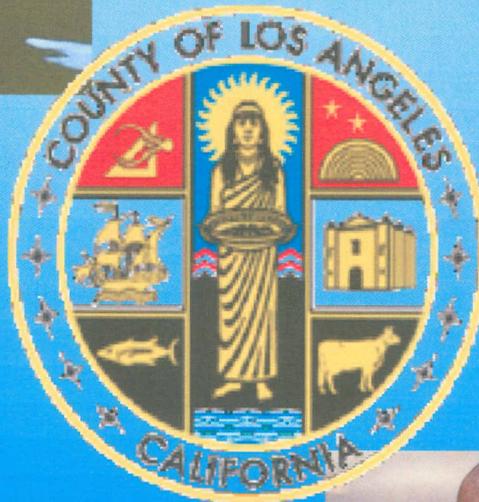
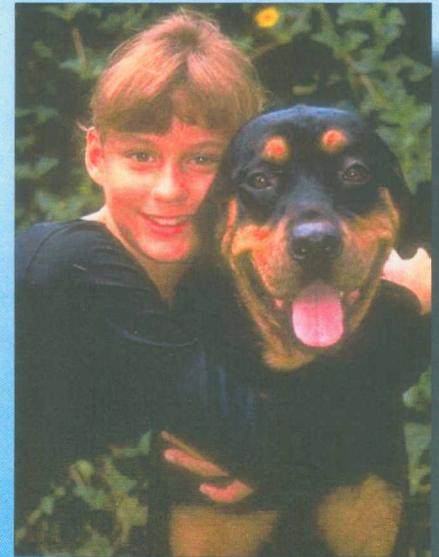


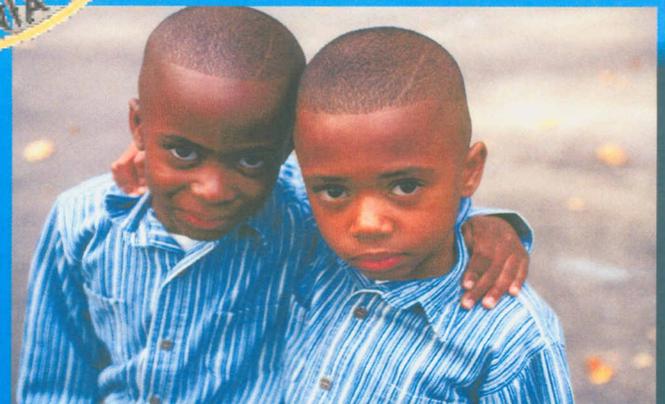
COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
LOCAL MENTAL HEALTH PLAN



QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR
CALENDAR YEAR 2007
AND
QUALITY IMPROVEMENT WORK PLAN FOR CALENDAR YEAR
2008



Marvin J. Southard, D.S.W
Director of Mental Health



**COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH**

LOCAL MENTAL HEALTH PLAN

**QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR
CALENDAR YEAR 2007**

AND

**QUALITY IMPROVEMENT WORK PLAN FOR
CALENDAR YEAR 2008**

JANUARY 2008

**Marvin J. Southard, D.S.W
Director of Mental Health**

COUNTY OF LOS ANGELES –DEPARTMENT OF MENTAL HEALTH
LOCAL MENTAL HEALTH PLAN
Calendar Years 2007 and 2008

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Section 1

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

**QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR
CALENDAR YEAR 2007
QUALITY IMPROVEMENT WORK PLAN FOR
CALENDAR YEAR 2008**

Introduction

Contents of This Report

The Los Angeles County Department of Mental Health (LAC-DMH) uses a calendar year for its Quality Improvement (QI) planning and management Program.

Section 1 contains descriptions of the demographics of Los Angeles County, LAC-DMH mental health services, and the LAC-DMH QI Program.

Section 2 contains year-to-date information on the status of the QI Work Plan and QI Program activities as adopted by the Department in 2007.

Section 3 contains plans, goals, descriptions and supporting information adopted by the Department for the Quality Improvement Work Plan for 2008.

Each Section addresses six (6) key areas of the LAC-DMH QI Program:

- Service Delivery Capacity
- Service Accessibility
- Beneficiary Satisfaction
- Clinical Issues
- Continuity and Coordination of Care and
- Provider Appeals

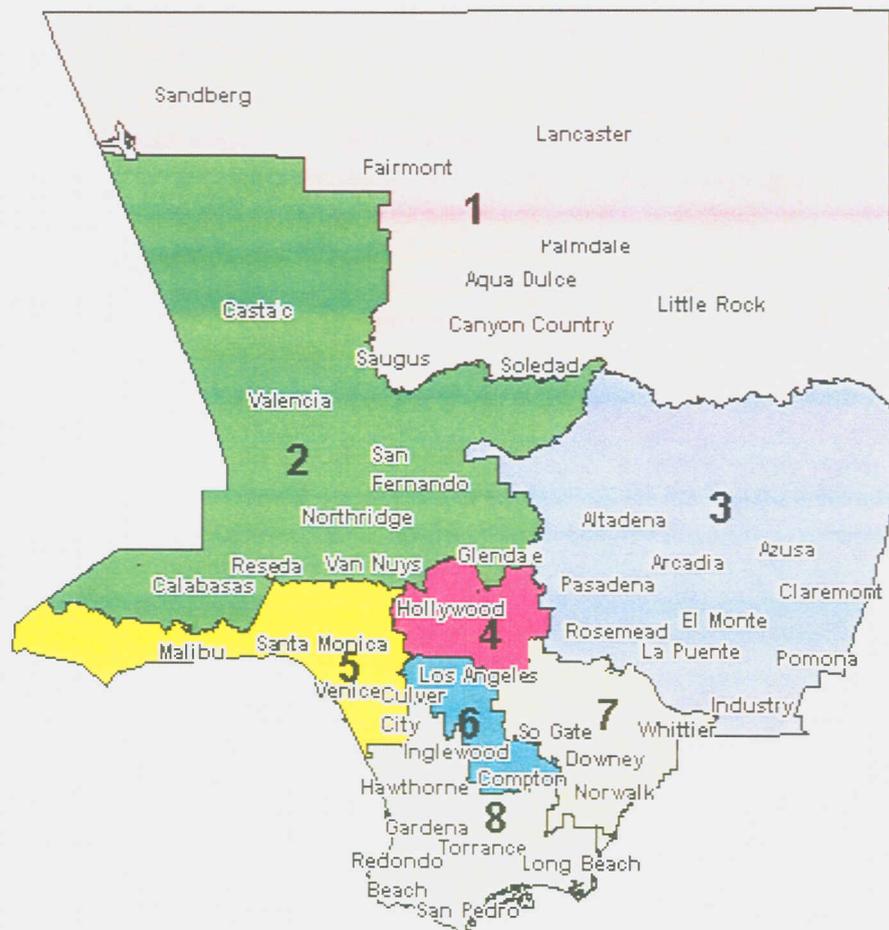
Appendix One describes the expanded programs under MHSA.

Appendix Two describes the activities for Service Delivery Capacity.

Appendices Three and Four contain one page summaries of the goals for each year.

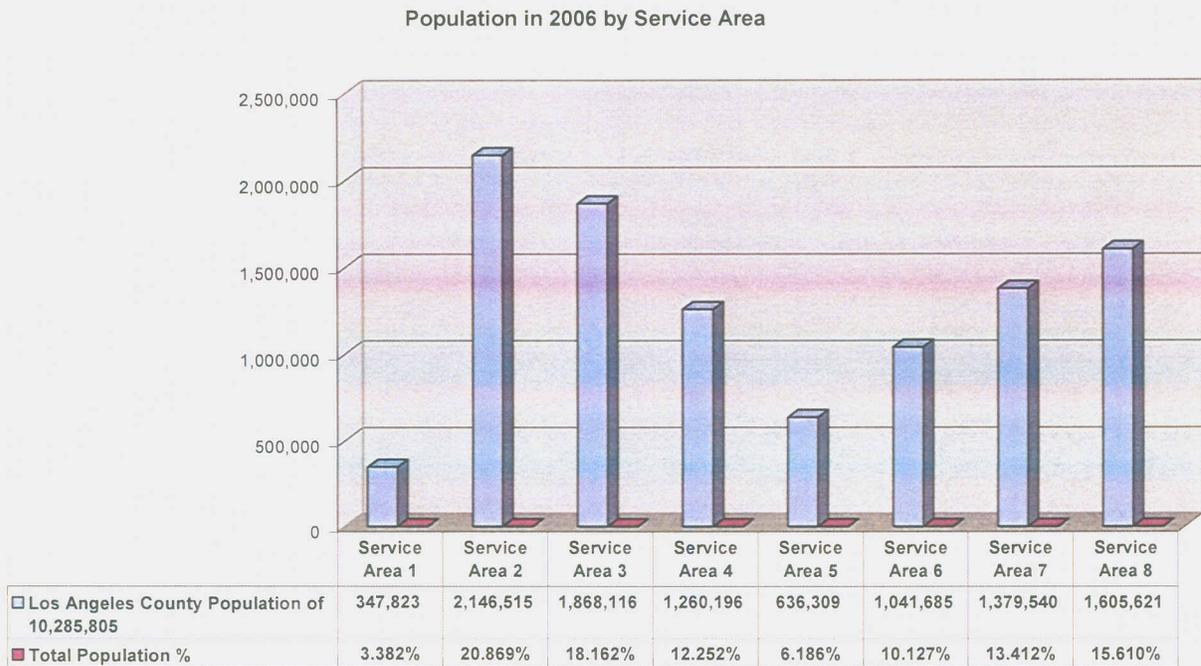
Los Angeles County Demographics

Los Angeles County is the most populous County in the United States. According to a 2006 estimated census, 10,285,800 people reside in the County. Of these, 31% are children between the ages of 0 and 19; 56% are adults between the ages of 20 and 64; and 13% are over 65 years old. Due to the size of the County, the service delivery system utilizes 8 geographic Service Areas.



The population of each Service Area varies in number and in sub-groups. **Table 1** shows the county population distributed by Service Area.

Table 1. Population Distribution by Service Area

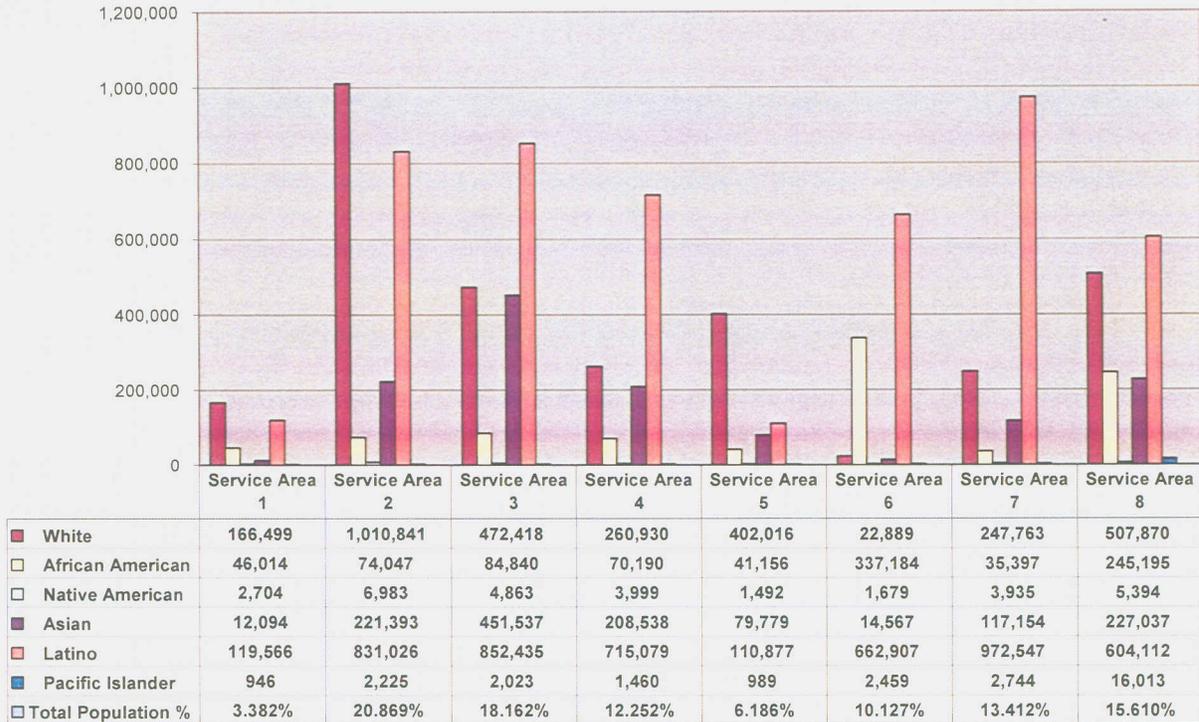


Data Source: Population Estimates by John Hedderson, Walter McDonald & Assoc., 2007

The population in Los Angeles is one of the most diverse in the nation. Latinos of all races comprise 47.3% of the population; Whites 30%; Asians/Pacific Islanders 13%; African Americans 9.1%; American Indian and Alaska Natives .31%. Nearly 40% speak Spanish and among these 28.9% state they do not speak English well. Ten percent speak Asian languages, of which 5.5% state they do not speak English well. Over 5.2% speak other Indo-European languages, of which 2.1% state they do not speak English well. **Table 2** illustrates the diversity of Los Angeles among its 8 Service Areas.

