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FY17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

VENTURA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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VENTURA MHP SUMMARY OF FINDINGS

Beneficiaries Served in Calendar Year 2016 — 9,723

MHP Threshold Language(s) — Spanish

MHP Size — Large

MHP Region — Southern

MHP Location — Oxnard

MHP County Seat — Ventura

Introduction

Ventura County Behavioral Health (VCBH) is a large Mental Health Plan (MHP) located within the Southern California region. The area is supported largely by agriculture, tourism, and military base activities. Hispanic/Latino individuals comprise 58 percent of Medi-Cal eligibles. In recent years, the MHP has emphasized the development of intensive services for its consumers, such as crisis stabilization, crisis residential and mental health rehabilitation facilities.

During the fiscal year 2017-2018 (FY17-18) review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the Mental Health Plan (MHP) and its contract provider services. Further details and findings from External Quality Review Organization (EQRO)-mandated activities are provided in this report.

Access

A number of initiatives for improving access have been a priority for the MHP during the past couple of years. This includes post-hospital discharge follow-up linkage, and in the last year, the piloting of same-day access at the Conejo Clinic. A discharge planning workgroup has recently targeted the reassessment of continuing consumers, adding more structure to the process, and looking to identify those who have progressed sufficiently to step-down or discontinue specialty mental health care. Targeted efforts also continue, aimed at improving access to Hispanic/Latino eligibles and particularly Spanish speakers. This is supported by a number of activities including the Logrando Bienestar that is heavily focused on outreach to agriculture workers. Efforts to improve convenient assessment times through after- business- hour appointments and clinical services are aimed at meeting the needs of these individuals. Telemedicine is being utilized on an increasing basis to distribute Spanish linguistic capacity and facilitate overall redistribution of psychiatry resources.

Timeliness

The MHP has made efforts to improve initial access in a pilot program that seeks to streamline the intake process for high acuity individuals and those with a significant previous treatment history. They are considering expanding this open access to a wider population and implementing at other MHP clinics. The MHP divides the initial psychiatry access metrics between the categories of expedited and routine, which provides favorable response times to high acuity individuals.

Quality

The MHP has continued efforts to improve the Quality Improvement (QI) function of the department, demonstrating ongoing involvement of the executive team with improvement activities. This past year the Quality Improvement Committee (QIC) Executive Work Group participated with projects on access, acuity, post-hospital follow-up, smoking cessation (PIP), and discharge planning. Integrated with this process is the Lean Six Sigma model, which produces a structure very similar to the PIP conceptualization and is heavily focused on data analytics. The MHP has plans for quarterly review of timeliness and other key data elements.

Outcomes

The MHP has utilized its customized Ventura County Outcome System (VCOS) for the aggregation and reporting of instrument data elements, the composition of which is drawn from accepted instruments such as the Basis-24 and others. The MHP has developed a customized, locally informed version of the Child, Adolescent Needs and Strengths (CANS) survey to comply with the state requirement and furnish consistent information for the evaluation of child/youth treatment progress. The MHP is considering instruments relevant to adult system of care consumers but has yet to select one to implement across the full population. The MHP recently finalized the process for annual clinical team review of each consumer, in which clinical observations and VCOS data are formally integrated.

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 programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid managed care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid managed care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan.

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 FY17-18 findings of an EQR of the Ventura MHP by the California External Quality Review Organization, Behavioral Health Concepts, Inc. (BHC).

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

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. The eight PMs include:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);

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

[2] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

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 discussed in detail later in this report.

MHP Health Information System Capabilities[4]

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

Validation of State and County Consumer Satisfaction Surveys

CalEQRO examined available consumer 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:

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

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

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY16-17

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, CalEQRO and MHP staff discussed the status of those FY16-17 recommendations, which 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.

Key Recommendations from FY16-17

Recommendation #1: It is essential that the MHP develop a process that ensures there are two active PIPs, one clinical and one non-clinical PIP.

Status: Met

- The MHP has embedded PIP planning in the annual Quality Improvement (QI) Work Plan.
- The MHP produced two PIPs for this review cycle.

Recommendation #2: The MHP needs to develop a tracking system for children and youth who receive an acute psychiatric admission and the related follow-up activities subsequent to discharge.

Status: Met

- A communication protocol was established in FY 16-17 ensuring that all inpatient unit or crisis stabilization unit (CSU) admissions for Medi-Cal youth that are brought to the attention of the utilization review (UR) team by way of the required 24-hour admission call as follows:

- If identified by way of an electronic health record (EHR) inquiry, the youth is identified as a current consumer and the UR team will notify the treating clinic within 24 hours for appropriate follow-up post discharge.

- If the youth is not a current consumer, the Rapid Integrated Support and Engagement (RISE) team is notified so that outreach to the youth/family can occur at discharge to assess appropriateness for ongoing services and to assist with linkage.

- The MHP was able to produce children's psychiatric hospitalization and follow-up event data for this current review cycle.

Recommendation #3: The MHP needs to develop a formal Quality Improvement (QI) Work Plan for the FY16-17 period and subsequently evaluate results of and develop a QI Work Plan within two months of the start of the next fiscal year.

Status: Met

- A QI Work Plan was developed and submitted for this FY17-18 review cycle. Evaluation of the FY 16-17 Work Plan was also provided.

Recommendation #4: The MHP needs to study and evaluate the impact that the segmented system process involving Access, STAR, RISE and subsequent clinic services have upon consumer access timeliness through the use of data and focus groups.

Status: Partially Met

- The MHP developed a same day access pilot to improve timeliness of service for those with a prior history of one year or more of treatment or are considered high to moderate in acuity. The acuity component is based on hospitalization history, with ongoing refinement of the criteria through the PIP process.

- The divisions between the assessment team (Screening, Assessment, Triage and Referral (STAR)), a relatively small centralized function that is distributed operationally among the various adult and children's clinics, and the outreach support team (Rapid Integrated Support and Engagement (RISE)), and ongoing services creates a series of potential silos vulnerable to staff turnover. This system creates a number of handoff points, and a potentially complex process for consumers.

- The related system complexities of the three described program elements were not directly addressed. The MHP might wish to consider increased system integration, which could provide greater concentration of resources and improved overall responsiveness.

Recommendation #5: The MHP should continue working on an integrated caseload and capacity analysis that monitors both active and inactive cases and provides predictive information to the executive team for program formation. With sufficient staffing, this project could become a real-time dashboard in the MHP's Kofax Analytics tool.

Status: Met

- The MHP has focused on using data analytics to analyze and meaningfully categorize consumers' needs as high, moderate and low to determine the amount of dedicated staff needed to meet their clinical needs. Using this categorization, the MHP reports the ability to work more efficiently with their staffing current resources. A management dashboard for the adult system of care was developed to assist the executive team in the ongoing monitoring and allocating of resources as needed.

Recommendation #6: The MHP should move forward with its interoperability project in an expeditious manner to alleviate many of the barriers to integrated care management that currently exist between directly operated and contract provider services.

Status: Partially Met

- There has been progress in this effort in FY 16-17 and FY 17-18. In December 2016, MHP partnered with Seneca Family of Agencies to open a CSU and the short-term crisis residential treatment program. Given the importance of having immediate access to clinical information in these programs, the MHP granted read-only access to all Avatar clinical records to select Seneca staff.

- In a separate effort to promote shared EHR platforms with contracted providers, the MHP began a pilot project in August, 2017 which granted a contract provider, Kids and Families Together, read-only access to the Avatar system. This read-only access for shared clients promotes expedited exchange of clinical information and went "live" in January 2018.

- While the MHP is not a member or a Health Information Exchange (HIE), in FY 16-17, an extensive stakeholder process was initiated to examine the possibilities and practicalities of employing an interface module that could allow for the exchange of information between unrelated EHRs. A solution was proposed by Netsmart Technologies that would allow for clinical record and data sharing between diverse systems which the MHP expects will address many of their needs as they move further into the world of integrated care with contract providers and other partners. Pending Board of Supervisor approval, the MHP expects to begin the initial planning stages of this technology with willing partners.

Changes in the MHP Environment and Within the MHP—Impact and Implications

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

Access to Care

- The crisis response protocol for consumers currently receiving services was altered during business hours, utilizing clinic staff who currently serve the consumers to respond, and resulting in quicker response from the Crisis Team during these hours to individuals not open to services.
- Three full-time clinical positions were added to the Educationally Related Social Emotional Services (ERSES) program which provides mental health services to special education students via a contract with school districts.
- The MHP established the Horizon View Mental Health Rehabilitation Center which has operated with a 96 percent occupancy rate in its first year.
- A six-bed youth crisis residential unit (COMPASS) opened adjacent to the children/youth crisis stabilization unit. This program strengthens the capacity to provide an extended period to achieve stabilization for children and youth at risk for hospitalization.

Timeliness of Services

- The STAR team implemented a streamlined version of the existing admission assessment to expedite the admission process.
- Same-day STAR admission appointments have been piloted at the Conejo clinic for individuals with a recent treatment history and/or those categorized as high or moderate acuity.
- The Childs Accelerated Assessment to Treatment and Services (CAATS) program was implemented for foster youth population. All children entering dependency now receive a full biopsychosocial assessment within 15 days of entry.

Quality of Care

- Adult services staff trained in the evidence-based practice of Cognitive Behavioral Therapy for Psychosis (CBT-p) provide more structured interventions for the adult population.

- The Benzodiazepine Monitoring Program (developed from the Safe Alprazolam Prescribing initiative, November 2014) is associated with an 86 percent reduction in alprazolam prescriptions, as well as reductions in the use of other medications in the same class. Alternatively, consumers are learning to manage their anxiety and insomnia with non-pharmacologic strategies, including CBT groups and relaxation skills classes.

- The juvenile justice collaborative program, Insights, provides mental health services to children and youth within the detention environment, with the aim of effectively addressing mental health needs, decreasing the likelihood of recidivism.

- Child and family team meeting (CFT) is a teaming practice that has been fully integrated within the dependency population and any Medi-Cal beneficiary receiving TBS, IHBS, or Wraparound services. It ensures that beneficiaries have a voice in the process and articulate their needs as the team coordinates their clinical care.

Consumer Outcomes

- Transitional Age Youth (TAY) are assisted with employment through a contract with the Department of Rehabilitation (DOR) to provide essential vocational services to MHP consumers for FY18-19.

- The CANS assessment tool is being piloted in the CAATS program in preparation for an October 1, 2018 MHP rollout with all children and youth.

PERFORMANCE MEASUREMENT

As noted above, CalEQRO is required to validate the following PMs as defined by DHCS:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of TBS Beneficiaries Served Compared to the 4% 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 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; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

HIPAA Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1: Ventura MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served**	**% Served**
White	55,321	22.7%	3,395	34.9%
Latino/Hispanic	122,764	50.4%	3,829	39.4%
African-American	3,778	1.6%	318	3.3%
Asian/Pacific Islander	35,274	14.5%	630	6.5%
Native American	610	0.3%	49	0.5%
Other	25,721	10.6%	1,502	15.4%
Total	**243,466**	**100%**	**9,723**	**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.				

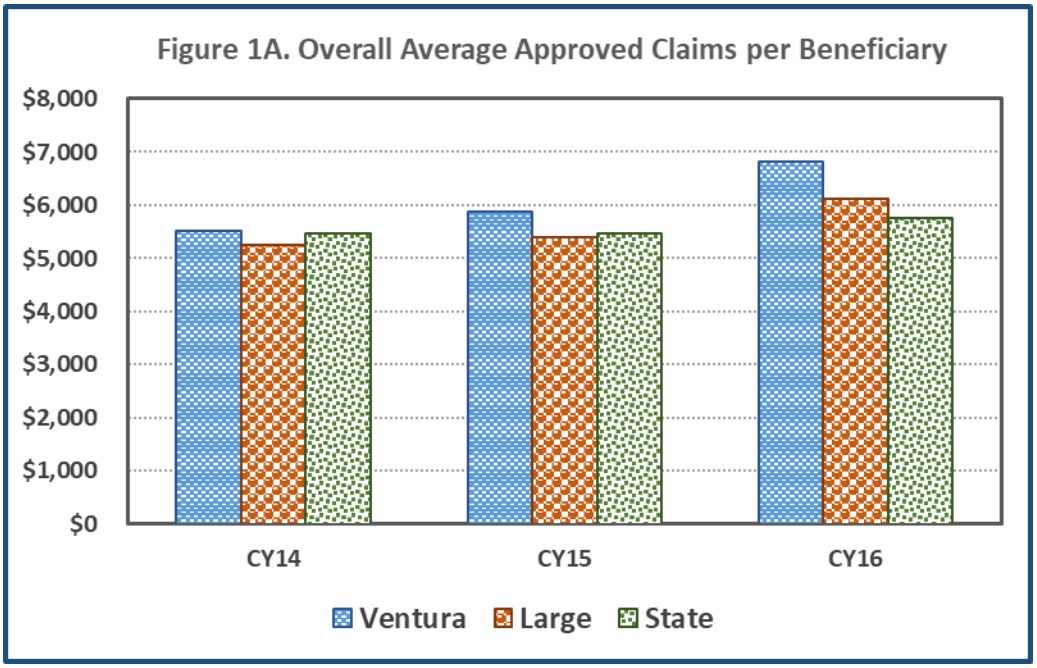
Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

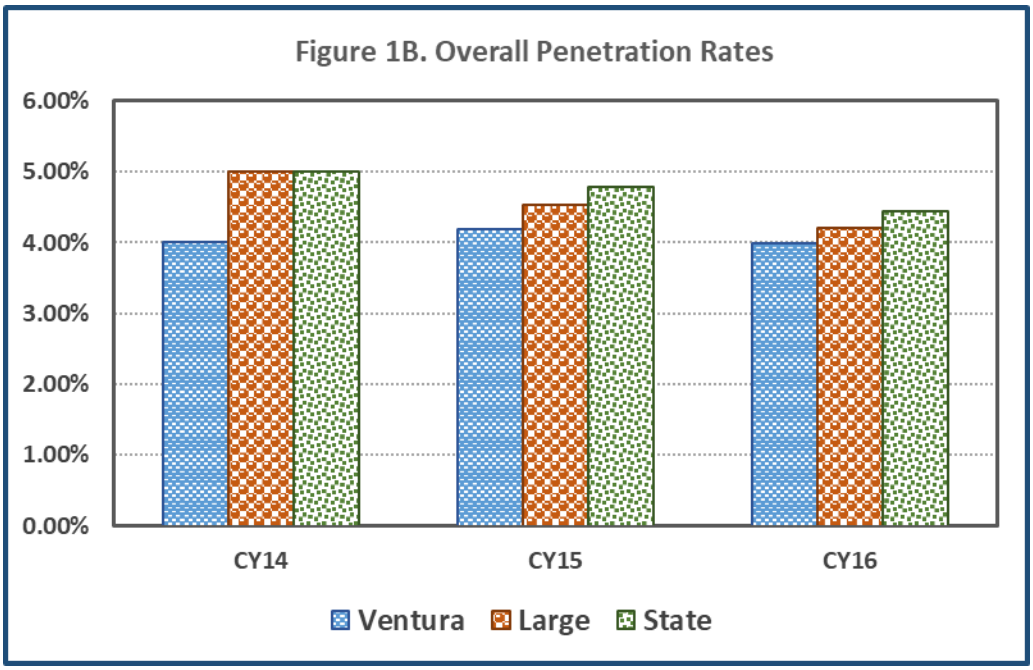
Penetration Rates and Approved Claim Dollars per Beneficiary

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

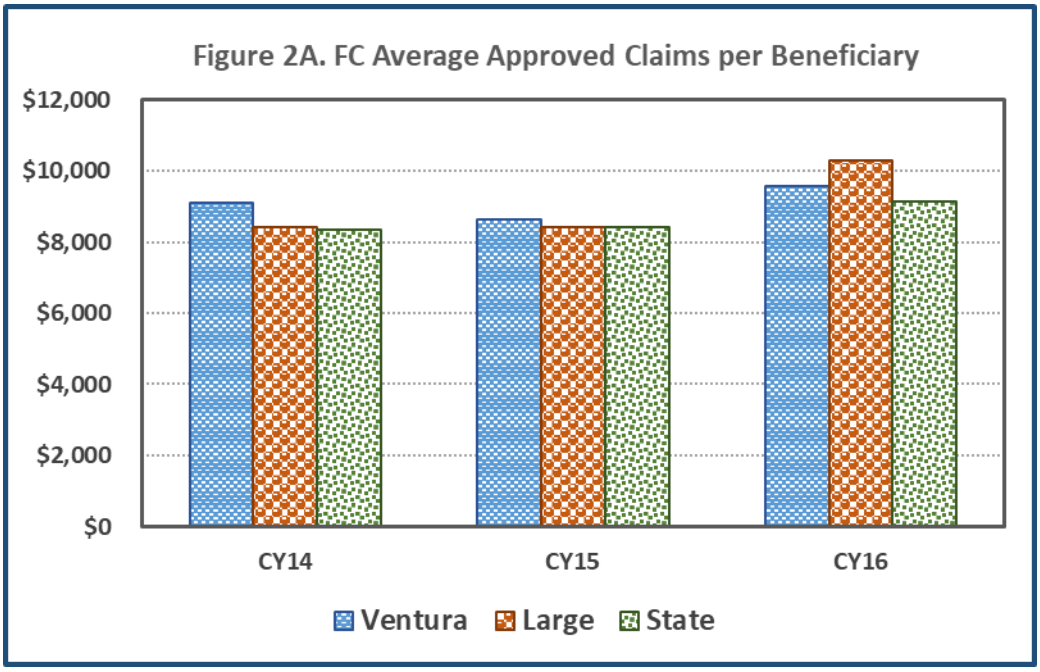
Regarding calculation of penetration rates, the Ventura MHP uses a different method than that used by CalEQRO.

