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FY 2022-23
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:

October 17-21, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Los Angeles" may be used to identify the Los Angeles County MHP, unless otherwise indicated. Due to the Very Large scale of the Los Angeles MHP, each year this review focuses upon two of eight Service Areas (SA), as well as providing an overview of countywide data and issues. For this FY 2022-23 EQR, SA-3 (San Gabriel) and SA-4 (Metro Los Angeles), were identified as the key areas for the review.

MHP INFORMATION

Review Type — Virtual

Date of Review — October 17-21, 2022

MHP Size — Very Large

MHP Region — Los Angeles

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	1	5	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	3	3	0
Quality of Care	10	5	5	0
Information Systems (IS)	6	6	0	0
TOTAL	**26**	**18**	**8**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improving Treatment Services for Individuals with Eating Disorders	Clinical	06/21	Other: Fourth Remeasurement	Low
Improving Referral Management and Efficiency Through an Online Provider Directory	Non-Clinical	09/21	Other: Completed	Low

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	4
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	1*
3	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	4
4	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	2*
* The sessions with fewer than 3 participants, the feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Vision and execution of significant countywide program improvements in both intensive services and recovery-oriented programs, including Hollywood 2.0 and Peer Resource Centers (PRC).
- First offered non-urgent services for adults, the highest demand area, significantly betters the 10-business day standard.
- The pilot Therapeutic Transportation (TT) program in downtown Los Angeles provides transportation of those in need of acute care by a team of mental health trained individuals, including a peer, and unburdens the emergency medical system response system from non-medical transports.
- The Information Technology (IT) strategic plan is well conceptualized and documented, aligning with organizational goals, in a secure, interoperable environment.
- The MHP acknowledges the importance of a personal health record (PHR) and has plans to increase users and perform upgrades to the existing application.

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

- Continued low numbers of some reported timeliness metrics, particularly first offered non-urgent psychiatry events, suggests that the MHP efforts to improve the comprehensiveness and accuracy continues to be a work in progress.
- The MHP's process of selecting and implementing a universally utilized adult level of care (LOC) tool is incomplete as of this review.
- Consistent with the prior review, the MHP's adult 30-day rehospitalization rate derived from the Assessment of Timely Access (ATA) submission, remains at 30.18 percent, essentially the same as the previous review.
- Significant stakeholder feedback indicates a frequent significant delay between assessment completion and access to psycho-social therapy, an apparent capacity issue that is also reflected frequently in reported long intervals between treatment sessions.
- Directly-Operated (DO) program beneficiaries have access to a PHR "Just4Me", which has the potential to enhance communication between programs and those served; however, it is not tracked which of the contract/legal entity (C/LE) programs offer similar access.

Recommendations for improvement based upon this review include:

- Continue MHP efforts to improve both comprehensiveness and accuracy of the tracked timeliness elements, with particular focus upon C/LE programs.
- Select, pilot, and implement a systemwide LOC tool for adults.
- Develop and implement a systemwide strategy to reduce the 7/30-day rehospitalization rates, emphasizing adult beneficiaries.
- Develop and implement an ongoing systemwide feedback system accessible to both DO and C/LE programs that provides MHP leadership with line staff and supervisor direct input on critical issues.
- Develop program reporting functionality that captures the time between assessment and treatment services, as well as frequency of clinical services.
- Develop and report on the availability of PHR functionality for those served by C/LE programs and consider development of standard threshold level of services at which PHR availability is expected of C/LE providers.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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 [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2022-23 findings of the EQR for Los Angeles County MHP by BHC, conducted as a virtual review on October 17-21, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to 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, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File; Short-Doyle/Medi-Cal (SDMC) approved claims; and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening Diagnosis and Treatment, FC, transitional age youth, and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results 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, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated 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 (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP experienced loss of staff, and a stringent hiring freeze. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges; however, there were difficulties with two of the four consumer focus groups having adequate participation.

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.

- Los Angeles County Department of Mental Health (LACDMH) experienced a change of departmental leadership in the roles of Director and Chief Deputy Director. This was followed by the appointment of an Acting Director and an Acting Chief Deputy.
- Hiring of a Director of Human Resources has resulted in a renewed HR process and the development of innovative recruitment and retention efforts. An area of emphasis has been the filling of Alternative Crisis Response (ACR) and full-service partnership vacancies, critical to the support of mobile teams and intensive services.
- The MHP has focused efforts on the development of Restorative Care Villages at four County healthcare campuses that support integrated direct care services including physical health, behavioral health, housing, social, and other wraparound services. The four campuses are located at: Olive View in the San Fernando Valley, Rancho Los Amigos in the City of Downey, Los Angeles County/University of Southern California in the Boyle Heights neighborhood, and on the Martin Luther King Campus.
- Hollywood 2.0 is a pilot, updated version of the Trieste project, inspired by the human-centered, hospitality-oriented approach to recovery developed in the Trieste area of Italy. Extensive reliance upon field-based services is a hallmark of this approach. Strong integration with community services, including housing and treatment resources, are envisioned to engage and serve the significant homeless population in this area of Los Angeles County.
- The ACR Office is a division created to provide 24/7 services to individuals in crisis and is comprised of a network of DO and C/LE programs. This is associated with an expansion of crisis stabilization units and urgent care centers,

which are also critical to those who experience crisis events. Integration with the 988 Call Center is a key centerpiece of ACR functionality.

- The MHP has launched new PRCs in SAs 2, 4, and 7, with another soon to come online in SA-6.
- SA-specific microsites have been developed to highlight resources specific to the SAs. Access can be done through QR code scanning with smartphones.
- The Emergency Outreach and Triage Division (EOTD), developed 24/7 capacity to resolve crises in the communities, ensuring resources are available in a timely manner. This includes the addition of peer staff to the Psychiatric Mobile Response Teams.
- The Therapeutic Transportation (TT) Program brings LACDMH psychiatric nursing personnel and other staff into emergency response to 911 calls that go straight to fire or police departments, integration with four programs.
- Starting in FY 2020-21, the School-Based Community Access Point (SBCAP) team shifted to the provision of virtual prevention workshops through partnership with the Department of Public Health Wellbeing Center sites. In FY 2021-22, SBCAP created additional workshops that included a parent/caregiver version and partnering with the School Threat Assessment and Response Team to provide virtual awareness workshops for school staff.
- Other critical additions included participation as the lead agency in the Veterans Suicide Review Team which is intended to identify factors and reduce the incidence of suicide among this high-risk population. Re-entry services for justice involved individuals, and changes related to the SB 317 Misdemeanor Incompetent to Stand Trial have also been the focus of MHP improvement efforts during the review period.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 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 2021-22

Recommendation 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 Urgent Care Centers (UCC) 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.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has addressed the challenges of recruitment and retention of prescribers through numerous strategies, including the utilization of the MH Deployment Workgroup to review and target placement of newly hired medical staff; telepsychiatry; collaboration with a university psychiatry residency program; loan forgiveness; hiring and relocation bonuses; flexible work schedules; standardized appointment time parameters; and the addition of nurse practitioners to augment prescriber coverage.
- Recruitment and hiring efforts were suspended during the April 2020 COVID-19 hiring freeze; although in winter 2020 and spring 2021 two rounds of hiring for critical clinical and administrative positions did occur. The freeze lifted in October 2021, and the department immediately started efforts to recruit for and fill vacancies.
- The Human Resources (HR) Director position was recently filled after being vacant for several years. Efforts to innovate recruitment and retention are moving ahead. Filling the other HR division vacancies should help expedite hiring processes.

- The department has emphasized hiring that supports staffing the ACR division's critical mobile co-response teams and the TT pilot with the City of Los Angeles.

Recommendation 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has developed a tracking mechanism for post-assessment psychiatry referral timelines tracking and is in the process of full implementation. Historically, the MHP has not tracked psychiatry referrals when determined during the clinical assessment. During staff sessions, reports of the first psychiatric appointment was often cited taking as long as two to three months. The use of urgent care centers remains a necessary option for those who need immediate medications, including those on long-acting injectables.
- In that the results of full implementation of this improved first offered non-urgent psychiatry service have yet to result in the anticipated improvement, this recommendation will be carried over for the FY 2020-23 review.

Recommendation 3: Develop a SB 1291 FC child/youth Healthcare Effectiveness Data and Information Set (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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- In Los Angeles County, the majority of children's services and particularly FC are provided by contract agencies. In that these entities typically utilize unique electronic health records (EHR) and e-prescribing platforms, MHP visibility into prescribing and other trends is not directly feasible. For the FY 2021-22 period, the MHP lead an effort to collect HEDIS measure data from its C/LE programs. HEDIS measure data was submitted by 14 C/LE's.
- Due to the challenges in obtaining the full FC prescribing dataset from C/LE's, a sampling approach was utilized. The numbers of cases reviewed are much lower than actual prescribing rates; however, of the case sampling reviews most measures are 100 percent in compliance. The MHP noted that Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) was an area in which as an area targeted for improvement due to only 13 percent of applicable cases reviewed demonstrating the required monitoring.

- The MHP intends to continue making improvements in the scope of SB 1291 HEDIS measure monitoring, but until it is able to fully access the prescribing of its C/LE providers this tracking will continue to be reliant upon the peer review sampling process. Since access to prescribing of C/LE entities is not within the MHP's control, the formal recommendation is ended despite the inability to perform a complete review of FC prescribing. The access to all prescribing for beneficiaries has been suggested to be on the horizon with functionality to be provided by the state.

Recommendation 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP convened a specialty committee from the Access To Care Workgroup. As of August 25, 2022, the committee has reviewed two tools used in other counties. These tools are the Reaching Recovery instrument and the Milestones of Recovery plus the Determinant of Care tool. The MHP plans on using an instrument for pilot implementation based on a number of evaluative factors, from which an instrument will be selected.
- The MHP's process continues to move forward in the selection of an adult clinical outcome instrument. Considering the scale of this MHP, it is understandable the MHP will pilot an instrument before full adoption occurs. As such, this recommendation will be continued.

Recommendation 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP's public information officer and webmaster have discussed the development of a feedback/suggestion webpage. As well a survey was developed in Spring of 2022; however, implementation is on hold pending feedback from Dr. Lisa Wong, Acting Director.
- From the prior review, the need for a mechanism for communicating directly to leadership was underscored. While the MHP has been able to identify interventions, implementation has not yet occurred. This recommendation will be continued for the FY 2022-23 cycle.

Recommendation 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP began activities to create a centralized scheduling pilot for hospital discharges in early 2021. This pilot was focused on SA-3 and provided a dedicated number at the Access Center for an appointment within that same area for aftercare appointments. Technical issues resulted in delayed implementation of this pilot until 9/1/2022.
- The MHP is also leveraging the concurrent authorization team to alert hospitals of those patients that have at least 12 hospitalizations within a 12-month period or were hospitalized twice in one month. The concurrent team will also provide information about the most recent or current outpatient program involvement and assist with discharge planning. Enhanced Case Management (ECM) is also applied to connect with additional resources, such as housing and providing warm handoff to the next level of care.
- Adults comprise 95 percent of all readmissions, similar to the previous review, and experience a 7-day readmission rate of`5.71 percent, with the 30-day rate of 30.18 percent. These data points are similar to the FY 2021-22 results. With the delayed start of the MHP's pilot, this recommendation will be continued for this current review period.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or 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.[1] 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 PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 22 percent of services were delivered by county-operated/staffed clinics and sites, and 78 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 87 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: FC system, self-presentation at MHP/contractor clinic sites. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries are linked to programs that are currently listed as possessing capacity to treat; county-operated programs do not have a specific capacity limit, but efforts are made to distribute requests for services across all available regional clinics. The access team screens based on acuity of need and age of beneficiary.

In addition to clinic-based MH services, the MHP provides psychiatry and/or MH services via telehealth video/phone to youth and/or adults. In FY 2021-22, the MHP reports having provided telehealth services to 32,822 adult beneficiaries, 57,219 youth beneficiaries, and 4,275 older adult beneficiaries across 99 county-operated sites and 625 contractor-operated sites. Among those served, 3,543 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Los Angeles County, the time and distance requirements are 15 miles and 30 minutes 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).

Table 1A: MHP Alternative Access Standards, FY 2021-22

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

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

Table 1B: MHP OON, FY 2021-22 {see NA Form EQRO Section III}

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No

- Because the MHP can 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.

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 2: Access Key Components

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

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

- 1B: The MHP's collaboration and significant engagement with community partners to improve access to care is impressive, with 78 percent of all Medi-Cal services delivered by C/LE agencies. In addition, partnering with law enforcement is evident in the Law Enforcement Teams, which include a clinician who works in tandem with a law enforcement officer. The TT teams work in concert with the LA Fire Department, to assist with transportation of individuals in need of acute care. The partnership with the housing authority and various specialized housing programs involves cross-agency communication and coordination. What does CalAIM mean?
- California Advancing and Innovating Medi-Cal (CalAIM) screening and transition protocols have the MHP increasing its collaboration with local managed care plans, particularly significant in the area of bidirectional referrals and beneficiary transitions between agencies as their needs change. One of the MHP's strengths is that it does not attempt to meet all needs only through DO programs, but also recognizes and works with the strengths of other agencies.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served

(receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) 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. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the PR is over 20 percent higher than other large counties and the statewide rate.

