QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR CALENDAR YEAR 2008
And
QUALITY IMPROVEMENT WORK PLAN FOR CALENDAR YEAR 2009

County of Los Angeles
Department of Mental Health
Quality Improvement Division

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COUNTY OF LOS ANGELES –DEPARTMENT OF MENTAL HEALTH
LOCAL MENTAL HEALTH PLAN
Calendar Years 2008 and 2009

Table Of Contents

COUNTY OF LOS ANGELES –DEPARTMENT OF MENTAL HEALTH
LOCAL MENTAL HEALTH PLAN

QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR CALENDAR YEAR 2008
QUALITY IMPROVEMENT WORK PLAN FOR CALENDAR YEAR 2009

Introduction

Los Angeles County Department of Mental Health since its inception has put forth the task of improving the quality of life for all who seek its services. In these times of increasing populations and rapidly morphing demographics, there exists the need to seek out those who may benefit from the myriad of expanded and enhanced services now available through LAC-DMH and its many community partners.

In order to maintain the focus of expanded and appropriate service delivery LAC-DMH has created the vision of: “Partnering with clients, families and communities to create hope, wellness, and recovery”.

This vision brings to light the development of the LAC-DMH mission: “Enriching lives through partnerships designed to strengthen the community’s capacity to support recovery and resiliency”.

As with any structure the true strength and longevity rest upon the quality of its foundation. LAC-DMH has laid out seven foundational values: “Integrity, Respect, Accountability, Collaboration, Dedication, Transparency, Quality and Excellence”.

Contents of This Report

LAC-DMH uses a calendar year for planning and management of its Quality Improvement (QI) Program.

Section 1 contains a description of the LAC-DMH Quality Improvement Program Structure and Processes.

Section 2 contains the Demographics, Persons Served, and Service Array of Los Angeles County.

Section 3 contains information on LAC-DMH new and expanded programs as adopted by LAC-DMH in 2008

Section 4 contains QI Work Plan and QI Work Plan Evaluation for 2008.

Section 5 contains Quality Work Plan goals and descriptions as adopted by LAC-DMH for 2009.

Section 1: LAC-DMH QUALITY IMPROVEMENT PROGRAM

QI Program Structure

The Quality Improvement (QI) Division is under the direction of the Deputy Director for the Program Support Bureau (PSB). The QI Division is responsible for coordinating and managing the Quality Improvement Program, which plans, designs, organizes, directs, and sustains the quality improvement activities and initiatives of the County of Los Angeles, Department of Mental Health (LAC-DMH). The structure and processes of the QI Program are defined to ensure that the quality and appropriateness of mental health services meets and exceeds local, State and Federal established standards. The QI Program is also designed to support QI oversight functions for both directly operated and contracted providers for the County's public mental health system, with a focus on a culture of continuous quality improvement processes.

The QI Division includes the Data Unit, which is specifically responsible for data collection, analyses and reporting for planning and measuring progress towards goal attainment including outcome measures for improved service capacity, accessibility, quality, cultural competency, penetration and retention rates, continuity and coordination of care, clinical care and consumer/family satisfaction. The QI Division and Data Unit staff coordinate with the Department's Standards and Quality Assurance Division and those Bureaus and Units directly responsible for conducting performance management activities throughout the Department that included but are not limited to: client and system outcomes, beneficiary grievances, fair hearings, clinical issues, clinical records and reviews, appeals on behalf of consumers and providers, accessibility and timeliness of services, and Performance Improvement Projects(PIPs). The analyses and management of data is used as a key tool for performance management and decision making, paying particular attention to data for use in monitoring the system for improved services and quality of care.

The LAC-DMH Quality Improvement structure is formally integrated within several key levels of the service delivery system. The Department's Countywide Quality Improvement Council (QIC) meets monthly and consists of representation from stakeholders from each of the eight (8) Services Areas of the County, including consumers and/or family members, practitioners for directly operated and contracted agencies, Cultural Competency Committee representatives, and other QI stakeholders. At the Service Area level, all Service Areas have their own regular Service Area Quality Improvement Committee (SA QIC) meetings and the SA QIC Chairpersons are standing members of the Departmental Countywide QIC. There is also a Countywide Children's QIC. At the service provider level, all directly operated and contracted organizational providers, maintain their own Organizational QIC. In order to ensure that the QI communication feedback loop is complete, all Service Area organizational providers are required to participate in their local SA QIC. This constitutes a structure supportive of effective performance of the QI Providers, to the

Service Areas, to the Quality Improvement Council, to the intended management structure and back through the system. Lastly, there is a communication loop between the SA QIC and the respective Service Area Advisory Committee (SAAC). The SAACs provide valuable information for program planning and opportunities for program and service improvement. It is used as an excellent venue for improved consumer/family member participation at the SA QIC level.

The Departmental Countywide QIC is chaired by the Program Support Bureau, District Chief, for the Quality Improvement and Training Divisions. It is Co-Chaired by the Regional Medical Director from the Office of the Medical Director. The District Chief for the Quality Improvement Division also participates on the Southern California QIC, the Statewide QIC, and the LAC-DMH STATS.

The LAC-DMH Cultural Competency Coordinator is under the Program Support Bureau, Planning Division, and is also the Chairperson for the Departmental Countywide QIC, Cultural Competency Committee. This structure facilitates system wide communication and collaboration for attaining the goals set for the provision of improved culturally competent services.

Quality Improvement Processes

The Quality Improvement Program works in collaboration with Bureaus and Units, responsible for performance management activities, to develop the Annual QI Work Plan and monitor the established measurable goals, for the system as a whole. The Quality Improvement Program consists of dynamic processes that occur continuously throughout the year and requires that interventions be applied based upon collected and analyzed information and data. This also requires collaboration with IS staff and resources whenever possible. The QI Program processes can be categorized into seven (7) main categories, which include: Service Delivery Capacity, Service Accessibility, Beneficiary Satisfaction, Clinical Issues, Continuity of Care and Provider Appeals.

The Quality Improvement Division is also responsible for the formal reporting on the effectiveness of QI processes through the development and completion of the Annual QI Work Plan Evaluation Report and the State and County Performance Outcomes Report that is completed twice a year. The State and County Outcome measures are new and were initiated in January 2008. These measures include access and timeliness of services with a focus on persons discharged from acute psychiatric inpatient hospitals. The ultimate goal of these QI measures and evaluation processes is to ensure a culture and system of continuous self-monitoring and self-correcting quality improvement strategies and best practices, at all levels of the system.

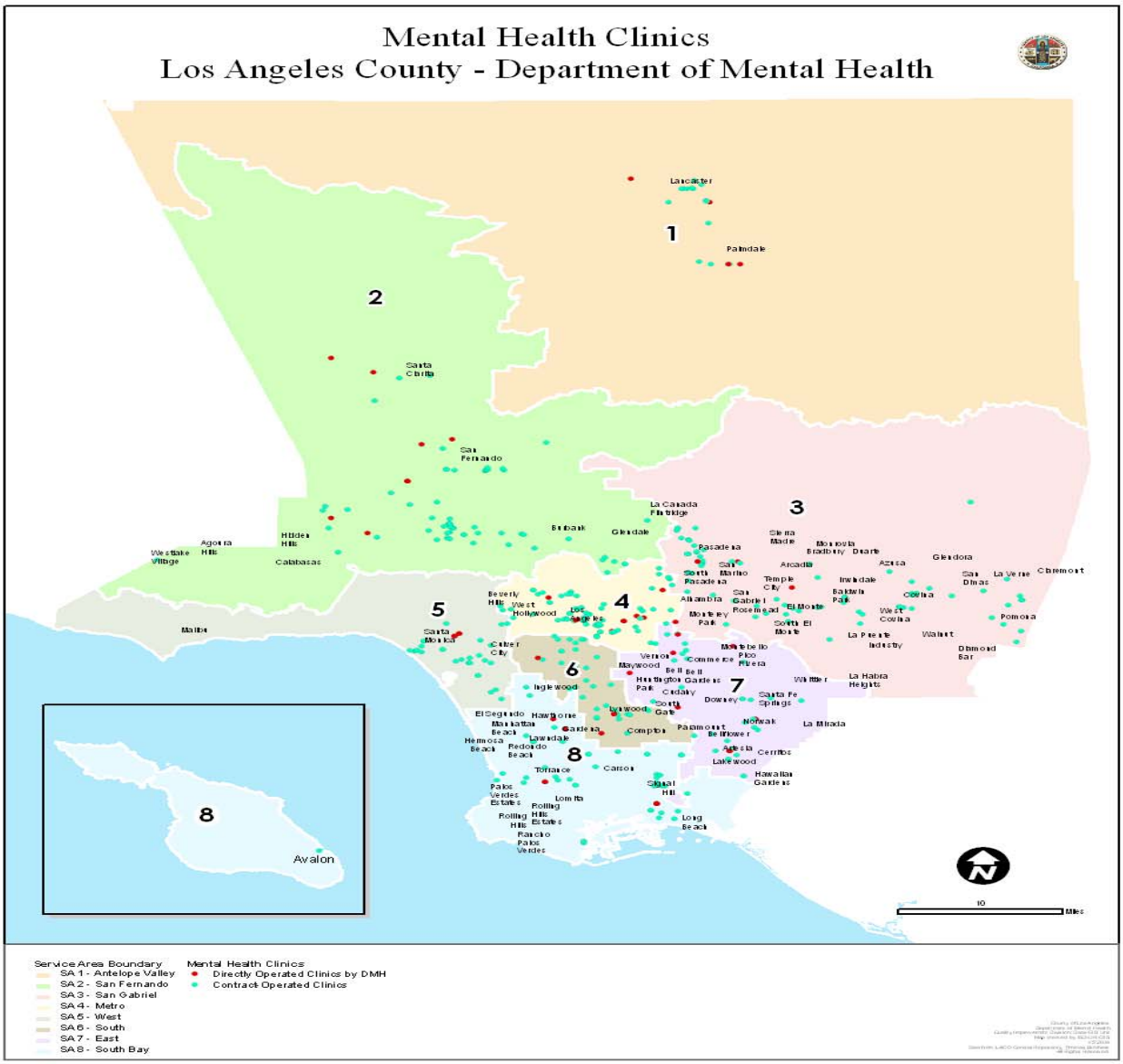
The Departmental Countywide QIC systematically and formally exchanges quality improvement information, data, and performance updates on QI goals and performance improvement projects. The Departmental QI Program also engages

and supports the SA QICs in QI processes related to the Work Plan, specific PIPs, and other QI projects at the SA level. In turn, SA QICs provide a structured forum for the identification of QI opportunities and action designed specifically to address the challenges and barriers encountered at the SA level and that may exist as a priority in a SA. SA QICs also engage and support Organizational QICs that are focused on their internal Organizational QI Program and activities. The Organizational QICs also monitor internally to ensure performance standards are met for: accessibility, consumer/family satisfaction, clinical care, coordination of care, complaints and grievances and other QI matters as needed.

Section 2: LOS ANGELES COUNTY DEMOGRAPHICS

Los Angeles County Demographics

Los Angeles County is the most populous County in the United States. According to a 2006 estimated census, 10,332,412 people reside in the County. Of these, 25% are children between the ages of 0 and 15; transitional age youth 16-25 represent 14%; 48% are adults between the ages of 26 and 59; and 14% are over 60 years old. Due to the size of the County, the service delivery system utilizes 8 geographic Service Areas as shown in the map below.



Ethnicity Distribution By Service Area

The population of each Service Area varies in number and in sub-groups. Table 1 shows the county population ethnicity distribution by Service Area. The population in Los Angeles is one of the most diverse in the nation. Latinos comprise 47% of the population; Whites 30%; Asians/Pacific Islanders 13%; African Americans 9.1%; Native American and Native Alaskans .2%. In addition to English, the threshold languages for Los Angeles County include: Arabic, Korean, Armenian, Mandarin, Farsi, Cantonese, Russian, Vietnamese, Cambodian, Spanish, Tagalog, and Other Chinese.

Table 1: Population Ethnicity Distribution by Service Area

	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Total	Per Cent
White	173,193	1,017,586	471,206	263,544	403,904	24,318	246,856	508,198	3,108,805	30%
African American	48,598	74,940	84,810	70,763	41,613	338,672	36,671	246,902	942,969	9%
Native American	2,425	6,640	5,036	3,916	1,488	1,751	4,122	5,341	30,719	0.2%
Asian	12,350	225,339	457,494	208,995	80,017	15,039	117,880	230,177	1,347,291	13%
Latino	120,929	832,125	854,846	713,801	112,675	662,473	971,362	607,078	4,875,289	47%
Pacific Islander	829	2,393	1,821	1,010	1,001	2,648	2,821	14,816	27,339	0.2%
Total	358,324	2,159,023	1,875,213	1,262,029	640,698	1,044,901	1,379,712	1,612,512	10,332,412	100%

LAC-DMH Population Served

During 2008, LAC-DMH served approximately 220,000 consumers with Severe and Persistent Mental Illness (SPMI) including Severely Emotionally Disturbed (SED) children and adolescents. LAC-DMH provides a full range of outpatient, inpatient, and day-treatment services. In addition to community-based therapeutic and supportive services, the Department and its partners deliver medication, medication support, targeted case management, crisis services, and numerous other mental health care services.

Mental Health Services Delivery System

Along with the more than 50 directly operated program sites throughout the County, LAC-DMH also, contracts with over 1,100 community providers, including non-governmental agencies and individual practitioners. The growth and development of the LAC-DMH Community Services and Support Plan (CSS) is monitored through ongoing updates and evaluations of the different components of the CSS plan. In essence each program and initiative within the LAC-DMH mental health service delivery system and related CSS plans have in their design evaluative and quality management components. Table 2 below summarizes the LAC-DMH public mental health service system.

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Table 2: Summary of LAC-DMH Public Mental Health Service System

Type of Facility or Program	Number
Clinical Facilities	
Community Mental Health Centers (CMHCs)	450
Contracted fee-for-service Medi-Cal network practitioners	586
Fee-for-service Medi-Cal group providers	25
Fee-for-service Medi-Cal organizational providers	4
Psychiatric Inpatient Hospitals	95
Client Run/Wellness Centers	31
Retail Pharmacies	105
Inpatient Facilities	
State Hospitals	4
County hospitals with Inpatient Psychiatric Units	4
Contracted Medi-Cal Hospitals	44
Short-Doyle Medi-Cal free-standing hospitals	2
Psychiatric Health Facility (PHF)	1
Mental Health Rehabilitation Center	1
Child-adolescent sub-acute Skilled Nursing Facility	1
Geriatric sub-acute Skilled Nursing Facilities	1
General sub-acute Skilled Nursing Facilities (other)	2
IMDs with special programs	7
Residential Facilities	
Crisis residential with homeless beds	3
Transitional residential with homeless beds	5
Long-term residential	3
Semi-independent living	2
RCL Group Home beds **	2,357
Community Treatment Facility (CTF) beds **	61
Law Enforcement Facilities	
County-operated custody facilities	7
City-operated custody facilities	1
Juvenile Probation Camp locations	19
Juvenile Halls	3

** equals # of beds

Section 3: LAC-DMH SERVICE ARRAY

SERVICE DELIVERY CAPACITY

Strategic Initiatives

LAC-DMH fulfills the need of Service Delivery Capacity through the *Strategic Initiatives* for CY2008. DMH remains consistent with MHSA intent and funding by bringing forth Strategic Initiatives that expand and enhance the service delivery capacity. The existing Strategic Initiatives include:

1. Psychiatric Urgent Care Centers and linkage to hospital beds.
2. Increase enrollment of Latinos and Asians into FSP programs.
3. Field Capable Older Adult Services.
4. Client Run / Wellness Centers.
5. Project 50 and Skid Row Programs.
6. Enhanced Specialized Foster Care.
7. Co-Occurring Disorder (COD) Training Projects including Evidence Based Practices for COD.
8. Workforce Education and Training (WET)
9. Prevention and Early Intervention Plan (PEI)
10. STATS

Below are summaries of these Strategic Initiatives.

