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FY 2022-23
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:

November 08-10, 2022

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — November 08-10, 2022

MHP Size — Large

MHP Region — Southern

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	1	4	0

Note: The MHP review was conducted within eight months of the previous EQR to align this review timing with DMC-ODS. As a result, the MHP did not have sufficient time to fully respond to all recommendations.

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	4	2	0
Quality of Care	10	5	5	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**17**	**9**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Post Hospitalization Performance Improvement Project	Clinical	07/2020	Second Remeasurement (completed)	Moderate
Beneficiary Engagement after Intake Assessment	Non-Clinical	06/2021	Second Remeasurement (completed)	Low

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	7
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	6
3	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Quality Management (QM) and data analytical functions.
- Leadership's commitment to data-driven decision making and improving communication with partners and stakeholders.
- Steps toward implementing the no-wrong-door policy.
- Strong culturally responsive outreach and engagement system.
- Very informative and easy-to-navigate website.

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

- Current challenges with accurately tracking initial psychiatry timeliness.
- Foster Care (FC) Healthcare Effectiveness Data and Information Set (HEDIS) measures tracking.
- Increase in high-cost beneficiaries (HCBs) and inpatient costs.
- Lack of quantifiable measures in the quality improvement (QI) plan.
- Lack of an operations continuity plan (OCP).

- Medicare certification process remains incomplete.

Recommendations for improvement based upon this review include:

- As the new electronic health records (EHR) gets implemented, ensure that the data system changes will allow for accurately capturing the first offered psychiatry timeliness.
- Implement a tracking and reporting mechanism for FC HEDIS measures.
- Investigate the reasons for increases in HCBs and inpatient costs, and identify strategies to contain the growth.
- Include quantifiable goals in the quality assessment and performance improvement (QAPI) plan and report quantifiable progress in the annual QAPI evaluation.
- Focus resources to develop an OCP concurrent with the implementation of the EHR to ensure services can continue in the event of a system disruption.
- 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 carry-over from FY 2021-22.)

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, representing of 58 counties, 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 MHP. DHCS contracts with Behavioral Health Concepts, Inc., (BHC) the CalEQRO to review and evaluate the care provided to the Medi-Cal beneficiaries.

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 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 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Ventura County MHP by BHC, conducted as a virtual review on November 08-10, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to 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, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's network adequacy (NA) as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results 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 suppresses values in the report tables when the count is less than 12, then "≤11" is indicated 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 (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP experienced significant staff turnover at all levels, especially in the leadership and clinical line staff levels. The impact of the loss of clinical line staff and the lingering effects of COVID-19 was apparent during this review. CalEQRO 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.

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 experienced significant leadership changes in the past one year including a new Ventura County Behavioral Health (VCBH) director, assistant director, youth and family division chief, access and outreach division chief, and substance use services chief.
- The access and outreach, and the quality care divisions were also newly created.
- The MHP experienced unprecedented clinical line staff turnover since COVID-19, and continues to experience significant new staff hiring challenges.
- The MHP created a CalAIM team to oversee and support implementation of CalAIM across VCBH.
- The MHP is actively implementing the Integrated Core Practice Model (ICPM) as part of the AB 2083 deliverables. It is using a train-the-trainer model to get its clinical line staff trained in ICPM.
- The MHP is utilizing a DHCS grant to create a crisis care mobile unit for the TAY beneficiaries.
- The MHP is creating a peer support system with peer support specialists hired directly by the county. During the past year, the MHP has worked with human resources to create new job classifications for this purpose. In recent years, all peer employees were hired by only the contract providers.
- VCBH has consolidated the access lines for the MHP and DMC-ODS. This will reduce duplication of efforts and improve the access experience for the beneficiaries.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 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 2021-22

Recommendation 1: Continue on-going QI efforts to reduce the 7-day post hospitalization follow-up timeliness to meet state standards.

(This recommendation is a carry-over from FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- After being awarded the DHCS Behavioral Health Integration (BHI) grant in Fall 2020, the MHP hired two intensive care coordinators as part of a newly formed care coordination program (CCP) to serve as hospital liaisons to support discharge planning and post-hospitalization outpatient care.
- The MHP reported an overall 71 percent 7-day post-hospitalization follow-up rates with even higher rates for the children and FC beneficiaries for FY 2021-22. However, the average was 12 days with a 3-day median, indicating a small percentage of inpatient-discharged beneficiaries take much longer while at least 50 percent receive follow-up services within 3 days.
- CalEQRO's analysis of Ventura's CY 2021 Medi-Cal claims data showed 55.29 percent follow-up rate within seven days for the Medi-Cal beneficiaries. While this is lower than the FY 2021-22 figure submitted by the MHP for all beneficiaries, it was higher than the corresponding statewide rate.

Recommendation 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP combined its QM meetings to bring the contract providers and county operations staff together to improve communication. Each contract provider also has an assigned contract monitor who acts as the conduit for communication between the MHP and the provider agency.
- Contract providers noted that there is good communication between them and the MHP contacts and they have been receiving timely information and able to provide input.
- The new director and leadership team members have been visiting each clinic and meeting with the clinical teams, including the line staff.
- With many new staff hired within the six months prior to the review, and many more vacancies that need to be filled, the line staff reported a further need for streamlining communication and creating more regular channels of communication.
- This recommendation will not be carried forward as the current leadership demonstrated commitment to improving communication and carrying on their efforts.

Recommendation 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 carry-over from FY 2019-20 and FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has partnered with a vendor to complete the Medicare certification and enrollment process.
- The vendor is awaiting answers the company CMS contracted with to adjudicate the Medicare claims for VCBH's region, regarding setting up the provider number. There is no specific timeline for completing the process.

Recommendation 4: Create opportunities to educate beneficiaries on medication management, including medication side effects.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has undertaken process improvements in order to address this recommendation. These involve ensuring that the policies and procedures that

are in place are followed by the staff who are involved in prescribing and medication management. In addition, the MHP is also trying to make sure that there is consistency across providers in following the procedures and using the adjunct forms.

- The MHP did not present evidence of tracking how these process improvement efforts are progressing and what the results are.
- The adult beneficiaries noted that the providers pay attention to their primary healthcare needs and coordinate with the primary care providers to ensure that medications do not have adverse or interactive effects.
- This recommendation will not be carried forward as the MHP has made sufficient progress and remains committed to further process improvement.

Recommendation 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP did not have any peer specialist positions employed by VCBH clinics or programs. These positions existed only through contract providers. During the past year, VCBH has worked on developing job classifications for peer specialist positions to have them embedded within VCBH clinics or programs.
- As a result of these efforts, the MHP has been able to start recruiting for peer support specialist positions. At the time of the EQR, three new staff in these positions had started their onboarding process.
- The MHP has utilized parent partners who are hired through contract providers in children and youth services.
- This recommendation will not be carried forward as the MHP has substantially addressed it and the recruitment of peer staff is moving forward satisfactorily.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or 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.[1] The cornerstone of MHP services must be access, without which beneficiaries are negatively impacted.

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 69 percent of services were delivered by county-operated/staffed clinics and sites, and 31 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 82 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: Outreach services and a specialized access team called the Access Pod. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. All beneficiaries' initial requests for services (RFS) are routed through the Access Pod which does the initial screening and assessment, and refers individuals based on their acuity and service needs.

In addition to clinic-based MH and psychiatry services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults**.** In FY 2021-22, the MHP reports having provided telehealth services to 3,802 adult beneficiaries, 4,116 youth beneficiaries, and 338 older adult beneficiaries across nine county-operated sites and 20 contractor-operated sites. Among those served, 1,840 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs

[1] CMS Data Navigator Glossary of Terms

and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B below.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

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

Table 1A: MHP Alternative Access Standards, FY 2021-22

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

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

Table 1B: MHP OON, FY 2021-22 {see NA Form EQRO Section III}

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☐ Yes ☒ No
Contracting status:	☐ The MHP is in the process of establishing contracts with OON providers ☒ The MHP does not have plans to establish contracts with OON providers
OON Access for Beneficiaries	
The MHP ensures OON access for beneficiaries in the following manner:	☐ The MHP has existing contracts with OON providers ☒ Other: The MHP has established agreements with OON providers to provide services requiring alternative access accommodations. The MHP did not need to use this resource in FY 2021-22.

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

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to 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 Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet 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:

- VCBH has consolidated its access functions under a newly created Access and Outreach Division and hired a new division chief since the FY 2021-22 EQR. This division provides direct oversight of VCBH's outreach efforts, access services, and coordination of mental health and substance use services.
- The MHP has several outreach functions including the Rapid Integrated Support and Engagement (RISE) and Logrando Bienestar.
    - RISE – This program provides a bridge to treatment by engaging those unable or unwilling to get mental health services but in need of such services. It provides an extended access function staying involved until case management and other individualized treatment services are in place.
    - Logrando Bienestar – This prevention and early intervention program provides education and awareness services to Latino/Hispanic individuals

in the community, and provides personal advocate services to provide guidance, support, and facilitation of access to services.

- The MHP has strong partnerships with all agencies that provide services to children and youth. These include the school districts, Child Welfare Services (CWS), and the juvenile facility. The MHP is contracted by the Ventura County Office of Education to provide educationally related social emotional services.
- VCBH has a very comprehensive website with easy-to-find access and treatment services information. The website prominently provides a Spanish translation button that translates all pages including those containing access and treatment information.
- The current challenges facing access to mental health services are primarily two-fold.
    - As part of CalAIM, the change in medical necessity criteria has resulted in a significant increase in the RFS since February 2022. The MHP presented a comprehensive report on the RFS trend since the beginning of FY 2021-22 that shows a 25 percent increase in RFS starting from February 2022.
    - As with many other MHPs, VCBH has experienced significant staff loss since the beginning of the COVID-19 pandemic. CalEQRO noted that a large percentage of the senior leadership and line staff participants in its review process were hired in the six months prior to this EQR.
    - These challenges have resulted in significant increases in case load for the line staff and delayed access or engagement in treatment services for the beneficiaries.
- To cope with the increased demand for its services and reduced staffing, the MHP is in the process of developing a “surge plan” to support beneficiaries.
- The demand for transportation services provided by the managed care plans (MCPs) has increased with the increase in gas prices. Some of the participants in the beneficiary focus group reported difficulties in accessing transportation services.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) 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. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, Ventura's PR has decreased over the last three years; however, it still exceeds the large-county average and statewide PR.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	247,861	9,745	3.93%	$85,596,005	$8,784
CY 2020	228,440	10,440	4.57%	$81,454,563	$7,802
CY 2019	224,372	10,405	4.64%	$75,074,518	$7,215

- The MHP's total Medi-Cal eligible count increased by more than 10 percent between CY 2019 and CY 2021. During the same period, the number of beneficiaries served decreased with a resulting decline in the PR.
- The total approved claims amount during CY 2019-21 increased by 14 percent, and the AACB increased by more than 21 percent.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	26,553	302	1.14%	1.29%	1.59%
Ages 6-17	63,999	3,148	4.92%	4.65%	5.20%
Ages 18-20	13,765	622	4.52%	3.66%	4.02%
Ages 21-64	122,317	5,254	4.30%	3.73%	4.07%
Ages 65+	21,229	419	1.97%	1.52%	1.77%
TOTAL	**247,861**	**9,745**	**3.93%**	**3.47%**	**3.85%**

- The PR exceeds similar size county averages in all age groups except zero to five, and exceeds the statewide average in all TAY and adult age groups.

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percent of Beneficiaries Served
Spanish	1,938	20.51%
Threshold language source: Open Data per BHIN 20-070		

- The unduplicated count of Spanish speaking beneficiaries decreased by 9 percent from the prior review period.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	75,926	2,453	3.23%	$19,270,813	$7,856
Large	2,153,582	62,972	2.92%	$387,366,612	$6,151
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligibles that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The MHP has a higher percentage of ACA beneficiaries served than the large county average and slightly lower than the statewide average.

