Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

LOS ANGELES MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 28 – October 1, 2020

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Los Angeles MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

Los Angeles County Department of Mental Health (LACDMH) delivers services within eight Service Areas (SA). During each review cycle, CalEQRO performs an overall review of LACDMH, and in addition performs a focused review of two of the eight SAs. The current review focused on the West (SA-2) and San Fernando Valley (SA-5) areas.

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

MHP Information

MHP Size — Very Large

MHP Region — Los Angeles

MHP Location — Los Angeles

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 221,136

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

CalEQRO obtained the MHP threshold language information from the DHCS Information Notice (IN) 13-09.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed AB 205 to specify how the NA requirements must be

---

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and INs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard (AAS) and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS IN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS will review these forms to determine if the provider networks met required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services to youth and adults. If these standards are not met, DHCS will require the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, these will be reviewed by CalEQRO as part of their annual quality review process with a structured protocol to assess access and timeliness and validation of the AAS and any plan of correction or improvement of the services to Medi-Cal recipients living in the zip codes requiring an AAS.

CalEQRO reviews the NACT provider files, maps of clinics closest to the AAS zip codes, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the MHP shall develop and propose an AAS plan, and access to any alternative providers who might become Medi-Cal certified for the MHP. The MHP shall submit a plan of correction addressing the needs to meet the AAS.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO will review grievance and complaint log reports, facilitate beneficiary focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

- 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 five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: The clinical PIP focused on improving services to individuals with co-occurring disorders (COD), and should continue to track the identified variables, including 7- and 30-day rehospitalization rates, service utilization levels, application of the Seeking Safety (SS) intervention in number of services and beneficiaries directly impacted.

Status: Met

- The Clinical PIP continued tracking dependent variables and reported findings through Quarter (Q) 3 FY 2019-20. Included were psychiatric inpatient 7- and 30-day readmission rates; treatment engagement (2 or more services within 30 days); treatment retention (6 or more services within 90 days); average mental health services attended; and average targeted case management services attended.

Recommendation 2: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs, and a non-clinical PIP topic needs to be developed. Several potential topics were discussed onsite which suggested potential. Important to this process remains continual TA, which the MHP is encouraged to seek early and often going forward. While this is a continuing recommendation, the MHP did engage in unsuccessful efforts to create a new non-clinical PIP for this review period. (This is a follow-up recommendation from FY 2018-19 and FY 2019-20.)

Status: Met

- As of February 2020, the MHP developed a non-clinical PIP which targeted aspects of initial access timeliness: first offered appointments, urgent services, and post-hospital/other facility follow-up.
- This PIP emphasized improvements to the process of reporting, review of data, and sharing with stakeholders in a focused way that prioritizes under-performing programs.
- Initially, the interventions were reliant on the positive effects produced by sharing under-performing program data with providers. The identification of specific interventions that may become best practices for actual improvement of results is pending. Refer to the PIP review section for more detail.
- The MHP continued the co-occurring treatment Clinical PIP.

Access Recommendations

Recommendation 3: To sustain adequate treatment capacity, the directly operated (DO) hiring process needs immediate analysis and improvement efforts targeting approval-to-fill through approval of final candidate selection and onboarding. Bottlenecks must be identified and resolved, and overall process time significantly reduced.

Status: Partially Met

- Preliminary work focused on identifying a more detailed continuum of outpatient care and creation of staffing models that would support this system. Included was the consideration of a process improvement consultant to provide review and recommendations for changes to the hiring process.
- The progress to date included the development of a two-week orientation protocol for new hires in the Psychiatric Social Worker I and Mental Health

Counselor I categories. This process aimed to decrease the time from hiring to actual assumption of line duties.

- Due to the fiscal uncertainties related to reductions in service levels and potential funding decreases from coronavirus disease 2019 (COVID-19), a hiring freeze was instituted within all Los Angeles County departments. The freeze is predicted to last until July 2021, and efforts to improve the hiring process have been paused.

- It is important for work in this area to restart as soon as practical, preferably before the hiring freeze lifts. The pent-up demand will place a premium on an efficient hiring process so that the most qualified candidates for key positions are not lost.

Recommendation 4: Develop a performance standard that monitors treatment capacity following assessment, such as access to third non-assessment clinical encounter. Utilizing data preceding implementation of the Final Rule standards as baseline, this will furnish important information about adequacy of treatment capacity as resources have shifted to meet initial timeliness requirements.

Status: Met

- The MHP exclusively focused on initial timeliness metrics required by the Final Rule and DHCS Information Notices (IN) and reducing the disparity between directly operated (DO) and contract/legal entity (C/LE) providers.

- The MHP established an access-to-care leadership committee to push forward with capacity standards, of which time to treatment will be an element.

- The MHP's master database allows multiple capacity domains to be examined at once; this includes practitioners, service types and requests for service.

- The MHP asserts that timeframes to post-assessment clinical encounters are primarily dependent on the results of the treatment planning process, not treatment capacity.

Timeliness Recommendations

Recommendation 5: Resolve the barriers to tracking and reporting of all timeliness metrics, until it can be assured that both DO and C/LE program information is fully and accurately represented, with specific emphasis on identification and response to urgent requests. (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- As of June 2020, the webservice functionality included all required elements to track all timeliness aspects including urgent response.
- The small number of C/LE providers that have yet to fully implement webservice functionality are submitting this information via Excel files. These programs have also submitted plans of correction to remedy this issue.
- Tracking between provider referrals through the Service Request Tracking System (SRTS), will have changes implemented that supports all types of initial access tracking accomplished with an estimated date of October 2020.

Quality Recommendations

Recommendation 6: Develop a medication monitoring system that provides a regular, structured process for the review of all prescribers in DO programs and oversight of C/LE contract providers. This to include a regular committee format and a mechanism for communicating findings and corrective actions across both DO and C/LE contractor domains. In addition, this is to include formal tracking and regular reporting on SB 1291 metrics. (This recommendation includes a follow-up from FY 2018-19.)

Status: Met

- LACDMH made significant progress with medication monitoring since the past review. A plan that spans both DO and C/LE programs was drafted. Execution of the plan and the resultant data was available for the initial efforts in DO programs. The results presented during the current review did not yet include C/LE programs and comprehensive system-wide information.
- Medication monitoring includes both pharmacy tracking of prescribed medications and peer review of all prescribing disciplines.
- The MHP presented reports of HEDIS and CMS measure results for DO programs. Some measures will be tracked in an ongoing dashboard of information; review of other elements will be derived from the peer review process.

  LACDMH selected the following HEDIS measures for 2019 quality metrics:

  - Use of multiple concurrent antipsychotics in children and adolescents
  - Documentation of current medications in the medical record
  - Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
  - Diabetes monitoring for people with diabetes and schizophrenia
  - Cardiovascular monitoring for people with cardiovascular disease and schizophrenia
  - Metabolic monitoring for children and adolescents on antipsychotics

  Other quality measures:

  - Patients with primary care provider (PCP) documented
  - Monitoring of medications with narrow therapeutic index

- Follow-up on progress during the next EQR as appropriate.

Recommendation 7: Identify and perform an analysis of quality areas outside of strict compliance that directly impact the beneficiary experience across both DO and C/LE contract programs. With the involvement of C/LE contract agencies and beneficiaries, identify the priority areas that merit a uniform approach. Examples may include: the use and content of welcome packets in both DO and C/LE contract programs; creating a standard and tracking of no-show events in both DO and C/LE contract programs; review of large scale LE contract providers for beneficiary portal access.

Status: Met

- The Service Area (SA) Level provider meeting was re-established, which is led by the SA Chief and also supported by the Contract Monitoring and Management Division (CMMD). This action works to augment and improve communications between all programs in each SA.

- LACDMH continued to work on the Full-Service Partnership (FSP) redesign to establish a consistent set of quality expectations and guidelines.

- The initial work on the psychiatry/prescriber peer review process and data-related dashboard move quality monitoring forward in the important area of medications and related health monitoring.

Recommendation 8: Review notification and circulation of consumer satisfaction results, including beneficiaries in this process, targeting the structure, and labelling of the uploaded files, with a focus on the utility of results to beneficiaries and parents/caregiver.

Status: Met

- The Quality Improvement (QI) unit created separate website subpages for satisfaction results which addressed the interests and concerns of beneficiaries separately from those of providers and staff. Beneficiaries are furnished a singled page that integrates data with graphics in a very accessible manner.

- In addition to the format change, an email link was included that supports provision of suggestions for changes in the presentation.

- The website "Resources" submenu of "Our Services" makes access to this information easier than before. The approach taken by the MHP is a best practice to the sharing of satisfaction information with beneficiaries.

Beneficiary Outcomes Recommendations

Recommendation 9: Continue to follow-up on the supported employment needs of beneficiaries and dialogue with both beneficiaries and the Department of Rehabilitation (DOR) about ways that services can better target the needs of enrollees who are preparing to re-enter the work force. (This is a follow-up recommendation from FY 2018-19).

Status: Met

- In response to this recommendation an Employment Education and Volunteer Resources brochure was created by LACDMH. It describes the range of support and services available, from volunteer work through education, apprenticeships and employment.

- The agreement between LACDMH and the DOR is distinguished from general DOR services. This clarification was shared with both DO and C/LE programs in August 2020.

- The effects of COVID-19 have diminished the opportunities for businesses to provide employment opportunities, halting progress in this area.

Recommendation 10: Consider broadening roles for lived experience employment such as inclusion in crisis response teams and other innovative roles, which may also help address critical staffing issues in clinical services.

Status: Met

- This past year, LACDMH expanded the roles of peers within two key programing areas, the Countywide Engagement Division and the Emergency Outreach and Triage Division.

- The Engagement Division expansion focused on the unsheltered homeless mentally ill and individuals in jails and prisons. Peers with lived experience serve in a critical role, using their life experience to connect in ways that others cannot. The component programs include:
    - Women's Community Reintegration: The use of peers has increased from 10 to 30 percent in Community Health Worker (CHW) positions. In addition to the customary interventions, in response to COVID-19 the program assisted participants in the acquisition of smartphones to mitigate social isolation and provide remote treatment access and support.
    - Women's Well Being: This program provides gender-specific wellness and recovery services, emphasizing peer support and services. This program will eventually reflect 38 percent CHW peer positions, and include recreation/leisure skills, self-employment opportunities, as well as Wellness and Recovery Action Plan (WRAP) development.
    - Homeless Outreach & Mobile Engagement (HOME): This program provides street-based services to unsheltered individuals with mental illness. In January 2020 the Homeless Services Team merged with HOME to create one uniform service that is focused on mentally ill individuals who are gravely disabled. Peers comprise 32 percent of the 143 total program staff.
    - Veterans Peer Access Network (VPAN): This program is a component of the larger Los Angeles County veterans' services and employs military veterans to serve as access agents/navigators and focus on overcoming stigma against help-seeking behavior. Peers comprise 87 percent of program staff.
- The Emergency Outreach and Triage Division includes key program elements:
    - School Threat Assessment Response Teams (START): These teams serve an important collaboration platform with law enforcement, school districts, and mental health targeting school violence. Activities include assessment and management of threats in schools. During FY 2019-20 a program expansion occurred. Peers comprise 15 percent of program staff.
    - Therapeutic Transportation (TT): This program focuses on reducing transport wait times and trauma for individuals on involuntary holds. TT is in the process of implementation during FY 2020-21. This program is intended to reduce the use of restraint and reduce stigma towards mental health beneficiaries. The vehicles used for

this program are modified vans with a minimum of one vehicle per supervisorial district, staffed by a driver, a licensed psychiatric technician, and a peer. Peers represent 33 percent of the program staff.

Recommendation 11: Examine the methodology of sharing consumer perception data with beneficiaries, including methodology of communicating new information, and configuring reports in a manner that is specifically geared to service utilizers. The inclusion of beneficiaries in this process will also help provide guidance to the MHP in designing effective communication.

Status: Met

- In July and August of 2020, the MHP's QI unit engaged stakeholder groups to review current material summarizing the Consumer Perception Survey (CPS) information and solicited feedback about how to create a more meaningful report. Feedback was also received from the Cultural Competency Committee (CCC) and the Service Area Leadership Team (SALT) meetings.

- The process was used to develop a one-page presentation for each of the key users of this information, beneficiaries and caregivers/parents. The Spring 2019 single page summaries are currently posted on the MHP's website. The summaries are a combination of graphics and text that present the information in a user-friendly format.

Foster Care Recommendations

Recommendation 12: Develop a capture mechanism for FC first offered psychiatry service. This metric requires the additional element to capture the request or referral decision event.

Status: Met

- The MHP established a tracking system for first offered psychiatry appointment for the FC population. This reporting was based on the Service Request Log (SRL) in the Integrated Behavioral Health Information System (IBHIS), the Service Log web service, and the Katie A. Enterprise Monitoring System (KAEMS).

- The resultant data will be fully discussed in the timeliness section of this report. The MHP believes under-reporting exists, and there is evidence of decreased events between this year and the prior (9 percent of prior DO reporting).

Recommendation 13: Develop a FC urgent service request and subsequent service tracking process.

Status: Partially Met

- The MHP reports urgent appointment requests and fulfillment in terms of business days and is not able to track and report in terms of hours. The MHP also tracks based on first offered or accepted appointment, not provided or kept. The MHP notes that beneficiaries may at times choose to accept an urgent appointment that falls outside of the two-day standard. Furthermore, beneficiaries can choose not to attend appointments that are established that meet the standard. Thus, the methodology used for tracking is both offered and accepted appointments, not kept.
- The MHP is unable to report C/LE provider urgent care timeliness for this time period.
- The urgent metric is included with the non-clinical timeliness PIP; therefore, the recommendation does not require carryover.

Information Systems Recommendations

Recommendation 14: Track and report the availability and functionality of personal health record (PHR) among large scale C/LE contract agencies and incorporate this technology in disaster/emergency beneficiary communication plan. Also consider development of PHR expectations within the contract language for large scale LE agencies.

Status: Partially Met

- Just4Me is a client portal that is exclusive to Netsmart Avatar. The functionality of this PHR is not available to beneficiaries that are served by the many C/LE providers that service Los Angeles MHP beneficiaries.
- The benefits of a consumer portal are well-known to provide improved engagement with treatment and useful functionality such as rescheduling appointments and establishing appointment reminders. The MHP may wish to create a standard that encourages C/LE's of a certain scale of operation to pursue PHR functionality.
- Due to the COVID-19 disruption, the MHP was unable to completely address this recommendation at the current time and merits follow-up during the next review.

Recommendation 15: Develop strategy using LACDMH/IS Vendor business contract terms and conditions to address IS vendor lack of timely responsiveness to projects and system work orders.

Status: Met

- The MHP has revised the IBHIS Amendment 5 in July 2020 to clarify Service Level Agreement language and procedures to enhance IS vendor responsiveness to reported deficiencies.
- The MHP created clearer definitions of priority levels to support more accurate LACDMH category assignment of reported issues.
- The MHP created detailed procedures for tracking and responding to issues.
- The MHP revised the frequency, formats, and agendas of scheduled calls with the EHR vendor to enhance collaboration and understanding when addressing mandated changes, bug fixes, and system work orders.
- The MHP moved to a quarterly release schedule of EHR promotions to manage the volume of changes which will allow for more rigorous testing.
- The active review by business subject-matter experts will result in reduced number of bugs.

Structure and Operations Recommendations

Recommendation 16: In order to minimize the disruptive impact of system programmatic changes, the MHP needs to develop a clear and transparent change management process for the proposal of change, one that ensures that all relevant stakeholders, and particularly beneficiaries and providers, are included from start to finish. In addition, these parties need inclusion through the implementation and follow-up process, wherein unanticipated problems that emerge receive analysis and resolution.

Status: Partially Met

- The MHP reported on a monthly stakeholder meeting process, during which there is an opportunity to review and provide feedback to proposals or changes in programming. The MHP's focus of this response was on the Mental Health Services Act (MHSA) process, mid-year adjustments, and annual and three-year plans.
- The MHP has also restarted the monthly SA meetings, in which both DO and C/LE providers participate. Although this element was not included in the response to this recommendation, it certain presents an opportunity for improved communication and feedback.
- A significant element of this recommendation was the changes in departmental structure that have occurred and seemed unclear in scope

and purpose to quite a few stakeholders. Examples include the creation of Discipline Chiefs and the impact of these positions upon the chain of command and hiring decisions within DO programs. Service delivery stakeholders in both DO and C/LE programs desire information as to the intended results of such changes before implementation. In this area, more work remains to be done.

- The continuing changes due to COVID-19 have placed an even greater premium on effective communication and change management, which the MHP was encouraged to continue.

Recommendation 17: Attend to the C/LE communication process, and ensure that sufficient liaison resources are provided by the administrative arm, and that budgetary planning is adequate to sustain the contractor capacity expectations that have come into focus with the implementation of network adequacy. This requires a robust and ongoing meeting forum, supported by frequent bidirectional forums, ensuring both contractors and MHP administration remain aware of emerging issues.

Status: Met

- With the leadership of Senior Deputy Director Lisa Wong and Deputy Director Terri Boykins, strategies were developed that focused on more frequent and consistent communication.

- In August 2019, LACDMH implemented a monthly Outpatient Services Division (OSD) and Contract Management and Monitoring Division (CMMD) meeting. One element of this meeting was to identify and scale best practices throughout the entire system of care. The intent was to provide a platform for joint decision-making, open communication, and strategic planning.