Psychiatric Urgent Care Centers (UCC)

Urgent Care Centers reduce unnecessary and lengthy involuntary inpatient treatment, as well as promote care in voluntary treatment settings that are recovery-oriented. The centers provide 23 hours of immediate care and linkage to hospitals, community-based solutions and crisis intervention services, including integrated services for co-occurring substance abuse disorders. LAC-DMH implemented two directly operated UCCs and two contracted UCCs during this reporting period. These include Augustus F. Hawkins UCC; Olive View Urgent Community Services Program (UCSP), Westside UCC, and Los Angeles County + University of Southern California Medical Center (LAC+USC) UCC.

To date the UCCs have served approximately 77% (8,285) of the targeted number of clients to be served in 2008 (10,800). During December 2008 the number of persons served may potentially increase.

Latino and Asian Increased Enrollment in Field Service Partnerships

This initiative focuses on the enhancement of culturally competent outreach and engagement strategies to increase access for Latino and Asian families with mental illness into the FSP programs.

The Planning Division's Cultural Competency Unit is responsible for completing the Departments Cultural Competency Plan and is committed to providing the

technical assistance, education, and the training necessary to integrate cultural competency in all Departmental operations. The Cultural Competency Unit maintains representation in the LAC-DMH Quality Improvement Council and works collaboratively with the membership to address disparities, especially at the service area level.

In 2008 the Unit re-administered the Organizational Assessment Tool that was originally administered in 2003 and again in 2005. The tool assesses changes in the capability of the system of providers to address the cultural and linguistic requirements of its diverse populations. It will produce specific recommendations for action based upon survey findings and comparison with the previous 2003 and 2005 assessments.

In 2008 the LAC-DMH sponsored and co-sponsors several ethnic conferences:

- 6th Annual African-American Conference, February 28th
- 10th Annual Multicultural Conference, May 15th
- 14th Annual Latino Behavioral Health Institute Conference, September 16-18th
- 14th Annual Asian American mental Health Training Conference, October 17th

In addition, the Department maintains the Multi-Linguistic Service Directory by Service Area and provider.

Field Capable Clinical Services (FCCS)

The Field Capable Clinical Services, also known as (FCCS), are the first system-wide DMH programs focused exclusively on Older Adults and designed to improve access to needed mental health services for this traditionally underserved population. Older Adult FSPs are comprehensive, intensive services for persons 60 and above who have been diagnosed with a mental illness and are interested in participating in a program designed to address their emotional, physical and living situation needs. FSP Programs are capable of providing an array of services beyond the scope of traditional outpatient services.

Wellness Centers and Client-Run Centers

The CSS Plan is committed to the development of client operated and managed Wellness Centers. This element of the CSS Plan speaks to LAC-DMH vision of "Partnering with clients, families and communities to create hope, wellness, and recovery". Wellness/Client-Run Centers provide opportunities for consumers to develop noninstitutional support mechanisms, reduce stigma, and decrease reliance on mental health and other related systems as they strengthen their self-reliance. Wellness/Client-Run Centers offer a variety of self-help, education and social/recreational activities. There are 14 directly operated Client Run and Wellness Centers and 17 contracted Centers to date. Wellness/Client-Run Centers served approximately 3,575 clients which exceeded the estimated 2,400

anticipated clients to be served. Currently, planning and implementation of 8 additional contracted Centers is underway.

Project 50 and Skid Row Programs

Outreach and Engagement Services to Homeless Persons: The Emergency Outreach Bureau (EOB), Homeless Outreach and Mobile Engagement Team (HOME) provide Countywide outreach and emergency services to the homeless population in Los Angeles County.

Crisis Resolution Services at the Downtown Mental Health Center provides crisis intervention and stabilization for new Skid Row consumers for up to 60 days. As of March 2008, 397 consumers had been served provided linkage to housing to 90% of homeless consumers on the day of intake, engaged 80% of all consumers with COD to consider or enroll in treatment, and reduced the average wait time to see a psychiatrist from 20 days to 5 days.

Project 50, a County demonstration project that began in December 2007, will transition 50 of the most medically vulnerable chronically homeless persons from Skid Row to permanent supportive housing. The Project provides housing with integrated supportive services on-site, including medical and mental health services, substance abuse treatment, and benefits establishment for Project participants. As of October 2008, the Project is providing housing and services to 43 individuals including those with co-occurring mental health and substance abuse disorders.

The CalWORKs Homeless Families Project and Skid Row Assessment Team, a multi-agency collaborative to address the needs of homeless families in the downtown area, expanded services in the past year and served over 100 families. Beyond Shelter was contracted to provide transitional and permanent housing, and case management services.

Enhanced Specialized Foster Care

The Los Angeles County Departments of Children and Family Services (DCFS) and Mental Health (DMH) developed a Strategic Plan to provide a single comprehensive vision for the delivery of mental health services to children under the supervision and care of Child Welfare, as well as for those at-risk of entering the Child Welfare system.

The Strategic Plan is a detailed road map for the implementation/delivery of mental health services Countywide, in fulfillment of the objectives identified in the Katie A. Settlement Agreement. The Strategic Plan includes reference to several systems-level enhancements, which are broad in scope and speak to the larger systems reform efforts that are underway countywide in both Departments.

A set of organizing principles centered around cultural competencies, implementing a strengths/child needs-based team approach to planning/service

delivery, integrated screening/assessment/service delivery processes, timeliness of response, etc. are informing the service delivery model for the provision of mental health services.

Co-Occurring Disorders

DMH continues its goals to further integrated recovery based Co-occurring Mental Health and Substance Services throughout our system of care. One of many goals DMH has set this fiscal year for COD integrated services is to incorporate the use of a Clinical COD Services Review Process into the provision of COD Services within our directly operated adult clinics and programs. To this end the Department's Nine Point COD Module's screening, assessment, and treatment forms have undergone updating and revision. In association with UCLA's Integrated Substance Abuse Program (ISAP), the Department currently is training directly operated clinic staff to ensure their core competencies in COD treatment provision through the effective use of these revised clinical tools, evidenced based interventions, and recovery based treatment approaches. The effectiveness of the current trainings and tools will be reflected in the Clinical COD Services Review Process.

Workforce Education and Training Plan

In August 2008, the Workforce Education and Training (WET) ten year plan was completed and approved by the Stakeholders. The Plan strongly utilizes recent stakeholder input and builds upon the initial community planning processes which began in 2005. There are 22 action plans and all funding categories include at least one action plan. Each action in the Plan addresses one or more of the gaps identified in the Workforce Needs Assessment including expanding a culturally and linguistically competent workforce. The overarching goal of this plan will be to further MHSA essential elements throughout the workforce and to expand capacity to implement all other components of MHSA.

LAC-DMH continues to increase its service delivery capacity with the implementation of more programs during 2008 in addition to the *Strategic Initiatives*. Below is a description of programs that have been developed and implemented to meet community needs.

Prevention and Early Intervention Plan

The LAC-DMH PEI Plan is poised to embody the five key community mental health needs and six priority population of the California Department of Mental Health PEI Guidelines. Priority Populations include: 1. Underserved cultural populations. 2. Individuals experiencing onset of serious psychiatric illness. 3. Children/youth in stressed families, 4. Trauma-exposed individuals, 5. Children/youth at risk for school failure and 6. Children and youth at risk of juvenile justice involvement.

STATS

The STATS Performance Outcome measures were initiated in 2007 and remain in effect. The three initial indicators are: Percent of Direct Services Provided, Timeliness of Claims Processing, and Benefits Establishment for consumers. The percent of Direct Services Provided Target is 65%. Interventions for sustained improvement have included, as examples, use of a model for staffing patterns (HR) and managing facilities renovations/readiness. The claims lag target is for percent of claims entered within 14 days of service delivery. Interventions for sustained improvement have included, as examples, use of careful monitoring of Medi-cal approval levels, filling vacant positions, and analyzing methods used to achieve successful claims lag targets such as careful completion of billing forms for cost center and other identifying information. The Benefits Establishment for consumers target has included improving staff knowledge for benefits establishment and analysis of unfunded consumers to determine process flow of benefits establishment charts.

Innovative Programs for 2008/2009

Countywide Housing, Employment and Education Resource Development (CHEERD)

CHEERD provides administrative oversight, management and technical support for:

- Housing Development which includes adult housing components of the Mental Health Services Act (MHSA) CSS Plan.
- Employment and Education Services (includes DMH's Cooperative Agreement with Dept. of Rehabilitation and employment website for consumers).
- Federal Housing Subsidies Program (Section 8 Housing Choice Vouchers and Shelter Plus Care grants).
- Rental Assistance/Eviction Prevention Programs; and, Specialized Shelter Bed Programs.

Training and advocacy is also provided through CHEERD, as well as development of new housing, employment and education resources for the mental health system and the community. In 2008, there were 682 consumers housed through DMH housing contracts. Most recently, the Federal Housing Subsidies Unit (FHSU), which is under CHEERD, submitted proposals in response to five RFP's issued by the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA), for 575 additional Homeless Section 8 vouchers and Shelter Plus Care certificates. The estimated number of clients to be serviced by TAY and Adult Housing Specialists is over 4,000.

Working Well Together-Technical Assistance Center (WWT TAC)
LAC-DMH has launched Working Well Together: The California Client and Family Employment Technical Assistance Center (WWT TAC). The training and technical assistance center is a statewide initiative funded by the MHSA through a grant with State department of Mental Health (DMH). Communities that are implementing the MHSA envision a multicultural, recovery and resilience oriented public mental health system that can improve clients' outcomes. A key contributor to an effective system that improves the outcomes of those it serves is the employment of multicultural clients, family members & parent/caregivers.

The key responsibility of the WWT TAC is to ensure the existing public mental health workforce is prepared to recruit, hire, and retain multicultural clients and family members as employees. WWT TAC is being developed and operated by a newly formed collaborative consisting of the California Network of Mental Health Clients (CNMHC), National Alliance on Mental Health (NAMI), United advocates for Children and Families (UACF), and the California Institute of Mental Health (CiMH). The contract between WWT and DMH was signed on June 30, 2008.

Adult Jail Transition and Linkage Services
The Adult Jail Linkage Program is fully operational and has received approximately 900 referrals during 2008 from various sources including the Jail Mental Health Services staff, Public Defenders, the Department of Mental Health Court Program and family members. The Jail Linkage team works in close collaboration with the Jail Mental Health Services team to complete thorough client assessments and to develop comprehensive discharge plans. The Jail Linkage staff is also working extensively with the FSP providers to provide consultations and support, and to ensure the client's release from the jail is well coordinated.

Evidence-Based Practices (EBP's) Implementation
The Intensive In-Home Mental Health Service Program (IIMHSP) was developed by the LAC-DM and DCFS to provide comprehensive therapy to children and youth in the child welfare systems.

The types of therapies that are available through the Intensive In-Home Mental Health Services Program are evidence-based. EBPs are interventions and treatment approaches proven effective through a rigorous scientific process. They provide the ability to evaluate practices to ensure they meet the Federal and State targets for the outcomes of safety, permanency and child/family well-being. The EBPs selected for the IIHMHSP are Comprehensive Children's Services Program (CCSP), (Incredible Years, Trauma Focused Cognitive Behavioral Therapy, and Functional Family Therapy), Multisystemic Therapy and Multidimensional Treatment Foster Care. The providers are using OMA as well as outcome measures for each model.

Assertive Community Treatment (ACT) is an Adult EBP used by the LAC-DMH. It is a team-based approach to the provision of treatment, rehabilitation, and support

services. LAC-DMH EBPs are reported in the State Client and Services Information Database also submitted to SAMSHA/CMHS.

Incubation Training Academy
In 2008, LAC-DMH initiated a program to "incubate" new providers. The Department has identified three potential groups of nonprofit agencies that could benefit from this program: 1) nonprofit agencies that could offer mental health services under MHSA but who have failed to meet the minimum requirements for contracting with the Department; 2) nonprofit organization that do not currently offer traditional mental health services but have an expressed interest in doing so; and 3) nonprofit organizations that are interested in offering nontraditional service, such as prevention, outreach, and stigma reduction. CY 2008 was devoted to planning and designing the curriculum as well as organizing expert presenters and working on the necessary logistics of rolling out this new training program for the development of potential new providers and capacity building.

SERVICE ACCESSIBILTIY

Community Outreach
Community outreach has from the outset been an endeavor of LAC-DMH. There are many of those that are Medi-Cal eligible and otherwise in need of services that do not have access either due to location or cultural barriers. LAC-DMH funds and staffs outreach efforts through the Community Services and Supports Plan of the MHSA to address disparities in accessibility to services and capacity building.

LAC-DMH directly-operated programs and many contract providers deliver community outreach services, education, information, community organization and community client engagement. The Department also operates programs specifically devoted to Outreach and Engagement (O&E), including the Planning Division O&E units. The main objective of O&E initiatives is to effectively carry out transformation by increasing MHSA awareness and services to unserved, underserved, and Under-Represented Ethnic Populations (UREP), across all eight service areas. The planning Division maintains O&E data and reports regularly on related goals and outcomes.

The System Leadership Team (SLT) introduced "Strategies for Increasing FSP Authorizations for Unserved Ethnic Populations" in September 2008. The focus of this initiative is to address the challenges and barriers to FSP authorization for the Latino and Asian/Pacific Islander populations. Strategies include: .1 Service Area Impact Units and Navigator Teams provide presentations and educational material to CBOs; 2. Collaboration with FSP providers; 3. Cultural Competent Outreach and Engagement Efforts and distribution of informational materials.

Access for Consumers
In keeping in step with the ongoing population growth and diversification LAC-DMH and its community partners focus on access for persons with language-specific

needs and location-specific needs. This is accomplished by requiring service provider agencies to locate service sites in proximity to the target population. Also, for those persons requiring needs that cannot be met in their immediate area, DMH staff utilizes web-based searches to assist the person in locating a service provider specific to their needs including interpreter service. The Quality Improvement Council has worked to assist in improving interpreter services and identifying Service Area prevalence, penetration and retention data. This is discussed in more detail in the Evaluation Section of this report.

The Empowerment and Advocacy Division

The goal of the Empowerment and Advocacy Division is to develop, promote and sustain recovery-based practices and policies to achieve its vision to enhance advocacy, support system change, expand peer support and foster consumer and family empowerment. This goal is realized through: programming, policy and systems transformation, empowerment, education and training, eliminating stigma and discrimination, outreach and engagement of under serviced /underrepresented communities. This newly formed Division is uniquely positioned in the LAC-DMH, and the Division Chief reports directly to the LAC-DMH Director. The Division is staffed primarily by consumers who are integrated vertically and horizontally throughout the organization to ensure consumer input into the planning, designing, implementing and evaluating of services. EAD is represented on the Quality Improvement Council and collaborates on improving consumer representation on Service Area Advisory Committees (SAAC) and Organizational QICs.

BENEFICIARY SATISFACTION

Patients Rights Performance Improvement Project (PIP)

LAC-DMH Patient's Rights Office has the responsibility for monitoring the Requests for Change of Provider for the MHP. The LAC-DMH Quality Improvement Division is working with the Patient's Rights Office to implement this PIP.

The Patient's Rights Office is also collaborating with the LAC-DMH Empowerment and Advocacy Division to use consumer Focus Groups to improve the Request for a Change of Provider Form. The Quality Improvement Program continues to coordinate and collaborate efforts with Patient's Rights Office, the Service Area District Chiefs, and Outpatient Service Providers Clinics (both directly operated and contracted agencies), to improve participation in the Requests for Change of Provider Log submission and related processes and to effectively increase consumer satisfaction of culturally competent clinical care.

LAC-DMH responds effectively and in a timely manner to beneficiary grievances. The Office of Patients Rights manages grievances and reports to the Quality Improvement Council. Reports are submitted bi-annually for further analysis and policy recommendations. Consumer requests to change service providers are

monitored and action taken on a timely basis when warranted and as documented in the reports submitted to the State.

Performance Based Outcomes
This year LAC-DMH introduced the first integrated report for State Performance Outcomes and County Performance Outcomes in compliance with the mandated State Performance Outcomes System, the Federal Block Grant, and the County of Los Angeles Board of Supervisors instructions for all Departments to convert to performance standards and measures for performance outcomes to improve the quality and effectiveness of services. Calendar year 2008 is dedicated to baseline data collection for selected survey items for consumers/family perception of care.

Service delivery as experienced first hand by the consumer and families is a measurement of consumer satisfaction. To measure consumer and family satisfaction, twice annually a survey is conducted to gather data for the California Performance Outcomes. Effective in 2008 surveys were conducted in outpatient and field bases settings.