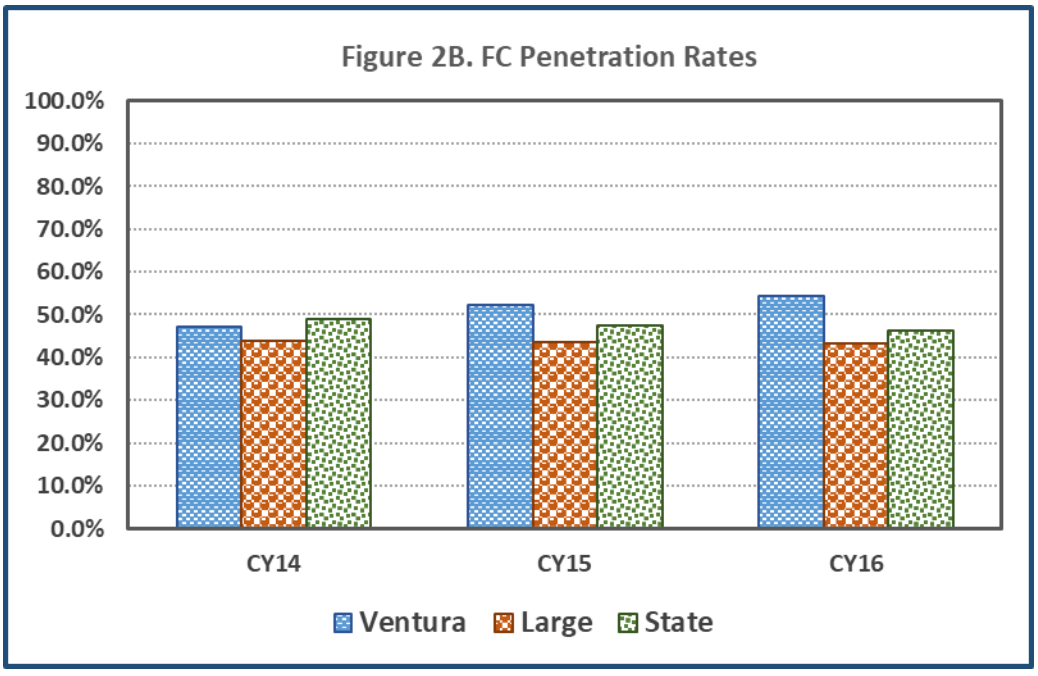
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



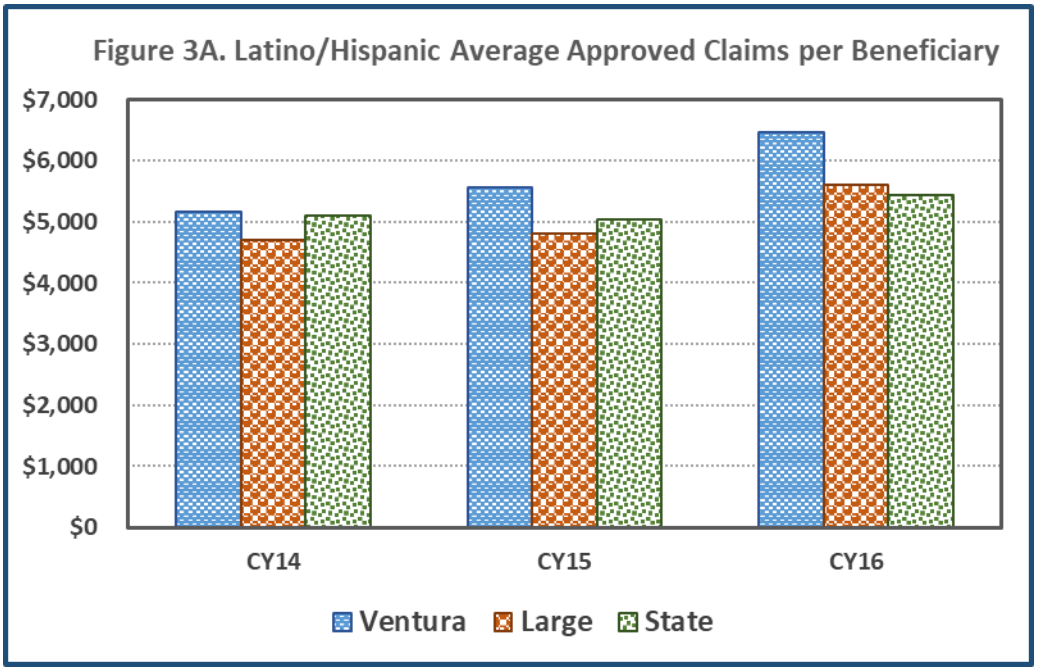


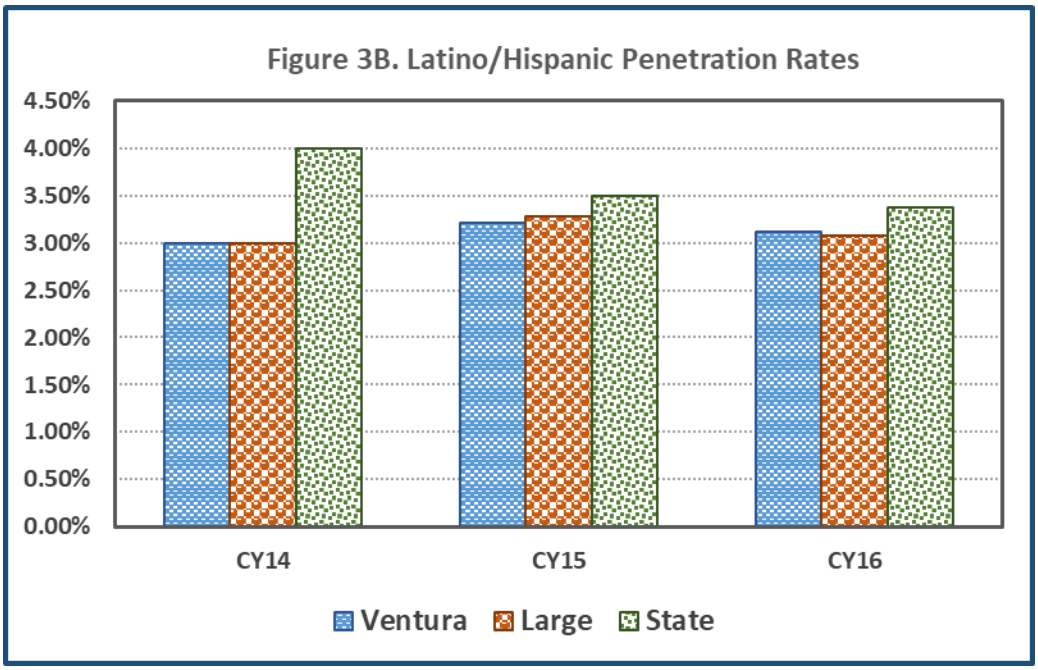
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





High-Cost Beneficiaries

Table 2 compares the statewide data for High-Cost Beneficiaries for CY16 with the MHP's data for CY16, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

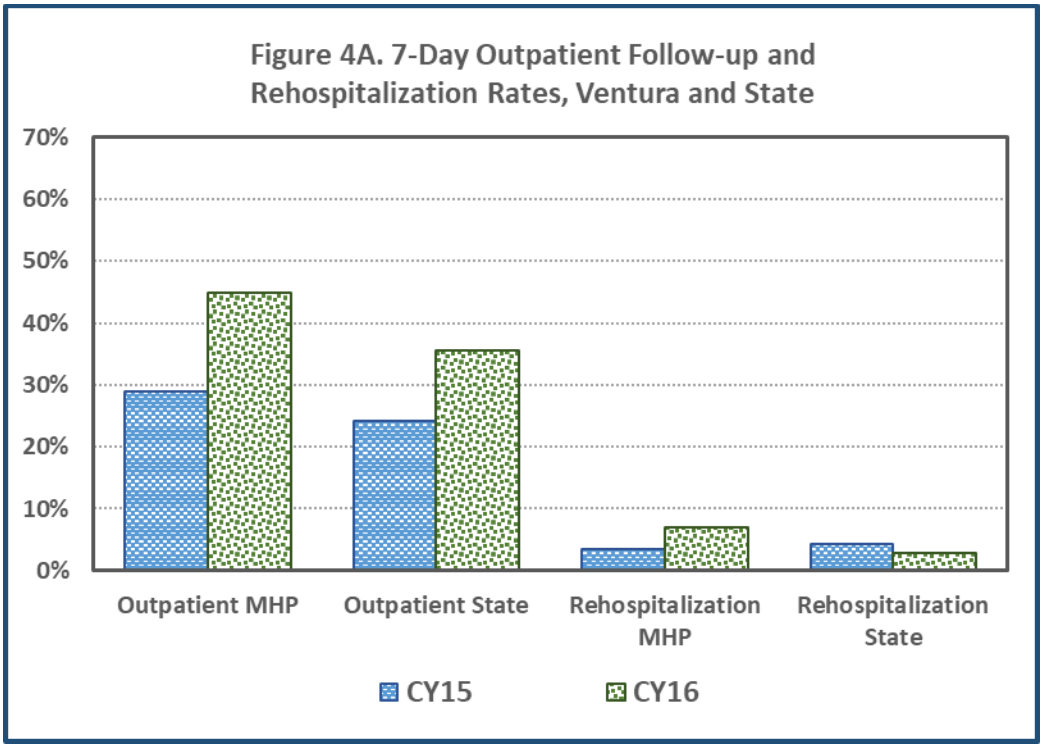
Table 2: Ventura MHP High-Cost Beneficiaries

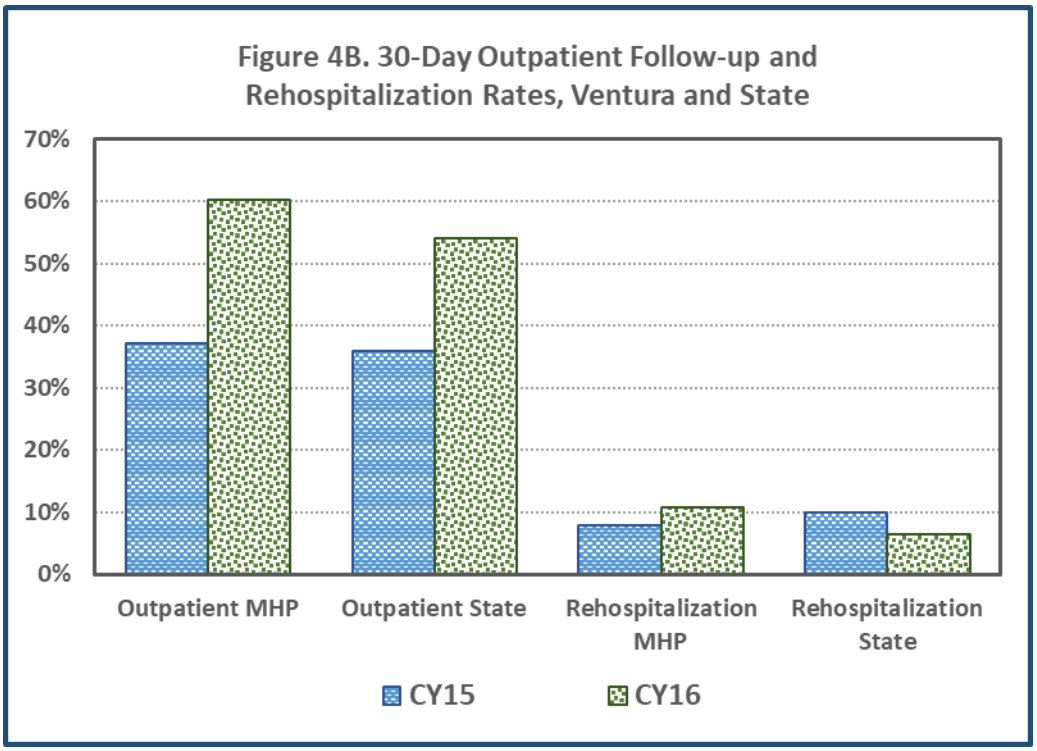
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	19,019	609,608	3.12%	$53,215	$1,012,099,960	28.90%
Ventura	CY16	394	9,723	4.05%	$54,043	$21,292,983	32.16%
	CY15	308	9,633	3.20%	$51,710	$15,926,791	28.17%
	CY14	203	7,464	2.72%	$48,316	$9,808,149	24.81%

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

Timely Follow-up After Psychiatric Inpatient Discharge

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY15 and CY16.

