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FY 2019-20
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

LOS ANGELES MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

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INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2018-19 findings of an EQR of the Los Angeles MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Very Large

MHP Region — Los Angeles

MHP Location — City of Los Angeles

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 210,337

MHP Threshold Language(s) — Spanish, Armenian, Mandarin, Cantonese, Korean, Vietnamese, Farsi, Tagalog, Russian, Cambodian, Other Chinese, and Arabic

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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[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] 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.

[3] 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, FY 2018-19

In this section, the status of last year's (FY 2018-19) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2018-19 Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2019-20 site visit, CalEQRO reviewed the status of those FY 2018-19 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2018-19

PIP Recommendations

Recommendation 1: Clarify the study population for the clinical PIP, align the interventions to affect that population, and select relevant indicators that address all parts of the identified problem.

Status: Not Met

- The MHP concluded the clinical PIP following the prior review, and began immediate work on the currently active and ongoing co-occurring disorders (COD) PIP. This recommendation will not be carried over.

Recommendation 2: Develop and present a new non-clinical PIP for the upcoming year.

Status: Partially Met

- The MHP initiated efforts to create a non-clinical PIP focused on development of the Peer Resource Center (PRC).

- The PRC activity did not meet requirements for a non-clinical PIP and the recommendation will be carried over.

Access Recommendations

Recommendation 3: Monitor and evaluate the availability and responsiveness to urgent conditions by crisis programs in various SAs, including SA 1.

Status: Met

- The MHP has steadily increased the development of resources targeting urgent care needs. These include: Field Response Operations (FRO), Psychiatric Mobile Response Teams (PMRT), Law Enforcement Teams (LET), the School Threat Assessment Response Team (START); as well as Urgent Care Centers (UCC); and Crisis Residential Treatment Programs (CRTPs).

- The increased resources have been linked to higher response numbers, which have reflected increases between FY 2016-17 and FY 2017-18 of 70 percent for PMRT, 175 percent for LET, and 55 percent for START.

- However, the increase in requests has been associated with an overall drop in response timeliness between CY 2016 and CY 2018. The increased call volume, particularly in significant after-hours demands, also corresponds to the increases in vehicular traffic in the LA area at the end of customary business hours. PMRT resources are scheduled during the peak call times, and are not available between 2 am and 8 am. Response to calls that arrive during these off-hours occur when 8 am staff arrive on-duty, but often involve delays. However, calls occurring during business hours (in CY 2018) were responded to within one hour 92 percent the time.

- To the specific focus of this recommendation, the large Antelope Valley region is part of Service Area (SA)-1. SA-1 PMRT clinicians responded to requests within 31 minutes once dispatched. This average is significantly better than SA-6 and SA-7 during the FY 2016-17 and FY 2017-18 periods.

- Additional services that target the crisis/urgent care needs are the eight UCCs, which are not present in every SA, and provide options to residents of all areas. The UCCs provide comprehensive mental health care and crisis stabilization unit (CSU) services for up to 23 hours. CRTPs offer longer periods of stabilization.

- The MHP tracks urgent responsiveness and has made improvements. During the onsite review, the MHP suggested that the greater crisis and urgent care capacity has significantly increased the confidence of the general public and law enforcement agencies in making referrals, thereby increasing the frequency and total call volume. Demand has yet to plateau and will likely continue to grow.

Recommendation 4: Review and evaluate the welcome packet and make necessary changes to include information and basic resources that all new beneficiaries should know.

Status: Met

- The MHP engaged in the review and update of the welcoming packets. With the assistance and input of SA navigation staff, the Outpatient Services Division (OSD) performed a review and update of the welcoming materials. In the process, a set of specific standard countywide resources were developed and incorporated into each SA's Welcome Packets.
- The MHP clarified that welcoming packets are currently an expectation limited to directly operated (DO) programs, and is not currently a requirement of contract/legal entities (LE) to furnish the same type of information.
- The MHP is in the process of procuring translation services for the welcome packet materials into needed threshold languages.
- The MHP furnished examples of welcome packets, which were individualized by program site, presenting a personalized approach for new beneficiaries, including photos of the clinic manager as well as outlining beneficiary expectations of services, and which provide information regarding other resources. This individualized approach is an exemplary practice which provides new service recipients a unique opportunity to connect with the treatment team.

Recommendation 5: Involve system navigators in the process of revising this welcome packet.

Status: Met

- System navigators provided input as to the needed content and review of the specific resources relevant to each SA. The information also included other resources deemed useful to beneficiaries.

Recommendation 6: Identify those contract providers and agencies that serve beneficiaries with co-occurring disorders.

Status: Partially Met

- The MHP is currently collecting COD capability information from all DO and LE contract providers. As part of the network adequacy requirements the MHP created an application to collect this capacity information from providers, which then is displayed in the online provider directory.

Timeliness Recommendations

Recommendation 7: Comply with the state standards for the following timeliness metrics as per Information Notice (IN) 18-011: Time to first offered appointment and time to psychiatric appointment.

Status: Partially Met

- Effective July 1, 2018, the MHP adopted the DHCS IN 18-011 timeliness standards for first offered clinical and psychiatry appointments. A Quality Assurance (QA) Bulletin notifying all providers of this change was also issued.
- The MHP reports that DO programs are monitored monthly and LE contract providers quarterly. The MHP is in the process of developing a tracking mechanism for first-time appointments with contract providers. Time to first psychiatry service is difficult to track, and the data are currently incomplete. The MHP is working to resolve this issue.
- The MHP, also known as the Los Angeles County Department of Mental Health (LACDMH), is developing a timeliness tracking dashboard, which will likely be available this next year.

Recommendation 8: Provide more consistent response to urgent conditions such that compliance with MHP's standard of five days is at least 70 percent.

Status: Partially Met

- The prior urgent standard of five days was developed by the MHP in concert with the local health plan, and has now been redefined as "priority." With the issuance of the DHCS IN 18-011, the standard has changed to 48 (non-preauthorized) and 96 (preauthorized) hours, which has been adopted by the MHP.
- In the MHP Assessment of Timely Access (MATA), the FY 2018-19 reported data, beginning in April 2019, was limited to DO programs. Due to technical issues with accessibility, information from LE contract providers that operate with other EHR systems could not be included. The MHP's efforts to include contractor data were apparent, and as of November 2018, some LE metrics are captured in the Service Request Tracking System (SRTS).
- The MHP reported in the MATA 48-hour urgent response data. The MHP achieved this standard 54 percent of the time for adults and 43 percent for children and youth. As stated, this is limited to DO programs. a partial representation of the full picture.
- This topic merits continuation and follow-up in the coming review period, with continued efforts to capture contractor urgent care timeliness and improve overall identification of urgent events.

Recommendation 9: Complete the development of web services functionality to collect service request data electronically from contract providers for timeliness data for psychiatric appointments, no-shows, and urgent conditions.

Status: Partially Met

- The Service Request Log (SRL) application programming interface (API) was initially released in November 2018. LE contract providers furnished their input, which was integrated into the SRL in June 2019.
- Additional SRL enhancements were developed in early August 2019, which are intended to support electronic reporting of psychiatry and urgent conditions by the end of fall 2019.
- The MHP reports that data collection from LE contractors is improving, but is incomplete at this time. This is a complex and wide-ranging project that requires successive iterations to identify and resolve all barriers.
- The MHP does not intend to capture contract provider no-shows because this element is not mandated element. Considering the complexity of the contract provider reporting functionality currently, this decision is understood by the EQRO.

Recommendation 10: Identify the adult beneficiaries that contributed the most to the rehospitalization rate in CY 2018 and develop targeted improvement activities to reduce their rehospitalization.

Status: Met

- The MHP runs monthly reports that identify individuals with 30-day rehospitalization events, and those who have been hospitalized more than five times in one calendar year. This information is shared with the Intensive Care Division (ICD) and, starting in September 2019, will be forwarded to Pharmacy, Whole Person Care (WPC), and Clinical Operations.
- Already the MHP has involved 11 DO clinics in a Transforming Clinical Practice Initiative (TCPI) that targets development of clinic workflows aimed at reducing rehospitalization rates.
- While the five rehospitalizations threshold has been established as criteria for increased attention, the MHP did not furnish exact numbers of the multiple admission cohort, how many of these individuals exist, their distribution among service areas, and how they are being specifically served with intensive post-hospital care.

Recommendation 11: Set benchmarks for rehospitalization rate and no-shows.

Status: Not Met

- The MHP runs reports on a monthly basis to determine the 30-day re-hospitalization rate (38 percent based on 2017 IS data), as well as identifying the beneficiaries that have been hospitalized more than five times per calendar year. Starting September 2019, this information is forwarded to the ICD, Pharmacy, WPC teams, and Clinical Operations.
- The MHP does not currently have a no-show standard for DO programs. The performance monitoring of contract/LE entities has not included reporting of no-shows, nor established standards for these entities. Rehospitalization rate standards have not been established for contract entities.

Quality Recommendations

Recommendation 12: Determine the number or percentage of beneficiaries with co-occurring disorders who have integrated or coordinated mental health and substance use services and increase this number over the upcoming year.

Status: Partially Met

- In the production of the requested information, the MHP identified individuals who received at least one outpatient service during CY 2018 and then flagged all with an ICD-10 substance use disorder (SUD) diagnosis. Based on the above criteria, 37,511 (23 percent) of adult beneficiaries 18 years and above have been diagnosed with a COD, and 41,341 (20 percent) of beneficiaries 13 years and above have been diagnosed with a COD.
- The recommendation regarding identification of individuals receiving integrated or coordinated mental health care is challenging, because the MHP does not have a mechanism for tracking simultaneous SUD services and SMHS. Furthermore, the interventions of substance abuse counselors (SAC) is not consistently tracked, and COD interventions could also be furnished by licensed clinical staff in a non-trackable manner.
- The MHP's clinical PIP is targeting COD and trauma issues through the use of Seeking Safety (SS). In the process of moving this PIP forward, there are intentions to capture this activity in the EHR, and developing a service coding process that will support tracking. This effort is currently limited to DO programs.
- The MHP's response underscored the complexity of this issue when long-term and systems issues are considered, particularly impactful is reconciling the disparate diagnoses that exist across providers in both DO and LE service areas. This requires creation of business rules that direct determination.

- While this recommendation is partially met, the MHP is making progress in the delivery and tracking of COD services. The progress in this area appears sufficient to permit elimination of the recommendation going forward. It will be necessary for the MHP to develop specific service delivery codes to track the integrated services for COD individuals in both DO and LE programs.

Recommendation 13: Identify opportunities outside of the MHP that may be used as a path to employment.

Status: Partially Met

- The MHP utilizes a third-party, cooperative agreement with the State Department of Rehabilitation (DOR), that supports outside employment options. There are numerous supports is access supported to WorkSource Centers, social enterprises, and Ticket To Work employment networks. There are also individualized placement and support (IPS) services that exist to support success in the California Work Opportunity and Responsibility to Kids (CalWORKs) program. Each clinic has an employment specialist who helps clients navigate these resources. The department holds monthly meetings for clinic (contract and DO) employment liaisons to share information including advertising materials – flyers, brochures. The MHP's employment division holds regular Service Area employment trainings for clinic (contract and DO) staff to ensure clinic employment liaisons have the most up to date information and resources. Finally, the Department has an employment, education, and training website which is kept up to date: https://dmh.lacounty.gov/our-services/ee/

- The DOR Co-op agreement requires DOR liaisons co-locate in clinics for intakes, meetings with clients, and consultation. Until July 2019, liaisons were only available in the DO clinics. Beginning July 2019, co-op agreements were offered to contract providers and a few have begun participating.

- Beneficiaries reported that the DOR support is focused on obtaining entry level employment and very basic support. It does not seem to address the needs of those who seek comprehensive career development help. It would likely prove helpful for the MHP to engage in obtaining systematic feedback from beneficiaries regarding perceptions of the employment support functions.

Foster Care Recommendations

Recommendation 14: Articulate the method used to track children's medications and the timeframe for rollout.

Status: Partially Met

- The MHP's approach to tracking medications for foster care (FC) children and youth is through the JV220 a/b consent request process.

- The MHP, in concert with Department of Children and Family Services (DCFS) and Superior Court, has sought the development of an electronic JV220 review process, but this has been deferred due to guidance from the state.
- The LACDMH Office of Clinical Operations is focusing on the development of medication monitoring protocols for FY 2019-20, which will incorporate the requirements for FC medication monitoring.

Recommendation 15: Articulate the steps that will be taken to prepare providers for Therapeutic Foster Care (TFC), pursuant to the feedback from the questionnaire.

Status: Partially Met

- The survey responses indicated needs for training on TFC, concerns about EHR access and confidentiality, the ability of parents to successfully document services, the ramifications of disallowances, and agency/supervisor risk in providing oversight. The limited reimbursement funding per diem for the agency/foster parent was an additional concern.
- The MHP is considering retention of a trainer to help foster family agencies (FFA) standardize processes and content for Intensive Services Foster Care (ISFC) and TFC.
- Reconsideration of the ISFC per diem rate is also in process by DCFS and the MHP.
- Other meetings will occur to ensure that the needs of FFAs and ISFC resource parents are fully addressed.

Information Systems Recommendations

Recommendation 16: Create Help Desk dashboard reports so that internal staff and users of the Help Desk can view service requests and the status of their request.

Status: Met

- Since the FY 2018-19 CalEQRO review, the MHP refreshed Provider Central website (http://lacounty.gov/pc) to further improve support for both LACDMH and contract provider staff. The website includes useful links to: support and technical information, frequently asked questions (FAQs), DMH alerts and system outages, and general announcements.
- All users with network logon accounts can create HEAT (name of the support portal) tickets for IT support.
- Monthly support cases (HEAT tickets) related to systems integration and IT support have increased during the past year. Thus far in 2019, the MHP reported

an average of 230 cases per month; compared to 110 cases per month during 2018.

- As of September 2019, the Help Desk dashboard reporting was in final development and implementation phase for systemwide rollout.

Structure and Operations Recommendations

Recommendation 17: Discuss with a cross section of staff and key informants the impact of the reorganization from a programmatic and service level to identify any unintended consequences of the reorganization.

Status: Not Met

- LACDMH has so far limited the formal reorganization feedback survey process to administrative staff, and has not yet included line staff.

- Consistent with feedback acquired during this current review, the MHP's change management process would benefit from a continuous staff, mid-level management and other stakeholder feedback process, one which is administered periodically over the course of the change process. Doing so will assist leadership identify key issues that may more easily be addressed if identified early in the process.

- The MHP has requested to defer this recommendation to the coming FY 2020-21 review period. From observations made during this onsite, the MHP should consider as a priority the establishment of an ongoing open feedback process that captures stakeholder feedback throughout the organization and provides this information to leadership. Ideally, this would be a portal open to both DO and LE contract agency input and would result in regular issue summaries to department leadership.

Recommendation 18: Engage various levels of staff through a task force, for example, to review documentation and identify those that are duplicative and/or unnecessary and then eliminate or streamline them.

Status: Met

- The MHP's Quality Improvement Division (QID) has provided a focused review of the required assessment documentation during the past year. Assessment streamlining occurred with a reduction in content product. The change was finalized on July 1, 2019.

- The MHP's effort in this area should resonate with and be appreciated by staff. However, during the review, the staff continued to mention the barrier presented by increasing documentation requirements. They often identified these

requirements as consuming between a quarter to a third of their work hours. More streamlining or merging of additional requirements is needed.

- This area seems important enough that an element of the QA/QID could be dedicated to ongoing collection of feedback/suggestions and implementation of changes. This is not an area where a one-time solution is sufficient.

Recommendation 19: Expand the rollout and use of myHealthPointe portal for beneficiaries to achieve a level of expertise to login, request appointments, and securely communicate with their clinician or case manager.

Status: Met

- Between February and June 2019, the MHP staged 39 "Just4Me" beneficiary portal go-live events, enrolling and registering for appointment reminders 85 to 90 percent of individuals scheduled for appointments on those days. Within three months, the registered user base increased from 2,200 to 5,457.
- Appointment requests, secure provider messaging, and requests for medication refills are planned for the next phase of this project, but are not currently available.
- The Just4Me Client Portal includes links to FAQs, how-to videos, and handouts. The online portal provides consumers easy and secure access to their online mental health record.
- At the time of this review, the MHP's implementation plan had not identified the scope of expected Just4Me enrollment, nor the anticipated successful retention percentages.

Recommendation 20: Implement Consumer Engagement Technology Initiative with sufficient resources to ensure the project can achieve a level of self-sufficiency going forward.

Status: Met

- This project is intended to furnish ongoing support to the users of Just4Me. It involves the use of volunteers and non-clinical staff to assist with registration and response to questions about functionality, such as scheduling of appointment reminders.
- SA chiefs identified a trainer for each SA. Program managers were tasked to identify two champions and volunteers for each Go-Live event, and to provide ongoing support to beneficiaries.

- To achieve sustainability, monthly conference calls are conducted with program managers, Just4Me champions, non-clinical staff, and SA volunteers going forward. The conference call is designed to work with DO programs to refine and implement each program's workflow, discuss successes/challenges, and provide ongoing support.

Recommendation 21: Investigate the availability of Skype for Business functionality not currently used to improve remote user's overall webinar experience.

Status: Met

- Microsoft is no longer improving Skype for Business application. A replacement suite of applications has been developed that integrates with Office 365 and Office Productivity Suites.
- The implementation of Microsoft web productivity tools such as Teams Meetings, Azure, and Teams Live will push webinars, web meetings, and web broadcasts beyond the capabilities of Skype for Business application.
- Currently the MHP is developing additional capabilities through web-based communications functionality to include:
    - More seamless user collaboration through teams' file-sharing and conversations when paired with Team Meetings;
    - Better integration with LACDMH network of Microsoft Surface Hubs through Teams Meetings;
    - Large-scale webcast events (1000+ participants) through Teams Live Events, which include American with Disabilities Act (ADA-compliant) webcasts, and recordings through Azure speech-to-text capabilities, and;
    - Multi-lingual and real-time translation of events through Azure translation using cloud services.

Recommendation 22: Analyze caseload sizes of case managers and clinicians in CY 2018 and more equitably distribute cases, if necessary.

Status: Partially Met

- The MHP performed a caseload analysis in September 2018, with a review by executive management in January 2019.
- The process involved extensive analysis of many factors, including level of care needs, specific discipline needs, and average amount of service time required by each beneficiary.
- This analysis provided data for recommendations for partial staffing increase in four DO clinics. The increased staffing is planned for the next budget cycle.

- Onsite discussions produced information about high vacancy rates related to staff departures for other organizations and also movement into non-clinical positions, which are compounded by difficulties in the hiring process that elevate caseloads These issues are also affected by the greater standards for timeliness related to network adequacy, and seriously impact treatment resources.

Recommendation 23: Survey internal and contract staff on training accessibility and identify which trainings, if any, are more difficult to obtain. *(This recommendation is a carry-over from FY 2017-18.)*

Status: Met

- The MHP performed a survey in 2019 and obtained responses from 16 DO and 74 LE/contracted providers. Obstacles to training were identified by 68 percent of the respondents.

- A number of specific issues were highlighted from this survey: while training capacity is a large, mandatory trainings are often limited to two participants per LE. It is generally understood by LEs that the two participants are expected to impart the knowledge gained to all agency staff; however, LE's with large contracts and numerous programs may experience compliance and fidelity benefits if more LE personnel experienced direct training from subject matter experts.

