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FY 2018–19
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 24 – 27, 2018

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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 Organizations (MCOs) 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 Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also takes into account the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

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 (FY) 2018-19 findings of an EQR of the Los Angeles MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Very Large

MHP Region — Los Angeles

MHP Location — City of Los Angeles

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 205,143

MHP Threshold Language(s) — Spanish, Armenian, Mandarin, Cantonese, Korean, Vietnamese, Farsi, Tagalog, Russian, Cambodian, Other Chinese, and Arabic

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

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 and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

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 reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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:

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[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.

[2] 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.

[3] 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.

- 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, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2017-18 Review of Recommendations

In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. The findings 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 FY 2017-18

Recommendation 1: 1a) Create a study of retention by type of staff as juxtaposed to average caseloads. 1b) Investigate further incentives that might be initiated for both recruitment and retention of licensed staff.

Status: Partially Met

- The MHP conducted an analysis of staff turnover and retention over a 24-month period. The primary reasons for staff departure were promotions and transfers to other programs within the county system.
- The study also showed that while managers communicated some incentives to staff and new recruits (e.g., pre-licensure preparation classes), they did not promote or communicate incentives such as educational stipends and flexible work schedules, which might be incentives for some staff. The MHP added that managers likely conveyed the incentives that were available, which were discipline-specific.
- The MHP featured several staff retention programs that were geared toward social workers and psychiatrists. The incentives were: educational stipends for second year master's level social workers; stipends for new psychiatrists who complete up to two years of employment with the MHP; a $50,000 annual

student loan repayment for psychiatrists; and, federal loan repayment for working in one of 11 MHP programs in health professional shortage areas.

- High caseloads of beneficiaries with more severe illnesses played a factor in turnover of social workers and clinical staff; however, no caseload review as such was conducted.

- Caseload size and composition remains an area for further examination.

Recommendation 2: 2a) Using the reorganization as an opportunity, MHP leadership should evaluate the level of parity across the entire System of Care (SOC), paying particular attention to ensuring that all levels of care are equitably represented in each of the eight service areas (SAs). 2b) In addition, consistently use data from a gap analysis or other assessment of the continuum of care in each SA to ensure parity in future resource allocations system-wide.

Status: Met

- The MHP evaluated the services available in each of the eight SAs. Overall, most levels of care were represented; however, two types of services/levels of care were not represented in each SA. Services for beneficiaries involved in the justice system and intensive mental health services were not in each SA.

- SA 1 stood apart from the other SAs in that there were no definitive plans/dates for provision of intensive mental health services. Neither an urgent care center nor a crisis residential treatment program was planned for this SA, while all the other SAs had these services or plans for those services in the upcoming year(s). In SAs 3, 4, 5, 6, and 8 urgent care centers provided intensive mental health services and in SAs 5 and 6 crisis residential treatment programs were available.

- The MHP has full-service partnership (FSP) programs in all eight SAs. The MHP has increased or planned to increase FSP slots in the current fiscal year, based on the demand in the given SA.

- The MHP conducted an analysis comparing distribution of services with dollars spent on those services. This analysis showed that utilization and dollars were not aligned in SA 6 and SA 4. Due to this finding, the MHP theorized that beneficiaries in these SAs obtained services from other, likely closely located, SAs. Further review by the MHP is needed to determine if this mismatch reflects service disparity or beneficiary preferences.

Recommendation 3: 3a) 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. 3b) Explore the possibility of leveraging transitional aged youth (TAY) as a component of the peer workforce throughout the SOC to assist in making mental health services more available in the community.
This recommendation was a carry-over from FY 2016-17.

Status: Met

- The MHP has established a Peer Discipline Chief position that is on par with chiefs for the other disciplines (e.g., psychology, social services). One of the responsibilities of this position is to provide structure around career development opportunities for peers. The Peer Discipline Chief position has been filled by a national and local leading advocate on peer inclusion in mental health.

- The MHP has a cadre of volunteer wellness outreach workers (WOWs) who use their lived experience to facilitate connections/services for other beneficiaries. The WOWs played a key role in the implementation of the Peer Resource Center (PRC), opened in May 2017, whose purpose is to provide beneficiaries and those not yet engaged with mental health services, wellness, and social support.

- The MHP utilizes peer positions through the Whole Person Care (WPC) Pilot program. “Kin Through Peer” and “Peer 2 Peer Support” are examples of WPC efforts to connect beneficiaries in need of acute services, such as Intensive Service Recipients (ISRs), and beneficiaries who are difficult to engage with community-based behavioral and physical health services.

- The MHP has leveraged TAY as part of the workforce. Over the past year, the MHP trained and certified 46 TAY as Peer Support Specialists who are eligible to work in programs that would like to have or need peer support. Through a Career Exposure Project in March 2018, the MHP trained and provided job shadowing to another nine youth who were then referred to Human Resources to participate in a specialized peer support program.

- More peers have been hired throughout the MHP’s system of care; however, the positions appear to be at the same level and do not show a trajectory or progressive advancement for peers.

Recommendation 4: 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 processing of up to two to three weeks for new user account ID activations.

Status: Met

- The MHP streamlined workflow processes for contract providers that were requesting credentials to remotely access the MHP’s online system resources.

- Wait times, counted from the time of receipt of the Downey Data Center Registration forms to issuance of credentials, were reduced from four to six weeks on average in FY 2016-17 to three days in FY 2017-18.

Recommendation 5: Assess current need against capacity of clinical and technical training sessions (0-5 years, and evidence-based practices), and investigate the feasibility of adding additional sessions or adjusting the frequency of trainings to accommodate demand for existing and new users.

Status: Partially Met

- The MHP has continued to train on the core competencies for serving the birth to age five population. As of July 2018, there were 90 legal entities and DMH clinics that have the capacity to serve this population.
- Over the past year, the MHP also provided trainings and ongoing consultation for the following birth to age five practices: Parent Child Interaction Therapy; Child Parent Psychotherapy; and Incredible Years. These trainings were sought after and attended by both directly-operated and contract provider staff.
- Staff, particularly case managers, reported limited capacity in their schedules to accommodate trainings. The emphasis was on productivity, which precluded time to attend trainings.
- Staff from contract provider agencies noted an increase in training offerings, but some felt that the trainings were still prioritized toward DMH staff and training slots were not readily available.
- In the response, the MHP presented training efforts relative only to the birth to age five population. Other populations or evidence-base practices were not discussed. Additionally (and as stated above), staff's schedules limit their ability to attend some trainings of interest.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent 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 length of stay (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.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following.
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). 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 details on beneficiaries served by race/ethnicity.

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2017, by Race/Ethnicity Los Angeles MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served**	**% Served**
White	528,245	13.1%	29,533	14.4%
Latino/Hispanic	2,340,000	58.2%	95,164	46.4%
African-American	387,837	9.6%	34,339	16.7%
Asian/Pacific Islander	383,667	9.5%	8,464	4.1%
Native American	5,257	0.1%	494	0.2%
Other	375,110	9.3%	37,149	18.1%
Total	**4,020,000**	**100%**	**205,143**	**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.				

Penetration Rates and Approved Claims per Beneficiary

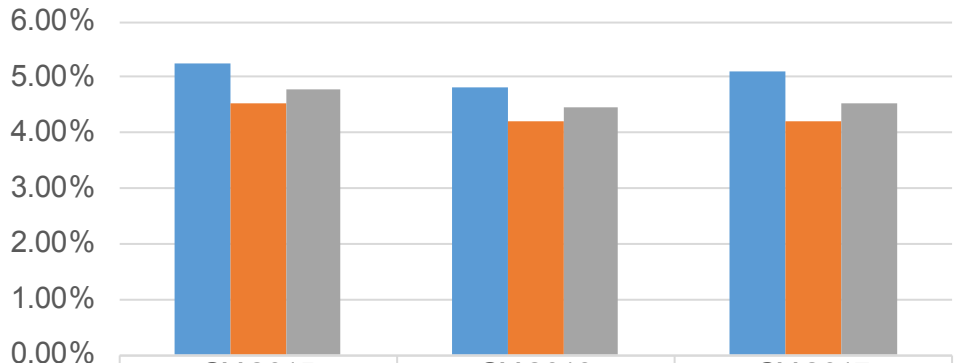
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Los Angeles MHP uses the same method used by

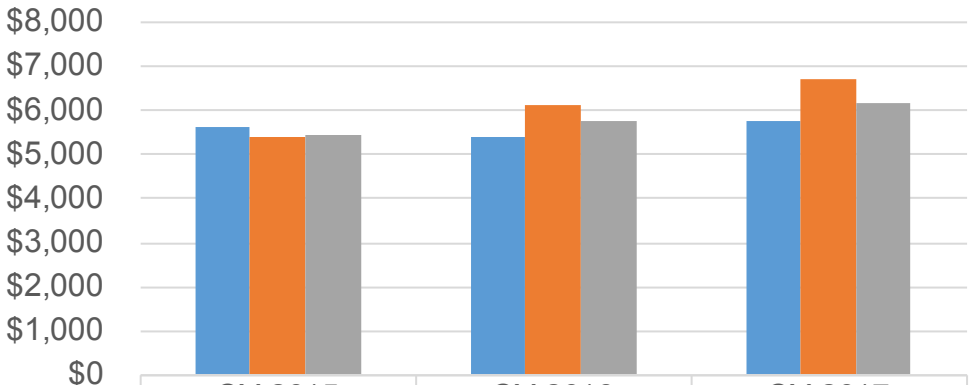
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large

Figure 1A. Overall Penetration Rates
Los Angeles MHP



	CY 2015	CY 2016	CY 2017
MHP	5.24%	4.82%	5.10%
Large	4.53%	4.20%	4.19%
State	4.78%	4.44%	4.52%

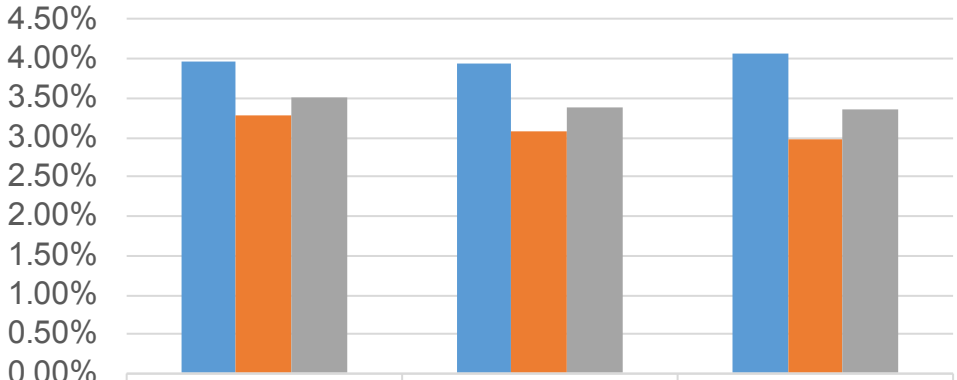
Figure 1B. Overall ACB
Los Angeles MHP



	CY 2015	CY 2016	CY 2017
MHP	$5,632	$5,420	$5,763
Large	$5,393	$6,121	$6,723
State	$5,458	$5,746	$6,170

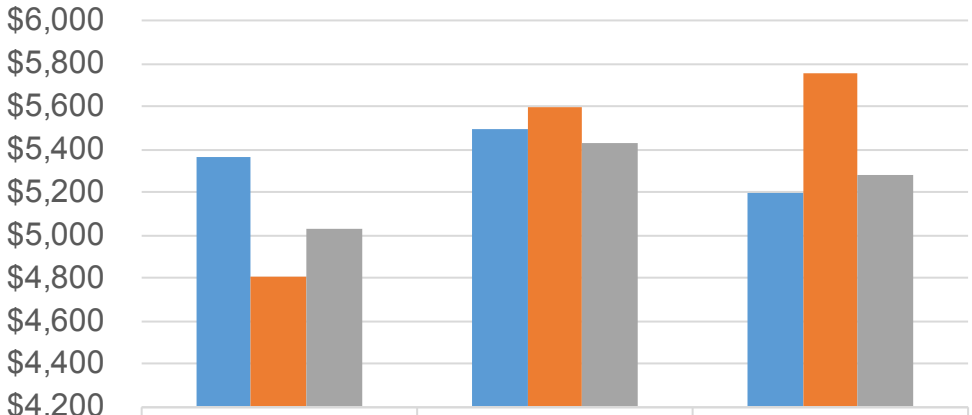
Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large

Figure 2A. Latino/Hispanic Penetration Rates
Los Angeles MHP



	CY 2015	CY 2016	CY 2017
MHP	3.98%	3.94%	4.06%
Large	3.28%	3.07%	2.97%
State	3.50%	3.38%	3.35%

