LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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Appendix A – LA County's Specialty Mental Health Services Quality Assessment Performance Improvement (QAPI) Work Plan Evaluation for Calendar Year 2023

Period: January 1, 2023, to December 31, 2023

Presented By:

Los Angeles County Department of Mental Health
Quality, Outcomes, and Training Division, Quality Improvement Unit

Service Delivery Capacity

Service Equity

Goal 1A.	Analyze root causes in the underrepresentation of self-identified Asian Pacific Islanders, and Communities with Physical Disabilities receiving DMH services.
Objective(s)	1. Through participation in the Solano County Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Learning Collaborative work with LACDMH stakeholders to develop a plan addressing barriers for engagement of Asian Pacific Islanders and communities with physical disabilities. • Prioritize unique community needs, current affairs (i.e., community violence and accessibility issues), and fluid resources. 2. Identify and address barriers to seeking mental health services for these populations. 3. Improve data collection for persons with disabilities to be able to better assess level of participation in DMH services.
Population	LACDMH and Legal Entity (LE)/Contracted programs providing outreach and outpatient SMHS to LACDMH clients and the Los Angeles County community at large.
Performance Indicator(s)	1. Unique Client Counts by Race/Ethnicity and physical disabilities 2. Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity 3. Service Equity Analysis Report Findings
Frequency of Collection	Annually
Responsible Entity	Quality, Outcomes, and Training Division – QA and QI Units

This goal was met.

The Plan to Address Barriers for Engagement of Asian Pacific Islander and Persons with Disabilities Community

DMH's strategy to address barriers for engagement of Asian Pacific Islanders and communities with disabilities is implementing capacity building projects aimed at reducing mental health stigma and increasing mental health education and awareness for these two communities.

To better address the mental health needs of the Asian Pacific Islander and persons with disabilities communities, we implemented capacity building projects specifically with a focus on accessibility issues and how we can reduce mental health disparities for the Asian Pacific Islander and persons with disabilities communities.

Four capacity building projects were completed which identified and addressed barriers to seeking mental health services for the Asian Pacific Islander community.

Asian Pacific Islander Capacity Building Projects

1. **1000 Cranes – Healing Through Arts and Culture Project**

   Barriers

   - Lack of bilingual and bicultural mental health care providers.
   - Cultural stigma and lack of understanding and knowledge of mental illness.

   How Barriers Were Addressed

   - Provided mental health education to the API community via culturally responsive virtual workshops focused on supporting mental well-being of individuals and their families.
   - Provided resources and information regarding available in-person and remote mental health services in Los Angeles County geared towards the API community.
   - Encouraged help-seeking behaviors and provided linkages to culturally responsive support services. As well as referrals to mental health services provided by directly operated and DMH-contracted agencies, whenever possible to the API community.
   - Built and strengthened resilience in the API community so that they can be better equipped to face the challenges and barriers associated with experiencing mental health difficulties.

2. **Korean Mental Health Navigation Services Project**

   Barriers

   - Limited number of easily accessible mental health resources especially for monolingual Korean community members.
   - Inability to provide effective outreach and connections with the Korean community which led to lack of ability to access mental health services.

   How Barriers Were Addressed

   - Engaged, empowered, and educated the Korean community through a series of educational workshops with specific emphasis on community members who are first generation monolingual Korean immigrants.
   - Developed and distributed culturally responsive Korean Mental Health Resource Booklet for community members to increase access to mental health services.
   - Provided support and assistance to community members in accessing and connecting with mental health services and resources provided by LACDMH.

3. **Cambodian American – Oral History of 1.5 Generation Project**

   Barriers

   - Cultural stigma and lack of understanding and knowledge of mental illness in first generation Cambodian Americans.
   - Lack of culturally responsive mental health services targeting the Cambodian community.

   How Barriers Were Addressed

   - Increased mental health education among the 1.5 generation of Cambodian Americans
   - Provided a better understanding of the cultural challenges to improve access to mental health services by the Cambodian community.

- Helped the community better understand how trauma impacts them and serves to normalize the acceptance of mental health services among Cambodian Americans.
- Identified coping strategies and mechanisms including resiliency and recovery used by this population to incorporate into future treatment modalities.

4. **Promoting Mental Health Wellness in South Asian Americans Project**

Barriers

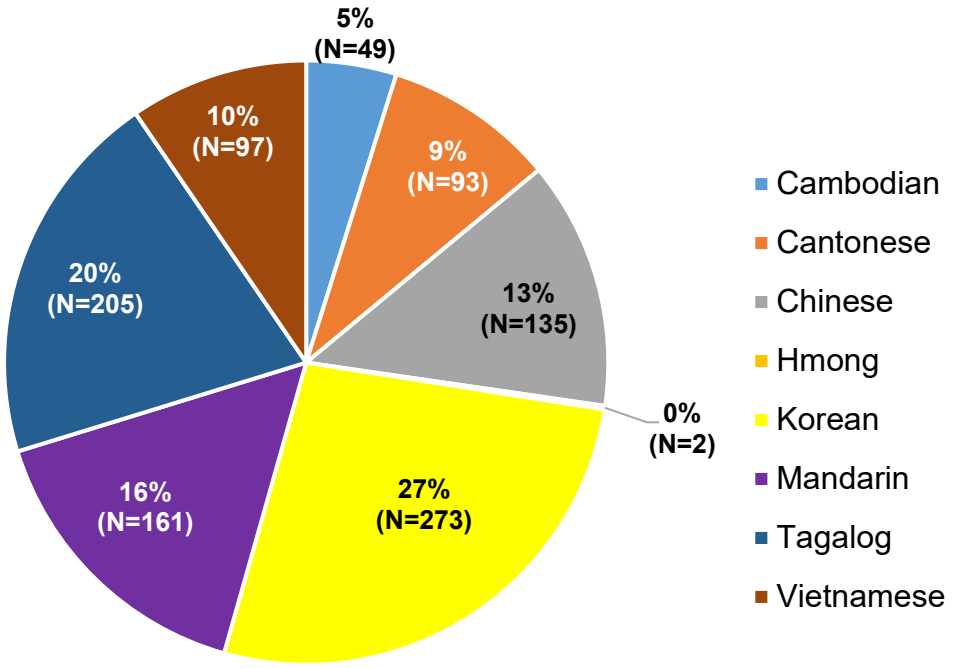
- Cultural stigma and lack of understanding and knowledge of mental illness in first generation South Asians.
- Cultural beliefs that hinder community members' ability to seek mental health services.
- Community members with lower levels of acculturation have limited understanding of available mental health resources and services.

How Barriers Were Addressed

- Provided relevant mental health education and outreach and engagement in the form of multi-generational workshops and short plays.
- Increased the community's understanding of mental health and connected them to available mental health resources.
- Provided safe space for community members to talk about mental health in a culturally congruent setting with bilingual, bicultural South Asian mental health community ambassadors to reduce stigma surrounding mental health.

In addition to the above capacity building projects, we increased the reach of the United Mental Health Promoters so that they can provide mental health education, stigma reduction strategies, linkages and outreach services targeting geographic areas within the API community. We also hired mental health promoters who speak Korean, Chinese, Tagalog, and other API languages. The chart below shows the language capacity and breakdown of our API practitioners.

Asian Pacific Islander Practitioners by Language Capacity, Calendar Year 2023



Capacity Building Projects Targeting Persons with Disabilities

Three different mental health capacity building projects were implemented to assess the needs of the disabled community in Los Angeles County. These three projects are listed below. All three projects have the same objectives and goals but targeted different subgroups within the disabled community.

1. Mental Health Needs Assessment for the Deaf and Hard of Hearing
2. Mental Health Needs Assessment for the Physically Disabled
3. Mental Health Needs Assessment for the Blind, Partially Sighted and Visually Impaired

The objectives of the above three projects were to outreach and engage people within the disabled communities from the eight Service Areas across Los Angeles County into a virtual discussion regarding the mental health needs, as well as to reduce the stigma associated with mental health services. These projects aimed to increase connections with mental health resources and provide opportunities to address concerns about mental health services. The contracted vendor outreached to people within these communities and engaged them in one of nine scheduled virtual Focus Groups to assess their mental health needs. Additionally, the contracted vendor identified gaps in accessibility to mental health services and determined how to effectively engage community members to mental health services provided by Los Angeles County Department of Mental Health.

Barriers

- Lack of accessibility of mental health services for individuals of the deaf and hard of hearing, physically disabled, and blind, partially sighted and visually impaired communities
- Lack of awareness of community resources that promote mental health well-being
- Lack of knowledge about the mental health resources for the deaf and hard of hearing community, physically disabled, and blind, partially sighted and visually impaired communities

How Barriers Were Addressed

- Developed promotional materials to recruit and educate the deaf and hard of hearing, physically disabled, and blind, partially sighted and visually impaired community members about mental health services
- Developed a resource guide specifically targeting the deaf and hard of hearing, physically disabled, and blind, partially sighted and visually impaired communities with a focus on mental health services
- Completed a marketing and outreach campaign using social media to engage these communities and promote mental health services
- Conducted mental health outreach events at each of the DMH Service Areas to increase mental health awareness and knowledge among the targeted communities

The Plan to Improve Data Collection for Persons with Disabilities

We are looking at strategies to enhance our electronic health record system to collect disability data. Due to the voluntary disability data collection practices and lack of staff training for the directly operated clinics, our data collection rate is low. Currently, we are in the planning process and looking at best strategies to improve DMH's data collection practices. Listed below are some of those strategies and recommendations that we hope to implement in the coming year.

1. Collect disability data in all contexts where other demographic data is collected

2. Collect and store disability data in ways that are respectful of personal and data privacy

3. Develop new and more inclusive methods of both defining disability and collecting disability data

4. Practitioners should embrace a growth mindset around disability data

5. Include people with disabilities in the creation, deployment, procurement, and auditing of all technologies

6. People with disabilities – particularly leaders with disabilities and those with technology, disability rights, or disability justice expertise – should be centered in the creation and implementation of technology and AI policies

7. Collect and store data in ways that are accessible to individuals with disabilities

Performance Indicators

1. Unique Client Counts by Race/Ethnicity and Physical Disabilities

Clients Served by Race/Ethnicity and Service Area

Service Area (SA)	Asian/ Pacific Islander	African American	Latino	Two or More Races	Native American	Unreported	White	Other	Total
SA 1	169	4,102	4,505	648	69	1,148	2,757	311	13,709
Percent	1.2%	29.9%	32.9%	4.7%	0.50%	8.4%	20.1%	2.3%	100.0%
SA 2	1,107	2,301	12,130	970	90	5,159	6,492	1856	30,105
Percent	3.7%	7.6%	40.3%	3.2%	0.30%	17.1%	21.6%	6.2%	100.0%
SA 3	2,780	3,155	11,001	953	142	7,723	4,309	1574	31,637
Percent	8.8%	10.0%	34.8%	3.0%	0.45%	24.4%	13.6%	5.0%	100.0%
SA 4	2,258	8,047	16,174	985	325	5,087	6,257	3038	42,171
Percent	5.4%	19.1%	38.4%	2.3%	0.77%	12.1%	14.8%	7.2%	100.0%
SA 5	369	2,574	2,738	502	54	1,765	3,273	673	11,948
Percent	3.1%	21.5%	22.9%	4.2%	0.45%	14.8%	27.4%	5.6%	100.0%
SA 6	364	10,581	12,862	670	155	3,053	2,053	919	30,657
Percent	1.2%	34.5%	42.0%	2.2%	0.51%	10.0%	6.7%	3.0%	100.0%
SA 7	596	1,470	11,860	688	229	3,753	2,233	765	21,594
Percent	2.8%	6.8%	54.9%	3.2%	1.06%	17.4%	10.3%	3.5%	100.0%
SA 8	2,171	7,426	13,724	1,249	126	4,850	5,423	1520	32,798
Percent	6.6%	22.6%	41.8%	3.8%	0.38%	14.8%	16.5%	4.6%	100.0%
Total	9,814	39,656	84,994	6,665	1,190	32,538	32,797	10656	197,840
Percent	5.0%	20.0%	43.0%	3.4%	0.60%	16.4%	16.6%	5.4%	100.0%

Clients Seen with Disability-by-Disability Type

	Distinct Clients	%
DMH Clients Seen by DO Providers in CY 2023*	102,600	100.00%
DMH Clients Seen by DO Providers in CY 2023 with any Disability (See Below)	20,048	19.54%

Disability Type	Source	Distinct Clients	Percent
Learning Disability	Adult Full Assessment	9,347	9.11%
Hearing Impairment	Child Full Assessment	202	0.20%
Sensory or Motor Impairment	Child/Adult Full Assessment	6,939	6.76%
Developmental Disability	CSI Assessment	905	0.88%
Developmental Diagnosis	Diagnosis	1,471	1.43%
Intellectual Disability		676	0.66%
Intellectual Disability	Problem List	513	0.50%
Developmental Disability		249	0.24%
Hearing-related Disability		7	0.01%
Mobility, Motor-related Disability		1	0.00%
Vision, Seeing-related Disability		11	0.01%
Hearing Impairment*	Immediate/Same Day Assessment	760	0.74%
Visual Impairment*		2,970	2.89%
Motor Impairment*		1,019	0.99%
Other Sensory Impairment*		323	0.31%

Note: *Hearing, Visual, Motor, and Other Sensory Impairment categories are new for CY 2023. Clients were able to select more than one disability causing the distinct clients by disability type (N=31,166) to be higher than the number of distinct clients with a disability (N=20,048). Data source: IBHIS data from LACDMH DO providers prepared by CIOB on 02/2024. Excludes clients who have received only one billable service or inpatient service.

2. Penetration Rates for Medi-Cal Enrolled Population with SED and SMI

The population of individuals enrolled in Medi-Cal who are estimated to be experiencing Severe Emotional Disturbance (SED)/Severe Mental Illness (SMI) is used as a sampling of people who may be in need of mental health services and who DMH should be prepared to serve. We use the penetration rate as an assessment of need for mental health services. The penetration rate is calculated by taking the number of consumers we have served and dividing it by the estimate of SED/SMI in the Medi-Cal enrolled population. Estimates of SED/SMI are calculated by taking 5% of the total population for each race/ethnicity. Applying the same percent across all race/ethnic categories, does not take into consideration differences in social determinants of health which can affect SED/SMI rates in the population. However, LACDMH uses this rate because SED/SMI prevalence rates specific to each ethnic group are not available from DHCS. Although the penetration rate is an estimate of the number of Medi-Cal enrolled members who may meet SED/SMI criteria and could potentially request mental health services from our system, it is important to recognize these individuals have the option of seeking services from other organizations such as non-profits, spiritual leaders, or other systems, or may not be interested in receiving mental health services at all.

Penetration Rates for Medi-Cal Eligible Beneficiaries with SED/SMI by Race/Ethnicity, Calendar Year 2023

	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Unreported	Other	Total
Medi-Cal Enrolled Population Estimated with SED and SMI	21,837	20,665	130,765	334	29,269		22,435		225,305
Outpatient Consumers Served	34,993	8,925	76,912	1,085	28,666	6,462	27,324	18,057	202,424
Penetration Rate	160.2%	43.2%	58.8%	324.9%	97.9%	N/A	121.8%	N/A	89.8%

Note: Number of Consumers Served represent consumers served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include consumers served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps as well as Inpatient Fee-For Service and County Hospitals. Data Source for Prevalence Rate: Dept. of Health Services (DHCS).

3. Service Equity Analysis Report Findings

We designed specific capacity-building projects tailored to the cultural norms and traditions of underserved communities. Our outreach, engagement, and educational efforts were focused on areas within the County with a significant concentration of API residents, especially in SA 3, 4, and 8. For the disability community, our efforts covered the entire county, with a particular focus on SA 1, home to a high concentration of individuals from the deaf and hard-of-hearing community. Each project was carefully developed to overcome cultural barriers preventing these communities from accessing mental health services. Our stigma reduction initiatives have also been shaped to incorporate cultural traditions, beliefs, customs, and non-traditional practices, ensuring a more personalized and inclusive approach to meeting the unique needs of these communities.

Delivering Culture-Specific Services

Goal 1B.	Share findings on the Department's capacity to deliver culture-specific services.
Objective(s)	1. Evaluate client satisfaction with American Sign Language (ASL) interpretation services, identify areas for improvement, and review findings with providers.
Population	Los Angeles County's deaf and hard of hearing communities, specifically, LACDMH DO clients and families receiving outpatient SMHS in ASL.
Performance Indicator(s)	1. Client satisfaction with ASL interpretation
Frequency of Collection	Annually
Responsible Entity	Cultural Competency Unit (CCU)

This goal was met.

The Anti-Racism, Diversity, and Inclusion (ARDI)- Cultural Competency Unit (CCU) and Language Assistance Services (LAS) Team were responsible for scheduling clinical appointments for Directly Operated and Legal Entities/Contracted providers during the business hours of 8:00 AM to 5:00 PM. All requests are submitted to and processed via the dedicated mailbox for ASL clinical appointments, ARDIaccessibility@dmh.lacounty.gov.

Additionally, the ARDI Division provided several LAS in-services to introduce the procedures to request ASL services for clinical appointments, the ARDI accessibility mailbox, responsibilities of the ARDI-LAS Team and the requesting provider, procedures for service request changes and/or cancellations, and importance of returning a completed ASL Service Satisfaction Survey (SSS). This same information was also disseminated to all providers in the system via a memorandum from the ARDI Division management and during key meetings such as Quality Assurance Forum, Quality Improvement Council, and Supervisors Forum.

The ARDI - LAS Team collected data on ASL satisfaction with interpreter services, from the online ASL SSS received during FY 2023-24. Briefly, the survey gathered feedback from service users on seven key areas:

1. How satisfied are you with the ASL interpreter services you received?
2. Did you have any problems with your ASL interpreter services?
   a. Tell us about the problem you experienced with your ASL interpreter services.
3. Was Interpreter able to meet your language needs?
4. Was the ASL interpretation accurate?
5. Did the ASL interpreter provide adequate uninterrupted service during the meeting?
6. Did the interpreter join the session in-person or via a virtual platform?
   a. If virtual, which platform?
   b. How likely are you to recommend ASL video conferencing interpreting to others?
   c. Were there any technical issues?
7. Open comments

During this reporting period, a total of 210 ASL SSS survey responses were received from consumers and staff coordinating ASL-facilitated clinical appointments, FY 2023-24. The analysis of responses gathered revealed the following outcomes:

A. Breakdown of 210 responses by type of respondent

- 188 satisfaction surveys were received from service providers (89%)
- 22 from clients/consumers (11%)

B. Breakdown of responses by ASL Vendor hired to provide the requested services.

- Language Line: 17 (9%)
- Lazar: 18 (10%)
- Purple Communications: 5 (3%)
- Other vendor: 19 (10%)
- Name of vendor not known by the survey respondent: 128 (68%)

C. Appointment modality

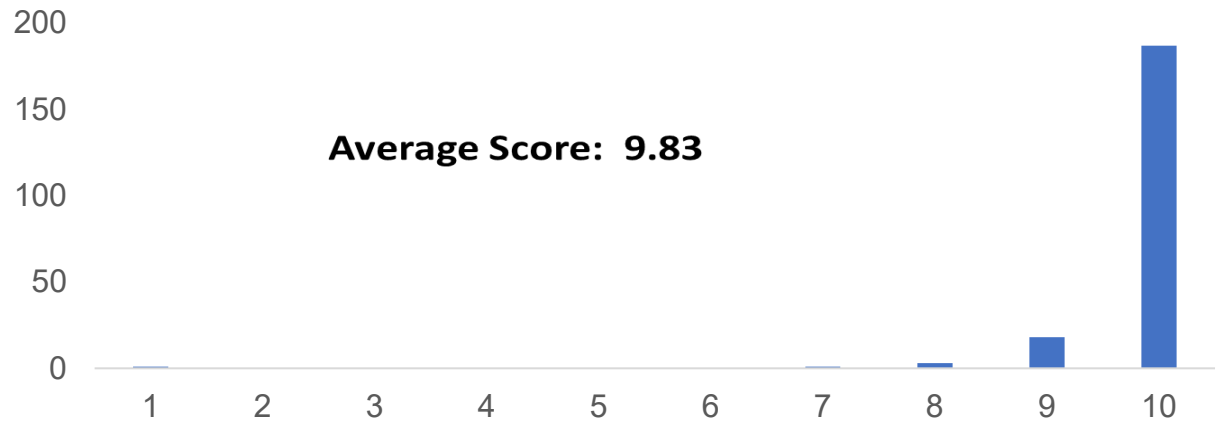
- 91 appointments were scheduled for In-Person ASL services (48%)
- 97 appointments were held via various virtual platforms (52%)
  - 46 Zoom (48%)
  - 32 Teams (34%)
  - 16 VSEE (17%)
  - 1 Other (1%)

D. Satisfaction ratings

The following section summarizes average satisfaction scores for ASL interpreter services by survey question and rating scale.

Out of 210 respondents, 187 or 89% reported being "completely satisfied with the ASL services received". The lowest score was seven, which was well above the mid-point of the rating range and was endorsed by only two respondents. The average score was 9.83.

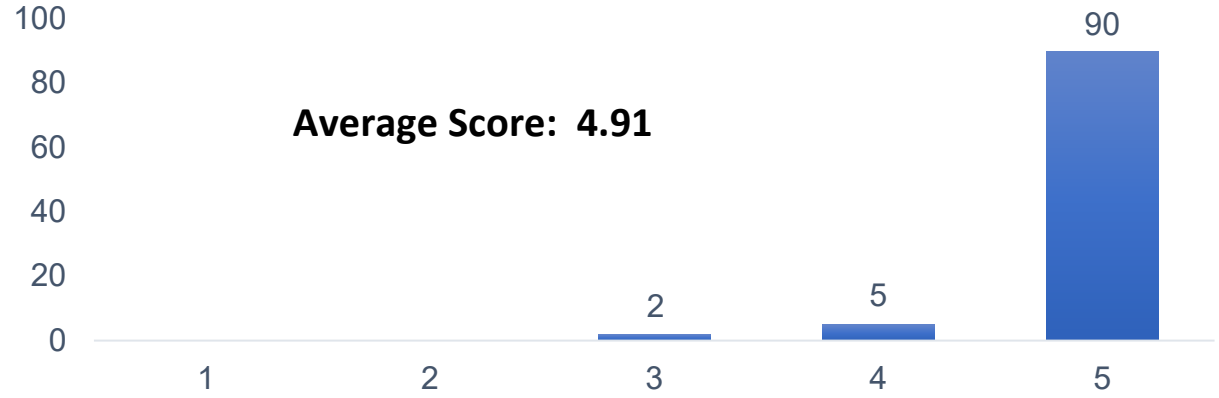
Satisfaction with the ASL Services Received



Note: Rating scale values: 0 = not at all satisfied, 10 = completely satisfied.

