC Leadership meeting which includes CSOC contracted programs leadership and the monthly STRTPs provider meeting.
- In addition, the SPOC provides informational meetings to the STRTPs individually. (e.g. SPOC met with Sierra Vista STRTP on June 10, 2020, Creative Alternatives STRTP on July 8, 2020, and Aspiranet STRTP on August 5, 2020).

Recommendation 10: Update the Presumptive Transfer orientation materials to provide further joint orientation to BHRS, Child Welfare and Probation new hires.

Status: Met

- A draft Continuing of Care Reform (CCR) Training material, which includes Presumptive Transfer has been developed and it is being reviewed with partner agencies (Child Welfare & Probation). The material is intended to provide orientation to BHRS, Child Welfare and Probation new hires.
- Additionally, there is now a specific Presumptive Transfer 101 Training material for any new staff or staff who needs a refresher training.

Recommendation 11: Finalize a new Presumptive Transfer Policy and Procedure.

Status: Met

- The Presumptive Transfer Policy & Procedure 90.1.107 – Final: September 9, 2019; Updated: July 6, 2020, and to be finalized by the end of September 2020.

Recommendation 12: Continue meetings with local licensed Short-Term Residential Therapeutic Programs (STRTPs) and other community partners as needed to ensure timely access and services.

Status: Met

- BHRS holds a monthly STRTP meeting. In addition, SPOC meets with each STRTP to review individual practices and share updated information. This allows open communication and to problem solve timely access and services.
- This past quarter, SPOC met with Sierra Vista STRTP on June 10, 2020, Creative Alternatives STRTP on July 8, 2020 and met Aspiranet STRTP on August 5, 2020.

- The SPOC also provides PT 101 Training and re-fresher training. The SPOC provided a re-fresher training for Creative Alternatives STRTP on September 15, 2020 and for Aspiranet STRTP on September 16, 2020.

Information Systems Recommendations

Recommendation 13: Move forward with discussions to join and participate in the San Joaquin Community Health Information Exchange (SJCHIE). (This recommendation is a carry-over from FY 2018-19.)

Status: Partially Met

- Stanislaus County has been in conversation with the SJCHIE but the COVID-19 pandemic halted discussions in March.
- Both the Stanislaus County Health Services Agency and BHRS are re-evaluating how this initiative aligns with their current strategic planning efforts.
- This recommendation will not be carried forward by CalEQRO during the COVID-19 pandemic.

Recommendation 14: Continue to monitor service needs and deploy telehealth services when needed to address service capacity issues.

Status: Met

- BHRS scaled up telehealth in the April-May timeframe and plan to continue to develop their capacity to provide mental health and substance use disorder (SUD) treatment services via telehealth along with the traditional onsite/in-person services. They anticipate the continued use of telehealth as a core part of their service delivery system.
- The MHP is working with contract providers to use the same video-conferencing software to ensure continuity of training, capability development, and client experience across the system.
- BHRS is also conducting a stakeholder survey to assess the impact of telehealth on clients with a particular focus on technology challenges.

Structure and Operations Recommendations

Recommendation 15: Review the budget dedicated to supporting Information Technology (IT) operations to determine if it is adequate to support the Electronic Health Record (EHR) and the MHP's QI data driven efforts.

Status: Met

- BHRS began a Strategic Planning exercise in Fiscal Year 2019-2020 that consists of an organizational review which may include restructuring. This process will identify increased efficiencies due to the impacts of COVID-19 and the need to ensure sustainability of programs and services into the future while prioritizing the provision of core mandated services.

- An assessment of the resources needed in IT operations has been included in this process and BHRS will report on the progress in future EQRO cycles.

- Two contract developers were hired to support BHRS in the use of data for QI and programmatic decisions.

Recommendation 16: After joining SJCHIE, replace the current process of faxing transition forms between the MHP and the managed care plans with Health Information Exchange (HIE) for tracking bi-directional health plan referrals and exchange of clinical information. (This is a follow-up recommendation from FY 2018-19.)

Status: Partially Met

- Stanislaus County is in conversation with the SJCHIE. However, due to challenges presented by the COVID-19 pandemic, discussions on using the HIE for clinical information exchange were halted in March.

- The current process of faxing transition forms between the MHP and managed care plans will continue until progress is made in HIE efforts. Meanwhile, Data Outcomes and Technology Services (DOTS) is implementing an eFax solution across BHRS to replace traditional faxing.

- This recommendation will not be carried forward during the COVID-19 pandemic.

PERFORMANCE MEASURES

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

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

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

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to: screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).

- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

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

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

Total Beneficiaries Served

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

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2019 by Race/Ethnicity: Stanislaus MHP

Stanislaus MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	61,866	25.9%	2,914	38.6%
Latino/Hispanic	127,376	53.4%	2,923	38.7%
African-American	7,646	3.2%	403	5.3%
Asian/Pacific Islander	13,342	5.6%	172	2.3%
Native American	539	0.2%	35	0.5%
Other	27,690	11.6%	1,099	14.6%
Total	**238,457**	**100%**	**7,546**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Table 2 provides details on beneficiaries served by threshold language.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Stanislaus MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	823	10.9%
Other Languages	6,723	89.1%
Total	**7,546**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

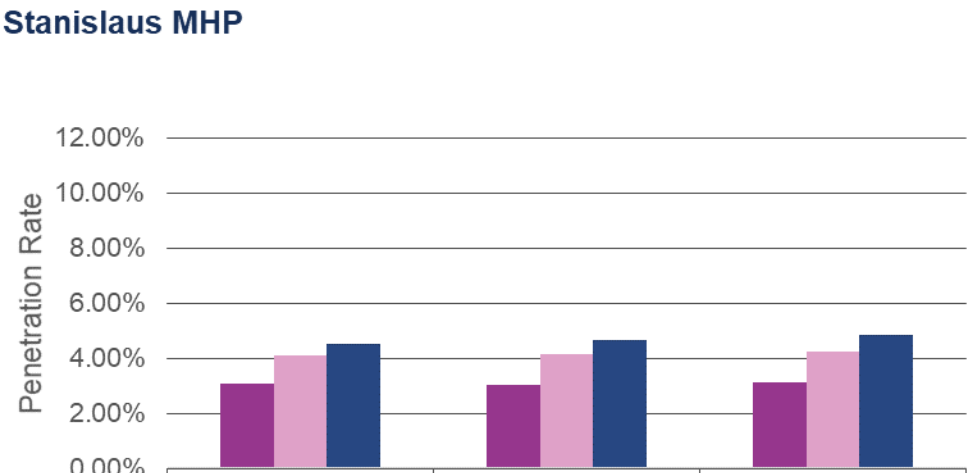
Penetration Rates and Approved Claims per Beneficiary

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

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2019. See Table C1 for the CY 2019 ACA penetration rate and ACB.

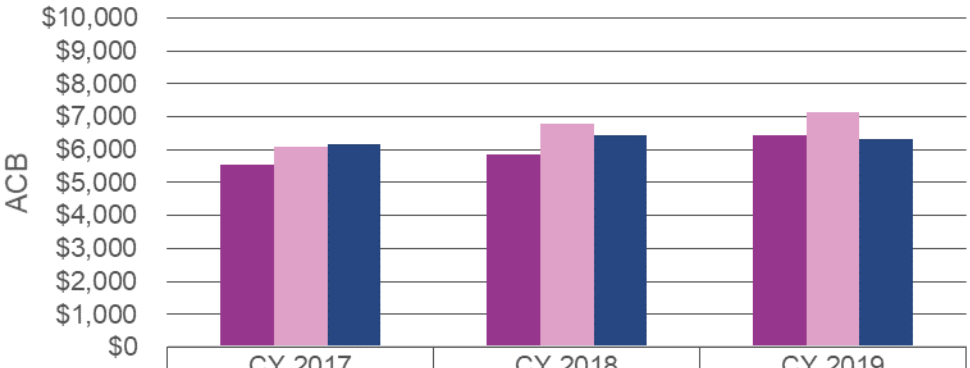
Regarding the calculation of penetration rates, the Stanislaus MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	3.10%	3.05%	3.16%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