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

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	4,156,251	193,049	4.64%	$1,116,146,422	$6,256
CY 2020	3,866,435	212,272	5.49%	$1,432,306,133	$5,782
CY 2019	3,843,353	221,136	5.75%	$1,383,504,729	$6,748

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Statewide Penetration Rate
Ages 0-5	363,747	10,078	2.77%	1.59%
Ages 6-17	877,130	61,000	6.95%	5.20%
Ages 18-20	208,344	10,077	4.84%	4.02%
Ages 21+	2,214,304	102,478	4.63%	4.07%
Ages 65+	492,728	9,416	1.91%	1.77%
TOTAL	**4,156,251**	**193,049**	**4.64%**	**3.85%**

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Arabic	109	0.06%
Armenian	1,339	0.70%
Cambodian	509	0.26%
Cantonese	603	0.31%
Farsi	545	0.28%
Korean	606	0.31%
Mandarin	566	0.29%
Russian	375	0.19%
Spanish	40,773	21.17%
Tagalog	133	0.07%
Vietnamese	567	0.29%
Total Threshold Languages	**46,125**	**23.95%**
Threshold language source: Open Data per BHIN 20-070		

- Nearly one in four MHP beneficiaries served speaks a threshold language.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	1,382,763	55,189	3.99%	$268,201,715	$4,860
Large	2,153,582	62,972	2.92%	$387,366,612	$6,151
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

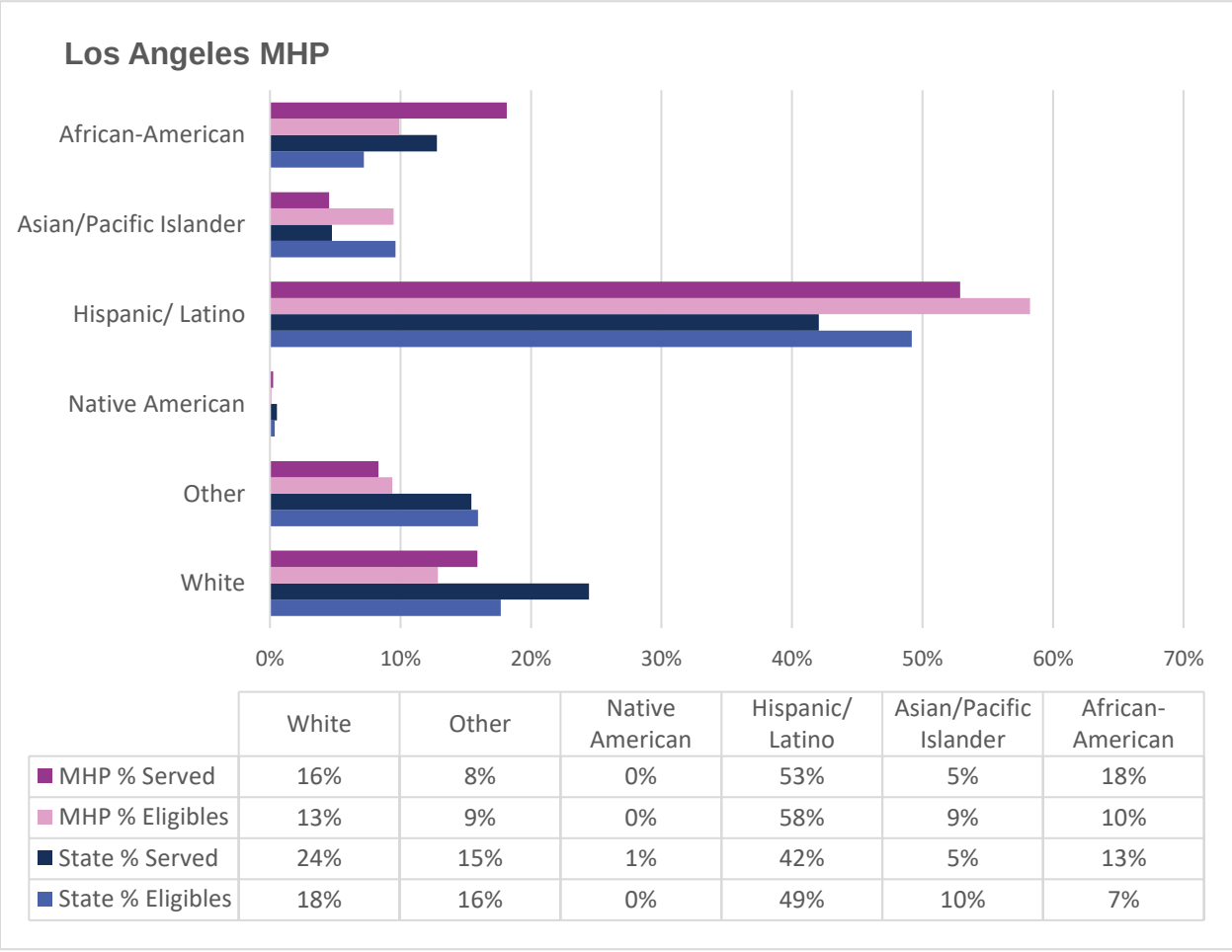
- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, the MHP's overall PR and AACB tend to be lower than non-ACA beneficiaries.
- ACA beneficiaries represent about one-third of the overall Medi-Cal population.

Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	# MHP Eligibles	# MHP Served	MHP PR	Statewide PR
African-American	411,535	35,016	8.51%	6.83%
Asian/Pacific Islander	394,088	8,736	2.22%	1.90%
Hispanic/Latino	2,420,000	102,080	4.22%	3.29%
Native American	5,349	475	8.88%	5.58%
Other	390,111	16,057	4.12%	3.72%
White	534,942	30,685	5.74%	5.32%
Total	**4,156,025**	**193,049**	**4.65%**	**3.85%**

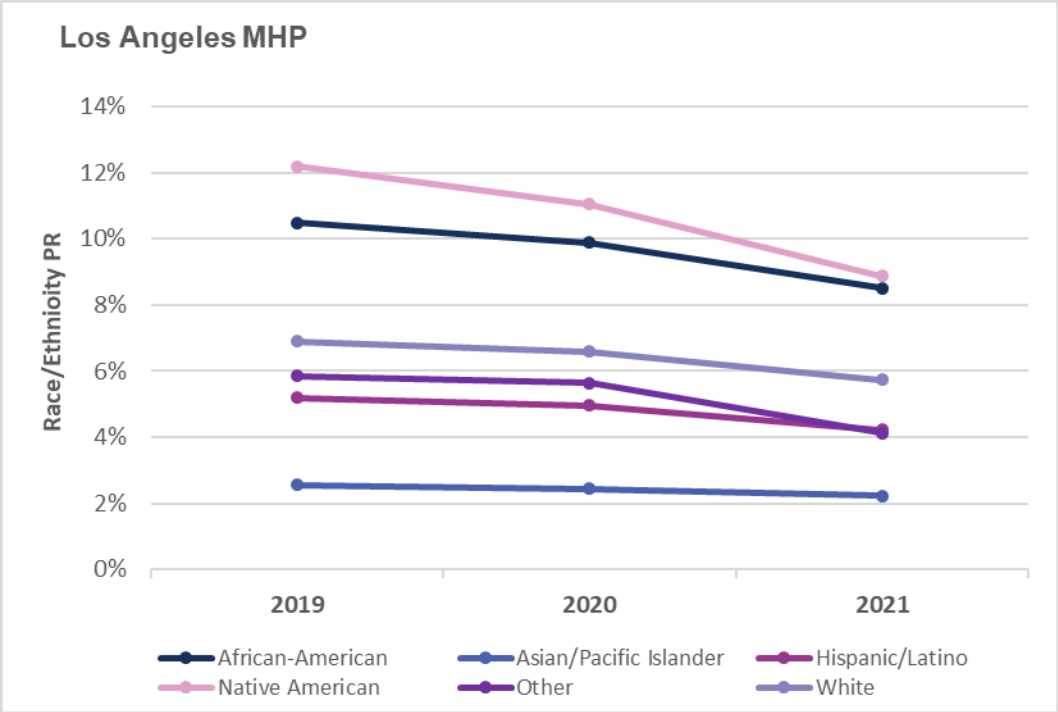
- The MHP's PR exceeds the statewide PR in all categories.

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021



	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	16%	8%	0%	53%	5%	18%
MHP % Eligibles	13%	9%	0%	58%	9%	10%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



- The PR has taken a downward trend in all race/ethnicity groups. The MHP's largest eligible population is the Hispanic/Latino population, and there is less of an access disparity at the MHP than across the state.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

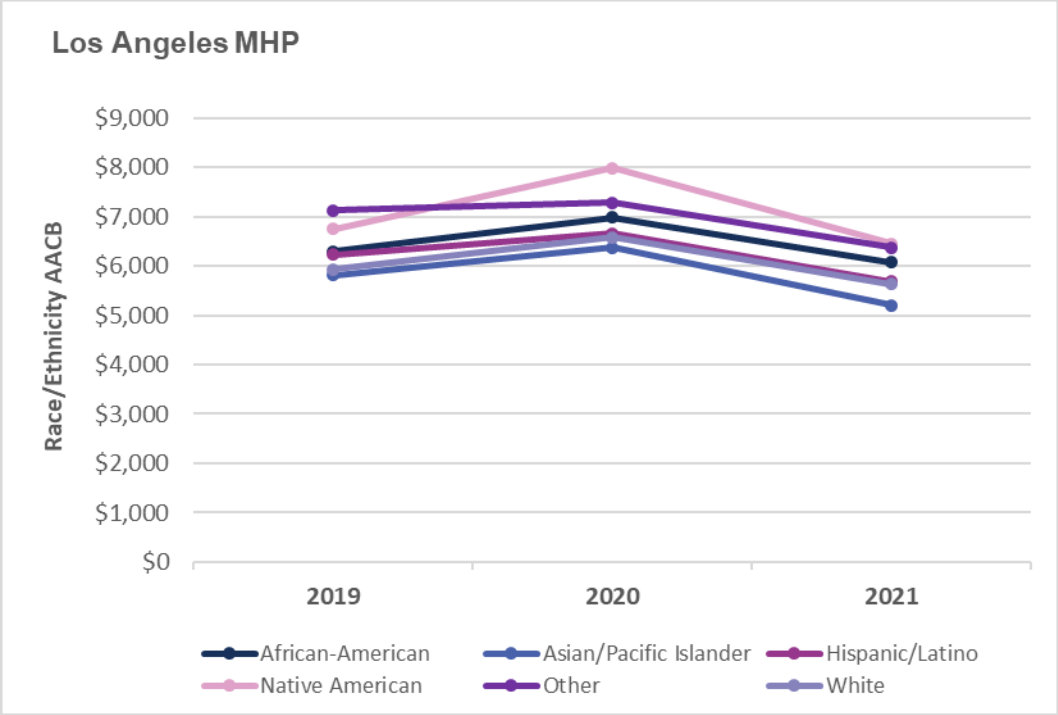
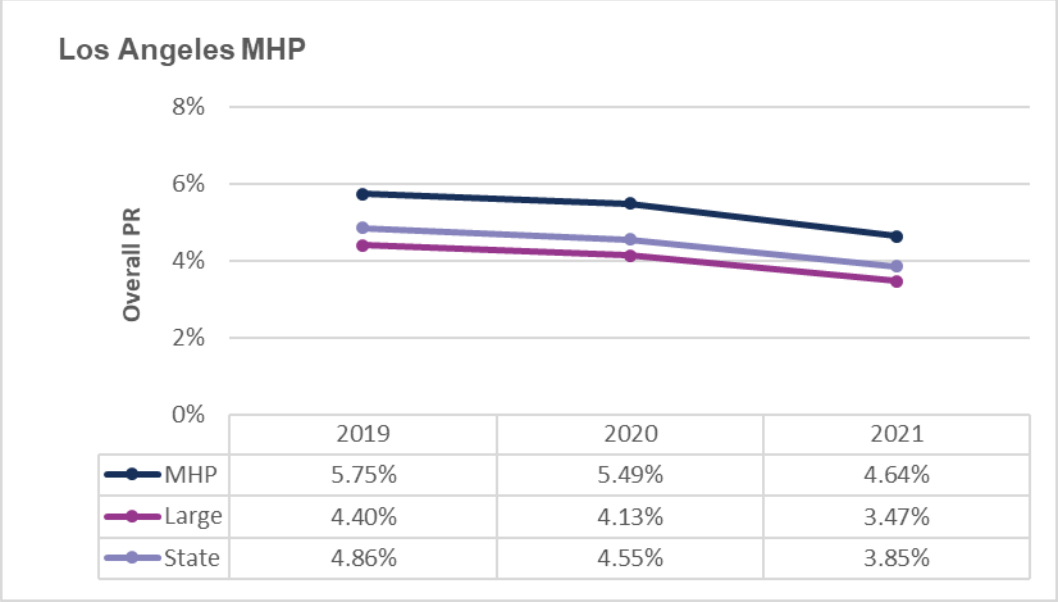


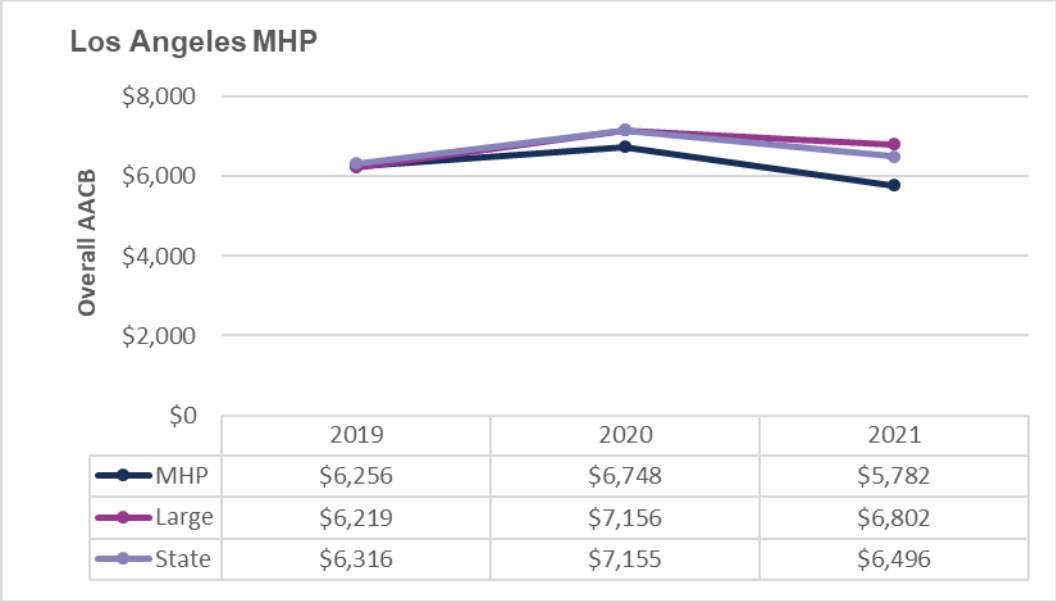
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	5.75%	5.49%	4.64%
Large	4.40%	4.13%	3.47%
State	4.86%	4.55%	3.85%

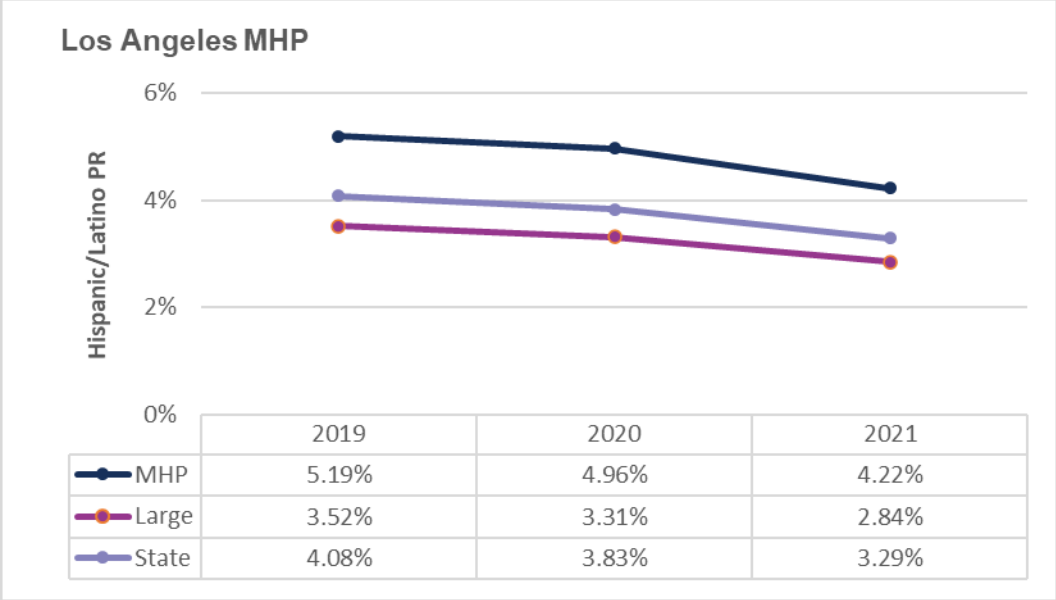
- The MHP has consistently had a higher PR during the last three years than other large counties and the statewide rate.

Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$6,256	$6,748	$5,782
Large	$6,219	$7,156	$6,802
State	$6,316	$7,155	$6,496

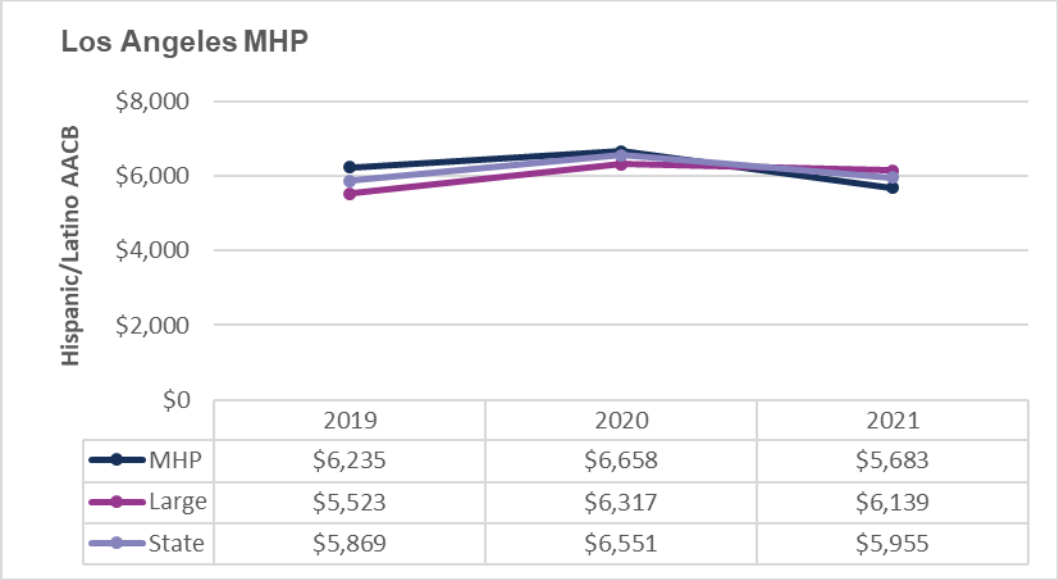
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	5.19%	4.96%	4.22%
Large	3.52%	3.31%	2.84%
State	4.08%	3.83%	3.29%

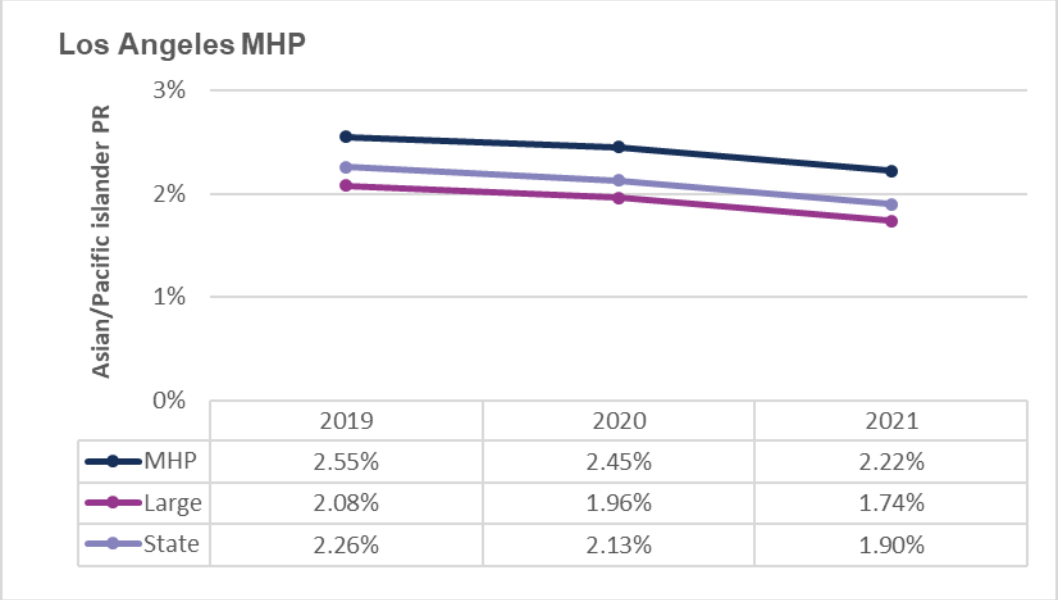
- The Latino/Hispanic PR has taken a downward trend during the last three years and remains consistent with both the large county and state PR; however, the MHP PR for this population is higher than the average large county and state PR.

Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$6,235	$6,658	$5,683
Large	$5,523	$6,317	$6,139
State	$5,869	$6,551	$5,955

Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.55%	2.45%	2.22%
Large	2.08%	1.96%	1.74%
State	2.26%	2.13%	1.90%

- The PR for the Asian/Pacific Islander population is trending downward since 2019, similar to the trend at other large counties and statewide; however, the MHP rate still exceeds both the large and state rates.

Figure 9: Asian/Pacific Islander AACB CY 2019-21

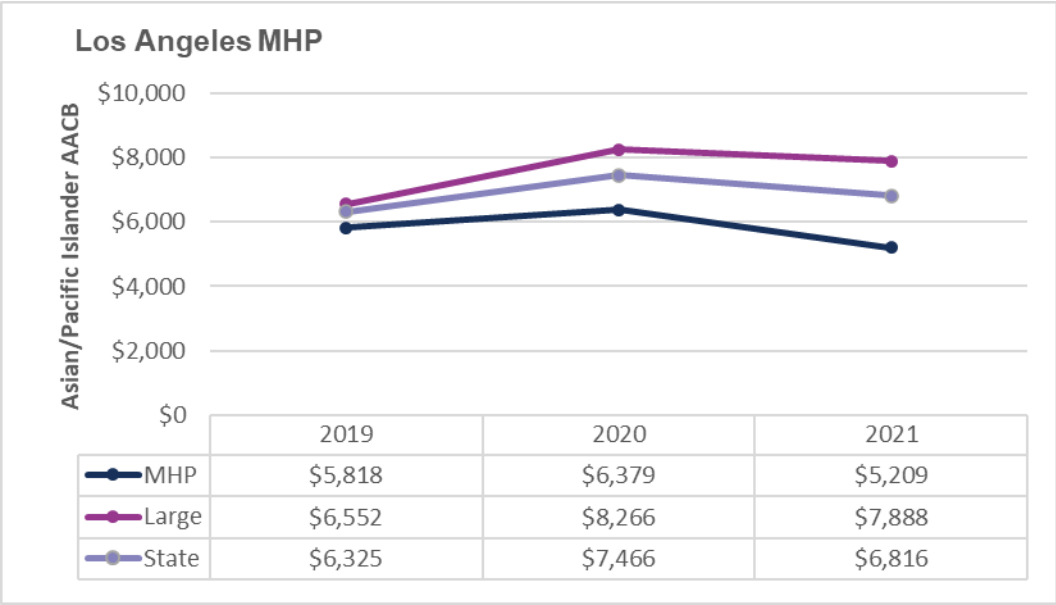
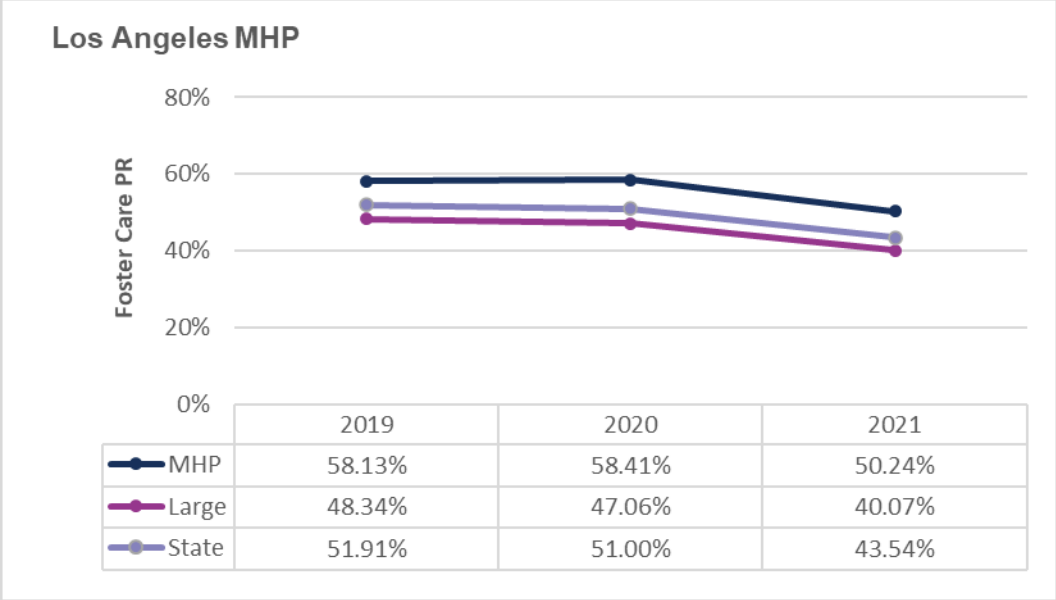
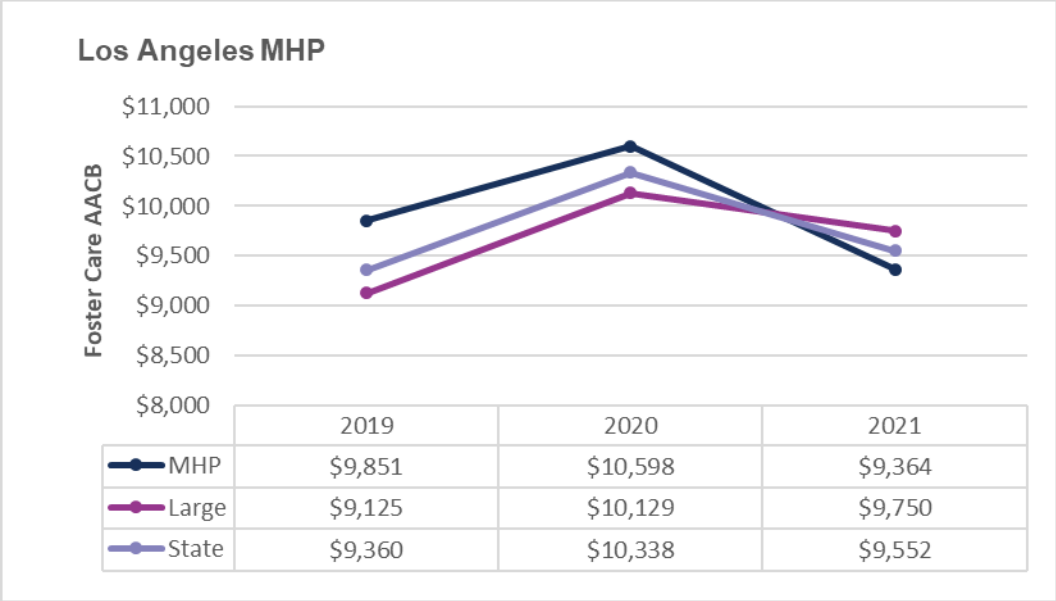


Figure 10: Foster Care PR CY 2019-21



- The MHP FC PR was stable between 2019 and 2020 but fell over 16 percent between 2020 and 2021. The downward trend is consistent with other large counties and the state.

Figure 11: Foster Care AACB CY 2019-21



Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 121,994				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	16,481	13.5%	17	10	10.8%	14	8
Inpatient Admin	95	0.1%	24	9	0.4%	16	7
Psychiatric Health Facility	215	0.2%	38	15	1.0%	16	8
Residential	50	0.0%	142	128	0.3%	93	73
Crisis Residential	508	0.4%	20	16	1.9%	20	14
Per Minute Services							
Crisis Stabilization	7,712	6.3%	986	780	9.7%	1,463	1,200
Crisis Intervention	11,483	9.4%	326	237	11.1%	240	150
Medication Support	75,388	61.8%	242	156	60.4%	255	165
Mental Health Services	79,607	65.3%	885	366	62.9%	763	334
Targeted Case Management	34,631	28.4%	424	133	35.7%	377	128

Table 9: Services Delivered by the MHP to Youth in Foster Care

Service Category	MHP N = 14,431				Statewide N=33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	679	4.7%	15	10	4.5%	13	8
Inpatient Admin	-	-	-	-	-	6	4
Psychiatric Health Facility	-	-	-	-	0.2%	25	9
Residential	-	-	-	-	-	140	140
Crisis Residential	-	-	-	-	0.1%	16	12
Full Day Intensive	48	0.3%	452	366	0.2%	452	360
Full Day Rehab	24	0.2%	95	57	0.4%	451	540
Per Minute Services							
Crisis Stabilization	218	1.5%	1,054	1,050	2.3%	1,354	1,200
Crisis Intervention	1,069	7.4%	501	270	6.7%	388	195
Medication Support	3,602	25.0%	390	260	28.5%	338	232
Therapeutic Behavioral Services	422	2.9%	4,394	2,618	3.8%	3,648	2,095
Therapeutic FC	-	-	-	-	0.1%	1,056	585
Intensive Home Based Services	4,926	34.1%	1,896	1,005	38.6%	1,193	445
Intensive Care Coordination	3,471	24.1%	2,335	1,510	19.9%	1,996	1,146
Katie-A-Like	-	-	-	-	0.2%	837	435
Mental Health Services	14,097	97.7%	1,727	1,188	95.7%	1,583	987
Targeted Case Management	3,308	22.9%	217	90	32.7%	308	114

IMPACT OF ACCESS FINDINGS

- Compared to the state, a smaller percentage of adult beneficiaries receive crisis intervention and Targeted Case Management (TCM) services but receive a higher number of units when these types of services are received. A higher percentage of beneficiaries receive Med Support and Mental Health Services than statewide but receive less units of service than statewide. A higher

percentage receive inpatient services, with the average number of units is 17 days compared to 14 days statewide.

- FC youth receive more units of service in almost all service categories when compared to statewide. The percentage of beneficiaries receiving TCM is less; however, 20 percent more FC youth receive Intensive Care Coordination services in LA than statewide. FC youth receiving inpatient services stay an average of two days longer than the statewide average. The numbers of youth served was much smaller than adults such that suppression rules were applied to Table 9.

