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

QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR CALENDAR YEAR 2005
QUALITY IMPROVEMENT WORK PLAN FOR CALENDAR YEAR 2006

Introduction

The Quality Improvement Work Plan is organized into six (6) areas identified by the State Department of Mental Health as components of a quality improvement program: Service Delivery, 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 2005 through December 2005 and is based on the Quality Improvement Work Plan, which was submitted to the State Department of Mental Health for calendar year 2005.

The Quality Improvement Work Plan for calendar year 2006 will be presented at the conclusion of the evaluation section. Goals will be outlined in accordance with the six (6) areas noted by the State Department of Mental Health.

QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR CALENDAR YEAR 2005

Los Angeles County-Department of Mental Health (LAC-DMH) quality activities are the responsibility of the Performance Excellence and Quality Improvement Council (PEQIC), under the auspices of the Program Support Bureau.

EVALUATION OF PLANNED ACTIVITIES FOR CALENDAR YEAR 2005

All of the activities, projects and goals identified and included in the Quality Improvement Work Plan for calendar year 2005 will be presented below, followed by an evaluation of the Department's results in achieving each goal.

MONITORING SERVICE DELIVERY CAPACITY – GOALS FOR 2005

1. **Based upon current budget and program projections, including the probable advent next year of significant funding from the Mental Health Services Act (MHSA) and the associated programmatic changes, LAC-DMH will ensure maintenance of Medi-Cal programs at current levels and likely enhance service access and quality throughout the LAC-DMH system.**

EVALUATION
During this calendar year, most departmental efforts were concentrated on planning for the Mental Health Services Act.

I. **Expansion of children's programs was minimal.**

II **Program expansion specific to adults included:**

a. Development of two urgent community care centers, one in the San Fernando Valley and one in South Central Los Angeles.

b. The Community of Specialized Programs at Augustus F. Hawkins was implemented in February 2005. Since that time it has seen hundreds of clients, created seven (7) groups, and started the first Spanish speaking Recovery Inc. group in its service area.

MONITORING ACCESSIBILITY OF SERVICES - GOALS FOR 2005

1. **Continue to monitor goal that "all patients being discharged from an acute psychiatric inpatient facility have a face-to-face contact within seven (7) days of discharge."**

The definition for this goal is "The percent of clients who are hospitalized for psychiatric disorders who receive a face-to-face follow-up visit with a licensed behavioral healthcare professional within seven (7) days of discharge."

EVALUATION
Currently, the Department is unable to accurately monitor this goal. In November 2003, LAC-DMH began using a new Information System, called Integrated Systems (IS), to comply with HIPAA requirements. Since that conversion, it has been difficult to obtain information from the system. Normally, quarterly reports are developed and presented to PEQIC and DMH managers for their review and use in decision-making. The last accurate data was December 2003. The Department's Quality Improvement Council agreed it would be better to suspend

looking at data received from the new Integrated Systems until more accurate information was available.

2. **Continue to monitor access to after hour care.**

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 records 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 PEQIC and is tracked on a quarterly basis.

EVALUATION
After-Hour response times for PMRT calls of one (1) hour or less is as follows:

January 2005	69
February 2005	74
March 2005	73
April 2005	74
May 2005	73
June 2005	74
July 2005	74
August 2005	70
September 2005	71
October 2005	70
November 2005	66

The percentage of After-Hour calls in 2005 responded to within one (1) hour remained about the same as 2004.

The Emergency Outreach Bureau has changed the way it responds to After-Hour calls. Beginning in January 2005, the County PMRT's go dark after 0200, since the number of calls are minimal between 0200 and 0800. However, there is a small contingent of County staff located at ACCESS and private PMRTs who can respond to calls between 0200 and 0800.

ACCESS also changed the way it captures After-Hour data. Prior to January 2005, staff had to manually identify if a call was an After-Hours call. The business rules were changed in the computer, so that now calls are automatically identified as After-Hours, resulting in more accurate data.

3. **Continue to monitor the responsiveness of the ACCESS 800 number for PMRT calls, general referrals and requests for culturally specific services.**

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.

EVALUATION
Through November 2005, the ACCESS 800 number responded to 253,650 general calls. Of the calls received, 3,447 were requests for services in languages other than English. Languages include: Amharic, Arabic, Armenian, Bengali, Cambodian, Cantonese, Creole, Farsi, German, Haitian, Hebrew, Italian, Japanese, Korean, Mandarin, Polish, Portuguese, Romanian, Russian, Spanish, Tagalog, Taiwanese, Thai, Urdu, and Vietnamese.

The ACCESS 800 number also responds to daytime and after-hour PMRT calls. During Calendar Year 2005, ACCESS received 6,085 daytime requests and 6,586 after-hour requests for emergency services.

ACCESS is using a new system called Symposium, which became effective November 15, 2005. The data reported for abandoned calls appears to have inaccuracies. PEQIC staff is beginning to meet with the ACCESS staff to have a better understanding of the intricacies of the new system and resolve data issues.

The ACCESS Center made 71,374 referrals for mental health services during 2005 and responded to 349 calls from Primary Care Physicians.

4. **Develop Phase II of the Latino Access Study**

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 exist on the outcomes of interpreter training programs in public sector mental health

settings. The LAC-DMH Training and Cultural Competence Bureau sponsors ongoing Countywide workshops on language interpretation in the mental health setting. Between June 2000 and June 2005 a total of 19 training sessions were conducted and a total of 481 persons received the training. Each participant completed training evaluations, which contain the following information: highest academic or professional degree; primary reasons for attending the training; satisfaction with the training related to "useful to my present job;" "useful to my professional growth," etc. Except for logging the number of persons in attendance at the workshops, no other information is gathered from the participants' evaluation forms. Consequently, data relevant to the interpretation workshop outcomes are not yet available.

The LAC-DMH and the University of Southern California are collaborating on a pilot study to address this gap in evaluating interpretation 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 current training program provided by the Training and Cultural Competency Bureau, which is 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. Towards this end, Phase I of this pilot study will be dedicated to developing and piloting questionnaires and interview protocols. Phase II of the study will be dedicated to the evaluation of the existing training courses for mental health staff interpreters and providers. The study was approved by the respective Institutional Review Boards of both the LAC-DMH and the University of Southern California.

