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 2024

Period: January 1, 2024, to December 31, 2024

Presented By:

Los Angeles County Department of Mental Health

Quality, Outcomes, and Training Division, Quality Improvement Unit

Monitoring Service Delivery Capacity, Calendar Year 2024

Service Equity

Goal Ia.	**Analyze root causes in the underrepresentation of self-identified Asian Pacific Islanders (and Communities with Physical Disabilities receiving DMH services.**
Objective(s)	1. Implement learning from 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. • Utilize recommendations from the ICCTM project to prioritize funding of community capacity building projects. 2. Standardize data collection for persons with disabilities to be able to better assess level of participation in DMH services using new demographic data in IBHIS.
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. Development of standards for disability reporting for all mental health service providers that meet local, state, and federal requirements 4. Service Equity Analysis Report Findings
Frequency of Collection	Annually
Responsible Entity	Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Division/Cultural Competency Unit (CCU)

This goal was partially met.

Objective #1: Implement learning from 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 Islander and (API) communities with physical disabilities.

- Utilize recommendations from the ICCTM project to prioritize funding of community capacity building projects.

LACDMH's strategy to address barriers for engagement of API and communities with disabilities was implementing capacity building projects aimed at reducing mental health stigma and increasing mental health education and awareness.

To better address the mental health needs of the API and disability communities, we implemented capacity building projects specifically with a focus on accessibility issues and how we can reduce mental health disparities. Four capacity building projects (see below) were completed which identified and addressed barriers to seeking mental health services for the API 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 LACDMH-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, individuals who were born in Cambodia or in refugee camps but immigrated to the United States as children or adolescents, 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 serve 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

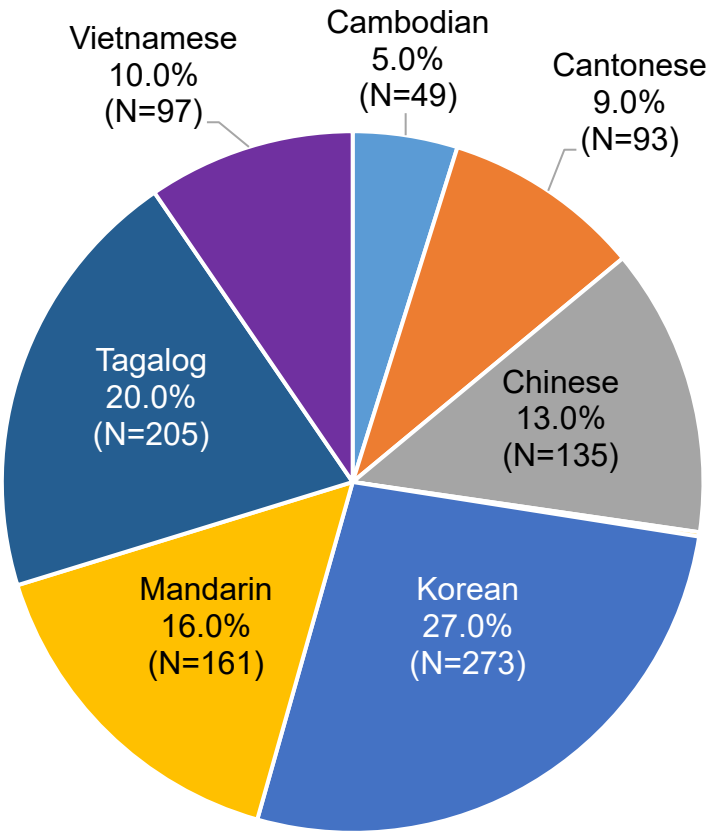
- Cultural stigma and lack of understanding and knowledge of mental illness in first generation South Asians
- Culturally beliefs that hinder community members' ability to seek mental health services
- Community members with lower levels of acculturation have limited understanding of available mental 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 increase the reach of Mental Health Promoters so that they can provide mental health education, stigma reduction strategies, linkages and outreach services targeted geographically areas within the API community. We are 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.

Percent of API Practitioners by Language



Note: Hmong is not listed due to having only two Hmong-speaking providers (0.0%) available. Data source: NAPPA, August 2024

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. The 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 SAs 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. The 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 LACDMH.

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 LACDMH SAs to increase mental health awareness and knowledge among the targeted communities

Objective #2: Standardize data collection for persons with disabilities to be able to better assess level of participation in DMH services using new demographic data in IBHIS.

Work continues with CIOB on defining demographic data based on input from the Access for All Under-Served Cultural Community (UsCC) group and interested stakeholders combined with State and federal requirements.

Performance Indicators

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

Figure: Clients Served in Outpatient Programs by Race/Ethnicity and Service Area, CY 2024

Note: Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, May 2025.

Service Area (SA)	African American	American Indian/ Native American	Asian	Latino	Native Hawaiian/ Pacific Islander	Other	Two or more races	Unreported	White	Total
SA1	4,406	66	208	4,619	69	570	729	3,621	2,682	16,970
Percent	1.63%	0.02%	0.07%	1.98%	0.03%	0.23%	0.31%	1.41%	1.07%	6.75%
SA2	2,443	74	526	12,759	289	2,529	1,016	8,116	5,864	33,616
Percent	0.96%	0.03%	0.23%	6.84%	0.13%	1.05%	0.49%	3.10%	2.51%	15.33%
SA3	2,967	157	2,283	10,557	236	7,098	941	7,364	4,263	35,866
Percent	1.16%	0.06%	1.14%	5.20%	0.11%	3.58%	0.41%	2.94%	1.99%	16.60%
SA4	5,966	239	1,452	14,117	382	1,822	765	7,874	4,381	36,998
Percent	1.99%	0.09%	0.63%	6.64%	0.13%	0.75%	0.29%	2.87%	1.80%	15.21%
SA5	1,844	38	178	2,090	61	733	395	1,842	2,244	9,425
Percent	0.65%	0.01%	0.11%	0.96%	0.03%	0.33%	0.15%	0.56%	0.89%	3.69%
SA6	9,678	188	216	14,055	108	1,492	669	5,357	2,090	33,853
Percent	3.51%	0.05%	0.09%	6.92%	0.05%	0.75%	0.29%	1.82%	0.96%	14.44%
SA7	1,513	246	353	12,554	163	2,768	738	3,073	2,211	23,619
Percent	0.55%	0.08%	0.15%	6.47%	0.07%	1.15%	0.32%	1.12%	0.99%	10.92%
SA8	6,892	114	1,147	12,832	416	2,107	1,182	7,955	3,887	36,532
Percent	2.66%	0.04%	0.44%	6.24%	0.19%	1.00%	0.54%	2.96%	1.59%	15.66%
Countywide	169	4	12	329	3	34	13	184	104	852
Percent	0.04%	0.00%	0.00%	0.10%	0.00%	0.01%	0.00%	0.06%	0.04%	0.26%
Out of County	572	9	50	754	19	118	65	1,647	416	3,650
Percent	0.15%	0.00%	0.01%	0.26%	0.00%	0.04%	0.02%	0.54%	0.13%	1.15%
Total	29,853	994	5,744	74,077	1,562	17,283	5,695	40,779	23,844	199,831
Percent	13.31%	0.38%	2.88%	41.61%	0.74%	8.89%	2.83%	17.38%	11.98%	100.00%

Number of Persons with Disabilities Served in Directly Operated Clinics, CY 2024

Year	Distinct Clients	Percent of Persons with Disabilities
2024	19,668	20.2%

Note: "Persons with Disabilities" counted are individuals served in a Directly Operated (DO) clinic, with a primary mental health diagnosis(es), AND one or more of the following disability types captured in IBHIS: Learning Disability; Hearing Impairment; Motor Impairment; Sensory or Motor Impairment; Military Related Disability; Developmental Disability; Developmental Diagnosis; Intellectual Disability; Hearing- related Disability; Hearing impairment; Visual Impairment; Vision, Seeing-related Disability; and Other Sensory Impairment. LACDMH served 97,418 distinct clients in outpatient services in CY 2024. Data source: IBHIS data from LACDMH DO providers prepared by CIOB in January 2025. Excludes clients who have received only one billable service or only inpatient service.

Number of Distinct Persons with Disabilities Served in Directly Operated Clinics by Disability Type, CY 2024

Disability Type (*Data Source*)	Distinct Clients	%
Learning Disability (*Adult Full Assessment*)	7,762	7.97%
Developmental Disability	2382	2.45%
Intellectual Disability	776	0.80%
Sensory or Motor Impairment (Adult or Child Full Assessment)	5,529	5.68%
Hearing Impairment	1443	1.48%
Hearing related Disability (Problem List)	11	0.01%
Vision/Seeing related Disability (*Problem List*)	14	0.01%
Military Related Disability (*Update Client Data, Admissions etc.*)	19	0.02%
Visual Impairment (*Immediate/ Same Day Assessment*)	5,116	5.25%
Motor Impairment (*Immediate/ Same Day Assessment*)	1,711	1.76%
Other Sensory Impairment (*Immediate/ Same Day Assessment*)	544	0.56%

Note: Clients were able to select more than one disability causing the distinct clients by disability type to be higher than the number of distinct clients with a disability. Data source: IBHIS data from LACDMH DO providers prepared by CIOB in January 2025. Excludes clients who have received only one billable service or inpatient service.

3. Development of standards for disability reporting for all mental health service providers that meet local, state, and federal requirements

   Work continues with CIOB on improving the quality and quantity of data collection about people with disabilities across the LACDMH system of care based on input from Access for All UsCC and interested stakeholders combined with State and federal requirements. A standardized set of disability status questions are needed for directly operated and legal entities to facilitate

interoperability across the system of care. Federal United States Core Data for Interoperability (USCDI) Disability Status elements and California's Data Exchange Framework (DxF) requirements will inform disability data collection methods as new and more inclusive metrics become available. Collecting a standardized set of disability data in electronic health records across the system of care is a critical step toward identifying disparities in care and behavioral health outcomes that persons with disabilities experience.

4. 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 that was 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 Ib.	Increase the Department's capacity to deliver culture (language)-specific services.
Objective(s)	1. Increase language access for Limited English Proficiency clients and family members by ensuring key informational materials are available in all threshold languages. 2. Increase response rate for assessing client satisfaction with American Sign Language (ASL) interpreter services by using new ASL Specialist to reach out to members who received services, identify areas for improvement, and review findings with providers.
Population	Los Angeles County's clients/families and deaf and hard of hearing clients and family members receiving outpatient SMHS in ASL from LACDMH DO and LE/Contracted providers and clients
Performance Indicator(s)	1. Assess which materials need additional translations and create a plan for completion and track progress 2. Show an increase in client perspective of satisfaction with ASL interpreter services to be combined with experience information from service provider requesting interpreter services
Frequency of Collection	Annually
Responsible Entity	ARISE/CCU

This goal was partially met.

The ARISE Division's CCU and Language Assistance Services (LAS) Unit were actively responsible for making multiple LAS more accessible to LACDMH clients, family members, staff and the community at large.

Objective 1: Increase language access for Limited English Proficiency clients and family members by ensuring key informational materials are available in all threshold languages.

Translation services provided via the ARISE Division

The CCU and LAS Units provide technical support to DO and LE/Contracted providers who seek

information on the procedures to be followed for language translation completion and quality review for accuracy and cultural meaning. LACDMH's mechanism for ensuring accuracy of translated materials is field testing. Field testing takes place via document reviews by bilingual certified staff, consumers, family members, or consumer caretakers who volunteer to read and comment on the linguistic and cultural meaningfulness of the translated documents. Edits gathered from the reviewers are then provided to the contracted vendor for the finalization of the translated documents.

The Speakers Bureau (SB) expanded the Department's capacity to create culture-specific informational materials in the threshold languages for the diverse communities of LA County. SB members have also been called upon to assist with the field testing of various public-facing materials such as program flyers, brochures, and consumer satisfaction surveys, among many others. SB members contribute their cultural and linguistic expertise to ensure cultural and language nuances, communication appropriateness, and clinical accuracy of reviewed materials.

A. Key departmental documents by language of translation

SAMPLE LACDMH FORMS, BROCHURES, AND WEBPAGE RESOURCES TRANSLATED INTO VARIOUS THRESHOLD AND NON-THRESHOLD LANGUAGES

Forms, Brochures and Webpage Resources	THRESHOLD AND NON-THRESHOLD LANGUAGES														
	Arabic	Armenian	Cambodian Khmer	English	Farsi	Hindi	Japanese	Korean	Russian	Spanish	Simplified Chinese	Tagalog	Thai	Traditional Chinese	Vietnamese
ACCESS Brochure	X	X	X	X	X			X	X	X	X	X		X	X
ACCESS Center Flyer “We are Here to Help”	X	X	X	X	X			X	X	X		X		X	X
Acknowledgement of Receipt				X						X					
Advance Health Care Directive Acknowledgement			X	X				X	X	X		X			
Alleviating Fear and Anxiety During Essential Trips in Public		X		X				X		X				X	
Authorization for Use or Use/Disclosure of	X	X	X	X	X			X	X	X	X	X		X	X

Protected Health Information (PHI)															
Beneficiary Problems Resolution Process	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Brief Universal Prevention Program Survey v2: Age 6-11		X		X				X		X					
Brief Universal Prevention Program Survey v2: Age 12+		X		X				X		X					
Brief Universal Prevention Program Survey v2: Parents		X		X				X		X					
Caregiver's Authorization Affidavit			X	X				X	X	X		X			
Child and Family Team Meetings Brochure				X						X					
Consent for Services	X	X	X	X	X			X	X	X	X	X		X	
Consent for Tele-Psychiatric Services			X	X				X	X	X		X			

Consent to Photograph/ Audio Record			X	X				X	X	X		X			
Coping with Stress During Infectious Disease Outbreaks	X	X	X	X	X		X	X	X	X	X	X		X	X
Coping with the Loss of a Loved One	X	X	X	X	X		X	X	X	X	X	X		X	X
Consumer Perception Survey (CPS) Announcement Flyers	X	X	X	X	X			X	X	X	X	X		X	X
Full- Service Partnership (FSP) brochures				X						X					
Adult FSP Client Satisfaction Survey	X	X	X	X	X			X	X	X	X	X		X	X
GENESIS brochure										X					
Grievance and Appeal Forms	X	X	X	X	X			X	X	X	X	X			X
Hope, Wellness and Recovery	X	X	X	X	X			X	X	X		X		X	X
Innovation (INN) 4 Transcranial Magnetic	X	X	X	X	X			X	X	X	X	X		X	X

Stimulation (TMS) Client Satisfaction Survey															
LACDMH Advance Health Care Directive Acknowledgement Form			X	X				X	X	X		X			
LACDMH Notice of Privacy Practices				X						X					
LACDMH Signage for New HQ Building				X						X					
LACDMH Strategic Plan				X						X					
Maintaining Health and Stability During COVID-19		X		X				X		X				X	
Mental Health Plan Beneficiary Handbooks	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mental Health Promoters/ Promotores de Salud Mental Brochure				X						X					

Multidisciplinary Assessment Teams Brochure				X						X					
My Wellness Toolbox				X						X					
Notice of Action A (Assessment)	X	X	X	X	X				X	X	X	X		X	X
Notice of Action E (Lack of Timely Service)	X	X	X	X	X				X	X	X	X		X	X
Older Adult FSP Annual Client Satisfaction				X	X					X	X			X	
Outpatient Medication Review	X	X	X	X	X			X	X	X	X	X		X	X
Portland Identification and Early Referral (PIER) Early Psychosis Program Brochure	X	X	X	X	X			X	X	X	X	X		X	X
PIER Early Psychosis Program Flyer	X	X	X	X	X			X	X	X	X	X		X	X
* Promotores Survey				X						X					
Request for Change of Provider				X						X					

Roybal Family Mental Health (MHC) Center brochure				X						X				X	
Service Area (SA) Provider Directories	X	X	X	X	X			X	X	X	X	X		X	X
Staying Connected during Physical Distancing		X		X				X		X				X	
Supportive Counseling Services				X						X					
Children and Young Adult FSP Brochure?	X	X		X	X			X		X		X			X
Telemental Health Services Brochure				X						X					
* Understanding the Mental Health and Emotional Aspects of COVID-19		X		X				X		X				X	
* Your Wellbeing on Your Terms - Online COVID-19 resource				X						X					
* 988 FAQs				X						X					

* 988 Comparison Chart				X						X					
* School Based Community Access Point Tips				X						X					
* Suicide Prevention Questionnaire				X						X	X			X	
* 2023 Consumer Perception Survey Announcement Flyer	X	X	X	X	X			X	X	X	X	X		X	X
* Various Public Information Office Messaging															
* American Disabilities Act (ADA) Complaint Form					X					X					
* ADA Notice to Employees and Applicants - Spanish translation review					X					X					
* ADA Notices for Posting at Facilities - Spanish translation review					X					X					

* Where Do I Call for Help during a Crisis? poster		X		X	X			X		X	X			X	

Note: * Translation or translation reviews for accuracy and cultural meaning completed by LACDMH Speakers Bureau.

Data Sources: Quality Assurance Division and ARISE Division - Cultural Competency Unit.

B. Translation Requests Fulfilled by the LACDMH SB

The SB serves as the departmental specialized public communication, clinical and community intervention resource. It is comprised of approximately 70 licensed clinicians serving as Subject Matter Experts (SME) who provide high level mental health presentations and practical resources to the community at large and internal DMH programs. All SB members are media-experienced and represent the Department in public speaking engagements on television, radio, print, and social media. Given the linguistic expertise of the SB in LA County threshold and three non-threshold languages, they have assisted various DMH programs in the field testing of vendor-translated documents to ensure their accuracy and cultural meaningfulness. The tables below summarize the SB activities pertinent to language translation services.

ANALYSIS OF SB TRANSLATION REQUESTS FULFILLED BY LANGUAGE, CY 2024

Language of Translation	Count
1. Arabic	7
2. Armenian	11
3. Cambodian	1
4. Chinese	21
5. Farsi	12
6. Hindi*	3
7. Japanese*	4
8. Khmer	6
9. Korean	64
10. Mandarin/Traditional Chinese	3
11. Russian	8
12. Spanish	93
13. Tagalog	8
14. Thai*	3
15. Vietnamese	9
Total Number of Requests	**253**

Source: ARISE Division – Cultural Competency Unit

**Specifies non-threshold languages*

ANALYSIS OF SB TRANSLATION REQUESTS FULFILLED BY DMH REQUESTOR TYPE, CY 2024

Requestor/Administrative Program	Requestor Type*
ARISE Division	2
Office of Administrative Operations – Special Programs	2
Quality Improvement Unit	1
LACDMH Service Area 3	1
SA 3 Outpatient Services Program	1
MHSA Administration and Oversight	77
SA3 Peer Resource Center	1
Public Information Office	2
ADA Unit	1
Public Information Office/Strategic Communications Division	1
Quality Assurance	2
CARE Court/Re-Entry	1
Patients' Rights Office	2
Service Area 7 Administration	6
Service Area 1 Administration	1
Assisted Outpatient Treatment Program	1
LACDMH Center Business Office	1
PEI Administration	1
Genesis Program	1
DMH-PIO	14
LACDMH-SA3 Peer Resource Center	1
LACDMH ADA Unit	7
LACDMH Prevention Bureau Family and Community Partnerships	2
Total number of requestors	**23**

Source: ARISE Division – Cultural Competency Unit

**SB may have received multiple requests from the DMH programs specified above*

C. Communication Access Realtime Translation (CART) services for LACDMH Stakeholder Groups

During FY 23-24, the ARISE Division-LAS Unit processed CART services for 38 different stakeholder meetings and events. Often, these meetings and events were held monthly and required more than one type of language or communication accommodation besides CART. The table below summarizes the types of meetings and events facilitated with CART services.

TRANSLATION AND CART LANGUAGE ASSISTANCE FOR STAKEHOLDER AND COMMUNITY MEETINGS AND EVENTS, FY 23-24

Name of Meeting/Event	Type of Language Assistance Provided	Frequency
1. ARDI Executive Leadership Administrative Meeting	CART	Varies
2. CAF Orientation	CART	Varies
3. CalBHBC Training for UsCC	CART	Varies
4. CCC UsCC Leadership Meeting	CART	Monthly
5. Co-Chair Meeting	CART	Varies
6. Co-Chair Orientation	CART	Varies
7. Countywide Activities Fund	CART	Varies
8. Cultural Competency Committee Meeting	CART	Monthly
9. May's Mental Health Month Community Grants	CART	Varies
10. Meeting with Patients' Rights Office	CART	Varies
11. Mental Health Commission - Executive Committee Meeting	CART	Monthly
12. Mental Health Commission - Full Commission Meeting	CART	Monthly
13. Mental Health Peer Advisory Council Meeting	CART	Monthly
14. MHSA CPT Stakeholder Meeting	CART	Monthly
15. CCC UsCC Leadership Meeting	CART	Monthly
16. Patients' Rights Grievance	CART	Varies
17. SALT 1 Meeting	CART	Monthly
18. SALT 2 Meeting	CART	Monthly
19. SALT 3 Meeting	CART	Monthly
20. SALT 4 Meeting	CART	Monthly
21. SALT 7 Meeting	CART	Monthly
22. SALT 8 Meeting	CART	Monthly
23. SALT 8 Mental Health Awareness Month Celebration Event	CART	Varies
24. SALT 8 Peer Celebration and Community Wellness Event	CART	Varies
25. UsCC - API Meeting	CART	Monthly
26. UsCC - Access for All Meeting	CART	Monthly
27. UsCC - Access for All Retreat	CART	Varies
28. UsCC - American Indian/Alaska Native (AI/AN)	CART	Monthly
29. UsCC - Black and African Heritage (BAH) Monthly Meeting	CART	Monthly
30. UsCC - EE/ME Subcommittee	CART	Monthly
31. UsCC - Latino Meeting	CART	Monthly
32. UsCC - Latino Retreat	CART	Monthly
33. UsCC - LGBTQIA2-S Meeting	CART	Monthly
34. UsCC - LGBTQIA2-S Retreat	CART	Varies
35. UsCC - LGBTQIA2-S Subcommittee Ad Hoc Meeting	CART	Varies
36. UsCC Vendor Recruitment Session	CART	Varies
37. WOMBAT MHS Meeting	CART	Varies
38. Women's Empower Event	CART	Varies

Data source: ARISE Division - Language Assistance Services Unit

D. Trending data on translation and CART information

Overall, the number of requests for translation and CART services provided by the ARISE Division has increased consistently over the last two years. The majority of requests received are for CART.

LANGUAGE TRANSLATION AND CART REQUESTS TRENDING QUARTERLY DATA, CY 2023 AND CY 2024

Service Type	January-December 2023	January-December 2024
CART Services	154	188
Translation Services	38	18
Total	192	206

Note: The ARISE Division started managing the CART services systemwide in FY 23-24.
Data Source: LACDMH ARISE Division – LAS Unit

Objective 2: Increase response rate for assessing client satisfaction with American Sign Language (ASL) interpreter services by using new ASL Specialist to reach out to members who received services, identify areas for improvement, and review findings with providers.

During CY 2024, the ARISE Division continued requesting and tracking feedback from ASL service recipients, Deaf and Hard of Hearing consumers and family members as well as clinic-based coordinators. As an area of improvement for CY 2024, the ARISE Division revised the tool to allow for the separation of consumer and service coordinator feedback to increase the number of ASL Services Satisfaction Surveys (SSS) from consumers. Additionally, the ASL SSS was also modified to capture feedback pertinent to the services provided by the ARISE Division's Sign Language Specialist (SLS). On-boarded as a DMH employee in March 2024, the SLS immediately increased the ARISE Division's response to emergency and non-emergency ASL services clinical encounters and ASL services for stakeholder meetings. Although the original intention of the ARISE Division was for the newly hired SLS to be involved in securing more ASL user consumer feedback, there were several issues that hindered that process. Specifically,

1. The need to prioritize the SLS's availability and work hours to fulfill requests to provide ASL services for clinical sessions such as psychotherapy or medication support. Given the shortage

of ASL interpreters in LA County and the nation, requests for the SLS facilitation of ASL services took precedent over gathering of feedback from Deaf and Hard of Hearing consumers and family members.

2. The impracticality of the SLS asking ASL users to recall and evaluate the quality of past ASL facilitation sessions they attended during CY 2024, especially in instances involving various hired vendors and interpreters.
3. Potential conflict of interest if the SLS requested feedback on her own performance from the consumers and family members she served. Doing so may have resulted in placing consumers in an uncomfortable position or potentially gathering incomplete feedback.
4. Internal shortage of staff to research the contact information of the clinic-based service coordinator, reaching out to all service coordinators and to set up individual appointments with the SLS and ASL services users.
5. Realization that with sustained reminders to clinic-based service coordinators, to request feedback from ASL users, their direct feedback could be obtained without taking the SLS time away from clinical ASL service delivery.

Nonetheless, the ARISE Division saw an increase in the number of surveys completed by ASL services users in comparison to CY 2023. The feedback gathered included performance evaluations for ASL services rendered by hired vendors and DMH's SLS.

ASL Service Satisfaction Survey (SSS) Results, CY 2024

During this reporting period, a total of 249 ASL SSS survey responses were received from consumers and staff coordinating ASL-facilitated clinical appointments. The analysis of responses gathered revealed the following outcomes:

A. Breakdown of responses by type of respondent (247 responses received):

- Service Providers: 215 (87%)
- Clients/Consumer: 32 (13%)

B. Breakdown of responses by ASL expert (vendor hired or internal SLS) providing the requested services (215 responses received):

- Internal Sign Language Specialist: 46 (21%)
- Language Line Solutions: 20 (9%)

- Lazar: 10 (5%)
- Unknown: 139 (65%)

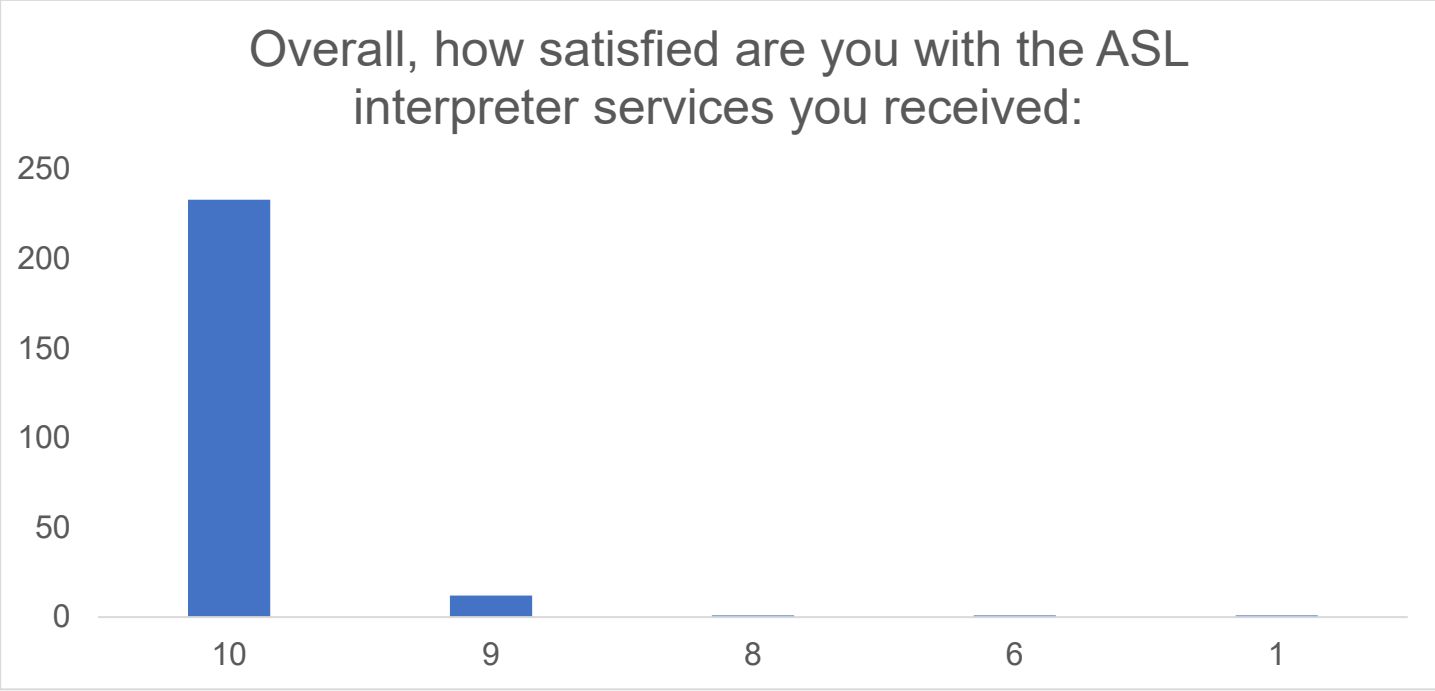
C. Appointment modality (215 responses received):

- 74 appointments were scheduled for In-Person ASL services (34%)
- 141 appointments were held via various virtual platforms (66%)

D. Virtual Session Platform (141 responses received):

- Teams: 73 (52%)
- Zoom: 47 (33%)
- VSEE: 17 (12%)
- IBHIS Telehealth: 4 (3%)

Survey Item: “Overall, how satisfied are you with the ASL interpreter services you received” (0= not at all satisfied, 10= completely satisfied)?

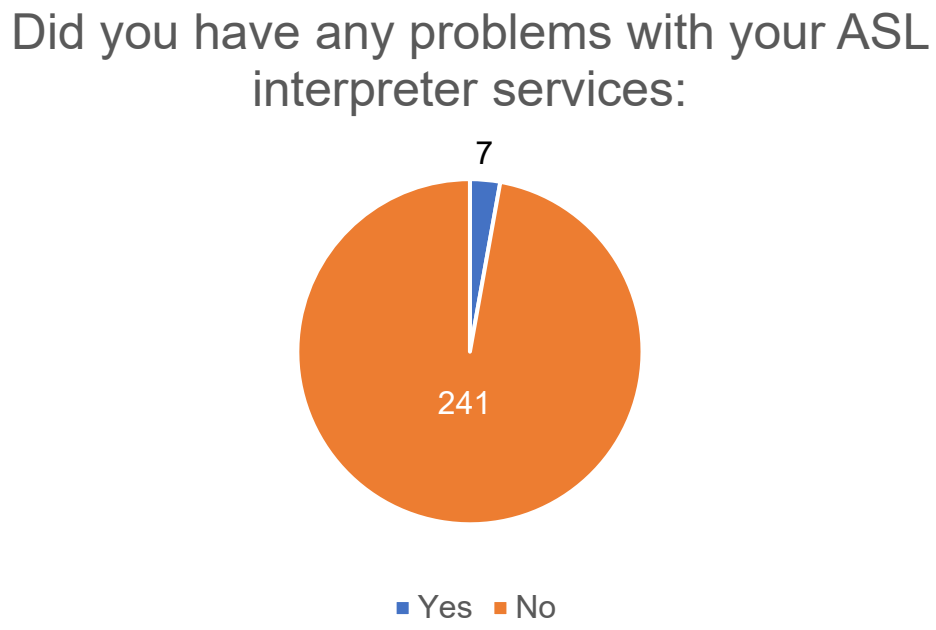


The figure above demonstrates that out of 244 respondents who answered this item, 233 or 95% reported being “completely satisfied with the ASL services received”. The next lowest score was nine. The average score was 9.85 out of a maximum score of 10.

Survey Item: “How likely are you to recommend ASL videoconferencing interpreting to others” (1= not at all, 3= maybe, and 5= definitely)?

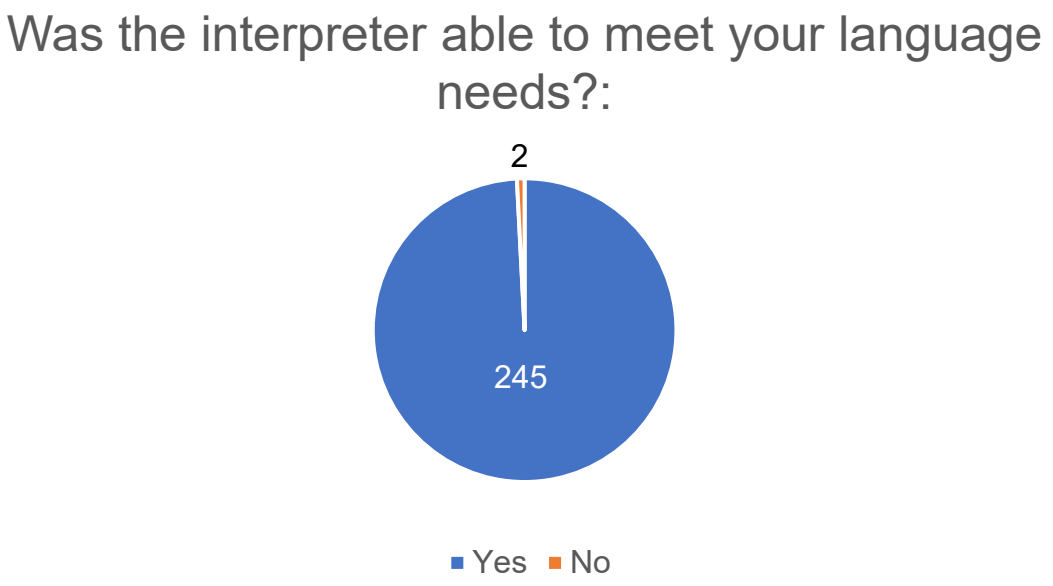
The figure above demonstrates that the majority of respondents who answered this survey question (N=135) endorsed a high likelihood of recommending ASL videoconferencing services, based on the average of 4.94 out of a maximum score of five.

Survey item: “Did you have any problems with your ASL interpreter services?”



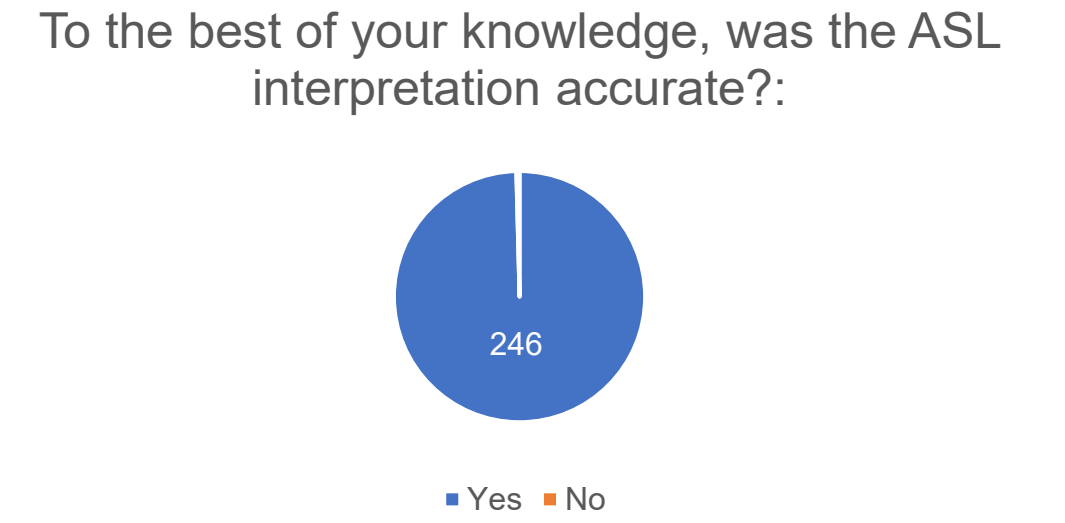
The figure above summarizes the results regarding perceptions about issues experienced during ASL-facilitated clinical appointments. Out of 249 respondents, 241 (97%) reported having no problems with the services received and 7 (3%) identified issues during the provision of ASL services. A careful review of the Open Remarks section of the survey revealed one comment pertinent to issues during ASL services. The statement specified the following: “Vendor interpreter may benefit from additional training. Seemed very not confident.” The ARISE Division disclosed this feedback to the vendor for quality improvement follow-up with the interpreter who provided this service.

Survey item: “Was the interpreter able to meet your language needs?”



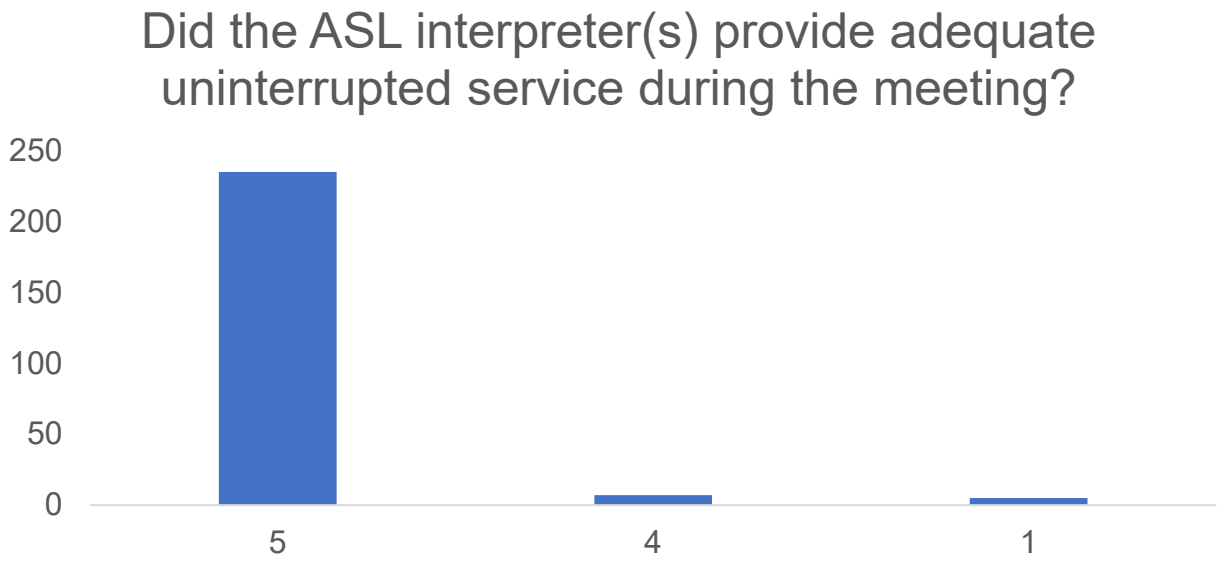
The figure above displays the ratings received to the ASL SSS survey item “Was the interpreter able to meet your language needs?” A total of 245 respondents or (99%) reported that their ASL language needs were fulfilled by the interpreter services received, while 2 or 1% respondents answered that their language needs had not been fulfilled. The Open Remarks section of the survey revealed one potential comment to inform the “no” response. The verbatim comment stated: “Vendor interpreter may benefit from additional training. Seemed very not confident.”