The majority of respondents who answered this survey question (N=90) endorsed a high likelihood of recommending ASL videoconferencing services, based on the average of 4.90 out of a maximum score of five.

Likelihood of Recommending ASL Videoconferencing Interpreting to Others



Note: Rating scale values: 1 = not at all, 3 = maybe, and 5 = definitely.

The range of responses regarding the ASL interpreters' ability to provide services without any interruptions. Most respondents (N=198) reported no interruptions while six or 2% reported interruptions. Although extremely small, the presence of results reporting interruptions during services could be utilized as an area of feedback for interpreters hired to facilitate clinical ASL appointments.

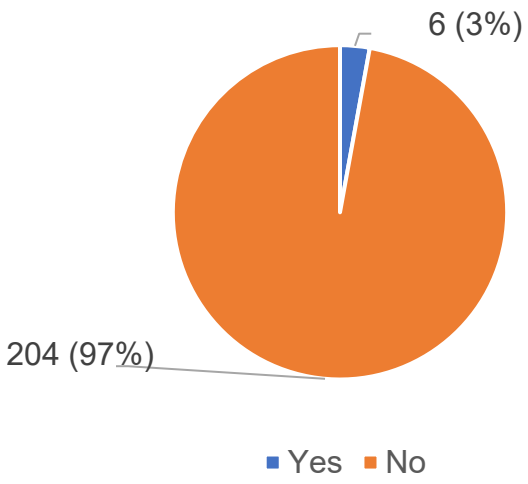
Provision of Uninterrupted ASL Interpreter Service During the Meeting

Note: Rating scale values: 1 = not at all, 3 = some, and 5 = nearly all meeting.

Out of 210 respondents, 204 (97%) reported having no problems with the services received and six respondents (3%) identified issues during the provision of ASL services. A careful review of the Open Remarks section of the survey revealed one comment pertinent to issues during ASL services. The statement specified the following: *"Yes, Internet connection issues [from the client's end]. The interpreter was patient and helpful in trying to problem solve. Unfortunately, the Internet connection was too poor for us to proceed with the session."*

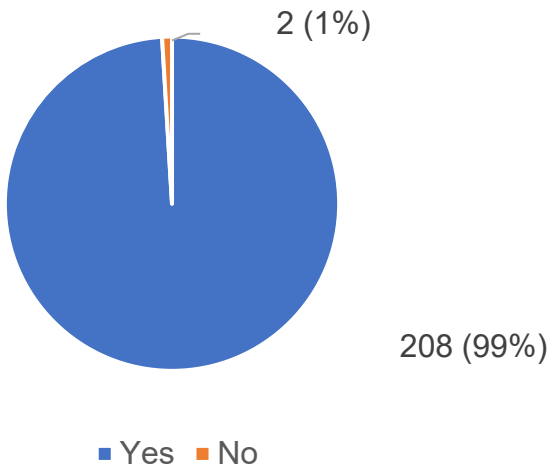
In an effort to obtain more information, the ARDI Division will revise the ASL SSS. The revision may include adding options for the respondents such as writing a comment about the issue(s) experienced with the ASL interpreter or providing a phone number to be contacted to further discuss their feedback.

Problems with ASL Interpreter Services Received



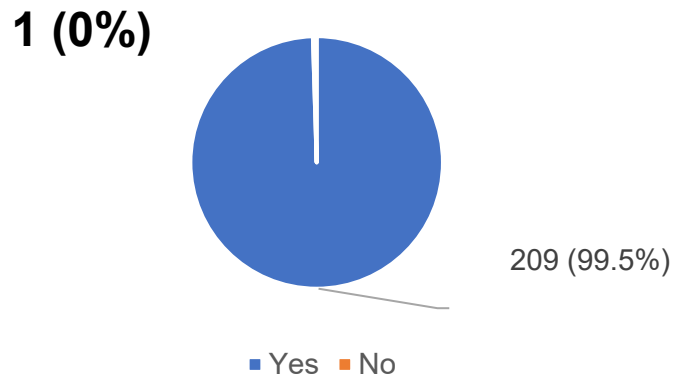
"Was the interpreter able to meet your language needs?" Out of 210 respondents, 208 (99%) reported that their ASL language needs were fulfilled by the interpreter services received, while two respondents answered that their language needs had not been fulfilled. The ARDI Division is currently working on a process to follow up on ASL SSS responses indicating dissatisfaction with services during FY 2024-25.

Fulfillment of Language Needs



"To the best of your knowledge, was the ASL interpretation accurate?" The most frequent answer to this question was "*yes*". A total of 207 respondents or 99.5% answered positively in comparison to one or 0.5% respondent answering negatively.

ASL Interpretation Accuracy



Finally, the ASL SSS' open comment section facilitated the collection of direct feedback from respondents regarding satisfaction with ASL interpreter services. Below is a list of verbatim comments about the ASL services provided by hired interpreters:

- *It was a good session.*
- *Amazing interpreters.*
- *Interpreters are great. They are patient and work well with the client and the clinician.*
- *Client was satisfied with interpreter services.*
- *Easy, straightforward, clear and professional; also, guidance and demeanor appropriate and approachable to client as well as provider.*
- *Great and very understanding with our client unique situation we are very appreciative of services.*
- *Great working with the interpreter.*
- *Great, calm, patient, accommodating and professional.*
- *I look forward to continuing working with interpreter.*
- *Interpreter is wonderful. I am grateful for her work, time, kindness, and support to my client.*
- *Interpreter was great.*
- *Interpreter was great, patient, efficient and was able to facilitate communication while compensating for some difficulties on the side of the client.*
- *Interpreter was very professional, nice, and overall, a great help for our session.*
- *Interpreters were on time, very professional, and client appeared very happy and comfortable with services provided by both interpreters.*
- *Interpreter is great to work with and I look forward to continuing working with her in future appointments.*
- *I am hoping to work with the same interpreter for future appointments interpreter was great and helpful.*
- *Patient requests the same interpreter for future appointments.*
- *Perfect interpreter was very helpful.*
- *Interpreter has been amazing with my client. I will continue to request the same interpreter.*
- *Excellent service. Interpreter was courteous, professional and friendly throughout the appointment.*
- *Interpreter did a great job, connected with patient and provider throughout the service.*
- *Interpreter is perfect.* 😊
- *Sign language communication very good.*
- *Thank you for the much-needed service.*
- *Thank you for your assistance with ASL for this session.*
- *Client was so impressed with the interpreter and requested the same interpreter in the future.*
- *Client provided positive feedback to me in session as well!!*

- *Very professional and easy to work with.*
- *Very good.*
- *Wonderful interpreter! I look forward to working with interpreter in the future.*

The ARDI-CCU made presentations to providers on ASL utilization and consumer satisfaction outcomes for FY 2022-23 at various departmental meetings attended by providers. Among them, the Quality Improvement Council in February 2023 and the Program Heads meeting in October 2023. Similarly, presentations on ASL services are scheduled for the QIC meeting and the departmental Cultural Competency Committee in September of 2024.

Telemental Health

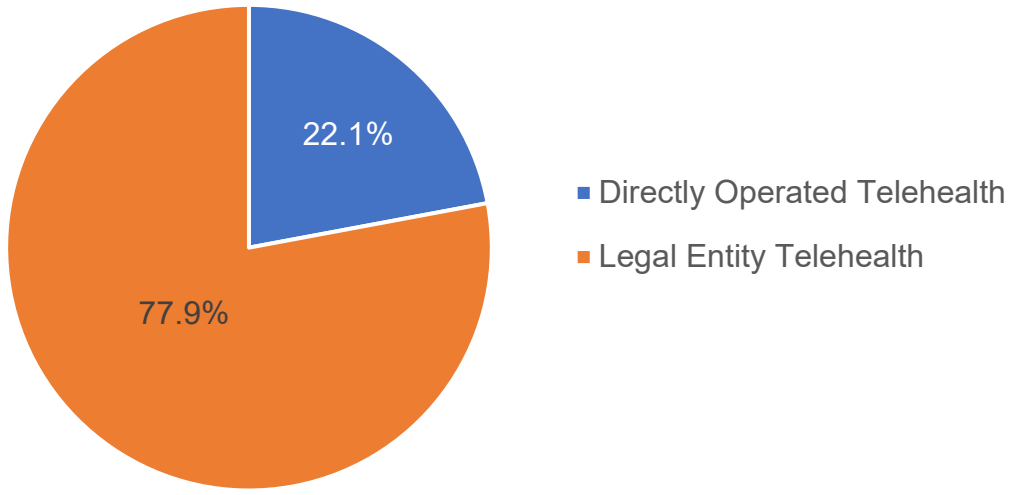
Goal 1C.	Ensure telemental health services, for those who choose to access services in that manner, are delivered with high quality.
Objective(s)	1. Utilize telemental health platforms as a way to deliver quality mental health services. Deliver telemental health services when a client requests it or prefers it.
Population	DO and LE/Contracted clients/families receiving outpatient SMHS.
Performance Indicator(s)	1. Number and percent of telehealth encounters by delivery type 2. Client satisfaction with telehealth services
Frequency of Collection	Annually
Responsible Entity	Chief Information Office Bureau (CIOB), Clinical Informatics Team

This goal was partially met.

Objective 1: Utilize telemental health platforms as a way to deliver quality mental health services. Deliver telemental health services when a client requests it or prefers it.

LACDMH delivered a total of 2,216,020 telehealth encounters in CY 2023 which were comprised of video or telephone visits. Of these, 488,934 telehealth encounters were provided by Directly Operated clinics and 1,727,086 were provided by Legal Entity/Contracted providers. Legal entities delivered 77.9% of all telemental health encounters in CY 2023.

Telehealth Encounters by Provider Type, Calendar Year 2023



Data source: CIOB, Clinical Informatics, July 2024.

Directly operated clinics experienced their highest percentage of telehealth encounters in the months of January through March, while the lowest percentage was in July. The months with the highest percentage of telehealth encounters for Legal Entity providers occurred during the months of January and February with the lowest percentage of telehealth encounters occurring in October. Of all the visits

delivered by Directly Operated clinics, 45% were delivered through telehealth whereas 40.4% of all encounters by Legal Entity providers were delivered through telehealth.

A satisfaction survey for telehealth services was not completed. However, in 2024 satisfaction questions regarding telehealth were added to the 2024 Consumer Perception Survey (CPS). Client and family feedback collected during the 2024 CPS on telehealth services is expected to be reported in 2025.

Number and Percent of Telehealth Encounters by Delivery Type for Directly Operated Clinics, Calendar Year 2023

Delivery Type	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2024	Dec 2023	Total
Face To Face/ Other	40,705	41,954	50,021	46,619	53,487	49,926	60,409	69,531	53,897	46,497	43,578	40,882	**597,506**
Percent	42.7%	45.2%	47.0%	49.0%	50.9%	51.3%	75.6%	74.3%	67.0%	53.6%	54.4%	55.3%	
Tele MH/ Video	8,072	7,943	9,340	8,271	9,101	8,440	4,635	6,029	6,506	9,445	8,816	7,951	**94,549**
Percent	8.5%	8.6%	8.8%	8.7%	8.7%	8.7%	5.8%	6.4%	8.1%	10.9%	11.0%	10.8%	
Telephone	46,524	42,827	47,068	40,164	42,452	38,915	14,830	17,978	20,083	30,772	27,741	25,031	**394,385**
Percent	48.8%	46.2%	44.2%	42.3%	40.4%	40.0%	18.6%	19.2%	25.0%	35.5%	34.6%	33.9%	
Total	**95,301**	**92,724**	**106,429**	**95,054**	**105,040**	**97,281**	**79,874**	**93,538**	**80,486**	**86,714**	**80,135**	**73,864**	**1,086,440**
Total Telehealth (Video + Telephone)	54,596	50,770	56,408	48,435	51,553	47,355	19,465	24,007	26,589	40,217	36,557	32,982	488,934
Telehealth Percent	**57.3%**	**54.8%**	**53.0%**	**51.0%**	**49.1%**	**48.7%**	**24.4%**	**25.7%**	**33.0%**	**46.4%**	**45.6%**	**44.7%**	**45.0%**

Note: Counts beginning in July 2023 exclude Prolong and other Add On codes introduced for CalAIM as that would falsely inflate counts. Data source: CIOB, Clinical Informatics, July 2024.

Number and Percent of Telehealth Encounters by Delivery Type for Legal Entity/Contracted Clinics, Calendar Year 2023

Delivery Type	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2024	Dec 2023	Total
Face To Face/ Other	224,561	220,295	255,767	222,625	246,820	209,285	175,311	212,292	190,177	213,828	195,289	178,290	**2,544,540**
Percent	57.2%	58.8%	59.1%	60.3%	60.9%	58.6%	59.4%	59.9%	60.0%	61.0%	60.1%	59.9%	
Tele MH/ Video	70,868	64,800	73,987	62,703	67,799	66,624	36,336	40,644	33,687	35,665	35,312	30,905	**619,330**
Percent	18.0%	17.3%	17.1%	17.0%	16.7%	18.7%	12.3%	11.5%	10.6%	10.2%	10.9%	10.4%	
Telephone	97,428	89,788	102,809	83,957	90,437	81,018	83,529	101,471	93,064	101,104	94,554	88597	**1,107,756**
Percent	24.8%	24.0%	23.8%	22.7%	22.3%	22.7%	28.3%	28.6%	29.4%	28.8%	29.1%	29.8%	
Total	**392,857**	**374,883**	**432,563**	**369,285**	**405,056**	**356,927**	**295,176**	**354,407**	**316,928**	**350,597**	**325,155**	**297,792**	**4,271,626**
Total Telehealth (Video + Telephone)	168,296	154,588	176,796	146,660	158,236	147,642	119,865	142,115	126,751	136,769	129,866	119,502	**1,727,086**
Telehealth Percent	**42.8%**	**41.2%**	**40.9%**	**39.7%**	**39.1%**	**41.4%**	**40.6%**	**40.1%**	**40.0%**	**39.0%**	**39.9%**	**40.1%**	**40.4%**

Note: Counts beginning in July 2023 exclude Prolong and other Add On codes introduced for CalAIM as that would falsely inflate counts. Data source: CIOB, Clinical Informatics, July 2024

Alternative Crisis Response

Goal 1D.	Create a robust, reliable, and timely 24/7 mental health alternative to law enforcement response for individuals in crisis
Objective(s)	1. Utilize the 988 Call Center for individuals experiencing a mental health crisis. 2. Establish criteria for 911 operators to transfer mental health crisis calls to 988 vs. initiating a law enforcement response. 3. Increase the availability of Field Intervention Teams to respond 24/7 when needed and improve response time.
Population	Persons in LA county experiencing a mental health crisis
Performance Indicator(s)	1. 988 Calls per month, including disposition and timely answering of calls. 2. Number of Field Intervention teams operating 3. Field Intervention Team time from deployment to responding on scene
Frequency of Collection	Monthly
Responsible Entity	Alternative Crisis Response Office, Chief Information Office Bureau (CIOB)

This goal was met.

Objective 1: Utilize the 988 Call Center for individuals experiencing a mental health crisis.

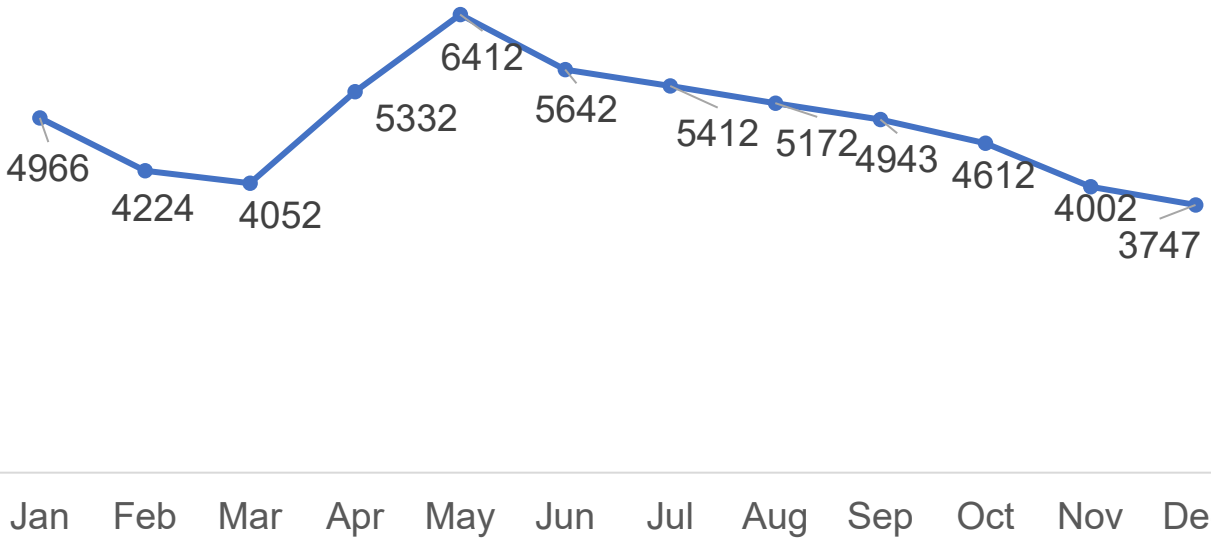
In July 2022, DMH contracted with the Didi Hirsch Suicide Prevention Center to serve as the local 988 Call Center operator for Los Angeles County. The 988 Call Center provides 24/7 access to crisis counselors via call, text, and chat, and serves the County as the preferred, "no wrong door" place to access support for individuals experiencing a behavioral health crisis. Didi Hirsch employs over 400 trained counselors, who provide crisis intervention, risk assessment and de-escalation to callers. They also share information on resources to help people in distress, as well as their friends/family. Didi Hirsch provides follow-up services to high-risk callers.

Approximately 97% of calls to the 988 Call Center are safely resolved over the phone. Around 2% are referred to 911 because they involve an immediate threat to public safety or require medical attention. Approximately 1% of calls are referred to the DMH Help Line for the potential deployment of a DMH Field Intervention Team (FIT). Through this model, DMH is able to provide 988 services to the public in a manner that is integrated with DMH's other crisis response resources, including an in-person response, ensuring that individuals can receive the appropriate level of care and remain in their community. DMH has provided training to Didi Hirsch counselors to ensure that callers who may benefit from an in-person mental health response are appropriately transferred to the DMH Help Line.

For Calendar Year (CY) 2023, the 988 Call Center received 58,516 calls, texts, and chats. Of the CY 2023 988 calls, 534 were transferred to the DMH Help Line for further support.

Next steps will include promoting 988 to the public through the current "Who Do I Call for Help?' marketing campaign, as well as the development of a multichannel marketing campaign designed to broaden awareness of 988 and DMH's crisis resources.

Monthly 988 Call Volume for Calendar Year 2023



Objective 2: Establish criteria for 911 operators to transfer mental health crisis calls to 988 vs. initiating a law enforcement response.

In 2023, DMH participated in the Alternative Crisis Response (ACR) Working Group of the Countywide Criminal Justice Coordinating Committee (CCJCC) to develop a Countywide framework for the diversion of certain behavioral health calls from 911 to 988, as a means of providing residents with a mental health-led response, rather than a law enforcement one. The working group included representatives from DMH, the Los Angeles Sheriff's Department (LASD), the Los Angeles Police Department (LAPD), and the Los Angeles Area Police Chiefs' Association. The group adopted a framework that may be adopted by each of the County's 47 police departments when implementing 911-to-988 call diversion.

The diversion protocol has been implemented by LAPD, covering 21 police stations within the City of Los Angeles. During CY 2023, 1,382 calls were diverted by LAPD to the 988 Call Center.

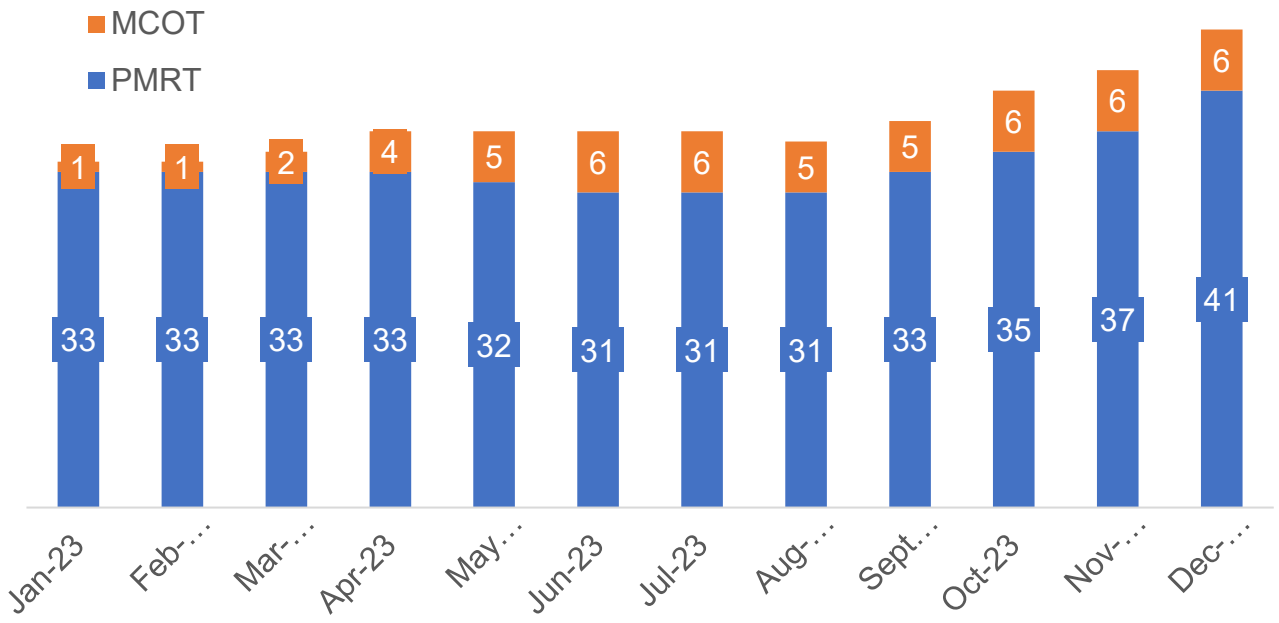
The framework is in the process of being implemented by LASD at the Lancaster station, with two additional LASD stations to follow during CY 2024. Discussions are underway to also implement the protocol at the Bell Gardens Police Department and Pomona Police Department.

Next steps include facilitating implementation of the framework at additional police departments; working with departments to increase volume of calls referred to 988; and adapting a framework for use by secondary Public Safety Answering Points (PSAPs) and Emergency Medical Services (EMS) agencies.