The two-year study will draw upon 100 mental health interpreters and providers, male and female, 18 years and older, who participate in existing interpreter training courses provided by the LAC-DMH. The study will employ a repeated measures design, over three (3) observation points: baseline, post-test, and 3-month follow-up. Using semi-structured interviews, outcomes will measure changes in interpreter and provider knowledge, skills and attitudes, course evaluation, barriers and facilitators, open-ended reflections on the experience of interpreting and the interpreting triad from the staff members' perspectives. Also included will be information on sociodemographic characteristics of the interpreter and the context of the interpreter activity.

The first training workshop was held on November 30, 2005. A total of 30 participants agreed to participate in the study. Modifications in the baseline and post-tests were completed. Subsequent trainings will be held in 2006.

5. **Monitor the outcomes of the IMD/State Hospital Transition Projects.**

One of the first principles established in the LAC-DMH Stakeholder Fiscal Year 2004-2005 Budget process was the importance of preserving, to the greatest extent possible, community-based mental health services. This decision resulted in a corollary recommendation to reduce DMH's client census in the State Hospitals and Institutions for Mental Disease (IMD) by approximately 65 and 85 clients, respectively. This transition in service delivery modality was accomplished through attaining maximal fluidity throughout the continuum of community-based resources. The goal was to prepare both the clients who would be impacted and an array of specialized and traditional resources in our communities so that these transitions would be safe, smooth and beneficial to all involved.

EVALUATION
The IMD Administration staff completed the IMD-State Hospital Transition Project in collaboration with peer support/advocacy groups and Assertive Community Treatment (ACT) providers, introduced DMH liaisons into the County hospital inpatient units and emergency rooms, implemented two intensive residential facilities for clients being discharged from IMDs in collaboration with Adult Systems of Care, and implemented the Psychiatric Outreach Diversion Program (PDP) in collaboration with the Office of the Medical Director.

The program staff members, in conjunction with many Departmental programs and community providers, transitioned approximately 210 individuals to various levels of psychiatric care over the past year.

MONITORING BENEFICIARY SATISFACTION – GOALS FOR 2005

The LAC-DMH participated in the State mandated Performance Outcomes process to monitor beneficiary satisfaction in outpatient settings. It also surveyed Fee-For-Service Hospitals twice during this year to monitor satisfaction in inpatient settings.

1. **The Local Mental Health Plan (LMHP) will conduct State Performance Outcome Surveys; distribute appropriate language versions as they become available; and conduct all other State-mandated surveys.**

The Department participated in the State mandated Performance Outcome survey from November 1-15, 2005. Surveys were completed in five languages – English, Chinese, Korean, Spanish and Tagalog.

For this survey period, the Department involved the Office of Consumer Affairs in recruiting clients to assist with the survey completion process at three (3) clinics. The clinic staff reported that the client volunteers were dedicated and helpful in assisting their peers in completing the surveys.

EVALUATION

A total of 17,247 Performance Outcome surveys were submitted by the agencies to the Department. The following represents the number and type of surveys submitted: 5,011 Youth Family, 3,636 Youth, 8,093 Adult and 786 Older Adult. **This number is greater than the total number submitted in May 2005 – 15,685 indicating an increase by 10% from the last survey period.**

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 developed to report and summarize the results of the open ended comments on the last page of the survey during this survey period. (See Attachment 1).

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.

Several providers submitted feedback forms with valuable comments and suggestions from the clients, as well as corrective actions to be taken. For example, one program reported that the clients had concerns about the long wait times between intake and first session and action was taken to reduce the wait times. Another agency reported that clients expressed a lack of cultural sensitivity on the part of front desk staff, who engaged in conversations that could be heard by clients in the waiting area. Corrective action to address these issues with the front desk staff were taken by discussing these issues and training them on being sensitive to cultural issues. Samples of these provider feedback forms without identifiers have been attached (See Attachment 1).

2. **The Department will report the State's findings regarding the May 2005 Performance Outcome Survey, when made available to providers and local QICs for use in quality improvement activities.**

The Los Angeles County - Department of Mental Health participated in the State mandated Performance Outcome survey conducted between May 2-13, 2005.

EVALUATION

The Department received survey data from the State Department of Mental Health in July 2005; the data was then analyzed by PEQIC staff. A Summary Report was prepared by Survey type for each Service Area, and disseminated to all Service Area District Chiefs, the Executive Leadership Team and all Quality Improvement Committees. (See Attachment 2) A total of 15,685 Performance Outcome surveys were submitted by the agencies to the Department. The following represents the number and type of surveys completed: 4,475 Youth Family, 2,719 Youth, 7,962 Adult and 529 Older Adult. This number was greater than the total number submitted in November 2004 – 15,179. The response rate was 29% showing an improvement over the November 2004 response rate, which was 27%. There was a notable improvement in the response rate for adult surveys as noted in the increase from 30% in November 2004 to 35% in May 2005.

In response to the question on written materials being available in preferred language of the client, results from the May 2005 survey showed that a high percentage of clients received the materials in their respective languages.

- **On the Adult survey, 64% 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 matrials.**
- **On the Older Adult survey, 60% responded to the question. Of these, 93% reported having received the written materials in their preferred language, while only 7% reported as not having received these materials.**
- **On the Youth Family survey, 79% 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, 77% 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.**

Quality Improvement staff held meetings with Service Area Liaisons and Quality Improvement Committee members to discuss problems in the implementation process and brainstormed ways to improve the response rates during future survey periods. Responses included: quality checks during the survey period at various provider sites, better estimations of the number of survey tools needed, Service Area Liaisons taking a more active role in quality checks of the completed surveys before submission to the Department, and providing reports and data feedback as incentives to providers who submit a fairly large number of

valid surveys. Also, letters were sent from the District Chiefs of each Service Area to the Executive Director of the Program highlighting the problems noted at the program during the survey period.

