Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

# FY 2019-20
# MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

## VENTURA MHP FINAL REPORT

Prepared for:

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

Review Dates:

**February 25 – 27, 2020**

# TABLE OF CONTENTS

# LIST OF TABLES AND FIGURES

# INTRODUCTION

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

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

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

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

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

## MHP Information

MHP Size — Large

MHP Region — Southern

MHP Location — Oxnard

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 9,839

MHP Threshold Language(s) — Spanish

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

## Validation of Performance Measures[1]

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

## Performance Improvement Projects[2]

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

## MHP Health Information System Capabilities[3]

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

## Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

## Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

---

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

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

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

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

# PRIOR YEAR REVIEW FINDINGS, FY 2018-19

In this section, the status of last year's (FY 2018-19) recommendations are presented, as well as changes within the MHP's environment since its last review.

## Status of FY 2018-19 Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2019-20 site visit, CalEQRO reviewed the status of those FY 2018-19 recommendations with the MHP. The findings are summarized below.

### Assignment of Ratings

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

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

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

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

## Recommendations from FY 2018-19

### PIP Recommendations

**Recommendation 1:** Two active PIPs are required, as per Title 42, CFR, Section 438.330.

Status: Partially Met

- The MHPs Quality Improvement (QI) team has implemented structured oversight of PIPs by establishing project timelines and milestones that can be tracked to completion over the course of the year. Several months ahead of completion of a PIP, QI reviews the current state of the PIP and is ready to propose updates or identify the next study topics based on findings in performance measure and outcome data.
- The MHP's non-clinical PIP to improve initial access in the Santa Paula area conforms to the requirements of an active improvement project, and has received sufficient modification to merit continuation through this current period.
- The MHP's effort to produce a clinical PIP is focused on improving post-hospital follow-up timeliness, and reducing rehospitalization rates. The initial effort will

target the county operated Hillmont Inpatient Psychiatric Unit (IPU) beneficiaries. This PIP is currently is in its concept phase and does not have active interventions. There are plans to address the aftercare and rehospitalization issues of the non-County facilities in the future. Notably, those hospital discharges experience a higher readmission rate than those discharged from the county unit.

**Recommendation 2:** The clinical telehealth submission targets the topic of acceptance of technology delivered psychiatry and nurse practitioner services. This effort first needs to actively involve telehealth participants as part of the PIP project team, and use their input to help in redesign of the current survey. This assessment should include feedback on potential strategies/interventions that can be applied to improve acceptance by beneficiaries. Baseline data, indicators, and clear substantive interventions all need to be in place before this can be considered an active PIP.

Status: Partially Met

- The MHP ended this clinical PIP and began working on a new project before these recommendations were addressed.
- The telehealth PIP was discontinued following transition to a new psychiatry contract provider entity. Initially, this provider did not utilize telehealth, resulting in the suspension of this PIP. Recently, the psychiatry provider has started using the telehealth modality. This opens up the potential for future consideration to a telehealth PIP.

**Recommendation 3:** The non-clinical improvement activity requires modifications to become active. The PIP needs to be based on the number of Medi-Cal beneficiaries in this region, and indicators must have baseline data before it can be active. Interventions need to be specific and clear and the indicator data must be available and reported monthly.

Status: Met

- The MHP identified baseline penetration rates in the Santa Paula region, starting with baseline 2017 data, and with follow-ups in 2018 and 2019.
- The identified indicator data included first offered appointments within 10 business days and first face-to-face appointments within 10 business days. The MHP also tracked penetration rate changes, an area of concern for them.

## Access Recommendations

**Recommendation 4:** Ensure that broad inclusion of stakeholders is involved in the selection of a Crisis Stabilization Unit (CSU) operator. The inclusion of key stakeholders is essential for the selection of the operator, and the development of the mission and operating principles, and should include: county-wide Emergency Department (ED) representation, beneficiaries, families, law enforcement, and Ventura County Behavioral Health (VCBH) leadership and key contractors.

Status: Met

- Ventura County Medical Center (VCMC) opened a crisis stabilization unit (CSU) certified for 12 beds, of which it is currently utilizing four. This is due to the need to limit the number of CSU beneficiaries that might need an acute inpatient admission. The IPU is certified for 41 beds, but due to currently available staffing, has limited use to 30 beds. This CSU is not under the aegis of Ventura County Behavioral Health (VCBH).

- Currently, the MHP is pursing CSU, CRT, MHRC development, but is also considering negotiations with a provider for a dual psychiatric health facility (PHF) and crisis residential treatment (CRT) program. The needs for more subacute and acute beds are acknowledged. VCBH has been clear in its advocacy for stakeholder input with both potential operators.

**Recommendation 5:** Increase the availability of bilingual psychiatry, ensuring that telehealth bilingual psychiatrists prioritize Spanish-preferred beneficiaries with the goal to eliminate all medication monitoring sessions that require an interpreter.

Status: Partially Met

- Discontinuation of the MHP's previous countywide psychiatry services contract in June 2019 triggered a quick response to expand the provider contract furnishing psychiatric inpatient services to cover outpatient services.

- Bilingual psychiatry providers for children and youth have remained stable; the adult system of care was most severely impacted by turnover. There are currently two bilingual psychiatrists on board with another to start in June 2020, followed by one in July 2020. The fulltime bilingual adult psychiatrist is requesting a Spanish language caseload. Current plans have this practitioner rotating through county clinics to serve this the Spanish language preferred beneficiaries.

**Recommendation 6:** Family therapy is considered a key strategy in the treatment of children and youth. The MHP should establish a minimum standard for family therapy and track to ensure this important service is provided to Y&F beneficiaries, and that families are aware of this modality.

Status: Met

- The MHP has reactivated the family therapy service code, enabling tracking and reporting of various aspects of this important service. Tracking aggregate numbers and by individual beneficiary will support practice monitoring.

- The separation of collateral services from family therapy will provide the MHP with the ability to separately analyze service patterns.

- It is appropriate for the MHP to deter the establishment of a standard until sufficient data is available to determine levels for clinical outcome improvements.

**Recommendation 7:** Request the participation of Gold Coast Health Plan representatives when meeting with the mild-to-moderate provider agency to discuss coordination issues.

Status: Met

- The MHP conducts monthly meetings with adult division managers, clinic administrators (CA) and Beacon representatives. These meetings discuss the challenges experienced in finding non-specialty mental health service resources for individuals served by the MHP that no longer require SMHS.
- The Screening Triage Assessment and Referral (STAR) team, the VCBH assessment unit, is in regular contact with the provider of non-specialty mental health services and consistently works to refer those without medical necessity for MHP services to Beacon providers.
- Some of the key challenges include the long delays in processing of referrals and achievement of screening, and adequacy of the provider network. During this review an instance was identified wherein it took six weeks for the non-SMHS provider to screen the referral. This is particularly evident in the more rural county regions, and with those who are Spanish-language preferred.
- Meetings are now scheduled that will include both Beacon and Gold Coast, the MCO entity, key personnel. The MHP reports delays is discharging of beneficiaries due to lack of follow-up capacity in the non-SMHS system.

**Recommendation 8:** Develop an active, data-driven process for determining level of care that is integrated with an effective process for referrals to non-specialty mental health and/or primary care and impacts the high level of retention with over 15 services.

Status: Partially Met

- The MHP is developing a data-driven adult level of care system that is going to include the Behavior and Symptom Identification Scale-24 (BASIS-24), Treatment Perception Survey (TPS), and the Milestones of Recovery Scale (MORS). Within the Youth and Family (Y&F) division the Child Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35), as well as the TPS are utilized to inform the clinical assessment process.
- The MHP plans to utilize these instruments to assist in determining service level needs and levels of care. This remains a work in progress, with some elements currently in active use. Development of a unified report which reflects aggregate, individual scores from the various elements for each major population is still in the development phase and is not ready for routine production.

**Recommendation 9:** By the next CalEQRO review, evaluate and improve the process by which beneficiaries gain access to services. Utilize the lessons learned from the same-day access pilots, modify and implement changes throughout the system that minimize the time from first contact to definitive clinical and psychiatry treatment

services. This should include attention to automating the remaining paper-based process with Netsmart Avatar, while involving staff from both Community Based Organizations (CBO) and directly operated programs for priorities and guidance.

Status: Met

- Since the previous review, the MHP has expanded initial access to care improvement strategies from Santa Paula to the North and Sound Oxnard Clinics. Each clinic and population have tailored changes that decrease time to first offered and kept service.
- Interventions include: 1) Embedding STAR staff at the clinics to improve linkage to the community and clinic teams, 2) Employing a group orientation/assessment model using peers assist in imparting information about resources, and address high numbers of referrals, 3) Training additional clinic staff to process requests for services (RFS) and perform assessments as an adjunct to STAR, and 4) Streamlining the referral and assessment process.
- The impact on time to service has been significant with recent most recent data indicating compliance with DHCS standards (70 percent, 10 business days, kept appointment) for timely access to services.
- The MHP plans to expand access to care improvements to the East County, Conejo/Simi Valley regional clinics, seeking to develop clinic-specific improvements that best fit the staffing, populations served, and demand volume at each location.

**Recommendation 10:** Evaluate the process that requires all contract providers to originate with STAR/Access functions. Test out alternatives to this process that results in improved utilization of open treatment slots.

Status: Met

- The MHP policy requiring RFS be sent to the STAR program has recently received review and modification. Contract programs which utilize licensed clinical staff will be able to receive and process initial requests for service, perform an assessment, and initiate treatment. This should improve access and time to treatment. Monitoring by the utilization review (UR) team will ensure medical necessity is met.
- Implementation of this change is pending changes to the RFS document.
- The expected outcomes of the operational change include improved access, shorter time to services, enhancing CBO relationships with the communities they serve, and decreased demand on STAR staff. It is expected that all CBOs will be trained and fully operational in this process by March 1, 2020.

**Recommendation 11:** Continue with the telehealth improvement project, while including telehealth recipients in the PIP team. Their input will assist with the refresh of

the telehealth survey document, the identification of key issues and furnish suggestions for solutions.

Status: Met

- The formal telehealth PIP has been terminated. However limited aspects of telehealth are continuing.
- The new provider of psychiatry/prescribing services seeks to meet capacity needs through direct hires of in vivo practitioners without reliance upon extensive telehealth services.
- During the course of the review, VCBH mentioned new developments for the use of telehealth. These include:
    - Telehealth consults with the Santa Paula Hospital emergency department patients.
    - Telehealth is being planned for redistribution of under-utilized practitioner capacity, such as when in one location a no-show occurs and psychiatry is needed at that time in another location.
    - Potential telehealth utilization with the Sprinter vans that are being acquired for crisis response and transport. Telehealth could support early medications and other clinical evaluations before transport occurs, and decrease the frequency with which crisis response requires a transport.
- The specifics of this recommendation were not applicable at the time of this review; however, the MHP's considerations around telehealth are in alignment with intent of recommendations. Telehealth is being considered as more than a replacement for onsite staffing, but as a platform for improving accessibility of psychiatry services in various use cases.

## Timeliness Recommendations

**Recommendation 12:** Utilize pilots such as Conejo and Santa Paula to develop sustained system changes that improve each regional clinic's capacity to meet spikes in demand, such as flexibly augmenting STAR assessors with clinic staff.

Status: Partially Met

- The improvement efforts to decrease time to first offered and first clinical service have demonstrated success, which the MHP is expanding to all regions and populations served with variations in approach according to demand, population, and location.
- The latest improvements have yet to impact across all regions, which results in this recommendation receiving a partially met rating.

**Recommendation 13:** Implement the Netsmart Avatar Scheduling module and require its use for all clinical appointments to address Timeliness Self-Assessment items the MHP cannot currently capture.

Status: Met

- The Avatar Scheduler module is projected to go-live as a pilot project in March 2020. After an evaluation period lasting between 45 to 60 days, the module will be rolled out department wide.
- All relevant staff will be trained on the use of the scheduler module. The module will allow the MHP to track timeliness of all (offered, scheduled, kept) clinical and psychiatric appointments to better evaluate quality of care and compliance.

**Recommendation 14:** Include MHP and CBO timeliness data in the MHPs dashboards. Depending on the contract provider program role, tracking the time from referral to first service could be a useful metric.

Status: Partially Met

- The inclusion of CBO timeliness data in MHP data dashboards is still under development.
- Licensing restrictions/costs limit making the dashboards available to the CBO. However, Avatar reports will be available to monitor their own performance.

## Quality Recommendations

**Recommendation 15:** Clarify the expectations of clinicians to provide call-backs to beneficiaries who leave requests between visits, and ensure staff are informed of the expectation.

Status: Met

- The MHP has communicated callback expectations to programs and staff. This is reinforced through ongoing clinical supervision discussions, staff meetings, treatment review, and clinical trainings.

**Recommendation 16:** Develop a mechanism to provide staff who are serving in an interpreter role to receive productivity credit or clear adjustment of expectations for this essential but non-Medi-Cal claimable activity.

Status: Met

- The MHP's staff providing interpretation services are to account for this time using a non-billable code (i.e., 6002). This is counted as "Other Productive Time" (OPT) which is tracked and included in productivity reports to ensure staff receive credit for this non-billable yet necessary activity.

- Clinic administrators' understandings of what constitutes for OPT varies. This area would benefit standard definitions that are consistently applied.

## Beneficiary Outcomes Recommendations

**Recommendation 17:** The development of a robust warmline, perhaps using the Friendship Line as a prototype, would offer a supportive option for beneficiaries that could decrease unnecessary calls to the crisis number.

Status: Met

- The MHP has started utilizing the peer-run warmline operated by the Mental Health Association of San Francisco. This should offer the support to beneficiaries that can help with support needs that do not require clinical or crisis services (https://www.mentalhealthsf.org/peer-run-warmline/).

**Recommendation 18:** Increase the percentage that the MHP meets the 7-day post-hospitalization follow-up rate.

Status: Partially Met

- The rate of 7-day post-hospitalization declined from 45 percent in CY 2017 to 40 percent in CY 2018 based on the EQRO Performance Measures report for CY 2018, although in both years it was above the state average.
- The MHP's clinical PIP to reduce rehospitalization rates reports the 7-day follow-up visit rate based on more recent data than the EQRO Performance Measures report. An overall 7-day follow-up visit rate of 47 percent is shown for the first six months of CY 2019.
- All outpatient programs have slots available each week to ensure access to appointments within the seven-day follow-up standard.
- The MHP has developed an internal AVATAR tracking form to more accurately capture and track all hospitalizations and follow-up services. This data will be available in the next reporting period.

**Recommendation 19:** Monitor whether improvements in post-hospital 7-day follow-up reduces the re-hospitalization rates.

Status: Partially Met

- The MHP is tracking post-hospitalization follow-up rates, and for FY 2018-19 Q4 was 61 percent for the 30-day metric, a very slight dip from the prior two quarters; it does not appear that 7-day post-hospital follow-up rates have improved.
- The 30-day readmission rates have increased during the period tracked for the concept PIP. Since late CY 2017, the 30-day rate has increased from 10 percent to 19 percent for FY 2018-19 Q4, with a small dip in mid-2018.

- The PIP addressing this topic was started on 1/1/2020, and has not yet gained active status with interventions that are currently implemented. This focus for a PIP would appear supported by the data, and also needs to address the non-County discharges that have a higher readmission rate than the Hillmont county facility.

**Recommendation 20:** The MHP needs to determine the most effective approaches to reaching beneficiaries, ensuring they remain informed of service delivery changes throughout treatment, and are reminded of their opportunities to participate in planning and feedback activities.

Status: Partially Met

- For the most part, beneficiaries in beneficiary focus groups were unaware of opportunities to participate in MHP planning and feedback activities.
- For Youth and Family, the MHP's response did not directly address providing information about opportunities to participate in MHP planning and feedback activities.
- The communication process with adults remains under development within the adult system of care.
- The current review identified the communication of consumer perception survey results for both adults and parents/caregivers of youth that currently lacks a methodology for ensuring information of survey results are available to interested stakeholders at individual clinic sites.

**Recommendation 21:** Provide CBOs with access to CANS and MORS data in Avatar.

Status: Met

- The Adult Division has expanded contractor use of Avatar to PathPoint and is doing the same with Golden State Crisis Residential Treatment and Golden State Hillmont House.
- Youth and Family has continued to offer and support CBOs in getting access to Avatar and to CANS reporting tools. A new set of reporting tools has been established and CBOs completing CANS have access.
- The MHP provides direct data entry into Avatar to all contract providers, and has recently moved to provide all CBOs not already using the MHPs Avatar system with read-only access to AVATAR information with beneficiaries they are serving.

## Foster Care Recommendations

**Recommendation 22:** Incorporate FC tracking of initial psychiatry access and urgent care in timeliness reporting improvements that will be made this year.

Status: Partially Met

- Tracking of initial psychiatry access is occurring with all children, inclusive of FC status which is flagged by the STAR program.
- The Assessment of Timely Access for this review included time to first psychiatry appointment for FY 2018-19. Overall, psychiatry referrals for foster care children, and youth to County-operated providers met the 15-day standard 17 percent of the time, with a mean time to appointment of 79 days. This data reflects events occurring before the changeover of psychiatry provider, with improvements anticipated as Traditions Behavioral Health fills the needed psychiatry slots with long-term hires.
- Urgent care data reporting for children and youth and FC reflected zero events.
- The absence of urgent events for children and youth and FC raises questions as to the sensitivity of the current process in the capture of all urgent care request events and the fulfillment of that service need, particularly those occurring following the initial assessment period.

**Recommendation 23:** Complete the process for providing Public Health Nurses (PHN) with Avatar access related to FC beneficiaries.

Status: Met

- PHNs supporting the FC/dependency services system have been provided to review the EHR and prescribing for FC youth.
- The nursing staff assigned to child welfare services, and who work at the juvenile facility, have access to the AVATAR EHR, to assist with follow-up and medication queries.

**Recommendation 24:** Explore with neighboring MHPs whether there exist strategies that expedite the JV-220 process and decrease the time for initial medication approvals and changes of dosage or medication.

Status: Met

- The MHP participated in a convening with the state department of social services (DSS) that reviewed and explored the barriers to effective strategies in the care of dependency children.
- The MHP maintains ongoing quarterly dialogue with local group homes and short-term residential treatment programs (STRTP), encouraging acceptance of referrals while documentation (outdated JV-220s for example) is updated.
- The delays related to the JV-220 court review process is a focus of discussions and problem solving with local child welfare representatives.
- Resolution of this matter appears to be reliant on state-level intervention.

## Information Systems Recommendations

**Recommendation 25:** In next year's ISCA, include at least one major initiative to improve workflow and access to information for contract providers. Consider eliminating double data entry for claims submission and/or simplifying and accelerating the authorization to provide services process.

