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FY 2023-24
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:

December 5-7, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Onsite

Date of Review — December 5-7, 2023

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 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	1	4	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	4	2	0
Quality of Care	10	9	1	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**22**	**4**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Screening and Identification of Psychosis Symptoms in Transitional Age Youth (TAY)	Clinical	08/2022	Planning	No confidence
Follow-Up After Emergency Department (ED) Visit for Mental Illness	Non-Clinical	09/2022	Baseline	Low confidence

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☐ TAY ☒Family Members ☐Other	9
2	☒Adults ☐TAY ☒Family Members ☒Other: Monolingual Spanish Speakers	5
3	☒Adults ☐ TAY ☐Family Members ☐Other	7

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has demonstrated improvements in multiple Quality Improvement (QI) related activities. (Quality)
- The QI team continues to have excellent data analytical capabilities. (Quality)
- The MHP has been able to start hiring for its newly developed peer employee positions. (Quality)
- During the implementation of the new Electronic Health Records (EHR) system, the MHP IS staff have been able to produce the necessary reports. (IS)
- The MHP evidenced strong collaborations with multiple agencies and external partners to facilitate access. (Access)

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

- The MHP has room for improvement in tracking of its timeliness metrics. (Timeliness)
- Communications with various stakeholders need improvement. (Quality)

- High-cost members (HCM) percentage and the associated average approved claims per member (AACM) significantly exceed the corresponding statewide figures. (Quality)
- Overall denied claims rate for the MHP was higher than the statewide average in CY 2022. (Quality, IS)
- The MHP has an opportunity to increase plan member participation in the Quality Improvement Committee (QIC) structure. (Quality)

Recommendations for improvement based upon this review include:

- Continue developing a robust timeliness reporting system that accurately captures timeliness according to Healthcare Effectiveness Data and Information Set (HEDIS) or other state and national practices. (Timeliness)
- Develop a two-way communication plan as part of a broader change management strategy that prioritizes communications with the contract providers, line staff, and plan members. (Quality)
- Examine the reasons for a high percentage of plan members being in the HCM category. Utilize the CalEQRO-provided approved claims analyses that show the higher costs are concentrated by certain race/ethnicity, age groups, service types, and aid codes. (Quality)
- Develop strategies to increase plan member participation in the QIC structure. (Quality)
- Complete the 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. (Quality)

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2023-24 findings of the EQR for Ventura County MHP by BHC, conducted as an onsite review on December 5-7, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

Since the previous EQR, the MHP had a change in leadership, and at the time of the EQR, an interim director was in place. The Office of Health Equity and Cultural Diversity (OHECD) Manager position has been vacant since March 2023. The MHP is in the process of recruiting and interviewing candidates for this role and anticipates filling the position by early 2024.

The MHP was able to reduce its staff vacancy rate since the time of the previous EQR, but still had a 16 percent vacancy rate. At the same time, the MHP reported that it had experienced a significantly higher number of plan members seeking mental health services. Similarly, CalEQRO's data showed a 15 percent increase in the Medi-Cal member counts during CY2020-22.

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.

- VCBH has undergone significant structural changes in the past year:
    - A new Quality Care Division (QCD) has been created to encompass all Quality and EHR teams.
    - A new Chief of the QCD started in this position in September 2023.
    - VCBH re-launched the QIC in early 2023. Seven subcommittees were formed under the QIC, with membership and terms now ratified in their respective charters. The subcommittees have cross-sectional representation of staff at various levels of the organizations, and some have external community members. The committees meet at least six times per year and discuss various initiatives or improvement projects within their respective areas of focus.
    - Additionally, the Strategy, Planning, and Administration Group was created and is positioned under the office of the Assistant Director.
- In July 2023, Ventura County Behavioral Health (VCBH) implemented a new EHR system, SmartCare by Streamline, as part of the California Mental Health Services Authority (CalMHSA) semi-statewide EHR initiative.
- VCBH has sunset the Screening, Triage, Assessment, & Referral program, the group previously responsible for completing assessments for mental health treatment services. The system has now shifted to decentralize initial services,

such as assessments. Plan members are now screened (most often by phone) and transitioned to the appropriate level of care, with assessments happening at the location where the treatment will be delivered.

- VCBH launched several significant California Advancing and Innovating Medi-Cal (CalAIM) initiatives in the last year: No Wrong Door, Documentation Redesign, Screening and Transition of Care Tools, and Payment Reform, among others. Clinical processes and service delivery continue to be impacted by these CalAIM changes. For example, payment reform has impacted the contract providers' willingness to be service providers or consider expansions due to the level of uncertainty.
- The MHP has seen a significant increase in collaborative efforts with the Managed Care Plans (MCPs):
    - Kaiser will become a Medi-Cal MCP as of January 2024. New workflows with Kaiser are currently being developed.
    - New DHCS-mandated memorandum of understanding templates are being implemented for use by MCPs and the MHP.
    - Gold Coast Health Plan will implement data exchange and sharing.
    - An increase in collaboration and care coordination efforts works to ensure that plan members do not experience the boundaries between the different systems of care.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2022-23

Recommendation 1: As the new EHR gets implemented, ensure that the data system changes will allow for accurately capturing the first offered psychiatry timeliness.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- CalMHSA created a dedicated screen in SmartCare, the new EHR system, to capture psychiatry appointment requests and scheduling. This data must be manually entered. It does not auto-populate from other screens. Recent CalAIM changes related to access allow for a psychiatry request to take place prior to the assessment, if deemed the most appropriate first appointment, or at any point during treatment, as is more common for youth plan members.
- With the workload of launching SmartCare and ensuring that the staff have general comfort with essential features and functions, operational procedures are still being updated to ensure that the screen is consistently completed. Staff will be doing more training and monitoring in early 2024.

Recommendation 2: Implement a tracking and reporting mechanism for FC HEDIS measures.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- VCBH has made progress in implementing a tracking and reporting mechanism for examining the four HEDIS measures pertaining to tracking medication monitoring within the foster care youth population served by the county-operated clinics.

- The data presented was current as of the end of FY 2022-23. With the transition to a new EHR, the MHP was continuing its work to achieve a regular reporting mechanism using the new EHR.

- This recommendation will not be carried forward as CalEQRO determined that VCBH has taken adequate steps to address this recommendation, though not yet fully implemented.

Recommendation 3: Investigate the reasons for increases in HCMs and inpatient costs and identify strategies to contain the growth.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP's subject matter experts (SMEs) in HCM-related factors from fiscal, billing, and QI have been fully deployed in the new EHR implementation and have not been able to address this recommendation. However, the MHP stated its intent to examine this issue and address it once the EHR is fully functional and the appropriate SMEs are able to devote time to this area.

Recommendation 4: Include quantifiable goals in the Quality Assurance Performance Improvement (QAPI) plan and report quantifiable progress in the annual QAPI evaluation.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP modified its goals in the FY 2023-24 QAPI plan to include more quantifiable performance indicators to the extent possible. The MHP noted that for some of the QAPI plan goals, qualitative measures were more appropriate and left to be as such.

- The MHP expects to report in more quantitative terms its QAPI evaluation of the FY 2023-24 plan.

Recommendation 5: Focus resources to develop an Operations Continuity Plan (OCP) concurrent with the implementation of the EHR to ensure services can continue in the event of a system disruption.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Ventura County Health Care Agency (HCA) has a business continuity and disaster recovery plan that is currently in development and is evolving due to VCBH's recent adoption of a new EHR. HCA also has an Incident Response plan, and the County has one as well.
- CalMHSA/SmartCare has created "downtime" forms to support staff in continuing to collect/document important client and service information in the event the EHR is not available.

- This recommendation will not be carried forward as CalEQRO determined that VCBH has taken adequate steps to address this recommendation.

Recommendation 6: Complete the 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 was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- VCBH has contracted with 1st Credentialing to support Medicare certification for its providers. The Quality Assurance (QA) team has been supporting the fiscal and billing units as well as working with 1st Credentialing to carry out the previously identified action steps by January 2024 for provider enrollment.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 70 percent of services were delivered by county-operated clinics and sites, and 30 percent were delivered by contractor-operated 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 members 24-hours, 7-days per week that is operated by the county staff; members may request services through the Access Line as well as through the following system entry points: regional outpatient clinics, specialized programs, inpatient units, EDs, primary care providers and MCPs, as well as through the MHP's outreach programs. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. From an initial contact, the MHP performs a triage to determine if the call should be routed to crisis response, the caller should be provided support and information, or be handled as a request for service (RFS). After the RFS, the MHP uses the DHCS screener to determine if the member should be assessed by VCBH or by the MCP. Following the screening, the individual is offered an assessment appointment, and after the assessment, if found to meet the medical necessity criteria, is offered appropriate service appointments.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 2,454 adults, 1,569 youth, and 44 older adults members across 10 county-operated sites and 16 contractor-operated sites. Among those served, 391

[1] CMS Data Navigator Glossary of Terms

members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

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

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

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

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

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

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

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

The MHP ensures OON access for members in the following manner:	☐ The MHP has existing contracts with OON providers ☒ Other: If applicable, the MHP has established agreement with OON providers to provide services requiring alternative access accommodations.

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- As part of its organizational restructuring, VCBH has significantly modified its access mechanism and created a new division called the Access and Outreach Division. This division is responsible for all age groups' access which is different from the previous structure where it was under the Adult Services Division.
    - Access has been decentralized whereby the initial assessment can be done at the individual clinics after screening by the Access line. The clinical line staff noted that this has facilitated better workflow and access despite the increased workload.

    - The MHP has also expanded its mobile crisis capacity to meet the new state requirements including a specialized mobile crisis team for the TAY.
- The MHP evidenced strong collaborations with multiple agencies and external partners to facilitate access. This year's EQR specifically focused on partnerships to improve crisis response, access for justice-involved youth and adults, and better coordination with MCPs, EDs, and hospitals. In each of these areas, VCBH has undertaken new initiatives in the past 12 months to improve access and to implement BHQIP and CalAIM requirements.
- The MHP has a comprehensive system for assessing and addressing cultural and demographic needs. One temporary setback has been the departure of the OHECD manager. As a result, ongoing cultural and demographic assessments were on hold at the time of this EQR pending the hiring of a new manager. VCBH reported that an active recruitment process was underway, and it hopes to fill this position in the near future.

ACCESS PERFORMANCE MEASURES

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

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

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

In CY 2022, the Statewide PR was 3.96 percent, with a statewide AACM of $7,442. The MHP PR was 4.14 percent with an AACM of $9,822. The MHP's PR was 4.5 percent higher than the statewide average while the MHP AACM was 32 percent higher than the statewide AACM.

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

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	262,795	10,872	4.14%	$106,781,444	$9,822
CY 2021	247,861	10,602	4.28%	$108,513,703	$10,235
CY 2020	228,440	10,440	4.57%	$81,454,563	$7,802

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

- The number of Medi-Cal eligibles and members served has been trending upward since CY 2020.
- Total approved claims increased more than $27 million between CY 2020 and CY 2021 and decreased more than $1.7 million in CY 2022 compared to the previous year.
- Total PR has been trending down over the past three years as Medi-Cal eligibles have increased each year since CY 2020.

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

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	26,451	251	0.95%	1.50%	1.82%
Ages 6-17	65,478	3,653	5.58%	5.01%	5.65%
Ages 18-20	15,150	686	4.53%	3.66%	3.97%
Ages 21-64	132,503	5,793	4.37%	3.73%	4.03%
Ages 65+	23,216	489	2.11%	1.64%	1.86%
Total	**262,795**	**10,872**	**4.14%**	**3.60%**	**3.96%**

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

- Overall, the PR for the MHP was higher than similar sized counties and statewide.
- Members aged 18-20, 21-64, and 65+ all had PR higher than similar sized counties and statewide.
- Members aged 6-17 had the highest PR in the MHP at 5.58 percent, which was higher than similar sized counties, but lower than statewide.
- PR was lower than similar sized counties and statewide in the 0-5 age group.

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

Threshold Language	# of Members Served	% of Members Served
Spanish	2,291	21.69%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the only threshold language, with about one-fifth of members reporting Spanish as their primary or preferred language.

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

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	83,511	2,809	3.36%	$26,500,106	$9,434
Large	2,532,274	76,457	3.02%	$535,657,742	$7,006
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This pattern holds true in the MHP.
- Compared to the similar sized counties and statewide, the MHP had the highest ACA AACM. The AACM was over $2,000 more than similar sized counties and $3,000 above statewide.