Additionally, Fee-For-Service (FFS) Hospitals were surveyed twice during the last year. All FFS Hospitals received a report of findings after each of the two (2) surveys conducted in 2005. The reports included beneficiary responses to each question and an overall score. They also received a summary sheet showing the number of surveys returned by each hospital compared to the number of discharges. (See Attachment 3 – CSQ 8 data) Hospital administrators were encouraged to use this information as part of their quality improvement efforts.

3. **The LMHP will continue to respond to beneficiary complaints, grievances and fair hearings; biannual reports will be submitted to PEQIC for further analysis and policy recommendations.**

Beneficiary grievances are investigated and resolved by the Patient's Rights Office. Grievance categories identified by Patient's Rights are: Access; Denied Services; Termination of Services; Request for Change of Provider; Quality of Care; HIPAA; Other. The total number of grievances for calendar year 2005 was 699; 30 cases were referred out; 564 cases were resolved and 105 cases are pending.

The Department has designated a State Fair Hearing Liaison to respond to all requests for State Fair Hearings.

Unlike the grievance data, the State Fair Hearing information is collected on a Fiscal Year basis. During Fiscal Year 2004-2005, there were 26 State Fair Hearings. A summary of activity status is as follows:

Cases resolved	**26**
Outcomes of resolved cases:	
➢ Claims dismissed by Administrative Law Judge (ALJ) as out of their jurisdiction	10
➢ Claims dismissed because the client did not attend or did not request a postponement	10
➢ Withdrawn by the beneficiary prior to the hearing	2
➢ Cases Postponed	3
➢ Cases Denied	1
Status Unknown	
Position paper returned marked "No such address"	1

EVALUATION
Due to efforts on the part of clinical and administrative staff in the field, clients are more aware of their rights to grieve either in writing or orally. The number of grievances have gone up from 520 to 699. The number of State Fair Hearings remained the same as in 2004.

4. **The LMHP will continue to monitor beneficiary requests to change service providers.**

Most requests to change service providers are handled at the program level, and/or between program managers.

EVALUATION
With the implementation of a policy for programs to use in tracking requests for change in service providers, more accurate information has been gathered. There were twelve (12) formal requests to Change Service Providers in calendar year 2005. This is an increase of six (6) formal requests over calendar year 2004.

CLINICAL ISSUES – GOALS FOR 2005

1. **Continue current protocols for reviewing medication practices.**

All DMH agencies that provide medication support are connected to the Department's electronic data system referred to as Prescription Authorization and Tracking System (PATS). PATS processes prescriptions written by DMH providers, excluding the network providers. It provides an inventory system to maintain the current inventory for and to track the distribution of DMH drugs by pharmacies and providers authorized by DMH. PATS reduces the use of paper prescriptions, eliminates the potential for fraud based on "lost or stolen" paper prescriptions, provides management with reports on drug usage by clients and facilities and monitors the types and quantities of prescribed drugs by performing edits on prescriptions as they are entered into PATS. DMH is able to monitor drug usage via the medication monitoring edits performed on every prescription and medication order recorded into PATS. Monthly reports identify those records that do not receive an "approved" status. PATS information is available only to those with a specific security level. PATS maintains prescriptions, medication orders, medication profiles on clients and requests for drug authorization.

On a daily basis, the DMH Pharmacist reviews all medication requests that are outside the DMH formulary. He decides if such requests are appropriate and if not, consults with the Medical Directors for adult, child or older adult services.

Significant issues are brought to the attention of the Department's Medical Director and, in turn, the Department's Clinical Policy Committee.

EVALUATION
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. When medications that are outside the formulary are requested, the DMH Pharmacist reviews and consults as required. There is approximately one (1) consultation with Department Medical Directors (adult, child, older adult) per month regarding requests for medications that are outside the formulary.

The office of the Medical Director develops and updates practice parameters related to a variety of medication and health monitoring practices. Acknowledging that persons on antipsychotic medications may have an increased vulnerability to several general medical conditions, the **PARAMETER FOR GENERAL HEALTH-RELATED MONITORING AND INTERVENTIONS IN ADULTS** (Nov 2005) was revised to include monitoring clients for weight gain and obesity, as well as diabetes. Additionally, the Department developed guidelines for the use of Psychotropic Medication for Children and Adolescents (April 2005). See Office of the Medical Director Website. http://www.rshaner.medem.com/

2. **Continue to monitor for occurrences of potentially poor quality of care though the Program Review process. If occurrences are discovered, this will be brought to the attention of PEQIC and Executive Management.**

Program Review continuously monitors the quality of work being provided by contract and directly operated agencies, along with staff from the Service Areas where the programs are located. Problems are brought to the attention of the Service Area managers and their team for resolution. If issues cannot be resolved at that level, Executive Management and occasionally the Board of Supervisors may be asked to intervene.

Hospitals are monitored by a team comprised of staff from the Medical Director's Office, the Office of Patients' Rights and Program Review. All questionable practices are brought to the attention of the Medical Director.

EVALUATION
A total of 24 legal entity contract and directly-operated agencies were reviewed throughout calendar year 2005. Additionally, 128 Medi-Cal re-certifications and 21 initial Medi-Cal certifications were completed. There were quality of care incidences discovered during this calendar year, which were referred to the

Auditor-Controller for further action. Other quality of care issues were handled immediately, by reporting it directly to the Service Area manager and the Deputy Director responsible for that Service Area.

3. **Monitor re-hospitalization rates.**
EVALUATION
Generally, PEQIC reviews information on the number of clients hospitalized and re-hospitalized each quarter. However, accurate data is not available and has not been available since 2003. A work group has been developed to work with the Department's information system staff to identify the exact issue with obtaining accurate information.

4. **Monitor the outcome of the review being conducted by the Office of the Medical Director related to the 9-Point Module.**

May 2004 marked the beginning of the clinical application of the Integrated Co-Occurring Disease (COD) Treatment "9 Point Module." Basically, the Module systematizes substance abuse interventions, referrals and documentation. It also serves as a quick guide to integrated substance abuse assessment and treatment in mental health settings.

EVALUATION
Only slight improvement was noted with reference to referrals and documentation. The Healthy Living groups, which was one of the steps in the "9-Point Module" are now being expanded to other populations beyond the co-occurring disorders. In this context, parameters for the Wellness Centers, developed in December 2005, include the Healthy Living component.

