Annual Report on Quality Improvement

Los Angeles County – Department of Mental Health
Office of Administrative Operations – Quality, Outcomes, and Training Division

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LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

Executive Summary

The Los Angeles County – Department of Mental Health (DMH) is the largest county mental health department in the country. The Department directly operates more than 35 programs, maintains approximately 300 co-located sites, and contracts with close to 1,000 organizations. There are greater than 250,000 Laos Angeles County residents under the care of DMH staff, non-governmental agencies (NGA), and individual practitioners whom provide a wide variety of services.

The Department's annual Quality Improvement (QI) Work Plan is organized into seven major domains, which include: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, Provider Appeals, and Performance Improvement Projects. Each domain is designed to address the quality of services provided. The QI program is dedicated to fostering consumer/family member-focused and culturally and linguistically competent services in addition to improving access to underserved populations.

Los Angeles County is the most populated county in the nation with an estimated population of 10,278,834 in Calendar Year (CY) 2018. The estimated distribution by race/ethnicity for the six designated categories includes: Latinos representing 48.8%, Whites 26.5%, Asian/Pacific Islanders 14.2%, African Americans 8.1%, Two or More Races 2.2%, and Native Americans representing 0.23%. During Fiscal Year (FY) 2018-19, a full array of mental health services were provided to children and youth with Serious Emotional Disturbance and adults and older adults with Serious Mental Illness in jails, juvenile halls, 24 hour acute psychiatric care or residential facilities, Directly-Operated (DO) and Legal Entities (LE)/Contracted outpatient programs and by Fee For-Service outpatient network providers. The Work Plan goals focused on the DO and LE/Contracted outpatient programs that served approximately 236,834 persons Countywide.

This QI Work Plan Evaluation report details the progress DMH has made with respect to the CY 2019 annual QI Work Plan goals. For CY 2019, 16 out of 21 of the QI Work Plan goals were met, two goals were not met, and three goals were not rated. Goals that were met indicated that the Department initiated expansion of telemental health services, completed significant outreach and education efforts through the Promotores de Salud (Health Promoter) program, and developed a clinical Performance Improvement Project (PIP) regarding improving services for individuals with co-occurring mental health and substance use problems. Evaluation of these goals also demonstrated continued success in providing short wait times for service hotlines, offering hotline support in multiple languages, including American Sign Language, providing a large percentage of priority appointments through hotlines, establishing high levels of consumer satisfaction around access, cultural sensitivity, and services, and tracking consumer grievances, appeals, change of provider requests, and prescription drug prior authorization (PA) requests. Goals that were not met were related to after-hours Psychiatric Mobile Response Teams (PMRT) response times and development of a non-clinical PIP. These goals will continue to be refined and be subject to continuous quality improvement (CQI) in CY 2020. The unrated goals were due to underlying data issues and there are ongoing efforts to identity sources of data that are valid, reliable, and accessible.

Executive Summary

The QI Work Plan goals for CY 2020 are set by the Office of Administrative Operations – Quality, Outcomes, and Training Division under the authorization of the Department's executive management team and in collaboration with various Divisions and programs including: ACCESS Center, Emergency Outreach and Triage Division, DO and LE/Contracted outpatient programs, Office of Clinical Operations, Patients' Rights Office, Service Area Quality Improvement Committees, and the multidisciplinary PIP teams who have all contributed to this report. The CY 2020 QI Work Plan goals focus on increasing services for individuals from underserved groups, including pregnant women and recent mothers, expanding telemental health care, using consumer feedback to drive satisfaction outcome priorities, developing new and ongoing PIPs, improving tracking mechanisms for important topics like access to care, beneficiary grievances, and medication monitoring.

The Quality, Outcomes, and Training Division (QOTD) was launched in January of 2020. The reorganization of DMH along with State mandates on access and timeliness has provided opportunity to highlight the value of QI practices. The vision for the QI unit is to promote a QI culture and increase skilled use of QI practices within the Department by partnering and consulting more closely with departmental improvement efforts where they occur. Collaboration with our Quality Assurance (QA) unit is a priority as they test and implement State mandates. Work towards this goal has already begun with the development and implementation of the Access to Care Leadership workgroup and collaborative facilitation of the QI and QA countywide meetings with providers to integrate discussions of departmental QA goals alongside discussions of QI practices which can be used to attain those goals. We look forward to our future reporting on these coordinated efforts.

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Mission Statement

Our mission at the Department of Mental Health is to optimize the hope, recovery, wellbeing, and life trajectory of Los Angeles County's most vulnerable through access to care and resources that promote not only independence and personal recovery but also connectedness and community reintegration.

Jonathan E. Sherin, M.D., Ph.D.
Director

Introduction

The Los Angeles (LA) County – Department of Mental Health (Department, DMH) is responsible for authorizing and providing inpatient and outpatient specialty mental health services (SMHS) to LA County's indigent and Medi-Cal enrolled population. The Department directly operates more than 35 programs, maintains approximately 300 co-located sites, and contracts with close to 1,000 organizations. There are greater than 250,000 LA County residents under the care of DMH staff, non-governmental agencies (NGA), and individual practitioners whom provide a wide variety of services. DMH is the largest county mental health plan (MHP) in the country, with a budget of $2.4 billion.

Purpose and Intent

The California Code of Regulations (CCR), Title 9, Section 1810.440 requires all county MHPs to establish a Quality Management Program[1] as defined by their contract with the Department of Health Care Services (DHCS). The Department's contract with DHCS also requires the establishment of a Quality Improvement (QI) Work Plan that contains goals and needs as identified by triennial oversight reviews and the DMH system at-large. The Department evaluates the QI Work Plan on an annual basis and with the active involvement of DMH staff, providers, and consumers/families. At DMH, the Quality, Improvement Division (QID)[2] facilitates the planning, design, and execution of the QI Work Plan and publishes a summary of these activities on an annual basis. Past QI reports are available via the QID website at https://dmh.lacounty.gov/qid/ and upon request.

1 CCR, Title 9, Division 1, Chapter 11, Subchapter 1, Article 4, Section 1810.440, MHP Quality Management Programs.
2 Effective January 2020, the QI program joined the Quality, Outcomes, and Training Division. Reporting responsibilities remained with QID during 2019 QI Work Plan tracking and reporting period.

Structure of Report

There are four sections in the following report. Section I provides a detailed overview of QID. QID is responsible for reviewing the quality of SMHS provided to DMH consumers. This section describes the Division's **organizational structure and elements**. Section II provides a demographic profile of LA County's residents and DMH consumers. In this section, race/ethnicity, age group, gender, language, and Service Area (SA) represent the **major categories of strategic data**. Section III contains the Department's annual QI Work Plan Evaluation Report. This section details the progress DMH has made with respect to the **calendar year (CY) 2019 QI Work Plan goals**. Additional information regarding the 21 QI Work Plan goals that were either met, not met, or unrated are described in this section. The final section (IV) of this report presents the QI Work Plan for CY 2020. Section IV details measurable goals that will aid in the evaluation of the Department's **follow-up performance management activities**.

SECTION I

Quality Improvement Division

In this Section:

Organizational Structure and Elements
Quality Improvement Program
Quality Improvement Council Charter
Cultural Competency Unit

Section I: Quality Improvement Division

Organizational Structure and Elements

QID[3] has reporting responsibilities to the DMH Director, Chief Deputy Director of Administrative Operations, and the Deputy Director of Quality and Risk Management. A licensed mental health professional supervises QID, which includes the Department's QI program and Cultural Competency Unit (CCU).[4] The QI program provides QI leadership and coordination, data monitoring and reporting, and technical assistance across DMH and in the execution of the annual QI Work Plan. The CCU promotes the delivery of SMHS that will meet the diverse needs of LA County's racial, ethnic, cultural, and linguistic populations. Effective communication is essential to the Department's QI efforts. The organizational structure of QID facilitates a downward and upward communication loop between SMHS providers countywide, the Departmental, SA, and internal QI programs, Cultural Competency, and DMH executive management. (Figure 1).

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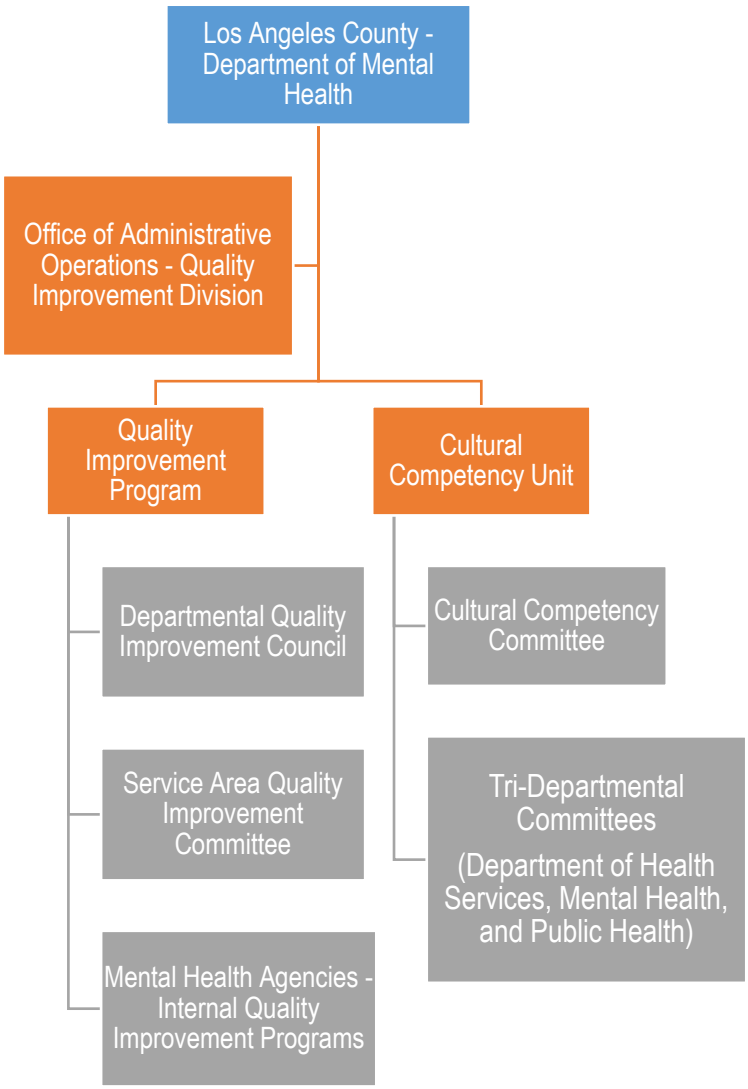
[3] The reporting responsibilities of the Quality Improvement program will transition to the Deputy Director of the Quality, Outcomes, and Training Division (QOTD), effective January 7, 2020. Details on the impact of this change, including revisions to the organizational structure of the "Quality Improvement Unit," will be outlined in the CY 2020 report. QID will be referenced in the following report to align with the activities conducted during the 2018 to 2019 reporting period.

[4] Effective January 1, 2019, the Department's Underserved Cultural Communities Unit transitioned out of QID and into the Strategic Communities Division.

Figure 1. Organizational Structure of the Quality Improvement Division



Quality Improvement Program

The QI program strives to coordinate program development and QI activities that effectively measure, assess, and continuously improve the access to and quality of care provided to DMH consumers. The program is consumer-focused and supports the Department's culture of continuous quality improvement (CQI) and total organizational involvement.

Continuous Quality Improvement

Continuous Quality Improvement (CQI) is a concept that incorporates quality assurance (QA), problem resolution, and quality improvement. More specifically, the science of provisioning services to meet a local, State, or Federal standard; engaging countywide programs and service providers in QI work; and coordinating improvement activities that involve all levels of DMH. The purpose of the design and implementation of the departmental QI program is to ensure an organizational culture of continuous self-monitoring through effective strategies, best practices, and collaborative QI activities.

Most Salient Quality Improvement Program Activities.

In accordance with the Department's contract with DHCS, QID is directly involved in the assessment and evaluation of the following performance management and process improvement activities:

- 24/7 ACCESS Center Test Calls project's procedures and findings;
- Access to and timeliness of services;
- Annual QI Work Plan goals and Work Plan evaluation findings;
- Beneficiary grievances, appeals, and State fair hearings;
- Consumer Perception Survey (CPS) data administration, collection, and reporting;
- Change of Provider (COP) trends;
- Cultural Competency Committee (CCC) updates and the Cultural Competency Plan;
- California External Quality Review Organization (EQRO) sessions and review materials;
- DHCS' triennial oversight reviews;
- Performance Improvement Projects (PIPs): clinical and administrative; and
- Maintaining the Departmental Quality Improvement Council (QIC) charter.

Summary

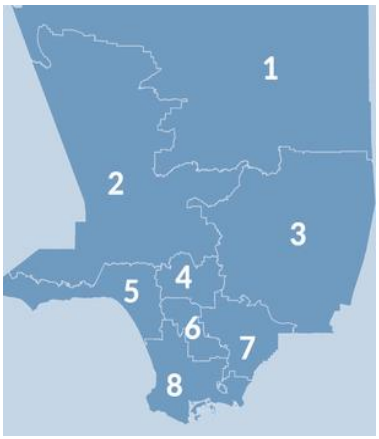
The QI program **executes mandated performance outcome studies, evaluations, and research** targeting the effectiveness of DMH services. In conformance with Federal, State, and local QI requirements, the QI program **oversees technical reporting** related to the annual QI Work Plan and Evaluation Reports, 24/7 ACCESS Center Test Calls Study, consumer satisfaction data, and PIPs. The QI program also **ensures adherence to prescribed site review protocols and timelines**, such as those assigned during triennial oversight reviews and EQRO visits. The QI program staff are obligated to maintain up-to-date knowledge on QI concepts and **provide technical assistance, consultation, and trainings** for Departmental and SA Quality Improvement Committees (QICs), SA Advisory Boards, and other community organizations/agencies as appropriate. **Effective communication and collaborative work** with CCU, other DMH Divisions, and providers supports the accelerated use of CQI countywide.

Quality Improvement Council Charter

Statement of Purpose

The purpose of QID is to ensure and improve the quality and appropriateness of SMHS in conformance with established local, State, and Federal service standards. The Departmental QIC and SA QICs provide opportunities to: identify QI issues and projects; foster an environment where QI activities can be discussed; identify possible best practices; and ensure performance standards are upheld according to the Department's mission and strategic plan. QID has a shared responsibility with its providers to maintain and improve the quality of its service and delivery infrastructure.

Committee Membership



The Departmental QIC has representation from each of the eight SAs of LA County, including consumers/families, practitioners from DO and LE/Contracted agencies, CCC representatives, and other QI stakeholders. All providers are required to participate in their local SA QICs. Local SA QIC meetings occur in each SA by standing members of the Departmental QIC. Each committee meeting provides a structured forum for the identification of QI opportunities to address challenges and barriers that are unique to their respective SAs.

The Department also promotes a communication loop between the SA QICs and their Service Area Leadership Teams (SALT). The SALTs ensure the active involvement of consumers/families and other stakeholders whom are interested in the implementation of QI Work Plan activities. The Departmental QI program works to engage and support the Departmental QIC, SA QIC, and SAAC members in QI processes related to the QI Work Plan and specific PIP activities.

Authority

The Departmental QIC Chair is responsible for chairing and facilitating the Departmental QIC meetings and ensuring members receive timely and relevant information. Each SA QIC has a Chair representing DO providers and most have a Co-Chair who represents the LE/Contracted providers.

