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FY 17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

LOS ANGELES MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 25-28, 2017

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LOS ANGELES MHP SUMMARY OF FINDINGS

Beneficiaries served in CY16 — 200,662

MHP Threshold Languages — Spanish, Armenian, Mandarin, Cantonese, Korean, Vietnamese, Farsi, Tagalog, Russian, Cambodian, Other Chinese, Arabic

MHP Size — Very Large

MHP Region — Los Angeles

MHP Location — City of Los Angeles

MHP County Seat — City of Los Angeles

Introduction

Los Angeles County, officially the County of Los Angeles, is the most populous county in the United States with an area of 4,751 square miles, and a population of over 10 million. Over one-quarter of California residents live in the county, which is one of the most ethnically diverse counties in the United States. The majority of the population is located in the south and southwest portions of the county, with major population centers in the Los Angeles Basin, San Fernando Valley and San Gabriel Valley.

The Los Angeles County Department of Mental Health (LACDMH) is the largest county-operated mental health system in the United States. The LACDMH provider network is composed of Directly Operated and Contracted programs that serve Los Angeles residents in more than 85 cities and approximately 300 co-located sites. More than 250,000 residents of all ages, speaking twelve threshold languages, are served every year, and nearly 200,000 are Medi-Cal beneficiaries.

Each year, the County contracts with more than 1,000 organizations and individual providers for a variety of mental health-related services. To provide access to services in such a widespread and diverse area, the Mental Health Plan (MHP) divides the county into eight service areas (SA).

The most significant challenges impacting the MHP and somewhat beyond their control include homelessness, a beneficiary population experiencing more acute and comorbid diagnoses, the lack of affordable housing for staff and consumers, along with population-

based trauma due to poverty, homelessness, isolation, immigration, domestic violence and criminal justice involvement.

During the FY17-18 review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the Mental Health Plan (MHP) and its contract provider services. Further details and findings from EQRO-mandated activities are provided in this report.

Access

The Los Angeles County Health Agency (LACHA) is taking on initiatives that address population issues at the policy level, including several integrated care models. This includes the co-location of mental health, primary care and public health substance use services for consumers with co-occurring disorders.

As part of the LACHA, the MHP is participating in a county-wide effort to significantly expand supportive housing for individuals that are homeless and have complex health and behavioral health conditions. These efforts are timely as the homeless population now exceeds 55,000 (sheltered and unsheltered) in Los Angeles County.

The MHP is in the process of an executive reorganization with the goal of consolidating a fragmented and overly complex structure. The goal is to improve overall coordination, collaboration and consumer outcomes, reducing disparities between programs and ensuring parity in all service areas. These efforts are aimed at positioning the department for more growth, flexibility and impact into the future. Simultaneously, the MHP is working on assessing and rectifying gaps in service provision at all levels of care to ensure a comprehensive and fully functioning system of care for Los Angeles County residents. The MHP continues to struggle with the difficulty of filling vacancies due to increasing demand and insufficient supply of licensed therapists and psychiatric providers.

Parity remains an issue across the entire system of care (SOC), and is particularly uneven between various service areas, which further impacts disparity. In response, the MHP is working on creating a more fluid and dynamic staff with the ability to shift between service areas in response to demographic changes. In addition, there is a shift towards more field-based service provision, particularly for intensive services.

Timeliness

Timeliness metrics vary considerably between county operated clinics and contract providers, as well as for adults and children, and by the language in which services are requested and provided. Several timeliness metrics are collected only for county operated clinics and providers, which in some cases is a small subset of total relevant events.

Expanding these timeliness metrics to the entire system of care (SOC) would benefit consumers in terms of overall quality of care.

The MHP tracks and trends timeliness data for initial assessments, first clinical appointments, urgent appointments, initial psychiatry appointments, emergent medication needs, hospitalization follow-up, no shows and drop-out rates. The MHP reported that timeliness reports are produced and reviewed monthly.

The MHP is initiating a PIP to improve post-hospitalization follow-up and engagement to reduce the rehospitalization rate of intensive service recipients, as the current rehospitalization rate for adults is 30.66%.

Quality

The MHP completed the consolidation of their 24 work plans from of the original Community Services and Supports work plan into six which represents an administrative simplification that creates greater service continuity without modifying program expectations, intentions or service capacity. The six new areas include: (1) Planning, Outreach and Engagement; (2) Full Service Partnership (FSP); (3) Alternative Crisis Services; (4) Recovery, Resilience and Reintegration; (5) Linkage; and (6) Housing.

As part of the county-wide effort to provide more integrated field-based services, the Office of Diversion and Re-entry was created by the Board of Supervisors and is addressing the needs of the forensic population with considerable success. Of the 6,000 calls the police and sheriff's departments received last year, only 3% ended up in jail, with the remainder receiving field-based crisis resolution, and subsequent mental health and other support services.

Outcomes

Starting July 1, 2017, the formerly known Integrated Care Program/Community-Designed Integrated Services Management Model became the Recovery, Resilience, and Reintegration – Community-Designed Integrated Services Management Model (RRR-ISM). This program promotes collaboration and community-based partnerships to integrate health, mental health, and substance abuse services with needed non-traditional care to support recovery for underserved ethnic communities. Stakeholders report that the changes have resulted in improved flexibility of staff to provide integrated field-based and other services such as mobile telepsychiatry for medication support.

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid managed care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid managed care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year 2017-2018 (FY17-18) findings of an EQR of the Los Angeles MHP by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS. The eight PMs include:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;

[1] *Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.*

- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

Each MHP is required to conduct two performance improvement projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are discussed in detail later in this report.

MHP Health Information System Capabilities[4]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirement for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of the MHP's reporting systems and methodologies for calculating PMs.

Validation of State and County Consumer Satisfaction Surveys

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

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[2] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[4] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY17-18

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, CalEQRO and MHP staff discussed the status of those FY16-17 recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY16-17

Recommendation #1: Begin to track timeliness from assessment to first clinical appointment. This will give a more accurate analysis of capacity in order to plan for program staffing needs.

Status: **Partially Met**

- While the MHP is not yet able to produce data on timeliness from assessment to first clinical appointment for contract providers, they did present this information for county operated services, disaggregated by age and language.
- The scale of this undertaking for the MHP is enormous, and requires varied strategies for directly operated versus contract providers. This is in part due to the fact that contractors are using different electronic health information systems throughout the system of care (SOC).

- The MHP presented data on initial offered, accepted, and kept appointments (by language) for both direct and contract providers.

- The time from initial request to first kept appointment, timeliness of initial psychiatry delivered services, and emergent need psychiatry appointments were reported for directly operated programs only.

Recommendation #2: Ensure there are two PIPs rated as active by CalEQRO on an annual basis during EQRO review.

- Use available data to identify issues that can be addressed through a PIP. Create a list of possible future PIPs (EQRO is offering TA to assist in this area).

Status: **Partially Met**

- As part of a larger county-wide initiative to serve and improve outcomes for high-need and high-cost individuals, the clinical PIP has targeted intensive service recipients (ISR), defined as adults 18 and older who have had four or more inpatient hospitalizations in the past 13 consecutive months. The goal of the PIP is to decrease rehospitalizations, including frequency and duration of stay, for ISRs. This PIP is considered concept only as some PIP components are unclear and/or missing.

- This is the second year of the non-clinical PIP, which is designed to improve call handling at the ACCESS Center. The impetus for the PIP was the MHP's performance on annual test calls, wherein the MHP identified three areas for improvement: 1) number of calls logged; 2) request of caller's name; and 3) caller's satisfaction. Over the past year, the PIP added new topics and addressed some of the recommendations made by CalEQRO during the FY16-17 review. The MHP increased the number of calls to be sampled; modified the sampling technique to be based on agents rather than supervisors; and incorporated or articulated the inclusion of other languages, besides Spanish, for review.

Recommendation #3: Continue to provide sufficient technical assistance resources for both legal entities and the Electronic Health Record (EHR) vendors during the Integrated Behavioral Health Information System (IBHIS) go-live roll-out and post go-live transition as the systems conversion is mission-critical for the MHP.

Status: **Met**

- The number of authorized positions were increased to support Chief Information Office Bureau (CIOB) operations and the ongoing IBHIS implementation for legal entities:

Date	Items	Vacancies	Vacancy Rate	Vacancy Rate (including hires in process)

April 2016	196	33	17%	12%
April 2017	208	27	13%	10%
August 2017	215	35	16%	10%

- While CIOB experienced challenges filling vacancies in recent years, during calendar year 2017 (CY17) they have been able to accelerate hiring, filling three to five items a month on average.
- The MHP increased authorized items during 2017. To support IBHIS onboarding and ongoing operations, they added technical assistance technicians to the following sections: Provider Advocacy, Help desk, Integration, and Data Management.

Recommendation #4: The MHP has depth and breadth of peer involvement across SOC. Investigate the feasibility of creating a system for peer/lived experience employment that includes a career ladder for those now volunteers and stipend paid lived experience staff in order to facilitate professional development. Research how these positions might be implemented to address some of the capacity issues that challenge the MHP.

Status: **Partially Met**

- The MHP reports difficulties with obtaining County Human Resources support for dedicated and specifically titled peer support positions. Progress has been made with the development of a Peer Support Discipline Chief position.
- Contract providers utilize peer support specialists in specifically titled positions, and include a career ladder for those with lived experience. However, the MHP remains limited to using positions which are typically open to any qualified individual for the peer employees. The MHP gives additional points during the interview process for those with lived experience, based on the recruitment specifications.
- While the creation of a Discipline Chief position is a positive change, the MHP remains yet unable to create a career ladder for peer/lived experience staff within the directly operated programs.
- The MHP has a number of peer roles, both volunteer (with stipend) and paid (with full benefits), throughout the SOC. However, there exists a lack of uniformity in how peer employees and volunteers are treated and utilized. Peer participation in MHP administrative activities (e.g. meetings, trainings) also varies considerably and is somewhat disjointed.

- While the MHP has a TAY youth program, they are not yet leveraging this resource to expand mental health service availability and delivery throughout the community. TAY youth expressed the desire to work through clinics, schools and social media, assisting with programs to reduce stigma and bullying, help lead teen support groups, normalize teens seeking help for feeling anxiety, depression, wanting to hurt oneself and/or others, and drug use. In addition, they are interested in teaching parents how to access services, and how to speak with their kids about the aforementioned issues. This work has the added benefit of helping these TAY youths with their own wellness and recovery.

Recommendation #5: Investigate if Service Request Tracking System (SRTS) and Vacancy Adjustment and Notification System (VANS) result in inappropriate referrals (referrals from out of SA when not appropriate, or referrals out of scope of contract for provider) for services from providers outside of their service area. Evaluate if additional business rules and staff training are necessary to further improve complex referral processes.

Status: **Met**

- The MHP surveyed programs and learned from respondents that 65% believed inappropriate referrals were not occurring, while 35% felt there were. The MHP described further exploration performed with this matter, and a plans to gather more information and provide additional training.

- It should be noted that participants in numerous sessions of this current review identified still having issues with VANS. The observations were that VANS information was almost always a month or more out of date, and as much as several years in some instances.

- VANS identifies program slots by funding source, which reportedly leads to greater probability of inaccuracy. Suggestions made were:

    - VANS would operate better if simply serving as a comprehensive listing of programs, by region, presenting a more global picture of program capacity, language capacity, and the treatment specialties of staff.

    - VANS, when presenting information of a specific program, provide a map which shows other similar programs in proximity to the highlighted program.

- The feedback indicated that VANS would be a more useful resource if configuration modifications were made. The MHP's plans for focus groups for input on VANS is a positive concept, and hopefully will be open to wide-ranging input on the product and not limited to technical changes within the existing design parameters.

Changes in the MHP Environment and Within the MHP—Impact and Implications

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

Access to Care

- Significant population changes have taken place in several service areas. There are now over 57,000 homeless in LA County (including sheltered and unsheltered adults and youth). In SA7, there was a 50% increase from last year (now 5,189), with the homeless Hispanic count increased by 148% and the TAY homeless population by 160%.

- The Los Angeles County Health Agency, which includes the Departments of Health Services (DHS), Mental Health (DMH) and Public Health (DPH), seeks to significantly expand supportive housing for individuals that are homeless and have complex health and behavioral health conditions. Together they have developed a new care model for people living in Permanent Supportive Housing (PSH) to integrate Intensive Case Management Services (ICMS) through DHS, specialty mental health services through DMH and substance use services through DPH Substance Abuse Prevention and Control Division. The model will be funded by the Mental Health Services Act (MHSA) and Measure H, a new ¼ cent tax for homeless services/resources adopted by Los Angeles County voters in March 2017. Each Department will leverage Medi-Cal revenue to offset the cost of services including through Whole Person Care, the Drug Medi-Cal waiver, and Mental Health Medi-Cal. In FY17-18, a minimum of 750 new housing units will be added to the existing 786 units for those with mental illness. Implementation will begin September 2017.

Timeliness of Services

- The MHP presented a six-step planned comprehensive approach to tracking of timeliness, including first assessment service, completion of assessment, time to first clinical appointment, drop-out rates, and retention in service for subsequent clinical appointments. The MHP also includes medication support timeliness for initial psychiatry appointments and emergent medication needs.

Quality of Care

- The MHP is in the process of an executive reorganization with the goal of consolidating a fragmented and overly complex structure. After moving through an intensive assessment of the structure of the entire SOC, the MHP is now streamlining for improved coordination, consistency, continuity, and productivity. The goal is to become better equipped to integrate strategy, clinical policies, operations, performance metrics, and administrative support, and position the department for more growth, flexibility and impact into the future. They are changing from a program-focus built around age groups into a matrix organization centered on the core functions of mental health services including delivery, design, policy, performance and support.
    - The executive reorganization includes repurposing of nine existing executive positions (Deputy Directors), the Chief Deputy Director and the Medical Director; and the establishment of five new executive-level Discipline Chiefs (one of whom will be a Peer Chief) who report directly to the Medical Director.
    - The timeline for the reorganization is as follows:
        - ▷ December 29, 2017 – all components of the Department moved into alignment with new executive structure.
        - ▷ June 30, 2018 – new policies, procedures, communication channels established in service to the reorganization.
        - ▷ June 30, 2019 – Full cultural change realized.
- As a sub-component of the Whole Person Care (WPC) initiative, the MHP is developing an Intensive Service Recipient (ISR) field-based program that focuses on serving high utilizers of mental health psychiatric in-patient hospitalizations. The program offers an array of non-Medi-Cal-billable services to Medi-Cal beneficiaries, including outreach and engagement, crisis support services, service navigation, linkage to housing resources, transportation, and many others. These services complement Medi-Cal-billable clinical and case management services.
    - The MHP has initiated a clinical PIP on reducing hospitalizations for ISRs.
    - Through the ISR program, the MHP is piloting a new approach and focus for STATS data on hospitalizations and drivers of avoidable rehospitalizations. This information will be used to generate system-wide monthly discussions with the goal of improving service quality and peer programming.

Consumer Outcomes

- As part of the executive reorganization, the MHP is in the process of establishing the Office of System Performance, Data and Quality which will oversee the Strategies for Total Accountability and Total Success (STATS) process. This transformation will affect performance evaluation, maintenance and improvement for both directly operated and contracted services. The goal of these service and administrative operations changes is to increase efficiency and productivity throughout the workplace, thereby improving services and outcomes for consumers.

- Starting July 1, 2017, the formerly known Integrated Care Program/Community-Designed Integrated Services Management Model became the Recovery, Resilience, and Reintegration – Community-Designed Integrated Services Management Model (RRR-ISM). This program promotes collaboration and community-based partnerships to integrate health, mental health, and substance abuse services with needed non-traditional care to support recovery for underserved ethnic communities.

PERFORMANCE MEASUREMENT

As noted above, CalEQRO is required to validate the following PMs as defined by DHCS:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of TBS Beneficiaries Served Compared to the 4% *Emily Q.* Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS);
- Total psychiatric inpatient hospital episodes, costs, and average LOS;
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

HIPAA Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to eleven (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides detail on beneficiaries served by race/ethnicity.