TIMELINESS OF CARE

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 likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful in providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to 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 PMs section.

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Partially Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- 2A - The SA-3 and SA-4 consumer focus groups for this review reported generally brief intervals from first request to first offered and delivered appointment, mostly well within the 10 business-day standard. CalAIM changes in documentation requirements were cited by staff as improving the

intake/assessment process by reducing documentation time. Except for the adult services population (7.54 business-day average), the MHP was unable to meet the 10 business-day standard, with children's services (15.98 business-day average) and FC (15.85 business-day average). In addition, the overall achievement of standard was 71.11 percent, significantly lower than the FY 2021-22 overall average of 81.77 percent.

- 2B - First offered non-urgent psychiatry service is an area that has presents challenges for comprehensive data capture, and currently only includes those events associated with the beneficiary's first service request – not when determined during the clinical assessment or after. The MHP was able to report a total of 319 events for the FY 2021-22 review period (405 events were reported during the previous review). For C/LE providers, the Quality Assurance Unit has submitted a request to the Chief Information Office Bureau (CIOB) to add relevant fields that support the capture of timeliness information to the Service Request Log (SRL) webservice functionality. The reported data for psychiatry requests met the 15-business day standard for all populations with the exception of FC, which averaged 18.0 days.
- 2C - In the area of urgent services, the best performing population was with children's services, with an average of 163.93 hours, which is more than three times the 48-hour standard. The other populations experience a longer access time for urgent care.
- 2D - The MHP raises the bar for a post-hospital discharge follow-up standard, reducing the 7-day standard to an expectation of 5-business days. Stakeholder feedback during this review indicated broad awareness for this standard, and general success in meeting it.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), that represented timeliness to care during the 12-month period of FY 2021-22. This data represented the entire system of care. The 319 reported first-offered psychiatry appointments reported for the entire system suggests the MHP's efforts to improve reporting by C/LE and DO providers is important and well-focused. Stakeholder feedback indicated that the psychiatry access data reported could be optimistic, with many reporting delays of up to several months to obtain psychiatry access at the treatment provider of ongoing care. From intake until that time, beneficiaries may be referred to urgent care centers when medications need to be continued or started for those with an immediate need. Table 11 and Figures 12 – 14 display data submitted by the MHP; an analysis follows.

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

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	10.91 Days	10 Business Days*	71.11%
First Non-Urgent Service Rendered	9.54 Days	No Standard Set**	N/A%
First Non-Urgent Psychiatry Appointment Offered	11.83 Days	15 Business Days*	73.98%
First Non-Urgent Psychiatry Service Rendered	14.66 Days	No Standard Set**	N/A%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	179.97 Hours	48 Hours*	33.82%
Follow-Up Appointments after Psychiatric Hospitalization	4.97 Days	5 business days**	80.25%
No-Show Rate – Psychiatry	7.59%	No Standard Set**	n/a
No-Show Rate – Clinicians	6.70%	No Standard Set**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

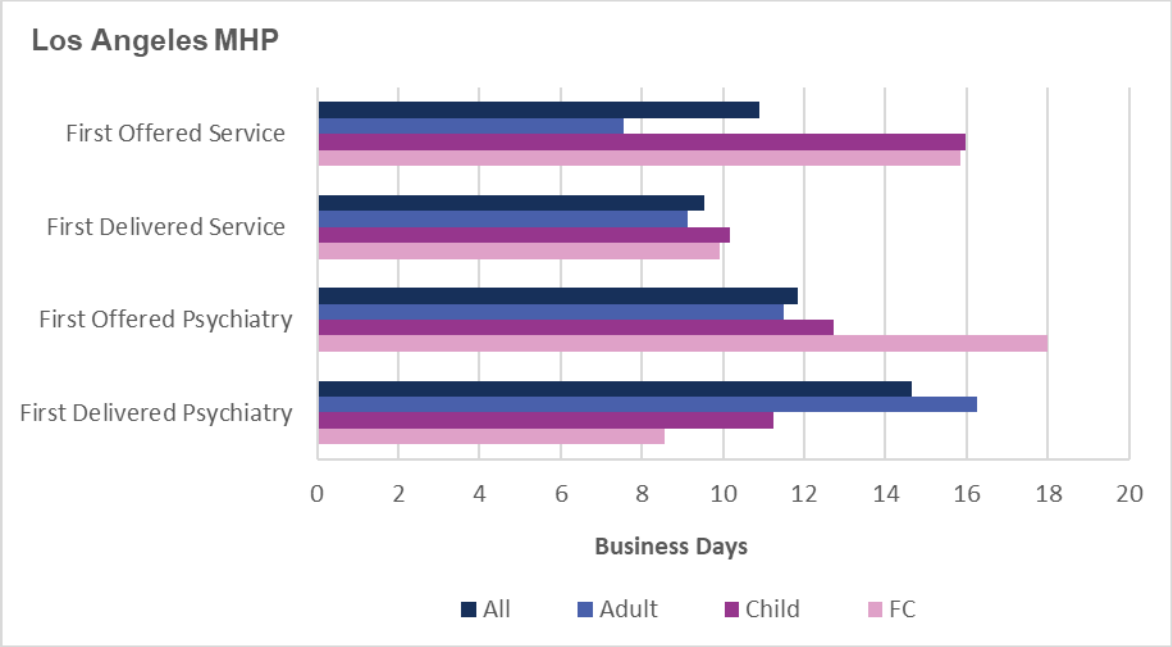


Figure 13: Wait Times for Urgent Services

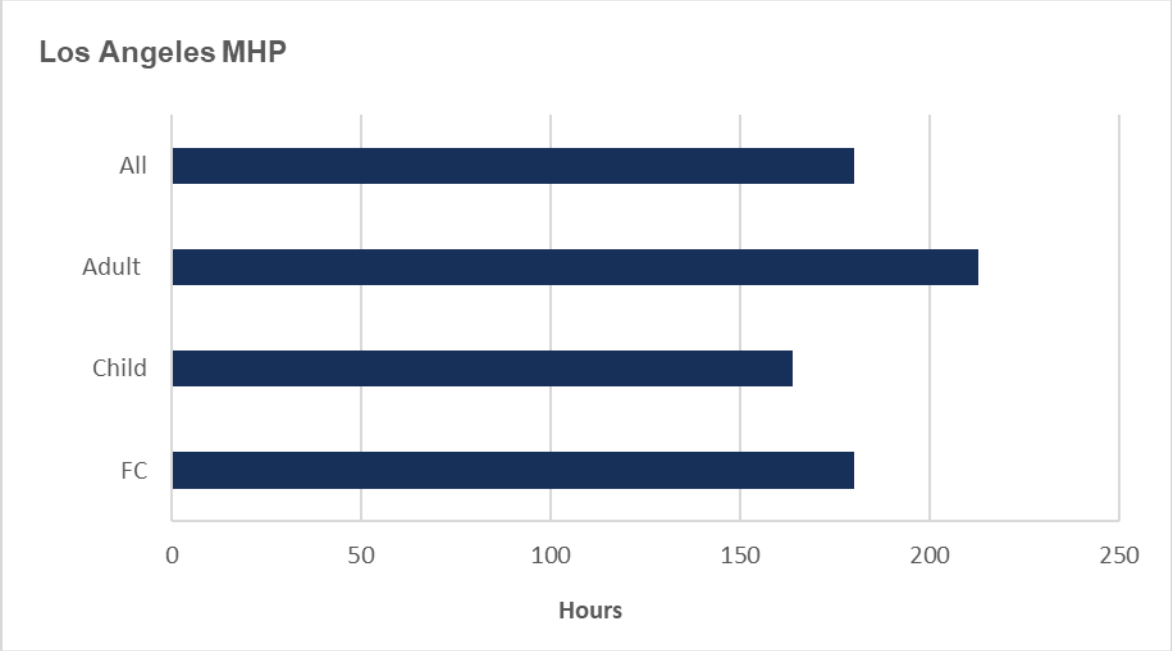
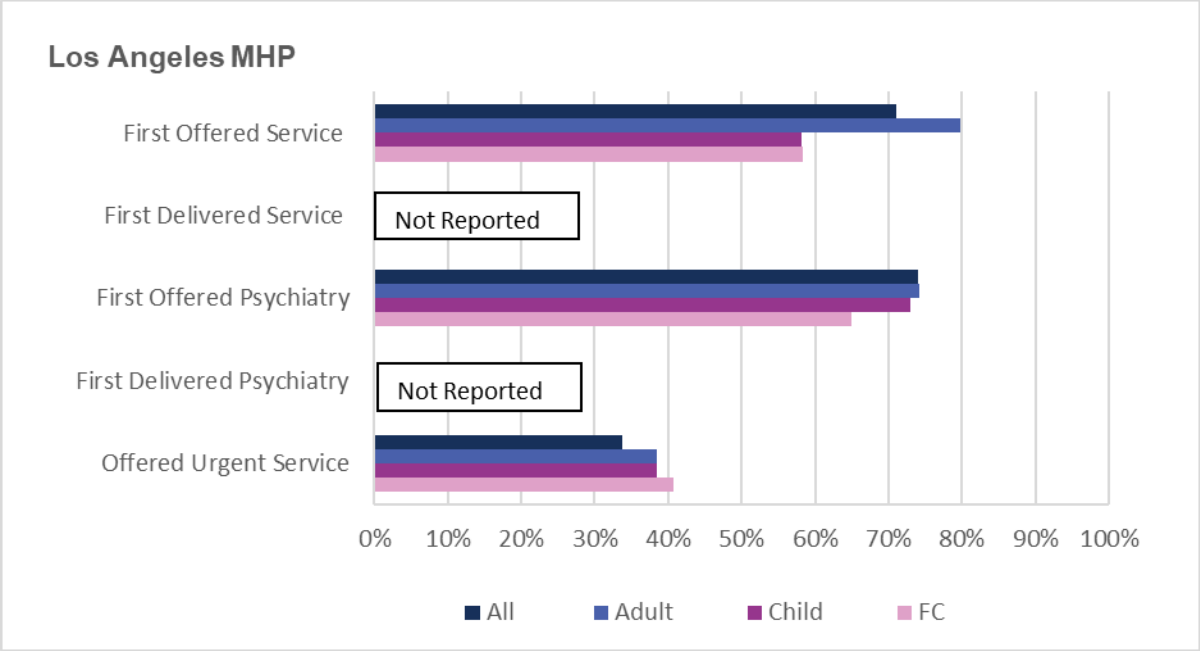


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments, and urgent unscheduled assessments.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined "urgent services" for purposes of the ATA as a "Service needed for potential client/client who may present with a condition or situation that, if not addressed, would be highly likely to result in an immediate emergency condition." There were reportedly 4,449 of urgent service requests with a reported actual average wait time for services for the overall population of 179.97 hours.
- While psychiatry services are expected to have a 15-day first offered standard, the tracking processes can be defined differently by counties and may differ for adults and children. The MHP has defined psychiatry access in the ATA submission as from the beneficiary's or caregiver's initial service request.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows represent a subset limited to DO programs, and excludes C/LE programs. The MHP reports a no-show rate of 7.87 percent for adult psychiatry, 3.25 percent for child psychiatry, and 2.71 percent for FC psychiatry; non-psychiatry practitioners

experience a no-show rate of 6.88 percent for adult services, 5.68 percent for children and youth services, and 2.71 percent for FC services.

IMPACT OF TIMELINESS FINDINGS

- Considering the scale of LACDMH MHP and the very high percentage of services provided by C/LE entities that use different EHRs, comprehensive and accurate timeliness data collection remains challenging. The MHP has initiatives intended to remedy these issues, but is a work in process, and impacts the ability to determine capacity accurately.
- From data on first offered and rendered requests and including stakeholder input from various sessions, it appears that the initial access to clinical services and assessment is rapid. Nothing was discovered in the course of this review that suggested anything to the contrary. However, access to a clinician/treatment provider following the assessment was consistently reported by stakeholders as taking as much as one month or more. It should be noted that the ATA timeliness data reporting does not contain an element for evaluating access to ongoing clinical treatment services.
- First offered psychiatry events appear few in number considering the MHP's very large scale. The overall 11.83 days reported for first offered psychiatric appointments and 14.66 days for first rendered appear quite rapid. However, this is contradicted by stakeholders familiar and involved with the process who often reported that frequently it may take up to two months to access a prescriber at an ongoing treatment program, unless one was experiencing an acute crisis. Referral to UCCs appears to continue to be the go-to solution at this time for those who require rapid psychiatry services during wait time for psychiatry/prescribers at high-demand, ongoing treatment clinics. From past reviews, the use of UCCs can be experienced as disruptive which impacts beneficiary engagement and retention, because prescribers may change, and medications may also be changed. In addition, beneficiaries must re-tell the history of their illness, which for some may be re-traumatizing. This appears to reflect continued challenges with the adequacy of prescriber staffing, despite the numerous improvement efforts enumerated by the MHP during the past year in the response to recommendations section of this report.
- Post-hospital discharge 7-day follow-up is reported as 80.25 percent overall, and at 30-days 96.64 percent. A companion metric to post-hospital follow-up is the 7-and 30-day readmission rates, which overall is 13.96 and 27.44 percent, respectively. The greatest number of hospitalizations and area of highest readmissions remains in the adult system, with 30.18 percent readmitted within 30-days. The MHP has engaged in efforts to improve follow-up, targeting SA-3 for a pilot program; however, a deeper dive into a root cause analysis may be important for this topic, leading to the development of more systemwide changes. During the review, feedback from some stakeholders indicated that the provision of follow-up appointments does not seem to be effective, with high no-shows and other issues emerging. These include follow-ups being scheduled at clinics not

relevant to the beneficiary's history; beneficiary lack of insight into the need for treatment; and the need for assertive post-discharge case management engagement efforts that bridge the gap between discharge and outpatient follow-up appointments.

- The impact of CalAIM changes was strongly focused on the reduction of documentation requirements. Stakeholders mentioned the elimination of the treatment plan, and use of the problem list as generally seen as a positive. Some felt the need to more robustly document defensively in the progress notes because the overall reduction in requirements felt disconcerting to them.

QUALITY OF CARE

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, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to 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 THE MHP

In the MHP, the responsibility for QI is located withing the Quality, Outcomes and Training Division (QOTD) of the department, and was launched in January of 2020. QOTD includes the Access Center, Quality Assurance Unit, QI Unit, Outcomes Unit and Training Unit. The QI Unit coordinates program development and QI activities that effectively measure, assess, and continuously improve access to and quality of care provided. The separate Quality Assurance (QA) Unit ensures adherence of DO and C/LE programs to federal, state and local laws and regulations. In addition, QA provides oversight of the response to triennial reviews and other audits. Each SA has its own local Quality Improvement Committee (QIC).