Responsibilities

The Departmental QIC, QID, and DMH staff collaborate on measurable QI Work Plan goals that aid in the evaluation of annual performance management activities. The annual QI Work Plan goals fit into one of seven domains that mirror State and Federal requirements (Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, Provider Appeals, and PIPs).

The Departmental QIC collaborates and coordinates related QI Work Plan activities with multiple DMH Divisions and programs. In addition to the Departmental QI program and CCU updates, the monthly Departmental QIC agendas may reflect performance and outcomes management discussions led by the:

- ACCESS Center;
- Chief Information Office (CIO);
- Clinical Risk Management (CLRM);
- Clinical Standards and Policy;
- Office of the Discipline Chiefs;
- Patient's Right Office (PRO);
- Prevention and Outcomes Division (POD);
- Multidisciplinary PIP teams; and
- QA.

Meetings

The Departmental QIC meets monthly. The SA QICs convene on a monthly or every other month basis. All Departmental QIC and SA QIC meeting materials (i.e., schedules, agendas, meeting minutes) are available on the QID website at https://dmh.lacounty.gov/qid/sa/ and upon request.

In December 2019, the Departmental QIC introduced an integrated and co-informed approach to the work of QA and QI. By integrating the QI and QA portions of the monthly meetings, DMH can introduce the use of QI processes, including PIPs, to address QA mandates such as Network Adequacy and Access to Care.

Summary

The Departmental QIC charter further **supports DMH in maintaining a culture of CQI**. The Departmental QIC and SA QICs foster the ideal environments to discuss QI activities, **identify possible best practices, and maintain performance standards** that align with the Department's mission and DHCS contract. The supervisor of the Cultural Competency Unit (CCU) is a standing member of the Departmental QIC and supports the integration of cultural competency into QID roles and responsibilities.

Cultural Competency Unit

The Cultural Competency Unit (CCU) promotes the delivery of mental health services that will meet the diverse needs of LA County's racial, ethnic, cultural, and linguistic populations. The Department's Ethnic Services Manager (ESM) reinforces the Departmental framework for cultural responsiveness via the implementation of the Cultural Competence Plan Requirements (CCPR)[5] and the Culturally and Linguistically Appropriate Services (CLAS) standards. The CCU promotes awareness and utilization of this framework to: reduce disparities and combat stigma; promote hope, wellbeing, recovery and resiliency; and serve LA County communities with quality care.

The Cultural Competency Committee (CCC) serves as an advisory group for the infusion of cultural competency in all DMH operations. Administratively, the CCC is housed within the QID – CCU. Composed of 46 members, the CCC membership includes the cultural perspectives of consumers, family members, advocates, DO providers, LE/Contracted providers, and community-based organizations. Additionally, the CCC considers the expertise from the SAs' clinical and administrative programs, front-line staff, and management essential for sustaining the mission of the Committee. The ESM monitors all activities pertaining to the CCC and provides technical support.

Most Salient Cultural Competency Unit Activities

In CY 2019, the CCU focused on supporting cultural competency for DMH staff, partners, and community members, planning for future cultural and linguistic inclusion activities, and ensuring that cultural competence is integrated into policies and procedures. To promote cultural competency for staff and community partners, the CCU spearheaded the planning and coordination of the Multicultural Mental Health Conference: Health Integration through a "WHOLISTIC" Approach. The main goal of the conference was to highlight the benefits of integrated health care for persons receiving services, family members, and communities. The conference, which was attended by approximately 700 participants from several County of Los Angeles Departments and community members from all SAs, addressed models of health integration for less-recognized yet well-established underserved populations. These populations include foster care youth, immigrants and asylum seekers, persons experiencing homelessness, older adults, persons who are incarcerated or recently released from prison, persons with disabilities, and persons who have substance use disorders, among others. Participants were submerged into a learning environment that promoted cross-departmental collaborative partnerships, health care coordination, and inclusion of cultural and linguistic responsiveness and feedback received from the participants' evaluation forms was overwhelmingly positive.

To facilitate planning for culturally and linguistically inclusive activities, the Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) membership group, comprised of representative members of the three Los Angeles County Health

[5] The most recent Cultural Competency Plan can be reviewed online at: https://dmh.lacounty.gov/ccu/

Departments; DMH, the Department of Public Health (DPH), and the Department of Health (DHS), developed an action plan with a comprehensive list of proposed deliverables for CY 2019. The deliverables were based on the four domains of the Institute: infrastructure, training and staff development, communication and community involvement, and virtual repository of resources. Subject matter experts from the three Health Departments along with ICLIR attended a launch event in September 2019 to discuss goals and deliverables for CY 2020 and 2021. Workgroups were formed representing under six areas of concentration, including data standards, consumer satisfaction outcome data collection and reporting, trainings related to cultural competency and implicit bias, language assistance services, quality improvement projects, and technological updates and solutions.

Each of these workgroups have an identified goal and worked to collaboratively set deliverables for the next two years.

- The **Data Standards Workgroup** has a goal to establish minimum standards for race, ethnicity, sexual orientation and gender identity, preferred language, and disability status data collection, analysis, and dissemination. These minimum data standards would allow for timely, reliable, consistent and continuous data collection, analysis, and comparison within and across Departments to monitor health disparities.

- The goal of the **Consumer Satisfaction Outcome Data Collection and Reporting Workgroup** is to implement the practice of collecting consumer demographic information pertinent to race, ethnicity and preferred language by each Department to make the data gathered from Consumer Satisfaction Surveys more meaningful.

- The **Trainings Related to Cultural Competency and Implicit Bias Workgroup** has a goal to develop at least one online training regarding cultural competency that can be made available to workforce members from all three Departments.

- The **Language Assistance Services Workgroup** has a goal to develop mechanisms for a more robust, integrated and responsive way to provide language assistance services to the consumers served by the Departments in order to promote meaningful access and equal opportunity for persons who have Limited English Proficiency (LEP) to participate in the services, programs, and activities for all three Departments.

- The **Quality Improvement Projects Workgroup** has a goal to develop quality improvement projects across the Departments to address gaps in services.

- Finally, the goal of the **Technological Upgrades and Solutions Workgroup** is to develop technological solutions to improve delivery of culturally and linguistically appropriate services.

To promote integration of cultural competence throughout policies and procedures, the CCU also developed and implemented Policy and Procedure (P&P) 200.09: Culturally and Linguistically Inclusive Services, which establishes guidelines for participation, implementation, and compliance with Federal and State regulations regarding cultural and linguistic competence. Effective September 2019, P&P 200.09 informs the system of care that culturally and linguistically appropriate, effective, and equitable services are provided at all points of entry in the Department. Further, it fosters a collective sense of shared responsibility for the implementation of culturally and linguistically responsive interventions that address health inequities among the staff from DO, LE/Contracted, and administrative programs. The policy framework is based on the Federal CLAS standards and the Cultural Competence Plan Requirements (CCPR) set forth by California's Department of Healthcare Services (DHCS, State). Additionally, it introduces key definitions that are conducive to the application of Federal and State mandates in daily Departmental operations, such as culture, individual cultural competence, organizational cultural competence, cultural humility, cultural identity, health disparities, health inequities, implicit bias, social determinants of health, and underserved communities.

In CY 2019, the CCC focused on implementing a cultural competency exchange initiative and providing recommendations to the Department related to cultural competency training topics and the Culturally and Linguistically Inclusive Services policy (P&P 200.09). The "Share Your Culture" initiative, which began in July 2019, is an information exchange regarding cultural backgrounds and practices that occurs as an on-going CCC meeting agenda item. This initiative empowers the membership, inclusive of consumers and peers to share stories that foster awareness and appreciation about different cultural backgrounds, experiences of collective trauma such as colonization, civil war, genocide, and traumatic experiences derived from such historical facts. Furthermore, the implementation of this segment promotes public-speaking skill building for consumers and peers, and allows for collaboration with DMH staff for the development of PowerPoint presentations. Representatives from Armenia, Germany, Ecuador, and El Salvador have thus far participated in the exchange.

The CCC proposed multiple ideas on trainings that would equip staff with awareness, sensitivity and skills related to cultural competence. These topics were divided into clinical, general, and function-specific categories. Within the clinical category, the CCC suggested trainings on clinical best-practices, gold-standards in operations, and customer service delivery, effectively serving persons with cognitive and other hidden disabilities, interacting appropriately with persons who have physical disabilities, listening and showing compassion particularly when persons are discussing disabilities, working effectively with persons from different faith backgrounds, and alternative treatment modalities that honor culture-specific holistic medications and healing practices. Within the general category, recommendations were around trainings on implicit bias and fairness, helping staff to analyze their own biases, cultural humility, culture-based communication styles, and cultural proxemics as related to different cultures. The CCC also advocated for opportunities for consumers to observe the trainings being conducted to DMH employees with the purpose of evaluating and providing input. Within the function-specific category, the CCC recommended training for managers and supervisors

on de-escalating those who have been triggered and working with employees and peers who have intellectual disabilities, learning disabilities, or difficulties processing information. The committee also recommended an all-staff training on managing personal stress and emotions to ensure that the quality of services is not negatively impacted.

After reviewing a draft of the "Culturally and Linguistically Inclusive Services" P&P in March 2019, the CCC also provided important feedback. The Committee's recommendations were that the Department should include "Cultural Identity" in the definitions section, specify and provide examples of "alternative formats" (e.g. audio visual and videos) in the paragraph addressing written materials, and add the words "resilience" and "hope" as specifiers for consumer-driven and wellbeing programs. These recommendations were then incorporated into the P&P.

Summary

The CCU is responsible for ensuring the **delivery of mental health services** that will **meet the diverse needs of LA County's racial, ethnic, cultural, and linguistic populations**. In CY 2019, the CCU focused on supporting **cultural competency** for DMH staff, partners, and community members, **planning for future cultural and linguistic inclusion activities**, and ensuring that **cultural competence** is integrated into **policies and procedures**. The CCC is housed within the CCU and serves as an advisory group for the infusion of cultural competency in all DMH operations. In CY 2019, the CCC focused on implementing a **cultural competency exchange initiative** and **providing recommendations** to the Department related to **cultural competency training topics** and the **Culturally and Linguistically Inclusive Services policy (P & P 200.09)**.

SECTION II

Population Needs Assessment

In this Section:

Estimated Total Population
Estimated Total Population living at or below 138% FPL
Population Enrolled in Medi-Cal
DMH Threshold Languages
Consumers Served in Outpatient Programs
Primary Language of Consumers Served
Service Utilization

Section II: Population Needs Assessment

Section II provides up-to-date and useful information for informed decision-making and planning. This section, also referred to as the Department's annual population needs assessment, presents strategic information as intentional data sets. These data sets offer a foundation for estimating the desired services and outcomes for DMH's target populations:

- Estimated total population by race/ethnicity, age group, and gender.
- Estimated total population living at or below 138% Federal Poverty Level (FPL) by race/ethnicity, age group, and gender.
- Population enrolled in Medi-Cal by race/ethnicity, age group, and primary language.
- Consumers served in outpatient programs by race/ethnicity, age group, gender and diagnosis.
- Primary language of consumers served in outpatient programs by SA and threshold language.
- Penetration rates by race/ethnicity, age group, and primary language for the Medi-Cal enrolled population.

These data sets can be used to evaluate whether the Department is providing services to groups that are reflective of the total population of LA County and those who are living at or below the Federal poverty level in the County. They can also assess whether the Department is meeting the needs of those with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) in terms of race/ethnicity, age group, gender and service utilization among different groups to identify disparities.

Methods

Population and poverty estimates are available by each SA, race/ethnicity, age group, and gender. The population living at or below the 138% FPL was applicable to the Department's methods of estimating prevalence of mental illness among the population eligible for Medi-Cal benefits. The population and poverty numbers prepared locally and annually by Hedderson Demographic Services, accounts for local variations in housing and household income. As of CY 2014, QI Work Plan goals related to access have been set for population living at or below 138% FPL to account for expansion of services under the ACA.

The Department monitors accessibility to services by calculating service utilization rates among consumers served in outpatient programs. The count of consumers served does not include those served in 24 Hour/Residential programs such as inpatient hospitals (both County and Fee-For-Service), residential facilities, Institutions for Mental Disease (IMD) facilities, Skilled Nursing Facilities (SNF), Psychiatric Health Facilities (PHF), or consumers served in Fee-for-Service (FFS) outpatient settings. In previous years, unique Client ID counts were used when reporting on the number of consumers served Countywide. The Office of Clinical Informatics has now implemented the deduplication

technique with a Dataflux statistical match to eliminate likely duplicate IDs. This process decreases the likelihood of "false positives."

The Research and Analytic Studies Division (RASD) at DHCS aggregates data on the certified Medi-Cal eligible population to assist MHPs with identifying gaps in assess, quality, and timeliness of the care provided. This data and information is available for public use via https://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASD_Default.aspx.

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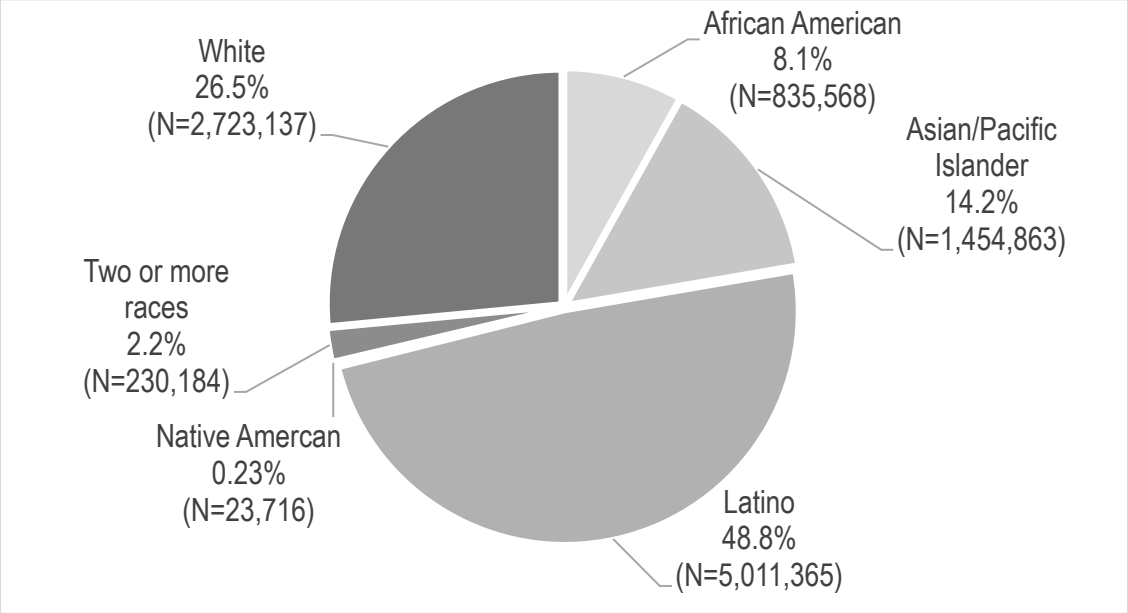
Total Population

The County of Los Angeles is the most populated county in the United States (U.S.) with an estimated population of 10,278,834 people in CY 2018. The County consists of 88 incorporated cities and includes 4,058 square miles of land area. Population density in the County, or the average number of people per square mile, is 2,531 as compared to 244 in the State of California.

Population distribution by race/ethnicity in the County of Los Angeles, as shown in Figure 2, is the highest among Latinos at 48.8%, followed by Whites at 26.5%, Asian/Pacific Islanders (API) at 14.2%, African Americans (AA) at 8.1%, Two or More Races at 2.2% and Native Americans (NA) at 0.23%. The Two or More Races group was added in CY 2016. In previous years, this group was distributed among other racial/ethnic groups.