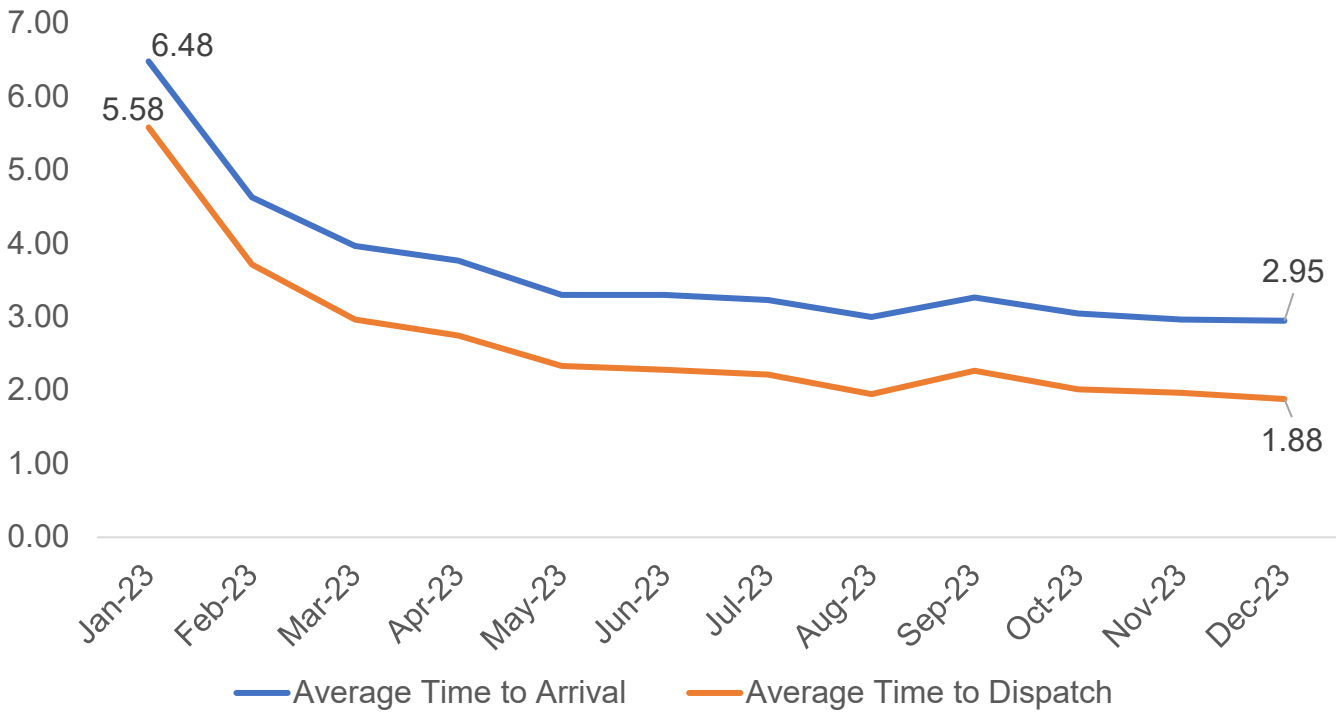
Objective 3: Increase the availability of Field Intervention Teams to respond 24/7 when needed and improve response time.

Since January 2023, the number of FIT teams has been expanded from 34 to 47. There were another 15 teams providing additional coverage during nights and weekends on an overtime basis. The FIT teams achieved Countywide 24/7 coverage in December 2023. Average FIT response times have declined from 6.48 hours in January 2023 to 2.95 hours in December 2023.

Number of Field Intervention Teams by Type, Calendar Year 2023



Average FIT Response Times in Hours, Calendar Year 2023



Making mobile crisis services timely and available Countywide 24/7 required a substantial expansion of the FIT teams, which was accomplished through a combination of financial recruitment incentives, creative outreach efforts, and aggressive recruitment. In August 2023, DMH announced a package of over $10,000 in retention and hiring bonuses, increased field staff bonuses, and doubled shift differentials for field personnel working evening, night and weekend shifts. This was accompanied by the creation of an ACR Hiring Strike Team, which developed new external outreach tools and worked collaboratively to streamline the hiring process.

DMH also leveraged the County's Proclamation of Local Emergency for Homelessness, which expedited the recruitment and hiring for positions providing mental health. The Proclamation allowed DMH to issue emergency hiring bulletins and hold a series of emergency hiring fairs, which vastly shortened the hiring timeline for interested candidates.

Through these efforts, DMH filled more than 50 vacancies in its field intervention programs. DMH also contracted with three agencies to provide additional FIT coverage specifically during the harder to fill night and weekend shifts.

Concurrently with this expansion, a number of technical tools were implemented to improve the speed and quality of DMH's mobile crisis services. These include the development of the County's Standardized Crisis Assessment Tool to aid dispatchers in determining whether an in-person FIT response was needed. A centralized Dispatch Board was implemented, which enabled Countywide visibility and situational awareness over crisis calls received by the ACCESS Help Line, the dispatch of FIT teams to respond to those calls, and the ultimate disposition of those calls. An ACR Dashboard was also implemented to synthesize crisis call data and develop reports to assist teams with quality improvement.

Next steps will include continued efforts to expand FIT capacity. DMH currently operates several Therapeutic Transportation units that may be integrated into the system to provide mobile crisis services. Hiring is underway for eight teams that will be dedicated to conducting follow-up and referral services for crisis patients, particularly those who have been the most difficult to connect to long-term treatment in our system.

To summarize, DMH has established a 24/7 mental health alternative to a law enforcement response for individuals in crisis and has integrated the 988 Call Center into its crisis continuum of care. While the system has drastically improved timeliness through a reduction of response times by our Field Intervention Teams, it has not yet reached the targets established by the state for compliance with its Mobile Crisis Benefit.

Accessibility of Services

Timely Access to Services

Goal 2.	DMH will meet 80% of initial requests for outpatient SMHS with a timely appointment.
Objective(s)	1. Monitor time to first offered appointment. • Providers should offer routine (non-urgent) appointments within ten business days (not including weekends and holidays) of the initial request. • Providers should offer urgent appointments within 48 hours (including weekends and county holidays) of the initial request. • Providers should offer follow-up hospital discharge or jail release appointments within five business days (not including weekends and holidays) of the initial request. 2. Monitor wait times to initial medication evaluation appointments.
Population	Any individual requesting outpatient SMHS from DMH as a client, potential client or on behalf of someone. This also includes Los Angeles County DMH clients receiving inpatient psychiatric services from the Department of Health Service (DHS), Fee-for-Service (FFS) Contracted, Non-Contracted, Non-Governmental Agency (NGA), and Contracted IMD Exclusion Hospitals seeking outpatient SMHS from a DMH provider
Performance Indicator(s)	1. Rates of timeliness by service request type (routine, urgent, and hospital discharge/jail release) 2. Wait times to initial medication evaluation appointments 3. Documentation and dissemination of best practices amongst providers with highest rates of timeliness
Frequency of Collection	Quarterly
Responsible Entity	Quality Assurance Unit

This goal was partially met.

Objective 1: Monitor time to first offered appointment.

The QA unit monitored timelines of initial requests for appointments for routine, urgent and hospital discharge/jail release request types. LACDMH met the 80% timeliness target for routine requests in the months of February, March and June and in the months of April, May and August over 79% of requests were scheduled timely. For Urgent requests, LACDMH only met the target in the months of October, November, and December. For Inpatient/Jail Discharge requests, LACDMH met the target for the entire calendar year.

Percent of Appointments Scheduled Timely by Service Request Type, Calendar Year 2023

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Routine												
% Timely Appointments or Declined Referral	75.0 %	81.8 %	89.9 %	79.9 %	79.1 %	84.0 %	76.9 %	79.2 %	77.7 %	75.3 %	73.5 %	72.8 %
Urgent												
% Timely Appointments or Declined Referral	49.1 %	43.3 %	24.8 %	31.8 %	36.1 %	34.2 %	29.3 %	37.8 %	36.8 %	88.8 %	89.7 %	90.4 %
Inpatient/Jail Discharge												
% Timely Appointments or Declined Referral	84.7 %	85.7 %	85.1 %	88.6 %	87.3 %	92.1 %	84.5 %	85.8 %	85.1 %	85.2 %	86.0 %	88.9 %

Note: Per consultation with DHCS, Urgent requests included Field Intervention Team Dispatches as of October 2023.

The QA unit identified five providers with high rates of timely access to care and collaborated with them on identifying best practices. These providers were asked to present during the Access to Care Webinars in February and April 2023. The five providers were Enki, Rio Hondo Mental Health Center, Antelope Valley Mental Health Center, Augustus Hawkins Family Mental Health Center, and Long Beach Child and Adolescent Program. Several of these providers updated their workflows to allow for more efficient scheduling of clients. Some of the providers created assessment only teams and added intake slots or created triage/screening teams to determine when other medically necessary services could be offered first, or if a client's level of need did not rise to the level of specialty mental health services and could be served through managed care plans. Additionally, various providers leveraged the flexibility afforded by the California Advancing and Innovating Medi-Cal (CalAIM) program to see patients sooner. One provider discussed their implementation of many groups to be able to serve more clients despite the staff shortages, and utilization of peers and paraprofessionals to offer rehabilitation services.

The best practices identified and presented by the QA unit during the Access to Care webinar in April 2023 were as follows:

- Create standardized intake slots
- Create assessment only teams
- Double book appointments due to no shows (create stand-by lists, wait 15 minutes, then assign a different intake or walk-in)
- Reduce intake slot duration to increase slots (implement Immediate/Same Day Assessment)
- Have clinicians take on additional assessments (increase # of intakes clinical staff are completing per week)
- Have supervisors complete assessments in order to create more intake slots
- Case management/rehab/or nursing evaluation first when medically necessary
- Implement screening and transition tools
- Closely monitor intake slots: add slots when appointments go beyond 8 or 9 days out, supplement with supervisor intake slots

Objective 2: Monitor wait times to initial medication evaluation appointments.

The QA unit monitored wait times for initial medication evaluation appointments for DO clinics for CY 2023. DO clinics did not meet the target for medication evaluation appointments in 2023. LACDMH is currently working on collecting wait times for medication evaluation appointments for contracted providers.

Percent of Medication Evaluation/Psychiatry Appointments Scheduled Timely by Directly Operated Providers, Calendar Year 2023

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
% Timely Appointments or Declined Referral	42.3%	42.3%	42.3%	42.2%	41.9%	44.1%	43.2%	48.5%	45.1%	54.9%	48.7%	50.1%
Median Business Days	-	-	-	21	20	22	19	17	18	14	17	16

Note: Working on collecting psychiatry data from Contracted Providers

Beneficiary Satisfaction

Client/Family Satisfaction

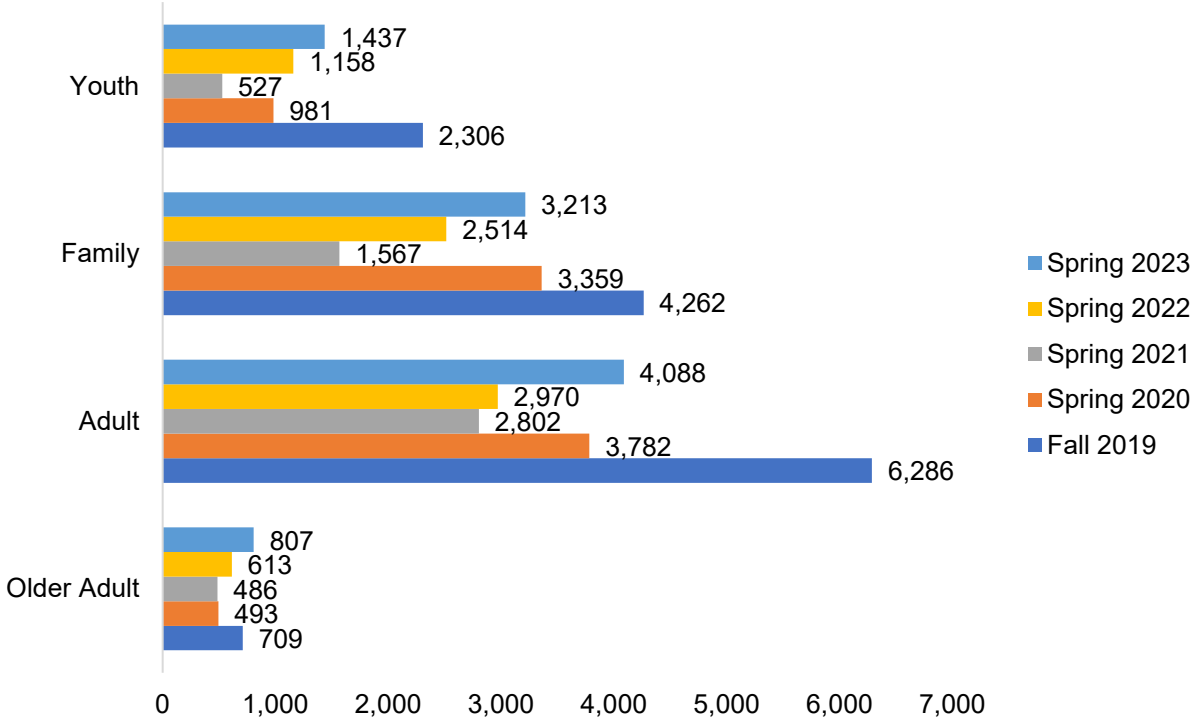
Goal 3A.	Evaluate findings and develop data-driven improvement strategies at the Service-Area level.
Objective(s)	1. Review the data on different manners in which CPS surveys were collected. 2. Increase data collection of Sexual Orientation and Gender Identity (SOGI) related demographics to assess the quality and delivery of affirming care. 3. Roll out a Power BI portal to evaluate and report out provider-level performance trends. 4. Monitor response rates and review the mechanism for tracking participation history and program types. 5. Share successful strategies to increase data collection and best practices to increase consumer satisfaction.
Population	DO and LE/Contracted clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Number of returned surveys/respondents by CPS form and administration method 2. Percentage of SOGI data collected vs Declined to Answer 3. Publication of Power BI report with accessible provider level reports 4. Increase in response rates and satisfaction ratings from year to year
Frequency of Collection	Annually
Responsible Entity	QI Unit

This goal was partially met.

Objective 1: Review the data on different manners in which CPS surveys were collected.

In 2023, a total of 12,180 surveys were returned for all age groups and 9,545 were completed, which was an increase of 2,320 completed surveys from 7,255 in 2022.

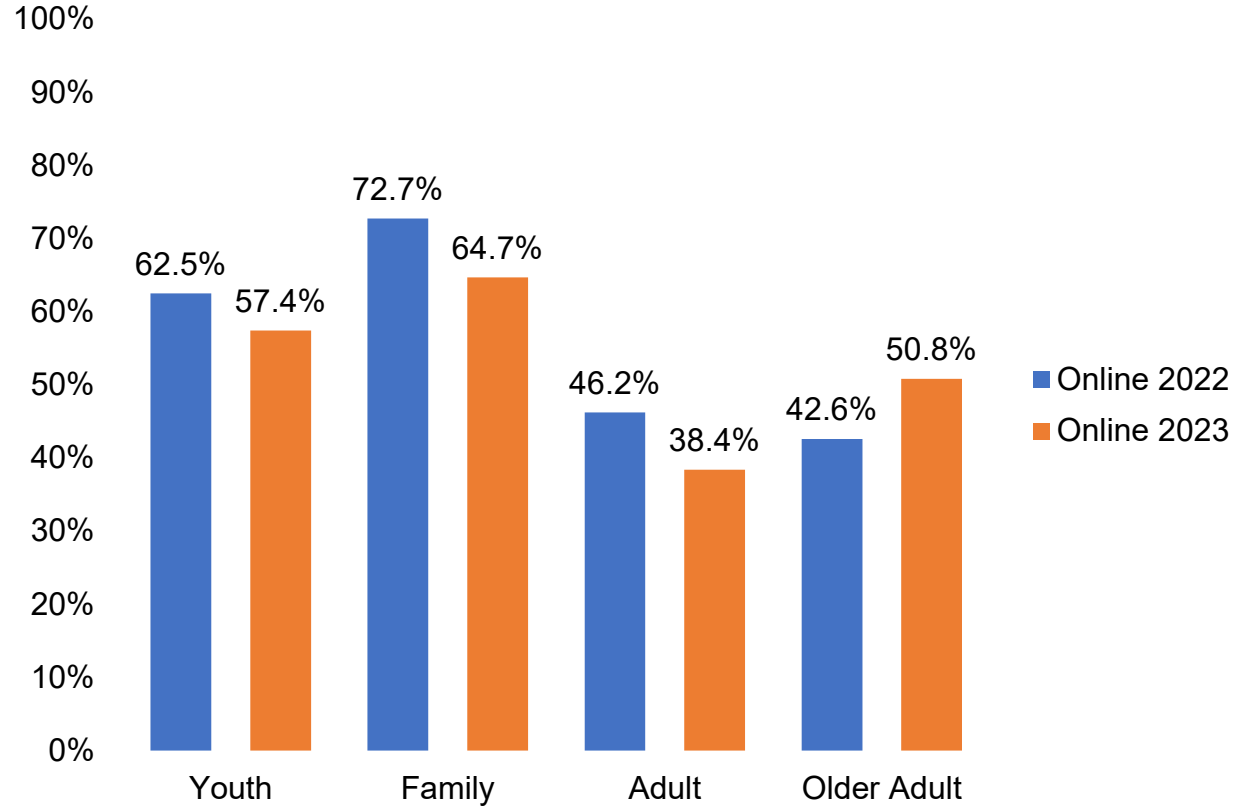
Completed Survey Five-Survey Period Trend, Fall 2019- Spring 2023



Data Source: CPS data reports, 2019-2022. UCLA Consumer Perception Survey Los Angeles County Report May 2023 Survey Period, December 2023.

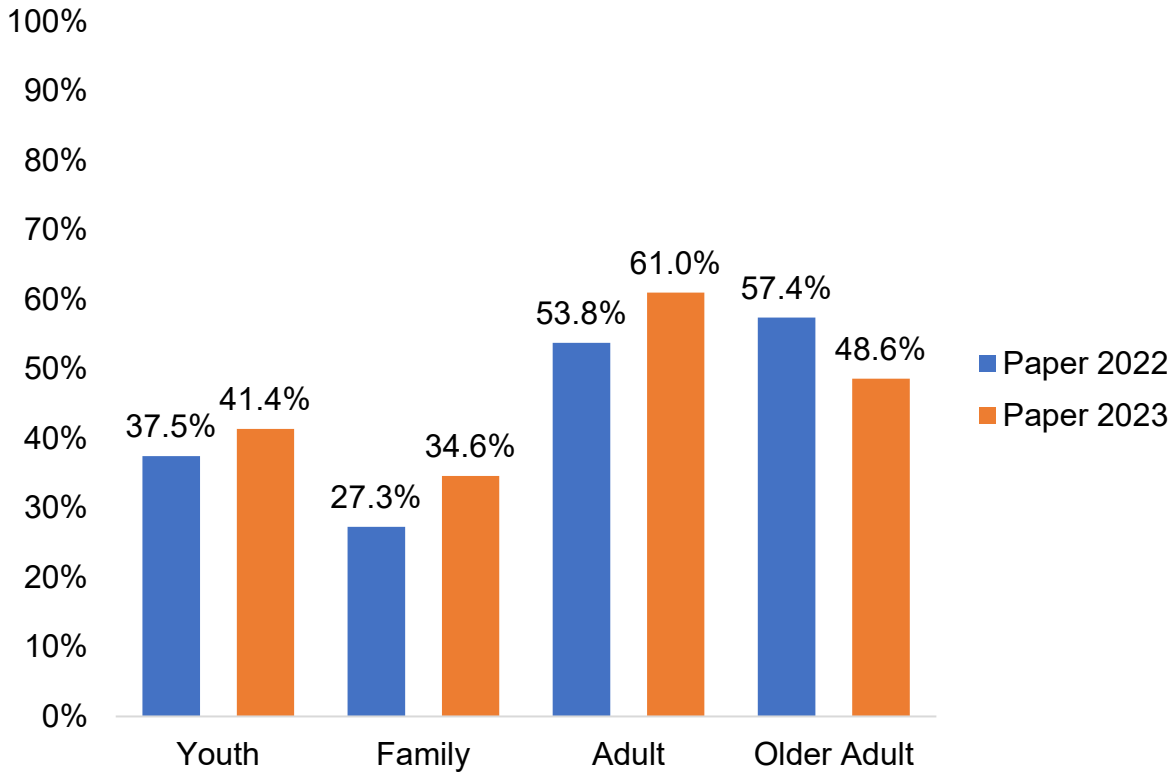
Use of the online formats, LACDMH electronic survey and UCLA electronic survey combined, decreased for all age groups in 2023, except Older Adults which increased by 8.2 Percentage Points (PP). Families, Youth, and Adults completed more paper surveys in 2023.

Completed Surveys by Format, Online 2022 and 2023



Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2022 Survey Period, February 2023. UCLA Consumer Perception Survey Los Angeles County Report May 2023 Survey Period, December 2023.

Completed Surveys by Format, Paper 2022 and 2023



Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2022 Survey Period, February 2023. UCLA Consumer Perception Survey Los Angeles County Report May 2023 Survey Period, December 2023

Objective 2: Increase data collection of Sexual Orientation and Gender Identity (SOGI) related demographics to assess the quality and delivery of affirming care.

During the CY 2023 CPS period, LACDMH included SOGI-related demographic questions into the LACDMH electronic surveys for all age groups. The SOGI questions were developed during Fiscal Year (FY) 2020-21 with stakeholder feedback prioritized and under the guidance of the DMH LGBTQIA2-S Specialty Care Workgroup, the LGBTQIA2-S UsCC Subcommittee, and the Cultural Competency Committee.

SOGI demographic questions included gender identity, sex designated at birth and sexual orientation. Consumers were given the opportunity to respond voluntarily to the questions asked. Listed on the Youth, Family, Adult and Older Adult surveys were the following questions and response options:

What is your gender identity?

- Man
- Woman
- Transgender man / Transmasculine
- Transgender woman / Transfeminine
- Non-binary (e.g., genderqueer or gender-expansive)
- Another category (e.g., Two-Spirit)
- Undecided/unknown at this time.
- Not sure what this question means.
- Prefer not to answer.

What was your sex designated or listed at birth?

- Male
- Female
- X
- Another category (e.g., Intersex)
- Prefer not to answer.