The Performance Based Contracting (PBC) initiative was implemented in January 2008. The initiative currently includes directly-operated and contracted service providers. It holds providers accountable for twelve (12) performance outcomes within three domains. The domains are: Access to Services, Client Satisfaction and Clinical Effectiveness. The Quality Improvement Program is responsible for completing survey and performance outcome activities including collection and analysis of data and preparation of the twice annual Performance Outcomes reports. The last report was issued in November of 2008 (See Attachment A).

CLINICAL CARE

EPSDT PIP
LAC-DMH is participating in the Statewide EPSDT PIP. Studies identified by the State Department of Mental Health suggest of other pediatric health care system highest-cost-of-service cohorts suggest that the cost and complexity of these EPSDT services could indicate a need for improved coordination, enhanced capacity, and other improvements to ensure that each client is receiving services that are appropriate, effective and efficient. The EPSDT PIP Goal is new in the QI Work Plan goals for 2009.

LAC-DMH in collaboration with EPSDT Service providers, is responsible for the identification and collection of relevant data such as clinical data derived from chart reviews, billing/reporting data, and treatment service factors. Continuing data exchange and reporting including the State Department of Mental Health and APS to inform, measure and continuously improve services to children and their families is essential to this process. (See Attachment E)

Program Integrity
The LAC-DMH Compliance Officer promotes ethical behavior within the LAC-DMH system of care and enforces its Code of Ethics and applicable law. The mission of the Compliance Program is to ensure compliance with applicable Federal, State, and County statutes, rules, regulations, policies and procedures; and to combat waste, fraud, and abuse. This mission is met through various training programs, audits, investigations and inspections; instructions and priorities identified by the Compliance Program Steering Committee, County Counsel and the Auditor-Controller. The Compliance Program Office has developed a mandatory ethics training program for all DMH employees which must be completed annually. Also, the Auditor-Controller has implemented the DMH Contract Compliance Training for contract providers. This training educates the provider about the criteria for common findings and expectations for billed services.

Best Practices/Parameters
As part of the Department's QI efforts, the Office of the Medical Director (OMD) has established a set of practice parameters that are developed, reviewed and/or updated through workgroups composed of multi-disciplinary academic experts and clinical leaders from within and outside the Department. The parameters address assessment, medication, psychotherapy, dual diagnosis, clinic environments, and other treatment and mental health support practices. They are available on the Department's website and are a focus of QI activities at clinician meetings and clinical risk management meetings;
(http://www.dmh.co.la.ca.us/directors/corner.htm).

In addition the OMD has developed a Peer Review system for physician mental health practices. To further enhance the quality control of medication practices LAC-DMH has instituted new revised Medication Support Services Forms (Reference: Clinical Records Bulletin 2008-04). (See Attachment B)

CONTINUITY OF CARE

The primary importance of continuity of care is to maintain a transparent service delivery system for consumers navigating through multiple service providers which occurs in many situations. This scenario requires collaboration and coordination amongst the providers. LAC-DMH is currently revising the Single Fixed Point of Responsibility (SFPR) policy to ensure proper collaboration of services and coordination of care. This is particularly important in the area of intensive programs, such as Children's System of Care and FSPs. This SFPR activity is being carefully tracked by the QI/QA Programs and in collaboration with responsible staff and providers, especially as related to the RC2 PIP.

RC2PIP
LAC-DMH is participating in the Statewide Re-Hospitalization Cohort 2 (RC2) PIP. The RC2 Roadmap to a PIP is a descriptive document that contains the relevant

components and data to develop this PIP. The QI Program submitted this document to the APS and to CIMH a the end of December 2008, for review and approval. The RC2 PIP Goal has been added to the Work Plan goals.

PROVIDER APPEALS

This is the last of the six areas and through this process DMH contracted providers have access to a two-tiered informal and formal review process for resolving authorization disputes. All disputes are assigned to a provider's relation specialist to track and coordinate resolution in an efficient and timely manner. The provider's relation specialist documents all disputes in a log and tracks and coordinates dispute resolution. The QI Work Plan Evaluation for CY 2008 contains specific information on the tracking and evaluation of this indicator.

Section 4: EVALUATION REPORT FOR CY 2008

Table 3. WORK PLAN GOALS FOR CY 2008

MONITORING SERVICE DELIVERY CAPACITY 1. *Utilize data to measure improvement in penetration and retention rates of populations with low penetration and retention rates.* 2. *Design effective services for identified underserved ethnic populations.* 3. *Initiate the "Next Steps" of the interpreter training outcomes developed as a result of the completed 2-year Latino Access Study (Cross-Cultural).*
MONITORING ACCESSIBILITY OF SERVICES 1. *Improve access to after-hours care to 75% of PMRT response time of one hour between PMRT acknowledgements of the call to PMRT arrival on the scene. (Source: Access Center)* 2. *Improve the rate of abandoned calls (responsiveness of the 24-hour toll free number) to an overall annual rate of 10% (Source: Access Center)* 3. *Improve the rate of clients able to receive services at convenient times and locations [Source: Performance Outcomes Measures].*
MONITORING BENEFICIARY SATISFACTION 1. *Increase the total number of surveys submitted by 1.5% from the November 2007 survey period to the May 2008 survey period. Implement a pilot project for the participation of peers/volunteers in assisting with Performance Outcome Survey completion in Wellness Centers and Community sites through the use of computers and staff assistance.* 2. *Increase to 80% or more of responding clients reporting that staff were sensitive to the client's cultural/ethnic background [Source: Performance Outcomes Measures].* 3. *Monitor and ensure that satisfaction rates in the biannual 2008 survey periods are about the same level as the previous survey periods.* 4. *90% or more of survey respondents agree that written materials are available in their preferred language.* 5. *Analyze the State's Performance Outcome Survey findings to identify areas for improvement for Service Area QICs for use in quality improvement activities.* 6. *Continue to respond to beneficiary grievances and fair hearings and to report the results bi-annually for policy recommendations.* 7. *Continue to monitor and improve the response rate of providers reporting Beneficiary Change of Provider Requests. Monitor and report on the reasons given by consumers for their request to change service provider.*
MONITORING CLINICAL GOALS 1. *Improve protocols for reviewing medication practices.*
MONITORING CONTINUITY OF CARE *Utilize baseline data collection for Performance Based Outcomes Measurement to monitor continuity of care in 2 areas:* • *Clients receiving continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital.* • *Clients seen and receiving timely on-going care within 30 calendar days time of discharge from mental health residential treatment program/institutional setting (excluding an acute psychiatric hospital).*
MONITORING OF PROVIDER APPEALS 1. *Evaluate trends in the informal and formal two-tiered review for any authorization disputes submitted to LMHP for a three year period.*

I. MONITORING SERVICE DELIVERY CAPACITY – EVALUATION OF GOALS FOR 2008

1. Utilize data to measure improvement in penetration and retention rates of ethnic populations with low penetration and retention rates.

EVALUATION

LAC-DMH achieved this goal.

LAC-DMH calculated penetration rates for Serious Mental Illness (SMI) and Serious Emotional Disorder (SED) SED based on estimated rates of prevalence among the total County population. Penetration Rates were also calculated based on estimated prevalence of SMI and SED living at or below 200% Federal Poverty Threshold. These rates were calculated for FY 06-07 and FY 07-08.

Table 4 shows that between FY 06-07 and FY 07-08 the greatest increase in penetration rates was among Latinos by 2.1%. Asians and Pacific Islanders had a very slight increase in penetration rates by approximately .02%. Penetration and retention rates have been lower than expected for Latinos and Asian/Pacific Islanders, in the past.

Table 4: Percent Change in Penetration Rates from FY 06-07 to FY 07-08

Ethnicity	Penetration Rates		Percent Change
	FY 06-07	FY 07-08	
White	16.6%	17.4%	+ .08%
African American	61.8%	62.1%	+ .03%
Latino	18.9%	21.0%	+ 2.10%
American Indian	45.7%	30.4%	-15.30%
Asian/Pacific Islander	7.2%	7.4%	+ .02%
Countywide	20.9%	23.2%	+ 2.30%

Note: Penetration Rate = Number of consumers served/Estimated prevalence of SMI and SED among total County population.

In FY 06-07 the penetration rate for Latino and Asian populations was 18.9% and 7.2% respectively. Among the population living at or below 200% poverty level, penetration rate for Latinos was 39.5% and 23.6% for Asian and Pacific Islanders.

Tables 5 and 6 show that in FY 07-08 the penetration rate for Latino and Asian populations was 21% and 7.4% respectively. Among the population living at or below 200% poverty level, penetration rates for Latinos was 41.1% and 27.6% among Asian and Pacific Islanders.

Table 5: Penetration Rates for Serious Mental Illness (SMI) and Serious Emotional Disorder (SED) By Ethnicity – FY 07/08

Ethnicity	Numbers Served	Total Population Estimated with SMI and SED	Penetration Rates Among Population Estimated with SMI and SED	Estimated Prevalence of SMI & SED Among Population Living At or Below 200% FPT	Penetration Rate Among Population Living at or Below 200% FPT
White	34,196	196,476	17.4%	42,022	81.4%
African-American	42,032	67,705	62.1%	27,580	152.4%
Latino	78,559	373,447	21.0%	191,083	41.1%
American Indian	615	2,024	30.4%	720	85.4%
Asian/pacific Islander	7,115	96,224	7.4%	25,825	27.6%
Total	162,517	700,538	23.2%	290,727	55.9%

Note: Numbers Served represent consumers served by LAC-DMH in Short Doyle/Medi-Cal Facilities only. The count does not include consumers served in Fee-For Service Outpatient facilities, institutional facilities such as jails and probation camps as well as Inpatient facilities including Fee-For-Service Inpatient Hospitals.

Table 6: Penetration Rates for Serious Mental Illness (SMI) and Serious Emotional Disorder (SED) By Ethnicity– FY 06/07

Ethnicity	Numbers Served	Total Population Estimated with SMI and SED	Penetration Rates Among Population Estimated with SMI and SED	Estimated Prevalence of SMI & SED Among Population Living At or Below 200% FPT	Penetration Rate Among Population Living at or Below 200% FPT
White	32,414	195,365	16.6%	36,903	87.8%
African-American	41,445	67,063	61.8%	27,650	149.9%
Latino	70,630	372,931	18.9%	178,775	39.5%
American Indian	934	2,046	45.7%	576	162.2%
Asian/pacific Islander	6,302	87,320	7.2%	26,754	23.6%
Total	151,725	724,725	20.9%	270,658	56.1%

Note: Numbers Served represent consumers served by LAC-DMH in Short Doyle/Medi-Cal Facilities only. The count does not include consumers served in Fee-For Service Outpatient facilities, institutional facilities such as jails and probation camps as well as Inpatient facilities including Fee-For-Service Inpatient Hospitals.

Table 7: Retention Rates- Percent Change in Number of Approved Outpatient Services (Retention Rates) from FY 06-07 to FY 07-08

Number Approved Outpatient Services	Fiscal Year 06-07		Fiscal Year 07-08		Percent Change
	Number	Percent	Number	Percent	
1	18,395	12.77%	16,602	10.99%	-1.78%
2	8,983	6.23%	8,447	5.59%	-0.64%
3	6,995	4.85%	6,949	4.60%	-0.25%
4	6,356	4.41%	6,429	4.26%	-0.15%
5-15	44,079	30.59%	46,604	30.86%	+.27%
16+	59,291	41.15%	65,973	43.69%	+ 2.54%
Total	144,099	100%	151,004	100%	

Tables 7 shows the percent change in number of approved outpatient services between FY 06-07 and FY 07-08. In FY 2007-08 there were 6,905 additional services rendered in outpatient facilities compared with the previous FY 2006-07. Consumers receiving one, two, three or four outpatient services declined and consumers receiving 5-15 or 16 or more services increased between the two years. Consumers that received 16 or more services increased by 2.54%, and consumers receiving between 5 and 15 services increased slightly by 0.27%.

Table 8: Retention Rates – Number of Approved Outpatient Services by Ethnicity – FY 07-08

Retention Rates – Number of Approved Outpatient Services by Ethnicity – FY 07-08														
Number of Services														
Ethnicity	1		2		3		4		5-15		16 or More		Totals	
	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent
White	3,457	20.82%	1,741	20.61%	1,469	21.14%	1,294	20.13%	9,800	21.03%	12,532	19.00%	30,293	20.06%
African American	4,260	25.66%	2,205	26.10%	1,835	26.41%	1,823	28.36%	11,829	25.38%	14,970	22.69%	36,922	24.45%
Latino	7,412	44.65%	3,821	45.23%	3,075	44.25%	2,754	42.84%	19,988	42.89%	32,013	48.52%	69,063	45.74%
American Indian	70	0.42%	38	0.45%	41	0.59%	39	0.61%	280	0.60%	407	0.62%	875	0.58%
Asian	506	3.05%	245	2.90%	219	3.15%	195	3.03%	1,990	4.27%	3,112	4.72%	6,267	4.15%
Other	897	5.40%	397	4.70%	310	4.46%	324	5.04%	2,717	5.83%	2,939	4.45%	7,584	5.02%
Total	16,602	100.00%	8,447	100.00%	6,949	100.00%	6,429	100.00%	46,604	100.00%	65,973	100.00%	151,004	100.00%

Table 8 shows that in FY 07-08, although penetration rates among Latinos and Asians are the lowest, these two ethnic groups show higher rates of retention compared with other ethnic groups. In FY 07-08 Latinos represent 44.6% and Asians represent 3.0% of the DMH population approved for one service. However, Latinos represent 48.5% and Asians represent 4.7% of the population approved for 16 or more services. See Table 8.

Table 9: Retention Rates – Number of Approved Outpatient Services by Ethnicity FY 06-07

Number of Approved Outpatient Services by Ethnicity – Fiscal Year 06-07														
	Number of Services													
Ethnicity	1		2		3		4		5-15		16 or More		Totals	
	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent	No of Consumers	Percent
White	4,030	21.91%	1,817	20.23%	1,519	21.72%	1,354	21.30%	9,466	21.48%	11,477	19.36%	29,663	20.59%
African American	4,743	25.78%	2,375	26.44%	1,962	28.05%	1,823	28.68%	11,379	25.82%	14,107	23.79%	36,389	25.25%
Latino	7,947	43.20%	3,989	44.41%	2,878	41.14%	2,545	40.04%	18,123	41.11%	27,728	46.77%	63,210	43.87%
American Indian	114	0.62%	60	0.67%	53	0.76%	35	0.55%	292	0.66%	370	0.62%	924	0.64%
Asian	558	3.03%	296	3.30%	195	2.79%	247	3.89%	2,015	4.57%	2,679	4.52%	5,990	4.16%
Other	1003	5.45%	446	4.96%	388	5.55%	352	5.54%	2,804	6.36%	2,930	4.94%	7,923	5.50%
Total	18,395	100.00%	8,983	100.00%	6,995	100.00%	6,356	100.00%	44,079	100.00%	59,291	100.00%	144,099	100.00%

Table 9 shows that in FY 06-07 Latinos represent 43.2% and Asians represent 3.0% of the DMH population approved for one service. However, Latinos represent 46.7% and Asians represent 4.5% of the population approved for 16 or more services.

2. Design effective services for identified underserved ethnic populations.

EVALUATION
LAC-DMH achieved this goal.

The Department's strategy is to address disparities in access and quality of care among the populations targeted in the CSS Plan through outreach and engagement to individuals and communities that traditionally have been unserved, underserved and/or inappropriately served in the existing mental health system. These communities include a sub-target known as Under-Represented Ethnic Populations (UREP). During this reporting period, UREP committees representing specific groups had convened to discuss principles and recommendations to DMH for MHSA services to address disparities in UREP populations. The UREP committees include the African/ African-American; American Indian; Asian Pacific Islander; Eastern-European / Middle-Eastern; and Latino populations. A number of strategies were developed and planning and implementation began during this reporting period. These strategies include:

1. The implementation of ascribed FSP slot allocations by UREP/ethnic targets, including African Americans, Asians, Latinos, Native Americans, and Whites based on specific Service Area demographics, and other indicators, including poverty, prevalence and penetration rates.

2. The development of specific UREP Workgroups to address appropriate outreach strategies to specific underrepresented ethnic groups.

