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

STANISLAUS FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 3-5, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2023-24 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Stanislaus" may be used to identify the Stanislaus County MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — October 3-5, 2023

MHP Size — Medium

MHP Region — Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2023-24 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	3	1	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	9	1	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**24**	**2**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department Visit for Mental Illness	Clinical	09/2022	Implementation	Moderate
Timeliness of Initial Psychiatric Medication Appointments	Non-Clinical	08/2021	Implementation	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	4
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	3

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP implemented SmartCare in July 2023 and believes it will further provide an environment that greatly assists in capturing and managing data.
- The MHP places an emphasis on becoming a data-driven agency.
- For CY 2022, the MHP maintained consistent and effective monthly claiming and timely submissions, which yielded an overall denied claims rate of 1.94 percent.
- The MHP has proactively addressed workforce and recruitment challenges, adding 28 positions to support their system and increase service capacity.
- Collaborative communication between providers and stakeholders provides ease in coordination of care resulting in satisfaction for adult members.

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

- The percentage of members that had only one service in the MHP continues to be considerably higher than was observed statewide.
- For both Latino/Hispanic and African American members, the MHP's PR continues to be less than half that of the statewide average.

- The MHP currently has an IS strategic plan, however, it has not been updated since 2017. This poses a potential risk due to technological advancements over the last several years.

- Although the MHP has an established contract with a Health Information Exchange (HIE) it has not engaged in any type of electronic exchange of information.

- The MHP currently employs peer positions, however, the MHP does not have a defined peer support career ladder.

Recommendations for improvement based upon this review include:

- Research and assess concerns regarding the high percentage of members who receive only one service. Develop and implement effective strategies to improve the overall engagement and retention of members.
- Research why the MHP's PRs for both Latino/Hispanic and African American members are less than half that of the state and develop and implement a plan to address these two populations' need for more access to services.
- Update the IS strategic plan to ensure the strategic plan meets current technological demands.
- Coordinate and plan to begin the data exchange process through HIE.
- Initiate efforts to create a defined peer support career ladder.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2023-24 findings of the EQR for Stanislaus County MHP by BHC, conducted as a virtual review on October 3-5, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding penetration rate (PR) percentages.

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

There were no significant environmental issues affecting the MHP's operations.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP transitioned from the Cerner Corporation's Electronic Health Record (EHR), Anasazi, and elected to replace it with the California Mental Health Services Authority (CalMHSA) semi-statewide EHR, SmartCare by Streamline. Stanislaus implemented SmartCare in July 2023.
- The MHP transitioned to a fee for services structure under California's Advancing and Innovating Medi-Cal (CalAIM). The MHP is currently learning the claiming functionality and has submitted test claim files.
- Two new positions were added to the human resources recruitment team to improve timeliness in the recruitment processes and improve applicant experience. During FY 2022-23, the MHP added a significant number of new direct service and administrative positions to meet the community's needs.
- Stanislaus County has combined local mental health and substance use prevention efforts under the direction of one manager to leverage staffing and financial resources as well as improve integration and collaboration.
- The MHP expanded their forensic services, including access to the mental health court program and implementation of CARE court.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2022-23

Recommendation 1: Study what is effective in the current dedication of additional resources to the recruitment functions, and what could be enhanced. Implement further activities that might bring positive outcomes in recruitment for both the MHP and Contractors.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP added two new positions to the human resources recruitment team to improve the timeliness of the recruitment process.
- The MHP implemented a workforce development and training plan to develop partnerships with school districts, colleges, and universities and introduce students to careers in behavioral health.
- The MHP introduced volunteer opportunities, developed internship programs, and specialized training programs to aid in staff recruitment efforts.

Recommendation 2: Research issues involved in staff resignations, design and implement a plan to increase staff retention.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- To incentivize staff and increase retention efforts, the MHP developed a loan repayment program and implemented the bonus choice plan, which is a benefit enhancement for current employees and new hires. The MHP also added Mental Health Clinician III as a new job classification.

- The MHP began utilizing the county exit questionnaire obtained from employees leaving county service to help identify process improvements.
- The MHP developed a remote work policy and enhanced training for workforce development and succession planning.

Recommendation 3: Continue to research ways to lower the number of members who receive only one appointment. Creating and implementing solutions to the one service for assessment as standing alone would help the MHP resolve this and accurately track engagement. Continue to research explanations and create and implement solutions to increase engagement. Track results.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP indicated that due to competing initiatives such as CalAIM and the implementation of SmartCare, there was not sufficient opportunity to fully research this issue. Although Stanislaus postulated that the number of members who were reported to have received only one appointment might be influenced by functionality limitations in their old EHR that pertained to the initial assessment process, wherein members were opened for an assessment and then closed as a single point of contact after the assessment was completed. No research was performed to evaluate this conjecture.
- Performance measure data associated with the retention of members served in CY 2022 demonstrated that the proportion of members that had only one service in the MHP during this timeframe was almost twice as high as statewide (22.38 percent vs. 11.21 percent).
- Additional investment of time and resources are required to adequately investigate this concern and develop effective strategies to improve member engagement and retention.

Recommendation 4: Continue efforts to increase IS staffing for the upcoming EHR implementation. Research ways to address this issue along with the increased funding for new positions and recruitment efforts now in place.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Between FY 2021-22 and FY 2022-23, the percentage of the total budget dedicated to IS in the MHP increased from 4.23 percent to 6.00 percent. This augmented funding was used to expand IS staffing levels from 15 to 24 full-time equivalent (FTE) staff positions to not only bolster the IS team's ability to respond to evolving needs associated with SmartCare system configurations and end-user training and support, but also to complete other infrastructural and data development projects that have been identified as priorities by the agency.
- To enhance the MHP's capacity to address ongoing data analytics needs in connection with monitoring and ensuring compliance with state and federal requirements, some of the additional IS funding has been leveraged to expand the contract with Kings View Consulting. This external organization provides

support by generating interactive dashboards that serve as tools that allow MHP leadership, QAPI analysts, and other end users to review and assess service-related information quickly and effectively. The MHP's relationship with Kings View Consulting has contributed to the development of a burgeoning environment that places an emphasis on the rendering of data-driven decisions.

Recommendation 5: Research why the MHPs PRs for both Latino/Hispanic and African American members are less than half that of the state and develop and implement a plan to address these two populations' need for more access to services.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- While the MHP suggested that the existence of potential barriers to service such as preferred language concerns, economic disparities, and sociocultural issues may be contributing to low PRs for both Latino/Hispanic and African American members, no formal analysis of this situation has been conducted. The MHP indicated that it is engaging in outreach and prevention efforts with these populations to establish rapport with these communities and apprise them of the availability of services; however, no particulars of the outcomes these activities yielded were provided.
- Performance measure data for CY 2022 illustrated that PRs for both Latino/Hispanic and African American members in the MHP were almost half the levels disclosed by the statewide PRs for these groups.
- Further research and evaluation are required to better isolate, define, and address the specific factors that are engendering persistently low PRs among Hispanic/Latino and African American members in the MHP. This recommendation will be included in this year's report.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 34 percent of services were delivered by county-operated/staffed clinics and sites, and 66 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 74 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff; members may request services through the Access Line as well as through community outreach, crisis services, inpatient discharge, FC, and juvenile justice. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. The access staff use a new statewide screening tool (CalAIM requirements) to determine the level of service needs and connect members to the appropriate services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 442 adults, 1008 youth, and 55 older adults across 30 county-operated sites and 17 contractor-operated sites. Among those served, 111 members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In

[1] CMS Data Navigator Glossary of Terms

addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

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

For Stanislaus County, the time and distance requirements are 30 miles and 60 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

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

- Because the MHP can provide necessary services to a member within time and distance standards using a network provider, the MHP was not required to allow members to access services via OON providers.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to members and family members. Examining

service accessibility and availability, system capacity and utilization, integration, and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access, and availability of services form the foundation of access to quality services that ultimately lead to improved member outcomes.

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

Table 2: Access Key Components

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

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

- During FY 2022-23 Stanislaus County added a total of 28 FTE to their workforce to meet CalAIM mandates and the needs of members.
- The MHP has an effective communication system where Systems of Care (SOC) meet weekly to monitor access and capacity, and leadership meet weekly to discuss system demands.
- The MHP has been reviewing prevalence rate data for local communities relating to language and ethnicity to develop targeted outreach for these populations. Additionally, a Diversity, Equity, and Inclusion (DEI) manager position has been created and filled to address these needs.
- The MHP initiated the “Promotores” program to focus on prevention and access efforts for the Hispanic/Latino population.
- During the last several years, the overall PR for the MHP has fallen below the statewide and similar-sized county PRs. Furthermore, Stanislaus’ PRs across all racial/ethnic and age groups have been lower than statewide levels. The Hispanic/Latino and African American PRs in the MHP were almost half the statewide PR for CY 2022.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Stanislaus demonstrated more challenges with access to care than was seen statewide.

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

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	267,005	6,567	2.46%	$53,117,371	$8,089
CY 2021	254,188	6,605	2.60%	$52,764,664	$7,989
CY 2020	241,096	6,704	2.78%	$47,640,686	$7,106

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

- Between CY 2020 and CY 2022, total members eligible increased, the number of members served decreased; therefore, the overall PR for the MHP steadily declined.
- During the same period, the MHP's total approved claims and AACMs increased.

Table 4: Stanislaus County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	28,991	300	1.03%	1.15%	1.82%
Ages 6-17	67,624	2,213	3.27%	4.80%	5.65%
Ages 18-20	15,316	350	2.29%	3.47%	3.97%
Ages 21-64	134,478	3,494	2.60%	3.60%	4.03%
Ages 65+	20,597	210	1.02%	1.98%	1.86%
Total	**267,005**	**6,567**	**2.46%**	**3.49%**	**3.96%**

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

- The largest eligibility group for Stanislaus was adults ages 21-64, followed by youth ages 6-17. These categories also represented the groups with the largest number of members served.
- The PRs in all age groups, however, were below both similar-sized counties and statewide PRs.
- The MHP's overall PR was lower than both the statewide and medium county PRs.

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

Threshold Language	# Members Served	% of Members Served
Spanish	680	10.95%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the only threshold language for Stanislaus, with 10.95 percent of members served reporting Spanish as their primary language in CY 2022. This represents a small increase from CY 2021 (10.27 percent).

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

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	75,618	1,770	2.34%	$14,292,750	$8,075
Medium	530,704	15,912	3.00%	$110,270,160	$6,930
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligibles that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This trend was evidenced by the MHP as well.
- At 2.34 percent, the MHP's ACA PR is lower than both the statewide and similar-sized counties; however, the ACA AACM is higher than both comparisons.

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

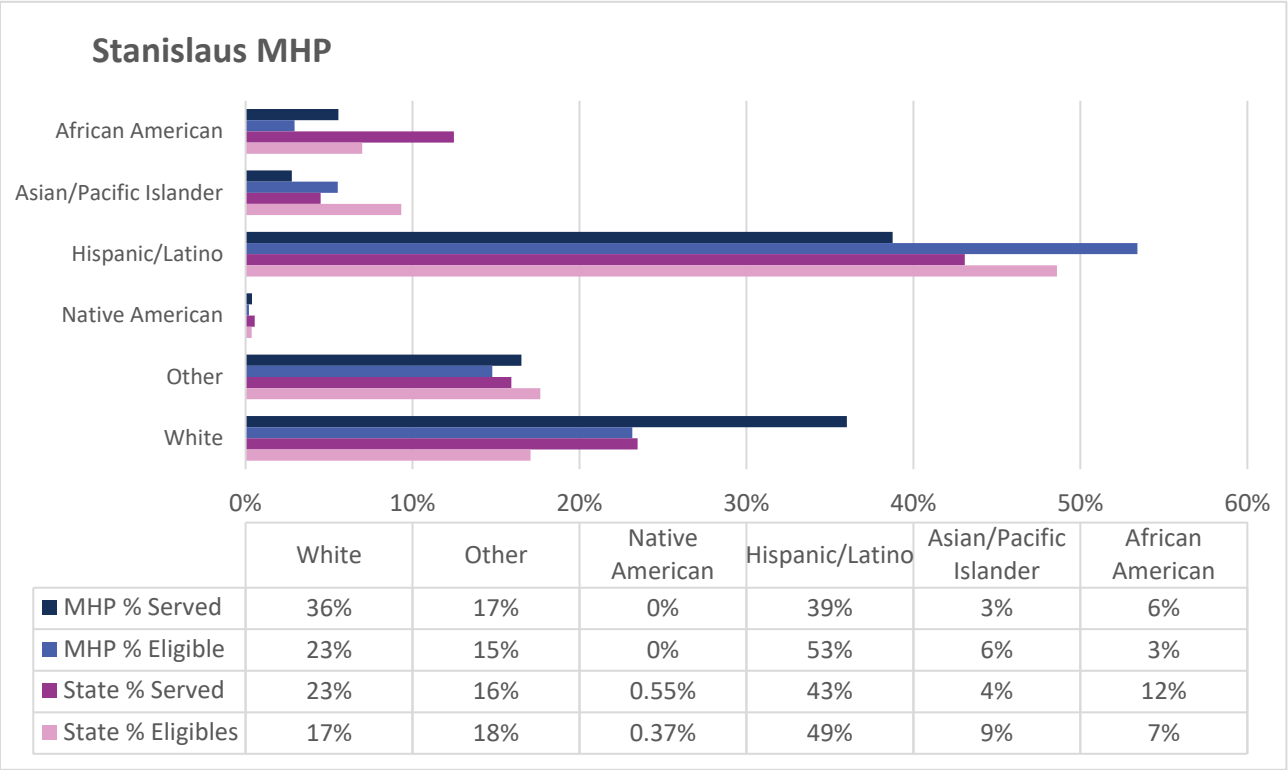
Table 7: Stanislaus MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	7,822	365	4.67%	7.08%
Asian/Pacific Islander	14,732	182	1.24%	1.91%
Hispanic/Latino	142,615	2,545	1.78%	3.51%
Native American	542	25	4.61%	5.94%
Other	39,456	1,085	2.75%	3.57%
White	61,840	2,365	3.82%	5.45%
Total	**267,007**	**6,567**	**2.46%**	**3.96%**

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

- The largest racial/ethnic group of eligibles was Hispanic/Latino, followed by White. This same pattern was manifested in the number of members served, with the Hispanic/Latino population representing the largest group, followed by White.
- Although the number of Hispanic/Latino members served was slightly greater than the number of White members, the PR for the White population in the MHP was more than twice the PR for the Hispanic/Latino population.
- The MHP's PRs in all racial/ethnic categories were lower than statewide numbers.