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. Each SA has a regional QIC meeting. The countywide QIC, known as the Quality Council, is comprised of broad SA representation, Patient Rights, QA staff, QI staff, Clinical Policy and Standards staff, Clinical Risk Management, Access staff, Cultural Competency staff, and contract providers, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met 11 times. Of the 16 identified FY 2021-22 QAPI workplan goals, the MHP 10 were met, and 6 were partially met.

The MHP utilizes the following LOC tools: The MHP does track all referrals and admissions but does not use a formal systemwide LOC instrument or process. The MHP is currently exploring potential LOC tools for the adult system.

The MHP utilizes the following outcomes tools: Trauma Symptom Checklist for Young Children, University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index – for DSM-5, Post-Traumatic Stress Disorder – 5, Revised Children's Anxiety and Depression Scale, Patient Health Questionnaire-9, Generalized Anxiety Disorder-7, Outcome Questionnaire 45.2, Global Assessment of Functioning – M, Eyberg Child Behavior Inventory, Sutter-Eyberg Student Behavior Inventory-Revised, Revised Behavior Problem Checklist, Youth Outcome Questionnaire, Youth Outcome Questionnaire – Self-Report, Devereux Early Childhood Assessment for Infants and Toddlers, Family Assessment Device, Difficulties in Emotion Regulation Scale,

Child-Adolescent Needs and Strengths-50 (CANS-50), Pediatric Symptom Checklist-35 (PSC-35), and the Needs Evaluation Tool.

The MHP methodically and regularly reports on the success and failure of CANS-50 and PSC-35 uploads. For CY 2021, the MHP set forth objectives to create CANS-50 aggregate reporting. This involved participation of C/LE providers, some of which have developed outcomes reporting for the CANS and PSC within their organizations. The MHP's Outcomes Unit developed a client-level Power Bi report that displays CANS-50 data over multiple administrations/time-periods. The Outcomes Unit plans to develop reporting that aggregates CANS-50 data at the provider level, and then create an additional report for the PSC-35 data.

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 12: Quality Key Components

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

- 3A: The MHP operates a robust QI process, which is supported by SA and countywide QI bodies. The MHP highlighted during the review the need to have a more formal, robust process that ensures consistent involvement and participation of beneficiaries and family members. They are targeting this area for improvement in the coming year.
- 3D: While some programs may episodically monitor fidelity of evidence-based practices (EBP) in use, the MHP does not have a formal monitoring for all EBPs in place. Routine tracking of transitions in care applies only to full-service partnerships, not between other levels of care. The MHP is looking to develop tracking for the step-downs to managed care plans in the future.
- 3E: Overall, medication monitoring shows continued growth for the MHP. Within the adult system of care, multiple antipsychotic agent use is tracked and reported. With e-prescribing performed through OrderConnect associated with the Avatar EHR, medication prescribing trends can tracked and reported for DO programs; however, in-depth review occurs by the chart sampling the peer review process. C/LE providers have joined the peer review process and review a sample of cases for each practitioner as well, which tends to be significantly focused on children's services. In addition, the MHP has performed an analysis of prescribing by drug class, race/ethnicity, and language, which helps to identify the existence of prescribing disparities.
- 3G: Currently, the MHP has not yet completed final review, instrument selection, pilot testing and adoption of an adult outcome instrument.
- 3H: The MHP's website includes a brief one-page summary for the Spring 2020 Consumer Perception Survey (CPS). The QAPI document tracks the CPS submission numbers over the past three years, but did not recently compare actual results over that period. The one-page beneficiary summary document limits its scope to review of Spring 2020 results. None of the beneficiaries who took part in this review could recall seeing the CPS results, nor knew where they were posted. The MHP has developed a list of best practices for improving beneficiary participation in the CPS process; in addition, another best practices document was developed to provide guidance in how to improve actual survey results. These best-practices are provided to programs for technical assistance.
- The MHP utilizes C/LE providers for the majority of children's and FC services. It uses a peer review sampling process (N=15) to track the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): 100 percent in compliance.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): 100 percent in compliance.

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): Zero percent in compliance; and this is an area targeted for improvement.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): 80 percent compliance, down from previous 85 percent.

QUALITY PERFORMANCE MEASURES

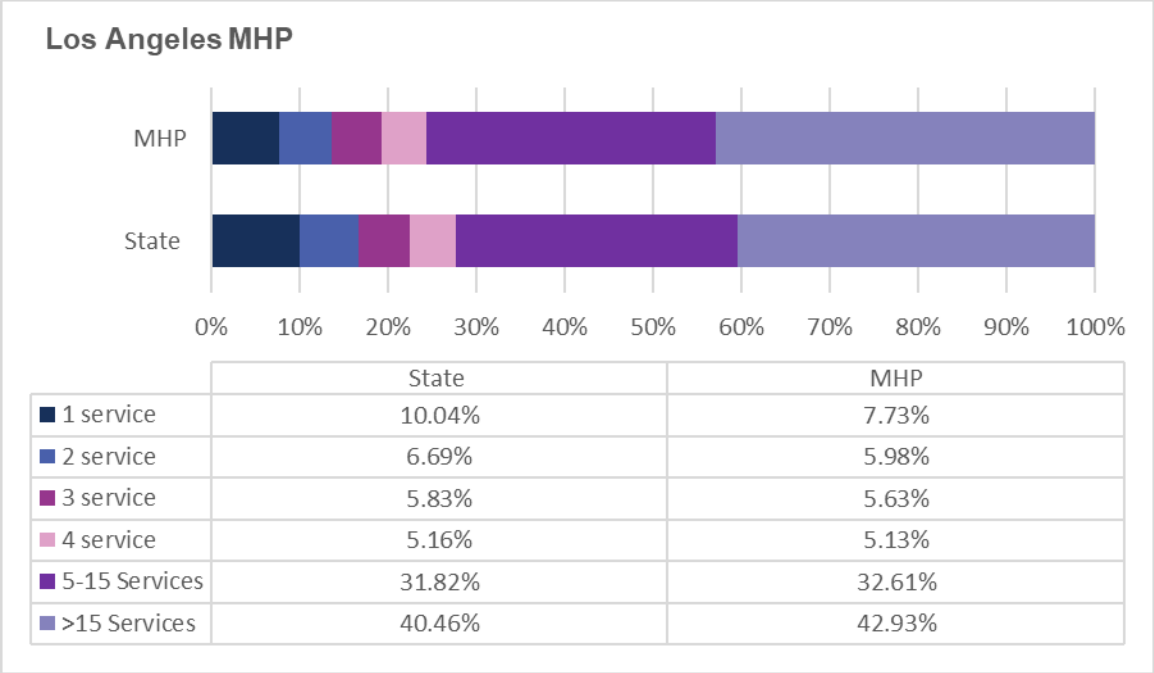
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Beneficiaries (HCB)

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



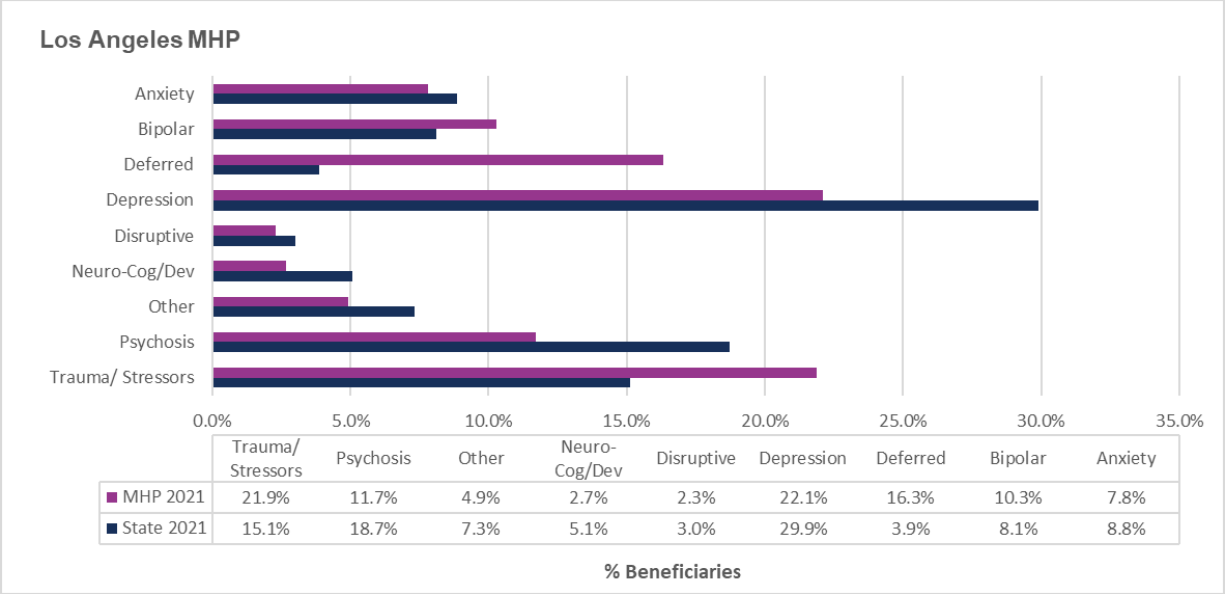
	State	MHP
1 service	10.04%	7.73%
2 service	6.69%	5.98%
3 service	5.83%	5.63%
4 service	5.16%	5.13%
5-15 Services	31.82%	32.61%
>15 Services	40.46%	42.93%

- The MHP has a greater percentage of beneficiaries who receive more services and fewer beneficiaries who receive only one, two, or three services. This suggests the MHP continues to demonstrate relatively strong engagement with their clients.

Diagnosis of Beneficiaries Served

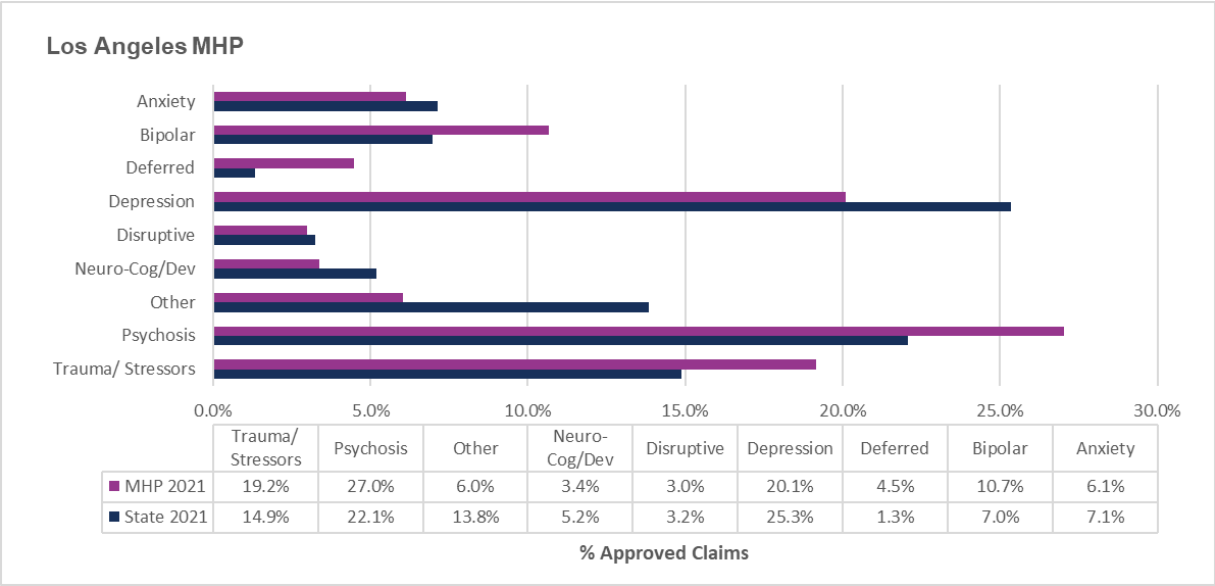
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	21.9%	11.7%	4.9%	2.7%	2.3%	22.1%	16.3%	10.3%	7.8%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	19.2%	27.0%	6.0%	3.4%	3.0%	20.1%	4.5%	10.7%	6.1%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- In comparison to the statewide average, the MHP has a higher percentage of beneficiaries with anxiety and depression diagnoses and a lower percentage of beneficiaries served who have a bipolar or psychosis diagnosis.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay.

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	16,006	61,942	8.49	8.79	$9,685	$12,052	$155,016,667
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	7.63	$8,460	$10,212	$152,030,457

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measures) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21

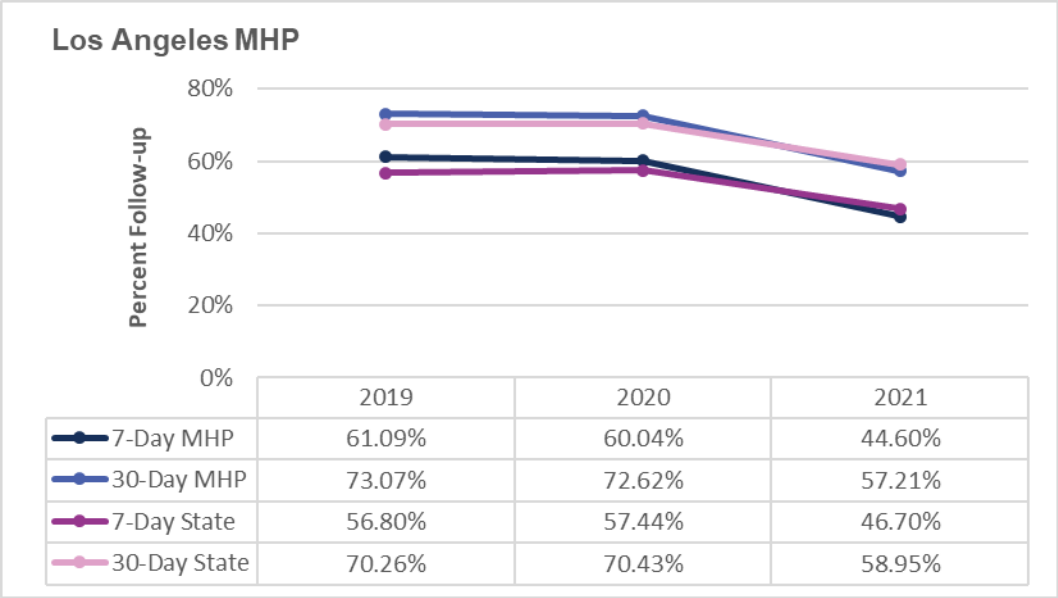
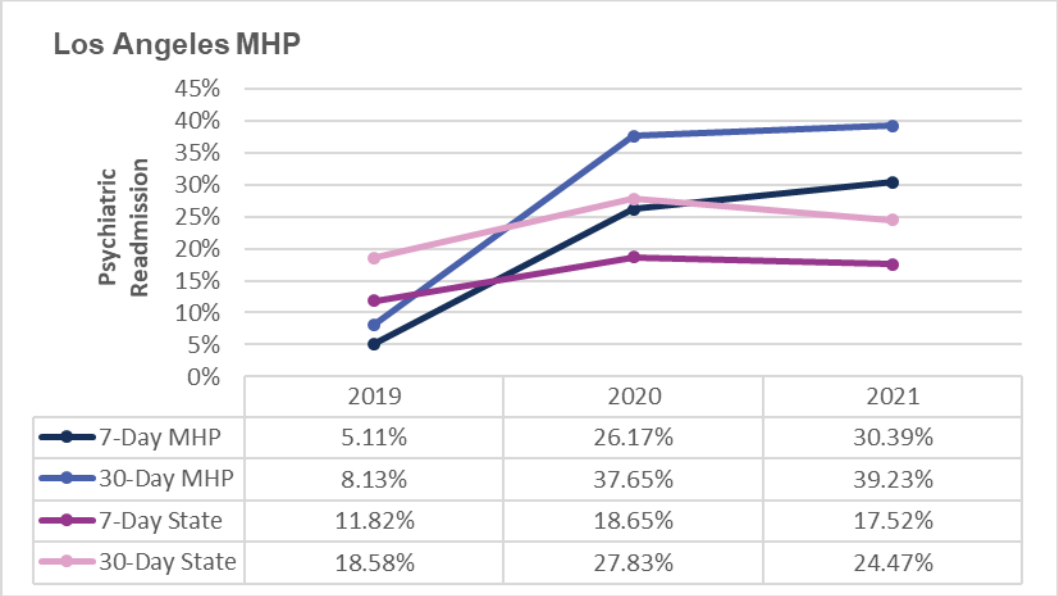