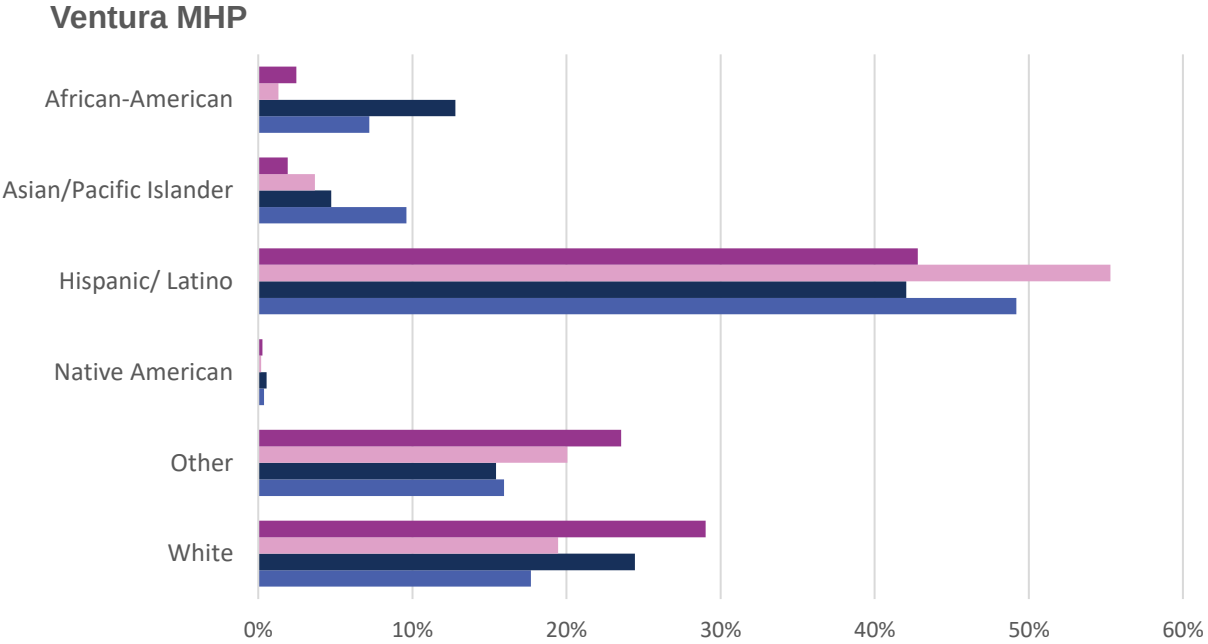
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	# MHP Served	# MHP Eligibles	MHP PR	Statewide PR
African-American	241	3,237	7.45%	6.83%
Asian/Pacific Islander	186	9,106	2.04%	1.90%
Hispanic/Latino	4,170	137,047	3.04%	3.29%
Native American	26	490	5.31%	5.58%
Other	2,294	49,731	4.61%	3.72%
White	2,828	48,251	5.86%	5.32%
Total	**9,745**	**247,861**	**3.93%**	**3.85%**

- The MHP PRs by race/ethnicity groups are higher than the corresponding statewide PRs except for the Hispanic/Latino and Native American groups.

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

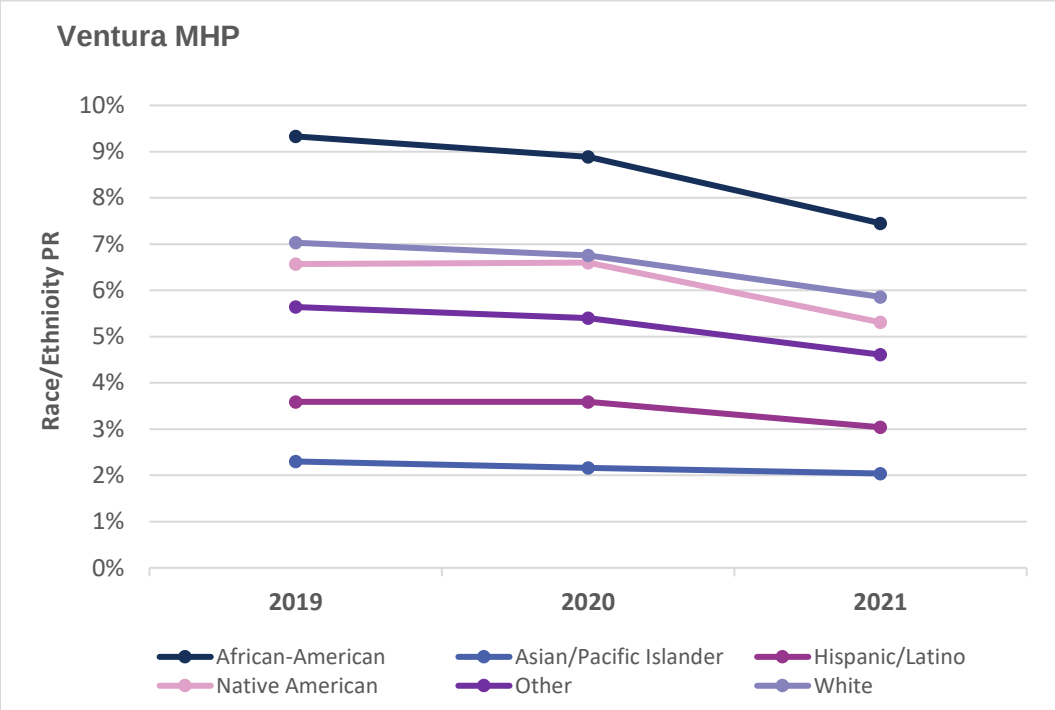


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	29%	24%	0%	43%	2%	2%
MHP % Eligibles	19%	20%	0%	55%	4%	1%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- The most notable gap between beneficiaries eligible and served is seen in the Hispanic/Latino and Asian/Pacific Islander population groups.

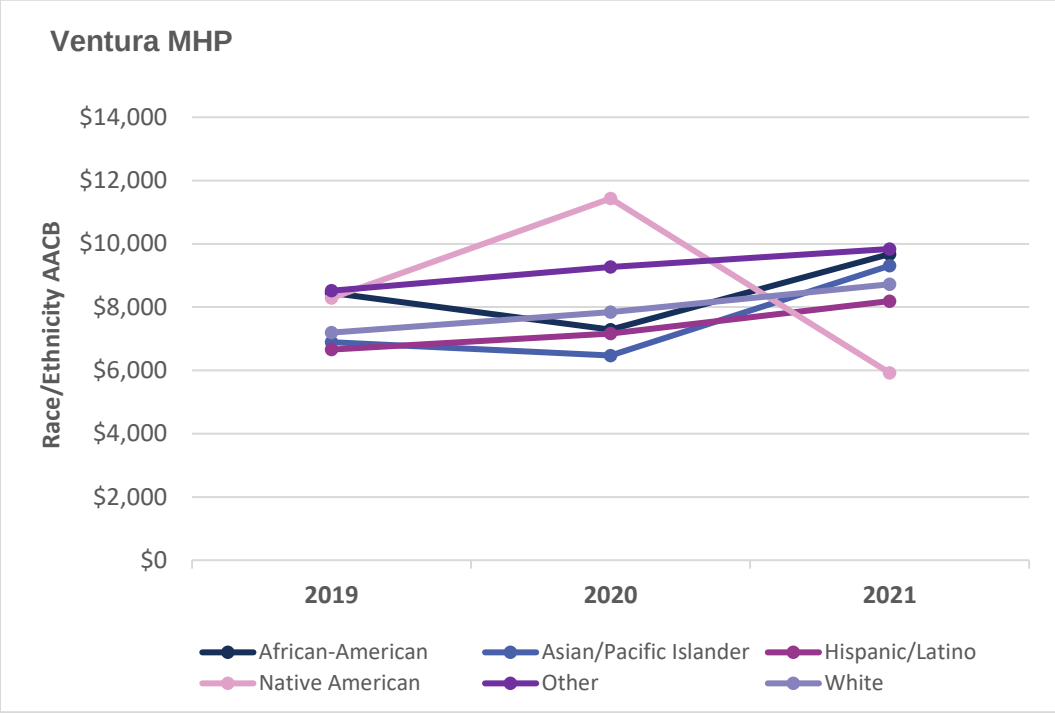
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



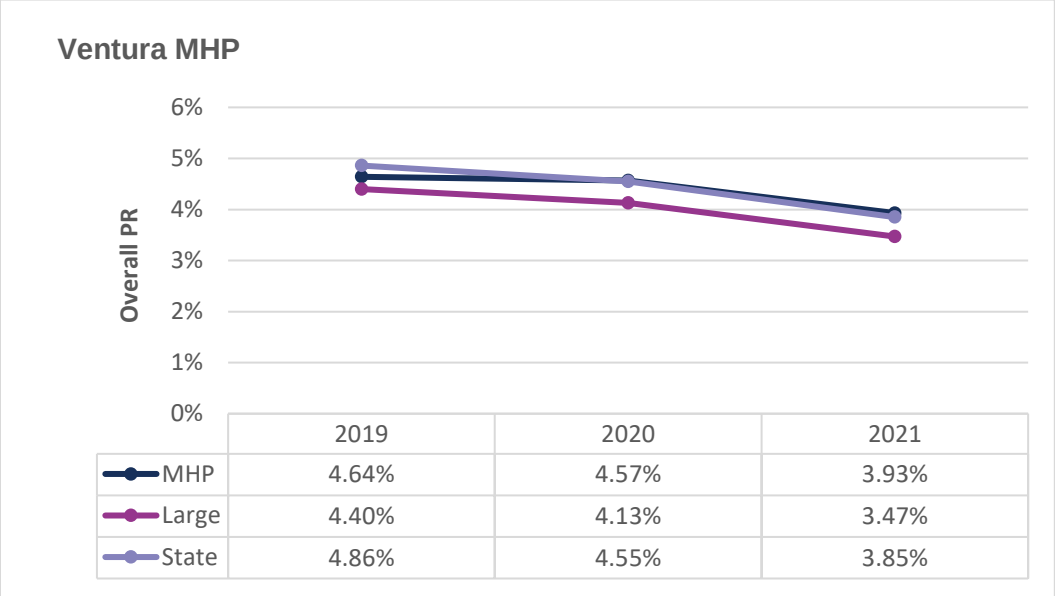
- The MHP PR has been declining between CY 2019 and CY 2021 for all race/ethnicity groups reflecting the overall PR trend for the MHP.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21



- The AACB has slightly increased over the last two years. The Native American AACB had a significant increase in 2020 and then fell below the historical 2019 AACB. The large fluctuation is likely impacted by the low number of Native American beneficiaries.

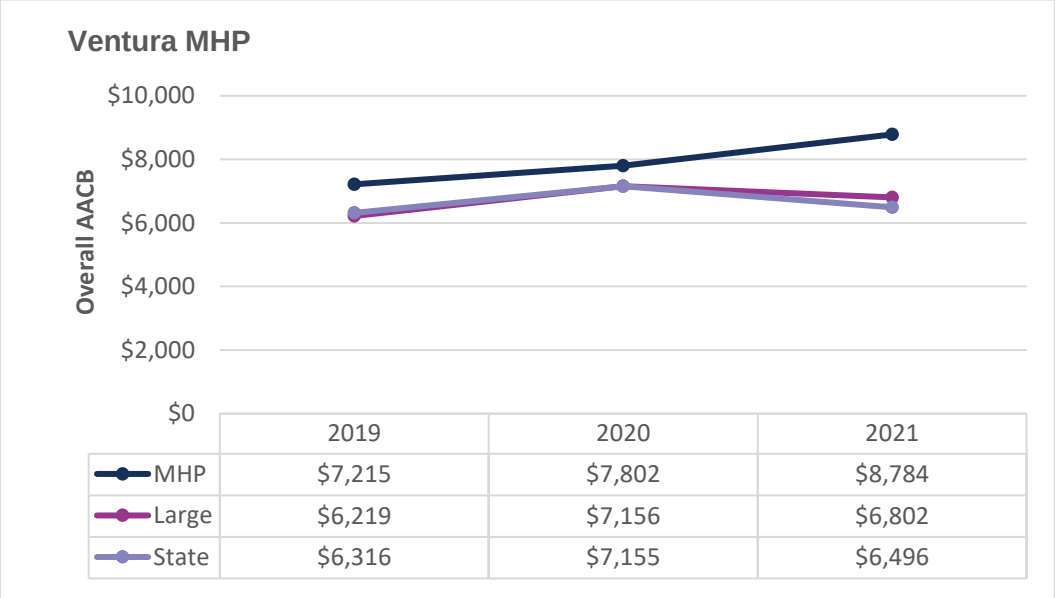
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.64%	4.57%	3.93%
Large	4.40%	4.13%	3.47%
State	4.86%	4.55%	3.85%

- The overall PR has decreased over the last two years while remaining consistent with large county and statewide trends.

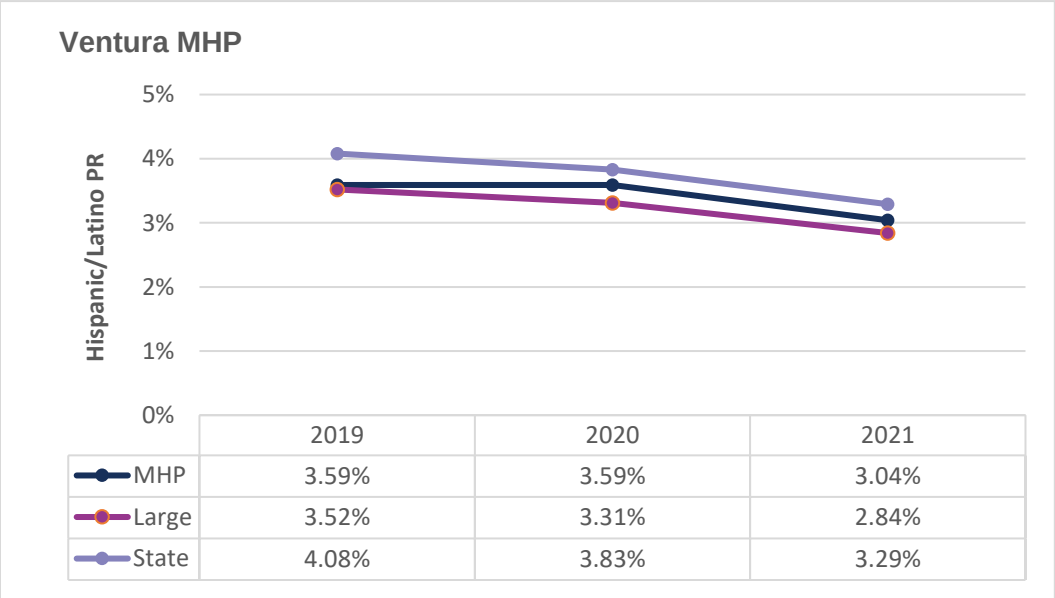
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$7,215	$7,802	$8,784
Large	$6,219	$7,156	$6,802
State	$6,316	$7,155	$6,496

- In CY 2021, the MHP's overall AACB was 29 percent higher than the large county average and 35 percent higher than the statewide average.