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

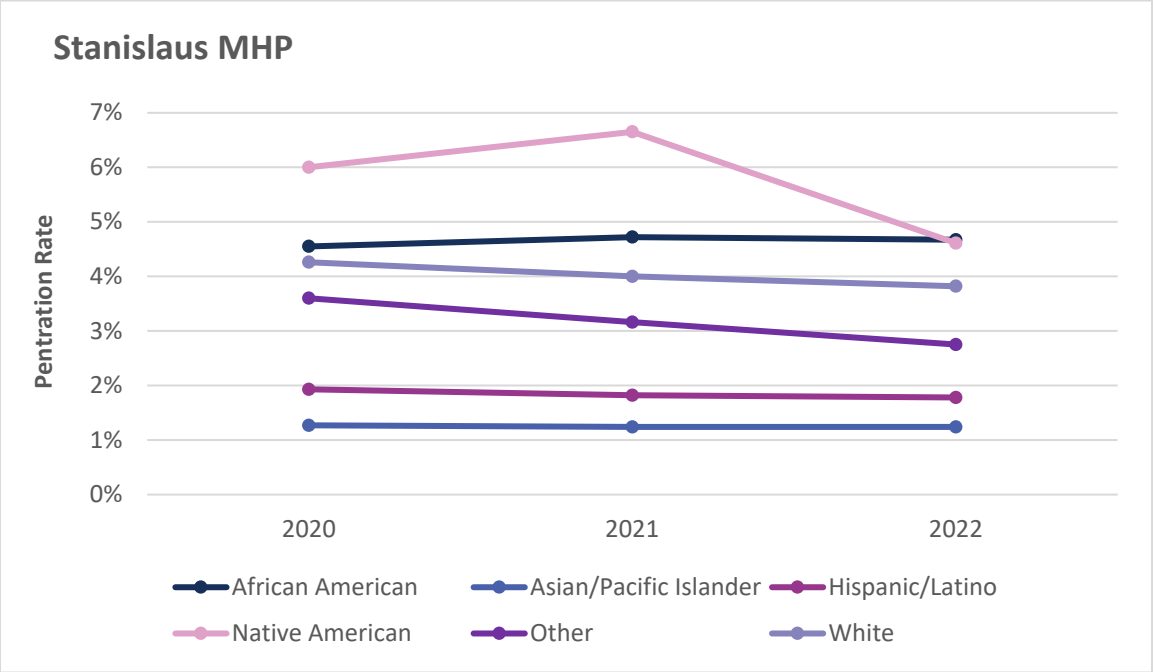


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	36%	17%	0%	39%	3%	6%
MHP % Eligible	23%	15%	0%	53%	6%	3%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The most proportionately overrepresented racial/ethnic group for both the MHP (23 percent eligible vs. 36 percent served) and statewide (17 percent eligible vs. 23 percent served) was White.
- The most proportionately underrepresented group for both the MHP and statewide was Hispanic/Latino. Within the MHP, there was a 14 percentage-point difference between members eligible (53 percent) and members served (39 percent).

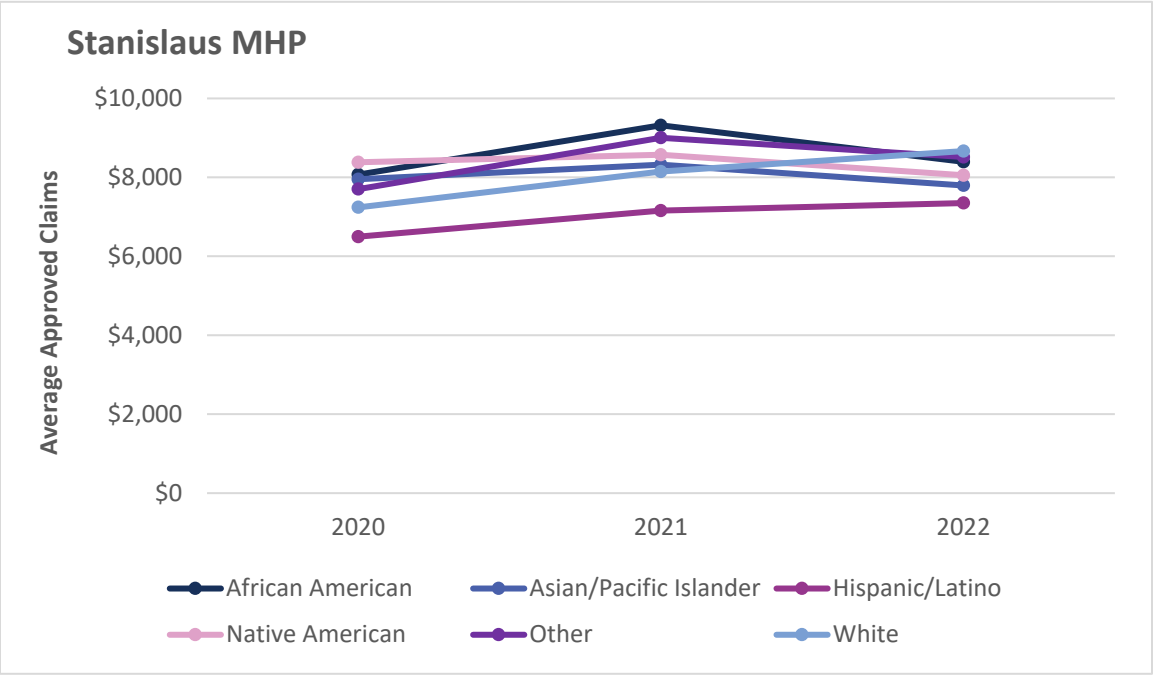
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



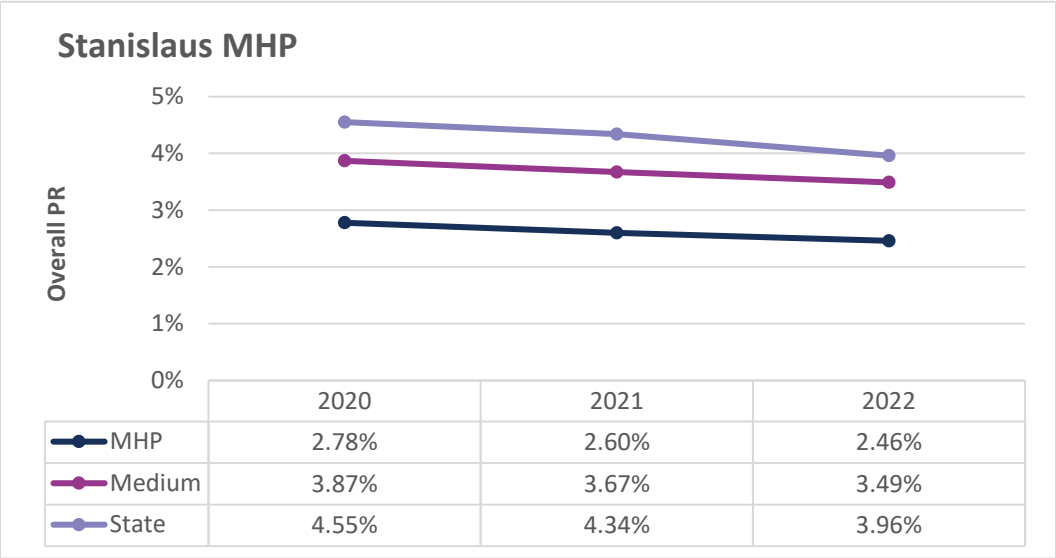
- Between CY 2020 and CY 2022, the PRs for all racial/ethnic groups were either flat or trended slightly downward, with the single exception of Native American. Due to the small counts related to the Native American population, however, changes in the numbers associated with this group over time can result in trend lines that suggest a level of significance that are not supported by the data.
- While the directionality of the trend lines indicate that Native American and African American communities have consistently evidenced the highest PRs over time, Asian/Pacific Islanders have consistently had the lowest PR.

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



- AACMs for almost all racial/ethnic groups were generally higher in CY 2022 as opposed to CY 2020, with White showing a 19.70 percent increase over this three-year period.
- Even though AACMs for the Hispanic/Latino population have conformed to this same trend, claims for this group have consistently been the lowest over time.

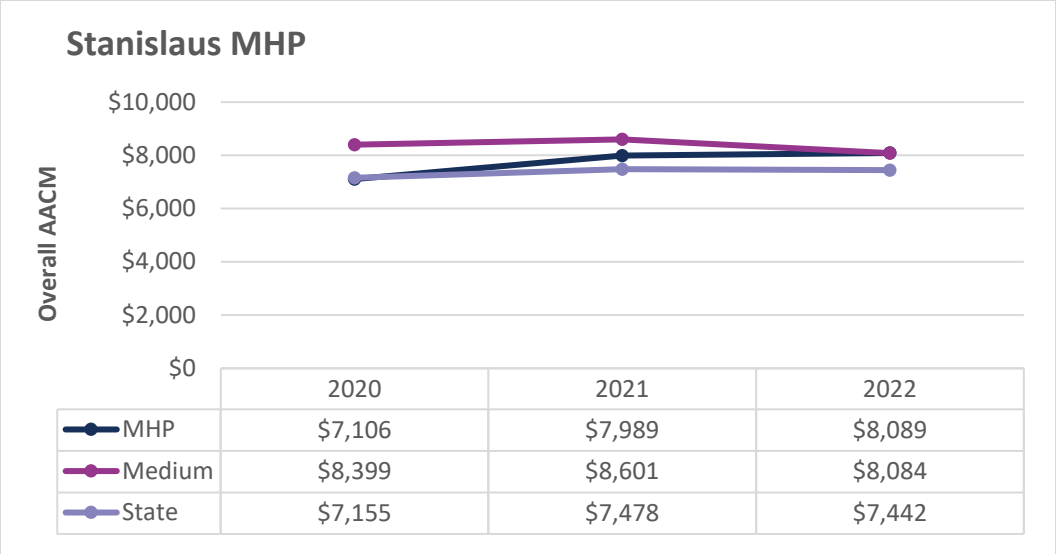
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	2.78%	2.60%	2.46%
Medium	3.87%	3.67%	3.49%
State	4.55%	4.34%	3.96%

- Between CY 2020 and CY 2022, the MHP's overall PR has been consistently lower than the PRs of medium-sized counties and statewide; however, PRs for all groups have generally trended downward during this timeframe.