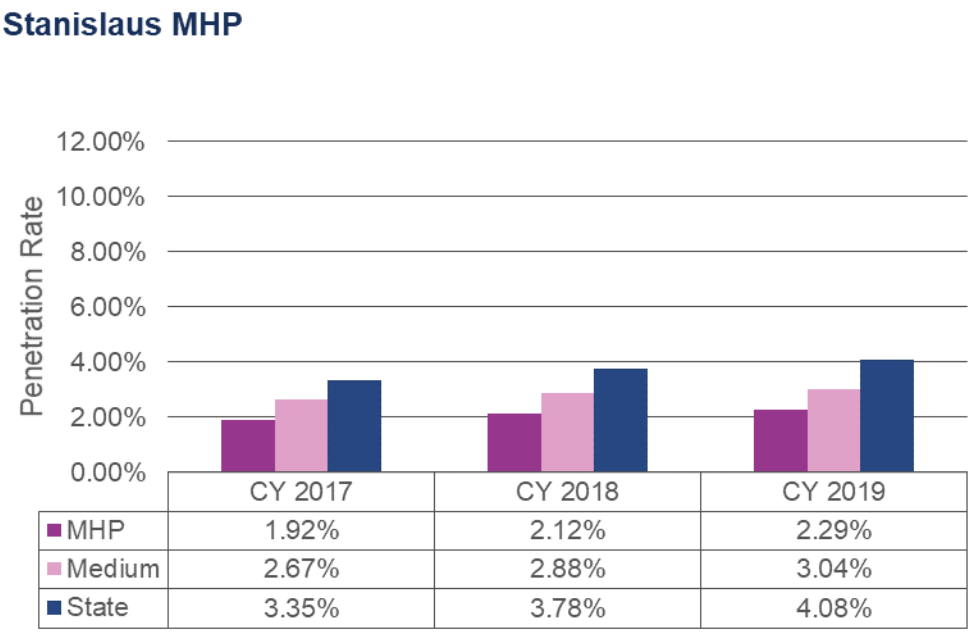
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$5,545	$5,845	$6,452
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

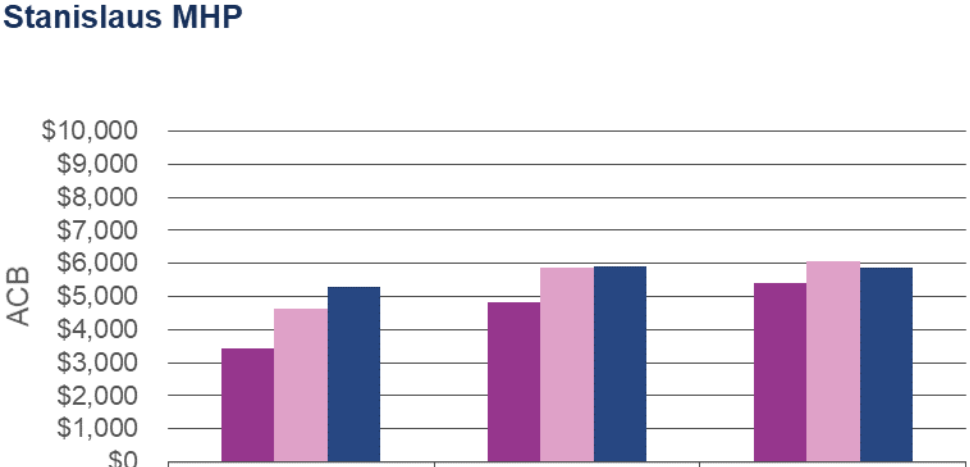
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	1.92%	2.12%	2.29%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

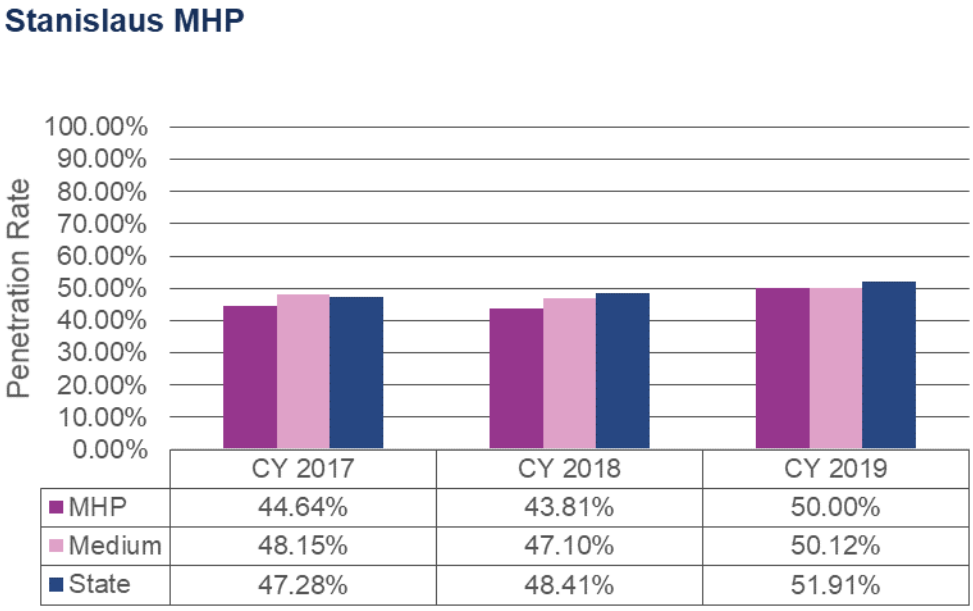
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,445	$4,823	$5,388
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

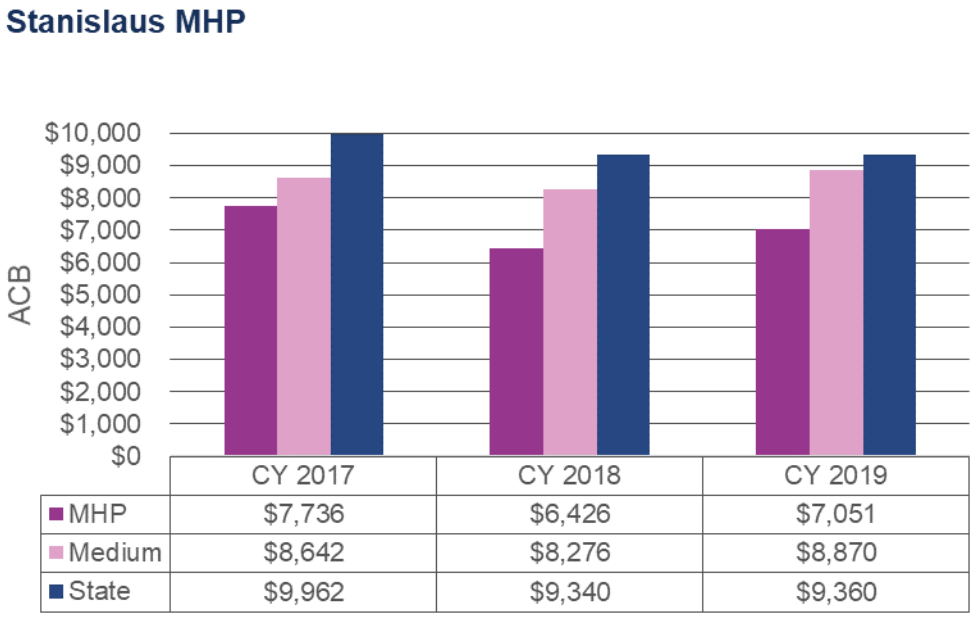
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	44.64%	43.81%	50.00%
Medium	48.15%	47.10%	50.12%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

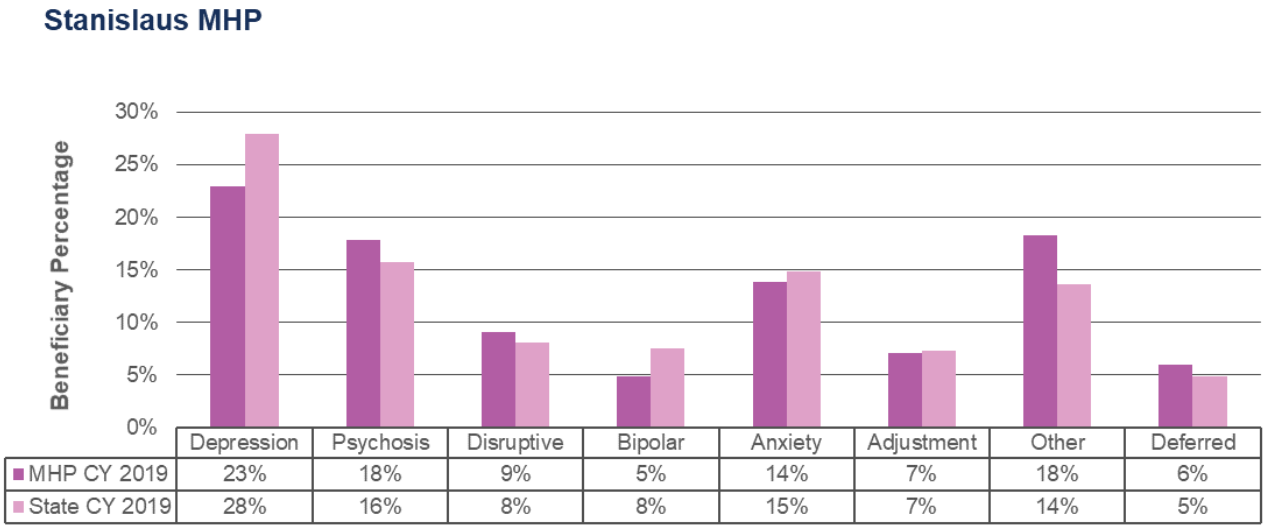


	CY 2017	CY 2018	CY 2019
MHP	$7,736	$6,426	$7,051
Medium	$8,642	$8,276	$8,870
State	$9,962	$9,340	$9,360