Status: Met

- During the past year, six contracted provider organizations have migrated into the MHP Avatar environment. Three of the providers are mental health contracted providers with over 130 Avatar licenses dedicated to their users. The other three contracted providers who migrated into the MHP Avatar environment are DMC-ODS contractors.
- A recent executive team decision will allow full Avatar access for all CBOs, allowing them to obtain clinical information for shared clients without the need to scan paper and exchange faxes.
- The MHP has also changed its policy so that CBO can now initiate RFSs themselves and move directly to providing an assessment. STAR is notified, but they are no longer required to wait for STAR to generate the RFS to initiate services.
- The MHP is not prepared to support acceptance of upload data tables submitted by contract providers, therefore for those entities not using the MHP's AVATAR EHR double data entry is required.

**Recommendation 26:** Implement the Netsmart Avatar scheduling system and link it to clinical documentation to streamline the documentation process, improve the capture of no shows, and capture timeliness data from contract provider who use Avatar. This should be a priority that begins before the next CalEQRO Review.

Status: Partially Met

- AVATAR Scheduler will begin a pilot phase in March 2020. It will go into MHP-wide use 45-60 days later.
- Use of this module will allow the MHP to track no-show data and timeliness of all (offered, scheduled, kept) clinical and psychiatric appointments by MHP and CBOs providers using the MHP instance of Avatar as their electronic health record system.
- The MHP is currently not linking Avatar Scheduler to documentation functions because of unresolved concerns regarding billing errors that may result. They will continue to work with Netsmart to evaluate this option for the future.

**Recommendation 27:** Formally monitor EHR percentage of uptime and availability (including telecommunications downtime that impacts system access) to determine if system hosting and telecommunications contract terms are being met by the vendors.

Consider making this information available to users so that they know the facts about uptime and availability.

Status: Met

- The Avatar Outage Log tracks all Avatar downtime events, including partial outages.
- An update of Avatar availability was provided during the EQRO ISCA session. No downtime was related to Netsmart data center issues.

**Recommendation 28:** By the next EQRO review, identify the causes of the very slow Avatar logon process and reduce logon time to something prescribers agree is acceptable.

Status: Partially Met

- The MHP is in the process of measuring Avatar logon times at all MHP clinic locations. Since the results vary widely by location, it does not appear that slow logon times originate at the Netsmart data center.
- The average logon time at MHP clinics is 70 seconds, but they have recorded times as long as three minutes. The MHP attributes the widely varying logon times to factors such as computer age or network links to and internal networks within clinic locations.
- The monitoring has identified locations or individual PCs that have slow logon times, but no changes have been made that directly and broadly reduce slow logon times.
- For clinicians already time-constrained by heavy caseloads and documentation requirements, slow logon times are just one more source of frustration. This item requires follow up in the FY 2020-21 CalEQRO review.

## Structure and Operations Recommendations

**Recommendation 29:** By the next CalEQRO, identify the causes of delayed submission of claims and inaccurate claims that result in denials and develop a plan of correction that includes specific actions to be taken, who is responsible for those actions, and the expected completion date.

Status: Partially Met

- The delayed submission of claims was due to brief leave of absence of an employee. Staffing was restructured and the submission of claims by the Billing Department returned to normal processing.
- The top three reasons for claim denial were: Other Health Coverage, Duplicate Service, and Beneficiary not Eligible. Corrective actions that have taken place are as follows:

  - For Other Health Coverage, training of staff to understand the order of other health coverage in Avatar was needed. This training took place and the guarantor order is now entered correctly in Avatar. The rate of occurrence for this error should decline in the coming months.

  - Beneficiary Not Eligible is also trending down compared to previous years. Staff is required to verify eligibility monthly and update Avatar with current information. The MEDS file is also used to populate Medi-Cal eligibility, but we still have challenges with the gender not matching in some cases. This can be fixed under the financial eligibility screen which is corrected by the Billing staff.

  - Duplicate Services are also trending down and a pre-billing duplicate service report is run to catch possible duplicates and determine if the modifier is to be added or if it is a true duplicate service. There have been discussions about updating Avatar to show a warning of a possible duplication of service. A decision has not yet been made about this change, but it remains under consideration because it could eliminate some of the manual process.

- The Billing Department has two additional employees that work the 835 reconciliation of claims and claim denials. This is an addition since last CalEQRO review and allows the Billing Department to review and work the 835's daily, including rebilling of previously denied claims.

**Recommendation 30:** Review CBO compensation levels and consider increases that recognize the cost of delivering services and the need to recruit and retain qualified employees who can consistently deliver timely quality care.

Status: Partially Met

- In FY 2018-19, the MHP provided salary rate increases for 52 percent of mental health contracts. These increases were largely driven by the minimum rate increases authorized by DHCS.

- In FY 2019-20, the MHP provided salary rate increases in 19 percent of mental health contracts. These increases were tied to the increase in the State minimum wage rates and included cost of living adjustments. This suggests that some CBO employees were earning at or near the minimum wage, which may explain why some contract agencies reported they are losing employees to fast food restaurants.

**Recommendation 31:** Make MHP dashboards accessible to line staff. Where necessary, adjust the drill-down capability so that line staff have access to summary information and their own performance data, but they do not have access to data on their colleague's performance except at the summary level.

Status: Not Met

- This is a work in progress, with licensing constraints for the dashboard software will limit how broadly dashboard access can be provided.
- The MHP may wish to explore alternatives for providing dashboard reporting to line staff and the CBOs that do not require the use of dashboard software.
- Given the new performance measurement tools implemented this past year (CANS, PSC-35, MORS, TPS), the MHP intends to develop a new project plan toward the goal of designing information distribution for direct-care staff.

**Recommendation 32:** Consider establishing an IT organizational division with its leader a member of the leadership team, reporting to the top-level leadership.

Status: Partially Met

- MHP IT staff report to the Ventura County Health Care Agency (HCA) IT Department.
- Three IT staff positions, plus an unknown level of support from HCA IT for network connectivity, currently support over 800 Avatar users.
- In the past year the MHP enhanced the electronic health record team with the addition of three full-time positions for data analysis.
- The Sr. Program Administrator now reports within the MHP to the newly designated Special Projects Division Chief.
- There is still no direct IT representation on the MHP Leadership team.

## Carry-over and Follow-up Recommendations from FY 2017-18

**Recommendation 33:** Develop a comprehensive plan for crisis services that includes establishment of a frequent, ongoing liaison and consultation relationship with each local emergency department, so coordination of MHP beneficiaries" care is optimized, alternative resources are considered, for those who either self-present or are taken by law enforcement to local hospitals.

Status: Partially Met

- This remains work under consideration in the Adult Division.
- In addition to the regular meetings facilitated by the Hospital Administrators of Southern California, a new series of meetings with emergency staff (i.e., ER physicians, county EMS, and private ambulance companies) hosted by Dr. Romero (head of VCMC's ER) have begun. VCBH is an active participant.

**Recommendation 34:** Identify and resolve issues that are related to current and future Medi-Cal claims denials, including the analysis, correction, and resubmission of previously denied claims as allowed under state regulations. A periodic analysis of the

contractor's performance with eligibility must occur. This is to include identification of the causes of delayed submission of claims and inaccurate claims that result in denials.

Status: Met

- See response to Recommendation 29 above.

**Recommendation 35:** Identify and resolve issues related to the MHP's inability to meet the urgent care three-day standard for the adult system of care, inclusive of contract providers.

Status: Partially Met

- VCBH FY 2018-19 data shows two requests for urgent services and both were delivered within the then three-day standard. This was also the case in the prior FY 2017-18 period.

- It seems unusual that only two events would comprise the urgent care requests for this large MHP's total served population, and some work seems needed to study the process and ensure the identification and capture of these events is effective and reliable. The tracking should address urgent need at initial request for service as well as those in mid-treatment.

**Recommendation 36:** The MHP has selected MORS as an adult level-of-care instrument and is currently involved in implementation. The work remaining is to incorporate MORS into the annual review of beneficiary status and the stepdown/discharge planning process.

Status: Partially Met

- The MHP has begun to collect and synthesize self-report data from beneficiaries clients regarding their experience of symptoms (i.e., Basis 24+) and perception of services (i.e., Treatment Perception Survey), which is beginning to be considered in combination with the staff assessment of progress using the Milestones of Recovery Scale (MORS) and the internally developed acuity rating (i.e., measures recent /frequency of psychiatric hospitalization).

- The information obtained from these metrics and process will be reviewed when determining level of care need, and possibility of step down to managed care providers.

- While this integrated multi-instrument approach is yet to be finalized and implemented, progress has been made. With the coming year, EQR will be looking to see regular production and use of this data in the clinical reassessment process.

# PERFORMANCE MEASUREMENT

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

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

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

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

---

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

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

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

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

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

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

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

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

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

## Total Beneficiaries Served

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

| Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Ventura MHP | | | | |
|---|---|---|---|---|
| **Race/Ethnicity** | **Average Monthly Unduplicated Medi-Cal Enrollees** | **% Enrollees** | **Unduplicated Annual Count Beneficiaries Served** | **% Served** |
| White | 48,943 | 21.3% | 3,253 | 33.1% |
| Latino/Hispanic | 137,557 | 59.7% | 4,355 | 44.3% |
| African-American | 3,312 | 1.4% | 289 | 2.9% |
| Asian/Pacific Islander | 9,009 | 3.9% | 196 | 2.0% |
| Native American | 491 | 0.2% | 34 | 0.3% |
| Other | 30,960 | 13.4% | 1,712 | 17.4% |
| **Total** | **230,271** | **100%** | **9,839** | **100%** |
| The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently. | | | | |

- The MHP experienced claims submission delays for November and December 2018 services that resulted in most of the claim transactions for those months not being included in CY 2018 Penetration Rates (PR) and Approved Claims per Beneficiary (ACB) results presented below in Figures 1-3 and Tables 2-3.

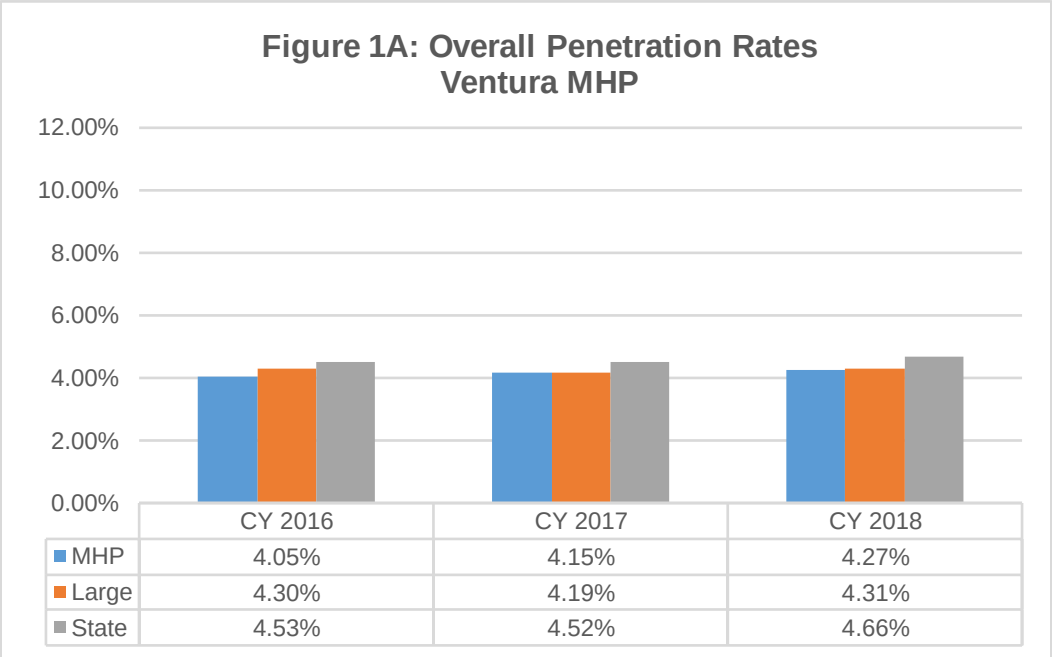
## Penetration Rates and Approved Claims per Beneficiary

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

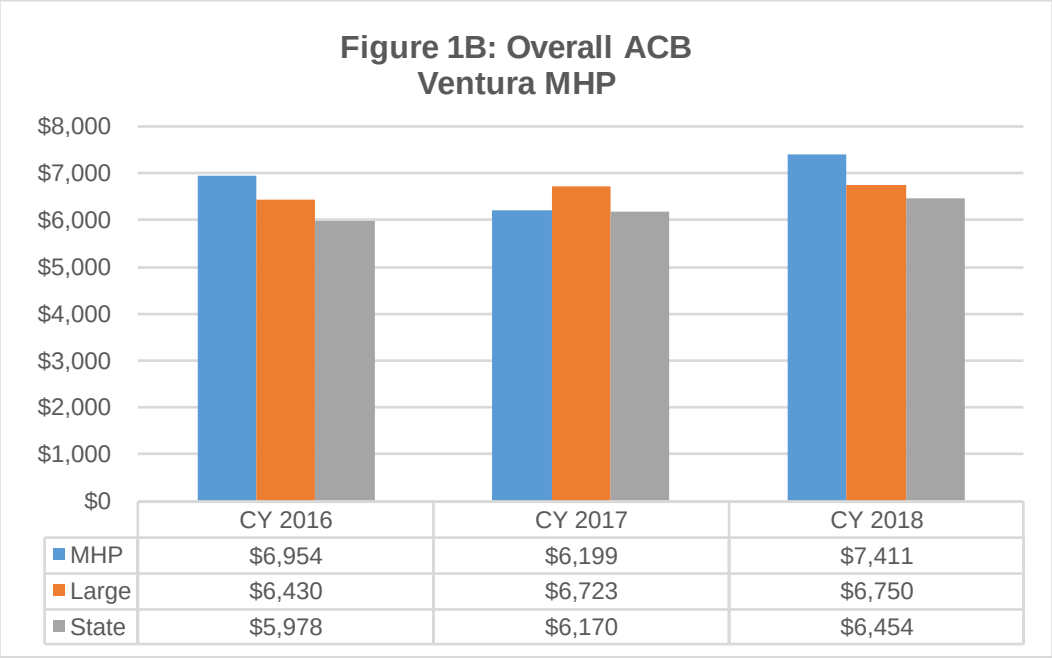
CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2018. See Table C1 for the CY 2018 ACA penetration rate and ACB.

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

Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.



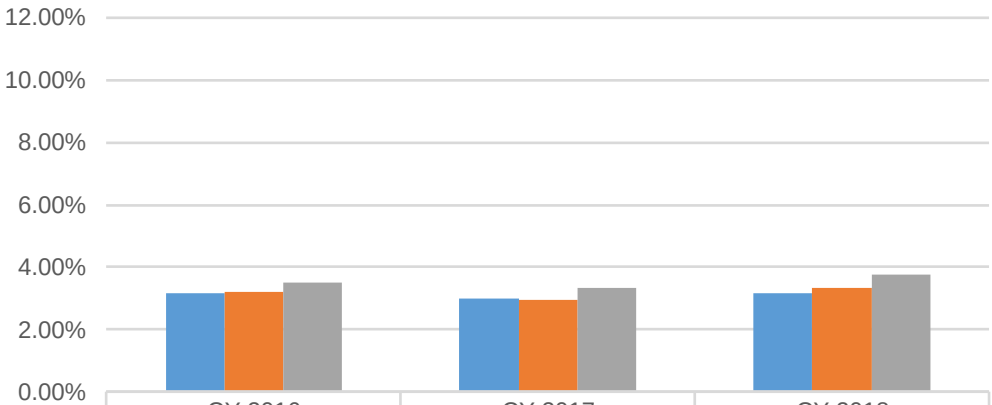

| | CY 2016 | CY 2017 | CY 2018 |
|---|---|---|---|
| MHP | 4.05% | 4.15% | 4.27% |
| Large | 4.30% | 4.19% | 4.31% |
| State | 4.53% | 4.52% | 4.66% |




| | CY 2016 | CY 2017 | CY 2018 |
|---|---|---|---|
| MHP | $6,954 | $6,199 | $7,411 |
| Large | $6,430 | $6,723 | $6,750 |
| State | $5,978 | $6,170 | $6,454 |

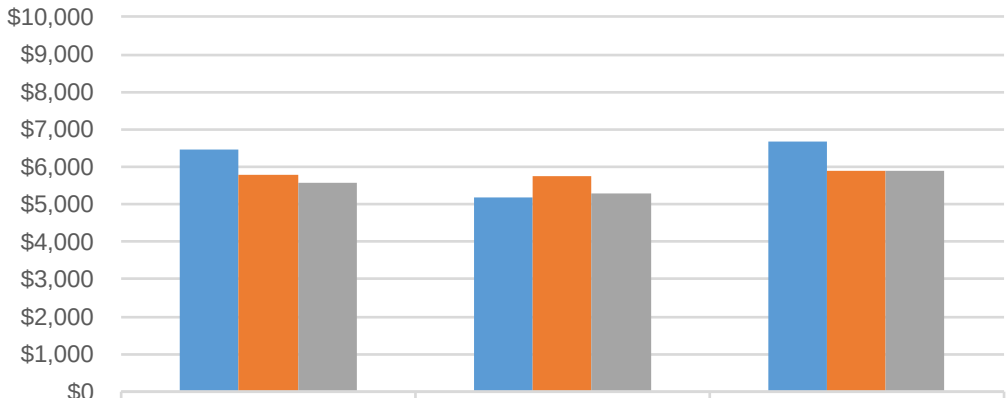
Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

**Figure 2A: Latino/Hispanic Penetration Rates**
**Ventura MHP**




| | CY 2016 | CY 2017 | CY 2018 |
|---|---|---|---|
| MHP | 3.18% | 2.98% | 3.17% |
| Large | 3.21% | 2.97% | 3.33% |
| State | 3.51% | 3.35% | 3.78% |

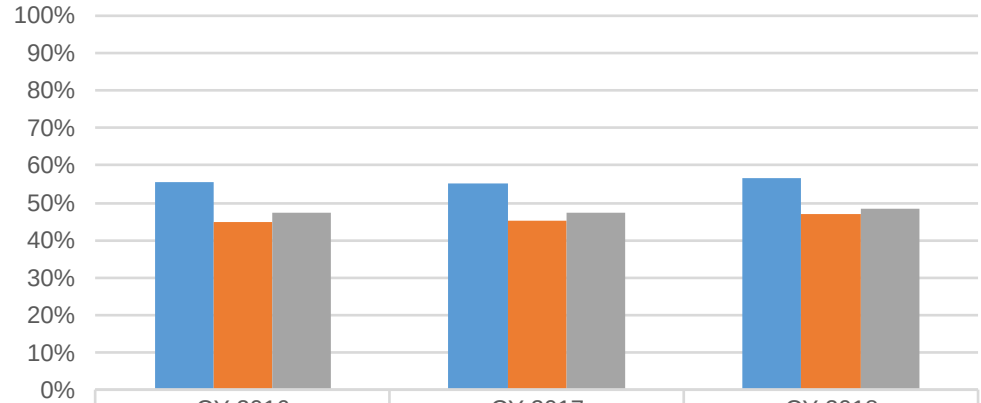
**Figure 2B: Latino/Hispanic ACB**
**Ventura MHP**




| | CY 2016 | CY 2017 | CY 2018 |
|---|---|---|---|
| MHP | $6,455 | $5,187 | $6,662 |
| Large | $5,785 | $5,758 | $5,884 |
| State | $5,588 | $5,278 | $5,904 |