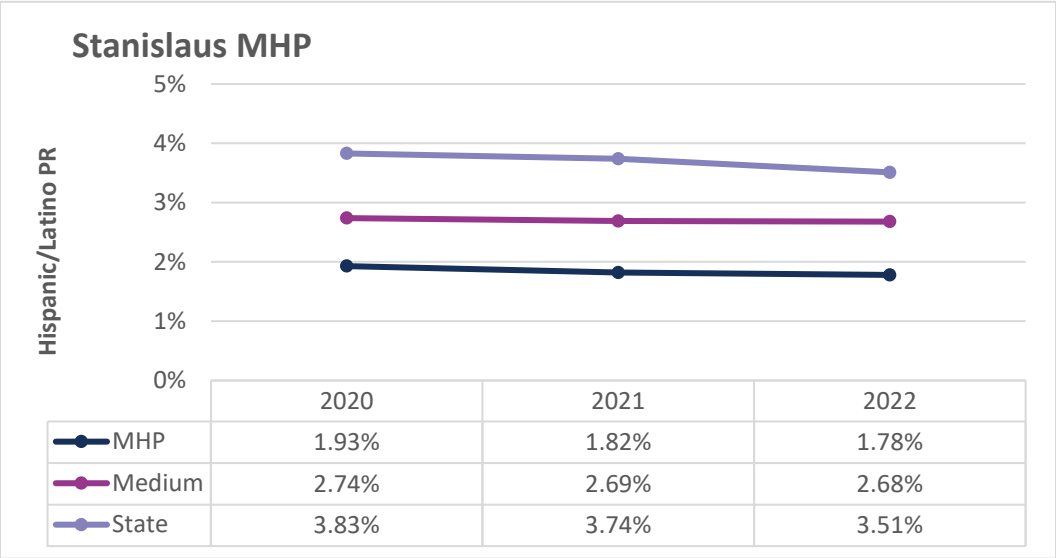
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$7,106	$7,989	$8,089
Medium	$8,399	$8,601	$8,084
State	$7,155	$7,478	$7,442

- Over this three-year period, the MHP's AACMs have increased by 13.83 percent, whereas the AACMs for the state as a whole and medium-sized counties have been relatively invariant and more stable.

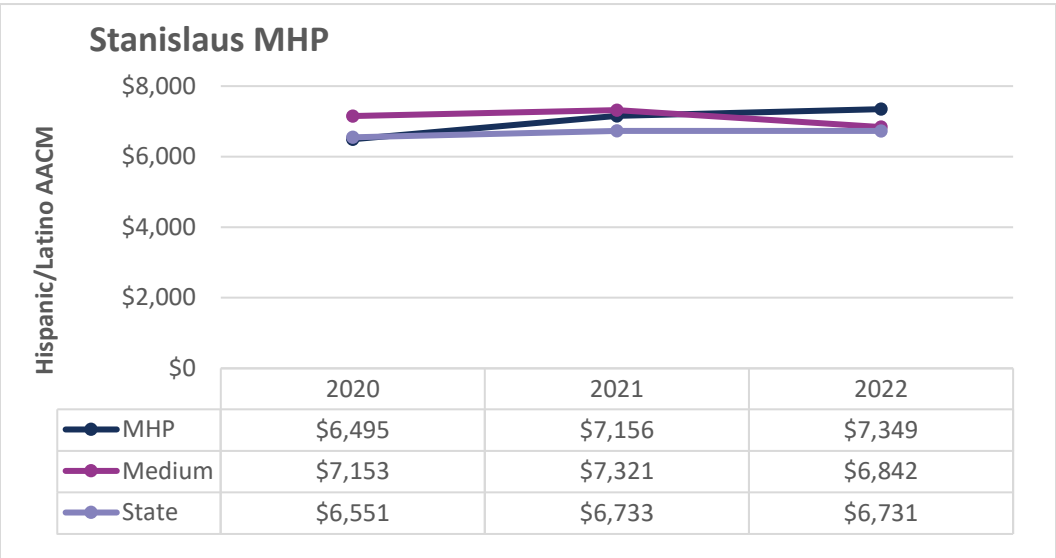
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	1.93%	1.82%	1.78%
Medium	2.74%	2.69%	2.68%
State	3.83%	3.74%	3.51%

- Stanislaus' Hispanic/Latino PRs have been notably lower than either similar-sized county or statewide PRs for each year between CY 2020 and CY 2022; however, PRs for all comparative groups have slowly decreased over time.

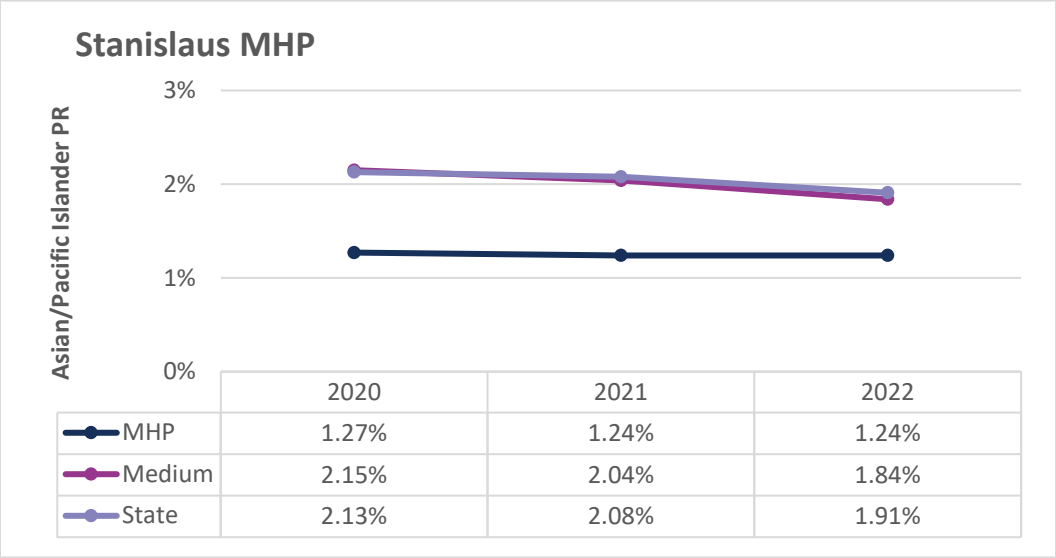
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$6,495	$7,156	$7,349
Medium	$7,153	$7,321	$6,842
State	$6,551	$6,733	$6,731

- In contrast to Stanislaus' low Hispanic/Latino PRs, the AACMs for this population in the MHP have increased by 13.15 percent between CY 2020 and CY 2022.
- During this same period, however, the Hispanic/Latino AACMs statewide and for medium-sized counties have been either flat or trended slightly downward.

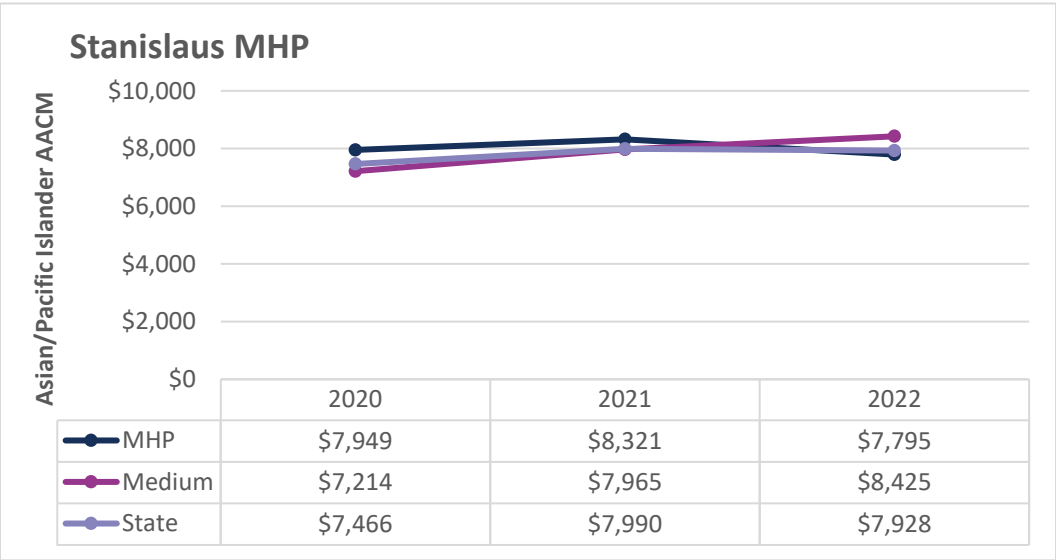
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	1.27%	1.24%	1.24%
Medium	2.15%	2.04%	1.84%
State	2.13%	2.08%	1.91%

- The Asian/Pacific Islander PRs in the MHP were substantially lower than both statewide and similar-sized county PRs across all three years.
- Although the MHP's trend for this metric has been rather stable, the Asian/Pacific Islander PRs statewide and for medium-sized counties have shown modest, yet steady, declines.

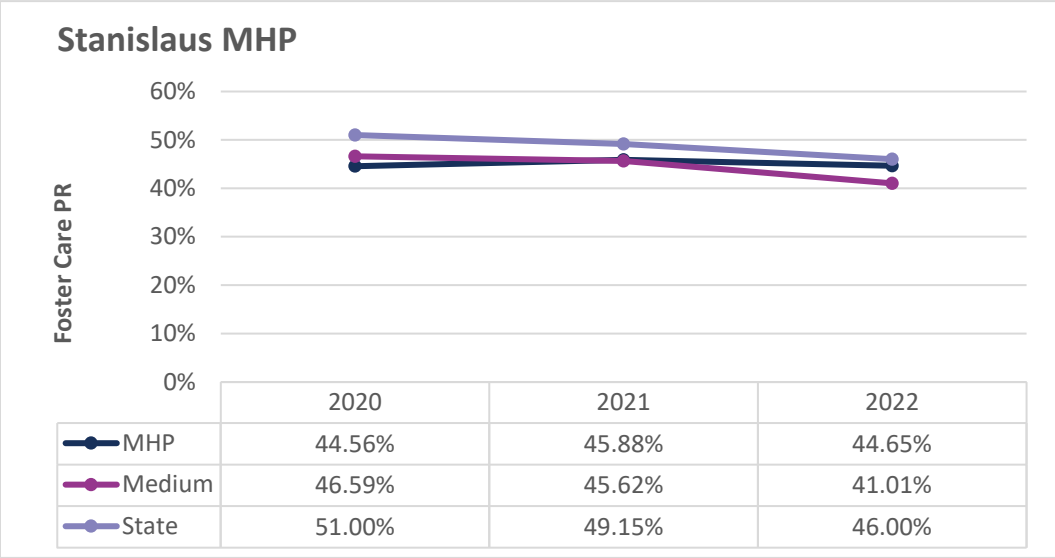
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$7,949	$8,321	$7,795
Medium	$7,214	$7,965	$8,425
State	$7,466	$7,990	$7,928

- While the MHP's AACMs for Asian/Pacific Islanders evidenced almost a 5 percent increase between CY 2020 and CY 2021, claims in CY 2022 for this group dropped below CY 2020 levels.
- AACMs for Asian/Pacific Islanders in medium-sized counties and statewide have generally trended upward.

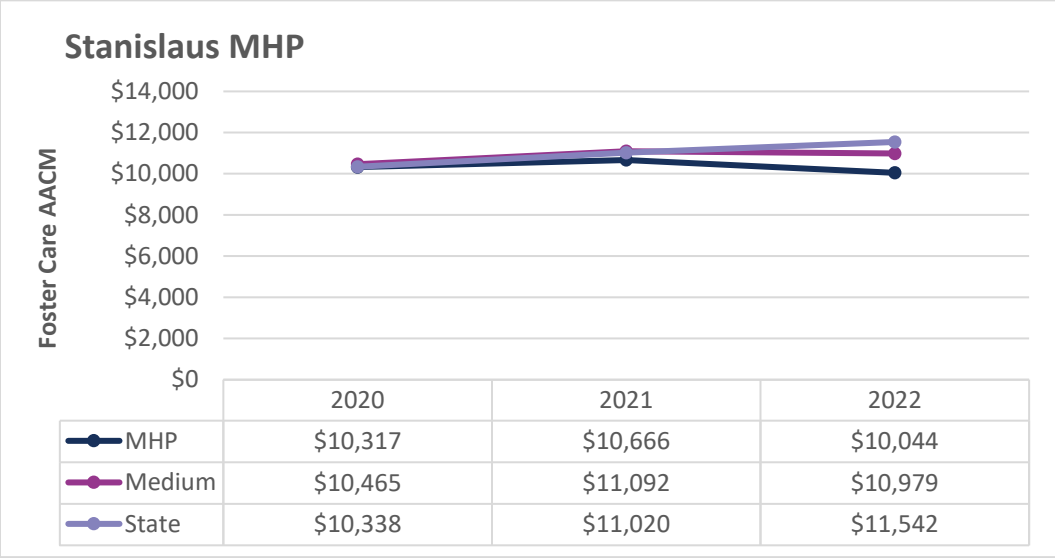
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	44.56%	45.88%	44.65%
Medium	46.59%	45.62%	41.01%
State	51.00%	49.15%	46.00%

- The MHP's FC PRs have been rather stable over this three-year period; however, FC PRs observed in medium-sized counties and statewide have gradually decreased.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$10,317	$10,666	$10,044
Medium	$10,465	$11,092	$10,979
State	$10,338	$11,020	$11,542

- The MHP's FC AACMs have marginally decreased over time and, by CY 2022, were lower than those seen in medium-sized counties or statewide.
- The CY 2022 FC AACMs for medium-sized counties and statewide, conversely, were higher than their corresponding CY 2020 numbers.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Stanislaus MHP to Adults, CY 2022

Service Category	MHP N = 4,054				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	864	21.3%	7	4	10.3%	14	8
Inpatient Admin	<11	-	6	6	0.4%	26	10
Psychiatric Health Facility	425	10.5%	6	3	1.2%	16	8
Residential	<11	-	8	7	0.3%	114	84
Crisis Residential	25	0.6%	29	29	1.9%	23	15
Per Minute Services							
Crisis Stabilization	93	2.3%	1,705	1,200	13.4%	1,449	1,200
Crisis Intervention	1,524	37.6%	309	175	12.2%	236	144
Medication Support	2,130	52.5%	246	159	59.7%	298	190
Mental Health Services	2,536	62.6%	800	375	62.7%	832	329
Targeted Case Management	1,801	44.4%	596	280	36.9%	445	135

- The MHP's overall inpatient utilization for adults was much higher than statewide, though with much shorter stays.
- The most frequently used service modalities in the MHP were mental health services, medication support, and targeted case management (TCM). Although the MHP's TCM utilization rate was higher than statewide (44.4 percent vs. 36.9 percent), the utilization rate for mental health services in the MHP was comparable to statewide utilization (62.6 percent vs. 62.7 percent). The MHP's rate associated with the delivery of medication support services was a bit lower than the statewide rate (52.5 percent vs. 59.7 percent).
- While the MHP's utilization rate for crisis stabilization was approximately 17 percent of the statewide rate (2.3 percent vs. 13.4 percent), crisis intervention

utilization in the MHP was more than three times higher than was seen statewide (37.6 percent vs. 12.2 percent).