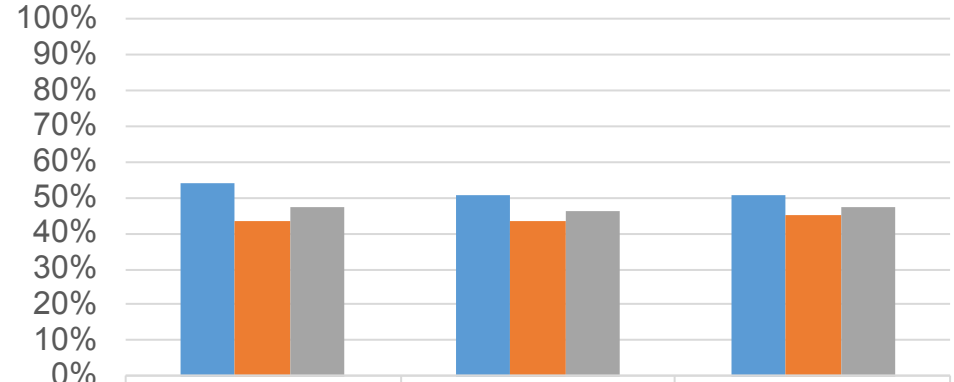
Figure 2B. Latino/Hispanic ACB - Los Angeles MHP



	CY 2015	CY 2016	CY 2017
MHP	$5,366	$5,496	$5,196
Large	$4,804	$5,599	$5,758
State	$5,029	$5,430	$5,278

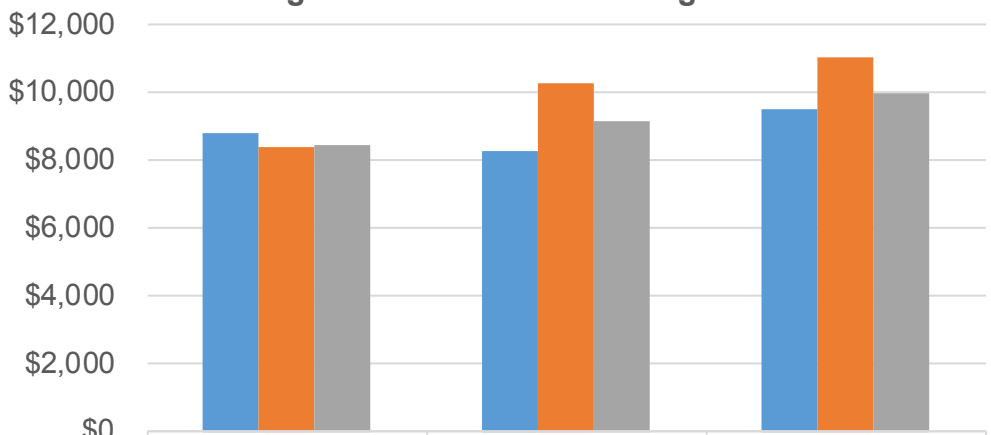
Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A. FC Penetration Rates
Los Angeles MHP



	CY 2015	CY 2016	CY 2017
MHP	54.14%	50.41%	50.83%
Large	43.42%	43.22%	45.37%
State	47.52%	46.26%	47.28%

Figure 3B. FC ACB - Los Angeles MHP



	CY 2015	CY 2016	CY 2017
MHP	$8,812	$8,305	$9,517
Large	$8,425	$10,301	$11,064
State	$8,432	$9,147	$9,962

High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP's data for CY 2017, 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: High-Cost Beneficiaries - Los Angeles MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2017	21,522	611,795	3.52%	$54,563	$1,174,305,701	31.11%
MHP	CY 2017	5,490	205,143	2.68%	$48,630	$266,979,411	22.58%
	CY 2016	4,659	200,661	2.32%	$49,012	$228,347,716	20.99%
	CY 2015	5,390	203,462	2.65%	$51,099	$275,425,631	24.04%

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

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-17) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

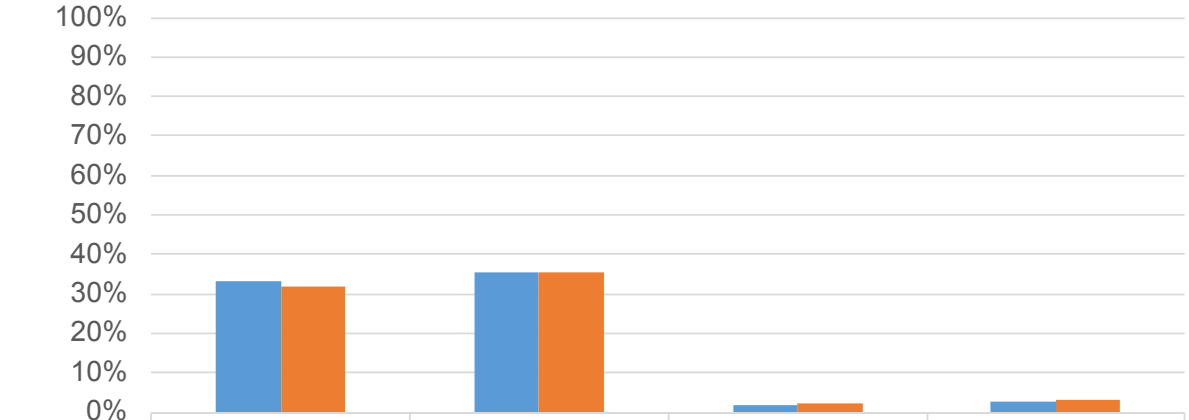
Table 3: Psychiatric Inpatient Utilization - Los Angeles MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	18,999	95,993	7.47	$8,041	$152,774,986
CY 2016	17,929	89,480	7.64	$8,143	$145,993,724
CY 2015	16,840	83,322	7.6	$6,343	$106,812,943

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

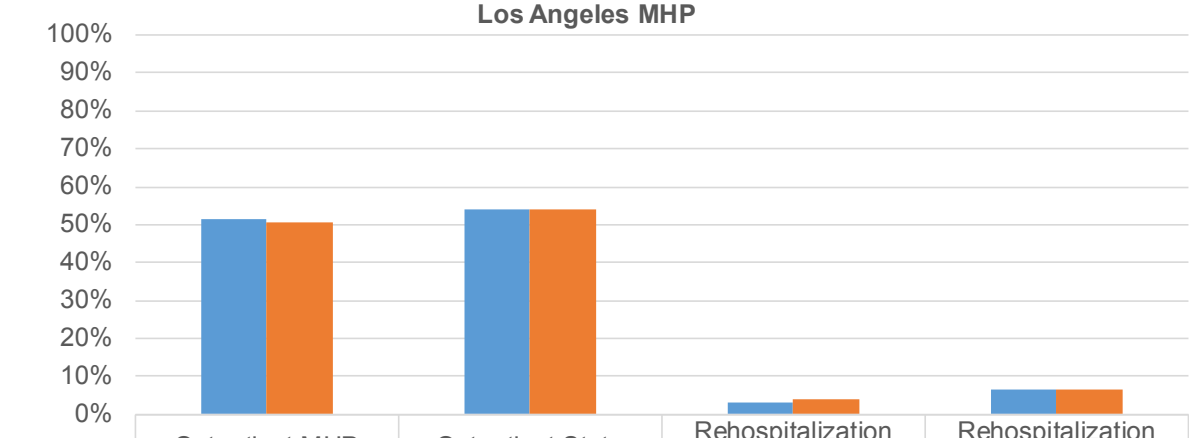
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
Los Angeles MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	33%	36%	2%	3%
CY 2017	32%	36%	2%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
Los Angeles MHP



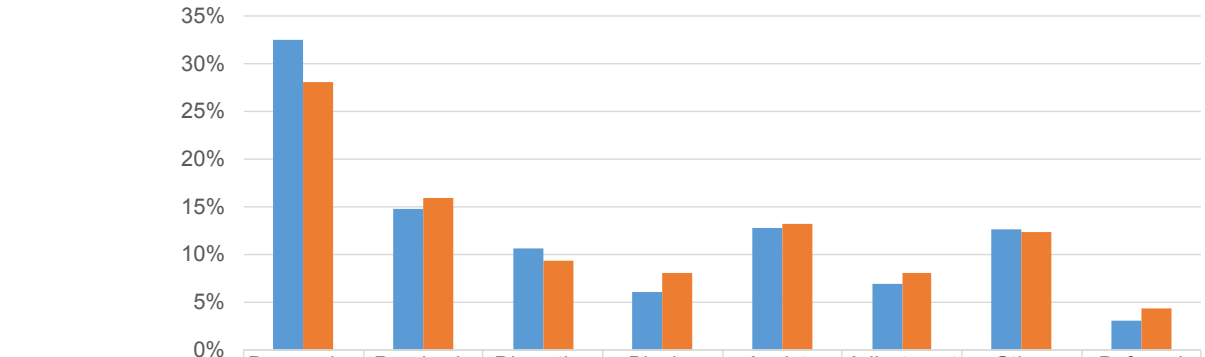
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	52%	54%	3%	6%
CY 2017	51%	54%	4%	7%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

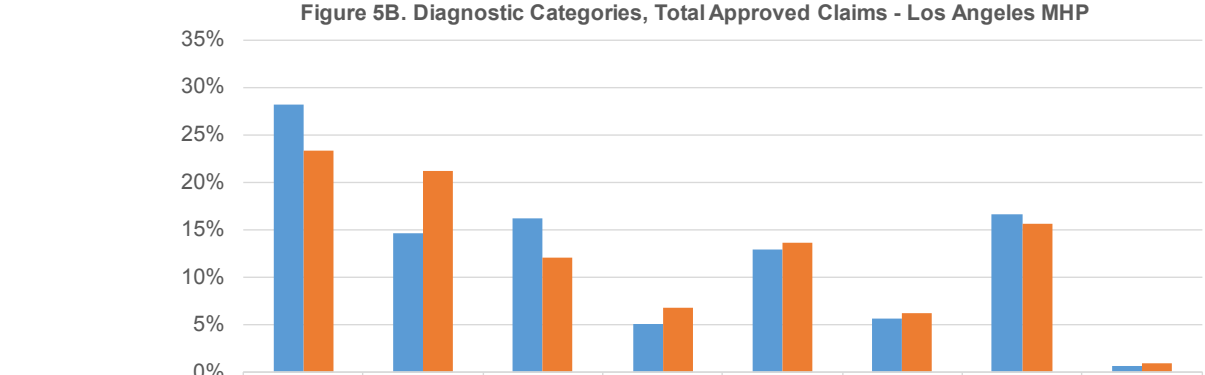
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 30 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served - Los Angeles MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
Los Angeles CY 2017	33%	15%	11%	6%	13%	7%	13%	3%
State CY 2017	28%	16%	9%	8%	13%	8%	12%	4%

Figure 5B. Diagnostic Categories, Total Approved Claims - Los Angeles MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
Los Angeles CY 2017	28%	15%	16%	5%	13%	6%	17%	1%
State CY 2017	23%	21%	12%	7%	14%	6%	16%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A 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." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Los Angeles MHP PIPs Identified for Validation

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

Table 4 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 4: PIPs Submitted by Los Angeles MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Post Discharge Outpatient Follow-up Appointment Scheduling for Hospital Discharges – Impact of Care Coordination and Clinical Quality Measures (CQM) Protocols
Non-clinical PIP	1	The Impact of Training and Psychoeducation to Front Office Staff on Consumer Satisfaction with Front Office Customer Services (FOCS)

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

Table 5: PIP Validation Review

	Item Rating

[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.

Step	PIP Section	Validation Item		Clinical	Non-Clinical
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	PM	PM
		1.3	Broad spectrum of key aspects of enrollee care and services	PM	M
		1.4	All enrolled populations	UTD	M
2	Study Question	2.1	Clearly stated	PM	PM
3	Study Population	3.1	Clear definition of study population	PM	M
		3.2	Inclusion of the entire study population	PM	PM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	PM	PM
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	M
		5.2	Valid sampling techniques that protected against bias were employed	NA	M
		5.3	Sample contained sufficient number of enrollees	NA	M
6	Data Collection Procedures	6.1	Clear specification of data	PM	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	PM
		6.4	Plan for consistent and accurate data collection	M	M

		6.5	Prospective data analysis plan including contingencies	NM	M
		6.6	Qualified data collection personnel	M	PM
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NM	PM
		8.2	PIP results and findings presented clearly and accurately	PM	M
		8.3	Threats to comparability, internal and external validity	PM	PM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	PM	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	PM	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	PM	M
		9.3	Improvement in performance linked to the PIP	NA	PM
		9.4	Statistical evidence of true improvement	NA	UTD
		9.5	Sustained improvement demonstrated through repeated measures	NA	NA

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	7	17
Number Partially Met	13	9
Number Not Met	2	0
Unable to Determine	0	1
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	22	27
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**61.36%**	**79.63%**

Clinical PIP— Post Discharge Outpatient Follow-up Appointment Scheduling for Hospital Discharges – Impact of Care Coordination and CQM Protocols

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

"Will implementing prolonged stabilization post hospital discharge impact hospital readmission rates? Will co-occurring disorders (COD) group participation contribute to positive perceptions regarding COD groups and self-reported reduction in substance use? Will implementing hospital discharge outpatient follow-up care coordination protocols reduce barriers to scheduling post hospital discharge urgent outpatient appointments at Los Angeles County Department of Mental Health directly operated (LACDMH DO) sites and contract programs?"

Date PIP began: July 2017

Projected End date: July 2019

Status of PIP: Active and ongoing

This is the second year that the MHP has presented this project as a PIP; however, last year, the project was rated as Concept Only. The purpose of this PIP is to reduce preventable hospital readmissions. The MHP presented data on 30-day readmission rates from CY 2015-17, which showed a trend of increasing rates. The target populations for the project are ISRs and all beneficiaries who are discharged from the fee for service hospitals. The MHP has implemented four interventions: prioritize beds

at a crisis residential facility; implement co-occurring disorders group at outpatient treatment programs; implement a coordination process between hospitals and outpatient programs called Hospital Discharge Outpatient Follow-up Care Coordination; and, establish a protocol for coordinating hospital discharge outpatient follow-up through Transforming Clinical Practice Initiative (TCPI).