- Challenges also exist ensuring adequate trainings occur regarding evidence-based practices (EBP) and other requirements such as the Child and Adolescent Needs and Strengths (CANS), which are in high demand.

- Communication regarding trainings was identified as an additional issue; sufficient advance notice to staff was lacking, which resulted in the need to immediately sign-up when a training was announced. Amid all the caseload and concurrent work issues, signing up quickly was often not possible—and the trainings would be sold out before staff could register.

- The inclusion of registration links in training notifications was mentioned as a positive change of the training branch. Creating trainings that are SA-focused was suggested, giving priority to those who work or live in a given SA then after a period of time, opening the remaining slots to other staff.

- While the survey input was limited in scale, the comments aligned with those obtained during EQR onsite sessions of the current review.

- The survey also generated some positive feedback about improvements to the process. Staff acknowledged the MHP's efforts to be responsive.

Recommendation 24: Implement a solution to increase staff training accessibility, per the survey results. *(This recommendation is a carry-over from FY 2017-18.)*

Status: Met

- The MHP has developed an eventsHub, an online conference/training registration and payment system. DO and LE contractor staff will access all events through this system, which includes automated email registration notices and e-ticket registration voucher, as well as continuing education units (CE/CEU) certificates.

- The MHP has requested/encouraged that entities coordinating trainings announce these opportunities one to two months in advance of the training date, addressing the request for early notification.

- High demand trainings will automatically be secured with eight sessions, one for each service area. In addition, the MHP will seek to broaden access to these trainings using conferencing technology, webinars and simultaneous access to large audiences in multiple sites (surface HUBs). In FY2018-19, the MHP piloted the use of various training platforms, which provided very useful information as to the most effective and well-received approaches.

- Survey information results regarding specific training sector needs, such as Lanterman-Petris-Short (LPS) Designation and Zero to Five training, have been shared with the providers of these trainings so that they are better able to tailor them.

- Periodic re-survey efforts are indicated to obtain follow-up feedback and further refine this important process.

Carry-over and Follow-up Recommendations from FY 2017-18

Recommendation 25: Analyze caseload sizes of case managers and clinicians in CY 2018 and more equitably distribute cases, if necessary.

Status: Partially Met

- See Recommendation #22.

- During the onsite sessions in SA-8, informants indicated that programs had been provided support to develop more efficient and effective teams that targeted specific level of care populations. This change was reported to produce more effective services, and decrease the stress on staff who were now working with a more homogenous population rather that attempt to serve a broader span of illness.

- Large caseload sizes are exacerbated by increasing numbers of vacant positions and difficulties in expeditious filling of those positions. Reportedly, the time from request-to-fill approval to onboarding has continued to increase. Concerns have surfaced about departing experienced staff moving into MHP non-clinical positions or into other health care agencies which serve a less severely ill population.

- Another variable that affects caseload sizes is network adequacy. The requirements of network advocacy have caused a shift in resources from treatment to initial assessment.

PERFORMANCE MEASUREMENT

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

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

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

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

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

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

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

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Los Angeles MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	514,888	13.0%	32,635	15.5%
Latino/Hispanic	2,320,000	58.6%	108,093	51.4%
African-American	390,371	9.9%	37,455	17.8%
Asian/Pacific Islander	377,714	9.5%	9,422	4.5%
Native American	5,042	0.1%	522	0.2%
Other	356,845	9.0%	22,210	10.6%
Total	**3,960,000**	**100%**	**210,337**	**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.				

During CY 2018 the MHP experienced claims submission delays that resulted in a significant number of claim transactions for November and December not being included in the analysis below for CY 2018 results. See Table 14 for monthly summary details.

Penetration Rates and Approved Claims per Beneficiary

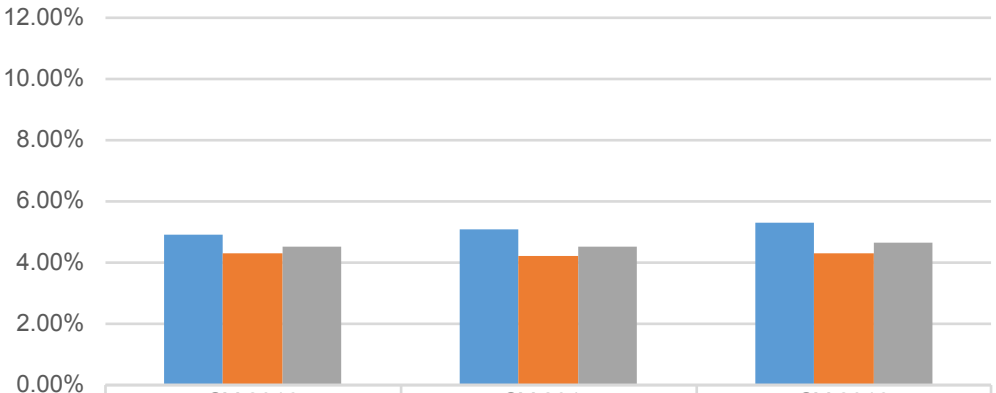
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2018. See Table C1 for the CY 2018 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Los Angeles MHP uses the same method used by

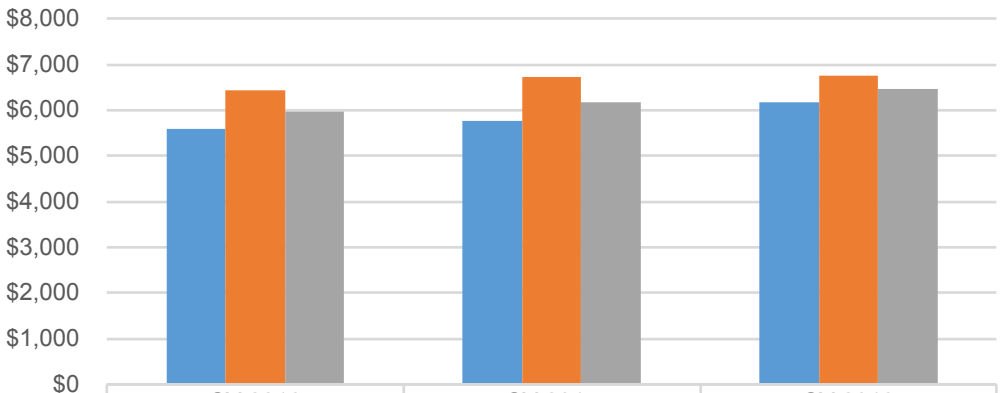
Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large

Figure 1A. Overall Penetration Rates
Los Angeles MHP



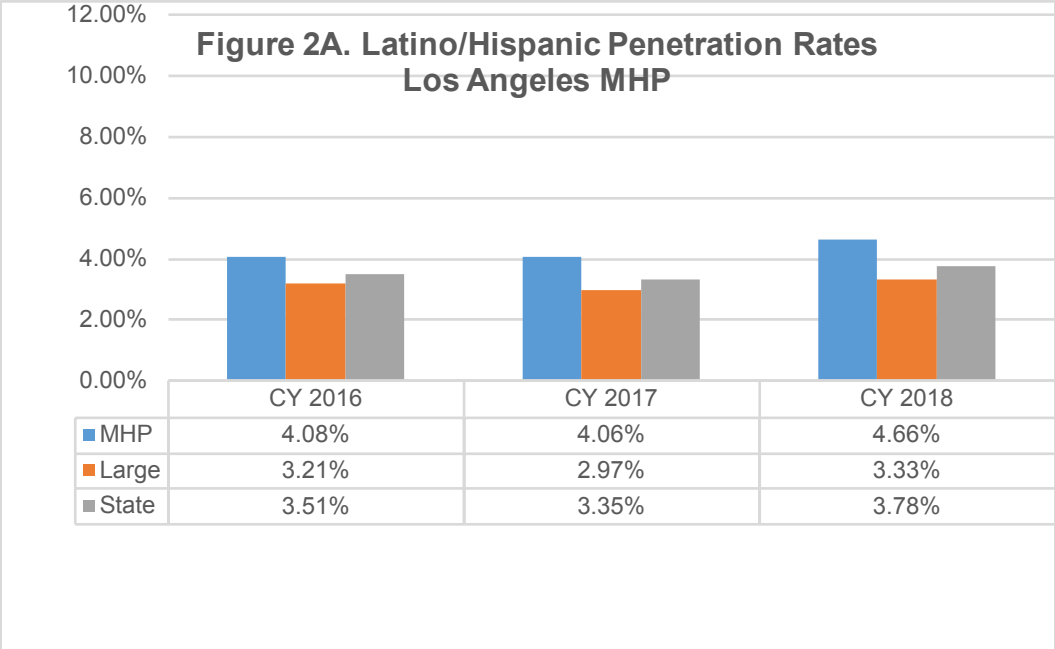
	CY 2016	CY 2017	CY 2018
MHP	4.91%	5.10%	5.31%
Large	4.30%	4.19%	4.31%
State	4.53%	4.52%	4.66%

Figure 1B. Overall ACB
Los Angeles MHP

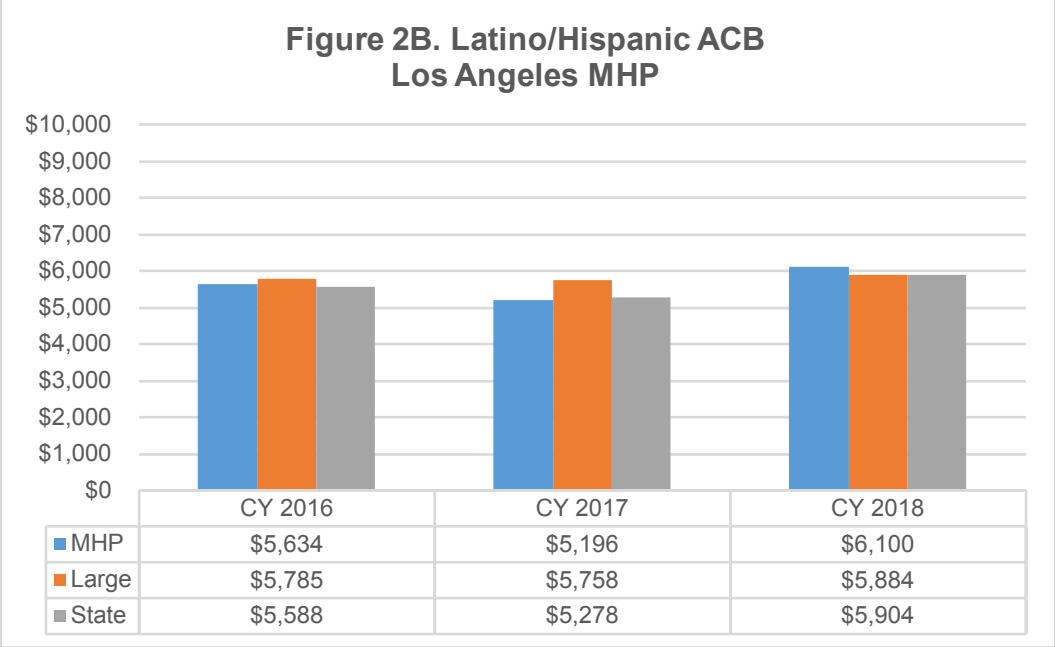


	CY 2016	CY 2017	CY 2018
MHP	$5,580	$5,763	$6,176
Large	$6,430	$6,723	$6,750
State	$5,978	$6,170	$6,454

Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large



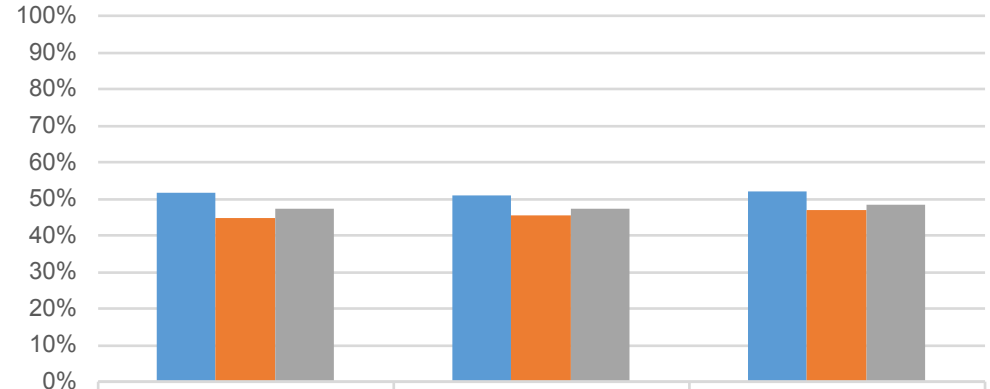
	CY 2016	CY 2017	CY 2018
MHP	4.08%	4.06%	4.66%
Large	3.21%	2.97%	3.33%
State	3.51%	3.35%	3.78%



	CY 2016	CY 2017	CY 2018
MHP	$5,634	$5,196	$6,100
Large	$5,785	$5,758	$5,884
State	$5,588	$5,278	$5,904

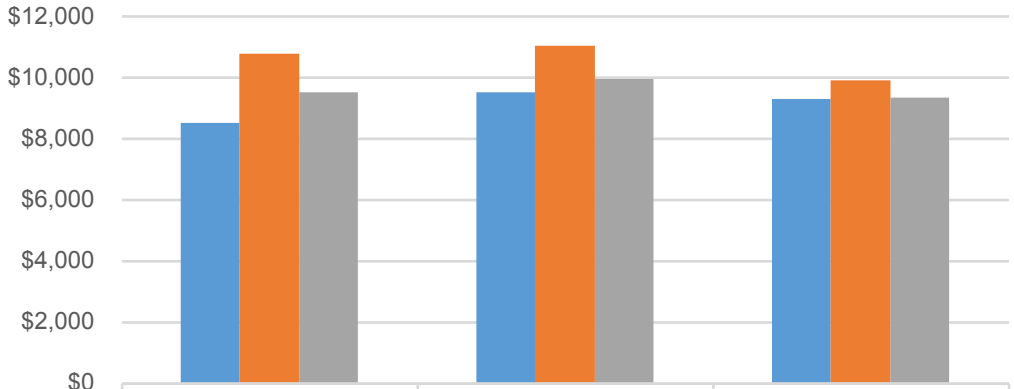
Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A. FC Penetration Rates
Los Angeles MHP



	CY 2016	CY 2017	CY 2018
MHP	51.49%	50.83%	52.08%
Large	44.78%	45.37%	46.87%
State	47.48%	47.28%	48.41%

Figure 3B. FC ACB
Los Angeles MHP



	CY 2016	CY 2017	CY 2018
MHP	$8,518	$9,517	$9,326
Large	$10,805	$11,064	$9,895
State	$9,521	$9,962	$9,340

High-Cost Beneficiaries

Table 2 provides the three-year summary (CY 2016-18) MHP HCBs and compares the statewide data for HCBs for CY 2018 with the MHP's data for CY 2018, 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. High-Cost Beneficiaries
Los Angeles MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2018	23,164	618,977	3.74%	$57,725	$1,337,141,530	33.47%
MHP	CY 2018	6,681	210,337	3.18%	$53,559	$357,825,966	27.54%
	CY 2017	5,490	205,143	2.68%	$48,630	$266,979,411	22.58%
	CY 2016	5,030	204,249	2.46%	$49,569	$249,329,843	21.88%

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

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2016-18) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

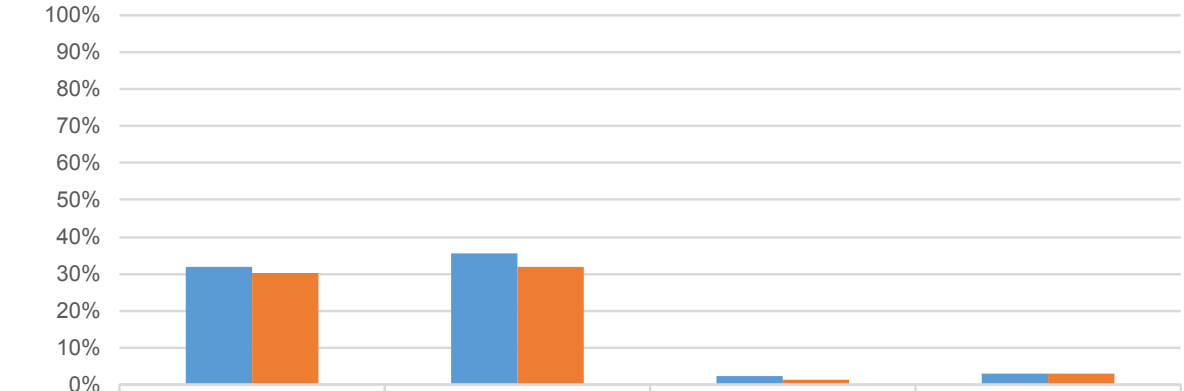
Table 3. Psychiatric Inpatient Utilization - Los Angeles MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	19,946	91,861	8.25	$12,002	$239,392,803
CY 2017	18,999	95,993	7.47	$8,041	$152,774,986
CY 2016	17,929	89,480	7.64	$8,143	$145,993,724

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

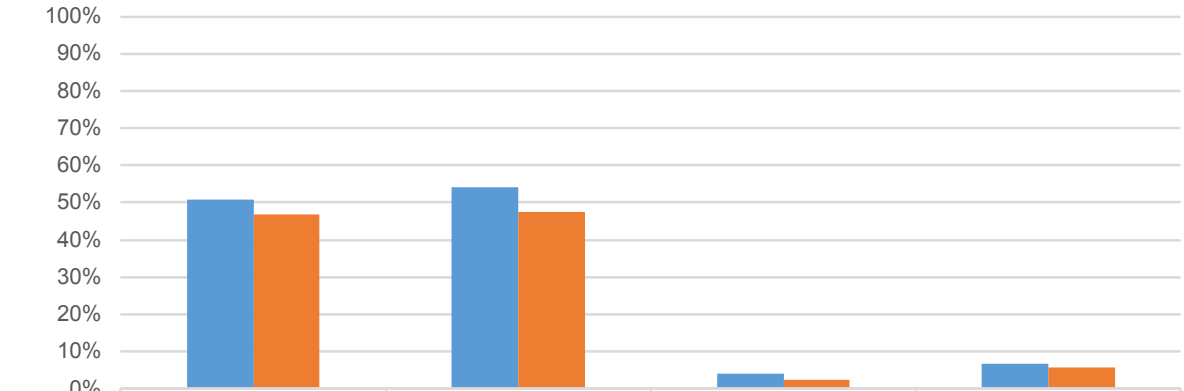
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
Los Angeles MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	32%	36%	2%	3%
CY 2018	30%	32%	1%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
Los Angeles MHP



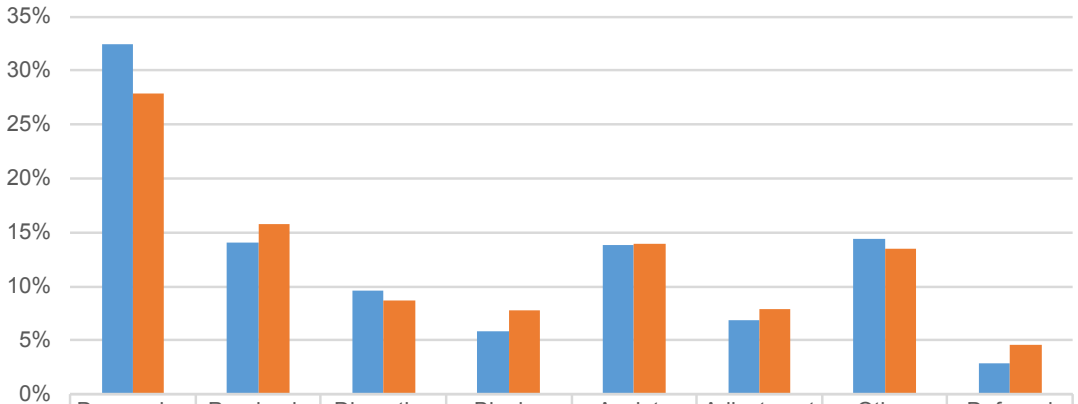
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	51%	54%	4%	7%
CY 2018	47%	48%	3%	6%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2018.

