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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

VENTURA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

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TABLE OF CONTENTS

List of Tables 4

List of Figures..5

INTRODUCTION 6
MHP Information 6
Validation of Performance Measures 7
Performance Improvement Projects...7
MHP Health Information System Capabilities 7
Network Adequacy..7
Validation of State and MHP Beneficiary Satisfaction Surveys............................8
Review of Recommendations and Assessment of MHP Strengths and Opportunities.......8

PRIOR YEAR REVIEW FINDINGS, FY 2019-20 10
Status of FY 2019-20 Review of Recommendations......................................10
Recommendations from FY 2019-20 10

PERFORMANCE MEASURES 17
Health Information Portability and Accountability Act Suppression Disclosure ...19
Total Beneficiaries Served 20
Penetration Rates and Approved Claims per Beneficiary 21
Diagnostic Categories...25
High-Cost Beneficiaries 26
Psychiatric Inpatient Utilization 26
Post-Psychiatric Inpatient Follow-Up and Rehospitalization 27

PERFORMANCE IMPROVEMENT PROJECT VALIDATION.......................28
Ventura MHP PIPs Identified for Validation 28
Clinical PIP 28
Non-Clinical PIP..37

INFORMATION SYSTEMS REVIEW 44
Key ISCA Information Provided by the MHP..44
Summary of Technology and Data Analytical Staffing 46
Summary of User Support and EHR Training 47
Availability and Use of Telehealth Services 49
Telehealth Services Delivered by Contract Providers......................................51
Current MHP Operations 52
Major Changes since Prior Year 52
The MHP's Priorities for the Coming Year 52
Other Areas for Improvement...53

Plans for Information Systems Change 53
MHP EHR Status 53
Contract Provider EHR Functionality and Services 55
Personal Health Record 56
Medi-Cal Claims Processing 57

NETWORK ADEQUACY 59
Network Adequacy Certification Tool Data Submitted in April 2020 59
Findings 60
Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients 60
Provider NPI and Taxonomy Codes – Technical Assistance 61

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S) 62

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS 63
Access to Care 63
Timeliness of Services 66
Quality of Care 69
Beneficiary Progress/Outcomes 73
Structure and Operations 75

SUMMARY OF FINDINGS 78
MHP Environment – Changes, Strengths and Opportunities 78
FY 2020-21 Recommendations 84

SITE REVIEW PROCESS BARRIERS 86

ATTACHMENTS 87
Attachment A—Review Agenda 88
Attachment B—Review Participants 89
Attachment C—Approved Claims Data 92
Attachment D—ACA Penetration Rates and ACBs 93
Attachment E—ACB Range Distributions 94
Attachment F—List of Commonly Used Acronyms 95

LIST OF TABLES

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity 20
Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language 21
Table 3: High-Cost Beneficiaries CY 2017-19 26
Table 4: Psychiatric Inpatient Utilization CY 2017-19 26
Table 5: PIPs Submitted by Ventura MHP 28
Table 6: General PIP Information – Clinical PIP 28
Table 7: Improvement Strategies or Interventions – Clinical PIP 29
Table 8: Performance Measures and Results – Clinical PIP....30
Table 9: General PIP Information – Non-Clinical PIP....37
Table 10: Improvement Strategies or Interventions – Non-Clinical PIP 38
Table 11: Performance Measures and Results – Non-Clinical PIP....39
Table 12: Budget Dedicated to Supporting IT Operations....44
Table 13: Business Operations....45
Table 14: Distribution of Services by Type of Provider 45
Table 15: Technology Staff 46
Table 16: Data Analytical Staff....46
Table 17: Count of Individuals with EHR Access 47
Table 18: Ratio of IT Staff to EHR User with Log-on Authority 48
Table 19: Additional Information on EHR User Support....48
Table 20: New Users' EHR Support....48
Table 21: Ongoing Support for the EHR Users....49
Table 22: Summary of MHP Telehealth Services 49
Table 23: Contract Providers Delivering Telehealth Services 51
Table 24: Primary EHR Systems/Applications....52
Table 25: EHR Functionality 53
Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR 55
Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP....56
Table 28: PHR Functionalities....56
Table 29: Summary of CY 2019 SD/MC Claims 58
Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial 58
Table 31: NPI and Taxonomy Code Exceptions 61
Table 32: Access to Care Components 63
Table 33: Timeliness of Services Components....66
Table 34: Quality of Care Components....69

Table 35: Beneficiary Progress/Outcomes Components 73
Table 36: Structure and Operations Components..75
Table A1: EQRO Review Sessions...88
Table B1: Participants Representing the MHP...90
Table D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB.......93
Table E1: CY 2019 Distribution of Beneficiaries by ACB Range..........................94
Table F1: List of Commonly Used Acronyms...95

LIST OF FIGURES

Figure 1: Overall Penetration Rates CY 2017-19..22
Figure 2: Overall ACB CY 2017-19..22
Figure 3: Latino/Hispanic Penetration Rates CY 2017-19...................................23
Figure 4: Latino/Hispanic ACB CY 2017-19..23
Figure 5: FC Penetration Rates CY 2017-19 24
Figure 6: FC ACB CY 2017-19...24
Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019 25
Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019...25
Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19......................27
Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19..................27

INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Ventura MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Large

MHP Region — Southern

MHP Location — Ventura

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 10,405

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed Assembly Bill (AB) 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and BHINs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard (AAS), and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, CalEQRO will review the AAS and ONA information as part of its annual EQR.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed

definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

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

Status: Met

- The MHP currently operates an active clinical PIP that targets reduction of 30-day rehospitalizations.
- The non-clinical PIP targeting enhanced access concluded at the end of July 2020.
- The replacement non-clinical PIP targeting creation of a beneficiary and clinician document that incorporates clinical outcome information is

currently in concept state. The goal is to improve satisfaction and engagement with services. Initial work began on this PIP in August of 2020, but to date no interventions are active.

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

Status: Met

- The updates to the non-clinical enhanced access PIP occurred as requested was made inclusive of the different locations and strategies for improving access.

Access Recommendations

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

Status: Partially Met

- Ventura County Behavioral Health (VCBH) and the Gold Coast Health Plan (GCHP) are contractually required to meet twice each fiscal year. Discussion includes referrals between levels of care, with a specific focus on GCHP's mental health service provider Beacon. During FY 2019-20, one of the two annual meetings occurred; the second meeting did not occur due to COVID-19.
- By November 2020, a coordination meeting between VCBH and GCHP did occur, and included identification of liaison staff to formalize communication and coordinate meetings for the current FY 2020-21 period.
- The MHP did not report on whether the issue of Beacon clinical capacity was discussed. This recommendation has the potential for carryover if there is more evidence of the MHP continuing treatment of those who no longer require specialty mental health services (SMHS) due to capacity limitations of the Beacon provider network.

Timeliness Recommendations

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

Status: Met

- In order to track clinical request for service (RFS) events, an Avatar on-demand "RFS to First Service (5927)" report was created. It captures the RFS date, and the first offered and first kept appointment dates. Quality improvement (QI) staff use this report with various timeliness needs, such as NACT. Clinical and operations staff also have access to this report.
- A modified version of the RFS to First Service report was developed to track the Enhanced Access PIP reporting needs, that includes the RFS method of request (fax, email, or telephone), and the source of (self, school).
- First offered psychiatry appointment timeliness reporting was addressed by another Avatar on-demand report that is currently in the process of being built-out. The "Psychiatric Appointment Timeliness Report 5960" will track the time from RFS to first offered and first actual appointments.

Quality Recommendations

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

Status: Met

- The MHP acknowledged the challenges encountered in the recruitment, hiring and retention of bilingual psychiatrists and other prescribers. This challenge also exists with cultural diversity, and prescribers from the black, indigenous, and people of color (BIPOC) groups.
- Two bilingual psychiatrists were on VCHB staff and the MHP was moving toward the hire of a third this past year. COVID-19 caused the recruited doctor to reconsider and reverse the decision to move. Also, one of the two onboard bilingual psychiatrists will soon be departing.
- The MHP has employed a number of strategies to improve the recruitment process. This includes providing the recruiter information regarding academic institutions that have a higher participation of BIPOC and

bilingual candidates. Leadership of the Community Memorial Psychiatry Residency Program has committed to increased efforts to recruit bilingual/bicultural psychiatry residents.

- The MHP met the recommendation to seek bilingual psychiatry practitioners but was unable to achieve the goal.

Beneficiary Outcomes Recommendations

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

Status: Met

- To help establish goals and priorities for the development of outcomes reporting, Quality Improvement (QI) held discussions with stakeholders. This included a 3-session work group with the Behavioral Health Advisory Board (BHAB) members during summer and fall of 2020, and a Quality Management Action Committee (QMAC) session during December 2020.
- On-demand Avatar reports that present outcome data measures that were implemented in summer through fall of 2019, including data from the Milestones of Recovery Scales (MORS), Behavior and Symptom Identification Scale (Basis-24), and the Treatment Perceptions Survey (TPS) are in process.
- During fall 2020, QI began to work with the Y&F lead team to design an individual client narrative and department/program aggregate Child and Adolescent Needs and Strengths (CANS) report. The goal is to publish this information as Avatar on-demand reports for clinical and management use. A sample of the mock-up individual client narrative report was provided for the current review. The department/program aggregate report is still in proof-of-concept phase, and not ready to share.

Foster Care Recommendations

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

Status: Met

- VCBH identified that performance issues with FC first kept appointments data related to changes made to the access to services data-entry screens in the EHR. The changes caused confusion among the MHP team. Retraining of staff occurred, and the MHP has confidence that tracking errors were resolved. Clinic administrators were requested to

verify that entry of required information by staff occurred, and follow-up with staff when elements were missing or incorrect. The MHP is now in the process of reviewing entered data to ensure accuracy of the initial time-period.

Information Systems Recommendations

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

Status: Met

- During late 2019, VCBH conducted a department-wide evaluation of the network logon process. The average time to complete the process was 70 seconds, and viewed as acceptable considering the multiple required steps. But inconsistent results and outliers continued to be found within the same clinic or facility.
- A deeper analysis was conducted, which revealed subpar results associated with several factors: 1) older computers running the Windows 7 operating system; and 2) intermittent network traffic spikes related to the ebb and flow of daily business activities.
- Solutions to these issues were implemented within VCBH: 1) identify and replace Windows 7 computers; and 2) upgrade of the AT&T MPLS circuit running from the Ventura County Firewall to the Avatar Hosted Data Center in Ohio.
- The MHP continues to monitor this area by conducting annual logon exercises in all VCBH clinics. Results from the current testing period will be available for review at the next EQRO ISCA discussion session.

Recommendation 9: Develop functionality that enables community-based organizations (CBOs) to perform batch uploads from their individual EHRs of claim files to the MHPs Avatar system.

Status: Not Met

- At this time VCBH lacks sufficient staffing to review and perform batch import file validation. This topic is slated for future review.

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

Status: Partially Met

- Insights is the sole MHP interactive dashboard with drill-down capability. Due to licensing cost considerations, access is currently limited to the management level (clinic administrators, managers, senior. managers, and division chiefs).
- There are existing Avatar on-demand reports available to line staff.
- The MHP is creating a comprehensive plan for reporting mechanisms. The plan, and what will be developed, will include reports designed to meet the needs of line staff.

Structure and Operations Recommendations

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

Status: Partially Met

- VCBH enrollment of providers who support county-operated sites continues. All physicians are enrolled and the MHP is working to enroll remaining eligible staff as well as Provider Application and Validation for Enrollment (PAVE).