The MHP has not seen any improvement in the primary indicators and outcomes of the project, which are the 7-day outpatient follow-up rate, the 7- and 30-day readmission rate, and the length of stay in hospitals. However, the MHP has seen an improvement in beneficiaries' perception of COD groups and increased participation in outpatient treatment services. That the improvement in this project is in engagement underlies two issues: The project seems to be (1) less about rehospitalization and (2) more about improving care for ISRs, who are difficult to treat and engage in services. As an example of the focus on ISR, when describing the target population (Step 3), there is no information on the beneficiaries who are discharged from hospitals; the detailed information relates only to ISRs. Rehospitalization works better as a key indicator of ISR's lack of engagement.

Hospital readmissions is a complex problem with multiple contributing factors. The MHP is attempting to address several of these factors with one project, with only varying degrees of success. The MHP would do well to hone the focus on the ISRs, their lack of engagement, and then use rehospitalization rates, among other indicators, as a measure of disengagement.

Suggestions to improve the PIP: If the focus of the PIP is on rehospitalization throughout the system, the MHP will need to expand the scope of the interventions. At present, the interventions related to coordination of post-hospitalization services are limited to certain participating hospitals and clinics. The MHP will also need to monitor and provide corresponding indicators of other aspects that relate to rehospitalization (e.g., time to placement in a housing/residential program; length of administrative days in hospital).

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

The technical assistance (TA) provided to the MHP by CalEQRO is included in the validation. During the onsite review, the MHP presented updated information on the project. There was not time for a discussion and technical review and assistance of the project.

Non-clinical PIP—The Impact of Training and Psychoeducation to Front Office Staff on Consumer Satisfaction with Front Office Customer Services (FOCS)

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

"Will implementing front office customer service training and psycho-education on mental health educational materials improve the consumer satisfaction rates related to front office customer service as evidenced by pre-post improvement in survey scores and qualitative feedback from consumers receiving services with MHP outpatient programs?"

Date PIP began: July 2017

Projected End date: July 2019

Status of PIP: Active and ongoing

The purpose of this PIP is to improve customer service of front office staff and thereby improve beneficiary satisfaction. The MHP contends that the front office experience and customer service is an under-evaluated area of the system, yet it plays a role in beneficiary access to initial and ongoing care.

The MHP conducted a survey to learn more about customer service of front office staff. The survey showed overall high and positive ratings in customer service, but with some suggestions for improvement around respectful communication and being more informed and knowledgeable. The MHP's interventions were (1) to provide front office staff with customer service training on the client experience and (2) to provide the staff with psychoeducation on mental health illness. The training was targeted toward all front office staff at outpatient programs throughout the system of care, including directly-operated and contracted programs. The MHP used a self-reported satisfaction survey that measured five aspects of customer service: helpfulness, flexibility, dignity and respect, feeling welcomed, and professionalism. The surveys were only administered at 35 directly-operated clinics some months before and after the training.

With the exception of flexibility (i.e., with late arrivals and missed appointments), there was no other improvement in beneficiaries' satisfaction. The MHP found that this question on flexibility was also the least answered. The MHP presumed that beneficiaries were either unsure of how to interpret that question or that beneficiaries were reluctant to provide a negative rating (i.e., related to a social desirability (response) bias). While the training did not make an appreciable difference in beneficiaries' satisfaction, staff had positive ratings of the customer service training and presumably can use the information in their interactions with beneficiaries.

Suggestions to improve the PIP: Given that satisfaction was already high, at upwards of 90 percent, it presented a challenge for the MHP to further increase the ratings. The PIP provides the MHP with confirmation that beneficiaries are generally satisfied with customer service experience, but that flexibility warrants for further investigation. While the MHP intends to expand this project to contracted programs, they are encouraged to identify and present a different project for their next non-clinical PIP.

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

The TA provided to the MHP by CalEQRO consisted of recommendations to provide more detail on the customer service issues and to focus on the areas of customer service about which beneficiaries had more negative comments.

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system 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.

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 2.1 percent.

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

Table 7 shows the percentage of services provided by type of service provider.

Table 7: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	17%
Contract providers	81%
Network providers	2%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Table 8 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System	
Type of Input Method	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	Daily
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Daily
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	Batch file

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of remote sites currently operational: 11

Identify primary reason(s) for using telehealth 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 beneficiaries temporarily residing outside the county
- ☒ To serve special populations (i.e. children/youth or older adult)
- ☒ To reduce travel time for healthcare professional staff
- ☐ To reduce travel time for beneficiaries

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

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 9.

Table 9: Technology Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
240	25	14	21

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

Table 10: Data Analytical Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
37	7.5	2.5	3

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

- Recruitment and retention of qualified technology and analytical staff remains a time-consuming process.
- The unfilled technology vacancy rate ranges between seven and eight percent, but the Chief Information Office Bureau (CIOB) would like to achieve a rate in the range of five to six percent.
- CIOB leadership indicated that it is difficult to recruit staff who are qualified in database administration and report writing. They are having to hire people with related skills and train them to do that work, in part due to the complexity of operations.

Current Operations

Table 11 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 Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 11: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar/IBHIS	EHR	Netsmart	5	Vendor/ CIOB
Order Connect	ePrescribing/eLab	Netsmart	5	Vendor/ CIOB
IBHIS Web Services	Legal Entity/HIE	CIOB/Netsmart	5	CIOB
Provider Connect	FFS Authorization/ Billing Portal	Netsmart	5	Vendor/ CIOB
Practitioner Registration Maintenance (PRM)	Practitioner Data	CIOB	3	CIOB
Care Connect	Integrated Care	Netsmart	3	Vendor/ CIOB
Access Call Center	Call Management	Verizon	5	Vendor
Pharmacy Benefit Management–(PBM)	Medication Claims Adjudication	Magellan	2	Vendor/ CIOB
DMH Data Warehouse	Data Warehouse & Reporting Environment	CIOB	14	CIOB/ County ISD

- As of June 2018, all legal entities and fee-for-service contract providers continuing to do business with the MHP have migrated from the legacy Integrated System (IS) to Integrated Behavioral Health Information System (IBHIS).
- The MHP electronically exchanges client demographic, clinical, and financial data between IBHIS and contract agency's local EHR systems. The following is a summary of the EHR vendor system that IBHIS currently supports.

Table 11a: Contract Providers' EHR

EHR Vendors	Legal Entities Supported	Percent
Allscripts	1	1%
Askesis	5	4%
Caminar	3	3%
Cerner	1	1%
Clinivate	14	12%
Custom	1	1%
Exym	54	45%
NTST-Avatar	5	4%
NTST-Evolve	6	5%
NTST-Tier	2	2%
Welligent	28	23%
Legal Entities	**120**	**100%***

*The total may not add up to 100 percent due to rounding.

- The Integrated System will be completely shut down by January 2019. Prior to IS shut down, a full back-up will be completed and archived for future retrieval of historical information.
- Workflow improvements in IBHIS for prescribing practitioners (i.e., psychiatrists and nurse practitioners) were designed to reduce the number of click-throughs for end users. Process improvements included a new 'widgets on demand' to pull medication, diagnosis, and lab data directly into notes instead of retyping. A refined set of clinical data views, more rigorously focused on prescriber-specific needs, was also added.
- New controls were implemented to IBHIS User Interface, Provider Connect portal, and Client Web-Services to reduce risk of creating duplicate client IDs as well as the risk of improper overwrites of client's demographic information.
- Contract providers are responsible for conducting vendor-specific EHR system training and support for their local staff.
- For directly-operated sites, a series of EHR trainings based on user roles and functions are available. The following EHR trainings are regularly conducted: Clinical practice and clinical operations (2-day); local user administration (1-day); clinical administration (1/2-day); and error correction (1/2-day). Other trainings are offered as needed.

- The MHP restructured the Help Desk operations and there have been some improvements in timeliness of response.
- Care coordination continues to expand through Los Angeles Network of Enhanced Services (LANES), a non-profit Health Information Exchange for secure one-to-one conversation between practitioners from their respective secured EHRs. IBHIS has functionality to send direct secure messages (DSM) to other practitioners who also have Meaningful Use-certified EHR system to share client specific information.
    - In June 2018, the MHP went live at the co-located site with Los Angeles County Department of Human Services (LACDHS) at East San Gabriel. A second pilot was implemented at Olive View Urgent Care Center in July 2018.
    - In May 2018, DSM went live between High Desert Regional Health Center, Lancaster, and LACDHS.
    - In prior years, DSM functionality was pilot tested between San Fernando Valley Mental Health and Tarzana Treatment Center. MHP Access Center and LACDHS were also implemented.

The MHP's Priorities for the Coming Year

- Clinical: Care Navigation
    - Mental Health Resource Locater and Navigator
    - ACCESS Center (Hotline) and Field Crisis Response
    - ACCESS Center New Call/Referral Application
    - Virtual Care: Telepsychiatry (Telehealth) Expansion
    - Katie A Database Modernization
    - Consumer Family Access to Computing Resources Expansion
    - MHSA Innovation Technology Suite (resources for beneficiaries)
- Clinical: Provider Information
    - DMH Interanet and Website Modernization
    - Credentialing System Modernization
    - Provider Directory/Registry
- Clinical: Quality and Outcomes
    - Healthcare Enterprise Analytics: Technology Framework

  - Grievance and Appeal System (grievances by clients or beneficiaries)
  - Recovery, Resilience & Reintegration Outcome Measures Application (RRR-OMA)
  - Early & Periodic Screening Diagnostic and Treatment (EPSDT) Outcome Measures
- Clinical: Care Coordination
  - IBHIS CareConnect Inbox Direct Messaging
  - LANES HIE initiative
  - County Wide Master Data Management : DMH Implementation Milestone 2 (realtime interface between Avatar and DMH Master Data Management)
  - Customer Engagement Technology Initiative (myHealthPointe)
  - LA Care Medi-Cal Data Match
- Administrative: Financial Services
  - Pharmacy Benefit Management Services (automate monthly charge back)
  - Provider Form Adjustment Request Automation
- Administrative: IT Services
  - User Access Request Process Automation
  - Digital Workplace: Wi-Fi access at DMH Clinic and Administrative Sites

Major Changes since Prior Year

- Care Coordination
  - Onboarding legal entities and fee-for-service providers to IBHIS.
  - Department of Child and Family Services (DCFS) Wraparound Contract transferred to the DMH.
  - Client and Asset Management System for Public Guardian.
- Care Navigation
  - Redesigned PRC with IT Infrastructure Expansion that expands beneficiary's access to systems.
  - FSP Referral Tracking Application (RTA).

  - Constituent Call Log. Log and track constituent complaints/issues and resolutions as a form of advocacy for both countywide and SAs.

- Provider Information
  - Board and Care Portal. Allows Board and Care entities to submit their residents for enhanced rate survey.
  - Network Adequacy Certification Tool (NACT). Web-solution to collect, verify and report data for both MHP directly-operated and contract provider sites.

- Quality and Outcomes
  - IBHIS RAD+ and ScriptLink to improve data quality through field-level validations.
  - Change of Provider. Supports a process for beneficiaries to request a change of provider (location) or rendering provider (clinician) that includes specific reporting requirements per CMS Final Rules.
  - Level of Care Tracking and Reporting.

Other Areas for Improvement

- There is a need for Help Desk dashboard reports which internal staff could use to track claims and the status of their claim. This report would further increase both transparency and trust in the function.
- The MHP currently uses Skype for Business application for remote meetings and trainings via Internet connectivity; previously WebEx application was used for remote webinar forums. It was brought to the attention of CalEQRO, during the onsite review, that Skype for Business lacks features, functions, and connectivity that were available in the WebEx application.
- The rollout of MyHealthPointe portal, a personal health record portal, has been slow due to demands of other project with higher priorities. The portal provides beneficiaries a secure way to schedule future appointment reminders and communicate securely with their clinicians and case managers.

Plans for Information Systems Change

- New EHR system in place, installed in past five years.

Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Alerts	Avatar/IBHIS	x			
Assessments	Avatar/IBHIS	x			
Care Coordination	Care Connect/IBHIS	x			
Document Imaging/ Storage	Avatar/IBHIS	x			
Electronic Signature—MHP Beneficiary	Avatar/IBHIS	x			
Laboratory results (eLab)	Order Connect/IBHS	x			
Level of Care/Level of Service	Avatar/OMC	X			
Outcomes	Order Connect/IBHIS	X			
Prescriptions (eRx)	Order Connect/IBHIS	X			
Progress Notes	Avatar/IBHIS	X			
Referral Management	SRL/SRTS/VANS	X			
Treatment Plans	Avatar/IBHIS	X			
Summary Totals for EHR Functionality:		12	0	0	0
FY 2018-19 Summary Totals for EHR Functionality:		12	0	0	0
FY 2017-18 Summary Totals for EHR Functionality*:		11	1	0	0
FY 2016-17 Summary Totals for EHR Functionality:		10	0	0	0

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

Progress and issues associated with implementing an EHR over the past year are summarized below:

- Table 12 ratings are based on IBHIS implementation only for directly-operated sites.