- In April 2020, a CMMD and SA Chief Monthly Provider Meeting was established. These meetings are co-facilitated by SA Chiefs and CMMD Chiefs, which involves both DO and C/LE programs.

- C/LE input indicated a continued desire for periodic, monthly or quarterly, meetings between MHP leadership and the contract program executive directors.

Recommendation 18: The difference in perceptions regarding availability of transportation assistance between SA-6 and SA-8 beneficiary participants merits review and exploration to ensure that any access disparities are identified and resolved.

Status: Met

- The MHP's response identified more than ten options for transportation assistance that is available to beneficiaries who need help in reaching services. Included is direct assistance provided by program staff.
- This recommendation originated with consumer focus group feedback during the FY 2019-20 review. There were distinctive and different experiences around transportation assistance had by those served in SA-6 from SA-8. There was less awareness of help experienced by the SA-6 participants.

PERFORMANCE MEASURES

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

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

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

---

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

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

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

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to: screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).

- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

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

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

  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

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

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Los Angeles MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	499,886	13.0%	34,467	15.6%
Latino/Hispanic	2,270,000	59.1%	117,531	53.1%
African-American	387,547	10.1%	40,669	18.4%
Asian/Pacific Islander	370,343	9.6%	9,430	4.3%
Native American	4,765	0.1%	581	0.3%
Other	314,957	8.2%	18,458	8.3%
Total	**3,840,000**	**100%**	**221,136**	**100%**

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

Table 2 provides details on beneficiaries served by threshold language.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Los Angeles MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	50,837	23.0%
Armenian	1,523	0.7%
Mandarin	599	0.3%
Cantonese	712	0.3%
Korean	716	0.3%
Vietnamese	680	0.3%
Farsi	574	0.3%
Russian	466	0.2%
Tagalog	144	0.1%
Cambodian	561	0.3%
Arabic	119	0.1%
Other Chinese	55	0.02%
Other Languages	164,150	74.2%
Total	**221,136**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

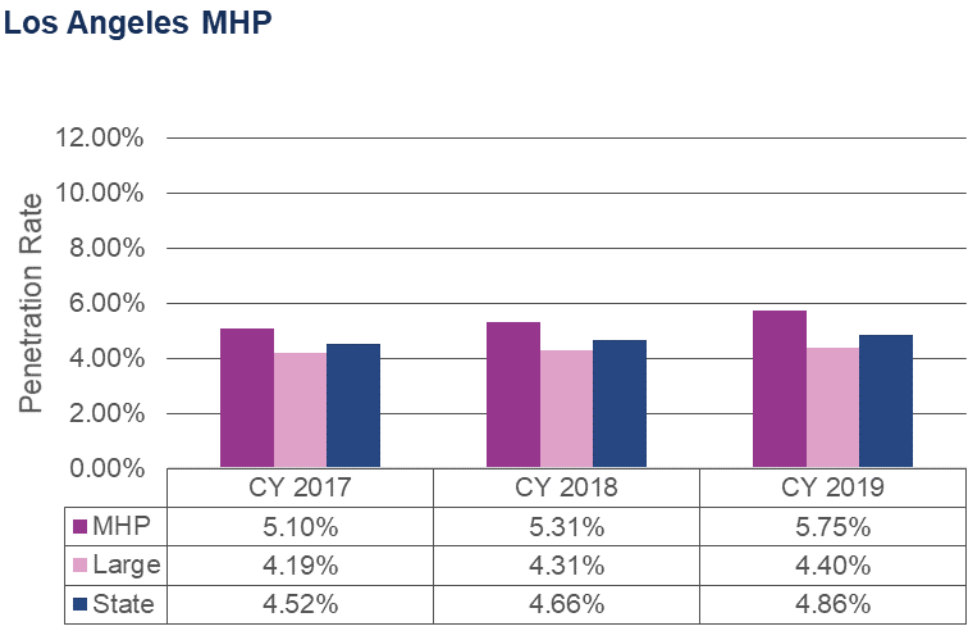
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further

ACA-specific utilization and performance data for CY 2019. See Table C1 for the CY 2019 ACA penetration rate and ACB.

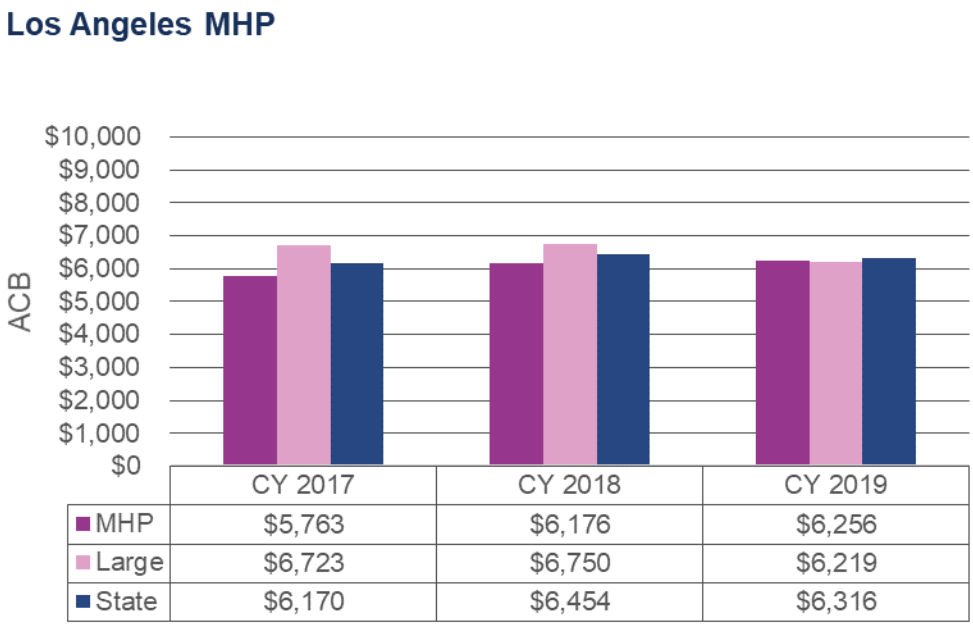
Regarding the calculation of penetration rates, the Los Angeles MHP uses the same method used Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for very large

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	5.10%	5.31%	5.75%
Large	4.19%	4.31%	4.40%
State	4.52%	4.66%	4.86%

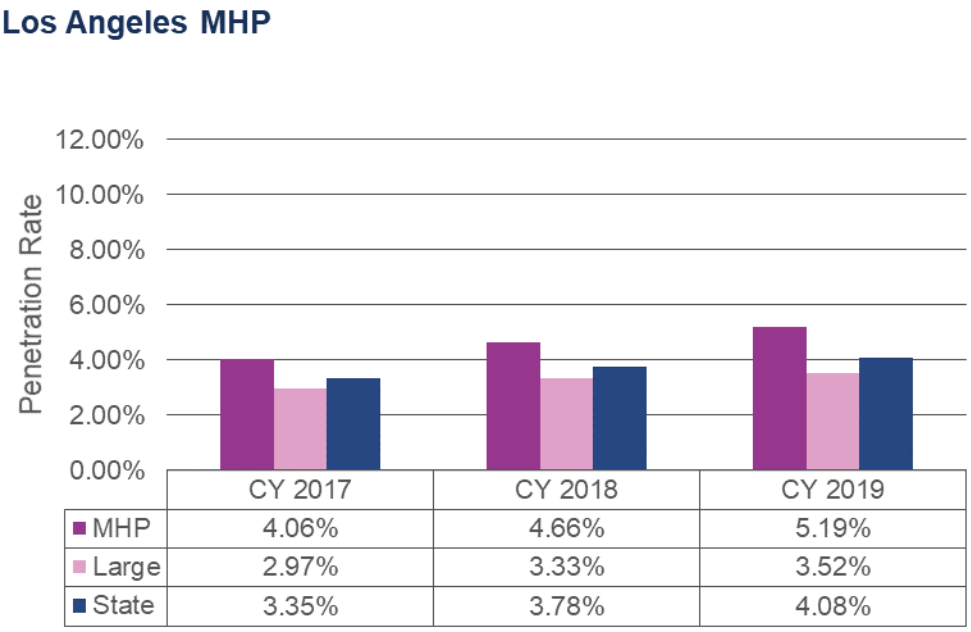
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$5,763	$6,176	$6,256
Large	$6,723	$6,750	$6,219
State	$6,170	$6,454	$6,316

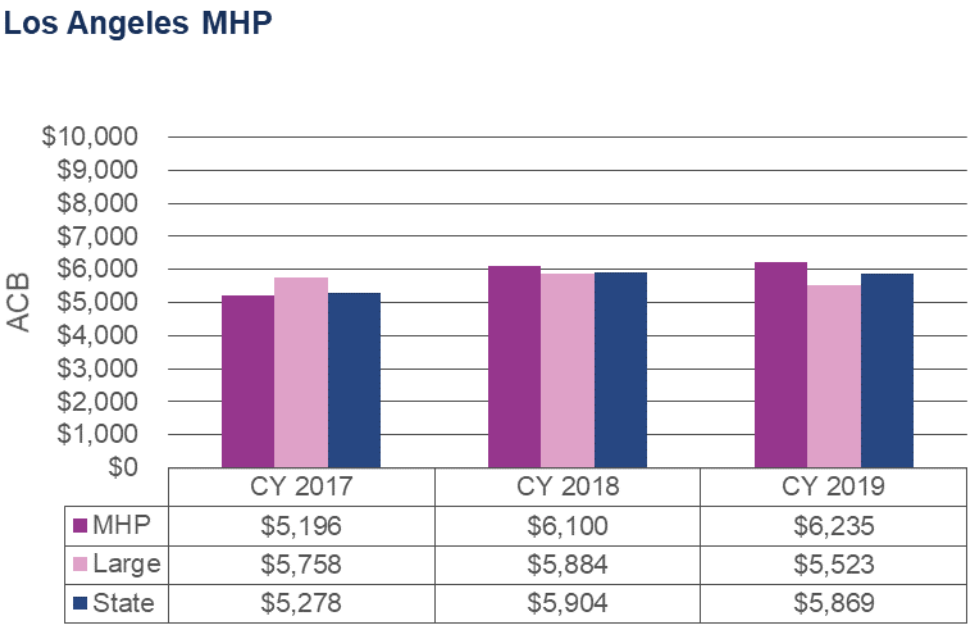
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for very large

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	4.06%	4.66%	5.19%
Large	2.97%	3.33%	3.52%
State	3.35%	3.78%	4.08%

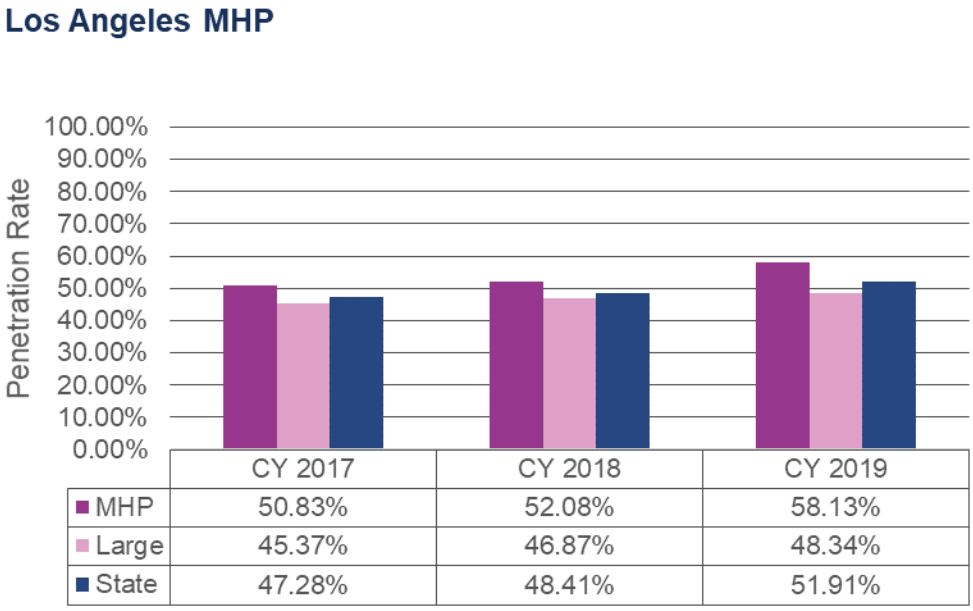
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$5,196	$6,100	$6,235
Large	$5,758	$5,884	$5,523
State	$5,278	$5,904	$5,869

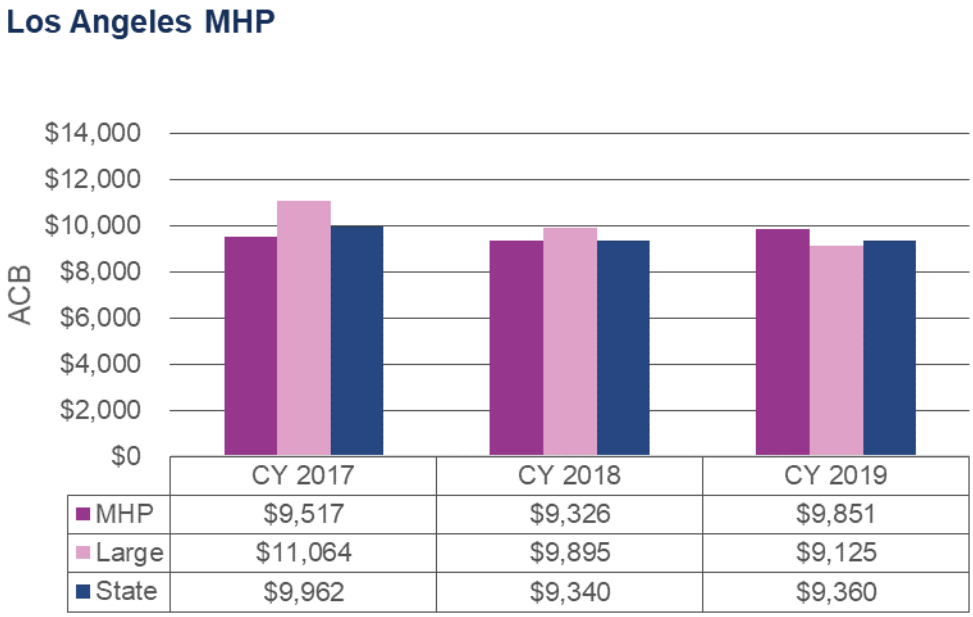
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for very large

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	50.83%	52.08%	58.13%
Large	45.37%	46.87%	48.34%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

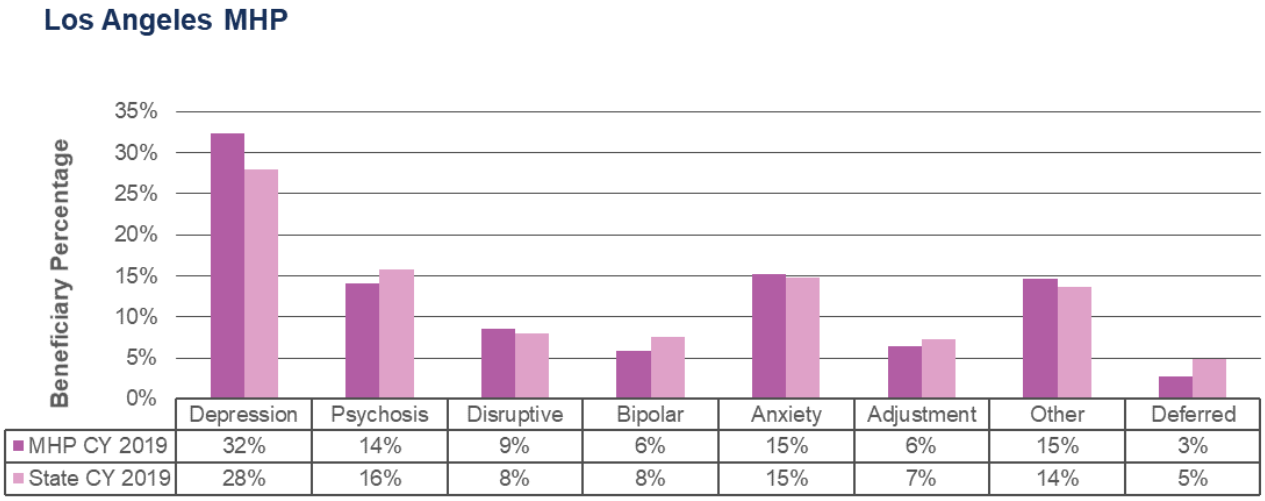


	CY 2017	CY 2018	CY 2019
MHP	$9,517	$9,326	$9,851
Large	$11,064	$9,895	$9,125
State	$9,962	$9,340	$9,360