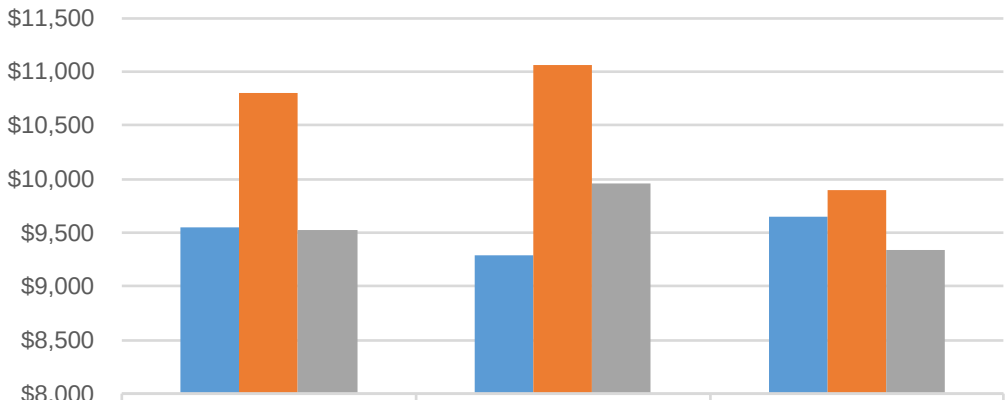
Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

**Figure 3A: FC Penetration Rates**
**Ventura MHP**




| | CY 2016 | CY 2017 | CY 2018 |
|---|---|---|---|
| MHP | 55.40% | 55.28% | 56.51% |
| Large | 44.78% | 45.37% | 46.87% |
| State | 47.48% | 47.28% | 48.41% |

**Figure 3B: FC ACB**
**Ventura MHP**




| | CY 2016 | CY 2017 | CY 2018 |
|---|---|---|---|
| MHP | $9,544 | $9,285 | $9,650 |
| Large | $10,805 | $11,064 | $9,895 |
| State | $9,521 | $9,962 | $9,340 |

## High-Cost Beneficiaries

Table 2 provides the three-year summary (CY 2016-18) MHP HCBs and compares the statewide data for HCBs for CY 2018 with the MHP's data for CY 2018, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

**Table 2: High-Cost Beneficiaries**
**Ventura MHP**

| MHP | Year | HCB Count | Total Beneficiary Count | HCB % by Count | Average Approved Claims per HCB | HCB Total Claims | HCB % by Total Claims |
|---|---|---|---|---|---|---|---|
| Statewide | CY 2018 | 23,164 | 618,977 | 3.74% | $57,725 | $1,337,141,530 | 33.47% |
| MHP | CY 2018 | 408 | 9,839 | 4.15% | $58,474 | $23,857,306 | 32.72% |
| | CY 2017 | 315 | 9,884 | 3.19% | $55,716 | $17,550,410 | 28.64% |
| | CY 2016 | 413 | 9,854 | 4.19% | $54,782 | $22,625,105 | 33.02% |

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

## Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2016-18) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

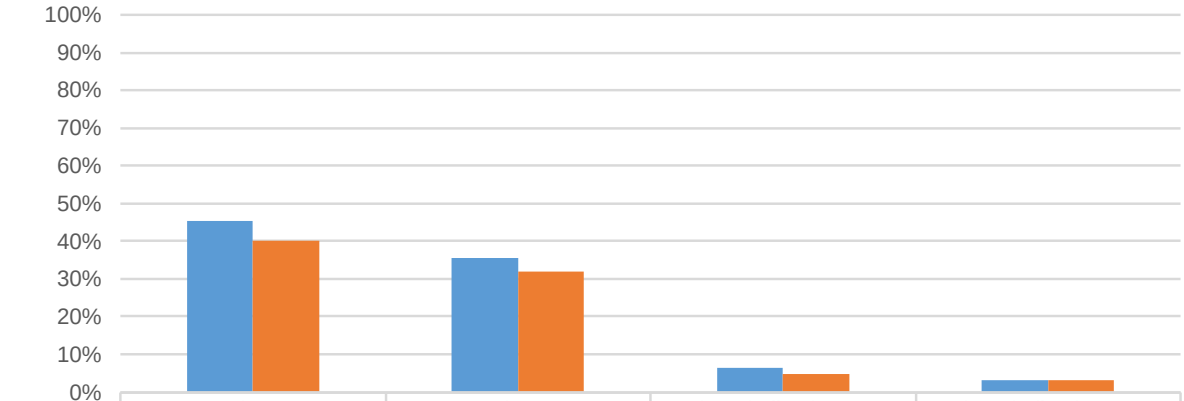
**Table 3: Psychiatric Inpatient Utilization - Ventura MHP**

| Year | Unique Beneficiary Count | Total Inpatient Admissions | Average LOS | ACB | Total Approved Claims |
|---|---|---|---|---|---|
| CY 2018 | 1,073 | 2,788 | 6.71 | $11,324 | $12,150,506 |
| CY 2017 | 985 | 2,201 | 6.32 | $9,040 | $8,904,597 |
| CY 2016 | 970 | 2,625 | 5.86 | $9,380 | $9,098,864 |

# Post-Psychiatric Inpatient Follow-Up and Rehospitalization

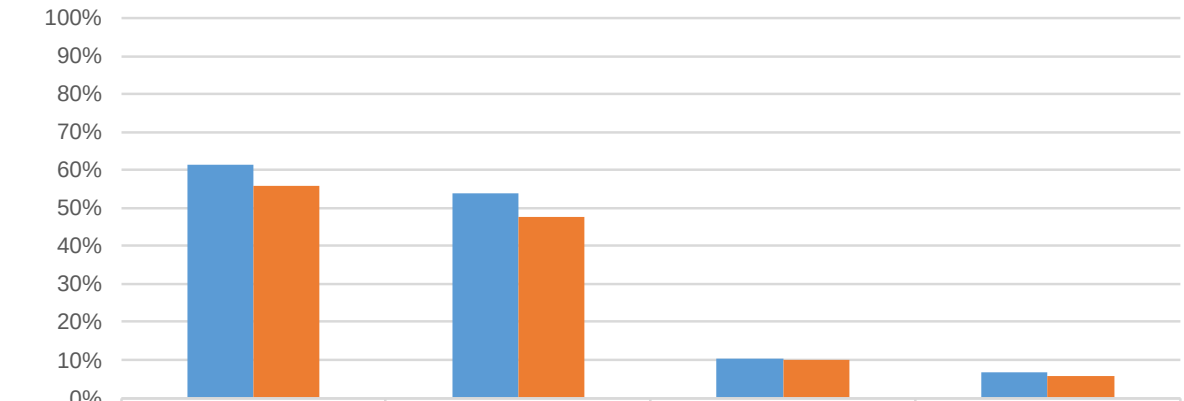
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

**Figure 4A: 7-Day Post-Psychiatric Inpatient Follow-up**
**Ventura MHP**




| | Outpatient MHP | Outpatient State | Rehospitalization MHP | Rehospitalization State |
|---|---|---|---|---|
| CY 2017 | 45% | 36% | 7% | 3% |
| CY 2018 | 40% | 32% | 5% | 3% |

**Figure 4B: 30-Day Post-Psychiatric Inpatient Follow-up**
**Ventura MHP**



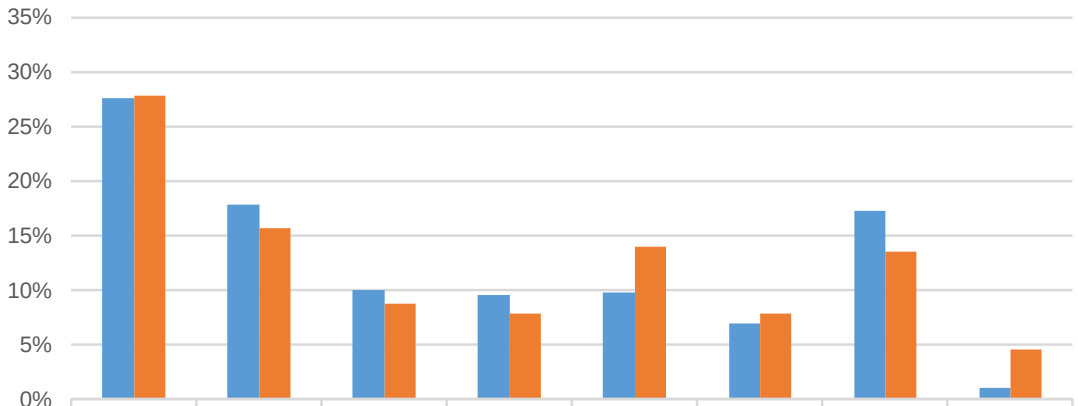

| | Outpatient MHP | Outpatient State | Rehospitalization MHP | Rehospitalization State |
|---|---|---|---|---|
| CY 2017 | 61% | 54% | 10% | 7% |
| CY 2018 | 56% | 48% | 10% | 6% |

# Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2018.

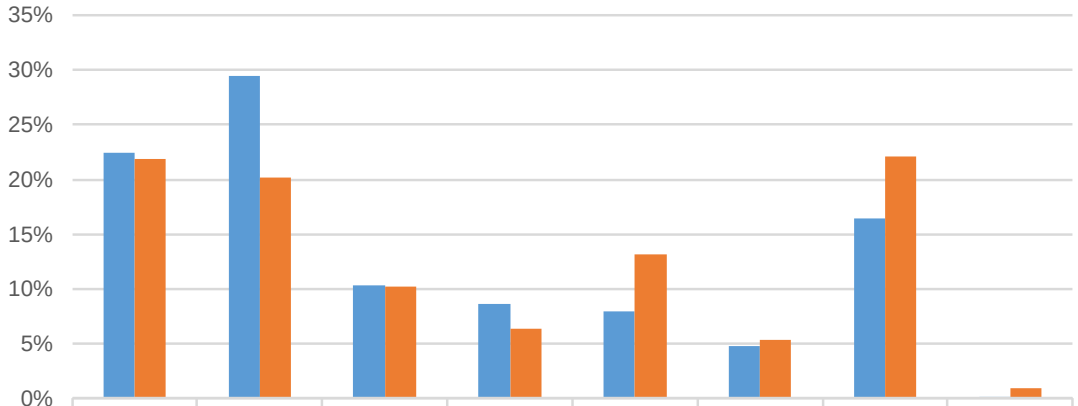
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 49 percent.

**Figure 5A: Diagnostic Categories, Beneficiaries Served Ventura MHP**




| | Depression | Psychosis | Disruptive | Bipolar | Anxiety | Adjustment | Other | Deferred |
|---|---|---|---|---|---|---|---|---|
| MHP CY 2018 | 28% | 18% | 10% | 10% | 10% | 7% | 17% | 1% |
| State CY 2018 | 28% | 16% | 9% | 8% | 14% | 8% | 14% | 5% |

**Figure 5B: Diagnostic Categories, Total Approved Claims Ventura MHP**




| | Depression | Psychosis | Disruptive | Bipolar | Anxiety | Adjustment | Other | Deferred |
|---|---|---|---|---|---|---|---|---|
| MHP CY 2018 | 22% | 29% | 10% | 9% | 8% | 5% | 16% | 0% |
| State CY 2018 | 22% | 20% | 10% | 6% | 13% | 5% | 22% | 1% |

# PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

## Ventura MHP PIPs Identified for Validation

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

Table 4 lists the PIPs, submitted by the MHP.

**Table 4: PIPs Submitted by Ventura MHP**

| PIPs for Validation | # of PIPs | PIP Titles |
|---|---|---|
| **Clinical PIP** | 1 | Post-Hospitalization Performance Improvement Project |
| **Non-clinical PIP** | 1 | Enhanced Access Performance Improvement Project |

## Clinical PIP—Post-Hospitalization Performance Improvement Project

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

"Will the use of a Post-Hospitalization Intensive Case Management model reduce 7-day and 30-day readmission rates for IPU cases by 25% in Year 1 and 50% in Year 2?"

**Date PIP began:** January 2020

**End date:** December 2021

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

The MHP tracked 7-day and 30-day rehospitalization rates following acute psychiatric inpatient unit discharges. From 2017 through 2019, both metrics have experienced steady increases in readmissions, with slight dips in October-December of 2018. The more inclusive 30-day metric for April-June 2019 reflected readmissions rising to 19 percent.

Post-hospitalization follow-up is a significant aspect of rehospitalization prevention. Between CY 2017 and 2018, EQR data reflected a 5 percent drop in the occurrence of 30-day follow-up, from 45 to 40 percent. Statewide, the average dropped by 4 percent, from 36 to 32 percent. The lower achievement percentages in addition to the drop in the metric support the importance of this topic.

The MHP has explored the reasons for readmissions, and has identified the need to perform better discharge planning and aftercare. This is conceptualized as improving continuity of care between inpatient and outpatient follow-up. The MHP plans to implement an intensive case management program with the individuals admitted to the Hillmont Inpatient Psychiatric Unit.

**Suggestions to improve the PIP:** The data provided by the MHP indicates that the non-county inpatient episodes have experienced the highest readmission rate (22 percent), much higher than the county psychiatric unit (13 percent). This would suggest that efforts to address the non-county discharge population should not be delayed and should perhaps be simultaneous with the county-operated hospital. The MHP already has a concurrent review process in place, as required by NACT/DHCS standards. This process might serve as possible dual function of concurrent inpatient review and aftercare planning without the resource intensity of dedicated case managers.

A clinical PIP requires the use of a clinical approach beyond the basic addition of more staff resources. An evidence-based practice that improves engagement with care would be a possibility. With regard to tracked metrics, a clinical outcome measure, such as improvement of MORS scores or satisfaction, is another aspect which needs to be identified and included in addition to rehospitalization rates.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of ongoing email and telephonic consultation to provide support to MHP efforts. Following the review there has been email communication of suggested revisions, with further telephonic TA available.

## Non-clinical PIP—Enhanced Access Performance Improvement Project

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

“Would the PIP interventions in the Santa Paula Adult and Youth & Family clinics, North Oxnard Adult Clinic, and South Oxnard Youth & Family Clinic increase the percentage of consumers receiving a first offered appointment and first face to face Medi-Cal service to meet the state’s standard of 70% receiving such services within 10 business days, consequently increasing penetration rates?”

**Date PIP began:** Phase I - August 2018; Phase II July 2019

**End date:** Phase I - August 2019; Phase II July 2020

**Status of PIP:** Active and ongoing

The non-clinical PIP has its origins in the concerns that the large Hispanic/Latino population in Santa Clara Valley, namely the Santa Paula and Fillmore areas, experienced lower penetration rates and more time from first request to first service compared to the rest of the county. These issues posed barriers to engagement with treatment services. Local advocacy groups highlighted the need for the adult and children's clinics to be more responsive, and provide quicker access than that provided by being furnished with the STAR telephone number and the related steps to obtain an assessment.

The MHP has changed practices in this region to encourage and support walk-ins, and provide quick engagement and assessment. This has entailed a change in practice for the local clinical staff as well as the assigned STAR staff. These changes have had the desired result.

In this past year, tailored approaches were also applied to the North and South Oxnard clinics. North Oxnard Adult Services implemented an orientation group, during which individuals who came for services were both provided with information by peer staff and one by one assessed by the assigned clinical staff. The South Oxnard clinic targeted Youth and Family services, enabling a new walk-in process.

The MHP's work within the PIP Outline document in which each of the regions are clearly separated for interventions and data reporting facilitates analysis for each regional implementation in a clear, cohesive fashion.

For this coming year the MHP plans to expand initial access to intakes through improvement interventions in the Conejo/Simi Valley areas. In these areas, the interventions will be tailored to the clinic and population demands of each site.

**Suggestions to improve the PIP:** As this PIP is a multi-year, continuing effort, which will see a change in regional focus and development of specific site-focused relevant interventions, both the PIP title and study question require modification to include the focus is on improving timeliness at specific clinic locations/sites beyond to Santa Paula. The study question requires separate elements that address application to each region of the county where circumstances and interventions will differ.

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

The TA provided to the MHP by CalEQRO consisted of discussion of the PIP onsite, and follow-up emails highlighting the needed modifications prior to the completion of the draft report. Further telephonic TA sessions are anticipated.

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

| Table 5: PIP Validation Review | | | | | |
|---|---|---|---|---|---|
| | | | | Item Rating | |
| **Step** | **PIP Section** | **Validation Item** | | **Clinical** | **Non-Clinical** |
| 1 | Selected Study Topics | 1.1 | Stakeholder input/multi-functional team | NR | M |
| | | 1.2 | Analysis of comprehensive aspects of enrollee needs, care, and services | NR | M |
| | | 1.3 | Broad spectrum of key aspects of enrollee care and services | NR | M |
| | | 1.4 | All enrolled populations | NR | M |
| 2 | Study Question | 2.1 | Clearly stated | NR | PM |
| 3 | Study Population | 3.1 | Clear definition of study population | NR | M |
| | | 3.2 | Inclusion of the entire study population | NR | M |
| 4 | Study Indicators | 4.1 | Objective, clearly defined, measurable indicators | NR | M |
| | | 4.2 | Changes in health states, functional status, enrollee satisfaction, or processes of care | NR | M |
| 5 | Sampling Methods | 5.1 | Sampling technique specified true frequency, confidence interval and margin of error | NR | NA |
| | | 5.2 | Valid sampling techniques that protected against bias were employed | NR | NA |
| | | 5.3 | Sample contained sufficient number of enrollees | NR | NA |
| 6 | Data Collection Procedures | 6.1 | Clear specification of data | NR | M |
| | | 6.2 | Clear specification of sources of data | NR | M |

| Table 5: PIP Validation Review | | | | | |
|---|---|---|---|---|---|
| | | | | Item Rating | |
| **Step** | **PIP Section** | **Validation Item** | | **Clinical** | **Non-Clinical** |
| | | 6.3 | Systematic collection of reliable and valid data for the study population | NR | M |
| | | 6.4 | Plan for consistent and accurate data collection | NR | M |
| | | 6.5 | Prospective data analysis plan including contingencies | NR | M |
| | | 6.6 | Qualified data collection personnel | NR | M |
| 7 | Assess Improvement Strategies | 7.1 | Reasonable interventions were undertaken to address causes/barriers | NR | M |
| 8 | Review Data Analysis and Interpretation of Study Results | 8.1 | Analysis of findings performed according to data analysis plan | NR | M |
| | | 8.2 | PIP results and findings presented clearly and accurately | NR | M |
| | | 8.3 | Threats to comparability, internal and external validity | NR | M |
| | | 8.4 | Interpretation of results indicating the success of the PIP and follow-up | NR | M |
| 9 | Validity of Improvement | 9.1 | Consistent methodology throughout the study | NR | M |
| | | 9.2 | Documented, quantitative improvement in processes or outcomes of care | NR | M |
| | | 9.3 | Improvement in performance linked to the PIP | NR | M |
| | | 9.4 | Statistical evidence of true improvement | NR | PM |
| | | 9.5 | Sustained improvement demonstrated through repeated measures | NR | PM |

Table 6 provides a summary of the PIP validation review.

| Table 6: PIP Validation Review Summary | | |
|---|---|---|
| **Summary Totals for PIP Validation** | **Clinical PIP** | **Non-clinical PIP** |
| Number Met | NR | 22 |
| Number Partially Met | NR | 3 |
| Number Not Met | NR | 0 |
| Unable to Determine | NR | 0 |
| Number Applicable (AP)<br>(Maximum = 28 with Sampling; 25 without Sampling) | NR | 25 |
| **Overall PIP Ratings** ((#M*2)+(#PM))/(AP*2) | **0%** | **94%** |

# INFORMATION SYSTEMS REVIEW

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

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

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

Table 7 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, and IT staff for the past four-year period. For comparative purposes, we have included similar size MHPs and statewide average IT budgets per year for prior three-year periods.