Table 1: Los Angeles MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	563,858	13.6%	30,317	15.1%
Latino/Hispanic	2,390,000	57.5%	94,145	46.9%
African-American	390,153	9.4%	36,455	18.2%
Asian/Pacific Islander	401,549	9.7%	9,312	4.6%
Native American	5,278	0.1%	611	0.3%
Other	411,750	9.9%	29,822	14.9%
Total	**4,160,000**	**100%**	**200,662**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

Penetration Rates and Approved Claim Dollars per Beneficiary

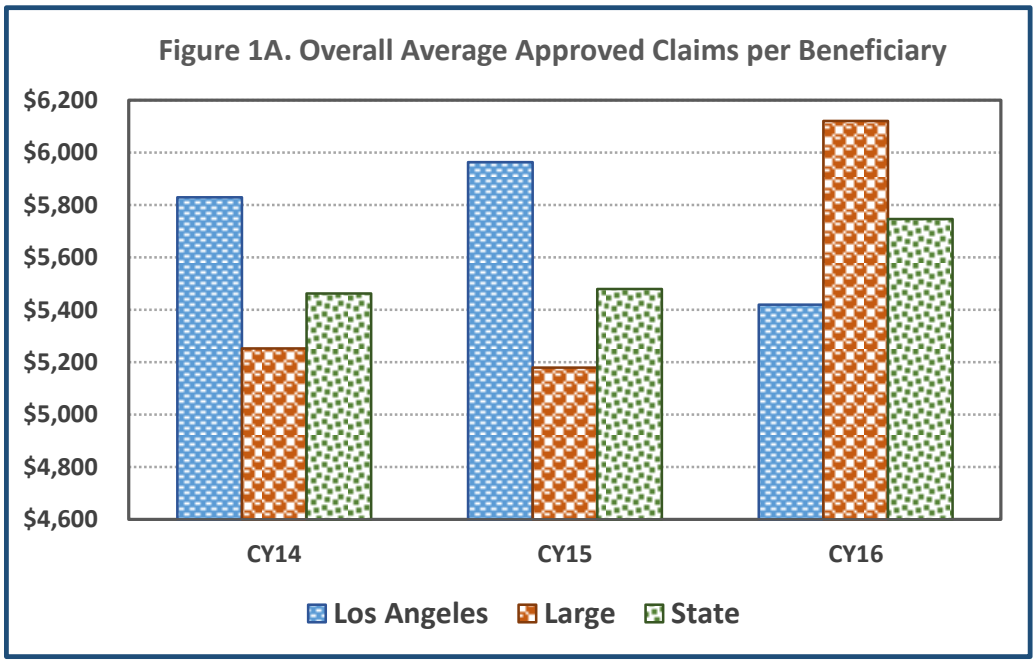
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

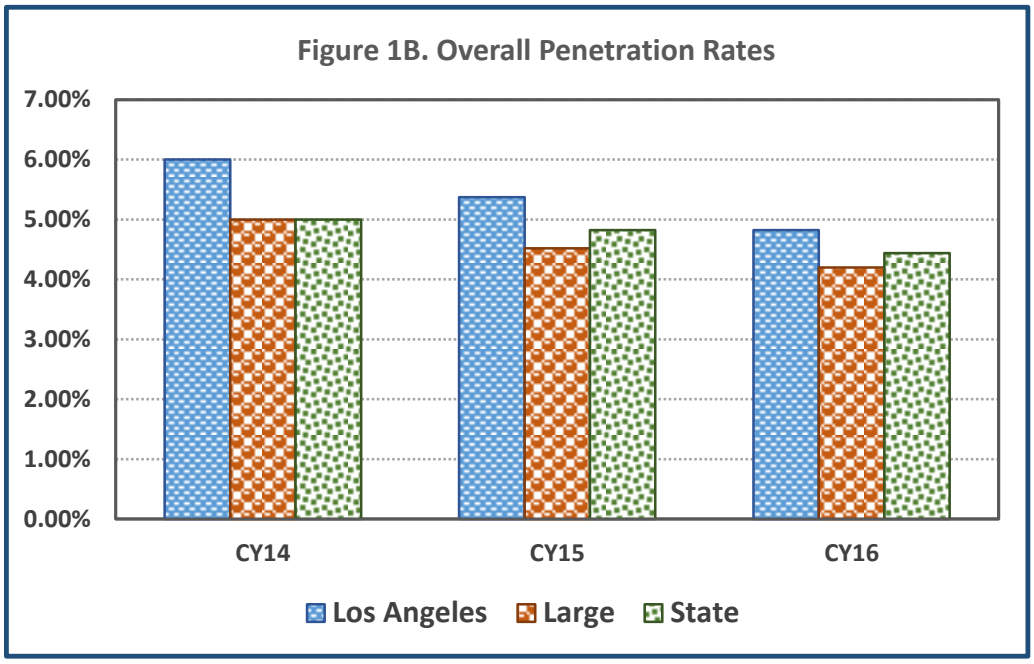
Regarding calculation of penetration rates, the Los Angeles MHP uses a different method.

NUMERATOR: Unduplicated number of consumers served in outpatient Short-Doyle Medi-Cal (SDMC) facilities at or below 138% Federal Poverty Level.

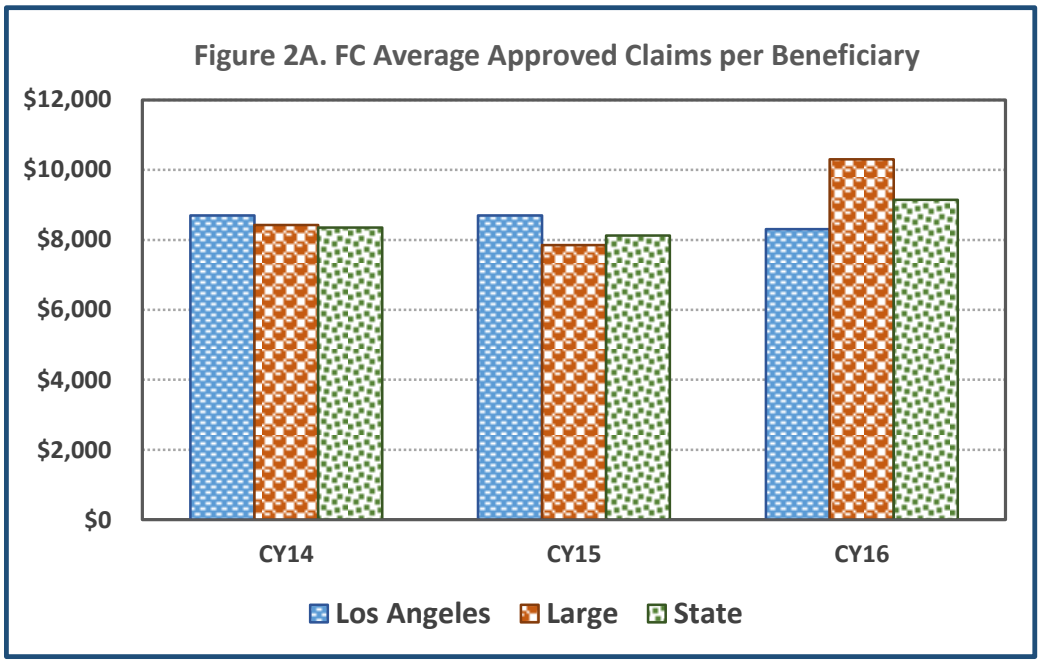
DENOMINATOR: County population estimated with SED and SMI at or below 138% Federal Poverty Level (Prevalence).

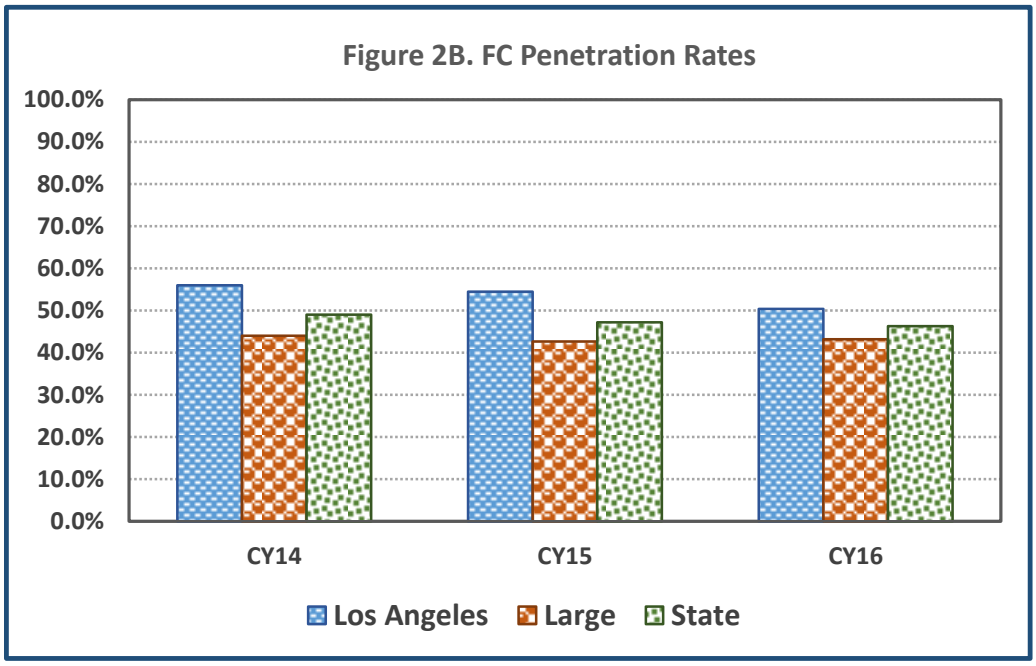
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



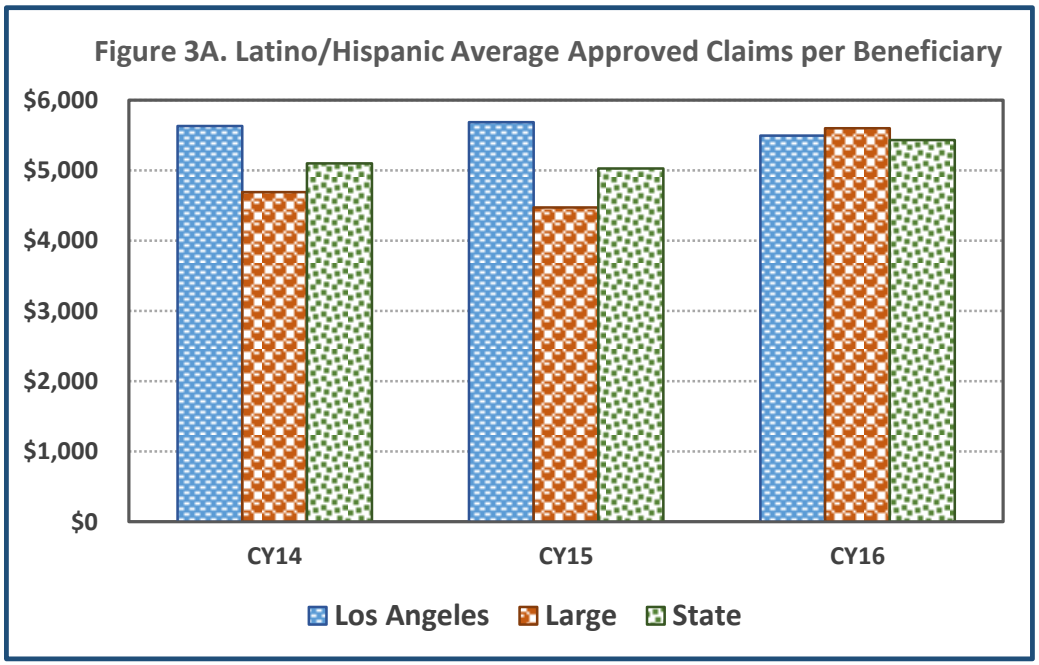


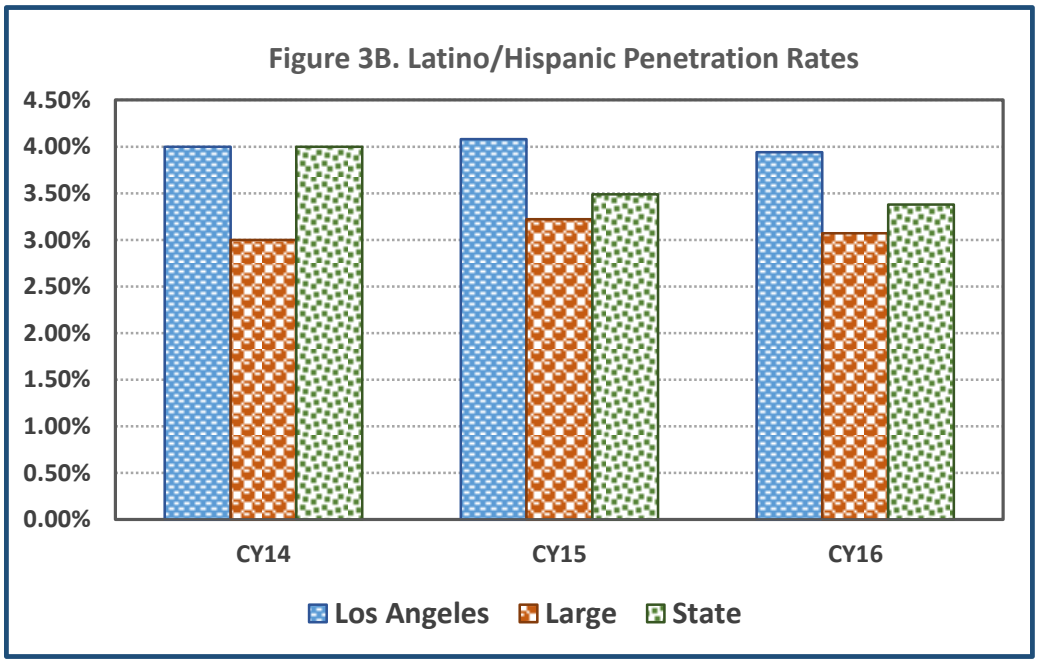
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





High-Cost Beneficiaries

Table 2 compares the statewide data for High-Cost Beneficiaries (HCBs) for CY16 with the MHP's data for CY16, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

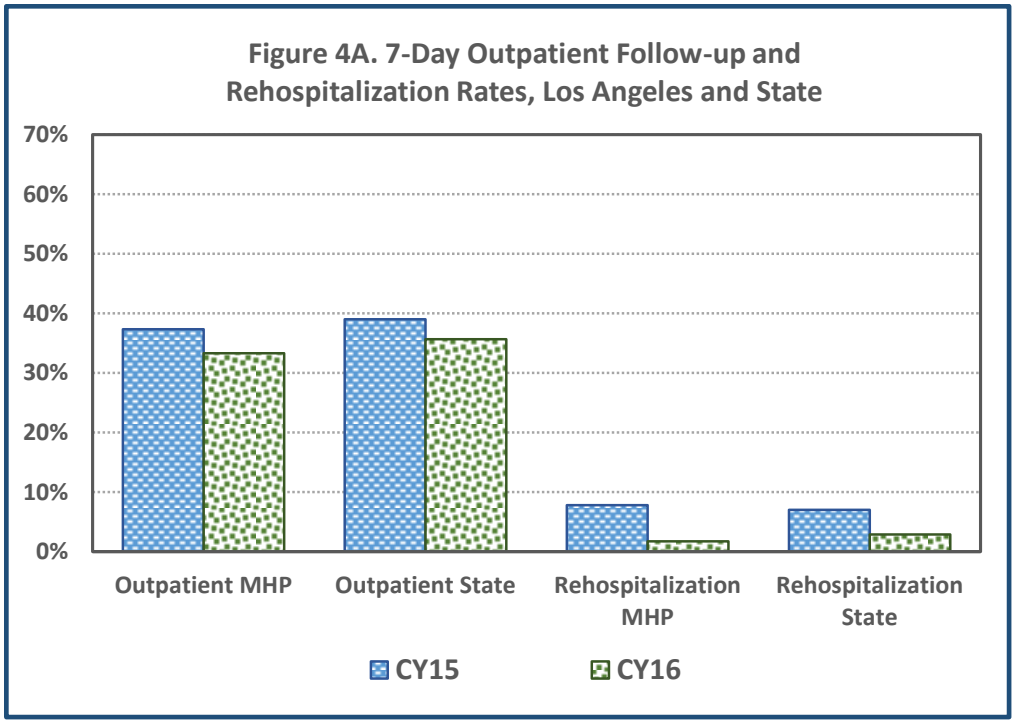
Table 2: Los Angeles MHP High-Cost Beneficiaries

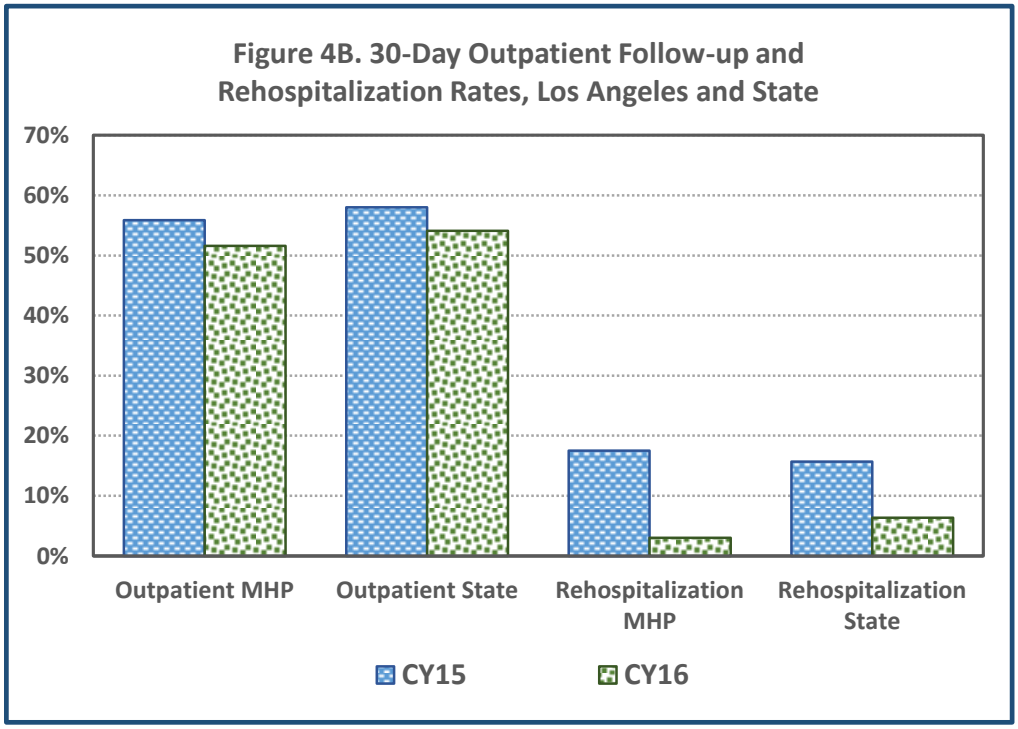
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	19,019	609,608	3.12%	$53,215	$1,012,099,960	28.90%
Los Angeles	CY16	4,659	200,661	2.32%	$49,012	$228,347,716	20.99%
	CY15	4,565	159,668	2.86%	$49,919	$227,880,311	23.93%
	CY14	3,656	160,946	2.27%	$47,797	$174,744,257	20.08%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under $20,000; $20,000 to $30,000; and those above $30,000.

Timely Follow-up After Psychiatric Inpatient Discharge

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY15 and CY16.

