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FY 2021-22
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

LOS ANGELES FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 27-29, 2021

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report.

MHP INFORMATION

MHP Reviewed — Los Angeles

Review Type — Virtual

Date of Review — September 27-29, 2021

MHP Size — Very Large

MHP Region — Los Angeles

MHP Location — Los Angeles

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 212,272

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

SUMMARY OF FINDINGS

Of the 15 recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed or partially addressed all 15 recommendations.

CalEQRO evaluated the MHP on the following four Key Components that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent (four of four components)
- Timeliness of Care: 83 percent (five of six components)
- Quality of Care: 80 percent (eight of ten components)
- Information Systems (IS): 100 percent (six of six components)

The MHP submitted both required Performance Improvement Projects (PIPs). The clinical PIP, “Improving the Use of Medication-Assisted Treatment (MAT) for Consumers with Co-Occurring Mental Health Disorders and Substance Use (COD)”, is in the second remeasurement phase with a low confidence validation rating. The non-clinical PIP, “Closing the Gap Between the Access to Care Beneficiaries Receive and What is

Expected", is in the third and final remeasurement phase with a high confidence validation rating.

CalEQRO conducted four consumer family member focus groups, comprised of a total of 16 participants.

SUMMARY OF STRENTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: overall penetration rate; maintained beneficiary satisfaction during COVID-19; medication monitoring continued improvement; established an outpatient Lanterman Petris Short (LPS) conservatorship process; continued telehealth expansion for resource distribution.

The MHP was found to have notable opportunities for improvement in the following areas: staff shortages in both clinician and psychiatry categories; first non-urgent psychiatry appointment data is incomplete; the use of urgent care centers (UCC) for transitional psychiatry services may negatively impact quality of care; psychiatric inpatient readmission statistics call for a systemwide analysis of factors and strategy development; a system for continuous feedback from county directly operated (DO) and contractor/legal entity (C/LE) line staff to leadership of successes and problem areas is absent.

FY 2021-22 CalEQRO recommendations for improvement include: resolve the psychiatry and clinical staffing shortages; resolve the timeliness tracking issues related to systemwide first offered psychiatry service and urgent care; develop a comprehensive SB 1291 Healthcare Effectiveness Data and Information Set (HEDIS) measure tracking reporting approach focused on C/LE programs; pursue the selection and implementation of an adult outcome or level of care (LOC) instrument; develop a continuous system feedback process for leadership; reduce rehospitalization rates.

INTRODUCTION

BACKGROUND

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

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

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

This report presents the fiscal year (FY) 2021-22 findings of the EQR for Los Angeles County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on September 27 – 29, 2021.

METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process,

CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File (IPC). CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020 and FY 2020-21, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data–overall, FC, transitional age youth, and Affordable Care Act (ACA). CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of three elements pertaining to NA: Alternative Access Standards (AAS) requests, use of out-of-network (OON) providers, and rendering provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).
- Summary of MHP-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, and an examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per SB 1291 (Chapter 844).
- Review and validation of submitted Performance Improvement Projects (PIPs).
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the MHP's quality and operational processes.
- Consumer perception of the MHP's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

In this section, the status of last year's (FY 2020-21) EQR recommendations are presented, as well as changes within the MHP's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the continued human and budgetary impacts of the Coronavirus Disease 2019 (COVID-19) pandemic waves that occurred in Los Angeles County. The MHP experienced the diversion of staff to disaster response roles, lost staff due to accelerated retirements and more lucrative work offers, and also experienced difficulties with filling vacant positions due to locally imposed budgetary restraints. CalEQRO collaborated with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

The Los Angeles County EQR process includes a countywide focus, and each year an additional review emphasis on two of eight Service Areas (SA). The current FY 2021-22 review period SA-1 (Antelope Valley) and SA-7 (East Los Angeles) were the two highlighted areas. In order to provide diverse beneficiary input, an adult and caregiver of youth focus groups were scheduled for each SA.

MHP SIGNIFICANT CHANGES AND INITIATIVES

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

- Telehealth expansion – in response to COVID-19 and continuing, the MHP has emphasized expansion of psychiatry and other services utilizing telehealth. This includes both telephone and video supported services enabled by broader adoption of technology, and facilitating staff to work from home. This has allowed the MHP's directly operated (DO) as well as contract/legal entity (C/LE) services to maintain high service levels for beneficiaries.
- The Access Center Call system was modernized, with updates that include a law enforcement line, warmline portal, and staff management tools.
- All Programs of Excellence (APEX) – the APEX process focuses on a single SA each month where characteristics of programs and served populations are discussed, as well as capacity and operational issues. These meetings are heavily supported by QI and Informatics reporting, such as business intelligence

analytics. Review of program strengths and challenges occurs, with a focus on efforts to address and remove barriers to system care.

- SB 803 and certification of the peer support specialist program is under review by Los Angeles County Department of Mental Health (LACDMH) leadership and stakeholders with a focus on development of a certification program, and a strategy for wide-spread inclusion of lived experience individuals in MHP service delivery.
- Peer Resource Center (PRC) – Since the first resource center opened in May 2017, the MHP worked to develop a countywide plan for development of centers in each of the eight SAs. By early 2022, five sites will be opened, covering SAs 2, 3, 4, 6, and 7. The remaining SAs (1, 5, 8) will be developed at a later date.
- Emergency Medical Services (EMS) Alternate Destination Program – Policies and procedures were drafted to provide alternate, non-hospital destinations for fire and other EMS first responders transporting a behavioral health beneficiary. The downtown sobering center and six UCCs were designated under these protocols, offering a reduction of time for EMS involvement and a more appropriate destination. The MHP is also evaluating LPS certification policy changes that could further support the project.
- Outpatient conservatorship program – This initiative is a joint Public Guardian and Homeless Outreach Mobile Engagement (HOME) program for individuals over 18 years old, who are experiencing chronic homelessness, and have profound mental health needs. This pilot program changes how the conservatorship process has historically occurred, which required individuals to remain in locked 24-hour facilities, usually acute inpatient units. The process is also enhanced by the video supported services shift which enables interviews and testimony to occur from the street. Another positive aspect of this pilot is that the process itself may result in the individual voluntarily engaging with services.
- Alternative Crisis Response initiatives
    - 911 Diversion – Development of standards and protocols for appropriate and reliable diversion of 911 calls to 988 and other connected services. This project is foundational to the development of a countywide call diversion model.
    - The Therapeutic Transportation pilot in the City of Los Angeles, involves dispatching a unit staffed by a peer and a nursing personnel to provide rapid transport of individuals in need of higher-level care. A related benefit is the reduction of demand on mobile ambulance and law enforcement units.
    - Psychiatric Mobile Response Teams are incorporating peers into the response teams and moving to a true 24/7/365-day operation. Teams are equipped to transport beneficiaries under almost all circumstances. To

improve linkage and follow-up care, field triage criteria and protocols are being revised.

- Crisis facilities expansion includes a new Antelope Valley UCC (18 beds; 12 adult and 6 adolescent); an Olive View UCC opening fall/winter 2021; two children's UCCs not yet open; and two sobering centers to open in October and December 2021.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2020-21

Recommendation 1: Clinical PIP: Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)

- Conclude the COD PIP and transform the process into general system improvement of substance abuse counselor (SAC) services.
- Develop a new clinical PIP topic that produces a broad beneficiary impact upon those served by both DO and C/LE programs.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP concluded the previous COD PIP that focused on SAC's improved intervention skills through the use of Seeking Safety to a new topic targeting the provision of MAT, augmented by Integr8Recovery groups. The increase in MAT

was supported by the development of an X-waiver certification program and a mentorship process for prescribers.

- Intentions to include C/LE providers existed, but COVID-19 waves resulted in the decision to put this element on hold. An additional challenge for C/LE programs, their use of unique prescribing platforms does not provide MHP QI access to prescribing data.

Recommendation 2: Non-Clinical PIP: Timeliness

- Revise the orientation of this PIP to target improvements that have a direct beneficiary timeliness impact, with compliance adherence in a secondary role.
- Develop a specific set of best-practice interventions that are presented to under-performing providers. Track and report results associated with each intervention.
- Track application of the audit and feedback process.
- Identify key metrics that track the beneficiary experience, including satisfaction.
- Ensure that timeliness data reporting resolves the recent extreme differences in event numbers of timeliness metrics year over year and ensures the capture of urgent timeliness for C/LE programs which was unsuccessful during the current reporting period.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP shifted the PIP focus to the effectiveness of various strategies and time-frame for successful outcomes.
- Best-practices were derived from the analysis of provider results using specific strategies.
- Difficulties occurred with tracking application and results of the audit and feedback process.
- Validation of the beneficiary experience with the timeliness improvement efforts is challenging to track considering the diverse providers involved. Lacking a survey feedback instrument, MHP data reflecting improvement is the best available metric.
- Unlike initial access, there remain some timeliness categories, such as urgent care and first offered psychiatry appointment, where the MHP continues to lack an effective solution that will assure comprehensive and reliable data collection.

Recommendation 3: Expedite DO program review that considers caseload size, service volume, and position vacancies for the development of a prioritized exemption request with county leadership so that key clinical and psychiatry positions are filled.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- MHP leadership developed a prioritized list of critical clinical, psychiatry, and administrative position vacancies for effective DO programs. A special emphasis was on the most intensive field-based programs, full-service partnerships (FSP), with a secondary focus on non-FSP clinical vacancies.
- The countywide hard hiring freeze impacted the ability to make progress in this area. In addition, ongoing personnel losses to behavioral health organizations that are seeking telehealth clinicians, MCOs, and to retirement all conspire to increase the difficulties involved in maintaining adequate staffing.

Recommendation 4: Closely monitor psychiatry timeliness for FC youth, and develop interventions if long wait times persist.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP identifies challenges in determination of first non-urgent psychiatry appointment offered. This data has not been included in the System Request Tracking System (SRTS) which is remedied by an update released in October 2021. This may improve the capture of psychiatry first offered appointments; however, the MHP considers the date of first request poorly defined and difficult to operationalize. In addition, FC youth are primarily served by C/LE programs for which psychiatry data has been minimally present in the MHP's timeliness statistics.
- Providers with insufficient psychiatry capacity to provide timely access to FC youth have been instructed to make referrals to primary care collaborations or regional UCCs. Review feedback discussed later in this report identified quality-of-care impacts that repeated use of UCC services not intended to fill ongoing care roles can have on beneficiary satisfaction and retention.

Recommendation 5: Provide focused attention to support of C/LE programs that currently experience the greatest challenges in meeting the 10-business-day initial access requirement.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The non-clinical PIP established by the MHP that included C/LE programs has produced both improvements in timeliness as well as identified best practices. The PIP process is being rolled into continued Quality Assurance (QA)/QI processes.

Recommendation 6: The MHP's reported psychiatric inpatient readmission rate for adults of 33.4 percent merits investigation. Consider if there are links between this and

the exclusion from post-hospital discharge follow-up tracking of those who were not specifically referred by hospitals for aftercare.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP's recent re-organization efforts results in the development of an Intensive Care Division, with 50 percent of contracted acute psychiatric hospitals onboarded to the concurrent review process. This will bring both county and C/LE hospitals into the concurrent process, which should also improve discharge planning and follow-up care. There had been plans to locate concurrent reviewers at the reviewed hospitals which had to be halted due to COVID-19.
- The MHP's post-hospital follow-up data demonstrates higher performance than seen statewide (CY 2019-20: 7-day follow-up - LA 61 percent vs. statewide 57 percent; 30-day follow-up – LA 73 percent vs. statewide 70 percent). It may be valuable to evaluate the type of follow-up provided in order to identify service patterns that are associated with rehospitalization reductions.
- The MHP created other interventions that may improve rehospitalization rates. These include a pilot in SA-3 whereby the clinical reviewers may approve placements to crisis residential treatment programs, other sub-acute facilities and enhanced residential services. These process changes should see improved step-downs to more structured treatment services.
- Another innovation in SA-3 includes a centralized scheduling pilot for area hospitals and UCCs. By calling a dedicated line, hospitals and UCCs can obtain a specific follow-up appointment for discharging beneficiaries.

Recommendation 7: Utilize the input of beneficiaries, family members, and staff to develop best practices for virtual services, that include frequency and duration of services, and populations best suited for virtual versus in-person services. Consider expansion of additional modalities, such as group therapy, and MHP-sponsored support groups, as suggested by beneficiaries. Consider development of direct telehealth technical support for beneficiaries that would decrease clinical staff time to resolving tech issues. Utilize findings for trainings with DO and C/LE program staff.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Groups and all treatment modalities have become available through telehealth and telephonic services. Groups have been provided through VSee, a HIPAA-compliant telehealth service.
- The MHP has made a priority of delivering services to match each beneficiary's preferences and capabilities.
- Staff input is solicited in various meetings, including the Chief information Office Bureau (CIOB) telework forum, the VSee group, and other mechanisms.

- The department is considering a beneficiary survey to solicit their experiences with telehealth. The intent of this recommendation was to obtain broad stakeholder feedback on telehealth services via a survey process. Follow-through on this item is highly recommended.

Recommendation 8: Finalize and implement the Medication Monitoring and Peer Review plan. Implement the DO component and target at least one SA for C/LE implementation. Include tracking of SB 1291 HEDIS and CMS metrics.

(This recommendation is a carry-over from FY 2018-19.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP initiated a prescriber review process that examined the practices of peers based on five-case sampling process. The review included HEDIS, National Committee for Quality Assurance and other metrics. For the past year, 178 responses were included.
- The MHP engaged a contract agency to also complete the Peer Review process. In addition, the MHP developed a survey of all C/LE providers to determine which have an existing internal review process in place.
- The MHP provides continuing CA education credits for those participants who complete additional requirements.
- The MHP is not currently able to complete a comprehensive review of any of the SB 1291 HEDIS measures in that the C/LE prescribers are using e-prescribing platforms which do not provide the option of review by MHP QI. The State DHCS Medi-Cal Rx system is anticipated to provide systemwide prescribing data and may support electronic automated reviews.