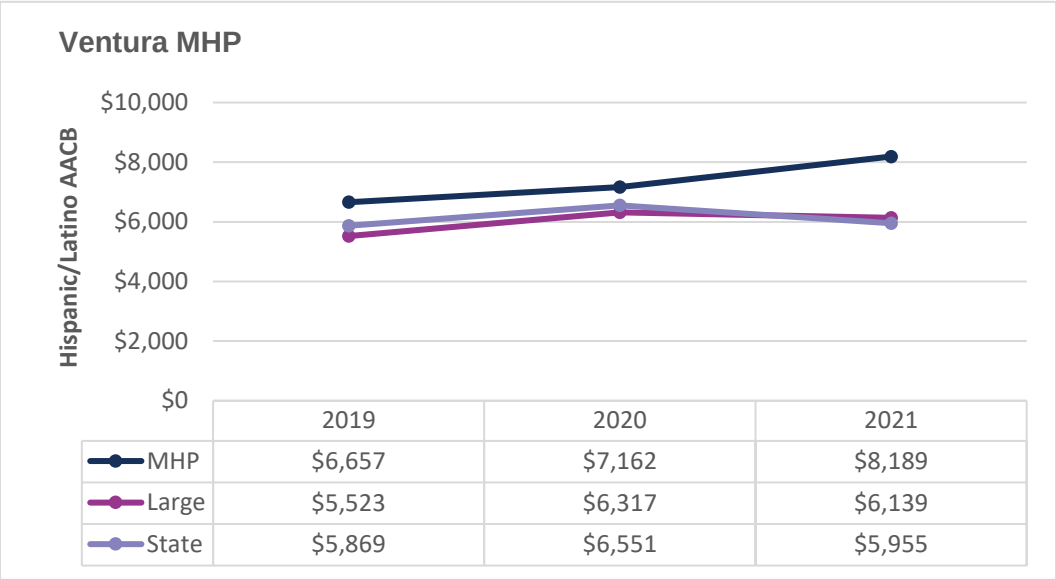
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.59%	3.59%	3.04%
Large	3.52%	3.31%	2.84%
State	4.08%	3.83%	3.29%

- The Hispanic/Latino PR decreased across the state as well as in the MHP, however the MHP PR remains higher than the large county average.

Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$6,657	$7,162	$8,189
Large	$5,523	$6,317	$6,139
State	$5,869	$6,551	$5,955

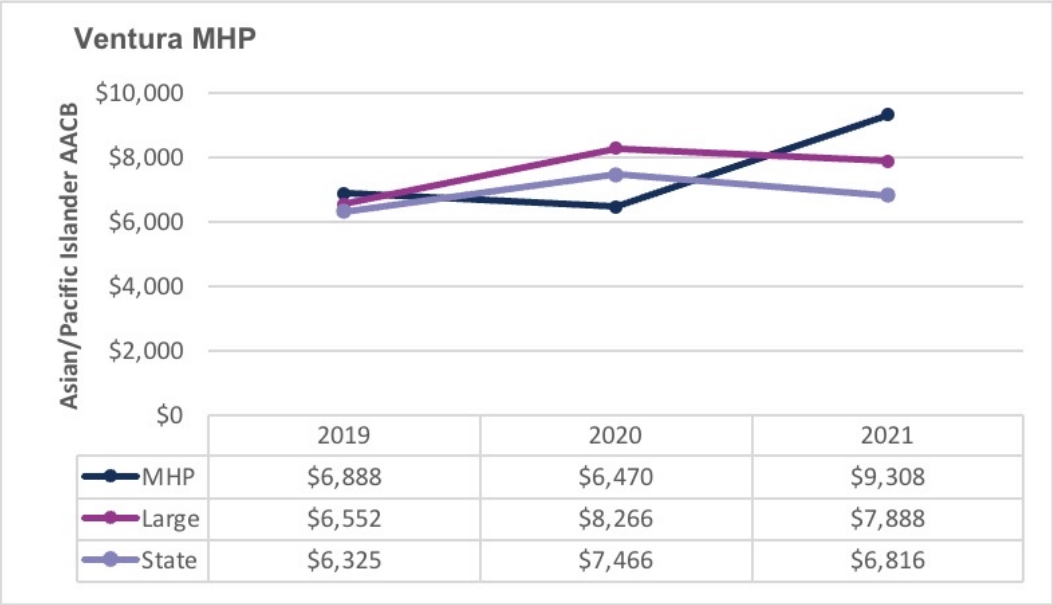
- The AACB for Hispanic/Latino population has increased in CY 2021, and is now 33 percent higher than similar sized counties and the statewide average.

Figure 8: Asian/Pacific Islander PR CY 2019-21

	2019	2020	2021
MHP	2.30%	2.16%	2.04%
Large	2.08%	1.96%	1.74%
State	2.26%	2.13%	1.90%

- The MHP's Asian/Pacific Islander PR for CY 2021 was higher than both the large county and statewide averages.

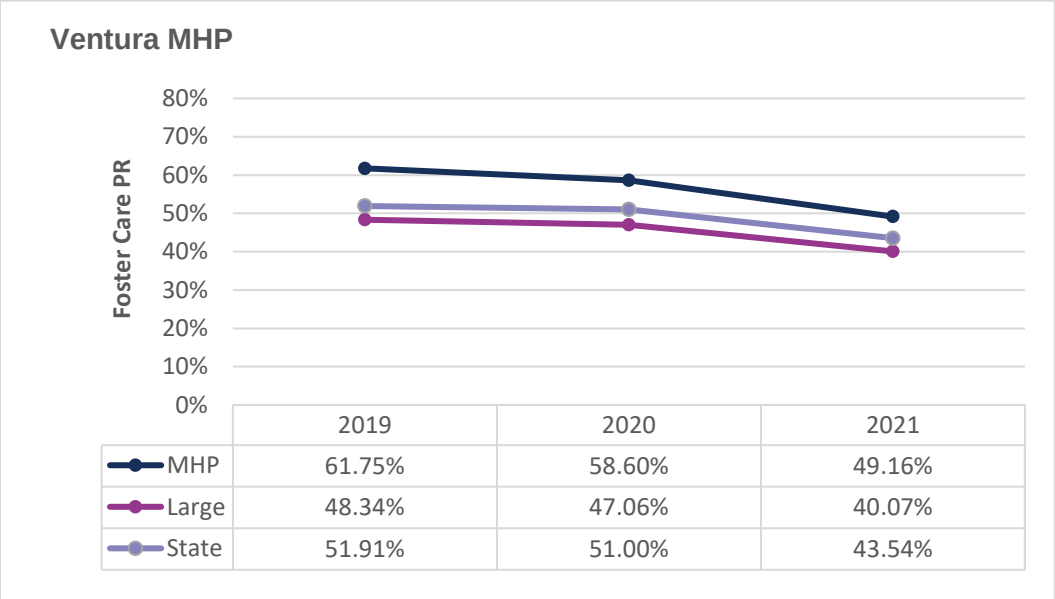
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$6,888	$6,470	$9,308
Large	$6,552	$8,266	$7,888
State	$6,325	$7,466	$6,816

- In CY 2021, the MHP's Asian/Pacific Islander AACB was at least a third higher than the statewide average, and a quarter higher than the large county average. This was in contrast to CY 2020, when the MHP's AACB for the Asian/Pacific Islander was much lower.

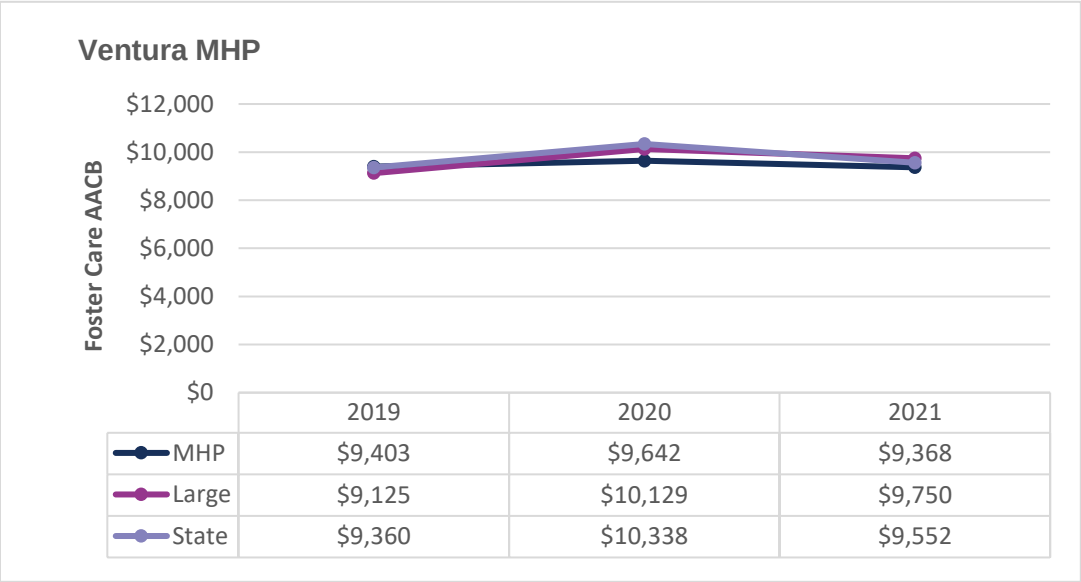
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	61.75%	58.60%	49.16%
Large	48.34%	47.06%	40.07%
State	51.91%	51.00%	43.54%

- The foster care PR has decreased across the state over the prior two years, and the MHP remains higher than similar sized counties and the statewide averages.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$9,403	$9,642	$9,368
Large	$9,125	$10,129	$9,750
State	$9,360	$10,338	$9,552

- The foster care AACB decreased slightly in the MHP and is consistent with the similar sized counties and the statewide average.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 6,296				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	552	8.8%	9	6	10.8%	14	8
Inpatient Admin	110	1.7%	14	7	0.4%	16	7
Psychiatric Health Facility	<11	-	7	7	1.0%	16	8
Residential	99	1.6%	158	153	0.3%	93	73
Crisis Residential	123	2.0%	22	15	1.9%	20	14
Per Minute Services							
Crisis Stabilization	340	5.4%	1,303	1,200	9.7%	1,463	1,200
Crisis Intervention	654	10.4%	201	147	11.1%	240	150
Medication Support	4,398	69.9%	311	195	60.4%	255	165
Mental Health Services	4,552	72.3%	531	246	62.9%	763	334
Targeted Case Management	4,069	64.6%	363	133	35.7%	377	128

- The MHP has a notably high percentage of adult beneficiaries accessing case management (64.6 percent), compared to the statewide average (35.7 percent). It also provides a greater percentage of other planned services such as medication support and mental health services than the statewide average, likely contributing to the lower than statewide average use of unplanned acute services, such as crisis intervention, crisis stabilization, and inpatient utilization.

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

Service Category	MHP N = 559				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	20	3.6%	12	7	4.5%	13	8
Inpatient Admin	<11	-	4	4	n ≤11	6	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	25	9
Residential	0	0.0%	0	0	n ≤11	140	140
Crisis Residential	<11	-	9	9	0.1%	16	12
Full Day Intensive	0	0.0%	0	0	0.2%	452	360
Full Day Rehab	0	0.0%	0	0	0.4%	451	540
Per Minute Services							
Crisis Stabilization	<11	-	1,217	1,080	2.3%	1,354	1,200
Crisis Intervention	18	3.2%	200	127	6.7%	388	195
Medication Support	178	31.8%	312	229	28.5%	338	232
Therapeutic Behavioral Services (TBS)	<11	-	1,596	1,118	3.8%	3,648	2,095
Therapeutic FC	0	0.0%	0	0	0.1%	1,056	585
Intensive Home Based Services	303	54.2%	530	188	38.6%	1,193	445
Intensive Care Coordination	65	11.6%	2,462	1,822	19.9%	1,996	1,146
Katie-A-Like	0	0.0%	0	0	0.2%	837	435
Mental Health Services	538	96.2%	1,373	908	95.7%	1,583	987
Targeted Case Management	305	54.6%	272	110	32.7%	308	114

- The MHP has a notably high percentage of foster youth beneficiaries accessing case management (54.6 percent) and IHBS (54.2 percent), compared to the statewide average (32.7 percent and 38.6 percent, respectively). As seen with the adult population, the greater use of planned services for FC youth likely contributes to a lower rate of acute services than seen statewide, such as crisis stabilization, crisis intervention, and inpatient utilization.

IMPACT OF ACCESS FINDINGS

- Ventura MHP's diversified access and outreach function allows for a number of avenues to access mental health services. With increased demand and the current staff shortages, the MHP is relying on a newly implemented surge plan evaluating how best to address access and timeliness issues and make adjustment when possible.
- During the COVID-19 pandemic, the MHP rapidly deployed telehealth services. This provides some flexibility in access to services, especially for the beneficiaries residing in remote locations. Telehealth has also provided some incentive in staff recruitment and retention.
- However, as the services start dialing back more toward face-to-face modalities, both transportation needs and staffing issues will have to be continually addressed in the next 12 months.
- The MHP's service distribution from CY 2021 demonstrates a closer to the ideal pattern whereby the provision of planned outpatient services obviate the need for more acute services such as crisis stabilization and inpatient services.
- The MHP's access related data and reports provided a clear view of some of the stressors in the system. These provide an excellent tool for the administration to continually evaluate and improve the access and outreach function.