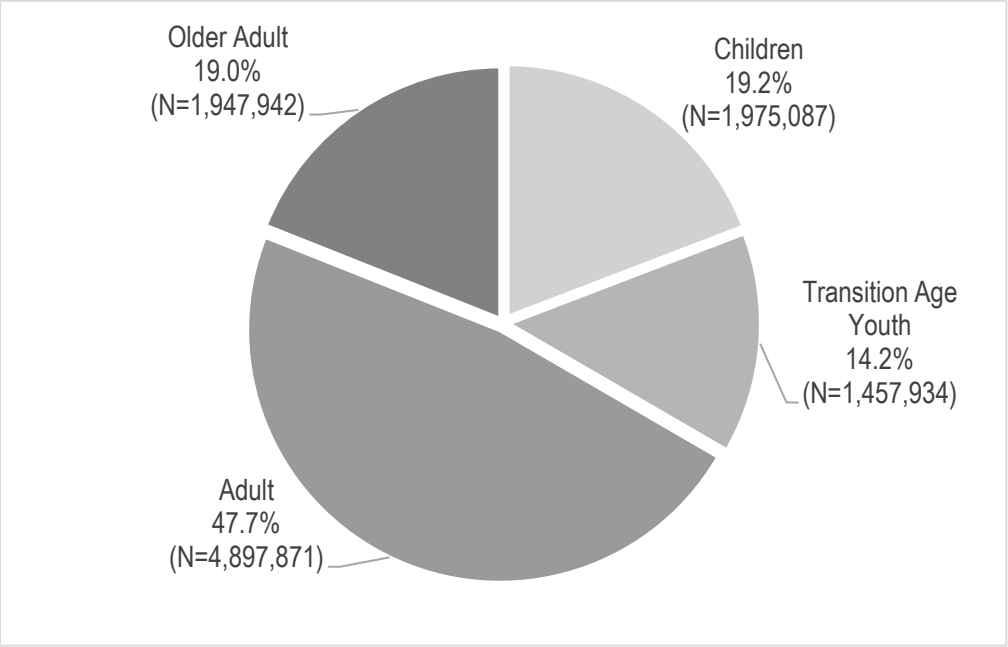
Figure 2. Total Population by Race/Ethnicity (N=10,278,834)



Note: Numbers and percentages may not total to 100% due to rounding. Data Source: ACS, U.S. Census Bureau, and Hedderson Demographic Services, 2019.

Figure 3 shows the total population for LA County by age group. In CY 2018, at 47.7%, Adults (26-59 years old) made up the largest age group, followed by Children (0-15 years old) at 19.2%, Older Adults (60 years old or greater) at 19.0%, and Transition Age Youth (TAY; 16-25 years old) at 14.2%.

Figure 3. Total Population by Age Group (N=10,278,834)



Note: Numbers and percentages may not total to 100% due to rounding. Data Source: ACS, U.S. Census Bureau, and Hedderson Demographic Services, 2019.

Differences by Race/Ethnicity

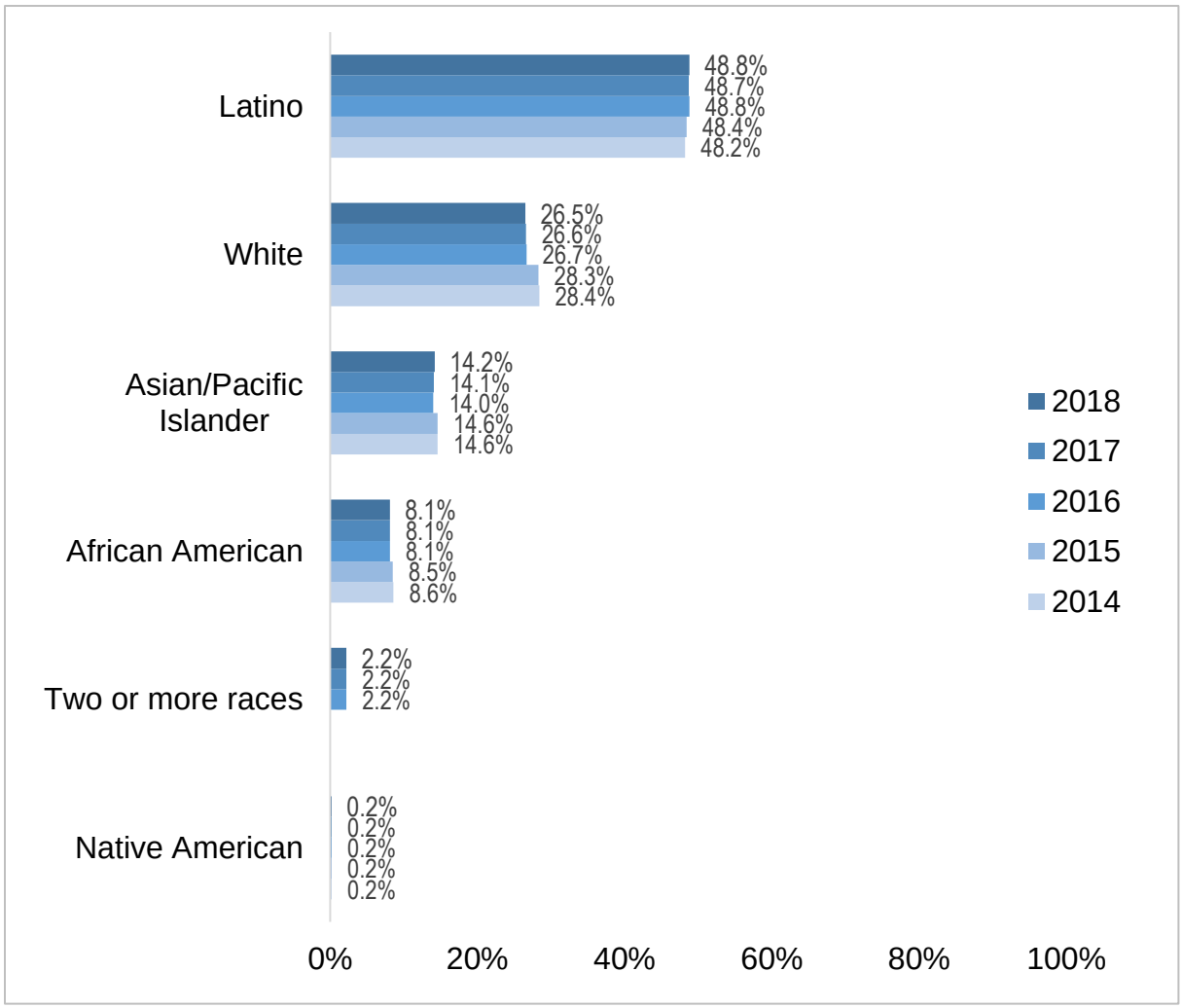
Table 1 presents the total population for LA County by race/ethnicity and SA. The Latino group was the highest represented race/ethnicity in all SAs except for SA 2 where the White group was among the highest. The Native American group was the lowest represented race/ethnicity in all eight SAs.

Table 1. Total Population by Race/Ethnicity and Service Area

SA	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	60,592	15,412	182,426	1,912	125,919	11,322	397,583
Percent	15.2%	3.9%	45.9%	**0.48%**	31.7%	2.8%	100.0%
SA 2	76,738	255,524	916,400	4,751	949,722	59,141	2,262,277
Percent	3.4%	11.3%	40.5%	0.21%	42.0%	2.6%	100.0%
SA 3	63,526	505,293	843,458	3,716	357,632	34,638	1,808,263
Percent	3.5%	**27.9%**	46.6%	0.21%	19.8%	1.9%	100.0%
SA 4	58,698	204,655	617,033	2,599	281,580	21,229	1,185,794
Percent	5.0%	17.3%	52.0%	0.22%	23.7%	1.8%	100.0%
SA 5	37,280	91,290	110,426	1,198	399,221	28,448	667,863
Percent	5.6%	13.7%	**16.5%**	0.18%	**59.8%**	**4.3%**	100.0%
SA 6	276,877	19,331	722,715	1,812	25,529	11,431	1,057,694
Percent	**26.2%**	**1.8%**	68.3%	**0.17%**	**2.4%**	**1.1%**	100.0%
SA 7	38,961	118,547	975,913	3,329	169,183	15,372	1,321,304
Percent	**2.9%**	9.0%	**73.9%**	0.25%	12.8%	1.2%	100.0%
SA 8	222,896	244,810	642,994	4,401	414,351	48,604	1,578,056
Percent	14.1%	15.5%	40.7%	0.28%	26.3%	3.1%	100.0%
Total	835,568	1,454,863	5,011,365	23,716	2,723,137	230,184	10,278,834
Percent	8.1%	14.2%	48.8%	0.23%	26.5%	2.2%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2019.

Figure 4. Total Population Percent Change by Race/Ethnicity (Five-Year)



Note: The "Two or more races" group was added in CY 2016. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2019.

The percentage of African Americans in LA County has decreased by 0.5 Percentage Points (PP) over the past five years. African Americans represented 8.6% of the total population in CY 2014 and represented 8.1% of the population in CY 2018.

The percentage of Asian/Pacific Islanders in LA County has decreased by 0.4 PP over the past five years. Asian/Pacific Islanders represented 14.6% of the total population in CY 2014 and represented 14.2% in CY 2018.

The percentage of Latinos in LA County has increased by 0.6 PP over the past five years. Latinos represented 48.2% of the total population in CY 2014 and represented 48.8% in CY 2018.

The percentage of Native Americans in LA County has remained the same over the past five years. Native Americans represented 0.2% of the total population in CY 2014 and CY 2018.

The percentage of Whites in LA County has decreased by 1.9 PP over the past five years. Whites represented 28.4% of the total population in CY 2014 and represented 26.5% in CY 2018.

The percentage of individuals with two or more races did not change between CY 2016 and CY 2018. Two or more races has represented 2.2% of the total population over the past three years.

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Differences by Age Group

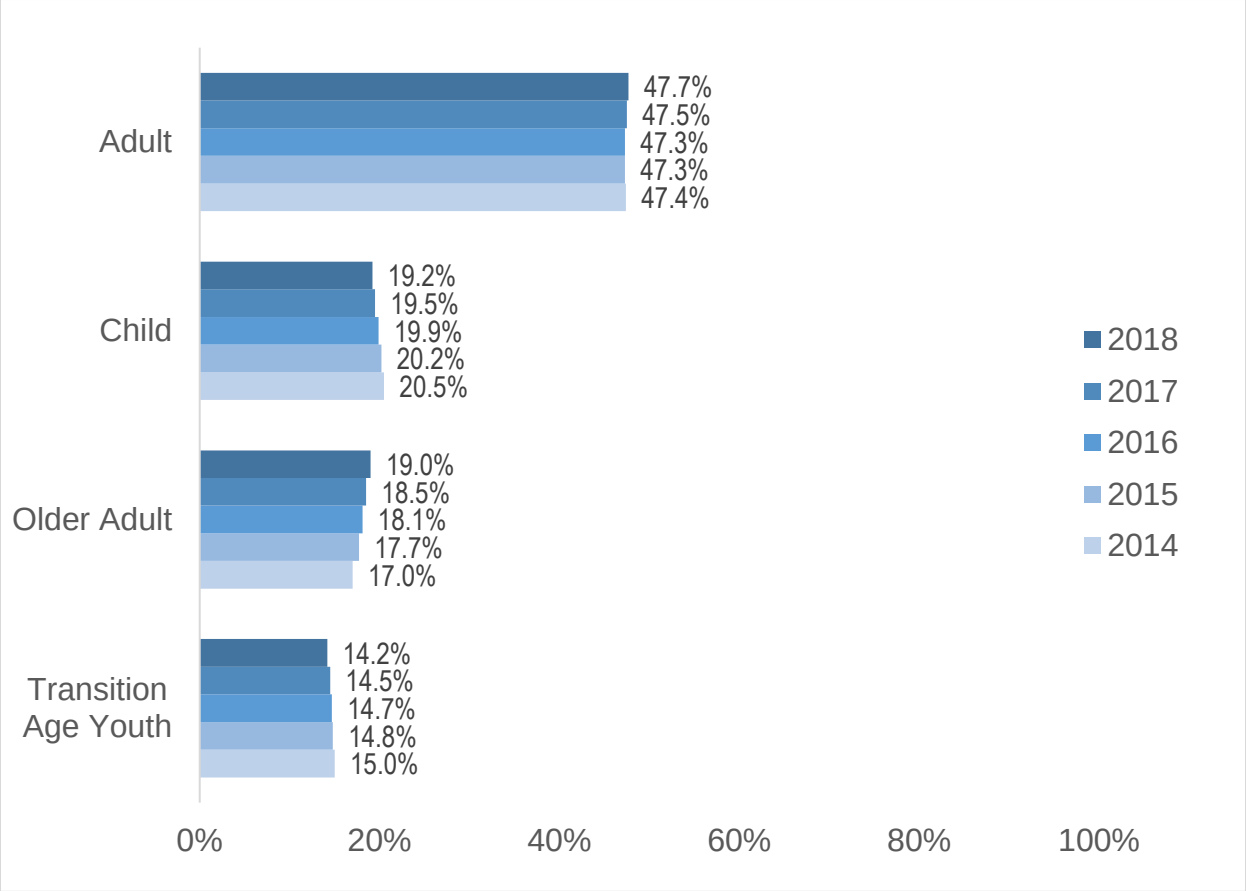
Table 2 presents the total population for LA County by age group and SA. Individuals ages 25 to 59 were the highest represented age group in all SAs. Individuals ages 19 to 20 were among the lowest represented age group in all SAs.

Table 2. Total Population by Age Group and Service Area

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	106,815	13,746	35,085	175,578	23,206	43,153	397,583
Percent	26.8%	3.5%	**8.8%**	**44.2%**	5.8%	10.9%	100.0%
SA 2	499,201	61,811	155,507	1,091,975	143,160	310,623	2,262,277
Percent	22.1%	2.7%	6.9%	48.3%	6.3%	13.7%	100.0%
SA 3	397,955	54,967	133,761	831,319	116,518	273,743	1,808,263
Percent	22.0%	3.0%	7.4%	46.0%	**6.4%**	15.2%	100.0%
SA 4	241,723	26,490	70,982	637,635	62,497	146,467	1,185,794
Percent	20.4%	**2.2%**	**6.0%**	**53.8%**	5.3%	12.3%	100.0%
SA 5	119,703	23,198	41,669	335,949	40,961	106,383	667,863
Percent	**17.9%**	3.5%	6.2%	50.3%	6.2%	**15.9%**	100.0%
SA 6	307,162	38,831	93,469	476,370	48,518	93,344	1,057,694
Percent	**29.0%**	**3.7%**	**8.8%**	45.0%	**4.7%**	**8.8%**	100.0%
SA 7	337,324	41,472	105,306	605,575	70,813	160,814	1,321,304
Percent	25.5%	3.1%	8.0%	45.8%	5.4%	12.2%	100.0%
SA 8	370,643	44,234	111,967	743,470	95,325	212,417	1,578,056
Percent	23.5%	2.8%	7.1%	47.1%	6.0%	13.5%	100.0%
Total	2,380,526	304,749	747,746	4,897,871	600,998	1,346,944	10,278,834
Percent	23.2%	3.0%	7.3%	47.7%	5.7%	13.1%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2019.