Diagnostic Categories

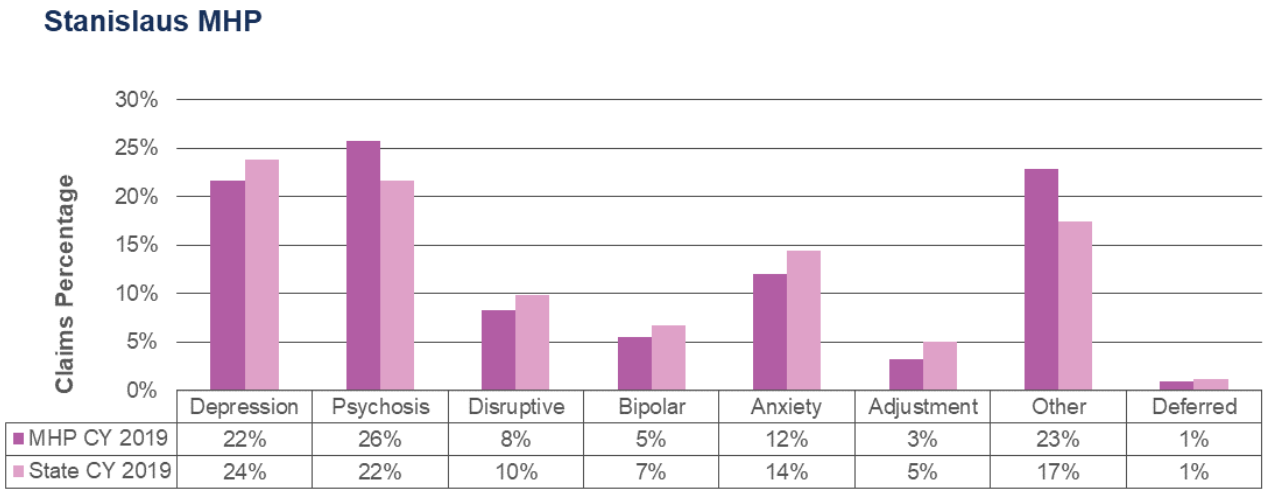
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	23%	18%	9%	5%	14%	7%	18%	6%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	22%	26%	8%	5%	12%	3%	23%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Stanislaus MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	266	7,546	3.53%	$48,227	$12,828,357	26.35%
	CY 2018	208	7,533	2.76%	$55,652	$11,575,694	26.29%
	CY 2017	204	7,815	2.61%	$49,433	$10,084,295	23.27%

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

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 4: Psychiatric Inpatient Utilization CY 2017-19

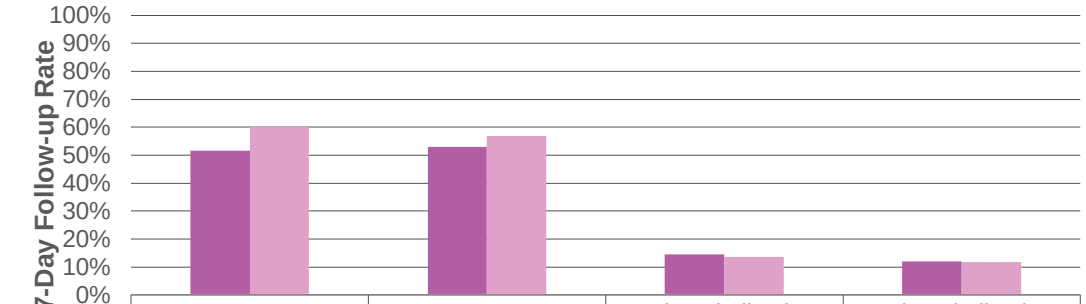
Stanislaus MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	1,470	4,323	4.87	7.80	$7,969	$10,535	$11,714,307
CY 2018	1,348	3,638	5.05	7.63	$9,924	$9,772	$13,377,951
CY 2017	1,398	4,723	4.49	7.36	$7,512	$9,737	$10,501,928

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19

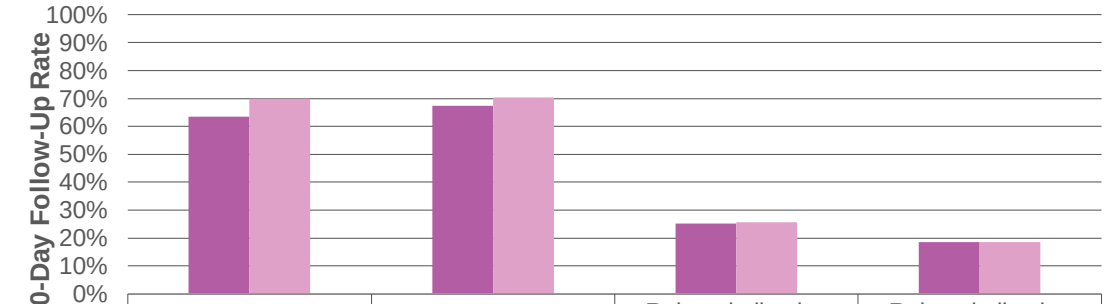
Stanislaus MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	52%	53%	15%	12%
CY 2019	60%	57%	14%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19

Stanislaus MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	64%	67%	25%	19%
CY 2019	70%	70%	26%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Stanislaus MHP PIPs Identified for Validation

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

Table 5 : PIPs Submitted by Stanislaus MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Timely Assessments for Children and Youth
Non-Clinical	1	Mental Health to SUD Referrals

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Stanislaus
PIP Title	Timely Assessments for Children and Youth
PIP Aim Statement	Will implementing a dedicated Children's Mobile Assessment Team (CMAT) increase the timeliness of an initial assessment for child/youth Medi-Cal beneficiaries from 56 percent of assessments occurring within the standard to 70 percent of assessments occurring within the standards within twelve months.
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	Stanislaus
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0-17) * ☐ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): All children and youth Medi-Cal beneficiaries, ages zero through 17, seeking services with the MHP.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested 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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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): Implementation of a CMAT with the goal to increase the timeliness of an initial assessment for child/youth Medi-Cal beneficiaries from 56 percent of assessments occurring within the standard to 70 percent of assessments occurring with the standards.

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Number and percent of child/ adolescent beneficiaries who receive an initial assessment within 10 business days of the request for services	FY 2017-18	1,361/ 2,432= 56%	FY 2019-20 (Q1-3) ☐ NA*	367/417 = 88%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 ☒ Other (specify): No test of statistical signifi-cance
Number and percent of assessments completed by CMAT team compared to number and percent of assessments completed by other BHRS children's programs	FY 2017-18	All other BHRS children's programs: 851/851= 100% Child Welfare: 470/851=55.2% Juvenile Justice: 80/851=9.4% Leaps & Bounds: 122/851=14.4%	FY 2019-20 (Q1-3) ☐ NA*	All other BHRS children's programs: 25% Child Welfare: 157/681= 23% Juvenile Justice: 14/681= 2% Leaps & Bounds: 0	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 ☒ Other (specify): No test of statistical signifi-cance

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
		School Based Services: 70/851=8.2% Youth & Family: 109/851=12.8% CMAT: 0/0=0% (not implemented yet)		School Based Services: 0 Youth & Family: 2/681= 0.3% CMAT: 75%		
Percent of overall satisfaction with services by youth and caregivers who receive an initial assessment with the CMAT team	N//A	No baseline data available; the goal was to achieve at least 85% favorable responses	FY2019-20 (Q1-3) ☐ NA*	559/582 = 96%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 ☒ Other (specify): No test of statistical signifi-cance
Number and percent of Spanish speaking child/ adolescent beneficiaries or caregivers who receive an initial	FY 2017-18	302/559= 54%	FY2019-20 (Q1-3) ☐ NA*	Q1: 84/98= 86% Q2: 83/95= 87% Q3: 83/93= 89%	☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
assessment within 10 business days of request for services						☒ Other (specify): No test of statistical signifi-cance
Number and percent of child/adolescent beneficiaries who receive an initial assessment within 10 business days in a home-community setting vs. office setting	FY 2017 -18	Community Setting 388/706 = 55% Q1: 100/179 = 56% Q2: 102/179 = 57% Q3: 113/156 = 72% Q4: 115/185 = 62% Office 973/1664 = 58% Q1: 249/374 = 67% Q2: 249/371 = 67%	FY2019 -20 (Q1-3) ☐ NA*	Community Setting FY: NA Q1: 121/138 = 88% Q2: 120/148 = 81% Q3: 127/142 = 89% Office FY: NA Q1: 256/275 = 93% Q2: 284/313 = 91% Q3: 235/255 = 92%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 ☒ Other (specify): No test of statistical signifi-cance

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
		Q3: 241/415 = 58% Q4: 273/410 = 67%				

Was the PIP validated? ☒ Yes ☐ No

Validation phase:

☒ PIP submitted for approval
☐ Planning phase
☐ Implementation phase
☐ Baseline year
☐ First remeasurement
☐ Second remeasurement
☒ Other (specify): Completed

Validation rating:

☒ High confidence
☐ Moderate confidence
☐ Low confidence
☐ No confidence

Although the PIP ended data collection in March, evidence supports 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:

- Although the PIP has ended, CalEQRO recommends that the MHP continue tracking the interventions of the PIP, which proved successful.
- Engage in TA with EQRO early and often in the creation of the new PIP.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • CalEQRO worked with the MHP to move forward with completing the PIP earlier than anticipated due to COVID-19 restrictions creating a barrier in gathering further valid data. • CalEQRO provided TA to the MHP in the process of executing the write-up of the PIP in the new PIP tool.						