Table 2. Population Diversity

2006 Population by Ethnicity & Service Area



Data Source: Population Estimates by John Hedderson, Walter McDonald & Assoc., 2007

In the Census classification, “Disability of the Civilian Non-institutionalized Population” 7.8% comprises individuals between the ages of 5-20, and 21.8% are between the ages of 21 and 64.

Los Angeles County Department of Mental Health (LAC-DMH)

LAC-DMH operates the public mental health system serving Los Angeles County and is the Mental Health Plan (MHP) for Los Angeles County.

LAC-DMH Services

During 2007, LAC-DMH served approximately 250,000 consumers with Severe and Persistent Mental Illness (SPMI) including Severely Emotionally Disturbed (SED) children. LAC-DMH provides a full range of outpatient, inpatient, and day-treatment services through the following mental health delivery system. In addition to community-based therapeutic and supportive services, the Department and its partners deliver medication, medication support, targeted case management, and crisis services.

Mental Health Services Delivery System

LAC-DMH directly operates more than 50 program sites throughout the County, and contracts with over 1,100 other providers, including non-governmental agencies and individual practitioners.

Table 3 summarizes the LAC-DMH public mental health services delivery system.

Delivery System Summary

Table 3. Summary of LAC-DMH Public Mental Health Services System

<u>Type of Facility or Program</u>	<u>Number</u>
<u>Clinical Facilities</u>	
Community mental health center sites	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 facilities	95
Retail pharmacies	105
<u>Inpatient Facilities</u>	
State Hospital	1
County hospitals with 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 facilities	1
Geriatric sub-acute skilled nursing facilities	1
General sub-acute skilled nursing facilities (other)	2
IMDs with special programs	7
<u>Residential Facilities</u>	
Crisis residential with homeless beds	3
Transitional residential with homeless beds	5
Long-term residential	3
Semi-independent living	2
RCL Level 2-4 Group Homes beds	2,357
Community Treatment Facility (CTF) beds	61
<u>Law Enforcement Facilities</u>	
County-operated custody facilities	7
City-operated custody facilities	1
Juvenile Probation Camp locations	19
Juvenile Halls	3

The LAC-DMH mental health service delivery system is described below as it pertains to the six key areas of Quality Improvement.

SERVICE DELIVERY CAPACITY

System Transformation

In keeping with MHSAs intent and funding, LAC-DMH has mounted vigorous efforts to transform its operations with a recovery-based, client/family-centered, community-based, culturally competent, and linguistically appropriate focus.

Service Area Navigator Teams have been implemented in designated geographical areas. These teams provide an explicit LAC-DMH acknowledgment that professionally delivered publicly funded human services by themselves are inadequate to achieve the outcomes we and our consumers seek. These teams provide the community-based supports and information that consumers and their families need in order to advance their recovery and strengthen their capacity for wellness.

Another significant element in the LAC-DMH transformation effort is the commitment of high-level energy and resources to client-operated and managed Wellness Centers. Wellness and Client-Run Centers employ trained, recovered consumers as peer advocates. These centers underscore a commitment by LAC-DMH to the involvement of consumers in the process of recovery.

Full Service Partnerships continue to expand in all Service Areas. Instrumental to the wrap-around services provided by the FSPs is the inclusion of the client and family in the development of treatment plans.

ACCESSIBILITY OF SERVICES

Community Outreach and Cultural Competency

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

Most LAC-DMH directly-operated programs and contract providers deliver community outreach services, education, information, community organization and community client engagement. The LAC-DMH ACCESS Center provides a 24/7 hotline service for all of Los Angeles County. The Department also operates programs devoted to Outreach and Engagement (O&E) to special populations including but not limited to unserved and underserved persons.

The Planning Division of the Department's Program Support Bureau (PSB) develops the Cultural Competency Plan, assesses the cultural and linguistic capacities of DMH staff, and provides education and technical assistance as needed to integrate cultural competence in all LAC-DMH operations and to eliminate cultural and linguistic barriers to access.

Last year the Department integrated the Cultural Competency Bureau (CCB) and Latino Access Program (LAP) into the Planning Division of the PSB.

The Empowerment and Consumer Advocacy Division

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, implementation and evaluation of services.

Access for Beneficiaries with Language-Specific Needs

A number of clinics focus on mentally ill populations with unique language and cultural needs. These agencies are located in close proximity to neighborhoods with minority populations.

Access for Beneficiaries with Location-Specific Needs

Department employees use a web-based resource directory at <http://247211.net/dmh> to help clients locate comprehensive local resource information, such as housing, food, legal, health and mental health services. The directory describes hours of operation, languages capacity, accessibility, eligibility requirements and fees. Information can be searched by keyword or category. The database provides maps, driving directions and public transportation information, which can easily be printed and given to clients.

Access for Out-of-County Beneficiaries

The LAC-DMH Children's System of Care ensures access to services for out-of-County Medi-Cal beneficiaries who are children. In addition, ACCESS Center staff ensure access to services for adult out-of-County Medi-Cal beneficiaries.

Outreach to Homeless Persons

The Emergency Outreach Bureau (EOB) provides emergency services and outreach to the homeless population. Downtown Mental Health and numerous DMH contract providers, housed in the Skid Row district of Los Angeles, provide outreach, housing and general mental health services to homeless residents. Several community-based providers serve the homeless in Long Beach, Santa Monica and the San Fernando Valley, where the largest homeless populations reside.

Collaborative Interagency Outreach

LA's Hope Project in Los Angeles County reaches out to mentally ill homeless people. LA's Hope Project is a \$3.6 million collaborative between LAC-DMH and nine (9) other governmental and private non-profit partners. It provides permanent housing and supported employment services to 76 chronically homeless individuals with mental illness who may have a co-occurring substance abuse disorder. The Project implemented the evidence-based practice "Housing First" to reach and house

individuals living on the streets or in emergency shelters who either had been homeless for one (1) year continuously or had experienced four (4) episodes of homelessness within three (3) years.

BENEFICIARY SATISFACTION

LAC-DMH participates in the California Performance Outcomes process to monitor beneficiary satisfaction in outpatient settings. It also surveys Fee-For-Service Hospitals twice during the year to monitor satisfaction in inpatient settings.

LAC-DMH responds effectively and in a timely manner to beneficiary grievances and fair hearings. Reports are submitted bi-annually for further analysis and policy recommendations.

Beneficiary requests to change service providers are monitored and action taken when warranted.

CLINICAL GOALS

Program Integrity

The LAC-DMH Compliance Officer promotes ethical behavior within LAC-DMH and its contractors and other stakeholders, 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.

Evidence-Based Practices (EBP's) Implementation

LAC-DMH has implemented the components of the Client and Services Information system (CSI) that conform to the Substance Abuse Mental Health Services Administration (SAMHSA) Data Infrastructure Grant (DIG) in accordance with SDMH policy. Therefore, as evidence-based practice and strategies become more prevalent in the delivery of service in Los Angeles County, the Department will report on the activities of participating providers and the levels of EBP fidelity and desired outcomes. Certain LAC-DMH providers already practice sanctioned evidence-based practices, such as Assertive Community Treatment (ACT) for the Adult System of Care and Multi-Systemic Therapy (MST) and Family Functional Therapy (FFT) for children and adolescents.

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 is developing a Peer Review system for physician mental health practices.

CONTINUITY OF CARE

LAC-DMH continues to evaluate the effectiveness of MOU's with other departments. LAC-DMH assigns staff to work with agencies that are parties to the MOUs. Los Angeles County also manages a number of children's collaboratives that are not formally included in the MOUs. In these cases, LAC-DMH assigns staff to identify issues and address problems in collaboration with other agencies.

Subsequent to the expansion of the MHSA programs, Service Area Navigators and Hospital Liaison staff from the various service areas maintain a network with the acute psychiatric hospitals. This network allows for improved discharge planning and community-based follow-up treatment for FSP clients discharged from the hospital. Improved quality of care and continuity is the goal of focused field based services provided through Full Service Partnerships (FSPs). A further description of the Service Area Navigators and field based services is contained in Appendix 1.

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'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 LAC-DMH Quality Improvement Program

QI Program Structure

LAC-DMH organizes its QI planning and management activities into central staff and geographically decentralized regional management structures. The Quality Improvement Division (QID) provides central support as part of the Program Support Bureau (PSB) under the direction of the Deputy Director. Its functions include QI leadership, QI coordination, data management, reporting, and support services for LAC-DMH management in the adoption and execution of QI Work Plans. QID and the QI staff are also responsible for coordinating and presenting this report.

The geographically decentralized functions are organized by Los Angeles County's eight Service Areas (SAs) approved by the Board of Supervisors and used by all L.A. County human service agencies. The District Chief for each Service Area convenes a Quality Improvement Committee (SA QIC) that works with community organizations, mental health service delivery programs, and other stakeholders to plan and execute locally developed and managed QI activities. Organizational Providers attend these meetings and provide data and other technical assistance to the planning function. The QI Program including the oversight of directly operated and contract providers is contained in LAC-DMH Policy and Procedure for the Quality Improvement Program, #105.1 available on the LAC-DMH website.

The 2007 evaluation information and the 2007 plans presented in this report derive from the oversight activities of the Service Area QICs and the Quality Improvement Division formally conducted and documented at their regularly held meetings.

Quality Improvement Program Processes

LAC-DMH has integrated QI throughout all levels. The Service Area QICs provide forums for identification of QI opportunities and action. QICs analyze data, identify barriers to quality service, monitor and review beneficiary satisfaction and assess current services within their SA QICs. LAC-DMH also uses this local activity to develop and implement QI initiatives, including performance improvement projects (PIPs). Directly operated and contract providers participate collaboratively, and the QICs are focusing on increasing their levels of beneficiary and family member participation.

The Department celebrates its opportunity to obtain input from consumers and family members as well as other stakeholders. The Director of Mental Health and the Executive Management Team (EMT) have sponsored continuing efforts to encourage ongoing and increasing participation of beneficiaries, family members and providers in the activities of the QICs and QID. To ensure the performance of the QI program, a complete information feedback loop has been instituted from the local Organizational Providers to the Service Areas and finally to the Quality Improvement Division and back. In addition, the LAC-DMH includes membership on the Southern California QIC and the Statewide QIC.

Data Collection & Reporting

Available information, data, and reports are regularly reviewed at all QICs for the identification of areas for opportunities for quality improvement. Discussions are initiated regarding those areas that lend themselves to possible PIPs. In addition to the Annual Work Plan Evaluation Report, Quarterly Data reports are also provided to the local SA QICs, the EMT, and the system as a whole.

Section 2

**QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR
CALENDAR YEAR 2007**

The Quality Improvement Work Plan is organized into six (6) areas: Service Delivery Capacity, Access to Services, Beneficiary Satisfaction, Clinical Issues, Continuity of Care and Monitoring of Provider Appeals. The Work Plan Evaluation covers the time period from January 2007 through December 2007 and is based on the Quality Improvement Work Plan, which was submitted to the State Department of Mental Health for calendar year 2007.

The Quality Improvement Work Plan for calendar year 2008 will be presented at the conclusion of the evaluation section. Goals will be outlined in accordance with the six (6) areas noted.

LAC-DMH QI activities are the responsibility of the QID, under the auspices of the PSB and its Deputy Director. It performs the QI initiatives in collaboration with other Divisions and Bureaus directly responsible for the activities identified in the QI Work Plan.

EVALUATION OF PLANNED ACTIVITIES FOR CALENDAR YEAR 2007

All of the activities, projects and goals identified and included in the Quality Improvement Work Plan for calendar year 2007 (see Table 4) will be presented below, followed by an evaluation of the Department's results in achieving each of these goals.