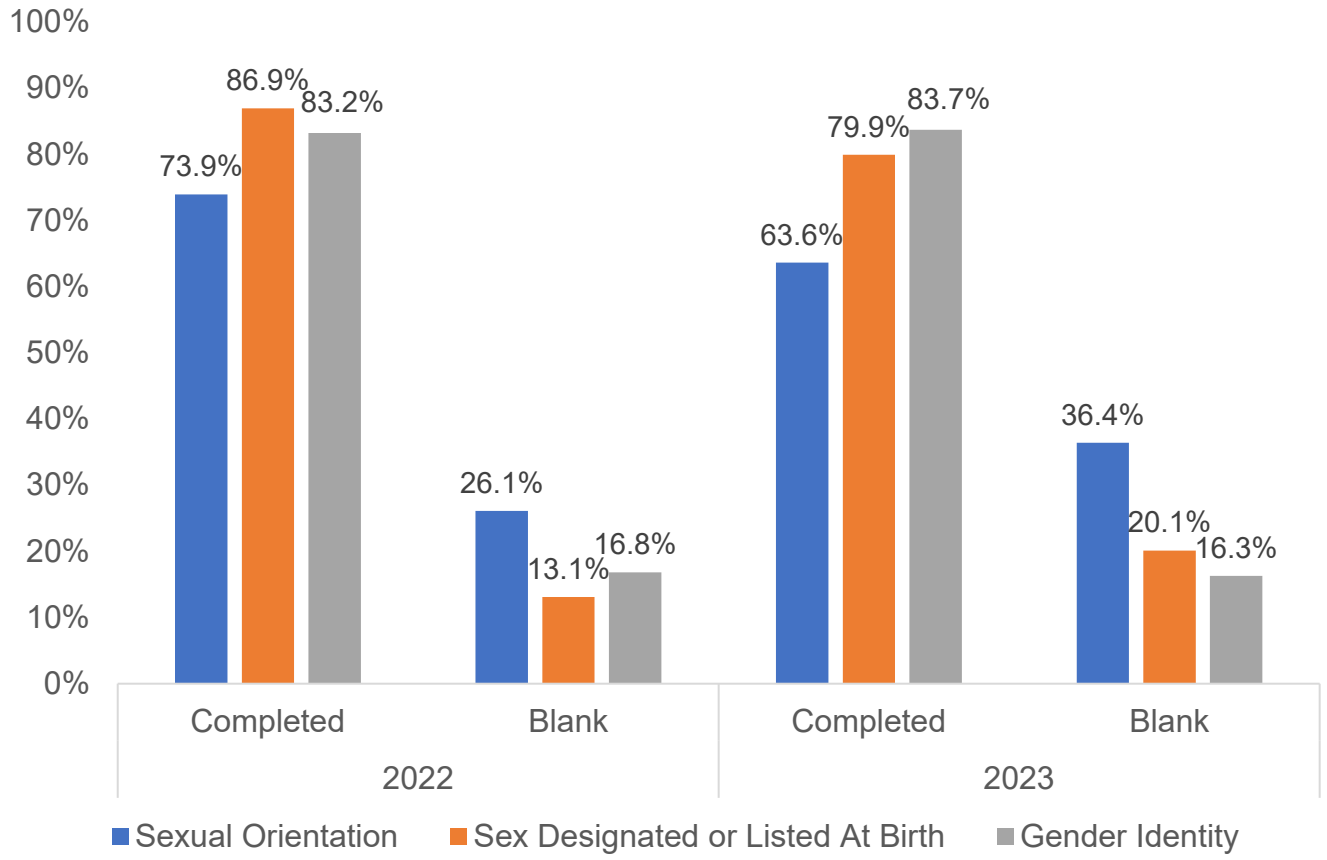
Do you think of yourself as:

- Heterosexual/straight
- Gay or lesbian
- Bisexual or pansexual
- Something else (e.g., queer, asexual)
- Undecided/unknown at this time.
- Not sure what this question means.
- Prefer not to answer/prefer no labels.

While SOGI questions were included in the LACDMH CPS electronic Family Surveys, analysis, and report of responses was not initiated and is not included here due to lack of formal reporting regulations from local, state, and federal guidelines regarding caregiver report of SOGI responses on behalf of minors. Data will be held until further guidance and regulations are implemented.

On the gender identity question, 1,071 (83.7%) adult respondents answered the question, 1,022 (79.9%) responded to the sex designated or listed at birth question, and 814 (63.6%) provided a response on the sexual orientation question. Adult responses to SOGI questions declined from 2022 to 2023, except for gender identity which remained about the same. The largest increase in blank responses was in the sexual orientation category.

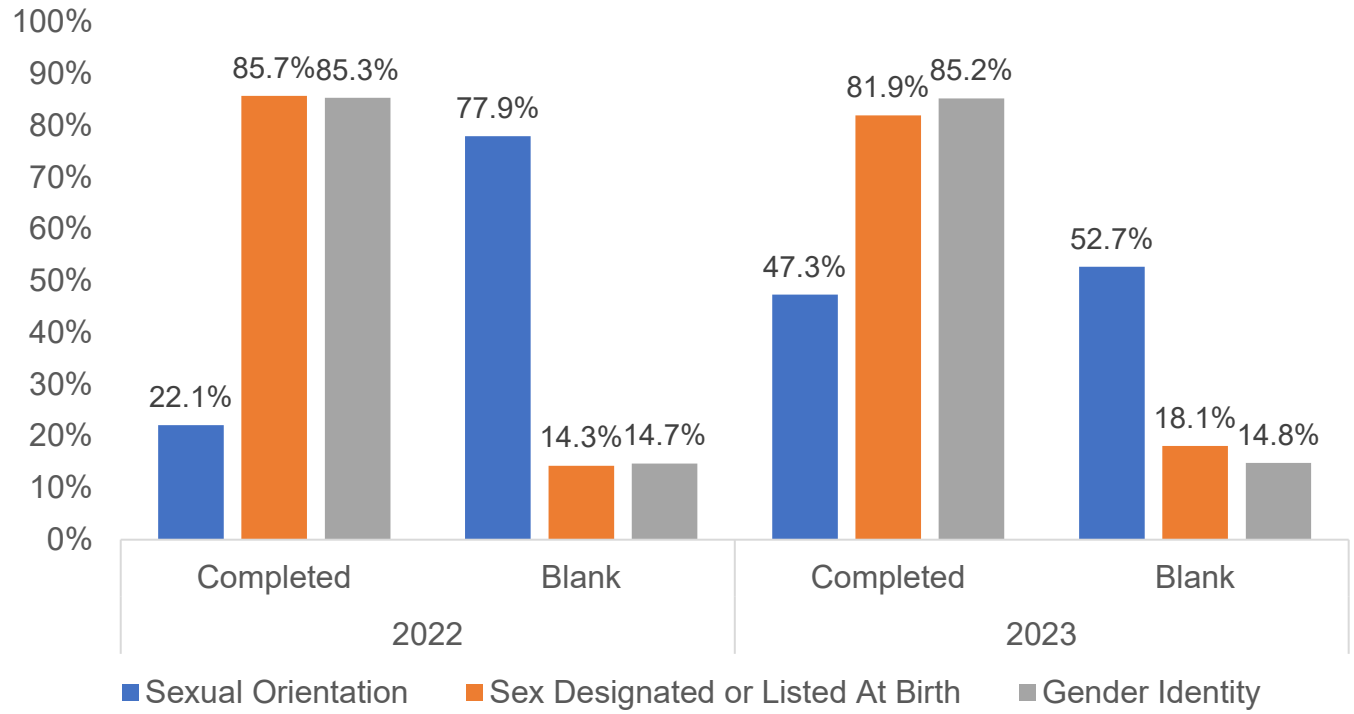
Percentage of Completed and Blank SOGI questions for Adults, Calendar Year 2022 and 2023



Data Source: Consumer Perception Survey data, May 2022 and May 2023.

On the gender identity question, 335 (85.2%) of Older Adult respondents answered the question, 322 (81.9%) responded to the sex designated or listed at birth question, and 186 (47.3%) provided a response on the sexual orientation question. Responses increased for Older Adults from 2022 to 2023, particularly for the sexual orientation category. For the categories of sex designated or listed at birth and gender identity there was a small increase in blank responses.

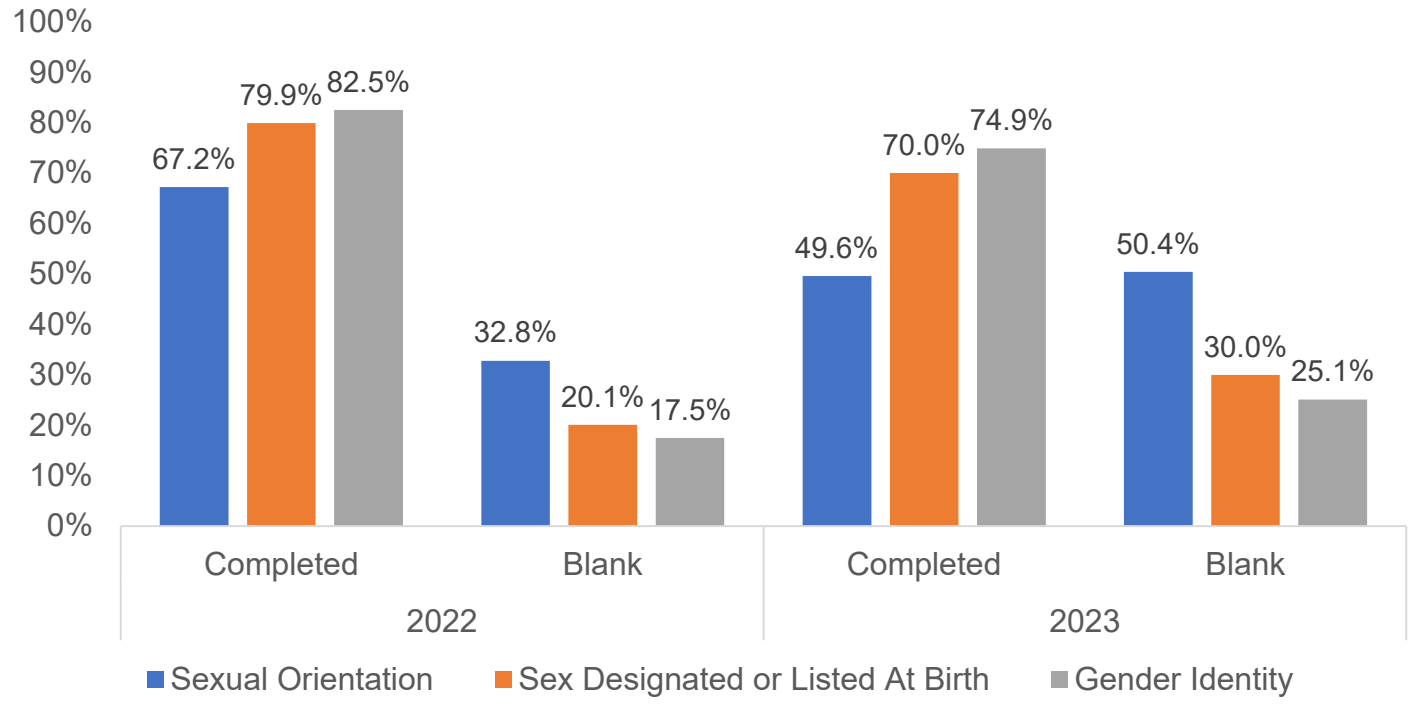
Percentage of Complete and Blank SOGI questions for Older Adults, Calendar Year 2022 and 2023



Data Source: Consumer Perception Survey data, May 2022 and May 2023.

On the gender identity question, 275 (74.9%) of youth respondents answered the question, 267 (70.0%) responded to the sex designated or listed at birth question, and 182 (49.6%) provided a response on the sexual orientation question. Responses to SOGI questions from youth decreased from 2022 to 2023 with the largest decrease in the sexual orientation category. Blanks increased for all categories.

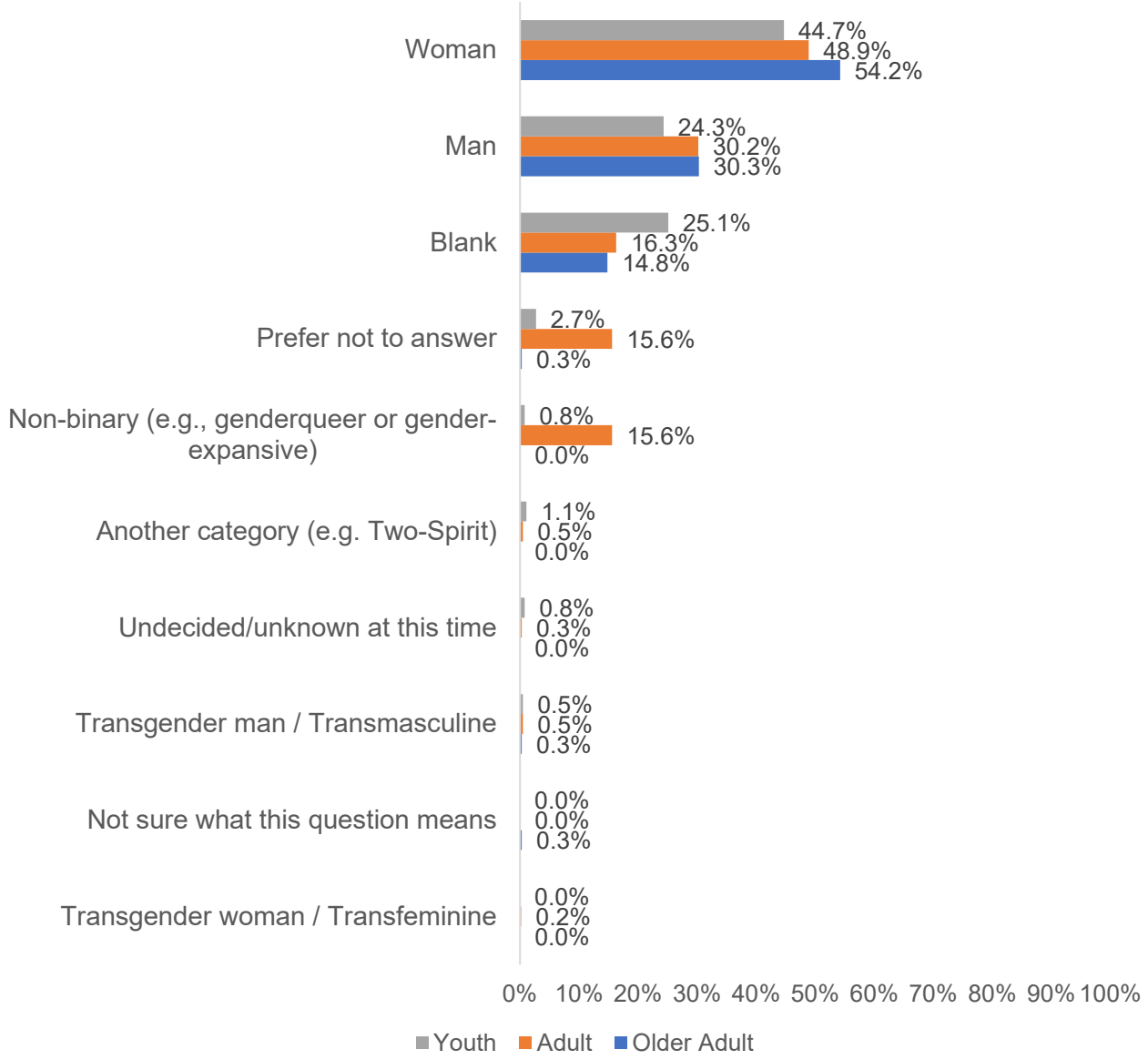
Percentage of Completed and Blank SOGI questions for Youth, Calendar Year 2022 and 2023



Data Source: Consumer Perception Survey data, May 2022 and May 2023.

Of those that responded to the gender identity question, the majority of responses came from people who identified as Woman with 54.2% of Older Adults, 48.9% of Adults, and 44.7% of Youth endorsing Woman as their gender identity. Man was the second most frequently endorsed gender identity for Older Adults (30.3%), Adults (30.2%), and Youth (24.3%). A large percentage of Youth (25.1%) opted to leave this question blank.

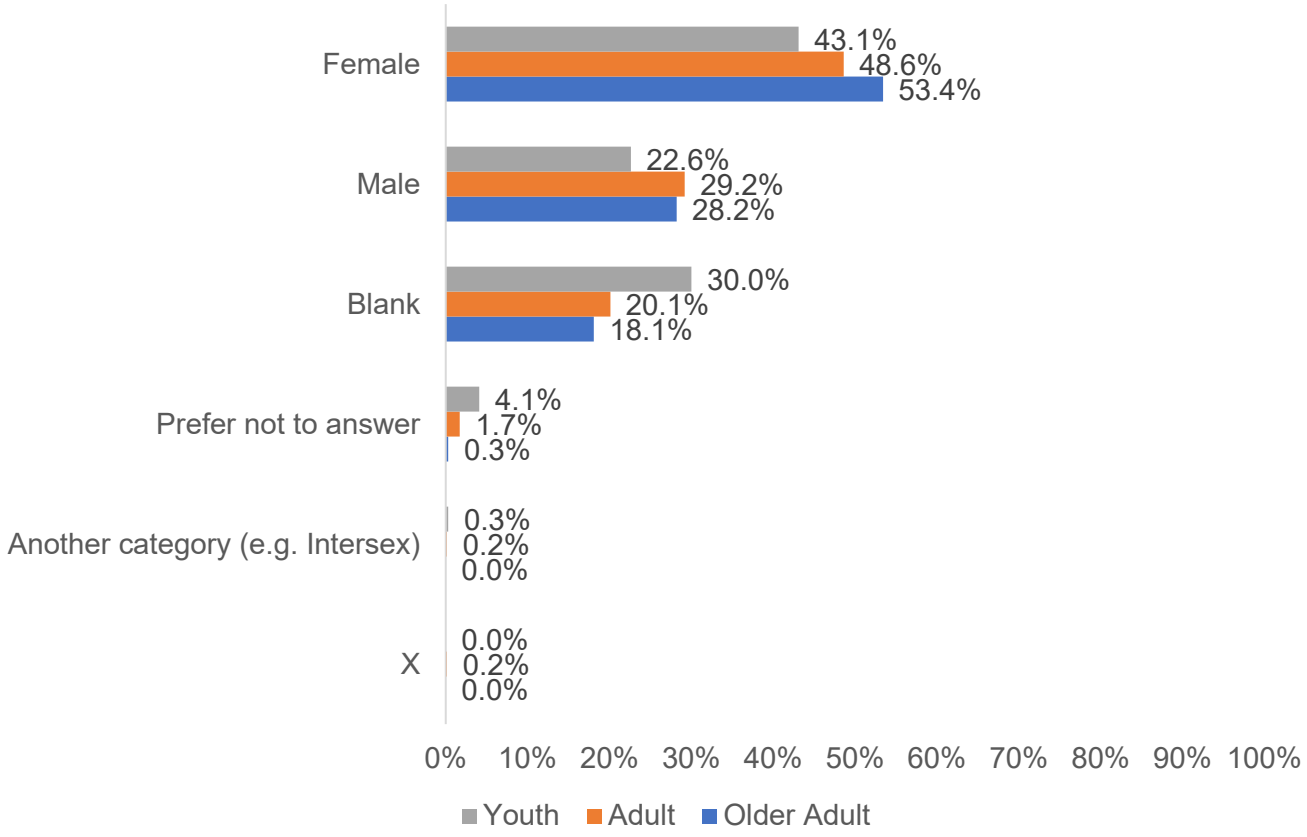
Percent of Responses to Gender Identity by Age Group, Calendar Year 2023



Data Source: Consumer Perception Survey data, May 2023.

Of those that responded to the sex designated at birth question, the majority of respondents endorsed Female as their sex designated at birth with 53.4% of Older Adults, 48.6 % of Adults, and 43.1% of Youth endorsing Female as their sex. Male was the second most frequently endorsed sex designated at birth as follows, Adults (29.2%), Older Adults (28.2%), and Youth (22.6%). Similarly to the gender identity question, a large percentage of Youth (30.0%) opted to leave this question blank.

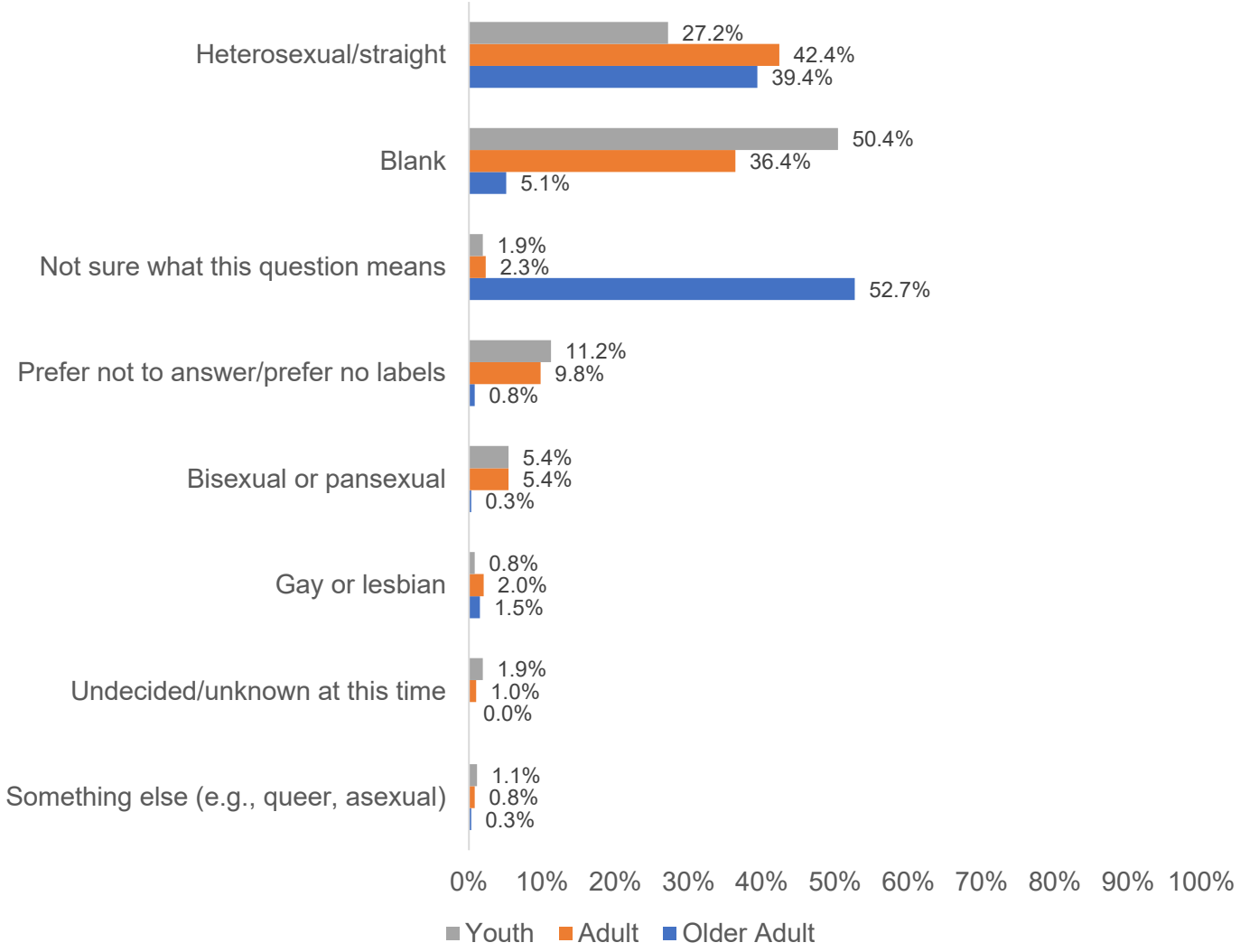
Percent of Responses to Sex Designated at Birth by Age Group, Calendar Year 2023



Data Source: Consumer Perception Survey data, May 2023.