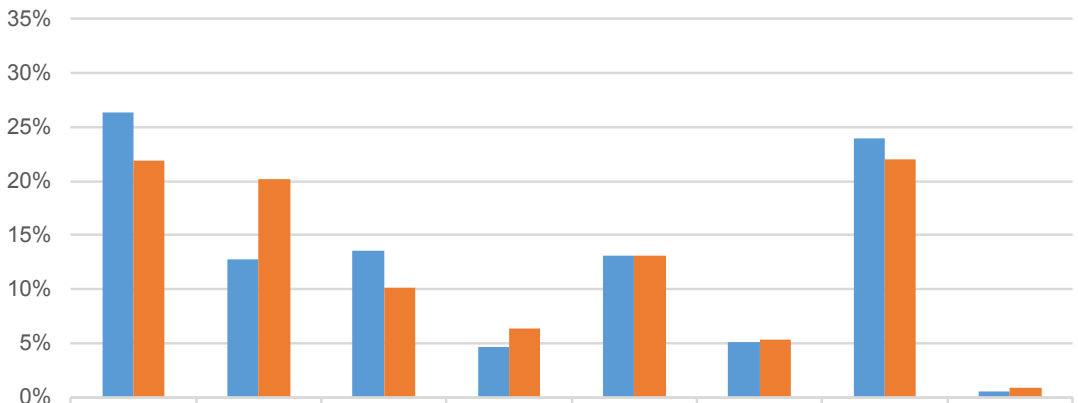
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 16.4 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Los Angeles MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	32%	14%	10%	6%	14%	7%	14%	3%
State CY 2018	28%	16%	9%	8%	14%	8%	14%	5%

Figure 5B. Diagnostic Categories, Total Approved Claims
Los Angeles MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	26%	13%	14%	5%	13%	5%	24%	1%
State CY 2018	22%	20%	10%	6%	13%	5%	22%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A 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." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Los Angeles MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs and validated one PIP, as shown below.

Table 4 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 4: PIPs Submitted by Los Angeles MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)
Non-clinical PIP	1	Strengthening DMH Peer Resource Center Services through Continuous Quality Improvement

Clinical PIP— Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)

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

"Will the provision of services using a multidisciplinary, integrated, evidence-based treatment model for consumers with co-occurring mental health and substance use disorders result in a positive impact on their functioning (i.e., 7-day and 30-day hospital re-admission rates) and treatment engagement/retention (i.e., number of visits within 30 days and 90 days) from pre-intervention to post-intervention?"

Date PIP began: February 2019

End date: February 2021

[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.

Status of PIP: Active and ongoing

The MHP has focused on the COD population in its provision of integrated care to beneficiaries served by 12 DO clinics. Substance abuse counselors (SAC) are utilized in DO clinics; however, there has been no specific model of care in place. Data for COD beneficiaries demonstrates higher hospitalization and rehospitalization rates for these individuals than those who have not been diagnosed with a COD condition, despite also receiving higher levels of mental health and targeted case management services. With the knowledge that SUD are often associated with trauma, the MHP identified SS as an approach to be utilized by SACs, with the primary goal of decreasing hospital utilization.

Suggestions to improve the PIP: During and after the review EQR and the MHP engaged in an email dialogue, including a follow-up TA call to improve the PIP. EQR provided suggestions that included (1) consideration of tracking the service utilization levels as an indicator, which were reportedly higher for the COD population (both MHS and targeted case management (TCM)) and (2) determining if the use of the SS intervention was associated with reduction of these service levels. This requires a method of tracking SS service delivery through development of a specific procedure code for SS, which the MHP has an interest in accomplishing. TA also included suggestions that the start date of the SS intervention was not clear in the PIP, which was subsequently corrected in an updated submission. Although SS is an EBP with existent validation, the MHP might find it useful to identify similar populations within contract/LE providers that may provide a basis for the comparison of service and hospitalization utilization in populations not utilizing SS.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of discussion of the PIP population and approaches written in the above section. Discussion also focused on the need for a PIP to track direct beneficiary interventions and recognize training does not meet the intervention requirement. At this point, development of an alternative clinical PIP is not applicable.

Non-clinical PIP— Strengthening DMH Peer Resource Center Services through Continuous Quality Improvement

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

“Will establishing a staff training series, continuous community feedback, and defining supervision standards for the Peer Resource Center effectively support visitors in their recovery plans and overall satisfaction with Peer Resource Center services?”

Date PIP began: December 2018

End date: December 2020

Status of PIP: Submission determined not to be a PIP (not rated)

In May 2017, the MHP created the PRC in the central SA-4 area. The MHP is in the process of better understanding the needs of PRC users and improving its operations so that it may be a model for the development of similar programs throughout Los Angeles County SAs. The PRC was established to assist under- and unserved individuals identify and locate needed resources; its focus is not upon engagement or linkage with behavioral health treatment services.

This is an important project and another avenue to improve support of disengaged individuals. However, the topic does not constitute a PIP, which must be based on significant system-wide data findings that have a broad immediate impact on Medi-Cal beneficiaries or eligibles. The focus must help improve service access, utilization, or outcomes for Medi-Cal beneficiaries.

Suggestions to improve the PIP: The current PIP topic presented does not furnish possibilities for modification that would result in an active PIP. The results of local surveys of satisfaction at the PRC produce actionable and important information for making program changes, but these do not constitute a PIP.

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

The TA provided to the MHP by CalEQRO consisted of discussions of potential topics that were identified in the course of the current onsite review. Some of these potential topics included, for directly operated programs: a review of all aspects of the hiring process and reduction of the time from approval-to-fill to final on-boarding of selected candidates. From numerous reports, the current process contributes to difficulties adequately serving beneficiaries with both timely care and adequate levels of care. A second potential non-clinical topic area that arose related to communication and contract amendment processes with LE contract providers. The challenges within that process reportedly were linked with inadequate capacity. Both of the above potentially have significant impacts on service delivery within the system and maintaining adequate service capacity.

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

Table 5: PIP Validation Review				
			Item Rating	
Step	PIP Section	Validation Item	Clinical	Non-Clinical

Table 5: 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	NR
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	NR
		1.3	Broad spectrum of key aspects of enrollee care and services	M	NR
		1.4	All enrolled populations	M	NR
2	Study Question	2.1	Clearly stated	M	NR
3	Study Population	3.1	Clear definition of study population	M	NR
		3.2	Inclusion of the entire study population	M	NR
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	NR
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	PM	NR
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NR
		5.2	Valid sampling techniques that protected against bias were employed	NA	NR
		5.3	Sample contained sufficient number of enrollees	NA	NR
6	Data Collection Procedures	6.1	Clear specification of data	M	NR
		6.2	Clear specification of sources of data	M	NR

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
		6.3	Systematic collection of reliable and valid data for the study population	M	NR
		6.4	Plan for consistent and accurate data collection	PM	NR
		6.5	Prospective data analysis plan including contingencies	M	NR
		6.6	Qualified data collection personnel	M	NR
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	NR
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NA	NR
		8.2	PIP results and findings presented clearly and accurately	NA	NR
		8.3	Threats to comparability, internal and external validity	NA	NR
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NR
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NR
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NR
		9.3	Improvement in performance linked to the PIP	NA	NR
		9.4	Statistical evidence of true improvement	NA	NR
		9.5	Sustained improvement demonstrated through repeated measures	NA	NR

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	14	NR
Number Partially Met	2	NR
Number Not Met	0	NR
Unable to Determine	0	NR
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	16	NR
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**93.75%**	**0%**

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written 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 7 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, and IT staff for the past four-year period. For comparative purposes, we have included similar size MHPs and statewide average IT budgets per year for prior three-year periods.

Table 7: Budget Dedicated to Supporting IT Operations

	FY 2019-20	FY 2018-19	FY 2017-18	FY 2016-17
Los Angeles	2.30%	2.10%	2.10%	1.98%
Large MHPs	N/A	2.70%	2.88%	2.72%
Statewide	N/A	3.40%	3.30%	3.40%

- The MHP budget for IT support has remained stable for three years, but is lower than statewide support level for the same period.

☒ Under MHP control
☐ Allocated to or managed by another County department
☐ Combination of MHP control and another County department or Agency

The budget determination process for information system operations is:

Table 8 shows the percentage of services provided by type of service provider.

Table 8: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	12%
Contract providers	86%
Network providers	2%
Total	**100%***

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

Table 9 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 9: Contract Providers Transmission of Beneficiary Information to MHP EHR System		
Type of Input Method	**Percent Used**	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	1%	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	33%	Daily
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	<1%	Daily
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	66%	Batch file

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of county-operated sites currently operational: 38
- Number of contract provider sites currently operational: 64

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

- ☒ Hiring healthcare professional staff locally is difficult
- ☒ For linguistic capacity or expansion
- ☒ To serve outlying areas within the county
- ☐ To serve beneficiaries temporarily residing outside the county
- ☒ To serve special populations (i.e. children/youth or older adult)
- ☒ To reduce travel time for healthcare professional staff
- ☐ To reduce travel time for beneficiaries

- Telehealth services are available with English, Spanish, Tagalog, Arabic, Mandarin, Russian, Armenian, and Korean speaking practitioners (not including the use of interpreters or language line).
- Approximately 104 telehealth sessions were conducted in Spanish and Korean.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

Fiscal Year	IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
2019-20	244	6	16	18
2018-19	240	25	14	21
2017-18	215	10	8	32

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

Table 11: Data Analytical Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	n/a	n/a	n/a	n/a
2018-19	37	7.5	2.5	3
2017-18	33	5	3	4

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

- Table 11: The clinical informatics unit was moved to the Chief Information Office Bureau (CIOB) since the previous CalEQRO review and now included in Table 10, Technology Staff results for FY 2018-19.
- Currently, the unfilled technology staff vacancy rate ranges between seven and eight percent. CIOB would like to achieve a vacancy rate in the range of five to six percent.
- CIOB leadership indicated that it is difficult to recruit staff who are qualified with database administration and report writing experience. They must hire people with related skills and train them to do that work, in part due to the complexity of operations.
- Recruitment and retention of qualified technology and analytical staff continues to be time-consuming activity.

Current Operations

- The MHP migrated to cloud-based application lifecycle management tools to utilize Continuous Integration Deployment – an industry best practice for developing and managing solutions quickly.
- Los Angeles County Integrated Behavioral Health Information System (IBHIS) Audit: County Auditor-Controller Office elected to perform an audit in accordance with County's Fiscal Manual focusing on claims processing and recoupment, user access controls, and activity monitoring to ensure security and privacy of beneficiary information.

- One of the projects include refinement of reconciliation process for denied claims; and evaluate possibility to change IBHIS to use pre-numbered claim forms and suspend claims with duplicate numbers.
- Los Angeles County Risk Assessment: At the Board of Supervisors' direction, Accenture conducted a risk assessment of eight county departments. LACDMH was one of the departments selected for review, and was found to adhere to industry best practice for security. Projects to address review recommendations include:
    - Automated solution for data loss prevention;
    - Security information and event management;
    - Malicious and suspicious activities blocking;
    - Multi-factor authentication;
    - Privacy inspection;
    - Updating policies and procedures;
    - Creation of a formal incident response, and;
    - Creation of a Facility Security plan.

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 EHR functionality; produce Short-Doyle Medi-Cal (SDMC) 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/IBHIS	EHR	Netsmart	6	Vendor/ CIOB
Order Connect	ePrescribing/eLab	Netsmart	6	Vendor/ CIOB
IBHIS Web Services	Legal Entity/HIE	CIOB/Netsmart	6	CIOB
Provider Connect	FFS Authorization/ Billing Portal	Netsmart	6	Vendor/ CIOB
Practitioner Registration Maintenance (PRM)	Practitioner Data	CIOB	4	CIOB
Care Connect	Integrated Care	Netsmart	4	Vendor/ CIOB
Care Pathways	Meaningful Use	Netsmart	4	Vendor/

Table 12: Primary EHR Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
				CIOB
Access Call Center	Call Management	Verizon	6	Vendor
Pharmacy Benefit Management–(PBM)	Medication Claims Adjudication	Magellan	3	Vendor/ CIOB

- The MHP electronically exchanges client demographic, clinical, and financial data between IBHIS and contract agency's local EHR systems. The following is a summary of the EHR vendor systems that IBHIS currently supports.

Table 12a: Contract Providers' EHR		
EHR Vendors	Legal Entities Supported	Percent
Allscripts	1	1%
Askesis	4	3%
Caminar	3	2%
Cerner	1	1%
Children's Institute, Inc.	1	1%
Clinivate	14	11%
Exym	61	49%
Netsmart	11	9%
The SSI Group, LLC	1	1%
Welligent	27	22%
Legal Entities	**124**	**100%***

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

- Contract providers are responsible for providing vendor specific EHR training and ongoing support for their local staff.

The MHP's Priorities for the Coming Year

The following CIOB initiatives include those projects in Active Status, from submitted ISCA Tool, item A.1. Projects noted in ISCA Tool with Pending Status responses were not included below.

Access to Care

- Service Access and Availability
    - ACCESS Center (Hotline) and Field Crisis Response
    - ACCESS Center Program: Call Logging and Triage
    - Network Adequacy Certification Tool (NACT) Re-Write
    - Virtual Care: Telepsychiatry Expansion
- Capacity Management
    - Mental Health Resource Locater and Navigator (MHRLN)
- Integration and Collaboration (Care Coordination)
    - DCFS/DMH Referral Portal
    - Department of Public Health (DPH)/DMH Interoperability Collaboration
    - IBHIS CareConnect Inbox Direct Messaging
    - LANES Health Information Exchange (HIE)

Timeliness of Care

- Client Services Information (CSI) Assessment Record 2018 Updates
- SRL Web Services Enhancements (capture1st psychiatry appointment data)

Quality of Care

- Beneficiary Needs are Matched to the Continuum of Care
    - Patients' Rights Call Log (PRCL)
    - Utilization Management (guidelines for Level of Care decisions)
- Quality Improvement Plan
    - Client Interview Recording

    - Early & Periodic Screening Diagnostic and Treatment (EPSDT) Outcome Measures
    - EBP Certification
    - Use Scriptlink tool to improve data quality, error prevention, data entry experience and time savings
- QM Reports Act as a Change Agent in the System
    - NACT Power Business Intel (Power BI Applications)

Beneficiary Progress/Outcomes

    - Beneficiary Progress Consumer Family Access to Computing Resources (CFACR) Expansion
    - EPSDT Outcome Measures
    - Grievance and Appeal System
- Beneficiary Perceptions
    - Client and Family Mobile Self-Assessments/Surveys (Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7))
- Supporting Beneficiaries through Wellness and Recovery
    - CFACR Expansion
    - PRC Application – Mobile Component
    - Recovery, Resilience & Reintegration Outcome Measures Application

Structure and Operations

- Financial Services
    - CBO Private Insurance Claim Tracking System
    - IT and Administrative Services Asset Management
    - IT Financial and Operations Management (for all CIOB)
    - Legal Entity Invoice Portal
    - Provider Form Adjustment Request (PFAR) Automation
- Human Resource Services
    - Credentialing System Modernization
    - Lanterman-Petris-Short (LPS) Phase III (Site Certification)

- IT Services
    - Digital Workplace: Phone System Modernization
    - Digital Workplace: Video Conferencing/Webcasting Expansion
    - Dynamic Data Masking
    - Help Desk Dashboard Reports
    - Healthcare Enterprise Analytics: Technology Framework (move to Cloud)
    - Risk Management: Multi-Factor Authentication for IBHIS
    - Risk Management: Privacy Monitoring Solution
    - Risk Management: Security Information and Event Management Analytics
    - User Access Request Process Automation
    - Websites Migration and Redesign

Major Changes since Prior Year

- The Integrated System, legacy MIS, used for Medi-Cal billing and state-mandated data reporting was officially shutdown. Full back-up was done and archived for future retrieval of historical information.
- The significant IS-supported projects and initiatives completed since the last CalEQRO review include:

Access to Care

- Service Access and Availability
    - NACT 1.0
    - NACT Data Submission
    - GIS Portal – supports NACT
    - Provider Directory – supports NACT
    - Capacity Management – supports NACT
    - Patient Rights Change of Provider
    - Mental Health Resource Locator and Navigator– Proof of Concept

  - County Wide Master Data Management: Milestone 2, Realtime Interface Avatar/DMH MDM
  - DMH Internet Website Redesign and Migration
  - L.A. Care Medi-Cal Data Exchange
  - Redesign and Automation of CEO/CIO Enterprise Multilingual Data Exchange
  - Data Exchange and IBHIS integration of Public Guardian Case Status data from CAMS

Timeliness of Care

  - Katie A. Application (days between MH screening to assessment)
  - SRL Form Modifications for IBHIS

Quality of Care

- Quality Improvement Plan – use Scriptlink tool to improve data quality, error prevention, data entry experience and time savings (auto fill fields, auto calculate assessment scores)
- Quality Management Structure
  - DCFS/DMH Child Abuse Reporting Website Security Enhancement
  - ACCESS Center Call Recording System Upgrade (Cloud-based)
- QM Reports Act as a Change Agent in the System - QA & IBHIS Error Monitoring Report
- Medication Management - Electronic Prescribing of Controlled Substances in IBHIS

Beneficiary Progress/Outcomes

- Beneficiary Progress (Includes beneficiaries in treatment and care planning)
  - Consumer Engagement Technology Initiative (Just4Me)
  - EPSDT Outcome Measures, Phase I
- Supporting Beneficiaries through Wellness and Recovery
  - PRC Mobile Application

Structure and Operations

- Financial Services

  - Client and Asset Management System (CAMS) Mobile Application Deployment
  - IT Financial and Operations Management (supports IBHIS)
  - Pharmacy Benefit Management Services Enhancements
- Human Resources Services
  - EOB Field Response Operations After Hours Crisis Team Database
  - Digital Workplace: Wi-Fi access at DMH Clinic and Admin Sites
  - LPS Phase II - (staff certification)
  - LPS Phase III - (Provider Portal)
- IT Services
  - Compliance Bridge Policy Management System
  - Data Center Consolidation
  - Digital Workplace: Wi-Fi access for DMH Clinic/Admin Sites - Phases 1-3
  - DCFS/DMH Child Abuse Reporting Website Security Enhancement
  - DMH Intranet Redesign
  - IT Assessment Management
  - Windows 10 Upgrade

Other Areas for Improvement

- The lack of responsiveness by IS vendor to complete system improvements, work-orders, and Avatar bug-fixes in a timely manner is impacting the MHP's operational readiness to support DHCS IN requirements.
- While rewriting the NACT application, the MHP needs to participate in DHCS Network Adequacy Stakeholder workgroup meetings for knowledge of ASC X12, 274 transaction requirements.