*PIP is in planning and implementation phase if NA is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Stanislaus
PIP Title	Mental Health to Substance Use Disorder (SUD) Referrals
PIP Aim Statement	To improve access and timeliness of engagement with SUD services, will streamlining the linkage process from Medi-Cal Assessment Team (MAT) to a SUD program, a. Increase the percentage of appropriate SUD referrals from 12 percent to 20 percent within one year; and, b. Increase timeliness of mental health assessments to completed SUD assessments (10 business days/3 business days for Opioid Treatment Programs (OTP) from 6.9 percent to 50 percent within one year?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	

MHP Name	Stanislaus
Target age group (check one): ☐ Children only (ages 0-17) * ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The study population is the whole population of Adult, Medi-Cal beneficiaries coming into MAT for an initial Mental Health Comprehensive Assessment.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested 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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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): The improvement strategy is to utilize the updated CAGE by MAT staff with clients completing the adult Mental Health Comprehensive Assessment. For clients who screen as being appropriate for a referral to SUD services, MAT staff will then complete the ASAM-based Level of Care Indicator (LOCI) Brief Screen embedded in the Contact Log with those clients who accepted a SUD

PIP Interventions (Changes tested in the PIP)
referral. MAT staff will then schedule those clients for a SUD assessment utilizing Scheduler.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Increase percent of appropriate SUD referrals (appropriate is defined as a "yes" on question 5 based on clinical judgment and/or client responses to questions 1-4 of the CAGE) to 20 percent.	FY 2017-2018	58/468 = 12%	FY2019-2020 ☐ NA*	151/576 = 26%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 ☒ Other (specify): No test of statistical signifi-cance
Increase percent of appropriate and client accepted SUD referrals resulting in a SUD Comprehensive Assessment to 60 percent	FY 2017-2018	26/58 = 45%	FY 2019-2020 ☐ NA*	3/12=25%	☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 ☒ Other (specify): No test of statistical signifi-cance

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Increase percent of SUD referrals that result in a SUD comprehensive assessment within 10 business days (3 days for OTP) to 50 percent within 1 year	FY 2017-2018	4/58 = 6.9% (within 10 days) 0/0 = 0% (within 3 days)	FY 2019-2020 ☐ NA*	2/3=67%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 ☒ Other (specify): No test of statistical signifi-cance
Was the PIP validated?				☒ Yes	☐ No	
Validation phase: ☒ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Completed						
Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
The MHP's results were attributable to the intervention, there were no apparent errors in collecting data or conducting data analysis. There was some evidence of improvement. "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: • CalEQRO recommends that the PIP team follow through with follow-up intervention options, including a development of a clinical PIP to address fostering increased acceptance of referrals to SUD assessment. • Engage with CalEQRO in TA as a new PIP is developed.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Cal EQRO provided the PIP team TA in the changes discussed. • CalEQRO and the PIP team discussed the possibility of a clinical PIP as a follow up to the non-clinical PIP just completed. • CalEQRO provided TA to the MHP in the process of executing the write-up of the PIP in the new PIP tool.						

*PIP is in planning and implementation phase if NA is checked.

INFORMATION SYSTEMS REVIEW

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

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

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

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT

staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Stanislaus	2.78%	2.94%	3.39%	3.66%
Medium MHP Group	NA	3.28%	3.34%	3.01%
Statewide	NA	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

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

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the MHP uses an ASP model to host EHR system which provides 24-hour operational support.	☐ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☒ Yes	☐ No

Business Operations	Status	
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- The Stanislaus County Cyber Security Officer is responsible for BHRS' information security and staff training on cyber security.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	40%
Contract providers	58%
Network providers	2%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	21	2	4	2
2019-20	24	0	5	5
2018-19	25	0	3	2

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	0	0	0	0
2019-20	0	0	0	0
2018-19	0	0	0	0

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

- Data analytical staffing is included in the technology FTE count.
- DOTS have 10 technology FTEs and 11 data analytical FTEs.
- A Senior Software Developer Analyst was hired in July 2020. Two contract developers filled a Staff Services Analyst position, and they were hired to support BHRS in the use of data for QI and programmatic decisions.
- A FY 2020-21 operations priority is to review DOTS staffing and position realignment.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by MHP and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	152	87	239
Clinical Healthcare Professional	400	569	969
Clinical Peer Specialist	0	0	0
Quality Improvement	4	0	4
Total	556	656	1,212

While there is no standard ratio of IT staff to support EHR user's, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Medium MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	10.00	7.87
Total EHR Users Supported by IT (Source: Table 17)	1,212.00	572.00
Ratio of IT Staff to EHR Users	1:121	1:73

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
The MHP utilizes an ASP model to support EHR operations.	☐ Yes	☒ No
The MHP also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☒	☐	☐	☒
Screen workflow and navigation	☒	☐	☐	☒

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☒ Yes	☐ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	36
Number of county-operated telehealth sites	5
Number of contract providers' telehealth sites	31
Total number of beneficiaries served via telehealth during the last 12 months	NA
• Adults	NA
• Children/Youth	NA
• Older Adults	NA
Total Number of telehealth encounters (services) provided between March and September 2020:	Telehealth: 5,439 Telemedicine: 2,452

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☒ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☒ To serve special populations (i.e. children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries
☒ To support NA time and distance standards
☒ To address and support COVID-19-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19- pandemic on beneficiaries and mental health provider staff.

- Hundreds of electronic devices (200 cell phones, just under 100 laptops and about a dozen iPads) were deployed and over 150 requests for

Remote Desktop Protocol (RDP) were processed to support county staff working at home to log into their office computers.

- BHRS selected Zoom for Healthcare as the video conferencing platform and staff were given virtual training on how to use it.
- Some clients who lack equipment to receive telehealth services were loaned iPads for their sessions.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☐	Russian	☒	Spanish	☐	Tagalog
☐	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Aspiranet	5
Center for Human Services	5
Sierra Vista Child & Family Services	16
Telecare	3

Contract Provider	Count of Sites
Central Star	1
Turning Point	1

Current MHP Operations

- BHRS continues to use Cerner Community Behavioral Health (CCBH) as its EHR.
- CCBH is hosted and supported by the DOTS IT team.
- Contract providers (CBOs) enter services directly in CCBH and have access to aggregated reports.
- DOTS support both Mental Health Treatment and Substance Use Disorder programs.
- A group led by DOTS Chief has been meeting to explore EHR system replacement options.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/ Application	Function	Vendor/Supplier	Years Used	Hosted By
CCBH	Practice Management System	Cerner Corporation	8.5	DOTS IT
CCBH	Electronic Health Record	Cerner Corporation	8.5	DOTS IT
CCBH	Managed Care Operations	Cerner Corporation	3	DOTS IT
LOCUS	Adult Level of Care	Deerfield Behavioral Health	10.5	DOTS IT

The MHP's Priorities for the Coming Year

- Deployment of resources for focused reporting and meaningful use of outcome data.
- Use of Results Based Accountability (RBA) across the department.
- Staffing to support BHRS Core Treatment Model.
- Completing mandated submission requests such as Client Services Information (CSI), Child and Adolescent Needs and Strengths (CANS), and the Pediatric Symptoms Checklist-35 (PSC-35).
- Work with Human Resources on Information technology/system job classification effort.
- DOTS staffing and position realignment.
- Deployment of wireless network solution at the main location.
- Adding a second Internet Service Provider (ISP).

Major Changes since Prior Year

- Amazon Web Services Interactive Voice Response (AWS IVR) deployed at the DOTS Help Desk main number.
- Implemented CCBH Promotions 229 and 230.
- Deployed Jira Ticketing System to track & manage incidents.
- Implemented Remote Desktop Protocol (RDP) for staff working remotely and/or at home.
- Recruitment and hiring of critical leadership positions.
- Implemented the ProSpec pre-project assessment tool.
- Implementation of Remote Lenovo Notebooks and iPhone 8 to support field-based services staff.
- Partnership with Information Technology Central (County IT) to embed contract staff.
- Implementation of Information Technology Asset Management (ITAM) Software.

- Implementation of COVID-19 Assessment Tool.
- Implementation of GoToMeeting.
- Implementation of Zoom as the default video conference platform.
- Continued implementation of eFax across the department.

Other Areas for Improvement

- Network connectivity and capacity needs improvement to better support telehealth services.