- Legal entities and fee-for-service providers have implemented local EHR systems, or have contracted with a healthcare clearinghouse, to submit EDI transactions that support two-way exchange of data between local systems and IBHIS.
- Legal entities have the capability to view (i.e., look up) beneficiary laboratory results via the CareView portal. CareView is also a Netsmart application.
- Directly-operated sites have the capability to view beneficiary laboratory results via CareConnect application.

Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

☒ Yes ☐ In Test Phase ☐ No

My Health Point was implemented June 2016. As of September 2018, the number of beneficaries with access to personal health portal was 2,347.

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

SQL server - DMH Data warehouse validates incoming and outbound claims

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 13 summarizes the MHP's SDMC claims.

Table 13: Summary of CY 2017 Short Doyle/Medi-Cal Claims - Los Angeles MHP

Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Claim Adjustments	Dollars Approved
5,162,050	$1,147,942,377	159,253	$38,259,340	3.33%	$1,109,683,037	$55,983,345	$1,053,699,692

Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2017 was **2.73 percent**.

Table 14 summarizes the top three reasons for claim denial.

Table 13: Summary of CY 2017 Short Doyle/Medi-Cal Claims - Los Angeles MHP							
Number Submitted	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Claim Adjustments**	**Dollars Approved**
5,162,050	$1,147,942,377	159,253	$38,259,340	3.33%	$1,109,683,037	$55,983,345	$1,053,699,692
Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2017 was **2.73 percent**.							

- Denied claim transactions with reason “Medicare or Other Health Coverage must be billed prior to the submission of this claim” are generally rebillable within the State resubmission guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted three 90-minute focus groups with beneficiaries (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested four focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

CFM Focus Group One

CalEQRO requested parents/caregivers of child/youth beneficiaries, including those receiving Katie A. services, who have initiated/utilized services within the past 15 months. The focus group participants were mostly women who identified as family members and also beneficiaries. The participants were multi-racial and multi-ethnic, with English as the predominant and preferred language. The focus group was held onsite at SA 1 at Palmdale Mental Health Center.

Number of participants: Seven

The five participants who entered services within the past year described their experiences as the following:

- Participants reported varying amounts to time to initiate services—from the next day to several weeks. Eight weeks appeared to be the average wait time for an initial assessment, while one week was the average wait time for an initial psychiatry appointment.
- Foster parent and/or step-parent participants reported that it was challenging to navigate services on behalf of dependent beneficiaries. These caregivers described delayed services and difficulties in gaining access to their dependents' health records.

Participants' general comments regarding service delivery included the following:

- That there were a variety of services, including individual therapy, family therapy, wrap-around services, case management, and family or foster parent support groups, available.
- Experiencing difficulty in changing therapists. When caregivers had expressed a concern or requested a change, they felt interrogated by supervisors and pressured to maintain the therapist.

- Inability of crisis teams and, in particular, the Psychiatric Emergency Teams to provide immediate or timely assistance, resulting in the need to contact law enforcement.
- That finding the right 'fit' of a therapist, case manager, or treatment team made the difference in continuing and benefiting from services.
- More frequent change of personnel, including therapists and psychiatrists, which was disruptive to services.
- Plentiful information about services, but requiring the individual to initially seek it out before the information is given.
- Stigma continues to be a critical barrier to access for Latino beneficiaries. Caregivers remarked that they had to overcome their reticence to bring their children for services.

Participants' recommendations for improving care included the following:

- Provide more crisis and urgent services.
- Increase funding, the number of locations or service providers, and the staff such that wait times are reduced and services are more accessible.
- Provide mentorship for new therapists as they are not as polished and attuned to the needs and circumstances of the families.
- Increase education and outreach to Hispanic community in Palmdale.

Interpreter used for focus group one: No Language(s): N/A

Consumer/Family Member Focus Group Two

CalEQRO requested a group of African-American adult beneficiaries who have initiated/utilized services within the past 15 months. The participants were as requested (i.e., African-Americans) and most were men. The focus group was held at Amanecer Community Counseling Services.

Number of participants: 12

There were no participants who entered services within the past year. Participants' general comments regarding service delivery included the following:

- More frequent contact with their case managers than other practitioners. Some participants did not know that therapy was available to them.

- Sufficient frequency of contact, on average monthly, with their psychiatric providers who were generally responsive to their needs and requests (e.g., changing medications).
- Liking and wanting more groups, such as relapse prevention, writing, mindfulness and meditation, and anger management. Some groups required regular attendance or referral from the case managers and some groups excluded individuals who were involved in the justice system.
- Use of the hotline or contacting case managers as the primary means of extra support. None of the participants were aware of a warm line to call.
- Waiting all day to be seen at the clinic and having shortened or reduced time with their therapists or psychiatric providers, which was attributed to programs being understaffed.
- Being informed of their medications and outcomes for routine labs by their psychiatric providers and that their psychiatric providers inquire regularly about their symptoms.

Participants' recommendations for improving care included the following:

- Remove some of the stipulations and restrictions that prevent beneficiaries from attending groups of interest (e.g., justice involvement precluding participation in anger management group).
- Increase transportation assistance and provide the appropriate transportation for beneficiaries in wheelchairs.
- Provide more housing options and reduce the processing time to obtain housing.
- Improve the communication and means of informing beneficiaries about the services that are available and for which they are eligible.

Interpreter used for focus group two: No Language(s): N/A

Consumer/Family Member Focus Group Three

CalEQRO requested a group of Korean adult beneficiaries and parents/caregivers of child/youth beneficiaries who have initiated/utilized services within the past 15 months. The participants were as requested (i.e., Koreans) and all were beneficiaries. More women than men were in the group. The focus group was held at the Amanecer Community Counseling Services.

Number of participants: Five

The one participant who entered services within the past year described his/her experiences as the following:

- Smooth process for entry into services and ongoing therapeutic services.
- Ease and comfort in talking with therapist.

Participants' general comments regarding service delivery included the following:

- Individual therapy was the primary service received with few participants using/having case management. Therapy was weekly and the frequency was described as sufficient.
- The frequency of psychiatry was every two or three months and was also sufficient.
- Availability of services in Korean.
- Uncertainty about what to do and whom to contact during an emergency or when extra care was needed. One participant stated that the psychiatrist encouraged him/her to call as needed, but the participant was reluctant to do so.
- Lack of knowledge of wellness centers, but use of Korean Family Services for social support.

Participants' recommendations for improving care included the following:

- Ensure that beneficiaries have access to the resources and phone numbers for urgent and emergent needs.
- Provide supplemental services after the program ends, such as periodic check-ins for support.

Interpreter used for focus group three: Yes Language(s): Korean

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 described below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries 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 15: Access to Care Components		
Component		**Quality Rating**
1A	Service accessibility and availability reflective of cultural competence principles and practices	M
The MHP had an updated and extensive cultural competency plan that described and presented many strategies to reach beneficiaries of diverse cultural, ethnic, racial, and linguistic backgrounds. The MHP presented a number of strategies employed over the past year to promote mental health awareness, facilitate access to services, and reduce mental health stigma. The MHP featured their media efforts via public service announcements in several languages including Korean, Mandarin, and Tagalog and an article in a publication catering to the LGBTQ communities of Iranian descent. The MHP has long used underserved cultural communities (UsCC) to raise awareness and serve identified underserved populations. This past year, the MHP established an UsCC for the Deaf, Hard-of-Hearing, Blind, and Physically Disabled. In addition to the cultural competency committee, each SA has an advisory council that is informed by the community and can help identify emerging community needs.		
1B	Manages and adapts its capacity to meet beneficiary service needs	M
The MHP assesses and implements routine strategies to provide the appropriate types and numbers of practitioners to meet the needs of their diverse beneficiary population. For Latino beneficiaries, who comprise 46 percent of the population served, the MHP has expanded the promotoras program in six SAs. The MHP maintains a database of bilingual certified staff, both directly-operated and contract,		

Table 15: Access to Care Components		
Component		**Quality Rating**
who are proficient in 60 languages. Staff remarked on increased training opportunities, including trauma-focused cognitive behavioral therapy, and services and practices for the birth to age five population. The MHP uses a caseload system that distributes beneficiaries by level of care. The caseloads of some case managers who had 'meds only' beneficiaries were upwards of 100. In the past year, the MHP conducted an analysis of types and levels of services across each SA. The MHP identified SAs where some disparities in service or access existed, but for the most part, there was parity across the SAs. Per the MHP's Quality Improvement (QI) plan evaluation, and confirmed through beneficiary focus groups, the MHP was challenged in providing/dispatching the Psychiatric Mobile Response Team. The MHP's teams were not sufficiently staffed to meet the demand for this service throughout the county.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP has an extensive network of community partners and stakeholders with whom they collaborate, including several hospitals, law enforcement agencies, faith-based organizations, educational systems including higher and advanced degree programs, and other public/county agencies (e.g., DCFS and the Department of Public Social Services). Through the Countywide Housing, Employment and Education Resource Development (CHEERD) team, the MHP collaborates with the Los Angeles Homeless Services Authority (LAHSA) to facilitate housing resources for beneficiaries. Related to housing, the MHP began a homeless full-service partnership earlier this year. The one area where collaboration appeared to be limited was with substance use disorders programs and providers.		

Timeliness of Services

As shown in Table 16, 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 beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 16: Timeliness of Services Components	
Component	**Quality Rating**

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first offered appointment	M
The MHP's CY 2017 standard for this metric was 15 business days. The MHP tracked and trended this metric for both directly-operated and contract provider programs, and reported on the following service categories: Adults, Children, and Foster Care. Overall, the MHP averaged 7.38 business days for directly-operated programs and 13.08 business days for contracted programs. Contracted programs experienced greater delays in appointments than directly-operated programs. Timeliness results reported were calculated using the standard of 15 business days, which exceeds the state's current (FY 2018-19) standard of 10 business days, as per DHCS Information Notice 18-011.		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
The MHP does not have a standard for the time to first psychiatry appointment from initial contact. Overall, the MHP averaged 22.52 business days from initial request for services to medication support services, and 14.70 business days from specific request for psychiatry services to medication support services. This metric was limited to directly-operated programs; the Service Request Tracking System used to send referrals to contract providers does not require matching of beneficiary identification numbers with subsequent service delivery, which precludes tracking beneficiaries by contract providers.		
2C	Tracks and trends access data for timely appointments for urgent conditions	PM
The MHP's urgent appointment standard was five business days. The MHP only provided urgent appointment data for directly-operated programs. The MHP met the standard 58.62 percent of the time for adults and 54.55 percent for children. The MHP pointed to data reporting issues as a factor in the decrease in compliance over the past year, from 69.87 percent for adults and 100 percent of the time for children. The decrease in response to urgent needs may be complicated by the data reporting problems that the MHP identified.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM
The MHP's standard was seven days for this metric. The MHP met this standard 32.4 percent of the time, with more timely access for youth in foster care (74.5 percent) and children (64.8 percent). The compliance for adults at only 27.3 percent contributed to the overall low rate. Beneficiaries who refuse or decline follow-up appointments are prime targets for engagement and improvement activities.		

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2E	Tracks and trends data on rehospitalizations	PM
The MHP does not have a standard for 30-day rehospitalizations. The rehospitalization rates for adults was 33.62 percent. The rates for children was 13.38 percent and youth in foster care was 24.34 percent. The MHP has a PIP to decrease rehospitalization rates, but the PIP seems to target a specific population and only those discharged from certain hospitals. To decrease the rehospitalization rate, the MHP should identify those beneficiaries that contribute most to rehospitalization and conduct subsequent improvement activities.		
2F	Tracks and trends no-shows	PM
The MHP does not have a standard for this metric. The no-show data reported were only for directly-operated programs. For psychiatry, the no-show rates were 10.29 percent for children in foster care, 12.94 percent for all children's services, and 16.55 percent for adults. The no-show rates were lower for clinician appointments at 3.07 percent for children in foster care, 6.17 percent for all children's services, and 8.21 percent for adults. As noted in FY 2017-18 CalEQRO report, while the MHP does not currently track this metric for contract providers, work is underway to develop a web platform that will allow electronic collection of service request data from contract providers in the future.		