3. The allocation of funding to UREP Workgroups to develop specialized projects to increase capacity for participation in MHSA planning and services.

   • Development of capacity building training and support program for non-traditional Asian Pacific Islander community based agencies.

   • Development of culturally competent MHSA outreach and engagement materials in Arabic, Armenian, Farsi, Russian, and African languages.

   • Enhancement of culturally competent outreach and engagement strategies to increase access for Latino individuals and families with mental illness via the training and integration of "Promotoras de Salud" into the FSP service teams.

   • Develop an MHSA website for the dispersed American Indian community

   • Update Multi Linguistic Services Directory for use as resource.

4. Complete Cultural Competency Organizational Assessment 2009.

Table 10 shows that according to the MHSA Implementation Report (August 15, 2007 update), slots allocated for consumers in all age groups identified as Asian and Latino were less than Sixty percent (62%) authorized.

To address under enrollment challenges LAC-DMH selected key individuals (e.g. FSP Program Managers, Outreach and Engagement Staff, MHSA Age Group Leads) to participate on an FSP Study Team. The FSP Study Team convened in early 2008 to identify the causes of under enrollment and make recommendations to resolve this challenge and increase authorizations.

Table 10 also shows that authorized slots for all ages as of December 31, 2007, as compared to authorized slots as of June 30, 2008, significantly increased for TAY, Adult and Older Adult programs. In addition, LAC-DMH in 2008 expanded slot allocations to ensure that adults and older adults with special needs were accommodated.

Table 10: Authorized FSP Slots by Age Group- CY 2007 and CY 2008

Age Group	*Slots as of Dec 31,2007*	*Auth as of Dec 31, 2007*	*% Auth as of Dec. 31, 2007*	*Slots as of June 30, 2008*	*Auth as of June 30,2008*	*% Auth as of June 30, 2008*
Child	*1,733*	*903*	*52%*	*1,733*	*1,677*	*97%*
TAY	*1,122*	*704*	*62%*	*1,112*	*976*	*87%*
Adult	*2,611*	*1,599*	*61%*	*2,611*	*2,368*	*91%*
Older Adult	*266*	*198*	*74%*	*289*	*225*	*78%*
Total	*5,732*	*3,404*	*59%*	*5,755*	*5,246*	*91%*

- **Initiate the "Next Steps" of the interpreter training outcomes developed as a result of the completed 2-year Latino Access Study.**

EVALUATION
LAC-DMH achieved this goal

The Cultural Competency Unit, in conjunction with the Training Division planned, designed and implemented curriculum for courses recommended as "Next Steps" of interpreter training outcomes. These Continuing Education Unit (6) trainings have been offered multiple dates within the 06/07 and 07/08 FY. These trainings are part of the on-going trainings offered by the LAC-DMH Training Decision.

They are as follows:
1. HOW TO USE INTERPRETER SERVICES: Lost in Translation?

The workshop is designed for clinicians and case managers to gain knowledge and skills in how to successfully use interpreter services in the therapeutic relationship.

2. HOW TO BE AN INTERPRETER: Encounters of the Three-Way-Kind

The workshop is designed for bilingual clerical and clinical staff who serve as interpreters in mental health settings. The training provides knowledge and skills in how to be an interpreter in the therapeutic triad. Culturally and linguistically appropriate services increase retention of clients in the service delivery system. In order to address the major barriers to retention, effective communication and management of the cultural dynamics between the provider, client and interpreter are addressed. Familiarity with variant beliefs concerning mental health in different cultures is covered. Similarly the Spanish WRAP trainings are provided to consumers and family members to support recovering and wellness in Spanish speaking recipients of care.

II. MONITORING ACCESSIBILITY OF SERVICES – EVALUATION OF GOALS FOR 2008

1. Improve access to after-hours care to 75% of PMRT response time of one hour between PMRT acknowledgement of the call to PMRT arrival on the scene.

EVALUATION

The goal was partially achieved.

The Department's ACCESS Center operates a 24-hour Statewide, toll-free number (1-800-854-7771) helping callers to access mental health services by linking them to resources close to either where they work or live. Center staff also provides after-hours emergency services and coordinates daytime emergency services. The staff assists callers including problem identification and referrals to appropriate resources. Triage operators speak a number of languages. For languages not available directly from Center operators, LAC-DMH contracts with the AT&T Language Line and provides telecommunications devices for the deaf (TDD). The ACCESS Center responds to approximately 285,000 calls annually.

ACCESS continues to strive to meet the DMH standard of a one-hour response time to a safe location for Psychiatric Mobile Response Teams (PMRT). The ACCESS Center logs for each call: the time the call is received, the time PMRT is contacted, as well as PMRT arrival and end times. ACCESS staff is able to incorporate a reporting component for managers that provides information related to duration of calls. This information is reported to the Quality Improvement Division and is tracked on a quarterly basis.

Table 11 shows that the annual average percent of after-hour calls responded to within one hour for January through December 2008 was 73% compared to the annual average percent of 74% in CY 2007. The slight drop from last year's rate and the slight disparity from the goal set for 75% appear to be attributed to the

lack of psychiatric inpatient bed availability. Nevertheless, there was definite improvement shown from 2005 and 2006 as compared with 2007 and 2008. PMRT secures inpatient psychiatric beds prior to responding to acute psychiatric crises in the field. Delay in PMRT response time has occurred due to the direct lack of psychiatric inpatient beds at hospitals such as Augustus Hawkins/MLK. These service needs are now met through services provided by the Psychiatric Urgent Care Centers (See page 11).

Table 11: PMRT After-Hour Response Rates of One Hour or Less

	2005	2006	2007	2008
January	69%	71%	76%	78%
February	74%	69%	71%	75%
March	73%	70%	72%	74%
April	74%	74%	74%	76%
May	73%	74%	75%	71%
June	74%	70%	75%	71%
July	74%	67%	72%	71%
August	70%	63%	75%	73%
September	71%	67%	73%	72%
October	70%	68%	71%	71%
November	66%	64%	77%	70%
December	68%	66%	73%	72%
Annual Average %	**71%**	**69%**	**74%**	**73%**

2. Improve the rate of abandoned calls (responsiveness of the 24-hour toll free number) to an overall annual rate of 10%.

EVALUATION

This goal was partially achieved.

The ACCESS 800 is available 24-hours a day, 7 days a week. All after-hours, as well as many daytime calls for (PMRT) services, are routed through this 800 number. Logs are kept for all calls that come through the ACCESS 800 number. Information recorded includes: dates, times, name of caller, type of request, referrals made for culturally appropriate services. Reports are prepared monthly. In addition, Test Calls or "Secret Shopper Calls" are to the ACCESS managers and the Departmental Quality Improvement Council. (See Attachment C)

During 2008, the ACCESS 800 number responded to 254,579 general calls. Table 12 shows that of the calls received, 3,983 or 1.6% were non-English requests for services. These languages include: Armenian, Cambodian,

Cantonese, Farsi, Hungarian, Italian, Japanese, Korean, Mandarin, Russian, Spanish, Tagalog, Thai, and Vietnamese.

Table 12: Language of Calls Received (Other Than English) CY 2008

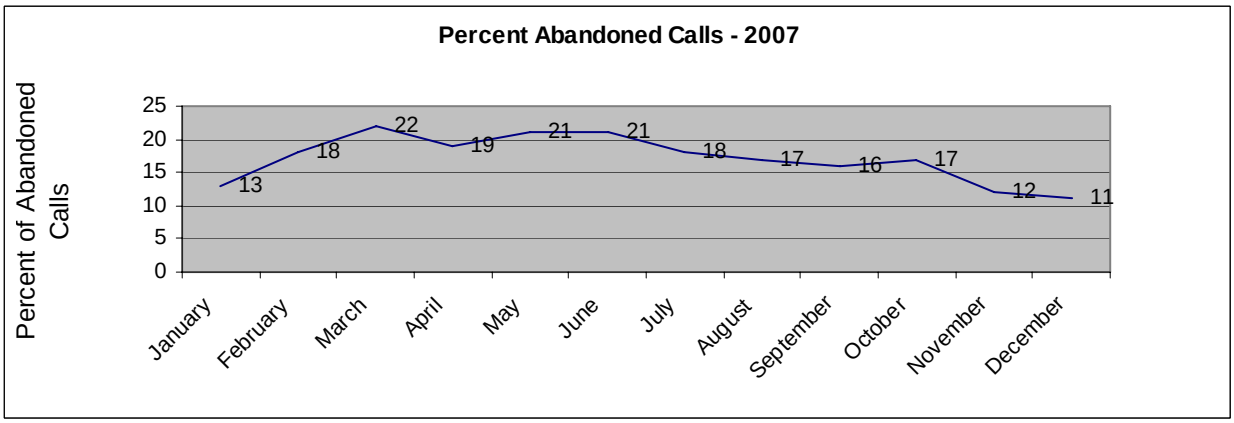
LANGUAGE	Jan 2008	Feb 2008	Mar 2008	Apr 2008	May 2008	June 2008	July 2008	Aug 2008	Sept 2008	Total
ARAB			1	1	2					4
ARMENIAN		**3**	**2**	**1**	**3**	**5**	**1**	**7**	**2**	**24**
CAMBODIAN		**2**	**1**			**1**				**4**
CANTONESE	**4**	**2**			**1**	**5**	**9**	**2**	**4**	**27**
FARSI	**2**			**2**	**1**	**1**		**2**	**3**	**11**
JAPANESE		**1**		**1**		**1**	**2**			**5**
KOREAN	**9**	**10**	**6**	**4**	**9**	**2**	**5**	**7**	**11**	**63**
LAOIAN					1					1
MANDARIN	**2**	**2**	**3**	**1**	**2**	**4**	**4**	**6**	**2**	**26**
POLISH							1	4		5
PORTUGUESE				1			1			2
ROMANIAN			1	2	1					4
RUSSIAN		**1**	**2**		**6**	**2**	**1**			**12**
SPANISH	**100**	**72**	**97**	**94**	**180**	**245**	**289**	**265**	**243**	**1585**
SPANISH ACCESS CTR*	**246**	**196**	**239**	**240**	**225**	**246**	**265**	**259**	**240**	**2156**
TAGALOG	**2**	**2**		**2**	**11**	**4**	**5**	**13**		**39**
THAI	**1**						**1**			**2**
URDU					1					1
VIETNAMESE	**1**	**3**	**3**	**3**	**1**		**1**			**12**
TOTAL	367	294	355	352	444	516	585	565	505	3,983

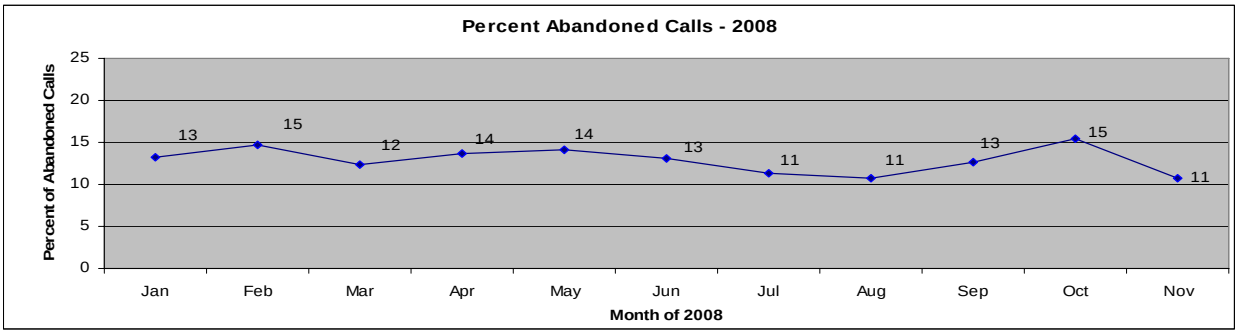
Note: The table shows data for non-English Calls received. Threshold languages for LAC-DMH is in bold. Data available through September 2008 excluding October to December.

Table 13 and graphs show that the average abandoned call rate from January through November 2008 was 13%. This shows a significant improvement from the annual average of 18% for the CY 2007. In anticipation of the telephone system upgrades for 2008, the goal set at 10% could not be fully met due to delays in implementing this upgrade. The Chief Executive Office (CEO) of Los Angeles County became aware of space issues related to the implementation of the telephone upgrade and the telephone upgrade has now been delayed tentatively to 2010. The Work Plan goals for 2009 are revised to reflect this delay and to target increased improvement for this goal. Secret Shopper calls will continue to occur in 2009.

Table 13: ABANDONED CALLS BY NUMBER AND PERCENT FOR CY 2007-2008

	2007			2008		
Month	Total Calls	Number Abandoned	Percent Abandoned	Total Calls	Number Abandoned	Percent Abandoned
January	25,553	3,444	13%	22,428	2,962	13%
February	23,753	4,327	18%	23,549	3,470	15%
March	27,084	6,027	22%	22,304	2,763	12%
April	24,959	4,826	19%	24,119	3,286	14%
May	25,836	5,532	21%	23,359	3,302	14%
June	23,393	4,934	21%	23,003	3,015	13%
July	23,094	4,232	18%	22,532	2,551	11%
August	23,097	3,829	17%	22,002	2,366	11%
September	21,334	3,514	16%	22,606	2,855	13%
October	27,242	4,740	17%	27,029	4,183	15%
November	21,818	2,688	12%	21,648	2,332	11%
December	17,793	1,940	11%			
Totals/Annual Average %	284,956	50,033	17 %	254,579	33,085	13%





Total calls received include all 800 number and direct number calls. Abandoned calls are included in the total calls received. *Effective January 1, 2006 the national Committee on Quality Assurance (NCQA) methodology and criteria are applied to measure the abandoned call rate for LAC-DMH. The *abandoned call rate* is determined by using the number of callers who hang up after 30 seconds divided by total calls.

3. Improve rate of clients able to receive services at convenient times and locations [Source: Performance Based Outcomes].

EVALUATION

This was not a goal in CY 2007. A year-to-year comparison cannot be made. Therefore, this is baseline data for CY 2008. Table 14 shows the percent totals for the May 2008 surveys in CY 2008 for the survey questions "Location of services was convenient " and "Services were available at times that were convenient." The May 2008 Survey results will be combined with the November CY 2008 results to establish the annual aggregate baseline for CY 2008 and for CY 2009 comparisons for Consumer and Family Perception of Convenient Time/ Location. The November CY 2008 findings will be available in March 2009. The QI Work Plan for CY 2009 establishes the new target goals.

Table 14: Percent Responses for "Services Received in Convenient Location/Time" By Age Group CY 2008 Baseline

May 2008				
	Survey Item #	Location by Percent	Survey Item #	Time by Percent
YSS-F	8	91%	9	92%
YSS	8	75%	9	76%
Adult	4	83%	7	88%
Older Adult	4	86%	7	91%
Average Percent		83.75%		86.75%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

III. MONITORING BENEFICIARY SATISFACTION –EVALUATION OF GOALS FOR 2008

1. Increase the total number of surveys submitted by 1.5% from the November 2007 survey period to the May 2008 survey period.

Implement a pilot project for the participation of peers/volunteers in assisting with Performance Outcome Survey completion in Wellness Centers and Community sites through the use of computers and staff assistance.

EVALUATION

DMH significantly exceeded this goal.

LAC-DMH participates in the California Performance Outcomes process to monitor beneficiary satisfaction in outpatient and field based settings. A total of 20,405 State Performance Outcome surveys were submitted by the agencies to the Department in May 2008. In CY 2008 LAC-DMH initiated Performance Outcomes which expanded survey distribution to field and school based settings.

This additional component increased the surveys submitted by 5,386 surveys for a total of 25,791. The November 2008 survey results are currently being completed and will be used to arrive at annual aggregate totals for CY 2008. Table 15 shows the total surveys submitted for CYs 2005, 2006 and 2007. Additionally, the surveys submitted for May CY 2008 for clinic and field-based services are shown. The November CY 2008 findings will be available in March CY 2009, and will be used to compute the annual aggregate totals for CY 2008.

Table 15: Consumer Surveys Submitted from CY 2005 to May 2008

Calendar Year	Adult	Older Adult	YSS	YSS-F	Totals
2005	15,988	1,119	6,104	9,443	32,654
2006	15,172	1,073	6,475	10,410	33,130
2007	13,117	988	6,327	9,572	30,004
May 2008					
Clinic	8,669	772	4,174	6,790	20,405
Field-Based	790	7	2,096	2,493	5,386
Total for May 2008	9,459	779	6,270	9,283	25,791

Note: November 2008 survey findings will be available in March 2009.