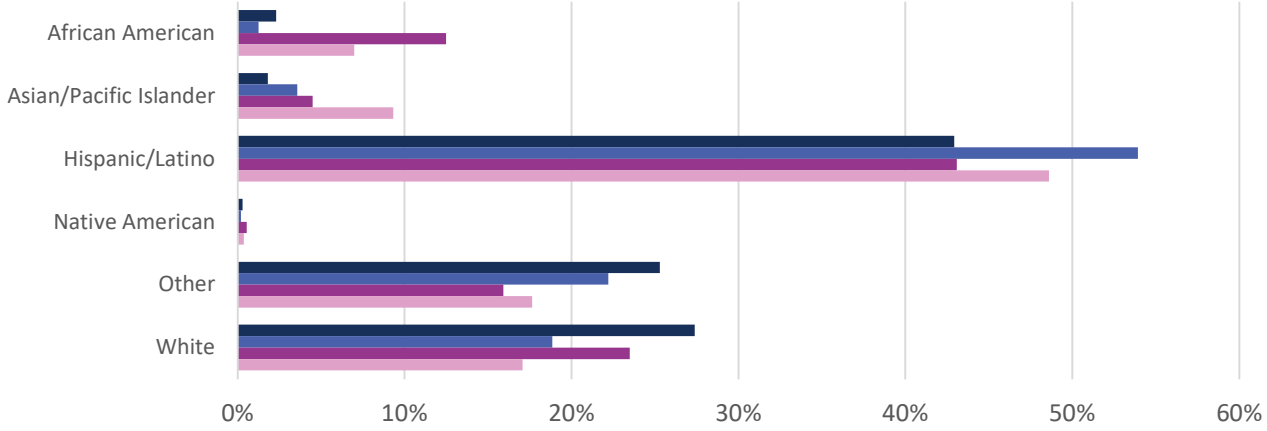
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they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

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

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	3,312	251	7.58%	7.08%
Asian/Pacific Islander	9,409	196	2.08%	1.91%
Hispanic/Latino	141,704	4,666	3.29%	3.51%
Native American	511	33	6.46%	5.94%
Other	58,335	2,749	4.71%	3.57%
White	49,527	2,977	6.01%	5.45%

- The largest group of eligibles in the MHP is Hispanic/Latino, accounting for more than half of the total eligibles, followed by Other and White.
- The Hispanic/Latino population is the largest group of eligibles and had the second lowest PR.
- The PRs for Hispanic/Latino and Native American are on par with statewide.
- African American members had the highest PR and the second to lowest number of eligibles.

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

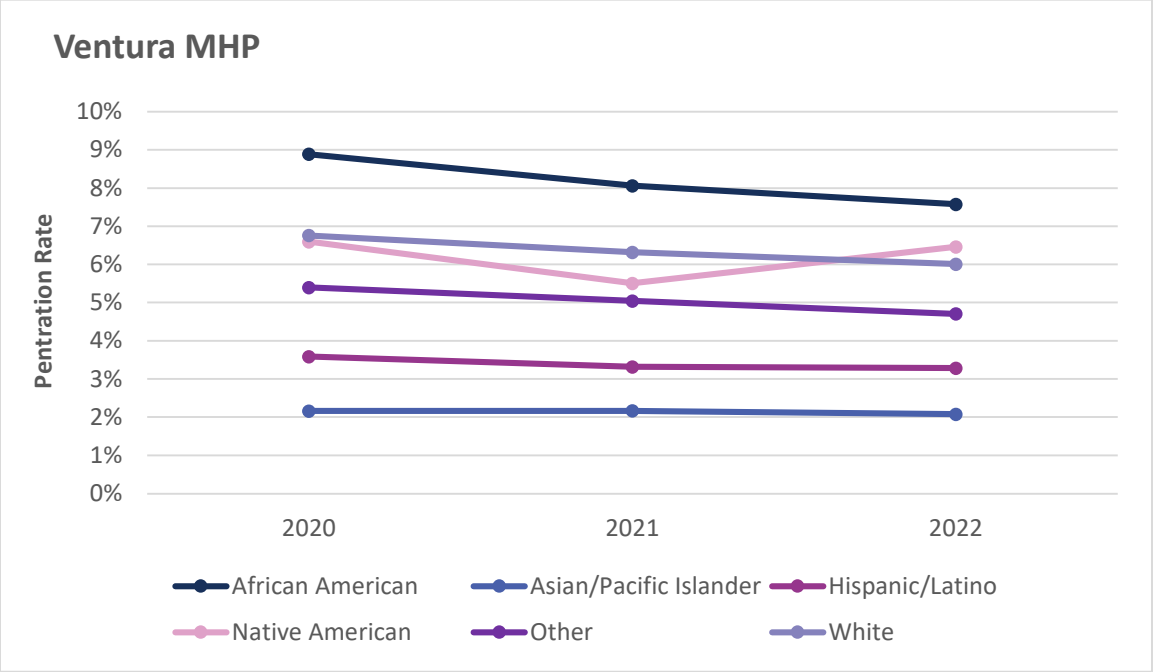


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	27%	25%	0.30%	43%	2%	2%
MHP % Eligible	19%	22%	0.19%	54%	4%	1%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- This figure shows how much the different populations are proportionally served statewide and the similarity in the MHP.
- The Other population has a higher percentage served with a lower percentage eligible in the MHP, but has a lower percentage served and a higher percentage eligible in the state.
- The White, Native American, and African American populations, all have higher percentages served than the eligibles in both the MHP and statewide.
- The Hispanic/Latino and Asian/Pacific Islander populations have a lower percentage served than eligible.

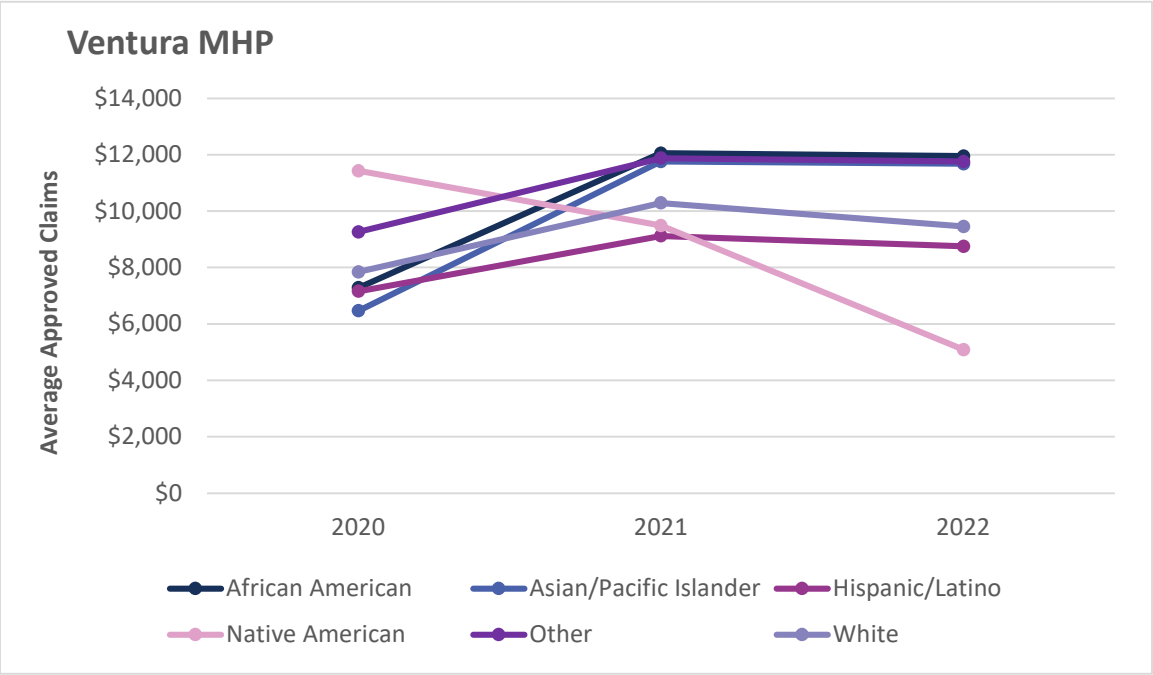
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



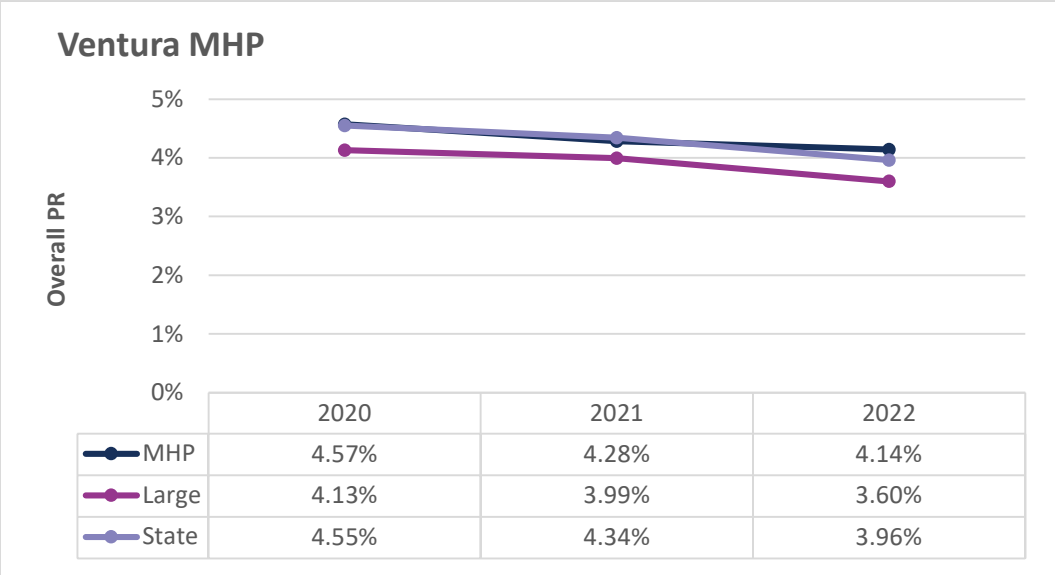
- This graph illustrates stability in PRs over the past three years across racial/ethnic groups, with the exception of Native American which declined in CY 2021 and then increased to higher than CY 2020 in CY 2022.
- African American members have consistently had the highest PRs in the MHP, whereas Asians/Pacific Islander and Hispanics/Latino groups have consistently had the lowest.

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



- AACMs for African American, Asian/Pacific Islander, and Other increased sharply between CY 2020 and CY 2021 and then stayed relatively static in CY 2022. AACMs for White and Hispanic/Latino members increased to a lesser degree for CY 2021. Native American was the only group that had a decrease in the AACM.

Figure 4: Overall PR C, 2020-22

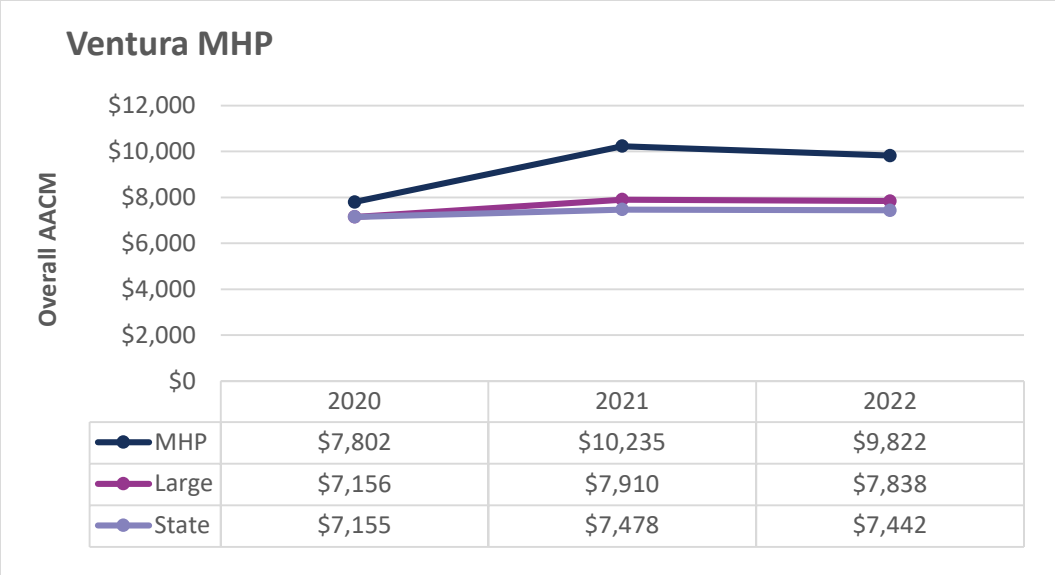


	2020	2021	2022
MHP	4.57%	4.28%	4.14%
Large	4.13%	3.99%	3.60%
State	4.55%	4.34%	3.96%

- Over the past three years PR has been trending downward in the MHP, similar sized counties, and statewide.

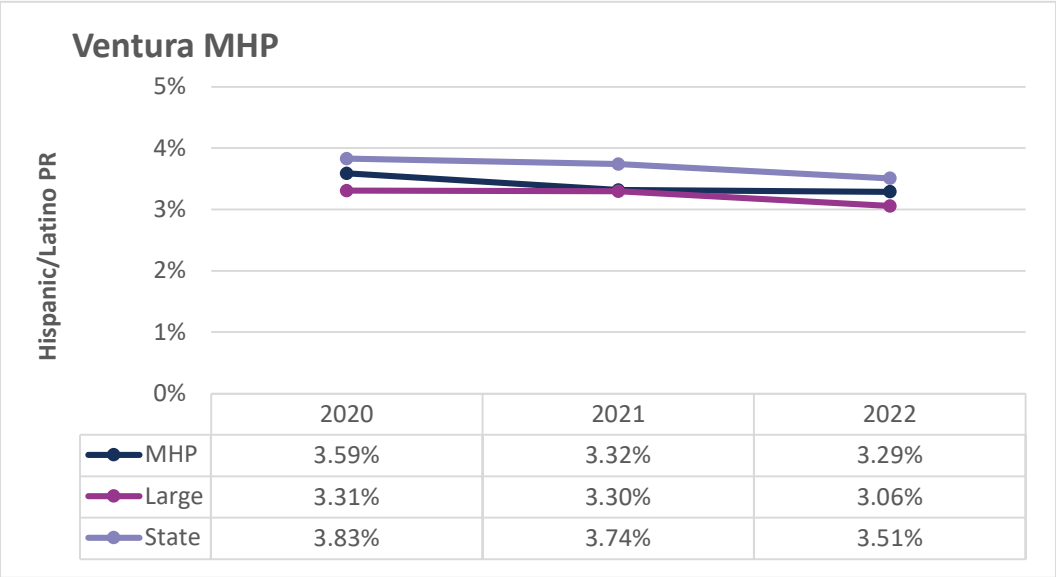
- The MHP had a slightly higher PR in CY 2020 compared to similar sized counties and statewide. Then in CY 2021, PR was closer to similar sized counties and was below statewide in CY 2021. In CY 2022, the gap in PR between the MHP and similar sized counties increased, while the MHP's PR continued to be higher than statewide.