Recommendation 9: Begin the production of aggregate Child and Adolescent Needs and Strengths-50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) information in a format that provides utility as programmatic guidance to Children and Youth services in both DO and C/LE areas.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has developed reports that assist in the management of CANS-50 and PSC-35 completion processes. Another report type is that of data submission errors. Under development is a process of producing similar reports for C/LE programs.
- Preliminary analyses of PSC-35 content data indicated levels below clinical cut-off for caregiver or self-report; yet improvements were seen in symptom presentation over time when comparing two data points for the same beneficiary.

The MHP prepared some draft reports for the current review. This reporting is not ready for production status.

Recommendation 10: Ensure the SB 1291 psychotropic and related HEDIS and CMS measure tracking has been implemented, including the health screening elements.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP achieved a review of SB1291 HEDIS measures for DO programs.
- C/LE providers, whose services comprise approximately 79 percent of all MHP care, which provide the majority of care for FC youth, are not included in the SB 1291 analysis.

Recommendation 11: Build on field-based services developed during COVID-19 by supporting line-staff with mobile devices such as laptops, iPads, and smartphones. Leverage Adobe's signature protocol to support more efficient workflow for beneficiaries and staff.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The Post-COVID-19 Project Plan contains the outline of the MHP's intentions to maintain and increase the use of telehealth.
- The MHP continues to provide LACDMH staff with additional mobile devices (laptops, iPads, and smartphones) for telework.
- The MHP has implemented mobile applications and mobile responsive applications that supports line-staff telework.
- The MHP has plans for the use of Adobe Sign to make workflows more efficient.

Recommendation 12: Implement a strategy to encourage and assist the LEs to engage in the Los Angeles Network of Enhanced Services (LANES).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has met with several C/LE's to emphasize how LANES participation improves services, especially crisis services, for beneficiaries. As of this review, no results from these efforts have been identified.

Recommendation 13: Target improvements in the system communication process with DO and C/LE programs, utilizing survey feedback to measure effectiveness. Obtain DO and C/LE program input to develop survey elements.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has quarterly All Provider Meetings which includes LACDMH executive management: Director, Chief Medical Officer, Chief and Senior Deputy Directors. Active participation is encouraged with discussion of questions and concerns.
- Both the MHP's DO programs and LEs are engaged in the development of meeting agendas.
- The MHP has a lead Contract Management and Monitoring Division manager, and team assigned to each contracted provider for communication and TA.
- The MHP has implemented various communication strategies, such as utilizing centralized email communications and virtual meeting platforms to assure regular communication.
- The MHP developed a webpage, Provider Central, to improve communication with DO and C/LE programs. This webpage contains information, departmental alerts, communications and other vital resources (including the ability to sign up for email notifications from LACDMH).

Recommendation 14: Develop regular meetings that promote a dialogue between contract providers' leadership and the MHP senior leadership to support a cohesive and collaborative integration of DO and C/LE programs.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- See response to #13.

Recommendation 15: Develop a comprehensive post-COVID-19 telehealth plan that maintains a robust telehealth presence.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The Post-COVID-19 Project Plan represents the MHP's detailed plan to maintain and increase the use of telehealth.
- The MHP will increase beneficiaries' access to telehealth services by assisting them to obtain mobile phones and data plans.
- The MHP provides, and will expand, critical emergency therapeutic consultation via telehealth.
- The MHP will expand its on-site telehealth services through kiosks at select LACDMH clinics.
- The MHP will continue to conduct weekly staff telehealth training to comprehensively address all levels of telehealth literacy.
- The MHP will continue the acquisition of VSee user licenses as demand increases. LACDMH has recently seen a 23 percent increase in telehealth sessions over a six-month time frame.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All MHPs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

FINDINGS

For Los Angeles County, the time and distance requirements are 30 minutes and 15 miles for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

The MHP met all time and distance standards and was not required to submit an AAS request. Further, because the MHP is able to provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access services via OON providers.

Planned Improvements to Meet NA Standards

Not Applicable.

MHP Activities in Response to FY 2020-21 AAS

Not Applicable.

PROVIDER NPI AND TAXONOMY CODES

CalEQRO provides the MHP a detailed list of its rendering provider's NPI Type 1 number and associated taxonomy code and description. Individual technical assistance is provided to MHPs to resolve issues which may result in claims denials, when indicated. The data comes from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. The data are linked to the NPPES using the rendering service provider's NPI, Type 1 number. A summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO will be presented in the FY 2021-22 Annual Aggregate Statewide report.

[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN LOS ANGELES COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 21 percent of services were delivered by county-operated/staffed clinics and sites, and 79 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 88 percent of services provided are claimed to Medi-Cal.

The MHP has a toll-free Help Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff. Beneficiaries may also request services through the following system entry points: psychiatric mobile response teams, homeless outreach services, as well as self-presentation to clinics. The centralized access team is responsible for linking beneficiaries to appropriate, medically necessary services. The access service screens and makes immediate need determinations, and then links the individual to an appropriate provider or crisis response team. Within SA-3, the LACDMH Line is operating a pilot program to equitably distribute post-hospital follow-up appointments among providers, ensuring rapid post-hospital care.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. Specifically, the MHP delivers psychiatry, crisis, assessment, case management, group, individual, and other mental health services via telehealth to youth and adults. In FY 2020-21, the MHP reports having served 34,269 adult beneficiaries, 62,149 youth beneficiaries, and 1,581 older adult beneficiaries across 95 county-operated sites and 544 contractor-operated sites. Counting only DO programs, 2,397 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

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

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

Table 1: Key Components - Access

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

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

- The MHP invests great effort into understanding and addressing the diverse needs of its beneficiaries. These efforts include a special focus on understanding and capturing the diversity that exists within the overall Asian/Pacific Islander (API) populations, so that the work done to improve penetration rates and services to these populations is more effective. Numerous other efforts to outreach and provide effective services include the LGBTQIA2-S, Middle Eastern/Eastern European, and Deaf and Hard of Hearing. and other underserved cultural populations. The MHP has embarked on an effort to improve services to the deaf, which includes an American Sign Language video conferencing pilot. Issues relating to the Black/African-American (served population and staff), have focused on efforts to improve equity and eliminate pervasive racism issues. The use of promotores for outreach and engagement is broadening to other cultural/ethnic populations beyond the Hispanic/Latino group.
- The MHP accomplished a major effort to create standardized psychiatry practices and caseload parameters, which is a topic that will be important to apply to other clinical staff categories.

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the MHP:

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.
- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

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

The MHP has the state's largest number of beneficiaries at 3,868,232. The majority of this population is Latino/Hispanic, at 58.9 percent. Latino/Hispanics are also fairly proportionally served, with 53.2 percent of all beneficiaries served. White and African-American beneficiaries are more likely to be served by the MHP compared to the percentage of eligibles. For African-American beneficiaries, who make up 10.1 percent of the beneficiary population, 18.1 percent of those served fall into this race/ethnicity. APIs are less likely to be served compared to their percentage of the population – 9.6 percent of beneficiaries and 4.3 percent of those served. Figure 1 illustrates the proportions of beneficiaries served compared to the population by race/ethnicity.

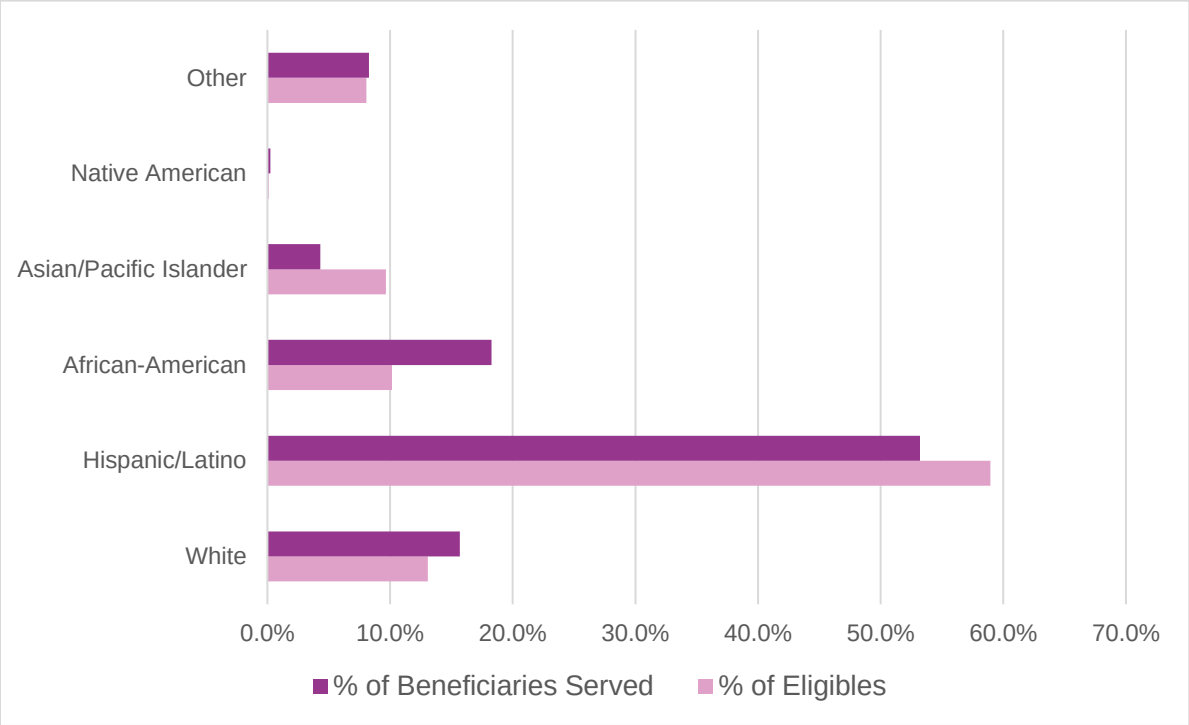
Table 2: County Medi-Cal Eligible Population and Beneficiaries Served in CY 2020, by Race/Ethnicity

Los Angeles MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	505,892	13.1%	33,290	15.7%
Latino/Hispanic	2,280,000	58.9%	112,962	53.2%
African-American	392,427	10.1%	38,800	18.3%
Asian/Pacific Islander	373,270	9.6%	9,141	4.3%
Native American	4,802	0.1%	530	0.2%
Other	311,841	8.1%	17,549	8.3%
Total	**3,868,232**	**100%**	**212,272**	**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.

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



This MHP has the greatest variety of threshold languages in the state with 13 languages represented. Spanish has, by far, the greatest number of beneficiaries at 46,865, with 22.1 percent of them being served. The frequency of the next 10 languages decreases rapidly.

Table 3: Beneficiaries Served in CY 2020, by Threshold Language

Los Angeles MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	46865	22.1%
Armenian	1423	0.7%
Mandarin	578	0.3%
Cantonese	643	0.3%
Korean	679	0.3%
Vietnamese	639	0.3%
Farsi	597	0.3%

Russian	418	0.2%
Tagalog	134	0.1%
Cambodian	531	0.3%
Arabic	115	0.1%
Other Chinese	0	0.0%
Other Languages	159,008	75.1%
Total	**211,630**	**100%**
Threshold language source: Open Data per IN 20-070 Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

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

CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2019 ACA penetration rate and ACB.

Figures 2 through 9 highlight three-year trends for penetration rates and average approved claims for all beneficiaries served by the MHP as well as the following three populations with historically low penetration rates: FC, Latino/Hispanic, and Asian/Pacific Islander (API) beneficiaries.

Although the MHP's overall penetration rate has decreased slightly from last year, it remains higher at 5.49 percent than both the averages of the state, 4.55 percent, and the other large MHPs at 4.13 percent.

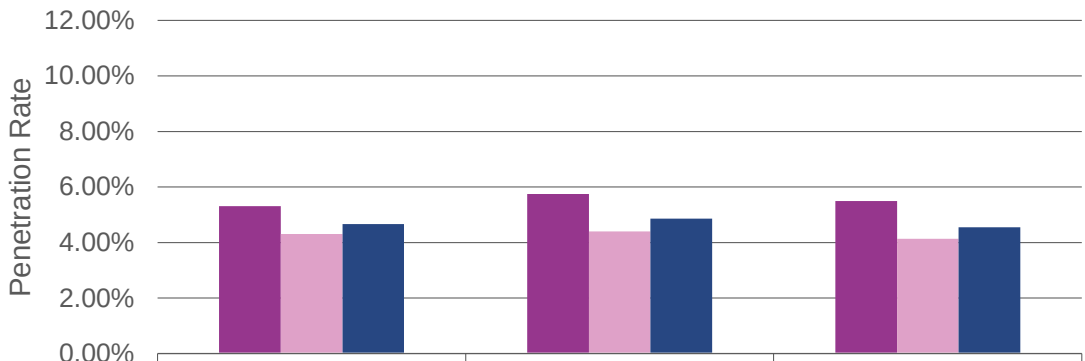
The MHP's overall ACB average has increased each of the last three years to $6,748, which is below the state average of $7,155. The Latino/Hispanic, API, and Foster Care ACB's have also gone up each of the last three years. The API ACB stands out at being $6,379 which is $1,887 less than the state average of $8,266.

The Latino/Hispanic and API penetration rates are higher than the state and large MHP averages.

Both the FC penetration rate and ACB rates have trended up over the last three years. They are notable for being higher than the state and large MHP averages.

