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FY 2021-22
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

VENTURA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

February 22 - 24, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report.

MHP INFORMATION

MHP Reviewed — Ventura

Review Type — Virtual

Date of Review — February 22 - 24, 2022

MHP Size — Large

MHP Region — Southern

MHP Location — Ventura

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 10,440

MHP Threshold Language(s) — English, Spanish

SUMMARY OF FINDINGS

Of the eight recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed or partially addressed eight recommendations.

California External Quality Review Organization (CalEQRO) evaluated the MHP on the following four Key Components (KC) that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent met (four of four components)
- Timeliness of Care: 100 percent met (six of six components)
- Quality of Care: 40 percent met (four of ten components) and 40 percent partially met (four of ten components)
- Information Systems (IS): 83.33 percent met (five of six components) and 16.67 percent partially met (one of six components)

The MHP submitted both required Performance Improvement Projects (PIP). The clinical PIP, “Post Hospitalization Performance Improvement Project”, is active in the final stage with a moderate confidence validation rating as the results and final measurements were not submitted at the time of this review. The non-clinical PIP, “Client Engagement after Intake Assessment” is active, and in the first year of implementation, with a low confidence validation rating as the first remeasurement data was not reported by the time of this review.

CalEQRO conducted four consumer family member focus groups, which included a total of 17 participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: commitment to cultural diversity and inclusion; timely access to care; creation of public-facing dashboard regarding services and demographics; improvement in Consumer Perception Survey (CPS) satisfaction with participation in treatment planning; and quality improvement (QI) efforts to improve post hospitalization follow-up QI activities.

The MHP was found to have notable opportunities for improvement in the following areas: long wait times for post hospitalization follow-up; bidirectional communication with clinical line staff and contract providers; incomplete Medicare certification to support claiming for both county and community based organization (CBO) sites; shortage of medication management education for beneficiaries; and underutilized peer support specialists.

FY 2021-22 CalEQRO recommendations for improvement include: continue QI efforts to improve the 7-day post hospitalization follow-up timeframe; improve current bidirectional communication process with clinical line staff and contract providers; complete the Medicare certification process; create opportunities to educate beneficiaries on medication management; create opportunities for peer specialists to participate in system planning and implementation and expand career and educational opportunities.

INTRODUCTION

BACKGROUND

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

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

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

This report presents the FY 2021-22 findings of the EQR for Ventura County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on February 22 - 24, 2022.

METHODOLOGY

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

year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File (IPC). CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020 and FY 2020-21, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data-overall, FC, transitional age youth (TAY), and Affordable Care Act (ACA). CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management - emphasizing utilization of data, specific reports, and activities designed to manage and improve quality of care - including responses to FY-2020-21 EQR recommendations.
- Review and validation of three elements pertaining to NA: Alternative Access Standards (AAS) requests, use of out-of-network providers and rendering provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).
- Summary of MHP-specific activities related to the following four KCs, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, and an examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per SB 1291 (Chapter 844).
- Review and validation of submitted PIPs.
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the MHP's quality and operational processes.
- Consumer perception of the MHP's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

In this section, the status of last year's (FY 2020-21) EQR recommendations are presented, as well as changes within the MHP's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic that occurred during the last 24 months across the state. The MHP faced significant staffing challenges over the past FY that includes unfilled vacancies, resignations, and retirements; reassignment of clinical staff as disaster service workers and other positions in the healthcare agency (HCA); shifting of supervisorial roles to support new initiatives, policies and procedures, trainings; and changes to the SMHS medical necessity criteria; and the implementation of California Advancing and Innovating MediCal (CalAIM) initiative (multiyear DHCS plan to transform the California healthcare services array of care). The MHP reported a 25 to 30 percent staff vacancy rate at the time of this review. EQR worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

MHP SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP allocated several executive leadership and management time to support current and future changes due to CalAIM; the MHP is recruiting for an Assistant Director of Behavioral Health to assist with implementation.
- The MHP was awarded the DHCS Behavioral Health Integration (BHI) grant that supported the creation of a care coordination team comprised of a behavioral health manager and a clinician to operate as hospital liaisons and care coordinators.
- The MHP demonstrated several improvements allowing greater access to SMHS such as:
    - Construction and staff hiring for Jackson House Santa Paula, a new crisis residential treatment program (pending licensure).
    - Preservation of two adult residential care facilities at risk of closing with private funding assistance (60 beds retained).

- A “no-cost” Substance Abuse and Mental Health Services Administration grant was extended for a fifth year to continue funding for the assisted outpatient treatment program.
- The MHP secured a $140,000 housing grant to support TAY and their families; an additional family apartment was added to the Mental Health Services Act (MHSA) housing program.
- Continued collaboration and planning with Dignity Health to develop a crisis residential unit.
- The MHP continues to develop plans for a non-profit funded 120-bed locked mental health rehabilitation center in Ventura County.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the MHP’s programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2020-21

Recommendation 1: The MHP’s active Post Hospitalization PIP needs to acquire the additional dedicated staffing planned to pursue the assertive tracking and follow-up of beneficiaries who have a within 30-day readmission. In addition, determination of which services are most impactful seems called for since the increased timeliness and volume of services tracks with increased readmission rates at the target facility.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP recently created a care coordination team to include a behavioral health manager and a mental health clinician. Team members are responsible for

care coordination with Vista Del Mar Hospital (VDMH) and Hillmont Psychiatric Hospital (HPH) during adult admissions and discharges.

- The MHP is collecting, tracking, and analyzing VDMH and HPH post hospitalization discharge follow-up services via Avatar electronic health record (EHR) post-hospitalization form; real-time data analysis is underway as the MHP's clinical PIP progresses.
- Due to the recent expansion of the care coordination team, the impact is yet to be realized; however, the MHP continues to adjust clinical interventions (outreach, care coordination, enrollment in services) as needed.

Recommendation 2: The MHP's under development "Client Report" non-clinical PIP. The current PIP rationale relies upon adult and youth CPS data that reflects fairly low neutral to negative responses, ranging from 9 to 20 percent. The MHP is encouraged to seek further TA.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- After receiving EQR PIP TA, and through conversations with the QI team, the MHP determined that the "Client Report" non-clinical PIP was not viable and further planning was discontinued.
- The MHP is pursuing a new non-clinical PIP focused on improving beneficiary engagement and timeliness to first rendered clinical service after initial assessment for the Youth and Family Division (YFD) clinics.

Recommendation 3: Begin tracking and analyzing objective call line metrics such as rings to pick-up, dropped calls, call volume and duration, to provide assist in making decisions that address capacity issues.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP made structural and operational changes integrating the mental health and substance use disorder access call lines in July 2021.
- Due to the time spent on these changes, as well as shifts and challenges with staffing, objective call line metrics as noted in the recommendation have not been used to assess capacity issues.
- Other metrics tracked in the Avatar EHR, such as total calls, types of calls (request, informational, or clinical), and the outcome of the call, are regularly reviewed by crisis and referral line lead staff.
- This recommendation will not transfer over to FY 2022-23.

Recommendation 4: Explore and improve the post-hospital 7-day follow-up reflected in the MHP self-report, which for adults indicates a 21-day average.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP's post hospitalization clinical PIP (July 2020 start) in tandem with the BHI grant project (October 2021 start) is focused on improving care coordination with VDMH and HPH and improving the timeliness of follow-up services post hospital discharge.
- Collaborative efforts between the rapid integrated support and engagement program (RISE), and the screening, triage, assessment, and referral team (STAR)–both front door programs–allow the MHP to identify and provide heightened focus on unenrolled beneficiaries recently discharged from the hospital. The MHP can enroll these individuals in services within approximately one month of discharge.
- Despite the initiated performance improvement activities, the MHP's self-reported 7-day post hospitalization follow-up is approximately 22-business days across all served populations; the average adult 7-day post hospitalization follow-up is approximately 26-business days.

Recommendation 5: Develop a routine reporting package of tracked metrics that is reviewed in the Quality Management Action Committee (QMAC) and other relevant forums to support concurrent examination of key data elements including service disparities.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP convened a mental health metrics team with representatives from across the MHP to include operations, billing/fiscal, contractors, MHSA representatives, quality assurance (QA) and information technology (IT) staff to systematically review core data sets; the team is tasked with establishing a methodology for data analysis, e.g., beneficiary demographics, and reporting.
- The MHP hired a research psychologist in January 2022 who will focus on beneficiary outcomes-based reporting.
- The QI team is developing a public-facing metrics dashboard that is readily available to interested stakeholders. The dashboard will provide information on timely access, beneficiary demographics, and count of services among other key data elements.
- QMAC meeting minutes submitted for this review reflect ad hoc discussions of PIP progress, beneficiary satisfaction survey results, metrics team updates and activities, and summary of services provided by the MHP. Minute meetings do not reflect a standing agenda item to discuss access, timeliness, quality or beneficiary outcome data.

Recommendation 6: The MHP should implement the Accredited Standards Committee X.12 270/271 eligibility transaction pair to address the claim denial reason of "beneficiary not eligible," which is 34 percent of all denials.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is not utilizing the 270/271 eligibility transaction process in Avatar.
- The MHP does provide eligibility transaction verification in Avatar using a third-party vendor who runs Medi-Cal batch eligibility; this information is posted and stored monthly in Avatar, along with the Medi-Cal eligibility verification confirmation number for verification.

Recommendation 7: Develop functionality that enables CBOs to perform batch uploads from their individual EHRs of claim files to the MHP's Avatar system. (*This recommendation is a carry-over from FY 2019-20*.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has determined the costs associated with developing this functionality outweigh the benefits.
- Currently, the senior management team use the data CBOs enter into Avatar to monitor their progress toward meeting assigned targets and goals.
- If CBOs were to send only claim submission files (which pass through the Avatar system but do not populate in it), the valuable means of tracking CBO activities would disappear, which the MHP desires to maintain.

Recommendation 8: Complete the Medicare certification process to support Medicare claiming for both county-operated and CBO sites and address the related Medi-Cal claims denial rate. (*This recommendation is a carry-over and consolidation of two recommendations from FY 2019-20*.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP continues to enroll providers in Medicare to bill for services.
- All doctors are enrolled and the MHP is currently reviewing the Medicare certification process for programs and anticipates having some approved by July 2022.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All MHPs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

FINDINGS

For Ventura County, the time and distance requirements are 60 minutes and 30 miles for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups - youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

DHCS required the MHP to submit an AAS request for 93255 and 93252 zip codes for which time and/or distance standards were not met. DHCS approved the MHP's AAS request. The communities in the 93255 and 93252 zip code areas straddle the Ventura and Kern County lines There is a reported total of 31 Medi-Cal beneficiaries in this remote part of Ventura County. The MHP reports the low number of total Medi-Cal beneficiaries would not support the establishment of certified provider sites in those areas.

Planned Improvements to Meet NA Standards

The MHP plans to provide full telehealth SMHS to beneficiaries residing in 93225 and 93255 zip code areas should the need arise.