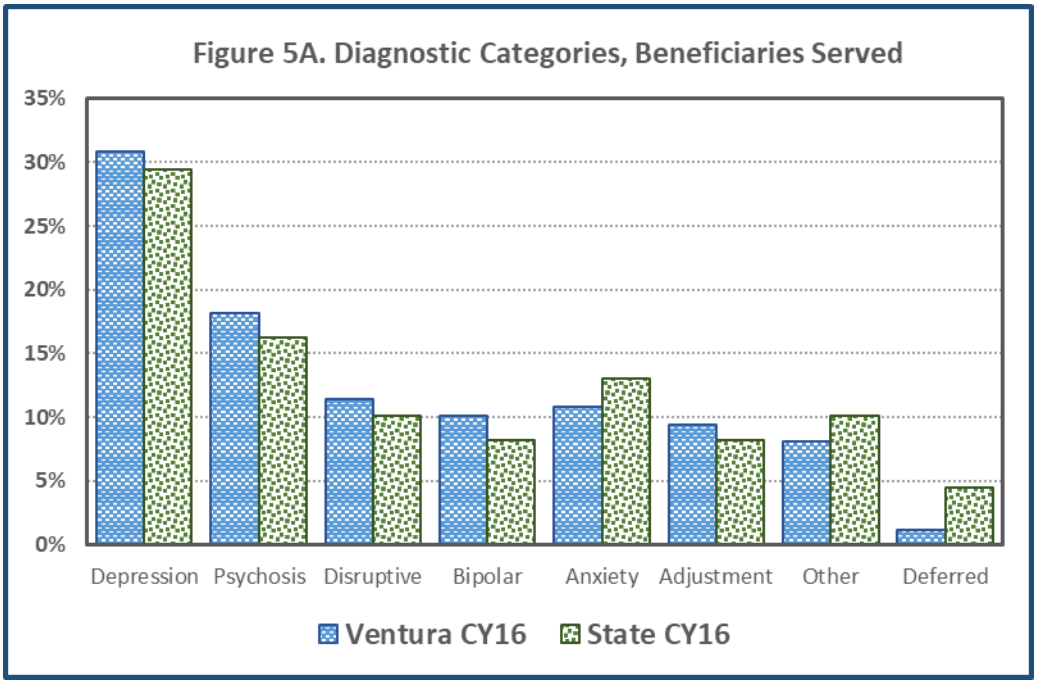


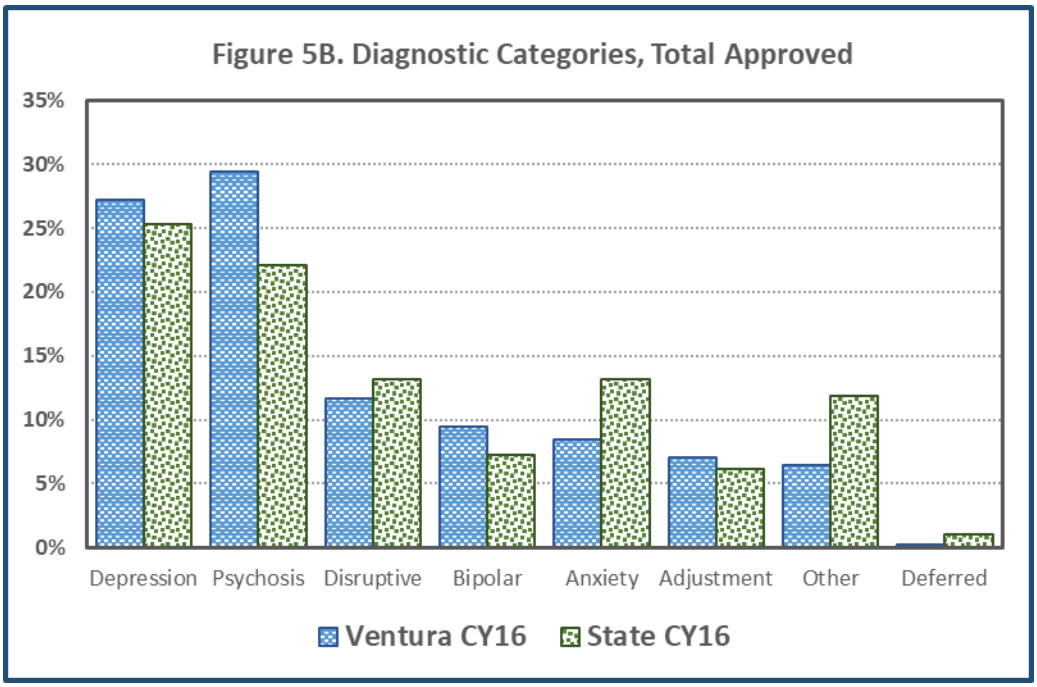


Diagnostic Categories

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 26 percent for adults and 9 percent for youth.





Performance Measures Findings—Impact and Implications

Access to Care

- Eligibles increased from CY15 to CY16, while beneficiaries served increased less, correlating to a year over year drop in overall penetration rate of approximately 0.20 percent. The MHPs CY16 overall penetration rate is comparable to the large county average but lower than the statewide average.
- The MHP's penetration rate rose slightly from CY15 to CY16 and is higher than both the large county average and the statewide average.
- The MHP's Latino/Hispanic penetration rate declined slightly from CY15 to CY16. This is comparable to the large county average but lower than the statewide average. The MHP continues to look to Logrando Bienestar, a Hispanic outreach program, to provide outreach and improve Hispanic penetration rates.

Timeliness of Services

- In CY16, the MHP's 7-day outpatient follow-up rate after discharge from a psychiatric inpatient episode increased from CY15 and exceeds the CY16 statewide average. This may be related to recent targeted efforts on this topic.
- In CY16, the MHP's 30-day outpatient follow-up rate after discharge from a psychiatric inpatient episode increased from CY15 and exceeds than the statewide average. Both will likely continue to improve as MHP has started tracking child/youth hospitalizations during this last year, and specifically focused attention on monitoring post-hospital discharge follow-up events.

Quality of Care

- The MHP's average overall approved claims per beneficiary increased from CY15 to CY16 and is higher than both the large county average and the statewide average in CY16.
- The MHP's average foster care approved claims per beneficiary increased from CY15 to CY16 but is lower than that for the large county average and greater than the statewide average in CY16.
- The MHP's average Latino/Hispanic approved claims per beneficiary increased from CY15 to CY16, and is higher than both the large county and statewide averages in CY16.
- The HCB percent continued to increase for CY16, and higher than the statewide average. The percent of all claims that are HCB also increased in CY16 and is higher than the statewide average. The MHP's analysis revealed the composition of the HCBs are

consumers who utilize high-level residential treatment programs or are high utilizers of inpatient and crisis care.

- Consistent with the statewide diagnostic pattern in CY16, a primary diagnosis of depressive disorders accounted for the largest percentage of beneficiaries served. The MHP had a rate of deferred diagnoses that is below the statewide average. The MHP's approved claims dollars are consistent with its diagnostic patterns.

Consumer Outcomes

- In CY16, the MHP's 7-day rehospitalization rate increased from CY15 and is slightly greater than the statewide average.
- In CY16, the MHP's 30-day rehospitalization rate increased from CY15 and is higher than the statewide average.
- Considering the improvements in 7- and 30-day post discharge follow-up rates, these rehospitalization rate increases merit attention to the type of follow-up provided and the effectiveness of care coordination activities. The lack of ongoing emergency department coordination activities and the absence of an adult CSU are factors worth exploring as related to these increases.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." The Validating Performance Improvement Projects Protocol specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year.

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 MHP-submitted PIPs, as shown below.

Table 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 3: PIPs Submitted by Ventura MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Integrating Smoking Cessation Programs into a Behavioral Health System
Non-clinical PIP	1	Client Acuity Index

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] *2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.*

Table 4: PIP Validation Review

				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	PM	PM
		1.4	All enrolled populations	M	PM
2	Study Question	2.1	Clearly stated	M	PM
3	Study Population	3.1	Clear definition of study population	M	PM
		3.2	Inclusion of the entire study population	M	PM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	PM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	PM	PM
		6.6	Qualified data collection personnel	M	NM
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	PM	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	M	M
		8.2	PIP results and findings presented clearly and accurately	PM	M
		8.3	Threats to comparability, internal and external validity	M	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	PM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	PM	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	NM	M
		9.3	Improvement in performance linked to the PIP	NM	PM
		9.4	Statistical evidence of true improvement	NM	PM
		9.5	Sustained improvement demonstrated through repeated measures	NM	NM

Table 5 provides a summary of the PIP validation review.

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	16	10
Number Partially Met	4	13
Number Not Met	4	1
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	24	24
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	**75%**	**68.75%**

Clinical PIP—Integrating Smoking Cessation Programs into a Behavioral Health System

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

"Will integration of smoking cessation services within VCBH decrease the proportion of consumers who describe themselves as active tobacco users. Addendum (5/7/2017): Will integration of smoking cessation services within VCBH result in the percentage of tobacco users remaining quit for 3 mos., 6 mos. and 12 mos. after completing a Call It Quits (CIQ) program be least 25%, 15% and 10% respectively?"

Date PIP began: June 2016

Status of PIP: Completed

Beginning in June 2016, the MHP focused on improving the health status of consumers who use tobacco products. The national data on smoking prevalence was supported by a sample survey of adult consumers across all sites. The survey validated high tobacco use (46 percent), three-quarters of whom wanted to stop smoking.

The effects of tobacco use on physical health is clearly evident from numerous studies, creating higher risks for many health conditions. The MHP's Medical Director sought to include psychiatric staff in using the 5-As, a protocol for consistent inquiry into tobacco use and encouragement of cessation, with referral to a public health operated CIQ cessation program. The MHP created a method of entering the smoking status with psychiatry session notes.

However, challenges emerged during the process, including: MHP consumers requiring specialized and tailored CIQ programming; intolerance for wait times while CIQ groups are being formed; and

data on completion of the full program is also low. To date, smoking cessation has a zero-percentage rate 90-days post-intervention.

The indicators and related data during the last year demonstrated: 19 percent of MHP tobacco users were referred to CIQ; 36 percent registered for CIQ; 70 percent attended at least one CIQ session; and 38 percent of those attending one session completed CIQ. In real terms, only 21(2 percent) of 1158 tobacco users completed the program. None of the consumers remained quit after 90 days.

The MHP has proposed changes to this PIP going forward. This involves the collection and reporting of perception survey data related to the CIQ curriculum. The additional measures include: self-perception information relating to confidence in ability to change smoking behavior; as well as self-perception of health status, anxiety levels, ability to manage stress, and feeling better about oneself.

While these additional parameters of perception could furnish related information, the MHP's key tracking of the health-related goal of actual smoking cessation is important. The original indicators remain of paramount importance, because only reduction or cessation of smoking will provide the desired health outcome.

The MHP has also proposed changes in interventions to include CIQ classes into all clinic sites and perhaps the wellness center.

The broad, positive impacts of this activity to date include the MHP's development of a process to routinely ask consumers about tobacco use, encourage and support smoking cessation, and collection of that data about smoking within the EHR. The successful screening of smoking status for 71 percent of the adult population is an accomplishment. The development of a referral process, coupled with effective interventions for this population, followed by tracking of results, is important.

It must be acknowledged that current results show no change for consumers. Reliance on CIQ sessions alone, even if embedded in clinics, seems unlikely to produce change unless specific elements are tailored to the MHP's population.

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

The technical assistance provided to the MHP by CalEQRO consisted of discussions about the limited number of consumers impacted by this improvement activity and the absence of positive results. That said, the screening aspect has been very successful. Strong consideration was given to termination of this PIP and exploring another issue that could have greater impact. However, this is an important topic, involving a large percentage of MHP adult consumers. There remains a strong rationale for continuation, if the MHP makes adjustments to its intervention strategy to improve efficacy for its unique population. The MHP may consider further literature review for proven strategies that could involve specific supportive approaches to smoking cessation not currently utilized.

Non-clinical PIP—Client Acuity Index

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

"Will an acuity index derived from the nature/extent of past psychiatric hospitalization(s) provide staff with a practical and effective guide to service delivery? Will providing staff with reference to an objective measure of acuity, along with associated services delivery expectations, increase productivity and caseload coverage thereby reducing psychiatric hospital admissions in the long-term?"

Date PIP began: February 2017

Status of PIP: Completed

The MHP's review of f high-cost beneficiaries revealed that consumers not in planned, high-cost, intensive intermediate to long-term care environments, acute hospitalizations constitute the key event among high-cost adults.

Looking further, the MHP sought to develop a level of care paradigm using hospitalization history involving total hospitalizations, length of hospitalization, and recency. Recognizing that this was a test or pilot approach, the MHP identified 12 staff to pilot this concept and provide feedback as to any adjustments that were necessary.

The aim of this PIP was to ensure that consumers identified as fitting into one of the categories of high, moderate, low, or uncategorized, were receiving a level of care likely to meet their service needs. The MHP then developed a minimum service level which was paired to the need categories. The MHP also established mechanisms for the consumer and staff to provide feedback to the service levels and scoring.

The finding that individuals evaluated as high-need did not necessarily receive intensive support was noteworthy. Proactive, intensive intervention could potentially reduce subsequent re-hospitalizations and assist the consumer in stabilizing. The MHP was aware that many "high-need" consumers do receive significant services, but this PIP aims to ensure all receive a certain minimum. This type of rating system will also assist staff in prioritizing their time, focusing on those with the greatest service need.

Considering the complexity of this process and the lack of an evidence-based model, the pilot was limited to 12 MHP adult service staff consisting of a combination of clinicians and case managers, to test out the concept. The MHP was not attempting to reduce services to high need consumers, instead it was seeking to assure that all high- need persons received a consistent high level of care.

The focus and approach to this PIP clearly reflects the MHP's orientation to the Lean Six Sigma approach and involves the use of data analytic techniques.

The MHP determined to discontinue this PIP in January of 2018. The MHP believes it is prepared to make system decisions based on this brief test process. Discussion included addition of level of care instrument to support a comprehensive process guiding service delivery across all levels of need and helping determine a consumer flow into recovery, is important as increases in eligibles and demand for services grows. Furthermore, approximately 50 percent of the MHP's adult consumers are uncategorized due to lack of recent hospitalization history, which may limit the application of this approach.

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

The technical assistance provided to the MHP by CalEQRO consisted of onsite encouragement, suggesting that the use of tested and validated level of care tools would provide additional data to augment the current approach. The use of instruments such as MORS, LOCUS, ANSA provide broad applicability. The uncategorized consumers, for whom the MHP lacks a specific service analytic strategy. For many MHPs, the larger challenge is developing standards for satisfactory level of improvement for stepping down service levels. This PIP was more basic in its approach, seeking to assure high level need consumers are so identified and receive a minimum level.

PIP Findings—Impact and Implications

Access to Care

- Smoking cessation assistance is often overlooked in SMHS treatment. Creating a link between mental health and physical health for this important health issue improves consumer access.
- The client acuity index furnishes a basic mechanism to guide service delivery and assure those with identified high-need status are provided a minimum of service, anticipating that this may promote stability and reduce acute episodes.

Timeliness of Services

- Neither PIP impacted timeliness of care.

Quality of Care

- The smoking cessation PIP, while unable to provide concrete outcomes, did result in a significant number of adult consumers screened, with referrals to CIQ, and participation in the programming to some level. Clearly it requires other efforts to tailor the program to mental health consumers, and perhaps additional supportive interventions provided at MHP clinic sites could actually result in smoking cessation.

- Development of a level of care system can constructively inform the process of care planning and service delivery. However, exclusive reliance upon acute hospitalization data alone is not likely the most effective approach as the paradigm omits nearly half of adult consumers. A broader strategy, which includes validated outcome instrument data, and the development of a structured team case review process, will likely produce a greater impact. The most challenging area for MHPs is with the lower acuity/need consumers and in the development of comprehensive step-down services, such as groups and other interventions that continue the support of the consumer and free up clinical time to serve those newly entering the system.

Consumer Outcomes

- The smoking cessation PIP has the potential of improving consumer health outcomes, with the opportunity to prevent or better manage related health conditions. For the goal to be attained, the PIP may require a smoking cessation intervention to be tailored to the mental health adult population, supported by ancillary clinic-based interventions, and support groups.

- Ensuring that consumers who are high-need receive at least a minimum level of weekly interventions has the potential to positively impact their outcomes, avoiding further acute episodes, hospitalizations, and possibly long-term care.