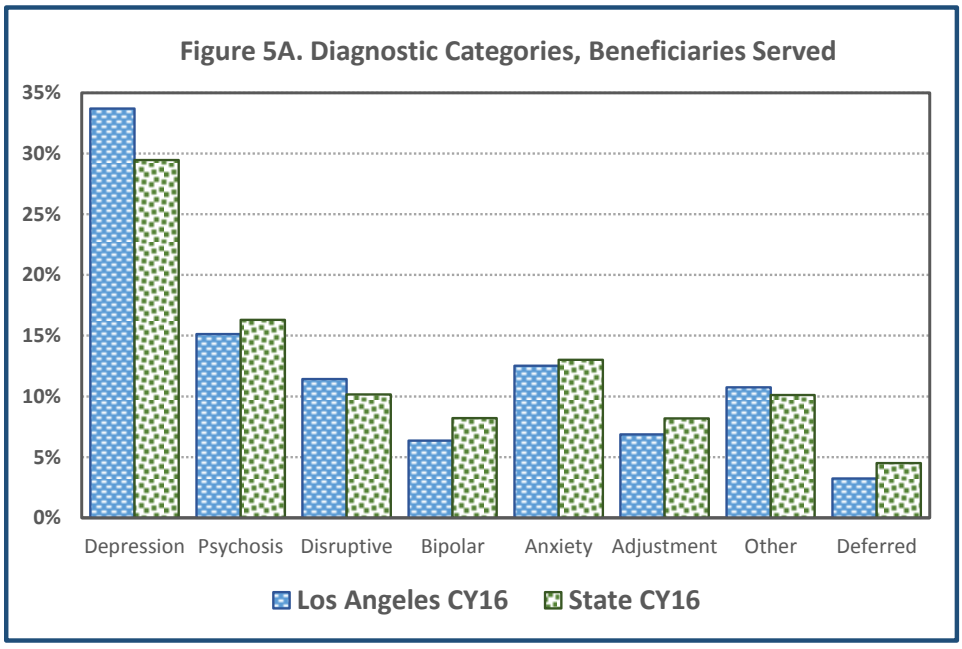


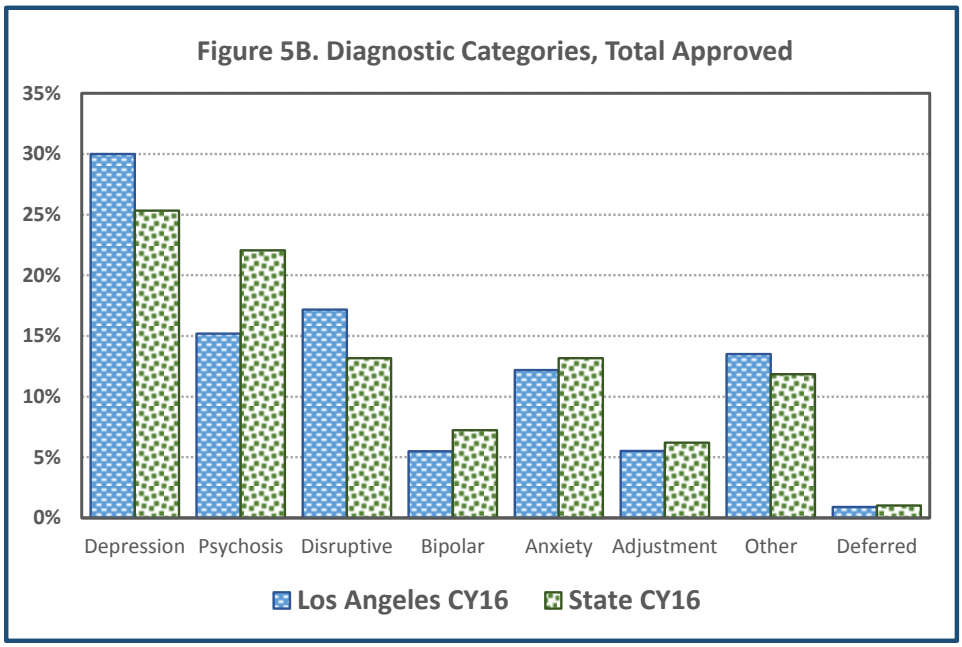


Diagnostic Categories

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 25%.





Performance Measures Findings—Impact and Implications

Access to Care

- The MHPs overall penetration rate for the three-year period was higher than both large and statewide averages.
- Foster Care penetration rates were relatively stable for the three-year period and higher than both large and statewide averages.
- Latino/Hispanic penetration rates were relatively stable for the three-year period and higher than both large and statewide average.

Timeliness of Services

- The MHP's 7-day and 30-day outpatient follow-up rates after discharge from a psychiatric inpatient episode declined slightly when compared to the corresponding CY15 rates, and are lower than statewide averages.
- The MHP's ACCESS Center log is integrated with IBHIS. As a result, the MHP can track time and date of first contact for consumers who initiate services through the ACCESS Center.

Quality of Care

- The MHP's average overall approved claims per beneficiary declined slightly from CY14 ($5,830) to CY16 ($5,420), and is lower than both large ($6,121) and statewide ($5,746) averages for CY16.
- Foster Care approved claims per beneficiary remained stable during the three-year period, and is lower than both the large and statewide average for CY16.
- Latino/Hispanic average approved claims per beneficiary remained stable during the three-year period, and is similar to both the large and statewide averages.
- Consistent with the statewide diagnostic pattern, a primary diagnosis of Depressive disorders accounted for the largest percentage of beneficiaries served by the MHP. The MHP had a notably lower rate of Psychotic disorders, and a higher rate of Disruptive disorders when compared to statewide averages.
- Corresponding with the MHP's diagnostic pattern, the percentage of total approved claims for individuals with Depressive disorders were higher than that of other diagnostic categories.

Consumer Outcomes

- Both 7-day and 30-day MHP rehospitalization rates remained stable between CY15 and CY16, and were higher than the statewide rates.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." The Validating Performance Improvement Projects Protocol specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year.

Los Angeles MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed and validated two MHP-submitted PIPs as shown below.

Table 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 3: PIPs Submitted by Los Angeles MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Addressing Drivers of Rehospitalization for Intensive Service Recipients (ISRs) – COD Related Issues and Inadequate Bridging Services
Non-clinical PIP	1	Improving the Responsiveness of the LACDMH 24/7 Hotline by Implementing the ACCESS Center QA Protocol

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] *2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.*

Table 4: PIP Validation Review					
Step		PIP Section	Validation Item	Item Rating	
				Clinical	Non-clinical
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	PM
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	M
		1.4	All enrolled populations	NR	M
2	Study Question	2.1	Clearly stated	NR	PM
3	Study Population	3.1	Clear definition of study population	NR	M
		3.2	Inclusion of the entire study population	NR	PM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	PM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	UTD
		5.2	Valid sampling techniques that protected against bias were employed	NR	UTD
		5.3	Sample contained sufficient number of enrollees	NR	NM
6	Data Collection Procedures	6.1	Clear specification of data	NR	M
		6.2	Clear specification of sources of data	NR	M
		6.3	Systematic collection of reliable and valid data for the study population	NR	PM
		6.4	Plan for consistent and accurate data collection	NR	M
		6.5	Prospective data analysis plan including contingencies	NR	M
		6.6	Qualified data collection personnel	NR	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	M
		8.2	PIP results and findings presented clearly and accurately	NR	M
		8.3	Threats to comparability, internal and external validity	NR	PM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	M
		9.3	Improvement in performance linked to the PIP	NR	PM
		9.4	Statistical evidence of true improvement	NR	NM
		9.5	Sustained improvement demonstrated through repeated measures.	NR	NA

Table 5 provides a summary of the PIP validation review.

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	NR	14
Number Partially Met	NR	9
Number Not Met	NR	2
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	NR	27
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	**NR**	**68.52%**

Clinical PIP—Addressing Drivers of Rehospitalization for Intensive Service Recipients (ISRs) – COD Related Issues and Inadequate Bridging Services

The MHP presented its study question for the clinical PIP as follows:

"Will the three interventions designed for this Clinical PIP result in:

1. A pre-post reduction (%TBD) in the 7-day and 30-day rehospitalization rates for ISRs six months post participation in the COD groups in FY 17-18 compared to the baseline rehospitalization rates in FY 16-17?

2. A pre-post reduction (%TBD) in the hospital days for the rehospitalizations in FY 17-18 for ISRs six months post participation in the groups compared to the baseline hospital days for rehospitalizations in FY 16-17?

3. A pre-post (TBD%) improvement in the 7-day post discharge outpatient follow up in FY 17-18 for ISRs six months post participation in COD group compared to the 7 day post discharge outpatient follow up in FY 16-17?

4. Increased participation in COD groups by ISRs in FY 17-18 as evidenced by participation in at least 2 groups per month compared to no or limited participation in COD groups during the baseline period for FY 16-17?

5. A pre-post reduction (%TBD) in the 30 day rehospitalization rates for ISRs in FY 17-18 post participation in the Crisis Residential Treatment Programs (CRTPs) compared to the baseline rehospitalization rates in FY 16-17?

6. A pre-post reduction (%TBD) in the hospital days for the rehospitalizations in FY 17-18 for ISRs post participation in the Crisis Residential Treatment Programs (CRTPs) compared to the baseline hospital days for rehospitalizations in FY 16-17?

7. A pre-post (TBD%) improvement in the 7-day post discharge outpatient follow up in FY 17-18 for ISRs in FY 17-18 compared to the 7-day post discharge outpatient follow up in FY 16-17?

8. Increased participation (%TBD) in outpatient services by ISRs in FY 17-18 post participation in the Crisis Residential Treatment Programs (CRTPs) compared to participation in outpatient services in FY 16-17?"

Date PIP began: July 2017 – not yet active

Status of PIP: Concept only (not rated)

As part of a larger county-wide initiative to serve and improve outcomes for high-need and high-cost individuals, the MHP has targeted intensive service recipients (ISR), defined as adults 18 and older who have had four or more inpatient hospitalizations in the past 13 consecutive months.

The goal of the PIP is to decrease rehospitalizations, including frequency and duration of stay, for ISRs. The MHP speculates that two factors contribute to repeated hospitalizations - untreated co-occurring disorders (COD) and failure to engage consumers after discharge from an inpatient hospital stay. However, the PIP does not present data that supports either of these contentions. Nevertheless, the interventions are designed around these two barriers. The interventions include to provide COD groups to ISRs, with a secondary diagnosis of an SUD, and to prioritize beds for ISRs within crisis residential facilities. The PIP listed two other interventions; however, these were considered by CalEQRO as activities that the MHP needs to (1) identify the study population (i.e., creation of a widget), and (2) to conduct groups (i.e., training of the staff). The MHP just—during the week of the onsite review—started a COD group in one of the service areas.

This PIP is considered concept only because some PIP components are unclear and/or missing. Although the MHP included a plan with target dates for interventions to begin, they did not implement the clinical intervention as stated in the write up. At the time of the onsite review, CalEQRO could not determine that the main clinical intervention had begun. The requirement for an active PIP is that at least one intervention has begun, all components of the PIP are in place, baseline data has been established, and data collection has begun.

The PIP seems to focus on ISRs with COD, which, at 60%, represents most, but not all, of the ISR population. The MHP also needs to address participation and enrollment in the project. If an ISR opts out of the crisis residential program (as some did) and the participant does not require a COD group, then the MHP has not provided any intervention to the population for whom the PIP is intended. Another component that the MHP needs to clarify is the study question, which at present, is a list of outcomes (and indicators). Rather, the MHP should prepare a comprehensive statement that captures what their stated (i.e., per the onsite discussion) intentions are—to increase engagement of ISRs. The MHP will also need to articulate the relevant data that was the basis of the PIP (e.g., ISR rehospitalization rates), additional indicators, and their data analysis plan.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of discussion about collaboration with the county's substance use program (e.g., the Substance Abuse Prevention Control), operationalizing engagement, and incorporating those measures of engagement into the PIP. The MHP expressed intentions to focus on collaboration with the Substance Abuse Prevention Control (SAPC) in the next year and has started conversations with SAPC to engage in this collaboration.

Non-clinical PIP—Improving the Responsiveness of the LACDMH 24/7 Hotline by Implementing the ACCESS Center QA Protocol

The MHP presented its study question for the non-clinical PIP as follows:

"This PIP set forth to examine if implementing the QA Protocol for the LACDMH ACCESS Center 24/7 Line would result in:

1. Ten (10) Percentage Points (PP) improvement in ACCESS Center calls *where language interpreter services were offered* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17?

2. Ten (10) PP improvement in ACCESS Center calls *where the Agent requested the caller's name* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17?

3. Two (2) PP improvement in referrals provided to Specialty Mental Health Services (SMHS) for calls requesting these services?

4. Five (5) PP improvement in ACCESS Center calls *where Agents demonstrated respect/customer service* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17?

5. Four (4) PP improvement in ACCESS Center calls *showing an identified presenting problem* in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18?

6. Four (4) PP improvement in ACCESS Center calls showing identified medical needs in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18?

7. Three (3) PP improvement in ACCESS Center calls showing identified substance abuse issues in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18?

8. Two (2) PP improvement in ACCESS Center calls *where the caller's information was documented* in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18?
9. Five PP improvement on the *test calls study results for CY 2017 compared to CY 2016* for the three indicators: a) Percent requesting caller's name; b) Percent of callers satisfied with ACCESS Center services; and c) Percent of actual calls logged by the ACCESS Center"

Date PIP began: July 2016

Status of PIP: Active and ongoing

This is the second year of this non-clinical PIP, which is designed to improve call handling at the ACCESS Center. The impetus for the PIP was the MHP's performance on annual test calls, wherein the MHP identified three areas for improvement: 1) number of calls logged; 2) request of caller's name; and 3) caller's satisfaction. The MHP selected these areas as there was either an overall decrease in performance from CY12-CY15 or a one-year decrease from CY14-CY15.

As of May 2017, the PIP also included three additional areas: 1) documentation of presenting problems; 2) medical needs; and 3) substance use issues. However, the MHP did not provide a rationale for inclusion of these three new areas. The PIP included documentation such as the call recording protocol, the data collection procedure, including randomized selection for sampling, and the customer service evaluation checklist. This was part of a Quality Assurance Protocol for ACCESS Center agents designed to provide consistency and uniformity. Also incorporated were supervisory reviews of calls, with a feedback loop to ACCESS Center staff.

For this second year, the PIP addressed some of the recommendations made by CalEQRO during the FY16-17 review. The MHP increased the number of calls to be sampled; modified

the sampling technique to be based on agents rather than supervisors; and incorporated or articulated the inclusion of other languages (besides Spanish) for review.

The PIP has not sufficiently addressed how these activities will benefit consumer outcomes. CalEQRO acknowledges the MHP's limited scope and contact with consumers, but believes that there are opportunities for the MHP to indicate the impact on the consumer. One opportunity may lie in the very reason why a consumer would call the ACCESS Center—to get information and be connected with services. The MHP ought to feature those components that relate to the ACCESS Center meeting the consumer's or pre-consumer's needs. This could be done through showing, for example, the number of referrals made (which the MHP already captures) to the number of appointments made and kept. The MHP could also highlight variables on the QA Checklist that relate to satisfaction, including restating the caller's request (Item 4.5), and/or that the action plan was appropriate (Item 5.3). Another area that the PIP needs to address is the sample size. While the MHP has increased the number of calls sampled, this number is still not sufficient for statistical significance, as it does not enable the MHP to generalize to approximately 13,500 calls per month, which vary by language and time of day.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of recommendations to include or highlight the consumer benefits resulting from the PIP. Also discussed was the inclusion of agents and, if possible, peers in the review process, thereby significantly increasing the number of calls reviewed to reach statistically significant representation, and subsequently decreasing the burden on supervisors. Lastly, for this PIP to continue, it will need to target a specific area for further investigation. Otherwise, the MHP will need to select a new PIP topic.

PIP Findings—Impact and Implications

Access to Care

- The clinical PIP aims to engage ISRs whom the MHP reported were a difficult to reach population. Ultimately, the MHP's goal is to motivate ISRs to have regular clinical contact, rather than crisis or emergency-based contact, with health care services which promotes health maintenance.
- The non-clinical PIP has the potential to increase access to care for consumers. The MHP would be well served to highlight the impact on access (e.g., referrals to Psychiatric Mobile Response Teams).

Timeliness of Services

- The non-clinical PIP included timeliness of calls answered by staff, within one minute, for ACCESS calls.
- The PIPs both have implications for timeliness to services when consumers receive necessary information on calls to the ACCESS Center and when ISRs are connected to follow-up care after hospitalization.

Quality of Care

- The clinical PIP is attempting to improve services to, and fill gaps in, services to a high-risk population. Coordinating care and addressing co-occurring substance use disorders are intended to improve clinical care for consumers.
- The aim of the non-clinical PIP is to improve the quality of calls answered by the ACCESS Center, so consumers' needs and reasons for calling are met. With the addition of the additional components (e.g., documentation of presenting problems, etc.), the MHP has factored in ways to optimize the quality of the interaction with call agents.

Consumer Outcomes

- The non-clinical PIP suggests consumer outcomes, but the explicit focus appears to be on the process of handing calls at the ACCESS Center.
- The clinical PIP is intending to improve consumer outcomes through decreased rehospitalizations.
- The clinical PIP demonstrates benefit to consumers through provision of services and treatment that address their presenting issues, including substance use.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 6 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 6: Access to Care Components

Component		Quality Rating
1A	Service accessibility and availability are reflective of cultural competence principles and practices	M

The MHP assesses, identifies, implements and evaluates strategies to address the cultural, ethnic, racial and linguistic needs of its consumers. Los Angeles County has twelve threshold languages, and provides services and communication materials in each of these languages. Data reports are disaggregated by age, gender, ethnicity and language. Special reports are produced on disparities among specific communities (e.g., API, homeless). The MHP is implementing a Cultural Competence Organizational Assessment (August-October 2017).

The Cultural Competency Committee (CCC) meets monthly, has a standing agenda and meeting minutes that include updates from the Ethnic Services Manager. The standing agenda would benefit from additional emphasis on data sharing, analysis and use for improvements in programs and service delivery. Examples of discussion topics at CCC meetings include the impact of federal immigration orders on consumers living in fear of deportation; and the meaning of cultural competence as it relates to mental health services for the African American community. Representation includes the MHP and several community groups, and significant consumer participation. The MHP is engaged in several current initiatives to address the homeless population.

The MHP used Public Service Announcements to reach various underserved linguistic groups

last year to increase the use of the ACCESS Line and available clinical services.

Stakeholders expressed the need for clinical services and wellness centers to be accessible outside of regular business hours (e.g., Monday–Friday, 8am-5pm), requesting evening and weekend hours that would accommodate consumers' and family members' schedules.