Plans for Information Systems Change

- The MHP is considering a conversion to a new system, but there is no formal project in place and no project team assigned to accomplish it.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	CCBH	☒	☐	☐	☐
Assessments	CCBH	☒	☐	☐	☐
Care Coordination	CCBH/ PCP Form	☐	☒	☐	☐
Document Imaging/Storage	CCBH	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	CCBH	☒	☐	☐	☐
Laboratory results (eLab)	CCBH	☐	☒	☐	☐
Level of Care/Level of Service	LOCUS	☒	☐	☐	☐
Outcomes	CCBH	☒	☐	☐	☐
Prescriptions (eRx)	CCBH	☒	☐	☐	☐
Progress Notes	CCBH	☒	☐	☐	☐
Referral Management	CCBH/Fax	☐	☒	☐	☐
Treatment Plans	CCBH	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		9	3	0	0
FY 2019-20 Summary Totals for EHR Functionality:		9	3	0	0
FY 2018-19 Summary Totals for EHR Functionality:		9	1	2	0

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

- None noted.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	100%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Not used

The rest of this section is applicable: ☐ Yes ☒ No

Some contract providers have EHR systems which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in-place to

support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission

EHR Vendor	Product	Count of Providers Supported
Not applicable.		

Personal Health Record (PHR)

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

☒ Yes ☐ No ☐ Implementation Phase

Stanislaus County Network of Care

Expected implementation timeline:

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

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☒ Yes	☐ No

PHR Functionality	Status	
Have ability to both send/receive secure Text Messages with provider team.	☒ Yes	☐ No

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☐ Web-based application, including your EHR system, supported by Vendor or ASP Staff
- ☐ Web-based application, supported by MHP or DMC staff
- ☒ Local SQL Database, supported by MHP/Health/County staff
- ☐ Local Excel Worksheet or Access Database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

Stanislaus MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**139,244**	**$43,415,491**	**1,567**	**$655,812**	**1.49%**	**$42,759,679**	**$40,981,957**
JAN19	11,410	$3,504,911	96	$47,612	1.34%	$3,457,299	$3,160,696
FEB19	11,417	$3,380,272	120	$53,282	1.55%	$3,326,990	$3,183,916
MAR19	12,805	$3,874,677	156	$63,714	1.62%	$3,810,963	$3,613,823
APR19	13,362	$4,140,927	135	$38,540	0.92%	$4,102,387	$3,903,393
MAY19	12,985	$3,828,571	189	$58,048	1.49%	$3,770,523	$3,597,606
JUN19	10,869	$3,316,358	144	$58,483	1.73%	$3,257,875	$3,093,614
JUL19	11,829	$3,605,289	190	$75,405	2.05%	$3,529,884	$3,381,277
AUG19	11,453	$3,758,530	111	$61,546	1.61%	$3,696,984	$3,589,191
SEP19	11,315	$3,705,828	135	$72,494	1.92%	$3,633,334	$3,522,221
OCT19	12,357	$4,060,440	101	$32,246	0.79%	$4,028,194	$3,961,822
NOV19	9,807	$3,241,328	103	$63,944	1.93%	$3,177,384	$3,069,614
DEC19	9,635	$2,998,361	87	$30,500	1.01%	$2,967,861	$2,904,785

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments by Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Stanislaus MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Beneficiary not eligible.	430	$190,548	29%
Beneficiary not eligible or non-covered charges.	99	$158,422	24%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	604	$156,922	24%
Medicare or Other Health Coverage must be billed before submission of claim.	350	$111,086	17%
NPI, Type 2 credentialing data missing, incomplete, or invalid.	20	$20,128	3%
Total	1,567	$655,812	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with reason "ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing,

incomplete, or invalid" are generally re-billable within the State claims resubmission guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate Network Adequacy as required by state law. The first document to be reviewed is the NACT which outlines in detail the MHP provider network by location, service provided, population served and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Stanislaus, the time and distance requirements are 60 minutes and 30 miles for mental health services, and 60 minutes and 30 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups- youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's Network Adequacy rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	1
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	58
NPI Type 1 number reported is associated with two or more providers	0
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	1
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	4

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CFM Focus Group One

Table 32 : Focus Group One Description and Findings

Topic	Description
Focus group type	A culturally diverse group of adult beneficiaries, including Spanish speaking, who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held on the virtual platform Zoom.
Total number of participants	Seven
Number of participants who initiated services during the previous 12 months	One
Interpreter used	No
Summary of the main findings of the focus group: Participants had some issues with using Zoom for the focus group interview. This lessened with familiarity of the technology as the group progressed. One participant left early due to technical issues with Zoom. The participants reported that overall, they are receiving positive and satisfactory services.	

Topic	Description
Access - new beneficiaries	The participant who began services within the last 12 months reported it took a week or less to access services and immediate assessment.
Access – overall	All participants reported access to all services, therapists and case managers as needed.
Timeliness	Participants agreed that services were provided in a timely manner with no long waits. Many participants attend support groups.
Urgent care and resource support	Participants received urgent care and resource support through Telecare, BHRS and Child Welfare Services (CWS). Several were aware of the warm line/24-hour access line.
Quality	All participants agree they receive quality services and help from their current providers.
Peer employment	Participants reported some knowledge of where to find help to prepare for and obtain employment. No structured system was mentioned.
Structure and operations	No information given.
Recommendations from this focus group	• Open wellness centers that were closed due to COVID-19. • Participants would like more input into the medication prescribed by the psychiatrist.
Any best practices or innovations (optional)	• None noted.

CFM Focus Group Two

Table 33 :Focus Group Two Description and Findings

Topic	Description
Focus group type	A culturally diverse group of parents/caregivers of child/youth beneficiaries to include Foster Care, including Spanish speaking, who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The group consisted of Latino/Hispanic and Caucasian women over the age of 25 who are both English and Spanish-speaking consumers and family members. The focus group was held on the virtual platform Zoom.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	One
Interpreter used	Yes If yes, specify language: Spanish
Summary of the main findings of the focus group: The group went well, and participants engaged and shared their experiences. Some participants noted that they had not had access to resource information others in the group had received. All participants agreed they were happy with their services had learned some valuable information during the focus group.	
Access - new beneficiaries	The participant who began services in the last 12 months reported it was easy to access services once referred.
Access – overall	All received services and access in a timely manner once connected to Stanislaus County. Referrals were through schools, police department and justice system, and previous service providers.
Timeliness	All consumers were assessed and opened to services within one week once connected to Stanislaus County services. Participants all reported receiving reminder calls or texts for appointments.

Topic	Description
Urgent care and resource support	Participants agreed that the main source of information for urgent care and resource support is obtained by contacting their clinicians and the pamphlets they received at initial assessment.
Quality	Participants agreed that the quality of the services they received was good. However, they noted a lack of information and input regarding medications prescribed.
Peer employment	No information given.
Structure and operations	No information given.
Recommendations from this focus group	• More one-on-one interaction with counselors and therapists. • Creation of basic skills and engaging programs for youth to help cope with isolation. • Receive care and parent help groups and tools to help parents cope and deal with children receiving mental health services • Know more advocacy information and rights as a parent with children in services.
Any best practices or innovations (optional)	• None noted.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 34 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 34: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
BHRS has in place various avenues to make the initial access for mental health services in Stanislaus County simple, including telehealth and telephone services while COVID-19 restrictions continue. The provider directory is up to date and accessible. The BHRS provides information on how to access services on its website, including all programs closed to public access. The website lists information on how to access services, sends the viewer to a COVID-19 information page, and provides a telephone number to call for information on services availability. It lists Emergency Support as first choice with non-English assistance noted to access language of preference. In response to COVID-19 changes in services, the MHP put out videos, radio spots, and print information to educate people on how to get treatment during COVID-19, and to ensure the public knew that treatment was still available.			