**Table 7: Budget Dedicated to Supporting IT Operations**

| | FY 2019-20 | FY 2018-19 | FY 2017-18 | FY 2016-17 |
|---|---|---|---|---|
| Ventura | 1.90%* | 4.75% | 4.32% | 5.00% |
| Large MHP Group | N/A | 2.70% | 3.00% | 0.00% |
| Statewide | N/A | 3.40% | 3.30% | 3.40% |

*The 1.90 percent of budget reported in Table 7 represents only the annual contract with Netsmart for the AVATAR software and related services. The numbers reported in prior years are closer to the budgeted amount for all IT systems and services as well as support staff, hardware, networking, etc.

The budget determination process for information system operations is:

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

Table 8 shows the percentage of services provided by type of service provider.

| Table 8: Distribution of Services, by Type of Provider | |
|---|---|
| **Type of Provider** | **Distribution** |
| County-operated/staffed clinics | 66.65% |
| Contract providers | 33.26% |
| Network providers | 0.09% |
| **Total** | **100%*** |

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

Table 9 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

| Table 9: Contract Providers Transmission of Beneficiary Information to MHP EHR System | | |
|---|---|---|
| **Type of Input Method** | **Percent Used** | **Frequency** |
| Direct data entry into MHP EHR system by contract provider staff | 100% | Daily |
| Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system | 0% | Not used |
| Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system | 0% | Not used |
| Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system | 0% | Not used |
| Paper documents submitted to MHP for data entry input by MHP staff into EHR system | 0% | Not used |
| Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR | 0% | Not used |

## Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of county-operated sites currently operational: 6
- Number of contract provider sites currently operational: 5

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

☒ Hiring healthcare professional staff locally is difficult
☒ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☒ To serve special populations (i.e. children/youth or older adult)
☒ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries

- Telehealth services are available with English and Spanish speaking practitioners (not including the use of interpreters or language line).
- Approximately 2400 telehealth sessions were conducted in Spanish.

## Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 10.

**Table 10: Technology Staff**

| Fiscal Year | IT FTEs (Include Employees and Contractors) | # of New FTEs | # Employees / Contractors Retired, Transferred, Terminated | Current # Unfilled Positions |
|---|---|---|---|---|
| 2019-20 | 3 | 0 | 0 | 0 |
| 2018-19 | 3 | 0 | 0 | 0 |
| 2017-18 | 3 | 0 | 0 | 1 |

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 11.

| Table 11: Data Analytical Staff | | | | |
|---|---|---|---|---|
| **Fiscal Year** | **IT FTEs (Include Employees and Contractors)** | **# of New FTEs** | **# Employees / Contractors Retired, Transferred, Terminated** | **Current # Unfilled Positions** |
| 2019-20 | 4 | 0 | 1 | 0 |
| 2018-19 | 5 | 1 | 0 | 0 |
| 2017-18 | 4 | 0 | 0 | 1 |

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

- Data Analytical staff serves both DMC-ODS and Short-Doyle/Medi-Cal programs.
- MHP QI added four new data analytical employees.

## Current Operations

- Some MHP Avatar users continue to have slow logon times. Slow logon times have not been linked to issues at the Netsmart data center where the MHP's instance of Avatar is hosted. The issues appear to be related to the MHP's network infrastructure (both WAN and LAN) and aging desktop hardware.
- There is functionality within Avatar relevant to some MHP issues that is not yet being used because of insufficient information systems resources to do additional projects. Batch uploads of CBO claim files, which would reduce CBO dual data entry, and possibly reduce claiming errors, is an example.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

| Table 12: Primary EHR Systems/Applications | | | | |
|---|---|---|---|---|
| **System/Application** | **Function** | **Vendor/Supplier** | **Years Used** | **Operated By** |
| Avatar Cal-PM | Practice Management | Netsmart | 10 | Netsmart Hosted |
| Avatar CWS | Electronic Health Record | Netsmart | 6 | Netsmart Hosted |
| Avatar Order Connect | Medications and Lab Orders | Netsmart | 6 | Netsmart Hosted |

## The MHP's Priorities for the Coming Year

- DMC-ODS Operational Treatment Model
- DMC-ODS Recovery Services Module
- MH Client Portal Implementation
- CSI Data Correction – comply with DHCS Plan of Correction notification
- Access to Service Collection & Reporting
- DHCS Network Adequacy Certification Tool (NACT) Collection & Reporting
- STRTP Enhancements to Full Service Partnership (FSP) Tracking Process
- DHCS NACT 274 Implementation

## Major Changes since Prior Year

- Psychiatric Inpatient Authorization and Access Tracking System
- Client Alert System Implementation
- CANS Data Submission to DHCS
- Notice of Adverse Benefits Determination Tracking System
- Incident Report Tracking System
- CSI Assessment Implementation
- Creation of a Special Projects Division Chief position to provide executive support for Quality, EHR, Access and other department wide initiatives.

- Conversion of Primary Care Integration records to Electronic Health Records (Cerner/Avatar). Fully transitioned to electronic billing/clinical documentation and care coordination.

## Other Areas for Improvement

- The MHP and Ventura Health Agency have yet to address the lack of IT staff resources and ongoing network connectivity issues as documented in this report.
- The MHP is not in compliance with billing Medicare Part B program for dual eligible (Medicare and Medi-Cal) beneficiaries. Refer to DHCS Behavioral Health Information Notices (IN) website for further information. Specifically reference IN 11-04, IN 10-23, IN 10-11, and IN 09-09 for guidance.
- The MHP public-facing website lacks ease-of-use (many click-throughs) for consumers who seek directory of provider information. The Provider Directory is not in compliance with some MHSUDS requirements, per IN 18-020.
- Two projects on the list of MHP priorities are on hold, STRTP Enhancements to FSP Tracking Process and DHCS NACT 274 Implementation, the reason provided was staffing limitations.
- The CSI Data Correction Plan of Correction (POC) provides corrected data to address errors in past CSI data submissions; as such it does not meet the requirement of a project that qualitatively moves the organization forward.
- The submitted project list is largely focused on response to regulatory changes and DMC-ODS implementation requirements. The MH Client Portal Implementation presents the most notable strategic change because of its potential for improving communication with beneficiaries.

## Plans for Information Systems Change

- There are no plans to replace current system (in place for more than five years).

## Current EHR Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

**Table 13: EHR Functionality**

| | | Rating | | | |
|---|---|---|---|---|---|
| **Function** | **System/Application** | **Present** | **Partially Present** | **Not Present** | **Not Rated** |
| Alerts | Netsmart Avatar | X | | | |

| Table 13: EHR Functionality | | | | | |
|---|---|---|---|---|---|
| | | Rating | | | |
| Function | System/Application | Present | Partially Present | Not Present | Not Rated |
| Assessments | Netsmart Avatar | X | | | |
| Care Coordination | Netsmart Avatar | | | X | |
| Document Imaging/ Storage | Netsmart Avatar | X | | | |
| Electronic Signature—MHP Beneficiary | Netsmart Avatar | X | | | |
| Laboratory results (eLab) | Netsmart Avatar | X | | | |
| Level of Care/Level of Service | Netsmart Avatar | | | X | |
| Outcomes | Netsmart Avatar | X | | | |
| Prescriptions (eRx) | Netsmart Avatar | X | | | |
| Progress Notes | Netsmart Avatar | X | | | |
| Referral Management | Netsmart Avatar | X | | | |
| Treatment Plans | Netsmart Avatar | X | | | |
| Summary Totals for EHR Functionality: | | | | | |
| FY 2019-20 Summary Totals for EHR Functionality: | | 10 | 0 | 2 | 0 |
| FY 2018-19 Summary Totals for EHR Functionality: | | 10 | 0 | 2 | 0 |
| FY 2017-18 Summary Totals for EHR Functionality: | | 7 | 1 | 4 | 0 |

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

- In the FY 19-20 ISCA, Level of Care/Level of Service was shown as Not Present, whereas last year it was shown as present.
- Referral Management was shown as Not Present both this year and last year, but discussion in the ISCA session indicated that Avatar referral functionality was being used.

## Personal Health Record (PHR)

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

☐ Yes ☐ In Test Phase ☒ No

| |
|---|
| Netsmart myHealthPointe |

If no, provide the expected implementation timeline.

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

## Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

| |
|---|
| Outside Consultant, Automated Data Retrieval System |

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

| Table 14: Summary of CY 2018 Short Doyle/Medi-Cal Claims<br>Ventura MHP | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Service Month** | **Number Submitted** | **Dollars Billed** | **Number Denied** | **Dollars Denied** | **Percent Denied** | **Dollars Adjudicated** | **Dollars Approved** |
| **TOTAL** | **335,525** | **$128,066,727** | **13,479** | **$7,228,483** | **5.64%** | **$120,838,244** | **$68,432,542** |
| JAN18 | 31,444 | $11,811,094 | 1,275 | $687,100 | 5.82% | $11,123,994 | $6,273,987 |
| FEB18 | 29,147 | $10,629,687 | 1,286 | $506,659 | 4.77% | $10,123,028 | $5,783,340 |
| MAR18 | 30,835 | $10,153,390 | 1,174 | $483,511 | 4.76% | $9,669,879 | $5,911,985 |
| APR18 | 29,474 | $11,274,623 | 1,197 | $715,410 | 6.35% | $10,559,213 | $5,934,834 |
| MAY18 | 31,930 | $12,421,416 | 1,275 | $810,540 | 6.53% | $11,610,876 | $6,283,996 |
| JUN18 | 27,254 | $11,342,208 | 1,062 | $669,895 | 5.91% | $10,672,313 | $5,418,310 |
| JUL18 | 27,109 | $10,917,326 | 1,054 | $520,261 | 4.77% | $10,397,065 | $5,777,443 |
| AUG18 | 28,281 | $11,755,640 | 1,137 | $792,232 | 6.74% | $10,963,408 | $6,021,715 |
| SEP18 | 25,641 | $10,767,480 | 1,024 | $664,634 | 6.17% | $10,102,846 | $5,469,689 |
| OCT18 | 29,359 | $11,914,275 | 1,309 | $773,208 | 6.49% | $11,141,067 | $6,293,978 |
| NOV18 | 23,391 | $9,387,521 | 853 | $373,865 | 3.98% | $9,013,656 | $5,280,689 |
| DEC18 | 21,660 | $5,692,067 | 833 | $231,168 | 4.06% | $5,460,899 | $3,982,577 |

Includes services provided during CY 2018 with the most recent DHCS claim processing date of June 7, 2019.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2018 was **3.25 percent.**

- The MHP experienced claims submission delays for November and December 2018 services that resulted in most of the claim transactions for those months not being included in table 14 results.
- The MHP denied claim rate (5.64 percent) for CY 2018 is higher than statewide denial rate (3.25 percent).

Table 15 summarizes the top three reasons for claim denial.

| Table 15: Summary of CY 2018 Top Three Reasons for Claim Denial<br>Ventura MHP | | | |
|---|---|---|---|
| **Denial Reason Description** | **Number Denied** | **Dollars Denied** | **Percent of Total Denied** |
| Medicare or Other Health Coverage must be billed before submission of claim. | 6,707 | $2,896,691 | 40% |
| Beneficiary not eligible, or emergency services or pregnancy indicator must be "Y" for this aid code. | 2,005 | $1,912,346 | 26% |
| Invalid procedure code and modifier combination OR single service exceeds maximum minutes per day. | 708 | $1,257,924 | 17% |
| **TOTAL** | 13,479 | $7,228,483 | N/A |

The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.

- Denied claim transactions with reason “Medicare or Other Health Coverage must be billed before submission of claim” are generally re-billable within the State guidelines.

# CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

## CFM Focus Group One

The first requested focus group was to consist of a culturally diverse group of 8-12 parents/caregivers of children and youth, with significant composition of Spanish-speakers, who have mostly initiated and utilized services within the prior 15 months. The session was conducted on day one of the review at the South Oxnard Clinic, 2500 South C street, Suite C, Oxnard, California. Actual session attendees were comprised of all female, several of who were monolingual Spanish-speakers.

Number of participants: seven.

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

- One participant was currently receiving services for herself, and was already aware of the children and youth services. It took one month or less for the child to receive an intake.
- Another participant was referred by the school system, following which it took six weeks to obtain an intake. The parent also was required to first acquire legal guardian status.
- A second caregiver was also referred for treatment by the school system. In this case, the wait time was two months. The caregiver was concerned that the assessor left the confidential file unsupervised on his desk.

Participants' general comments regarding service delivery included the following:

- The remainder of participants also primarily accessed services through the school system. Another was referred after calling 911.
- Transportation is provided when needed.

- Services are provided in Spanish.
- One mentioned his/her request to see a psychiatrist was refused.
- Another beneficiary suggested the MHP communicate with email rather than hardcopy material.

Participants' recommendations for improving care included the following:

- No recommendations were forthcoming from this session.

Interpreter used for focus group one: Yes Language(s): Spanish

## CFM Focus Group Two

The second requested focus group was to be composed of a culturally diverse group of 10-12 Santa Paula area adult beneficiaries, who have mostly initiated and utilized services within the prior 15 months. The session was conducted at the Santa Paula Adult Clinic, 725 East Main Street, 3rd Floor, Santa Paula, California. The actual focus group attendees conformed to the request, with a majority of female attendees, Caucasian/White and English language preferred participants.

Number of participants: eight

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

- Referral to mental health services occurred by physician referral, direct accessing of an MHP clinic, and aftercare arrangements following a stay on the inpatient psychiatric unit.
- Time for initial access to care was reported as one month, two weeks, three weeks; and direct, immediate access.

Participants' general comments regarding service delivery included the following:

- Some participants have obtained information about the full scope of available services from the treating clinician, while others received assistance from the promotores.
- While they are provided with MHP health information in Spanish, much of the supplementary material is only in English.
- When initially accessing care, one beneficiary recalled being provided with a facility tour, and given an orientation to the types of services available.
- Continuous turnover of psychiatry provider was cited as a barrier to treatment and stability. Several mentioned changing doctors three or four times. One

mentioned an upcoming telehealth appointment which was not the preferred venue. One positive instance of consistency of psychiatric provider was reported.

- One participant cited being scheduled to switch psychiatrists, but when the time to be seen came that physician was not available, resulting in another delay. This individual experienced a lack of medications for a period of time during the provider transition process.

- Some participants commented about the limited experience of some of the incoming psychiatric providers. In one instance the provider was felt to have poor skills in establishing rapport. However, a change in provider was made possible, and the current experience is good.

- Initial access to psychiatry was reported as taking three months in one case, and eight weeks for another. A number of participants reported difficulties in obtaining medications. Those served within the FC system experienced rapid advocacy, but others experienced issues with coverage of medication costs. Staff attempt to find the least expensive route, or work with the insurance provider, but it remains difficult for those without full-scope Medi-Cal. There is a resource that provides free medication, but that program has limited inventory.

- Most of the participants drive or walk themselves to appointments. Free bus passes were had by some. A small number would like more help with transportation.

- All reported psychiatrists currently were monolingual English speakers requiring an interpreter. All preferred a Spanish-speaking psychiatrist. Psychotherapy was universally provided in Spanish when that language was preferred by the beneficiary. Medication information is typically first offered in English, but it is possible to obtain in Spanish.

- The frequency of psychotherapy varies, with some every other to every three weeks, but most receive psychotherapy weekly. Those served less frequently expressed concerns about the adequacy of the treatment, and feel they are slipping.

- None of these participants experienced the need for an emergency contact number, but the majority have been told the number to contact. If extra help is needed during working hours, beneficiaries are instructed to call the clinic officer of the day.

- Most have developed a personal safety plan, but were not aware of the Wellness and Recovery Action Plan (WRAP) format by name.

- Some participants think their primary care provider is aware of the psychiatry services, but are unaware if this ever results in communication between the two providers.

- Wellness centers are not currently utilized by these participants. One observed that mostly English-speaking people attend the Oxnard wellness program.
- Ongoing information is obtained through various channels. Some receive information from therapists, others read flyers, and one monitors the MHP website. The consumer perception survey (CPS) is completed, some in private and some in front of the therapist.

Participants' recommendations for improving care included the following:

- More information about the available services.
- Hire more specialists, because there are waiting lists to receive some services.
- Provide more written health information in Spanish.
- Provide more information as how to apply for Supplemental Security Income (SSI).

Interpreter used for focus group two: Yes Language(s): Spanish

## CFM Focus Group Three

The third focus group requested was to consist of a culturally diverse group of 10-12 older adults from the Ventura area who initiated and utilized services within the prior 15 months. This session was conducted at the Ralston Older Adult Clinic, 5740 Ralston Street, Suite 200, Ventura California. The actual participants met the requested criteria, with female participants in the majority.

There were no participants who entered services within the past year.

The seven participants' general comments regarding service delivery included the following:

- Many were transferred from the adult program to the older adult program after turning 60 years of age. Others were referred following a hospital stay or emergency room visit. Another was referred by Adult Protective Services after experiencing a number of social and living situation changes.
- The program staff will provide assistance with accessing other resources upon request.
- Reminder calls are usually provided. If appointments are missed, the staff assertively follow-up.
- Groups were provided in the past, but have been discontinued. Also included were activities such as field trips.

- Transportation is three dollars each way, but the older adult program will provide free transit tickets.
- All participants are aware of the crisis team number in the case of emergency.
- When there were problems with making rental payments, the older adult program has helped out.

Participants' recommendations for improving care included the following:

- Increase the number of case managers and other staff.
- Make more passes available for Access transportation.
- Increase the focus on securing housing resources for this population because housing resources are steadily disappearing.

Interpreter used for focus group three: No

# PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

## Access to Care

Table 16 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

**Table 16: Access to Care Components**

| | Component | Maximum Possible | MHP Score |
|---|---|---|---|
| 1A | Service Access and Availability | 14 | 14 |

The MHP utilizes web-based and telephonic support for accessing care. In efforts to improve access to care, the MHP has been stressing walk-in and same-day types of service access.

The MHP provides transportation assistance, verified by focus group participants. Improved communication about transportation options would be appreciated by beneficiaries.

