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FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

LOS ANGELES FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 16-18, 2023, and October 24, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, “Los Angeles” may be used to identify the Los Angeles County MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — October 16-18, 2023, and October 24, 2023

MHP Size — Very Large

MHP Region — Los Angeles

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	2	4	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	9	1	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**23**	**3**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improving Treatment Services for Individuals with Eating Disorders (EDs)	Clinical	06/2021	Completed	High confidence
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	12/2022	Implementation	Low confidence

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	12
2	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	8
3	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	2*
4	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	1*
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Cultural competency programs across the system of care are noteworthy in engagement within the community and include collaboration with a variety of groups.
- The MHP exhibits a robust peer employment system which includes Peer Resource Centers (PRC) and a promotional ladder across service areas (SA).
- The MHP has maintained a higher penetration rate (PR) than statewide even with multiple years of increased numbers of eligibles.
- The updates required by California Advancing and Innovating Medi-Cal (CalAIM) and, more specifically, payment reform, appear to have been implemented with synergy and care by the various MHP teams involved.
- The MHP initiated collaborative charting to increase clinical line staff service capacity.

The MHP was found to have notable opportunities for improvement in the following areas:

- The MHP's adult 30-day rehospitalization remains higher than statewide.
- Peers lack information and awareness of opportunities for promotion on the peer ladder of positions.
- Insufficient clinical staffing levels have led to elevated caseloads in both Directly Operated (DO) and Contracted Legal Entity) (C/LE programs, which impacts timeliness and service availability for members.
- The need for system-wide data available closer to real-time is an ongoing focus of multiple MHP development initiatives and planned updates.
- Some new clinical line staff find collaborative charting difficult to do while involved in the clinical session.

Recommendations for improvement based upon this review include:

- Continue and broaden the systemwide focus on reducing the 7/30-day rehospitalization rates.

  (This recommendation is continued from FY 2022-23.)
- Engage in a barrier analysis of why information on peer opportunities is not transparent and implement changes to resolve this issue.
- Continue to focus resources and efforts on recruitment and retention of clinical line staff to reduce timeliness to care.
- Continue development efforts to provide interoperability solutions for more up to date and aggregated data collection and reporting inclusive of C/LE provider data.
- Consider additional data analytical positions to strengthen ongoing data and reporting efforts.
- Investigate issues that create barriers to effective collaborative charting and initiate solutions.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services 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). The EQRO conducts an EQR that is an analysis and evaluation 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 (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, comprised of 58 counties, to provide specialty mental health services (SMHS) to Medi-Cal members under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal MHP. DHCS contracts with Behavioral Health Concepts, Inc. (BHC), the CalEQRO to review and evaluate the care provided to the Medi-Cal members.

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Los Angeles County MHP by BHC, conducted as a virtual review on October 16-18, 2023, with the PIP review on October 24, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, members, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws

upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and the Inpatient Consolidation (IPC) File.

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY) 2022 and FY 2022-23, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment E.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its

subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding PR percentages.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the COVID-19 pandemic. The MHP is still experiencing the effects of loss of staff and reintegrating to in-person services.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP has implemented CARE Court. SB 1338, the Community Assistance, Recovery and Empowerment (CARE) Act, became law. Referred to as CARE Court, this meant that parties could file a civil court petition to create a CARE plan for adults who would meet criteria for schizophrenia spectrum and/or other psychotic disorders and do not receive on-going outpatient treatment.
    - On January 10, 2023, the County of Los Angeles declared a State of Emergency on homelessness and the CARE implementation date advanced to December 1, 2023 – a year ahead of schedule.
    - To implement this funded mandate, the Los Angeles Department of Mental Health (DMH) created the operational plan to successfully implement the CARE Act.
    - CARE is using the State of Emergency protocols to hire staff via an emergency appointment process for 117 FTEs to ensure viable clinical and administrative services to be operational by December 1, 2023. CARE will expand the DMH current continuum of care through a field-based full service partnership (FSP) .
- Hollywood 2.0 Pilot Project is underway. This recovery informed proposal aims to provide comprehensive, community-based care and services to people experiencing mental illness in Hollywood. The goal is to apply an innovative service strategy to the community as opposed to a delivery from a single service site. Of the 54 approved vacancies, DMH has hired and onboarded 31 staff. Progress this past year has been encouraging.
- Alternative Crisis Response (ACR) implementation is underway. DMH has contracted with three contractors to provide field intervention team services (mobile crisis response teams) and is working toward full implementation of the Medi-Cal mobile crisis benefit.

- On July 20, 2023- DMH held the ACR City Summit, attended by over 30 cities as well as law enforcement agencies, field intervention teams, MH crisis stabilization unit (CSU) providers, and DMH's Access Center. The goal of the summit was to initiate a coordinated systemwide approach to reducing unnecessary institutional care and minimize law enforcement response to MH crises in Los Angeles County.
  - DMH implemented a pilot for urgent appointment scheduling when crisis response teams do not hospitalize an individual and the person needs an urgent treatment appointment. This allows the appointment to be scheduled with one phone call with any of the DO or C/LE providers in the area.
  - DMH is finalizing 911-988 diversion from the Sheriff's system and three other law enforcement agencies. This is modeled after the Los Angeles Police Department 911-988 Diversion Program and a toolkit developed by a DMH lead law enforcement/MH workgroup.
  - DMH won a 2023 LA County Quality and Productivity award for their leadership and implementation of ACR.
- The MHP established the Health Access and Information unit that coordinates cross sector work related to creating stronger working relationships with Managed Care Plans (MCP), including strengthening Memorandums of Understanding and work between Public Health's Substance Abuse Prevention and Control for purposes of planning administrative integration.
- As each element of CalAIM was implemented, the Quality Assurance (QA) unit did extraordinary work to inform providers in advance and at the time of changes, through QA/QI meetings, "QA On the Air" webinars, recorded trainings, published QA Bulletins, and updated versions of the DMH Guide to Procedure Codes.
- Lisa Wong, Psy.D. was officially appointed the MHP Director on February 28, 2023.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2022-23

Recommendation 1: Continue implementation of a comprehensive solution to tracking of timeliness metrics that applies to both DO and C/LE programs, specifically first offered non urgent psychiatry and urgent care services. This would include criteria development and a system for tracking post-assessment psychiatry referral timeliness.

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP developed criteria for tracking post-assessment psychiatry timeliness. This was implemented for DO and work is progressing to capture this information from C/LE as well. The work to integrate C/LE providers into the criteria for tracking post-assessment psychiatry timeliness is in the testing process and is expected to progress to final testing and be completed by December 2023.
- For urgent appointments, the MHP continues to track this and is working on new workflows to improve timeliness.
- This recommendation will not be carried forward this year as the MHP is engaged in successful response to it.

Recommendation 2: Continue efforts to select an adult Level of Care (LOC)/outcome instrument for pilot testing, and eventual adoption systemwide to inform a periodic case review process and re determination of clinical need across all levels of care.

(This recommendation was continued from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The selection of an adult LOC/outcome instrument has been a major activity of the DMH Access to Care Action workgroup. Dr. Innes-Gomberg led the work on surveying adult LOC tools and an associated analysis, including feedback from DMH management and providers.
- The analysis included Reaching Recovery, Level of Care Utilization System (LOCUS), Needs Evaluation Tool and the Determinants of Care/Milestones of Recovery Scales and evaluated benefits, issues identified, and costs. Recommendations were submitted to Acting Chief Deputy Director and the Director.
- The decision was made to pursue LOCUS. DMH has had two meetings with the American Academy of Community Psychiatrists and Deerfield Solutions and is awaiting a quote from them on licensing and training costs.

Recommendation 3: Continue and broaden the systemwide focus on reducing the 7/30-day rehospitalization rates, by provision of post-hospital appointments and case management follow-up which is tailored to factors identified by data analysis and stakeholder input.

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP began a pilot program to increase offered appointments within five business days from the date of hospital discharge.
- The purpose and goal of this pilot is to centrally schedule hospital discharge appointments through the Access Center in order to maximize capacity and efficiently provide members with appointments.
- The Access Center identifies the most appropriate provider and available appointment, provides the hospital with appointment date/time/location, and schedules the member's appointment with the provider.
- At the time of this review, the process was still a pilot program and efficacy has not been determined. It is also unclear what case management follow-up to setting the appointment has been initiated, and there is no indication of stakeholder input.

- This recommendation will be carried forward this year to include highlighting the need for case management follow-up.

Recommendation 4: Continue development of a systemwide ongoing feedback process accessible to both DO and C/LE programs to provide feedback to MHP leadership directly from line and supervisory levels, aggregated feedback by service areas, which will provide the department with identification of critical issues from the service delivery level.

(This recommendation was continued from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Under the leadership of the Director and Acting Chief Deputy Director; DMH has created a more open and transparent bidirectional communication through a thoughtfully developed community leadership team, regular Town Halls, “Hello DMH” publications, and meetings with LE providers.
- DO and LE stakeholders reported that communication is more open and transparent. Attendees of meetings commented that this is an improvement in communication.
- While this recommendation is rated as addressed, it is noted that new clinical line staff would appreciate more information on how to take part and be aware of meetings and opportunities for communication with leadership. The LE new clinical line staff felt less aware of opportunities in this area than DO.
- It appears that there may be a disparity in information and communication flow for DO versus LE staff. LE staff report that they are sometimes less aware of opportunities for bidirectional communication.

Recommendation 5: Develop a tracking and reporting system element that reflects by program the time between assessment and treatment, with an additional element that reports out the average frequency of clinical services by program. This should assist the MHP in its appraisal of capacity adequacy and staffing needs.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has incorporated time between assessment and first appointment into access to care monitoring reports. This is also added to the access to the care dashboard. It is reviewed regularly in the data review meeting.
- Work continues to incorporate frequency of clinical services into the QA monitoring process, which also will include average services provided by member and by program.
- This recommendation will not be carried forward this year as the MHP is engaged in resolving this issue.

Recommendation 6: Develop tracking of C/LE providers for the availability of a PHR for those served under MHP contract, and secondarily begin the development of standards for the type and scale of services for which a PHR would be expected to be provided by contract providers.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP reports shifting away from patient portals due to federal guidelines, such as the Office of the National Coordinator for Health Information Technology 21st Century Cures Act Final Rule and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F), that require organizations to provide Application Programming Interfaces (API), which can be leveraged by members to access information from the platform of their choosing. DMH further refers to the California Data Exchange Framework reinforcing the API strategy by requiring that organizations share information in real time via interoperability.
- DMH and C/LE providers are using APIs in lieu of a patient portal within the Electronic Health Record (EHR). The expanded prevalence of accessing data through mobile devices is also driving the decision to develop member access to data through API.
- Tracking and setting standards for the provider PHRs was not addressed. Broader interoperability projects have the potential to address this in the future.
- This recommendation will not be carried forward as the MHP is involved in an implementation as the resolution of this issue.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or members) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which members live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which members are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both directly operated and C/LE providers in the MHP. Regardless of payment source, approximately 21 percent of services were delivered by DO clinics and sites, and 79 percent were delivered by C/LE operated clinics and sites. Overall, approximately 87 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free access line available to members 24-hours, 7-days per week that is operated by contract provider staff; members may request services through the Access Line as well as through the FC system and self-presentation at MHP/contractor clinic sites. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries are linked to programs that are currently listed as having capacity to treat; county-operated programs do not have a specific capacity limit, but efforts are made to distribute requests for services across all available regional clinics.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 35,186 adults, 49,934 youth, and 4,936 older adults across 105 DO sites and 596 C/LE sites. The number of members that received telehealth services for both DO and C/LE sites in a language other than English was not provided by the MHP.

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In

[1] CMS Data Navigator Glossary of Terms

addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Los Angeles County, the time and distance requirements are 15 miles and 30 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2022-23

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	☐ Yes ☒ No

- The MHP met all time and distance standards and was not required to submit an AAS request.

Table 1B: MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☐ Yes ☒ No
Contracting status:	☒ The MHP is in the process of establishing contracts with OON providers ☐ The MHP does not have plans to establish contracts with OON providers
Contracting efforts and barriers cited by MHP:	☒ Other: Currently determining what providers are available as OON providers.
OON Access for Members	
The MHP ensures OON access for members in the following manner:	☐ The MHP has existing contracts with OON providers ☒ Other: Currently determining what providers are available for out of network.

- Because the MHP can provide necessary services to a member within time and distance standards using a network provider, the MHP was not required to allow members to access services via OON providers. However, the MHP is working to contract with multiple OON providers to expand services available to members.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to members and family members. Examining service accessibility and availability, system capacity and utilization, integration, and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access, and availability of services form the foundation of access to quality services that ultimately lead to improved member outcomes.

Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Member Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Strengths and opportunities associated with the access components identified above include:

- The MHP sponsors multiple cultural events, which include, but is not limited to, the celebration of Black Heritage Month; Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S) month; and Latin Heritage Month. The MHP collaborates with Promotores equivalents in the Korean, African American, tribal and other cultural communities. These events and outreach efforts are documented as well received by the various communities.
- Both DO and C/LE programs note staffing shortages with larger caseloads. Line staff reported stressful work situations due to staff turnover; yet, remarked on the number of new hires in the past several months.
- Integration and collaboration with multiple entities county-wide is positive and effective. One example is Health Neighborhoods (HN), a partnership with the

Department of Public Health and Department of Health Services), HNs increase health equity and access to quality services through integrated care and community collaboration.