Table 4. WORK PLAN GOALS FOR 2007

QUALITY IMPROVEMENT WORK PLAN GOALS FOR 2007

<p><i>MONITORING SERVICE DELIVERY CAPACITY</i></p> <ol style="list-style-type: none"> 1. Continue to implement the approved CSS programs and to apply for additional MHSAs programs.
<p><i>MONITORING ACCESSIBILITY OF SERVICES</i></p> <ol style="list-style-type: none"> 1. Maintain current performance of access to after-hours care at 69% of PMRT response times 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 10%. 3. Evaluate the results of the two (2) year Latino Access study and incorporate the results in plans for improved access.
<p><i>MONITORING BENEFICIARY SATISFACTION</i></p> <ol style="list-style-type: none"> 1. Increase the total number of surveys submitted by 1.5% from the November 2006 survey period. 2. Increase the participation of peers / volunteers in assisting with the survey completion to six or more sites. 3. Maintain satisfaction rates in the May 2007 survey period at about the same level as the November 2006 survey period. 4. Ensure that 90% or more survey respondents agree that written materials are available in their preferred language. 5. Continue to report the State's Performance Outcome Survey findings to providers and local 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 beneficiary requests to change service providers and to take action when the annual number reaches 25.
<p><i>MONITORING CLINICAL GOALS</i></p> <ol style="list-style-type: none"> 1. Continue current protocols for reviewing medication practices. 2. Monitor for occurrences of potentially poor quality of care through the Program Review process. Report such occurrences to district chiefs, QI staff and executive management. When quality of care issues are significant, report these occurrences to the County's-Auditor Controller for further review. 3. Implement the framework for Performance Based Contracting for all DMH contract human services providers and administrative contractors.
<p><i>MONITORING CONTINUITY OF CARE</i></p> <ol style="list-style-type: none"> 1. Continue to evaluate the effectiveness of the MOUs with the Regional Centers, the Department of Children and Family Services, and other human service agencies through liaison meetings and through identification of issues within the Service Area QICs. 2. Establish a work group to develop specific data definitions and standards to analyze and report service utilization and access rates.
<p><i>MONITORING OF PROVIDER APPEALS</i></p> <ol style="list-style-type: none"> 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 2007

1. Continue to implement the approved CSS programs and to apply for additional MHPSA programs.

The primary accomplishments for this goal occurred in the period between January 1 and June 30, 2007. During that time, the county created Full Service Partnership (FSP) Programs. Under FSPs, the county works with the client and his/her family, as appropriate, to provide mental health services and supports in order to provide person/family focused goal achievement. This included increasing the number of “slots” for persons receiving services to build capacity as well as service expansion for a more comprehensive array of services.

EVALUATION

During this calendar year, much has been accomplished subsequent to the funding of the Mental Health Services Act. Additional FSPs have been implemented for all age groups (see Table 5).

Table 5 – FSP Authorized Slots (as of 11/30/07)

Domain	Goals	Performance Indicator	Target / Benchmark	Actual Authorized Slots 2007				
			2007	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD
1. Monitor Service Delivery Capacity	1.1 Increase capacity for Adult FSP	1.1.1 # New Adult Authorizations	1766	632	518	232	155	1,537
	1.2 Increase Capacity for Older Adult FSP	1.2.1 # New Older Adult Authorizations	205	32	58	47	32	169
	1.3 Increase Capacity for Child FSP	1.3.1 # New Child Authorizations	1534	119	190	294	196	799
	1.4 Increase Capacity for TAY	1.4.1 # New TAY Authorizations	828	144	111	121	81	457
	1.5 Increase Total Capacity for FSP	1.5.1 # Total New Authorizations	4333	927	877	694	464	2,962

In addition to the FSPs, the following programs have been expanded or initiated subsequent to the MHPSA funding, including increased authorized slots and expanded services. These programs have significantly increased the Service Delivery Capacity within the LAC-DMH Mental Health Plan. A further description of these services are detailed in Appendix 3.

- Family Support Services for Children
- Children's Integrated Mental Health/COD Services
- Children's Family Crisis Services- Respite Care
- TAY Housing Services: Housing Specialists
- TAY Drop-In Centers
- TAY Housing Services Emergency Housing Vouchers
- TAY-Housing Services Project-Based Subsidies
- TAY Probation Services
- Adult Wellness/Client-Run Centers
- Adult IMD Step-Down Facilities and Alternative Crisis Services- Enriched Services
- Adult Housing Specialists
- Adult Jail Transition and Linkage Services
- Adult Supportive Housing Services Safe Haven Housing Trust Fund
- Older Adult Training
- Older Adult Field Capable Clinical Services (FCCS)
- Older Adult Service Extenders
Older Adults Training
- Alternative Crisis Services: Urgent Care Centers
- Alternative Crisis Services: Countywide Resources
- Alternative Crisis Services: Residential and Bridging
- Service Area Navigators

II. MONITORING ACCESSIBILITY OF SERVICES – EVALUATION OF GOALS FOR 2007

- 1. Maintain current performance of access to after-hours care at 69% of PMRT response times of one hour between PMRT acknowledgement of the call to PMRT arrival on the scene.**

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 are 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.

EVALUATION

The goal of PMRT after-hour response times was achieved. Table 6 shows the percentage of PMRT calls to the 800 number that resulted in PMRT arrival at the client location within one hour of the point in time that the PMRT unit received a call. The average percentage of after-hour calls responded to within one hour for calendar year 2007 (74%) improved from 2006 (69%). Further, the table shows the response percentages of past years for comparison. The graphs below are based on this same data, and are shown to illustrate trends, where applicable.

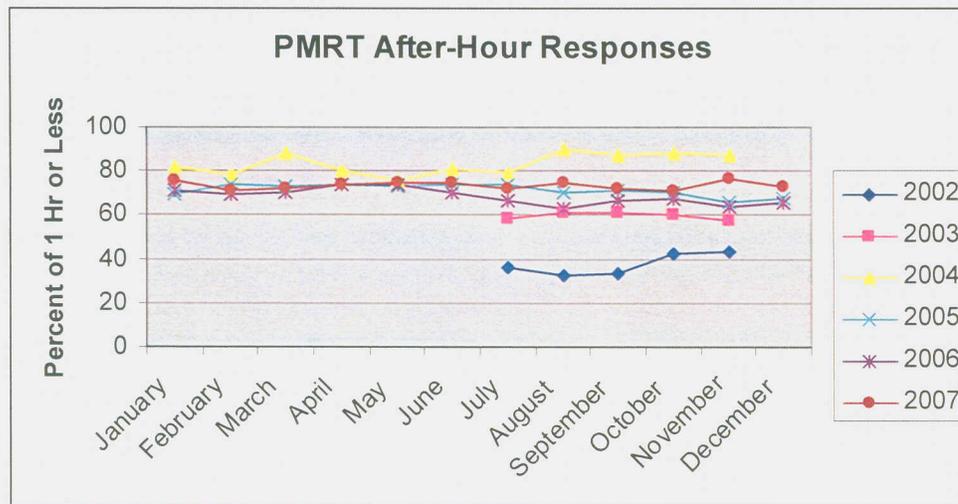
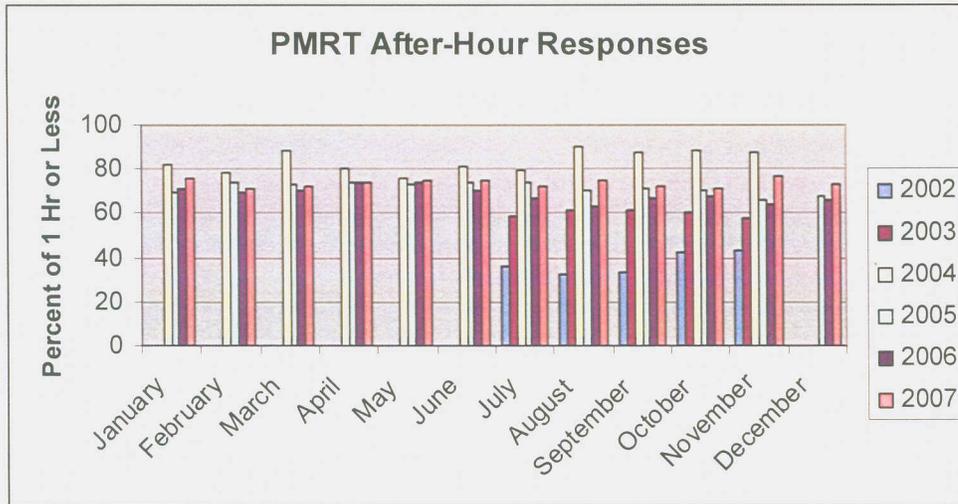
Table 6 – PMRT After-Hour Responses

PMRT After-Hour Responses of One Hour or Less (%)

	2002	2003	2004	2005	2006	2007
January	NA*	NA*	82	69	71	76
February	NA*	NA*	78	74	69	71
March	NA*	NA*	88	73	70	72
April	NA*	NA*	80	74	74	74
May	NA*	NA*	76	73	74	75
June	NA*	NA*	81	74	70	75
July	36	59	79	74	67	72
August	32	61	90	70	63	75
September	33.6	61	87	71	67	72
October	42.3	60	88	70	68	71
November	43.6	58	87	66	64	77
December	NA*	NA*	NA*	68	66	73

Source: ACCESS Center PMRT Record Keeping System

*NA: Data not available



2. Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) at current levels, averaging 10%.

The ACCESS 800 number 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, caller, type of request, referrals made for culturally appropriate services, etc. Reports are prepared monthly for management purposes. In addition, Test Calls or "Secret Shopper Calls" are made by the ACCESS managers.

EVALUATION

During 2007, the ACCESS 800 number responded to 284,956 general calls. Of the calls received, 4,263 were requests for services in languages other than English. Languages include: Amharic, Armenian, Bengali, Cambodian, Cantonese, Farsi, German, Hindi, Hungarian, Italian, Japanese, Korean, Mandarin, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese. (See Table 7)

TABLE 7—Language of Calls Received (other than English)

LANGUAGE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
AMHARIC				1	1								2
ARABIC											1		1
ARMENIAN	2	2	1	1	1	1	3	2		1	5		19
BENGALI	1					1			1		1		4
CAMBODIAN				1				2	2	1		1	7
CANTONESE	3		1	1	2		2	2	3	3		1	18
FARSI	4	4	1	3	1	1	1	3		1	4	2	25
FRENCH		1											1
GERMAN				1				2					3
HEBREW										1			1
HINDI		1							1				2
HUNGARIAN	1											1	2
JAPANESE	1			5	7					3	2		18
KOREAN	8	8	7	6	9		7		8	9	4	2	68
MANDARIN	5	2		4	3	1	1	1	1	1	5	2	26
PUNJABI								1					1
RUSSIAN	1	3	1	2	1	2			1	1	2		14
SPANISH	132	97	53	57	72	100	69	88	71	82	93	79	993
SPANISH ACCESS CTR	210	330	258	260	271	271	253	229	194	275	251	167	2969
TAGALOG	10	8		7	3	5	3	6		2	4	1	49
THAI		3		1					1				5
URDU												1	1
VIETNAMESE	3	2	2	2	4	3	5	6	2	2	2	1	34
TOTAL	381	461	324	352	375	385	344	342	285	382	374	258	4263

BOLD: THRESHOLD LANGUAGE

The ACCESS 800 number also responds to daytime and after-hour PMRT calls. During Calendar Year 2007, ACCESS received 5,988 daytime requests and 4,680 after-hour requests for emergency services.

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In addition, the ACCESS Center made 81,864 referrals for mental health services through Calendar Year 2007 and responded to 407 calls from Primary Care Physicians.

We continue to be in need of improvement for the rate of abandoned calls. The percentage of abandoned calls during 2007 is greater than 2006. The QICs are reviewing data to determine the feasibility of a PIP. ACCESS anticipates that the new telephone system upgrades planned for calendar year 2008 should have an immediate positive impact on the abandoned calls rate.

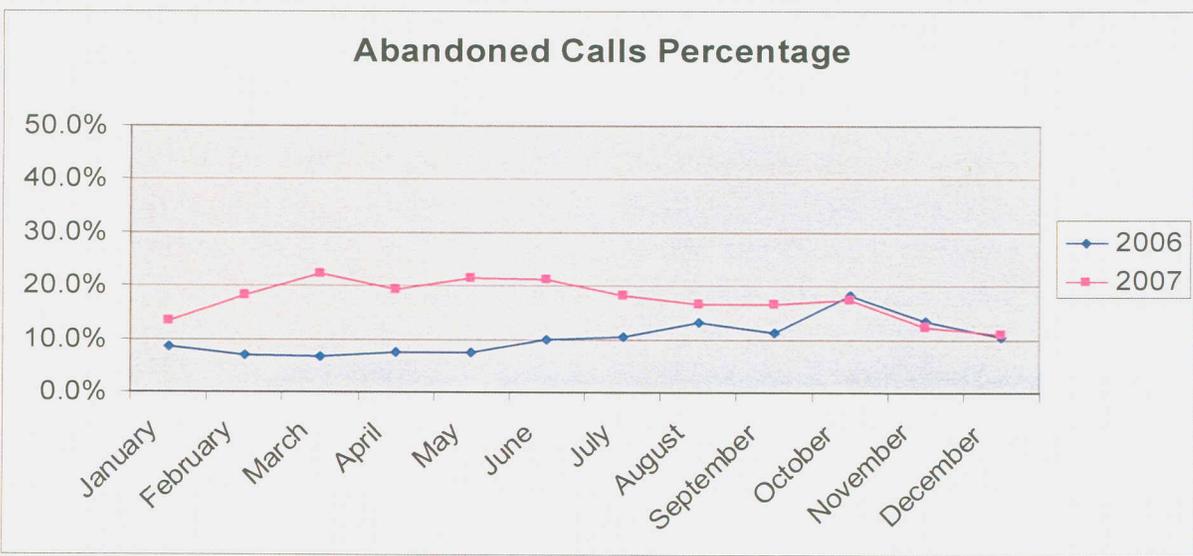
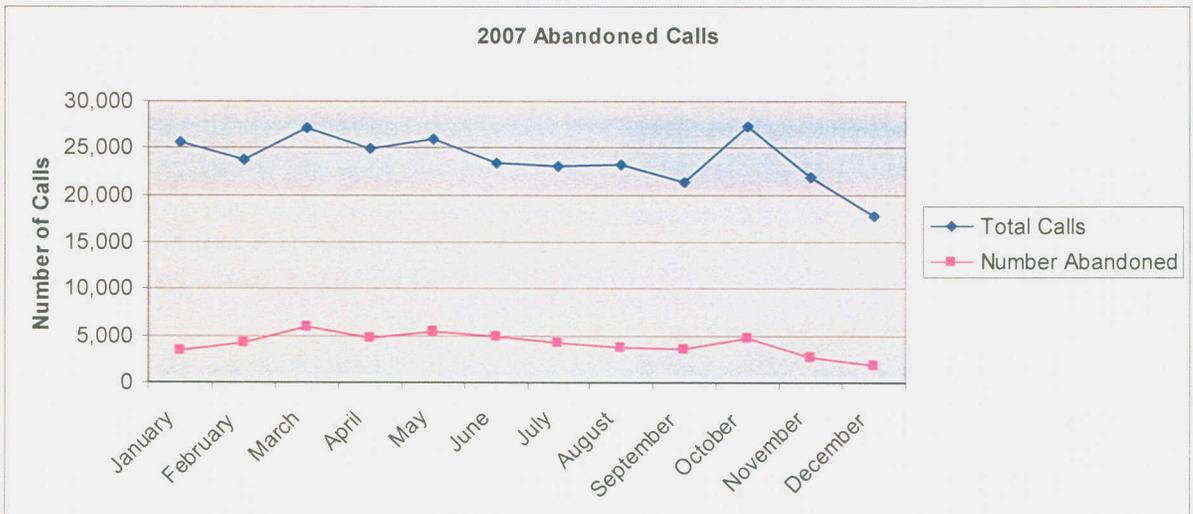
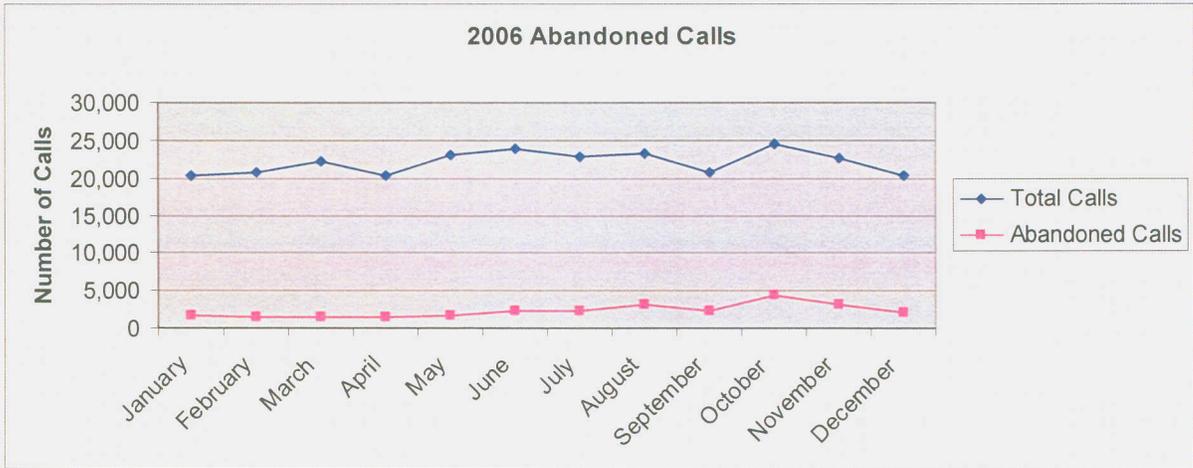
The following table (Table 7) and graphs show the number and percentages of abandoned calls for 2006 and 2007:

Table 8 – Abandoned Calls

ABANDONED CALLS STATISTICS

Month	2006			2007		
	Total Calls	Number Abandoned	Percent Abandoned	Total Calls	Number Abandoned	Percent Abandoned
January	20,361	1,741	8.6%	25,553	3,444	13%
February	20,823	1,439	6.9%	23,753	4,327	18%
March	22,262	1,491	6.7%	27,084	6,027	22%
April	20,353	1,518	7.5%	24,959	4,826	19%
May	23,179	1,768	7.6%	25,836	5,532	21%
June	23,893	2,379	10.0%	23,393	4,934	21%
July	22,818	2,339	10.3%	23,094	4,232	18%
August	23,320	3,049	13.1%	23,097	3,829	17%
September	20,688	2,325	11.2%	21,334	3,514	16%
October	24,466	4,466	18.3%	27,242	4,740	17%
November	22,755	3,048	13.4%	21,818	2,688	12%
December	20,323	2,091	10.3%	17,793	1,940	11%
Totals	265,241	27,654	10.4%	284,956	50,033	18%

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3. Evaluate the results of the two (2) year Latino Access Study and incorporate the results into plans for improved access.

As part of the Department's contract with the State Department of Mental Health, counties with populations over 10,000 are required to conduct a Latino Access Study.

EVALUATION

The need for well-prepared, competent interpreters in mental health settings has been a concern in the mental health arena, yet no systematic examinations had existed on the outcomes of interpreter training programs in public sector mental health settings.

The following is from the Final Report Draft of the USC LACDMH Interpreter Study issued in September, 2007.

Results of Three-Month Follow Up Interviews:

Qualitative data derived from the post-test and three-month interviews indicate high satisfaction with the course and instruction strategies, success with implementing new knowledge and skills in the workplace, and positive effects on consumers. Other areas include identification of barriers to—and facilitators of—effective interpretation strategies, individual and agency-level recommendations, and positive perceptions of the role of interpreter.

Future Steps and Recommendations:

1. More focused trainings
 - A. Focused training for Spanish-language interpreters who clearly comprise almost 80% of the sample.
 - B. More monolingual providers to be trained. They are least likely to attend these trainings, but are involved in the interpreter triad as part of their work.
 - C. Language proficiency. Although the average language proficiency score was moderate to high, some interpreters had low scores. Second, these scores were self-reported, so there is some question as to the level of objective language proficiency.
 - D. Mental health terminology. There was interest in learning more terms related to mental health in particular.
 - E. A booster session for those who have taken the initial course, have used the information and skills in the field, but need more training.
 - F. Develop an Academy in conjunction with an academic institution in order to provide more advanced training with an evaluation

component.

2. Departmental or agency-level changes
 - A. Implement quarterly meetings with interpreters in each Service Area to discuss common challenges, problem solving strategies, training needs, case study discussions, terminology, language accuracy, legal and ethical issues, networking, etc.
 - B. Web-based site for training, discussion of terminology, case studies, legal and ethical issues, etc.
 - C. Requirement of #xx continuing education units every xx years
 - D. Develop policies specifically for interpreters in DMH operated programs.
 - E. Develop a "Mental Health Interpreters Association of L.A. County" to facilitate education and training, support, networking, etc.
3. Statewide Activities
 - A. Facilitate an interpreters' network throughout the state
4. Additional research with specific focus
 - A. Replicate this study with more rigorous controls (control group).
 - B. Add information on structural issues (bilingual pay, space/time constraints, union/labor issues, work force development).
 - C. Add a consumer component, e.g., interview consumers who have had interpreting as part of their mental health treatment experience, and who are matched with providers who have gone through the study.

Additionally, the Planning Division of the Program Support Bureau has accomplished a number of steps to improve accessibility. The unit has initiated a new series of surveys to improve local understanding of the LAC-DMH level of cultural competency and to determine appropriate alternative course of action. The department regularly validates its linguistic capabilities. It examines staff who speak various languages and certifies their capabilities to write, speak, and conceptualize in each language, as well as to provide appropriate mental health services.

LAC-DMH has identified twelve Threshold Languages: Arabic, Armenian, Cambodian, Cantonese or Mandarin/Other Chinese, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese. The Beneficiary Handbook and the Complaint and Grievance Procedures are available in English and these twelve other threshold languages. The Handbook describes how beneficiaries can identify providers and access options for linguistically and culturally appropriate services. Every clinic maintains these documents in the languages needed by clients served at their sites. Copies of the Handbook and Complaint procedures are placed in LAC-DMH clinic waiting rooms. Also, the Department assists hearing-impaired clients through contracts with St. John's Hospital's Deaf Program and the Greater LA Services for the Deaf agency.

In addition to the above, other expanded services and activities to improve Accessibility to Services include Outreach and Engagement, Cultural Competency, and activities to engage Under-Represented Ethnic Populations. Further description of these services are detailed in Appendix 4.

**III. MONITORING BENEFICIARY SATISFACTION –
 EVALUATION OF GOALS FOR 2007**

LAC-DMH participates in the California Performance Outcomes process to monitor beneficiary satisfaction in outpatient settings. It also surveys Fee-For-Service Hospitals twice during the year to monitor satisfaction in inpatient settings. LAC-DMH adopted the following quality improvement goals for the beneficiary satisfaction component during the 2007 reporting period.

- 1. Increase the total number of surveys submitted in the survey period (May 2007) by 1.5% from the previous survey period (November 2006).**

The Department participated in the State mandated Performance Outcome survey from November 1-15, 2007. Surveys were completed in four languages – English, Chinese, Spanish and Russian.

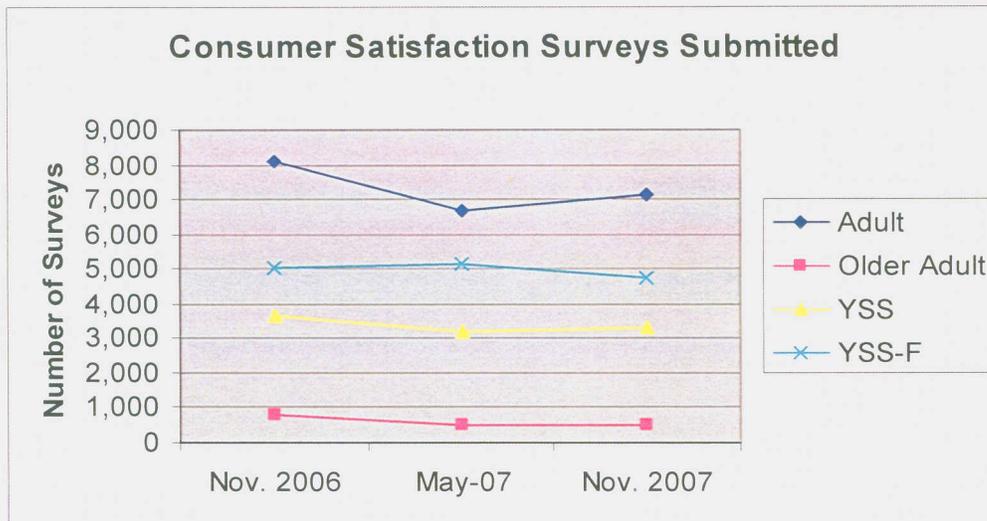
For this survey period, the Department involved the Empowerment and Consumer Advocacy Division in recruiting clients to assist with the survey completion process at six (6) clinics. The clinic staff reported that the client volunteers were dedicated and helpful in assisting their peers in completing the surveys.

EVALUATION

DMH did not achieve this goal this year. A total of 15,679 Performance Outcome surveys were submitted by the agencies to the Department in November 2007. This was a 1% increase from the previous survey period in May 2007. The following represents the number and type of surveys submitted: 4,737 Youth Family, 3,292 Youth, 7,138 Adult and 512 Older Adult. This number is slightly greater than the total number submitted in May 2007 (15,523). However, these numbers are less than the number of surveys submitted last year, 2006. Table 9 illustrates a comparison of the last 3 survey periods.

Table 9: Consumer Surveys Submitted

	Adult	Older Adult	YSS	YSS-F	Totals
Nov. 2006	8,093	786	3,636	5,011	17,526
May 2007	6,676	498	3,211	5,138	15,523
Nov. 2007	7,138	512	3,292	4,737	15,679



In an effort to improve the response of clients completing and submitting the surveys, LAC-DMH QID staff are enhancing the coordination between the Empowerment and Consumer Advocacy Division and all providers via the SA QIC meetings.

In order to increase the utility of the results of the surveys to the individual providers, irrespective of the response rates, a provider feedback form was used to report and summarize the results of the open ended comments on the last page of the survey during this survey period.

The report summarizes:

1. the areas of concerns/issues expressed by the clients in the areas related to access, satisfaction, cultural sensitivity, treatment outcomes, and participation in treatment planning;
2. corrective action or plan of action in response to these concerns; and
3. explanation of reasons if no action was taken.

2. **Through collaboration with the Empowerment and Consumer Advocacy Division, Client Coalition, and clinics in different Service Areas, QI staff will support Department efforts to increase the participation of peers/volunteers in assisting with the survey completion at three additional sites; from three (3) to six (6).**

EVALUATION

LAC-DMH achieved this goal. Peer/volunteer participation has increased during the reporting period. Consumer and volunteer groups, with oversight by the Empowerment and Consumer Advocacy Division, increased their assistance with the survey completion to 6 different sites.

3. **Monitor and ensure that satisfaction rates in the survey period (May 2007) are maintained at about the same level as the prior survey level (November 2006).**

EVALUATION

DMH achieved this goal. Table 10 below contains the rates of positive responses for 2006 and 2007.

Table 10: Percent Positive Responses to Consumer Survey

Age Group	Nov 2004 (%)	May 2005 (%)	Nov 2005 (%)	May 2006 (%)	Nov 2006 (%)	May 2007 (%)
Adult	85	85	85	85	85	81
Older Adult	87	92	92	92	92	89
Youth	79	79	79	78	78	82
Youth Family	90	90	90	89	89	89
Average	85	87	87	86	86	85

Source: County of Los Angeles, *State Performance Outcomes Summary Report by Service Area*, November 2004 thru May 2007

4. **Monitor responses on the MHSIP question to ensure that written materials are available in the client’s preferred language at least 90% of the time.**

EVALUATION

DMH exceeded this goal. **Table 11** contains the results for written materials available in the language preferred by the consumer.

Table 11: Percent of Time DMH Provides Language-Appropriate Materials

Percent	Survey
Adult	95%
Older Adult	94%
Youth	91%
Youth Family	96%

Source: *County of Los Angeles, State Performance Outcomes Survey Data*, November 2006 and May 2007

All written materials published by LAC-DMH are available in the twelve (12) threshold languages listed in Section 1.3.4.2. LAC-DMH administered the performance outcomes surveys in English, Chinese, Russian, and Spanish

- On the Adult survey, 62% responded to the question. Of these, 95% reported having received the written materials in their preferred language, while only 5% reported not having received these materials.
- On the Older Adult survey, 57% responded to the question. Of these, 94% reported having received the written materials in their preferred language, while only 6% reported as not having received these materials.
- On the Youth Family survey, 71% responded to the question. Of these, 96% reported having received the written materials in their preferred language, while only 4% reported as not having received these materials.
- On the Youth survey, 70% responded to the question. Of these, 91% reported having received the written materials in their preferred language, while only 9% reported as not having received these materials.

5. Report the State's findings for the Performance Outcome Survey (MHSIP) to providers and SA QICs for use in QI activities.

EVALUATION

LAC-DMH achieved this goal.

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

2. A General Summary of the Countywide and Service Area findings sent to the Executive Staff, District Chiefs, Program Heads, Departmental QIC, Local Service Area QICs, and Providers (both directly operated and contractors).

3. A Summary of results for individual provider units and group reports in each Service Area.
4. Summary and detail reports for District Chiefs to monitor provider performance in their Service Area.
5. Recommendations for individual survey items that can assist the Service Areas in developing Quality Improvement Projects.

QI staff held meetings with SA Survey Liaisons and QIC members to discuss problems in the survey implementation process, and brainstormed ways to improve the response rates during future survey periods. Proposals included:

1. Quality checks during the survey period at various provider sites,
2. Better estimates of the number of survey tools needed,
3. Increased quality checking of completed surveys by Service Area Liaisons before submittal, and
4. Feedback as incentives to providers who submit a large number of valid surveys.

LAC-DMH surveyed Fee-For-Service (FFS) Hospital consumers twice in 2007. Staff sent a report to all FFS Hospitals after each of the two surveys were conducted. The reports included beneficiary responses to each question, an overall score, and a summary sheet showing the number of surveys returned by each hospital compared to the number of discharges. The Department encourages hospital administrators to use this information as part of their quality improvement efforts.

- 6. Respond effectively and in a timely manner to beneficiary grievances and fair hearings and submit bi-annual reports for further analysis and policy recommendations.**

EVALUATION

LAC-DMH achieved this goal.

The Department responds effectively and timely to consumer grievances and fair practice hearings. During 2007, consumers or family members requested 26 hearings. The outcomes were as follows:

- 5 were withdrawn by the client or family,
- 7 had a ruled outcome of request being "abandoned" (usually due to failure to

appear at the hearing with no further notification) resulting in the request being denied,

- 3 were deemed to be out of jurisdiction,
- 3 were resolved, and
- 8 were still pending at the time of this report

The LAC-DMH Patients' Rights Office submits timely reports to the state evidencing the receipt of 735 beneficiary grievances involving issues such as termination of services, denial of services, change of provider, quality of care and confidentiality. LAC-DMH has received and resolved a total of 735 grievances/appeals/SFHs, including 37 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. Below is a detailed description.

(Source: LAC-DMH Office of Patients' Rights; Annual Beneficiary Grievance/Appeal Report, Fiscal Year 2006/2007)

7. Monitor beneficiary requests to change service providers and take action when the number of resulting grievances increases from 12 to 25 per year.

EVALUATION

LAC-DMH achieved this goal.

Due to a low number of providers reporting in previous years, a thorough analysis could not be done regarding the reasons for the submission of the requests to change providers. This year, as a result of concerted efforts, there has been a significant increase in the number of providers reporting, and subsequent number of requests received. In comparing year-to-year reports for the 3rd quarter, there was an increase from 89 in 2006 to 254 in 2007; a 285% increase in the number of requests received. This increase is due, in part, to the importance of the reporting being underscored in each of the SA QIC meetings by the Co-Chairs and the QID staff. These reports are being analyzed to focus on the reasons for the requests and grievances, including those related to medications.

IV. CLINICAL ISSUES – EVALUATION OF GOALS FOR 2007

1. Continue current protocols for reviewing medication practices.

EVALUATION

LAC-DMH achieved this goal.

LAC-DMH continued to enforce and monitor current medication protocols. The Prescription Authorization and Tracking System (PATS) provides an electronic means to reduce medication errors and prevent fraud. PATS provides a current protocol that is observed effectively for all providers except fee for service network providers. Fee-for-service network providers' prescriptions for children must be approved by the court. LAC-DMH monitors and tracks this process using a separate database technology. The Department has hired and deployed supervising psychiatrists in directly operated clinics. The new staffing has made the use of peer review as a key medication decision quality control feasible for the first time. On a daily basis, the DMH Pharmacist reviews all medication requests that are outside the DMH formulary. The pharmacist decides if such requests are appropriate and if not, consults with the Medical Directors for adult, child or older adult services.

LAC-DMH Pharmacy Department has been actively engaged in the monthly Departmental QIC Meetings. Collaborative efforts are being made to identify the data available from the current electronic data system, and compare to the current identified needs for proper medication oversight and review

The Medical Director develops, updates and publishes parameters governing medication and health monitoring practices. Since persons taking antipsychotic medications may have an increased vulnerability to several general medical conditions, the Parameter For General Health-Related Monitoring And Interventions In Adults includes monitoring clients for weight gain, obesity, and diabetes. The Department has also published guidelines for the use of Psychotropic Medication for Children and Adolescents.

Although PATS is an older generation system, it monitors medication practices and identifies when prescribers are outside current parameters. It also provides prescribers with cues as to what is required for medication authorization. The LAC-DMH is currently exploring appropriate updates to the system that will yield improved medication management methods.

2. Monitor for occurrences of potentially poor quality of care through the Program Review process. Report such occurrences to District Chiefs, QI staff and executive management. When quality of care issues are

significant, report these occurrences to the County's Auditor-Controller for further review.

EVALUATION

LAC-DMH achieved this goal.

As a means of meeting statutory requirements, the County's Auditor-Controller is now conducting program reviews within the LAC-DMH system including clinical, administrative, programmatic, documentation, and other review components. The County's Auditor-Controller staff refers issues to the Service Area District Chief, the Deputy Directors and, if appropriate, the Director of Financial Services for appropriate action. In addition, the LAC-DMH QI Program has begun to review these reports to assess for opportunities for improvement in the mental health system. The LAC-DMH Program Review Unit continues to review for certification and re-certification for Medi-Cal.

There were 15 Program Reviews conducted during the reporting period. There were 52 Medi-Cal Certification Reviews and 46 Re-Certification Reviews. In addition, 344 Provider File Adjustment Requests (PFAR) were processed in 2007.

In addition, QI staff brings issues and problems to the attention of the Service Area District Chiefs for action and resolution, and to the LAC-DMH EMT, as appropriate.

A team comprised of staff from the Medical Director's Office, the Office of Patients' Rights and Program Review monitors the quality of care in hospitals. All questionable practices are brought to the attention of the Medical Director.

To accomplish this goal, QID staff participate on the membership of the Clinical Policy Committee, Risk Management Committee, Performance-Based Contracting Committee, STATS, the Provider Self-Assessment Committee, and the Policy Review Committee.

5. Implement the framework for Performance Based Contracting for all DMH contract human services providers and administrative contractors.

EVALUATION

LAC-DMH achieved this goal.

During 2007, LAC-DMH increased the scope of this goal to include contracts for human services for adults and older adults as well as children, and to include administrative contracts.

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During the reporting period, a working team comprised of operations management and QI staff developed a Charter for the performance contracting project. LAC-DMH adopted the Charter for implementation in August 2006.

LAC-DMH established an interdisciplinary implementation team with target completion dates in 2007. At the request of the Auditor-Controller, LAC-DMH expanded the framework to include all LAC-DMH social services and administrative contracts. Over the past year, the work group consisting of Department's personnel, contract provider representatives, and the Auditor-Controller met to determine: specific performance outcome measures to be used, guidelines for effective administration of performance outcomes, and strategies for ensuring a constant quality improvement environment for both directly operated and contracted providers.

In December of 2007 LAC-DMH hosted a Performance-based Contracting Informational Session. Representatives of legal entities contracting with LAC-DMH were invited, along with DMH Executives and District Chiefs who oversee contracts. The purpose was to inform all providers of the measures, criteria, requirements, process and timeline for implementing performance-based mental health service contracts.

V. MONITORING CONTINUITY OF CARE – EVALUATION OF GOALS FOR 2007

1. **Continue to evaluate the effectiveness of the MOUs with the Regional Centers, the Department of Children and Family Services, and other human service agencies through liaison meetings and through identification of issues within the Service QICs.**

EVALUATION

LAC-DMH achieved this goal.

LAC-DMH has Memoranda of Understanding (MOUs) with:

1. Seven (7) Regional Centers for the Developmentally Disabled;
2. Medi-Cal Managed Care health plans;
3. Los Angeles Unified School District;
4. County Department of Children and Family Services (DCFS);
5. County Department of Public Social Services; and
6. Probation Department.

LAC-DMH assigns staff to work with agencies that are parties to the MOUs. Los

Angeles County also manages a number of children's collaboratives that are not formally included in the MOUs. In these cases, LAC-DMH assigns staff to identify issues and address problems in collaboration with other agencies.

Department staff represents the County at the State Mental Health Developmental Services Collaborative, where County and State issues are addressed and resolved.

During 2007, the Service Integration Branch of the County Administrative Office (CAO) developed and implemented an Operational Agreement between the CAO, the Departments of Children and Family Services, Mental Health, Probation, and the seven Los Angeles Regional Centers. On September 27, 2006, the CAO and Regional Centers convened a Countywide meeting attended by 100 upper level management staff of Regional Centers, DCFS, LAC-DMH, and juvenile and adult Probation. The purpose of the meeting was to discuss the Operational Agreement and strategies for assuring that the terms of the Agreement are implemented at the local level. Workgroups in LAC-DMH Service Areas meet to discuss issues related to delivering service to specific clients, strategies for improved collaboration, and case presentations. These meetings serve to ensure that all LAC-DMH directly operated and contract providers are aware of and compliant with the specifics of the Operational Agreement.

Both the State Collaborative and the County workgroup are focusing on the needs of clients who require psychiatric hospitalization. In September 2005, a new unit was established at one of the private psychiatric hospitals that continued to function in 2006. This unit works with clients that require placement options that address voluntary and involuntary hospitalization, living arrangements for up to 120 days, and medication titration and crisis beds for providers of day programs, independent/supported living placements and parents. LAC-DMH expects this facility to provide for the intensity of psychiatric and other supportive services needed by a certain segment of adults with a developmental disability and mental illness.

2. Continue to review and analyze data quality to improve utilization of data for planning and decision-making.

LAC-DMH achieved this goal.

The Department has established several workgroups to initiate dashboards and a Citi-STATS project. The Department has also implemented a number of improvements to its data collection and reporting technology to incorporate the Client and Services Information changes mandated by SDMH and the SAMHSA Data Infrastructure Grant. QI staff, the QICs and the Quality Improvement Division will continue to focus on data quality improvements during 2008.

**VI. MONITORING OF PROVIDER APPEALS –
EVALUATION OF GOALS FOR 2007**

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

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’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.

EVALUATION

LAC-DMH achieved this goal.

Table 12 summarizes the levels and disposition of appeals during the period 2004-2007.

Table 12: Level and Disposition of Authorization Appeals

Year / Level	Day Treatment	TBS Authorization	Network	Total Appeals
2004				
First Level	6	4	0	10
Second	0	0	0	0
2005				
First Level	1	2	0	3
Second		1	0	1
2006				
First Level	1	1	0	2
Second	0	0	0	0
2007				
First Level	1	2	0	3
Second	0	0	0	0
Totals	9	10	0	19

Source: Provider Relations Unit, Medi-Cal Managed Care Division, County of Los Angeles Department of Mental Health

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 ten in 2004 to a total of 3 year-to-date in 2007. For 2007 there were no informal or second level appeals. No network provider had filed an appeal of LAC-DMH psychological testing, but there were 16 appeals of over-threshold authorization decisions.

Section 3

PLANNED ACTIVITIES FOR 2008

LAC-DMH has endorsed the performance outcome measures recommended in 2007 by the Performance-Based Contracting Workgroup. These measures reflect three (3) domains of critical importance to our system of mental health services: Access to Services, Customer Satisfaction, and Clinical Effectiveness. During calendar year 2008, we will collect baseline data and further develop the infrastructure to support performance outcome measurement. The Department's Integrated System (IS) will be the data source for Access to Services domain's operational measures. The State Department of Mental Health's (DMH) Consumer Perception Survey will be the data source for the Customer Satisfaction and Clinical Effectiveness domains. These performance outcome measures have been integrated into the QI Work Plan for 2008 and are identified below. The QI Work Plan for 2008 and the Performance Based Outcomes are inclusive of directly operated and contracted providers.

MONITORING SERVICE DELIVERY CAPACITY

MONITORING SERVICE DELIVERY CAPACITY - GOALS FOR 2008

1. Utilize data to measure improvement in penetration and retention rates of ethnic populations with low penetration and retention rates. Goal for 2008 will focus on improving the service delivery capacity for the Latino and Asian populations, which have had a low penetration rate historically.
2. To design effective services for identified underserved ethnic populations. Involve the different underserved communities in the planning and development of specific strategies that are responsive to these communities' interests and needs.
3. Initiate the "Next Steps" of the interpreter training outcomes developed as a result of the completed 2 year Latino Access Study. The final report of the Latino Access Study is pending. The goal of the Quality Improvement Work Plan is to work closely with the Cultural Competency Division, and implement at least two of the study's final recommendations during 2008. Other recommendations will also be prioritized and followed up in subsequent work plans.

MONITORING ACCESSIBILITY OF SERVICES

MONITORING ACCESSIBILITY OF SERVICES – GOALS FOR 2008

1. Improve access to after-hours care of PMRT response time of one hour between PMRT acknowledgement of the call to PMRT arrival on the scene. The improvement is to be from an overall annual response rate of 74% in 2007 to an overall annual response rate of 75% in 2008.
 2. Decrease the number of abandoned calls (responsiveness of the 24 hour toll free number) to an overall annual rate of 10%. Continue the downward trend noted in the 3rd and 4th quarters of 2007.
 3. Improve the rate of responding clients who were able to receive services at convenient times and location. The baseline data will be obtained from the Performance Based Outcomes Measures.
-

MONITORING BENEFICIARY SATISFACTION

As part of the performance outcome project, the Department administers the State 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. The Performance Outcome Survey administered in May 2007 resulted in 15,523 responses. Those for November 2007 were 15,679.

MONITORING BENEFICIARY SATISFACTION - 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. The surveys are to be used as source data for the Customer Satisfaction and Clinical Effectiveness domains for Performance Based Outcomes Measurement. During 2008, the data collected will serve as baseline data. A pilot project will be implemented 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. The baseline data will be obtained from the Performance Based 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. Since November 2004, the satisfaction rates have been consistent within age groups. As the survey data is collected for baseline Performance Based Outcomes Measures, further analysis will be completed to identify future potential quality improvement items.
4. 90% or more of respondents agree that written materials are available in their preferred language. This data has been used to provide trending data for cultural competency concerning this measure.
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 the beneficiary requests to change service providers. Monitor and report on the reasons given by consumers for their request to change service provider.

CLINICAL ISSUES

MEDICATION MONITORING

Work with the Office of the Medical Director and Pharmacy Dept. to identify areas for improvement in medication monitoring and safety. A QI medication monitoring work group has been created to help identify medication protocols.

PERFORMANCE BASED CONTRACTING

The Department has developed the framework for Performance Based Contracting with implementation effective 1/1/2008. Over the past year, a work group consisting of

Department's personnel, contract provider representatives, and the Auditor-Controller has met to determine:

- Specific performance outcome measures to be used;
- Guidelines for effective administration of performance outcomes; and
- Strategies for ensuring a constant quality improvement environment.

Additionally, several workgroups have been formed to identify which Evidence-Based Practice (EBP) might be utilized, how agencies will identify which EBP are being used by staff, and how these practices will effect contracting processes. During calendar year 2008 the following plan is to be implemented:

- Accumulate baseline outcomes data;
- Refine performance outcome measures including the percentages to be employed in order to help us measure success;
- Develop for future implementation incentives and sanctions associated with the performance based outcomes;
- Make adjustments to the performance outcomes program as appropriate based upon the data analysis; and
- Plan the steps to be taken beginning calendar year 2009.

MONITORING CLINICAL ISSUES - GOALS FOR 2008

1. Improve current protocols for reviewing medication practices.

Specific areas for quality improvement will be identified by a work group that will include representation of the appropriate bureaus and divisions within the department. Implementation of work plans developed will be coordinated through the work group.

MONITORING CONTINUITY OF CARE

MONITORING CONTINUITY OF CARE - GOALS FOR 2008

Data collection to establish a baseline for the Performance Based Outcomes Measurement will allow for monitoring continuity of care 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 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's relation specialist to track and coordinate resolution in an efficient and timely manner. The provider relations specialist documents all disputes in a log and tracks and coordinates dispute resolution.

MONITORING OF PROVIDER APPEALS - GOAL 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.

APPENDIX 1

Description of expanded MHSA Programs and Service Delivery Capacity

- **Family Support Services for Children**
Family Support Services provide access to mental health services for parents of Seriously Emotionally Disturbed (SED) children. These services continue to be implemented concurrently with the FSPs.

- **Children's Integrated Mental Health/COD Services**
During the first year, the focus has been on intensive training for FSP treatment teams to ensure COD competence

- **Children's Family Crisis Services- Respite Care**
This service provides needed in-home supportive care for families providing constant care for SED children

- **TAY Housing Services: Housing Specialists**
Housing Specialists assist in securing housing for TAY consumers, who often have no history of living independently. This program is currently comprised of six Housing Specialists. In collaboration with the Department's Adult Systems of Care (ASOC) and Training Bureau, in June, 2007, staff participated in the First Annual Housing Specialists' Training Institute's series of trainings. The topics in the trainings included the Recovery Model; Linkage between PTSD and Substance Abuse; Crisis Intervention with Suicidal Individuals in the Field; Field Safety; Effective Housing Placement and Retention; American Disabilities Act (ADA), Fair Housing, Reasonable Accommodations; Tenants Rights; and Administering Emergency Shelters. Additional trainings are being planned for Fiscal Year 2007-2008.

- **TAY Drop-In Centers**
Request for Services (RFS) #12 for TAY Drop-In Centers was approved and released on February 9, 2007. Scoring was completed, and at the end of June, 2007, the Department was in the process of making final decisions regarding award recommendations. Two TAY Drop-In Centers are planned to be running by December, 2007.

- **TAY Housing Services Emergency Housing Vouchers**
The TAY Housing adhoc workgroup developed a plan for an Enhanced Emergency Shelter Program for SED/SPMI TAY. The program addresses basic

needs (e.g. food, clothing, and shelter) in addition to enhancements that may include other support services.

- **TAY-Housing Services Project-Based Subsidies**

The TAY Housing Services Project-based subsidies provide operating subsidies that assist eligible SED/SPMI TAY clients in securing permanent housing. Between January and June, 2007, The Department formalized its collaborative partnership with the Los Angeles County Community Development Commission (CDC), whose role is to manage a portion of the funding made available by the Board of Supervisors through the Homeless Prevention Initiative (HPI). The MHSA TAY Project-Based operating subsidies are leveraged through the HPI Homeless and Housing Program Fund Request for Proposal (HHPF-RFP).

- **TAY Probation Services**

Request for Services (RFS) #13, Probation Camp Services, was approved and released on February 9, 2007. The consensus scoring process was completed in May 2007. Award recommendations were completed and approved by the Department's Executive Management Team (EMT), at the end of Fiscal Year 2006-2007. The following agencies were awarded: San Fernando Community Mental Health Centers, Inc; Gateways Hospital and Mental Health Center; and Associated League of Mexican Americans (ALMA).

- **Adult Wellness/Client-Run Centers**

There are now 21 Wellness Centers and 8 Client-Run Centers. Contract and directly operated providers are in the process of hiring staff and finding locations for these programs. Programs are identifying clients who are ready to transition to Wellness Center services and developing engagement strategies for those clients who require additional time to make the transition. Consumers are beginning to consider employment and education as viable, achievable options in their lives. Similarly, mental health professionals are adopting greater understandings of recovery. In one case, a supervising social worker has developed a collaborative of staff hired for Wellness Centers with the goal of increasing staff exposure to various program and operational models of service. Monthly provider meetings initiated in May have focused on core service strategies and providing services in the field while new sites are being located. By virtue of the fact that Wellness and Client-Run Centers employ trained, recovered consumers as peer advocates, transformation is occurring.

- **Adult IMD Step-Down Facilities and Alternative Crisis Services-Enriched Services**

LAC-DMH has implemented four Institutions for Mental Disease (IMD) Step-down Facilities and one Enriched Services program. The programs are: Percy Village I and II; Normandie Village; Telecare Atlas Step-Down Program; and SSG IMD

Step-Down Program. These programs provide supportive on-site mental health services and limited operational costs for 165 individuals at selected licensed Adult Residential Facilities, and in some instances, assisted living, congregate housing, or other independent living situations. The programs serve persons being discharged from IMDs, acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care. These programs target individuals in higher levels of care who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent living. Programs are designed to break the cycle of costly emergency and inpatient care and promote successful community reintegration. As of June 2007, 93 individuals were served and moved to less restrictive levels of care.

- **Adult Housing Specialists**

On June 18, 19, & 20, 2007, DMH conducted the Housing Specialist Training Institute for the recently hired DMH Countywide Housing Specialists and the housing specialists hired in the directly operated and contracted Full Service Partnership Programs. The 3-day Institute was an overwhelming success with an average daily attendance of approximately 87 participants. The initial review of training evaluations indicates that the Institute was well received by all attendees. The housing specialists are outreaching to property owners/landlords to develop new housing resources for clients. They are also assisting clients with finding affordable and safe places to live and applying for housing subsidies such as Shelter Plus Care and Homeless Section 8.

- **Adult Jail Transition and Linkage Services**

The Adult Jail Linkage Program has been fully operational for the period between January and June 2007. The Jail Linkage Program has received approximately 900 referrals 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 is working 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.

- **Adult Supportive Housing Services Safe Haven**

The Safe Haven Transitional Housing Program provides housing for adults who are chronically homeless and have been unable or unwilling to seek treatment or housing due to their psychiatric disorder. Development of the program was coordinated with the County's interdepartmental process to address homelessness through the implementation of the Homeless Prevention Initiative. The Request for Proposals for the Homeless and Housing Programs, a

component of the Homeless Prevention Initiative, was released July 17, 2007 which included the Safe Haven Transitional Housing Program. It is anticipated that a contractor will be selected and a contract entered into by early 2008, upon the Board's approval.