TIMELINESS OF CARE

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 likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to 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 Key Components ratings, and the performance for each measure is addressed in the PMs section.

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

Table 10: Timeliness Key Components

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

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

- The MHP has a robust inpatient follow-up protocol. With grant funding, the MHP created the CCP for timely care coordination for hospitalized beneficiaries. In addition to CCP, the RISE and the Screening, Triage, Assessment, and Referral (STAR) teams are involved as needed for unenrolled Medi-Cal beneficiaries who

get hospitalized, and the clinic staff get involved for those who are already enrolled in their program. The MHP's recently concluded clinical PIP was focused on improving the care coordination post-hospital discharge.

- The MHP established a Timely Access Data Tool (TADT) within its QI database as a systematic way to pull, analyze, and track timeliness/retention for beneficiaries. RFS and subsequent offered appointments are stored in TADT.
- For adult beneficiaries, the MHP has a protocol of providing psychiatry assessment appointments. However, due to the challenges in its tracking mechanism for psychiatry appointments, neither the count of those adult beneficiaries who were actually offered a psychiatry appointment, nor the actual timeframe for those offered psychiatry appointments is reliable. The sources of errors or low reliability across the mental health service delivery system include:
    - On the children's side, psychiatry appointments are offered upon clinical determination of need for psychiatry.
    - TADT data is dependent on the staff accurately recording the offered appointment time.
    - On the adult side, the MHP reported that the staff are recording psychiatry offered appointments on TADT much less consistently, though the practice is to offer the appointment at the time of the assessment.
    - Consequently, the MHP used the actual service date recorded in the EHR as a proxy for the offered date. This has the effect of artificially lengthening the average offered appointment time by including those who may have rescheduled their psychiatry appointments.
- The count of urgent appointments reported by the MHP was very low for a large county. For this metric, the MHP is dependent on the Access Pod staff to accurately determine and record urgent appointments. The low number of urgent appointments can be due to the staff offering more crisis care and providing it more immediately, or some service requests that should have been treated as urgent are not determined and/or tracked properly.
- The urgent appointment timeliness also appears slower than what the actual performance might be since the EHR records only in days and the MHP must then convert that to hours. As a result, for example, if an urgent appointment is offered within six hours but is the next business day, the MHP is forced to count it as 24 hours, driving up the average reported time for response.
- Some beneficiary focus group participants and some line staff noted delays in getting appointments after the initial assessment. The MHP's non-clinical PIP tried to address this for the children and youth during the previous 12 months.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 21-22. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows. This data represented the entire system of care.

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

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	12.6 Days	10 Business Days*	57%
First Non-Urgent Service Rendered	16.3 Days	10 Days**	44%
First Non-Urgent Psychiatry Appointment Offered	**** Days	15 Business Days*	****%
First Non-Urgent Psychiatry Service Rendered	**** Days	15 Days**	****%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	56 Hours	48 Hours*	68%
Follow-Up Appointments after Psychiatric Hospitalization	12 Days	7 Days**	90%
No-Show Rate – Psychiatry	17%	5%**	n/a
No-Show Rate – Clinicians	14%	5%**	n/a

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

** MHP-defined timeliness standards

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

**** The MHP reported psychiatry timeliness separately for adult, children, and FC services, but due to methodological constraints was unable to combine those for the overall metrics.

For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22.

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

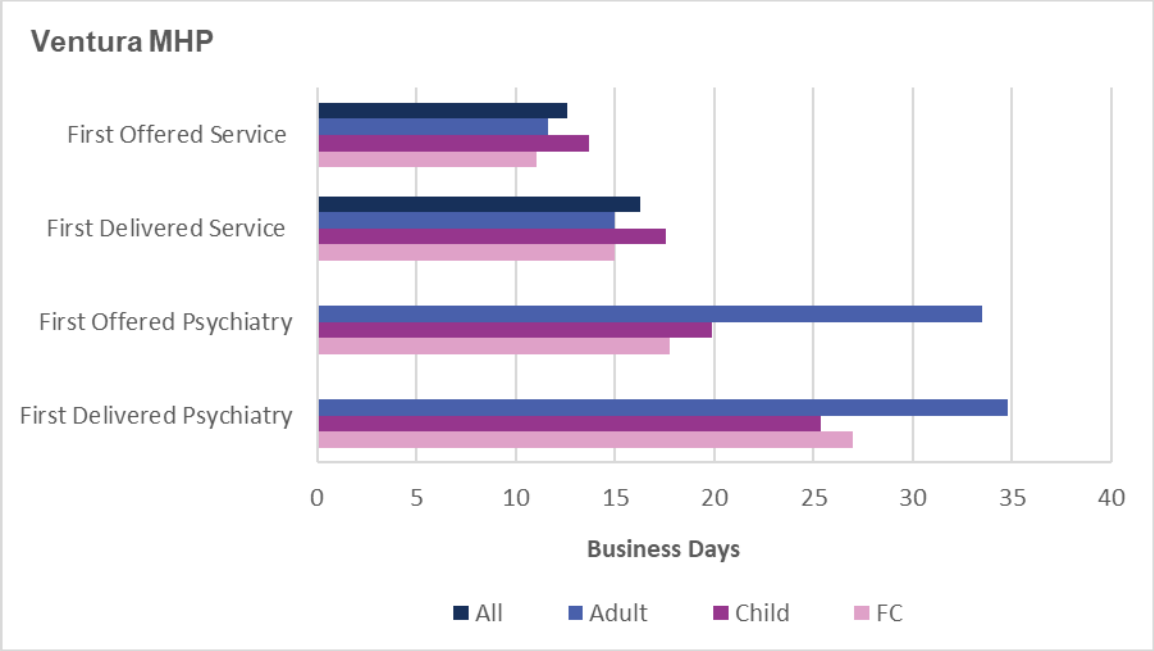


Figure 13: Wait Times for Urgent Services

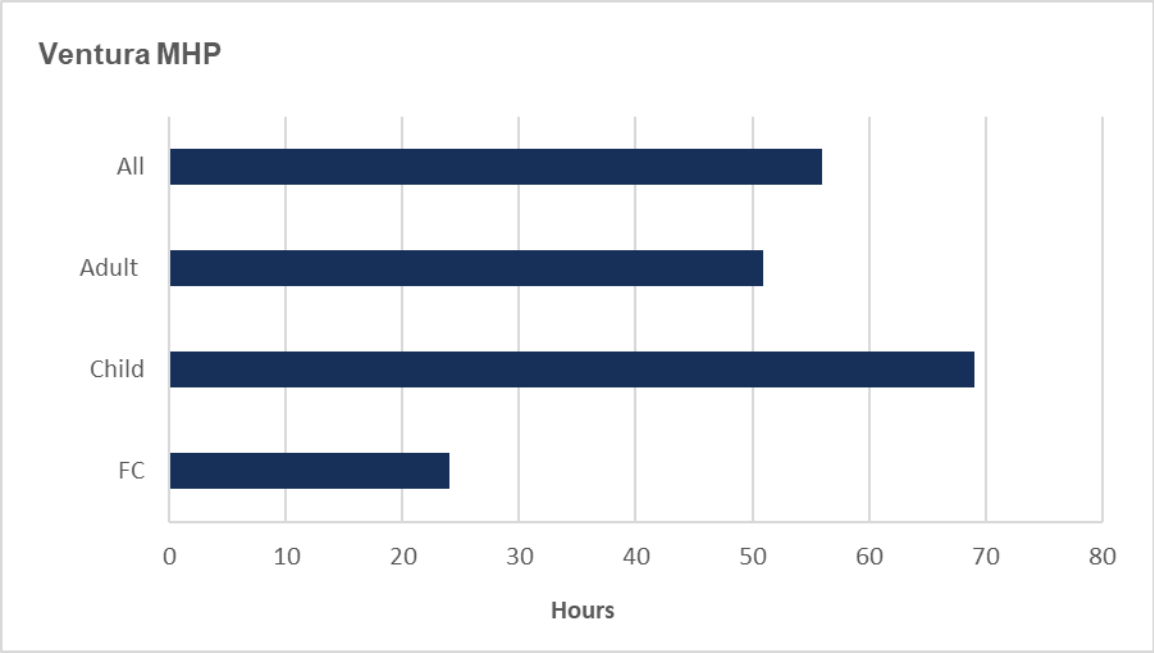
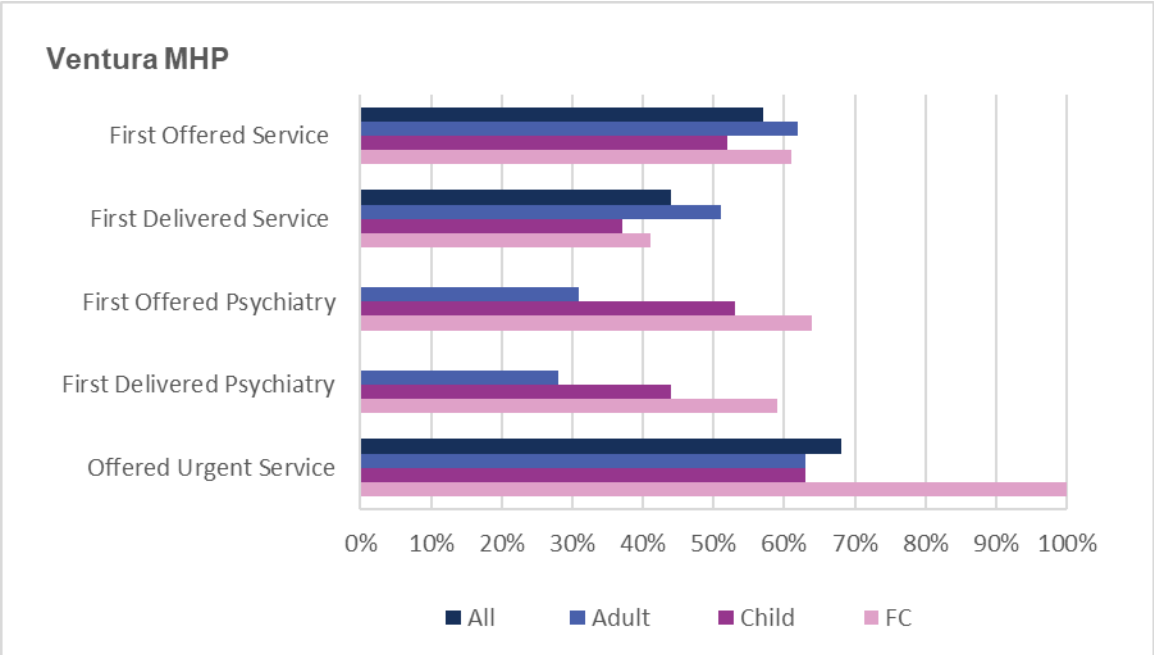


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments or scheduled mental health services such as those that might be provided during the access or intake teams' engagement.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined "urgent services" for purposes of the ATA as those that need priority in scheduling, but not those that needed immediate crisis care. There were reportedly 57 of urgent service requests with a reported actual wait time to services for the overall population at 56 hours.
- The process as well as the definitions and tracking of timely access to psychiatry may differ for adults and children across MHPs. In Ventura, the MHP has defined psychiatry access in the submission as from the point of first clinical determination of need. However, that is only true for children and youth. For adults, the MHP offers psychiatry appointment at the time of the first assessment.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked using a provider-generated progress note for no-shows. The MHP reports a no-show rate of 17 percent for psychiatry services, and 14 percent for non-psychiatry clinical staff.

- The MHP was unable to combine the adult and children's first offered psychiatry appointment timeliness data to report the overall metric due to methodological differences.
- All calls from individuals seeking mental health services are routed through the Access Pod, a specialized group of clinical staff within the access and outreach division who are trained to provide an initial assessment of the caller's condition and determine the urgency of follow-up needed.

IMPACT OF TIMELINESS FINDINGS

- The challenges in the MHP's tracking of timeliness data lead to its performance on several metrics appear worse than it actually may be. The lack of reliability of this data also limits an in-depth understanding of any performance improvement needs for these metrics.

QUALITY OF CARE

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, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to 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 THE MHP

In the MHP, the responsibility for QI is with the QM program. The QM Program resides within the VCBH Administration Division and is overseen by the Administration Division Chief with support from the Compliance Senior Manager. QM is responsible for overseeing and reviewing the quality of behavioral health services provided to Medi-Cal beneficiaries and ensuring compliance with contract requirements and relevant County, Federal and State regulations. The following units reside within the QM program for it to achieve its stated goals: Quality Assurance, QI, Medical Records, Training, and Pharmacist.