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 an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 6 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to consumers 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 6: Access to Care Components

Component		Quality Rating
1A	Service accessibility and availability are reflective of cultural competence principles and practices	M
The MHP's Cultural Competence Plan (CCP), updated for the 2016 through 2018, demonstrates an in-depth analysis of the Latino/Hispanic and Spanish speaking population, including monitoring of services to this important and large segment of eligibles. Noteworthy is that the CCP presented for this current cycle is a comprehensive update, only a portion of which was available during the prior review, and now contains material beyond the limited Hispanic/Latino focus in the prior submission. All programs must report number of bilingual/bicultural staff by position; the number and ethnicities of consumers served; preferred language of consumers; language of service provision; and when interpreting services are used, information about the interpreter provider. The MHP's CCP includes culture and ethnicity, gender identity and sexual orientation. This MHP has made a particular commitment to improving the services to high-need individuals, which involves the development of costly programs that can divert individuals from acute inpatient care, and also provide prolonged stabilization for those who would often require out of area placements.		
1B	Manages and adapts its capacity to meet consumer service needs	M

The MHP made significant steps to improve access to high acuity services through the development of a children's crisis stabilization unit, followed in this last year by the COMPASS unit, a six-bed crisis residential program. These programs provide options for acute diversion from inpatient admissions, and also provide a longer stabilization period when needed.

In the adult system of care, the crisis stabilization unit that had previously been located near the Hillmont Psychiatric Unit (located at the county hospital campus) was closed due to regulatory oversight actions, and replacement with OPOS (outpatient psychiatric observation service) has resulted in a number of unanticipated system impacts. These include individuals with acute psychiatric conditions now being taken to the nearest emergency department, where reports of long waits for services and definitive treatment occur.

Conflicts with emergency department priorities are identified, and challenges with transportation exist. The MHP has no current crisis service presence at emergency departments countywide. The MHP is appealing the dissolution of adult crisis stabilization unit decision at the state level, which will hopefully see some relief in the future. The MHP is also studying the possibility of contracting with a local program to provide crisis service presence at the various emergency departments.

In the children and educational systems area, three fulltime clinical positions were added to the ERSES program.

On a pilot basis, the MHP has created a targeted same-day access track at the Conejo adult clinic to provide immediate intake by STAR representatives, the MHPs access component This function is open to those who present meeting high acuity (local rating system which typically indicates psychiatric hospitalization history), moderate acuity, and those with a prior history of a year or more of treatment, and are returning to care. The MHP is considering expansion of this approach to all who present, and also creating this track at other clinic sites.

In recent years, the MHP brought back to the directly operated Crisis Team the responsibility for children and youth crisis response. However, there have also been challenges with maintaining staffing levels of the Crisis Team, and policy adjustment has seen the crisis response during business hours for open individuals now aligned with the treatment team. While this can be beneficial, bringing the relationship and knowledge of treatment staff into play, it can have a disruptive effect on the regular treatment schedule of clinics.

Within the dependency/foster care system, all children entering dependency now receive a full biopsychosocial assessment within 15 days of entry into the Child and Family Services system, with referral for treatment within 10 days. On a related issue, concerns exist that there will be significant loss of up to 50 percent of bed capacity during the conversion from group home to STRTPs. On a positive note, dependency social workers can obtain treatment authorization from

the court before a treatment referral is made. Pathways now supports the provision of TBS to TAY consumers, after the age of 18 years.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP has nine clinicians and two psychiatrists stationed and integrated with public health clinics. In a number of locations, MHP clinics are located at the same site as health clinics. While this improves access for those individuals utilizing the County Health system, the reverse flow, arranging physical health care for mental health consumers, is identified as a gap. Historically, identified nurses acted as liaisons between the two services. But over time and with attrition, these relationships have largely disappeared, and challenges obtaining physical health care have emerged. The other relationships include, interaction with Beacon for the mild-to-moderate consumer. Community based organizations are involved with care, such as Casa Pacifica, a highly regarded provider of services to children and youth. The Telecare corporation has provided full-service partnership programs, the high-level Mental Health Rehabilitation Center (MHRC) of Horizon View and other local programs. Turning Point is yet another key provider, as well as Pacific Clinics and others. The ERSES education related service system is extensive, with additional staff positions added during this past year. PathPoint is a multi-county provider which has operations in the Conejo Valley area and operates Life Skills, a day rehabilitation program that coordinates with MHP services.		

Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. This ensures successful engagement with consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 7: Timeliness of Services Components

Component		Quality Rating
2A	Tracks and trends access data from initial contact to first appointment	PM
VCBH states that initial access is tracked for all directly operated and contracted programs. The MHP established a 28-day first offered appointment standard for both adult and children/youth. Adult services report a mean of 12 days; children and youth are 16 days (increased by two days over the prior year). Achievement of standard is 92% for both populations. Based on this data, the MHP appears able to meet a higher standard. However, the 28-day standard is longer than that used by many MHPs, particularly as they ramp up to meet network		

adequacy requirements. Consumer focus group feedback indicated their experiences often exceeded the timeliness data provided. However, focus group information was based on actual appointments received, which often represents longer intervals.

The MHP has targeted the improvement of initial access with a same-day/open access pilot at one adult site, and plans exist for broader implementation. The concept sounds promising and leveraging this experience into a larger clinic population with much greater traffic will likely benefit from brainstorming sessions with line staff on how to successfully implement and manage the inevitable spikes in demand.

2B	Tracks and trends access data from initial contact to first psychiatric appointment	PM

The MHP has not established an initial psychiatric access standard. Two categories of initial psychiatric access have been created: expedited and routine. Expedited status relates to the acuity of the individual, i.e., those who are categorized as high and moderate, and acuity is based on recent hospitalizations or crisis events. Adult services show a12-day mean for expedited, four days less the previous year, and a 37-day mean for routine; children and youth have a 25-day mean for expedited (same as prior year), and a 37-day mean for routine (half the prior year average).

This data collection is limited to directly operated services of the MHP, excluding contract providers. It should also be noted that some contract providers utilize MHP psychiatrists so it could be challenging to appropriately attribute timeliness to a given entity.

The use of telepsychiatry increased from 108 consumers to 386 in this past year and expanded from the original intent to improve Spanish linguistic capacity to include basic resource redistribution. Constraints on telepsychiatry expansion include the high cost of equipment and infrastructure installation to implement this technology countywide.

Psychiatry initial timeliness was included in one of the MHP's PIPs for this year, but it has been decided to separately address psychiatry timeliness in a future PIP.

2C	Tracks and trends access data for timely appointments for urgent conditions	PM

The MHP utilizes a three-day standard for urgent services. The adult mean is five days, two days longer than prior year, and children and youth one-half day, a half-day improvement over the prior year. Meeting standard is 50 percent for adults, and 100percent for children and youth.

2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM

The MHP tracks data on all hospitalization events and facilities that serve its consumers. The post-discharge follow-up data tracked is limited to individuals served by directly operated programs.

The MHP utilizes the seven-day HEDIS standard, with local data reflecting a mean of 15 days for adults (4-day improvement over prior year) and six days for children and youth. Attainment of standard is 76 percent for adults and 81 percent for children and youth. The data is reported annually, with plans going forward to change to quarterly reporting. The MHP has programs in place to improve the follow-up of discharges, particularly with the county Hillmont acute facility. At that facility, a RISE clinician visits daily to assess and link individuals with aftercare, with the capability to continue services for up to 90 days.		
2E	Tracks and trends data on rehospitalizations	M
The MHP identified a 30-day acute inpatient readmission rate of 17 percent for adults and 14 percent for children and youth. All hospitalizations are included in this tracking, with the addition of children and youth tracking within the last year. The MHP has several initiatives aimed at reducing rehospitalizations.		
2F	Tracks and trends no-shows	PM
The clinician no-show rate is 15 percent for adults and 12 percent for children/youth. The psychiatry no-show rate is 11 percent for adults and 16 percent for children/youth. The MHP does not identify standards for no show rates. The MHP does not track no-shows by type.		

Quality of Care

In Table 8, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 8: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
The MHP evaluated the results of the prior QI Work Plan and established a current plan for this current cycle. There exists a robust QI unit, with analytic staffing that demonstrates the capacity to provide analysis of many different metrics. This analysis extends to the evaluation of Ventura County Outcome System (VCOS) data, which contains elements of a variety of established instruments (Basis-24, Ohio Helpfulness, Ohio Symptoms, Ohio Roles and Perception of Care). The MHP appears to be ready to embark on more frequent review of data relating to quality indicators such as initial timeliness, which is slated to occur quarterly during the coming year. Other quality efforts include piloting of same-day access, which is anticipated to extend beyond the original Conejo Valley test location in this coming year. Other efforts to improve quality and access include the streamlining of the initial intake assessment used by the STAR team, which should expedite entry into services. Other access streamlining activities include: facilitating outpatient episode re-openings for those with a prior extensive history with the MHP and/or those coming from a first contact of hospitalization or crisis events. The MHP has a QIC Executive Workgroup which is involved with the oversight and direction of various initiatives such as disallowances, post-hospitalization follow-up, and the adult system acuity project. The projects are presented in a four-quadrant layout that includes project description, metrics, performance, and status/accomplishments. The approach is informed by the Lean Six Sigma management approach and is founded in statistical analysis. In essence, these workgroups approximate a performance improvement project in appearance and methodology. Review sessions uncovered issues with intake and assessment paperwork consuming valuable clinical time. It is recommended that re-evaluation of which documents are clinical versus administrative should occur and redistribution of these tasks away from the clinical staff to interns or admin staff.		
3B	Data are used to inform management and guide decisions	M
The MHP reports and reviews a variety of types of data, and performs extensive analysis on its VCOS information. While this important information receives analysis, and there is a mechanism for formal inclusion in the re-assessment and annual review process, the effectiveness of this process merits evaluation. The type of information contained within VCOS and other instruments could serve as a useful addition to the developing acuity categorization recently piloted for the adult system of care. Because of the acuity system		

Table 8: Quality of Care Components		
Component		**Quality Rating**
focus upon hospitalization history, approximately 50 percent of adult consumers are uncategorized and not included in this schema. In related areas, an adult system of care dashboard was developed for the management team. A similar dashboard for child/youth services is in development. An inpatient unit hospitalization tracking system has also been developed.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
The transitions in top management have resulted in the acting leadership focusing on system refinements and improvements, rather than operationalizing a refreshed system vision, which will wait the selection of a new director. There have been other retirements of management team members, which has resulted in internal promotions and changes at the team and clinic level, disrupting relationships with contractors and internal staff. Supervisors and those directly responsible for clinic operations convey a sense of being informed and supported. At the management and supervisory level, some feel it the best they have experienced. Other stakeholders have noticed that some of the regular meetings that were frequently occurring are now being canceled and rescheduled to the extent that a vital communications link is suffering in both internal and external communications. Management changes have disrupted some of the historic close relationships with external providers including the external referral process. For some contracted programs, this can result in difficulties meeting budgetary expectations. The MHP would be well served to consider an electronic survey of contract providers that focused on the identification of key problematic issues and recommended remedies. Communications with consumers and family members remains robust. Their participation in EQR sessions was evident in both physical presence and verbal participation. Advocacy and monitoring representatives including the Advisory Board and NAMI were evident in numerous sessions throughout the review process.		
3D	Evidence of a systematic clinical continuum of care	M
The MHP uses a number of level of care and outcome instruments to inform its VCOS system. There exists clear direction to utilize this information in periodic and annual review processes. The mechanisms used by the MHP to observe consumer engagement in their treatment plan include the consumer perception survey questions related to involvement in treatment planning.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
The MHP has displayed remarkable advances in the depth of high-end resources for both adult and children/youth consumers. For the youth population, the crisis stabilization unit has been augmented by a crisis residential unit. The adult severely ill population has numerous in-county options for treatment, which minimize the need for out of county placements. The Horizon View program provides options that would have historically been served at an Institute for Mental Disease (IMD) or state hospital. The Casas programs offer step downs, and nearby is an open MHRC. A large unmet need is for a formal crisis stabilization unit serving adult consumers. Also, the MHPs role in serving individuals presenting at local emergency departments seems unclear and disengaged. That aspect of the crisis response would benefit from the MHPs robust participation in countywide comprehensive planning initiative involving all participant agencies, such as hospitals, law enforcement, and ambulance systems for transport assistance planning. The MHP reports regular meetings of programs and staff who take part in level of care discussions in regard to individuals needing prolonged stabilization stays and those in high-level programs who need to be placed within the community. While there are notable efforts of the MHP to take action and transition individuals from high-level programs, the efforts to accomplish the same with long-term individuals served at the outpatient clinic level seems less well-structured and monitored. For example, some MHPs establish step-down targets for programs and periodically review case turnover data. This MHP relies on the application of a process but seems to lack meaningful targets and tracking of level of care determination on an aggregate scale. The policy requirement of an annual level of care determination did not appear to be accompanied by any demonstrable analysis of results nor observed review of the process to assure a systematic approach is being utilized and results achieved.		
3E	Evidence of consumer and family member employment in key roles throughout the system	PM
During this last year, the Pacific Clinics Peer Partnership contract was terminated. This contract was a key vehicle for consumer and lived experience employment. During this review EQR learned that seven individuals with lived experience are directly employed by the MHP. Approximately 20 others are employed by Turning Point, one by the Client Network, and six by Pacific Clinics TAY Tunnel wellness center. Additional individuals may be employed by other contractors. Parent partners bring their unique experiences and perspective to each VCBH youth and family clinic, where they are embedded. As well, they are part of the CSU and the Insight FSP program.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
Contract providers also utilized parent partners in Therapeutic Behavioral Services, In Home Behavioral Services and Wraparound programs. Reportedly, the contact between the consumer-employees and MHP leadership occurs through the program supervisor or contractor. There is not a direct, regular connection between the overall consumer-employee voice and MHP leadership.		
3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	M
The main adult wellness center, located in Oxnard and operated by Turning Point, services approximately 280 individuals per month, of which 60 percent are VCBH consumers. Another adult wellness center operates part-time in Ventura. The MHP also funds the TAY Tunnel wellness center, also located in Oxnard and operated by Pacific Clinics.		
3G	Measures clinical and/or functional outcomes of consumers served	M
The MHP has utilized the Ventura County Outcome System (VCOS), which contains elements of a number of various measures. The CANS assessment tool is being piloted in the CAATS program in preparation for an October 1, 2018 MHP rollout. The CANS tool was modified by the MHP to incorporate additional needed elements such as trauma and will be replacing VCOS for children and youth. In the fall, the CANS will be applied to all youth. Onsite discussion indicated some consideration for adoption of a universal adult clinical or level of care tool. No decision was shared on this matter during the review.		
3H	Utilizes information from Consumer Satisfaction Surveys	M
The MHP performed analysis of satisfaction, and in the analysis of the children and youth data found a relationship between culture and satisfaction. There were correlations also established to outcome instruments. Other correlational analyses were shared during the review. There were no examples of changes made due to this information.		

Key Components Findings—Impact and Implications

Access to Care

- This MHP demonstrates strength it its commitment to the development of resources targeted to high-need children and youth, and adults. With two adult MHRCs, one locked and one open, and a crisis residential program for adults; for children and youth a crisis stabilization unit, recently augmented by a youth crisis residential program.

- The directly operated Crisis Team is responsible for adult and children/youth crisis response. Crisis staffing has been challenging during at least this last year, with vacancies remaining for long periods. The treatment team is now responsible for handling these open cases during working hours. This shift impacts effectiveness of care to ongoing consumers, disrupting scheduled appointments at times. It is unclear if there has a demonstrable impact on other consumers who are receiving routine care.

- The MHP seems to have no standard agreements to provide consultation to local emergency rooms with its Crisis Team. This may be impacting the quality and effectiveness of care to individuals who are brought to an emergency department in crisis, and potentially be leading to less than optimal clinical decisions regarding hospitalization.