Of the sexual orientation options provided, most respondents who opted to answer the question selected the Heterosexual orientation with 42.4% of Adults, 39.4% of Older Adults, and 27.2% of Youth identifying as Heterosexual. It's important to note that 52.7% of Older Adults selected the response option "Not sure what this question means" and 50.4 % of Youth left this question blank.

Percent of Responses to Sexual Orientation by Age Group, Calendar Year 2022



Data Source: Consumer Perception Survey data, May 2023.

The QI Unit will continue working towards increasing the amount of SOGI data collected. Based on the percentages of SOGI related questions that were left blank, and the large percentage of older adults that indicated not knowing what the sexual orientation question was asking, it appears that efforts need to be made to educate consumers about the meaning of SOGI questions.

Objective 3: Roll out a Power BI portal to evaluate and report out provider-level performance trends.

In CY 2023, development of the CPS PowerBI Dashboard was continued by the Outcomes Unit in collaboration with the QI Unit. Due to staffing changes in both units, completion of the dashboard was challenging; however, CPS data for CY 2019 through 2022 was loaded into the dashboard in 2023. The Outcomes and QI units remain committed to this project and anticipate completing the dashboard in CY 2024.

Objective 4: Monitor response rates and review the mechanism for tracking participation history and program types.

The QI Unit was unable to monitor response rates and review the mechanism for tracking participation history and program types due to challenges with staffing. This goal was continued into CY 2024.

Objective 5: Share successful strategies to increase data collection and best practices to increase consumer satisfaction.

During the CPS 2023 preparation period, providers were presented information on and given the *Consumer Satisfaction Survey Best Practices: Survey Collection* and *Consumer Satisfaction Survey Best Practices: Maintaining High Satisfaction* handouts to support their CPS workflows and processes. SA QIC Leadership teams also encouraged providers to present and discuss their agency workflows during SA QIC meetings prior to the CPS period to assist other agencies in developing workflows.

Client Grievances, Appeals, and Change of Provider Requests

Goal 3B.	Monitor grievances, appeals, and requests for a Change of Provider.
Objective(s)	1. Automate data collection processes to eliminate waste and improve the availability of real-time data. • Implement a public-facing portal to receive client grievances and complaints. • Develop a provider application to track monthly submissions of COP requests. 2. Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies.
Population	Los Angeles County residents engaging in DMH services (outpatient, inpatient, FFS)
Performance Indicator(s)	1. Total beneficiary complaints and resolutions by type in FY 2022-23 2. COP requests by type in FY 2022-23
Frequency of Collection	Annually
Responsible Entity	Patient's Rights Office

This goal was partially met.

Objective 1: Automate data collection processes to eliminate waste and improve the availability of real-time data.

In May 2023, the Patients Right's Office (PRO) updated the DMH Policy 200.05 Request for Change of Provider (COP) for outpatient services. In August 2023, PRO provided a Quarter (Q) 4 COP report for DO and LE/Contracted providers. Many providers had not submitted COPs by the July 31, 2023, deadline. Overall, there is a decrease in the number of outpatient providers that submitted COP information.

In November 2023, an updated electronic COP submission application for outpatient services was approved. The update included increased user-friendly design for both DO and LE/Contracted providers to submit COP information.

Objective 2: Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies.

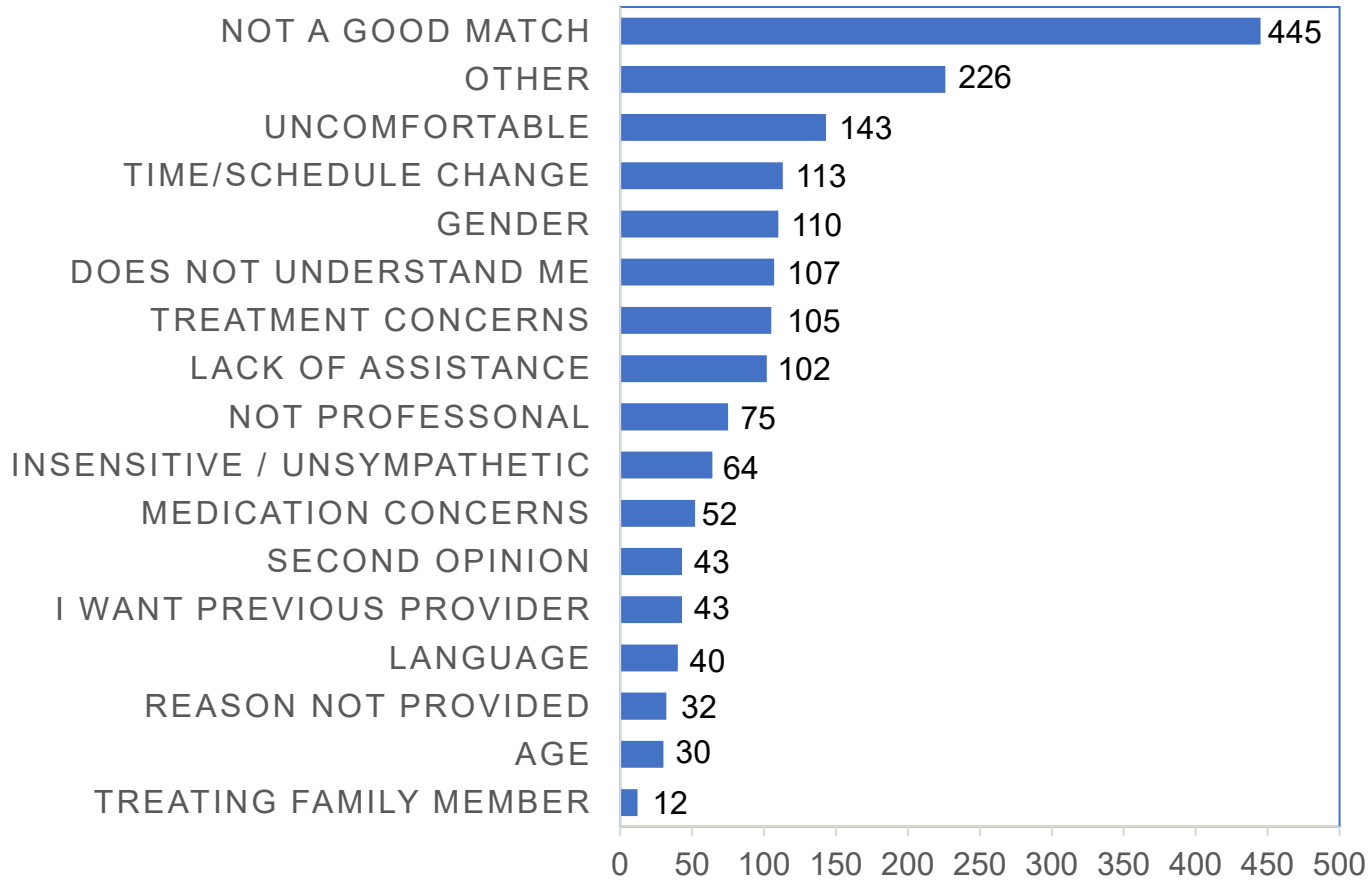
The majority of grievance reasons identified were for Quality of Care and Filed for Other Reasons categories.

Inpatient and Outpatient Grievances for LACDMH Medi-Cal Beneficiaries by Category, Fiscal Year 2022-23

Type of Grievance	Number
Customer Service	0
Case Management	0
Access to Care	36
Quality of Care	267
County (Plan) Communication	0
Payment/Billing Issues	4
Suspected Fraud	0
Abuse, Neglect, or Exploitation	21
Lack of Timely Response	0
Denial of Expedited Appeal	0
Filed for Other Reasons	160

For FY 2022-23, 1,093 Change of Provider Requests were submitted. Clients were able to indicate more than one reason for the COP request. Of those requests, 1,021 were granted and 72 were not granted. The majority of requests were due to Not a Good Match, Other, and Uncomfortable. The lowest frequency reasons were Reason Not Provided, Age, and Treating Family Member. The number of Appeals for FY 2022-23 was not available.

Change of Provider Request Reasons, Fiscal Year 2022-23



Note: There was no description available for the requests that were identified as Other category. Data source: LACDMH PRO Change of Provider Logs, September 2024.

Clinical Care

Clinical Reporting

Goal 4A.	Rollout Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.
Objective(s)	1. Providers will have access to client-level aggregate reports. 2. Develop program-level reports based on input from provider network. 3. Run tests with a sample of providers. 4. Make clinical utility training available to more supervisors through publishing a recording of training and track attendance. 5. Expand training to LE staff and supervisors. 6. Research and explore relevant and user-friendly reporting elements to include on an LACDMH public-facing dashboard. 7. Research and explore developing algorithm for using CANS as a level of care tool for children and plan pilot to implement.
Population	DMH Directly Operated (DO) and LE/Contracted programs providing SMHS to children and youth between ages 3 and 21 years.
Performance Indicator(s)	1. One client-level report 2. One provider-level report 3. Clinical utility training with supporting materials
Frequency of Collection	Annually
Responsible Entity	Outcomes Unit and Outpatient Care Services

This goal was partially met.

Objective 1: Providers will have access to client-level aggregate reports.

The Outcomes team developed a Child and Adolescent Needs and Strengths (CANS) Client Level Report in Power BI that provides data aggregated by each consumer. From the report, directly operated (DO) and legal entity (LE) providers will be able to view all CANS assessments completed for an individual consumer across the LACDMH system. Providers will also be able to compare consumers' CANS scores across assessments over time to evaluate progress. During 2023, this Outcomes team implemented multiple steps to ensure the report would be ready for production and easily accessible for both directly operated and contracted programs. As the report was being validated some issues were identified that required some development and correction at the source data tables. Multiple teams within DMH including our Chief Information Office Bureau's reporting team, data integration team, database administrator and business intelligence teams and clinical informatics worked closely with our Outcomes team to resolve these data issues. The report is undergoing final validation to ready the report to move to a production environment. The outcomes team also started development on a client level report for the Pediatric Symptom Checklist (PSC) similar to the CANS client level report. The same issues encountered with the source data also needed to be addressed during initial validation of the report.

Objective 2: Develop Program Level Reports Based on Input from Provider Network

Following the CANS Client Level Report in Power BI, in CY 2022, the Outcomes Unit worked on developing a CANS Provider Level Report. The report development team gathered requirements for the provider level report based on provider feedback to determine report elements that best fit the needs of LACDMH DO and LE providers. In CY 2023, the CANS Provider Level Report continued to be in development. The Outcomes Unit ran validation tests internally and with a sample of LACDMH providers to identify and resolve any potential issues following development of the report.

Objective 3: Run tests with a sample of providers.

The Outcomes Unit provided access to a sample of LACDMH DO supervisors at selected children's providers to run validation tests on the CANS Client Level Report following development. Supervisors were asked to provide feedback and recommendations regarding the CANS Client Level Report following testing. Recommendations included requests for increased capability to filter domains, items, and timeframes for specific content viewing and suggestions on where to house the report to allow for increased provider accessibility. Feedback also stated that the CANS Client Level Report is helpful for staff training purposes to guide treatment and determine appropriate level of care for consumers. The Outcomes Unit utilized feedback from provider testing and addressed requests for increased filter options. Based on provider feedback, the Outcomes Unit continues to explore with CIOB options for the final location of the report to ensure both DO and LE providers can easily access the report. The Outcomes Unit plans to utilize the same sample of providers to run validation tests with the PSC Client Level Report when ready.

Objective 4: Make clinical utility training available to more supervisors through publishing a recording of training and track attendance.

In CY 2023, the Outcomes Unit conducted two training courses of the Clinical Utility of the CANS for Supervisors Training with CEUs to LACDMH DO providers. One was held on January 17, 2023, with 23 participants and the other was held on May 16, 2023, with 15 participants. The May 16, 2023, training was recorded and has been made available on the LACDMH EPSDT Outcomes page on the LACDMH website.

Objective 5: Expand training to LE staff and supervisors.

In CY 2023, the Outcomes Unit was able to offer training courses of the Clinical Utility of the CANS for Supervisor training to LACDMH LE Providers on September 12, 2023, to 75 participants. Participants were able to earn 3 CEUs. There was great interest in attending this training with capacity filling up quickly. Additional training offerings were planned for 2024 of at least one per quarter.

After each training, evaluations from participants were reviewed, and adjustments were made to the training based on the feedback that was provided. Some of the adjustments that were made to the trainings were allocating more time for discussion and Q&A, making sure the resources shared were up to date, and acknowledging at the beginning of the training that participants may fall on a spectrum in their understanding and use of the CANS in the hopes that they may gain some level of insight regardless of where they fall in their knowledge of the CANS. Overall, the themes of the feedback that was shared from the training participants indicated that the training was informative, appreciating the sharing of helpful resources, how the training will impact their workflow approach, and how the training has shifted their attitude about the CANS

Objective 6: Research and explore relevant and user-friendly reporting elements to include on an LACDMH public-facing dashboard.

LACDMH engages in ongoing research to explore and identify relevant and user-friendly reporting elements to include on public-facing dashboards. With stakeholder involvement, LACDMH developed a Dashboards committee with team members across LACDMH programs. Committee members participate in monthly meetings to review, identify appropriate and useful elements to include and address issues related to development and publishing of public facing dashboards. Committee members include members of LACDMH Clinical Informatics, Chief Information Office Bureau, Cultural Competence, Prevention, MHSA Services, Outcomes, and Quality Improvement teams. Dashboard committee members are committed to ongoing review and development of user-friendly, public-facing dashboards to provide consumers with access to necessary LACDMH information and data.

Objective 7: Research and explore developing algorithm for using CANS as a level of care (LOC) tool for children and plan pilot to implement

LACDMH met with a few other counties who were implementing a level of care system for children using the CANS. We worked with Santa Clara County on learning from their process of developing a decision-making tool about level of care based on CANS ratings. We worked internally with our Access to Care leadership team to map out the levels of care available for children. Continued development is needed to agree upon decision model that will be used to determine clinical LOC for children served by DMH.

Performance Indicators:

1) One client-level report- Developed the client level CANS report that is going through testing and validation with providers to ensure accuracy before publishing. The report allows a user to view CANS scores over time for an individual client. The ratings higher than a 1 are color coded for easy viewing and the multiple administrations are listed side by side for easy viewing of progress.

2) One provider level report- Created a report that looked at providers in one of our service areas to look at aggregate CANS scores to see if there were differences in degree of needs and strengths between providers. We found that one of the provider sites tended to have clients with more risk behaviors and more needs identified than other provider sites in the area which was consistent with the type of programming offered and referral sources for that site.

3) Clinical utility training with supporting materials- In CY 2023, the Outcomes Unit conducted two training courses of the Clinical Utility of the CANS for Supervisors Training with CEUs to LACDMH DO providers. One was held on January 17, 2023, with 23 participants and the other was held on May 16, 2023, with 15 participants. The May 16, 2023 training was recorded and has been made available on the LACDMH EPSDT Outcomes page on the LACDMH website TRAININGS AND EVENTS - Department of Mental Health.

Provider-Level Improvement

Goal 4B.	Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS.
Objective(s)	1. Within one year, 50% of LACDMH outpatient treatment providers will participate in the QA Knowledge Assessment Surveys. 2. Create a communication strategy around changes related to documentation and claiming requirements related to CalAIM implementation. 3. Revise tools to align with revised documentation requirements.
Population	Outpatient programs providing outpatient SMHS to LACDMH clients/families.
Performance Indicator(s)	1. Number and percent of providers completing the QA Knowledge Assessment Surveys 2. Number and percent of providers attending QA information sessions and evidence of communication plan being implemented 3. Compliance rates concerning required documentation (average compliance rate per item in CY 2023); and 4. Qualitative data from providers on the effectiveness and efficiency of these processes.
Frequency of Collection	• QA will collect QA Knowledge Assessment survey data quarterly. • At least 20 LE/Contracted chart reviews are completed annually.
Responsible Entity	Quality Assurance Unit

This goal was partially met.

Objective 1: Within one year, 50% of LACDMH outpatient treatment providers will participate in the QA Knowledge Assessment Surveys.

There were two QA Knowledge Assessment survey cycles that took place in CY 2023, surveys #6 and #7. Of the 779 LACDMH outpatient Legal Entity (LE)/Contracted providers, an average of 17% completed the surveys. The QA team was unable to complete quarterly knowledge assessments due to insufficient staff that were dedicated to covering all the duties and responsibilities of the QA Unit's Provider Support & Review team that coordinated and developed the QA Knowledge Assessment Survey. In 2023, the QA Unit worked with LACDMH's HR team to expand the unit to cover all functions and responsibilities.

Additionally, since the inception of the QA Knowledge Assessment Survey process, we have been evaluating what a reasonable frequency is to allow sufficient time for all phases of the process that does not oversaturate or overwhelm providers. Towards the end of 2023, we determined that a good frequency and flow for the Knowledge Assessment Survey Process would be 3x/year, with each phase having a Planning month, a Development month, a survey release month and a survey results month.

Calendar Year 2023 Quality Assurance Knowledge Assessment Development Timeline

Planning	Development	Survey Release	Answers/Results Release
January	February	March	April
May	June	July	August
September	October	November	December

Objective 2: Create a communication strategy around changes related to documentation and claiming requirements related to CalAIM implementation.

The QA information sessions that focused on documentation/claiming under CalAIM were the QA on the Air and QA/QI Central webinar meetings. Below are the dates and number of attendees that signed in for QA information sessions in CY 2023, including the total averages.

Number of Attendees for Calendar Year 2023 QA Information Sessions by Meeting Type

QA On the Air (QOTA)	QOTA Number of Attendees	QA/QI Central	QA/QI Central Number of Attendees
1/25/23	351	1/9/23	320
2/22/23	315	2/13/23	214
3/22/23	389		
4/26/23	423	4/10/23	210
5/24/23	376	5/8/23	191
6/14/24	270		
6/28/23	387	6/12/23	190
7/26/23	310	7/10/23	145
8/23/23	376	8/14/23	235
9/27/23	362		
10/25/23	364		
		11/13/23	191
12/27/23	223	12/11/23	191
Total Average for 2023	345	Total Average for 2023	209

Evidence that the communication plan was implemented includes sign in sheet tracking for the QA information sessions, posting the QA/QI meeting recordings on the QA website at https://dmh.lacounty.gov/qa/qaw/qa-qi-monthly-central-meetings/, and providing recordings of the QA on the Air meetings directly to providers.

There were six chart reviews conducted in CY 2023 for LE/Contract providers representing 16 provider sites. The average compliance rate for those reviews was 64%. The QA Unit was unable to complete the projected 20 chart reviews due to insufficient staffing. Plans to increase staffing are in development with HR.

Objective 3: Revise tools to align with revised documentation requirements.

Below is the qualitative data from providers on the effectiveness and efficiency of the QA Knowledge Assessment survey and chart review processes.

- QA Knowledge Assessment Survey Process
  - Providers have given general feedback regarding the process during regular QA Lead segments of regularly scheduled SA QIC meetings.

- Some providers found the QA Knowledge Assessment survey most helpful when reviewing and discuss it together with staff in a meeting.
- Some survey content does not necessarily apply to all staff so that can impact how staff respond to questions. If an area of information is not relevant to what staff in specific roles are doing, then it may not make sense to incorporate or emphasize that information or concept in training for those staff.
- For LE/Contracted providers, some staff do not take the survey even though the link is sent to them by the QA person at their agency. One idea is to incorporate the questions into polls in their virtual staff meetings and have everyone respond at the same time and discuss how everyone answered.

- Chart Review Process
  - We did not have a mechanism to gather qualitative feedback/data from providers regarding the chart review process for contract providers during 2023 but for our new QA process we will be incorporating a post-review feedback survey into the process. Here is the link to the questions we have been developed for that survey so far: https://forms.office.com/g/6M6qTLmG1H

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

Goal 4C.	Develop a mechanism to measure and track HEDIS Measures for children and youth.
Objective(s)	1. Identify and pilot a data collection process for dependent foster Child/Youth HEDIS data.
Population	Dependent foster youth
Performance Indicator(s)	1. Summarize results in an Annual Findings Report
Frequency of Collection	Ongoing, as medications are prescribed
Responsible Entity	Chief Medical Director, Psychiatry Services

This goal was met.

In 2022, LACDMH identified and implemented a data collection process for dependent foster Child/Youth HEDIS data in compliance with Senate Bill (SB) 1291. SB 1291 is a California bill that aims to improve the availability of mental health services for children and youth, particularly those in foster care. The bill requires that LACDMH annually review its monitoring of medication to be consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any HEDIS measures related to psychotropic medications. SB 1291 HEDIS are included in the Centers for Medicare and Medicaid Services (CMS) Child Core Set that LACDMH tracks and reports on annually:

- *Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (ADD)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)*
- *Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH)*

The Office of the Medical Director's Pharmacy and Laboratory Services reviewed their process for receiving data to calculate performance on related HEDIS measures. Data for DO clinics is available to be pulled by the Chief Information Office Bureau (CIOB) from LACDMH's Electronic Health Record (EHR). LE/Contracted Providers utilize their own systems, so a separate process was created for them. Each provider sourced data from their own EHR, medication prescribing system, and laboratory result tracking system. Providers were given a data collection workbook, technical guidance documents for each measure, and a timeline for submission which was no later than August each year. LACDMH further supplemented these resources with workgroup meetings and ad hoc consultations to support providers through their individual data collection processes. Each provider submitted their completed data collection workbook to LACDMH via a secure electronic file transfer (EFT) process mediated by information technology (IT) staff. Once the workbooks and reports were received by LACDMH, the data was compiled, reviewed, and findings were summarized.

Shortly after this process was put in place, Clinical Informatics, QA and QI staff were made aware that the MH Plan Data Feed from DHCS is available to LACDMH and may contain the information needed to calculate results without burdening LE providers in completing manual chart reviews. LEs would only need to submit lab data for foster care population for the APM measure. The Plan Data Feed continues to be explored for HEDIS reporting needs. Clinical Informatics is also actively working on a dashboard that identifies which clients are meeting criteria for denominators and/or numerators on

these HEDIS measures.