The MHP's website presents an option for viewing programs via a map-based format which facilitates the identification of relevant resources.

The MHP also provided the monthly performance data on the dropped calls, including missed and abandoned calls. The MHP provided an annual summary with monthly breakout of data. This type of information is important to review at least quarterly throughout the year.

The provider directory is updated on a monthly basis, with challenges identified in updating some of the individual providers and smaller entities.

Beneficiaries report the presence of MHP health information at clinic sites. Other health information from non-MHP sources is frequently provided in only English. This was confirmed by multiple focus groups and participants.

| Table 16: Access to Care Components | | | |
|---|---|---|---|
| **Component** | | **Maximum Possible** | **MHP Score** |
| 1B | Capacity Management | 10 | 8 |

The MHP uses ethnicity/language beneficiary data to inform specific strategies to improve access. This includes Logrando Bienestar, an outreach program to Latino/Hispanic beneficiaries. The MHP has also developed PIPs to target improvement in penetration rates and increase timely access. This has included expansions of services that are located in areas of significant Spanish-speaking population. The emergence of Mixteco and other regional Mexican dialects is an area of additional challenge for the MHP, wherein community resources are utilized to assist with interpreting. Currently, the MHP lacks staff fluent in Mixteco and other regional dialectics.

In evaluating capacity, the MHP has considered the NACT staffing requirements. Concerns emerged as how the suggested ratios indicated that the MHP is overstaffed. Many find the ratios puzzling and at odds with the needs produced by ongoing increases in administrative overhead and compliance requirements.

The MHP's requests of staff to increase clinical documentation has resulted in the MHP committing to providing explanations for any documentation requests being made. The intent of this is to reduce the negative morale impact these changes have upon staff, by helping staff understand how these changes are driven by state or federal requirements.

Examples of these include the requirement that progress notes have all original text, even when the service and beneficiary circumstances remain the same. These and other aspects, such as outcome tracking, create a documentation burden that many say consumes one-third or more of available work hours.

The MHP routinely monitors caseloads and productivity. The MHP's tracking of results of strategies on access is well-reported and documented in the initial access to care PIP.

The MHP's capacity is facing challenges due to the 20 percent vacancy rate. Recruitment and retention are both posing difficulties to MHP maintaining capacity. In addition, the processing of applicants is another stressor for the system with reports of insufficient staffing available to sustain the process. The concept of establishing two permanent float positions was mentioned by some, a suggestion that emerged during prior reviews. With inevitable vacancies that do occur, float positions would provide trained, oriented personnel to flex into critical gaps.

| | | | |
|---|---|---|---|
| 1C | Integration and Collaboration | 24 | 22 |

| Table 16: Access to Care Components | | |
|---|---|---|
| **Component** | **Maximum Possible** | **MHP Score** |
| VCBH continues to expand the use of contract organizational provider partners. Currently, approximately one-third of programming is contract versus the two-thirds directly-operated.<br><br>Psychiatry has developed a telehealth consultation process with the Ventura County Santa Paula Hospital emergency department. Collaboration with the school districts enables access to care by children and youth. Plans exist for the creation of wellness programs within secondary schools.<br><br>The MHP refocused on care coordination in the Primary Care Integration Program in the ambulatory care setting.<br><br>The MHP provides care coordination for referrals in response to Commercial Sexual Exploitation-Identification Tool (CSE-IT) risk tool used in the Juvenile Facility for identifying trafficked and commercial exploited youth. The instrument scores if a child is high risk in this area and generates a referral to a clinician embedded at the Juvenile Facility. The MHP has representatives on the steering committee for the Ventura County multi-agency commercially/sexually exploited cross-agency collaborative.<br><br>Collaboration with housing resources enables select MHP staff to access and identify available housing resources for beneficiaries.<br><br>The MHP has been meeting with Beacon, the local non-SMHS behavioral health resources, and Gold Coast, the local MCO, to seek adequate resources for step-down care. To date, many issues appear unresolved, with problems in timely processing of requests for services by Beacon and inadequate numbers of providers available. This is particularly significant for the more rural and regions of the county that have large Spanish-speaking, Latino/Hispanic populations. | | |

## Timeliness of Services

As shown in Table 17, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

| Table 17: Timeliness of Services Components | | | |
|---|---|---|---|
| **Component** | | **Maximum Possible** | **MHP Score** |
| 2A | First Offered Appointment | 16 | 16 |

| Table 17: Timeliness of Services Components | | | |
|---|---|---|---|
| **Component** | | **Maximum Possible** | **MHP Score** |
| The MHP reported first offered appointment averages as 10.8 days for adults, 10.26 days for children and youth, and 3.27 days for foster care (FC). Achievement of standard for FC is 96 percent, and 54 percent for adults and 61 percent for children and youth. The data is run and reviewed quarterly.<br><br>This metric is one of several targeted by the non-clinical PIP, and has demonstrated improvements. | | | |
| 2B | Assessment Follow-up and Routine Appointments | 8 | 5 |
| The MHP reports first kept appointment means of 30.58 days for adults, 30.87 for children and youth, and 22.04 for FC youth. The adopted standard is ten business days. Achievement of standard is 36 percent for adults, 39 percent for children and youth, and 54 percent for FC.<br><br>Continued effort in this area is important to meet the achievement expectation and decrease the mean days to 10 or less for of the major serviced populations, per IN 18-011.<br><br>It is clearly a significant undertaking to achieve such rapid access expectations, particularly without the infusion of additional staffing resources. Both leadership and line staff report the challenges that exist in providing adequate services to ongoing beneficiaries when ramping up the initial access response.<br><br>Leadership conveyed they had anticipated a ten percent increase in caseload, but it is currently much greater. Furthermore, the impact of improvements in timely access, are reported by staff and supervisors to be stressing the current system and ongoing beneficiary care to such an extent that line staff are seeking administrative jobs, retiring if eligible, or looking for alternate employment. | | | |
| 2C | First Offered Psychiatry Appointment | 12 | 6 |
| The MHP has adopted the DHCS required 15 business day standard for initial psychiatric service access. For this current review, the MHP's reporting was limited to adult services, which has a 48.82 day mean, and 26 percent achievement of standard. The MHP was unable to report children and youth, and FC for this period.<br><br>Performance on this metric was impacted by the changeover in psychiatry contractor at the start of FY 2019-20. The subsequent partial turnover of practitioners impacted beneficiaries, as verified by the beneficiary focus group participants for both initial and follow-up med support visits. | | | |

| Table 17: Timeliness of Services Components | | | |
|---|---|---|---|
| **Component** | | **Maximum Possible** | **MHP Score** |
| This will be an important area for the MHP to closely track in this coming year with the anticipated stabilization of psychiatry providers by the start of FY 2020-21. A recommendation from this review period will include the MHP to focus on an initial psychiatric appointment within 15 business days to comply with state timeliness per IN 18-011. | | | |
| 2D | Timely Appointments for Urgent Conditions | 18 | 14 |
| The MHP utilizes a 24/7 line to respond to requests for services, including urgent needs. The MHP tracked the 48-hour, non-preauthorized standard for this review period. The 96-hour standard for pre-authorized urgent needs is not relevant for this MHP.<br><br>The MHP has emphasized tracking urgent intakes for this metric. It is unclear how effectively the MHP is capturing urgent events that occur following intake, those that do not meet crisis criteria.<br><br>The MHP was able to report a total of four events for this period, one for children and youth, and three for adults. The adult mean reported was 24 hours. This small number of events reported does raise questions whether the system in place for urgent event identification is sufficiently sensitive. It remains unclear, as well, if the MHP has an effective process to capture urgent needs within the ongoing care system. | | | |
| 2E | Timely Access to Follow-up Appointments after Hospitalization | 10 | 8 |
| The MHP utilizes the Healthcare Effectiveness Data and Information Set (HEDIS) seven-day standard for post-hospital discharge follow-up tracking. All hospitals and all age groups as well as FC are included in the data tracking.<br><br>Adult services demonstrated a 41.5 day mean and 44 percent achievement of standard; children and youth have a 16.54 day mean and 73 percent achievement of standard; FC has a 4.29 day mean and 86 percent achievement of standard.<br><br>The MHP has developed a clinical PIP that targets post-hospital discharge follow-up. Currently, this PIP does not have active interventions, and it is exclusively focused upon the adult county-operated inpatient unit. Future iterations will address non-county hospitals and children and youth age groups.<br><br>The data clearly highlights the need to immediately focus upon the adult population. | | | |
| 2F | Tracks and Trends Data on Rehospitalizations | 6 | 5 |

| Table 17: Timeliness of Services Components | | | |
|---|---|---|---|
| **Component** | | **Maximum Possible** | **MHP Score** |
| The MHP provided data on rehospitalization rates, which included all populations and hospitals. The data included 1704 hospitalization events and 234 readmissions. Within 30 days of discharge, 17 percent of adult discharges experienced a readmission; for children and youth 6 percent; and for FC 29 percent. The FC metric was based on a very small N of 10, and thus with two readmissions presents limited analysis utility.<br><br>The MHP is tracking this metric in the concept PIP which has been developed but is yet to achieve active status. It is notable that the greatest contribution to readmissions is within the universe of non-county hospital acute admissions. Interventions for this population are, at this time, deferred to the next review cycle. | | | |
| 2G | Tracks and Trends No-Shows | 10 | 5 |
| The MHP tracks no-shows for psychiatry/prescribers and non-medical clinicians, for both categories a five percent standard is established. Psychiatrist no-shows are highest for adult and children and youth services (nine percent), with FC the lowest (six percent). Non-medical clinicians experience low no-shows across all reported populations (five percent). The scheduler is not universally adopted by all programs; therefore, this data is a subset of all events. | | | |

## Quality of Care

In Table 18, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

| Table 18: Quality of Care Components | | | |
|---|---|---|---|
| **Component** | | **Maximum Possible** | **MHP Score** |
| 3A | Beneficiary Needs are Matched to the Continuum of Care | 12 | 12 |
| The MHP continues to evolve a system for determining beneficiary needs by level of acuity and clinical status using a combined rating system that displays two metrics for each individual. | | | |

The acuity index is based on the history of inpatient admissions, housing status and crisis visits. The second metric reflects the Milestones of Recovery System (MORS) score. The housing status metric is derived from a recently developed mandatory progress note element.

The MHP uses level of care meetings to review beneficiaries who are ready to consider a change of level of care, including coordinating transfers between high and lower levels of care.

In the scope of level of care issues, a number of line staff expressed concern that the dangerousness has received diminished importance at a time that the general acuity of new intakes is perceived as very high. While safety is a key issue leadership has recently addressed, line staff feedback indicate more effort in this area is indicated.

| | | | |
|---|---|---|---|
| 3B | Quality Improvement Plan | 10 | 8 |

The Quality Assessment and Performance Improvement (QAPI) plan for FY 2019-20 includes targets for both MHP and DMC areas. The areas targeted include quite a few with quantifiable metrics that support tracking over time.

The MHP performed an evaluation of the FY 2018-19 prior QAPI workplan. This evaluation included a review of data from the Avatar acuity rating established to help guide level of care work. Another aspect of this workplan review was the post-IPU follow-up process. Further effort in this workplan review focused upon summary of efforts to reduce disallowances due to documentation errors.

The current and prior QAPI workplan analysis did not contain elements that focused on service disparities by site, region or population. There exists a Health Equity subcommittee that focuses upon disparities without consistent and specific reviews of data.

Quality Management Action Committee (QMAC), operates with a number of subcommittee elements, such as substance use, youth and family, and adults. The topics and minutes of these meetings provide an in-depth look at current challenges and needed changes. These minutes include actions both planned and taken to improve the identified issues.

Quarterly review of all QAPI plan metrics is not evidenced by the minutes. That said, the focus on specific issues in many cases mirror those issues identified by both line staff and beneficiaries.

| | | | |
|---|---|---|---|
| 3C | Quality Management Structure | 14 | 9 |

The MHP has a robust quality management structure that has gained the majority of the ten additional positions added during the past year. The QI Manager position remains vacant and is temporarily being covered by the Special Projects Division Chief. From the perspective of QI operations, the direction of activities appears seamless.

The MHP's Quality Management Action Committee (QMAC) meeting sign-in process makes it difficult to determine if family members and other individuals with lived experience are consistent participants in meetings. The format also does not readily identify the involvement of contract agencies or line staff.

There exist significant analytic skills among quality management staff. MHP position expansion has seen additions to the QMAC area, including those requirements driven by NACT implementation. This includes concurrent inpatient utilization review, and support to the ODS-DMC Waiver implementation.

Communication between QA/QI and programs is evident. This includes providing staff with an explanation of the what and why changes are implemented, with the intent of communicating the rationale for changes.

There does appear to be significant reporting generated by the QMAC area, which indicate deep focus on making reports and data meaningful and informative to the end user.

The MHP has largely discontinued its Ventura County Outcomes System (VCOS) reporting and is in the process of building a new system that provides a unified and informative outcome dashboard. This remains in process and will likely be operational at the time of the next review.

Related to the DHCS/CMS timeliness requirements, the MHP is reporting and reviewing timeliness on a quarterly basis.

| | | | |
|---|---|---|---|
| 3D | QM Reports Act as a Change Agent in the System | 10 | 9 |

Within the VCOS reporting system, the MHP historically used data to assist with monitoring service delivery and assisting with informing programming changes.

The staff engagement survey provided leadership with employee perceptions, with significant positive results. The opportunities identified are also receiving attention. The follow-up focus groups saw less participation. There are plans to annually continue this process. Efforts are underway to address the key areas of staff dissatisfaction.

Based on staff feedback, it may take another iteration and directly experiencing changes in the key areas for the process to be more fully accepted as useful.

The MHP also reports summary data for consumer perception surveys, sets targets for grievance and appeal numbers,

Reporting of initial timeliness, post-hospital follow-up and 30-day readmission rates have informed performance improvement activities that are currently seeking to improve initial access countywide with the concept clinical PIP that is awaiting availability of resources to move forward.

MHP staff are trained in LEAN Six Sigma, and also use the Plan-Do-Study-Act (PDSA) process to address smaller improvement needs that do not require the scope of a PIP.

| | | | |
|---|---|---|---|
| 3E | Medication Management | 12 | 9 |

The transition from Sterling to Traditions Behavioral Health psychiatry providers at the start of FY 2019-20 had significant impact upon the medication monitoring process activities for this current period. The records from the prior provider were not available for this review. The MHP presented an outline of targeted activities for FY 2019-20, but documentation of activities was sparse, with the exception of FC.

Quarterly, all FC beneficiaries receiving psychotropic medications are screened by the Behavioral Health pharmacist. Outliers are referred to the Medical Director or designee for further review. As determined from these reviews, additional information from the prescriber and/or additional oversight provided by the Medication Monitoring Workgroup (MMW).

Cures monitoring is reviewed by a quarterly review of five charts from each Y&F and adult providers prescribing benzodiazepines. The MHP requirement directs completion of an initial CURES report within 120 days of prescribing a controlled substance. The result of these reviews is provided as feedback to prescribers, medical directors and medication staff.

Medication management coordination with primary providers occurs most frequently with the collocated program sites. Beneficiaries were unaware of instances wherein they became aware of this coordination occurring.

Other medication management issues pursued by the MHP include:

- Development of a clinical practice guideline for the prescribing of naltrexone.
- A minimum of 25 percent of all clozapine beneficiary charts are reviewed monthly for compliance with Federal Drug Administration (FDA) prescribing standards.
- Annual review of two charts per prescribing practitioner are reviewed to determine if medication usage falls within the standard of care. Issues of clinical concern, when identified, are referred to the MMW and the Ventura County Medical Center (VCMC) Department of Medical Staff.
- Development of clinical practice guidelines for lab ordering.
- Provision of monitoring and oversight of pharmacies that dispense to MHP beneficiaries. This includes monitoring for dispensing of discontinued medications and/or refilling controlled substance prescriptions without authorization.

The MHP has a written policy that describes who may be prescribed for and what types of medications are permissible to be prescribed by psychiatric and related providers.

The MHP did supply de-identified examples of results from selected reviews for this the FY 2019-20 period.

## Beneficiary Progress/Outcomes

In Table 19, CalEQRO identifies the components of an organization that is dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

**Table 19: Beneficiary Progress/Outcomes Components**

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| 4A | Beneficiary Progress | 16 | 14 |

For the adult system, the MHP has adopted the Milestones of Recovery Scale (MORS) and Behavior and Symptom Identification Scale, (BASIS-plus). The Patient Health Questionnaire-9 (PHQ-9) is used with depressive disorder identification, and with anxiety disorders the General Anxiety Disorder-7 (GAD-7) may also be used.

These instruments are administered at intake, every six months thereafter and at exit from treatment. Significant changes in clinical status may also indicate for another administration.

Youth & Family programs utilize the Child Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35)] to track progress of children and youth. These instruments are administered at intake, every six months thereafter, and at exit from treatment.

On an individual beneficiary basis, there is the ability to compare results over time. As yet there do not exist trend tracking reports that provide a view of progress at a quick glance.

In aggregate, this type of information was historically integrated into the VCOS reporting system. The replacement for VCOS remains under development with drafts shared during this review.

Currently, summary information is not widely distributed and line staff reported no current ability to view program or overall department results over time.

It will be important to produce this information quarterly and be able to share with various stakeholder groups, as well as use for planning. Another key area, which other MHPs are also taking on, is providing this information to beneficiaries in a very

information and user-friendly format. From the draft concepts presented during this review, the MHP appears to have a good start.

| | | | |
|---|---|---|---|
| 4B | Beneficiary Perceptions | 10 | 6 |

The MHP adheres to the twice annual administration of the Consumer Perception Survey (CPS) and the Youth/Family Satisfaction Survey (YSS, YSS-F). The Treatment Perception Survey (TPS), intended for SUD services, has been implemented within the MHP due to brief number of questions and content that addresses key aspects of care.

Focus group beneficiaries, reported varied experiences with the administration process, including completing the survey in the presence of clinical staff. The MHP also shared plans to move the consumer perception survey process to waiting room iPad. This may improve completion rates, sense of anonymity, privacy, accuracy, and utility of the data collected.

The MHP's QMAC analytic process has examined the perception data and has plans to address the neutral responses because these seem to indicate discomfort with answering the question honestly. These efforts are intended to improve the generation of more actionable reporting from this process.

| | | | |
|---|---|---|---|
| 4C | Supporting Beneficiaries through Wellness and Recovery | 4 | 4 |

The MHP provides a centrally located Wellness Center, operated by Turning Point, near the Centerpointe Mall. This program is open to adults and is does not require enrollment in MHP services. The Wellness Center reports tri-lingual capability, English, Spanish and Mixteco.

The TAY Tunnel is operated by Pacific Clinics and targets Transitional Age Youth (TAY). It is located in the South Oxnard area as well.

These programs are located in the most densely populated area of the county. Beneficiary feedback was that typically very limited numbers of Spanish speakers participate, which reduces the attraction for non-English speakers to utilize services.