Quality of Care

In Table 17, 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 CFM 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 17: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
The MHP has a current (CY 2018) QI work plan and an evaluation of the previous year's QI activities. The evaluation closely matches and serves as the foundation for the current work plan. The MHP has a dedicated QI management team. As of late, there have been changes in the department, including of the QI Director. Nevertheless, QI activities and participation from internal and stakeholders were evident in the central and also regional/SA Quality Improvement Committee (QIC). The SA QIC meetings are supportive in nature and intended as a forum to facilitate informative discussion regarding QA requirements and QI activities. While the meetings reflect a combination of both QI and QA content, the minutes of the SA QICs were more focused on compliance than on an ongoing or continuous quality improvement (CQI) approach.		
3B	Data used to inform management and guide decisions	M
The QI department collects, reviews, and disseminates data to support various programs in the MHP. Some examples of this data include staff language capacity; availability of multi- and bi-lingual staff and interpreter services; penetration rates; prevalence rates for severe mental illness and severe emotional disturbance in their population. Some programs used dashboards to monitor clinic activity, services, and output. The MHP uses a variety of evidenced-based practices along with the corresponding outcome indicators and standardized assessments (e.g., the Child and Adolescent Functional Assessment Scale; the Patient Health Questionnaire; and the Milestones of Recovery Scale). Data are available on an individual basis and also in aggregate for program managers and supervisors. The MHP is aware of and has reviewed the EPSDT data on children's medications, but the MHP finds them outdated. The MHP's child welfare partners reviews the data from Berkeley. Programs monitor and provide data on timeliness to services to the QI department.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	PM
The MHP has an extensive stakeholder group with whom they need to communicate. The MHP has used a number of mechanisms in the past year to involve and communicate with their stakeholders, including meetings, emails, social media (e.g., Facebook), surveys, presence of administration in local meetings, and communication directly with line staff and case managers. A commentary from a variety of stakeholders was that communication in the past year has been more unidirectional and top-down. Stakeholders received communication after the fact and have felt less involved in processes and decisions than in previous years; the process and flow of		

communication needed improvement. Internal stakeholders noted a concerted effort to communicate with the public and those external to the MHP, citing as examples, the widespread awareness of the We Rise campaign and several public service announcements. Beneficiaries communicated with their case managers and clinicians. While this has mostly worked, some indicated that they were not aware of all the services that were otherwise available to them because their clinician or case manager did not present or broach it.		
3D	Evidence of a systematic clinical continuum of care	M
The MHP has a comprehensive range of treatment options for beneficiaries, but as the analyses indicated, SA 1 lags that of other SAs in urgent and high intensity services. When disparities in services were noted, staffing shortfalls and vacancies were identified as contributing factors. While level of care tools are used, they are used more frequently at an individual level and, at times, as a matter of course. Clinical judgement, based on functional outcomes and achievement of treatment goals, were more commonly endorsed. Wellness centers and integration of the WOW were cited as mechanisms that facilitated transitions to/from most to least restrictive service settings. The WOWs were particularly skilled in outreaching to homeless beneficiaries. Navigators also played a key role in connecting beneficiaries to services. The workload and content knowledge required of navigators have appeared to increase in the past year, without comparable increase in navigators to connect beneficiaries to services.		
3E	Evidence of peer and family member employment in key roles throughout the system	M
The MHP has designated positions for beneficiaries and family members, including the community workers, peer advocates (e.g., for TAY), and family advocates. Additionally, there are several supported volunteer opportunities, such as WOW, which provide pre-employment entry points for potential peer staff. Over the past year, there was a considerable increase in the number of peer positions, purported to be approximately 100. With the new Peer Discipline Chief position, the MHP has now formalized a position that is part of the executive management team. A number of managerial and supervisory positions were held by beneficiaries and those with lived experience. Peer support and opportunities for progressive career advancement were perceived as limited, particularly if directly through the MHP. However, there was a sense of optimism that advanced positions designated for individuals with lived experience would increase in the upcoming year, given the installment of the Peer Discipline Chief.		
3F	Peer run and/or peer driven programs exist to enhance wellness and recovery	M
The MHP has beneficiary-run, beneficiary-driven, and in certain places (e.g., SA 1), beneficiary-informed programs. The program offerings were recovery-focused and included groups and activities on wellness, personal finance, social connectedness, volunteer and entry-level work opportunities, and substance use, among others. There did not appear to be a structured and consistent way of informing and		

educating beneficiaries about the wellness centers. The non-English speaking beneficiaries that participated in the focus groups were mostly unaware of the wellness centers; they used their local community groups as sources of social support.		
3G	Measures clinical and/or functional outcomes of beneficiaries served	M
The MHP collects beneficiary level outcome data and the data, along with clinical impressions, are used to improve or adapt services. Managers and supervisors appeared to have easier access to the data and reports, which they could share with their direct reports, mostly clinicians and case managers. The MHP's aggregation and systemic review of outcomes appeared to be related to particular program requirements (e.g., FSP programs). The MHP director indicated that this has been the approach of the MHP—outcomes to satisfy program obligations—but, the new direction is to be customer service focused. Contracts, partnerships, and services will be performance-based and focus on how beneficiaries are doing. The Program Development and Outcomes Division is uniquely positioned to use the indicators and types of data that they gather and analyze for programs to extend to their larger beneficiary population.		
3H	Utilizes information from Beneficiary Satisfaction Surveys	M
In addition to the Consumer Perception Survey (CPS) that the MHP conducts twice yearly, the MHP administers other surveys to their beneficiary population. Some examples of surveys conducted in the past year include TAY drop-in center satisfaction survey, TAY focus groups, the front office survey (as part of the non-clinical PIP), and a Child Respite Care Services Program Survey. Some surveys were foundational, to provide the MHP with the current state of services (e.g., the front office survey) and others were geared toward outcomes and improvement (e.g., TAY focus groups). With regard to the CPS, the MHP drills down to the provider level and shares the information with the providers who can then use the survey results and the open-ended comments to identify themes and guide improvement efforts.		

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of Los Angeles MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities and Recommendations

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Recommendations:

- Clarify the study population for the clinical PIP, align the interventions to affect that population, and select relevant indicators that address all parts of the identified problem.
- Develop and present a new non-clinical PIP for the upcoming year.

Access to Care

Changes within the Past Year:

- The MHP continued with the restructuring of the management positions, which is meant to better connect the various divisions and programs under the MHP.
- Four new units were established under the Continuum of Care division of the MHP. The units assist with implementation of various components of the reform, from appropriate placement; outcomes and quality of mental health services; STRTP conversion and mental health approval; and ongoing training and technical assistance.
- In November 2017, the MHP established “Kin Through Peer” teams of clinicians and community health workers whose task it is to identify the highest-need beneficiaries and then support the beneficiary and work with service providers to facilitate the resources and services that the beneficiary needs.

Strengths:

- The MHP continues to expand the use of telehealth to serve beneficiaries in remote services areas. Telehealth is now used at 11 sites.
- The media campaigns proved an effective strategy to reach the MHP’s population, particularly the cultural and ethnic communities for whom stigma is a barrier to access.

- The UsCC are a valuable resource that enable the MHP to reach their diverse beneficiary population and to identify unmet needs of these communities.

Opportunities for Improvement:

- PMRT responses increased by nearly 1,000 between CY 2016 and CY 2017, and was associated with increased wait times due to demand.
- Beneficiaries are not uniformly informed or aware of the services (e.g., individual therapy), programs, and resources (e.g., wellness centers; warm line) available to them and provided through the MHP.
- Thirty percent of the MHP's population has a co-occurring substance use disorder; however, there were few programs and partnerships that facilitated or ensured that the substance use conditions were being addressed.

Recommendations:

- Monitor and evaluate the availability and responsiveness to urgent conditions by crisis programs in various SAs, including SA 1.
- Review and evaluate the welcome packet and make necessary changes to include information and basic resources that all new beneficiaries should know.
- Involve system navigators in the process of revising this welcome packet.
- Identify those contract providers and agencies that serve beneficiaries with co-occurring disorders.

Timeliness of Services

Changes within the Past Year:

- None noted

Strengths:

- The MHP has the ability to track timeliness of some directly-operated services by languages. Based on the data, disparities by language were minimal.

Opportunities for Improvement:

- The MHP's standard for time to first offered appointment (15 business days) exceeds the new state standards of 10 business days
- The MHP has no standard or benchmark for time to psychiatry appointment and rehospitalization rate. For CY 2017, just over one-third of the adult beneficiaries discharged from an inpatient hospitalization were readmitted within 30 days.

- The MHP's timeliness data for psychiatric appointments and urgent conditions were limited to directly-operated sites.
- The MHP has no standard rate or benchmark for no-show appointments, particularly for psychiatry appointments, which at 16.33 percent is more than twice the rate for clinicians.

Recommendations:

- Comply with the state standards for the following timeliness metrics as per Information Notice 18-011: Time to first offered appointment and time to psychiatric appointment.
- Provide more consistent response to urgent conditions such that compliance with MHP's standard of five days is at least 70 percent.
- Complete the development of web services functionality to collect service request data electronically from contract providers for timeliness data for psychiatric appointments, no-shows, and urgent conditions.
- Identify the adult beneficiaries that contributed the most to the rehospitalization rate in CY 2018 and develop targeted improvement activities to reduce their rehospitalization.
- Set benchmarks for rehospitalization rate and no-shows.

Quality of Care

Changes within the Past Year:

- The MHP expanded the number of promotoras and has established the program in six of the eight SAs.
- The "Kin Through Peer" program adds another level of support and connection for disengaged and difficult to engage beneficiaries.

Strengths:

- The MHP provides services in beneficiaries' preferred languages through multi-lingual and bicultural staff. In so doing, the MHP improves the quality of services that their multi-ethnic and multi-cultural population receives.
- The MHP does robust data collection and analysis to understand gaps in service continuum, identify unmet service needs, explain service usage, and determine areas for improvement.

Opportunities for Improvement:

- Coordination of care and integration of services for beneficiaries with co-occurring substance use disorders appeared to be limited.

Recommendations:

- Determine the number or percentage of beneficiaries with co-occurring disorders who have integrated or coordinated mental health and substance use services and increase this number over the upcoming year.

Beneficiary Outcomes

Changes within the Past Year:

- None noted

Strengths:

- None noted

Opportunities for Improvement:

- There have been efforts to improve the career ladder for peer roles within the MHP, but peers report frustration that there are no clear opportunities for advancement.

Recommendations:

- Identify opportunities outside of the MHP that may be used as a path to employment.

Foster Care

Changes within the Past Year:

- The MHP has established four units that support service providers and programs that serve youth in foster care. Through these units, the MHP has worked with eleven agencies to become licensed STRTPs and eight of which are contracted with the MHP to provide mental health services to youth.

Strengths:

- In collaboration with the DCFS and Probation, the MHP has developed a questionnaire to assess provider readiness for Therapeutic Foster Care services.
- The MHP tracks and is able to report on timeliness metrics for FC beneficiaries.

Opportunities for Improvement:

- The feedback/response to the questionnaire may identify service gaps and areas of need by service providers.
- The MHP has found EPSDT data on children's medications outdated.

Recommendations:

- Articulate the method used to track children's medications and the timeframe for rollout.
- Articulate the steps that will be taken to prepare providers for Therapeutic Foster Care, pursuant to the feedback from the questionnaire.

Information Systems

Changes within the Past Year:

- The MHP completed migration from the legacy IS to IHBIS for both legal entities and fee for services contract providers.
- The Integrated System will be completely shut down before January 2019.

Strengths:

- The MHP continues to expand interoperability functionality through LANES, which provides secure one-to-one conversation between practitioners to exchange information from their respective, secured EHRs.
- IBHIS has functionality that supports direct secure messages to other practitioners who have Meaningful Use certified EHR system to share beneficiary specific clinical and treatment information.

Opportunities for Improvement:

- Help Desk dashboard reports are needed to increase both transparency and trust of the function for both internal staff and users of the Help Desk.

Recommendations:

- Create Help Desk dashboard reports so that internal staff and users of the Help Desk can view service requests and the status of their request.

Structure and Operations

Changes within the Past Year:

- All the Discipline Chiefs have been recruited and started or nearly started.

Strengths:

- Through the discipline chiefs, the MHP has a mechanism to streamline the recruitment and hiring of qualified candidates. This responsibility of discipline chiefs decreases the burden on SA chiefs and program managers.

Opportunities for Improvement:

- Paperwork and documentation was perceived as inordinate, duplicative, and time-consuming. Documentation diverted time from direct care to administrative and bureaucratic functions.
- While reorganization has been met positively overall, there are some concerns about the loss of expertise that was associated with having systems of care. (e.g., children, TAY, and older adults). The expertise that went along with these systems of care are disbursed and not readily located.
- The rollout and adoption of personal health record portal remains under-used; 2,400 beneficiaries currently have access through myHealthPointe.
- Skype for Business, a productivity tool to support remote meetings and trainings via Internet connectivity, lacks features and functions that were available in previous productivity application.

Recommendations:

- Discuss with a cross section of staff and key informants the impact of the reorganization from a programmatic and service level to identify any unintended consequences of the reorganization.
- Engage various levels of staff through a task force, for example, to review documentation and identify those that are duplicative and/or unnecessary and then eliminate or streamline them.
- Expand the rollout and use of myHealthPointe portal for beneficiaries to achieve a level of expertise to login, request appointments, and securely communicate with their clinician or case manager.
- Implement Consumer Engagement Technology Initiative with sufficient resources to ensure the project can achieve a level of self-sufficiency going forward.
- Investigate the availability of Skype for Business functionality not currently used to improve remote user's overall webinar experience.
- Analyze caseload sizes of case managers and clinicians in CY 2018 and more equitably distribute cases, if necessary.
- Survey internal and contract staff on training accessibility and identify which trainings, if any, are more difficult to obtain.
- Implement a solution to increase staff training accessibility, per the survey results.