Figure 5: Overall AACM, CY 2020-22



- AACM in the MHP increased over $2,000 from CY 2020 to CY 2021, and then leveled off in CY 2022. Similar sized counties increased just under $800, and the state increased about $300 during the same timeframe.
- AACM has been consistently higher in the MHP than similar sized counties and statewide.

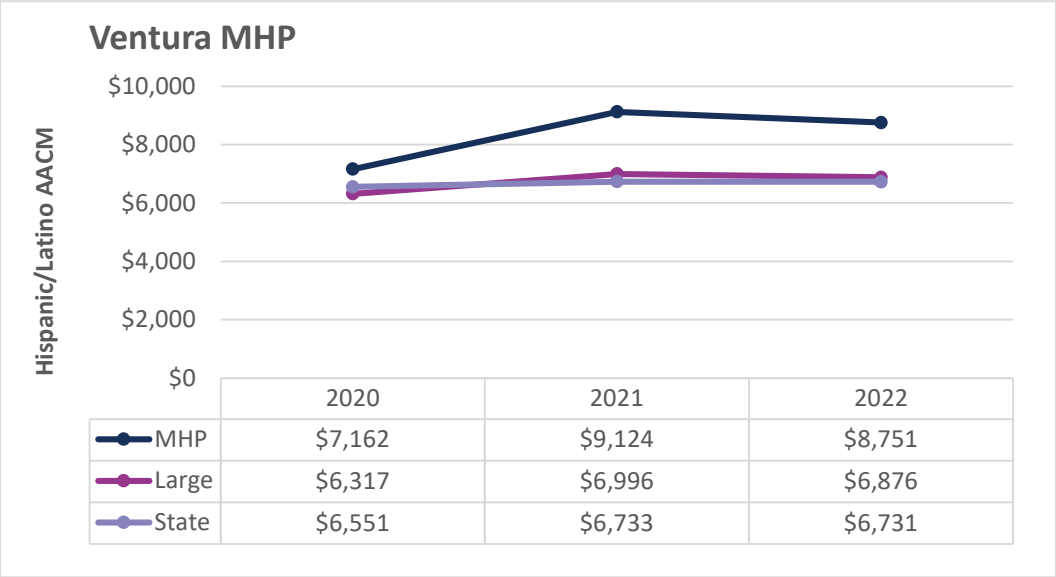
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	3.59%	3.32%	3.29%
Large	3.31%	3.30%	3.06%
State	3.83%	3.74%	3.51%

- Hispanic/Latino PR has been decreasing since CY 2020, and the MHP has consistently had higher PRs than similar sized counties and lower than statewide.

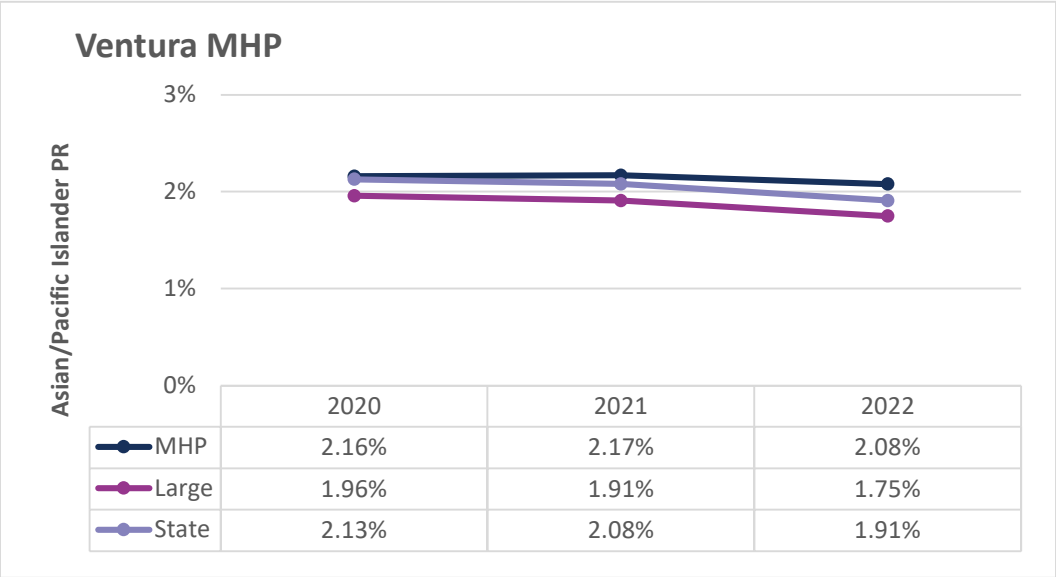
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$7,162	$9,124	$8,751
Large	$6,317	$6,996	$6,876
State	$6,551	$6,733	$6,731

- AACM for Hispanic/Latino members increased by almost $2,000 in CY 2021 and decreased by nearly $400 in CY 2022. Both similar sized counties and the statewide averages stayed mostly stable between CYs 2020 and 2022.

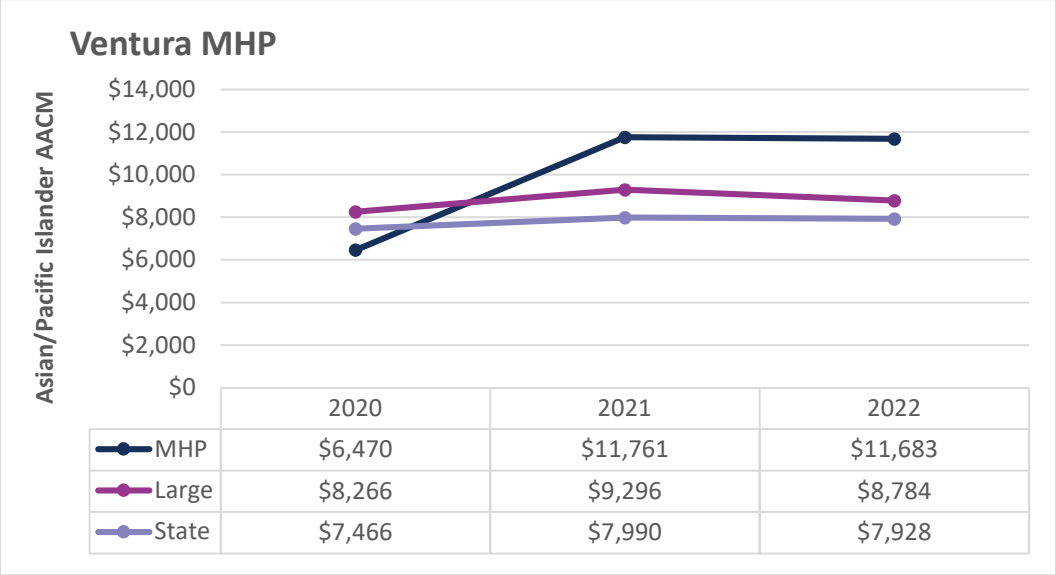
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.16%	2.17%	2.08%
Large	1.96%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- The fluctuation in PR for the Asian/Pacific Islander population was very small over the past three CYs.
- The MHP had a slightly higher penetration in all three years compared to similar sized counties and statewide.

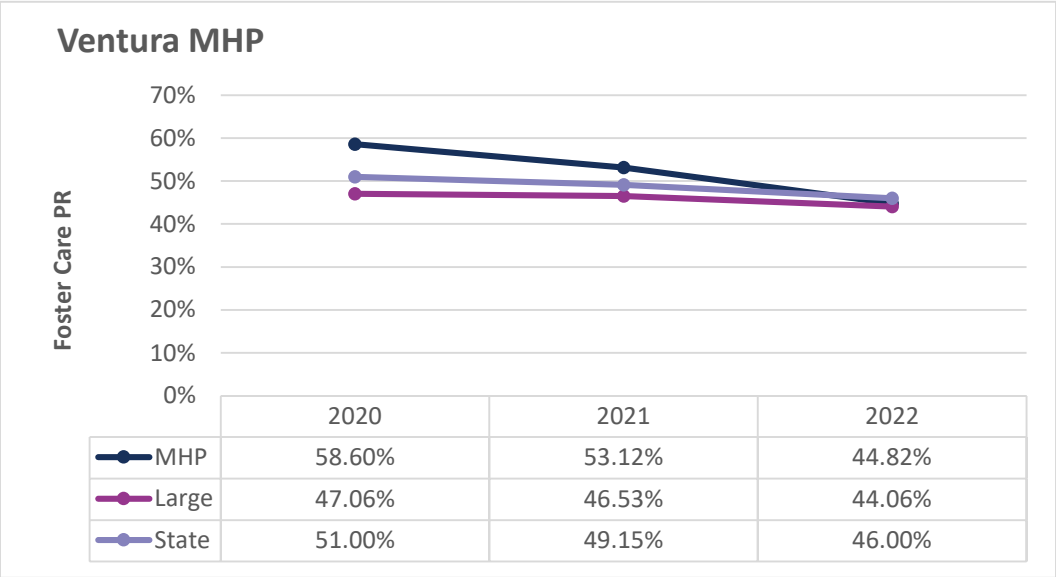
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$6,470	$11,761	$11,683
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

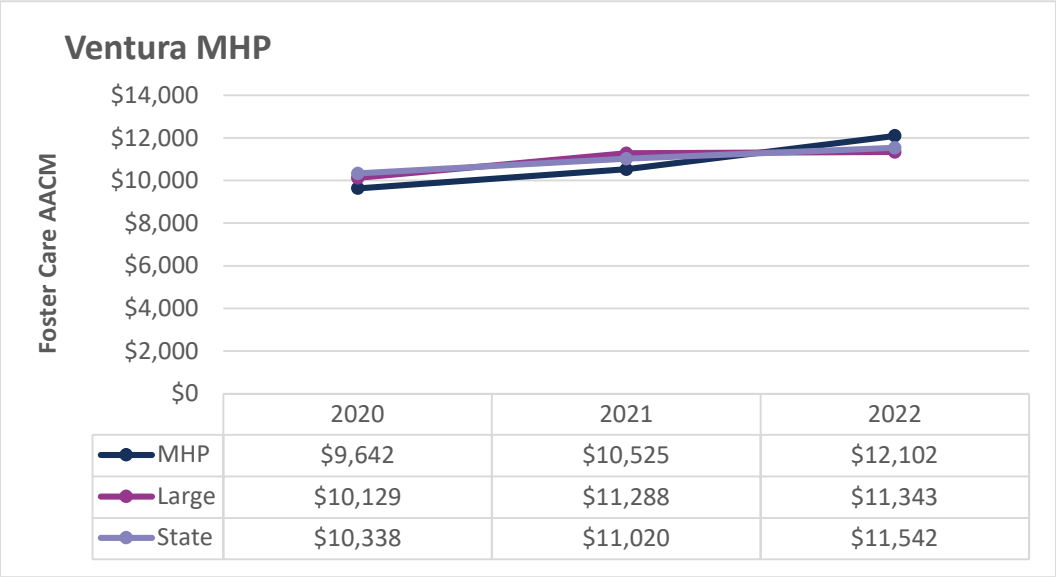
- Asian/Pacific Islander AACM was lower in the MHP in CY 2020 compared to similar sized counties and statewide but increased higher than large counties and statewide in CY 2021 and has remained higher through CY 2022.

Figure 10: Foster Care PR, CY 2020-22



- Ventura MHP's FC PR decreased by almost 14 percentage points between CYs 2020 and 2022 to become very similar to statewide and similar sized county averages.

Figure 11: Foster Care AACM, CY 2020-22



- The MHP, the similar-sized MHP average, and the statewide average, all three AACMs increased between CY 2020 and CY 2022. The MHP's AACM was slightly lower than both the large counties and the state in CY 2020 and the highest in CY 2022.

Units of Service Delivered to Adults and Foster Youth

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

Service Category	MHP N = 6,971				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	630	9.0%	10	5	10.3%	14	8
Inpatient Admin	163	2.3%	16	6	0.4%	26	10
Psychiatric Health Facility	<11	-	56	7	1.2%	16	8
Residential	102	1.5%	201	206	0.3%	114	84
Crisis Residential	248	3.6%	24	19	1.9%	23	15
Per Minute Services							
Crisis Stabilization	421	6.0%	1,346	1,200	13.4%	1,449	1,200
Crisis Intervention	772	11.1%	206	149	12.2%	236	144
Medication Support	4,733	67.9%	311	210	59.7%	298	190
Mental Health Services	4,803	68.9%	580	238	62.7%	832	329
Targeted Case Management	4,508	64.7%	376	128	36.9%	445	135

- Inpatient administrative, residential, and crisis residential were the per day services with higher utilization than statewide. The only modality with less utilization was inpatient, 1.3 percentage points less.
- The utilization rate for targeted case management (TCM) was nearly 30 percentage points higher than statewide.
- Medication support and mental health services were utilized more in the MHP than statewide, while crisis stabilization and crisis intervention utilization rates were lower. Mental health services showed comparatively fewer units of service on average.