Table 9: Services Delivered by the Stanislaus MHP to Youth in Foster Care, CY 2022

Service Category	MHP N = 367				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	23	6.3%	7	5	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	11	10	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	<11	-	9	9	0.1%	24	22
Full Day Intensive	<11	-	1,350	1,350	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	<11	-	3,480	2,880	3.1%	1,166	1,095
Crisis Intervention	39	10.6%	357	180	8.5%	371	182
Medication Support	125	34.1%	294	250	27.6%	364	257
TBS	23	6.3%	2,466	1,495	3.9%	4,077	2,457
Therapeutic FC	<11	-	795	795	0.1%	911	495
Intensive Care Coordination	154	42.0%	923	327	40.8%	1,458	441
Intensive Home-Based Services	92	25.1%	1,124	589	19.5%	2,440	1,334
Katie-A-Like	<11	-	35	35	0.2%	390	158
Mental Health Services	343	93.5%	1,148	643	95.4%	1,846	1,053
Targeted Case Management	143	39.0%	241	113	35.8%	307	118

- Overall inpatient utilization in the MHP for FC youth was slightly higher than statewide.
- The per-minute services with the highest utilization rates among FC youth in the MHP were mental health services, intensive care coordination (ICC), and TCM. Utilization rates were slightly higher for ICC (42.0 percent vs. 40.8 percent) and TCM (39.0 percent vs. 35.8 percent) in the MHP when compared to statewide

levels, and mental health services were slightly lower (93.5 percent vs. 95.4 percent).

- The MHP's utilization rate for Intensive Home-Based Services (IHBS) was higher than was seen statewide (25.1 percent vs. 19.5 percent).
- While likely influenced by the small number of FC youth served, the average and median number of crisis stabilization units billed by the MHP were more than twice as high as statewide numbers. Additionally, the overall utilization of crisis services for FC youth in the MHP was higher than the statewide rate as well.

IMPACT OF ACCESS FINDINGS

- Over the last three years, the MHP's overall PR has steadily decreased and remains well below statewide rates. Also, the PRs relating to all racial/ethnic and age groups in the MHP were lower than statewide. While Stanislaus is attempting to improve access for underserved members by creating and filling a new DEI manager position that will place an emphasis on reviewing prevalence rate data for local communities to address barriers to service engendered by issues pertaining to language and ethnicity, more work is still required to stimulate the growth of PRs. It could be helpful for the MHP to track data surrounding the impact of the "Promotores" program. Further, the MHP can invest in the process of cultivating meaningful relationships with partner agencies and community stakeholders to collaboratively initiate outreach and engagement strategies that will afford greater access to care for members.
- While total eligibles have increased by 10.75 percent between CY 2020 and CY 2022, total members served during this timeframe have decreased by 2.04 percent. This decrease in numbers served may relate to capacity issues arising from clinical staff shortages within the MHP. According to responses that Stanislaus provided to two recommendations associated with this concern from the last EQR cycle, the agency is currently endeavoring to address staffing vacancies through the implementation of vigorous recruitment and retention efforts.
- Continuous and effective communication and collaboration between SOC, stakeholders, and executive leadership has demonstrated to be a good model in managing system demands.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP made significant improvement to their timeliness to first offered appointments for all services, from 47 percent in FY 2021-22 to 87 percent in FY 2022-23.

- While the MHP meets the requirement for urgent appointments within 48 hours, only 59 percent of adult urgent services were delivered within the timeliness standard. The MHP discussed currently implementing workaround processes to monitor and implement strategies to improve urgent appointments, although interoperability in some reporting functionalities within SmartCare present difficulties in monitoring and making data driven decisions.
- The average no-show rate for psychiatrists improved from 12 percent in FY 2021-22 to 9 percent in FY 2022-23, a 25 percent improvement.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	7 Business Days	10 Business Days*	87%
First Non-Urgent Service Rendered	9 Business Days	10 Business Days**	81%
First Non-Urgent Psychiatry Appointment Offered	8 Business Days	15 Business Days*	88%
First Non-Urgent Psychiatry Service Rendered	9 Business Days	15 Business Days**	86%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	69.1 Hours ***	48 Hours*	72%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	7 Calendar Days	7 Calendar Days	77%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	7 Calendar Days	30 Calendar Days	94%
No-Show Rate – Psychiatry	9%	20%**	n/a
No-Show Rate – Clinicians	8%	20%**	n/a

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

** MHP-defined timeliness standards

*** The MHP does not track separately urgent services requiring prior authorization that can be offered within 96 hours.

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23

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

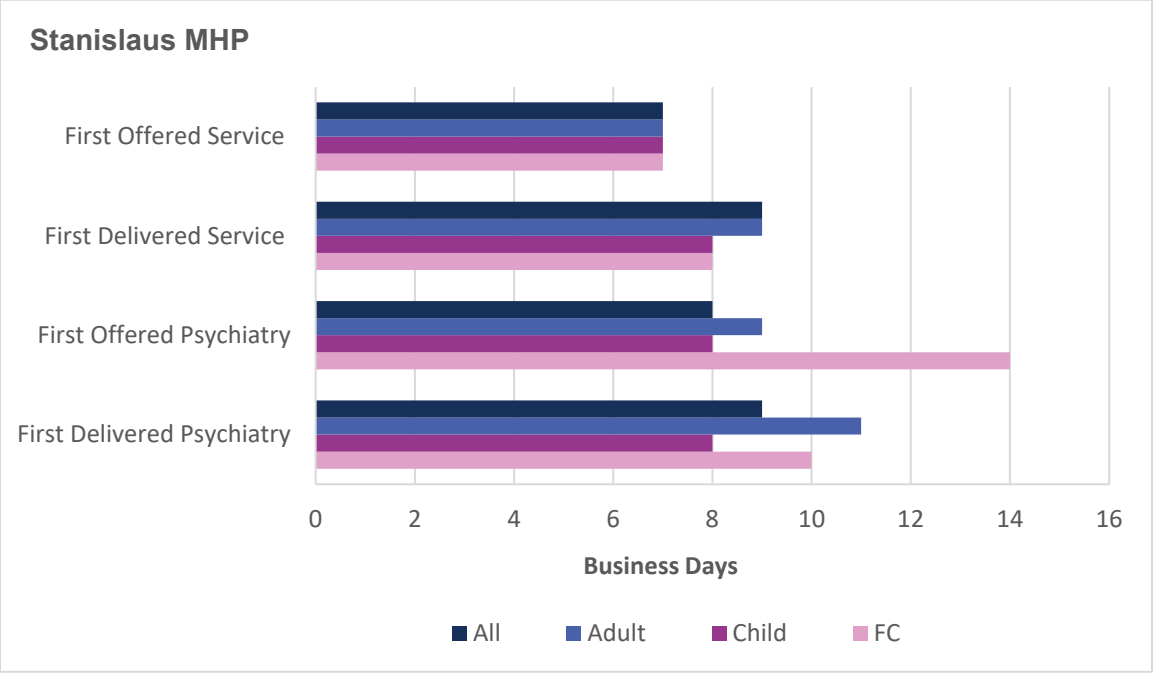


Figure 13: Wait Times for Urgent Services

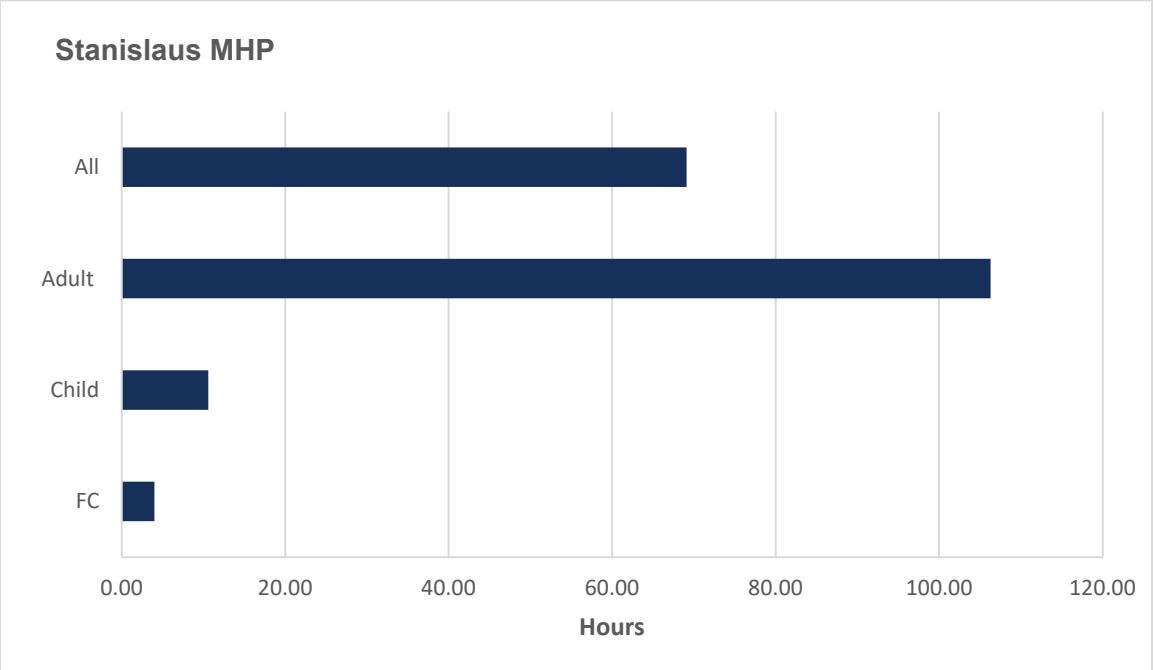
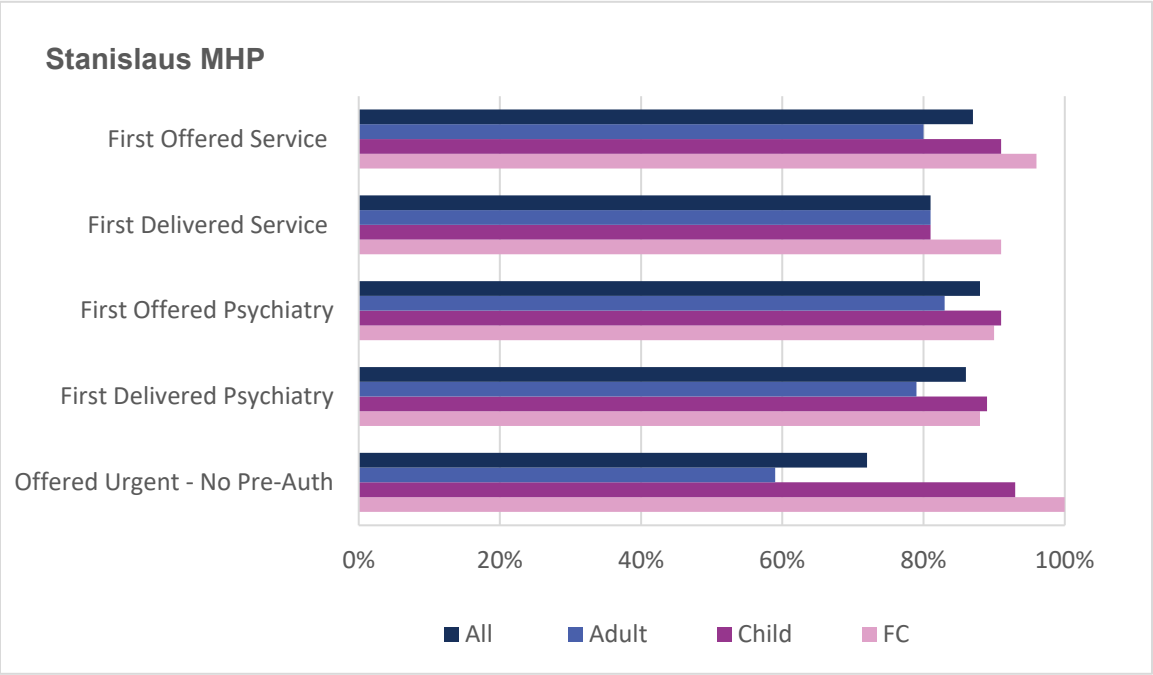