MONITORING CONTINUITY OF CARE – GOALS FOR 2005

1. **Continue to collaborate with the County-Wide Service Integration Branch (SIB) to improve access to services, facilitate access to shared data, better coordinate the multi-agency service delivery system and enhance customer service and satisfaction.**

Over the past four (4) years, the Department's Bureau of Standards, Practices and Conduct, (now known as the Program Support Bureau) has been part of a Countywide initiative to improve services to children and families (relates to County Strategic Goal #5: Children and Families' Well-Being). As a result of this campaign, all participating County departments have agreed upon basic service delivery standards and are in the process of developing others, such as waiting list standards.

EVALUATION
The SIB has been working to develop a new Customer Satisfaction Tool. This survey will be administered during the 2006 time frame. Selective County departments participated in the 2004 survey Future surveys will include all County departments.

2. **Continue to monitor the effectiveness of the MOUs with the Regional Centers, the Medi-Cal Managed Care Plans, 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.**

LAC-DMH has a number of Memoranda of Understanding (MOU) with various entities including: the seven (7) Regional Centers; the Medi-Cal Managed Care health plans; Los Angeles Unified School District; Department of Children and Family Services; Department of Public Social Services; and the Probation Department. DMH staff are assigned as liaisons to work with staff from the agencies represented by the MOUs. In addition to the MOUs, the County of Los Angeles has a number of children's collaboratives. Again, staff are assigned to these collaboratives who can identify issues and address problems.

The collaborative effort with the Regional Centers continues. There is a central County work group comprised of a representative from the Regional Center Directors, staff liaisons from each Regional Center Office; staff from DMH who represent children, adult and emergency services and a staff liaison from Metropolitan State Hospital who works on the unit that serves the developmentally disabled. There are workgroups in some of the Service Areas where issues specific to that area are addressed. The Service Area meetings frequently include representatives from hospitals and schools, as well as the local DMH clinics and the Regional Centers. Service Area staff also participate on a Countywide workgroup that deals with specific issues related to jailed individuals with developmental disabilities. LAC-DMH staff represent the County at the State Mental Health/Developmentally Disabled Task Force, where County and State issues are addressed and problem resolution takes place.

EVALUATION
During this calendar year, the County Administrative Office (CAO), in conjunction with the Service Integration Branch, developed an MOU with Mental Health, Probation, the Regional Centers and the Department of Children and Family Services. The MOU between the Department of Mental Health and the seven (7) Regional Centers served as the boiler plate for the language in the new MOU. The goal of the MOU was to establish a document that would allow for the sharing of information about "like" clients among all agencies.

The effectiveness of the MOUs and collaboratives continues to be a concern for the Department. Although staff attend meetings, network, and have excellent working relationships within the liaison forums, ensuring that all directly operated and contract providers are aware of and compliant with the specifics of the MOUs is a difficult task. Communication related to the MOUs will remain a continued goal for the Department and the other MOU participants.

Both the State task force and County work group are focusing on the needs of clients who require hospitalization. It is believed that many developmentally disabled clients are hospitalized for acting out behaviors rather than a psychiatric disorder. In September 2005, a new unit was established at one of the free-standing psychiatric hospitals. This unit will work with clients with acting out behaviors, medication issues and housing issues related to their developmental disability. These clients will be assessed first to determine that they do not have a mental illness. It is hoped that this approach will decrease the number of inappropriate referrals into psychiatric hospitals.

MONITORING OF PROVIDER APPEALS – GOALS FOR 2005

1. **Continue to monitor and evaluate informal and formal two-tiered review for any authorization disputes submitted to LMHP.**

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

During calendar year 2005, there were five (5) appeals received. This is an increase of one (1) over the calendar year 2004 data. There was one (1) informal Therapeutic Behavioral Services (TBS) Appeal that was rescinded and approved/paid. There were two (2) First Level appeals upheld/denied (1 TBS) and one (1) Day Treatment Intensive (DTI). There was one (1) First Level Appeal that was rescinded and approved/paid. One (1) Second Level Appeal was upheld/denied.

QUALITY IMPROVEMENT WORK PLAN FOR CALENDAR YEAR 2006

Introduction

The Quality Improvement Work Plan is organized into six (6) areas identified by the State Department of Mental Health as components of a quality improvement program: Service Delivery, Access to Services, Beneficiary Satisfaction, Clinical Issues, Continuity of Care and Monitoring of Provider Appeals. Goals will be outlined in accordance with the six (6) areas noted by the State Department of Mental Health.

The Quality Improvement (QI) program is integrated throughout the various levels of the Department, i.e., in the clinics, in the Service Areas and at the Executive Management level. The Service Area Quality Improvement Committees (QICs) are essentially the basic arena for both problem formulation and decision-making. These QICs are a critical component, as many of our providers do not have the opportunity to participate in an in-house QI process. Although each Service Area QIC has provider representation, each QIC is working toward enhancing its beneficiary and family member representation. It is at the local QIC that data are analyzed, barriers to quality service identified, beneficiary satisfaction monitored and reviewed and current services within a Service Area assessed.

The Department recognizes the importance of obtaining input from various stakeholders; therefore further efforts are underway to encourage the ongoing participation of beneficiaries, family members and providers. To ensure the smooth performance of the QI program, a complete information feedback loop has been instituted from the clinics to the Service Areas and finally to the PEQIC and vice versa.

LOS ANGELES COUNTY

Los Angeles County has the following demographic information. According to 2000 census and demographic data, there are 9,519,338 people who reside in the County. 2,946,796 are between the ages of 0-19 (31%); 5,339,106 are between the ages of 20-64 (56%) and 1,233,436 are over 65 (13%). Hispanics or Latinos of all races represent 44.6% of the population; Whites represent 31%; Blacks or African Americans represent 9.47%; Asians/Pacific Islanders are 12%; others represent 2.55%; and American Indian and Alaska Natives are .28%.

Regarding language proficiency, 37.9% speak Spanish; of this 28.9% state they do not speak English well. 5.2% speak other Indo-European languages; 2.1% state they do not speak English well. 10% speak Asian languages; 5.5% state they do not speak English well.

In the classification "Disability of the Civilian Non-institutionalized Population" 7.8% are 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

2004-2005 Fiscal Year data indicates the Department served 96,761 Medi-Cal beneficiaries; 99,818 indigent; 36,970 Fee-For-Service Outpatient/Medi-Cal; and 9,892 Fee-For-Service Inpatient/Medi-Cal. Since we still are unable to obtain a clear unduplicated client count from our Integrated System (IS), we have provided the numbers as separate data elements. Data was obtained from the Medi-Cal approved files.

LAC-DMH is organized into a number of Bureaus and Divisions, as well as eight (8) Services Areas. Each Service Area is managed by a Service Area Administrative Team. Salient among the Service Area's activities is the relationship it develops with the community. Each Service Area has an Executive Provider Team, comprised of the executive directors/program managers of the mental health programs in that Service Area. The management teams have strongly encouraged the participation of Fee-For-Service providers, law enforcement, schools, social service agencies, as well as hospital providers, with varying degrees of success. In addition to the Executive Provider Team, each Service Area has a Service Area Advisory Committee (SAAC), composed of providers, clients, family members and other interested parties.

OUTREACH ACTIVITIES TO THE HOMELESS MENTALLY ILL AND HARD TO REACH POPULATIONS

The Department has a number of programs devoted to outreach to special populations and the hard to reach. Examples of such efforts include:

The Emergency Outreach Bureau specifically 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 the homeless. The Department also has directly operated and contract providers that provide outreach to the homeless in Long Beach, Santa Monica and the San Fernando Valley, where the largest homeless populations reside.

In addition, the Department has a number of specialty mental health clinics that focus on populations with language and cultural needs. These agencies are located in areas throughout the County within close proximity to neighborhoods with minority populations.

The Department has contracts with St. John's Hospital's Deaf Program and GLAD (Greater LA Services for the Deaf) to assist clients who are hearing impaired.

The Older Adult Program (GENESIS) operates using a multi-disciplinary team model serving all of Los Angeles County. It works in close collaboration with Adult Protective Services, mental health agencies, physical health providers, the Public Guardian, law enforcement agencies and other community-based service providers. The teams consist of a registered nurse and licensed clinical social worker who conduct joint in-home visits to: provide mental health assessment, crisis stabilization and short-term treatment; health screening, medication support and linkage to primary care; linkage to other needed services; coordination within and among service providers and families; advocacy; and consultation.

LA's Hope Project, the $3.6 million collaborative between the LAC-DMH and nine (9) other governmental and private non-profit partners was launched in January 2004 to provide permanent housing and customized employment services to 76 individuals with mental illness who are chronically homeless and may have a co-occurring substance abuse disorder. The implementation of the LA's HOPE Project has been conducted in three (3) major stages: outreach, housing and employment.

The Project has implemented evidence-based practices such as utilizing a "Housing First" model to outreach and house individuals living on the streets or in an emergency shelter who had either been homeless for one (1) year continuously or had experienced four (4) episodes of homelessness within three (3) years. The Project will utilize a similar approach in implementing the employment component. Since initiating the Project:

1219 individuals have received outreach services
98 have been enrolled in LA's HOPE/AB 2034 and have been approved for a Shelter Plus Care certificate
45 have been placed in permanent housing
47 are participating in employment service groups being co-led by staff from the AB 2034 Programs and Work Source Center
34 are engaged in vocational-related activity
9 have been placed in non-competitive employment in the community
7 have been placed in competitive employment in the community.

ACCESS PROGRAM

The Department's ACCESS program operates the 24-hour Statewide, toll-free number – 1-800-854-7771. This number is available 24 hours a day, 7 days a week. Staff assist callers to access mental health services by linking them to resources either close to where they work or where they live. They also operate after-hours emergency services and coordinate many of the day-time emergency services activities. The ACCESS staff assist callers in many ways including attempting to identify problems and make referrals to an appropriate resource when individuals call with complaints. Although staff within the unit speak a number of languages, they have available to them the AT&T system for language assistance, as well as TDD.

ACCESS TO PROGRAMS AND INFORMATION

The Department has in place processes for ensuring access to services for beneficiaries that are out-of-County. Children are handled through the Children's System of Care, and adults through staff assigned to the ACCESS Telecommunication Center.

The Beneficiary Handbook and the Complaint and Grievance Procedures are available in English and the other threshold languages inherent to Los Angeles County. Each clinic site, both contract and directly operated, maintain these documents in the languages consistent with the population served. The Handbook and Complaint procedures are usually found in the clinic waiting rooms. The Handbook has a plethora of information including how beneficiaries can obtain a list of providers and options for linguistic and culturally appropriate services.

As of March 2005, the Department has a **Web Based Resource Directory** available through an intranet link <http://247211.net/dmh>. Through this mechanism employees can assist clients find comprehensive community resource information, such as housing, food, legal, health and mental health services. The directory also contains information on hours of operation, languages spoken, accessibility, eligibility requirements and fees. Locating resources can be easily done by keyword or category search terms. The database provides maps, driving directions and public transportation information, which can easily be printed and handed out to clients.

CULTURAL COMPETENCY

The Department's Cultural Competency Plan is developed through the Department's Program Support Bureau. The staff assigned to this section has a process to evaluate the competencies of County staff providing services to the culturally and linguistically diverse populations within the County. The Department's contract with each legal entity requires a breakdown of staff and their linguistic capabilities. However, staffing does not always meet the explicit needs of specific neighborhoods. For example, many neighborhoods have changed their cultural orientation over the last several years. Agencies had staffing that reflected the original culture of the surrounding communities. The communities changed, but the staff remained constant.

The Department has a process for examining staff who speak various languages, certifying their language capabilities through writing, speaking and ability to conceptualize. If staff are providing services to clients, their knowledge of mental health is also evaluated. Through this process staff who pass the test are given a bi-lingual bonus.

PENETRATION AND RETENTION RATES: Information regarding Penetration and Retention Rates require further analysis.