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

Service Category	MHP N = 467				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	24	5.1%	9	6	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	12	2.6%	1,290	1,110	3.1%	1,166	1,095
Crisis Intervention	27	5.8%	282	205	8.5%	371	182
Medication Support	166	35.5%	290	233	27.6%	364	257
TBS	17	3.6%	2,300	2,137	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	261	55.9%	727	238	40.8%	1,458	441
Intensive Home-Based Services	42	9.0%	2,738	2,289	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	451	96.6%	1,974	1,211	95.4%	1,846	1,053
Targeted Case Management	263	56.3%	312	85	35.8%	307	118

- The only per day service with FC utilization was inpatient, which was utilized at a comparable rate to statewide. Average billed days and median billed days were lower in the MHP than statewide.
- Like statewide, the most-used service for FC youth was mental health services. The MHP's utilization rate was slightly higher than statewide but with fewer units of service on average.
- The second most-used service in the MHP was TCM, which had a much higher utilization rate than seen statewide and comparable units of service. Just behind

TCM was intensive care coordination (ICC) which had lower average and median units. ICC utilization was higher than statewide but intensive home-based services (IHBS) was less than half of the statewide rate.

- Utilization of medication support was almost 8 percentage points higher than statewide but with fewer units of service delivered on average.

IMPACT OF ACCESS FINDINGS

- The MHP provides more members with services at the lower levels of care including mental health services, TCM, and medication support than the corresponding statewide averages. Although this has not translated to lower percentages of inpatient or residential treatment, greater utilization of lower levels of care has the potential to reduce episodes of higher acuity care.
- The MHP has focused on improving access for children and youth to needed mental health services through its access system reorganization and creating a specialized mobile response team for the youth.
- The MHP's efforts at improving access for justice-involved youth has provided onsite psychiatry services in the juvenile justice facility.
- The MHP provides ICC and TCM to more of the FC youth than the statewide averages.
- The MHP has fully implemented the new statewide screening and transition tools as part of the CalAIM requirements. This has the potential for quicker and more appropriate level of care decision making both within the MHP and between the MHP and the MCPs.
- The MHP needs to update its CCP to reflect the most current cultural and demographic needs and strategies to address them.

TIMELINESS OF CARE

The amount of time it takes for members to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful 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 members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	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 reported a median of only one day for offered appointment for the first non-urgent service request as well as for the first delivered service. The MHP attributes its quick initial access to the care coordination efforts and having a specialized access team for members.

- The MHP is unable to report on the overall first offered psychiatry appointment timeliness metric, but reports separately for adults, children, and FC members. The mechanism for tracking the first request for psychiatry is different for adults and children, as most adults receive a psychiatry appointment shortly after their assessment and enrollment in outpatient services. The tracking mechanism depends in part on manual tracking and the MHP will rely on data entry into a psychiatry appointment screen on its new EHR for more consistent tracking.
- The MHP reported a very low number of urgent appointment requests. It stated that a specialized group of clinicians within the Access and Outreach Division are trained to provide an initial assessment of the caller's condition and determine the urgency of follow-up needed. The designation of "urgent" is used for requests where individuals need timelier follow-up but are not in an immediate crisis (e.g., danger to self or others, acute psychosis). If determined to be more of a crisis situation, timeliness would not be tracked as an RFS; immediate action by the crisis team would occur and be documented. Given this design, it is likely that a significant number of urgent request calls are treated as crisis for risk mitigation, reducing the number of calls listed as urgent.
- The MHP is also only able to calculate urgent appointments in days and converting it to hours. This leads to longer reported timeliness than the actual timeliness.
- The MHP includes linkage and brokerage as an inpatient follow-up service in its calculations. This particular procedure code is not included in the HEDIS definition of inpatient follow-up services. The MHP stated that it has included this procedure code to capture the breadth of inpatient follow-up services and that it is not currently required by DHCS to strictly adhere to the HEDIS definitions.
- For the first offered non-urgent services, the MHP chooses between the first offered and first delivered based on the billed service if the latter has a date stamp sooner than the first offered service. Since the first screening based on the DHCS screening tool is now reimbursable regardless of a caller meeting the medical necessity criteria, the actual first billed service time is less than a day if that caller ultimately gets included in the dataset following a positive screen and meeting the medical necessity criteria later. While the screening may be considered a billed service, this is not necessarily a SMHS as the metric is intended to measure.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care except for non-urgent psychiatry and urgent services which are based only on appointments offered or services provided by county-operated programs and exclude any contract provider services.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.64 Business Days	10 Business Days*	84%
First Non-Urgent Service Rendered	6.06 Business Days	10 Business Days**	82%
First Non-Urgent Psychiatry Appointment Offered	6.73 Business Days (Adults) 20.73 Business Days (Youth) 12.22 Business Days (FC)	15 Business Days*	87% (Adults) 49% (Youth) 77% (FC)
First Non-Urgent Psychiatry Service Rendered	6.89 Business Days (Adults) 25.13 Business Days (Youth) 16.14 Business Days (FC)	15 Business Days**	86% (Adults) 40% (Youth) 64% (FC)
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	52.44 Hours	48 Hours*	67%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	11.83 Calendar Days	7 Calendar Days	68%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	11.83 Calendar Days	30 Calendar Days	90%
No-Show Rate – Psychiatry	16%	10%**	n/a
No-Show Rate – Clinicians	12%	5%**	n/a

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

** MHP-defined timeliness standards

*** The MHP does not offer urgent services requiring prior authorization

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

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

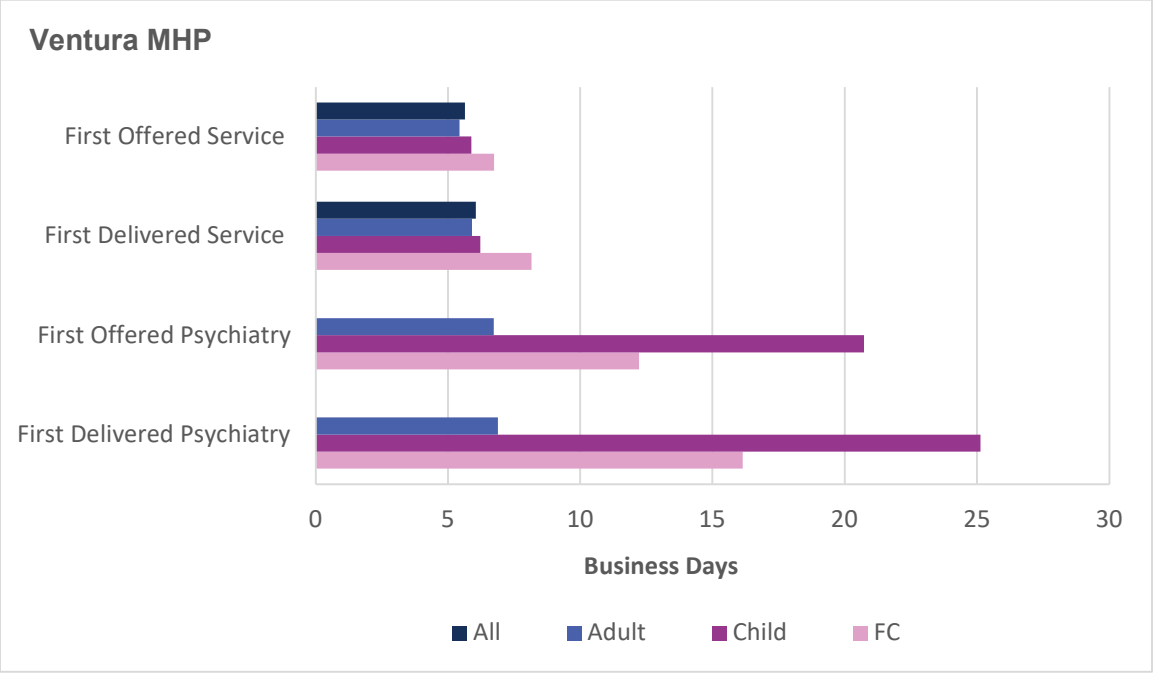


Figure 13: Wait Times for Urgent Services

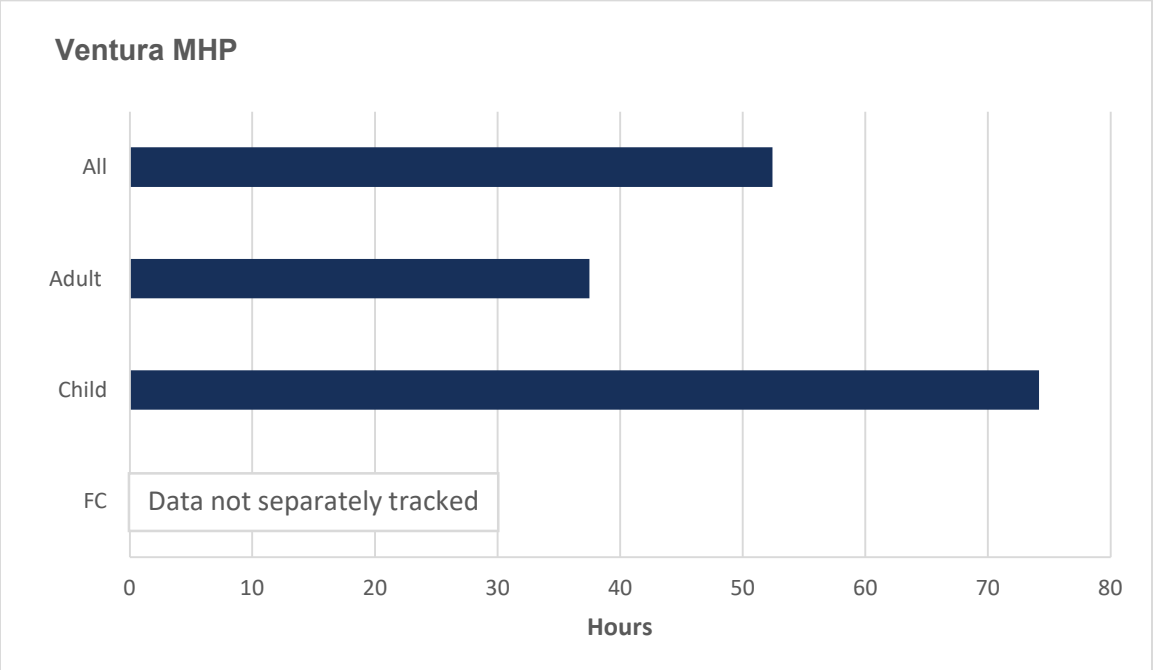
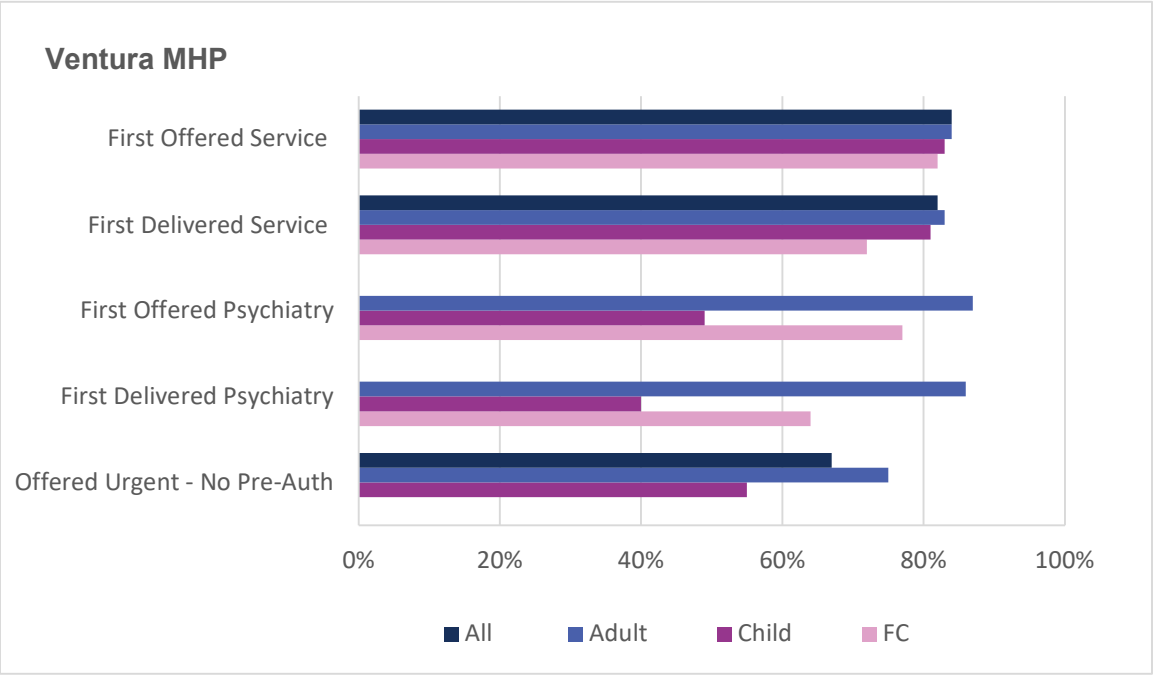


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments, unscheduled assessments, and scheduled mental health services such as psychiatry appointments, if needed, prior to assessment.
- The MHP defined “urgent services” for purposes of the ATA as requests where individuals are in need of timelier follow-up but are not in an immediate crisis (e.g., danger to self or others, acute psychosis). There were reportedly 27 urgent service requests with a reported actual wait time to services for the overall population of 52.44 hours. The MHP does not offer urgent services that require pre-authorization.
- The MHP defines timeliness to first delivered/rendered psychiatry services as first appointment for adults when requested, typically after the first appointment, and for children, from the time of clinical determination need. In other words, more adults receive a psychiatrist service in the beginning while most children and youth receive the first one at any time when needed for the first time.
- No-shows are tracked for the entire system using a no-show code. The MHP reports a no-show rate of 16 percent for psychiatry and 12 percent for other non-psychiatry appointments.