It should be noted that in order to increase the utility of the results of the surveys for individual provider use, the survey comment section is intended for providers to gather information from open ended comments on the last page of the survey forms during each survey period.

The pilot project goal was completed in November 2007 when additional "consumer kiosks" were added to selected sites in the County. This was determined to be an effective way to increase consumer participation and these consumer kiosks will continue to be utilized during survey periods. However, no new kiosks are anticipated in CY 2009.

2. Increase to 80% or more of responding clients reporting that staff were sensitive to their cultural/ethnic background [Source: Performance Outcomes, May 2008].

EVALUATION
This goal was exceeded.

Table 16 contains the results for the survey question, "Staff were sensitive to my cultural/ethnic background." The total survey response average for all surveys was 88% in May CY 2008. The November CY 2008 findings will be available in March 2009, and will be used to compute the annual aggregate totals for CY 2008 for comparison purposes.

Table 16: Percent Responses for "Staff Sensitive to Cultural and Ethnic Background."

Age Group	Survey Item #	Percent
YSS-F	15	95%
YSS	15	83%
Adult	18	85%
Older Adult	18	90%
Average Total		88%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

3. Monitor and ensure that overall satisfaction rates remain about the same.

EVALUATION
DMH achieved this goal.

Table 17 below contains the Average Mean Score for the Overall Satisfaction scale by the four age-groups. In CY 2005 to CY 2007, the Average Mean Score for all age-groups was between 4.2 and 4.3. In May CY 2008 the Average Mean Score was a bit lower at 4.1. However, this only reflects the Average Mean Score for one survey period, May CY 2008. The November CY 2008 survey findings will be available in March CY 2009 and will be used to compute the annual aggregate totals for CY 2008. Again it is important to note that the LAC-DMH is focusing on identifying accurate baseline data for CY 2008 and focusing on those data which indicate reliable and significant differences.

Table 17: Comparison of Overall Satisfaction Average Mean Scores by Survey Periods CY 2005, 2006, 2007, and May 2008.

Age Group	2005	2006	2007	2008 (May)
Adult	4.4	4.3	4.4	4.1
Older Adult	4.5	4.5	4.5	4.1
YSS	4.0	3.9	4.1	3.9
YSS-F	4.3	4.3	4.1	4.2
Average Mean	4.3	4.2	4.3	4.1

Source: County of Los Angeles, *State Performance Outcomes Survey Data*, May 2005 thru May 2008

4. 90% or more of survey respondents agree that written materials are available in their preferred language.

EVALUATION
DMH exceeded this goal.

The Department participated in the State mandated Performance Outcome survey in May 2008. Surveys were distributed in four languages – English, Chinese, Spanish, and Russian. Table 18 contains the results for the survey question "Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer?" The total survey response average percent was 97% in May 2008.

Table 18: Percent Responses for "Time DMH Provides Language-Appropriate Materials."

Survey Age Group	Survey Item #	Percent
Adult	13	96%
Older Adult	13	98%
YSS	23	95%
YSS-F	24	97%
Average Total		97%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

5. Analyze the State's Performance Outcome Survey findings to identify areas for improvement for Service Area QICs for use in quality improvement activities.

EVALUATION

LAC-DMH met this goal

The results of the State Performance Outcomes are widely distributed through the Service Area QICs. The Service Area selects data and information as relevant to their service delivery system. The data is reviewed and analyzed at Service Area meetings such as the QIC, SAAC and provider meeting.

Quality Improvement staff documents four types of findings of the State Surveys and sends them to appropriate LAC-DMH personnel for action.

1. A General Summary of the Countywide and Service Area findings sent to the Executive Management Team (EMT), District Chiefs, Program Heads, Departmental QIC, Local Service Area QICs, and Providers (both directly operated and contractors).
2. A Summary of results for individual provider and age group reports in each Service Area.
3. Summary and detail reports for District Chiefs to monitor provider compliance to survey participation expectations in their Service Area.

4. Results of individual survey items that can assist the Service Areas in developing Quality Improvement Projects.

QI staff conducts training meetings with SA Survey Liaisons, QIC members, and other survey participants to discuss problems in the survey implementation process, and brainstorm ways to improve the response rates during future survey periods. Service Areas may select specific quality improvement projects for their Service Area. Through Performance Outcome initiatives including statewide and countywide PIPs, data will be integrated by the QI Program staff for continuous quality improvement processes and activities.

6. Continue to respond to beneficiary grievances and fair hearings and to report the results bi-annually for policy recommendations.

EVALUATION

LAC-DMH achieved this goal.

The Department responds effectively and timely to consumer grievances and fair practice hearings. During 2008, consumers or family members requested 35 hearings. Table 19 shows the distribution of beneficiary grievances and fair hearings.

The LAC-DMH Patients' Rights Office (PRO) reporting to the state evidences the receipt of 711 beneficiary grievances in the categories of: Access, Termination of Services, Denial of Services, Request for Change of Provider, Quality of Care, Confidentiality and Other. LAC-DMH has received and resolved a total of 669 grievances/appeals/SFHs, including 42 cases that were referred out to the appropriate agency or jurisdiction, on a timely basis. The LAC-DMH identifies Beneficiary Change of Provider Requests for QI activities.

It is important to note that the category "Denial of Services" is per the "NOA-A" type. This type is determined by the provider, but not always at the time of the initial assessment. It may be determined at a later time during the period in which services are being provided.

The 500 "Quality of Care" events are a composite of sub-categories. The PRO maintains an internal report that lists the sub-categories and associated numbers. The report to the State has historically only included the total number for the "Quality of Care" category. The focus of the Request for Change of Provider is to obtain specific reasons attached to these requests, complaints, and/or grievances. Of the 15 grievances filed for Change of Provider Request, all 15 or 100% were satisfactorily resolved. The PRO office continues to focus on their PIP for improved services to consumers/families, especially for culturally competent services. Table 19 also shows that for all categories there are no remaining "Still Pending."

Table 19: Disposition of Beneficiary Grievances

CATEGORY	NUMBER BY CATEGORY	CATEGORIES					DISPOSITION		
		Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited State Fair Hearing	Referred Out	Resolved	Still Pending
ACCESS	10	8	2	0	0	0	0	10	0
Termination of Services	10	0	9	0	1	0	0	10	0
DENIED SERVICES (NOA-A Assessment)	18	0	11	0	7	0	0	18	0
CHANGE OF PROVIDER	15	15		0	0	0	0	15	0
QUALITY OF CARE:	500	480	7	0	13	0	17	483	0
CONFIDENTIALITY	30	30		0	0	0	6	24	0
OTHER:	128	114		0	14	0	19	109	0
TOTALS	*711*	*647*	*29*	*0*	*35*	*0*	*42*	*669*	*0*

Source: Date of Report/September 30, 2008, Prepared by: Mandy Viso -Department of Mental Health - Patient's Right's Office

7. Continue to monitor and improve the response rate of providers reporting Change of Provider Requests. Monitor and report on the reasons given by consumers for their request to change service provider.

EVALUATION

LAC-DMH achieved this goal.

The Patients' Rights Office (PRO) is responsible for collecting the Request to Change Provider Logs submitted by directly-operated and contract providers in LAC-DMH. The information is analyzed based on the Reporting Unit number listed by the provider.

During the second quarter of 2008, PRO received logs for 150 Reporting Units within Los Angeles County. The Total Reporting Units were: SA1= 6; SA2:= 29; SA3= 23; SA4= 16; SA5= 22; SA6= 8; SA7= 14; SA8= 31.

The total number of Change of Provider Requests submitted through November 2008 was 323. The requests were analyzed based on the categories and information that the Reporting Units provided. Additionally categories were developed to capture consumer needs in the following areas: *Culture; Time/Schedule; Service Concerns (treating family member, treatment concerns,*

medication concerns, lack of assistance); 2nd Opinion Request; Other; None Provider.

Of the logs received some contained multiple reasons for the request given by the consumer. The following is a breakdown of how the requests were categorized: None Provided=14; Culture=20; Time/Schedule=14; Service Concerns=15; Personal Experience/Perception=35; 2nd Opinion=3; Other=18.

Change of Provider Requests due to Personal Experience/Perception had the highest response rate with 29% and Culture at 17% had the second highest response rate. The percent of the remaining reasons are: Service Concerns= 12.6%; Time=11.7%; 2nd Opinion=2.5% Other=15.1%; Not Provided=11.7%
The PRO Roadmap to a PIP details the activities and interventions related to this project.

IV. MONITORING CLINICAL CARE – EVALUATION OF GOALS FOR 2008

1. Improve current protocols for reviewing medication practices.

EVALUATION
LAC-DMH achieved this goal.

This goal was addressed by reassessing and restructuring the documentation protocols and forms. Newly revised forms allow for an improved and uniform method of documenting Medication Support Services as described in Clinical Records Bulletin 2008-04 (Attachment B). The newly revised forms were created in order to clarify the documentation elements needed for medication support services to ensure reimbursement. Similarly, they support the appropriate usage of Procedure Codes. Furthermore, as the Department moves towards an Electronic Health Record (EHR), these forms will provide the basis to which prompts will be developed in the new EHR. The new and revised forms include:

- MH 657 – Initial Medication Support Service
- MH 653 – Complex Medication Support Service
- MH 655 – Brief Follow-up medications Support Service
- MH 654A – Medication Support Service Addendum
- MH 519 – Medication Log

In May CY 2008, the LAC-DMH initiated the tracking of survey responses from the YSS–F and the YSS. These new items introduced by the State are summarized below.

Tables 20 - 25 provide the results for the survey questions that address health care and/or medication management protocols. Each table represents a survey question and the percent response by service area and service delivery site.

Tables 20 and 23 show some disparity with families reporting that “In the last year, did you child see a medical doctor or nurse for a health check up sick?” at 66% for “seen at

a clinic" site as compared with the youth responding to the same question at 53%. This discrepancy may be related to families taking younger children to clinics than youth is taken to clinics or going to the clinics by themselves. Simultaneously, families responded to the same question at 6% for "seen at an Emergency Room," while youth responded to the same question at 10% for "seen at an Emergency Room." This appears to indicate that youth may be requiring more Emergency Room care with crisis conditions as compared with younger children. More data is needed concerning these findings.

Tables 21 and 24 show that there is some disparity between youth reporting that they are "on medication for behavioral/emotional problems" at 34% for "Yes" as compared with their family responding to the same question at a somewhat higher 38% for "Yes."

Tables 22 and 25 show that there is more of a disparity between youth reporting "did the doctor or nurse tell you of medication side effects to watch for" at 54% for "Yes" as compared with their families responding to the same question at a much higher 69% for "Yes." It is unclear if youth were not present when the families were provided with this information or if other variables are lending to this discrepancy. Further analyses needs to occur for these findings.

Table 20: YSS-F – Percent Responses for "In the last year, did your child see a medical doctor or nurse for a health check-up or because he/she was sick?"

Service Area	May 2008 Survey Period (N=6,050)				
	Clinic	Emergency Room	No	Don't Remember	Unknown
SA 1	70.3%	4.4%	19.2%	3.3%	2.9%
SA 2	64.6%	6.7%	18.1%	4.0%	6.5%
SA 3	66.1%	6.6%	18.1%	3.5%	5.6%
SA 4	64.4%	6.4%	17.3%	4.4%	7.4%
SA 5	65.6%	4.5%	21.9%	2.0%	6.1%
SA 6	66.3%	5.8%	18.9%	3.1%	5.9%
SA 7	67.0%	4.2%	21.5%	3.6%	3.6%
SA 8	67.5%	5.9%	19.0%	2.6%	5.1%
Percent within Service Area	66.3%	5.7%	19.0%	3.5%	5.5%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

Table 21: YSS-F- Percent Responses for "Is your child on medication for emotional / behavioral problems?"

Service Area	May 2008 Survey Period (N=6,050)		
	Yes	No	Unknown
SA 1	50.8%	44.8%	4.4%
SA 2	37.0%	54.3%	8.7%
SA 3	40.2%	50.9%	8.9%
SA 4	29.9%	58.1%	12.0%
SA 5	35.6%	55.1%	9.3%
SA 6	36.6%	51.8%	11.6%
SA 7	32.5%	60.8%	6.7%
SA 8	43.8%	48.9%	7.3%
All Service Areas	37.9%	53.4%	8.7%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

Table 22: YSS-F – Percent Responses for "Did the doctor or nurse tell you and/or your child about medication side effects to watch for?"

Service Area	May 2008 Survey Period (N=2,710)	
	Yes	No
SA 1	77.8%	22.2%
SA 2	69.8%	30.2%
SA 3	68.8%	31.2%
SA 4	52.8%	47.2%
SA 5	75.0%	25.0%
SA 6	65.3%	34.7%
SA 7	66.9%	33.1%
SA 8	78.0%	22.0%
All Service Areas	68.7%	31.3%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

* Smaller N represents the number of family members that answered "Yes" to the question "Is your child on medication for emotional / behavioral problems?"

Table 23: YSS – Percent Responses for "In the last year, did you see a medical doctor or nurse for a health check-up or because you were sick?"

Service Area	May 2008 Survey Period (N=3,780)				
	Clinic	Emergency Room	No	Don't Remember	Unknown
SA 1	53.0%	11.1%	16.6%	16.2%	3.2%
SA 2	48.4%	12.3%	14.9%	18.7%	5.7%
SA 3	60.0%	8.7%	13.9%	13.8%	3.6%
SA 4	54.4%	9.3%	16.9%	14.8%	4.4%
SA 5	51.7%	10.7%	13.5%	16.9%	7.3%
SA 6	55.5%	8.6%	13.4%	18.6%	3.9%
SA 7	53.1%	8.4%	18.8%	15.5%	4.1%
SA 8	50.7%	12.1%	15.4%	16.4%	5.5%
Percent within Service Area	53.3%	10.3%	15.3%	16.4%	4.7%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

Table 24: YSS – Percent Responses for "Are you on medication for emotional behavioral problems?"

Service Area	May 2008 Survey Period (N=3,780)		
	Yes	No	Unknown
SA 1	41.2%	48.7%	10.1%
SA 2	35.6%	43.0%	21.4%
SA 3	41.2%	48.4%	10.4%
SA 4	26.0%	63.4%	10.6%
SA 5	41.7%	44.3%	14.1%
SA 6	30.9%	58.1%	11.0%
SA 7	26.8%	57.2%	15.9%
SA 8	33.4%	51.0%	15.6%
All Service Areas	34.2%	51.1%	14.6%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

Table 25: YSS – Percent Responses for "Did the doctor or nurse tell you of medication side effects to watch for?"

Service Area	May 2008 Survey Period (N=1,919)	
	Yes	No
SA 1	57.4%	42.6%
SA 2	69.6%	30.4%
SA 3	50.7%	49.3%
SA 4	46.6%	53.4%
SA 5	59.2%	40.8%
SA 6	49.1%	50.9%
SA 7	54.4%	45.6%
SA 8	58.1%	41.9%
All Service Areas	53.9%	46.1%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, May 2008

* Smaller N represents the number of youth that answered "Yes" to the question "Are you on medication for emotional / behavioral problems?"

V. MONITORING CONTINUITY OF CARE

Utilize baseline data collection for Performance Outcomes to monitor continuity of care and timeliness of services in 2 areas:

1. Clients receiving continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital.

2. Clients seen and receiving timely on-going care within 30 calendar days time of discharge from mental health residential treatment program/institutional setting (excluding an acute psychiatric hospital).

EVALUATION
LAC-DMH achieved this goal

Goal #1: A Re-Hospitalization (Cohort 2) Performance Improvement Project (RC2PIP) has been developed by LAC-DMH, including the assembly of a Multi-Functional Team, to specifically address high utilization patterns, coordination of care issues, and other barriers to timely access, as identified in the data reviewed for the study group. This RC2PIP serves to initiate appropriate quality improvement interventions directed at identified factors contributing to the problem of re-hospitalizations. This also includes participation in PIP statewide teleconferences, technical assistance, and consultation available throughout the life of this PIP. This PIP is a multi-year process of continuous quality improvement with on-going data collection and reporting.

Goal #2: The criterion was selected consistent with the measure: *"timely access for Residential treatment/Institutional post-discharge care"*, with the overall goals of: improved quality of life, productive tenure in the community in least restrictive settings, and improved service provision. Likewise, the systems capacity to capture relevant data for this measure exists through the IS data system. Similar to the above described measure, this measure would capture fiscal year data for date of the first service/activity billed to the IS after the date of discharge from a 24-hour facility (excluding acute psychiatric hospitalizations).

LAC-DMH has a multi-disciplined group preparing for the implementation of this measure, which will be formally reviewed and evaluated in semi-annual and annual intervals. Continuous quality improvement activities will be on-going.

VI. MONITORING OF PROVIDER APPEALS – EVALUATION OF GOALS FOR 2008

1. Evaluate trends in the informal and formal two-tiered review for any authorization disputes submitted to LMHP for a three year period.

EVALUATION

LAC-DMH achieved this goal.

LAC-DMH has successfully controlled the level of provider appeals. Contractors have filed fewer appeals for Day Treatment and TBS authorization over the past four calendar years, from a total of 2 in 2006, 3 in 2007 and zero year-to-date in 2008. For 2008 there were no informal or second level appeals. No network provider had filed an appeal of LAC-DMH psychological testing. As providers gain knowledge and skills in the authorization process including correct documentation and billing activities, the LAC-DMH has had fewer problems in this area.

Table 26 summarizes the levels and disposition of appeals during a three year period.

Table 26: First and Second Level Provider Appeals

Level	Day Treatment	TBS Authorization	Network	Total Appeals
2006				
First Level	1	1	0	2
Second	0	0	0	0
2007				
First Level	1	2	0	3
Second	0	0	0	0
2008				
First Level	0	0	0	0
Second	0	0	0	0
Totals	2	3	0	5

Section 5:
ATTACHMENT A: QUALITY IMPROVEMENT WORK PLAN GOALS FOR 2009

MONITORING SERVICE DELIVERY CAPACITY

1. *Utilize data to set percentage of improvement in penetration and retention rates for underserved Latino and Asian/Pacific Islander populations.*
   - *a. Increase Latino penetration rates from FY 07-08 by 1% in FY 08-09.*
   - *b. Increase Asian/Pacific Islander penetration rates from FY 07-08 by .25% in FY 08-09.*
   - *c. Increase Latino retention rates from FY 07-08 by 1.5% in FY 08-09 for 16 or more services.*
   - *d. Increase Asian/Pacific Islander retention rates from FY 07-08 by .2% in FY 08-09 for 16 or more services.*
2. *Complete the 2009 Cultural Competency Organizational Assessment to compare with the findings of the previous Organizational Assessment.*
3. *Continue to evaluate the Interpreter Training Program and provide 6 trainings for the CY 2009.*

MONITORING ACCESSIBILITY OF SERVICES

1. *Maintain access to after-hours care at 73% of PMRT response time of one hour between PMRT acknowledgement of the call to PMRT arrival on the scene.*
2. *Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) to an overall annual rate of 13%..*
3. *Maintain the overall rate of 84% of consumers/families reporting that they are able to receive services at convenient locations. Maintain the overall rate of 87% of consumer/families reporting that they are able to receive services at convenient times. [Source: Performance Outcomes].*

MONITORING BENEFICIARY SATISFACTION

1. *Maintain current level of consumer/family participation in the statewide Performance Outcomes Survey and determine ways to improve sampling methodology.*
2. *Maintain at 88% consumer/family reporting that staff were sensitive to cultural/ethnic background [Source: Performance Outcomes Measures].*
3. *Maintain at 4.3 the Overall Satisfaction Average Mean Score and initiate year to year trending.*
4. *Maintain at 97% consumer/family reporting that written materials are available in their preferred language.*
5. *Apply Performance Outcomes findings to identify areas for improvement for Service Area QICs for use in quality improvement activities.*
6. *Continue to respond to beneficiary grievances and fair hearings and to report the results bi-annually for policy recommendations.*
7. *Continue to monitor and improve the response rates of providers reporting Beneficiary Change of Provider Requests. Monitor reports on the reasons given by consumers for their request to change service provider.*

MONITORING CLINICAL CARE

1. *Continue to improve medication practices through systematic use of medication protocols and trainings for the use of medication forms and clinical documentation for existing staff and for new staff.*

MONITORING CONTINUITY OF CARE

Utilize baseline data collection for Performance Outcomes to monitor continuity of care in 2 areas:

1. *Consumers receiving continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital.*
2. *Consumers seen and receiving timely on-going care within 30 calendar days time of discharge from mental health residential treatment program/institutional setting (excluding an acute psychiatric hospital).*

MONITORING OF PROVIDER APPEALS

1. *Continue monitoring the rate of zero appeals through CY 2009.*

PLANNED GOALS and ACTIVITIES FOR 2009

The QI Work Plan for 2009 and the Performance Based Outcomes pertain to the system as a whole and are inclusive of directly operated and contract providers. In CY 2008 LAC-DMH also collected baseline data for May CY 2008 for the Performance Outcomes recommended in 2007 by the Performance Outcomes Workgroup. The November CY 2008 data and results will be available March 2009 for completion of 2008 annual findings. During CY 2009, performance outcomes will be monitored and interventions identified and implemented for improvement. The Department's Integrated System (IS) will be the data source for operational measures for all applicable service providers.

MONITORING SERVICE DELIVERY CAPACITY

MONITORING SERVICE DELIVERY CAPACITY - GOALS FOR 2009

1. Utilize data to set percentage of improvement in penetration and retention rates for underserved Latino and Asian/Pacific Islander populations.

a. Increase Latino penetration rates from FY 07-08 by 1% in FY 08-09.

b. Increase Asian/pacific Islander penetration rates from FY 07-08 by .25% in FY 08-09.

Numerator: Number of consumers served.
Denominator: Estimated prevalence of SMI and SED among total County population.

c. Increase Latino retention rates from FY 07-08 to FY 08- 09 by 1.5% for 16 or more services.

d. Increase Asian/Pacific Islander retention rates from 07-08 to FY 08-09 by .2% for 16 or more services.

The actual retention rate for Asian/Pacific Islanders from FY 06-07 to FY 07-08 show little change. Additionally, LAC-DMH will focus on possible factors affecting low retention rates for this population.

2 Complete the 2009 Cultural Competency Organizational Assessment to compare with findings of the previous Organizational Assessment.

3. Continue to evaluate the Interpreter Training Program and provide 6 trainings for the CY 2009.

MONITORING ACCESSIBILITY OF SERVICES

LAC-DMH has allocated significant funding to outreach through the Community Services and Supports Plan of the Mental Health Services Act (MHSA) to address disparities in accessibility to services and capacity building.

MONITORING ACCESSIBILITY OF SERVICES – GOALS FOR 2009

1. **Maintain access to after-hours care at 73% of PMRT response time of one hour between PMRT acknowledgement of the call to PMRT arrival on the scene.**
2. **Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) at current levels, averaging 13%.**
3. **Maintain overall rate of 84% of consumers/families able to receive services at convenient locations (Source: Performance Outcomes).**
4. **Maintain overall rate of 87% of consumers/families able to receive services at convenient times (Source: Performance Outcomes).**

These projected outcomes for convenient location and time are inclusive of the November 2008 data that will be available in March 2009.

MONITORING BENEFICIARY SATISFACTION

As part of the performance outcomes project, the Department administers the mandated satisfaction surveys. QID participates in the review of the data collected from the surveys and in making suggestions for continuous quality improvement based on the data.

MONITORING BENEFICIARY SATISFACTION - GOALS FOR 2009

1. **Maintain current level of consumer/family participation in the statewide Performance Outcomes Survey.**

2. **Maintain at 88% consumers/families reporting that staff were sensitive to the client's cultural/ethnic background. The baseline data will be obtained from the Performance Outcomes Measures.**

3. **Maintain at 4.3 the Overall Satisfaction Average Mean Score and initiate year to year trending. This projected outcome is inclusive of the November 2008 data that will be available in March 2009. As the baseline survey data is collected for Performance Outcomes, further analysis will be completed to identify future potential quality improvement items.**

4. **Maintain at 97% consumers/families reporting that written materials are available in their preferred language. Continue to work with State to obtain survey translations in all threshold languages..**

5. **Apply the State's Performance Outcomes findings to identify areas for improvement for Service Area QICs for use in quality improvement activities.**

6. **Continue to respond to beneficiary grievances and fair hearings and to report the results bi-annually for policy recommendations.**

7. **Continue to monitor and improve the response rate of providers reporting the beneficiary change of provider requests. Monitor and report on the reasons given by consumers for their request to change service provider.**

CLINICAL CARE

Collaborate with the Office of the Medical Director and Quality Assurance to identify areas for improvement in medication monitoring, documentation and safety.

MONITORING CLINICAL CARE - GOALS FOR 2009

1. **Continue to improve medication practices through the systematic use of the medication protocols and trainings for use of medication forms and clinical documentation for existing staff and for new staff.**

CONTINUITY OF CARE

LAC-DMH is participating in the Re-Hospitalization, Cohort 2 (RC2) PIP. The RC2 PIP is designed to reduce psychiatric inpatient re-admission rates.

MONITORING CONTINUITY OF CARE - GOALS FOR 2009

Data collection to establish a baseline for the Performance Based Outcomes Measurement will allow for monitoring continuity of care in 2 areas:

1. **Consumers receiving continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital.**

2. **Consumers seen and receiving timely on-going care within 30 calendar days time of discharge from mental health residential treatment program/institutional setting (excluding acute psychiatric hospitals).**

MONITORING OF PROVIDER APPEALS

Contracted providers have access to an informal and a two-tiered formal review process for resolving authorization disputes. All disputes are assigned to a provider relations specialist to track and coordinate resolution in an efficient and timely manner.

1. **Continue to monitor the rate of zero appeals through CY 2009.**

COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
QUALITY IMPROVEMENT DIVISION

SUMMARY REPORT OF ACCESSIBILITY DOMAIN FOR TEST CALLS TO 24/7 TOLL FREE ACCESS LINE
July 1, 2008

I. Goal:

To identify potential areas for improvement for the responsiveness of the 24-hour toll free number, especially for Threshold languages.

This report summarizes the Quality Improvement (QI) Division test call data for the 24-hour toll fee number responsiveness for the period of July 2007 to March 2008.

II. Overview:

The Department's ACCESS Center operates the 24-hour, 7-Day Statewide, toll-free number, 1-800-854-7771. Calls are triaged by Access staff and many times this is the first point of contact with the County of Los Angeles, Department of Mental Health. This includes responding to psychiatric Mobile Response Team services. The staff is also prepared to provide direct language services to link callers to language assistance as well as TDD. Call logs are maintained for: date, time, caller identification, types of request, referrals made and other information as required and in accordance with ACCESS protocols. During 2007, the ACCESS Center responded to approximately 285,000 calls.

Plans are currently under way for the ACCESS Center to undergo a major telephone technology upgrade and funds have been allocated for this purpose. In a related effort, QI staff and ACCESS Center management staff collaborated to initiate a process of test calls protocol to identify potential areas for improvement. This was accomplished by using a "Secret Shopper Test Calls" approach.

III. Data Collection:

A data collection method was designed to monitor calls to the 24-hour toll free number by conducting test calls. A total of 12 test calls, including 11 calls in Threshold languages, were conducted and/or coordinated by QI staff from July 14, 2008 to March 16, 2008. A form was created to document and track test call data. The Accessibility Test Call Form was used for the first six calls. Subsequently, the Worksheet for Test-Callers to the Access Line and an

Instructions form, both modeled after the State's test call form, were developed as recommended by ACCESS administrative staff and were used for subsequent test calls. Additionally, a Test Call Log was developed to track cumulative call data by test call date.

IV. Test Call Findings:

a. The data indicate that ACCESS staff responded "immediately" for seven (7) of the twelve (12) test calls and three (3) of the twelve (12) test calls were responded to in two (2) to three (3) rings. Two (2) of the twelve (12) test calls had no information recorded for number of rings and one of these test calls recorded "2 minutes and 22 seconds" for # of rings, while waiting for the call to be picked up. ACCESS staff provided the caller with his/her name on one (1) of the twelve (12) test calls. ACCESS staff asked for the caller's name in two (2) of the twelve (12) test calls. Staff did not ask if the caller had an emergency on any of the twelve (12) test calls. However, Test Caller Instructions state: "Do not call with a crisis scenario".

- For the eleven (11) Threshold language test calls, ACCESS staff hung-up on two (2) non-English test callers prior to connecting with an interpreter and one (1) Mandarin-speaking caller hung-up after being left on hold for approximately 5 minutes. One (1) test caller was disconnected after being transferred to Interpreter Services. In six (6) of the eleven (11) Threshold language test calls, "satisfactory" information was not obtained as reported by test callers, including referrals for services. In five (5) of the eleven (11) Threshold language test calls, "satisfactory" information was obtained as reported by test callers, including referrals for services. Per the Test Call Log, this appeared to be directly related to whether the test caller was or was not effectively transferred to Interpreter services.

- For the eleven (11) Threshold language test calls, a total of five (5) calls had wait times. ACCESS staff placed test callers on hold for 5 minutes in one (1) call, 3 minutes and 30 seconds in another test call, 3 minutes in two (2) test calls, 2 minutes and 26 seconds in one (1) test call and 2 minutes in one (1) test call, while attempting to connect the caller with Interpreter Services.

- Seven (7) of the twelve (12) test callers received a referral to the closest mental health agency in their area of residence. They were also

- given specific instructions on how to secure an assessment. Six (6) of the twelve (12) test callers reported they were satisfied with the information received including the referrals provided.

- Six (6) of the twelve (12) callers reported on the total length of the test calls with these test calls reportedly ranging from half a minute to nine minutes in duration.

- Test callers did not report on the evaluation of ACCESS staff knowledge of Fair Hearing Procedures for any of the twelve (12) test calls nor did they report if they made any inquiries concerning these procedures.

- Test callers did not necessarily request specialty mental health services.

V. ACCESS Site Visit Findings:

On March 18, 2008, QI Staff met with ACCESS Center admininistrative staff. The purpose of this visit to the ACCESS Center was to verify that the ACCESS Center's staff had appropriately documented and logged all of the test calls. Review of the "ACCESS Telecommunication Center" call logs corresponding to the specific dates of the twelve test calls revealed that one (1) of the twelve (12) test calls had been recorded. This cannot be generalized to all calls received by ACCESS. This pertains only to the test calls protocols and especially to test calls in Threshold languages.

VI. Recommendations:

- Revised Test Call Worksheet (Attached).

- Revised Test Call Log (Attached)
- Revised Purpose of Test Calls document (Attached)
- Continue to conduct random test calls including Threshold Language Test Calls.
- Provide summary reports on test calls to ACCESS staff and the Departmental QIC on a regular basis.

Page 4

VII. Summary

The revised protocols and forms will continue to be implemented in future test calls. Data will be reviewed and shared to assess for potential areas of improvement. One important area identified for improvement is “documentation & recording”. The test calls monitoring showed that only one (1) of twelve (12) test calls was documented. All documentation categories must be included on the log consistent with ACCESS protocols.

Follow-up included having the results of the test calls reviewed and discussed by the ACCESS program manager at the monthly general staff meeting and the importance of documentation for each call received by the system was emphasized. The program manager also encouraged a continued focus on “good customer service”, while sharing the results that test callers successfully transferred to Interpreter services expressed satisfaction with the information and referrals received. There was also a discussion on the delays and unsuccessful transfers to Interpreter services including exploring the reasons/causes of these barriers to access for non-English speaking test callers. Reason/causes identified during this meeting included: 1. Technical problems as a result of an outdated phone system; 2. Identified issues pertaining to the Interpreter services currently being used; and, 3. More training to enhance call center agent skills for “warm transfer” while accessing/using interpreter services. Lastly, during this meeting, possible solutions and strategies to address these issues were also discussed until the new telephone system is installed. However, the new telephone system will require plan, design, and engineering by the selected contractor prior to implementation.