Summary of Recommendations

FY 2018-19 Recommendations:

- Develop and present a new non-clinical performance improvement project (PIP) for the upcoming year.
- Comply with the state standards for the following timeliness metrics as per Information Notice (IN) 18-011: Time to first offered appointment and time to psychiatric appointment
- Monitor and evaluate the availability and responsiveness to urgent conditions by crisis programs in various service areas (SA), including SA 1.
- Determine the number or percentage of beneficiaries with co-occurring disorders who have some integrated or coordinated mental health and substance use services and increase this number over the upcoming year.
- Provide more consistent response to urgent conditions such that compliance with the standard of five days is at least 70 percent.
- Discuss with a cross section of staff and key informants the impact of the reorganization from a programmatic and service level to identify any unintended consequences of the reorganization.
- Complete the development of web services functionality to collect service request data electronically from contract providers for timeliness data for psychiatric appointments, no-shows, and urgent conditions.
- Create Help Desk dashboard reports so that internal staff and users of the Help Desk can view service requests and the status of their requests.
- Engage various levels of staff through a task force, for example, to review documentation and identify those that are duplicative and/or unnecessary and then eliminate or streamline them.
- Expand the rollout and use of MyHealthPointe portal for beneficiaries to achieve a level of expertise to login, request appointments, and securely communicate with their clinician or case manager.
- Implement Consumer Engagement Technology Initiative with sufficient resources to ensure the project can achieve a level of self-sufficiency going forward.
- Clarify the study population for the clinical PIP, align the interventions to affect that population, and select relevant indicators that address all parts of the identified problem.
- Investigate the availability of Skype for Business functionality not currently used to improve remote user's overall webinar experience.

- Review and evaluate the welcome packet and make necessary changes to include information and basic resources that all new beneficiaries should know.
- Involve system navigators in the process of revising this welcome packet.
- Identify those contract providers and agencies that serve beneficiaries with co-occurring disorders.
- Identify the adult beneficiaries that contributed the most to the rehospitalization rate in CY 2018 and develop targeted improvement activities to reduce their rehospitalization.
- Set benchmarks for rehospitalization rate and no-shows

FY 2018-19 Foster Care Recommendations:

- Articulate the method used to track children's medications and the timeframe for rollout.
- Articulate the steps that will be taken to prepare providers for Therapeutic Foster Care, pursuant to the feedback from the questionnaire.

Carry-over and Follow-up Recommendations from FY 2017-18:

- Analyze caseload sizes of case managers and clinicians in CY 2018 and more equitably distribute cases, if necessary.
- Survey internal and contract staff on training accessibility and identify which trainings, if any, are more difficult to obtain.
- Implement a solution to increase staff training accessibility, per the survey results.

SITE REVIEW PROCESS BARRIERS

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

- Only two participants attended the focus group for Adult and TAY Latino/Hispanic beneficiaries. Due to the low number, a true focus group was not held.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: 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
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Consumer Satisfaction and Other Surveys
Performance Improvement Projects
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer Family Member Focus Group(s)
Consumer Employee/Peer Employee/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Services Focused on High Acuity and Engagement-Challenged Consumers
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation
Telehealth
Wellness Center Site Visit

Table A1—EQRO Review Sessions - Los Angeles MHP
Contract Provider Site Visit
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Ewurama Shaw-Taylor, PhD, Lead Quality Reviewer
Robert Walton, RN, Quality Reviewer
Maureen Bauman, Quality Reviewer
Bill Ullom, Chief Information Systems Reviewer
Melissa Martin-Mollard, PhD, Information Systems Reviewer
Marilyn Hillerman, Consumer/Family Member Consultant
Deb Strong, Consumer/Family Member Consultant
Saumitra Sengupta, PhD, Executive Director, Quality Reviewer

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

Sites of MHP Review

MHP Sites

Los Angeles County Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Los Angeles County Department of Mental Health
695 S. Vermont Avenue
Los Angeles, CA 90020

Service Area 1, Palmdale Mental Health Center
2323 A. E. Palmdale Boulevard
Palmdale, CA 93550

Service Area 4, Hollywood Mental Health Center
1224 N. Vine Street
Los Angeles, CA 90038

Service Area 4, Northeast Wellness Center
5564 N. Figueroa Street
Los Angeles, CA 90042

Contract Provider Sites

Antelope Valley Wellness & Enrichment Center
251-H East Avenue, K-6
Lancaster, CA 93535

Amanecer Community Counseling Services
1200 Wilshire Boulevard, Suite 200
Los Angeles, CA 90017

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Acuna	Jeannelli	Psychiatric Social Worker II, Northeast Mental Health Center (NEMHC)	Department of Mental Health (DMH)
Acosta Castaneda	Connie	Intermediate Typist Clerk	DMH
Adat	Levana	QA Coordinator	Child & Family Guidance Center
Ahn	Jung	Psychiatric Social Worker II	DMH
Alba	Patricia	Clinical Director	Hathaway-Sycamores Child and Family Services (HSCFS)
Alkass	Sermed	TAY-SOC Psychiatrist	DMH
Alvarado	Anthony	Program Manager II, NEMH	DMH
Alvarez	Christina	Wellness Outreach Worker (WOW) Volunteer	DMH
Alvarez	Erika	Outpatient Therapist	Children's Bureau
Amini	Minoo	Mental Health Clinical Supervisor	DMH
An	Hyunmi	Counseling Manager	Korean American Family Service Center
Anderson	Amber	Program Manager II	DMH
Anderson	David	Enterprise Arch	DMH
Archambeault	Michele	Clinical Psychologist II	DMH
Archer	Stella	Community Health Worker WOW Supervisor	DMH
Arellanos	Naomi	Psychiatric Social Worker II, SA 4 Navigation	DMH
Arns	Paul	Chief, Clinical Informatics	DMH
August	Carol	WOW Volunteer	DMH
Babakhyi	Khalid	Information Technology (IT) Supervisor	DMH
Bagorio	Elaine	Associate Director	Para Los Ninos
Bajnath	Jolene	QI Specialist	Children's Bureau
Baker	Angel	Division Chief	DMH
Bando	Lillian	Mental Health Clinical Program Manager III	DMH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Barraza	Mary Romero	Mental Health Clinical Program Manager III	DMH
Bascos	Victor	Housing Liaison	DMH
Berzon-Leitelt	Debra	Health Program Analyst II, SA 1, ADM	DMH
Beverly	Edwallyn	FROST Grandparent	
Bonds	Curley	Chief Deputy, Clinical Operations	DMH
Bonwitt	Karin	MH Clinical Supervisor, Hollywood Mental Health Center (HMHC)	DMH
Boykins	Terri	Deputy Director	DMH
Bran	Marlene	MH Clinical Supervisor	DMH
Brown	Miriam A.	Deputy Director	DMH
Bryant	Carla	Psychiatric Social Worker II	DMH
Burgess	Racheal	IT Specialist I, Chief Information Office Bureau (CIOB)	DMH
Byrd	April	Mental Health Clinical Program Manager I	DMH
Byrd	Robert	Mental Health Clinical District Chief	DMH
Cabil	Wendy	WOW Volunteer	DMH
Cacialli	Douglas	Clinical Psychologist II, Informatics, CIOB	DMH
Calmelat	Jennifer	Chief Operating Officer	Scharp
Camacho	Catarino (Alex)	IT Supervision	DMH
Cantrell	Rowin	MH Psychiatrist	DMH
Cardenas	Amber	Psychiatric Social Work II	DMH
Cardenas Fragoso	Diana	Psychiatric Social Worker	DMH
Carlos	Kara	Therapist	LA USD School Mental Health
Carrera	Eva	Program Manager III	DMH
Centeno	Soyla	Program Assistant	St. Anne's Maternity Home

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Chairez	Pauline	Child & Family Specialist	Compton MHC
Chang Ptasinski	Sandra	Ethnic Services Manager	DMH
Cheng	Mark	Information Technology Manager	DMH
Childs Seagle	Carlotta	Deputy Director	DMH
Chiu	Chuck	IT Manager	DMH
Cho	Jessie	Community Worker	DMH Northeast Wellness Center
Cho	Kimie	Marriage & Family Therapist	Asian Pacific Counseling and Treatment Center
Chow	Jocelyn	Associate Marriage & Family Therapist	Asian Pacific Counseling and Treatment Center
Cianfrini	Crystal	Mental Health Program Manager II, Collaboration Program	DMH
Coleman	Angela	Mental Health Senior Coordinator II	DMH
Collar	Carol	Clinical Supervisor	Children's Bureau
Contreras	Vilma	Coach	IBHP
Coon	Brenda	MH Clinical Supervisor	DMH
Cox	Jaddie C.	MHC Program Manager II	Augustus F. Hawkins
Crain	Kathryn	Program Manager I	DMH
Cunnane	Daiya	Clinical Psychologist II	DMH
Dalgleist	Stacy	MHC/BOS	DMH
Damerla	Hanumantha	Supervising MH Psychiatrist	DMH
DeGennaro	Cathy	Clinical Psychologist	DMH
Denz	Daniel	Contracts Chief	SAPC
Deshay-Weakley	Desiree	African-American African Underserved Cultural Communities (UsCC) Liaison	DMH
Dhungana	Josephina	MH Clinical Supervisor	DMH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Diaz	Carlo	Mental Health Clinical Supervisor, Northeast Wellness Center	DMH
Diaz	Charlie	Information Systems Supervisor II, CIOB	DMH
Diaz-Akahori	Angelita	Mental Health Program Manager III, WET Division	DMH
Ditko	Helena	Program Director Consumer Rights and Advocacy	DMH
Doan	Christy	Interim Pharmacy Chief	DMH
Domingo	Joana	Director of TAY Services	Mental Health America of Los Angeles
Doucette	Michelle	Supervisor	HSCFS
Eliott	Alex	Psychiatric Social Worker	DMH
Enriquez	Juan Carlos	Psychiatric Social Worker	DMH
Estrada	Elizabeth	Parent Partner	St. Anne's Maternity Home
Estrada	Jessica	Office Manager	Koreatown Youth & Community Center
Evans	Jennifer	Director	Optimist
Everhart	Matthew	Therapist	Aviva
Farias	Elena	Program Manager III	DMH
Farr	Tamika	Executive Director	El Centro de Amistad
Fay	Terri	APAIT, LGBTQRS Co-Chair	APATT
Ferguson	Cindy	Senior Mental Health Counselor	DMH
Fimbong	Nadine	Program Manager	Amanecer Community Counseling Services
Flores	Dina	Community Worker	DMH
Flores	Javier	Outpatient Therapist	Masada Homes
Gabai	Nadia	Case Manager	Jewish Family Services of Los Angeles
Gibbs	Marcie	Mental Health Clinical Program Manager I	DMH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		Downtown Mental Health Center (DMHC)	
Gidwani	Kiran	Principle Information Systems Analyst	DMH
Girgis	Jackie	Program Director, Mental Health	McKintry Children's Center
Glover	Ashon	Senior MHC RN	DMH
Gomez	Michelle	Psychiatric Social Worker I	DMH
Gonzalez	Maria	Senior Secretary Management II	DMH
Granados	Eileen	Case Manager	Aviva
Grant	Patrice	MHC Program Head	Edelman-Child
Green	Julia	Licensed Clinical Social Worker	Child & Family Guidance Center
Gridwani	Kiran	Principle Information Systems Analyst, CIOB	DMH
Gutierrez	Marisela	Administrative Assistant	Special Services for Groups
Hallman	Jen	Health Program Analyst III	DMH
Hamilton	Fred	Service Extender	DMH
Hanada	Scott	Mental Health Clinical Program Manager III	DMH
Haratounian	Vahe	DISO	DMH
Harvey	Lisa	QA Manager	Para Los Ninos
Hayes	Phyllis	Mental Health Services Coordinator II, SA 4	DMH
Henry	Rhasheda	Director of Adult Team Services	Mental Health America of Los Angeles
Herbert	Elva	Case Manager	Amanecer Community Counseling Services
Herod	Andy	Vice President	Para Los Ninos
Herrera	Eisa	Psychiatric Social Worker II, HMHC	DMH
Hoichi	Makiko	Director	Masada Homes
Houghton	Catherine	Assistant Regional Manager	Penny Lane

