**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH**

**PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

**CULTURAL COMPETENCY UNIT**

# CULTURAL COMPETENCE PLAN UPDATE – CY 2016

## Criterion 8

## Adaptation of Services

**February 2017**

## Criterion 8: Adaptation of Services

### I. Client-driven/operated recovery and wellness programs

LACDMH has been invested in providing wellness services that are recovery focused and rich in peer support with minimal mental health services. Developed with stakeholder inputs, these wellness services are the results of efforts to transform our outpatient system of care. Originally implemented in 2006, the wellness services went through a comprehensive review and subsequently a new service exhibit was created in 2014. The purpose of the new service exhibit was to expand the target population to include a broader spectrum of recovery levels and age groups, cultural diversity, greater peer support and peer roles in wellness centers, employment and education services, housing support services and care integration.

- **Wellness Centers**

  Our Wellness Centers offer a broad array of culturally congruent and recovery oriented outpatient mental health services, which are designed to support the individual recovery of our consumers. Wellness Centers are programs staffed by at least 51% consumer staff who provide an array of mental health and supportive services to clients at higher levels of recovery. Services include medication support, linkage to physical health and substance use services, self-help and a variety of peer-supported services, including crisis and self-management skill development.

  The services and activities offered at the wellness centers are developed based on consumer specific care plans that address the individualized needs and goals of each consumer seeking services. Wellness Centers emphasize activities that are geared toward helping individual consumers maintain wellness by enhancing cultural sensitivity, recovery, ensuring healthy living, and fostering community integration.

  Wellness Centers are designed to provide culturally competent, recovery oriented outpatient mental health services for adults 18 years of age or older, who live in the community or in identified Health Neighborhoods. Participants of Wellness Centers are those who can benefit from recovery oriented outpatient services. Individuals in need of intensive mental health services will be better served in higher levels of care, such as Full Service Partnerships (FSP) or Field Capable Clinical Services Programs (FCCS). Individuals seeking services at Wellness Centers are assessed to determine appropriateness of this level of care. Services are delivered by professional and paraprofessional staff who have the cultural and linguistic backgrounds to meet the needs of their consumers. Service providers at wellness centers understand and utilize the strengths of culture in service delivery, and the preferred languages and cultures of their consumers into the services in order to achieve the most effective outcomes.

  Wellness Centers will provide the following services:
  - Biopsychosocial/spiritual assessment
  - Mental health services, inclusive of psychotherapy, mental health rehabilitation, individual and group clinical mental health services and crisis services

- Medication support services inclusive of physical health screenings and referrals as needed
- Case management, which include linkage and coordination where there are specialized services such as substance abuse, physical health, financial assistance, alternative treatment options, or other community resources needed to support recovery
- Mental health recovery education that includes the provision of information regarding mental illness, the recovery model, and services available to support each consumer's path to recovery
- Physical health care access which includes referrals to and assistance for the consumer to access physical health care for insured and uninsured consumers
- Continuity and coordination of care to include the coordination of services needed with the appropriate providers in order to ensure the continuity of care in support of the consumer's wellness and recovery
- Healthy living services, inclusive of healthy leaving educational groups and self-help activities
- Peer support services [self-help groups and one on one support], which are provided by individuals with lived experience in mental health
- Self-help and peer support groups for consumers, and family members/caregivers/conservatory to self-help supports
- Housing support services, which are designed to support in finding and maintaining consumer housing in the community and independent living.
- Education and support services, which supports consumers interested in pursuing an achieving educational goals
- Employment services that focus on support and preparation of consumers for preemployment, competitive employment, and career development assessment
- Volunteer services to assist interesting consumers in identifying and securing volunteer positions
- Services to address co-occurring disorders for consumers assessed as having a co-occurring substance use disorder
- Family/caregiver/significant other support in the form of recovery oriented education, referrals to family self-help groups and advocacy services in the community
- Older Adult services, which meet the unique and diverse care needs of older adults, ages 60 and above who are receiving services at Wellness Centers
- Transition Age Youth (TAY) services target the unique and diverse needs of participating transition age youth in wellness centers
- Mechanism for consumer and community feedback, which may take different forms such as consumer advisory boards, QWERTY forums, feedback surveys
- Benefit establishment and services to the uninsured, these services are often provided as referrals to providers that can assess the consumer's financial status, identification of benefits for which they may be eligible, and assistance in the pursuit of these benefits until they are established
- Culturally sensitive community engagement and education, which involves providing presentations and information on the Wellness Center services to a diverse consumers and community agencies

- Interagency collaboration formal and informal relationships with community agencies and resources that also serve Wellness Center consumers and share accountability for achieving the recovery goals and outcomes
- Community partnerships between the Wellness Centers and community-based organizations to form service collaboratives

Additionally, Wellness Centers also provide wellness adjuncts services, which are defined as a level of care within the wellness program, and are designed to continue the support of consumers who have moved along the recovery continuum, and who need minimal support to successfully integrate into the community. These adjunct services are focused on community integration. At a minimum, the services include: medication support [e.g. assessment, provision of prescriptions, and consultation with a collaborative provider as needed], case management, and assessment of mental health needs. Other support services are also made available to consumers at this level of care.

Wellness and ClientRun Contacts.xls

A total of 54,521 unique clients have been served by the Wellness Centers. For FY 16-17, the Wellness Program will remain the largest program serving the adult population. The focus will be on the collaboration and integration of healthcare and substance abuse services. Wellness Programs will continue with the expansion of peer supports with treatment teams in both paid and volunteer roles. A major emphasis will be placed to hire DMH social workers and peers who will use Individual Placement and Support (IPS), an Evidence-Based Practice, to provide employment services to Wellness Centers.