- The MHP's services are a broad blend of directly operated programs and contracted services. Many of the contractors provide very specific, targeted services, such as full-service partnerships, or alternately intensive programs such as MHRC or augmented living situations such as the "Casas." In children and youth services, TBS and other services are provided by programs such as Aspiranet and others.

- The recent Thomas Fire resulted in the nearly complete loss of Vista Del Mar, a free-standing psychiatric facility that also operated partial hospitalization programming. That facility included beds for adults, children and youth. Currently, children and youth hospitalizations either occur in Bakersfield or the greater Los Angeles area. When hospitalization is required, the long-distance transportation need is impacted by local ambulance availability which can result in delays and long waits in emergency departments.

- As a unit of the Ventura County Health Care Agency, efforts have been made to co-locate MHP clinics with public health. The collocating of mental health practitioner at physical health sites has expanded access to mental health care for the general health recipient. However, the flow of referrals from behavioral health to public health had in the past been facilitated by behavioral health nurses who had that specific responsibility. Currently this linkage is in need of revitalization due to the loss of incumbents to retirement and transfers.

Timeliness of Services

- The MHP has established a somewhat conservative 28-day standard for initial access. Data indicates achievement of this standard is very high. Since the MHP appears to be able to meet a higher standard, with data reflecting means of 12 days for adult services and 16 days for children and youth, it is worth considering improving that standard. The MHP has partially addressed the initial access topic by creating a pilot of same-day access at the Conejo Clinic, focused on individuals returning to treatment and individuals with high acuity. Focus group input was positive regarding the initial access experience, including those with Spanish language preferred.

- At the time of this review, a standard for tracking initial psychiatric access had not been established. However, the MHP does track data for this important service. Absent a local standard, the MHP continues to engage in efforts to improve timeliness in this area. Data for expedited access seems to indicate very good access; however, consumers in the routine category experience long wait times. It should be noted that focus group consumers had no complaints about timeliness in this area.

- The post-hospital follow-up of adults has a mean of 15 days, more than double the HEDIS 7-day standard. Post-hospital discharge follow-up for adults treated at the Hillmont Psychiatric Unit (County hospital) should be positively impacted by the MHP stationing of a RISE clinician there to initially assess and engage discharging new consumers. The long adult follow-up interval data may be related to hospitalizations that occur from local emergency departments that send consumers to out of area hospitals. The MHP's Crisis Team provides no emergency department presence at local hospitals, and the admissions the MHP is unaware of may be accompanied by discharges that occur without their involvement or notification.

Quality of Care

- The MHP possesses a well-staffed quality improvement unit, with extensive data analytic capacity. The use of Lean Six Sigma principles is evident throughout the processes utilized to evaluate data, identify challenges and set forth efforts to improve. The QIC Executive Workgroups on various challenge areas utilize a process very similar to a PIP, heavily reliant upon statistical evaluation techniques.

- The MHP's quality improvement efforts emphasize the inclusion of line staff, and their participation in designing and shaping the projects. An example is found in the acuity PIP, where line staff input shaped decisions about defining the boundaries of the acuity levels and in development of minimum service standards. In other sessions, staff mentioned disappointment that many months of participation could be discarded without explanation. While both circumstances may be true, it would likely be beneficial for projects to be wrapped up with debriefings that cover the "takeaways" and explanations for moving in another direction.

- The MHP's efforts to develop a robust system of care for both adults and children and youth is evident in the new programming. A CSU for adults is the most evident gap in services. As well, a comprehensive coordinated relationship between the MHP's services and the multiple local emergency departments seems absent.

Consumer Outcomes

- The cancellation of the Pacific Clinics contract to provide peer specialist employees to support mental health clinic operations has been experienced by many consumers as a loss. The information reported by the MHP indicates there are numerous consumer employees hired in specific programs to fulfill designated functional roles. It was not

possible during this review to calibrate if there has been any net loss of positions for consumers and family members.

- Three wellness centers support the MHP's efforts to provide recovery services to consumers, two adult programs and one TAY.

- Consumer outcomes are tracked through the use of the VCOS system, incorporating elements of a number of instruments. The move of children's services to the CANS, starting with the CAATS service, may take the MHP in another direction for collection and presentation of outcome data. This is an apt time to consider the identification of a universal outcome or level of care instrument for adults, such as the ANSA, MORS, LOCUS. With a process established for the annual team review of each open case, the contributions of a consistent and validated tool could prove useful.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted four 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested four focus groups with 8 to 10 participants each, the details of which can be found in each section below.

The consumer/family member focus group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions are specific to the MHP being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift certificates to thank the consumers and family members for their participation.

Consumer/Family Member Focus Group 1

The first focus group consisted of a culturally diverse group of adult Hispanic and Spanish speaking beneficiaries, the majority of whom initiated services within the prior 6 to 12 months, occurring at South Oxnard clinic, 2500 South "C" Street, Suite C, Oxnard CA 93033.

Number of participants: five

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

- Initial access to services took between one and two weeks, with the majority experiencing the longer duration.
- Following the assessment session, the time to first therapy appointment was one week.
- The first psychiatry appointment occurred within one month for all participants.
- All were pleased with the ease of access to care. Several consumers came through a hospital referral, and others were referred by primary care.
- No barriers to access were experienced by these participants.

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

- The majority receive therapy on an individual basis, with a smaller percentage of participants receiving treatment in a group setting. All feel the frequency of service is sufficient to make progress.

- All of these participants have received group treatment, some through the wellness center and others at alternate sites. They also report receiving services in Spanish, their preferred language.
- The majority of participants also receive psychiatric services and medications. Half of these participants receive monthly psychiatry sessions, and the other half range from every two to three months. All feel the frequency is sufficient to make needed progress, and that their medication issues are adequately addressed.
- Nearly all receive case management assistance in connecting with other resources or benefits, and from someone other than the therapist. The frequency varies from weekly to as needed. All of these individuals are satisfied with the support received and feel the frequency is sufficient.
- A very small number of participants report utilizing the wellness center for groups and other activities and reported how this process improved the motivation to exercise and make positive lifestyle choices. The others, however, also reported attending medication and support groups with clinicians, the aims of which were to improve confidence and focus on physical health issues.
- Urgent, unscheduled care needs are met through calling the clinician of record or case manager. All report possessing the direct number for that contact. All state they are contacted within a day of making the call.
- The majority of participants have not experienced a crisis event. For the small segment that had needed crisis services, it was easily met without any reported difficulties.
- All participants felt they had a voice in the development of their treatment plans. None had awareness for WRAP or other self-help programs. But all recall being queried about their symptoms and status during the course of sessions. Lab work was done with all participants, with varying frequency.
- None have experienced a need to make a change in therapist or psychiatrist/prescriber.
- Use of the wellness center is limited to a very small subset of session participants. The classes and groups were reportedly beneficial. A need for more activities, outreach, and groups in Spanish was identified.
- All participants report receiving services in their preferred language, Spanish.
- All of the focus group members have completed a satisfaction or perception survey but could not recall any opportunity to meet in a group and provide feedback.

Recommendations for improving care included the following:

- More wellness center activities, groups, and sessions in Spanish.

- Provide bus passes or other transportation assistance to consumers.
- Do not curtail or cut service levels

Interpreter used for focus group 1: Yes Language(s): Spanish

Consumer/Family Member Focus Group 2

The second focus group consisted of a culturally diverse group of Hispanic/Spanish speaking parents/caregivers of child/youth beneficiaries, the majority of whom initiated services within the prior 6 to 12 months, occurring at South Oxnard clinic. 2500 South "C" Street Suite C, Oxnard CA 93033.

Number of participants: Eight

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

- Initial access to an assessment appointment ranged from less than one week to two weeks.
- The first therapy appointment occurred approximately within the following two weeks.
- Access to the first psychiatry appointment was reportedly one month.
- Most of the barriers to seeking care were internal for these parents and caregivers, with stigma and custody issues the main issues.
- The sources of information about mental health treatment included family members, school recommendations, and hospital referrals.

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

- Psychotherapy frequency is reported as weekly for the majority, every two weeks for some consumers. Except for a small minority, most feel the current frequency is sufficient.
- Approximately half of the participants have children who receive psychiatry services, with the majority seen monthly. Reportedly, these service levels are sufficient to achieve hoped for results.
- Participants report receiving group or family treatment, often occurring in the home.
- Case management is not utilized by any of these participants.

- For urgent care needs all participants possess a phone number and specific contact, which is either the therapist or parent partner. Most report receiving help immediately.
- While participants were unsure about their involvement in the treatment planning process, but they do report receiving information from the therapist and psychiatrist about status of treatment.
- Transportation was not reported as an issue, with most citing that therapists or parent partners come to the home.
- All receive services in their preferred language, Spanish.
- Consumers typically learn about various services from the clinician or parent partner.
- Participants were too new to services to have received any survey about care.
- Support groups are utilized by half of the participants, and family therapy has been offered to the majority. It was unclear how many have actually utilized these services.

Recommendations for improving care included the following:

- Improve the privacy offered in the school therapy rooms, which have limited sound-proofing.
- Improve the communication between the therapists and the schools so that messages are more consistent and uniform. and therapists, which is often experienced by parents as conflicting messages.

Interpreter used for focus group 2: Yes Language(s): Spanish

Consumer/Family Member Focus Group 3

The third consumer-family member focus group consisted of a culturally diverse group of Hispanic/Spanish speaking parents/caregivers of child/youth beneficiaries, the majority of whom initiated services within the prior 6 to 12 months, occurring at Santa Paula clinic. Spanish speaking parents/caregivers and English speakers were both included. Santa Paula Children's Clinic, 725 E. Main St., Santa Paula CA. 93060.

Number of participants: Seven

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

- Initial access to care ranged from one to two months, with the subsequent first therapy appointment taking from three weeks to two months.

- Initial psychiatric access took from one to two months, the majority on the longer side.
- Overall, the experience was generally positive. One experience involved a child needing to change psychiatrist because the initial did not have an effective rapport with the child and reportedly was not a child psychiatry specialist.
- Information about services and referral involved inpatient unit referral, school referral, and a faith organization provided referral in another instance. No barriers were identified.

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

- All children receive regular therapy services, the majority weekly. Half of these caregivers feel the frequency is sufficient. In one example, the psychiatrist had recommended therapy two to three times each week, which was not provided. This disparity between recommended frequency and actual caused parental distress.
- Other supports can include a Santa Paula group for parents, but due to insufficient participation, the group was cancelled. In addition, a twelve-week parenting class is provided through a project based in a local church.
- Psychiatry services are utilized by the overwhelming majority of participants. All feel the frequency is sufficient to achieve positive changes. The frequency ranges from monthly to every two to three months, and when medication changes are made monthly sessions are scheduled to monitor results.
- Participants were unsure about what was meant by case management, and likely did not receive this sort of support.
- For urgent care needs, the majority have a specific number to call when the need arises. Half call their therapist, two would call the crisis line. Overall, participants know how to call the crisis team if needed.
- Crisis needs are answered right away and response arrives in thirty minutes.
- No significant changes in services were observed have occurred in the last year. It remains difficult and a lengthy process to change the psychiatric provider.
- The children's group was cancelled, and was experienced as very useful, teaching children/youth how to play with one another, respect each other. A teen group continues that provides field trips and other activities.
- Information about services is obtained from posted flyers, the therapist, and reminder calls. Participants have been queried about what types of services would be helpful to offer. Half have completed an annual survey.

Recommendations for improving care included the following:

- Expand support group offerings for both children and the parents. The shared experience process would improve how each feel about themselves.
- Provide transportation assistance, such as bus passes or shuttle buses.
- Provide child care for times an older child has an appointment.
- Provide assistance in engaging children is sports, particular when participation costs for uniforms or other equipment is high.

Interpreter used for focus group 3: Yes Language(s): Spanish

Consumer/Family Member Focus Group 4

A culturally diverse group of TAY beneficiaries, the majority of whom initiated services within the prior 5 to 12 months. The focus group was conducted at the MHP main offices, at 1911 Williams Dr., Lake Casitas Room, Oxnard, CA 93036.

Number of participants: Six

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

- These TAY youth obtained initial access anywhere from one week to one month.
- First therapy appointment took approximately two weeks.
- First psychiatry service ranged from two days to three weeks.
- The initial access experience was described as very easy. Communication was good, and staff all worked to reduce the stress of that experience.
- Information about services was obtained in various ways. Some were referred by a crisis residential program. Others were referred by family members, some in response to NAMI guidance.
- The greatest challenge identified by participants was internal, themselves. Staff were described as very patient, even though the consumer was reluctant or resistant.

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

- The majority of participants receive weekly psychotherapy sessions, with a small portion monthly.
- Group therapy is accessible to those located in Ventura but is not for those from the Conejo area.

- Case management support is received by the majority of participants. Most often, it is received week, with one as needed.
- Support groups were obtained in Ventura by a small number of participants.
- When urgent or crisis services are needed, all participants have the phone numbers for help and know who to call.
- Unscheduled needs for services usually require that a voice mail message be left, which is returned the same or next day. If the officer of the day is seen, the consumer can be told they cannot help you if not suicidal.
- If additional services cannot be provided soon enough, half of the participants would call the crisis team. But this is not a circumstance that has developed yet for these participants.
- Experiences with services when in crisis was reported as variable. Some had very positive experiences with ambulance, police and Crisis Team contact. Long waits in the emergency room, cited as lasting as long as eight hours, were also reported. Half of the focus group participants reported having unsettling and frightening experiences while waiting long hours in the emergency department for the resolution of their situation.
- Overall, these consumers reported services declining as personnel turnover occurred during the past several months. About half of the participants have heard of Wellness and Recovery Action Plan (WRAP), with a third finding WRAP useful, and the remaining individuals either have taken classes or are in the process.
- Approximately a quarter of focus group participants were aware of communication between their psychiatrist and primary care provider. A larger group of participants recall being asked about their symptoms and side effects of medications during sessions. A quarter of the group recalled being sent to have lab work done related to psychiatric medications.
- Among the greatest changes cited during this last year are changing therapists, which in one instance, included three different therapist changes in the course of moving from TAY to adult services. The retirement of a psychiatrist resulted in two-month gap for one participant.
- Access to the Wellness Center (TAY Tunnel) is assisted for those who live at Esperanza, but once independent living transition has occurred, reliance on public transport creates challenges. It can take up to two hours of bus travel from south county and can involve delays.
- Information about services are provided through the peer to peer program, the NAMI walk, MHSA committee participation, and Casa Esperanza groups. Overall, the county website was noted to be very helpful in learning about services.

Recommendations for improving care included the following:

- Improve methods for sharing information about services via a uniform, easily accessible resource guide.
- Continue to focus on the issue of dispelling stigma relating to mental health conditions and treatment.
- Increase the use of community field trips to the beach, the mall, and other places.
- Provide more support and groups for those transitioning from TAY to adult services.
- Expand the number of clinic locations and related resources so as to reduce the need to travel for services.
- Provide more therapy groups to the more distant areas of the county, beyond the Oxnard/Ventura areas. The specific services requested include: Seeking Safety, relationship groups, substance and adult diagnosis groups.
- Improve the Wellness Center's welcoming through more staff and training of staff.
- Create a Warm Line that consumers may use for support.
- Develop alternatives for the lost Vista Del Mar beds.

Interpreter used for focus group 4: No

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- Of the four consumer-family focus groups conducted for this review, three targeted the experiences of Hispanic/Latino and Spanish speakers. None of the focus groups identified any unmet needs related to language or culture in the clinical services provided. The wellness center was identified as lacking significant Spanish groups and activities sufficient to attract and serve this population.
- Limited access to family support groups were often mentioned because of limitations on these groups when low participation occurs, leaving those wishing to attend without a needed service.
- The greatest access barrier cited by caregivers of children and youth was internal to participants, based on stigma and indicating that continued efforts to dispel stigma at the larger community level are important to sustain.