Figure 5. Total Population Percent Change by Age Group (Five-Year)



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2015 to 2019.

The percentage of children in LA County has decreased by 1.3 PP over the past five years. Children represented 20.5% of the total population in CY 2014 and represented 19.2% in CY 2018.

The percentage of TAY in LA County has decreased by 0.8 PP over the past five years. TAY represented 15.0% of the total population in CY 2014 and represented 14.2% in CY 2018.

The percentage of adults in LA County has increased by 0.3 PP over the past five years. Adults represented 47.4% of the total population in CY 2014 and represented 47.7% CY 2018.

The percentage of older adults in LA County has increased by 2.0 PP over the past five years. Older Adults represented 17.0% of the total population in CY 2014 and represented 19.0% in CY 2018.

Differences by Gender

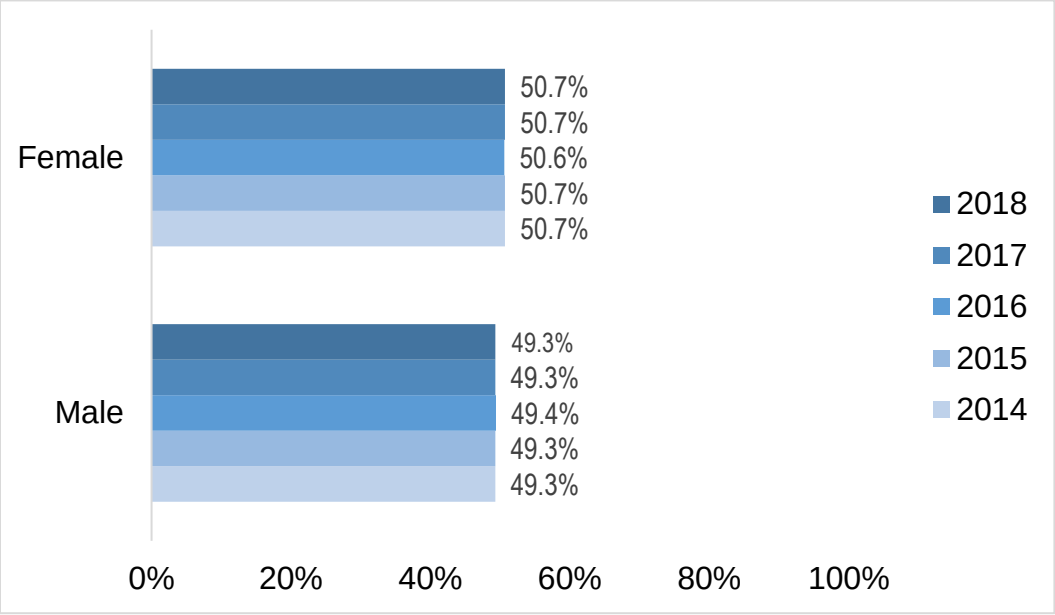
Table 3 presents the total population for LA County by gender and SA. Of those whom identified as either Male or Female, Females were among the most represented gender in all SAs except for SA 4.

Table 3. Population by Gender and Service Area

SA	Male	Female	Total
SA 1	197,170	200,413	397,583
Percent	49.6%	50.4%	100.0%
SA 2	1,118,659	1,143,618	2,262,277
Percent	49.4%	50.6%	100.0%
SA 3	882,513	925,750	1,808,263
Percent	48.8%	51.2%	100.0%
SA 4	608,556	577,238	1,185,794
Percent	**51.3%**	**48.7%**	100.0%
SA 5	323,606	344,257	667,863
Percent	**48.5%**	**51.5%**	100.0%
SA 6	515,744	541,950	1,057,694
Percent	48.8%	51.2%	100.0%
SA 7	649,613	671,691	1,321,304
Percent	49.2%	50.8%	100.0%
SA 8	771,878	806,178	1,578,056
Percent	48.9%	51.1%	100.0%
Total	5,067,739	5,211,095	10,278,834
Percent	49.3%	50.7%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

Figure 6. Total Population Percent Change by Gender and Service Area (Five-Year)



Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2015 to 2019.

The percentage of Males in LA County has remained stable over the past five years. Males represented 49.3% of the total population in CY 2014 and CY 2018.

The percentage of Females in LA County has also remained stable over the past five years. Females represented 50.7% of the total population in CY 2014 and CY 2018.

Summary

LA County's total population increased from CY 2017 to CY 2018. The **largest population changes were seen in race/ethnicity**. The Latino ethnic group increased by 0.6 PP. Of note, the White ethnic group decreased by 1.9 PP. At 73.9%, the Latino group was the highest in SA 7 when compared to SA 2 (40.5%) with the lowest. **Native Americans remained the lowest represented race/ethnicity** across all eight SAs.

Population changes in age group distribution were also noted between CY 2017 to CY 2018. The older adult age group increased by 2 PP and demonstrated the largest growth. Conversely, **the child age group declined by 2 PP and was among the least represented**. Despite these shifts, **adults remained the largest population with the highest concentration** seen in SA 4 (53.8%). The 19 and 20 years old age group had the lowest percentages across all eight SAs.

Gender distribution remained relatively unchanged over the last five years with Males at 49.3% and Females at 50.7% for CY 2018. Females were the most represented gender.

Estimated Population Living at or below Federal Poverty Level

Differences by Race/Ethnicity

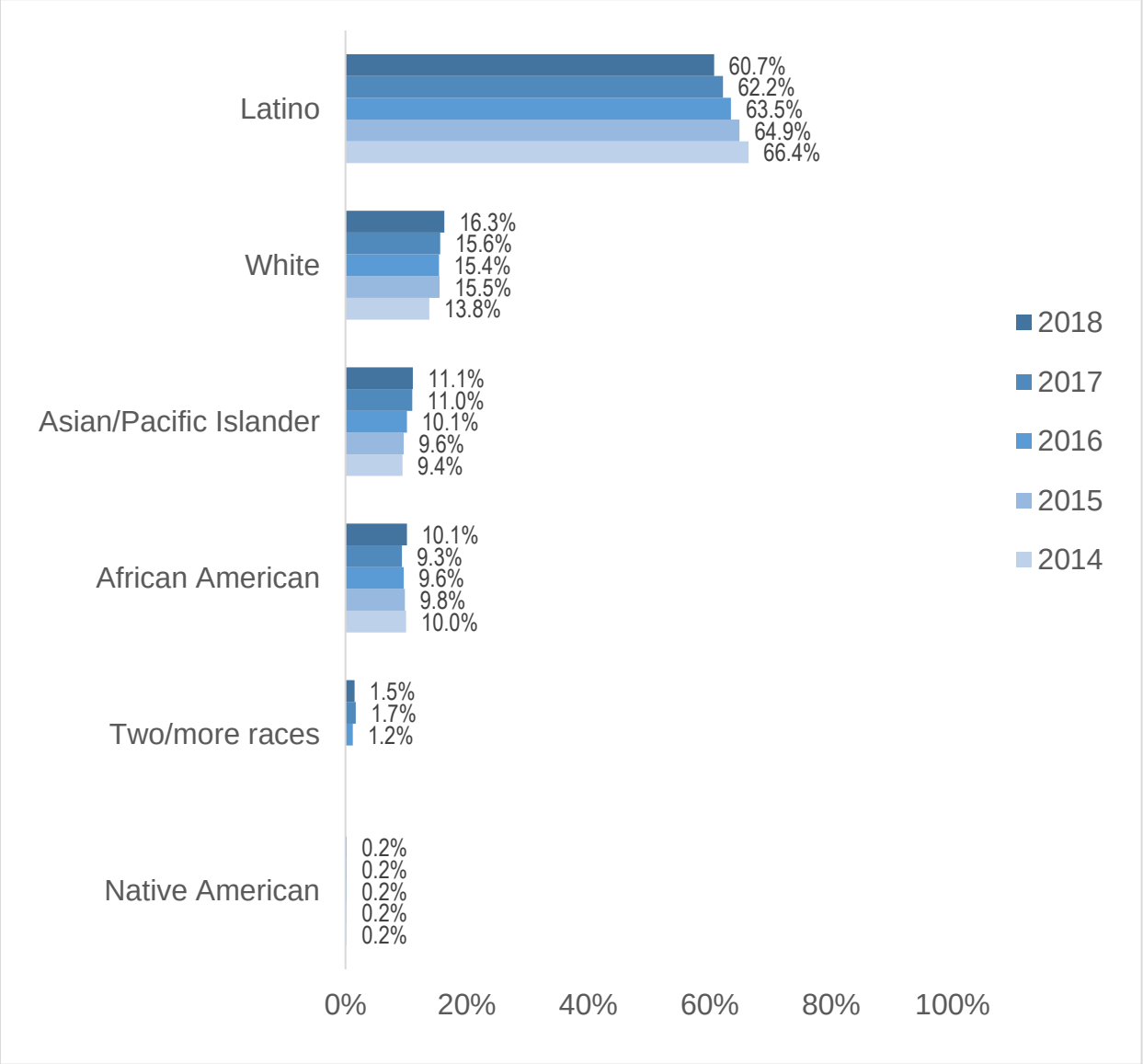
Table 4 presents the estimated population living at or below 138% FPL by race/ethnicity and SA. The Latino group were among the most represented race/ethnicity for the estimated population living at or below 138% FPL in all SAs. The Native American group were the least represented race/ethnicity among the estimated population living at or below 138% FPL in all SAs.

Table 4. Estimated Population Living at or Below 138% FPL by Race/Ethnicity and Service Area

SA	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	19,759	2,888	55,602	554	26,790	2,585	108,178
Percent	18.3%	2.7%	51.4%	**0.51%**	24.8%	2.4%	100.0%
SA 2	14,851	36,670	225,047	797	124,324	7,566	409,255
Percent	3.6%	9.0%	55.0%	0.19%	30.4%	1.8%	100.0%
SA 3	10,716	84,371	175,510	628	44,274	4,013	319,512
Percent	3.4%	**26.4%**	54.9%	0.20%	13.9%	1.3%	100.0%
SA 4	13,453	49,037	193,753	796	51,201	4,008	312,248
Percent	4.3%	15.7%	62.1%	0.25%	16.4%	1.3%	100.0%
SA 5	5,107	13,760	15,637	147	46,758	3,109	84,518
Percent	6.0%	16.3%	**18.5%**	**0.17%**	**55.3%**	**3.7%**	100.0%
SA 6	95,750	7,720	293,640	780	8,517	3,329	409,735
Percent	**23.4%**	**1.9%**	71.7%	0.19%	**2.1%**	0.8%	100.0%
SA 7	7,755	15,156	227,693	618	22,313	1,655	275,191
Percent	**2.8%**	5.5%	**82.7%**	0.22%	8.1%	**0.6%**	100.0%
SA 8	60,985	40,135	182,103	935	44,330	6,942	335,429
Percent	18.2%	12.0%	54.3%	0.28%	13.2%	2.1%	100.0%
Total	228,375	249,736	1,368,985	5,255	368,507	33,208	2,254,066
Percent	10.1%	11.1%	60.7%	0.23%	16.3%	1.5%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

Figure 7. Estimated Percent Change Among Population Living at or Below 138% FPL by Race/Ethnicity (Five Year)



Note: The "Two or More Races" category was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

The percentage of African Americans living at or below 138% FPL has increased by 0.1 PP from 10.0% in CY 2014 to 10.1% in CY 2018.

The percentage of Asian/Pacific Islanders living at or below 138% FPL has increased by 1.7 PP from 9.4% in CY 2014 to 11.1% in CY 2018.

The percentage of Latinos living at or below 138% FPL has decreased by 5.7 PP from 66.4% in CY 2014 to 60.7% in CY 2018.

The percentage of Native Americans living at or below 138% FPL has remained the same at 0.2% from CY 2014 to CY 2018.

The percentage of Whites living at or below 138% FPL has increased by 2.5 PP from 13.8% in CY 2014 to 16.3% in CY 2018.

The percentage of Two or More Races living at or below 138% FPL increased by 0.3 PP from 1.2% in CY 2016 to 1.5% in CY 2018.

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Differences by Age Group

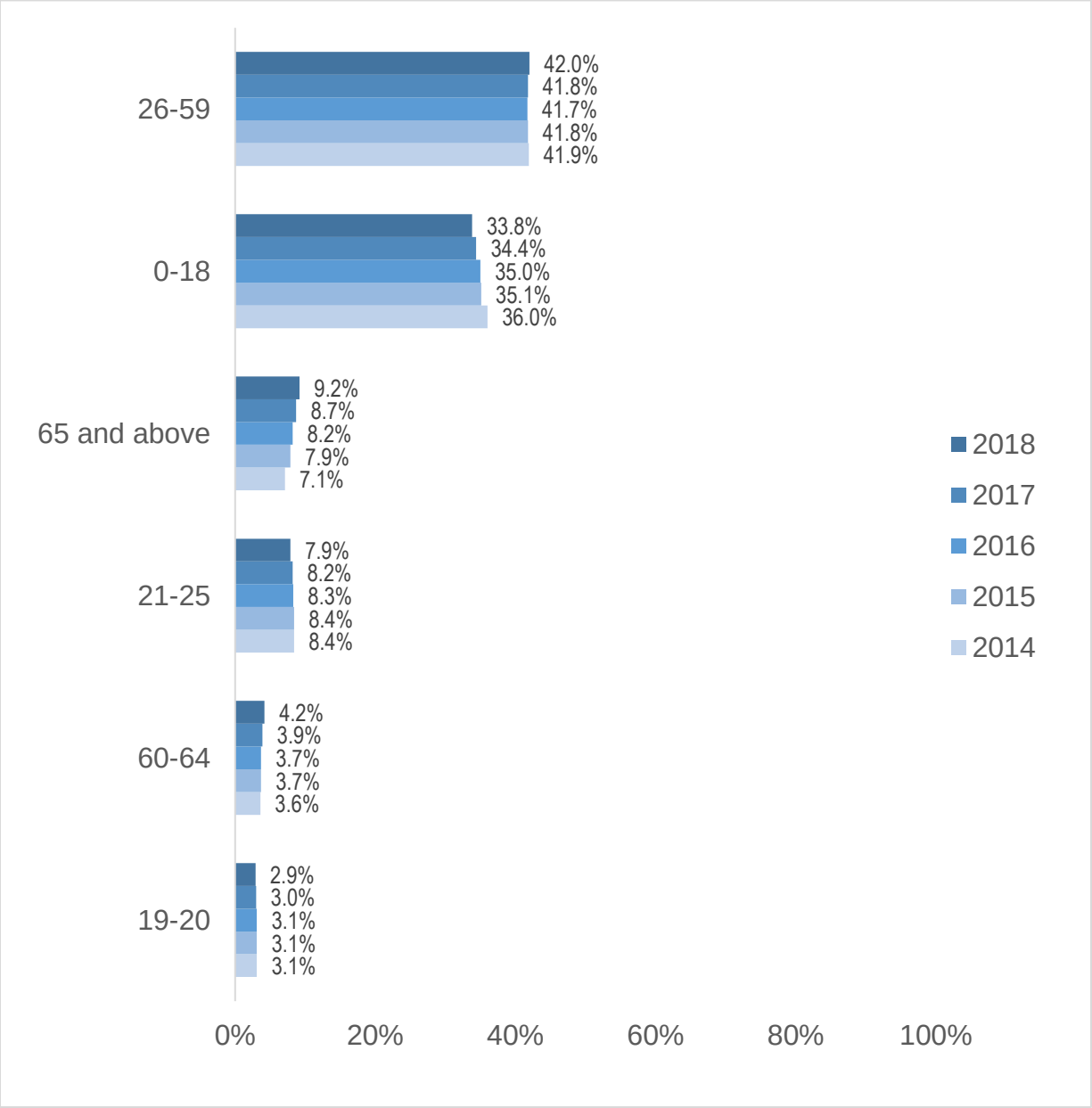
Table 5 shows the estimated population living at or below 138% FPL by age group and SA. Individuals ages 26 to 59 years old were the most represented age group living at or below 138% FPL in all SAs, except for SA 6 where the 0 to 18 age group was the highest. Individuals ages 19 and 20 years old were the least represented age group living at or below 138%FPL in all SAs.

