DEPARTMENT OF MENTAL HEALTH

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LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

February 15, 2024

TO: Supervisor Lindsey P. Horvath, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Lisa H. Wong, Psy.D.
Director

SUBJECT: **ESTABLISHING A ROADMAP TO ADDRESS THE MENTAL HEALTH BED SHORTAGE (ITEM NO. 41-D, AGENDA OF JANUARY 24, 2023)**

On January 24, 2023, the Board of Supervisors (Board) approved the motion, *"Establishing a Roadmap to Address the Mental Health Bed Shortage,"* to reinforce the Los Angeles County's (County) commitment in addressing barriers to provide housing and services for individuals suffering from severe mental illness. The motion directed the Department of Mental Health (DMH), in consultation with the Chief Executive Office (CEO), to evaluate the current and forecasted bed capacity needs of the County and build a roadmap on how to fund and sustain these beds, and included the following directives:

1. Retain a consultant to work with the departments on the analysis and roadmap, and analyze existing data and reports;
2. Perform a gap analysis analyzing the current and future projected needs for inpatient mental health beds and facilities, consulting existing data and reports, as well as other relevant departments, service providers and labor, and report back in writing to the Board in 180 days; and
3. Develop a comprehensive roadmap to address the specific gaps in the mental health bed continuum at each bed type and level, including existing and potential funding sources, bed procurement opportunities, and legal, contracting or regulatory barriers, and include this in the report back due in 180 days.

The attached report **Establishing A Roadmap to Address the Mental Health Bed Shortage** in concert with the **Mental Health Resources Planning Report** developed by an outside consultant, Health Management Associates (HMA), serves to fulfill the directives of the Board.

If you have any questions regarding this interim report back, please contact me, or staff may contact Health Access and Integration Deputy Director, Jaclyn Baucum, at (213) 943-8387 or via email at jbaucum@dmh.lacounty.gov.

LHW:CDD:JB:ln

Attachments

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

Los Angeles County

Department of Mental Health

Establishing A Roadmap to Address the Mental Health Bed Shortage: Board of Supervisors Motion Response

Lisa H. Wong, Psy.D.

Director

Department of Mental Health

Introduction

In response to the January 24, 2023, *"Establishing a Roadmap to Address the Mental Health Bed Shortage"* Board motion directives, Los Angeles County Department of Mental Health (DMH) conducted a Root Cause Analysis project in 2023 and commissioned Health Management Associates (HMA) to prepare the **Mental Health Resources Planning Report** (referenced going forward as the HMA Report). The HMA Report (full report follows) offers an assessment of the DMH mental health service continuum including a synthesis of existing data and reports, a gap analysis, a comprehensive roadmap that offers recommendations on addressing the identified gaps, and insights from dynamic forecasting tools that can provide DMH with the ability to see capacity demands across the DMH system of care. These internal forecasting tools that HMA and DMH developed will give the department a more objective look at its bed network and system of care. In the HMA Report, Table 15, HMA inserted informed proxy estimates to illustrate how the model will allow DMH to change inputs and assumptions to generate projection ranges that address changing needs. The forecasting tools initiate new modeling capabilities within DMH to more dynamically estimate bed capacity. As is the case with any dynamic tool, the inputs will create adjusted outputs. The forecasting of bed numbers will expand or contract based on the demands to the system. The HMA report highlights a point in time estimate for the current bed projections.

To develop a full picture of the continuum of care that impacts the demand for inpatient, residential, and supportive housing beds, DMH has paired the HMA Report with an assessment of regulatory, policy, financial and contracting issues that impede access to mental health beds across the DMH system of care (referred to as the 2023 Root Cause Analysis project).

Executive Summary

The HMA Report identifies three systemic gaps and offers implementation priorities to strengthen DMHs internal governance and oversight of the full continuum of mental health resources for which it organizes. Adoption of these changes will improve DMH's ability to effectively plan and manage the mental health safety net in Los Angeles County (County).

As recommended in the HMA Report, the HMA implementation priorities include:

1. Strengthening DMH's internal governance and oversight of the full continuum of mental health resources.

   DMH's most urgent needs are to increase internal governance and visibility into actual utilization and capacity of the full continuum of care. This includes increasing resources in the analytics team, adding in a Managed Health Plan (MHP) financial analyst and creating the

governance structures necessary to track trends and monitor the full continuum of services.

2. Expanding the capacity of DMH's subacute level of care.
   Based on the analysis of the model outputs, there are significant bottlenecks at the subacute level of care.

3. Developing County strategies to dramatically reduce the 30-day readmission rates for County residents.
   According to the EQRO report and the data analyzed by HMA of utilization patterns, readmissions are currently using up capacity at a rate that is higher than many regions in California.

4. Aligning HMA's systemic gaps roadmap (referred to as Roadmap A below and on pages 37-42 in the HMA Report) with DMH's internal analysis roadmap (referred to as Roadmap B below) of regulatory, policy, financial and contracting issues.
   HMA encourages DMH to further examine internal policies by leveraging the work already done to identify barriers, which will allow DMH the ability to effectively plan.

Key Systemic Gaps and Recommendations

Also recommended in the HMA Report are three systemic gaps. The tables below identify related gap areas and the associated HMA observations and recommendations.

1. Importance of a Full Continuum Approach to Mental Health Resources

Gap Area	Gap Observation and Recommendation
1. Need for Stronger Operational Approach to Manage the Full Continuum to Mental Health Resources	*Gap Observation: The current LAC DMH system is managed in separate databases with siloed oversight. As a result, LAC DMH has limited visibility into the access, availability, and resources for the full continuum of care.* Recommendation: 1.1 LAC DMH needs to adopt a management and operational philosophy and approach centered on the full continuum of care.

2. Internal Governance and Oversight

Gap Area	Observation and Recommendations
2. Siloed Oversight	*Gap Observation: Structure of oversight and areas of responsibility are siloed with very few leaders who have visibility and responsibility for the total system of care.* Recommendations: 2.1 To support a full continuum approach, LAC DMH needs to develop a continuum of care network governance structure comprised of LAC DMH leaders possessing visibility and oversight of the full continuum of care. 2.2 Develop a strategic operational plan used by the leadership governance structure to set the direction and prioritize and approve system resources, including pilots and new initiatives. 2.3 Establish a MHP Project Implementation Office and empower them to provide implementation support for the full continuum. This office will ensure that all pilots measure outcomes and will work to identify and scale best practices across the MHP system of care.
3. Lack of Internal Governance Structure for the Full Continuum	*Gap Observation: No single point of accountability and supporting governance/ committee structure for the full continuum of LAC DMH Mental Health Plan.* Recommendations: 3.1 Create a reporting structure that mirrors other Medicaid health plan structures. 3.2 Include in the reporting structure a dyad of a Senior Administrator and a Medical Director. Ensure that all divisions associated with the MHP care and benefits report up to the dyad. 3.3 Develop a Mental Health Plan (MHP) Continuum of Care Committee with leadership team representation that analyzes financial, utilization, quality of care, and system-wide performance against key performance metrics.

Gap Area	Observation and Recommendations
4. Siloed Utilization Management	*Gap Observations: Utilization analysis is siloed by division. LAC DMH needs visibility into the impacts of access (or lack of access) to resources up and down the continuum on bed utilization.* *Multiple systems are used to track utilization; currently there is not a single system showing the full network average length of stay (ALOS) or tracking ALOS trends across the full continuum of care.* Recommendations: 4.1 Develop a data warehouse that all systems feed into to allow for analyses of the full continuum. 4.2 Expand the data analytics team currently focused on outpatient care to encompass data analysis for the entire continuum of care. 4.3 Develop a Utilization Management (UM) Committee with appropriate division representation that analyzes trends in utilization across levels of care and makes recommendations for system-level approaches to trends and gaps identified.
5. Lack of Common Definitions and Terminology for Levels of Care Across LAC DMH Continuum	*Gap Observation: There is a lack of common terminology and definitions for levels of care across the continuum, which can contribute to gaps, double counting of beds, and a confounding of the ability to analyze the actual capacity of the full continuum.* Recommendation: 5.1 Create a commonly accepted data dictionary and language regarding levels of care. Use agreed upon terms in all reporting and dashboards.

3. Visibility and Tools to Support Governance and Oversight

Gap Area	Observation and Recommendation
6. Limited Visibility into Actual Capacity (Used, Needed, Available)	*Gap Observation: <u>LAC DMH needs to improve data and analytic capabilities and tools to effectively manage the full continuum.</u>* Recommendations: 6.1 Develop a MHP dashboard with bed capacity by level of care, utilization trends by level of care, and metrics such as wait time by level of care. 6.2 Build dashboards to give overall system feedback in regular intervals to monitor and respond nimbly to changing system demands and capacity requirements. 6.3 Dedicate system analyst resources to develop, maintain, track, and trend data across the full continuum of care.
7. Limited Visibility into Actual Versus Forecasted Cost of Care by Level of Care	*Gap Observations: Current financial reporting is not sensitive to the specific levels of care in the system. LAC DMH is not currently reporting on budgeted versus actual spend by level of care.* Recommendations:

Gap Area	Observation and Recommendation
	7.1 Develop a specific role of MHP financial analyst who reconciles utilization to invoices, and tracks and trends reimbursements paid by facility and level of care. 7.2 Report budgeted-to-actual and variance analysis for MHP care continuum to the MHP Continuum of Care Committee monthly. Committee to analyze financial, utilization, quality of care, and system-wide performance against key performance metrics.

ROADMAP A: KEY STEPS FOR RECOMMENDATIONS

Throughout 2023, DMH worked with HMA to support the development of the HMA Report by facilitating access to County data, interviews with subject matter experts representing all the relevant DMH Units and providing valuable context on the DMH system of care. DMH took the HMA Roadmap (starting on page 37 of the HMA Report) and transformed it into an initial implementation document. As DMH begins the work, it will build out additional key steps as necessary to meet the recommendations.

RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
		0-90	91-180	181-270	271-360
2.1 To support a full continuum approach, LAC DMH needs to develop a continuum of care network governance structure comprised of LAC DMH leaders possessing visibility and oversight of the full continuum of care.	1-Convene the MHP Continuum of Care Committee with appropriate DMH leadership representation.	X			
3.3 Develop a Mental Health Plan (MHP) Continuum of Care Committee with leadership team representation with responsibility to analyze financial, utilization, quality of care, and system-wide performance against key performance metrics.	2-MHP Continuum of Care Committee to develop a Committee Charter and management and operational philosophy.		X		
1.1 LAC DMH needs to adopt a management and operational philosophy and approach centered on the full continuum of care.	3-MHP Continuum of Care Committee to adopt and implement its Committee Charter and management and operational philosophy.			X	

RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
		0-90	91-180	181-270	271-360
2.2 Develop a strategic operational plan used by the leadership governance structure to set the direction and prioritize and approve system resources, including pilots and new initiatives.	1-Prioritize which capacity approaches by level of impact and level of effort needed to make the changes.	X			
	2-Refine interventions for each level of care (reduce ALOS, increase upstream services, reduce 30-day readmissions, etc.)		X		
	3-Identify accountability structure for strategies.			X	
	4-Develop measurement Key Performance Indicators (KPIs).			X	
	5-Write a strategic operational plan.				X
	6-Adopt and implement a strategic operational plan.				X
3.1 Create a reporting structure that mirrors other Medicaid health plan structures.	1-Confirm a dyadic MHP Leadership Team.	X			
3.2 Include in the reporting structure a dyad of a Senior Administrator and Medical Director. Ensure that all divisions associated with the MHP care and benefits report up to the dyad.	2-Develop a strategy and timeline that operationalizes the proposed reporting structure and includes the proposed new items/units (e.g., analytics team, financial analyst, project implementation office, etc.) and alignment with the County budget process.		X		
2.3 Establish a MHP Project Implementation Office and empower them to provide implementation support for the full continuum. This office will ensure that all pilots measure outcomes and will work to identify and scale best practices across the MHP system of care.	3-Reorganize reporting relationships, roles and functions to support the proposed new structure.			X	

RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
		0-90	91-180	181-270	271-360
5.1 Create a commonly accepted data dictionary and language regarding levels of care. Use agreed upon terms in all reporting and dashboards.	1-Develop DMH standard level of care naming convention and data dictionary including consensus on level of care nomenclature and definitions.	X			
	2-Submit standard level of care nomenclature and data dictionary to the MHP Continuum of Care Committee for adoption across DMH.		X		
4.1 Develop a data warehouse that all systems feed into to allow for analyses of the full continuum.	1-Continuum of Care Committee to have CIOB lead an Ad Hoc Data Workgroup to begin developing a single full continuum data warehouse with integrated data for all levels of care, using the established data dictionary.			X	
	2-Ad Hoc Workgroup to develop and implement cross functional data sharing workflows including enhanced data quality, monitoring, oversight, and parameters.				X
4.2 Expand the data analytics team currently focused on outpatient care to encompass data analysis for the entire continuum of care.	1-Create System Analyst role(s) and initiate process to increase staff resources with alignment to the County budget process.		X		
6.3 Dedicate system analyst resources to develop, maintain, track, and trend data across the full continuum of care.	2-Assign system analyst resources and include the data warehouse, dashboards, utilization management, etc. in their scope of work.			X	
4.3 Develop a Utilization Management (UM) Committee with appropriate DMH division representation that	1-Convene a Utilization Management Committee with appropriate division representation.		X		

RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
		0-90	91-180	181-270	271-360
analyzes trends in utilization across levels of care and makes recommendations for system-level approaches to trends and gaps identified.	2- UM Committee to develop and adopt a Committee Charter including operating principles.		X		
	3- Adopt and implement a Committee Charter that includes its management and operational philosophy.		X		
	4-Develop measurement KPIs.			X	
	5-Identify accountability structure for strategies.			X	
6.1 Develop a MHP dashboard with bed capacity by level of care, utilization trends by level of care, and metrics such as wait time by level of care.	1-Care Continuum Committee to have CIOB develop and implement the dashboard project plans and workflows.			X	
6.2 Build dashboards to give overall system feedback in regular intervals to monitor and respond nimbly to changing system demands and capacity requirements.	2-Define data sources, automated reporting intervals and data platforms for dashboards and financial reporting and variance analysis.				X
7.1 Develop a specific role of MHP financial analyst(s) who reconciles utilization to invoices, and tracks and trends reimbursements paid by facility and level of care.	1-Create Financial Analyst role and initiate process to increase staff resources with alignment to the County budget process.		X		

RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
		0-90	91-180	181-270	271-360
7.2 Report budgeted-to-actual and variance analysis for MHP care continuum to the MHP Continuum of Care Committee monthly.	2-Care Continuum Committee to have Finance prepare budget to actual and variance analysis monthly reports to present to the Committee.				X

During the development of this report, DMH has begun certain efforts to align with the recommendations/key steps including:

- Translated HMA Report roadmap recommendations into the beginning stages of an implementation document (above table).
- DMH has created a Master Bed Tracker with DMH divisions reporting monthly.
- DMH has begun scoping the development of an interim Bed Dashboard with the goal of progressing to a permanent Bed Dashboard.
- DMH has begun using standard level of care naming convention and creation of a data dictionary.

ROADMAP B: REGULATORY, POLICY, FINANCIAL AND CONTRACTING

The roadmap below identifies regulatory, policy, financial or contracting issues that may impact DMH's ability to manage its network. It also includes recommendations for addressing these issues. Identification of these issues was initiated in a 2023 DMH Root Cause Analysis project lead by the DMH Health Access and Integration (HAI) Unit and was supplemented through key informant interviews facilitated by HMA.

REGULATORY, POLICY, FINANCIAL & CONTRACTING ROADMAP						
Regulatory / Legal	Policy	Financial	Contracting	ISSUES	IMPACTS	RECOMMENDATIONS & KEY STEPS
		X		Medi-Cal mobile crisis funding opportunity	DHCS BHIN 23-025 has established mobile crisis services as a new benefit in the Medi-Cal program. Medi-Cal behavioral health delivery systems in LA County shall have the benefit fully implemented by December 31, 2023.	Leverage the State opportunity to use Medi-Cal funds to increase capacity in Mobile crisis supports.
X	X	X		Medicaid reimbursement is prohibited for IMD beds	Institute for Mental Disease (IMD) is a federal designation for inpatient psychiatric facilities that treat more than 16 people at a time. The County cannot use Medicaid dollars to pay for IMD facilities unless there is an IMD waiver in place with Centers for Medicare and Medicaid Services (CMS). There is no IMD waiver in place for CA at this time so DMH must use County Realignment Funds to pay for these services.	In developing more acute inpatient capacity, focus on 16 or fewer bed facility contracts (until IMD waiver can be instituted).

Regulatory / Legal	Policy	Financial	Contracting	ISSUES	IMPACTS	RECOMMENDATIONS & KEY STEPS
	X			MHSA funds are not eligible to pay for locked beds	Prop 1 might address this and allow for BHSA funds to be spent for new acute care inpatient psychiatric beds.	Continue to monitor this policy change potential.
X				Conflicting SNF-STP licensing requirements	Skilled Nursing Facility-Special Treatment Program (SNF-STP) facilities are required to gradually reduce medications for clients under their care or risk a citation from licensing entity. If they wean patients off psychiatric medications, then clients can destabilize. As a result, if there are assaults or incidents the facility can be cited for maintaining an unsafe environment.	Advocate for legislative reform for SNF-STPs
			X	Missing a level of subacute care	There seems to be a gap in the levels of care when stepping down some clients from locked sub-acute facilities which contributes to long lengths of stay.	Develop a subacute level of care that offers day treatment and medication services, has more staff supervision, but is not a locked facility.
			X	DMH's current approach to contracting restricts the MHP	Because of the way DMH contracts, it can impact our access to the correct level of care. For example, DMH has a historical practice of not paying to hold beds or pay a premium to have beds exclusively available to the County. Yet long waiting lists with long wait times means that DMH is paying premium acute inpatient care rates for people who are waiting for a subacute bed.	In levels of care with the greatest shortages (e.g., sub-acute) and longest wait times, consider creating capacity agreements with providers that pay for guaranteed access to DMH clients (with some ability to deny for clinical reasons). Monitor the average daily census (ADC) of capacity beds closely. For example, requiring 90% occupancy or better can tie quality or capacity withholds for not meeting an ADC of

Regulatory / Legal	Policy	Financial	Contracting	ISSUES	IMPACTS	RECOMMENDATIONS & KEY STEPS
						90% or more or give incentives that can be earned for running at 95% occupancy or better.
			X	More attention needs to be paid to expand the contract mechanisms of the MHP to meet its network requirements.	The County contracting process is long and there are many requirements, so providers have a hard time becoming a County provider which can impact the MHP network.	Work with County Counsel to understand which County contracting requirements must be applied to the MHP and which requirements can be carved out from the MHP to protect network adequacy.
	X	X	X	Clients with a history of sex offenses, fire setting or other high acuity needs are difficult to place.	This creates discharge and placement issues which can lead to reduced bed capacity in acute levels of care.	Ensure there is a policy or contract clause that does not allow providers to discriminate against difficult to place clients. Expand on current incentive payments to further incentivize facilities to accept difficult to place clients. Ensure that providers who accept difficult to place clients receive the right training and support from DMH.

Regulatory / Legal	Policy	Financial	Contracting	ISSUES	IMPACTS	RECOMMENDATIONS & KEY STEPS
			X	The number of clients or potential clients eligible for a level of care is increasing.	With initiatives and new legislation that expand access to the MHP continuum there will be an increased demand for beds.	Use a governance structure (further referenced in the report recommendations) to consider up and downstream impacts of new initiatives such as ACR, BH-CONNECT, CalAIM JI, SB 43, jail closure, diversion and reentry efforts, and field-based interventions for homeless populations. For each identified initiative, assess if a new project adds capacity or demands capacity within and across the continuum of care. In the event a new project demands capacity, identify the resources needed to appropriately implement the project.

During the development of this report, DMH has begun certain efforts to align with the recommendations/key steps including:

- DMH launched a pilot program to test guaranteed beds for field-based teams.
- DMH has leveraged single case agreements, as needed.
- DMH received Round 3 BHCIP funds to support construction on the LA General Hospital campus of a 128 bed MHRC facility with eight 16 bed pods.

Recommended Actions for the Board of Supervisors

To support the implementation of key report recommendations, DMH is recommending that the Board of Supervisors take the following actions proposed over the next 12-months.

	Apr-Jun 2024	Jul-Sep	Oct-Dec	Jan-Mar 2025
1-Direct DMH to prioritize the key steps recommended in Roadmaps A and B and move forward with implementation.	→	→		
2-Direct DMH to develop a strategy and implementation plan to address the four key recommendations from the HMA Report: 1-strengthening DMH's internal governance and oversight of the full continuum of mental health resources with specific recommendations on the changes appropriate to achieve the proposed governance structure; 2-expanding the capacity of DMH's subacute level of care; 3-developing County strategies to reduce the 30-day readmission rates; and 4-aligning HMA's systemic gaps roadmap (Roadmap A) with DMH's internal analysis roadmap of regulatory, policy, financial and contracting issues (Roadmap B).	→	→	→	
3-Direct DMH to map client flows and treatment capacity across the continuum factoring in anticipated increases in client volumes from programs such as SB 43, CalAIM Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, and the CalAIM PATH Justice Involved Initiative.	→	→		
4-Direct DMH to report back in 180 days on the progress of directives 1, 2, and 3 and then annually thereafter.		X		
5-Direct DMH to continue to do stakeholder outreach to inform the assumptions used in the DMH forecasting model that will generate projections and targeted ranges for bed needs.	→	→	→	→

HMA

HEALTH MANAGEMENT ASSOCIATES

Mental Health Resources Planning

PRESENTED TO

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

FEBRUARY 2024

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

Table of Contents

Executive Summary

The Los Angeles County Department of Mental Health (LAC DMH) has engaged Health Management Associates (HMA) to assess the County's mental health service continuum. This project is in response to a January 24, 2023, Board Motion, "Establishing a Roadmap to Address the Mental Health Bed Shortage", and is focused on developing a roadmap for the current system, identifying service gaps, developing a comprehensive roadmap to address the specific gaps, and building upon a smaller scope *Behavioral Health Forecasting Model* developed by HMA in late 2022/early 2023 through a Behavioral Health Continuum Infrastructure Program (BHCIP) planning grant.

The project builds on other previous assessments conducted for LAC DMH, seeking to refresh the data in light of updates to the system of care and other significant impacts related to the COVID-19 pandemic. The forecasting tools were developed as an outflow of the BHCIP work. These tools were designed to give LAC DMH visibility into the specific gap areas and levels of care that would benefit from immediate expansion. The tools developed give LAC DMH the ability to see capacity demands from two important vantage points. The first approach gives a view of the expected demands for resources, including beds and outpatient services based on the burden of mental illness across the County's population. The second approach provides a forecasting based on actual utilization experience of the LAC DMH system. By considering both models, LAC DMH can plan for anticipated capacity needs with strategies that are responsive to the population while avoiding over- building the system of care.

The turbulence of the COVID-19 pandemic, increases in economic insecurity and homelessness, and changes in our approach to criminal justice are placing greater demand on the array of services configured and managed by the LAC DMH. Over the past three years, the County has initiated task forces, internal work groups, and consultant studies examining components of the BH continuum, such as acute and subacute beds for jail diversion, but there has not been a comprehensive approach to looking at the full continuum of services ranging from outpatient to residential to inpatient services.

In this report, HMA provides recommendations to strengthen the management of the LAC DMH continuum of care and estimates of beds and other care resources needed. The recommendations are informed by key informant interviews of LAC DMH leaders, incorporation of state and national approaches to measuring behavioral health (BH) capacity and system resources, and a proposed roadmap to address the gaps identified in the continuum.

Key Findings

Strengths

Based on key informant interviews, data analyses and reviews, program descriptions, and reviews of previous related reports, HMA found many strengths in the system, including the following:

- LAC DMH staff are engaged and passionate about providing excellent care to LA County residents. They are interested in designing pilots to improve quality and outcomes for the people they serve.
- There are currently several pilot projects in progress designed to address inpatient overstays and readmissions. The energy and intention being directed to these efforts represent strengths.
- The development of the Mental Health Resource Locator Navigator (MHRLN) system is of significant benefit to LAC DMH. Capturing the level of detail and granularity of admission and referral-to-admission data gives LA County the opportunity to build reports with actionable intelligence about how the system is working.
- LAC DMH has been building a unified bed dashboard that will give visibility to the available capacity by facility. This tool will be updated regularly and will significantly improve the County's ability to estimate the current capacity for each level of care at any given point in time.
- The County has been working to create diverse payment incentives to increase the capacity and acceptance rates of the most difficult-to-place individuals. This approach has allowed the County to increase capacity for those clients who would have otherwise boarded in emergency departments (EDs) for long periods of time or experienced excessively long stays in acute inpatient units awaiting placement.

Gaps and Recommendations

In working to develop a full picture of the continuum of care that impacts the demand for inpatient, residential, and supported housing beds, HMA found three key systemic gaps which impact the ability of LAC DMH to make data-driven decisions about which parts of the system have the greatest impact on bed capacity.

I. Importance of a Full Continuum Approach to Mental Health Resources

Effective and efficient mental health care requires a full continuum of services, from outpatient to crisis intervention, acute inpatient treatment, subacute treatment, and an array of supportive housing services. While each level of care provides distinctly different services, they are interrelated from a care delivery perspective. As examples:

- When the supply of subacute treatment facilities is reduced, it creates a backlog in the acute inpatient care settings caused by clients who are ready to move to the next level of care but who no longer have safe places to discharge.
- Adding capacity in crisis resolution and triage care can reduce the demand for acute inpatient care beds by giving clients the care they need earlier in the process and preventing decompensation requiring an acute inpatient level of care.

These examples illustrate that the services, while separate, are interdependent and comprise a full continuum of care. While one level of care may experience a gap or note a need for increased capacity, the LAC DMH is currently unable to develop service planning estimates to consider whether the gap can be more appropriately filled by another part of the system of care.

Table 1. Full Continuum Approach Recommendation

Gap Area	Observation and Recommendation
1. Need for Stronger Operational Approach to Manage the Full Continuum to Mental Health Resources	*Gap Observation: The current LAC DMH system is managed in separate databases with siloed oversight. As a result, LAC DMH has limited visibility into the access, availability, and resources for the full continuum of care.* Recommendation: 5.1 LAC DMH needs to adopt a management and operational philosophy and approach centered on the full continuum of care.

II. Internal Governance and Oversight

The Medi-Cal Specialty Mental Health services organized and financed by LAC DMH for Medi-Cal beneficiaries in the County brings unique requirements. As a Medicaid managed care entity, LAC DMH needs to ensure alignment of clinical, financial, operational, and compliance functions. Internal governance needs to be in place to ensure alignment, and LAC DMH should consider some organization re-alignments to bring managed care functions closer together and thus reduce the challenge of coordinating across organization reporting lines. Internal governance and organization realignments would ensure better coordination between levels of care and provides oversight and direction to address the impacts of changing capacity at different levels to system of care.

The following table provides the internal governance and oversight gaps identified through the assessment and recommendations to address those gaps.

Table 2. Internal Governance and Oversight Gaps Recommendations

Gap Area	Observation and Recommendations
2. Siloed Oversight	*Gap Observation: Structure of oversight and areas of responsibility are siloed with very few leaders who have visibility and responsibility for the total system of care.* Recommendations: 2.1 To support a full continuum approach, LAC DMH needs to develop a continuum of care network governance structure comprised of LAC DMH leaders possessing visibility and oversight of the full continuum of care. 2.2 Develop a strategic operational plan used by the leadership governance structure to set the direction and prioritize and approve system resources, including pilots and new initiatives. 2.3 Establish a Mental Health Plan (MHP) Project Implementation Office and empower them to provide implementation support for the full continuum. This office will ensure that all pilots measure outcomes and will work to identify and scale best practices across the MHP system of care.

Gap Area	Observation and Recommendations
3. Lack of Internal Governance Structure for the Full Continuum	*Gap Observation: No single point of accountability and supporting governance/ committee structure for the full continuum of LAC DMH MHP.* Recommendations: 3.1 Create a reporting structure that mirrors other Medicaid health plan structures. 3.2 Include in the reporting structure a dyad of a Senior Administrator and a Medical Director. Ensure that all divisions associated with the MHP care and benefits report up to the dyad. 3.3 Develop a MHP Continuum of Care Committee with leadership team representation that analyzes financial, utilization, quality of care, and system-wide performance against key performance metrics.
4. Siloed Utilization Management	*Gap Observations: Utilization analysis is siloed by division. LAC DMH needs visibility into the impacts of access (or lack of access) to resources up and down the continuum on bed utilization.* *Multiple systems are used to track utilization; currently there is not a single system showing the full network average length of stay (ALOS) or tracking ALOS trends across the full continuum of care.* Recommendations: 4.1 Develop a data warehouse that all systems feed into to allow for analysis of the full continuum. 4.2 Expand the data analytics team currently focused on outpatient care to encompass data analysis for the entire continuum of care. 4.3 Develop a Utilization Management (UM) Committee with appropriate division representation that analyzes trends in utilization across levels of care and makes recommendations for system-level approaches to trends and gaps identified.
5. Lack of Common Definitions and Terminology for Levels of Care Across LAC DMH Continuum	*Gap Observation: There is a lack of common terminology and definitions for levels of care across the continuum, which can contribute to gaps, double counting of beds, and a confounding of the ability to analyze the actual capacity of the full continuum.* Recommendation: 5.1 Create a commonly accepted data dictionary and language regarding levels of care. Use agreed upon terms in all reporting and dashboards.

III. Visibility and Tools to Support Governance and Oversight

LAC DMH needs to strengthen availability of data and analytics to be able to have a "total view" of the continuum of care and support governance and oversight. The following table outlines data and analytic gaps and provides recommendations to address those gaps.

Table 3. Visibility and Tools to Support Governance and Oversight

Gap Area	Observation and Recommendation
6. Limited Visibility into Actual Capacity (Used, Needed, Available)	*Gap Observation: LAC DMH needs to improve data and analytic capabilities and tools to effectively manage the full continuum.* Recommendations: 10.1 Develop a MHP dashboard with bed capacity by level of care, utilization trends by level of care, and metrics such as wait time by level of care. 10.2 Build dashboards to give overall system feedback in regular intervals to monitor and respond nimbly to changing system demands and capacity requirements. 10.3 Dedicate system analyst resources to develop, maintain, track, and trend data across the full continuum of care.
7. Limited Visibility into Actual Versus Forecasted Cost of Care by Level of Care	*Gap Observation: Current financial reporting is not sensitive to the specific levels of care in the system. LAC DMH is not currently reporting on budgeted versus actual spend by level of care.* Recommendations: 7.1 Develop a specific role of MHP financial analyst who reconciles utilization to invoices, and tracks and trends reimbursements paid by facility and level of care. 7.2 Report budgeted-to-actual and variance analysis for MHP care continuum to the MHP Continuum of Care Committee monthly. Committee to analyze financial, utilization, quality of care, and system-wide performance against key performance metrics.

Conclusion

As the mental health agency serving the most populous county in the nation, LAC DMH has a critical role to play in the community. LAC DMH has a varied portfolio of functions ranging from providing and organizing care for the most vulnerable to community-wide services like crisis intervention and prevention and early intervention. The Medi-Cal Specialty Mental Health segment of the LAC DMH is among its most significant obligations in which LAC DMH needs to ensure alignment of clinical, financial, operational, and compliance functions.

This report provides an assessment, recommendations, and tools for LAC DMH to strengthen its internal governance and oversight of the full continuum of mental health resources for which is organizes and manages. Adoption of these changes will improve LAC DMH's ability effectively plan and manage the mental health safety net in the County.

Introduction

LA County comprises a vast geography of more than 4,000 square miles and has a population of nearly 10 million. That scale is coupled with factors such as high proportion of the population in poverty; ethnic and linguistic diversity; and wide income and wealth disparities. In many ways, overall health, well-being, and economic indicators for Los Angeles show it ranking well in comparison to many states and developed nations, but those indicators mask challenges within our communities where significant gaps and disparities exist.[1]

More recently, the turbulence of the COVID-19 pandemic, increases in economic insecurity and homelessness, and changes in our approach to criminal justice are placing greater demand on the array of services configured and managed by the LAC DMH.

Over the past three years, the County has initiated task forces, internal work groups, and consultant studies examining components of the BH continuum, such as acute and subacute beds for jail diversion, but there has not been a comprehensive approach to looking at the full continuum of services ranging from outpatient to residential to inpatient services.

This project is in response to a January 24, 2023, Board Motion "Establishing a Roadmap to Address the Mental Health Bed Shortage" and is focused on developing a roadmap for the current system, identifying service gaps, developing a comprehensive roadmap to address the specific gaps, and building upon a smaller scope Behavioral Health Forecasting Model developed by HMA in late 2022/early 2023 through a Behavioral Health Continuum Infrastructure Program (BHCIP) planning grant.

The project builds on other previous assessments conducted for LAC DMH, seeking to refresh the data in light of updates to the system of care and other significant impacts related to the COVID-19 pandemic. The forecasting tools were developed as an outflow of the BHCIP work. These tools have been designed to give LAC DMH visibility into the specific gap areas and levels of care that would benefit from immediate expansion.

The tools developed give LAC DMH the ability to see capacity demands from two important vantage points. The first approach gives a view of the expected demands for resources, including beds and outpatient services based on the burden of mental illness across the County's population. The second approach provides a forecasting based on actual utilization experience of the LAC DMH system. By considering both models, LAC DMH can plan for anticipated capacity needs with strategies that are responsive to the population while avoiding over- building the system of care. These tools support recommendations for the number of beds and other care resources needed within the system.

These forecasting and analytic tools aim to enhance the LAC DMH's capacity to meet the diverse BH needs of its residents. HMA has coupled these models with takeaways from discussions and interviews with key LAC DMH operational and executive leaders to address relevant elements such as clinical model design, new operational demands, and policy and funding trends. Lastly, HMA provides in this report a comprehensive roadmap by which LAC DMH can address identified gaps in the continuum of care and consider best practices and other recommendations for ongoing improvement and

[1] Portrait of Los Angeles County: https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/bb6d2970-95f3-4607-b4f9-2f90d426f833/01%20Portrait%20of%20Los%20Angeles%20County%20%2811-28-2017%29%20%282%29.pdf

transformation of the MHP system, so that individuals in LA County have access to the high-quality BH care they need and deserve.

Background

Los Angeles County Department of Mental Health

LAC DMH is the principal entity organizing, administering, and delivering specialty mental health care in the County. It is a multifaceted agency with a number of concurrent functions, including but not limited to:

- Ensuring a range of outpatient, residential, and inpatient services for the County's Medi-Cal and low income populations;
- Providing a range of community-wide services ranging from crisis intervention, prevention and early intervention, civil commitment, and conservatorships;
- Planning and delivering services specified in California's Mental Health Services Act (MHSA); and
- Providing specialized services for child welfare and juvenile justice populations.

LAC DMH accomplishes these functions through a range of directly operated and contracted providers. The service array for mental health in Los Angeles County is outlined by the following figure.

Table 4. Service Array for Mental Health in Los Angeles County

Types of Clients	Children and Adults with Medi-Cal Coverage		Uninsured	Children and Adults (All Groups)
Services	Mild to Moderate	Severe and Persistent Mental Illness (SPMI)	Full Continuum	Prevention and Early Intervention; Full-Service Partnerships (FSPs)
Service Responsibility	Medi-Cal Managed Care Plans (L.A. Care and Health Net)	LAC DMH	LAC DMH	LAC DMH

LAC DMH is financed by a mix of local, state, and federal funding streams including Medi-Cal, Realignment funds, and MHSA resources. Importantly, the non-federal share of the Medi-Cal program that LAC DMH administers, known as Specialty Mental Health Services (SMHS), is funded through Realignment sales tax funds allocated to counties. Both Realignment and MHSA revenues are volatile and sensitive to changes in the economy, making it very important for the County to carefully forecast revenues and expenditures.

Thus, LAC DMH is simultaneously a system organizer, a payer of care, and a deliverer of care. These combined functions require LAC DMH to not only be concerned and up to date on clinical practice, but also on how best to organize and manage a large, complex portfolio of services in an effective and efficient manner.

Health Insurance Coverage in Los Angeles County

Health insurance coverage is a strong indicator for the range of services LAC DMH needs to consider when planning and organizing mental health care in the County. The following table provides a snapshot of health coverage in Los Angeles by major sources of coverage. As shown in the table, more than 30% (3.1 million) of the County's population is covered by Medi-Cal or uninsured. It is for these segments of the populations that LAC DMH has primary responsibility for organizing mental health care.

Table 5. Health Coverage in Los Angeles County by Major Sources of Coverage

Type of current health insurance coverage - all ages									
	Service Planning Area								Total
	1 AV	2 SFV	3 SGV	4 Metro	5 West	6 South	7 East	8 South Bay	
Uninsured	22,000	98,000	113,000	114,000	-	142,000	68,000	134,000	695,000
Medicare & Medicaid	17,000	85,000	47,000	83,000	40,000	67,000	73,000	62,000	474,000
Medicare & Others	32,000	250,000	146,000	99,000	111,000	61,000	89,000	179,000	967,000
Medicare only	7,000	44,000	28,000	7,000	23,000	17,000	16,000	25,000	168,000
Medicaid only	125,000	467,000	342,000	312,000	29,000	383,000	385,000	371,000	2,414,000
Employment-based	159,000	1,004,000	931,000	410,000	369,000	275,000	558,000	672,000	4,377,000
Privately purchased	6,000	116,000	94,000	59,000	56,000	18,000	59,000	28,000	437,000
Other public	5,000	16,000	9,000	19,000	-	5,000	9,000	18,000	81,000
Total	373,000	2,082,000	1,709,000	1,102,000	631,000	969,000	1,257,000	1,490,000	9,613,000

Note: missing data due to sample size. Source: 2022 California Health Interview Survey

Mental Health Burden

The proportion of the County's population with severe mental health burden is an indicator of the potential size of the service population for LAC DMH. The State of California has estimated the burden of mental illness at the county level for the overall population and for the population under 200% of the Federal Poverty Level.[2] The following table provides the estimated burden of mental illness in the County.

The table suggests that roughly 300,000 of the County's low-income population have severe mental health burden. This represents a narrow view of mental health burden because the estimates are heavily based on utilization experience, which does not reflect individuals with morbidity who did not, or were unable to, access care.

[2] California Department of Health Care Services, https://www.dhcs.ca.gov/provgovpart/Documents/California%20Prevalence%20Estimates%20-%20Introduction.pdf

Table 6. Estimates of Burden of Mental Illness in Los Angeles County

	Estimates of Severe Mental Health Burden in Los Angeles County					
	Total Population			Total Below 200% FPL		
	Cases	Population	Percent	Cases	Population	Percent
Countywide Population	525,468	9,848,011	5.34	308,881	3,850,659	8.02
Youth (0-17)	195,233	2,502,78	7.8	113,979	1,273,470	8.95
Adult (18+)	330,235	7,345,224	4.5	194,901	2,577,189	7.56

Source: Adapted from California Mental Health Prevalence Estimates

The State also computed prevalence estimates using criteria that include lower-level conditions than severe mental illness. The following table provides estimates of the County using a broader definition of mental health burden. The table suggests that more than 725,000 of the County's low-income population have mental health burden.

Table 7. Estimates of The County Using A Broader Definition of Mental Health Burden

	Estimates of Mental Health Burden (Broader Definition) in Los Angeles County					
	Total Population			Total Below 200% FPL		
	Cases	Population	Percent	Cases	Population	Percent
Countywide Population	1,419,709	9,848,011	14.42	725,510	3,850,659	18.84

Source: Adapted from California Mental Health Prevalence Estimates

Review of Prior Reports

One goal for this assessment was to build upon previous research. A review of prior reports on the mental health continuum of care and bed utilization in LA County was conducted to help better understand the current state as well as, what data sources may be available for the purpose of this assessment, and to inform our methodology. The reviewed reports included:

1. 2019 Mercer Report on Shortage of Mental Health Hospital Beds
2. 2021 Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California
3. Men's Central Jail Closure Plan: Achieving a Care First Vision
4. Medi-Cal Specialty Behavioral Health External Quality Review (EQR) August 2023

2019 Mercer Report on Shortage of Mental Health Hospital Beds[3]

Mercer Health & Benefits LLC highlighted the complex problem of assessing the availability of mental health hospital beds and the limitations of point-in-time capacity projections. Hospital bed availability in the system is a function of what happens before and after a given hospital stay, including pre-hospital services (e.g., Urgent Care, Psych Emergency Room, Mobile Response, Crisis Residential), and post-hospital services (e.g., Subacute Care, State Hospitals, Residential Care, Supportive Housing), as depicted in the figure below:

[3] https://file.lacounty.gov/SDSInter/coc/co/1105240_DMHBedReport_Oct2019_andStatusUpdate_Dec2020_.pdf

Figure 1. Pre and Post Hospital Stays for Mental Health

Source: 2019 Mercer Report

Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California-2021[4]

The RAND Corporation's (herein referred to as "RAND") report examined variations in adult psychiatric bed capacity, need, and shortage across three major levels of care: acute (for those with high acuity, shorter term needs – days to weeks), subacute (for those with moderate-to-high acuity, longer-term needs – multiple months) and community residential care (for those with lower acuity and longer-term needs focused on recovery – multiple years).

Findings across both reports, specific to LA County, are summarized in Table 8. Key Findings of Mercer and RAND Reports

below. Both reports highlight the shortage for subacute and community residential beds for adults. The RAND report suggests no shortfall in acute beds, while the Mercer report suggests some shortfall in acute capacity. This difference is due to different analytic methods between RAND and Mercer. The Mercer report differs from the RAND report in that Mercer examined beds for youth as well as substance use disorder (SUD) and crisis services, and highlighted needs in those areas.

Table 8. Key Findings of Mercer and RAND Reports

Mercer Report	RAND Report (LA County-portion)
Key Findings	
• Estimated approximately 10-15% of persons with severe mental illness (equal to 19,600 - 29,400 individuals) will utilize an acute or subacute care setting each year. • Projected increase of ~10,000 users by 2022. • Estimated population growth in mental health needs in next five years is 2-6% for children/adolescents; 4-8% for adults with mental health issues; and 5-10% for persons with SUD (age 12+). • Access to crisis and inpatient resources is insufficient. • Care coordination and continuity of care are lacking, particularly for people of color and non-English speakers.	• Estimated psychiatric bed capacity need for adults (age 18+) in 2021. • No shortfall in acute psychiatric beds. • Shortfall in subacute (400 beds) and community residential beds (900 beds). • Specific hard-to-place populations contribute disproportionately to bottlenecks. Across all levels, these include those with co-occurring dementia or traumatic brain injury (TBI), non-ambulatory individuals, those who are COVID-19 positive, and those who need oxygen; in community residential settings, hard-to-place populations include justice-involved individuals, especially those with arson or sexual offense convictions.

[4] https://www.rand.org/pubs/research_reports/RRA1824-1-v2.html

	• Quality information about psychiatric facilities is lacking (especially licensure data), challenging the ability to track bed occupancy, wait lists, transfer requests to different levels of care, and boarding in EDs. • No review of SUD treatment needs/capacity.
Recommendations	
Develop more acute, subacute beds and community services: ○ Add 12 child and 32 adult beds in acute inpatient hospital settings; ○ Add 1,508 adult beds to subacute settings; ○ Expand SUD bed capacity of 150-400 beds depending on type of residential facility; ○ Develop more residential treatment beds and services which provide longer-term care; ○ Improve quality of care and client transitions across subacute and residential treatment beds and services; and ○ Standardize an approach to assessing network adequacy and other system improvements.	• Focus on subacute and community residential beds. • Focus on building infrastructure for hard-to-place populations. • Establish a mechanism for reporting on bed occupancy rates, wait list volume, transfer requests, and psychiatric boarding in EDs.

Men's Central Jail Closure Plan: Achieving a Care First Vision[5]

The Office of Diversion and Reentry and the LA Sheriff's Department convened a workgroup to capitalize on a historic opportunity presented by the COVID-19 public health emergency (PHE) to realize alternatives to incarceration and shift to a "Care First, Jail Last" approach. The plan to close Men's Central Jail and achieve a jail population reduction included three key components: facilities plan to redistribute the existing jail population among existing facilities; a community plan to expand community-based system of care to serve vulnerable individuals released or diverted from jail to avoid repeat incarceration; and a diversion plan to move approximately 4,500 individuals out of jail. The Care First vision will require implementing a diversion plan that involves community strategies and system solutions for new service models. The workgroup identified several target groups for diversion, prioritizing those with serious mental health needs to address significant racial disparities.

Based on a RAND study, the report noted that 61% of the mental health population in LA county jails could be diverted out of jail (~3,600 of 6,000 individuals). To support the successful transition of these diverted individuals, "many of whom have serious mental health, medical and/or substance use needs," building the capacity of a system of care to support community pathways from jail is critical. These pathways need to include a range of health, mental health, and SUD treatment needs, creating capacity

[5] https://file.lacounty.gov/SDSInter/bos/bc/1104568_DEVELO_1.PDF?_ga=2.150323573.2146998256.1657211988-504140296.1599672143&_gl=1*wrrd5d*_ga*NTA0MTQwMjk2LjE1OTk2NzIxNDM.*_ga_P89HFNJ6PB*MTY1NzIxODkyNC4zLjEuMTY1NzIxOTEyNS4w*_ga_HYDNR8V2E5*MTY1NzIxODkyNC4zLjEuMTY1NzIxOTEyNS4w#search=%22jail%22

to support a continuum of community-based options with supportive services, treatment, and housing options matched to assessed needs. The committee recommended the following:

- Expanding residential programs that serve justice-involved populations by 4,000 beds within 18-24 months, prioritizing the mental health population.
    - Specifically, this includes adding 3,600 beds for community-based mental health care and approximately 400 beds for those with serious medical, SUD and/or housing needs within 36 months.
- Expanding enhanced services that support people with mental health and substance use needs in field-based programs to support individuals served across a range of housing options.

Medi-Cal Specialty Behavioral Health External Quality Review (EQR) August 2023[6]

The most recent external quality review (EQR) report recognizes multiple strengths and system improvements for fiscal year (FY) 2022-2023. These include the expanded Peer Resource Centers (PRC), Hollywood 2.0 improvements, a therapeutic transportation program (TT), and the information technology (IT) strategic plan. The EQR noted several opportunities for improvement that impact the system capacity, including a continuing high 30-day readmission rate of 30.18%, the need for a system-wide level of care (LOC) tool for adults and improvements in the feedback loop to give leaders better visibility into wait times for services and the functionality of the corrections/ law enforcement (C/LE) providers.

The report acknowledged other significant improvements such as the Emergency Outreach and Triage Division (EOTD), which developed 24/7 capacity to resolve crises in the communities, ensuring resources are available in a timely manner. This includes the addition of peer staff to the Psychiatric Mobile Response Teams. The TT Program integrates LAC DMH psychiatric nursing personnel and other staff into emergency response to 911 calls that go straight to fire or police departments.

The report showed the following metrics related to access and utilization in LA County.

[6] FY 2022-2023 Medi-Cal Specialty Behavioral Health External Quality Review August 2023. https://www.caleqro.com/data/MH/Reports and Summaries/Prior Years Reports and Summaries/Fiscal Year 2022-2023 Reports/MHP Reports/Los Angeles MHP EQR Revised Final Report FY 22-23 RW 1.18.23 Rev. 8.15.23.pdf

Table 9. Access and Utilization In LA County

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

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

Source FY 2022-2023 Medi-Cal Specialty Behavioral Health External Quality Review August 2023.

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

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

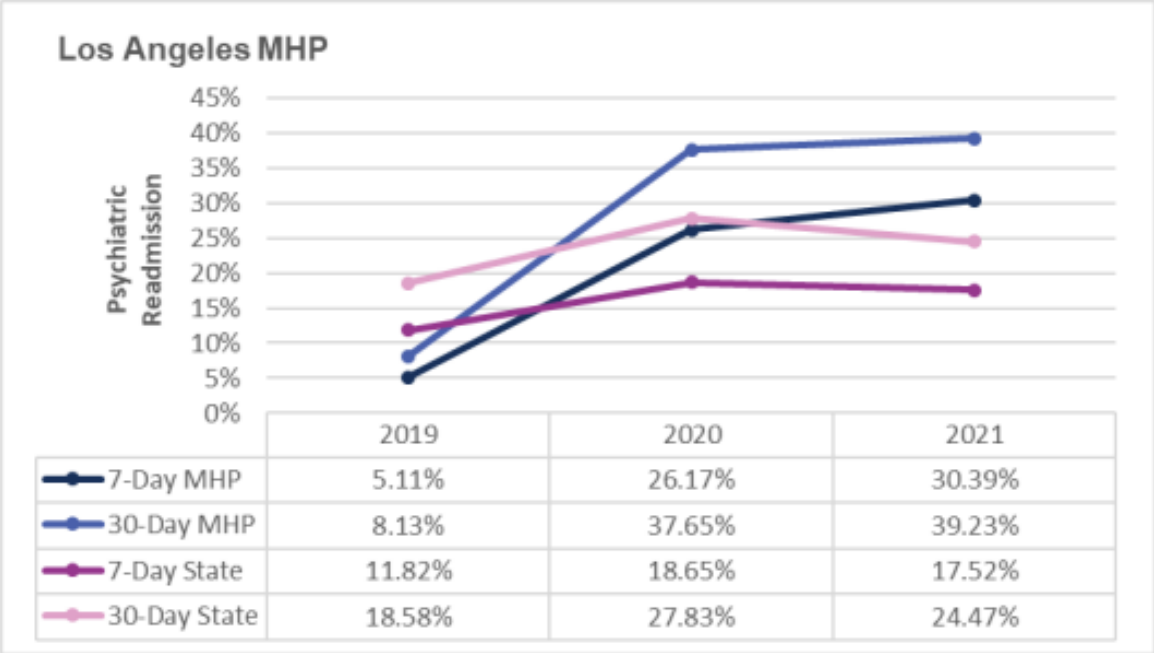
Source: FY 2022-2023 Medi-Cal Specialty Behavioral Health External Quality Review August 2023.
Note re: missing data: Per CalEQRO, "To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts."

The EQR noted that LA County adults receive fewer crisis intervention and targeted case management (TCM) services compared to the rate of use in the State. However, the numbers reflect that when LA County residents do receive these services, they receive a higher number of units of care than their

counterparts in other parts of California. The EQR study also found that a higher percentage of beneficiaries receive inpatient services than the statewide average. Another data finding from the EQR report that impacts inpatient bed capacity is that for youth in foster care, their bed utilization is, on average, two days longer than their counterparts in the rest of the state.

Lastly, the EQR report showed that LA County has a significantly higher 30-day readmission rate compared to the state average as seen in the table below.

Figure 2. 7-Day and 30-Day Psychiatric Readmissions Rates CY2019-21



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

Source: EQR report

The impact of the dynamics shown above is that a higher number of individuals using beds, paired with a longer length of stay and a higher 30-day rehospitalization rate, combine to reduce the inpatient bed capacity in LA County.

HMA Project Approach

Model Development

This project is focused on developing capabilities for LAC DMH to estimate service demand. HMA has approached this topic by developing two approaches to answer service planning questions.

One approach is utilization-based, using LAC DMH's actual service history to model future service use. This model uses a utilization approach and provides a window into how the service system is actually functioning. The Utilization Model (U) projects unique client counts and service utilization volume for the full mental health care continuum for FY2024-25 (July 1, 2024 - June 30, 2025). It is organized by

levels of care, service/setting types (i.e., sub-units), age groups, and mental health/substance use disorder (MH/SUD) co-occurring statuses.

The model is based on data pulled from LAC DMH's IBHIS (2022) and includes experience-informed utilization trend factors. The Utilization Model also provides upper and lower bound projections so the LAC DMH service projections can be expressed as ranges depending on service need and/or changes in service configuration, and system performance.

The other approach is a high-level estimation of service demand based on the proportion of the County population for which LAC DMH has service responsibility. This model can be expressed as:

Service Populations X Service Take-Up Rate = Estimated Outpatient, Residential and Inpatient Care

The High-Level model (HL) is subject to a series of assumptions about the prevalence of mental health burden and access to care (i.e., the take-up rate for services), and does not factor in some issues like geographic distance and language which can present barriers to care.

LAC DMH's use of the two models – High Level (HL) and Utilization (U) can provide useful insights about how "the system" should run versus how it actually runs.

HMA used the following array of services for the resource planning models.

Table 10. Distinct Levels of Care

Level of Care	Sub-Unit
Crisis Resolution and Triage	Psychiatric Emergency Rooms, Urgent Care Centers (UCC), Crisis Stabilization Units (CSU)
Acute Inpatient	Fee For Service (FFS) Hospitals (Including Freestanding)
	County/DHS Operated Hospitals
	Short-Doyle Facilities
	Psychiatric Health Facilities (PHF)
Subacute	State Hospitals
	General
Crisis/Extended Residential	Enriched Residential Services (ERS) - Residential Services
	Crisis Residential Treatment Programs (CRTPs)
Housing	Enriched Residential Care (ERC)
	Interim Housing
	Permanent Supportive Housing (PSH)
Outpatient	Enriched Residential Services (ERS) - Outpatient Services Component
	Short-Term Residential Therapeutic Program (STRTP) – Outpatient Services Component
	Directly Operated (DO)
	Legal Entity (LE)
	Day Treatment and Rehabilitation

Outputs of Service Planning Models

This section details the outputs of the two models – Utilization (U) and High Level (HL) – developed by HMA.

Output 1: Clients Served vs. Potential Clients Forecasted

The following table provides a comparison of unique clients derived by the HMA Utilization Model vs. estimated clients derived by the HMA High Level model. The Utilization model is based on 2022 data, and the High-Level model is based on 2025 population projections by the California Department of Finance. As anticipated, in general, the actual number of clients served are less than the potential estimated clients, but in a number of service categories DMH serves a high proportion of estimated clients.

Table 11. Clients Served vs. Potential Clients Forecasted

	Client Comparison: HMA Utilization model (U) vs. HMA High Level model (HL)									
	Children (00-15)		TAY (16-25)		Adult (26-59)		Older Adult (60+)		TOTAL	
Level of Care	**U**	**HL**	**U**	**HL**	**U**	**HL**	**U**	**HL**	**U**	**HL**
Crisis Resolution and Triage	2,044	2,963	5,879	10,914	18,281	26,784	1,672	2,591	27,876	43,252
Acute Inpatient	2,540	3,703	4,936	8,681	12,863	19,573	1,363	2,073	21,702	34,031
Subacute	-	148	102	744	1,260	4,121	305	1,036	1,667	6,049
Residential	-	-	160	298	1,204	1,854	104	207	1,468	2,359
Housing	9	15	279	496	4,255	6,696	1,946	2,850	6,489	10,057
Outpatient	64,482	92,585	34,645	62,009	83,292	128,771	19,863	28,503	202,282	311,867

Source: HMA. Note: missing data due to no clients in U model and no clients projected in HL model.

Output 2: Services Provided vs. Potential Services Forecasted

The following table provides a comparison of service units derived by the HMA Utilization model vs. estimated service units derived by the HMA High Level model. Like the client comparison, in general actual service units are less than the estimated service units, but in a number of service categories DMH generates a high proportion of estimated services.

Table 12. Services Provided vs. Potential Services Forecasted

	Service Unit Comparison: HMA Utilization model (U) vs. HMA High Level model (HL)									
	Children (00-15)		TAY (16-25)		Adult (26-59)		Older Adult (60+)		TOTAL	
Level of Care	**U**	**HL**	**U**	**HL**	**U**	**HL**	**U**	**HL**	**U**	**HL**
Crisis Resolution and Triage	4	9	13	36	46	102	3	9	66	156
Acute Inpatient	80	89	173	265	679	960	91	67	1,024	1,381
Subacute	-	43	70	389	1,004	3,339	267	993	1,342	4,765
Residential	-	-	38	68	392	575	43	82	473	725
Housing	7	11	171	331	3,690	5,959	1,817	2,799	5,686	9,100
FSP	120,170	174,236	47,027	100,954	80,573	122,702	19,875	28,979	267,646	426,871
Outpatient	327,596	442,098	168,545	340,980	216,326	334,698	54,050	86,603	766,517	1,204,379

Source: HMA. Note: missing data due to no clients in U model and no clients projected in HL model.

Output 3: Average Length of Stay

The following table provides average length of stay based Utilization model.

Table 13. Average Length of Stay (in days) Trends Fiscal Year 21-22 to 22-23

Level of Care	FY 21-22	FY 22-23	% Change
Acute Inpatient	11	11	0%
Subacute	402	550	37%
Residential	141	140	-.5%

Source: HMA.

Capacity Assessment

Estimating the bed needs for each level of care is a complex process that includes analysis of the following factors:

- Current and past utilization trends
- Wait lists and/or anticipated service demand for each level of care (both volume and the average length of time spent on the waiting list)
- Average length of stay (ALOS)
- Rehospitalization rates
- Availability of resources and supports throughout the continuum
- The effectiveness of lower levels of care at providing alternative support that reduces utilization of higher levels of care such as acute inpatient hospitalization

Figure 3. Continuum Factors that Influence Bed Capacity

Average Length of Stay (ALOS): The ALOS impacts bed capacity in that a bed that is used for a shorter length of stay can be used by more people over the course of a year. As the length of stay increases, it reduces the number of people who have access to this level of care. One bed can serve up to 122 unique clients over the course of a year with a 3-day ALOS. An increase to an ALOS of 14 days reduces the client care capacity of that bed to 26 clients in a year. ALOS is multifaceted in that it is contingent on both the clinical acuity and need of the patient, and the availability of appropriate discharge supports including shelter, outpatient, or intensive outpatient follow-up. ALOS is an important factor for increasing bed capacity in existing beds. However, it requires system capacity improvements in outpatient treatment, crisis stabilization, housing support, and post discharge follow-up care to sustain reductions in ALOS.

Rehospitalization/ Re-admission Rate: Rehospitalization rates impact capacity in a similar way to ALOS. The more bed days that a single client uses, the less capacity the system has to treat other clients who need that level of care. Even a short stay for a rehospitalization of three days can have a significant impact on bed capacity. One bed that is used for an average of 3 days per admission that has readmissions of another episode of 3 days will have a reduction of capacity of approximately 50%. A bed with an ALOS of 3 with no readmissions could treat 122 clients in a year. Adding on a single readmission of 3 days reduces the capacity of that bed to 61 clients per day. A readmission that has a higher ALOS would have a larger impact, reducing the capacity of the bed to 21 clients per year. Reducing readmission rates requires many of the same strategies described above for reducing ALOS.

Number of Unique People Served/ Average of Encounters Per Person Served: For outpatient services, the same capacity calculations apply. The appropriate capacity of outpatient and intensive services is calculated by understanding the volume of people who are served by a program and the average number of encounters that each unique individual receives. It is important for clients to have timely access to outpatient care so that they can proactively treat their behavioral health conditions and avoid the need for emergency and inpatient levels of care. To have a true understanding of the system's capacity for outpatient care, the health plan needs to know both the time to-first appointment and the time to follow-up appointments. A person who can receive a timely intake but then must wait a long time for follow-up care is more likely to drop out of care, losing the benefits of outpatient treatment.

Crisis Stabilization Utilization: Crisis stabilization is an important level of support to help clients receive timely support for behavioral health crises to prevent decompensation and the need for acute inpatient care. The most important part of this metric for a health plan in considering bed capacity needs is the number of clients who receive crisis stabilization care who do not end up in acute inpatient care. This will show the health plan how effective stabilization care is at diverting and preventing higher levels of care.

Access to Outpatient Care, Housing Supports, Intensive Outpatient Treatment: As discussed in the ALOS and the rehospitalization sections, access to outpatient care, housing supports and intensive outpatient treatment, such as Assisted Outpatient Treatment (AOT) can serve to prevent, and/ or shorten inpatient stays. These supports are important tools for preventing readmissions and preserving bed capacity in the County.

Overstays (also known as Diagnostic Group Overstays or Stays Beyond Medical Necessity): Overstays occur when a client has met their needs for the inpatient level of care and no longer meets medical necessity criteria for the stay. However, because there is not a safe discharge setting for the client to discharge into, the client remains in the inpatient setting until an appropriate resource can be located. Some health plans pay the treating facilities an "administrative" rate for the days beyond the medically necessary days of care. The impact is best described above in the ALOS section.

In analyzing these factors, this study has found that LAC DMH needs to increase capacity in several levels of care. This can be accomplished through reducing ALOS and/or rehospitalization rates, increasing utilization of crisis resolution and triage, the availability of housing, and intensive outpatient supports. The numbers below reflect the number of beds (capacity) that LAC DMH has a shortfall of in the current configuration of services.

Capacity Needed to Meet Current and Projected Demand

Tables 14 and 15 describe the current capacity and capacity needed to meet anticipated new demand for the LAC DMH continuum. The service unit figures in Table 14 are derived from modeling historic utilization trends in the LAC DMH portfolio. Service use trend rates were developed by reviewing data for unique utilizers and units of service from January 2021 through December 2022. Data were summarized by month of utilization, level of care, and age group to control for service mix and allow changes over time to be observed. Once data were arrayed in this manner, monthly utilization, 3-month moving averages, and 6-month moving averages were calculated. The moving average analysis smooths month-to-month data variance and allows for a more reasonable basis for projection.

Table 15 incorporates known demand and waiting times for service tracked by DMH. Where those data were not tracked, HMA used estimates as proxy figures for demand and waiting times. HMA's estimates were informed by known new service demand like jail reduction initiatives and waiting times in other Medicaid-funded programs. To serve the projected demand the study calculated the number of additional beds that would be needed based on the utilization from LAC DMH data and forecasted in the Utilization Model. The HMA proxy estimates represent a "stress test" of the model to show the service capacity needed if, in fact, LAC DMH experienced high demand in a service category. However, as discussed above, adding beds is not the only way to increase capacity. Capacity can be increased by developing stronger transitions of care to lower-level settings and reducing rehospitalizations. This

means that LAC DMH will need to determine which approaches to increasing capacity are the most feasible based on budget, available community capacity, and other factors.

Table 14. Model Projections to Meet Status Quo Service Demand

Level of Care	Current Number of Service Units CY 2022	Total Service Units Needed to Meet Status Quo Service Demand FY 2024-25
	Encounters	**Encounters**
Crisis Resolution and Triage	66	96 - 105
	Beds	**Beds**
Acute inpatient	1,025	993 – 1,057
Subacute	1,343	1,407 - 1,508
Crisis/Extended Residential		
ERS	406	367 – 407
CRTP	67	60 – 67
Housing	5,686	5,602 – 6,177
	Hours	**Hours**
Outpatient	6,291,156	6,056,073 - 6,660,712

Table 15. Model Projections Status Quo and Additional Service Demand

Level of Care	Current Number of Service Units CY 2022	Total Service Units Needed to Meet Status Quo Service Demand FY 2024-25	Projection		
			Clients to be served**	Waiting Time to Service**	Total Service Units Needed to Meet Status Quo and Additional Demand FY 2024-25
	Encounters	**Encounters**			**Encounters**
Crisis Resolution and Triage	66	96 - 105	*500*	*2 days*	100-110
	Beds	**Beds**			**Beds**
Acute inpatient	1,025	993 – 1,057	*500*	*5 days*	1,000-1,064
Subacute	1,343	1,407 - 1,508	360	226 days	1,641-1,758
Crisis/Extended Residential					
ERS	406	367 – 407	502	191 days	604 – 671
CRTP	67	60 – 67	1415	9 days	92 – 102
Housing	5,686	5,602 – 6,177	*500*	*90 days*	5,724 – 6,311
	Hours	**Hours**			**Hours**
Outpatient	6,291,156	6,056,073 - 6,660,712	*5000*	*60 days*	6,060,884 - 6,666,002

*** Demand figures based on LAC DMH actuals or HMA proxy estimates. HMA proxy estimates in italics.*

Child and Adult Capacity Needed

While there are similarities between mental health services for children and adults, recognizing and adapting to the unique needs of each population is crucial for providing effective and age-appropriate care. Mental health services for children and adults differ due to several factors, including developmental stages, communication styles, treatment approaches, and the unique needs of each population. The following table provides estimates of capacity needed for adults and children.

Table 16. Service Unit Projections by Age Group

Level of care	Current Number of Service Units in CY 2022 by age group (% by age group)		Projection	
			Total Service Units Needed to Meet Status Quo and Additional Demand FY 2024-25	
	Child	Adult	Child	Adult
	Encounters	Encounters	Encounters	Encounters
Crisis Resolution and Triage	17 (26%)	49 (74%)	24 - 27	72 - 79
	Beds	Beds	Beds	Beds
Acute Inpatient	254 (25%)	771 (75%)	230 - 250	721-779
Subacute	71 (5%)	1,272 (95%)	84 - 91	1,392-1,503
Residential	38 (8%)	434 (92%)	35 - 38	392 - 436
Housing	178 (3%)	5,508 (97%)	186 - 606	5,416 - 5,977
	Hours	Hours	Hours	Hours
Outpatient	4,035,309 (64%)	2,255,847 (36%)	3,877,761 - 4,313,157	2,178,310 - 2,347,551

Conclusions and Recommendations

Through the development of the Utilization and High-Level models, and key informant interviews, HMA gained a comprehensive understanding of the strengths, weaknesses, challenges, and opportunities within the LA County MHP system.

The data and information obtained from the key informant interviews and meetings were compiled and analyzed by HMA and can be found in Appendix A. HMA learned that there are several structural design limitations to the current system of data collection, oversight, and governance that impede LAC DMH's efforts to measure, track, and improve capacity across the full continuum of care.

Specifically, LAC DMH needs to develop:

- A leadership governance structure that adds to the group of leaders who have visibility and oversight of the full continuum of care. This team of senior leaders is also responsible for communicating system perspectives, initiatives, and priorities to the division leaders whose programs carry out the day-to-day operations of each component of the continuum.
- A strategic operational plan that the leadership governance structure uses to set the direction and prioritize and approve system resources, including pilots and new initiatives.

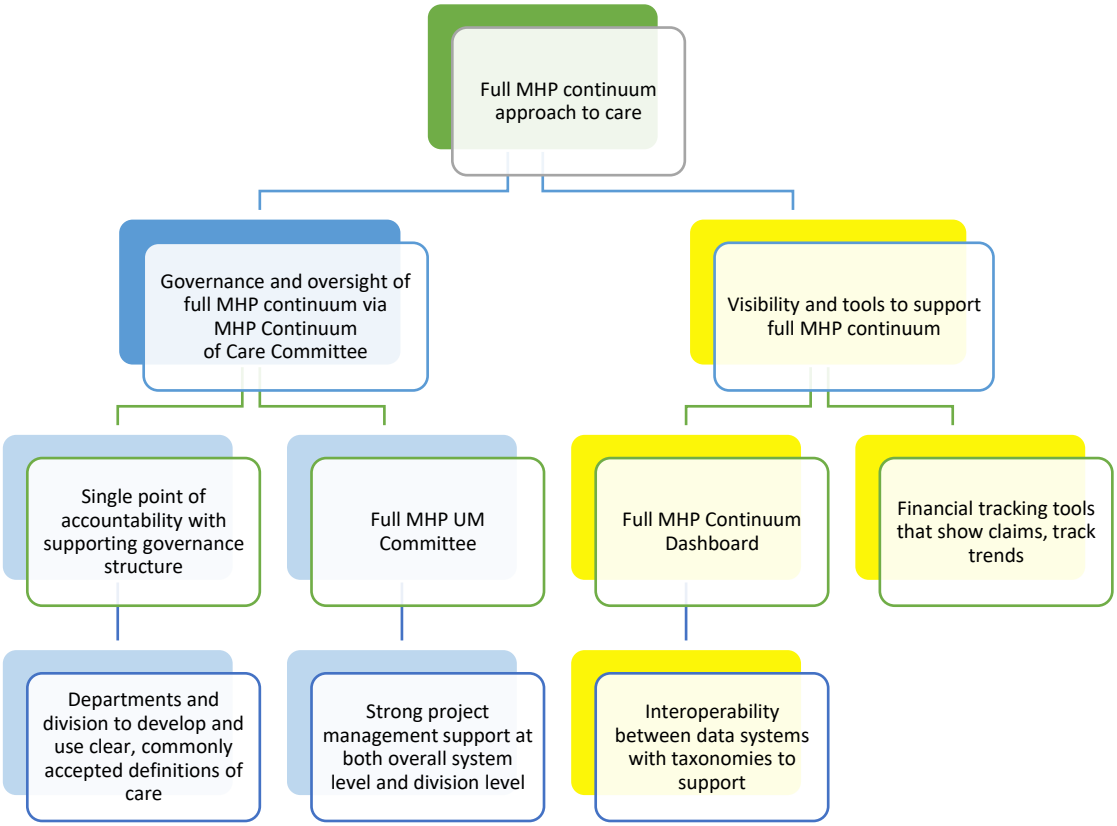
- A system dashboard and interoperable tools (and analyst staff to prepare the system-level dashboard) to give leaders actionable information on the functional capacity, utilization of resources, trends, and forecasting for future capacity needs.
- A clear visual with commonly shared definitions of each level of care across the continuum. Train all staff in the levels of care and how each level interacts with the other levels of care. Use case studies and client stories to illustrate how clients move across the continuum throughout the course of their care.
- A coordinated system-level bed tracking tool that gives real time data to the intensive care unit to use for bed-finding, and additionally provides feedback on system utilization for oversight, capacity planning, and management. Ideally, the capacity tracking tool would give leadership visibility into the capacity by service area of outpatient capacity, FSP capacity, slots in the supportive housing programs, and the full care continuum.

To support a full continuum approach to care, LAC DMH needs to:

1. Center Efforts on a Full Continuum Approach to Mental Health Resources
2. Strengthen Internal Governance and Oversight
3. Improve Visibility and Tools to Support Governance and Oversight

The array of activities to support a full continuum approach is depicted in the following Figure 5 and detailed in following tables.

Figure 4. Gaps and Recommendations by Category See Appendix C for full size figure



I. Importance of a Full Continuum Approach to Mental Health Resources

Effective and efficient mental health care requires a full continuum of services, from outpatient to crisis intervention, acute inpatient treatment, subacute treatment, and an array of supportive housing services. While each level of care provides distinctly different services, they are interrelated from a care delivery perspective. As examples:

- When the supply of subacute treatment facilities is reduced, it creates a backlog in the acute inpatient care settings caused by clients who are ready to move to the next level of care but who no longer have safe places to discharge.
- Adding capacity in crisis resolution and triage care can reduce the demand for acute inpatient care beds by giving clients the care they need earlier in the process and preventing decompensation requiring an acute inpatient level of care.

These examples illustrate that the services, while separate, are interdependent and comprise a full continuum of care. While one level of care may experience a gap or note a need for increased capacity, the system is currently unable to consider whether the gap can be more appropriately filled by another part of the system of care.

Gap Area	Observation and Recommendation
1. Need for Stronger Operational Approach to Manage the Full Continuum to Mental Health Resources	*Gap Observation: The current LAC DMH system is managed in separate databases with siloed oversight. As a result, LAC DMH has limited visibility into the access, availability, and resources for the full continuum of care.* Recommendation: 1.1 LAC DMH needs to adopt a management and operational philosophy centered on the full continuum of care.

II. Internal Governance and Oversight

The Medi-Cal Specialty Mental Health services organized and financed by LAC DMH for Medi-Cal beneficiaries in the County brings unique requirements. As a Medicaid managed care entity, LAC DMH needs to ensure alignment of clinical, financial, operational, and compliance functions. Internal governance needs to be in place to ensure alignment, and LAC DMH should consider some organization realignments to bring managed care functions closer together and thus reduce the challenge of coordinating across organization reporting lines. Governance and organization realignments would ensure better coordination between levels of care and provides oversight and direction to address the impacts of changing capacity at different levels to system of care.

Error! Reference source not found.provides the governance and oversight gaps identified through the a ssessment and recommendations to address those gaps.

Gap Area	Observation and Recommendations
2. Siloed Oversight	*Gap Observation: Structure of oversight and areas of responsibility are siloed with very few leaders who have visibility and responsibility for the total system of care.* Recommendations: 2.1 To support a full continuum approach, LAC DMH needs to develop a continuum of care network governance structure comprised of LAC DMH leaders possessing visibility and oversight of the full continuum of care. 2.2 Develop a strategic operational plan used by the leadership governance structure to set the direction and prioritize and approve system resources, including pilot projects and new initiatives. 2.3 Establish a MHP Project Implementation Office and empower them to provide implementation support for the full continuum. This office will ensure that all pilots measure outcomes and will work to identify and scale best practices across the MHP system of care.
3. Lack of Internal Governance Structure for the Full Continuum	*Gap Observation: No single point of accountability and supporting governance/committee structure for the full continuum of LAC DMH MHP.* Recommendations: 3.1 Create a reporting structure that mirrors other Medicaid health plan structures. 3.2 Include in the reporting structure a dyad of a Senior Administrator and a Medical Director. Ensure that all divisions associated with the MHP care and benefits report up to the dyad. 3.3 Develop a Mental Health Plan (MHP) Continuum of Care Committee with leadership team representation that analyzes financial, utilization, quality of care, and system-wide performance against key performance metrics.

Gap Area	Observation and Recommendations
4. Siloed Utilization Management	*Gap Observations: Utilization analysis is siloed by division. LAC DMH needs visibility into the impacts of access (or lack of access) to resources up and down the continuum on bed utilization.* *Multiple systems are used to track utilization; currently there is not a single system showing the full network average length of stay (ALOS) or tracking ALOS trends across the full continuum of care.* Recommendations: 4.1 Develop a data warehouse that all systems feed into to allow for analyses of the full continuum. 4.2 Expand the data analytics team currently focused on outpatient care to encompass data analysis for the entire continuum of care. 4.3 Develop a Utilization Management (UM) Committee with appropriate division representation that analyzes trends in utilization across levels of care and makes recommendations for system-level approaches to trends and gaps identified.
5. Lack of Common Definitions and Terminology for Levels of Care Across LAC DMH Continuum	*Gap Observation: There is a lack of common terminology and definitions for levels of care across the continuum, which can contribute to gaps, double counting of beds, and a confounding of the ability to analyze the actual capacity of the full continuum.* Recommendation: 5.1 Create a commonly accepted data dictionary and language regarding levels of care. Use agreed upon terms in all reporting and dashboards.

Discussion

Gap Area 2: Siloed Oversight

Structure of oversight and areas of responsibility are siloed with very few leaders who have visibility and responsibility for the total system of care. This results in division pilots that are not coordinated with the rest of the system which risk potential duplication and may leave key system gaps unaddressed.

Recommendations to Close Gap:

2.1 LAC DMH needs to develop an internal capability to ensure oversight of the full continuum. This should be accomplished via a continuum of care network governance structure comprised of LAC DMH leaders who have visibility and oversight of the full continuum of care.

2.2 Because of limited competing priorities, limited resources, and consideration of mental health performance, LAC DMH should develop a strategic operational plan that the leadership governance structure uses to set the direction and prioritize and approve system resources,

including pilots and new initiatives. Key components of MHP oversight and governance structure are illustrated in the figure below.

Figure 5. Key components of MHP oversight and governance structure (Full Size figure in Appendix D)

Essential Health Plan Functional Components

	Mental Health Plan Governance				
Role	• Coordinated Continuum of Care • Oversight of overall Health Plan functions • Accountable to State, County Leaders and Community				
	Mental Health Plan				
Organization	**Clinical**	**Financial**	**Operations**	**Compliance**	**Project Management**
Role	• Member care • Medical Necessity • Safety • High Quality Care	• Financial management • Revenue and expenditure management • Efficient care (stewardship of finances)	• Partner with Providers • Ensure Network Adequacy • Responsive to Member requests and needs • Responsive to Community needs	• Regulatory oversight and compliance with State Contract • Oversight of network's compliance • Responsive to member and community complaints • Ensures members' rights are protected	• Ensure Coordinated implementation of projects • Ensure measurement of pilots • Spot pockets of excellence for scaling • Protect system from duplication or unintended system impacts
Functions	• Model of care • CM • UM • Quality • Credentialling	• Provider Payments/ Claims • Data Analytics	• Network • IT • Member Services (call center)	• Grievances and Appeals • Audits • Regulatory Oversight	• Project Management Office

2.3 LAC DMH's MHP needs a Project Implementation Office that is empowered across the department to provide implementation support for the full continuum. This office will ensure that all pilots measure outcomes and will work to identify and scale best practices across the MHP system of care.

Gap Area 3: Lack of Internal Governance Structure for the Full Continuum

No single point of accountability and supporting governance/ committee structure for the full continuum of LAC DMH Mental Health Plan.

Recommendations to Close Gap:

3.1 LAC DMH should develop a role within the organization that has oversight and accountability for the full mental health plan continuum. This role would complement the responsibilities of the DMH Director and Chief Deputy by providing full management focus to the mental health plan continuum.

3.2 Medicaid Managed Care Health Plans generally have a BH oversight structure that is led by dyadic leadership team comprised of a Medical Director and a Senior Executive role that oversee the full BH continuum of care.

3.3 Use of a dyadic model and full continuum governance allows LAC DMH to ensure coordination between levels of care and provides oversight and direction to address the impacts of changing capacity at different levels to the system of care.

Gap Area 4: Siloed Utilization Management

Utilization analysis is siloed by division. LAC DMH needs visibility into the impacts of access (or lack of access) to resources up and down the mental health plan continuum on bed utilization. Currently, multiple systems are used to track utilization. There is not a single system that shows the full network average length of stay or tracks ALOS trends across the full continuum of care.

Recommendations to Close Gaps:

LAC DMH should develop structures to give MHP leaders visibility and oversight into the variables that impact bed utilization across all levels of care and develop a single system that tracks system utilization management tools to manage network average length of stay and system ALOS trends.

The system needs to develop a UM Committee with access to interoperable tools for monitoring expected discharge dates against diagnostic related groupings (DRGs), clinical need, medical necessity, and tracking trends to determine which units or facilities are doing well with providing treatment and discharging within expected timelines at all levels of care (inpatient, outpatient, acute and subacute. LAC DMH should:

4.1 Strengthen its data warehouse to improve the capability to analyze the full continuum.

4.2 Expand analytics capabilities to encompass data analysis for the entire continuum of care.

4.3 The UM Committee should be charged with reviewing utilization trends across all levels of mental health care, making recommendations for system-level approaches to trends and gaps identified, and developing strategies and approaches used to address units/facilities that struggle to meet expected discharge timelines as well as overall system root causes for readmission rates, average length of stay, and access and discharge issues that arise.

Gap Area 5: Lack of Common Definitions and Terminology for Levels of Care Across LAC DMH Continuum

There is an observed lack of common terminology and definitions for levels of care across the continuum. This contributes to gaps and double counting of beds and confounds the ability to analyze the actual capacity of the full continuum.

Recommendation to Close Gaps:

5.1 Create a commonly accepted data dictionary and language regarding levels of care. Use agreed upon terms in all reporting and dashboards.

III. Visibility and Tools to Support Governance and Oversight

LAC DMH needs to strengthen availability of data and analytics to be able to have a "total view" of the continuum of care and support governance and oversight. The following table outlines data and analytic gaps and provides recommendations to address those gaps.

Gap Area	Observation and Recommendation
6. Limited Visibility into Actual Capacity (Used, Needed, Available)	*Gap Observation: LAC DMH needs to improve data and analytic capabilities and tools to effectively manage the full continuum.* Recommendations: 6.1 Develop a MHP dashboard with bed capacity by level of care, provider, utilization trends, and metrics such as wait time and boarding by level of care. 6.2 Build dashboards to give overall system feedback in regular intervals to monitor and respond nimbly to changing system demands and capacity requirements. 6.3 Dedicate system analyst resources to develop, maintain, track, and trend data across the full continuum of care.
7. Limited Visibility into Actual Versus Forecasted Cost of Care by Level of Care	*Gap Observation: Current financial reporting is not sensitive to the specific levels of care in the system. LAC DMH is not currently reporting on budgeted versus actual spend by level of care.* Recommendations: 7.1 Develop a specific role of MHP financial analyst who reconciles utilization to invoices, and tracks and trends reimbursements paid by facility and level of care. 7.2 Report budgeted-to-actual and variance analysis for MHP care continuum to the MHP Continuum of Care Committee monthly. Committee to analyze financial, utilization, quality of care, and system-wide performance against key performance metrics.