Plans for Information Systems Change

- The MHP has no plans to replace current system, which has been in place more than five years.

Current EHR 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/IBHIS	X			
Assessments	Avatar/IBHIS	X			
Care Coordination	Care Connect/IBHIS	X			
Document Imaging/ Storage	Avatar/IBHIS	X			
Electronic Signature—MHP Beneficiary	Avatar/IBHIS	X			
Laboratory results (eLab)	Order Connect/IBHS	X			
Level of Care/Level of Service	Avatar/OMC	X			
Outcomes	Order Connect/IBHIS	X			
Prescriptions (eRx)	Order Connect/IBHIS	X			
Progress Notes	Avatar/IBHIS	X			
Referral Management	SRL/SRTS/VANS	X			
Treatment Plans	Avatar/IBHIS	X			
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		12	0	0	0
FY 2018-19 Summary Totals for EHR Functionality:		12	0	0	0
FY 2017-18 Summary Totals for EHR Functionality:		11	0	0	0

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

- Table 13 ratings based on IBHIS implementation for LACDMH directly-operated sites.

- LEs and fee-for-service providers have implemented local EHR systems or have contracted with a healthcare clearinghouse to submit electronic data interchange (EDI) transactions that support two-way exchange of data between local systems and IBHIS.
- LEs have the capability to view (i.e., look up) beneficiary laboratory results via the CareView portal. CareView is also a Netsmart application.
- DO sites have the capability to view beneficiary laboratory results via CareConnect application.

Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

☒ Yes ☐ In Test Phase ☐ No

The MHP rebranded myHealthPointe as Just4Me.

- Most DO sites provide beneficiaries with information to register on Just4Me.
- The MHP reported over 92,000 personal identification numbers (PINs) have been given, while 5,989 beneficiaries have created their personal PIN.
- There are designated peer staff onsite at DO programs to assist beneficiaries with Just4Me training and provide ongoing support.

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

SQL Server – DMH Data Warehouse validates outbound and incoming claims.

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14. Summary of CY 2018 Short Doyle/Medi-Cal Claims Los Angeles MHP							
Service Month	**Number Submitted**	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Dollars Approved**
TOTAL	**5,126,625**	**$1,177,698,095**	**160,461**	**$38,761,166**	**3.29%**	**$1,138,936,929**	**$1,077,171,591**
JAN18	480,460	$111,108,599	16,257	$3,866,556	3.48%	$107,242,043	$101,631,280
FEB18	458,506	$104,709,884	16,214	$3,820,657	3.65%	$100,889,227	$95,149,120
MAR18	499,935	$114,864,302	20,485	$4,499,484	3.92%	$110,364,818	$103,915,558
APR18	482,501	$110,473,180	16,730	$3,849,975	3.48%	$106,623,205	$100,682,390
MAY18	502,248	$115,678,120	16,715	$4,081,158	3.53%	$111,596,962	$105,015,638
JUN18	426,625	$96,542,403	12,512	$2,901,663	3.01%	$93,640,740	$88,977,157
JUL18	427,344	$101,430,112	11,204	$3,055,865	3.01%	$98,374,247	$92,938,466
AUG18	471,154	$109,122,670	11,780	$2,942,222	2.70%	$106,180,448	$100,760,794
SEP18	409,870	$93,967,840	10,118	$2,492,734	2.65%	$91,475,106	$86,812,052
OCT18	469,751	$107,901,748	11,411	$2,742,092	2.54%	$105,159,656	$100,132,784
NOV18	348,617	$79,993,417	9,511	$2,569,283	3.21%	$77,424,134	$73,323,087
DEC18	149,614	$31,905,822	7,524	$1,939,478	6.08%	$29,966,344	$27,833,264
Includes services provided during CY 2018 with the most recent DHCS claim processing date of June 7, 2019. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2018 was **3.25 percent.**							

- CalEQRO monthly claim results presented in Table 14 are incomplete as a significant number of November and December transactions were not available when data download from DHCS claims adjudication system occurred in May 2019.

Table 15 summarizes the top three reasons for claim denial.

Table 15. Summary of CY 2018 Top Three Reasons for Claim Denial Los Angeles MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Payment denied - prior processing information incorrect. Void/replacement condition.	77,808	$17,948,380	46%
Medicare or Other Health Coverage must be billed before submission of claim.	29,958	$7,815,875	20%
Service line is a duplicate and repeat service procedure modifier is not present.	22,010	$4,408,072	11%
TOTAL	160,461	$38,761,166	N/A
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with reasons of Medicare or Other Health Coverage must be billed before of claim, or service line is a duplicate and repeat service procedure modifier is not present, are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted four 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested four focus groups with 10 to 12 participants each, the details of which can be found in each section below.

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

CFM Focus Group One

The first requested focus group occurred in SA-8 at Harbor-UCLA, 21730 South Vermont Avenue, Suite 210, Torrance, California. The requested participants were a culturally diverse adult beneficiaries, who are mostly new and have initiated/utilized services within the past 12 months.

Actual participants conformed to the request, and were a multi-ethnic/-cultural mix of African-American, Caucasian/White, including a Hispanic/Latino majority. A Spanish language interpreter assisted with the non-English speakers. All were in the 25-59-year age group.

Number of participants: Eight

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

- Participants reported learning about services from an array of sources: primary care providers, online information, social workers, and psychiatrists.
- Most reported initial access times that ranged from two to three weeks, with the entire range spanning from two weeks to two months.
- The experience with access varied widely; however, most stated that contact with someone who had direct, personal experience with services would have been helpful to guide them through the process – someone to listen, provide empathy, and support.

Participants' general comments regarding service delivery included the following:

- Transportation assistance was provided to those receiving SUD treatment, but the remainder felt left on their own to navigate to and from appointments.

- Participants expressed awareness for service information in non-English, specifically Spanish, Tagalog, and Chinese.
- Regarding other available services, CalWORKS was mentioned as a link to affordable (i.e., Section 8) housing. Access to food resources was also identified as useful information that is furnished.
- All of the participants saw a therapist weekly, except for a small minority. Related to quality of services, concerns about receiving treatment from interns emerged. This is related to frequent turnover of provider and disruption of the therapeutic relationship.
- The majority of participants received psychiatry/prescriber services, with monthly contact for most and every three months for one. All expressed satisfaction with the frequency of these visits and the responsiveness of practitioners to their concerns.
- All participants reported receiving appointment reminder calls, and that there were no issues with rescheduling if an appointment was missed.
- Less than half received or were offered group therapy; other modalities such as craft groups and Cognitive Behavioral Therapy (CBT) groups were mentioned.
- Participant's urgent care needs were met by contacting case workers or the front office.
- Regarding quality of care:
    - Participants were involved in the development of their treatment plans. None reported having a Wellness and Recovery Action Plan (WRAP) or similar wellness plan.
    - Written information about medication is provided by pharmacies. None could recall offers of medication education classes provided by the MHP.
    - Communication between primary care and psychiatry occurred for this group in only one case.
    - The changes impacting these participants in the last year included, for one, loss of eligibility to see a therapist due to graduation; and for another, help with housing which was a positive experience.
    - None were aware of wellness centers or peer-run programs. Many were trying to determine what resources were appropriate and accessible to/for them.
    - Immediate information regarding resources is obtained from case managers. Most participants would appreciate more outreach to inform them of available resources.

  - None of the participants participated in MHP committees, such as QIC.
  - Support in finding employment was acknowledged by the majority of participants, including Wellness Outreach Workers (WOW) opportunities and assistance from the Department of Rehabilitation (DoR).

Participants' recommendations for improving care included the following:

- Provide bus passes and/or transportation support.
- Hire more bilingual staff.
- Incentivize group participation (gift cards).
- Improve/increase therapist consistency/stability.
- Provide more and varied outings, like walking dogs.
- Recognize participants with awards.
- Expand support systems, such as mentorship.
- Greater beneficiary appreciation.

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

CFM Focus Group Two

The second requested focus group occurred in SA-8, at the Children's Institute, Inc., 1500 Hughes Way, B-Pod, Long Beach, California. The requested participants were a culturally diverse group of 10-12 caregivers of children and youth beneficiaries, with significant representation of Hispanic/Latino and African-Americans, who are mostly new and have initiated/utilized services within the past 12 months.

Actual participants generally conformed to the request, and were a multi-ethnic/-cultural mix of Caucasian/White and Hispanic/Latino. A Spanish language interpreter assisted with the non-English speaker present. All were in the 60+ age group. The number of participants was significantly fewer than the 8-10 requested.

Number of participants: Three

There were no participants who entered services within the past year. Participants described their experience as the following:

- Participants related learning about mental health services from their prior contact with services.

- When asked about transportation assistance, some reported home visits occurred, which resolved the transportation issue. Others reported weekly or twice weekly outpatient visits where transportation help was provided.
- Regarding non-English language capability, some reported services in Spanish, and others stated they receive help in Spanish from Parent Partners at Masada.
- Participants report receiving telephone call reminders in English and Spanish for upcoming appointments.
- Weekly therapy sessions were reported by all, and considered sufficient to make the desired progress.
- A small element of this group has a child who receives medication and sees a psychiatrist. The monthly frequency of psychiatry is considered sufficient. The psychiatrist discusses the medications with the parents/caregivers, and gives information about intended therapeutic effects.
- Missed appointments require a reschedule with no difficulties in timely rescheduling.
- Some participants have sessions with the therapist to talk about the child's progress.
- Groups that have been utilized by these caregivers are a parents' group.
- For unscheduled, urgent needs, participants were aware of a telephone number to call for assistance.
- All voiced participation in the treatment plan development process with their children.
- Participants received medication information and had the opportunity for discussions with the psychiatrist.
- Communication between psychiatry and primary care/pediatrics was cited as routine.
- Step-down in services was mentioned by one family as related to progress.
- Regarding information and involvement with MHP services, some receive information from the therapist and other attend larger meetings. Some meeting participants identified obtaining more detailed information about external programs – such as a recent mental health training of first responders.
- None of these participants were aware of NAMI or Family To Family.
- None recalled participating in a consumer survey process.

- Other than holiday and celebratory parties, none were involved in any larger planning or input groups. Several would like to partake in such opportunities.

Participants' recommendations for improving care included the following:

- Greater circulation of information about resources and input meetings, through text, website, posted calendars, and therapists providing information.
- More encouragement of participation in meetings and avenues to provide input.

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

CFM Focus Group Three

The third requested focus group occurred in SA-6, at the Children's Bureau, 1910 Magnolia Avenue, Los Angeles, California. The requested participants were a culturally diverse group of caregivers or parents of children and youth beneficiaries, who are mostly new and have initiated/utilized services within the past 12 months.

Actual participants generally conformed to the request, and were a multi-ethnic/-cultural mix of Hispanic/Latino and African/American. The four participants were significantly less that the 8-10 requested.

Number of participants: Four

There were no participants who entered services within the past year. Participants described their experience as the following:

- Several participants obtained Information about mental health services from contact with the DCFS. Another obtained information from the school system.
- A welcome packet describing available services was received by one participant, none of the others could recall receiving this information. KinGap resource information was received by one.
- None of the participants experienced any transportation related needs. One individual recalled transportation assistance was explored by the treatment staff.
- Case management services are utilized by one of the caregivers. This includes availability on weekends. Others receive KinGap services.
- Therapy sessions occur once weekly for most, and for another twice per week, supplemented by a monthly family session. All characterize their current service levels as sufficient to make improvements.

- Psychiatry service experiences vary widely. Several participants have children who see a psychiatrist, but not all are on medications. One participant is experiencing a conflict about the recommended medications and is in the process of switching to another practitioner. However, extensive experience with medications and psychiatry was not evident in this group.
- Missed appointments are rescheduled, without any issues or delays identified. If the parent has not called to reschedule, the clinic typically calls back. Multiple appointment reminder calls were mentioned by some.
- Family therapy is utilized by half of the participants.
- Urgent care needs are met by calling a case manager, crisis hotline, or crisis team. Alternatively, some go to the hospital emergency department.
- Information about medications are furnished by the pharmacy. General service information is provided when a need arises and in conversations with therapists.
- Some participants have taken part in a satisfaction survey, but none have received or seen the results.
- Most report that stigma and fear are barriers to others accessing mental health care.
- Participants mentioned learning in therapy sessions about Just4Me, the client portal, but have not followed up. Comments include lack of access to the internet and lack of trust in computer access. The preference is to relate directly and in person.

Participants' recommendations for improving care included the following:

- Campaigns to address stigma and educate the community about mental health services.
- Outreach to the Spanish speaking community in order to overcome the barriers of immigration status fears, and to help immigrants understand that treatment can be a well-kept secret.
- Improve coordination and communication between different providers. There are often conflicts between what providers and supervisors state. This is often involving home visitations.
- Paperwork and administrative details are overly complex and could be made simpler.
- The attitudes of providers often do not seem to reflect welcoming, and the family experiences a sense the clinician projects that they are doing a favor by providing services.

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

CFM Focus Group Four

The fourth requested focus group occurred in SA-6, at the Children's Bureau, 1910 Magnolia Avenue, Los Angeles, California. The requested participants were culturally diverse adult beneficiaries, with the greatest representation by Hispanic/Latino and African-American beneficiaries, who are mostly new and have initiated/utilized services within the past 12 months.

The actual six session participants were exclusively African-American/Black and English-speakers. The majority were in the 25-59-year age group.

Number of participants: Six

There were no participants who entered services within the past year. Participants described their experience as the following:

- Initial access to care and information about mental health services varied widely, ranging from continuation of services that started in prison or jail; a recommendation from family; or recommendations of a UCLA or Kaiser physician. Another was a self-referral.
- Regarding transportation, no participants could recall being offered tokens or bus passes. At best, reduced bus fare cards were obtained with a physician's signature. One participant received cash for the bus from a counselor, who then connected him with a transportation program.
- One participant has seen a welcome packet that describes clinic and related services.
- Experience with supported employment varied among the participants. One attempted services through the DoR, but the push to return to work conflicted with the participant's desire to complete an advanced degree. The employment support was perceived as basic, and a comprehensive approach that addressed a long-term higher education and career plan was not available. DoR's support was limited to professional/work clothes and bus passes; help with housing and managing the other stresses of employment after being out of the workforce, including attending school were not addressed.
- Generally, the experiences were quite individual and unique, but turnover in clinic personnel was associated with lack of care continuity and a sense that "You can't depend on mental health," as stated by one.
- Participants who were coming from forensic re-entry programs and were on parole were referred to mental health but with little perceived follow-up and support by parole or mental health. Participants' comments related to a sense that services were configured around billable activities, not necessarily what the beneficiary needed at the time.

- Approximately half of the group have a case manager. Others could not recall being offered a case manager, but have received similar kind of assistance.
- Cultural and linguistic support were felt to be insufficient, with the front office lacking Spanish speakers and difficulties finding specific services for African-American women or LGBTQ individuals. Participants were unaware of emergency housing for LGBTQ in Compton/SA-6.
- The criteria for housing assistance have recently changed and participants who had been waiting for housing assistance were told “severe homelessness” was the new requirement and they were no longer eligible.

Participants’ recommendations for improving care included the following:

- More peer support workers are needed, particularly of individuals whose skills focus on community re-entry.
- More help is needed beyond medication and psychotherapy, specifically on helping beneficiaries to become self-sufficient – beneficiaries believe one has to do it themselves or turn to nonprofits outside of the mental health system. Coordination and integration with programs that support learning to be independent was identified as missing in LACDMH.
- WOW staff need to be part of the CalCard county process for paying for beneficiary expenses, such as water, food, and other basic needs.
- Alternative treatment approaches should be considered first, rather than turning first to medications. In addition to alternative therapies, help with basic living needs such as housing and education are priorities that need to be addressed early and often.
- More individualized approaches to case management are needed, instead of using a standardized, cookie-cutter approach.

Interpreter used for focus group four: No Language(s): N/A

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

Table 16 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
1A	Service Access and Availability	14	14
The MHP operates a 24/7 Access Line, which has the capability of responding to requests in threshold languages, many by in-house multi-lingual personnel, and some requiring linguistic support by other services such as the Language Line. The experience of SA indicates that the majority of requests for service come via calls directly to local programs or walk-ins. SRTS and Field Response Operations teams dispatch are functions of the Access Center, and are coordinated with DO and LE contract clinics and SRTS referrals, consistent with the current timeliness standards. The functionality of the Access Line is monitored across numerous parameters, including non-English response and other needs. This monitoring is part of the LACDMH continuous quality improvement (QI) process. Activities include setting of performance/response standards and secret shopper calls performed monthly by SA QICs. Daily reports and dashboards help the MHP monitor for potential delays. Referrals from schools and health plans occur through established clinic and regional liaisons. The MHP's website has undergone many improvements since the prior review, and reflects ongoing efforts to create a more logical, user-friendly display of information, including the required provider directory. The directory has been modified to specifically provide useful information to those who might call with urgent or crisis needs. Submitted for the review were the welcoming packets created by a number DO			

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
programs, which provide a personalized approach to services at specific locations, and include a photo and brief biography of the clinic lead. Clear, written descriptions of the service process and beneficiary expectations are also included. These welcome packets also outline other services available and, for some, also include basic living resources. This additional information is not uniform among all programs and is not an expectation of LE contract providers at this time.			
1B	Capacity Management	10	7
The Cultural Competence Plan (CCP) tracks the linguistic and cultural needs of each SA. The CCP also describes the outreach, education, and engagement efforts to meet these needs and the partnerships with relevant providers to improve access. Cultural Competence Committee (CCC) minutes reflect a wide-ranging discussion of needs, actions to improve information to local ethnic communities, skills to improve staff competencies, and efforts to meet treatment resource needs. During this past year, the MHP engaged in a study to determine caseload and staffing needs utilizing a service delivery model, which considered needs of beneficiaries at the various levels of care. This has resulted in proposals for staffing increases at some locations for the next fiscal year. This specific analysis was focused upon DO programs. LACDMH service delivery is a matrix of MHSA and Medi-Cal funded activities, frequently involving blending of both funding sources. There is an emphasis on the identification and use of EBP, which poses challenges to the maintenance of fidelity when staff turnover occurs. The MHP monitors caseload numbers, system demand volume, and productivity for DO programs. The data reviewed did not include contract providers. LE contractors currently have fixed capacity based on funding, frequently slot-based. DO programs have no cap on individuals served, and must absorb new beneficiaries without additional resources. There are areas of bottlenecks in service, which are often patched with the provision of transitional care, for example, following urgent care admissions 60-day follow-up is provided by a dedicated team, until beneficiaries can be connected to specific outpatient services. Mentioned many times during the review process, the Final Rule requirements of 10-day initial access has caused resource shifts from treatment to increase intake capacity. This comes at a time when many programs are experiencing vacancies, and reported long delays from position requests-to-fill approval to onboarding of selected candidates. While precise data on this process was not available during the review, this phenomenon was mentioned in the two SAs that were visited during this onsite.			