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

Status: Not Met

- Ventura County will be assisting the CBO's with the application process for PAVE and Medicare, as necessary. Availability of staff to support this process is limited, and the MHP is looking to identify staff to support this project. The MHP plans to provide CBO's with step-by-step instructions on the application process and offer assistance with any questions or issues that arise.

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

Status: Met

- VCBH made progress with the development of the OPT activities grid, resulting from the input of Y&F and Adult senior managers. The 2010 OPT guidance was the foundation of this work, which was modified with input from management staff and adjusted to reflect current operations. The grid was disseminated to both adult and Y&F divisions during summer of 2020.

PERFORMANCE MEASURES

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

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

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

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

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

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf
2. EPSDT POS Data Dashboards: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
   - 5A (1&2) Use of Psychotropic Medications
   - 5C Use of Multiple Concurrent Psychotropic Medications
   - 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure
4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf
5. *Katie A. v. Bonta*:
   The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

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

Health Information Portability and Accountability Act Suppression Disclosure

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

Total Beneficiaries Served

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

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Ventura MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Beneficiaries	Percentage of Medi-Cal Beneficiaries	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
White	46,191	20.6%	3,245	31.2%
Latino/Hispanic	133,173	59.4%	4,783	46.0%
African-American	3,259	1.5%	304	2.9%
Asian/Pacific Islander	8,591	3.8%	198	1.9%
Native American	487	0.2%	32	0.3%
Other	32,673	14.6%	1,843	17.7%
Total	**224,372**	**100%**	**10,405**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Table 2 provides details on beneficiaries served by threshold language identified in DHCS BHIN 20-070.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Ventura MHP		
Threshold Language	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
Spanish	2,133	20.5%
Other Languages	8,272	79.5%
Total	**10,405**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

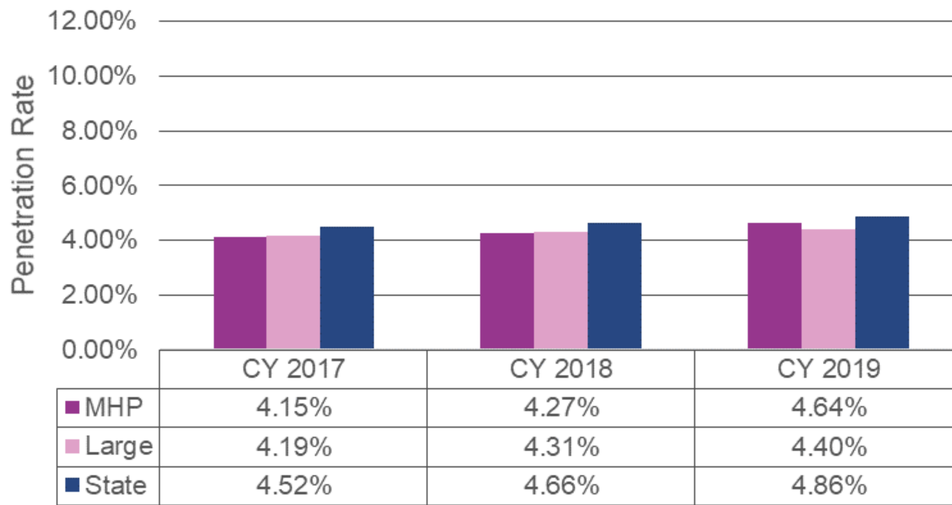
Penetration Rates and Approved Claims per Beneficiary

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

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

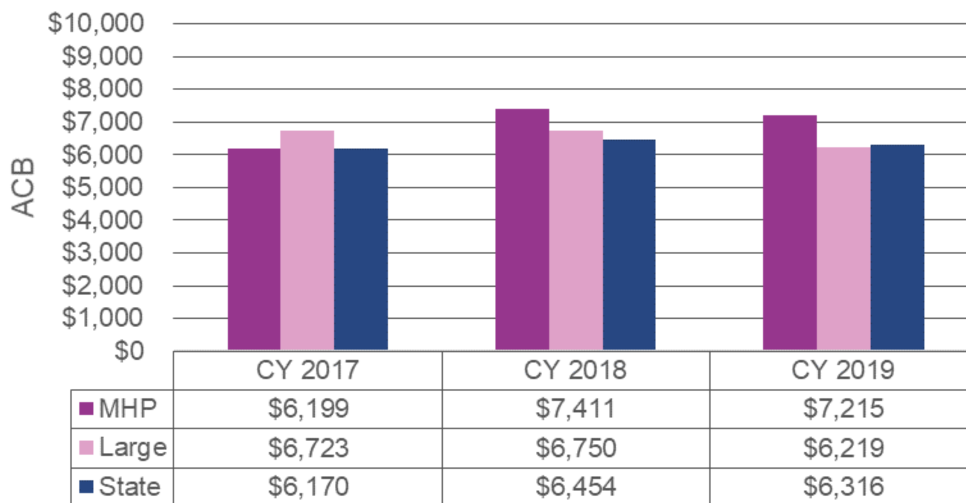
Regarding the calculation of penetration rates, the Ventura MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	4.15%	4.27%	4.64%
Large	4.19%	4.31%	4.40%
State	4.52%	4.66%	4.86%

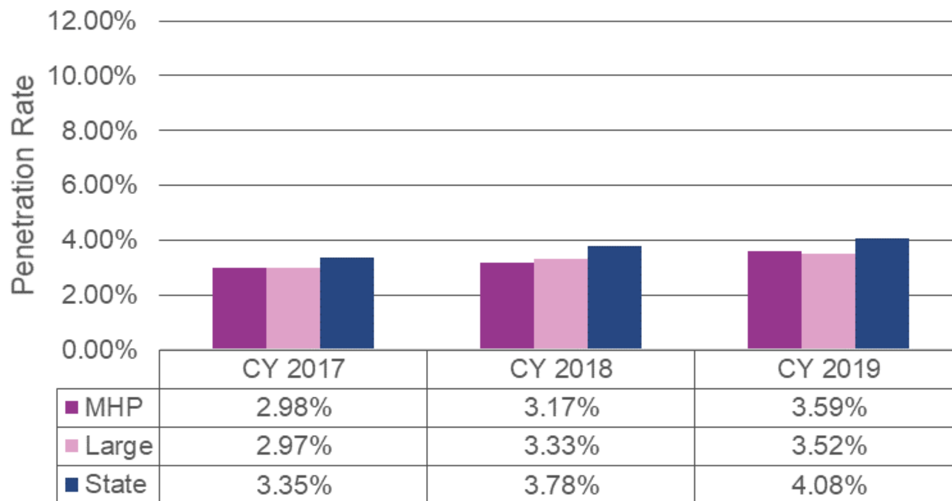
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,199	$7,411	$7,215
Large	$6,723	$6,750	$6,219
State	$6,170	$6,454	$6,316

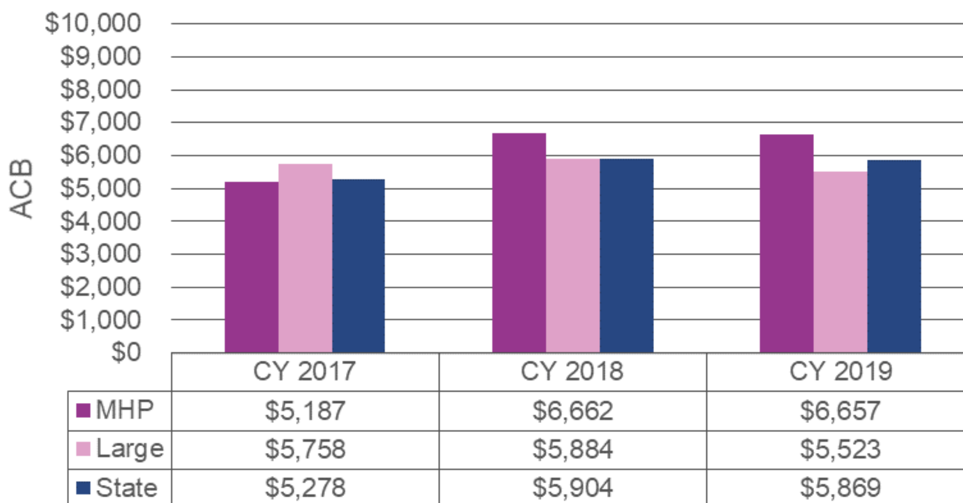
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	2.98%	3.17%	3.59%
Large	2.97%	3.33%	3.52%
State	3.35%	3.78%	4.08%

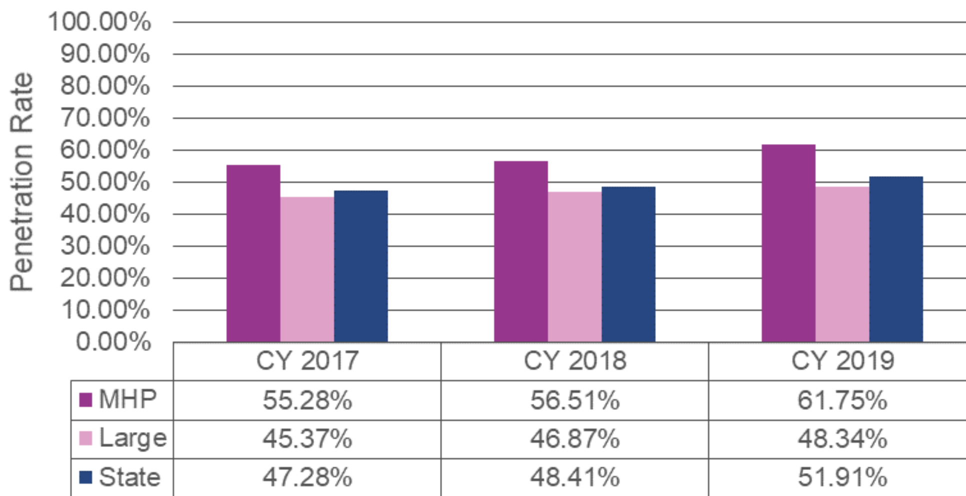
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$5,187	$6,662	$6,657
Large	$5,758	$5,884	$5,523
State	$5,278	$5,904	$5,869

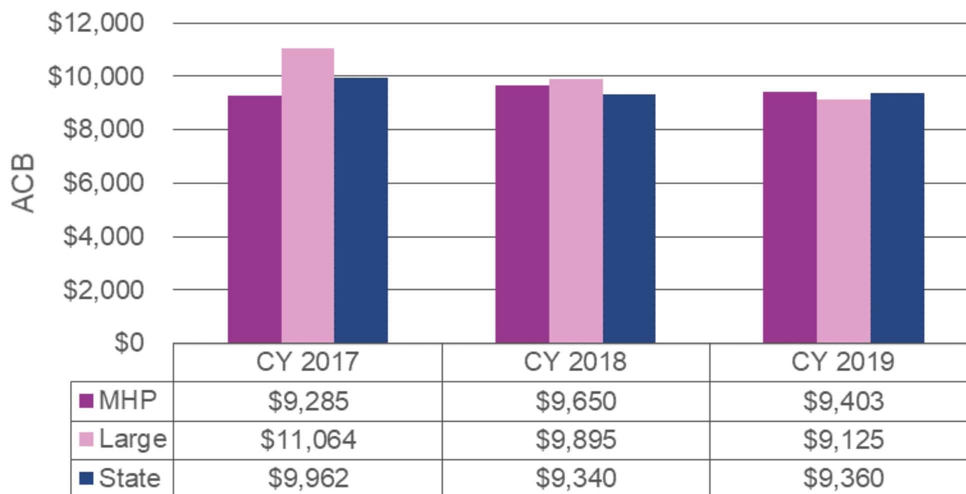
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	55.28%	56.51%	61.75%
Large	45.37%	46.87%	48.34%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