IMPACT OF TIMELINESS FINDINGS

- The MHP provides timely services for initial access, urgent conditions, and psychiatry appointments. At the same time, the data tracking for each of these metrics remains a work in progress. The change in EHR and some CalAIM-related changes have contributed to some of the current situations as follows:
    - The MHP noted that the timeliness data for FY 2022-23 may not be as complete after the switch over to the new EHR on July 1, 2023, because it limited its ability to fully tabulate the data for the last month of the reporting period.
    - Using the first billed service as a proxy for the first offered, non-urgent appointment, coupled with the initial screening being a billed service, skews the actual timeliness data positively without any real improvement in timely access to the first clinical service. While the screening is billable, it is not necessarily a specialty mental health service. The MHP should track the first service after the screening.
    - Urgent appointment counts are low for a large county, pointing to issues either in operational processes or accurate recording.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is embedded in the newly formed QCD. QCD is responsible for the following functions: QI, QA, Utilization Review, Training, and Pharmacy. QI team manages the QAPI, tracking of the QAPI indicators, annual evaluation of the QAPI, data analytics to facilitate data-driven decision making at the agency level and for other divisions, and the PIPs.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the leadership of the MHP, is scheduled to meet bi-monthly or six times a year. Since the previous EQR, the MHP QIC met four times as the new structure was put in place in 2023. In addition, VCBH has QIC sub-committees that address specific areas and meet at different times. These sub-committees report to the QIC and have a more diverse membership including the plan members, the community, and other stakeholders. Of the 15 identified FY 2022-23 QAPI workplan goals, the MHP provided status updates with barriers and future steps for all the indicators. Starting FY 2023-24, the MHP has converted a number of the QAPI indicators to more quantitative ones with measurable goals.

The MHP utilizes the following level of care (LOC) tools: DHCS MH Screening Tool, DHCS MH Transition of Care Tool, Child and Adolescent Needs and Strengths, and Milestones of Recovery.

The MHP does not have any systemwide outcomes tools but tracks outcomes for members served by the full-service partnership (FSP) programs.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- Since the FY 2022-23 EQR, the MHP has further implemented steps identified in its five-year strategic plan. A major change has been in the QI structure both organizationally as well as in the QIC. Alongside the creation of the QCD, the QIC now has seven sub-committees that are closely aligned with the goals identified in the strategic plan. While the QIC meets bi-monthly, the frequency of meetings varies among the subcommittees, depending on a subcommittee's particular mandate and tasks.
- The MHP noted that the recruitment and engagement of plan members in the QIC structure is a work in progress at this time; however, one of the sub-committees, Community Experience, has some plan members on its roster.
- The QI team continues to have excellent data analytical capabilities and produces a number of internal and external reports on performance, quality, and outcomes. At the time of this EQR, the MHP noted being close to opening up the public facing data dashboard on its website that will add to its external reporting capabilities and greater access to these reports by the community members and other stakeholders.
- The MHP has made progress in tracking the FC HEDIS measures. It has been able to produce reports from the previous EHR until June 2023. At the time of

this EQR, the MHP was in the process of extracting data from the new EHR for regular tracking and reporting purposes.

- The MHP provided multiple reports on outcomes, LOC tools, and CPS. While the outcomes are primarily limited to those served in the FSP programs, the LOC and CPS findings were systemwide. The MHP presented reports on both adult FSP and youth FSP outcomes.
- Since the previous EQR, the MHP has hired peer employees with lived experience. The peer employees reported being included in committees and supported by their supervisors. They expressed a desire for better role clarity and future opportunities for advancement in their career.
- There remains room for improvement in the MHP's communication with the internal stakeholders including the line staff and the contract providers. These stakeholders reported a lack of awareness of the committee structures and other avenues for communications with the administration.
- The MHP tracks but does not trend the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): 16 percent (January – June 2023)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): 0.002 percent (January – June 2023)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): 0.001 percent (January – June 2023)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): 31 percent (January – June 2023)

QUALITY PERFORMANCE MEASURES

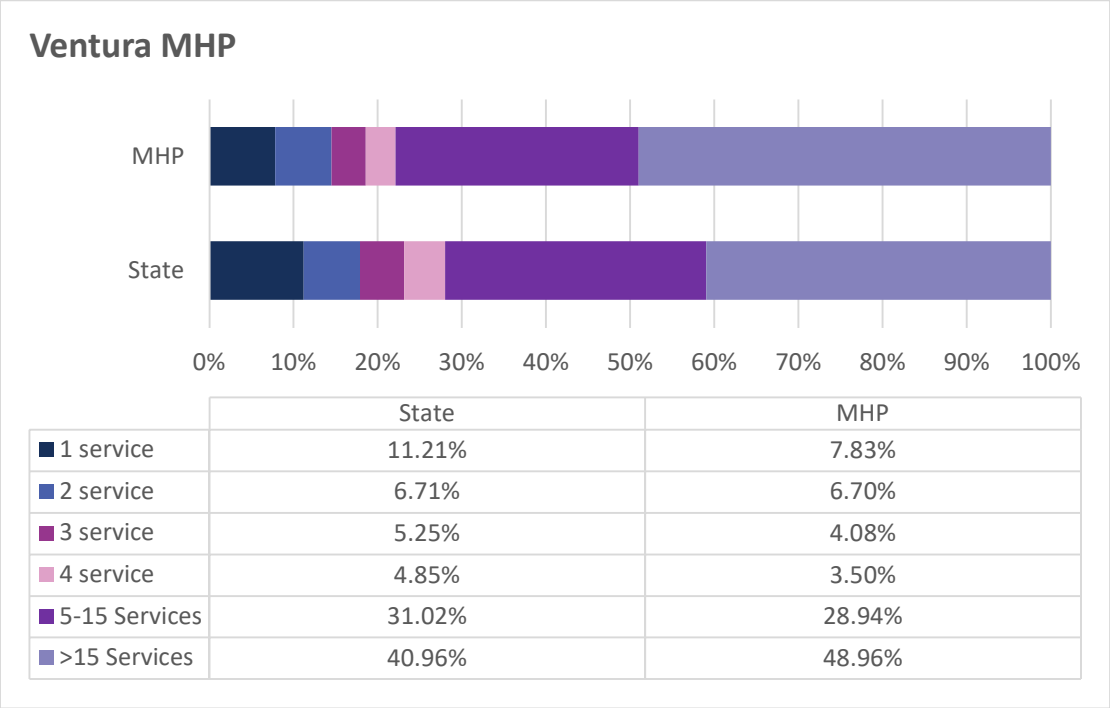
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served, CY 2022



	State	MHP
1 service	11.21%	7.83%
2 service	6.71%	6.70%
3 service	5.25%	4.08%
4 service	4.85%	3.50%
5-15 Services	31.02%	28.94%
>15 Services	40.96%	48.96%

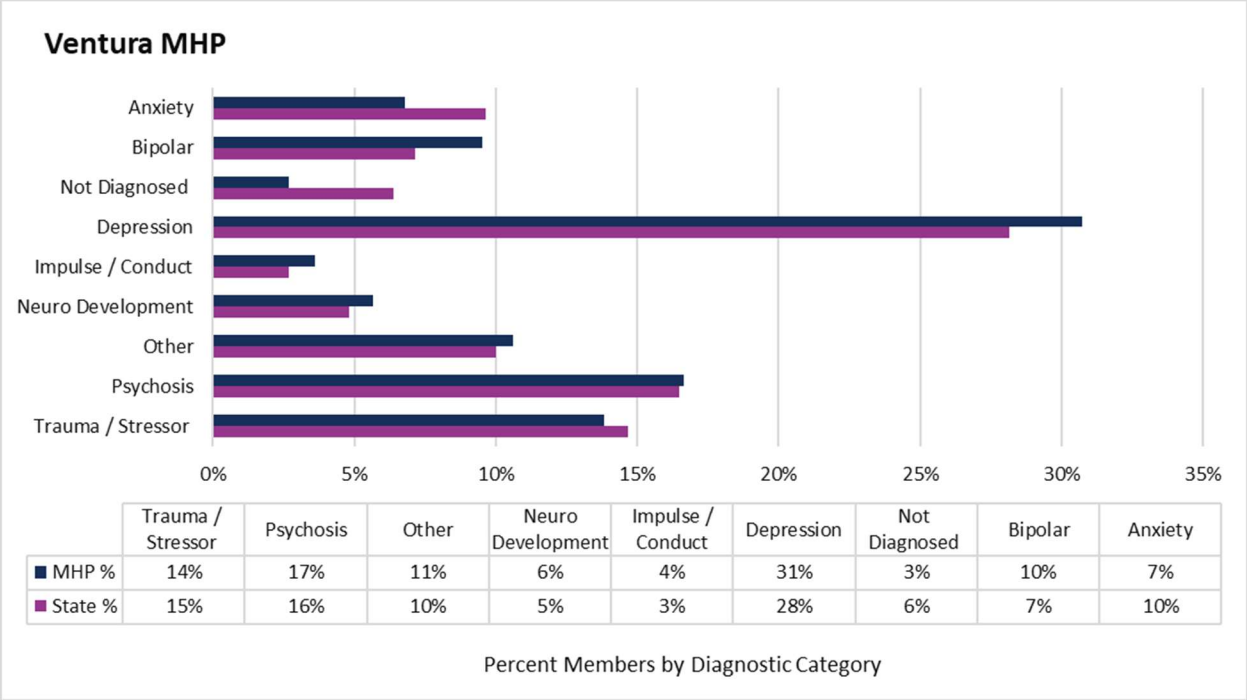
- Ventura MHP's retention rate exceeds the statewide retention for five or more services, with 78 percent of Ventura County members received five or more services compared to 72 percent statewide. Conversely, the MHP had a lower percentage of members receiving one service only.
- More members receive greater than 15 services compared to statewide.

Diagnosis of Members Served

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

Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

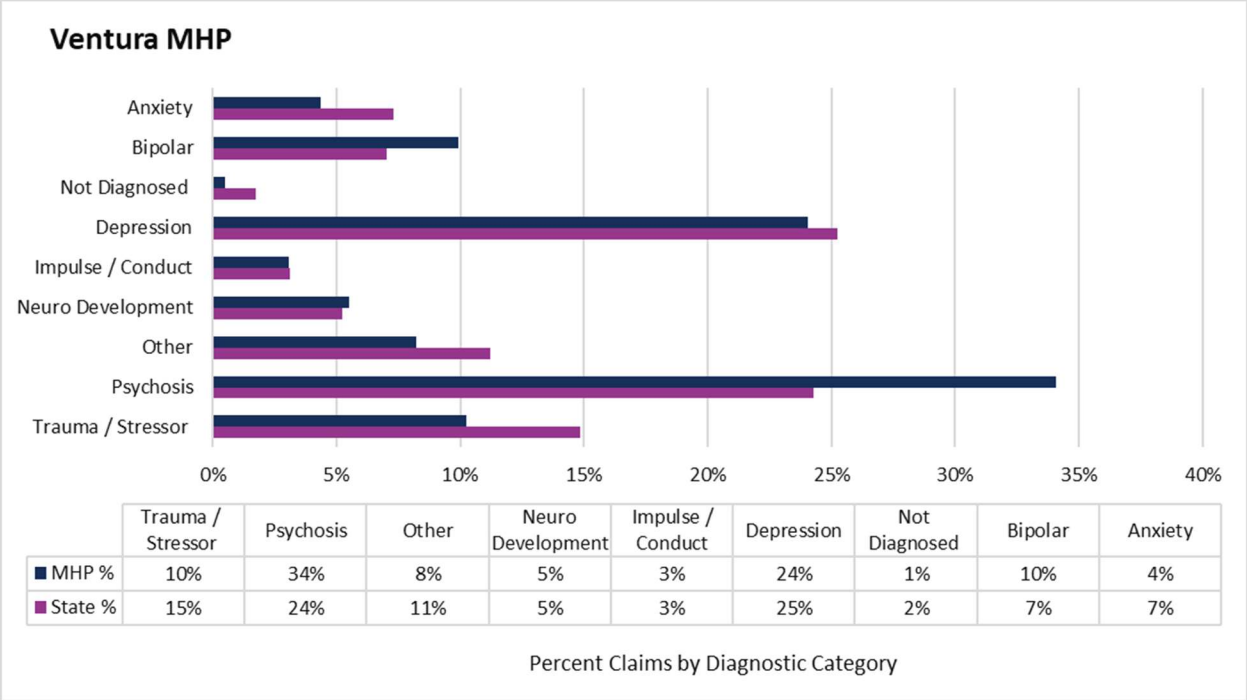
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	17%	11%	6%	4%	31%	3%	10%	7%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Following statewide trends, depression is the leading diagnosis for the MHP. Psychosis is the second most common diagnosis both in the MHP and statewide.
- Trauma/stressor is the third most common diagnosis in the MHP.
- The MHP had half the percentage statewide of members who were not diagnosed.

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



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	10%	34%	8%	5%	3%	24%	1%	10%	4%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The proportion of approved claims attributed to psychosis is substantially higher than statewide, despite having similar proportions of members with that diagnosis.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS. CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

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

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	953	1,484	1.56	7.89	8.45	$26,184	$12,763	$24,953,044
CY 2021	989	1,512	1.53	7.98	8.86	$24,574	$12,696	$24,303,830
CY 2020	808	1,141	1.41	7.61	8.68	$15,442	$11,814	$12,476,952

- Average LOS is slightly lower in the MHP as compared to the statewide LOS.