Housing Trust Fund

In early 2007, the Director of LACDMH, Marvin J. Southard, DSW, appointed a Housing Trust Fund (HTF) Advisory Board composed of stakeholders, including consumers, family members, other city and county housing departments, county departments and homeless and housing community advocates. The purpose of the HTF Advisory Board is to provide recommendations to the Department regarding housing issues related to MHSA funding. The Advisory Board has developed and recommended funding criteria and principles for the \$11.5 million allocated in the Community Services and Supports Plan for supportive services and operating subsidies.

- **Older Adult Training**

Between January 1st and June 30th, 2007, a 5-pronged Older Adult training program was implemented which included: 1) Retraining existing mental health professionals through a certificated older adult training program (96 hours); 2) Service extender training program (Service Extenders are peer counselors and family advocates that work with interdisciplinary teams to reduce older adults' social isolation); 3) DMH and contract older adults specialty training; 4) Ancillary training for community partners such as Adult Protective Services, law enforcement, etc.); and 5) System navigator training. Training was conducted on the following topics: Service Extender Provider Training the Trainer (5-day intensive training in April, 2007); Mental Health – Health Collaborative Model; Recovery Model Retreat; and Faith-Clergy Leaders and Older Adults (2 sessions).

- **Older Adult Field Capable Clinical Services (FCCS)**

The Field Capable Clinical Services (FCCS) Program for Older Adults is the first system-wide, service area-based clinical program in the Department focused exclusively on older adults, ages sixty (60) and above. FCCS will build the capacity of DMH to serve this significantly underserved population with specifically trained professional and paraprofessional staff working together as part of a multi-disciplinary team. A minimum of sixty percent (60%) of the services are provided outside the traditional mental health clinic in field-based locations often preferred by older adults, such as clients' homes, senior centers, senior public housing complexes, or primary care provider offices. Between January 1, 2007 and June 30, 2007, 130 clients were served by FCCS. FCCS represents a critical component in the development of a continuum of care for

older adults. FCCS orientation meetings were held in May, 2007 for the DMH directly-operated and contract agencies.

- **Older Adult Service Extenders**

Service Extenders are peers in recovery or family members who are working as a part of Field Capable Clinical Services teams to provide support and serve as “bridgers” to the FCCS clients, especially for those who are isolated. This is a stipend program, and volunteering is also welcomed. Funding for service extender stipends were approved as part of the Board Action on FCCS programs. It is anticipated that service extenders will be recruited once training has been provided in Fiscal Year 2007-08.

Older Adults Training

As part of the Older Adult training plan adopted by the older adults stakeholders, the following are highlights of the older adult training implemented during this reporting period:

(1) Completion of provider solicitation and selection through the Department’s Request for Service (RFS) process to develop a curriculum and provide two repeated certificated 96-hour older adult training programs. The selected training agency is Center for Healthy Aging (CHA). Training has been targeted for implementation in Fiscal Year 2007-08.

(2) A five-day immersion training to staff who were interested or hired to provide mental health services to MHSA funded older adult programs

(3) Completion of the second repeated five-day “training the trainer” course on service extenders.

- **Alternative Crisis Services: Urgent Care Centers**

Urgent Care Centers (UCC), which are geographically located, provide intensive crisis services to individuals who otherwise would be brought to emergency rooms. The UCC focus is on recovery and linkage to ongoing community services and supports, and are designed to impact unnecessary and lengthy involuntary inpatient treatment, as well as promote care in voluntary treatment settings that are recovery-oriented. LAC-DMH has implemented two directly operated UCCs and one contracted UCC, which opened in December 2006. These include Augustus F. Hawkins UCC; Olive View Urgent Community Services, and Westside Urgent UCC. 2,201 clients have been served through these Urgent Care Centers. A Crisis Resolution Services program has been approved by the Board of Supervisors in March 2007 and is being implemented at Downtown Mental Health Center. An additional UCC is currently under development for Los Angeles County /University of Southern California Medical

Center with implementation planned for October 2007. The Urgent Community Services Project is not yet LPS designated, and is currently co-located with a directly operated clinic and only operates during clinic hours. As a result, referrals are received from the Olive View psychiatric emergency room, rather than diverting the clients by having them come in directly. We will not have that capacity until a permanent site is built for the urgent care services.

- **Alternative Crisis Services: Countywide Resources**

Countywide Resource Management (CRM) has centralized and provided overall administrative, clinical, integrative, and fiscal management functions for the Department's acute inpatient program for uninsured children and adults; adult/older adult long-term institutional, crisis residential, intensive residential and supportive residential resources; the Interim Fund program; and Residential and Bridging Services.

Under MHSA, CRM implemented four Institutions for Mental Disease (IMD) Step-down Facilities and the Enriched Services that serve 165 individuals being discharged from higher levels of care. CRM has overseen the transition of approximately 5,667 clients between higher levels of care and community-based services and supports over the past six months.

- **Alternative Crisis Services: Residential and Bridging**

Psychiatric social workers and peer advocates assist in the coordination of psychiatric services and supports for TAY, adults and older adults with complicated psychiatric and medical needs who are being discharged from County hospital psychiatric emergency services and inpatient units, IMDs, crisis residential, and intensive residential programs. The program ensures linkage to appropriate levels and types of mental health and supportive services through collaboration with Service Area Navigators, FSPs, residential providers, self-help groups, and other community providers. Peer advocates provide self-help support groups in IMDs and intensive residential programs to support individuals successfully transitioning to community living. The program has participated in the transition of 5,591 clients over the past six months.

- **Service Area Navigators**

Service Area Navigators are responsible for developing community partnerships that result in a community network that addresses the needs of individuals and families with mental illness. This involves outreach and engagement to the community, linking individuals and families to appropriate mental health services, oversight of client enrollment into Full Service Partnership (FSP) Programs and consultation on available mental health resources.

Key activities during this period have been overseeing the enrollment of clients into FSP Programs and linking community members with services to meet their

mental health needs. Navigators have responded to a variety of needs of community members including referrals for mental health services, housing, general information about DMH and our services, clinical consultation, and working through barriers that prevent clients from receiving services.

60% of the sixty Child, Adult/Older Adult Service Area Navigator positions have now been filled. While most navigators are focused primarily on authorization of FSP clients, navigation activities also include mental health promotion in various communities and MHS provider support and monitoring. Between January and June 2007, 3,270 referrals were made by Child, Adult/Older Adult Service Area Navigators to Mental Health Services.

In January and February, Navigators participated in "Navigator Boot Camp", two day-long training sessions focused on mental health and ancillary services, including the mental health court program, homeless and housing resources, benefits establishment services, hospital and other institutional programs. Navigators spend the bulk of their time developing community partnerships and networks, outreaching and engaging clients to bring them into the mental health system and providing consultation about mental health resources available in our system that can assist consumers.

From January through June 2007, the TAY Division focused on growing its countywide Navigation Team. During this reporting period the TAY Navigation Team grew in number to thirteen (13) team members comprised of one (1) Supervising Psychiatric Social Worker, six (6) System Navigators, and six (6) Housing Specialists. Additionally, the TAY Division added a Program Head to manage all TAY Navigation Team activities.

The TAY Navigators bring with them diverse backgrounds and work experiences. For example, the TAY staff has expertise in working with the juvenile justice system, the Department of Children and Family Services, Probation, family counseling services, medical and psychiatric hospitals, and the adult jail system. The TAY Navigation Team is represented by a variety of ethnic backgrounds and cultures, including Asian/Pacific Islander, Latino/Hispanic American, African American, Armenian, Caucasian, Costa Rican, and Cuban American. Languages spoken include English, Spanish, Mandarin, Taiwanese, Armenian, Farsi, Russian, German, and Yoruba (an African language).

The TAY Navigation Team continued to actively participate in the FSP referral screening and disposition processes, in collaboration with the Service Area Impact Unit Coordinators. During the reporting period, the TAY Navigators conducted outreach and engagement, screenings, research, and/or resource linkages on over 200 case referrals.

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Finally, the TAY Navigation Team continued to conduct MHSA outreach presentations in collaboration with Service Area Navigators, Outreach Specialists, and FSP providers to promote knowledge about MHSA and increase utilization of the FSP programs. Outreach activities have been conducted at a variety of sites, including Edelman Children's Court, local colleges, and mental health conferences.

APPENDIX 2

These expanded services and activities have been implemented and are designed to improve Accessibility of Services within LAC-DMH. They include Outreach and Engagement, Cultural Competency, and activities to engage Under-Represented Ethnic Populations.

Outreach and Engagement

The main objective of Outreach and Engagement is to effectively initiate transformation by increasing MHSA awareness to unserved, underserved, and inappropriately served populations and Under-Represented Ethnic Populations (UREP), across all eight (8) Service Areas. Between January 1 and June 30, 2007, LACDMH Outreach and Engagement staff outreached and engaged over 18,750 people throughout Los Angeles County.

Consumers, family members, parents, and caregivers were given the opportunity, through a series of three orientation trainings, to not only increase their understanding of MHSA, but also to increase their skill development and involvement. These trainings addressed MHSA, information pertaining to SAACs and Service Areas, and Meeting Decorum. In addition, outreach and engagement efforts are ongoing to promote the inclusion of consumers, family members, parents, and caregivers in the process to increase MHSA awareness to UREP and unserved, underserved, and inappropriately served communities.

MHSA outreach and engagement staff has:

- Attended a Mental Health Conference for Faith-based leaders sponsored by the National Endowment where over 200 Clergy and Faith-based organizations were in attendance. (Service Area 4, Supervisory District 1)
- Participated in a Health Fair sponsored by Supervisor Michael Antonovich, 5th District, attended by more than 250 community members, consumers, and family members. (Service Area 2, Supervisory District 5)
- Attended a Resources Event at La Casita Treatment Shelter for women recovering from addiction attended by Supervisor Don Knabe, 4th District, and Kirk Cartozian, Downey City Councilmember. (Service Area 7, Supervisory District 4)
- Participated in a City of Beverly Hills Human Services Roundtable discussion on how to better serve at-risk populations, attended by clergy, faith-based organizations and other county and city departments. (Service Area 5, Supervisorial District 3)
- Provided MHSA information and training to 70 employees in the City of Hawthorne, including the Hawthorne Police Department. (Service Area 8, Supervisorial District 2)

- Established working relationships with local neighborhood councils and community leaders by providing them with educational materials and information about MHSA services. Outreach and engagement efforts are focused on increasing awareness to reduce stigma, countering Nimby-ism, and integrating consumer and family member feedback into the planning process for transformation of our mental health system. (Countywide)
- Provided MHSA informational handouts at the Valley College Youth Summit in Van Nuys attended by over 400 student leaders, TAY and children. (Service Area 2, Supervisorial District 3)
- Participated in the "Remembering Our Veterans" resource fair. (Service Area 3, Supervisorial District 5)
- Outreached to disabled students at Cal State University, Long Beach's Disabled Student Services and Counseling Center (Service Area 8, Supervisorial District 4).
- Participated in a Women's Health Fair in Lancaster attended by over 300 individuals (Service Area 1, Supervisorial District 5)
- Attended a Westside Faith Leaders Collaboration on Mental Health (Service Area 5, Supervisorial District 3).

Between January 1 to June 30, 2007, LACDMH Outreach and Engagement staff has:

- Continued to support countywide stakeholder meetings attended by approximately 200 consumers, family members, mental health professionals, service providers, LACDMH line staff and management, faith based organizations and various community leaders.
- Increased awareness at Service Area Advisory Committee meetings in all eight Service Areas.
- Worked with the Office of Consumer Affairs, the Client Coalition, Project Return, NAMI, and families to engage and increase consumer participation in the planning and implementation processes.

Under-Represented Ethnic Populations (UREP)

During the initial planning process for the CSS Plan, the UREP Workgroup had met extensively to develop guiding principles and recommendations for DMH and MHSA services. These recommendations were instrumental in establishing the Department's MHSA values and strategies in working with under-represented ethnic groups. In June, 2007, DMH established an internal UREP workgroup unit within the Planning Division to address the ongoing needs of targeted ethnic and cultural groups. The UREP unit has established sub-groups dedicated to working

with the various under-represented ethnic populations in order to address their individual needs. These groups are: African; Asian/Pacific Islander; Eastern European/Middle Eastern; Latino, American-Indian.

Homeless Outreach and Mobile Engagement (HOME) Team

Appropriation of MHSA funds for the Homeless Outreach and Mobile Engagement (HOME) Team was approved by the Board on March 6, 2007. During the four month period from March – June 30, 2007, the HOME Program (1) recruited and hired two of the eleven allocated staff (2) trained staff on homeless outreach, engagement, linkage and recovery model (3) developed outcome measures and outreach/linkage tracking documents (4) met with 15 community agencies and County programs to begin the process of collaborating on outreach and engagement (5) conducted street outreach to over 400 homeless persons in Skid Row through the Safer City Initiative.