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
Worthy of mention, the MHP's overall penetration rate is at least a full percentage point greater than the statewide average and other large MHP average for CY 2018. This is also true for the Hispanic/Latino penetration rate.			
1C	Integration and Collaboration	24	24
The MHP reports 86 percent of all services delivered are provided by contract agencies; this involves collaboration and partnerships that are key to the services delivered by LACDMH. Across the spectrum of outpatient programs, hospitals, joint response teams with law enforcement, linkages with DCFS, the Housing Authority, DoR, and schools, the MHP's services involve partnerships. The Health Homes also provides partnering opportunities. In SA-6, a large integrated health care and social services program site is being built on Martin Luther King (MLK) campus, that will house a virtual one-stop operation for medical, mental health, substance use and other social needs.			

Timeliness of Services

As shown in Table 17, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
2A	First Offered Appointment	16	11
LACDMH has adopted the "within ten business days" offered appointment standard, per IN 18-011, effective July 1, 2018. LACDMH has been collecting timeliness information from both DO and LE/contract providers related to first offered appointment tracking of initial requests, DO providers are monitored on a monthly basis, and LE contracted providers are monitored quarterly. The operations of a very large system with multiple disparate electronic systems creates tracking and reporting challenges due to the many different EHRs in use and disparate calendaring systems. The SRTS is a unique stand-alone referral and service tracking system, including all fields of the SRL, an IBHIS-based (EHR) product. Wraparound and Full Service Partnership (FSP) programs use the SRTS in a manner inconsistent with the current			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
timeliness requirements. This information is therefore not part of the MHP's reporting. Some contract providers also lacked the ability to provide information through the SRL. Understanding the limitations of this data during this ramp-up period, the MHP's mean times for first offered appointments were at least one day less (i.e., better) than the required ten business days for all populations served by DO programs. For all contracted programs, the results were one to three days more (i.e., worse) than the 10-business day standard. LACDMH has set a target of 93 percent minimum for achievement of standard target by December 31, 2019 for DO programs; LE providers have a standard of 96 percent minimum.			
2B	Assessment Follow-up and Routine Appointments	8	1
There was no evidence that the MHP routinely tracks assessment follow-up and routine appointment data, but there was some discussion about this stated potential for DO programs. There were instances of absence of service data reporting, which occurs when the system reports identify cases wherein no services have been received in the previous 90 days. However, this type of reporting does not support presence of regular follow-up appointment monitoring, and identifies service outliers only.			
2C	First Offered Psychiatry Appointment	12	8
The MHP adheres to the DHCS IN 18-011 first offered psychiatric appointment standard of 15 business days. Data on this aspect of psychiatry access was not available due to data capture issues that are in the midst of resolution, and reports will be available during the next EQR review. For the purposes of this review, the MHP provided data on average length of time from first request for service to first psychiatry kept appointment (business days). The median number of days for DO programs were: Adults 20.42; Children's 24.9; FC 23.18. The median number of days for contract programs were: Adults 27.41; Children's 27.63; FC 22.60. Achievement of the 15-day standard is not relevant to this metric due to the reported information not conforming to network adequacy requirements. During the course of the review, direct service participants reported initial psychiatry			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
access frequently took two weeks, but it was not uncommon for as much as four to six weeks wait times, with exceptions for urgent presentations.			
2D	Timely Appointments for Urgent Conditions	18	14
LACDMH beneficiaries who receive urgent appointments do not require prior authorization. The MHP is tracking the 48-hour standard for the urgent metric. All beneficiaries who receive urgent appointments are expected to receive an actual encounter within 48 hours. For the review period, data capture was limited to DO programs until November of 2018, when SRTS changes enabled reporting on this metric for all LE contract providers. The MHP reports on DO mean hours and achievement of 48-hour standard as: adults 145.54 hours/ 54.29 percent and children 78.43 hours/ 42.86 percent. There were 42 total events reported, which appears to be an underreporting of the actual number of urgent events that have occurred. The process for tracking continues to be refined, and will certainly reflect greater numbers as identification and reporting issues are resolved.			
2E	Timely Access to Follow-up Appointments after Hospitalization	10	8
The MHP reports adherence to the 7-day HEDIS standard; however, the data reported were based on the locally developed 5-day standard which has been derived from an existing agreement with the local health plan. In addition, the MHP policy is to track follow-up only for individuals who were so referred at discharge. That said, the data analysis calculations are based on all inpatient discharges and readmission events, even when there are multiple hospitalizations in one year. An added complication to the data is the reported large number of individuals readmitted during the 7-day immediate post-hospital period. Understanding the various limitations of this data, the MHP reported the following mean days and meeting of standard percentages: adult Services: 4.87 days / 71.05 percent; children's: 3.30 days / 81.61 percent; and FC 1.97 days / 90.59 percent. These results are in context of total discharge events, which were 32,880 adults, 5,978 children's; and 251 FC. EQR approved claims data for psychiatric inpatient utilization demonstrated a steady increase over the CY 2016-18 period, with the average length of stay (ALOS) and costs per beneficiary rising steadily to the most recent CY 2018 ALOS of 8.25-day.			
2F	Tracks and Trends Data on Rehospitalizations	6	4
The MHP presented a 38 percent readmission rate for CY 2017 and a 31.09 percent			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
30-day rehospitalization rate for the current review period, which includes those with a discharge date prior to June 1, 2019. The MHP includes only one event per individual as the statistic. While this may be an actual readmit rate, it is complicated by the presence of serial re-admitters, and likely both statistics should be tracked and evaluated. Onsite discussion suggested that the MHP includes each and all rehospitalizations. The MHP's reported 30-day readmission data were as follows: 34.29 percent for adults; 13.71 percent for children's; and 27.08 percent for FC. A related issue can be found in the ALOS for LACDMH Medi-Cal admissions. CY 2018 is the most recent year for which the EQR has complete data, and that period shows an ALOS of 8.25, which is higher than both of the previous two years. The combination of an adult 32 percent readmission rate with longer LOS is worth exploring. The MHP is exploring some mechanisms to decrease readmission rates, including TCPI that involves the potential use of psychologists as hospital liaisons. Also, IBHIS contains a widget for tracking access callers for risk factors, including high inpatient utilization. The MHP also has created numerous specialized teams that provide post-crisis and post-UCC follow-up for a limited, often 60-day period, until firm outpatient linkage and engagement occurs.			
2G	Tracks and Trends No-Shows	10	7
The MHP utilizes IBHIS for DO program appointment scheduling, and is able to track those events that are recorded when no-show events occur. LE contractors use differing systems and do not report to the MHP on their no-show events. This area reflects another disconnection in the MHP monitoring, which includes no-show data from DO programs but not contractor data. This is an area in which the MHP may wish to include LE contractor data, in that it provides more complete information for the management of the local mental health plan. The MHP continues to not set benchmarks or standards for no-show events of psychiatry/prescribing or other clinical staff. Limited to DO programs, the no-show data for psychiatry was adults15.84 percent; Children's 12.60 percent; and FC 13.86 percent. For other clinical staff no-show data was adults 9.47 percent; children's 7.33; and FC 3.96. Where significant field services are involved, the issue of no-shows has more limited utility due to the many intervening factors that can impact out-of-clinic services, such as local traffic and transportation issues. Traffic in particular is a reportedly			

Table 17: Timeliness of Services Components		
Component	**Maximum Possible**	**MHP Score**
troublesome issue for this MHP, especially for FC children and youth who may have a worker located centrally but are in placements in the distant Antelope Valley area.		

Quality of Care

In Table 18, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 18: Quality of Care Components			
Component		Maximum Possible	MHP Score
3A	Beneficiary Needs are Matched to the Continuum of Care	12	9
The MHP's SA navigators provide assistance in screening to determine need for FSP level of care and help callers link with appropriate services. This type of service matching also occurs at the Access Line. Beneficiary focus group participants uniformly reported participation in treatment planning. The MHP provided information regarding continued refinements to level of care determination. Based on determinations regarding service needs, level of care constructs were used to perform a gap analysis of DO programs and identify additional staffing needs. The inclusion of outcome/level of care tools is part of this process. The level of care tools in current use include the Child and Adolescent Needs and Strengths (CANS), with anticipation that Determinants of Care will furnish a wider picture of beneficiary wellness than provided by the CANS, Pediatric Symptom Checklist-35 (PSC-35), and Milestones of Recovery Scale (MORS) in current use. Staff who work in the SAs visited for this review mentioned the existence of sub-team at some DO sites that have been created to better serve beneficiaries and create more coherent caseloads and workflow. For example, there is a medical sub-team for beneficiaries who are primarily medication management that can also provide limited case management. Clinician resources are heavily allocated to teams with individuals who are presenting with psychotherapy needs. Beneficiaries who have severe		

Table 18: Quality of Care Components			
	Component	Maximum Possible	MHP Score
functional impairments are either part of full-service partnerships or teams that have a significant presence of peer support and case management staff. A gap analysis of DO programs that looked at needed service hours, types of services, and staffing have incorporated level concepts and resulted in adjustments to future staffing. FSP redesign is underway, with the intention to move from slot-based to team-based programs, including having staffing ratios. Part of this redesign involves evaluating some of the very small FSPs and considering merging them to achieve improved efficiency of scale.			
3B	Quality Improvement Plan	10	9
The MHP performed an analysis of the 2018 QI Work Plan (QIWP) results and formulated a calendar year 2019 QIWP. The QIC Minutes typically reflected high level issues, policy and procedure changes, and corrective actions. QIC review of actual data relating to QI targets was not evident during this review. Within SA-6 and SA-8 specific areas of review, discussions indicated Final Rule timeliness results of these areas have been presented and discussed. Some participants mentioned data review occurring in other meetings, such as adult and children's systems of care, but did not specifically identify review of QI targeted metrics. That QIC minutes did not reflect regular review of performance targets which were identified in the QIWP, and is consistent with prior EQR report findings. Understanding the scale of LACDMH operations would suggest that complete review of QIWP performance measures on a quarterly basis may not be feasible, but review of those metrics wherein performance targets were not met would be anticipated. If other venues are seen as providing more appropriate audience for metric review, these sessions should be identified as part of the MHP's QIC process.			
3C	Quality Management Structure	14	11
LACDMH has established a QID that is comprised of the QI Program, the Cultural Competence Unit (CCU) and the Underserved Cultural Communities (UsCC) Unit. The UsCC implements one-time funded capacity building projects that improve specialty mental health resources for underserved cultural communities. QID is broadly involved in all aspects of MHP operations involving quality improvement, compliance, including coordination with the Access Center, Emergency Outreach and Triage Division, DO and contract program interface, SA QICs, the Workforce Development Division, as well as production of consumer perception satisfaction reports. PIPs are an important element of QID operations.			

Table 18: Quality of Care Components			
Component		Maximum Possible	MHP Score
3D	QM Reports Act as a Change Agent in the System	10	5
QID reports include disparity status in LACDMH SAs. Regional reports include DO program dashboards that present the number of active beneficiaries, percentage of initial access to care meeting standards, missing treatment plans, and absence of service for 180 days. The MHP produces reports that span the MHPs lines of business, with expectations that LE contract agencies do much of their own monitoring. This information relates to changes in staffing and programming, particularly in the MHSA plan update area. In the areas of disparities, system and demographic data is used to assess progress. The quarterly or semi-annual use of this information was not clearly demonstrated during the review, particularly in how this information impacts planning and services. Based on staff input, the use of productivity data and other performance measures were mentioned as occurring routinely. There do exist significant differences between DO and LE contract agencies and their tracking of data. But data related to compliance issues such as timeliness and equity are discussed in QIC sessions.			
3E	Medication Management	12	2
The MHP operates with clinical practice guidelines which are published on the LACDMH website and available to all practitioners. These guidelines are expected to shape the clinical practice of prescribers and outline standards. The psychiatry oversight process is currently focused on review of incidents and adverse events. Pharmacy staff provide oversight of medications prescribed for uninsured individuals and managed through the Pharmacy Benefits Management (PBM) system. This system operates with protocols and requirements including prior authorization standards for certain medications. The PBM provides the MHP with greater control and oversight of prescribing, but this monitoring does not exist for Medi-Cal beneficiaries served by contract providers; however, DO program prescribers utilize OrderConnect which is a component of the IBHIS EHR. This element supports queries regarding prescribing patterns and specific drugs, combinations, and dosage ranges.			

Table 18: Quality of Care Components		
Component	Maximum Possible	MHP Score
The MHP's current focus with regard to prescriber oversight is on DO programs; but in this area, procedures for routine peer review (medication monitoring) prescribing practices was not in place as of this review. Contract entities are expected to monitor their own operations without direct structured oversight by the MHP. In some sessions, psychiatry capacity issues emerged, which included absence of caseload maximums for DO programs and the dearth of child psychiatry was mentioned at some children's hospitals. Prescribers gave suggestions about workflow changes that would improve efficiency. These included streamlining to eliminate the need for psychiatrists to take vital signs or to create a process that streamlines and integrates lab work onsite. It was not clear if these were site-specific issues or had broader relevance. Other prescriber issues included identification of regional center referrals, frequently considered inappropriate because of the need for specialized neuropsychiatry training and experience in working with this complex population, and often with complicating seizure disorders, and perhaps better served by the regional centers having their own dedicated neuro-psychiatry consultants for the frequent behavioral issues that emerge rather than referring to an already overburdened community mental health system. Contract providers are using different EHR systems, reportedly some of which often lacking e-prescribing capacity and result in paper prescriptions and use of faxes. The paper prescribing process also makes remote system monitoring difficult to develop. EHRs were identified by prescribers as continuing to serve as a practice barrier. Improvements that would reduce clicks and pull-down menus would be of value to practitioners. None of the prescriber sessions reflected any use of aggregate data or reporting on trends in prescribing, with the exception of the FC youth prescribing review from the JV-220 process.		

Beneficiary Progress/Outcomes

In Table 19, CalEQRO identifies the components of an organization that is dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 19: Beneficiary Progress/Outcomes Components			
Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	11
Level of care tools tested for use with FSPs include the Child & Adolescent Service Intensity Instrument (CASII), the Early Childhood Service Intensity Instrument (ECSII), and nine case management targets. The proposed adult FSP level of care tool under consideration, and not currently implemented, would focus on the determinants of care. The MORS is in universal use with adults. With children and youth, in current use are the CANS-50-T, with 12 additional trauma questions, and the Pediatric Symptom Checklist-35 (PSC-35). The Outcome Questionnaire (OQ) is an adult instrument used on a limited basis with MHSA Prevention and Early Intervention (PEI) served adults. The Gallup Wellbeing is an adult instrument also in testing. EBP programs see the positives from application of the OQ and Youth OQ because of their clinical utility with informing care. The Youth Outcome Questionnaire-Self Report (YOQ-SR) was recently replaced by the PSC-35. There is evidence of compilation and reporting on, at least, an annual basis of this data and sharing with clinical staff, management, and contract providers. The MHP leadership is sensitive to the added administrative burden these instruments have on clinical staff and is committed to merging and streamlining where possible. While that streamlining is promised, both DO and LE contract agency staff often comment upon the seemingly never-ending administrative documentation burden. Those LE contractor providers that use Exym (45 percent) and Welligent (23 percent) have the CANS and PSC-35 incorporated into their EHRs. The remaining 18 percent of contract providers which use other systems are utilizing paper and pencil versions of outcome instruments. The utility of outcome instruments is enhanced with electronic entry, and provides the opportunity for software reporting to present trending information of beneficiary progress. In this format, the information is much more usable as a clinical assist tool which can be easily shared with beneficiaries.			
4B	Beneficiary Perceptions	10	8
The MHP performs the twice annual consumer perception survey (CPS) required by DHCS. This survey process includes instruments for adults and caregivers of children			

Table 19: Beneficiary Progress/Outcomes Components			
Component		Maximum Possible	MHP Score
and youth. The MHP's website for consumer satisfaction positions the blank survey form first and then presents the summaries of results last. The posted reports are identified as May and November CY2017. These are comprehensive analyses that present information in a format that may be more appropriate for health care professionals and other oversight bodies, and are not formatted in a way that would prioritize information that aligns with likely beneficiary interests. The website does contain a more useful "Open-Ended Comments Report - Spring 2018." The open-ended comments summary furnishes useful information, with key findings listed by region, and includes suggestions about increased after-hours service availability. Beneficiaries interviewed during the focus groups were unaware that any analysis of their input was available to them. It would appear that while this information is circulated internally and electronically posted, there is no specific mechanism to communicate new postings to beneficiaries. The MHP should also consider development of a satisfaction report format that specifically conforms to the needs of differing audiences, which is partially met by the separate analysis of suggestion comments. The informational needs of programs and staff will differ significantly from that of beneficiaries. For example, participation numbers by region or site is important to program operators, but likely less important to beneficiaries. As well, the labelling conventions for public facing items should be considered, such as the open-ended comments report title lacking reference to consumer satisfaction. The MHP should consider inclusion of beneficiaries in the process that oversees the design and circulation of this information, and have it supported by the participation of a communication professional. For this current period, no specific beneficiary feedback information was identified that was used to develop an improvement project.			
4C	Supporting Beneficiaries through Wellness and Recovery	4	4
The MHP has established 11 peer run centers. Wellness programs, in the MHP's context, are typically smaller scale clinic programs that also include a strong supportive function for beneficiaries.			

Table 19: Beneficiary Progress/Outcomes Components		
Component	Maximum Possible	MHP Score
The PRC is relatively new concept that involves strong beneficiary focus, and is being developed as a model for implementation throughout all SAs. This PRC approach is to support individuals in locating all types of helpful and supportive resources. Wellness and recovery concepts align with determinants of care and addressing life needs such as housing and nutrition within the mental health department's lens. This may include working with immigrant families who are now reluctant to seek clinic-based services. The support to these individuals has included the use of flex funds to help pay rent at times.		

Structure and Operations

In Table 20, CalEQRO identifies the structural and operational components of an organization that is facilitates access, timeliness, quality, and beneficiary outcomes.

Table 20: Structure and Operations Components			
Component		Quality Rating	
5A	Capability and Capacity of the MHP	30	27
Clinical services have been reorganized with merging of age group divisions and other aspects of care such as client engagement; intensive care services; outreach, and engagement and triage services (including access and linkage services); prevention services; child welfare; outpatient services; forensic psychiatry; and public guardian. The MHP provides the basic modalities of services such as outpatient mental health services, medication management, and targeted case management with both DO and LE contracted programs. The crisis programs are also in existence and expansion has occurred, with a focus on UCC and mobile crisis/ Psychiatric Emergency Response Team (PERT) teams. For extended stabilization, the MHP has eight crisis residential programs for adults and youth. LACDMH operates eight day treatment intensive programs countywide and day rehabilitation as well. Day treatment intensive and day rehabilitation are modalities not often present in many of the medium and smaller MHPs. The MHP has contracts for therapeutic foster care (TFC) in place, but the programs are being finalized and the services have yet to be offered.			