MHP Activities in Response to FY 2020-21 AAS

The MHP has significantly increased the number of telehealth providers in their system of care. Furthermore, the MHP collaborated with Clinica Sierra Vista and College Community Services to establish single case agreements to provide SMHS to Ventura County Medi-Cal beneficiaries living in 93225 and 93255 zip code areas should the need arise (to include in-person appointment requests).

PROVIDER NPI AND TAXONOMY CODES

CalEQRO provides the MHP a detailed list of its rendering provider's NPI Type 1 number and associated taxonomy code and description. Individual TA is provided to MHPs to resolve issues which may result in claims denials, when indicated. The data comes from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. The data are linked to the NPPES using the rendering service provider's NPI, Type 1 number. A summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO will be presented in the FY 2021-22 Annual Aggregate Statewide report.

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[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN VENTURA COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP's system of care. Regardless of payment source, approximately 66.7 percent of services were delivered by county-operated/staffed clinics and sites, and 33.3 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 79.8 percent of services provided are claimed to Medi-Cal.

The Behavioral Health Services Crisis and Referral line is county-operated and is available to beneficiaries 24 hours, 7 days per week. This line is the entry point for access to all of the MHP services to include substance use services (SUS) services. Beneficiaries can enter the system of care through referrals by providers, local school district, sheriff's department and probation, hospitals, child welfare services (CWS), and through the STAR team. A STAR clinician is embedded in all YFD and adult clinics to triage walk-ins and perform assessments; smaller clinics share STAR assessors. If the STAR team determines that a beneficiary is not eligible for services, community and managed care plan referrals are provided. The RISE team provides field-based outreach, assessments, and treatment on an on-going basis. The children's accelerated access to treatment and services MHSA innovation project provides a comprehensive intake process and coordinated interagency service linkages for all youth entering CWS. The Ventura County HCA is the lead entity for the Whole Person Care pilot program. Eligible beneficiaries are pre-identified based on health plan data and flagged in a health registry, so that any provider (not just partner organizations) is notified and able to offer the appropriate referrals. Field outreach is conducted in community clinics, shelters, and bivouac sites for the unhoused population to reach eligible individuals who are not yet enrolled.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. Specifically, the MHP delivers psychiatry and mental

health services via telehealth to youth and adults. In FY 2020-21, the MHP reports having served 3,218 adult beneficiaries, 3,734 youth beneficiaries, and 421 older adult beneficiaries across 18 county-operated sites and five contractor-operated sites. Among those served, 1,111 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

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

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

Table 1: Key Components – Access

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

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

- The MHP is an integrated department of the Ventura County HCA and provides a full continuum of collaborative mental health and SUS.
- The MHP is committed to cultural diversity and health equity; policies, procedures, and practices are reflective of communities served. The Office of Health Equity and Cultural Diversity (OHE) is embedded in the MHP's administrative division and is focused on reducing physical and mental health disparities.
- The MHP's Logrando Bienestar program provides information on services, wellness and recovery, education, and advocacy, to the Latino/Hispanic

community. The program is working diligently to recruit and hire trilingual staff competent in English, Spanish, and Mixteco languages.

- Even though the MHP works hard to recruit and retain bilingual providers to meet beneficiary needs, bilingual psychiatric representation is still needed.

PERFORMANCE MEASURES

In addition to the KCs identified above, the following PMs further reflect access to care in the MHP:

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.
- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

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

The Latino/Hispanic population constitutes almost 60 percent of the Medi-Cal beneficiaries in Ventura County and slightly less than 50 percent of the beneficiaries served by the MHP. Whites constitute approximately 20 percent of Medi-Cal beneficiaries in the county and account for approximately 30 percent served by the MHP. The only other race/ethnicity category that has any significant numbers is the Other category which are beneficiaries with no identified specific race or ethnicity, or more than one identified race/ethnicity.

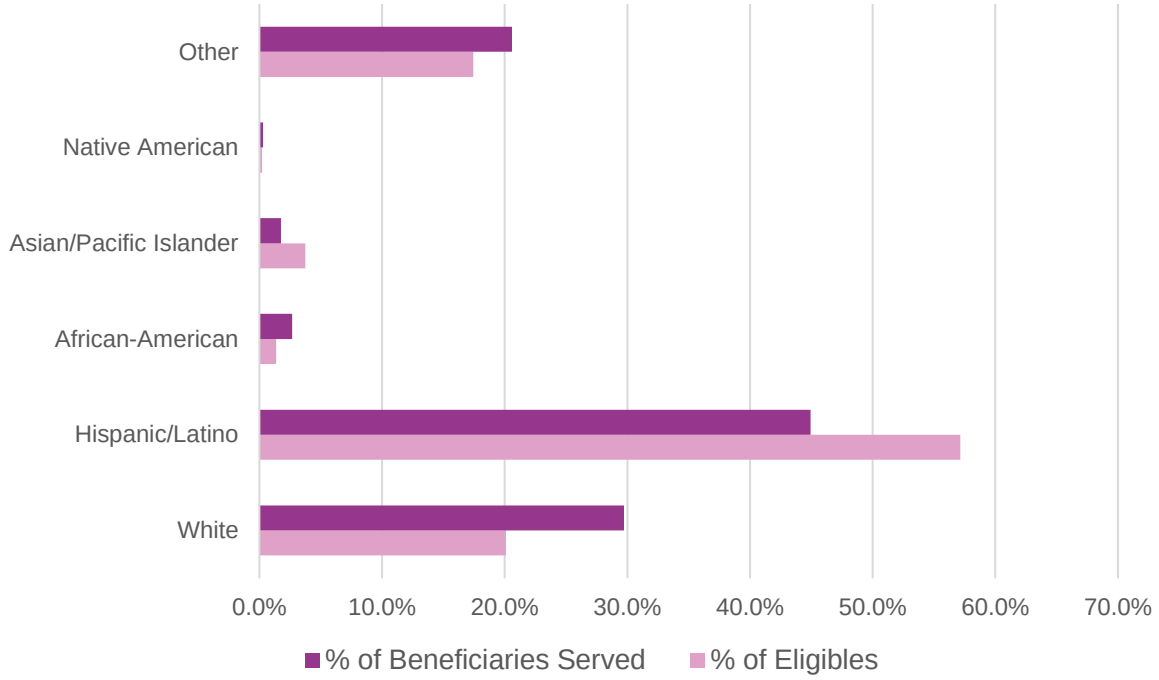
Table 2: County Medi-Cal Eligible Population and Beneficiaries Served in CY 2020, by Race/Ethnicity

Ventura MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	45,889	20.1%	3,104	29.7%
Latino/Hispanic	130,557	57.2%	4,691	44.9%
African-American	3,140	1.4%	279	2.7%
Asian/Pacific Islander	8,526	3.7%	184	1.8%
Native American	485	0.2%	32	0.3%
Other	39,846	17.4%	2,150	20.6%
Total	**228,443**	**100%**	**10,440**	**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 race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

The disparity in access to SMHS for Latino/Hispanic beneficiaries is noticed in figure 1.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



Less than one-fourth of beneficiaries served by the MHP in CY 2020 listed Spanish as their primary language, while English accounted for the majority of other languages spoken by beneficiaries.

Table 3: Beneficiaries Served in CY 2020, by Threshold Language

Ventura MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Other Language	7,947	78.7%
Spanish	2,145	21.3%
Total	**10,092**	**100.0%**
Threshold language source: Open Data per IN 20-070		
Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The ACB served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2019 ACA penetration rate and ACB.

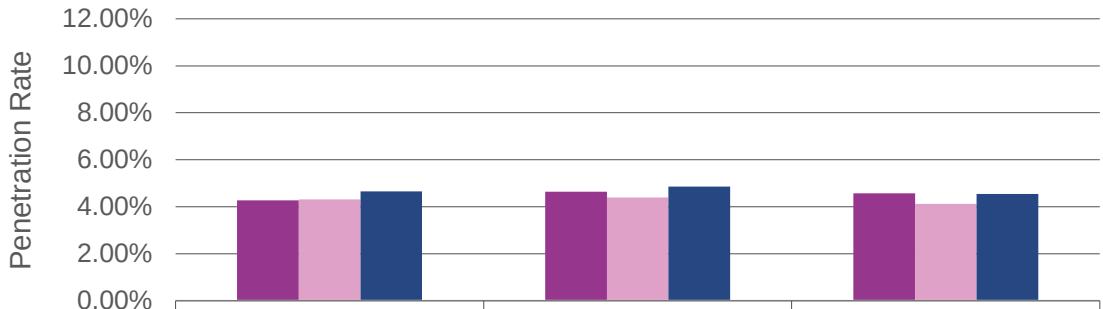
Figures 2 through 9 highlight three-year trends for penetration rates and average approved claims for all beneficiaries served by the MHP as well as the following three populations with historically low penetration rates: FC, Latino/Hispanic, and Asian/Pacific Islander (API) beneficiaries.

The MHP's average penetration rate between CY 2018 and CY 2020 was similar to rates seen statewide and in large counties during the same period. The same pattern holds true for the MHP's Latino/Hispanic and API populations.

The MHP's ACB remained consistent to large county and statewide averages from CY 2018 to CY 2020. This pattern holds true for the Latino/Hispanic population. While the MHP's API ACB declined slightly from CY 2018 to CY 2020, the state and large counties saw a slight increase. The MHP's FC penetration rate from CY 2018 to CY 2020 was consistently higher than large county and statewide averages.