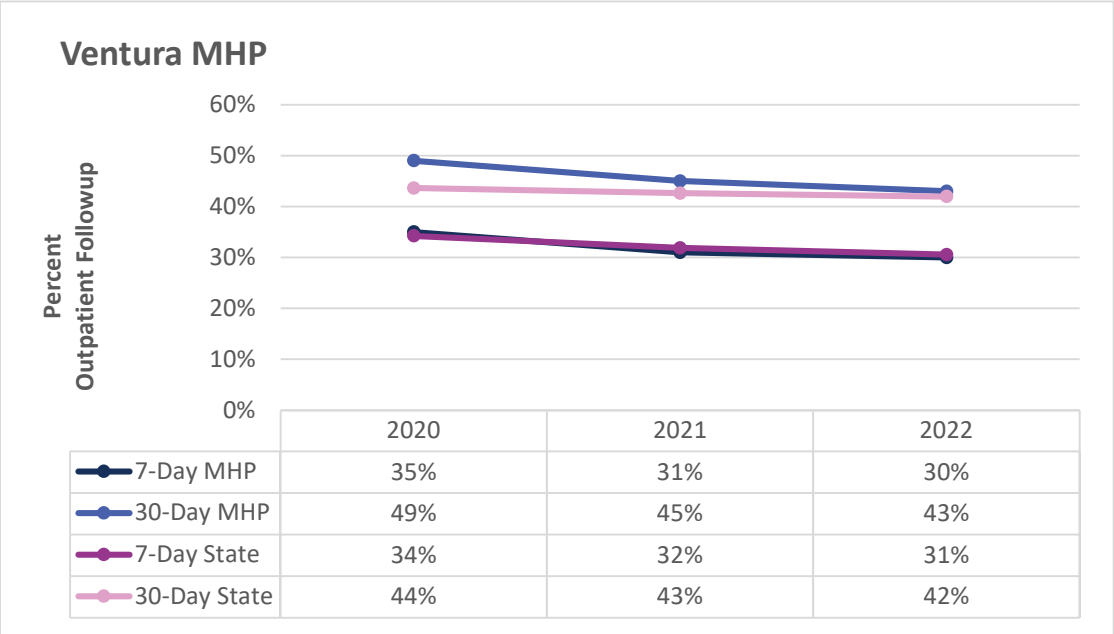
- AACMs in the MHP for CYs 2021 and 2022 are both roughly twice as high as statewide after the MHP AACM increased substantially between CYs 2020 and 2021.

Follow-Up Post Hospital Discharge and Readmission Rates

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

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and 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. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

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

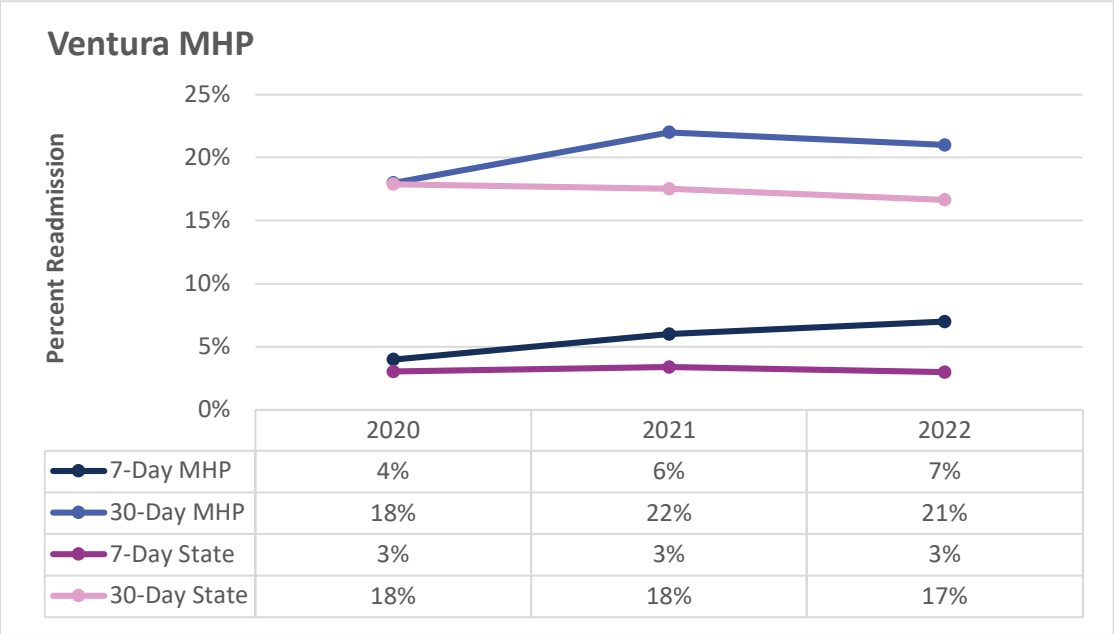


	2020	2021	2022
7-Day MHP	35%	31%	30%
30-Day MHP	49%	45%	43%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- Both the 7-day and 30-day inpatient follow-up rates are comparable between the MHP and statewide. 7-day rate was more consistently similar to statewide between CY 2020-22.
- Both follow-up rates have declined in the MHP and statewide over the past three years.

- The MHP's own calculation of the same metric showed consistently higher inpatient follow-up rates which appears to be primarily due to the MHP counting linkage case management as a follow-up service. That is not an included follow-up service in the HEDIS specification.

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



	2020	2021	2022
7-Day MHP	4%	6%	7%
30-Day MHP	18%	22%	21%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP had higher 7- and 30-day readmission rates than the corresponding statewide figures in CY 2022.
- The 7-day readmission rate statewide was consistent for the past three years, but the MHP had an upward trend.

High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with

approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are “low-cost” (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

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

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	655	6.02%	44.14%	$47,130,068	$71,954	$48,998
	CY 2021	671	6.33%	42.45%	$46,069,118	$68,657	$50,076
	CY 2020	441	4.22%	32.96%	$26,850,466	$60,885	$47,205

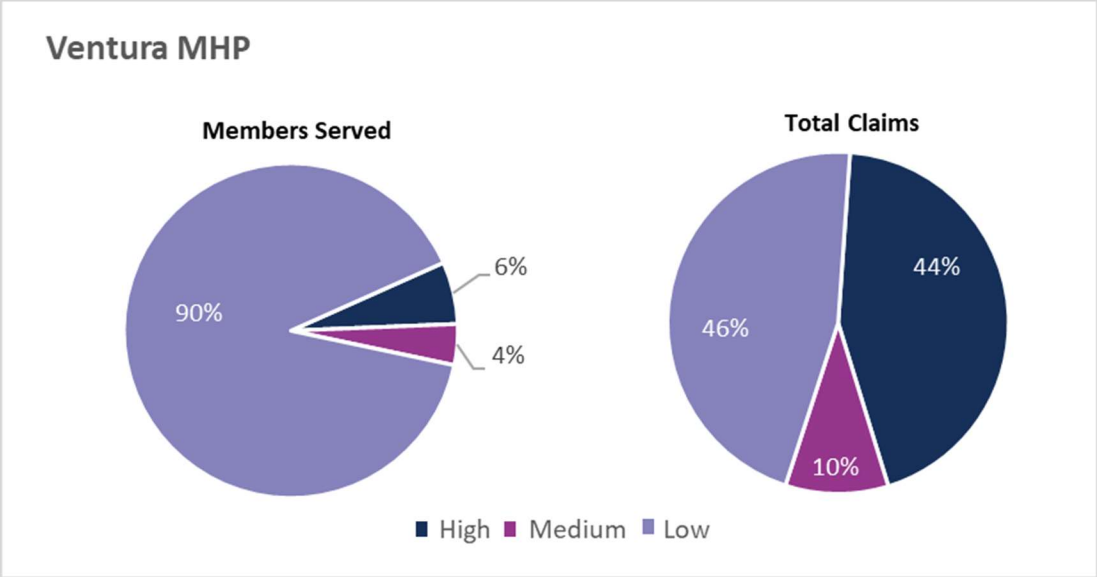
- 6.02 percent of members served accounted for 44.14 percent of the total claims in CY 2022
- The HCM percentage and AACM per HCM for the MHP continued to significantly exceed the statewide figure.

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

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	430	3.96%	9.76%	$10,421,699	$24,237	$23,748
Low-Cost (Less than $20K)	9,787	90.02%	46.10%	$49,229,677	$5,030	$3,554

- Medium-cost - 3.96 percent of members served accounted for 9.76 percent of the total claims.
- Low-cost - 90.02 percent of members served accounted for 46.1 percent of the total claims.

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



- 90 percent of the members served were low-cost. The medium-cost members and HCMs together only comprised 10 percent of the members served.
- For the total claims, the claims attributed to low-cost members represented 46 percent of all claims, and the claims attributed to HCMs represented 44 percent of the total claims.

IMPACT OF QUALITY FINDINGS

- Since the previous EQR, the MHP has demonstrated improvements in multiple QI-related activities that were in planning or implementation stages. These include QIC and Quality structure redesign in accordance with the five-year strategic plan, tracking of FC HEDIS measures, and the development of a public facing data dashboard.
- With the QIC restructuring and creation of multiple subcommittees, the MHP has created opportunities for improved communications with and receiving input from the stakeholders. This remains a work in progress as some of these intended stakeholders expressed a lack of awareness of some of these changes and how these will facilitate better communication.
- Like other MHPs, VCBH is undergoing rapid changes on multiple fronts related to BHQIP, CalAIM, staff vacancies since the aftermath of COVID-19, and implementation of a new EHR. In addition, VCBH has also undertaken major organizational restructuring. This will require formulating change management strategies with stakeholder communication as an important aspect.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Screening and Identification of Psychosis Symptoms in TAY

Date Started: 08/2022

Date Completed: N/A

Aim Statement: Will the implementation of a psychosis screening checklist at the point of referral increase the accurate identification and placement of plan members into Ventura County's Power Over Prodromal Psychosis (VCPOP) program by 10 percent over a 6-month period in 2024?

Target Population: Predominantly 16 to 25-year-old TAY who have developed or are at risk for developing psychosis symptoms or are identified as experiencing symptoms of psychosis. The MHP is also including the 12 to 16-year-old adolescent group in its

[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

target population if they are identified with similar issues or at-risk of developing psychosis.

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

Summary

Through its clinical PIP, the MHP is trying to improve the identification and treatment of adolescent and TAY members with known risk factors and displaying prodromal symptoms and early onset of psychosis. In the first phase of the PIP, the MHP is in the process of instituting a referral checklist for use by the access and intake staff that will help in identifying those at risk or showing symptoms of early psychosis. Once this is fully implemented, those identified will be referred to the MHP's specialized team for earlier and more appropriate treatment.

The MHP had expected to begin implementation of the checklist earlier; however, multiple factors have delayed the implementation of this PIP since the MHP started its planning process a year ago. Refer to Significant Changes earlier in this report for discussion of competing factors for staff resources.

The QI and VCPOP staff have worked closely with the other divisions to devise new workflows that will incorporate all these changes. The MHP now expects to implement the referral screening tool by Spring 2024.

TA and Recommendations

As submitted, this clinical PIP was found to have no confidence because at the time of the EQR, the MHP was still in the process of finalizing its implementation strategies and no evidence of potential success was available.

CalEQRO considers this project a valuable tool to improve services for a particularly vulnerable potentially high-cost population. However, multiple circumstances need to be navigated and barriers resolved before that can become a reality.

CalEQRO recommendations for improvement of this clinical PIP:

- Under the circumstances, the MHP needs to evaluate if this can become a fully implemented PIP over the next 12 months, with all relevant data and information available for the validation of this PIP. Barring that, the MHP may consider continuing this as a QI project, but not a formal PIP submission for EQR purposes.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After ED Visit for Mental Illness

Date Started: 09/2022

Date Completed: N/A

Aim Statement: In the six months following the intervention, the aim is to increase referrals from hospital staff/navigators for individuals with an ED visit for mental illness-related issues or self-referrals by 5 percent.

Target Population: Individuals presenting at the EDs with a mental illness diagnosis.

Status of PIP: The MHP's non-clinical PIP is in the baseline year.

Summary

In this non-clinical PIP, the MHP is attempting to improve the follow-up appointment rates after an ED visit by a plan member with a primary diagnosis of mental illness (HEDIS measure FUM) as part of the DHCS Behavioral Health QI Plan. In its updated submission of the project plan and findings for FY 2023-24, the MHP has changed its approach to the implementation of the PIP by shifting its improvement strategy. Previously, the MHP focused on creating a data tracking system.

This year, the focus has been on creating better connections with hospital staff who provide direct member care. Consequently, the MHP has started providing trainings to improve awareness and knowledge of available mental health services and how to access them to the navigators and the hospital staff who treat members at the ED. The MHP has partially completed the training for the ED staff. The attendance has so far been lower than expected, but those who attended reported improvements in their knowledge and inclination to use that knowledge. The MHP reported the baseline data for 7- and 30-day follow-up rates but no remeasurements were completed at the time of this EQR. The MHP is continuing to track the 7- and 30-day FUM measures as was originally planned.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence because the actual implementation of improving the connections with the ED staff remained incomplete with less than expected attendance at the initial trainings with the navigators, and there was no remeasurement data available to evaluate impact.

The MHP's baseline data indicated an already high 30-day follow-up rate, in the top quartile in the state. Therefore, meeting the improvement goals for that measure may be difficult to achieve. However, the 7-day follow-up rate may be improved once the training series is completed.