Table 5. Estimated Population Living at or Below 138% FPL by Age Group and SA

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	40,346	3,664	9,353	41,571	4,588	8,656	108,178
Percent	37.3%	3.4%	8.6%	38.4%	4.2%	8.0%	100.0%
SA 2	127,585	11,561	30,153	180,651	18,497	40,808	409,255
Percent	31.2%	2.8%	7.4%	44.1%	4.5%	10.0%	100.0%
SA 3	97,327	9,361	24,735	132,937	15,189	39,963	319,512
Percent	30.5%	2.9%	7.7%	41.6%	**4.8%**	**12.5%**	100.0%
SA 4	92,514	7,046	20,360	147,136	12,780	32,412	312,248
Percent	29.6%	**2.3%**	**6.5%**	47.1%	4.1%	10.4%	100.0%
SA 5	14,157	3,191	10,342	42,983	3,845	10,000	84,518
Percent	**16.8%**	**3.8%**	**12.2%**	**50.9%**	4.5%	11.8%	100.0%
SA 6	168,301	13,484	35,862	154,566	14,191	23,331	409,735
Percent	**41.1%**	3.3%	8.8%	**37.7%**	**3.5%**	**5.7%**	100.0%
SA 7	104,477	8,055	21,032	107,425	10,705	23,497	275,191
Percent	38.0%	2.9%	7.6%	39.0%	3.9%	8.5%	100.0%
SA 8	116,271	9,820	25,579	139,868	14,117	29,774	335,429
Percent	34.7%	2.9%	7.6%	41.7%	4.2%	8.9%	100.0%
Total	760,978	66,182	177,416	947,137	93,912	208,441	2,254,066
Percent	33.8%	2.9%	7.9%	42.0%	4.2%	9.2%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas.
Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2019.

Figure 8. Estimated Percent Change among Population Living at or Below 138% FPL by Age Group (Five Year)



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

The percentage of individuals between 0 and 18 years old and estimated to be living at or below 138% FPL decreased by 2.2 PP from 36.0% in CY 2014 to 33.8% in CY 2018.

The percentage of individuals between 19 and 20 years old and estimated to be living at or below 138% FPL decreased by 0.2 PP from 3.1% in CY 2014 to 2.9% in CY 2018.

The percentage of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL decreased by 0.5 PP from 8.4% in CY 2014 to 7.9% in CY 2018.

The percentage of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL increased from 41.9% in CY 2014 to 42.0% in CY 2018.

The percentage of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL increased by 0.6 PP from 3.6% in CY 2014 to 4.2% in CY 2018.

The percentage of individuals age 65 years and older and estimated to be living at or below 138% FPL increased by 2.1 PP from 7.1% in CY 2014 to 9.2% in CY 2018.

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Differences by Gender

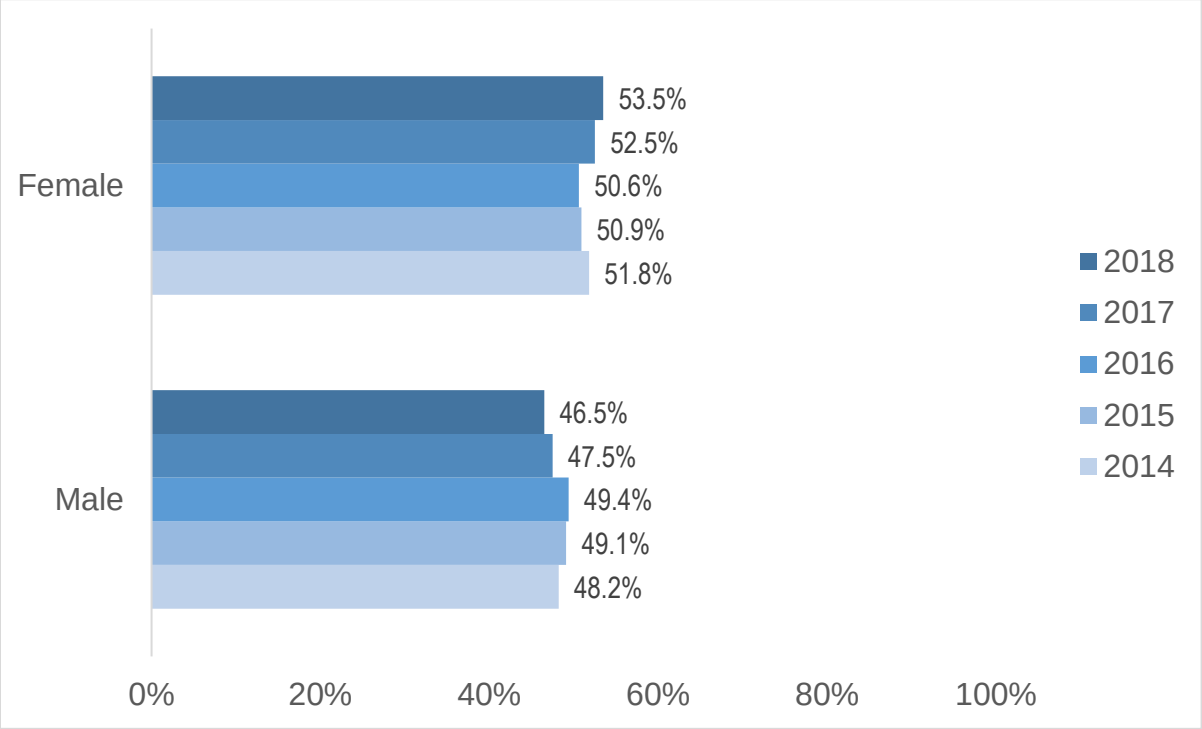
Table 6 presents the estimated population living at or below 138% FPL by gender and SA. Of those whom identified as either Male or Female, Females accounted for a higher percentage of the estimated population living at or below 138% FPL across all SAs.

Table 6. Estimated Population Living at or Below 138% FPL by Gender and SA

SA	Males	Females	Total
SA 1	49,972	58,206	108,178
Percent	46.2%	53.8%	100.0%
SA 2	191,558	217,697	409,255
Percent	46.8%	53.2%	100.0%
SA 3	147,609	171,903	319,512
Percent	46.2%	53.8%	100.0%
SA 4	148,808	163,440	312,248
Percent	**47.7%**	**52.3%**	100.0%
SA 5	39,169	45,349	84,518
Percent	46.3%	53.7%	100.0%
SA 6	189,554	220,181	409,735
Percent	46.3%	53.7%	100.0%
SA 7	126,836	148,355	275,191
Percent	**46.1%**	**53.9%**	100.0%
SA 8	155,029	180,400	335,429
Percent	46.2%	53.8%	100.0%
Total	1,048,535	1,205,531	2,254,066
Percent	46.5%	53.5%	100.0%

Note: Bold values represent the highest and lowest percentage within each ethnic group across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2019.

Figure 9. Estimated Percent Change Among Population Living at or Below 138% FPL by Gender (Five Year)



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

The percentage of Males in Los Angeles estimated to be living at or below 138% FPL decreased by 1.7 PP from 48.2% in CY 2014 to 46.5% in CY 2018.

The percentage of Females in Los Angeles estimated to be living at or below 138% FPL increased by 1.7 PP from 51.8% in CY 2014 to 53.5% in CY 2018.

Differences by Primary Language

Table 7 shows the estimated population living at or below 138% FPL whose primary language met the criteria of a threshold language for the Department.

A total of 97.9% (N = 2,206,807) of the estimated population living at or below 138% FPL (N = 2,254,066) spoke one of the Department's threshold languages. Among these, 32.1% (N = 708,200) were English speaking, 54.9% were Spanish speaking (N = 1,211,533) and 13.0% spoke the Department's remaining threshold languages.

Table 7. Primary Languages of Estimated Population Living at or Below 138% FPL by Service Area and Threshold Language

SA	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Other	Total
SA 1	813	597	98	197	66,883	159	321	57	20	95	35,538	588	402	2,120	107,888
%	0.77%	0.56%	0.09%	0.19%	**63.24%**	0.15%	0.30%	0.05%	0.02%	0.09%	**33.60%**	0.56%	0.38%	1.97%	100.00%
SA 2	4,950	48,981	155	820	120,313	6,482	4,885	1,234	1,176	7,134	195,094	7,304	2,612	6,554	407,694
%	1.23%	**12.21%**	0.04%	0.20%	**29.99%**	**1.62%**	**1.22%**	0.31%	0.29%	**1.78%**	**48.63%**	**1.82%**	**0.65%**	1.61%	100.00%
SA 3	2,302	2,555	893	14,251	93,097	426	3,614	21,974	20,611	294	136,877	4,078	11,177	5,982	318,131
%	0.74%	0.82%	0.29%	**4.57%**	**29.82%**	0.14%	**1.16%**	**7.04%**	**6.60%**	0.09%	**43.85%**	1.31%	**3.58%**	1.88%	100.00%
SA 4	1,445	7,595	566	3,493	76,987	1,063	20,310	1,163	5,371	4,895	175,795	5,441	1,498	5,659	311,281
%	0.47%	**2.49%**	0.19%	**1.14%**	**25.19%**	0.35%	**6.65%**	0.38%	1.76%	**1.60%**	**57.52%**	1.78%	0.49%	1.82%	100.00%
SA 5	1,478	696	70	362	51,052	4,668	1,600	1,336	3,048	1,482	15,495	596	596	1,487	83,966
%	1.79%	0.84%	0.08%	0.44%	**61.90%**	**5.66%**	1.94%	1.62%	3.70%	1.80%	**18.79%**	0.72%	0.72%	1.77%	100.00%
SA 6	373	124	166	389	107,015	262	2,254	837	2,361	144	286,679	395	509	7,847	409,355
%	0.09%	0.03%	0.04%	0.10%	**26.65%**	0.07%	0.56%	0.21%	0.59%	0.04%	**71.40%**	0.10%	0.13%	1.92%	100.00%
SA 7	1,758	879	503	931	60,133	161	3,195	524	1,678	197	195,563	2,653	1,308	5,246	274,729
%	0.65%	0.33%	0.19%	0.35%	**22.31%**	0.06%	**1.19%**	0.19%	0.62%	0.07%	**72.57%**	0.98%	0.49%	1.91%	100.00%
SA 8	2,240	488	4,922	235	132,720	616	4,402	1,464	1,570	448	170,492	5,871	3,190	6,039	334,697
%	0.68%	0.15%	**1.50%**	0.07%	**40.38%**	0.19%	**1.34%**	0.45%	0.48%	0.14%	**51.88%**	1.79%	**0.97%**	1.80%	100.00%
Total	15,359	61,915	7,373	20,678	708,200	13,837	40,581	28,589	35,835	14,689	1,211,533	26,926	21,292	40,934	2,247,741
%	0.70%	2.81%	0.33%	0.94%	32.09%	0.63%	1.84%	1.30%	1.62%	0.67%	54.90%	1.22%	0.96%	1.82%	100.00%

Note: SA threshold languages are in bold. "Threshold language" means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

As applicable to DMH, below is a breakdown of the 138% FPL population's threshold languages:

- SA 1 reported two threshold languages as primary languages: English (63.2%) and Spanish (33.6%).
- SA 2 reported eight SA threshold languages as primary languages: Armenian (12.2%), English (30.0%), Farsi (1.6%), Korean (1.2%), Russian (1.8%), Spanish (48.6%), and Tagalog (1.8%), and Vietnamese (0.7%).
- SA 3 reported seven SA threshold languages as primary languages: Cantonese (4.6%), English (29.3%), Korean (1.2%), Mandarin (7.0%), Other Chinese (6.6%), Spanish (43.9%), and Vietnamese (3.6%).
- SA 4 reported six SA threshold languages as primary languages: Armenian (2.5%), Cantonese (1.1%), English (25.2%), Korean (6.7%), Russian (1.6%), and Spanish (57.5%).
- SA 5 reported three SA threshold languages as primary languages: English (61.9%), Farsi (5.7%), and Spanish (18.8%).
- SA 6 reported two SA threshold languages as primary languages: English (26.7%) and Spanish (71.4%).
- SA 7 reported three SA threshold languages as primary languages: English (22.3%), Korean (1.2%) and Spanish (72.6%).
- SA 8 reported five SA threshold languages as primary languages: Cambodian (1.5%), English (40.4%), Korean (1.3%), Spanish (51.9%), and Vietnamese (1.0%).

Summary

LA County's estimated population living at or below 138% FPL decreased from CY 2017 to CY 2018. The **largest changes across the past five CYs were seen in race/ethnicity**. The Latino ethnic group decreased by 5.7 PP. Of note, the White ethnic group increased by 2.5 PP and the Asian/Pacific Islander ethnic group increased by 1.7 PP. At 82.7%, the Latino group was the highest in SA 7 when compared to SA 5 (18.5%) with the lowest in CY 2018.

Trends in the percentage of the estimated population living at or below 138% FPL **varied by age group across CY 2014 to CY 2018**. Youth ages 0 to 18 **decreased by 2.2 PP** representing fewer individuals living in poverty over time. Conversely, **the adults over 65 age group increased by 2.1 PP**. Despite these shifts, **adults remained the largest population with the highest concentration** seen in SA 5 (50.9%) in CY 2018. The 19- and 20-years-old age group had the lowest percentages across all eight SAs.

Gender distribution also varied by group over the last five CYs with Males living at or below 138% FPL decreasing by 1.7 PP and Females increasing by 1.7 PP. Females were the most represented gender.

Threshold language distribution for the estimated population living at or below 138% FPL **changed for some SAs from CY 2017 to CY 2018**. Of note, the population of Armenian speakers in SA 2 increased by 3.4 PP. For SA 4, Cantonese met the threshold language criteria and increased by 0.3 PP. Armenian speakers in this area also increased by 0.9 PP. For SA 5, Farsi speakers decreased 1.3 PP. For SA 6, Other Chinese no longer met threshold language criteria. For SA 7, Korean was introduced as a threshold language and increased 0.3 PP. For SA 8, Other Chinese no longer met threshold language criteria and Vietnamese was introduced as a threshold language increasing 0.2 PP from CY 2017 to CY 2018.

Population Enrolled in Medi-Cal November 2019

This section presents the demographic trends for LA County residents deemed eligible for Medi-Cal based on valid eligibility determination. The following data tables include counts by race/ethnicity, age group, and primary language.

Differences by Race/Ethnicity

Table 8 presents the Medi-Cal enrolled population by race/ethnicity for CY. The Latino group is the race/ethnicity with the highest Medi-Cal enrollment (58.9%) followed by Whites (13.0%), African Americans (10.1%), Asian/Pacific Islanders (9.6%), and Native Americans (0.12%). A sizeable proportion (8.3%) did not report a specific race/ethnicity.