The Santa Clara Valley area residents may experience challenges in reaching Oxnard on a regular basis, as are the Conejo/Simi Valley areas. The MHP may wish to explore development of a mobile wellness program. Mobile services have been explored by other MHPs, and the wellness concept might provide a suitable program type that could have a schedule of regional availability and would resolve the commitment to fixed sites which do not promote flexibility when demands shift. A mobile approach would provide support to the beneficiaries in other less populated regions, which now require extensive travel time.

## Structure and Operations

In Table 20, CalEQRO identifies the structural and operational components of an organization that is facilitates access, timeliness, quality, and beneficiary outcomes.

| Table 20: Structure and Operations Components | | | |
|---|---|---|---|
| **Component** | | **Quality Rating** | |
| 5A | Capability and Capacity of the MHP | 30 | 22 |
| Of the service modalities provided by the MHP, medication support has experienced significant turnover, particularly for adult beneficiaries. Coverage is anticipated to stabilize before the end of summer 2020.<br><br>At this time, the MHP neither provides day treatment intensive nor day rehabilitation; however, the addition of both modalities is under consideration as the MHP evaluates local needs. There are possibilities of involving a contract provider to furnish these levels of care. The 30-day readmission stats and challenges with limited local acute beds are drivers for more support of beneficiary needs pre- and post-hospital admission.<br><br>Following the wildfires that severely damaged the Aurora Vista Del Mar (AVDM) freestanding acute facility, work has occurred to restore buildings destroyed by fire and bring beds back into use. The MHP looks to utilize some of the beds for overflow as services are restored, and also to possibly partner with AVDM on other local projects that will improve capacity and response.<br><br>The VCMC campus sited CSU serves adults, with limitations on capacity utilization imposed by current staffing of the inpatient acute unit. This limits utilization of licensed beds (30 of 41 licensed beds utilized), which in turn impacts the number of CSU slots that can be utilized.<br><br>The MHP is exploring the development of partnerships with a local hospital for the addition of another adult CSU. Some area EDs have such high traffic of psychiatric patients that the creation of a CSU is motivating force to consider development of such as unit. Determining location for a CSU is a key issue in that appropriate locations and community acceptance can be challenging. There are also clear needs for a CSU location in the east county area.<br><br>A full-time housing manager was hired to support improved data collection on housing/living situation of beneficiaries and the use of the Homeless Management Information System (HMIS) that connects those in need with appropriate housing.<br><br>The Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program was moved from a contracted provider to the MHP. | | | |
| 5B | Network Adequacy | 18 | 10 |

Telehealth is not currently utilized as a key element in psychiatric service delivery. There are recent innovations with telehealth usage that include consulting with the Santa Paula ED patients. When the newly developed Sprinter vans for assessment and transport are online, this venue will provide another use case for telehealth psychiatric consultation. Consideration for telehealth at one of the Y&F clinics is being explored but not yet active. The children and youth CSU utilizes telehealth exclusively for all psychiatry services. Telehealth will be used for redistribution of unused capacity and coverage for absent prescribers.

The MHPs integration with physical health is most notable with three health department clinic locations. The MHP's clinics in these areas are on the same campus, and clinical staff are assigned to work at ambulatory care health clinics for screening, assessment and brief treatment.

Whole person care (WPC) programming exists on the health side, from which referrals are made to the MHP with specific cases meeting SMHS criteria.

The MHP also utilizes mobile crisis teams and outreach and engagement teams that provide follow-up until high-risk individuals are engaged in treatment with respective outpatient programs. Maintaining mobile crisis staffing is an ongoing challenge, with work schedule and unique aspects of crisis work obstacles to recruitment and retention.

| | | | |
|---|---|---|---|
| 5C | Subcontracts/Contract Providers | 16 | 12 |

The MHP has twice yearly provider meetings. There are also two to three annual coordination and/or training meetings with contractors to advise and inform about compliance changes. There are monthly operational contractor meetings with county liaisons.

There has been a decrease in the larger contractor and MHP meetings which had agendas significantly driven by contractor concerns.

With the currently designed PIPs there is no contractor representation involved in these processes. Both PIPs are not directly involving contractors; however, when non-county hospitals become a focus of the clinical aftercare PIP, this will certainly change.

The MHP has managed several significant transitions between contract entities, which include: Transition of crisis residential treatment center and a mental health rehabilitation center from a financially insolvent entity to a new provider in less than two months without interruption in services. Both programs remain in operation at their original capacities.

As previously noted, the transition in psychiatry providers with overall continuity of services and limited areas of disruption. Many psychiatrists were retained which allowed for continuity of care for clients.

| | | | |
|---|---|---|---|
| 5D | Stakeholder Engagement | 12 | 9 |

The MHP has two townhalls each year involving staff. Regional retreats also occur where managers meet with staff. The purpose is to address morale issues, celebrate accomplishments, and provide information about coming changes in direction. Most recently, the focus has been upon staff self-care and response to the trauma created by local wildfires and a night club mass shooting.

In this past year, the MHP initiated a project to create staff engagement and input. The use of a Survey Monkey instrument provided information about staff satisfaction, which was followed-up by focus groups that were externally facilitated. The intent was to follow-up on the survey issues with the focus groups and to develop action plans. The survey participation was very high, but the focus groups were not as well attended.

While there were significant positives identified by the survey, the smaller number of issues that identify challenge areas are seen by all sides as important. Safety and capacity are among the topics that arose from the feedback process, and also emerged in staff sessions during this review. Many of those issues are exacerbated by the chronic vacancy issues, which is approximately 20 percent.

The key issue to line staff and supervisors is expedient filling of vacancies, followed by an immediate onboarding process which addresses all aspects of program operations and provides new staff with the tools to be a fully functional employee. After that a need was identified for an onboarding process that ensures new employees are oriented and trained before arriving at the clinic assignment. The chronicity of vacancies and difficulties with hiring and retaining staff have resulted in recommendations to create a float pool of staff experienced with adults and another for Y&F system. The chronicity of vacancies that exist would seem to provide float staff with a continual need for program assignment.

Similar to line staff vacancies are those of clinic administrators (CA). Gaps in administrator coverage are not easily replaced by interim assignment of off-site leadership. Line staff need local leadership to help respond to emergencies or other issues that require experienced judgement.

Contractor engagement efforts continue, with some pullback experienced by these agencies due to internal and external issues that have been in effect over the past several years. The DMC-ODS waiver implementation has severely taxed administrative capacity in the past two years.

Robust family and beneficiary involvement is not currently evident in the QMAC program. Consumer focus group participants were unaware of the local program or countywide CPS results. The MHP is advised to develop a strategy that directs beneficiaries to CPS results, whether through clinic postings of local results or posted alerts to a web-site that publishes the results.

| | | | |
|---|---|---|---|
| 5E | Peer Employment | 8 | 6 |

The MHP utilizes individuals with lived experience in a variety of roles which include parent partners (PP), case managers, and peers. There are peer staff within both adult and TAY services. They are employed by contract agencies and by directly-operated services such as the Rapid Integrated Support & Engagement (RISE) program.

There is also a Transformational Liaison position, designed to train peers and assist with their integration in programming. However, this position has been vacant for more than one year.

Several years ago, a large agency contract was ended that employed many adult system peers. Some of these individuals moved into directly operated roles, others were employed by other contract agencies.

During this review input from lived experience individuals was specifically sought. They reported duration of employment ranging from one to ten year. Those in a parent partner role relayed satisfaction with the comprehensive training and supervision provided before assuming their work role. The PPs conveyed an array of mandatory and optional trainings, all directly related to success in their roles. Some useful trainings are limited to MHP staff. The need for comprehensive and on-going de-escalation training was cited, including a hands-on component. There is satisfaction found by lived experience workers in using past difficult experiences to help others successfully respond to behavioral health issues.

Frequently, caseload growth is cited as outpacing the staff resources. All reported feeling supported by the agencies that employ them, and respected by co-workers. Opportunities for advancement vary, but are mainly limited to some salary increases. The existence of a comprehensive career ladder for those with lived experience is not evident, with the exception of United Parents.

Those who wish to pursue an advanced degree usually find their employers willing to support this through a flexed work schedule. The work benefits provided are inconsistent between agencies, and can take the form of sick and vacation days, and some who have a limited 401k plan.

The MHP is utilizing individuals with lived experience in an increasing number of roles. It would be useful for a comprehensive forward-looking plan to be developed for the use of these individuals, Career ladder and support for further education are aspects that should be part of such a plan.

Wish list items for these individuals include: Provide use of an agency vehicle or mileage reimbursement. Cap staff caseload size. Provide increased hours if the staff member is interested and willing to work more than half-time.

| | | | |
|---|---|---|---|
| 5F | Peer-Run Programs | 10 | 8 |

The Turning Point Wellness Center and the TAY Tunnel are the two primary wellness and peer driven programs that are operated, both with significant involvement of peer employees. As previously mentioned, the two programs are located in the South Oxnard area. While this meets the needs of area residents and with transportation support, those who live in the Santa Clara Valley and Conejo/Simi Valley areas have challenges in access. The MHP might wish to explore a mobile wellness program that could flex hours and days among the other regions depending upon demand.

The wellness programs have no enrollment limitations. Hours of operation, for the most part, mirror those of clinical services. Provision of information to beneficiaries about the wellness program is determined by clinicians based on clinical assessment and perceived need, and is not automatically provided to all beneficiaries.

| | | | |
|---|---|---|---|
| 5G | Cultural Competency | 12 | 11 |

The MHP's cultural competency efforts include extensive analysis of the Latino/Hispanic and Spanish-speaking populations. There have been many efforts over the past five years that focused on improving engagement and retention of this population. Logrando Bienestar and community outreach to field workers has played a large part improving access for this population. The non-clinical PIP has targeted improvements in initial access for the Santa Paula region, and resulted in changes that enable immediate walk-in access. This rapid access conforms to the needs of this population, and avoids delays that can cause individuals to drop out when seeking treatment. Contract providers participate in disparities and cultural competence efforts.

# SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2019-20 review of Ventura County MHP related to access, timeliness, and quality of care.

## MHP Environment – Changes, Strengths and Opportunities

### PIP Status

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

**Non-clinical PIP Status:** Active and ongoing

### Access to Care

**Changes within the Past Year:**

- The MHP embedded Screening Triage Assessment and Referral (STAR) staff at clinics to improve intake responsiveness.
- The MHP has employed a group orientation/assessment model using peers to support multiple simultaneous assessments to address high numbers of intakes at the North Oxnard adult services clinic.
- The MHP developed a walk-in RFS process at the Youth and Family (Y&F) South Oxnard clinic, to decrease time to assessment.
- Clinic treatment staff have been trained to process RFSs and perform assessments as an adjunct to STAR.

**Strengths:**

- The MHP has established ongoing meetings with Beacon to refer non-SMHS individuals, and has recently requested Gold Coast MCO to participate.
- The MHP is relying on external partners to furnish additional high intensity programs such as CSU and PHF programs, which can be quicker to operationalize when not provided as directly operated services.
- Beneficiaries have access to online presentation of the mental health programs on a map, which provides assistance to individuals seeking services in specific areas of the county.

**Opportunities for Improvement:**

- This MHP continues to experience the negative impact on capacity that the very limited availability and slow response time of the non-SMHS system that comprise the Gold Coast MCO and its Beacon behavioral health provider network.

- As the MHP has shifted resources to provide improved timeliness of initial services, there is an impact on the capacity to provide continued treatment to existing beneficiaries. These challenges require a reassessment of staffing resources, and consideration of shifts to a group model of care after a period of individual treatment.
- The MHP's vacancy rate and turnover would suggest exploration of a pool of staff who are can quickly be deployed to fill unanticipated or difficult to fill vacancies.

## Timeliness of Services

**Changes within the Past Year:**

- The MHP has used PIPs to implement changes that improve timeliness of access to programs, varying intervention by location and service population.
- Streamlining the referral and assessment process, and re-aligning some aspects of assessment with the treatment process.

**Strengths:**

- The most recent PIP data indicates improvements to timeliness that meet DHCS standards.
- CBOs are now permitted to process their own requests for services (RFS) and perform the assessments without direct STAR involvement. This reduces the time to assessment, reduces the burden on STAR, and strengthens CBO clinic relationships with the communities they serve.

**Opportunities for Improvement:**

- MHP reporting on first offered psychiatry appointment and the 15-business day standard was limited to adult services, reflecting a 48.82 day mean and 26 percent achievement of standard. The MHP will need to successfully track both Y&F service access as well as FC for this coming review period.
- The low number of urgent events identified suggests the MHP process for identification of this need may need revisiting, including exploration as to whether urgent needs are being met with a crisis level response. Efforts to ensure accuracy of identification will likely also involve training for staff.
- Post-hospital discharge follow-up greatly exceeds the seven-day HEDIS standard for adults (41.5 day mean). Positively, the MHP has a concept PIP designed to address this issue.

## Quality of Care

**Changes within the Past Year:**

- The MHP has continued to work on the development of a level of care tracking system that includes outcome tools and acuity rating scales, which will be used to support transitions between levels of treatment within the system.
- The MHP's QMAC system now includes elements that address both SMHS/MHP and SUD/DMC-ODS waiver topics for quality monitoring.
- The sudden and unexpected transition in psychiatric service provider resulted in disruptions for many beneficiaries, accompanied by frequent changes in prescribers. For some, medication refills were not available for a period of time. This process unsettled confidence in the system for beneficiaries and staff, for whom advance notice and communication were often lacking.
- All CBOs have access to the MHPs Avatar information for beneficiaries they serve. This optimizes the CBOs ability to make informed clinical decisions based on existing information about the beneficiary's history, care, and medications.
- Additional staffing resources have been added in this past year to QMAC to assist with the workload increase created by the DMC-ODS waiver process and NACT requirements.

**Strengths:**

- The MHP leadership has continued its assertive efforts to improve step-down to non-SMHS care through persistent meetings with the local MCO and its behavioral health provider Beacon in which it has lobbied for increased resources and responsiveness.
- The MHP's work in the area of quality is clearly informed by the familiarity of staff with the LEAN Six-Sigma process, use of PDSAs for basic problems, and extensive awareness of data analytic techniques.
- The staff survey process and follow-up focus groups serve as a model for obtaining staff concerns and input. Consistent steps toward addressing the problem areas, with action steps are important to communicate with stakeholders.

**Opportunities for Improvement:**

- QMAC meeting minutes did not include regular and ongoing review of data metrics throughout the year.
- QMAC participation lists do not clearly capture the presence of contract agencies or individuals with lived experience, such as family members or beneficiaries.
- The staff survey process would benefit from a staff workgroup that helps to design the survey questions and also provide input on subsequent focus group structure and process.

## Beneficiary Outcomes

**Changes within the Past Year:**

- Development is underway of a dashboard that will present information from outcome instruments in a useful, comprehensive fashion.
- The MHP has performed extensive analysis of the treatment perception survey (TPS) results, and identified areas in which there is evidence of beneficiary reluctance to provide honest feedback. The MHP is developing strategies to promote greater comfort for the beneficiaries and thereby increase the utility of feedback.

**Strengths:**

- The MHP new programming developments typically incorporate the use of individuals with lived experience as key participants in service delivery.
- The MHP plans to convert the consumer perception survey for administration on a tablet with the intention of improving beneficiary privacy and honesty of feedback.

**Opportunities for Improvement:**

- MHP beneficiaries who reside in the Conejo/Simi Valley and Santa Clara Valley areas must overcome distance and transportation issues to participate in wellness center activities.
- The MHP created a specific leadership position for a lived experience individual, the Transformational Liaison, which has been vacant for nearly two years. The roles of lived experience individuals have been expanding; however, the MHP has yet to develop a master plan for the use of lived experience individuals, a task appropriate for a peer leadership individual to pursue.

## Foster Care

**Changes within the Past Year:**

- In early 2017, 15-16 percent of youth in foster care (FC) were on psychotropic medications; by late 2018, the rate had decreased to 11 percent. This is the result of effective monitoring of psychotropic medications prescribed to children in foster care and a commitment to reduced reliance on medication for this population.

**Strengths:**

- The 209 FC beneficiaries whose initial first offered appointment was reported for FY 2018-19, the mean was 3.27 days, with 96 percent meeting the 10-business day standard.

- The Children's Accelerated Access to Treatment and Service (CAATS) provides a mental health assessment for every child/youth entering foster care based on the reasonable assumption that entering foster care is traumatic for a child. CAATS works on the 5-5-5 model – a referral to assessment within 5 days of case opening, an assessment within 5 days of referral, and starting treatment within 5 days of the assessment.

- The Ventura County commitment to family maintenance has resulted in fewer children in out-of-home placement. In January 2017, 909 children were in out-of-home placement in Ventura County; in October 2018, 747 children were in out-of-home placement.

- The FC penetration rate is ten percentage points higher than the average for other large counties. This is driven by the MHP's commitment to provide an assessment of every child with a case open with Child Welfare Services.

- An important measure for FC is the number of placement changes during their time in foster care. In 2017 Ventura County averaged 3.6 placement changes for children not on probation. In 2018, they averaged 2.9 changes. The National Standard is 4.12.

- Ventura County is one of a few California counties that has taken on the responsibility of approving group home conversions to STRTPs.

- Child Family Teams (CFT), multi-disciplinary and multi-agency groups assembled and tailored for the needs of each family, provide a coordinated range of services aimed at preserving the family unit whenever possible and helping to sustain the family to avoid out of home placement.

- Parent Partners, with foster care lived experience, participate in the CFTs and promote clarity and understanding for the family.

- The MHP has co-located staff with Child Welfare and Probation.

- Public Health Nurses and juvenile justice medical staff have access to the Avatar system and are able to directly review medications prescribed for FC youth to assist with the JV220 process.

- The Behavioral Health Pharmacist provides quarterly oversight of all FC youth who receive psychotropic drugs.

**Opportunities for Improvement:**

- The first kept FC appointment reflected the likely impact of various barriers unrelated to capacity, including consent for treatment for those accessing services through STAR and often out-of-county youth placed in local group homes. The mean number of days to first kept appointment was 22.04, with 54 percent meeting the 10 business days standard.

- First kept psychiatric appointment for the FY 2018-19 period included only 30 beneficiaries, with a 79.63 day mean, and 17 percent achievement of 15 business day standard. It is not apparent what factors are affecting this metric, and if they are local capacity issues, or beneficiary related, such as consent for treatment. Certainly, when the JV-220 process for medications is included, there are process related delays that impact FC access timeliness.

- The requirement for a group home to become a STRTP has resulted in some formerly successful and valued group homes closing. Conversion has been difficult for all and overwhelming for some. Group homes must absorb all the work and cost of successfully converting to a STRTP before they see any new revenue.

- The focus on STRTP capacity has been somewhat at the cost of the MHP's ability to address its capacity for Intensive Treatment Foster Care or other serves appropriate to someone exiting a STRTP placement.

## Information Systems

**Changes within the Past Year:**

- Avatar's Scheduling module was implemented for a March 2020 pilot, to be followed by full production use four to six weeks later.

- A Special Projects Division Chief position was created to provide executive support for Quality, EHR, Access and other department wide initiatives.