The MHP monitors its quality processes through the Quality Management Action Committee (QMAC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QMAC, comprised of MHP and Substance Use Services practitioners, providers, community members, consumers, and family members, in addition to the QM staff and leadership representatives is scheduled to meet twice in FY 2022-23. In addition, the QMAC Special Interests Group (Q-SIG), which facilitates smaller groups to gather feedback on QI initiatives, will meet four to five times in FY 2022-23. Since the previous EQR, the MHP QMAC met three times and the Q-SIG had two meetings. Of the nine identified FY 2021 QAPI workplan goals, and a total of 16 objectives under those goals, the MHP accomplished a number of process milestones, but the outcomes were not clear. One of the clear trends that have emerged is the increase in the number of Medi-Cal beneficiaries who requested mental health services during FY 2021-22. Another area where the VCBH has been successful is establishing the partnerships with other agencies and community partners needed for successful implementation of CalAIM.

The MHP utilizes the following level of care (LOC) tools: Child and Adolescent Needs and Strengths (CANS) and Milestones of Recovery Scale (MORS). The MHP recently implemented Opeeka, an online CANS data reporting system. It has also trained most of the adult clinicians in MORS in the past year, which is expected to improve the MORS rating and contribute to better adjustment of services.

The MHP utilizes the following outcomes tools: Behavior and Symptom Identification Scale-24, General Anxiety Disorder-7, Patient Health Questionnaire-9, Pediatric Symptoms Checklist-35.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Partially Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	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	Partially Met

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

- The MHP is in the middle of a 5-year strategic planning period between CY 2021-26. The goals include quality, service excellence and innovation, beneficiary and community engagement, financial stability and performance, staff engagement and leadership development, and growth and access. For each of these areas, the MHP has been establishing baselines and setting goals.

- The MHP has a strong QM team with excellent data analytical capabilities. During the review, the QM team presented extensive analysis of a number of its access and quality indicators.
- VCBH has undertaken a public facing data dashboard project that will tremendously upgrade its reporting capabilities and also make communication of data analytical findings more accessible to stakeholders.
- The MHP has taken significant steps toward care coordination for higher acuity beneficiaries through collaboration with the MCPs, the MCPs' behavioral health network provider, Beacon, and the contract providers. This also advances the No-Wrong-Door policy mandated by CalAIM.
- The MHP has strong partnerships with CWS, juvenile probation, and schools to ensure quick access for FC and justice-involved children and youth to be served promptly. This was confirmed by TAY focus group participants who were referred from these sources.
- The MHP deploys parent partners through its contract providers, but does not have any county-employed peer support specialists (PSCs). During the past 12 months, the MHP has worked with human resources to establish PSC job classifications, and at the time of the review reported that the first two offer letters had been issued.
- While the contract providers reported significantly improved communication with the MHP staff, the line staff reported an inadequate communication system for both receiving information and providing input to the MHP leadership. The MHP reported that it has started a staff survey that will address this issue. It has already piloted the survey with the Full-Service Partnership (FSP) staff.
- The MHP does not track the following HEDIS measures as required by WIC Section 14717.5. The MHP reported reviewing the data from the CWS dashboards, but did not present any evidence of formal reporting on the following HEDIS measures despite presenting evidence of a robust medication monitoring system.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): The MHP did not present any data on this metric.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): The MHP provided strong evidence of this being a centerpiece of its medication monitoring system, but did not present any data that follows the HEDIS specifications.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): The MHP indicated that it tracks this metric, but did not present any data that follows the HEDIS specifications.
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): The MHP did not present any data that follows the HEDIS specifications

QUALITY PERFORMANCE MEASURES

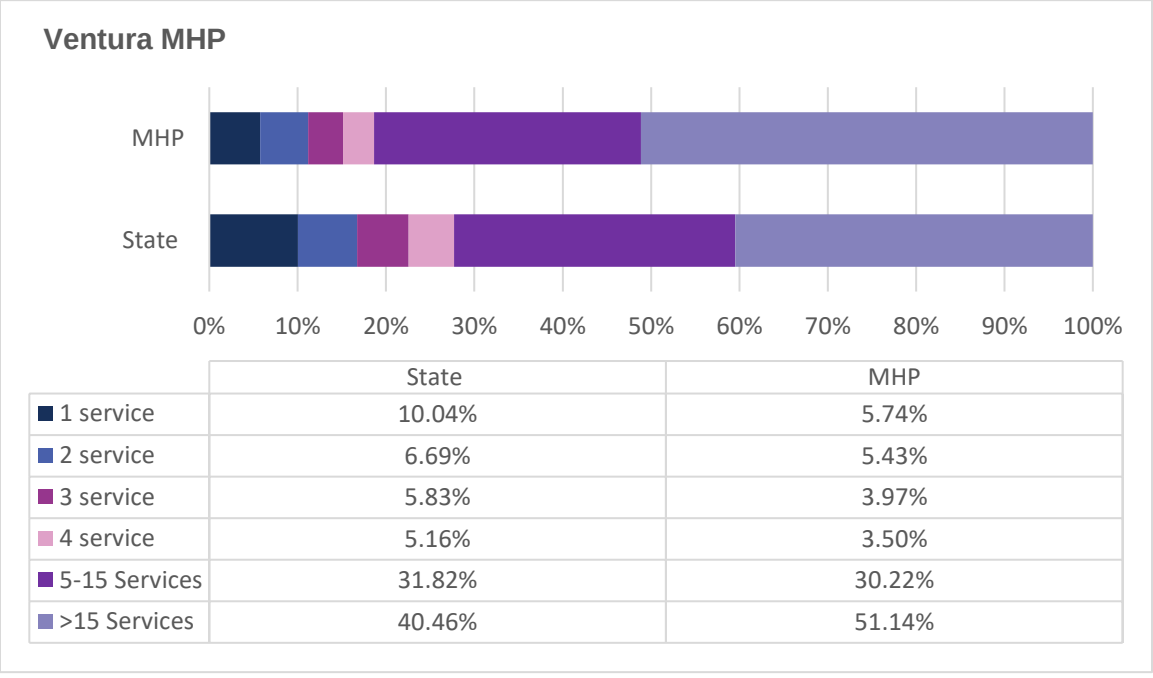
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- HCB

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.04%	5.74%
2 service	6.69%	5.43%
3 service	5.83%	3.97%
4 service	5.16%	3.50%
5-15 Services	31.82%	30.22%
>15 Services	40.46%	51.14%

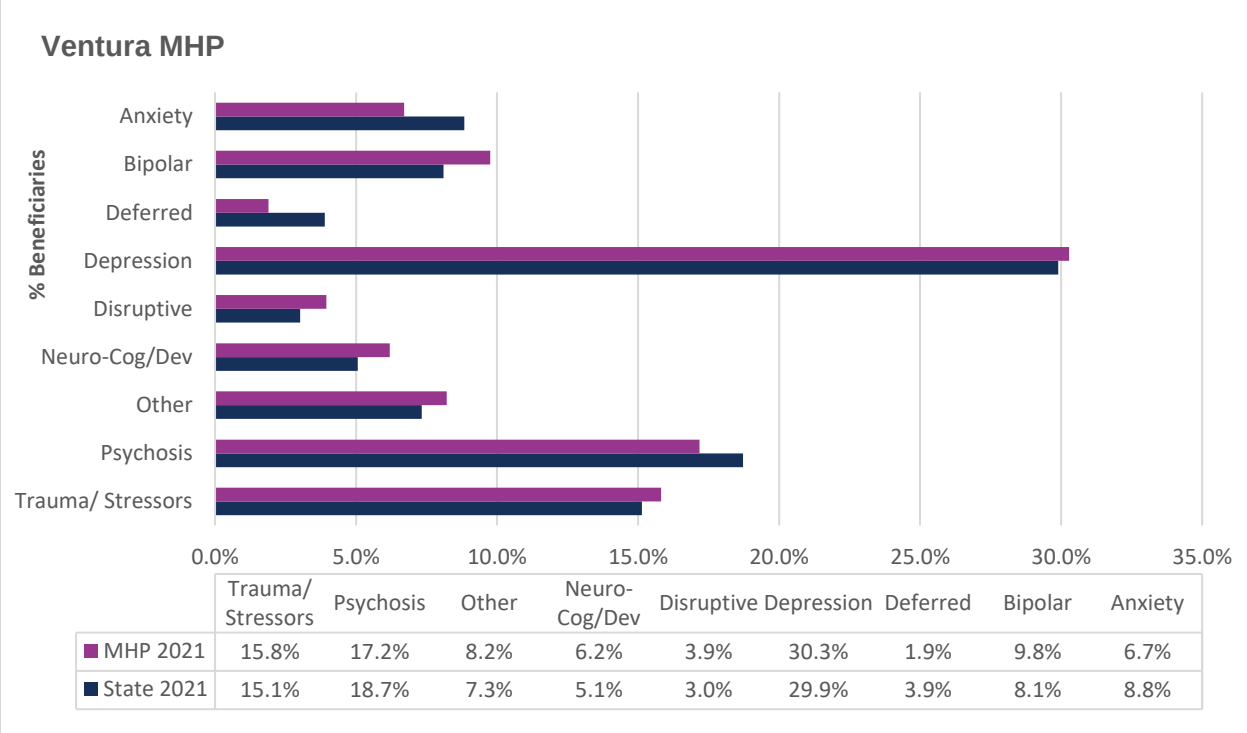
- Compared to the statewide averages, the MHP typically provides more service encounters annually to the beneficiaries. The number of beneficiaries receiving

four or fewer services is nearly half that of the state. In contrast, those receiving 15 or more services annually is 27 percent higher than the statewide average.

Diagnosis of Beneficiaries Served

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

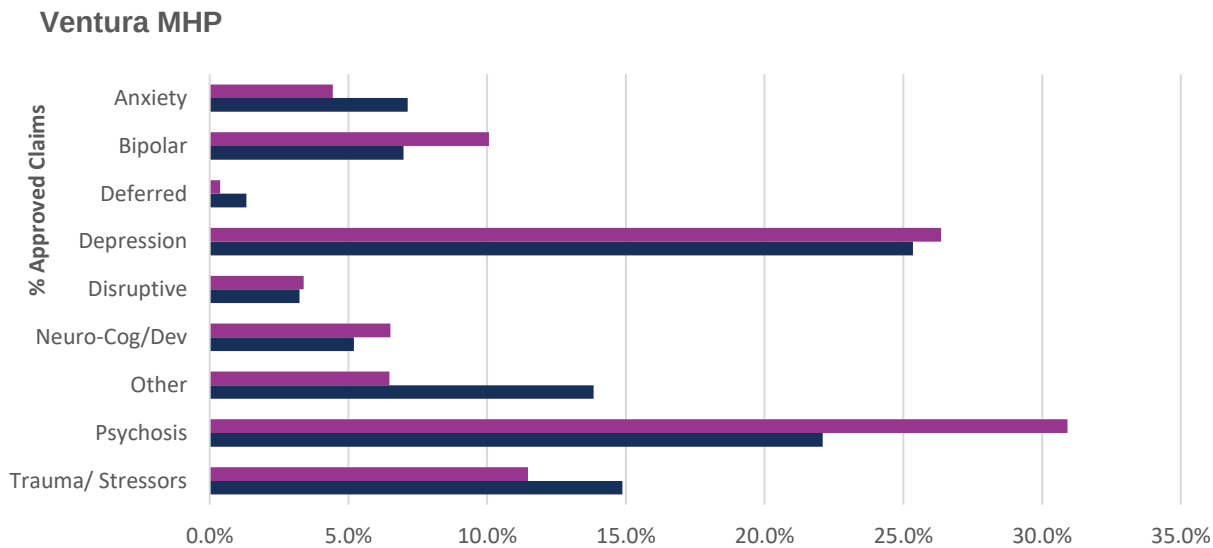
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	15.8%	17.2%	8.2%	6.2%	3.9%	30.3%	1.9%	9.8%	6.7%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- The distribution of MHP beneficiaries by diagnostic categories closely resembles that statewide. The MHP has half the statewide rate of deferred diagnosis potentially contributing to more appropriate determination of the beneficiaries' service needs.

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	11.5%	30.9%	6.5%	6.5%	3.4%	26.4%	0.4%	10.1%	4.4%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- The MHP's AACB for psychosis and bipolar disorder categories are significantly higher than the corresponding statewide averages. On the other hand, the AACB for other, anxiety, and trauma/stressors categories are considerably lower than the state.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay.