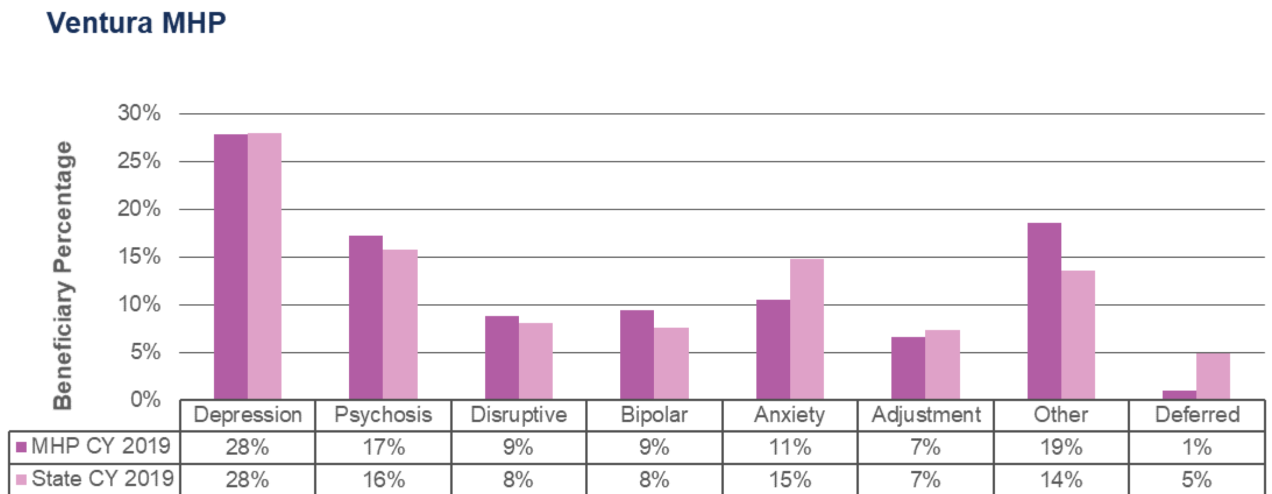


	CY 2017	CY 2018	CY 2019
MHP	$9,285	$9,650	$9,403
Large	$11,064	$9,895	$9,125
State	$9,962	$9,340	$9,360

Diagnostic Categories

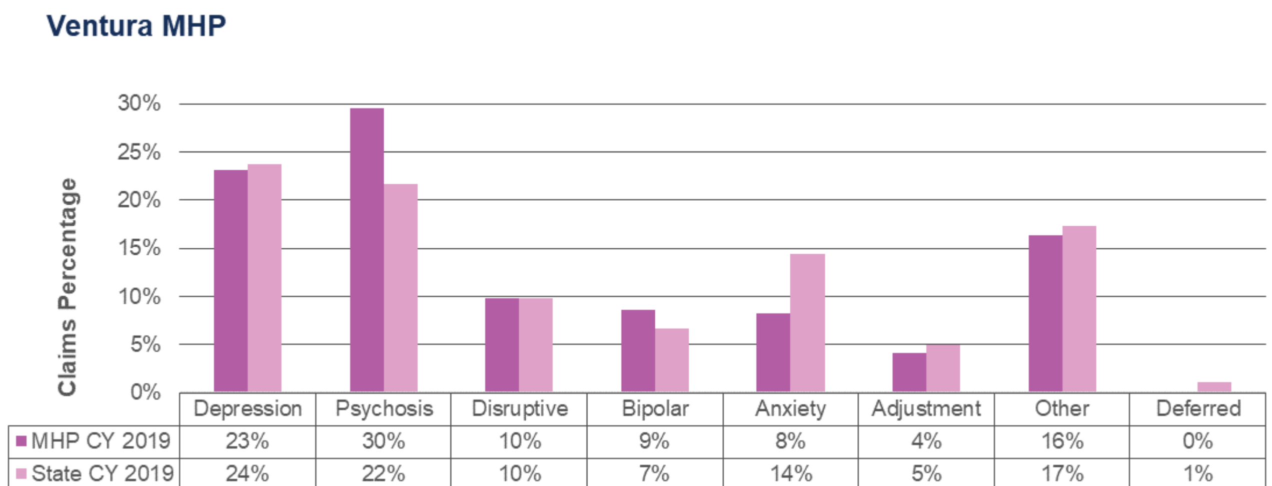
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	28%	17%	9%	9%	11%	7%	19%	1%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	23%	30%	10%	9%	8%	4%	16%	0%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Ventura MHP								
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	426	10,405	4.09%	$56,372	$24,014,417	31.99%
	CY 2018	408	9,839	4.15%	$58,474	$23,857,306	32.72%
	CY 2017	315	9,884	3.19%	$55,716	$17,550,410	28.64%

See Attachment E, Table E1 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

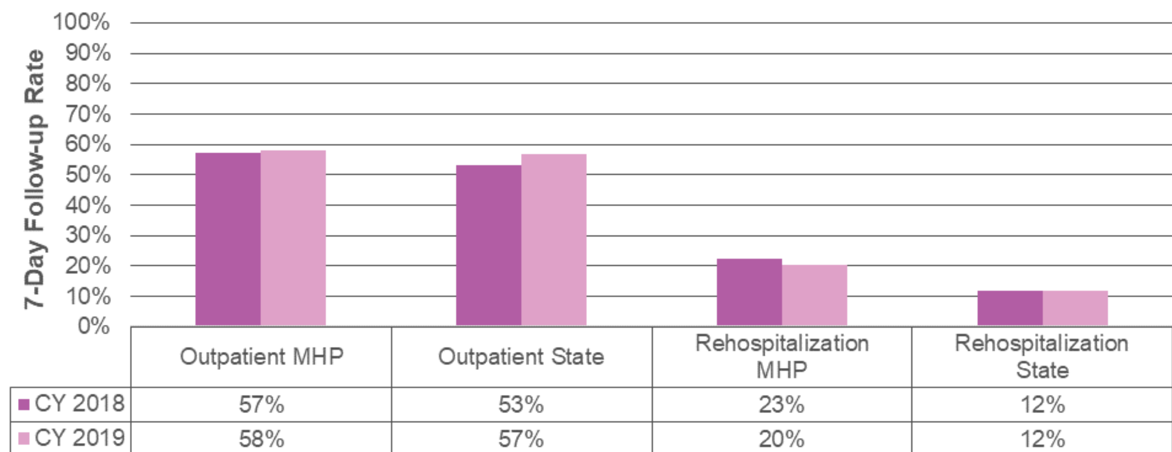
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Ventura MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	1,063	2,675	6.29	7.80	$9,879	$10,535	$10,500,899
CY 2018	1,073	2,788	6.71	7.63	$11,324	$9,772	$12,150,506
CY 2017	985	2,201	6.32	7.36	$9,040	$9,737	$8,904,597

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

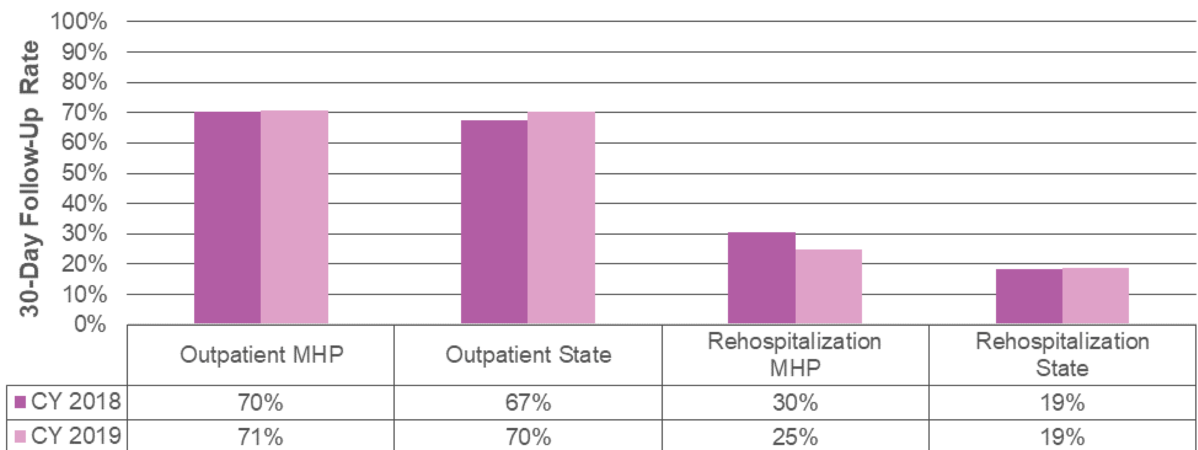
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	57%	53%	23%	12%
CY 2019	58%	57%	20%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	70%	67%	30%	19%
CY 2019	71%	70%	25%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

Ventura MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed and validated two PIPs, as shown below. The Enhanced Access non-clinical PIP was completed at the end of July 2020. A replacement PIP focused on the development of a beneficiary progress report is under development. TA feedback on that PIP was also provided during this review.

Table 5: PIPs Submitted by Ventura MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Post Hospitalization Performance Improvement Project
Non-Clinical	1	Enhanced Access Performance Improvement Project

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Ventura
PIP Title	Post Hospitalization Performance Improvement Project
PIP Aim Statement	"Will the use of a Post-Hospitalization Intensive Case Management model reduce 7- and 30-day readmission rates for inpatient psychiatric unit (IPU) cases for the target population by 25% in year 1 and 50% in year 2?" (Note: In Phase 1, the target population is VCBH enrolled adults admitted to Vista Del Mar, following a IPU discharge within the past 30 days.)

MHP Name	Ventura
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ 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): *Study Population #1 (Phase 1) – Vista Del Mar Adults – Enrolled VCBH Clients:* The population will be adults hospitalized at Vista Del Mar that meet the following criteria: 1. Had a prior IPU discharge within 30 days of their IPU admission 2. Enrolled in a VCBH prior to their IPU admission 3. As of March 2021, the target population will be expanded to include individuals hospitalized at other facilities, with the focus being on 30-day readmissions.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested 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): The MHP will provide an intensive case management program (ICMP) to beneficiaries who are hospitalized at an in-patient unit (IPU), who had a prior IPU discharge within 30 days of their IPU admission and are enrolled in VCBH services prior to their IPU admission. The intent is to improve provision of specific, targeted follow-up care.

PIP Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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): Application of an intensive case management intervention strategy that targets individuals with 30-day readmission events.