Figure 2: Overall Penetration Rates CY 2018-20

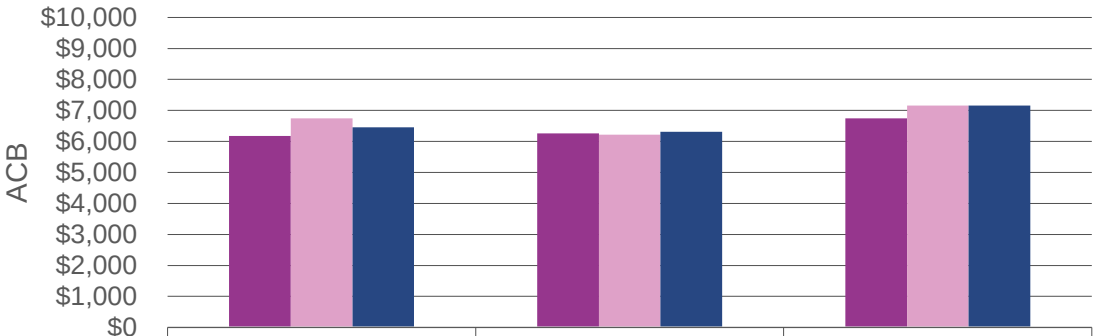
Los Angeles MHP



	CY 2018	CY 2019	CY 2020
MHP	5.31%	5.75%	5.49%
Large	4.31%	4.40%	4.13%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20

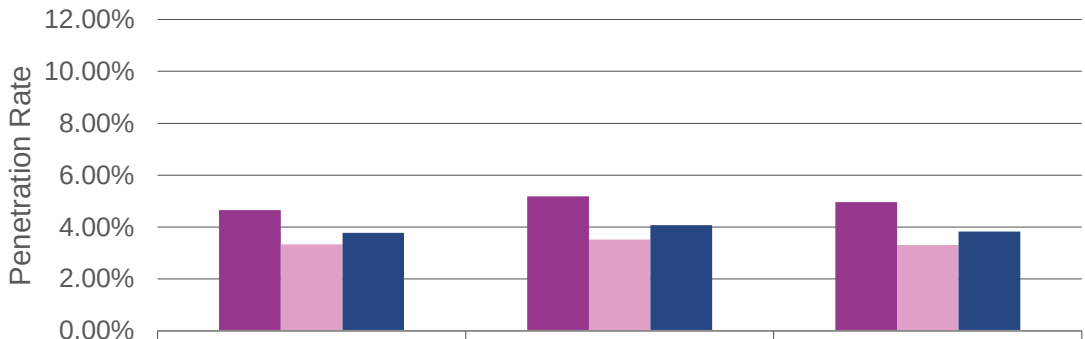
Los Angeles MHP



	CY 2018	CY 2019	CY 2020
MHP	$6,176	$6,256	$6,748
Large	$6,750	$6,219	$7,156
State	$6,454	$6,316	$7,155

Figure 4: Latino/Hispanic Penetration Rates CY 2018-20

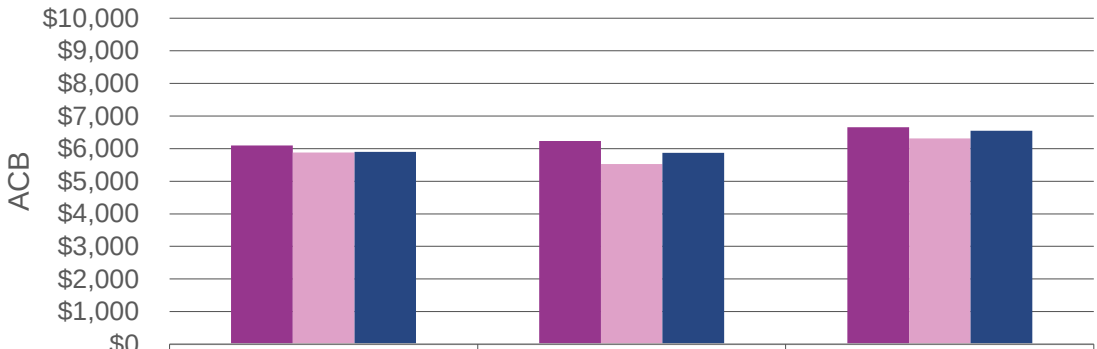
Los Angeles MHP



	CY 2018	CY 2019	CY 2020
MHP	4.66%	5.19%	4.96%
Large	3.33%	3.52%	3.31%
State	3.78%	4.08%	3.83%

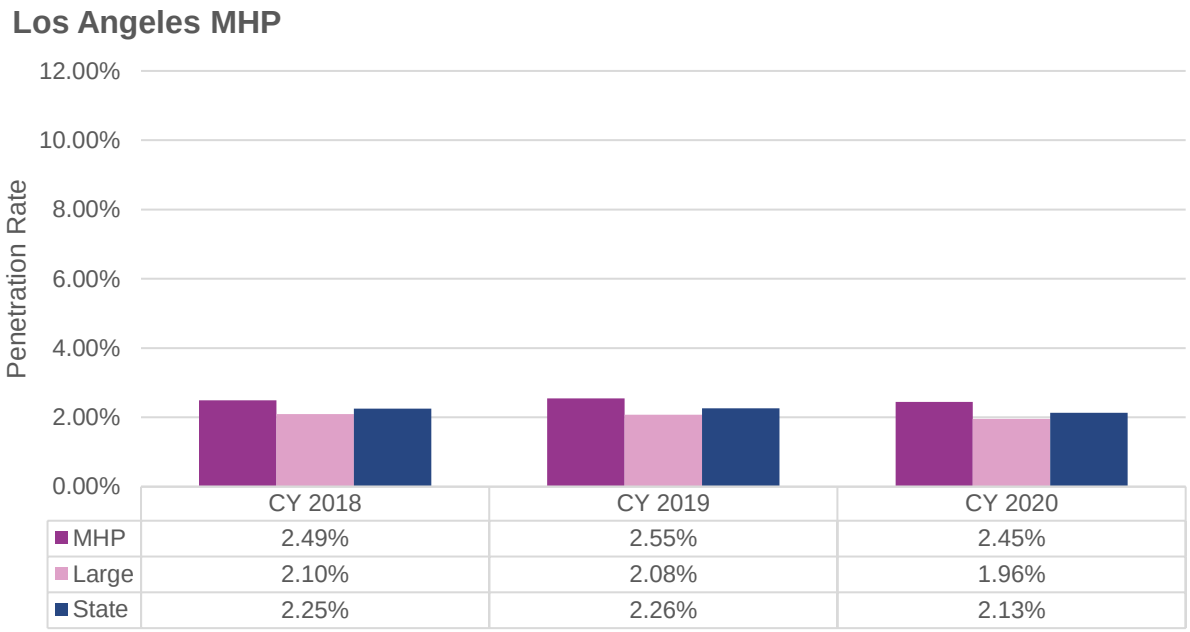
Figure 5: Latino/Hispanic ACB CY 2018-20

Los Angeles MHP



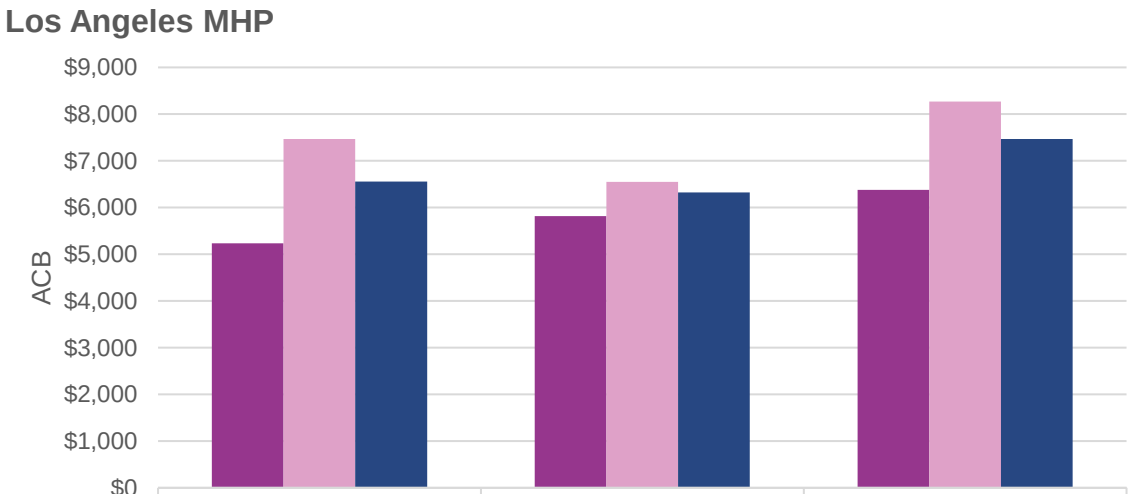
	CY 2018	CY 2019	CY 2020
MHP	$6,100	$6,235	$6,658
Large	$5,884	$5,523	$6,317
State	$5,904	$5,869	$6,551

Figure 6: Asian/Pacific Islander Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	2.49%	2.55%	2.45%
Large	2.10%	2.08%	1.96%
State	2.25%	2.26%	2.13%

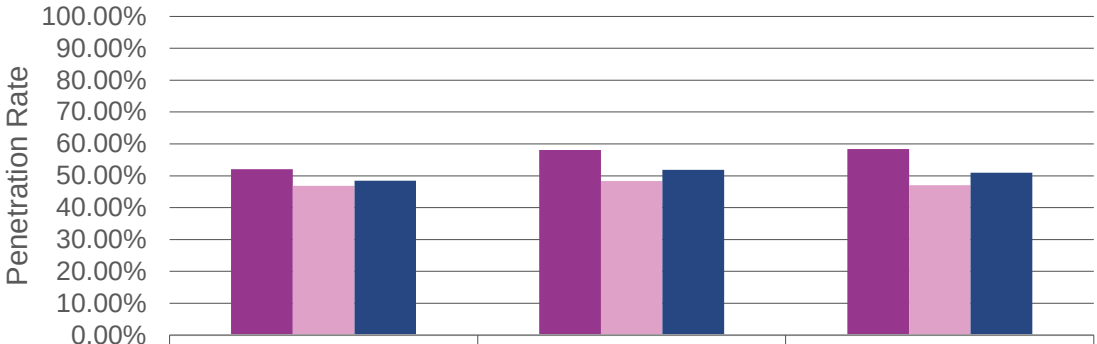
Figure 7: Asian/Pacific Islander ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$5,232	$5,818	$6,379
Large	$7,464	$6,552	$8,266
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20

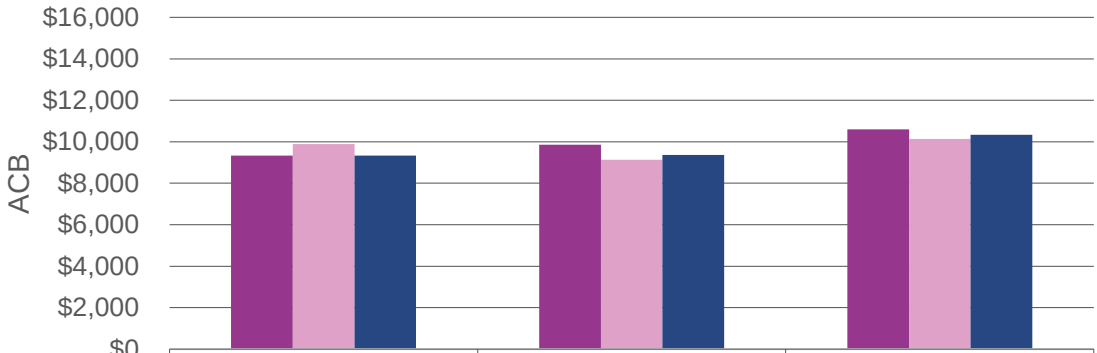
Los Angeles MHP



	CY 2018	CY 2019	CY 2020
MHP	52.08%	58.13%	58.41%
Large	46.87%	48.34%	47.06%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20

Los Angeles MHP



	CY 2018	CY 2019	CY 2020
MHP	$9,326	$9,851	$10,598
Large	$9,895	$9,125	$10,129
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

The MHP continues to fairly proportionately serve its Hispanic/Latino beneficiaries. Further, the MHP continues to increase its penetration rate for this population. In CY 2020, the MHP penetration rate (4.96 percent) was 50 percent higher than the large MHP average (3.31 percent) and 29.5 percent higher than the statewide average (3.83 percent).

The MHP's ACB for APIs, at $6,379 is below both the state average of $7,466, and other large MHPs, $8,266. This differential would benefit from continued investigation.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track the timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. CalEQRO uses a number of indicators for tracking and trending timeliness, including the Key Components and Performance Measures addressed below.

TIMELINESS IN LOS ANGELES COUNTY

The MHP reported timeliness data stratified by age and FC status. Further, timeliness data presented to CalEQRO represented the complete SMHS delivery system, with specific limitations discussed below.

Limitations of the MHP's timeliness reporting includes first request to first offered non-urgent psychiatric appointment, which currently tracks only those who request psychiatry at first contact and may experience significant under-reporting particularly for C/LE agency programs. C/LE contract provider urgent reporting cannot report in hours; and C/LE provider no-show reporting is absent.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the Performance Measures section.

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

Table 4: Key Components – Timeliness

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Not Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Partially Met

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

- The MHP's first offered timeliness has improved over the prior year and includes 121,919 events with an overall 7.30 business-day mean, and 81.7 percent meeting standard.
- First offered non-urgent psychiatry appointment included 483 reported events, and experiences significant limitations in data capture. These results are limited to when a psychiatry request is logged at the time of initial request for service. Subsequent determinations of psychiatry need at assessment completion or later in treatment, as common with children and youth, are not included.
- Reporting of urgent services includes 356 events, and for C/LE providers does not reflect hours due to the lack of system capability. For a very large system, the relatively low number of events could potentially reflect under-reporting and merits further analysis.
- Post-hospital follow-up with the MHP's self-defined 5-day standard averages 5.54 days, with a 77.75 percent 7-day follow-up rate, and 96.2 percent follow-up within 30-days.
- No-shows and cancellation data do not include C/LE providers. Inclusion of this data is important to capacity analysis in a system whereby 79 percent of services are claimed to Medi-Cal by external agencies.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across

several key timeliness metrics for a specified time period. Additionally, utilizing approved claims data, CalEQRO analyzes MHP performance on psychiatric inpatient readmission and follow-up after inpatient discharge.

