FY16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Los Angeles

Conducted on

April 10-13, 2017

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LOS ANGELES MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—159,673
- MHP Threshold Languages—Spanish, Vietnamese, Cantonese, Mandarin, Other Chinese, Armenian, Russian, Tagalog, Korean, Farsi, Arabic, Cambodian
- MHP Size—Very Large
- MHP Region—Los Angeles
- MHP Location—Los Angeles
- MHP County Seat—City of Los Angeles

Introduction

Los Angeles County, officially the County of Los Angeles, is the most populous county in the United States. It has an area of 4,751 square miles. Its population, 10.12 million in 2014, is larger than that of 42 individual U.S. states. It has 88 incorporated cities and many unincorporated areas. Over one-quarter of California residents live in the county, which is one of the most ethnically diverse counties in the United States.

The majority of the population is located in the south and southwest portions of the county, with major population centers in the Los Angeles Basin, San Fernando Valley and San Gabriel Valley. The City of Los Angeles is the county seat with a population of over four million people.

Los Angeles County has the largest number of millionaires of any county in the nation (over 261,000 households). Juxtaposed to that are also more than 48,000 people living on the streets, including over 6,000 veterans.

The Los Angeles County Department of Mental Health (LACDMH) is the largest county-operated mental health department in the United States, directly operating programs in more than 85 sites, and providing services via contract programs and Department of Mental Health (DMH) staff at approximately 300 sites co-located with other County departments, schools, courts and other organizations. Each year, the County contracts with more than 1,000 organizations and individual practitioners to provide a variety of mental health-related services. In order to provide access to services in such a widespread and diverse area, the Mental Health Plan (MHP) divides the county into eight service areas.

During the FY16-17 review, CalEQRO found the following overall significant changes, efforts and opportunities related to Access, Timeliness, Quality and Outcomes of the MHP and its contract provider services. Further details and findings from EQRO mandated activities are provided in the rest of the report.

Access

LACDMH continues to strive to address homeless Medi-Cal beneficiaries in their outreach services. Homelessness is a priority issue for the entire Los Angeles County Health Agency integrated Departments, to include Health Services, Public Health and Mental Health.

Service Area Advisory Councils (SAAC) meet with providers to collect information on access of consumers to services. This promotes the use of peers as a vital component in engaging people and helping in the access phase of services.

The Non-Clinical PIP submitted by the MHP addresses the ACCESS Center 24/7 line response to callers and attempts to increase in engagement resulting from calls requesting services.

The MHP Emergency Outreach Bureau (EOB) expanded its Mental Health –Law Enforcement Teams (MH-LET) that provide field based crisis intervention services to children, adolescents, TAY and adults throughout Los Angeles County.

Timeliness

The MHP continues to strive to increase timeliness to services across the eight service areas. Capacity issues were noted in both Service Areas (SAs) 2 and 5 that CalEQRO visited during this review. Time to initial assessment is within normal boundaries, however, time from initial assessment to first clinical appointment can be quite long.

Quality

Director Jonathan E. Sherin, MD, PhD. arrived in November 2016, and has made consistency of quality of care across service areas a priority. He is touring the SAs, meeting with the SAACs, providers, consumers and family members and other groups to become aware of what is working well and where there are opportunities for quality improvement. “The sacred interface” between line staff providers and the consumer is the new Director’s key phrase for characterizing his top priority because it is this interface that informs the department about what type of resources are needed and it is to this interface that resources must also be deployed.

The Clinical PIP addresses transition of children and youth to a lower level of care when intensive services are no longer needed.

Outcomes

On average, more than 250,000 County residents of all ages are served every year. The Department’s mission – “enriching lives through partnership to strengthen our community’s capacity to support recovery and resiliency” – is accomplished by working with stakeholders and community partners to provide clinically competent, culturally sensitive, and linguistically appropriate mental health services to clients in the least restrictive setting.

INTRODUCTION

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

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

This report presents the FY16-17 findings of an EQR of the Los Angeles MHP by the California EQRO (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **eight Mandatory Performance Measures (PMs)** as defined by DHCS. The eight performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four 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
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

[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) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs) during the 12 months preceding the review. The PIPs are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

The EQRO examined available consumer 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.

(5) KEY COMPONENTS, SIGNIFICANT CHANGES, ASSESSMENT OF STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT, RECOMMENDATIONS

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

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

[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.

PRIOR YEAR REVIEW FINDINGS, FY15-16

In this section the status of last year's (FY15-16) recommendations are presented, as well as changes within the MHP's environment since its last review.

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

In the FY15-16 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY16-17 site visit, CalEQRO and MHP staff discussed the status of those FY15-16 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed is assigned when the identified issue has been resolved:
  - resolved the identified issue
- Partially addressed is assigned when the MHP has either:
  - made clear plans, and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY15-16

- Recommendation #1: Provide sufficient technical assistance resources for both legal entities and the Electronic Health Record (EHR) vendors during the Integrated Behavioral Health Information System (IBHIS) go-live preparation and post go-live transition as the systems conversion is mission-critical for the department.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - While the Chief Information Office Bureau (CIOB) has been reassigning all possible staff to the onboarding work and continues the process to gain approval to hire temporary resources as recommended in the November 2015 report by Gartner on DMH IT governance, organizational structure, staffing and skills assessment. CIOB resources to support Contract Provider's onboarding to IBHIS remains constrained.
  - In addition, the scope of the project expanded beyond the originally planned number of Legal Entities (LEs) and Fee-For-Service (FFS) providers - more

contract provider groups are now being incorporated into the onboarding schedule.

- As a part of Mental Health Services Act (MHSA) goals, Federally Qualified Health Centers (FQHCs) will be paired with other providers to serve individuals with serious mental illness in the Los Angeles County. DMH anticipates onboarding to IBHIS approximately 30 FQHCs once the department completes its upcoming solicitation for FQHCs.
- To comply with California Assembly Bill (AB) 1997 guidelines, DMH plans to accommodate insertion of 43 Continuum of Care Reform Providers into the schedule. LEs who serve children/adolescents will be onboarded to IBHIS as a top priority, impacting the schedule for onboarding LEs and FFS providers and delaying the shutdown of the legacy system (the Integrated System).
- DMH also anticipates adding four Crisis Residential Treatment Program Providers to the IBHIS onboarding schedule as early as August 2017.

- Recommendation #2: Maintain the Chief Information Office Bureau (CIOB) and Central Business Office (CBO) staffing support at least at current levels during transition from Information Systems (IS) to the Integrated Behavioral Health Information System (IBHIS) until go-live on IBHIS is achieved for all providers and practitioners to ensure success in serving individuals timely and adequately.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The CIOB staffing support resources were maintained in the past year and not reduced. CBO support staff is being maintained at current levels during the transition from Integrated System (IS) to the Integrated Behavioral Health Information System (IBHIS).
  - The long-time, over twelve years, Chief Information Officer (CIO) retired August 2016. The Assistant CIO assumed the duties and responsibility of CIOB operations. A recruitment process was initiated and the new CIO is scheduled to start May 2017.
  - While there are no plans at this time to decrease staffing support resources, the loss of staff members with IBHIS onboarding technical skills results in spreading the workload to a smaller pool of experts.

- Recommendation #3: Investigate the feasibility of integrating both the MHP Human Resources and Central Information Office Bureau (CIOB) Help Desk units into the recently formed Health Agency organizational structure to further improve support for the MHP. The lack of sufficient staff resources currently continues to impact the MHP's capability to provide timely support functions.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - At this time there are no plans to integrate Human Resources into the Agency.

- The MHP contends that the three departmental resources are working collaboratively in support of each other. The three departments have identified areas where resources can be shared to effect efficiencies and plan to continue working in this partnership
- CIOB has set up a MHP IT Help Desk routing queue to direct IBHIS related Contract Provider calls to level two support at the CIOB Provider Assistance Office.
- A project is underway to move first level MHP IT Help Desk calls to the Health Agency Enterprise Help Desk.
- A tentative strategy would move after-hours calls to the Enterprise Help Desk as Phase 1, but plans are not currently finalized.
- Project timelines are dependent upon resource availability and MHP IT governance approvals.

- Recommendation #4: Determine which Evidence Based Practices (EBPs) the MHP will continue to incorporate within its service delivery. Inform key stakeholders and initiate a training calendar.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP plans to continue to incorporate 37 EBPs, Promising Practices (PP), and Community Defined Evidence (CDE) practices within its Prevention and Early Intervention (PEI) Plan.
  - The MHP added three new EBP in PEI in the past year: Asian American Family Enrichment Network, Family Connections, and School, Community and Law Enforcement Program.
  - Training calendars for EBPs were sent to PEI provider network, stakeholders, agency training coordinators and MHP staff.
  - Various staff members interviewed report that it is difficult to retain line staff who are trained and certified in various EBPs. This issue is particularly acute for the contract providers. It takes time and expense to bring new staff up to standard for certification in many EBPs. Contract providers are trying out different incentive strategies for such specially trained line staff.

- Recommendation #5: Create supportive staff training covering quality service and safety issues including:

  1. Implement a Welcoming Training for front desk/reception staff to utilize which supports quality customer service in a wellness and recovery-based environment. Provide culturally inclusive and cultural humility and sensitivity trainings system wide, include contract providers.
  2. Implement a staff safety refresher course in each Service Area secondary to the composition of the neighborhood concerns to enhance quality safety measures.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- LA worked with a vendor to develop a Welcoming Training for front desk staff designed to address staff needs and appropriate training for each clinic environment. These trainings are projected to be fully implemented in FY17-18.
- The MHP Quality Improvement Division – Cultural Competency Unit (QID-CCU) developed a basic cultural competency training to create training in cultural humility and sensitivity. Approximately 230 providers were trained, inclusive of management/administration, direct service providers, and clerical support staff. A 53 slide PowerPoint presentation was made available to trainees. The time duration of the online version of the training is 1.5 hours, strategically divided into three parts: Part 1 – Basic definitions, regulations related to cultural competency, MHP strategies to reduce mental health disparities, and MHP demographical and client utilization data; Part 2 – Cultural humility, client culture, stigma, elements of cultural competency in service delivery, and resources; Part 3 – Cultural competency scenarios and group discussion.
- This training meets the Cultural Competence Plan Requirement for 100% of staff to receive annual cultural competence training, inclusive of management/administration, direct service providers, and clerical support staff.
- Staff safety trainings were offered for all Service Areas between 5/1/2016 and 1/31/17 to enhance quality safety measures. Trainings provided were as follows: Field Safety, 5 sessions – 134 employees trained; Non-Violent Crisis Intervention – two days training, six sessions – 142 employees trained; Workplace Violence, two sessions – 47 employees trained.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS

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

- Access to Care
  - The MHP Emergency Outreach Bureau (EOB) expanded its Mental Health –Law Enforcement Teams (MH-LET) that provide field based crisis intervention services to children and adolescents, TAY and adults throughout Los Angeles County. SB82 offered this opportunity for growth. In March 2015, MOUs were developed with several police departments within LA County. It is a co-response model wherein one clinician and one law enforcement officer respond together. There are now 36 teams with three coming onboard later this year. The MHP reports enthusiastic support of this model by law enforcement.

- The new Director's focus on access and addressing those issues that hinder/prevent access seems to have resonated throughout the Systems of Care. This would imply increase in access through time.
- The MHP has made a number of changes that increase their capacity to serve youth in foster care. Fourteen new providers have been contracted to provide Wraparound, intensive programming for youth in foster care. The MHP has also increased the funding of Full Service Partnerships, enabling increased provision of Intensive Care Coordination. The MHP in collaboration with their partners (i.e., Child Welfare Services and Probation) has centralized the referral process for Intensive Field Capable Clinical Services (IFCCS), adding four more 'portals' (totaling nine) to increase the points of entry and coordination of services. There has been a seven-fold increase in the number of youth served through IFCCS.

- Timeliness of Services
  - The LET expansion improves timeliness of access to mental health services to individuals who are in acute crisis that come to the attention of law enforcement through the 9-1-1 system or patrol officers.
  - The Vacancy Adjustment Notification System (VANS) is designed to help providers receive information of vacancies on a timely basis in order to increase timeliness of referrals to appropriate services. There is considerable variation on how often contractors are updating VANS to reflect current opening, from daily to monthly.
  - Clinical Staff users of VANS report difficulty in searching for program and language information simultaneously. S
  - All directly operated sites and contract providers have access to VANS.

- Quality of Care
  - The new Director's priorities/vision/actions on wellness, personal recovery and community reintegration thus far are met with enthusiasm by staff and consumers. This includes commitment to consumer involvement in treatment planning and service delivery, an overall whole person approach. Peer employees perceive the Director as committed to a wellbeing, personal and recovery, and community reintegration oriented system. The time utilized to meet with and listen to staff, consumers, family members and advocates is viewed as proof of that commitment. This is especially noted in that the MHP Director has gone across the service areas for these meetings.
  - IBHIS implementation continues to be a priority project in the past year. At the time of last year's review, nine of the MHP's Legal Entity (LE) Contracted Providers had made the transition to IBHIS. At the time of this year's review 73

LEs and four Fee-For-Service providers have made the transition, including some of the largest entities.

- In the coming year, the MHP will continue the transition of contracted providers to IBHIS, including new processes and functionality (e.g. manage the Local Mental Health Plan's Fee for Service inpatient facilities), enhance functionality to support clinical information exchange across the Health Agency and with other healthcare partners, as well as continue efforts around system optimization.
- The Community Services and Supports (CSS) Plan Consolidation of 24 MHSA work plans into six enhanced administration efficiency as well as created greater service continuity without modifying program expectations, intentions or service capacity. It supports a more seamless system of care for clients and their families. Capacity within Full Service Partnership (FSP) programs will increase significantly via the expansion and its criteria. These include:
    - Expansion of FSP eligibility criteria allows clients at risk of certain conditions, such as homelessness, to be eligible for enrollment into an FSP program.
    - The creation of various services outside of FSP, named Recovery, Resiliency and Reintegration (RRR) Services, including field based, clinic based, wellness and client run, medication support and employment support services.

- Consumer Outcomes
    - Existing FSP outcomes will continue to be collected.
    - Level of Care will be collected and recorded for each client.
    - The three county departments within the LAC Health Agency work collaboratively to address homelessness. The MHP plans to use Strategies for Total Accountability and Total Success (STATS), a performance-based management program, to measure engagement and identify improvements.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following performance measures as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of TBS Beneficiaries Served Compared to the four 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
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

TOTAL BENEFICIARIES SERVED

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

Table 1—Los Angeles MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	351,212	11.8%	34,012	21.3%
Hispanic	1,791,040	60.2%	72,997	45.7%
African-American	273,816	9.2%	26,751	16.8%
Asian/Pacific Islander	251,373	8.5%	6,839	4.3%
Native American	3,286	0.1%	426	0.3%
Other	302,884	10.2%	18,648	11.7%
Total	2,973,608	100%	159,673	100%

The total is not a direct sum of the averages above it. The averages are calculated separately.
The actual counts are suppressed for cells containing n ≤11.

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

Regarding calculation of penetration rates, the Los Angeles MHP:

☐ Uses the same method as used by the EQRO.