- The MHP converted primary care integration records to the Cerner/AVATAR EHR, and have fully transitioned to electronic billing/clinical documentation and care coordination.

**Strengths:**

- Given the small IT team at the MHP, Netsmart hosting of Avatar EHR is a strength.

**Opportunities for Improvement:**

- All contract providers that do not use the MHP's Netsmart/AVATAR EHR/PM system must manually enter client and service information. The absence of electronic data exchange and/or acceptance of batch claims files is burdensome, duplicative and creates the very real risk of entry errors.

- Three IS employees to serve the needs for DMC-ODS and MHP AVATAR users are insufficient to obtain the full value from the Netsmart AVATAR system. There exists significant unused AVATAR functionality because of insufficient information systems resources to do the projects. Batch uploads of CBO claims are one example that would reduce CBO dual entry and potential errors.

- Some MHP Avatar users continue to have slow logon times. This logon issues has not been linked Netsmart data center problems where the MHP's instance of Avatar is hosted. The issues appear to be related to the MHP's network infrastructure (both WAN and LAN) and some aging desktop hardware.

## Structure and Operations

**Changes within the Past Year:**

- A Special Projects Division Chief position was created to provide executive support for Quality, EHR, Access and other department wide initiatives.

**Strengths:**

- The MHP is continuing to develop strategies to meet the high acuity needs, which includes the development of regional crisis stabilization units, and additional acute/PHF beds.

**Opportunities for Improvement:**

- The MHP is not certified for outpatient Medicare claiming. The Medicare Part B program is not billed for services provided to dual eligible (Medicare and Medi-Cal) beneficiaries at both county-operated and CBO sites by Medicare-qualified healthcare staff. (References: MH Information Notices 11-04, IN 10-23, IN 10-11, and 09-09.)

- Staff are expected to provide a number of non-Medi-Cal claimable activities as part of their duties. Review feedback indicated a great deal of variance between supervisors as to what activities qualify as OPT. This inconsistency impacts morale and actual rated performance of staff.

- Beneficiary access to Provider Directory through MHP public-facing website is difficult to locate and not updated monthly as required. Reference: MHSUDS IN 18-020.

- Most MHP initiatives will require significant IT support and services. The presence of IT early and often in leadership discussions of changes will decrease ramp-up time and lead to more effective solutions.

# FY 2019-20 Recommendations

## PIP Status

1. Per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. (This recommendation is a carry-over from FY 2018-19.)

2. The Non-Clinical PIP requires update of the title and study question in order to encompass the modifications that provide site specific interventions at MHP locations outside of the Santa Paula area.

## Access to Care

3. Continue to pursue resolution of mild-to-moderate service capacity with ongoing meetings that include MCO Gold Coast Health Plan and Beacon. (This recommendation is a carry-over from FY 2018-19.)

## Timeliness of Services

4. Continue to track the timeliness of first kept clinical and psychiatry appointments for adult, Y&F and FC in order to ensure that DHCS NACT standards are consistently met.

## Quality of Care

5. Prioritize the recruitment of bilingual psychiatry and other prescribers to serve Spanish-preferred beneficiaries with the goal of eliminating the need for interpreters. (This recommendation is a follow-up from FY 2018-19.)

## Beneficiary Outcomes

6. Complete development of an informative outcomes dashboard that provides both relevant individual and aggregate data to line staff external stakeholders.

## Foster Care

7. Identify and categorize the barriers to FC first kept appointments, and develop relevant strategies to impact these issues.

## Information Systems

8. Complete the analysis of the Avatar logon process to assess reasons for its slowness, and develop strategies that result in lowering to meet industry standards and is acceptable to clinicians and prescribers. (*This is a modified recommendation from FY 2018-19*.)

9. Develop functionality that enables CBOs to perform batch uploads from their individual EHRs of claim files to the MHPs Avatar system.

10. Provide dashboards to line staff, limiting the drill-down access to summary and individual performance data.

## Structure and Operations

11. Complete and submit provider enrollment applications for all county-operated sites who serve dual eligible beneficiaries (Medicare/Medi-Cal) to Noridian Medicare Portal as soon as practical for compliance with DHCS IN's.

12. Provide guidance and support for Community Based Organizations (CBO) who serve dual eligible (Medicare/Medi-Cal) beneficiaries with Medicare provider enrollment applications for compliance with DHCS IN's.

13. Review and improve the "other productive time" (OPT) policy, which gives staff engaged in essential activities, such as interpreting, credit for productive time. Develop a comprehensive documented procedure that removes individual interpretation from the process, and that ensure supervisors and line staff possess a uniform understanding.

# SITE REVIEW PROCESS BARRIERS

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

- A session involving Spanish speaking individuals was scheduled to have an interpreter whose presence was cancelled in error.

# ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

# Attachment A—On-site Review Agenda

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

| Table A1—EQRO Review Sessions - Ventura MHP |
|---|
| Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations |
| Cultural Competence, Disparities and Performance Measures |
| Timeliness Performance Measures/Timeliness Self-Assessment |
| Quality Management, Quality Improvement and System-wide Outcomes |
| Beneficiary Satisfaction and Other Surveys |
| Performance Improvement Projects |
| Acute and Crisis Care Collaboration and Integration |
| Adult Clinical Line Staff Group Interview |
| Children's Clinical Line Staff Group Interview |
| Clinical Supervisors Group Interview |
| Program Managers Group Interview |
| Consumer and Family Member Focus Group(s) |
| Peer Employee/Parent Partner Group Interview |
| Contract Provider Group Interview – Operations and Quality Management |
| Medical Prescribers Group Interview |
| Juvenile Forensics and Mental Health Integration |
| Validation of Findings for Pathways to Mental Health Services (Katie A./CCR) |
| Information Systems Billing and Fiscal Interview |
| Access Call Center Site Visit |
| Wellness Center Site Visit |
| Contract Provider Site Visit |
| Crisis Stabilization/Psychiatric Inpatient Site Visit |
| Final Questions and Answers - Exit Interview |

# Attachment B—Review Participants

## CalEQRO Reviewers

Robert Walton, Quality Reviewer
Oliva Kosarev, Quality Reviewer
Bob Greenless, Information Systems Reviewer
Nosente Uhuti, Consumer/Family Member

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

## Sites of MHP Review

MHP Sites

Ventura County Behavioral Health
1911 Williams Drive
Oxnard, CA 93036

VCBH South Oxnard Clinic
2500 South C Street
Oxnard, CA 93033

VCBH Santa Paula Adult Outpatient Clinic
725 East Main Street, 3rd Floor
Santa Paula, CA 93060

VCBH Older Adult Clinic
5740 Ralston Street, Suite 200
Ventura, CA 93003

Ventura County Medical Center – CSU/IPU
200 Hillmont Avenue
Ventura, CA 93003

Ventura County Probation Department
4333 East Vineyard Avenue
Oxnard, CA 93036

| Table B1—Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| **Agosto** | Almira | East County | VCBH – Youth & Family Services |
| **Aguila** | Gabriela | BH Manager II – CAATS, CWS & CalWorks | VCBH – Youth & Family Services |
| **Aguilar** | David | Peer Recovery Coach - RISE | VCBH – Adult Services |
| **Alvarez** | Elizabeth | Parent Partner | Aspiranet COEDs |
| **Ashur** | Ophra | Compliance Senior BH Manager | VCBH – Quality Management |
| **Barreto** | Robert | TBS/IHBS Program Supervisor | Aspiranet |
| **Bennett** | Kimberly | Director Community Based Services | Casa Pacifica |
| **Buice** | Allyson | Clinic Administrator | VCBH – Youth & Family Services |
| **Burt** | Sloane | Senior Program Administrator | VCBH – Quality Improvement |
| **Catapusan** | Anita | Substance Use Disorder Program Manager | VCBH – ADP Programs |
| **Centeno** | Araceli | Community Services Coordinator | VCBH |
| **Chandrasekera** | Ajith | Program Administrator III | VCBH - Administration |
| **Chen** | Yvette | Program Administrator | VCBH – Quality Improvement |
| **Cleland** | Don | Regional Director | Golden |
| **Colton** | Michael | BH Clinic Administrator III – S. Oxnard | VCBH – Adult Services |
| **Cooper** | Dr. Jason | Medical Director | VCBH – Adult Services |
| **Cowie** | Stephanie | Clinic Administrator - Phoenix | VCBH – Youth & Family Services |
| **Cruz** | Danielle | Management Assistant II | VCBH – Quality Improvement |
| **Cruz** | Mark | IT Analyst | VCBH – Information Technology |
| **Devaney** | Connie | Administrative Assistant | VCBH - Avatar |

| Table B1—Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| **Di Battista** | Maria | Clinic Administrator | VCBH – Youth & Family Services |
| **Donovan** | Leisa | Senior Manager - Accounting | VCBH - Fiscal |
| **Dougherty** | Jennifer | Senior Manager – Youth & Family | VCBH – Youth & Family Services |
| **Drap** | Barry | Crisis Team | VCBH - Adult Services |
| **Duenas** | Alicia | Program Administrator III | VCBH – Data System Implementation |
| **Eden** | Savannah | BH Program Manager | Kids & Families Together |
| **Egan** | Narci | Assistant Chief Financial Officer | HCA |
| **Ehret** | Julie | RN – Older Adults | VCBH – Adult Services |
| **Elhard** | Erick | BH Clinic Administrator III - CRISIS | VCBH – Adult Services |
| **Fekete** | Doreen | Program Administrator | VCBH - Billing |
| **Flores** | Roxanna | BH Clinician III | CWS |
| **Fox** | Cheryl | BH Manager II | VCBH – Ventura YFS/JJ/PCI/INSIGHTS/Santa Clara Valley |
| **Franco** | Carmen | CFS Senior Admin Spec | CFS |
| **Galicia** | Irene | BHC - Ventura | VCBH – Adult Services |
| **Garcia** | Jesse | Parent Partner | United Parents |
| **Gardner** | Janice | BHAB Chair | VCBH - BHAB |
| **Garman** | Kari | Administrative Specialist III | HSA - CFS |
| **Glantz** | Julie | Senior BH Manager - Adults | VCBH – Adult Services |
| **Glickman** | Emily | Simi Valley | VCBH – Adult Services |
| **Goble** | Jennifer | Program Director | Pacific Clinics |
| **Godtel** | Beau | Administrative Specialist III | HSA - CFS |

| Table B1—Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| **Gonzalez** | Dr. Patricia | Research Psychologist | VCBH – Quality Improvement |
| **Goodnight** | Danielle | Parent Partner | United Parents |
| **Guerrero** | Breanna | Family Case Manager Supervisor | Aspiranet COEDs |
| **Guillin** | Heather | Clinic Administrator | VCBH – Youth & Family Services |
| **Gutierrez** | Alfonso | Clinic Administrator II – S. Oxnard/ERSES | VCBH – Youth & Family Services |
| **Ha** | Richard | Youth & Family Lead | VCBH – Youth & Family Services |
| **Johnson** | Heather L. | Clinic Administrator - Conejo | VCBH – Youth & Family Services |
| **Johnson** | Sevet | Behavioral Health Director | VCBH |
| **Khan** | Traci | BH Clinic Administrator III | VCBH – Adult Services |
| **Lagunas** | Jorge | Nursery Employee | Growing Works |
| **Lehtonen** | William “Bill” | Parent Partner | Aspiranet COEDs |
| **Lee** | Jason | Clinic Administrator | VCBH – Youth & Family Services |
| **Locklear** | Erin | Clinical Services Manager, Mental Health | Interface |
| **Lopez** | Annette | MHA - Ventura | VCBH – Adult Services |
| **Lopez** | Rebecca | MHA – S Oxnard | VCBH – Adult Services |
| **Lopez** | Yesica | BHC II - N. Oxnard | VCBH – Adult Services |
| **Lubell** | Courtney | Program Administrator – Policies & Procedures | VCBH – Quality Assurance |
| **MacKay** | Rosemary | Parent Partner | United Parents |
| **Magbitang** | Ana | BH Clinic Administrator III - STAR | VCBH – Adult Services |

| Table B1—Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| **Manzo** | Sal | BH Manager II – N. Oxnard Adult/ S. Oxnard/ Santa Paula | VCBH – Adult Services |
| **Matisek** | Katie | Clinical Director | Turning Point Rehab Services |
| **McCormick-Soll** | Angelina | Clinic Administrator III – Santa Paula/Fillmore/ERSES | VCBH – Youth & Family Services |
| **McDonald** | Tina | BH Clinic Administrator III | VCBH – Adult Services |
| **Mesa** | Marady | Program Administrator II | VCBH – Quality Improvement |
| **Mikkelson** | Sandra | Program Administrator III | VCBH – Quality Improvement |
| **Miles** | Martie | Director | Aspiranet COEDs |
| **Moneyhun** | Stephanie | STAR | VCBH – Adult Services |
| **Mungaray** | Yvette | Parent Partner | Aspiranet COEDs |
| **Nagle** | Laura | Clinic Administrator III | VCBH – Youth & Family Services |
| **Newbold** | Jennifer | Executive Director | PathPoint |
| **O'Cain** | Kristen | East County | VCBH – Youth & Family Services |
| **Olivera** | Erin | Nurse Manager | VCMC IPU/CSU |
| **Olivas** | Dina | Division Chief | VCBH – Youth & Family Services |
| **Ornelas** | Jesus | MHA/ADTS – N Oxnard | VCBH – Adult Services |
| **Owen** | Peter | Contracts | VCBH - Administration |
| **Perez** | Mary | ACSW – S Oxnard | VCBH – Adult Services |
| **Perlman** | Lori | LPT - Ventura | VCBH – Adult Services |
| **Pineda** | John | TBS Program Manager | Casa Pacifica |
| **Plante** | Theresa | Wraparound Program Manager | Casa Pacifica |
| **Pond** | Sabrina | Parent Partner | Aspiranet COEDs |

| Table B1—Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| **Powell** | Dan | Manager | VCMC IPU/CSU |
| **Pringle** | Pete | Division Chief | VCBH – Special Projects |
| **Ramirez** | Jesus | BH Clinician II | CWS |
| **Riddle** | Angela | Oxnard Manager | VCBH – Youth & Family Services |
| **Roberts** | Jeannene | Administrative Specialist III | HSA - CFS |
| **Roman** | Dave | Senior Program Administrator | VCBH – Electronic Records |
| **Rosas** | Ruby | BH Clinician III | CWS |
| **Ross** | Mark | MHA - TAY | VCBH – Adult Services |
| **Roylance** | Leah | BH Clinic Administrator III | VCBH – Adult Services |
| **Ruiz** | Deanna | Clinic Administrator | VCBH - CalWorks |
| **Sahota** | Kiran | MHSA & Community Engagement Senior Manager | VCBH - MHSA |
| **Salas** | Cynthia | Cultural Competence Manager | VCBH – Cultural Competency |
| **Salib** | Samantha | BH Core Program Supervisor | Aspiranet |
| **Sanchez** | Sara | Clinic Administrator | VCBH – Adult Services |
| **Schipper** | Dr. John | Division Chief | VCBH – Adult Services |
| **Schreiner** | Peter | Clinic Administrator III – Older Adults/Benefits | VCBH – Adult Services |
| **Schryer** | Anna | Oxnard | VCBH – Youth & Family Services |
| **Schumaker** | Mark | Director | Turning Point Wellness Center, Growing Works & Quality of Life |
| **Simental** | Cindy | Clinic Administrator - Ventura | VCBH – Youth & Family Services |
| **Skaggs** | Felicia | BH Clinic Administrator III– RISE/ASSIST | VCBH – Adult Services |

| Table B1—Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| **Small** | Angeles | Logrando Bienestar | VCBH |
| **Soltero** | Peter | Oxnard | VCBH – Youth & Family Services |
| **Springer** | Nancy | Clinic Administrator | VCBH – Adult Services |
| **Sullivan** | Jarrod | Nursery Employee | Growing Works |
| **Tadeo** | Zandra | BH Clinic Administrator III – Santa Paula | VCBH – Adult Services |
| **Taylor** | Thomas | ARS/EPICS/Intensive Service Contracts Manager | VCBH – Adult Services |
| **Thurber** | Dr. Deborah | Clinician | VCBH – Youth & Family Services |
| **Torres** | Cynthia | CEO | New Dawn |
| **Torres** | Kristen | LMFT - TAY | VCBH – Adult Services |
| **Tripp** | Andrew | Recovery Coach - RISE | VCBH – Adult Services |
| **Urzua** | Veronica | Vice President | New Dawn |
| **Valles** | Lionel | MFT – Santa Paula | VCBH – Adult Services |
| **Vazquez** | Rene | Parent Partner | United Parents |
| **Vessels** | Joelle | Director, Mental Health & Youth Services | Interface |
| **Volf** | Dr. Nora | Pharmacist | VCBH - Pharmacy |
| **Wake** | Casey | Clinical Director | Telecare Vista & Voice |
| **Wallace** | Andrea | Administrative Assistant | VCBH – Quality Assurance |

# Attachment C—Approved Claims Source Data

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

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

**Table C1: CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB**
**Ventura MHP**

| Entity | Average Monthly ACA Enrollees | Beneficiaries Served | Penetration Rate | Total Approved Claims | ACB |
|---|---|---|---|---|---|
| Statewide | 3,807,829 | 152,568 | 4.01% | $832,986,475 | $5,460 |
| Large | 1,833,373 | 69,835 | 3.81% | $406,057,927 | $5,815 |
| MHP | 63,533 | 2,304 | 3.63% | $15,100,704 | $6,554 |

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

**Table C2: CY 2018 Distribution of Beneficiaries by ACB Cost Band**
**Ventura MHP**

| ACB Cost Bands | MHP Beneficiaries Served | MHP Percentage of Beneficiaries | Statewide Percentage of Beneficiaries | MHP Total Approved Claims | MHP ACB | Statewide ACB | MHP Percentage of Total Approved Claims | Statewide Percentage of Total Approved Claims |
|---|---|---|---|---|---|---|---|---|
| < $20K | 9,032 | 91.80% | 93.16% | $39,422,619 | $4,365 | $3,802 | 54.06% | 54.88% |
| >$20K - $30K | 399 | 4.06% | 3.10% | $9,638,233 | $24,156 | $24,272 | 13.22% | 11.65% |
| >$30K | 408 | 4.15% | 3.74% | $23,857,306 | $58,474 | $57,725 | 32.72% | 33.47% |