Revised 10/2/08

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CLINICAL RECORDS BULLETIN

Edition 2008-04

Program Support Bureau
550 S. Vermont, 10th Floor
Los Angeles, CA 90020

July 31, 2008

Clinical Records Staff: Rose Esquibel, Director Phone: (213) 739-6335 Fax: (213) 739-6298
Jen Eberle Phone: (213) 738-3770 Fax: (213) 381-8386
Yvonne Mijares Phone: (213) 738-2157 Fax: (213) 381-8386

Announcements

Next Keeper of Clinical Records Meeting:
Wednesday, August 6th 9:00am - 11:00am 10th Floor Conference Room-550 S. Vermont

MEDICATION SUPPORT SERVICES FORMS

NEW/REVISED FORMS AVAILABLE ON THE INTERNET AND IN THE WAREHOUSE

http://dmh.lacounty.gov/Forms.asp

DMH Official Form Usage for Medication Support Service Forms

Directly-Operated Clinics: *must* use these forms, when medication support services are provided, in their original format.

Contractors: *may* use these forms in their original format by placing their agency name on the bottom of the form in place of "Los Angeles County-Department of Mental Health."

During the Medication Support Form revisions, there was extensive discussion with and comment from psychiatrists throughout the Department. This dialogue was instrumental in arriving at the final formats of the forms. The Bureau greatly appreciates the time taken by busy staff to enhance the required documentation process.

New Medication Support Forms were created and revised in order to clarify the documentation elements needed to satisfy all payer requirements for medication support services to ensure reimbursement. Similarly, it will also ensure the appropriate usage of Procedure Codes. The new and revised forms will also allow for a uniform method of documenting medication support services as described in this Bulletin. Furthermore, as the Department moves towards an Electronic Medical Record, these forms will provide the basis to which prompts will be developed in the new EMR.

Forms are available in both PDF Fillable format and NCR format. All non-NCR versions of forms can be found on the internet under Provider Tools/Forms/Medication Notes in a PDF Form Fillable format and must continue to be used along with a Daily Service Log. All NCR versions of forms must be ordered from the Department Warehouse and do not require the use of a Daily Service Log.

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS?

1. Does a non-English speaking client need to sign the English version of the Consent for Services?
2. When transferring Clinical Records and/or PHI from one site to another (e.g., from Clinic to DMH Headquarters or from the field to the Clinic), is it necessary to use a secure lockable container?

Answers on the last page

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
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550 S. Vermont, 10th Floor
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July 31, 2008

New/Revised Forms and usage:

MH 657 - Initial Medication Support Service (90862): An optional form which may be used when prescribing me cations during the first medication evaluation with a new client. This form should always be used if an Initial A sessment has not been completed at the time of the medication evaluation. The form allows for a more comprehe sive evaluation of the client's history and current status.

MH 653 - Complex Medication Support Service (90862): A form used with clients not yet stable on medicati which requires detailed assessment, history, and decision-making for prescribing medication. This form may used in place of the Initial Medication Support Service (90862) form in cases where a detailed Initial Assessment h been completed by clinical staff, and the psychiatrist has determined that that level of assessment is not needed.

MH 655 - Brief Follow-Up Medication Support Service (M0064 or H2010): A form used when prescribing medi tions to clients stable on medication (M0064), or when prescribing medications based on a phone call or collate contact (H2010).

MH 656 - Non-Prescription Medication Note: A form used when a non-prescription medication support service h been provided.

MH 654A - Medication Support Service Addendum: A form used when additional space is needed to complete a of the above forms. No claiming information should be included on this form.

MH 519 - Medication Log: An optional form for use as a reference for medication history. It may not be used in pla of any of the above forms.

Key changes/revisions to the forms used for Medication Support Services include:

- Prompts to ensure all elements to meet payer requirements are included in the note
- Forms that distinguish medication support services by their associated procedure code
- One claimable service per note
- A cross-reference no longer has to be made in the Progress Note
- Physician orders have been incorporated into the form
- Uniform location and tracking of medications prescribed on all medication support service forms

OBSOLETE Medication Support Service Forms:

MH 504—Evaluation by Physician
MH 519—Medication Note
MH 519 NCR—Medication Note
MH 504—Physician's Orders

Key points to remember:

- Diagnosis should only be found on the Initial Assessment or Diagnosis Information form.
- Any time a diagnosis is added or changed from what is listed on the Initial Assessment or Diagnosis Informati form, a new Diagnosis Information form must be completed.
- All BOLDED areas on the medication support service forms MUST include detailed information. Checking box or writing "Ø" is not appropriate. When using the Initial Medication Support Service form, boxes may be checked relevant parts of the Clinical Record have been reviewed and referenced.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
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July 31, 2008

Key points to remember (continued from previous page)

- The documentation for all medication support services should be on the revised forms filed in the Medication Support Section (for directly operated clinics only).
- No Shows should be documented on the Non-Prescription Medication Note.
- The use of the Medication Log must be determined at the Program level. If used, the form may be printed on colored paper at the discretion of the Program Manager so that it is easily distinguishable in the Medication Section of the chart.
- If at anytime it is determined that no medications will be prescribed, the H2010 code, which is an available option on each of the prescription forms, must be chosen.
- If NCR forms are used, note that the last page of the form has been placed on top in order to prevent writing from going through to other pages due to the carbon paper used on the last page of the NCR forms.
- The preparation of reports or letters, even though medications may be a part of the report/letter, should continue to be documented on a Progress Note form using Procedure Code 90889 and filed in the Progress Note Section of the Clinical Record.
- Time spent by MD/DO, NP, RN, PT, LVNs discussing medications for an individual client during a consultation/team conference should be documented using the Non-Prescription Medication Note and Procedure Code H2010.
- Only the Physician/Nurse Practitioner's time will be claimed on the three new prescription forms. Any other staff who participates in the contact should document any claimable service in a separate note.

Implementation of New Medication Forms:

1. New forms were presented at both District Chiefs Meeting (July 9th) and Program Heads Meeting (July 31st)
2. Training will be provided to all physicians in each Service Area by the end of August
3. Programs should immediately implement the use of the new forms once training has been provided in their Service Area
4. Forms MUST be in use by September 1, 2008

Please direct any questions regarding the above information to Jennifer Eberle at (213) 738-3770.

c: Executive Leadership Team, District Chiefs, All DMH Physicians; Program Heads, Provider Record Keepers; ACHSA, Revenue Management Division

I KNOW THE ANSWERS TO THOSE QUESTIONS!

1. No, a non-English speaking client may sign a Consent for Services in their native language if such a document is available. In order to prevent any confusion, there should be an "unfilled" English version of the form either on the back of or attached to the non-English signed version of the form that the client signed with a notation written, signed and dated by the staff at the bottom of the English version form indicating "*The attached Consent for Services form was signed by the client in his/her own native language.*"
2. Yes, a secure lockable container (lockbox) is required and should be locked in the trunk during transportation of a Clinical Record and/or PHI. In addition, each clinic should have their own policy and procedures regarding safeguarding Clinical Records and/or PHI during transportation. Some situations apply in which Clinical Records and/or PHI do not fit in a large secure lockable container, and an alternative cannot be found. In these situations, please contact Rose Esquibel at (213) 739-6335 for assistance.

California EQRO
560 J Street, Suite 390
Sacramento, CA 95814

This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that County proposes to use in evaluation the Re-hospitalization PIP, Cohort 2.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH (MHP) RE-HOSPITALIZATION TOPIC: Reducing system wide acute Psychiatric Inpatient Hospital re-admission rates among consumers with one or more discharge(s) from an acute Psychiatric Inpatient Hospital within the Fiscal Year.

CAEQRO PIP Outline via Road Map

MHP: County of Los Angeles Department of Mental Health
Date PIP Began: PIP Began: July 1, 2008
Title of PIP: Re-hospitalization, Cohort 2
Clinical or Non-Clinical:

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.

   LAC-DMH MHP:
   - DMH staff representing: Quality Improvement Including Data Unit staff; Chief Information Office Bureau; Adult Systems of Care; Child and Family Services Bureaus; Program District Chiefs for TAY; Older Adults; Countywide Resource Management (Including Residential & IMD); and, MH Specialty Services.
   - LAC-DMH Office of Medical Director (OMD)
   - LAC-DMH Director of Empowerment and Advocacy
   - Association of Community Human Services Agencies (ACHSA)

- Hospital Association of Southern California (HASC)
- County Department of Health Services (DHS)
- Statewide RC2 PIP consulting staff (Including Ed Diksa, CIMH)

"Is there really a problem?"

2. Define the problem by describing the data reviewed and relevant benchmarks. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

Why is this a problem priority for the MHP and how is it in the scope of influence?

- It is significant for consumers and their families: Utilization of Psychiatric Inpatient Hospitals impacts consumer/family satisfaction with services. It is likely less disruptive for consumers and their families to have timely and accessible outpatient services to assist them in resolving crises early on and in the least restrictive setting.
- It is measurable: Psychiatric Inpatient Hospitalization discharges, re-admission rates, and lengths of stay are nationally considered relevant measures. The LAC-DMH Integrated System (IS) tracks the relevant Psychiatric Inpatient Hospital data.
- It can be within the MHP's influence: While not all Psychiatric Inpatient Hospitalizations are preventable, there are many factors within our influence which can contribute to reducing hospitalizations and re-hospitalizations. Through good discharge planning, collaboration, coordination, and follow up when a client is hospitalized, it is more likely that re-admissions can be prevented.

Consumer Population affected:

In order to define the population the following parameters are used subject to the availability of data:

- Consumers that have had one or more discharges from a Psychiatric Inpatient Hospital facility within a fiscal year will be affected, given that they are individuals that the MHP can impact (i.e. MHP's target population).
- MHP's consumers irrespective of payor type will be included.
- For the Medi-Cal Medicare (Medi-Medi) population tracking necessary information for the period of when the hospital is billing the Medicare Intermediary/Carrier and not the Mental Health Plan

(MHP) will not be possible. Hospitalizations that are billed to Medicare are not generally reported to the Mental Health Plan (MHP). With this in mind, the MHP will limit tracking of the Medi-Medi population to the period of days when the Medicare benefit has been exhausted and Medi-Cal benefits are being drawn down.

- All age groups are included since some interventions aimed at reducing hospitalizations and re-hospitalizations may be universally applied across all age groups.
- For consumers suffering co-occurring disorders, tracking necessary information will be difficult. At this time, the specific identification of consumers with co-occurring disorders will not be made because toxicology screen results are not available and data on this population is difficult to collect. However, COD codes recorded at the time of Psychiatric Inpatient Hospital admission will be tracked as reported to determine its' potential utility in addressing this important factor in consumer outcomes.

Gather and analyze data:

The MHP's baseline data on Psychiatric Inpatient Hospital Discharges, Re-Admissions, and Average LOS is for FY 2007-08. Annual follow up will be for FY 2008-09, 2009-10 and 2010-11.

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
RE-HOSPITALIZATION PERFORMANCE IMPROVEMENT PROJECT (PIP) COHORT 2

Table1. Discharges, Re-Admissions, and Average LOS
By Psychiatric Inpatient Hospital for FY 2007-08
(Data Extract 12/12/2008)

Hospital		1 Total Number of Discharges	2 24 Hr Re-Admissions	3 30 Day Re-Admissions	4 30 Day Re-Admissions (Excluding 24- Hr)	5 Percent 30 Day Re-Admissions	6 Percent 30 Day Re-Admissions (Excluding 24- Hr)	7 Average LOS Days
DHS	**1**	898	19	122	104	13.6%	11.6%	13.8
DHS	**2**	1,334	26	182	161	13.6%	12.1%	16.2
DHS	**3**	889	14	98	84	11.0%	9.4%	18.9
FFS	**1**	205	1	28	28	13.7%	13.7%	4.4
FFS	**2**	414	27	170	162	41.1%	39.1%	12.5

Hospital		1 Total Number of Discharges	2 24 Hr Re-Admissions	3 30 Day Re-Admissions	4 30 Day Re-Admissions (Excluding 24- Hr)	5 Percent 30 Day Re-Admissions	6 Percent 30 Day Re-Admissions (Excluding 24- Hr)	7 Average LOS Days
FFS	**3**	262	10	80	76	30.5%	29.0%	12.9
FFS	**4**	487	21	96	82	19.7%	16.8%	13.7
FFS	**5**	1,658	63	447	417	27.0%	25.2%	15.1
FFS	**6**	605	11	92	82	15.2%	13.6%	7.1
FFS	**7**	740	13	112	101	15.1%	13.6%	6.5
FFS	**8**	398	15	143	139	35.9%	34.9%	8.7
FFS	**9**	344	13	96	92	27.9%	26.7%	10.8
FFS	**10**	270	4	59	56	21.9%	20.7%	5.7
FFS	**11**	1,534	88	554	515	36.1%	33.6%	9.1
FFS	**12**	1,561	94	546	494	35.0%	31.6%	9.2
FFS	**13**	1,114	62	386	358	34.6%	32.1%	8.2
FFS	**14**	933	24	283	271	30.3%	29.0%	8.5
FFS	**15**	1,369	40	310	292	22.6%	21.3%	4.8
FFS	**16**	683	17	148	136	21.7%	19.9%	5.5
FFS	**17**	1,687	73	640	617	37.9%	36.6%	6
FFS	**18**	90	3	13	10	14.4%	11.1%	28.3
FFS	**19**	1,197	53	441	419	36.8%	35.0%	8.6
FFS	**20**	16	0	2	2	12.5%	12.5%	10.7
FFS	**21**	812	28	154	139	19.0%	17.1%	5.9
FFS	**22**	407	25	127	110	31.2%	27.0%	9.3
FFS	**23**	27	0	4	4	14.8%	14.8%	9.6
FFS	**24**	10	0	0	0	0.0%	0.0%	9.1
FFS	**25**	616	25	190	177	30.8%	28.7%	13.9
FFS	**26**	18	0	5	5	27.8%	27.8%	12.3
FFS	**27**	128	3	26	26	20.3%	20.3%	6.1
FFS	**28**	1	1	1	0	100.0%	0.0%	5

Hospital		1 Total Number of Discharges	2 24 Hr Re-Admissions	3 30 Day Re-Admissions	4 30 Day Re-Admissions (Excluding 24- Hr)	5 Percent 30 Day Re-Admissions	6 Percent 30 Day Re-Admissions (Excluding 24- Hr)	7 Average LOS Days
FFS	**29**	19	1	4	4	21.1%	21.1%	7.3
FFS	**30**	29	0	9	9	31.0%	31.0%	7.1
FFS	**31**	554	28	174	162	31.4%	29.2%	7.8
FFS	**32**	1,750	138	959	922	54.8%	52.7%	5.5
FFS	**33**	35	13	19	10	54.3%	28.6%	3.8
NGA	**1**	906	16	107	94	11.8%	10.4%	13.9
NGA	**2**	7	0	0	0	0.0%	0.0%	4.9
NGA	**3**	10	0	2	2	20.0%	20.0%	4.4
NGA	**4**	71	1	8	7	11.3%	9.9%	4
NGA	**5**	1,287	8	148	142	11.5%	11.0%	15.8
NGA	**6**	126	6	18	12	14.3%	9.5%	42.6
NGA	**7**	264	9	31	26	11.7%	9.8%	10.1
NGA	**8**	733	17	132	124	18.0%	16.9%	5.8
NGA	**9**	624	10	97	87	15.5%	13.9%	5.8
STATE	**1**	1	0	0	0	0.0%	0.0%	2587
STATE	**2**	199	3	9	6	4.5%	3.0%	388.7
STATE	**3**	18	1	1	0	5.6%	0.0%	897.6
STATE	**4**	2	1	1	0	50.0%	0.0%	866.5
Totals		***27,342***	***1,025***	***7,274***	***6,766***			

Discharges, Re-Admissions, and Average LOS Days are counted based on the FY in which they occurred.

DHS – Department of Health Services
FFS – Fee for Service
NGA – Non Governmental Agency
STATE – State Hospitals (AKA Other Public Agency)

1. Total Number of Discharges from Psychiatric Inpatient Hospitals in FY 2007-2008.
2. Among those discharges, how many re-admissions to a Psychiatric Inpatient Hospital on the same day as the prior discharge or the next day. In most instances these may, in fact, be hospital to hospital transfers (hence not a "re-admission" in the usual sense).
3. Among those discharges, how many re-admissions to a Psychiatric Inpatient Hospital within 30 days of the prior discharge.
4. Among those discharges, how many re-admissions to a Psychiatric Inpatient Hospital within 30 days of the prior discharge, excluding those whose only re-admission occurred on the same or next day of original discharge.
5. 30 Day Re-Admission Rate.
6. 30 Day Re-Admission Rate excluding same/next day "re-admission".
7. Average length of stay in days for prior admission among clients discharged.