Additionally, the Community Services and Supports (CSS) Program Expansion has provided additional opportunities to increase services to address the needed support for Wellness/Client Run Centers. The Adults System of Care (ASOC) has added several positons and programs through the CSS expansion. A total of 69 new Wellness Housing Retention positions were added countywide, to both Directly-Operated and contracted agencies, with one position designated to each Wellness Program. These housing specialists have provided advocacy and skill building for consumers, who lived in the community with their families, and independent living settings. These housing specialists also provided housing retention support to consumers. There was also the expansion of Peer Support staff, who focused on employment and specific peer support needs.

The CSS expansion also included the hiring of DMH social workers and peers support staff to implement two IPS pilot programs at San Fernando and Rio Hondo Mental Health Centers, in order to provide specialized employment services to Wellness consumers and train Wellness staff in the IPS model. Further, through the CSS

expansion, Wellness will expand the Client Run Centers in Service Areas III and VI, which will result in Client Run Centers in each of the eight Service Areas countywide. This in turn has allowed peer support staff the opportunity to provide increased services to communities and consumers.

According to a sample survey from 13 providers and 2,017 clients, Wellness/Client Run Centers' consumers reported improvement in their daily lives in the following areas:

- 71% usually or sometime did well in work/ school/ preferred activities
- 83% usually or sometime made progress in wellness/ recovery goals
- 16% worked part or full time
- 86% usually or sometime were able to manage symptoms
- 82% usually or sometime felt welcomed and respected by staff
- 72% usually or sometime have opportunities to join social, spiritual, and/ or recreational activities in their lives
- 50% were involved in meaningful activities
- 79% usually or sometime felt satisfied with their role in making decisions about their care
- 73% reported living in their own place (house, apartment, etc.), living with family, or living with roommates

- **Drop-in Centers**
  LACDMH's Drop-In Centers provide temporary safety and basic supports for seriously emotionally disturbed and severely and persistently mentally ill transitional age youth (TAY) who are living on the streets or in unstable living situations. Drop-In Centers provide "low demand, high tolerance" environments in which TAY can make new friends; participate in social activities; and access computers, books, music and games. When the youth are ready, staff persons can connect them to the services and supports they need in order to work toward stability and recovery. Drop-In Center services include the following: showers, meals, clothing, computer and Internet access, DVD and games, social activities, peer support groups, linkage to mental health and case management services, linkage to substance abuse treatment, educational services, employment assistance, and housing assistance, among others.

- **Client-Run Programs**
  Through the MHSA CSS Plan, LACDMH has funded 12 Client-Run Centers, which are designed to be entirely staffed by consumers. These contracted programs provide recovery, wellness, personal care planning and supportive services in a peer model in every Service Area of the County. The Client-Run Programs provide all the same services as the Wellness Centers except for psychiatric services, medication support and prescription management. These sites provide support groups, meeting space and a welcoming environment to hundreds of persons daily.

As community-based programs, Client-Run programs connect to their local communities, thereby creating new opportunities for consumers, providers and family members to challenge stigma and raise awareness of recovery. Although most of these programs operate under broader provider agencies, their innovation and recovery focus has helped foster a growing acceptance of consumer-provided services and supports.

- **The Office of Consumer and Family Affairs (OCFA)**
  The vision of the LACDMH OCFA is "partnering with consumers, families and the community to create hope, wellness and recovery." Representative of the consumer and family member voice, the OCFA sustains that the journey to recovery requires the expertise of consumers, family members, friends, multi-disciplinary teams and community partners. OCFA services include:
    - Advocacy
    - Consumer operated services
    - Family run non-profits collaboration
    - Consumer leadership
    - Solution focused support
    - Hope and Recovery Conferences
    - Trainings
    - Conference sponsorships
    - Quality Improvement

- **Service Extenders**
  Service Extenders are volunteers and members of the Older Adult (OA) Field Capable Clinical (FCCS) Services inter-disciplinary team. They are consumers in recovery, family members, or other individuals interested in working with Older Adults. They receive specialized training to serve as members of the team and are paid a small stipend. Service Extenders receive supervision from professional clinical staff within the program in which they are placed.

  **Achievements for FY 14-15**
  - As of June 2015, there were 28 Service Extenders working in Directly-Operated and Contracted agencies
  - Languages spoken other than English are Spanish, Tagalog, Mandarin, Cantonese, Khmer, Vietnamese, Korean and Farsi
  - Service Extenders continue to meet on a quarterly basis with the Older Adult System of Care (OASOC) Program Head to discuss issues and concerns about their placements in a supportive atmosphere. This meeting also provides an opportunity for the Service Extenders to network and learn from each other. This meeting has a consistent attendance of at least 15 Service Extenders. Examples of topics explored include: Boundaries, cultural competency, working within the FCCS teams, and resources/linkage information

- Two Service Extenders were hired by DMH as full-time employees in the SB 82 Program as Mental Health Advocates
- Five of ten Directly-Operated OA FCCS programs have at least one Service Extender in their teams

For FY 2016-17, LACDMH will develop and implement a Service Extender Academy to train a new group of volunteers as Service Extenders. Additionally, OA FCCS Directly-Operated clinics will be encouraged to hire at least one Service Extender.

## II. Responsiveness of Mental Health Services

- **MHSA Innovation (INN) Programs – Integrated Mobile Health Team (IMHT), Integrated Clinic Model (ICM) and Community-Designed Integrated Service Management Model (ISM)**

  All INN Programs exemplify how LACDMH is committed to the adaptation of services to meet the needs of the culturally and linguistically diverse communities we serve. Each of the INN Programs aimed to identify new and promising practices that could be applied to the integration of mental health, physical health, and substance use services for uninsured, homeless and underrepresented populations.

  The IMHT model was designed as a client-centered, housing-first approach that used harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. IMHT particularly focused on individuals who 1) are homeless or recently moved to Permanent Supportive Housing (PSH) and 2) have additional vulnerabilities related to age, years homeless, co-occurring substance use disorders, and/or physical health conditions.

  The ICM model was designed to improve access to quality culturally competent care for individuals with physical health, mental health, and substance use diagnoses by integrating care within mental health and primary care provider sites.