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
7-Day readmission rate for Vista Del Mar (Adults Only)	FY 2019-20	9%	July-September 2020	13%	☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
30-Day readmission rate for Vista Del Mar (Adults Only)	FY 2019-20	25%	n/a	n/a	☐ Yes ☒ No	☐ Yes ☐ No p-value:

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
						☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Intensive Case Management Program (ICMP) penetration rate	n/a	n/a	July-September 2020	9%	☐ Yes ☒ No No planning data pre-existed intervention for this aspect.	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Intensive Case Management Program (ICMP) enrollment rate	n/a	n/a	July-September 2020	68%	☐ Yes ☒ No No planning data pre-existed intervention for this aspect	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☐ No test of statistical significance	
Intensive Case Management Program (ICMP) success rate	FY 2019-20	57%	July-September 2020	71%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
ICMP Re-Hospitalized Cases – Percent with follow-up in 7 days	FY 2019-20	52%	July-September 2020	100%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
ICMP Not Re-Hospitalized Cases – Percent	FY 2019-20	75%	July-September 2020	85%	☒ Yes ☐ No	☐ Yes ☐ No p-value:

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
with follow-up in 7 days						☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
ICMP Re-Hospitalized Cases – Percent with follow-up in 30 days	FY 2019-20	96%	July-September 2020	100%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
ICMP Not Re-Hospitalized Cases – Percent with follow-up in 30 days	7/1/2020-12/31/2020	89%	July-September 2020	100%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☒ No test of statistical significance	
ICMP Re-Hospitalized Cases – Average days to first follow-up appointment	FY 2019-20	10.00	July-September 2020	1.75	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
ICMP Not Re-Hospitalized Cases – Average days to first follow-up appointment	7/1/2020-12/31/2020	14.00	July-September 2020	3.71	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
ICMP Re-Hospitalized Cases – Encounters per week (30 days	FY 2019-20	0.80	July-September 2020	2.21	☐ Yes ☒ No	☐ Yes ☐ No p-value:

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
post-discharge or until readmit)						☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
ICMP Not Re-Hospitalized Cases – Encounters per week (30 days post-discharge)	FY 2019-20	2.04	July-September 2020	2.73	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	

Was the PIP validated?	☒ Yes	☐ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☒ First remeasurement	
☐ Second remeasurement	

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ Other, completed in n/a months prior to the current EQR	Completed					
☐ PIP submitted for approval	Concept only, Not Yet Active					
☐ Planning phase						
☐ Other, inactive	Inactive, Developed in a Prior Year					
Validation rating:						

☐ High confidence[5]

☐ Moderate confidence[6]

☒ Low confidence[7]

☐ No confidence[8]

Justification for validation rating:

The validation rating of this PIP was determined as low confidence at this time. The interventions and time to follow-up all reflect positive changes, but the key 7- and 30-day readmission rates have increased (worsened) between baseline and application of Phase 1 interventions.

The phase 2 (March and Summer 2021) addition of dedicated staff may improve results; but the data currently suggests that some evaluation regarding the optimal types and frequency of service provided should occur to determine exactly what intervention or combination of interventions will produce significant results. It currently appears that more timely follow-up post-discharge may not in itself be a sufficient strategy.

The low confidence rating speaks more to the lack of results, than to the selection of interventions which appear logical and would seem to target the problem.

"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

[5] Credible, reliable, and valid methods for the PIP were documented.

[6] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.

[7] Errors in logic were noted or contradictory information was presented or interpreted erroneously.

[8] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • Provide greater detail as to the specific activities and methods related to ICM, such as how services are delivered and what is being done. • Develop the package of specific services and frequency which achieves the best outcomes. • Include individuals who meet admission criteria who are not currently open to VCBH, so long as they diagnostically meet criteria for services and are local residents.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Emails and multiple telephone/video sessions to discuss this PIP and the relevant recommendations.						

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Ventura
PIP Title	Enhanced Access Performance Improvement Project
PIP Aim Statement	"Would the PIP interventions in the Santa Paula Adult and Youth & Family clinics, North Oxnard Adult Clinic, and South Oxnard Youth & Family Clinic increase the percentage of consumers receiving a first offered appointment and first face to face Medi-Cal service to meet the state's standard of 70% receiving such services within 10-business days, consequently increasing penetration rates?" (For the current review the focus is exclusively upon the North and South Oxnard clinic intervention applications.)
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	Ventura
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The target population of this study were originally the youth and adult residents of the Santa Paula region. According to the Latino Equity 3-Year Plan published by the Office of Health Equity (OHE), there is a growing Hispanic/Latino population in Ventura County. Similar to Santa Paula, Oxnard's population is predominantly Hispanic; 73.7 percent of North and South Oxnard's population are Latino. More specifically, 68 percent of the North Oxnard consumers and 63 percent of the South Oxnard consumers who requested a service during July 1, 2018 to July 31, 2019 were Hispanic. Only 41 percent of North Oxnard consumers and 41 percent of South Oxnard consumers received a first face to face Medi-Cal service within 10-business days.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a

PIP Interventions (Changes tested in the PIP)
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): Over the duration of this PIP, different interventions were applied to each of the targeted area to address specific clinic and local needs. The last year focused exclusively on the Oxnard area. North Oxnard: The MHP implemented an adult group orientation model. Beneficiaries are offered a group orientation, which expedited their assessments since the group orientation is offered twice a week in the North Oxnard Adult clinic. Enabled walk-in request for services in the North Oxnard Adult clinic. South Oxnard: The MHP embedded a full-time Screening, Triage, Assessment & Referral (STAR) clinician in the South Oxnard Youth and Family clinic to triage walk-ins, perform assessments, consult with team, and serve as a liaison for the community. Also trained additional clinical staff on RFS process to serve as a back up to the STAR clinician.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
North Oxnard Adults **Walk-In request for service**	**FY 2018-19**	**131 of 733** **18%**	**FY 2019-20**	**120 of 698** **17%**	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☒ No test of statistical significance	
North Oxnard Adults phone request for service	FY 2018-19	236 of 733 32%	FY 2019-20	289 of 698 41%	☒ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
South Oxnard walk-in request for service	FY 2018-19	121 of 618 20%	FY 2019-20 ☐ n/a	87 of 589 15%	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
South Oxnard phone request for service	FY 2018-19	84 of 618 14%	FY 2019-20 ☐ n/a	107 of 589 18%	☒ Yes ☐ No	☐ Yes ☒ No p-value:

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
						☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Time to Service for North Oxnard Adult consumers making an RFS: First Face to Face Medi-Cal Service within 10 business days	**7/1/2018 – 6/30/2019**	**29%** **124 out of 430**	**7/1/2019 – 6/30/2020**	**68%** **297 out of 436**	☒ Yes ☐ No	☒ Yes ☐ No Significant increase (Wilcoxon Signed-Rank test p-values <0.001) in the number of consumers receiving a first offered and first kept Medi-Cal appointment
					☐ No test of statistical significance	
		33%		**56%**	☒ Yes	☒ Yes

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Time to Service for South Oxnard Youth consumers making an RFS: First Face to Face Medi-Cal Service within 10 business days	**7/1/2018 – 6/30/2019**	**148 out of 446**	**7/1/2019 – 6/30/2020**	**230 out of 411**	☐ No	☐ No Significant increase (Wilcoxon Signed-Rank test p-values <0.001) in the number of consumers receiving a first offered and first kept Medi-Cal appointment):
					☐ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	

<table>
<tr><th>Performance Measures</th><th>Baseline Year</th><th>Baseline Sample Size and Rate</th><th>Most Recent Remeasurement Year</th><th>Most Recent Remeasurement Sample Size and Rate (if applicable)</th><th>Demonstrated Performance Improvement</th><th>Statistically Significant Change in Performance</th></tr>
<tr><td colspan="4">☒ Other, completed in 5 months prior to the current EQR</td><td colspan="3">Completed</td></tr>
<tr><td colspan="4">☐ PIP submitted for approval</td><td colspan="3" rowspan="2">Concept only, Not Yet Active</td></tr>
<tr><td colspan="4">☐ Planning phase</td></tr>
<tr><td colspan="4">☐ Other, inactive</td><td colspan="3">Inactive, Developed in a Prior Year</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7">Validation rating:</td></tr>
<tr><td colspan="7">☐ High confidence[5]
☒ Moderate confidence[6]
☐ Low confidence[7]
☐ No confidence[8]

Justification for validation rating: The key element of this PIP was to improve time of initial access at locations that had lower usage by the predominant Latino/Hispanic local population. In this last phase of improving timeliness, the MHP significantly increased the percentage of appointments that occurred within the 10-business day standard, with North Oxnard moving from 29 to 68 percent, and South Oxnard improving from 33 to 56 percent. This was a complex, multi-year PIP that attempted to provide tailored interventions that were appropriate and fitting to each unique region of the county and clinic environment.

“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.</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7">EQRO recommendations for improvement of PIP:
• n/a – PIP has ended.</td></tr>
<tr><td colspan="7">The TA provided to the MHP by CalEQRO consisted of:
• TA focus was on the development of a replacement PIP that intends to provide treatment outcome information to beneficiaries in a way that better engages them in treatment.</td></tr>
</table>

INFORMATION SYSTEMS REVIEW

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

Key ISCA Information Provided by the MHP

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

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Ventura	3.64%	1.90%	4.75%	4.32%
Large MHP Group	n/a	2.81%	2.59%	2.88%
Statewide	n/a	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

☐ Under MHP control
☐ Allocated to or managed by another county department
☒ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☐ Yes	☒ No
If the BCP status is “No,” the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☒ Yes	☐ No
If the BCP status is “Yes,” it is tested at least annually.	☐ Yes	☐ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☐ Yes	☒ No
If no one within the MHP is identified as having responsibility for information security, the parent agency or county IT assume responsibility and control of information security.	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☐ Yes	☒ No

- The MHP has not yet completed the certification process for Medicare Part B claims, which directly impacts the number of Medi-Cal claims denied due to failure to bill “Medicare or Other Health Coverage.”

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	66.3%
Contract providers	34.5%
Network providers	0.2%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	12	2	0	2
2019-20	3	0	0	0
2018-19	3	0	0	0

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	10	0	0	1
2019-20	4	0	1	0
2018-19	5	1	0	0

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

- The 12 IT employees serve both the MHP and DMC-ODS.
- The 10 data analytic employees serve both the MHP and DMC-ODS.

- The higher numbers for IT staff and data analytic staff for FY 2020-21 reflect a different understanding of EQRO reporting criteria and not a sudden large increase in resources.
- The MHP has added a Behavioral Health Manager position to oversee the EHR Team; hiring pending.
- The MHP has added another position, for which they are currently recruiting, to lead EHR-related integration efforts, including the implementation of Netsmart's CareManager module.
- The MHP has added two Senior Program Administrators to the Quality Improvement team to support growing data needs.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by the MHP and does not account for users' log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	156	41	197
Clinical Healthcare Professional	421	83	504
Clinical Peer Specialist	0	74	74
Quality Improvement	22	5	27
Total	599	203	802

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Large MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	12	37.85
Total EHR Users Supported by IT (Source: Table 17)	802	2084.00
Ratio of IT Staff to EHR Users	1:67	1:55

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☐ Yes	☒ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☐ Yes	☒ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☒	☐	☐
Screen workflow and navigation	☐	☒	☐	☐

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	63
Number of county-operated telehealth sites	37
Number of contract providers' telehealth sites	33
Total number of beneficiaries served via telehealth during the last 12 months	2592
• Adults	1,633
• Children/Youth	848
• Older Adults	111
Total number of telehealth encounters (services) provided during the last 12 months:	16,898

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

- ☒ Hiring healthcare professional staff locally is difficult
- ☒ For linguistic capacity or expansion
- ☒ To serve outlying areas within the county
- ☒ To serve beneficiaries temporarily residing outside the county
- ☒ To serve special populations (i.e., children/youth or older adult)
- ☒ To reduce travel time for healthcare professional staff
- ☒ To reduce travel time for beneficiaries
- ☒ To support NA time and distance standards
- ☒ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- In the previous year ISCA, the MHP reported delivering 2400 telehealth sessions at six MHP directly operated sites and five CBO sites. The current year ISCA reported 16,898 telehealth services at 37 MHP directly operated sites and 33 CBO sites. That is a very rapid expansion of the use of telehealth driven by the need for staff to work remotely under COVID-19 protocols.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☐	Russian	☒	Spanish	☐	Tagalog
☐	Vietnamese	☐	n/a		

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Aspiranet	4
Casa Pacifica Centers for Children and Families	5
Interface Children and Family Services	2
Kids and Families Together	2
New Dawn Counseling and Consulting, Inc.	1
Seneca Family of Agencies	2
ASC Treatment Group – Bakersfield	1
ASC Treatment Group – Los Angeles	1
Golden Ventura CRT, LLC-CRT	1
Golden State Health Centers, Inc. – Hillmont House MHRC	1
Pathpoint – Social Rehabilitation	1
Telecare Corporation	4
Turning Point Foundation – Social Rehabilitation	2
Dennis M. Giroux & Associates	1

Current MHP Operations

- The MHP continues to operate with a medical record which is a combination of electronic information and paper documents.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SD/MC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
myAVATAR	Practice Management	Netsmart	11	Netsmart
myAVATAR	Clinical Workstation	Netsmart	7	Netsmart
myAVATAR/ OrderConnect	Medication and Laboratory Orders	Netsmart	7	Netsmart

Major Changes since Prior Year

- Logrando Bienestar Outreach Tracking System
- Homeless Client Status Tracking System
- MH Discharge Summary Services
- MH Treatment Plan Re-Design (in-process)
- DHCS NACT Data Collection and Reporting

The MHP's Priorities for the Coming Year

- Client Portal Implementation
- MH Scheduling Implementation
- Population Health Services Implementation

- DHCS CSI Data Correction Plan of Correction

Other Areas for Improvement

- The MHP does not use the X.12 270/271 eligibility transaction pair.
- ISCA A.18.3 indicates the MHP intends to implement Netsmart's CareManager to facilitate efficient data exchange with contract providers, primary care providers, and other business partners. They are in the process of recruiting to fill a new position to lead this effort.

Plans for Information Systems Change

- The MHP has no plans to replace the current system (in place more than five years).

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Netsmart/ myAvatar	☒	☐	☐	☐
Assessments	Netsmart/ myAvatar	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/Storage	Netsmart/ myAvatar	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Netsmart/ myAvatar	☒	☐	☐	☐
Laboratory results (eLab)	Netsmart/	☒	☐	☐	☐
Level of Care/Level of Service	myAvatar	☒	☐	☐	☐
Outcomes	Netsmart/	☒	☐	☐	☐
Prescriptions (eRx)	myAvatar	☒	☐	☐	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Progress Notes	Netsmart/	☒	☐	☐	☐
Referral Management	myAvatar	☐	☐	☒	☐
Treatment Plans	Netsmart/	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		10	0	2	0
FY 2019-20 Summary Totals for EHR Functionality:		10	0	2	0
FY 2018-19 Summary Totals for EHR Functionality:		10	0	2	0

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

- The myAvatar modules and functionality remained static over the past three EQRO reviews. Care Coordination and Referrals functionality remain unimplemented.
- The MHP continues to maintain paper charts for medical consent forms, release of information, and hospital release documents.
- Implementation of the scheduling functionality continues as an active project.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

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

The rest of this section is applicable: ☒ Yes ☐ No

Some contract providers have EHR systems, which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP

EHR Vendor	Product	Count of Providers Supported
Netsmart	AVATAR	7
Netsmart	TIER	1
Seneca	In-house developed system	1

Personal Health Record

The beneficiaries have online access to their health records through a personal health record (PHR) feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☐ Yes ☒ No ☐ Implementation Phase

Expected implementation timeline:

☐ Already in place	☐ Within 6 months
☒ Within the next year	☐ Within the next two years
☐ Longer than 2 years	☐ n/a

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☐ Yes	☒ No

PHR Functionality	Status	
Have ability to both send/receive secure text messages with provider team.	☒ Yes	☐ No

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☐ Web-based application, including the MHP EHR system, supported by vendor or ASP staff
- ☐ Web-based application, supported by MHP or DMC staff
- ☒ Local SQL database, supported by MHP/Health/County staff
- ☒ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

Table 29 summarizes the MHP's SD/MC claims.

Table 29: Summary of CY 2019 SD/MC Claims

Ventura MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**349,768**	**$127,979,765**	**14,401**	**$7,523,365**	**5.55%**	**$120,456,400**	**$71,853,111**
JAN19	30,361	$11,007,039	1,120	$554,798	4.80%	$10,452,241	$6,336,805
FEB19	29,098	$10,506,632	1,010	$479,671	4.37%	$10,026,961	$6,011,573
MAR19	31,779	$10,582,936	1,199	$436,832	3.96%	$10,146,104	$6,408,379
APR19	32,553	$11,907,455	1,524	$924,798	7.21%	$10,982,657	$6,591,984
MAY19	32,735	$13,278,819	1,345	$1,011,623	7.08%	$12,267,196	$7,037,507
JUN19	27,009	$11,289,238	911	$647,481	5.42%	$10,641,757	$5,972,741
JUL19	27,649	$7,546,534	1,043	$328,825	4.18%	$7,217,709	$5,244,916
AUG19	25,363	$10,779,728	817	$664,843	5.81%	$10,114,885	$5,561,060
SEP19	30,038	$11,715,569	1,826	$868,894	6.90%	$10,846,675	$5,988,599
OCT19	31,101	$11,888,257	1,471	$699,300	5.56%	$11,188,957	$6,330,298
NOV19	26,008	$10,470,505	1,059	$607,681	5.49%	$9,862,824	$5,487,914
DEC19	26,074	$7,007,053	1,076	$298,619	4.09%	$6,708,434	$4,881,335

The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments from Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Ventura MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Beneficiary not eligible.	1,426	$2,555,720	34%
Medicare or Other Health Coverage must be billed before submission of claim.	7,304	$1,808,551	24%
Beneficiary not eligible or non-covered charges.	628	$1,659,840	22%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	2,322	$837,903	11%
Service line is a duplicate and a repeat service procedure code modifier not present.	1,751	$296,739	4%
Total	14,401	$7,523,365	NA

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

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

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For VCBH, the time and distance requirements are 60 minutes and 30 miles for mental health services, and 60 minutes and 30 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted no key informant interviews during the review process due to COVID-19 protocols, and MHP lack of resources to support beneficiary focus groups and staff reassignments to public health emergency roles.

Findings

There were two zip codes with an approved AAS in Ventura County. These zip codes (93225, 93252) are in the northeastern area of the county and straddle Ventura and Kern counties. These areas are far from urban centers and did not meet time or distance standards for mental health or psychiatry services for youth and adults. The other zip codes for the MHP for youth and adult mental health services or psychiatry services met time and distance standards as required by DHCS.

The two adjoining zip code areas contained a total of 31 Medi-Cal beneficiaries during the December 2019 to the end of February 2020 NACT review period. No requests for SMHS services have been received from these areas.

On October 7, 2020, DHCS notified the MHP of its approval of the Alternative Access Standard (AAS) using telehealth services to meet the need for adult and child psychiatry services in zip codes 93225 and 93252.

If in-person services are requested and/or deemed necessary, VCBH has received written commitment from Clinica Sierra Vista and College Community Services, two agencies that provide contracted SMHS for Kern County Behavioral Health and Recovery Services in the 93225 and 93255 zip codes. These providers expressed willingness to establish single case agreements to provide SMHS to Ventura County Medi-Cal beneficiaries living in those zip code areas should the need arise.

If Medi-Cal eligible beneficiaries living in the Ventura County sections of the 93255 and/or 93252 zip code areas are not willing to receive services via Telehealth, and if for whatever reasons VCBH is unable to establish a single case agreement with any of the above out-of-network providers, VCBH would make arrangements to transport the beneficiary to the closest in-network provider site to receive appropriate outpatient/psychiatric SMHS.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

Not Applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider’s NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP’s NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider’s NPI, Type 1 number.

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	0
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	5
NPI Type 1 number reported is associated with two or more providers	1
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	1
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	6

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO was not able to conduct the customary 90-minute consumer-family member focus groups during the desk review of the MHP. The CalEQRO focus groups with 10 to 12 participants each could not be conducted due to impact of COVID-19.

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

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 32 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 32: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	12
VCBH's overall penetration rates increased over the past three reviews (CY 2017-2019), with the most recent statistic (4.64 percent) greater than the statewide large MHP average. A similar pattern exists for the Latino/Hispanic penetration rates. With FC penetration rates, the MHP has exceeded both the overall statewide average and the large MHP average penetration rates for the CY 2017 through CY 2019 periods. The most recent MHP data (CY 2019) has FC more than 10 percentage points above the statewide average. Regarding the MHP's efforts to provide information about services, the VCBH website underwent significant changes and updates since the previous review. Key service access phone numbers are prominently placed. Essentially, all service-related information is made first and foremost accessible, including a Google Map supported identification of regional programs including adult and children's mental health and substance use programs. Ancillary information is located under the About Us tab, including quality management, cultural competence, news and updates, and more. Click-through to dial phone technology is not integrated, but the overall functionality			

Component	Maximum Possible	MHP Score
and ease of use is much improved. A prominent button translates all content into Spanish. The VCBH website has a sister site called Wellness Every Day, which provides practical information about achieving and sustaining wellness, with prominent tips related to responding to the effects of COVID-19 (https://www.wellnesseveryday.org/). The provider directory was updated January 2021. The directory contains information regarding no-cost interpreter services should a bilingual clinician not be available, and transportation options. Transportation assistance is not prominently mentioned in other locations. The MHP plans to add a search feature, breadcrumbs, and a roadmap to services in the future. The COVID-19 public health emergency and related shift to telehealth resulted in front office practice changes that emphasize connections with new beneficiaries. Office assistants now call new beneficiaries at the time of their appointment in order to obtain essential episode opening information and complete the financial agreement. In the event the beneficiary does not respond to the call, reminders are placed within the system for the incomplete items. These administrative process changes have also improved beneficiary continuity of care, reducing those events where timely follow-up may have not occurred in the past. The STAR assessment program provides adults with countywide initial access services. To improve tracking of these requests for service (RFS) events, a STAR Action tab was added for to-do items, which includes follow-up items, needed contact with third parties, and alert messages to close cases. This provides a focused platform for status information about all pending intakes without the need to individually review progress notes. The MHP was required to develop an alternate access standard (AAS) for two zip codes that are in a remote area of the northeastern Ventura county border with Kern county. The MHP's AAS plan was approved by DHCS, utilizing a combination of telehealth and Kern County contract resources that provide services in this area, with an option of providing transportation to the nearest VCBH clinic if necessary. The MHP's monitoring of its access line currently consists of test calls that are reviewed, with results used for training. Data on rings to pick-up, dropped calls, and other objective metrics were not reported for this review. This type of monitoring is, however, performed with the substance use disorder treatment call center data. COVID-19 has not proven an obstacle to FC dependency children and youth services. More than 300 child and family team (CFT) Zoom meetings have occurred since the start of the pandemic. The Children's Accelerated Access To Treatment (CAATS) Mental Health Services Act (MHSA) Innovations program modeled a 5-5-5 program, that called for a mental health referral made within five days of a dependency hearing; which was followed by assessment completion within another five days; and mental		