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments.
- The MHP defined “urgent services” for purposes of the ATA as a condition that is assessed to require immediate attention and if not addressed, could result in significant deficits, including an emergent psychiatric condition (Title 9 Regulations: 1810.253). There were reportedly 36 urgent service requests with a reported actual wait time for services for the overall population of 69.1 hours. Urgent appointment data, however, may be underreported or incomplete. Considering that there were 6,567 members served during CY 2022, it seems incongruous that the MHP only had 36 requests for urgent services.
- A 15-business day standard is expected for initial access to psychiatry, though the MHP may define when and how this is measured, and often MHP processes, definitions, and tracking may differ for adults and children. The MHP defines timeliness to first delivered/rendered psychiatry services as the time from member’s initial request for psychiatry services to the point of the first attended appointment.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 9.0 percent for psychiatrists and 8.0 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- The MHP's strategic response in capacity and communication improved timeliness of first offered appointments, successfully raising the percentage in FY 2022-23 to 87 percent across all services.
- CalAIM changes in the assessment process may have also contributed to improvement in timeliness, as providers report an easier and faster assessment process.
- Data for urgent appointments is questionable. The MHP reports only 36 urgent service requests for FY 2022-23, which is very small for a medium sized county with over 6,567 members served in CY 2022. It could be beneficial for the MHP to explore the urgent appointment definition and data collection further.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is the responsibility of the Quality Management Team. The Quality Services/Risk Manager (QS/RM) has overall responsibility for implementation of Behavioral Health and Recovery Services (BHRS) quality improvement functions as well as risk management. The Quality Improvement Program (QIP) is multi-disciplinary.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of two separate groups, one for QIC Adult SOC and one for QIC Children's SOC. And each is scheduled to meet monthly. Since the previous EQR, the MHP QICs have each met nine times. Of the 11 identified FY 2021-22 QAPI workplan goals, the MHP has met or is in progress of all items and sub items.

The MHP utilizes the following level of care (LOC) tools: the Child and Adolescent Needs and Strengths (CANS) and the Level of Care Utilization System (LOCUS).

Although the LOCUS, which is used exclusively for adult members, is the only standardized LOC instrument that is employed by the MHP, the CANS, in connection with clinical judgement and practice guidelines, is utilized as well to ascertain LOC needs for children and youth members. LOC data are captured and tracked in reports that offer end users perspectives on individual members, clinical staff, programs, and the system of care at large. These reports are disseminated to clinical staff, program managers, QIC, and executive leadership to promote the rendering of data-driven decisions regarding member LOC placement, member transitions within and out of the MHP, and LOC-related evaluations of caseload levels, and program capacities.

The MHP utilizes the following outcomes tools: the CANS, the LOCUS, Milestones of Recovery (MORS), the Patient Health Questionnaire-9 (PHQ-9), and the Pediatric Symptom Checklist-35 (PSC-35).

One of the MHP's stated objectives is to become a data-driven agency. Toward this end, Stanislaus has not only expanded the contract it has with Kings View Consulting

for the development of more interactive dashboards that will strategically display LOC, outcome, and service data, but also a new Outcomes, Evaluations, and Management (OEM) unit has been created by the MHP to address internal data-analytics needs. The primary thrust of activities surrounding both Kings View and the OEM is to translate raw LOC, outcome, and service-related data into user-friendly reports. These reports, which are available in member level, provider level, program level, and agency-wide level versions, are distributed to clinical staff, QIC, program managers, and executive leadership to monitor system demand and flow. More specifically, these tools are crafted to track and trend member LOC placements, assess and manage caseloads on the service-provider and program levels, and evaluate member progress as measured by changes in MORS and CANS domain scores over time. Executive leadership meets weekly to review LOC, outcome, and service data from a macro vantage point. Then, smaller gatherings, referred to as "leadership huddles," occur twice a week with program management to review these data to effectuate changes relating to staffing, service delivery patterns, and caseload levels to define and address member needs in a timely fashion and to improve the overall system of care.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP QAPI is well organized and easy to follow.
- Executive leadership places an emphasis on pursuing a data-driven decision-making model.
- Contractors report frequent communication with the MHP and being involved in system planning and implementation.
- The MHP has a robust process of bidirectional communication. BHRS staff and contracted staff have a myriad of opportunities to share insights, concerns, and observations with MHP leadership.
- The MHP does employ peers; however, it does not have a defined career ladder for peer positions.
- The MHP tracks and trends the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

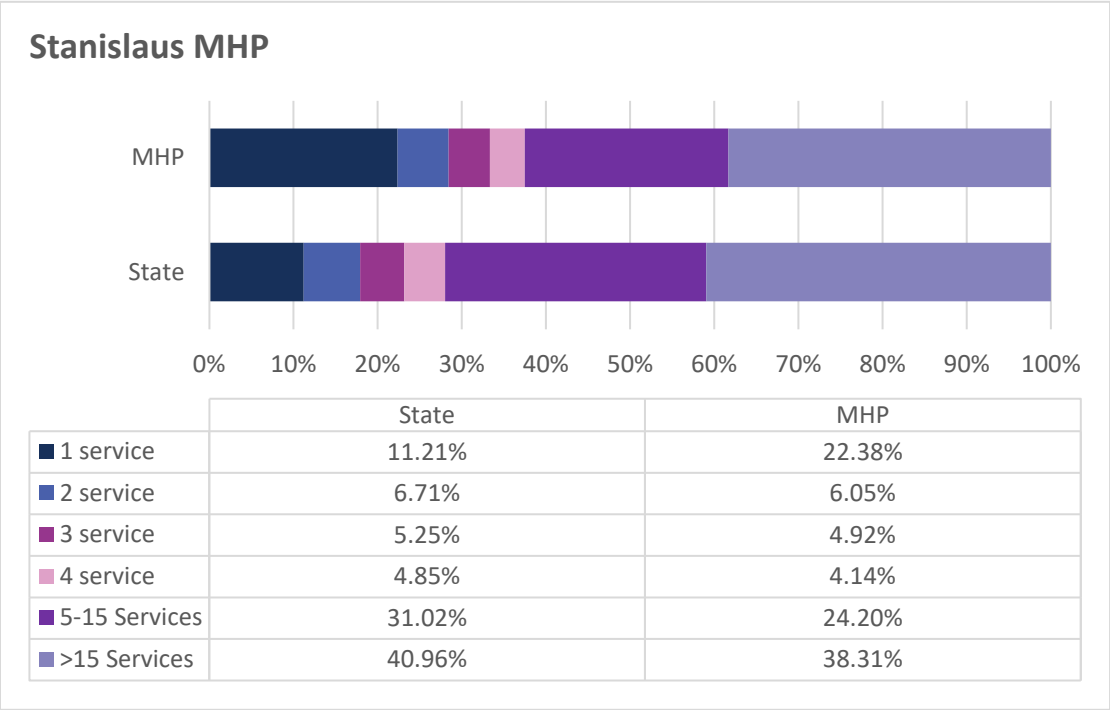
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served, CY 2022



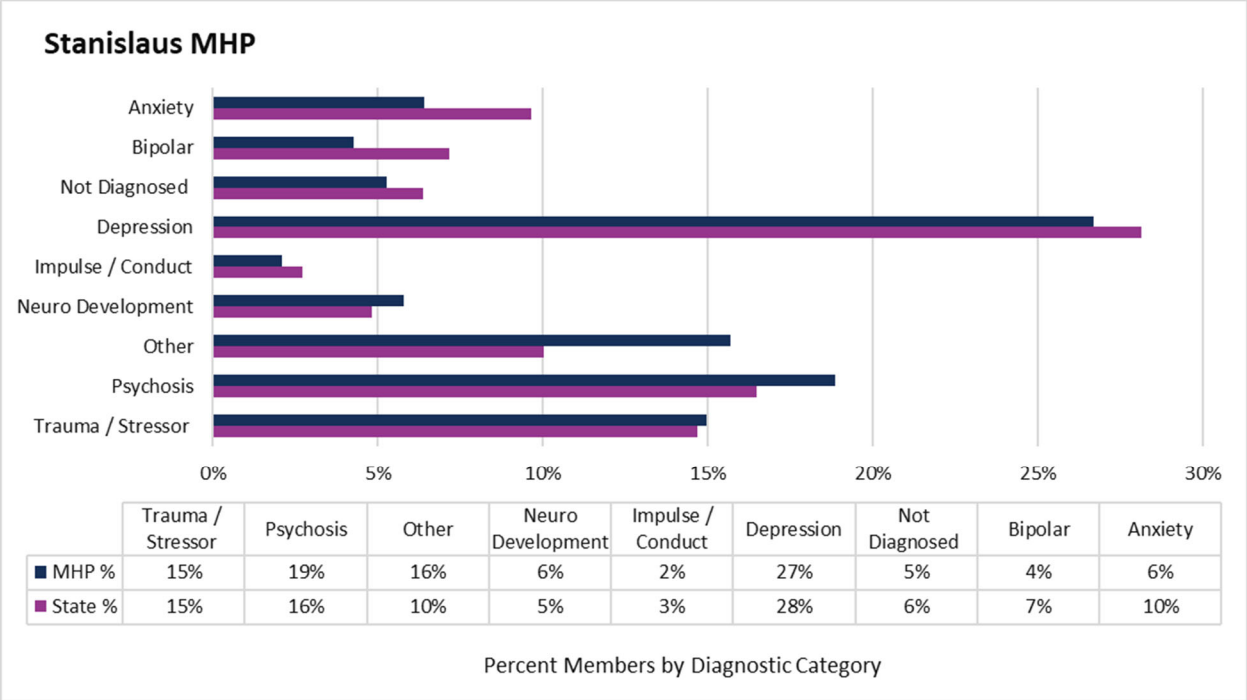
	State	MHP
1 service	11.21%	22.38%
2 service	6.71%	6.05%
3 service	5.25%	4.92%
4 service	4.85%	4.14%
5-15 Services	31.02%	24.20%
>15 Services	40.96%	38.31%

- While the percentages of members who received two, three, four, five, or more services were a bit lower in the MHP than was seen statewide, the proportion of members who received only one service in the MHP was almost double the statewide rate (22.38 percent vs. 11.21 percent). Although this concern was communicated to the MHP by way of a recommendation last year, no progress has been made to investigate this issue due to the existence of competing projects within the agency.