Survey item: “To the best of your knowledge, was the ASL interpretation accurate?



The figure above summarizes responses to the item “To the best of your knowledge, was the ASL interpretation accurate?” The most frequent answer to this question was “*yes*”. A total of 246 respondents or 100% answered positively in comparison to 1 or 0% respondent answering negatively. Mathematically, 0% indicates that the percentage was too small of a fraction to be accounted for.

Survey item: Did the ASL interpreter(s) provide adequate uninterrupted service during the meeting (1 = not at all, 3 = some, and 5 = nearly all meeting)?



The figure above displays the range of responses regarding the ASL interpreters' ability to provide services without any interruptions. Most respondents who answered this survey item (N=235) reported no interruptions while 7 or .03% reported some interruptions, and 5 or .02% of users experienced inadequate uninterrupted services. 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. Average score was 4.87.

Open-ended comments (verbatim)*

It was a good session with the patient and her brother. Vendor interpreter was very good
Interpreters are great! They are patient and work well together with client and myself.
Interpreter was great, very helpful, and friendly.
Client satisfied with interpreter services.
Client was a no show for appointment on 11/5/24 1:30mp to 2pm. Interpreter was on time and available, however, I did not use the interpretation services as client was not present during appointment, and we were unable to reach client.
Easy, straightforward, clear, and professional; also guidance and demeanor appropriate and approachable to patient as well as provider. Thank you sincerely.
Great working with interpreter!
I look forward to continuing working with interpreter.

Interpreter was present for appointment, but client was a no-show.
Interpreter is wonderful, I am grateful for her work, time, kindness, and support to my client.
Interpreter was great!
Vendor interpreter may benefit from additional training. Seemed very not confident. Please have this feedback remain anonymous. Thank you.
SLS professional, nice, and overall a great help for our session.
My interpreters were on time, very professional and my client appeared very happy and comfortable with services provided by both interpreters.
Interpreter provided the best interpretation services, we will request her again.
Interpreter is AMAZING! Thankyou!
INTERPRETER IS AWESOME, THANK YOU!
Interpreter is Great!
Interpreter is great!
Interpreter is great!
Interpreter is Great! Thank you for your support.
Interpreter is GREAT! THANK YOU!
Interpreter was great and helpful.
No Comments
None
None of the above questions are valid because they never showed up.
Consumer missed scheduled appointment. Interpreter was here on time.
Perfect!
Professional and welcoming. I highly appreciate her services
Interpreter was very helpful.
Interpreter has been amazing with my client. I will continue to request him
Interpreter provided excellent service.
Interpreter was great, would like to work with him again.
Interpreter is a great ASL interpreter!
SLS did a great job, connected with patient and the provider throughout the service.
SLS is very approachable, skillful, and maintains the therapy setting well. My client has requested to continue to have Sharon Little provide ASL interpretation based on positive services received.
SLS was most helpful.
Interpreter is perfect :)

Interpreter was great
Sign language communication, very good
Thank you for the service.
Thank you for your assistance with ASL for this session.
Thank you!
The client provided positive feedback to me in session as well!
Interpreters are both awesome, AMAZING!
Unable to answer questions 16 and 17 due to client did not show after 15 minutes (grace period) of waiting.
Very professional and provides great service each time Interpreter comes in
Interpreter was very good

*Specification as to whether the interpreter was a hired vendor or the SLS could only be made when the feedback identified interpreter names. Responses such as “She was” could not be properly sorted and therefore are reported as “interpreter”.

Standardized Scheduling

Goal Ic.	Implement standardized scheduling for all clinics to increase access to care and ability to monitor quality of care, yielding more efficient service delivery.
Objective(s)	1. Standardize scheduling prioritizing psychiatric appointments and moving towards standardization of all disciplines to optimize accessibility of services and staff performing at highest level. 2. Front desk staff will have standardized appointments on set days for intakes, groups, and follow-up appointments which will reduce inconsistent scheduling practices. Meetings, times for consultation, and Officer of the Day will be blocked on schedules. 3. Create training and communication plan for staff on the new process and start dates.
Population	DO staff and clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Number of Clinics and Psychiatrists set up for Standardized Scheduling 2. Meeting standard for first psychiatry appointments offered and urgent appointments
Frequency of Collection	Annually
Responsible Entity	Outpatient Care Services

This goal was not met.

Objective #1: Standardize scheduling, prioritizing psychiatric appointments and moving towards standardization of all disciplines to optimize accessibility of services and staff performing at highest level.

Standardized scheduling was not able to be implemented in CY 2024. However, despite this routine psychiatry timeliness improved from 54% in January to 69% in December 2024 for a 15% increase. The highest timeliness rate for psychiatry was in November 2024 at 73%. Standardized scheduling will continue to be explored as a possible intervention to increase DMH's access to psychiatry to the standard of 80%.

Rate of Timely Psychiatry Appointments for Directly Operated Clinics, CY 2024

Metric	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec
System wide routine non-psychiatry timeliness	82%	81%	83%	80%	79%	83%	83%	84%	83%	81%	82%	82%
Psychiatry Timeliness (DO Only Jan-Nov; LE Data Collection implemented December 2024)	54%	57%	57%	61%	65%	63%	63%	63%	62%	64%	73%	69%

Data source: LACDMH Access to Care data, retrieved December 2025.

Objective #2: Front desk staff will have standardized appointments on set days for intakes, groups, and follow-up appointments which will reduce inconsistent scheduling practices. Meetings, times for consultation, and Officer of the Day will be blocked on schedules and Objective #3: Create training and communication plan for staff on the new process and start dates.

This goal was not completed due to challenges with infostructure establishment and will continue into CY 2025.

Peer Services

Goal Id.	Increase the visibility of Peer Services by enhancing the skills of Peer Workers and creating a meaningful career path.
Objective(s)	1. Provide financial assistance for Peer Support Specialist certification. 2. Create a logic model for implementation of a Peer Support Specialist item for those who are certified. 3. Negotiate bonuses in the interim while Peer Specialist item is being created to differentiate skills from Community Health Workers. 4. Create a career ladder for peers. 5. Develop an internship program for those with lived experience as a pathway into employment as Peer Specialists. 6. Engage in a barrier analysis of why information on peer opportunities is not more well-known and use this information to create a system to increase information flow to ensure peers know of promotional opportunities, requirements, and how to apply. 7. Educate DMH Workforce on duties and value of Peer Support services.
Population	Peer Workforce, DO clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Increase Medi-Cal certified Peer Support Specialists from 7-10% currently to 30% this year 2. Creating training materials for new clinicians on the role of peer services and ways peers can help advance service delivery goals
Frequency of Collection	Annually
Responsible Entity	Office of Peer Services (OPS)

This goal was met.

Objective 1: Provide financial assistance for Peer Support Specialist certification.

In August 2023, LACDMH had 19 DO certified Peer Support Specialists on staff. In CY 2024, OPS provided 92 California Mental Health Services Authority (CalMHSA) scholarships to LACDMH employees interested in Peer Support Specialist training, exam, and recertification. Currently, there

are 58 DO certified Peer Support Specialists, 11 staff in the exam preparation stage, and 13 staff currently in training (15 are in the CalMHSA application process).

Objective 2: Create a logic model for implementation of a Peer Support Specialist item for those who are certified.

In CY 2024, the logic model was completed as well as a justification. These items were sent to the executive team and Human Resources (HR). OPS is awaiting approval.

Objective 3: Negotiate bonuses in the interim while Peer Specialist item is being created to differentiate skills from Community Health Workers.

For CY 2024, a bonus was negotiated and approved at the Department level for $225 monthly. OPS is awaiting County approval. Once approved, bonuses will be retroactive to July 1, 2024.

Objective 4: Create a career ladder for peers.

In CY 2024, a draft of a career ladder was created but has not yet been approved. Additionally, OPS was able to secure the unused item of Community Services Coordinator as a promotional role after the Supervising Community Health Worker (CHW). These two positions will be rolled out in FY 2025-26.

Objective 5: Develop an internship program for those with lived experience as a pathway into employment as Peer Specialists.

In CY 2024, OPS took over the Wellness Outreach Workers (WOW) Volunteer program and will be using a portion of the program to create a pathway to employment internship program. Additionally, OPS is piloting an internship program with the TAY division.

Objective 6: Engage in a barrier analysis of why information on peer opportunities is not more well-known and use this information to create a system to increase information flow to ensure peers know of promotional opportunities, requirements, and how to apply.

As a result of the CY 2024 barrier analysis, OPS created a Peer Network group that informs Peers of updates, changes, and general department information. Additionally, HR now e-blasts opportunities to all employees.

Objective 7: Educate LACDMH Workforce on duties and value of Peer Support services.

In CY 2024, Peer Services 101 training was developed and will be a departmentwide requirement for teams with Peers.

Monitoring Accessibility of Services, Calendar Year 2024

Timely Access to Services

Goal IIa.	Improve timely access to care.
Objective(s)	1. Continue regular monitoring of access to care for both directly operated (DO) and legal entity (LE) providers to ensure standards are being met. 2. Reduce outliers for routine appointments. 3. Improve access to care for hospital and urgent appointments through centralized scheduling.
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. Maintain 80% benchmark for routine appointments 2. Reduce range of days to appointment for routine appointments. 3. Expansion of centralized scheduling for hospital discharge planners and PMRT for urgent appointments.
Frequency of Collection	Quarterly
Responsible Entity	Quality Assurance (QA) Unit

This goal was met.

Objective 1: Continue regular monitoring of access to care for both DO and LE providers to ensure standards are being met.

LACDMH maintained/improved timely access over calendar year 2024. It went from 79% timely in April 2024 up to 82% timely in December 2024.

Overall Percentage of Timely Appointments, April 2024 to December 2024

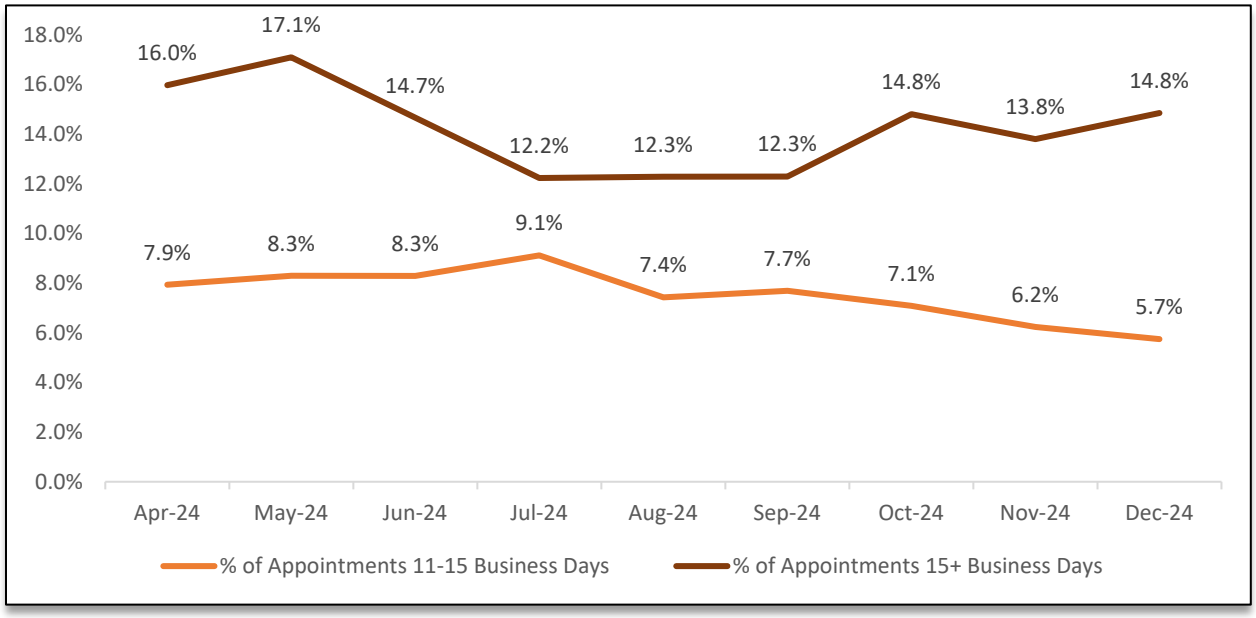
2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12
79%	77%	81%	82%	84%	83%	81%	82%	82%

Data source: AccessToCare PowerBI Dashboard, September 2025.

Objective 2: Reduce outliers for routine appointments.

DMH reduced the range of days to appointment for routine appointments. Rates of outlier appointments (appointments provided between 11-15 business days from request or 15+ business days from date of request) dropped, as the rate of timely appointments increased.

Percent of Routine Appointments Greater than 10 Business Days, April 2024 to December 2024



Data source: AccessToCare PowerBI Dashboard, September 2025.

Objective 3: Improve access to care for hospital and urgent appointments through centralized scheduling.

On October 30, 2024, LACDMH expanded centralized scheduling for SA 3 hospital discharge planners to be available 24/7. On November 13, 2024, centralized scheduling was further expanded to include our SA 3 Law Enforcement Team (LET), Mental Evaluation Team (MET), and Risk Assessment &

Management Team (RAMP). Lastly, on December 23, 25, LACDMH expanded centralized scheduling to include our SA 3 contracted field response team, Mobile Crisis Outreach Team (MCOT).

Goal IIb.	Develop protocols for access to care monitoring.
Objective(s)	1. Establish data collection and monitoring processes for psychiatry for LE providers. 2. Establish data collection and monitoring processes for treatment services following assessment. 3. Review and revise existing processes for data collection and monitoring for psychiatry for DO providers. 4. Establish data collection and monitoring processes for providers who are not accepting new clients.
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. Having revised quarterly monitoring reports to gather data for psychiatry and treatment services. 2. Establishing workflows for data submission from LEs (psychiatry and treatment services). 3. Written protocols for monitoring process of providers not accepting new clients.
Frequency of Collection	Quarterly
Responsible Entity	QA Unit

This goal was partially met.

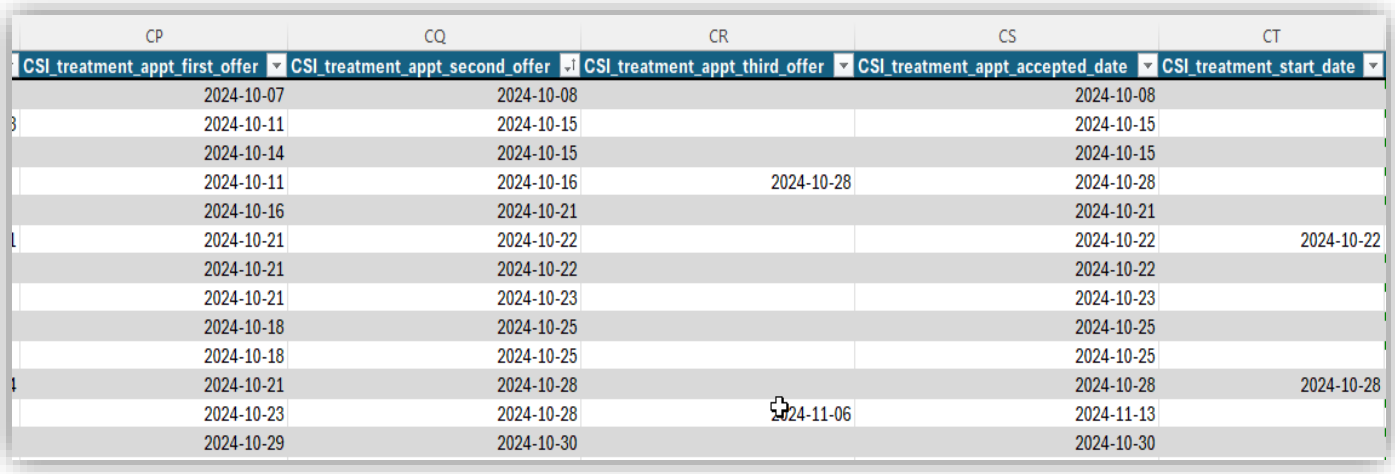
Objective 1: Establish data collection and monitoring processes for psychiatry for LE providers, and Objective 2: Establish data collection and monitoring processes for treatment services following assessment.

New reports were developed to incorporate new data field sources for psychiatry data. Data is currently collected and monitored for DO providers, and new data will incorporate data from LE providers as soon as data is submitted. For first treatment offered, the data is available within the detail reports;

however, it is still in the process of being summarized in the detail reports. A sample of detailed data reports is below:

Timely Access-Systemwide Quarterly Detail Report-First Offered Treatment Service

Data source: LACDMH Quarterly Report



CP	CQ	CR	CS	CT
CSI_treatment_appt_first_offer	CSI_treatment_appt_second_offer	CSI_treatment_appt_third_offer	CSI_treatment_appt_accepted_date	CSI_treatment_start_date
2024-10-07	2024-10-08		2024-10-08	
2024-10-11	2024-10-15		2024-10-15	
2024-10-14	2024-10-15		2024-10-15	
2024-10-11	2024-10-16	2024-10-28	2024-10-28	
2024-10-16	2024-10-21		2024-10-21	
2024-10-21	2024-10-22		2024-10-22	2024-10-22
2024-10-21	2024-10-22		2024-10-22	
2024-10-21	2024-10-23		2024-10-23	
2024-10-18	2024-10-25		2024-10-25	
2024-10-18	2024-10-25		2024-10-25	
2024-10-21	2024-10-28		2024-10-28	2024-10-28
2024-10-23	2024-10-28	2024-11-06	2024-11-13	
2024-10-29	2024-10-30		2024-10-30	

In December 2024, LACDMH implemented a new web service to collect psychiatry data from LE providers. QA announced the web service in the November 5, 2024, Network Adequacy & Access to Care Webinar and provided ongoing support to LE providers in the February and March 2025 webinars. LACDMH issued a QA Bulletin in early 2025 reinforcing this information: [1182721_QABulletin25-02TrackingTimelyAccesstoPsychiatryAppointments_1_.pdf]

Objective #3: Review and revise existing processes for data collection and monitoring for psychiatry for DO providers.

Data is currently collected and monitored for DO providers. Data is gathered quarterly and sent out to DO providers as part of the regular monitoring process. CAPs are requested if needed.

Objective #4: Establish data collection and monitoring processes for providers who are not accepting new clients.

A formalized tracking and monitoring protocol was implemented between Contract Management and Monitoring Division (CMMD) and QA – Network Adequacy. Elements include:

- Service Location Number

- Service Location Name
- Organization Number
- Service Area (SA)
- Accepting Status
- All Programs Count
- General Outpatient Care Services (GOCS)-PEI Programs Count
- Accepting Yes-Count
- Accepting No-Count
- GOCS-PEI Programs List – Accepting No
- All GOCS-PEI Programs List
- All Programs List
- Additional Notes (QA Use Only)
- SA Chief Agrees? Yes/No
- Date Approved for Not Accepting
- Proposed Date to Accept Again
- Actual Re-opening Date
- Reason for Closure
- Date of Entry
- Name of Staff Entering Data
- Notes (CMMD Use Only)

Monitoring Beneficiary Satisfaction, Calendar Year 2024

Client/Family Satisfaction

Goal IIIa.	Evaluate Consumer Perception Survey (CPS) 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. Continue to 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. Pilot surveys being accessible in My Health 2.0. 6. Work with Peer Services Division on how to optimize client participation.
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 demographic data collected vs Declined to Answer including SOGI and Race 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.