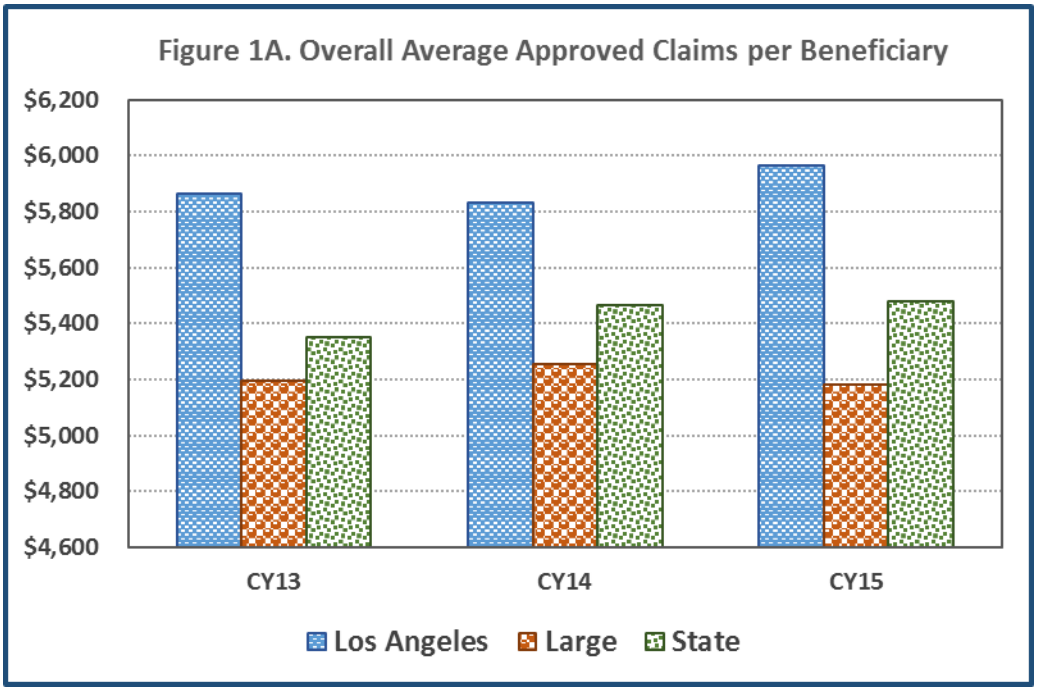
☒ Uses a different method:

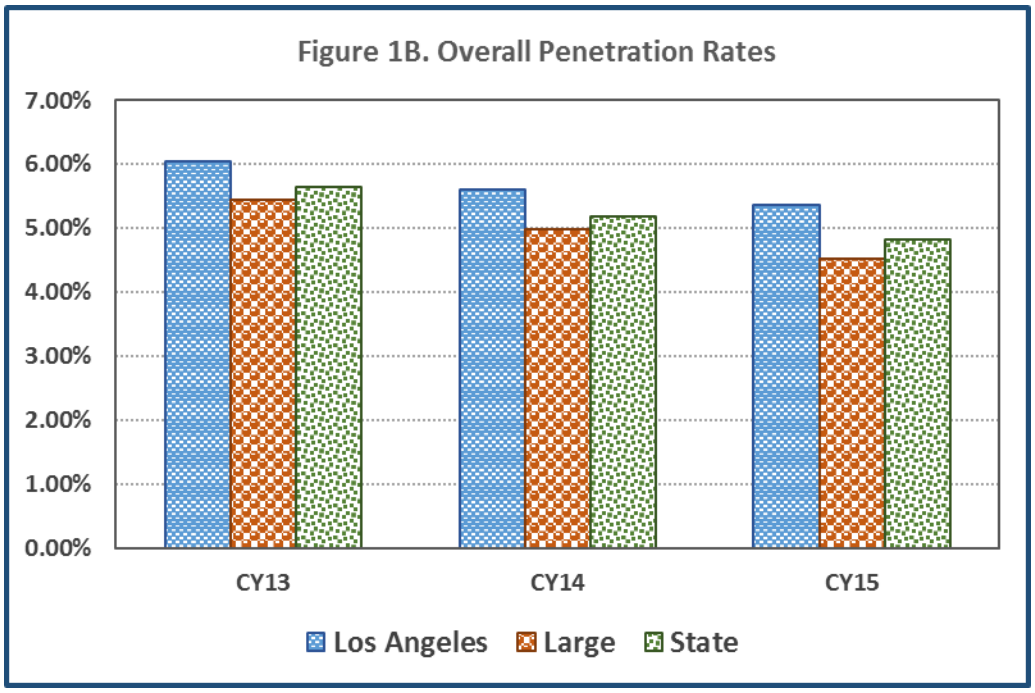
NUMERATOR: Unduplicated number of consumers served during the fiscal year in Outpatient and Day Treatment programs.

DENOMINATOR: County population estimated with SED and SMI at or below 138% federal poverty level (Prevalence).

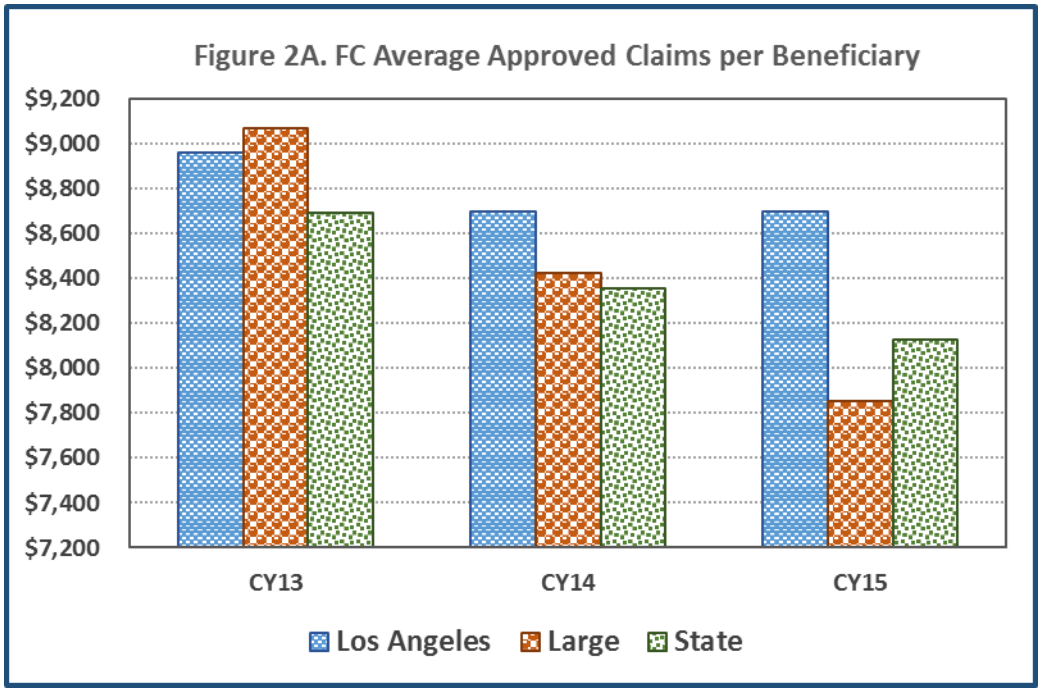
☐ Does not calculate its penetration rate.

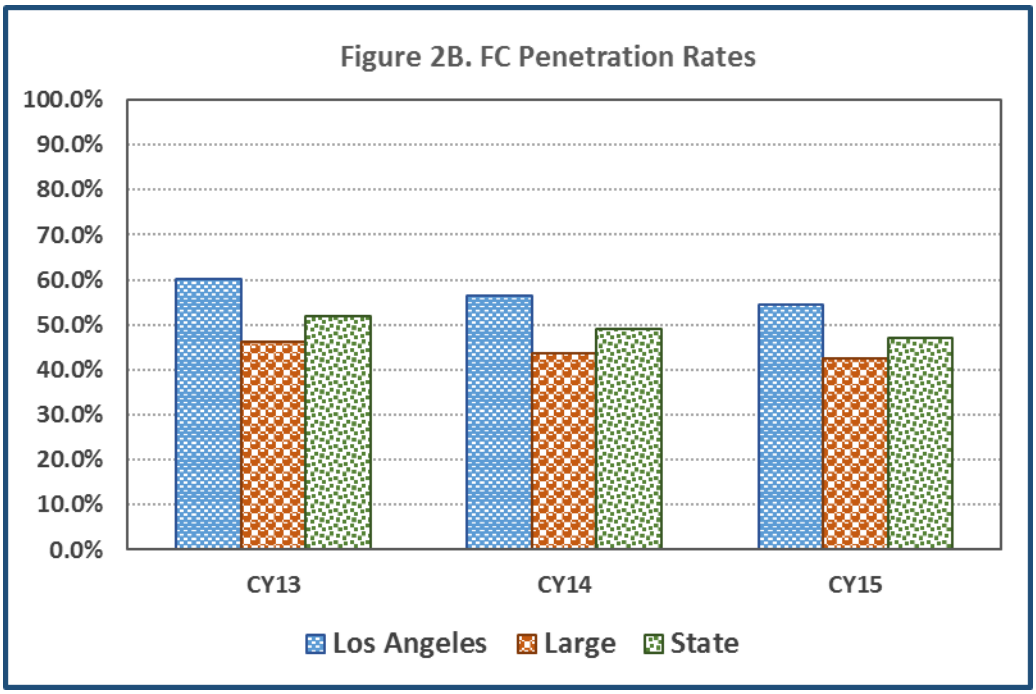
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



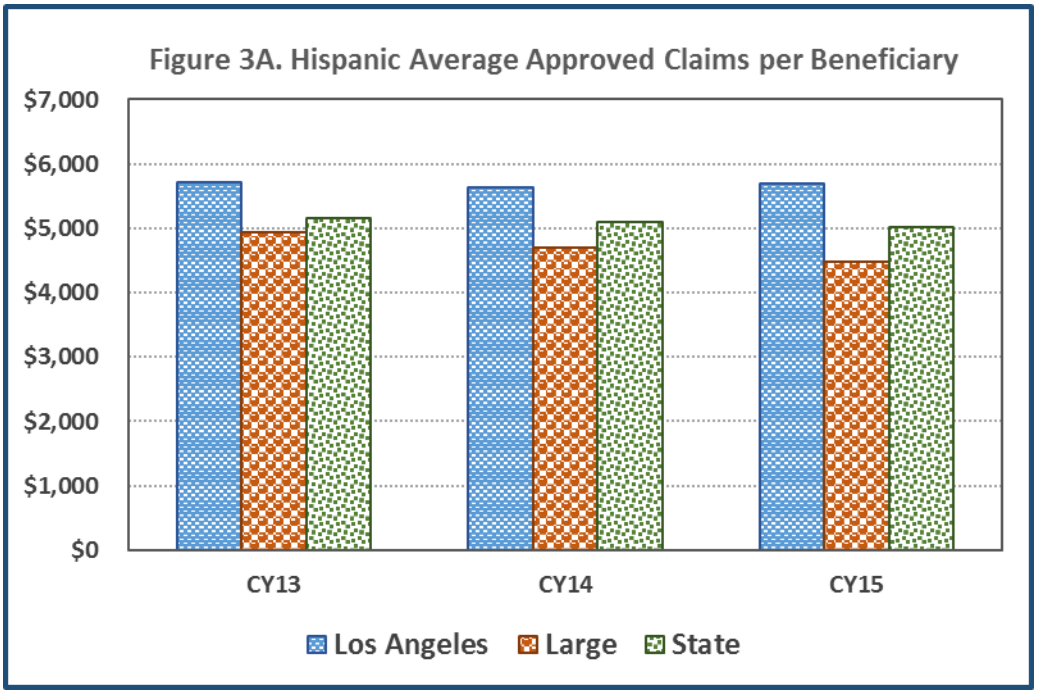


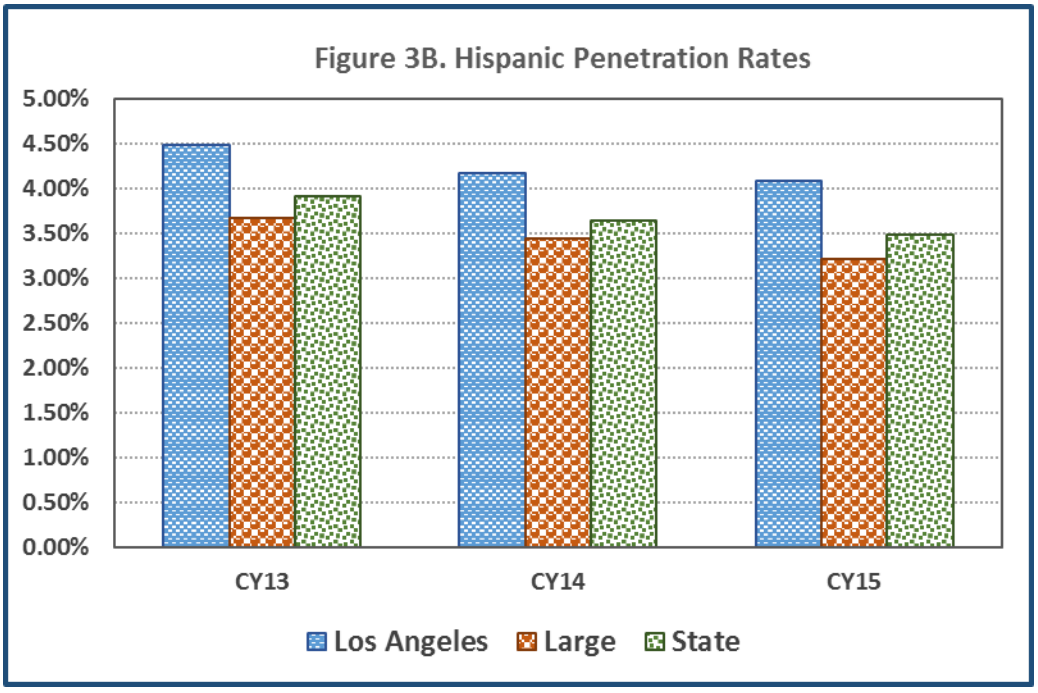
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





Figures 3A and 3B show 3-year trends of the MHP's Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary.

HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for High-Cost Beneficiaries (HCB) for CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than $30,000 in a year.