Figure 2: Overall Penetration Rates CY 2018-20

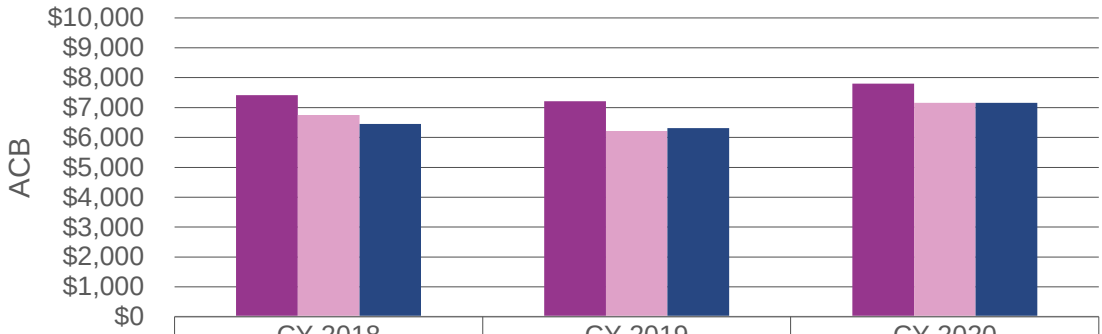
Ventura MHP



	CY 2018	CY 2019	CY 2020
MHP	4.27%	4.64%	4.57%
Large	4.31%	4.40%	4.13%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20

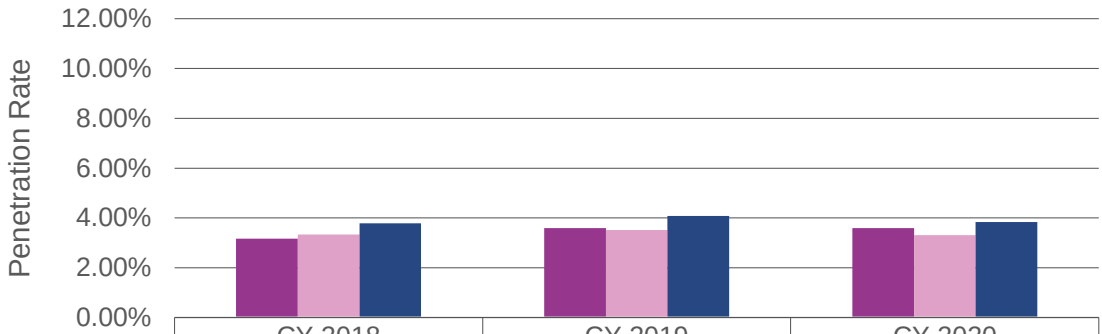
Ventura MHP



	CY 2018	CY 2019	CY 2020
MHP	$7,411	$7,215	$7,802
Large	$6,750	$6,219	$7,156
State	$6,454	$6,316	$7,155

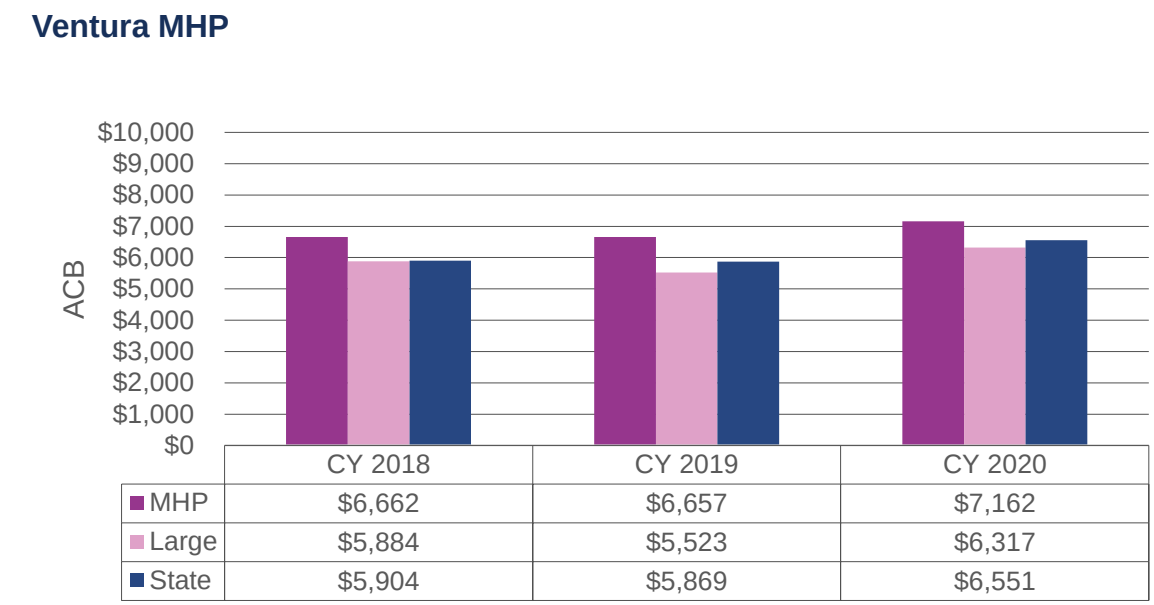
Figure 4: Latino/Hispanic Penetration Rates CY 2018-20

Ventura MHP



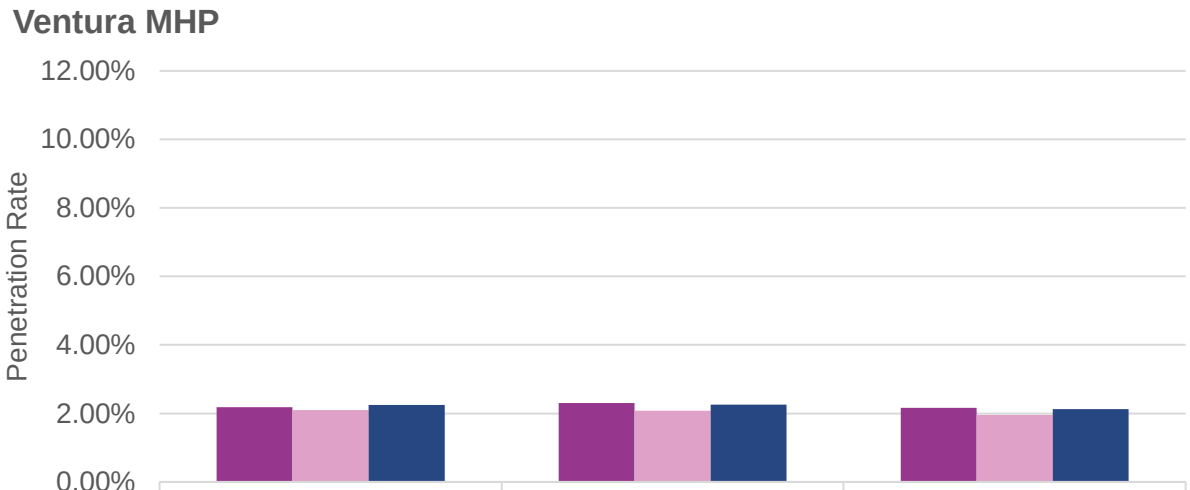
	CY 2018	CY 2019	CY 2020
MHP	3.17%	3.59%	3.59%
Large	3.33%	3.52%	3.31%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20



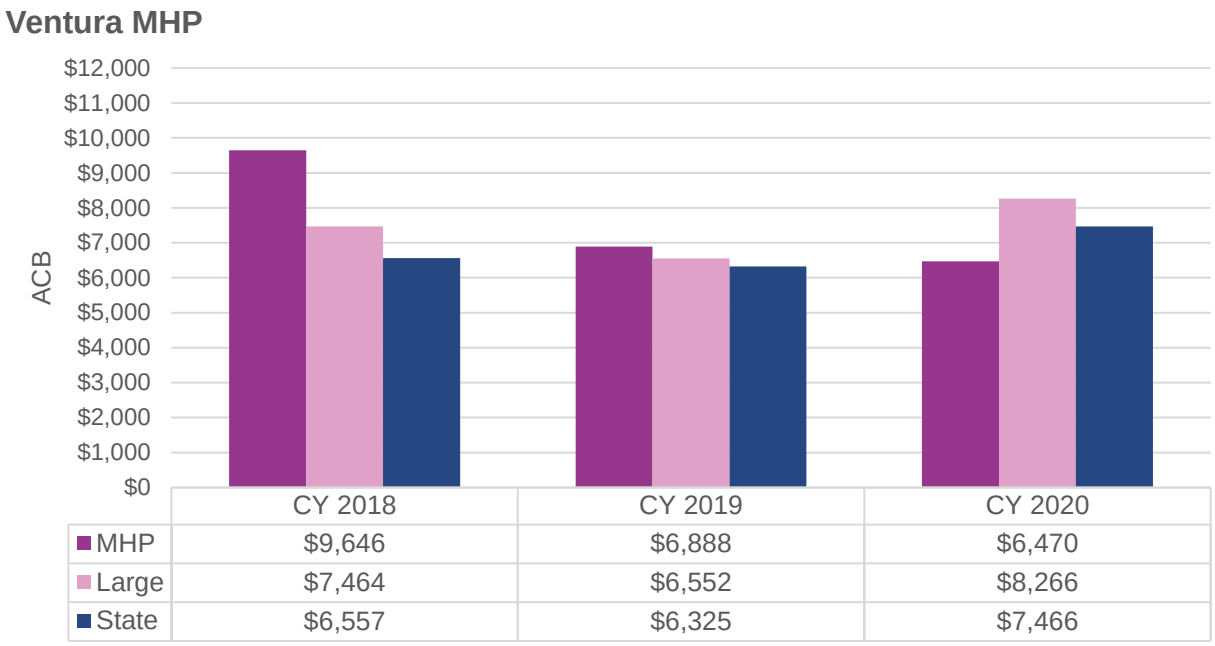
	CY 2018	CY 2019	CY 2020
MHP	$6,662	$6,657	$7,162
Large	$5,884	$5,523	$6,317
State	$5,904	$5,869	$6,551

Figure 6: Asian/Pacific Islander Penetration Rates CY 2018-20



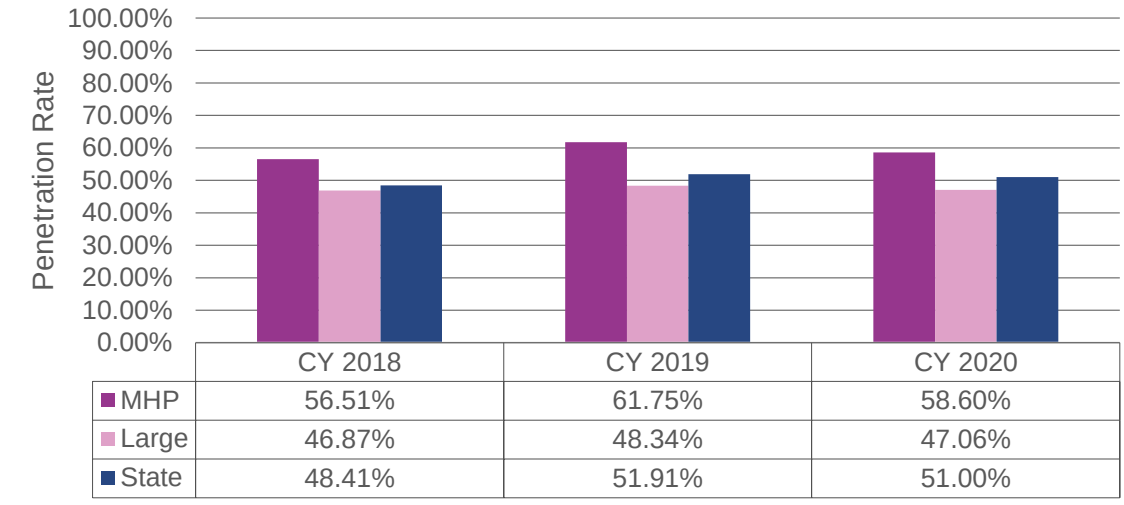
	CY 2018	CY 2019	CY 2020
MHP	2.18%	2.30%	2.16%
Large	2.10%	2.08%	1.96%
State	2.25%	2.26%	2.13%

Figure 7: Asian/Pacific Islander ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$9,646	$6,888	$6,470
Large	$7,464	$6,552	$8,266
State	$6,557	$6,325	$7,466