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	5.11%	26.17%	30.39%
30-Day MHP	8.13%	37.65%	39.23%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- Inpatient follow-up rates have decreased 35 percent for 7-day and 27 percent for 30-day since 2020.
- The 7-day and 30-day readmission rates have increased significantly over the last 3 years and are notably higher than the statewide rate.
- Note the CY 2021 approved claims data presented in this section for 7/30 day post-hospital discharge follow-up and readmission rates differ significantly from the MHP's ATA submission of the same metrics with a six-month offset to the tracked FY 2021-22 period. Th MHP reports much higher follow-up percentages for both 7/30 days, and lower readmission rates. Of note, the MHP excludes those who are not referred at discharge for post-hospital follow-up and utilizes other exclusionary factors; whereas the CalEQRO data assumes all discharges would be appropriate for follow-up.
- The MHP has initiated an SA-3 post-hospital follow-up appointment process, which has not yet impacted countywide readmission rates. During this review, some stakeholder groups suggested there could be issues with mismatch between the follow-up appointment and the actual preferred locale of the beneficiary. In addition, assertive case management follow-up was also cited as a need for many who have unstable housing and/or are recently accessing care for the follow-up efforts to be successful.

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis

services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCBs may disproportionately occupy treatment slots that may prevent access to levels of care by other beneficiaries. HCB percentage of total claims, when compared with the HCB count percentage, provides a subset of the beneficiary population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are “low cost” (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Total Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	3.46%	28.46%	$53,476	$43,231
MHP	CY 2021	4,631	2.40%	20.35%	$49,048	$41,014
	CY 2020	7,058	3.32%	24.58%	$49,877	$41,755
	CY 2019	6,909	3.12%	24.64%	$49,351	$41,768

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	5,247	2.72%	$126,917,932	11.37%	$24,189	$23,795
Low Cost (Less than $20K)	183,171	94.88%	$762,087,380	63.13%	$4,161	$2,833

- High and Medium Cost Beneficiaries represent about 5 percent of the beneficiaries and over 30 percent of the approved claims.

Figure 20: Proportion of Beneficiary Count by Claim Amount Grouping CY 2021

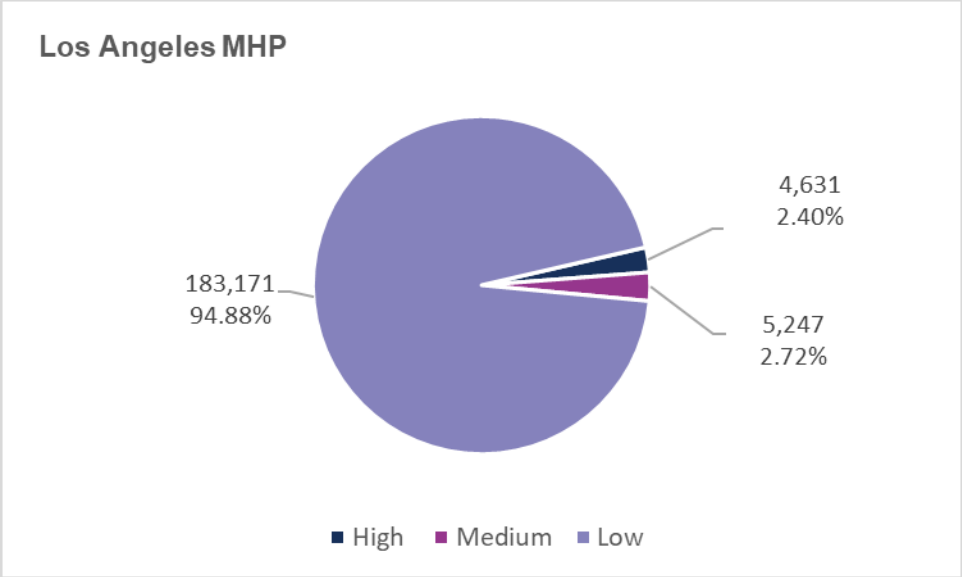
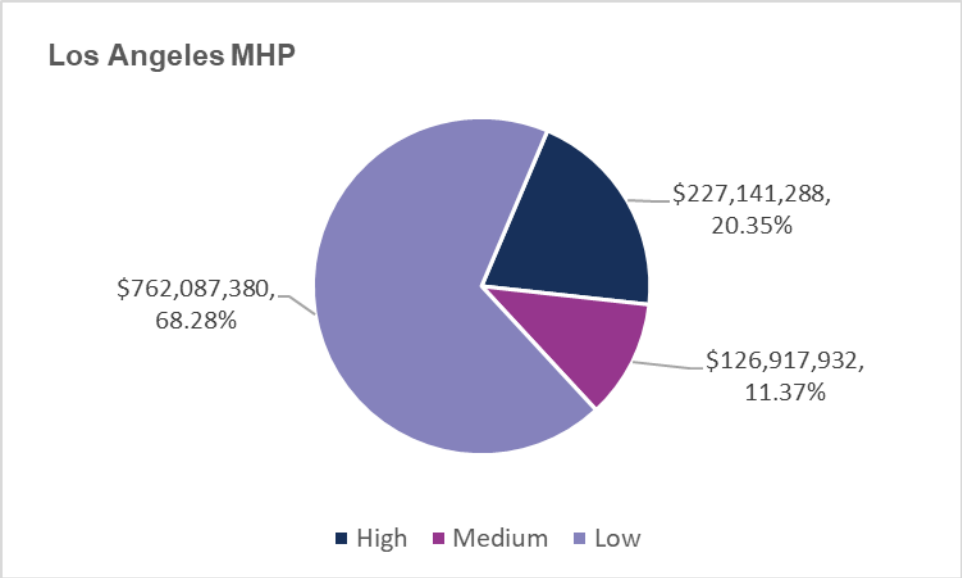


Figure 21: Approved Claims by Cost Type CY 2021



IMPACT OF QUALITY FINDINGS

- Overall, medication monitoring is improving. The FC SB 1291 tracking remains based on peer review sampling due to disparate e-prescribing systems. Access to all prescribing for MHP C/LE served individuals through a portal into the Medi-Cal prescription claiming system at the state level would facilitate an improvement of tracking in this area.
- With continued heavy demand for services, the implementation of an adult LOC tool will be important to help with decision-support with beneficiary step-downs

and referral to MCP behavioral health care. The MHP's 2 percentage point differential with the statewide average for those receiving > 15 services underscores the importance of this issue.

- It should be noted that there are two sets of data on post-hospital discharge follow-up and rehospitalization rates cited in this report. The FY 2021-22 data provided by the MHP in the timeliness section indicates a 30 percent 30-day rehospitalization rate, while the BHC data analysis of approved claims data indicates a CY 2021 39 percent rehospitalization rate for a six-month reporting window offset. The trend of both data sets suggests the MHP's efforts to improve in this area are justified and should be continued and expanded.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and 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.caleqro.com.

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Improving Treatment Services for Individuals with Eating Disorders (ED)

Date Started: 06/2021 (thru 6/2023)

Aim Statement: Will implementing training, consultation, a best practice toolkit, and an integrated practice network decrease the percent of Medi-Cal beneficiaries with EDs requiring a higher level of care from 4 percent to 2 percent per quarter, improve engagement rates from 70 percent to 75 percent and increase the number of individuals screened and assessed for EDs from 0.4 percent to 1.0 percent to reflect the nationwide one-year prevalence rates within 18 months?

Target Population: All individuals with ED.

Status of PIP: The MHP's clinical PIP is in the Other phase, in the fourth quarterly remeasurement, with intention of continuation to June of 2023.

[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

Summary

The MHP notes that referrals for treatment of ED have increased in recent years. Clinicians who lack training and support in the treatment of these individuals also make referrals for specialized treatment. Notably, individuals with an ED also often require higher levels of care and may experience life-threatening complications.

The MHP intended to initiate a training and consultation program, with the focus on improving the skills of clinicians and providing a forum for case treatment consultation for ED. The MHP's interventions include training on the application of cognitive behavioral therapy for ED, creation of an ED practice network, an ED case consultation series, and various other consultation and/or training elements. The MHP's performance measures included increased stepdown to lower level of care; attending at least two services within 30 days, and six services within 90 days; and overall increasing the number/percent of individuals diagnosed with ED on the problem list.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: The MHP did not see the desired improvements reflected on any of the performance measures.

The provision of training and ongoing support to clinicians engaged in ED treatment is likely to show improvements over time, but that has yet to be reflected in the outcome data. Clearly, this is an important topic for improvement.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this clinical PIP including:

- It is possible that the MHP might wish to continue its focus on increasing the numbers of those diagnosed with ED, and narrowly focus PIP outcomes on the clinical improvement of those diagnosed and treated for ED using a relevant outcome instrument. Perhaps this approach would result in improvements in the tracked data. This type of change could be implemented during the PIP continuation period, before the planned termination of this PIP, in June 2023.
- As far as changes to the training and consultation strategy, the approach adopted by the MHP appears logical and well thought-out. No changes to the approach are being suggested at this point.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improving Referral Management and Efficiency Through an Online Provider Directory

Date Started: 09/2021

Date Completed: 10/2022

Aim Statement: By adding additional provider data fields to the Network Adequacy: Provider and Practitioner Administration (NAPPA) application, implementing data update standards, and introducing a comprehensive Provider Directory training highlighting the system's latest developments, LACDMH will ensure providers have access to real-time program data within six months (such as clinic availability for beneficiaries) as evidenced by:

A) Decrease in the number of System Request Tracking System (SRTS) referrals with greater than two transfers from 6.1 to 5.0 percent.
B) Decrease in the number of business days to transfer resolution from 6.9 days to 5.0 days.

Target Population: This PIP will impact beneficiaries seeking services - including individuals of any age and diagnosis. The primary impact is upon individuals initially requesting services, current beneficiaries seeking additional services or a higher/lower level of care. C/LEs and DO providers that provide services to beneficiaries and new enrollees will be impacted by this PIP.

Status of PIP: The MHP's non-clinical PIP is in the Other: completed phase.

Summary

As verified by various stakeholders, the topic of improving the accuracy of the SRTS/Provider Directory is an important one. To the extent possible, a reduction in the number of providers called before contacting one with open capacity is important to those seeking treatment; also important is the reduction in the total time between experiencing the need for treatment and connecting with an available provider.

The interventions include training in the update of the NAPPA application whenever a provider experiences a significant change and/or every 30 days. This is particularly focused upon changes in the ability of a provider to accept new referrals. Release of the Provider Directory occurred to the public in April 2022. The Directory receives updates from the NAPPA application every 24 hours. Providers were furnished with trainings as to how the application should be used.

While there may have been some early improvement in several process measures, which reflect provider survey results, the more significant beneficiary-related performance measures did not improve - the number of beneficiary referrals with multiple transfers, and the number of business days to resolution of the request (finding an available program or provider). Neither of these measures show improvement for the final period.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: The key metrics of this PIP relate to the number of providers that must be contacted to find a clinician, and the total duration of that search. None of these key beneficiary experience items show an improvement at the end of the PIP.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this non-clinical PIP including:

- Both the provider survey-based performance measures and the direct beneficiary measures showed no real improvement, particularly important were those items that reflect direct beneficiary experience. It is not clear if this process is experienced as complicated and difficult to manage by participating providers, but it certainly has yet to change the beneficiary experience.
- As identified by the MHP and stakeholders involved in this review, this remains an important topic and should continue to receive MHP attention even if this occurs outside of a PIP process.
- As the MHP has ended this PIP further discussion about specific improvements is not relevant.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/Avatar, which has been in use for nine years. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 2.1 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 3,847 named users with log-on authority to the EHR, including approximately 3,550 county staff and 297 contractor staff. Support for the users is provided by 242 full-time equivalent IS technology positions. Currently there are 52 vacant IS positions.

As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
Electronic Data Interchange to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	99%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	1%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
		100%

Beneficiary Personal Health Record

The 21st Century 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. The MHP has implemented a PHR, Just4Me, for beneficiaries receiving services directly from county staff and is only used by a very small number of beneficiaries. A project to upgrade their PHR is in the beginning phases.