Component		Maximum Possible	MHP Score
As part of the QI Work Plan, BHRS is in the process of contracting with a new answering service in order to improve the 24/7 telephone line that provides information, in beneficiary's language of choice on how to access SMHS, the beneficiary resolution process and responds to urgent conditions. Beneficiaries may obtain information about community events and services provided on the county's social media pages (e.g. Facebook). Beneficiaries interviewed reported that they are provided information about services in languages other than English. Beneficiaries may access translation services from Spanish speaking clinicians during psychiatry services when other translation is unavailable. BHRS developed and presented Behavioral Health & Wellness Crisis Response Plan (BHWCRP) related to COVID-19. BHWCRP provides weekly videos on Wellness in both English and Spanish; and, they have compiled a robust list of Behavioral Health Resources, reaching target populations by internet, flyers, and even yard signs. To further the campaign message to the Spanish speaking community, *El Rotafoloio* training program was added. It prepares staff, peers, and community members to conduct and facilitate Spanish presentations. The Warm Line has been expanded due to noticed increase in stress, anxiety and fear related to the COVID-19 pandemic.			
1B	Capacity Management	10	10
BHRS participated the Rapid Response Network (RRN), a joint initiative between the California Mental Health Services Oversight and Accountability Commission (MHSOAC) and Social Finance, Incorporated to support jurisdictions in fast-paced research and decision making driven by COVID-19 to ensure capacity management. BHRS received 'No Place Like Home' funding to refurbish a hotel to increase housing units for adults, older adults, and transitional age youth with a severe mental illness. This will provide 100 total units, with a minimum of 50 additional Permanent Supportive Housing units for BHRS clients. They also secured 25 dedicated beds at the new emergency low barrier shelter. The MHP tracks penetration rates and other utilization reports by beneficiary types and demographics. Minutes from the Cultural Competency Committee (CCC) meetings show how the MHP strategies address the clinical, cultural, and/or linguistic disparities in access,			

Component		Maximum Possible	MHP Score
and documents how decisions are made on resources committed to the process (See Quality of Care Section 3A).			
1C	Integration and Collaboration	24	24
BHRS continues, even during COVID-19, to have integrated and collaborative programs with partnering agencies and a variety of CBOs. As was noted in last year's report, the MHP continues to strengthen partnership and collaboration with CBOs. The MHP holds quarterly meetings with MCOs to discuss operations issues, bi-directional referrals, and specific clinical cases as needed. This is done virtually during the COVID-19 pandemic. BHRS continues to work with Stanislaus County to address the needs of the homeless, including more attention to this issue during the pandemic.			

Timeliness of Services

As shown in Table 35, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 35: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
In compliance with IN 18-011, the MHP standard for length of time from initial request to first offered appointment is ten business days. They met the standard 89 percent overall, 91 percent for adults, 92 percent for older adults, 89 percent for children, 94 percent for adult FC, and 81 percent for children's FC. The CMAT did not meet the clinical PIP goal of 90 percent, they continue to track this metric in CSOC QIC, which meets monthly. This goal is included in the QI Work Plan and involves community partners. Walk-ins are discouraged during the COVID-19 restrictions.			
2B	First Offered Psychiatry Appointment	12	12

Component		Maximum Possible	MHP Score
In compliance with IN 18-011, the MHP standard for length of time from initial request to first offered psychiatry appointment is 15 business days. They met the standard 76 percent of the time overall; 78 percent for adults, 68 percent for older adults, 74 percent for children, 33 percent for adult FC; and 84 percent for children's FC. The MHP did not comment on the possible reason for the low percentage of adult FC receiving an appointment offer within the standard. Psychiatry continues to be on-site for most adults, with the in-house psychiatrist and beneficiary in separate rooms using the Zoom virtual platform. The MHP's forensics team reported that there is timely access to psychiatry services after release from incarceration. Clinicians collaborate with probation and connect beneficiaries with services immediately upon release.			
2C	Timely Appointments for Urgent Conditions	18	18
BHRS had been tracking, monitoring, and reporting the timeliness of urgent requests for services using the standard of two calendar days rather than 48 hours for urgent appointments that do not require prior authorization. The Request for Urgent Referral Form in the EHR was revised to capture this data. Staff was informed regarding the change to ensure the collection of the time of requests and time of services. This was completed in January 2020, and the data from that point forward reflects the 48-hour timeliness standard. In addition, policy number 50.1.119, *Timely Access, and Service Availability*, reflects the 48-hour urgent request timeliness standard. The 48-hour standard was met 98 percent of the time overall, 94 percent for adults, 100 percent for children, and FC children. Older adults were not tracked.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	10
The MHP standard for timeliness of follow-up appointments post-psychiatric inpatient discharge is the HEDIS measure of seven days post discharge. Of the discharges that kept follow-up appointments, the standard was met 82 percent of the time overall, adults 79 percent, children 97 percent, adult FC 75 percent, and children FC 100 percent. Clinicians reported that they collaborate with hospital staff to provide seven-day follow-up post discharge. Some beneficiaries will not engage in follow-up stating COVID-19 as an issue.			

Component		Maximum Possible	MHP Score
2E	Psychiatric Inpatient Rehospitalizations	6	6
The MHP reported a readmission rate within 30 days was 26 percent overall (2465/635), adults 27 percent (596/2223), children 16 percent (39/242), adult FC 0 percent (0/3), and children FC 25 percent (4/16).			
2F	Tracks and Trends No-Shows	10	10
The MHP no-show standard for both psychiatrists and clinicians other than psychiatrists is 20 percent. No-shows for psychiatrist was 14 percent overall, adults 14 percent, children 14 percent, adult FC 18 percent, and children FC 11 percent. No-shows for clinicians other than psychiatrists was 5 percent overall, adults 3 percent, children 11 percent, adult FC 18 percent, and children FC 11 percent.			

Quality of Care

In Table 36, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 36: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The Cultural Competence Plan (CCP) outlines penetration rates (age, gender, race, location); however, the MHP does not separately track services provided in threshold languages. The CCP outlines strategies to reduce racial, ethnic, cultural, and linguistic mental health disparities. Meeting minutes from the CCC reflect staff breakout sessions and trainings to discuss the best method to provide services that are equitable, understandable, and respectful. The CCC meeting minutes reflect that the MHP follows the national Culturally and Linguistically Appropriate Services (CLAS)			

Component		Maximum Possible	MHP Score
standards, and workgroups convene on how to best implement CLAS Standards with the MHP core treatment model. The QI Work Plan Objective 8/Goal 8, promotes monitoring of activities to identify barriers among ethnic/cultural groups that are underserved. CCC and QI committees collaborate, however to date there is not an Ethnic Services Manager to monitor this area fully. Recruitment continues for this position, with a candidate identified at the time of the CalEQRO review.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
Level of Care Utilization System (LOCUS) and CANS are used as level of care (LOC) tools and to guide treatment and care transition. BHRS continues to monitor services and activities including training reports, the department's Cultural Competency, Equity and Social Justice (CCESJ) minutes, and dashboard/reports. These tools are tied to the BHRS Core Treatment Model.			
3C	Quality Improvement Plan	10	10
BHRS has a Quality Assessment and Performance Improvement (QAPI) Program: QI Program Description and Work Plan for 2020-2021. The MHP current QI Work Plan is inclusive of measurable goals and objectives, responsible partners, evaluation methods/tools and prior year's findings and results .The MHP provided QI meeting minutes to support at least quarterly progress on the goals and objectives in the plan. The QAPI is a revision in the past year to include DHCS' preferred format for work plans.			
3D	Quality Management Structure	14	14
The MHP has a designated quality management (QM) unit that effectively interfaces with other units within the MHP. The MHP has a designated QI Coordinator, and additional QI staff (e.g., analysts), adequate to perform quality management functions. The QM functions include data extraction and analysis pertaining to access, timeliness, quality, and outcomes. These activities are performed by DOTS staff and the findings are shared with leadership and throughout the MHP SOC.			
3E	QM Reports Act as a Change Agent in the System	10	10
The MHP successfully recruited a. Software Developer Analyst in July 2020 and a Staff Services Coordinator (focusing on NACT & EHR). The Staff Services Analyst III position was filled for a short period of time the MHP is now contracting two			

Component		Maximum Possible	MHP Score
embedded developers from ITC for this position. These positions facilitate the use of data for QI and programmatic decisions. Clinicians interviewed stated that they review QM reports with their supervisors and are aware of the beneficiary outcome trends. This information is utilized for treatment and program planning. BHRS management has access to i-Dashboards that provides recent data of the individuals receiving services - from age, race/ethnicity, to languages spoken. Another report recently developed summarizes the data for individuals who did not show for appointments. This report allows the MHP to establish parameters to analyze the data more granularly. The report also provides the no-show rates by the city of residence, by age, gender, primary language, race/ethnicity, and age group by regions. This report is discussed at the Quality Improvement Committees to help identify areas of concern and that need to be addressed. The MHP produces a County Staff report which breaks down staff demographics by ethnicity and language, which is used to assist in cultural competency capacity. The MHP uses Medi-Cal Key Indictors Report to monitor service access, timeliness quality and care outcomes.			
3F	Medication Management	12	12
The MHP uses a Medication Monitoring Questionnaire with outcomes metrics. The MHP tracks and trends HEDIS and other national measures related to diagnoses, medication practices and care standards. Medication prescription, administration and monitoring were identified as Key Treatment Services in the MHP's Core Treatment Model. QI Work Plan Object 5/Goal 5 addresses monitoring of medication practices. Of note is that this year scheduling conflicts prevented quarterly reviews of medication practices via chart reviews. Two quarters were reported. The MHP and CWS staff responsible for the Katie A. subclass and Pathways to Well-Being FC children confirm adherence to the requirements of SB1291, specifically in reviewing all data on FC dependents receiving psychotropic and or antipsychotic			

Component	Maximum Possible	MHP Score
medications. Clinicians interviewed endorsed ongoing routine communication with prescribers. Policies and procedures are in place to oversee psychiatric service frequency and follow-up standards, as well as guidelines for medication use.		