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Huang	Lishi (Leo)	Co-Chair Asian and Pacific Islander UsCC Liaison	Asian Pacific Counseling and Treatment Center
Hurtado	Cynthia	Clinical Psychologist II, SA 3 Administration	DMH
In	MiGa	Mental Health Services Coordinator, DMHC	DMH
Innes-Gomberg	Debbie	Deputy Director	DMH
Jackson	LaTina	Service Chief, SA2 & Women's Re-integration	DMH
Jackson	Monica	WOW Volunteer	DMH
Jeon	Eunice	Service Coordinator, Counseling Department	Korean American Family Service Center
Jones, Jr.	Martin	Program Manager III	DMH
Jones-Chambers	Makesha	Co-Chair, African-American UsCC	DMH
Kasarabada	Naga	Clinical Psychologist II, Access Center	DMH
Kay	Amy	Member, UsCC DHNBBA	Five Acres
Kelartinian	Vatcme	Chief Executive Officer	Heritage Clinic
Kibby	Crystal	Executive Assistant	DMH
Kim	David	Associate Marriage & Family Therapist	Asian Pacific Counseling and Treatment Center
Kim	Jeehye	Clinician	Korean American Family Service Center
Kubojiri	Christina	QA Supervisor, CU SA 4	DMH
Kudlick	Susan	Mental Health Clinical Supervisor, Palmdale Mental Health Center	DMH
Kuilken	Dirk	Supervising Psychologist, Downtown Mental Health Center	DMH
Kyupelyan	Lucy	Clinician	Heritage Clinic
Lane	Jennifer	Regional Director	Penny Lane
Lee	Amy	Pharmacist	DMH
Lee	Ann	Clinical Psychologist II, SA 8	DMH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Lee	Hyun Kyang	Clinical Psychologist II	DMH
Lehaisa	Gurudarshan	QI Director	Aviva
Lemus	Evelyn	Psychiatric Social Worker II, SA 3	DMH
Lennon	Charles	Program Manager III	DMH
Levine	Robert	Health Program Analyst, Office of Integrated Care	DMH
Llamas	Sandra	Case Manager	Heritage Clinic
Lo	Gwen	Quality Assurance Director	Child & Family Guidance Center
Lopez	Velia	Mental Health Clinical Supervisor	DMH
Lucas	Alejandro	Assistant Director	Amanecer Community Counseling Services
Majors	Michelle	MHC Program Head	East San Gabriel Valley Mental Health Center
Maldonado	Guadalupe	Senior Information System Analyst, CIOB	DMH
Mandili	Carla	Mental Health Psychiatrist	DMH
Marshall	Elizabeth	Mental Health Clinical Supervisor, AUMHC	
Marshall	Roy	Chief Executive Officer	Child & Family Guidance Center
Martinez Perez	Ivan	WOW Volunteer	DMH
Marx	Mary	Mental Health Clinical Program Manager III	DMH
Mascher	Bernice	Cultural Broker/Cultural Competence Committee	
McKinnon	Ben	Psychiatric Social Worker II	DMH
Meenieta	Percilla	WOW	DMH
Melbourne	Erica	MH Training Coordinator SA6	DMH
Mendoza	Emily	Parent Partner	Amanecer Community Counseling Services
Mielczazek	Rebecca	Program Supervisor	Project 180
Miller	Tiffani	Clinical Director	For the Child

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Mims	LeKeitha	Supervising Clerk	Augustus F. Hawkins
Moghadam	Mastareh	Executive Director	CCE
Montes	Luis	Chief Service Officer	Mental Health America of Los Angeles
Morkos	Michael	Regional Director	Pathways Community Services
Murata	Dennis	Deputy Director, SA 8	DMH
Musktez	Donovan	Assistant Director	Mental Health America of Los Angeles
Myrick	Keris	Peer Services Discipline Chief	DMH
Naliboff	Laurie	IT Specialist I, CIOB	DMH
Nunez	Adriana	Community Health	DMH
Ochoa	Anna	Therapist	Para Los Ninos
O'Hudson, PsyD	Bradley	Clinical Director	Children's Hospital of Los Angeles
Ortega	John	IT Manager	DMH
Ortiz, PhD	Berta E.	Chief Operating Officer, Program Planning and Development	Kedren Community Health Center
Paczona	Carolyn	Palmdale Mental Health Center	DMH
Padilla	Christina	Satay Navigator	DMH
Palacios	Marlo	Clinical Supervisor	DMH
Patel	Jay	Chief Enterprise Application	DMH
Parada Ward	Mirtala	Program Manager II	DMH
Paradise	Barbara	Program Director, QIC Co-chair SPAI	Pathways Community Services
Paraja Dominquez	Monica	Human Resources Manager III	DMH
Park	Grace	Manager	Koreatown Youth & Community Center
Park	Jane	QA Clinical Coordinator	Children's Institute
Parong	Glorivic	Wellness Support	Asian Pacific

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		Specialist	Counseling and Treatment Center
Partida	Jorge	Chief of Psychology	DMH
Pattenkalam	Crivisaram	IT Manager I, CIOB	DMH
Patton	Stephanie	Psychiatric Social Worker	DMH
Percy	Yvette	Program Manager I	CCAV
Perez	Dennis	Social Services Case Worker	Children's Hospital of Los Angeles
Perkins	Theion	Program Manager III	DMH
Permenter	Lauren	QA Coordinator	El Centro del Pueblo
Phillips	Carol	SA 4 Housing Navigator	DMH
Phillips	Seth	Psychiatric Social Worker II, Adult Protective Services	DMH
Pijuan	Julian	MHC Program Head II, Adult Protective Services	DMH
Polk	Gregory	Chief Deputy	DMH
Potto	Sharwigan	Administrative Assistant II, SA 4	DMH
Prado	Ruth	WOW Volunteer, Northeast Wellness Center	DMH
Quevedo	Nancy	Community Worker, HMHC	DMH
Quintana	Javier	Supervising Mental Health Psychiatrist, Palmdale Mental Health Center	DMH
Radeva	Zlatina	Mental Health Clinical Supervisor, HMHC FSP	DMH
Ramirez, II	Luis D. L.	Clinical Director	Children's Center of the Antelope Valley
Ramos	Grecia	Therapist	Amanecer Community Counseling Services
Raskin	Xenia	FSP Mental Health Therapist	Optimist
Rauck	Robert	Psychiatric Social Worker II, HMHC	DMH
Redding	Salem	Mental Health Services Coordinator	DMH
Renner	Kym	Deputy Director	Department Children

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
			Family Services
Ribleza	Rosario	Mental Health Services Coordinator	DMH
Riederle	Monika	Supervising Psychologist, HMHC	DMH
Rittel	Michelle	SA 2 Children's QIC Chair	DMH
Rivas	Wendy	Mental Health Services Coordinator I	DMH
Rivera	April	Assistant Director, BHS	Children Youth & Family Services
Rivera	Maria	Psychiatric Social Worker III, HMHC	DMH
Robinson	Jason	Program Director	Share!
Rodriguez	Anabel	Acting Deputy Director	DMH
Rodriguez	Katherine	Community Health Worker	DMH-KTP/WPC
Rogers	Mary	WOW Volunteer	DMH
Rojas	Daniel	Staff Assistant, SA 4	DMH
Rosa	Rosemary	CFS	Amanecer Community Counseling Services
Ruskin	David	Chief Psychiatry	DMH
Russel	Dana	WOW Volunteer	DMH
Sacco	Paul	Clinical Program Manager II	DMH
Salas	G. Kaliah	Program Manager II	DMH
Saltzer	Bruce	Executive Director	Association of Community Service Agencies
Salvaggio	Kimber	Training Coordinator/QA-QI Liaison	DMH
Sanchez	Marisol	Facilitator	Amanecer Community Counseling Services
Sanchez-Baynham	Olivia	CIO Administration	DMH
Sanderson	LuAnn	Chief Nurse	DMH
Schaefer	Angela	Community Worker	DMH
Scott	Sharon	MH Clinical Supervisor, SA 4	DMH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Sheynman	Lilia	Assistant Director	Gateways
Shields	Angela	Acting SA Chief, SA 6	DMH
Shields	Sandra	Senior Disaster Services Analyst	DMH
Shonibare	Lynetta	Supervising Psychologist	DMH
Sierra	John Franklin	Strategic Planning	DMH
Silva	Alex	Supervising Psychologist, Project Development & Outcomes	DMH
Simonian	Sarkis	Co-chair EE/ME UsCC Liaison	DMH
Smith	Luz	MHSC II, Child Navigator	DMH
Son	Jae	Acting Program Head, HMHC	DMH
Soto	Dianna	TCPI Coach	IBHP
Spallino	James	IT Specialist I	DMH
Stroupe	Kathryn	Continuum of Care Reform	DMH
Streich	Karen	Program Manager III, AB 109	DMH
Suarez	Ana	District Chief, SA 7	DMH
Sweet	Tosha	Mental Health Clinical Program Manager II	DMH
Taguchi	Kara	Mental Health Clinical Program Head, Project Development & Outcomes	DMH
Tanner	William	Program Head	Compton MHC
Taylor	Romalis	Co-Chair, African-American African UsCC Liaison	DMH
Tayyib	Nina	Clinical Psychologist II	DMH
Thede	Jennifer	WOW Volunteer	DMH
Thigpen	Lisa	Mental Health Clinical Supervisor	DMH
Thompson	Lisa	Director	Child & Family Guidance Center
Thornburgen	Chu	Associate Director	Pacific Clinics

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Tredinnick	Michael	Program Manager III	DMH Intensive Care Division
Umanzor	Suyapa	MHSC II/Administrative Supervisor, SA 4	DMH
Valenvuela	Charvel	Counselor	Koreatown Youth & Community Center
Vallejos	Irma	Senior Community Worker	Northeast Wellness Center
Van Sant	Karen	CIOB	DMH
Vanegas	Maria	Case Manager	El Centro del Pueblo
Walendzik	Gary	Mental Health Clinical Program Manager III	DMH
Walters	Jessica	Supervising Psychologist	DMH
Wassilenko	Ekaterina	Psychiatrist	DMH
Weiner	Nancy	MH Clinical Supervisor, SA 4	DMH
Weissman	Brittney	Executive Director	National Alliance on Mental Illness Los Angeles County Council
Wheeler	Mark	Senior Lead Officer	Los Aneles Police Department, Mental Evaluation Unit/System-wide Mental Assessment Response Team
Whipple	Sunnie	Co-Chair American Indian/Alaska Native UsCC Liaison	DMH
Wilkerson	Kelly	UsCC Liaison	DHM
Williams	Stacy	Service Area Chief, SA 4	DMH
Williamson	Cathy	Community Service Counselor	DMH
Willock	Yvette	Discipline Chief of Social Services	DMH
Winckler	Keith	CWS	HSCFS
Xionen	Leticia	Office of the Director, Cultural Competence Committee Co-chair	DMH
Yaralyan	Anna	Co-chair, LGBTQ, EE/ME	DMH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		UsCC Liaison	
Yoon	Joo	Research Analyst	DMH
Yoon	Joseph	Program Support Specialist	Asian Pacific Counseling and Treatment Center
Yu	Jacqueline	MHC Program Head, CRM	DMH
Yu	Rebecca	QI Coordinator	Koreatown Youth & Community Center
Zaidel	Liam	Clinical Psychologist II	DMH
Zaldivar	Richard	Community LGBTQ Latino	
Zenner	James	Mental Health Clinical Program Manager III	DMH

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 11 (*). 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 ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB - Los Angeles MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,816,091	147,196	3.86%	$703,932,487	$4,782
Large	1,848,772	68,086	3.68%	$362,898,987	$5,330
MHP	1,210,153	49,408	4.08%	$207,342,203	$4,197

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

Table C2: CY 2017 Distribution of Beneficiaries by ACB Range - Los Angeles MHP

Range of ACB	MHP Beneficiaries Served	MHP Percentage Beneficiaries	Statewide Percentage Beneficiaries	MHP Approved Claims	MHP ACB	Statewide ACB	MHP Percentage Approved Claims	Statewide Percentage Approved Claims
< $20K	193,880	94.51%	93.38%	$775,173,632	$3,998	$3,746	65.56%	56.69%
>$20K - $30K	5,773	2.81%	3.10%	$140,164,239	$24,279	$24,287	11.86%	12.19%
>$30K	5,490	2.68%	3.52%	$266,979,411	$48,630	$54,563	22.58%	31.11%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms	
IHBS	Intensive Home Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Los Angeles	
PIP Title: Post Discharge Outpatient Follow-up Appointment Scheduling for Hospital Discharges – Impact of Care Coordination and CQM Protocols	
Start Date: 07/19/17 **Completion Date**: 07/19/19 **Projected Study Period**: 24 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 09/24-27/18 **Name of Reviewer**: Shaw-Taylor	**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 (including goal and what PIP is attempting to accomplish): The goal of this PIP is to reduce preventable hospital readmissions. The MHP has developed a systems-level approach to target the factors that they believe contribute to hospital readmissions. The MHP has expanded the target population to include all adults discharged from fee for service hospitals as well as ISR, who are beneficiaries who have had four or more hospitalizations within the past 13 months.	