1B	Manages and adapts its capacity to meet consumer service needs	M

The MHP identifies, implements and evaluates utilization data, caseloads and strategies to address the types and numbers of practitioners and providers necessary to meet the clinical, cultural, and/or linguistic needs of its beneficiaries. Additional emphasis on quality of care, turnover and long-term retention of consumers would further reflect quality efforts.

The MHP continues addressing the challenge of creating new positions for providers, and hiring and retention. Telemedicine is being utilized to leverage existing capacity throughout the MHP, and to hire outside practitioners. The MHP is developing a process to track and trend metrics on workload and productivity for MDs.

Parity remains an issue across the entire SOC, and is particularly uneven between various service areas, which further impacts disparity. In response, the MHP is working on creating a more fluid and dynamic staff with the ability to shift between service areas in response to demographic changes. In addition, there is a shift towards more field-based service provision, particularly for intensive services. However, there remains a shortage of staff which slows access and timeliness of care. Additionally, the shortage of psychiatric beds is a challenge.

Clinical staff vacancies in most clinics (county and contracted) for adults and children are putting pressure on existing staff, who report that while self-care is encouraged at the agency level, it is difficult to take time off due to heavy caseloads and vacancies. While the MHP is utilizing interns, they require significant supervision which further stresses existing licensed staff.

While the MHP provides training in EBPs and has moved training sites closer to agencies requesting training, attendance has not increased. Training funds are also provided directly to contracted agencies as needed, and funding can be increased when requested. Trainings and workshops are free to both county and contracted agency staff. However, the MHP reports that funds are not always maximized as managers and supervisors are reluctant to send staff due to the perceived loss of billing, and contracted agencies prefer to go through the MHP for training. However, County and contracted staff report that while trainings are a professional opportunity for all, there is frustration with the limited number of training slots available, which also seem to fill up quickly, particularly for evidence based practices.

The MHP meets current demand for Katie A. services, and has excess capacity available. To ensure all children's intensive services become Katie A. capable, Full Service Partnership (FSP) capacity has been expanded to include intensive services (IHBS, ICC) and child family teams (CFTs). As 80% of foster children remain within Southern California counties, these

counties are working together to develop processes for seamless service delivery, and policies/protocols are in progress. The MHP provided ample documentation on program data, evaluation processes and fidelity tools.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP provided multiple examples of collaboration and integration with community-based services to improve overall access, including embedded staff and field-based operations in numerous programs and sites throughout the county. However, providing integrated services for consumers with co-occurring disorders remains challenging. The Office of Consumer and Family Affairs has been changed to the Office of Constituent Advocacy/BOS Inquiries. Having staff co-located in the jails is reportedly effective for linkages and seamless jail releases/engagement in outpatient mental health services and programs. Stakeholders report that outreach and linkages with the faith-based community have improved. Every Service Area has at least one Health Neighborhood (a virtual neighborhood determined by geographic boundaries and governed by a non-financial MOU), established to improve needed access to care (health, mental health, public health, substance use, and other supportive services) for residents living in that boundary. Participating agencies gather monthly to learn about services in the area, improve referral and care coordination processes, and plan locally relevant activities, resulting in better communication, coordination, record reviews, and follow-up for consumers. Site certification issues are being addressed. Tracking utilization data, survey results and consumer outcomes, while not yet successfully implemented, is recommended. There appears to be a lack of clarity among stakeholders around school-based services, claiming for travel time, and the need for Medi-Cal site certification of schools. These changes are statewide and took effect July 2017. For the Wellness Recovery Action Plan (WRAP) program to be successful, more consistent participation is needed from DCFS social workers and from probation officers.		

Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to mental health services. This ensures successful engagement with consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 7: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first appointment	M
The MHP tracks and trends this metric for offered, accepted and kept appointments for both adults and children (by language) in both county operated and contract providers, and has a standard of 15 business days. For county operated clinics, the MHP meets this standard for children 84.67% of the time, and for adults 95.78%. For contract providers, timeliness lags that of county operated clinics for children, met 68.77% of the time, and for adults 70.06%. The MHP continues to work on their timeliness metrics, and has developed a 6-step plan for improvement of timeliness from assessment to first clinical appointment.		
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PM
The MHP tracks and trends this metric for both initial requests for psychiatry and for emergent medication needs only, for both adults and children (by language). This metric is only tracked for county operated providers, and has a standard of five business days. The MHP meets this standard for children 4.82% of the time, and for adults 14.32%. Both are very low and performance improvement activities should be initiated. While the MHP tracks this metric for both county and contracted providers, the MHP stated that not all consumer present as needing medication support services on initial assessment, and therefore this metric may misrepresent the efficiency with which they provide these services, once identified.		
2C	Tracks and trends access data for timely appointments for urgent conditions	M
The MHP tracks and trends the length of time from service request for urgent appointment to actual encounter for adults and children (by language) for both county operated and contract providers. The MHP has a standard of five business days, and would benefit from shortening it to 48-72 hours. The MHP meets this standard 100% of time for children, and 69.87% for adults in directly operated clinics; and contract providers meet the standard 97.62% for children and 84.04% for adults. For children served by intensive programs, the crisis teams will not respond unless the clinician is onsite. While that may be a sound clinical perspective, often intensive team		

caseloads are widely dispersed throughout the region. This may result in delay in service to those individuals when the clinician must travel through high traffic zones, such as the 405/101 interchange which is often backed up.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM
The MHP tracks and trends this metric for 7-day post hospitalization for both adults and children (by language). This metric is tracked for county operated and contracted hospital facilities, and has a standard of five business days. The MHP meets this standard for children 70.21% of the time, and for adults 78.72%. The data reported includes timeliness of follow-up encounters post-psychiatric inpatient discharge for individuals not already receiving services from a mental health provider. Individuals who are active at a directly-operated program of service would not be tracked using the EHR Service Request Log, but rather referred directly back to the established outpatient provider, and the timeliness of appointments provided to that subset of individuals is not captured in this metric.		
2E	Tracks and trends data on rehospitalizations	M
The MHP tracks and trends this metric for rehospitalizations for both adults and children (Medi-Cal and indigent clients) in both county operated and contract provider clinics. The MHP is currently engaged in a PIP to improve post-hospitalization follow-up and engagement to reduce the rehospitalization rate of intensive service recipients. The MHP does not have a standard for this metric. The rehospitalization rate for children is 12.15%, and for adults is 30.66%.		
2F	Tracks and trends no shows	PM
The MHP tracks and trends this metric for no shows for both adults and children (by language) for county operated clinics only. The MHP has no standard for this metric. For psychiatry, the no show rate for children is 13.22% and for adults is 16.59%. For clinicians, the no show rate for children is 5.93% and for adults is 8.15%. While the MHP does not track this metric for contract providers, work is currently underway to develop web services that will allow the MHP to collect service request data electronically from contract providers in the future. Even with significant efforts to engage consumers, contract providers reported frustration around the lack of a system-wide rule and protocols they can leverage (e.g. double or triple booking, closing episodes) regarding consumer accountability for no shows.		

Quality of Care

In Table 8, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 8: Quality of Care Components

Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	M

The MHP has Quality Improvement Committees (QIC) in each service area, centrally, and for the children's SOC. The central QIC is made up of service area QIC chairs and co-chairs. Representation for the service area QICs includes the MHP, contract providers and several community groups, but additional consumer participation is needed. QIC chairs are filled by county staff, and co-chairs by contract provider staff. The QICs meet monthly to quarterly, have a standing agenda and meeting minutes that include updates on Clinical Quality Improvement, Consumer Satisfaction, and compliance issues. The MHP has a current Quality Improvement (QI) work plan with measurable QI goals and objectives, and an evaluation of the previous year's accomplishments. The MHP is encouraged to include regular review of their timeliness self-assessment metrics in their QI work plan and QIC meetings.

Stakeholders report that service area QIC meetings focus mainly on providing information on compliance issues (e.g. bulletins, policies) rather than an open dialogue on quality care issues. In addition, while communication of QI goals is largely occurring, interpretation of standards has great variance across the SOC, showing room for improvement. Contract providers report that their agencies are actively engaged in clinical QI activities and projects, with internal advisory councils and peer involvement.

The service area QICs would benefit from a more balanced focus on performance and clinical consumer care and outcomes juxtaposed with compliance issues. The QI work plan should include timeliness of access service goals. The standing agenda would benefit from additional emphasis on data sharing, analysis and use of data for improvements in programs, service delivery and consumer outcomes. In addition, the standards set forth in the QI work plan and PIPs should be included in the standing agenda.

Table 8: Quality of Care Components		
Component		**Quality Rating**
3B	Data are used to inform management and guide decisions	M
The MHP collects, analyzes and uses program-specific data to identify good practices, explain patterns of care, identify issues in the provision of care, and determine areas for improvement. Metrics are tracked and trended for performance measures, program-specific outcome measures, and consumer satisfaction surveys. The delivery of services and the target levels to specific ethnic groups is reported and reviewed each year. Emergency Service supervisors meet twice monthly to review crisis data (e.g. call volume, response time, demographics, outcomes). However, MHP leadership stated that they have not consistently used data to inform programs with parity across the entire SOC, and that the reorganization is an opportunity to rectify this. Program-specific, e.g. Evidence Based Practices (EBPs) outcome measures are limited in scope so aggregate data does not reflect the entire SOC. The MHP informed CalEQRO that the Child and Adolescent Needs and Strengths Assessment (CANS) tool is not an outcome measure. Contract providers report that they routinely submit data to the MHP, and receive a limited report card only quarterly, which is insufficient for program and staffing management. They also stated that the information regarding data requirements varies considerably from different bureaus, and with frequent changes implemented from the MHP. This creates challenges in developing consistent policies and protocols, and to train staff.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
Stakeholders report that while communication is effective and the MHP is open to feedback, their perception is that they are solicited for their input only after system changes have been decided upon and are being implemented. Additionally, while communication of QI goals is largely occurring, interpretation of standards has great variance across the SOC (with stakeholders in various service areas each having a different understanding), showing room for improvement. Communication from the MHP executive and management teams is more streamlined with directly operated staff than with contract providers who report not receiving the same consistent messaging. Input and feedback from clinical line staff and other stakeholders to the MHP executive team, while improving, needs to be further strengthened. A consistent structure, frequency, duration and agenda is needed for		

Table 8: Quality of Care Components		
Component		**Quality Rating**
meetings held in all eight service areas to ensure clear and consistent messaging and a strong feedback loop. The MHP maintains an extensive website with program pages, calendars and brochures in the threshold languages. Communication with staff is primarily through monthly staff meetings, team meetings, emails, notification bulletins, and some text messaging for field-based staff. Inconsistent staff surveys were also reported. Staff reported frustration due to the lack of clear and consistent information regarding funding sources, regulations and restrictions. Consumer employees reported attending staff meetings and numerous MHSA-funded program and stakeholder meetings. Voice-to-text capability was mentioned for documentation. There remains general staff uncertainty throughout the SOC regarding the impact of the current reorganization, specifically on jobs, workload, funding, and resource distribution. The MHP held a 3-day event entitled "Day of Dialogue" in May with 4,000 participants attending various health education sessions and activities. No consumer family member focus group participants and very few line staff reported being invited to participate on committees (e.g. QIC, CCC).		
3D	Evidence of a systematic clinical continuum of care	M
Stakeholders report that the acuity of consumers seems to be generally increasing, with initial assessments at higher levels of need, more co-morbidity and co-occurring disorders with substance abuse and physical health problems, along with population-based trauma due to poverty, homelessness, isolation, domestic violence and criminal justice involvement. While all levels of care exist within the MHP, they are not equally distributed throughout the eight service areas resulting in some service areas having no or inadequate service provision. The evaluation of strategies tends to be countywide and not based on service areas, which provides a biased assessment and not a true reflection of the level of parity. As part of the reorganization, the Emergency Outreach Bureau and Mobile Crisis will be changing its name to the Emergency Outreach and Triage Bureau, with renewed focus on engaging the disengaged. The MHP continues to work towards having a full continuum of care for all crisis services, including for consumers who don't meet medical necessity but who continue to have high suicidality. There is much diversity in the tools used by the MHP and its providers to measure levels		

Table 8: Quality of Care Components		
Component		**Quality Rating**
of care and consumer acuity. However, there is no universal use of level of care tools, and many tools are clinical instruments for measuring severity of illness/progress. The MHP plans to implement a level of care system for adults and pilot one for children. Consultation and integration between mental health, primary care, SUD and other services are achieving results in Health Neighborhoods, but are less successful elsewhere. Staff report a tension between trying to provide quality of care and service delivery versus productivity and documentation requirements. County and contracted staff are using multiple EBPs. They report that EBP trainings are a requirement, however limited slots impact availability and subsequent staff functionality. Collaborative documentation is being done in some county-operated clinics.		
3E	Evidence of consumer and family member employment in key roles throughout the system	M
The MHP has a number of peer roles including parent partners, consumer and family advocates (e.g. Kin through Peer Program), mental health advocates, and Wellness Outreach Workers (WOW) who function in various roles from greeters to group facilitators, working in English and Spanish. A number of Mental Health Advocate positions exist, which are paid and fully benefitted, and volunteers often advance into these paid positions. Many of these volunteer positions, and all the paid positions are offered through contract providers, where supervisory/peer support exists for consumer staff to maintain and expand in their positions. Approximately 100 volunteers are located within the MHP's directly operated clinics, managed through the Program Development and Outcomes Bureau. Currently there are no designated consumer family member positions on the Executive Management team, although the MHP has recently established a Peer Support leadership position that is currently being filled. The roles and responsibilities of peer employees and volunteers will be developed by the Chief of Peers, who will be a member of the executive team. Although there are lived experience staff employed by the MHP, and there is support for advancement through training, education and experience, there does not appear to be a career ladder allowing for promotion from entry level to administration positions for peer and family members. Parent advocates reported participating on the newly formed Volunteer Program		

Table 8: Quality of Care Components		
Component		**Quality Rating**
Development Steering Committee with the executive management team, with the goal of providing input to assist in improving MHP programs by increasing peer and family advocates and having peer workers in all areas of the county to help with navigation and transitions through levels of care. While peer partners are encouraged to be more integrated and consultative with the rest of the team, they reported still feeling marginalized, and expressed concern that clinical and supervisory staff and sometimes consumers do not really understand their role or value added. An example heard on more than one occasion was that peers were solicited for their opinions only to find out that decisions had already been made. They reported that often peer roles are filled by non-peers. Peers generally indicated that their roles had a major, positive effect on their own recovery, and they felt it was integral to their continued wellness. They reported that the peer programs are strength-based, compassionate and helpful with hope and resilience. Peers reported feeling anxiety around not knowing how their roles might change after the reorganization, particularly with the new emphasis placed on having peers bill for services.		
3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	M
There are eleven client-run and driven well-being centers located within six of the eight MHP service areas, operated by contract providers. Many of the programs are entirely staffed by peers and the rest of the programs are primarily staffed by individuals with lived experience. Tri City Wellness Center has a defined career ladder with three different positions and three steps within each position. An example would be Wellness Advocate I, II and III. In addition, there are multiple program-specific wellness centers that serve only clients on their caseload. The newly created Peer Resource Centers is a directly operated program located in the MHP's headquarters building and will be staffed by peers including a Community Service Counselor who will lead the team.		
3G	Measures clinical and/or functional outcomes of consumers served	PM
The MHP collects and analyzes consumer level outcomes for specific programs only, in both directly operated and contracted clinics. The MHP does not currently have system-		

Table 8: Quality of Care Components		
Component		**Quality Rating**
wide outcome measures that are aggregated and used to improve or adapt services across the entire SOC. The MHP is considering collecting continuum of care data in the future. Many tools are clinical instruments used for measuring severity of illness and progress. These include the PHQ-9 screen for depression, the Columbia Risk Assessment, Milestones of Recovery (MORS), Youth Outcomes Questionnaire (YOQ), and other measures applicable to specific EBPs, only some of which are embedded in the EHR. Other tools are scanned in, making it impossible to aggregate the data. Contract providers send completed tools to the MHP for input into the EHR, and there does not seem to be a functioning feedback loop. Contract providers reported maintaining their own system for collecting, analyzing and using this data internally. As consumers transition to different programs, they are administered new outcome measures, creating a fragmented system for tracking individual and aggregate level outcomes. The MHP is preparing to use the CANS tool throughout the children's SOC, as is required through CCR.		
3H	Utilizes information from Consumer Satisfaction Surveys	M
The MHP administers the Performance Outcomes and Quality Improvement (POQI) survey twice each year, receiving between 7,000 to 10,000 surveys biannually. The MHP compares results against prior findings and produces reports on findings, including examples of how this data is used to improve program quality. Results are shared at QIC meetings, and with providers who are encouraged to review open-ended comments. Examples of additional program-specific surveys conducted include the TAY Enhanced Emergency Shelter Survey, TAY Participant Satisfaction Survey, FSP Family Satisfaction Survey, 24/7 ACCESS Line Test Calls Survey, Workforce Education and Training One Month Outcome Survey, Non-Traditional Services Survey.		

Key Components Findings—Impact and Implications

Access to Care

- The MHP assesses, identifies, implements and evaluates strategies to address the cultural, ethnic, racial and linguistic needs of its consumers. As an example, the MHP is implementing a Cultural Competence Organizational Assessment (August-October 2017).
- The MHP provided multiple examples of collaboration and integration with community-based services to improve overall access, including embedded staff and field-based operations in numerous programs and sites throughout the county. However, providing integrated services for consumers with co-occurring disorders remains challenging.
- While all levels of care exist within the MHP, they are not equally distributed throughout the eight service areas resulting in some service areas having no or inadequate service provision. Therefore, parity remains an issue across the entire SOC, which further impacts disparity.