Discussion

Gap Area 6: Limited Visibility into Actual Capacity (Used, Needed, Available)

There is limited visibility into actual operational capacity of inpatient beds. Contracts pay for the beds utilized, not a designated number of inpatient beds. Currently, while MHRLN is gathering data on individual referrals to beds, placements, and discharges, there is no mechanism to track or trend this data to give feedback about utilization trends of beds by facility or unit type. This means that LA County has an unknown number of contracted beds and only estimates of the bed utilization trends. Without a systematic way of measuring actual utilization of the contracted beds, LA County will struggle to know how many beds should be contracted for in order to meet the capacity needs of its residents.

Recommendations to Close Gap:

LAC DMH has separate data systems for different levels of care which limit coordination of care efforts and system capacity analysis by leaders at regular intervals. Leadership needs to be able to see the capacity of the system and how well each component (and the system as a whole) is performing without needing to hire consultants to analyze large data sets and give LA County the data needed to make resource allocation decisions. Currently, the system is too complex and is stored in systems that are not interoperable. As a result, leaders lack the tools they need to make data-driven decisions about resource allocation.

Because the capacity in one part of the system can impact inflow and outflow for all other levels of care, LAC DMH should ensure analysts develop, maintain, and provide analyses on a set of system-wide dashboards and tools that give an overall view of the full system of MHP care. This will provide feedback at regular intervals, and sample metrics to track include:

- Time from request for an inpatient psychiatric bed to actual admission;
- Percentage of and reasons for denial of referrals by unit/facility;
- Actual utilization of contracted beds by unit and type; and
- Average length of stay and 30-day readmission rates by inpatient facility.

Given the aforementioned, LAC DMH should:

6.1 Develop a MHP dashboard with bed capacity by level of care, utilization trends by level of care, and metrics which include wait time and boarding by level of care.

6.2. Build dashboards to give overall system feedback in regular intervals to monitor and respond nimbly to changing system demands and capacity requirements.

6.3. Dedicate system analyst resources to develop, maintain, track and trend data across the full continuum of care.

Gap Area 7: Limited Visibility into Actual Versus Forecasted Cost of Care by Level of Care

Current financial reporting is not sensitive to the specific levels of care in the system. LAC DMH is not currently reporting on budgeted versus actual spend by level of care.

Recommendations to Close Gap:

Health plans often use their claims paid data to show bed utilization and facility bed use trends. This will give the mental health plan the ability to determine whether utilization patterns for a particular facility are trending as forecasted, or above or below budgeted levels. MHP leaders need to analyze financial trends with the context of utilization data extracted from dashboards powered by MHRLN to give LAC DMH a claims-based, data-driven view of the actual use patterns in the region. The UM Committee should review denial reasons and wait times for particular levels of care or specific facilities. This combination of data points will give LAC DMH regular feedback on the gap areas in the continuum on regular intervals. LAC DMH should use the models developed by HMA and align them with financing by levels of care. To advance, financial acumen, LAC DMH should:

7.1 Add a MHP financial analyst role (or roles) to begin reconciling the numbers of days and claims paid for each level of care. This will give the MHP the ability to determine whether

utilization patterns for a particular facility are trending as forecasted, or above or below budgeted levels. The analyst(s) will provide data to MHP division leaders to analyze financial trends with the context of utilization data extracted from dashboards powered by MHRLN to give LAC DMH a claims-based, data-driven view of the actual use patterns in the region.

7.2 Report budgeted-to-actual and variance analysis for MHP care continuum to the MHP Continuum of Care Committee monthly. The committee should analyze financial, utilization, quality of care, and system-wide performance against key performance metrics.

Implementation Road Maps

The following road maps are provided to outline the steps over a 1-year time frame that LAC DMH should undertake to implement the changes recommended in this report.

ROADMAP						
	RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
			0-90	91-180	181-270	271-360
FULL CONTINUUM	1.1 LAC DMH needs to adopt a management and operational philosophy and approach centered on the full continuum of care.	Refine interventions for each level of care (reduce ALOS, increase upstream services, reduce 30-day readmissions, etc.)	X			
		Prioritize which capacity approaches by level of impact and level of effort needed to make the changes		X		
		Develop strategy for increasing capacity			X	
		Identify accountability structure for strategies			X	
		Develop measurement KPIs				X

ROADMAP						
	RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
			0-90	91-180	181-270	271-360
INTERNAL GOVERNANCE AND OVERSIGHT	2.1 To support a full continuum approach, LAC DMH needs to develop a continuum of care network governance structure comprised of LAC DMH leaders possessing visibility and oversight of the full continuum of care. 2.2 Develop a strategic operational plan used by the leadership governance structure to set the direction and prioritize and approve system resources, including pilots and new initiatives. 2.3 Establish a MHP Project Implementation Office and empower them to provide implementation support for the	Development of Dyadic Leadership Team for MHP	X			
		Reorganize reporting relationships to support new structure Establish MHP Project Implementation Office	X			

ROADMAP						
	RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
			0-90	91-180	181-270	271-360
	full continuum. This office will ensure that all pilots measure outcomes and will work to identify and scale best practices across the MHP system of care. 3.1 Create a reporting structure that mirrors other Medicaid health plan structures. 3.2 Include in the reporting structure a dyad of an administrative Senior Executive and a Medical Director. 3.3 Ensure that all departments associated with the MHP care and benefits report up to the dyad. Develop a Mental Health Plan (MHP) Continuum of Care	Establish commonly agreed up levels of care, definitions for levels, naming conventions			X	
		Establish parameters for measuring and quality data			X	

ROADMAP						
	RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
			0-90	91-180	181-270	271-360
	Committee that analyzes financial, utilization, quality of care, and system-wide performance against key performance metrics. 4.1 Develop a data warehouse that all systems feed into to allow for analyses of the full continuum. 4.2 Expand the data analytics team currently focused on outpatient care to encompass data analysis for the entire continuum of care. 4.3 Develop a Utilization Management (UM) Committee that analyzes trends in utilization across levels of care and makes recommendations for system-level approaches to trends and gaps identified. 5.1 Create a commonly accepted data dictionary and language regarding levels of care. Use	Create UM and Continuum of Care Committee		X		
		Develop cross functional data sharing workflows – enhanced data quality, monitoring and oversight				X

ROADMAP						
	RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
			0-90	91-180	181-270	271-360
	agreed upon terms in all reporting and dashboards.					
ANALYTICS AND TOOLS	6.1 Develop a MHP dashboard with bed capacity by level of care, utilization trends by level of care, and metrics such as wait time and boarding by level of care. 6.2 Build dashboards to give overall system feedback in regular intervals to monitor and	Increase capacity of analytics team – initiate process to increase staff resources	X			
		Create MHP Financial Analyst role	X			

ROADMAP						
	RECOMMENDATIONS	KEY STEPS	TIME FRAME (DAYS)			
			0-90	91-180	181-270	271-360
	respond nimbly to changing system demands and capacity requirements. 6.3 Dedicate system analyst resources to develop, maintain, track, and trend data across the full continuum of care. 7.1 Develop a specific role of BH financial analyst who reconciles utilization to invoices, and tracks and trends reimbursements paid by facility and level of care. 7.2 Report budgeted-to-actual and variance analysis for MHP care continuum to the MHP Continuum of Care Committee monthly. Committee to analyze financial, utilization, quality of care, and system-wide performance against key performance metrics.	Establish common taxonomies for levels of care		X		
		Create plan for integrating data for all levels of care into a single data warehouse			X	
		Define reports, intervals and data sources for financial reporting and variance analysis			X	
		Expand capacity for financial reconciliation and reporting			X	
		Create dashboards, financial trends, variance reporting				X

Overall Conclusion

As the mental health agency serving the most populous county in the nation, LAC DMH has a critical role to play in the community. LAC DMH has a varied portfolio of functions ranging from providing and organizing care for the most vulnerable to community-wide services like crisis intervention and prevention and early intervention. The Medi-Cal Specialty Mental Health segment of the LAC DMH is among its most significant obligations in which LAC DMH needs to ensure alignment of clinical, financial, operational, and compliance functions.

This report provides an assessment, recommendations, and insight from forecasting tools for LAC DMH to strengthen its internal governance and oversight of the full continuum of mental health resources for which it organizes. It also provides a roadmap for LAC DMH to consider regarding the HMA recommendations. Additionally, there are internal policies, such as contracting models, approach to IMD exclusion, and Medi-Cal financing reform, that need to be aligned against the full continuum of care. LAC DMH has performed an internal analysis of some of these issues in a 2023 DMH Root Cause Analysis project. HMA encourages LAC DMH to further examine internal policies by aligning with the work already done to identify barriers, which will allow LAC DMH the ability effectively plan and manage the mental health safety net in the County.

LAC DMH's most urgent structural needs are to increase internal governance and visibility into actual utilization and capacity of the full continuum of care. This includes increasing resources in the analytics team, adding in a MHP financial analyst and creating the governance structures, such as the MHP Continuum of Care Committee, necessary to track trends and monitor the full continuum of services. These internal governance structures and the utilization tools shared in this report will allow LAC DMH to quickly identify the best approaches to increasing capacity. The most urgent resource need, according to the data analyzed, is the need to substantially increase capacity in the subacute level of care. The most effective way to ensure that LAC residents have access to beds is to purchase beds on a capacity basis. LAC DMH should examine a strategy to access beds by paying for standing capacity that is reserved for LAC DMH clients. A final implementation priority among the recommendations is to develop strategies to dramatically reduce the 30-day readmission rates for LAC residents. According to the EQR report and the data analyzed by HMA of utilization patterns, readmissions are currently using up capacity at a rate that is higher than many regions in CA. The UM Management Committee should take this issue up as its first priority to address.

Appendix A – Key Informant Interviews

Interview Guide

Introduction: Thank you for taking time to provide your valued input on LA County's project to determine LA County's need for inpatient psychiatry resources and the MHP crisis continuum of care. Your participation in this process is critical.

LA County engaged Health Management Associates (HMA) to assist and support the County's needs and capacity in the MH crisis and inpatient psychiatric levels of care. The assessment will include consideration of options for diversion, facilities, and potential partners for strategies and approaches to meeting the needs.

Before we begin, do you have any questions?

Name and role of Key Informant(s)/ Organization/ Department/ Division:
Populations Served

Question
Describe the population you serve ▪ Region/Catchment Area ▪ **Age range** ▪ **Special populations**
What volumes/ % of people served are in MH crisis? (justice-involved, co-morbid SUD, comorbid physical health, older adults, developmentally disabled) What volume/% are involuntarily detained under LPS (due to a mental disorder, danger to self/others or gravely mentally disabled)?
First responders: how long is a typical MH encounter/ response versus a non-bh encounter? What makes MH different (if it is)
What are your typical dispositions/discharge plans? What are the challenges to timely discharges? What are the opportunities to improve availability of inpatient beds?

What do you view as the major MH/SUD health needs of the community that might be more appropriately addressed outside of inpatient psychiatry?

Service Model

Question
What are the current types of services you currently provide MH hospital MH subacute care MH Residential Other?
What are the current types of services you typically partner with or refer to?
What services are available to adults/ youth in MH crisis?
What barriers do you or the people you serve encounter when trying to access those services?

Gaps

Next, we would like to ask you about specific gaps or barriers you are aware of in the community (specific to MH crisis care). In particular, we'd like to focus on unhoused individuals, BIPOC communities, LGBTQIA individuals, and other vulnerable populations (including youth).

Question
What are the specific gaps or barriers you are aware of with respect to services for each population listed?

What **MH crisis resources** do you think are missing/ have limited access to that could assist you best with the people who are in MH crisis that you serve? (ex.:

- ☐ Crisis Stabilization Center
- ☐ Crisis Call Center
- ☐ Mobile Crisis Services
- ☐ Psych ERs or MH urgent care centers
- ☐ Law enforcement co-response teams (e.g., LAPD's SMART and LA County Sheriff's MET)
- ☐ Primary Care Integration
- ☐ Population specific – Adolescent, Geriatric
- ☐ Inpatient
- ☐ Intensive Outpatient/Partial Hospitalization programs
- ☐ Full-Service Partnership programs
- ☐ Crisis residential treatment, peer respites
- ☐ Dual Diagnosis
- ☐ SUD
    - SBIRT
    - OP Withdrawal
    - MAT
    - Opioid Overdose Prevention
- ☐ Supportive housing programs
- ☐ Inpatient beds – what types of beds, age groups, number.

Boarding: How long, what age groups, are boarding in ED's waiting for beds?

Familiar Faces

Question
Do you have protocols for working with individuals who are frequent users of crisis services? Any additional supports or resources?
What resources are available to support people after the crisis has occurred?

Quality Metrics

Question
What quality metrics do you track/ trend? ☐ Readmission rates ☐ Follow-up after psych hospitalization (7 vs 30 days) ☐ Medication continuation following inpatient psychiatric discharge (for MDD, SZ, Bipolar Disorder) (within 2 days prior to discharge and 30 days post discharge) ☐ Waitlists to transition to next level of care ☐ Others? (e.g., Diversion from jails; ED wait times)
How often measured?

Closing

Question
Is there anything else you'd like to share that we haven't asked about?

Key Informant Interview Themes

To gather valuable insights and input from key informants, HMA conducted a series of interviews and meetings with individuals who have operational and managerial expertise in the LA County MHP system. These key informants included the following departmental units.