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td colspan="4">health services starting within five days of the assessment. Although the innovations funding has ended, this practice continues.
The most recent FC data indicates Ventura has a 61.75 percent penetration rate, compared to the statewide 51.91 percent overall. This reflects the universal access approach that originated with the Innovations MHSA program.</td></tr>
<tr><td>1B</td><td>Capacity Management</td><td>10</td><td>7</td></tr>
<tr><td colspan="4">Through the lens of the Cultural Competence Plan (CCP), VCBH tracks the cultural and ethnic needs of its Medi-Cal eligibles. Over time, several PIPs have targeted the needs of Latino/Hispanic population, with a strong focus on the Spanish language preferred individuals. This has included providing service documents such as treatment plans in Spanish, and the ability to track and report the language of each service. Over the last several years a non-clinical PIP focused on improving engagement with services by the Latino/Hispanic population. This PIP included clinic focused efforts to reduce barriers to access and outreach to farm workers and others who did not routinely access health care.
Monitoring of system demand, such as caseloads by provider type and location, appears to occur with a clinic or program focus. The MHP has closely tracked capacity of Spanish-speaking psychiatry for many years. The MHP continues to experience ongoing challenges in the recruitment and retention of psychiatry and psychiatric nurse practitioners. This past year, newly recruited bilingual psychiatry was lost before starting work, and the loss of current capacity is anticipated. It may be appropriate to seek out-of-area and out-of-state telehealth providers to fill this need</td></tr>
<tr><td>1C</td><td>Integration and Collaboration</td><td>24</td><td>21</td></tr>
<tr><td colspan="4">VCBH has been on a multi-year expansion of local services needed by beneficiaries. The long history in this area includes the co-location of outpatient mental health services with county primary care clinics in Oxnard and the Conejo area. The replacement plans for the Santa Paula county hospital will in the long-term also support colocation of behavioral health clinics at the new county hospital site, accompanied by medical outpatient clinics.
The MHP has collaborated with local hospitals and their emergency departments (ED) to develop alternatives to long ED stays of psychiatric patients awaiting acute beds. This has resulted in the commitment to create an eight-chair crisis stabilization unit (CSU) by July 2021. Dignity Health, the primary partner and operator of St. John’s and Pleasant Valley Hospitals, has contracted with Aurora Vista Del Mar to be the treatment provider. This partnership should relieve some of the pressure upon emergency departments and improve time to treatment for those with acute psychiatric treatment needs.</td></tr>
</table>

Component	Maximum Possible	MHP Score
In another partnership, the MHP is working with Alvarado Parkway Institute to open a crisis residential treatment program in Santa Paula in the fall of 2021. This 15-bed facility will take both voluntary referrals from VCBH and accept those who are discharged from inpatient stays and would benefit from a longer stabilization period. Referrals also may come from the CSU, where stays are limited to 23 hours. The MHP has started planning that focused on the development of a 120-bed locked mental health rehabilitation center within the county. Early consideration was given to creation of various levels of programming, including an intensive treatment unit, a behavior unit, a general recovery unit, a medical support unit, and a step-down unit. The concept includes a home-like and client-centered design ethos. These are but a few of the collaborative projects VCBH is involved with to improve capacity and services for those with mental health treatment needs		

Timeliness of Services

As shown in Table 33, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 33: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	14
VCBH conforms to the mandated 10-business day standard. All tracked subgroups meet this standard, with the longest average first offered interval for children and youth at 8.59 days, which also has the lowest achievement of standard at 71 percent. The MHP was operating a multi-year PIP targeting improvements to initial access which ended in July 2020. Adjustments to practice occurred in response to the pandemic, with support staff making early calls to obtain necessary information and remind beneficiaries of their appointments. Processes were developed that aided tracking completion of necessary steps. This reduced the number of instances in which timely follow-up to missed appointments did not occur.			
2B	First Offered Psychiatry Appointment	12	10

Component		Maximum Possible	MHP Score
The MHP conforms to the 15-business day standard, with the data for all measured subgroups experiencing averages less than permitted (better) by standard. Children and youth experience the longest wait period, with a 9.58 business day average (mean). Achievement of standard is below 75 percent for children and youth (62 percent) and foster care (FC) (67 percent). The MHP should consider identification and resolution of the barriers in this area.			
2C	Timely Appointments for Urgent Conditions	18	15
The MHP adheres to the 48-hour non-preauthorized urgent care standard, with adult services (N=4) a 6-hour average as the longest time to service. No qualifying FC events were reported, and children and youth reported only two events. The MHP states 100 percent of all events meet the 48-hour timeliness standard. The MHP does not provide any services that require pre-authorization with a 96-hour timeliness requirement. With a total of only six urgent events reported for the FY 2019-20 period, the MHP needs to explore if further training of staff needs to occur in order to improve identification of urgent service requests. There may exist barriers to appropriate identification. The MHP provided additional information about recent changes to urgent services that indicated daily urgent slots were created for the crisis team. Previously there were two slots each week that were not regularly used due to staff lacking awareness of these options or the time was inconvenient for beneficiaries. Currently, these slots are used more for routine appointments, which improves access time, and improves chances of connecting with beneficiaries.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	9
Two relevant sources of data exist for follow-up appointments after hospitalization. The first is the MHP assessment of timely access (MATA), a CalEQRO supplied document into which the MHP populates their system data from FY 2019-20 on a variety of timeliness indicators. The second element is the performance measure section of this report and figures 9 and 10, which provide the results of a DHCS data download and analysis by CalEQRO. These figures represent CY 2018 and CY 2019 VCBH and statewide post-hospital follow-up data and rehospitalization rates. Within the MATA, the MHP reported FY 2019-20 data for all follow-up appointments post-hospital discharge for all hospitals utilized for psychiatric inpatient care. The HEDIS 7-day standard is followed. FC (7 events) met the 7-day standard with a 2.14-day average (mean), while the adult average was three times standard (21.08 days), and children were approaching twice standard (12.93 days).			

Component		Maximum Possible	MHP Score
CalEQRO's DHCS data analysis reported the overall 7-day follow-up rates for VCBH were: CY 2018, 57 percent and CY 2019, 58 percent. Additional 30-day follow-up data indicated for VCBH CY 2018 was at 70 percent, and CY 2019 at 71 percent follow-up. Both elements were slightly better than the statewide averages during the cited periods. However, when viewed by age of treatment population, the MATA self-reporting seems to indicate local follow-up challenges for the post-hospital discharge timeliness for children and youth (12.93 day mean), but particularly for adults (21.08 day mean).			
2E	Psychiatric Inpatient Rehospitalizations	6	6
Psychiatric inpatient rehospitalization data was also obtained from two sources, as described above. The MATA self-assessment by the MHP, and Figures 9 and 10 that are listed earlier is this report and furnish the most recent information but lack the comparison of other large MHPs. MATA data presents 30-day rehospitalization information by age groups and FC for the FY 2019-20 period. The adult 30-day readmission rate was 20 percent, children were 18 percent, and FC did not provide useful information. The performance measure data section of this report presents 7- and 30-day aggregate readmission rates for CY 2018 and CY 2019, and furnished comparisons with the statewide average. The MHP 7-day readmission rate improved (decreased) from 23 percent in CY 2018 to 20 percent in CY 2019. The statewide average for both periods remained flat at 12 percent. The MHP 30-day readmission rate improved (decreased) from 30 percent in CY 2018 to 25 percent in CY 2019. The statewide average remained flat across both periods, at 19 percent. Both metrics indicate higher readmission rates for VCBH versus the statewide average, but VCBH also showed improved results in CY 2019. The MHP is utilizing 30-day readmission rates as a metric for a recently developed PIP which is intended to provide better aftercare for individuals with 30-day readmissions. The MHP reports out on this and other timeliness data annually, or when required by the demands of a project, which is occurring in this case with a PIP.			
2F	Tracks and Trends No-Shows	10	9
The MHP tracks no-shows for the entire system. A 5 percent no-show standard applies to both prescribers (psychiatry/psychiatric nurse practitioner and non-medical clinicians. Psychiatry no-show results were: adults, 11 percent; children, 8 percent; and FC, 9 percent. Clinical staff no-shows were: adults, 7 percent; children, 9 percent; FC 11 percent.			

Component	Maximum Possible	MHP Score
These no-show percentages are relatively low, and not likely indicative of a need for deeper exploration. The MHP reports that this data is produced annually, unless needed for a specific project.		

Quality of Care

In Table 34, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 34: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	10
The MHP provided the 2018 through 2021 three-year CCP. The plan presents aspects of cultural competence that include a focus on training, work force development, outreach and engagement, and development of specialized programs. The plan includes a roadmap for the participation of key organizations that represent a number of community advocates, including Mixteco beneficiaries. The CCP data timeline for penetration rates is based on CY 2016 numbers and would benefit from update and further analysis. EQRO provides penetration rates through CY 2019. The CCP includes training data through May 2019. A greater focus on video trainings was beneficial during this past year of COVID-19 changes. In regard to concurrent tracking of timeliness by cultural groups, the MHP developed a request for service report for Logrando Bienestar and Hispanic/Latino access timeliness which helps to inform efforts to serve this important population. The MHP engaged in an effort to improve collection of gender identity and sexual orientation and gender identity (SOGI), among other variables, during the initial intake process. The MHP is exploring best practice reporting options for demographics, including SOGI data, and awaits state guidance as DHCS finalizes the approach to collection of SOGI information. As previously mentioned, past PIPs have focused on meeting the linguistic needs of Spanish speakers and improving access for the Latino/Hispanic community. The MHP was in the process of updating its CCP during the time of this current review.			

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>3B</td><td>Beneficiary Needs are Matched to the Continuum of Care</td><td>12</td><td>11</td></tr>
<tr><td colspan="4">At the clinical team level within both adult and Y&F systems of care, the MHP has a process for individual beneficiary review of needs. At the intensive service need level, there is an adult weekly meeting with the county inpatient team to discuss both high utilizers and complex cases. This meeting includes participants from numerous high-level programs including crisis residential treatment (CRT), Horizon View (mental health rehabilitation facility (MHRC)), and others. Discussion and case planning occurs that also incorporates participation of the public guardian's representative where this is relevant with conservatees. The MHP is also seeking board of supervisors' approval to implement the Welfare & Institutions Code (WIC) 5270, which provides a 30-day involuntary treatment stay and could avert some of the rehospitalizations and multiple crisis events through a longer stabilization stay. This option would also likely reduce requests for temporary conservatorship.

Within the Y&F system, a twice monthly Interagency Case Management Committee (ICMC) meeting occurs in which high risk youth who are frequent CSU, short-term residential treatment program (STRTP), or inpatient utilizers. The Y&F system also utilizes the child and family team meetings (CFTM) to review dependency youth who have complex needs and cross-system involvement which requires regular and intensive coordination. Driven by need, some receive monthly reviews.</td></tr>
<tr><td>3C</td><td>Quality Improvement Plan</td><td>10</td><td>7</td></tr>
<tr><td colspan="4">The MHP provided a Quality Assessment and Performance Improvement (QAPI) work plan for this review, which Included evaluation of the prior year's results, and also contained metrics and targets for both MHP and DMC-ODS areas. The QAPI plan does contain numerous quantifiable metrics, particularly those related to timeliness. The QAPI does not currently present data or goals for service disparities by population and site or region. There is an extensive evaluation of grievance patterns. The QAPI goals do not include retention, comparisons of service levels, and other indicators that reflect progress with disparities.