Diagnosis of Members Served

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

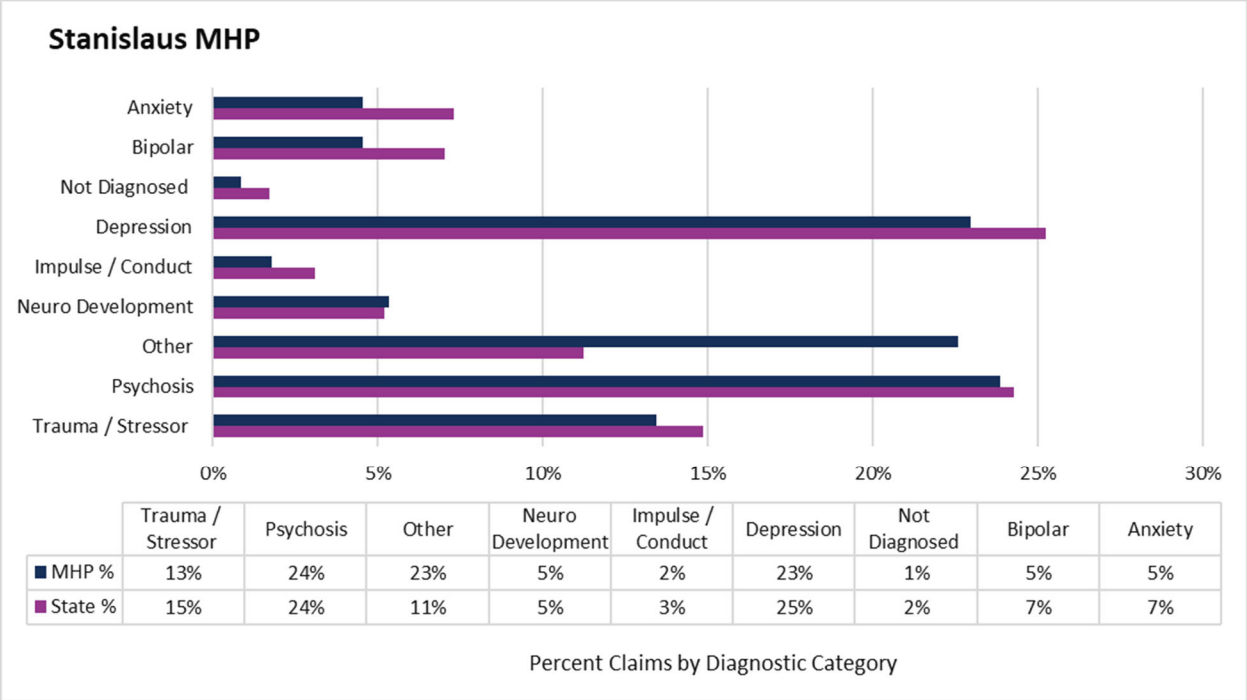
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	15%	19%	16%	6%	2%	27%	5%	4%	6%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- The most prevalent diagnostic category in the MHP – as well as statewide – was depression. The MHP showed more members with psychosis and other, and fewer members with depression, anxiety, and bipolar diagnoses.

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



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	24%	23%	5%	2%	23%	1%	5%	5%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The largest diagnostic category for approved claims in CY 2022 was Psychosis, followed by Depression, and Other. These three diagnostic categories account for 70 percent of the MHP's total claims. The Other category was double statewide. While the MHP showed more members with psychosis, their claiming was in line with statewide.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average length of stay (LOS).

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

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2021	1,484	2,302	1.55	5.56	8.45	$9,939	$12,763	$14,749,339
CY 2020	1,536	2,445	1.59	5.12	8.86	$8,999	$12,696	$13,822,592
CY 2019	1,433	2,278	1.59	4.66	8.68	$7,598	$11,814	$10,888,231

Note: CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

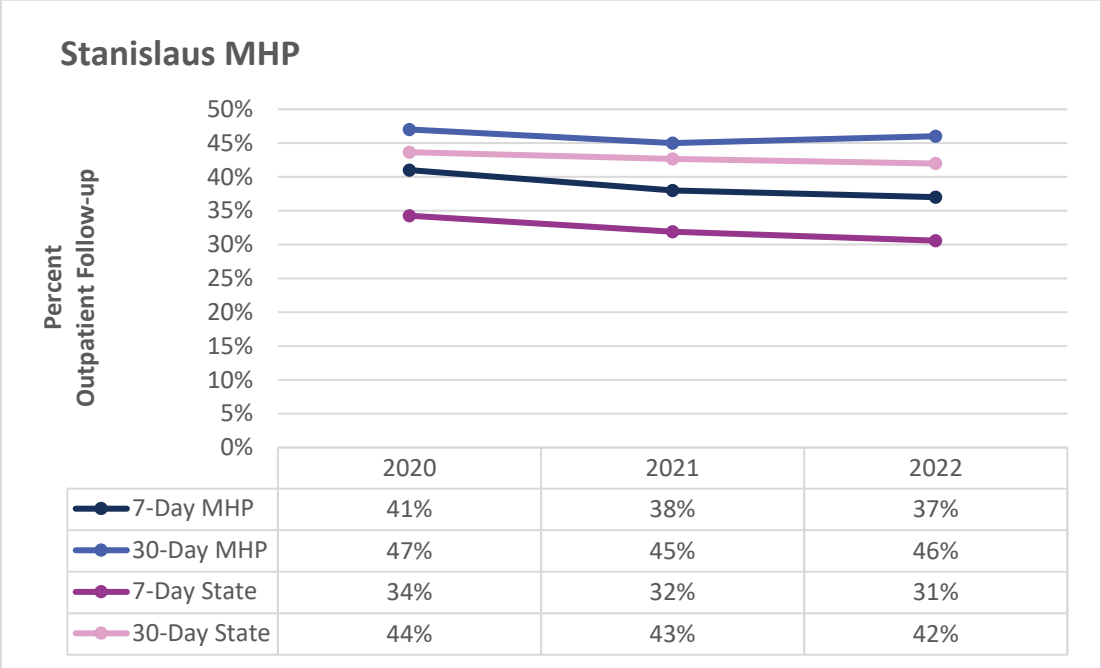
- The MHP showed a decrease in inpatient admissions – both number of members and number of admissions – with a slightly higher ALOS.

Follow-Up Post Hospital Discharge and Readmission Rates

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

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

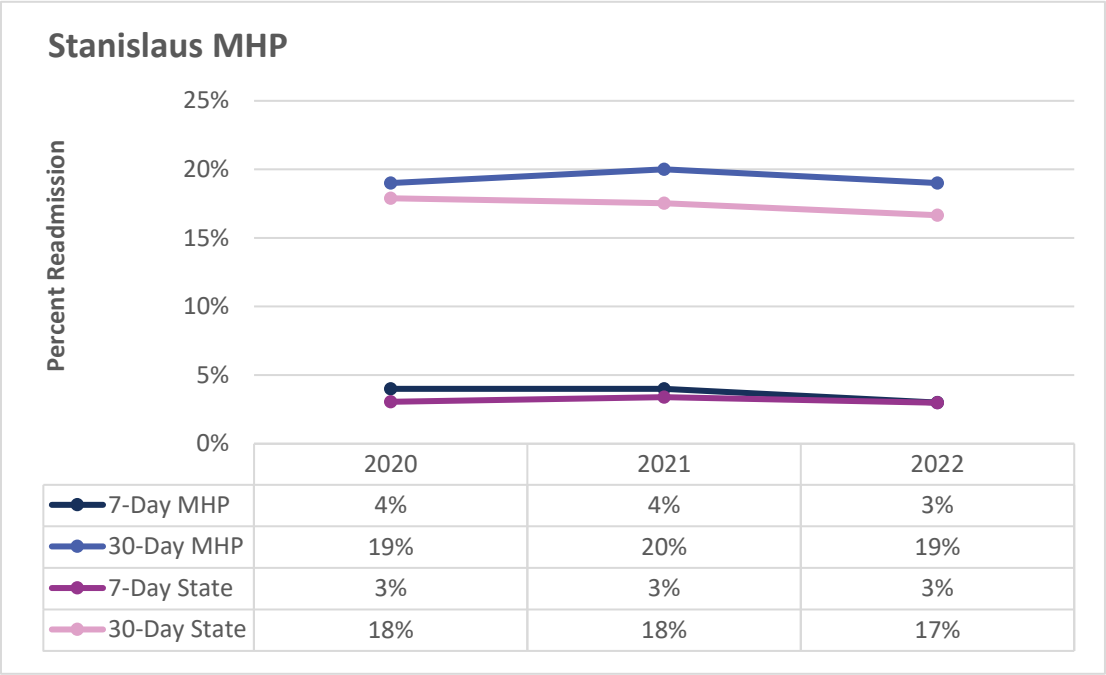
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	41%	38%	37%
30-Day MHP	47%	45%	46%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- While post psychiatric inpatient follow-up rates for both the MHP and the state slowly decreased over the past three years, the MHP's 7-day and 30-day rates have been consistently higher than those observed statewide.

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



	2020	2021	2022
7-Day MHP	4%	4%	3%
30-Day MHP	19%	20%	19%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP's 7-day and 30-day psychiatric readmission rates have approximated the statewide rates.

High-Cost Members

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

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

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive

54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

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

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	301	4.58%	29.64%	$15,746,267	$52,313	$44,062
	CY 2021	309	4.68%	30.88%	$16,294,840	$52,734	$44,342
	CY 2020	244	3.64%	25.08%	$11,947,740	$48,966	$41,187

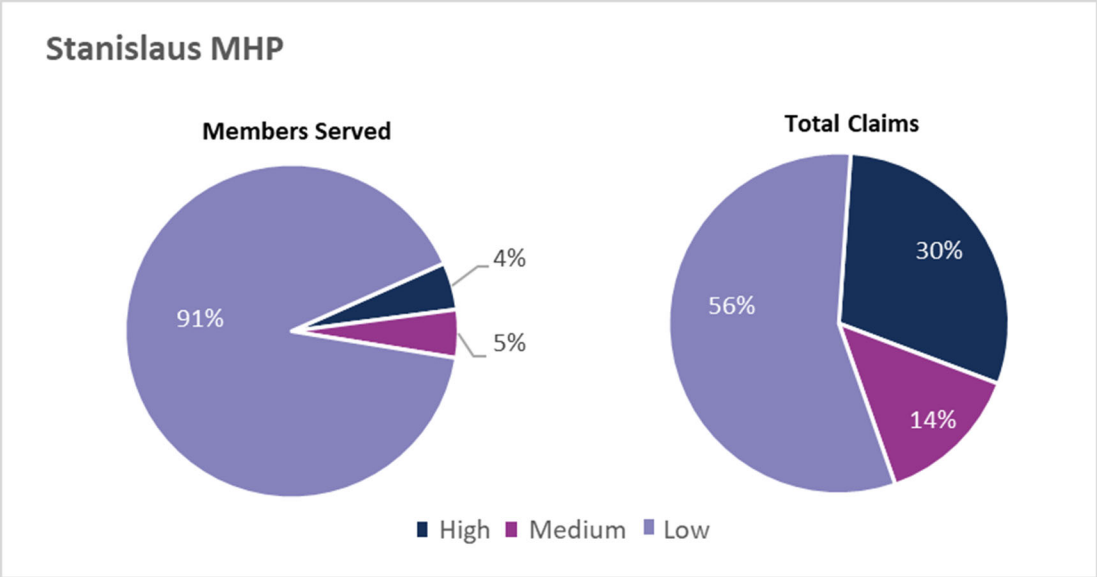
- Compared to CY 2020, the count of HCMs, the proportion of members in the high-cost category, and the proportion of total claims billed for services provided to HCMs increased; however, there were slight decreases from CY 2021 to CY 2022 for each of those variables. Additionally, while the proportion of members considered to be HCMs was roughly analogous to statewide, the proportion of claims attributed to them was lower.
- Over the past three years, the total, average, and median approved claims for HCMs generally increased. Nonetheless, average approved claims for HCMs in the MHP were slightly lower than was seen statewide.
- Although HCMs represented 4.58 percent of all Medi-Cal members who were served in CY 2022, the services delivered to this same group produced approximately 30 percent of total claims.

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

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	306	4.66%	13.88%	$7,372,639	$24,094	$23,441
Low-Cost (Less than $20K)	5,960	90.76%	56.48%	$29,998,465	$5,033	$3,352

- At 4.66 percent, the MHP's proportion of medium-cost members was roughly comparable to its proportion of HCMs (4.58 percent).

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



- 91 percent of members served were low-cost members, defined as having generated total claims of less than $20,000. More than half of all claims submitted for CY 2022 were associated with this same group.

IMPACT OF QUALITY FINDINGS

- The data-based decision-making process by middle management and executive leadership plays an important role in system wide monitoring and improvements including CalAIM implementation and system support.
- The bidirectional communication between MHP providers, prevention staff, substance use disorder providers, criminal justice partners, and other stakeholders ensures rapid response and coordination of care.
- Despite unexpected difficulties encountered through the implementation of SmartCare, the MHP continues to provide support and problem solve with providers to ensure successful implementation of CalAIM changes including payment reform.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Date Started: 09/2022

Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up MH services with the MHP within 7 and 30 days by 5 percent by May 1, 2024.

Target Population: The target population will be operationalized within the parameters of the HEDIS FUM. The MHP will focus on members with a qualifying event who present to Doctors Medical Center Modesto as defined in the FUM metric.

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

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

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

Summary

The MHP presented their CalAIM BHQIP PIP to serve as the clinical PIP. The problem statement was presented as: Gaps in care coordination practices and related data exchange processes contribute to delays in receiving services post-discharge from the hospital Emergency Department (ED) for individuals with MH conditions. The MHP conducted stakeholder outreach to assess facilitators of and barriers to (a) engaging members in timely follow-up MH treatment after ED visits and, (b) tracking/exchanging related data to make person-centered, data-informed decisions. The stakeholder discussions identified that there is currently no consistent process in place for the ED to notify the MHP of any members needing a follow up after an ED visit. With no consistent referral pathway in place, there is no current process for scheduling appointments for a post-ED discharge follow-up appointment. With no referral or scheduling process in place, care coordination and engagement services are in turn also not in place. Data related to ED discharges is not currently exchanged between the MCP or the MHP. The result is members are missed by the MHP for follow up care.