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including HEDIS measures:

- First Non-Urgent Appointment Offered
- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered
- Urgent Services Offered – Prior Authorization not Required
- Urgent Services Offered – Prior Authorization Required
- No-Shows – Psychiatry
- No-Shows – Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-21 as follows:

Overall, the majority of elements reflect results well within required timeliness standards. The exception is urgent care, with a 257.28-hour median. Reportedly urgent care experienced over-coding from call center staff which is in the process of correction. Lastly, the comprehensiveness of reported data is subject to the limitations described in the timeliness key component previous section.

Table 5: FY 2021-22 MHP Assessment of Timely Access

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	7.30 Days	10 Business Days*	81.77%
First Non-Urgent Service Rendered	9.33 Days	n/a	n/a
First Non-Urgent Psychiatry Appointment Offered	10.04 Days	15 Business Days*	83.85%
First Non-Urgent Psychiatry Service Rendered	16.02 Days	n/a	n/a
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	257.28 Hours	48 Hours*	18.26%
Urgent Services Offered – Prior Authorization Required	****	96 Hours*	****
Follow-Up Appointments after Psychiatric Hospitalization	5.54 Days	5 Business Days**	77.75%
No-Show Rate – Psychiatry	7.36%	n/a**	n/a
No-Show Rate – Clinicians	6.24%	n/a**	n/a

* DHCS-defined timeliness standards as per BHIN 20-012

** MHP-defined timeliness standards

**** MHP does not separately track urgent services offered based on authorization requirements; all urgent services are held to a 48-hour standard.

Medi-Cal Claims Data

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained mental health professionals is critically important.

Follow-up post hospital discharge

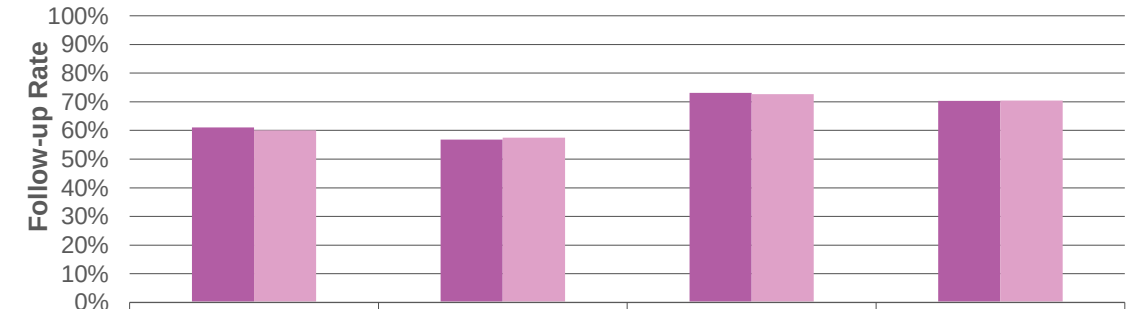
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measures) in CY 2020 were slightly higher than the statewide average (3-4 percent).

The 7-day post psychiatric inpatient follow-up rate remained relatively stable from CY 2019 to CY 2020 (61 percent vs. 60 percent) and continued to surpass the statewide average of 57 percent.

Figure 10: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-20

Los Angeles MHP



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	61%	57%	73%	70%
CY 2020	60%	57%	73%	70%

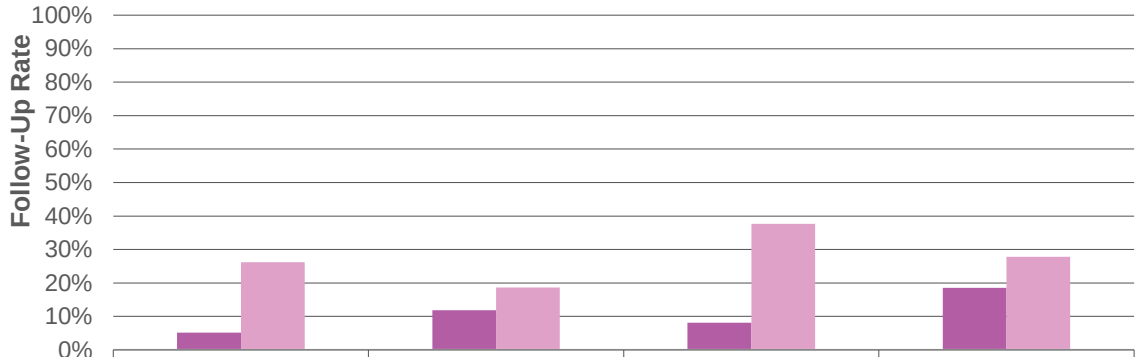
Readmission rates

The 7- and 30-day rehospitalization rates (HEDIS measures) are important proximate indicators of outcomes.

The MHP's rehospitalization rates significantly increased CY 2020 over CY 2019. The 7-day rate increase from CY 2019 was 21 percentage points, while the 30-day increase from CY 2019 was 30 percentage points. Both 7 and 30-day rates were well above the state averages for CY 2020. The 7-day MHP rate was 26 percent while the state average was 19 percent. The 30-day rate, at 38 percent was ten percent more than the state's average of 28 percent.

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-20

Los Angeles MHP



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	5%	12%	8%	19%
CY 2020	26%	19%	38%	28%

IMPACT OF FINDINGS

The MHP's beneficiaries benefit from the MHP's efforts at post-hospitalization follow-up as it is typically indicative of efforts at engagement in outpatient treatment. Post-hospital services frequently resolve the variety of issues leading to hospitalization.

The MHP's CY 2020 high rehospitalization rates may have been impacted by the protocols for managing COVID-19. The significant increases in both 7 and 30-day rehospitalization (21 percentage points and 30 percentage points, respectively) could be indicative of both the inability to engage beneficiaries in services after discharge and difficulty in finding placements in the community at a lower LOC. The MHP has engaged in pilot programs to improve post-hospital follow-up, but further analysis related to the type and frequency of follow-up is likely indicated. The elevated rehospitalization rate bears continued observation and development of other improvement strategies.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

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

QUALITY IN LOS ANGELES COUNTY

In the MHP, the responsibility for QI is located within the Quality, Outcomes, and Training Division (QOTD) of LACDMH. Within the QOTD division four discrete units exist: QA, QI, Outcomes, and Training. QA ensures programs adhere to all regulatory requirements and responds to all audits. QI is focused on program development and quality improvement processes. QI and QA operate separately but often collaborate on projects and in the countywide QA/QI meeting. Each unit has separate leadership. The QI unit includes three full-time equivalents (FTEs), one support staff, and a QI program manager.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the Quality Improvement Workplan (QIWP), and the annual evaluation of the QIWP. Due to the scale of LACDMH, there are regional or SA QICs (SA-1 through SA-8) and a Central QIC, which bring together SA leads for updates on changes and initiatives in the department. There is also a countywide QA/QI meeting focused on information-sharing and delivered in broadcast mode to approximately 300 participants. Updated BHINs are reviewed, timeliness data is discussed, and system issues are covered. The SA QICs occur on a monthly to quarterly basis, depending on SA leadership and need. These QICs include both DO and C/LE programs, with participation expected. The Central QIC is comprised of SA QIC leads (C/LE and DO), the QI team, QA leads, and leads for Policy, Access Center, Patient Rights, Cultural Competency, and Peer Discipline Chief (currently vacant). The absence of beneficiary and family members is noted and something the MHP plans to work on this year. The Central QIC is scheduled to meet monthly. Since the previous EQR, the MHP QIC met

12 times. Of the 18 identified CY 2020 QIWP goals, 12 were met, 2 were partially met, and four were not met.

The MHP utilizes the following LOC tool: Currently no LOC tool has been adopted

The MHP utilizes the following outcomes tools: Youth Outcome Questionnaire, Revised Behavior Problem Checklist, Post-traumatic Diagnostic Scale-5, Post-traumatic Stress Disorder Checklist, Family Assessment Device, Trauma Symptom Checklist for Children, Post-Traumatic Stress Disorder Reaction Index, Patient Health Questionnaire-9, Eyberg Child Behavior Inventory, CANS-50, Sutter-Eyberg Student Behavior Inventory-Revised, PSC-35, Milestones of Recovery Scales, General Anxiety Disorder-7, and the Difficulties in Emotion Regulation Scale.

In the area of wellness and recovery, by early 2022 five PRCs will be open, with three more in the process of development. These programs provide information and support in obtaining key life supporting services, ranging from treatment to housing and nutrition. The pandemic caused the PRCs to close in March 2020, and services moved to a virtual platform. The SA-3 PRC (West Covina) is piloting a Clubhouse model. In addition, LACMDH has 11 C/LE operated peer run centers, which have been in operation for over 10 years and are well established in their communities. There is at least one peer center currently open in each Service Area with the exception of SA 6. Finally, there are Wellness Centers and FSP programs in every Service Area which include peer staffing.

QUALITY KEY COMPONENTS

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

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

Table 6: Key Components – Quality

KC #	Key Components - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Not Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The QAPI organizational function incorporates separate but collaborative QI and QA functions. These functions operate centrally, addressing countywide organizational issues impacting both C/LE and DO programs; and there are regular SA QIC meetings that focus on the unique issues of each area. In this way the department is able to focus on both quality and compliance matters. The department also has a QI Council which meets monthly and co-hosts monthly QI/QA meetings.
- A MHP strength is the use of data to inform management through business intelligence dashboards of DO programs, containing data sets regarding approved claims, service array appointment status, timeliness and attendance rates.
- The MHP has a multitude of communication and participation options at all levels, for beneficiaries, other stakeholders, and contract agencies. While many stakeholders feel this is sufficient, the MHP does not have a continuous open process, such as an anonymous email, for leadership to receive feedback from line staff that is summarized and aggregated by SA and trend issues.

- The MHP continues to progress with its medication monitoring efforts, developing a peer review format for DO programs. One C/LE agency was engaged with establishing an internal peer review process that produced results this year. The DO medication monitoring program includes both a pilot peer review process as well as reporting out from the pharmacy database on a broad swath of HEDIS adult and child measures.
- The MHP does not possess a process to receive SB 1291 HEDIS measure data from C/LE programs which serve the vast majority of FC youth who are prescribed psychotropics. The process of extending peer review into C/LE programs will provide limited HEDIS measure data, limited by the small sampling process involved. There are possibilities of the MHP exploring alternative approaches, such as modification of the JV-220 process to capture the required SB 1291 youth HEDIS measure information.
- The MHP does not utilize an adult outcome instrument. With children and youth, the CANS-50 and PSC-35 are utilized. Initial efforts at aggregating and analyzing this data occurred this past year, and more progress is anticipated going forward.

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP:

- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

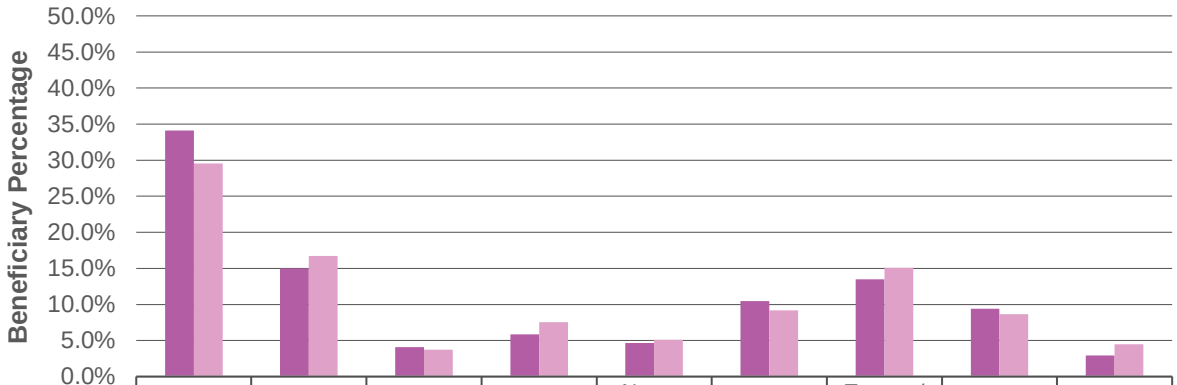
Diagnosis Data

Figures 12 and 13 compare the percentage of beneficiaries served and the total approved claims by major diagnostic categories, as seen at the MHP and statewide for CY 2020.

The MHP has a typical spread and range of diagnosis.

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020

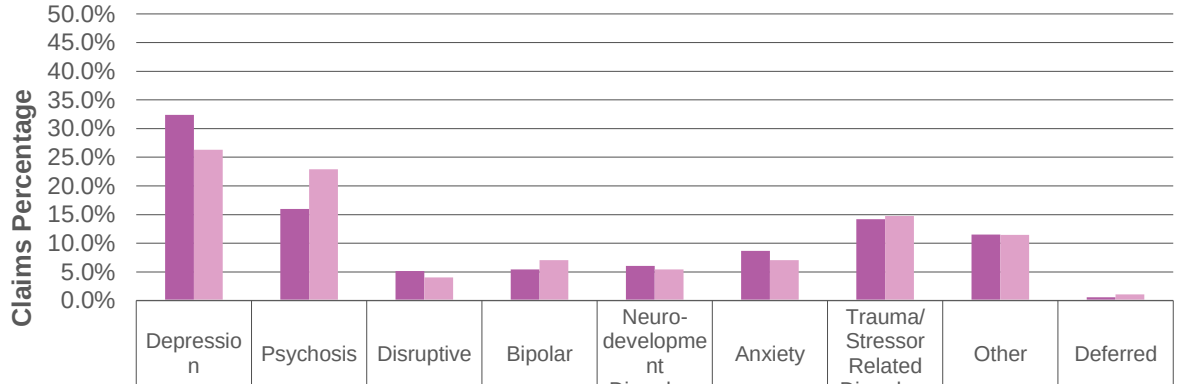
Los Angeles MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	34.1%	15.0%	4.1%	5.8%	4.7%	10.5%	13.5%	9.4%	2.9%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2020

Los Angeles MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	32.4%	16.0%	5.2%	5.5%	6.0%	8.7%	14.2%	11.5%	0.6%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

Psychiatric Inpatient Services

Table 7 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

The MHP saw a significant reduction in both numbers of beneficiaries hospitalized and in the number of admissions to inpatient stays from CY 2018 to CY 2019 which has continued into CY 2020. The MHP's average LOS, at 8.45 days is in-line with the state's average of 8.68 days. These numbers should be contrasted with the significant increase of readmissions noted in Figure 11.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

Los Angeles MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2020	16,424	65,947	8.45	8.68	$9,502	$11,814	$156,059,336
CY 2019	17,970	78,405	7.92	7.80	$8,460	$10,535	$152,030,457
CY 2018	19,946	91,861	8.25	7.63	$12,002	$9,772	$239,392,803

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of

total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

Both the MHP's HCB count and total beneficiary count have increased from CY 2018 to CY 2020 (the HCB count has increased from CY 2018 level of 6,681 to CY 2020 level of 7,058). The total beneficiary count of CY 2018 was 210,337, increasing to 221,136 in CY 2019, and decreasing in CY 2020 to 212,272.

The HCB percentage by count for CY 2020 was 3.32 percent, lower than the state average of 4.07 percent. The average approved claims per HCB for CY 2020 was $49,877, lower than the state average which was $55,969. These lower cost numbers are consistent with the lower cost findings in Figures 3 and 7.

Table 8: HCB CY 2018-20

Los Angeles MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	7,058	212,272	3.32%	$49,877	$352,029,368	24.58%
	CY 2019	6,909	221,136	3.12%	$49,351	$340,963,693	24.64%
	CY 2018	6,681	210,337	3.18%	$53,559	$357,825,966	27.54%

See Attachment D, Table D2 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.

Retention Data

The MHP has a slightly lower number of initial contacts (7.76) than the state average (9.76), and its service delivery levels drop in each of the next two following categories of services: two services and three services, each of these being lower than the state averages. The MHP's percentage of clients receiving 5 to 15 services, 29.81, correlates to the state's average of 29.47. Note that 48.09 percent of the MHP's beneficiaries receive 15 or more services, compared to the state's average of 45.33 percent receiving this number of services.

Table 9: Retention of Beneficiaries

	LOS ANGELES			STATEWIDE			
Number of Services Approved per Beneficiary Served	**# of beneficiaries**	**%**	**Cumulative %**	**%**	**Cumulative %**	**Minimum %**	**Maximum %**
1 Service	16,472	7.76	7.76	9.76	9.76	5.69	21.86
2 Services	11,850	5.58	13.34	6.16	15.91	4.39	17.07
3 Services	9,279	4.37	17.71	4.78	20.69	2.44	9.17
4 Services	9,311	4.39	22.10	4.50	25.19	2.44	7.78
5-15 Services	63,288	29.81	51.91	29.47	54.67	19.96	42.46
>15 Services	102,072	48.09	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

The MHP's beneficiaries have a higher percentage (48.09 vs 45.33 percent) receiving >15 services than the statewide average, suggesting that capacity may be consumed by longer-term beneficiaries which could also negatively impact capacity and access to definitive treatment. This area suggests continued work on LOC as occurred with FSP redesign, and may argue for adoption of a universally applied LOC instrument with periodic, structured case review and determination of need.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Improving the Use of MAT for Consumers with Co-Occurring Mental Health Disorders and Substance Use (COD)

Date Started: February 2021

Aim Statement: "The provision of MAT and interdisciplinary treatment groups, as well as staff training and a peer mentoring network, will result in a five percent increase in the percent of consumers with Alcohol Use Disorders (AUD) receiving MAT (from 7 percent to 12 percent) out of those consumers diagnosed with an AUD and a five percent increase in the percent of consumers with Opiate Use Disorders (OUD) receiving MAT (from 5 percent to 10 percent) out of those consumers diagnosed with an OUD from CY 2020 to CY 2021. The use of MAT will also result in a five percent decrease in the 30-day rehospitalization rates for consumers that receive any MAT medication (from 16.7 percent to 11.7 percent) from FY 20-21 Quarter 2 to Quarter 4. In addition, the

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

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

interdisciplinary treatment groups and MAT will result in a 30 percent reduction in mood (from 4.3/10 to 3/10), anxiety (from 6.6/10 to 4.6/10), and substance use impact (from 3.3/10 to 0/10) ratings from the first weekly measurement to the most recent weekly measurement for those consumers receiving both interventions [EQR: These data elements were derived from a from a weekly check-in measure]."

Target Population: LACDMH beneficiaries (most of whom are Medi-Cal beneficiaries) who are experiencing co-occurring mental health and substance use problems, particularly with alcohol and opioids. This includes any mental health diagnosis as well as problematic substance use, whether or not it is documented as a secondary substance use diagnosis, and can be any age for which MAT would be indicated (typically transition age youth and up).

Validation Information:

The MHP's clinical PIP is in the second remeasurement phase and considered active and ongoing.

Summary

This PIP is intended to improve the health and functioning of individuals who have COD in addition to mental illness. The key beneficiary focused interventions are the provision of MAT to those experiencing alcohol or opioid use disorders, and the provision of Integr8Recovery groups. The groups also provide assistance to those not formally diagnosed with substance use conditions. The approach utilized by the MHP is well supported by literature. Local data derived from a partnership with RAND Corporation also found under-utilization of MAT with COD beneficiaries. In addition to integrated care being a best practice, data indicated that individuals with a secondary SUD experienced a 30.4 percent rehospitalization rate compared to 24.8 percent for those without a co-occurring condition.

The MAT intervention included an effort to increase the number of X-waivered prescribers, which was supported by a mentorship program. Various trainings and a co-occurring disorder mini-conference were aimed at improving knowledge and reducing myths about MAT. It should be noted that expansion of the Integr8Recovery groups and realization of positive results from the other efforts were impacted by COVID-19 continued waves and practice constraints, as well as pandemic response personnel reassignments.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: the indicators showed mixed results and the numbers of participants are often low.

The TA provided to the MHP by CalEQRO consisted of:

- TA calls occurred approximately every other month since inception.
- EQR provided validation of the importance of MAT provided in an integrated care approach.
- Discussion occurred of concerns regarding rollout limitations and impact on the performance measures.
- The EQR acknowledges the importance of this topic outweighed the rollout scale issues and related data limitations.

CalEQRO recommendations for improvement of this clinical PIP include:

- The MHP will end this project and summarize the data in February 2022.
- LACDMH will continue this activity as a departmental quality improvement project (QIP) and select a new clinical PIP topic.
- As part of the conclusions the MHP will review data on clinical outcomes for the OUD MAT group based on prescribed medication – Naltrexone versus Butrans.
- The MHP will also apply a repeat measures approach to evaluate individual change and level of significance according to beneficiary self-report.
- Retention rate trends will be evaluated by MAT administration aggregate data.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected

Date Started: September 2020

Aim Statement: “Will providers with timely appointment rates at 69 percent and below develop and implement improvement strategies targeting staffing shortages, intake and referral challenges, or other challenges to timely access successfully meet 80 percent of their consumers’ requests for an initial routine outpatient specialty mental health services appointment within six months?”

Target Population: All adult and child beneficiaries seeking first offered non-urgent appointments who are served by programs that have received more than five referrals and are below 69 percent attainment of the 10-day timeliness standard.

Validation Information: The MHP's non-clinical PIP is in the third collection period, and was considered active. The MHP plans to summarize the results of this PIP and develop a new PIP in a similar topic area.

Summary

The MHP engaged in a project to improve timeliness of initial access within a very large environment composed of both DO and C/LE programs. Those programs meeting the inclusion criteria were brought into one of three cohorts over time, A, B and C. Programs were expected to review their unique operational issues and develop improvement action plans. The strategies that were applied were later evaluated for both magnitude of improvement and time-frame for success. Confirmation of results occurred by MHP QI staff running actual timeliness data off the MHP's reporting system.

Timeliness ratings were reviewed monthly but reported-out quarterly. Improvement was assessed through comparison of quarterly timeliness percentages with baselines for cohorts A, B, C. Overall results saw a range of improvements across the cohorts: A: +40 percentage points (PP), B: +32 PP, and C: 30.77 PP. Each cohort was evaluated individually, and most cohorts were found to have statistically significant measurements of change over time.

TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence, because: Significant improvements in timeliness occurred across all cohorts. Some implemented multiple strategies which made it impossible to ascertain the key intervention. But those which implemented single strategies found the greatest success with site specific workflow changes and other administrative actions of an immediate nature. Provider self-report aspects were validated by system timeliness data.

The TA provided to the MHP by CalEQRO consisted of:

- EQR recognition of the importance of the timeliness topic and challenges with moving all providers towards timely access to care.
- Ongoing provision of TA calls to review and discuss PIP progress every two months.
- Discussion and feedback regarding the importance of tracking improvement by implemented strategy, and development of a best-practice menu of interventions.

CalEQRO recommendations for improvement of this non-clinical PIP include:

- None – this PIP will be phased into an ongoing QIP that involves sustained efforts to support providers that face challenges in meeting timeliness requirements.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

IS IN LOS ANGELES COUNTY

California MHP EHRs fall into two main categories-- those that are managed by county of MHP IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/Avatar, which has been in use for eight years. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years. After a thorough analysis of the market, the costs of implementation of a new system, and the staffing a new implementation would require, the MHP has decided to continue with Netsmart as a provider. The intent is to have a new contract spelling out required new functionality so that state requirements may be readily met.

Approximately 2.3 percent of the MHP budget is dedicated to support the IS (County IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control.

The MHP has 5,553 named users with log-on authority to the EHR, including approximately 3,928 county-operated staff and 1,625 contractor-operated staff. This number of community-based organizations (CBO) staff does not reflect the total number of hands-on users as the MHP does not track staff in agencies that do not use Avatar. As 79 percent of beneficiary services are provided by CBOs, this is a large number. Support for the users is provided by 242 FTE IS technology positions which includes 34 vacancies. There are several issues that have resulted in reduced staffing; staff have left county employment for other opportunities while several staff have retired, and some staff have promoted to other departments. In addition, because of the budget crisis the Information Bureau has only been authorized to hire five critical staff every three months; further complicating hiring, the county CEO will not allow the backfilling of staff who have promoted from within the bureau.

As of the FY 2021-22 EQR, a minority of contract providers have access to directly enter clinical data into the MHP's EHR. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes

and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 10: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
☒	Electronic Data Interchange (EDI) to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	80%
☐	Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☒	Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	10%
☒	Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	5%
☒	Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	5%
			100%

Beneficiary Personal Health Record

The 21st Century Cures Act (Cures Act) of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a PHR enhances beneficiaries' and their families' engagement and participation in treatment. Beneficiaries served by the MHP's DO clinics have access to a PHR, Just4Me. There are 8,029 beneficiaries who have created their personal identification number (PIN). While 116,389 beneficiaries were given a system generated PIN, they have yet to create an individualized PIN. The MHP does not track the numbers of beneficiaries in C/LE programs that have a PHR. As this is such a large percentage of the served population, the MHP needs to acquire information regarding C/LE entities and availability of a PHR on other EHR platforms that are in use.

Interoperability Support

The MHP is a member or participant in a HIE, LANES. The MHP engages in electronic exchange of information with its CBOs.

IS KEY COMPONENTS

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

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

Table 11: Key Components – IS Infrastructure

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

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

- The MHP has a data warehouse that is effectively used to provide a rich variety of reports used for data governance from line staff up to the executive team.
- The MHP maintains consistent claims volume with an annual denial rate of 2.97 percent. This denial rate is below the state average of 3.19 percent.
- MHP beneficiaries will benefit from the implementation of the new 988 phone number.
- The MHP has a detailed plan for the continued use of telehealth to better address both ease of access and the culturally specific needs of beneficiaries.
- Transitioning to cloud base will facilitate the integration of DO and LE MHP data.

- Transitioning to ONE drive to be able to work from any location is a great advantage in these days of increased field-based services.
- The MHP would benefit from assuring that all LEs provide PHRs for their beneficiaries.
- The MHP would benefit from requiring the LEs to fully participate in the LANES HIE.
- The use of one consistent LOC across all adult programs in both DO and LE programs is a standard tool that is currently lacking.
- The MHP will benefit from robustly staffing and funding the efforts to implement multi-factor authentication for all staff.

IMPACT OF FINDINGS

- While the MHP has a full range of reports for the DO programs, it does not consistently include data from the C/LEs due to incompatibility of EHR systems. This is a significant gap as 79 percent of services are provided by the C/LEs.
- The inability to fully track the first request for medical services for C/LE programs handicaps the MHP's ability to accurately complete state required timeliness reports.
- The MHP has provided numbers for PHR users for the DO's beneficiaries. It is not able to provide numbers of the LE's beneficiaries who are using a PHR. The C/LE providers use a variety of disparate EHR's, each potentially with a different PHR.
- Although the MHP has significant gaps in CIOB staffing, they are making do by wearing many hats and sharing responsibilities. There is a risk of burnout and a downward spiral with the inability to provide a full range of services if this is not ameliorated.
- The MHP's consistently strong volume of Medi-Cal billing results in a reliable cash-flow.
- As 70 percent of denied claims as referenced in Table D 4 ($40,259,632) are billable if corrected, substantial resources should be directed to obtaining this lost revenue.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

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

CONSUMER PERCEPTION SURVEYS

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

The MHP focused this past year on improving the availability and collection of CPS surveys to the large number of threshold and other additional languages of beneficiaries. The process involved a redesign of the CPS report format, and development of mechanisms to ensure those with non-threshold languages had access to translated forms. Historically, the MHP has directed SA QICs to identify low scoring CPS areas, and develop a related intervention strategy. For this review period, reports included trends over a three-year period, and low scoring areas were identified; but the development of specific intervention strategies did not occur.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

As part of the pre-site planning process, CalEQRO requested four 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of beneficiary caregivers/parents of children from SA-1, including those served by DO and C/LE programs; the group was requested to have one-third who started services in the past year. The focus group was held through

video conference, via Microsoft Teams, and included two participants. All family members participating have a child who receives clinical services from the MHP.