Timeliness of Services

- The MHP reported that timeliness reports are produced and reviewed monthly.
- The MHP tracks and trends access data from initial contact to first psychiatric appointment for county operated services only, and should expand to include contract providers as well. In addition, while the standard is five business days, the MHP only meets this standard for 4.82% of children's appointments and 14.32% of adult appointments, both of which are very low. Performance improvement activities should be initiated to address this issue.
- The MHP has a standard of five business days for length of time from service request for urgent appointment to actual encounter for adults and children, and consumers would benefit from shortening it to 48-72 hours.
- While the MHP tracks and trends 7-day post hospitalization for both adults and children (by language) for both county operated and contracted hospital facilities, the data only includes individuals not already receiving services from a mental health provider.
- The MHP tracks no shows for county providers only, resulting in significant under-reporting. The MHP should consider tracking this data for contract providers as well.

Quality of Care

- While communication of QI goals is largely occurring, interpretation of standards has great variance across the SOC, showing room for improvement.

MHP leadership stated that they have not consistently used data to inform programs with parity across the entire SOC, and that the reorganization is an opportunity to rectify this.

- The QIC would benefit from a more balanced focus on performance and clinical consumer outcomes juxtaposed with compliance issues. The QI work plan should include timeliness of access service goals. The standing agenda would benefit from additional emphasis on data sharing, analysis and use of data for improvements in programs, service delivery and consumer outcomes. In addition, the standards set forth in the QI work plan and PIPs should be included in the standing agenda.
- The MHP is initiating a PIP to improve post-hospitalization follow-up and engagement to reduce the rehospitalization rate of intensive service recipients, as the current rehospitalization rate for adults is 30.66%.
- Tracking utilization data, survey results and consumer outcomes, while not yet successfully implemented, is recommended.
- Communication from the MHP executive and management teams is more streamlined with directly operated staff than with contract providers who report not receiving the same consistent messaging. Input and feedback from clinical line staff and other stakeholders to the MHP executive team, while improving, needs to be further strengthened. A consistent structure, frequency, duration and agenda is needed for meetings held in all eight service areas to ensure clear and consistent messaging and a strong feedback loop.
- There remains general staff uncertainty throughout the SOC regarding the impact of the current reorganization, specifically on jobs, workload, funding, and resource distribution.

Consumer Outcomes

- The MHP collects and analyzes consumer level outcomes for specific programs only, in both directly operated and contracted clinics. The MHP does not currently have system-wide outcome measures that are aggregated and used improve or adapt services across the entire SOC. The MHP is preparing to use the CANS tool throughout the children's SOC, as is required through CCR.
- The MHP administers the POQI survey twice each year, along with additional program-specific surveys conducted throughout the year. Results are shared at QIC meetings, and with providers who are encouraged to review open-ended comments.

- Currently there are no designated consumer family member positions on the Executive Management team, although the MHP is in the process of hiring a Chief of Peer Services who will oversee the advancement of the peer role and services throughout the system. The MHP has a number of peer roles throughout the SOC, with paid positions primarily located with contract providers, where a career ladder exists, which is not the case with directly operated clinics. While peer partners are encouraged to be more integrated and consultative with the rest of the team, they reported still feeling marginalized, and expressed concern that clinical and supervisory staff and sometimes consumers do not fully understand their role or value added.
- There are eleven client-run and driven well-being centers located within six of the eight MHP service areas, operated by contract providers. Many of the programs are entirely staffed by peers and the rest of the programs are primarily staffed by individuals with lived experience. In addition, there are multiple program-specific wellness centers that serve only clients on their caseload.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted four 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested four focus groups with 8 to 10 participants each, the details of which can be found in each section below.

The consumer/family member focus group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions are specific to the MHP being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift certificates to thank the consumers and family members for their participation.

Consumer/Family Member Focus Group 1

CalEQRO requested an adult consumer focus group of Mandarin-speaking beneficiaries who are mostly new clients who have initiated/utilized services in a Directly Operated Clinic in Service Area 3 (SA3) within the past 12 months.

This focus group was held at the East San Gabriel Valley Mental Health Center in Covina, CA.

Number of participants: 9

Only one consumer initiated services within the past year. To protect consumer confidentiality, his/her information is incorporated into the general comments.

General comments regarding service delivery that were mentioned included the following:

- There is availability of a variety of services including groups in the preferred language.
- Participants reported feeling involved in the development of their treatment plans, and recognizing improvement in their health or that of their family members due to the mental health services received.
- Some participants voiced frustration with the frequent turnover of both psychiatric providers and therapists.

Recommendations for improving care included the following:

- Minimize the turnover and continuous change in mental health staff and providers.

Interpreter used for focus group 1: Yes Languages: Mandarin

Consumer/Family Member Focus Group 2

CalEQRO requested a consumer focus group of Vietnamese-speaking parents/caregivers of child/youth beneficiaries who are mostly new clients who have initiated/utilized services in a Contract Provider Clinic in SA3 within the past 12 months.

This focus group was held at the pacific Clinics Asian Pacific Family Center in Rosemead, CA.

Number of participants: 22

For the nine participants who entered services within the past year, they described their experience as the following:

- Positive, helpful, and having noticeable benefits on the wellbeing of their children.
- Taking variable amounts of time from two to five weeks to receive ongoing services after the referral process.

General comments regarding service delivery that were mentioned included the following:

- Participants reported feeling that the frequency of contact with therapists and case managers was adequate.
- Some reported having difficulty accessing psychiatric services, particularly when the youth are 'medication only'.
- Several participants reported that their therapists were responsive and supportive to their needs.

Recommendations for improving care included the following:

- Retaining staff is very important for continuity of care, and it is recommended that consumers maintain the same therapists over time.
- Make some of the therapy rooms more child-friendly by adding toys, games and electronics.

Interpreter used for focus group 2: Yes Language: Vietnamese

Consumer/Family Member Focus Group 3

CalEQRO requested an adult consumer focus group of Spanish-speaking beneficiaries who are mostly new clients who have initiated/utilized services in a Directly Operated Clinic in SA 7 within the past 12 months.

This focus group was held at the San Antonio Family Center in Huntington Park, CA.

Number of participants: 11

Only two consumers initiated services within the past year. To protect consumer confidentiality, their information is incorporated into the general comments.

General comments regarding service delivery that were mentioned included the following:

- Initial assessments, individual therapy and case management services are delivered in a timely fashion, and in the preferred language. Medication support is easy to navigate, and is available with appropriate frequency.
- Participants stated they felt welcomed, and received information, fliers and a calendar in Spanish with available services. They all had a number to call and reported quickly receiving extra care outside a regular appointment when needed.
- Support groups provide assistance with coping skills, which are very helpful. Participants also enjoy the recreational groups such as knitting, cooking and painting.

Recommendations for improving care included the following:

- Participants would like to receive check-in calls from their therapists between appointments.
- A Spanish-speaking wellness center is needed in Rio Hondo.
- The room used for groups in Rio Hondo is too small, and a larger room should be used.
- Family outings such as picnics should be arranged periodically.

Interpreter used for focus group 3: Yes Language: Spanish

Consumer/Family Member Focus Group 4

CalEQRO requested a consumer focus group of English-speaking Transitional Age Youth (TAY) beneficiaries who are mostly new clients who have initiated/utilized services in a Contract Provider Clinic in SA7 within the past 12 months.

This focus group was held at the Hathaway Sycamores Clinic in Commerce, CA.

Number of participants: 14

Only two consumers initiated services within the past year. To protect consumer confidentiality, their information is incorporated into the general comments.

General comments regarding service delivery that were mentioned included the following:

- Initial assessments, individual therapy and case management services are delivered in a timely fashion, and in the preferred language. Medication support is easy to navigate, and is available with appropriate frequency. All participants commented on having a treatment plan, and working toward their goals.
- The TAY Program is helpful with securing transitional and permanent housing, employment, food, transportation and other basic necessities.
- The TAY drop-in center provides opportunities to make new friends, get support, learn new skills, and get work experience as a peer volunteer.
- Participants commented that many of their friends choose drugs over mental health services, and this makes them sad. Most were aware of the number to call when they were in crisis, or just needed someone to talk to when they were "feeling bad".

Recommendations for improving care included the following:

- It would be helpful to have more opportunities available with job placement, and permanent housing.
- The TAY drop-in centers should stay open for more hours each day, every evening, and all weekend.
- Mental health services need to be made more available in the community and through social media. Junior high and high schools to should have ample programs to reduce stigma and bullying, and to normalize talking about how kids are feeling. Counselors are needed for every classroom to talk with students individually and in groups, and to mitigate feelings of anxiety and depression, wanting to hurt oneself and/or others, and drug use. It's very difficult for teens to ask for help. TAY youth should be used to assist in this role.

- Parents need to be taught how to speak with their kids about mental health issues, their feelings, drug use and sexuality. Youth in school mental health programs should be taught how to help their parents access services for their families.

- More support groups are needed everywhere, so youth can access them where they go to school, and near their homes.

Interpreter used for focus group 4: No Language: N/A

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- TAY youth should be used to assist in making mental health services more available in the community (e.g. schools) and through social media.
    - To reduce stigma and bullying.
    - To help lead teen support groups.
    - To normalize teens seeking help for feeling anxiety and depression, wanting to hurt oneself and/or others, and drug use.
    - To teach parents how to speak with their kids about mental health issues, their feelings, drug use and sexuality.
    - To teach parents how to access services for their families.
- Participants were reportedly satisfied with their access to a variety of services.
- While TAY participants knew of a number to call if they needed additional support, other participants were not aware of a hotline or warm line to call for urgent care.
- Turnover of staff was found to be disruptive, and participants expressed a desire for more consistency in therapists and providers.

Timeliness of Services

- Participants stated that initial assessments, individual therapy, and case management services are delivered in a timely fashion, and in the preferred language. Medication support is easy to navigate, and is available with appropriate frequency.

Quality of Care

- Participants found it helpful to have a treatment plan and work toward their goals.

- Staff were found to be very supportive and instrumental in improving mental health status.

Consumer Outcomes

- Wellness and drop-in centers are reportedly very effective at helping participants meet their basic needs, and reach toward their goals for wellness and recovery.
- The MHP made considerable effort to engage their stakeholders in the EQR process, particularly mono-lingual Asian consumers who had expressed reluctance to discuss their mental health services with outsiders.
- Participants enjoyed the opportunity to interact with each other. Many welcomed future opportunities to share their experiences.

INFORMATION SYSTEMS REVIEW

Understanding an MHP's information system's capabilities is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 9 shows the percentage of services provided by type of service provider.

Table 9: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	21%
Contract providers	76%
Network providers	3%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 2.1%

☒ Under MHP control
☐ Allocated to or managed by another County department
☐ Combination of MHP control and another County department or Agency

The budget determination process for information system operations is:

MHP currently provides services to consumers using a telepsychiatry application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: 19

Identify primary reasons for using tele-psychiatry as a service extender (check all that apply):

- ☒ Hiring healthcare professional staff locally is difficult
- ☐ For linguistic capacity or expansion
- ☒ To serve outlying areas within the county
- ☐ To serve consumers temporarily residing outside the county
- ☒ Reduce travel time for healthcare professional staff
- ☒ Reduce travel time for consumers

Telepsychiatry services are available with English, Spanish, Armenian, Farsi, Mandarin, and Russian-speaking practitioners (not including the use of interpreters or language line).

Three legal entities currently provide telepsychiatry services: DiDi Hirsch, Sycamore-Hathaway, and Pacific Clinics.

Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
215	10	8	32

CalEQRO review are shown in Table 10.

MHP self-reported data analytical staff changes (in FTEs) that occurred since the previous

Table 11: Data Analytical Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
33	5	3	4

CalEQRO review are shown in Table 11.

The following should be noted with regard to the above information:

- Table 10 provides a summary of technology staff changes since the previous CalEQRO review in April 2017. Since then the number of authorized IS FTE increased by seven positions.
- The Chief Information Office Bureau (CIOB) experienced significant technology staff turnover, but they were able to hire more staff than the number that departed.
- Approximately 15% of technology positions (32) are currently unfilled, and the MHP is challenged with attracting and retaining staff with the level of expertise necessary to support complex operations. County Human Resources needs to identify and address recruitment and retention issues to support the MHP.
- CIOB has been able to hire additional staff resources for Help Desk support. Maintaining an adequate level of staff to respond in a timely manner to varying levels of call volume and open work orders is mission-critical for the success of the MHP.
- Table 11 provides a summary of staff changes since the previous CalEQRO review. The Office of STATS and Informatics is responsible for data analytical support, and has allocated 33 FTE positions.
- Four of the data analytical positions, approximately 12%, are currently unfilled.

Current Operations

- All county operated sites exclusively use Integrated Behavioral Health Information System (IBHIS) as the EHR. This includes sites where MHP staff are co-located with the Department of Health Services, the Department of Children and Family Services, and Medical HUB's.
- Integrated System (IS), the legacy EHR system, is being replaced by IBHIS for all legal entities, fee-for-service hospitals and fee-for-service network providers. Sierra Systems US, Inc., is the vendor for IS, and continues to support its operations during the cutover transition phase. Current plans include sun-setting the IS legacy system during CY18 or FY18-19.
- As of September 2017, approximately 110 legal entities have become EDI transaction certified and IBHIS operational. The remaining 20 or so legal entities are scheduled for IBHIS cutover by early 2018.

- Netsmart Technologies continues to host the Primary Data Center for IBHIS, which is located in the State of Ohio. The MHP connects through a dedicated 1GB fiber connection at the Primary Data Center.
- A secondary data center is located in the State of Kansas.
- A failover VPN mesh topology is in place in the event of a network outage via the dedicated fiber connection.
- The MHP discontinued the use of RSA tokens and fixed passwords. Effective July 31, 2017 contract and FFS providers/billers were required to migrate to RSA Adaptive Authentication credentials, which replaced the hard tokens/fobs and fixed passwords previously used.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce SDMC and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar/IBHIS	CalPM, MSO, Billing, Provider Connect, Care Connect, My Health Point	Netsmart Technologies	4	Vendor IS/CIOB
OrderConnect	ePrescribing, eLab	Netsmart Technologies	4	Vendor IS/CIOB
Pharmacy Benefit Management (PBM)	Medication Claims Adjudication	Magellan RX Management	<1	Vendor/CIOB
ACCESS Call Center	Call Management System	Verizon	4	Vendor
Integrated Systems (Legacy system)	Practice Management, Billing	Sierra Systems, US, Inc.	16	Vendor IS/CIOB
DMH Data Warehouse	Data Warehouse and Reporting Environment		13	CIOB

Priorities for the Coming Year

The following significant initiatives are currently in various stages of development:

- Care Improvement
    - Wrap-Around Tracking System
    - Mental Health Services Search – Feasibility Study
    - Migrate remaining originally planned Contract Providers from the IS to IBHIS (LEs and FFS Providers)
    - Onboard additional Contract Providers to IBHIS (Federally Qualified Health Centers (FQHC); Continuity of Care Reform LEs (Short Term Residential Therapeutic programs (STRTP) and Foster Family Agencies (FFA)); and Crisis Residential Treatment Centers (CRTP))
    - Level of Care Tracking/Reporting
    - Issues Tracking for Patients' Rights Consumer & Family
    - Bi-directional Referral with CCD Exchange and Direct Messaging
    - Pharmacy Benefit Management – Integration Automation
    - Los Angeles Network of Enhance Services (LANES)
- Data Management
    - Data Warehouse Redesign
    - Homeless Reporting
    - Outcome Measures Rationalization
    - Application Rationalization: SAS for Health Agency
- Infrastructure
    - Wi-Fi for county-operated clinics
    - Help Desk/Service Management Suite (HEAT) upgrade
    - IBHIS Integration Infrastructure Expansion
    - Migration to County Mobile Device Management Solution
    - Windows 10 Upgrade
    - Active Directory Migration
    - Data Center Consolidation (Health Agency)
    - Website Redesign and Migration (MHP and Health Agency)
    - Risk Management Methodology and Standardization

Major Changes Since Prior Year

- Onboarded approximately thirty-six legal entities since April 2017.
- Hired and onboarded a new Chief Information Officer for CIOB.
- Since April 2017, the MHP converted approximately twenty-five Fee-For-Service hospitals from IS to IBHIS.
- The MHP implemented additional FFS outpatient providers since April 2017.
- The new Pharmacy Benefit Management system went live July 2017.
- Implemented Wrap-Around, Phase 1 – Enrollment phase.
- Expanded telepsychiatry services for the Older Adults SOC.
- Implemented Microsoft Office 365 Suite Migration: Skype for Business.
- Upgraded Help Desk/Service Management Suite (HEAT), and went live with enhanced Incident Management.

Other Significant Issues

- At present CIOB continues to support two mission-critical systems - IBHIS and IS. Until the IBHIS system cutover is complete, the retention of subject matter expert technology and billing staff are critical since both systems produce revenue and support state reporting requirements.
- The recent retirement of RSA hard tokens/fobs and fixed length passwords was a significant process improvement. While the RSA Adaptive Authentication credentials eliminate hard tokens/fobs, it has not expedited the process to obtain new logon IDs. According to key informants, it can take up to 2-3 weeks for a new user account to be established when submitting the Downey Data Center Registration form for Contractors/Vendors for activation.
- A number of interviewed contract provider key informants report that the CIOB Reports Committee no longer meets regularly or frequently enough for provider staff to achieve a level of competency with Secure Internet File Transfer (SIFT) data files. Specifically, IS701-UP (Claim Detail Export by Billing Provider) was mentioned most frequently as being difficult to understand with the multitude of variables.

Plans for Information Systems Change

- The MHP has no plans to replace the current EHR system – IBHIS.
- IHBIS supports EHR functionality, SDMC billing, and other State reporting requirements for county operated sites and for legal entities that have transitioned from IS.

Current Electronic Health Record Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Avatar/IBHIS	X			
Assessments	Avatar/IBHIS	X			
Care Coordination	CareConnect/IBHS		X		
Document imaging/storage	Avatar/IBHIS	X			
Electronic signature—consumer	Avatar/IBHIS	X			
Laboratory results (eLab)	OrderConnect/ Care View/IBHIS	X			
Level of Care/Level of Service	Avatar/Outcomes Measure Application	X			
Outcomes	OrderConnect/ IBHIS	X			
Prescriptions (eRx)	Avatar/IBHIS	X			
Progress notes	Avatar/IBHIS	X			
Referral Management	SRL/SRTS/VANS	X			
Treatment plans	Avatar/IBHIS	X			
Summary Totals for EHR Functionality		**11**	**1**	**0**	**0**

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- Table 13 ratings are based on IBHIS/EHR implementation only for county operated sites. Legal entities are required to implement local EHR systems and use EDI transactions to support two-way exchange of data between their local EHR system and IBHIS.
- Electronic referrals to primary care are now operational to support care coordination. San Fernando Mental Health, a county operated site, and Tarzana

Treatment Center, a primary care site, securely exchange clinical documents and data.