The MHP identified interventions to include utilizing the Community Emergency Response Team (CERT) to provide case management services to members 18 or older and linking them to Access Crisis and Support (ACS) for ongoing services.

Implementation of intervention with manual data collection started February 15, 2023, and data tracking though the EHR began July 8, 2023. The MHP conducts weekly FUM PIP meetings.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence because credible, reliable, or valid methods were implied or established for the PIP.

The MHP did not request TA for this PIP outside of the review.

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

- Explore methods to maintain validity of the data collection process and reduce barriers experienced due to SmartCare implementation.
- Engage in TA with CalEQRO on a consistent, at least quarterly, basis throughout the life of the PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Timeliness of Initial Psychiatric Medication Appointments

Date Started: 08/2021

Aim Statement: “The aim of the PIP will be to focus on timely access to psychiatric medication services for children and adolescent beneficiaries, ages 0-17 and open to the Children’s Intensive Community Support (ICS) program, when the parent/legal representative is requesting that service. The goal to increase the timeliness of the initial psychiatric service from 79 percent to 90 percent over 12 months.”

Target Population: Child and adolescent Medi-Cal members open to the Children’s ICS program, ages 0 – 17 years, who meet criteria for the specialty mental health services and are requesting an initial psychiatric appointment.

Status of PIP: The MHP’s non-clinical PIP is in the implementation phase.

Summary

Medi-Cal Key Indicator data identified a problem with timeliness of the target population to first psychiatry service. The MHP’s internal standard is 90 percent to meet the 15-business day standard. They were not meeting this goal. Further investigation of the data showed that part of the problem was no-shows to the psychiatry appointment. Interventions selected included: The MHP implemented a Psychiatric Medication Services Referral (PMSR) Script/Questionnaire that clinical staff would utilize when a youth/parent made the initial request for psychiatry services. The training for the PMSR Script/Questionnaire was developed and staff were trained on October 10, 2022. The other intervention included training all Children’s System of Care (CSOC) staff in the PMSR process to ensure it was completed accurately. This was decided due to timeliness data for psychiatry services depending on the PSR form being completed accurately. The data showed that there were inconsistencies amongst programs in completing this process. This training was developed and all CSOC staff were trained on approximately October 31, 2022. The PMSR Script/Questionnaire intervention will be tracked in the medication service code 20 in the EHR. The reduction of no-show for psychiatry medication appointments will be measured to track the outcome tied to the intervention utilizing the PSMR Script/Questionnaire. The hypothesis is that this will positively impact the timeliness of psychiatry medication appointments.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence because credible, reliable, or valid methods were implied or established for part of the PIP that are tracked and reported from the EHR.

The MHP did not request TA for this PIP outside of the review.

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

- Review the impact of added psychiatry slots on the data collection and reporting process.
- Engage in TA with CalEQRO on a consistent, at least quarterly, basis throughout the life of the PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is the CalMHSA Semi-Statewide EHR SmartCare by Streamline, which was implemented in July 2023. Currently, the MHP is actively implementing this new system which requires heavy staff involvement to fully develop.

Approximately 6 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. With the accelerating demand for IS support in connection with the MHP's ongoing efforts to fully implement and develop SmartCare functionality and reporting, Stanislaus has not only witnessed a 41.84 percent increase in the funding being allocated to the IS budget over the last fiscal year, but also a 60 percent increase in IS staffing has occurred.

The MHP has 704 named users with log-on authority to the EHR, including approximately 342 county staff and 362 contractor staff. Support for the users is provided by 24 FTE IS technology positions. Currently, there is one vacancy for an IS Staff Developer position that remains to be filled.

As of the FY 2023-24 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers directly enter member practice management and service data into the MHP's EHR as reported in the following table:

Table 16: Contract Provider Transmission of Information to Stanislaus MHP EHR

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

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP has an existing PHR that only permits members to view active medication prescriptions. During the COVID-19 pandemic, however, the terminals dedicated for member use were not accessible. Currently, the MHP's IS department is in the process of reestablishing member access to the PHR. Nonetheless, there were 12 members who were able to access their PHR in the last year.

Interoperability Support

The MHP is a member of a HIE. The MHP engages in electronic exchange of information with MHP and substance use disorder contract providers. Although the MHP has executed a contract with the San Joaquin County HIE and has partnered with two Managed Care Plans (MCPs) (i.e., Health Plan of San Joaquin and HealthNet), Stanislaus has yet to engage in the electronic exchange of information with any of these agencies.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- To address IS vacancies and ongoing needs related to the implementation of SmartCare, the MHP increased the percentage of the total fiscal year budget that is dedicated to IS support from 4.23 percent in FY 2021-22 to 6.00 percent in FY 2022-23, yielding an overall increase in IS funding of 41.84 percent.
- During the last EQR cycle, it was noted that the MHP had a significant IS vacancy rate. Over the past year, however, Stanislaus has been able to effectuate a 60 percent increase in the number of FTE positions that were budgeted for IS from 15 to 24. Currently, all but one of these positions has been filled.
- Stanislaus places an emphasis on becoming a data-driven agency. As a result, the MHP created the new OEM unit to assist with identifying and addressing internal data-analytics needs. The unit encompasses three positions, a manager and two data analysts. These OEM staff are responsible for translating raw LOC, outcome, and service-related data into reports that can be used by executive leadership, program managers, and clinical staff to make data-informed decisions.
- Following the implementation of the CalMHSA semi-statewide EHR SmartCare by Streamline, the MHP still does not have access to a data warehouse that replicates the new EHR system to support data analytics. Consequently, a “Partially Met” rating was assigned to IS Infrastructure Key Component 4B relating to Integrity of Data Collection and Processing; however, establishing a SmartCare data warehouse has been identified by the MHP as a top priority.
- Although the MHP has made strides toward promoting interoperability by becoming a member of the San Joaquin HIE and partnering with two MCPs, it has not yet engaged in the electronic exchange of information with any of these agencies.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	10,236	$3,265,497	$75,964	2.33%	$3,189,533
Feb	10,101	$3,420,148	$75,911	2.22%	$3,344,237
Mar	12,432	$4,303,001	$91,817	2.13%	$4,211,184
April	11,154	$3,806,300	$61,177	1.61%	$3,745,123
May	10,408	$3,640,547	$42,011	1.15%	$3,598,536
June	10,238	$3,537,750	$52,879	1.49%	$3,484,871
July	9,814	$3,475,095	$62,943	1.81%	$3,412,152
Aug	10,904	$3,937,107	$94,470	2.40%	$3,842,637
Sept	9,924	$3,617,166	$71,153	1.97%	$3,546,013
Oct	9,933	$3,632,576	$61,292	1.69%	$3,571,284
Nov	8,984	$3,271,361	$65,491	2.00%	$3,205,870
Dec	8,061	$2,406,310	$64,873	2.70%	$2,341,437
Total	**122,189**	**$42,312,858**	**$819,981**	**1.94%**	**$41,492,877**

- The MHP generated consistent monthly claim lines and made timely submissions throughout CY 2022.

Table 19: Summary of Stanislaus MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Medicare Part B must be billed before submission of claim	753	$307,215	37.47%
Other healthcare coverage must be billed first	711	$216,338	26.38%
Beneficiary is not eligible or non-covered charges	418	$154,976	18.90%
Deactivated NPI	172	$104,249	12.71%
Service line is a duplicate and repeat service modifier is not present	31	$13,838	1.69%
Late claim submission	75	$13,509	1.65%
Service location NPI issue	12	$4,612	0.56%
Other	4	$2,623	0.32%
Place of service incomplete or invalid	2	$2,622	0.32%
Total Denied Claims	**2,178**	**$819,982**	**100.00%**
Overall Denied Claims Rate	**1.94%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The MHP's overall denied claims rate was 1.94 percent, which is 3.98 percentage points below the statewide denial rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The IS budget and the number of FTEs currently available to provide IS support to end users have increased significantly over the last year. With the increase in staffing, the IS department was able to effectively leverage these changes by not only orchestrating the MHP's transition to SmartCare, but also by expeditiously training and equipping all end users in the MHP with the requisite skills and knowledge to navigate and engage with the new system in a successful manner. During the recent EQR visit, many staff expressed high levels of satisfaction with the incredibly responsive technical support that they have received from the IS team.
- The MHP's overall denied claims rate for CY 2022 of 1.94 percent is well below the statewide rate, thereby suggesting that the MHP has a fiscal team that employs effective strategies in the process of addressing billing needs in an accurate and timely fashion.
- Stanislaus does not have a written IS strategic plan that focuses exclusively on the MHP. Instead, it is presently relying on a copy of a strategic plan that was crafted more than six years ago (March 2017) as an overarching tool for the entire county. Given that the MHP was the target of a ransomware attack in

December 2017 that resulted in the disabling of hundreds of computers, it may want to consider investing resources to produce an IS strategic plan that is MHP-specific to better prepare for the potential need to successfully navigate through such future events. The lack of a current agency specific IS strategic plan represents a potential liability for the MHP.

- Following the implementation of SmartCare in July 2023, Stanislaus was confronted with the challenge that much of the data and reporting functionality in this Streamline product was either completely missing or inoperative. As a result, the MHP has not been able to perform any state-mandated reporting since the implementation of the new EHR. More specifically, no data relating to CSI, CANS, PSC-35, or the DCR have been submitted through the state's dedicated Behavioral Health Information System (BHIS) portal since June 2023. Although the IS department has been proactively working with CalMHSA and Streamline to develop reports that will resolve this issue, no meaningful solutions have yet been developed.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP uses the CPS data for its QI purposes. It produces summaries for each of the four surveys and analyzes both at the overall system level and each reporting unit level.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

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

Participants report they were able to access services quickly and are satisfied with current services. Participants report providers coordinate well with primary care physicians and assist with coordinating transportation to their services. They appreciated the timely response to service requests and receiving follow-up appointments when needed.

Recommendations from focus group participants included:

- "Would like art class or art therapy to deal with substance use issues through art."

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parents/care givers of youth receiving services. The focus group was held virtually and included three participants. All care givers/family members participating have a family member who receives clinical services from the MHP.

Participants reported difficulties with timeliness for access to services for their children. It was reported it took a long time to start services and had difficulties with communication and coordination of care to transition child between levels of care. Participants reported better coordination is needed in the program to make process smoother.

Recommendations from focus group participants included:

- “Case manager is needed to help support navigation process.”
- “Appointment slots are needed outside of school hours.”
- Timelier initial access to appointments.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Members receiving adult services were satisfied with services and assistance, however, parents and caregivers reported dissatisfaction with communication, timeliness to access to services and difficulties navigating transition of services and different programs. The feedback suggests there is an opportunity for the MHP to look at timeliness to services for children and overall coordination of care experience for children.

CONCLUSIONS

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

STRENGTHS

1. Stanislaus was one of several counties that decided to implement the CalMHSA semi-statewide EHR, SmartCare by Streamline, in July 2023. Many County and contracted staff have already disclosed that they are, in general, pleased with the transition to this new EHR, and believe that it will offer a powerful environment within which to capture, manage, and report on information critical to performing their mission. (IS)

2. The MHP places an emphasis on becoming a data-driven agency. In this connection, it has created a new OEM unit to address internal data analytics needs. Additionally, Stanislaus has expanded its contract with Kings View Consulting to promote the development of more interactive dashboards. The primary function of both groups is to translate raw LOC, outcome, and service-related data into reports that can be used by executive leadership, QIC, program management, and both internal and contracted clinical staff to support the rendering of data-informed decisions. (Quality, IS)

3. For CY 2022, the MHP maintained consistent and effective monthly claiming and timely submissions, which yielded an overall denied claims rate of 1.94 percent. (IS)

4. Through data analysis of needs in the MHP and improved recruitment and hiring practices, 28 positions were added to support the system, with plans to continue expansion in areas of need. (Quality, IS)

5. Collaborative communication between providers and stakeholders provides ease in coordination of care resulting in satisfaction for adult members. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Over the last several years, performance measure data relating to the engagement and retention of members have demonstrated that the percentage of members that had only one service in the MHP was considerably higher than was observed statewide. Although this concern was communicated to the MHP by way of the issuance of a recommendation during the last EQR cycle, no

substantive efforts have been made to assess and remediate this pattern of care. (Access, Quality)

2. The largest racial/ethnic group that Stanislaus serves is the Hispanic/Latino population, which, in CY 2022, constituted more than 53 percent of total eligibles. The MHP's PR for this group, however, was markedly lower than either the state or similar-sized county percentages. Additionally, while the current performance measure data illustrated that Hispanic/Latino and African American PRs in the MHP were almost half the levels reported statewide for these groups, PRs for all racial/ethnic populations (i.e., African American, Asian/Pacific Islander, Hispanic/Latino, Other, and White) served by Stanislaus have fallen well below statewide rates. Although the MHP has undertaken outreach and prevention efforts with many of these local communities to build rapport and inform them about the availability of services, these activities have yet to translate into improved PRs with any of these populations. (Access)

3. The MHP currently utilizes an IS strategic plan, however, it has not been updated since 2017. This poses a potential risk due to technological advancements over the last several years. (IS)

4. Although the MHP has an established contract with an HIE it has not engaged in any type of electronic exchange of information. (Quality, IS)

5. The MHP currently employs peer positions, however, the MHP does not have a defined peer support position career ladder. (Quality)

RECOMMENDATIONS

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

1. Research and assess concerns regarding the high percentage of members who receive only one service. Develop and implement effective strategies to improve the overall engagement and retention of members. (Access, Quality)

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

2. Research why the MHPs decreasing PRs for both Latino/Hispanic and African American members are less than half that of the state and develop and implement a plan to address these two populations' need for more access to services. (Access)

   (This recommendation was continued from FY 2022-23.)