Interoperability Support

The MHP is a member or participant in a HIE. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: MH CBO/Contract Providers and Hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive 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 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	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 well-documented and thought-out strategic plan to ensure their systems align with organizational goals, are secure, and are interoperable with one another.
- The data warehouse provides the ability to effectively develop reports from several data sources and deliver reports to all levels of staff in the department as well as contract providers.
- The MHP has a strong IS team and fiscal team that work cohesively together to overcome claiming challenges and keep all elements of the claims process progressing, resulting in a consistent monthly claims volume, positive cash flow, and a denial rate of 2.12 percent, which is below the statewide average.
- Maximizes use of technology by developing validation methods to ensure information entered in IS systems is accurate and reliable.
- Use of multi factor authentication at all endpoints keeps systems secure and will prevent data breaches.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

For the MHP, it appears that significant claims lag begins in October and likely represents $223 million in services not yet shown in the approved claims provided. The MHP reports that their claim is current through December 2021.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	530,175	$107,148,056	$2,457,686	2.29%	$104,690,370
Feb	537,289	$110,599,215	$2,620,632	2.37%	$107,978,583
Mar	606,789	$126,455,933	$2,974,216	2.35%	$123,481,717
April	555,888	$116,417,866	$2,522,184	2.17%	$113,895,682
May	487,164	$104,111,770	$2,359,987	2.27%	$101,751,783
June	477,784	$102,304,541	$2,176,728	2.13%	$100,127,813
July	445,668	$97,353,507	$1,913,387	1.97%	$95,440,120
Aug	441,996	$96,234,120	$1,876,602	1.95%	$94,357,518
Sept	410,801	$91,515,251	$1,592,499	1.74%	$89,922,752
Oct	222,486	$46,209,698	$669,863	1.45%	$45,539,835
Nov	3,761	$839,713	$18,780	2.24%	$820,933
Dec	693	$202,556	$1,369	0.68%	$202,556
Total	**4,720,494**	**$999,393,595**	**$21,183,933**	**2.12%**	**$978,209,662**

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	40,414	$10,093,799	47.65%
Medicare Part B or Other Health Coverage must be billed before submission of claim	22,273	$5,803,124	27.39%
Beneficiary not eligible or non-covered charges	10,289	$2,760,110	13.03%
Service line is a duplicate and a repeat service procedure code modifier not present	10,450	$1,816,275	8.57%
NPI related	4,758	$602,349	2.84%
Other	459	$108,278	0.51%
Total Denied Claims	**88,643**	**$21,183,935**	**100.00%**
Overall Denied Claims Rate	**2.12%**		
Statewide Overall Denied Claims Rate	**2.78%**		

- The percentage of total denied claims is similar to the previous year's denial percentages. The MHP's overall denied claims rate is below the statewide rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The innovative project, Healthcare Interoperability Data Exchange, should allow the MHP to securely exchange data with contract providers and other partners, as well as develop Fast Healthcare Interoperability Resource compliant interoperability support within the EHR to provide and deliver connected care for beneficiaries.
- Use of Power BI to develop data dashboards provides information at the right time to aid in decision-making, problem solving, and training.
- Implementing an upgraded SRTS capable of communicating with other existing systems should reduce client lookup repetition and help streamline provider referrals.
- Incorporating functionality into SRTS to track first service requests, appointments offered and first service delivery for both internal and contract provided programs may streamline data collection efforts and ensure ability to not only complete state required timeliness reports but most importantly, ensure beneficiaries receive services in a timely manner.
- Upgrading the PHR and including a marketing campaign to advertise and train beneficiaries may increase user enrollment and provide scheduling functionality and health information easily to beneficiaries.
- Piloting an integrated EHR telehealth solution may increase use of video telehealth services to provide more comprehensive services to beneficiaries.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

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 has recently focused primarily on the numbers of surveys collected, which have seen a dramatic and continued decrease since 2019. For its QAPI process, the MHP tracked three-year participation numbers in the survey process. The MHP has made efforts to improve and noted that the online CPS submission process has high levels of incomplete surveys from the process. When sufficient data exists, the MHP creates brief one-page summaries that highlight the key feedback issues. The most recent posted material is from Spring 2020.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested four 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each. In that this review highlighted SA-3 and SA-4, an adult and a caregiver of children/youth beneficiaries focus group was requested for each of the two service areas.

Consumer Family Member Focus Group One

CalEQRO requested diverse group of SA-3 parents/caregivers the majority of whom initiated services in the preceding 12 months. The focus group was held virtually by a LACDMH sponsored Teams session and included four participants; all were English-speakers and did not require an interpreter. All family members participating have a family member who receives clinical services from the MHP.

Initial access varied from immediate, or the day of first request, and ranged up to two weeks. One of the participants whose access time was not immediate received phone calls from the program during the wait period.

Since starting treatment these participants varied in whether they received appointment reminder calls. The majority did receive such calls. In regard to assistance with transportation to appointments, the majority either receive services in the home, or the child receives school-based services.

All participants responded affirmatively to the involvement of family in the treatment of their child/youth who is receiving services.

Approximately one-half of the participants have experienced issues with poor therapist fit. The reasons range from lack of clear direction from the therapist to instances where the therapist seems new and inexperienced. Parents mentioned encouraging the child to request a change of clinician if they feel treatment is not working well. Some caregivers need more readily available support to help process the decision to request a change of therapist with their child and to also provide assistance with the change itself. It should be noted that some of the caregivers feel very positive about the child's clinician and also know how to make a change, if that was needed.

While telehealth is a newer option for more service types, some have returned to in-person care; another has a child who refuses telehealth and has switched to in-person care. Overall, the majority have returned to in-person care.

The caregivers who receive support mostly receive this help in the form of a parent-advocate, which can help in linking to resources and connecting with other parents who have similar issues. Another participant values the help of a trusted transportation service. Social workers may also provide help in navigating other system complexities, including those encountered when seeking benefits.

Access to ongoing care issues varied among the focus group participants. When school campuses are the site of care, appointment changes are easily accomplished with little difficulty. This treatment location also provides good consistency with weekly sessions. The only issue with routine appointments was reported as related to the child's reluctance to attend, and unilaterally cancelling appointments.

None of the participants have a child that is currently receiving medications. In only one instance was lack of psychiatric capacity identified as a possible barrier.

In response to a crisis event, several participants recall being referred to go to an urgent care center or emergency room. Knowledge of the crisis hotline and offline support was possessed by a very limited set of these participants.

Most of the participants could recall having completed a satisfaction survey but were not aware of the results. Most would also like to participate in MHP planning and/or feedback sessions but have not and did not know how to access this process.

Wellness centers which provide activities were identified by some, but those activities that require cash support by the caregiver for outings frequently cannot be utilized due to family financial challenges.

All participants believe their cultural needs are being met, and that services would be available in a non-English preferred language, if this was needed.

Regarding other venues of care, telehealth has been a positive for some who were unable to leave home due to high COVID-19 risks. In other cases, the therapist/counselor has provided transportation and supportive activities in the course of attending a session, which may include lunch out for a child. Some felt that in-person care was an improvement and that the return to face-to-face care was a positive option. Another brought out that the last year involved frequent therapist changes, which had a negative impact on the children who must then retell their personal stories. In addition, there has been an influx of new and inexperienced clinicians which can sometimes be challenging.

As to improvements from the care received, the majority feel that significant positive change has occurred. A minority has not been in treatment for long and were not able to comment yet.

The elements that would result in improved care were identified as: allow open-ended participation in treatment. Reduce the number of provider changes – greater continuity of therapist. Provide a weekly podcast, newsletter or warmline that provides an opportunity to receive assistance from those who are knowledgeable about resources and can assist in accessing them. Some participants also felt the EQR session was helpful in providing caregivers with a sense that they are not alone, and others face similar problems.

Recommendations from focus group participants included:

- Eliminate the time restrictions on services so that open-ended care can be provided. In addition, reduce or eliminate the changes in agencies and therapists that tend to frequently occur.
- Provide FC caregivers with a central resource database, newsletter or support group that enables parents to share their resource findings and/or strategies for addressing specific types of problems.
- Consider highlighting the benefits of “211” which can offer in-depth resources. This may also suggest incorporating with 988 extensive resource support for caregivers.

Consumer Family Member Focus Group Two

- CalEQRO requested a diverse group of caregivers, the majority of whom initiated services in the preceding 12 months from SA-4 providers. The focus group was held virtually by a LACDMH sponsored Teams session and included one participant. Due to the small number of attendees, the feedback from this session is incorporated in the overall focus group findings at the end of this section.

Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of SA-3 adult consumers, the majority of whom initiated services in the preceding 12 months. The focus group was held virtually by a LACDMH sponsored Teams session and included four participants; all were English-speakers and did not require an interpreter. All consumers participating receive clinical services from the MHP.

A limited number of participants initiated services during the past year. These individuals reported initial access of between two to four weeks. They felt this timeframe was sufficiently rapid.

As to assistance with appointments, text and phone call reminders are received by most. None require translation assistance. Telehealth resolves the issue of transportation to appointments for some. Family involvement is provided if wished.

As to integration with physical health concerns, aspects of physical health are addressed by some clinicians. All were aware of mechanisms to address provider fit issues.

While telehealth is reported by some, it was noted that moving back to in-person services is becoming an option, and some experience this as a positive change. Session frequency was reported as every one to two weeks. Rescheduling of appointments was reported as relatively easy, facilitated by wait/cancellation list placement for the next opening.

In regard to urgent care needs, the group reported availability of an 800- number, the option of reaching out to a program supervisor, or seeking hospital admission. Few lacked information about what to do in a crisis. However, none were aware of the 988 number.

Many have completed a satisfaction survey. Information about services and changes are obtained from the therapist/counselor, with some receiving emails and text messages. Most have not utilized the MHP's website content for information, but there was a small segment that has briefly scanned it. A small number of this group has provided direct input about services. Also, few were aware of the wellness center programming. None were aware of opportunities to use their life experience in employment with LACDMH or its contract providers.

Overall, the group expressed a high level of satisfaction with services.

Recommendations from focus group participants included:

- Provide more social activities, including field trips to augment the talk approach to care.
- Publicize field-based services, which can help beneficiaries with self-care and confidence.

Consumer Family Member Focus Group Four

CalEQRO requested a diverse group of adult consumers, the majority of whom initiated services in the preceding 12 months from SA-4 providers. The focus group was held virtually by a LACDMH sponsored Teams session and included two participants. Due to the small number of participants, the session findings are incorporated into the overall summary for consumer focus groups.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, services were experienced as helpful and positive. Improvements in their conditions was frequently cited.

In general, the notable turnover of clinical staff has impacted service recipients in a number of ways – gaps in care when programs lose a clinician; adapting to a new provider of services and the telling of their story again; less frequent services when programs are understaffed.

Caregivers in particular have a need for a central information repository of relevant resources. The promotion of “211” and “988” was suggested. Some mentioned a monthly newsletter could meet this need. A newsletter could also provide special articles that provide suggestions as how to address specific situational behaviors with children. Also, parenting groups could help sustain caregiver skills in working with their children; this could be more easily attended in a virtual format.

While telehealth remains a useful vehicle for services for those with transportation or family issues, many identified the return to in-person care as an improvement.

Adult beneficiaries value community-based activities such as outings as helpful to them. Field-based services are also noted as helpful for those with transportation issues, which allows for in-person care to occur.

CONCLUSIONS

During the FY 2022-23 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 continues to reflect a vision and commitment to improving services at all levels of care, such as the Restorative Care Villages that leverage healthcare campus sites for the creation of high-level services and housing as well as wraparound services. Hollywood 2.0 is yet another re-imagining of services in an area noted for significant homeless mentally ill and adapting a model of care that is a "human-centered" and "hospitality-oriented" recovery approach. The ACR Office provides alternatives to anyone who happens to experience a crisis, with DO and C/LE programs providing services. EOTD programs have now added peers to eight mobile teams countywide. In the area of recovery services, PRCs have expanded into SAs 2, 4, 7, with another in process. These are just a few of the innovations the MHP has produced even during times of uncertainty. (Access, Quality)
2. In the adult services system, comprising approximately 60 percent of all first offered appointments, the first offered non-urgent average of 7.54 business days and 80 percent achievement of standard significantly betters the 10-business day requirement. This was also confirmed by stakeholder session feedback and has occurred in the presence of clinical staff vacancies, high caseload numbers, and high demand for services. (Access, Timeliness)
3. The TT pilot program in downtown Los Angeles provides a peer, a psychiatric technician and a clinical driver to assist in responding to individuals in need of transport to treatment facilities, co-located at Los Angeles City Fire Stations. This approach reduces the diversion of emergency medical service personnel from medical calls and improves the experience of those in need of acute or high-level services. (Access, Quality,)
4. The MHP has a well-documented and thought-out IT strategic plan to ensure their systems align with organizational goals, are secure, and are interoperable with one another. (IS)
5. The MHP recognizes the benefits of providing a PHR to beneficiaries and has developed a plan to increase the number of enrolled users and began upgrading the existing PHR. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The relatively low numbers of first offered, non-urgent psychiatry services (Total N=319) suggest the MHP's efforts to improve comprehensiveness and accuracy of data collection is unfinished at this time. This is reinforced by the discrepancies in time to first psychiatry appointment between submitted data and the reports of stakeholders with direct involvement in the service delivery process. (Access, Timeliness)
2. The MHP's evaluation, selection, and piloting of a universal adult LOC/Outcome instrument was incomplete as of this review. The availability of regular data to support the clinical decision-making process is particularly important considering the MHP's volume of service demand and ongoing caseload numbers, which assists in connecting beneficiaries with the correct level of care. (Access, Quality)
3. Adult beneficiaries comprise nearly 85 percent of all hospital discharges, and 93 percent of all readmissions within 30 days, resulting in a 30 percent 30-day readmission rate (MHP ATA data). This statistic is virtually the same as the prior year. (Quality)
4. The MHP has made efforts to establish a staff survey process, which as of this current review has not been implemented. The importance of providing an ongoing venue for staff of both DO and C/LE programs to directly inform leadership of critical issues that relate to service delivery is commonly accepted as essential to organizational functionality, morale, and system cohesiveness. (Quality)
5. The consistently reported gap between the completion of the assessment process and access to treatment is not reflected in any of the metrics tracked by the MHP. In addition, those who do start receiving treatment report service frequency quickly reduced to monthly therapy sessions shortly after starting care. (Access, Timeliness, Quality)
6. Considering that a large percentage of beneficiaries receive services from C/LE providers, and the importance of beneficiary access to their health information, appointments, and reminders, the MHP does not have information as to which providers furnish a PHR 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. Continue implementation of 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)

(This recommendation is a revised carry-over from FY 2021-22.)

2. Continue efforts to select an adult LOC/outcome instrument for pilot testing, and eventual adoption systemwide to inform a periodic case review process and re-determination of clinical need across all levels of care. (Quality, IS)

   (This recommendation is a revised carry-over from FY 2021-22.)

3. Continue and broaden the systemwide focus on reducing the 7/30-day rehospitalization rates, by provision of post-hospital appointments and case management follow-up which is tailored to factors identified by data analysis and stakeholder input. (Access, Quality, Timeliness)

   (This recommendation is a revised carry-over from FY 2021-22.)

4. Continue development of a systemwide ongoing feedback process accessible to both DO and C/LE programs to provide feedback to MHP leadership directly from line and supervisory levels, aggregated feedback by service areas, which will provide the department with identification of critical issues from the service delivery level. (Quality)

   (This recommendation is a revised carry-over from FY 2021-22.)

5. Develop a tracking and reporting system element that reflects by program the time between assessment and treatment, with an additional element that reports out the average frequency of clinical services by program. This should assist the MHP in its appraisal of capacity adequacy and staffing needs. (Access, Quality)

6. Develop tracking of C/LE providers for the availability of a PHR for those served under MHP contract, and secondarily begin the development of standards for the type and scale of services for which a PHR would be expected to be provided by contract providers. (Quality/IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

The barrier identified for this FY 2022-23 were the very small numbers of beneficiaries that attended two of the four virtual consumer focus groups, which limited access to information regarding the beneficiary experience.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Los Angeles County MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIP
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Outcomes and Satisfaction Interview
Wellness and Recovery
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
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Health Plan and MHP Collaboration Initiatives
Telehealth
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Robert Walton, Quality Reviewer
Ewurama Shaw-Taylor, Quality Reviewer
Rita Samartino, Information Systems Reviewer
Saumitra Sengupta, Information Systems Reviewer
Gloria Marrin, Consumer-Family Member Reviewer
Pamela Roach, Consumer-Family Member Reviewer

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

MHP County Sites

All sessions were held via video conference.