- Legal entities who have cutover to IBHIS have the capability to view (look up) clients' laboratory results via the CareView portal. The CareView application is a Netsmart Technologies product.
- County operated and legal entities have access to the Outcomes Measure Application.
- The Service Request Log and Service Request Tracking System applications, along with Vacancy Adjustment Notification System continue to improve consumer referral management, as well as monitor providers' open treatment slot capacity.

Consumer's Chart of Record for county-operated programs (self-reported by MHP):

☐ Paper ☒ Electronic ☐ Combination

Personal Health Record

Do consumers have online access to their health records either through a Personal Health Record feature provided within the EHR, consumer portal, or third-party PHR?

☒ Yes ☐ No

My Health Pointe, Netsmart Technologies. Implemented June 2016.

- Number of county-operated or contract provider sites where consumers can access their personal health record: 29.
- Number of consumers with access accounts to their personal health records: over 52,000.

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

Local SQL Database, supported by CIOB.

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: Los Angeles MHP Summary of CY16 Short Doyle/Medi-Cal Claims							
Number Submitted	**Gross Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Gross Dollars Adjudicated**	**Claim Adjustments**	**Gross Dollars Approved**
4,836,969	$1,019,762,083	**265,058**	$59,480,790	5.83%	$960,281,293	$42,237,228	$918,044,065
Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017. The statewide average denial rate for CY2016 was 4.48 percent. Change to the FFP reimbursement percentage for ACA aid codes delayed all claim payments between the months of January-May 2017.							

Table 15 summarizes the most frequently cited reasons for claim denial.

Table 15: Los Angeles MHP Summary of CY16 Top Three Reasons for Claim Denial			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	159,330	$34,183,346	57%
Missing, incomplete, invalid ICD-10 diagnosis or condition	44,100	$10,188,215	17%
Other coverage must be billed prior to submission of this claim	40,489	$9,138,053	15%
Total Denied Claims	265,058	$59,480,790	100%

- Denied claim transactions with denial reason description "Missing, incomplete, invalid ICD-10 diagnosis or condition" are generally re-billable within the State guidelines for timely claim submission or re-submission.

Information Systems Review Findings—Implications

Access to Care

- The MHP Service Request Log (SRL) for county operated sites, and the Service Request Tracking System (SRTS) application for contract providers, along with the ACCESS Call Center screenings provide the means to electronically track requests for services system-wide.
- The MHP continues to expand the use of telepsychiatry services to serve consumers who live in remote service areas, and those that are in the Older Adult SOC. There are three contract providers who additionally provide tele-mental health services.

Timeliness of Services

- The Vacancy Adjustment and Notification System (VANS) application tracks program capacity information system-wide. It allows staff the capability to determine the best site to send a request for timely access to services.
- Electronic referrals to primary care are now operational. San Fernando Mental Health, a county operated site, and Tarzana Treatment Center, a primary care site, securely exchange clinical documents and data.

Quality of Care

- The MHP continues to expand bi-directional care between primary care providers and mental health programs, including the care needs of individuals with co-occurring disorders.
- Legal entities who use IBHIS have the capability to view (look up) individuals' laboratory results via the CareView portal. The CareView application is a Netsmart Technologies product.

Consumer Outcomes

- None noted.

SITE REVIEW PROCESS BARRIERS

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

- No barriers were encountered during this review.

CONCLUSIONS

During the FY17-18 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

Strengths and Opportunities

Access to Care

Strengths:

- The MHP is in the process of an executive reorganization with the goal of consolidating a fragmented and overly complex structure.
- As part of the Los Angeles County Health Agency, the MHP is participating in a county-wide effort to significantly expand supportive housing for individuals that are homeless and have complex health and behavioral health conditions.
- The MHP assesses, identifies, implements and evaluates strategies to address the cultural, ethnic, racial and linguistic needs of its consumers.

Opportunities:

- Turnover of staff was found to be disruptive to clinical care, and consumer focus group participants expressed their desire for more consistency in therapists and providers.
- Providing integrated services for consumers with co-occurring disorders remains a challenge throughout the SOC.
- TAY youth should be used to assist in making mental health services more available in the community, through clinics, schools and social media, which will also assist with their own wellness and recovery.
- Stakeholders expressed the need for clinical services and wellness centers to be accessible evenings and weekends to accommodate consumer and family member schedules.

Timeliness of Services

Strengths:

- The MHP reported that timeliness reports are produced and reviewed on a monthly basis.
- The MHP tracks and trends county operated outpatient clinic timeliness metrics by the language in which services are requested and delivered.
- Focus group participants stated that initial assessments, individual therapy, and case management services are delivered in a timely fashion, and in the preferred language. Medication support is easy to navigate, and is available with appropriate frequency.

Opportunities:

- The MHP tracks and trends access data from initial contact to first psychiatric appointment for county operated services only, and should expand to include contract providers as well. In addition, while the standard is five business days, the MHP only meets this standard for 4.82% of children's appointments and 14.32% of adult appointments, both of which are very low, and performance improvement activities should be initiated.
- The MHP tracks and trends 7-day post hospitalizations for both adults and children (by language) for directly operated clinics and hospitals, but does not presently track this metric for contract providers. A web-based solution for contract providers is under development.

Quality of Care

Strengths:

- The MHP collects, analyzes and uses program-specific data to identify good practices, explain patterns of care, identify issues in the provision of care, and determine areas for improvement. Metrics are tracked and trended for performance measures, program-specific outcome measures, and consumer satisfaction surveys.
- Consumer focus group participants found staff to be very supportive and instrumental in improving their mental health status, and participants were reportedly satisfied with their access to a variety of services.

Opportunities:

- The QIC would benefit from a more balanced focus on performance and clinical consumer outcomes juxtaposed with compliance issues. Additional participation from consumers is also needed at committee meetings.
- While the MHP submitted two PIPs, the clinical PIP was determined to be concept only and needs further work to become active and ongoing.
- The CCC would benefit from additional emphasis on the sharing, analysis and use of data for program and service improvements. Additional participation from consumers is also needed at committee meetings.
- Contract providers report that they routinely submit data to the MHP, and receive a limited report card only quarterly, which is insufficient for program and staffing management. They also stated that the information regarding data requirements varies considerably from different bureaus, and with frequent changes implemented from the MHP it is challenging to develop consistent policies and protocols, and to train staff.
- Communication with MHP management staff is reportedly better than it is with contract providers, and communication from MHP leadership outwards is more streamlined than is input and feedback from clinical line staff and other stakeholders to the MHP executive team. A consistent structure, frequency, duration and agenda is needed for meetings held in all eight service areas to ensure clear and consistent messaging and a strong feedback loop.
- There remains general staff uncertainty throughout the SOC regarding the impact of the current reorganization, specifically on jobs, workload, funding, and resource distribution.

Consumer Outcomes

Strengths:

- The executive reorganization includes the establishment of five new executive-level Discipline Chiefs, one of whom will be a Peer Chief who will report directly to the Medical Director and represent the consumer voice at the highest level of the MHP.
- The MHP administers the POQI survey twice each year, along with additional program-specific surveys conducted throughout the year. Results are shared at QIC meetings, and with providers who are encouraged to review open-ended comments.

- The MHP collects and analyzes consumer level outcomes for specific programs in both directly operated and contracted clinics. The MHP is preparing to use the CANS tool throughout the children's SOC, as is required through CCR.
- Wellness and drop-in centers are reportedly very effective at helping consumers meet their basic needs, and reach toward their goals for wellness and recovery.

Opportunities:

- The MHP does not currently have system-wide outcome measures that are aggregated and used to improve or adapt services across the entire SOC.
- The MHP has a number of peer roles throughout the SOC, with paid positions primarily located with contract providers, where a career ladder exists, which is not the case with directly operated clinics. TAY youth are not yet considered for positions to augment other peer worker roles.
- While peer partners are encouraged to be more integrated and consultative with the rest of the team, they reported still feeling marginalized, and expressed concern that clinical and supervisory staff and sometimes consumers do not fully understand their role or value added.

Recommendations

Due to a request by Los Angeles MHP to change the date of their annual quality reviews from April to September, two reviews occurred during the 2017 calendar year, spanning FY2016-17 (April) and FY2017-18 (September).

- (For September 2018 review - FY18-19) Caseloads reported by staff point directly to system capacity issues. This lends itself to the issue of staff recruitment and retention. Recruitment of licensed staff was discussed in sessions during the onsite portion of the review.
    - Create a study of retention by type of staff as juxtaposed to average caseloads.
    - Investigate further incentives that might be initiated for both recruitment and retention of licensed staff.
- Using the reorganization as an opportunity, MHP leadership should evaluate the level of parity across the entire SOC, paying particular attention to ensuring that all levels of care are equitably represented in each of the eight service areas. In addition, consistently use data from a gap analysis or other assessment of the continuum of care in each service area to ensure parity in future resource allocations system-wide. (Added for September 2018 review – FY18-19)
- (For September 2017 review – FY17-18 and September 2018 review - FY18-19) Investigate the feasibility of creating a system for peer/lived experience employment that includes a career ladder for those now volunteers and stipend paid lived experience staff in order to facilitate professional development. Research how these positions might be implemented to address some of the capacity issues that challenge the MHP.

  (Added for September 2018 review – FY18-19)

    - Explore the possibility of leveraging TAY youth as a component of the peer workforce throughout the SOC to assist in making mental health services more available in the community.
- Investigate the current work flow processes to activate new user network logon IDs using the Downey Data Center Registration - For Contractors/Vendors form. Identify processes that are prone to delays in timely processing of up to 2-3 weeks for new user account ID activations. (Added for September 2018 review – FY18-19)
- Assess current need against capacity of clinical and technical training sessions (0-5 years, and EBPs), and investigate the feasibility of adding additional sessions or adjusting the frequency of trainings to accommodate demand for existing and new users.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO Performance Improvement Plan (PIP) Validation Tools

Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, either individually or in combination with other sessions.

Table A1—EQRO Review Sessions - Los Angeles MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Primary Care Collaboration and Integration
System Leadership Team (SLT) Group Interview
Pharmacy Benefits Management Group Interview
Medical and Nursing Leadership/Prescriber's Group Interview
Emergency Outreach and Mobile Crisis Group Interview
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer Empowerment/Peer Inclusion Group Interview
Consumer Family Member Focus Groups
Contract Provider Group Interviews – Administration/Operations/Quality Management
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Tele Mental Health
Consumer Satisfaction and Surveys Group Interview
Wellness Center Site Visit

Attachment B—Review Participants

CalEQRO Reviewers

Della Dash, Senior Quality Reviewer, Lead Quality Reviewer
Saumitra SenGupta, Ph.D., Executive Director, Quality Reviewer
Gale Berkowitz, DrPH, Deputy Director, Quality Reviewer
Ewurama Shaw-Taylor, Ph.D., Quality Reviewer
Rob Walton, MPA, RN, Quality Reviewer
Bill Ullom, Chief Information Systems Reviewer
Marilyn Hillerman, Consumer/Family Member, Consultant
Walter Shwe, Consumer/Family Member, Consultant
Luann Baldwin, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Sites

550 S. Vermont Avenue
Los Angeles, CA 90020

695 S. Vermont Ave
Los Angeles, CA 90020

East San Gabriel Valley Mental Health Center
1359 N. Grand Ave., Covina, CA 91724

San Antonio Family Center
2629 Clarendon Ave., Huntington Park, CA 90255

Contract Provider Sites

Tri City Wellness Center
2008 N. Garey Ave., Pomona, CA 91767

Pacific Clinics Asian Pacific Family Center
9395 Valley Blvd, Suite C, Rosemead, CA 91770

Hathaway Sycamores
5100 South Eastern Ave., Commerce, CA 90040

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Abernathy	Chris	Senior Director	Social Model Recovery Services
Adegbola	Moses	Chief Research Analyst	LACDMH-QID
Ahearn	Jessica	LCSW, Admin.	LACDMH
Allevato	Dr. Joseph	Chief Physician II Family Practice	Department of Health Services
Alvarado	Edna	MH Therapist	TTC
Alvarado	Julio	MH Services Coordinator I	LACDMH
Alvarez	Douglas	Parent Partner	Mary Vale
Alves	George	MH Clinical Supervisor	LACDMH
Amezcua	Maria	CFS	Masnda Homes
Anderson	David	Enterprise Arch Manger	LACDMH-CIOB
Anderson	Kristen	QI Clinic Supervisor	Penny Lane Centers
Anderson	Jill	Program Director	DiDi Hirsch
Archambeault	Michele	Clinical Psychologist	LACDMH
Argento	Charles	Volunteer	ESGMH
Arnold	Dr. Lori	Training Coordinator	LACDMH
Arns	Paul	Chief, Clinical Informatics	LACDMH-CI
Arvizu	Guadalupe	MH Clinician	LACDMH
Avalos	Miriam	CIO	LACDMH-CIOB
Badovsky	Lilian	Supervising Psychiatrist	LACDMH
Baker	Angel	Division Chief, Program Development	LACDMH-PSB
Baker	Cyndi	Director, Behavioral Health	Alma Family Services

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Baker	Rehana	Therapist	California Renew
Ballenger	Christina	INN II QID	LACDMC
Banuelos	Isabel	Community Worker	LACDMH
Banvelos	Antonio	Interim QIC Chair	LACDMH
Barajas	Elsa	Promotora	LACDMH
Bennett	Kelley	ITFC Clinician	Five Acres
Bernal	Viola	QI Coordinator	Social Model Recovery Systems
Berzon-Leitelt	Debra	Health Program Analyst II	LACDMH
Best	Margaret	Quality Improvement	Alma Family Services
Bhatt	Alka	Program Manager I	LACDMH
Blawn	Janet	Clinician	ENKI
Bologna	Joe	Quality Manager	Trinity Youth Services
Brawn	Carolyn	PISA	LACDMH-CIOB
Brignoni	Kelly	HN Liaison	LACDMH
Brown	Miriam	Deputy Director	LACDMH-EOB
Burgess	Racheal	CP Special Projects	LACDMH
Bush Spurlin	Jocelyn	Program Manager	UMMA Community Clinic
Byrd	Robert	MH Clinical District Chief	LACDMH
Cain	Melanie	MH Clinical Program Head	LACDMH
Camacho	Paola	Parent Partner	Pathways Community Services

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Carlock	Mark	Research Analyst II	LACDMH ACCESS
Carlson	Vivian	Peer Partner	El Camino Pacific Clinics
Carrillo	Rachel	Community Services Manager	LA Caba
Celade	Teresa	Housing Navigator	LACDMH
Ceniceros	Elizabeth	HR Analyst	LACDMH-QID
Cevallos	Maria	MHSC II	LACDMH
Chang Ptasinski	Sandra	Ethnic Services Manager	LACDMH-PSB-QID
Chavez	Mayra	Clinician	Alma Family Services
Chen	Eddy	Supervisor	Prototypes
Cheng	Mark	Chief, Solutions Delivery	LACDMH
Chhim	Phoeun	Peer Advocate	PACS
Childs	Eka	Program Manager	Homes for Life
Childs Seagle	Carlotta	Chief Deputy Director	LACDMH-OASOC
Chin	Sandra	Research Analyst	LACDMH
Ching	Alison	MH Clinician II	LACDMH
Cianfrini	Crystal	MH Clinical Program Manager	LACDMH
Claros	Jennifer	CFS Coordinator	Starview
Connolly	John	Deputy Director	LACDPH-SAPC
Cope	Elizabeth	Rio Hondo Clinical Supervisor	LACDMH
Copeland	Denise	Director of MH	Helpline Youth Counseling
Cota	Lucia	MHCS	LACDMH
Cox Jr.	Randall	Medical Case Worker I	LACDMH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Dades	Dawn	Senior Clinical Director	Social Model Recovery Systems
De la Cruz	Roberta	Case Manager	Pathways Community Services
De la Rosa	Raquel	Business Office Manager	Harbor View Community
De Simas	Michelle	MH Therapist	Pacific Clinics
Delgado	Shelley	Peer Partner	El Camino Pacific Clinics
DeRousse	Sonia	Clinical Supervisor/Clinician	The Whole Child
DeShay-Weakley	Desiree	AAA/ISM Liaison	LACDMH
Diaz	Charlie	PAO	LACDMH
Diaz	Aaron	Supervisor	Prototypes
Ditko	Helena	Program Director, Office of Consumer and Family Affairs	LACDMH
Ditrascio	Leslie	Director of Adult OP & Recovery Services	SFVCHMC
Dixon	Chrystal	Case Manager	Bvow
Dominguez	Eydie		LACDMH Performance
Duenas	Marlon	Community Worker	LACDMH
Eisen	Carol	Regional Medical Director	LACDMH
Ellison	Monica	Clinician	Hathaway-Sycamore
Ellizion	Bassia	QA/QI Director	Foothill Family
Enezliyan	Araksia	Peer Advocate	DiDi Hirsch
Engleman	Barbara	MH Clinical Program Head	LACDMH
Espinosa	Richard	Executive Assistant	LACDMH Office of the Director