# Attachment D—List of Commonly Used Acronyms

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

| Table D1—List of Commonly Used Acronyms | |
|---|---|
| **IHBS** | Intensive Home-Based Services |
| **IT** | Information Technology |
| **LEA** | Local Education Agency |
| **LGBTQ** | Lesbian, Gay, Bisexual, Transgender or Questioning |
| **LOS** | Length of Stay |
| **LSU** | Litigation Support Unit |
| **M2M** | Mild-to-Moderate |
| **MDT** | Multi-Disciplinary Team |
| **MHBG** | Mental Health Block Grant |
| **MHFA** | Mental Health First Aid |
| **MHP** | Mental Health Plan |
| **MHSA** | Mental Health Services Act |
| **MHSD** | Mental Health Services Division (of DHCS) |
| **MHSIP** | Mental Health Statistics Improvement Project |
| **MHST** | Mental Health Screening Tool |
| **MHWA** | Mental Health Wellness Act (SB 82) |
| **MOU** | Memorandum of Understanding |
| **MRT** | Moral Reconation Therapy |
| **NP** | Nurse Practitioner |
| **PA** | Physician Assistant |
| **PATH** | Projects for Assistance in Transition from Homelessness |
| **PHI** | Protected Health Information |
| **PIHP** | Prepaid Inpatient Health Plan |
| **PIP** | Performance Improvement Project |
| **PM** | Performance Measure |
| **QI** | Quality Improvement |
| **QIC** | Quality Improvement Committee |
| **RN** | Registered Nurse |
| **ROI** | Release of Information |
| **SAR** | Service Authorization Request |
| **SB** | Senate Bill |
| **SBIRT** | Screening, Brief Intervention, and Referral to Treatment |
| **SDMC** | Short-Doyle Medi-Cal |
| **SELPA** | Special Education Local Planning Area |
| **SED** | Seriously Emotionally Disturbed |
| **SMHS** | Specialty Mental Health Services |
| **SMI** | Seriously Mentally Ill |
| **SOP** | Safety Organized Practice |
| **SUD** | Substance Use Disorders |
| **TAY** | Transition Age Youth |
| **TBS** | Therapeutic Behavioral Services |
| **TFC** | Therapeutic Foster Care |
| **TSA** | Timeliness Self-Assessment |

| Table D1—List of Commonly Used Acronyms | |
|---|---|
| **WET** | Workforce Education and Training |
| **WRAP** | Wellness Recovery Action Plan |
| **YSS** | Youth Satisfaction Survey |
| **YSS-F** | Youth Satisfaction Survey-Family Version |

## Attachment E—PIP Validation Tools

| PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20<br>CLINICAL PIP | |
|---|---|
| **GENERAL INFORMATION** | |
| **MHP**: Ventura County Behavioral Health | |
| **PIP Title**: Post-Hospitalization Performance Improvement Project | |
| **Start Date**: 01/01/20<br><br>**Completion Date**: 12/31/21<br><br>**Projected Study Period**: 24 Months<br><br>**Completed**: Yes ☐ No ☒<br><br>**Date(s) of On-Site Review**: 02/25-27/2020<br><br>**Name of Reviewer**:<br><br>Robert Walton; Olivia Kosarev | **Status of PIP (Only Active and ongoing, and completed PIPs are rated):**<br><br>**Rated**<br>☐ Active and ongoing (baseline established and interventions started)<br>☐ Completed since the prior External Quality Review (EQR)<br><br>**Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.**<br>☒ Concept only, not yet active (interventions not started)<br>☐ Inactive, developed in a prior year<br>☐ Submission determined not to be a PIP<br>☐ No Clinical PIP was submitted |
| **Brief Description of PIP** (including goal and what PIP is attempting to accomplish): | |

# PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20
# NON-CLINICAL PIP

## GENERAL INFORMATION

**MHP**: Ventura County Behavioral Health

**PIP Title**: Enhanced Access Performance Improvement Project

**Start Date**: 08/01/18

**Completion Date**: 07/31/20

**Projected Study Period**: 18 Months

**Completed**: Yes ☐ No ☒

**Date(s) of On-Site Review**: 02/25-27/2020

**Name of Reviewer**:

Rob Walton/Olivia Kosarev

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

**Rated**

☒ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

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

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

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

**Brief Description of PIP** (including goal and what PIP is attempting to accomplish): This improvement activity has its origins in the reducing the time of access to beneficiaries in the Santa Paula region, with an emphasis upon the Latino/Hispanic population. As this activity has demonstrated success, other clinic sites in the North and South Oxnard area were also targeted with interventions specific to their needs. In the final phase of this PIP the MHP will be targeting the Conejo and Simi Valley areas.

## ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

| STEP 1: Review the Selected Study Topic(s) | | |
|---|---|---|
| **Component/Standard** | **Score** | **Comments** |
| 1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | A multifunctional team actively participated in the planning, design, and execution of the PIP. The team consisted of the project lead, Quality Improvement staff, Behavioral Health executive staff, Santa Paula Youth & Family clinic manager and administrator, Santa Paula Adult clinic manager and administrator, electronic health records staff, a QI research analyst, the Quality Management Action Committee (QMAC) members, and the Santa Paula community members and stakeholders. |
| 1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The topic was selected through the analysis of the baseline data consisting access timeliness and penetration rates for July 1,2017 to July 31, 2018. |

***Select the category for each PIP:***

*Non-clinical:*

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

| | | |
|---|---|---|
| 1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services?<br>*Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.* | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The PIP addressed the issues of long wait time, which resulted to an improved access to timely mental health services preventing crisis and increasing penetration rates of a historically underserved Hispanic/Latino population. |
| 1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?<br>*Demographics:*<br>☒ Age Range ☒ Race/Ethnicity ☐ Gender ☐ Language<br>☐ Other | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The PIP included all enrolled populations from the zip code 93060. |
| **Totals** | | **4** Met Partially Met Not Met UTD |

| STEP 2: Review the Study Question(s) | | |
|---|---|---|
| 2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?<br>*Include study question as stated in narrative:*<br>Would the following changes in operation in the Santa Paula Adult and Youth & Family clinics increase the percentage of consumers receiving a first offered appointment and first Medi-Cal service to meet the state's standard of 70% receiving such services within 10 business days, consequently increasing penetration rates?<br>Changes in Operation:<br>• Allow for walk-in requests for service (RFS) at the Santa Paula Adult and Youth & Family clinics<br>• Increase available hours for completing RFSs from 0 to approximately 30 hours per week (0.75 FTE increase) by expanding the duties and responsibilities of Santa Paula clinicians, Logrando Bienestar staff, and RISE staff<br>• Increase the number of hours available for assessments from approximately 28 to approximately 48 hours per week (0.5 FTE increase) | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The study question was clearing stated in writing and consisted a measurable impact such as increasing the percentage of consumers receiving a first offered appointment and first Medi-Cal service within the standard 10 business days to 70M.<br>However, in the course of this past year the North and South Oxnard clinic locations have been added. As currently written, the study question does not speak to those locations. In addition, the upcoming inclusion of Conejo/Simi Valley clinics are additional elements that is needed. It appears that this activity has evolved from a single site effort to now be focused on generalized improvement in initial access timeliness. That metamorphosis has been incompletely captured in the current study question. |
| | **Totals** | Met **1** Partially Met Not Met UTD |

| STEP 3: Review the Identified Study Population | | |
|---|---|---|
| 3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language<br>☒ Other: All initial requests for service in each area of the county. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The study defined the target population as all residents living in Santa Paula which is predominantly Latino, who requested services in the Santa Paula Mental Health clinics during July 1, 2017 to July 31, 2018 and August 1, 2018 to August 31, 2019. |
| 3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?<br>*Methods of identifying participants:*<br>☐ Utilization data ☐ Referral ☐ Self-identification<br>☐ Other: All individuals who present for service access | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |
| | **Totals** | **2** Met Partially Met Not Met UTD |

| STEP 4: Review Selected Study Indicators | | |
|---|---|---|
| 4.1 Did the study use objective, clearly defined, measurable indicators?<br>*List indicators:*<br><br>**Time to service indicators:**<br>• Time to Service for Santa Paula consumers making a RFS: First Offered Appointment within 10 business days<br>• Time to Service for Santa Paula consumers making a RFS: First face to face Medi-Cal Service within 10 business days<br>**Contact Method Indicators**<br>• Contact Method: Santa Paula consumers who made a RFS via Walk-In<br>• Contact Method: Santa Paula consumers who made a RFS via Phone<br>• Total number of RFS from Santa Paula consumers | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary focused.<br>☒ Health Status ☐ Functional Status<br>☒ Member Satisfaction ☐ Provider Satisfaction<br><br>Are long-term outcomes clearly stated? ☒ Yes ☐ No<br><br>Are long-term outcomes implied? ☒ Yes ☐ No | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Decreased time to first service is associated with improved satisfaction and clinical status. |
| | **Totals** | **2** Met Partially Met Not Met UTD |
| **STEP 5: Review Sampling Methods** | | |
| 5.1 Did the sampling technique consider and specify the:<br>a) True (or estimated) frequency of occurrence of the event?<br>b) Confidence interval to be used?<br>c) Margin of error that will be acceptable? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | Sampling was not used. |

| | | |
|---|---|---|
| 5.2 Were valid sampling techniques that protected against bias employed?<br><br>*Specify the type of sampling or census used:* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 5.3 Did the sample contain a sufficient number of enrollees?<br><br>_____N of enrollees in sampling frame<br>_____N of sample<br>_____N of participants (i.e. – return rate) | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| **Totals** | Met Partially Met Not Met **3** NA UTD | |

| STEP 6: Review Data Collection Procedures | | |
|---|---|---|
| 6.1 Did the study design clearly specify the data to be collected? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | ○ Client ID<br>○ Zip Code – only consumers with zip code 93060<br>○ Ethnicity<br>○ RFS Date<br>○ Contact Method – method used for service request (either through E-correspondence, Walk-In, or Phone)<br>○ Referral Source – where the RFS came from if client was referred and VCBH received a RFS via E-correspondence<br>○ Mental Health Service – where or which MH service the client was referred to after the RFS<br>○ First Appointment Date Offered<br>○ First face to face Medi-Cal Service Date – date of client's first service (includes all face to face, Medi-Cal services)<br>○ Program Value – where the assessment was performed<br>○ Age<br>○ Division – either adult or youth |
| 6.2 Did the study design clearly specify the sources of data?<br>*Sources of data:* | ☒ Met<br>☐ Partially Met | Chiefly, data is derived from the AVATAR system, and the STAR system tracking. |

| | | |
|---|---|---|
| ☐ Member ☒ Claims ☐ Provider<br>☐ Other: EHR and tracking system in Avatar | ☐ Not Met<br>☐ Unable to Determine | |
| 6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Microsoft Excel is used for managing the data from Avatar, maintaining the data and creating charts and tables. To test for significant differences between the baseline data and pilot data and to evaluate the success of the interventions. SAS Studio will be used for statistical analyses. The test to be performed in SAS Studio is the Wilcoxon Signed-Rank Test to compare the median time to service from RFS to First Offered Appointment, as well as RFS to face to face Medi-Cal service. Such test is performed because this project collected live data that consists of outliers. |
| 6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?<br>*Instruments used:*<br>☐ Survey ☐ Medical record abstraction tool<br>☐ Outcomes tool ☐ Level of Care tools<br>☒ Other: First offered appointment data; actual first face-to-face appointment data; changes in penetration rates in the Santa Paula area. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 6.5 Did the study design prospectively specify a data analysis plan?<br>Did the plan include contingencies for untoward results? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | In advance of the data analysis a number of statistical tests were specified. |
| 6.6 Were qualified staff and personnel used to collect the data?<br>*Project leader:*<br>Name: Salvador Manzo, LCSW<br>Title: Behavioral Health Manager<br>Role: Project lead<br>Other team members*:*<br>1. QMAC:. Shanna Zanolini, Psy.D. / Sloane Burt, M.A.<br>2. BH Executive Team: Pete Pringle, LCSW<br>3. Santa Paula Youth and Family Clinic Team: Cheryl Fox, LCSW / Angelina McCormick Soll, LCSW<br>4. Santa Paula Adult Clinic Team: Salvador Manzo, LCSW / Zandra Tadeo, LCSW<br>5. Data Team: Dave Roman and Faizal Ummer, M.B.A.<br>6. Research Analyst: Marady Mesa, M.P.H. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |
| | **Totals** | **6** Met Partially Met Not Met UTD |

| STEP 7: Assess Improvement Strategies | | |
|---|---|---|
| 7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?<br><br>*Describe Interventions:*<br>1. Allow for "walk-in" requests for service (RFS) at the Santa Paula Adult and Youth and Family clinics. Through this intervention, individuals can walk into clinics to make a request for service. This option was advertised to the community via stakeholder groups to inform them of the process change. This intervention aids in addressing the lack in personal engagement to help consumers feel more connected right from their first contact with VCBH.<br>2. Expand the duties and responsibilities of Santa Paula clinicians, Logrando Bienestar* staff, and RISE** staff to help with completing RFSs, thus increasing available hours for completing RFSs from 0 to approximately 30 hours per week (.75 FTE).<br>3. Increase the number of hours available for assessments from approximately 28 to approximately 48 hours per week (.5 FTE increase) to allow for an increase in available assessment slots at the Santa Paula clinics. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The interventions were designed to reduce or eliminate the time-based barriers to accessing care. As well, the use of culturally appropriate staff to help engage the Latino/Hispanic population. The shift in resources and flexing of clinical staff to respond to intakes helps to ensure that no delays occur. |
| | **Totals** | **1** Met Partially Met Not Met UTD |

| STEP 8: Review Data Analysis and Interpretation of Study Results | | |
|---|---|---|
| 8.1 Was an analysis of the findings performed according to the data analysis plan? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The data analysis process consisted of using Microsoft Excel to calculate the median number of business days waited from the RFS to the assessment for the adult consumer dataset, youth consumer dataset, and combined dataset. A bar graph was also created in Microsoft Excel to visualize the data trend in number of business days waited for the adult and youth datasets. SAS was used to test for a significant difference between the 2017-2018 and 2018-2019 median number of business days waited from RFS to assessment. The data analysis process occurred as planned. |
| 8.2 Were the PIP results and findings presented accurately and clearly?<br>Are tables and figures labeled?<br>☒ Yes ☐ No<br>Are they labeled clearly and accurately?<br>☒ Yes ☐ No | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?<br>Indicate the time periods of measurements: FY207-18 & FY2018-19<br>Indicate the statistical analysis used: Mean, median, standard deviation, range, and Wilcoxon Signed-Rank Test.<br>Indicate the statistical significance level or confidence level if available/known: p-value of less than 0.001; the alpha is 0.05 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The MHP describes comparison of data based on two fiscal year periods. However tabular data also represents this PIP with quarterly data displays.<br><br>Wilcoxon Signed-Rank Test was performed in SAS to compare the median number of business days waited from a RFS to a first offered appointment. A p-value of less than 0.001 was generated. Therefore, there was a significant difference in the number of days waited from a RFS to a first offered appointment between the years before and after the three interventions have been implemented.<br><br>First face to face improved from 45 percent within 10 business days to 57 percent. This MHP prefers to consider median values due to the significant outlier presence in this data. Median days went from 14 to 9 days after the interventions were applied. |

| | | |
|---|---|---|
| 8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?<br>*Limitations described:*<br>See text comments.<br>*Conclusions regarding the success of the interpretation:*<br>Improved, but there are limitations<br>*Recommendations for follow-up:*<br>Continue to seek improvement in the Santa Paula area while also targeting Oxnard North and South, and Conejo/Simi Valley areas with unique regional interventions. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | There were 45 outliers in the baseline data vs 16 in the study period. Data entry error and improper documentations were found to be recurring factors. Other factors such as difficulty contacting consumers and the consumers' engagement influenced the timeliness of services. To prevent outliers for future studies, training on proper documentation and data entry should be performed. |
| **Totals** | **4** Met | Partially Met Not Met NA UTD |

| STEP 9: Assess Whether Improvement is "Real" Improvement | | |
|---|---|---|
| 9.1 Was the same methodology as the baseline measurement used when measurement was repeated?<br>*Ask: At what interval(s) was the data measurement repeated?*<br>*Were the same sources of data used? -* ***yes***<br>*Did they use the same method of data collection? yes*<br>*Were the same participants examined? -****same category of individuals***<br>*Did they utilize the same measurement tools?* ***yes*** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | There are notable limitations to the study. For instance, conclusions from this study can only be generalizable to the study population of this project. The study did not collect data that identifies consumers who accept a later appointment date. Therefore, these data are still calculated in the results. Such factor would be considered extrinsic but could still affect the timeliness data.<br><br>**Conclusions:**<br>The three interventions did result in a positive impact on improving access to mental health services for the predominantly Latino population in Santa Paula. The most significant impacts were as follows:<br>• Noticeable increase in the number of consumers requesting services once the walk-in RFS became an option.<br>• Significant increase (Wilcoxon Signed-Rank test p-values <0.001) in the number of consumers receiving a first offered and first kept Medi-Cal appointment within the DHCS 10 day standard (FY 17-18 vs FY 18-19 vs FY 19-20 Q1)<br>• Overall increase in penetration rates for consumers in the study region (FY 17-18 Q1 vs FY 19-20 Q1) |

| | | |
|---|---|---|
| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?<br>Was there: ☒ Improvement ☐ Deterioration<br>Statistical significance: ☒ Yes ☐ No<br>Clinical significance: ☒ Yes ☒ No | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?<br>*Degree to which the intervention was the reason for change:*<br>☐ No relevance ☐ Small ☐ Fair ☒ High | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.4 Is there any statistical evidence that any observed performance improvement is true improvement?<br>☒ Weak ☐ Moderate ☐ Strong | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The baseline period was followed by the intervention year, which is the only data. A longer period would provide more information and also give the opportunity to resolve some of the problems that created data integrity issues. |
| **Totals** | **3** Met **2** Partially Met Not Met NA UTD | |

| **ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)** | | |
|---|---|---|
| **Component/Standard** | **Score** | **Comments** |
| Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement? | ☐ Yes<br>☒ No | |

**ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS**

*Conclusions:*

The PIP has seen an impact, improving penetration rates and timeliness for the Santa Paula area adult and youth and family clinics.

Due to similar issues with timeliness in Simi/Conejo and the Oxnard areas, this PIP has branched out to include regional specific interventions at those other sites. This includes walk-in capacity for youth & family in South Oxnard, and an orientation group merged within simultaneous individual intakes in North Oxnard for adults. Conejo/Simi areas will have their own unique strategies to improve timeliness.

**ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS**

*Recommendations:*

Continue to refine the approach in Santa Paula, building on the existent successes and striving to increase to the required 70 percent. Move forward with the other locales in which initial timeliness is being targeted, and ensure the correct strategies for those areas are being implemented.

It must also be noted that a key element underpinning both access and ongoing treatment is the issue of capacity and the vacancies that seem to prolific for this MHP. It seems that for all clinic sites, this MHP is somewhat reliant upon the shift of treatment resources to support assessment. While this can be done and will improve the timeliness for new beneficiaries, it is likely to have a negative impact upon the ability to sustain clinical treatment at the level required for existing beneficiaries to make progress.

During the review, PIP team members conveyed that a 10 percent caseload increase was anticipated by this process. They had thought this level of caseload increase was manageable. Subsequent analysis, however, has revealed that the increases are much more than that. Additional resources are needed, as are exit strategies for those who no longer meet SMHS requirements. But to do so requires the Gold Coast MCO's behavioral health contractor Beacon to have sufficient providers to absorb these cases. At this time, that is not the case.

Check one:

☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☒ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time

Note: This PIP is continuing until at least this coming summer, testing other regional strategies.