DMH Units	
Full Service Partnership (FSP)	Mental Health Court Linkage Program
Child Welfare Division	Housing and Job Development Division
Intensive Care Division	Clinical Informatics (Data Dashboard Metrics)
County Wide Engagement Division	Finance
Assisted Outpatient Treatment (AOT)	Outpatient Services Division
Public Guardian LPS	Mental Health Resource Locator Navigator (MHRLN) Demonstration

Adopt a Continuum of Care View

Themes that emerged from the stakeholder and key informant interviews included:

- The need for a single system to track the full continuum of care across the mental health plan. Multiple stakeholder groups noted how the lack of a single data system impacts their ability to make plans or to coordinate improvement efforts across levels of care.
    - Stakeholders noted it would be most useful if the metrics tracked were in a centralized location that could be viewed at program levels. This data could then be used to prompt system improvement efforts.
- The use of pilot projects to solve specific issues that have cross-system impacts. Several of the pilots have the potential to positively impact important bed capacity issues such as rehospitalization and wait times for transitions between levels of care. These pilots were listed as strengths in the EQR report and may have the desired impact of improving access to existing beds. However, pilots need coordination to ensure that increasing access to one sector of the continuum does not have an unintended adverse impact on another part of the system of care.
    - One of the pilots is being conducted by the full-service partnership (FSP). This pilot project seeks to reduce and prevent rehospitalizations. It plans to increase the communication and coordination between inpatient units and outpatient or FSP teams who will care for individuals post-discharge. The pilot is testing the use of a centralized communication hub to connect inpatient units and follow-up resources to avoid missed opportunities for connection prior to discharge. If successful, this could serve to increase bed capacity without having to add physical beds to the system.
- A key gap that the interviews highlighted is the contracting practice of identifying the total number of licensed beds in a facility and the rate at which LAC DMH will reimburse the beds but not identifying an estimated number of beds that will be used by LAC patients. Several stakeholders noted that there is significant competition for bed capacity across the state. The current practice relies on accurate and timely accounting of trends and average utilization rates to estimate the capacity of beds that are available to LAC DMH by facility and level of care.
- Limited to no reconciliation of claims and authorizations to actual bed utilization. The necessary calculations that are needed to estimate true system bed capacity are currently being performed on spreadsheets and are not reconciled to finances. This means that bed capacity represents a rough estimate, as opposed to a true forecast based on verified run rate calculations.
- Little consensus across the system as to the definition and categorization of the different levels of care.
- Multiple programs note having difficulty locating transitional care and appropriate discharge options, including housing options, for their clients who have a history of criminal justice involvement. There is also a noted shortage of resources for youth who are experiencing both BH conditions and autism or other intellectual and developmental disabilities (IDD).
- Youth-serving divisions and supports noted there is a lack of adequate beds for this population. This is seen most acutely in the lack of available beds for youth who have many high needs or multi-system involvement. Team members note that investments in early engagement and prevention programs could ease the stress on the more acute levels of care.

Strengthen Analytics

LAC DMH capabilities to view the full continuum are limited. It is important to note that there is not a single system that tracks the full continuum of care at LAC DMH. This means that there is not a single system-wide dashboard or view which supports capacity management currently.

For example, the assisted outpatient treatment (AOT) program documents into the integrated behavioral health information system (IBHIS) system while the Intensive care division (ICD) uses the MHRLN system and a series of Excel spreadsheets to track average length of stay, rehospitalization rates, and average daily census. Leaders shared their desire to have a more comprehensive system view. One leader noted it would be helpful in contracting for additional bed capacity to know what is being done in other levels of care as each potentially impacts one another's demand, throughput, and average lengths of stay. Another theme that arose was the issue that a lot of the data are hand-entered or self-reported. Leaders indicate that reporting from many of the systems requires staff to create ad hoc or one-off reports.

Strengthen Provider Network/Capacity Management

New capacity has been added to the network since 2019. Some examples of additions include but are not limited to those in acute care beds, Murphy beds, and a new youth care residential facility. Additional care capacity includes the AOT and additional Care First Community Investment (CFCI) beds. However, there have also been losses in capacity within the system. Local capacity has also been reduced due to changes in policy at the State Hospital affecting the volume of new admissions that they accept. A challenge that stakeholders note regarding the loss of State Hospital capacity is that some patients who need the State Hospital level of care face barriers to acceptance at other facilities. Clients who have histories of sexually related offenses, fire setting behaviors or extensive assault histories are often not accepted by other care facilities. This results in a number of clients remaining in acute care settings for significant periods of time while alternative discharge plans are developed.

Strategies employed to address the needs of individuals requiring a State Hospital level of care include continuously working with the treating facility to see if clients are getting better and can be considered by an IMD subacute provider, ICD-provided special payments to help incentivize providers to accept difficult-to-place clients, contracting with MHRCs out of the county to take difficult clients, and working to secure additional contracts with providers creating units specifically for hard to place clients.

Improve Managing Cross-System Transitions of Care

The BH "system" in California is highly fragmented, with publicly funded mental health and SUD services provided through a patchwork of systems and providers. This fragmentation is most acutely challenging for individuals living with co-occurring disorders and medical complexity.[7] In Los Angeles County, where the substance use treatment and mental health systems are bifurcated, individuals with co-occurring

[7] Anthony, Susan. "In Their Own Words: How Fragmented Care Harms People with Both Mental Illness and Substance Use Disorder." California Healthcare Foundation. August 2021. Available at https://www.chcf.org/wpcontent/uploads/2021/08/InTheirOwnWordsFragmentedCareMentalIllnessSUD.pdf

mental health and substance use conditions are confronted with multiple services systems. Those individuals who also have a physical health condition—a common occurrence for individuals living with mental health and SUD—must seek care from yet another source (e.g., a managed care plan or Medi-Cal's fee-for-service system). The currently siloed system is confusing for enrollees, their families, and providers.

To promote better integration of care and support a comprehensive whole-person approach, California is undergoing a transformation of its behavioral health system to expand access to affordable and quality mental health and substance use services, including a range of behavioral health treatment, residential, and housing interventions to address the needs of the most vulnerable and at-risk children, youth, and adults with mental illness or substance use disorder. The behavioral health modernization effort also calls for improved transparency and accountability for behavioral health funding and outcomes.[8]

[8] https://www.dhcs.ca.gov/services/Documents/Transformation-of-Our-Behavioral-Health-System-Webinar-06-23-23.pdf

Appendix B – Utilization and High-Level Model Methodologies

The Utilization Model (U) projects unique client counts and service utilization volume for the entire mental health care continuum for FY2024-25 (July 1, 2024 - June 30, 2025). It is organized by levels of care, service/setting types (i.e., sub-units), age groups, and mental health/substance use disorder (MH/SUD) co-occurring statuses. The model is based on data pulled from LAC DMH's IBHIS (2022) and includes experience-informed utilization trend factors.

The Utilization Model includes the following specific factors:

- Projections of unique client counts and service utilization volumes for the entire mental health care continuum for FY2024-25 (July 1, 2024 - June 30, 2025), including estimates by levels of care, service/setting types (i.e., sub-units), age, and mental health/substance use disorder (MH/SUD) co-occurring status. Projections were based on recent historical episodic data (2022) and experience-informed utilization trend factors.
- Service use trend rates were developed by reviewing data for unique utilizers and units of service from January 2021 through December 2022. Data were summarized by month of utilization, level of care, and age group to control for service mix and allow changes over time to be observed. Once data were arrayed in this manner, monthly utilization, 3-month moving averages, and 6-month moving averages were calculated. Actuarial judgement was used to determine when data periods were outliers or were inconsistent with recent utilization levels. The outlier-adjusted data were used to determine the basis for trend development.
- Model outputs include estimated clients by age, and estimated service units by levels of care. The model includes the ability to incorporate supplemental information (e.g., new service demand, waitlists) to forecast additional service units the need to be added to address unmet demand.

The High-Level (HL) model is an estimation of service demand based on the proportion of the County population for which LAC DMH has service responsibility. This model can be expressed as:

Service Populations X Service Take-Up Rate = Estimated Outpatient, Residential and Inpatient Care

The High-Level model is subject to a series of assumptions about the prevalence of mental health burden and access to care (i.e., the take-up rate for services), and does not factor in some issues like geographic distance and language which can present barriers to care.

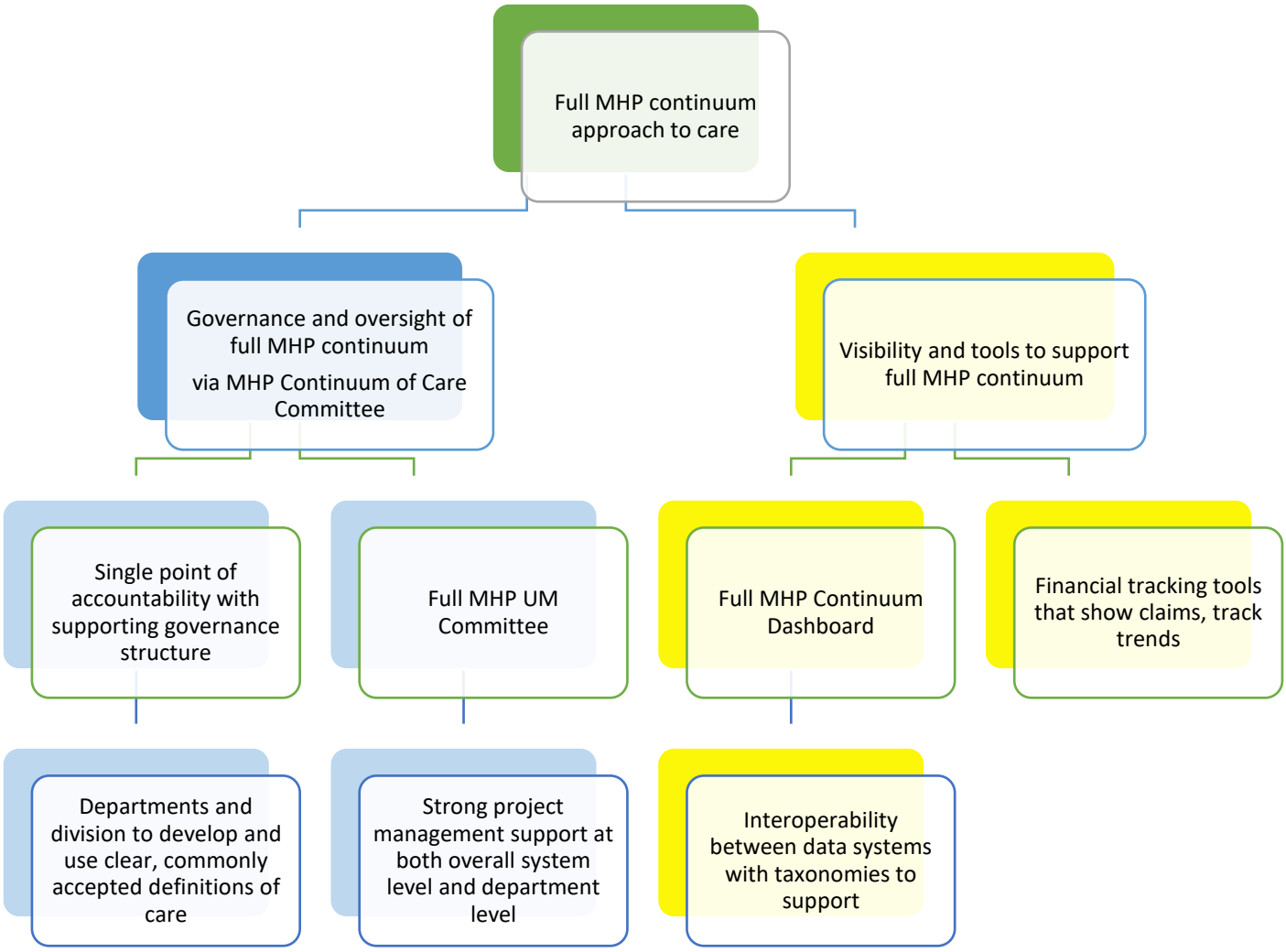
The High-Level Model includes the following specific factors:

- Population estimated from the California Department of Finance.[9]
- Prevalence estimated from California Department of Health Care Services.[10]

[9] California Department of Finance, https://dof.ca.gov/forecasting/demographics/estimates/
[10] California Department of Health Care Services, https://www.dhcs.ca.gov/Documents/California%20Prevalence%20Estimates.pdf

- Use rates estimated from the National Institutes of Mental Illness.[11]

Appendix C – Gaps and Recommendations by Category



[11] National Institute of Mental Illness, https://www.nimh.nih.gov/health/statistics/mental-illness#part_2542

Appendix D – Essential Health Plan Functional Components

Essential Health Plan Functional Components

	Mental Health Plan Governance				
Role	• Coordinated Continuum of Care • Oversight of overall Health Plan functions • Accountable to State, County Leaders and Community				
	Mental Health Plan				
Organization	**Clinical**	**Financial**	**Operations**	**Compliance**	**Project Management**
Role	• Member care • Medical Necessity • Safety • High Quality Care	• Financial management • Revenue and expenditure management • Efficient care (stewardship of finances)	• Partner with Providers • Ensure Network Adequacy • Responsive to Member requests and needs • Responsive to Community needs	• Regulatory oversight and compliance with State Contract • Oversight of network's compliance • Responsive to member and community complaints • Ensures members' rights are protected	• Ensure Coordinated implementation of projects • Ensure measurement of pilots • Spot pockets of excellence for scaling • Protect system from duplication or unintended system impacts
Functions	• Model of care • CM • UM • Quality • Credentialling	• Provider Payments/ Claims • Data Analytics	• Network • IT • Member Services (call center)	• Grievances and Appeals • Audits • Regulatory Oversight	• Project Management Office