The MHP was required to defer some work plan goals for FY 2019-20 to FY 2020-21 due to the impact of COVID-19. The demands of adapting services to the COVID-19 limitations considering the various regions and populations served by the MHP was a significant draw upon the MHP's quality resources.</td></tr>
<tr><td>3D</td><td>Quality Management Structure</td><td>14</td><td>11</td></tr>
<tr><td colspan="4">The QMAC is the MHP's equivalent of a quality improvement committee. QMAC has very low attendance of contract providers and also of beneficiaries and family members. The QMAC minutes did not reflect regular and recurring review of timeliness and other metrics. This review acknowledges that many of the QAPI</td></tr>
</table>

Component		Maximum Possible	MHP Score
meetings were conducted by Zoom due to COVID-19, which may have had an impact on the nature and scope of QIC meetings. Minutes reflect useful input from QMAC meeting attendees, such as concerns about how safe front office staff feel around beneficiaries, and ideas how to improve so not to impact the treatment experience. Other QMAC input include decorating clinics to be in alignment with the cultures of the beneficiaries. From the recent QMAC meetings reviewed it was not evident where routine data on timeliness tracking and other key metrics are reviewed, and how QAPI metrics are regularly shared throughout the department and with key stakeholders. In relation to FC children and youth, VCBH collaborated with the Human Services Agency and Probation Department to participate (one of seven counties) in the CANS/CFTM Implementation pilot with the state. Participating agencies mapped current CANS/CFT to outline strengths, needs and gaps in Ventura County. On a monthly basis, data trends and bi-annual executive summary of services is completed by the VCBH QI/QA team. In the past year, QI positions have been added to improve the capacity of VCBH's quality efforts.			
3E	QM Reports Act as a Change Agent in the System	10	8
VCBH produces comprehensive outcome reports periodically. Historically, the Ventura County Outcomes System (VCOS) incorporated aspects of a number of other reports. Examples of reports produced includes the caseload report with acuity, that presents summary MORS score and narrative diagnosis. A comprehensive review of the Logrando Bienestar program was provided for this review, which contains a large number of reporting elements that support better understanding of that program's impact. This MHP serves a significant Latino/Hispanic population, and regular reports that breakout engagement by race/ethnicity/culture, retention, provides comparative service level data, would support continued understanding of progress in this important area. There are areas where this has occurred, such as breakout by language of service. It would be beneficial for the MHP to identify some key reports that would be useful to line staff, supervisors as well as leadership, that provide a regular window into the services delivered.			
3F	Medication Management	12	9
The MHP reports that the Medication Monitoring Workgroup (MMW) is a multi-disciplinary team which meets monthly to monitor the safe use of medications. This group develops policies and procedures, as well as provides training and feedback to practitioners and clinical oversight of safe medication practices.			

Component	Maximum Possible	MHP Score
The workgroup created a FY 2020-21 medication monitoring plan. The plan reflects activities that include review of outlier findings by the behavioral health pharmacist during the review of medications prescribed for FC dependents. Other activities include the development of practice guidelines, most recently focused upon a policy on the free distribution of naloxone inhalation supplies. The workgroup also developed the protocol for Controlled Substance Utilization Review and Evaluation System (CURES) reports that must be run, and as well the number of charts reviewed each quarter. The results of these reviews were provided for two periods, and included monitoring of benzodiazepine prescriptions. Other activities include clozapine monitoring, individual practitioner review of two cases annually, and monitoring of pharmacy dispensing to behavioral health beneficiaries. The scope of pharmacy review includes inappropriate refills and continuation of discontinued medications. The MMW recently determined that an independent substance use services medication workgroup should be created to focus specifically upon the needs of DMC-ODS waiver. The MHP provided a summary of the FC HEDIS measures related to SB 1291 monitoring that covered the 2019 through 2020 period. No issues surfaced from this review. The monitoring incorporates use of CURES for tracking stimulant usage. Work is in process to develop a mechanism for memorializing in the medical record that the SB 1291 review occurred. Cases that are outliers are reviewed on a quarterly basis to determine if additional follow-up is indicated.		

Beneficiary Progress/Outcomes

In Table 35, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 35: Beneficiary Progress/Outcomes Components

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>4A</td><td>Beneficiary Progress</td><td>16</td><td>14</td></tr>
<tr><td colspan="4">With the adult and older adult populations, VCBH adopted the MORS. The MHP is also in the final phase of development of a direct measurement of beneficiary outcomes through the use of tablets deployed to clinics that is part of a larger "client-centered" progress report. The tablet devices will be the platform for direct collection of the TPS in the adult division, via a 4-item random sample, which will enable more real time data gathering.
The MORS is administered at entry, annually and at exit from treatment.
For the children and youth population, the Child, Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35) are universally utilized, first at intake, at discharge, and every six months during the course of treatment. On an individual beneficiary level, the PSC-35 is used to inform the clinician about the caregiver's behavioral concerns. Since COVID-19 impacted practice, this information is now gathered by phone or Zoom from the caregiver.
With the exception of FC children and youth, aggregation of this data by program or systemwide was not evident during this review, which could provide indications of overall treatment success or challenges. The PSC-35 is undergoing development of an aggregate reporting process which enables use of summary results to inform practice.
With the exception of CANS and FC children and youth, regular sharing of this information with staff and stakeholders was not included in the submissions for this year.
With the FC population, the MHP has administered the Ventura County CANS to all court dependent youth since October 2018. The CANS data is entered and tracked within the MHP's EHR, and a series of CANS monitoring reports were created that follow CANS completion and beneficiary progress. The MHP is developing additional</td></tr>
</table>

Component		Maximum Possible	MHP Score
CANS narrative reports to guide treatment and provide aggregate data trends to clinics.			
4B	Beneficiary Perceptions	10	6
By the end of December 2021, VCBH will have a system of assessing and reporting beneficiary and family satisfaction to providers including annual satisfaction survey results, grievance, appeal and state fair hearing results. While this information is routinely collected by the MHP, there has not been a system for aggregating and communicating this information consistently to stakeholders. The Ventura County Outcomes System (VCOS) Perceptions of Care Survey was replaced in August 2019 by the TPS. In addition to this instrument, the MHP participates in the state-mandated Consumer Perception Survey (CPS) process, which is typically a twice per year collection event. For this current review, the MHP provided a report on the Spring and Fall 2019 CPS summary prepared in December 2020, which specifically identified key issue responses such as arrest and re-arrest for adult and older adults. This compared those with one year or less in treatment with those having more than one year. Analysis of survey summary results was provided. Survey return rates were presented with the increases or decreases mentioned. A similar process was used when reviewing children and youth data. The MHP's most recent triennial review indicated that while the MHP did collect the required outcome information, the systematic communication of the results to providers/programs was not evident. Informing other interested stakeholders would also be an important part of the communication process.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	10
Contract provider Turning Point operates on behalf of the MHP a wellness program in Oxnard, and delivers services in English, Spanish and Mixteco. It is usually open 9 am to 4 pm Monday through Saturday. Peer support is available 9 am to 8 pm. The website does not provide information about changes to programming in response to COVID-19 for this program, but other Turning Point programs detail session access via video and telephonic posted links. Peer staff are utilized in the operation of the Oxnard Wellness Center. Turning Point also operates the Growing Works program, a primarily wholesale horticulture program with some limited retail options. Located in Camarillo, Growing Works provides the opportunity for employment in a supportive environment.			

Structure and Operations

In Table 36, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 36: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	25
The MHP provides all DHCS contract specified services, with the exception of day treatment intensive and day rehabilitation. These two services are not included by many MHPs, so this is not unusual. Conversations about these services focus on a discussion of alternatives that meet beneficiary needs through a blend of other modalities. The MHP is looking to expand crisis residential and CSU services within the county in response to the frequent long waits that occur in acute hospital emergency departments. Dignity Health, operator of St. Johns and Pleasant Valley hospitals, is the MHP’s partner in the development of another adult CSU. In regards to the frequently mentioned needs of families to have not just a mobile crisis response available, but a program that can provide longer duration in-home services, VCBH is in the process of implementing AB 2043, the family urgent response system (FURS). This response process will be useful to child and youth beneficiaries and their families, and reducing out of home treatment episodes. For the adult system of care, the MHP started planning with a prospective partner to develop a 120-bed facility in Ventura county that will function as a MHRC) and will have a unique client-centered and homelike design. This facility will have a number of modules, each with a specific level of care as the focus – intensive treatment, behavior unit, recovery unit, a support unit and a step-down unit. In the spectrum of ages served, the MHP is also focused on older adults and the establishment of a residential care for the elderly (RCFE), to provide support to beneficiaries 60 and older operated by Turning Point. This program expands the support and services to the older adult population which has typically seen shelter and support beds declining. VCBH received a $2.4m grant from the Department of State Hospitals to develop and operate an interagency mental health diversion program for accused felons. The program will target 18 individuals who were at risk of requiring a competency restoration stay at a state hospital. This program complements an existing diversion program which has less restrictive criteria.			
5B	Network Enhancements	18	12
In the past, the MHP utilized the formal telehealth settings to augment locally difficult to hire psychiatry positions, redistribute linguistic psychiatry capacity, and to redistribute capacity when needed. Immediately prior to the pandemic, psychiatry			

Component		Maximum Possible	MHP Score
telehealth was not being recently utilized. But the PHE declaration, triggered development of a variety of telehealth services have been developed and delivered. These include psychiatry, psychotherapy, case management, and other services such as assessment. With the ongoing challenges experienced with retention of psychiatry and other prescribers, in particular bilingual and bicultural practitioners, commitment to the expansion of telehealth seems advisable. For many years VCBH clinics have been collocated with Health Care Agency ambulatory care clinics in the Conejo Valley (Thousand Oaks) and Oxnard. Plans are also in process to replace the Santa Paula county hospital and include space for VCBH adult and children and youth clinics collocated with the hospital and medical clinics to serve the Santa Clara Valley region. Whole person care is largely health department focus, with collaborative mental health services as indicated by the presentation of each individual.			
5C	Subcontracts/Contract Providers	16	12
Due to the nature of this desk review, direct contract agency input was not possible. The MHP's adult and children/youth systems of care reflect robust partnerships with many local and statewide programs that have subject matter expertise in specific treatment areas. This expertise is implemented to improve the services available to VCBH beneficiaries. Examples include Turning Point for adult services, and Casa Pacifica for children and youth. Telecare corporation also operates Horizon View, a sophisticated MHRC which is able to serve individuals with high level treatment needs within the county. The Rapid Integrated Support and Engagement (RISE) program is also operated by Turning Point and provides outreach to individuals who have mental health treatment needs. This includes individuals who are homeless and persons referred by family and others. Each contract agency receives a twice each year meeting arranged by the contracts team and involves the participation of operations and quality management staff as well. In addition, quality management now holds quarterly group meetings with all contractors to share information, address new or changing requirements, and furnish Avatar updates. Similar participants are involved in both quarterly meetings and the twice annual meetings.			
5D	Stakeholder Engagement	12	8
The MHP made an effort to improve representation of those with lived experience on the Behavioral Health Advisory Board (BHAB), with a special focus on adult beneficiaries interested in serving in this capacity. The MHP performed further analysis of the 2019 employee engagement survey during the FY 2019-20 period. This work resulted in three action items: 1) creation of a standing employee engagement section within the quarterly VCBH department			

Component		Maximum Possible	MHP Score
newsletter; 2) commitment to the development of a standardized onboarding process; and, 3) commitment to furnishing the reasons “why” policy or procedures have been added or changed. VCBH continued this process during CY 2020. As of the current review, the data was being analyzed and was not yet available for circulation. MHP leadership also conducted division-specific townhall meetings, with two rounds through the review period. Each townhall reportedly included 100-190 participants. In these forums, staff were able to ask questions directly or in writing. Any questions that could not be answered during the townhalls were later included in a frequently asked questions (FAQ) response that was circulated as follow-up. Due to the desk review process and lack of stakeholder review sessions it was not possible to obtain feedback as to the effectiveness of the MHP’s actions in this area.			
5E	Peer Employment	8	6
Based on current submissions and historic information, the MHP is expanding the use of lived-experience positions, utilizing their skills and experience in numerous areas, including the RISE program and others. The vision expressed in current submissions indicates plans for continued expansion in this area, with the inclusion of a peer support specialist training program. Current and future initiatives, where relevant, speak to the use of peers and others with lived experience to improve engagement and services. In addition to lived experience individuals working in the mental health field, the MHP’s partnership with Turning Point and the Growing Works wholesale nursery provides both skills training and employment for beneficiaries. Participants learn horticulture skills and participate in a production environment.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Ventura County MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- The MHP immediately initiated changes to department practices upon recognition of the COVID-19 public health emergency, which included equipment, training, policy changes, all intended to support continuation of access and services while decreasing risk of virus transmission.
- Website enhancements improved the navigation experience for beneficiaries and stakeholders. A referral section with related forms was created. A quality management page was added, but placed where it would not be disruptive to those initiating services. A search feature is under development, as are the addition of "bread-crumbs" and a "roadmap to services," and other user-friendly features.
- Overhauling of the utilization management process was initiated, including benchmarking with other MHPs, revisions undertaken in response to the Compliance Review report, and development of the Insights Dashboard. This includes addition of exit interviews for departing personnel, and a focus on education and training.