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 PIP was developed and managed by a large multi-functional team of QI department staff, service area chiefs, service area hospital liaisons, contract providers, and directly-operated (DO) program staff. The PIP team convened two focus groups of beneficiaries, from service areas 2 and 4.
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 team presented data on rehospitalization rates for their system, but not (disaggregated) for beneficiaries with co-occurring disorders, who are also the targets for this study.
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 project addresses a broad aspect of beneficiary care--engagement; however, the team did not provide evidence of lack 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	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	The project identifies two study populations, ISRs and adults discharged from fee for service hospitals. The project indicated adults who were discharged from all fee for service hospitals, but then subsequently only four hospitals were included and then only three were tracked for appointment scheduling. Are there only four fee for service hospitals? Additionally, while demographics are presented on ISRs, no demographic information were provided on the beneficiaries discharged from hospitals.
	Totals	**1** Met **2** Partially Met **0** Not Met **1** 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 implementing prolonged stabilization post hospital discharge impact hospital readmission rates? Will COD group participation contribute to positive perceptions regarding COD groups and self-reported reduction in substance use? Will implementing hospital discharge outpatient follow-up care coordination protocols reduce barriers to scheduling post hospital discharge urgent outpatient appointments at LACDMH DO and contract programs?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The team presented a three-part study question. Parts one and three are measureable; "impact" is taken to mean decrease in hospital readmissions. While part three is measurable, the focus is on reducing barriers as opposed to reducing the time that it would take a beneficiary to receive his/her post-hospitalization appointment. It is unclear how beneficiaries' positive perceptions of COD groups affects hospital readmissions.
	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 team defined the Medi-Cal enrollees to whom the study question was relevant; however, much of the focus was on ISRs. No information were provided on the beneficiaries who were discharged from the hospital and were also part of the study.
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: Discharged from hospitals	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	As above, no data were provided on the beneficiaries who were discharged from the hospital.
	Totals	**0** Met **2** 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. Number of ISRs admitted to Crisis Residential Treatment Program (CRTP) services 2. A. Level of understanding in the assessment and screening of CODs B. Perception of COD treatment as reported by group participants 3. Consumers participating in LACDMH COD treatment groups 4. Psychiatric Inpatient Hospital 7-Day Rehospitalization Rates (Adult Services) 5. Psychiatric Inpatient Hospital 30-Day Rehospitalization Rates (Adult Services) 6. Post-Psychiatric Inpatient Hospital 7-Day Outpatient Service Follow-Up Rates (Adult Services) 7. Average Length of Stay (LOS) at Psychiatric Inpatient Hospitals (Adult Services) 8. Increased engagement in the number of ISRs in outpatient treatment services 9. Problem resolution on issues reported with scheduling post-discharge appointments (HDOFFC) 10. Percent of consumers receiving a post-discharge appointment within five business days	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The team has four indicators that are objective and measurable and are directly relevant to the premise that has been established: Indicators 4, 5, 6, and 7. Indictor 9 is a process indicator to show staff's resolution of barriers; it is not a beneficiary indicator. Indicators 1, 3, and 10 are the interventions, as evidenced by '0' as the baseline. Indicator 2 may be helpful for the team to know, but it is not relevant to the study. Indicator 8 is relevant for the study, but it is not related to any of the interventions and it is not clear how the team will affect this change. Other indicators are important for the study, but were not included: a. The number/percentage of ISRs discharged and placed in any housing/residential program within a certain number of days of discharge. b. Length of stay disaggregated by clinical days versus administrative days c. Time (days) to urgent post-hospitalization appointment

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 beneficiary 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, 4, 5, 6, and 7 measure change in health and functional status.
	Totals	**1** Met **1** 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	No sampling.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
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	
Totals	**0** Met **0** Partially Met **0** Not Met **3** NA **0** 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 to be collected were stated; however, not all the relevant and necessary data were collected. As an example of missing data, there are several references to “barriers” to outpatient follow-up, but the exact nature of the barriers and the frequency of the occurrence were not provided. The team also appears to limit the data by only including certain hospitals and clinics, despite the focus to serve all discharged beneficiaries.

6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Surveys, Sign-In Sheets, Coordination Logs, Hospital reports, and the EHR.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The sources of data were indicated.
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	
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:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Besides the survey tools, which were self-reports, there was nothing to suggest that the instruments would not provide consistent and accurate data.
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 team did not provide an analysis plan beyond "review" data. The data to be collected was restated.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Dr. Michael Tredinnick Title: Mental Health Clinic Program Manager III Role: Lead Manager, Intensive Care Division *Other team members:* Names: Many others, over 60, were part of the team.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The staff overseeing the project included QI staff, program managers, clinical informatics staff, DO and contracted program staff, service area chiefs, and intensive care and crisis residential staff.
	Totals	**3** Met **2** Partially Met **1** 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. Prioritization of access to 10 beds (monthly/ongoing) for crisis residential services 2. Provision of COD groups training for LACDMH outpatient programs in all 8 SAs and implementation of integrated COD group treatment services at LACDMH outpatient programs in all 8 SAs 3. Implement the Hospital Discharge Outpatient Follow up Care Coordination (HDOFCC) 4. Establishing Transforming Clinical Practice Initiative (TCPI) CQI protocols for hospital discharge outpatient follow up at 14 DO outpatient clinics and one countywide program.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The interventions are reasonable and address some of the contributors to rehospitalization. The interventions appear to have been limited to certain locations (e.g., the hospitals participating in HDOFCC and the clinics participating in TCPI), rather than the entire population to whom the study is relevant. It was unclear if the COD groups are for all those who are diagnosed with a co-occurring disorder or only the ISRs with co-occurring disorders.

	Totals	**1** Met **0** Partially Met **0** Not Met **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? *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	No *a priori* analysis plan was indicated.
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 team provided outcomes following re-measurement of their indicators. The four indicators which where the crux of the study did not show improvement in outcomes. For the crisis residential, the team provided data from the point of view of the CRTP rather than the ISRs who are eligible for placement. This way of presenting placement confounds the need for placement for ISRs with actual placement.

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: variable, including monthly and one year Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	While there was ample opportunity for repeated measures for some of the variables only two time points are given, initial and one re-measurement. No statistical analyses were conducted.
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:* ISRs were still not engaged. Difficulty in placements at CRTPs *Conclusions regarding the success of the interpretation:* This study "…demonstrates the intense efforts and dedication of all involved to continuously improve in this area despite not so significant outcomes noted." *Recommendations for follow-up:* Follow-up was provided relative to each intervention.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The team provided an interpretation of their findings and the outcome, to date, of the study. The team acknowledged that there was a need to course correct and that some of their interventions were more successful than others (e.g., COD groups). While the team has expanded the population, their interventions are proscribed (e.g., by hospital, clinic, etc.). An issue that the team has not addressed is that they present rehospitalization rates on the entire system, but those whom they can affect with their interventions are actually quite limited. Additionally, the improvements that they feature relate to staff changes and impact (e.g., care coordination protocol) and not beneficiary impact.
Totals	**0** Met **3** Partially Met **1** 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 has repeated measures on some variables, but not others.
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 has shown some improvement; however, the PIP is still in process and additional information is yet to be reported."
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	**0** Met **2** Partially Met **0** Not Met **3** 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: The MHP presents the focus of this PIP as rehospitalization, for which there is evidence of a need to decrease. The MHP first identifies ISRs as the targets for this population, but ISRs' actual contribution to the rehospitalization rate was not stated. The MHP has expanded the population to include all discharged beneficiaries, but the interventions do not reach all beneficiaries discharged from inpatient hospitals. With this one PIP, the MHP is attempting to resolve several issues--engagement of ISRs, rehospitalization rate throughout their system, and care coordination for beneficiaries. The scope of the project is too broad for the interventions that have been implemented. The MHP would be better served by taking only one of these issues and presenting it as the focus of the clinical PIP.
Recommendations: Collect, analyze, and present data on more frequent basis, at least quarterly Refine the study indicators to include all of the relevant data that gives an accurate impression of the status
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 FY 2018-19
NON-CLINICAL PIP

GENERAL INFORMATION

MHP: Los Angeles

PIP Title: The impact of training and psycho-education to front office staff on consumer satisfaction with front office customer service

Start Date: 07/01/17

Completion Date: 06/30/19

Projected Study Period: 24 Months

Completed: Yes ☐ No ☒

Date(s) of On-Site Review:

Name of Reviewer: Shaw-Taylor and Walton

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 (including goal and what PIP is attempting to accomplish):
The purpose of this PIP was to improve customer service and front office care for beneficiaries and uninsured individuals who seek services from DO or contracted outpatient programs in FY 2017-18. To gauge the front office customer service, the MHP conducted a brief 5-question survey. The overall feedback was positive, but the MHP received some feedback to which they wanted to address.

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 PIP was developed by a large multi-functional team of QI department staff, Outpatient Services Bureau (OSB), Human Resources Bureau (HRB), Worker Education and Resource Center (WERC) Inc. – Service Employee Local Union (SEIU) 721, Cultural Competence Committee (CCC) members, DO, and contracted outpatient programs. Beneficiary participation was through the CCC and via the focus groups & surveys.
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 team collected feedback from CCC members about front office customer service. This feedback provided qualitative information about the front office customer service, but no quantitative information on the customer service (e.g., the numbers and types of negative comments, the frequency of negative comments, etc.).

Select the category for each PIP:

Non-clinical:

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition
☒ Process of accessing or delivering care
☐ High volume services
☐ High risk conditions

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 addresses the sense of welcome and support that beneficiaries feel or experience upon coming to an outpatient clinic/program. Given that approximately 78 percent of the MHP's beneficiaries are seen in the outpatient environment, there was the potential to affect beneficiaries' (ongoing) engagement in treatment.
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 project was geared toward front office and financial staff at outpatient programs in all service areas. The project would have include all beneficiaries who receive services at those programs and clinics.
	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? *Include study question as stated in narrative:* Will implementing front office customer service training and psycho-education on mental health educational materials improve the consumer satisfaction rates related to front office customer service as evidenced by pre-post improvement in survey scores and qualitative feedback from consumers receiving services with LACDMH outpatient programs?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study question was clear, but the MHP did not link satisfaction with front office customer service with any aspect of services. For example, are less satisfied beneficiaries more likely to no-show? Are they more likely to prematurely end services?

	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	All beneficiaries could benefit from this project, as the training was meant to extend to all outpatient programs. The survey, from which the data were derived, was limited to those who were at the programs/clinics when the survey was being conducted.
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: <Text if checked>	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	It appears that the surveys were only distributed and administered to 35 DO clinics and not to any contracted programs. Although the survey was offered at the 35 DO clinics, the MHP cannot be assured that all consumers were given an opportunity to complete the survey.
	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. Percentage Point (PP) Improvement in scores related to "Helpfulness" 2. PP improvement in scores related to "Flexibility" 3. PP Improvement in scores related to "Dignity and Respect" 4. PP Improvement in scores related to "Feeling Welcomed" 5. PP Improvement in scores related to "Professionalism"	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	These five indicators are the same as the outcome for the study. The study would benefit from some process indicators, including: a. The number/percent of front office and financial staff that received the training b. Some measure of staff's proficiency in customer service
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 beneficiary 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	The indicators measured change in satisfaction.
	Totals	**1** Met **1** 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	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	A convenience sample was used consisting of beneficiaries who were at the clinics during the time that the survey was administered. The surveys were administered anonymously. There was no matching of the responses between the pre and post intervention surveys.
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	
Totals	**3** Met **0** Partially Met **0** Not Met **0** NA **0** 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 study specified the data to be collected, beneficiary responses to satisfaction questionnaire.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Front Office Customer Service Satisfaction survey	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes. The survey was provided in multiple languages as well.
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 detail of how the surveys were distributed (i.e., by whom) and collected were not explained. If the surveys are distributed or collected by the front office staff, about whom the survey is, then there is the risk of that influencing beneficiaries' responses.
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:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

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 data analysis plan was to compare the pre- and post-survey responses. The contingency plan was to review untoward results on an ongoing basis. The detail of the analysis
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Martin Jones, LCSW Title: Mental Health Clinical Program Manager III Role: Lead Manager, Outpatient Support Bureau *Other team members:* Names: Many members in the MHP	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Staff from QI department, DO service providers, and the outpatient support bureau were involved in data collection. It appears that front desk staff (whom the survey are about) were involved in administering and/or collecting the surveys, which presents a potential bias.
	Totals	**3** Met **3** 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 Client Experience Workshop through the Worker Education and Resource Center, Inc. 2. Provide psychoeducation by discussing mental health issues outlined in the curriculum	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP provided staff training in customer service and educated staff about mental health illness.
	Totals	**1** Met **0** Partially Met **0** Not Met **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? *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 pre- and post- intervention surveys were compared. The pre-intervention surveys showed already high ratings on most of the areas of satisfaction. The only area that had low ratings was flexibility with appointments. This was an opportunity for the team to look more closely at this aspect of satisfaction, which the MHP believes is related to actual, practical help of front office staff.
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: ____percent _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The repeated measure was the post intervention survey. The timing of the second survey was not explained, except that it followed the training that staff received. Results of a statistical analysis were provided, with p values, but the analysis was not indicated. Subsequently, a chi-square test was referenced.
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:* Insufficient sample size Non-matched pairs *Conclusions regarding the success of the interpretation:* Changes to the pre-and post-satisfaction were minimal. An analysis of the comments revealed a significant but selective improvement in relation to the training. *Recommendations for follow-up:* Clarification of question 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	An interpretation of the findings and measure of success was discussed. The limitations of the study and confounding factors were discussed.
Totals	**2** Met	**2** 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 same survey and the same methodology for distributing and collecting the survey was used upon re-measurement.
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	There was only measure of satisfaction that showed improvement. The others decreased, albeit minimally.
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	The improvement was minimal and there were some limitations that preclude ascribing the changes to the intervention.

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	Statistical results were presented of significant difference between the survey ratings, but given confounds and statement by the team that their sample size was too small, it is difficult to determine true improvement.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The team has not had time to conduct another round of measurement.
Totals	**2** Met **1** Partially Met **0** Not Met **1** NA **1** 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: Customer service training of front office staff had only a minimal impact on beneficiaries' self-reported satisfaction with services. The one area that showed improvement was in flexibility; however, it was also the one measure where the responses were the lowest (suggesting some reluctance to provide any information at all). A measure of knowledge in customer service principles and proficiency in customer service skill was needed, rather the staff's perception of the training and the trainers. Staff may also benefit from a manual or protocol that has concrete and actionable items for staff to do related to customer service.
Recommendations: Identify the issues around flexibility with which beneficiaries are less satisfied. Provide hands-on or in-the-moment support to front office staff who have difficult interactions with beneficiaries. Provide front office staff with a protocol of what to do in given situations.
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