Table 8. Population Enrolled in Medi-Cal by Race/Ethnicity

	African American	Asian/ Pacific Islander	Latino	Native American	White	Not Reported	Total
Total	380,148	358,819	2,213,132	4,504	487,236	310,768	3,754,607
Percent	10.1%	9.6%	58.9%	0.12%	13.0%	8.3%	100.0%

Data Source: State of California, Department of Health Care Services Research and Analytic Studies Division, Medi-Cal Certified Eligible Data Table by County, Age Group, ACA Aid Group, Race/Ethnicity, and Primary Language - November 2019, Report Date: March 2020. Due to rounding, some estimated totals and percentages may not total 100%.

Differences by Age Group

Table 9 presents the Medi-Cal enrolled population by age group. The age group with the highest percentage of Medi-Cal enrollees are individuals ages 19 to 64 (54.2%), followed by youth ages 0 to 18 (34.8%), and older adults ages 65 and above (11.0%).

Table 9. Population Enrolled in Medi-Cal by Age Group

	Age Group			
	0-18	19-64	65+	Total
Total	1,306,932	2,034,927	412,748	3,754,607
Percent	34.8%	54.2%	11.0%	100.0%

Data Source: State of California, Department of Health Care Services Research and Analytic Studies Division, Medi-Cal Certified Eligible Data Table by County, Age Group, ACA Aid Group, Race/Ethnicity, and Primary Language - November 2019, Report Date: March 2020.

Differences by Primary Language

Table 10 presents the Medi-Cal enrolled population by primary language. The primary language with the highest percentage of Medi-Cal enrollees is English (56.6%), followed by Spanish (34.7%), and other or unknown languages (8.7%).

Table 10. Primary Language of Population Enrolled in Medi-Cal

	Language			
	English	Other/Unknown	Spanish	Total
Total	2,124,415	326,548	1,303,644	3,754,607
Percent	56.6%	8.7%	34.7%	100%

Data Source: State of California, Department of Health Care Services Research and Analytic Studies Division, Medi-Cal Certified Eligible Data Table by County, Age Group, ACA Aid Group, Race/Ethnicity, and Primary Language - November 2019, Report Date: March 2020.

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Consumers Served in Outpatient Programs Fiscal Year 2018-2019

In FY 18-19, DMH served approximately 236,834 consumers in outpatient programs. Approximately, 20,895 were served by Fee-For-Service outpatient network providers, another 4,491 were served in jails and juvenile halls and 24,189 were served in 24-Hour acute psychiatric care or residential facilities.

Differences by Race/Ethnicity

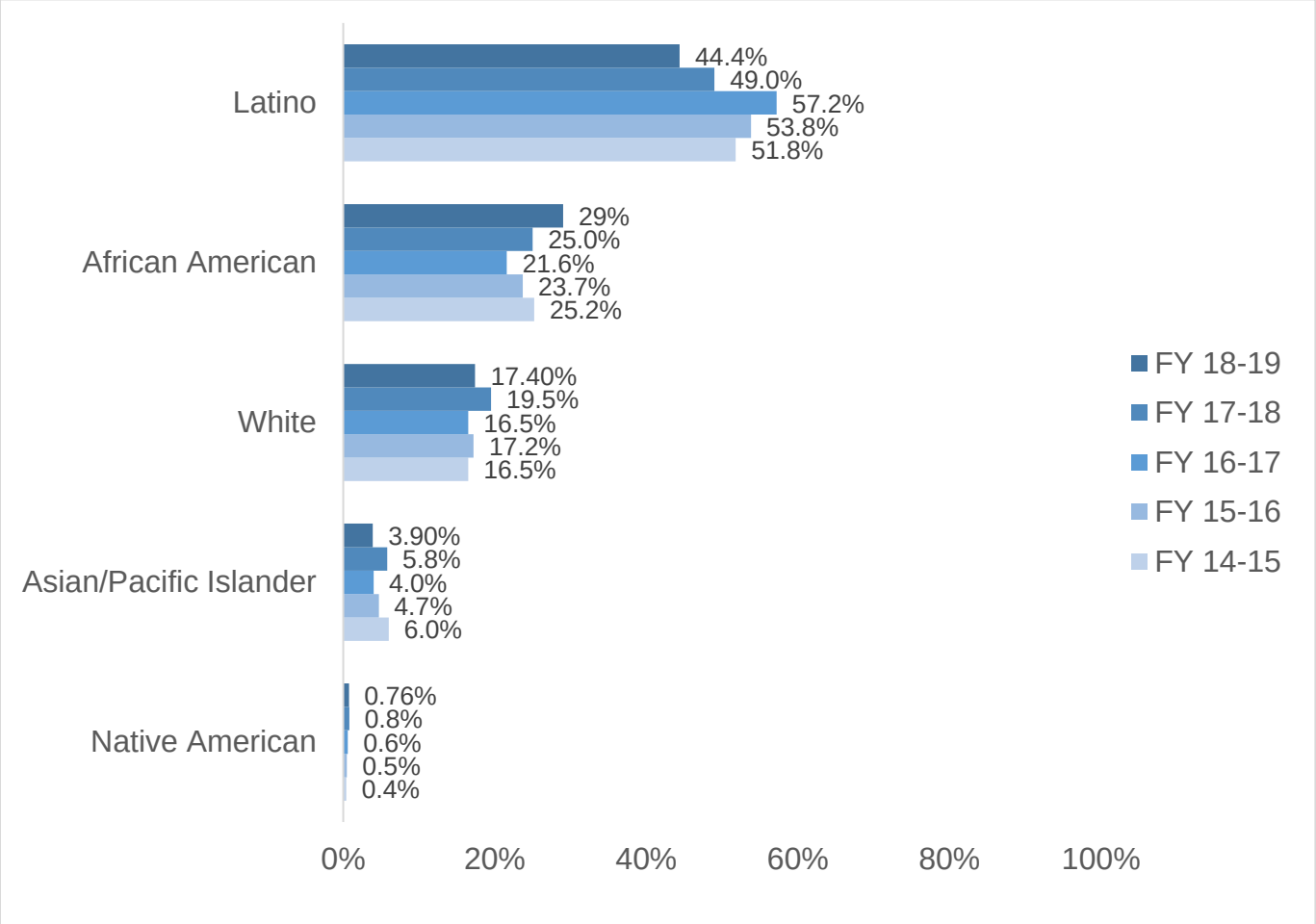
Table 11 presents the unduplicated count of consumers served in outpatient programs by race/ethnicity and SA. The Latino group is the most represented race/ethnicity among consumers served in all SAs, except for SAs 1 and 6 where the African American group is the highest. The Native American group is the least represented race/ethnicity among consumers served and across all SAs.

Table 11. Consumers Served in Outpatient Programs by Race/Ethnicity and Service Area

SA	African American	Asian/ Pacific Islander	Latino	Native American	Other Races	Unknown	White	Total
SA 1	4,648	126	3,655	106	158	321	2,571	11,585
Percent	40.1%	**1.1%**	31.5%	0.91%	1.4%	2.8%	22.2%	100.0%
SA 2	2,865	876	11,233	146	816	753	7,750	24,439
Percent	11.7%	3.6%	46.0%	0.60%	3.3%	3.1%	31.7%	100.0%
SA 3	2,805	1,872	11,620	169	388	698	3,273	20,825
Percent	13.5%	**9.0%**	55.8%	0.81%	1.9%	3.4%	15.7%	100.0%
SA 4	5,829	1,450	10,890	160	352	385	3,929	22,995
Percent	25.3%	6.3%	47.4%	0.70%	1.5%	**1.7%**	17.1%	100.0%
SA 5	1,431	191	1,297	57	210	163	2,560	5,909
Percent	24.2%	3.2%	**21.9%**	0.96%	**3.6%**	2.8%	**43.3%**	100.0%
SA 6	16,405	346	12,240	119	244	585	1,617	31,556
Percent	**52.0%**	**1.1%**	38.8%	**0.38%**	**0.8%**	1.9%	**5.1%**	100.0%
SA 7	1,491	473	13,256	215	228	668	2,041	18,372
Percent	**8.1%**	2.6%	**72.2%**	**1.17%**	1.2%	3.6%	11.1%	100.0%
SA 8	8,642	1,076	9,066	202	437	944	4,633	25,000
Percent	34.6%	4.3%	36.3%	0.81%	1.7%	**3.8%**	18.5%	100.0%
Total	35,320	4,762	54,125	920	2,105	3,335	21,206	121,773
Percent	29.0%	3.9%	44.4%	0.76%	1.7%	2.7%	17.4%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, September 2019.

Figure 10. Percent Change in Consumers Served in Outpatient Programs by Race/Ethnicity (Five Year)



Data Source: DMH, IS-IBHIS, September 2019.

Figure 10 shows the change in race/ethnicity that has occurred within consumers served in outpatient settings over the last five FYs.

The percentage of African Americans served in outpatient programs increased by 3.8 PP from 25.2% to 29.0% between FY 14-15 and FY 18-19.

The percentage of Asian Pacific Islanders served in outpatient programs decreased by 2.1 PP from 6.0% to 3.9% between FY 14-15 and FY 18-19.

The percentage of Latinos served in outpatient programs decreased by 7.4 PP from 51.8% to 44.4% between FY 14-15 and FY 18-19.

The percentage of Native Americans served in outpatient programs increased by 0.36 PP from 0.40% to 0.76% between FY 14-15 and FY 18-19.

The percentage of Whites served in outpatient programs increased by 0.9 PP from 16.5% to 17.4% between FY 14-15 and FY 18-19.

Differences by Age Group

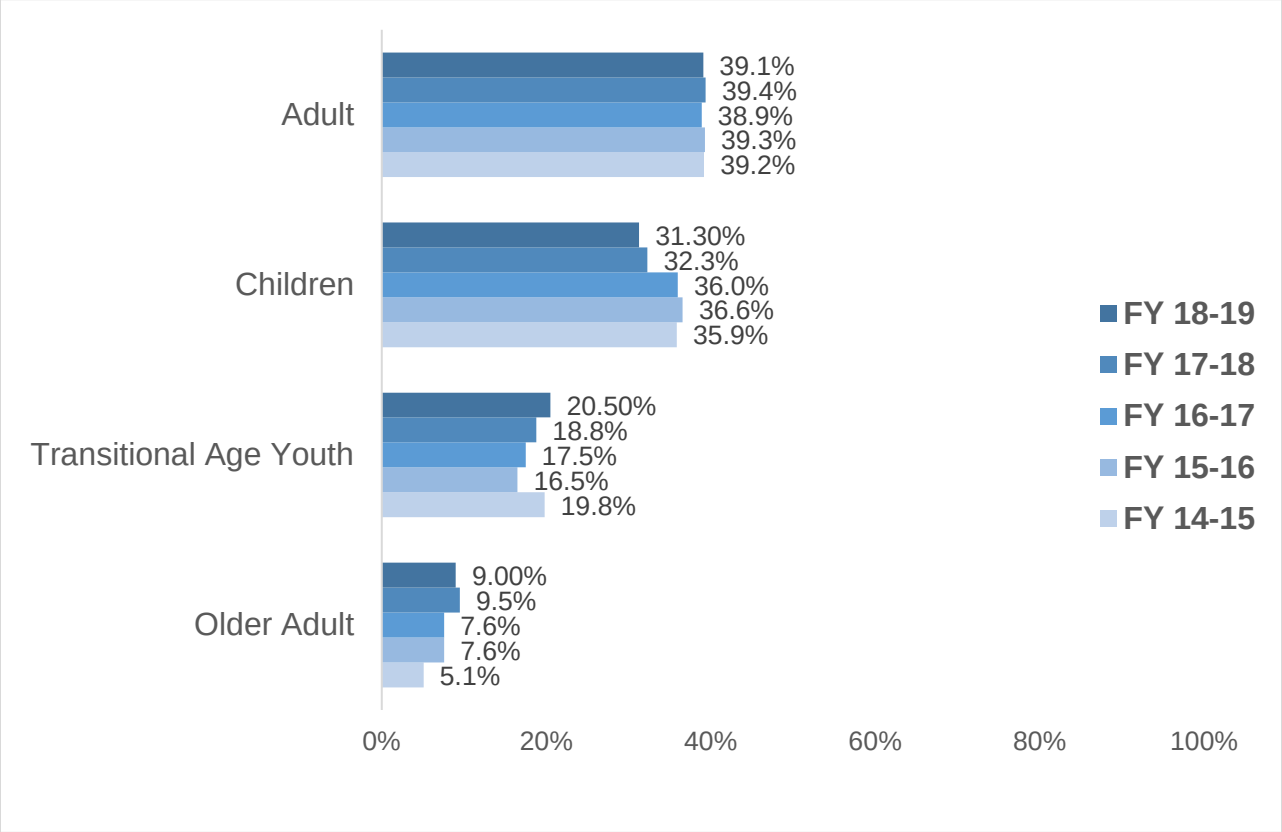
Table 12 shows the unduplicated count of consumers served in outpatient programs by age group and SA. Individuals ages 26 to 59 years old was the most represented age group among consumers served. Of note, the 0-15 age group was the highest in SAs 3 and 7. Individuals ages 60 years and above were the least represented age group among consumers served and across all SAs.

Table 12. Consumers Served in Outpatient Programs by Age Group and Service Area

SA	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	6,285	3,488	7,885	1,268	18,926
Percent	33.2%	18.4%	41.7%	**6.7%**	100.0%
SA 2	13,606	10,585	19,089	4,749	48,029
Percent	28.3%	22.0%	39.7%	9.9%	100.0%
SA 3	15,281	9,963	13,076	2,862	41,182
Percent	37.1%	**24.2%**	**31.8%**	6.9%	100.0%
SA 4	9,819	7,301	18,180	4,756	40,056
Percent	24.5%	18.2%	45.4%	11.9%	100.0%
SA 5	1,678	1,658	5,518	1,594	10,448
Percent	**16.1%**	**15.9%**	**52.8%**	**15.3%**	100.0%
SA 6	17,939	11,233	21,568	4,460	55,200
Percent	32.5%	20.3%	39.1%	8.1%	100.0%
SA 7	13,774	8,385	12,206	2,565	36,930
Percent	**37.3%**	22.7%	33.1%	6.9%	100.0%
SA 8	12,906	8,301	18,824	4,746	44,777
Percent	28.8%	18.5%	42.0%	10.6%	100.0%
Total	72,365	47,481	90,419	20,881	231,146
Percent	31.3%	20.5%	39.1%	9.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Total reflects unduplicated count of consumers served. Data source: DMH IS-IBHIS, September 2019.

Figure 11. Percent Change in Consumers Served in Outpatient Programs by Age Group (Five Year)



Data Source: DMH, IS-IBHIS, September 2019.

Figure 11 shows the change in age groups that has occurred within consumers served in outpatient settings over the last five FY.

The percentage of Children served in outpatient programs decreased by 4.6 PP from 35.9% to 31.3% between FY 14-15 and FY 18-19.

The percentage of TAY served in outpatient programs increased by 0.7 PP from 19.8% to 20.5% between FY 14-15 and FY 18-19.

The percentage of Adults served in outpatient programs decreased by 0.1 PP from 39.2% to 39.1% between FY 14-15 and FY 18-19.

The percentage of Older Adults served in outpatient programs increased by 3.9 PP from 5.1% to 9.0% between FY 14-15 and FY 18-19.

Differences by Gender

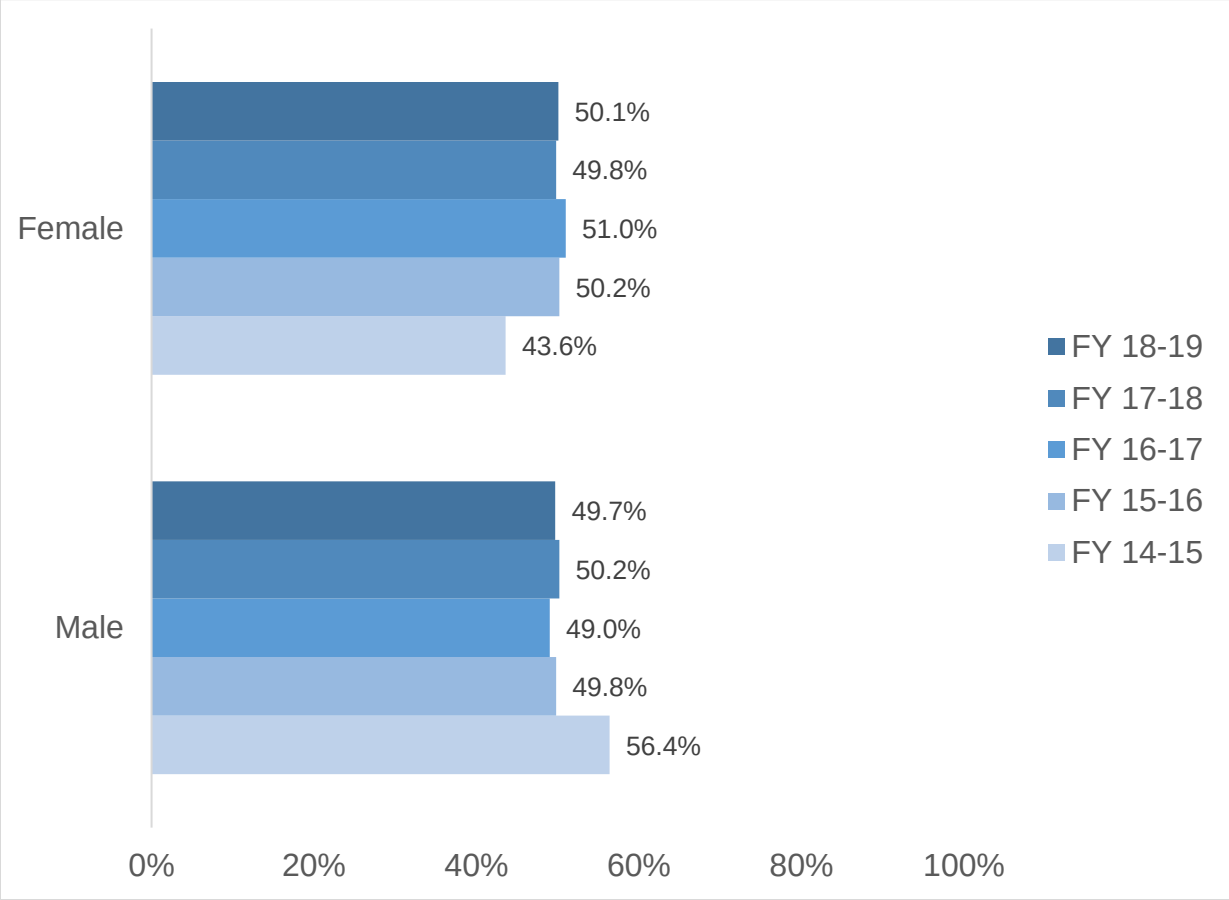
Table 13 presents the unduplicated count of consumers served in outpatient programs by gender and SA. The highest number of consumers served identified as male in all SAs.

Table 13. Consumers Served in Outpatient Programs by Gender and Service Area

SA	Male	Female	Transgender (F to M)	Transgender (M to F)	Unknown	Total
SA 1	9,751	9,146	10	12	7	18,926
Percent	**51.5%**	**48.3%**	0.05%	0.06%	0.04%	100.0%
SA 2	24,350	23,617	24	27	13	48,031
Percent	50.7%	49.2%	0.05%	0.06%	0.03%	100.0%
SA 3	20,918	20,206	27	18	13	41,182
Percent	50.8%	49.1%	0.07%	0.04%	0.03%	100.0%
SA 4	20,504	19,500	26	21	9	40,060
Percent	51.2%	48.7%	0.06%	0.05%	0.02%	100.0%
SA 5	5,300	5,136	6	5	2	10,449
Percent	50.7%	49.2%	0.06%	0.05%	0.0%	100.0%
SA 6	27,881	27,251	36	18	15	55,201
Percent	50.5%	**49.4%**	0.07%	0.03%	0.03%	100.0%
SA 7	18,631	18,245	20	22	12	36,930
Percent	**50.4%**	**49.4%**	0.05%	0.06%	0.03%	100.0%
SA 8	22,921	21,781	32	25	19	44,778
Percent	51.2%	48.6%	0.07%	0.06%	0.04%	100.0%
Total	114,994	115,838	137	114	70	231,153
Percent	49.7%	50.1%	0.06%	0.05%	0.03%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Data source: DMH-IS-IBHIS, September 2019

Figure 12. Percent Change in Consumers Served in Outpatient Programs by Gender (Five Year)



Note: Transgender and Unknown as not represented as FY 19-20 is the first year that these numbers are reported. Data Source: DMH – IS-IBHIS Database, September 2019.

Figure 12 shows Males served in outpatient programs decreased 6.7 PP from 56.4% to 49.7% between FY 14-15 and FY 18-19.

Females served in outpatient programs increased 6.5 PP from 43.6% to 50.1% between FY 14-15 and FY 18-19.

Differences by Primary Language.

Table 14 compares the outpatient programs of consumers served by SA and threshold language.

English was the highest reported primary language among consumers served in outpatient programs, in all SAs. A total of 180,722 (81.4%) English-speaking consumers were served followed by 35,304 (15.9%) Spanish-speaking consumers. The remaining 6,129 (2.8%) consumers served spoke the Department's other threshold languages. A total of 41,433 (18.6%) of the consumers served reported a primary language other than English. SA 1 (93.8%) had the highest percentage of English-speaking consumers, as compared to SA 7 (76.3%) which had the lowest percentage.

Spanish was the highest reported non-English threshold language for consumers served in all SAs. The SA with the highest percentage of consumers served reporting Spanish as their primary language was in SA 7 (22.8%) and the lowest percentage was in SA 1 (6.0%).

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Table 14. Primary Language of Consumers Served in Outpatient Programs by Service Area and Threshold Language

SA	Arabic	Arme-nian	Cambo-dian	Canton-ese	English	Farsi	Korean	Man-darin	Other Chinese	Russian	Spanish	Tagalog	Vietna-mese	Total
SA 1	5	9	1	1	17,392	8	3	5	0	3	1,117	6	2	18,552
%	0.03%	0.05%	0.01%	0.01%	**93.75%**	0.04%	0.02%	0.03%	0.00%	0.02%	**6.02%**	0.03%	0.01%	100.0%
SA 2	106	1,105	25	12	36,835	524	106	17	16	260	6,851	118	59	46,034
%	0.23%	**2.40%**	0.05%	0.03%	**80.02%**	**1.14%**	**0.23%**	0.04%	0.03%	**0.56%**	**14.88%**	**0.26%**	**0.13%**	100.0%
SA 3	30	26	70	575	30,976	11	95	569	90	9	6,723	37	421	39,632
%	0.08%	0.07%	0.18%	**1.45%**	**78.16%**	0.03%	**0.24%**	**1.44%**	**0.23%**	0.02%	**16.96%**	0.09%	**1.06%**	100.0%
SA 4	10	115	71	104	29,894	40	602	43	19	192	6,845	86	79	38,100
%	0.03%	**0.30%**	0.19%	**0.27%**	**78.46%**	0.10%	**1.58%**	0.11%	0.05%	**0.50%**	**17.97%**	0.23%	0.21%	100.00%
SA 5	11	5	0	4	8,911	168	31	8	1	37	594	2	5	9,777
%	0.11%	0.05%	0.00%	0.04%	**91.14%**	**1.72%**	0.32%	0.08%	0.01%	0.38%	**6.08%**	0.02%	0.05%	100.00%
SA 6	7	1	23	18	43,835	12	86	10	6	8	9,394	8	18	53,426
%	0.01%	0.00%	0.04%	0.03%	**82.05%**	0.02%	0.16%	0.02%	0.01%	0.01%	**17.58%**	0.01%	0.03%	100.00%
SA 7	24	10	96	21	27,255	3	56	28	14	7	8,137	24	31	35,706
%	0.07%	0.03%	0.27%	0.06%	**76.33%**	0.01%	**0.16%**	0.08%	0.04%	0.02%	**22.79%**	0.07%	0.09%	100.00%
SA 8	17	3	652	10	35,484	10	105	20	10	10	6,137	86	130	42,674
%	0.04%	0.01%	**1.53%**	0.02%	**83.15%**	0.02%	**0.25%**	0.05%	0.02%	0.02%	**14.38%**	0.20%	**0.30%**	100.00%
Total	167	1,274	694	594	180,722	620	819	559	133	407	35,304	295	567	222,155
%	0.08%	0.57%	0.31%	0.27%	81.35%	0.28%	0.37%	0.25%	0.06%	0.18%	15.89%	0.13%	0.26%	100.00%

Note: "Threshold Language" means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. A total of 1,215 consumers served in Outpatient Programs specified another non-threshold primary language show in in Table 16. Another 1,302 consumers had primary languages that were "Unknown" or "Missing". Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. Data source: LACDMH-IS-IBHIS, September 2019.

The following information highlights the additional non-English threshold languages reported for consumers served in outpatient programs by SA:

- SA 1: Spanish (6.0%);
- SA 2: Armenian (2.4%), Farsi (1.1%), Korean (0.2%), Russian (0.6%), Spanish (14.9%), Tagalog (0.3%), and Vietnamese (0.1%);
- SA 3: Cantonese (1.5%), Korean (0.2%), Mandarin (1.4%), Other Chinese (0.2%), Spanish (17.0%), and Vietnamese (1.1%);
- SA 4: Armenian (0.3%), Cantonese (0.3%), Korean (1.6%), Russian (0.5%), and Spanish (18.0%);
- SA 5: Farsi (1.7%) and Spanish (6.1%);
- SA 6: Spanish (17.6%);
- SA 7: Korean (0.2%) and Spanish (22.8%);and
- SA 8: Cambodian (1.5%), Korean (0.3%), Spanish (14.4%), and Vietnamese (0.3%).

Differences by "Other" non-Threshold Languages. Table 15 reports the distribution of "Other" non-threshold languages spoken by consumers served in FY 18-19. The highest number of consumers who spoke "Other" non-threshold languages was in SA 4 (N = 156), followed by SA 2 (N = 140).

The language with the highest number of speakers was Japanese (N= 87). SA 8 (N = 48) and SA 6 (N = 36) served the highest number of consumers who spoke Japanese, followed by SA 3 (N = 11) and SA 2 (N = 10).

The language with the second highest number of speakers was Thai (N = 67), followed by 58 consumers who preferred ASL, and 56 consumers who preferred Ethiopian.

Table 15. "Other" non-Threshold Languages Spoken by Consumers Served in Outpatient Programs by Service Area

Languages	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Total
Afghan, Pashto, Pusho	1	19	2	2	1	1	0	2	23
Percent	5.9%	**13.6%**	2.3%	1.3%	1.7%	2.0%	**0.0%**	1.5%	4.0%
American Sign Language	0	0	0	2	0	0	1	0	58
Percent	**0.0%**	**0.0%**	**0.0%**	1.3%	**0.0%**	**0.0%**	**2.7%**	**0.0%**	10.2%
Burmese	0	4	14	1	0	0	1	1	17
Percent	**0.0%**	2.9%	**15.9%**	0.6%	**0.0%**	**0.0%**	2.7%	0.7%	3.0%
Ethiopian	0	13	2	22	4	14	4	12	56
Percent	**0.0%**	9.3%	2.3%	14.1%	6.9%	**27.5%**	10.8%	8.8%	9.8%
French	4	10	4	16	15	6	0	4	39
Percent	**23.5%**	7.1%	4.5%	10.3%	**25.9%**	11.8%	**0.0%**	2.9%	6.8%
Hebrew	0	14	0	6	2	1	1	0	22
Percent	**0.0%**	**10.0%**	**0.0%**	3.8%	3.4%	2.0%	2.7%	**0.0%**	3.9%
Hindi	1	7	2	3	6	0	5	6	24
Percent	5.9%	5.0%	2.3%	1.9%	**10.3%**	**0.0%**	13.5%	4.4%	4.2%
Japanese	0	10	11	36	9	3	3	48	87
Percent	**0.0%**	7.1%	12.5%	**23.1%**	**15.5%**	5.9%	8.1%	**35.3%**	15.2%
Lao	0	3	10	14	0	5	1	27	44
Percent	**0.0%**	2.1%	11.4%	9.0%	**0.0%**	9.8%	2.7%	**19.9%**	7.7%
Portuguese	4	4	6	6	14	3	1	10	41
Percent	**23.5%**	2.9%	6.8%	3.8%	**24.1%**	5.9%	**2.7%**	7.4%	7.2%
Punjabi	1	15	0	0	1	0	2	1	16
Percent	5.9%	**10.7%**	**0.0%**	**0.0%**	1.7%	**0.0%**	5.4%	0.7%	2.8%
Romanian	1	6	1	3	0	0	0	0	9
Percent	**5.9%**	4.3%	1.1%	1.9%	**0.0%**	**0.0%**	**0.0%**	**0.0%**	1.6%
Thai	2	17	10	33	1	4	7	11	67
Percent	11.8%	12.1%	11.4%	**21.2%**	**1.7%**	7.8%	**18.9%**	8.1%	11.7%
Toisan	0	1	11	4	0	2	1	0	10
Percent	**0.0%**	0.7%	**12.5%**	2.6%	**0.0%**	3.9%	2.7%	**0.0%**	1.8%
Urdu	0	6	2	1	1	2	7	10	18
Percent	**0.0%**	4.3%	2.3%	0.6%	1.7%	3.9%	**18.9%**	7.4%	3.2%
Other Non-English	3	11	13	7	4	10	3	4	40
Percent	17.6%	7.9%	14.8%	4.5%	6.9%	**19.6%**	8.1%	**2.9%**	7.0%
Total	17	140	88	156	58	51	37	136	571
Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each "Other" non-threshold language and across SAs. Column total is for unduplicated count of Consumers Non - Threshold language. Data source: DMH-IS-IBHIS, September 2019.

Summary

The number of consumers served in LACDMH outpatient programs decreased from FY 17-18 to FY 18-19. The **largest changes over the past five fiscal years were seen in race/ethnicity**. The Latino ethnic group decreased by 7.4 PP. Of note, the African American ethnic group increased by 3.8 PP and the Asian/Pacific Islander ethnic group decreased by 2.1 PP. At 72.2%, the Latino group was the highest in SA 7 when compared to SA 5 (21.9%) with the lowest in FY 18-19.

Trends in the percentage of consumers served in outpatient program **differed by age group** from FY 14-15 to FY 18-19. Children **decreased by 4.6 PP** representing fewer youth served over time. Conversely, **older adults increased by 3.9 PP**. Despite these shifts, **adults remained the largest population with the highest concentration** seen in SA 5 in FY 18-19 (52.8%).

Gender distribution for consumers served also varied by group from FY 14-15 to FY 18-19. Males served **decreased by 6.7 PP** and females served **increased by 6.5 PP**. Females were the most represented gender in FY 18-19 (50.1%).