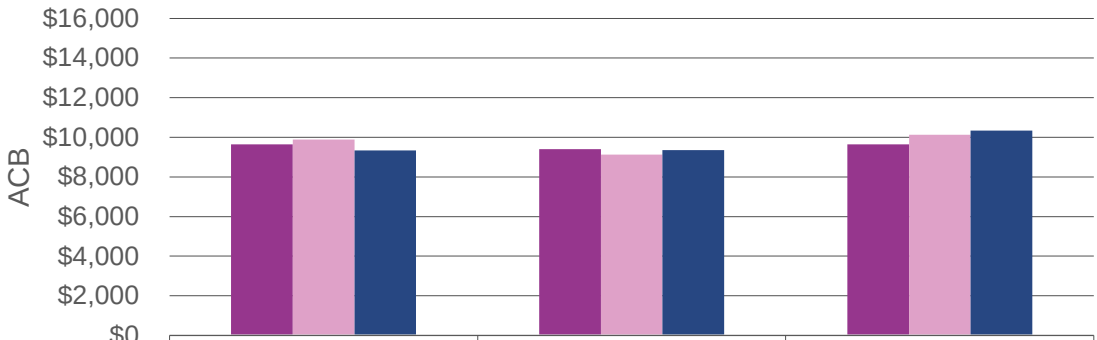
Figure 8: FC Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	56.51%	61.75%	58.60%
Large	46.87%	48.34%	47.06%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20

Ventura MHP



	CY 2018	CY 2019	CY 2020
MHP	$9,650	$9,403	$9,642
Large	$9,895	$9,125	$10,129
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

The MHP's has similar penetration rates to large sized counties and statewide, which is also noticed in the Latino/Hispanic and API penetration rates. The MHP's FC penetration rate is noticeably higher than the large county and statewide averages from CY 2018 to CY 2020. In CY 2018, the MHP's penetration was 17 percent higher than the statewide average, 19 percent higher than the state in CY 2019, and 15 percent higher than the state in CY 2020 The MHP's commitment to cultural diversity, outreach, and use of a beneficiary driven program model may account for the MHP's ability to ensure access to services.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track the timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. CalEQRO uses a number of indicators for tracking and trending timeliness, including the KCs and PMs addressed below.

TIMELINESS IN VENTURA COUNTY

The MHP reported timeliness data stratified by age and FC status. Further, timeliness data presented to CalEQRO represented the complete SMHS delivery system.

TIMELINESS KEY COMPONENTS

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

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

Table 4: Key Components – Timeliness

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

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

- The average time from first request for services to first offered appointment is 6.89 day across all services; furthermore, the MHP can provide the first rendered clinical service after the initial assessment in 10.25 business days on average.
- The time from initial request to first offered psychiatry appointment is 8.04 business days across all services. Contracted psychiatrists are embedded in clinics and provide telehealth and in-person appointments.
- The MHP can offer an initial psychiatry appointment within 8.04 business days across all services. Although the FC population is very low, the average amount of time to first rendered psychiatry appointment is approximately 23 business days versus 15 business days for adults and children.
- The MHP meets the 48-hour DHCS standard 74 percent of the time for urgent requests that do not require pre-authorization. Although the MHP has a mechanism to flag urgent requests, there is no standardized definition of urgent appointment requests.
- The current clinical PIP and BHI grant is focused on improving the timeliness of post hospitalization follow-up as the current average is 22 business days for all services.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Additionally, utilizing approved claims data, CalEQRO analyzes MHP performance on psychiatric inpatient readmission and follow up after inpatient discharge.

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including Healthcare Effectiveness Data and Information Set (HEDIS) measures:

- First Non-Urgent Appointment Offered
- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered
- Urgent Services Offered - Prior Authorization not Required
- Urgent Services Offered - Prior Authorization Required
- No-Shows - Psychiatry
- No-Shows - Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-21 as follows:

- The average time from initial request to first offered appointment is 6.89 business days, and MHP met the 10-business day standard 81 percent of the time across all services.
- The average time from initial request to first offered psychiatry appointment is 8.04 business days, and MHP met the 15-business day standard 89 percent of the time across all services.
- The average time from initial request to first offered urgent appointment is 40.72 average hours, and MHP met the 48-hour standard 74 percent of the time across all services.

- The amount of time from psychiatric hospital discharge to the first follow-up appointment is 22 days, and the MHP only meets the 7-day standard 70 percent of the time. On average, the MHP provides post hospital discharge follow-up appointments within 30 days for all services and meets the 30-day standard 85 percent of the time.
- For children, the average no-show rate for clinicians other than psychiatrists is noticeably higher than the average for all services (17.19 percent versus 12.51 percent). The MHP grouped nurse practitioner no-shows with the psychiatry no-show rate for all services.

Table 5: FY 2020-21 MHP Assessment of Timely Access

FY 2020-21 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6.89 Days	10-Business Days*	81 %
First Non-Urgent Service Rendered	10.25 Days	10 Days**	68 %
First Non-Urgent Psychiatry Appointment Offered	8.04 Days	15-Business Days*	89 %
First Non-Urgent Psychiatry Service Rendered	15.55 Days	15 Days**	64 %
Urgent Services Offered (including all outpatient services) - Prior Authorization not Required	40.72 Hours	48 Hours*	74 %
Urgent Services Offered - Prior Authorization Required	*** Hours	96 Hours*	*** %
Follow-Up Appointments after Psychiatric Hospitalization	22 Days	7 Days**	70 %
No-Show Rate - Psychiatry	13.64%	5%**	n/a
No-Show Rate - Clinicians	12.51%	5%**	n/a
* DHCS-defined timeliness standards as per BHIN 20-012 ** MHP-defined timeliness standards *** MHP does not separately track urgent services offered based on authorization requirements; all urgent services are held to a 48-hour standard.			

Medi-Cal Claims Data

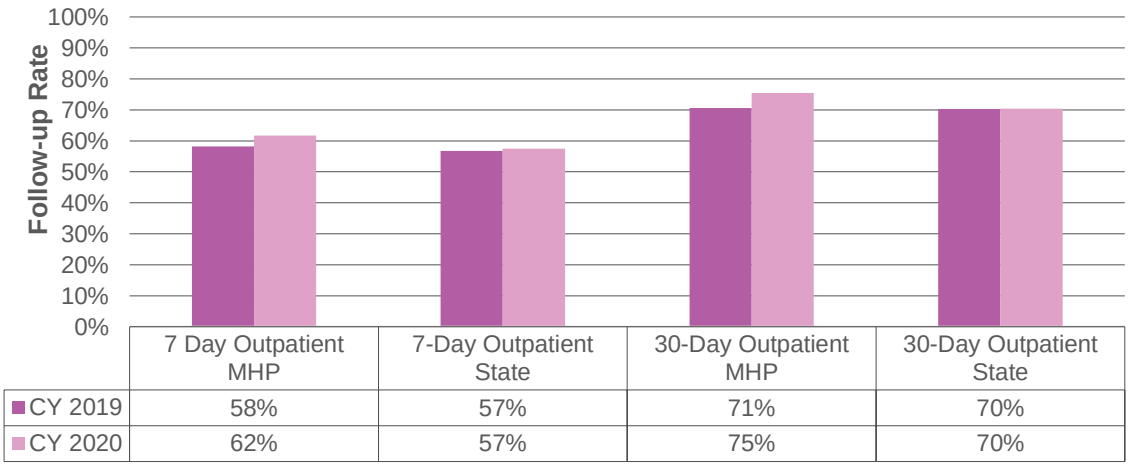
The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained mental health professionals is critically important.

Follow-up post hospital discharge

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care.

CalEQRO's data shows the MHP's 7-day and 30-day post psychiatric inpatient follow-up between CY 2019-20 was higher than the statewide average. The MHP's data shows the 7-day follow-up rate for FY 2020-21 was met 70 percent of the time while CalEQRO's data showed it was met 62 percent of the time in CY 2020. The MHP's data for FY 2020-21 shows 85 percent of services were provided within 30 days post hospital discharge, while CalEQRO's data shows that it was met 75 percent of the time in CY 2020. The CalEQRO data shows the MHP's 7-day and 30-day post psychiatric inpatient follow-up between CY 2019-20 is on par with the statewide averages.

Figure 10: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-20



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	58%	57%	71%	70%
CY 2020	62%	57%	75%	70%

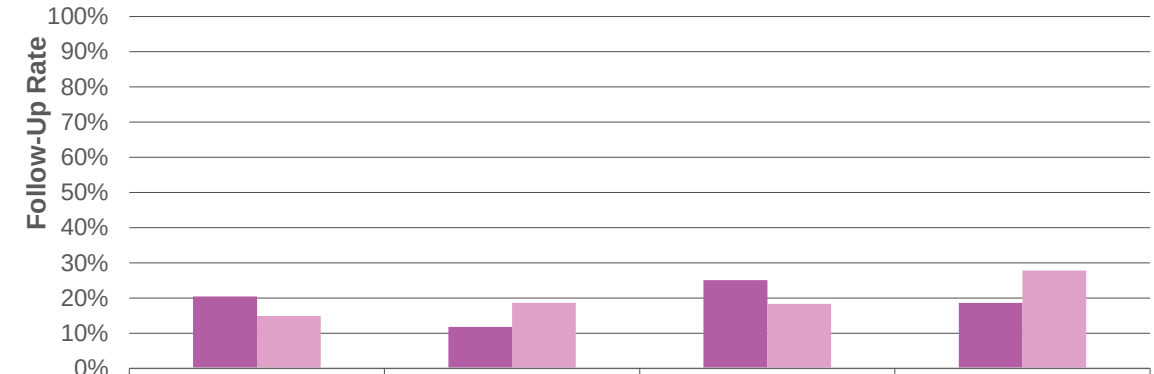
Readmission rates

The 7- and 30-day rehospitalization rates (HEDIS measures) are important proximate indicators of outcomes.

The MHP's data shows the 7-day hospital readmission rate in FY 2020-21 was 9 percent while CalEQRO's data showed the 7-day readmission rate was 15 percent in CY 2020. The MHP's 30-day rehospitalization rate for FY 2020-21 was 20 percent while CalEQRO's data for CY 2020 shows 18 percent. CalEQRO data shows that in CY 2020, both the 7-day and 30-day rehospitalizations rates were lower than statewide averages. The MHP includes each hospitalization episode for any MHP enrolled or Ventura County Medi-Cal beneficiary in their data calculations, while CalEQRO data reflects paid Medi-Cal claims only which contributes to the difference in rehospitalization as well as follow-up rates.

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-20

Ventura MHP



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	20%	12%	25%	19%
CY 2020	15%	19%	18%	28%

IMPACT OF FINDINGS

CalEQRO's data shows the MHP's 7-day rehospitalization rates were higher than the statewide average in CY 2019 (20 percent versus 12 percent) despite the higher than statewide 7-day post hospitalization follow-up rates (58 percent versus 57 percent). The 30-day readmission rate in CY 2019 was also higher than the statewide average (25 percent versus 19 percent). The MHP attributed this discrepancy as an indication of gaps in the provision of services for beneficiaries around hospitalizations.