  The ISM model provided a holistic model of care incorporating components were defined by specific Underserved Cultural Communities (UsCC). The ISM promoted collaboration and community-based partnerships to integrate health, mental health, and substance use services together with alternative, or nontraditional services to support recovery. The ISM model served African/African-American, American Indian/Alaska Native, Asian Pacific Islander, Eastern European/Middle Easterner and Latino communities. The ISM enhances the resources of the formal network of regulatory providers (e.g. mental health, health, substance abuse, child welfare, and other formal service providers) with culturally-specific strategies and values. The culturally-effective services are grounded in ethnic communities with a strong foundation on community-based services, non-traditional healing practices, and natural support systems such as faith-based organizations, homeopathic healers, voluntary associations, recreational providers, and any other community-defined

approach for wellness and recovery (e.g. music studios and community club houses.) ISM providers incorporate these non-traditional healing practices as part of the treatment in response to the cultural needs of the various underserved and underrepresented groups that they serve. Further, Outreach and Engagement strategies are provided by community leaders and community peers as a way to promote mental health services in a culturally relevant manner. In addition, the staffing patterns of all the ISM providers reflect the linguistic and cultural needs of the communities that they serve. These culturally defined and culturally relevant approaches to services have proven to be effective and are slowly contributing to eliminate the stigma related to the use of mental health services by the underserved and underrepresented communities of the County of Los Angeles.

The attachment below contains detailed information on the culture-specific outreach and engagement strategies implemented by the ISM to increase service accessibility for underrepresented populations.

2016 UsCC Projects OEE Summary.xlsx

- **MHSA Innovation - Health Neighborhoods Initiative**

  Approved by LACDMH's Stakeholder Process, the Health Neighborhoods support distinct communities in partnerships that decrease the risk of or reduce the degree of trauma experienced by individuals who have a mental health condition. The vision of the Health Neighborhoods is to improve the outcomes for consumers, families and the communities and to create hope, wellness and recovery. A total of eight strategies have been identified for the successful implementation of health neighborhoods. These strategies are:
  - Community Clubhouse
  - Trauma informed psychoeducation and support for school communities in the Health Neighborhood
  - TAY peer support networks and outreach and engagement to TAY by TAY
  - Coordinated employment within a Health Neighborhood
  - Community integration for individuals with a mental illness with recent incarcerations or who were diverted from the criminal justice system
  - Support networks without walls for older adults at risk of developing mental illness
  - Community-based strategies to support caregivers for older adults with a mental illness
  - Culturally competent nontraditional self-help activities for families with multiple generations experiencing trauma

  Furthermore, the five components of Health Neighborhoods include:
  - A reciprocal interconnectedness between the community's health and well-being, and that of individual community members

- Social determinants of health as a foundation
- Upstream prevention approach
- Partnerships to engage community in service systems
- Collective ownership and coordinated action


cms1_225095.pdf

- **Telemental Health Initiative**
  The Telemental Health and Consultation program is at the forefront of LACDMH's goals of providing culturally and linguistically matched mental health services. Not only do we have the ability to provide much-needed assessment and continuity of care, medication management services of patients who speak Spanish, Farsi and Ethiopian Amharic, but we are also initiating a pilot to decentralize the activities of the TeleHub and have more of our non-English speaking psychiatric workforce involved in delivering linguistically matched care utilizing video teleconferencing strategies.

  The LACDMH Telemental Health Initiative continues to grow in terms of the number of hubs and language capability. The Telemental Health Network allows for Limited English Proficiency (LEP) consumers to receive services from a psychiatrist who speaks their language, and regardless of their geographic location. This initiative also takes into consideration the needs of persons with physical disabilities to make services more accessible. When the Program started, there were approximately 10 sites:
  - Augustus F. Hawkins (AFH) Older Adults
  - West Valley
  - West Central
  - Santa Clarita
  - Antelope Valley MHC
  - Palmdale MHC
  - Downtown
  - Women's Reintegration
  - Acton

  The primary endpoints for the Telemental Health and Consultation program are located in Service Area 1. This part of Los Angeles County has perennially struggled with recruiting and retaining qualified psychiatrists. Services delivered by Tele psychiatrists at the program via video teleconferencing allow patients to still be seen at the mental health clinic that is closest to their place of residence. Without the program's services patients would be forced to travel burdensome distances in order to access care – in this region of Los Angeles County that would be the Olive View Urgent Care Center which for many would be greater than 60 miles round-trip. It is difficult to estimate, however, it can be assumed that the program's presence in

Service Area 1 has mitigated patient decompensation as well as psychiatric hospitalizations.


Telemental Health Brochure (English).pu


Telemental Health Brochure (Spanish).pı

- **Family Resource Centers (FRCs**)
  FRCs are designed to act as a welcoming and family-friendly center within the community where families with children in need of mental health services can go to obtain information and resources to navigate the mental health, physical health and educational systems and participate in self-help meetings and workshops. There is a great reliance on parents to provide care for their child who is demonstrating symptoms of a Serious Emotional Disturbance (SED). FRC services are designed for Children and TAY (birth to 21 years of age), their parents/relatives and other caregivers. Clients who demonstrate moderate symptoms of SED and no longer meet the criteria for enrollment in Full Service Partnership (FSP) or Field Capable Clinical Services (FCCS) programs are eligible for enrollment in FRCs. Services will also be made available to Children and TAY who have no prior mental health treatment history and will benefit from FRC services. FRC services will fall into one of two categories: Family Support Services and Mental Health Services. Approximately, 200-300 clients will be enrolled in FRC programs and thirteen (13) FRCs at directly operated (DO) programs with three positions each will be implemented.

  For the Clinical PIP, the LACDMH Clinical PIP team will: (1) track number of unique clients transitioned to a higher level of resiliency following implementation of the FRCs at the Children's Mental Health Centers (MHCs) and number of clients enrolled who have no prior LACDMH treatment history, (2) track reduction in the use of inpatient and urgent care services at three and six months post enrollment in FRC, (3) report satisfaction rates for clients and their families on four subscales of the YSS, YSS-F, and Adult survey at three and six months post enrollment in FRC services, and (4) track number of services provided (claims) to parents/family members and the unduplicated number of parents/family members receiving mental health services.

  The Clinical PIP team of stakeholders, that consists of FRC Project Leads from the Children's System of Care Bureau (CSOC) Administration, the Quality Improvement Division (QID), as well as managers, supervisors and key staff from FRC programs in SA 2, SA 3, SA 4, and SA 8, addressed program design elements critical to the implementation of FRCs while the budget approval process was in progress. In October 2016, the Clinical PIP team Leads made essential steps towards FRC implementation by submitting the duty statements for 38 positions and completing the FRC organizational charts for the Directly Operated (DO) programs and Request for Service (RFS) to implement FRCs with contract programs. In December 2016,

the PIP team reviewed the Youth Services Survey (YSS), Youth Service Survey for Families (YSS-F) and Adult Consumer Perception Survey domains and agreed to use the General Satisfaction, Perception of Access, Perception of Cultural Sensitivity/Quality and Appropriateness and Perception of Participation in Treatment Planning subscales of the Mental Health Statistical Improvement Program (MHSIP) domains as outcome measures, within FRC programs. In January and February 2017, the PIP team explored and identified the role of Parent Advocates (Community Workers) at FRCs. In February 2017, the process of developing the FRC workflow was initiated and the potential sources of referrals and the services that FRC programs will provide were discussed. The FRC implementation for DO programs is tentatively scheduled for May 2017. Following implementation, the PIP team will focus on reviewing referrals to FRCs, enrollment of eligible clients, and outcomes measures data collection.

## III. Quality of Care: Contract Providers

- **LACDMH Contractual Agreements**

The LACDMH boilerplate language for Contractual Agreements specify that the prospective Contractor's Quality Management Program shall be consistent with the Department's Cultural Competence Plan. Contractors pursuing a contractual relationship with LACDMH submit a proposal in response to Request for Services (RFS). The RFS preamble specifies that "County agencies and their partners work together seamlessly to demonstrate substantial progress towards making the system more strength-based, family-focused, culturally-competent, accessible, user-friendly, responsive, cohesive, efficient, professional, and accountable." Furthermore, the RFS documents the expectation that service delivery will be "responsive to cultural and linguistic needs of the communities served."

In 2016, the boilerplate language in the Contractual Agreement was revised by the Quality Improvement Division Management and the Ethnic Services Manager to include specific information on the Cultural Competency Plan Requirement for 100% of the LACDMH to receive cultural competence training. The new language also builds the accountability of Program Directors/Managers to ensure that this requirement is met as follows:

1) Directly Operated and Legal Entity/Contracted Programs shall monitor, track, document completion of staff's cultural competence training on an annual basis (e.g., training bulletins/flyers, sign-in sheets specifying the name and function of staff, and/or individual certificates of completion, etc.)

2) Directly Operated and Legal Entity/Contracted Programs shall make available upon request from Federal, State, County and LACDMH reviewers proof to the Ethnic Services Manager (ESM) that their staff receive annual cultural competence training by function.

3) Program Directors/Managers of Directly Operated Programs will attest to the completion of annual cultural competence training by 100% of their staff in the Fourth Quarterly Monitoring Report for every Calendar Year (CY).

4) Program Directors/Managers of Legal Entity/Contracted Providers will attest to the completion of annual cultural competence training by 100% of their staff in the Annual Quality Assurance Monitoring Report for every CY.

- **The Vacancy Adjustment and Notification System (VANS)**
  The VANS is an online tool that allows Directly Operated and Contracted Providers to share real-time information on appointment lots available at their agencies. Sharing this information facilitates appropriate and timely consumer referrals. The VANS allows for the tracking of slot availability by type of service, funding source, age group, language and Evidence-Based Practices. The VANS Project began in SA IV in 2013. Each contract provider agency in SA 4 who expressed an interest in using this tool was trained on the use of VANS and User IDs were given for provider analysts to access this application on the internet.

  Since, other SAs have also implemented the VANS, such as SA V and VI. A provider training webinar has been made available to train direct service providers and administrators on the use of VANS. Future VANS plans include its implementation in SAs 1, 2, 3, and 7. Once all the SAs have implemented VANS, it will also be made available to the Access Center.

  The VANS indicators gather information in the following areas:
  - Number of providers issued a VANS ID
  - Number of providers using VANS
  - Number of providers updating available slots by SA and program type
  - Number of providers updating available slots for language capacity
  - Number of providers updating available slots by funding source
  - Number of referrals made using VANS
  - Number of referrals from vans with an appointment in the SRTS (please refer to CR 7).

  Real time data is collected from Providers that have implemented the VANS. For FY 15-16, the results demonstrate statistically significant improvement in the number of providers using VANS, number of providers updating available slots on a monthly basis, number of referrals made to consumers, number of providers making referrals to consumers, and number of providers with additional language capacity making referrals.

  Additionally, the VANS was the Non-Clinical PIP successfully completed in April 2016. The LACDMH VANS PIP team members have continued their efforts to increase the use of the application in additional Service Areas (SAs) as well as improve the ability to search for available slots. During CY 2016, the VANS team

has made notable efforts towards enhancing the application such as linking it to the Service Request Tracking System (SRTS) for making timely and appropriate appointments.

The VANS team members collaborated with the Office of Integrated Care and the ACCESS Center staff to technically link the VANS application to the SRTS application. The main purpose of this was to allow SRTS users to view currently available open program slots when offering an appointment to a potential client. This would increase the appropriateness of referral by searching for slots by service type as well as provide geographic options to the client for receiving services. The PIP members worked collaboratively with the IT teams from LACDMH and the Internal Services Department (ISD) to create a revised and a more efficient search page by including filters for slots by Age Groups served by providers, types of services available under General and Special Outpatient Programs, Funding Type such as Medi-Cal versus Uninsured or Indigent and Threshold Languages served by providers. This collaborative effort was successfully launched in May of 2016.

In CY 2016 additional SAs, namely SA 2, SA 3, SA 6 and SA 8 were added to the application. User IDs were created for providers in these SAs and technical webinars were conducted for users as part of training for VANS users. Monthly SA reports that show utilization patterns of the VANS application by providers were generated by QID staff and made available to the SA District Chiefs. The outcome variable measuring the number of clients referred for services using the VANS application was replaced with number of Look-Ups of available slots in the VANS application through the SRTS application and number of these Look Ups that led to an actual referral for an appointment. Outcomes data for this new variable is currently in progress in collaboration with the Chief Information Office Bureau (CIOB). In addition, a technical webinar by QID for SRTS users on how to view available program slots in VANS inside the SRTS application is tentatively scheduled for April 2017.

The VANS team continues to meet every other month to discuss the use of the application and any technical or programmatic issues associated with the use of the application. The remaining two SAs, SA 1 and SA 7 are currently in the process of being rolled into the VANS application.

## IV. Quality Assurance: Culturally Relevant Consumer Outcome Measures

### Mental Health Statistical Improvement Program (MHSIP) Survey

The survey is designed to measure Overall Satisfaction and has seven (7) Subscales: Perception of General Satisfaction, Perception of Access, Perception of Quality and Appropriateness, Perception of Participation in Treatment Planning, Perception of Outcomes, Perception of Functioning and Perception of Social Connectedness.

- The MHSIP Adult survey is administered to adults age 18 to 59 years;

- The MHSIP Older Adult survey is administered to adults age 60 years and above;
- The Child/Youth version (YSS) is administered to children ages 13 to 17 years;
- The Child/Family (YSS-F) is administered to families of children who are 0-12 years.

The survey items by age group are as follows:

1) Youth Services Survey for Families (YSS-F family member of consumers ages 0-17 years)
   - I felt my child had someone to talk to when he/she was troubled. (Source: YSS-F, #5)
   - The location of services was convenient for me. (Source: YSS-F, #8)
   - Services were available at times that were convenient for me. (Source: YSS-F, #9)
   - Staff was sensitive to my cultural/ethnic background. (Source: YSS-F, #15)
   - My child gets along better with family members. (Source: YSS-F, #17)
   - My child is doing better in school and/or work. (Source: YSS-F, #19)
   - In a crisis, I would have the support I need from family or friends (Source: YSS-F, #25)

2) Youth Services Survey for Youth (YSS; ages 13-17 years)
   - I felt I had someone to talk to when I was troubled. (Source: YSS, #5)
   - The location of services was convenient for me. (Source: YSS, #8)
   - Services were available at times that were convenient for me. (Source: YSS, #9)
   - Staff was sensitive to my cultural/ethnic background. (Source: YSS, #15)
   - I get along better with family members. (Source: YSS, #17)
   - I am doing better in school and/or work. (Source: YSS, #19)
   - In a crisis, I would have the support I need from family or friends. (Source: YSS, #25)

3) Adult survey (ages 18-59 years)
   - The location of services was convenient for me. (Source: Adult MHSIP, #4)
   - Staff was willing to see me as often as I felt it was necessary. (Source: Adult MHSIP, #5)
   - Services were available at times that were good for me. (Source: Adult MHSIP, #7)
   - Staff was sensitive to my cultural background. (Source: Adult MHSIP, #18)
   - I deal more effectively with daily problems. (Source: Adult MHSIP, #21)
   - I do better in school and/or work. (Source: Adult MHSIP, #26)
   - My symptoms are not bothering me as much. (Source: Adult MHSIP #28)

4) Older adult survey (ages 60 years and over)
   - The location of services was convenient. (Source: Older Adult MHSIP, #4)
   - Staff was willing to see me as often as I felt it was necessary. (Source:

Older Adult MHSIP, #5)

- Services were available at times that were good for me. (Source: Older Adult MHSIP, #7)
- Staff was sensitive to my cultural background. (Source: Older Adult MHSIP, #18)
- I deal more effectively with daily problems. (Source: Older Adult MHSIP, #21)
- I do better in school and/or work. (Source: Older Adult MHSIP, #26)
- My symptoms are not bothering me as much. (Source: Older Adult MHSIP, #28)

LACDMH conducts consumer satisfaction surveys twice a year. The MHSIP Survey is utilized and administered to consumers seen in randomly selected Outpatient Clinics. During the period of May 16 to May 20, 2016, surveys were collected from youth (ages 13-17) using the Youth Services Survey (YSS), from adults (ages 18–59) using the Adult Survey, and from older adults (ages 60 and older) using the Older Adult Survey. In addition, families of youth (ages 0-17) completed a survey for services received by their children using the Youth Services Survey for Families (YSS-F).

Out of 8,549 surveys returned during the Spring 2016 survey period 44.9% (N = 3,841) were from Adults, 6.0% (N = 511) from Older Adults, 33.3% (N = 2,847) from Families of Youth (YSS-F), and 15.8% (N = 1,350) from Youth (YSS). Approximately 78.6% (N = 6,596) of the surveys were returned in English followed by 20.3% (N =1,708) in Spanish, and 1.1% (N =92) of the surveys were returned in additional languages such as Chinese, Russian and Vietnamese. The findings from this survey period indicate that language capacity is strength for LACDMH, as over 94% of respondents reported having written materials available to them in their preferred language and over 96% reported receiving their services in their preferred language.

Among YSS-F and YSS, the highest mean score was for Perception of Quality and Appropriateness at 4.5 and 4.3, respectively (on a Likert scale of 1 to 5 with 5 representing the highest score). Among Adult and Older Adult surveys, the highest mean score was for General Satisfaction with 4.4 and 4.6 respectively (on a Likert scale of 1 to 5 with 5 representing the highest score).

The Substance Abuse and Mental Health Services Administration's (SAMHSA) recommended positive scoring of subscales is calculated as the percent respondents scoring 3.5 or above (Agree or Strongly Agree) on a 5 point Likert scale. The May 2016 MHSIP survey results show that among the YSS-F and the Adult surveys, the County average was higher than the State and the US average on all the seven subscales.

Trending data from the previous three survey periods (May 2015 to May 2016) shows a 3.1% increase in satisfaction with "Location of services was convenient," 1.2% increase in "Services were available at times that were convenient," 1.1%

increase in “Staff were sensitive to my cultural/ethnic background,” and 1.3% increase in “Doing better in school and or work,” across all the four survey types. Furthermore, Families of Youth (YSS-F) receiving services and Youth (YSS) reported a 2% and 1.2% respectively increase in satisfaction with “I felt my child/I had someone to talk to when he/she/I was troubled.” Older Adults reported a 2% increase in “Staff was willing to see me as often as I felt was necessary,” and “I deal more effectively with daily problems.”

The following tables and figures summarize the Follow-up Data County Performance Outcome results obtained during the May 2016 survey period.

**FIGURE 1.01: SURVEYS RETURNED BY AGE GROUP AND SERVICE AREA**

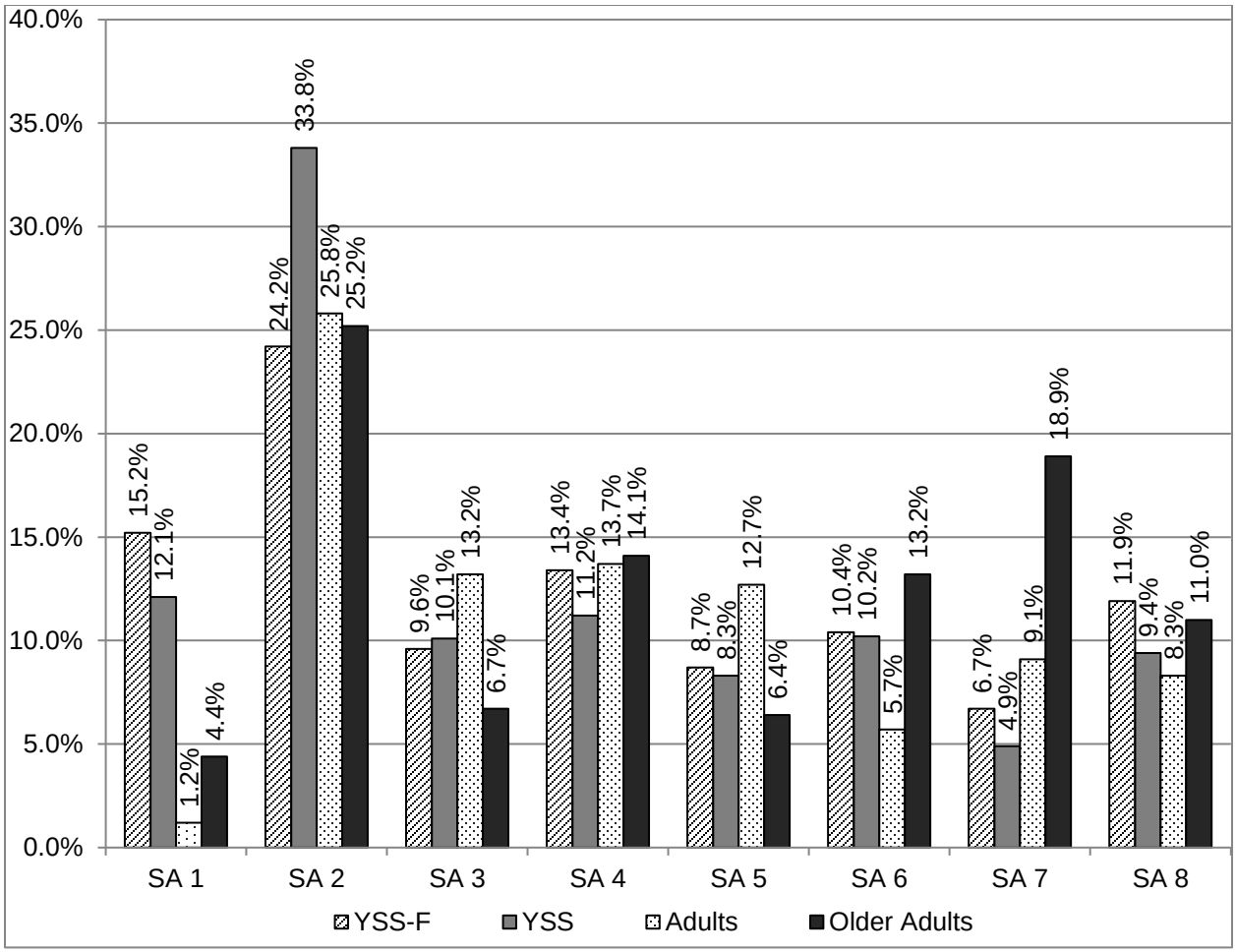



Figure 1.01 shows the May 2016 MHSIP Response Rate for Surveys Completed from randomly selected LACDMH funded Outpatient Clinic and Day Treatment Programs. The Response Rate for Surveys Completed was calculated by dividing the number of surveys completed by the number of consumers that received face-to-face services within randomly selected LACDMH funded Outpatient Clinic and Day Treatment

Programs during the May survey period. The Total Response Rate for May 2016 MHSIP Survey was 12.0% (i.e. 7,121/ 59,180). Adults had the highest Response Rate at 13.0%, followed by Older Adult at 9.9%. The Response Rate among YSS was 9.5%, and 7.7% among YSS-F.

Figure 1.01 also shows that SA 2 had the highest number of Surveys Returned from all Age Groups. SA 2 returned 33.8 % of YSS surveys, 25.8% of Adult surveys, 24.2% of YSS-F surveys, and 25.5% of Older Adult surveys.

**FIGURE 1.02: SURVEYS COMPLETED BY LANGUAGE AND AGE GROUP**

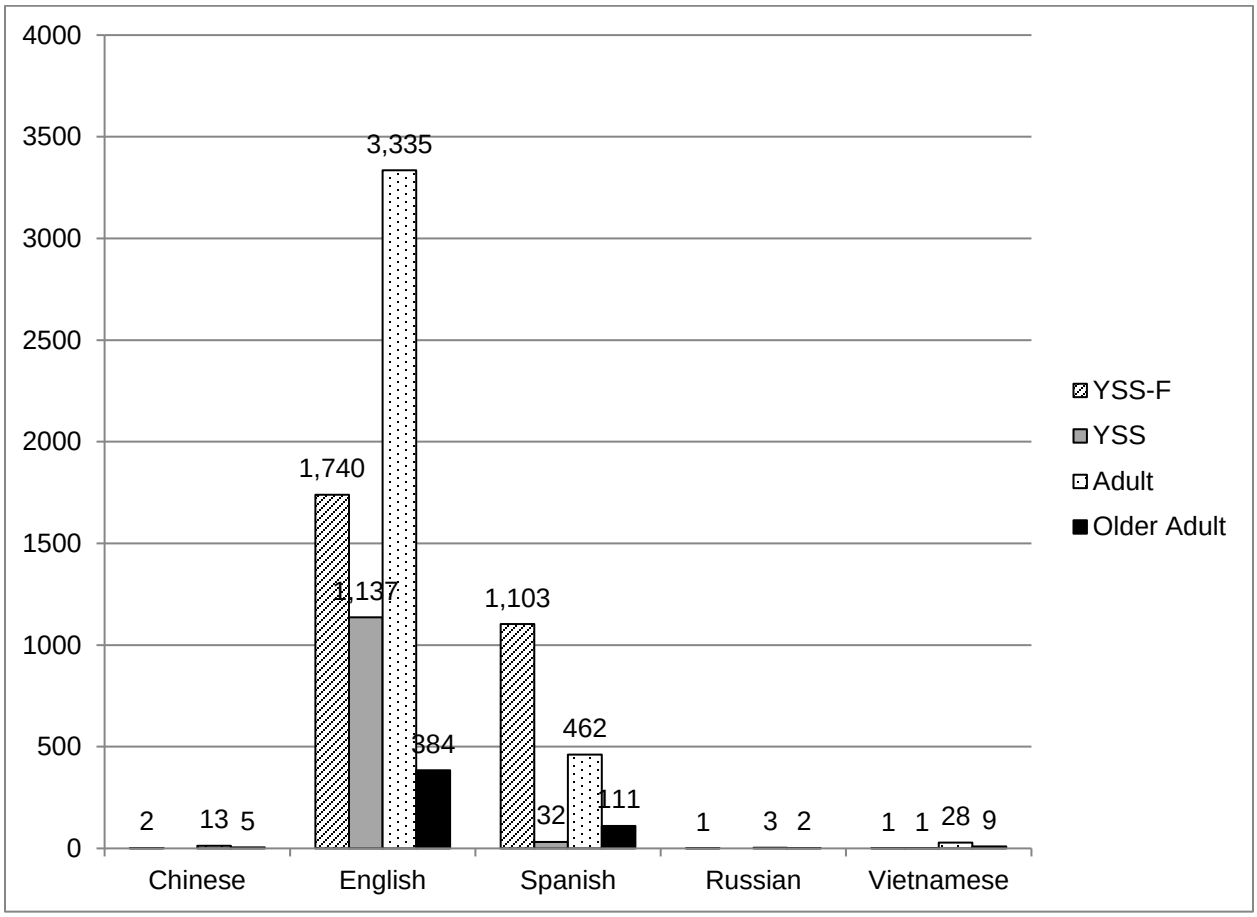
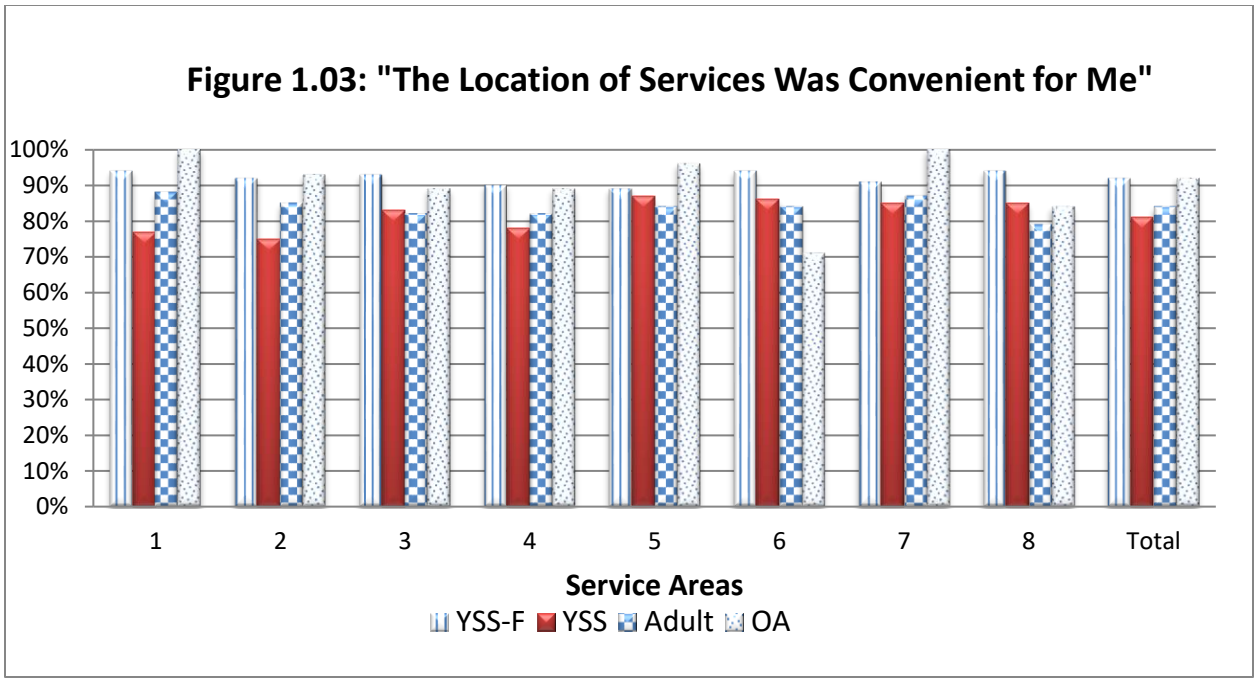



Figure 1.02 shows that the majority of consumers 6,596 or 78.6% completed surveys in English. A total of 1,708 or 20.3% completed surveys in Spanish. Most of the Spanish surveys were completed by the families of Youth (N = 1,103) followed by Adults (N = 462) and Older Adults (N = 111). Only 32 youth completed the YSS survey in Spanish.

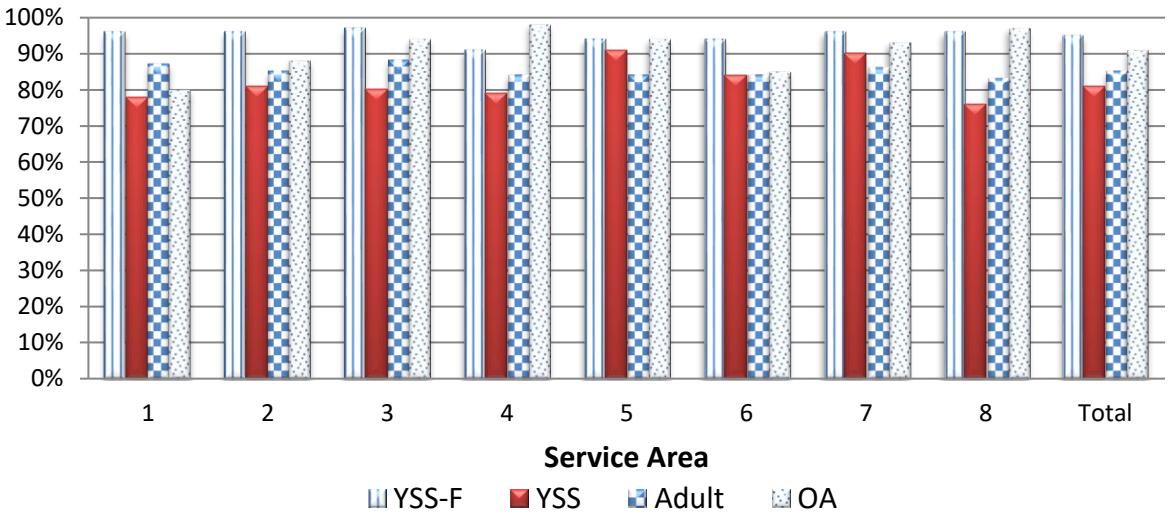
A combined total of 65 or 0.8% of the surveys were completed in other languages such as Vietnamese (N = 39), Chinese (N = 20) and Russian (N = 6).




The highest percentage of consumers who 'agreed' or 'strongly agreed' with "the location of services was convenient for me" was in SA 1, SA 6, and SA 8 at 94% for YSS-F, in SA 6 at 86% for YSS, in SA 1 at 88% for Adults and in SA 1 and SA 7 at 100% for Older Adults.

The highest percentage of consumers who ‘agreed’ or ‘strongly agreed’ with “services were available at times that were convenient/good for me/us” was in SA 7 at 96% for YSS-F, in SA 8 at 90% for YSS, in SA 6 at 93% for Adults and in SA 1 at 100% for Older Adults.

**Figure 1.05: "Staff Was Sensitive to My Cultural/Ethnic Background"**




The highest percentage of consumers who ‘agreed’ or ‘strongly agreed’ with “staff was sensitive to my cultural/ethnic background” was in SA 3 at 97% for YSS-F, in SA 5 at 91% for YSS, in SA 3 and SA 8 at 88% for Adults and in SA 8 at 97% for Older Adults.

The complete MHSIP Report can be accessed below:

May 2016 MHSIP FINAL.docx

## V. Grievances and Complaints

LACDMH monitors grievances, appeals and requests for State Fair Hearings and their resolution. The following Tables summarize the number and percentage of inpatient and outpatient grievances and appeals by reason, level and disposition.

**TABLE 5: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS**
**FY 2014-2015**

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

Data Source: Patients' Rights Office.

Table 5 shows the total number of inpatient and outpatient grievances and appeals by category in FY 14-15. The majority of inpatient and outpatient grievances and appeals (85.1%) were for Quality of Care, followed by Other (8.6%), Access (4.4%), Change of Provider (1.3%), and Denied Services (0.6%). Table 5 also shows that among the inpatient and outpatient grievances and appeals in FY 14-15, there were 461 grievances, 1 appeal, and 15 requests for State Fair Hearings.

## TABLE 6: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS DISPOSITION FY 2014-2015

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

Data Source: Patients' Rights Office.

Table 6 shows the disposition of the 477 grievances and appeals in FY 14-15, of which 446 (93.5%) were resolved and the remaining 31 (6.5%) were reported as still pending. Specifically, all 21 access cases were resolved; all three denied services cases were resolved, all six change of provider cases were resolved, and 386 (95.1%) of the 406 quality of care cases were resolved.