Table 20: Structure and Operations Components			
Component			Quality Rating
Recently, the MHP has developed a number of specific programs to address community needs. The School Threat Assessment Response Team (START) has been developed that has assessed 219 youth and provided intervention to 86 youth in the school environment. Of the youth served, 38 were admitted into treatment the day of referral. The focus of START is on both (decreasing) external violence and suicidality risks.			
5B	Network Adequacy	18	15
Alternative or adjunctive service delivery options are a priority for this MHP and are part of the LACDMH system. While telehealth was originally envisioned as a mechanism of providing linguistically competent services, it has evolved to serve primarily as a resource redistribution tool. This is of particular importance when the more difficult to serve or remote areas have staffing absences and coverage is difficult to arrange with an onsite provider. Nevertheless, there continues to be psychiatry needs for professionals who speak Korean and Spanish. The MHP has established a new collaboration with the library system and intends to have a liaison at the libraries that are frequented by homeless and often mentally ill individuals. The MLK behavioral health center, under development, will be a prototype health campus, providing a broad spectrum of health and social needs. Co-located services will include probation, public health, mental health, workforce development and re-integration assistance. Two peer respite programs are modelled after Santa Cruz Second Stop and are reportedly having a positive impact on preserving living situations and preventing homelessness without the use of a clinical program like crisis residential. The MHP is providing robust field-based services with emphasis on the Genesis older adult program, homeless services, and Triple-R field-based services. The department is partnering with the child welfare system (CWS), in seven medical hubs which provide mental and physical health services. In addition, parenting, financial, and housing assistance are available. Specialized mental health transport is in the process of approval and implementation and is expected to reduce the use of ambulance and law enforcement for the transport of individuals with mental health needs/illness.			
5C	Subcontracts/Contract Providers	16	11

Table 20: Structure and Operations Components			
Component		Quality Rating	
The MHP's total services delivered by contract agencies has increased from 81 to 86 percent between the prior and current review periods. Partnerships with contractors are key to the clinical operations. System navigators operate in each service area to assist with screening referrals to FSP programs and linking with resources within both contractors and DO programs/services. The feedback during the review was that there had been changes in the frequency of the MHP's meetings with LE contract agencies and the format of these meetings. There were suggestions that the MHP should include the focus on questions from contractors as part of the agenda of these meetings. The MHP has a robust contract management function with liaisons established. However, the reorganization has restructured the roles and many processes involved in contract liaison and budgeting. The onsite review feedback indicates that the MHP would benefit from an ongoing, continuous process to collect anonymous feedback from agencies as to what is working well and what needs to improve. More standardization of the contract monitoring and communication process would be helpful across all SAs. Contractors indicated that attention to the change management process and ensuring that communication regarding possible changes should be revisited and focused upon. In the area of participation in MHP oversight and monitoring, the SA-6 and SA-8 sessions demonstrated that LE contract agencies participate in regional QICs and other meetings. Communication within these regions appears effective and focused on the interests of beneficiaries. LE contract agencies participate in PIPs and the department's cultural competence efforts.			
5D	Stakeholder Engagement	12	9
The changes in the MHP's divisional structure for DO program organizational structure may be having an impact on the communication with line staff. Reportedly leadership communication is less frequent and provides less information that is meaningful on a program level. Line staff often possess a limited understanding of the changes planned for the department. The role of discipline chiefs is reportedly impacting a number of processes, which at times reportedly includes the hiring process. The changes in an operation of this scale likely benefits from a process wherein continual stakeholder feedback is sought, analyzed and reported back on a periodic but frequent basis. Having robust capability in this area is critically important, particularly when sweeping system changes are occurring, and will help leadership identify and address both communication and			

Table 20: Structure and Operations Components	
Component	Quality Rating
unintended consequences issues. Along with other reorganization changes, the MHP reframed the Service Area Advisory Council (SAAC) into YourDMH, seeking to standardize the approach to stakeholder input across all SAs. This focus is also an element of departmental reorganization emphasis. As of this review, it seems too early to determine if this structure is meeting the intended goals. The TCPI includes a focus upon patient and family engagement (PFE). The PFE initiative was focused upon DO programs and emphasized provision of electronic communication for beneficiaries. At this time, portal function is limited to appointment reminders. Shared decision-making is emphasized by PFE, utilizing a culturally-informed approach. Measuring beneficiary activation, and surveying health literacy are also included. This practice includes a focus on successful medication management and implementation of practices that see greater emphasis on beneficiary and family guiding treatment. PFE includes the use of suggestion boxes placed in the lobby and a process for reviewing feedback and communicating this to beneficiaries. An additional, and potentially customized, beneficiary survey instrument is also utilized. The MHP is aware that the turnaround time for the mandated CPS is insufficient to promote a sense of responsiveness to beneficiaries. For direct service participants in this review, the most significant concerns at this level were staffing, caseloads, and timeliness expectations. The Final Rule standards have had an impact on all programs, on both sides of the DO and contractor service delivery. LE contract agencies face their own staffing problems, typically experiencing high turnover due to difficulties competing with salary levels of MHP, Kaiser, and other health plans. Contract entities have become a defacto post-degree, internship training ground, where staff seek other better paid and less stressful working environments after licensure. DO programs face the same competitive challenges, but are currently experiencing spiraling vacancies, which are not filled quickly resulting in further vacancies from personnel moving into non-clinical positions or leaving the agency. Communication and change management were identified by both the MHP and contractors as key issues within the greater system. Many stakeholders are unclear about the impact initiatives and system changes in focus will have upon their services. Contractors also voiced challenges with timely budget increases when this is needed, which has been a long-standing issue, partially related to the scale of operations and administrative processes, but has also reportedly worsened.	

Table 20: Structure and Operations Components			
Component		Quality Rating	
5E	Peer Employment	8	8

The MHP and LE contract agencies have peer positions, with one position in DO programs that has supervisory authority. There are three tiers for designated peer positions. Contract programs that serve transitional aged youth (TAY) and adults typically have extensive peer positions, particularly the FSPs.

The utilization of peer employees does not yet reach inclusion acute psychiatric inpatient units and PMRT. County operated psychiatric inpatient units are administratively within the Department of Health Services, therefore staffing and direct usage of peers is not within the MHP's scope of control. The roles of individuals with lived experience include peer-led FSP "Peer First," peer respite, peer/family advocates, and parent partners. The discrete categories of peer workers within DO programs include: volunteer peer support workers, Mental Health Advocates, Community Health Workers (CHW), and Senior CHW, with future planning efforts going into development of a Supervisory CHW.

There are 370 CHWs, 132 of who are in peer roles. The CHW job title is shared across all health agencies, which has been part of the challenge in attempting to create a "certified peer specialist" job title. The MHP continues to pursue a county process for peer specialist certification, while awaiting passage of SB-10 into law. Funding to support general educational development (GED) certificate attainment is being sought, since this will be a claiming requirement for Medi-Cal reimbursement per SB-10.

Promotoras differ from the CHWs and peers but are part of the outreach and engagement strategies. There are currently 75 promotoras, with an intent to extend this model beyond the Spanish-speaking, Latino/Hispanic communities to include Filipino, Armenian, and Russian-speaking communities.

The Office of Consumer Affairs (OCA) was recently staffed with 20 individuals located at the MHP's central offices, but the MHP has shifted to a more community-based approach, siting this function within SA regions. The vision is for OCA to be a hub for advocacy that links people to advocacy groups within their communities, rather than chiefly focusing on internal referrals.

The linkage with the DoR provides the opportunity for education, training, and work support outside of the mental health. Feedback of beneficiaries revealed some opinions about the DoR employment support being minimal and more focused on ancillary issues such as clothing and transportation and not as much on developing education, employment, and career plans for beneficiaries.

Table 20: Structure and Operations Components			
Component		Quality Rating	
5F	Peer-Run Programs	10	10
The MHP reports 11 peer run programs and 56 wellness programs across all SAs. The MHP's wellness programs furnish clinical services and medication support, as well as groups, socialization activities, which are providing a clinically focused program and are not specifically beneficiary directed. Within the DO programs, the MHP envisions the PRC model as a key element of helping unengaged individuals obtain information about assistance, from housing to health care. The PRC in SA4 is expected to become a model for expansion into all SA.			
5G	Cultural Competency	12	12
The MHP engages in a comprehensive process of analysis of the diverse nature of its served populations. The CCC and the UsCC work closely to examine needs of these communities and make changes to approaches that serve numerous populations. The MHP's use of promotores resulted in 5,521 presentations, conducted at 556 unique sites, and reaching 44,242 community members. The efforts to include family members occurs through YourDMH, NAMI, and other entities. Family members were frequently present during various aspects of this review. NAMI is also represented in the CCC.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2019-20 review of Los Angeles MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Submission determined not to be a PIP (not rated)

Access to Care

Changes within the Past Year:

- Additional PMRT have been added, improving crisis response capacity. The START addresses school violence issues, and the Law Enforcement Team (LET) provides another approach pairing of mental health professionals with peace officers.
- Aspects of the departmental reorganization remain under review by county administration. The reorganization includes merging and reducing the number of discrete age-based divisions and shifting emphasis to stages of treatment, also linked with level of care, which may produce improved access and services.
- The implementation of discipline chief positions is a significant change that may alter how services are delivered within DO programs. These individuals are expected to lead developments around best-practices in each specialty area. How these changes will interface with historic program operations within the SAs is not yet completely clear.
- The FSP model is undergoing an evaluation and re-visioning with the assembly of a team of consultants that focus on a performance-based approach. An aspect of these expected changes includes plans to shift from a slot-based to team-based FSP design. The small-scale FSPs that have come into operation over the years are under review to determine if greater efficiency and effectiveness could be gained through increased scale and reorganization.
- A DO clinic staffing review has recently occurred, using data and care levels to inform decisions regarding staffing needs. The redesign of care divisions presumes these changes will be more effective in delivering multi-disciplinary treatment and bridging the discipline silos. It is not completely clear how the creation of discipline chief leadership positions, oriented around disciplines, will be involved in bridging discipline silos.

- The MHP is moving closer to implementation of the True Recovery Innovation Embraces Systems That Empower (TRIESTE) project, with the Hollywood region as the intended target, which has significant homelessness and unengaged mentally ill populations. The TRIESTE model includes numerous aspects that ease access to care, focus on the needs and wishes of beneficiaries, and lowers barriers to access that are either program or fiscally driven. The innovations are largely framed as recovery-informed and shift focus to wellbeing. The MHP also hopes TRIESTE can be used to focus on outcomes rather than claiming strategies, which underpin customary mental health programming.

- The centralized contracts management structure has undergone study and transformation, which has the potential for improving the support of the contract agencies that provide over 80 percent of services delivered through the MHP. Reportedly significant changes in the LE contract entity provider liaison role have also occurred, which include efforts to reduce redundancy and introduce simplification. This will still require extensive communication efforts to understand and incorporate specific local application issues, which may not always be completely clear and present in contract language alone. The liaisons between these entities and the providers have a sizeable learning curve in gaining understanding of the LE contractors as well as their operations, which may differ across regions.

Strengths:

- Department leadership appears driven to innovate and seek more effective service delivery models, pursuing system evolution beyond the medical, clinical treatment, and recovery schema to a broader inclusion of life domains such as envisioned in “determinants of care” that include areas such as shelter, food, and meaningful engagement with one’s community.

- The Emergency, Triage and Outreach Division is a separate care division that includes various elements from crisis response to homeless outreach. Increasing resources have been applied to this area, and response volume continues to grow.

- MHP staff reported a number of strategies have been utilized to ensure access for the immigrant populations which has felt threatened by recent federal government actions. The strategies have included increased field visits and beneficiary/caregiver messages to provide reassurance as to their safety when served by the MHP. LACMHP Hispanic/Latino penetration rates may be considered as a proxy for success, which increased from 4.06 percent in CY 2017 to 4.66 percent CY 2018, despite concerns about deportation and family separation. The MHP increased Hispanic/Latino average approved claims per beneficiary (ACB) from $5,196 in CY 2017 to $6,100 in CY 2018, a figure higher than for other large MHPs and statewide. For children and youth aged 6 to 17 the MHP’s penetration rate increased from 8.14 percent CY 2017 to 8.57 percent in CY 2018. While 2019 is incomplete, the data thus far do not reflect a decline.

Opportunities for Improvement:

- Stakeholders reported increasing number of vacancies in clinical positions. Historically, the pace at which the hiring process moved has been an ongoing source of complaints by DO programs. These delays have become even longer over this past year. Informants suspect that delayed hiring processes were related to issues within the MHP's operations.

- When vacancies are not filled, caseload are distributed to already overburdened staff, which contributes to an escalating job stress and personnel departures. Conversations with DO clinical staff in both service areas visited revealed that walk-ins and scheduled intakes consistently number in the mid- to high 20s each day.

- During this current review, EQR staff received information from both the MHP and contractor providers about the MHP's LE contractor budgeting process. It seems that the right-sizing of contracts eliminated much of the budgetary cushion and flexibility provided in the past to LEs, which permitted programs to maintain service levels if unanticipated demand spikes occurred. This cushion also permitted these changes to occur without formal budget increases, which given the scale of the LA county's fiscal operation would take some time. The unresolved DO vacant positions and high demands due to network adequacy requirements have resulted in increased referrals to LE contract agencies. Those capacity issues, when added to the timeliness requirements of the Final Rule, seem to have created a perfect storm of capacity challenges.

- The revisiting of FSP design and LE contract FSP program scale is unveiling concerns that decisions will be made prior to discussion. The LE contract agencies believe they can be more helpful and effective if they were involved early in the discussion process and in a transparent as possible means. The unintended consequences of FSP changes can be many, and it is more difficult to fix problems once they have received final approval, than while options and decisions are being weighed.

Timeliness of Services

Changes within the Past Year:

- Implementation of the timeliness requirements per IN-18011 has been a strong focus of DO and LE contract agency programs, involving frequent review of timeliness data in SA regional QI meetings.

Strengths:

- The time to actual initial clinical access first offered appointment for DO programs is better than the 10-business day standard, as well as time to first kept appointment.

Opportunities for Improvement:

- LE entities' first offered appointments exceed the 10-business day standard by one to three days.
- At the time of this review, the MHP was not able to report first offered psychiatric appointment. The reported data was that of first kept psychiatry appointment, tracking back to date of initial beneficiary contact. The DO programs average between 20 and 24.9 days; LE contractors average 22.6 to 27.63 days.
- The MHP continues its efforts to improve timeliness tracking with contracted LE programs. Improvements in this area are important for the MHP to fully track time to first clinical assessment, first psychiatry appointment, and subsequent clinical treatment events. Progress is being made, but reporting in this area remains incomplete. Both the scale of MHP contract operations and the complexities related to use of disparate EHRs adds to the challenges.
- The low number of urgent events (42) reported for this period would appear to reflect difficulties in the MHP's identification and capture of urgent requests within the combined DO and LE contract agency systems. In addition, the reported data reflected means for both adults and children that exceeded standard.
- The efforts to meet timeliness requirements of DHCS IN 18-011 reportedly have resulted in shifts of staff resources from treatment to intake/assessment. Those shifts are anecdotally resulting in delays to treatment and may also be impacting frequency of clinical services for those currently in treatment.
- The MHP reported the adult psychiatric hospital 30-day readmission rate of 34.29 percent, which suggests a relatively high level of readmissions, certainly worthy of study and evaluation. It may also present a potential PIP topic.
- The MHP does not track LE no-shows, nor does it expect this data to be reported to regional QICs. No-show standards are not set for psychiatry or other clinician staff categories. While outside agency performance is indeed the responsibility of the LE, it benefits efficient operations to understand the standards set and actual performance of these contract entities. There may exist practices or strategies that bear sharing across the system, which would improve efficiencies if applied by all. (Revised recommendation from FY 2018-19)
- As previously mentioned, the effort to provide rapid access to care, per DHCS IN 18-011, is reportedly producing a severe stress on system capacity. Comments about resource shifts from treatment to intake/assessment were frequently heard in review sessions. Supervisors are more frequently stepping in and directly performing assessments, wherein in the past this was limited to unusual peak demand times. In some sessions, a tacit acceptance emerged from participants that meeting standards was often simply not possible, given existent staffing and vacancies. Also, the impact of these resource shits is calling into question the

capacity to provide adequate treatment to those who are already open to services.

- EQR approved claims data for psychiatric inpatient utilization demonstrated a steady increase over the CY 2016-18 period, with the average length of stay (ALOS) and costs per beneficiary rising steadily to the most recent CY 2018 ALOS of 8.25-day. These increases may suggest considering analysis of the non-referred individuals, for whom the MHP manages costs, for significant subsequent crisis or inpatient events.

Quality of Care

Changes within the Past Year:

- Several SAs have utilized an improvement team to re-assess service delivery within the DO programs. This has involved realignment of staff and duties in order to be more effective in the delivery of care. Some of these changes involve development of sub teams that target specific levels of care. Reportedly, these changes have been positive, improving effective service delivery and positively impacting staff morale.

- The Consumer Engagement Technology Initiative was implemented using existing non-clinical staff and volunteers at the clinics to assist beneficiaries with Just4Me consumer portal registration and appointment reminder setup. To achieve self-sufficiency going forward, monthly conference calls are conducted with program managers, Just4Me champions, non-clinical staff, and SA volunteers.

Strengths:

- The MHP's QID functions both as a central process that targets quality and compliance, and is imbedded in each SA. The SA meetings provide the opportunity for DO and LE contract programs to see data together and discuss challenges. SAs also have specialized meetings, many of which focus on high-need individuals and transitions between care levels and programs

- The MHP has continued its TCPI, that seeks to improve the way services are delivered to beneficiaries and have an impact on improved outcomes.

Opportunities for Improvement:

- Within prescribing practice monitoring or medication monitoring, the MHP has chiefly focused upon the review of prescription-related incident reports or adverse events. There are focused areas, such as with FC children and youth, where the JV-220 process provides a structured 100 percent review of all medications prescribed by system practitioners and their rationale. With the LE agencies, the MHP has relied upon contractual language for these agencies to provide oversight to their prescribers. Under development of a comprehensive system to ensure a minimum percentage review of all prescribers, looking for

trends in prescribing or documentation that merit further exploration and/or improvement actions.

- The QID involvement is clearly present across the DO and LE contractor service areas; and across the DO/LE domains there are data elements commonly reviewed and discussed. However, in the course of this review, it became apparent that there exist areas in which there are inconsistencies between DO and LE contract programs. The creation of welcoming packets, appears limited to DO programs; it is not evident if this approach is expected to be implemented by LE contractors. The consumer portal, a vehicle for beneficiaries to receive appointment alerts, and in the future communicate appointment requests, is limited to DO programs. It is not clear if the MHP has an expectation that LE contract programs of a specific scale will be expected to offer a similar access experience to the beneficiaries served.

- Regarding review of data, outside of compliance standards monitoring, satisfaction and other outcome instrument tracking, there are some areas in which the DO programs are tracked. but not the LE contract agencies. An example of this includes no-shows, in which the MHP reports and reviews only DO programs and not on LE contractors.

- The MHP's public facing postings of consumer perception survey (CPS) does not present information in a format that would seem to align closely with beneficiary or family friendly concerns. This includes the structure and guidance provided by the text, the naming of the files posted, and the presentation of content in the reports. The current postings lead with information that would be of interest to healthcare evaluators and administrative staff.

Beneficiary Outcomes

Changes within the Past Year:

- The PRC, while initially established in 2017, has been identified as the "heart forward" emerging model of a resource center for beneficiaries, one that will be standardized and eventually implemented throughout all SAs. Unlike most other peer staffed programs, the PRC is not focused on engaging beneficiaries with mental health services, but is intended to provide effective linkage that meets the individual's needs – be it housing, food resources, or transportation.

- The MHP has placed an increased emphasis upon beneficiary service needs and program design as related to level of care. This approach is escalating the use of outcome measures such as CANS and MORS, to inform level of care decisions and also to tie to staffing of programs.