CalEQRO data from CY 2020 showed an improvement in both the 7-day and 30-day readmission rates from CY 2019, and the rates were also lower than the statewide averages. This improvement may be attributed to the MHP's QI efforts using the BHI grant and clinical PIP interventions.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

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

QUALITY IN VENTURA COUNTY

The MHP's quality management (QM) program resides within the administrative division and is overseen by the administration division chief and the compliance senior manager and is accountable to the MHP's director. The QM scope of responsibilities includes oversight of timeliness, access, quality, coordination of care, wellness and recovery, beneficiary satisfaction, and cultural competency. The QM program is divided into five units that work together to achieve the goals of the Quality Assessment and Performance Improvement Plan (QAPI): quality assurance (QA), QI, medical records, training, and pharmacist. The QAPI includes goals and objectives for SUS and mental health divisions.

The QA unit is tasked with monitoring compliance with contract requirements, federal and state regulations, and department policies and procedures. The MHP's QI unit is responsible for the coordination, planning, oversight, and communication of QI projects, and monitoring/evaluating services provided in the mental health and SUS divisions. The QA and QI units share many QI goals such as promoting continuous quality improvement (CQI), identifying opportunities for improvement, collecting, and analyzing data to measure against goals and standards, comprehensive oversight of service delivery to ensure quality of care, and communicating QI project results with staff and stakeholders.

The MHP monitors its quality processes through the QMAC, QAPI plan, and the annual evaluation of the QAPI plan. The QMAC meets on a quarterly basis and is comprised of representatives from the Behavioral Health Advisory Board (BHAB); QI, QM, and QA

units; fiscal/billing team; beneficiaries and community stakeholders. Since the previous EQR, the MHP QMAC met three times. The FY 2020-21 QAPI includes goals and objectives for the mental health and SUS divisions. The plan includes ten identified goals with one to two objectives listed for each goal. The MHP was successful in meeting all annual QAPI goals except for creating a standardized review process with operational and executive staff. The plan also reflects the impact of COVID-19 on QI activities, e.g., low CPS response rate.

The MHP utilizes the following Level of Care (LOC) tools: Milestones of Recovery Scale for adult and older adult beneficiaries. For children and youth population, the MHP uses the Child and Adolescent Needs and Strengths (CANS-50) in addition to an extensive version with 50 modules.

The MHP utilizes the following outcomes tools: Behavior and Symptom Identification Scale, General Anxiety Disorder-7, Patient Health Questionnaire for adults. The Pediatric Symptom Checklist (PSC-35) and CANS-50 and are utilized with children and youth.

Several clinics are located throughout the county to ensure access to services. There are eight high school YFD wellness centers in the county. The MHP's Oxnard Adult Wellness Center is operated by Turning Point Foundation (TPF), and provides outreach, on-site supports, referrals, and transitional support. The MHP also provides referrals to the TPF New Visions Rehabilitation Center in Ventura. There are no adult wellness centers in the eastern portion of the county. Ventura County operates the TAY Tunnel Walk-In Center in Oxnard. Two peer recovery coaches and one parent partner are members of the MHP's TAY engager team to provide outreach and engagement of this population. The wellness center is operated by staff and peers to support beneficiaries with wellness and recovery. Stakeholder feedback during the review demonstrate that peers adapted to changes in service delivery in response to COVID 19; have positive rapport with supervisors; are interested in peer support certification; and are highly effective at engaging beneficiaries by using their lived experience. Stakeholders also reported the need for peer training relative to their job duties and cultural competency; more opportunities for career advancement; peers are underutilized in the system of care; and peer support specialists desire integration into the system of care, e.g., committees and policy planning.

QUALITY KEY COMPONENTS

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

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

Table 6: Key Components – Quality

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Not Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP collects and reports on data from various sources to inform QI processes; however, the MHP continued efforts to address past inaccurate and/or incomplete data within multiple data sets, e.g., CANS-50, PSC-35.
- To address data integrity, the MHP created a data metrics team and hired a research psychologist to focus on design, implementation, and outcomes-based reporting.
- The MHP does not aggregate beneficiary-level outcomes; however, the newly hired research psychologist is tasked with the design and implementation of outcome-based reporting.

- Stakeholder feedback during interviews reflect opportunities to improve bidirectional communication with contract providers and the need to standardized quarterly meetings.
- The MHP is addressing opportunities for improvement in medication management regarding collaboration with primary care providers and documentation accuracy. Improvement areas include improving coordination of care between providers and increasing the focus on specialty groups.
- The MHP does track and trend the following HEDIS measures as required by SB 1291:
    - The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
    - Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
- The MHP does not track and trend the following HEDIS measures as required by SB 1291:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)
    - The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

In addition to the KCs identified above, the following PMs further reflect the Quality of Care in the MHP:

- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

Diagnosis Data

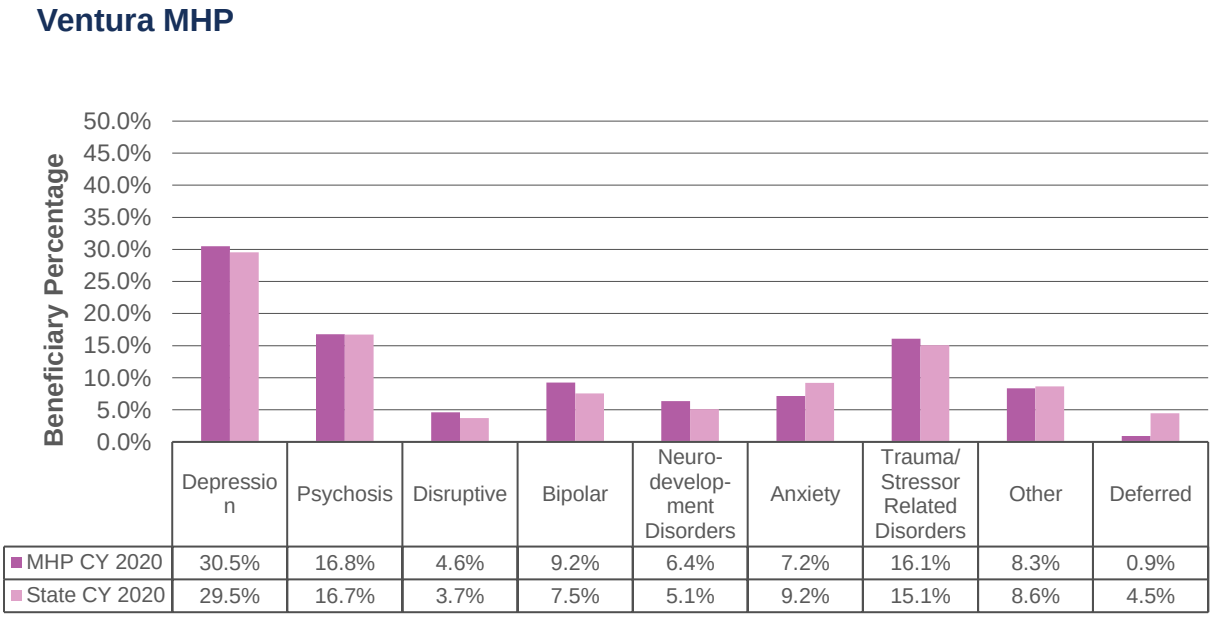
Figures 12 and 13 compare the percentage of beneficiaries served and the total approved claims by major diagnostic categories, as seen at the MHP and statewide for CY 2020.

The MHP's diagnostic patterns are similar to those noticed statewide except for the deferred category. The MHP's deferred diagnostic rate (0.9 percent) is almost four times less than that seen throughout the state (4.5 percent). This may be explained by the

MHP's focus on the importance of a well-considered, accurate diagnosis to increase clarity regarding the full nature of the beneficiary's symptoms.

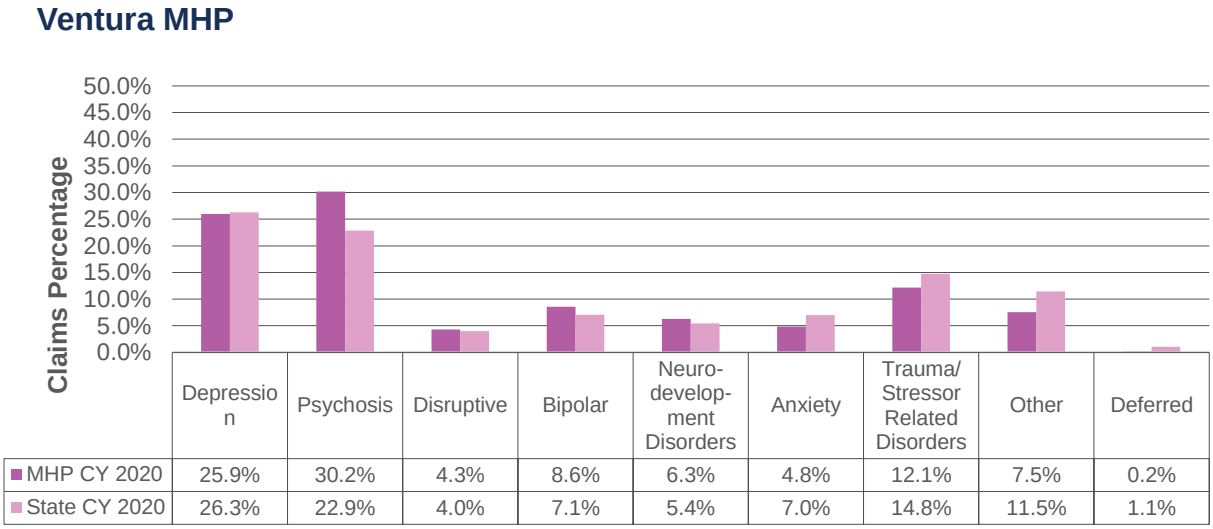
The majority of claims were approved for beneficiaries diagnosed with depression (25.9 percent), which is also noticed in statewide patterns (26.3 percent). This composition accurately reflects the high percentage of MHP beneficiaries diagnosed with depression (30.5 percent). Although the psychosis diagnosis accounts for 16.1 percent of all beneficiaries served, the MHP's approved claims reflect that it accounts for 30.2 percent of all approved claims in CY 2020.