Diagnostic Categories

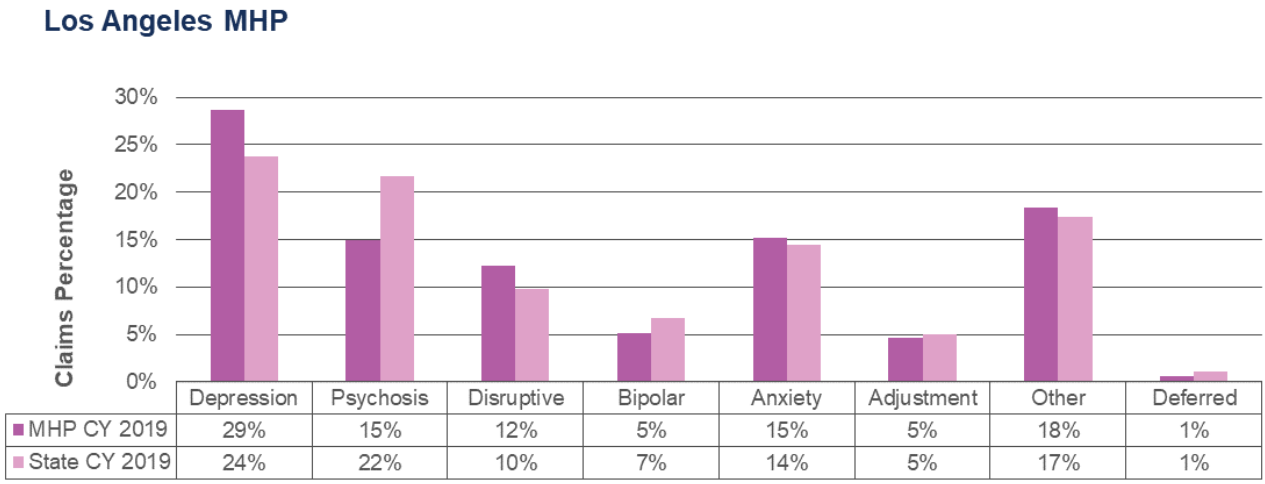
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	32%	14%	9%	6%	15%	6%	15%	3%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	29%	15%	12%	5%	15%	5%	18%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Los Angeles MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	6,909	221,136	3.12%	$49,351	$340,963,693	24.64%
	CY 2018	6,681	210,337	3.18%	$53,559	$357,825,966	27.54%
	CY 2017	5,490	205,143	2.68%	$48,630	$266,979,411	22.58%

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

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 4: Psychiatric Inpatient Utilization CY 2017-19

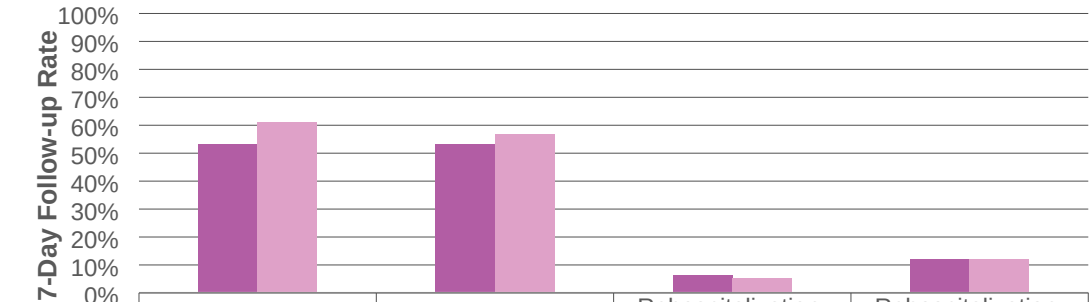
Los Angeles MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	17,970	78,405	7.92	7.80	$8,460	$10,535	$152,030,457
CY 2018	19,946	91,861	8.25	7.63	$12,002	$9,772	$239,392,803
CY 2017	18,999	95,993	7.47	7.36	$8,041	$9,737	$152,774,986

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19

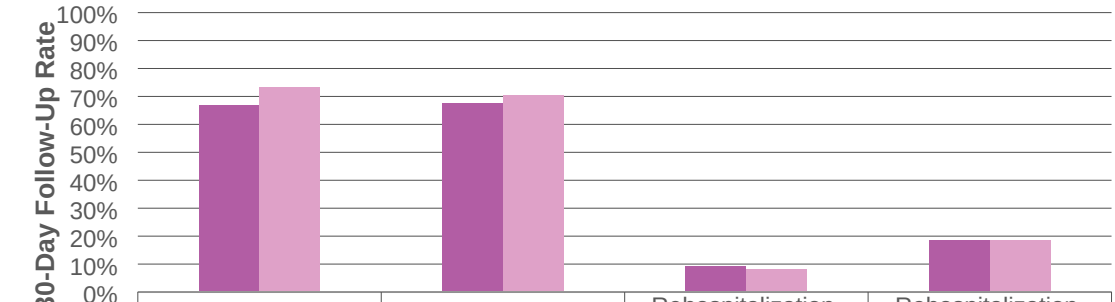
Los Angeles MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	53%	53%	6%	12%
CY 2019	61%	57%	5%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19

Los Angeles MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	67%	67%	9%	19%
CY 2019	73%	70%	8%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

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 PIPs, as shown below.

Table 5 : PIPs Submitted by Los Angeles MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)
Non-Clinical	1	Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Los Angeles County MHP
PIP Title	Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)
PIP Aim Statement	Will the provision of services using multidisciplinary, integrated, evidence-based treatment models for consumers with co-occurring mental health and substance use disorders result in a positive impact on their functioning (i.e., 7-day and 30-day hospital re-admission rates) and treatment engagement/retention (i.e., number of visits within 30 days and 90 days, average Mental Health Services and Targeted Case Management services) from pre-intervention to post-intervention across Fiscal Year 2018-19 to 2021-22?

MHP Name	Los Angeles County MHP
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The clinical PIP efforts targeted all adult LACDMH beneficiaries (ages 18 years and over) with a history of recreational or illicit substance use and receiving SMHS in a DO clinic.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): The improvement strategy was focused on delivering integrated treatment models to consumers with CODs to directly address and mitigate the impact of substance use. The intent was to address mental health symptoms as well as enhance their ability to reduce substance use and improve functioning by coping and practicing safety in relationships, feelings, thoughts and actions. In Phase I (year one) of this project, interventions included implementing treatment strategies with Seeking Safety (SS), a specific evidence-based practice (EBP) for trauma and substance use, broader education of Substance Abuse Counselor (SAC) staff in substance use disorder (SUD) treatment through the University of California, Los Angeles (UCLA) extension classes, and implementation of Integr8Recovery groups. In Phase II (year two) of this project, interventions will focus on improved teaming and use of multidisciplinary groups.

PIP Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): SACs employed in 41 DO programs were trained in the provision of SS, a structured EBP that addresses both substance use and trauma. In addition, a SUD treatment course was developed by UCLA that imparts a broader knowledge base to these staff. Lastly, training in the use of Integr8Recovery groups was provided.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The changes involve planned expansion to all DO programs to create a uniform platform of COD treatment services that are consistently available to all beneficiaries. In addition, the MHP plans to include C/LE programs in this process, obtain knowledge of the training utilized in these programs, and seek to develop a consistent, system-wide process.

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Psychiatric Inpatient Hospital 7-Day Readmission Rates – SACs SS trained August 2019	Q4 FY18-19 (B)	8/32 X 100 = 25%	Q3 FY19-20 (F) ☐ n/a*	11/42 X 100 = 26.2%	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☒ <.05 Other (specify): Improvement (R2 to Final): 14%;

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
						Improvement (B to F): -4.8% $X^2 = 2.73$, $p > .05$
Psychiatric Inpatient Hospital 30-Day Readmission Rates – SACs SS trained Oct 2019	Q1 FY19-20 (B)	5/33 X 100 = 15.2%	Q3 FY19-20 (R2) ☐ n/a*	4/24 X 100 = 16.7% Improvement (B to F): -10.2%	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☒ <.05 Other (specify): Actual: $X^2 = 0.02$, $p > .05$
Treatment Engagement (2 or more services within 30 days) served by SACs that attended the Seeking Safety August 2019 Training	Q4 FY 18-19 (B)	308/587 X 100 = 52.5%	Q3 FY19-20 (F) ☐ n/a*	231/436 X 100 = 53% Improvement (B to F): -5%; Improvement (B): 1%,	☒ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☒ <.05 Other (specify): Actual: $X^2 = 6.98$, $p > .05$
Treatment Retention (6 or more services within 90 days) Consumers of SACs that attended the	Q4 FY18-19 (B)	227/587 x 100 = 38.7%	Q3 FY19-20 (F) ☐ n/a*	165/436 X 100 = 37.8% Improvement	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Seeking Safety August Training				(B to F): -2.3%,		☒ <.05 Other (specify): Actual: $X^2 = 3.57$, p > .05
Average Mental Health Services Attended	Q4 FY18-19	4,594/587 = 7.8	Q3 FY19-20 (F) ☐ n/a*	2,855/436 = 6.5 B to F -16.5%	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☒ <.05 Other (specify): Actual: t = -1.80, p > .05
Average Targeted Case Management Services Attended	Q4 FY18-19	1,222/587 = 2.1	Q3 FY19-20 (F) ☐ n/a*	Q3 FY19-20 (F) 534/436 = 1.2 B to F -30.7%,	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☒ <.05 Other (specify): Actual t = 3.04, p < .05

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Note: Above performance measures are a single representation of each tracked indicator or performance measure and are not all inclusive of all cohorts.						
Was the PIP validated? ☒ Yes ☐ No						
Validation phase: ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year ☒ First remeasurement ☒ Second remeasurement ☒ Other (specify): Due to the sequential/rolling application of interventions, some active areas are awaiting final data reporting. In addition, the expansion of this PIP to a broader number of DO programs did not follow the implementation roll-out plan due to COVID-19 limitations. Finally, other interventions, such as case teaming, are slated to start in the next phase or year of this PIP.						
Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. • The MHP's sequencing of interventions and data-tracking strategies supports data tracking of multiple staff and beneficiary cohorts which has provided for accuracy in analysis. • The MHP provided strong statistical analysis of the results.						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• In the key elements of high hospitalization and rehospitalization rates for individuals with COD that provided the rationale for this PIP, there was no positive effect. • The measurable positive impacts occurred with engagement and increased utilization of services. The improvements are narrowly focused on those who received SS or participated in Integr8Recovery groups. • The battery of interventions applied to this clinical topic, including the testing of improvements with teaming and multi-disciplinary groups with COD beneficiaries, raises a question of if this is a broad systemic improvement to COD care or a focused PIP.						
EQRO recommendations for improvement of PIP: • The inclusion of C/LE programs during the development and modification of this PIP would have been beneficial. These programs have utilized SACs for many years and their participation would have been useful in the development of system-wide COD treatment training and treatment process; this would also address the matter of PIPs having a system-wide impact, bridging DO and C/LE programs. • The key indicators that provided the rationale for this PIP were unaffected at this point and seem unlikely to change. • The MHP should consider conversion of this PIP to a general system improvement process for SAC services to individuals with COD and seek another clinical PIP topic.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Input on this PIP both during and after the review. • A formal TA session to occur in November 2020 with the current and next year's review team.						

*PIP is in planning and implementation phase if n/a is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Los Angeles County MHP
PIP Title	Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected
PIP Aim Statement	Will the implementation of audit and feedback (A&F) processes (i.e., access to care monitoring reports, timeliness template, and conference call) for DO and LE/Contracted providers with access to care timeliness in the 79% or less range in May, June, and July 2020 improve the rate at which beneficiaries are receiving timely routine, urgent, and follow-up care appointments from these providers, by Quarter 3 (January, February, and March 2021)?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☒ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☐ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The PIP population shall encompass all Los Angeles County Medi-Cal beneficiaries, regardless of their race/ethnicity, age, gender, and/or geographical location. LACDMH is required to monitor and maintain networks sufficient to provide all Medi-Cal beneficiaries access to covered mental health services within specified timely access standards. Access to care monitoring and parallel improvement efforts will be adopted across the entire system to include both covered and uninsured beneficiaries, irrespective of their program or funding source.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Direct, member-focused interventions are not currently identified.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): This PIP focuses on the production of timeliness data, sharing and reviewing this information with providers, and engaging their involvement in developing actions that improve timeliness. The MHP uses an A&F process with the intent of spurring development of changes that improve timeliness.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The MHP's interventions can be considered system changes because, historically, the timeliness monitoring and interventions were restricted to DO programs. This has now expanded into an inclusive system-wide approach.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of Timely Routine Appointments *Expected Percentage Point (PP) Improvement: +20 PP (Range: 67% to 79%)*	May, June, July 2020		☒ n/a*		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of Timely Urgent Appointments *Expected PP Improvement*: +20 PP (Range: 20% to 70%)	May, June, July 2020		☒ n/a*		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of Timely Inpatient/Jail Release Follow-up Appointments *Expected PP Improvement*: +20 PP (Range: 37.4% to 74.6%)	May, June, July 2020		☒ n/a*		☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?				☐ Yes	☒ No	
Validation phase: ☒ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):						
Validation rating:						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. • As of September 2020, the MHP initiated the A&F cluster of interventions that included: access to care timeliness reports, email notifications to providers when timeliness is less than 79 percent, and requirement of a plan of correction and conference calls. The MHP was not able to produce the baseline data in May, June, and July 2020. This was due to a multitude of issues including re-tasking of many staff to pandemic response. The identification of a specific menu of interventions that directly impact the timeliness process has not occurred. Reliance is currently upon a Hawthorne effect that includes feedback.						
EQRO recommendations for improvement of PIP: • Produce the baseline data for the May, June, and July 2020 period. • Begin reporting the post-intervention results. • Track and report the A&F process frequency of application. • Identify a menu of best practices to present options to be implemented by under-performing providers. • Track the results of provider interventions utilized to improve timeliness. • Add tracking of first offered psychiatry appointments to the PIP, including both DO and C/LE programs.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Review and feedback during and after the review. • Scheduling of specific post-review TA sessions for November 2020.						

*PIP is in planning and implementation phase if n/a is checked.

INFORMATION SYSTEMS REVIEW

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

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

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

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Los Angeles	2.20%	2.30%	2.10%	2.10%
Very Large MHP Group	n/a	2.30%	2.10%	2.10%
Statewide	n/a	3.58%	3.35%	3.34%

The MHP budget for IT support has remained stable for the last four years but is lower than statewide support level for each of those years.

The budget determination process for information system operations is:

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

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☐ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the MHP uses an ASP model to host EHR system which provides 24-hour operational support.	☒ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☐ Yes	☒ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☒ Yes	☐ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☐ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- The MHP has a dedicated FTE position in the org chart who is responsible for IS security.
- The MHP security office vets and approves all proposed apps and solutions prior to implementation.
- A month before the stay-at-home orders were issued by the Governor, the Chief Information Officer chaired a table-top exercise to explore possible scenarios as COVID-19 began to spread. At that time, they considered 40 percent of staff staying home to be an extreme contingency.
- The MHP followed the county in embracing Everbridge Mass Notification as a response to COVID-19. It proved to be a valuable tool for assisting staff in managing the civil disruptions in central Los Angeles.
- Data was instrumental for the MHP management to effectively respond to COVID-19. Priority was given to develop dashboards for tracking resources such as shelters, access & warm line calls, personal protective equipment (PPE) distribution, and staffing.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	21%
Contract providers	77%
Network providers	2%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	246	2	7	23
2019-20	244	6	16	18
2018-19	240	25	14	21

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	n/a	n/a	n/a	n/a
2019-20	n/a	n/a	n/a	n/a
2018-19	37	7.50	2.50	3

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

- Table 16: The Clinical Informatics Unit was moved to the Chief Information Office Bureau (CIOB) and is now included in Table 15 Technology Staff results for FY 2019-20 (current review reporting period).
- The county Chief Administrative Officer has implemented a hiring freeze and procurement slow-down in response to the economic downturn with COVID-19, resulting in a high vacancy rate.
- Filling vacant positions will continue to be a challenge even after the COVID-19 emergency as recruiting qualified staff is both time consuming and challenging.
- The MHP has ranked the most needed staff to petition for exceptions from the hiring freeze with app developers topping the list as they support the needs of the whole agency.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by MHP and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	820	0	820
Clinical Healthcare Professional	3726	237	3963
Clinical Peer Specialist	0	0	0
Quality Improvement	0	0	0
Total	4546	237	4783

While there is no standard ratio of IT staff to support EHR user's, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Very Large MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	246.00	37.85
Total EHR Users Supported by IT (Source: Table 17)	4783.00	2084.00

Type of Staff	MHP FY 2020-21	Very Large MHP Average FY 2019-20
Ratio of IT Staff to EHR Users	1:19	1:55

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☒	☒	☐	☒
Screen workflow and navigation	☒	☐	☐	☒

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No

Ongoing EHR Training and Support	Status	
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	544
Number of county-operated telehealth sites	81
Number of contract providers' telehealth sites	463
Total number of beneficiaries served via telehealth during the last 12 months	48,577
• Adults	12,776
• Children/Youth	34,220
• Older Adults	1,581
Total Number of telehealth encounters (services) provided during the last 12 months:	346,770

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

- ☒ Hiring healthcare professional staff locally is difficult
- ☒ For linguistic capacity or expansion
- ☒ To serve outlying areas within the county
- ☐ To serve beneficiaries temporarily residing outside the county
- ☒ To serve special populations (i.e. children/youth or older adult)
- ☒ To reduce travel time for healthcare professional staff
- ☒ To reduce travel time for beneficiaries
- ☒ To support NA time and distance standards
- ☒ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- Prior to the COVID-19 emergency, telehealth was used primarily to deliver psychiatry services; since March 2020, as much as 90 percent of all services are provided via telehealth.
- As a response to COVID-19, the MHP has purchased 2,800 VSee video licenses to enable staff to use a HIPAA-compliant platform for the delivery of telehealth services.
- Of the 346,770 telehealth services provided in the last year, 1,315 were provided in a language other than English.
- Telehealth services are available with Arabic, Armenian, Cambodian, English, Farsi, Korean, Mandarin, Russian, Spanish, Tagalog, and Vietnamese speaking practitioners.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☒	Arabic	☒	Armenian	☒	Cambodian
☐	Cantonese	☒	Farsi	☐	Hmong
☒	Korean	☒	Mandarin	☐	Other Chinese
☒	Russian	☒	Spanish	☒	Tagalog
☒	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
There are 109 C/LEs providing telehealth	463

Current MHP Operations

- With limitations imposed by the county-wide hiring freeze, the loss of 10 percent of the MHP's revenue management staff will be challenging.
- As a response to COVID-19, a variety of dashboards had to be brought up quickly to give transparency to the many changes. Using Power BI, they were developed to be available on phones, iPads, laptops, and desktops.
- In response to State directives, the MHP quickly allowed various types of telehealth to take place in multiple venues. It tracks and runs reports on this delivery mode via a service delivery code with appropriate modifier.
- The MHP is working on automating the download of Medi-Cal Eligibility Data System (MEDS) files.
- The MHP is pushing the expansion of Los Angeles Network for Enhanced Services (LANES) into the C/LEs to enhance beneficiary services and produce continuity of care documents that support integrated care decision making.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Avatar/IBHIS	EHR	Netsmart	7	Vendor/CIOB
OrderConnect	ePrescribing/ eLab	Netsmart	7	Vendor/CIOB
IBHIS Web Services	Legal Entity/HIE	CIOB/Netsmart	7	CIOB
Provider Connect (IBHIS)	Fee-For-Service (FFS) Authorization /Billing Porta	Netsmart	7	Vendor/CIOB
Practitioner Registration Maintenance (PRM)	Practitioner Data	CIOB	7	CIOB
Care Connect	Integrated Care	Netsmart	5	Vendor/CIOB
Care Pathways	Meaningful Use	Netsmart	5	Vendor/CIOB
Access Call Center	Call Management	Verizon	7	Verizon
Pharmacy Benefit Management (PBM)	Medication Claims Adjudication	Magellan	3	Magellan/CIOB

The MHP's Priorities for the Coming Year

Access To Care

- Service Access and Availability
    - Access Center Program: call logging and triage.
    - Access Center Call System: Adding live chat, outbound Short Messaging Service text and email.
    - NA Solution 3.0: Incorporate practitioner registration and maintenance functionality, add American National Service Institute Electronic Data Interchange (EDI) 274 capability, and enhance base solution.