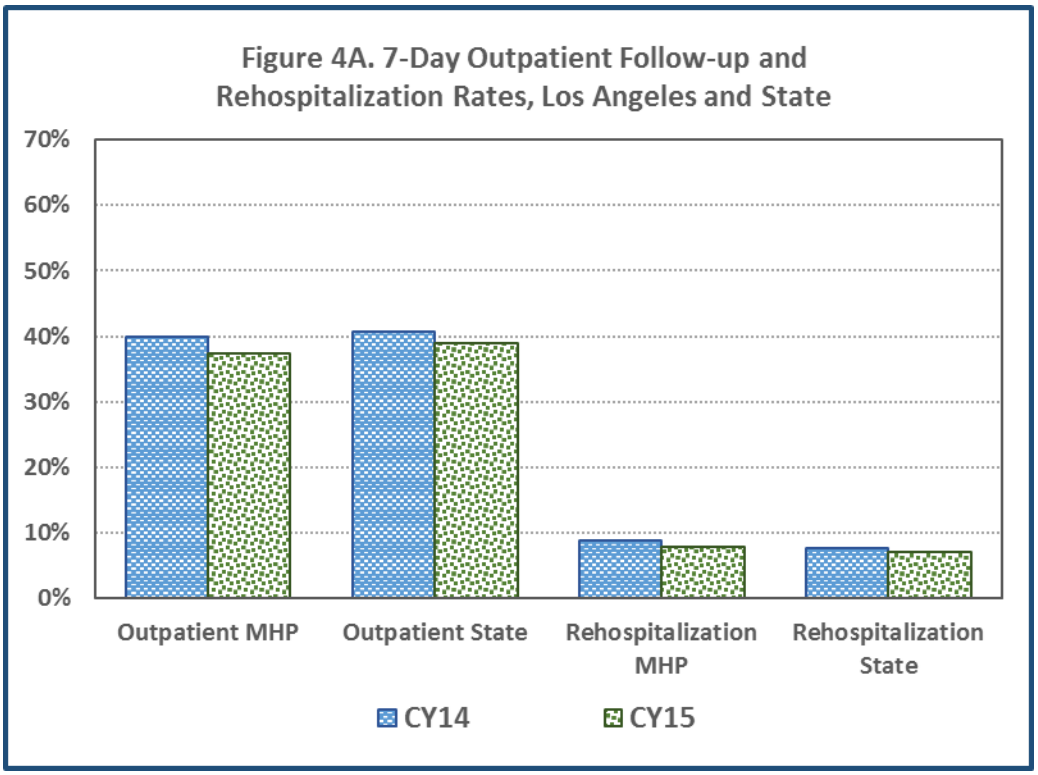
Table 2—High-Cost Beneficiaries

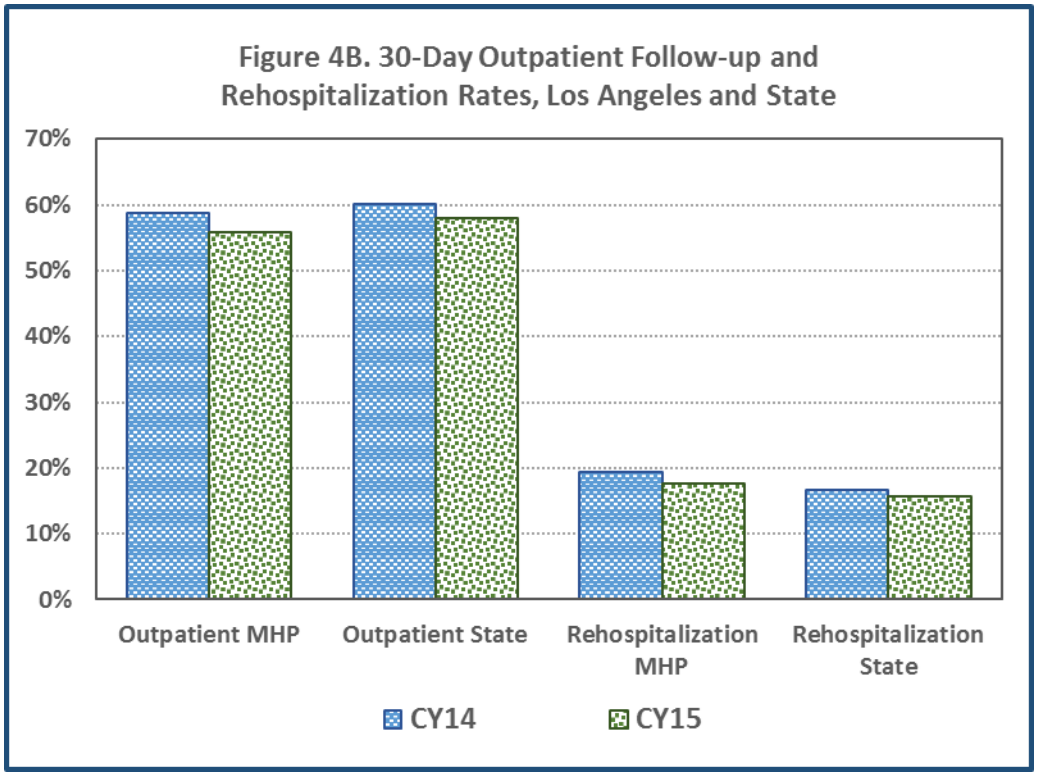
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
Los Angeles	CY15	4,565	159,668	2.86%	$49,919	$227,880,311	23.93%
	CY14	3,656	160,946	2.27%	$47,797	$174,744,257	20.08%
	CY13	4,353	160,258	2.72%	$49,104	$213,748,386	22.75%

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

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY14 and CY15.

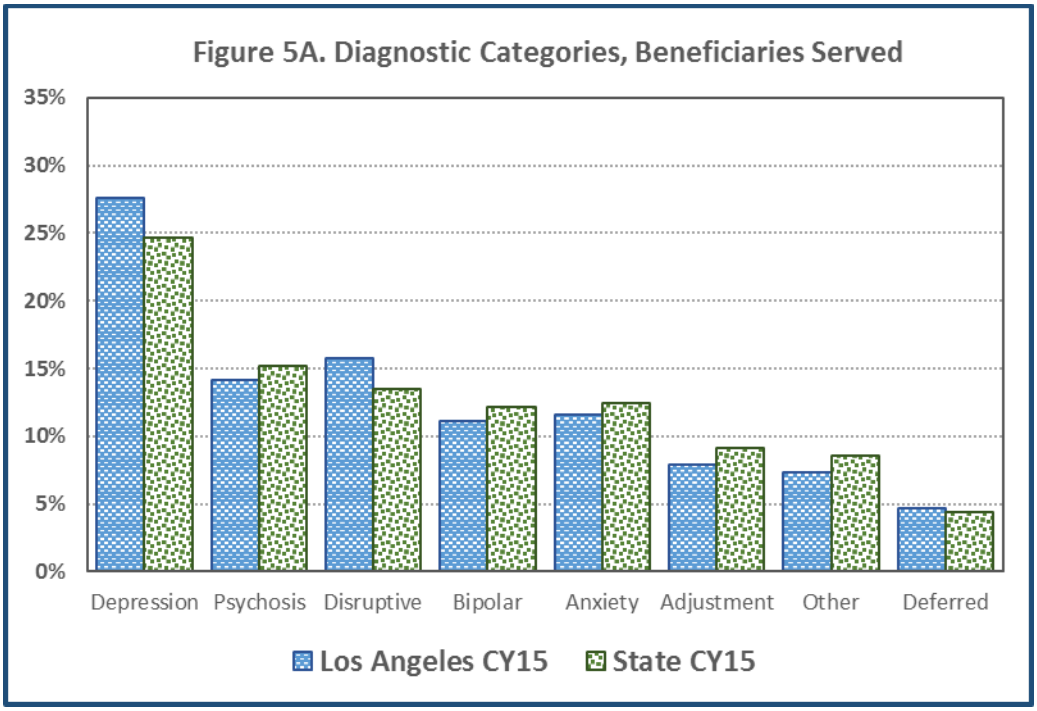


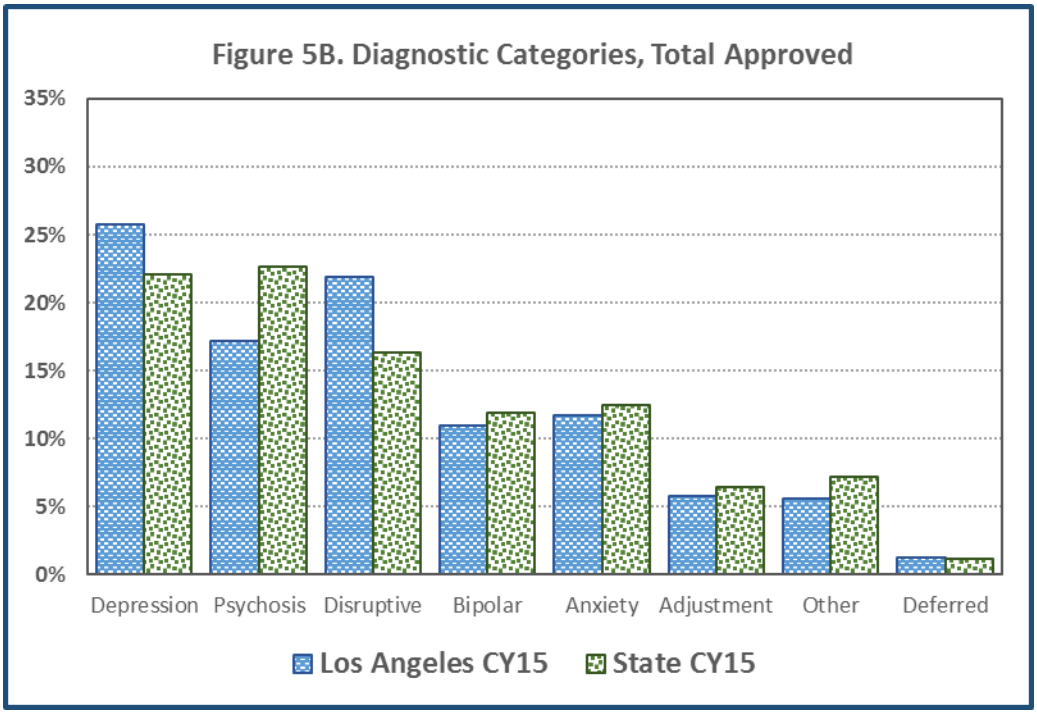


DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY15.

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





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The MHP's number of eligibles rose from 2,888,478 in CY14 to 2,973,608 in CY15 and the number of beneficiaries served declined from 161,888 to 159,673 during this period. This correlates to a penetration rate drop from 5.60% in CY14 to 5.37% in CY15. The MHP's Overall CY15 penetration rate continues to exceed large MHP (4.52%) and statewide (4.82%) averages. (See Fig. 1B.)
    - The MHP served 24,669 Affordable Care Act (ACA) beneficiaries out of 431,473 ACA eligibles in CY15 for a penetration rate of 5.72% for this sub-group (see Table C1 in Appendix C).
    - The MHP's Foster Care penetration rate decreased from 56.49% in CY14 to 54.45% in CY15 but remains higher than both large MHP (42.62%) and statewide (47.19%) averages. The number of Foster Care beneficiaries served during CY14 was 13,156, compared to 13,270 during CY15. (See Fig. 2B.)
    - The MHP's Hispanic penetration rate dropped from 4.17% in CY14 to 4.08% in CY15 but remains greater than both large MHP (3.22%) and statewide (3.49%) averages. The number of Hispanic beneficiaries served during CY14 was 73,098, compared to 72,997 during CY15 (See Fig. 3B.)
- Timeliness of Services
    - In CY15, the MHP's 7- and 30-day outpatient follow-up rates after discharge from a psychiatric inpatient episode decreased when compared to the corresponding CY14 rates but remain slightly below statewide averages. (See Fig. 4A and 4B.)
- Quality of Care
    - The MHP's average Overall approved claims per beneficiary increased from $5,830 in CY14 to $5,976 in CY15, and is greater than large MHP ($5,256) and the statewide averages ($5,522). (See Fig. 1A.)
    - The MHP's Foster Care approved claims per beneficiary remain unchanged from $8,696 in CY14 to $8,701 in CY15, and is greater than both large MHP ($7,653) and statewide averages ($8,127). (See Fig. 2A.)
    - The MHP's CY15 average Hispanic approved claims per beneficiary increased from $5,628 in CY14 to $5,692 in CY15 and remains greater than both large MHP ($4,514) and statewide ($5,045) averages. (See Fig. 3A.)
    - The MHP's percentage of high-cost beneficiaries (HCBs) in CY15 (2.86%) increased from CY14 (2.27%) and is the same as the statewide average (2.86%). (See Table 2.)
    - The percentage of total HCB claim dollars was slightly less than the statewide average in CY15 (23.93% vs. 26.96%). The MHP's average approved claims per

HCB increased from CY14 ($47,797) to CY 15 ($49,919), and is less than the CY15 statewide average ($51,635). (See Table 2.)

- The MHP had higher rates of Depression and Disruptive diagnoses when compared to statewide averages. (See Fig. 5A and 5B.)

- Consumer Outcomes
  - The MHP's 7- and 30-day rehospitalization rates declined slightly similar to the statewide averages.

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." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2015.

LOS ANGELES MHP PIPS IDENTIFIED FOR VALIDATION

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

Table 3—PIPs Submitted

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Implementation of Family Resource Centers (FRCs) to Improve Access and Continuity of Care
Non-Clinical PIP	1	ACCESS Center: Implementing the QA Protocol at the ACCESS Center

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.[4]

Table 4—PIP Validation Review

Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	PM
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	PM
		1.4	All enrolled populations	NR	M
2	Study Question	2.1	Clearly stated	NR	PM

[4] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	NR	M
		3.2	Inclusion of the entire study population	NR	PM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	NM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	PM
		5.2	Valid sampling techniques that protected against bias were employed	NR	PM
		5.3	Sample contained sufficient number of enrollees	NR	NM
6	Data Collection Procedures	6.1	Clear specification of data	NR	PM
		6.2	Clear specification of sources of data	NR	PM
		6.3	Systematic collection of reliable and valid data for the study population	NR	PM
		6.4	Plan for consistent and accurate data collection	NR	M
		6.5	Prospective data analysis plan including contingencies	NR	PM
		6.6	Qualified data collection personnel	NR	PM
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	UTD
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	PM
		8.2	PIP results and findings presented clearly and accurately	NR	PM
		8.3	Threats to comparability, internal and external validity	NR	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	PM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	NA

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		9.3	Improvement in performance linked to the PIP	NR	NA
		9.4	Statistical evidence of true improvement	NR	NA
		9.5	Sustained improvement demonstrated through repeated measures.	NR	NA

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine; NR = Not Rated (Concept Only or None Submitted)*

Table 5 gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 5—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	NR	5
Number Partially Met	NR	15
Number Not Met	NR	1
Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling)	NR	21
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	00.00%	59.52%

CLINICAL PIP—IMPLEMENTATION OF FAMILY RESOURCE CENTERS (FRCS) TO IMPROVE ACCESS AND CONTINUITY OF CARE

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

1. "Will the implementation of FRCs at existing Children's Mental Health Clinics (MHCs) result in: a) transitioning Children and Youth (who no longer need an intensive level of services) to a higher level of resiliency and b) enrollment of clients who have no prior LACDMH treatment history and may benefit from FRC services?

2. Will enrollment in the FRCs result in: a) a reduction in frequency of hospitalizations and b) a reduction in Urgent Care visits for Children and Youth that transitioned from FSP programs at 3 months and 6 months post enrollment?

3. Will implementation of the FRCs result in 85% of the clients enrolled in FRCs reporting high satisfaction rates (means of 3.5 and higher) on the "General Satisfaction," "Perception of Access," "Perception of Cultural Sensitivity/Quality and Appropriateness," and "Perception of Participation in Treatment Planning" subscale measures of the Youth Satisfaction Survey (YSS; 13-17 years), the YSS- Family (YSS-F; 0-17 years), and the Adult Consumer Survey (18+ years) at 3 months and 6 months post enrollment?

4. Will the implementation of the FRCs result in an increase in Family Support Services to parents/family members of Children and Youth being treated at Children's MHCs?"

- Date PIP began: July 2016
- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year *(Not Rated)*

  ☒ Concept only, not yet active *(Not Rated)*

  ☐ Submission determined not to be a PIP *(Not Rated)*

  ☐ No PIP submitted *(Not Rated)*

This Clinical PIP was determined to be Concept Only and was therefore not rated. Implementation is now scheduled for July 2017.

The goal of this Clinical PIP is to decrease the need for urgent care and (re)hospitalizations for Severely Emotionally Disturbed (SED) Children/Youth (0-21 years) through the establishment of Family Resource Centers (FRC). The LACDMH Children's SOC Bureau (CSOC) is implementing this PIP to address the identified gap in Child/Youth services related to continuity of care issues, and the gap in supportive services available for parents of Children and Youth with SED.

The PIP includes a subset (estimated to be about 5%) of the 6,000 youth currently enrolled in intensive outpatient treatment programs (FSP, FCCS, PEI-medication only) but are ready to step down to a lower level of care, along with walk-ins who meet medical necessity, have no prior LACDMH treatment history, and may benefit from FRC services. This subset, targeted through this PIP, is estimated to be approximately 200-300 youth (birth to 21 years of age). It would be advantageous to include a phased approach of outreach and engagement for the wider population

of SED youth in LA (148,237) in general, and specifically the SED youth included in the 109,215 total consumers served in FY14-15.

The current title of this PIP reflects the intervention rather than the goal. Therefore, the MHP should consider renaming this PIP: "Improving stability for FSP/FCCS youth", and the study question could become: "Will providing x, y, z services to those transitioning from FSP/FCCS to a lower LOC result in greater stability, resiliency, etc. by x%?" This would reflect the MHP's current process of consolidating all Non-FSP programs in order to transition into a Recovery, Resilience & Reintegration (RRR) Service Continuum.

The PIP would show more construct validity if it contained an indicator that measured recidivism back to FSP after the client is enrolled in FRC services.

The PIP lacks a robust data analysis plan, and specific, measurable interventions which need to be fully articulated. Parent Advocates will play an integral role in this PIP.

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

The technical assistance provided to the MHP by CalEQRO consisted of a detailed discussion on the strengths and challenges of this PIP concept. The MHP is encouraged to have several PIP topics in process simultaneously so as to fully meet this requirement annually.

NON-CLINICAL PIP—ACCESS CENTER: IMPLEMENTING THE QA PROTOCOL AT THE ACCESS CENTER

The MHP presented its study question for the Non-Clinical PIP as follows:

1. "Will implementing a Quality Assurance Protocol for the Los Angeles County Department of Mental Health (LACDMH) 24/7 Hotline result in a ten (10) Percentage Point (PP) improvement in offering language interpreter service to callers who need this service in the fourth quarter of FY 2016-17 as compared with the First (Baseline) quarter of FY 16-17?

2. Will implementing a Quality Assurance Protocol for LACDMH 24/7 Hotline result in an increase by ten (10) Percentage Points (PP) in the ACCESS Center actual calls where the ACCESS Center agent requested the caller's name in the fourth quarter of FY 2016-17 as compared with the First (Baseline) quarter of FY 16-17?

3. Will implementing a Quality Assurance Protocol for the LACDMH 24/7 Hotline result in an increase by five (5) PP in the demonstrated respect/customer service on actual calls in the fourth quarter of FY 2016-17 as compared with the First (Baseline) quarter of FY 16-17?

4. Will implementing a Quality Assurance Protocol for County LACDMH 24/7 Hotline result in:

a. An increase by two (2) PP in the actual calls logged between "Pre-Post Study" periods and thereby lead to:

b. Improved triage and related scheduling of appointments for consumers requesting Specialty Mental Health Services by two (2) PP?"

- Date PIP began: July 2016
- Status of PIP:

☒ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year *(Not Rated)*

☐ Concept only, not yet active *(Not Rated)*

☐ Submission determined not to be a PIP *(Not Rated)*

☐ No PIP submitted *(Not Rated)*

This Non-Clinical Performance Improvement Project (PIP) involves the Implementation of a Quality Assurance (QA) Protocol within the ACCESS Center (AC). Often the ACCESS Center 24/7 Line may be a Medi-Cal beneficiary caller's first point of contact with the Los Angeles County Department of Mental Health (LACDMH). The ACCESS Center operates the 24/7 Statewide, Toll Free number for both emergency and non-emergency calls.

Based on a four-year review of test calls, from calendar year 2012 through 2015, the MHP identified underperformance in six of eight domains of test calls. As the Access Line is a critical component of initial and ongoing access to mental health services, the MHP sought to improve call handling from the Access Line. Initially, the MHP stated three areas for improvement: request of caller's name; caller satisfaction; and logging of calls. Subsequently, the MHP also sought to improve whether calls were offered language assistance. With regard to customer satisfaction, the MHP reframed this component as customer service/respect.

The MHP noted that a variety of factors come into play when a consumer makes that first call to the ACCESS Center 24/7 Line including individual factors such as stigma and fear, language barriers, practitioner factors such as communication, cultural attitudes, and language capacity; system factors such as wait times, lack of well qualified interpreters, and practical factors such as lack of time to call back if they are disconnected or don't get the information they called for. Therefore, it is very critical that the above potential barriers to access to care are systematically addressed. The AC test call study results trends focusing on some of these barriers showed that there are three potential areas for improvement –AC Call Center Agents requesting Caller's/Client's name, Customer Satisfaction, and Documentation of calls. In order to address these three areas, LACDMH focused on implementing the QA Protocol at the AC as a Non-Clinical PIP for FY 16-17.

The MHP implemented an ACCESS Quality Assurance (QA) Protocol, which includes customer service standards and a documentation protocol that prompts the Access Line agent to obtain necessary information from callers, and trained agents on this protocol. But the MHP's stated intervention was the implementation of supervisory review of the agent's calls. Specifically, an Access Line supervisor would review pre-recorded Access calls from a given agent, complete a QA Protocol Checklist, meet with the agent to listen to the call, and together review the components of the call. The MHP believes that this intervention would bolster agent's use of and proficiency in the protocol and, overall, improve agent's handling of calls to the Access Line. And, to date, this is what the MHP has accomplished. The MHP has improved their internal processes to affect the Access Line, but the MHP has not demonstrated as successfully the impact on consumers. There were two areas for improvement that had potential for consumer impact—customer satisfaction and triage and related scheduling, but neither were directly assessed. Rather, the MHP measured third-party (i.e., supervisory) assessment of customer service/respect. It is possible for an agent to be respectful and provide customer service, but for the caller to leave dissatisfied. With regard to triage and scheduling, the MHP measures the number of referrals only, but not if the referrals equate to faster triage or shorter time to assessments. The MHP has not adequately addressed the consumer impact and improved access because of this PIP.

The QA Protocol process is non-punitive and designed to improve service delivery, customer service and documentation of calls information by: 1) evaluating monthly 24-32 random calls from the entire consumer population that call the ACCESS Center during the study period, 2) reviewing calls received on the 1 (800) line only, 3) providing feedback, consultation and training all agents on the QA Protocol, 4) training all ACCESS Center supervisors on the QA Protocol and validation of the calibration process, and 5) reviewing the outcomes on a quarterly basis, This was designed to enable the MHP to address areas identified for improvement.

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

The technical assistance provided to the MHP by CalEQRO consisted of offering TA to continue and improve the PIP. The recommendation was made to articulate or hypothesize the reasons for the underperformance noted in the test calls and to link those reasons with their intervention. The MHP indicated that the supervisory review (of 24-32 calls per month) is meant to be an ongoing process. CalEQRO cautioned that given how demanding the review is (and proven uncertain in availability of supervisors), the MHP should consider if this is process is sustainable. It was noted that Study Questions are actually indicators. There is still a need for an overarching study question that encompasses the indicators.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

  - The Clinical PIP targets SED youth who are ready to move to a lower level of care, along with walk-ins who meet medical necessity, have no prior MHP treatment history, and may benefit from FRC services.
  - The Non-Clinical PIP describes barriers to access and the variety of factors involved when a consumer makes the initial call to the ACCESS 24/7 Line. The goal of this PIP is to systematically address these barriers to allow access in a timely and appropriate manner.

- Timeliness of Services
  - The Non-Clinical PIP has a goal of reducing wait times for response when consumers call the ACCESS 24/7 Line.

- Quality of Care
  - The MHP did a thorough job of collecting and utilizing data for the Non-Clinical PIP.
  - The Clinical PIP seeks to increase quality by eliminating the identified gap in Child/Youth services for those no longer requiring an intensive level of mental health services, the related continuity of care issues, and the gap in supportive services for parents of Children and Youth with SED.
  - The Non-Clinical PIP addresses the quality of the ACCESS Center 24/7 line response to callers and has a goal to increase engagement resulting from calls requesting services.

- Consumer Outcomes
  - The goal of the Clinical PIP is to decrease the need for urgent care and (re)hospitalizations for SED Children/Youth (0-21 years).
  - The goal of the Non-Clinical PIP is to increase engagement in appropriate level of services as an outcome of the call to the ACCESS 24/7 line.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below.

Access to Care

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

Table 6—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	The MHP tracks, trends, and analyzes service delivery timeliness for each SA by language preference, gender, ethnicity and age, and includes geo-mapping of its services and satisfaction results. The Cultural Competency Committee (CCC) collaborates with the Underserved Cultural Communities (UsCC) subcommittees and UsCC leadership group. In the past year the MHP has added more consumers and stakeholders to the group, with a focus on giving them a voice and closing gaps in service that are due to disparities. They had a workgroup on access to Culturally and Linguistically Appropriate Services (CLAS) this past year. The MHP has a robust Mental Health Promotores program that began approximately six years ago in one service area, and has now expanded to two service areas. In SA7, the initial SA, there are currently 30 Promotores who reach about 10,000 people annually. The second SA (8) also has 30 Promotores. By the end of this fiscal year an additional 20 Promotores will be trained in each of the other service areas for a total of 100 Promotores across 4 SAs. Promotores liaise with community leaders and offer their services as mental health educators, establish relationships and provide outreach using a community change model that emphasizes self-advocacy and empowerment. The plan is to train Promotores in all 8 SAs by 2017-2018. Several group session participants noted that more services and easier access is needed with respect to deaf/hearing impaired and eating disorders.

Table 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The MHP is engaged in telepsychiatry that extends access to remote and isolated communities through a hub and spoke model. The MHP is in the process of launching a pilot to enhance cultural competency by linguistically matching patients and providers in a spoke to spoke model. Thirty-three languages are spoken by the DMH psychiatric workforce and are potentially available as needed to provide these enhanced culturally competent services. The program currently has more than 1,400 active clients (primarily adults). SA2 Contract Providers report that they receive referrals from the MHP, however their capacity is limited and finite due to challenges with staff recruitment and retention. Due to the fact that the provider is contractually obligated to accept referrals, the time between being entered into the system with an assessment and first clinical service appointment is lengthy. The largest challenge in adapting capacity at this time is recruitment of new providers, followed by retention of staff already employed. Contract Provider staff are using VANS to find clinicians with language capabilities. There is considerable variation on how often contractors are updating VANS to reflect current openings, from daily to monthly. Clinical staff users of VANS report difficulty in searching for program and language information simultaneously. . SA 5 went live with VANS October 2016. VANS was not noted as an issue insofar as finding information. However, all contract providers in the SA noted that Service Request Tracking System (SRTS) and VANS result in inappropriate referrals for services from providers outside of their service area. Underserved Cultural Communities (UsCC) Graduate Recruitment Program targets individuals (with a bachelor degree) from unserved/underserved communities who are committed to providing culturally and linguistically competent mental health services to communities. The program funds two years of a master's degree leading to a license in Clinical Social Work (LCSW), Marriage and Family Therapy (LMFT) or Professional Clinical Counseling (LPCC).
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP has staff embedded throughout the Systems of Care (SOC) and with partners in order to meet consumer needs. This includes schools, primary care, public health and law enforcement. The MHP participates in a collaborative with the City of Los Angeles Police Department (LAPD) and LA Sheriff's

Table 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			Department for co-response to calls from the community through the mental health evaluation team (MET). There are 32 clinicians embedded with LET for day crisis and another eight for the Case Assessment and Management Program (CAMP). About one-third to one-half speak Spanish. Data demonstrates a reduction in use of force as a result of this collaborative. The ACCESS Center monitors the calls for MET. Health Neighborhoods, at various stages of implementation, are active in all eight SAs. The collaboration with a variety of community based services and effective communication of resources available have increased both capacity and quality of service delivery. Continuum of Care Reform (CCR) initiative is part of the MHPs current strategies. Short Term Residential Therapeutic Programs (STRTPs), a new licensing category for congregate care placements, as well as Foster Family Agencies (FFA) contracting began in January 2017. Full implementation of CCR is expected to take approximately 18-24 months.

**FC =Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

Timeliness of Services

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

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP sets its standard for the length of time between initial contact and first appointment at 15 business days. This refers to the first appointment available provided to the client, whether accepted or not. The standard is met 92.15% of the time for Directly Operated Clinics in IBHIS data captured via the Service Request Log (SRL) (92.42% for adults and 89.96% for children). The standard is met 70.25% of the time for Contract Providers – data captured via the Service Request Tracking System (SRTS) (74.93% for adults and 68.11% for children). The standard is met 80.17% of the time for ACCESS Center 24/7 Line to track referrals using

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
			SRTS (83.06% for adults and 77.21% for children). The MHP also tracks time from initial contact to first appointment by preferred language. The MHP does not track from the time from initial assessment to first clinical appointment although this was noted as a problem area by the contract providers due to contractual obligations to fast track intake without regard to capacity.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	NC	The MHP does not track this indicator, although the MHP did present extensive policies regarding triage of presenting issues. These included emergent, expedited, immediate and routine appointment criteria.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The MHP sets its standard for the length of time for Urgent requests for the Medi-Cal Managed Care Appointment Line using IBHIS SRL at 5 business days and meets this standard 74.53% of the time (74.73% for adults and 75% for children). The standard set for Urgent requests for appointment referrals made through the Medi-Cal Managed Care Appointment Line using SRTS is 5 business days and meets this standard 90.71% of the time (89.08% for adults and 96.05% for children).
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP sets the standard for follow up appointments after hospitalization at 5 business days for Directly Operated sites. The standard is met 79.77% of the time (79.88% for adults and 77.38% for children). The MHP noted that this is a conservative measure as the referral date precedes the actual date of discharge is the date the MHP uses to calculate the measure.
2E	Tracks and trends data on rehospitalizations	FC	The MHP reports a 24% overall readmission rate goal, 27% standard for adults, higher than statewide average and 12.08% for children. Currently readmission rate for 30 days is 26.4% overall (29.2% for adults and 13% for children.)
2F	Tracks and trends no-shows	PC	Contract Providers' no shows are not tracked. No standard/goal is set for no shows for direct service scheduled in IBHIS. No shows for clinicians, non-psychiatrist calculated in IHBIS were 7.48% for all services (7.82% for adults and 5.85% for children). The rate for psychiatrists was 16.62% overall (16.95% for adults and 11.90% for children). No standard for no shows is established.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

Quality of Care

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

Table 8—Quality of Care

Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP has a current QI Work Plan with measurable QI goals and objectives. The department's Quality Improvement Council (QIC) which includes representative from all 8 SAs, meets monthly and each SA representative participates in the Service Area Advisory Committee. QI structure is centrally coordinated, and there were many projects being worked on linked to key issues. The QA/QM session also discussed how they linked to the service areas. The Service Area QIC Chairs reported reviewing the data from the central projects as it applied to their service areas. The discussion that followed reflected the SA Chair opinions that this worked for them and central QM worked with them, thus no separate QA/QM structure was needed at the Service Area level. Some of the areas discussed and worked on per the SA chiefs were identification of problems, analysis and action steps, access to care, and quality and the consumer perceptions of care from services in general and service providers. For example, in SA 5 a Peer Training Curriculum was being developed. QI Chairs report that they have difficulty getting consumers to be members of their QIC meetings. The consumers' feedback was that it was not interesting and more like a utilization meeting. The MHP seems to focus QI on compliance and gives less emphasis to using outcomes data and PIPs as tools for continuous quality improvement. SA2 reports that no contract providers have ever been involved in PIPs.
3B	Data are used to inform management and guide decisions	FC	The MHP measures and monitors data elements through various lenses which include STATS and dashboards. The MHP uses outcome measures tied to various

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			evidence based practices. The PEI programs use outcomes measures and state that it gives them as well as the consumers and family members concrete and tangible evidence of progress. The MHP provided to EQRO multiple examples and documents of EBP outcome tools. 73 Legal Entities (LE) providers are currently on IBHIS, including several of the MHP's largest providers (over 75,000 distinct clients served in FY15-16 across those 73 LEs). This also included Day Treatment providers as well as 4 FFS Medi-Cal provider network.
3C	Evidence of effective communication from MHP administration	FC	The MHP has well documented its communication with both directly operated and contract providers. SA2 and SA5 report that communication up the chain of command in their respective SAs is robust and effective. There are also various program-specific meetings where SAs report they get adequate information that they need from Central Administration and Leadership. The MHP Director's meetings with consumers and family members across the service areas to get their input and share his vision for future service delivery is met with enthusiasm. Those who have attended such meetings report that they feel informed and that they have a voice there. Consumers and family members in SA2 and SA5 access the website, receive fliers to keep them informed, learn of information through staff including the Wellness Outreach Workers (WOW), the SAACs, the National Alliance of Mental Illness (NAMI), Steering Committees, Town Hall meetings (also provides information in Spanish) and faith based collaborative meetings.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	Consumers and Family Members have a consistent and formal process for providing input into the Mental Health system planning and delivery of services including leadership roles in SAACs. District Chiefs agreed that they are part of the system planning as well as participants in key committees. All eight service areas have Advisory Committees (SAAC) that meets monthly in that SA. The SAAC is a forum for community members (to include consumers and family members) to give feedback and provide input to the MHP regarding access and timeliness of service delivery, needs and gaps in service, use of resources and community concerns. Each SAAC is co-

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			facilitated by two community stakeholders. Service Area Chiefs and staff expressed enthusiasm for the involvement of community input into the DMH. Another example of the LACDMH stakeholder process is the Cultural Competence Committee (CCC). For CY 2017, the CCC has implemented a workgroup that is focusing on the consumer/peer experience. The name of the workgroup is "System Transformation". Workgroup goals include: • Provide recommendations to improve linkage services and cultural competence training for peers • Research existing certifications The Underserved Cultural Communities (UsCC) subcommittees involve stakeholders in their six subcommittees and work closely and collaboratively with LACDMH in identifying capacity building projects aimed at reducing stigma and increasing outreach in a culturally competent and linguistically appropriate manner to these underserved populations. The MHP has an extensive network of providers and stakeholders, including former youth, parents, and parent advocates, that provide input on the services for youth in foster care.
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	In the interest of integrated services, dually diagnosed programs have mandatory shared treatment plans and coordinate care with primary care. MHP PEI is co-located in eight physical health clinics. The Primary Care Providers partner with mental health, substance abuse, public health and other services and support agencies in each Health Neighborhood to ensure that their patients/clients have access to the full array of services and other support resources provided in the community. The MHP partners with faith based organizations to facilitate outreach to underserved populations. The MHP collaborates with the other departments within the LA County Health Agency, Public Health and Health Services, to address the issue of the burgeoning homeless population in LA County.
3F	Evidence of a systematic clinical Continuum of Care	FC	The MHP currently utilizes over 35 EBP related outcome instruments, however it has yet to adopt specific system-wide instruments for all consumers. Contract providers in SAs 2 and 5 expressed a need for adopting a "train the trainers" approach to address the issue of staff turnover that at times leaves a provider without a certified EBP clinician.

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			CSOC contract providers state that there is a lack of adequate psychiatrists to support ongoing medication management for children. This is especially true when a child moves from specialty mental health to moderate or mild diagnosis treatment provider. Many providers are unwilling to do medication support when there is no therapy in place. Co-located in Department of Health Services (DHS) outpatient sites the MHP/DHS Collaboration Program provides short term mental health treatment to patients diagnosed with moderate depression and anxiety.
3G	Evidence of individualized, client-driven treatment and recovery	FC	The focus of the new MHP Director and reiterated by program staff is on wellness, personal recovery and community reintegration. This involves consumer involvement in treatment planning and service delivery, and a whole person approach. The MHP embraces the SAMHSA wellness and recovery model. Recovery language is used in the Adult SOC and resiliency in the CSOC. SAs 2 and 5 programs incorporate Wellness Recovery Action Plan (WRAP) workshops into their programs. This EBP focuses on the client guiding the treatment and recovery with the goal of wellness. WRAP is 100% consumer driven.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP Director specifically endorses the need to increase the roles of consumer and family members within the MHP systems of care. Approximately 500 WOW volunteers have been trained with more than 100 currently serving throughout the SOC. This is an entry level position which providers consumers and family members the experience to become eligible to be paid Mental Health Advocates, Community Workers and Senior Community Workers. The WOW volunteers would like the county and contract staff to have a better understanding of their roles and value to services. WOW volunteers reported that they sometimes feel devalued and misunderstood when working with clients in the clinics. The Director of Office of Consumer and Family Affairs reports to the MHP Director. The MHP is restricted by the county regulations of disclosure (federally protected right) in hiring practices for consumers with lived experience. The MHP continues to actively seek options for consumer employment through their contract providers. Consumer Employees are represented on the SA QIC

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			and SAAC.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	There are eleven client-run and driven well-being centers located within six of the eight MHP SAs. Many of the programs are entirely staffed by peers and the rest of the programs are primarily staff by individuals with lived experience. The MHP and contract providers have consumer/family member staff in all SOC. Consumer employees note that there is no career ladder to allow them to become full time benefited employees.
3J	Measures clinical and/or functional outcomes of consumers served	FC	Performance Outcomes and Quality Improvement (POQI) surveys are administered by the MHP two times a year. The PHQ-9 screen for depression and Columbia Risk Assessment are embedded in IBHIS. Consumer outcomes are collected through surveys, MORS, YOQ and other measures applicable to each EBP.
3K	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP routinely compares previous data collected from all surveys, to include the POQI. Program changes for quality improvement are made based in this information. Contract provider staff reported that it would be most useful if they received program specific survey results from surveys given across SOC. They MHSIP/POQI is provided to SAs and presented at QIC meetings.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Department of Public Health (DPH) and Department of Health Services (DHS) are partnering with Department of Mental Health Promotores on public health issues such as the Exide Battery Plant Soil contamination and vector borne illness such as Zika. Promotores access the community through door to door outreach and in the schools. This is designed to increase integrated care, to include access to mental health services by underserved communities.
    - The MET uses a risk assessment tool and the Columbia Suicide Scale as needed. The ACCESS 24/7 call center monitors the calls for MET. Beginning January

2017 the MHP tracks response time, disposition, homelessness, encounters and results.

- While the MHP ran a media campaign to reach several million people (i.e. commercials on television and radio), they did not compare Access call line data before and after to analyze the impact on engagement, enrollment and retention. Some clinics offering culturally specific services (i.e. Armenian, Farsi, and Native American) did receive calls and clients following the media campaign, and stakeholder input was incorporated into the ACCESS line script to ensure preferred language and cultural needs were addressed in a culturally responsive manner.
- VANS System does not currently show language specific appointment openings and therefore the person querying it doesn't know if a specific program with availability has the language capacity they need. Several programs suggested that the system needs to be searchable simultaneously for language and program. The MHP plans to include this capability in future upgrades of the VANS.
- Expectation of the UsCC Graduate Recruitment Program include a mandate that upon graduation from a master degree program, awardees are expected to work in either MHP directly operated or MHP contractor agencies servicing the underserved communities they represent.

- Timeliness of Services
  - Information collected in IBHIS is subject to limited validity checks in data fields where this functionality is available.
  - The MHP presented additional data of Service Delivery Timeliness Analysis by Preferred Language.
  - Some contractors reported that due to contractual obligation to not have a waiting list they accept and screen referrals. However, the time between initial assessment and first clinical appointment can, at times, be lengthy.
- Quality of Care
  - The MHP utilizes multiple EBPs. However, use of the outcomes to design programs is not consistent across SOC.
  - The MHP meets criteria of quality management and performance improvement being an organizational priority. The information appears to show a focus that is heavily on compliance versus on a true Continuous Quality Improvement (CQI) using outcomes data as tools.
  - The MHP is currently working on Mental Health Program Approval and Medi-Cal Certification of STRTPs and FFAs for the CCR initiative for the MHP.
- Consumer Outcomes

- Consumers are made aware of opportunities to be involved in Wellness Centers early in their treatment protocol. These centers offer multiple activities and self-improvement groups to support wellness and recovery.
- The Health Neighborhood provider networks based in particular geographic areas greatly enhance consumer ability to engage in a variety of services that increase positive outcomes of wellness and recovery for the residents of those communities. It also facilitates networking between providers for referrals and resource information collection.
- Survey outcomes are utilized across SOC to decide program changes for quality improvement.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

A culturally diverse group of 8 -10 Transitional Age Youth (TAY) beneficiaries receiving services within the past year, including a mix of existing and new clients who have initiated/utilized services within the past 12 months. Emphasis preferred TAY beneficiaries served by Service Area 2.

The focus group was held at TAY Drop-in Center a Village Family Services, 6801Coldwater Canyon Blvd. North Hollywood, CA 91604.

Number of participants – 5

For the 2 participants *who entered services within the past year*, they described their experience as the following:

- One person reported that it took two to three weeks to meet with a therapist.
- One person stated that it was only one week until an appointment with a psychiatrist.
- In general, both participants thought the services were good and felt understood and supported by staff.

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

- All of the participants reported that they have case managers and therapists.
- The participants generally agree that the services they receive have a positive effect on their wellness and recovery. They agree that the frequency of services is sufficient to their needs.
- All participants could note changes within themselves and progress in their recovery.
- Several of the participants engage in group or family therapy.

- No one in the group reported that they had needed a change in therapist or psychiatrist in the past year, but all said they could talk to their case managers if this were an issue.
- Several participants have attended support groups on topics such as stress managements, NAMI, and coping mechanisms. One attends Bridges Program which gives information about LGBTQ groups and resources.
- All participants were aware of how to contact their therapist if they need to see someone sooner than the scheduled appointment. All were aware of the after-hours number available to them if they need assistance, however none were aware of the term "warm line".
- The participants agreed that when they reach out for assistance that the provider's response is usually timely.
- When queried about wellness and recovery, only one had heard of WRAP. Three participants are part of developing their treatment plan.

Recommendations for improving care included the following:

- The participants agreed that transportation was an issue in accessing services and that some type of assistance from the county would be helpful.
- The general agreement among the participants was that more outreach and prevention programs were needed to support recovery.
- Service Area 2 has limited programs/clinics in the San Fernando Valley. Specifically, the group recommended more eating disorder treatment availability in their area.

Interpreter used for focus group 1: ☒ No ☐ Yes Language(s):

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

A culturally diverse group of 8 – 10 adult caregivers/parents of youth beneficiaries receiving services within the past year, emphasizing the Latino population served by Service Area 5.

The focus group was held at the Edelman Wellness Center, 11080 W. Olympic Blvd. Los Angeles, CA 90064

Number of participants – 7

For the singular participant *who entered services within the past year*, the experience was described as the following:

- The individual who began services within the past year reported that access was right away, a case manager was assigned and there was an appointment within a week.

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

- The participants all reported seeing a therapist every one to two weeks, which they considered adequate.
- All participants agreed that they see a psychiatrist and appointments run between one time a month and once every three months, depending on the need.
- The majority of the participants have a case manager. They report that the case manager is helpful with issues like housing and employment.
- Several of the participants reported they attended groups. Wellness groups are led by peers and clinical therapy groups are led by clinicians.
- Although most of the participants knew the crisis number to call, two of the monolingual Spanish speaking participants had no knowledge of this number. The participants reported that if they call the crisis number after hours it is routed to 9-1-1.
- One participant reported having participated in treatment planning at Edelman Clinic and stated that was standard practice at this clinic. Two other participants confirmed this statement. However, one monolingual Spanish speaking participant reported that this was not the case for that person. Two other participants stated that they participated in their treatment planning at the Wellness Center.
- Participants reported various stories of how they were receiving help in recovery. These stories included one participant who reported assistance in connecting with the Department of Rehabilitation to assist in getting back into the workforce. Another group participant reported receiving help from the case manager with selling artwork. One participant stated help was received from the MHP in seeking employment.
- All participants report that Wellness Center consumers are encouraged to give feedback and bring concerns to the staff's attention. One reported receiving a survey to complete in the past year. In general, all agreed that there is more information available to them at the Wellness Center than at the clinic.

Recommendations for improving care included the following:

- There was consensus among the participants that information is not as available to monolingual Spanish speaking consumer/family members and this needs to be improved in order to allow them to be aware of their resources.
- Participants agreed that there needed to be more outreach to Spanish speaking consumers to encourage attendance in groups and other activities.

Interpreter used for focus group 1: ☐ No ☒ Yes Language(s): Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

A culturally diverse group of 8 -10 adult beneficiaries receiving services within the past year, including a mix of existing and new clients who have initiated/utilized services within the past 12 months. Emphasis preferred Armenian speaking consumer/family members served by Service Area 2.

The focus group was held at Zev Yaroslavsky Family Support Center, Van Nuys. CA 91405.

Number of participants – 2

Note: Staff reported to EQRO reviewers that ten consumer/family members had confirmed they would attend this focus group. Possible reasons given that prevented this included 1) that the participants are part of a cultural group that does not like to venture too far from their residence and 2) there was a local freeway closure that caused traffic issues. It was suggested that EQRO might consider a location closer to the participants' residence area in future times this group is scheduled.

There were no participants *who entered services within the past year*.

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

- Due to the small number of participants in the group, comments are included in general narrative at the end of this section of the report.

Recommendations for improving care included the following:

- Due to the small number of participants in the group, comments are included in general narrative at the end of this section of the report.

Interpreter used for focus group 1: ☐ No ☒ Yes Language(s): Armenian

CONSUMER/FAMILY MEMBER FOCUS GROUP 4

A culturally diverse group of 8 – 10 adult caregivers/parents of youth beneficiaries receiving services within the past year, emphasizing the population served by Service Area 5.

The focus group was held at 11303 Washington Blvd, Suite 200, Los Angeles, CA

Number of participants – 4

For the 2 participants *who entered services within the past year*, they described their experience as the following:

- Both participants felt the MHP services have been timely and useful to the child and family.
- One participant found services by searching and interviewing counselors at child's school, talking to friends, and searching on line. The other participant was referred by Child Welfare Services (CWS).

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

- The participants all reported their children having one appointment a week with a therapist.
- Some participants said their children received Wraparound services and they participated in team meetings.
- The participants varied as to whether services were delivered during school. Some were and some said that the school district they were in did not allow outside of school therapists to come in to deliver services.
- Only one participant stated there was a psychiatrist involved in the child's treatment. Appointment frequency was said to be sufficient.
- All participants agreed that they had received offers to participate in a support group.
- All participants agreed that they knew who to contact if they needed assistance between appointments. All agreed that they knew who to call if the situation was urgent or an emergency.
- All participants agreed that their language and/or cultural needs were met by the staff providing them services.
- One participant had been asked to complete a survey.

Recommendations for improving care included the following:

- The participants generally agreed that information through text and/or email of meetings and resources available would be the most useful way to receive the information.
- All concurred that extended hours of services to accommodate family needs, especially evening hours, would be useful.
- After hours clinical staff that can be reached by telephone when not an emergency situation was recommended by the group.
- The participants all agreed that they would like to see a Mental Health Awareness night for parents and students at the schools.