- Transportation assistance is needed in the form of bus passes, shuttles, or case manager assistance is key to those adult consumers who do not reside near services.

- The multi-family caregiver support and education groups would benefit from some format changes, such as permitting families to join or discontinue, or groups not being discontinued because of low attendance. Caregivers believe ongoing support is critical for them to reinforce the changes clinicians are attempting to achieve with their children.

Timeliness of Services

- A wide range of initial access experiences was reported by the four focus groups. The South Oxnard adult Hispanic consumers received assessments within one to two weeks. South Oxnard caregivers' experience was from less than one week to two weeks. Santa Paula caregiver/children's access ranged from three weeks to two months. TAY consumers experienced initial services between one week and one month. None of the participants felt there were any obstacles to their care.

- Time to first therapeutic appointment following assessment was one to two weeks for South Oxnard Adult Hispanic Spanish speakers; and for Santa Paula Hispanic and Spanish speaker users of children's services, three weeks to two months; for TAY, two weeks. No concerns about initial therapy access were expressed by these participants.

- Initial psychiatry access varied among the focus groups, ranging from two days to two months. All felt the timeliness was adequate to meet their needs.

Quality of Care

- School-based services (ERSES) were identified as needing greater privacy, as related to the rooms in which sessions are conducted lacking adequate sound-proofing, to ensure confidentiality.

- The nature of the response to crisis events varies, with positives cited regarding treating clinician response and MHP crisis services, but significant negatives expressed about the current system of waiting in emergency departments for many hours while acute beds are located. The emergency department wait times and the environment before acute admission occurs is identified as exposing individuals to traumatizing and anxiety provoking situations.

- Consumers report they would benefit from a comprehensive list of services located in one handout. The MHP web presence seems to group programs by funding source, such as MHSA, which is neither comprehensive nor written to the consumers perspective.

- Dedicated child care services are important and needed to be routinely available at child youth and family clinics so that caregivers can attend sessions with their children and

have a safe place for younger children to be supervised. This should be routinely available and not require advanced planning.

Consumer Outcomes

- The wellness centers and their services are not available in all regions of the county, and for some consumers, present time-consuming transportation challenges.
- TAY consumers report services that help them prepare for independent living and job seeking, as well as assistance in transitioning to adult services, where appropriate.

INFORMATION SYSTEMS REVIEW

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

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

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

Table 9 shows the percentage of services provided by type of service provider.

Table 9: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	66.80%
Contract providers	33.09%
Network providers	0.12%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, IT staff): 4.32 percent

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

MHP currently provides services to consumers using a telepsychiatry application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: 5

Identify primary reason(s) for using telepsychiatry 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 consumers temporarily residing outside the county
- ☐ Reduce travel time for healthcare professional staff
- ☒ Reduce travel time for consumers

- Telepsychiatry services are available with English and Spanish speaking practitioners (not including the use of interpreters or language line).
- The MHP provided 386 telepsychiatry sessions in CY16, serving 356 adults and 32 older adult consumers.
- Approximately 167 telepsychiatry sessions were conducted in Spanish.

Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
3	0	0	1

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

Table 11: Data Analytical Staff			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
4	0	0	1

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

- The data analytic staff include three staff in Quality Improvement and one staff who is a Fiscal Office Systems Coordinator.
- An Office Systems Coordinator IV position is in recruitment.

Current Operations

- The MHP has no plans to replace the current Avatar system which is operated in an application service provider (ASP) model with Netsmart Technologies supporting system functionality, including backup and recovery operations.
- Contract provider Kids and Families Together has been entering the entire clinical record for consumers into Avatar since 1/23/2018. Seneca, operating the Children's CSU, has been granted access to view the entire Avatar mental health dataset, including that of VCBH and other contracted providers.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (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 12: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Avatar/CalPM	Practice Management	Netsmart	8	Netsmart Hosted
Avatar/Clinicians Work Station (CWS)	Clinical Record	Netsmart	4	Netsmart Hosted
Avatar/OrderConnect	eRx	Netsmart	4	Netsmart Hosted
Avatar/Data Warehouse	Data Warehouse	Netsmart	2	Netsmart Hosted

Kofax Insight	Data Analytics	Kofax/Western Integrated Systems	2	VCBH IT

Priorities for the Coming Year

- Continue certification of physicians and implementation of electronic prescribing of controlled substances.
- Create and implement a management level dashboard for Youth and Family Services.
- Implement personal health record functionality.
- Implement Avatar Client Scheduling functionality for AOD.
- Continue Avatar ADP form development.
- Implement eLab functionality with Quest Diagnostics.
- Implement Avatar Remote User (CarePOV) Services.
- Revise the current five-year Avatar support contract with Netsmart Technologies.

Major Changes Since Prior Year

- Completed document scanning implementation and resolved initial server and configuration issues.
- Read-only Avatar access was granted to contract provider Kids and Families Together.
- Developed an adult system of care dashboard targeted for the management team.
- ADP Adoption of the Avatar EHR as the official record.
- Avatar Client Scheduling functionality is in test mode for ADP.
- An inpatient unit hospitalization tracking system was developed.
- Reporting functionality was enhanced for the grievance and appeals tracking system.
- Smoking cessation notification was added to the progress note.
- The MHP is working collaberatively with Quest Diagnostics in the planning eLab functionality.
- Approximately eight physicians have been certified for prescribing of controlled substances.

Other Significant Issues

- While the MHP has granted access over the past year to the contract provider, Kids and Families Together, multiple other contract providers expressed the desire to have Avatar access shared with the MHP.
- The MHP does not currently have the capacity to track no-shows by type (consumer cancelled an appointment, consumer did not show for an appointment, clinician cancelled an appointment).

Plans for Information Systems Change

- The MHP has no plans to replace the Avatar system.

Current Electronic Health Record Status

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

Table 13: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	Avatar/Netsmart		x		
Assessments	Avatar/Netsmart	x			
Care Coordination				x	
Document imaging/storage	Avatar/Netsmart	x			
Electronic signature—consumer	Avatar/Netsmart	x			
Laboratory results (eLab)				x	
Level of Care/Level of Service				x	
Outcomes	Avatar/Netsmart	x			
Prescriptions (eRx)	Avatar/Netsmart	x			
Progress notes	yAvatar/Netsmart	x			
Referral Management				x	
Treatment plans	Avatar/Netsmart	x			
Summary Totals for EHR Functionality:		7	1	4	0

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- Document imaging was implemented and initial configuration issues have been resolved.
- The MHP has been working collaboratively with Quest Diagnostics and is testing initial eLab functionality.

Consumer's Chart of Record for county-operated programs (self-reported by MHP):

☐ Paper ☒ Electronic ☐ Combination

Personal Health Record

Do consumers have online access to their health records either through a Personal Health Record (PHR) feature provided within the EHR, consumer portal, or third-party PHR?

☐ Yes ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Automated Data Retrieval System in combination with Excel

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Number Submitted	Gross Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
368,974	$115,386,315	**34,945**	$9,899,607	8.58%	$105,486,708	$48,668,105	$56,818,603

Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017.
The statewide average denial rate for CY2016 was 4.48 percent.
Change to the FFP reimbursement percentage for ACA aid codes delayed all claim payments between the months of January-May 2017.

- While still above the statewide average of 4.48 percent, the MHP's denied claim rate of 8.58 percent has declined from the CY15 rate of 9.30 percent.

Table 15 summarizes the most frequently cited reasons for claim denial.

Table 15: Ventura MHP Summary of CY16 Top Three Reasons for Claim Denial

Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	9,928	$3,416,253	35%
Other coverage must be billed prior to submission of this claim	7,770	$2,264,682	23%
Duplicate service or repeat modifer not present	10,522	$2,234,328	23%
Total Denied Claims	34,945	$9,899,607	100%

- Denied claim transactions with reason {insert denial reason description(s) from Table 15} are generally re-billable within the State guidelines.

Information Systems Review Findings—Implications

Access to Care

- The MHP provided 386 telepsychiatry encounters in CY16, serving 356 adults and 32 older adult consumers.

Timeliness of Services

- The MHP does not currently have the capacity to track no-shows by type.
- The MHP has a three-day standard for urgent appointments and meets this standard 50 percent of the time for adult consumers.
- An inpatient unit hospitalization tracking system is under development.

Quality of Care

- An adult system of care dashboard targeted for the management team was developed.
- A youth and family dashboard began development at the end of FY 16-17.
- Smoking cessation notification was added to the progress note.
- Reporting functionality was enhanced for the grievance and appeals tracking system.
- The MHP continues to experience a rate of denied claims that significantly exceeds the statewide average.

Consumer Outcomes

- The CANS assessment tool is being piloted in the CAATS program.

SITE REVIEW PROCESS BARRIERS

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

- No barriers were encountered during this review.

CONCLUSIONS

During the FY17-18 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

Strengths and Opportunities

Access to Care

Strengths:

- MHP provided 386 telepsychiatry encounters in CY16 (356 adults and 32 older adults), significantly increasing over the 108 reported for the prior review.
- The foster care penetration rate increased slightly and is greater than the statewide and other large MHP averages.
- The MHP's Horizon View MHRC has been open for a little over a year and shows a 96 percent occupancy rate.
- The recently opened children and youth crisis residential unit provides a longer stabilization option to those in need and completes the continuum of care.
- The MHP's efforts to improve Latino/Hispanic penetration rates are supported by the four outreach workers who provide information at work sites.
- Approved claims average for the Latino/Hispanic population has increased, and is higher than the statewide average and average of other large MHPs.
- TAY consumers acknowledge the vocational support provided through the Department of Rehabilitation contract.
- The MHP has increased STAR after-hours assessment and clinic treatment slots to improve access for those are unable to utilize 8am to 5pm appointments.

Opportunities:

- Wellness center availability is limited to the Oxnard and Ventura areas, leaving consumers in the Santa Paula, Conejo and Simi Valley areas with transportation challenges.

- While increased after-hours assessment and treatment slots are reported by the MHP, focus group participants who are parents and caregivers feel more is needed.
- Continuous and flexible child care is needed at the children's service clinics, to allow for circumstances when the caregiver has been unable to anticipate the child care need, so that caregiver session participation can occur without disruption.
- Wellness center Spanish-speaker utilization requires the continual presence of Spanish-speaking staff and continuous offering of programming, groups and activities.
- Transportation is a challenge from some of the more remote areas of the county, particularly when seeking regionally limited programming such as the wellness centers.
- Consumers would like to see a comprehensive resource manual that identifies all programs by region and service type and containing descriptions of eligibility criteria and services. The type of detail is often present in the brochures for individual programs, but no single document informs both consumer and staff on the full range of services.
- There has been a slight overall decrease in the Medi-Cal penetration rate, reflecting an increase in eligibles with a smaller increase in served consumers.
- The Latino/Hispanic penetration rate has decreased, and is about even with the large MHP average, but 10 percent less that statewide average.
- The shift of crisis response duties to the treatment team of record during business hours for open individuals may impact routine care, and merits evaluation.
- Critical elements of the MHP's service delivery system have experienced challenges with hiring and retention of staff, most notable the Crisis Team and the STARS assessment component, resulting in modification in protocol that further stresses treatment resources.

Timeliness of Services

Strengths:

- The MHP reports fairly brief initial offered appointment times for accessing care, 12 day mean for adults, and 16 days for children and youth.
- To support the tracking of post-hospital discharge follow-up for children and youth, the MHP developed a mechanism for tracking these admissions and communicating follow-up.
- The Conejo Clinic same-day access pilot demonstrates the ability to accelerate the assessment and treatment process and may have applicability to other locations.

- The CAATS team completes the child biopsychosocial assessment within 5 days for the dependency population. Treatment begins within five days of assessment completion. Total time from referral to treatment is 15 days.

Opportunities:

- The MHP's urgent care standard of three days is met 50 percent of the time for adult consumers.
- No-shows currently cannot be tracked by type, limiting the utility of this information in identifying system issues.
- The MHP does not have a standard timeline for initial psychiatry access.

Quality of Care

Strengths:

- The MHP established a protocol for annual case review of all consumers.
- The MHP is testing the locally adapted CANS with a pilot in CAATS/foster care services, in preparation for universal adoption in children and youth services.
- To improve the quality of interventions with adult consumers, the MHP provided training to staff on CBT-p which is tailored to individuals with serious mental illness.
- The MHP has leveraged its previous PIP on Safe Alprazolam Prescribing into an ongoing benzodiazepine monitoring protocol that has reduced the prescribing of drugs which have a potential for dependence and abuse.
- The QI Work Plan incorporates participation of the executive team in providing guidance and support to workgroup projects.
- An adult system of care dashboard was developed that provides essential information to the management team.
- The grievance and appeals tracking system was provided with improved reporting functionality.
- The system for tracking inpatient admission of children and youth enables improved follow-up and quality of care functionality post-discharge.
- The smoking cessation PIP resulted in tobacco consumption status being added to the psychiatry/prescriber progress note as a required element.
- The MHP has made steps in developing an adult level of care categorization system based on an acuity determination that is tied to hospitalization history. Further

integration with an adult level of care or clinical assessment tool would be an important addition.

- The MHP's adoption of Lean Six Sigma practices informs its approach to the analysis of challenge areas and development of intervention strategies, and is heavily reliant upon data analytics.

Opportunities:

- Challenges in the crisis and acute care system were identified during this review, with individuals in crisis arriving, experiencing long waits, and often resulting in being transported long distances to out of area psychiatric hospitals. The MHP has no formal agreement to provide consultation with emergency departments. Efforts to establish a crisis stabilization unit and develop an ongoing collaboration forum and consultation at emergency departments are important elements.

- The documents involved with the initial intake and assessment process include time-consuming administrative paperwork elements that could be completed by support staff, interns and/or mental health associates. Reallocating these tasks away from the clinical workflow would improve the time available to clinicians for their main task – clinical services.

- MHP's CY16 denied claims were nearly double the statewide average.

- The MHP lacks a universally applied adult outcome and/or or level of care instrument to help inform service delivery and readiness for stepdown and discharge decisions.

- Over time, the MHP's clinic medical liaison role has largely disappeared. Previously, MHP nurses communicated to co-located public health clinics and advocated for the physical health needs of consumers.

- The MHP cannot track no-shows by type– e.g., clinician cancelled, consumer rescheduled, consumer no-show – reducing the utility of this information in providing actionable information.

- Contract provider access to Avatar is limited and does not provide adequate support to the clinical need partner programs have in accessing the full history of referred consumers. The providers must rely upon the limited information from the referral document which is typically focused on most recent events and lacks the totality of the consumer's history. In that these referrals often relate to individuals with significant risk factors, access to the full history is imperative.

- The rooms used to conduct child and family sessions for school-based services are reportedly poorly sound-proofed and impacts the sense of security and safety of parents and caregivers. privacy offered by school-based therapy services merits evaluation by MHP clinical staff,

Consumer Outcomes

Strengths:

- The CANS will be fully operational in Fall 2018.
- The CANS assessment tool is being piloted in the CAATS dependency services program, and has been modified to include additional variables such as trauma.
- The MHP is working to improve TAY outcomes with the Department of Rehabilitation vocational support program.

Opportunities:

- The CY16 7-day rehospitalization rate increased and is slightly greater than statewide average.
- The CY16 30-day rehospitalization rate increased, and is higher than the statewide rate.
- The interventions of the smoking cessation PIP were not effective in producing the intended change and demonstrates the importance of tailoring this type of program to the specific needs of the MHP's adult population.