PROGRAM INTEGRITY

LAC-DMH has a Compliance Program. As recommended by the Office of the Inspector General, Department of Health and Human Services, compliance programs are intended to support and ensure that health care organizations uphold the highest ethical and legal standards, ensure the delivery of high quality health care services and eliminate fraud, abuse and waste associated with all Federally funded health care programs.

BEST PRACTICES/PARAMETERS

As part of the Department's quality improvement efforts, the Office of the Medical Director has a set of practice parameters. These parameters are developed, reviewed or updated through workgroups composed of both academic experts and clinical leaders from within and outside the Department. The parameters span assessment, medication treatment, psychotherapy, dual diagnosis and clinic environments. They are available on the Department's website and are a focus of quality improvement activities via clinician meetings and clinical risk management activities. http://www.dmh.co.la.ca.us/directors_corner.htm)

PLANNED ACTIVITIES FOR 2006

[redacted]

MONITORING SERVICE DELIVERY CAPACITY

As noted above, Los Angeles County has 9,519,388 residents. The County has a diverse ethnic and cultural population who speak over 90 languages, 12 of which are threshold languages. It has both rural and urban settings.

The Los Angeles County–Department of Mental Health has 144 legal entity Short-Doyle/Medi-Cal providers and 58 directly operated providers located at 450 sites throughout the County. Additionally, the Department has a Fee-For-Service network consisting of 586 individual network providers, 25 group network providers, and four (4) network organizational providers. There are 44 psychiatric inpatient facilities, 41 of which are designated.

LAC-DMH provides the following types of services for children, adults and older adults:

- *INPATIENT SERVICES*:
  - 1 State Hospital;
  - 4 County hospitals with psychiatric units;
  - 44 Fee-For-Service Hospitals;
  - 2 Short-Doyle/Medi-Cal free standing hospitals;

- 1 Psychiatric Health Facility (PHF);
- 1 Mental Health Rehabilitation Center;
- 4 sub-acute skilled nursing facilities, including 1 child/adolescent; 1 geriatric;
- 7 IMDs with special programs.

➢ *JAILS:*
- extensive number of jail locations in all cities;
- jail locations throughout the County;
- many camp locations;
- 3 Juvenile Halls.

➢ *RESIDENTIAL SERVICES:*
- 3 crisis residential, with homeless beds;
- 8 transitional residential, 5 with homeless beds;
- 3 long-term residential;
- 2 semi-independent living;
- RCL Level 12-14 Group Homes: bed capacity is 2,357;
- Community Treatment Facility (CTF) bed capacity is 61.

➢ *OUTPATIENT SERVICES*: Approximately 450 sites throughout the County deliver outpatient, medication support, targeted case management and crisis services.

➢ *DAY SERVICES* are provided through intensive day care, rehabilitation day services, socialization and vocational services.

➢

➢ *COMMUNITY OUTREACH SERVICES*, which includes community outreach, education, information, community organization and community client are provided by most agencies. One agency provides a hotline service for all of Los Angeles County. Data for 2005 is unavailable.

There are special programs for the high utilizing populations through the Assertive Community Treatment (ACT), school based programs, services at various levels of group homes, Therapeutic Behavioral Services (TBS) and Wraparound Services.

There are specialized services through GROW, CalWorks and the DPSS Co-Located programs.

The Department has procedures to ensure access to services for clients placed in out of County facilities.

The Department contracts with 13 Shelters throughout the County to provide temporary shelter for our adult clients who are homeless. Because these are unlicensed facilities, shelter beds are available for clients that do not require "care and supervision" as

defined by community care licensing. To access a Shelter bed, the client's DMH outpatient case manager must submit a request to the DMH gatekeeper for the respective Shelter. Because the stay in the shelter is limited to six months, the case manager is responsible for continuing to assist the client in finding a more permanent housing situation.

There are specialized services for the dually diagnosed/substance abusing mentally ill, the developmentally disabled, the deaf and victims of abuse and violence.

There are programs that target clients with specific language and cultural needs, such as the Asian Pacific Counseling Center, the Latino Mental Health Center, the United Cambodian Community Center, the Long Beach Asian Program, Coastal Asian Mental Health, and the American Indian program to name only a few.

The Department of Mental Health in Los Angeles County is divided into eight (8) Service Areas. A full array of services is available either within the boundaries of the Service Area or in adjacent Service Areas. At this time, the goal is to maintain services and providers at the current level.

Each Service Area has an in-depth mechanism for evaluating what services are needed through Service Planning Area (SPA) committees, Service Area Advisory Committees (SAAC), Interagency Committees, Children's Planning Committees, Quality Improvement Committees and client councils. Committees are comprised of interested stakeholders, including providers, clients and family members. Each committee advises the Service Area manager, in writing, of the identified needs. Each manager develops a document that outlines Service Area needs. This, in turn, is presented and discussed with the manager's respective Deputy Director. As monies become available, programs/services are developed according to a Departmental methodology on need or the types of monies being sent to the County. See the DMH webpage for distribution of services by Service Area.

Due to the extensive system of programs throughout Los Angeles County, the Department does not have a prescribed number of programs, by type, per Service Area or by population size. Since Medi-Cal Consolidation, Phase II, the Department generally sees anyone who requests services, both indigent and Medi-Cal, based on Medical Necessity.

As noted earlier, substantial work was done through 2005 to complete the requirements set forth by the Mental Health Services Act (ACT). The ACT is one of the few options available to enhance services; consequently the goal set under this category related to the ACT.

MONITORING SERVICE DELIVERY CAPACITY - GOALS FOR 2006

1. **Increase the Service Delivery Capacity by one (1) adult Full Service Partnership and one (1) child Full Service Partnership.**

MONITORING ACCESSIBILITY OF SERVICES

LAC-DMH has the continued goal to improve access to consumers by providing an increasingly "seamless" mental health delivery system. This requires improved coordination of services at all levels.

URGENT AND EMERGENT CONDITIONS

As specified in the Department's policy manual, all persons with urgent conditions will be offered an appointment to be seen within 24 hours. However, many agencies throughout the system are set up to evaluate clients on a "walk in" basis, so that client needs are met in a more timely manner.