Interpreter used for focus group 1: ☐ No ☒ Yes Language(s): Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Some Spanish speaking Consumer/Family members reported that they are hesitant to seek services at any official county location since January 2017 due to their perceived issue concerning immigration.
  - Expansion of service hours into the evenings and/or weekends would increase consumers' ability to engage in treatment.
- Timeliness of Services
  - The majority of the participants concur that access to assessment is timely.
  - The time between initial assessment and first clinical appointment is lengthy at times.
- Quality of Care
  - While the participants generally concur that they are involved in their treatment planning, there is not an overall understanding of the wellness and recovery model.
  - The participants for whom English was not their preferred language concurred that forms and/or information from the MHP are mostly in English, followed by Spanish. Other languages are not as readily available.
  - The majority of participants report they are involved in their treatment planning and ongoing treatment decisions.
- Consumer Outcomes
  - The majority of the focus groups participants were not aware of being asked to complete any type of satisfaction survey.

INFORMATION SYSTEMS REVIEW

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's 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 ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 9—Distribution of Services by Type of Provider

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

- Percentage of total annual MHP budget is dedicated to support information technology operations: (includes hardware, network, software license, IT staff)

  1.98%

- Consumers have on-line access to their health records either through a Personal Health Record (PHR) feature provided within EHR or a consumer portal or a third-party PHR:

  ☒ Yes ☐ In Testing/Pilot Phase ☐ No

  My Health Point

- MHP currently provides services to consumers using a telepsychiatry application:

  ☒ Yes ☐ In Testing/Pilot Phase ☐ No

  - If yes, the number of remote sites currently operational:

8

- Four Legal Entities also provide telepsychiatry services: Didi Hirsch, El Dorado, Hathaway Sycamore, and Pacific Clinics.
- Direct services through telepsychiatry practitioners are available in the following languages (does not include the use of additional translators) (e.g. English, Spanish): Farsi, Spanish, and Ahmaric.
- A pilot is planned to provide direct services through telepsychiatry with providers that speak Armenian, Russian, and Mandarin.

- MHP self-reported technology staff changes since the previous CalEQRO review (FTE):

Table 10 – Summary of Technology Staff Changes

Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
180	22	17	29

- MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE):

Table 11 – Summary of Data Analytical Staff Changes

Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
33	5	3	4

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

- Table 10 provides the summary of technology staff changes since the previous CalEQRO review. As noted, CIOB did experience a significant percent of technology staff turnover, but did hire more staff than left.
- Slightly more than 15% of the technology items (29) remain unfilled. It's a huge effort to attract and retain staff with the level of expertise necessary to support such complex operations. Staff recruitment and retention is beyond the control of the MHP or Health Agency to effectively address and respond to – County Human Resources needs to identify and address recruitment and retention issues.
- Office of STATS and Informatics is responsible for data analytical support and is allocated 33 full-time equivalent items (positions). Table 11 provides a summary of staff changes since the previous CalEQRO review.
- Approximately 12% of the data analytical items are unfilled.

CURRENT OPERATIONS

- Currently all directly-operated (county) sites exclusively use Integrated Behavioral Health Information System (IBHIS). This includes sites where MHP staff are co-located with DHS, DCFS, and Medical HUB's.
- Integrated System (IS), the legacy system, is being replaced by IBHIS for all LEs, Fee-for-Service Hospitals and Fee-for-Service providers. Sierra-Cedar, Inc. is the vendor for IS and continues to support its operations during the cutover transition phase.
- As of April 2017, seventy-three (73) LEs and two (2) Fee-for-Service providers have achieved EDI Claims Certification LIVE Status and no longer use the IS for current operations.
- Netsmart Technologies hosts the Primary Data Center for IBHIS; which is located in the state of Ohio. The Secondary Data Center is located in Kansas.
- The MHP connects to IBHIS through a dedicated 1Gb fiber connection to the Primary Data Center. A failover VPN mesh topology is in place in the event there is a network outage via the dedicated fiber connection.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 12— Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar/IBHIS	CalPM, MSO, Billing, Provider Connect, Care Connect, My Health Point	Netsmart Technologies	4	Vendor IS/CIOB
OrderConnect	ePrescribing, eLabs	Netsmart Technologies	4	Vendor IS/CIOB
Pharmacy Adjudication and Tracking System (PATS) (To be decommission 2017)	Pharmacy	County ISD	21	CIOB
Integrated Systems (Legacy system)	Practice Management, Billing	Sierra-Cedar, Inc.	15	Vendor IS/CIOB
DMH Data Warehouse	Data Warehouse and Reporting Environment	CIOB	12	CIOB
Verizon Call Center	ACCESS Call Center	Verizon	4	Vendor

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans to replace the current EHR system – Integrated Behavioral Health Information System (IBHIS).
- IBHS fully supports EHR functionality and SD/MC billing and other State reporting requirements for Directly Operated (DO) sites and for those Legal Entities (LEs) who have transitioned.

ELECTRONIC HEALTH RECORD STATUS

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

Table 13—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Avatar/IBHIS	X			
Assessments	Avatar/IBHIS	X			
Document imaging/storage	Avatar/IBHIS	X			
Electronic signature—consumer	Avatar/IBHIS	X			
Laboratory results (eLab)	Avatar/IBHIS	X			
Level of Care/Level of Service	OrderConnect/IBHIS	X			
Outcomes	Avatar/Outcomes Measure Application (OMA)	X			
Prescriptions (eRx)	OrderConnect/IBHIS	X			
Progress notes	Avatar/IBHIS	X			
Treatment plans	Avatar/IBHIS	X			
Summary Totals for EHR Functionality		10	0	0	0

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

- Table 13 ratings are based on IBHIS/EHR implementation only for Directly Operated (DO) sites. Legal Entities (LEs) are required to implement local EHR systems and use EDI transactions to support two-way exchange of data between their local system and IBHIS.

- Legal Entities who cutover to IBHIS have the capability to view (look up) client's laboratory results via CareView portal. CareView application is a Netsmart Technologies product.
- Legal Entities who cutover to IBHIS have the capability to view (look up) client's prescriptions via CareView portal. CareView application is a Netsmart Technologies product.
- Legal Entities have full access to Outcomes Measure Application (OMA).
- Consumer's Chart of Record for county-operated sites (self-reported by MHP):

☐ Paper ☐ Electronic ☒ Combination

MAJOR CHANGES SINCE LAST YEAR

- Integrated Behavioral Health Information System (IBHIS) implementation remains an ongoing multi-year project with a number of sub-projects. The following lists significant initiatives that were completed or began during the past year:
- Onboarded about seventy-three (73) Legal Entities (LE) and four (4) FFS Providers
- Provided Personal Health Record awareness, training, and education – Phase II (at clinics for consumers)
- Implemented enhancements to the Practitioner Registration Maintenance application, e.g., lookup to the State NPPES NPI Registry
- Upgraded Biz Talk to Version 2013 to support LE onboarding operations
- Expanded integration infrastructure to support LE onboarding operations
- Enhanced Client Web Services to streamline the setup of client financial eligibility
- Optimized Avatar incremental Data Warehouse load
- Implemented ICD-10 diagnostic codes
- Re-established MHP IT governance
- Completed twenty-four (24) Physical Security assessments
- Integrated Security Awareness training into new hire orientation
- Retirement of Chief Information Officer (CIO) during 2016. The Assistant CIO assumed the acting duties and responsibility of CIOB operations while recruitment for permanent replacement is under way.

- Implemented Vacancy Adjustment and Notification System (VANS) countywide. Previously it was a pilot project in SA4 and SA5 to track and share real-time program capacity information.
- Continued to support Access to Care Data program
- Implemented Service Request Tracking System (SRTS) general enhancements
- Developed SRTS Access to Care report
- Implemented enhancements to Full Service Partnership Referral Tracking application (FSP-RTA)
- County Wide Master Data Management (CWMDM) System –MHP implementation – Milestone 1. Completed MHP Data Sharing with CWMDM
- Continued to support Meaningful Use Incentive Program, Stage 2 activities
- Implemented tele-psychiatry services
- Deployed MHP Desktop and Mobile support and improvements
- Migrated to County Centralized Microsoft Office 365, email and Skype for business migration
- Implement consumer/family access to computer resources (My Health Point)

PRIORITIES FOR THE COMING YEAR

- As of April 2017, approximately forty-seven (47) Legal Entities (LEs) and twenty-nine (29) Fee-For-Service Hospitals and the remaining Fee-for-Services providers continue to use Integrated System (IS), which has been operational for more than 10 years and supports Practice Management and SDMC billing and other State reporting requirements.
- IBHS onboarding of LEs remains a high-priority project. The current pace is to onboard anywhere from five to ten LEs each month.
- The twenty-nine (29) Fee-for-Service Hospitals are scheduled to cutover later this calendar year.
- The following significant initiatives are currently in various stages of development:
- Access to Care
    - Service Request Log
- Coordination of Care
    - IBHIS Contract Provider Onboarding

  - Countywide Master Data Management (CWMDM) IBHIS to MHP MDM Integration
  - Los Angeles Network of Enhanced Services (LANES)
  - Whole Person Care
  - Wraparound Tracking System
  - Pharmacy Benefit Management (PBM)
- Data Management
  - Data Warehouse Redesign
  - Homeless Reporting
  - Outcome Measures Rationalization
- Infrastructure
  - Help Desk/Service Management Suite (HEAT) Upgrade
  - IBHIS Integration Infrastructure Expansion
  - Migrate to County Enterprise Mobility Management Solution
  - Windows 10 Upgrade
  - Migration to CACTUS Provider Credentialing System
  - Asset LifeCycle Management System
  - Data Center Consolidation
- Risk Mitigation
  - Information Security Framework

OTHER SIGNIFICANT ISSUES

- CIOB continues to support two mission-critical systems - IBHIS and IS for the next 12 months or so as IBHIS rollout to LE's approaches a tipping-point phase. The retention of subject matter expert technology and billing staff are critical while both systems produce revenue and support state-reporting requirements.
- CIOB Help Desk continues to lack sufficient staff resources to provide timely response for some Work Orders. A number of interviewed key informants reported timely response for non-expedited Work Orders (WOs) can extend to days, with the upper range being weeks before the WOs are resolved.

MEDI-CAL CLAIMS PROCESSING

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☐ Monthly ☐ More than 1x month ☒ Weekly ☐ More than 1x weekly

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

  ☒ Yes ☐ No

  If yes, product or application:

  Local SQL Database supported by CIOB

- Method used to submit Medicare Part B claims:

  ☐ Clearinghouse ☒ Electronic ☐ Paper

Table 14 – Los Angeles Summary of Short Doyle/Medi-Cal Claims

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
4,437,348	$876,609,270	$20,273,837	2.31%	91,189	$856,335,433	$4,416,469	$851,918,964

Note: Includes services provided during CY15 with the most recent DHCS processing date of May 19, 2016.

- The MHP tracks directly operated sites' performance via Claim Submission Lag Time Summary graph used by Strategies for Total Accountability and Total Success (STATS). The graph represents a floating 13 month range by provider and is produced monthly.
- The MHP Program liaison staff monitors Service Area contract providers to ensure services are entered correctly.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - Universal Screening uses a standardized process to evaluate whether an individual should receive an access to care initial clinical appointment. The same set of questions and data elements are currently recorded in either Service Request Log (SRL) for Directly Operated sites, or, Service Request Tracking System (SRTS) application for contract providers, or, ACCESS Call Center screenings.
  - Vacancy Adjustment and Notification System (VANS) to track and share program capacity information is operational system wide – Directly Operated sites, contract provider's, and ACCESS Call Center. This allows staff the ability to determine the best site to send a request for timely access to service. However,

as is noted elsewhere in this report, there are some issues with timely update of VANS.

- The use of tele-psychiatry services by the MHP to serve consumers who live in remote Service Areas continues to expand; and there are now four contract providers who provide tele-mental health services.
- Tele-mental health services program is expanding to track services for LA Care consumers with mild to moderate mental health diagnoses who are elderly or transportation challenged is operational. Case managers are onsite with individuals and use laptop network for connectivity with psychiatrist.

- Timeliness of Services
  - Both SRTS and SRL applications provide directly operated and contract provider's staffs' access to individuals request for service referrals.
  - Electronic referral to primary care is now operational. San Fernando Mental Health, directly operated site, and Tarzana Treatment Center (primary care site) securely exchange clinical documents and data.
- Quality of Care
  - Improved bi-directional care between primary care providers and mental health programs, including the care need of individuals with co-occurring disorders.
  - Legal Entities, who cutover to IBHIS, have the capability to view (look up) individual's laboratory results via CareView portal. CareView application is a Netsmart Technologies product.
  - Since June 2016, over 52,000 individuals have gained access to their personal health record information through My Health Point application.
- Consumer Outcomes
  - Many of the outcome measures are used to evaluate Early Intervention services funded through Mental Health Services Act. Outcomes are communicated through reports created for providers to help manage their data. Summary reports are distributed widely once a quarter.

SITE REVIEW PROCESS BARRIERS

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

- The Armenian CFM focus group had only two participants. This is an insufficient number to survey access, timeliness and quality of service delivery in SA2. The report of this CFM Focus Group is generalized in order to protect the participants' anonymity.
- There were no other barriers or conditions that significantly affected CalEQRO's ability to prepare for and/or conduct this review.

CONCLUSIONS

During the FY16-17 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
    - The MHP's electronic Service Request Log (SRL) and Service Request Tracking System (SRTS) applications, along with Vacancy Adjustment Notification System (VANS) have improved the awareness of capacity and improved access for consumers.
    - The continuing development of the Health Neighborhoods in all eight SAs has helped in making resources available to those reluctant to seek mental health care due to stigma or lack of information of resources. It is also providing information of resources available for those who do not meet medical necessity for specialty mental health.
- Opportunities:
    - The contract providers report issues with capacity in that they often use the number of client slots they are to serve before the end of the contract year.
    - Contract providers noted that SRTS and VANS result in inappropriate referrals (out of SA or not within scope of contract) for services from providers outside of their service area.

Timeliness of Services

- Strengths:
    - The Vacancy Adjustment Notification System (VANS) helps providers receive accurate information of vacancies on a timely basis in order to increase timeliness of referrals to appropriate services. All contract providers have access to VANS.
- Opportunities:

- As reported by contract providers, only two people per legal entity can access VANS to update/edit information. This results in a bottleneck in entering and retrieving information for larger contractors.
- SA5 Navigators reported that they do not use VANS because they effectively manage the slots. They report VANS is not always accurate and up to date.
- The MHP sets its standard for timeliness for Urgent requests at five days, which is longer than most of the other California MHP standards and exceeds national standards.
- The MHP does not have a goal/standard for No Shows for Direct Services.
- The MHP does not capture timeliness to initial psychiatry appointments.

Quality of Care

- Strengths:
  - The depth and breadth of peers involved in the MHP SOC is noteworthy.
  - The MHP incorporates 37 EBPs, PPs, and CDE practices within its PEI program.
  - The MHP routinely utilizes survey outcomes across the SOC to decide program changes for continuous quality improvement.
  - The UsCC Graduate Recruitment Program addresses access issues of unserved/underserved communities by recruiting from those communities, offering funding for graduate education which leads to a two years master degree that is utilized working in the communities they represent in an MHP directly operated or contractor agency.
- Opportunities:
  - Lack of career ladders inhibits peers from developing professionally within the MHP.
  - Requests for service that are assessed as "Urgent" need a better definition that is the same for directly operated and contracted provider organizations.
  - Both recruitment and retention of staff continue to be an issue for contractors and directly operated positions. This continues to create challenges in continuity of care and maintenance of adequate staffing capacity. The MHP and contractors continue to struggle with salary and benefit parity. Lack of an expeditious hiring timeline for direct operations staff is a deterrent for recruitment.
  - In the past, psychiatrists attended case consultations and discussed medications, side effects, medical issues around medication compliance and extrapyramidal symptoms (EPS). This is no longer done. Staff members report this would be useful for treatment planning if reinstated.