Beneficiary Progress/Outcomes

In Table 37, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 37: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	16
The MHP utilizes CANS-50 and PSC-35 for children and youth, and LOCUS for adults, to assess progress. There are standards as to when to utilize tools and documentation of assessment results are in the beneficiary chart. CANS-50 is administered at admission, discharge, every six months and/or as needed when sooner would be effective. LOCUS is administered at admission, discharge, transfer between programs, every six months to yearly depending on program, and every three months for Full-Service Partnership (FSP) Assertive Community Treatment (ACT). Clinical staff reported that they review outcome measure reports with their supervisors on a routine basis. They use standardized assessment tools. No beneficiaries in focus groups reported being aware of their performance outcomes in an official way, although they all agreed they discuss progress in sessions.			
4B	Beneficiary Perceptions	10	10

Component		Maximum Possible	MHP Score
The MHP administers the DHCS Consumer Perception Survey (CPS). QI Work Plan Objective 3/Goal 3 speaks to the CPS and compares results to the previous two years. The CCP outlines the CPS and SUD Treatment Survey and provides results. The results are used as part of program planning within the SOC. The MHP shares CPS results with leadership, the mental health board, staff, contract providers and beneficiaries. Clinical staff reported that the CPS results are shared with them during staff meetings. The MHP administers other surveys to specific programs or groups to obtain current feedback, including focus groups. (The focus groups have been paused during the COVID-19 restrictions.) The MHP initiated a remote survey of beneficiaries to measure technology readiness for receiving telehealth. This survey asked clients what devices they have access to (e.g. landline phones, smart phones, tablets, laptops, etc.) and used the information in implementing telehealth.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
All wellness centers in Stanislaus County are closed due to COVID-19 restrictions on gatherings. Beneficiaries noted that the wellness centers were missed as part of their recovery support. Before COVID-19, the MHP had four wellness centers for adults, open Monday through Friday 8:00 a.m. – 5:00 p.m., in alignment with MHP service hours. The centers were consumer-run and consumer-driven. All were open to the public. TAY had two drop-in centers, with programing directed by participants. The score on this item is valid for the period up until March 2020 when the centers closed.			

Structure and Operations

In Table 38, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 38: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	30
Stanislaus BHRS has a robust array and full continuum of services. The MHP provided documentation of the various services in the SOC. During the COVID-19			

Component		Maximum Possible	MHP Score
pandemic, most services are delivered via telehealth. The MHP effectively implemented telework across the system for employees during COVID-19 restrictions. Providers have been resilient in pivoting to telephone and telehealth services for all but emergency and crisis services requiring onsite staff. Capacity has been maintained through this pandemic thus far. The MHP assisted providers in finding technology and equipment to pivot to telehealth delivery of services. Adult crisis residential treatment is available in Merced as part of a five-counties collaborative. Beneficiaries interviewed reported that group therapy is not offered during COVID-19 restrictions. However, the MHP provided evidence of group services available via telehealth platforms.			
5B	Network Enhancements	18	18
In response to COVID-19, the MHP, directly operated and contract providers, transitioned to providing the majority of services through telehealth. Crisis response and situations requiring in-person services (e.g. injections) are still operational. The MHP's approach to services is holistic and whole person based. Staff reported connecting beneficiaries with resources that they need—housing, services, and educational programs. BHRS began the year following the last CalEQRO visit focusing on Strategic Planning; however, with the pandemic unfolding, they shifted to a COVID-19 response. The department implemented the Continuity of Operation Plan (COOP), ensuring that mandated and critical services remained operational. The Children's Triage Linkage and Coordination Team and the Adult Triage Support Team continue to function. The MHP continues to deploy field-based staff where necessary during the pandemic.			
5C	Subcontracts/Contract Providers	16	16
CCC meeting minutes reflect participation from various contract providers, to include Central Star FSP, Telecare, Sierra Vista, Aspiranet, Center for Human Services, Downtown Streets Team, West Modesto Collaborative, Turning Point Empowerment Center, among others.			

Component		Maximum Possible	MHP Score
When COVID-19 restrictions began, there were daily updates with the MHP, and now they are one day a week. Contractors report pandemic fatigue due to all the changes and ongoing issues of health and safety for staff and clients. Initially, there were issues with getting the technology to deploy employees to work remotely. Personal Protection Equipment (PPE) (e.g. hand sanitizer, masks, face shields) were initially in short supply; however, they are now more available. Stanislaus BHRS provided masks as needed. Most services are now telehealth services. Outreach teams are still outdoors all day and deal with both poor air quality from recent fires and COVID-19 safety issues. There are staffing issues with staff who have children who need to be home schooled. Contractors reported that they work with staff to develop schedules and options that are doable for all whenever possible. Contractors reported feeling supported by MHP, and that all have a common goal and common issue during COVID-19 in supporting service delivery to clients.			
5D	Stakeholder Engagement	12	10
The MHP includes multiple levels of stakeholders in program planning, committees, and management meetings. This includes, supervisors, managers, line staff, contract providers, beneficiaries, family advocates, and community-based organizations. The CSOC reported difficulties in getting beneficiaries to be involved in the QIC. ASOC does not report this issue. Both QICs attempt to invite and include interested beneficiaries.			
5E	Peer Employment	8	8
Due to COVID-19 restrictions peer employees were for the most part unable to see clients face-to-face, except for crisis clients. Therefore, clients cannot be seen in the environment in which they live (e.g. not able to do drop-in visits). Peers reported feeling supported by supervisors and management, and that bidirectional communication is effective. The peers interviewed had all received and continue to receive training. There are some issues of remote platform access to continue this during COVID-19 restrictions. Most beneficiaries interviewed said that they receive assistance from their case managers (MHP and contract providers) in connecting them with vocational and educational services. .			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Stanislaus MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- Stanislaus BHRS expanded its telehealth service capability across the system, including directly operated and contracted providers.

Strengths:

- During the implementation of telehealth, the BHRS facilitated contracted providers ability to obtain equipment to make telehealth possible.
- The BHRS employed multiple avenues of outreach to inform beneficiaries of resources available and how to access them during the COVID-19 pandemic.

Opportunities for Improvement:

- None noted.

Timeliness of Services

Changes within the Past Year:

- The Request for Urgent Referral Form in the EHR was revised to capture this data. This was completed in January 2020, and the data from that point forward reflects the 48-hour timeliness standard. BHRS policy number 50.1.119, Timely Access, and Service Availability, reflects the 48-hour urgent request timeliness standard. Staff was informed regarding the change to ensure the collection of the time of requests and time of services.

Strengths:

- Beneficiaries in focus groups reported that they have been able to receive resources and urgent support (from directly operated and contract providers). Beneficiaries report that they contact the MHP front-end staff for issues if they cannot contact their clinician. All beneficiaries reported that their urgent issues were resolved in a timely manner.

Opportunities for Improvement:

- The current no-show rate for psychiatric evaluations remains at about 20 percent, per BHRS data, despite the recommended adjustments in scheduling.

Quality of Care

Changes within the Past Year:

- The MHP revised the QAPI in the past year to reflect DHCS' preferred work plan format.

Strengths:

- The MHP developed a report that tracks no-show data to establish parameters to be able to analyze the data closer. This includes date range, whether it was mental health services or SUD, the program and type of service provided to include whether psychiatrist or clinical appointment. The report also provides the no-show rates by the city of residence, by age, gender, primary language, race/ethnicity, and age group by regions. This report is discussed at the Quality Improvement Committee meetings to help identify areas of concern and that need to be addressed.

Opportunities for Improvement:

- None noted.

Beneficiary Outcomes

Changes within the Past Year:

- All wellness centers in Stanislaus County are closed as a result of COVID-19 restrictions on gatherings.

Strengths:

- The MHP initiated a remote survey of beneficiaries to measure technology readiness for receiving telehealth and used the information to successfully implement telehealth.
- The MHP uses LOCUS for adults and CANS-50 for children and youth; these tools are tied to the BHRS Core Treatment Model and reviewed by leadership and staff.

Opportunities for Improvement:

- Beneficiaries noted that the wellness centers were missed as part of their recovery support.

Foster Care

Changes within the Past Year:

- None noted.

Strengths:

- The MHP continues to address FC and track timeliness and access during the COVID-19 pandemic.

Opportunities for Improvement:

- Therapeutic Foster Care (TFC) continues to be a challenge for the MHP. The MHP continues to have collaborative discussions with partner agencies (e.g. Child Welfare and Juvenile Probation) and Foster Family Agencies (FFAs) with the plan too contract with FFAs for TFC.
- The MHP reports 33 percent for adult FC meet the timeliness standard for first offered psychiatry appointment. This is far below other demographics groups the MHP tracks for this metric.

Information Systems

Changes within the Past Year:

- The only changes made in CCBH in the last year were the implementation of Promotions 229 and 230.

Strengths:

- BHRS uses a Medi-Cal Key Indicators Report to track and monitor QI work plan goals and objectives, and to show system performances. This report is comprehensive and captures many pieces of operations data. It

is reviewed quarterly by multiple levels of the department including senior management for improvement opportunities.