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Estrada-Moreno	Marcela	Medical Case Worker	LACDMH
Faye	Margaret	Quality Management	Hathaway Sycamores
Fisher	Tracy	Clinician	Hathaway-Sycamore
Fonseca	Stacey	Clinical Psych II, QA Coordinator	LACDMH
Franco	Evelio	MH Clinical Supervisor	LACDMH
Friestad	Jolene	MH Clinical Program Manager II	LACDMH
Funk	Maria	District Chief	DMH CHEERD
Gaddis	Doma	Compliance Manager	Children's Center of the Antelope Valley
Garcia	Sharlene	Service Extender	El Camino Pacific Clinics
Garcia	Michael	Parent Partner	CA Mentor
Garcia	Cecilia	HPA II	LACDMH
Gardner	Tselane	Clinician	Heritage Clinic
Gilbert	Kalene	MH Clinical Program Manager III	LACDMH
Gildemontes	Elisabeth	Health Program Analyst	LACDMH
Giphagen	Rachel	QI/A Coordinator	Center for Integrated Family and Health Services
Gomez	Jaime	Intake Coordinator	ENKI
Gomez	Arthur	Promotora Supervisor	LACDMH
Gomez	Arthur	Parent Advocate	LACDMH
Gonzales	Christine	WOW Worker	ESGMH
Graham	Christine	VP, Chief Clinical Services Officer	Stars Behavioral Health Group

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Granda	Tiffany	Supervisor, Whole Person Care	LACDMH
Gross	Elizabeth	MH Clinical Program Head	Arcadia Mental Health Center
Guirguis	Nahed	MH Clinical Program Head	LACDMH
Guzman	Daniel	Clinic Manager	LACDMH
Haig	Seta	Program Coordinator	DiDi Hirsch
Hallman	Jennifer	QA	LACDMH
Hanada	Scott	MH Clinical Program Head	LACDMH
Haratounian	Vahe	A-DISO	LACDMH-CIOB
Harvey	Lisa	Legal Entity Co-Chair	Para Los Ninos
Hassan	Imran	Psychiatrist	LACDMH
Haw	Tom	Assistant Director	HSCFS
Hendrawan	Hendra	Pharmacy Technician	LACDMH
Hendrickson	Steven	Roybal Manager	LACDMH
Henriquez	Hilda	Program Manager	Molinda
Hernandez	Julian	PSW II	LACDMH
Hernandez	Arlene	Call Center Supervisor	Pacific Clinics
Hernandez	Juan	Community Based Therapist	Pathways by Molina
Hernandez-Paz	Armando	MHC Supervisor	LACDMH
Herrera	Ivan	Clinician	Star View
Hetterscheidt	Genevieve	PMO	LACDMH-CIOB
Hicks	Toia	ECRS Manger	The Guidance Center
Hollman	Ruth	SLT Rep	SHARE

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Horne	Garrett	Supervising Psychologist	LACDMH
Howard	Chris	IT Director	FF
Hsu	Hsiang-Ling	Program Manager	SSG-APCTC Cerritos
Hudson	Bradley	Clinical Director	Children's Hospital, LA
Ibarra	Alicia	MHSC II	LACDMH
Innes-Gomberg	Debbie	Deputy Director	LACDMH-ADSOC
Isaac-Palma	Angelica	Psychiatric Social Worker II	LACDMH
Jackson	Cynthia	Executive Director	Heritage Clinic
Jackson	LaTina	District Chief	LACDMH
Jai	Edward	Chief, Pharmacy/Lab	LACDMH
Jarquin	Violeta	Administrator	Pathways by Molina
Jauregul	Yolanda	Parent Partner	Haynes Family Program
Jearman	Radmillia	Senior Analyst	LACDMH
Jeffries	Patrick	Peer Partner	William H. Compton Jr.
Jimenez	Mia	Clinician	Alma Family Servcies
Johnson	Carrie	Director	UA II
Kaiser	Felipe	Director	Social Model Recovery Services
Kang	Jonathan	Clinical Director	Korean-American Family Services
Kasarabada	Naga	MH Clinical Program Manager III	LACDMH-QID
Kay	Robin	Chief Deputy Director	LACDMH-OCCD

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Kelartinian	Vatche	CEO	Heritage Clinic
Kelly	Caroline	Chair, Los Angeles County MH Commission Chair	MH Clinic
Kelso	Adele	RHMC	LACDMH
Kim	Mary	Health Program Analyst	LACDMH
Kim-Sasaki	Youngsook		LACDMH
Kisch	Stephanie	Counselor/Assessor	River Community, Social Model Recovery Systems
Koits	Roas Maria	Program Director	Pacific Clinics
Kubota	Aracely	Secretary to DC	LACDMH
LaFave	Dee	EHRS Analyst	Child Institute
Lam	Susan	QI Director	Alma Family Services
Lane	Celeste	Team Supervisor	Pacific Clinics
Lau	Wil	QA Specialist	Pacific Clinics
Lee	Karen	Regional Medical Director	LACDMH
Lee	Amy	Pharmacist	LACDMH
Lemus	Evelyn	Psychiatric Social Worker II	LACDMH
Leon	Lisa	Project Manager II	LACDMH
Levine	Robert	Health Program Analyst	LACDMH
Lishi Huang	Leo	Asian Pacific Islander (API), Underserved Cultural Communities Subcommittee Co-Chair	Pacific Asian Counseling Services
Llamas	Alicia	MHSC II	LACDMH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Lo	Gwen	QA Director	Community Family Guidance
Lopez	Josephine	WOW Worker	ESGMH
Lopez	Cheryl	MHSC I	LACDMH
Lopez	Priscilla	School-based Therapist	Pacific Clinics
Lopez White	Patricia	Training Coordinator	LACDMH
Lu	Charles	Division Chief	LACDMH-CIOB
Lue	Lawrence	Commissioner	LA County MH Commission
Macedonio	Karen	SLT Member	Co-chair SAAC 5
Maeder	Christina	MH Clinical Program Head	LACDMH
Maes	Iva	WOW Volunteer	American Indian Counseling Center
Mahoney	Debra	Psychiatric Social Worker II	LACDMH
Majors	Michelle	MH Clinical Program Head	LACDMH
Maldonado	Arnaldo	SLT Rep	DMH Long Beach Adult Center
Mallory	Lou	Lead Health Navigator	Pacific Clinics
Manzano	Miguel	Therapist	Alma Family Services
Mar	Zosima	Research Analyst	LACDMH-QID
Marquez	Eugene	Supervisor, Housing and Outreach	LACDMH
Masangcay-Gavinet	Marissa	Community Liaison Public Health Nurse	LACDMH
Mccraven	Eva	CEO	Hillview MH Center
McEwen	James	MHCS	LACDMH
Mckay	Mimi	Deputy Director	LACDMH-SP

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Mehra	Penny	Executive Director	Alcott Center
Mejia	Ana	Director of Services Coordinator	The Whole Child
Meltzer	Beth	COO	Hillview MH Center
Mendoza	Marcel	Assistance Regional Manager	Penny Lane
Meraz	David	MH Advocate	LACDMH
Mershon	Bryan	Deputy Director	LACDMH Children's System of Care
Molina	Elsy	Program Director	Alma Family Services
Morales	Margo	Administrative Deputy III	LACDMH-OAD
Moreno	Adrian	EAD	LACDMH-CIOB
Morris	Lyn	Senior VP, Clinical Operations	DiDi Hirsch MHS
Munde	Michele	Director, Quality and Compliance	Starview
Murata	Dennis	Deputy Director, Program Support Bureau	LACDMH-PSB
Murch	Lezlie	Chief Program Officer	Exodus Recovery
Murde	Michele	Director of Q&C	Star View
Myers	Epia	Cambodian ISM Program Coordinator	PACS
Navarro	Antonette	Executive Director	Tri-City
Navarro	Carlos	Peer Partner	Wilshire Pacific Clinics
Nevarez	Javier	MH Clinical Supervisor	LACDMH
Nguyen	Hoa	Therapist	Pacific Clinics
Norris	Elizabeth	Supervising Psychologist	LACDPH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Nowlin Finch	Nancy	Supervising Psychiatrist	LACDMH
O'Donnell	Mary Ann	Clinical Risk Management	LACDMH
Oja	Denise	Program Director	Pathways Community Services
Ojeda	Claudia	Clinician	Pathways Community Services
Olsen	Michael	Director of QA	ENKI
Ortega	John	DMBI	LACDMH-CIOB
Osakue	Clement	Program Director	Pacific Clinics
Osegueda	Patricia	MH Services Coordinator II	LACDMH
Othman	Nancy	Manger/Supervisor	Spirit Family Services
Pace	Melissa	QI Manager	Foothill Family
Paez	Eduardo	Supervisor	Prototypes
Pak	Susan	Psychiatrist	LACDMH
Panguluri	Sandhya	Supervising MH Psychiatrist	LACDMH
Parada Ward	Mirtala	Clinical Program Manager	LACDMH-QID
Paraja Dominguez	Monica	HR Director	LACDMH-HRB
Paredes	Angelica	Therapist	JWCH
Park	Susan	QID/CCU, Clinical Psychologist II	LACDMH
Patel	Jay	Division Chief	LACDMH-CIOB
Patel Escamilla	Shivani	Clinical Director	Telecare
Patterikalam	Girivasan	Revenue Systems Manager	LACDMH
Parada Ward	Mirtala	Program Head	LACDMH-PSB-QID

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Perez	Cynthia	Program Coordinator/SLT Rep	MHA
Perez	Tammy	Director, Outpatient Programs	CFGC
Peterson	Cheryl	Supervisor AA III	LACDMH
Petrisca	Elizabeth	Clinician	ENKI
Poche	Monique	Support Services Director	Pacific Clinics
Powers	Elizabette	MH Clinical Supervisor	LACDMH
Preis	James	Executive Director	MH LA Advocacy Services
Prince	Yolanda	Parent Partner	Pacific Clinics
Pullen	Demitress	Peer Advocate	SSG/Weber
Qadeer	Khair	Outpatient	Alma Family Services
Quiroz	Judith	Community Worker	LACDMH
Quivoz	Frances	Forensic Advocate Community Services	Prototypes
Ragosta	Lorraine	Clinical Supervisor	TTC
Rajo	Elia	Peer Advocate	TTC
Ramirez	Regina	QID/ISM Analyst	LACDMH
Ramirez	Jesse	PEI Clinician	Telecare Corporation
Ramos	Socorro	MH Services Coordinator II	LACDMH
Ramos	Nelly	Parent Partner	Foothill Family
Ramos	Evelyn	Intake Coordinator	The Whole Child
Ramos	Emily	Program Manager	LACDMH
Ranney	Rachel	Manager PEI	Prototypes
Rea	Amy	Regional Director	ENKI

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Renfrow	Michele	Admin	LACDMH
Renteria	Jaime	MH Services Coordinator II	LACDMH
Retana	Paco	Latino, Underserved Cultural Communities Subcommittee Co-Chair	Los Angeles Child Guidance Clinic
Ribleza	Rosario	Latino USCC Liaison	LACDMH
Richt Modesta	Pulido	ED./Outreach/Organizer	LA County NAMI
Rittel	Michelle	Children's QIC	LACDMH
Rivas-Castaneda	Julie	MH Clinical Supervisor	LACDMH
Rivera	Jennifer	Nurse Manager	LACDMH
Rivera	Irma	Case Manager	Pacific Clinics
Rivera	Ericka	Assistant Director QA	Pacific Clinics
Robles	Esther	QI Coordinator	Pathways Community Services
Rodriguez	Maria Laura	MH Clinical Supervisor	LACDMH
Rodriguez	Adriana	Promotora	LACDMH
Rodriguez	Misleidny	Case Manager	JWCH Institute
Rodriguez	Anabel	MHC Program Manager	LACDMH
Rosas	Manuel	MH Clinical Program Head	LACDMH
Rosser	Lindsay	Clinician	Community Family Guidance Center
Salas	Kaliah	Program Head	LACDMH
Salvaggio	Kimber	Training Coordinator	LACDMH
Sam	Phaly	Peer Advocate	PACS

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Sanchez	Victor	MH Clinical Supervisor	LACDMH Access
Sanchez	Cinthia	Office Manager	Pathways Community Services
Sanchez	Linda	Promotora	LACDMH
Sandoval	Miriam	Senior Typist Clerk	LACDMH-QID
Santamaria	Nicole	QA Manager	Helpline Youth Counseling
Schmoeller	Bethanie	Clinical Director	Hathaway-Sycamore
Seanez	Maria	Parent Partner	Mary Vale
Sefiane	Jerry	Health Program Analyst II	LACDMH
Sekhon	Navjot	Outpatient Clinician	Mary Vale
Servin	Josephine	BH Therapist/BH Coordinator	FHCCGLA
Shah	Sanjay	MH Clinical Program Manager II	LACDMH
Shaner	Dr. Roderick	Medical Director	LACDMH-OMD
Shastry	Vivahni	Quality Improvement Coordinator	Children's Hospital, LA
Shepherd	Michele	Asst. Director, Older Adult Services	SFVCMHC Inc.
Sherin	Jonathan	MH Director	LACDMH Office of the Director
Shockney	Stephanie	Team Supervisor	Pacific Clinics
Simonian	Sarkis	Com. Rep. Co-chair	
Sims	Laura	Therapist	Trinity Youth Services
Singh	Shauna	Therapist	Haynes Family
Slattery	Gwen	Parent Advocate	LACDMH
Spallino	Jim	Protect Delivery Management	LACDMH-CIOB

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Spinoza	Ernest	Director	El Monte Comprehensive Health Center & La Puente
Starr	Michael	WOW Volunteer	LACDMH
Stone-Abrams	Linda	Family Advocate	LACDMH
Suarez	Ana	District Chief	LACDMH
Sweet	Tosha	Program Manager	LACDMH
Taguchi	Kara	MH Clinical Program Head	LACDMH
Taylor	Romalis	African/African American (AAA), Underserved Cultural Communities Subcommittee Co-Chair	Community Member
Tayyib	Nina	API USCC Liaison	LACDMH
Tchakmakjian	Greg	Clinical Psychologist	LACDMH
Tello	Irene	WRAP, Outpatient Therapist	Crittenton
Tiscareno	Ruth	Parent Advocate	LACDMH
To	Kary	Admin	LACDMH
Torok	Veronica	Community Worker	LACDMH
Torres	Vanessa	Psychiatric Social Worker II	LACDMH
Tran	Tiffany	QA Director	Five Acres
Tredinnick	Michael	MH Clinical Program Manager III	LACDMH
Trias-Ruiz	Rosalba	Supervising Psychologist	LACDMH
Tse-Yee	Judy	Program Director, Adults	Pacific Clinics
Tucker	Julia	Supervisor	Healthright 360/Prototypes

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Tudor	Sandra	Lead/Supervisor Peer Support	Hathaway-Scycamore
Unrein	Nicole	Manger, QI	Prototypes
Valdez	Julie	MH Clinical Program Manager III	LACDMH ACCESS
Valenzuela-Meza	Nattaly	MH Clinical Supervisor	LACDMH
Van Sant	Karen	Associate CIO	LACDMH-CIOB
Vega	Laura	MH Therapist	Alma Family Services
Velasquez	Rani	QA Coordinator	JWCH Institute
Vergara	Soledad	MCW I	LACDMH
Villano	Sandy	Director	STARview
Vindell	Karle	Therapist	Alma Family Services
Walters	Jessica	Supervising Psychologist	LACDMH ACCESS
Wang	Charity	VP	Hathaway-Sycamore
Washington	Duayne	SA3 Administration	LACDMH
Weiner	Nancy	MH Clinical Supervisor	LACDMH
Whipple	Sunnie	SLT Rep AI/AN/USCC	LACDMH
Whitfield	Montoya	Program Coordinator	SSG/Weber
Wilkerson	Kelly	Psychiatric Social Worker II	LACDMH
Wong	Lisa	MHC District Chief	LACDMH
Woo	Karin	Program Director	Pathways Community Services
Woo	Karin	Program Director	Pathways Community Services

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Worcester	Leya	Regional Clinic Manager	LACDMH
Ximenez	Leticia	Cultural Competence Committee Co-Chair, MH Services Coordinator II	LACDMH Office of the Director
Yamada	Mariko	Executive Director	St. Francis
Yan	Phillip	Program App Dev	LACDMH
Yang	Janet	Clinical and Training Director	Heritage Clinic
Yaralyan	Anna	EE/ME USCC	
Yau	Phillip	Principal App Dev	LACDMH Access
Yen-Jui	Lyn	Admin	LACDMH
Zableckis	David	Clinical Director	CIFHS
Zaldivar	Richard	Executive Director	The Walls Las Memorias Project
Zelman	Michael	Assistant VP Clinical Servcies	ENKI
Zimmerman	Elizabeth	MHCS	ESGVMHC
Zuniga	Claudia	Clinician	Pathways

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to eleven (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: Los Angeles MHP CY16 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,674,069	141,926	3.86%	$611,752,899	$4,310
Large	1,778,582	67,721	3.81%	$318,050,214	$4,696
Los Angeles	1,168,416	45,553	3.90%	$176,017,825	$3,864

Table C2 shows the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under $20,000; $20,000 to $30,000, and those above $30,000.

Table C2: Los Angeles MHP CY16 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	190,714	95.04%	94.05%	$731,098,358	$3,833	$3,612	67.22%	59.13%
>$20K - $30K	5,288	2.64%	2.83%	$128,209,754	$24,245	$24,282	11.79%	11.98%
>$30K	4,659	2.32%	3.12%	$228,347,716	$49,012	$53,215	20.99%	28.90%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18	CLINICAL PIP
GENERAL INFORMATION	
MHP: Los Angeles	
PIP Title: Addressing Drivers of Rehospitalization for Intensive Service Recipients (ISRs) – COD Related Issues and Inadequate Bridging Services	
Start Date: 7/19/2017 **Completion Date**: 7/19/2019 **Projected Study Period**: 24 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: September 25-28, 2017 **Name of Reviewer**: Shaw-Taylor and Dash	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP: The goal of this clinical PIP is to reduce rehospitalization rates for Intensive Service Recipients (ISRs), defined as consumers that have had four or more hospitalizations within the past 13 months. The MHP contends that untreated co-occurring disorders (COD) and lack of supportive bridge housing contribute to rehospitalization rates in this population. The MHP intends to affect rehospitalization rates through two interventions, by provision of	

COD groups and by prioritizing beds in acute crisis residential facilities. The PIP will build on existing and new programs, and will leverage current staff knowledge and skills along with training. The COD intervention targets co-occurring ISRs who are currently being served in outpatient programs (FSP or WPC-LA).