The time from initial request to services ranged from two weeks to two months. The caregiver with the two-month wait time felt that time period worked out well for the family due to changing life circumstances. Both families receive weekly services, for one it is by telephone. Neither received psychiatry services. Scheduling is flexible, and both state it is easy to reschedule if an appointment is missed. Appointment reminders occur via telephone calls and texts. Neither were aware of the Just4Me PHR. It was also not clear if these families are served by DO programs, which is necessary for access to Just4Me.

Transportation is not an issue for either caregiver. Both are aware of crisis resources if such were needed. Both have been provided with information about the emotional support line, one via email and the other via clinician. Both are satisfied with the way services meet their cultural needs. Clinicians are sensitive to physical health issues and provide referral information when this type of concern arises, including health and diet.

The health concerns related to COVID-19 resulted in a variety of service adaptations. For one family, services started in-person and have since shifted to telephonic. For the other, services started in the office and now home visits are received.

Information about services and events with the mental health department are provided by the therapists, such as whole-body wellness, and web links to specific programs. Awareness and use of the MHP's website were split between these participants. Some found additional helpful resources on the website.

Neither were aware of opportunities to participate in committees or opportunities to provide feedback regarding services. Neither have completed a service feedback survey, nor were aware of results from those others have taken.

These participants praised current therapists for instilling a sense of optimism and creating positive exercises when things are not going well. However, one recalled requesting a different therapist and was referred back to the current clinician.

Recommendations from focus group participants included:

- Supportive group activities for younger children who are dealing with similar issues would be a helpful adjunct to the formal treatment services, such as a mental health camp.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult Spanish speaking beneficiaries, drawn from DO and C/LE programs from the SA-7 area. Participants were to include high and

low utilizers as well as one-third to have initiated services during the last year. The focus group was held through video conference format, and included six participants and one Spanish language interpreter. All participating consumers receive clinical services from the MHP.

One participant initiated services within the last year. Regardless of when services started, all reported very brief wait times of about one week. The exception was one individual who for personal reasons was hesitant to respond to an offered assessment appointment.

The majority have been in treatment from 2 to 16 years, and have moved from monthly psychiatric appointments to every three months. Most report receiving psychiatry services every three months. Other participants who started services within the last year and a half are seen anywhere from weekly to every other week.

Participants reported receiving text and/or telephonic reminders, and if an appointment is missed the doctor or clinician reaches out and reschedules. These individuals reported no difficulties in rescheduling, and program staff also ensure the consumer has adequate medications until the rescheduled appointment.

Transportation is not a barrier for these participants. Health plan transportation is provided for some, others receive bus fare monthly.

Options for support during times of crisis are well planned. These include calling the treating clinic and reaching the clinician or supervisor by telephone or text. Other support numbers are provided in advance, with instructions as to the use of each one.

The cultural needs of these Spanish speaking consumers are met by the treatment staff. Informational materials are provided in English and Spanish for the most part, and there are always staff available to translate flyers that are only available in English. In addition, traditional indigenous customs are accepted and valued. Inclusion of family members in treatment is offered and supported.

Physical health issues are included in the focus of MHP services, which includes at times speaking with the primary care physician, and assisting with creating medical appointments. Most were uncertain regarding whether coordination with primary care occurred. Support includes social needs as well.

Changes in the past year were largely related to adaptation to COVID-19. When in-person care was not available, clinicians would text and provide services by telephone. Some of these individuals prefer the telehealth services due to providing safer care. Most would prefer in-person services, but have also joined groups and received treatment via telehealth.

Those who use telehealth believe service duration is about one hour per session, similar to in-person. Others reported being trained in the use of a computer, so that telehealth sessions would be possible.

Uniform among these participants was surprise and appreciation at the dedication of clinical staff to remain connected, provide information, treatment and support regarding resources throughout the stressful acute pandemic period.

Information about services is received through texts, emails, printed materials, and directly from clinicians. Support groups have flourished during COVID-19 times. A small subset of participants utilized the LACDMH website for obtaining service information.

Services to the homeless involve a multi-agency approach, which can complicate grievances. For some this multi-agency approach made it difficult to identify which agency a grievance should be filed with. As a result, it seemed impossible to get a resolution when school systems, homeless programs and LACDMH services were all involved.

Participants felt they could provide input on services, which can involve attending the service area leadership team (SALT) meetings. Others would check in with the clinician when wanting to provide specific input. This includes participating in other MHP committees, such as the Client Advisory Board), which nearly one-half of this group reported.

The majority of participants completed a satisfaction survey within the last year. Also, the majority had visited a wellness center.

Overall, the majority cited clinician shortages impacting the ability to have timely response to changing service needs – with time from request to services taking as long as 60 days for a newly identified therapy need. Some suggested a need for random program inspections to ensure that protocols and standards are being met. The need to retain options for providing services post-COVID-19 that fit the preferences and capacity of consumers was cited, particularly with telehealth.

Recommendations from focus group participants included:

- More staff and therapists
- Hold programs accountable for meeting standards, using random inspections/reviews
- Ensure standardized training for all staff in all programs
- Retain the hybrid service delivery options, supported by hardware purchases, and bandwidth support.

Consumer Family Member Focus Group Three

CalEQRO requested an adult focus group comprised of a diverse SA-1 consumers served by DO and C/LE providers, including high and low utilizers, with one-third who initiated services in the preceding 12 months. The focus group was held via video conference format and included three English-speaking participants. All participants receive clinical services from the MHP. One individual had relevant initial access experience from the prior year.

The initial access experience reported involved a clinic intake approximately two weeks after a hospital discharge. The consumer considered this a reasonable period of time. For those who initially accessed care more than a year ago, intake occurred within one week, and psychiatry services involved a one-month wait.

The frequency of services for these individuals is reportedly based on clinical need. When stable, psychiatric services may be every three months, but if severe symptoms emerge the frequency can increase to once every two weeks. The same type of frequency adjustments was cited for clinician care, in response to symptom changes. A minority do not receive psychiatry services, but receive group and individual therapy services.

All mention the ease of rescheduling missed appointments in most instances. One individual mentioned seeing a psychiatrist at his private practice, who will charge a fee if a session is missed. Appointment reminders are reportedly received by all.

Regarding use of the patient portal, Just4Me, none were aware of this option. It is difficult to determine if these participants were served by a DO program, which is required for this patient portal access.

All receive information about transportation assistance. This includes support from LA Care, and can include bus pass or something like a ride assistance program. In other cases, therapists will come to the home.

Options for crisis care are known to most participants, which includes the Mental Evaluation Team team or going to Starview Urgent Care Center in Lancaster. The majority have knowledge of the Emotional Support Warmline. Cultural needs are perceived as met by all. The option of involving family members in treatment is known. Clinicians also support a focus on physical health, nutrition, and well-being. Communication between clinician and psychiatrist is understood; however, primary care provider communication was not acknowledged.

The changes to service delivery due to COVID-19 were mentioned by all participants, which meant primarily Zoom, Teams or telephone. The majority reported video services during the past year. One participant expressed a desire to return to face-to-face services.

Information about changes in the LACDMH department come from therapists, Beacon Health website, and from community contacts. None report using the LACDMH website for information. All participants feel comfortable sharing their thoughts and wishes with clinicians. A minority of the group have attended input sessions sponsored by the MHP. The majority had not previous to this session participated in any input sessions. The majority did recall having completed a written feedback survey in the past, but were unaware of the results. A small segment of this group was aware of survey results and had attended wellness center activities.

A majority have realized a sense of hope and optimism from services. They feel involved in their own care. A minority had awareness of employment opportunities for individuals with lived experience. Most felt they could change therapists if the fit did not seem right.

The service delivery challenges experienced by these individuals include: There is a need for more group activities based on the consumers characteristics, such as single parents; options that revolve around more humanistic religious preferences. Some clinics operate in a manner that has the beneficiary seeing a different case manager each time, and consistency for the sake of relationship building is important.

Recommendations from focus group participants included:

- Clinics to structure group activities around the characteristics of beneficiaries, such as support groups for single parents.
- Assisting beneficiaries to find support in a church home that is more humanistic and contains less of a formal religious focus.
- Improve consistency of case manager to beneficiary assignments, in which the relationship stability and continuity is important.

Consumer Family Member Focus Group Four

CalEQRO requested a diverse group of parent/caregivers of children and youth in treatment from SA-7 DO and C/LE provider consumers. The focus was on both high and low utilizers, one-third who were to have initiated services in the preceding 12 months. The focus group was held by teleconference, and initially included six participants, one of who was unable to fully participate due to connectivity issues, resulting in five actually participating; a Spanish language interpreter was used for this focus group. All family members participating have a family member who receives clinical services from the MHP.

Those participants who had accessed services in the last year voiced complaints about difficulties with a specific program. With comments about it taking a month or more to

access services. With the specific provider, individuals were having to call back numerous times in order to find out when an intake option was available.

Even with the delays in access, participants praised the quality of the clinical services provided. Generally, the frequency of service is weekly, with flexibility on the provider's side to make time for telephone calls and additional sessions if needed. The group remarked about the flexibility in accommodating to the child's needs, such as providing telehealth if that is preferred.

In regards to appointment flexibility, if sessions must be cancelled the clinician will provide an alternate session within one week or offer a telehealth session. The majority of participants receive text or front office calls to remind them of appointments.

For all, transportation assistance is not needed. Some group participants were aware of the possible options, others were not.

Options for crisis events include a phone number provided by the treating clinician. Some clinics have an after-hours number that will connect the family to supportive services. Only one of the participants did not have a number or specific strategy for crisis response.

Culture and language needs are reportedly well supported. This ranges from a clinic based on cultural teachings, to having clinicians that speak preferred language of participants, in this case Spanish.

The treating psychiatrist, in one example, provides the child with information about medications and treatment, and inquires directly of his progress despite his age. The focus is to engage the child in his own treatment. One participant was impressed with the psychiatrist's effort to have the caregiver involved in discussions about medications, and a focus on keeping medication dosages as low as possible. Some participants have experienced the psychiatrist focusing on physical health issues, and first ruling out possible health issues before considering a psychiatric diagnosis and related medications.

The participants miss the face-to-face services that existed prior to the pandemic. As one mentioned, their cultures are people-centric and they prefer to be able to get together and miss that social interaction.

The mode of services is up to the family/consumer preferences. Some have clinicians providing home visits. Those who have received telehealth specifically identified LACDMH's VSee option as problematic, with video lag among other issues. They mention that clinicians are also reluctant to use VSee, and will instead use county phone face-time or voice only services. Those served by a provider that uses Zoom may also experience problems with connectivity. When there exist video telehealth barriers, phone calls are the default modality.

Information about services, changes and updates may be obtained from clinics that send out newsletters to all clients. Case managers and clinicians are also noted to provide information when changes occur. A small component of this focus group has accessed the MHP's website. Those that access that site have found the information useful, although ease of navigation could be improved.

Only one participant was aware of the LACDMH patient portal, Just4Me, but had stopped using it. Familiarity with that functionality was gained from a role within the department. Participation in MHP committees was not desired by the majority of focus group members, nor could the majority recall being asked to provide a response to the feedback survey.

Participants appreciate the sense that improvement can occur, and that the family unit is included in the focus of treatment. Clinicians seek caregiver input as to the child's progress.

As to system challenges, improvements to the crisis response system were identified. One aspect is response time. When families call in crisis, the quick response needed is not always provided. One specific comment was that it should not take a month and multiple phone calls for a family to receive a response. In one case there were extended periods waiting for a definitive call back, and finally having to escalate to supervisors. Another participant cited their child was exposed to traumatic situation and had to wait one month to access a therapist.

Recommendations from focus group participants included:

- Improve the responsiveness of the child/youth crisis response system to provide in-home services without prolonged wait services.
- Reduce the wait times to therapy for children and youth exposed to traumatic events.
- Continue to focus on resolution of the barriers to telehealth services, including bandwidth issues, hardware and improving technology skills of beneficiaries.

IMPACT OF FINDINGS

With some specific program exceptions, the time from first request to offered appointment was within a 10-day time-frame.

Despite the challenges of COVID-19 consumers and family members reported highly satisfactory services in both quality, quantity, and responsiveness to clinical status changes.

While praising the quality of psychotherapy and psychiatry services, participants identified the need for more clinical staff and quicker access to treatment.

Participants were uncertain that service standards were always met, and questioned whether or not the MHP had a process in place that effectively monitor those issues and take corrective action when needed.

Due to different experiences with services within and between programs, participants were concerned if standardized training for all was provided across all agencies to assure a consistent response.

The responsiveness of child/youth crisis services was identified as an area needing improvement. The lack of a rapid, definitive in-home response was mentioned by a number of parent/caregivers. Too many phone calls and days waiting for help to arrive were mentioned by participants, at times requiring escalation to program managers. This is a recurring theme over many review cycles.

While many consumers would prefer in-person services, they were also clear that maintaining and improving telehealth services is an important option to retain.

A recurring theme from previous reviews is the development of more group support and treatment services that are oriented around the characteristics of individuals, such as single parents.

The use of an on-call or rotating assignment case manager is not preferred by beneficiaries. For relationships, establishing trust and continuity, a single case manager improves the quality of care and supports the development of a therapeutic connection.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP's overall penetration rate remains higher at 5.49 percent than both the statewide average, 4.55 percent, and the other large MHPs at 4.13 percent.

   (Access)

2. In the face of numerous COVID-19 waves and related capacity challenges, focus group beneficiaries reported appreciation of the MHP's ability to provide timely, quality services, by whatever method they preferred.

   (Quality)

3. The medication monitoring of DO programs has made progress this past year through a combination of peer and pharmacy review of prescribing. Steps to initiate C/LE program peer review occurred, led by the MHP, with expansion anticipated in the coming year. Operationalizing the pharmacy review findings in a practitioner communication is anticipated and critical to an effective process.

   (Quality)

4. APEX is a monthly revolving SA review of DO programs. APEX data and discussions include financial, direct service percentages, access to care data, documentation timeliness, time to service finalization, telehealth video vs. telephone/other, total DO beneficiaries served, monthly total assessments and other information. SA leadership in collaboration with program leadership, identify strategies to remedy underperformance and share success stories of changes improving access and care.