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020



	Depression	Psychosis	Disruptive	Bipolar	Neuro-develop-ment Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	30.5%	16.8%	4.6%	9.2%	6.4%	7.2%	16.1%	8.3%	0.9%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2020



	Depression	Psychosis	Disruptive	Bipolar	Neuro-develop-ment Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	25.9%	30.2%	4.3%	8.6%	6.3%	4.8%	12.1%	7.5%	0.2%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

Psychiatric Inpatient Services

Table 7 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

The MHP's count of beneficiaries who required inpatient hospitalization and the number of admissions remained stable from CY 2018 to CY 2019. From CY 2018 to CY 2020, the MHP experienced a 34 percent decrease in total hospitalizations, and a 25 percent decrease in the unique count of beneficiaries needing psychiatric inpatient services. The MHP's average LOS remained stable from CY 2018 to CY 2020, with similar trends seen statewide. Although the average inpatient LOS remained stable over the last three CY, the ACB increased more than 50 percent from CY 2019 to CY 2020 which was not experienced statewide.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

Ventura MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2020	808	1,840	7.61	8.68	$15,442	$11,814	$12,476,952
CY 2019	1,063	2,675	6.29	7.80	$9,879	$10,535	$10,500,899
CY 2018	1,073	2,788	6.71	7.63	$11,324	$9,772	$12,150,506

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

From CY 2018 to CY 2020, the HCB count and the HCB percentage by count remained stable. The HCB percentage by total claims remained fairly consistent over the last three CY, which followed statewide trends (approximately 30 percent).

Table 8: HCB CY 2018-20

Ventura MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	441	10,440	4.22%	$60,885	$26,850,466	32.96%
	CY 2019	426	10,405	4.09%	$56,372	$24,014,417	31.99%
	CY 2018	408	9,839	4.15%	$58,474	$23,857,306	32.72%

See Attachment D, Table D2 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.

Retention Data

The MHP's service retention pattern is consistently below the statewide average between one and four services. Most beneficiaries receive 5-15 or more services accounting for approximately 80 percent of the MHP beneficiaries. The MHP's non clinical PIP is focused on reducing the time from initial assessment to first rendered

service. The MHP's data showed varying wait times for first rendered service, with several YFD appointments taking place outside the critical window for engagement.

Table 9: Retention of Beneficiaries

	Ventura			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 Service	708	6.78	6.78	9.76	9.76	5.69	21.86
2 Services	604	5.79	12.57	6.16	15.91	4.39	17.07
3 Services	397	3.80	16.37	4.78	20.69	2.44	9.17
4 Services	373	3.57	19.94	4.50	25.19	2.44	7.78
5-15 Services	2,938	28.14	48.08	29.47	54.67	19.96	42.46
>15 Services	5,420	51.92	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

The MHP is committed to cultural diversity, identifying the root causes of health disparities, and promotion of wellness and recovery throughout the adult division and YFD. The MHP is addressing several opportunities for improvement including medication management and accurate data to inform QI activities. Several clinics are located throughout Ventura County to ensure access to services, and there are eight high school YFD wellness centers. Adults have several choices for wellness centers although there are no centers in the eastern part of the county. During the review it was identified that peers need more involvement in beneficiary treatment planning, educational and career advancement, and involvement in system planning and implementation. The MHP's clinical PIP and BHI grant activities are focused on improving post hospitalization follow-up timeliness. It would benefit the MHP to explore root causes of long FC youth wait times for the first rendered psychiatry services. The HCB count and HCB percentage by count remained stable, and the total count of beneficiaries requiring hospitalization decreased by 34 percent from CY 2018 to CY 2020. The MHP's average hospitalization LOS remained stable from CY 2018 to CY 2020, with similar trends seen statewide; however, the ACB for inpatient hospitalization increased more than 50 percent from CY 2019 to CY 2020.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Post Hospitalization Performance Improvement Project.

Date Started: July 2020

Aim Statement: "Will improved coordination and collaboration amongst Ventura County Behavioral Health (VCBH) and hospital staff, as well as enhanced outpatient follow-up service provision, reduce the 7-day and 30-day readmission rates for VCBH beneficiaries by 50% by June 2022?"

Target Population: In this phase of the PIP, the population includes beneficiaries recently discharged from VDMH or HPC that are enrolled in an MHP program prior to

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

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

the hospital admission, and unenrolled beneficiaries that the MHP is attempting to connect to mental health services.

Validation Information: The MHP's clinical PIP is active and in the final stage with a moderate confidence validation rating.

Summary

The MHP found in July 2020 that the rehospitalization rates for all MHP beneficiaries was higher than the statewide average despite (negative performance) higher than state averages for the 7-day and 30-day post-hospitalization follow-up (positive performance). The MHP determined after a root cause analysis that the higher rehospitalization rates were indicative of gaps in in the provision of services for beneficiaries recently discharged from the hospital.

The 7-day post-hospitalization follow-up rate in CY 2019 was 58 percent (versus 57 percent statewide), and the 30-day post hospitalization follow-up rate for the same period was 71 percent (versus 70 percent statewide). This shows the MHP hospitalization follow-up rates were on par with statewide averages. At the same time, the MHP's 7-day hospital readmission rate was 20 percent versus the statewide average of 12 percent, and the 30-day readmission rate was 25 percent versus the 19 percent statewide average. This reflects the MHP's 7-day follow-up was 66.7 percent higher than the statewide average, and the 30-day follow-up was 32 percent higher.

The MHP reported this data showed that expedited contacts with outpatient services post-hospitalization, in of themselves, are not resulting in the desired decrease in readmission rates. To address this issue, the MHP deployed an intensive case management program (ICMP) to beneficiaries who are hospitalized at VDMH or HPC. The ICMP strategy includes improving reporting structures in the EHR; tracking census and data tracking errors; collaboration between MHP and hospital staff; performing regular status checks with hospital staff; integration of RISE and STAR in discharge planning and on-the-spot assessments; ensuring timely post-hospitalization follow-up, providing enhanced case management to beneficiaries; and reintegration of beneficiaries into outpatient care.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: the final measurements and results of the study were not submitted at the time of this review. At the same time, CalEQRO data shows the 7-day post hospitalization follow-up rate from CY 2019 to CY 2020 improved by 7 percent, and the 30-day follow-up rate improved by six percent.

The TA provided to the MHP by CalEQRO consisted of:

- Review of selected PIP interventions and discussion of clinical impact.
- Discussion of relevant recommendations.

CalEQRO recommendations for improvement of this clinical PIP include:

- Clearly identify and integrate clinical interventions that directly impact beneficiary outcomes such as changes in beneficiary health, functional status, or satisfaction resulting from the PIP.
- Describe the final data analysis and interpretation of PIP results to include lessons learned and opportunities for improvement.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Client Engagement after Intake Assessment

Date Started: June 2021

Aim Statement: "At YFD regional outpatient clinics, can operational efficiencies in the process of engaging VCBH YFD beneficiaries result in a 5 percent increase in beneficiaries who receive their first outpatient service within 15-business days after the intake assessment?"

Target Population: YFD clinic population (primarily youth, ages 0-17) at VCBH. Seven YFD clinics are participating in Oxnard, South Oxnard, Ventura, Simi, Santa Paula, Conejo, and Fillmore.

Validation Information: The MHP's non-clinical PIP is active, in the first year of implementation, with a low confidence validation rating as the first re-measurement data was not reported at the time of this review. The low confidence speaks more to the lack of results versus the intervention selection.

Summary

The MHP's non-clinical PIP is focused on reducing the time from initial assessment to first rendered services. The MHP's data showed varying wait times for first rendered service in the YFD, with many appointments taking place outside the critical window for engagement. Several operational issues impacted the timeliness of the first rendered service such as delay in notification of a completed assessment, assignment of provider, or other barriers such as lack of transportation. Furthermore, the YFD clinics serve different demographic populations that may also pose greater challenges with access to services.

The MHP created a new client engagement process (CEP) that is designed to identify newly assigned beneficiaries in the EHR; improve departmental communication; administrative review of no-show appointments and timely follow-up; twice-per-week distribution list of new beneficiaries and timeliness of services; alert notes to identify beneficiaries who have gone more than ten days to the first outpatient appointment; and expedited outreach and services to high acuity/non-urgent beneficiaries.

The baseline data from CY 2021 reflects 64 percent of YFD beneficiaries (n=762) was 64 percent. The MHP is also tracking the no-show rate which was 75 percent (n=61) in CY 2021. First re-measurement data was not available at the time of this review.

TA and Recommendations

As submitted, this non-clinical PIP was found to have the low confidence, which speaks more to the lack of results versus the intervention selection.

The TA provided to the MHP by CalEQRO consisted of:

- Review of selected PIP interventions and discussion of clinical impact.

CalEQRO recommendations for improvement of this non-clinical PIP include:

- The MHP may want to consider issuing the alert notice prior to the 10-day mark rather than when the beneficiary has gone more than ten days for a first rendered clinical service. This will allow the MHP to preemptively identify beneficiaries who are approaching the critical window of opportunity.
- Conduct at least quarterly data re-measurements to identify possible untoward results and modification of interventions if needed.

INFORMATION SYSTEMS

BACKGROUND

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

INFORMATION SYSTEMS IN VENTURA COUNTY

California MHP EHRs fall into two main categories—those that are managed by county of MHP IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary her system used by the MHP is Netsmart/myAvatar, which has been in use for 12 years. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 7.03 percent of the MHP budget is dedicated to support the IS (County IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 752 named users with log-on authority to therEHR, including approximately 554 county-operated staff and 198 contractor-operated staff. Support for the users is provided by 14 full-time equivalent (FTE) IS technology positions. Currently all positions are filled. These IS positions support both the mental health and substance use disorder system of care.

As of the FY 2021-22 EQR, all contract providers have access to directly enter clinical data into the her's EHR. Line staff having direct acceshero the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all provihers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 10: Contract Providers' Transmission of Beneficiary Information to MHP EHR

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

Beneficiary Personal Health Record

The 21st Century Cures Act (Cures Act) of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a PHR enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not currently have PHR functionality, although implementation is expected within the next year.

Interoperability Support

The MHP is not a member or participant in a Health Information Exchange (HIE). Healthcare professional staff use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information with MHP contracted providers, substance use disorder providers, whole person care, and hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following KCs related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in

extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 11: Key Components – IS Infrastructure

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

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

- The MHP s implementing an updated public data dashboard with interactive data for the continuum of care.
- The IS components are generally rated positively, however, there are multiple opportunities to improve the interoperability, data collection, and reporting functionality of system-wide data within the EHR.
- The MHP still has not completed Medicare certification to bill prior to Medi-Cal billing.

IMPACT OF FINDINGS

While the MHP maintains dedicated technology staffing, the initiatives and development projects and evaluation of transitioning to a new EHR, are substantial and require additional staffing to ensure successful implementation. Current level of staffing does not provide redundancy of coverage for multiple systems.

With approximately half of contracted providers not utilizing the MHP EHR, there are opportunities to enhance data collection and timeliness reporting to ensure comprehensive data is available to inform decisions related to service need within the continuum of care.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

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

CONSUMER PERCEPTION SURVEYS

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

The MHP shares CPS results with executive leadership, division chiefs, QM, MHSA program, fiscal leadership, clinical staff, CBO representatives, community members, advocates, contractors, and administration. The MHP encourages these entities to share results with clinical line staff. The survey results are also shared during QMAC meetings, and previous CY results are compared to current findings. The May 2021 CPS summary report showed a three percent increase in satisfaction in perception of participation in treatment planning for adults, older adults, and YFD; the average scores in all domains met the MHP's goal (3.5 percent threshold); decrease in self-reported school expulsions in YFD for those receiving services for more than a year; and a decrease in self-reported arrests for adults and older adult who began services in the last year. The MHP identified two opportunities for improvement including: perception of satisfaction with services (71 percent for adult and older adults, and 70 percent for YFD beneficiaries); and perception of satisfaction with level of functioning (71 percent satisfaction for adult and older adults, and 72 percent satisfaction for YFD beneficiaries).