CalEQRO recommendations for improvement of this non-clinical PIP:

- The MHP needs to work closely with its ED and navigation partners to improve attendance at the trainings.
- The MHP needs to continually monitor any additional barriers to implementation strategies and improvements in the FUM measures. This may include monitoring the referral call volume and appropriateness as performance indicators as already identified by the MHP.
- As the MHP noted, it needs to work with its Access and follow-up system for more streamlined and timely access after ED visits and inpatient discharges.

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 SmartCare by Streamline which has been in use for six months. Currently, the MHP is actively implementing SmartCare which requires heavy staff involvement.

Approximately 6.6 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department.

The MHP has 1,012 named users with log-on authority to the EHR, including approximately 760 county staff and 252 contractor staff. Support for the users is provided by 14 full-time equivalent (FTE) IS technology positions. Currently there is one vacant position, whereas last year there were 2.7 positions vacant.

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

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

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

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	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	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not have PHR capability as of today. The estimated time to bring it online is within two years.

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 hospitals**.** VCBH and Gold Coast Health Plan (Ventura's MCP) have been working to create the infrastructure through its policies and procedures to exchange data.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The percentage of the total annual MHP and DMC-ODS budget was 6.6 percent. The number of currently budgeted IS FTEs for MHP and DMC-ODS is 14 with 1 vacancy. The Avatar/SmartCare EHR team has ten and the IT team has four positions.
- The MHP uses telehealth services for: medication support, crisis services, group therapy, individual therapy, case management, and new client intake and assessment. Telehealth usage is down from last year when COVID-19 played a role in the utilization.
- The MHP IT, for both county and contracted clinics and programs, manages initial network logon training. For the EHR, the IT staff are responsible for setting up user profile and access, screen navigation, reports, dashboard, and alerts. MHP QI provides trainings on EHR reports, dashboard, and alerts to both county and contract provider personnel.
- The overall claims denial rate for the MHP in CY 2022 was 8.36 percent and the statewide denial rate was 5.92 percent. The three highest denial reasons were not eligible or non-covered charges, Medicare Part B must be billed first, and other coverage must be billed first. In total, those three denial reasons made up over 81 percent of the denials. Eligibility and type of charges along with other entities needing to be billed first needs to be incorporated into the claims process to reduce the denial rate.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	25,581	$8,495,858	$901,675	10.61%	$7,594,183
Feb	25,773	$8,476,664	$497,238	5.87%	$7,979,426
Mar	31,302	$10,775,250	$696,454	6.46%	$10,078,796
April	26,895	$9,700,036	$713,655	7.36%	$8,986,381
May	28,025	$9,792,498	$464,768	4.75%	$9,327,730
June	26,326	$9,942,261	$803,906	8.09%	$9,138,355
July	23,978	$9,647,486	$936,085	9.70%	$8,711,401
Aug	27,658	$10,426,740	$995,293	9.55%	$9,431,447
Sept	25,464	$10,039,835	$1,088,281	10.84%	$8,951,554
Oct	23,461	$7,295,859	$721,667	9.89%	$6,574,192
Nov	21,792	$5,180,472	$457,930	8.84%	$4,722,542
Dec	21,170	$4,278,891	$418,859	9.79%	$3,860,032
Total	**307,425**	**$104,051,850**	**$8,695,811**	**8.36%**	**$95,356,039**

- The MHP's denied claims rates varied significantly from month to month during CY 2022.
- Overall, the claim volume was consistent from month to month across CY 2022.

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Plan member is not eligible or non-covered charges	1,704	$3,060,189	35.19%
Medicare Part B must be billed before submission of claim	5,974	$2,278,498	26.20%
Other healthcare coverage must be billed first	3,439	$1,738,474	19.99%
Other	249	$632,444	7.27%
Deactivated NPI	3,267	$511,322	5.88%
Service line is a duplicate and repeat service modifier is not present	1,992	$432,554	4.97%
Service location NPI issue	85	$40,617	0.47%
Late claim submission	7	$1,714	0.02%
Total Denied Claims	**16,717**	**$8,695,812**	**100.00%**
Overall Denied Claims Rate	**8.36%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The overall denied claims rate for the MHP was 8.36 percent, which was higher than the statewide rate of 5.92 percent.
- The largest proportion of denied claims dollars (35 percent) were denied due to the member not being eligible or non-covered charges, followed by Medicare Part B needing to be billed first (26 percent), and other healthcare coverage needing to be billed first (20 percent).

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has experienced significant impact from the implementation of the new EHR system. The MHP has been struggling to provide the necessary data to track the quality and timeliness of care metrics, as well as making sure all users know how to use the EHR to enter the healthcare data and for contract providers, the billing information.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP conducts thorough analyses and tabulation of all CPS surveys by domains and the survey types. These are part of the dashboard that QI produces and used in the QIC and QAPI evaluation.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of family members of children and youth who had initiated services in the preceding 12 months. All participants fulfilled the requested parameters. The focus group was held at the MHP administration building in Oxnard, CA and included nine participants; a Spanish language interpreter was used for this focus group. All participants have at least one family member who receives clinical services from the MHP.

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

- Regularity of services ranging from once a week to every two weeks.
- Utilization of telehealth by everyone, with sessions being of the same length as in-person.
- Availability of translation/interpretation services for all monolingual individuals.

- Positive feedback on handling crises, with quick and helpful responses from counselors.
- General satisfaction with the therapists and the impact of the services on behavioral issues.

General comments regarding service delivery that were mentioned included the following:

- Reminder calls are made for appointments.
- The clinic proactively reschedules missed appointments.
- Lack of awareness about transportation services, with some interest in learning about them in the future.
- Most family members are involved in the care process.
- Lack of familiarity with wellness centers among most participants.
- Staff is perceived as understanding cultural needs, and materials are available in Spanish.

Recommendations for improving care included the following:

- All participants expressed a desire for involvement in mental health committees.

Consumer Family Member Focus Group Two

CalEQRO requested monolingual Spanish speaking members and family members of children and youth who initiated services in the preceding 12 months. All participants fulfilled the requested parameters. The focus group was held at the MHP administration building in Oxnard, CA and included five participants; a Spanish language interpreter was used for this focus group. All consumers and family members participating receive or have a family member who receives clinical services from the MHP.

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

- Varied experiences regarding wait times for initial appointments, with some finding the wait too long, while others did not specify.
- The wait times between regular appointments, including psychiatry and therapy sessions, were inconsistent; some members were satisfied, while others did not elaborate.
- New members, who transitioned from other programs or saw multiple clinicians or psychiatrists before, mentioned prompt appointments, sometimes on the same day.

- There was no consistent protocol for handling missed appointments; some members mentioned receiving regular reminders, while others noted inconsistency.

General comments regarding service delivery that were mentioned included the following:

- The use of translation or interpretation services was mentioned.
- Transportation services provided by the county for mental health services need improvement.
- Family involvement in treatment was possible.
- During crises, members had the option to call their doctor or psychiatrist.
- Some members reported filling out satisfaction surveys.

Recommendations from focus group participants included:

- Members expressed the need for improved communication regarding mental health system updates and a desire for more involvement in mental health committees or decision-making.
- Concerns were raised about the sustainability of housing assistance provided by the county, with at least one member worried about future support.
- In terms of service quality, members recommended maintaining the current level, with a particular call for a change of doctor when facing repetitive medication prescriptions without change.

Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. All participants fulfilled the requested parameters. The focus group was held at the MHP administration building in Oxnard, CA and included seven participants; no interpreter was used for this focus group. All consumers participating receive clinical services from the MHP.

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

- Wait times for initial appointments varied significantly, with some members being seen right away and others experiencing delays.
- The transition between programs was not always smooth, with some members experiencing a lack of support or difficulty with the transition process.
- The inconsistency in handling missed appointments and reminder calls was noted.

General comments regarding service delivery that were mentioned included the following:

- While some members received reminder calls and were followed up with if they missed appointments, others reported an inconsistent approach.
- Transportation services were discussed, with some members unaware of their availability and others facing challenges such as long wait times or no-shows.
- Telehealth services were available, but not all members could access them easily, and there were mixed feelings about the effectiveness of telehealth versus in-person visits.
- Family involvement in treatment was possible, but some members felt that the mental health system was not as inclusive as it could be.
- There was a desire for improved communication about mental health system updates and participation in committees or decision-making processes.

Recommendations from focus group participants included:

- More consistent communication and follow-ups for appointments, including reminders and checks when appointments are missed.
- More efficient transportation services, considering the wait times and reliability issues experienced by some members.
- Greater integration of family in the treatment process, respecting privacy but also valuing the input and support of family members.
- The need for better responsiveness and flexibility in the system was highlighted, especially for those in crisis or with complex needs.
- The need for a choice between telehealth and in-person appointments, emphasizing the importance of trust and connection in mental health treatment.

SUMMARY OF MEMBER FEEDBACK FINDINGS

The MHP successfully facilitated the plan member focus groups following the requested parameters for each of the three focus groups. As a result, all participants in the three focus groups represented plan members who had started receiving services in the past year.

Most plan members and family members of children and youth reported that their clinicians and case managers did a good job in terms of treatment. The participants also mostly reported that family members can be involved in their treatment if they so desired.

With major organizational changes taking place in the past year, including the revamping of the service access structure and a significant number of new staff hired, the participants in these focus groups experienced varied timeliness to services.

The plan members also reported that the communications related to services or MHP changes were not consistently received. This experience mirrors what was reported by other key informants. As the MHP continues to recruit for the various QIC sub-committees, these focus groups revealed that there was no dearth of plan members or family members willing to be involved in committees.

CONCLUSIONS

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

STRENGTHS

1. The MHP has demonstrated improvements in multiple QI-related activities. These include QIC and Quality structure redesign in accordance with the five-year strategic plan, tracking of FC HEDIS measures, and the development of a public facing data dashboard. (Quality)
2. The QI team continues to have excellent data analytical capabilities and produces a number of internal and external reports on performance, quality, and outcomes. (Quality)
3. The MHP has been able to start hiring for its newly developed peer employee positions. Those who are newly hired in these positions reported their experience as significant and transformative. (Quality)
4. The MHP IS staff who are responsible for supporting the implementation of SmartCare have performed well. One of the biggest accomplishments has been developing workarounds to produce the necessary reports while the new EHR's functionalities fully come online. (IS)
5. The MHP evidenced strong collaborations with multiple agencies and external partners to facilitate access. Additionally, the restructuring of the access system has strengthened the processes for children and youth members to access services. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP continues to have room for improvement in its tracking of timeliness metrics. It has progressed in tracking the first offered psychiatry appointment, but the work is not complete yet. In addition, the methodology for first offered appointments and psychiatric inpatient follow-up includes service types that may not reflect true access to care for these metrics. (Timeliness)
2. Organizational changes, CalAIM changes, payment reform, and staff shortages have underscored the needs for improving two-way communications with the contract providers, line staff, and plan members as part of a larger change management strategy. (Quality)

3. The HCM percentage and AACM per HCM for the MHP continued to significantly exceed the statewide figure. With the new EHR implementation, the MHP lacked enough staff time to adequately investigate the root causes. In-depth analyses of this topic can yield pointers to QI needs by certain demographics or service types. (Quality)
4. Overall denied claims rate for the MHP was higher than the statewide average in CY 2022. The MHP needs to be able to determine eligibility and to check if Medicare needs to be billed first. (Quality, IS)
5. With the new QIC structure, there is an opportunity to increase the participation by the plan members in different sub-committees and inclusion in the QIC. CalEQRO's plan member focus groups indicated a desire to learn about any opportunities for participation in committees. (Quality)

RECOMMENDATIONS

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

1. Continue developing a robust timeliness reporting system that accurately captures timeliness according to HEDIS or other state and national practices; improve urgent need tracking and analyze access to SMHS rather than the initial screening. (Timeliness)

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

2. Develop a two-way communication plan as part of a broader change management strategy that prioritizes communications with the contract providers, line staff, and plan members. (Quality)

3. Examine the reasons for a high percentage of plan members being in the HCM category. Utilize the CalEQRO-provided approved claims analyses that show the higher costs are concentrated by certain race/ethnicity, age groups, service types, and aid codes. (Quality)

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

4. Develop strategies to increase plan member participation in the QIC structure or other committees across the system. (Quality)

5. Complete the 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. (Quality)

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

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Ventura MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Consumer and Family Member Focus Groups
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Specialized Service Systems: Criminal Justice, Law Enforcement, Crisis Response
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Clinical Management and Supervision
Forensics and Law Enforcement Group Interview
Community-Based Services Agencies Group Interview
Information Systems Billing and Fiscal Interview
EHR Deployment
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, PhD, Lead Quality Reviewer
Pamela Springer, Information Systems Reviewer
Christin Zamora, Consumer/Family Member Reviewer

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

MHP County Sites

Ventura County Behavioral Health Services
1911 Williams Drive, Oxnard, 93036

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Adato	Levana	Clinic Administrator	VCBH
Aguila	Gabriela	BH Manager	VCBH
Amezquita	Wendi	Clinic Administrator	VCBH
Avila-Hererra	Ruby	Clinic Administrator	VCBH
Baca-Leanos	Kathleen	Clinic Administrator	VCBH
Barajas	Maria	Peer	VCBH
Bednarz	Daniella	Clinic Administrator	VCBH
Bennett	Kimberly	Chief Clinical Officer	Casa Pacifica
Bezdjian	Serena	Research Psychologist	VCBH
Block	Sherri	Clinic Administrator	Hillmont Residential
Boscarelli	Robin	Clinic Administrator	VCBH
Burt	Sloane	BH Manager	VCBH QI
Calica	Anne	Clinic Administrator	Aegis Treatment
Cameron	Jena	Clinic Administrator	VCBH
Carson	Hilary	Senior Program	VCBH
Castro	Chris	Program Administrator	VCBH
Chen	Yvette	Senior Program	VCBH
Cleland	Don	Regional Director	Golden Hillmont House
Clemens	Frank	COO	Casa Pacifica
Clemore	Brandy	Compliance coordinator	Protypes/Healthright