    - SRTS 2.0.

- Capacity Management
    - Mental Health Resource Locater and Navigator, Phase II (waitlisting and case management).
- Integration and Collaboration
    - Department of Public Health/LACDMH interoperability collaboration.
    - IBHIS CareConnect inbox direct messaging.

Quality Of Care

- Cultural Competence
    - American Sign Language services and technologies.
- Beneficiary needs are matched to the continuum of care
    - Utilization management (guidelines for level of care decisions).
    - Computer-based psych testing.
- QI Plan
    - EBP certification.
    - Use Scriptlink tool to continuously improve data quality, error prevention, data entry experience, and time savings.

Beneficiary Progress

- Grievance and appeal system.

Structure And Operations

- Financial Services
    - Cental Business Office claims transmission solution.
    - IT Financial and Operations Management.
- Human Resource Services
    - Continuing medical education tracking.
- IT Services

    - Digital Signature (Adobe).
    - Digital Workplace: phone system modernization.
    - Risk Management: dynamic data masking.
    - Risk Management: multi-factor authentication for IBHIS.
    - Risk Management: security information and event management analytics.
    - User access request process automation.
- VSee secure video chat expansion.

Major Changes since Prior Year

Access to Care

- Access Center
    - Access Center caller place in queue (English only, state mandate).
    - Access Center Warm Lines and Portal (three COVID-19 lines for Community Emotional Support; Veterans; and Employee Well-Being).
    - Just4Me appointment reminders.
    - NACT Phase I - rewrite NACT 1.0 (enhanced data quality and integrity).
    - NACT Phase II - include FFS, hospital contacts and providers.
- Capacity Management
    - Mental Health Resource Locater and Navigator, Phase I.
- Integration and Collaboration
    - Department of Child & Family Services/LACDMH referral portal.
- Timeliness of Care
    - Client Services Information assessment record 2018 updates.
    - SRL web services enhancements (capture first psychiatry appointment data).

Quality of Care

- Cultural Competence
    - Multi-lingual translation services: Provider Directory.
- Beneficiary needs are matched to the continuum of care
    - Patients' Rights call log.

- QI Plan
    - Access Center CXone Performance Management (Provides agents with performance feedback/assist meeting Key Performance Indicators).
    - Scriptlink accomplishments:
        - Preventing filing of records under incorrect episodes deployed in the scheduling calendar, on progress notes, and during group registration.
        - Preventing concurrent assignment of more than one Primary Program of Service.
        - Preventing erroneous service code usage on progress notes (e.g., requiring or preventing face-to-face time based on requirements of selected service codes).
        - Auto-populating pertinent data for users (e.g. email and phone numbers for certain Client Consent and Acknowledgement forms).
        - Facilitating workflow by auto-launching a form based on a value selected on a different form (e.g., Special Use Progress Note option when appointments are marked as missed or cancelled).
- Quality management reports act as a change agent in the system
    - NACT Power Business Intel (Power BI application with approximately 28 reports in the dashboard).

Beneficiary Progress/Outcomes

- Access Center Customer Survey - NICE inContact Echo.

Structure and Operations

- IT Services
    - Amazon web services virtual desktop infrastructure.
- COVID-19 Dashboards:
    - Access Center calls.
    - Claiming and client services.
    - PPE distributions.
    - LACDMH Staff Teleworking.
    - Emergency Contacts.
    - Everbridge notification system.
    - Hardware and asset management.
    - HelpDesk incident volume.

  - Mental health services (DO).
  - Psychiatric Mobile Response Team dispatches.

- Everbridge mass communication notification system
- Risk Management:
  - Risk Management: advanced malware protection.
  - Risk Management: vulnerability assessment solution.
- VSee secure video chat initial rollout.

Other Areas for Improvement

- Plan the protocols necessary to benefit from the enhanced funding rates for services retroactively authorized by the state to manage COVID-19.
- Implement co-practitioner billing throughout the MHP to take advantage of increased revenues.

Plans for Information Systems Change

- The MHP is considering a new system but has no formal project plan in place and no project team assigned to accomplish it.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☒	☐	☐	☐
Assessments		☒	☐	☐	☐
Care Coordination		☒	☐	☐	☐
Document Imaging/Storage		☒	☐	☐	☐
Electronic Signature—MHP Beneficiary		☒	☐	☐	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Laboratory results (eLab)		☒	☐	☐	☐
Level of Care/Level of Service		☒	☐	☐	☐
Outcomes		☒	☐	☐	☐
Prescriptions (eRx)		☒	☐	☐	☐
Progress Notes		☒	☐	☐	☐
Referral Management		☒	☐	☐	☐
Treatment Plans		☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		12	0	0	0
FY 2019-20 Summary Totals for EHR Functionality:		12	0	0	0
FY 2018-19 Summary Totals for EHR Functionality:		12	0	0	0

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

- Table 25 ratings are based on IBHIS implementation for DO sites.
- The MHP's rollout of the Adobe Digital Signature platform has greatly facilitated staff doing telehealth work.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0.0%	Not Applicable
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	80.0%	Daily
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0.0%	Not Applicable
Direct data entry into MHP EHR system by contract provider staff	10.0%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0.0%	Not Applicable
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	10.0%	Daily

The rest of this section is applicable: ☒ Yes ☐ No

Some contract providers have EHR systems which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission

EHR Vendor	Product	Count of Providers Supported
Exym Inc.	EHR	63
Welligent	EHR	28
Clinivate	EHR	16
Netsmart Technologies, Inc	EHR	11
Caminar	EHR	2
The SSI Group LLC	EHR	2
Allscripts	EHR	1
Cerner	EHR	1
Local EHR	EHR	1
eSolutions	EHR	1
Qualifacts	EHR	1
Physcians' Management	Clearinghouse	64
UltraMED	Clearinghouse	7
California Medical Systems	Clearinghouse	6
EZ Claim	Clearinghouse	6
Classic Data Service	Clearinghouse	4
DP Medical	Clearinghouse	4
Professional Systems Corp.	Clearinghouse	4
Lytec	Clearinghouse	2
MD Systems	Clearinghouse	2
Office Ally, Inc.	Clearinghouse	2
Prime Clinical System	Clearinghouse	2

- C/LEs and FFS providers have implemented local EHR systems or have contracted with a healthcare clearinghouse to submit EDI transactions that support two-way exchange of data between local systems and IBHIS.

Personal Health Record (PHR)

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

☒ Yes ☐ No ☐ Implementation Phase

Expected implementation timeline:

☒ Already in place
☐ Within 6 months ☐ Within the next year
☐ Within the next two years ☐ Longer than 2 years

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☒ Yes	☐ No
View list of current medications through portal.	☒ Yes	☐ No
Have ability to both send/receive secure text messages with provider team.	☐ Yes	☒ No

- Although the PHR is capable of sending out appointment reminders, the MHP has turned this feature off during the COVID-19 crisis as it automatically informs beneficiaries that they need to come into the office for their appointment, even if this service is being delivered via telehealth.
- The PHR demonstrated by the MHP, Just4Me, is set up to only work in the DO programs. It is not working for the beneficiaries of the C/LEs.

- The PHR has a multi-step protocol for messaging. If a beneficiary texts into the PHR, it goes to a centralized location where staff will review to see what service team the message needs to be sent to. The message is then forwarded to the service team for response. The centralized staff monitor the forwarded messages to assure staff response.
- When beneficiaries begin services, they are assigned a personal identification number (PIN). They are not considered registered in the PHR until log-in using this PIN.
- The PHR has a suite of reports that will enable it to be effectively managed: who logged in, who sent a message, if the message was responded to, last log-in, how many times logged in, and how many medication refill requests were submitted.

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☐ Web-based application, including the MHP EHR system, supported by vendor or ASP staff
- ☐ Web-based application, supported by MHP or DMC staff
- ☒ Local SQL database, supported by MHP/Health/County staff
- ☐ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

Los Angeles MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**5,849,134**	**$1,367,891,444**	**142,735**	**$38,841,144**	**2.76%**	**$1,329,050,300**	**$1,250,678,702**
JAN19	541,883	$127,561,346	15,229	$3,915,893	2.98%	$123,645,453	$116,472,064
FEB19	470,638	$109,533,113	11,236	$3,313,749	2.94%	$106,219,364	$100,542,506
MAR19	504,099	$118,152,874	13,463	$3,914,687	3.21%	$114,238,187	$107,789,513
APR19	524,811	$122,867,642	12,707	$3,602,141	2.85%	$119,265,501	$112,077,005
MAY19	530,542	$123,627,756	13,202	$3,667,669	2.88%	$119,960,087	$112,540,369
JUN19	446,982	$104,238,603	11,602	$3,040,360	2.83%	$101,198,243	$94,605,847
JUL19	498,467	$116,289,941	12,584	$3,287,337	2.75%	$113,002,604	$105,547,761
AUG19	493,423	$115,156,339	12,285	$3,140,713	2.65%	$112,015,626	$105,338,565
SEP19	470,911	$110,437,374	11,015	$3,001,163	2.65%	$107,436,211	$101,105,170
OCT19	532,541	$125,455,183	12,159	$3,297,024	2.56%	$122,158,159	$115,127,675
NOV19	429,922	$101,187,342	8,851	$2,414,435	2.33%	$98,772,907	$93,322,137
DEC19	404,915	$93,383,933	8,402	$2,245,974	2.35%	$91,137,959	$86,210,091

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Los Angeles MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	69,695	$18,012,319	46%
Medicare or Other Health Coverage must be billed before submission of claim.	31,486	$9,018,432	23%
Beneficiary not eligible.	18,779	$4,653,978	12%
Beneficiary not eligible or non-covered charges.	3,666	$3,152,022	8%
Service line is a duplicate and a repeat service procedure code modifier not present.	15,162	$2,757,035	7%
Total	142,735	$38,841,144	NA

The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.

- Denied claim transactions with reason ‘Medicare or Other Health Coverage must be billed before submission of claim’ and ‘Service line is a duplicate and a repeat service procedure code modifier is not present’ are generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For LACDMH MHP, the time and distance requirements are 90 minutes and 60 miles for mental health services, and 90 minutes and 60 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's Network Adequacy rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	0
NPI Type 1 and 2 numbers are the same	1
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	46
NPI Type 1 number reported is associated with two or more providers	1
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	2
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	49

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted six 90-minute focus groups, three focus groups each from SA-2 and SA-5, with adult, transition age youth (TAY) consumers (MHP beneficiaries) and caregivers/family members of children/youth during the virtual review of the MHP. As part of the pre-site planning process, CalEQRO requested the six focus groups to consist of 10 to 12 participants each, the details of which can be found in each section below.

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

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	The SA-5 focus group was composed of DO and C/LE program adult beneficiaries who received services from the West area. The group was consistent with that requested by EQRO. Participants were all English speakers. The focus group was conducted via a Microsoft Teams session hosted by the MHP.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Zero
Interpreter used	No If yes, specify language: n/a

Topic	Description
Summary of the main findings of the focus group: Telehealth is a positive experience for the all of these individuals. Services are experienced as adequate to achieve progress.	
Access – new beneficiaries	n/a
Access – overall	Participants reported accessing care through referrals of an acute hospital and primary care clinics. Other agencies, such as Medi-Cal eligibility, provided information about other services in languages other than English. Prior to COVID-19 restrictions, some had received transportation support.
Timeliness	Some reported receiving twice per week therapy sessions for their children. Others reported once per week frequency which was considered sufficient. The majority receive psychiatry services for a medication evaluation once monthly; one participant currently has a pending referral to see a psychiatrist.
Urgent care and resource support	The need for additional services outside of routine appointments was met through a variety of mechanisms. Some call a peer advocate; others reach out to the therapist via text, email, or telephone. Only one identified the local emergency room as an option. All were aware of the warmline and crisis numbers.
Quality	These participants experienced involvement with treatment planning. Two participants have a WRAP in place. The others either did not know about or did not have a WRAP in place. Approximately half of the participants felt that information regarding their medications was adequate. Communication between PCPs and psychiatrists was known to occur by half of the participants. The majority recalled participating in satisfaction surveys with wide variance as to accessibility of the actual results. Some have seen survey results, but others have not.
Peer employment	All of the participants received offers of support in finding and keeping a job. None have secured employment.

Topic	Description
Structure and operations	During the past year, Wellness Outreach Workers started reaching out to all beneficiaries for check-ins which has been a positive for those experiencing isolation. The shift to telehealth – telephone and video – is thought to be improving the number and frequency of kept appointments. Some noted a preference for using telehealth such as Zoom over going to a clinic, which has helped with time management. Juggling family responsibilities and therapy needs was much easier with video appointments, which eliminates the issues of childcare and transportation.
Recommendations from this focus group	• All participants supported retention of telehealth after COVID-19 because of ease of access and improved integration with other responsibilities. • Create more online group therapy opportunities. • Improve the compassion of clinic front office staff; they are clearly stressed, and it shows.
Any best practices or innovations (optional)	• Telehealth is a very useful and convenient mechanism for providing services. • Didi Hirsch in Culver City received a specific commendation regarding the empathy and understanding conveyed to beneficiaries.

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	The SA-2 adult focus group was composed of DO and C/LE program beneficiaries who received services from the San Fernando Valley area. The focus group was consistent with that requested by EQRO. Participants were all English speakers. The focus group was conducted via a Microsoft Teams session hosted by the MHP.
Total number of participants	Ten
Number of participants who initiated services during the previous 12 months	One
Interpreter used	No If yes, specify language: N/A
Summary of the main findings of the focus group: The focus group participants were generally quite satisfied with their services and received varying levels of service intensity according to their needs. The majority expressed a desire for reinstatement of treatment groups and increased use of Zoom (contract providers only) for virtual sessions. A number of participants expressed dissatisfaction with a local acute inpatient unit, which was felt to be an unsafe and threatening environment. The MHP was advised of specifics.	
Access – new beneficiaries	Only one individual had a relevant initial access experience and was referred by a physical health provider following diagnosis of a major health condition. The referral process took 30 days, but the experience was considered very good. This individual was surprised at the availability of mental health services from the MHP that would not have been covered by private health insurance.
Access – overall	The remaining participants reportedly referrals to care were made by a wide variety of entities which included friends and family, hospitals and medical clinics, a homeless shelter, and programs for victims of crime.

Topic	Description
	Assistance with access to care included transportation for the vast majority, with some provided bus passes and others physically transported to doctor appointments. The majority were aware of services in non-English languages. Information about other health and supportive services were said to be posted in lobbies. For most, it has been months since clinic visits and face-to-face sessions occurred.
Timeliness	Almost all participants received psychotherapy (90 percent); six participants were weekly, two participants were every two weeks, and one participant was monthly. The majority felt this frequency was sufficient; one was arranging to increase frequency. Half of this group received psychiatry services. The psychiatry service frequency ranged between every two and three months. All considered this level of service sufficient. Responsiveness to emerging medication related needs, such as side-effects or need for refills, was considered adequate by all. Clinic nurses also provided assistance with pharmacy-related issues. Missed appointments were followed by MHP calls to reschedule. Half of this group received appointment reminder calls. Session participants reported attending telehealth video sessions furnished by both DO and contracted legal entity providers.
Urgent care and resource support	Urgent needs were met through contacting the provider clinic, therapist, or case manager. They found the staff to be easily reached and quick to respond. Several complaints were registered about a local psychiatric inpatient facility that were conveyed in detail to the MHP. Few were aware of the MHP's warmline.
Quality	All participants felt involved in treatment planning. Several had WRAP plans, with the remainder unaware of the WRAP process. Medication information was either provided directly by the psychiatrists or in combination with written material. None have been offered any sort of formal medication education class, but many were interested. Less than half were aware of any communication between psychiatry and PCPs.

Topic	Description
	One participant has membership to the Client Advisory Council, and functions as a liaison between beneficiaries and administration. Meetings occur once per month. Participants provided feedback on what was working, what consumers thought about services, and furnished suggestions for improvements. Participation in system planning activities beyond the council was not experienced as an option by these individuals.
Peer employment	Three participants received assistance with job seeking and employment. This included referrals to a local employment agency.
Structure and operations	n/a
Recommendations from this focus group	• Reinstate groups discontinued due to COVID-19, substituting virtual groups for in-person sessions. • Investigate the complaints about the local psychiatric hospital.
Any best practices or innovations (optional)	• Zoom therapy groups.

CFM Focus Group Three

Table 34: Focus Group Three Description and Findings

Topic	Description
Focus group type	The SA-2 TAY focus group was composed of contract and DO program beneficiaries who received services from the San Fernando Valley area. The focus group was consistent with that requested by EQRO. Participants were all English speakers. The focus group was conducted via a Microsoft Teams session hosted by the MHP.
Total number of participants	Four
Number of participants who initiated services during the previous 12 months	Three
Interpreter used	No If yes, specify language: N/A
Summary of the main findings of the focus group: This SA-2 TAY focus group consisted of a limited number of participants who were quite satisfied with services. Their chief complaints were about technical connectivity issues with telehealth, mainly bandwidth problems that disrupted treatment sessions.	
Access – new beneficiaries	Referral to services occurred by either by a PCP or by a group home. The experience was considered quick and easy, with some supported through the process by group home personnel. The need to repeat one's story multiple times was the only negative identified.
Access – overall	Social workers or other community practitioners were identified as the source of referral and service information for those who entered services more than one year ago. Some received information from school about mental health services. Transportation help to appointments was offered but not needed by these participants. All participants received weekly therapy.

Topic	Description
	The majority of participants did not receive psychiatry services. Most have not missed any appointments, but for those who have, immediate follow-up calls to reschedule occurred.
Timeliness	Initial access to care occurred within one or two weeks of first request.
Urgent care and resource support	All participants would call their therapist if an urgent issue arose. None had experienced that need. Only one was aware of the warmline.
Quality	Appointment reminder calls were not routinely received by these participants, but they did receive a message with a VSee or Zoom link for telehealth sessions. Involvement in treatment planning was an experience all shared. The psychiatrist regularly discusses medications and also will go online during sessions to obtain more medication information. None were aware of information sharing between PCPs and psychiatry. This EQR focus group was the first time any could recall being asked for their feedback regarding services.
Peer employment	The school program and educational process prepared participants for employment. Some have received therapist assistance enrolling in college. Others have received help preparing for independent living.
Structure and operations	Telehealth technical issues were present at times for most participants. Data feed lag sometimes occurred during video sessions, and telephonic sessions also lost connectivity at times. But overall, the telehealth experience was positive. For those who were interested in more information about mental health services, social media and school workshops were cited as a source. Another participated in Mental Health Month, and Suicide Awareness Month.
Recommendations from this focus group	• No suggestions to improve services were provided by this group.
Any best practices or innovations (optional)	n/a

CFM Focus Group Four

Table 35: Focus Group Four Description and Findings

Topic	Description
Focus group type	The SA-5 TAY focus group was composed of DO and C/LE program beneficiaries who received services from the West area. The focus group was consistent with that requested by EQRO. Participants were all English speakers. The focus group was conducted via a Microsoft Teams session hosted by the MHP.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Three
Interpreter used	No If yes, specify language: N/A
Summary of the main findings of the focus group: Overall, TAY beneficiaries were satisfied with services and experienced telehealth as a convenient and efficient way of obtaining services. Social isolation remains a significant issue. Lastly, stigma around mental health treatment requires greater effort to reach parents from the Latino culture.	
Access – new beneficiaries	Participants became aware of services through a number of avenues, including referral by a friend, a social worker, and another through a college contact. The ease with which the initial access process was navigated varied among these participants. Only one felt the process was straightforward, but also acknowledged that stigma and ambivalence towards seeking treatment was a personal issue. The participant referred to treatment by a college experienced the support of school contact, which made the process easier. Another participant succinctly described the experience as: If one did not have mental health issues, it might be easier.
Access – overall	For those who have been in treatment for more than one year, access occurred when walking by a clinic on the way to work. This individual entered treatment within two to three

Topic	Description
	weeks of first contact. The reception was described as supportive and friendly, which was a pleasant surprise. Transportation to services was addressed through varied mechanisms. LA Care, the local health plan, provides transportation for some. Other participants recounted the offer of services at school or at home. Several have no need for transportation help. All were aware of services offered in English and Spanish. Several had seen posters offering services supported by an interpreter. Some thought the actual capacity to provide services in Spanish and serve the Latino culture was inadequate. Brochures promoting treatment were reported at schools and county programs. Some feedback indicated that the content of these flyers would benefit from more review and input by consumers because the content was less than informative regarding their questions prior to accessing care. Appointment reminders are frequently received by these TAY individuals. This includes text and voice mail messages. If an appointment is missed, most receive follow-up contact from the therapist.
Timeliness	For those initially accessing services during the last year, time to service was mostly within two weeks, with one experiencing a month between request and services. Psychiatry service access was stated as much quicker than the LA Care process, which was reportedly as long as six months.
Urgent care and resource support	None of the participants were aware of a warmline. When services are needed outside of regular appointments, some call the hotline. Most were apprehensive about calling suicide or crisis lines due to experiences with escalation to an ER visit and thereafter being heavily medicated. Several felt calls to express current feelings went awry when contact made with formal telephone support lines resulted in an unneeded crisis team response.
Quality	The majority reported weekly sessions at the onset of treatment. Currently, the participants all had differing frequencies of services. Some received services every two weeks; others continued with weekly sessions with more as needed. Only a small minority felt the current frequency was

Topic	Description
	insufficient – but this was due to limitations placed upon payment by personal health insurance. Psychiatric services are usually monthly, and access is rapid. More frequent contact occurs when medications are changed and if side-effects develop. Turnover in psychiatric provider was identified as producing barriers to maintaining rapport with the practitioner; however, all providers were friendly and attentive. Communication between clinician and psychiatrist was known to be frequent and comprehensive. Family and group therapy were offered to these individuals, but participation varied according to individual preferences and circumstances. Less formal support services were utilized by some. These include after school programs, Active Minds, and NAMI programs. None were aware of any formal online support groups. All participants were involved in treatment plan development, identifying treatment goals and tracking progress. None were aware of the WRAP process. Medication information was provided verbally by the psychiatrist, with written material provided by the pharmacy. Several participants have authorized communication between psychiatry and PCPs. The changes in service delivery since COVID-19 restrictions occurred were positive with telehealth, which makes it easy to hop on and off appointments. Beneficiaries have received more surveys to assess satisfaction. Experience with wellness centers was limited to a Hollywood Lesbian, Gay, Bisexual, Transgender or Questioning program that provides an open, welcoming, and supportive drop-in center for youth.
Peer employment	TAY participants received assistance from an occupational therapist, educational support, and help with college applications.
Structure and operations	The use of telehealth was a topic with considerable feedback. On a personal level, most of the TAY participants missed face-to-face sessions because it was an opportunity to get out of the house and make social contacts. The technical issues with virtual sessions were also mentioned. Some find Microsoft Teams troublesome and a

Topic	Description
	barrier (contract provider). Others mentioned WI-FI and connectivity drops to occur at times which makes for challenging virtual sessions. Some mentioned the transition to Zoom as a positive change, actually preferring appointment by phone and/or video. The white board feature in Zoom was seen as a positive way to share thoughts and participate in therapy exercises. One of the challenges identified by the group was the lack of a direct line to therapists and the need to go through the front office. It would be helpful to have direct access to the therapist's message number to ensure that calls are quickly and accurately routed. Communication regarding changes in services was provided by case managers, emailed flyers, and therapists. The majority of participants have provided feedback through email or at the program. Some believe the surveys are too vague to be helpful. Also, none of the participants have seen the survey results. None of the participants were aware of opportunities to participate in MHP committees, such as the Quality Improvement Committee (QIC).
Recommendations from this focus group	• Increase efforts to address stigma among Latinos regarding mental health. • Provide townhall meetings for parents to learn about mental health conditions and treatment. • Treatment staff to adopt a non-judgmental acceptance approach to substance use for self-medication. • Obtain input from beneficiaries when developing satisfaction surveys. • MHP to provide more outreach and engagement activities.
Any best practices or innovations (optional)	• Telehealth is a very useful change that would have greater impact if technical issues were resolved.

CFM Focus Group Five

Table 36: Focus Group Five Description and Findings

Topic	Description
Focus group type	The SA-5 child caregiver focus group was composed of DO and C/LE program beneficiaries who received services from the West area. The focus group was consistent with that requested by EQRO. Participants were all English speakers. The focus group was conducted via a Microsoft Teams session hosted by the MHP.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Two
Interpreter used	No If yes, specify language: N/A
Summary of the main findings of the focus group: Overall, the caregivers were satisfied with treatment, with the exception of preferring face-to-face to telehealth services. The most prominent request targeted the wish for ongoing video support groups for the children in treatment.	
Access – new beneficiaries	Initial access overall went smoothly. The UCLA Ties access process, which involved a survey and scheduling an assessment, was experienced as extending the time to treatment.
Access – overall	Pre-adoption training linked one family to the UCLA Ties program. Another experienced some difficulties getting quickly into treatment, which resulted in a crisis event occurring which then resulted in expedited access. Another was referred by a pediatrician, and the time to service was only one week. Most recalled the offer of services in non-English languages. Information about other supportive services was found in lobbies and handed out by providers and parent partners. Psychiatry services were not required by many of the participants. The few that have received psychiatry services consider the frequency adequate and that they are provided with adequate information about the medication effects.

Topic	Description
Timeliness	Initial access ranged from several weeks to a few months.
Urgent care and resource support	All participants had phone numbers and a plan on how to proceed should a crisis occur. That plan included a call to the therapist or crisis response. None were aware of a warmline service for support.
Quality	The level of services aligned well with the needs of the child. FSP children received twice weekly therapy and behavioral interventions. One caregiver opined that twice weekly sessions may be too much. The level of services was generally well-matched to the needs of the child. Services by Zoom or Microsoft Teams were considered acceptable; however, an aspect of the connection was missing when not provided in person. Appointment reminders were relevant to some of these caregivers. Others did not require reminders and followed a regular appointment schedule. A minority found it difficult to reschedule appointments. Most were offered family therapy, and some have also utilized support groups run by the provider. All experienced involvement in treatment plan development, with both child and parents asked for input. For some, therapy sessions were more frequent since COVID-19 forced the shift to telehealth. But some higher acuity or reluctant to engage children may not progress as well with the absence of face-to-face sessions.
Peer employment	N/A
Structure and operations	A few of these participants have not been kept up to date on changes since COVID-19. Others received updates and pamphlets from the clinician or the website. Some reported receiving flyers via email. In regard to providing feedback on services, some have taken a survey; others have used an “open-door” policy to inform the program of their needs. None could recall seeing survey results. There was only one instance where feedback was acted upon and the caregiver was made aware of the changes. None of the caregivers knew of or took part in MHP planning or monitoring committees.

Topic	Description
Recommendations from this focus group	• Structure TBS and WRAP as continuous programs for those in need, instead of arbitrarily time-limited – which requires cycling through again. • Actively seek out and hire more black male therapists to improve the connection between child and therapist, particularly with clinicians who have themselves been through the system of care. • Less red tape and barriers to accessing higher levels of care when they are needed – such as TBS, Wraparound. • Provide more ongoing support groups for children to be able to share amongst themselves and learn from each other on how to deal with challenging life situations.
Any best practices or innovations (optional)	n/a

CFM Focus Group Six

Table 37: Focus Group Six Description and Findings

Topic	Description
Focus group type	The SA-2 parent/caregiver focus group was composed of DO and C/LE program beneficiaries who received services from the San Fernando Valley area. The focus group was consistent with that requested by EQRO. Participants were all English speakers. The focus group was conducted via a Microsoft Teams session hosted by the MHP. A Spanish-speaking caregiver joined after the interpreter left the call and was separately interviewed after the review concluded.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Three
Interpreter used	No If yes, specify language: N/A
Summary of the main findings of the focus group: Participants were very satisfied with services, both therapy and psychiatry. Overall, the changes in treatment with COVID-19 restrictions were experienced as positive. There remains a preference for face-to-face sessions for very young children, the cognitively impaired, and for treatment resistive youth. The absence of ongoing support group availability merits exploration, in that COVID-19 restrictions are resulting in a sense of social isolation for so many.	
Access – new beneficiaries	Referral for treatment was by a social worker, and the time to service approximately one week. For another, referral for treatment was automatic due to foster care status. The time to treatment ranged from one to two weeks.
Access – overall	Overall, the frequency of services was tailored to the needs of the child and family. Frequency varied from weekly to every other week. Session length and mode of service delivery also varied, with video sessions most common but telephonic services used in some cases.

Topic	Description
	Most reported that reminder calls do not occur, but sessions are sent to them electronically. Missed appointments received follow-up with a telephone call by the clinician. For most, transportation assistance was not relevant in that services were by telehealth. All felt the intensity of services was adequate to make progress. Most were informed of the languages in which services were available, specifically citing Spanish, Armenian, and Korean. Family therapy was received by one participant, and others voiced the opinion that this modality would be appreciated due to complex family issues. None were aware of nor offered support groups. Psychiatry was not utilized by all. Those few who received psychiatry services had positive comments about the quality of care and connection by virtual sessions. Psychiatry frequency was every two weeks to monthly.
Timeliness	Initial timeliness access was for most within one to two weeks.
Urgent care and resource support	All participants had information about crisis and urgent responses including during working hours and after-hours.
Quality	Psychiatrist communication with PCPs did occur at times, particularly with complicated issues. The quality of psychiatry services was praised by all who received them. Information about other available resources was frequently shared via new flyers that described the resources, such as food pantries and other options. Support groups did not appear to be available to these participants. Active involvement in treatment planning was reported by all. The focus group's preference for services were: face-to-face first; Zoom/virtual sessions second; and telephone last. Telephone was preferred as a temporary measure, not for ongoing care. The MHP's web presence was experienced as complicated and confusing when information relevant to families was sought. It was not known if the MHP website experiences were prior or after the recent redesign.

Topic	Description
	Most of the participants had not provided feedback through an MHP survey. For others the first feedback opportunity was the EQR Survey Monkey questionnaire. Those who had responded to an MHP survey were unaware of the results. (Note: Within the past six months the MHP used beneficiary feedback to create more beneficiary-friendly summaries of the state CPS.) The theme of stigma emerged also in this focus group. The specifics were associated with fear of losing children to child welfare services action if seeking treatment because of the mandated reporting process.
Peer employment	N/A
Structure and operations	The shift to telehealth, including telephonic services, was apparent. To varying degrees programs have adopted virtual sessions, such as Microsoft Teams, Zoom, or VSee. For certain populations, such as very young children and the cognitively impaired, a clear preference for face-to-face sessions emerged. It was unclear the extent that this preference was influenced by technical problems, such as internet bandwidth and session disruptions. But technical issues do impact satisfaction with telehealth. Some programs seem to prefer the use of telephone for telehealth services, which is less satisfactory for the beneficiary. Also, the beneficiaries who are reluctant or resistant to engage with treatment are more difficult to reach with telehealth.
Recommendations from this focus group	• Refinement of telehealth service delivery and resolution of technical issues, such as connectivity. • Universal availability of support groups for children and youth would likely be utilized considering the social isolation associated with COVID-19 control measures. • Return to face-to-face is desired by some, particularly those with very young children or engagement-resistant youth.
Any best practices or innovations (optional)	n/a

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 38 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 38: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	13
The MHP shifted to 90 percent telework for staff and 80 percent telehealth for beneficiaries in response to COVID-19, including the Help Line. The MHP adopted VSee, a HIPAA compliant telehealth platform. This platform is seeing increasing use in DO programs and is anticipated to eventually integrate with the Avatar EHR. C/LE providers each have adapted to the telehealth modality as well, variously using Zoom or Microsoft Teams as the virtual platform and also using telephonic treatment. The MHP transformed the website since the last review period, creating a more user-friendly, accessible format. The redesign made the provider directory very easy to locate on the MHP's homepage; however, CPS summaries modified to better serve beneficiaries and caregivers remain challenging to locate unless one knows what they are called or the exact location. LACDMH recently created an overarching Help Line (800-854-7771), which serves as the primary entry point for mental health services and to connect to other virtual support within the county.			

Component		Maximum Possible	MHP Score
The Help Line offers free and confidential services to callers through three distinct lines: the ACCESS Center, Emotional Support Services, and Veteran or Military Family Member Support. Callers engage with staff in any of the Los Angeles threshold languages. Beneficiaries are also offered a text line for access to support and for those reluctant to use the telephone. This online resource includes a prominent description of available linguistic and transportation assistance. LACDMH actively monitors the Access Line for number of calls received, wait times, and performance of tests calls. Since the COVID-19 practice changes, Access Line call pick-up times were quicker than previously, despite increased volume and staff working from home. Information from test calls are submitted to the state and are also used for QI at the Access Line. PCP referrals are tracked through a special hotline for managed care providers. The MHP presented actions taken to correct for quality of interpreting issues identified during the review period. Beneficiary feedback regarding the website was largely positive, with a few comments about the quite complex website information presentation. Provider sites offer pamphlets and printed information on services and community and partnering agencies. Overall, the MHP received largely positive comments about the changes since the prior structure.			
1B	Capacity Management	10	9
The MHP provided the 2019 Annual QI Work Plan Evaluation. This document contains a complex review of the various populations, including linguistic, cultural/ethnic needs, and service efforts. As part of LACDMH's capacity analysis, the MHP includes individuals at 138 percent of the poverty level. Contract monitoring staff are also included in the review and consideration of this information as part of contract re-evaluations and updates. The MHP also provided the Cultural Competence Plan (CCP) that was updated August 2020. This document provided a detailed picture of the populations served, with emphasis on identification of groups that require particular skills and linguistic needs. Efforts to improve engagement were identified and tracked. The Access to Care Leadership Committee performs a monthly review of timeliness by entity and program and will also consider the issue of access parity between DO and C/LE programs. Part of this committee's work is to look at equality and proportionate referrals routed to the two categories of DO and C/LE programs. Line staff and clinical supervision staff mentioned monitoring of caseload sizes, intensity of service needs, and productivity. Following the initial month or so of COVID-19 restrictions, there was a significant dip in productivity which has subsequently rebounded and is currently greater than pre-COVID-19.			

Component		Maximum Possible	MHP Score
The MHP is tracking the trends of service delivery methods, separating reporting of telephone services from video telehealth services. Effort was made to understand the challenges, abilities, and support needed by various populations. Noteworthy is the hiring freeze in all DO programs. There has been turnover since the COVID-19 pandemic struck, and the inability to fill vacant clinical positions creates challenges in provision of standard levels of care. Currently, it appears that the hiring freeze will likely last until June 2021; however, there have also been discussions of possible selective lifting of the hiring freeze in January 2021 for some essential positions such as psychiatry. C/LE programs have no restrictions on filling vacant positions.			
1C	Integration and Collaboration	24	23
LACDMH engages in collaborative efforts with a wide range of formal health programs and community entities that provide ancillary support such as the Housing Authority. Co-location occurs with PCPs at Federally Qualified Health Centers (FQHC). Hospital liaisons provide linkage to services; schools have onsite services through the provider network; and law enforcement integration and collaboration occurs with Mental Health Evaluation Team (MET) and System-wide Mental Health Assessment Response Teams (SMART) within the City of Los Angeles. In addition, the School Threat Assessment Response Team (START) provides interventions with potential self- or other-directed violence in schools. The MHP and DOR have a contract to perform work/vocational assessments at a clinic site. Collaboration with the County Public Health Department's Substance Abuse Prevention and Control is an ongoing relationship. Other partnerships with Community Based Organizations and faith-based organizations are most notable within the SA and Health Neighborhood community partner meetings.			

Timeliness of Services

As shown in Table 39, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 39: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16

Component		Maximum Possible	MHP Score
The MHP reports first offered appointment data separately for DO programs and C/LE agencies. Of the 64,932 first offered DO appointment events reported during the current reporting period (FY 2019-20 data), 55,514 (85.77 percent) of all events met the 10-business day standard. The total reported events increased by 32 percent between the prior and current review periods. The MHP cites FC information as likely under-reported. The data is reliant upon a number of systems in which consistent reporting is not assured. This data is under continuous scrutiny which should also cause improved information quality. Contract providers reported an aggregate 40,615 first offered appointments, with 23,869 (58.77) percent meeting the 10-business day standard. Adult data indicated a 10.29 day mean and 69.88 percent achievement; children's services had a 15.05 day mean with 55.49 percent achievement; and FC experienced an 18.03 day mean with 48.50 percent achievement of standard. The total number of contract provider reported events increased by 282 percent from the FY 2019-20 review. First offered appointments were reported by language split out by DO and C/LE programs. DO: The 10-business day standard was achieved 86 percent for English, 85 percent for Spanish, and all others were 73 percent. C/LE programs: The 10-business day standard was met 60 percent for English, 52 percent for Spanish, and all others were 71 percent. Due to some programs facing challenges with meeting the 10-business day standard, the MHP developed a non-clinical PIP that was focused on improvement of timeliness. The Access to Care Leadership Committee meeting was tasked with regular, monthly review of this information. The MHP has not established a standard or goal for the time from initial request to first kept appointment.			
2B	First Offered Psychiatry Appointment	12	10
The number of DO first offered psychiatry appointment events for the FY 2020-21 review cycle reflected a 97 percent drop from those reported for the prior review (467 vs. 16,760). From C/LE programs, the reported events were also less, by 85 percent. The prior FY 2019-20 review (FY 2018-19 data) utilized kept appointments, which should have reduced rather than increased the total reported events. Both DO and C/LE metrics indicate the need for further exploration of the data collection components for first offered psychiatry services to ensure accuracy. Data for DO programs of first offered psychiatric appointments for adults and children/youth were well under the 15-business day standard, with achievement above 85 percent. FC youth events were small in number and reflected a 30.18 business day mean and 45.45 percent achievement of standard. Here, too, FC reflected a decrease of 90			

Component		Maximum Possible	MHP Score
percent in the number of reported events between the prior and current year (120 vs. 11). The total of C/LE psychiatry offered events reported in the previous year was 637, contrasted with 94 events during the current period, marking an 85 percent decrease. Actual C/LE provider performance data was slightly less than the 15-business day standard for adults and FC, while children and youth were better at 9.01 mean business days. Achievement of standard was lowest for FC at 51.43 percent, adults at 60.87 percent, and children and youth at 74.29 percent. When reported by preferred language, DO programs met the 15-business day standard in English 86 percent, and in Spanish 91 percent. C/LE providers were able to meet the 15-business day standard in English 71 percent, Spanish 100 percent (caveat: two events). As previously mentioned, timeliness is an area targeted for improvement with a PIP and involves monthly review of data by the Access to Care Leadership Committee. The first offered psychiatry appointment is not a metric included in that PIP. The significant reductions in reported events is a topic worthy of exploration to ensure there is not a data capture issue with the multiple and complex systems in place that include the SRL, SRTS, KAEMS, and IBHIS.			
2C	Timely Appointments for Urgent Conditions	18	15
The MHP's reporting on urgent service requests was limited to SRL events with DO programs, consistent with the previous review. This reporting relies on the proxy of business days for actual hours, which are requested in the metric. In addition, the reporting is based on the offered or accepted appointment, not actual received service as described in the metric. The MHP reported a total of 244 adult urgent requests, with a mean of 248 hours; 47 children's requests were recorded with a mean of 218 hours; and 21 FC requests, with a mean of 183 hours. Achievement of standard ranged from 23 percent for FC, to a high of nearly 33 percent for adults. This data provides support to the rationale for inclusion of urgent care in the timeliness PIP. The experience of beneficiaries who participated in one of the six focus groups conducted was that urgent needs were met in a quick manner, often same day and usually within 24 hours. Very few reported delays in urgent care need response. When viewed by language, DO urgent requests met the 48-hour standard highest in: Spanish 38 percent, English 33 percent, and other languages 17 percent. There was no data available from C/LE programs. The MHP needs to develop a mechanism to track time to actual received urgent care service, which better reflects performance and positive beneficiary impact, and is specified by the metric.			

Component		Maximum Possible	MHP Score
2D	Timely Access to Follow-up Appointments after Hospitalization	10	8
The MHP reported a total of 36,296 hospitalization events for the review period, a 7.3 percent decrease over the FY 2019-20 (FY 2018-19 data). Achievement of standard was above 84 percent for all populations. The MHP utilizes a five-business day standard for post-hospital follow-up, equivalent to the seven-calendar day HEDIS measure. The MHP excludes hospitalizations wherein an outpatient referral was not made by the treating hospital. Since post-discharge follow-up is known to be a key factor in prevention of rehospitalizations (see 2E metric below), the MHP is advised to seek development of a methodology that requests treating hospitals to make referrals for outpatient follow-up, as appropriate. The MHP is in the process of implementing concurrent review of all Medi-Cal (MC) acute admissions, and this process may provide an opportunity to communicate that message. LACDMH established a PIP for improving timeliness metrics, including post-hospital follow-up. All review sessions that included line staff and/or supervisors confirmed that a five-day follow-up standard was expected and in almost all cases occurred.			
2E	Psychiatric Inpatient Rehospitalizations	6	4
LACDMH total rehospitalizations decreased by 8.67 percent between the prior and current review periods. The reported readmission rates were adult's 33.4 percent, children's 14.98 percent; and FC 23.97 percent. The adult population experiencing in excess of 30 percent rehospitalizations merits further exploration. This would couple well with the post-hospital follow-up, and targeted efforts to communicate the importance of notifying LACDMH of discharges so that aftercare can be assured.			
2F	Tracks and Trends No-Shows	10	9
Due to the different EHR systems in use by the MHP's DO programs versus C/LE providers, reporting is limited to DO programs. Reporting out by C/LE entities is not required by DHCS in their monitoring. LACDMH does not have a no-show standard for clinicians or psychiatrists/other prescribers. The MHP's reporting of psychiatry no-show events increased by 5.9 percent between the prior and current review periods. Psychiatry no-shows: adults averaged 13.53 percent, children's 8.99 percent, and FC 10.66 percent. DO reporting for other clinicians: adults' 8.98 percent, children's 7.39 percent, and FC 5.89 percent. Non-prescriber events reported reflected a 10.8 percent increase over			

Component	Maximum Possible	MHP Score
the prior year. The reported no-show percentages do not present an unusually high picture that would merit deeper study.		

Quality of Care

In Table 40, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 40: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
LACDMH submitted a CCP of FY 2018-19, updated August 2020. It demonstrates ongoing review and update of the assessment of the cultural, ethnic, racial, and linguistic needs of beneficiaries. Based on data analysis the MHP established strategies with both an overarching and specific SA focus. The MHP also describes the success and challenge areas and includes data from CY 2019.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	9
LACDMH utilizes a structured process for the referrals to FSP programs in each SA. Within routine clinic operations there are processes for determining level of services. These levels typically start with clinician services, and often includes psychiatry, case management, and other services. Stabilized individuals may graduate to largely medications-only. The majority of beneficiaries interviewed for this review felt their wishes and needs were respected. Over time, the MHP has considered development of a more formal level of care system but considering the scale of operations and the blend of DO and C/LE programs this will be a lengthy and complicated process. Within the child and youth population, consistent, system-wide instruments are universally applied and used to inform the assessment process. In the months since the impact of COVID-19 was initially experienced, the stress of social isolation and pandemic-related fears have delayed the typical transitioning of beneficiaries out of treatment. Focus group input from this review also indicated that the MHP's			

Component		Maximum Possible	MHP Score
sponsorship of online support groups would be a welcomed adjunct to more formalized treatment.			
3C	Quality Improvement Plan	10	10
The MHP operates with a current QI Work Plan and produced a summary of results for the prior year plan. Elements of this plan are reviewed monthly, others quarterly or every six months. The QI team, in collaboration with multiple other units and divisions, develops a work plan each calendar year with goals related to seven domains: service delivery capacity, accessibility of services, beneficiary satisfaction, clinical care, continuity of care, provider appeals, and performance improvement projects. The individual goals include measurable objectives, relevant indicators, and target populations. The QI Evaluation Report, which is also completed on a calendar year basis, includes the prior year's findings and results for each goal in terms of whether or not the objective was met. To develop work plan goals for the upcoming calendar year, the QI team completes an analysis of the previous year's work plan goals and solicits other department priorities from leadership feedback and data review.			
3D	Quality Management Structure	14	13
The Quality, Outcomes, and Training Division (QOTD) was launched in January 2020 and includes the QI and Quality Assurance (QA) units. The QI and QA managers have direct communication with the Deputy Director over the QOTD and regularly participate in executive leadership meetings. The reorganization of LACDMH along with state mandates on access and timeliness has provided sharper focus on the value of QI and QA practices and for these two units to work in tandem. The vision for the QI unit is to promote a QI culture and increase skilled use of QI practices within the department by partnering with departmental improvement efforts where they occur. Collaboration between QI and QA is a priority as they both test and implement state mandates and report on findings related to access, timeliness, quality, and outcomes of the larger system. Work toward this goal has already begun with the development and implementation of the Access to Care Leadership Workgroup and collaborative facilitation of the QI and QA countywide QIC meetings with providers to integrate discussions of departmental QA goals alongside discussions of QI practices which can be used to attain those goals. The Countywide QIC meetings represent a forum for QI to report on performance improvement project findings and beneficiary satisfaction trends and include representation from contract providers and SA leadership. The SA QIC monthly meetings allow for region-specific data review and include beneficiaries and community stakeholders. The QA unit also holds Network Adequacy webinars on a			

Component		Maximum Possible	MHP Score
monthly basis to ensure that providers are submitting timely and accurate data related to access to care. The efforts of QA and QI are clear and apparent at a higher organizational level; however, some review feedback identified short timelines for implementation of necessary changes and insufficient dialogue to discuss the specific expectations of implementation. General feedback was that greater continuous transparency between the QOTD, and the DO and C/LE programs would be a great assistance, including alerts to potential changes before the changes are thrust upon programs to implement.			
3E	QM Reports Act as a Change Agent in the System	10	10
LACDMH utilizes a broad array of reporting to monitor service access and quality. These reports are clearly used to help focus improvement efforts, as evidenced by the co-occurring treatment and timeliness PIPs. Routine use of baselines and sophisticated data analysis and reporting were evident in the work, using a combination of Plan-Do-Study-Act (PDSA) cycles coupled with more rigorous processes. The scale of MHP operations and data analytics elements that are resident in C/LE agency EHRs create challenges in some areas, such as timeliness reporting. This results in the need to develop ancillary external tracking and reporting platforms which do not always capture all the necessary data. Sustained efforts continue to be made to implement improvements in these systems.			
3F	Medication Management	12	8
The MHP made significant progress in the development of a draft system-wide medication monitoring process that encompasses DO and C/LE programs. The MHP presented a dashboard concept for medication monitoring of DO active beneficiaries, with reporting on the various monitored measures by SA. The dashboard will provide demographic information on prescribed individuals and support breakdown by clinic and SA. The MHP has created a peer review process internally, and created guidance for C/LE programs in performing their own reviews and reporting results. The MHP began the Peer Review process in December of 2019 through February 2020, with a pause occurring due to COVID-19. The process again resumed in June 2020 and was finalized in August 2020. A component of the review included the HEDIS and CMS measures. These include: Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS 2017); Diabetes Screening for people with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (HEDIS 2017); Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (CMS eMeasure), and many others. The process			

Component	Maximum Possible	MHP Score
will move to five charts per practitioner and will be extended to C/LE providers in FY 2021-22.		

Beneficiary Progress/Outcomes

In Table 41, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 41: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	9
Standardized instruments exist within the adult system and are related to diagnostic or symptomatology categories. The MHP has not adopted a specific instrument for use with all adult beneficiaries. The Child, Adolescent Needs and Strengths-50 (CANS-50) and the Pediatric Symptom Checklist – 35 (PSC-35) are universally used with children and youth, with additional diagnosis- or risk-related instruments also selectively used. The information presented by the MHP did not indicate aggregate information was currently available and under analysis for either the PSC-35 or the CANS-50			
4B	Beneficiary Perceptions	10	10
LACDMH participates in DHCS-mandated CPS data collection biannually, during spring and fall. Starting in 2019, the QI unit began presenting data on the percent of beneficiaries that agreed or strongly agreed with items in each of the eight survey domains over the past five survey periods to analyze and detect trends. Presentations of the domain-level data occurred in both the countywide QIC meeting and the SA QIC meetings. Following initial review of the domains over the past five survey periods, each SA also nominated two domains per age group for item-level review. Following item-level data review, SA QIC memberships were prompted to select up to three interventions to target trends in the data. For example, the SA 5 membership discussed offering more youth groups to address ratings regarding participation in choosing services and cultivating more community			

Component		Maximum Possible	MHP Score
and self-help resources across the services areas. This focus addressed the lower social connectedness in adults and older adults. Provider sites reported using the open-ended comments from the surveys to address immediate feedback, such as making the waiting room more inviting and offering a wider variety of appointment times. Quantitative data from the CPS data and qualitative data from the open-ended comments, when available, are compiled into annual CPS Outcomes Report and Open-Ended Comments reports, which are shared with the QIC membership and posted publicly on the QI website. Provider-level domain data reports are also compiled twice a year for each survey period and are distributed by email and at SA QIC meetings. Starting in 2020, the QI team conducted a stakeholder engagement process to elicit feedback on the CPS reports from beneficiaries during SA Leadership Teams and CCC meetings. Feedback was compiled in a PDSA cycle and incorporated into a plan to make reporting more user-friendly and accessible. One-page data handouts with a brief overview of several select data indicators were created and shared with QIC membership and made publicly available on the QI website. This is a best practice for communication of complex information to beneficiaries. (http://file.lacounty.gov/SDSInter/dmh/1077084_Example1pagehandoutSpring2019DifferentFormatAdults.pdf) In addition to the CPS data, LACDMH also administers beneficiary surveys and facilitates focus groups as part of performance improvement projects.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
Peer-run programs are available in all SAs across Los Angeles County. Peer provider agencies include Self Help and Recovery Exchange (SHARE!), Project Return, and the Westside Center for Independent Living. These agencies are 100 percent peer-run. Formal wellness centers are located throughout Los Angeles County and offer programming with at least 50 percent peer staff. The Peer Center is a DO drop-in center located at LACDMH headquarters; it is almost exclusively staffed by peers. The MHP has continued development of roles for peers in all facets of service delivery. Six CHWs were brought back to work in schools. TT included the hire of 20 CHWs to staff the transportation alternative to ambulances and paramedics 24/7. This operation will work closely with the HOME team that is focused on serving the homeless.			

Component	Maximum Possible	MHP Score
The HOME team also heavily relies on lived experience for its operation, which with a recent expansion resulted in peers comprising 35 percent of the 123 staff.		

Structure and Operations

In Table 42, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 42: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	28
The MHP provides the full array of SMHS, with day treatment intensive and day rehabilitation limited to children and youth and on a smaller scale than other services. During the COVID-19 changes in service delivery, face-to-face was limited to urgent and crisis needs at clinics; ongoing services are primarily delivered via telehealth. Outreach efforts have continued in the community to support engagement of the homeless. A substantial number of these individuals were temporarily housed in hotels under Project Roomkey, with CHWs providing support services. The Urgent Care Centers (UCCs) have continued their operations and report activity higher than pre-COVID-19. Challenges exist with UCCs acting as the backup program to outpatient clinics for beneficiaries with a need for medication refills. In addition, UCCs serve as an entry portal for individuals first accessing care, and due to clinic caseload changes may be required to maintain these individuals for 60 to 90 days. The MHP may wish to explore the role of UCCs to see if the broad role they are serving – bridge medication visits, crisis/urgent response to open beneficiaries, and carrying new entry individuals for up to three months until a clinic opening occurs - could be compromising the urgent response capacity.			
5B	Network Enhancements	18	18
The COVID-19 changes in practice resulted in 90 percent of the workforce working from home, with skeleton crews staffing clinics to respond to urgent and crisis needs. The data reported by the MHP indicated the majority of services were delivered by telephone, with a slowly increasing percentage of services occurring by video link. The MHP uses VSee, a HIPAA-compliant platform, for this function. C/LE agencies			

Component		Maximum Possible	MHP Score
use a variety of options, with some using the Zoom for Business with the HIPAA-compliant add-on. Other network enhancements such as wellness centers are still operational but provide video sessions. Mobile crisis response continues during COVID-19, as do some limited field-based services, often in support of the homeless mentally ill who are also at-risk for the virus.			
5C	Subcontracts/Contract Providers	16	10
The MHP reported nearly 80 percent of services provided by C/LE programs. To improve communication and coordination in each area, inclusion of C/LE providers with SA meetings was reinstated. C/LE providers are included in the CCC meetings. These providers are participants in the non-clinical PIP; however, their involvement was not evident in the development and planning process but are involved with implementation. C/LE agency key personnel note the loss of previously existing meeting formats that provided a venue to engage directly with MHP leadership on a regular basis and be better informed as to system priorities and coming changes. Much of current communications were reported as compliance focused.			
5D	Stakeholder Engagement	12	8
LACDMH has numerous stakeholder processes that include regional Service Area Leadership Team (SALT) meetings, Health Neighborhood meetings, and faith-based meetings. These meetings are accessible and attended by providers, beneficiaries, family, and community members. In addition, LACDMH has a long-standing CCC made up of beneficiaries, providers, and community members. LACDMH implemented a survey of non-county and county first responders, created with input from the Department of Public Health and other community partners. It was circulated in June 2020 and included Disaster Service Workers and first responders. The information gained was used to link respondents with many of the existent support resources to help them cope with the unusual and stressful COVID-19 work environment. The clear preference was for online resources, not in-person resources, likely reflecting apprehensions of COVID-19 exposure. The MHP holds countywide stakeholder meetings as part of the MHSA planning and approval process, and quarterly virtual townhalls for all LACDMH staff to provide regular updates. In general, beneficiaries receive information about changes from programs and clinicians. Involvement with planning or other administrative quality meetings like QIC is not common.			

Component		Maximum Possible	MHP Score
The MHP's efforts to configure CPS information into one-page highlights using input from stakeholders is a best practice. To be effective, this may require a home page prominent link for beneficiaries or family members to locate this material.			
5E	Peer Employment	8	6
The MHP utilizes peer positions within both DO and C/LE programs. Within the past year there have been significant expansions in a number of areas including TT which is nearing implementation. While the CHW position numbers are expanding, some reported that the second tier is not currently available within the LACDMH itself; to promote, incumbents must apply to other county departments that have implemented the second level. The efforts to support beneficiaries who are seeking jobs outside of mental health have been severely impacted because of the COVID-19 restrictions. Job opportunities are much more limited and job searches take much longer than previously. The need for digital literacy has become more prominent with the pandemic.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Los Angeles County MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- The MHP shifted service delivery from in-person based care to 80 percent telehealth in response to COVID-19, starting with telephonic services and soon thereafter making efforts to provide more video-supported telehealth. Clinics remain open for urgent and crisis services with limited coverage, with 90 percent of staff performing telework.
- The MHP's web presence underwent significant revision, with updating, simplification, and streamlining.
- A hiring freeze was instituted for all county programs, which has resulted in the MHP's inability to fill vacancies occurring in DO programs, including psychiatrist and other clinical line staff. The freeze was scheduled to be in effect until June 2021.

Strengths:

- In order to preserve C/LE programs immediately following the COVID-19 stay-at-home order, the MHP Director advocated successfully for these programs to receive advances on their contracts, thereby preserving programs and capacity that might have otherwise gone bankrupt.
- The MHP's overall penetration rates currently and for the past three-year period (CY 2017-19) exceeded both the statewide and large MHP averages. The same pattern holds true for Latino/Hispanic beneficiaries.
- Service delivery levels rebounded from the immediate effects of the COVID-19 impacts and are now at or above pre-COVID-19 levels. Some

beneficiaries report increased access to services, in both number and frequency of treatment.

- The MHP's Access Line is part of a larger Help Line that has components providing support and resources as well as assistance in seeking services.
- The data on Access Line staff performance when working from home indicates an overall faster call response in the face of much higher call volume.
- LACDMH created an Access to Care Leadership Committee that is tasked with the responsibility to track access and timeliness data and to provide intervention where programs demonstrate substandard results.

Opportunities for Improvement:

- The psychological effects of social isolation, civil unrest, and fears related to COVID-19 have caused an increased demand for services. This resulted in increased DO program caseload sizes and has presented challenges to provision of adequate levels of service in the face of the loss of program staff.
- Focus group participants were unaware of the additional supportive services that are available to them, such as the warmline, Active Minds, and other supports. This suggests review of the process which ensures that periodically throughout the course of treatment reminders of these important resources occurs.
- The increased demand for services since COVID-19 impacted the MHP does not seem to be a factor considered in the across-the-board hiring freeze that is affecting both licensed clinician positions and psychiatrists/nurse practitioners.

Timeliness of Services

Changes within the Past Year:

- The MHP initiated a non-clinical PIP targeting timeliness of first offered appointments, urgent services, post-hospital/jail events, juvenile hall release follow-up events.
- First offered psychiatry events involving DO programs decreased by 97 percent over the prior review period data (467 vs. 16,760). C/LE programs experienced an 85 percent decrease.

Strengths:

- DO programs reported 85.77 percent of first offered routine appointments met the 10-business day standard.
- The timeliness PIP includes the tracking of C/LE provider timeliness, a function historically limited to DO programs.

Opportunities for Improvement:

- In aggregate, C/LE providers met the 10-business day first offered clinical service 58.77 percent of the time. Tracked sub-populations were consistently below 70 percent achievement of standard.
- The timeliness PIP does not include the important metric of first offered psychiatry service.
- Current urgent care reporting was limited to DO programs and not able to capture time to actual kept appointments. DO programs used first offered or accepted appointment as a proxy.
- The MHP reported psychiatric inpatient readmission rates for adults was 33.4 percent.

Quality of Care

Changes within the Past Year:

- The MHP launched a revised departmental quality structure in January 2020. This created the QOTD and includes QI and QA units. There exists direct communication with the Deputy Director of QOTD, which in turn creates a presence within the Executive Team and leadership meetings. This change improves the MHP's ability to respond to changing compliance requirements and also create a strong QI process.
- One of the contract providers (Heritage Clinic) supplied the elderly population with a simpler technology to address their needs: GrandPads. This provided an effective means for increasing engagement. (https://www.grandpad.net/overview).
- The MHP's adoption of a HIPAA-compliant video service delivery platform (VSee) led to lower no-show rates and aids in the provision of culturally and linguistically competent services.

Strengths:

- The MHP has made strides in the development of a draft comprehensive medication monitoring plan that includes a peer review protocol, and

spans DO and C/LE programs. Some of the initial DO program findings were presented for this review.

- The MHP CY 2019 reported percentage of high-cost beneficiaries was 3.12 percent versus the statewide 3.49 percent figure. The average approved claims for high-cost beneficiaries was $49,351, and less than the statewide $51,883 figure.
- The MHP has initiated efforts to provide beneficiaries and other stakeholders with CPS results in a format that incorporates feedback into the design.
- The MHP demonstrated creativity and strong collaboration in utilizing various digital platform supports to meet the requirements of the EQR and other reviews.

Opportunities for Improvement:

- Communication between QA and programs – both DO and C/LE – remains a priority to focus upon. This includes the need to inform programs of possible changes due to mandates well in advance of implementation. It also includes a greater focus on obtaining input before compliance directions are finalized so that rework is not necessary. Identification of a consistent, specific liaison between QA and each program might be beneficial.
- MHP sponsored support groups for TAY, caregivers, and families were suggested multiple times during focus groups. This would assist families in learning from each other and provide a support network during these trying times.
- Greater provision of group therapy was suggested as a mechanism of treatment and also a benefit of bridging the social isolation that has occurred due to COVID-19 requirements.
- Complete implementation of the medication monitoring plan and peer review process, including C/LE providers, is an essential component of tracking quality. Tracking the SB 1291 HEDIS and CMS metrics is also essential to monitoring quality of services in this area.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP's QI program created a process which facilitated beneficiary and family input on the presentation of CPS data in a format easily accessed

and understood by key stakeholders. A one-page combination graphic and data presentation is now on the website for each key population.

- The MHP has made progress towards being able to produce aggregate CANS-50 and PSC-35 information from three discrete sources of LACDMH DO data (IBHIS), C/LE program data (web service), and direct entry into a useful reporting format that will be able to inform overall clinical services.

Strengths:

- Regional SA QIC meetings were used to identify two domains of the CPS to target for improvement based on data. Three interventions per SA were selected to target improvements in the key areas.

- Current program expansions include greater utilization of individuals with lived experience. Examples include the HOME team outreach to the homeless TT.

Opportunities for Improvement:

- The development of CANS-50 and PSC-35 aggregate reporting is not yet at a level to provide guidance to children and youth program operations.

Foster Care

Changes within the Past Year:

- A focus group was conducted with resource parents to identify the additional supports and training that would help them prepare to provide Therapeutic Foster Care services. The identified training needs are being delivered to resource parents during FY 2020-21.

- Between July 2019 and August 2020, 440 youth were placed into Los Angeles County and 3,044 youth were placed outside of the county.

Strengths:

- As of 2019, LACDMH began using the SRTS to support the linkage of children who are placed within and outside of Los Angeles County to access needed mental health care. This mechanism streamlines the referral process and provides an improved tracking process.

- The MHP tracks and trends prescribing data on follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) medications (HEDIS 2017 Measure; CMS eMeasure).

- The MHP implemented the CANS-50 and PSC-35 system-wide in July 2019. Progress is being made towards the creation of aggregated reports which present the data in a clinically useful manner. Currently, the CANS -50 information is utilized to assist with care planning through targeting the strengths and needs identified. The MHP is developing aggregate report tables that bring together CANS-50 and PSC-35 data from three collection portals: IBHIS for DO programs; web service for contractor administered instruments; and an EPSDT Outcome Measures Application, custom-built application.

Opportunities for Improvement:

- Contract provider first offered appointment data for this review period (FY 2019-20 data) reflected an 18.03 day mean, and 48.5 percent achievement of 10-business day standard. FC first offered psychiatry service reflected a 30.18 business day mean, with a quite small number of events that indicated a 90 percent decrease from the prior year. These changes may relate to a changed methodology in reporting.

- The MHP cannot yet produce all of the psychotropic tracking described in SB 1291 but is in the process of developing an automated system that will make this happen. This will include reporting the use of multiple concurrent psychotropics, antipsychotic use trends, multiple antipsychotics, metabolic monitoring, and also tracking first-line psychosocial care for children and adolescents receiving antipsychotics.

Information Systems

Changes within the Past Year:

- The MHP has hired a staff proficient in the use of Global Information Services to focus on integrating maps into reports and dashboards, increasing both utility and efficiency.

Strengths:

- Implementing Adobe Digital Signature facilitates beneficiaries being able to receive the full array of services in their homes.

- The MHP purchased 2,800 VSee video licenses for a large-scale implementation of a HIPAA-compliant video platform supporting staff in delivery of services from their homes.

- The Continuity of Care Document that is available through LANES is a benefit to both the providers and the beneficiaries of the MHP as it will decrease the need for multiple contacts to coordinate care.

Opportunities for Improvement:

- The MHP will consider the integration of a Reminder Call program into their EHR. Several beneficiaries in a consumer focus group shared that they had never received reminder calls before an appointment.

Structure and Operations

Changes within the Past Year:

- On-boarding staff via the NACT assures that all requirements are met prior to incorporation into the IBHIS. The Provider Application and Validation for Enrollment is then integrated to reduce likelihood of conflicting information.

- The MHP is implementing an advanced Help Line access call-in center with several new phone lines that will feed through one system with the goal of being as uniform as an air traffic control center.

Strengths:

- The MHP conducted a table-top exercise, one month before the stay-at-home orders were issued by the Governor, to begin preparations for the COVID-19 medical emergency. At that time, they considered 40 percent of staff staying home to be an extreme contingency.

- The MHP embraced Everbridge Mass Notification as a response to COVID-19 and then found it to be a valuable tool for assisting staff to manage the civil disruptions in central Los Angeles.

- Despite the challenges posed by COVID-19, the MHP continues the on-boarding process of C/LE's. There are two new LE's since the last review.

Opportunities for Improvement:

- Continued efforts to promote communication with both DO and C/LE programs remains a priority for this MHP.

- The loss of 10 percent of the MHP's revenue management staff will create difficulties in maintaining support for the current claiming environment.

- While the scope of the COVID-19 impacts could not be predicted, effective response required clear, consistent, and ongoing attention to

communication at all levels. Some review informants indicated the frequency and clarity of communication was disappointing, often with conflicting messages.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Clinical PIP: Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)

- Conclude the COD PIP and transform the process into general system improvement of SAC services.
- Develop a new clinical PIP topic that produces a broad beneficiary impact upon those served by both Directly Operated (DO) and Contract/Legal Entity (C/LE) programs.

Recommendation 2: Non-Clinical PIP: Timeliness

- Revise the orientation of this PIP to target improvements that have a direct beneficiary timeliness impact, with compliance adherence in a secondary role.
- Develop a specific set of best-practice interventions that are presented to under-performing providers. Track and report results associated with each intervention.
- Track application of the audit and feedback (A&F) process.
- Identify key metrics that track the beneficiary experience, including satisfaction.
- Ensure that timeliness data reporting resolves the recent extreme differences in event numbers of timeliness metrics year over year, and ensures the capture of urgent timeliness for C/LE programs which was unsuccessful during the current reporting period.

Access to Care

Recommendation 3: Expedite DO program review that considers caseload size, service volume, and position vacancies for the development of a prioritized exemption request with county leadership so that key clinical and psychiatry position are filled.

Timeliness of Services

Recommendation 4: Closely monitor psychiatry timeliness for FC youth, and develop interventions if long wait times persist.

Recommendation 5: Provide focused attention to support of Contract/LE programs that currently experience the greatest challenges in meeting the 10-business day initial access requirement.

Recommendation 6: The MHP's reported psychiatric inpatient readmission rate for adults of 33.4 percent merits investigation. Consider if there are links between this and the exclusion from post-hospital discharge follow-up tracking of those who were not specifically referred by hospitals for aftercare.

Quality of Care

Recommendation 7: Utilize the input of beneficiaries, family members, and staff to develop best practices for virtual services, that include frequency and duration of services, and populations best suited for virtual versus in-person. Consider expansion of additional modalities, such as group therapy, and MHP sponsored support groups, as suggested by beneficiaries. Consider development of direct telehealth technical support for beneficiaries that would decrease clinical staff time to resolving tech issues. Utilize findings for trainings with DO and C/LE program staff.

Recommendation 8: Finalize and implement the Medication Monitoring and Peer Review plan. Implement the DO component and target at least one Service Area (SA) for C/LE implementation. Include tracking of SB 1291 HEDIS and CMS metrics. (This recommendation is a follow-up from FY 2018-19.)

Beneficiary Outcomes

Recommendation 9: Begin the production of aggregate CANS-50 and PSC-35 information in a format that provides utility as programmatic guidance to Children and Youth services in both DO and C/LE areas.

Foster Care

Recommendation 10: Ensure the SB 1291 psychotropic and related HEDIS and CMS measure tracking has been implemented, including the health screening elements.