Strengths:

- The MHP has recognized the importance of lived experience individuals through the creation of a peer discipline chief, which assists the department in focusing on the needs of beneficiaries through a non-clinical lens.
- Refinement of the PRC concept and plans to roll out like programs to each SA bring lived experience and consumer-directed services within the realm of DO programs, with an approach that focuses on beneficiary needs rather than clinical services.

Opportunities for Improvement:

- Attention to beneficiary supported employment is critical to individuals developing opportunities for recovery and life fulfilling activities in a work area of their choice. The feedback about supported employment reflected some gaps in meeting the needs of the individuals who wish to return to work and desire a career.
- Continued work on the development of a comprehensive lived experience employment category, including career ladder and support for further training and education is needed. This includes greater integration with high level clinical programs.
- Circulation of consumer perception survey results lacks a clear, effective mechanism for altering beneficiaries and family members to the existence of survey results on the MHP website. As well, the formulation of these presentations inconsistently aligns with the primary concerns of beneficiaries – survey results of these perceptions.

Foster Care

Changes within the Past Year:

- LACDMH and DCFS have established a plan to improve services to FC children and youth. It includes improving crisis response, assessment, treatment, and outcomes. Also planned are improvements in collecting, tracking, and sharing service delivery and outcomes.
- The DCFS and the MHP have determined a need for 400-450 TFC parents.
- There are 9,995 currently identified subclass members, an increase over the previous year of more than 300. ICC is received by 4,380, which also increased by more than 300; for IHBS a similar scale of increase occurred, to 4,289. In addition, there are 12,763 non-subclass members identified as eligible for ICC and IHBS, a decrease of more than 3,000 from the previous year.

Strengths:

- The MHP tracks and reports first offered appointment timeliness for FC children and youth. The DO program mean is slightly less than for children overall (FC 8.03 days, other children 8.40 days) and has high achievement of standard (80.64 percent).
- DO no-show rates for FC children and youth is at a low 3.98 percent for clinicians, and 13.86 percent for psychiatry services.
- The MHP has issued prescribing guidelines specific to the Katie A. FC population.

Opportunities for Improvement:

- First offered appointment data for LE contract agencies reflect a mean of 13.04 business days, with an achievement of the standard at 59 percent, both of which are worse than DO programs
- The MHP is not currently able to report first offered psychiatry appointment, but has data on first kept medication management appointment. DO programs report a mean of 23.18 days for first kept appointment, and LE contract agencies 22.60 days. Attainment of standard ranges from 36 (DO) to 38 (LE) percent, for which it is unclear if the intervening factors relate to service capacity or to the needs of FC families.
- The MHP was not able to report FC urgent care timeliness for this period.
- Psychiatric hospital readmissions rates for FC is 27.08 percent, a concerningly high value considering the extent that intensive services are accessible for this population.
- Centralized review and tracking of SB 1291 data has not been possible because 80-85 percent of the prescribing is done by LE contract agencies, which do not use e-prescribing systems accessible to MHP quality activities. The monitoring that does occur is limited to the JV-220 review process.
- While identification of all subclass members has increased over the past six years, it is much less than 100 percent. The MHP reports this is due to a number of complex issues such as presumptive transfers, claims delays, and declining acceptance of services.
- The MHP is waiting for the MH approval tool to help launch STRTP programs into operation.
- A recent survey of 12 FFAs indicated that 92 percent have requested to become an ISFC provider. However, only 41 percent were interested in delivering TFC and only 25 have the appropriate training in place. This indicates that the work

planned by the MHP and DCFS to target this area and concerns about rates and documentation are needed.

Information Systems

Changes within the Past Year:

- Provider Central website provides Help Desk access for both LACDMH and contract provider staff. All users with network logon access can open HEAT tickets for IT support. Systemwide rollout of dashboard reporting is expected soon.
- While rewriting NACT application, the MHP also participates in DHCS Network Adequacy Stakeholder workgroup meetings for knowledge of ASC X12, 274 transaction requirements.

Strengths:

- None noted.

Opportunities for Improvement:

- Just4Me is limited to DO programs, resulting in a significant portion of MHP served beneficiaries lacking consistent expectations for beneficiary information and interaction with providers.
- The lack of responsiveness by IS vendor to timely complete state-mandated system improvements, work-orders, and Avatar bug-fixes is impacting the MHPs operational readiness to support DHCS IN requirements.

Structure and Operations

Changes within the Past Year:

- The MHP's reorganization efforts have come into greater focus during this past year. This has included changes to the divisional age-based structure that previously existed.
- The MHP has reconfigured the SAAC meetings into a countywide YourDMH format, which promotes greater consistency and opportunity for stakeholder input from all areas.
- The FSP program redesign is intended to create more efficient and effective programs, with an evaluation of the smaller scale operations that have evolved over time. The aim is for greater team-focus rather than slot, and the development of more effective scale programs.
- The MHP conducted a beneficiary-led campaign to rebrand myHealthPointe portal. The selected rebranded name was Just4Me. Phase One included

beneficiary registration and appointment reminder functions rolled out at 39 LACDMH clinics. During the three-month roll-out period, the number of Just4Me registered consumers increased from 2,200 to 5,457.

Strengths:

- The creation of a peer discipline chief position appears to be unique among MHPs. It makes a statement about the importance that peer contributions bring to services and the MHP culture.
- The MHP's participation in the development of specialized transportation for beneficiaries in crisis will result in improved timeliness to acute care treatment and reduce the dependence on emergency physical health treatment resources.
- The MHP's cultural competence efforts are a strength of the department, including a focus on underserved communities, and strong efforts to include programs that provide culturally relevant and linguistically competent services.
- The Los Angeles County Board of Supervisors authorized a risk assessment of eight departments to assess security and safety of electronic systems. The reviewing entity, Accenture, determined LACDMH to adhere to industry best practice for security.

Opportunities for Improvement:

- The breadth of the numerous redesign efforts creates challenges to the process of communication and inclusion of stakeholders throughout the department. Away from the central offices, participants possessed a limited level of comprehension regarding the intent of the changes and uncertainty about what they should anticipate. An effective change management process and robust communication has not been experienced by all, particularly those remote from leadership and among the LE contract agencies.
- There was variability regarding the furnishing of stipends for participation. It is also noteworthy that SA-6 participants identified a lack of transportation assistance in attending appointments, whereas those from SA-8 found ample transportation support.
- The MHP continues to pursue the development of DO positions for peer support specialists, and is awaiting state legislation.
- The MHP has not developed a role for peers in the staffing of crisis response (e.g., PMRT) and other high-level field response services.

FY 2019-20 Recommendations

PIP Status

1. The clinical PIP involves focuses on improving services to individuals with co-occurring disorders (COD), and should continue to track the identified variables, including 7/30-day rehospitalization rates, service utilization levels, application of the SS intervention in number of services and beneficiaries directly impacted.

2. As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs, and a non-clinical PIP topic needs to be developed. A number of potential topics were discussed onsite which suggested potential. Important to this process remains continual TA, which the MHP is encouraged to seek early and often going forward. While this is a continuing recommendation, the MHP did engage in unsuccessful efforts to create a new non-clinical PIP for this review period. *(This is a follow-up recommendation from FY 2018-19.)*

Access to Care

3. In order to sustain adequate treatment capacity, the directly operated (DO) hiring process needs immediate analysis and improvement efforts targeting approval-to-fill through approval of final candidate selection and onboarding. Bottlenecks must be identified and resolved, and overall process time significantly reduced.

4. Develop a performance standard that monitors treatment capacity following assessment, such as access to third non-assessment clinical encounter. Utilizing data preceding implementation of the Final Rule standards as baseline, this will furnish important information about adequacy of treatment capacity as resources have shifted to meet initial timeliness requirements.

Timeliness of Services

5. Resolve the barriers to tracking and reporting of all timeliness metrics, until it can be assured that both DO and LE contract program information is fully and accurately represented, with specific emphasis on identification and response to urgent requests.

Quality of Care

6. Develop a medication monitoring system that provides a regular, structured process for the review of all prescribers in DO programs and oversight of LE contract providers. This is to include a regular committee format and a mechanism for communicating findings and corrective actions across both DO and LE contractor domains. In addition, this is to include formal tracking and regular reporting on SB 1291 metrics. *(This recommendation includes a follow-up from FY 2018-19.)*

7. Identify and perform an analysis of quality areas outside of strict compliance that directly impact the beneficiary experience across both DO and LE contract programs. With the involvement of LE contract agencies and beneficiaries, identify the priority areas that merit a uniform approach. Examples may include: the use and content of welcome packets in both DO and LE contract programs; creating a standard and tracking of no-show events in both DO and LE contract programs; review of large scale LE contract providers for beneficiary portal access.

8. Review notification and circulation of consumer satisfaction results, including beneficiaries in this process, targeting the structure and labelling of the uploaded files, with a focus on the utility of results to beneficiaries and parents/caregivers.

Beneficiary Outcomes

9. Continue to follow-up on the supported employment needs of beneficiaries and dialogue with both beneficiaries and the Department of Rehabilitation (DoR) about ways that services can better target the needs of enrollees who are preparing to re-enter the work force. *(This is a follow-up recommendation from FY 2018-19).*

10. Consider broadening roles for lived experience employment such as inclusion in crisis response teams and other innovative roles, which may also help address critical staffing issues in clinical services.

11. Examine the methodology of sharing consumer perception data with beneficiaries, including methodology of communicating new information, and configuring reports in a manner that is specifically geared to service utilizers. The inclusion of beneficiaries in this process will also help provide guidance to the MHP in designing effective communication.

Foster Care

12. Develop a capture mechanism for FC first offered psychiatry service. This metric requires the additional element to capture the request or referral decision event.

13. Develop a FC urgent service request and subsequent service tracking process.

Information Systems

14. Track and report the availability and functionality of personal health record (PHR) among large scale LE contract agencies, and incorporate this technology in disaster/emergency beneficiary communication plan. Consider also development of PHR expectations within the contract language for large scale LE agencies.

15. Develop strategy using LACDMH/IS Vendor business contract terms and conditions to address IS vendor lack of timely responsiveness to projects and system work orders.

Structure and Operations

16. In order to minimize the disruptive impact of system programmatic changes, the MHP needs to develop a clear and transparent change management process for the proposal of change, that ensures that all relevant stakeholders, and particularly beneficiaries and providers, are included from start to finish. In addition, these parties need inclusion through the implementation and follow-up process, wherein unanticipated problems that emerge receive analysis and resolution.

17. Attend to the contract/legal entity (LE) communication process, and ensure that sufficient liaison resources are provided by the administrative arm, and that budgetary planning is adequate to sustain the capacity needs that have come into focus with the implementation of network adequacy. This requires a robust and ongoing meeting forum, supported by frequent bidirectional forums, ensuring both contractors and MHP administration remain aware of emerging issues.

18. The difference in perceptions regarding availability of transportation assistance between SA-6 and SA-8 beneficiary participants merits review and exploration to ensure that any access disparities are identified and resolved.

SITE REVIEW PROCESS BARRIERS

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

- The MHP was unable to recruit the requested 10-12 focus group participants.
- Only one of the four focus groups had participants who had recently initiated services, therefore creating a barrier to the EQR evaluation of recent initial access experiences.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: 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 – Los Angeles MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Central Business Office
Fiscal Services Bureau
Consumer and Family Member Focus Group(s)
Peer Employee/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Special Populations Access To Care – TAY, Women's reintegration
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Capabilities Assessment (ISCA)
Access, Structure & Operations
Wellness Center Site Visit
Contract Provider Site Visit
Crisis Stabilization/Psychiatric Health Facility Site Visit
Site Visit to Innovative Clinical Programs: Urgent Care Center

Table A1—EQRO Review Sessions – Los Angeles MHP
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, MPA, RN, Quality Reviewer
Lynda Hutchens, NCC, LMFT, Quality Reviewer
Laysha Ostrow, Ph.D., Quality Reviewer
Bill Ullom, Chief Information Systems Reviewer
Marilyn Hillerman, Consumer/Family Member, Consultant
Gloria Marrin, Consumer/Family Member, Consultant
Mark Refowitz, MSW, Information Systems Reviewer
Saumitra SenGupta, Ph.D., Executive Director

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

Los Angeles County Department of Mental Health
695 South Vermont Avenue
Los Angeles, CA 9002

Los Angeles County Department of Mental Health
550 South Vermont Avenue
Los Angeles, CA 9002

Long Beach Mental Health Services Adult Outpatient Clinic
2600 Redondo Blvd.
Long Beach, CA 90806

Harbor-UCLA Wellness Center
21730 South Vermont Avenue, Ste. 210
Torrance, CA 90502

Augustus F. Hawkins Mental Health Center
1720 East 120th Street
Los Angeles, CA 90059

Contract Provider Sites

Children's Bureau
1910 Magnolia Avenue
Los Angeles, CA 90007

Exodus Urgent Care Center
12021 Wilmington Avenue, Bldg. 10
Los Angeles, CA 90059

Children's Institute
1500 Hughes Way
Long Beach, CA 90810

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Adams	Cecelia	Personal Service Coordinator	Mental Health America of LA
Allen	Anthony	MHC Supervisor	LACDMH
Anabalon	Pablo	VP Clinical Services	Pacific Clinics
Anderson	David	IT Spec II, Enterprise Architecture	LACDMH
Argean	Jessica	Therapist	Children's Bureau
Arns	Paul	Mental Health District Chief, Clinical Informatics	LACDMH
Ashtar	Ali	Clinical Supervisor – Intensive Services	Wellnest
Baer	Jeff	Mental Health Clinical Supervisor	Long Beach Child & Adolescent Program
Bailey	Jennifer	MH Clinical Program Head	South Bay MHC
Bando	Lillian	Mental Health Program Manager III	LACDMH
Barbagallo	Gary	Personal Service Coordinator	Mental Health America of LA
Benjamin	Daniel	Staff Therapist	South Bay Children's Health Center
Benosa	Doris	Sr. MH Counselor	LACDMH
Bhatt	Alka	MH Program Manager I	LACDMH
Bonds III	Curley	Medical Director	LACDMH
Boyden	Jasmine		LACDMH
Brawn	Carolyn	Principal Info Sys Analyst	LACDMH
Brister	Rajeeyah	Staff Assistant I	Harbor UCLA Adult Outpatient MHS
Brooks	Lois		
Brown	Miriam	Deputy Director	LACDMH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Bucton	Roque		Contract
Byrd	Robert	MH Program Manager III	LACDMH
Cacialli	Douglas	Clinical Psychologist II	LACDMH
Carrera	Eva	Mental Health Program Manager III	LACDMH
Carroll	Charkeia	FSP Child Case Manager	Wellnest LA
Chang	Helen	MH Clinical Program Head	Coastal APA Family MHC
Chang	Sandra	Mental Health Program Manager I	LACDMH
Cheng	Mark	IT Manager II, Solutions Delivery	LACDMH
Coker	Kecia	Occupational Therapy Supervisor I	LACDMH
Coomes	James	MH Clinical Program Head	Olive View Community MH UCC
Cox	Jackie	SA-6 Chief	LACDMH
Craigs-Thomas	Toni	FSP-TAY Supervisor	West Central
Crain	Kathryn	Program Manager I	LACDMH Outpatient Services
Crecelius	Gia	Mental Health Psychiatrist	LACDMH
Cuevas	Joseph	Mental Health Advocate	LACDMH
Cunnane	Daiya	Clinical Psychologist II	LACDMH
Damerla	Hanumantha	Supervising Mental Health Psychiatrist	LACDMH
De Pasquale	Cristina	Medical Case Worker I	Long Beach Child & Adolescent Program
Delgado	Carissa	Therapist	Tessie Cleveland
Diaz	Rosa		Alma Family Services
Diaz	Charlie	ISS II	LACDMH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Diraimondo	Gail	MH Program Manager I	LACDMH
Ditko	Helena	Program Director	LACDMH
Dizzo	Deborah	Clinician	Barbara Floyd Medical Associates
Doi	Katherine	Mat Assessor	For The Child
Dovicle	Sacha		LACDMH
Draper	Oreta	Directory Of Quality Care	The Guidance Center
Earley	Rochelle	Parent Partner	Wellnest
Ekstrom	Leeann	BHS Director	Childnet Youth And Family Services
Elder	Julie	Contract Specialist	SCHARP
Escobar	Fredie	Psychiatric Social Worker I	Long Beach Child & Adolescent Program
Esparza	Carrie	Mental Health Program Manager III	LACDMH
Farias	Aurora	MH Clinical Supervisor	Harbor UCLA Adult Outpatient MHS
Farias	Elena	Mental Health Program Manager III	LACDMH
Farmer	Shari		LA County DA Victim Services
Faye	Margaret	QM, AVP	Hathaway-Sycamores
Fermin	Juan	IT Manager I, Solutions Delivery	LACDMH
Fernandez	Jose	Parent Partner	Counseling And Research Assoc DBA Masada Homes
Ferrell	Phratt	Child Psychiatrist	Children's Bureau
Fleishman	Janet	Child Outpatient Supervisor	Compton
Flynn	John	INH/IT	LACDMH
Francisco	Carla	AOP Clinician	AFH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Franklin	Lydia	Nurse Practitioner	SCHARP
Friestad	Joelene	MHC Program Head	LACDMH
Fullah	Omaru	Case Manager	SCHARP
Fuller	Belen		LACDMH
Garcia	Flor	Mat Assessor/Therapist	For The Child
Garcia	Lorena	Therapist	Tessie Cleveland
Gertmenian	Socorro	Director of Total Quality Management	Alma Family Services
Giambone	Leslie	Sr Director of Veteran And Healthlink Services	Mental Health America of LA
Gilbert	Kalene	MH Program Manager III	LACDMH
Gilmore	Keeley	Community Worker	LACDMH SA 8 Administration
Godinez	Jessie	MH Advocate	LBMH
Gonzalez	Blanca	Community Health Worker	Long Beach Child & Adol. Program
Gonzalez	Herminio	AOP Clinician	AFH
Gonzalez	Maria	AOP Clinician	AFH
Grim	Kai		Contract
Guvercinci	Ozge	Clinical Coordinator Adult Mental Health	Shields For Families
Hallman	Jennifer	Health Program Analyst II, Quality Assurance	LACDMH
Hanada	Scott	Mental Health Program Manager III	LACDMH
Haratounian	Vahe	Dept. Information Security Officer II	LACDMH
Hartigan	Libby		Share Self Help
Hernandez	Leeann	QA/QI Coordinator	Shields For Families

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Hernandez	Laura	Clinical Director	TCCSC
Hill	Hazel	Parent Partner	Counseling And Research Assoc DBA Masada Homes
Hira	Harmandeep	MH Counselor Rn	Harbor UCLA MHS
Hirschmann	Lisa		Contract
Holguin	Robert	Mental Health Clinical Supervisor	Harbor UCLA Wellness Center
Hollingsworth	Mark	Personal Service Coordinator	Mental Health America of LA
Hottenroth	Jennifer	Assistant Division Chief	DCFS
Howieson	John	Principle Information Systems Analyst, Project Management Office	LACDMH
Hsieh	Derek	MH Clinical Program Head	Long Beach API Family MHC
Innes-Gomberg	Debbie	Deputy Director	LACDMH
Jang	Alvin	Psychiatric Social Worker I	San Pedro MHC
Jensen	Heather	MH Clinical Program Head	Long Beach Child & Adol. Program
Jones	Robert	MH Advocate	Compton LACDMH
Ka Wai Sou	Susana	Pharmacy Services Chief III	LACDMH
Kang	Myles	Health Prog Analyst III	LACDMH – FSB
Kasarabada	Naga	Clinical Psychologist II	LACDMH
Kermoyan	Katia	Principle Information Systems Analyst, Project Delivery	LACDMH
King	Daphne	QA Supervisor	South Bay Children's Health Center
Kramer	Sandra	MH Clinical Program	Harbor UCLA