CONSUMER FAMILY MEMBER FOCUS GROUP

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

As part of the pre-review planning process, CalEQRO requested four 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing six to eight participants each.

Consumer Family Member Focus Group One

CalEQRO conducted one 90-minute focus group with a culturally diverse group of Spanish-speaking adult beneficiaries who are mostly new clients who have initiated/utilized services within the past 12 months. The focus group was held via videoconference and included six participants; a Spanish language interpreter was not used for this focus group as the CalEQRO CFM consultant is proficient in Spanish.

Two beneficiaries received services immediately after psychiatric inpatient discharge; one beneficiary reported a difficult experience entering services due to cultural stigma; and one participant reported a positive experience when entering the system of care. All participants reported satisfaction with the MHP, and their services improved their level of functioning. All participants were able to access transportation, to include obtaining bus passes. Most participants were offered information regarding services translated in Spanish and were able to access a translator when needed. The frequency of appointments varied across the participants from once per week to once every three months. Most participants were satisfied with telehealth. Frequency of psychiatry services varied from once per month to once every three months. All participants reported they receive assistance when experiencing issues with medication. Most participants receive appointment reminders. Feedback was not obtained regarding access to crisis services, participation in MHP committees, employment assistance and opportunities. One participant reported participation in an action and wellness recovery plan. Half of the participants were aware that their psychiatrist coordinated care with their primary care provider.

Recommendations from focus group participants included:

- Provide more guidance and assistance to beneficiaries when in crisis.

Consumer Family Member Focus Group Two

CalEQRO conducted one 90-minute focus group with a culturally diverse group of Spanish-speaking parents/caregivers of child/youth beneficiaries who are mostly new clients who have initiated/utilized services within the past 12 months. The focus group was held via videoconference and included four participants; a Spanish language interpreter was not used for this focus group as the CalEQRO CFM consultant is proficient in Spanish. Only one participant began services within the previous 12 months.

Participants reported their children's appointments are held via telehealth, in-home, and in the school setting. Appointment frequency ranged from one to two times per week. Caregivers are reminded about their child's appointments. Caregivers know to call 911, their child's therapist or the crisis line for immediate assistance. Participants feel their cultural needs are met and services are available in their preferred language. Half of the participants reported their child experienced stress and difficulties with the onset of

COVID-19 but have since improved since schools have been opened back up. Information regarding services is provided by the child's treatment team. Participants feel they can share their opinion with the MHP. None of the participants participate in an MHP committee but are interested. Most participants are aware of peer support and wellness centers. Participants feel that recovery is possible for their child.

Recommendations from focus group participants included:

- Continue to provide motivation and support to caregivers and beneficiaries to receive services.
- Provide information on medication changes and the use of medications.
- Include FC caregivers in treatment planning and service delivery.

Consumer Family Member Focus Group Three

CalEQRO conducted one 90-minute focus group with a culturally diverse group of English-speaking adults who are mostly new clients that have initiated/utilized services in the past 12 months. The focus group was held via videoconference and included four participants. All of the participants began services within the previous 12 months.

Participants are satisfied with the wait times between initial and on-going appointments. The beneficiaries receive appointment reminders and find it easy to reschedule missed appointments. One beneficiary reported they could call family for support when in crisis, and one beneficiary was unaware of who to contact. Participants feel that family members are supported as part of their treatment team. COVID-19 did not make a big impact on their recovery, as telehealth is available, and some were able to see their providers more often. Beneficiaries are aware of consumer rights, information is posted on the lobby waiting rooms and the clinic newspaper, and information can also be obtained from their provider. Most participants were not invited to participate in an MHP committee. There were no participants who have utilized a wellness center. Only one participant reported participation in MHP offered volunteer opportunities. All beneficiaries believe that recovery is possible. Participants know they can ask for a new provider, a clinical director, personal psychiatrist, or call a clinic and ask for a new staff member if they felt that their provider was not a good fit for them.

Recommendations from focus group participants included:

- Provide information on medication changes and the use of medications.
- Provide more comprehensive outpatient care.

Consumer Family Member Focus Group Four

CalEQRO conducted one 90-minute focus group with a culturally diverse group of English-speaking parents/caregivers of child/youth beneficiaries that have initiated/utilized services in the past 12 months. The focus group was held via videoconference and included three participants. There were three participants. One participant received initial services three weeks past the initial request, and a second participant waited two months after a referral from the beneficiary's primary care provider. The third participant did not address timeliness regarding the MHP, but rather the historical involvement in mental health services across states and programs. All participants began services more than 12 months ago.

Due to the low number of participants, specific findings are not possible to maintain anonymity. Overall, participants reported longer than usual wait times for initial access to services and acceptable wait times between appointments; receive reminders and can reschedule appointments when needed; have access to crisis number and crisis resources; feel their cultural needs are met and feel supported; the impacts of COVID-19 on service provision were both positive and negative; information about services is not always readily available; have mixed experiences when sharing input with the MHP; were not offered participation in MHP committees and are not aware of wellness centers; and do feel a sense of hope that recovery is possible; are able to communicate issues when/if they present.

Recommendations from focus group participants included:

- Improve access and proximity to in-patient hospitalization options for youth.
- Maintain frequent and on-going communication between caregiver and provider.
- More in-home support and information regarding services offered by the MHP.

IMPACT OF FINDINGS

In all CFM groups, there is an overall sense that hope and recovery is possible. There are similar findings in two CFM groups that more education on medications and their side effects is needed. Information regarding the services offered by the MHP was noticed in more than one group. Participants know who to call when they are in crisis and feel comfortable reaching out to the MHP should they have an issue with their provider.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP is committed to cultural diversity and health equity; policies, procedures, and practices are reflective of communities served. The OHE is embedded in the MHP's administrative division and is focused on reducing physical and mental health disparities. (Access, Quality)
2. The average time from first request for services to first offered appointment is 6.89 day across all services; furthermore, the MHP can provide the first rendered clinical service after the initial assessment in 10.25 business days. (Timeliness)
3. The MHP created an updated public-facing dashboard in coordination with County IT (using ESRI/GIS mapping) to report on pulled billed data (progress notes) from Avatar to report on services at geographic locations, race ethnicity, clients served, etc. (Quality, IS)
4. The MHP's May 2021 CPS summary report showed an improvement in satisfaction in perception of participation in treatment planning, and CalEQRO beneficiary focus groups indicate that beneficiaries feel hopeful that recovery is possible. (Quality)

The MHP created a new care coordination team that is responsible for care coordination with VDMH and HPH for adult admissions and discharges. (Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Despite the initiated performance improvement activities, the MHP's self-reported 7-day post hospitalization follow-up is approximately 22-business days across all services; the average adult 7-day post hospitalization follow-up is approximately 26-business days. (Timeliness)
2. While the MHP has maintained communication across the system of care, there are opportunities to improve bidirectional communication with contracted providers and clinical line staff to ensure clear direction and successful implementation of future initiatives. (Quality)
3. The MHP is still not Medicare certified which contributes to higher levels of claim denials when Medicare must be billed prior to Medi-Cal claiming. The MHP

continues to pursue this and hopes to have the application complete in the Spring of 2022. (IS)

4. There are similar findings in two CFM groups that more education on medications and their side effects is needed. (Quality)
5. Stakeholder feedback in several sessions reflect peer specialists are underutilized in the MHP's system of care. (Quality)

RECOMMENDATIONS

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

1. Continue on-going quality improvement (QI) efforts to reduce the 7-day post hospitalization follow-up timeliness to meet state standards (*This recommendation is a follow-up from FY 2020-21*.) (Timeliness, Quality)
2. Improve the current communication process with clinical line staff and contract providers to create more opportunities to provide input into system planning, policy formation, and procedural changes. (Quality)
3. Complete Medicare certification process and perform analysis on the Medi-Cal claims denied due to eligibility and non-covered charges to address higher than average denial rates. (*This recommendation is a follow-up from FY 2019-20 and FY 2020-21*.) (IS)
4. Create opportunities to educate beneficiaries on medication management, including medication side effects. (Quality)
5. Create opportunities for peer specialist in the system of care to participate in policy planning and implementation, educational and career development, and involvement in beneficiary treatment. (Quality)

REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a public health emergency (PHE) exists. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned with video sessions, necessitated by the PHE, having limited impact on the review process.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: CALEQRO REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Ventura
Opening Session - Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview - Operations and Quality Management
Medical Prescribers Group Interview
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Aguila	Gabriela	BH Manager II, CAATS, CWS and California Work Opportunity and Responsibility to Kids (CalWORKs)	VCBH
Amezquita	Wendi	Clinic Administrator-Adults, TAY	VCBH
Ashur	Ophra	Compliance-Senior Behavioral Manager	VCBH
Bennet	Kimberly	Director-Community Based Services	Casa Pacifica
Bezdjian	Serena	Research Psychologist	VCBH- QI
Burt	Sloane	QI Manager	VCBH QI
Carson	Hilary	Senior Program Administrator-MHSA	VCBH
Catapusan	Anita	Substance Use Disorder Program-Manager	VCBH
Chen	Yvette	Program Administrator	VCBH-QI
Ciancutti	Lily	Executive Director	Seneca Crisis Stabilization Unit, Comprehensive Assessment and Stabilization Services-Acute Care
Cleland	Don	Regional Director	Golden
Colton	Michael	Behavioral Health Clinic Administrator-South Oxnard	VCBH-Adult
Cook	Morgan	Operations Manager	Interface
Cooper	Dr. Jason	Medical director	VCBH
Cowie	Stephanie	Clinic Administrator	VCBH-YFD
Denering	Dr. Loretta	Division Chief	VCBH-SUS
Di Battista	Maria	Clinic Administrator	VCBH- CWS