In 2023, the Chief of Pharmacy and Laboratory Services presented a PowerPoint to the External Quality Review Organization (EQRO) Behavioral Health Concepts Inc. (BHC) on LACDMH's findings for all tracked HEDIS measures for Measurement Year 2022 including the Child Core Set. Subsequently, DHCS changed their EQRO contract to Health Services Advisory Group Inc. (HSAG) in 2024. HSAG has requested that HEDIS measures for Measurement Year 2023 be reported in January 2025.

Level of Care

Goal 4D.	Roll out an Adult Level of Care Tool.
Objective(s)	1. Review common clinical tools and identify modifications that would best meet the needs of LACDMH's adult population.
Population	Adult clients
Performance Indicator(s)	1. Select a level of care tool to use for adults 2. Adopt an algorithm to use to recommend a level of care based on information gathered on the tool
Frequency of Collection	Annual
Responsible Entity	Outpatient Services

This goal was met.

Objective 1: Review common clinical tools and identify modifications that would best meet the needs of LACDMH's adult population.

DMH consulted with other California counties and did an extensive review over several months of available level of care tools, as documented below. The analysis was reviewed with providers and within DMH before a final recommendation was made to pursue a contract to utilize the LOCUS.

Tools Reviewed:

1. Reaching Recovery. Netsmart is the vendor and Wellpower is the clinical expert. Annual cost estimate was $499,419, with one-time initial fees of approximately $245,000.
2. Adults Needs and Strengths Assessment (ANSA). Lengthy instrument that would add high levels of clinical burden and annual costs for training re-certification, in excess of $120,000/year.
3. Determinants of Care. Provider developed tool with limited psychometric testing. In the public domain. One time training cost for the associated Milestones of Recovery (MORS Scale) which is proprietary and owned by Pacific Clinics. This scale was deemed not to meet the needs of the Department.
4. Needs Evaluation Tool. An instrument already in use to document targeted case management needs and establish a treatment plan related to case management. The tool was deemed not suitable as a level of care tool.
5. LOCUS (Level of Care Utilization Scale). AACP holds the copyright and delivers training. Deerfield Solutions is the electronic vendor of the product. Instrument can be used by anyone with knowledge of the client and is easy and quick to administer. LOCUS training for year one and two budgeted at $45,000, with year 3 and beyond at $17,500. Licensing fees are $80,000 annually.

Performance Indicators:

1. Select a level of care tool to use for adults- LACDMH selected the Level of Care Utilization Scale (LOCUS)

2. Adopt an algorithm to use to recommend a level of care based on information gathered on the tool – The LOCUS has a validated proprietary algorithm for recommending a level of care that is calculated through an Application Programming Interface using the responses on the

LOCUS assessment. No further algorithm needed to be developed once the LOCUS was selected.

Continuity of Care

Goal 5.	Develop a systemwide strategy to reduce seven- and 30-day rehospitalization rates.
Objective(s)	1. Establish a committee to review data monthly. 2. Identify and implement at least one intervention targeting systemwide readmission rates. 3. Development of a Power BI dashboard to examine rates of rehospitalization and identify any patterns to address.
Population	LACDMH clients receiving outpatient SMHS
Performance Indicator(s)	1. Rates of rehospitalization at seven- and 30-day post-inpatient discharge
Frequency of Collection	Monthly
Responsible Entity	Intensive Care Division, Outpatient Services, Clinical Informatics

This goal was met.

To address the objective of reducing the rehospitalization rate across the DMH system, two pilot program phases were implemented targeting specific hospitals. A variety of interventions were tested at these sites with the goal of scaling interventions more broadly. A committee was established to initiate, guide and develop the strategy and specifically design and track the Phase 1 pilot program.

Objective 1. Establish a committee to review data monthly.

The Intensive Care Division (ICD) team lead a monthly Re-hospitalization Plan meeting to inform the Phase 1 pilot program that initiated in 2022 and continued through the end of the Phase 1 pilot in mid-2023. The committee included the following LACDMH stakeholders:

- CIOB Clinical Informatics
- Clinical Pharmacy
- Emergency, Outreach, and Triage Division (EODT)
- Enhanced Care Management (ECM)
- Full-Service Partnership (FSP) Administration
- Health Access Integration (HAI)
- Hospital Navigation
- Outcomes Unit
- Outpatient Services
- QA Unit
- QI Unit

These meetings discussed and reviewed the project timeline, data collection process, trends and patterns, and lessons learned. At the conclusion of the Phase 1 pilot, the ICD team presented the Phase 1 results and recommended next steps that included the launch of a Phase 2 pilot with two new hospitals.

During Phase 2, DMH went through a reorganization that impacted the ICD Unit including some leadership and staff transitions such as a key Phase 1 pilot staff who was reassigned from the LACDMH Intensive Care Division-Treatment Authorization Requests Unit (ICD-TAR) to the LACDMH ICD 24-

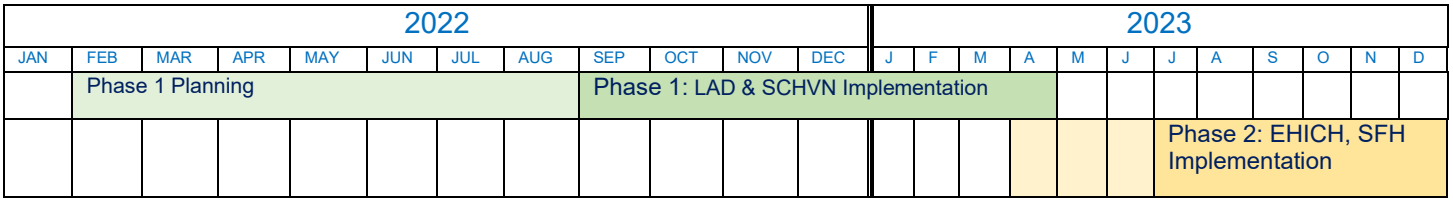
hour Unit, the retirement of the Program Manager and lead of the pilot and new division leadership. All of this affected the continuity of Phase 2.

Objective 2: Identify and implement at least one intervention targeting systemwide re-admission rates.

Background

The LACDMH ICD-TAR Unit initiated Phase 1 30-day Hospital Re-Admission Reduction Project to reduce rehospitalization rates among Los Angeles County consumers. The pilot started in February 2022 and went live in September 2022 with two hospitals - Los Angeles Downtown (LAD) and Southern California Hospital at Van Nuys (SCHVN) and lasted until April 2023. Phase 2 started April 2023 and went live in May 2023 with two new hospitals - Emanate Health Inter-Community Hospital (EHICH) and Saint Francis Medical Center (SFMC) and has continued beyond December 2023 and into 2024.

Pilot Phases 1 & 2 Implementation Timeline



The aim of the Phase 2 pilot is to impact factors that may lead to repetitive hospitalizations by increasing the support of the LACDMH teams and programs to aid the hospitals as part of the discharge planning process. The population focus is on those patients who have had 4 hospitalizations within the year or have been hospitalized twice in the past 30 days.

To support a multi-disciplinary team approach, a pilot committee format that was established in Phase 1 was continued in Phase 2. The purpose of the committee is to oversee the project. The LACDMH Intensive Care Division-Treatment Authorization Requests Unit (ICD-TAR) re-established the committee meetings to support Phase 2.

Each committee roster includes the following members:

- Two pilot hospitals
- TAR Unit
- Clinical Pharmacy
- Enhanced Care Management
- Service Area Hospital Navigation Teams
- Department of Public Health/SAPC

The committees meet monthly to review data, share the progress and status of the Re-Admission Reduction Pilot, identify and problem-solve barriers, and determine steps for expansion of the pilot project.

While the aim of the Phase 2 pilot continued forward from the Phase 1 pilot, access to 2023 data that is consistent with what was reported for 2022 was impacted by a couple of factors: 1) a shift in data platforms for the ECM program and 2) the LACDMH reorganization that was noted above. All of which resulted in reporting of a broader set of data.

Interventions

The interventions used to decrease rehospitalization rates and improve follow-up mental health care included services from LACDMH Service Area (SA) Navigation, ECM, FSP, Clinical Pharmacy, and LACDPH SAPC programs. Due to the nature of the proposed interventions, it was determined there was alignment with the criteria for a clinical PIP and therefore, the data and outcomes related to the pilot interventions are highlighted in both the 2023 QAPI Work Plan Goal 5 and Clinical PIP Goal 7A. located below.

One of the interventions in the pilot was to observe the follow up visits within seven and 30 days along with the readmission rates for the participating hospitals. Specific to follow up visits after hospitalization for the two pilot hospitals, LACDMH looked at encounter data to determine what percentage of all discharges within the pilot intervention period received a follow up visit within the seven and 30-day timeframes.

Follow-up after Hospitalization

Between May 1, 2023, and March 31, 2024, there were 2,768 inpatient psychiatric hospital discharges tracked at St. Francis Medical Center and Emanate Inter-community Hospital.

For 901 of the 2,768 discharges, the client was re-hospitalized within 30 days of the original hospitalization. Per the specifications of the HEDIS measure, these discharges are removed from the denominator for the measure because the rehospitalization may have interfered with attempts to complete outpatient mental health follow-up. The remaining hospital discharges total 1,867.

Of the 1,867 remaining discharges, for 344 (18.4%) the client received an outpatient mental health follow-up visit anywhere in the specialty mental health system within seven calendar days of discharge.

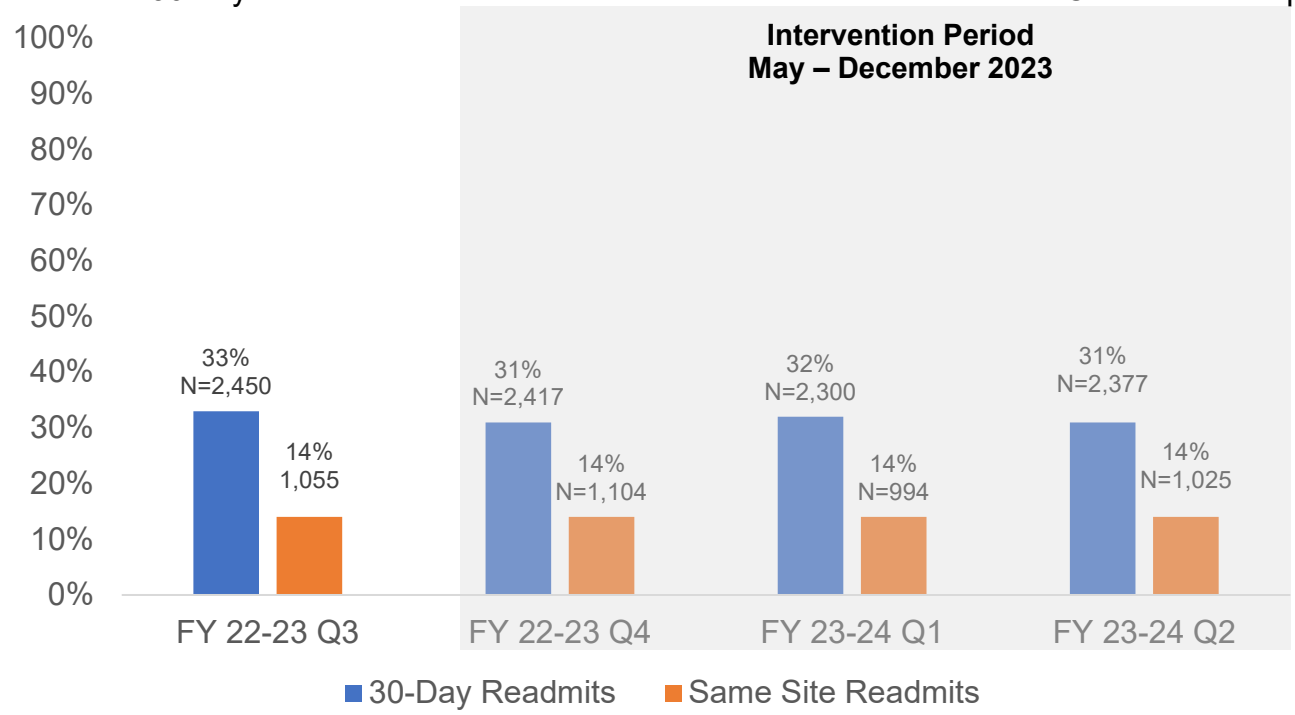
For 559 of the 1,867 (30%) discharges, the client received an outpatient mental health follow-up visit anywhere in the specialty mental health system within 30 calendar days of discharge. The remaining 964 of 1,867 (52%) did not receive a follow-up visit within seven or 30 days.

In summary, for the two pilot hospitals, a total of 48% of clients received a follow-up visit within seven or 30 days of discharge and 52% did not between May 2023 and March 2024 (11 months).

30-Day Rehospitalizations

The other way to analyze the impact of the pilot intervention was to look at the number of clients re-hospitalized within 30 days of discharge. The percent of total 30-day and 30-day same site (where a client was re-hospitalized at the same hospital) readmission rates for all LACDMH contracted hospitals (N=30) for CY 2023 is illustrated below. The total re-hospitalizations remained relatively steady at around 32% as did the 30-day same site rehospitalization rate that held consistently at 14%.

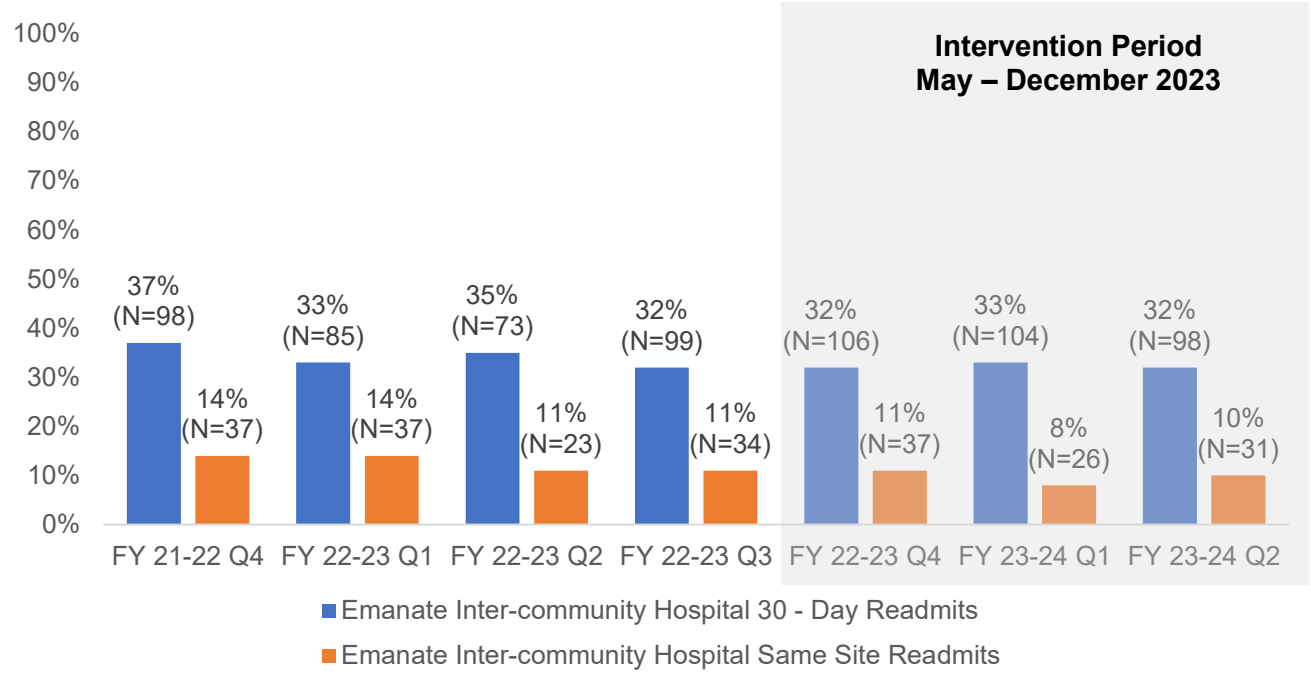
Percent of 30-day Re-Admission and Same Site Re-Admission Rates at All Contracted Hospitals



Note: The data excludes the Institute of Mental Disease (IMD) population. The Phase 2 pilot hospitals are included. Data source: LACDMH PowerBI Inpatient Rehospitalization Report, July 2024.

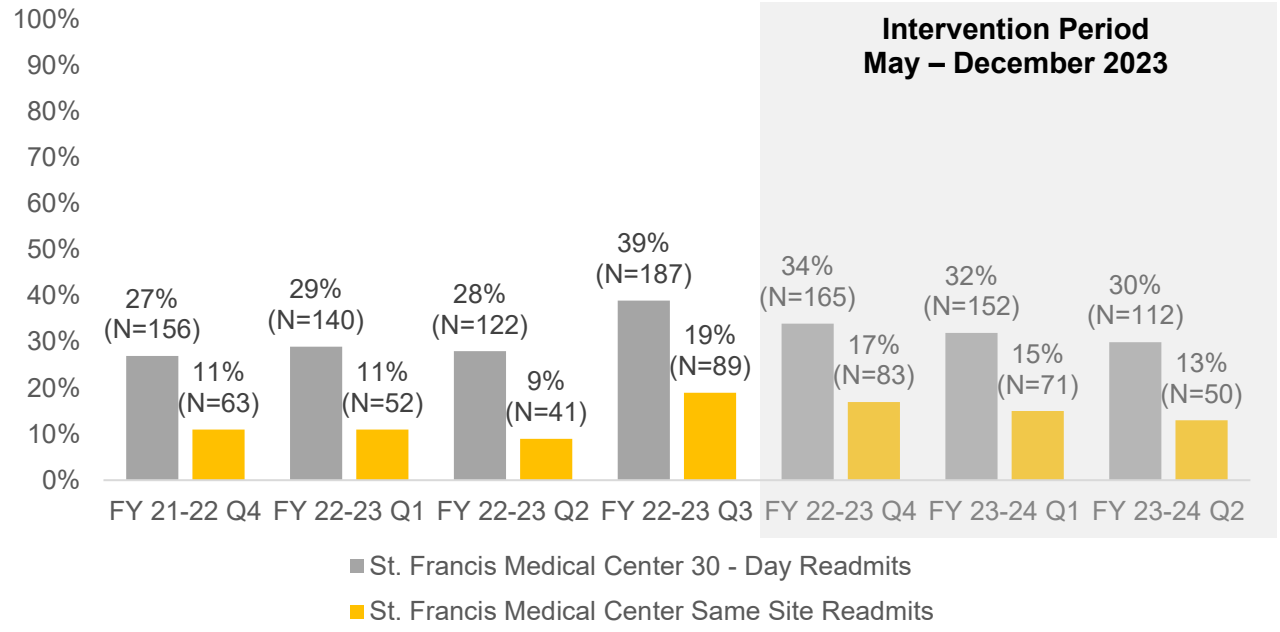
Figures below allow for a comparison between the rates for all LACDMH contracted hospitals and the rates for the two pilot hospitals. There was a decrease in 30-day re-hospitalizations in the later part of the initial eight-month intervention period (FY 23-24 Q2). Through the intervention period of May 2023 to December 2023, Emanate remained stable in total re-hospitalizations and showed a 1% decrease in same site re-hospitalizations while St. Francis realized a more significant decrease of 9% in total re-hospitalizations and 6% reduction in same site re-hospitalizations.

Percent of 30-day Re-Admission and Same Site Re-Admission Rates at Emanate Health Inter-Community Hospital, Baseline Compared to Intervention Period



Data source: LACDMH PowerBI Inpatient Rehospitalization Report, January 2024.

Percent of 30-day Re-Admission and Same Site Re-Admission Rates at Saint Francis Medical Center, Baseline Compared to Intervention Period



Data source: LACDMH PowerBI Inpatient Rehospitalization Report, January 2024.

In summary, SFMC reported lower rates of 30-day re-hospitalization rates and both hospitals showed a decrease in same site re-hospitalization rates in FY 2023-24 Q2 of the Phase 2 pilot intervention period compared to all LACDMH contracted hospitals during the same period. The intervention period will continue into CY 2024.

Looking ahead to CYs 2024 and 2025, LACDMH remains committed to addressing hospital readmissions. With the conclusion of the Phase 2 pilot estimated in CY 2024, evaluation of both Phase 1 and 2 pilots will be incorporated into the design of Phase 3 targeted to start in 2025.

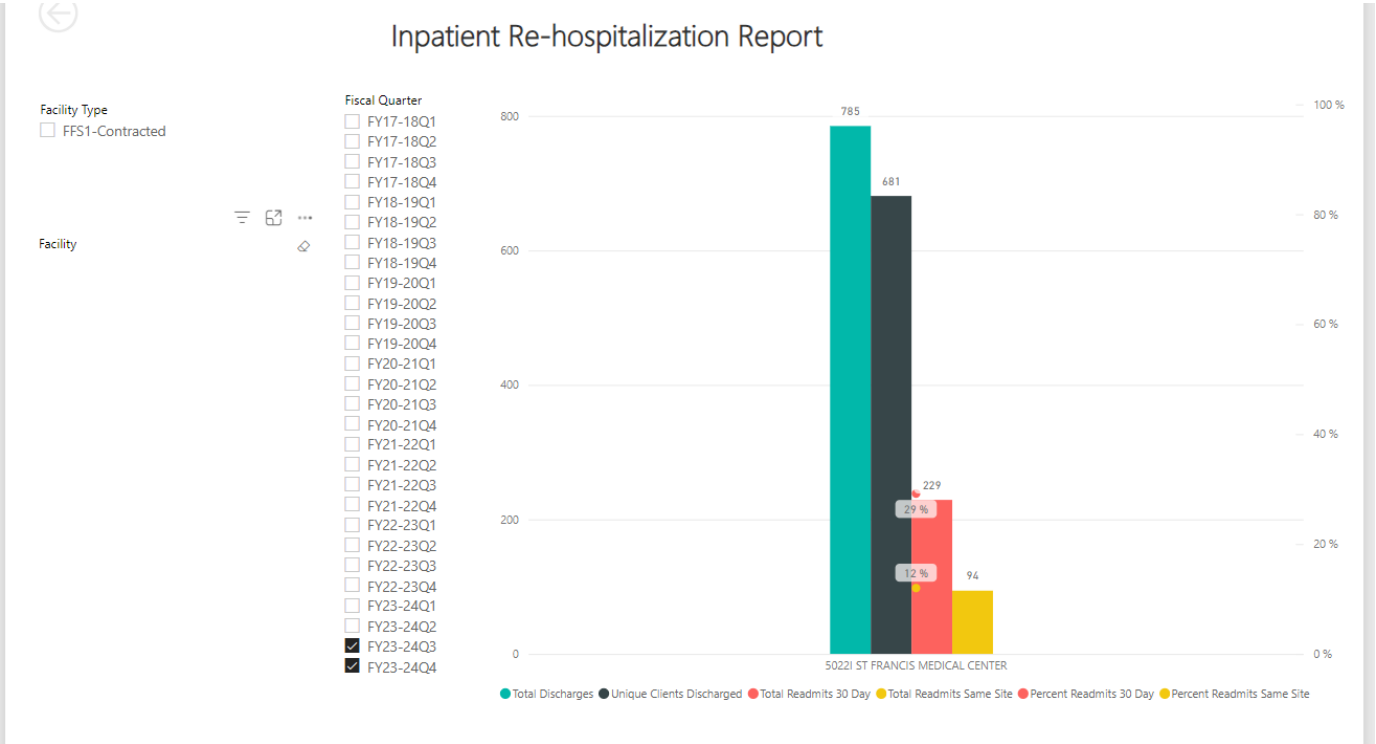
Objective #3: Development of a Power BI dashboard to examine rates of rehospitalization and identify any patterns to address.

To better track and respond to hospital readmissions in Los Angeles County, a Power BI dashboard was developed by the DMH Clinical Informatics Unit. This dashboard pulls data from hospital Electronic Health Records (EHRs), largely from the episode creation field. The data is comprehensive for Medi-Cal hospitalizations and does not include Medicare supported hospitalizations.

Using the dashboard, users can view the total discharges, unique clients discharged, total readmissions in summary chart or detailed line listing format. Users can select to see data by facility type, contracted, non-contracted hospitals, Department of Health Services (DHS), or Non-Governmental Agency (NGA). Individual facilities can also be selected to see data on a specific hospital. This data will continue to be used as the pilot continues and evolves.

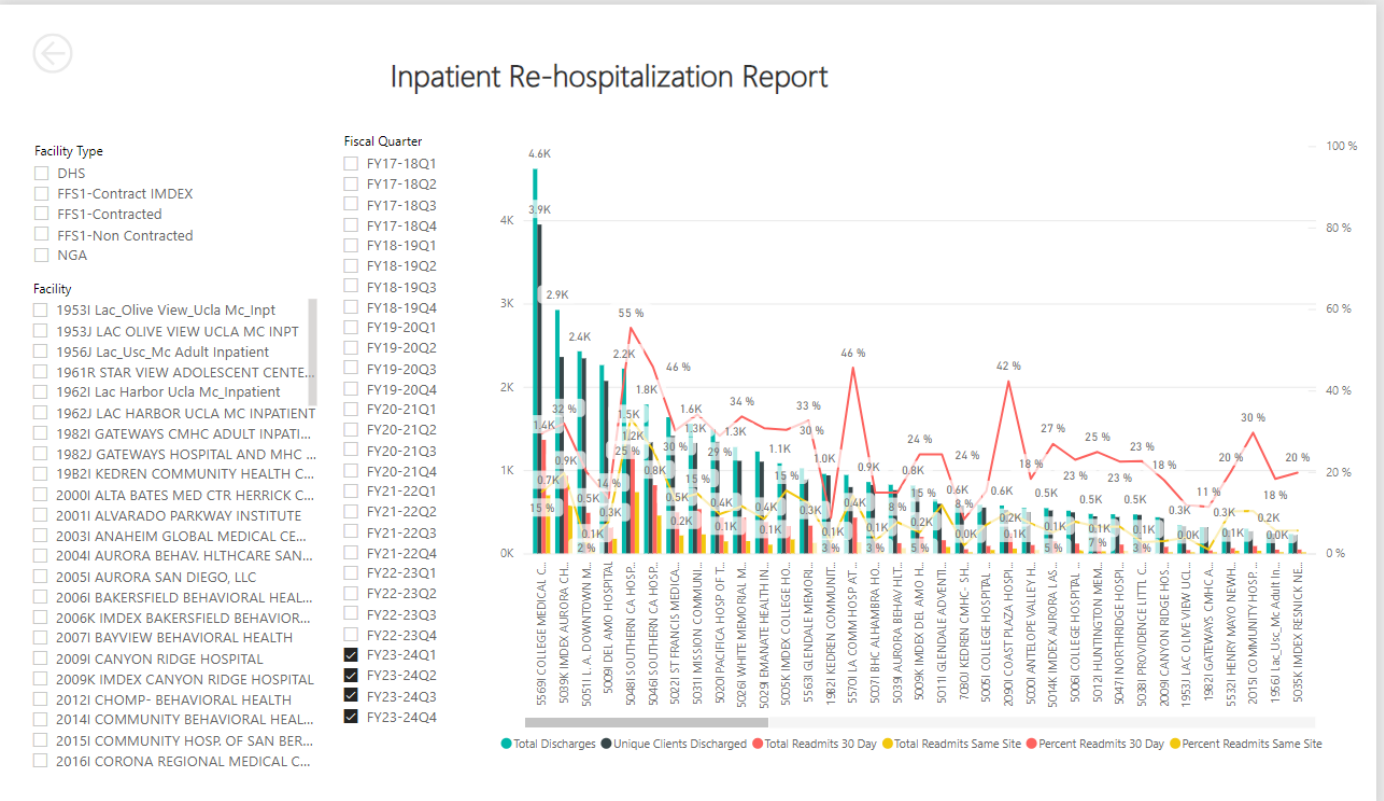
The pictures below provide example views from the dashboard that allows the user to view data on a specific hospital including total discharges, unique client discharges, total and same site readmissions, percent readmits 30-days and percent readmits same site and select by facility type and quarters by fiscal year.

Data Specific to Individual Hospitals, St. Francis Medical Center



Data Source: [DMH_Rehospitalization_Report - Power BI (powerbigov.us)](), updated 7/3/2024.

Data Filtered by All Facility Types by Fiscal Year, FY 2023/2024.



Data Source: Power BI, [https://app.powerbigov.us/links/iJgaVGpwcE?ctid=07597248-ea38-451b-8abe-a638eddbac81&pbi_source=linkShare&bookmarkGuid=f55cce5b-7fdd-4c59-b15f-f8c172895da5](), updated July 3, 2024.

In closing, the Phase 2 pilot mirrored the Phase 1 approach to addressing Goal 5 to develop a systemwide strategy to reduce seven and 30-day rehospitalization rates by adapting interventions with two new hospitals. In addition to the reorganization and staff and leadership changes that affected the pilot implementation and outcomes, there were also important lessons learned in Phase 2 regarding data continuity and data sharing agreements as well as examination of the variations in client referral processes between the hospitals and DMH.

DMH is committed to addressing Goal 5 that has been carried forward to the QAPI 2024 Workplan. With the Phase 2 pilot running its course and concluding in 2024, DMH will develop a Phase 3 pilot informed by the previous pilot phases with focus on and alignment with recommendations from a 2024 DMH report titled, *Establishing a Roadmap to Address the Mental Health Bed Shortage*, specifically: 1- developing County strategies to dramatically reduce the 30-day readmission rates for County residents and 2- expanding the capacity of DMH's subacute level of care (QAPI Workplan Goal 5B). The Phase 3 pilot is estimated to launch in early 2025.

Provider Appeals

Goal 6.	Monitor Provider Appeals.
Objective(s)	1. Review the Provider Appeal Tracking Log for trends and share findings with appropriate entities. 2. Concurrent authorization will be operational at all hospitals.
Population	LACDMH clients receiving inpatient psychiatric services from the Department of Health Service (DHS), Fee-for-Service (FFS) Contracted, Non-Contracted, Non-Governmental Agency (NGA), and Contracted IMD Exclusion Hospitals.
Performance Indicator(s)	1. Number of Notice of Adverse Benefits Determinations (NOABDs) issued, including the percentage of upheld or overturned appeals.
Frequency of Collection	Monthly
Responsible Entity	Intensive Care Division – Treatment Authorization Requests Unit

This goal was met.

Objective 1: Review the Provider Appeal Tracking Log for trends and share findings with appropriate entities.

In CY 2021, the Intensive Care Division – Compliance Unit (ICD) developed a Provider Appeal Tracking log to keep track of dates of submitted appeals, resolutions, reasons for denial, and next steps, if any. The Provider Appeal Tracking Log and Denial Tracking Log are available and shared with the QI unit, as appropriate. These two logs supplement the unit's macro-level data reports, the Hospital Association of Southern California (HASC) report, and the Treatment Authorization Request (TAR) summary report. The HASC report includes monthly data regarding the number of TARs, the number of unique consumers for whom TARs are requested, days requested, days denied, days approved, and percent of days approved overall for the first request, and for the first and second appeals. The TAR summary report includes the same metrics as the HASC report on overall TARs in addition to the average requested and approved length of stay and cost by the hospital.

In CY 2023, the TAR Unit continues to discuss trends in individual meetings with providers and offers training to address the reasons for denials in an effort to reduce them.

There were 30,956 TARs received during Calendar Year 2023. This is an increase of 1,048 over the previous year. In CY 2023, 97% were approved, which is consistent with trends over the last two years. This seems to correlate with the decrease (336) in the number of first appeal TARs received. Improvements in this data reflect enhancements implemented by the TAR Unit including training and maintenance work with facilities specific to issues identified around denials and an administrative assignment adjustment where TAR Unit staff are assigned to specific hospitals to promote more continuity and consistent follow-up.

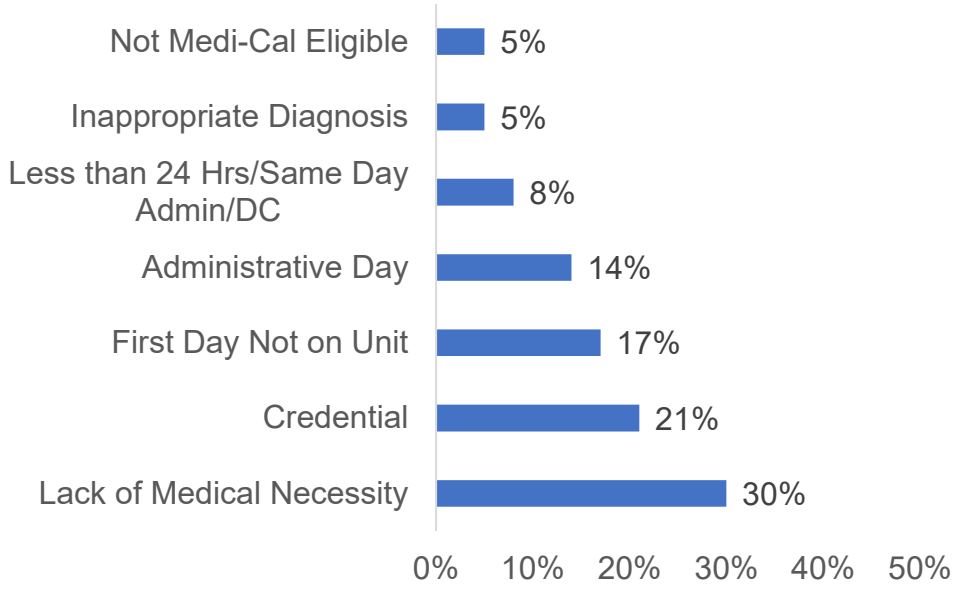
Four-Year Trend in TARs Received and Percent Approved

	CY 2020	CY 2021	CY 2022	CY2023
Overall TARs Received	28,501	27,939	29,908	30,956
% Overall Approved	67.7%	93.0%	95.6%	97%
First Appeal TARs Received	660	689	532	336
% First Appeal Approved	29.7%	34.1%	41.3%	75%

Data Source: TARs and Appeals COGNOS reports, (IBHIS on 6/26/2024).

During CY 2023, the ICD Unit issued 988 Notice of Adverse Benefits Determinations (NOABDs). The NOABD is a notification to the patient and provider letting them know what was denied for reimbursement and the reason why. Fifty-one percent of NOABDs were issued due to a lack of medical necessity (30%) and appropriate credentialing of the provider (21%). These are perennially seen as the most common reasons and are areas that DMH provides technical assistance to hospitals seeking improvement. Medical necessity must be demonstrated through appropriate documentation and may require ongoing support. For appropriate credentialing, some providers may be in the process of being credentialed and, therefore, approvals are reported retroactively. In addition, 410 NOABDs were sent to the provider but not to the beneficiary because they were homeless and could not be reached to obtain consent for the appeal.

Percent of NOABD Denials by Reason, Calendar Year 2023



Data Source: TAR Unit Logs reviewed 7/1/2024. Links to: Charts for 2023 QAPI Appeals Goal.xlsx

The ICD – Compliance Unit engages in several quality improvement efforts to address the NOABD data trends. They conduct multiple Technical Assistance trainings with hospital staff to ensure understanding of the procedures that must be followed to establish medical necessity, approve acute and, particularly, administrative days, to improve documentation so that the need for continuing days are clearly supported in the notes, and to increase communication around discharge planning. The unit also has a weekly standing call with the hospitals participating in concurrent review to track the data and address any issues as they arise. The unit has been improving communication with hospitals by sending the Treatment Authorization Status form within 24 hours.

Next steps include continued collection of dates of submitted appeals, resolutions, and reasons for denial, using the Provider Appeal Tracking log on a monthly basis. The Provider Appeal Tracking log will be utilized to identify and analyze trends, incorporate trends within provider update meetings, explore provider, system, and process issues that impact denials, analyze data to compare denials from contracted versus non-contracted and IMD Exclusion versus GACH stays, and review denials by psychiatrists.

Objective 2: Concurrent authorization will be operational at all hospitals.

Concurrent authorization is operational at all contracted hospitals. The ICD Unit conducted a concurrent rollout for contracted providers on October 7th, 2021. An All-Provider Concurrent Authorization meeting was conducted on December 2, 2022, to ensure that all providers were informed of procedures and requirements for implementation. Standing weekly concurrent authorization meetings are held for both contracted and non-contracted providers.

Currently, 100% of contracted providers received information for the All-Provider Concurrent Authorization Implementation meeting. All contracted providers (100%) participated in an individual concurrent review support meeting and 100% of contracted providers are utilizing the concurrent review process. For non-contracted providers, 100% received information for the All-Provider Concurrent Authorization Implementation meeting, 33% of non-contracted providers participated in an individual concurrent review support meeting, 30% of non-contracted providers are utilizing the concurrent review process, and 70% of non-contracted providers are awaiting Los Angeles County Medi-Cal certification to start the concurrent process.

The ICD Unit continues to support contracted and non-contracted providers in concurrent authorization implementation. Currently, LACDMH is doing some functions of concurrent review for contracted Psychiatric Health Facilities (PHFs) and Short Doyle Hospitals. While LACDMH is receiving and reviewing referrals for PHFs, we are preparing to implement full concurrent review by end of year 2025 which will include hiring more staff and making updates to the DMH IT system.

Performance Improvement Projects

Goal 7A.	Clinical PIP for FY22-23 focuses on improving quality of care for clients with Eating Disorders (ED) by implementing best practices and training clinicians to feel more comfortable working with this population
Objective	1. Continue to convene PIP committee. 2. Develop an ED Practice Network. 3. Develop and conduct overview training (ED 101) and CBT specific training with consultation. 4. Create place to share information related to service delivery and best practices for ED clients.
Population	Clients receiving SMHS
Performance Indicator(s)	1. The number of clinicians receiving training 2. Rate of diagnosis of clients with eating disorders pre and post training 3. Number of users of MS Teams website used for consultation and information dissemination 4. ED best practice toolkit is compiled and can be accessed
Frequency of Collection	Quarterly through June of 2023
Responsible Entity	Quality, Outcomes, and Training Division - Quality Improvement Unit

This goal was met.

The FY 2022-23 clinical PIP, *Improving Treatment Services for Individuals with Eating Disorders*, was sunset in October 2022. The ED Practice Network continues to support providers with meetings every other month. Additionally, the ED Best Practices tool kit is available on the LACDMH website, https://dmh.lacounty.gov/resources/eating-disorder-resources/. The tool kit also provides information, resources, and training opportunities. The ED 101 general overview and CBT specific training continue to be available in addition to a monthly consultation series.

A new clinical PIP was developed as a result of one of the EQRO recommendations in FY 2022-2023. The focus was on decreasing the inpatient psychiatric rehospitalization rates. The Intensive Care Division (ICD)- Treatment Authorization Request (TAR) Unit had an ongoing pilot called the Readmission Reduction Project. The goal of the pilot project was to decrease rehospitalization rates to no more than the 19% nationwide rate. Phase I of the project was initiated in FY 2021-22 and included 2 pilot hospitals, Southern California Hospital at Van Nuys and Los Angeles Downtown Medical Center. Phase II of the project began in April 2023 and focused on two new hospitals, St. Francis Medical Center and Emanate Inter-community Hospital Parkside West. The Quality Improvement Unit joined the ICD-TAR unit on the pilot project during Phase II for the purpose of carrying out this clinical PIP.

The aim of the pilot project was to reduce those factors that may contribute to repetitive hospitalization by increasing the support from LACDMH teams/programs to the hospitals during the discharge planning process. The population of focus for this project was Adult and Older Adult Medi-Cal beneficiaries with a history a mental health diagnosis and/or history of self-harm who have had 4 hospitalizations within a year or had been hospitalized twice within 30 days. The interventions included referring clients to Enhanced Care Management (ECM) services, Full-Service Partnership (FSP) program, Clinical Pharmacy, and Department of Public Health's Substance Abuse Prevention and Control (SAPC)

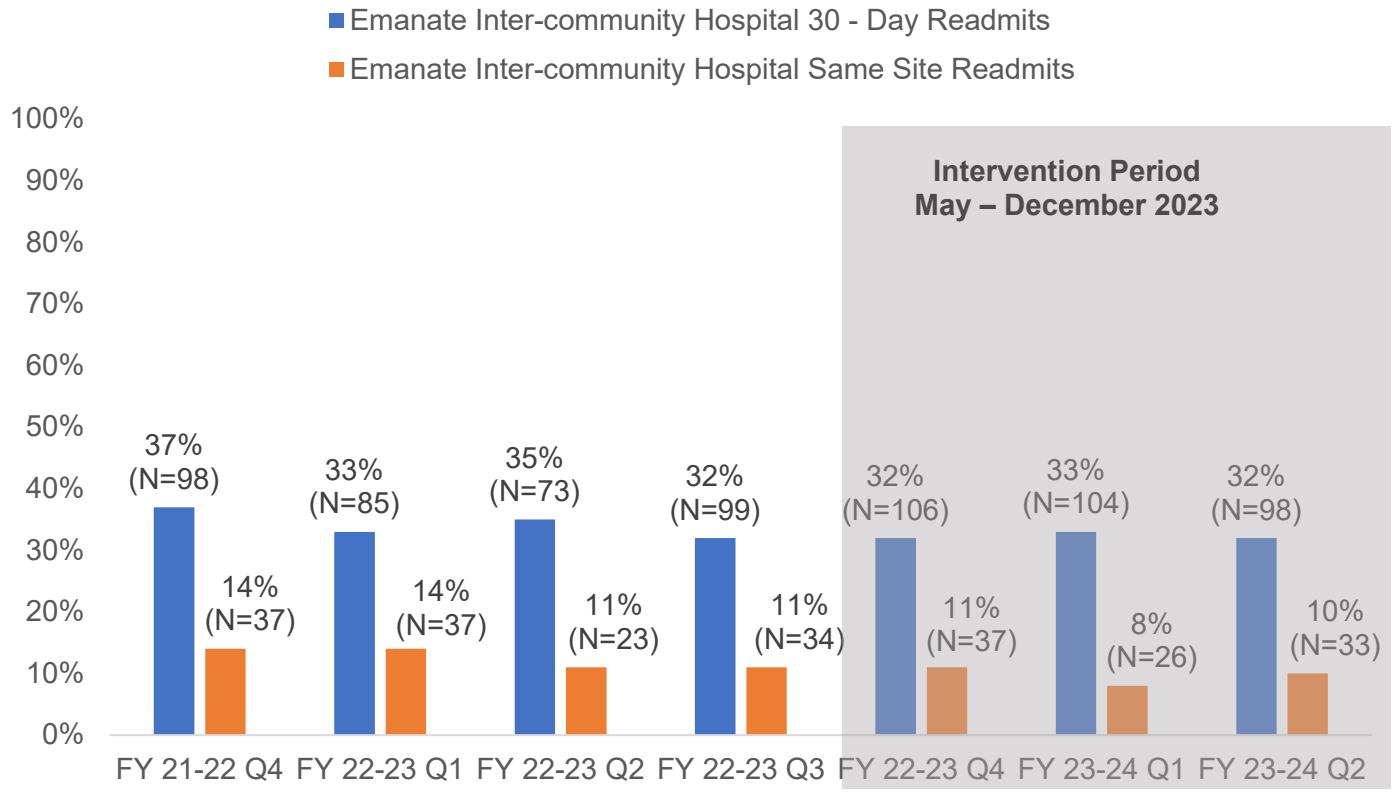
Services. Processes that were part of the pilot project included the use of Los Angeles Network for Enhanced Services (LANES), a Health Information Exchange (HIE), and multidisciplinary case consultation which were intended to facilitate collaboration and care coordination. Additionally, in-reach of patients was carried out by the ECM unit, FSP program, and Clinical Pharmacy.