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		Head	Outpatient MHS
Krisiloff	Flora	Special Services Assistant III	LACDMH
Krogh	Lindsey	Psychiatric Social Worker II	Ties For Families
Kurata	Jodi	Mental Health Policy Dir	ACHSA
Kwon	Hosun	MH Program Manager I	LACDMH
Lambert	Corbette	AOP Clinician	AFH
Lan	Kevin	Intermediate Typist-Clerk	Coastal API Family MHC
Lang	Yoshado	AOP Supervisor	AFH
Le	Myan	Clinical Psychologist II	Coastal API Family MHC
Lee	Hyun	Clinical Psychologist II	LACDMH
Lee	Ann	SA 8 QI Liaison	LACDMH SA 8 Administration
Lee	Katherine	Regional Director Of Operations	Telecare MHUCC
Lee	Karen	Supervising MH Psychiatrist	LACDMH
Lee	Linda	MHCS	Costal API Family MH
Lennon	Charles	MH Program Manager III	LACDMH
Levi	Traci	VP Outpt. Services	Vista Del Mar
Levy	Hayley	Dir. Of Admin & Clinical Svcs.	SSG
Liu	Kwan	Administrative Services Manager III	LACDMH
Lopez	Belia	Community Health Worker	Harbor UCLA Outpatient MHS
Lopez	Xiomara	Promoter	Promotoras
Lopez	Lauren	Human Services Intern	LACDMH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Lozano	Yvonne	Administrator	Star View BHUCC
Lundy	Kathrine	MH Clinical Program Head	San Pedro MHC
Maciel	Mayra	Psychiatric Social Worker II	Ties For Families
Maclauren	Timothy	Wraparound Therapist	Counseling And Research Assoc DBA Masada Homes
Maeder	Christina	MHC Program Head	LACDMH
Magee	Edana	Prog. Director	SCHARP
Malanok	Rosanna	PISA/DWSI	LACDMH-DM BT
Martinez	Jeremy	Unknown	LACDMH
Mascher	Bernice	Unknown	Stakeholder Representative
McClellan	April	Program Supervisor	PIC
Medina	Sandra	Intake Coordinator	Childnet Youth And Family Services
Medina	Jose	Frequent Visitor	LACDMH
Melbourne	Erica	Unknown	LACDMH
Mendoza	Betty	Child/Adult Supervisor	Wellnest
Menon	Kumar	Health Program Analyst III	LACDMH
Miller	Tiffani	Clinical Director	For The Child
Mitchell	Teleshia	Parent Partner	Aspiranet
Moore	Kim	PSW II	LBMH
Morales	Patricia	Clinical Supervisor – Oakwood Site	Children's Bureau
Moreno	Jacqueline	Wraparound Case Manager/Facilitator	Wellnest LA – LA Child Guidance
Morgan	Llanette	Community Health Worker	LB API Family MHC

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Munde	Michele	Senior Director of Quality & Compliance	Stars Behavioral Health Group (Star View)
Murata	Dennis	SA 8 Chief	LACDMH SA 8 Administration
Murch	Lezlie	Chief Program Officer	Exodus Recovery
Myles	Josie	Clinical Director, Behavioral Health Division	Shields For Families
Myrick	Keris	Chief Of Peer Services	LACDMH
Nakamura	Linda	Clinician	Masada Homes
Naliboff	Laurie	IT Spec I (BI)	LACDMH
Nava	Esmeralda	FSP Case Manager	BAFMA
Nelson	Isabelle	Program Manager	Mental Health America of LA
Nelson	Alissa		IBHP
Ngo	Ly	MH Counselor	LACDMH
Nguyen	Andrew	Clinical Pharmacist	LACDMH
Obika	Charles		LACDMH
Odom	Gary	Mental Health Clinical Supervisor	Long Beach API Family MHC
Olivera	Jennifer	Program Director	Exodus Recovery
Orozco	Gustavo	Community Health Worker	Harbor UCLA Outpatient MHS
Osorio	Andrew	Associate VP of Nursing	Exodus UCC

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Owens	Keisha	Clinical Supervisor	PIC
Padilla	Lilia	MH Program Manager I	LACDMH
Pancake	Laura	Vice President	Pacific Clinics
Parra	Jesus	VP of Behavioral Health & Wellness	Children's Institute, Inc
Partida Del Toro	Jorge	Chief of Psychology	LACDMH
Paseli	Paul	AOP Clinician	AFH
Pataki	Carolyn	MH Psychiatrist	LACDMH
Patel	Jay	IT Manager II, Enterprise Application	LACDMH
Patterikalam	Girivasan	IT Manager I, Enterprise Application	LACDMH
Peoples	Stephanie	PIC Clinician	PIC
Perez	Nancy	PSWII	LBMHC
Perkins	Theion	Mental Health Program Manager III	LACDMH
Phan	Kim	MH Services Coordinator	LACDMH SA 8 Administration
Pitaccio	Nicholas	Director, Member Services	Mental Health America of Los Angeles
Placide	Ontson	Unknown	LACDMH
Poon	Layhearb	Mental Health Clinical Supervisor	Long Beach API Family MHC
Porter	Marcia	Triage/Intake	West Central

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		Supervisor	
Powell	Lisa	MH Clinical Supervisor	Homeless Services Team (HST)
Quint	Charles	AOP Supervisor	Compton
Ramirez	Norma	Mental Health Promotora	LACDMH
Ramirez	Hector		Contract
Ramos	Emilia	MH Clinical Program Head	Long Beach Adult MHC
Ramos	Alejandra	Quality Assurance/Interim Clinitrak Liaison	Tessie Cleveland
Regan	Jennifer	Clinical Psychologist II	LACDMH
Retina	Paco	Unknown	Contract
Retrana	Paco		Contract
Reyes	Sandra Yesenia		
Richert	Luther	Chief Program Officer – South County	Mental Health America of Los Angeles
Rittel	Michelle	MHC Supervisor	LACDMH
Rivera	April	BHS Asst. Director	Children, Youth and Families Serv.
Rivera	Robert	IT Manager (App Development)	LACDMH
Rivera-Ortiz	Gabriela	Clinician	SCHARP
Rojas	Gloria	Director of Children's Outpatient	SCHARP

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Roman	Janis	MHCS	LBMH
Rosario	Vernon	Psychiatrist	AFH
Rosas	Manuel	Mental Health Program Manager III	LACDMH
Ruiz	Lise	MH Clinical Program Head	LACDMH
Ruiz	Amanda	Director, Acting – Intensive Care	LACDMH
Saadalla	Madolin	Community Therapist	Counseling And Research Assoc DBA Masada Homes
Saiyeda	Rick	Asst. Director	Wellnest
Salas	G. Kaliah	MH Clinical Program Head	Ties For Families
Salvaggio	Kimber	Training Coordinator	LACDMH
Sanchez	Grey		
Sanchez	Yolanda	Revenue Management AVP	HSCFS
Sanchez	Dario	LACDMH Intern	LACDMH Outpatient Services
Sanchez	Grey	Program Manager	SCHARP
Santa Cruz-Polak	Sofia	Psychiatric Social Worker I	San Pedro MHC
Scurlark	Jenice	Case Manager	PIC
Sharma	Jagadev "JD"	Program Coordinator, Adult MH	Shields For Families
Shecter	Natalie	Psychiatric Social	Harbor UCLA Adult

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		Worker II	Outpatient MHS
Sheehe	John	MH Clinical Program Manager II	LACDMH
Sherin	Jonathan	Director	LACDMH
Shoemaker	Kathy	Chief Clinical Officer	Exodus Recovery
Shonibare	Lynetta	Supervising Psychologist	LACDMH
Sigmund	Melvin	Psychiatrist	West Central
Simonain	Sarkis		Contract
Som-Keo	Bonavy	Mental Health Clinician I	Coastal API Family MHC
Sosna	Todd	Chief Program Officer	Children's Institute
Soto	Deborah	Community Health Worker	Compton
Sou	Susana Ka Wai	Pharmacy Services Chief III	LACDMH
Spallino	James	IT Spec I, Project Delivery	LACDMH
Spurlin	Jocelyn Bush		Contract Provider
Stephens	Courtney	Sr. Director of Evaluation and Compliance	MHALA
Suarez	Ana	Mental Health Program Manager III	LACDMH
Svetlikova	Iva	Director of Quality Improvement	Counseling And Research Assoc DBA Masada Homes
Tamayo	Sandy	Community Health Worker	San Pedro MHC
Tanner	William	Mental Health Program Manager III	LACDMH
Taylor	Alexa	AOP Clinician	AFH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Templeton Poe	Monique	Mental Health Therapist	Shields For Families
Theam	Darlene	Intermediate Clerk	Long Beach API Family MHC
Thomas	Tylana	CHW	Outpatient Svcs LBMH
Tindbaek	Patricia	Executive Administrator	Counseling And Research Assoc DBA Masada Homes
Torres	Cynthia	Parent Partner	Wellnest
Tran	Anh	MHCS	LBMHC
Tredinnick	Michael	Mental Health Program Manager III	LACDMH
Trias-Tuiz	Rosalba	Supervising Psychologist	LACDMH
Uglesic	Lora	Clinical Program Mgr.	Children's Institute
Valdez	Julie	Mental Health Program Manager III	LACDMH
Van Sant	Karen	Associate Chief Information Officer	LACDMH
Vega	Evelyn	Director of Intensive Services	Wellnest
Vines	Dara	Clinical Psychologist II	LACDMH
Vo-Jutabha	Dawn	Chief Clinical Officer	The Guidance Center
Walters	Jessica	Supervising Psychologist	LACDMH
Ward	Nichelle	Therapist	Tessie Cleveland
Washington	Stephanie	Mental Health Advocate	AFH
Watts	Lore	Case Manager	PIC
Weeks	Maurice	Personal Service Coordinator	Mental Health America of LA
Wherry	Judy Porter	Health Programs Analyst	LACDMH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
White	Geraldine	Psychiatric Social Worker II	Long Beach API Family MHC
Wilcoxen	Jacquelyn	Mental Health Program Manager III	LACDMH
Williamson	Cathy	Community Services Counselor	LACDMH
Wilson	Angela	Director of Mental Health	South Bay Children's Health Center
Wilson	Kristina	Staff Assistant I	Long Beach Child & Adolescent Program
Winn	Jeremy	Child Outpatient Supervisor	AFH
Winterstein	Michele	Executive Director	For The Child
Withers	Alexandria	Intermediate Clerk	Long Beach Child & Adol. Program
Wong	Lisa	Mental Health Program Manager III	LACDMH
Wood	Susan	Director	Children's Bureau
Wu	Karen		LACDMH
Wylie	Aldonia	WOW Volunteer	Pacbell
Yamada	Mariko	Director	Contract Provider – St Francis
Zhang	Ju	Psychiatrist	Compton

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 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Los Angeles MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,807,829	152,568	4.01%	$832,986,475	$5,460
Large	1,833,373	69,835	3.81%	$406,057,927	$5,815
MHP	1,225,789	52,134	4.25%	$262,110,931	$5,028

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

Table C2. CY 2018 Distribution of Beneficiaries by ACB Cost Band
Los Angeles MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	197,421	93.86%	93.16%	$790,141,741	$4,002	$3,802	60.82%	54.88%
>$20K - $30K	6,235	2.96%	3.10%	$151,131,828	$24,239	$24,272	11.63%	11.65%
>$30K	6,681	3.18%	3.74%	$357,825,966	$53,559	$57,725	27.54%	33.47%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms	
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Los Angeles	
PIP Title: Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)	
Start Date: 02/01/19 **Completion Date**: 02/01/20 **Projected Study Period**: 12 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 09/23/19 – 09/26/19 **Name of Reviewer**: Robert 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's review of data indicated that beneficiaries with co-occurring disorders (COD) had higher hospitalization and rehospitalization rates. However, substance abuse counselors (SAC) did not have a specific, consistent approach to working with this population. Substance use disorders and trauma frequently occur together, and Seeking Safety (SS) is an evidence-based practice that provides a structured approach to working with individuals who have a COD. SS can be utilized by unlicensed staff in working with this population. The	

MHP embarked on testing whether improved outcomes – specifically reductions in hospitalization and rehospitalization – can be achieved.		
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	SAC may possess lived experience and bring that to the project development. Two SACs are on the PIP team, and others have been contacted for providing their input. Aside from lived experience individuals, a broad participation of quality improvement (QI), clinic staff and leadership and numerous clinic sites were involved.

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 identified the California treatment gap for COD, wherein 95 percent of individuals received no treatment for the mental health or substance use disorder condition, as compared to 91.7 percent nationally. Examining LACDMH internal data, 30 percent (FY 2018-19) of treated beneficiaries have COD diagnoses. When exploring service usage of COD individuals, MHP staff discovered that 14 percent of adult COD beneficiaries were hospitalized at least once and 21 percent were rehospitalized within 7 days; 32 percent within 30 days. For the same period, only 7 percent of those without a COD diagnosis were hospitalized and 12 percent were readmitted within 7 days; 19 percent within 30 days. A similar pattern emerged when the data was limited to only directly-operated (DO) programs. In brief, COD diagnoses were associated with higher levels of hospitalization and repeat hospitalization. When examining the service levels of COD/non-COD beneficiaries, the MHP identified a pattern. COD beneficiaries in DO programs received more mental health services (MHS) and targeted case management (TCM), averaging 10.68 MHS and 2.02 TCM; as compared to non-COD who received 6.38 MHS, 1.29 TCM. The increased services were not associated with better outcomes in relation to hospitalization. The MHP also noted that the SAC (41) had some training in working with both mental health and

		substance use conditions, did not practice a specific model of care. In addition, 71 percent of the beneficiaries served by SACs have a history of trauma that was inconsistently addressed by existing services. The MHP Quality Assurance review of SACs services indicated these tended to target only the substance use issue and did not address the high level of trauma often associated with SUD beneficiaries.
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 MHP is seeking to improve the services to those with COD with histories of trauma. This includes reducing hospitalization and rehospitalizations.
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 – DO programs	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This PIP is currently limited to DO programs, and 37,000 beneficiaries (and other clients) with a COD in FY 2018-19 period. As a baseline number, 3,595 adults received services from SACs in the identified fiscal year.

	Totals	**4** Met **0** 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 the provision of services using a multidisciplinary, integrated, evidence-based treatment model for consumers with co-occurring mental health and substance use disorders result in a positive impact on their functioning (i.e., 7-day and 30-day hospital re-admission rates) and treatment engagement/retention (i.e., number of visits within 30 days and 90 days) from pre-intervention to post-intervention?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	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 – DO programs	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

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: COD diagnosis	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study is based on the diagnoses with a COD.
	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:* Functional status of consumers receiving integrated treatment for CODs 1a) Psychiatric Inpatient Hospital 7-Day Readmission Rates 1b) Psychiatric Inpatient Hospital 30-Day Readmission Rates • Outpatient treatment activity for consumers receiving integrated treatment for CODs • Total number of consumers who received two or more MH or TCM services within 30 days of the initial visit with a SAC • Total number of consumers who received six or more MH or TCM within 90 days of the initial visit with a SAC • Increase in SAC understanding of their role and partnering with others on the treatment team regarding consumers with CODs • Increase in SAC level of comfort with integrated care for CODs • Number of SACs who received training in integrated treatment for CODs • Fidelity to the SS model following initial training • Fidelity to the SS model following theme-based calls	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP also presented the rationale and relevance of each measure, why they were selected and how it reflects progress.

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 beneficiary-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 were clear and measurable. Those that related to beneficiary outcomes were limited to the two focused on hospitalization and rehospitalization.
	Totals	**1** Met **1** 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	Sampling was not utilized. The MHP applied this approach to DO programs, narrowing the scope of implementation.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ 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 **0** Not Met **3** 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	
6.2 Did the study design clearly specify the sources of data? *Sources of data:*	☒ Met ☐ Partially Met ☐ Not Met	

☐ Member ☐ Claims ☐ Provider ☒ Other: IS, and SS instruments	☐ Unable to Determine	
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: Information system, treatment, hospitalization reporting	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The training in SS occurred in August 2019, and thereby has had little time for impacting beneficiaries. The data collection and reporting has been limited to the hospitalization rates, with reporting run 9/18/19.
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	

6.6 Were qualified staff and personnel used to collect the data? *Project leader: Jorge Partida, PsyD* - Quality improvement staff and program managers - Clinical Informatics staff - SACs housed in DO clinics	☒ 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:* 1a) Rollout of COD Champions Meetings - monthly case consultations and didactic training 1b) Provision of SS Training adapted to the needs of LACDMH consumers and the role of SACs 1c) Rollout of UCLA Extension 11-week Course on MH and Substance Abuse Treatment 1c) Application of SS to LACDMH consumers 1d) Rollout of UCLA Extension 10-week Course on MH and Substance Abuse Treatment Implementation of SS Theme-based calls Development of clinical Practice Parameters for consumers with CODs Dissemination of a Quality Assurance Bulletin and a supplemental paper on Frequently Asked Questions regarding reimbursable guidelines on the provision of SMHS and substance use interventions Implementation of Clinical workgroup focused on CODs	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**1** Met **0** 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?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP identified a training and start date for the SS intervention. The formal data reporting, even that limited to hospitalization/rehospitalization data, appears to have occurred approximately one month after the intervention started.
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	

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: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
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:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Too early in PIP process
Totals	**0** Met **0** Partially Met **0** Not Met **4** 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	
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	

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 **0** Partially Met **0** Not Met **5** 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: The topic of improving care for individuals with COD is an important one, since these and mental health diagnosis so frequently co-exist. In MHPs that have SUD and SMHS services located in separate departments, addressing appropriate and effective care for dually diagnosed is critical and needs to be present in the treatment capacity of each side of the MH/SUD divide. At this point, the PIP is early in its process. Data collection is very early as well.
Recommendations: Place emphasis upon collection of data regarding extent, number of beneficiaries receiving Seeking Safety, and the frequency of application. Without that type of information, this can become a general improvement strategy but could lack the rigor of a PIP. This MHP struggles with the PIP concepts, and like many others, may focus on training and generalized program implementation. Whereas it is also important to track the application of this specific intervention.
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

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20
NON-CLINICAL PIP

GENERAL INFORMATION

MHP: Los Angeles County

PIP Title: Strengthening DMH Peer Resource Center Services through Continuous Quality Improvement

Start Date: 12/20/18

Completion Date: 12/20/20

Projected Study Period: 24 Months

Completed: Yes ☐ No ☐ N/A

Date(s) of On-Site Review: 9/23-26/19

Name of Reviewer: Robert 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): The project is focused on the improvement and standardization of the Peer Resource Center (PRC) for implementation throughout all SAs. This program incorporates the feedback of community users of the service, and is intended to have a non-clinical focus. Essentially, it is designed to meet the needs of individuals who may be homeless and experience other needs within the community, but is treatment agnostic.