Opportunities for Improvement:

- None noted.

Structure and Operations

Changes within the Past Year:

- In collaboration with Stanislaus County IT, DOTS added contract staffing as a resource to support data analytical and QI projects.
- RDP and hundreds of electronic devices (cell phones, laptops, and tablets) were deployed at the outset of the COVID-19-19 pandemic to support county staff who work remotely.
- Zoom for Healthcare was selected as the department's video conferencing platform to deliver telehealth services.
- Beneficiaries interviewed reported that group therapy is not offered during COVID-19 restrictions.

Strengths:

- Increased technology (1 FTE) and data analytics (1 FTE) resources to support BHRS' Core Treatment Model and QI initiatives.
- DOTS' leadership and quick response in pivoting the department to telehealth was acknowledged throughout the EQRO review.
- BHRS was awarded a Substance Abuse Prevention and Treatment Block Grant (SABG) telehealth grant that can be used to improve the department's technology infrastructure.

Opportunities for Improvement:

- An enhanced network infrastructure will positively impact the delivery of telehealth services.
- Contract providers have access to reports and qualitative summaries of dashboard data but not the actual dashboards. Providers would benefit significantly from access to management information that is dynamic and filterable.
- The MHP is researching the possibility of implementing groups through telehealth platforms.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Both PIPs the MHP presented were validated as completed. As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.

Recommendation 2: Engage in technical assistance (TA) from EQRO in a timely and frequent manner during the development of the next clinical and non-clinical PIP.

Access to Care

None noted.

Timeliness of Services

Recommendation 3: Develop a PIP to address psychiatrist no-shows with the goal of reducing no-shows to a meaningful percent that, will be decided through a review of data.(*This is a follow-up recommendation from FY 2019-20*.)

Quality of Care

None noted.

Beneficiary Outcomes

Recommendation 4: Investigate the feasibility of implementing virtual platform conducted groups and classes to replace in-person wellness center activities.

Foster Care

Recommendation 5: Continue to meet with Child Welfare to develop an implementation plan to offer to Foster Family Agencies (FFAs) that show an interest in Therapeutic Foster Care (TFC) contracts.

Information Systems

None noted.

Structure and Operations

Recommendation 6: Use the Substance Abuse Prevention and Treatment Block Grant (SABG) to enhance the network infrastructure so staff who work at home or in the field will have better connectivity to county systems and to deliver telehealth services.

Recommendation 7: Review the benefits and options of rolling out BHRS dashboards to contract providers.

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible, such as site visits. All sessions were conducted via Zoom virtual platform.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1: EQRO Review Sessions

Stanislaus
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Angela Kozak-Embrey, Quality Reviewer
Caroline Yip, Information Systems Reviewer
Valerie Garcia, 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-site and the post-site meetings and in preparing the recommendations within this report.

Sites of MHP Review

MHP Sites

All sessions for this review were conducted via Zoom and/or desk review of documentation

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Amador	Coral	MH Clinician II	SCBHRS
Amacher	Carlie	MH Clinician II	SCBHRS
Amarant	Lisa	MH Director	Creative Alternative
Andres	Abraham	Manager III, Administration	SCBHRS
Anguiano	Kara	Chief Fiscal Officer	SCBHRS
Ayala	Hector	Sr. Systems Engineer, DOTS	SCBHRS
Azevedo	Jessica	CST II	SCBHRS
Barnett	Andrea	Clinical Director	Aspiranet
Boyd	Ashley	MH Coordinator	SCBHRS
Buckles	Debra	Chief of Forensics	SCBHRS
Camarillo	Maria	Staff Serv Coordinator	SCBHRS
Campbell	Chandra	Manager III, Integrated Forensic Team	SCBHRS
Chalabi	Miranda	Staff Serv Coordinator	SCBHRS
Cisneros	Martha	Manager II	SCBHRS
Collins	Steve	Behavioral Health Manager	CHS
Delayne	Olivia	Manager III, Contracts	SCBHRS
Dhami	Jasbir	Manager III, CERT/MAT	SCBHRS
Dockery	Cherie	Associate Director, Administration	SCBHRS
Ford	Daniel	BHS II	SCBHRS
Galvan	Victoria	MH Clinician II	SCBHRS
Garcia	Laura	Manager III, HR	SCBHRS
Gonzalez	Teresa	Manager II, HRH/SATT	SCBHRS

Last Name	First Name	Position	Agency
Gutierrez	Francine	Manager IV, Accounting Services	SCBHRS
Hillas-Buck	Summer	Clinical Director	Telecare
Housden	Robert	Manager II, Administration	SCBHRS
Hovasine	Nanette	Clinical Serv Tech II	SCBHRS
Howard	Margaret	Accounting Technician	SCBHRS
Imperial	Ruben	BHRS Director	SCBHRS
Jamison	Tina	Manager II, Business Office	SCBHRS
Jasek-Rysdahl	Kirsten	Manager III, DOTS	SCBHRS
Jimenez	Olivia	Admin Clerk III	SCBHRS
Johnson	Kristy	MH Coordinator	SCBHRS
Kaldani	Bernadet	Training Coordinator	SCBHRS
LaGro	Ronald	Clinical Directory of ISA	ISA
Levy	Michael	Chief of DOTS	SCBHRS
Lonsinger	Richard	CST II	SCBHRS
Lopez	Maribel	MH Coordinator	SCBHRS
Magee	Keri	Chief of CSOC	SCBHRS
Marquez	Gabriela	MH Coordinator	SCBHRS
Matott	Kendra	Regional Director of ISA+	ISA
McCay	Melissa	Behavioral Health Specialist. II	SCBHRS
McKnight	Tracey	Staff Serv Coordinator	SCBHRS
Mora, MD	Bernardo	Medical Director	SCBHRS
Munguia	Gabriela	Quality Services Specialist	SCBHRS
Muniz	Veronica	Behavioral Health Specialist II	SCBHRS

Last Name	First Name	Position	Agency
Nunez-Pineda	Janet	Manager III, PEI	SCBHRS
Oster	Jacqueline	Personal Service Coordinator	ISA
Panyanouvong	Kevin	Chief of ASOC	SCBHRS
Panyanouvong	Tommy	Behavioral Health Coordinator	SCBHRS
Pere-Deniz	Dali	MH Clinician II	SCBHRS
Petroni	Joe	Mental Health Coordinator	SCBHRS
Rameno	Maria	Quality Services Specialist	SCBHRS
Raybon	Lori	Software Developer, DOTS	SCBHRS
Ream	Aricka	MH Coordinator	SCBHRS
Rivera	Tiffany	Outpatient Director	SVFCS
Rivers	Donna	Behavioral Health Specialist II	SCBHRS
Rodriguez	Norma	Manager II, HR	SCBHRS
Sabean	Jeff	Manager III, SRC	SCBHRS
Safi	Nasrin	Manager III, QS/Risk Management/Compliance	SCBHRS
Saing	Kim	Manager III, Administration	SCBHRS
Salazar	Monica	Chief of Managed Care, Quality, Compliance, and Risk Management	SCBHRS
Simms	Lori	MH Coordinator	SCBHRS
Simpson	Scott	Manager III, Facilities/General Serv	SCBHRS
Tallent-Alvarado	Christine	Behavioral Health Specialist I	SCBHRS
Tijerina	Jose	MH Coordinator	SCBHRS

Last Name	First Name	Position	Agency
Torres	Alma	Manager III, Housing & Employment Services	SCBHRS
Urzua	Laura	Administrator	Central Star
Van Der Woude	Sandra	CST II	SCBHRS
Vann	Sarah	Manager II, MRS	SCBHRS
Vargas	Mary Cruz	Quality Services Specialist	SCBHRS
Vylonis	Megan	Quality Services Specialist	SCBHRS
Yanez	Alisa	Behavioral Health Specialist II	SCBHRS

Attachment C—Approved Claims Source Data

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

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Stanislaus MHP					
Entity	**Average Monthly ACA Enrollees**	**Beneficiaries Served**	**Penetration Rate**	**Total Approved Claims**	**ACB**
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Medium	519,441	20,353	3.92%	$121,346,017	$5,962
MHP	62,289	1,716	2.75%	$11,945,036	$6,961

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

Table C2: CY 2019 Distribution of Beneficiaries by ACB Range

Stanislaus MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	7,037	93.25%	93.31%	$30,058,966	$4,272	$3,998	61.74%	59.06%
>$20K - $30K	243	3.22%	3.20%	$5,796,791	$23,855	$24,251	11.91%	12.29%
>$30K	266	3.53%	3.49%	$12,828,357	$48,227	$51,883	26.35%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CCBH	Community Care Behavioral Health
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIT	Crisis Intervention Team or Training
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSD	Community Services Division
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services

Acronym	Full Term
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay

Acronym	Full Term
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NA	Network Adequacy
NA (alt)	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
ONA	Out-of-Network Access
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PM (alt)	Partially Met
QI	Quality Improvement

Acronym	Full Term
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version