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP developed a multi-functional team to provide feedback and perspective on rehospitalization for ISRs. The MHP also convened four focus groups of service providers and consumers, who brainstormed solutions to purported untoward rehospitalization of ISRs. The PIP team may benefit from Involvement from SAPC/DPH to design other interventions.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The ISR study population is stable (N=1653), and is comprised of individuals age 18 and above who had an acute psychiatric inpatient hospitalization during the 395 days prior to June 2017.
Select the category for each PIP: *Clinical:* ☒ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☒ High risk conditions	*Non-Clinical:* ☐ Process of accessing or delivering care	
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The COD groups and prioritization of placements are part of a larger effort to increase engagement of ISRs, which the MHP articulated during the onsite discussion as the goal of the project. Engagement of ISRs addresses a broad spectrum of enrollee care and services; the MHP would do well to provide more information about engagement (e.g., how engagement is operationalized; current engagement activities; projected engagement activities; evidence of engagement).

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other (co-occurring disorders)	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP's plan appears to include all applicable enrolled populations. The MHP has a variety of means of identifying the ISRs through review of lists/databases from multiple providers and programs (e.g., the Homeless Initiative Top 5% and the MHP's COD secondary diagnosis). The MHP has also developed an IBHIS widget that will automatically identify consumers who meet criteria for ISR (and inclusion on the project). The MHP anticipates that the widget will be operable by the end of September 2017.
	Totals	Met Partially Met Not Met UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* "Will the **three** interventions designed for this Clinical PIP result in: 1. A pre-post reduction (%TBD) in the 7 day and 30 day rehospitalization rates for ISRs six months post participation in the COD groups in FY 17-18 compared to the baseline rehospitalization rates in FY 16-17? 2. A pre-post reduction (%TBD) in the hospital days for the rehospitalizations in FY 17-18 for ISRs six months post participation in the groups compared to the baseline hospital days for rehospitalizations in FY 16-17? 3. A pre-post (TBD%) improvement in the 7 day post discharge outpatient follow up in FY 17-18 for ISRs six months post participation in COD group compared to the 7 day post discharge outpatient follow up in FY 16-17? 4. Increased participation in COD groups by ISRs in FY 17-18 as evidenced by participation in at least 2 groups per month compared to no or limited participation in COD groups during the baseline period for FY 16-17? 5. A pre-post reduction (%TBD) in the 30 day rehospitalization rates for ISRs in FY 17-18 post participation in the Crisis Residential Treatment Programs (CRTPs) compared to the baseline rehospitalization rates in FY 16-17? 6. A pre-post reduction (%TBD) in the hospital days for the rehospitalizations in FY 17-18 for ISRs post participation in the Crisis Residential Treatment Programs (CRTPs) compared to the baseline hospital days for rehospitalizations in FY 16-17? 7. A pre-post (TBD%) improvement in the 7 day post discharge outpatient follow up in FY 17-18 for ISRs in FY 17-18 compared to the 7 day post discharge outpatient follow up in FY 16-17? 8. Increased participation (%TBD) in outpatient services by ISRs in FY 17-18 post participation in the Crisis Residential Treatment Programs (CRTPs) compared to participation in outpatient services in FY 16-17?"	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question reads as a list of indicators, rather than an overarching question regarding engagement or rehospitalization. The MHP should rephrase the question to be more targeted and concise. The MHP might consider: Will the provision of COD groups and (timely) dedicated bed space post-hospitalization increase engagement of ISRs, defined as… The MHP should also clarify the interventions that will be implemented; the MHP made references to (a total number of) two, three, and four interventions for this PIP.
	Totals	Met Partially Met Not Met UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other (co-occurring disorder secondary diagnosis)	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The plan clearly defines the Medi-Cal enrollees to whom the study question is applicable—ISRs with four or more rehospitalizations within the past 13 months. Within this population, the MHP has identified two subpopulations: (1) ISRs who have received any outpatient services in the past six months (i.e., prior to June 13, 2016) and (2) ISRs who have not had any outpatient services.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☒ Referral ☐ Self-identification ☒ Other: Diagnoses from IBHIS	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The ISR study population is stable (N=1653), and is comprised of individuals age 18 and above who had an acute psychiatric inpatient hospitalization during the 395 days prior to June 2017.
	Totals	Met Partially Met Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1) Clinical Care indicators pre-post participation in CRTPs and COD groups focusing on Rehospitalization Rates; Post Discharge Outpatient Follow up; Length of Hospital Stay; and Process Measures related to an increase in outpatient treatment participation 2) Increased Engagement as evidenced by increased engagement in outpatient services and participation in COD groups.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators listed in the study question could be used here. The PIP states that indicators will be presented onsite during the review. The clinical care indicators that were presented as the study question are the outcomes of the study, reflecting a change in rehospitalization rate and engagement. The MHP still needs measurable indicators to track performance (i.e., process/progress of the PIP) and improvement over the course of a specific time. The MHP may wish to consider the following indicators: • COD Group Training – the number (and %) of trained staff who meet training objectives with a minimum score of X. • Motivational Interviewing (MI) Skill – the number of trained staff who are proficient in (or score X) on MI evaluation • Fidelity to Matric Model – the number (and %) of COD Groups that met at least three times a week
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	In their current state, the indicators are the same thing as the outcomes. The MHP did not state the timeframe for improved outcomes, but engagement implies some sort of long-term outcome for ISRs.
	Totals	Met Partially Met Not Met UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not sampling, as the entire ISR population is targeted.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	NA
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	NA
	Totals	Met Partially Met **N**ot Met **N**ot Applicable UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP will collect data related to hospitalizations and post-discharge follow-up. The MHP will also collect various social, financial, interpersonal, and vocational data of participants using the Outcome Measures Application (OMA). The OMA will also be used to collect relevant substance use data.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: IBHIS and IS	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data are from IBHIS, other IS databases, and the OMA.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide much data on their data collection method, with the exception of completion of the Key Event Change section of the OMA at baseline and three months.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	As the MHP did not provide detail on the data collection (e.g., who will collect or pull the data; frequency of data collection), it is difficult to determine if the instruments will provide consistent and accurate data. We note that the OMA is a lengthy (11 page) document; completion or thoroughness of completions might be a concern.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not articulate a data analysis plan or contingencies for untoward results. One consideration the MHP should make is if ISRs opt out of the COD groups or the crisis residential placement, as has already happened. In effect, the participants would not get the intervention.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: The MHP did not identify a project leader. Title: <Text> Role: <Text> *Other team members:* Names: The MHP provided a list of XX who are part of the PIP team.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not identify a project leader. Rather, the service area chiefs have oversight of the project in their service areas. It might benefit the MHP to have a dedicated project leader, who could be tasked with (1 identifying the finite number of ISRs who make up the study population and (2) to ensure consistency in program implementation (e.g., sufficient training of staff, frequency of groups, etc.).
	Totals	Met Partially Met Not Met UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Provision of COD related services, specifically COD support services to address COD related issues 2. COD Support Group Implementation 3. Prioritization of Access to Crisis Residential Services to ISRs who meet the Criteria 4. Integrated Behavioral Health Information System (IBHIS) Widget	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Of the four interventions proposed, two (Nos. 1 and 4) are administrative activities that the MHP will do/has done to furnish COD groups and identify the ISR population.
	Totals	Met Partially Met Not Met NA UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

	Totals	Met Partially Met Not Met NA UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals	Met Partially Met Not Met NA UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

This PIP is concept only and therefore not rated.

Recommendations:

The MHP is encouraged to further elucidate the elements and goal of this PIP, and activate the interventions as soon as possible.

Check one:

☐ High confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☐ Confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible
☐ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Los Angeles	
PIP Title: Improving the Responsiveness of the LACDMH 24/7 Hotline by implementing the ACCESS Center QA Protocol	
Start Date: 07/01/16 **Completion Date**: 09/30/18 **Projected Study Period:** 27 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 09/24-28/17 **Name of Reviewer**: Shaw-Taylor and Dash	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-Clinical PIP was submitted
Brief Description of PIP: This is year two of the non-clinical PIP. The goal of this PIP is to implement a Quality Assurance (QA) Protocol within the ACCESS Center (AC). AC test calls and evaluation of a small percent of actual received calls showed three areas for improvement addressed by the PIP in the first year: ACCESS Call Center Agents requesting Caller's / Client's name, Customer Satisfaction, and Documentation of calls. During the second year, the PIP expanded these areas to include new issues. This PIP is an effort to address all of these issues by implementing and refining the QA Protocol process. The process is non-	

punitive, and designed to improve service delivery, customer service and documentation of calls information. During year two, the MHP also expanded the number of calls being reviewed for both test calls and actual consumer calls (which were recorded).		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The stakeholders are those who work, supervise, and are involved in ACCESS, including members of the QIC, Children's Programs, Office of Consumer and Family Affairs, ACCESS Center staff, Adult Program providers, Service Coordinators, and Research Analysts. A family advocate who can speak to a consumer or prospective consumer's experience calling into the ACCESS Call Center was also added to the team. The MHP also indicated who on the PIP team is bilingual in Spanish, likely the majority of non-English calls, and also Korean.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The main source of data and the foundation for the study was four-year (CY12 to CY15) trending of test calls. The team reviewed nine areas related to test call handling and identified three areas for improvement—the (number of) calls logged, request of caller's name, and caller's satisfaction. The team selected these areas because there was either an overall decrease in performance from CY2012-CY2015 or a one-year decrease from CY2014-CY2015. In this continuation of the PIP, the team has also included: documentation of presenting problems; medical needs; and substance use issues. However, the team did not articulate why these clinical care outcome measures were included, except to say that they are reflective of an integrated healthcare approach that the MHP endorses. These area do not necessarily identify any deficits in performance.

Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-Clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP focuses on aspects of a call that a calling agent can do or modify to ultimately have an effect on consumer's and pre-consumer's (initial) contact with the MHP.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP includes all Medi-Cal enrollees, including existing and pre-consumers, and anyone who may call the ACCESS Line. The MHP provided data on call volume by language, which is a demographic that is relevant for this study.
	Totals	**3** Met **1** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? This PIP set forth to examine if implementing the QA Protocol for the LACDMH ACCESS Center 24/7 Line would result in: 1. Ten (10) Percentage Points (PP) improvement in ACCESS Center calls *where language interpreter services were offered* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17? So, from April – June 2017? 2. Ten (10) PP improvement in ACCESS Center calls *where the Agent requested the caller's name* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17? 3. Two (2) PP improvement in referrals provided to Specialty Mental Health Services (SMHS) for calls requesting these services? 4. Five (5) PP improvement in ACCESS Center calls *where Agents demonstrated respect/customer service* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17? 5. Four (4) PP improvement in ACCESS Center calls *showing an identified presenting problem* in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18? 6. Four (4) PP improvement in ACCESS Center calls showing identified medical needs in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18? 7. Three (3) PP improvement in ACCESS Center calls showing identified substance abuse issues in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18? 8. Two (2) PP improvement in ACCESS Center calls *where the caller's information was documented* in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18? 9. Five PP improvement on the *test calls study results for CY 2017 compared to CY 2016* for the three indicators: a) Percent requesting caller's name; b) Percent of callers satisfied with ACCESS Center services; and c) Percent of actual calls logged by the ACCESS Center?"	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study question reads as a list of indicators rather than an all-encompassing question about improving the quality of ACCESS Center call handling, which presumably should lead to improved consumer outcomes. The MHP should consider rephrasing the question to be more targeted and concise. The MHP might consider: "Will implementing a QA protocol for the LACDMH ACCESS Center 24/7 Line result in measurably improved ACCESS Center metrics?"
	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is relevant to all consumers and pre-consumers who may call the ACCESS Center.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: Agent	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The data collection approach—and its ability to include the entire population of calls/callers—is not clear. While the MHP stated that the calls were selected at random, the call review were also based on the specific agent who was to be evaluated, which is not random.
	Totals	**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Culturally Competent and Linguistically Appropriate Services 2. Access to Care 3. Consumer/Customer Satisfaction 4. Clinical Care 5. Continuity of Care	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators are not actually indicators. The indicators are categories or areas for improvement. The items under Corresponding Outcome Measure, as listed in Table 4, are more akin to indicators, however, some of them do not "indicate", but establish the baseline. For example, rather than tracking the number of calls showing identified presenting problem, the MHP should have tracked how many of those with identified presenting problem were actually provided information relative to the identified presenting problem.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☐ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☐ Yes ☒ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Some of the indicators relate to (potential) change in the caller's satisfaction with the call, and perhaps positive view of the MHP, but others do not. For example, rather than tracking the number of non-English calls where language interpreter services were offered, the MHP would be better served by measuring how many of these non-English calls actually received (and in what time frame) the language interpretation services. . Similarly, the MHP could have tracked the number that were given substance use information after identifying substance abuse issues.
	Totals	**0** Met **2** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The MHP mentions many "random" components, but given some amount of matching (e.g., agent calls by time of day, calls by language, etc.) it would not be possible to randomize all of these components. It is not clear why the MHP has chosen to select calls by agent. With over 80,000 calls in 6 months, there would be an average of 1,111 calls per each of the 72 agents. With enough calls selected (i.e., a large enough sample), it could include most of the agents. Reviewing by agent, puts the emphasis on the agent rather than a uniform process for call handling by any and all agents.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☒ Unable to Determine	The MHP used Random.org to select calls based on supervisor and agent availability. However more detail is needed to understand the MHPs sampling technique, which appears to include convenience sampling and perhaps others.

5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP increased the number of calls by modifying the evaluation process of the supervisors. Supervisors review more calls during the week, a minimum of 8, rather than 1. This has increased the sampling from 0.26% of the population to 1.3%. The MHP also included calls during business hours. The sampling to ensure adequate number of business hour calls was not articulated—and was only mentioned in 8. Overall, the MHP does not have a sufficient sample from which to draw conclusions about calls and call handling by agents.
	Totals	**0** Met **0** Partially Met **1** Not Met **2** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data will be derived from the Teleform QA checklist, which has fields to assess various aspects of a call to the ACCESS line.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: QA Checklist	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, the QA Checklist.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The document articulates a plan for the supervisors to select and review calls, but this plan is not clear. The plan did not indicate, for example, how many calls required subsequent face-to-face review (i.e., had a 'No' response in at least one of the four specified areas).

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: QA Checklist	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The document indicates that inter-rater reliability among supervisors was obtained, which would address consistency of supervisors and reliability of the scoring.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has a data analysis plan that includes monthly submission to the QI department for analysis and then review by the PIP team. The MHP also used PDSA cycle and extemporaneous changes to process to address contingencies and untoward results.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Julie Valdez Title: Mental Health Clinical Program Manager III Role: Project Leader *Other team members:* Names: The team consists of 26 staff from the ACCESS Center, service area QI chairs and co-chairs, and analysts. See the PIP document for the full list.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The analysis were conducted by the QI department and reviewed by the PIP Team.
Totals		**5** Met **1** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Implement ACCESS Center Quality Assurance (QA) Protocol for supervisors 2. Launch QA Protocol at the ACCESS Center for review of calls by supervisors and feedback to agents 3. Implement Skill Sets/Workgroup Protocol 4. Implement the New Call Center Application 5. Memo issued by ACCESS Management (Attachment 3E.11) clarifying how to document calls where caller's DOB is not available	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The impetus for the PIP was the MHP's performance on certain components of the test calls. In a subsequent review of the test calls, from FY17, the MHP found decreased performance in some of those areas, despite their interventions. What this highlights is the difference between live calls and test calls and the ability of agents to discern test calls. The MHP's interventions are meant to improve call handling and agent's responsiveness to the needs of callers. Some of the interventions the MHP presented (e.g., Nos., 3 and 5) activities related to their PIP and not interventions.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP conducted an analysis of test calls and (as mentioned above) showed a decrease in performance in some of the areas. The MHP continues to do supervisor review of calls and subsequent one-on-one as needed.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP presented results. The MHP characterized some results as improvement, based on small percentage point increases (e.g., 71% vs. 70% on showing identified medical need). Given the small sample, these differences are rather miniscule and may not actually relate to practical difference.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The analysis identified repeated measures, which the MHP captured on a quarterly basis. Again, the MHP did not indicate the statistical analysis use, significance level, or confidence level.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* Overall, on 3 of the 5 outcome measures tracked for FY16-17 for this PIP, there was improvement indicative of the effectiveness of interventions implemented including the QA reviews and feedback to Agents and other related interventions via PDSAs to address barriers identified. *Recommendations for follow-up:* <Text>	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP provided their analysis of the study and their conclusion that the PIP was successful. The MHP did not speak to any limitations of the PIP. The MHP has plans to continue the PIP and incorporate more interventions and trainings.
Totals		**3** Met **1** Partially Met **0** Not Met **0** NA **0** UTD

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP made changes along the project to improve data collection and implementation. These changes did not have an effect on the methodology and measurement of data.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP showed an improvement in outcomes. The MHP did not present statistical significance.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☒ Fair ☐ High	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	While the MHP has some improvements, some of these are very modest.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not conduct analyses to determine if there is a statistically significant difference in the performance and if it is based on the interventions.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**1** Met **1** Partially Met **1** Not Met **1** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

For this second year, the PIP addressed some of the recommendations made by CalEQRO during the FY16-17 review. The MHP increased the number of calls to be sampled; modified the sampling technique to be based on agents rather than supervisors; and incorporated or articulated the inclusion of other languages, besides Spanish, for review.

The PIP has not sufficiently addressed how these activities will benefit consumer outcomes.

While the MHP has increased the number of calls sampled, this number is still not sufficient for statistical significance, as it does not enable the MHP to generalize to approximately 13,500 calls per month, which vary by language and time of day.

Recommendations:

The PIP should include or highlight the consumer benefits as a result of the activities being carried out.

The PIP should include agents and, if possible, peers in the review process, thereby significantly increasing the number of calls reviewed in order to reach statistically significant representation, and subsequently decreasing the burden on supervisors.

For this PIP to continue, it will need to target a specific area for further investigation. Otherwise, the MHP will need to select a new PIP topic.

Check one:

☐ High confidence in reported Plan PIP results

☒ Confidence in reported Plan PIP results

☐ Confidence in PIP results cannot be determined at this time

☐ Low confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible