

**QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR
CALENDAR YEAR 2009
and
QUALITY IMPROVEMENT WORK PLAN FOR
CALENDAR YEAR 2010**



**County of Los Angeles
Department of Mental Health
Program Support Bureau
Quality Improvement Division**

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COUNTY OF LOS ANGELES –DEPARTMENT OF MENTAL HEALTH

**QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR
CALENDAR YEAR 2009
QUALITY IMPROVEMENT WORK PLAN FOR
CALENDAR YEAR 2010**

Introduction

The County of Los Angeles Department of Mental Health (LAC-DMH) Vision is: “Partnering with clients, families and communities to create hope, wellness, and recovery”. Today, the LAC-DMH has a continuous and ever increasing focus on consumer satisfaction through effective service delivery and accessibility. LAC-DMH also faces increasingly diverse Los Angeles County population demographics. LAC-DMH is successfully meeting this challenge through the implementation of The Community Services and Supports (CSS) Plan. The CSS Plan includes services intended to increase access and decrease disparities such as: Community Outreach Services, Field-Based Services, Full Service Partnerships and other transformational initiatives. This impetus is essential to fulfill the Mission of “Enriching lives through partnerships designed to strengthen the community’s capacity to support recovery and resiliency”. The LAC-DMH Values of “Integrity, Respect, Accountability, Collaboration, Dedication, Transparency, Quality and Excellence” form the foundation for constructing client quality of life in their communities.

This Report is completed in compliance with the Mental Health Plan reporting requirements of the Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440, concerning Quality Improvement.

Section 1

LAC-DMH QUALITY IMPROVEMENT PROGRAM DESCRIPTION

QI Program Structure

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

The QID includes the Data Unit, which is specifically responsible for data collection, analyses and reporting for planning and measuring progress towards goal attainment including; outcome measures for improved service capacity, accessibility, quality, cultural competency, penetration and retention rates, continuity and coordination of care, clinical care and consumer/family satisfaction. The QID and Data Unit staff coordinates with the Department's Standards and Quality Assurance Division and those Bureaus and Units directly responsible for conducting performance management activities such as: client and system outcomes, beneficiary grievances, appeals, clinical issues, clinical records documentation and reviews, provider appeals, accessibility, timeliness of services, and Performance Improvement Projects (PIPs). The analyses and management of data is used as a key tool for performance management and decision making, paying particular attention to data for use in monitoring the system for improved services and quality of care.

The LAC-DMH Quality Improvement structure is formally integrated within several key levels of the service delivery system. The Department's Countywide Quality Improvement Council (QIC) meets monthly and consists of representation from each of the eight (8) Services Areas and Countywide DMH programs, including consumers and/or family members, Cultural Competency Subcommittee representatives, and other QI stakeholders. At the Service Area level, all Service Areas have their own regular Service Area Quality Improvement Committee (SA QIC) meetings and the SA QIC Chairpersons are standing members of the Departmental Countywide QIC. Whenever possible each Service Area has a Chairperson and Co-Chairperson or two Co-chairpersons with one representing Directly Operated Providers and the other representing Contract Providers. At the Provider level, all Directly Operated and Contracted Organizational Providers, maintain their own Organizational QIC. In order to ensure that the QIC communication feedback loop is complete, all Service Area

Organizational Providers are required to participate in their local SA QIC. This also constitutes a structure supportive of effective communication of the Providers to the Service Areas QIC's, to the Quality Improvement Council, to the intended management structure and back through the system. Lastly, there is a communication loop between the SA QIC Chairperson and/or Co-Chairpersons and the respective Service Area District Chiefs and Service Area Advisory Committee (SAAC) that is comprised of consumers, family members, providers and LAC-DMH staff. The SAACs provide valuable information for program planning and opportunities for program and service improvement. It is used as an excellent venue for improved consumer/family member participation at the SA QIC level.

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

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

Quality Improvement Processes

The ultimate goal of QI Program performance outcomes and evaluation processes is to ensure a culture and system of continuous self-monitoring and self-correcting quality improvement strategies and best practices, at all levels of the system.

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

The QID is also responsible for the formal reporting on the effectiveness of QI processes through the development and completion of the State and County Performance Outcomes Report. The County Outcome measures were initiated in January 2008 at the request of the County of Los Angeles Board of Supervisors and reflect three critical domains of importance to our system. These domains are *Access to Services*, *Customer Satisfaction* and *Clinical Effectiveness*.

The Departmental Countywide QIC systematically and formally exchanges quality improvement information, data, and performance updates on QI goals and Performance Improvement Projects. These communications are documented in QI meeting minutes, website posting, and other reports as appropriate. The Departmental QI Program also engages and supports the SA QICs in QI processes related to the QI Work Plan, specific PIPs, and other QI projects at the SA level. In turn, SA QICs provide a structured forum for the identification of QI opportunities and action designed specifically to address the challenges and barriers encountered at the SA level and that may exist as a priority in a SA. SA QICs also engage and support Organizational QICs that are focused on their internal Organizational QI Program and activities. The Organizational QICs also monitor internally to ensure performance standards are met consistent with Quality Assurance and Quality Improvement standards.

Historical Background

It is also important to note that the goals of the “President’s New Freedom Commission on Mental Health – Transforming Mental Health Care in America” (July 2003), the Institute of Medicine’s (IOM’s) “Crossing the Chasm”, and the SAMHSA/CMHS, NASMHPD Research Institute (NRI) National Outcome Measures (NOM’s) have served to guide the LAC-DMH direction and selection of Performance Outcomes and goals for improved quality. This national perspective has provided a valuable framework for transformation of the system through measurable indicators that were identified by consumers and other stakeholders throughout the Nation as having universal meaning and significance for improving the lives of the persons we serve.

Section 2

LAC-DMH COUNTY DEMOGRAPHICS

Los Angeles County Demographics

Los Angeles County is the most populous County in the United States. According to population estimates based on the 2000 census, 10,418,695 persons lived in Los Angeles County in 2008. Of this number, 23% are Children and Youth between 0 and 15 years; 15% are Transitional Aged Youth (TAY) between 16-25 years; 47% are Adults between 26-59 years; 14% are Older Adults over 60 years of age. Due to the size of the County, the service delivery system utilizes 8 geographic Service Areas.

Estimated Population and Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) by Service Area

Tables 1, 2 and 3 show the Service Area distribution of Los Angeles County's estimated population by ethnicity, age group and gender. The highest Prevalence Rates by ethnicity, age, and gender are for Latinos at 7.66%, TAY ages 16-25 at 8.44%, and females at 7.77%, respectively. In addition, the SED and SMI distribution is shown for each of the above population groupings. Tables 4, 5 and 6 show the estimated Service Area estimated populations by ethnicity, age group and gender respectively, living at or below 200% of poverty. The highest Prevalence Rates by ethnicity, age and gender, for persons living at or below the 200% Federal poverty level are for Latinos at 7.58%, TAY ages 16-25 at 8.44%, and females at 9.70%, respectively.

TABLE 1: ESTIMATED POPULATION AND PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) FOR TOTAL POPULATION BY ETHNICITY & SERVICE AREA - CY 2008

Service Area (SA)	White	African American	Native American	Asian/Pacific Islander	Latino	Total
SA 1 Estimated Population	170,483	50,486	2,168	13,617	129,814	366,568
Estimated Population with SED & SMI	10,775	3,625	143	953	9,944	25,439
SA 2 Estimated Population	1,027,255	76,721	5,909	231,648	846,974	2,188,507
Estimated Population with SED & SMI	64,923	5,509	389	16,215	64,878	151,914
SA 3 Estimated Population	470,983	84,096	4,364	469,732	856,235	1,885,410
Estimated Population with SED & SMI	29,766	6,038	288	32,881	65,588	134,561
SA 4 Estimated Population	268,855	71,486	3,415	212,140	717,614	1,273,510
Estimated Population with SED & SMI	16,992	5,133	225	14,850	54,969	92,168
SA 5 Estimated Population	406,450	42,242	1,317	82,852	113,175	646,036
Estimated Population with SED & SMI	25,688	3,033	87	5,800	8,669	43,276
SA 6 Estimated Population	24,896	338,574	1,465	17,964	671,570	1,054,469
Estimated Population with SED & SMI	1,573	24,310	97	1,257	51,442	78,679
SA 7 Estimated Population	244,753	37,229	3,757	122,029	976,556	1,384,324
Estimated Population with SED & SMI	15,468	2,673	248	8,542	74,804	101,735
SA 8 Estimated Population	510,108	246,160	4,442	245,092	614,069	1,619,871
Estimated Population with SED & SMI	32,239	17,674	293	17,156	47,038	114,400
All Service Areas	3,123,783	946,994	26,837	1,395,074	4,926,007	10,418,695
Total Estimated Population with SED & SMI	197,423	67,994	1,769	97,655	377,332	706,388
Prevalence Rate for SED & SMI	6.32%	7.18%	6.59%	7.00%	7.66%	6.78%

Source: John Hedderson, Walter McDonald Associates (WRMA), Sacramento 2009 – Tables prepared by Data GIS Unit – Training & Quality Improvement Divisions

TABLE 2: ESTIMATED POPULATION AND PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) FOR TOTAL POPULATION BY AGE GROUP & SERVICE AREA - CY 2008

Service Area (SA)	Children 0-15 yrs	TAY 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs	Total
SA 1 Estimated Population	93,019	70,971	158,698	43,880	366,568
Estimated Population with SED & SMI	7,237	5,990	9,506	2,527	24,853
SA 2 Estimated Population	481,875	315,502	1,058,433	332,697	2,188,507
Estimated Population with SED & SMI	37,490	26,628	63,400	19,163	148,381
SA 3 Estimated Population	413,493	296,187	878,492	297,238	1,885,410
Estimated Population with SED & SMI	32,170	24,998	52,622	17,121	127,831
SA 4 Estimated Population	277,744	157,522	663,130	175,114	1,273,510
Estimated Population with SED & SMI	21,608	13,295	39,721	10,087	86,344
SA 5 Estimated Population	103,205	71,037	351,015	120,779	646,036
Estimated Population with SED & SMI	8,029	5,996	21,026	6,957	43,801
SA 6 Estimated Population	317,828	183,658	445,569	107,414	1,054,469
Estimated Population with SED & SMI	24,727	15,501	26,690	6,187	71,493
SA 7 Estimated Population	352,486	226,189	621,321	184,328	1,384,324
Estimated Population with SED & SMI	27,423	19,090	37,217	10,617	93,857
SA 8 Estimated Population	379,319	234,509	764,058	241,985	1,619,871
Estimated Population with SED & SMI	29,511	19,793	45,767	13,938	109,827
All Service Areas	2,418,969	1,555,575	4,940,716	1,503,435	10,418,695
Total Estimated Population with SED & SMI	188,196	131,291	295,949	86,598	706,388
Prevalence Rate for SED & SMI	7.78%	8.44%	5.99%	5.76%	6.78%

Source: John Hedderson, Walter McDonald Associates (WRMA), Sacramento 2009

TABLE 3: ESTIMATED POPULATION AND PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) BY GENDER & SERVICE AREA - CY 2008

Service Area (SA)	Male	Female	Total
SA 1 Estimated Population	184,039	182,529	366,568
Estimated Population with SED & SMI	11,742	14,183	24,853
SA 2 Estimated Population	1,089,734	1,098,773	2,188,507
Estimated Population with SED & SMI	69,525	85,375	148,381
SA 3 Estimated Population	924,099	961,311	1,885,410
Estimated Population with SED & SMI	58,958	74,694	127,831
SA 4 Estimated Population	654,582	618,928	1,273,510
Estimated Population with SED & SMI	41,762	48,091	86,344
SA 5 Estimated Population	313,512	332,524	646,036
Estimated Population with SED & SMI	20,002	25,837	43,801
SA 6 Estimated Population	516,263	538,206	1,054,469
Estimated Population with SED & SMI	32,938	41,819	71,493
SA 7 Estimated Population	685,828	698,496	1,384,324
Estimated Population with SED & SMI	43,756	54,273	93,857
SA 8 Estimated Population	796,020	823,851	1,619,871
Estimated Population with SED & SMI	50,786	64,013	109,827
All Service Areas	5,164,077	5,254,618	10,418,695
Total Estimated Population with SED & SMI	329,468	408,284	706,388
Prevalence Rate for SED & SMI	6.38%	7.77%	6.78%

Source: John Hedderson, Walter McDonald Associates (WRMA), Sacramento 2009

TABLE 4: ESTIMATED POPULATION AND PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL BY ETHNICITY AND SERVICE AREA - CY 2008

Service Area (SA)	White	African American	Native American	Asian/ Pacific Islander	Latino	Total
SA 1 Estimated Population	48,380	29,347	1,214	4,076	69,739	152,756
Estimated Population with SED & SMI	3,343	2,154	86	285	5,286	11,154
SA 2 Estimated Population	246,084	34,786	2,758	62,292	482,979	828,899
Estimated Population with SED & SMI	17,004	2,553	194	4,360	36,610	60,722
SA 3 Estimated Population	92,117	35,169	1,611	147,013	396,641	672,551
Estimated Population with SED & SMI	6,365	2,581	114	10,291	30,065	49,417
SA 4 Estimated Population	80,273	27,653	1,224	82,547	483,586	675,283
Estimated Population with SED & SMI	5,547	2,030	86	5,778	36,656	50,097
SA 5 Estimated Population	79,218	13,605	408	24,866	56,227	174,324
Estimated Population with SED & SMI	5,474	999	29	1,741	4,262	12,504
SA 6 Estimated Population	7,546	177,919	515	7,117	494,935	688,032
Estimated Population with SED & SMI	521	13,059	36	1,056	37,516	52,190
SA 7 Estimated Population	49,518	14,573	1,415	29,727	489,773	585,006
Estimated Population with SED & SMI	3,422	1,070	100	2,081	37,125	43,797
SA 8 Estimated Population	93,647	113,778	1,785	70,862	357,835	637,907
Estimated Population with SED & SMI	6,471	8,351	126	4,960	27,124	47,032
Total Estimated Population Below 200% Poverty	696,783	446,830	10,930	428,500	2,831,715	4,414,758
Total Estimated Population with SED & SMI	48,148	32,797	771	30,553	214,644	326,913
Prevalence Rate for SED & SMI	6.91%	7.34%	7.05%	7.00%	7.58%	7.18%

Source: John Hedderson, Walter McDonald Associates (WRMA), Sacramento 2009

TABLE 5: ESTIMATED POPULATION AND PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP & SERVICE AREA - CY 2008

Service Area (SA)	Children 0-15 yrs	TAY 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs	Total
SA 1 Estimated Population	51,888	29,840	55,371	15,657	152,756
Estimated Population with SED & SMI	4,037	2,518	3,317	902	11,457
SA 2 Estimated Population	235,365	125,281	354,113	114,140	828,899
Estimated Population with SED & SMI	18,311	10,574	21,211	6,574	62,167
SA 3 Estimated Population	192,412	101,831	274,537	103,771	672,551
Estimated Population with SED & SMI	14,970	8,595	16,445	5,977	50,441
SA 4 Estimated Population	193,910	89,093	312,253	80,027	675,283
Estimated Population with SED & SMI	15,086	7,519	18,704	4,610	50,646
SA 5 Estimated Population	34,911	20,634	89,436	29,343	174,324
Estimated Population with SED & SMI	2,716	1,742	5,357	1,690	13,074
SA 6 Estimated Population	253,305	119,159	264,069	51,499	688,032
Estimated Population with SED & SMI	19,707	10,057	15,818	2,966	51,602
SA 7 Estimated Population	195,671	94,989	225,444	68,902	585,006
Estimated Population with SED & SMI	15,223	8,017	13,504	3,969	43,875
SA 8 Estimated Population	197,782	99,533	264,125	76,467	637,907
Estimated Population with SED & SMI	15,387	8,401	15,821	4,404	47,843
All Service Areas	1,355,244	680,360	1,839,348	539,806	4,414,758
Total Estimated Population with SED & SMI	105,438	57,422	110,177	31,093	331,107
Prevalence Rate for SED & SMI	7.78%	8.44%	5.99%	5.76%	7.50%

Source: John Hedderson, Walter McDonald Associates (WRMA), Sacramento 2009

TABLE 6: ESTIMATED POPULATION AND PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) BY GENDER & SERVICE AREA AMONG POPULATION LIVING AT OR BELOW 200% POVERTY - CY 2008

Service Area (SA)	Male	Female	Total
SA 1 Estimated Population	70,463	82,293	152,756
Estimated Population with SED & SMI	5,496	7,982	28,519
SA 2 Estimated Population	394,822	434,077	828,899
Estimated Population with SED & SMI	30,796	42,105	170,266
SA 3 Estimated Population	316,621	355,930	672,551
Estimated Population with SED & SMI	24,696	34,525	146,685
SA 4 Estimated Population	331,398	343,885	675,283
Estimated Population with SED & SMI	25,849	33,357	99,079
SA 5 Estimated Population	81,443	92,881	174,324
Estimated Population with SED & SMI	6,353	9,009	50,262
SA 6 Estimated Population	328,776	359,256	688,032
Estimated Population with SED & SMI	25,645	34,848	82,038
SA 7 Estimated Population	274,716	310,290	585,006
Estimated Population with SED & SMI	21,428	30,098	107,700
SA 8 Estimated Population	299,655	338,252	637,907
Estimated Population with SED & SMI	23,373	32,810	126,026
All Service Areas	2,097,894	2,316,864	4,414,758
Total Estimated Population with SED & SMI	163,636	224,736	387,174
Prevalence Rate for SED & SMI	7.80%	9.70%	8.77%

Source: John Hedderson, Walter McDonald Associates (WRMA), Sacramento 2009

Section 3

LAC-DMH ARRAY OF SERVICES

Strategic Plan

The LAC-DMH Strategic Plan is intended to promote the County of Los Angeles Department of Mental Health Mission to “improve the quality of life in Los Angeles County by providing responsive, efficient and high quality public services that promote the self-sufficiency, well-being and prosperity of individuals, families, businesses and communities” The Strategic Plan creates an Organizational Culture that identifies priority goals, objectives, and action steps and establishes the value of quality improvement principles as a critical foundation for effective performance management. The Plan has five goals that are activated with a list of objectives and steps:

1. Enhance treatment quality through innovation to serve clients in ways that help them achieve hope, wellness and recovery.
2. Create mental health services without walls to treat underserved populations more effectively.
3. Become a community asset especially through our prevention, early intervention and workforce development activities.
4. Develop wellness, resiliency and recovery focus that creates hope in every aspect of our work.
5. Develop approaches that enhance revenues and promote collaboration to create a fiscally-stable system of care.

Mental Health Services Delivery System

The Community Services and Support (CSS) Plan for the LAC-DMH was initiated in 2005 and funds new service delivery programs. The growth and development of the LAC-DMH CSS Plan is monitored through ongoing updates and evaluations of the different components of the CSS plan.

Each program and initiative within the LAC-DMH Mental Health Service Delivery System and the CSS Plan have in their design evaluative and quality management components. Additionally, the CSS Plan was followed by a series of adjunctive plans intended to support and foster the transformation of services, and to build service capacity appropriately and reduce disparities.

The LAC-DMH Array of Services includes a full range of Specialty Mental Health Services (SMHS) including:

- Mental Health Services
- Medication Support Services
- Day Treatment Intensive
- Day Treatment Rehabilitation
- Crisis Intervention
- Crisis Stabilization

- Adult Residential Treatment Services
- Crisis Residential Treatment Services
- Psychiatric Health Facility (PHF) Services

Other Specialty Mental Health Services (SMHS) include:

- Psychiatric Inpatient Hospital Services
- Targeted Case Management (TCM)
- Psychiatrist Services
- Psychological Services
- EPSDT Supplemental Specialty Mental Health Services

Mental Health Services Act

The Mental Health Services Act (MHSA) defines the requirements of service delivery to Children and Youth with Serious Emotional Disturbances (SED): and Adults and Older Adults with Severe Mental Illness (SMI). LAC-DMH has put measurements in place to monitor outcomes and progress of services and activities for:

- Meaningful use of time and capabilities
- Safe Housing
- A Network of Supportive Relationships
- Access to Help in a Crisis
- Reduction in Incarceration
- Reduction in Involuntary Services

Access for Consumers

LAC-DMH and its community partners focus on access for persons with cultural/language-specific needs. Additionally, LAC-DMH contracts required service provider agencies to locate service sites in proximity to target populations. For those persons requiring needs that cannot be met in their immediate area, DMH staff utilizes web-based searches to assist the person in locating a service provider specific to their needs including interpreter services. The Quality Improvement Council has worked to assist in improving interpreter services and identifying Service Area prevalence, penetration and retention data for Service Area and County service planning. This will be discussed in more detail in the Evaluation Section of this report.

Provider Directories

The LAC-DMH Mental Health Services Delivery System occurs through a network of more than 80 directly operated providers' sites and over 400 contracted providers, including non-governmental agencies and individual practitioners.

There are two primary provider directories available for use by both consumers and community providers. In January 2010, the LAC-DMH developed the first Service Area Provider Directories. The eight (8) Service Area Provider

Directories serve as geographical provider locators with available specific services information. Consumers, family members, clinical professionals and other staff can use the guide and maps to find appropriate services that are as close to consumers as possible. The Directories include provider names, addresses, phone numbers, type of services, organizational types, and general age groups served by Service Area. This Directory may be found at: <http://gis.lacounty.gov/dmh/>

The other directory is the CIOB *Provider Directory* which includes the provider site reporting unit number, address and phone number as it appears in the integrated System (IS). This directory is used to assist providers during billing and treatment coordination. The CIOB Provider Directory is also used to delete providers who are no longer actively providing services and/or whose contract with LAC-DMH is no longer in effect. The online address is <http://dmh.lacounty.gov/hipaa/index.html>.

STRATEGIC INITIATIVES

The current LAC-DMH Strategic Initiatives include but are not limited to the: MHSAs Innovations Plan, MHSAs Workforce Education and Training Plan (WET), MHSAs Prevention and Early Intervention Plan (PEI), Specialized Foster Care, Co-Occurring Disorder (COD) Training Projects, including Evidence Based Practices, STATS, Learning Net System, Electronic Health Records and work to enhance system capacity to serve clients in a manner that provides quality services and creates client flow through the system.

MHSA Innovations Plan

The MHSAs Innovations plan currently under review by the MHSAs Oversight and Accountability Commission and the State Department of Mental Health proposes 4 distinct approaches to the integration of health, mental health and substance abuse treatment services. The service approaches target three distinct focal populations; individuals with a mental illness who are homeless, uninsured or from an under-represented ethnic population (UREP). The four models are:

- The Integrated Clinic Model – co-location of health and mental health.
- The Integrated Mobile Health Team – field-based health, mental health and permanent housing services and supports.
- Community-Designed Integrated Service Management model- integrated health, mental health and substance abuse services individually tailored to the African American, Latino, American Indian, Middle Eastern/Eastern European and Asian Pacific Islander populations.
- Integrated Peer Run Crisis Services.

The LAC-DMH is committed to working alongside ethnic and cultural communities that have been historically on the periphery of the mental health system. These communities, referred to as UREP (Under-Represented Ethnic

Populations), provide LAC-DMH with a wealth of resources and information on how to best serve currently unserved, underserved, and inappropriately served ethnic populations with the goal of bettering their mental health outcomes and overall well being. In Los Angeles County, there are five distinct UREP subcommittees representing the mental health needs and concerns of their communities. These include African Immigrant/African American (A/AA), American Indian (AI), Asian Pacific Islander (API), Eastern European/Middle Eastern (EE/ME) and Latino. By establishing these five UREP subcommittees as a staple in various MHSA planning and stakeholder processes, Los Angeles County created a learning lab for the traditional public mental health system to develop culturally competent approaches and services successful at reaching marginalized ethnic communities.

MHSA Workforce Education and Training Plan

LAC-DMH, MHSA–Workforce Education and Training Plan is committed to increasing the quantity and quality of trained persons available for employment in the mental health system while increasing family and consumer involvement in service delivery and encouraging development of a diverse workforce.

Workforce development, education and training needs include:

- Addressing core clinical competencies; enhancing the skills of individuals with unique cultural and linguistic competence; and, partnering with Directly Operated Providers and Contracted Providers to ensure staff development supportive of wellness, recovery and resiliency.
- Providing education and training programs for staff, consumer/family employees, students and volunteers who provide services in the Public Mental Health System, including fostering leadership skills. This education and training contributes to developing and maintaining a culturally competent client and family workforce. The programs also include training to promote wellness, recovery and resilience, and lead to measurable, values-driven outcomes.

Specialized Foster Care (SFC)

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

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

The Strategic Plan calls for a number of systemic improvements including the expansion of Medical Hubs, standardized mental health screenings for all

children entering foster care, the Co-Location of mental health staff in DCFS offices, use of Evidence Based Practices and an increase the County's capacity to provide intensive in-home mental health services.

The LAC-DMH EPSDT PIP Multifunctional Team is assessing related accessibility challenges and areas for potential quality improvement using selected interventions.

Co-Occurring Disorders

LAC-DMH hosted the well-attended Seventh Annual Statewide Conference on Co-Occurring Disorders (COD): "Transforming Challenges into Opportunities", held at the Long Beach Convention Center, March 31-April 1, 2009. The primary objectives were to accomplish the following:

- Identify challenges and solutions within existing systems for the integration of COD services.
- Increase collaboration between Alcohol and Drug Programs (ADP) and the Department of Mental Health with the multiple systems of care serving COD clients at the State and local levels.
- Identify Evidence-Based Practices that address the complex needs of clients with COD.

LAC-DMH continues its goals to further integrate recovery based Co-Occurring Mental Health and Substance Services throughout our system of care. Another continuing goal for COD integrated services is to incorporate the use of a Clinical COD Services Review Process into the provision of COD Services within our Directly Operated and contracted clinics and programs. To this end a new COD STATS objective has been added to ensure appropriate COD screening, assessment and treatment services are provided to consumers.

MHSA Prevention and Early Intervention Plan

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

During Fiscal Year 2008-09, LAC-DMH conducted a comprehensive needs assessment that included gathering demographic and other statistical data regarding the county population and conducting 65 Key Individual Interviews, 54 Focus Groups, and 16 Community Forums to obtain further input from community stakeholders. This resulted in a comprehensive community-based PEI Plan approved by the MHSA Oversight and Accountability Commission and the California Department of Mental Health in August, 2009. The plan involves

the use of evidence-based and community-defined evidence practices in the areas of prevention and early intervention across each of the 8 Service Areas for each of the four age groups. It will be the single largest move in the Department's history toward the use of evidence-based practices.

STATS

The STATS (Strategies for Total Accountability and Total Success) process involves structured monthly meetings that are chaired by the Chief Deputy Director, with active participation by the Executive Management Team (EMT), District Chiefs and Program Heads. Office of STATS analysts conduct a preliminary analysis of performance indicators relative to established targets or benchmarks and prepares an agenda and questions to help focus the formal session. During the STATS meetings, the EMT reviews relevant performance data and, as necessary, strategizes with clinical program and administrative managers to develop specific action plans designed to improve performance. Follow-up is an integral part of the process, with program-specific reports provided to monitor follow-through on action plan commitments and to measure performance improvement over time.

At its inception in May 2007, the DMH STATS process focused on three core operational process metrics:

- **Direct Services** – Percent of staff time spent on direct services.
- **Benefits Establishment** – Percentage of clients with benefits.
- **Claim Lag Time** – Percentage of claims entered within 14 days of date of service.

Since that time, the following indicators have been introduced to the STATS process and reviewed at the monthly meetings:

- **Medi-Cal Approval** Percent Indicator and **Medi-Cal Revenue Capture**. These indicators help assure that an improvement in timeliness of claim submission doesn't come at the cost of quality of data entry and revenue capture.
- **Post-Hospitalization Outpatient Service Access** Indicator. Facilitates linking clients to outpatient services within seven days after discharge from the hospital.
- **Quality Assurance (QA) Claiming** Indicator. Indicator to assure that QA programs are in place to assure regulatory accountability and compliance. This has resulted in previously unrealized revenue capture.
- **Full Service Partnership (FSP) Baseline Completion** indicator. Monitors and enhances the completeness and quality of the FSP client's outcome data.
- **Full Service Partnership Reduction in Homelessness** Indicator
- **Co-Morbid Substance Abuse (Dual Diagnosis) Assessment Indicator**
- Indicators tracking centralized Administrative Support functions including Timeliness of (1) **Rendering Provider Processing** (CIOB), (2) **Certification List Request Processing** (Human Resources) and (3) **Performance Evaluation Completion** (Executive Management Team).

For each metric, data is aggregated at the department level, by Service Area and by individual programs. Programs are measured against specific targets, which

are established by LAC-DMH, as well as against their peers. The STATS program also provides extensive didactic and lab-based training, mentoring, as well as numerous supplemental reports in order to enhance the skills and ability of managers and supervisors to use data to help monitor and improve their programs.

As each metric has been introduced to the STATS process, substantial performance improvements have been noted in every relevant operational or clinical domain. Examples include: a 16% increase in staff Direct Service levels and 18% increase in claim submission timeliness over the first 2 years; an increase in annual revenues of approximately \$3 Million / year; and an 8% increase (to 92%) of consumers showing clear evidence of assessment for co-morbid substance abuse in the first six months since introduction of that metric.

The Learning Net

The Los Angeles County Learning Net (TLN) is a web-based learning management system that enables the Department of Mental Health to manage, deliver and report various types of learning content and resources to all employees and non-compensated personnel, as well as employees of contract providers. In addition, TLN can provide career management assistance to employees when the system is fully implemented. Some of the benefits for employees include a training record which will follow the employee throughout their county career, centralized access to training available to all employees, increased access to training records and transcripts, course self-enrollment and an increasing catalog of web-based training and tutorials. Some of the benefits for supervisors and managers include the replacement of manual registration process with on-line registration, access to employee training records and management reports for various authorized levels and the ability to easily monitor employee training and compliance for completion of mandatory training.

Electronic Health Record

LAC-DMH is faced with an enormous task of implementing a countywide Electronic Health Record (EHR) system. A primary challenge is securing a vendor to develop a system that supports data collection and storage, provides electronic health record (EHR) functionality, produces Short-Doyle/Medi-Cal (SD/MC) and other third party claims, tracks revenue, perform managed care activities, and provides information for analyses and reporting.

EDI (Electronic Data Input) remains an area of focus and all Providers are expected to be compliant by July 2010. The IBHIS selection process is scheduled to begin in April 2010. LAC-DMH is encouraging contract providers to become EDI compliant during the coming year.

Incubation Academy Training

LAC-DMH has implemented an Incubation Academy Program to assist nonprofit organizations in pursuing a mental health contract with LAC-DMH. These organizations have a desire to provide mental health services to build capacity within the Mental Health Plan. The program provides a training academy, resource references, technical assistance, and mentorship and/or sponsorship by existing County service providers. The Academy provides on-going training in the Basic Core informational courses and Advanced Specific Mental Health Courses including Quality Assurance and Quality improvement components.

Community Outreach Services (COS)

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

As part of the MHSA plan, a UREP Work Group, consisting of 56 culturally diverse mental health professionals and community client advocates was created to make implementation recommendations to the Department of Mental Health. This Work Group established the UREP Guiding Principles and five subcommittees' representative of the major ethnic groups within Los Angeles County. The UREP groups meet regularly to provide service and funding recommendations to the LAC-DMH, that are culturally and linguistically competent to each of their respective communities.

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

System Leadership Team

The System Leadership Team (SLT) introduced "Strategies for Increasing FSP Authorizations for Unserved Ethnic Populations" in September 2008, to address challenges and barriers to FSP authorized services for the Latino and Asian/Pacific Islander populations. Strategies include: 1. Service Area Impact Units and Navigator Teams provide coordination and linkage services; 2. Collaboration with FSP providers; 3. Cultural Competent Outreach and Engagement services including community education. This objective to improve services to Latinos and Asians is included in the QI Work Plan goals.

The Empowerment and Advocacy Division

Empowerment and Advocacy (EAD) advances the realization of consumer-centered, family-focused system of mental health services and supports. EAD promotes wellness, eliminates stigma and discrimination associated with mental illnesses by removing barriers to recovery and community integration. EAD works to improve the quality of life of the citizens of the County of Los Angeles through comprehensive implementation of the recovery model in mental health services, policy and programming. EAD develops, promotes, and sustains recovery-based practices and policies to achieve its Vision of enhancing advocacy, supporting systems change, expanding peer support and fostering consumer and family empowerment. EAD and QID work collaboratively including projects such as the RC2 PIP, the EPSDT PIP, Patient's rights issues and other consumer driven initiatives and projects.

Performance Outcomes

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

This initiative currently includes Directly Operated and Contract Providers. It holds providers accountable for twelve (12) performance outcomes within three domains. The domains are: Access to Services, Client Satisfaction and Clinical Effectiveness. The Department continues to be on schedule with the performance-based contracting initiative required by the Board of Supervisors.

Additionally, LAC-DMH has successfully developed and produced real time MHSA FSP outcome reports. The first of these reports involves living arrangements of FSP clients, including reports by age group and by provider that compare living arrangements (including hospitalizations, incarcerations and homelessness) the year prior to the client's enrollment in an FSP to client living arrangements since enrollment. Most age groups have noted large reductions in the number of clients psychiatrically hospitalized since enrollment, reductions in the number of and days incarcerated since enrollment and reductions in days homeless since entering an FSP program.

EPSDT PIP

LAC-DMH participates in the Statewide EPSDT PIP. The focus of this PIP is to ensure that each client is receiving services that are appropriate in type, duration, and intensity, effective and efficient.

The EPSDT Roadmap to a PIP details the study population, study question, IS data collected, and interventions selected. (See Road Maps for both EPSDT and RC2 attached)

Enhancing System Capacity and Client Flow

LACDMH has developed a strategy document for enhancing system capacity and increasing the flow of clients into and through the system. This document has served as the basis for statewide discussions on how to enhance system capacity. In January, 2010 a workgroup will be convened to operationalize the plan and a group of adult providers will be selected to pilot an approach to increasing system capacity. These providers will be receiving technical assistance and support from the MHS Implementation Unit, CiMH and a project consultant employed through CiMH with expertise in Continuous Quality Improvement.

Section 4

QI WORK PLAN EVALUATION REPORT FOR CY 2009

LAC-DMH maintains program principles and the full array of treatment options required under W&IC Sections 5600.9, State Medi-Cal Oversight Review Protocols. The QI Work Plan Goals are in place to continuously improve the quality of the service delivery system. Measurable goals for each calendar and/or fiscal year are evaluated by way of performance outcomes and substantiated with data. The Work Plan goals are structured within the six quality improvement domains and include performance Improvement Projects (PIP) activities:

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 of Provider Appeals

Monitoring Service Delivery Capacity goals are designed to address the need to specifically outreach to the under represented ethnic populations. At this time the focus is on Latino and Asian populations due to their increasing census and low penetration and retention rates throughout Los Angeles County.

Monitoring Accessibility of Services goals assures the availability of after hours care and measured community access to services through PMRT response time, and response of ACCESS 24/7 Toll-Free phones lines. Also included are consumer/family perceptions of satisfaction with service locations and times.

Monitoring Beneficiary Satisfaction goals address perhaps the most critical aspect of quality improvement. Results are measured through the eyes of consumers and families by the administration of consumer and family member perception of satisfaction surveys to ensure consumer/family input for improvement of the service delivery system.

Monitoring Clinical Care goals address the important issues of medication practices including medication protocols, training of clinical professionals, and Psychiatrist Clinical Peer Review, and other clinical care issues as identified.

Monitoring Continuity of Care focuses on measures for Post Hospitalization Outpatient Access (PHOA) within seven days and improved EPSDT services provided to eligible recipients. The PHOA is also a STATS Indicator. Monitoring Provider Appeals measures appeals received from TBS Day Treatment Providers for denied authorizations and potential access issues.

SUMMARY OF QI WORK PLAN GOALS FOR CY 2009

I. MONITORING SERVICE DELIVERY CAPACITY

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

II. MONITORING ACCESSIBILITY OF SERVICES

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

III. MONITORING BENEFICIARY SATISFACTION

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

IV. MONITORING CLINICAL CARE

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

V. MONITORING CONTINUITY OF CARE

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

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

VI. MONITORING OF PROVIDER APPEALS

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

I. MONITORING SERVICE DELIVERY CAPACITY – EVALUATION OF GOALS FOR 2009

Goal #1

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

- a. Increase Latino penetration rates from FY 07-08 by 1% in FY 08-09.***
- b. Increase Asian/Pacific Islander penetration rates from FY 07-08 by .25% in FY 08-09.***
- c. Increase Latino retention rates from FY 07-08 by 1.5% in FY 08-09 for 16 or more services.***
- d. Increase Asian/Pacific Islander retention rates from FY 07-08 by .2% in FY 08-09 for 16 or more services***

Numerator: Number of consumers served by ethnicity.

Denominator: Estimated prevalence of SMI SED among total County population by ethnicity.

EVALUATION

This goal was partially achieved.

Table 7 shows that from FY 07-08 to FY 08-09, the Latino Penetration Rate increased by .5% and for those living at or below the 200% Federal Poverty level there was a .1% increase. During the same period, the Asian/Pacific Islander Penetration Rate increased by 2.9% and for those living at or below the 200% Federal Poverty level there was a 4.3 % increase. During the three year period from FY 06-07 to 08-09, the Latino Penetration Rate increased by 2.6% and for those living at or below the 200% Federal Poverty level there was a 1.7% increase. The data in this section clearly supports the need to reach and provide services to this underserved population.

During the same period, the Asian/Pacific Islander Penetration Rate increased by 3.1% and for those living at or below the 200% Federal Poverty level there was an 8.3% increase. Table 8 shows Consumers served in Short-Doyle Medi-Cal Facilities in FY 06-07 to FY 08-09 by Ethnicity. This data was used to compute the Penetration and Retention Rates as shown in this section.

The LAC-DMH has slightly improved access to mental health services for the Latino population, consistent with the CAEQRO recommendations commencing in FY 07-08 to “focus on access and engagement issues for the Latino Population, including the availability of Spanish Language services.” The MHP has also focused outreach and engagement activities to underserved Asian populations. Each Service Area has designated numbers of “FSP slots” to increase the authorization of services to underserved ethnic populations, especially Hispanic/Latino populations. Examples of Outreach and Engagement (O&E) activities have included, but are not limited to: the use of bilingual Spanish speaking Navigators and O&E staff; Community Forums, Community Work

Groups & Focus Groups to plan for culturally competent roll-out of the WET and PEI Plans; Faith-Based and Community Clinic Association collaborative; LAC-DMH participation in local neighborhood councils; and, training of Queens Care Promotoras.

Table 7: Percent Change in Penetration Rates¹ Between FY 06-07 to FY 08-09 For Total Population and Population Living Below 200% Poverty by Ethnicity

Ethnicity	FY 06-07	FY 07-08	Percent Change in FY 07-08	FY 07-08	FY 08-09	Percent Change in FY 08-09
White						
Total Population	195,365	196,476		196,476	184,650	
Percent	16.6%	17.4%	+ .08%	17.4%	19.81%	+ 2.4%
Population Below 200% Poverty	36,903	42,022		42,022	48,148	
Percent	87.8%	81.4%	- 6.6%	81.4%	87.2%	+ 5.8%
African American						
Total Population	67,063	67,705		67,705	67,089	
Percent	61.8%	62.1%	+ .03%	62.1%	64.9%	+ 2.8%
Population Below 200% Poverty	27,650	27,580		27,580	32,797	
Percent	149.9%	152.4%	+ 2.5%	152.4%	157.8%	+ 5.4%
Latino						
Total Population	372,931	373,447		373,447	366,713	
Percent	18.9%	21.0%	+ 2.10%	21.0%	21.5%	+ 0.5%
Population Below 200% Poverty	178,775	191,083		191,083	214,644	
Percent	39.5%	41.1%	+ 1.6%	41.1%	41.2%	+ 0.1%
American Indian*						
Total Population	2,046	2,024		2,024	1,707	
Percent	45.7%	30.4%	-15.30%	30.4%	54.9%	+ 24.5%
Population Below 200% Poverty*	576	720		720	771	
Percent	162.2%	85.4%	- 76.8%	85.4%	130.1%	+ 44.7%
Asian/Pacific Islander						
Total Population	87,320	96,224		96,224	79,629	
Percent	7.2%	7.4%	+ .2%	7.4%	10.3%	+ 2.9%
Population Below 200% Poverty	26,754	25,825		25,825	30,553	
Percent	23.6%	27.6%	+ 4.0%	27.6%	31.9%	+ 4.3%
Countywide						
Total Population	724,725	700,538		700,538	699,788	
Percent	20.9%	23.2%	+ 2.30%	23.2%	24.0%	+ 0.8%
Population Below 200% Poverty	270,658	290,727		290,727	326,913	
Percent	56.1%	55.9%	- 1.8%	55.9%	57.8%	+ 1.9%

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

*Penetration Rate for American Indian is not stable due low population count.

Table 8 shows the percent change in number of approved outpatient services between FY 06-07 and FY 08-09. In FY 07-08 there were 6,905 additional outpatient services rendered as compared with FY 06-07. Consumers receiving fewer outpatient services (1, 2, 3, or 4) declined and consumers receiving 5-15 or 16 or more outpatient services increased between the same two years. Consumers that received 16 or more outpatient services increased by 2.54%, and consumers receiving between 5 and 15 outpatient services increased slightly by 0.27%. In FY 08-09 the additional outpatient services rendered were 10,202 as compared with 6,905 in FY 07-08. However, consumers receiving 5-15 outpatient services declined by -1.16% and consumers receiving 16 or more services increased by 1.53%.

Table 8: Retention Rates – ¹ Percent Change in Number of Approved Outpatient Services (Retention Rates) from FY 06-07 to FY 08-09

Number Approved Outpatient Services	FY 06-07		FY 07-08		Percent Change 06-07 to 07-08	FY 07-08		FY 08-09		Percent Change 07-08 to 08-09
	Number of Consumers	Percent	Number of Consumers	Percent		Number of Consumers	Percent	Number of Consumers	Percent	
1	18,395	12.77%	16,602	10.99%	-1.78%	16,602	10.99%	17,296	10.73%	-.26%
2	8,983	6.23%	8,447	5.59%	-0.64%	8,447	5.59%	9,222	5.72%	+.13%
3	6,995	4.85%	6,949	4.60%	-0.25%	6,949	4.60%	7,444	4.62%	+.02%
4	6,356	4.41%	6,429	4.26%	-0.15%	6,429	4.26%	6,471	4.01%	-.25%
5-15	44,079	30.59%	46,604	30.86%	+.27%	46,604	30.86%	47,872	29.70%	-1.16%
16+	59,291	41.15%	65,973	43.69%	+ 2.54%	65,973	43.69%	72,901	45.22%	+1.53%
Total	144,099	100%	151,004	100%		151,004	100%	161,206	100%	

1. Retention Rate = Number of outpatient services/claims for consumers served.

Table 9 shows Retention Rates – Number of Approved Outpatient Services by Ethnicity – FY 08-09 and evidences that the Latino population has higher Retention Rates for 5-15 and 16 or more services as compared with other ethnic groups and as compared with Latino Penetration Rates in the same year (FY 08-09). This is consistent with LAC-DMH Retention Rates reporting (QI Work Plan Evaluation Reports) in previous years (FY 06-07 and FY 07-08). Similar stronger Retention Rates are shown for the Asian population as well. (See Table 10) This trending data and analyses also support a continued focus on improving Penetration Rates, especially for Latinos.

Table 9: Retention Rates – Number of Approved Outpatient Services by Ethnicity – FY 08-09

Ethnicity	Number of Services													
	1		2		3		4		5-15		16 or More		Totals	
	No of Consumers	%	No of Consumers	%	No of Consumers	%	No of Consumers	%	No of Consumers	%	No of Consumers	%	No of Consumers	%
White	3,618	20.92%	1,821	19.75%	1,505	20.22%	1,374	21.23%	9,877	20.63%	13,241	18.16%	31,436	19.50%
African American	4,375	25.29%	2,384	25.85%	1,988	26.71%	1,752	27.07%	12,209	25.50%	16,407	22.51%	39,115	24.26%
Latino	7,835	45.30%	4,280	46.41%	3,329	44.72%	2,803	43.32%	20,931	43.72%	36,744	50.40%	75,922	47.10%
American Indian	92	0.53%	46	0.50%	47	0.63%	37	0.57%	232	0.48%	428	0.59%	882	0.55%
Asian	538	3.11%	288	3.12%	241	3.24%	210	3.25%	2,042	4.27%	3,402	4.67%	6,721	4.17%
Other	838	4.85%	403	4.37%	334	4.49%	295	4.56%	2,581	5.39%	2,679	3.67%	7,130	4.42%
Total	17,296	100.00%	9,222	100.00%	7,444	100.00%	6,471	100.00%	47,872	100.00%	72,901	100.00%	161,206	100.00%

Table 10 shows Percent Change in 16 or More Services between FY 06-07 to FY 08-09 by Ethnicity for Retention Rates of Approved Outpatient Services. This data further evidences generally higher Retention Rates over time for the Latino population.

Table 10: Percent Change in 16 or More Services between FY 06-07 to FY 08-09 by Ethnicity for Retention Rates of Approved Outpatient Services

	Number of Services 06-07	Number of Services 07-08		Number of Services 08-09	
Ethnicity	16 or More	16 or More		16 or More	
	No of Consumers/ Percent	No of Consumers/ Percent	06-07 to 07-08 % Change 16+Services	No of Consumers/ Percent	07-08 to 08-09 % Change 16+Services
White	11,477 19.36%	12,532 19.00%	-.36%	13,241 18.16%	-.84%
African American	14,107 23.79%	14,970 22.69%	-1.1%	16,407 22.51%	-.18%
Latino	27,728 46.77%	32,013 48.52%	+1.75%	36,744 50.40%	+1.88%
American Indian	370 0.62%	407 0.62%	0%	428 0.59%	-.03%
Asian	2,679 4.52%	3,112 4.72%	+2%	3,402 4.67%	-.05%
Other	2,930 4.94%	2,939 4.45%	-.48%	2,679 3.67%	-.79%
Total	59,291 100.00%	65,973 100.00%	+.01%	72,901 100.00%	-.01%

Goal #2

Complete the 2008 Cultural Competency Organizational Assessment to compare with the findings of the previous Organizational Assessments.

EVALUATION

LAC-DMH achieved this goal.

The Cultural Competency Unit administered the Cultural Competency Organizational Assessment instrument in 2003, 2005, and 2008. The data for the 2008 administration of the instrument is currently undergoing further in depth analyses. Neutral responses are being factored out and “data drilling” is occurring to establish the strength of significant favorable and unfavorable responses. The resulting findings will be used by the LAC-DMH EMT to determine and prioritize next steps and future quality improvement activities.

Goal #3

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

EVALUATION

LAC-DMH achieved this Goal

LAC-DMH originally implemented two (2) Interpreter Trainings, consistent with the recommendations of the Latino Access Study, which was completed previously in 2008. These courses were also developed to provide Continuing Education Units. Additionally, the Department offers numerous other Cultural Competency Courses, Conferences and Workshops. The Training Division in collaboration with the Cultural Competency Unit and Workforce Education and Training (WET) staff evolved the initial two (2) courses into the Interpreter Training Program by the addition of new course upgrades for increased practicum interaction between course participants and instructor lead panels and for the inclusion of DSM IV Culture-Bound Syndromes. The two (2) new courses: 1. *Language Interpreting In Mental Health Settings*, and 2. *Improving Access – Removing Language Barriers*, replace the original two basic Interpreters training courses. The Training Division staff, Workforce Education and Training staff and Cultural Competency Unit staff continue to assess and enhance the Interpreter Training Program with curriculum upgrades consistent with best practices.

During 2009, the following Interpreter Training Program courses were offered: February 13 and March 16 - *How to be an Interpreter in a Mental Health Setting*; February 27- *How to Use Interpreter Services*; November 30 – *Language Interpreting in Mental Health Settings*; December 7 and 22 – *Improving Access – Removing Language Barriers*.

Spanish WRAP Trainings -The Spanish WRAP trainings are provided to consumers and family members to support recovery and wellness in Spanish speaking recipients of care.

Policy and Procedure - Policy and Procedure (P&P) No. 202.21, *Language Interpreters* and P&P No. 609.5, *Employee Trainings: Minimum Standards*, specify training requirements for content and frequency as related to cultural competency and cultural diversity.

Certified Interpreters - LAC–DMH has a program that ensures Certified Interpreters are available throughout the system to interpret in approximately thirty (30) different languages. These employees undergo rigorous language testing and are also provided with a bilingual pay bonus for their language proficiencies. The MHP is assessing potential strategies to maximize the use of the certified Interpreters Program throughout the system and especially where needs arise related to service delivery.

II. MONITORING ACCESSIBILITY OF SERVICES EVALUATION OF GOALS FOR 2009

Goal #1

Maintain access to After-Hour care at 73% of PMRT response time of one hour between PMRT acknowledgements of the call to PMRT arrival on the scene.

Numerator: PMRT Response Time of One Hour (60 mins.)

Denominator: PMRT Response Time for all field calls.

EVALUATION

This goal was not achieved

Table 11 shows that the Psychiatric Mobile Response Team (PMRT) after hour response time for CY 2009 is 68%. The goal of maintaining access to after-hours care at 73% for PMRT response time of one hour between PMRT acknowledgements of the call to PMRT arrival on the scene could not be met due to the following reasons:

Reduction in PMRT After-Hour Coverage: Effective August 1, 2009, after hour PMRT coverage was reduced from 9 teams to 3 teams due to the budget crisis. This reduction resulted in delays in response time as demonstrated by the lowest PMRT after hour response times in the month of August 2009, which was 62%. In September 2009, the number of teams was increased to 5 teams and as a result response rates for September 2009, October 2009, and November 2009 increased to 63%, 69% and 66% respectively. This latter response rate continues to be below the goal of 73% due to the large geographical area that must be covered by the 5 PMRT teams, whereas previously there was one team for each of the eight (8) Service Areas. This reduction in staff has resulted in a 5% decrease in the PMRT Response Time of One Hour from 73% in 2008 to 68% in 2009. The MHP continues to monitor this goal and assess crisis services that are effective in preventing acute psychiatric hospitalization.

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

	2005	2006	2007	2008	2009
January	69%	71%	76%	78%	68%
February	74%	69%	71%	75%	69%
March	73%	70%	72%	74%	64%
April	74%	74%	74%	76%	68%
May	73%	74%	75%	71%	72%
June	74%	70%	75%	71%	72%
July	74%	67%	72%	71%	72%
August	70%	63%	75%	73%	62%
September	71%	67%	73%	72%	63%
October	70%	68%	71%	71%	69%
November	66%	64%	77%	70%	66%
December	68%	66%	73%	72%	66%
Annual Average %	71%	69%	74%	73%	68%

Goal #2

Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) to an overall annual rate of 13%.

EVALUATION

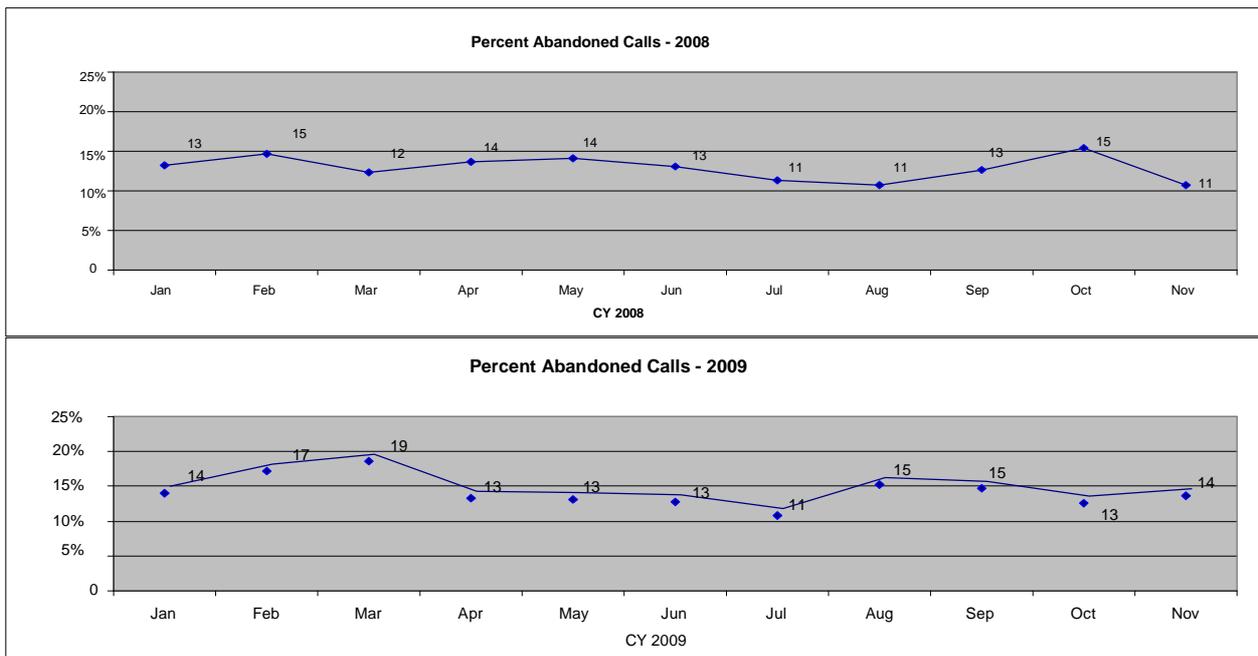
This goal was achieved

Table 12 shows that the rate of abandoned calls for CY 2009 is 12.5%. During CY 2009, the ACCESS Toll Free Line responded to a total of 283,098 calls as compared to CY 2008, which had 188,397 calls.

The Access Center achieved this goal in the face of numerous challenges. The current telephone system and staffing patterns are planned to manage routine call patterns. During the past year, a number of anomalies occurred in the call patterns experienced including unusual spikes in the volume of calls received. Examples of the conditions that attributed to the spikes in call volume included: loss of jobs, home foreclosures, high profile sentinel events with media involvement, and an unexplainable significant spike in Non-English calls, especially calls in Spanish (See Table 13), that almost tripled (from 1,585 in 2008 to 4,647 in 2009). The MHP plans to further assess the data for accuracy and determine the reasons for these significant increases. More importantly, the MHP will assess ways in which these increases can be best managed.

Table 12: ABANDONED CALLS BY NUMBER AND PERCENT FOR CY 2008-2009

Month	2008			2009		
	Total Calls	Number Abandoned	Percent Abandoned	Total Calls	Number Abandoned	Percent Abandoned
January	22,428	2,962	13%	24345	3399	14%
February	23,549	3,470	15%	24387	4208	17%
March	22,304	2,763	12%	27025	5016	13%
April	24,119	3,286	14%	24757	3304	13%
May	23,359	3,302	14%	23344	3064	13%
June	23,003	3,015	13%	23135	2941	13%
July	22,532	2,551	11%	22814	2451	11%
August	22,002	2,366	11%	22103	3383	15%
September	22,606	2,855	13%	23104	3405	15%
October	27,029	4,183	15%	24531	3074	13%
November	21,648	2,332	11%	22964	3133	14%
December	20,472	2,316	9%	20,589	2,729	13%
Totals/Annual Average %	188,397	33,035	12.6 %	283,098	40,107	12.5%



The data in Table 13 shows that Non-English calls more than doubled between CY 2008 and CY 2009. The languages that had the greatest increase include: Spanish, Cantonese, Mandarin and Korean.

**Table 13: Language of Calls Received (Other than English)
CY 2007 thru CY 2009**

Language	2007	2008	2009
AMHARIC	2	0	4
ARABIC	0	4	5
ARMENIAN	13	24	29
BENGALI	3	0	0
CAMBODIAN	5	4	6
CANTONESE	14	27	46
FARSI	18	11	19
FRENCH	1	0	0
GERMAN	3	0	0
HEBREW	0	0	1
HINDI	2	0	5
HUNGARIAN	1	0	0
JAPANESE	13	5	0
KOREAN	53	63	75
LAOTIAN	0	1	0
MANDARIN	18	26	37
OROMO	0	0	2
POLISH	0	5	3
PORTUGUESE	0	2	1
PUNJABI	1	0	2
ROMANIAN	0	4	0
RUSSIAN	11	12	5
SPANISH	739	1585	4647
SPANISH ACCESS CTR	2276	2156	3802
TAGALOG	42	39	34
THAI	5	2	0
TURKISH	0	0	2
URDU	0	1	1
VIETNAMESE	29	12	29
TOTAL	3,249	3,983	8,761

Note: The table shows data for non-English Calls received.

Goal #3

Maintain the overall rate of 84% of consumers/families reporting that they are able to receive services at convenient locations.

Goal # 4

Maintain the overall rate of 87% of consumer/families reporting that they are able to receive services at convenient times.

The LAC-DMH continues to improve on the overall rate of consumers/families that are able to receive services at convenient locations/times (State County Performance Outcomes).

Numerator: Number of surveys completed with positive responses for that question during the survey period (and averages).

Denominator: Number of surveys completed by consumers/families during the survey period.

EVALUATION

This goal was achieved.

Table 14 shows the percent totals for the CY 2008 and CY 2009 survey question for: “The Location of Services was Convenient”. Table 15 shows the percent totals for the CY 2008 and CY 2009 survey question, “Services were Available at Times that were Good for Me/Us”. There is an increase in satisfaction for “Convenient Location” across all age groups (Table 14), however, for “Convenient Times”, the YSS shows a significant decrease of 12% (Table 15). The MHP is further analyzing this data to determine the accuracy of the data and potential explanations for this decrease.

Table 14: The Location of Services was Convenient (parking, public transportation, distance, etc.) by Age Group

Age Group	Percent Strongly Agree/Agree	
	CY 2008	May 2009
YSS-F	91.9%	93.4%
YSS	80.6%	82.9%
Adult	82.9%	84.7%
Older Adult	86.7%	90.0%
All Age Groups	85.5%	87.8%

Source: Annual Performance Outcomes Summary Report CY 2008 and GIS Data Unit 2009

Table 15: Services were Available at Times that were Convenient by Age Group

Age Group	Percent Strongly Agree/Agree	
	CY 2008	May 2009
YSS-F	79.8%	94.0%
YSS	93.6%	81.8%
Adult	88.6%	89.7%
Older Adult	91.8%	93.4%
All Age Groups	89%	89.7%

Source: Annual Performance Outcomes Summary Report CY 2008 and GIS Data Unit 2009

The CY 2008 Survey results are an average of the May and November 2008 survey results and establish the annual aggregate baseline for CY 2008. In CY 2009, the State DMH, in response to requests for improved sampling methodology for the Consumer and Family Perception Satisfaction Surveys, revised the survey period from twice a year to once a year (May 2009).

III. MONITORING BENEFICIARY SATISFACTION EVALUATION OF GOALS FOR 2009

The LAC-DMH QI Work Plan Beneficiary Satisfaction goals and activities are related to two components. The first component is completed in collaboration with the State DMH, POQI Unit, to obtain consumers/families perception of satisfaction. The second component is completed in collaboration with the LAC-DMH Patients' Rights Office for Beneficiary Complaints, Grievances, and Appeals as well as for Change of Provider Requests.

The LAC-DMH participates in the Statewide Performance Outcomes Project. In 2009, the State DMH revised their survey data collection requirements from two (2) times a year to once a year, consistent with the federal requirements for the Federal Block Grant for Mental Health Services. In May 2009, the LAC-DMH submitted more than 23,000 surveys. The results from the surveys are also used to assist LAC-DMH Service Areas initiate activities and projects to improve the quality of services to the recipients of services.

The LAC-DMH QI Work Plan for the 2010 level of participation goal is being re-assessed in view of the State's revised requirement for survey administration from two (2) times a year to once a year. This will provide the State DMH the opportunity to focus on improving the reliability and accuracy (completeness) of the data obtained by designing random sampling methods for the counties to implement, consistent with the new State DMH requirements, which are to be initiated in May 2010. In CY 2008, LAC-DMH submitted approximately 40,000 surveys. In May 2009, with only one survey administration required, more than half the number of surveys were submitted as the previous year.

Numerator: Number of surveys completed by consumers/families served during the survey period.

Denominator: Number of consumers/families served in the survey period.

Goal #1

Maintain current level of consumer/family participation in the statewide Performance Outcomes Survey and determine ways to improve sampling methodology.

EVALUATION

This goal was achieved.

Table 16 shows that LAC-DMH participated in the California Performance Outcomes for May 2009. A total of 23,312 Performance Outcome surveys were received for CY 2009. Table 16 shows Surveys Received from CY 2006 to CY 2009.

Table 16: Surveys Received by Age Group CY 2006 to CY 2009

Calendar Year	Adult	Older Adult	YSS	YSS-F	Totals
2006	15,172	1,073	6,475	10,410	33,130
2007	13,117	988	6,327	9,572	30,004
2008	16,696	1,397	8,279	13,595	*39,967
May 2009	8,253	972	5,789	8,298	**23,312

Source: Annual Performance Outcomes Summary Report CY 2008 * Total includes Clinic and Field-Based surveys for May and November 2008. **Total includes Clinic and Field-Based for one survey period, May 2009, per State DMH revised requirements.

Goal #2

Maintain at 88% or more of responding consumers/families reporting that staff were sensitive to their cultural/ethnic background.

The LAC-DMH continues to monitor and improve the QI Work Plan Goal for consumers/families reporting that staff was sensitive to the consumer's cultural/ethnic background.

Numerator: Number of surveys completed with positive responses for that question during the survey period (and averages).

Denominator: Number of surveys completed by consumers/families served during the survey period.

EVALUATION

This goal was achieved.

Table 17 shows an overall positive response rate at 89% for the survey question: "Staff was sensitive to my cultural/ethnic background". Table 17 also shows an increase for all age groups from CY 2008 to May 2009, except for Adults with a slight .6% decrease in May 2009.

Table 17: Staff Were Sensitive to My Cultural/Ethnic Background by Age Group

Age Group	Percent Strongly Agree/Agree	
	CY 2008	May 2009
YSS-F	95.0%	95.5%
YSS	82.9%	84.6%
Adult	85.2%	84.6%
Older Adult	90.5%	91.2%
All Age Groups	88.4%	89.0%

Source: Performance Outcomes Annual Summary Report CY 2008 and GIS Data Unit 200

Goal #3

Maintain at 4.3 (139) the Overall Satisfaction Average Mean Score and initiate year to year trending.

The LAC-DMH continues to monitor and improve the QI Work Plan Goals for the Overall Satisfaction Average Mean Scores and continues to complete data trending for this measure.

Numerator: Number of surveys completed with positive responses for all domains during the survey period (and averages).

Denominator: Number of surveys completed by consumers/ families served during the survey period.

EVALUATION

This goal was partially achieved.

Table 18 below shows the May 2009 Overall Satisfaction Average Mean Score (137.7) by age-group. From CY 2008 to May 2009, the Overall Satisfaction Average Mean Score for all age-groups increased except for Older Adults which slightly decreased from 159.6 to 157.9 (-1.7). In 2010 the QI Work Plan goal for the Overall Satisfaction Average Mean Score value was converted from the previous scoring scale to a scoring scale consistent with the Performance Outcomes Report scale.

Table 18: Comparison of Overall Satisfaction Average Mean Scores by Survey Periods CY 2008 and May 2009.

Age Group	CY 2008	May 2009
Adult	153.6	154.0
Older Adult	159.6	157.9
YSS	116.0	116.8
YSS-F	121.5	122.1
Average Mean	137.6	137.7

Source: Annual Performance Outcomes Summary Report CY 2008, Report Date August 2009

Goal #4

Maintain at 97% consumer/family reporting that written materials are available in their preferred language.

The LAC-DMH continues to monitor and improve the QI Work Plan Goal for consumers/families receiving written materials in their preferred language. Additionally, the LAC-DMH continues to work actively with the State DMH to secure survey translations for all threshold languages.

Numerator: Number of surveys completed with positive responses for that question during the survey period (and averages).

Denominator: Number of surveys completed by consumers/families served during the survey period.

EVALUATION

This goal was partially met.

Surveys were distributed in the seven Threshold Languages of English, Chinese, Spanish, Russian, Hmong, Tagalog, and Vietnamese in May 2009. Table 19 contains the results at (95.1%) for the survey question “Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer?” While the goal of 97% was not fully met, there was an increase from CY 2008 at 94.3% to May 2009 at 95.1%.

Table 19: Percent Responses for “Was Written Information Available To You In The Language You Preferred?”

Age Group	CY 2008		Total	May-09		Total
	Yes	No		Yes	No	
Adult	10,213	595	10,808	3,969	203	4,172
<i>Percent</i>	94.5%	5.5%	100%	95.1%	4.9%	100%
Older Adult	743	40	783	291	22	313
<i>Percent</i>	94.9%	5.1%	100%	93.0%	7.0%	100%
YSS	5,780	510	6,290	2,276	178	2,454
<i>Percent</i>	91.9%	8.1%	100%	92.7%	7.3%	100%
YSS-F	10,251	475	10,726	4,134	148	4,282
<i>Percent</i>	95.6%	4.4%	100%	96.5%	3.5%	100%
Total	26,987	1,620	28,607	10,670	551	11,221
<i>Percent</i>	94.3%	5.7%	100%	95.1%	4.9%	100%

Source: Annual Performance Outcomes Summary Report CY 2008 and GIS Data Unit, 2009

Goal #5

Apply Performance Outcome findings to identify areas for improvement for Service Area QICs for use in Quality improvement activities.

EVALUATION

This goal was achieved.

The LAC-DMH continues to monitor and improve on methods to apply the State & County Performance Outcomes findings and to identify areas for improvement for the SA QICs through the implementation of QI Work Plan Status Reports and tracking of selected measures, especially for underserved Latino populations and language services, which were completed in 2009 and are included in the Service Area Provider Directories for 2010.

The results of the State Performance Outcomes are widely distributed in Los Angeles County including the Service Area QICs. The Service Area selects data and information as relevant to their service delivery system for Quality Improvement Projects. Additionally, consistent with CAEQRO recommendations and the development of the Service Area Provider

Directories, the MHP is expanding Service Area use of Performance Outcomes Findings to address: language services needs and translating forms; improved penetration/retention rates for Latinos and Asians; and “No Shows” (See QI Work Plan 2010).

Goal #6

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

EVALUATION

This goal was achieved

The Department responds effectively and timely to consumer grievances, and fair practice hearings. During FY 08-09, there was a 50% reduction in Request for State Fair Hearings: 35 in FY 07-08 (Table 20) as compared with 17 in FY 08-09 (Table 21).

In FY 08-09, the Patients’ Rights Office (PRO) reported a drop in beneficiary grievances from 711 last year to 695 this year. Table 21 also indicates a reduction in: Termination of Services, Denial of Services, Change of Provider and Confidentiality. However, there was a slight increase in: Quality of Care, Confidentiality, and Other. LAC-DMH has received and resolved a total of 668 grievances/appeals/SFHs, including 27 cases that were referred out to the appropriate agency or jurisdiction, on a timely basis.

Table 20: Disposition of Beneficiary Grievance: FY 07- 08

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

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

Table 21: Disposition of Beneficiary Grievance: FY 08- 09

CATEGORY	NUMBER BY CATEGORY	CATEGORIES					DISPOSITION		
		Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited State Fair Hearing	Referred Out	Resolved	Still Pending
ACCESS	7	6	1	0	0	0	0	7	0
Termination of Services	8	5	3	0	0	0	0	8	0
DENIED SERVICES (NOA-A Assessment)	8	2	0	0	6	0	0	8	0
CHANGE OF PROVIDER	13	13		0	0	0	0	13	0
QUALITY OF CARE:	502	493	2	0	7	0	7	495	0
CONFIDENTIALITY	18	18		0	0	0	7	11	0
OTHER:	139	135		0	4	0	13	126	0
TOTALS	695	672	6	0	17	0	27	668	0

Source: Date of Report/October 23, 2009, Prepared by: Ebony Loot -Department of Mental Health - Patient's Right's Office

Goal #7

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

EVALUATION

This goal was achieved

The Patients' Rights Office (PRO) is responsible for collecting the Request to Change Provider Logs submitted by directly-operated and contracted providers in LAC-DMH.

The number of providers reporting *Beneficiary Change of Provider Requests* improved from 150 in FY 07-08 to 227 in FY 08-09. The total number of Change of Provider Requests in FY 08-09 were 427 as compared with 388 in FY 07-08 with 13 or 3% resulting in a formal grievance.

The Change of Provider Requests was analyzed based on the categories and information from the providers. Additionally categories were developed to capture consumer needs in the following areas: *Culture; Time/Schedule; Service Concerns (treating family member, treatment concerns, medication concerns, lack of assistance); 2nd Opinion Request; Other; No Reason Provided.*

The Change of Provider Request reasons by rank order were as follows:

Personal Experience/Perception.....	24.8%
Service Concerns.....	24.22%
Other.....	17.97%
No Reason Provided.....	13.67%
Culture.....	12.89%
Time/Schedule.....	5.66%
2 nd Opinion Requested.....	0.78%

The Quality Improvement Division prepared Quality Improvement Status Reports (09.III.7-1 and 09-III.6-2, see Appendix), which were presented to the Departmental QIC on November 9, 2009, and recommended Policy Changes occurred.

IV. MONITORING CLINICAL CARE

Goal #1

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

EVALUATION

LAC-DMH achieved this goal.

The LAC-DMH, Office of the Medical Director (OMD) completed the Clinical Peer Review Report, Dated September 22, 2009, as a summary of the clinical peer review of psychiatrist's practice (March-May2009) related to the use of lower than recommended dosages of Quetiapine. The implemented recommendations included: Ongoing emphasis on the importance of documentation in the clinical record for both quality and risk management and increased access to both training and tools for both clinicians and consumers. This report is part of the OMD quality improvement activities and includes presentations, discussions, and distribution that include Service Area Quality Improvement Committees in the sharing of pertinent information.

The LAC-DMH has defined Clinical Documentation Core Competencies which also include pertinent training for Medication Support Services, Co-Occurring Disorders, and Specialty areas such Specialized Foster Care. The Quality Improvement Division also prepares Quality Improvement Work Plan Status Reports related to these activities (See Quality Improvement Work Plan Status Reports for: Medication Support Services and Co-Occurring Disorders) and collaborates with the Training Division for the integration of the core competencies into the new employee training program and courses for existing staff.

LAC-DMH monitored and tracked the May 2009 survey responses from the YSS-F and the YSS Tables (22 to 27). The following Tables illustrate the results for the survey questions that address health care and/or medication management protocols.

Tables 22 and 23 show some disparity with families reporting that "In the last year, did your child see a medical doctor or nurse for a health check up when sick?" at 63.9% for "seen at a clinic" as compared with the youth responding to the same question at 51.9%. This discrepancy may be related to families taking younger children to clinics as compared with older youth taken to clinics or perhaps youth are going to the clinics by themselves. Simultaneously, families responded to the same question at 4.9% for "seen at an Emergency Room," while youth responded to the same question at 9.0% for "seen at an Emergency Room." This appears to indicate that youth may be requiring more Emergency Room care with crisis conditions as compared with younger children.

Tables 24 and 25 show that for May 2009, youth reported that they are, “on medication for behavioral/emotional problems” at 35.3% for “Yes” and their families responded to the same question at a slightly lower 34.9% for “Yes.”

Tables 26 and 27 show that the disparity between youth reporting “did the doctor or nurse tell you of medication side effects to watch for” at 58.6% for “Yes” and their families responding to the same question at a much higher 70.2% for “Yes”, remain statistically the same from last year.

Table 22: Percent Responses for “In the last year, did your child see a medical doctor or nurse for a health check-up or because he/she was sick?” YSS-F

Table 22		MAY 2009				
Service Area	Clinic	Emergency Room	No	Don't Remember	No Response	Total
SA 1	445 62.4%	36 5.0%	127 17.8%	10 1.4%	95 13.3%	713 100.0%
SA 2	637 60.4%	54 5.1%	168 15.9%	26 2.5%	169 16.0%	1,054 100.0%
SA 3	104 56.5%	10 5.4%	42 22.8%	6 3.3%	22 12.0%	184 100.0%
SA 4	354 55.1%	32 5.0%	127 19.8%	20 3.1%	110 17.1%	643 100.0%
SA 5	214 59.0%	13 3.6%	70 19.3%	3 0.8%	63 17.4%	363 100.0%
SA 6	543 62.2%	38 4.4%	151 17.3%	35 4.0%	106 12.1%	873 100.0%
SA 7	326 65.2%	28 5.6%	86 17.2%	16 3.2%	44 8.8%	500 100.0%
SA 8	592 61.5%	50 5.2%	134 13.9%	27 2.8%	159 16.5%	962 100.0%
Percent within Service Area	3,215 60.8%	261 4.9%	905 17.1%	143 2.7%	768 14.5%	5,292 100.0%

Source: Annual Performance Outcomes Summary Report CY 2008 and GIS Data Unit 2009

Table 23: Percent Responses for “In the last year, did your child see a medical doctor or nurse for a health check-up or because he/she was sick?”-YSS

Table 23		MAY 2009				
Service Area	Clinic	Emergency Room	No	Don't Remember	No Response	Total
SA 1	197 50.9%	48 12.4%	49 12.7%	59 15.2%	34 8.8%	387 100.0%
SA 2	379 45.5%	84 10.1%	88 10.6%	120 14.4%	162 19.4%	833 100.0%
SA 3	119 57.8%	14 6.8%	24 11.7%	22 10.7%	27 13.1%	206 100.0%
SA 4	185 49.7%	37 9.9%	65 17.5%	42 11.3%	43 11.6%	372 100.0%
SA 5	108 47.0%	17 7.4%	36 15.7%	39 17.0%	30 13.0%	230 100.0%
SA 6	177 49.0%	19 5.3%	53 14.7%	56 15.5%	56 15.5%	361 100.0%
SA 7	124 52.8%	20 8.5%	30 12.8%	36 15.3%	25 10.6%	235 100.0%
SA 8	314 47.4%	57 8.6%	77 11.6%	114 17.2%	101 15.2%	663 100.0%
Percent within Service Area	1,603 48.8%	296 9.0%	422 12.8%	488 14.8%	478 14.5%	3,287 100.0%

Source: Annual Performance Outcomes Summary Report CY 2008 and GIS Data Unit 2009

Table 24 and 25: Percent Responses for “Is your child on medication for emotional / behavioral problems?”

Table 24 YSS-F Service Area	CY 2009			
	Yes	No	Unknown	Total
SA 1	317 44.5%	290 40.7%	106 14.9%	713 100.0%
SA 2	360 34.2%	489 46.4%	205 19.4%	1054 100.0%
SA 3	68 37.0%	93 50.5%	23 12.5%	184 100.0%
SA 4	152 23.6%	343 53.3%	148 23.0%	643 100.0%
SA 5	131 36.1%	163 44.9%	69 19.0%	363 100.0%
SA 6	285 32.6%	437 50.1%	151 17.3%	873 100.0%
SA 7	182 36.4%	257 51.4%	61 12.2%	500 100.0%
SA 8	350 36.4%	418 43.5%	194 20.2%	962 100.0%
Total	1,845	2,490	957	5,292
Percent	34.9%	47.1%	18.1%	100.0%

Table 25 YSS Service Area	CY 2009			
	Yes	No	Unknown	Total
SA 1	165 42.6%	170 43.9%	52 13.4%	387 100.0%
SA 2	281 33.7%	374 44.9%	178 21.4%	833 100.0%
SA 3	113 54.9%	69 33.5%	24 11.7%	206 100.0%
SA 4	84 22.6%	240 64.5%	48 12.9%	372 100.0%
SA 5	89 38.7%	104 45.2%	37 16.1%	230 100.0%
SA 6	113 31.3%	178 49.3%	70 19.4%	361 100.0%
SA 7	91 38.7%	111 47.2%	33 14.0%	235 100.0%
SA 8	223 33.6%	335 50.5%	105 15.8%	663 100.0%
Total	1,159	1,581	547	3,287
Percent	35.3%	48.1%	16.6%	100.0%

Source: Annual Performance Outcomes Summary Report CY 2008 and GIS Data Unit 2009

Table 26 and 27: YSS-F – Percent Responses for: “Did the doctor or nurse tell you and/or your child about medication side effects to watch for?”

Table 26 YSS-F	CY 2009		
Service Area	Yes	No	Total
SA 1	247 84.6%	45 15.4%	292 100.0%
SA 2	313 71.0%	128 29.0%	441 100.0%
SA 3	60 64.5%	33 35.5%	93 100.0%
SA 4	134 49.3%	138 50.7%	272 100.0%
SA 5	114 87.0%	17 13.0%	131 100.0%
SA 6	229 64.7%	125 35.3%	354 100.0%
SA 7	154 68.4%	71 31.6%	225 100.0%
SA 8	278 75.3%	91 24.7%	369 100.0%
Total	1,529	648	2,177
Percent	70.2%	29.8%	100.0%

Table 27 YSS	CY 2009		
Service Area	Yes	No	Total
SA 1	111 58.4%	79 41.6%	190 100.0%
SA 2	219 58.7%	154 41.3%	373 100.0%
SA 3	78 60.5%	51 39.5%	129 100.0%
SA 4	66 42.0%	91 58.0%	157 100.0%
SA 5	73 69.5%	32 30.5%	105 100.0%
SA 6	91 57.6%	67 42.4%	158 100.0%
SA 7	81 71.1%	33 28.9%	114 100.0%
SA 8	180 58.4%	128 41.6%	308 100.0%
Total	899	635	1,534
Percent	58.6%	41.4%	100.0%

Source: Annual Performance Outcomes Summary Report CY 2008 and GIS Data Unit 2009

V. MONITORING CONTINUITY OF CARE

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

Goal #1

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

Goal #2

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

EVALUATION

These goals are part of a multi-year process and performance Improvement Projects (PIP) members continue to meet and perform activities consistent with the PIP Road Maps.

Goal #1: A Re-Hospitalization (Cohort 2) Performance Improvement Project (RC2 PIP) has been developed by LAC-DMH, including the assembly of a Multi-Functional Team, to specifically address high utilization patterns, coordination of care issues, and other barriers to timely access, as identified in the data reviewed for the study group. This RC2 PIP serves to initiate appropriate quality improvement interventions directed at identified factors contributing to the problem of re-hospitalizations. This also includes participation in PIP statewide teleconferences, technical assistance, and consultation available throughout the life of this PIP. This PIP is a multi-year process of continuous quality improvement with on-going data collection and reporting. The interventions explored include: Report Cards to Providers and managers and a Peer Bridgers Program to assist hospitalized adult consumers. (See Roadmap attached)

Goal #2: The criterion was selected consistent with the measure: *“timely access for Residential treatment/Institutional post-discharge care”*, with the overall goals of: improved quality of life, productive tenure in the community in least restrictive settings, and improved service provision. Likewise, the systems capacity to capture relevant data for this measure exists through the IS data system. This measure has been deferred and the EPSDT PIP has taken its place as a top priority for the Department. The EPSDT PIP team continues to meet and is exploring suitable and feasible interventions.

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

Goal #1

Continue monitoring the rate of zero appeals through CY 2009.

EVALUATION

LAC-DMH achieved this goal.

LAC-DMH has successfully controlled the level of provider appeals. Contractors have filed fewer appeals for Day Treatment and TBS authorization over the past four calendar years, from a total of 2 in 2006, 3 in 2007 and zero in 2008 and 2009. No network provider had filed an appeal of LAC-DMH psychological testing. As providers gain knowledge and skills in the authorization process including correct documentation and billing activities, the number of appeals has significantly decreased. Table 28 summarizes the levels and disposition of appeals during a four year period.

Table 28: First and Second Level Provider Appeals

Level	Day Treatment	TBS Authorization	Network	Total Appeals
2006				
First Level	1	1	0	2
Second	0	0	0	0
2007				
First Level	1	2	0	3
Second	0	0	0	0
2008				
First Level	0	0	0	0
Second	0	0	0	0
2009				
First Level	0	0	0	0
Second	0	0	0	0
Totals	2	3	0	5

SUMMARY OF PLANNED GOALS AND ACTIVITIES FOR 2010

The LAC-DMH QI Work Plan Goals for 2010 and the selected Performance Outcomes pertain to the system as a whole and are inclusive of directly operated and contracted providers. The LAC-DMH QI Work Plan goals and activities are evaluated annually and began more than five (5) years ago, consistent with the agreements with State DMH to prepare the findings on a Calendar Year (CY). The Evaluation of the QI Work Plan Goals for 2009, served as a foundation for setting the QI Work Plan Goals for 2010. In CY 2008, the LAC-DMH also completed the initial baseline data for State & Countywide Performance Outcomes for Clinic-Based and Field-Based services using the consumer and family perception of satisfaction surveys issued by the State DMH. The LAC-DMH has used the resulting baseline data and trending data to identify areas for improvement. The LAC-DMH State & County Performance Outcomes include Post-Hospitalization Outpatient Access measures and a corresponding Performance Improvement Project (RC2 PIP). The LAC-DMH is also participating in the EPSDT PIP for improved services to children and adolescents. Lastly, in CY 2009, the LAC-DMH instituted QI Work Plan Status Reports on goals and activities, which are routinely, provided to the Service Area (SA) Quality Improvement Committees for their use via the QIC processes.

LAC – DMH QUALITY IMPROVEMENT WORK PLAN GOALS FOR 2010

<p>I. MONITORING SERVICE DELIVERY CAPACITY</p> <ol style="list-style-type: none"> 1. Utilize data to set percentage of improvement in penetration and retention rates for underserved Latino and Asian/Pacific Islander populations. <ol style="list-style-type: none"> a. Increase Latino penetration rates by 1.3%; from 21.5% in FY 08-09 to 22.8% in FY 09-10. b. Increase Asian/Pacific Islander penetration rates by 1.5%; from 10.3% in FY 08-09 to 11.8% in FY 09-10. c. Increase Latino retention rates by 1.5%; from 50.4% in FY 08-09 to 51.9% in FY 09-10 for 16 or more services and from 43.7% in FY 08-09 to 45.2% in FY 09-10 for 5 to 15 services. d. Increase Asian/Pacific Islander retention rates by 1.5% from 4.17% in FY 08-09 to 5.67% in FY 09-10 for 16 or more services and from 4.27% to 5.77 for 5 to 15 services. 2. The Cultural Competency Unit, in collaboration with the Cultural Competency Subcommittee and the Quality Improvement Council, will identify and select LAC-DMH forms for translation into the threshold languages following approval by the Executive Management Team by the end of CY 2010. 3. By April 2010, the 2008 Cultural Competency Organizational Assessment will be further developed by factoring out neutral responses to establish the strength of favorable and unfavorable responses in order for EMT to determine action steps. 4. Interpreter Training Program upgrades to be completed to: a. increase practicum interactions between staff and class instructor, b. increase focus on interpreter training for mental health settings and c. include DSM IV Culture-Bound Syndromes. Continue to provide a minimum of six (6) Interpreter Training Courses during the year. 5. Completion of the Cultural Competency Plan with date of completion to be established once the new guidelines become available from the State Department of Mental Health.
<p>II. MONITORING ACCESSIBILITY OF SERVICES</p> <ol style="list-style-type: none"> 1. Re-Adjust access to after-hours care at 68% of PMRT response time of one hour between PMRT acknowledgements of the call to PMRT arrival on the scene and continue year to year trending (significant system changes justify this goal adjustment – see evaluation report for this goal adjustment – see new system for inpatient admissions and use of. 2. Re-Adjust the rate of abandoned calls (responsiveness of the 24-hour toll free number) to an overall annual rate from 13% to 14% (significant system changes justify this goal adjustment –see evaluation report for sharp (more than double) increase in non-English calls over last 12 month period.) 3. Increase the overall rate by 4% from 84% in CY 2009 to 88% in CY 2010 for consumers/families reporting that they are able to receive services at convenient locations and continue year to year trending. [Source: Performance Outcomes]. 4. Increase the overall rate by 3% from 87% in CY 2009 to 90% in CY 2010 for consumer/families reporting that they are able to receive services at convenient times and continue year to year trending. [Source: Performance Outcomes].
<p>III. MONITORING BENEFICIARY SATISFACTION</p> <ol style="list-style-type: none"> 1. Participate with CDMH new survey methodology (once a year) for the Statewide Performance Outcomes, determine improved survey sampling methodology, and continue year to year trending. 2. Increase by 1% from 89% in CY 2009 to 90% in CY 2010 consumers/families reporting that staff was sensitive to cultural/ethnic background [Source: Performance Outcomes]. 3. Increase by 1% from 137.7 in CY 2009 to 139.1 in CY 2010 for the Overall Satisfaction Average Mean Score and initiate year to year trending. [Source: Performance Outcomes] 4. Maintain at 97% consumers/families reporting that written materials are available in their preferred language and continue year to year trending. 5. Apply Performance Outcomes findings to identify areas for improvement for Service Area QICs for use in quality improvement activities, especially to support capacity, access, language services, and application of Service Area Directories. 6. Monitor and improve beneficiary grievances, appeals and State Fair Hearings processes including instituting new electronic system and annual reporting for policy changes. 7. Monitor and improve responsiveness to Beneficiary Change of Provider Requests. Monitor reports on the reasons given by consumers for their change of provider request and integrate measures into new electronic system.
<p>IV. MONITORING CLINICAL CARE</p> <ol style="list-style-type: none"> 1. Continue to improve medication practices through systematic use of medication protocols and trainings for the use of medication forms and clinical documentation for existing staff and for new staff. 2. Conduct EPSDT Performance Improvement Project (PIP) to ensure that each consumer receives services that are appropriate, effective and efficient.
<p>V. MONITORING CONTINUITY OF CARE</p> <p>Utilize Performance Outcome measures to monitor continuity of care in 2 areas:</p> <ol style="list-style-type: none"> 1. Consumers receiving continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital (Post Hospitalization Outpatient Access – PHOA) and conduct RC2 PIP in collaboration with APS/EQRO and Statewide consultants. 2. Conduct pilot project for timeliness of appointments as related to tracking and assessing “no shows”.
<p>VI. MONITORING OF PROVIDER APPEALS</p> <ol style="list-style-type: none"> 1. Continue monitoring the rate of zero appeals through CY 2010.