As noted above, in Los Angeles County calls for emergency services are processed through the Department's ACCESS 800 telephone line. ACCESS utilizes a computerized program to monitor and track all calls. PEQIC receives reports throughout the year on how long it takes for PMRT staff to respond to emergency calls. Because of changes in the computer system at ACCESS and the difficulty with understanding the data in the new reports, PEQIC staff is working with ACCESS center staff to interpret the data.

LATINO ACCESS PROJECT (ADMINISTRATIVE PERFORMANCE IMPROVEMENT PROJECT)

The need for well-prepared, competent interpreters in mental health settings has been a concern in the mental health arena, yet no systematic examinations exist on the outcomes of interpreter training programs in public sector mental health settings. The LAC-DMH Training and Cultural Competence Bureau sponsors ongoing Countywide workshops on language interpretation in the mental health setting. Between June 2000 and June, 2005 a total of 19 training sessions were conducted and a total of 481 persons received the training. Each participant completed training evaluations, which contain the following information: highest academic or professional degree; primary reasons for attending the training; satisfaction with the training related to "useful to my present job," "useful to my professional growth," etc.). Except for logging number of persons in attendance at the workshops, no other information is gathered from the participants' evaluation forms. Consequently, data relevant to the interpretation workshop outcomes are not yet available.

The LAC-DMH and the University of Southern California are collaborating on a pilot study to address this gap in evaluating interpretation 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 current training program provided by the Training and Cultural Competency Bureau, which is 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. Towards this end, Phase I of this pilot study will be dedicated to developing and piloting questionnaires and interview protocols. Phase II of the study will be dedicated to the evaluation of the existing training courses for mental health staff interpreters and providers. The study was approved by the respective Institutional Review Boards of both the LAC-DMH and the University of Southern California.

The two-year study will draw upon 100 mental health interpreters and providers, male and female, 18 years and older, who participate in existing interpreter training courses provided by the LAC-DMH. The study will employ a repeated measures design over three (3) observation points: baseline, post-test, and 3-month follow-up. Using semi-structured interviews, outcomes will measure changes in interpreter and provider knowledge, skills and attitudes, course evaluation, barriers and facilitators, and open-ended reflections on the experience of interpreting and the interpreting triad from the staff members' perspectives. Also included will be information on sociodemographic characteristics of the interpreter and the context of the interpreter activity.

The first training workshop was held on November 30, 2005. A total of 30 participants agreed to participate in the study. Modifications in the baseline and post-tests were completed. Subsequent trainings will be held in 2006.

PSYCHIATRIC EMERGENCY SERVICE RELIEF PLAN

Beginning in 2005, the Department of Mental Health (DMH) and the Department of Health Services (DHS) implemented a plan for the relief of the County Hospital Psychiatric Emergency Services (PES) operated by the Department of Health Services.

The PES Relief Plan was a part of the DMH Stakeholder's Recommendations to address the increased demand on the psychiatric emergency rooms and the inpatient units. The plan was the result of findings by a DMH/DHS Collaborative Workgroup.

The unrelenting demand for emergent psychiatric services at all four (4) County hospitals has resulted in a critical situation. All too often, the existing system stabilizes individuals in crisis and discharges them, without effective connection to the outpatient system of care, only to have them return again in crisis. The PES Relief Plan began at Augustus F. Hawkins Mental Health Center (AFHMHC) and moved to other County hospital Psychiatric Emergency Services. The plan consists of: Urgent Care Services

(UCS); Intensive Residential Resources; Peer Support Services and PES Augmentation

Urgent Care Services (UCS)
Presently, AFHMHC's Adult Outpatient Clinic (AOP) operates one of the busiest weekday walk-in services in the mental health system. However, on weekends and holidays, individuals who could be treated by the AOP, such as those needing medication refills, are referred to the Martin Luther King, Jr./Drew Medical Center's (MLK) PES. The UCS will serve as an extension of the AOP, providing a similar service on weekends and holidays, but taking only referrals from the PES. The UCS staff will be utilized during the week to follow-up with clients discharged from the UCS, PES or the MLK Augustus F. Hawkins' inpatient units, to assist them in continuing to address their mental illness and other needs through community-based programs.

Intensive Residential Resources
This component is directed at maximizing DMH's ability to provide residential treatment resources, particularly for uninsured clients, as an additional means of diverting clients from the PES and inpatient units. DMH currently contracts with three (3) Crisis Residential Facilities that provide treatment up to 30 days and one (1) Psychiatric Health Facility (PHF) that provides acute inpatient care as a less costly alternative to acute hospital care. DMH will provide augmented funding to these programs to enable them to serve a higher proportion of uninsured clients. Additionally, six (6) DMH positions will be included in this component to manage the Crisis Residential/PHF resources and to work collaboratively with DHS staff in the PES and inpatient units to facilitate the flow of clients through the various levels of outpatient treatment and housing.

Peer Support Services
As part of the Stakeholder supported initiative to expand peer support services throughout the system of care, the PES Relief Plan includes 2.5 positions to provide peer bridgers in the PES. These individuals will assist in linking clients in the PES back to community-based care, thus "bridging" inpatient and outpatient care and reducing PES recidivism. The Office of Consumer Affairs reports that during 2005 clients have participated 34 trainings, attended conferences and participated in a number of DMH projects.

MONITORING ACCESSIBILITY OF SERVICES – GOALS FOR 2006

1. **Increase access to after-hours care by 2%, as measured by PMRT response times of one (1) hour to a safe environment,**

2. **Decrease the number of abandoned calls (responsiveness of the 24 hour toll free number) by 1%.**

3. **Evaluate the results of the two (2) year Latino Access study regarding interpreter training outcomes.**

MONITORING BENEFICIARY SATISFACTION

As part of the performance outcome project, the Department administers the State mandated satisfaction surveys. PEQIC 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 2005 resulted in 15,685 responses, which was significantly higher than the responses gathered in previous surveys.