Strengths:

- Website changes have tailored the experience to the needs of individuals and families seeking treatment services.
- The MHP plans to add search, bread crumbs and other website enhancements.

Opportunities for Improvement:

- The MHP does not track objective call line metrics such as rings to pick-up, dropped calls, call volume, call duration, etc., which is performed on the DMC-ODS call line.
- The MHP experiences continued challenges with the hire and retention of Spanish-speaking bilingual psychiatry and other prescribers, with continuation of losses among existing staff.
- It is unclear if the MHP and Gold Coast Health Plan (GCHP) have resolved capacity issues related to treating beneficiaries with a mild-to-moderate level of mental health issues.

Timeliness of Services

Changes within the Past Year:

- As the MHP was ordered to work remotely as much as possible, STAR created an almost completely digital operational process to complete the beneficiary assessment. This process uses staff time and energy more efficiently and that increased STAR service capacity. The more efficient process has also reduced operational costs associated with paper, ink, and maintenance services for copiers and fax machines.
- The MHP offers daily after-hours urgent appointment slots with the Crisis Team (CT). This improves access time and engagement with the beneficiary.

Strengths:

- First offered clinical appointments for all subgroups fall within the 10-business day standard, with youth and family services the longest average at 8.59 days

Opportunities for Improvement:

- First offered psychiatry appointments conform to the 15-business day average standard, with all subgroups better than standard; however, achievement of standard is at 62 percent for children and families, and 67 percent for FC.
- Urgent care timeliness identified only four events for adults, with a total of six events for all subgroups combined. This small number of urgent requests raises the question as to whether all urgent need presentations are correctly identified.

- Post-hospital discharge follow-up for adults was reported in the MATA submission as having an average of 21.08 days (mean). This is nearly three times the 7-day HEDIS value. Children and youth have a 12.93-day average post-hospital follow-up statistic.

Quality of Care

Changes within the Past Year:

- The MHP initiated standardized documentation protocol, inclusive of training, to ensure compliance with DHCS regulations and requirements. This included documentation training, service code training, and Policy Stat training.

Strengths:

- The MHP's grievance analysis included simple but clear descriptions of categories such as treatment delays, insufficient level of care, and minimization of beneficiary perceptions of treatment needs. Suggestions as to possible remedies were also included.
- The grievance and appeals team staffing was reassessed, which resulted in the assignment of two VCBH clinicians to oversee the problem resolution process. Weekly meetings between clinicians and supervisor were initiated to review grievance issues and discuss trends, which were subsequently presented to the QMAC team.
- Positions were added to the quality management area to improve the MHP's ability to perform analytic and compliance functions.

Opportunities for Improvement:

- The MHP runs timeliness reporting when there is an identified problem or project which requires this data. QMAC minutes did not appear to include review and discussion of key data-focused reporting. Without routine timeliness review and reports by program of potential disparities, such as timeliness and retention by race/ethnicity and language, early identification of trends may be slow to occur.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP is adding a tablet-based beneficiary satisfaction system that will be implemented by December 2021. This will improve the timeliness and usefulness of beneficiary-centered data collection efforts.

Strengths:

- The MHP provided a December 2020 analysis of the 2019 Spring and Fall CPS data, which included comparison of results between those with less than a year in treatment and those with more. Included were analysis of specific scoring areas as well as participation trends.

Opportunities for Improvement:

- Ongoing analysis of outcome and level of care instruments does not appear to be regularly occurring since the MHP began to construct a new format for aggregating outcome information. This process appears incomplete at this time.

Foster Care

Changes within the Past Year:

- Short-Term Residential Treatment Program (STRTP) expansion, with an additional STRTP contracted to enhance care opportunities for foster youth, with others in process.

Strengths:

- The MHP's policy of universal access to mental health services for all FC youth is reflected in the 61.75 percent FC penetration rate vs the statewide 51.91 percent and 48.34 percent other large MHP averages.
- SB 1291 FC medication monitoring is occurring, with the use of CURES to assist with stimulant tracking for Attention Deficit Hyperactivity Disorder (ADHD). The process tracks compliance with medications as well. Under development is a process that will append to the medical record documentation that a review has occurred.
- Implementing AB 2083, mandating the development of a county interagency trauma-informed system of care for dependent children and youth.

Opportunities for Improvement:

- Continued challenges exist with the development of therapeutic foster care (TFC), due to local foster family agencies (FFAs) experiencing difficulties identifying a resource parent pool
- adequate to meet the anticipated needs of 15 families.
- Other FC challenges continue: delays in change of residence code to Ventura County with incoming transfers; required documents absent from

some transfers; court ordered assessments for all youth regardless of age or symptoms; incorrectly completed presumptive transfer documents.

Information Systems

Changes within the Past Year:

- As of February 2021, all VCBH forms are now in PDF format, and available for online completion, with DocuSign used for electronic signatures. Because electronic forms are available system-wide and less prone to loss, the MHP plans to move selected forms into Avatar.
- PolicyStat has been implemented to host policies and procedures, making the most recent updates widely available online.
- Last year the MHP reported six directly operated sites and five CBO sites using telehealth. This year they report 37 directly operated sites and 33 CBO sites using telehealth.

Strengths:

- The MHP's EHR is vendor hosted.
- The MHP added IS staff in two key roles, EHR oversight and system integration, and added data analysis and reporting resources.

Opportunities for Improvement:

- The claim denial reason "beneficiary not eligible," accounting for 34 percent of denials, would be addressed by implementation of the Accredited Standards Committee X.12 270/271 eligibility transaction pair.
- Twenty percent of DMC-ODS service data from CBOs arrives through a batch file transfer from the CBO's EHR. The same approach should be offered to mental health CBOs to reduce the amount of redundant data entry required of them.

Structure and Operations

Changes within the Past Year:

- The MHP acquired telecommuting equipment and services to support work from home for staff, that included laptops, headsets, webcams, and Zoom accounts.
- The MHP embarked on the creation of numerous capacity enhancement projects that include a new adult CSU a locked MHRC, with multiple level

of care programs, and the development of an elderly residential care facility.

Strengths:

- The MHP's efforts to understand the needs and feedback of staff was reflected in the analysis of the 2019 engagement survey and actions taken to respond to identified areas of need. This included: 1) including an employee engagement section in each quarterly VCBH newsletter; 2) development of a standardized VCBH employee onboarding process; 3) inclusion of the "why" or the reason for new policies or changes when they are introduced.
- The employee engagement survey process continued for a second year, with resultant data analysis in process at the time of this review.

Opportunities for Improvement

- The MHP has not yet completed the Medicare certification process for county-operated sites and CBO sites who also serve dual eligible beneficiaries, which directly impacts the number of Medi-Cal claims denied due to failure to bill "Medicare or Other Health Coverage."

FY 2020-21 Recommendations

PIP Status

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

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

Access to Care

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

Timeliness of Services

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

Quality of Care

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

Beneficiary Outcomes

- None noted.

Foster Care

- None noted.

Information Systems

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

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

Structure and Operations

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

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible, such as conducting beneficiary focus groups.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

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

Table A1: EQRO Review Sessions

Ventura BHCS
Performance Improvement Projects
Quality Submission Clarification Session
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, Quality Reviewer
Robert Greenless, Information Systems Reviewer
Walter Shwe, Consumer-Family Member

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

MHP Review Sites and Participants

All sessions were held via video conference due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Aguila	Gabriela	BH Manager	VCBH – Youth & Family
Ashur	Ophra	Sr. BH Manager	VCBH – Quality Management
Burt	Sloane	BH Manager	VCBH – Quality Improvement
Cooper	Jason	Medical Director	VCBH
Cruz	Danielle	Management Assistant	VCBH – Quality Improvement
Donovan	Leisa	Sr. BH Manager	VCBH - Fiscal
Dougherty	Jennifer	Sr. BH Manager	VCBH – Youth & Family
Egan	Narci	Assistant CFO	HCA
Fekete	Doreen	Program Administrator	VCBH - Billing
Glantz	Julie	Sr. BH Manager	VCBH - Adults
Goldner	Richard	Sr. Program Administrator	VCBH – Quality Improvement
Johnson	Sevet	Director	VCBH
Lee	Karen	BH Manager	VCBH – Quality Management
Lubell	Courtney	BH Manager	VCBH - Special Projects
Mesa	Marady	Program Administrator	VCBH – Quality Improvement
Mikkelson	Sandi	Program Administrator	VCBH – Quality Improvement
Olivas	Dina	Division Chief	VCBH - Youth & Family
Riddle	Angela	BH Manager	VCBH – Training
Roman	Dave	Sr. Program Administrator	VCBH - EHR
Salas	Cynthia	BH Manager	VCBH – Equity Services

Last Name	First Name	Position	Agency
Schipper	John	Division Chief	VCBH - Adults
Seal	Maryza	BH Manager	VCBH - Contracts
Shah	Brinda	Sr. Program Administrator	VCBH – Quality Improvement
Villegas	Alexis	Program Administrator	VCBH – Quality Improvement
Washington	Chauntrece	BH Manager	VCBH – Quality Management
Yanez	Terri	Division Chief	VCBH - Administration
Yomtov	Dani	Program Administrator	VCBH – Quality Improvement
Zanolini	Shanna	Sr. Program Administrator	VCBH – Quality Improvement

Attachment C—Approved Claims Data

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

Attachment D—ACA Penetration Rates and ACBs

Table D1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Ventura MHP					
Entity	**Average Monthly ACA Enrollees**	**Beneficiaries Served**	**Penetration Rate**	**Total Approved Claims**	**ACB**
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Large	1,791,890	69,726	3.89%	$372,190,347	$5,338
MHP	61,952	2,390	3.86%	$14,344,029	$6,002

Attachment E—ACB Range Distributions

Table E1 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Table E1: CY 2019 Distribution of Beneficiaries by ACB Range

Ventura MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	9,644	92.69%	93.31%	$42,924,018	$4,451	$3,998	57.18%	59.06%
>$20K - $30K	335	3.22%	3.20%	$8,136,083	$24,287	$24,251	10.84%	12.29%
>$30K	426	4.09%	3.49%	$24,014,417	$56,372	$51,883	31.99%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Full Term
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HR	Human Resources
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Diseases
IN	Information Notice
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioner of the Healing Arts
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MHBG	Mental Health Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act

Acronym	Full Term
MHST	Mental Health Screening Tool
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSO	Management Services Organization
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTP	Narcotic Treatment Program
OON	Out-of-Network
OTP	Opioid Treatment Program
PA	Physician Assistant
PDSA	Plan Do Study Act
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIN	Personal Identification Number
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Full Term
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
VOIP	Voice Over Internet Protocol
WET	Workforce Education and Training
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan