COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU
QUALITY IMPROVEMENT DIVISION

QUALITY IMPROVEMENT WORK PLAN EVALUATION REPORT
CALENDAR YEAR 2015

AND

QUALITY IMPROVEMENT WORK PLAN
CALENDAR YEAR 2016

Robin Kay, Ph.D.
Acting Director

March 2016

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Executive Summary

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The County of Los Angeles Department of Mental Health (LACDMH) Quality Improvement Annual Work Plan is organized into six (6) major domains, which include: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, and Provider Appeals. Each domain is designed to address service needs and the quality of services provided. The Quality Improvement Program is dedicated to fostering consumer focused, culturally competent services and improving access to underserved populations.

The County of Los Angeles is the most populated county in the nation with an estimated population of 10,069,036 in CY 2014. The estimated distribution by ethnicity in the major designated ethnic categories is: Latinos representing 48.2%, Whites 28.4%, Asian and Pacific Islanders 14.6%, African Americans 8.6%, and Native Americans representing 0.2%. During FY 2014-2015, the Department and its contracted and directly operated agencies provided a full array of mental health services to approximately 265,000 children and youth with Serious Emotional Disturbance (SED) and adults and older adults with Serious Mental Illness (SMI). The work plan goals focus on the outpatient programs that served approximately 214,067 persons countywide.

This Quality Improvement Work Plan Evaluation Report details the progress LACDMH has made with respect to the 2015 Annual Work Plan Goals. Out of the 19 goals for CY 2015, 12 goals either met or exceeded the goal. Within the six domains for work plan goals, each domain had at least one goal that was met.

In addition to analysis of unmet needs via Penetration Rates, trending analysis of data for the last five years is used to further understand and assess the adequacy of meeting the mental health service needs of the population. Service delivery capacity work plan goals for 2016 are based on population living at or below 138% Federal Poverty Level (FPL) population to include services to newly eligible under the Medicaid Expansion as of January 2014. The expansion of services with healthcare reform is significant for LACDMH requiring integration of physical health, mental health, and substance abuse services.

The 2016 Quality Improvement Work Plan Goals are set by the Program Support Bureau-Quality Improvement Division (PSB-QID) under the authorization of the LACDMH Executive Management Team and in collaboration with LACDMH Bureaus and Divisions including: Emergency Outreach Bureau, Patients' Rights Office, Office of the Medical Director, ACCESS Center, the Mental Health Services Act (MHSA) Implementation and Outcomes Division, Office of the Director, Community and Government Relations Division, Systems of Care, and Service Area Quality Improvement Committees who have all contributed to this report.

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COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH

QUALITY IMPROVEMENT WORK PLAN EVALUATION CALENDAR YEAR 2015 AND QUALITY IMPROVEMENT WORK PLAN CALENDAR YEAR 2016

In partnering with consumers, families and communities to create culturally competent opportunities for Hope, Wellness and Recovery, the County of Los Angeles Department of Mental Health (LACDMH) is committed to serving, improving and making a difference in the lives of Los Angeles County residents who have been diagnosed with mental illness.

The Affordable Care Act National Strategies for Quality Improvement in Health Care have guided our efforts to achieve the three aims of improving the quality of care, improving the health of consumers, and providing affordable care. Through ongoing innovation we strive for an integrated model of healthcare that encompasses mental health, physical health, and substance abuse services. LACDMH is working to design and implement a next-generation behavioral health service delivery system, which provides an integrated array of high-quality, recovery-focused behavioral health services achieving the triple aim. We embrace the cultural diversity of the communities we serve and recognize the highly diverse and interconnected set of communities with unique cultures, strengths, challenges, and behavioral health needs.

The QI Work Plan goals are in place in order to monitor and evaluate the accessibility of services and service delivery capacity; beneficiary satisfaction; clinical care; and the quality of the service delivery system.

SECTION 1

QUALITY IMPROVEMENT PROGRAM DESCRIPTION

Quality Improvement Program Structure

The Program Support Bureau (PSB), Quality Improvement Division (QID) is under the administration and direction of the PSB Deputy Director. PSB-QID shares responsibility with providers to maintain and improve the quality of service and the delivery infrastructure. QID establishes annual Work Plan goals, monitors departmental activities for effectiveness, and conducts processes for continuous improvement of services in collaboration with other Departmental Bureaus. The structure and process of the LACDMH QI Program are outlined in the Department's Policy and Procedure 1100.01, Quality Improvement Program Policy. QID works to ensure that the quality and appropriateness of care delivered to consumers meets or exceeds local, State, and Federal service standards. The QI Program is organized and implemented in support of an organizational culture of continuous quality improvement that fosters wellness and recovery; reduces disparities; promotes consumer and family involvement; improves cultural competency; and integrates the treatment of mental health and substance use disorders with physical healthcare.

PSB-QID includes the following three (3) Units: the Quality Improvement (QI) and Data-Geographic Information System (GIS) Unit, the Under Served Cultural Communities (UsCC)/Innovations (INN) Unit, and the Cultural Competency Unit (CCU). The QI-Data GIS Unit is responsible for the collection, analysis, and reporting of LACDMH demographic and clinical data. The QI-Data GIS Unit conducts assessments of the Department's geographic distribution of mental health services. The UsCC/INN Unit has responsibility for implementing one-time funded projects within our system of care to build capacity and increase access for underserved cultural communities specifically the African/African American, the American Indian/Alaska Native, Asian Pacific Islander, Eastern-European/Middle Eastern, Latino and the Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two Spirit (LGBTQI2-S) communities. The UsCC/INN Unit also implements the Community-Designed Integrated Care Program (ICP) Model which promotes the establishment of networks of care that include formal providers, non-traditional healers, and community-based organizations to integrate physical healthcare, mental health care, and substance use treatment for the five ethnic UsCC groups. CCU, managed by the LACDMH Ethnic Services Manager (ESM), promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations. CCU provides technical assistance and training necessary to integrate cultural competency into departmental operations and works to implement the Department's Cultural Competency Plan.

The QI Work Plan includes areas of performance measurement, monitoring, and management regarding service delivery capacity; timeliness, accessibility, and quality of services; cultural competency; and consumer and family satisfaction. The data collected is analyzed and used for decision making, monitoring change, and for performance management to improve services and the quality of care.

Performance Improvement Projects (PIPs): Departmental PIPs are conducted to ensure that selected administrative and clinical processes are studied to improve performance outcomes.

Each year QID conducts a clinical and a non-clinical PIP. The clinical PIP for FY 2014-2015 was on Commercially Sexual Exploitation of Children (CSEC). This Clinical PIP was focused on the population of commercially sexually exploited children (CSEC). According to Federal Bureau of Investigations (FBI) statistics, three of the largest child prostitution trafficking areas are located within California. During the past two years 1,277 CSEC victims have been identified in the state of California. Available information indicates that accurate identification of these individuals is challenging for a number of reasons – not the least is the reluctance for these individuals to self-identify.

Due to local concerns, in 2013 local members of the County of Los Angeles Board of Supervisors introduced a resolution to create a countywide, multi-agency response to sexual trafficking of minors. The belief was that the number of individuals victimized by sex trafficking was quite high and therefore a combination of legal, social services and mental health interventions were required. An element of this includes a Succeeding Through Achievement and Resilience (STAR) court for addressing these individuals' needs and helping them resume a more successful lifestyle.

As a clinical matter, LACDMH cites studies, one which indicated that 68% of CSEC victims suffer from Post-Traumatic Stress Disorder (PTSD); another study indicated that 35% engaged in self-injurious behavior. Equally concerning was the finding that 25% remained aligned with their exploiters, and felt these individuals cared about their welfare. Unplanned pregnancies and significant drug abuse were additional risk factors.

LACDMH identified 17,921 consumers under the age of 21 years who received trauma-focused Evidence-Based Practices (EBPs) during FY 13-14. The clinicians who were involved in this care were provided additional training regarding the identification and treatment of CSEC victims. Based on pre/post surveys, LACDMH estimates that as many as 750 CSEC victims have been treated by LACDMH clinicians per year. The number is expected to increase as the results of training are seen in clinical assessments.

LACDMH's interventions included training of staff who is already involved in providing trauma-focused EBPs with CSEC specific information. The intended outcome was to increase their awareness of CSEC and related mental health issues, including both treatment issues and strategies to improve CSEC identification in clinical interviews. Additionally, the focus of this training included a survey to determine improved clinician confidence in treatment of this population.

The strongest clinical indicator proposed in this PIP was the comparison of clinical outcome instruments pre/post training, which involved the use of the PTSD-Reaction Index (RI), and Youth Outcome Questionnaire (YOQ), or Outcome Questionnaire (OQ), depending upon consumer age.

The non-Clinical PIP for FY 2014-2015 was the Vacancy Adjustment and Notification System (VANS). This PIP's origins are with the Service Area 4, a small but densely populated LACDMH region including Hollywood, and the City of Los Angeles. Challenges in filling open treatment slots existed for some providers; for others there was not a reliable way of knowing where unused capacity existed when the provider had requests for services it was currently unable to meet. In some instances, this related to needs for EBPs; in other cases it related to specific linguistic capacity or geographic proximity of services.

Following efforts to survey providers and identify the needed elements, VANS, an electronic tracking system was created. Starting with four of the 75 providers expressing interest in the use of VANS, it increased to 24 providers by February of 2015. Using VANS, 31 documented referrals have been made by five providers. It is not known how many times VANS was used in a manner that did not support tracking. In March of 2015, efforts began to bring SA 5 into the VANS user pool.

During the past year, in response to External Quality Review Organization (EQRO) feedback, LACDMH has added a referral button that creates a counting event for VANS referrals. This mechanism has assisted the referral tracking process. A more recent enhancement planned for future implementation includes adding a hyperlink to the referral button which sends an email message to the selected provider.

The QI Division collaborates and coordinates with many of the Department's Bureaus, Divisions and Units to conduct related QI activities including, but not limited to the following: Quality Assurance Division; ACCESS Center; Patients' Rights Office; Office of Strategies for Total Accountability and Total Success (STATS) and Informatics; Office of the Medical Director (OMD); Systems of Care – Children, Transitional Age Youth (TAY), Adult, and Older Adult; Mental Health Services Act (MHSA) Implementation and Outcomes Division; Emergency Outreach Bureau (EOB); Service Area QI Committees, and the multidisciplinary PIP Teams.

The departmental Countywide Quality Improvement Council (QIC) is chaired by the PSB-QID Mental Health Clinical Program Manager. It is Co-Chaired by a Regional Medical Director from OMD. The PSB-QID Mental Health Clinical Program Manager also participates on the Southern California QIC, the Statewide QIC, the State Metrics Workgroup, the LACDMH STATS, the Clinical Policy Committee, and the Executive Dashboard. The supervisor of the CCU serves as the LACDMH Ethnic Services Manager and is a standing member of the departmental Countywide QIC, the departmental Countywide Cultural Competency Committee (CCC), and the Cultural Competency, Equity, and Social Justice Committee (CCESJC).

The QI Program acts in coordination with the service delivery system. The departmental Countywide QIC meets monthly and includes standing representation from each of the eight (8) Services Areas, departmental programs and divisions, and other stakeholders. All Service Areas have their own Service Area Quality Improvement Committee (SA QIC) meetings. Each SA QIC has a Chair representing Directly Operated Providers and most have a Co-Chair who represents Contract Providers. The

SA QIC Chair and Co-Chair are representative members of the departmental Countywide QIC.

At the provider level, all Directly Operated and Contracted Providers participate in their own Organizational QIC. In order to ensure that the QIC communication feedback loop is complete, all SA Organizational Providers are required to participate in their local SA QIC. This constitutes a structure that supports effective communication between Providers and Service Area QICs, up to the departmental QIC, and back through the system of care. An additional communication loop exists between the SA QIC Chairs and/or Co-Chairs and the respective Service Area District Chiefs and Service Area Advisory Committee (SAAC). The SAACs are comprised of consumers, family members, providers and LACDMH staff. The SAACs provide valuable information for program planning and opportunities for program and service improvement. SAACs are a centralized venue for consumers and family members to participate. The QID Program manager presents important departmental PIPs and QI related information at the SAAC meetings. Feedback from these meetings is then incorporated into QI activities.

The PSB-QID Cultural Competency Unit

The Cultural Competency Unit (CCU) is under the direction of PSB-QID. This organizational structure allows for cultural competency to be integrated into PSB-QID roles and responsibilities to systematically improve services and accountability to our consumers, their family members, and the communities we serve. This structure also places the CCU in a position to collaborate with several LACDMH Programs such as the PSB-QID's UsCC/INN Unit, the Patients' Rights Office (PRO), the Workforce, Education and Training (WET) Division, MHSA Implementation and Outcomes Division and the Service Area Quality Improvement Committees. The supervisor for the CCU is also the LACDMH Ethnic Services Manager. This strategy facilitates the administrative oversight of the Cultural Competency Committee (CCC) activities and for the Unit to anchor the Cultural Competence Plan Requirements (CCPR) and the California Reducing Disparities Project (CRDP) Reports as our departmental framework to integrate cultural competency in service planning and delivery. The CCU promotes awareness and utilization of this framework to reduce disparities; combat stigma; promote hope, wellness, recovery and resiliency; and serve our communities with quality care.

Most salient activities of the CCU in CY 2015:

1) <u>Revision of LACDMH Policies and Procedures (P&Ps) related to cultural competency</u>
   - Policy No. 602.01 - Bilingual Bonus, revisions include:
     - Definitions for language translation and interpretation
     - Expansion of the eligibility criteria for bilingual certified employees to qualify for bilingual bonus
     - DMH-Human Resources Bureau's responsibility for maintaining a current list of employees receiving bilingual bonus

- Introduction of the "Request for Interpretation/Translation Services" (RITS) form to be submitted when language interpretation and translation services are requested across LACDMH programs

  This P&P became effective in May 2015

- Policy No 200.03 - Language Translation and Interpretation Services, revisions include:
  - Definitions for Limited English Proficiency (LEP), threshold language, non-threshold language, primary or preferred language, language translation, and types of language interpretation (face-to-face, simultaneous, and telephonic)
  - Delineation of procedures to be followed by directly-operated programs when language translation and interpretation services are needed, including hearing impaired language interpretation

    This P&P became effective in February 2016

2) <u>Cultural Competence Plan Requirements (CCPR)</u>

   In preparation for the release of the revised CCPR by the Department of Health Care Services, the ESM gathered content information for inclusion in the LACDMH Cultural Competence Plan. Due to the postponement of the revised CCPR release, this information was utilized to complete the CC Plan Update for CY 2015. Some examples of the information gathered include:

   - Departmental initiatives related to cultural competency
   - SA based outreach and engagement activities
   - CCC demographics
   - MHSA Plan updates

3) <u>Review of the CRDP Strategic Plan Draft</u>

   The ESM led the CRDP Strategic Plan Ad hoc Workgroup for the purpose of reviewing the 56 page long draft plan and developing recommendations. Once completed, the recommendations were vetted through the Cultural Competency Committee and subsequently submitted to the California Department of Public Health, Office of Health Equity. The recommendations were organized under the following themes:

   - CRDP Strategic Plan language revisions
   - Strategic Plan rollout and distribution to the community
   - Service accessibility
   - Inclusion of traditional and non-traditional service providers
   - Inclusion of faith-based providers
   - Workforce
   - Proposal evaluation

4) <u>External Quality Review Organization (EQRO) System Review</u>

   The CCU played an active role in the EQRO System Review. The Unit coordinated the collection of reports from 14 Programs regarding their current strategies to reduce mental health disparities, consumer utilization data, staff trainings and workforce development. The CCU also provided technical assistance to the

Programs for the completion of these reports. The collective information gathered was utilized for the 2015 LACDMH CC Plan Update and EQRO evidentiary documentation. Additionally, the CCU and CCC Co-Chairs participated in the disparities session of the EQRO System Review, during which the ESM presented on the CCC's projects and activities.

5) Cultural Competency (CC) Web-based Training Project

The ESM, in close collaboration with QID and PSB Administration managers, is in the process of implementing a county wide three-hour foundational CC Web-based Training that is relevant to the diverse cultural and linguistic populations served by LACDMH. The purpose of this training is for administration/ management, direct service providers and support/clerical staff to acquire and build cross-cultural knowledge and skills to serve our communities with culturally sound and linguistically appropriate services. Once implemented, this project will meet the CC Plan requirements related to foundational cultural competency trainings.

6) Cultural Competence Organizational Assessment Project

The ESM, in close collaboration with QID and PSB Administration managers, developed a Statement of Work (SOW) to carry out a system-wide cultural competence organizational assessment. Currently in draft form, the SOW specifies content areas for development of the organizational assessment tool, data collection and analysis, and outcomes report. As a system-wide endeavor, the CC Organizational Assessment will evaluate the Department's progress in integrating cultural and linguistic competency in service planning, delivery and evaluation. The data outcomes and recommendations from the CC Organizational Assessment will inform future cultural and linguistic competence strategies to reduce disparities within our system of care. The results will also guide future dissemination of cultural and linguistic competency information to the LACDMH workforce. Once the SOW is approved for implementation, the CCC will play an active role in providing stakeholder input for this project.

7) Mental Health Promoters Program

The CCU was initially identified as the lead for the implementation of a countywide Mental Health Promoters Program. The purpose of the countywide expansion of Mental Health Promoters Program is to provide specialized outreach and engagement for four additional UsCC populations (African/African-American, American Indian/Alaska Native, Asian Pacific Islander, and Eastern-European/Middle Easterner); increase service accessibility; reduce stigma; and increase UsCC penetration rates. In September 2015, the implementation of the countywide program was relocated to the SA 7 Administration. The CCU and UsCC Units continue to be involved in the implementation of this project to ensure inclusion of cultural and linguistic competency in service delivery to underrepresented populations.

8) Cultural Competency Trainings and Presentations

The CCU participates in the New Employee Orientation and provides cultural competency presentations to introduce new employees to the functions of the CCU, the County of Los Angeles Demographics and threshold languages, the CCPR and

the Department's strategies to reduce mental health disparities. In addition to delivering presentations regarding cultural competency within LACDMH, the ESM also collaborated with various community-based organizations by serving as a key note speaker for the Legal Aid Foundation of Los Angeles conference, and as a cultural competency trainer for management and administrative staff at the Charles R. University of Medicine and Science. Most significantly, the ESM represented LACDMH at a panel presentation on departmental cultural competency strategies for the County Behavioral Health Directors Association (CBHDA) meeting in July 2015.

9) CCC Administrative Oversight

The CCU continues to provide on-going technical assistance and administrative oversight conducive to the attainment of the Committee's goals and objectives. The ESM monitors all activities pertaining to the CCC and provides updates on the CCU's projects as well as cultural competency initiatives at the State and County levels during CCC meetings. The ESM also participates in the CCC Leadership meetings, with the CCC Co-Chairs and the Acting Chief Deputy Director to plan meeting agendas, objectives and activities. Additionally, the ESM facilitated an ad hoc workgroup to create the CCC logo.

10) Provision of CC Technical Assistance for Various LACDMH Programs

- Workforce, Education and Training (WET) Division

  The CCU conducted an analysis of the cultural competency trainings offered by the WET Division during FY 14-15. All trainings were classified in accordance to areas of cultural competency content specified in the CCPR. The areas of classification include:

  - Specific areas of cultural competency addressed by the trainings (i.e. ethnicity; gender; sexual orientation; age group; language interpretation; spirituality; client culture; and special populations such as homeless, substance use, hearing impaired, and forensic)
  - Cultural formulation
  - Multicultural knowledge
  - Cultural sensitivity
  - Cultural awareness
  - Social/cultural diversity
  - Mental health interpreter training series
  - General cultural competency

  A summary chart was generated as a reporting tool on the number, frequency and cultural competency content of the trainings offered by the WET Division.

- MHSA Implementation and Outcomes Division

  The ESM participated in the Prevention and Early Intervention (PEI) Regulations Stakeholder Workgroup for the System Leadership Team. The purpose of this collaboration was: (1) Providing recommendations regarding the inclusion of cultural competency in the implementation of these regulatory requirements, and (2) Providing stakeholder input regarding reporting requirements for the annual PEI Program and Evaluation Report.

- ACCESS Center and Administrative Support Bureau (ASB)

The ESM participated in collaborative meetings with the ACCESS Center, ASB, and QID for the purpose of responding to complaints received regarding the contracted language interpretation vendor. The contractual agreement was reviewed to determine the interpretation services parameters in the threshold and non-threshold languages. Further, areas of improvement were identified to strengthen these services.

11) Service Area Quality Improvement Committees (SA QICs)

The CCU continued to participate in SA QIC meetings to provide departmental updates related to cultural competency activities, such as the CCPR and CRDP Strategic Plan, CCC activities, and the UsCC subcommittees' capacity building projects. Examples of information presented at the SA QICs include:

- Live demo of the online Provider Directory highlighting the cultural and language translation features of the directory
- CRDP Strategic Plan
- LACDMH's P&Ps related to cultural competency such as Bilingual Bonus and Hearing Impaired Mental Health Access
- CCC workgroups and activities
- UsCC capacity building projects for FY 14-15

12) Data Collection, Analysis and Reporting of Preferred Language Requests

The CCU continues the collection and analysis of all the preferred language requests reported by LACDMH providers via their Initial Request & Referral Logs for Culture Specific Mental Health Services. The Unit produces monthly and annual summaries of the total requests for preferred threshold and non-threshold languages by Service Area. These reports are utilized to track the language requests from LEP consumers at the time they access mental health services.

Cultural Competency Committee (CCC)

The CCC serves as an advisory group for the infusion of cultural competency in all County of Los Angeles Department of Mental Health (LACDMH) operations, service planning, delivery and evaluation. Administratively, the CCC is housed within the PSB – QID's CCU. Comprised of 77 members, the CCC membership includes the cultural perspectives of consumers, family members, advocates, directly operated providers, contract providers, and community-based organizations. In addition to promoting participation of consumers, family members and community members, the CCC considers the expertise from the Service Areas' clinical programs and administrative programs, front line staff, and management to be essential for the mission of the Committee as well as the impact that it hopes to have in our current system of care.

CCC Mission Statement

"Increase cultural awareness, sensitivity, and responsiveness in the County of Los Angeles Department of Mental Health's response to the needs of diverse cultural populations to foster hope, wellness, resilience, and recovery in our communities."

Leadership

The CCC is led by two Co-Chairs elected annually by members of the Committee. The roles and responsibilities of the Co-Chairs include:

- Facilitate all meetings
- Engagement of members in Committee discussions
- Collaborate with the CCU in the development of meeting agendas
- Appoint ad hoc subcommittees as needed
- Communicate the focus of the CCC activities and recommendations to diverse LACDMH entities
- Co-Chair is a member of LACDMH's System Leadership Team meetings and holds appointed seat for the CCC.

The LACDMH Ethnic Services Manager (ESM) monitors all activities pertaining to the CCC and provides technical support. The ESM is also the supervisor for the QID-CCU and is a member of the Departmental Countywide Quality Improvement Council (QIC). This structure facilitates communication and collaboration for attaining the goals as set forth in the Departmental QI Work Plan and the Cultural Competence Plan to reduce disparities, increase capacity, and improve the quality and availability of services. Additionally, relevant CCC decisions and activities are reported to the membership at each Departmental QIC meeting.

For Calendar Year (CY) 2015, the CCC leadership was composed of:

- CCC Co-Chairs (LACDMH representative and Community representative)
- LACDMH Program Support Bureau Deputy Director
- LACDMH Ethnic Services Manager

The CCC Co-Chairs and the ESM meet on a monthly basis with the PSB Deputy Director to discuss CCC activities and projects. The CCC Co-Chairs are also members of the UsCC Leadership Committee.

Membership

The membership of the CCC is culturally and linguistically diverse. Every year, the ESM gathers demographical information on the CCC membership. For CY 2015, the CCC members described their racial/ethnic identity as follows: African American, Anglo European, American Indian, Armenian, Asian, Chinese, Eastern European, German, Korean, Vietnamese and White/Caucasian. The biracial/multiracial membership of the CCC includes: American Indian/Chicano, Cahuilla/Caucasian, Chicano, Iranian American, Japanese American, Latino/Chinese, Mexican American, and Spaniard/ Latino/American Indian. These descriptors translate into fourteen ethnic/racial/biracial/ multiracial groups represented within the CCC. Additionally, the following 11 languages are represented in the CCC membership: Armenian, Cahuilla, Cantonese, English, Farsi, French, German, Korean, Spanish, Swahili, and Vietnamese.

CCC Goals and Objectives

At the end of each CY, the Committee holds an annual retreat to review its goals, activities and accomplishments; vote on cultural competency objectives to be undertaken for the next year; and reinforce the collaborative team atmosphere among Committee members. Once the CCC identifies areas of organizational cultural competency to be addressed, it proceeds to operationalize its goals and objectives in the form of workgroups. Each CCC workgroup identifies two co-leads and determines their goals, projects, and meeting frequency. Throughout the CY, the co-leads from each workgroup provide updates to the Committee at large during the monthly meetings for purposes of receiving feedback.

1) For CY 2015, the Committee had three active workgroups. These include the following:

   - The Data Workgroup
   - The Outreach and Presentations Workgroup
   - Juvenile Justice Disparities Workgroup
   - The Data Workgroup: The goal of this workgroup was to develop presentations to be delivered at the Service Area Advisory Committee (SAAC) meetings highlighting culture-related data collection practices by County organizations and LACDMH in order to orient these Committees regarding the relevance of data collection and utilization.
   - Outreach and Presentations Workgroup: The goal of this workgroup was to increase visibility and awareness of the PSB-CCU and the CCC through Outreach and Presentations to the various departmental venues in all Service Areas, such as the Service Area Advisory Committees. By disseminating culturally relevant information at the Service Areas, the Outreach and Presentations Workgroup aims to: Learn about the cultural competency needs of the different Service Areas and establish a feedback loop that will provide relevant information regarding the cultural needs of each Service Area.
   - Juvenile Justice Disparities Workgroup: The goal of this workgroup was to reduce recidivism and increase parity within the juvenile justice system by promoting clinicians' awareness of the impact of cultural issues on their clients' risk behaviors and protective factors while detained.

2) Key words to guide the CCC in 2015

   The CCC engaged in a reflective exercise on what the concept of "cultural competency" means to each member. Feedback from the CCC members on the meaning of "cultural competency" included:

   - Developing understanding of others
   - Demonstrating curiosity and empathy
   - Acknowledging differences
   - Engaging in healthy dialogue
   - Not being offensive

- Having a voice and a choice
- Being relevant and knowledgeable
- Listening and not assuming
- Not assuming you know everything about others within your culture
- Not being judgmental
- Appreciating all cultures
- Having respect for the unknown
- Being respectful to each human being
- Applying cultural sensitivity techniques
- Bridging to other people
- Developing a sense of community
- Respecting the dignity of others
- Self-awareness
- Honest self-assessment
- Accountability
- Empowerment
- Teaching
- Humility
- Inclusiveness
- Cultural humility
- Commitment
- "It does not matter how much we know until others know how much we care."

The four words chosen by the CCC to frame its activities for 2015 were:

- Collaboration
- Communication
- Inclusion
- Equality

3) <u>Development of the CCC Logo:</u>

To give the CCC a public image, a logo creation ad hoc workgroup was led by the ESM. The following logo themes and mottos generated by the workgroup were presented to the Committee for feedback:

- "Cultural Competency as unique as your fingerprint"

Illustrated as a hand with the thumb up

- "On the road to Cultural Competency"

Illustrated as a bus on the road to Cultural Competency, a road sign that reads 'CC continue ahead' and the lanes separated by words describing different aspects of culture

- "Seeing eye to eye"

Illustrated as an eye and underneath the eye are two people shaking hands

- "The heart of Cultural Competency values"

Illustrated as a heart with a flowing ray coming out of the center of the heart with the words humility, openness, and appreciation

The CCC reviewed several logo sketches created based on the themes described above and selected the following as its official logo and motto:

Many cultures, one world.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

Annual Report of CCC

Evaluation of Goals and Objectives

1) The Data Workgroup
   Accomplishments include:

   - Revisions and CCC approval of the PowerPoint presentation titled: "Using Data to Identify Community Cultural Needs"
   - The Data Workgroup PowerPoint presentation was restructured and modified to make it more focused, clear, and easy to understand
   - The Workgroup created pre and post presentation evaluation forms titled "Beginning Presentation Questionnaire" and "Ending Presentation Questionnaire" to gather audience feedback when CCC Workgroups presentations take place
   - Reviewed data and identified Providers with low scores in the Mental Health Statistical Improvement Program (MHSIP) consumer survey's item: "Staff was sensitive to my cultural background"
   - Created a fact sheet to introduce the MHSIP at various LACDMH venues
   - Collaborated with the Outreach and Presentation Workgroup to discuss scheduling the PowerPoint presentation for the SAACs.

2) The Outreach and Presentations Workgroup

   Accomplishments include:

   - Creation of packets containing basic information pertinent to cultural competency for the SAACs. This information included, but was not limited to the CCC's meeting schedule, CCC Workgroups and their projects, and the Culturally and Linguistically Appropriate Services (CLAS) definition of culture, among others
   - Recruitment of cultural competency liaisons for all SAACs with the purpose of having monthly CCC updates in SAAC meetings
   - Collaborated with the Data Workgroup in introducing the presentation to the SAACs as a potential presentation

3) The Juvenile Justice Workgroup

   Accomplishments include:

   - The Workgroup drafted culturally sensitive questions to be included in the "Juvenile Justice Mental Health Assessment"
   - The questionnaire was reviewed by the Workgroup members and the ESM for additional feedback. The revised questionnaire will be presented to the CCC in early 2016 for stakeholder input.

4) Four guiding words for 2015 evaluation

   The CCC engaged in a reflective exercise on how the Committee had applied its four guiding words [Collaboration, Communication, Inclusion and Equality] during CY 2015.

The Committee concluded that the four guiding words had been consistently applied in way the workgroups interacted. Several examples were provided on how the Workgroups kept open communication and collaboration amongst them when planning and coordinating their activities. Examples:

- The Data Workgroup and Outreach and Presentations Workgroup have collaborated in the review of the Data Workgroup's PowerPoint presentation
- The Outreach and Presentations Workgroup introduced the Data Workgroup PowerPoint to the cultural competency liaison at each SAAC for purposes of scheduling the presentation.

Reviews and Recommendations to County Programs and Services

As an advisory group to the Department, the CCC provides feedback and recommendations to various Programs. The collective voice of the CCC is also represented at the SLT monthly meetings. This practice ensures that the voice and recommendations of the Committee are heard at these system-wide decision-making meetings. The voice of the CCC is also strengthened by the Co-Chairs' participation in the UsCC Leadership Team. Together, the CCC and UsCC subcommittees advocate for the needs of diverse underserved cultural groups and the elimination of mental health disparities.

The CCC also has an impact on the system of care by inviting and scheduling presentations from various LACDMH programs. These presentations take place during the monthly meetings. Feedback is either provided by the Committee at large or an ad hoc workgroup, when the Committee deems that an in-depth project review is necessary. In CY 2015, the CCC was involved in reviewing and provided feedback for the following developmental, county and state level projects:

1) <u>Consolidation of the Departments of Health Services (DHS), Mental Health (DMH) and Public Health (DPH)</u>

   In February 2015, the CCC dedicated meetings and formed an ad hoc workgroup to respond to the County of Los Angeles Board of Supervisors' motion for the creation of a Health Agency with oversight of the DMH, DPH, and DHS under one umbrella. Specifically, the CCC organized and hosted meetings with the DHS representative to express concerns about the consolidation and provided specific recommendations to ensure that cultural and linguistic competency continue to be a priority under the proposed Health Agency Model.

   The Co-Chairs from the CCC and UsCC subcommittees (African/African American [AAA]; American Indian/Alaska Native [AI/AN]; Asian Pacific Islander [API]; Eastern-European/Middle Eastern [EE/ME]; Latino; and Lesbian, Gay, Bisexual, Transgender, and Questioning [LGBTQ]) presented specific concerns for their communities:

   - "The consolidation will add layers of additional bureaucracy and administrative cost, which will ultimately take away services from our underserved, unserved, and inappropriately served communities
   - A bureaucratic management design is not favorable to the elimination of mental health disparities

- The documentation regarding the merger (e.g. planning principles and operation parameters) failed to include cultural competency
- The consolidation will operate based on the medical model which has historically lacked the cultural sensitivity as well as linguistic competency in service delivery
- The philosophy of the medical model will replace the recovery model, which is the framework for DMH's service planning and delivery
- DMH's current efforts for service integration, elimination of stigma, and reduction of mental health disparities will vanish
- Different aspects of cultural competency such as spirituality and collaborations with community partners will also vanish
- The proposed consolidation model will regress DMH's progress and success in engaging and serving underserved communities with culturally and linguistically appropriate services, and in promoting stakeholder involvement
- The DHS's lack of experience in community involvement and partnering with Stakeholders will result in the needs of underserved groups being neglected and ignored
- The consolidation will result in a managed care system and that will eradicate DMH's effort to provide client-driven and culture driven services
- The Mental Health Services Act (MHSA) funding for underserved populations to access services, reduce stigma, and fund innovative programs that incorporate community-design approaches will be negatively impacted by the consolidation
- The consolidation of the three Departments will affect the community negatively as there will be a greater need to build a cultural and linguistic competent workforce."

Later in 2015, when the draft report for the "Creation of a Health Agency" was released for public comments, the CCC actively advocated to the inclusion of cultural competency at every level of planning and implementation of this new motion.

2) <u>The CRDP Strategic Plan</u>

The CCC has a high regard for the CRDP Reports for voicing the perspectives of underserved communities and providing strategies to reduce mental health disparities. An ad hoc workgroup was created and led by the ESM to review the 56 page-long CRDP Strategic Plan. Specific recommendations were drafted under the following themes:

- CRDP Strategic Plan language revisions
- Strategic Plan rollout and distribution to the community
- Service accessibility
- Inclusion of traditional and nontraditional service providers
- Inclusion of faith-based providers
- Workforce
- Proposal evaluation

Once completed, the recommendations were vetted through the Committee and subsequently submitted to the California Department of Public Health, Office of Health Equity.

3) INN 2

In August 2015, the CCC welcomed speakers from the MHSA Outcomes and Implementation Division who provided a presentation on the latest developments regarding Innovation 2 (INN 2) - Health Neighborhoods. Of particular interest to the CCC were:

- The primary purpose of the Health Neighborhoods
  - Increase access to underserved groups
  - Increase access to mental health services
  - Promote inter-agency or community collaboration related to mental health services

- The 10 health neighborhood strategies
  - Community club house
  - Trauma-informed psycho-education and support for school communities
  - Transitional Age Youth (TAY) peer support networks
  - Outreach and Engagement to TAY
  - Coordinated employment within a Health Neighborhood
  - Community integration for individuals with a mental illness with recent incarcerations or diverted from the criminal justice system
  - Veterans peer support via social media application for Smartphones
  - Support networks without walls for older adults at risk of developing mental illness
  - Community-based strategies to support caregivers for older adults with a mental illness
  - Culturally competent non-traditional self-help activities for families with multiple generations experiencing trauma

The CCC praised the inclusion of cultural competency in the INN 2 – Health Neighborhood Initiative. Specifically, underserved communities, TAY, older adults, caregivers and families, veterans, and incarcerated persons.

4) In September 2015, the LACDMH former Director, Dr. Marvin Southard visited the CCC and asked the Committee for recommendations regarding cultural competency that can be advocated for during the rollout of the Health Agency Model.

- The CCC formed an ad hoc workgroup to draft the recommendations and vetted them by the Committee at large. The CCC recommendations addressed the following topics:
  - Culturally and linguistically responsive service delivery
  - Cultural competency training
  - Advocacy for cultural groups

5) LGBTQI2-S UsCC Presentation

In October 2015, the CCC invited the LGBTQI2-S UsCC subcommittee to present on their capacity-building projects:

- LGBTQI2-S glossary, which will serve as an educational tool for the LACDMH workforce
- LGBTQ survey, which aims to gather data pertaining to mental health clinicians' level of awareness and sensitivity when providing services for the LGBTQ population. The findings of the survey will be used to assist the subcommittee to better identify future capacity building projects targeted for the LGBTQ community. The survey will be implemented in February 1, 2016. The CCC will request a presentation of the survey results once these become available.

Additionally, the CCC learned about the expansion of the subcommittee's acronym, which now includes "I" for Intersex and "2-S" for Two Spirit. Handouts relevant to the two projects were distributed to the CCC membership

6) Under Represented Ethnic Populations (UREP) subcommittees' name change

The UsCC Leadership Committee met in November 2015 and discussed a possible name change for the former UREP subcommittees to be inclusive of cultural diversity. The name change was considered in light of the fact that cultural diversity transcends ethnicity and language. In January 2016, the UREP subcommittees became the UsCC subcommittees.

Goals of Cultural Competence Plan

1) Cultural Competence Plan Requirements (CCPR) Updates

The ESM provides a monthly update on various cultural competency initiatives at departmental and state levels, including the status of the CCPR release. During CY 2015, the Committee engaged in discussions regarding updates to the Criterion 4 of the CCPR, "Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System".

In particular, Criterion 4 of the CC Plan will include information on the group affiliations of the CCC membership. A template table was circulated for members to report group affiliations in which they act as cultural competency representatives.

2) External Quality Review Organization (EQRO) System Review

Cultural competence is one of the core areas of content for the annual EQRO System Review. The CCC and CCU play an active role by participating in sessions pertinent to the Cultural Competence Plan and mental health disparities. A presentation regarding the CCC's projects and activities was delivered by the ESM during the EQRO System Review. Additionally, monthly CCC meeting minutes were submitted as evidentiary documentation. The CCC and UsCC subcommittee Co-Chairs attended the EQRO session on disparities and answered follow-up questions from the reviewers.

3) Medi-Cal System Review Protocol Training

The CCU members attended a training regarding the 2015 annual review protocol for "Consolidated Specialty Mental Health Services and Other Funded Services." The ESM brought information back to the CCC regarding protocol items pertinent to the Committee's goals and activities. The membership was also informed that the Medi-Cal System Review will take place the week of February 8, 2016.

The CCC engaged in a discussion on the importance of documenting workgroup activities in order to capture the activities of the three workgroups. Each workgroup will provide detailed information regarding their activities and accomplishments for inclusion in the 2015 CCC annual report, which will be featured as Medi-Cal System Review documentation, along with the CCC meeting minutes and agendas.

4) Cultural Competence Organizational Assessment

The ESM developed a Statement of Work (SOW) to carry out a system-wide cultural competence organizational assessment. Currently in draft form, the SOW specifies content areas for development of the organizational assessment tool, data collection and analysis, and outcomes report.

As a system-wide endeavor, the CC Organizational Assessment will evaluate the Department's progress in integrating cultural and linguistic competency in service planning, delivery and evaluation. The data outcomes and recommendations from the CC Organizational Assessment will inform future cultural and linguistic competence strategies to reduce disparities within our system of care. The results will also guide future dissemination of cultural and linguistic competency information to the LACDMH workforce.

Once the SOW is approved for implementation, the CCC will play an active role in providing stakeholder input for this project.

5) Online Provider Directory

The ESM demonstration to the CCC and SA QICs on how to access the online provider directory highlighted the culture and language-related features of the directory. The objective of the live demonstration was for the Committees to become familiarized with the directory. They learned that online directory searches can be done by Service Area, service type, organization type, age groups served, languages/cultures, and Specialty Mental Health Services. Additionally, they were informed that the online directory has the capability for language translation via its "Google Translate" feature, with more than 90 languages listed in the drop down menu. The link for the online provider directory is provided below.

http://psbqi.dmh.lacounty.gov/providerdirectory.htm

The CCC was pleased with the online Provider Directory as a tool that provides culturally and linguistically diverse communities the option to access information regarding mental health services in their preferred languages.

6) DMH Policies and Procedures (P&P) previously revised by the CCC

The revised DMH P&P 602.01 - Bilingual Bonus revisions became effective in May 2015. The CCC provided input on the P&P with the goal of increasing intradepartmental collaboration in language translation and interpretation services. The revised policy specifies the procedure to request language translation or interpretation services by a bilingual certified employee across Programs/Units. Additionally, it promotes tracking of departmental translations by directing Programs to notify the ESM when documents are translated.

Human Resources Report

The CCC requested a presentation from the PSB-QID - Data/GIS Unit regarding the location of service providers, language capability, and distance traveled by LACDMH consumers to obtain mental health services. The presentation highlighted the multiple uses of the DMH Online Provider Directory and the Google maps feature in mapping geographic areas, provider service delivery capacity, and data analysis of services received by LACDMH consumers. After the presentation, the CCC had a lengthy discussion on how the Workgroups could utilize this information in various presentations and to continuously be informed about mental health disparities, consumer population demographics, and the needs of ethnically diverse consumer populations.

In CY 2015, the CCC gained access to LACDMH bilingual certified employee information, through the PSB-QID. The lists are reviewed to determine the number of bilingual certified employees in the threshold languages. This information is valuable to the CCC and CCU as inquiries are often received from Programs seeking assistance with language translation and interpretation services.

Additionally, the CCC has delegate representation and voting privileges at the departmental System Leadership Team (SLT) meetings via the appointed CCC Co-Chair. These meetings focus on the implementation of MHSA-funded programs, inclusive of hiring of culturally and linguistic competent new staff, and translation of brochures and other materials. The CCC Co-Chair provides input during SLT meetings and brings the information back to the Committee for further guidance and recommendations.

County Organizational Assessment

The CCC utilizes the strategic areas identified in the LACDMH Cultural Competence Organizational Assessment in planning its activities. The strategic areas include:

- Cultural Competent System of Care
- Funding
- Human Resources
- Policy
- Structure
- Training
- Treatment Outcome Measurement
- MHSA

Different presentations are scheduled throughout each CY to provide information and updates on various initiatives that fall under the cultural competence organizational assessment strategic areas.

1) To address the strategic areas of *Culturally Competent System of Care, MHSA, and Funding*, the CCC has delegate representation at the LACDMH System Leadership Team (SLT) meetings. This allows the CCC to actually vote on departmental initiatives that are related to the cultural competency. Some examples include: Expansion in services for the homeless and wellness centers, MHSA Three Year Program and Expenditure Plan, Proposal for the use of unallocated MHSA CSS funds, adjustments to the Adult Field Capable Clinical services, and the renewal of voucher program for veteran housing.

2) To address the strategic areas of *Human Resources and Training*, the ESM represented the CCC in providing input on cultural competency trainings to be considered by the PSB – Workforce, Education and Training Division. Areas of potential trainings suggested by the CCC were Client Culture and a multicultural competency conference.

3) To address the strategic area of *Structure*, cultural competency updates have been provided in all the monthly Service Area-based Quality Improvement Committee meetings. The updates include CCC activities, CCU projects and UsCC capacity-building projects. Additionally, the ESM also provides technical information to various LACDMH Programs and reports back to the CCC during the monthly meetings. For example: Information pertinent to cultural competency was provided to the PSB - Quality Assurance Division for inclusion in the Services Request Tracking System (SRTS) Bulletin and the Short-Doyle/Medi-Cal Organization Provider's Manual for documentation of "Cultural Considerations", p. 10.

4) To address the strategic area of *Policy*, the CCC was updated on the revisions of LACDMH's Policy No 602.01 - Bilingual Bonus had become effective in May 2015. [Please see section titled "Goals of Cultural Competence Plan"].

Training Plan

1) The CCC regularly provides information on LACDMH trainings and conferences related to cultural competency that are available to service providers and community members. This information is documented in the CCC minutes, which in turn are distributed to all the Service Area QICs.

2) The CCC's Outreach and Presentations Workgroup delivered a presentation on the Cultural Competency Committee at some of the SAACs. A brief PowerPoint, developed by the ESM and approved by the CCC, was utilized by this purpose. The PowerPoint features the CLAS definition of culture, the definition of cultural competency, federal, state and county regulations related to cultural competency, CCC mission statement and structure, CCC demographic, agencies represented in the CCC membership and 2015 workgroups.

3) Hope and Recovery Conference

The CCC hosted a panel presentation at the Hope and Recovery Conference held on June 24, 2015. The theme of the conference was "Each one teach one." Selected CCC and UsCC subcommittee members, inclusive of consumers and family members participated in a 60-minute panel presentation during the plenary session of the conference. The goal of the panel was to raise awareness about LACDMH Committees, programs, projects and meetings that provide opportunities for consumer involvement and participation.

Quality Improvement Program Processes

The purpose of design and implementation of the Countywide QI Program is to ensure an organizational culture of continuous self-monitoring through effective strategies, best practices, and activities at all levels of the system.

PSB-QID works in collaboration with departmental staff to establish annual measureable QI Work Plan goals to evaluate performance management activities. The QI Work Plan Goals are categorized into six (6) domains of State and Federal requirements including the following: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care and Provider Appeals. Evaluation of the work plan goals is published annually in a report and is available online at http://psbqi.dmh.lacounty.gov/QI.htm.

PSB-QID is responsible for the formal reporting on annual measurement of consumer perception of satisfaction in six areas namely General Satisfaction, Perception of Access, Perception of Quality and Appropriateness, Perception of Participation in Treatment Planning, Perception of Outcome, Perception of Functioning and Perception of Social Connectedness. The results are reported annually in the State and County Performance Outcomes Report and are available online at:

http://psbqi.dmh.lacounty.gov/QI.htm

The PSB-QID team works to engage and support the SA QIC members in QI processes related to the QI Work Plan, specific PIP activities, and other QI projects conducted at the SA level. SA QIC meetings provide a structured forum for the identification of QI opportunities to address challenges and barriers unique to a SA. SA QIC members also support the provider organizational QICs that are focused on internal organization of QI Programs and activities. Organizational QICs conduct internal monitoring to ensure adherence to performance standards related to Quality Assurance and Quality Improvement. This includes activities such as: client record reviews, identifying clinical issues, and client satisfaction surveys.

PSB-QID Unit Program Descriptions

The PSB-QID Underserved Cultural Communities (UsCC) / Innovations (INN) Unit

(Formerly known as the Under Represented Ethnic Populations – (UREP)/INN Unit)

One of the cornerstones of the Mental Health Services Act (MHSA) is to empower Under Represented Ethnic Populations (UREP). During the planning phase of MHSA, a UREP Work Group, consisting of 56 culturally diverse mental health professionals and community and consumer advocates, was created to make implementation recommendations to LACDMH. This workgroup met extensively to develop guiding principles and recommendations for LACDMH as well as MHSA services. These recommendations were instrumental in establishing the Department's MHSA values and strategies in working with underrepresented ethnic groups. In June 2007, the Department established an internal UREP Unit within the Planning, Outreach and Engagement Division to address the ongoing needs of targeted ethnic and cultural groups. The UREP Unit has established subcommittees dedicated to working with the various under represented ethnic populations in order to address their individual needs. These subcommittees are: African/African American; American Indian/Alaska Native; Asian/Pacific Islander; Eastern European/Middle Eastern; Latino; and Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two Spirit (LGBTQI2-S). In March 2012, the UREP/INN Unit was transitioned to the PSB-QID.

As of January 2016, UREP was renamed as Underserved Cultural Communities (UsCC). Each UsCC subcommittee is allotted one-time funding totaling $100,000 per fiscal year to focus on Community Services and Supports (CSS) based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals were created and submitted via a participatory and consensus-based approach. The following are the projects implemented:

African/African American (AAA) – **1) Resource Mapping Project**: Funds were allocated to identify useful community resources, service providers, and agencies in South Los Angeles County where there is a large African/African American (AAA) population. The directory, of approximately 300 services and listings of unique interest to specific cultural groups, includes names, addresses, contact information, hotlines and toll-free numbers for many categories of various sources. The third reprinting/ updated version of this popular resource was released and all 6,000 printed copies were successfully distributed in SA 6 between November 2014 and March 2015. This directory continues to be in demand. **2) Community Mental Health Stigma Reduction Project:** Funds were allocated to community service providers in Los Angeles County to provide tailored community awareness and service strategies to specific, underserved subcultures in the African/African-American community. The focus of this project was to reduce the stigma of mental illness by funding agencies to provide outreach, engagement, training, education, and non-traditional wellness activities. Technological approaches were also employed, as each agency targeted a unique subpopulation with unique concerns and needs.

The targeted subpopulations were the LGBTQ community, the Somali community and the Pan-African community. Projects for all three subpopulations were successfully completed and each agency met its service deliverables. **3) Mental Health Informational Brochures:** Brochures will be used to outreach and engage underserved, inappropriately served and hard-to-reach ethnic communities. The purpose is to reduce stigma by identifying common mental health conditions experienced in the AAA community. The brochures will be used to educate and inform these ethnically diverse communities of the benefits of utilizing mental health services, and to provide referrals and contact information. The informational brochure will be translated into two (2) different African languages: Amharic and Somali. The brochure's content has been completed, and translations and graphics are in the process of being completed. This phase and the printing phase are expected to be completed by the end of the first quarter of 2016. **4) The Sierra Leone Community Mental Health Education and Training Project** is a joint effort of the Los Angeles County Department of Mental Health (LACDMH) and the African Communities Public Health Coalition (ACPHC) to reduce the stigma of mental illness, specifically in the Sierra Leone community. The purpose is to set a precedent of using culturally appropriate mental health education when working with ethnic communities, and to increase access to culturally appropriate mental health services for people of Sierra Leone descent (especially during a mental health crisis). This nine-month project will provide training to trusted and selected volunteer community members, referred to as Sierra Leone Community Advocates (SLCAs), for them to become 'lay-experts' of mental health issues, crisis intervention, and appropriate mental health resources. This Project was implemented on October 1, 2015 and is scheduled to be completed by June 30, 2016.

Asian Pacific Islander (API) – The API Consumer and Family Member Training and Employment Program was completed on June 30, 2015. The goal of this project was to train API consumers and family members to become culturally competent Peer/Family Advocates. Of the 12 API consumers and family members who graduated from the program, 8 were employed as Peer/Family Advocates at mental health agencies that serve the API community in Los Angeles County. The Peer/Family Advocates are assisting API consumers, especially those with limited English-speaking skills, to navigate the public mental health system and access mental health services.

The API Family Member Mental Health Outreach, Education and Engagement Program was implemented on August 17, 2015. The purpose of this program is to increase awareness of mental illness signs and symptoms for API families so that they know when and how to connect family members to mental health services. The ethnic communities being targeted include the following: Chinese community (Cantonese and Mandarin speaking); Vietnamese community; Korean community; South Asian (Asian Indian/Hindi speaking) community; Cambodian community; and the Samoan community. The program entails 1) The collection and distribution of linguistically and culturally appropriate mental health education and resource materials, 2) The development of an API Family Mental Health Resource List of mental health services and supports for API families in LA County, 3) The implementation of Outreach,

Education and Engagement (OEE) events countywide targeting API families from specific Service Areas and API ethnic communities. The OEE events will be held in collaboration with consumer and family member support groups that serve the API community. Through this Program, API families will receive important information on mental illness, treatment and resources. Participation in this program will increase the knowledge of signs and symptoms of mental illness and encourage early access of services by API families, resulting in an increase in penetration rates in the targeted API communities.

In addition to the capacity building projects, in 2015 the Department utilized CSS funds to develop the Samoan Outreach and Engagement Program. This program was implemented on July 1, 2015 in order to increase awareness of mental illness, knowledge of mental health resources and decrease stigma related to mental health in the Samoan community. DMH contracted with Special Services for Groups (SSG) who partners with two Samoan community based agencies to conduct individual and group outreach and engagement activities with the Samoan community in Service Area 8, which has the largest concentration of Samoans in LA County. As of November 2015, 142 mental health education workshops have been conducted that have reached 729 individuals. Workshop topics were related to mental health and included mental health and nutrition, stress management, substance abuse, teen stress, depression, peer pressure, culture and mental health. Workshops were held at various community locations including Samoan churches (43% of activities), community member homes (32%), high schools, middle schools and at community centers. The workshop attendees were mostly adults (71%), females (61%), and Samoans (99%) who spoke English (93%). By participating in the activity, the majority of attendees (59%) stated that they had improved their emotional well-being, increased understanding of mental health, increased self-awareness and/or received information on how to improve relationships. Most attendees stated that the first person they would contact to help them or someone they know with mental health issues was Pastor/Clergy (34%), Friend (28%) and/or Samoan mental health provider (14%).

Eastern European/Middle Eastern (EE/ME) – The Eastern European and Middle Eastern UsCC subcommittee funded three different capacity building projects. For the Armenian community, televised mental health talk shows were funded to increase mental health awareness, access, reduce stigma, and increase penetration rates. This project consists of forty-four (44) DMH approved mental health TV talk shows to inform the Armenian community about common mental health issues and how to access services in the County of Los Angeles. The shows began to air on June 7th, 2015 and will continue to air for 22 consecutive weeks in the local Armenian television station. The TV shows included, but not limited to the following mental health topics: Introduction to mental health, immigration and acculturation, loss and grief, divorce and its effects on children, bullying, depression, and parenting.

There has been positive feedback from the community pertaining to these shows as they have increased awareness and knowledge of mental illness signs and symptoms among the Armenian community. It was reported by one LACDMH legal entity that specialize in serving the Armenian Speaking community that they are experiencing an increase in calls from Armenian speaking community members seeking mental health

services since the talk shows started to air. In addition, for the Farsi speaking community, the second phase of the mental health radio talk shows was implemented. A total of twenty two (22) new mental health radio shows aired on the local Farsi speaking radio station. The radio talk shows included, but not limited to the following mental health topics: Definition of psychology, mental health issues related to aging, the psychological effects of violence, and healthy relationships. This project was completed on November 1, 2015.

The radio station reported that they received positive feedback from their listeners and that this project educated the community about common mental health issue and how to access services. For the Arabic-speaking community, the Community Mental Health Education Project was funded to increase mental health awareness. This project was implemented on December 1, 2014 and is scheduled to be completed by March 16, 2016. The Community Mental Health Education Project has been providing outreach and engagement services by partnering with faith-based organizations and schools to facilitate mental health community presentations as well as making these materials available by using technological approaches such as web-based informational sites.

Latino – As an expansion of a previous capacity building project that funded the recruitment, training, and integration of Promotoras de Salud Project Model (Health Promoters) within the Latino Community, the Latino UsCC subcommittee funded a six month research project that was implemented in 2015. This research project measured the effectiveness of the Promotoras Project Model as an outreach and engagement strategy aimed at Latinos within the County of Los Angeles. The research findings provided LACDMH with recommendations that focused on the mental health disparities that are significantly impacting the Latino community. The results of this study showed that the Promotores de Salud Mental Model is capable of lowering many of the primary barriers Latina women face in accessing mental health services. Women who participated in a Promotores Project Model (PPM) were more likely to seek mental health services, and had fewer stigmatizing beliefs about mental disorders than women who did not attend a PPM. Furthermore, almost all PPM respondents who wanted mental health services were linked to a provider. These results suggest the PPM helped to reduce the negative outcomes associated with mental disorders. It does so by improving access to mental health services, reducing stigma associated with mental disorders and linking people to mental health resources.

The Latino UsCC subcommittee funded the printing of mental health promotional materials that will be disseminated to increase awareness and promote mental health services targeting all age groups who are monolingual Spanish speakers. These promotional materials will include mental health information and resources to unserved Latino communities within the County of Los Angeles.

In addition, the Latino UsCC subcommittee funded a media outreach campaign. The media outreach campaign consisted of two LACDMH approved media advertisements (commercials) that aired from December 10, 2015 through January 3, 2016 in the local Spanish-speaking television and radio stations. The Ads aired on KMEX on television and KLVE-FM on the radio. The KMEX report shows that the original estimated numbered of Spanish-speaking adults over the age of 18 in the Los Angeles market to be reached was 14.4% and the final number reached was 17.9%. The KLVE-FM report

shows 36.4% of Spanish-speaking adults over the age of 18 in the Los Angeles market were reached. This project was successfully completed by January 3, 2016.

***American Indian/Alaska Native* (AI/AN)** – The AI/AN UsCC subcommittee funded the Community Spirit Healers Wellness Project. The project was launched on August 1, 2014 and was completed on July 31, 2015. To implement this project, five (5) AI/AN community members were recruited and trained as Community Spirit Healers. The Community Spirit Healers were trained to conduct community trainings and forums, which focused on mental health awareness and education. There were a total of 329 community members who participated in the trainings and forums. Overall this project was a success as community members were provided with a venue where they engaged in discussions pertaining to wellness issues and healing. Additionally, the AI/AN UsCC subcommittee funded the development of a media advertisement (commercials) campaign that aired from December 7, 2015 through January 3, 2016 on the local radio and television channels in the County of Los Angeles. This media campaign outreached to the AI/AN community as well as increased mental health awareness throughout the County of Los Angeles. This project was implemented on October 1, 2015 and was successfully completed by January 3, 2016. The Ads aired on KABC-TV on television and KNX 10.70 on the radio. The KABC-TV report shows an achieved rating of 29.1, which means 29.1 of adults over the age of 18 in the Los Angeles market, were reached. The KNX-AM report shows a gross rating point (GRP) of 14.4, which means the radio spots, reached approximately 14.4% of adults over the age of 18 in the Los Angeles market.

This project was successful and the final outcome report was submitted on February 2016.

Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two Spirit (LGBTQI2-S) - The LGBTQI2-S UsCC subcommittee was established on August 27, 2014. As their first project, this subcommittee is currently in the process of launching a LGBTQI2-S survey by March 2016, which aims to gather data pertaining to mental health clinicians' level of awareness and sensitivity when providing services for the LGTBQI2-S population. The LGBTQI2-S UsCC subcommittee funded the LGBTQI2-S Clinical Mental Health Training Project, which focuses on providing mental health clinicians with the unprecedented opportunity to become trained in identifying and treating the unique mental health needs and challenges faced by the LGBTQI2-S youth population. This will be a two-day clinical training with a total of twelve (12) Continuing Education Units for mental health clinicians and there will be one training in Service Areas 2, 4, 6, and 8. It is estimated that a total of 120-160 mental health clinicians will be successfully trained by the end of this project. This project was implemented on October 1, 2015 and is scheduled to be completed by April 1, 2016. Thus far, the training curriculum was approved and all the trainings were conducted. The final summary report for this project will be completed by April 1, 2016.

The QI-Data-GIS Unit

The QI-Data-GIS Unit is responsible for compiling systemwide information on consumers served and estimating populations in need of mental health services. The QI-Data GIS Unit annually calculates the population estimates for persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI), in addition to penetration and retention rates by all demographic categories: age, gender, ethnicity and primary language. Trend analysis is conducted on these data to assess fluctuations in service utilization and service delivery capacity. The Prevalence and Penetration Rates are also calculated for the eight (8) Service Areas for dissemination to the respective District Chiefs and Quality Improvement Liaisons for use in Quality and Performance Improvement Projects.

Mental Health Service Utilization Rates are calculated by census tracts to conduct spatial analysis to estimate geographic areas in need of services. This information is used to estimate service delivery capacity and set targets for meeting the needs of underserved populations. The QI-Data-GIS Unit provides mapping support to all Divisions in the Department and conducts data analysis of services received by consumers by various geo-political boundaries in the County such as Supervisorial Districts, Service Areas, and Health Districts, Medically Underserved Areas, Senate and Congressional boundaries.

The Data GIS Unit maintains and updates the LACDMH Provider Directory of Specialty Mental Health Services (SMHS). The provider directory has information on age groups served, contact information, hours of operation and SMHS provided at each service location to enable consumers and the public to find appropriate mental health services in the County of Los Angeles. The provider directory by Service Area is disseminated as a hard copy annually to Service Area providers for use by consumers and their family members, provider staff, and other stakeholders. This provider directory was also translated into 11 threshold languages and produced in large print format in February 2016. It is available on the internet at:

http://psbqi.dmh.lacounty.gov/providerdirectory.htm.

The provider information can also be searched via the LACDMH Service Locator at http://maps.lacounty.gov/dmhSL/.

Information on this Online Service Locator can be translated into 90 or more languages, including the LACDMH threshold languages. This enables increased access for consumers seeking mental health services in non-English languages.

The QI-Data-GIS Unit is responsible for selecting a random sample for the bi-annual consumer satisfaction survey administration in Outpatient Clinics and Day Treatment Programs. The Unit is also responsible for conducting data analysis of the seven (7) domains of perception, consumer satisfaction, and preparing a final report. Additionally, the QI-Data-GIS unit provides assistance with survey design and implementation and data support to the Department's Divisions and Bureaus. Some examples include assisting the Office of Consumer Affairs with the annual Peer Survey, the Office of Medical Director with the Seclusions and Restraints Report, and the UsCC/INN/CCU with data on disparities for UsCC groups.

Summary

The QI Work Plan Evaluation report that follows assesses the goals identified in the LACDMH Quality Improvement Work Plan for CY 2015. The foundation for this evaluation is presented in the context of population demographics, both Countywide and by Service Area, as well as other clinical and consumer satisfaction data, including trend data. Evaluation of the Quality Improvement Work Plan provides a basis for the establishment of goals and objectives for CY 2016.

SECTION 2

POPULATION NEEDS ASSESSMENT

The County of Los Angeles is the most populated county in the United States (US) with an estimated population of 10,069,036 people in CY 2014. The County consists of 88 incorporated cities and includes 4,058 square miles of land area. Population density in the County, or the average number of people per square mile, is 2,440 as compared to 244 in the State of California.

Population distribution by Ethnicity in the County of Los Angeles, as shown in Fig. 1, is the highest among Latinos at 48.2%, followed by Whites at 28.4%, Asian/Pacific Islanders (API) at 14.6%, African Americans (AA) at 8.6%, and Native Americans (NA) at 0.2%.

This section contains estimated population in CY 2014 for the County of Los Angeles by Ethnicity, Age, and Gender.

Methods

Population and poverty estimates are derived from the American Community Survey conducted by the US Census Bureau. These numbers are further adjusted locally and standardized to annual data provided by the Department of Finance to account for local variations in housing and household income in the County of Los Angeles. Data for the Federal Poverty level (FPL) is reported for population living at or below 138% FPL. Data for population living at or below 138% FPL is used to estimate prevalence of mental illness among the population eligible for Medi-Cal benefits under the Affordable Care Act (ACA). Population and poverty data is reported by each Service Area (SA), ethnicity, age-group, and gender.

Threshold languages for each SA are identified for the population enrolled in Medi-Cal and consumers served by LACDMH. Title 9 of the California Code of Regulations (CCR) defines beneficiaries with threshold languages as “the annual numeric identification on a countywide basis and as indicated on the Medi-Cal Eligibility Data System (MEDS), from the 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, in an identified geographic area, whose primary language is other than English, and for whom information and services shall be provided in their primary language.”

Access to services is assessed by calculating Penetration Rates among consumers served in Outpatient facilities in Fiscal Year (FY) 2014-2015. The count of consumers served does not include those served in 24 Hour/Residential programs such as inpatient hospitals (both County and Fee-For-Service), residential facilities, Institution of Mental Disease (IMD), Skilled Nursing Facilities (SNF), Psychiatric Health Facilities (PHF), and clients served in Fee-For-Service Outpatient settings.

The presented data includes the following:

- Estimated Total Population living at or below 138% Federal Poverty Level (FPL) by ethnicity, age group and gender, in CY 2014

- Estimated Prevalence of SED in Children and Youth, and SMI in Adults and Older Adults for Total Population and population living at or below 138% FPL
- Population enrolled in Medi-Cal by ethnicity, age group and gender
- Estimated prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) among population enrolled in Medi-Cal by ethnicity, age group and gender
- LACDMH threshold languages spoken by population enrolled in Medi-Cal Consumers served in Outpatient Facilities by ethnicity, age group, gender, and threshold languages

These data sets provide a basic foundation for estimating target population needs for mental health services.

Estimated Prevalence Rates for persons with SED and SMI are derived by using Prevalence Rates estimated by the California Health Interview Survey (CHIS) that are conducted every two years by the University of California, Los Angeles (UCLA). This report includes prevalence estimates by CHIS in 2015.

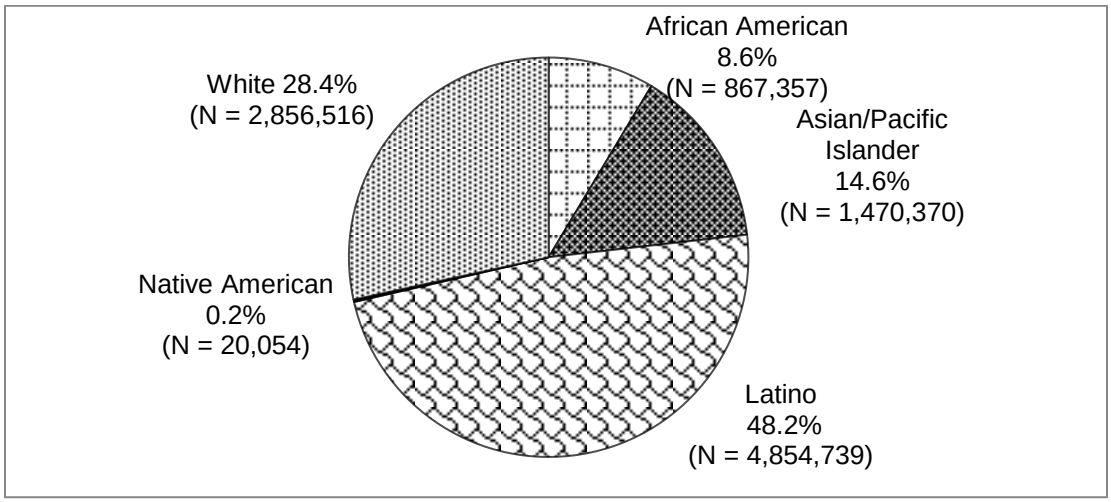
Penetration Rates are derived by applying Prevalence Rates for the ethnic, gender, or age-groups to demographic data for consumers served. These figures are helpful in understanding the needs of the target and underserved populations.

The use of trend analysis is useful towards understanding changes in population demographics and performance measures over time, and in this case, over a five-year period.

As of CY 2014, QI Work Plan goals related to Access and Penetration Rates have been set for population living at or below 138% FPL to account for expansion of services under the Affordable Care Act (ACA).

Total Population

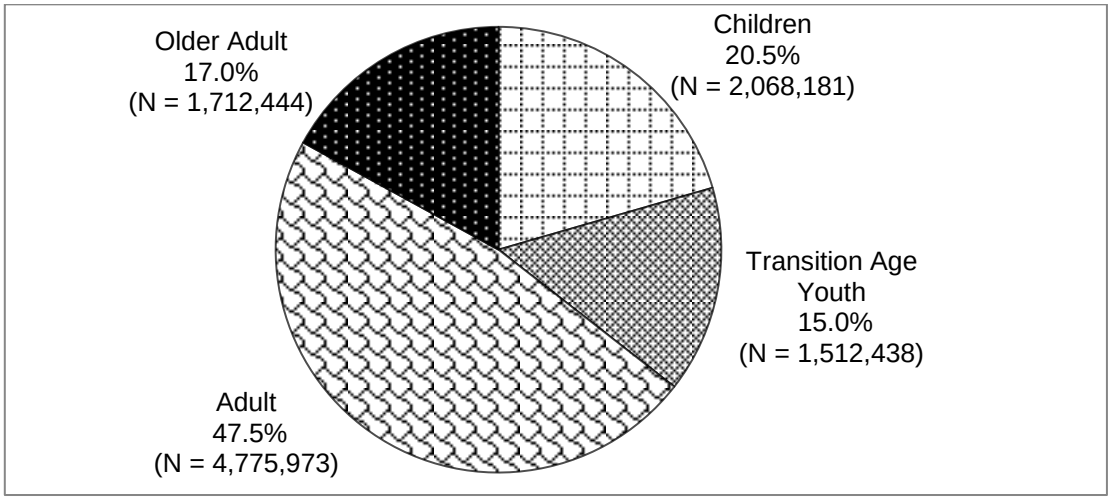
FIGURE 1: POPULATION BY ETHNICITY
CY 2014 (N = 10,069,036)



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Figure 1 shows population by ethnicity for CY 2014. Latinos are the largest group at 48.2%, followed by Whites at 28.4%, Asian/Pacific Islanders (API) at 14.6%, African Americans at 8.6%, and Native Americans at 0.2%.

FIGURE 2: POPULATION BY AGE GROUP
CY 2014 (N = 10,069,036)



Note: The total percentage does not equal 100 due to rounding. Data Source: American Community Survey, US Census Bureau, and Hedderson Demographic Services, 2015.

Figure 2 shows population by age group for CY 2014. Adults (26-59 years) make up the largest group at 47.4%, followed by Children (0-15 years) at 20.5%, Older Adults (60+ years) at 17.0%, and Transition Age Youth (TAY; 16-25 years) at 15.0%.

TABLE 1: POPULATION BY ETHNICITY AND SERVICE AREA CY 2014

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA1	63,624	15,619	175,206	1,639	136,642	392,730
Percent	16.2%	4.0%	44.6%	**0.42%**	34.8%	100.0%
SA2	78,517	253,666	872,920	4,062	981,232	2,190,397
Percent	3.6%	11.6%	39.9%	0.18%	44.8%	100.0%
SA3	66,601	511,030	822,220	3,121	380,066	1,783,038
Percent	3.7%	**28.7%**	46.1%	0.17%	21.3%	100.0%
SA4	61,667	206,329	594,396	2,163	285,133	1,149,688
Percent	5.4%	17.9%	51.7%	0.19%	24.8%	100.0%
SA5	37,816	91,083	104,634	1,006	417,621	652,160
Percent	5.8%	14.0%	**16.0%**	**0.15%**	**64.0%**	100.0%
SA6	287,767	19,162	699,907	1,541	25,295	1,033,672
Percent	**27.8%**	**1.9%**	67.7%	**0.15%**	**2.4%**	100.0%
SA7	40,153	121,273	962,061	2,819	185,709	1,312,015
Percent	**3.1%**	9.2%	**73.3%**	0.21%	14.2%	100.0%
SA8	231,212	252,208	623,395	3,703	444,818	1,555,336
Percent	14.9%	16.2%	40.1%	0.23%	28.6%	100.0%
Total	867,357	1,470,370	4,854,739	20,054	2,856,516	10,069,036
Percent	8.6%	14.6%	48.2%	0.20%	28.4%	100.0%

Note: Bold values represent the highest and lowest percentage within each ethnic group across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Ethnicity

The highest percentage of African Americans (AA) was in SA 6 (27.8%) compared to SA 7 (3.1%) with the lowest percentage.

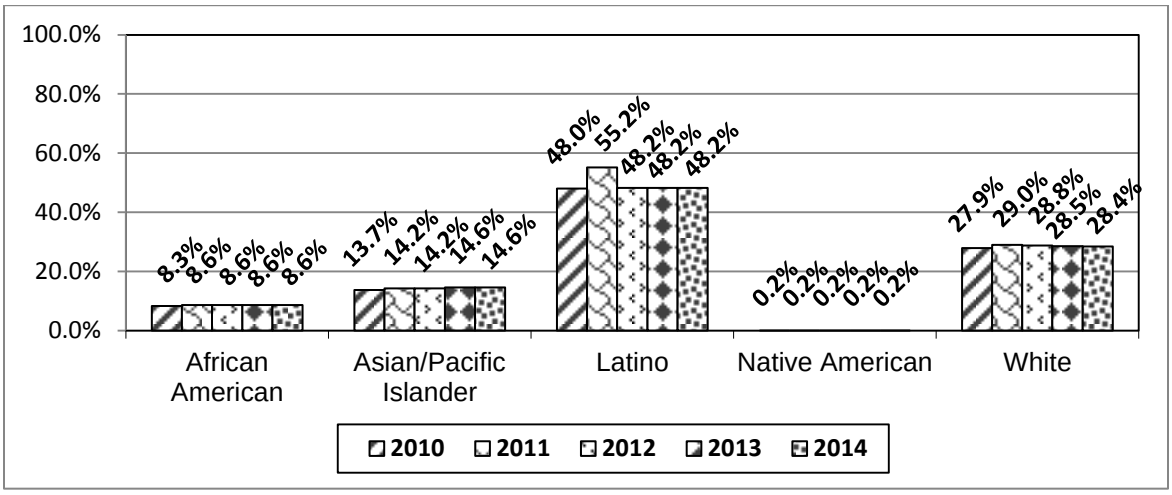
The highest percentage of Asian/Pacific Islanders (API) was in SA 3 (28.7%) compared to SA 6 (1.9%) with the lowest percentage.

The highest percentage of Latinos was in SA 7 (73.3%) compared to SA 5 (16.0%) with the lowest percentage.

The highest percentage of Native Americans (NA) was in SA 1 (0.42%) compared to SA 5 and SA 6 (0.15%) with the lowest percentage.

The highest percentage of Whites was in SA 5 (64.0%) compared to SA 6 (2.4%) with the lowest percentage.

FIGURE 3: POPULATION PERCENT CHANGE BY ETHNICITY
CY 2010-2014



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

The percentage of African Americans (AA) in the County has increased by 0.3 percentage points (PP) over the past five years. AA represented 8.3% of the total population in CY 2010 and represented 8.6% of the population in CY 2014.

The percentage of Asian/Pacific Islanders (API) in the County has increased by 0.9 PP over the past five years. API represented 13.7% of the total population in CY 2010 and represented 14.6% in CY 2014.

The percentage of Latinos in the County has increased by 0.2 PP over the past five years. Latinos represented 48.0% of the total population in CY 2010 and represented 48.2% in CY 2014.

The percentage of Native Americans (NA) in the County has remained the same over the past five years. NA represented 0.2% of the total population in CY 2010 and in CY 2014.

The percentage of Whites in the County has increased by 0.5 PP over the past five years. Whites represented 27.9% of the total population in CY 2010 and represented 28.4% in CY 2014.

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2014

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	115,631	14,608	35,490	171,586	18,444	36,971	392,730
Percent	29.4%	3.7%	9.0%	43.7%	4.7%	9.4%	100.0%
SA2	517,924	62,052	159,792	1,059,763	118,669	272,197	2,190,397
Percent	23.6%	2.8%	7.3%	48.4%	5.4%	12.4%	100.0%
SA3	424,989	57,467	137,201	818,373	101,740	243,268	1,783,038
Percent	23.8%	3.2%	7.7%	45.9%	**5.7%**	13.6%	100.0%
SA4	241,898	27,526	78,946	616,053	54,072	131,193	1,149,688
Percent	21.0%	**2.4%**	**6.9%**	**53.6%**	4.7%	11.4%	100.0%
SA5	114,808	22,410	44,693	335,600	36,695	97,954	652,160
Percent	**17.6%**	3.4%	**6.9%**	51.5%	5.6%	**15.0%**	100.0%
SA6	321,502	40,840	95,279	452,624	39,336	84,091	1,033,672
Percent	**31.1%**	**4.0%**	**9.2%**	**43.8%**	**3.8%**	**8.1%**	100.0%
SA7	364,240	44,817	109,330	587,817	60,648	145,163	1,312,015
Percent	27.8%	3.4%	8.3%	44.8%	4.6%	11.1%	100.0%
SA8	389,524	45,966	113,686	734,157	80,630	191,373	1,555,336
Percent	25.0%	3.0%	7.3%	47.2%	5.2%	12.3%	100.0%
Total	2,490,516	315,686	774,417	4,775,973	510,234	1,202,210	10,069,036
Percent	24.7%	3.1%	7.7%	47.4%	5.1%	11.9%	100.0%

Note: Bold values represent the highest and lowest percentage within each age group across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Age Group

The highest percentage of 0-18 year olds was in SA 6 (31.1%) compared to SA 5 (17.6%) with the lowest percentage.

The highest percentage of 19-20 year olds was in SA 6 (4.0%) compared to SA 4 (2.4%) with the lowest percentage.

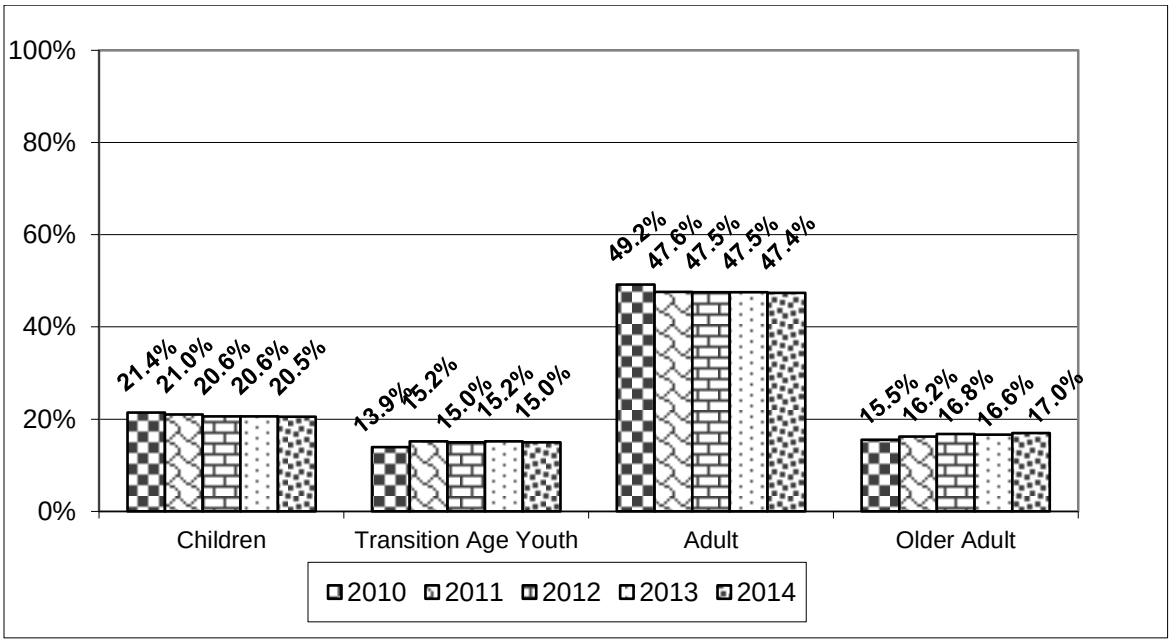
The highest percentage of 21-25 year olds was in SA 6 (9.2%) compared to SA 4 and SA 5 (6.9%) with the lowest percentage.

The highest percentage of 26-59 year olds was in SA 4 (53.6%) compared to SA 6 (43.8%) with the lowest percentage.

The highest percentage of 60-64 year olds was in SA 3 (5.7%) compared to SA 6 (3.8%) with the lowest percentage.

The highest percentage of 65+ year olds was in SA 5 (15.0%) compared to SA 6 (8.1%) with the lowest percentage.

FIGURE 4: POPULATION PERCENT CHANGE BY AGE GROUP CY 2010-2014



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

The percentage of Children in the County has decreased by 0.9 percentage points (PP) over the past five years. Children represented 21.4% of the total population in CY 2010 and represented 20.5% in CY 2014.

The percentage of Transition Age Youth (TAY) in the County has increased by 1.1 PP over the past five years. TAY represented 13.9% of the total population in CY 2010 and represented 15.0% in CY 2014.

The percentage of Adults in the County has decreased by 1.8 PP over the past five years. Adults represented 49.2% of the total population in CY 2010 and represented 47.4% in CY 2014.

The percentage of Older Adults in the County has increased by 1.5 PP over the past five years. Older Adults represented 15.5% of the total population in CY 2010 and represented 17.0% in CY 2014.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA
CY 2014

Service Area (SA)	Male	Female	Total
SA1	195,187	197,543	392,730
Percent	49.7%	50.3%	100.0%
SA2	1,084,861	1,105,536	2,190,397
Percent	49.5%	50.5%	100.0%
SA3	871,246	911,792	1,783,038
Percent	48.9%	51.1%	100.0%
SA4	589,540	560,148	1,149,688
Percent	**51.3%**	**48.7%**	100.0%
SA5	316,041	336,119	652,160
Percent	**48.5%**	**51.5%**	100.0%
SA6	503,384	530,288	1,033,672
Percent	48.7%	51.3%	100.0%
SA7	645,054	666,961	1,312,015
Percent	49.2%	50.8%	100.0%
SA8	761,140	794,196	1,555,336
Percent	48.9%	51.1%	100.0%
Total	4,966,453	5,102,583	10,069,036
Percent	49.3%	50.7%	100.0%

Note: Bold values represent highest and lowest percent within each gender across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Gender

The highest percentage of Males was in SA 4 (51.3%) compared to SA 5 (48.5%) with the lowest percentage.

The highest percentage of Females was in SA 5 (51.5%) compared to SA 4 (48.7%) with the lowest percentage.

Estimated Population Living at or Below 138% Federal Poverty Level (FPL)

TABLE 4: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA CY 2014

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA1	24,801	2,104	64,174	509	23,118	114,706
Percent	21.6%	1.8%	55.9%	**0.44%**	20.2%	100.0%
SA2	17,532	32,922	305,237	751	130,339	486,781
Percent	3.6%	6.8%	62.7%	0.15%	26.8%	100.0%
SA3	13,317	86,210	229,510	508	43,813	373,358
Percent	3.6%	**23.1%**	61.5%	0.14%	11.7%	100.0%
SA4	20,113	56,636	279,450	879	58,436	415,514
Percent	4.8%	13.6%	67.3%	0.21%	14.1%	100.0%
SA5	6,959	16,767	26,292	117	50,679	100,814
Percent	6.9%	16.6%	**26.1%**	**0.12%**	**50.3%**	100.0%
SA6	116,897	7,510	366,355	826	7,873	499,461
Percent	**23.4%**	**1.5%**	73.4%	0.17%	**1.6%**	100.0%
SA7	8,282	14,836	314,637	640	22,380	360,775
Percent	**2.3%**	4.1%	**87.2%**	0.18%	6.2%	100.0%
SA8	66,904	42,164	235,846	916	45,650	391,480
Percent	17.1%	10.8%	60.2%	0.23%	11.7%	100.0%
Total	274,805	259,149	1,821,501	5,146	382,288	2,742,889
Percent	10.0%	9.4%	66.4%	0.19%	13.9%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Ethnicity

The highest percentage of African Americans (AA) living at or below 138% FPL was in SA 6 (23.4%) compared to SA 7 (2.3%) with the lowest percentage. Of the County's population living at or below 138% FPL, 10.0% self-identified as AA.

The highest percentage of Asian/Pacific Islanders (API) living at or below 138% FPL was in SA 3 (23.1%) compared to SA 6 (1.5%) with the lowest percentage. Of the County's population living at or below 138% FPL, 9.4% self-identified as API.

The highest percentage of Latinos living at or below 138% FPL was in SA 7 (87.2%) compared to SA 5 (26.1%) with the lowest percentage.

The highest percentage of Native Americans (NA) living at or below 138% FPL was in SA 1 (0.44%) compared to SA 5 (0.12%) with the lowest percentage.

The highest percentage of Whites living at or below 138% FPL was in SA 5 (50.3%) compared to SA 6 (1.6%) with the lowest percentage.

TABLE 5: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA CY 2014

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	47,731	4,280	10,228	42,340	3,734	6,393	114,706
Percent	41.6%	**3.7%**	8.9%	**36.9%**	3.3%	5.6%	100.0%
SA2	164,965	14,168	38,992	213,365	18,417	36,874	486,781
Percent	33.9%	2.9%	8.0%	43.8%	3.8%	7.6%	100.0%
SA3	126,464	11,671	30,562	155,346	15,633	33,682	373,358
Percent	33.9%	3.1%	8.2%	41.6%	**4.2%**	9.0%	100.0%
SA4	128,003	10,404	31,249	195,055	15,477	35,326	415,514
Percent	30.8%	**2.5%**	7.5%	46.9%	3.7%	8.5%	100.0%
SA5	16,394	3,754	14,039	53,339	4,080	9,208	100,814
Percent	**16.3%**	**3.7%**	**13.9%**	**52.9%**	4.0%	**9.1%**	100.0%
SA6	210,755	17,396	44,269	188,460	14,674	23,907	499,461
Percent	**42.2%**	3.5%	8.9%	37.7%	**2.9%**	**4.8%**	100.0%
SA7	147,718	11,387	27,921	137,660	11,975	24,114	360,775
Percent	40.9%	3.2%	**7.7%**	38.2%	3.3%	6.7%	100.0%
SA8	144,787	12,514	32,077	163,727	13,822	24,553	391,480
Percent	37.0%	3.2%	8.2%	41.8%	3.5%	6.3%	100.0%
Total	986,817	85,574	229,337	1,149,292	97,812	194,057	2,742,889
Percent	36.0%	3.1%	8.4%	41.9%	3.6%	7.1%	100.0%

Note: Bold values represent the highest and lowest percentage within each age group across Service Areas. Age groups relevant to the Affordable Care Act are used in the 138% table by contrast with other age group tables. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Age Group

The highest percentage of 0-18 year olds estimated to be living at or below 138% FPL was in SA 6 (42.2%) compared to SA 5 (16.3%) with the lowest percentage.

The highest percentage of 19-20 year olds estimated to be living at or below 138% FPL was in SA 1 and SA 5 (3.7%) compared to SA 4 (2.5%) with the lowest percentage.

The highest percentage of 21-25 year olds estimated to be living at or below 138% FPL was in SA 5 (13.9%) compared to SA 7 (7.7%) with the lowest percentage.

The highest percentage of 26-59 year olds estimated to be living at or below 138% FPL was in SA 5 (52.9%) compared to SA 1 (36.9%) with the lowest percentage.

The highest percentage of 60-64 year olds estimated to be living at or below 138% FPL was in SA 3 (4.2%) compared to SA 6 (2.9%) with the lowest percentage.

The highest percentage of 65 year old and over estimated to be living at or below 138% FPL was in SA 5 (9.1%) compared to SA 6 (4.8%) with the lowest percentage.

TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2014

Service Area (SA)	Male	Female	Total
SA1	54,548	60,158	114,706
Percent	**47.6%**	**52.4%**	100.0%
SA2	235,995	250,786	486,781
Percent	48.5%	51.5%	100.0%
SA3	179,212	194,146	373,358
Percent	48.0%	52.0%	100.0%
SA4	205,938	209,576	415,514
Percent	**49.6%**	**50.4%**	100.0%
SA5	47,982	52,832	100,814
Percent	**47.6%**	**52.4%**	100.0%
SA6	239,013	260,448	499,461
Percent	47.9%	52.1%	100.0%
SA7	173,678	187,097	360,775
Percent	48.1%	51.9%	100.0%
SA8	186,906	204,574	391,480
Percent	47.7%	52.3%	100.0%
Total	1,323,272	1,419,617	2,742,889
Percent	48.2%	51.8%	100.0%

Note: Bold values represent the highest and lowest percentage within each gender across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Gender

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (49.6%) compared to SA 1 and SA 5 (47.6%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SA 1 and SA 5 (52.4%) compared to SA 4 (50.4%) with the lowest percentage.

TABLE 7: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA CY 2015

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA1	3,423	175	7,316	122	2,543	13,578
Percent	25.2%	1.3%	53.9%	**0.90%**	18.7%	100.0%
SA2	2,419	2,733	34,797	180	14,337	54,466
Percent	4.4%	5.0%	63.9%	0.33%	26.3%	100.0%
SA3	1,838	7,155	26,164	122	4,819	35,469
Percent	5.2%	**20.2%**	73.8%	0.34%	13.6%	100.0%
SA4	2,776	4,701	31,857	211	6,428	45,973
Percent	6.0%	10.2%	69.3%	0.50%	14.0%	100.0%
SA5	960	1,392	2,997	28	5,575	10,952
Percent	8.8%	12.7%	**27.4%**	**0.26%**	**50.9%**	100.0%
SA6	16,132	623	41,764	198	866	59,584
Percent	**27.1%**	**1.1%**	70.1%	0.33%	**1.5%**	100.0%
SA7	1,143	1,231	35,869	154	2,462	40,858
Percent	**2.8%**	3.0%	**87.8%**	0.38%	6.0%	100.0%
SA8	9,233	3,500	26,886	220	5,022	44,860
Percent	20.6%	7.8%	59.9%	0.49%	11.2%	100.0%
Total	37,923	21,509	207,651	1,235	42,052	310,370

Note**:** Bold values represent the highest and lowest percentages within each ethnic group and across the Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Ethnicity

The highest rate of prevalence of SED and SMI among the African American (AA) ethnic group was in SA 6 (27.1%) compared to SA 7 (2.8%) with the lowest percentage.

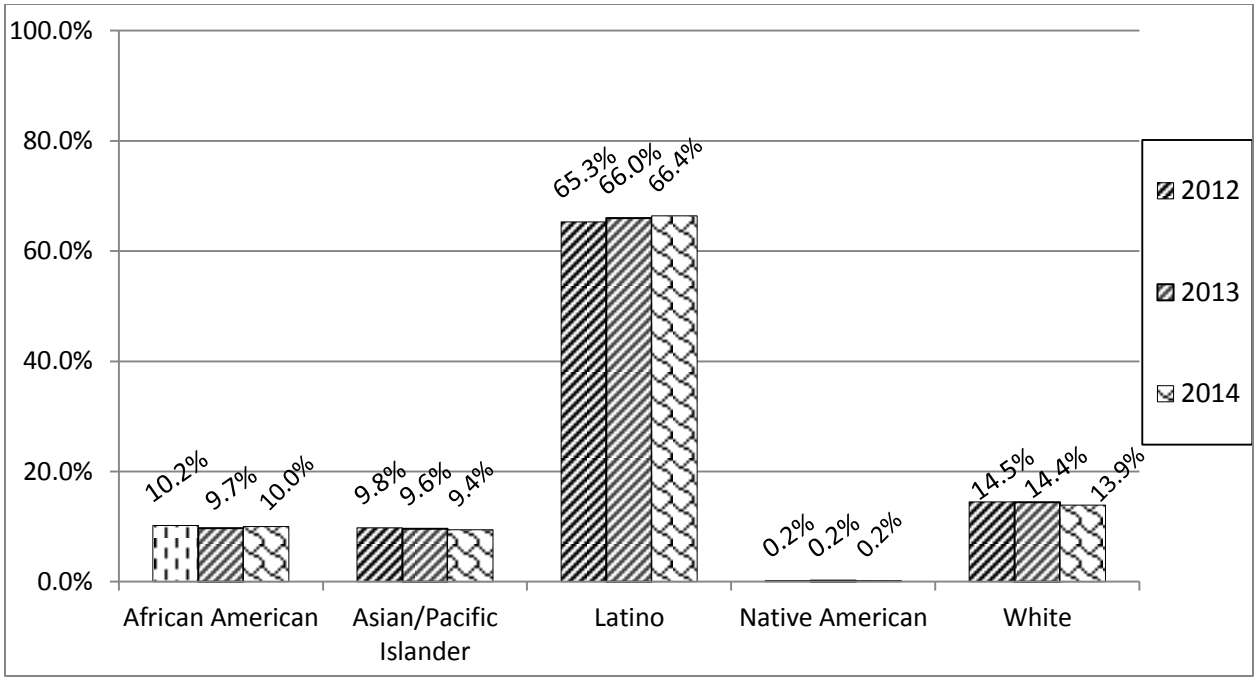
The highest rate of prevalence of SED and SMI among the Asian/Pacific Islander (API) ethnic group was in SA 3 (20.2%) compared to SA 6 (1.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Latino ethnic group was in SA 7 (87.8%) compared to SA 5 (27.4%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Native American (NA) ethnic group was in SA 1 (0.90%) compared to SA 5 (0.26%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the White ethnic group was in SA 5 (50.9%) compared to SA 6 (1.5%) with the lowest percentage.

FIGURE 5: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY CY 2012 – 2014



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2014.

The percent of African Americans (AA) living at or below 138% FPL has decreased by 0.2 percentage points (PP), from 10.2% in CY 2012 to 10.0% in CY 2014.

The percent of Asian/Pacific Islanders (API) living at or below 138% FPL has decreased by 0.4 PP, from 9.8% in CY 2012 to 9.4% in CY 2014.

The percent of Latinos living at or below 138% FPL has increased by 1.1 PP, from 65.3% in CY 2012 to 66.4% in CY 2014.

The percent of Native Americans (NA) living at or below 138% FPL has remained unchanged at 0.2% from CY 2012 to CY 2014.

The percent of Whites living at or below 138% FPL has decreased by 0.6 PP, from 14.5% in CY 2012 to 13.9% in CY 2014.

TABLE 8: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA CY 2015

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	7,828	193	1,074	4,149	470	345	13,076
Percent	59.9%	**1.5%**	8.2%	**31.7%**	3.6%	2.6%	100.0%
SA2	27,054	638	4,094	20,910	2,321	1,991	55,493
Percent	48.8%	1.2%	7.4%	37.7%	4.2%	3.6%	100.0%
SA3	20,740	525	3,209	15,224	1,970	1,819	42,563
Percent	48.7%	1.2%	7.5%	35.8%	**4.6%**	**4.3%**	100.0%
SA4	20,992	468	3,281	19,115	1,950	1,908	47,369
Percent	44.3%	**1.0%**	**6.9%**	40.4%	4.1%	4.0%	100.0%
SA5	2,689	169	1,474	5,227	514	497	11,493
Percent	**23.4%**	**1.5%**	**12.8%**	**45.5%**	4.5%	**4.3%**	100.0%
SA6	34,564	783	4,648	18,469	1,849	1,291	56,939
Percent	**60.7%**	1.4%	8.2%	32.4%	**3.3%**	**2.3%**	100.0%
SA7	24,226	512	2,932	13,491	1,509	1,302	41,128
Percent	58.9%	1.3%	7.1%	32.8%	3.7%	3.2%	100.0%
SA8	23,745	563	3,368	16,045	1,742	1,326	44,629
Percent	53.2%	1.3%	7.6%	36.0%	3.9%	3.0%	100.0%
Total	161,838	3,851	24,080	112,631	12,324	10,479	312,689
Total Percent	51.8%	1.2%	7.7%	36.0%	3.9%	3.4%	100.0%

Note: Bold values represent the highest and lowest percentage within each age group across Service Areas. Values in italics represent the highest percent across age groups within a Service Area. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Age Group

The highest rate of prevalence of SED and SMI among age 0-18 years was in SA 6 (60.7%) compared to SA 5 (23.4%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among age 19-20 years was in SA 1 and SA 5 (1.5%) compared to SA 4 (1.0%) with the lowest percentage.

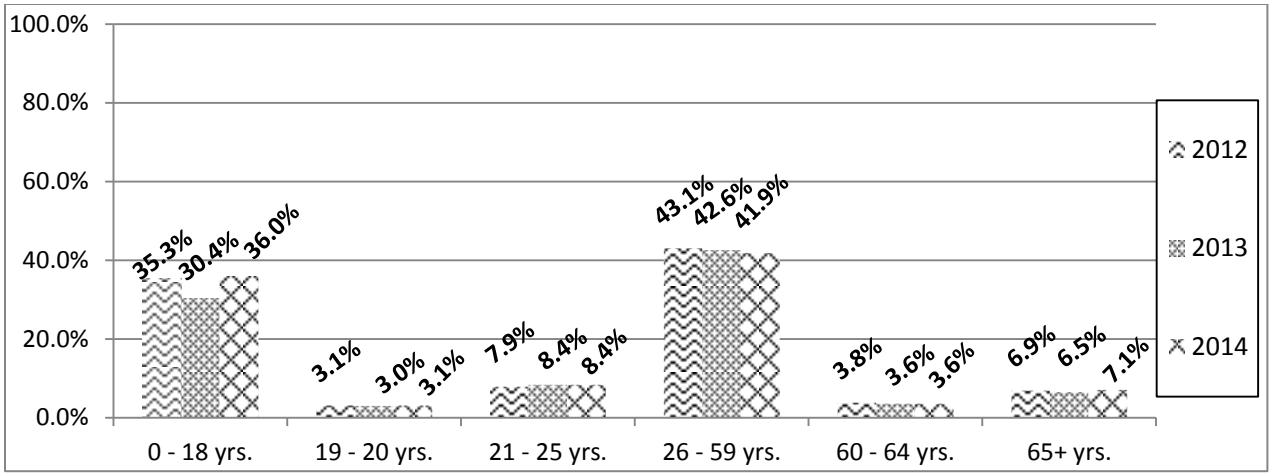
The highest rate of prevalence of SED and SMI among age 21-25 years was in SA 5 (12.8%) compared to SA 4 (6.9%) the lowest percentage.

The highest rate of prevalence of SED and SMI among age 26-59 years was in SA 5 (45.5%) compared to SA 1 (31.7%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among age 60-64 years was in SA 3 (4.6%) compared to SA 6 (3.3%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among age 65 years and older was in SA 3 and SA 5 (4.3%) compared to SA 6 (2.3%) with the lowest percentage.

FIGURE 6: ESTIMATED POVERTY PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2012 – 2014



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2014.

The percentage of 0-18 year olds living at or below 138% FPL increased by 0.7 percentage points (PP), from 35.3% in CY 2012 to 36.0% in CY 2014.

The percentage of 19-20 year olds living at or below 138% FPL remains unchanged at 3.1% in CY 2012 to CY 2014.

The percentage of 21-25 year olds living at or below 138% FPL increased by 0.5 PP, from 7.9% in CY 2012 to 8.4% in CY 2014.

The percentage of 26-59 year olds living at or below 138% FPL decreased by 1.2 PP, from 43.1% in CY 2012 to 41.9% in CY 2014.

The percentage of 60-64 year olds living at or below 138% FPL decreased by 0.2 PP, from 3.8% in CY 2012 to 3.6% in CY 2014.

The percentage of 65+ year olds living at or below 138% FPL increased by 0.2 PP, from 6.9% in CY 2012 to 7.1% in CY 2014.

TABLE 9: ESTIMATED PREVALENCE OF SED and SMI AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2015

Service Area (SA)	Male	Female	Total
SA1	5,509	8,542	14,052
Percent	39.2%	60.8%	100.0%
SA2	23,835	35,612	59,447
Percent	40.1%	59.9%	100.0%
SA3	18,100	27,569	45,669
Percent	39.6%	60.4%	100.0%
SA4	20,800	27,569	48,368
Percent	**43.0%**	**57.0%**	100.0%
SA5	4,846	29,760	34,606
Percent	**14.0%**	**86.0%**	100.0%
SA6	24,140	36,984	61,124
Percent	39.5%	60.5%	100.0%
SA7	17,541	26,568	44,109
Percent	39.8%	60.2%	100.0%
SA8	18,878	29,050	47,927
Percent	39.4%	60.6%	100.0%
Total	133,650	221,652	355,303
Percent	37.6%	62.4%	100.0%

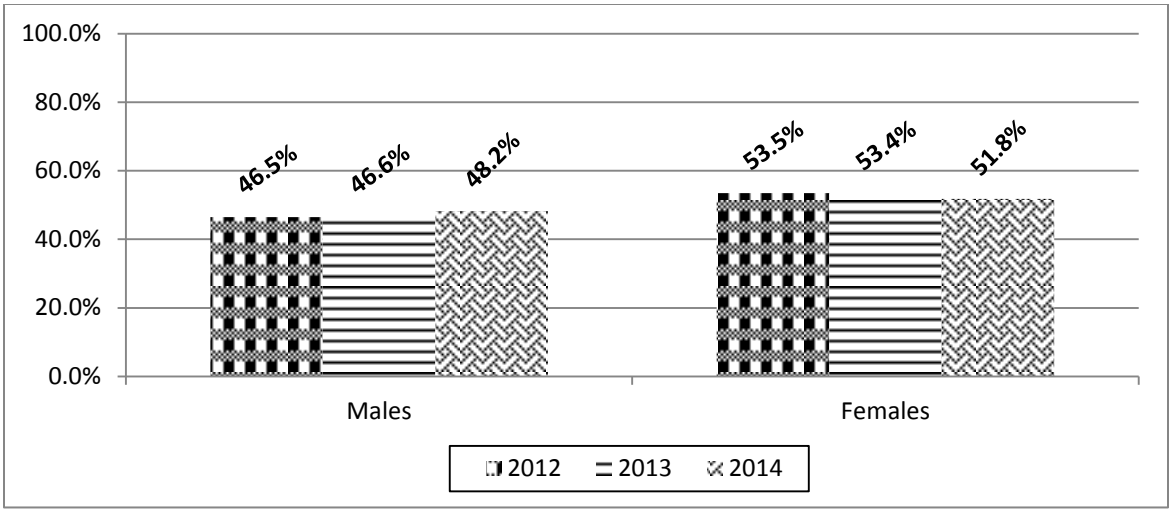
Note: Bold values represent the highest and lowest percent within each gender across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2015.

Differences by Gender

The highest rate of prevalence of SED and SMI among Males was in SA 4 (43.0%) compared to SA 5 (14.0%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among Females was in SA 5 (86.0%) compared to SA 4 (57.0%) with the lowest percentage.

FIGURE 7: ESTIMATED PERCENT OF POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2012 – 2014



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2014.

The percentage of Males living at or below 138% FPL increased by 1.7 percentage points (PP) from 46.5% in CY 2012 to 48.2% in CY 2014. Conversely, the percentage of Females living at or below 138% FPL decreased by 1.7 PP, from 53.5% in CY 2012 to 51.8% in CY 2014.

Population Enrolled in Medi-Cal

TABLE 10: POPULATION ENROLLED IN MEDI-CAL BY ETHNICITY AND SERVICE AREA MARCH 2015

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA1	24,335	1,904	43,162	250	17,182	94,940
Percent	25.6%	2.0%	45.5%	**0.26%**	18.1%	100.0%
SA2	12,228	20,800	163,634	382	105,673	338,061
Percent	3.6%	6.2%	48.4%	0.11%	31.3%	100.0%
SA3	11,297	63,583	149,997	339	27,281	287,212
Percent	3.9%	**22.1%**	52.2%	0.12%	9.5%	100.0%
SA4	13,021	29,642	135,528	300	25,737	227,560
Percent	5.7%	13.0%	59.6%	0.13%	11.3%	100.0%
SA5	4,943	2,911	12,125	97	16,156	43,598
Percent	11.3%	6.7%	**27.8%**	0.22%	**37.1%**	100.0%
SA6	84,717	3,021	195,941	207	6,746	319,698
Percent	**26.5%**	**0.9%**	61.3%	**0.10%**	**2.1%**	100.0%
SA7	6,979	11,787	187,434	321	16,713	247,340
Percent	**2.8%**	4.8%	**75.8%**	0.13%	6.8%	100.0%
SA8	49,303	26,063	121,822	428	23,757	254,518
Percent	19.4%	10.2%	47.9%	0.17%	9.3%	100.0%
Total	206,823	159,711	1,009,643	2,324	239,245	1,617,746
Percent	12.8%	9.9%	62.4%	0.14%	14.8%	100.0%

Note: Bold values represent the highest and lowest percent within each ethnic group across Service Areas. Unknown Service Area N=103,463 and Unknown Ethnicity N=181,772 were not included in the Ethnicity table. Data Source: State MEDS File, March 2015.

Differences by Ethnicity

The highest percentage of African Americans (AA) enrolled in Medi-Cal was in SA 6 (26.5%) compared to SA 7 (2.8%) with the lowest percentage.

The highest percentage of Asian/Pacific Islanders (API) enrolled in Medi-Cal was in SA 3 (22.1%) compared to SA 6 (0.9%) with the lowest percentage.

The highest percentage of Latinos enrolled in Medi-Cal was in SA 7 (75.8%) compared to SA 5 (27.8%) with the lowest percentage.

The highest percentage of Native Americans (NA) enrolled in Medi-Cal was in SA 1 (0.26%) compared to SA 6 (0.10%) with the lowest percentage.

The highest percentage of Whites enrolled in Medi-Cal was in SA 5 (37.1%) compared to SA 6 (2.1%) with the lowest percentage

TABLE 11: POPULATION ENROLLED IN MEDI-CAL BY AGE GROUP AND SERVICE AREA MARCH 2015

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	45,946	3,842	6,000	27,165	2,767	9,220	94,940
Percent	48.4%	**4.0%**	**6.3%**	**28.6%**	2.9%	**9.7%**	100.0%
SA2	135,845	11,168	13,707	80,690	13,102	83,549	338,061
Percent	40.2%	3.3%	4.1%	23.9%	3.9%	24.7%	100.0%
SA3	116,220	10,052	12,896	66,281	8,303	73,460	287,212
Percent	40.5%	3.5%	4.5%	23.1%	2.9%	25.6%	100.0%
SA4	94,570	7,658	9,119	48,732	8,189	59,292	227,560
Percent	41.6%	3.4%	4.0%	**21.4%**	3.6%	26.1%	100.0%
SA5	13,330	1,144	1,562	11,548	1,982	14,032	43,598
Percent	**30.6%**	**2.6%**	**3.6%**	26.5%	**4.5%**	**32.2%**	100.0%
SA6	167,868	12,732	17,999	74,931	9,391	36,777	319,698
Percent	**52.5%**	**4.0%**	5.6%	23.4%	2.9%	11.5%	100.0%
SA7	119,811	9,428	12,592	54,642	6,445	44,422	247,340
Percent	48.4%	3.8%	5.1%	22.1%	**2.6%**	18.0%	100.0%
SA8	115,804	9,285	13,186	65,640	8,407	42,196	254,518
Percent	45.5%	3.6%	5.2%	25.8%	3.3%	16.6%	100.0%
Total	809,394	65,309	87,061	429,629	58,586	362,948	1,812,927
Percent	44.6%	3.6%	4.8%	23.7%	3.2%	20.0%	100.0%

Note: Bold values represent the highest and lowest percent within each age group across Service Areas. Unknown Service Area N=103,463. Data Source: State MEDS File, March 2015.

Differences by Age Group

The highest percentage of 0-18 year olds enrolled in Medi-Cal was in SA 6 (52.5%) compared to SA 5 (30.6%) with the lowest percentage.

The highest percentages of 19-20 year olds enrolled in Medi-Cal were in SA 1 and SA 6 (4.0%) compared to SA 5 (2.6%) with the lowest percentage.

The highest percentage of 21-25 year olds enrolled in Medi-Cal was in SA 1 (6.3%) compared to SA 5 (3.6%) with the lowest percentage.

The highest percentage of 26-59 year olds enrolled in Medi-Cal was in SA 1 (28.6%) compared to SA 4 (21.4%) with the lowest percentage.

The highest percentage of 60-64 year olds enrolled in Medi-Cal was in SA 5 (4.5%) compared to SA 7 (2.6%) with the lowest percentage.

The highest percentage of 65 year and older enrolled in Medi-Cal was in SA 5 (32.2%) compared to SA 1 (9.7%) with the lowest percentage.

TABLE 12: POPULATION ENROLLED IN MEDI-CAL BY GENDER AND SERVICE AREA MARCH 2015

Service Area (SA)	Male	Female	Total
SA1	41,502	53,438	94,940
Percent	**43.7%**	**56.3%**	100.0%
SA2	148,987	189,073	338,061
Percent	44.1%	55.9%	100.0%
SA3	125,831	161,381	287,212
Percent	43.8%	56.2%	100.0%
SA4	102,564	124,996	227,560
Percent	**45.1%**	**54.9%**	100.0%
SA5	19,357	24,241	43,598
Percent	44.4%	55.6%	100.0%
SA6	141,544	178,154	319,698
Percent	44.3%	55.7%	100.0%
SA7	108,451	138,889	247,340
Percent	43.8%	56.2%	100.0%
SA8	111,249	143,269	254,518
Percent	**43.7%**	**56.3%**	100.0%
Total	799,485	1,013,441	1,812,926
Percent	44.1%	55.9%	100.0%

Note: Bold values represent the highest and lowest percent within each gender across Service Areas. Unknown Service Area N=103,463. Data Source: State MEDS File, March 2015.

Differences by Gender

The highest percentage of Males enrolled in Medi-Cal was in SA 4 (45.1%) as compared with the lowest in SA 1 and SA 8 (43.7%).

The highest percentage of Females enrolled in Medi-Cal was in SA 1 and SA 8 (56.3%) compared to SA 4 (54.9%) with the lowest percentage.

TABLE 13: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY ETHNICITY AND SERVICE AREA MARCH 2015

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total*
SA1	3,423	175	7,316	122	2,543	13,578
Percent	25.2%	1.3%	53.9%	**0.90%**	18.7%	100.0%
SA2	2,419	2,733	34,797	180	14,337	54,466
Percent	4.4%	5.0%	63.9%	0.33%	26.3%	100.0%
SA3	1,838	7,155	26,164	122	4,819	35,469
Percent	5.2%	**20.2%**	73.8%	0.34%	13.6%	100.0%
SA4	2,776	4,701	31,857	211	6,428	45,973
Percent	6.0%	10.2%	69.3%	0.46%	14.0%	100.0%
SA5	960	1,392	2,997	28	5,575	10,952
Percent	8.8%	12.7%	**27.4%**	**0.25%**	**50.9%**	100.0%
SA6	16,132	623	41,764	198	866	59,584
Percent	**27.1%**	**1.1%**	70.1%	0.33%	**1.5%**	100.0%
SA7	1,143	1,231	35,869	154	2,462	40,858
Percent	**2.8%**	3.0%	**87.8%**	0.38%	6.0%	100.0%
SA8	9,233	3,500	26,886	220	5,022	44,860
Percent	20.6%	7.8%	59.9%	0.49%	11.2%	100.0%
Total	37,923	21,509	207,651	1,235	42,052	310,370

Note: Bold values represent the highest and lowest percent within each ethnic group across Service Areas. Estimated prevalence rates of mental illness by ethnicity for the County of Los Angeles are provided by the California Health Interview Survey (CHIS) for population living at or below 100% FPL.

Differences by Ethnicity

The highest prevalence of SED and SMI among the African American (AA) ethnic group was in SA 6 (27.1%) compared to SA 7 (2.8%) with the lowest percentage.

The highest prevalence of SED and SMI among the Asian/Pacific Islander (API) ethnic group was in SA 3 (20.2%) compared to SA 6 (1.1%) with the lowest percentage.

The highest prevalence of SED and SMI among the Latino ethnic group was in SA 7 (87.8%) compared to SA 5 (27.4%) with the lowest percentage.

The highest prevalence of SED and SMI among the Native American (NA) ethnic group was in SA 1 (0.90%) compared to SA 5 (0.25%) with the lowest percentage.

The highest prevalence of SED and SMI among the White ethnic group was in SA 5 (50.9%) compared to SA 6 (1.5%) with the lowest percentage.

TABLE 14: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY AGE GROUP AND SERVICE AREA MARCH 2015

Service Area (SA)	Age Group						
	0-18*	19-20**	21-25	26-59	60-64	65+	Total
SA1	7,535	315	630	3,477	324	719	10,823
Percent	69.6%	**2.9%**	**5.8%**	**32.1%**	3.0%	**6.6%**	100.0%
SA2	22,279	916	1,439	10,328	1,533	6,517	38,539
Percent	57.8%	2.4%	3.7%	26.8%	4.0%	16.9%	100.0%
SA3	19,060	824	1,354	8,484	971	5,730	32,742
Percent	58.2%	2.5%	4.1%	25.9%	3.0%	17.5%	100.0%
SA4	15,509	628	957	6,238	958	4,625	25,942
Percent	59.8%	2.4%	3.7%	**24.0%**	3.7%	17.8%	100.0%
SA5	2,186	94	164	1,478	232	1,094	4,970
Percent	**44.0%**	**1.9%**	**3.3%**	29.7%	**4.7%**	**22.0%**	100.0%
SA6	27,530	1,044	1,890	9,591	1,099	2,869	36,446
Percent	**75.5%**	2.9%	5.2%	26.3%	3.0%	7.9%	100.0%
SA7	19,649	773	1,322	6,994	754	3,465	28,197
Percent	69.7%	2.7%	4.7%	24.8%	**2.7%**	12.3%	100.0%
SA8	18,992	761	1,385	8,402	984	3,291	29,015
Percent	65.5%	2.6%	4.8%	29.0%	3.4%	11.3%	100.0%
Total	132,741	5,355	9,141	54,993	6,855	28,310	206,674
Total Percent	64.2%	2.6%	4.4%	26.6%	3.3%	13.7%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group across Service Areas. Estimated prevalence rates of mental illness by age group for the County of Los Angeles are provided by the California Health Interview Survey (CHIS) for population living at or below 100% FPL. * 0-18: calculated using rate for 0-17 age group; ** 19-20: calculated using rate for 18-20 age group.

Differences by Age Group

Table 14 compares the prevalence of SED and SMI among Medi-Cal enrolled population for each age group.

The highest prevalence of SED and SMI among age 0-18 years was in SA 6 (75.5%) compared to SA 5 (44.0%) with the lowest percentage.

The highest prevalence of SED and SMI among age 19-20 years was in SA 1 (2.9%) compared to SA 5 (1.9%) with the lowest percentage.

The highest prevalence of SED and SMI among age 21-25 years was in SA 1 (5.8%) compared to SA 5 (3.3%) with the lowest percentage

The highest prevalence of SED and SMI among age 26-59 years was in SA 1 (32.1%) compared to SA 4 (24.0%) with the lowest percentage.

The highest prevalence of SED and SMI among age 60-64 years was in SA 5 (4.7%) compared to SA 7 (2.7%) with the lowest percentage.

The highest prevalence of SED and SMI among age 65+ years was in SA 5 (22.0%) compared to SA 1 (6.6%) with the lowest percentage.

TABLE 15: ESTIMATED PREVALENCE OF SED and SMI AMONG MEDI-CAL ENROLLED POPULATION BY GENDER AND SERVICE AREA MARCH 2015

Service Area (SA)	Male	Female	Total
SA1	4,690	9,245	13,935
Percent	**33.7%**	**66.3%**	100.0%
SA2	16,836	32,710	49,545
Percent	34.0%	66.0%	100.0%
SA3	14,219	27,919	42,138
Percent	**33.7%**	**66.3%**	100.0%
SA4	11,590	21,624	33,214
Percent	**34.9%**	**65.1%**	100.0%
SA5	2,187	4,194	6,381
Percent	34.3%	65.7%	100.0%
SA6	15,994	30,821	46,815
Percent	34.2%	65.8%	100.0%
SA7	12,255	24,028	36,283
Percent	33.8%	66.2%	100.0%
SA8	12,571	24,786	37,357
Percent	**33.7%**	**66.3%**	100.0%
Total	95,690	185,036	280,726
Percent	34.1%	65.9%	100.0%

Note: Bold values represent the highest and lowest percent within each gender across Service Areas. Estimated prevalence rates of mental illness by gender for the County of Los Angeles are provided by the California Health Interview Survey (CHIS) for population living at or below 100% FPL.

Differences by Gender

The highest prevalence of SED and SMI among Males was in SA 4 (34.9%) compared to SA 1, SA 3 and SA 8 (33.7%) with the lowest percentage among the Medi-Cal enrolled population.

The highest prevalence of SED and SMI among Females was in SA 1, SA 3 and SA 8 (66.3%) compared to SA 4 (65.1%) with the lowest percentage among the Medi-Cal enrolled population.

TABLE 16: PRIMARY LANGUAGE OF POPULATION ENROLLED IN MEDI-CAL BY SERVICE AREA AND THRESHOLD LANGUAGE MARCH 2015

Service Area (SA)	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Other	Total
SA1	92	16	19	72,388	29	64	24	7	9	20,278	146	75	372	93,519
Percent	0.1%	0.0%	0.0%	**77.4%**	0.0%	0.1%	0.0%	0.0%	0.0%	**21.7%**	0.2%	0.1%	0.4%	100.0%
SA2	45,875	138	178	152,235	6,524	2,477	305	25	3,878	110,359	2,792	1,827	3,997	330,610
Percent	**13.9%**	0.0%	0.1%	**46.0%**	**2.0%**	0.7%	0.1%	0.0%	**1.2%**	**33.4%**	**0.8%**	0.6%	1.2%	100.0%
SA3	1,887	710	17,424	143,923	243	1,333	15,989	21	95	78,593	1,647	12,483	4,370	278,718
Percent	0.7%	0.3%	**6.3%**	**51.6%**	0.1%	0.5%	**5.7%**	0.0%	0.0%	**28.2%**	0.6%	**4.5%**	1.6%	100.0%
SA4	5,966	461	5,383	87,550	444	10,826	842	9	4,396	99,208	2,778	1,034	1,829	220,726
Percent	**2.7%**	0.2%	**2.4%**	**39.7%**	0.2%	**4.9%**	0.4%	0.0%	**2.0%**	**44.9%**	**1.3%**	0.5%	0.8%	100.0%
SA5	47	4	49	27,631	3,327	267	147	4	1,299	7,937	76	63	735	41,586
Percent	0.1%	0.0%	0.1%	**66.4%**	**8.0%**	0.6%	0.4%	0.0%	3.1%	**19.1%**	0.2%	0.2%	1.8%	100.0%
SA6	18	95	56	169,996	17	1,040	28	8	30	142,423	86	60	773	314,630
Percent	0.0%	0.0%	0.0%	**54.0%**	0.0%	0.3%	0.0%	0.0%	0.0%	**45.3%**	0.0%	0.0%	0.2%	100.0%
SA7	569	728	576	123,961	42	1,641	882	17	58	110,010	837	563	1,425	241,309
Percent	0.2%	0.3%	0.2%	**51.4%**	0.0%	0.7%	0.4%	0.0%	0.0%	**45.6%**	0.3%	0.2%	0.6%	100.0%
SA8	95	4,684	233	157,113	315	1,897	415	10	148	77,690	1,650	1,883	1,675	247,808
Percent	0.0%	**1.9%**	0.1%	**63.4%**	0.1%	0.8%	0.2%	0.0%	0.1%	**31.4%**	0.7%	0.8%	0.7%	100.0%
Total	54,549	6,836	23,918	934,797	10,941	19,545	18,632	118	9,913	646,498	10,012	17,988	15,176	1,768,906
Percent	3.1%	0.4%	1.4%	52.8%	0.6%	1.1%	1.1%	0.0%	0.6%	36.5%	0.6%	1.0%	0.9%	100.0%

Note: "Threshold Language" means a language that has been identified as the primary language, as indicated on the MEDS, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. SA Threshold Languages are in bold. Arabic is a countywide threshold language and does not meet the threshold language criteria at the SA level and therefore not reported in the above table. A total of 4,436 (.2%) individuals enrolled in Medi-Cal reported Arabic as their primary language in March 2015. 15,176 (0.8%) individuals enrolled in Medi-Cal reported "Other" as a primary language. 47,656 (2.6%) were "Unknown/Missing" for primary language and were missing a Service Area designation Data Source: LACDMH-IS Database, December 2015, State MEDS File, March 2015.

Table 16 shows the thirteen (13) LACDMH threshold languages by Service Area (SA). Of the twelve Non-English threshold languages spoken among the population enrolled in Medi-Cal, Spanish had the highest percentage within the eight SAs.

The Service Area with the highest percentage of Medi-Cal enrolled population with English as the primary language was SA 1 (77.4%) and the lowest percentage was SA 4 (39.7%).

The Service Area with the highest percentage of Medi-Cal enrolled population with Spanish as the primary language was SA 7 (45.6%) and the lowest percentage was SA 5 (19.1%).

The following compares threshold languages spoken by Medi-Cal enrollees by SA:

SA 1 has two (2) threshold languages: English (77.4%) and Spanish (21.7%).

SA 2 has six (6) threshold languages: Armenian (13.9%), English (46.0%), Farsi (2.0%), Russian (1.2%), Spanish (33.4%), and Tagalog (0.8%).

SA 3 has five (5) threshold languages: Cantonese (6.3%), English (51.6%), Mandarin (5.7%), Spanish (28.2%), and Vietnamese (4.5%).

SA 4 has seven (7) threshold languages: Armenian (2.7%), Cantonese (2.4%), English (39.7%), Korean (4.9%), Russian (2.0%), Spanish (44.9%), and Tagalog (1.3%).

SA 5 has three (3) threshold languages: English (66.5%), Farsi (8.0%), and Spanish (19.1%).

SA 6 and SA 7 have two (2) threshold languages. SA 6: English (54.0%) and Spanish (45.3%). SA 7: English (51.4%) and Spanish (45.6%).

SA 8 has three (3) threshold languages: Cambodian (1.9%), English (63.4%), and Spanish (31.4%).

Countywide, the highest percentage of Medi-Cal Enrolled persons with English as the primary language is 52.8% and the second highest is Spanish at 36.5%. All other threshold languages range between 0.0% (Other Chinese) and 13.9% (Armenian).

Consumers Served In Outpatient Facilities

In FY 2014-15, LACDMH served approximately 265,000 consumers (unduplicated). A majority were served in Outpatient facilities (N = 214,067). Approximately 10,000 were served by Fee for Service Outpatient network providers, another 39,000 were served in jails and juvenile halls and 19,000 were served in 24 Hour acute psychiatric care or residential facilities.

TABLE 17: CONSUMERS SERVED IN OUTPATIENT FACILITIES BY ETHNICITY AND SERVICE AREA FY 2014 – 2015

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA1	2,967	44	3,832	28	1,356	8,227
Percent	36.1%	**0.5%**	46.6%	0.3%	16.5%	100.0%
SA2	3,200	594	14,300	68	7,037	25,199
Percent	12.7%	2.4%	56.7%	0.3%	27.9%	100.0%
SA3	2,432	1,405	12,033	90	2,898	18,858
Percent	12.9%	**7.5%**	63.8%	0.5%	15.4%	100.0%
SA4	20,738	2,585	31,432	456	13,156	68,367
Percent	30.3%	3.8%	46.0%	**0.7%**	19.2%	100.0%
SA5	1,499	112	2,107	25	1,914	5,657
Percent	26.5%	2.0%	**37.2%**	0.4%	**33.8%**	100.0%
SA6	10,761	190	12,349	24	759	24,083
Percent	**44.7%**	0.8%	51.3%	**0.1%**	**3.2%**	100.0%
SA7	1,752	312	14,007	52	1,513	17,636
Percent	**9.9%**	1.8%	**79.4%**	0.3%	8.6%	100.0%
SA8	8,961	1,076	12,612	113	5,005	27,767
Percent	32.3%	3.9%	45.4%	0.4%	18.0%	100.0%
Total	56,011	9,171	106,891	1,184	40,810	214,067
Percent	25.2%	6.0%	51.8%	0.4%	16.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. The total served excludes those whose ethnicity is unknown (N = 15,000) and "Other" (N = 2,144). Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS Database, December 2015.

Differences by Ethnicity

The highest percentage of African American (AA) consumers served in Outpatient facilities was in SA 6 (44.7%) as compared to SA 7 (9.9%) with the lowest percentage.

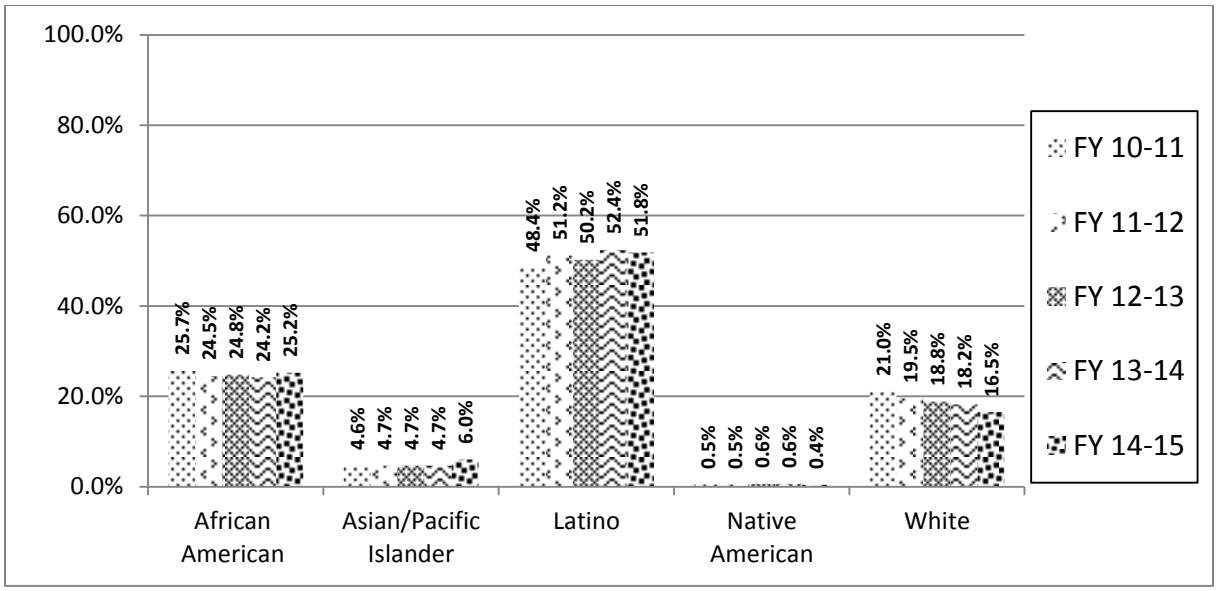
The highest percentage of Asian/Pacific Islander (API) consumers served in Outpatient facilities was in SA 3 (7.5%) as compared to SA 1 (0.5%) with the lowest percentage.

The highest percentage of Latino consumers served in Outpatient facilities was in SA 7 (79.4%) as compared to SA 5 (37.2%) with the lowest percentage.

The highest percentage of Native American (NA) consumers served in Outpatient facilities was in SA 4 (0.7%) as compared to SA 6 (0.1%) with the lowest percentage.

The highest percentage of White consumers served in Outpatient facilities was in SA 5 (33.8%) as compared to SA 6 (3.2%) with the lowest percentage.

FIGURE 8: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT FACILITIES BY ETHNICITY FY 2010 – 2011 TO FY 2014 – 2015



Data Source: LACDMH-IS Database, December 2015.

As a percentage of consumers served, African Americans (AA) served in Outpatient facilities decreased by 0.5 percentage points (PP), from 25.7% to 25.2% between FY 10-11 and FY 14-15. In FY 11-12, the percentage of AA served in Outpatient facilities was 24.5%, in FY 12-13 it was 24.8%, and in FY 13-14 it was 24.2%.

As a percentage of consumers served, Asian/Pacific Islanders (API) served in Outpatient facilities increased by 1.4 PP, from 4.6% to 6.0% between FY 10-11 and FY 14-15. The percentage of API served in Outpatient facilities remained constant at 4.7% for FY 11-12, FY 12-13, and FY 13-14.

As a percentage of consumers served, Latinos served in Outpatient facilities increased by 3.4 PP, from 48.4% to 51.8% between FY 10-11 and FY 14-15. In FY 11-12, the percentage of Latinos served in Outpatient facilities was 51.2%, in FY 11-12 it was 50.2%, and in FY 12-13 it was 52.4%.

As a percentage of consumers served, Native Americans (NA) served in Outpatient facilities decreased by 0.1 PP, from 0.5% in FY 10-11 to 0.4% in FY 14-15. In FY 11-

12, the percentage of NA served in Outpatient facilities was 0.5%. In FY 12-13 and FY 13-14, the percentage of NA served in Outpatient facilities was 0.6%.

As a percentage of consumers served, Whites served in Outpatient facilities decreased by 4.5 PP, from 21.0% to 16.5% between FY 10-11 and FY 14-15. In FY 11-12, the percentage of Whites served in Outpatient facilities was 19.5%, in FY 12-13 it was 18.8%, and in FY 13-14 it was 18.2%.

TABLE 18: CONSUMERS SERVED IN OUTPATIENT FACILITIES BY AGE GROUP AND SERVICE AREA FY 2014 - 2015

Service Area (SA)	0-15	16-25	26-59	60+	Total
SA1	5,043	2,463	632	89	8,227
Percent	**61.3%**	**29.9%**	**7.7%**	**1.1%**	100.0%
SA2	10,382	5,514	7,888	1,415	25,199
Percent	41.2%	21.9%	31.3%	5.6%	100.0%
SA3	9,396	3,666	4,791	1,005	18,858
Percent	49.8%	19.4%	25.4%	5.3%	100.0%
SA4	12,509	14,162	38,027	3,669	68,367
Percent	**18.3%**	20.7%	**55.6%**	5.4%	100.0%
SA5	1,921	907	2,298	531	5,657
Percent	34.0%	16.0%	40.6%	**9.4%**	100.0%
SA6	11,474	3,376	8,199	1,034	24,083
Percent	47.6%	**14.0%**	34.0%	4.3%	100.0%
SA7	8,560	4,087	4,201	788	17,636
Percent	48.5%	23.2%	23.8%	4.5%	100.0%
SA8	11,082	4,476	10,783	1,426	27,767
Percent	39.9%	16.1%	38.8%	5.1%	100.0%
Total	70,419	38,796	76,819	9,957	195,991
Percent	35.9%	19.8%	39.2%	5.1%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group across Service Areas. Total reflects unduplicated count of consumers served. Data Source: LACDMH-IS Database, December 2015.

Differences by Age Group

Table 18 shows the number of consumers served in Outpatient facilities by Age Group and Service Area (SA).

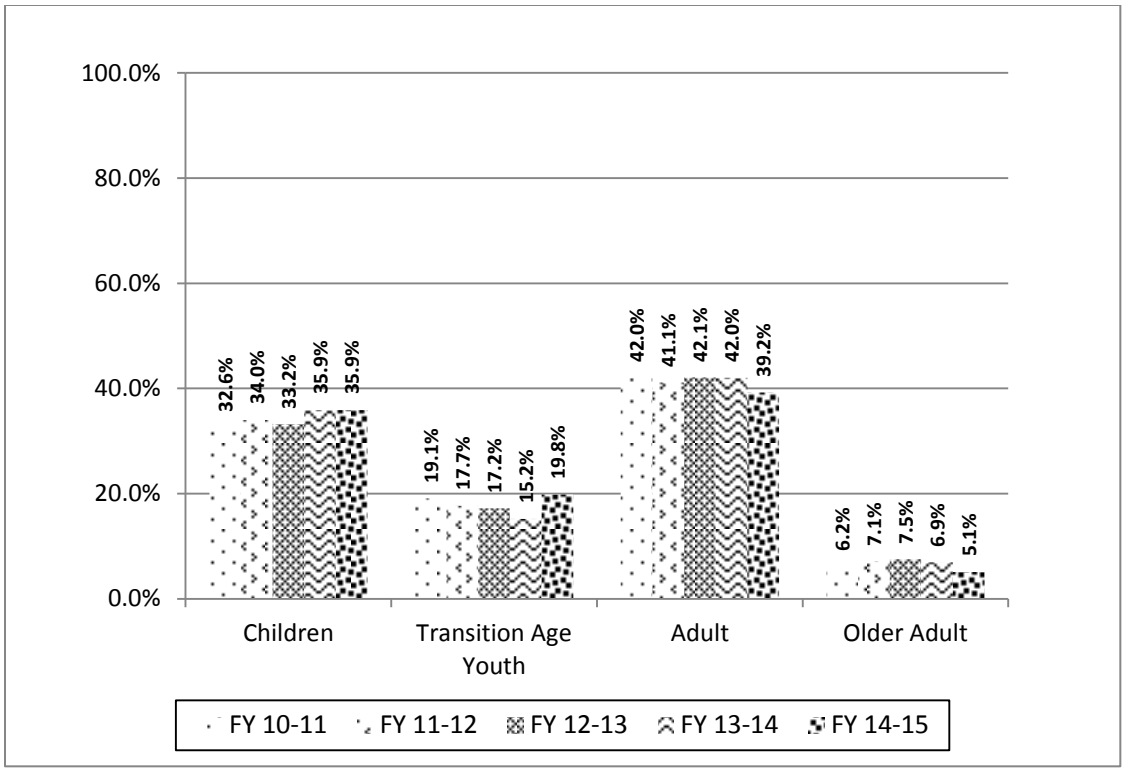
The highest percentage of Children (0-15) served was in SA 1 (61.3%) compared to SA 4 (18.3%) with the lowest percentage.

The highest percentage of TAY (16-25) served was in SA 1 (29.9%) compared to SA 6 (14.0%) with the lowest percentage.

The highest percentage of Adults (26-59) served was in SA 4 (55.6%) compared to SA 1 (7.7%) with the lowest percentage.

The highest percentage of Older Adults (60+) served was in SA 5 at (9.4%) compared to SA 1 (1.1%) with the lowest percentage.

FIGURE 9: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT FACILITIES BY AGE GROUP FY 2010 – 2011 TO FY 2014 – 2015



Data Source: LACDMH-IS Database, December 2015.

As a percentage of consumers served, Children served in Outpatient facilities increased by 3.3 percentage points (PP), from 32.6% to 35.9% between FY 10-11 and FY 14-15. In FY 11-12, the percentage of Children served in Outpatient facilities was 34.0%, in FY 12-13 it was 33.2%, and in FY 13-14 it was 35.9%.

As a percentage of consumers served, TAY served in Outpatient facilities increased by 0.7 PP, from 19.1% to 19.8% between FY 10-11 and FY 14-15. In FY 11-12, the percentage of TAY served in Outpatient facilities was 17.7%, in FY 12-13 it was 17.2%, and in FY 12-13 it was 15.2%.

As a percentage of consumers served, Adults served in Outpatient facilities decreased by 2.8 PP, from 42.0% to 39.2% between FY 10-11 and FY 14-15. In FY 11-12, the percentage of Adults served in Outpatient facilities was 41.1%, in FY 12-13 it was 42.1%, and in FY 13-14 it was 42.0%.

As a percentage of consumers served, Older Adults served in Outpatient facilities decreased by 1.1 PP, from 6.2% to 5.1% between FY 10-11 and FY 14-15. In FY 11-12, the percentage of Older Adults served in Outpatient facilities was 7.1%, in FY 12-13 it was 7.5%, and in FY 13-14 it was 6.9%.

TABLE 19: CONSUMERS SERVED IN OUTPATIENT FACILITIES BY GENDER AND SERVICE AREA FY 2014 - 2015

Service Area (SA)	Male	Female	Total
SA1	5,298	3,523	8,823
Percent	60.1%	39.9%	100.0%
SA2	12,197	10,951	23,148
Percent	52.7%	47.3%	100.0%
SA3	10,368	9,996	20,364
Percent	50.9%	49.1%	100.0%
SA4	45,259	23,106	68,365
Percent	**66.1%**	**33.8%**	100.0%
SA5	2,817	2,592	5,409
Percent	52.0%	48.0%	100.0%
SA6	12,108	12,522	24,630
Percent	**49.2%**	**50.8%**	100.0%
SA7	10,646	9,168	19,814
Percent	53.7%	46.3%	100.0%
SA8	13,585	12,846	26,431
Percent	51.3%	48.7%	100.0%
Total	112,278	84,706	196,984
Percent	56.9%	43.1%	100.0%

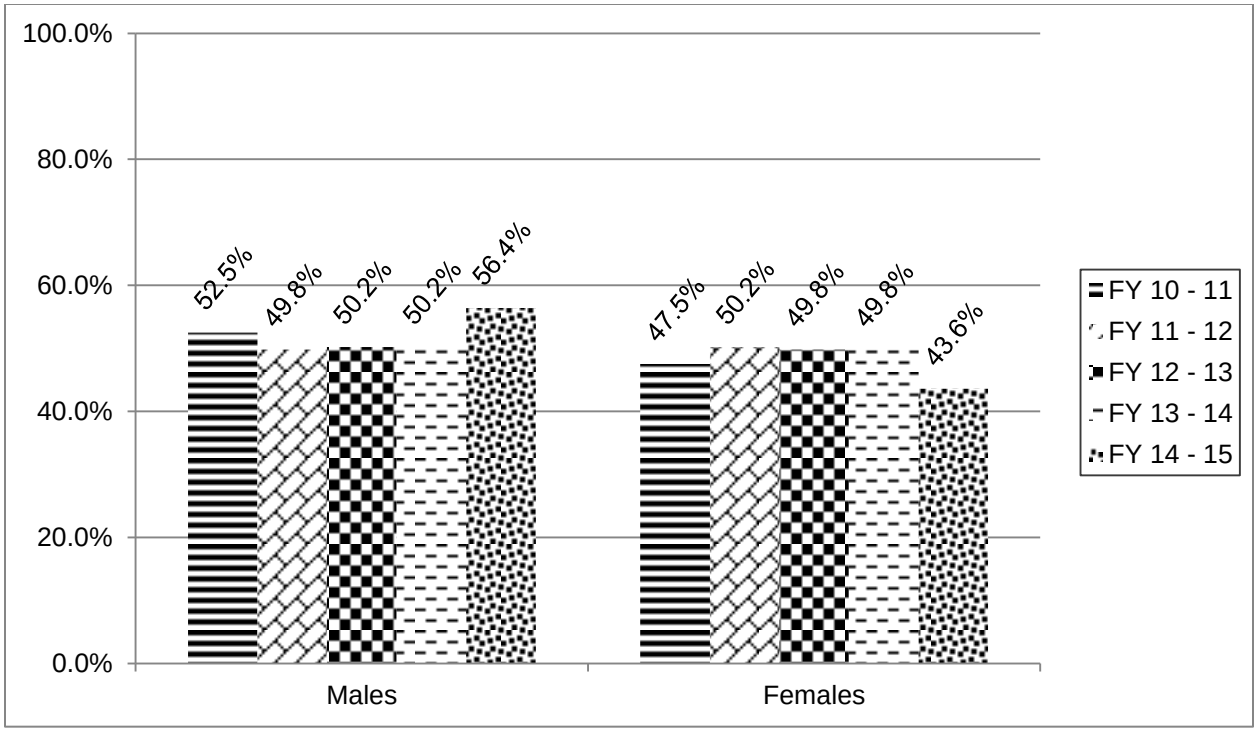
Note: Bold values represent the highest and lowest percentages within each gender across Service Areas. Excludes consumers not reporting their gender, (N = 133). Total reflects unduplicated count of consumers served. Data Source: LACDMH-IS Database, 2015.

Differences by Gender

The highest percentage of Males served in Outpatient facilities was in SA 4 (66.1%) compared to SA 6 (49.2%) with the lowest percentage.

The highest percentage of Females served in Outpatient facilities was in SA 6 (50.8%) compared to SA 4 (33.8%) with the lowest percentage.

FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT FACILITIES BY GENDER
FY 2010 - 2011 TO FY 2014 – 2015



Data Source: LACDMH-IS Database, December 2015.

As a percentage of consumers served, males served in Outpatient facilities increased by 3.9 percentage points (PP), from 52.5% to 56.4% between FY 10-11 and FY 14-15. In FY 11-12 the percent of males served in Outpatient facilities was 49.8%, in FY 12-13 it was at 50.2%, and in FY 13-14 it was at 50.2%.

As a percentage of consumers served, females served in Outpatient facilities decreased by 3.9 PP, from 47.5% to 43.6% between FY 10-11 and FY 14-15. In FY 11-12 the percentage of females served in Outpatient facilities was 50.2%, in FY 12-13 it was at 49.8%, and in FY 13-14 it was at 49.8%.

TABLE 20: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT FACILITIES BY SERVICE AREA AND THRESHOLD LANGUAGE FY 2014 – 2015

Service Area (SA)	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA1	1	2	0	7,325	1	1	6	0	0	864	0	0	8,200
Percent	0.01%	0.02%	0.0%	89.3%	0.01%	0.01%	0.07%	0.0%	0.0%	10.5%	0.0%	0.0%	100.0%
SA2	743	19	14	18,367	189	47	24	5	38	5,016	38	48	24,548
Percent	3.0%	0.08%	0.06%	74.8%	0.8%	0.19%	0.10%	0.02%	0.15%	20.4%	0.15%	0.20%	100.0%
SA3	51	17	314	14,365	4	30	213	38	0	3,416	0	183	18,631
Percent	0.27%	0.09%	1.7%	77.1%	0.02%	0.16%	1.1%	0.20%	0.0%	18.3%	0.0%	0.98%	100.0%
SA4	157	147	162	49,599	113	668	175	48	35	10,978	1	156	62,239
Percent	0.25%	0.24%	0.26%	79.7%	0.18%	1.1%	0.28%	0.08%	0.06%	17.6%	0.0%	0.25%	100.0%
SA5	3	0	2	4,831	31	4	4	0	5	558	0	1	5,439
Percent	0.06%	0.0%	0.04%	88.8%	0.57%	0.07%	0.07%	0.0%	0.09%	10.3%	0.0%	0.02%	100.0%
SA6	1	3	10	18,100	7	40	12	2	3	5,689	0	12	23,879
Percent	0.0%	0.01%	0.04%	75.8%	0.03%	0.17%	0.05%	0.01%	0.01%	23.8%	0.0%	0.05%	100.0%
SA7	5	47	6	12,662	1	50	36	4	1	4,608	0	1	17,421
Percent	0.03%	0.27%	0.03%	72.7%	0.01%	0.29%	0.21%	0.02%	0.01%	26.5%	0.0%	0.01%	100.0%
SA8	11	126	4	21,522	10	101	22	10	1	5,213	0	114	27,134
Percent	0.04%	0.46%	0.01%	79.3%	0.04%	0.37%	0.08%	0.04%	0.0%	19.2%	0.0%	0.42%	100.0%
Total	972	361	512	146,771	356	941	492	107	83	36,342	39	515	187,491
Percent	0.52%	0.19%	0.27%	78.3%	0.19%	0.50%	0.26%	0.06%	0.04%	19.4%	0.02%	0.27%	100.0%

Note: "Threshold Language" means a language that has been identified as the primary language, as indicated on the MEDS, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. 260 consumers served in Outpatient facilities reported "Other" as their primary language. 13,172 consumers served in outpatient facilities reported their primary language as "Unknown" or were "Missing" in the IS database. Arabic is a countywide threshold language and does not meet the threshold language criteria at the SA level and is not reported in the above table. A total of 99 Arabic speaking consumers were served in FY 14-15. Data Source: LACDMH-IS Database, December 2015.

Table 20 shows the primary language of consumers served by threshold language. Below is a discussion of the threshold languages by Service Area (SA).

English was the highest reported primary language among consumers served in Outpatient facilities, in all SAs. A total of 146,771 (78.3%) English speaking consumers were served. SA 1 had the highest percentage of English speaking consumers (89.3%), as compared to SA 7 (72.7%) which has the lowest percentage. A total of 40,720 (21.7%) of the consumers served reported a primary language other than English.

Spanish was the highest reported Non-English threshold language for consumers served in all SAs. The SA with the highest percentage of consumers served reporting Spanish as the primary language was SA 7 (26.5%) and the lowest percentage was SA 5 (10.3%).

The following highlights the additional non-English threshold languages reported for consumers served in Outpatient facilities by Service Area:

- SA 2 - Armenian (3.0%) Farsi (0.8%), Russian (0.2%), and Tagalog (0.2%)
- SA 3 - Cantonese (1.7%), Mandarin (1.1%), and Vietnamese (1%)
- SA 4 - Korean (1.1%), Armenian (0.3%), Cantonese (0.3%), and Russian (0.1%)
- SA 5 - Farsi (0.6%)
- SA 8 - Cambodian (0.5%)

SECTION 3

QI WORK PLAN EVALUATION REPORT FOR CY 2015

LACDMH provides a full array of treatment services as required under Welfare and Institutions Code (W&IC) Sections 5600.3, State Medi-Cal Oversight Review Protocol. The QI Work Plan Goals are in place to monitor and evaluate the quality of the service delivery system. In accordance with the Mental Health Plan's reporting requirements of the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440, concerning Quality Improvement, the LACDMH evaluation of Quality Improvement activities are structured and organized according to the following domains:

1. Monitoring Service Delivery Capacity
2. Monitoring Accessibility of Services
3. Monitoring Beneficiary Satisfaction
4. Monitoring Clinical Care
5. Monitoring Continuity of Care
6. Monitoring Provider Appeals

The QI Work Plan Goals for CY 2015 focus on monitoring access to services for target populations, service delivery capacity, timeliness of the services provided, language needs of consumers, consumer satisfaction with the services received, the quality of services provided, and other areas of quality improvement as identified by the LACDMH.

Section 3 provides an evaluation summary on the progress made by LACDMH in reaching each goal.

QUALITY IMPROVEMENT WORK PLAN EVALUATION SUMMARY - CY 2015

I. MONITORING SERVICE DELIVERY CAPACITY

1. *At least 50% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 14-15.* ***This goal was met.***
2. *At least 47% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 14-15.* ***This goal was not met.***
3. *Maintain the number of clients served by tele-psychiatry in CY 2015 at the same capacity as in CY 2014 (N=512).* ***This goal was met.***

II. MONITORING ACCESSIBILITY OF SERVICES

1. *Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 73%.* ***This goal was not met.***

2a. *Seventy-five percent of after-hours calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll free hotline.* ***This goal was met.***

2b. *Sixty percent of daytime calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll free hotline.* ***This goal was not met.***

3. *Maintain percent of completed test calls to the toll free hotline at 98% in CY 2015.* ***This goal was met****.*
4. *Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations at 88% in CY 2015.* ***This goal was not met****.*
5. *Maintain the percent of consumers/families reporting that they are able to receive services at convenient times at 91.2% in CY 2015.* ***This goal was not met.***

III. MONITORING BENEFICIARY SATISFACTION

1. *Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background at 89.8% in CY 2015.* ***This goal was not met.***
2. *Maintain the percent of consumers/families reporting overall satisfaction with services provided at 85% in CY 2015 and continue year-to-year trending of the data.* ***This goal was met.***
3. *Monitor the grievances, appeals and requests for State Fair Hearings for FY 2014-2015. Resolve all standard appeals within 45 calendar days of receipt of appeal by Patients' Rights Office. Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log.* ***This goal was met.***
4. *Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their change of provider requests. Ninety-five percent of providers will report the requests for change of provider in at least 11 of 12 months in CY 2015.* ***This goal was not met.***
5. *Implement the revised peer survey in CY 2015.* ***This goal was met.***

IV. MONITORING CLINICAL CARE

1. *Continue to improve medication practices through systematic use of medication parameters, peer review related to medication practices, and trainings for the use of medication.* ***This goal was met.***
2. *Implement the Spiritual Self-Care Facilitator training at Wellness Centers in LACDMH Directly Operated Programs in CY 2015 to facilitate Spirituality Self-Care groups with consumers at these Centers.* ***This goal was met.***
3. *Continue to improve Clinical Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD) through on-site and online revised COD 101 training targeting all LACDMH Directly Operated and Contracted Adult System of Care (ASOC) programs in Calendar Year 2015.* ***This goal was met.***

V. MONITORING CONTINUITY OF CARE

1. *90% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center will receive appointments for a Specialty Mental Health Service Assessment within 5 business days.* ***This goal was met.***

VI. MONITORING OF PROVIDER APPEALS

1. *The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal.* ***This goal was met.***

I. MONITORING SERVICE DELIVERY CAPACITY

Goal I.1

At least 50% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 14-15.

Penetration Rate Numerator: Unduplicated number of consumers served by ethnicity during the fiscal year in Outpatient facilities and Day Treatment facilities.

Penetration Rate Denominator: Total County population living at or below 138% FPL estimated with SED and SMI.

Prevalence rates utilized to estimate SED and SMI were derived from the California Health Interview Survey (CHIS). The CHIS rates are estimated from a random sample of the population in the County of Los Angeles. The CHIS collects survey data on mental health utilization patterns from the population of the County of Los Angeles every two years, within each Service Area, and by the ethnicity. This allows for more precise estimates of prevalence and provides the ability to conduct trend analysis.

EVALUATION

This goal was met. Approximately 51.5% of Latinos estimated with SED and SMI at or below the 138% FPL were served in FY 14-15. Table 21A below shows the penetration rates for FY 12-13, FY 13-14 and FY 14-15, using prevalence estimates from CHIS survey data.

Goal I.2

At least 47% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 14-15.

Penetration Rate Numerator: Unduplicated number of consumers served by ethnicity during the fiscal year in Outpatient facilities and Day Treatment facilities.

Penetration Rate Denominator: Total County population living at or below 138% FPL estimated with SED and SMI.

Prevalence rates utilized to estimate SED and SMI were derived from the California Health Interview Survey (CHIS). The CHIS rates are estimated from a random sample of the population in the County of Los Angeles. The CHIS collects survey data on mental health utilization patterns from the population of the County of Los Angeles every two years, within each Service Area, and by the ethnicity. This allows for more precise estimates of prevalence and provides the ability to conduct trend analysis.

EVALUATION

This goal was not met. Forty-two point six percent (42.6%) of Asians and Pacific Islanders estimated with SED and SMI and living at or below the 138% FPL were served in FY 14-15. Table 21A below shows the penetration rates for FY12-13, FY 13-14 and FY 14-15, using prevalence estimates derived from CHIS data. The table below shows a drop in Penetration Rates for the API population. While the number of API

consumers served stayed relatively stable in FY 14-15 as compared with previous years, the decrease in the API Penetration Rates is largely due to the increase in the prevalence estimates for API population FY 14-15.

TABLE 21A: THREE YEAR TREND IN PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 138% FPL BASED ON PREVALENCE RATE FROM CHIS[1] FY 12-13 TO FY 14-15

Ethnicity	FY 12-13	FY 13-14	FY 14-15
African American	111.2%	112.9%	147.7%
Consumers Served	49,087	47,343	56,011
Estimated population with SED/SMI	44,161	41,939	37,923
Asian/Pacific Islander	47.1%	47.5%	42.6%
Consumers Served	9,227	9,117	9,171
Estimated population with SED/SMI	19,578	19,208	21,509
Latino	49.6%	50.0%	51.5%
Consumers Served	101,353	102,640	106,891
Estimated population with SED/SMI	204,379	205,131	207,651
Native American	82.5%	103.6%	95.9%
Consumers Served	1,102	1,192	1,184
Estimated population with SED/SMI	1,336	1,151	1,235
White	84.7%	82.4%	97.0%
Consumers Served	37,166	35,710	40,810
Estimated population with SED/SMI	43,872	43,337	42,052

Note: Ethnic specific Prevalence Rate for SED for Youth and SMI for Adults from [1] 2011-2012 California Health Interview Survey (CHIS) were applied to calculate Penetration Rate.
Data Source: LACDMH-IS Database, December 2015.

TABLE 21B: PENETRATION RATE AMONG TOTAL POPULATION AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND SERVICE AREA FY 2014 – 2015

Ethnicity and Service Area	Number of Consumers Served[1]	Total Population Estimated with SED and SMI	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 1					
African American	2,967	4,963	59.8%	3,423	86.7%
Asian/Pacific Islander	44	1,078	4.1%	175	25.1%
Latino	3,832	15,068	25.4%	7,316	52.4%
Native American	28	318	8.8%	122	23.0%
White	1,356	10,521	12.9%	2,543	53.3%
Total	8,227	31,948	25.8%	13,579	60.6%
SA 2					
African American	3,200	6,124	52.3%	2,419	132.3%
Asian/Pacific Islander	594	17,503	3.4%	2,733	21.7%
Latino	14,300	75,071	19.0%	34,797	41.1%
Native American	68	788	8.6%	180	37.8%
White	7,037	75,555	9.3%	14,337	49.1%
Total	25,199	175,041	14.4%	54,466	46.3%
SA 3					
African American	2,432	5,195	46.8%	1,838	132.3%
Asian/Pacific Islander	1,405	35,261	4.0%	7,155	19.6%
Latino	12,033	70,711	17.0%	26,164	46.0%
Native American	90	605	14.9%	122	73.8%
White	2,898	29,265	9.9%	4,819	60.1%
Total	18,858	141,037	13.4%	40,098	47.0%
SA 4					
African American	20,738	4,810	431.1%	2,776	747.0%
Asian/Pacific Islander	2,585	14,237	18.2%	4,701	55.0%
Latino	31,432	51,118	61.5%	31,857	98.7%
Native American	456	420	108.6%	211	216.1%
White	13,156	21,955	59.9%	6,428	204.7%
Total	68,367	92,540	73.9%	45,973	148.7%
SA 5					
African American	1,499	2,950	50.8%	960	156.1%
Asian/Pacific Islander	112	6,285	1.8%	1,392	8.0%
Latino	2,107	8,999	23.4%	2,997	70.3%
Native American	25	195	12.8%	28	89.3%
White	1,914	32,157	6.0%	5,575	34.3%
Total	9,518	50,137	19.0%	11,570	82.3%

TABLE 21B (CONTD.): PENETRATION RATE AMONG TOTAL POPULATION AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND SERVICE AREA FY 2014 – 2015

Ethnicity and Service Area	Number of Consumers Served[1]	Total Population Estimated with SED and SMI	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 6					
African American	10,761	22,446	47.9%	16,132	66.7%
Asian/Pacific Islander	190	1,322	14.4%	623	30.5%
Latino	12,349	60,192	20.5%	41,764	29.6%
Native American	24	299	8.0%	198	12.1%
White	759	1,948	39.0%	866	87.6%
Total	24,083	86,207	27.9%	59,583	40.4%
SA 7					
African American	1,752	3,132	55.9%	1,143	153.3%
Asian/Pacific Islander	312	8,368	3.7%	1,231	25.3%
Latino	14,007	82,737	16.9%	35,869	39.1%
Native American	52	547	9.5%	154	33.8%
White	1,513	14,300	10.6%	2,462	61.5%
Total	17,636	109,084	16.2%	40,859	43.2%
SA 8					
African American	8,961	18,035	49.7%	9,233	97.1%
Asian/Pacific Islander	1,076	17,402	6.2%	3,500	30.7%
Latino	12,612	53,612	23.5%	26,886	46.9%
Native American	113	718	15.7%	220	51.4%
White	5,005	34,251	14.6%	5,022	99.7%
Total	27,767	124,018	22.4%	44,861	61.9%

TABLE 21B (CONTD.): PENETRATION RATE AMONG TOTAL POPULATION AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND SERVICE AREA FY 2014 – 2015

Ethnicity and Service Area	Number of Consumers Served[1]	Total Population Estimated with SED and SMI	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
Unduplicated Consumers Served in At least 1 Service Area					
African American	56,011	67,654	82.7%	37,923	147.7%
Asian/Pacific Islander	9,171	101,456	9.4%	21,509	42.6%
Latino	106,891	417,508	25.6%	207,651	51.5%
Native American	1,184	3,890	30.4%	1,235	95.9%
White	40,810	219,952	18.6%	42,052	97.0%
Total	214,067*	810,460	26.4%	310,370	69.0%

Data Source: Prevalence Rate by ethnicity from 2011 - 2012 California Health Interview Survey (CHIS). Note: [1] Number of Consumers Served represents consumers served by LACDMH in Outpatient facilities and Day Treatment Facilities. The count does not include consumers served by 24 Hour/Residential Facilities such as Acute Care Inpatient Hospitals etc. [2] Penetration Rate = Number of Consumers Served / Number of People Estimated with SED and SMI. In some Service Areas, Penetration Rates for some ethnic groups exceed 100% because of small distribution of that population in that Service Area.

TABLE 22: ESTIMATED PREVALANCE RATES FOR SED and SMI BY CALIFORNIA HEALTH INTERVIEW SURVEY (CHIS) WITH CONFIDENCE INTERVALS: 2009 AND 2011-2012

Total Population				
	2009	Confidence Interval	2011-12	Confidence Interval
Total	7.3%	(6.0-8.6)	8.0%	(7.1-8.9)
African American	14.6*	(5.2-24.1)	7.8%	(5.0-10.6)
API	6.1%	(3.7-8.4)	6.9%	(4.4-9.4)
Latino	7.3%	(5.5-9.1)	8.6%	(7.2-10.0)
Native American	.025*	(0.0-7.3)	19.4*	(1.6-37.2)
White	6.1%	(4.5-7.7)	7.7%	(6.2-9.3)
Two or More Races	.056*	(1.3-9.9)	6.9%*	(0.7-13.1)
Population at or Below 138% FPL				
	2009	Confidence Interval	2011-12	Confidence Interval
Total	8.8%	(6.1 - 11.6)	11.4%	(9.5 - 13.3)
African American	29.3%*	(4.8 - 53.8)	15.8%	(9.0 - 22.6)
API	7.6%*	(2.3 - 13.0)	7.3%	(3.1 - 11.5)
Latino	7.0%	(5.1 - 8.9)	11.4%	(9.0 - 13.8)
Native American	-	-	24.0%*	(0.0 - 63.2)
White	8.2%	(4.7 - 11.6)	11.0%	(5.8 - 16.2)
Two or More Races	7.4%*	(0.0 - 17.9)	14.8%*	(0.0 - 37.7)
Population at or Below 200% FPL				
	2009	Confidence Interval	2011-12	Confidence Interval
Total	9.7%	(7.2-12.2)	10.7%	(9.1-12.3)
African American	26.4%*	(7.6-45.3)	14.0%	(8.6-19.5)
API	6.1%*	(2.2-10.1)	5.3%	(2.4-8.2)
Latino	8.2%	(6.0-10.4)	10.6%	(8.6-12.6)
Native American	9.2%*	(0.0-27.0)	19%*	(0.0-40.7)
White	9.7%	(5.8-13.6)	13.0%	(8.1-7.8)
Two or More Races	7.4%*	(0.0-16.6)	14.1%*	(0.0-32.1)

Note: * = Statistically Unreliable. Data Source: California Health Interview Survey (CHIS), 2011-2012.

Goal I.3.

Maintain the number of clients served by tele-psychiatry in CY 2015 at the same capacity as in CY 2014 (N=512).

EVALUATION

This goal was met. In CY 2015, 941 consumers were served through tele-psychiatry appointments. This represents a 84% increase over the 512 clients served in 2014. Several factors contributed to the increase in tele-psychiatry appointments for CY 2015. A stable cohort of psychiatrists allowed for a consistent presence at all connecting endpoints. The Acton Antelope Valley Rehabilitation Center was added as a supportive endpoint. Residents of this drug rehabilitation center are allotted a maximum 90 day stay and three psychiatrists are staffed at this site on different days. This contributed to a significant turnover in which psychiatrists were regularly evaluating new clients. Sites that yielded less tele-psychiatry appointments were monitored closer and subsequent moves by psychiatrists to sites that demonstrated a higher need for services were made accordingly.

II. MONITORING ACCESSIBILITY OF SERVICES

Goal II.1.

Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 73%.

Numerator: The number of after-hours PMRT responses with a response time of one hour or less.

Denominator: Total number of after-hours PMRT responses.

EVALUATION

This goal has not been met.

TABLE 23: PSYCHIATRIC MOBILE RESPONSE TEAM (PMRT) AFTER-HOURS RESPONSE RATES OF ONE HOUR OR LESS CY 2011 – 2015

Month	2011	2012	2013	2014	2015
January	76%	69%	75%	75%	72%
February	72%	64%	68%	73%	70%
March	71%	66%	68%	73%	69%
April	69%	61%	72%	72%	68%
May	74%	66%	71%	71%	70%
June	68%	65%	71%	73%	73%
July	71%	70%	71%	74%	75%
August	67%	70%	71%	76%	72%
September	68%	65%	74%	73%	69%
October	68%	67%	75%	74%	71%
November	66%	70%	73%	67%	70%
December	68%	N/A[1]	74%	73%	71%
Annual Total	**4,288**	**3,984**	**4,859**	**5,824**	**3,670**
Annual Average %	**70%**	**67%**	**72%**	**73%**	**71%**

Note: [1]December 2012 data is not available due to transition to the new phone monitoring system on November 27, 2012.

LACDMH utilizes the ACCESS Center PMRT responsiveness as an indicator of timeliness of field visits requiring rapid intervention and assistance. The rationale for this indicator was concerns about providing alternatives to hospitalization and linkage with other appropriate levels of care such as Urgent Care Centers.

Table 23 shows that in CY 2015, an average of 71% of PMRT calls resulted in mobile teams being present at the scene within one hour or less from acknowledgement of receipt of the call. This reflects a 2% decrease over the previous year's performance of 73%. PMRT after-hours responders' recruitment from LACDMH's existing workforce of clinicians, as volunteers, to work has been modified. Primarily, licensed clinicians are being recruited and deployed as after-hours responders, whereas previously PMRT utilized unlicensed staff as a second member of a two-person team. Additionally, use of licensed psychiatric technicians has also been limited to adult clients and only as the non-lead for a two member team. These changes resulted in a 3% decrease in the number of clinicians who agreed to volunteer to work as PMRT after-hours field responders. With a 3% decrease in the number of after-hours field responders, PMRT after-hours teams required reconfiguration, given that teams were no longer assigned by Service Area, but instead were deployed across wide geographical areas in LA County. This reconfiguration had an impact on response times due to increase travel time required to commute to calls when a clinician was deployed to a location that was significant distance from their assigned Service Area.

An additional factor indirectly affecting the PMRT after-hours arrival times in 2015 is related to response times associated with ambulance transport. Over the course of CY 2015, PMRT after-hours responders began to experience a steady increase in the estimated arrival times and/or frequency of the lack of available patient transport throughout the county. This caused extended periods to complete field calls, thereby affecting the arrival time for the calls in queue and resulting delays in team availability for dispatch to calls in the ACCESS queue.

In CY 2016, the Emergency Outreach Bureau will be implementing a two tiered approach to improving after-hours arrival times: (1) Concentrated recruitment and training for new after-hours staff (30 voluntary overtime staff over the calendar year). Recruitment will begin in January with a plan to start training the first cohort by no later than March 15, 2016; (2) Long term plan to examine overtime expenditures for PMRT after-hours response to identify possible budgetary offset to fund dedicated after-hours staff instead of relying solely on voluntary overtime.

Trend analysis during a five (5) year period, from CY 2011 to CY 2015, shows a fluctuation in the annual number of after-hours PMRT responses to calls in one hour or less. The total number of after-hours PMRT responses to calls in one hour or less in CY 2011 was 4,288; in CY 2012 there were 3,984; in CY 2013 there were 4,859; in CY 2014 there were 5,824, and in CY 2015, there were 3,670. However, the percentage of after-hours PMRT responses with the response time of one hour of less increased from 70% in CY 2011 to 71% in CY 2015.

ACCESS Center Response Time

Goal II.2a.

Seventy-five percent of after-hours calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll free hotline.

Numerator: Total number of after-hours calls in which caller reached a live agent within 1 minute.

Denominator: Total number of after-hours calls to the ACCESS Center.

EVALUATION

The ACCESS Center successfully met this work plan goal, achieving an annual average of 76% of the after-hours calls to the toll-free hotline being answered by a live agent within 1 minute.

GOAL II.2.b

Sixty-percent of daytime calls to the toll free hotline are answered by a live agent within one minute from when they present to the Virtual Call Center (VCC) of the toll free hotline.

EVALUATION

This work plan goal was not met as the annual average of the daytime calls to the toll free hotline answered by a live agent within 1 minute was 56%. The data was

significantly impacted by the planning and training necessitated by the implementation of a new electronic health record (IBHIS/Avatar) which went live at the ACCESS Center in July 6, 2015 with concomitant changes in work flow practices. The daytime data was also affected by staffing shortages. However, the ACCESS Center has met this work plan goal since August 2015. This improvement is partly the result of hiring to fill vacancies, working with QID closely in reviewing monthly data related to this measure and developing strategies such as altering agent work schedules to better match the anticipated call volume and improve performance, and the increased familiarity with new IBHIS/AVATAR procedures. Nonetheless, addressing agent turnover remains a challenge to improved performance.

ACCESS Center management will continue to closely monitor the monthly data on this measure and collaborate with QID in implementing strategies and changes in operation to improve the performance on this measure.

TABLE 24: CALLS ANSWERED WITHIN 1 MINUTE BY NUMBER AND PERCENT CY 2015

Month	Total # of Calls	Total # of Calls Answered Within 1 Minute	Percentage of Calls Answered Within 1 Minute
January			
Daytime	7,142	3,413	48%
After Hours	7,022	5,299	75%
February			
Daytime	7,243	3,733	52%
After Hours	6,114	4,853	79%
March			
Daytime	8,834	4,154	47%
After Hours	7,652	5,990	78%
April			
Daytime	8,030	3,974	49%
After Hours	6,747	5,287	78%
May			
Daytime	7,823	3,369	43%
After Hours	7,619	5,908	78%
June			
Daytime	7,642	3,749	49%
After Hours	6,630	4,813	73%
July			
Daytime	6,465	3,508	54%
After Hours	6,641	4,815	73%
August			
Daytime	6,185	3,966	64%
After Hours	6,700	5,308	79%
September			
Daytime	6,737	4,598	68%
After Hours	7,122	5,088	71%
October			
Daytime	6,661	4,598	69%
After Hours	6,920	5,056	73%
November			
Daytime	4,918	4,117	84%
After Hours	5,803	4,733	82%
December			
Daytime	5,314	4,350	82%
After Hours	5,340	4,206	79%
Year-to-Date			
Daytime	*82,994*	*47,529*	*57%*
After Hours	*80,310*	*61,356*	*76%*
Grand Total	*163,304*	*108,885*	*66.7%*

Note: Daytime hours are 8 am – 5 pm Monday through Friday, excluding holidays. After hours are outside of Daytime hours and include weekends, and holidays. Data Source: LACDMH ACCESS Center, CY 2015.

Background about ACCESS

LACDMH's ACCESS Center provides emergency and non-emergency services. The ACCESS Center strives to meet the cultural and linguistic needs of our communities by providing language assistance services in threshold and non-threshold languages, at the time of first contact. Callers request information related to mental health services and other social needs, and the ACCESS Center provides them with referrals to culture-specific providers and services that are appropriate to their needs and conveniently located.

ACCESS Center Calls Received in Non-English Languages

Non-English speaking and Limited English Proficiency beneficiaries have a right to receive services in their primary or preferred language. LACDMH has 13 threshold languages including: Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese. When ACCESS Center staff is unable to assist callers due to a language barrier, they are able to immediately contact the Language Line for assistance with language interpretation services.

The ACCESS Center also provides equitable language assistance services to deaf/hearing impaired consumers and providers requesting American Sign Language (ASL) interpretation services for their consumers.

TABLE 25: SUMMARY OF APPOINTMENTS FOR HEARING IMPAIRED SERVICES BY FISCAL YEAR FY 2010-2011 TO FY 2014-2015

Fiscal Year (FY)	Number of Assigned Appointments
FY 10-11	817
FY 11-12	963
FY 12-13	1025
FY 13-14	937
FY 14-15	1137
TOTAL	**4,533**

Data Source: LACDMH ACCESS Center, CY 2015.

Table 25 presents the summary of appointments for hearing impaired services at the ACCESS Center for the last five years. There was an increase in total hearing impaired services' appointments from FY 10-11 to FY 11-12 and from FY 11-12 to FY 12-13. In FY 14-15, the number of assigned appointments increased by 200 appointments over the FY 13-14 period.

TABLE 26: NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FIVE YEAR TREND CY 2011 – 2015

Language	2011	2012	2013	2014	2015
AMHARIC	2	2	0	1	0
*ARABIC	7	4	21	24	6
*ARMENIAN	35	61	48	225	80
BENGALI	1	2	1	0	0
BOSNIAN	0	0	0	1	0
BULGARIAN	0	0	0	0	0
BURMESE	0	0	0	0	0
*CANTONESE	19	7	46	60	46
CEBUANO	0	0	0	1	0
*FARSI	46	59	70	81	58
FRENCH	2	1	1	2	2
GERMAN	0	0	0	0	1
GREEK	0	0	0	0	1
HEBREW	0	0	1	2	1
HINDI	1	5	0	1	0
HUNGARIAN	0	0	0	0	3
ITALIAN	0	0	0	0	0
JAPANESE	6	5	3	2	2
KHMER	16	35	10	5	3
*KOREAN	54	83	109	132	108
KURDISH-BEHDINI	0	0	0	1	0
LAOTIAN	0	0	0	2	0
*MANDARIN	52	40	57	30	62
MONGOLIAN	0	0	1	0	0
NEPALI	0	0	1	2	0
PASHTO	0	0	0	3	0
POLISH	0	0	0	0	0
PORTUGUESE	0	0	0	1	0
PUNJABI	0	0	0	0	1
SERBIAN	0	0	5	0	
ROMANIAN	0	1	0	0	0

TABLE 26 (CONTD.) NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FIVE YEAR TREND CY 2011 – 2015

Language	2011	2012	2013	2014	2015
*RUSSIAN	21	26	15	11	12
SAMOAN	0	0	5	0	0
SERBIAN	0	0	0	0	0
*SPANISH (AVAZA Language Services)	4,282	4,552	2,509	1,402	1,089
SPANISH ACCESS CTR	4,393	4,043	11,240	6,135	6,159
SPANISH SUBTOTAL	8,675	8,595	13,749	7,537	7,248
*TAGALOG	35	14	16	18	7
THAI	2	1	1	2	1
TURKISH	0	1	0	0	0
URDU	1	3	2	1	0
*VIETNAMESE	15	23	24	24	**17**
TOTAL	**8,990**	**8,968**	**14,186**	**8,169**	**7,659**

*LACDMH Threshold Language excluding Other Chinese and English. [1] The total for non-English calls and Spanish ACCESS Center Calls for CY 2013 is inaccurate and over reported due to errors in the Web Center System. Data Source: LACDMH ACCESS Center, CY 2015.

Table 26 summarizes the total number of non-English language calls received by the ACCESS Center for CY 2011 through CY 2015. The trend over the last five years indicates that the majority of non-English callers have requested Spanish language interpretation services.

In CY 2015, the ACCESS Center staff provided interpreter services for 6,159 calls in Spanish and for 1,089 calls, Language Line Services in Spanish were provided and thus, a total of 94.6% were Spanish calls among all non-English calls. The second most common language for non-English calls received by the ACCESS Center in CY 2015 was Korean at 108 calls or 1.4% of all non-English calls, followed by Armenian (80 or 1.0%), Mandarin (62 or 0.8%), Farsi (58 or 0.7%) and Cantonese (46 or 0.6%).

As compared with CY 2014, in CY 2015 there was a decline in Armenian calls from 225 to 80, Korean calls from 132 to 108, Farsi calls from 81 to 58, Cantonese calls from 60 to 46 and Vietnamese calls from 24 to 17. In contrast, Mandarin calls increased from 30 to 62 in CY 2015 as compared with CY 2014.

Languages in which at least 10 or more callers requested interpretation services in CY 2015 included Armenian, Cantonese, Farsi, Korean, Mandarin, Russian and Vietnamese.

ACCESS Call Center Test Calls

Goal II.3.

Maintain percent of completed test calls to the toll free hotline at 98% in CY 2015.

EVALUATION

This goal has been met, with the percent of completed calls at 100% in CY 2015. The Test Calls Report is available via this link. http://psbqi.dmh.lacounty.gov/QI.htm

Consumer Satisfaction Survey Goals

Goal II.4.

Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations at 88% in CY 2015.

EVALUATION

This goal has not been met, with 84.1% of consumers/families in CY 2015 agreeing or strongly agreeing that the location of services were convenient for them. This represents a 1.4% decrease from CY 2012.

TABLE 27: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY AGREE OR AGREE WITH "LOCATION OF SERVICES WAS CONVENIENT FOR ME" BY AGE GROUP

Age Group	FY 12-13 (CY 12) August	FY 13-14 (CY 13) August	FY 13-14 (CY 14) April	FY 14-15 (CY 14) November	FY 14-15 (CY 15) May
YSS-F					
Number	3,384	2,898	2,797	1,977	2,622
Percent	91.0%	91.5%	90.9%	89.0%	91.0%
YSS					
Number	1,727	1,371	1,166	894	1,223
Percent	80.6%	82.1%	82.9%	79.5%	78.3%
Adult					
Number	3,244	4,431	2,907	2,743	3,346
Percent	82.0%	83.0%	82.6%	83.7%	82.5%
Older Adult					
Number	292	267	268	235	427
Percent	87.7%	87.6%	88.4%	90.5%	84.5%
Total					
Number	8,647	8,967	7,138	5,849	7,658
Percent	85.5%	85.7%	85.9%	85.7%	84.1%

Note: YSS-F = Survey for Families of Children and Youth 0-17 years old; YSS = Survey for Youth 12-17 years old. Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from 1 to 5. The denominator was all survey responses on the 5 point Likert scale.

Table 27 shows the percentage of consumers and families that agree or strongly agree that they received services at convenient locations for five (5) distinct survey periods, during CY 2012 to CY 2015. Overall, between CY 2012 to CY 2015, for all the age groups combined, the percent reporting positively on convenient location declined by 1.4 percentage points (PP), from 85.5% to 84.1%. Among YSS-F, this percentage stayed the same at 91.0%. Among YSS, it declined by 2.3 PP from 80.6% to 78.3%; among Adults it increased by 0.5 PP from 82.0% to 82.5%; and among Older Adults it decreased by 3.2 PP from 87.7% to 84.5%.

Goal II.5.

Maintain the percent of consumers/families reporting that they are able to receive services at convenient times at 91.2% in CY 2015.

EVALUATION

This goal has not been met, with 89.3% of consumers/families in CY 2015 agreeing or strongly agreeing that they were able to receive services at convenient times.

TABLE 28: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY AGREE OR AGREE WITH "SERVICES WERE AVAILABLE AT TIMES THAT WERE GOOD FOR ME" BY AGE GROUP

Age Group	FY 12-13 (CY 12) August	FY 13-14 (CY 13) August	FY 13-14 (CY 14) April	FY 14-15 (CY 14) November	FY 14-15 (CY 15) May
YSS-F					
Number	4,028	3,471	2,843	1,977	2,622
Percent	93.2%	92.6%	92.2%	91.4%	92.0%
YSS					
Number	2,025	2,638	1,241	899	1,226
Percent	80.6%	81.9%	81.0%	83.1%	81.1%
Adult					
Number	3,973	2,891	3,158	2,743	3,346
Percent	89.0%	91.4%	88.8%	91.0%	90.0%
Older Adult					
Number	426	354	261	427	427
Percent	95.3%	90.8%	94.9%	96.1%	94.1%
Total					
Number	10,452	9,354	7,503	6,046	7,621
Percent	89.5%	89.2%	89.2%	90.4%	89.3%

Note: YSS-F = survey for families of children 0-12 years old; YSS = survey for youth 12-17 years old. Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from 1 to 5. The denominator was all survey responses on the 5 point Likert scale.

Table 28 shows the percentage of consumers and families that agree or strongly agree that services were available at times that were convenient for them for five (5) distinct survey periods, from CY 2012 to CY May 2015. Overall, between CY 2012 and CY 2015, for all the age groups combined, the percent reporting positively that services were available at times that was convenient decreased by 0.2 percentage points (PP) from 89.5% to 89.3%. Among YSS-F, this percentage decreased by 1.2 PP from 93.2% to 92.0%. However, among YSS it increased by 0.5 PP from 80.6% to 81.1%, among Adults it increased by 1.0 PP from 89.0% to 90.0%, and among Older Adults, it decreased by 1.2 PP from 95.3% to 94.1%.

III. MONITORING BENEFICIARY SATISFACTION

Goal III.1.

Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background at 89.8% in CY 2015.

EVALUATION

This goal has not been met, with 87.3% of consumers/families in CY 2015 agreeing or strongly agreeing that staff were sensitive to their cultural/ethnic background. This represents a 1.0% decrease from CY 2012.

TABLE 29: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY AGREE OR AGREE WITH "STAFF WERE SENSITIVE TO MY CULTURAL BACKGROUND" BY AGE GROUP

Age Group	FY 12-13 (CY 12) August	FY 13-14 (CY 13) August	FY 13-14 (CY 14) April	FY 14-15 (CY 14) November	FY 14-15 (CY 15) May
YSS-F					
Number	4,028	3,471	2,843	1,977	2,622
Percent	94.8%	95.2%	93.7%	94.3%	94.9%
YSS					
Number	2,025	2,638	1,241	899	1,226
Percent	82.7%	85.7%	83.8%	84.5%	81.5%
Adult					
Number	3,973	2,891	3,158	2,743	3,346
Percent	85.2%	86.3%	84.1%	86.7%	85.1%
Older Adult					
Number	426	354	261	427	427
Percent	90.3%	97.9%	89.2%	91.8%	87.6%
Total					
Number	10,452	9,354	7,503	6,046	7,621
Percent	88.3%	91.3%	87.7%	89.3%	87.3%

Note: YSS-F = survey for families of children 0-12 years old; YSS = survey for youth 12-17 years old. Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from 1 to 5. The denominator was all survey responses on the 5 point Likert scale.

Table 29 shows the percentage of consumers and families that agree or strongly agree that staff were sensitive to their cultural background for five (5) distinct survey periods, from CY 2012 to CY 2015. For YSS-F, the percentage increased by 0.1 percentage points (PP) from 94.8% to 94.9%. For YSS, the percentage decreased by 1.2 PP from 82.7% to 81.5%. For Adults, the percentage decreased by 0.1 PP from 85.2% to 85.1%. For Older Adults, the percentage decreased by 2.7 PP from 90.3% to 87.6%.

Overall, for all age groups combined the percentage decreased by 1 PP from 88.3% to 87.3%.

Goal III.2.

Maintain the percent of all age group consumers/families reporting overall satisfaction with services provided at 85% in CY 2015 and continue year to year trending of the data.

EVALUATION

This goal was exceeded, with 87% of consumers/families in all age groups reporting overall satisfaction with services.

Goal III.3.

Monitor the grievances, appeals and requests for State Fair Hearings for FY 2014-2015. Resolve all standard appeals within 45 calendar days of receipt of appeal by Patients' Rights Office. Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log.

EVALUATION

This goal has been met. 100% of standard appeals were resolved within 45 days and 100% of grievances were resolved within 60 days.

The Quality Improvement Division is responsible for conducting the annual evaluation of beneficiary grievances, appeals, and fair hearings. (State Department of Health Care Services, Program Oversight and Compliance, 2012-2013)

The MHP shall insure that a procedure is included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the MHP's Quality Improvement Council, the MHP's administration or another appropriate body within the MHP. (State Department of Health Care Services, Program Oversight and Compliance, 2012-2013)

TABLE 30: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FY 2012-2013 TO FY 2014-2015

CATEGORY	FY 12 - 13	FY 13 -14	FY 14 -15
	Inpatient/ Outpatient	Inpatient/ Outpatient	Inpatient/ Outpatient
ACCESS	0	28	21
Percent	0.0%	100.0%	100.0%
TERMINATION OF SERVICES	8	N/A	N/A
Percent	100.0%	N/A	N/A
DENIED SERVICES (NOA - A Assessment)	5	5	3
Percent	100.0%	100.0%	100.0%
CHANGE OF PROVIDER	5	3	6
Percent	100.0%	100.0%	100.0%
QUALITY OF CARE			
Provider Relations	317	200	255
Percent	64.2%	52.8%	62.8%
Medication	95	38	30
Percent	19.2%	10.0%	7.3%
Discharge/Transfer	22	6	3
Percent	4.5%	1.6%	.7%
Patient's Rights Materials	2	0	0
Percent	0.4%	0.0%	0.0%
Treatment Concerns	8	64	36
Percent	1.6%	16.9%	8.9%
Abuse - Physical	26	40	18
Percent	5.30%	10.60%	4.4%
Abuse - Sexual	4	6	4
Percent	0.8%	1.6%	1.0%
Abuse Verbal	5	14	2
Percent	1.0%	3.7%	.5%
Abuse (Total)	35	60	24
Percent	7.1%	15.8%	5.9%
Delayed Services	0	1	1
Percent	0.0%	0.3%	.3%
Seclusion and Restraint	14	4	1
Percent	2.8%	1.1%	.3%
Quality of Care	1	6	1
Percent	0.2%	1.6%	.3%
Reduction of Services	0	0	0
Percent	0.0%	0.0%	0.0%
Other QC	N/A	N/A	31
Percent			7.6%
Sub-Total for Quality of Care	494	379	406
Percent	100.0%	100.0%	100.0%

TABLE 30 (CONTD.): INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FY2012-2013 TO FY 2014-2015

CATEGORY	FY 12 - 13	FY 13 -14	FY 14 -15
Percent	100.0%	100.0%	100.0%
OTHER			
Access to Personal Belongings	0	1	2
Percent	0.0%	2.0%	4.9%
Housing Concerns	13	11	7
Percent	15.3%	22.0%	17.1%
Legal Concerns	0	3	3
Percent	0.0%	6.0%	7.3%
Lost/Stolen Belongings	17	10	4
Percent	20.0%	20.0%	9.8%
Money/Funding/Billing	10	5	4
Percent	11.8%	10.0%	9.8%
Non HIPAA Concerns	2	N/A	
Percent	2.4%	N/A	
Non Provider Concerns	15	3	5
Percent	17.6%	6.0%	12.2%
Phone	5	1	1
Percent	5.9%	2.0%	2.4%
Smoking	6	N/A	
Percent	7.1%	N/A	
Visitors	4	1	0
Percent	4.7%	2.0%	
Miscellaneous	6	10	8
Percent	7.1%	20.0%	19.5%
Clothing	4	2	1
Percent	4.7%	4.0%	2.4%
Forms		1	0
Percent		2.00%	0.0%
Letter Writing Material		1	0
Percent		2.00%	0.0%
Other		2	6
Percent		0.4%	14.6%
Sub-Total	85	50	41
Percent	100.0%	100.0%	100.0%
Total	603	469	477
Percent	100.0%	100.0%	100.0%

Note: Shaded cells without numerical values indicate that data is not available for the fiscal year. Data Source: LACDMH Patients' Rights Office.

Table 30 shows that the total number of inpatient and outpatient grievances and appeals increased by 1.7 percentage points (PP) from 469 in FY 13-14 to 477 in FY 14-15. The majority of inpatient and outpatient grievances and appeals were for Quality of Care for both FY 13-14 (81%) and FY 14-15 (85.1%).

TABLE 31A: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FY 2014-2015

CATEGORY	TOTAL NUMBER BY CATEGORY	PROCESS				
		Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited State Fair Hearing
ACCESS	21	5	1	0	15	0
Percent	4.4%	1.1%	100.0%	0.0%	100.0%	0.0%
DENIED SERVICES (Notice of Action)	3	3	0	0	0	0
Percent	0.6%	0.7%	0.0%	0.0%	0.0%	0.0%
CHANGE OF PROVIDER	6	6	0	0	0	0
Percent	1.3%	1.3%	0.0%	0.0%	0.0%	0.0%
QUALITY OF CARE	406	406	0	0	0	0
Percent	85.1%	88.1%	0.0%	0.0%	0.0%	0.0%
CONFIDENTIALITY	0	0	0	0	0	0
Percent	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OTHER	41	41	0	0	0	0
Percent	8.6%	8.9%	0.0%	0.0%	0.0%	0.0%
TOTALS	477	461	1	0	15	0
Percent	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%

Data Source: Patients' Rights Office.

Table 31A shows the total number of inpatient and outpatient grievances and appeals by category in FY 14-15. The majority of inpatient and outpatient grievances and appeals (85.1%) were for Quality of Care, followed by Other (8.6%), Access (4.4%), Change of Provider (1.3%), and Denied Services (0.6%). Table 31A also shows that among the inpatient and outpatient grievances and appeals in FY 14-15, there were 461 grievances, 1 appeal, and 15 requests for State Fair Hearings.

TABLE 31B: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS DISPOSITION FY 2014-2015

CATEGORY	TOTAL NUMBER BY CATEGORY	DISPOSITION		
		Referred Out	Resolved	Still Pending
ACCESS	21	0	21	0
Percent	4.4%	0.0%	4.7%	0.0%
DENIED SERVICES (Notice of Action)	3	0	3	0
Percent	0.6%	0.0%	0.7%	0.0%
CHANGE OF PROVIDER	6	0	6	0
Percent	1.3%	0.0%	1.3%	0.0%
QUALITY OF CARE	406	20	386	0
Percent	85.1%	64.5%	86.5%	0.0%
CONFIDENTIALITY	0	0	0	0
Percent	0.0%	0.0%	0.0%	0.0%
OTHER	41	11	30	0
Percent	8.6%	35.5%	6.7%	0.0%
TOTALS	477	31	446	0
Percent	100.0%	100.0%	100.0%	0.0%

Data Source: Patients' Rights Office.

Table 31B shows the disposition of the 477 grievances and appeals in FY 14-15, of which 446 (93.5%) were resolved and the remaining 31 (6.5%) were reported as still pending. Specifically, all 21 access cases were resolved; all three denied services cases were resolved, all six change of provider cases were resolved, and 386 (95.1%) of the 406 quality of care cases were resolved.

Goal III.4.

Monitor Beneficiary Requests for Change of Provider (COP) including reasons given by consumers for their change of provider requests. Ninety-five percent of providers will report the requests for change of provider in at least 11 of 12 months in CY 2015.

EVALUATION

This goal has not been met. However the total number of recorded requests for COP increased from 2,187 in FY 12-13 to 3,101 in FY 13-14 and to 4,610 in FY 14-15.

QID has acquired Tele-form software and converted the COP form into a machine scan-able form to improve data accuracy and timeliness of monthly reports. As of March 2016 this form is being used to track COP requests data in an electronic format.

TABLE 32: REQUEST FOR CHANGE OF PROVIDER BY REASONS AND PERCENT APPROVED FY 2012 - 2013 TO FY 2014 - 2015

	FY 2012 - 2013		FY 2013 - 2014		FY 2014 - 2015	
Reason[1]	**Number of Requests**	**Percent Approved**	**Number of Requests**	**Percent Approved**	**Number of Requests**	**Percent Approved**
Time/Schedule	43	81.4%	88	76.1%	317	92.7%
Language	75	93.3%	89	85.4%	199	82.9%
Age	28	85.7%	57	77.2%	62	75.8%
Gender	109	89.9%	114	89.5%	184	84.8%
Treating Family Member	15	93.3%	21	85.7%	23	74.0%
Treatment Concerns	221	91.9%	251	82.5%	356	77.2%
Medication Concerns	121	86.0%	191	80.1%	270	74.8%
Lack of Assistance	157	89.2%	238	80.7%	385	80.5%
Want Previous Provider	62	90.3%	101	89.1%	66	72.7%
Want 2nd Option	45	75.6%	77	80.5%	98	77.6%
Uncomfortable	255	89.0%	371	80.3%	507	80.1%
Insensitive/unsympathetic	155	87.1%	225	76.0%	323	78.6%
Not Professional	112	84.8%	111	82.0%	237	82.7%
Does Not Understand Me	168	87.5%	254	76.4%	408	77.2%
Not a Good Match	320	91.3%	452	83.6%	642	82.2%
Other	193	89.1%	278	82.4%	378	84.7%
No Reason Given	108	88.0%	183	82.5%	155	82.6%
Total	**2,187**	**87.8%**	**3,101**	**81.8%**	**4,610**	**81.1%**

Data Source: Patients' Rights Office. [1]Multiple reasons may be given by a consumer.

Table 32 shows the number of Requests for Change of Provider (COP) by reasons and percent approved for FY 12-13, FY 13-14, and FY 14-15. Data for the requests for

Change of Provider are based on information from forms that agencies are required to submit on a monthly basis, to the Patients' Rights Office (PRO). The data shows a 110.1% increase in the number of COP requests from 2,187 in FY 12-13 to 4,610 in FY 14-15.

Goal III.5.

Implement the revised peer survey in CY 2015.

EVALUATION

This goal was met. A peer survey was conducted in November 2015 in 35 sites across the County's eight Service Areas. Participating sites were comprised of both directly operated clinics and contracted clinics. The result shows that during the CY 2015 peer surveying period, 932 surveys were completed, of which 161 (17.3%) were received from consumers who were visiting the clinics for the first time. More than three quarters (79.2%) of the consumers visiting the clinic for their first time were very satisfied or satisfied with the timeliness of the appointments offered by the clinic. Further, 81.9% of the consumers who had previously visited the clinics were very satisfied or satisfied with the timeliness of the appointments and 83.2% indicated they were treated with respect over the past three months. When asked if they were satisfied with the overall services at the clinics, 90.3% of the consumers said yes and 95.4% were satisfied with the cleanliness of the clinics.

When asked if they wanted their families to be included in their mental health treatment, the consumers were statistically evenly divided; 50.3% said yes, and 49.7% said no. When asked if their families were supportive of their mental health treatment and if the families were willing and able to participate in their treatment, 79.2% and 55.2% respectively, said yes. When asked if their families were included in their treatment plan, per their approval, 42.9% indicated that they were.

With respect to communication, 45.8% of the consumers either had a Smart phone or a Smart phone and an email address; 35.9% indicated that they checked them on a daily basis. While 93.2% of the consumers had connectivity via a home computer, a Smart phone, or an email address, only 51.4% indicated that they would like to receive appointment reminders via this route.

When asked if they were aware of the 24/7 toll free hotline number to reach out for help, 62.5% of the consumers indicated that they were aware. Less than a quarter (24.5%) of the consumers received Full Service Partnership (FSP) services; 60% of them had the FSP Team's after-hours telephone number.

IV. MONITORING CLINICAL CARE

Goal IV.1.

Continue to improve medication practices through systematic use of medication parameters, peer review related to medication practices, and trainings for the use of medication.

EVALUATION

This goal has been met.

During 2015, LACDMH initiated or revised the following policies and parameters regarding medications through the work of an internal group and in consultation with outside experts.

A. Policy:

1. Revised:

   a. DMH Policy 306.03 Storing, Administering and Accountability of Medications, December 2015

B. DMH Parameters:

1. New:

   a. Parameter 3.9 JCMHS PMAF Review Initiated in May, 2015.
   These parameters define both the general categories of Juvenile Court Mental Health Services' (JCMHS') findings after reviewing Psychotropic Medication Authorization Form(s) (PMAFs) and specific fact patterns that trigger a categorical finding of "Recommend Approval for 45 days only" or "Do not recommend approval" by JCMHS. These forms are required by the Court when prescribers would like to initiate or continue psychotropic medications for youth in state custody (e.g., Probation wards or Department of Children and Family Services dependents). The PMAF can be accessed at http://www.courts.ca.gov/documents/jv220a.pdf. JCMHS must have a sufficient level of confidence in any given prescriber's PMAFs, based upon that provider's history of medication requests, accompanying clinical data, and cooperation with the review process, to permit JMHCS to make recommendations to the Court regarding approval of submitted requests.

2. Revised:

   a. Parameter 3.7 Parameters for General Health Monitoring-Revised December, 2015
   b. Parameter 3.8 Use of Psychotropic Medication in Children and Adolescents –Revised June 2015
   c. Parameter 3.10 Use of Medication Assisted Treatment (MAT) in Invididuals with Co-Occurring Substance Abuse Disorders- Revised April, 2015

3. Peer Review Activities:

   During 2015, the LACDMH Office of the Medical Director finalized the Peer Review report reviewed in the 2014 Plan that examined compliance with annual documentation of Body Mass Index (BMI) for patients receiving antipsychotic medication outlined in DMH 3.7 Parameters for General Health Monitoring, as well as documentation on the Outpatient Medication Review (OMR) form that demonstrates the psychiatrist reviewed the current dosages, side effects, and when to take medications with the patient within past 12 months (as required in DMH Policy 103.1 Standards for Prescribing and Furnishing Psychoactive

Medications). The findings were that 34% of charts sampled included a BMI calculation within the past 12 months and 74% of sampled charts included current medications on the OMR (a 10% increase from 2012), with 71% of sampled charts having an OMR dated within the past 12 months (a 7% increase from 2012).

A discussion at the Executive level determined that as the Meaningful Use Requirements concerning the measurement and recording of BMI in the Electronic Medical record was put into place during September of 2015, the presence of a BMI in the EMR would be addressed.

4. CME Trainings related to Medication Practices:

   During 2015, 2 trainings were sponsored by the Department regarding medication practices, attended by 72 physicians.

Goal IV.2.

Implement the Spiritual Self-Care Facilitator training at Wellness Centers in LACDMH Directly Operated Programs in CY 2015 to facilitate Spirituality Self-Care groups with consumers at these Centers.

EVALUATION

This goal has been met. Two 2-day trainings were conducted during CY 2015. A total of 23 individuals from 10 different Wellness and Client-run centers were trained. Eight evaluations were completed for the April 21-22, 2016 LACDMH Spiritual Self Care Facilitator training; 10 evaluations were completed for the May 19-20 training. A follow-up post-survey was conducted in March 2016.

Goal IV.3.

Continue to improve Clinical Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD) through on-site and online revised COD 101 training targeting all LACDMH Directly Operated and Contracted Adult System of Care (ASOC) programs in Calendar Year (CY) 2015.

EVALUATION

This goal has been met. In CY 2015, a total of 5,005 individuals participated in trainings aimed at improving clinical care for Consumers with Co-Occurring Mental Health and Substance Use Disorders; 1,326 participants have received continuing education credits. One hundred and six revised on-site and online COD 101 trainings were conducted throughout CY 2015.

Importantly, of the 5,005 individuals trained 2,123 (42%) were from LACDMH Directly Operated and Contracted ASOC programs.

V. MONITORING CONTINUITY OF CARE

Goal V.1.

90% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center will receive appointments for a Specialty Mental Health Service Assessment within 5 business days.

EVALUATION

This goal has been met. 95% of the consumers referred for urgent appointments by the Medi-Cal managed care plans to the urgent appointment line received an appointment for a specialty mental health service assessment within 5 business days.

VI. MONITORING PROVIDER APPEALS

Goal VI.1.

The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal.

EVALUATION

This goal has been met. 100% of provider appeals were responded to within 60 calendar days. For the FFS Inpatient hospitals, 11,830 appealed days for CY 2015 were processed within 60 calendar days from the date of the receipt of the appeal. There were no appeals for Day Treatment and FFS Network Outpatient providers.

TABLE 33: PROVIDER APPEALS
CY 2015

Appeals	Day Treatment	Network Inpatient	Network Outpatient
Total	0	11,830 days Appealed, 1,910 Appeals	0
Approved	0	3,416 days Appealed approved, 551 appeals approved	0
Denied	0	8,414 days Appealed denied, 1,359 appeals denied	0
Pending	0	0	0

QUALITY IMPROVEMENT WORK PLAN GOALS SUMMARY - CY 2016

I. MONITORING SERVICE DELIVERY CAPACITY

1. *Between 49% and 55% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 15-16.*
2. *Between 41.6% and 43.6% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 15-16.*
3. *Maintain the number of clients served by tele-psychiatry in CY 2016 at a minimum of 650.*
4. *Improve Service Delivery Capacity for Lesbian Gay Bi-sexual Transgender and Questioning (LGBTQ) youth with mental illness through providing a series of trainings to staff of both contracted and/or directly operated agencies to improve their skills for assessment and treatment of this population*

II. MONITORING ACCESSIBILITY OF SERVICES

1. *Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 71%.*

2a. *Seventy-five Percent of after-hours calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll free hotline.*

2b. *Sixty-five percent of daytime calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll free hotline.*

3. *Maintain percent of completed test calls to the toll free hotline in CY 2016 at a minimum of 95%.*
4. *Monitor the number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 2015- 2016.*
5. *Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations between 83% and 85% for the May 2016 survey period.*
6. *Maintain the percent of consumers/families reporting that they are able to receive services at convenient times between 88% and 90% for the May 2016 survey period.*

III. MONITORING BENEFICIARY SATISFACTION

1. *Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background between 86% and 88% for the May 2016 survey period.*
2. *Maintain the percent of consumers/families reporting overall satisfaction with services provided between 84% and 86% for the May 2016 survey period and continue year-to-year trending of the data.*

3a. *Monitor the grievances, appeals and requests for State Fair Hearings for FY 2015-2016.*

3b *Resolve all standard appeals within 45 calendar days of receipt of appeal by Patients' Rights Office.*

3c *Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log.*

4. *Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their change of provider requests.*

IV. MONITORING CLINICAL CARE

1. *Address evolving standards and requirements associated with the use of medication in mental health programs through systematic application of DMH Medication Parameters to supervision of prescribing practices, and through provision of ongoing training by clinical experts in state-of-the-art use of medication.*
2. *Continue to improve Clinical Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD) through on-site and online trainings and Annual State Wide Integrated Care Conference targeting LACDMH Directly Operated and Contracted programs.*
3. *Continue to improve Clinical Care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System through providing a series of trainings to staff of both contracted and/or directly operated agencies.*

V. MONITORING CONTINUITY OF CARE

1. *At least 90% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center will receive appointments for a Specialty Mental Health Service Assessment within 5 business days.*
2. *Improve Continuity of Care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System through providing consultation on complex cases to enhance treatment planning and intervention process.*

VI. MONITORING OF PROVIDER APPEALS

1. *The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal.*

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 1: Between 49% and 55% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 15-16.

Population: Latino population estimated with SED and SMI and living at or below 138% FPL

Indicator: Latino consumers receiving outpatient services in LACDMH outpatient programs.

Measure: Unduplicated number of Latino consumers served in LACDMH outpatient programs **/** By Latino population estimated with SED and SMI and living at or below 138% FPL multiplied by 100. The estimated goal is derived from calculating a statistically significant change for number of Latinos served at 99% Confidence Level with a 2 (+/-%) margin of error.

Source(s) of Information:

1. Prevalence: California Health Interview Survey (CHIS)
2. Consumers Served: LACDMH Integrated System (IS)
3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau

Responsible Entity: PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 2: Between 41.6% and 43.6% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 15-16.

Population: API population estimated with SED and SMI and living at or below 138% FPL

Indicator: API consumers receiving outpatient services in LACDMH outpatient programs

Measure: Unduplicated number of API consumers served in LACDMH outpatient programs / By API population estimated with SED and SMI and living at or below 138% FPL multiplied by 100. The small number of API consumers served in FY 14-15 makes it statistically unreliable to calculate the change in number of consumers served at 90% or 95% Confidence Level. Therefore the estimated goal for API consumers served in FY 15-16 is based on Confidence Interval of + or - 1.01 with an estimated range of serving between 41.6% to 43.6% API consumers.

Source(s) of Information:
1. Prevalence: California Health Interview Survey (CHIS)
2. Consumers Served: LACDMH Integrated System (IS)
3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau

Responsible Entity: PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 3: Maintain the number of clients served by tele-psychiatry in CY 2016 at a minimum of 650.

Population: Consumers receiving mental health services through tele-psychiatry at various end points in LACDMH Directly Operated Clinics

Indicator: Service delivery capacity for psychiatry appointments via tele-psychiatry

Measure: Number of consumers receiving mental health services through tele-psychiatry appointments in CY 2016.

Source(s) of Information/: LACDMH IS approved claims data

Responsible Entity: Office of the Medical Director (OMD), PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 4: Improve Service Delivery Capacity for Lesbian Gay Bi-sexual Transgender and Questioning (LGBTQ) youth with mental illness through providing a series of trainings to staff of both contracted and/or directly operated agencies to improve their skills for assessment and treatment of this population.

Population: LGBTQ youth with mental illness

Indicator: Training Protocols and Procedures to improve assessment and treatment for LGBTQ youth

Measure: Review, provision, and evaluation of Service Area LGBTQ trainings; total number of staff who completed these trainings in CY 2016, and training evaluation summaries completed for these trainings

.

Source(s) of Information: Program Support Bureau-Quality Improvement Division, Underserved Cultural Communities

Responsible Entity: PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 1: Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 71%.

Population: Consumers receiving urgent after-hours care from Psychiatric Mobile Response Teams (PMRT) of LACDMH **-** Emergency Outreach Bureau (EOB)

Indicator: Timeliness of after-hours care

Measure: The number of after-hours PMRT responses with response times of one hour or less / the total number of after-hours PMRT responses for the Calendar Year 2016 multiplied by 100

Source(s) of Information: ACCESS Center Data

Responsible Entity: EOB, ACCESS Center, PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 2a: Seventy-five percent of after-hours calls to the toll-free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll-free hotline.

GOAL 2b: Sixty-five percent of daytime calls to the toll-free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll-free hotline.

Population: Callers using the ACCESS 24/7 Toll Free number: 1-800-854-7771

Indicator: Timeliness of the MHP's toll free hotline

Measure: 2a. The number of after-hours calls for the Calendar Year 2016 that are answered within one minute from when they present to the Virtual Call Center (VCC) / the total number of after-hours calls extended to the VCC for the Calendar Year 2016 multiplied by 100.

2b. The number of daytime calls for the Calendar Year 2016 that are answered within one minute from when they present to the Virtual Call Center (VCC) / the total number of daytime calls extended to the VCC for the Calendar Year 2016 multiplied by 100.

Source(s) of Information: ACCESS Center Data

Responsible Entity: ACCESS Center, PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 3: Maintain the percent of completed test calls to the toll free hotline at a minimum of 95% in CY 2016.

Population: Test Callers using the 24/7 Toll Free number: 1-800-854-7771

Indicator: Percent of Test Calls completed

Measure: Number of Test Calls completed / Total Number of Test Calls multiplied by 100

Source(s) of Information: Service Area Quality Improvement Committee (SA QIC) Test Calls

Responsible Entity: ACCESS Center, SA QICs, PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 4: Monitor the number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 2015-2016.

Population: Consumers who need hearing impaired interpreter services

Indicator: Cultural and Linguistic Access to Care

Measure: Number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 2015- 2016

Source(s) of Information: ACCESS Center Hearing Impaired Interpreter Services Appointment Schedules

Responsible Entity: ACCESS Center, PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 5: Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations between 83% and 85% for the May 2016 survey period.

Population: Consumers served in Outpatient Programs

Indicator: Convenience of service locations

Measure: The number of consumers/families that agree or strongly agree on the MHSIP survey that they are able to receive services at convenient locations / by the total number of consumers/families completed the survey during the survey period multiplied by 100. The estimated goal is derived from calculating the range for true population proportion of the May 2015 response rate of 84.1%. At 95% Confidence Level, the confidence interval for 84.1% response rate is plus or minus .82 which is between 83.2% to 84.9%

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

Responsible Entity: PSB-QID, LACDMH Outpatient Programs

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 6: Maintain the percent of consumers/families reporting that they are able to receive services at convenient times between 88% and 90% for the May 2016 survey period.

Population: Consumers served in Outpatient Programs

Indicator: Convenience of appointment times

Measure: The number of consumers/family members that agree or strongly agree on the MHSIP survey that they are able to receive services at convenient times / by the total number of consumers/family members that completed the survey during the survey period multiplied by 100. The estimated goal is derived from calculating the range for true population proportion of the May 2015 response rate of 89.3%. At 95% Confidence Level, the confidence interval for 89.3% response rate is plus or minus .64 which is between 88.6% to 89.9%.

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

Responsible Entity: PSB-QID, LACDMH Outpatient Programs

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 1: Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background between 86% and 88% for the May 2016 survey period.

Population: Consumers served in Outpatient Programs

Indicator: Sensitivity of staff to consumers' cultural/ethnic backgrounds

Measure: The number of consumers/family members that agree or strongly agree that staff is sensitive to their cultural/ethnic background / by the total number of consumers/family members that completed the survey during the survey period multiplied by 100. The estimated goal is derived from calculating the range for true population proportion of the May 2015 response rate of 87.3%. At 95% Confidence Level, the confidence interval for 87.3% response rate is plus or minus .74 which is between 86.6% to 88.0%.

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

Responsible Entity: PSB-QID, LACDMH Outpatient Programs

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 2: Maintain the percent of consumers/families reporting overall satisfaction with services provided between 84% and 86% for the May 2016 survey period and continue year to year trending of the data.

Population: Consumers served in Outpatient Programs

Indicator: Overall satisfaction with services provided

Measure: The number of consumers/families that agree or strongly agree they are satisfied overall with the services they have received / by the total number of consumers/families that completed the survey during the survey period multiplied by 100. The estimated goal is derived from calculating the range for true population proportion of the May 2015 response rate of 87.3%. At 95% Confidence Level, the confidence interval for 87.3% response rate is plus or minus .8 which is between 84.2% to 85.8%.

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

Responsible Entity: PSB-QID, LACDMH Outpatient Programs

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 3: **a. Monitor the grievances, appeals and requests for State Fair Hearings for FY 2015-2016.**

b. Resolve all standard appeals within 45 calendar days of receipt of appeal by Patients' Rights Office.

c. Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log.

Population: Consumers/families served by LACDMH

Indicator: Resolution of beneficiary grievances, appeals, and requested State Fair Hearings

Measure: Number and type of the beneficiary grievances, appeals, and State Fair Hearings resolved and referred out, and pending for FY 2015-2016

Source(s) of Information: Patients' Rights Office (PRO) Data Reports

Responsible Entity: Patients' Rights Office (PRO), PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 4: Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests.

Population: Consumers and their families served by LACDMH

Indicator: Number and type of Requests for Change of Provider

Measure: Number of providers reporting consumers' requests for change of provider for FY 2015-2016

Source(s) of Information: Patients' Rights Office (PRO) Data Reports

Responsible Entity: Patients' Rights Office (PRO), PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN IV: MONITORING CLINICAL CARE

GOAL 1: **Address evolving standards and requirements associated with the use of medication in mental health programs through systematic application of DMH Medication Parameters to supervision of prescribing practices, and through provision of ongoing training by clinical experts in state-of-the-art use of medication.**

Population: Consumers receiving medication support services

Indicator: Prescribing standards and parameters

Measure: Review and update of medication parameters, medication-related trainings, and supervisory structure of Mental Health Practitioners and Nurse Practitioners

Source(s) of Information: Office of the Medical Director (OMD) Reports

Responsible Entity: Office of the Medical Director (OMD), PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN IV: MONITORING CLINICAL CARE

GOAL 2: Continue to improve Clinical Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD) through on-site and online trainings and Annual State Wide Integrated Care Conference targeting LACDMH Directly Operated and Contracted programs.

Population: Consumers receiving COD treatment services

Indicator: COD Training Protocols and Procedures to improve clinical care related to COD treatment

Measure: Review, update, and provision of COD on-site trainings and online trainings and Annual Statewide Integrated Care Conference; total number of clinicians who completed these trainings in CY 2016, and training evaluation summaries completed for these trainings

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Source(s) of Information: Office of the Medical Director (OMD) Reports

Responsible Entity: Office of the Medical Director (OMD), PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN IV: MONITORING CLINICAL CARE

GOAL 3: Continue to improve clinical care for older adult consumers with mental illness with or at risk for involvement in the Criminal Justice System through providing a series of trainings to staff of both contracted and/or directly operated agencies.

Population: Older adults (60+) with mental illnesses receiving mental health services through LACDMH

Indicator: Clinical care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System

Measure: Review and evaluate the total number of clinical and case management staff that attended each training for FY 15-16. Review and evaluate training evaluation summaries for each training.

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Source(s) of Information: Older Adult System of Care Reports

Responsible Entity: Office of the Medical Director (OMD), PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN V: MONITORING CONTINUITY OF CARE

GOAL 1: At least 90% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center will receive appointments for a Specialty Mental Health Service Assessment within 5 business days.

Population: Consumers referred for urgent appointments by the Medi-Cal Managed Care Plans

Indicator: Continuity of Care for consumers referred for specialty mental health services by primary care providers and behavioral health network providers of the Medi-Cal Managed Care Plans

Measure: Number of Urgent Appointments received within five (5) business days from the date referred by the Medi-Cal Managed Care Plans to the Urgent Appointment Line for Calendar Year 2016 divided by the Total Number of Urgent Appointment Referrals received from the Medi-Cal Managed Care Plans to the Urgent Appointment Line for the Calendar Year 2016 multiplied by 100

Source(s) of Information: ACCESS Center, Health Care Reform Operations Bureau, Special Projects Unit

Responsible Entity: ACCESS Center, Health Care Reform Operations Bureau, Special Projects Unit, PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN V: MONITORING CONTINUITY OF CARE

GOAL 2: Improve Continuity of Care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System through providing consultation on complex cases to enhance treatment planning and intervention process.

Population: Older adults (60+) with mental illnesses receiving mental health services through LACDMH

Indicator: Continuity of Care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System

Measure: Review the case consultation outcomes on the cases consulted at the five consultation meetings scheduled for FY 15-16 by the Community Diversion and Re-entry Program for Seniors (CDRPS) and provide a brief report on the cases consulted and related outcomes.

Source(s) of Information: Older Adult System of Care Reports

Responsible Entity: Older Adult System of Care (OASOC), PSB-QID

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

QI WORK PLAN GOALS FOR CALENDAR YEAR 2016

DOMAIN VI: MONITORING PROVIDER APPEALS

GOAL 1: The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal.

Population: Contracted Providers

Indicator: Timeliness of the MHP's written response to Provider Appeals

Measure: Number of MHP's responses to Provider Appeals (day treatment, inpatient, and outpatient) within 60 calendar days for Calendar Year 2016 / by the total number of provider appeals for Calendar Year 2016 multiplied by 100

Source(s) of Information: LACDMH OMD - Managed Care Division.

Responsible Entity: OMD - Managed Care Division, PSB-QID