MONITORING BENEFICIARY SATISFACTION - GOALS FOR 2006

1. **Increase the total number of surveys submitted by 5% from the November 2005 survey period.**

2. **Through collaboration with the Office of Consumer Affairs, Client Coalition, and Clinics in different Service Areas, PEQIC will dedicate efforts to increase the participation of peers/volunteers in assisting with the survey completion in May 2006. Efforts will be made to increase the participation to six (6) or more sites compared to three (3) clinics in the November 2005 survey period.**

3. **The Department will monitor satisfaction rates in the November 2005 survey period to ensure they are maintained at about the same level as the May 2005 survey period – 90% positive responses on Adult survey, 96% positive response on Older Adult survey, 89% positive responses on Youth family, and 75% positive responses on the Youth survey.**

4. **The Department will monitor responses to the question on the MHSIP regarding written materials being available in client's preferred language to ensure these percentages are always 90% or above.**

5. **The Department will report the State's findings regarding the Performance Outcome Survey, to providers and local QICs for use in quality improvement activities.**

6. **The LMHP will continue to respond to beneficiary grievances and fair hearings; bi-annual reports will be submitted to PEQIC for further analysis and policy recommendations.**

7. **The LMHP will continue to monitor beneficiary requests to change service providers. Action will be taken when the request go from 12 to 25 per year.**

CLINICAL ISSUES

MEDICATION MONITORING: LAC-DMH will continue to utilize its electronic data Prescription Authorization and Tracking System (PATS) as a method of monitoring medications. As mentioned above, PATS processes prescriptions written by DMH providers, currently excluding the network providers. It provides an inventory system to maintain the current inventory for and to track the distribution of DMH drugs by pharmacies and providers authorized by DMH.

As part of the Department's ongoing monitoring of medication practices and procedures, Program Review staff conduct the Medi-Cal certification process, which includes reviewing medication protocols. The Office of the Medical Director updates practice parameters to ensure the most current drug information is available to staff with prescription privileges.

PROGRAM REVIEW/MEDI-CAL CERTIFICATION
As a means of meeting requirements set out in CCR Title 9, Chapter 11, Section 1810.110, the Program Review unit continues to review providers within the DMH system to ensure compliance with Federal, State and County regulations. Although the review process is lengthy, it evaluates agencies' administrative, programmatic and clinical processes, as well as compliance with documentation standards. Part of the review includes re-certification for Medi-Cal. New providers go through a separate Med-Cal certifications process. Due to the fact that Program Review staff are not directly responsible for providers, issues discovered/uncovered during reviews are referred to the Service Area Manager, the Deputy Directors and, if appropriate, the Director of Financial Services.

LA COUNTY AWARDED SUBSTANCE ABUSE MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) GRANT FOR CHILD MENTAL HEALTH SERVICES

The Department of Mental Health of the County of Los Angeles was awarded $1,000,000 in first year funding to enable the Integrated Service System for Infants, Preschoolers, and Families Program to provide comprehensive mental health services

to children from birth to five (5) years of age, and their families. The children served are in the child welfare system or at risk of entry, have a serious emotional or behavioral problem, and live in an underserved area of Los Angeles County. Two LA County contract agencies were awarded the contract for these additional service, Children's Institute International and Children's Hospital. Additionally the Asian American Drug Abuse Program was awarded dollars for three (3) underserved Asian communities.

These grants will be used to implement a "Systems of Care" approach to services that are based on the premise that the mental health needs of children and adolescents can be best met within their home, school and community and families and youth should be the driving force in the transformation of their own care. The grants will be used to establish a full array of mental health and support services organized into a coordinated network in order to meet the unique clinical and functional needs of each child and family.

MANAGING WEIGHT GAIN THROUGH PARTICIPATION IN HEALTHY LIVING GROUPS (Performance Improvement Project [PIP])

LA County community stakeholders endorsed improving physical health outcomes as a priority for DMH and mental health consumers. As part of the stakeholder process for the Mental Health Services Act, Los Angeles County embraced the idea of Healthy Living Groups (HLGs). Medical illness among individuals with serious mental illness is an important problem to address. Adults with serious mental illness are at higher risk for serious medical illnesses such as diabetes, obesity and cardiovascular disease. Healthy Living programs provide a structured intervention aimed at improving mental and physical well being by supporting changes in diet and exercise habits.

The overall goal of the PIP is to study the effectiveness of the HLGs in decreasing health risks associated with weight gain and second generation antipsychotics (SGAs) as measured by an average 10% decrease in Body Mass Index (BMI) from baseline after six (6) months of participation in a Group (HLGs).

PERFORMANCE BASED CONTRACTING

As part of an initiative by the County's Auditor-Controller, the Department is developing the framework for Performance Based Contracting. 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.

MONITORING CLINICAL ISSUES - GOALS FOR 2006

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 respective District Chiefs, PEQIC and Executive Management. When quality of care issues are significant, report these occurrences to the County's Auditor-Controller for further review.**

3. **Increase initiation and engagement in two (2) existing-clinic-based Healthy Living Groups by 20%.**

4. **Decrease BMI by 10% from baseline to six (6) months of participation in Healthy Living Groups.**

5. **Develop a framework for Performance Based Contracting related to child contract providers.**

MONITORING CONTINUITY OF CARE

SERVICE INTEGRATION FOR CHILDREN AND FAMILIES: The Los Angeles County Services Integration Branch (SIB) developed the Service Integration Action Plan for Children and Families. The current Action Plan includes the following tasks: Access to Services, Data Sharing, Multi-Agency Service Delivery, Customer Service and Satisfaction and Revenue for Services. Sub-committees for each of these tasks were created. LAC-DMH staff currently participate on these committees and will continue to have an active role.

COLLABORATION WITH OTHER HUMAN SERVICE AGENCIES: For many years, LAC-DMH has collaborated with such agencies as the Regional Center, Department of Public Social Services, Department of Children and Family Services, and the various school districts within the County. Liaison staff sit on a number of committees and task forces in an attempt to resolve issues between and among agencies.

MONITORING CONTINUITY OF CARE - GOALS FOR 2006

1. **Continue to evaluate the effectiveness of the MOUs with the Regional Centers, 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. **Due to the problems encountered with the Integrated System, a work group will be established to develop specific data definitions and standards to**

collect accurate information related to the number of patients being discharged from acute psychiatric inpatient facilities.

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 2006

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