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	871	2,233	7.70	8.79	$20,638	$12,052	$17,975,995
CY 2020	808	1,840	7.61	8.68	$15,442	$11,814	$12,476,952
CY 2019	1,063	2,675	6.29	7.63	$9,879	$10,212	$10,500,899

- While the MHP's average inpatient LOS has been lower than the statewide average for each year between CY 2019-21, its corresponding AACB has more

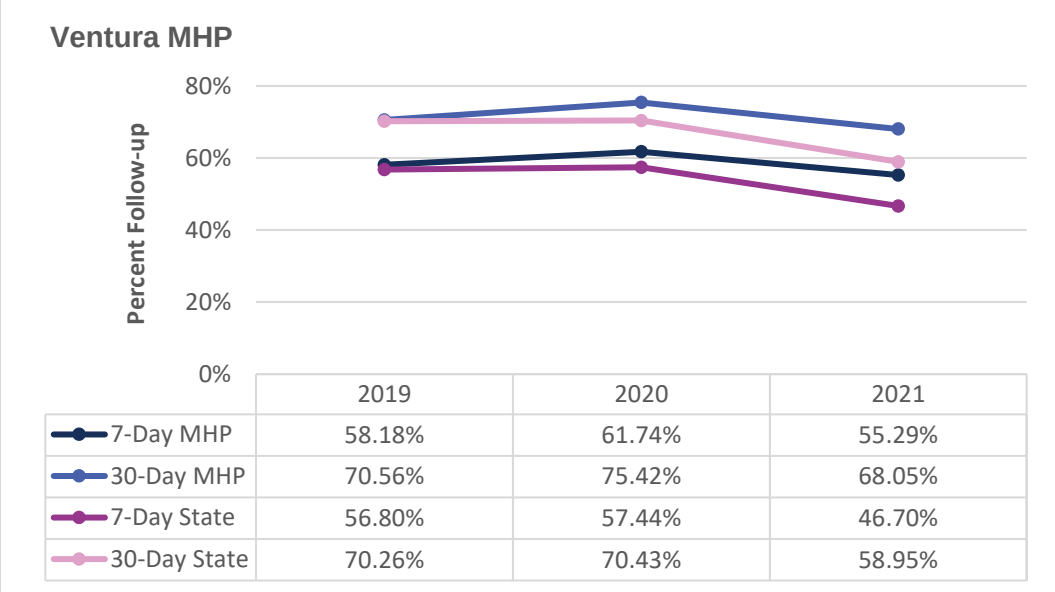
than doubled during the same period. As a result, it has moved from being lower than the state to 50 percent higher within two years.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

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

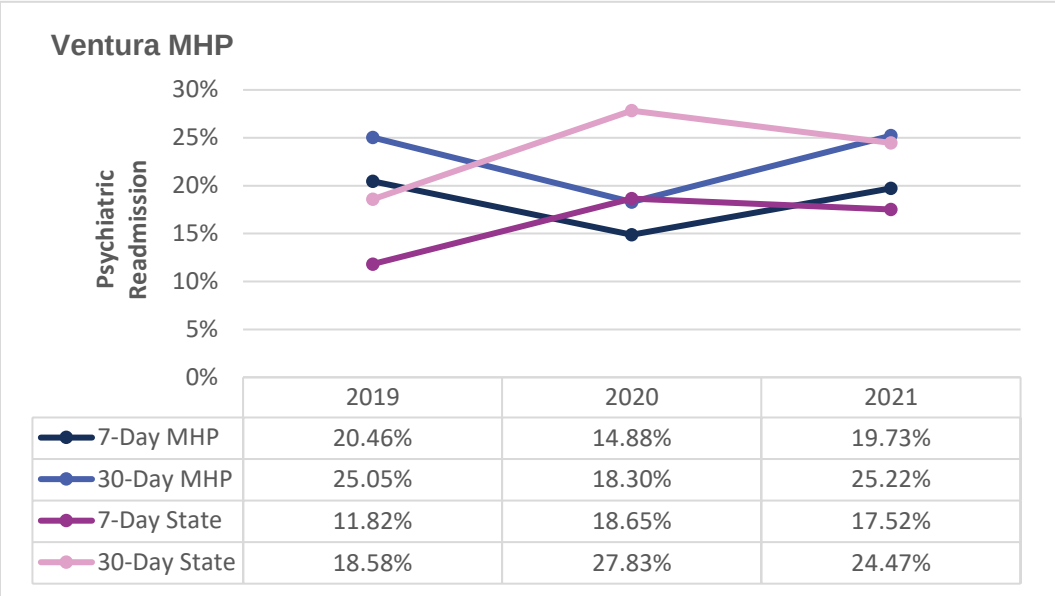
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	58.18%	61.74%	55.29%
30-Day MHP	70.56%	75.42%	68.05%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

- The MHP's 7- and 30-day inpatient follow-up rates declined in CY 2021, but remained higher than the corresponding statewide rates. The MHP reported 71 and 90 percent follow-up rates within 7 and 90 days respectively in FY 2021-22.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	20.46%	14.88%	19.73%
30-Day MHP	25.05%	18.30%	25.22%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The MHP's 7- and 30-day rehospitalization rates in CY 2021 were similar to its rates in CY 2019 after a dip in CY 2020 in the middle. These rates are similar to the statewide averages.
- The MHP's recently concluded clinical PIP aimed to reduce rehospitalization rates through improved care coordination after inpatient discharge.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent

of the statewide beneficiaries are “low cost” (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	497	9,745	5.10%	$63,827	$47,952
	CY 2020	441	10,440	4.22%	$60,885	$47,205
	CY 2019	426	10,405	4.09%	$56,372	$43,334

- The number of HCBs increased by 56 (13 percent) from CY 2020 to CY 2021. The percentage of HCBs in CY 2021 remains higher (5.10 percent) than the statewide average (3.46 percent) and the average approved claim amount per HCB was 19.4 percent higher than the statewide average ($63,827 vs. $53,476).
- The average approved claims per HCB increased by 13.22 percent between CY 2019 and CY 2021.

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	359	3.68%	$8,799,480	10.28%	$24,511	$24,119
Low Cost (Less than $20K)	8,889	91.22%	$45,074,402	52.66%	$5,071	$3,651

Figure 20: Proportion of Beneficiary Count by Claim Amount Grouping CY 2021

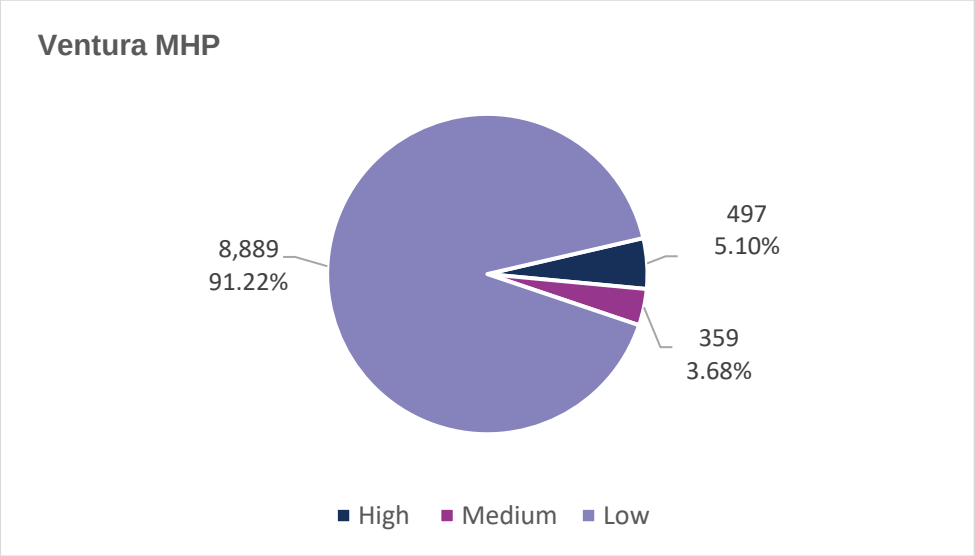
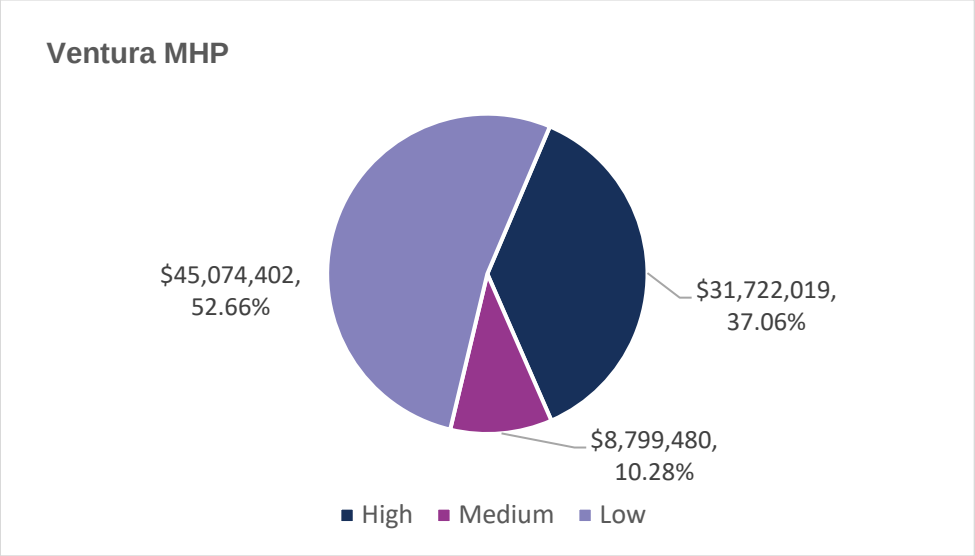


Figure 21: Approved Claims by Claim Amount Grouping



- Figures 20 and 21 show that when the HCBs and the medium-cost beneficiaries are combined, only 8.78 percent of the beneficiaries account for nearly half of the total approved claims (47.34 percent). Conversely, a vast majority of the beneficiaries, 91.22 percent account for only 52.66 percent of the total approved claims.

IMPACT OF QUALITY FINDINGS

- As stated elsewhere, the MHP has had significant staff turnover at all levels during the past 12 to 18 months. The new leadership appears to be genuinely interested in strengthening its data-driven decision-making process.
- The MHP's strong QM function and data analytical capabilities provide it with some opportunities for improvement in its QAPI plan:
    - Ensuring that the QAPI goals are measurable with quantifiable targets to the extent possible.
    - Annual QAPI evaluation clearly identifying how well those targets were met, again making it quantifiable to the extent possible.
- The public-facing data dashboard project will bring forth the desired transparency and greater access to reports by the line staff and beneficiaries among others. It is critical that as the data dashboards start coming online, the MHP undertakes a campaign to inform and engage the various stakeholders and community partners about the purpose and availability of these dashboards to maximize their utilization.
- The MHP should closely monitor and analyze its trends in HCBs. In examining these, the MHP may consider the following:
    - From the CalEQRO PMs, it appears that there is a strong correlation between the upward trend in the HCB approved claims and the inpatient AACB.
    - As seen in Table 8, the MHP's actual inpatient admission rate is lower than the state while its rate of inpatient administrative days is higher than the state.
    - At the same time, its inpatient LOS is also lower than the state (Table 13).
    - Another associated factor could be the MHP's retention rate with 51.14 percent of the beneficiaries receiving more than 15 encounters annually.
- The MHP's significantly lower deferred diagnosis rate than the statewide average points toward a good practice in ensuring the quality and appropriateness of treatment.
- While the MHP has a strong medication monitoring system with many of the HEDIS measures being tracked conceptually, the FC HEDIS measures need more formal tracking and reporting using the HEDIS specifications.
- The MHP's attention to providing inpatient follow-up care ensures greater continuity of service and engagement, which in turn leads to reduced rehospitalization.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and 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.caleqro.com.

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Post Hospitalization Performance Improvement Project

Date Started: 07/2020

Date Completed: 06/2022

Aim Statement: "Will the interventions supported by the Care Coordination Program (CCP) reduce the 7- and 30-day readmission rates for VCBH beneficiaries and unenrolled clients by 50 percent by the end of Phase 2?"

Target Population: Beneficiaries discharged from two of the inpatient units that account for the largest segment of VCBH inpatient admissions.

Status of PIP: The MHP's clinical PIP is in the second remeasurement phase and recently concluded.

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

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

Summary

This clinical PIP aimed to reduce rehospitalization rates by focusing on providing timely follow-up care for beneficiaries discharged from two psychiatric hospitals that accounted for the largest segment of VCBH hospitalized beneficiaries. This year, CalEQRO reviewed the findings from phase 2 of the PIP that started in October 2021. Previously, in phases 1A and 1B, the PIP population was limited to one hospital only and the intervention did not include an important component, the CCP. Since the CCP was established, it enhanced the care coordination provided by the two existing teams, RISE and STAR.

The PIP population included both those who were already receiving services from a VCBH clinic and those who were not enrolled in any VCBH program. Care coordination, the main intervention, was slightly different for the already enrolled and unenrolled beneficiaries. For both groups, the intervention started while they were still hospitalized so the CCP could clearly plan and implement a post-discharge plan including medication continuity and temporary case management and other treatment services as needed. For those who were already enrolled, their clinics were responsible for ensuring that their beneficiaries were connected back to their programs. For the unenrolled beneficiaries, the CCP, along with RISE and STAR was responsible for connecting them to a program, and as needed, providing interim care.

The PIP showed significant improvements for the previously unenrolled beneficiaries while there was no improvement among the already enrolled population.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: the MHP used a comparison group of beneficiaries who received treatment as usual upon discharge from other inpatient units than the two included in this study. Further, the magnitude of difference between the two treatment groups, as well as with the comparison group was significant.

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

- In order to understand the success with the previously unenrolled beneficiaries better, and the lack of success with the already enrolled beneficiaries, the MHP should continue its analysis taking into account available demographic and other clinical variables. As a continuing quality improvement project, such analyses are likely to provide greater insight into what can be done differently to replicate success with the existing beneficiaries.
- Since this PIP has concluded, work on identifying PIP topics and seek TA from CalEQRO on an ongoing basis.

NON-CLINICAL PIP

General Information

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

Date Started: 06/2021

Date Completed: 09/2022

Aim Statement: "At youth and family (Y&F) regional outpatient clinics, can operational efficiencies in the process of engaging VCBH youth and family members result in a 5 percent increase in consumers who receive their first outpatient service within 15 business days after the intake assessment?"

Target Population: Children and youth aged 0-17, and their family members.