   (Quality)

5. LACDMH and the Office of the Public Guardian are collaborating in a pilot outpatient conservatorship program, which can initiate an LPS conservatorship outside of an acute inpatient unit. The MHP's HOME program is key to identifying and working with the chronically homeless and seriously mentally ill who cannot engage in services. Expectations are for a number of these individuals to actually engage with services voluntarily, and not require the completion of a conservatorship process. Telehealth technology is being used to support the process.

(Access)

6. Telehealth expansion, inclusive of video and telephonic services, has increased during the response to COVID-19. It is a useful choice in the redistribution of key services which have limited capacity, such as psychiatry. It is also a resource for families and individuals whose circumstances make travel to a clinic difficult. Telehealth kiosks are provided at numerous sites, with more coming, which allows a beneficiary to receive services at a clinic from a remotely located provider. C/LE programs achieved a higher rate of video supported services. Determination of how and why this happened is not completely clear, but some input suggested provision of tech hardware to staff and adoption of user-friendly telehealth platforms may be involved.

   (Access)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP first offered non-urgent psychiatric appointment review data reflects very low event numbers for the review period (483 total for FY 2020-21), with tracking limited to when psychiatry was requested at initial access. Although improvements have recently occurred, the MHP's data collection in this area potentially under-reports a significant number of events. Children and youth, often referred to psychiatry after a period of psychosocial treatment, cannot easily be tracked. Comprehensive tracking requires clear criteria and a functional process applied across the system of DO and C/LE programs to memorialize decision/referral date. C/LE programs which serve the majority of FC youth, are not included. This information is important for the MHP to fully understand psychiatry demand and capacity across both DO and contracted programs.

   (Timeliness)

2. The use of UCCs for transitional psychiatry services for newly open beneficiaries has been linked to possible quality of care issues, such as beneficiaries experiencing a new psychiatry intake with each UCC service, re-traumatizing beneficiaries when having to tell their story each time, medication changes that are more likely when physician coverage changes, and beneficiaries abandoning treatment due to engagement issues.

   (Quality)

3. The MHP's post-hospital follow-up is higher than the statewide average, yet readmission rates remain high (30-day, 28 percent). The MHP has implemented regional pilots (SA-3) for improving linkage and follow-up. However, more analysis as to the type and frequency of follow-up could be important to discovery of the elements that significantly impact readmissions and development of a systemwide strategy.

(Quality)

4. The MHP utilizes a variety of communication strategies with stakeholders, beneficiaries, staff, and contract agencies. However, there is not a continuous process for gathering input from C/LE programs, DO line staff, and other stakeholders in an anonymous format which could provide leadership with useful information when summarized by respondent category, region and issue. The existing institutional systems may not be efficient at this task. Specific project queries could be launched, such as with VSee, in which the direct users' experiences may differ significantly from that of project champions.

   (Quality)

5. LACDMH beneficiaries have a higher retention rate in the >15 service category than the statewide average (48.09 vs 45.33 percent). LACDMH continues to emphasize LOC determinations, particularly within FSP and other higher levels; however, an adult outcome or LOC tool has yet to be adopted that could inform the re-assessment process for beneficiaries at all levels, and accelerate availability of capacity.

   (Quality)

6. The MHP is unable to determine if C/LEs provide PHRs for their beneficiaries.

   (Quality, IS)

RECOMMENDATIONS

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

1. Develop a strategic plan and begin to resolve the critical psychiatry and clinical staffing issues that are linked to less effective workarounds in care such as the use of UCCs for transitional psychiatry care. This should also include attention to clinician caseload levels as well as assignment of consistent, adequate psychiatry coverage to each program.

   (Access)

2. Develop a comprehensive solution to tracking of timeliness metrics that applies to both DO and C/LE programs, specifically first offered non-urgent psychiatry and urgent care services. This would include criteria development and a system for tracking post-assessment psychiatry referral timeliness.

   (Access, Timeliness, IS)

3. Develop a SB 1291 FC child/youth HEDIS measure tracking system, potentially derived from C/LE self-report or through the modification of another existing

process such as the JV-220 (judicial application and approval process for psychotropic medication with a dependent minor) reviews with alignment of criteria to match the HEDIS elements. With the majority of FC children/youth served by C/LE's, this information is not within the MHP's data or pharmacy reporting capabilities.

(Quality)

4. Pursue identification and implementation of an adult clinical instrument – LOC or outcome tool - to inform a periodic review process and re-determination of clinical need across all levels of care.

   (Quality)

5. Develop a system feedback process that encourages participation through the use of an anonymous process and provides MHP leadership with direct staff and C/LE program comments, parsed by Service Area and other critical elements.

   (Quality)

6. Develop a systemwide strategy to reduce 7/30-day rehospitalization rates, by provision of post-hospital follow-up which is tailored to factors identified by data analysis and stakeholder input.

   (Quality)

SITE REVIEW BARRIERS

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

For the FY 2021-22 review period, continued waves of COVID-19 impacted Los Angeles County, and an abundance of caution resulted in the review process utilizing a video conference approach without in-person sessions. The totality of information obtained during the review can be affected by absence of in-person sessions.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: CALEQRO REVIEW AGENDA

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

Table A1: EQRO Review Sessions

Los Angeles
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 Systemwide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Revenue Management Claims Processing
CIOB & Data Warehouse
Information Systems - ISCA & IBHIS
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, Lead Quality Reviewer

Lynda Hutchens, Second Quality Reviewer

Oliva Kosarev, Quality Reviewer

Lamar Brandsky, Information Systems Reviewer

Gloria Marrin, Consumer-Family Member

Pamela Roach, Consumer-Family Member

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

MHP and Contract Provider Sites

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Acevedo	Elodia	Community Health Worker	DMH
Albrecht	Steve	Regional Administrator	Starview
Alvarado	Frances	Peer Worker	Spiritt
Alvardo	Francesa	Parent Partner	SPIRITT
Alvarez	Oscar	Medical Case Worker II	Roybal MH Center
Alvarez	Vanessa	Clinician	The Whole Child
Alvarez	Maria	Psychiatric Social Worker II	DMH
Andersen	Justin	Administrator	Telecare
Anderson	Amber	Mental Health Program Manager II	DMH
Angeles	Adrianne	Director	Alcott
Arnett	David	Psychiatric Social Worker I	DMH
Arns	Paul	Mental Health Clinical District Chief	DMH
Arreola	Margarita	Peer and Consumer	WOW Volunteer
Ashtari	Nahid	Clinician	Heritage
Avalos	Mirian	Departmental Chief Information Officer II	DMH
Avilas	Sandra	Clinician	ALMA
Avitia	Yolanda	Senior Community Worker	Rio Hondo MHC
Babbitt	Tonia	Supervisor	Penny Lane
Baker	Angel	Mental Health Division Chief Program Development	DMH
Bañuelos	Antonio	Mental Health Program Manager II	DMH
Bautista	Cynthia	Community Health Worker	SA 7 Specialized Foster Care
Bilotta-Smith	Michelle	Mental Health Clinical Supervisor	Rio Hondo MHC
Blanks	Jill	Stakeholder	SA 1 SALT
Bonds II	Curley	Medical Director	DMH

Last Name	First Name	Position	Agency
Boykins	Terry	Mental Health Deputy Director	DMH
Brown	Miriam	Mental Health Deputy Director	DMH
Brown	Crystal	Medical Case Worker II	DMH
Brown	Aaliyah	Community Health Worker	DMH
Bryan	Madison	Clinician	The Whole Child
Byrd	Robert	Mental Health Program Manager III	DMH
Cacialli	Douglas	Clinical Psychologist II	DMH
Cain	Melanie	Mental Health Clinical Program Head	DMH
Camacho	Merllely	0-5 Therapist	SAFC
Camacho-Fuentes	Mary	Mental Health Clinical Program Head	DMH
Campbell	Veronica	Mental Health Clinical Supervisor	AVMHC
Carlton	Susan	Medical Case Worker II	DMH
Carrillo	Alicia	Peer Employee	Pathways
Cavalheiro	Marcelo	Director of Reg. Operations	Telecare
Chang	Sandra	Mental Health Program Manager I	DMH
Chavez	Marlene	Mental Health Clinical Supervisor	DMH
Cheng	Mark	Information Technology Manager II	DMH
Cheung	Lauren (Man Ching)	Mental Health Clinical Supervisor	DMH
Clay	Catherine	Community Health Worker	DMH
Cohen	James	Peer Worker	MHA
Colindres	Erika	Psychiatric Social Worker	Rio Hondo MHC
Colocho	Marta	Mental Health Clinical Supervisor	DMH
Coomes	James	Mental Health Clinical Program Head	DMH
Corral	Erika	Stakeholder	SA 7 SALT
Cota	Lucia	Mental Health Clinical Supervisor	DMH

Last Name	First Name	Position	Agency
Cunnane	Daiya	Clinical Psychologist II	DMH
Dang	Nga	Principal Information Systems Analyst	DMH
DeAro	Ashlyn	Peer Worker	Penny Lane
DePalm	Farah	Clinician	Heritage
Diaz-Akahori	Angelita	Mental Health Program Manager III	DMH
Draxler	Connie	Mental Health Deputy Director	DMH
Duong	Cynthia	Mental Health Program Manager III	DMH
Elliot	Alex	Psychiatric Social Worker I	DMH
Escamilla	Arturo	Psychiatric Social Worker	Rio Hondo MH
Faye	Margaret	VP, Quality Mgmt.	Hathaway-Sycamores
Ferguson	Cindy	Senior Mental Health Counselor	DMH
Fermin	Juan	Information Technology Manager I	DMH
Fernandez	Hugo	Supervisor	Spirit
Figueroa	Jonathan	Clinician	Penny Lane
Fish	Sherlyn	Supervisor	The Whole Child
Funk	Maria	Deputy Director	DMH
Garcia	Raul	Community Health Worker	AICC
Gidwani	Kiran	Principal Information Systems Analyst	DMH
Gil	Saul	Clinician	Spiritt
Gilbert	Kalene	Mental Health Program Manager III	DMH
Gomez	Arthur	Senior Community Health Worker	Promotoras
Hagerty	Denis	Clinician	Heritage
Hallman	Jennifer	Mental Health Program Manager I	DMH
Hanada	Scott	Mental Health Program Manager III	DMH

Last Name	First Name	Position	Agency
Hansen	Deborah	Mental Health Clinical Supervisor	DMH
Heiser	Marc	Supervising Mental Health Psychiatrist	DMH
Howieson	John	Information Technology Manager I	DMH
Im	Marylune	Mental Health Clinician II	DMH
Innes-Gomberg	Debbie	Mental Health Deputy Director	DMH
Jackson	La Tina	Deputy Director	DMH
Jones	Martin	Mental Health Program Manager III	DMH
Joseph	Michelle	Clinician	Penny Lane
Juarez	Cynthia	Mental Health Clinical Supervisor	San Antonio MHC
Kaiwi	Nicole	Peer Advocate	AICC
Kasarabada	Naga	Clinical Psychologist II	DMH
Khawaja	Christine	Mental Health Program Director	Olive Crest
Kudlick	Susan	Mental Health Clinical Supervisor	DMH
Lear	Marta	Supervisor	Pathways
Levy	Hayley	Director of Adm. and Clin. Services	SSG
Liu	Kwan	Administrative Services Manager III	DMH
Lopez	Marissa	Clinician	Community Family Guidance Center
Lopez	Yessenia Rocha	Counseling for Kids Therapist	SAFC
Lowe	Danielle	Behavioral Health Director	Shields
Lozano	Rene	Community Health Worker	CFS
Luevano	Rocio Ortiz	Menta Health Clinical Supervisor	Roybal MHC
Macias	Gloria	Clinical Psychologist II	Roybal MH Center
Maes	Iva	Peer Employee	AICC
Maiorino	Nick	CEO	Alcott

Last Name	First Name	Position	Agency
Majors	Michelle	Mental Health Clinical Program Head	DMH
Mangwa	Blanca	Clinician	Heritage
Martin	Amanda	Clinician	McKinley
Martinez	Karla	Medical Case Worker II	DMH
Martinez	Jeremy	Supervising Mental Health Psychiatrist	DMH
McClain	Carmen	Psychiatric Social Worker I	DMH
Mehta	Pinki	Executive Assistant	DMH
Mendoza	Griselda	Peer Worker	ALMA
Mortellaro	Krista	Psychiatric Social Worker II	DMH
Mushrush	Stephanie	Psychiatric Social Worker	AICC
Nall	Kimberly	Departmental Finance Manager III	DMH
Ojeda	Diana	Medical Case Worker II	DMH
Ortega	John	Information Technology Manager II	DMH
Pap	Mariann	Health Program Analyst II	DMH
Pap	Mariann	Health Program Analyst II	DMH
Park	Grace	Clinical Service Manager	Korean Youth and Community Center
Partida del Toro	Jorge	Chief of Psychology	DMH
Patterikalam	Girivasan	Information Technology Manager II	DMH
Perius	Imee	Marketing and Communications	DMH
Pesanti	Keri	Mental Health Clinical Program Head	DMH
Philips	Seth	Mental Health Clinical Supervisor	DMH
Pierson	Jessica	Supervisor	ALMA
Pinedo	Lisette	Child/Family Therapist	SAFC
Platt	Stephanie	Mental Health Clinical Supervisor	Rio Hondo MHC