3. Update the IS strategic plan to ensure the strategic plan meets current technological demands. (IS)
4. Coordinate and plan to begin the data exchange process through HIE. (Quality, IS)

5. Initiate efforts to create a defined peer support career ladder for career growth. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Stanislaus MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Health Information System
Consumer and Family Member Focus Groups
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Use of Data to Support Program Operations
Interagency Coordination
Youth Services and Collaboration
Criminal Justice Group Interview
Information Systems Billing and Fiscal Interview
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Nathan Lacle, PsyD(c), MPA, Lead Quality Reviewer
Rick Jackson, Information Systems Reviewer
David Czarnecki, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Acosta	Rachel	CERT Coordinator	SCBHRS
Andres	Abraham	ASOC - Chief	SCBHRS - Administration
Anguiano	Kara	Chief Fiscal Officer	SCBHRS - Administration
Arcaina	Carmela	MH Clinician I CCT	SCBHRS - ASOC
Banikweze	Bosa	Software Admin III	SCBHRS - IT
Banning	Danielle	Staff Services Analyst	SCBHRS – Outcomes and Evaluations Management (OEM)
Benton	Kierra	QS Specialist	SCBHRS
Bibbins	Tiffany	Medical Records Coordinator	SCBHRS
Bravo	Vanessa	Crime Analyst	Stanislaus County Probation
Brown	Ashley	MH Clinician I	SCBHRS - ASOC
Brown	Vanessa	Executive Director	Aegis (Contractor)
Buckles	Debra	Chief of Forensics	SCBHRS - Administration
Camarillo	Maria	Staff Serv Coordinator	SCBHRS - OEM
Campbell	Chandra	Manager III	SCBHRS - ASOC
Campos	Elizabeth	Manager of Social Work	Health Plan of San Joaquin (HPSJ) (MCP)
Chapman	Dave	Core Program Director II	Aspiranet – Contractor
Clarke	Stacy-Ann	BH Specialist II	SCBHRS – DMC-ODS
Collins	Steve	Behavioral Health Manager	CHS (Center for Human Services)
Cooke	Debi	MH Clinician II	SCBHRS - CSOC

Last Name	First Name	Position	County or Contracted Agency
Cox	Angela	MH Clinician I	SCBHRS - CSOC
Diaz	Susanna	MH Clinician I	SCBHRS - ASOC
Dietz-Neves	Deborah	Manager II	SCBHRS - CERT
Dominguez	Raul	Manager IV	Stanislaus County Probation
Ellis	Desti	MH Coordinator	SCBHRS
Ervin	Lezzette	Behavioral Health Equity – Manager II	SCBHRS
Esparza	Pam	Chief of Consumer Affairs	SCBHRS - Administration
Gaona	April	Program Manager	Redwoods (Contractor)
Garcia	Erica	BH Specialist II	SCBHRS – StanWorks
Garza	Roberta	Staff Service Coordinator DOTS	SCBHRS
Gonzales	Frances	Mental Health Coordinator II	SCBHRS
Green	Joni	MH Director	Creative Alternatives (Contractor)
Griffin	Tameika	PEI MH Coordinator	SCBHRS
Gulino	Nick	CEO	Recovery Med Group
Guzman	Eunice	Administrative Clerk III	SCBHRS
Hahn	Joe	Med Clinic Manager III	SCBHRS
Haley	Lauren	Substance Use Navigator	Doctor's Medical Center (DMC)
Hermosilla	Estefania	MH Coordinator	SCBHRS - CSOC
Hibler-Kamara	Monica	Manager III	SCBHRS - CSOC
Hunt	Lauren		Contractor

Last Name	First Name	Position	County or Contracted Agency
Inthavong	Dyana	Executive Director	Aegis – (Contractor)
Jamison	Tina	Manager IV	SCBHRS – Business Office (BO)
Johnson	Kristy	Manager III	SCBHRS - ASOC
Kraus	James	Physician	SCBHRS - Contractor
Lawrence	Jessie	BH Specialist II	SCBHRS
Lewis	Robin	Sr. Manager, Clinical Services	Health Net (MCP)
Lopez	Karissa	Program Director	Central Star (Contractor)
Lysaythong	Yeng	Manager II	SCBHRS – Business Office (BO)
Magee	Keri	Chief of CSOC	SCBHRS - Administration
Maeyma	Emily	Regional Director	Turning Point (Contractor)
Margarite	Shelli	Manager II	Public Defender
Marquez	Gabriela	Mental Health Coordinator	SCBHRS – Utilization Management (UM)
Marquez	Maria	Custodial Lieutenant	Stanislaus County Sheriff
Marsh	Jennifer	Staff Service Coordinator	SCBHRS – Substance Use Education & Prevention Services
Mason	Jeff	Program Manager	Center for Human Services (CHS-Contractor)
McCay	Melissa	Staff Service Analyst	SCBHRS - OEM
McCullough	Tracey	Manager III	SCBHRS – DMC - ODS
McDowell	Paula	Manager III	SCBHRS – DMC - ODS

Last Name	First Name	Position	County or Contracted Agency
McVey	Emily	MH Clinician I	SCBHRS - ASOC
Miranda	Cristal	MH Clinician III	SCBHRS – Workforce Development & Training
Montoya	Michael	Chief, Information & Technology	SCBHRS - Administration
Mora, MD	Bernardo	Medical Director	SCBHRS - Administration
Moun-Eldridge	Saroun	BH Program Coordinator	SCBHRS – DMC - ODS
Moya	Edgar	Staff Service Analyst	SCBHRS
Nelson	Beth	Program Coordinator	Redwood Family Treatment Center (Contractor)
Nerell	Jodi	Local MH Engagement Director	Sutter Health
Nunez-Pineda	Janet	Manager III, PEI	SCBHRS - PEI
Olivia	Delayne	Manager III, Contracts	SCBHRS - Contracts
Orozco	Maday	MH Coordinator	SCBHRS - CSOC
Panyanouvong	Kevin	Chief of ASOC/Associate Director	SCBHRS - Administration
Patla	Sushma	MH Coordinator	SCBHRS – Access & Crisis Support
Petroni	Joe	MH Coordinator	SCBHRS - ASOC
Pike	Elizabeth	BH Coordinator	SCBHRS – DMC - ODS
Pruitt	Samantha	Behavioral Health Specialist II	SCBHRS – Care Coordination Team (CCT)
Quach	Cam	Staff Services Analyst, DOTS	SCBHRS
Ramos	Margarita	Staff Service Analyst	SCBHRS - DOTS

Last Name	First Name	Position	County or Contracted Agency
Rodriguez	Catrina	Director of BH & Social Services	Health Plan of San Joaquin (MCP)
Rios-Moran	Marisol	MH Clinician I	ASOC-BHRS
Rittenmyer	Julie	Clinical Supervisor	Aspiranet
Rivera	Alicia	Psychiatric Nurse II, Utilization Mgmt.	SCBHRS
Rivera	Tiffany	Intern	City Parks Department
Rose	Diane	Program Coordinator	SVCFS
Safi	Nasrin	Manager III, QS/Risk Mgmt	SCBHRS
Saing	Kim	Manager III, Administration	SCBHRS
Salazar	Monica	Chief of Managed Care, Quality, Compliance, and Risk Management/ Manager IV	SCBHRS
Saleh	Melonie	MH Clinician II, Compliance	SCBHRS
Samra	Nikita	SUN	Emanuel Medical Center
Santos	Lisette		Sierra Vista Child & Family Services (Contractor)
Scoles	Cyrise	MH Clinician I	SCBHRS – CSOC
Shelton	Perry	Community Liaison, Service Coordination	HealthNet (MCP)
Silva	Mary	Clinical Service Technician II	SCBHRS
Sims	Lori	MH Coordinator	SCBHRS - ASOC
Sinchak	Kayla	Staff Service Analyst	SCBHRS
Sprague	Tabitha	Manager IV	SCBHRS

Last Name	First Name	Position	County or Contracted Agency
Taylor	Cory	BH Coordinator, SUD	SCBHRS
Teicheira	Trinity		Contractor
Thao	Bee	MH Clinician II, QS	SCBHRS
Tijerina	Jose	MH Coordinator	SCBHRS
Torres	Alma	Manager III, Housing & Employment Services	SCBHRS
Urzua	Laura	Administrator	Central Star
Vang	Kong	BH Specialist II	SCBHRS
Valencia	Oscar	Staff Service Coordinator	SCBHRS – Business Office
Vann	Sarah	Manager II, MRS	SCBHRS - MICS
Vargas	MaryCruz	Quality Service Specialist/MH Clinician I	SCBHRS
Vartan	Tony	Behavorial Health Director	SCBHRS - Administration
Vaughn	Jason	MH Clinician II	SCBHRS - TAY
Vencente	Valerie	Program Coordinator	Sierra Vista Child and Family Services (SVCFS) (Intensive Community Support)
Vierra	Janet	Clinician	Central Star
Vylonis	Megan	Manager II, Compliance	SCBHRS
Weston	Robert	Manager III, SUD	SCBHRS
Yarnell	Charles	Manager II	SCBHRS

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	As submitted, this clinical PIP was found to have moderate confidence because credible, reliable, or valid methods were implied or established for part of the PIP.

General PIP Information
MHP/DMC-ODS Name: Stanislaus
PIP Title: "Follow-Up After Emergency Department Visit for Mental Illness (FUM)"
PIP Aim Statement: For Medi-Cal members with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up MH services with the MHP within 7 and 30 days by 5 percent by May 1, 2024.
Date Started: 09/2022
Date Complete: 05/01/2024
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17) * ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): The target population will be operationalized within the parameters of the HEDIS FUM. The MHP will focus on members with a qualifying event who present to Doctors Medical Center Modesto as defined in the FUM metric.

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): For beneficiaries identified as needing the MHP level of care, the MHP will provide coordination services to ensure follow up with the MHP.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): utilizing the Community Emergency Response Team (CERT) to provide case management services to beneficiaries 18 or older and linking them to Access Crisis and Support (ACS) for ongoing services.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Bridge care coordination between MHP and ED in order to decrease ED visits for beneficiaries

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Referral tracking mechanism	2022		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Explore methods to maintain validity of data collection process and reduce barriers experienced due to SmartCare implementation. • Engage in TA with CalEQRO on a consistent, at least quarterly, basis throughout the life of the PIP.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	As submitted, this clinical PIP was found to have moderate confidence because credible, reliable, or valid methods were implied or established for part of the PIP.
General PIP Information	
MHP/DMC-ODS Name: Stanislaus	
PIP Title: Timeliness of Initial Psychiatric Medication Appointments	
PIP Aim Statement: The aim of the PIP will be to focus on timely access to psychiatric medication services for children and adolescent beneficiaries, ages 0-17 and open to the Children's Intensive Community Support (ICS) program, when the parent/legal representative is requesting that service. The goal to increase the timeliness of the initial psychiatric service from 79 percent to 90 percent over 12 months	
Date Started: 08/2021	
Date Completed: 12/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0–17) * ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): Child and adolescent Medi-Cal beneficiaries open to the Children's ICS program, ages 0 – 17 years, who meet criteria for the specialty mental health services and are requesting an initial psychiatric appointment.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Beneficiary will be given the PMSR Script/Questionnaire
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Provider will administer PMSR Script/Questionnaire
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): All clinicians will be trained to administer the PMSR Script/Questionnaire and instructed to administer it to each beneficiary in the population who requests a psychiatry service appointment.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PMSR Script/Questionnaire	2022		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Review the impact of added psychiatry slots on the data collection and reporting process. • Engage in TA with CalEQRO on a consistent, at least quarterly, basis throughout the life of the PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.