Status of PIP: The MHP's non-clinical PIP was in the second remeasurement phase and recently concluded.

Summary

This PIP addressed the issue of delays in receiving the first service appointment after the initial assessment. The MHP examined the STAR and RISE teams' processes at the point of intake and the time to submit the assessment information to the assigned clinic. The MHP also looked at the processes of the receiving clinic. In addition, the obtained input from both the line staff and beneficiaries on the barriers and improvements needed. Based on this, the MHP devised a New Client Engagement Process (NCEP).

As part of the NCEP, the MHP created a report for use by the STAR, RISE, and the Y&F clinic administrators that shows the new beneficiaries in the system along with their status during the transition phase between assessment to the first Y&F appointment. This allows the clinic administrators or their designated staff to contact the beneficiaries during the waiting period as well as fast tracking the processes. In addition, in the case of no-shows for the first appointment, the PIP also included a special outreach component to get the no-show beneficiary to come back for their first services.

This PIP was not successful primarily due to external circumstances after the COVID-19 pandemic that included severe staffing shortages and a simultaneous rise in demand for mental health services. However, the MHP noted that there were important lessons learned that will be valuable in ongoing process improvement to fast track follow-up appointments after intake. Further, the MHP plans to expand this effort to other clinics in the future.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: of its negative outcomes precipitated by extenuating circumstances beyond the control of the MHP. The PIP particularly failed in the targeted follow-up appointments within 15 days after the initial assessment. It maintained the same rate of attendance following a no-show.

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

- The MHP has terminated this PIP and plans to expand the improvement strategy to other clinics despite the failures. The MHP needs to keep the data tracking mechanism in place to see if there are improvements after the extenuating circumstances are under control.
- Since this PIP has concluded, the MHP is planning to implement a new non-clinical PIP to address one of the areas identified in the state behavioral health quality improvement plan. The MHP was encouraged to seek TA on that PIP as the interventions and goals are identified.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart Avatar, which has been in use for 13 years. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 6.3 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. There has been a 10 percent decrease in the percentage of the annual budget allocated since the prior year.

The MHP has 938 named users with log-on authority to the EHR, including approximately 711 county staff and 227 contractor staff. Support for the users is provided by 14.6 full-time equivalent (FTE) IS technology positions. Currently there is one vacant position.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

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

Beneficiary Personal Health Record

The 21st Century 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 Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not currently have a PHR. The MHP anticipates implementing this functionality within the next two years with the new EHR implementation.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: hospitals, county sheriff, and the Homeless Management Information System.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive 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 Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 17: IS Infrastructure Key Components

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

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

- Telehealth delivery is robust across both county and contract provider programs and includes capacity for telehealth delivery for non-English speaking clients.
- The Mental Health Services Act (MHSA) FSP population data integration project increases notification and reporting of key events to the state.
- While the MHP has policies and procedures supporting the Medi-Cal claiming process, the MHP claim denial rate (6.59 percent), is double the statewide average of 2.78 percent. The primary reason for denial was not billing Medicare prior to Medi-Cal claim submission. The MHP is still working towards certification, to address this issue.
- Related to the security and controls rating, the MHP does not have an OCP in place to support critical business functions in the event of a cyber-attack, disaster, or other cause for a disruption to the EHR system. With an OCP in place, best practices would include annual testing and setting a standard of time for restoring the system following a disruption of service.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the table below, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

For the MHP, it appears that significant claims lag begins in November and likely represents $14 million in services not yet shown in the approved claims provided. The MHP reports that their claims are current through October 2022.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	23,967	$7,536,249	$893,138	11.85%	$6,643,111
Feb	28,239	$8,795,366	$623,468	7.09%	$8,171,898
Mar	33,818	$10,368,563	$570,644	5.50%	$9,797,919
April	29,608	$9,264,190	$620,405	6.70%	$8,643,785
May	27,565	$8,598,148	$549,033	6.39%	$8,049,115
June	28,916	$9,076,599	$593,841	6.54%	$8,482,758
July	25,157	$9,095,610	$447,589	4.92%	$8,648,021
Aug	26,832	$9,229,756	$556,369	6.03%	$8,673,387
Sept	23,305	$7,749,571	$306,406	3.95%	$7,443,165
Oct	25,097	$8,061,094	$623,665	7.74%	$7,437,429
Nov	57	$20,876	$0	0.00%	$20,876
Dec	3	$672	$0	0.00%	$672
Total	**272,564**	**$87,796,694**	**$5,784,558**	**6.59%**	**$82,012,136**

- CalEQRO's claims data shows that Ventura's claims were mostly current until October 2021; however, the claims data that CalEQRO received, is almost completely missing the last two months of data. This may have implications for some of the PMs such as PR, AACB, and inpatient follow-up and readmission.

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B or Other Health Coverage must be billed before submission of claim	6,223	$2,333,650	40.34%
Beneficiary not eligible or non-covered charges	1,263	$1,692,473	29.26%
Claim/service lacks information which is needed for adjudication	2,218	$1,087,890	18.81%
Service line is a duplicate and a repeat service procedure code modifier not present	1,708	$336,599	5.82%
Other	68	$218,456	3.78%
NPI related	609	$115,491	2.00%
Total Denied Claims	12,089	$5,784,559	100.00%
Overall Denied Claims Rate	6.59%		
Statewide Overall Denied Claims Rate	2.78%		

- The top three denial reasons account for $5.1 million and 88 percent of denied claims. The MHP's denial rate is more than twice that of the statewide average.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Strong collaboration with the contracted providers and ongoing communication will assist the MHP in the efforts implementing a new EHR.
- The base of 14.6 FTEs supporting the overall health agency IS functionality will provide a good foundation during the EHR transition. The dedicated data analytics staff assigned to the mental health system of care may benefit from additional staffing resources as they confirm the new system reporting capabilities and the level of staffing required to develop and maintain the system.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (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 pays close attention to the CPS data. However, it has not received the results from the latest survey and presented the reports from the previous CPS. In addition to the CPS, the MHP also uses a brief 4-item Treatment Perceptions Survey (TPS) in the adult division, as well as the full TPS for all youth and adult beneficiaries. This allows the MHP to more regularly collect and track beneficiary satisfaction.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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 three 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 to 18 months. The focus group was held via videoconferencing and included seven participants some of whom were Spanish speakers; CalEQRO focus group facilitator conducted the session in both English and Spanish. All consumers participating receive clinical services from the MHP.

The participants reported mixed experiences with timely access. While two of the participants reported getting initial appointments within a week, the others reported delays from one to three months. Those needing services in Spanish, the MHP's threshold language, reported experiencing a shortage of Spanish-speaking staff in the past year.

About half the participants reported that their ongoing service frequency was just right. The others felt the wait times between appointments were too long either for clinician or

for psychiatry. Most reported that they receive appointment reminders by text or phone calls. All participants knew how to reschedule in case of no-shows, but reported that if one misses an appointment, it can take a long time to reschedule because of staff shortage.

No one in the group needed or received transportation in the past year, although one participant reported difficulty accessing it and another reported receiving transportation from the case manager in the past. Although the participants were aware of how to request a change of provider in case of incompatibility, the majority reported being uncomfortable asking for any change.

All participants reported that their provider addresses their primary health care needs and communicates with their primary care provider, as needed. All participants knew who to contact in case of a crisis or urgent care need and reported that this has been helpful. All participants felt that their cultural needs are taken into account by the providers.

Most participants were unaware of the wellness centers except one who reported attending wellness center groups by Zoom. All participants reported receiving telehealth services as needed. No participant recalled filling out a satisfaction survey, and no one was aware of any way to provide feedback about services to the MHP. However, one participant reported having the best care and provider possible.

Recommendations from focus group participants included:

- Need more staff so the wait time is reduced, caseloads are lower, bilingual needs are met, and more time with therapist.
- “Stronger emphasis in culture competency training across county services.”
- More program options such as yoga, nutrition, healthy living, and dialectical behavior therapy.
- Clearer messages and dedicated portal on the services available.
- Training for the front desk staff to reduce miscommunication.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of family members and caregivers of child and youth beneficiaries who initiated services in the preceding 12 to 18 months. The focus group was held via videoconferencing and included six participants some of whom were Spanish speakers; CalEQRO focus group facilitator conducted the session in both English and Spanish. All family members and caregivers participating have a child or youth family member who receives clinical services from the MHP.

Most participants reported that their children received services within one to three weeks. One took a month for the first appointment and another one reported five to six weeks for both children. All of them reported receiving reminder calls the day before the

appointment. None of the participants needed transportation for their children. Those who need interpretation service, receive them.

The participants all reported that their mental health provider pay attention to primary care needs and speak to their primary care providers.as needed. Those participants whose children need psychiatry reported being satisfied with their psychiatrists. A few of the participants had to ask for a different therapist for their children and reported that the process was easy. All participants reported that telehealth is available and they can use it if they needed it.

Therapist appointments can be rescheduled rapidly, but psychiatrist appointment rescheduling can take longer if the child misses an appointment. However, in those situations, the participants reported that their children have been given phone appointments and their medication refills were ensured.

All participants reported that they are aware of who to contact in case of crisis and urgent care needs. However, some of the participants reported that they are afraid to call law enforcement in case of their children's crisis situation, lest the situation spins "out-of-control." All participants reported that the staff give them a sense of hope for wellness and recovery of their children.

None of the participants recalled filling out any satisfaction surveys. None have been involved in any committees either. However, they all felt that they can easily access any information they need, and can provide feedback to the psychiatrist or therapist, if needed. Some of the participants were interested in joining any committees or advisory groups, if such opportunities are available. Some participants would also like to volunteer in any peer advocacy or other parent support activities.

Recommendations from focus group participants included:

- More home-based services like TBS.
- More opportunities for youth to be able to interact with peers.
- More therapist hours.
- More information to make the parents aware of the services available.

Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of TAY beneficiaries who initiated services in the preceding 12 to 18 months. The focus group was held via videoconferencing and included six participants. All beneficiaries participating receive clinical services from the MHP.

Most participants felt that it took too long to receive the first appointment ranging between one to three months. Only those with any special referrals from schools or social services were able to get in sooner. But once in services, most participants had regular appointments.

All participants reported that they only receive reminder calls or texts for psychiatry appointments. All participants were aware that they could receive services in other languages, but none of this focus group participants needed linguistic services.

All participants were aware of the option of receiving services through videoconference. They were all aware of other community resources through which they can receive additional services.

For ongoing services, the most common concern among the participants was running out of medications.

The participants reported being to the TAY wellness center and acknowledged that the center provides computers, showers, laundry, snacks and help with housing. However, they also reported that sometimes the laundry machines are not clean and some snacks are old.

No participants reported having filled out a satisfaction survey. A few of the participants expressed their lack of expectation that anything will change as a result of a satisfaction survey. The participants were also unaware of any other avenues to provide feedback about their experience. Three of them said that they would be uncomfortable providing any feedback about their providers. Some participants felt their preferred gender and pronouns are not respected.

Recommendations from focus group participants included:

- More youth peer groups.
- More frequent and longer psychiatry sessions.
- Improve options other than medications.
- More training for the group facilitators.
- More staff training on Lesbian, Gay, Bisexual, Transgender, and Queer issues.
- More one-on-one time with the therapists.
- Better continuity of medication supply.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The most salient finding from the focus group concerned delays in initial access and subsequent appointment timeliness. In addition, the participants noted further needs for peer support and more diversified service activities. Most participants were acutely aware of the current staff shortages that the MHP is facing.

CONCLUSIONS

During the FY 2022-23 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 has strong QM and data analytical capabilities. (Quality)
2. The new leadership is interested in maintaining and enhancing a data-driven decision-making system. It is also showing interest in improving communications by visiting the clinics. (Access, Quality)
3. The MHP has established the needed partnerships communication channels with other agencies, MCPs, and community-based organizations to implement the no-wrong-door policy. (Access)
4. The MHP has a strong culturally responsive outreach and engagement system through its RISE and Logrando Bienestar programs. (Access)
5. VCBH has one of the most informative and easy-to-navigate behavioral health websites with easy Spanish translation facility. (Access, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP lacks a reliable and accurate system for tracking its timeliness of for first offered psychiatry appointments. (Timeliness)
2. Although the MHP has strong medication monitoring system in place, it does not currently track the FC HEDIS measures following the prescribed methodology. (Quality)
3. The HCB count and associated claims, including inpatient costs, have been increasing rapidly in the past three years. (Quality)
4. The MHP's QAPI plan, while comprehensive, lacks quantifiable measures. The MHP already analyzes and presented a number of access and quality indicators during the review, but these are not included in the QAPI goals in a quantifiable manner. (Quality)
5. The MHP does not currently have an OCP in place in the event of a system disruption. (IS)
6. The Medicare certification process is still pending completion, and claim denials remain high due to the inability to bill Medicare. (IS)

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. As the new EHR gets implemented, ensure that the data system changes will allow for accurately capturing the first offered psychiatry timeliness. (Timeliness, IS)
2. Implement a tracking and reporting mechanism for FC HEDIS measures. (Quality)
3. Investigate the reasons for increases in HCBs and inpatient costs and identify strategies to contain the growth. (Quality)
4. Include quantifiable goals in the QAPI plan and report quantifiable progress in the annual QAPI evaluation. (Quality)
5. Focus resources to develop an OCP concurrent with the implementation of the EHR to ensure services can continue in the event of a system disruption. (IS)
6. 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. (IS)

   (This recommendation is a carry-over from FY 2021-22.)