Last Name	First Name	Position	County or Contracted Agency
Colton	Michael	Clinic Administrator	VCBH
Contreras	Ricardo	Head of Service	New Way Group Home
Cooper	Jason	Medical Director	Executive Leadership/VCBH
Corona	Eileen	Clinic Administrator	VCBH
Cowie	Stephanie	Clinic Administrator	VCBH
Cunningham	Lindsey	Program Administrator	Telecare
Denering	Loretta	Interim MHP Director	Executive Leadership/VCBH
Diaz	Amber	Senior Program Administrator	VCBH
DiBattista	Maria	Treatment Services Manager	VCBH
Donovan	Leisa	Senior Accounting	VCBH
Dougherty	Jennifer	Senior Manager	VCBH
Dougherty	Ria	Clinic Administrator	VCBH
Doutt	Cynthia	Director	Telecare
Duenas	Alicia	Program Administrator	VCBH
Duran	Jose L	Senior Program	VCBH
Ebner	Patricia	Clinical Line Staff	VCBH
Egan	Narci	Assistant CFO	Executive Leadership/VCBH
Elhard	Erick	BH Manager	VCBH
Elizalde	Estefania	Clinician	VCBH
Escoto	Stephanie	Clinician	VCBH

Last Name	First Name	Position	County or Contracted Agency
Farhat	Linda	Director of Ventura BH	Pathpoint
Fernandez	Araly	Administrative Assistant	Telecare
Flores	Anna	BH Manager	VCBH
Flores	Raudel	Clinic Administrator	VCBH
Fox	Cheryl	Y&F division Chief	VCBH
Gailey	Kenneth	BH Manager	VCBH
Galvan	Ramon	Peer	VCBH
Garcia	Adriana	SUS-Office assistant	VCBH
Garcia	Abigail	Peer	VCBH
Glantz	Julie	Senior Manager	VCBH
Gonzalez	Juanita	Peer	VCBH
Gooden	Toni	Clinician	VCBH
Guffee	Susan	Program Director CSU and COMPASS	Seneca
Guilin	Heather	Clinic Administrator	VCBH
Hagerty	David	SUS-Clinical line staff	VCBH
Handel	Deanna	Manager	HCA
Hannah	Melissa	Executive Director	United Parents
Heath	Curtis	Program Administrator	Contracts
Hernandez-Lopez	Yuleni	Clinician	VCBH

Last Name	First Name	Position	County or Contracted Agency
Hickman	Mark	President and CEO	Western Pacific
Hicks	Daniel	BH Manager/Prevention	VCBH
Hipple	Wendy	Clinic Administrator	VCBH
Johnson	Heather L	Clinic Administrator	VCBH
Kennedy	Kelly	Compliance	Khepera House
Keeler	Samantha	Clinician/ Care Coordinator	VCBH
Khan	Traci	Clinic Administrator	VCBH
Kory	Leah	Medical Director	VCMC
Kramer	Barbara	Program Administrator	VCBH
Ladner	Spencer	Program Administrator	Peer
Lee	Karen	Senior Manager	VCBH
Lemus	Alex	Clinician	VCBH
Linden	Vel	Clinic Administrator	VCBH
Lomeli	Nicole	Program/Administrative	Jackson House
Lopez	Gracie	Management Assistant	VCBH
Lopez	Marcus	Clinic Administrator	VCBH
Lubell	Courtney	BH Manager	VCBH
Magbitang	Ana	BH Manager	VCBH
Magdaleno-Ortega	Estela	Admin Administrative	VCBH
Mahdavi	Amir	Division Chief Quality	VCBH

Last Name	First Name	Position	County or Contracted Agency
Mahon	Joni	BH Clinician	VCBH
Manzo	Sal	BH Manager	VCBH
Marrero	Lucy	Director of Behavioral Health	Gold Coast Health Plan
Martinez	Rocio	SUS-Clinician	VCBH
Matisek	Kalie	Clinical Director	Turning Point
Medina	Leo	Program Administrator	VCBH
Mendoza	Juan F.	Billing Manager	VCBH
Meza	Maria E	Clinic Administrator	VCBH
Mikkelson	Sandra	Program Administrator	VCBH
Miles	Martie	Director	Aspiranet
Moneyhun	Stephanie	Clinic Administrator	VCBH
Morris	Shawna	CEO	Casa Pacifica
Munoz	Monica	Senior Psychologist	VCBH
Muslow	Christina	Probation Officer	VC Probation
Nagle	Laura	Clinic Administrator	VCBH
Nelson	Pamela	Peer	VCBH
Newman	Arielle	Clinic Administrator	VCBH
Norton	Phinette	Clinician	VCBH
Ortiz	Lillian	SUS-Clinician	VCBH
Ortiz	Ruben	Clinic Administrator	Western Pacific

Last Name	First Name	Position	County or Contracted Agency
Palermino	Tony	IT Supervisor	VCBH
Pavlovskaya	Aliona	Program Administrator	VCBH
Perez	Laticha	Clinic Administrator	VCBH
Perry	Mark	Clinician	VCBH
Pletcher	Rachel	Caregiver Clinical Prog	Kids and Families
Preciado	Pauline	Director of Population Health	Aspiranet
Pratt	Krista	Clinician	VCBH
Price	Megan	Compliance Supervisor	Aspiranet
Rabinovitz	Katheryn	Program Administrator	VCBH
Reyes	Richardo	Peer	VCBH
Riddle	Angela	BH Manager	VCBH
Rivera	John	Clinic Administrator	VCBH
Rodriguez	Jenn	Program Manager	Turning Point
Rodriguez	Mike	BH Manager	VCBH
Rosenstein	Irving	Physician's Assistant	VCMC
Ruiz	Deanna	Clinic Administrator	VCBH
Sajjad	Tahera	Quality Assurance and Operations Manager	Seneca
Salazar	Nicole	BH Manager	VCBH
Sanchez	Sara	A&O Division Chief	VCBH

Last Name	First Name	Position	County or Contracted Agency
Schipper	John	Adult Division Chief	VCBH
Schriener	Peter	Clinic Administrator	VCBH
Seal	Maryza	BH Manager	VCBH
Shafa	Shahram	Clinic Administrator	VCBH
Shah	Brinda	Senior Program	VCBH
Shannon	Jeff	Clinic Administrator	VCBH
Silvey	Richard	Clinical Director	Khepera House
Simental	Cindy	Clinic Administrator	VCBH
Snee	Rachel	Peer	VCBH
Springer	Nancy	BH Manager	VCBH
Supan	Valerie	Line staff	VCBH
Swanson	Kaj	Clinic Administrator	VCBH
Tadeo	Zandra	BH Manager	VCBH
Taylor	Thomas	BH Manager	VCBH
Thomas	Alice	SUS-Clinician	VCBH
Torres	Crystal	Clinician	VCBH
Torres	Monica	BH Manager	VCBH
Tryk	Lisa	Senior Program	VCBH
Turcios	Vanessa	BH Clinician	VCBH
Ummer	Faizel	Program Administrator	VCBH

Last Name	First Name	Position	County or Contracted Agency
Urutia	Sara	Peer	VCBH
Valdivia	Angelic	Program Director	Prototypes/ Healthright
Villegas	Alexis	Program Administrator	VCBH
Vlaskovits	Joseph	Medical Director SUS	VCBH
Volf	Eleonora	Pharmacist	VCBH
Weaver	Bradley	Peer	VCBH
West	Raena	SUS Division Chief	VCBH
Westhoff	Shannon	Clinic Administrator	VCBH
Westhoff	Shannon	Clinic Administrator	VCBH
White Wood	Susan	BH Manager	VCBH
Yomtov	Dani	Program Administrator	VCBH
Zapeda	Geneveve	Clinical Nurse Manager	VCBH
Zavala	Yazmin	CSC- TAY	VCBH
Zarate	Laura	Director of Case Management	VCMC
Buckley	Lara	Horizon View	Clinical Director
Sternad	Erik	Interface	Executive Director
Churn	Ayana	Telecare-Casa Esperanza	Program Administrator
Espinoza	Yesenia	VCBH	Clinical line Staff
Isaac	Carmela	VCBH	Clinical line Staff
Kapp	Ciara	VCBH	Clinical line Staff

Last Name	First Name	Position	County or Contracted Agency
Montes	Raquel	VCBH	Clinical line Staff
Nogueira	Ana	VCBH	Clinical line Staff
Reynoso	Eileen	VCBH	Clinical line Staff
Satterlee	David	VCBH	Clinical line Staff
Torres	Miguel	VCBH	Clinical line Staff
Vaca	Mayra	VCBH	Clinical line Staff
Padilla	Rosa	Probation Officer	VC Probation
Warran	Liz	Peer Advocate	Client Network
Kagan	Melissa	Administrator	Guiding our youth
Star	Keith	Independent Detox Hospital Director	Tarzana Treatment Center
Gonzalez- Seitz	Nicholle	Clinic Administrator	VCBH
Hodge	Hayley	Clinic Administrator	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	At the time of the EQR, the MHP was still in the process of finalizing its implementation strategies and no evidence of potential success was available.

General PIP Information
MHP/DMC-ODS Name: Ventura MHP
PIP Title: Screening and Identification of Psychosis Symptoms in TAY
PIP Aim Statement: Will the implementation of a psychosis screening checklist at the point of referral increase the accurate identification and placement of plan members into Ventura County's Power Over Prodromal Psychosis (VCPOP) program by 10 percent over a 6-month period in 2024?
Date Started: 08/202
Date Completed: N/A
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: 12-25 age group

General PIP Information
Target population description, such as specific diagnosis (please specify): Predominantly 16-25-year-old TAY who have developed or are at risk for developing psychosis symptoms or are identified as experiencing symptoms of psychosis. The MHP is also including 12-16-year-old adolescent group in its target population if they are identified with similar issues or at-risk of developing psychosis.
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): Not developed yet.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training on screening for prodromal symptoms and early onset psychosis.
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): Development and use of a referral checklist for VCPOP referrals.

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
Improve referrals to VCPOP via the checklist for identifying TAY at risk for psychosis.	N/A	N/A	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ 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
Decreased symptoms of psychosis (as assessed with the SIBs) among TAY at risk for psychosis	N/A	N/A	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Reduced Hospitalizations	N/A	N/A	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Reduced crisis interventions	N/A	N/A	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ 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):

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: The MHP needs to evaluate if this can become a fully implemented PIP by the next EQR with all relevant data and information available for the validation of this PIP. Barring that, the MHP may consider continuing this as a QI project, but not a formal PIP submission for EQR purposes.

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 actual implementation of improving the connections with the ED staff remained incomplete with less than expected attendance at the initial trainings and there was no remeasurement data available for the FUM measures. The MHP's baseline data indicated already high 30-day follow-up rate, in the top quartile in the state. Therefore, meeting the improvement goals for that measure may not actually be accomplished. However, the 7-day follow-up rate may be improved once the training series is completed.

General PIP Information
MHP/DMC-ODS Name: Ventura MHP
PIP Title: Follow-Up After ED Visit for Mental Illness
PIP Aim Statement: In the six months following the intervention, the aim is to increase referrals from hospital staff/navigators for individuals with an ED visit for MI-related issues or self-referrals by 5 percent.
Date Started: 09/2022
Date Completed: N/A
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (Check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Individuals presenting at the EDs with a mental illness diagnosis.

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): Encouraging members to connect with Access.						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Orientation on the separate entities providing follow-up care (County system and community providers), service access and provision specific to the Medi-Cal population, the importance of level-of-care determination and its effect on timeliness to follow-up, care coordination and No Wrong Door, and considerations with privacy and information sharing						
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): Improving data interchange with the managed care plans, hospitals, and EDs.						
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**
Percentage of participants who attended trainings out of all invitees.	2023	N=7 43%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent change measuring knowledge gap related to MH services available for Medi-Cal members.	2023	N=3 Pre-test average=4	☐ Not applicable—PIP is in planning or implementation phase, results not available	N=3 Post-test average=4.7 Improvement=17.5%	☒ 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
Percent change measuring knowledge gap related to access points to MH services in Ventura County.	2023	N=3 Pre-test average=3.7	☐ Not applicable—PIP is in planning or implementation phase, results not available	N=3 Post-test average=4.7 Improvement=25%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent agreement measuring willingness to use knowledge gained in day-to-day care coordination work	2023	N=3 Baseline score=N/A	☐ Not applicable—PIP is in planning or implementation phase, results not available	N=3 Post-test score=100%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of referrals from hospital which resulted in a mental health service follow-up a) Within 7 days b) Within 30 days	2023	N=28 7-day FUM=50% 30-day FUM=93%	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ 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):

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: • The MHP needs to work closely with its ED and navigation partners to improve attendance at the trainings. • In addition, the MHP needs to continually monitor any additional barriers to implementation strategies and improvements in the FUM measures. This may include monitoring the referral call volume and appropriateness as performance indicators. • As the MHP noted, it needs to work with its Access and follow-up system for more streamlined and timely access after ED visits and inpatient discharges. • The MHP needs to continually monitor any additional barriers to implementation strategies and improvements in the FUM measures.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, CalEQRO Approved Claims Definitions, 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 as part of this report.