Consumer Outcomes

- Strengths:
    - The Cultural Competency through Underserved Cultural Communities activities continue to increase access and information delivery to the underserved communities in LA County.
    - The MHP has effectively leveraged MHSA Innovations funds for various cultural competency programs.
- Opportunities:
    - Contract Providers state that they are not involved in PIPs. This loses an opportunity for performance improvement studies that affect consumers served by these organizations.
    - Contract Providers stated that they do not receive data back from MHP on outcome measures. This would be useful for program planning and establishing staffing needs to facilitate positive consumer outcomes.

RECOMMENDATIONS

- (For September 2017 review – FY17-18) Begin to track timeliness from assessment to first clinical appointment. This will give a more accurate analysis of capacity in order to plan for program staffing needs.
- (For September 2017 review – FY17-18) Ensure there are two PIPs rated as active by CalEQRO on an annual basis during EQRO review.
    - Use available data to identify issues that can be addressed through a PIP. Create a list of possible future PIPs (EQRO is offering TA to assist in this area).
- (For September 2017 review – FY17-18) Continue to provide sufficient technical assistance resources for both legal entities and the Electronic Health Record (EHR) vendors during the Integrated Behavioral Health Information System (IBHIS) go-live roll-out and post go-live transition as the systems conversion is mission-critical for the MHP.
- (For September 2017 review – FY17-18 and September 2018 review - FY18-19) The MHP has depth and breadth of peer involvement across SOC. Investigate the feasibility of creating a system for peer/lived experience employment that includes a career ladder for those now volunteers and stipend paid lived experience staff in order to facilitate professional development. Research how these positions might be implemented to address some of the capacity issues that challenge the MHP.

- (For September 2017 review – FY17-18 and September 2018 review - FY18-19) Investigate if SRTS and VANS result in inappropriate referrals (referrals from out of SA when not appropriate, or referrals out of scope of contract for provider) for services from providers outside of their service area. Evaluate if additional business rules and staff training are necessary to further improve complex referral processes.
- (For September 2018 review - FY18-19) Caseloads reported by staff point directly to system capacity issues. This lends itself to the issue of staff recruitment and retention. Recruitment of licensed staff was discussed in sessions during the onsite portion of the review.
    - Create a study of retention by type of staff as juxtaposed to average caseloads.
    - Investigate further incentives that might be initiated for both recruitment and retention of licensed staff.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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

Table A1—EQRO Review Sessions - Los Angeles MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations
Contract Provider Group Interview –Quality Management
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Tele Mental Health
Access Call Center Site Visit
Wellness Center Site Visit
Contract Provider Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Della Dash, Sr. Quality Reviewer
Ewurama Shaw-Taylor, Quality Reviewer
Saumitra SenGupta, Executive Director, CalEQRO
Bill Ullom, Chief, Information Systems
Rama Khalsa, Director, CalEQRO DMC-ODS
Marilyn Hillerman, Consumer Family Member Consultant
Deb Strong, Consumer Family Member Consultant

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

Sites of Review

MHP SITES

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Los Angeles, CA 90020

695 S. Vermont Avenue
Los Angeles, CA 90020

SA2- Zev Yaroslavsky Family Support Center
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Van Nuys, CA 91405

San Fernando Mental Health Center
10605 Balboa Boulevard
Granada Hills, CA 91344

SA5-WLA-GI
11303 W. Washington Blvd.
Los Angeles, CA 90066

Edelman Wellness Center
11080 W. Olympic Blvd.

Los Angeles, CA 90064

CONTRACT PROVIDER SITES

The TAY Drop-in Center at Village Family Services
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Solazzo	Dayna	Clinical Supervisor	The Help Group
Sorg, MD	Jim	Director of Information Technology	Tarzana Treatment Center
Soria	Alejandro	Clinician	The Village

Soulier	Yanela	Acting Human Resources Manager	LACDMH
Spallino	James	Information Technology Specialist I	Chief Information Office Bureau
Stanley	Paul	Data Analysis	Child & Family Ctr
Stone	Maria	Clinician	Hillview MHC
Suarez	Ana	Mental Health Clinical Program Manager III	LACDMH
Suciu	Denisa	PSW	LACDMH WVMHC
Sultanian	Maral	Program Mgr	Pacific Clinics
Taguchi	Kara	Mental Health Clinical Program Head	LACDMH
Tan	Maria	Volunteer ASOC Bureau	DMH
Tate	Kanchana	Mental Health Clinical Program Manager I	LACDMH
Tavlin	David	QM Director	Step Up on Second
Taylor	Romalis	African/African American (AAA), Underserved Cultural Communities Subcommittee Co-Chair	Community Member
Tayyib	Neelofer	Clinical Psychologist II	LACDMH
Tewksbury	Tracie	Clinician	Child & Family Ctr
Thomas	Ken	Community Worker	DMH
To	Kary	Clinical Psychologist II	LACDMH
Torres	Laura	Intake Coordinator	Hillview MHC
Tran	Lisa	Senior Accountant/Financial Analyst	Aviva Family And Children's Services
Tredinnick	Michael	Mental Health Clinical Program Manager I	LACDMH
Trias-Ruiz	Rosalba	Supervising Psychologist	LACDMH
Tripodis, MD	Konstantino	Supervising Psychiatrist	LACDMH SFMHC
Tsai	Gary	Medical Director – Substance Abuse Prevention & Control	DPH SAPC
Um	Harry	PSW I	DMH Edelman
Valdez	Julie	Mental Health Clinical Program Manager III	LACDMH
Valdovinos	Esther	UR Nursing Supervisor	SAPC
Valle	Joselyn	Facilitator	The Help Group
Van Sant	Karen	Acting Chief Information Officer	LACDMH Chief Information Office Bureau

Velassco	Carlos		The Help Group
Vines	Dara	Clinical Psychologist II	DMH
Walters	Jessica	Supervising Psychologist	LACDMH
Walters	Terri	Community Worker	DMH
Weissman	Brittney	Executive Director	NAMI LA County Council
Wells	Michelle	Dir Child Adolescent & TAY Services	SFVCMHC, INC.
Whittington	Yolanda	Mental Health Clinical District Chief	LACDMH
Wicker	Lisa	MH Clinical District Chief	LACDMH Health Care Reform Operations Unit
Wilcuxen	Jacquelyn	District Chief, DMH	DMH
Wilkerson	Kelly	Psychiatric Social Worker II	LACDMH
Williams	Richard	WOW Ambassador	Edelman
Williams	Stacy	Mental Health Clinical Program Manager III	LACDMH
Willock	Yvette	Program Manager	Managed Care Division, Head Medical Director
Wong	Lisa	Mental Health Clinical Program Manager III	LACDMH
Wright	Toni	Peer Advocate	St. Joseph Center
Xie	Fang (Aka Colin)	PSW Child Navigator	LACDMH
Ximenez	Leticia	Cultural Competence Committee Co-Chair, Mental Health Services Coordinator II	LACDMH Office of the Director
Yam	Philip	Principle App Dev.	LACDMH
Yamata	Mariko	ED	St. Francis
Yaralyan	Anna	Clinical Psychologist II	LACDMH
Young	Cheyna	Clinician	Exceptional Children’s Foundation
Zaldivar	Richard	Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, Two-Spirit (LGBTQI2-S), Underserved Cultural Committees Subcommittee Co-Chair	The Walls Las Memorias Project
Zapata	Gabriella	ITC SB 82 Team	LACDMH
Zubiate	Sonia	Mental Health Services Coordinator II	DMH

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

Approved Claims Summaries are separately provided to the MHP in a HIPAA-compliant manner.

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands. The actual counts are suppressed for cells containing n ≤11.

Table C1 shows the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal ACA Expansion Penetration Rate and Approved Claims per Beneficiary.

Table C1—CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary
Los Angeles

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,045,306	131,350	4.31%	$533,318,886	$4,060
Large	1,497,986	63,298	4.23%	$263,166,307	$4,158
Los Angeles	929,847	41,317	4.44%	$163,006,777	$3,945

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

Table C2—CY15 Distribution of Beneficiaries by ACB Range
Los Angeles

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
$0K - $20K	150,374	94.18%	94.46%	$609,546,407	$4,054	$3,553	64.01%	61.20%
>$20K - $30K	4,729	2.96%	2.67%	$114,844,969	$24,285	$24,306	12.06%	11.85%
>$30K	4,565	2.86%	2.86%	$227,880,311	$49,919	$51,635	23.93%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 CLINICAL PIP

GENERAL INFORMATION	
MHP: Los Angeles	
PIP Title: Implementation of Family Resource Centers (FRCs) to Improve Access and Continuity of Care	
Start Date: Postponed to 07/01/2017 **Completion Date**: 06/30/2019 **Projected Study Period**: 24 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 04/10-13/2017 **Name of Reviewers**: Lynda Hutchens, Della Dash	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted

Brief Description of PIP:

Family Resource Centers (FRCs) are specifically designed to serve Children/Youth (0-21 years) who no longer require an intensive level of mental health services and are transitioning to a higher level of resiliency and their families/caregivers. Services will also be available to Children/Youth who do not have a prior mental health treatment history and will benefit from FRC services. In order to address an identified gap in Child/Youth services for those no longer requiring an intensive level of mental health services, the related continuity of care issues, and the gap in supportive services for parents of Children and

Youth with SED, LACDMH Children's System of Care Bureau (CSOC) is implementing this Clinical PIP that involves implementing FRCs as an important intervention. Parent Advocates (Community Workers) are integral to FRCs.

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	Team of stakeholders that consists of FRC Project Leads from the Children's System of Care (CSOC) Administration, Quality Improvement Division (QID), as well as managers, supervisors, and key staff from FRC programs in SA2, SA3, SA4 and SA8. While the PIP team includes both a parent advocate and a family advocate, both are MHP employees, and no other consumers or family members participate on the PIP team.
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	Per estimated prevalence rates of SED by Age Group for the County provided by UCLA California Health Interview Survey (CHIS) for Medi-Cal population (March 2015), a total 148,237 Children and TAY have been estimated with SED. Based on the total consumers served in FY14-15 (N = 109,215) there is an identified gap in services for both children (0-15) and TAY (16-25).

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 FRC's contribute to the provision of a continuum of care by providing lower level services (higher level of recovery) for youth consumers who are transitioning from intensive outpatient services (FSP, FCCS, PEI-medication only) and walk-ins who meet medical necessity, have no prior LACDMH treatment history, and may benefit from FRC services. The FRC's aim to decrease the need for urgent care and (re)hospitalizations for this population. The program provides services for the resiliency of both the consumer and their family and parents/caregivers.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP includes a subset (estimated to be about 5%) of the 6,000 youth enrolled in FSP, FCCS, PEI-medication only programs. It also includes walk-ins who meet medical necessity, have no prior LACDMH treatment history, and may benefit from FRC services. The subset includes approximately 200-300 youth (birth to 21 years of age) who demonstrate moderate symptoms of SED and no longer meet the criteria for enrollment in intensive outpatient services, as well as walk-ins. It would be advantageous to include a phased approach of outreach and engagement for the wider population of SED youth in LA (148,237) in general, and specifically the SED youth included in the 109,215 total consumers served in FY14-15.
	Totals	**Met** **Partially Met** **Not Met** **NA** **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:* 1. Will the implementation of FRCs at existing Children's Mental Health Clinics (MHCs) result in: a) transitioning Children and Youth (who no longer need an intensive level of services) to a higher level of resiliency and b) enrollment of clients who have no prior LACDMH treatment history and may benefit from FRC services? 2. Will enrollment in the FRCs result in: a) a reduction in frequency of hospitalizations and b) a reduction in Urgent Care visits for Children and Youth that transitioned from FSP programs at 3 months and 6 months post enrollment? 3. Will implementation of the FRCs result in 85% of the clients enrolled in FRCs reporting high satisfaction rates (means of 3.5 and higher) on the "General Satisfaction," "Perception of Access," "Perception of Cultural Sensitivity/Quality and Appropriateness," and "Perception of Participation in Treatment Planning" subscale measures of the Youth Satisfaction Survey (YSS; 13-17 years), the YSS- Family (YSS-F; 0-17 years), and the Adult Consumer Survey (18+ years) at 3 months and 6 months post enrollment? 4. Will the implementation of the FRCs result in an increase in Family Support Services to parents/family members of Children and Youth being treated at Children's MHCs?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The overall study question is comprehensive and partially measurable. To strengthen the question, the following is suggested: 1. The first part of the study question is unclear and needs to be further defined: a) …transitioning children and youth – is this operationally or clinically? It would also be helpful to add "as evidenced by…" and then add some measure such as improved scores or functional status scales. Also it would be helpful to identify the mechanism/criteria used to determine "transitioning". 2. Would it be possible to quantify the "reduction" in each part of this question (e.g. by x%). 4. "…result in an increase…" It would be helpful to quantify by how much. For instance, what % could be considered "successful" and over what period of time?
	Totals	**Met** **Partially Met** **Not Met** **NA** **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: SED	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Children and Youth (birth to 21 years of age), their parents/relatives and other caregivers. Eligible clients will be those who demonstrate moderate symptoms of SED and no longer meet the criteria for enrollment in FSP/FCCS/PEI programs or services. Further, children who do not have a history of mental health treatment and may benefit from FRC program services will also be eligible.

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: Claims	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Criteria include disenrollment from intensive outpatient program by demonstrating treatment goal progress associated with decreased hospitalizations (e.g. suicidality), increased socialization, and/or improved school performance.
	Totals	**Met Partially Met Not Met NA UTD**
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Study Measure 1: Track number of unique clients transitioned to a higher level of resiliency following implementation of the FRCs at the Children's Mental Health Centers (MHCs and number of client enrolled who have no prior LACDMH treatment history. Study Measure #2: Track reduction in the use of inpatient and urgent care services at three and six months post enrollment in FRCs. Study Measure #3. Report satisfaction rates for clients and their families on the four subscales of the YSS, YSS-F, and Adult survey at three and six months post enrollment in FRC services. Study Measure #4: Track number of services provided (claims) to parents/family members and the unduplicated number of parents/family members receiving these services.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP lists both Study Measures and Quantifiable Measures. The study measures are objective, clearly defined and measurable. The quantifiable measures would benefit from the following consideration: 1. a) "Number of unique FRC clients served that were referred…". It would be advantageous to track BOTH those referred AND those ENROLLED. Referral is not sufficient since this measure does not reach consumer outcomes. 2. b) "Decrease in the number of urgent care visits…""urgent care" needs to be defined – is this crisis at a CSU, or urgent in a clinic? This is unclear. 3. The PIP lacks an indicator that measures recidivism to FSP by clients who have enrolled in FRC.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP lacks a discussion of "length of stay (LOS)" anticipated in the FRC. Developing a metric around enrollment LOS would be helpful as a counter-measure to hospitalization/rehospitalization and urgent/crisis service utilization. The PIP does not include indicator goals.
	Totals	**Met Partially Met Not Met NA 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 will be involved in this PIP.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The sampling is based on availability of supervisors and not the number of calls. Because of that,
	Totals	**Met Partially Met Not Met NA 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 design does not include the data to be collected. The indicators list various data including consumer surveys, hospitalizations, urgent care visits, clients served and services provided.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☐ Provider ☐ Other: <Text if checked>	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study design does not specify sources of data other than members completing surveys.
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 study design does not include a systematic method of collecting valid and reliable data.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: <Text if checked>	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP does not specify instruments to be used for data collection other than consumer surveys.
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	There doesn't seem to be a detailed data analysis plan, which is a basic requirement of a PIP. This section needs to be fully articulated.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: <Text> Title: <Text> Role: <Text> *Other team members:* Names: <Text>	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The PIP does not articulate who will be responsible for data collection. The PIP does include the names and titles of stakeholders involved in PIP development, and lists their activities in the design and initial planning stages.
	Totals	**Met** **Partially Met** **Not Met** **NA** **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. Implementation of the FRCs to provide continuity of care services for those who no longer require an intensive level of mental health services and are transitioning to a higher level of resiliency and to improve access to care those who have never received LACDMH services but may benefit from FRC services.* *2. Implementation of the FRCs to provide Family Support Services to parents/family members of Children and Youth.*	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	The PIP lists only two interventions, neither of which has been initiated or implemented. Interventions regarding the establishment and initial stages of the PIP rollout are not listed. The PIP states that, "FRC interventions are pending at this time", and the date applied to both interventions is "Pending Approval".
	Totals	**Met** **Partially Met** **Not Met** **NA** **UTD**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals		**Met Partially Met Not Met NA UTD**

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

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

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

Conclusions:

This PIP is currently being designed and no implementation has yet begun. The Clinical PIP is therefore Concept Only.

The concept, justification and clinical model for this PIP are well articulated, as is the gap in service availability for SED youth.

Recommendations:

The MHP is encouraged, pending approval, to implement the steps of this PIP, and consider the suggestions listed in this Validation Tool to strengthen this submission.

Check one:

☐ High confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results

☒ Confidence in PIP results cannot be determined at this time

☐ Low confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 NON- CLINICAL PIP

GENERAL INFORMATION

MHP: Los Angeles

PIP Title: ACCESS Center: Implementing the QA Protocol at the Access Center

Start Date: 07/01/2016

Completion Date: 06/30/2018

Projected Study Period: 24

Completed: Yes ☐ No ☒

Date(s) of On-Site Review: 04/10-13/2017

Name of Reviewer: Lynda Hutchens

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:

PIP involves implementation of a Quality Assurance (QA) Protocol within the ACCESS Center (AC). AC test calls and evaluation of a small percent of actual received calls showed three areas for improvement addressed by PIP: AC Call Center Agents requesting Caller's/Client's name, Customer Satisfaction, and Documentation of calls. This PIP is an effort to address these three issues by implementing the QA Protocol process. The process is non-punitive designed to improve service delivery, customer service and documentation of calls information.

The PIP is evaluating 0.26% of real calls (32 calls per month x 12 months = 384. 384/147,565 calls received = 0.26%)

This Non-Clinical Performance Improvement Project (PIP) involves the Implementation of a Quality Assurance (QA) Protocol within the ACCESS Center (AC). Often the ACCESS Center 24/7 Line may be a Medi-Cal beneficiary caller's first point of contact with the Los Angeles County Department of Mental Health (LACDMH). The ACCESS Center operates the 24/7 Statewide, Toll Free number (1-800-854-7771) for both emergency and non-emergency calls. A variety of factors come into play when a caller makes that first call to the ACCESS Center 24/7 Line including individual factors such as stigma and fear, language barriers, practitioner factors such as communication, cultural attitudes, and language capacity, system factors such as wait times, lack of well qualified interpreters, and practical factors such as lack of time to call back if they are disconnected or don't get the information they called for. Therefore, it is very critical that the above potential barriers to access to care are systematically addressed. The AC test calls study result trends focusing on some of these barriers showed that there are three potential areas for improvement –AC Call Center Agents requesting Caller's/Client's name, Customer Satisfaction, and Documentation of calls. In order to address these three areas, LACDMH focused on implementing the QA Protocol at the AC as a Non-Clinical PIP for FY 16-17.

The QA Protocol process is non-punitive and designed to improve service delivery, customer service and documentation of calls information by: 1) evaluating monthly 24-32 random calls from the entire consumer population that call the ACCESS Center during the study period, 2) reviewing calls received on the 1 (800) line only, 3) providing feedback, consultation, and training all agents on the QA Protocol, 4) training all ACCESS Center supervisors on the QA Protocol and validation of the calibration process, and 5) reviewing the outcomes on a quarterly basis, This will enable MHP to address areas identified for improvement.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The stakeholders are those who work, supervise and are involved in Access, including members of the QIC, Children's Programs, Office of Consumer and Family Affairs, ACCESS Center staff, Adult Program providers, Service Coordinators, Research Analysts, and Medical Case Worker among others. The team also includes consumer/family member advocates. It would be helpful to know (1) if the advocates have experience with the Access Line and (2) who on the PIP team is bi- or multilingual in Spanish or any other language. The PIP team might benefit from representation by one of the three new vendors who provide translation services.

1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The main source of data and the foundation for the study was four-year (CY12 to CY15) trending of test calls. The team reviewed nine areas related to test call handling and identified three areas for improvement—the (number of) calls logged, request of caller's name, and caller's satisfaction. The team selected these areas because there was either an overall decrease in performance from CY2012-CY2015 or a one-year decrease from CY2014-CY2015. By this rationale, the team also should have included: (1) agent's name; (2) non-English calls; and, (3) assessment of crisis and emergency, as these also had either an overall decrease or a one-year decrease in the requisite time frames. Thus, the team's analysis and determination of/rationale for what should be studied is unclear.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-Clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP begins with an explanation of multiple factors that are barriers to access to services (e.g., individual level, practitioner level, systems-level, etc.). But, then the team does not explicitly link the Access Line to any of the identified barriers. The team goes on to provide considerable detail about call volume in CY15 and CY16, the number of non-English calls, and the number of calls in less than one minute. The only clear deficiency that the PIP is addressing is improving test call performance in certain areas.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP includes all Medi-Cal enrollees, including existing and pre-consumers, and anyone who may call the Access Line.
	Totals	**<2>** Met **<2>** Partially Met **<#>** Not Met **<#>** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* 1. Will implementing a Quality Assurance Protocol for the LACDMH 24/7 Hotline result in a ten (10) PP improvement in offering language interpreter service to callers who need this service in the fourth quarter of FY 2016-17 as compared with the First (Baseline) quarter of FY 16-17? 2. Will implementing a Quality Assurance Protocol for Los Angeles County Department of Mental Health (LACDMH) 24/7 Hotline result in an increase by ten (10) Percentage Points (PP) in the ACCESS Center actual calls where the ACCESS Center agent requested the caller's name in the fourth quarter of FY 2016-17 as compared with the First (Baseline) quarter of FY 16-17? 3. Will implementing a Quality Assurance Protocol for the LACDMH 24/7 Hotline result in an increase by five (5) PP in the demonstrated respect/customer service on actual calls in the fourth quarter of FY 2016-17 as compared with the First (Baseline) quarter of FY 16-17? 4. Will implementing a Quality Assurance Protocol for County LACDMH 24/7 Hotline result in: a. an increase by two (2) PP in the actual calls logged between "Pre-Post Study" periods and thereby lead to b. improved triage and related scheduling of appointments for consumers requesting Specialty Mental Health Services by two (2) PP?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is stated clearly and is time-bound; however, the measurable impact, particularly for consumers, was not articulated. The outcomes are related to the Access agent's *process* in handling calls, (e.g., logging calls, offering language assistance, and requesting caller's name) but stops short of impact on the consumer/caller. The closest the team comes to consumer impact is Question 3, rating of the agent's customer service and respect. Question 4 also has the potential for consumer impact, but the team does not articulate what is meant by "improve triage and related scheduling". Does this mean that triage will be faster? More appointments will be scheduled? Scheduling will be sooner? These were opportunities to measure the impact on consumers. Based on four-year trending of test calls, the team presented three areas for improvement—the (number) of calls logged, caller's name, and caller satisfaction. But in the study question, the team also intends to affect processing of calls for non-English speakers and scheduling of appointments. The inclusion of these two additional components warranted explanation. PIP needs to address consumers' outcomes, e.g. data that shows the interventions of interpreter services, requesting caller's name, referral process. Need to track how this effects outcomes as consumers are connected to services at a higher rate.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question defines the relevant Medi-Cal enrollees as those who call the Access line.
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: Call Recordings and Customer Service Evaluation Checklist	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study includes the entire population of callers. The callers could be from all geographic areas of the County. The callers could be both those with Limited English Proficiency who need interpreter services and English-speaking callers. The team will randomly sample some of the Access Line calls and, per the sampling methodology, the supervisor and agent will only review English and Spanish language calls. This may limit the benefit of this study to those consumers who speak English and/or Spanish. While English and Spanish are two of the primary languages in the county, there are many other threshold and dominant languages. At a minimum it would be useful to include threshold languages at the percentage that they are represented in the county. While the PIP document states that the study includes all callers and will "encompass both callers with Limited English Proficiency (LEP) who need interpreter services as well as callers who speak English", the study protocol only indicates review of calls in English and Spanish. This limits the benefit of the study to those who speak English and Spanish. The county has other threshold and dominant languages and therefore a greater probability of receiving calls in languages other than English and Spanish.
	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. Non-English calls were language interpreter services were offered 2. Calls where callers name was requested 3. Calls demonstrating respect/customer Service 4. Calls were agent provided referral to Specialty Mental Health Services 5. Calls document client information	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study does not have study indicators per se; the team presented the outcomes as indicators. But, indicators are also needed to track the team's performance in executing the study over time. No process indicators were included, such as percentage of agents trained on the QA protocol within a certain timeframe; the percentage of supervisory reviews that occur as scheduled (or monthly); percentage of calls appropriate for referral; and supervisor proficiency in rating calls/scoring of inter-rater reliability.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The indicators are the same as the outcome measures. Only referrals to services, Indicator 4, relate to change in functional status, wherein more consumers would be getting access to services. Indicator 3 is a proxy for satisfaction. The drawback is that it is from a third person perspective. Consumer's themselves do not weigh in on satisfaction of the call or receipt of information. The measure does not assess consumer' own satisfaction.
	Totals	**0** Met **1** Partially Met **1** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The team's sample attempts to capture the types of calls received by the Access line, including by language, time of day, and nature (i.e., Crisis, Ambulance, Referral and Informational). The team intends to sample 24-32 calls per month. This number is based on the supervisors (9-12) who will each conduct one call per week. Estimating that an average of 8 supervisors are able to review calls each month, then 32 should be the lower limit of calls, not the upper limit. Additionally, to capture the diversity of calls, the team should oversample to obtain adequate (or representative) numbers.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* Random.org site is used to select a random sample every week based on the number of supervisors available, across all shifts, English and Spanish and all types of calls such as Crisis, Ambulance, Referral and Informational, and AC agents.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	It is unclear how the sampling technique was carried out. First, the study indicated that actual calls will be evaluated, but did not indicate if these are live or recorded calls, presumably recorded. Second, it does not explain how the calls are linked to the reviewers. Per the discussion during the onsite review, the calls that are reviewed require the availability of both the supervisor and the agent who conducted the call. This suggests that the selection of calls are actually not random, as they do require some matching. However, Attachment 3E.1 ACCESS Center Call Recording Protocol provided by the MHP helps to explain sampling technique.

5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The sampling is based on availability of supervisors and not the number of calls. Because of that, the team did not (or could not) determine at the outset the number of calls for the study sample. A minimum number of calls should have been determined, which would not be dependent on supervisors.
	Totals	**0** Met **2** Partially Met **1** Not Met **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 does not explicitly state (in this section) what data will be collected. The team states that the data will be derived from the calls. There is also data related to volume or number that the team did not mention at all.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: ACCESS Center Quality Assurance (QA) Checklist	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study indicates that the source of data is the Access Center QA Checklist that is completed by supervisors, monthly (or weekly). Of note is that this checklist has many more components, over 30, than are part of the study. The team should have articulated what it intends to do with this information or how it relates to the four areas that they are intending on improving. A Customer Service Evaluation is referenced, but it is not explained how this is to be used. Similarly, the ACCESS/FRO Incident Tracking (referenced in the protocol) must also be used, but this is not stated.
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 team did not articulate their method of collecting data. The document only indicates that supervisors will review calls, but the process of review, meeting the agent, subsequent follow-up with the agent, completion and submission of the form, were not stated. The matching of the agent and the call (and potentially the supervisor) bears explaining.
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: Access Center QA Checklist	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The ACCESS Center QA Checklist is used by supervisors to rate the calls each month. While most of the variables on the checklist are objective (e.g., requested caller's phone number), some were subjective (e.g., spoke to caller in terms they could understand). It would be helpful if supervisors documented the evidence they used for their rating. Elsewhere it was mentioned that supervisors underwent some training to do the evaluation, the inter-rater reliability and certain level of proficiency of the supervisors should have been required prior (or stated) as the foundation for ensuring 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 data analysis plan states quarterly reviews only, without detail about how the data is to be analyzed. The plan does not include contingencies for (future) untoward results, only stated that they will be addressed on a case by case basis. One contingency that was not addressed (and should have been) was the number of calls reviewed. In the first quarter, a total of 43 compared to 84 in the second quarter. Nevertheless, when some untoward results were found, the MHP addressed them through their Plan-Do-Study-Act (PDSA) process. To date, the MHP has conducted six PDSAs.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Julie Valdez Title: Clinical Program Manager III Role: Project Leader *Other team members:* Names: The team includes approximately 25 members, many of whom are Access Center staff then followed by service area QI Chairs. See full list on PIP document.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The Access supervisors are the personnel who will evaluate the calls and collect the data. The PIP document indicates that "available" supervisors were given one call to evaluate and presumably from there were able to evaluate the calls. Inter-rater reliability is mentioned, but no detail about how each supervisors scored and his/her proficiency in scoring (or assessing language needs of consumers) were provided.
	Totals	**1** Met **5** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Implement ACCESS Center Quality Assurance (QA) protocol for supervisors. 2. Launch QA Protocol at the ACCESS center for review of calls by supervisors and feedback to agents.	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	Presented in table format with barriers/causes Intervention designed to target as well as corresponding indicator and dates applied. The study does not actually articulate the barriers and causes of the decreased scoring on the three (or four) areas that the team intends to improve. There was no discussion of why calls decreased (by about 16,000) from CY15 and CY16, why test callers were dissatisfied with the calls, and why agents were not were not requesting caller's names. Because, the proximate causes of these were not explored, it is difficult to determine if the interventions that the team used are the reasonable or appropriate. For example, there may also be staff factors (e.g., experience, comfort level, knowledge, etc.) that accounted for the decreased ratings, which were not explored.
	Totals	**0** Met **0** Partially Met **0** Not Met **0** NA **1** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP presented data related to calls answered within one minute. The inclusion of this data element and its relationship to the other data are unclear (and not explained). The team is, in effect, introducing another outcome measure, that they had not identified previously as problematic.

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 interim data from the first two quarters and two months of the third quarter. The data show sustained improvements in some areas (e.g., offering of language assistance), but not in others (e.g., logging of calls/client information). Some components of the data need explanation and more clarity. For the first quarter, 40 out of 43 calls were referred for services and for the second quarter, 81 out of 84, which reflects approximately 95% of all calls to the Access Line. As the team did not provide data related to the types of calls that are received, it is difficult to determine whether this result is accurate.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The study indicates repeated measures and the analysis, to date, reflects this. However, the team is still collecting data and analyzing, thus rating of this variable and subsequent ones were not made.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did discuss some improvement and follow-up activities. However, they do not discuss many of the areas of opportunity that CalEQRO has delineated.
	Totals	**0** Met **3** Partially Met **0** Not Met **1** 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	

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☒ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **5** 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:

Face validity is observable.

MHP has done a thorough job of collecting and utilizing data for this PIP.

Recommendations:

Continue PIP through next year and implement statistical test to measure outcomes.

Study Questions are actually indicators. Still need an overarching study question that encompasses them.

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