EXTERNAL 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 requirements 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.

There were no barriers to this FY 2022-23 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Ventura MHP
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 PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer and Family Member Focus Groups (Three)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Forensics and Law Enforcement Group Interview
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
EHR Deployment
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, Ph.D., Lead Quality Reviewer
Samantha Fusselman, LCSW, CPHQ, Executive Director
Joel Chain, Lead Information Systems Reviewer
Rita Samartino, Information Systems Reviewer
Valerie Garcia, Consumer/Family Member Reviewer
Sandra Sinz, LCSW, CPHQ, Clinical Quality Strategist

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.

MHP County Sites

N/A

MHP Contract Provider Sites

N/A

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Aguila	Gabriela	Manager - Y &F	VCBH
Amezquita	Wendy	Clinic Administrator - TAY VCPOP	VCBH
Ashur	Ophra	Compliance Senior Manager	VCBH
Avila	Ruby	Clinic Administrator – Access & Outreach	VCBH
Bakst	Danny	Head of Service	Kids to Kids
Bezdjian	Serena	Research Psychologist -QI	VCBH
Blum	Chris	Administrator	Telecare
Block	Sherri	Director of Nursing	HCA Ambulatory Care
Bosoletti	Paula	Manager of Care Management	Gold Coast Health Plan
Boules-Syta	Jennifer	Program Manager	Turning Point Foundation
Burke	Shannon	Clinician – SUS	VCBH
Burt	Sloane	Manager - QI	VCBH
Calica	Anne	Clinic Administrator	Aegis - Ventura
Carson	Hillary	Senior Program Administrator-MHSA	VCBH
Castro	Chris	Program Administrator - QA	VCBH
Cervantez	Joseph	Clinic Administrator	Aegis - Santa Paula
Chen	Yvette	Sr. Program Administrator - QI	VCBH
Ciancutti	Lily	Executive Director	Seneca
Cleland	Don	Executive Director	Golden HH MHRC and Ventura CRT

Last Name	First Name	Position	County or Contracted Agency
Connelly-Cumming	Nancy	Clinician	VCBH SUS Care Coordination
Cooper	Dr. Jason	Medical Director	VCBH
Corona	Eileen	Clinic Administrator - SUS	VCBH
Cowie	Stephanie	Clinic Administrator - Y&F	VCBH
Davis	Jessica	Manager - SUS	VCBH
Denering	Dr. Loretta	Assistant Director	VCBH
Di Battista	Maria	Clinic Administrator- SUS	VCBH
Diaz	Amber	Program Administrator – Contracts	VCBH
Donavan	Leisa	Sr. Manager - Fiscal	VCBH
Dougherty	Jennifer	Sr. Manager – Y&F	VCBH
Duenas	Alicia	Program Administrator – EHR	VCBH
Duplessis	Germeen	Manager - CalAIM	VCBH
Duran	Jose	Community Services Coordinator	VCBH
Eden	Savannah	Clinic Administrator - CWS	VCBH
Egan	Narcisa	CFO – HCA	VCBH
Elhard	Erick	Manager - MH Care Coordination	VCBH
Fekete	Doreen	Senior Program Administrator	VCBH - Fiscal/Accounting
Flores	Raudel	Clinic Administrator - Y&F	VCBH
Fox	Cheryl	Division Chief - Youth and Family	VCBH

Last Name	First Name	Position	County or Contracted Agency
Gardner	Janis	Member	Behavioral Health Advisory Board
Gilbert	Alexander	Program Manager	Anne Sippi Clinic
Gilman	Scott	Director	VCBH
Glantz	Julie	Sr. Manager - Adult Division	VCBH
Goldner	Richard	Sr. Program Administrator – EHR	VCBH
Greenland	Sandy	Clinician	Casa Pacifica
Guilin	Heather	Clinic Administrator -Y &F	VCBH
Handel	Deanna	Manager	HCA Ambulatory Care
Hannah	Melissa	Director	United Parents
Heath	Curtis	Program Administrator -Contracts	VCBH
Hicks	Dan	Manager - SUS Prevention Services	VCBH
Hipple	Wendy	Clinic Administrator – Access & Outreach	VCBH
Hodge	Hayley	Clinic Administrator - CWS	VCBH
Huey	Chris	Clinic Administrator - SUS	VCBH
Johnson	Heather	Clinic Administrator -Y&F	VCBH
Juarez	Dr. Michael	Executive Director	Alternative Action Programs
Keeler	Samantha	Clinician – SUS Care Coordination	VCBH
Kramer	Barbara	Program Administrator -Contracts	VCBH
Lee	Karen	Manager – QM lead	VCBH Quality

Last Name	First Name	Position	County or Contracted Agency
Liguori	Nick	CEO	Gold Coast Health Plan
Lomeli	Nicole	Program/Administrative Director	Jackson House
Lopez	Cindy	Clinic Manager	Alternative Action Programs
Lopez	Gracie	Management Assistant - QI	VCBH
Lopez	Marcus	Clinic Administrator – Y&F Juvenile Justice	VCBH
Lubell	Courtney	Manager - Special Projects	VCBH
Magbitang	Ana	Manager - Y&F	VCBH
Malandra	Nicole	Clinician	Prototypes
Manzo	Salvador	Manager – Adult Division	VCBH
Marrero	Lucy	Director of Behavioral Health	Gold Coast Health Plan
Matisek	Kalie	Clinical Director	Turning Point Rehab Services
McDuffee	Rachel	Regional Clinic Manager	Aegis
Medina	Leo	Clinician - SUS Care Coordination	VCBH
Mendoza	Juan	Sr. Program Administrator -Billing	VCBH
Mikkelson	Sandi	Program Administrator - QI	VCBH
Moneyhun	Stephanie	Clinic Administrator Y&F	VCBH
Nagle	Laura	Clinic Administrator -Y & F	VCBH
Napolitano	Dr. Ralph	Physician	Aegis
Nestroyl	Brandy	Compliance Coordinator	Prototypes

Last Name	First Name	Position	County or Contracted Agency
Newbold	Jennifer	Vice President	PathPoint
Pavloskaya	Aliona	Program Administrator -QM	VCBH
Pletcher	Rachel	Program Manager	Kid & Family Together
Preciado	Pauline	Director of Population Health	Gold Coast Health Plan
Rabinovitz	Katheryn	Program Administrator – QI	VCBH
Riddle	Angela	Manager - Training	VCBH
Rodriguez	Michael	Adults Div Clinic Administrator	VCBH
Rojas	Michelle	Program Administrator - EHR	VCBH
Roman	Dave	Manager - EHR	VCBH
Rosenstein	Irving	Physician's Assistant – SUS	VCBH
Rotnofsky	Dr. Jamie	Sr. Manager - MHSA	VCBH
Ruiz	Deanna	Clinic Administrator -CalWorks	VCBH
Salas	Cynthia	Manager - Health Equity and Cultural Diversity	VCBH
Salazar	Nicole	Sr. Program Administrator - CalAIM	VCBH
Sanchez	Sara	Division Chief - Access & Outreach	VCBH
Schipper	Dr. John	Division Chief - Adults	VCBH
Seal	Maryza	Contract Manager	VCBH
Shah	Brinda	Sr. Program Administrator -QI	VCBH
Simental	Cindy	Clinic Administrator	VCBH - New Start For Moms

Last Name	First Name	Position	County or Contracted Agency
Springer	Nancy	Manager - Adults	VCBH
Star	Keith	Clinic Manager	Tarzana Treatment Centers
Starr	Billy	Compliance Officer	Casa Pacifica
Stone	Elizabeth	Consumer Advocate	Ventura County Advisory Board
Swanson	Kaj	Clinic Administrator - SUS	VCBH
Tadeo	Zandra	Manager - Y&F	VCBH
Taylor	Thomas	Manager - Adults	VCBH
Tith	Melissa	Program Director	Seneca
Torres	Monica	Manager - Y&F	VCBH
Torres	Cynthia	CEO	New Dawn
Turcios	Vanessa	Program Administrator – QA	VCBH
Ummer	Faizal	Program Administrator EHR	VCBH
Valdiva	Angelic	Program Director	Prototypes
Vargas	Laura	Acministrator	ASC Treatment group
Vessels	Joelle	Director	Interface Children & Family services
Villegas	Alexis	Program Administrator -QI	VCBH
Vlaskovitz	Dr. Joseph	Medical Director – SUS	VCBH
Volf	Nora	Pharmacist	VCBH
Warren	Liz	MHRP	Client Network
Washington	Chauntrece	Sr. Manager -CalAIM	VCBH

Last Name	First Name	Position	County or Contracted Agency
West	Raena	Division Chief – Substance Use Services	VCBH
Wharfield	Nancy	Chief Medical Officer	Gold Coast Health Plan
White Wood	Susan	Manager - Housing	VCBH
Yomtov	Dani	Program Administrator- QI	VCBH
Zepeda	Geneveve	Clinical Nurse Manager - UR	VCBH

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP accomplished significant success with a segment of the PIP population while the others did not show any change in the indicators.

General PIP Information
MHP/DMC-ODS Name: Ventura
PIP Title: Post Hospitalization Performance Improvement Project
PIP Aim Statement: "Will the interventions supported by the Care Coordination Program (CCP) reduce the 7- and 30-day readmission rates for VCBH beneficiaries and unenrolled clients by 50 percent by the end of Phase 2?"
Date Started: 07/2020
Date Completed: 06/2022
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): ☐ 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: N/A
Target population description, such as specific diagnosis (please specify): Beneficiaries discharged from two of the inpatient units that account for the largest segment of VCBH inpatient admissions.

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 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): The staff of the CCP, STAR, and RISE were trained in a specific protocol to enhance care coordination from the time the beneficiaries were already in the hospital through discharge to engagement in the follow-up programs.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The enhanced care coordination protocol adopted for this PIP was a new practice for the MHP.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
7-day readmission rate	FY 2020-21	Overall N=1,551; Rate=9% Unenrolled N=905; Rate=10% Enrolled N=646; Rate=8%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	Overall N=153; Rate=7% Unenrolled N=83; Rate=5% Enrolled N=70; Rate=10%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
30-day readmission rate		Overall 21% Unenrolled 19% Enrolled 23%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	Overall 13% Unenrolled 8% Enrolled 19%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Follow-up during hospitalization		Unenrolled 14%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	Unenrolled 64%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
7-day follow-up rate		Unenrolled 32% Enrolled 82%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	Unenrolled 60% Enrolled 77%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
30-day follow-up rate		Unenrolled 49% Enrolled 93%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	Unenrolled 76% Enrolled 96%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
7-day follow-up rate (HEDIS)		Unenrolled 17% Enrolled 42%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	Unenrolled 20% Enrolled 39%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
30-day follow-up rate (HEDIS)		Unenrolled 30% Enrolled 65%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	Unenrolled 36% Enrolled 70%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
30-day VCBH enrollment		Unenrolled 28%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	Unenrolled 40%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Note:

1. Not all indicators were tracked through the three phrases of the PIP. All of them were tracked for the previously unenrolled beneficiaries.
2. The sample size for each category is provided in the first indicator row. Those remained the same for each indicator and have not been repeated.

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): Completed

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
EQRO recommendations for improvement of PIP: • In order to understand the success with the previously unenrolled beneficiaries better, and the lack of success with the already enrolled beneficiaries, the MHP should continue its analysis taking into account available demographic and other clinical variables. As a continuing quality improvement project, such analyses are likely to provide greater insight into what can be done differently to replicate success with the existing beneficiaries. • Since this PIP has concluded, work on identifying our PIP topics and seek TA from CalEQRO on an ongoing basis.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The PIP experienced negative outcomes precipitated by extenuating circumstances beyond the control of the MHP. The PIP particularly failed in the targeted follow-up appointments within 15 days after the initial assessment. It maintained the same rate of attendance following a no-show.
General PIP Information	
MHP/DMC-ODS Name: Ventura	
PIP Title: Beneficiary Engagement after Intake Assessment	
PIP Aim Statement: At Y&F regional outpatient clinics, can operational efficiencies in the process of engaging VCBH youth and family members result in a 5 percent increase in consumers who receive their first outpatient service within 15 business days after the intake assessment?	
Date Started: 06/2021	
Date Completed: 09/2022	
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): ☒ 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: N/A	
Target population description, such as specific diagnosis (please specify): Children and youth aged 0-17, and their family members.	

General PIP Information						
Improvement Strategies or Interventions (Changes in the PIP)						
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 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): Practice changes at the access points and clinics where the treatments continued to improve outreach and communication with the beneficiaries, and improve timeliness of follow-up appointments.						
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): New protocol and reporting mechanism as tools for the staff to improve their practice.						
PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Overall percentage of beneficiaries with outpatient appointment within 15 business days of clinic assignment	CY 2021	N=765 64%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	N=183 36%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Overall percentage of new beneficiaries with a no-show who subsequently completed first outpatient appointment.	CY 2021	N=61 75%	☐ Not applicable—PIP is in planning or implementation phase, results not available CY 2022	N=36 75%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant 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): Completed Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • The MHP has terminated this PIP and plans to expand the improvement strategy to other clinics despite the failures. The MHP needs to keep the data tracking mechanism in place to see if there are improvements after the extenuating circumstances are under control.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required to be included in this report.