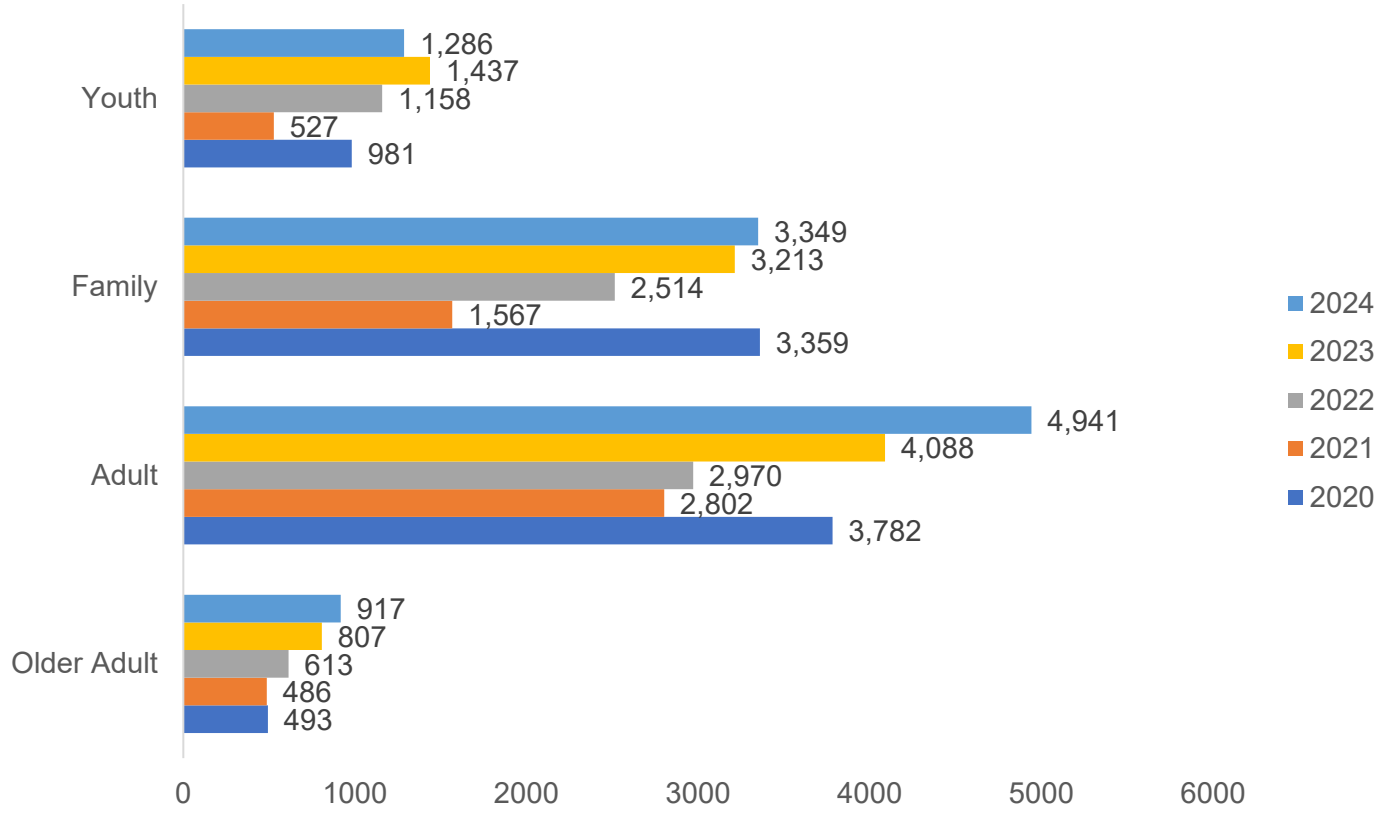
Objective 1: Review the data on different manners in which CPS surveys were collected.

The Consumer Perception Survey (CPS) is an annual satisfaction survey of clients and caregivers who receive outpatient services from LACDMH providers. There are four types of the survey based on age group: Family (client aged 0-17), Youth (ages 13-17), Adult (ages 18-59), and Older Adult (ages 60 and older). Clients and caregivers provide demographic information, ratings of satisfaction, and other relevant information on their experience with services in the open-ended comment box. LACDMH

offers surveys in paper and two different electronic formats. In 2024, LACDMH also launched a pilot of the CPS in a patient portal system, MyHealthPointe. The patient portal is specific to Directly Operated (DO) providers. One DO provider, Rio Hondo Community Mental Health Center, participated in the pilot.

The figure below shows a 9.9% increase in the number of CPS surveys returned from 9,545 in 2023 to 10,493 in 2024.

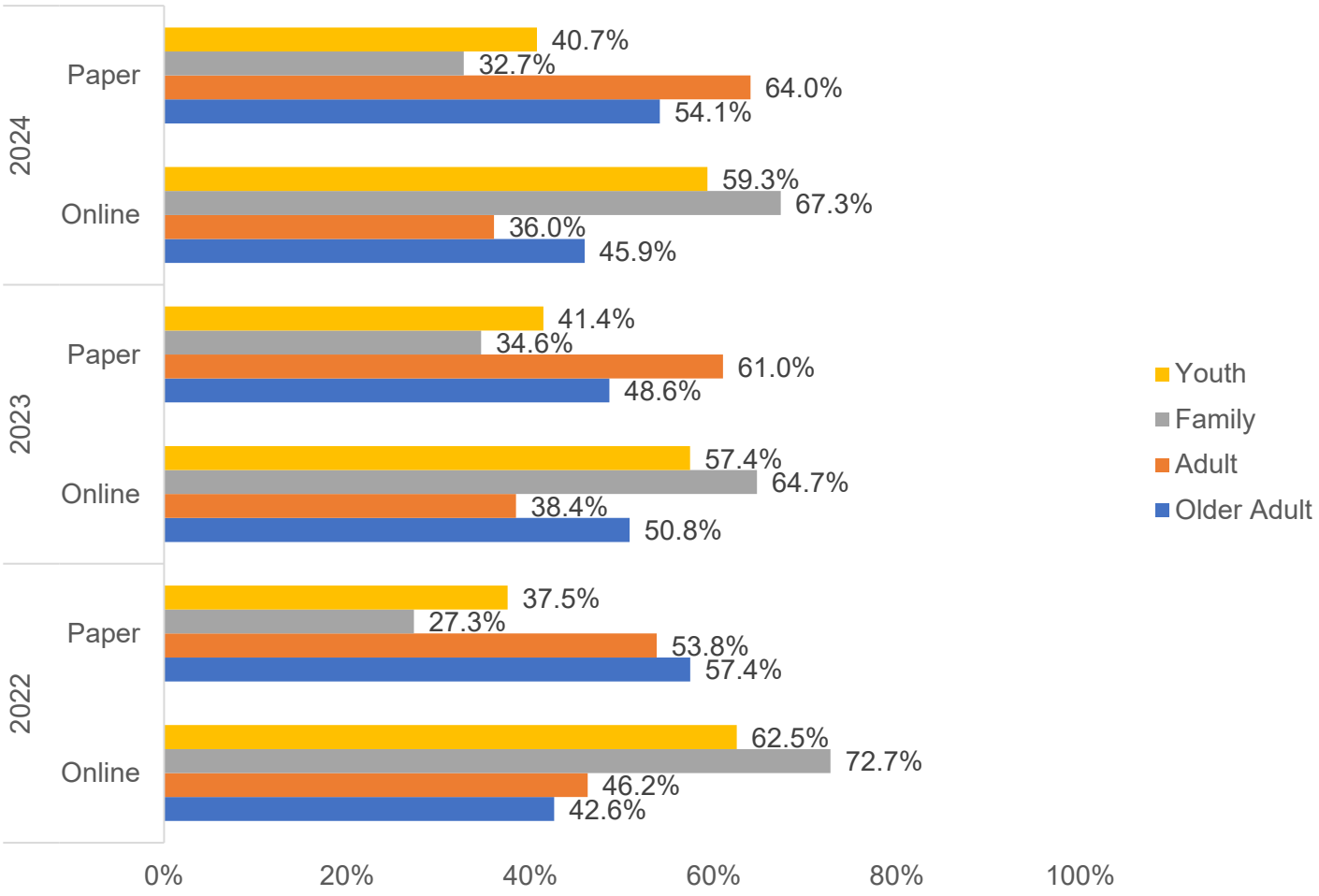
Countywide Total CPS Surveys Five-Year Trends by Survey Type



Note: Surveys are consider "completed" when the data was useable and at least two questions were answered. Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

The figure below shows the preferences in completing the paper or online/electronic version of the surveys by age group over the last three years. Youth and Family survey groups tend to prefer the online/electronic version of the surveys, while Adult and Older Adult consistently prefer paper.

Countywide CPS Completed Surveys by Format, 2022-2024

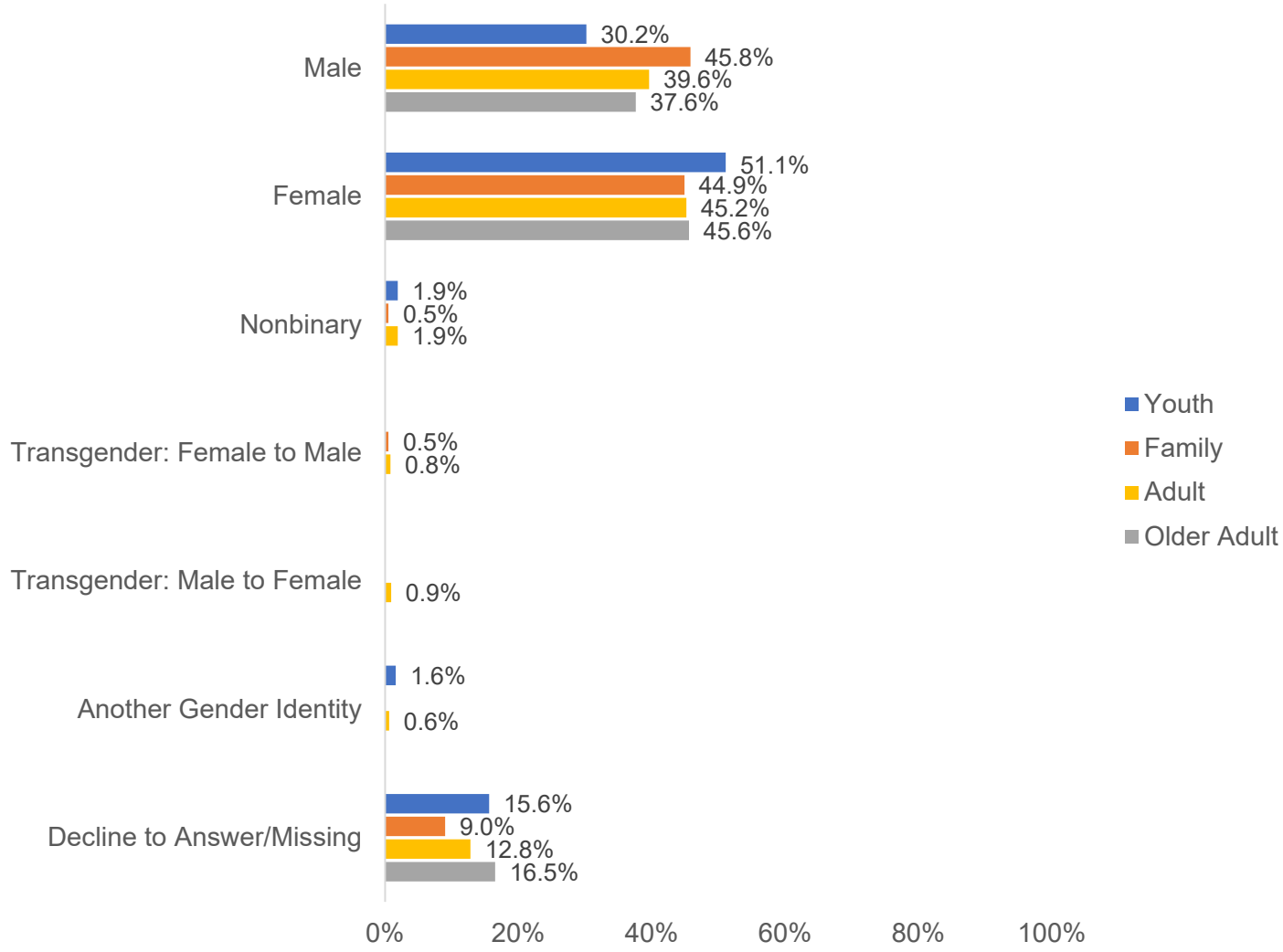


Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

Objective 2: Increase data collection of Sexual Orientation and Gender Identity (SOGI) related demographics to assess the quality and delivery of affirming care. Race was added to the SOGI performance indicator and is reported concurrently for this objective.

Prior to 2023, SOGI questions were only available on the LACDMH electronic survey. For the 2024 CPS period, SOGI questions were expanded to all versions of the CPS survey, which increased the number of clients surveyed for SOGI information. The figure below shows the distribution of gender identities among the individuals who chose to answer the SOGI questions.

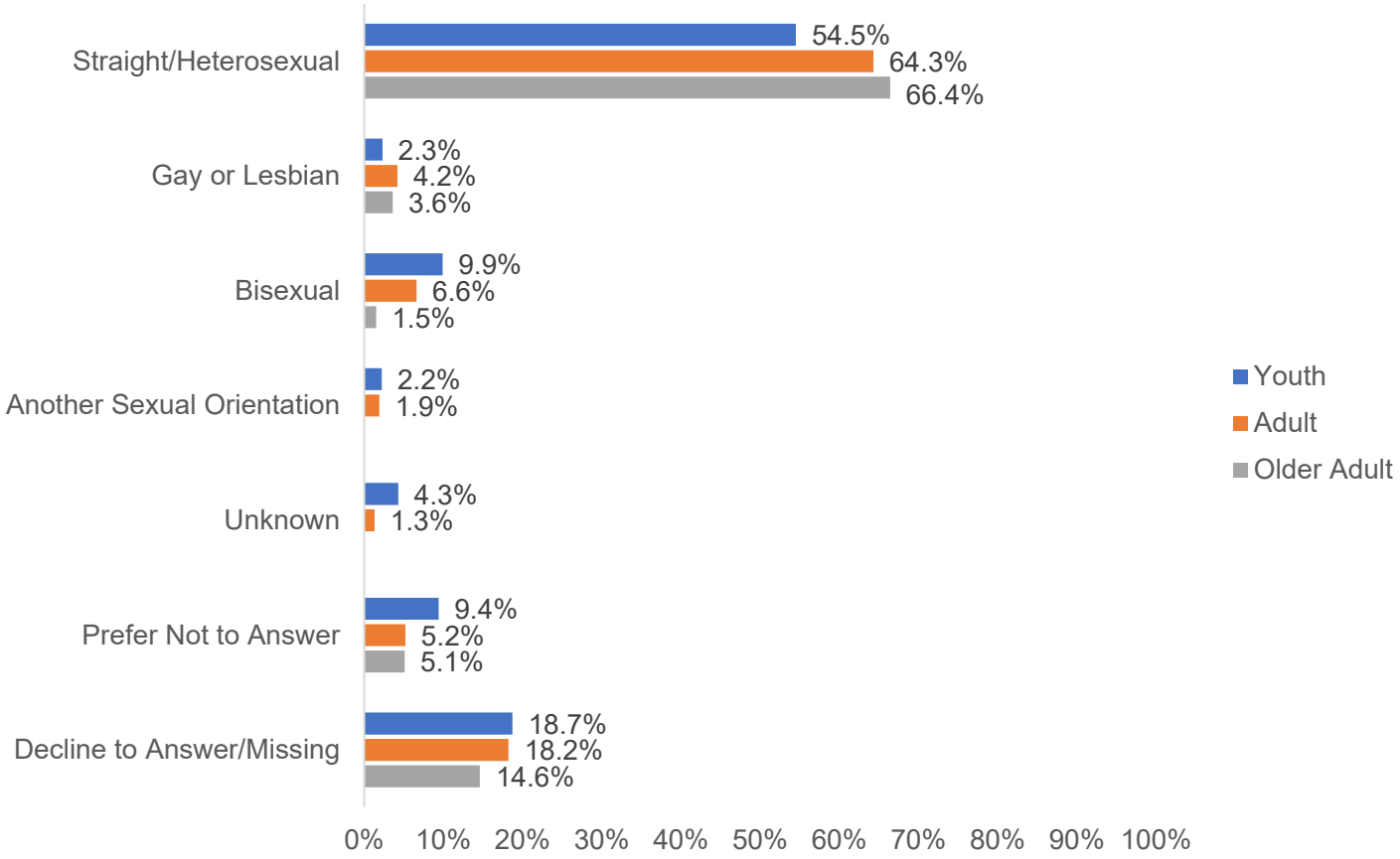
Countywide CPS Survey Gender Identity Distribution, May 2024



Note: Survey respondents were able to indicate more than one gender identity. Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

The figure below shows the distribution of sexual orientation identity for Youth, Adult, and Older Adult survey respondents.

Countywide CPS Survey Sexual Orientation Distribution, May 2024



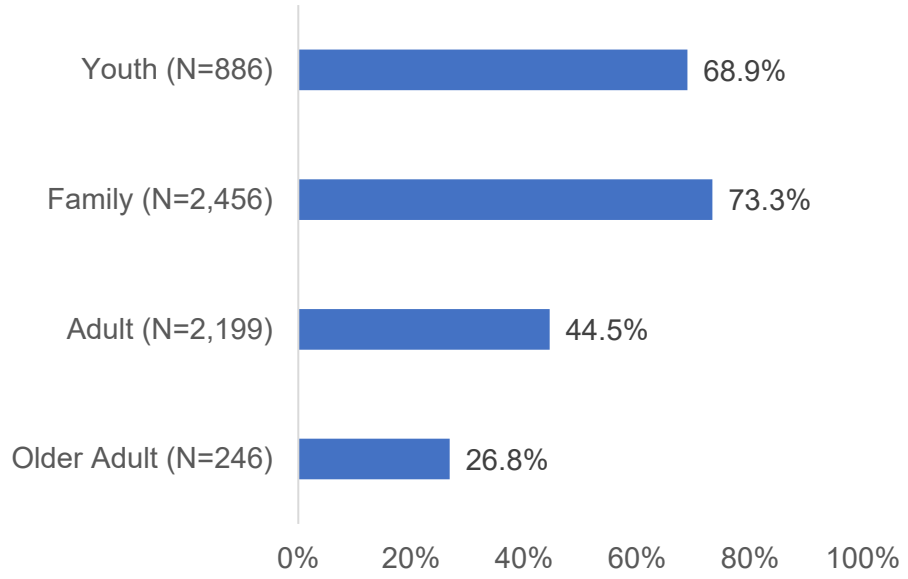
Note: Sexual orientation was not reported for Family surveys. Youth, Adult, and Older Adult survey respondents were able to indicate more than one sexual orientation. Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

It is important to note that in both Figures # and #, there is a 9.0% to 18.7% rate of Decline to Answer/Missing responses. Family surveys had the lowest rate at 9.0% on gender identity reporting while Older Adult surveys had the highest rate at 16.5%. Older Adult surveys had the lowest rate of Decline to Answer/Missing responses for sexual orientation identification at 14.6% and Youth had the highest at 18.7%.

Historically, the State and federally mandated CPS form has collected demographic data on Mexican/Hispanic/Latino ethnicities in a question separate from other race/ethnicities. The figure below shows the percent of survey respondents that indicated having a Mexican/Hispanic/Latino origin by age group. Family and Youth survey respondents had a greater rate of Mexican/Hispanic/Latino origin than Adult and Older Adult respondents.

In March 2024, the United States Office of Management and Budget (OMB) released the updated Statistical Policy Directive (SPD) 15. SPD 15 mandates a combined format for race/ethnicity rather than separate questions, https://www.federalregister.gov/documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and. The CPS demographic questions will likely receive an update to reflect SPD 15 in coming survey periods.

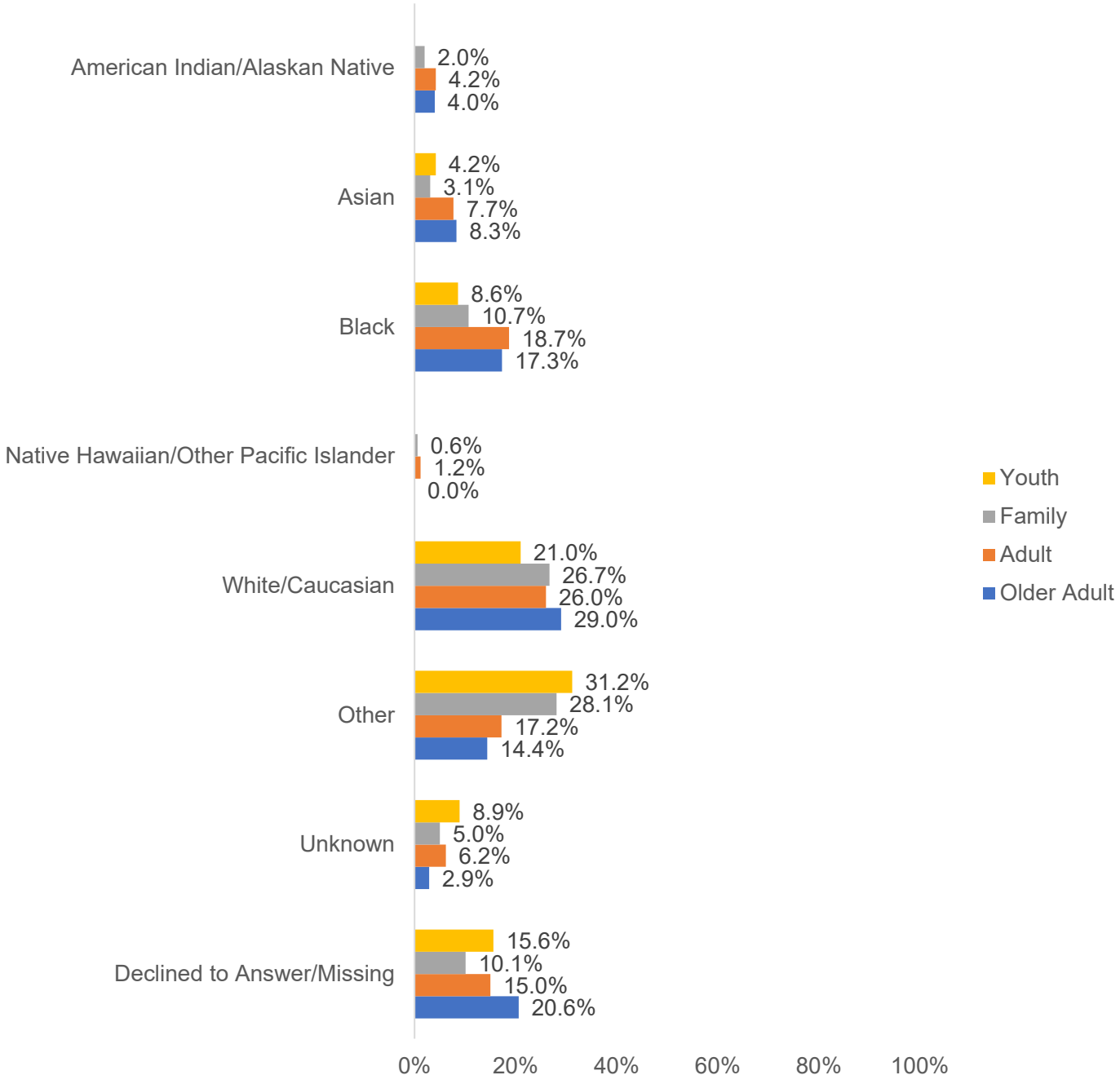
Countywide Rate of Mexican/Hispanic/Latino Origin for CPS Survey Respondents by Survey Type, May 2024



Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

The figure below shows the distribution of race/ethnicity backgrounds identified by CPS survey respondents by survey type. The Other and White community groups have the highest rates. It is important to note that there is a range of 10.1% to 20.6% of Declined to Answer/Missing responses.

Countywide CPS Survey Race/Ethnicity Distribution, May 2024



Note: Survey respondents were able to indicate the identification with more than one race/ethnicity. Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

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

The Quality Improvement (QI) Unit worked collaboratively with the Outcomes Unit in developing a PowerBI-facilitated Provider-level report for CPS data used to create the 2023 CPS reports that were distributed in November 2023. Challenges with the organization of multi-year data delayed the development of trend data. The QI Unit is currently pursuing concatenated CPS data sets to assist with the development of trend reporting.

The QI and Outcomes units continue to collaborate on refining the PowerBI generated Provider Level reports. This objective will continue into CY 2025.

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

The QI Unit explored options for accurately identifying providers who were expected to participate in the 2024 CPS from those who were not expected to participate. Staffing and data source challenges delayed the project from moving forward. It was determined that a PowerBI dashboard could be created to identify providers “missing” from the survey participation. Development of the Provider Participation report will begin in CY 2025.

Objective 5: Pilot surveys being accessible in My Health 2.0.

In CY 2024, a pilot project for the administration of the CPS survey through the MyHealthPointe client portal was implemented. A single Directly Operated (DO) clinic, Rio Hondo Community Mental Health Center, received training and support from CIOB and the QI Unit to administer the CPS survey to Adult and Older Adult clients enrolled in the MyHealthPointe portal. Rio Hondo Community Mental Health Center was able to distribute 179 surveys and received 24 completed English-language surveys and one declined survey for a response rate of 13.4%. The pilot will be continued for the 2025 CPS with an increase in the number of participating DO clinics.

Objective 6: Work with Peer Services Division on how to optimize client participation.

The Peer Services Division was invited to participate on the CPS Planning Committee for the first time during the 2024 CPS period. The QI Unit was invited by Peer Services to present information on the

CPS and receive feedback and recommendations from peers in the Peer Services Division Support meeting and Peer Resource Center (PRC) Peer Academy meeting in April 2024.

Peer staff suggested updating and increasing CPS marketing. They also suggested increasing peer familiarity with the survey to help them better inform and assist clients and caregivers with survey completion.

Client Grievances, Appeals, and Change of Provider Requests

Goal IIIb.	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. • Implement new 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 CY 2024 2. COP requests by type in CY 2024
Frequency of Collection	Annually
Responsible Entity	Patient's Rights Office (PRO)

This goal was met.

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

PRO utilizes the Patient Complaint/Grievance Portal and the Change of Provider (COP) Portal, both are web-based applications. Since April 2024, PRO has been utilizing a public facing portal to receive client grievances/complaints. This allows the PRO team to monitor the status of a grievance, as well as enter progress notes, and upload pertinent information/correspondence. The web-based application allows for categorizing of the data by type of grievance, and location (inpatient and outpatient).

Since June 2024, PRO has been utilizing the COP portal. This web-based application allows DO and LE/Contracted providers the opportunity to upload their monthly data of clients who wish to change their provider as well as indicate the identifying reason for the change. PRO analysts are then able to

export the data.

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

Most grievance reasons identified were for Staff Behavior Concerns and Other Grievance Not Listed categories. Clients were able to indicate more than one reason for their Grievance. Access to Care was the lowest category of grievances for CY 2024.

Inpatient and Outpatient Grievances for LACDMH Medi-Cal Beneficiaries by Category, CY 2024

GRIEVANCES	
INDICATOR	**COUNT**
Resolved	691
Active	80
TYPE	
Access to Care	
Other Access Issues	24
Timeliness of Services	14
Service Not Available	12
Service Not Accessible	8
Linguistic Services	1
Quality of Care	
Staff Behavior Concerns	328
Treatment Issues or Concerns	95
Medication Concerns	34
Other Quality of Care Issues	28
Cultural Appropriateness	1
Other	
Other Grievance Not Listed	100
Patient's Rights	96
Lost Property	20
Physical Environment	13
Peer Behaviors	12
Abuse Neglect or Exploitation	8
Americans with Disabilities Act (ADA)	7
Financial	7
Operational	6
Payment/Billing Issues	5
Suspect Fraud	2

Data source: LACDMH Patient Complaint/Grievance Portal, 2024.

There were 542 Appeals received in CY 2024. All appeals were from inpatient providers regarding payment denial and were resolved.

For CY 2024, 1,093 COP 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. Most requests were due to Not a Good Match, Other, and Uncomfortable. The lowest frequency reasons were Treating a Family Member, Age, and I Want Previous Provider.

Change of Provider Request Reasons, CY 2024

Reason	Count
Not a Good Match	524
Other	412
Uncomfortable	258
Does Not Understand Me	226
Treatment Concerns	217
Lack of Assistance	201
Time/Schedule Change	192
Gender (Male/Female)	153
Insensitive / Unsympathetic	149
Not Professional	141
Medication Concerns	128
Language	78
Reason Not Provided	54
I Want a Second Opinion	42
I Want Previous Provider	41
Age (Too old / Too young)	37
Treating Family Member	14

Data source: LACDMH Change of Provider Portal, 2024.

Monitoring Clinical Care, Calendar Year 2024

Clinical Reporting

Goal IVa.	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. Validate reports with a sample of providers. 4. Increase clinical utility training for supervisors and create training to expand to include line staff. 5. Implement pilot of using CANS as a Level of Care tool by working with clinicians to validate structured decision-making tool.
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. Finalized Level of Care structured decision-making tool utilizing the CANS
Frequency of Collection	Annually
Responsible Entity	Outcomes Unit, CIOB, and Outpatient Care Services

This goal was partially met.

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

In CY 2022, the LACDMH Outcomes Unit 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.

Following development of the CANS Client Level Report, the Outcomes Unit did internal testing to identify and address issues. The Outcomes Unit also granted access to a selected group of supervisors from LACDMH DO children's programs to test the report to provide feedback. In CY

2023, the Outcomes Unit worked on identifying and resolving problem areas with the CANS Client Level Report. In CY 2024, the Outcomes Unit addressed a few more problem areas with the CANS Client Level Report and it is ready to move to production for DO and LE providers.

In CY 2022, the Outcomes Unit initiated development of a Pediatric Symptom Checklist (PSC) Client Level Report in Power BI. In CY 2023, the PSC Client Level Report continued to be in development and validation tests were run internally where some problem areas were identified and resolved in collaborating with CIOB.

In CY 2024, the Outcomes Unit shifted focus by developing a PSC Power BI report due to feedback from providers requesting aggregate level data at the program level. The Outcomes Unit compared changes in PSC scores from initial to reassessment at the different program levels in 2023 and used this as the basis to get feedback for reports in development. The data presentation created a jumping-off point for a discussion between the Outcomes Unit and LACDMH providers about how data is collected in different programs and how current data analysis can be improved.

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. In CY 2023, ad hoc CANS Provider Level Reports were developed to address system inquiries and a systemwide provider level report continued to be in development in 2024. The Outcomes Unit ran validation tests internally and with a sample of LACDMH providers to identify and resolve any potential issues during development of the report.
In CY 2024, the Outcomes Unit developed the PSC Power BI report due to feedback from providers requesting aggregate level data at the program level. The report compares changes in PSC scores from initial to reassessment at the different program levels looking back at FY 2022-23. A report can be created from the PSC Power BI report at the request of a provider on an ad hoc basis.

Objective 3: Validate reports 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. The Outcomes Unit will continue to work with CIOB to explore options for final location of the report to ensure both DO and LE providers can easily access the report.

Objective 4: Increase clinical utility training for supervisors and create training to expand to include line staff.

In CY 2024, the Outcomes Unit conducted four training courses of the Clinical Utility of the CANS for Supervisor training to LACDMH LE Providers. The dates and number of participants are as follows:

	Date of Training	Number of Participants
1	January 23, 2024	63
2	March 19, 2024	61
3	May 14, 2024	68
4	August 6, 2024	79

Participants were able to earn 3 CEUs. The August 6, 2024, training was recorded and has been made available on the LACDMH EPSDT Outcomes page on the LAC DMH website.

Objective 5: Implement pilot of using CANS as a Level of Care tool by working with clinicians to validate structured decision-making tool.

In CY 2024, the Outcomes Unit collaborated with other counties in California to develop a decision model tool in using the CANS as a Level of Care tool. The Outcomes Unit will start to work on developing a LACDMH template decision model tool in using the CANS based on its primary collaboration with Santa Clara County. The Outcomes Unit will also plan to develop a CANS Booster Training to improve the quality of providers' CANS ratings. In 2024, a report using the structured decision-making tool with a sample of CANS to see the distribution of LOC yielded was created. The model validated that it was calculating properly and next steps will be to validate data with chart reviews and reviewing service data.

Mentorship Program

Goal IVb.	Create and implement standardized training and mentoring for new staff to increase clinician competencies, satisfaction, and retention.
Objective(s)	1. Create standardized training materials/videos for onboarding new staff including 'What is Community Mental Health' and 'Understanding Peer Services'. 2. Develop framework for mentorship program where clinicians receive support from more seasoned staff or supervisors to learn and demonstrate proficiency in certain areas such as assessment, concurrent documentation, and other elements of quality service provision before titrating up to a full caseload. 3. Survey new staff to find out what needs are and what needs to be tracked in terms of milestones. 4. Gauge new staff satisfaction and adjust support accordingly. 5. Commitment statement/ contract between clinician, supervisor, and manager to ensure consistent onboarding.
Population	DO and LE/Contracted clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Staff Retention rates for new hires at 6 and 12 months 2. Time it takes new staff to achieve all checklist proficiencies 3. Staff Satisfaction Surveys
Frequency of Collection	Annually
Responsible Entity	Outpatient Care Services, Office of Peer Services

This goal was partially met.

Objective #1: Create standardized training materials/videos for onboarding new staff including 'What is Community Mental Health' and 'Understanding Peer Services'.

In CY 2024, planning began to identify materials needed to better support new clinicians and staff. A checklist for onboarding staff is in development. A countywide supervisor's shared electronic folder of support materials was created to distribute information. This goal has been continued into CY 2025.

Objective #2: Develop framework for mentorship program where clinicians receive support from more seasoned staff or supervisors to learn and demonstrate proficiency in certain areas such as

assessment, concurrent documentation, and other elements of quality service provision before titrating up to a full caseload.

In CY 2024, the Supervisor's Leadership Development program was launched. SA Chiefs identified individuals to enroll in cohorts of new supervisors who were linked with more seasoned supervisors. The cohorts met for eight sessions to discuss with Subject Matter Experts (SME) topics on onboarding, supervision, discipline, Human Resources, Union issues, documentation, benefits, performance monitoring, safety intelligence, etc. There was a cohort for each item level (supervisors and managers I, II, and III) averaging 22 individuals. Additionally, weekly guest speakers provided presentations with question-and-answer periods for 10 weeks. Participants were able to provide feedback and make suggestions for improvements.

CY 2024 also saw an increase in in-person trainings and treatment with clients.

Objective #3: Survey new staff to find out what needs are and what needs to be tracked in terms of milestones and Objective #4: Gauge new staff satisfaction and adjust support accordingly.

In CY 2024, verbal feedback was collected from staff about needs through the Supervisors Forum, All Programs of Excellence (APEX) meetings, and the Transition of Care tool and Level of Care Utilization System (LOCUS) trainings. Feeback from participating staff was also collected during the implementation of the pilot programs.
OCS efforts in increasing staff satisfaction and support showed that of the 143 staff hired in CY 2024 there was a 91.0% retention rate after 6 months of being hired and an 83.5% retention rate after a year.

OCS Hiring and Retention Rates, CY 2024

TOTAL NUMBER OF OCS NEW HIRES IN CY 2024	143
TOTAL NUMBER OF OCS REHIRES IN CY 2024	37
TOTAL NUMBER OF OCS PROMOTIONS IN CY 2024	120
RETENTION RATE 1/1/2024 - 7/1/2024	91.0%
RETENTION RATE 1/1/2024 - 12/31/2024	83.5%

Data source: LACDMH Human Resources.

This goal will be continued into CY 2025 by development of staff satisfaction surveys and implementation of Café Connect, a series of regular meetings between executive staff and line staff to discuss areas of need and concern.

Objective #5: Commitment statement/ contract between clinician, supervisor, and manager to ensure consistent onboarding.

LACDMH OCS provided a Duties and Expectations Statement form that identifies duties and activities specific to an individual's role within the program they work in. Managers completed the form with staff, and each staff member was required to sign.

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

Goal IVc.	Develop a mechanism to measure and track HEDIS Measures for Quality Performance Measures.
Objective(s)	1. Define measurement process for DMH to track progress on the following County MHP Priority Quality Measures: • Follow Up After Emergency Department Visit for Mental Illness (FUM) • Follow Up After Hospitalization for Mental Illness (FUH) • Antidepressant Medication Management (AMM) • Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) • Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) 2. Convene workgroups for any measures below Minimum Performance Level (MPL) to plan for interventions designed to improve performance.
Population	All Medi-Cal members that meet criteria to be included in any of these HEDIS measures
Performance Indicator(s)	1. Have regular reports to review and present findings to all levels of QI Process including upper management 2. Will achieve 50th percentile for all measures or an increase 5% over baseline year for any measure below MPL
Frequency of Collection	Quarterly
Responsible Entity	Clinical Pharmacy, QI, Health Access and Integration Division (HAI)

This goal was partially met.

Objective 1: Define measurement process for LACDMH to track progress on the County MHP Priority Quality Measures.

In CY 2024, Clinical Informatics created Power BI Dashboards for the Pharmacy Unit to easily analyze data and identify possible areas of improvement for AMM, APP, and SAA. Clinical Informatics is creating additional Power BI Dashboards for FUM and FUH to view quarterly trends and aims to have

the dashboards completed by the end of 2025.

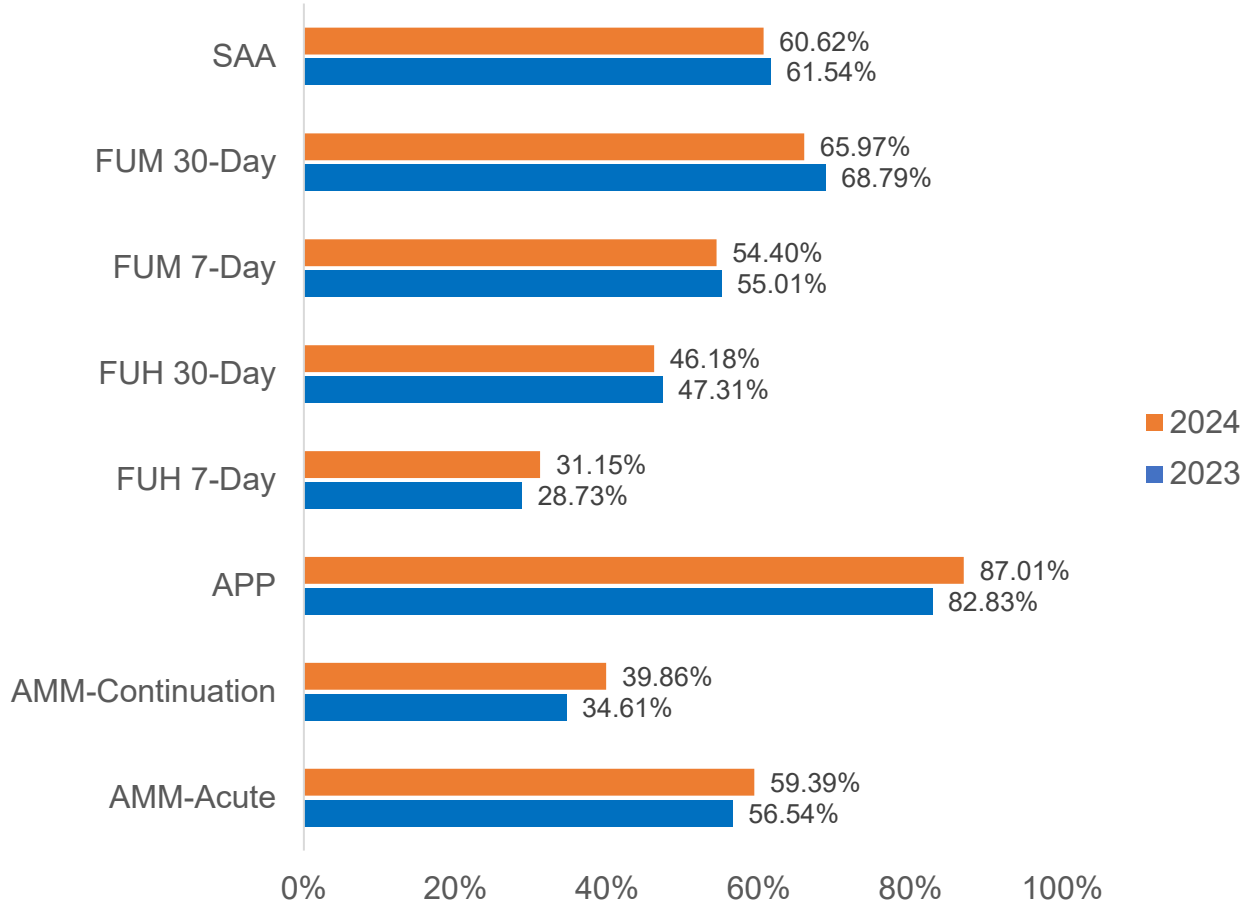
Additionally, in CY 2024, FUM was identified as the clinical Performance Improvement Project (PIP) that will continue on for three years under the oversight of the External Quality Review Organization (EQRO) Health Services Advisory Group, Inc. (HSAG). Prior to the start of this PIP, the former EQRO Behavioral Health Concepts (BHC) had oversight of LACDMH's non-clinical PIP that was also around FUM. Details on the work completed in CY 2024 and conclusion of the nonclinical PIP can be viewed in Goal xx below.

During FY 2024-25 EQR Performance Measure Validation (PMV), HSAG reviewed and confirmed that LACDMH source codes for each measure had no deviations from the measure specifications required by the State. LACDMH will pursue the National Committee for Quality Assurance (NCQA) HEDIS Certification for MHPs for MY 2025 and 2026.

Objective 2: Convene workgroups for any measures below Minimum Performance Level (MPL) to plan for interventions designed to improve performance.

All HEDIS measures were over the 50th percentile in 2024 except AMM Continuation Phase and FUH 7- and 30-day. AMM Continuation Phase was able to achieve a 5% increase over the previous year's rate. FUH 7- and 30-day metrics were unable to increase by 5% from MY 2023 to MY 2024. Efforts are under way by the QA Unit to provide direction to providers in our system on which taxonomies and billing codes are allowable. Providers have been informed that clinicians completing follow-up appointments after a client has been hospitalized for a mental illness need to have a Master's degree or higher. In CY 2025, the Pharmacy Unit will 1.) initiate a QI project to improve lab compliance at an adult directly operated clinic. 2.) initiate a QI project to improve lab compliance for child and adolescents seen at directly operated clinics. 3.) issue a memo with detailed instructions for prescribers to follow and improve outcomes of AMM, SAA, APM, APP, and ADD among other quality metrics. AMM will not continue as a HEDIS measure in MY 2025.

HEDIS Measure Trends for CY 2023-2024



Data source: Health Services Advisory Group (HASG), Los Angeles California Mental Health Plan Report data, 2023 and 2024.

Level of Care

Goal IVd.	Roll out Level of Care Utilization System (LOCUS) as Adult Level of Care Tool.
Objective(s)	1. Develop training and communication plan for administering LOCUS and derived recommendation of adult Level of Care. 2. Fully define all DMH Levels of Care for adults and test fit with LOCUS recommended levels of care. 3. Work with contracted providers and CIOB to develop mechanisms for data collection and submission of results to DMH. 4. Start data collection for Directly Operated clinics utilizing Netsmart built tool for LOCUS.
Population	Adult clients receiving outpatient services
Performance Indicator(s)	1. Number of staff trained to administer LOCUS 2. Monitor progress of data collection readiness and needs for support 3. Evaluate early concordance rates with derived level of care from LOCUS with types and level of services clients receive
Frequency of Collection	Annually
Responsible Entity	Outpatient Care Services, Outcomes, QI, QA, CIOB, Clinical Informatics

This goal was met.

Objective 1: Develop training and communication plan for administering LOCUS and derived recommendations of adult Level of Care.

Developed a plan for a staged roll out of the LOCUS starting with our Directly operated clinics which included presentations given at multiple meetings in front of DMH leadership. Used the Access to Care Action group to get stakeholder feedback on implementation of the tool and to map adult services offered by DMH to the recommended levels of care on LOCUS. Secured contracts with American Association for Community Psychiatry (AACP) and Deerfield Solutions to provide training and scoring of LOCUS. Issued a Quality Assurance Bulletin 24-09 with policy and guidelines around the LOCUS including information on data collection timelines, training, and requirements, and resources.

Objective 2: Fully Define all DMH Levels of Care for adults and test fit with LOCUS recommended levels of care.

The process of defining all DMH levels of care took place in the Access to Care Action and Leadership groups and were mapped to the LOCUS recommended levels of care. The results of this process were presented in various departmental meetings with DMH leadership and mental health providers, and the continuum and definitions were communicated in QA bulletin 24-09.

Objective 3: Work with contracted providers and CIOB to develop mechanisms for data collection and submission of results to DMH.

Throughout 2024 worked with Deerfield Solutions and our own Chief Information Office Bureau to get information on the Application Programming Interface that would be used to send LOCUS data captured to score and return a recommended level of care. Due to the complexities of our contracted network and multiple EHR vendors involved, many conversations were needed to determine the licensing structure for the API and develop requirements around how contractors would onboard and submit data to DMH. Providers would work with their EHR vendors to develop their forms to interface with DMH's specific API for LOCUS. Specifications are being prepared and are expected to be released in early 2025.

Objective 4: Start data collection for directly operated clinics utilizing NetSmart built tool for LOCUS.

LOCUS data collection began for 11 DO clinics starting in December 2024 using the LOCUS form built into IBHIS by NetSmart.

Performance indicator 1: Number of staff trained in the LOCUS

386 staff representing 27 different provider sites were trained in the LOCUS through December of 2024. They received the 5-hour virtual certification training.

Performance indicator 2: Monitor Progress of data collection readiness and needs for support

Regular check ins with Directly Operated clinic managers in Phase 1 of implementation were engaged weekly to determine readiness to implement the LOCUS, were provided materials about the value of assessing clients in adult outpatient care with a LOCUS and provided support in a variety of ways until

all were in live data collection. A group email box was established for centralized communication, requests for support, and troubleshooting any implementation problems.

Performance indicator 3: Evaluate early concordance rates with derived level of care LOCUS with types and level of services clients receive

Once LOCUS data was entered into electronic health record (EHR) scores were reviewed and reported back to program managers. Results were discussed in a LOCUS implementation meeting, and findings were shared based on discussions taking place at early implementation clinics. Distributions of recommended level of care derived from LOCUS responses were compared to distributions of assigned level of care from the clinician and data was used to inform action. Best practices are starting to be developed and systemic issues around transitions in care are being defined and potential solutions are being discussed.

Provider Level Improvement

Goal IVe.	Enhance provider understanding of Medi-Cal Requirements by refining mechanisms of support as well as collaborative monitoring for providers, to ensure the delivery of efficient, quality Specialty Mental Health Services that meet federal, State and County requirements.
Objective(s)	1. Within one year, 35% of LACDMH contracted outpatient treatment providers will participate in the QA Knowledge Assessment Surveys. 2. Continue implementing and refining communication strategies with providers aimed at avoiding waste in claiming and service delivery practices in order to enhance countywide capacity. 3. Revise QA Review Process with the focus on the simplification of documentation requirements as emphasized by CalAIM.
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 2024) 4. Qualitative data from providers on the effectiveness and efficiency of these processes.
Frequency of Collection	1. Collection of QA Knowledge Assessment Survey data three times a year 2. Annually conduct QA reviews of minimum of 100 LE/Contracted provider sites
Responsible Entity	Quality Assurance Unit

This goal was partially met.

Objective 1: Within one year, 35% of LACDMH contracted outpatient treatment providers will participate in the QA Knowledge Assessment Surveys.

There were two cycles of the QA Knowledge Assessment in 2024, one in March in which there were 89 unique provider sites that participated, and one in October in which there were 113 unique provider

sites that participated. The number of provider sites increased over the course of 2024. During the second survey in 2024, the number of sites completing the QA Knowledge Assessment was about 15% of LE provider sites.

Provider attendance of QA Information Sessions increased over the course of 2024. While the data below does not include all attendees (not all attendees logged their attendance), it does show an increase in attendance over the course of the year.

QA on the Air Webinar Attendance Totals, CY 2024

Month	Total Attendees
January	193
February	N/A
March	N/A
April	229
May	204
June	256
July	274
August	273
September	233
October	N/A
November	216
December	N/A
Total 2024	1878

Objective #2: Continue implementing and refining communication strategies with providers aimed at avoiding waste in claiming and service delivery practices in order to enhance countywide capacity.

For DO providers out of 183 charts reviewed across programs, 64% of the charts had assessments with all the required components, 63% of charts had progress notes with all the service components, 45% had an up-to-date problem list, and 42% had a care plan. QA will be continuing to gather this data for LE providers and identifying trends over time.

Objective #3: Revise QA Review Process with the focus on the simplification of documentation requirements as emphasized by CalAIM.

QA developed a survey tool to send out to providers to gather data on the effectiveness and efficiency of the QA review process. In 2024, all Directly Operated providers who responded to a feedback survey reported that they were satisfied with the QA review process and reported that the feedback was helpful in addressing areas of improvement around documentation compliance. All Legal Entity providers who responded to the feedback survey in 2024 indicated that they were generally satisfied with their experience of the QA review process.

Monitoring Continuity of Care, Calendar Year 2024

Goal Va.	Develop a systemwide strategy to reduce 7- and 30-day rehospitalization rates.
Objective(s)	1. Root cause analysis on 7- and 30-day rehospitalizations with help from clinical informatics. 2. Work with Managed Care Plans (MCP) to understand how they track rehospitalization rates and what they have implemented. 3. Continue with a committee to review data monthly. 4. Identify and implement at least one intervention targeting systemwide readmission rates. 5. Train hospital staff on connecting clients to services. 6. Data mining of demographics of clients who are being rehospitalized in 7- and 30-days. 7. Increase FSP referrals from hospitals. 8. Track data of clients going into subacute centers after hospitalizations. 9. 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. Decrease in rates of rehospitalization at 7- and 30-day post-inpatient discharge 2. Modify implementation plan depending on data collected on population getting re-hospitalized within 7 and 30 days of discharge
Frequency of Collection	Monthly
Responsible Entity	HAI, Outpatient Services, Clinical Informatics, QI

This goal was partially met.

Background

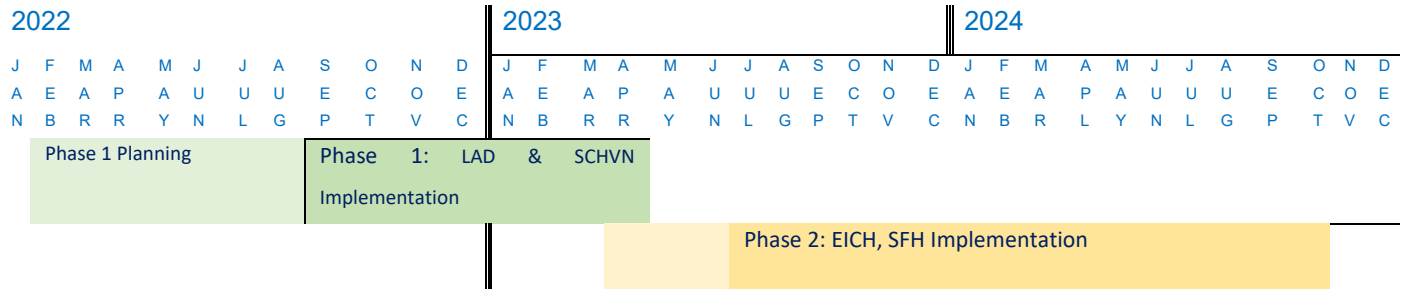
A number of objectives were developed to support the goal of reducing the rehospitalization rate within LACDMH's contracted acute inpatient hospitals during 2023 and 2024. During this time, LACDMH's MCO developed two pilot programs with the aim of reducing repetitive hospitalizations by increasing

the support of the County teams and programs to aid the hospitals as part of the discharge planning process. The population focus is on those patients who have had four hospitalizations within the year or have been hospitalized twice in the past 30 days.

An outcome of testing interventions through the pilot programs was to identify a successful intervention and scale it systemwide. However, as described in more detail below, there was a limited, intermittent impact on rehospitalization rates. To that end, using the root cause analysis, data and lessons learned from the pilot programs, LACDMH is assessing its approach by focusing on the LACDMH full continuum of care and systemic issues that impact readmission rates.

The first phase of a 30-day Hospital Re-Admission Reduction Project was implemented from September of 2022 to April 2023 with two hospitals - Los Angeles Downtown (LAD) and Southern California Hospital at Van Nuys (SCHVN). The second phase was from May 2023 to October 2024 with two new hospitals - Emanate Health Inter-Community Hospital (EHICH) and Saint Francis Medical Center (SFMC). Below is the implementation timeline table.

Pilot Phases 1 & 2 Implementation Timeline



Pilot Program Development and Discovery

Objective 1: Root cause analysis on 7- and 30-day rehospitalizations with help of clinical informatics.

In Progress: During 2024, MCO conducted a literature review and key informant interviews to investigate causes for rehospitalization, to obtain a better understanding of the issues over the past two years (2022-2024) and to identify new approaches and best practices to consider for future interventions.

The key informant interviews, as well as lessons learned from the two rehospitalization pilots, revealed the value of the multi-disciplinary committee to discuss the patient's case to improve care. Participants cited that communication between the sectors, bringing together resources such as pharmacy and service area navigation, were valuable to provide the hospital discharge team with appropriate resources. The need to better integrate ECM to link clients to resources post- discharge and improve communication between these sectors was also cited. These lessons inform how DMH approaches its plans to reduce readmissions moving forward.

In addition, MCO leveraged a health management consultant, who in 2024, released a report recommending LACDMH adopt an enhanced full continuum of care approach to support its role as the Mental Health Plan (MHP). The LA County Board of Supervisors adopted a Board Motion, *Establishing a Roadmap to Address the Mental Health Bed Shortage*, with a wide array of Board directives and recommendations. Two directives specifically address Goals Va. and Vb.:

> Va. Developing County strategies to dramatically reduce the 30-day readmission rates for County residents and
>
> Vb. Expanding the capacity of LACDMH's subacute level of care

The report's action plan with a multi-year timeline expands and extends the original intention and scope of these 2024 QAPI goals.

The consultant also provided DMH with a framework to support transitions of care that DMH intends to implement to help prevent avoidable readmissions. This framework includes care considerations that provide guidance on interventions to implement at different stages of a patient's care including at admission, during the acute inpatient treatment episode and supporting transitions of care after hospital discharge.

To better understand DMH's population who have frequent readmissions, DMH's data scientists are producing a data set of selected indicators for a cohort of clients who are frequent users. These include client demographics, social and clinical factors, medical history, and discharge information. We plan to use the data to identify trends/issues related to re-hospitalization rates and specifically address Objective 8: track data of clients going into subacute centers after hospitalizations (see below). The review will also inform if there are missing data that we need to consider.

Objective 2: Work with Managed Care Plans (MCP) to understand how they track rehospitalization rates and what they have implemented

Incomplete: The HAI Managed Care Operations Division executed data sharing Memorandums of Understanding (MOU) with the MCPs for the purpose of better alignment around shared clients. One takeaway is that MCP data is specific to physical health hospitalizations and not behavioral health hospitalizations, which may necessitate revision of this objective.

The MCP MOU includes a data sharing agreement to match mutual clients. For this process, the MCP sends DMH a list of their members and DMH sends back those who are active in our system. This indicates to the MCP that their member is receiving specialty mental health services from DMH, the mental health provider.

Since the MCP is the physical health provider, the information the MCP sends to DMH reveals hospitalizations for physical health needs, as the primary diagnosis. This match does not provide DMH with new behavioral health information and, as such, limits our ability to address this objective.

To further this goal and inform strategies in the coming year, DMH is utilizing data such as the rehospitalization Power BI dashboard (Objective 9) which documents hospital visits based on a behavioral health issue including client level data and can deepen our collaboration with the MCP related to care coordination and discharge planning for high utilizers. However, it is recommended that Objective 2 be removed since the original assumptions have been negated.

Objective 3: Continue with a committee to review data monthly.

Complete: To support a multi-disciplinary team approach, a committee format that was established in Phase 1 was continued in Phase 2 to oversee the project. The LACDMH HAI Unit re-established the committee meetings to support Phase 2 during the spring of 2024. These meetings adapted as LACDMH went through a reorganization resulting in some leadership and staff transitions.

Each committee roster included the following members:

- Two pilot hospitals
- TAR Unit
- Clinical Pharmacy
- Enhanced Care Management
- Service Area Hospital Navigation Teams
- Department of Public Health/Substance Abuse Prevention and Control (SAPC)

The committee met monthly to share the progress and status of the interventions, identify and problem-solve barriers, and determine steps for expansion of the pilot project.

Objective 6: Data mining of clients who are being re-hospitalized at 7 and 30 days.

Complete: A list of data characteristics/indicators was developed and reviewed with LACDMH's Data Scientist along with potential strategies to reduce rehospitalizations. To learn specifically about LACDMH clients who engage in a persistent pattern of seeking inpatient services, the Data Scientist produced a dataset for a cohort of LACDMH clients re-hospitalized within 30 days during 2023 and 2024 and those who had four or more hospitalizations in calendar year 2024 with the selected indicators.

As a future activity, the HAI will work closely with CIOB to produce a patient profile that can enable DMH to better address this issue in Los Angeles County.

Interventions

Objective 4: Identify and implement at least one intervention targeting systemwide re-admission rates.

Continued: no scalable intervention was identified.
Due to changes in leadership on this goal, no scalable intervention was identified. For next year, an intervention will be developed based on review of the root cause analysis, implementation of the *Establishing a Roadmap to Address the Mental Health Bed Shortage* Board Motion directives, and available data.

Objective 5: Train hospital staff on connecting clients to services.

Complete: Enhanced Care Management (ECM) conducted significant outreach to hospitals building bridges and pathways for client engagement and referrals. ECM, is a Medi-Cal benefit that provides intensive one-on-one care coordination to assist clients navigate their care and access necessary services. Hospital staff were advised to refer clients to ECM providers who would visit the clients in the hospital. When a client enrolled with the ECM program, the ECM care manager would connect patients with outpatient programs, physical or medical providers, and other resources a client may need. These referrals were often successful for enrolled clients; however, the number of clients who expressed

interest in ECM and referred from the hospital was relatively low. In addition, linking back to the hospital staff to let them know that a patient agreed to participate in ECM was an area for improvement. This would be helpful because hospital staff could document the client is enrolled in ECM so if they are rehospitalized, they have the ability to contact the ECM care manager directly to let them know their client returned. Monthly Committee meetings attended by the multi-disciplinary team were also a platform for hospitals and LACDMH to identify barriers and challenges related discharge planning, discuss solutions, and implement action plans to address the issues, as discussed above in Objective 3.

Objective 7: Increase Full-Service Partnerships (FSP) referrals from hospitals.

Complete: Referrals to LACDMH's FSP programs were prioritized for hospitals participating in the pilots. Hospital staff contacted LACDMH's FSP which assists with housing, employment, and education in addition to providing mental health services and integrated treatment for individuals with co-occurring mental health and substance abuse disorder. The Service Area Navigators and hospital discharge planners reported anecdotally in the monthly committee meetings that FSP was a priority as a destination for clients upon discharge. However, they were not tracked systematically and due to the limited outcomes of this pilot, further follow-up is not warranted.

Objective 8: Track data of clients going into subacute centers after hospitalizations

As noted in Objective 1 above, the data set produced by DMH's data scientists will focus on the cohort of clients who are frequent users defined as DMH clients re-hospitalized more than one time in the past 30 days or four or more times in 12-months. Once the baseline data is available, DMH will identify how to track and analyze subacute stays and other relevant indicators.

In addition to interventions in Objectives 4, 5, 7, and 8, there were other interventions initiated during phases one and two:

- LACDMH Clinical Pharmacist Referral: Pilot hospitals were invited to refer patients to LACDMH's clinical pharmacists. If a patient met criteria for the program such as concern for medication/adherence issues, or if the patient had hesitancy to begin or continue medications, the LACDMH pharmacist met with patient before discharge to offer medication access and education and to help link patients with LACDMH clinics post-discharge. This personal attention from the pharmacist was intended to build rapport with the patient to encourage them to continue to seek

care and take medications after release. This program realized some success in phase one, but the phase two hospitals were not as engaged.

- Substance Use Services: For patients requiring substance use services, hospital staff were encouraged to refer to the DPH-SAPC through ACCESS, a telephone line that provides information, support, and referrals 24 hours per day, 7 days per week. The SAPC staff who attended monthly meetings also offered their own contact information to hospital staff. The meetings helped to troubleshoot issues when accessing the line and expedite referrals. They also offered recovery incentives of gift cards for clean tests.

Outcomes

Objective 9: Develop a Power BI dashboard to examine rates of rehospitalization and identify any patterns to address.

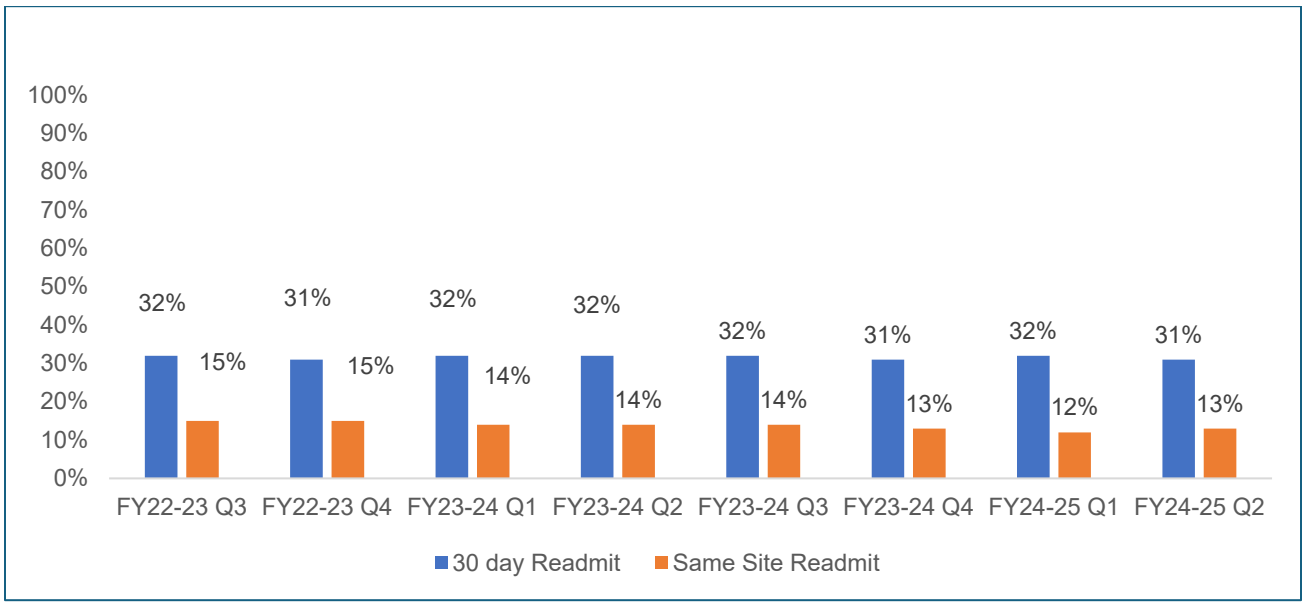
Complete: A LACDMH Rehospitalization Dashboard was developed to help track and trend hospital data. These data are listed below.

Figure below illustrates the percentage 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 for CY 2024 (N=36).

The time period reflects the baseline for Phase 2 Pilot, January through March 2023, (FY22-23 Quarter 3), through the end of the Pilot in October 2024 (FY24-25 Quarter 2).

The total re-hospitalizations remained relatively steady at around 32% as did the 30-day same site rehospitalization rate that held consistently at 14% throughout the time period.

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

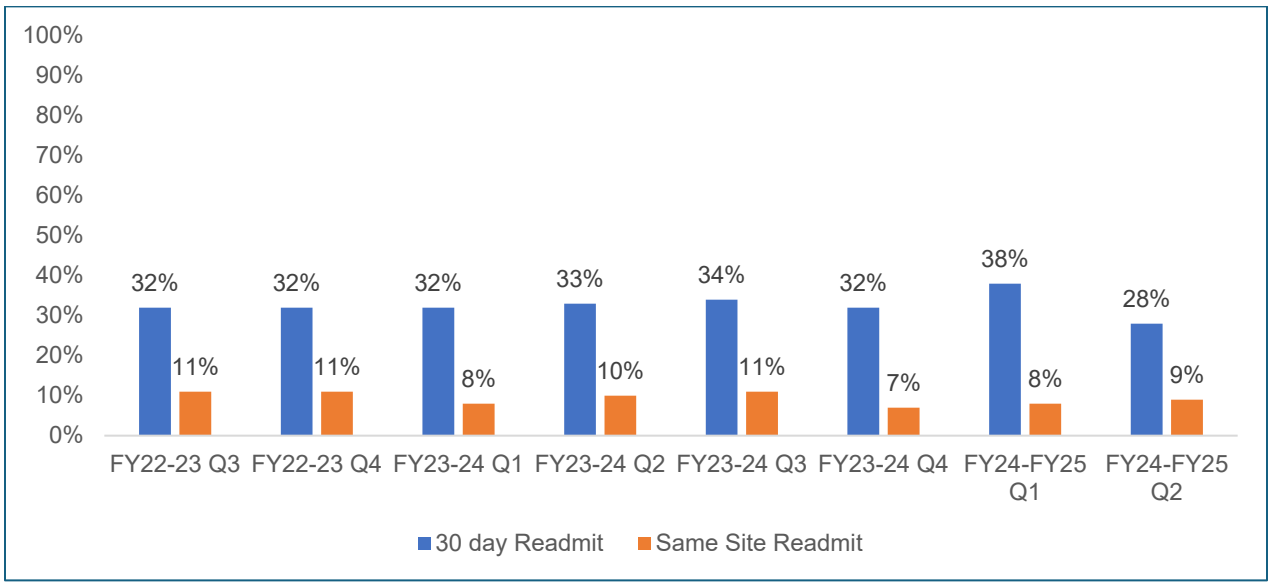


Note: Phase 2 pilot hospitals are included. Data source: LACDMH PowerBI Inpatient Rehospitalization Report, June 2025.

Figures below display the rehospitalization rates for the two pilot hospitals from the baseline through the intervention period of May 2023 to October 2024.

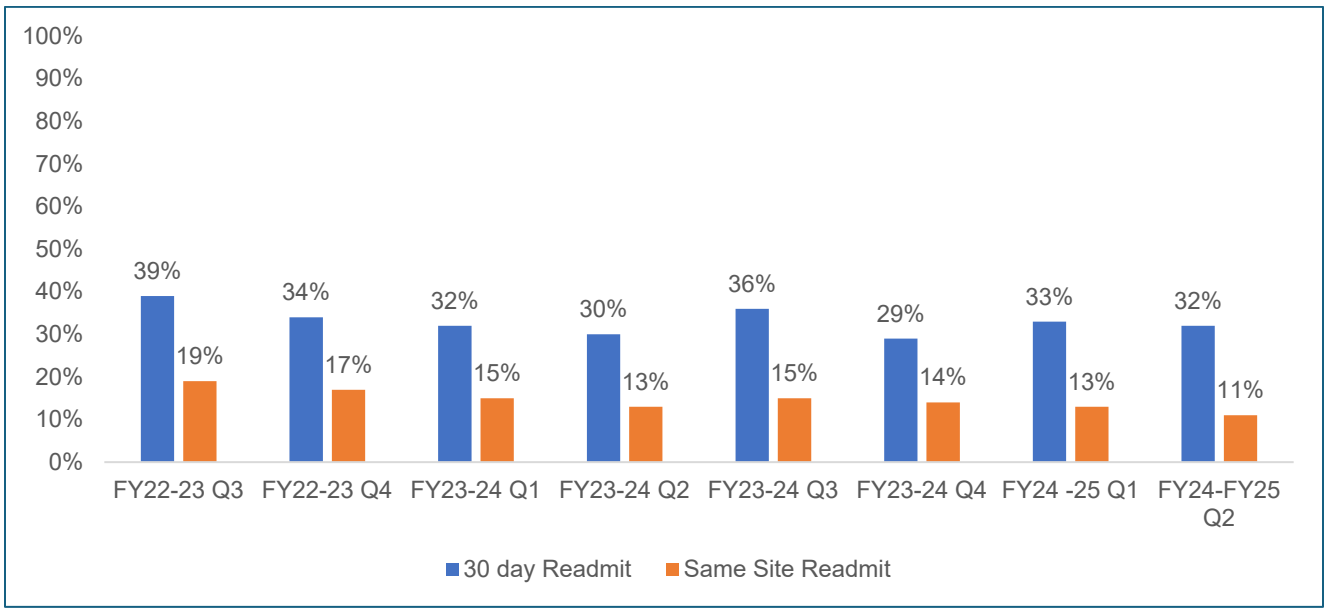
Emanate remained generally stable in total re-hospitalizations until the end of the reporting period when there was a 10% decrease in all admissions in FY24-25, Quarter 2. Same site readmissions did fluctuate somewhat and most prominently between FY23-24 Q3 and Q4 from 11% to 7% but ultimately went back up to 9% by the end of the year, still 2% lower than the baseline.

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, June 2025.

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, June 2025.

St. Francis Medical Center realized an overall decrease of 7% in total re-hospitalizations and 8% reduction in same site re-hospitalizations from the baseline to the end of the reporting period.

In summary, both hospitals showed decreases in both same site and 30-day readmissions from baseline to the end of the Phase 2 pilot intervention period and became comparable to the overall rate of all LACDMH contracted hospitals during the same period (Figure #1).

Goal Vb.	Increase Bed Capacity in Subacute Facilities by Reducing Time to Step Clients Down into Lower Levels of Care.
Objective(s)	1. Increase access to community-based care 2. Improve successful transitions to the community
Population	Los Angeles County clients who are ready to transition into and out of IMD level of care.
Performance Indicator(s)	1. Reduced time from referral to enrollment in community-based services 2. Increased percentage of individuals engaged in services after being successfully discharged from IMD through this intervention process.
Frequency of Collection	Quarterly
Responsible Entity	HAI, MHSA

This goal was not met.

In CY 2024, an LACDMH team of the Mental Health Service Act (MHSA), HAI - 24-Hour Unit, and QI Unit explored whether improving client transitions from subacute settings to LACDMH's intensive Full-Service Partnership (FSP) program could be a viable intervention. The team investigated the reasons for discharge from subacute facilities and identified the successes and challenges specific to transitioning clients to FSP and other community treatment settings.

The LACDMH team met regularly and documented a broad range of issues and considerations including but not limited to:

- Medical issues coupled with behavioral health issues that limit the step-down options for clients
- Clients that lack family support
- Staffing and workforce challenges at facilities
- Competing priorities related to conservatorship
- Unique needs of forensic clients
- Services for clients with co-occurring SUD and mental health

The assessment differentiated client pathways to FSP and other community treatment settings such as Enriched Residential Services (ERS). It was revealed that ERS was a more prevalent referral for clients stepping down from a subacute level of care than FSP. The ERS program is designed to provide comprehensive mental health and rehabilitative services in a non-institutional residential setting for

individuals aged 18 years and older, who would be at risk of hospitalization, re-hospitalization, or other institutional placement if they were not in the ERS program.

Before implementing any new efforts, the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative was announced. Among its key features, BH-CONNECT included Community Transition Services meant to ensure individuals transitioning from long-term institutional care receive continuous support and services to successfully reintegrate into their communities. BH-CONNECT aims to expand access to care, improve outcomes, and address long-standing gaps in mental health and substance use disorder services.

With this DHCS implementation, LACDMH elected to pause these objectives and address the goal through the planning and future implementation of the BH-CONNECT initiative. To supplement the BH-CONNECT work, LACDMH is also implementing Board directives from a Bed Motion that prioritized expanded capacity at the subacute level of care.

Monitoring Provider Appeals, Calendar Year 2024

Goal VI.	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	HAI

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) (*now named Managed Care Operations-Compliance Unit*) 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 were available and shared with the QI unit, as appropriate. These two logs supplement the ICD 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 included monthly data regarding the number of TARs, the number of unique consumers for whom TARs were 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 included 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 2024, the TAR Unit continued to discuss trends in individual meetings with providers and offers training to address the reasons for denials to reduce them.

There were 40,603 TARs received during CY 2024. This is an increase of 9,647 over the previous year. The large increase in the number of TARs received in 2024 may be due to additional providers that were onboarded as part of the concurrent review process. With more providers using concurrent review, there were more TARs to review. Additional information on Concurrent Review is detailed in Objective 2 below.

In CY 2024, 97% of TARs were approved, which is consistent with trends over the last three years. Improvement in the percentage of first appeal TARs received seems to correlate with the increase in overall approved TARs. The number of first appeal approvals (73.0%) is similar to 2023 (75.0%). Improvements in these data reflect enhancements implemented by the TAR Unit including training and maintenance with facilities on specific 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.

The table below presents the five-year trend in the number of TARs received, the percentage approved, and the number of first appeals received and approved.

Five-Year Trend in TARs Received and Percent Approved for IMD and Specialized Inpatient Facilities

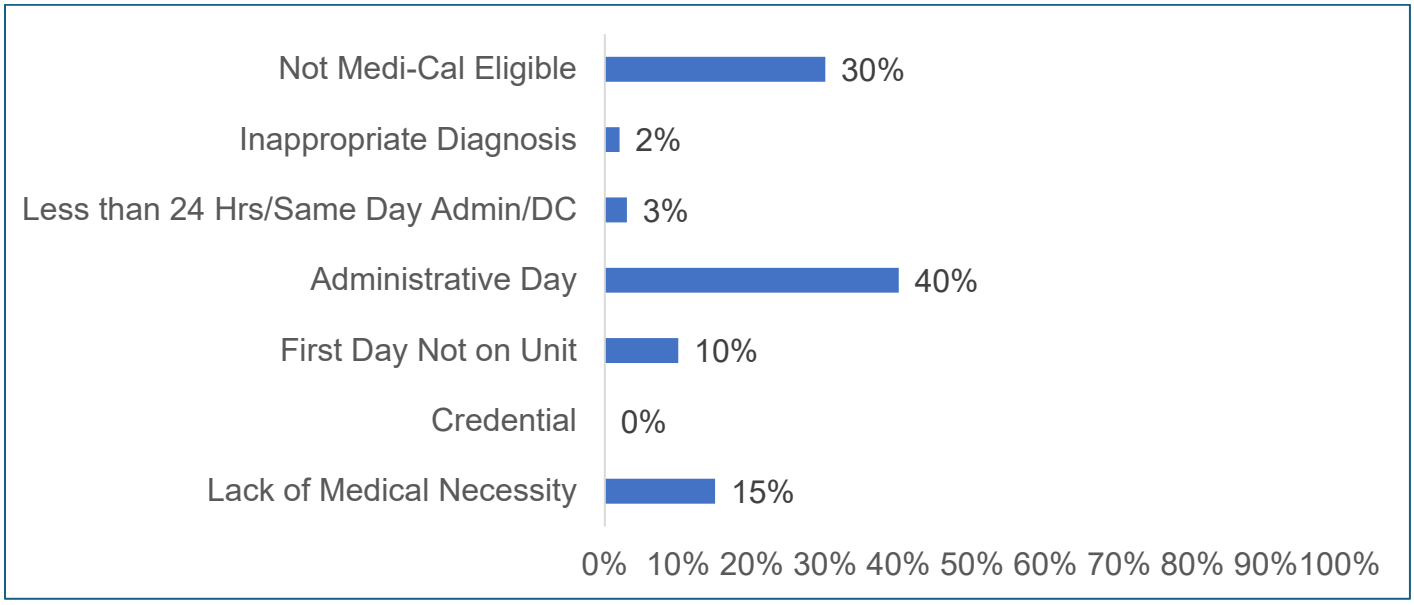
	CY 2020	CY 2021	CY 2022	CY2023	CY2024
Overall TARs Received	28,501	27,939	29,908	30,956	40,603
% Overall Approved	67.7%	93.0%	95.6%	97.0%	97.0%
First Appeal TARs Received	660	689	532	336	535
% First Appeal Approved	29.7%	34.1%	41.3%	75.0%	73.0%

Data Source: IBHIS May 6, 2025.

During CY 2024, the MCO issued 1,414 Notice of Adverse Benefits Determinations (NOABD) as noted in Table 2 below. The NOABD is a notification to patients and providers letting them know what was denied for reimbursement and the reason. In 2024, the most common reasons were clients who were not Medi-Cal eligible when the TAR was sent to LACDMH (30%) and Administrative Days (40%). The Administrative Day Waiver is a type of protocol for hospitals to get paid while their clients are waiting

for placement. It is provided when a patient no longer requires acute inpatient care and is waiting to be discharged to a non-acute care setting.

Percent of NOABD Denials by Reason, Calendar Year 2024



Data Source: TAR Unit Logs reviewed May 6, 2025. Links to: Charts for 2024 QAPI_Appeals Goal.xlsx.

In CY 2024 many of the most common reasons for which NOABDs were issued differed from the reasons provided last year. The MCO – Compliance Unit engaged in several quality improvement efforts to address the NOABD data trends. They conducted 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. These trainings may have impacted the decreases seen between 2023 and 2024.

Particularly notable in this year's data was that provider credentialing is no longer a reason for denial. Prior to this year, if the psychiatrist was not appropriately credentialed, there was reason for complete denial. Credentialling was added to the Compliance Unit's provider training program. With it no longer being a reason for denial in 2024, this training appears to have been very successful. Also, potentially due to the training program, denials for a lack of medical necessity decreased from 30% of denials in 2023 and to half of that, at 15% in 2024.

Increases were seen in the denial of Administrative Days and Medi-Cal eligibility in 2024. However, this may be attributed to changes in staffing and leadership that led to a closer adherence to the regulations in both of these areas.

Next steps include continued collection of dates of submitted appeals, resolutions, and reasons for denial, using the Provider Appeal Tracking log monthly. 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 General Acute Care Hospital (GACH) stays, and review denials by psychiatrists.

Moving forward, the Compliance Unit continues to look at data by provider to see if there are patterns for providers being denied consistently who may need support. In addition, the team is standardizing the language for the Provider Appeals and NOABDs which may impact data collection for 2025.

Of note is that with the concurrent review system, denials occur when there are missing notes or documents at the time of review. If there is an appeal and the NOABD is overturned, it is not documented so the data in Table 1 chart reflects initial denials and may reflect higher rate than 'true denial.'

In the coming year, the MCO Division will re-visit this goal to refine the measures including documenting when an appeal overturns a denial.

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

Currently, 100% of LACDMH contracted Acute hospital providers are adhering to the concurrent authorization review process, per DHCS Behavioral Health Information Notice (BHIN) 22-017. For non-contracted providers, LACDMH is in the process of rolling out a system to support the concurrent authorization review process with a target date of December 2025.

LACDMH's HAI - Managed Care Operations 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 (PHF) and Short Doyle Hospitals. While LACDMH is receiving and reviewing referrals for PHFs, HAI is in the process of preparing to implement full concurrent review. However, a target date is currently unknown as HAI continues to work on updating our EHR system to support the PHF concurrent review process.

Monitoring Performance Improvement Projects, Calendar Year 2024

Goal VIIa.	Clinical PIP for CY 2024 will improve the rate of 30-day and same site rehospitalization for inpatient hospitalization discharges at two pilot hospitals.
Objective	1. Work collaboratively with pilot team/PIP committee. 2. Refer identified beneficiaries discharged from two inpatient hospitals back to their mental health provider or provide linkage to needed mental health services. 3. Participate in health information exchange (HIE) data between LACDMH and two pilot hospitals
Population	Beneficiaries that receive care from inpatient hospitals that are existing SMHS clients or potential clients
Performance Indicator(s)	1. Rate of 30-day rehospitalization of beneficiaries that are discharged from inpatient hospitalization 2. Rate of same site rehospitalization of beneficiaries that are discharged from inpatient hospitalization 3. Number of Enhanced Care Management (ECM) referrals 4. Number of Full-Service Partnership referrals
Frequency of Collection	Quarterly
Responsible Entity	QI, HAI, CIOB

This goal was partially met.

Objective 1: Work collaboratively with pilot team/PIP committee.

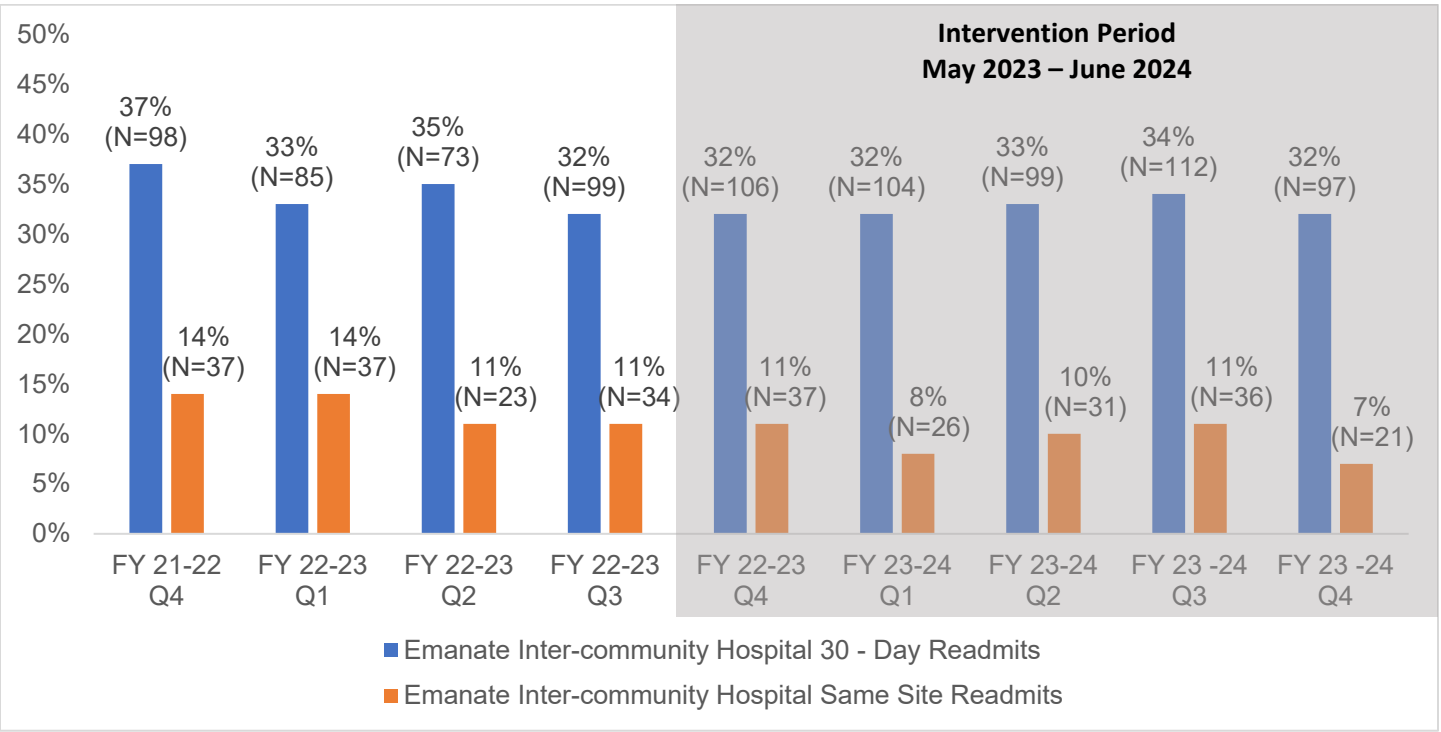
This clinical PIP was developed as a result of one of the EQRO recommendations in FY 2022-23. The focus was on decreasing the inpatient psychiatric rehospitalization rates. The Intensive Care Division (ICD)-Treatment Authorization Request (TAR) Unit had an ongoing pilot called the Readmission Reduction Project. The goal of the pilot project was to decrease rehospitalization rates to no more than the 19% nationwide rate. Phase II of the project began in April 2023 and focused on two 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 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.

Readmission Rates

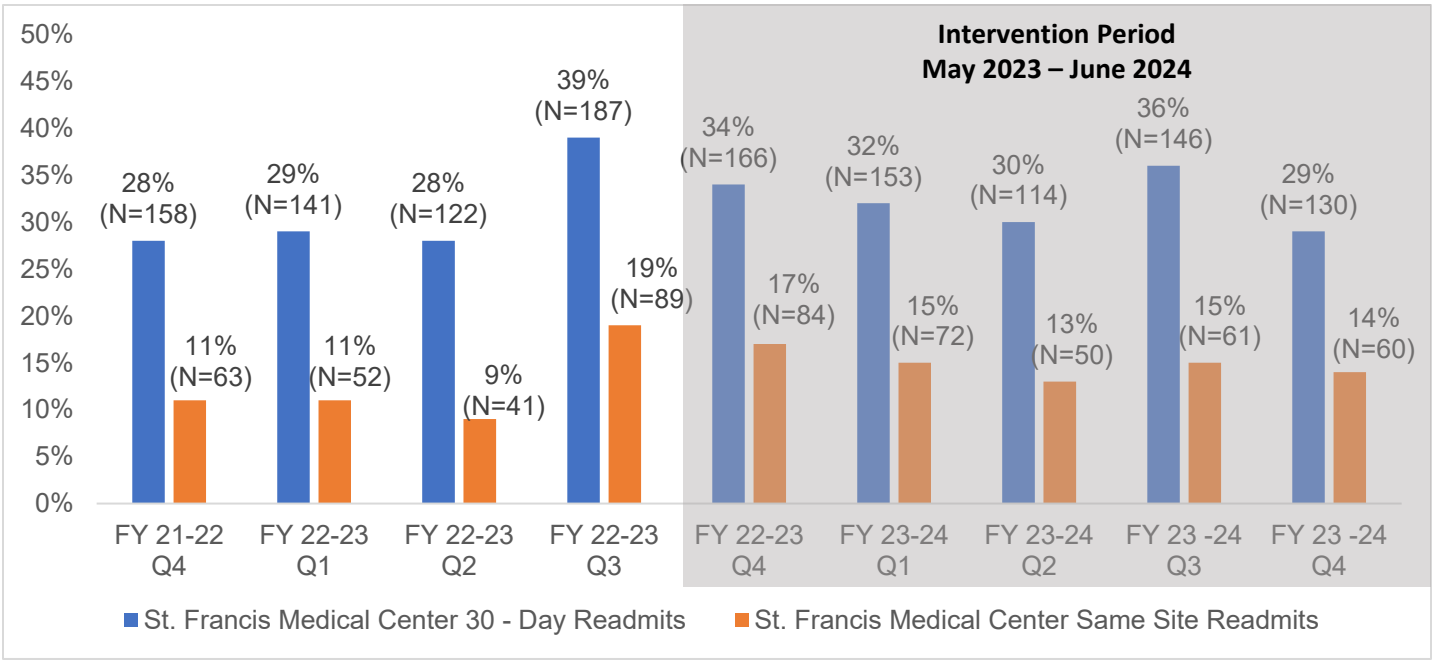
Phase II of the pilot went live in May 2023 (FY 2022-23 Q4) at which point the interventions were introduced at both hospitals. The 30-day readmission rate for Emanate Inter-community Hospital during the intervention period between May 2023 and June 2024 was an average rate of 32.6%. This is a decrease of 1.7 Percentage Points (PP) from the baseline 30-day readmission average rate of 34.3%. The same site readmission average rate of 9.4% is a 3.1 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 increased during the intervention period. Specifically, the 30-day readmission was an average rate of 32.2% which was a 1.2 PP increase from the baseline average rate of 31%. The same site readmission average rate of 14.8% was a 2.3 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, June 2025.

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



Data source: LACDMH PowerBI Inpatient Rehospitalization Report, June 2025.

Objective 2: Refer identified beneficiaries discharged from two inpatient hospitals back to their mental health provider or provide linkage to needed mental health services.

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	Total Discharges	Total Readmits 30 Day	30-day Rehospitalization
No ECM	16672	4174	25.0%
Year Before ECM Referral	686	450	65.6%
ECM Referred	341	172	50.4%
ECM Enrolled	77	46	59.7%
ECM Other	1661	961	57.9%
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 2023 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 to identify clients who could benefit from their services.

Objective 3: Participate in health information exchange (HIE) data between LACDMH and two pilot hospitals.

During the PIP, ECM, Pharmacy, and QI attempted to utilize HIE information from the Los Angeles Network for Enhanced Services (LANES) to communicate about patient discharges. However, it was determined that only one of the two hospitals was linked to the LANES HIE. Information that was available in the HIE was often incomplete. It was determined that more infostructure development would be needed to effectively communicate about care coordination with the HIEs.

Status of PIP

During Phase II of the pilot, the Intensive Care Division (ICD)- Treatment Authorization Request (TAR) Unit experienced staff turnover as well as a change in leadership. In addition, the QI Lead over this PIP left the department. Staff turnover in the TAR unit involved key staff members who had spearheaded this project and oversaw phase I of the pilot. In the absence of these key staff members, and their subject matter expertise, there was a lack of guidance regarding referral procedures, coordination of referrals between pilot partners, and there was uncertainty around the procedures for data collection. Data previously collected in phase I was unable to be replicated as the source of the

data was unclear to the new leadership. It is possible that these changes in staffing and leadership contributed to low number of referrals from the pilot hospitals to ECM, FSP and ICD, and no referrals to Clinical Pharmacy and SAPC. Furthermore, there is a lack of available data to determine the effectiveness of the interventions. As result, a decision was made to discontinue Phase II of this pilot with the goal of developing phase III of this project and incorporate lessons learned from Phase II.

At about this same time, the DHCS contracted with a new External Quality Review Organization, Health Services Advisory Group (HSAG), whose contract began in July 2024. HSAG communicated to counties that the process for reviewing performance improvement projects would change and that they would not be evaluating existing PIP's which further supported the decision to discontinue Phase II. Phase III of the pilot project is currently in development but will not be part of a performance improvement project. LACDMH will carry out a new state-mandated PIP project during the next reporting period.

Goal VIIb.	Non-clinical PIP: Develop and implement an administrative data-driven performance improvement project for CY 2024 to improve follow up for mental health services after emergency department (ED) visit for mental illness (FUM) for DMH Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) clients
Objective	1. Connect GENESIS program to Health Information Exchange (HIE) including ED encounter alerts for enrolled clients. 2. Connect identified clients in EDs back to their mental health provider or provide linkage to needed mental health services. 3. Develop workflows and procedures to address alerts of GENESIS client encounters at EDs.
Population	Clients that receive care from EDs that are existing SMHS clients or potential clients
Performance Indicator(s)	1. Access to real time data on clients served in EDs with mental health issues 2. Reduction in percentage of clients not receiving 7- and 30-day follow- up mental health care 3. Increased percentage of clients receiving more than one SMHS claim post ED visit
Frequency of Collection	Quarterly
Responsible Entity	QI, GENESIS, CIOB

This goal was met.

The FY 2023-24 *Improving Follow-Up After Emergency Department Visit for Mental Illness (FUM) for Older Adult Beneficiaries that Present with Mental Health Concerns* Performance Improvement Project (PIP) proposed to increase mental health follow-up for Older Adult clients who present to emergency departments (EDs) for care. This project utilized health information exchange (HIE) systems to improve engagement and follow-up with Medi-Cal clients enrolled in the Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) program who visit EDs and received a mental health diagnosis or displayed self-harm behavior by initiating outreach and data exchange with facilities serving these clients to ensure better continuity of care and reduce their ED visits.

According to the National Committee for Quality Assurance (NCQA), using Healthcare Effectiveness Data and Information Set (HEDIS) measures can provide a consistent way to measure the quality of healthcare services while decreasing waste. Monitoring the timeliness of follow-up care after ED visits for mental illness is a HEDIS measure that should be widely used to ensure consistent care is provided to individuals in high need of mental health services. Increasing the rate of follow-up care for individuals experiencing mental illness could decrease the number of repeat visits to the ED, improve whole-person care, and improve the adherence to follow-up instructions (NCQA, 2023).

The aim of this project was to determine if the application of new HIE alerts, workflows, and follow-up services from the LACDMH GENESIS program to enrolled Medi-Cal clients who present to EDs with mental health diagnoses increases the percent of linkage to seven and 30-day follow-up from 27.0% and 46.0% to 33.0% and 51% in six months for older adults?

The Quality Improvement (QI) Unit collaborated with the Quality Assurance (QA) Unit, Chief Information Office Bureau (CIOB), GENESIS program, and Health Access and Integration (HAI) Unit to design and implement interventions. Additionally, LACDMH engaged with Managed Care Plans (MCPs) LA Care and Healthnet to review data sources to support monitoring of FUM for LACDMH clients served.

Objective 1: Connect GENESIS program to a HIE including ED encounter alerts for enrolled clients.

In April 2024, the GENESIS team was connected to PointClickCare (PCC). PCC is a nationwide HIE that connects healthcare providers who are enrolled in the service. PCC provided the GENESIS team with email alerts when a client enrolled in the GENESIS program had an encounter at an ED for both mental and physical issues.

Objective 2: Connect identified clients in EDs back to their mental health provider or provide linkage to needed mental health services.

Prior to the intervention, the Department of Healthcare Services (DHCS) Plan Data Feed data for CY 2023 showed that the systemwide Older Adult 7-day FUM was at 27.0% and 30-day FUM was at 46.0%. The Plan Data Feed also showed that the GENESIS program had a 7-day FUM at 50.0% and 30-day FUM at 81.8%.

At the completion of the April to August 2024 intervention period, the DHCS Plan Data Feed showed that the systemwide Older Adult 7-day FUM was at 39.6.0% and 30-day FUM was at 59.9%. The GENESIS program 7-day FUM increased to 53.6% and 30-day FUM increased to 82.1%.

Objective 3: Develop workflows and procedures to address alerts of GENESIS client encounters at EDs.

GENESIS team members developed a workflow for responding to a PCC alert, connecting with the GENESIS client, and scheduling follow-up mental health services. PCC alerts were received by the administrative team and distributed to the client's treatment team. The client's service provider reviewed the information and contacted the client to schedule a follow-up appointment. The GENESIS team reported that this process was useful in understanding what symptoms the client was experiencing and locating the client as ED visits tended to occur without warning and admissions to hospitals were frequently unknown.

This PIP was completed in October 2024 when the External Quality Review (EQR) contract holder for the State was changed to a new organization who asked counties to cease work on current PIPs in order to start on new pre-selected PIPs. The GENESIS team continued to receive alerts from PCC to increase follow-up with client following ED encounters and also incorporated encounter alerts from a second HIE, the Los Angeles Network for Enhanced Services (LANES). LACDMH is working to develop policies and procedures on how providers should receive and respond to PCC and LANES alerts systemwide. The Department is also exploring the expansion of HIE use to other treatment providers and programs. LACDMH will continue the development of processes to monitor 7-day and 30-day FUM monitoring for the systemwide older adult population.