The HOME program will extend its street outreach to other areas of LA County, including a permanent team in Antelope Valley and will continue collaborating with local agencies on homeless outreach and engagement.

Outreach Efforts

Engaging target populations and communities was accomplished by participating in forum discussions on domestic violence at schools and supporting local NAMI meetings and activities throughout the County. Partnerships and collaborations with other County departments (such as Probation, Department of Children and Family Services, District Attorney's Office, and Department of Public Social Services), and educational institutions and school districts (Whittier Union High School District, Los Angeles Unified School District, and Cal State University, Northridge) are vital to the work of the Outreach and Engagement staff.

Involving specifically targeted populations in the MHSA planning and system transformation is the charge of the Outreach and Engagement staff. Staff is assigned to each Service Area, including a Mental Health Services Coordinator paired with a consumer or family member Community Worker. Outreach and engagement efforts have focused extensively on establishing communication with local neighborhood councils and community leaders. These efforts are aimed at increasing awareness about mental health to reduce stigma, and integrating consumer and family member feedback into the planning process for transformation of our mental health system. Service Area staff have outreached to the following targeted underserved and ethnic populations: African American,

Armenian, Asian, Egyptian, faith based organizations, hearing impaired (using American Sign Language), Hispanic/Latino, homeless, Indian, Iranian, Korean, Russian, older adults, TAY, Gay, Lesbian, Bisexual, and Trans-gendered individuals, probation youth, and foster care youth.

Cultural Competency

Cultural competence goals in all aspects of program design, administration and service delivery have included the following activities:

- Conducted and participated in conferences on Hope and Recovery: Empowering Our Lives; a Countywide Multicultural conference, and The African American Conference: Best Practices in Providing Culturally Competent Mental Health Services to Persons of African Heritage.
- Offered training to all FSP mental health staff addressing the following diversity and unlearning prejudice; Geriatric Field Capable Screening Protocol; Assessment and Treatment of the Elderly in a Mental Health Setting; Integration of Spirituality in Clinical Practice and Recovery Model; How to be an Interpreter; How to use an Interpreter; Embracing Recovery Mental Health Providers and Faith Leaders Working Together, Shifting to the Culture of Recovery.
- Sponsored and coordinated various activities to partner with the faith-based/spiritual community. The Annual conference for Faith-Based Leadership on Fighting Stigma was held on May 21, 2007 at the California Endowment's Center for Health communities. The Westside Faith Leaders Collaboration on Mental Health in Service Area 5 conducted a workshop and an open forum on May 10, 2007. The purpose of the event was to provide the participants with the mental health resources available and to gather data on the mental health needs of their communities.
- Piloted a program in Service Area 2 for older adults diagnosed with depression and diabetes from different ethnic/racial heritage including Latinos, Armenians, and Pacific Islanders.
- Coordinated several services and activities to ensure the inclusion of the consumers, family members, and caregivers representing the diverse population of the Los Angeles County. One such activity was to reconvene the Under-represented and Underserved Population (UREP) Workgroup to clarify their issues for CSS Implementation, WET and PEI planning and implementation.

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- Provided Spanish translation for pertinent written materials distributed at all stakeholders' System Leadership Team meetings, and MHSA presentations and/or events. Also provided interpretation and supports for consumers, family members, parents, and caregivers at these events.
- Began translating the Beneficiary Medi-Cal Guide into Arabic (Thirteenth threshold language).

APPENDIX 3

Draft of Cultural Competency Work Plan

**Cultural Competency Work Plan Evaluation for Fiscal-Year 2006-07
&
Work Plan for Fiscal-Year 2007-08**

The Cultural Competency Work Plan is developed by the Cultural Competency Unit. The Unit has undergone a restructuring within the past year and is currently a part of the Planning Division under the Program Support Bureau.

Cultural Competency Work Plan Goals for 2006-07:

1. Evaluate the results of the two (2) year Latino Access study and incorporate the recommendations to improve access.
2. Reassess the system to evaluate the Department's ability to provide culturally and linguistically appropriate services based on the analysis of the population served and the providers.
3. Continue to develop appropriate infrastructures to capture and aggregate accurate data on staff by ethnicity, language, and discipline Countywide and by service area including bilingual staff and interpreters.
4. Reassess the progress made by the organization toward cultural competency.

New Goal for 2006-07:

5. Integrate cultural competence goals in all aspects of program design, administration and service delivery.

Work Plan Goals Evaluation:

1. As part of the Department's contract with the State Department of Mental Health, counties with populations over 10,000 are required to conduct a Latino Access Study. The LAC-DMH and the University of Southern California have been collaborating on a pilot study to evaluate interpreter training outcomes. Information from the pilot study will serve to address current strategies to increase the cultural competence of public sector mental health providers. The study is intended to evaluate the effectiveness of interpreter training programs provided to the staff who either serve as

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interpreters in public sector mental health settings or who utilize interpreters in the provisions of mental health care. The objectives of the current training programs provided by the Training Division, are intended to enhance the knowledge, skills and attitudes of bilingual staff and non-bilingual providers from County-operated, county-contract or other service

providers in mental health settings.

This pilot study collected data on 120 participants using semi-structured questionnaires (on site pre-and post-test) and open-ended interviews (3-month telephone follow-up).

The results indicate that the countywide training "Lost in Interpretation" was an effective tool in increasing the knowledge, skills and attitudes of persons providing interpretation services in Los Angeles County public sector mental health programs. Overall, participants significantly improved their knowledge, skills, and attitudes from baseline to post-test. Qualitative data derived from the post-test and three-month interviews indicate high satisfaction with the course and instruction strategies, success with implementing new knowledge and skills in the workplace, and positive effects on consumers.

The final report on the study is in progress. Plans for specific training for Spanish-language interpreters, for monolingual providers, and for booster sessions for those who completed the training are some of the future steps that will be recommended as a result of this study.

2. To plan for the workforce assessment, the Department collected feedback and input on workforce needs from its stakeholders in the different eight service areas. Feedback was provided during focus groups, stakeholders meetings, and the Underrepresented Ethnic Populations (UREP) workgroups.
3. The Cultural Competency Unit, is, on an on-going basis, collaborating with the Department Data Unit to create the infrastructure needed to aggregate accurate data on staff and consumers by ethnicity and language Countywide and by service area including interpreters.
4. The Department developed a proposal including the funding needed to initiate the second phase of the qualitative data collection of the cultural competency organizational assessment.
5. The Department sponsored and coordinated various activities to Integrate cultural competence goals in all aspects of program design, administration and service delivery. The following are examples of these activities:

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- Developed strategies and procedures in partnership with different universities including California State – Los Angeles University and Southern California University to facilitate the recruitment and hiring of bi-lingual and bi-cultural mental health professionals.
- Piloted a program in Service Area 2 for older adults diagnosed with depression and diabetes from different ethnic/racial heritage including Latinos, Armenians, and Pacific Islanders.
- Collaborated with different community-based agencies and participated in various events to promote mental health awareness. Examples of these events include Service Area 3 participated in a campus health fair at Mount San Antonio College, and a resource fair in collaboration with the Foster Kinship Program at Pasadena City College.
- Coordinated various services and activities to ensure the inclusion of the consumers, family members, and caregivers representing the diverse population of the Los Angeles County. One of the activities was to reconvene the Under-represented and Underserved Population (UREP) Workgroup to clarify their issues for the Community Services and Support (CSS), the Workforce Education and Training (WET), and PEI planning and implementation.
- Provided Spanish translation for pertinent written materials distributed at all stakeholders, System Leadership Team meetings, and MHSA presentations and/or events.
- Provided interpretation and support for consumers, family members, and caregivers in attendance at all stakeholders, System Leadership Team meetings, and MHSA presentations and/or events when needed.
- Allocated the necessary funds to translate the Beneficiary Medi-Cal Guide in the Arabic Language.

Cultural Competency Work Plan Goals for 2008:

1. Implement, at a minimum, two of the Interpreters study's recommendations to (check with training Division).
2. Assess the Department's workforce to evaluate its capacity to deliver relevant and effective services to the culturally and linguistically diverse communities.
3. Develop effective recruiting, hiring, and retaining strategies to increase bilingual and bicultural staff capacity.

4. Assess the culture competency of the organization to evaluate the progress made toward cultural competency.
5. Continue to integrate cultural competence goals in all aspects of program design, administration and service delivery.

New Goals:

6. Involve the different underserved/underrepresented communities in the planning and the development of specific strategies that are responsive to these communities' interests and needs. The goal is to increase access and design effective services for the under-represented ethnic populations (UREP).
7. Develop the infrastructures necessary to support accurate and effective communication with consumers, family members, caregivers, and providers.

Planned Activities for 2008:

1. Two of the future steps recommended by the study will be implemented a) Conduct focused training for Spanish-Language interpreters as they comprise 80% of the study sample, and b) conduct booster sessions for staff who have taken the initial course.
2. Conduct a workforce and training assessment. The assessment will provide a quantitative and qualitative data that will be utilized to evaluate the Department's capacity to deliver relevant and effective services to the culturally and linguistically diverse communities.
3. The findings of the workforce and training assessment will be utilized in designing effective recruiting, hiring, and retaining strategies to increase bilingual and bicultural staff capacity and enhance staff culture competency.
4. Conduct a culture competency organizational assessment. The assessment will collect quantitative and qualitative data to evaluate the progress made toward cultural competency.
5. The Department established five (5) workgroups representing the following Underrepresented Ethnic Populations: 1) the African/African Americas, 2) the American Indians, 3) the Asian Pacific Islanders, 4) the Easter European/Middle Easterns, and 5) the Latinos. The Department will be working with these workgroups to obtain their input as they plan, design, and deliver culturally and linguistically appropriate services.

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6. To ensure the inclusion of the consumers, family members, and caregivers representing the underserved/underrepresented diverse population of the Los Angeles County, the Department established five UREP ethnic subcommittees. These subcommittees represent the African American/African Refugees, The American Indian, The Asian Pacific Islanders, The Latino, and the Eastern European/Middle-Eastern ethnic groups. The subcommittees will assist in system transformation by engaging their

members in the planning for the Workforce Education and Training (WET) and the Prevention and Early Intervention (PEI) plans.

7. To support accurate and effective communication with consumers, family members, caregivers, and providers, the Department will: a) Translate consumer informing written materials in the 12 threshold languages including consumer satisfaction surveys, at an appropriate reading level (5th grade), b) establish a mechanism to ensure language and culture accuracy of translated materials.

Compiled by Nahed Guirguis.12.21.07

APPENDIX 4

QUALITY IMPROVEMENT WORK PLAN GOALS FOR 2007

<p><i>MONITORING SERVICE DELIVERY CAPACITY</i></p> <ol style="list-style-type: none">1. Continue to implement the approved CSS programs and to apply for additional MHSA programs.
<p><i>MONITORING ACCESSIBILITY OF SERVICES</i></p> <ol style="list-style-type: none">1. Maintain current performance of access to after-hours care at 69% of PMRT response times 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 10%.3. Evaluate the results of the two (2) year Latino Access study and incorporate the results in plans for improved access.
<p><i>MONITORING BENEFICIARY SATISFACTION</i></p> <ol style="list-style-type: none">1. Increase the total number of surveys submitted by 1.5% from the November 2006 survey period.2. Increase the participation of peers / volunteers in assisting with the survey completion to six or more sites.3. Maintain satisfaction rates in the May 2007 survey period at about the same level as the November 2006 survey period.4. Ensure that 90% or more survey respondents agree that written materials are available in their preferred language.5. Continue to report the State's Performance Outcome Survey findings to providers and local 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 beneficiary requests to change service providers and to take action when the annual number reaches 25.
<p><i>MONITORING CLINICAL GOALS</i></p> <ol style="list-style-type: none">1. Continue current protocols for reviewing medication practices.2. Monitor for occurrences of potentially poor quality of care through the Program Review process. Report such occurrences to district chiefs, QI staff and executive management. When quality of care issues are significant, report these occurrences to the County's-Auditor Controller for further review.3. Implement the framework for Performance Based Contracting for all DMH contract human services providers and administrative contractors.
<p><i>MONITORING CONTINUITY OF CARE</i></p> <ol style="list-style-type: none">1. Continue to evaluate the effectiveness of the MOUs with the Regional Centers, the Department of Children and Family Services, and other human service agencies through liaison meetings and through identification of issues within the Service Area QICs.2. Establish a work group to develop specific data definitions and standards to analyze and report service utilization and access rates.
<p><i>MONITORING OF PROVIDER APPEALS</i></p> <ol style="list-style-type: none">1. Evaluate trends in the informal and formal two-tiered review for any authorization disputes submitted to LMHP for a three year period.

APPENDIX 5

QUALITY IMPROVEMENT WORK PLAN GOALS FOR 2008

MONITORING SERVICE DELIVERY CAPACITY

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

MONITORING ACCESSIBILITY OF SERVICES

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

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).

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.