Recommendations

- Develop a comprehensive plan for crisis services that includes establishment of a liaison and consultation relationship with local emergency departments, and actions to develop an adult crisis stabilization unit, so that the needs of mental health consumers in crisis are addressed in a timely manner.
- Review the current standard for initial access and consider decreasing the allowable time to services
- Identify and resolve issues that are related to current and future Medi-Cal claims denials, including the analysis, correction, and resubmission of previously denied claims as allowed under state regulations.
- Identify and resolve issues related to the MHP's inability to meet the urgent care three-day standard for the adult system of care.
- Perform a review of rooms used for school-based therapy to determine where corrective actions need to be taken to ensure confidentiality of the participants.

- Develop a comprehensive process for determining adult system levels of care with recommended service levels, including implementation of a level of care instrument, incorporating the annual review and stepdown/discharge planning process.
- Preserve clinical staff time through a comprehensive effort to streamline and combine forms and realign completion of non-clinical forms to interns and support staff. Utilize line staff participation to help inform the process. Renew efforts to bring administrative paperwork documents into Avatar so that repetitive elements such as consumer name and case number are automatically populated.
- Develop a comprehensive listing of MHP direct and contracted resources, including both clinical and wellness and recovery programs, listing program elements by region, including comprehensive service and eligibility descriptions, with MHSA integrated. The structure of this document needs to be informed by consumer and line staff participant needs and available in an online and physical/paper format to consumers and line staff.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO Performance Improvement Plan (PIP) Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - Ventura MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations
Contract Provider Group Interview –Quality Management
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Wellness Center Site Visit
Contract Provider Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, Quality Reviewer, Consultant
Gale Berkowitz, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Marilyn Hillerman, Consumer-Family Member, Consultant

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

Sites of MHP Review

MHP Sites

Ventura County Behavioral Health
1911 Williams Drive
Oxnard, CA 93036

VCBHS - Adult Mental Health Services
2005 South "C" Street
Oxnard, CA

VCBHCS - Santa Paula Children's Clinic
725 E. Main Street
Santa Paula, CA 93060

Contract Provider Sites

Telecare Horizon View
333 Skyway Drive
Camarillo, CA 93010

Telecare Casas Esperanza
1750 South Lewis Road
Camarillo, CA 93012

Turning Point Wellness Center
2697 Saviers Road
Oxnard, CA 93033

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Abarca	Emilio	Program Administrator	VCBH - QI
Acosta	Lisa	Youth Division Medical Director	Ventura County Behavioral Health
Agosto	Almira	BH Clinician III	Conejo Y&F
Aguila	Gabriela	BH Manager II	VCBH – CWS/CalWorks/Katie A
Ashur	Ophra	BH Quality Management/UM Manager	VCBH
Bailey	Christina	Mental Health Associate	VCBH - RISE
Baker-Wilkinson	Tyler	Program Director	Seneca
Banos	Veronica	Parent Partner	VCBH
Barr	Shimul	Psychiatrist	VCBH
Barrientos	Sandra	Staff Psychologist	No. Oxnard Y&F
Boscarelli	Robin	Crisis Team- Clinic Administrator	HCA/VCBH
Bradley	Victoria	Ventura Adult Clinic Administrator	VCBH
Brooking	Jane	Co-Chair Adult Services	BHAB
Burau	Mary	CA North Oxnard Adults	VCBH
Carbajal	Nancy		
Carson	Hilary	Program Administrator	VCBH - MHSA
Carter	Lisa	Clinician	Aspiranet
Catapusan	Anita	BH Manager-DMC-ODS	VCBH-SUD
Chavez	Dayzee	Mental Health Associate	North Oxnard Adult
Colton	Michael	CA- S. Oxnard Adults	VCBH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Cowie	Stephanie	Clinic Admin Phoenix Schools	VCBH
Cunningham	Lindsay	Clinical Director	Telecare Horizons
Damerjian	Vania	BH Clinician	Simi Y&FS - ERSES
DiBattista	Maria	BH Clinic Administrator III	VCBH – CWS (CAAT)
Donovan	Leisa	Sr. Accounting Manager	VCBH
Dougherty	Jennifer	BH Manager	Conejo YFS & ERSES, Simi YFS & ERSES, Phoenix ERSES
Duenas	Alicia	Program Administrator	VCBH – Electronic Record
Egan	Narci	Asst. CFO	Health Care Agency
Elhard	Erick	Crisis Team Administrator	VCBH
Ellis	Carly	BH Clinician III	EPICS
Farhat	Linda	Program Manager	PathPoint
Fekete	Doreen	Sr. Fiscal Manager	VCBH
Ferguson	Erin	Program Manager	Aspiranet
Foreman	Theresa	RN Mental Health	So. Oxnard Adults
Fox	Cheryl	BH Manager	Ventura Y&FS/JJ/Ventura/ERSES/ Diabetes Team
Fregoso	Marisol	Associate MFT	New Dawn
Fukue	Keiko	BH Clinician	Ventura County Behavioral Health
Garcia	Karina	EPSDT Manager	Kids, Families Together
Garcia	Jessie		
Garcia	Debbie	Recovery Coach	Turning Point
Garman	Kari	Program Admin II	Human Services Agency

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Glantz	Julie	Behavioral Health Manager	VCBH
Godtel	Beau	Program Manager	Casa Pacifica
Gomez	Anel	Lead Rehabilitation Specialist	Turning Point
Gonzalez	Patricia	Research Psychologist	VCBH - QI
Goodnight	Danielle		
Grewal	Navjot		Casa Pacifica
Gross	Bob	CA-Simi Adults	VCBH
Harris	Jerry	Chair	VCBH MHAB
Hartman	Josh		Horizon View/Telecare
Haven	Erin	PhD Clinical Supervisor	Casa Pacific
Hernandez	Maria	Ethnic Services Manager	VCBH
Herzog	Harmony	Mental Health Associate	Conejo
Hughes	Stephen	Psychiatrist	VCBH
Inchaurregui	Jennifer	MHRN Lead	Anka Ventura CRT
Jimenez	Rudy	Mental Health Associate	So. Oxnard Adult
Johnson	Sevet	Senior Manager	VCBH – Youth & Families / Adults
Johnson	Heather	Clinic Administrator – Conejo Youth & Family	VCBH
Kemp	Kathy	Clinical Supervisor	Casa Pacifica
Locklear	Erin	Clinical Manager	Interface Children's and Family Services
Lombardo	Michael	Behavioral Rehabilitation Specialist	Pathpoint - VCBH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Lopez	Gabriela	BH Clinic Administrator III	VCBH Y&F
Lopez	Marcus	Clinic Administrator-South Oxnard Adults	VCBH
Macias	Faviola	Interim Clinic Administrator	Santa Paula-VCBH
Madueno	Jonny	Tech	OPOS
Magbitang	Ana	BH Clinician	Ventura County Behavioral Health
Manzo	Salvador	BH Manager	North Oxnard Adult / South Oxnard Adult
Manzo	Salvador	BH Manager	VCBH
Marron	Anthony	Recovery Specialist	Pacific Clinics
Martinez	Maggie		
McDonald	Tina	CA EPIC/ARS	VCBH
Mercy	Helena	Senior Psychologist	Ventura
Mulford	Kathy	BH Manager	VCBH – DUI
Nagle	Laura	Clinic Administrator – Juvenile Facilities	VCBH
Olivas	Dina	Senior Manager	VCBH – Youth and Families/ Adults
Ortiz	Kayla	Clinician	Interface Children Family Services
Peterson	Brittany	BH Clinician II	No. Oxnard Y&F
Pringle	Pete	Interim BH Director	VCBH
Puntup-Khan	Traci	CA-Transitions	VCBH
Putt	Jennifer	STAR-Clinic Administrator	HCA
Riddle	Angela	BH Manager Y&F	VCBH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Roach	Pam	Program Administrator	Admin - Adult - Transitional Liaison
Roach	Pamela	Transformational Liaison Program Administrator	VCBH
Roberts	Julie	CA-PCI	VCBH
Rodriguez	Antonio	Community Services Coordintor	Ventura County Behavioral Health
Rojas	Michelle	Program Administrator	VCBH
Roman	Dave	Sr. Program Administrator	Data Systems Implementation
Rosas Ruiz	Ruby	BH Clinician III	Child Welfare Subsystem
Ross	Mark	Mental Health Associate	Ventura Adults
Roylance	Leah	BH Clinician IV	North Oxnard
Ruiz	Deanna	Clinic Administrator	VCBH
Sahota	Kiran	Sr. BH Manager	VCBH - MHSA
Saldivar	Elizabeth	BH Clinician III	South Oxnard
Sanchez	Sara	CA-Transitions	VCBH
Schipper	John	Adult Division Chief	VCBH
Seal	Maryza	BH Manager	VCBH - Contracts
Silveira	Chelsea	BH Clinician	Ventura County Behavioral Health
Skaggs	Felicia	Rise/Assist/PATH C Administrator	HCA/VCBH
Swanson	Ky	BH Clinician	Ventura County Behavioral Health
Swanson-Hollinger	David	Senior Manager	Human Services Agency
Tadeo	Zandra	Clinic Administrator	Ventura County Behavioral Health
Taylor	Thomas	BHMII EPICs/ARS	VCBH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Thurber	Deborah	Child and Adolescent Psychiatry	VCBH
Torres	Monica	BH Clinic Administrator III	VCBH – CWS/Katie A
Tovar	Luis	Senior Program Administrator-DMC-ODS	VCBH-SUD
Turcios	Vanessa	Sr. Crisis Team Clinician	Ventura County Behavioral Health
Ummer	Faizal	Program Administrator	VCBH - QI
Valles	Lionel	BH Clinician III	Santa Paula
Velasquez	Eric	PSCII	Telecare
Wissinger	Mandy	LVN	Telecare
Wojek	Irene	Psychiatric Nurse Practitioner	VCBH
Yanez	Terri	Administrative Division Chief	VCBH
Yazujian	Rachel	Clinic Administrator	VCBH – Y&F
Yokomizo	Jeff	BH Clinician	Simi Y&FS
Yoshida	Patti	Pharmacist	VCBH
Zanolini	Shanna	Clinical Psychologist	VCBH -QI

Attachment C—Approved Claims Source Data

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

Table C1 shows the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: Ventura MHP CY16 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,674,069	141,926	3.86%	$611,752,899	$4,310
Large	1,778,582	67,721	3.81%	$318,050,214	$4,696
Ventura	64,908	2,289	3.53%	$11,941,116	$5,217

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

Table C2: Ventura MHP CY16 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	9,015	92.72%	94.05%	$37,274,761	$4,135	$3,612	56.29%	59.13%
>$20K - $30K	314	3.23%	2.83%	$7,646,786	$24,353	$24,282	11.55%	11.98%
>$30K	394	4.05%	3.12%	$21,292,983	$54,043	$53,215	32.16%	28.90%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Ventura	
PIP Title: Smoking Cessation	
Start Date (MM/DD/YY): June 2016 **Completion Date** (MM/DD/YY): NA **Projected Study Period** (#of Months): 18 months **Completed**: Unknown Yes ☒ No ☐ **Date(s) of On-Site Review** (MM/DD/YY): 4/3-5/18 **Name of Reviewer**: Rob Walton	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP decided to target a clear health issue for its adult consumers, which presents as the consumption of tobacco products and smoking related illness, the number one cause of death for individuals with mental illness and	

addiction. This is a topic some MHPs have identified in the past, particularly when statewide emphasis on health integration and consumer health issues was a new priority.

The MHP based this focus on smoking prevalence and morbidity literature, with particular emphasis on the specific issues relating to individuals with mental illness. To bolster the appropriateness of this topic, a random sampling survey process was internally initiated. This validation study surveyed 95 consumers, 46 percent were smokers, 73 percent of the smokers expressed a desire to quit tobacco.

As part of this PIP activity, the MHP needed to create a mechanism for identification of consumers who smoke. The MHP observed inconsistency in psychiatry review of this topic, along with other health issues, during the annual assessment. Recording of smoking status was also inconsistent.

A change in procedure and documentation in the EHR was made to the psychiatry/prescriber documentation process that required tobacco use screening.

The MHP developed a relationship with the Public Health department which operates smoking cessation classes, including the Call It Quits (CIQ) classes. A number of indicators were established to track the various aspects of this process. The MHP discovered that the delays that occur between wanting to quit and establishment of a sufficiently large cohort of enrollees to exist resulted in high drop-out rates. Drop-out rates of those who managed to attend are also high.

At this 18-month point, zero participants have remained quit for 90 days. The MHP has explored addition perception indicators to the more concrete outcomes established initially. Also, the MHP is considering ending this PIP and identifying a new topic.

Unless there are yet undiscovered interventions that offer low barriers to adoption and high outcome potential, there remains little to be attained from continuing this PIP. The MHP has considered exploring additional clinic-focused activities that would improve smoking cessation results. As well, moving the groups to the MHP's wellness center(s) could be another way of creating a MHP consumer-focused smoking cessation program. At this time, it is not clear if the MHP will end or continue this PIP.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Consumers, via a survey. Public health participation. VCBH adult clinical and administrative staff.

1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	While locally limited to a small survey size, the resultant data validated MHP hypotheses about the prevalence of this health issue, and the desire of smokers to receive assistance with quitting.
Select the category for each PIP: *Clinical:* ☒ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The focus exclusively was upon smoking cessation, identification of same and assistance with quitting.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Adult services was the focus, although this topic could very well be applied to TAY.
Totals		**3** Met **1** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* *Will integration of smoking cessation services within VCBH decrease the proportion of consumers who describe themselves as active tobacco users. Addendum (5/7/2017): Will integration of smoking cessation services within VCBH result in the percentage of tobacco users remaining quit for 3 mos., 6 mos. and 12 mos. after completing a "Call It Quits" program be least 25%, 15% and 10% respectively?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The SQ is comprehensive and quantitative in nature.
Totals		**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Those identified as smokers during the psychiatry assessment.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Specialized note content in the EHR for prescribers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* **First Indicators:** *%VCBH adult consumers are screened annually for tobacco use* *% of tobacco users referred to Call It Quits program* *% of tobacco users who registered for the Call It Quits program* *% of tobacco users registered who attended at least one Call It Quits Class* *% of tobacco users who remain quit for 90 days after completing a Call It Quits program* *% of tobacco users who remain quit for 6 mos. after completing a Call It Quits program* *% of tobacco users who remain quit for 12 mos. after completing a Call It Quits program* **2018 Second Set of Indicators:** (Perception focused rather than primary outcomes) *% of consumers reporting increased confidence in ability to change smoking behavior* *% of consumers describing themselves as healthier physically* *% of consumers reporting a lower level of anxiety* *% of consumers reporting an improved ability to manage stress* *% of consumers who said they felt better about themselves*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Executive Workgroup focused on smoking cessation included slightly different metrics, below, that are not mentioned in the PIP Outline. **Metric #1:** %of VCBH adult consumers screened annually for tobacco use. **Metric #2:** % of tobacco referred to Call It Quits Program **Metric #3:** % of tobacco users registered for the Call It Quits Program **Metric #4:** % of tobacco users registered who attended at least 1 Call It Quits program **Metric #5:** % of tobacco users who remain quit for 3 mos. after completing a Call it Quits program. **Metric #6:** % of tobacco users who remain quit for 9 mos. after completing a Call it Quits program. **Metric #7:** % of tobacco users who remain quit for 12 mos. after completing a Call it Quits program. **How are you measuring?-**Using EHR, Public Health data. **Intervals for measurement-**Annually, 90 days, 6 months, 12 mos.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☐ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators cover self-perception as well as actual data-driven questions. Smoking behavior tracked.
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling involved.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