Information Systems

Recommendation 11: Build on field-based services developed during COVID-19 by supporting line-staff with mobile devices such as laptops, iPads, and smartphones. Leverage Adobe's signature protocol to support more efficient workflow for beneficiaries and staff.

Recommendation 12: Implement a strategy to encourage and assist the LEs to engage in LANES.

Structure and Operations

Recommendation 13: Target improvements in the system communication process with DO and C/LE programs, utilizing survey feedback to measure effectiveness. Obtain DO and C/LE program input to develop survey elements.

Recommendation 14: Develop regular meetings that promote a dialogue between contract providers' leadership and the MHP senior leadership to support a cohesive and collaborative integration of DO and C/LE programs.

Recommendation 15: Develop a comprehensive post-COVID-19 telehealth plan that maintains a robust telehealth presence.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment A—On-site Review Agenda

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

Table A1: EQRO Review Sessions

Los Angeles MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Supported Employment Interview
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, Lead Quality Reviewer
Lynda Hutchens, Second Quality Reviewer
Olivia Kozarev, Quality Reviewer
Bill Ullom, Chief Information Systems Reviewer
Lamar Brandysky, Information Systems Reviewer
Gloria Marrin, Consumer-Family Member
Pamela Roach, Consumer-Family Member

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

Sites of MHP Review

No MHP or C/LE sites were visited during this review.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Anderson	David	Division Chief, Enterprise Architecture	LACDMH CIOB
Andreani	Martha	QA Specialist – Mental Health	Providence St. John's
Arns	Paul	Clinical District Chief, Office of STATS and Informatics	LACDMH CIOB
Aronoff	Misty	QA/QI Manager / SA5 QIC Co-Chair	Step Up on Second
Avalos	Mirian	CIO	LACDMH CIOB
Avelar	Alicia	Senior Secretary III	LACDMH
Baikov	Sima	Mental Health Clinical Supervisor	West Valley MHC
Barajas	Araceli	QA/QI Manager	UCLA Ties for Adoption
Barraza	Mary R.	Mental Health Program Manager III	LACDMH
Barscheski	Sabrina	MH Program Manager Adult OP program	Santa Clarita Valley MH Center
Becerra	Presley	Section Head, Data Mgmt. And Business Intelligence	LACDMH CIOB
Benson	Lisa	Supervisor, Office of STATS and Informatics	LACDMH CIOB
Bonds II	Curley	Medical Director	LACDMH
Boykins	Terri	Deputy Director	LACDMH
Bracken	John	Mental Health Clinician	Rancho San Antonio
Brown	Miriam	Deputy Director	LACDMH
Bryant	Bradley	Mental Health Program Manager III	LACDMH
Buchanan	Brittney	Clinical Supervisor	The People Concern
Buehler	Diana	Chief Administrative Officer	Hillside
Burgess	Rachel	Information Technology Specialist I	LACDMH

Last Name	First Name	Position	Agency
Burse	Zeena	Director of Clinical Quality Assurance and Improvement	El Centro de Amistad
Byrd	Robert	Mental Health Program Manager III	LACDMH
Camacho	Catarino	IBHIS System Administrator	LACDMH CIOB
Canas	Jae	Senior Administrative Analyst	Gita Cugley and Associates
Caracoza	Lourdes	CEO/President	ALMA
Cardenas	Sofia	Mental Health Counselor	San Fernando MHC
Carrington	Cheryl	Director Quality, Standards and Compliance	Vista Del Mar
Chan	Priscilla	Project Manager	LACDMH CIOB
Chang	Sandra	Mental Health Program Manager I	LACDMH
Chappell	Amy	Mental Health Clinical Supervisor	Edelman
Clinton	Andre	Project Manager	LACDMH CIOB
Coker	Kecia	Occupational Therapy Supervisor I	LACDMH
Coloma	Wendy	Clinical Quality Assurance Manager	The People Concern
Coomes	James	Program Manager	Olive View UCC
Corr	Casey	Program Supervisor	Rancho San Antonio
Corral	Martin	Principal Information Systems Analyst	LACDMH
Cox	Jackie	Mental Health Program Manager III	LACDMH
Cozolino	Susan	Quality Assurance	LACDMH
Crain	Kathryn	Mental Health Program Manger I	Outpatient Services
Cunnane	Daiya	Clinical Psychologist II	LACDMH
Cunningham	Milagro	Psychiatric Social Worker II	San Fernando Child & Family Center

Last Name	First Name	Position	Agency
Davis	Cheryl	Clinical Psychologist II	Valley Coordinated Children's Services
Dayson	Nathalie	Mental Health Counselor	San Fernando MHC
Debora	Mayra	Mental Health Clinician	San Fernando Valley CMHC
Dedhia	Monica	Program Supervisor	Child & Family Center
Diaz	Charlie	Information Systems Supervisor II	LACDMH CIOB
Diaz-Akahori	Angelita	Mental Health Program Manager III	LACDMH
Dimascio	Leslie	Director - Audit/OQ Outpatient Services	San Fernando Valley CMHC
Edwards	Brittany	San Fernando	Program Coordinator
Esquivel	Monica	Mental Health Clinician	Exceptional Children's Foundation
Fermin	Juan	Integration Manager	LACDMH CIOB
Fonseca	Abigail	Psychiatric Social Worker II	Olive View-DMH Urgent Care Center
Fuller	Diana		Hillside
Funk	Maria	Deputy Director	LACDMH
Gallardo	Nilsa	Mental Health Clinical Program Manager (MHCPM) II	Edelman – Adult (LACDMH)
Garcia	Paul	Mental Health Clinical Supervisor	Edelman
Garcia	Diana	Mental Health Clinical Supervisor	San Fernando MHC
Gibson	James	Chief Program Officer	Vista del Mar
Gilbert	Kalene	MH Program Manager III	LACDMH
Giles	Rachel	Director of Mental Health	St. Joseph Center
Glover	Susan	Psychiatric Social Worker II	San Fernando Child & Family Center
Goldstein	Alison	Clinical Supervisor	Vista Del Mar

Last Name	First Name	Position	Agency
Grant	Patrice	Mental Health Clinical Program Manager (MHCPM) II	Edelman – Child and Family (LACDMH)
Hallman	Jennifer	Health Program Analyst II, Quality Assurance	LACDMH
Hanada	Scott	Mental Health Program Manager III	LACDMH
Haratounian	Vahe	Division Chief, Information Security	LACDMH CIOB
Hardy	Richilda	Clinical Director of STRTP	Penny Lane
Hearn	Regina	Mental Health Clinical Supervisor	Santa Clarita MHC
Hernandez	Laura	Clinical Director	Tessie Cleveland
Hetterscheidt	Genevieve	Information Technology Specialist I / PMP Manager	LACDMH
Holland	Marureen	Supervising Psychologist	Valley Coordinated Children's Services
Holt	Nick	Mental Health Clinical Supervisor	The Home Team
Howieson	John	Principal Information System Analyst	LACDMH
Ihrig	Katy	Senior Mental Health Counselor, RN	Santa Clarita Valley MHC
Innes-Gomberg	Debbie	Deputy Director	LACDMH
Jackson	La Tina	Deputy Director	LACDMH
Jacobi	Zena	Chief of Revenue Management	Revenue Management
Jacobs	Rebecca	Psychiatric Social Worker	Edelman Children's Program, LACDMH
Jones	Martin	Mental Health Program Manager III	LACDMH
Jones	Julie	Vice President of Clinical Administration	Olive View
Kaneko	Carolyn	Program Manager	San Fernando Child and Family Center
Kasarabada	Naga	Clinical Psychologist II	LACDMH

Last Name	First Name	Position	Agency
Kelartinian	Cynthia	Executive Director	Heritage Clinic/Ctr. For Aging Resources
Kermoyan	Katia	Project Manager	LACDMH CIOB
King	Bryan	Psychiatric Social Worker II	San Fernando Child & Family Center
Kubojiri	Christina	Clinical Quality Assurance Supervisor	Children's Institute
Lam	Thuan	Mental Health Clinical Supervisor	San Fernando MHC
Lam	Susan	Director of Quality Improvement & Compliance	Alma Family Service
Larner	Karla	Mental Health Counselor	San Fernando MHC
Lawrence	Amanda	Clinical Psychologist I	Valley Coordinated Children's Services
Lawrence	Amanda	Clinical Psychologist I	Valley Coordinated Children's Services
Lee	Ann	Clinical Psychologist II	LACDMH
Lee	Hyun Kyung	Clinical Psychologist II	LACDMH
Lee	Karen	Associate Med Director	LACDMH
Leland	Melanie	Program Manager	Valley Coordinated Children's Services
Levi	Traci	Vice President of Outpatient Services	Vista Del Mar
Liskin	Ahab	Staff Therapist	UCLA TIES for Families
Liu	Kwan	Administrative Services Manager III	LACDMH Revenue Management
Lopez	Erika	Clinical Psychologist II	San Fernando Child & Family Clinic
Lopez	Melissa	Registered Clinical Social Worker, Domestic Violence	Child and Family Center
Lynch	Marshay	Mental Health Clinician	Rancho San Antonio

Last Name	First Name	Position	Agency
Maeyima	Sayaka	Mental Health Clinician	Child and Family Center
Majors	Michelle	Mental Health Clinical Program Head	LACDMH
Maldonado	Guadalupe	Project Manager	LACDMH CIOB
Marina	Eckart	Division Director of Quality Management	Hirsch Mental Health Services
Martinez	Arianna	Mental Health Clinician	Rancho San Antonio
Martinez	Fernando	Psychiatric Social Worker II	Santa Clarita MHC
Martinez	Arianna	Mental Health Clinician	Rancho San Antonio
Martinez	Jeremy	Assoc Medical Director	LACDMH
Matthews	Michelle	LCSW, SA5 QIC Member	Edelman – Adult (LACDMH)
Maze	Jennell	Mental Health Clinical Supervisor	LACDMH Edelman Child
McCraven	Eva	CEO	Hillview Mental Health Center, Inc.
Mehta	Pinki	Executive Assistant, Mental Health Commission	LACDMH
Mehta	Pinki	Executive Assistant, Mental Health Commission	LACDMH
Melbourne	Erica	Training Coordinator	LACDMH
Monge	Sonny	Mental Health Clinical Supervisor	Olive View - LACDMH Urgent Care Center
Montes	Luis		Mental Health America
Moreno	Stephany	Psychiatric Social Worker	Edelman Children's Program, LACDMH
Moreno	Caesar	Director of Quality Improvement and Training	The Whole Child
Munde	Michele	Director of Quality Improvement and Compliance	Stars, Inc.

Last Name	First Name	Position	Agency
Murthy	Gita	Consultant	Gita Cugley and Associates
Myrick	Keris	Chief of Peer Services	LACDMH
Naliboff	Laurie	Section Head, Data Mgmt. and Business Intelligence	LACDMH CIOB
Nelson	Ashanique	Psychiatric Social Worker I	Edelman Children's Program, LACDMH
O'Hara	Caitlyn	Quality Assurance Manager	Alcott Center
Ochoa	Araceli	Mental Health Clinician	San Fernando Valley CMHC
Ofumbi	Aminah	Manager of Quality Improvement	Didi Hirsch
Ortega	John	Division Chief, Division Chief of Data Mgmt. and Business Intelligence	LACDMH CIOB
Pap	Marian	Health Program Analyst II	LACDMH
Paradise	Barbara	Program Director, Lancaster	Pathways
Parsekhian	Adik	Director of Quality Assurance	The Village Family Services
Partida del Toro	Jorge	Chief of Psychology	LACDMH
Paseld	Brittany	Mental Health Clinician, TAY FSP Therapist	Didi Hirsch
Patterikalam	Girivasan	Acting Division Chief, Enterprise Applications	LACDMH CIOB
Pattow	Jonathan	Mental Health Services, Coord I	San Fernando MHC
Pereira	Luis	Clinical Supervisor and QA team staff	San Fernando Child and Family Services
Perkins	Theion	Mental Health Program Manager III	LACDMH
Polk	Gregory	Chief Deputy Director	LACDMH
Porter Wherry	Judy	Mental Health Analyst II	LACDMH Revenue Management
Prada-Quan	Gloria	Mental Health Clinical Supervisor	Valley Coordinated Children's Services

Last Name	First Name	Position	Agency
Preston	Andres		
Price	Danielle	QA Director	The Help Group
Quinteros	Juan Carlos	Program Coordinator/Child	San Fernando Valley CMHC
Racela	Wally	Chief Financial Officer	ALMA
Ramos	Emilia	Mental Health Clinical Program Head	LACDMH
Regan	Jennifer	Clinical Psychologist II	LACDMH
Rittel	Michelle	SA2 Children's QIC Chair	LACDMH SA2 Administration
Rivera	Robert	Applications Development Manager	LACDMH CIOB
Rodrigues	Diego	COO/VP	ALMA
Romero	Jesus	Mental Health Program Manager III	LACDMH
Romero	Ulma	Psychiatric Social Worker	Edelman Children's Program, LACDMH
Romero, Jr.	Jesus	Mental Health Program Manager III	MH SA2 Administration
Rosales	Abel	Project Manager	LACDMH CIOB
Rosas	Manuel	Mental Health Program Manager III	LACDMH
Rosero	Romina	Mental Health Clinician	Friendship Center
Rowland	Scott	Clinical Supervisor	Didi Hirsch
Ruchika	P	Associate MFT	El Centro (CAL Works)
Ruiz	Amanda	Director, Acting-Intensive Care	LACDMH
Ruiz	Lise	Mental Health Clinical Program Head	LACDMH
Salvaggio	Kimber	Training Coordinator	LACDMH
Sanchez	Dario	Mental Health Clinician	St. Joseph Center
Scholte	Darrell	Mental Health Svc Coord/SA Navigation	LAC DMH SA 2 ADMIN

Last Name	First Name	Position	Agency
Scholte	Darrell	Adult and OA Navigation	LACDMH SA2 Administration
Sherin	Jonathan	Director	LACDMH
Shields	Angela	Mental Health Program Manager III	LACDMH
Shing	Linda	Director of Mental Health Services	Exceptional Children's Foundation
Shonibare	Lynetta	Supervising Psychologist	LACDMH
Smith	Monique		
Smith-White	Katherine	Psychiatrist	LACDMH
So	Hiu Chung	Public Information Officer II	LACDMH
Sommers	Mandy	Director of QA and Clinical Services	St. Joseph Center
Sosna	Todd	Chief Program Officer	Children's Institute
Soto	Edgar	Administrative Deputy III	LACDMH
Sou	Susan	Chief pharmacist	LACDMH
Spallino	James	Solutions Deliver Manager	LACDMH CIOB
Stanfield	Stephen	DBA, Data Mgmt. and Business Intelligence	LACDMH CIOB
Stephens	Courtney	Senior Director of Evaluation and Compliance	MHALA
Taguchi	Kara	Mental Health Clinical Program Head	LACDMH
Tate	Kanchana	Mental Health Program Manager II	LACDMH
Tchakmakjian	Greg	Clinical Psychologist II	LACDMH
Thomas	Anil	MHC	West Valley
Torres	Patricia	Program Manager OA Services	San Fernando Valley CMHC
Tran	Chena	Mental Health Clinician	Pacific Asian Counseling Services

Last Name	First Name	Position	Agency
Tredinnick	Michael	Mental Health Program Manager III	LACDMH
Valdez	Julie	Mental Health Program Manager III	LACDMH
Valenzuela	Teddie	Executive Director	Amanecer Community Counseling Services
Vines	Dara	SA5 QIC Chair	LACDMH
Vines	Dara	Clinical Psychologist II	LACDMH
Wally	Racela	Chief Financial Officer	ALMA
Washington	Howard	Health Program Analyst I	LACDMH
Wells	Michelle	Director of Child/Adolescent/TAY Services	San Fernando Valley CMHC
Werner	Mandy	Psychiatric Social Worker II	Valley Coordinated Children's Services
Wilcoxen	Jacquelyn	Mental Health Program Manager III	LACDMH
Williams	Stacy	Mental Health Program Manager III	LACDMH
Willis	Lori	Division Chief	LACDMH
Wilson	Adrina	Clinical Supervisor	St. Joseph Center
Wong	Lisa	Mental Health Program Manager III	LACDMH
Yeom	Katherine	Executive Director	Korean American Family Services
Yoon	Joo	Administrative Services Manager III	LACDMH
Young	Cheyna	Clinical Supervisor	Exceptional Children's Foundation
Zatz	Jennifer	QI Liaison	LACDMH

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Los Angeles MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Large	1,791,890	69,726	3.89%	$372,190,347	$5,338
MHP	1,207,217	58,929	4.88%	$281,938,135	$4,784

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

Table C2: CY 2019 Distribution of Beneficiaries by ACB Range

Los Angeles MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	207,320	93.75%	93.31%	$874,844,234	$4,220	$3,998	63.23%	59.06%
>$20K - $30K	6,907	3.12%	3.20%	$167,696,802	$24,279	$24,251	12.12%	12.29%
>$30K	6,909	3.12%	3.49%	$340,963,693	$49,351	$51,883	24.64%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CCBH	Community Care Behavioral Health
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIT	Crisis Intervention Team or Training
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSD	Community Services Division
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services

Acronym	Full Term
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay

Acronym	Full Term
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
ONA	Out-of-Network Access
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PM (alt)	Partially Met
QI	Quality Improvement

Acronym	Full Term
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version