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
RE-HOSPITALIZATION PERFORMANCE IMPROVEMENT PROJECT (PIP) COHORT 2

Table 2. Discharges, Re-Admissions, and Average LOS
By Provider Type for FY 2007-08

	1	2	3	4	5	6	7
Hospital Type	**Total Number of Discharges**	**24 Hr Re-Admissions**	**30 Day Re-Admissions**	**30 Day Re-Admissions (Excluding 24- Hr)**	**Percent 30 Day Re-Admissions**	**Percent 30 Day Re-Admissions (Excluding 24- Hr)**	**Average LOS Days**
DHS	3,121	59	402	349	12.9%	11.2%	16.3
FFS	19,973	894	6,318	5,917	31.6%	29.6%	8.5
NGA	4,028	67	543	494	13.5%	12.3%	12.2
STATE	220	5	11	6	5.0%	2.7%	444.7
Totals	***27,342***	**1,025**	**7,274**	**6,766**			

DHS – Department of Health Services
FFS – Fee for Service
NGA – Non Governmental Agency
STATE – State Hospitals (AKA Other Public Agency)

1. Total Number of Discharges from Psychiatric Inpatient Hospitals in FY 2007-2008.
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3. Among those discharges, how many re-admissions to a Psychiatric Inpatient Hospital within 30 days of the prior discharge.
4. Among those discharges, how many re-admissions to a Psychiatric Inpatient Hospital within 30 days of the prior discharge, excluding those whose only re-admission occurred on the same or next day of original discharge.
5. 30 Day Re-Admission Rate.
6. 30 Day Re-Admission Rate excluding same/next day "re-admission".
7. Average length of stay in days for prior admission among clients discharged.

RE-HOSPITALIZATION PERFORMANCE IMPROVEMENT PROJECT (PIP) COHORT 2

Table 3. Total Psychiatric Inpatient Hospital Discharges
By Gender for FY 2007-08

Hospital Type	1 Number of Males	2 Number of Females	3 Number Indentifying as "Other"	4 Total Number of Discharges by Gender
DHS	1,788	1,332	1	***3,121***
FFS	10,966	8,995	12	***19,973***
NGA	2,746	1,282	0	***4,028***
STATE	110	110	0	***220***
Totals	***15,610***	***11,719***	***13***	***27,342***
% of Total	***57.09%***	***42.86%***	***0.05%***	***100.00%***

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
RE-HOSPITALIZATION PERFORMANCE IMPROVEMENT PROJECT (PIP) COHORT 2

Table 4. Total Psychiatric Inpatient Hospital Discharges
By Age Group for FY 2007-08

Hospital Type	1 Age 0-15	2 Age 16-25	3 Age 26-59	4 Age 60+	5 Total Number of Discharges by Age Group
DHS	88	705	2,199	129	3,121
FFS	2,039	3,829	12,984	1,121	19,973
NGA	709	943	2312	64	4,028
STATE	8	35	165	12	220
Totals	***2,844***	***5,512***	***17,660***	***1,326***	***27,342***

% of Total	*10.40%*	*20.16%*	*64.59%*	*4.85%*	100.00%

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
RE-HOSPITALIZATION PERFORMANCE IMPROVEMENT PROJECT (PIP) COHORT 2

Table 5. Psychiatric Inpatient Hospital Discharges
By Substance Use/Abuse for FY 2007-08

Hospital	1 Number with substance use/abuse	2 Number of No substance use/abuse	3 Number with SA status Not Reported	4 Total Number of Discharges
DHS	0	0	3,121	3,121
FFS	6	14	19,953	19,973
NGA	344	1,276	2,408	4,028
STATE	4	0	216	220
Totals	354	1,290	25,698	27,342
% of Total	*1.30%*	4.7%	94%	

Footnote:
Substance Use - This data is taken from the Dual Status field as recorded at the time that the admission is registered in the IS. Response codes indicate whether or not the client is currently using and/or abusing alcohol and/or street drugs. Data indicates that Psychiatric Inpatient Hospitals are only completing this field sporadically.

Team Brainstorming: "Why is this happening?"
Root cause analysis to identify challenges/barriers

3. Describe the data and other information to be gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

a. Data to be collected for FY 07-08 and subsequent years for MHP Inpatient Psychiatric Hospitals are as follows:
   1. Total Number of Discharges, Re-Admission rates, Average Length of Stay by hospital.
   2. Total Number of Discharges, Re-Admissions rates, Average Length of Stay by Inpatient Psychiatric Hospital type.
   3. Total Number of Discharges by Age.
   4. Average Length of Stay Days (LOS) by hospital and hospital type.
   5. Total Number of Discharges by Substance Use/Abuse Status.

b. What are barriers/causes that require intervention?
   Re-Admissions work group members are to discuss the issue of the number of discharges, re-admissions, and average length of stay. Also to be discussed will be a number of issues which may contribute to the re-admissions rate and agreement is to be reached on the following two, and other, categories of barriers.
   1. Lack of coordination of care <u>during</u> a Psychiatric Inpatient Hospital admission.
      i. Limited contact between County MHP outpatient service provider(s) and hospital staff to discuss consumer care while the consumer is in the Psychiatric Inpatient Hospital.
      ii. Limited contact between County MHP outpatient service provider(s) and hospital discharge staff to discuss discharge plans while the consumer is in the Psychiatric Inpatient Hospital.
      iii. Lack of a procedure for clinician and/or case manager of a MHP outpatient service provider(s) assigned to connect with consumer prior to discharge from Psychiatric Inpatient Hospital.
      iv. Insufficient coordination with family members/conservator/support systems during hospital stay or at the time of discharge from the Psychiatric Inpatient Hospital.
      v. Issues regarding consent to share information among service providers.

   2. Inadequate post discharge follow up and coordination of services.

i. Upon discharge from the Psychiatric Inpatient Hospital, even when an appointment is scheduled at the Outpatient Clinic, consumers frequently do not keep these appointments. There are no current uniformly established procedures for follow up upon discharge from Psychiatric Inpatient Hospitals.
ii. Existing MHP Outpatient Intake procedures and timelines can make it difficult to obtain an appointment for consumers close to their date of discharge.
iii. Current contact information can be lost between Psychiatric Inpatient Hospitals and the MHP outpatient service providers.
iv. Consumers who are hospitalized a great distance from the MHP outpatient service providers sometimes choose to go elsewhere upon discharge and this is difficult to follow up on.
v. There is a lack of established outpatient service provider procedures for prioritizing duties to allow for follow up with consumer post-discharge and/or no dedicated MHP direct or contracted staff positions to do so.

Table 6 – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
1. Lack of collaboration and coordination of care during an inpatient admission.	**1.1 Consumer** record and hospital discharge summary reviews indicated inadequate collaboration and coordination between the provider(s).
2. Possible discharge of patient prior to sufficient inpatient stabilization.	**2.1** Examination of relationship between Hospital Readmission rates and Average Length of Stay.
3. Inadequate post-discharge follow-up and coordination of care with consumers.	**3.1.** Examination of post-discharge outpatient utilization services patterns indicated inadequate post-discharge follow-up and coordination of care with consumers.

Formulate the study question

Example: If we improve care coordination and linkages, then can we reduce the number and percent of adults with unplanned re-admissions for acute psychiatric hospitalizations within 30 days of discharge?

4. Will improved care coordination, discharge planning, and linkage activities reduce the number and percent of consumer re-admission within 30 days of discharge from Psychiatric Inpatient Hospitals.
   The study question is:
   a) Will the specified interventions to be implemented reduce the system-wide 30 day re-admission rates?
   b) Will the specified interventions to be implemented reduce the number of Psychiatric Inpatient Hospitals that exceed the established Re-Admission Rate Threshold?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.
   Yes. However, to maximize impact of interventions, the initial focus will be directed toward those inpatient facilities that had 50 or more discharges during FY2007-08 and exceeded the threshold of a 20% 30-day readmission rate (excluding same day/next day readmissions). There were 36 Psychiatric Inpatient Hospitals in the MHP that had at least 50 discharges in FY 2007/08. Among these, 17 of 35 had a 30-day re-admission rate of at least 20%.

6. Describe the population to be included in the PIP. The total study population includes all consumer discharged from Psychiatric Inpatient Hospitals associated with the MHP in FY 2007-08. The baseline period is FY 2007-08.

7. Describe how the population is being identified for the collection of data.
   Data for the study population will be collected from the MHP's data collection systems, reports, and ITWS claims data. Among 27,342 MHP Psychiatric Inpatient Hospital discharges during FY 2007/08, a total of 6,766 re-admissions within 30 days (excluding same/next day "re-admissions" – these are often transfers). This is a systemwide re-admission rate of 24.75%. (See Table 2, Page 6)

8. If a sampling technique was used, how will the MHP ensure that the sample was selected without bias?
   Not Applicable. No Sampling used.

"How can we try to address the broken elements/barriers?"
Planned interventions

Specify the indicators in Table 7 and the Interventions in Table 8.

9. What are the indicators and why were these indicators selected?

a) Indicator # 1: Number and percent of re-admissions each fiscal year, beginning with FY 2008-09.
#1a. System-wide rate
#1b. # Psychiatric Inpatient Hospitals with over 50 discharges exceeding 20% threshold

1) Reason for the indicator:
   i. This indicator provides an objective proxy measurement of consumer access to effective discharge planning and post-discharge care.

Table 7 – List of Indicators, Baselines, and Goals

Indicator #	Describe Indicator	Numerator	Denominator	Baseline for indicator	Goal/Outcome
#1.a	System-wide 30-day hospital readmission rates (excluding same day/next day "readmission")	Total number of consumer re-admissions within 30 days of discharge (excluding 24 Hr "Re-admission"). 6,766	Total number of discharges from Psychiatric Inpatient Hospitals. 27,342	24,75%	Reduce system wide re-admissions by 2% per FY.
#1.b	Proportion of hospital with 50 or more FY discharges that exceeded 20% readmission rate threshold.	Total number of In-County Psychiatric Inpatient Hospitals with more than 50 discharges and a FY re-admission rate exceeding 20%. 17	Total number of In-County Psychiatric Inpatient Hospital with more than 50 discharges. 36	47.2%	Number of Psychiatric Inpatient Hospitals exceeding the indicated threshold will be reduced by 8% per FY.

10. Use Table C to summarize interventions. In column 2, describe each intervention. Then, for each intervention, in column 3, identify the barriers/causes each intervention is designed to address. Do not cluster different interventions together.

Table 8 - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
#1	Initiate and facilitate dialog between the MHP Outpatient Service Provider(s) and Psychiatric Inpatient Hospitals for prior to discharge collaboration and coordination including discharge planning.	Lack of collaboration and coordination between outpatient service provider(s) and Psychiatric Inpatient Hospitals for discharge planning.	Ongoing
	Initiate and facilitate dialog between Outpatient Service	Lack of mental health outpatient services provider(s)	Ongoing

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
#2	Providers(s) and MHP regarding post-hospitalization follow-up.	policies and procedures	
#3	Examine discharge Policies and Procedures and other relevant MHP Policies and Procedures, including consent to share information amongst service provider(s) and coordination with family members/conservatory/support systems, as well as, roll (s) and responsibilities to clinicians of MHP Outpatient Services Provider(s), during hospitals stay and revised as needed/appropriate.	Insufficient contract package language for Psychiatric Inpatient Hospitals.	Ongoing
#4	Examine contract package language for Psychiatric Inpatient Hospitals.	Insufficient contract package language for Psychiatric Inpatient Hospitals.	Ongoing
#5	IS data review and reporting to MHP providers.	Insufficient identification of high-risk consumers prior to psychiatric re-admission.	Quarterly Intervals
#6	Engagement of outpatient mental health service provider personnel with the discharge planning process through increased outpatient mental health contracts with Psychiatric Inpatient Hospital personnel, the consumer, family, conservators, support systems during the psychiatric inpatient stay. For example; Introduction of mental health outpatient service provider's case manager prior to transport, face-to-face or telephone contract by outpatient service provider with consumers in the development of a comprehensive after-care plan which includes appropriate services and support referrals.	Lack of collaboration and coordination between County MHP Outpatient Services Providers(s) and the Psychiatric Inpatient Hospitals during hospital stay.	Ongoing

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
#7	Outpatient service provider staff make contact with consumers and/or consumers support system) following discharge from the Psychiatric Inpatient Hospital to engage them in community integration activities and on-going treatment. For example: Consumer seen for first medication appointment (if indicated) within 10 business days of being discharged from a psychiatric inpatient hospital; consumer seen by outpatient service providers within seven (7) calendar days of being discharged from the Psychiatric Inpatient Hospital; consumer and service providers develop and /or update a coordinated service plan for ongoing treatment and/or linkage to community supports; and introduce consumer to "Drop-in" and Wellness Centers within 14 calendar days of discharge from an acute Psychiatric Inpatient Hospital.	Inadequate outpatient service provider post-discharge follow-up and lack of coordination of services with the consumer.	Ongoing
#8	Implementation of Contract Language for Outpatient Service Providers(s) to focus on service access post-discharge from Psychiatric Inpatient Hospitals.	Insufficient contract package language for Outpatient Service Provider(s)	January 1, 2009

Apply Interventions: "What do we see?"
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.
    - Psychiatric Inpatient Hospital Discharges during FY 2008-09, 09-10, 10-11. Table 1. *Psychiatric Inpatient Hospital Discharges, Re-Admissions, and Average LOS (Data Extract* 12/12/2008; Table 2. *Psychiatric Inpatient Hospital Discharges, Re-Admissions, and Average LOS by Provider Type;* Table 3. *Total Psychiatric Inpatient Hospitals by Gender Admission; Table* 4. *Total Psychiatric Inpatient Hospital Discharges by Age Group;* Table 5. *Psychiatric Inpatient Hospital Discharges by Substance Use/Abuse.*
    - Outpatient service provider contact within 7 calendar day of discharge from Psychiatric Inpatient Hospital.

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.
    - County claims management information system.
    - Short-Doyle Medi-Cal paid claims Explanation of Balances (EOB) and 835 claim files.
    - State Fee-For-Service (FFS) Inpatient Consolidation 134 claim files.
    - Miscellaneous Department data (i.e. ACCESS, Excel spread sheets, etc.).
    - Review of ITWS claims.
    - Tracking of outpatient service provider 7 calendar day contacts.
    - Review of hospitals discharge paperwork submitted to MHP's Managed Care and Countywide Resources Management Divisions.

13. Describe the plan for data analysis. Include contingencies for untoward results.
    - MHP will validate the data.
    - Baseline data will be used as comparison to data and percents collected at quarterly intervals.
    - Untoward results (understood as unusual or difficult to address results identified in data) will be reviewed quarterly and adjustments to data collection or intervention will be made as indicated.

14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.
    - Quality Improvement staff and Program Managers.
    - IT and Research/Clinical Informatics staff.
    - Staff of LAC DMH division of Managed Care and Countywide Resources Management.
    - Support staff with instruction and oversight from Quality Improvement staff and Program Mangers.
    - Directly operated and Contracted outpatient service providers/consultative personnel; and others as necessary.
    - Qualifications: licensed mental health professionals, statisticians, demographers, and research psychologists.

15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?

16. Present objective data results for each indicator. Use Table D and attach supporting data as tables, charts, or graphs.

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

    a. Data cycles clearly identify when measurements occur.

    b. Statistical significance.

    c. Are there any factors that influence comparability of the initial and repeat measures?

    d. Are there any factors that threaten the internal or the external validity?

18. To what extent was the PIP successful? Describe any follow-up activities and their success.

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?

20. Does data analysis demonstrate an improvement in processes or client outcomes?

21. Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).

22. Describe statistical evidence that supports that the improvement is true improvement.

23. Was the improvement sustained over repeated measurements over comparable time periods?

Table 9 - Table of Results for Each Indicator and Each Measurement Period

Describe indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator) and %	Goal/Outcome for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator) and %	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES 7, 8, AND 9 USED HERE FOR COMPARISON AGAINST RESULTS							