MHP Contract Provider Sites

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Agregado	Fatima	Mental Health Clinical Supervisor	LACDMH arcadia
Aharonian	LIda	Supervising Psychologist	LACDMH
Ahart	Jeni	Clinical Supervisor	Social Model River community
Alvarado	Kathy	Parent Partner	Institute for Multicultural Counseling & Education Services
Aquino	Laura	Clinical Supervisor	Amanecer Community Counseling Services
Arns	Paul	Mental Health Clinical District Chief	LACDMH
Arredondo	Alejandra	Parent Partner	Victor Treatment Center
Avalos	Mirian	Departmental Chief Information Officer II	LACDMH
Baker	Sharon	Chief	LACDMH
Barajas-Calkins	Rosalinda	Clinical Director	Center for Integrated Family and Health Services
Bautista	Gerard	Program Manager	Maryvale
Becerra	Presley	Information Technology Specialist I	LACDMH
Benitez	Christopher	Supervising Mental Health Psychiatrist	LACDMH
Benson	Lisa	Supervising Psychologist	LACDMH
Berumen	Bertha	Community Health Worker	LACDMH
Boardman	Bruce	CEO	Social Model Recovery Systems
Boileau	Sean	Clinical Supervisor	AIDS Project LA
Bonds	Curley II	Medical Director	LACDMH
Cacialli	Douglas	Clinical Psychologist II	LACDMH

Last Name	First Name	Position	County or Contracted Agency
Camacho	Catarino	Information Technology Supervisor	LACDMH
Cezere	Chondrelle	Therapist	Institute for Multicultural Counseling & Education Services
Chacon	Sandra	Medical Case Worker II	LACDMH
Chen	Sandy	Management Analyst	LACDMH
Cheng	Mark	Information Technology Manager II	LACDMH
Clinton	Andre	Principal Information Systems Analyst	LACDMH
Cornejo	Beatriz	Parent Advocate	LACDMH
Corral	Martin	Principal Information Systems Analyst	LACDMH
Cozolino	Susan	Health Program Analyst III	LACDMH
Culver	Michelle	MH Services Director	Maryvale
Cunnane	Daiya	Clinical Psychologist II	LACDMH
Dang	Nga	Principal Information Analyst	LACDMH
Davis	Erik	Clinical Supervisor	Institute for Multicultural Counseling & Education Services
Diaz	Charlie	Information Technology Specialist I	LACDMH
Donatto-Mallett	Danita	Clinical Supervisor	Institute for Multicultural Counseling & Education Services
Duong	Jack	Therapist	Center for Integrated Family and Health Services
Emadi	Makan	Mental Health Clinical Supervisor	LACDMH
Fermin	Juan	Information Technology Specialist II	LACDMH
Franco	Evelio	Mental Health Program Manager II	LACDMH

Last Name	First Name	Position	County or Contracted Agency
Gilbert	Kalene	Mental Health Program Manager IV	LACDMH
Griffin	William	Information Technology Manager I	LACDMH
Gutman	Nicole	Mental Health Clinical Supervisor	LACDMH
Hallman	Jennifer	Mental Health Program Manager I	LACDMH
Hernandez	Brian	Information Systems Analyst II	LACDMH
Hernandez	Yuliana	Community Health Worker	LACDMH
Herrera	Erica	Parent Partner	Aviva (Hamburger Home)
Howieson	John	Information Technology Manager I	LACDMH
Innes-Gomberg	Debbie	Deputy Director	LACDMH
Irwin	Susana	Community Health Worker	LACDMH
Jackson	La Tina	Deputy Director	LACDMH
Jamerson	Jeffrey	VP of Programs and Services	Aviva (Hamburger Home)
Jones	Martin	Mental Health Program Manager IV	LACDMH
Kasarabada	Naga	Clinical Psychologist II	LACDMH
Kermoyan	Katia	Principal Information Systems Analyst	LACDMH
Ko	Jennie	Health Program Analyst I	LACDMH
Kwon	Hosun	Mental Health Program Manager I	LACDMH
Lee	Kristina Punzalan	Senior Information Systems Analyst	LACDMH
Levy	Hayley	Director of Administration and Clinical Services	Special Services for Groups
Liu	Kwan	Administrative Services Manager III	LACDMH
Loera	Mari	Psychiatric Social Worker II	LACDMH

Last Name	First Name	Position	County or Contracted Agency
Majors	Michelle	Mental Health Program Manager III	LACDMH
Malanok	Ruzanna	Principal Information Systems Analyst	LACDMH
Maldonado	Guadalupe	Senior Information Systems Analyst	LACDMH
Martin	Jones	Mental Health Program Manager IV	LACDMH
Martinez	Jeremy	Supervising Mental Health Psychiatrist	LACDMH
Medina	Jon	General Manager	Center for Integrated Family and Health Services
Moreno	Maria	Clinical Psychologist II	LACDMH
Moser	Kimberly	Psychiatric Social Worker II	LACDMH SA3
Nairn	Christina	Mental Health Program Manager II	LACDMH
Natividad	Veronica	Community health worker	Arcadia MH SA3
Nga	Dang	Principal Information Systems Analyst	LACDMH
Ngo	Philip	Senior Information Systems Analyst	LACDMH
Nierodzik	Misook	Director of QA	Center for Integrated Family and Health Services
Obinwanne	Kennedy	Senior Mental Health Counselor	LACDMH
Patterikalam	Girivasan	Information Technology Manager II	LACDMH
Pelk	James	Assistant Director	Institute for Multicultural Counseling & Education Services
Perkins	Theion	Mental Health Program Manager IV	LACDMH
Pesanti	Keri	Mental Health Clinical Program Head	LACDMH
Ponce	Victor	Senior Information Systems Analyst	LACDMH

Last Name	First Name	Position	County or Contracted Agency
Ramirez	Nancy	Clinical Supervisor	Amanecer Community Counseling Services
Ramos	Nelly	Parent Partner	Woodhill Family
Regan	Jennifer	Clinical Psychologist II	LACDMH
Rodriguez	Anabel	Deputy Director	LACDMH
Santhirasegari	Josephine	Therapist	Center for Integrated Family and Health Services
Sauceda	Nancy	Mental Health Clinical Supervisor	LACDMH
Sheehe	John	Mental Health Program Manager II	LACDMH
Shonibare	LyNetta	Mental Health Program Manager II	LACDMH
Smith-White	Katherine	Supervising Mental Health Psychiatrist	LACDMH
Sou	Susana Ka Wai	Pharmacy Services Chief III	LACDMH
Spahn	Charles	LCSW	Northeast MH LACDMH SA4
Taguchi	Kara	Mental Health Clinical Program Head	LACDMH
Tanner	William	Mental Health Program Manager III	LACDMH
Tepaz	Nancy	Therapist	Dignity Community Care
Thomas	Eric	VP of Mental Health	San Gabriel Children's Center
Tostado	Sarah	Clinical Supervisor	Social Model River Community
Tran	Anthony	Database Administrator	LACDMH
Tredinnick	Michael	Mental Health Program Manager III	LACDMH
Trias-Ruiz	Rosalba	Supervising Psychologist	LACDMH
Valadez	Melina	Parent Partner	Hillsides
Valdez	Julie	Mental Health Program Manager III	LACDMH

Last Name	First Name	Position	County or Contracted Agency
Valencia	Nicole	Psychiatric Social Worker II	LACDMH
Vallejos	Irma	Community Health Worker	LACDMH
Vega	Edith	Community Health Worker	LACDMH
Weiner	Nancy	Mental Health Clinical Supervisor	LACDMH
Williams	Stacy	Mental Health Program Manager III	LACDMH
Willock	Yvette	Chief of Social Services	LACDMH
Wong	Lisa	Interim Director	LACDMH
Yow	Alexandra	Therapist	Center for Integrated Family and Health Services
Zelman	Michael	VP of External Relations	Enki Health Services

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	While the purpose and focus of PIP activities are logical for the improvement of MHP ED treatment, to date the measured metrics have failed to produce the intended changes. Therefore, low confidence is selected. With time and continued training and support efforts, this PIP may produce better results.

General PIP Information
MHP/DMC-ODS Name: LACDMH
PIP Title: Improving Treatment Services for Individuals with Eating Disorders
PIP Aim Statement: Will implementing training, consultation, a best practice toolkit, and an integrated practice network decrease the percent of Medi-Cal beneficiaries with EDs requiring a higher level of care from 4% to 2% per quarter, improve engagement rates from 70% to 75% and increase the number of individuals screened and assessed for EDs from 0.4% to 1.0% to reflect the nationwide one-year prevalence rates within 18 months?
Date Started: 06/2021
Date Completed: 06/2023
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:

General PIP Information
Target population description, such as specific diagnosis (please specify): Beneficiaries with ED.
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): Development of in-house ED expertise that reduces the need to refer out for specialized treatment.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Additional education of staff regarding diagnosis and treatment of EDs.
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): Provision of CBT training specific to ED, provision of workgroups and consultation forums to support clinician practice.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Number of clients receiving HLOC that step down to a lower level of care Target: Increase of 5 percentage points from baseline, 70.8%	FY 2020-21 Q4	N = 38 25/38 = 65.8%	FY 2021-22 Q4	N = 42 18/42 = 42.9%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2. a. # of clients that attend at least 2 services within 30 days b. 6 services within 90 days Target: Increase of 5 percentage points from baseline, a) 75.4%; b) 67.3%	FY 2020-21 Q3	N = 597 a) 420/597 = 70.4% 372/597 = 62.3%	FY 2021-22 Q4	N = 42 18/42 = 42.9%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3. Number of individuals diagnosed with EDs or eating concerns indicated on problem list Target: n/a	FY 2020-21 Q3 FY 2021-22 Q3	CBT training: N = 5509 40/5509 = 0.73% ED 101 trainings: N = 5954 39/5954 = 0.66%	FY 2021-22 Q4	CBT training: N = 4778 30/4778 = 0.63%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.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.

PIP Validation Information
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.
EQRO recommendations for improvement of PIP: The approach taken by the MHP of ED training and several aspects of consultation and case review would appear to be a logical process. But to date the data improvement has not corresponded to the effort. As this is a clinical PIP, the MHP should consider implementation of an instrument that provides case-related progress data, which would likely provide more granular information regarding the progress of those in treatment. Instrument selection and training on its use would be an appropriate addition to this PIP and may reveal the progress which the other metrics might not reflect. It is a common practice to pair use of a clinical outcome instrument with a clinical PIP.

Non-Clinical PIP

Table C1: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	This non-clinical PIP was initiated in response to the need to have accurate information regarding the capacity of MHP providers available on the MHP's website, and thereby reduce the number of programs contacted by beneficiaries and the overall time from request to the identification of an available provider. This PIP was intended as a one-year effort and resulted in changes to the SRTS system and improvements to the Provider Directory. However, both metrics that reflect the beneficiary experience did not show improvement as of the last measurement. These metrics included the number of programs contacted and the time from first attempt to find a provider to when an available provider is located. The process metrics tracked also did not show improvement between the baseline and last data reporting periods. Regardless of the low confidence reflected in the data, this effort was a logical and needed initiative. It may take continued improvement and streamlining efforts for improvements to emerge quantitatively in the performance data.
General PIP Information	
MHP/DMC-ODS Name: LACDMH	
PIP Title: Improving Referral Management and Efficiency Through an Online Provider Directory	
PIP Aim Statement: By adding additional provider data fields to the NAPPA application, implementing data update standards, and introducing a comprehensive Provider Directory training highlighting the system's latest developments, LACDMH will ensure providers have access to real-time program data within six months (such as clinic availability for beneficiaries) as evidenced by: a) decrease in the number of SRTS referrals with greater than two transfers from X to X b) decrease in the number of business days to multiple transfer resolution from X to X c) decrease in the percentage of providers that find the "accuracy of identifying service provider availability" a challenge from 33.4% to X% d) decrease in the percentage of providers that find the "speed at which needed information can be found" a challenge from 26.4% to X%	
Date Started: 9/2021	
Date Completed: 10/2022	

General PIP Information
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): All ages and diagnoses seeking initial treatment from the MHP.
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 accurate, up-to-date provider capacity information so that beneficiaries are not required to perform multiple searches and experience extended periods of time to find an available provider.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Encouraging providers to concurrently and monthly update their web presence with their ability to accept additional referrals.
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): Revision of the SRTS system (SRTS 2.0), which then provides status change information to the Provider Directory. This occurs through inputs into the NAPPA system.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Beneficiary Experience Measures						
Number of beneficiary referrals with multiple transfers Target: -1.1 Percentage Points (PP)	2021	Sample Size: 865 6.1%	June to August 2022	Sample Size: 509 12.4%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify): n/a
Number of business days to resolution of transfer request Target: -1.9 PP	2021	Sample Size: 11,959 6.9 days	June to August 2022	Sample Size: 6,463 8.2 days	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify): n/a
Process Measures						
Percentage of providers that report accurately identifying service provider availability is a challenge -10 PP	May 2022	Sample Size: 83 33.4%	August 2022	Sample Size: 55 52.7% (+28.7PP)	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of providers that report finding the information needed quickly is a challenge -10 PP	May 2022	Sample Size: 83 26.4%	August 2022	Sample Size: 55 32.8% (+8.8PP)	☐ Yes ☒No	☐ Yes ☒ No P-value: ☐ <.01 ☒ <.05 Other:
Percentage of providers that report the amount of staffing time and resources needed to update provider information is a challenge -5 PP	May 2022	Sample Size: 83 15.4%	August 2022	Sample Size: 55 16.4% (+7.5PP)	☐Yes ☒ No	☐ Yes ☒ No P-value: ☐ <.01 ☒ <.05 Other:
Percentage of providers that report the directory is challenging to use -5 PP	May 2022	Sample Size: 83 14.8%	August 2022	Sample Size: 55 30.9% (+10.6PP)	☐ Yes ☒ No	☐ Yes ☒ No P-value: ☐ <.01 ☒ <.05 Other:

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.

PIP Validation Information
Validation phase (check all that apply): ☒ ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Completed 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. Low confidence was selected due to the lack of improvement in the two beneficiary focused metrics, which were: number of providers contacted to locate an available program/clinician; and the total time between first request and actual securing of a treatment program.
EQRO recommendations for improvement of PIP: This PIP ends in October 2022, coinciding with the current FY 2022-23 EQR review. The MHP is encouraged to continue the efforts to improve the accuracy of provider capacity for the Directory. This likely needs to include continued responsiveness to input from providers to streamline and simplify the update process and remove any obstacles to timely updates.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, and PIP Validation Tool, are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required to be included in this report.