PIP Data

Readmission Rates

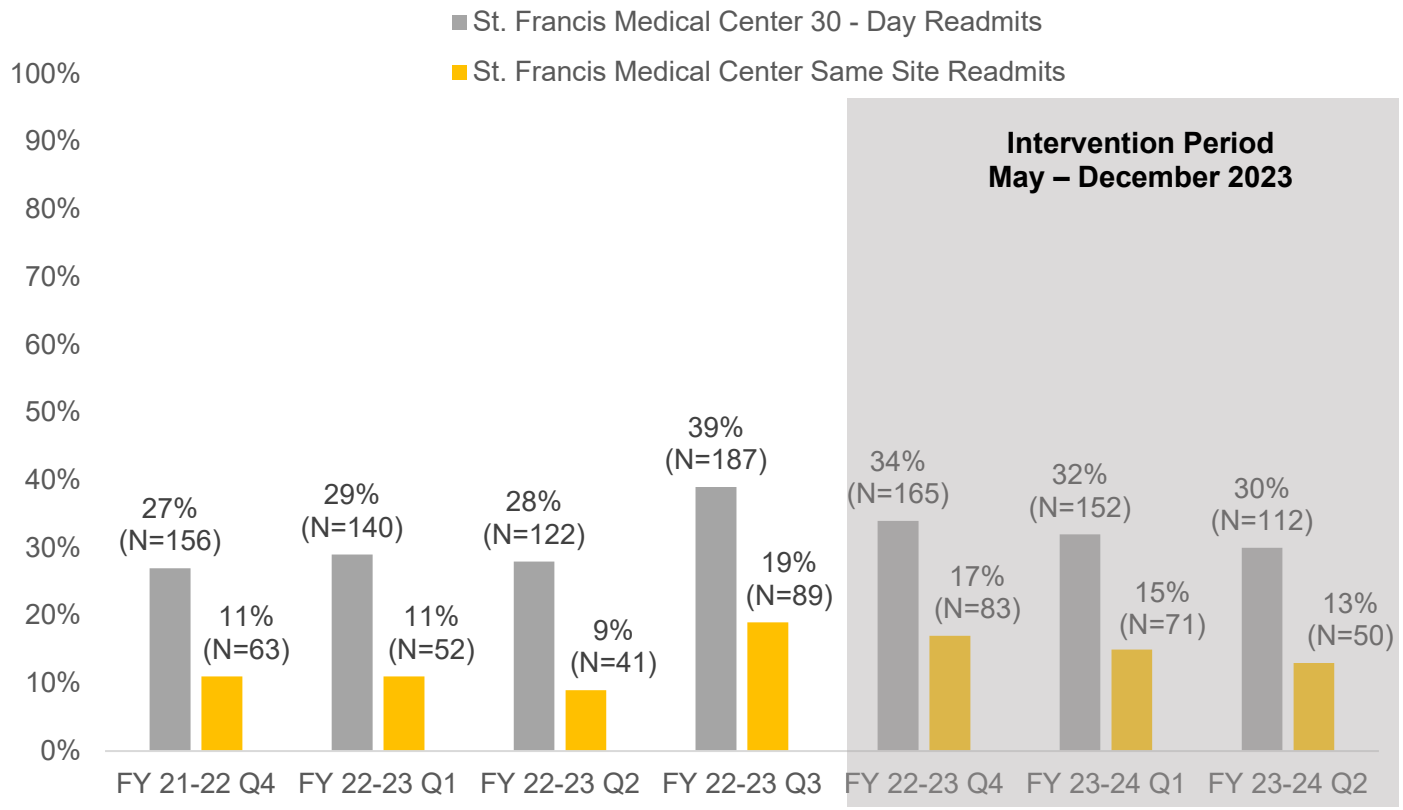
Phase II of the pilot went live in May 2023 (FY 2022-23 Q4) at which point the interventions were introduced at both hospitals. The 30-day readmission rate for Emanate Inter-community Hospital during the intervention period between May and December was an average rate of 32.3%. This is a decrease of 2.0 Percentage Points (PP) from the baseline 30-day readmission average rate of 34.3%. The same site readmission average rate of 9.7% is a 2.8 PP decrease from the baseline rate of 12.5%. As for St. Francis Medical Center, both the 30-day readmission and the same site readmission rates increase during the intervention period. Specifically, the 30-day readmission was an average rate of 32.0% which was a 1.2 PP increase from the baseline average rate of 30.8%. The same site readmission average rate of 15.0% was a 2.5 PP increase from the baseline average rate of 12.5%.

30-day and Same Site Readmission Rates for Emanate Intercommunity Hospital, Pre- and Post-Intervention Period



Data source: LACDMH PowerBI Inpatient Rehospitalization Report, January 2024.

30-day and Same Site Readmission Rates for St. Francis Medical Center, Pre- and Post-Intervention Period



Data source: LACDMH PowerBI Inpatient Rehospitalization Report, January 2024.

Enhanced Care Management (ECM) Referrals

From July 1, 2023, to November 30, 2023, 19,437 psychiatric inpatient discharges took place at Emanate Inter-community Hospital and St. Francis Medical Center. Of the discharges, 16,672 (86%) were for clients who have never been referred to ECM. For 25% (N=4,174) of these non-ECM discharges, the client was admitted for a second inpatient stay within 30 days of the discharge: the 30-day rehospitalization rate. Rehospitalization was not necessarily to the same facility. Hospitalized clients in general may represent a different clinical population than ECM-referred clients. Of the same discharges, 686 involved clients who would soon be referred to ECM; their first lifetime ECM referral would take place within one year of the date of discharge. The 30-day rehospitalization rate for these year-before discharges was **65.6%** (450/686). 341 discharges took place between the date a client was referred to ECM and the date they either enrolled in ECM or were discontinued from outreach. The 30-day rehospitalization rate for these referral/outreach discharges was **50.4%** (172/341). 77 discharges took place between the date a client was enrolled in ECM and the date they were discontinued from outreach (or through November 30). The 30-day rehospitalization rate for these enrollment discharges was **59.7%** (46/77). This is a relatively smaller number of discharges and may be influenced by outliers or the clients' level of clinical severity.

Hospitalization Category	30-day Rehospitalization	Total Discharges	Total Readmits 30 Day
No ECM	25%	16672	4174
Year Before ECM Referral	65.6%	686	450
ECM Referred	50.4%	341	172
ECM Enrolled	59.7%	77	46
ECM Other	57.9%	1661	961
TOTAL		19437	5803

The remaining 1661 discharges were for clients who had a lifetime ECM referral but were not currently in either referral/outreach or enrollment status at the time of the discharge.

Full-Service Partnership (FSP) Referrals

Between May 2023 and December 2023 both pilot hospitals submitted 75 Full-Service Partnership (FSP) referrals. Seventy-one discharges were referred for Adult FSP, two were referred for Child FSP, and two were referred for Homeless FSP.

Intensive Care Division (ICD) Referrals

From May 2023 to December 2023, Emanate Inter-community Hospital submitted seven referrals to the Intensive Care Division (ICD) of which three were approved and admitted for continued care. Of the Emanate referrals, 42.9% (N=3) were Male and 57.1% (N=4) were Female. St. Francis Medical Center submitted 62 ICD referrals of which 51 were approved and admitted. Of the St. Francis referrals, 69.4% (N=43) were Male and 37.1% (N=23) were Female.

Pharmacy and Substance Abuse Prevention and Control (SAPC) Referrals

There were no referrals made to Clinical Pharmacy or the Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) between May and December 2023. Representatives from Clinical Pharmacy and DPH SAPC continued to participate in multidisciplinary case consultations, provided information about their services and the referral process, and continued to make themselves available to hospital staff in an effort to identify clients who could benefit from their services.

Next Steps
Phase II of the Readmission Reduction Project is ongoing and will continue through the remainder of FY 2023-2024. Phase III of the pilot project is in development.

Goal 7B.	Develop and implement an administrative data-driven performance improvement project for FY 22-23 to improve follow up mental health services after presenting in an emergency room (ER) with mental health issues (BHQIP-FUM).
Objective	1. Gain insight into clients with mental health issues that visit emergency rooms to improve post ER follow up for mental health services by creating timely exchange of data between ERs and LACDMH. 2. Connect identified beneficiaries in ERs back to their mental health provider or provide linkage to needed mental health services.
Population	Beneficiaries that receive care from ERs that are existing SMHS clients or potential clients
Performance Indicator(s)	1. Access to real time data on clients served in ERs with mental health issues 2. Reduction in percentage of clients not receiving any follow-up mental health care 3. Increased percentage of clients receiving more than one SMHS claim post ER visit
Frequency of Collection	To be determined
Responsible Entity	Quality Improvement Unit, Enhanced Care Management, Chief Information Office Bureau

This goal was met.

The FY 2022-23 non-clinical PIP, *Improving Follow-Up After Emergency Department Visit for Mental Illness (FUM) for Beneficiaries that Present with Mental Health Concerns,* was selected to parallel the California Department of Healthcare Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Quality Improvement Program (BHQIP). The BHQIP is an incentive program to assist Mental Health Plans (MHPs), Drug Medi-Cal State Plans (DMC), and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) through changes required for the CalAIM initiative. The BHQIP FUM PIP focuses on the CalAIM BHQIP milestones for bi-directional data exchange between systems of care to improve quality, outcomes, and care coordination for beneficiaries in need of mental health services who present for care at local emergency departments (EDs).

This project proposes to increase mental health linkage opportunities for vulnerable populations in urgent need of care by improving engagement and follow-up with Medi-Cal beneficiaries visiting EDs for mental illness by initiating outreach and data exchange with facilities serving these beneficiaries to ensure better continuity of care and reduce their emergency room visits.

The following LACDMH Units/Teams were members of the PIP committee:

- Quality Improvement (QI) Unit
- Enhanced Care Management (ECM) Team
- Quality Assurance (QA) Unit
- Intensive Care Division (ICD)
- Chief Information Office Bureau (CIOB)
- Geriatric Services Intervention Support (GENESIS) program
- Health Access Integration (HAI) Unit

Additionally, LACDMH engaged with Managed Care Plans (MCPs) LA Care and Healthnet and worked in partnership with ED staff at two pilot hospitals, Emanate Inter-Community Hospital in Covina, CA and St. Francis Medical Center in Lynwood, CA.

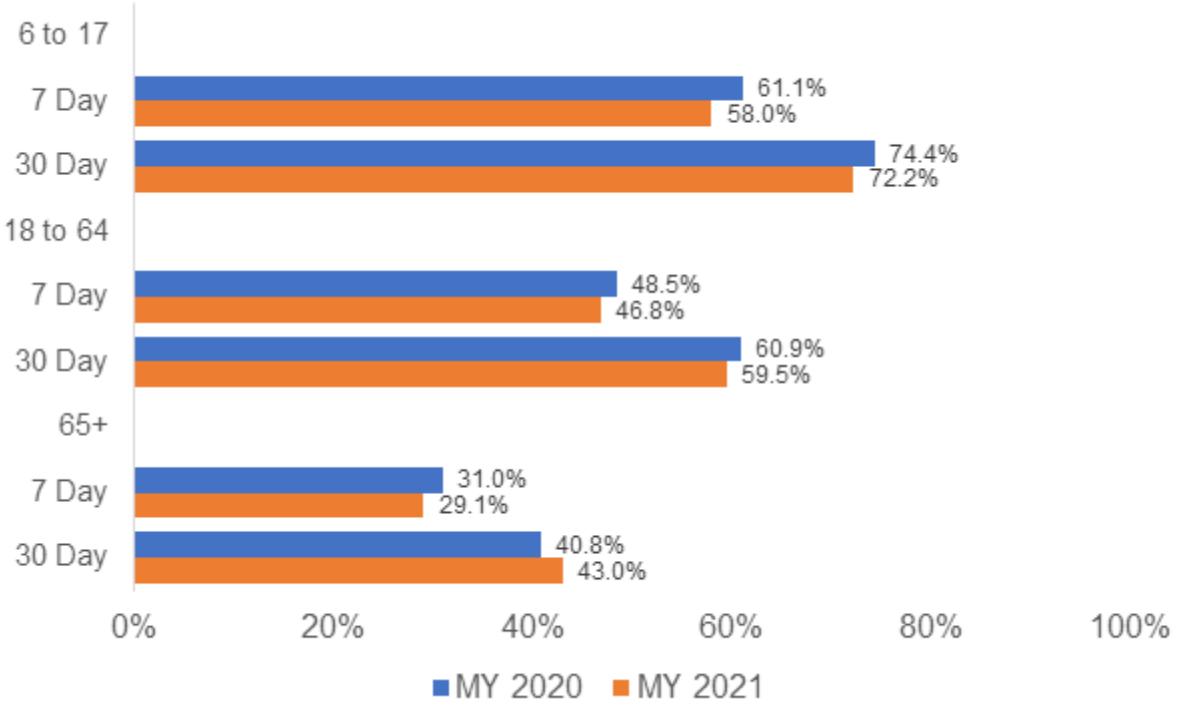
This PIP will focus on individuals who may not be connected to LACDMH and beneficiaries previously connected to mental health services at LACDMH, Legal Entity (LE)/Contacted provider, or another provider. Individuals with any diagnosis, race/ethnicity, age, gender, primary language, and housing status will be included in the study population.

Baseline Data

Department of Healthcare Services, Measurement Year 2020 and 2021 Data

LACDMH did not previously track referrals from EDs for mental health services. Baseline data was limited to the DHCS data report provided to each County. The data was not current. Data from DHCS shows that LA County has the lowest rate of seven- and 30-day FUM in the 18-64 and 65+ age groups.

LA County 7-Day and 30-Day FUM by Age Group, MY 2020 and MY 2021



Note: For MY 2020, N=18,546 and for MY 2021, N=16,487. Data source: California Department of Healthcare Services (DHCS), August 2022.

The NCQA website lists national averages for Medicaid Health Maintenance Organizations (HMOs) for 7-day FUM as 41.4% in 2019, 40.4% in 2020, and 40.1% in 2021. For 30-day FUM, Medicaid HMOs averaged 55.6% in 2019, 54.4% in 2020, and 53.4% in 2021. For LACDMH MY 20 and 21 data, all ages met the NCQA national averages, except the older adult age group (NCQA, 2023).

Aim Statement

The aim of this PIP was that during the Fiscal Years 2022-24, the application of the LACDMH Enhanced Care Management (ECM) Team outreach and linkage services to hospital emergency

departments, revision of emergency department referral workflows, and connection of California Bridge Navigation or hospital staff to a health information exchange would increase the percent of linkage to seven and 30-day follow-up mental health appointments for Medi-Cal beneficiaries who present to emergency departments with mental health diagnoses from 0% to 5% in six months, specifically adults and older adults.

Interventions

Interventions for this PIP included the following:

1. **ED Staff Education: The** ECM team provided education on ECM and LACDMH services to existing ED staff at the start of this pilot. ECM will continue to provide education as needed when new ED staff arrive.
2. **Revised referral workflows:** ED staff revised their workflows for making mental health referrals. Additional revisions were to occur when challenges arose. The agreed upon revised workflow is as follows:
    a) Patient receives a mental health diagnosis by an ED provider
    b) Hospital ED social workers/CA Bridge Navigators refers patient to the ECM team
    c) ECM team searches for the patient in Los Angeles Network for Enhanced Services (LANES) for additional contacts with LANES-connected EDs
    d) ECM contacts the patient to arrange a meeting
    e) ECM provides services to the patient per the patient's agreement
    f) ECM assists the patient in connecting with FUM
3. **Checking HIE: ECM** staff will check referrals for previous contact with EDs in the LANES system as referrals are received.
4. **Providing Linkage to Mental Health Services:** Upon receipt of a referral, ECM will provide outreach to Medi-Cal beneficiaries referred to ECM services, utilize motivational interviewing, assess for transportation and housing needs, assist with Motivational Interviewing, assist with linkage to follow-up appointments and connect clients to the next level of care when appropriate.

Improvement Strategy Summary

#	Intervention	Date Intervention Began	Frequency of Intervention	Corresponding Variable (Indicator)
1	Enhanced Care Management (ECM) team provided educational presentations on LACDMH mental health services to ED staff	1a. 05/31/2023 – Emanate ED 1b. 06/28/2023 – St. Francis ED	As needed	1. Percent of hospital ED staff that received the ECM educational presentations
2	Review ED workflow to include checking of LANES and referral to the ECM team	2a. 05/31/2023 – Emanate ED 2b. 07/10/2023 – St. Francis ED	One time	2. Percent of hospital ED referrals that enroll in ECM services
3	Staff/ECM team members will search mental health referrals in LANES for previous contact with LANES-lined EDs where mental health concerns were present	3a. 05/31/2023 – Emanate ED 3b. 08/2023 – St. Francis ED	Upon receipt of a referral	3. Percent of hospital ED referrals checked in LANES
4	ECM will provide outreach to beneficiaries referred to ECM services, assist with linkage to follow-up appointments, assess for transportation needs, assess for housing needs, utilize Motivational Interviewing, and assisting with connections to the next level of care	3a. 07/01/2023 – Emanate ED 3b. 08/2023 – St. Francis ED	Upon receipt of a referral	4a. Percent of patients that attend their follow-up 7 or 30-day FUM 4b. Percent of adults that attend their follow-up 7 or 30-day FUM 4c. Percent of older adults that attend their follow-up 7 or 30-day FUM

Data source: Los Angeles County BHQIP FUM Nonclinical PIP Development Tool FY 2023-24.

Results

Although the pilot project began in May 2023 at Emanate ED and June 2023 at St. Francis ED, hospital staff, patient engagement, and data collection were slow to begin. An unexcepted amount of time was needed for the ECM team to develop relationships with hospital ED staff, create buy-in, and facilitate engagement in the interventions. When mental health referrals began, some patients declined referrals and the ECM had difficulty contacting others due to patients not having phones, limited resources, and unhoused statuses. A total of 28 referrals were submitted to ECM during the intervention period. However, two referrals had no known client ID and no demographic information recorded preventing them from being tracked in the Integrated Behavioral Health Information System (IBHIS). The total number of referrals during this PIP was 26.

Of the 26 referrals with demographics, the majority were adults (N=19, 73.1%) and identified as male (N=20, 76.9%). The majority of referrals identified their primary language was English (N=21, 80.7%). No primary language recorded for the remaining five. Five referrals (19.2%) had an entry of Homelessness on their Problem List. Eight referrals (30.8%) identified race/ethnicity as Hispanic/Latino, six (23.1%) as White, four (15.4%) as Black/African American, two (7.7%) as Asian, one (3.8%) as Other, and five (19.2%) as Unknown.

ECM education of ED staff increased from 0 to a combined total of 19 which met the goal of increasing the ED staff education by 100% for the 1st Remeasure period of June-September 2023. However, no new educational opportunities were able to occur during the 2nd Remeasurement period of October-December 2023 due to both hospital EDs limiting access of the ECM team. This goal was not met for the 2nd Remeasurement period.

Overall, the ECM number of referrals received during the PIP was low. At the completion of the PIP, the number of ECM referrals that enrolled into ECM services was a combined total of 28. Of these 28 referrals, four (14.3%) were enrolled in ECM as a result of the hospital ED referral. An additional four (14.3%) were found to have already been enrolled in ECM at the time of the referral. An additional four (14.3%) referrals declined to participate in ECM. Five referrals (17.9%) did not have Medi-Cal or did not meet ECM criteria in other ways. For eight referrals (28.6%), ECM staff was unable to contact the client or upon contact found the client was not stable enough to engage. One referral did not have this information entered. The goal of increasing the number of ECM referrals enrolled into services by 5% was met.

All ECM referrals were checked in LANES by ECM staff for contact with other hospitals. The goal of checking 100% of the referrals was met.

For the FUM measures, it was assumed the ECM date of referral corresponded to the date of discharge from the ED, since this date was not separately recorded. Billing data was used to identify a billable service that was considered a follow-up service for calculating the FUM numerator, since the codes used by ECM staff are specific to ECM and not currently included in the FUM code set. Given those assumptions, for the 1st Remeasurement period, a total of 17 discharged patients were tracked with a known client ID and received at least one billable service within the DMH system of care within seven or 30-days. Six (35.3%) discharged patients attended their seven-day follow-up (FUM7) mental health appointments, and nine (52.9%) discharged patients attended their 30-day follow-up (FUM30) mental health appointments. At the 2nd Remeasurement period, an additional nine discharged patients were tracked making a grand total of 26 discharged patients tracked with a known client ID and received at least one billable service within the DMH system of care within seven or 30 days. Eleven (42.3%) attended their FUM7 appointments, and 16 (61.5%) discharged patients attended their FUM30 mental health appointments. FUM7 increased by 7 Percentage Points (PP) and FUM30 increased by 8.6 PP at the end of the data collection. The goal to increase FUM7 and FUM30 by 5% was met.

For adults, the 1st Remeasurement period FUM7 was at 33.3% and FUM30 was at 50.0%. In the 2nd Remeasurement for adults, FUM7 increased 14.1 PP to 47.4%. For older adults, the 1st Remeasurement period FUM7 was at 40.0% and FUM30 was at 60.0%. In the 2nd Remeasurement for older adults FUM7 decreased 11.4 PP to 28.6%, and FUM30 decreased by 2.9 PP to 57.1%. The goal to increase adult and older adult FUM7 and FUM30 by 5% was met. However, the rate of FUM7 for older adults appeared lower at the completion of the data collection, indicating that further exploration of barriers is needed.

PIP Results Summary

Performance Measure Description	Target Performance Rate	Baseline Dates/Year	Baseline sample size and rate	1st Remeasure	1st Remeasure sample size and rate	2nd Remeasure	2nd Remeasure sample size and rate
PM 1. Percent of hospital ED staff that received the ECM educational presentations	Increase to 100%	[1]*Pending*	1a. Emanate ED = 10 1b. St. Francis ED = 9	1a. Emanate ED = June – Sept 2023 1b. St. Francis ED = July 2023 - Sept 2023	1a. Emanate ED, N=10 1b. St. Francis ED, N=9; 100%	October-December 2023	1a. Emanate ED, N=0 1b. St. Francis ED, N=0, 100%
PM 2. Percent of hospital ED referrals that enroll in ECM services	Increase by 5%	[1]*Pending*	N = 0	June – Sept 2023	N=0, 0%	October-December 2023	N=4, 14.3%
PM 3. Percent of hospital ED referrals checked in LANES	Increase to 100%	[1]*Pending*	N = 0	June – Sept 2023	N=20, 100%	October-December 2023	N=28, 100%
PM 4. Percent of patients that attend their follow-up 7 or 30-day FUM	Increase by 5%	[1]*Pending*	N = 0	June – Sept 2023	a) FUM7 = 6/17 (35.3%) b) FUM30 = 9/17 (52.9%)	October-December 2023	a) FUM7 = 11/26 (42.3%) b) FUM30 = 16/26 (61.5%)
PM 5. Percent of adults that attend their follow-up 7 or 30-day FUM	Increase by 5%	[1]*Pending*	N=0	June – Sept 2023	a) FUM7 = 4/12 (33.3%) b) FUM30 = 6/12 (50.0%)	October-December 2023	a) FUM7 = 9/19 (47.4%) b) FUM30 = 12/19 (63.2%)
PM 6. Percent of older adults that attend their follow-up 7 or 30-day FUM	Increase by 5%	[1]*Pending*	N=0	June – Sept 2023	a) FUM7 = 2/5 (40.0%) b) FUM30 = 3/5 (60.0%)	October-December 2023	a) FUM7 = 2/7 (28.6%) b) FUM30 = 4/7 (57.1%)

Note: [1]The date of the Baseline Date/Year is still pending as LACDMH explores more recent data sources than MY 2020 and 2021. Data source: Los Angeles County BHQIP FUM Nonclinical PIP Development Tool FY 2023-24.

At the conclusion of the PIP, it appears that all goals were met despite the low number of referrals. Lessons learned include:

- Hospital ED administration buy-in takes longer due to relationship building and education needs.
- Hospital ED staff face challenges in implementing new processes due to time limitations of patient encounters.
- Hospital EDs vary in resources, staffing, and openness to revising workflows.
- HIEs are limited in the information that is collected and shared.

Next Steps

The MHP plans to continue this project for FY 2023-24 with a focus on connecting the LADCMH GENESIS program to HIE alerts for enrolled beneficiaries. Integration of HIEs such as PointClickCare (PCC) are being considered to assist with data collection and communication. Other data resources are being explored for better quality baseline data and overall data collection. Creation of a training on making referrals and available mental health services provided by LACDMH for CA Bridge Navigators is also being considered. Emanate ED has also discussed including ECM information in their discharge packets and creating hospital emails for ECM staff to directly receive a list of admitted patients.