Last Name	First Name	Position	Agency
Polk	Gregory	Chief Deputy Director	DMH
Quimbayo	Angie	Clinician	Pathways
Quirarte	Sergio	Clinician	ALMA
Ramirez	Melissa	Clinical Psychologist II	DMH
Rios	Irma	Community Health Worker	Rio Hondo MHC
Rix	Celeste	Chief of Clin. Services	Comm. Family Guidance Center
Rodriguez	Rigoberto		DMH
Rodriguez	Anabel	Deputy Director	DMH
Rodriguez	Alicia	Mental Health Advocate	Rio Hondo MHC
Roman	Dagoberto	Mental Health Clinical Supervisor	Rio Hondo MHC
Rosas	Manuel	Mental Health Program Manager III	DMH
Rowe	Silvia	Mental Health Clinical Program Head	DMH
Ruiz	Amanda	Supervising Mental Health Psychiatrist	DMH
Saki	Evelina Panossian	Medical Case Worker II	DMH
Salcedo	Sandra	Clinician	ALMA
Serna	Javier	Mental Health Clinical Supervisor	DMH
Sherin	Jonathan	Director of Mental Health	DMH
Shonibare	LyNetta	Supervising Psychologist	DMH
Sierra	John Franklin	Senior Staff Analyst	DMH
Sierra	Erika	Supervisor	Comm. Family Guidance Center
Sou	Susana Ka Wai	Pharmacy Services Chief III	DMH
Steiner	Martina	Psychiatric Social Worker II	DMH
Taguchi	Kara	Mental Health Clinical Program Head	DMH
Tchakmakjian	Greg	Clinical Psychologist II	DMH
Theus	Chaka Khan	Psychiatric Social Worker II	DMH

Last Name	First Name	Position	Agency
Thomas	Geanna	Peer Employee	MHA
Tiscareno	Ruth	Parent Advocate	DMH
Tiscareno	Ruth	Community Health Worker	SA 7 Administration
Torok	Veronica	Community Health Worker	Rio Hondo MHC
Tovey	Wendi	Mental Health Program Manager III	DMH
Tran	Kristina	Supervisor	The Whole Child
Tredinnick	Michael	Mental Health Program Manager III	DMH
Trenado	Angela	Mental Health Clinical Supervisor	DMH
Tse	Yuchai	Mental Health Clinical Supervisor	Rio Hondo MHC
Tunks	Andrew	CIOB	DMH
Valdez	Julie	Mental Health Program Manager III	DMH
Vasquez Lopez	Alisandra	CW Therapist	SAFC
Velasco-Vidana	Lucero	Clinician	ALMA
Vielle	Keith	Substance Abuse Counselor	AICC
Walker	Sean-Paul	Mental Health Clinician I	AICC
Wherry	Judy Porter	Health Program Analyst II	DMH
Willock	Yvette	(CalAIM specialist speaker)	DMH
Wong	Lisa	Senior Deputy Director	DMH
Yoon	Joon	Administrative Services Manager III	DMH
Zamora	Alisa Aslanyan	Mental Health Clinical Supervisor	DMH
Zavala	Melissa	Peer Employee	Penny Lane
Zuniga	Casey	Supervisor	Penny Lane

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☐ →Moderate confidence ☒ →Low confidence ☐ →No confidence	The results were mixed, with some elements showing consistent positive changes and others reflecting inconsistencies. Based on literature this PIP should have experienced consistent positive results, but perhaps due to COVID-19 impacts on interventions and staff participation results are much less than anticipated.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: LACDMH	
PIP Title: Clinical - Improving the Use of MAT for Consumers with Co-Occurring Mental Health Disorders and Substance Use (COD)	
PIP Aim Statement: The provision of MAT and interdisciplinary treatment groups, as well as staff training and a peer mentoring network, will result in a five percent increase in the percent of consumers with AUDs receiving MAT (from 7 percent to 12 percent) out of those consumers diagnosed with an AUD and a five percent increase in the percent of consumers with OUDs receiving MAT (from 5 percent to 10 percent) out of those consumers diagnosed with an OUD from CY 2020 to CY 2021. The use of MAT will also result in a five percent decrease in the 30-day rehospitalization rates for consumers that receive any MAT medication (from 16.7 percent to 11.7 percent) from FY 20-21 Quarter 2 to Quarter 4. In addition, the interdisciplinary treatment groups and MAT will result in a thirty percent reduction in mood (from 4.3/10 to 3/10), anxiety (from 6.6/10 to 4.6/10), and substance use impact (from 3.3/10 to 0/10) ratings from the first weekly measurement to the most recent weekly measurement for those consumers receiving both interventions.	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☒ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one):	

☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children

*If PIP uses different age threshold for children, specify age range here:

Target population description, such as specific diagnosis (please specify): Individuals with mental health and COD conditions, specifically OUDs and AUDs.

Improvement Strategies or Interventions (Changes in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Provision of MAT for AUD and OUD disorders; and Interg8Recovery groups

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
X-Waiver training for prescribers, and a mentorship program to support MAT use.

MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
The MHP has targeted the improvement of treatment for individuals with co-occurring conditions, such as OUD and AUD, with low-threshold access as priority, and including the use of support groups, MAT, and system changes to lower barriers to prescribing agents that require an X-waiver.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Consumers with AUDs receiving MAT for AUD Goal: Increase by 5%	(Q2 FY 20-21)	221/3,669 = 6.0%	☒ Not applicable—PIP is in Planning or implementation phase, results not available (Q4 FY 20-21)	289/3,939 = 7.3%	☒ Yes ☐ No +1.3% PP	☒ Yes ☐ No Specify P-value: .00 ☐ <.01 ☐ <.05 Other (specify): n/a

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Consumers with OUDs receiving MAT for OUD Goal: Increase by 5%	(Q2 FY 20-21)	36/551 = 6.5%	☐ Not applicable—PIP is in Planning or implementation phase, results not available (Q4 FY 20-21)	40/606 = 6.6%	☒ Yes ☐ No + 0.1`% PP	☒ Yes ☐ No Specify P-value: .00 ☐ <.01 ☐ <.05 Other (specify): n/a
30-day rehospitalization rates Goal: Reduce by 5%	(Q2 FY 20-21)	5/30 = 16.7%	☐ Not applicable—PIP is in Planning or implementation phase, results not available (Q4 FY 20-21)	2/28 = 10.7%	☒ Yes ☐ No -6.0 % PP	☐ Yes ☒ No Specify P-value: .62 ☐ <.01 ☐ <.05 Other (specify): n/a
Weekly Check-In **Depressed mood ratings** (For all scales, 10 is worst)	n/a	Week 1 Depressed mood: 4.3/10	☒ Not applicable—PIP is in Planning or implementation phase, results not available	Week 8: Depressed mood: 3/10	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: 0.88 ☐ <.01 ☐ <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Goal: Reduce by 30%			(Q4 FY 20-21)			n/a
Weekly Check-In **Anxiety ratings** (For all scales, 10 is worst) Goal: Reduce by 30%	n/a	Week 1 Anxiety: 6.6/10	☒ Not applicable—PIP is in Planning or implementation phase, results not available (Q4 FY 20-21)	Week 8: Anxiety: 7/10	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: 0.81 ☐ <.01 ☐ <.05 Other (specify): n/a
Weekly Check-In **substance use impact ratings** (For all scales, 10 is worst) Goal: Reduce by 30%	n/a	Week 1 Substance Use Impact: 3.3/10	☒ Not applicable—PIP is in Planning or implementation phase, results not available (Q4 FY 20-21)	Week 8: Substance Use Impact: 0/10	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: 0.08 ☐ <.01 ☐ <.05 Other (specify): n/a
PIP Validation Information						

Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. The increases in MAT were quite small, with only the AUD having a significantly large base population. The OUD population was at the second and most recent remeasurement N=606 and percentages receiving MAT showed little change, most recently 6.6 percent. Rehospitalization rates varied some but went from 16.7 percent at baseline to 10.7 percent at second remeasurement, with very small total N. The substance use measure showed consistent over time improvement. The MHP reports COVID-19 impacting both the extent of COD group treatment expansion and availability of staff to support the process.
EQRO recommendations for improvement of PIP: This PIP will receive final data remeasurement in February 2022, and will end at that point. The impacts of COVID-19 have limited to extent this PIP could be operationalized. Efforts to continue to increase use of MAT will occur but not as a PIP.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☒ →High confidence ☐ →Moderate confidence ☐ →Low confidence	This PIP targeted an area where the MHP had experienced challenges in both tracking and improving timeliness. The approach involved cohorts of

☐ →No confidence	providers, both DO and C/LE, and developed a system for recording improvement strategies and results.

General PIP Information
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: LACDMH
PIP Title: Non-Clinical - Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected
PIP Aim Statement: Will providers with timely appointment rates at 69 percent and below develop and implement improvement strategies targeting staffing shortages, intake and referral challenges, or other challenges to timely access successfully meet 80 percent of their consumers' requests for an initial routine outpatient specialty mental health services appointment within six months?
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): The study population includes DO and LE/Contracted providers with greater than five referrals and timely appointments falling in the 69 percent and below range at three data collection points between May 2020 and December 2020.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Interventions targeted initial non-urgent appointments, and utilized provider coaching in the identification and development of specific timeliness improvement strategies that were tailored to provider circumstances.

MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
Monitoring of timeliness and communication with providers experiencing challenges in a structured manner was a new approach for this MHP. The development of an Access to Care Committee at the highest level provides additional leadership monitoring and attention to under-performing areas.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Pre/post survey provider timeliness ratings	**2021**	20 providers	2021 ☐ Not applicable—PIP is in Planning or implementation phase, results not available	20 providers	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: Paired T-test, 0.4 ☐ <.01 ☒ <.05 Other (specify):
69% and below Timeliness Provider **Cohort A (N=17)**	**2020**	17 providers 49.7%	2021 ☐ Not applicable—PIP is in Planning or implementation phase, results not available	16 Providers 89.7%	☒ Yes ☐ No +40 PP	☒ Yes ☐ No Specify P-value: Mauchly's Test of Sphericity, 0.022 ☐ <.01 ☒ <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
69% and below Timeliness Provider **Cohort B (N=16)**	**2020**	16 providers 49.0%	2021 ☐ Not applicable—PIP is in Planning or implementation phase, results not available	16 Providers 81.2%	☒ Yes ☐ No +32.2 PP	☒ Yes ☐ No Specify P-value: Mauchly's Test of Sphericity, 0.013 ☐ <.01 ☒ <.05 Other (specify):
69% and below Timeliness Provider **Cohort C (N=17)**	**2020**	17 providers 50.9%	2021 ☐ Not applicable—PIP is in Planning or implementation phase, results not available	15 Providers 81.6%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: Mauchly's Test of Sphericity, not enough measurement data for a test. ☐ <.01 ☒ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☒ Other (specify):

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

This PIP has produced improvements in initial timeliness, and programs seemed to have greatest success with site specific work strategies of either workflow or administrative changes. The MHP now has a system in place that can provide recommendations of practice changes to other programs that demonstrate challenges in this area which include a menu of established effective strategies. Program self-report was validated by system timeliness data reporting. This PIP has influenced the development of a learning collaborative for SA-2 focused on child service providers and helping them develop improved timeliness, capacity and staff well-being. Attention to this area is also perpetuated by the Access to Care Committee which monitors system trends and capacity issues.

EQRO recommendations for improvement of PIP: This PIP has achieved the intended goals. The timeliness focus and work with under-performing programs for initial access will be continued as part of ongoing QI/QA practices. The MHP may wish to shift attention to first psychiatry/prescriber appointment timeliness which merits attention, and also requires improvement to the event capture process.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CY 2020 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	3,835,638	155,154	4.05%	$934,903,862	$6,026
Large	1,859,411	68,297	3.67%	$419,802,216	$6,147
MHP	1,235,310	57,934	4.69%	$315,468,609	$5,445

Table D2: CY 2020 Distribution of Beneficiaries by ACB Range

Los Angeles MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
<$20K	197,981	93.27%	92.22%	$904,280,869	$4,568	$4,399	63.13%	56.70%
>$20K-$30K	123	4.56%	3.71%	$3,020,783	$24,559	$24,274	13.54%	12.59%
>$30K	7,058	3.32%	4.07%	$352,029,368	$49,877	$53,969	24.58%	30.70%

Table D3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Los Angeles MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
JAN20	537,154	$123,915,821	12,166	$3,168,260	2.56%	$120,747,561	$114,158,645
FEB20	512,947	$120,025,277	11,597	$3,278,952	2.73%	$116,746,325	$110,160,904
MAR20	588,023	$116,496,526	13,391	$3,230,336	2.77%	$113,266,190	$107,487,745
APR20	662,201	$120,315,413	15,088	$3,212,182	2.67%	$117,103,231	$113,452,445
MAY20	591,172	$111,906,569	14,896	$3,139,924	2.81%	$108,766,645	$105,332,847
JUN20	583,202	$112,060,571	14,790	$3,084,122	2.75%	$108,976,449	$105,660,428
JUL20	609,538	$122,509,818	18,508	$3,929,756	3.21%	$118,580,062	$114,295,321
AUG20	575,302	$117,045,413	18,294	$4,054,129	3.46%	$112,991,284	$108,632,409
SEP20	590,082	$121,942,423	18,653	$4,224,314	3.46%	$117,718,109	$113,108,895
OCT20	597,536	$123,338,746	18,605	$3,934,031	3.19%	$119,404,715	$115,002,166
NOV20	504,534	$104,521,030	14,686	$3,201,842	3.06%	$101,319,188	$97,639,302
DEC20	512,722	$105,438,869	14,322	$3,116,439	2.96%	$102,322,430	$98,906,753
TOTAL	**6,864,413**	**$1,399,516,478**	**184,996**	**$41,574,287**	**2.97%**	**$1,357,942,191**	**$1,303,837,860**

Includes services provided during CY 2020 with the most recent DHCS claim processing date of July 30th, 2021. Only reports Short-Doyle Medi-Cal claim transactions and does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2020 was 3.19 percent.

Table D4: Summary of CY 2020 Top Five Reasons for Claim Denial

Los Angeles MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	74,181	$17,259,306	42%
Beneficiary not eligible or non-covered charges	35,807	$7,978,974	19%
Medicare Part B or Other Health Coverage must be billed before submission of claim	28,326	$6,930,557	17%
Service line is a duplicate and a repeat service procedure code modifier not present	26,437	$4,409,687	11%
Beneficiary not eligible	14,170	$3,681,108	9%
TOTAL	**178,921**	**$40,259,632**	**97%**