Last Name	First Name	Position	Agency
Donavan	Leisa	Senior Manager-Accounting	VCBH-Fiscal
Dougherty	Jennifer	Senior Manager-YFD (Interim Chief)	VCBH-YFD
Egan	Narci	Assistant Chief Financial Officer	HCA
Elhard	Erick	Behavioral Health Manager	VCBH-Care Coordination
Farhat	Linda	Stakeholder	PathPoint
Fekete	Doreen	Senior Program Administrator	VCBH-Billing
Flores	Raudel	Clinic Administrator-South Oxnard	VCBH-YFD
Fox	Cheryl	Behavioral Health Manager/Chief	VCBH-YFD
Gardner	Janis	Stakeholder	BHAB Board
Glantz	Julie	Senior Behavioral Health Manager-Adults	VCBH-Adults
Globe	Jennifer	Program Director	Pacific Clinics
Greenland	Sandy	QA Manager	Casa Pacifica
Guilin	Heather	Clinic Administrator-North Oxnard	VCBH-YFD
Heath	Curtis	Program Administrator II	VCBH Contracts
Johnson	Heather, L	Clinic Administrator-Conejo	VCBH-YFD
Johnson	Dr. Sevet	Behavioral Health Director	VCBH-Administration
Khan	Traci	Clinic Administrator	VCBH-Adult
Lee	Karen	QA Manager	VCBH-QA
Lomeli	Nicole	Program/Administrative Director	Jackson House
Lopez	Marcus	Clinic Administrator-South. Oxnard	VCBH-Adults
Lubell	Courtney	Special Projects Manager	VCBH-Administration
Magbitang	Ana	Clinic Administrator-STAR	VCBH-Adults

Last Name	First Name	Position	Agency
Manzo	Sal	Behavioral Health Manager- North and South Oxnard, Santa Paula	VCBH-Adults
Matisek	Kaile	Clinical Director	Turning Point Rehab Services
McCormick-Soll	Angelina	Clinic Administrator- Santa Paula/Fillmore	VCBH-YFD
McDonald	Tina	Behavioral Health Clinic Administrator	VCBH-Adults
Mikkelson	Sandra	Program Administrator II	VCBH-QI
Moncada	Allyson	Clinic Administrator- Simi	VCBH- Youth and Family
Nagle	Laura	Clinic Administrator- Juvenile Facilities	VCBH-Youth and Family
Newbold	Jennifer	Executive Director	PathPoint
Palermino	Tony	IT Supervisor	VCBH-Administration
Price	Megan	Core Program Supervisor	Aspiranet
Rabinovitz	Katheryn	Program Administrator	VCBH-QI
Riddle	Angela	Training Manager	VCBH-QM
Roman	Dave	Behavioral Health Manager-E.H.R.	VCBH-Administration
Rotnofsky	Dr. Jamie	MHSA	VCBH-Administration
Roylance	Leah	Clinic Administrator	VCBH-Adults
Ruiz	Deanna	Clinic Administrator	VCBH-CalWORKs
Salas	Cynthia	OHE Manager	VCBH-Administration
Sanchez	Sara	Behavioral Health Manager- STAR/RISE/Assisted Outpatient Treatment	VCBH-Adults
Schipper	John	Division Chief	VCBH-Adults
Seal	Maryza	Administration	VCBH-
Shah	Brinda	Senior Program Administrator	VCBH-QI

Last Name	First Name	Position	Agency
Springer	Nancy	Behavioral Health Manager Adults-Conejo, Simi Valley and Transitions/Ventura County Power over Prodromal Psychosis	VCBH-Adults
Stone	Elizabeth	Consumer Advocate	Ventura County Advisory Board
Tadeo	Zandra	Behavioral Health Manager	VCBH-YFD
Taylor	Thomas	Integrated Community Services/Intensive Service Contracts-Manager	VCBH-Adults
Torres Monica	Monica	Behavioral Health Manager	VCBH-YFD
Tryk	Lisa	Human Resources	VCBH-Administration
Villegas	Alexis	Program Administrator	VCBH-QI
Wake	Casey	Clinical Director	Telecare Vista and Voice
Warren	Liz	Executive Director	The Client Network
Washington	Chauntrece	Behavioral Health Manager-CalAIM Implementation	VCBH-Administration
White	Michael	Facilities, Safety, Disaster Manager	VCBH-Administration
Whitewood	Susan	Behavioral Health Manager-Housing	VCBH-Adults
Yanez	Terri	Admin Services Division Chief	VCBH-Administration
Yomtov	Dani	Program Administrator	VCBH-QI
Zanolini	Dr. Shanna	Senior Program Administrator	VCBH-QI
Zepeda	Geneveve	Clinical Nurse Manager	VCBH-QA

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

Clinical PIP Validation Rating (check one box)	Comments
☐ →High confidence ☒ →Moderate confidence ☐ →Low confidence ☐ →No confidence	As submitted, this clinical PIP was found to have moderate confidence, because: the final measurements and results of the study were not submitted at the time of this review. At the same time, CalEQRO data shows the 7-day post hospitalization follow-up rate from CY 2019 to CY 2020 improved by 7 percent, and the 30-day follow-up rate improved by six percent.
General PIP Information	
MHP/DMC-ODS Name: VCBH	
PIP Title: Post Hospitalization Performance Improvement Project	
PIP Aim Statement: "Will improved coordination and collaboration amongst Ventura County Behavioral Health (VCBH) and hospital staff, as well as enhanced outpatient follow-up service provision, reduce the 7-day and 30-day readmission rates for VCBH beneficiaries by 50% by June 2022?"	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one):	

General PIP Information
☐ Children only (ages 0-17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Beneficiaries recently discharged from VDMH or HPC that are enrolled in an MHP program prior to the hospital admission, and unenrolled beneficiaries that the MHP is attempting to connect to mental health services.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) ICMP to beneficiaries who are hospitalized at VDMH or HPC., providing enhanced case management to beneficiaries; and reintegration of beneficiaries into outpatient care.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Improving reporting structures in the EHR; tracking census and data tracking errors; collaboration between MHP and hospital staff; performing regular status checks with hospital staff; integration of RISE and STAR in discharge planning and on-the-spot assessments; ensuring timely post-hospitalization follow-up
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) n/a

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
7-day hospital readmission rate	CY 2020	n=unknown 8 %	☐ Not applicable—PIP is in Planning or implementation phase, results not available October 2021-December 2021	7%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): no tests run
30-day hospital readmission rate	CY 2020	n=unknown 17 %	☐ Not applicable—PIP is in Planning or implementation phase, results not available October 2021-December 2021	15 %	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): no tests run
Crisis Counseling Assistance and Training Program (CCP) penetration rate	CY 2020	n=unknown 6 %	☐ Not applicable—PIP is in Planning or implementation phase, results not available October 2021-December 2021	97 %	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): no tests run
CCP enrollment rate	CY 2020	n=unknown 62 %	☐ Not applicable—PIP is in Planning or implementation phase, results not	85 %	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): no tests

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
			available October 2021-December 2021			run
CCP success rate	CY 2020	N=unknown 62 %	October 2021-December 2021	85 %	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): no tests run

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Final measurements

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

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

As submitted, this clinical PIP was found to have moderate confidence, because: the final measurements and results of the study were not submitted at the time of this review. At the same time, CalEQRO data shows the 7-day post hospitalization follow-up rate from CY 2019 to CY 2020 improved by seven percent, and the 30-day follow-up rate improved by six percent.

PIP Validation Information
EQRO recommendations for improvement of PIP: • Clearly identify and integrate clinical interventions that directly impact beneficiary outcomes such as changes in beneficiary health, functional status, or satisfaction resulting from the PIP. • Describe the final data analysis and interpretation of PIP results to include lessons learned and opportunities for improvement.

Non-Clinical PIP

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

Non-Clinical PIP Validation Rating (check one box)	Comments
☐ →High confidence ☐ →Moderate confidence ☒ →Low confidence ☐ →No confidence	The MHP's non-clinical PIP is active, in the first year of implementation, with a low confidence validation rating as the first re-measurement data was not reported at the time of this review. The low confidence speaks more to the lack of results versus the intervention selection.
General PIP Information	
MHP/DMC-ODS Name: VCBH	
PIP Title: Client Engagement after Intake Assessment	
PIP Aim Statement: "At YFD regional outpatient clinics, can operational efficiencies in the process of engaging VCBH YFD beneficiaries result in a 5 percent increase in beneficiaries who receive their first outpatient service within 15-business days after the intake assessment?"	

General PIP Information
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0-17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): YFD clinic population (primarily youth, ages 0-17) at VCBH. Seven YFD clinics are participating in Oxnard, South Oxnard, Ventura, Simi, Santa Paula, Conejo, and Fillmore.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) CEP designed to identify newly assigned beneficiaries in the EHR; improve departmental communication; administrative review of no-show appointments and timely follow-up; twice-per-week distribution list of new beneficiaries and timeliness of services; alert notes to identify beneficiaries who have gone more than ten days to the first outpatient appointment; and expedited outreach and services to high acuity/non-urgent beneficiaries.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) n/a

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Overall percentage of beneficiaries with an outpatient appointment within 15 business days of clinic assignment	CY 2021	n=494/765 64 %	☐ Not applicable—PIP is in Planning or implementation phase, results not available n/a	n/a	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Overall percentage of beneficiaries with a no-show who subsequently completed first outpatient appointment	CY 2021	No baseline data provided	☐ Not applicable—PIP is in Planning or implementation phase, results not available n/a	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PIP Validation Information

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

Validation phase (check all that apply):

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

☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

PIP Validation Information
The MHP's non-clinical PIP is active, in the first year of implementation, with a low confidence validation rating as the first re-measurement data was not reported at the time of this review. The low confidence speaks more to the lack of results versus the intervention selection.
EQRO recommendations for improvement of PIP: • The MHP may want to consider issuing the alert notice at the 10-day mark rather than when the beneficiary has gone more than ten days for a first rendered clinical service. This will allow the MHP to preemptively identify beneficiaries who are approaching the critical window of opportunity. • Conduct at least quarterly data re-measurements to identify possible untoward results and modification of interventions if needed

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Ventura MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Large	1,859,411	68,297	3.67%	$419,802,216	$6,147
MHP	64,916	2,523	3.89%	$16,914,570	$6,704

Table D2: CY 2020 Distribution of Beneficiaries by ACB Range

Ventura MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
<$20K	9,655	92.48%	92.22%	$46,238,408	$4,789	$4,399	56.77%	56.70%
>$20K-$30K	344	3.30%	3.71%	$8,365,689	$24,319	$24,274	10.27%	12.59%
>$30K	441	4.22%	4.07%	$26,850,466	$60,885	$53,969	32.96%	30.70%

Table D3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Ventura MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
<$20K	9,655	92.48%	92.22%	$46,238,408	$4,789	$4,399	56.77%	56.70%
>$20K-$30K	344	3.30%	3.71%	$8,365,689	$24,319	$24,274	10.27%	12.59%
>$30K	441	4.22%	4.07%	$26,850,466	$60,885	$53,969	32.96%	30.70%

Table D4: Summary of CY 2020 Top Five Reasons for Claim Denial

Ventura MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	1,215	$1,896,363	24%
Beneficiary not eligible	1,183	$1,821,018	23%
Medicare Part B or Other Health Coverage must be billed before submission of claim	5,447	$1,560,468	20%
Service line is a duplicate and a repeat service procedure code modifier not present	5,747	$1,278,453	16%
Claim/service lacks information which is needed for adjudication	3,202	$1,276,317	16%
TOTAL	**16,794**	**$7,832,619**	**99%**