- The opening page of the County website provides 988, suicide and crisis numbers, the 24-hour helpline to access services, as well as a suicide prevention public service announcement video prominently visible and accessible. Those with hearing or speech disabilities are given information on how to access assistance. Language translations are available.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

The following information provides details on Medi-Cal eligibles, and members served by age, race/ethnicity, and threshold language.

PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Los Angeles demonstrates better access to services than statewide.

Table 3: Los Angeles MHP Annual Members Served and Total Approved Claims, CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	4,470,000	207,203	4.63%	$1,435,383,442	$6,927
CY 2021	4,160,000	214,658	5.16%	$1,422,201,068	$6,625
CY 2020	3,870,000	212,272	5.49%	$1,432,306,133	$6,748

Note: Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The PR for Los Angeles has decreased over the prior two years and was impacted by a decrease in members served and an increase in eligibles in CY 2022.

Table 4: Los Angeles County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	356,123	10,619	2.98%	1.50%	1.82%
Ages 6-17	908,034	65,289	7.19%	5.01%	5.65%
Ages 18-20	223,045	10,161	4.56%	3.66%	3.97%
Ages 21-64	2,450,000	110,223	4.50%	3.73%	4.03%
Ages 65+	534,634	10,911	2.04%	1.64%	1.86%
Total	**4,470,000**	**207,203**	**4.63%**	**3.60%**	**3.96%**

Note: Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The PR is higher than large counties and statewide PRs for all age groups.
- Youth ages 6-17 have the highest PR in the MHP, while older adults have the lowest.

Table 5: Threshold Language of Los Angeles MHP Medi-Cal Members Served in CY 2022

Threshold Language	# of Members Served	% of Members Served
Spanish	44,090	21.35%
Armenian	1,302	0.63%
Korean	618	0.30%
Mandarin	610	0.30%
Vietnamese	593	0.29%
Cantonese	575	0.28%
Farsi	553	0.27%
Cambodian	505	0.24%
Russian	389	0.19%
Tagalog	145	0.07%
Arabic	110	0.05%
Members Served in Threshold Languages	**49,490**	**23.96%**
Threshold language source: Open Data per BHIN 20-070		

- The count of members served in threshold languages decreased by 4 percent from CY 2021.
- Members served in threshold languages accounted for almost 24 percent of the total members served, with Spanish being the most prevalent by a wide margin.

Table 6: Los Angeles MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	1,511,808	61,461	4.07%	$346,885,884	$5,644
Large	2,532,274	76,457	3.02%	$535,657,742	$7,006
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members, and this pattern is reflected in the MHP.
- The MHP PR for the ACA eligible members remains higher than similar size counties and the statewide PR.

The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total members served. Table 7 and Figures 1-9 compare the MHP's data with MHPs of similar size and the statewide average.

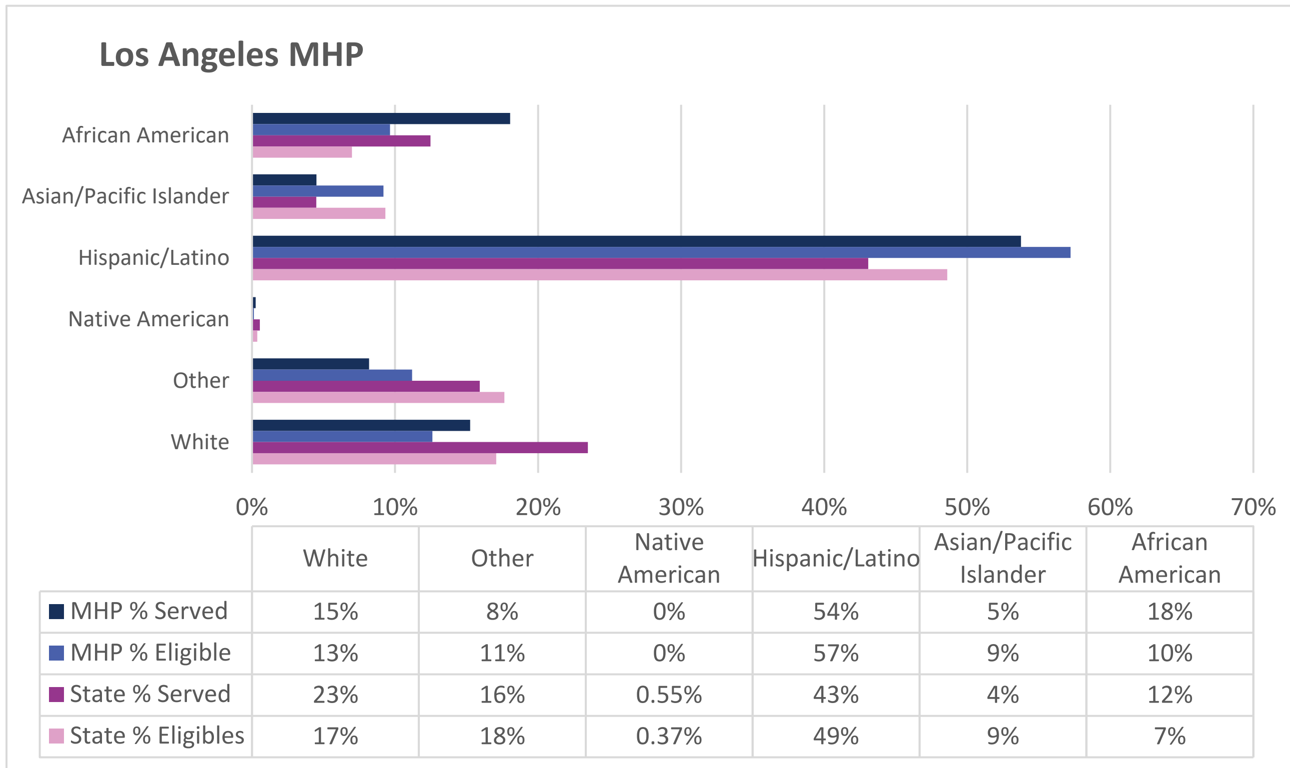
Table 7: Los Angeles MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	431,582	37,384	8.66%	7.08%
Asian/Pacific Islander	411,336	9,338	2.27%	1.91%
Hispanic/Latino	2,560,000	111,382	4.35%	3.51%
Native American	6,252	538	8.61%	5.94%
Other	500,625	16,953	3.39%	3.57%
White	564,459	31,608	5.60%	5.45%
Total*	**4,474,254**	**207,203**	**4.63%**	**3.96%**

Note: Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The MHP PR by race/ethnicity groups is higher than the statewide PR except for the Other group.

Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022

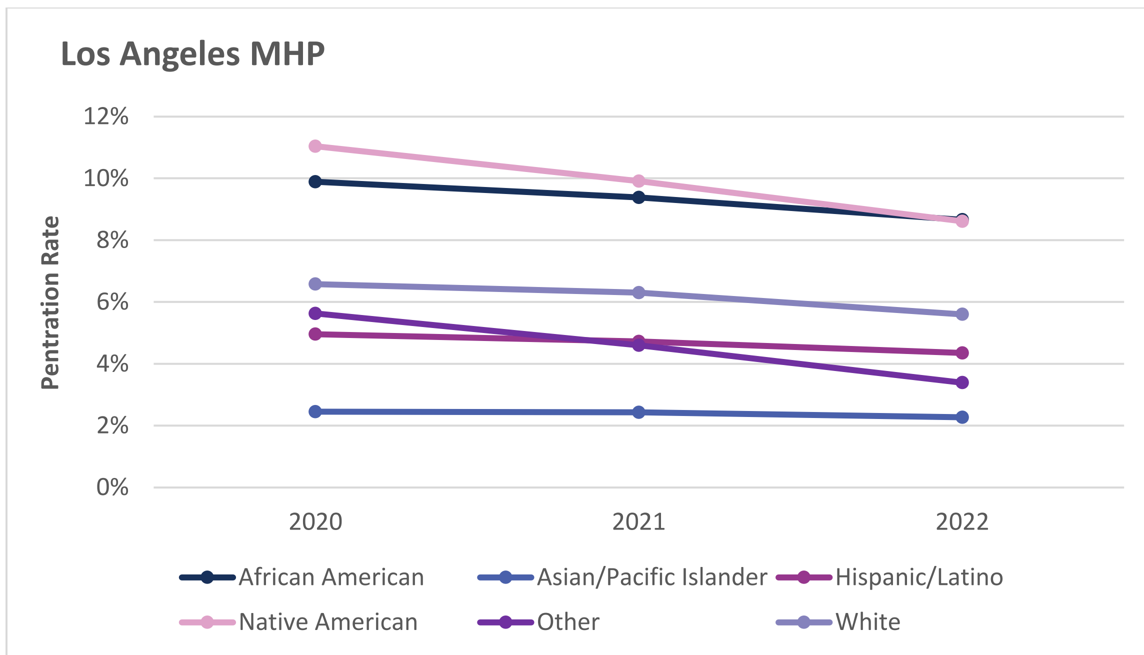


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	15%	8%	0%	54%	5%	18%
MHP % Eligible	13%	11%	0%	57%	9%	10%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The most notable gaps between members eligible and served are seen in the Hispanic/Latino, Asian/Pacific Islander, and Other group populations, indicating these groups are proportionally underrepresented in the MHP.

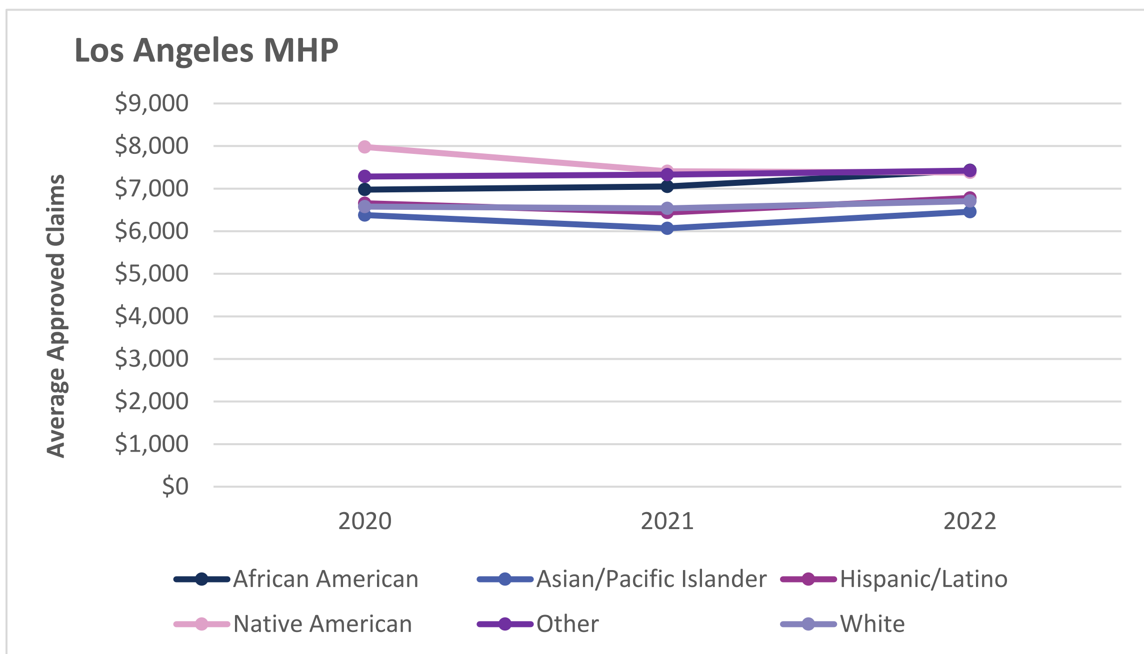
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

Figure 2: MHP PR by Race/Ethnicity, CY 2020-22



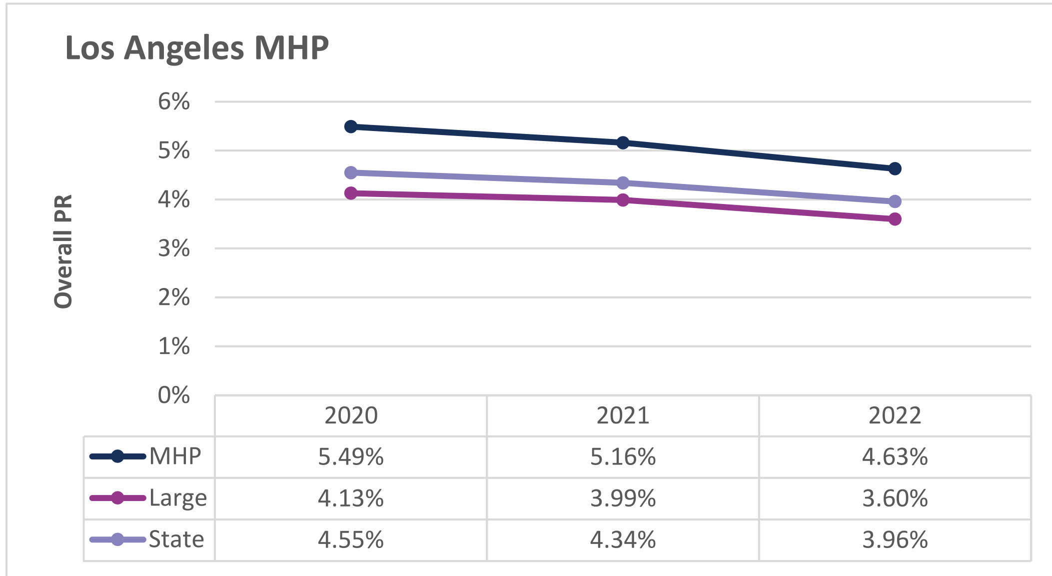
- The MHP's PRs for all racial/ethnic groups have been declining slightly over the last two years.
- Native American and African American PRs have consistently been the highest across the past three years, whereas the Asian/Pacific Islander PRs have consistently been the lowest.

Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22



- The AACM remained fairly static from CY 2020 to CY 2021 for most race/ethnicity groups and slightly increased in CY 2022.

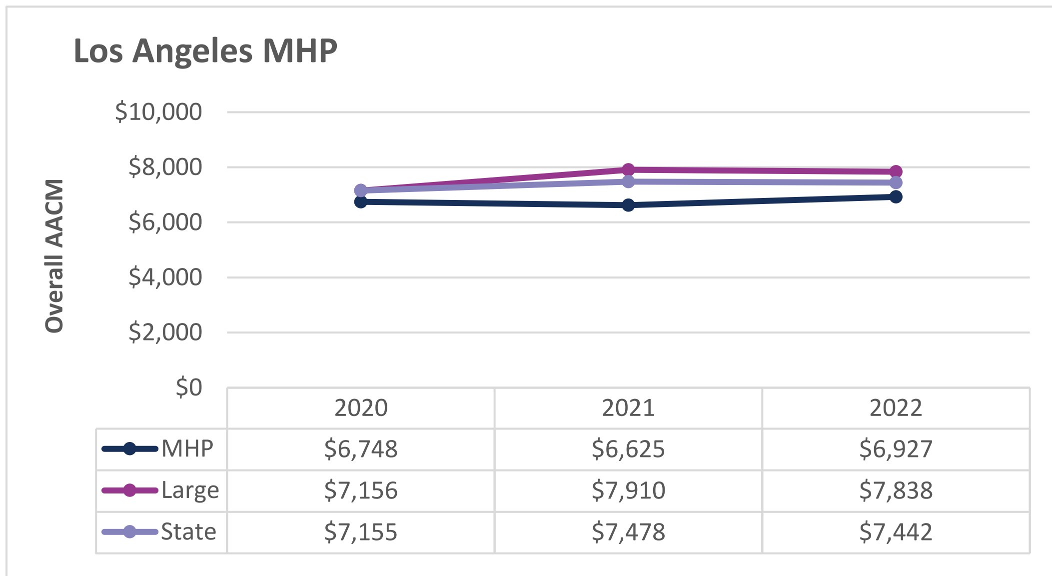
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	5.49%	5.16%	4.63%
Large	4.13%	3.99%	3.60%
State	4.55%	4.34%	3.96%

- The overall PR has decreased over the last two years, and the MHP PR remains higher than the large county and statewide PRs in CY 2022.

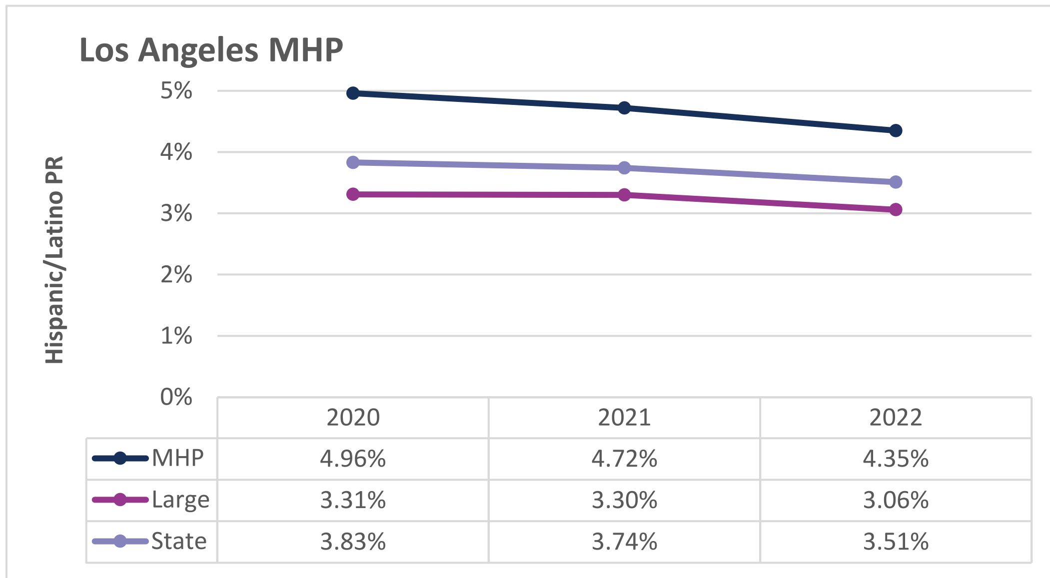
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$6,748	$6,625	$6,927
Large	$7,156	$7,910	$7,838
State	$7,155	$7,478	$7,442

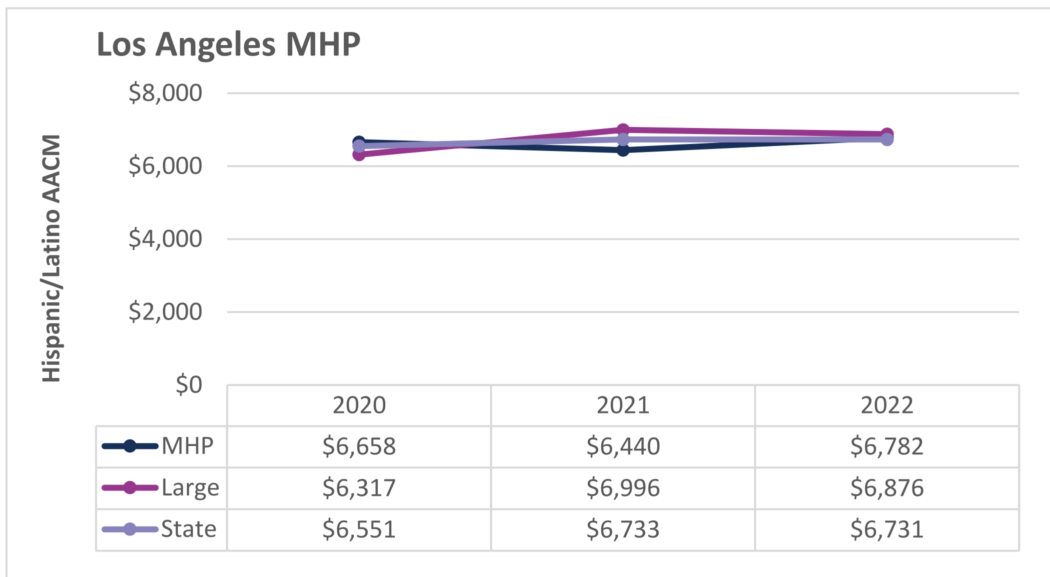
- The overall AACM has consistently been lower than the large county average as well as the statewide average across the past three CYs.

Figure 6: Hispanic/Latino PR, CY 2020-22



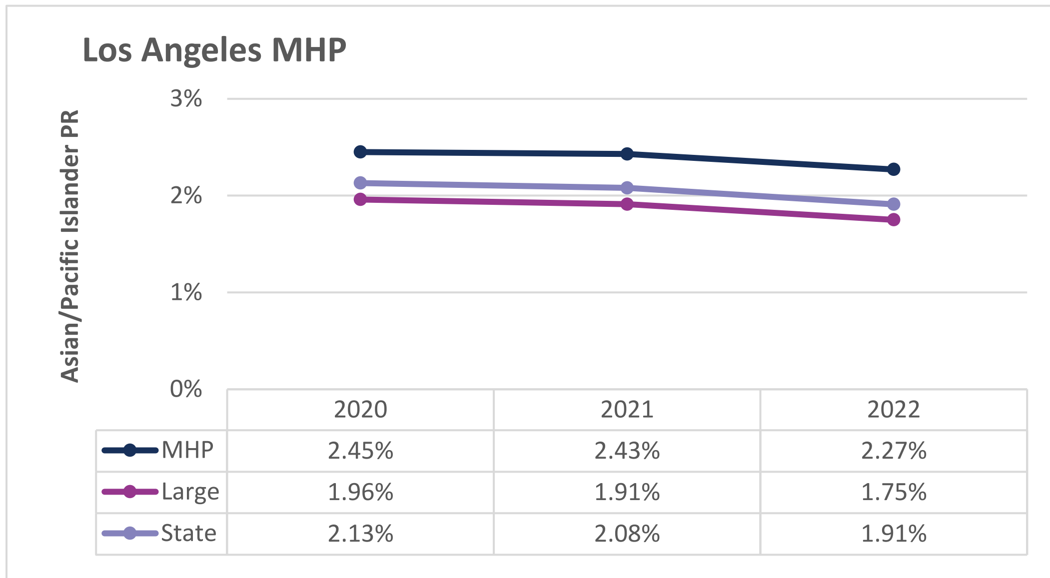
- The Hispanic/Latino PR decreased statewide over the past three Cys, while the PR in the MHP decreased by a larger margin yet remains higher than the large county and statewide PRs.

Figure 7: Hispanic/Latino AACM, CY 2020-22



- The AACM for the Hispanic/Latino population increased statewide in CY 2021, while the MHP AACM had a slight decrease. In CY 2022 the statewide AACM remained static and increased in the MHP. Statewide and MHP AACMs are comparable for CY 2022.

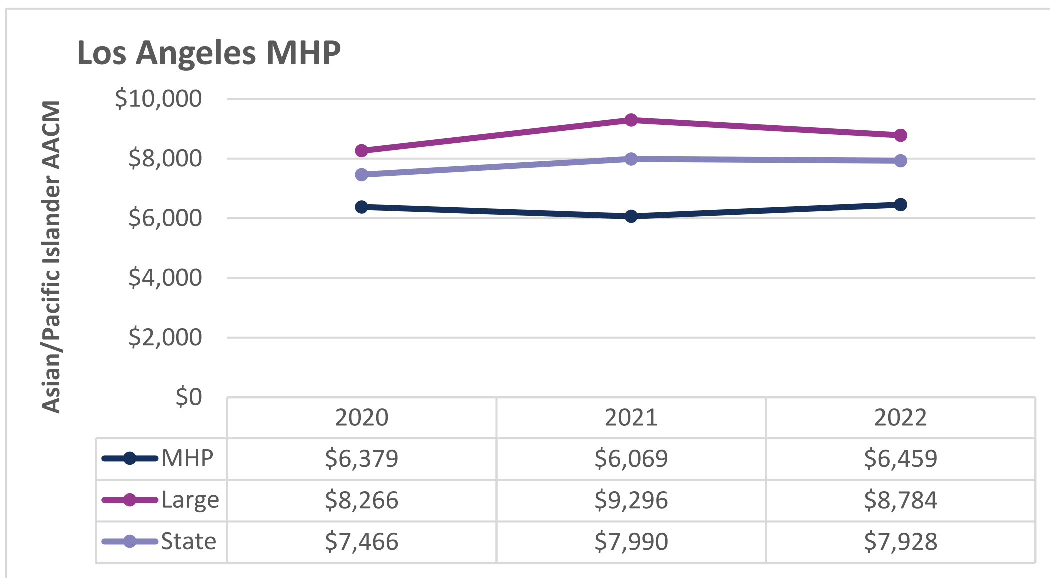
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.45%	2.43%	2.27%
Large	1.96%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- The Asian/Pacific Islander PR has slightly decreased over the prior two years and remains higher in the MHP than large counties and the statewide PR.

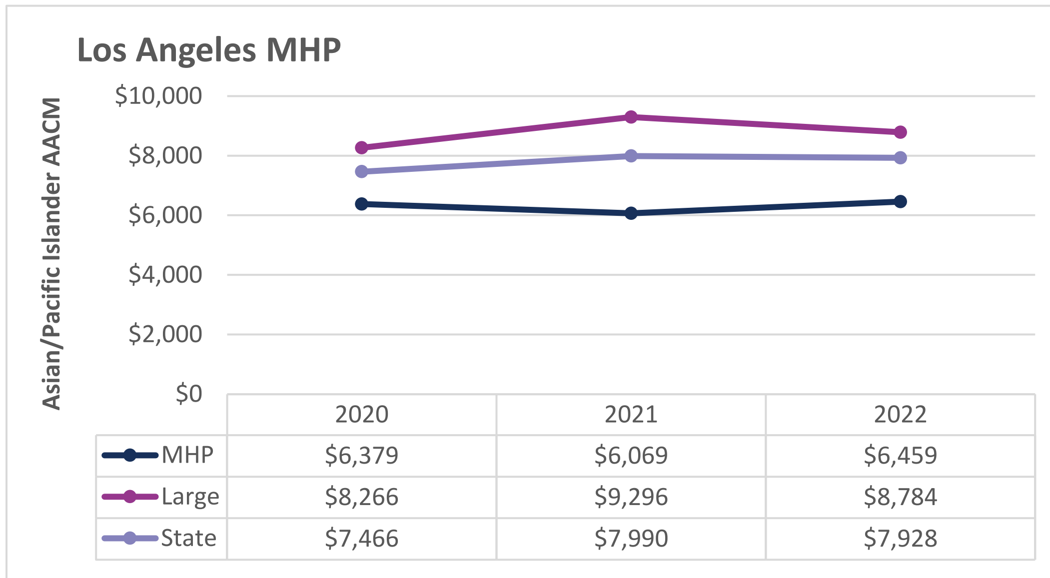
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$6,379	$6,069	$6,459
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

- The Asian/Pacific Islander AACM decreased slightly within the MHP in CY 2021, followed by an increase in CY 2022. The MHP AACM has consistently been lower than the large counties and statewide AACMs.

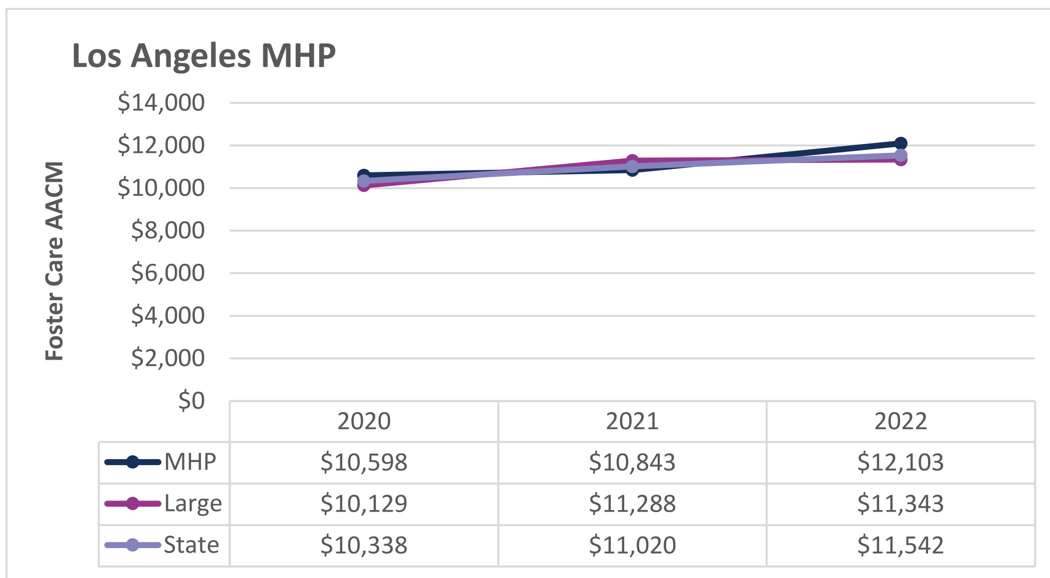
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	$6,379	$6,069	$6,459
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

- The foster care PR has decreased across the state over the prior two years, and the MHP remains higher than the similar size county average and statewide PRs.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$10,598	$10,843	$12,103
Large	$10,129	$11,288	$11,343
State	$10,338	$11,020	$11,542

- Statewide, similar size county, and MHP FC AACMs have all increased each year for the past three years.
- The MHP FC AACM increased at a higher rate in CY 2022 and now exceeds the large county and statewide AACMs.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Los Angeles MHP to Adults, CY 2022

Service Category	MHP N = 131,317				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	17,987	13.7%	18	11	10.3%	14	8
Inpatient Admin	244	0.2%	32	19	0.4%	26	10
Psychiatric Health Facility	219	0.2%	43	15	1.2%	16	8
Residential	55	0.0%	152	88	0.3%	114	84
Crisis Residential	668	0.5%	26	19	1.9%	23	15
Per Minute Services							
Crisis Stabilization	16,267	12.4%	1,109	780	13.4%	1,449	1,200
Crisis Intervention	13,172	10.0%	334	240	12.2%	236	144
Medication Support	82,302	62.7%	286	180	59.7%	298	190
Mental Health Services	82,408	62.8%	976	359	62.7%	832	329
Targeted Case Management	38,487	29.3%	522	135	36.9%	445	135

- The MHP has a higher utilization by adult members of inpatient services (13.7 percent), compared to statewide (10.3 percent).
- Targeted Case Management (TCM) was notably lower in billed claims for adults in the MHP (29.3 percent) compared to statewide (36.9 percent).

Table 9: Services Delivered by the MHP to Los Angeles MHP Youth in Foster Care, CY 2022

Service Category	MHP N = 13,714				Statewide N = 33,234		
	# of Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	690	5.0%	14	10	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	42	30	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	<11	-	6	6	0.1%	24	22
Full Day Intensive	49	0.4%	558	312	0.2%	673	435
Full Day Rehab	<11	-	564	568	0.2%	111	84
Per Minute Services							
Crisis Stabilization	397	2.9%	905	720	3.1%	1,166	1,095
Crisis Intervention	1,479	10.8%	445	205	8.5%	371	182
Medication Support	3,393	24.7%	425	285	27.6%	364	257
TBS	374	2.7%	5,845	3,624	3.9%	4,077	2,457
Therapeutic FC	<11	-	2,325	2,325	0.1%	911	495
Intensive Care Coordination	5,307	38.7%	2,313	839	40.8%	1,458	441
Intensive Home-Based Services	3,047	22.2%	3,058	2,027	19.5%	2,440	1,334
Katie-A-Like	<11	-	117	59	0.2%	390	158
Mental Health Services	13,247	96.6%	2,029	1,274	95.4%	1,846	1,053
Targeted Case Management	3,479	25.4%	209	104	35.8%	307	118

- The MHP's utilization is largely comparable with the statewide utilization rates for service delivery to FC members.
- 25.4 percent of FC youth in the MHP received TCM compared to 35.8 percent statewide. Intensive Care Coordination (ICC) utilization is slightly lower and Intensive Home Based Services (IHBS) slightly higher than statewide, demonstrating Pathways to Well-Being implementation.

IMPACT OF ACCESS FINDINGS

- The decrease in members served and increase in eligibles in CY 2022, juxtaposed to the decrease of 4 percent in members served in threshold languages, with the most notable gaps between members eligible and served seen in, speaks to proportional underserving of the Hispanic/Latino, Asian/Pacific Islanders, and Other group populations. This may be due to fewer culturally and linguistically diverse staff in the workforce, which was mentioned during review sessions as something the MHP was emphasizing in current recruitment efforts.
- The lower than statewide utilization of FC youth receiving TCM (25.4 vs 35.8 percent) – without an increase in ICC – implies that more integration of services may be needed for this cohort. The MHP may want to review TCM and ICC for FC youth to ensure that Pathways services are offered and delivered.

TIMELINESS OF CARE

The amount of time it takes for members to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

Each Timeliness Component is comprised of individual subcomponents, which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

Strengths and opportunities associated with the timeliness components identified above include:

- Follow-up appointments reported in the Assessment of Timely Access (ATA) after psychiatric hospitalization is 96.74 percent for services delivered within 30-days of discharge, with 79.65 percent delivered within 7-days.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Counties are also expected to submit the source data used to prepare these calculations. This is particularly relevant to data validation for the additional statewide focused study on timeliness that BHC is conducting.

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. This data represents the entire system of care except no-shows which were reported only for directly operated services.

Claims data for timely access to post-hospital care and readmissions are discussed in the Quality of Care section.

Table 11: FY 2023-24 Los Angeles MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	11.66 Business Days	10 Business Days*	69.83%
First Non-Urgent Service Rendered	9.49 Business Days	**	Not reported
First Non-Urgent Psychiatry Appointment Offered	16.81 Business Days	15 Business Days*	Not reported
First Non-Urgent Psychiatry Service Rendered	N/A	**	N/A
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	42.17 Hours	48 Hours	88.16%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	5.05 Calendar Days	7 Calendar Days	79.65%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	5.05 Calendar Days	30 Calendar Days	96.74
No-Show Rate – Psychiatry	7.60%	**	n/a
No-Show Rate – Clinicians	6.49%	**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP does not have a timeliness standard for this measure

*** The MHP does not separately track urgent services requiring pre-authorization.

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23

Figure 12: Wait Times to First Service and First Psychiatry Service

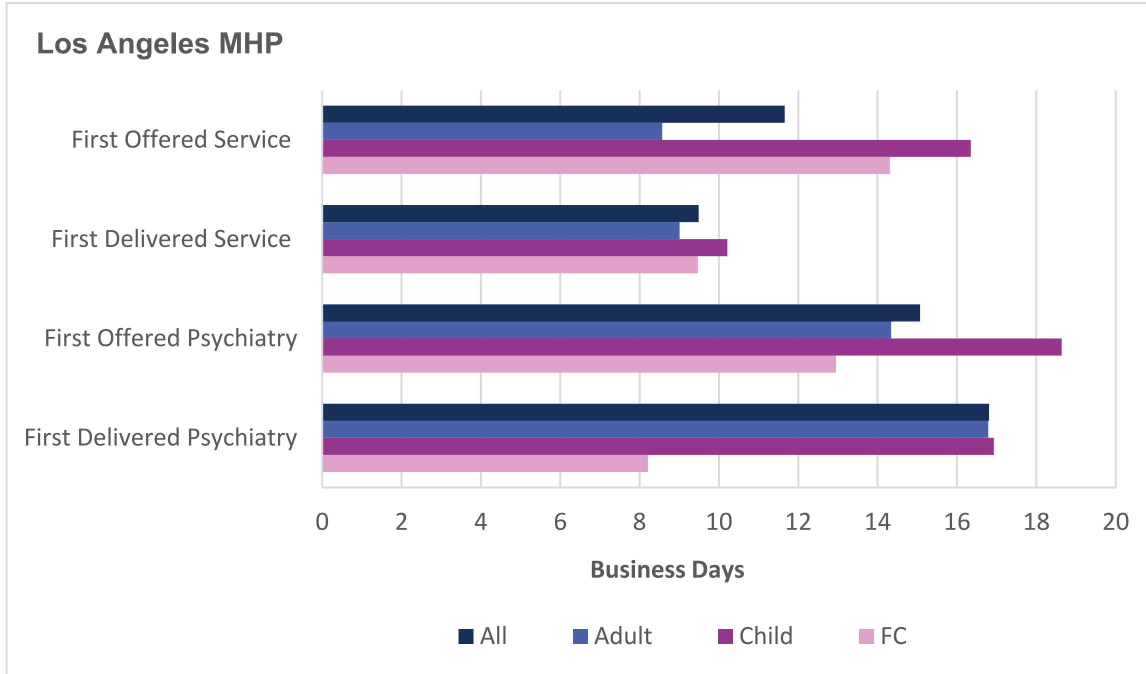


Figure 13: Wait Times for Urgent Services

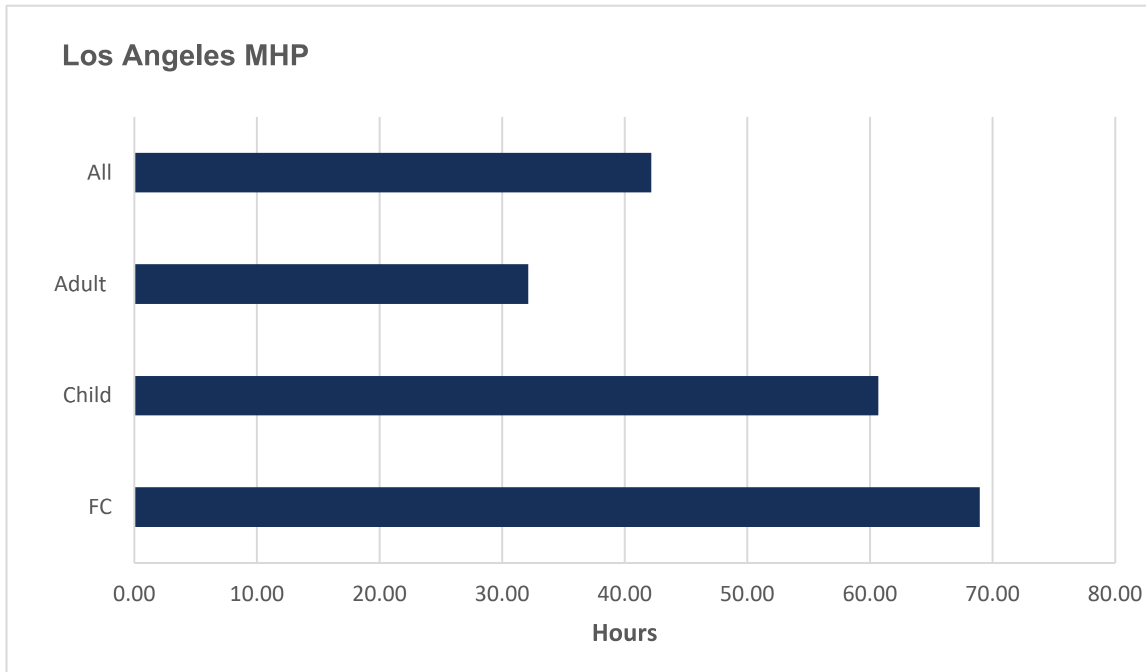
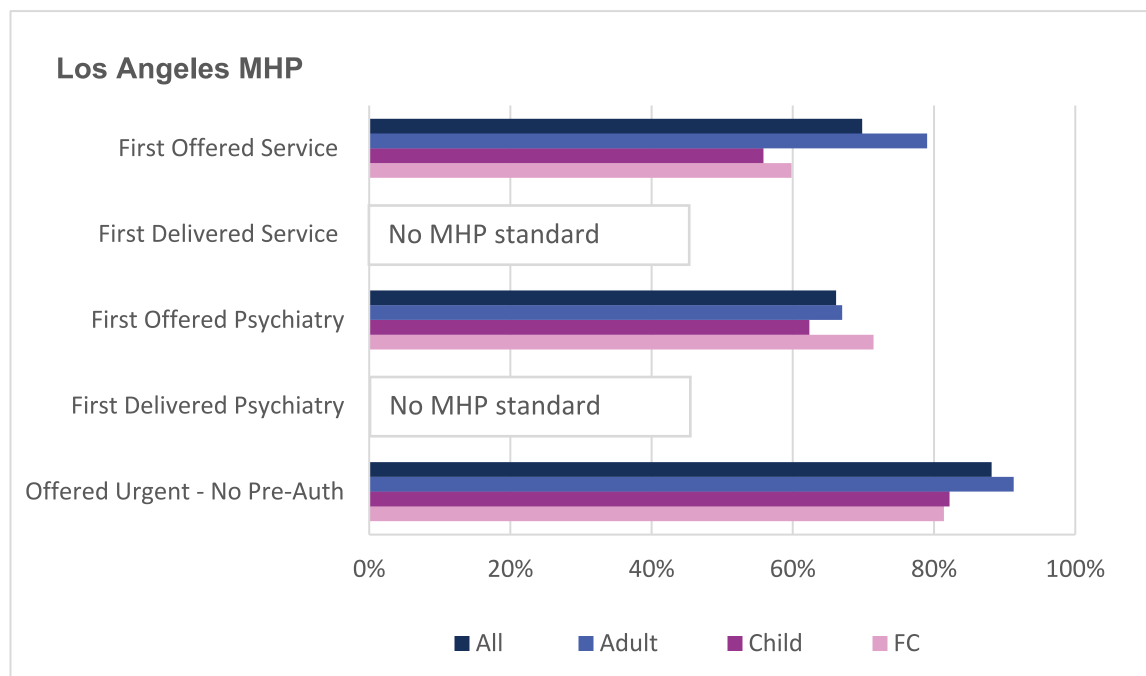


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide MH services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments.
- The MHP defined “urgent services” for purposes of the ATA as a service needed for a potential member/member who may present with a condition or situation that, if not addressed, would be highly likely to result in an immediate emergency condition. There were reportedly 20,916 urgent service requests with a reported actual wait time to services for the overall population of 42.17 hours. The MHP does not offer urgent services that require pre-authorization separately. The MHP noted that for urgent service requests that were missing a time of request, 12:00pm was used as the request time, with the rationale that the middle of normal operating hours would average out in the analysis.
- No-shows represent a subset of the data as it is solely based on DO programs, and only captures a no-show when appointments are entered into the EHR and subsequently designated as a missed or cancelled event. The MHP reports a no-show rate of 6.49 percent.

IMPACT OF TIMELINESS FINDINGS

- The MHP sets a minimum standard of 10-business days for non-urgent first offered appointments and meets this standard 69.83 percent of the time overall. Children's services meet the standard 55.85 percent of the time.
- The MHP sets a minimum standard of 15-business days got non-urgent psychiatry appointments and meets this standard 66.14 percent of the time overall. Some adult programs reported that psychiatrist appointments can take two to three months, and they need to send members to an urgent care clinic for medications during this time.
- The MHP's timeliness for urgent appointments improved this year (88.16 percent vs 33.82 percent last year), partially due to information now included in urgent appointments requested. This year traditional initial requests for service identified as urgent as well as requests for field-based response are included. For requests for field-based responses the date and time of "urgent appointment" is operationalized as the date and time of arrival of field-based clinicians, which influences timeliness data.
- The MHP does not set standards for timeliness for first delivered non-urgent delivered service, first non-urgent psychiatry appointment delivered, or no-show rates for psychiatry or non-psychiatry clinical appointments. This makes it difficult for the MHP to know when to do a barrier study to design improvement strategies to improve timeliness.
- The MHP reports no-show rates for county-operated services only. This does not give a system wide picture of no-shows, which could be useful in addressing ways to increase capacity.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the members through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to members. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

In the MHP, the responsibility for QI is located withing the Quality, Outcomes and Training Division (QOTD) of the department and was launched in January of 2020. QOTD includes the Access Center, QA Unit, QI Unit, Outcomes Unit and Training Unit. The QI Unit coordinates program development and QI activities that effectively measure, assess, and continuously improve access to, and quality of care provided. The separate QA unit ensures adherence of DO and C/LE programs to federal, state and local laws and regulations. In addition, QA provides oversight of the response to triennial reviews and other audits. Each SA has its own local quality improvement committee (QIC).

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. Each SA has a regional QIC meeting scheduled quarterly. The countywide QIC, known as the Quality Council, meets monthly and is comprised of broad SA representation, patient rights, QA staff, QI staff, clinical policy and standards staff, clinical risk management, access staff, cultural competency staff, and C/LE providers. Since the previous EQR, the MHP QIC met 11 times. Of the 12 identified FY 2022-23 QAPI workplan goals 7 were met, and 3 were partially met.

The MHP does not currently utilize a standardized LOC tool, though they have implemented use of the DHCS adult and youth screening tools. The MHP is actively evaluating the use of the LOCUS for adults and the Child and Adolescent Needs and Strengths-50 (CANS-50) for youth as future LOC tools.

The MHP utilizes the following many outcomes tools throughout the system: CANS-50, Difficulties in Emotion Regulation Scale, Eyberg Child Behavior Inventory, Family Assessment Device, FSP Baseline, FSP Partnership Assessment Form, Generalized Anxiety Disorder-7, Global Assessment of Functioning-M, Hamilton Depression Rating Scale, Key Event Changes, Needs Evaluation Tool, Outcome Questionnaire 45.2, Patient Health Questionnaire-9, Pediatric Symptom Checklist-35, Post-Traumatic Stress Disorder (PTSD)-5, PTSD Checklist-Civilian, Quick Inventory of Depressive Symptomatology, Revised Behavior Problem Checklist, Revised Children's Anxiety and

Depression Scale, Sutter-Eyberg Student Behavior Inventory-Revised, Trauma Symptom Checklist for Young Children, and the University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index – for Diagnostic and Statistical Manual of Mental Disorder-5.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for members. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

Each Quality Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Met
3H	Utilizes Information from Member Satisfaction Surveys	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Member and Member Employment in Key Roles throughout the System	Met

Strengths and opportunities associated with the quality components identified above include:

- The MHP is a data driven system. Data is used to inform leadership and assist in creating continuous quality improvement. The MHP has a comprehensive QI process, supported by SA and countywide QICs. The MHP continues to work toward having consistent participation of members and family members in the QI process.

- Medication monitoring shows continued growth. A pharmacy benefit management company manages pharmacies on behalf of the county. With e-prescribing performed through OrderConnect associated with the Avatar EHR, medication prescribing trends can be tracked and reported for DO programs; however, in-depth review occurs by the chart sampling for the peer review process. DO and some of the larger C/LE providers (less than 50 percent) participated in the peer review process and reviewed a sample of cases for each practitioner. This tends to be significantly focused on children's services. Within the adult system of care, multiple antipsychotic agent use is tracked and reported. In addition, the MHP has performed an analysis of prescribing by drug class, race/ethnicity, and language, which helps to identify the existence of prescribing disparities. DO and C/LE providers obtain metabolic data through chart review with a compliance of approximately 23 percent. There remain areas of opportunity for medication monitoring.
- The MHP monitors the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5
  - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD):
  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC):
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM):
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

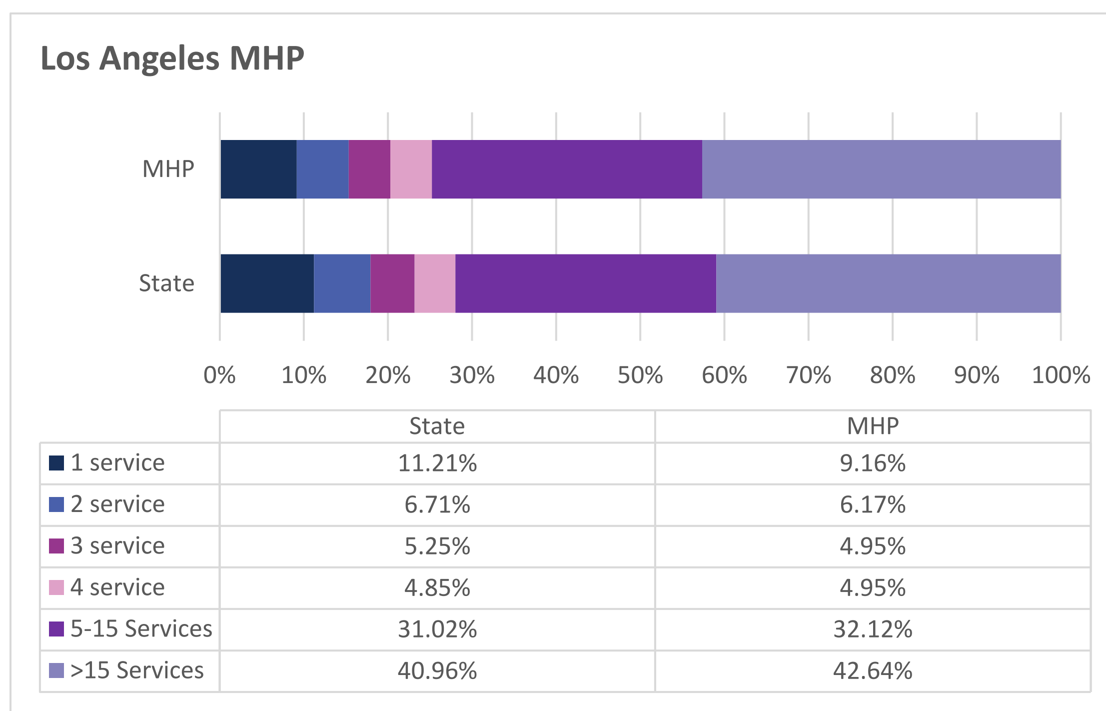
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented in the approved claims:

- Retention in Services
- Diagnosis of Members Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Members (HCMs)

Retention in Services

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022



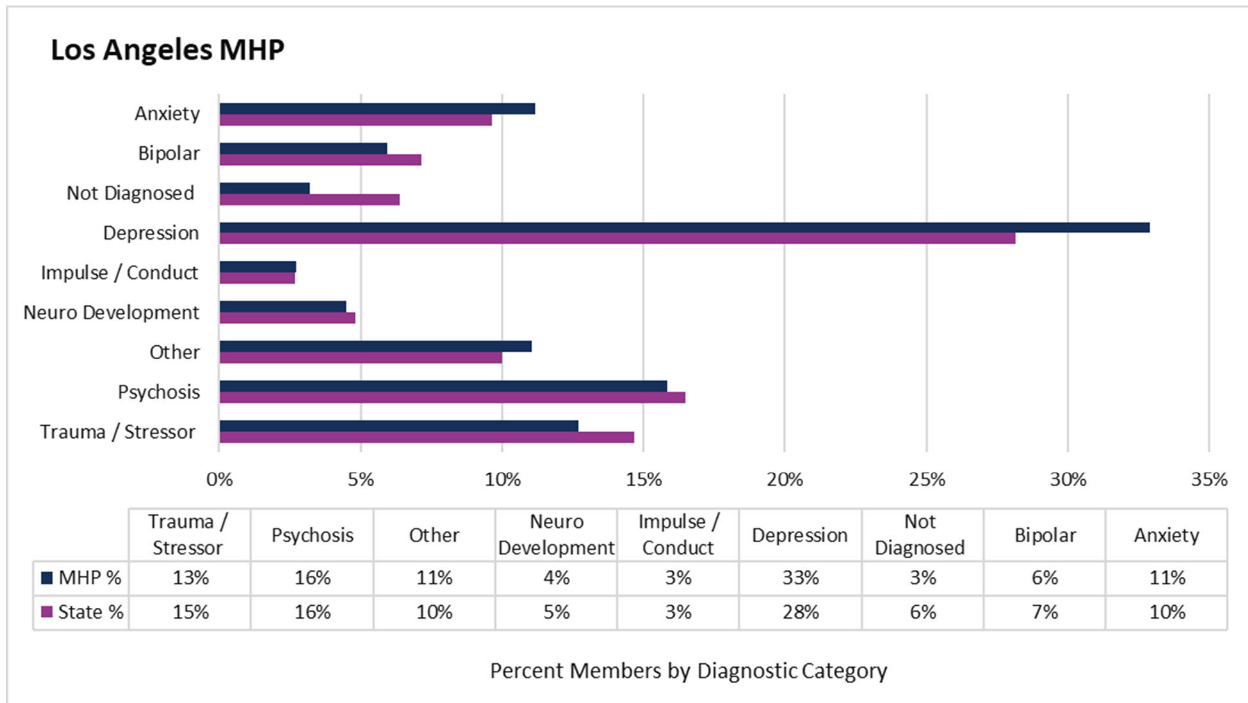
	State	MHP
1 service	11.21%	9.16%
2 service	6.71%	6.17%
3 service	5.25%	4.95%
4 service	4.85%	4.95%
5-15 Services	31.02%	32.12%
>15 Services	40.96%	42.64%

- Members not continuing in services after one initial service is less common in the MHP (9.16 percent) compared to statewide (11.21 percent). The rate of members receiving four or more services is higher in the MHP than statewide.

Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

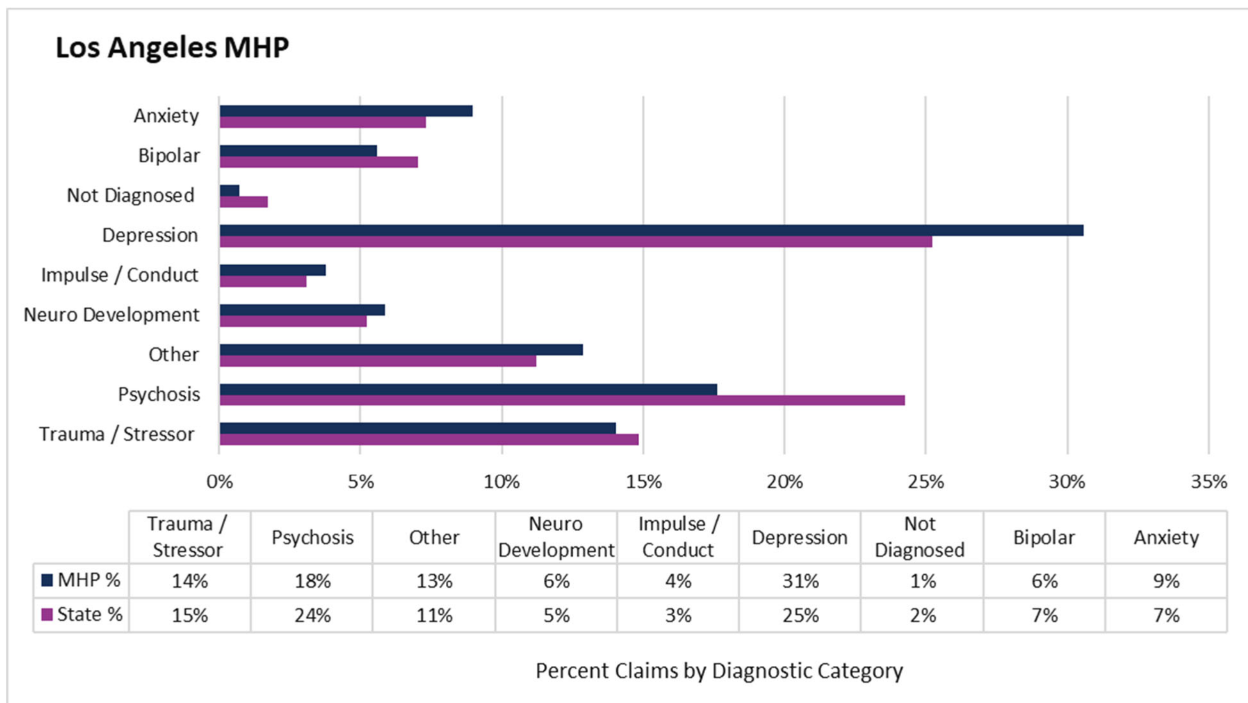
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	16%	11%	4%	3%	33%	3%	6%	11%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- The MHP shows more depression diagnoses than statewide, with the balance showing slightly less bipolar and trauma/stressor diagnoses.

Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	18%	13%	6%	4%	31%	1%	6%	9%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- Approved claims for those diagnosed with depression account for 31 percent of the total MHP Medi-Cal claims, which is higher than statewide (25 percent) but in line with its member proportion. While the MHP showed a comparable proportion of members with psychosis diagnoses (16 percent), their claims are well below statewide (18 versus 24 percent).
- The distribution of claims by diagnostic category in the MHP were generally congruent with the distribution of diagnoses.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS. CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year’s PMs and prior year PMs are a result of these improvements.

Table 13: Los Angeles MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	16,556	25,638	1.55	8.40	8.45	$10,552	$12,763	$174,702,605
CY 2021	17,067	28,293	1.66	8.56	8.86	$10,309	$12,696	$175,941,744
CY 2020	16,424	27,366	1.67	8.45	8.68	$9,502	$11,814	$156,059,336

- Member admissions to psychiatric inpatient services decreased by over 9 percent in CY 2022.

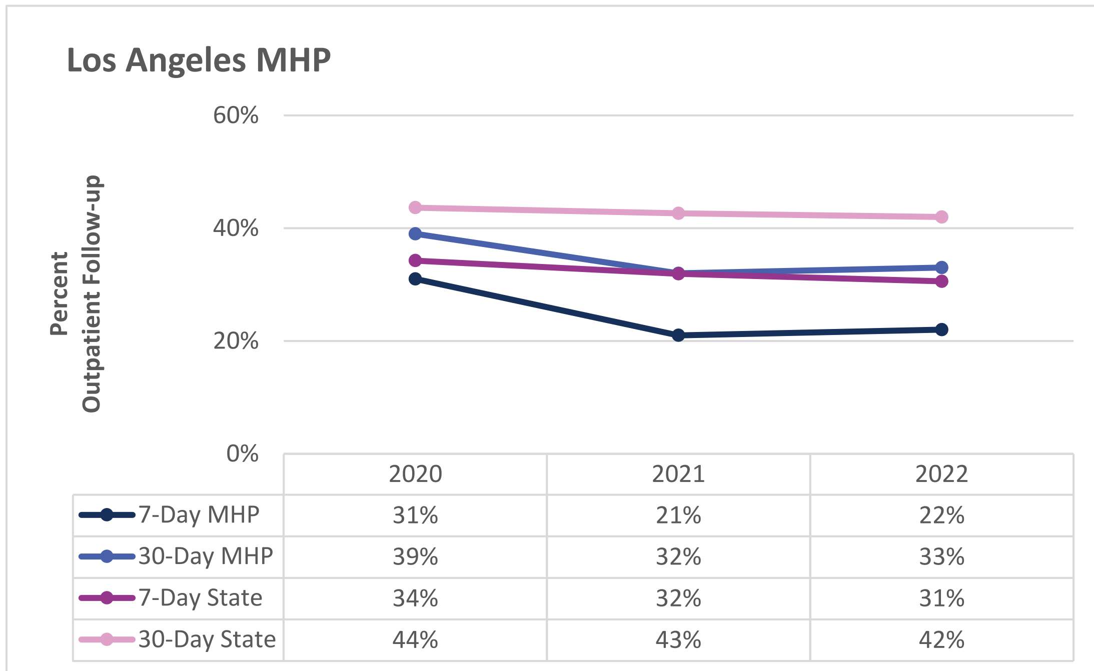
Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and are reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

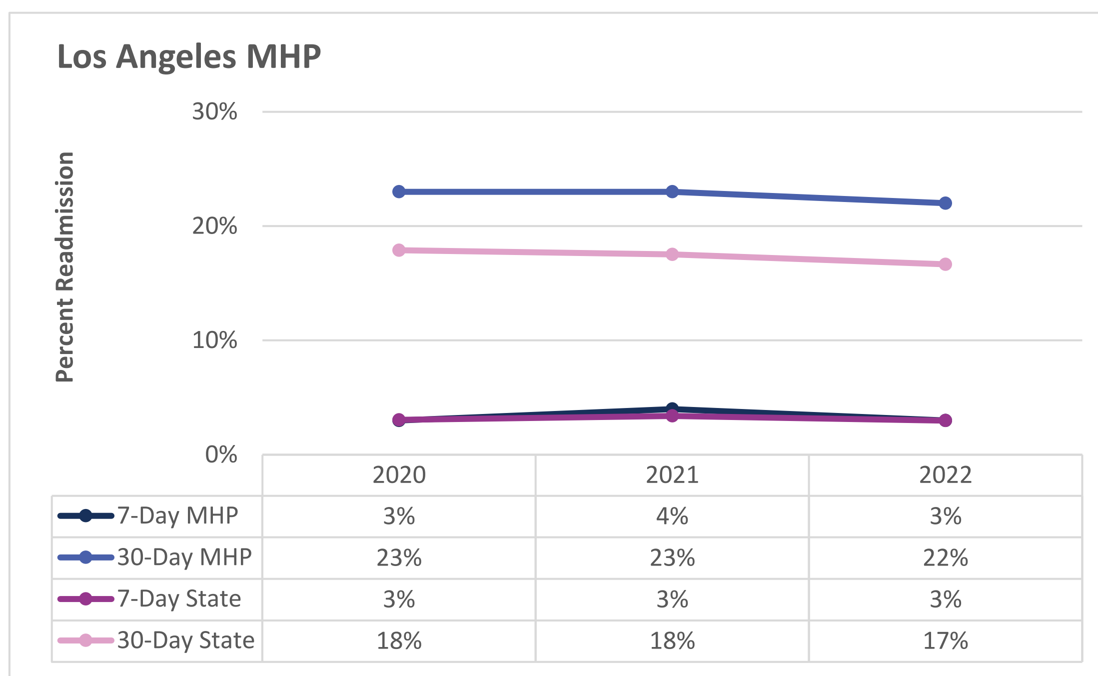
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	31%	21%	22%
30-Day MHP	39%	32%	33%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- Timely follow-up care for members following psychiatric inpatient continued a decreasing trend statewide, while the MHP had a slight improved rate in both the 7-day and 30-day time periods.
- The MHP's rates of timely follow-up within 7-day and 30-day time periods after discharge from psychiatric inpatient services are lower than statewide for CY 2022. This diverges greatly from the MHP's submitted data, which may be due to the MHP tracking all clients served and EQRO data only including Medi-Cal members in Medi-Cal billable facilities.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22



	2020	2021	2022
7-Day MHP	3%	4%	3%
30-Day MHP	23%	23%	22%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- Overall, the MHP had a similar readmission rate to the statewide rate for the 7-day time period and had a higher readmission rate than statewide for the 30-day time period. This comparison has been consistent in each of the last three years.

High-Cost Members

Tracking the HCMs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some members, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCMs may disproportionately occupy treatment slots that may prevent access to levels of care by other members. HCB percentage of total claims, when compared with the HCM count percentage, provides a subset of the member population that warrants close utilization review, both for appropriateness of LOC and expected outcomes.

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of

the statewide members are “low-cost” (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: Los Angeles MHP High-Cost Members (Greater than $30,000), CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	7,957	3.84%	28.76%	$412,763,158	$51,874	$43,584
	CY 2021	7,131	3.32%	25.50%	$362,714,092	$50,864	$42,184
	CY 2020	7,058	3.32%	24.58%	$352,029,368	$49,877	$41,755

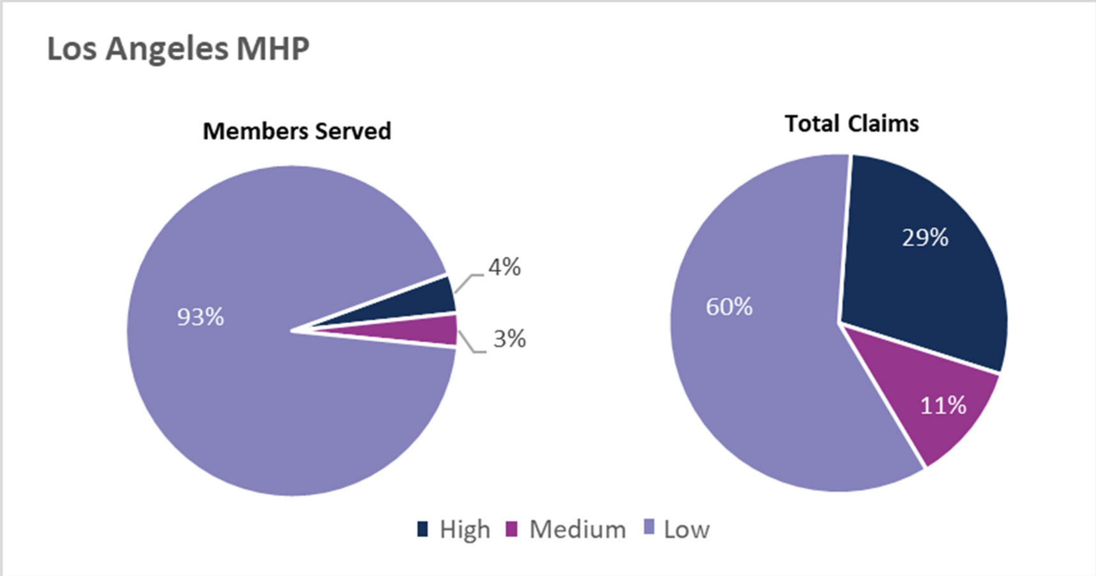
- The number of HCMs increased by 826 members (11.6 percent) for the MHP from CY 2021 to CY 2022.
- The proportion of HCMs in the MHP in CY 2022 (3.84 percent) remains lower than statewide (4.54 percent), and the average approved claims per HCM was 7 percent lower than the statewide average ($51,874 vs. $55,518).

Table 15: Los Angeles MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	6,841	3.30%	11.56%	$165,916,810	$24,253	$23,883
Low-Cost (Less than $20K)	192,405	92.86%	59.68%	$856,703,473	$4,453	$2,967

- The vast majority of members served (92.86 percent) are considered low-cost, with total services accounting for almost 60 percent of annual Medi-Cal claims for the MHP.
- Members categorized as medium-cost are only 3.3 percent of those served in the MHP, with 11.56 percent of annualized approved claims.

Figure 20: Los Angeles MHP Members and Approved Claims by Claim Category, CY 2022



IMPACT OF QUALITY FINDINGS

- Retention and engagement are indicated by data stating the MHP has fewer than statewide average of member not continuing services after one, two, or three services. Four services and more are higher than statewide averages.
- Hospital readmissions in 7- and 30-days are higher than statewide average, while timeliness of follow-up post discharge from psychiatric hospital is lower than statewide average, point to an issue with engagement that the MHP would benefit from investigating.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Improving Treatment Services for Individuals with Eating Disorders (ED)

Date Started: 06/2021

Date Completed: 06/2023

Aim Statement: "Will implementing training, consultation, a best practice toolkit, and an integrated practice network decrease the percent of Medi-Cal beneficiaries with Eds requiring a higher level of care (HLOC) from 4% to 2% per quarter and increase the number of individuals transitioning from HLOC to outpatient services from 14.8% to 19.8% as well as those screened and assessed for ED from 0.4% to 1.0% to approach the nationwide one-year prevalence rates within 18 months?"

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[2] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[3] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

Target Population: The total population of plan members served who may meet criteria for an ED with enhanced screening and assessment, and the population of members with diagnosed ED that would receive the treatment interventions.

Status of PIP: The MHP's clinical PIP is in the other (completed) phase.

Summary

Over a five-year period from CY 2017-21, Los Angeles MHP experienced a two-fold increase in its number of members with either ED diagnoses or eating concerns referenced in the members' charts. Members with ED diagnoses or concerns often required HLOC services at a higher rate than other members, causing a significant impact on the members and family functioning, and limiting opportunities for school and work.

To address this issue, through this PIP, the MHP set up a clinical practice network (CPN) and provided training, consultation, and a clinical toolkit to its clinicians. Through these strategies, the MHP sought to provide quality, evidence-based treatment to an increasing number of members and improve screening and assessment methods to address the discrepancy between expected ED prevalence rates and the actual diagnostic rates. The PIP aimed to 1) decrease the percent of Medi-Cal members with EDs requiring HLOC, 2) increase the number transitioning from HLOC to outpatient services, and 3) increase the number of members assessed for ED.

As of June 2023, at the end of the project as a formal PIP, the PIP produced modest but statistically significant improvements in all three PMs. A comparative analysis of clinicians who received the training with those who did not demonstrate the most significant success of the PIP in detecting and treating members with ED. This analysis showed that the overall finding of modest improvements masked the actual, more significant effect of the fully implemented planned interventions. Based on these findings, the MHP is continuing with the CPN and offering ED trainings.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence because the project employed a robust research design and the MHP conducted thorough statistical analyses of both the process and outcome measures to provide evidence for its findings. The MHP also provided a comprehensive summary of the challenges and limitations of the study.

CalEQRO recommendations for improvement of this clinical PIP:

- Continue with and expand the interventions to include more clinicians across the system with regular training opportunities for new hires with the ED training modules utilized in this PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improving Follow-Up After Emergency Department Visit for Mental Illness (FUM) for Beneficiaries that Present with MH Concerns

Date Started: 12/2022

Date Complete: 06/2024 (estimated)

Aim Statement: "During the Fiscal Years 2022-24, the application of the Los Angeles County Department of Mental Health Enhanced Care Management (LACDMH ECM) team outreach and linkage services to hospital emergency departments, revision of emergency department referral workflows, and connection of CBN or hospital staff to a Health Information Exchange (HIE) will increase the percent of linkage to seven and 30-day follow-up MH appointments for Medi-Cal beneficiaries who present to emergency departments with MH diagnoses from 0 to 5 percent in six months, specifically adults and older adults.

Target Population: This PIP will focus on individuals who get seen at an ED, have a MH diagnosis, and not currently connected to MH services at LACDMH, either through DO or C/LE. Individuals with any MH diagnosis, race/ethnicity, age, gender, primary language, and housing status will be included in the study population.

Status of PIP: The MHP's non-clinical PIP is in the implementation phase.

Summary

For this PIP, Los Angeles MHP chose two emergency departments in two different service areas to pilot the project. At the time of the review, the MHP was at different stages of establishing the mechanism for collaboration with the two emergency departments, including the HIE status. At the time of the review, the MHP's baseline and findings were incomplete.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence because, at the time of the review, the MHP did not have adequate data to establish any reliable baseline, and consequently, the remeasurement data that was available for the process measures was not reliable.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Continue establishing reliable baselines for all PMs.

- Continue establishing relationships with other emergency departments and expanding the scope of the project.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is myAvatar by Netsmart, which has been in use for ten years. Currently, the MHP has no plans to replace the current system, which has been functioning in a satisfactory manner.

Approximately 1 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control and decreased from 2.1 percent reported at the time of the prior EQR.

The MHP has 4,162 named users with log-on authority to the EHR, including approximately 3,704 county staff and 458 C/LE staff. Support for the users is provided by 229 FTE IS technology positions. Currently there are 39 vacant FTE positions.

As of the FY 2023-24 EQR, no C/LE providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

C/LEs submit member practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to Los Angeles MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
HIE between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	99%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	1%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. While the MHP has had some level of PHR functionality in the past, only one program had PHR available to members with 15 members accessing records over the past year.

Interoperability Support

The MHP is a member or participant in the Los Angeles Network for Enhanced Services (LANES) and Carequality HIEs. The MHP engages in electronic exchange of information with contract providers, hospitals, and MCPs.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive member outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations: contract providers, hospitals, and managed care plans.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

Strengths and opportunities associated with the IS components identified above include:

- The MHP does well ensuring security and controls are in place. The MHP has a designated system security officer and an Operations Continuity Plan (OCP) in place, although the OCP is not tested annually.
- The 13 FTE data analytics positions appear to be low to support such a large system.
- The MHP does not currently allow C/LE providers the full use of the MHP EHR. Interoperability continues to be a focus of development for the MHP. Currently C/LE providers do not have the capability to directly enter member service data or clinical data into the MHP EHR.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

Table 18: Summary of Los Angeles MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	447,444	$98,207,055	$2,611,310	2.66%	$95,595,745
Feb	454,969	$103,129,152	$2,366,105	2.29%	$100,763,047
Mar	535,166	$124,554,240	$3,072,263	2.47%	$121,481,977
April	471,415	$110,430,736	$2,463,781	2.23%	$107,966,955
May	472,709	$112,774,645	$2,342,832	2.08%	$110,431,813
June	450,804	$107,772,516	$2,645,503	2.45%	$105,127,013
July	421,200	$103,711,709	$2,326,385	2.24%	$101,385,324
Aug	491,651	$123,052,199	$2,705,962	2.20%	$120,346,237
Sept	465,194	$118,829,782	$2,674,694	2.25%	$116,155,088
Oct	448,298	$115,207,754	$2,266,214	1.97%	$112,941,540
Nov	411,424	$105,679,589	$2,105,574	1.99%	$103,574,015
Dec	368,528	$93,360,683	$2,050,463	2.20%	$91,310,220
Total	**5,438,802**	**$1,316,710,060**	**$29,631,086**	**2.25%**	**$1,287,078,974**

- The MHP had a relatively stable volume of claim lines across CY 2022.

Table 19: Summary of Los Angeles MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	44,565	$12,685,394	42.81%
Medicare Part B must be billed before submission of claim	30,032	$8,932,639	30.15%
Beneficiary is not eligible or non-covered charges	13,518	$3,916,629	13.22%
Service line is a duplicate and repeat service modifier is not present	7,273	$2,064,133	6.97%
Other	7,020	$1,152,822	3.89%
Late claim submission	1,596	$450,571	1.52%
Deactivated NPI	1,077	$241,933	0.82%
Service location NPI issue	545	$173,115	0.58%
Place of service incomplete or invalid	10	$13,851	0.05%
Total Denied Claims	**105,636**	**$29,631,087**	**100.00%**
Overall Denied Claims Rate	**2.25%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The top three denial reasons account for $25.5 million and 86 percent of the denied claims amount, with claiming other coverage or Medicare first, being the predominant reason.
- The MHP denied claim percentage is less than half the statewide rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The base of 229 FTEs approved to support the overall IS functionality provides a solid foundation as EHR updates and development continue. The successful recruitment of the 39 vacant FTEs will be key to successfully moving initiatives forward in a timely manner.
- The 13 approved FTE data analytics positions appear to be low to support a system as large as Los Angeles. While other positions do partner and support the data and reporting functionality, an increase in dedicated data analytic positions to expedite and increase the capacity of data development and support the interoperability efforts would benefit the MHP and C/LE providers.
- The MHP Medi-Cal claiming process and the EHR were updated to align with CalAIM at the beginning of FY 2023-24. Claim submission has continued; however as of the review, no Medi-Cal claim approvals have been received for FY 2023-24 claims, which impacts cash flow for the MHP and C/LE providers.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting members' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of members: adult, older adult, youth, and family members. MHPs administer these surveys to members receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP reviews the CPS and uses it to decide on system/program decisions along with the Power BI report for quality improvement. The MHP has made efforts to improve the numbers of CPS surveys submitted and noted that the online CPS submission process has high levels of incomplete surveys. When sufficient data exists, the MHP creates brief one-page summaries that highlight the key feedback issues.

PLAN MEMBER/FAMILY FOCUS GROUPS

Plan member and family member (PMF) focus groups are an important component of the CalEQRO review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and PMF involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested four 90-minute focus groups with members and/or their family, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested CalEQRO requested a diverse group of SA-8 Khmer speaking adult consumers, the majority of whom initiated services in the preceding 12 months. The focus group was held virtually by a DMH-sponsored Teams session and included 12 participants; all were Khmer-speakers, and the MHP provided an interpreter. All participants receive clinical services from the MHP.

Timeliness in between ongoing appointments varies between monthly and bimonthly. This was currently meeting member needs but in the past year it was more difficult to be seen sooner if needed.

Transportation is an issue and a barrier at times, and they can do sessions through Zoom if needed. Language interpretation and cultural needs are provided, and participants feel very supported in this area.

Communication with psychiatrists is adequate and members felt listened to.

None experienced a crisis in the past year. They were all aware of the option for crisis text and warm line numbers but did not know what to do in a MH crisis or if they needed urgent care.

All participants had completed a CPS, but none have seen the results of the survey. No one had been invited to be a part of a committee, and all stated that they would like to do so if they had the opportunity.

Recommendations from focus group participants included:

- Better communication in getting the crisis/emergency information to members.
- Transportation options could be improved.
- More information on where services can be found and resources in general.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of SA-6 adult consumers, the majority of whom initiated services in the preceding 12 months. The focus group was held virtually by a DMH-sponsored Teams session and included eight participants; no interpreter was necessary for this focus group. All participants receive clinical services from the MHP.

Of the participants who initiated services in the past year, they accessed services in a variety of ways. One individual was referred by the Multidisciplinary Assessment Team; a homeless member was referred by supportive housing. Another member walked into Martin Luther King, Jr. outpatient clinic and was informed about services. The third member had received services previously, contacted his former provider for additional sessions, and was referred to the SHIELDS program. All reported that it was relatively easy and took a month or less to begin receiving services.

Frequency of psychiatry services ranged from every two weeks to every two months. Most psychiatry services were provided by phone and lasted 15 to 30 minutes. Psychiatry is difficult to schedule for some participants. One participant reported that he had an appointment, waited for an hour, and eventually had to leave for another appointment; he had not contacted the psychiatrist for an appointment since then.

Frequency of therapy was reported weekly to monthly, with the majority reporting therapy services occurring monthly. Several participants noted that the frequency of their clinical therapy appointments is less than they received prior to the COVID-19 pandemic and was not sufficient to meet their needs. The duration of telehealth services, when utilized, was substantially shorter than in-person sessions.

All reported options of in-person or telehealth and flexibility within those options, apart from one member who has not returned to in person services since COVID-19 pandemic. Members seemed to have limited knowledge about crisis resources, or resources in general, including the PRCs. However, all reported being involved in their plan of care and stated that staff gave them hope for recovery.

Recommendations from focus group participants included:

- It would be helpful if there were more therapists working who could relate to the members, to include people of color, and other diverse characteristics. People with lived experience would be useful and those who are not from middle class backgrounds.
- Participants thought that it might be due to staff shortages, but they believe one on one therapy should be weekly, and they preferred not having to change therapists.
- One participant stated that there are a lot of resources that were learned through this meeting that could have been shared with members. “When you aren’t aware you can’t take advantage of the resources, not communicated to members.”
- It would be useful to have more Promotores who can help with both mental and physical health.

Consumer Family Member Focus Group Three

CalEQRO requested CalEQRO requested a diverse group of SA-8 parents/caregivers of children, the majority of whom initiated services in the preceding 12 months. The focus group was held virtually by a DMH-sponsored Teams session and included two participants receiving clinical services from the MHP.

The number of participants was fewer than three; therefore, feedback received during the session is incorporated into other sections of this report to ensure anonymity of the participants.

Consumer Family Member Focus Group Four

CalEQRO requested a diverse group of SA-6 TAY consumers who initiated services in the preceding 12 months. The focus group was held virtually by a DMH-sponsored Teams session and included one participant receiving clinical services from the MHP.

The number of participants was fewer than three; therefore, feedback received during the
session is incorporated into other sections of this report to ensure anonymity of the participant.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall, services were experienced as helpful and positive. All participants in the groups found the services they receive to be helpful in their recovery. They report the staff as giving them hope and being respectful of their cultural and personal beliefs.

While telehealth remains a useful choice for members with transportation or other issues that prevent coming to the clinic, it was noted that telehealth services were often shorter in duration than in-person. This was perceived as less useful than in-person sessions.

Frequency of services was seen as not sufficient for both therapy and psychiatry, and there was an awareness of staffing shortages.

Members all agreed that information, especially about resources, is not as ubiquitously \ shared as would be useful.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. Cultural competency programs across the system of care show strong engagement with their communities and include collaboration with a variety of groups. The Anti-Racism, Diversity and Inclusion Initiative is noteworthy in its efforts against all form of structural racism and stigma. (Access)
2. The MHP exhibits a robust peer specialist system which includes PRCs and a promotional ladder across SAs. (Quality)
3. The MHP has maintained a higher PR than statewide even with multiple years of increased numbers of eligibles. This is a positive indicator for members' access to care. (Access)
4. The updates required by CalAIM and, more specifically, payment reform, appear to have been implemented with synergy and care by the various MHP teams involved. The scale of this substantial change and the ongoing training and communication efforts are notable, and C/LE provider leadership expressed positive feedback for the MHP's process. (IS, Quality)
5. The MHP initiated collaborative charting to increase clinical line staff service capacity. (Access, Timeliness)

OPPORTUNITIES FOR IMPROVEMENT

1. Consistent with prior reviews, the MHP's adult 30-day rehospitalization rate remains higher than statewide. (Quality)
2. Peer employees lack information and awareness of opportunities for promotion on the peer ladder of positions. (Quality)
3. Insufficient clinical staffing levels have led to elevated caseloads in both DO and C/LE programs, which impacts timeliness and service availability for members. (Timeliness, Quality)
4. The need for system-wide data available closer to real-time is an ongoing focus of multiple MHP development initiatives and planned updates. Multiple system-wide initiatives would benefit from an increase in data analytics positions. Initiatives include the evaluation and implementation of LOC tools for both adult

and youth members, and the future interoperability development, data aggregation, and reporting of system-wide data. (IS)

5. Some new clinical line staff find collaborative charting difficult to do while involved in the clinical session. (Quality)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve member outcomes:

1. Continue and broaden the systemwide focus on reducing the 7/30-day rehospitalization rates, by provision of post-hospital appointments and case management follow-up which is tailored to factors identified by data analysis and stakeholder input. (Quality)

   (This recommendation was continued from FY 2022-23.)
2. Engage in a barrier analysis of why information on peer opportunities is not more well-known, and use this information found to create a system to increase information flow to ensure peers know of promotional opportunities , requirements, and how to apply. (Quality)
3. Continue to focus resources and efforts on recruitment and retention of clinical line staff to improve timeliness to care and increase system capacity. (Timeliness, Quality)
4. Continue development efforts to provide interoperability solutions for more up to date and aggregated data collection and reporting inclusive of C/LE provider data. These efforts should include setting standards, implementation, and monitoring of member record access either through PHRs or API functionality for both DO and C/LE programs. (IS)
5. Additional data analytical positions would strengthen data integrity and the ongoing data and reporting efforts, the future implementation and assessment of LOC tools, and interoperability efforts. (IS)
6. Investigate issues that create barriers to effective collaborative charting; create and implement training and mentoring to increase clinician competence for this task. (Access, Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

Staffing shortages and recent turnover affected the planning of sessions for the review. However, there were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Los Angeles MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Member and Family Member Focus Groups
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Clinical Directors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Saumitra Sengupta, Quality Reviewer
Joel Chain, Information Systems Reviewer
Leah Hanzlicek, Data and Information Systems Manager
Gloria Marrin, Consumer/Family Member Reviewer
Pamela Roach, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Alvarado	David	Psychiatric Social Worker II	DMH
Arns	Paul	Chief, Clinical Informatics	DMH
Bailey	Jennifer	South Bay MH Center	DMH
Barraza	Mary	Sr. Deputy Director, Prevention & Child Well-Being Services	DMH
Baucum	Jaclyn	Health Access and Integration	DMH
Beard	Kalisha	Psychiatric Social Worker II	DMH
Bennett	Karla	Program Manager, Hollywood 2.0	DMH
Benson	Lisa	Supervisor, Clinical Informatics	DMH
Bonds	Curley	Chief Medical Director	DMH
Boykins	Terri	Deputy, Contract Monitoring and Management	DMH
Brown	Miriam	Deputy, Emergency Outreach and Triage	DMH
Bryant	Brad	Chief, QA	DMH
Byrd	Robert	Deputy, Prevention	DMH
Cacialli	Doug	Psychologist, Clinical Informatics	DMH
Cadena	Daisy	Psychiatric Social Worker I	DMH
Chang	Sandra	MH Program Manager I	DMH
Chapman	Sharon	Supervising Psychologist	DMH
Chen	Sandy	Management Analyst	DMH
Cheng	Mark	Acting CIO	DMH
Corral	Martin	Chief Information Office Bureau	DMH
Cox	Jackie	MH Program Manager III	DMH
Cozolino	Susan	QA Supervisor	DMH

Last Name	First Name	Position	County or Contracted Agency
Crain	David	QA Analyst, Access to Care	DMH
Cunnane	Daiya	Clinical Psychologist II	DMH
Draxler	Connie	Acting Chief Deputy Director	DMH
Eckart	George	Clinical Psychologist II	DMH
Funk	Maria	Deputy, Housing & Employment	DMH
Gambino	Elisa	Clinical Psychologist II	DMH
Gertmenian	Socorro	SA6 QIC Co-Chair	Welnest LA
Gilbert	Kalene	MHSA Admin & Stakeholder Engagement	DMH
Gitlin	Rebecca	Clinical Psychologist II	DMH
Gonzalez	Herminio	SA-6 QIC Co-Chair	DMH
Hallman	Jennifer	QA Manager	DMH
Hernandez	Rosa		DMH
Herrera	Dinessa	Psychiatric Social Worker I	DMH
Hunt	Jennifer	Acting Sr. Deputy Director, Reentry Services	DMH
Huynh	Judy	Management Secretary III	DMH
Innes-Gomberg	Debbie	Deputy, Quality, Outcomes and Training	DMH
Jackson	La Tina	Deputy, Countywide Engagement	DMH
Jensen	Heather	MH Program Manager III	DMH
Jones	Martin	Outpatient Care	DMH
Kato	Allison	Manager, Health Access and Integration	DMH
Kermoyan	Katia	Information Technology Specialist I	DMH
Lee	Ann	SA-8 QIC Co-Chair	DMH
Lin	Yen-Jui (Ray)	Clinical Psychologist II	DMH

Last Name	First Name	Position	County or Contracted Agency
Maciel	Mayra	Psychiatric Social Worker (PSW) II	DMH
Martinez	Imelda Alas	PSW I	DMH
Melbourne	Erica	SA-6 QIC Co-Chair	DMH
Munde	Michele	SA-8 Co-chair	Stars Behavioral Health Group
Nall	Kimberly	Admin Deputy	DMH
Ortega	John	Information Technology Manager II	DMH
Parada Ward	Mirtala	Mental Health Program Manager III	DMH
Patterikalam	Girivasan	Information Technology Manager II	DMH
Perkins	Theion	Acting Sr. Deputy Director, Outpatient Care Services	DMH
Pesanti	Keri	Program Manager, Prevention	DMH
Powers	Elizabeth	MH Program Manager I	DMH
Ramos	Emilia "Emily"	MH Clinical Program Head	DMH
Rivera	Robert	Information Technology Manager I	DMH
Robinson	Tonica	Chief of Peer Services, MH (UC)	DMH
Rodriguez	Anabel	Deputy, Child Welfare	DMH
Ruiz	Amanda	Acting Sr. Deputy Director, Intensive Care Division	DMH
Smith	Vilka Jasmin	MH Clinician II	DMH
Sou	Susana	Pharmacy Services Chief III	DMH
Stephens	Courtney	SA-8 Co-chair	Mental Health America LA
Taguchi	Kara	Manager, QI & Outcomes	DMH
Thurmond	James	Departmental Info Security Officer II	DMH
Unanyan	Ani	Staff Assistant II	DMH
Valdez	Julie	Manager, ACCESS	DMH

Last Name	First Name	Position	County or Contracted Agency
Vargas	Janet	Psychiatric Social Worker II	DMH
Vinh	Sharon	Principal Application Developer	DMH
Wills	Lori	MH Program Manager III	DMH
Wong	Lisa	Director	DMH

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	As submitted, this clinical PIP was found to have high confidence, because: the project employed a robust research design and the MHP conducted thorough statistical analyses of both the process and outcome measures to provide evidence for its findings. The MHP also provided a comprehensive summary of the challenges and limitations of the study.

General PIP Information
MHP/DMC-ODS Name: Los Angeles
PIP Title: Improving Treatment Services for Individuals with Eds
PIP Aim Statement: "Will implementing training, consultation, a best practice toolkit, and an integrated practice network decrease the percent of Medi-Cal beneficiaries with Eds requiring a higher level of care (HLOC) from 4% to 2% per quarter and increase the number of individuals transitioning from HLOC to outpatient services from 14.8% to 19.8% as well as those screened and assessed for Eds from 0.4% to 1.0% to approach the nationwide one-year prevalence rates within 18 months? "
Date Started: 06/2021
Date Completed: 06/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): The total population of plan members served that may meet criteria for an eating disorder with enhanced screening and assessment, and the population of members with diagnosed EDs that would receive the treatment interventions.

Improvement Strategies or Interventions (Changes 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): Ed Screening and Assessment; Cognitive Behavior Therapy (CBT) for Members with ED Diagnosis or Concerns.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Ed Screening and Assessment; Cognitive Behavior Therapy (CBT) for Members with Ed Diagnosis or Concerns
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): Eating Disorders Practice Network; Case Consultation Series for Eds; QA Bulletin; Eds Clinical Practice Consultation TEAMS group; Eds Best Practice Toolkit.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Clinical PM 1: # of members with EDs that engaged in HLOC	FY2021-22 Q1	N = 28 28/632 = 4.4%	☐ Not applicable—PIP is in planning or implementation phase, results not available	N = 25 25/697= 3.6% FY2022-23 Q3	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Clinical PM 2: # of members receiving HLOC that step down to a lower level of care	FY2021-22 Q1	N = 4 4/28 = 14.3%	☐ Not applicable—PIP is in planning or implementation phase, results not available	N = 25 7/25 = 28% FY2022-23 Q3	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Process Measure 1: # of members served who are diagnosed with Eds	FY2020-21 Q3	N = 592 592/160,721 = 0.37%	☐ Not applicable—PIP is in planning or implementation phase, results not available	N =697 697/151,706 = 0.46% FY2022-23 Q3	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Sixth quarterly remeasurement

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.

EQRO recommendations for improvement of PIP: The MHP has completed this PIP with modest but notable successes. EQRO recommends that the MHP continues with and expands the interventions to include more clinicians across the system with regular training opportunities for new hires with the Ed training modules utilized in this PIP.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	At the time of the review, the MHP did not have adequate data to establish any reliable baseline, and consequently, the remeasurement data that was available for the process measures, was not reliable.

General PIP Information
MHP/DMC-ODS Name: Los Angeles
PIP Title: Improving Follow-Up After Emergency Department Visit for Mental Illness (FUM) for Beneficiaries that Present with MH Concerns
PIP Aim Statement: "During the Fiscal Years 2022-24, the application of the LACDMH ECM Team outreach and linkage services to hospital emergency departments, revision of emergency department referral workflows, and connection of CBN or hospital staff to a HIE will increase the percent of linkage to seven and 30-day follow-up MH appointments for Medi-Cal beneficiaries who present to emergency departments with MH diagnoses from 0 to 5 percent in six months, specifically adults and older adults."
Date Started: 12/2022
Date Completed: 06/2024 (estimated)
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): Those who present at an Emergency Department with a MH diagnosis without any recent services from LACDMH.

Improvement Strategies or Interventions (Changes 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): ECM will provide outreach to MH referrals, assist with linkage to follow-up appointments, assess for transportation needs, assess for housing needs, assisting with Motivational Interviewing, and assisting with connections to the next level of care.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): (ECM) team will provide educational presentations on LACDMH MH services to Emergency Department staff
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): Review Emergency Department workflow to include checking of LANES (the local HIE); Staff/ECM team members will search MH referrals in LANES for previous contact with LANES-lined EDs where MH concerns were presented in a referral to the ECM team.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Increase the knowledge of emergency department staff about making MH service referrals	2023	Pending	☐ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2. Improve the efficiency and completion of emergency department workflows for MH referrals	2023	Pending	☐ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3. Increase the rate of linkage for MH referrals to seven and 30-day follow-up appointments	2023	Pending	☐ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☐ Yes ☒ No

"Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

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.

EQRO recommendations for improvement of PIP:

- Continue establishing reliable baselines for all PMs.
- Continue establishing relationships with other Emergency Departments and expanding the scope of the project

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, and PIP Validation Tool, are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.