	Totals	**0** Met **0** Partially Met **3 Not** App. **0** NA **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Consumer perception survey associated with the CIQ groups and programs following each session.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☒ Provider ☐ Other: Public health CIQ program	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	EHR smoking screening tool.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP had no issues with the data collection. The data on outcomes was disappointing, and it created a need for the MHP to identify other options and approaches if smoking cessation was going to have an impact. There were no contingencies identified.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* ➢ *VCBH Pharmacist, VCBH Medical Director, VCBH Quality Medical Director; public health staff will assist with data collection.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**5** Met **1** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* **Utilizing 5A's Strategy for smoking cessation to motivate consumer to stop smoking.** **Integrate BH consumer specific Call It Quits classes into all VCBH clinic sites**	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has stopped including the screening of all consumers at least annually for smoking/tobacco use as a listed intervention. That should be intervention #1, ongoing. The PIP appears to have been piloted at the Ventura Adult Clinic. It seems the MHP's role in this PIP was largely limited to screening of consumers and referral to public health for CIQ. With perhaps some coordination activity. But with the degree of difficulty mental health consumers often experience with quitting tobacco, the MHP likely should have early on developed supportive and adjunctive interventions related to smoking cessation. Considering the planned frequency of data reporting, the MHP was likely aware of the problems with outcomes from simple referral to CIQ interventions. Some aspect of tailored interventions integrated with its clinic operations would have been useful to test out early on. This awareness is present in the newly added intervention of consumer specific CIQ classes at all clinic sites.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☒ No Are they labeled clearly and accurately? ☐ Yes ☒ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not complete the tables within the PIP outline, but furnished an external summary excel table containing the data from the original set of metrics.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: Annual summary presented. Indicate the statistical analysis used: simple percentage Indicate the statistical significance level or confidence level if available/known: _____% ____X__Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP provided external data tables and a PowerPoint for the Exec team which provided oversight. The Exec team document stated frequent data reporting, but the tables appended to the PIP were annual rollup. • 3168/4480=71% of adult consumers were screened annually for tobacco use. • 217 of 1158 adult tobacco users were referred to a Call It Quits Class. • 79 of 217 referred consumers registered for the class • 55 of 79 registered consumers attended at least 1 class session. •

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* Did not achieve goals, and like needs programs at MHP clinics, tailored to MHP consumers. *Conclusions regarding the success of the interpretation:* Accurate *Recommendations for follow-up:* Broadening the intervention and making it more specific to MHP consumers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP states awareness for the failure to achieve tobacco cessation even on a limited basis. There has been reliance on public health provision of a non-tailored program. The MHP appropriately concludes that integration with adult clinic sites, and tailoring the CIQ program to consumers, and consideration of adding CIQ to the Wellness Center programs is quite appropriate.
	Totals	**2** Met **2** Partially Met **0** Not Met **0** NA **0** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Reporting presented as annual, but in various venues more frequent reporting is mentioned. Supporting information does not validate this. The same source of data for screening was used, entered into EHR, and has broad application to MHP population. The baseline data only reported out percent of consumers that smoked. The final/one-year data indicates none have quit.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☒ No	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP does not track whether non-smoking consumers started, so there is no evidence of deterioration. And there is also no evidence of any improvement, beyond participation in smoking cessation groups which is a positive but not an outcome.

9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change: No change* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **1** Partially Met **4** Not Met **0** NA **0** UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Smoking cessation efforts by the MHP with adult consumers has been unsuccessful in creating any change. The PIP largely focused on the MHP's identification of smoking/tobacco use behavior and referral to the public health Call It Quits program. The prescribers/psychiatrists did apply the 5P motivating and informing techniques when screening each consumer annually. However, the MHP did not have a plan to provide any organized and structured support to consumers who had participated to an extent or completed CIQ. With the knowledge of the unique characteristics of MHP consumers it seems fair to have expected the MHP to anticipate consumer challenges in quitting tobacco and would have considered clinic-based supportive activities, information, and encouragement.		
Recommendations: As currently written and structured, it seems the MHP should either consider development of another PIP for this current cycle, or identifying new, relatively easy to deliver and high probability of positive impact interventions woven into the fabric of usual clinic operations. This could include CIQ groups at MHP clinics or wellness center, but it seems there needs to be more effort to include smoking cessation information and support within the MHP clinics.		
Check one:	☒ High confidence in reported Plan PIP results – no change	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Ventura	
PIP Title: Client Acuity Index	
Start Date (MM/DD/YY): 2/3/2017 **Completion Date** (MM/DD/YY): 3/31/2018 **Projected Study Period** (#of Months): 12 **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review** (MM/DD/YY): 4/3-5/2018 **Name of Reviewer**: Rob Walton	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): A byproduct of MHP efforts to analyze the high-cost adult consumer population, a subset was identified which had potential for being impacted - those with a prior history of crisis and acute inpatient stays. The MHP determined it would develop an acuity classification system, including high, moderate, low, and uncategorized. The levels were determined by acute episodes: total, duration and recency, factors in the developing algorithm. The MHP also determined a frequency of services would be paired to the need level, high: twice a week; moderate: once per week; and low: one time per month. The MHP also seems to explore the notion of considering individuals in the low category for closure to services. The MHP utilized statistical parameters to help in creating the levels, particularly as related to	

inpatient admissions that could be spread over a significant period of time. The participating staff were brought to focus on these parameters and provide feedback to adjust according to experiences about validity. The PIP involved a specifically selected group of 12 staff, thought to include those with significant experience and interest in participating. The concept is these individuals would test out the parameters which would then be applied to the greater MHP adult consumer population. The PIP has concluded with plans to continue development of automated acuity rating system.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Adult Division Chief and Senior Behavior Health Manager, staff on the EHR team, a Quality Assurance representative, and the twelve clinic/program staff selected for the pilot. Stakeholders are all the VCBH-enrolled adult consumers and VCBH Adult Division managers and line staff at work in the clinics providing mental health services and treatment. Participating staff identified the frequency of service, thus at a line level staff provided significant input to the process. The involvement of consumers in the process is not detailed.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP began with the study of high-cost consumers and determined to focus on those who seem to offer opportunities to impact. This group are those with a history of hospitalizations, for the highest it may be multiple admissions. The MHP sought to test out a prescriptive approach, wherein a minimum level of service is provided or attempted based on acuity status.

Select the category for each PIP:

Clinical:

☐ Prevention of an acute or chronic condition ☐ High volume services

☐ Care for an acute or chronic condition ☐ High risk conditions

Non-clinical:

☒ Process of accessing or delivering care

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The only aspect of care that was explored was matching level of service with determined level of need. The nature of the intervention itself not discussed. The sole aspect related to services that was tested is the frequency.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP states its intent to eventually implement with all adult consumers, but at the current time the population was described as semi-randomly selected consumers from each of the adult clinics, transitions, and older adults. The PIP was in effective for one year, and this did not provide sufficient time to roll out to over 18-year-old consumers. It also excludes the approximately 50% of adult consumers without a hospitalization history.
	Totals	**1** Met **3** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* The study question is will providing staff with an acuity-based, systematic approach to service effect the distribution of their work effort? The focus or overarching goal of this non-clinical PIP is to increase the proportion of units of services and contacts being delivered to higher acuity clients. The framework for this PIP is a pre- and post-intervention comparison of units of services and contacts by levels of acuity. "Work effort" or units of service and number of contacts, as provided by a representative group staff, was first measured in July 2017 and subsequently in February 2018. The intervention was the introduction of prescribed minimum frequencies of contact ascribed to different levels of acuity (i.e., twice a week for the high acuity group; once a week for the moderate group; and once a month for the low acuity group). Again, level of acuity was based on history of psychiatric hospitalization (i.e., "high", "moderate", and "low") and those "uncategorized" as a result of having no HPC admissions recorded in AVATAR.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study question lacks a clear measurable goal regarding the anticipated extent of increase, and the outcome of that increase. The MHP is not actively tracking subsequent hospitalizations.
Totals		**0** Met **1** Partially Met **0** Not Met **0** UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The adult consumer population included in this study are the consumers found on the caseloads of the Adult Division staff selected for inclusion in this PIP. However, being a non-clinical PIP with its focus on influencing VCBH staff and the distribution of their work effort, the twelve participants selected for "inclusion" are more accurately identified as the pilot providers. The relatively small size of sample was chosen to mitigate operational impact. As noted above, they were selected to represent all the adult clinics/program, with reference to their positions (i.e., majority of Mental Health Associates, but also included Behavioral Health Clinicians), years of experience working for VCBH, and productivity. The goal was to insure a diverse group of participants. By starting with this pilot, the goal is to expand to the other behavioral health clinic sites. Further analysis is being conducted currently to identify common threads among the consumers in the "uncategorized" category due to having a lack of psychiatric hospitalizations. Using a measure such as the MORS is also being considered in order to have a tool that can be utilized to assist in appropriately categorizing consumers in addition to using the input of staff.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Pilot study that involved semi-random selection	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has plans to extend this approach to the entire adult population but for the duration of this PIP a small segment of the was included as the concept was being piloted.
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* **High categorization contact frequency** **Moderate categorization contact frequency** **Low categorization contact frequency** **Number of contacts**	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP does track the number of contacts. While it seems valid to track whether or not service delivery matches the categorization level, the impetus of this PIP was to reduce hospitalizations. That type of event would be important to track and compare to prior history of these individuals.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators measure level of service, which is not directly related to long-term outcomes. The implication of higher service level for high categorization individuals is assumed to be related to fewer acute episodes and need for hospitalization and improved outcomes. However, it seems the MHP would have been well advised to track hospitalization use of the semi-randomly selected consumers in regards to their baseline/prior history. This would be particularly relevant for those who are high categorization. The high and moderate categorization are metrics founded in hospitalization history, and likely reflect some measure of health and functional status. In addition, overlooked in this process are those without a hospitalization history, which comprise approximately 50 percent of the caseloads.
	Totals	**0** Met **1** Partially Met **1** Not Met **0** UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Pilot stage, no sampling. Not a population sample but still limited involvement of adult consumers.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **3** Not App **0** UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data considered for this PIP was derived from AVATAR, VCBH's electronic health record (EHR). Both units of service and contacts are directly entered into AVATAR by staff for the purpose of documentation and Medi-Cal billing. Using existing EHR data; increased the validity and reliability of data, without adding to the burden on staff. Subsequently, preprogramed AVATAR reports were run in order to secure counts of units of service (i.e., billable and unbillable), contacts, and lack of any contacts, broken down by staff and by individual clients. The results were exported and the analyses were conducted in Excel. VCBH's AVATAR team developed the computer program based on the acuity algorithm (see above) which sorted clients into the three levels of acuity based on history of hospitalization (i.e., "high", "moderate", and "low") and those "uncategorized" as a result of having no HPC admissions recorded in AVATAR.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☒ Claims ☐ Provider ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Avatar

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	AVATAR reports were run in order to secure counts of units of service (i.e., billable and unbillable), contacts, and lack of any contacts, broken down by staff and by individual clients. The results were exported and the analyses were conducted in Excel. VCBH's AVATAR team developed the computer program based on the acuity algorithm (see above) which sorted clients into the three levels of acuity based on history of hospitalization (i.e., "high", "moderate", and "low") and those "uncategorized" as a result of having no HPC admissions recorded in AVATAR.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☒ Level of Care tools ☒ Other: Avatar EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	As written, the PIP was planned for a brief pilot. Analysis provided post the initial pilot activity.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: <Text> Title: <Text> Role: <Text> *Other team members:* Names: <Text>	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	Data collection staff not specifically identified in the written PIP.
	Totals	**4** Met **1** Partially Met **1** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Develop acuity index Test acuity validity Develop algorithm for caseloads Test algorithm Pre-test questionnaire 30-day pilot implementation Post-Test questionnaire Post-Test Data Analysis **Updated PIP -** Develop acuity algorithm Develop of minimum frequencies of contact by acuity	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The unmentioned intervention is the application of the minimum contact frequency, which for the high acuity consumers seemed to increase the amount of services received by that group as a block. While perhaps not completely relevant to this section, the MHP has noted an increase in the uncategorized individuals due to lack of hospitalization history. This would seem to indicate that the MHP's methodology should be paired by a validated level of care tool which can be applied to both those with and those without hospitalization histories. The above would create a more broad-based level of care approach which could be also informed by hospitalization history. This type of strategy would find applicability to all adult consumers. The MORS, ANSA, and others could serve to augment the acuity index.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP included its data analysis in the data analysis plan section. It provided a comprehensive analysis of the acuity findings, level of services, and pre-/post-data. Challenges to the PIP were identified.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	MHP provided information on Avatar determined acuity for the pilot group, involving 449 consumers. This is a significant number considering this is a pilot. The data groupings included high, medium, low, with a separate uncategorized table. That in one table 59% of consumers were uncategorized indicates an issue with this approach. It does not seem to serve those without a hospitalization history, who are the majority of consumers. The MHP also studied billable services, which was not described as an indicator in the PIP and looked for changes in billables across the acuity distribution. This information provided a sense about how the ranking system could have impacted services and attention to higher acuity consumers.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: baseline and follow-up one year later Indicate the statistical analysis used: simple percentages Indicate the statistical significance level or confidence level if available/known: NA _____Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	While the PIP started in early 2017, wherein a baseline was created, no testing/pilot activity occurred until early 2018. The data from that period was not presented. Insufficient data was available for statistical significance evaluation. Additional information is acknowledged as needed by the MHP, which could be an opportunity to include an adult level of care instrument. When paired with the acuity index, a level of care instrument could help inform staff, particularly with the uncategorized with guidance as to service level needs.

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* Small size, does not address individuals without hospitalization history. *Conclusions regarding the success of the interpretation:* The MHP needs to add level of care instruments particularly to add depth to the uncategorized population, and to provide additional information to the categorized. *Recommendations for follow-up:* Continue developing level of care informing tools along with advising algorithms regarding service lives.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Conclusion written and references percentages. However, the adults without an acute hospital episode cannot be served by this approach.
	Totals	**3** Met **1** Partially Met **0** Not Met **0** NA **0** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☒ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The approach seemed to guide staff working with a consumer who has a hospitalization history to provide a certain minimum of services. Although the type of service and the specific approach would also be useful to know. The higher and moderate rated individuals did receive more services per the MHP's data.

9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☒ Fair ☐ High	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The absence of statistical significance tests prevents conclusions about the change. However, in the high acuity consumers a 10 percent increase in services is attributed to the prescriptive paradigm. There could be other factors such as increased caseload that are also relevant and may impact the data.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☒ Weak ☐ Moderate ☐ Strong	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Just in simple percentage.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Baseline and one-time data production post-intervention
	Totals	**1** Met **3** Partially Met **1** Not Met **0** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	NA

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: This PIP attempts to identify high acuity/need adult consumers and provide guidance to a minimum level of services commensurate with the ranking. This approach is based on a county operated acute hospitalization history to determine acuity rankings. The MHP is attempting a solution that can be automated and requires little staff intervention, which is seen as a positive. An issue is that this approach is limited to approximately 50 percent of adult consumers. The strategy appears to be linked with a higher service level to those with a higher acuity rating but is limited to a pre/post data review. Further analysis and consideration of what the increased overall caseload impact may have been. This seems like a positive first step into the development of a comprehensive level of care system that is paired with recommended service levels. Some outcome analysis of the results from the additional, type-unspecified services, seems required. This analysis could focus on hospital readmissions		
Recommendations: Continue with development of automated level of care system using hospitalization data, broadened to include any psychiatric hospital admission. Identify and implement a validated level of care tool to assist with consumers lacking an acute hospitalization history and providing more information for those with a history of acute admissions. Continue to explore the service recommendation paradigm, seeking to identify of there are any patterns or service or contact types that create improved outcomes.		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☒ Confidence in PIP results cannot be determined at this time	