Threshold language distribution for consumers served remained relatively stable across SAs from CY 2017 to CY 2018. Of note, the population of Korean speakers in SA 4 increased 0.4 PP from 1.6% to 2.0%.

Penetration Rates

The Mental Health Services Division at DHCS contracts with Behavioral Health Concepts, Inc. (BHC) to provide EQRO services for California's MHPs. Information on Medi-Cal beneficiaries served and penetration rates represent two of the seven performance measures summarized in their annual BHC-CalEQRO Validation of Performance Measures (PM) Reports. The statewide annual EQRO and PM reports are available for public review via BHC's website. The full 2019 LA County PM report is included in Appendix A. A brief overview of LA County's five- and three-year penetration rate changes – for the Medi-Cal enrolled population – is presented in the following.

Table 16. Penetration Rates by Race/Ethnicity (Five Year)

Race/Ethnicity	2015	2016	2017	2018	2019
White	10.40%	9.68%	7.15%	5.59%	6.34%
Hispanic	4.17%	4.08%	3.73%	4.06%	4.66%
African-American	10.29%	9.77%	8.82%	8.85%	9.59%
Asian/Pacific Islander	3.03%	2.72%	2.21%	2.21%	2.49%
Native American	14.22%	12.96%	10.53%	9.40%	10.35%

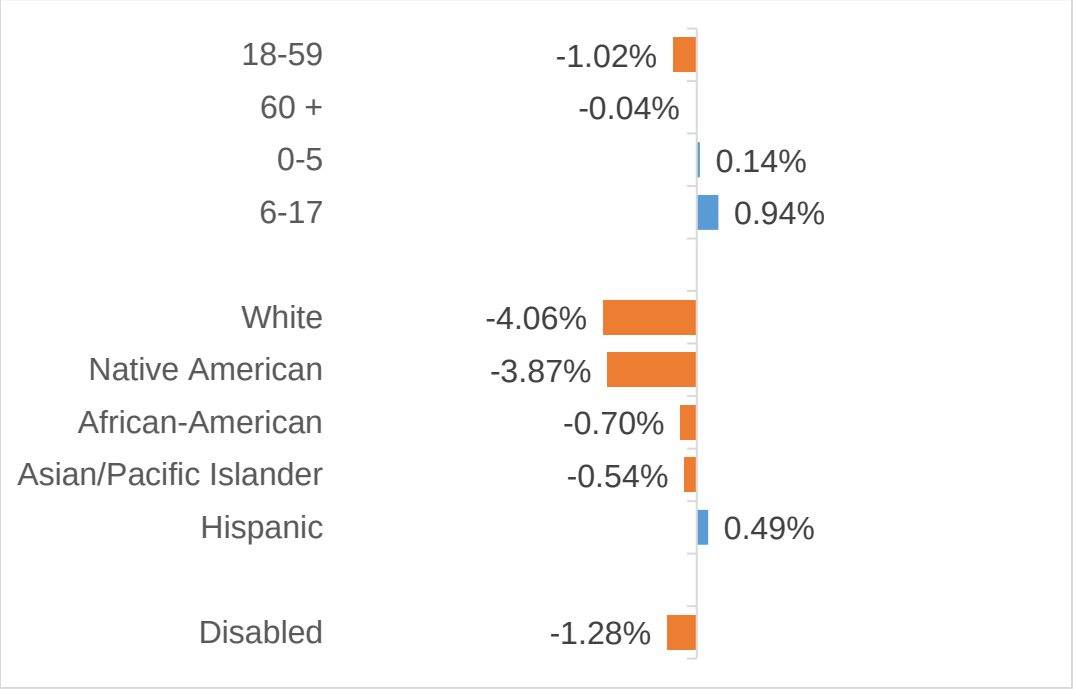
Data Source: Los Angeles PM Reports FY 2014-15 to 2019-20, BHC.

Table 17. Penetration Rates by Age Group (Five Year)

Age Group	2015	2016	2017	2018	2019
0-5	3.16%	3.24%	2.79%	3.20%	3.30%
6-17	7.63%	7.58%	7.29%	8.14%	8.57%
18-59	6.03%	5.50%	4.61%	4.84%	5.01%
60 +	3.05%	2.88%	2.78%	2.88%	3.01%

Data Source: Los Angeles PM Reports FY 2014-15 to 2019-20, BHC.

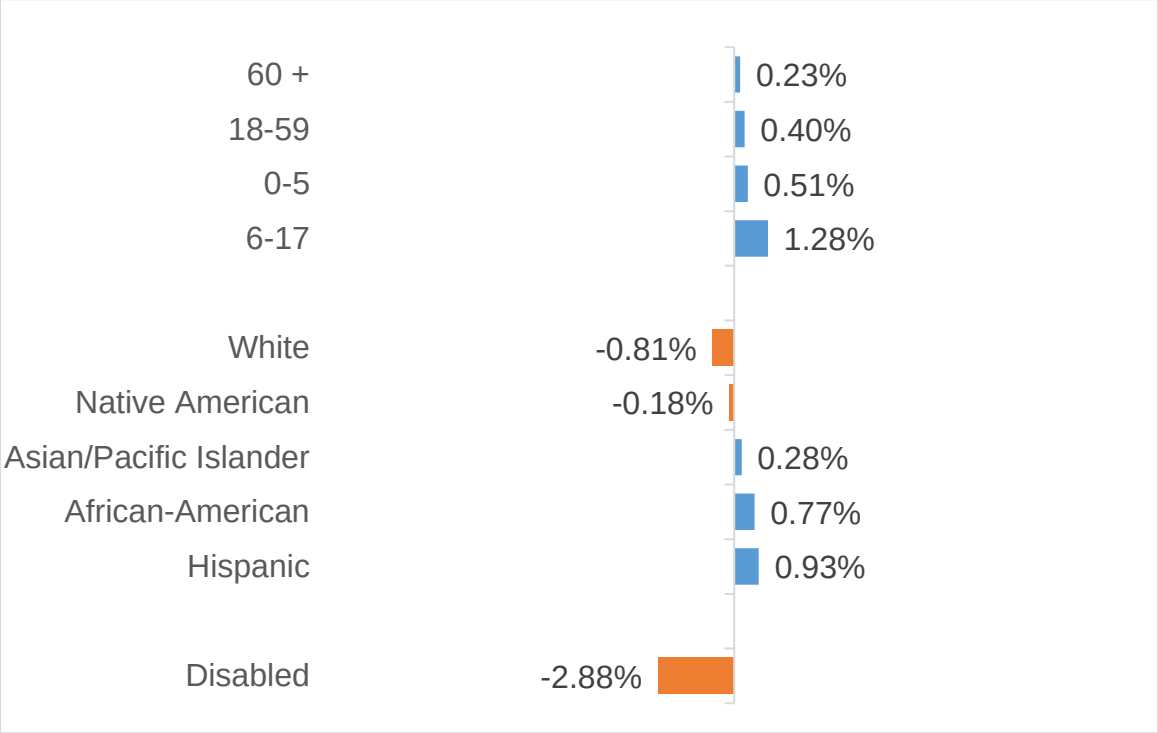
Figure 13. Trend Analysis for Penetration Rates Across Age Group, Race/Ethnicity, and Disability Status (Five Year)



Data Source: Los Angeles PM Reports FY 2014-15 to 2019-20, BHC.

The five-year trend analysis for penetration rates shows an increase for younger age groups and Hispanic consumers.

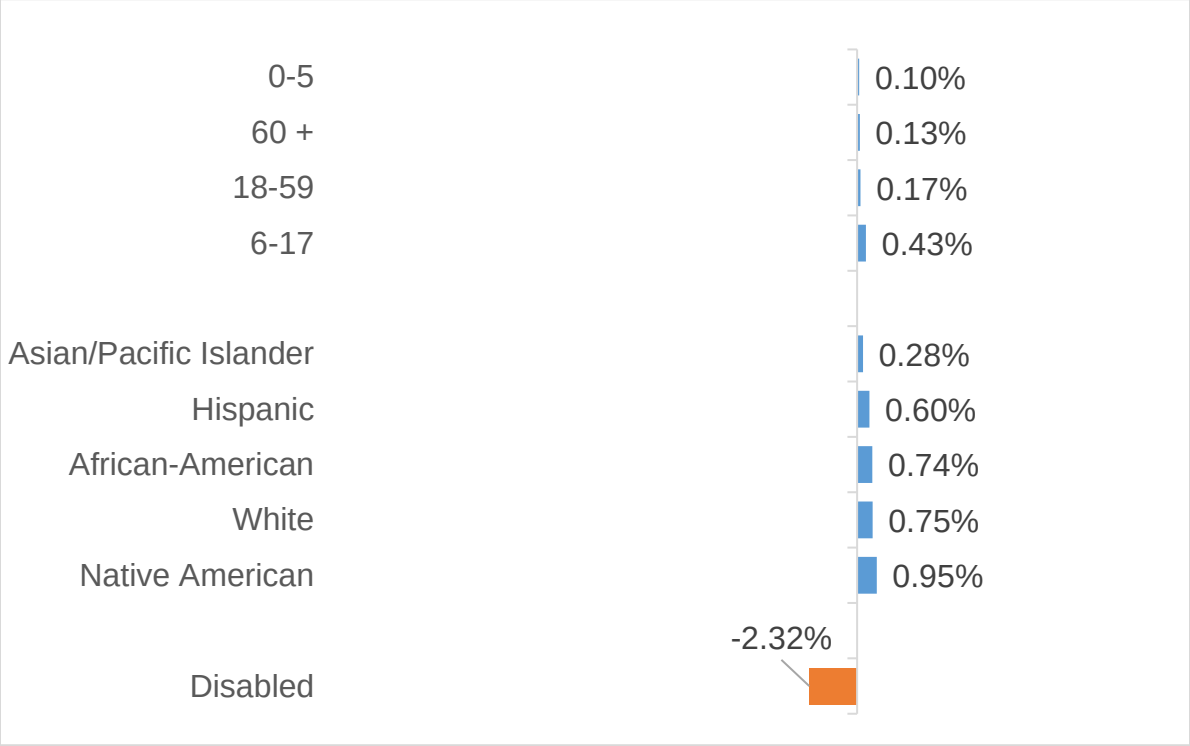
Figure 14. Trend Analysis for Penetration Rates Across Age Group, Race/Ethnicity, and Disability Status (Three Year)



Data Source: Los Angeles PM Reports FY 2014-15 to 2019-20, BHC.

The three-year trend analysis of penetration rates shows increases for all age groups and race/ethnicities except for White and Native American.

Figure 15. Trend Analysis for Penetration Rates Across Age Group, Race/Ethnicity, and Disability Status (One Year)



Data Source: Los Angeles PM Reports FY 2014-15 to 2019-20, BHC.

The one-year trend analysis for penetration rates shows an increase in all age groups and race/ethnicities and a decrease in consumers with disabilities.

SECTION III

Quality Improvement Work Plan Evaluation
Calendar Year 2019

In this Section:

Monitoring Service Delivery Capacity
Monitoring Accessibility of Services
Monitoring Beneficiary Satisfaction
Monitoring Clinical Care
Monitoring Continuity of Care
Monitoring Provider Appeals
Monitoring Performance Improvement Projects

Section III: Quality Improvement Work Plan Evaluation Report
Calendar Year 2019

The QI Work Plan goals are in place to monitor and evaluate the quality of the service delivery system. In accordance with the MHP's reporting requirements of the CCR Title 9, Chapter 11, Section 1810.440, concerning QI, the Department's evaluation of QI activities is structured and organized according to the following domains:

I. Monitoring Service Delivery Capacity
II. Monitoring Accessibility of Services
III. Monitoring Beneficiary Satisfaction
IV. Monitoring Clinical Care
V. Monitoring Continuity of Care
VI. Monitoring Provider Appeals
Monitoring Performance Improvement Projects

The QI Work Plan Evaluation report that follows provides an assessment of the goals identified in the QI Work Plan. The QI Work Plan goals for CY 2019 address: access to services for consumers, service delivery capacity for underserved populations, the timeliness of DMH services provided, beneficiary satisfaction with the services received, the quality of services provided, and other prioritized areas of quality improvement. The evaluation of the QI Work Plan provides a basis for the establishment of goals and objectives for CY 2020.

2019 Quality Improvement Work Plan Goals Evaluation Summary

Domain	No.	Goal	Evaluation
Service Delivery Capacity	I.1.	By June 30, 2019, between 78.2% and 79.2% of the total Los Angeles County African American population estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) and at or below the 138% Federal Poverty Level (FPL) will be served in DMH outpatient programs.	**UNRATED**
	I.2.	By June 30, 2019, between 49.7% and 50.3% of the total Los Angeles County Latino population estimated with SED and SMI and at or below the 138% FPL will be served in DMH outpatient programs.	**UNRATED**
	I.3.	By December 31, 2019, a Community Mental Health Needs Assessment that identifies gaps in service delivery for the deaf, hard-of-hearing, and blind communities as well as people with physical disabilities will be implemented.	**UNRATED**
	I.4.	By December 31, 2019, at least 500 DMH consumers will receive Telemental Health (TMH) services.	**MET**
	I.5.	By December 31, 2019, Promotores de Salud (Health Promoters) trained in delivering community-designed, peer-based engagement and education will serve the Latino population in all eight Service Areas (SAs) of Los Angeles County.	**MET**
Accessibility of Services	II.1.	Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 60% for Calendar Year (CY) 2019.	**NOT MET**
	II.2.	By December 31, 2019, 80% of the calls to the toll-free hotline received during after-hours will be answered by a live agent within one minute from when they present to the Virtual Contact Center (VCC).	**MET**
	II.3.	By December 31, 2019, 80% of the calls to the toll-free hotline received during business-hours will be answered by a live agent within one minute from when they present to the VCC.	**MET**
	II.4.	By June 30, 2019, a report on the number of sign language interpreter services appointments coordinated by the toll-free hotline will be evaluated for trends.	**MET**
	II.5.	In May 2019, between 86.5% and 87.7% of DMH consumers/families will report satisfaction with location of their outpatient programs.	**MET**
	II.6.	In May 2019, between 90.2% and 91.2% of DMH consumers/families will report satisfaction with the times of their outpatient services.	**MET**
Beneficiary Satisfaction	III.1.	In May 2019, between 88.0% and 89.2% of DMH consumers/families will report satisfaction with their outpatient program staff's sensitivity to their cultural/ethnic background.	**MET**
	III.2.	In May 2019, between 88.5% and 89.6% of DMH consumers/families will report overall satisfaction with their outpatient program.	**MET**
	III.3.	By June 30, 2019, a report on the number of grievances, appeals (standard and expedited), and State Fair Hearings will be categorized by type and disposition and evaluated.	**MET**
	III.4.	By June 30, 2019, a report on the number of beneficiary requests for a Change of Provider (COP) including reasons given by consumers for their requests as well as changes to the providers' COP submission process will be monitored and evaluated.	**MET**
Clinical Care	IV.1.	By June 30, 2019, the number and reasons for approved, denied, and returned Prescription Drug Prior Authorization (PA) Requests will be evaluated for trends.	**MET**
Continuity of Care	V.1.	By December 31, 2019, at least 93% of the consumers referred to DMH Directly-Operated (DO) programs by the toll-free line will be offered priority appointments for Specialty Mental Health Services (SMHS) assessments within five business days.	**MET**
	V.2.	By December 31, 2019, at least 96% of the consumers referred to DMH LE/Contracted programs by the toll-free line will be offered priority appointments for SMHS assessments within five business days.	**MET**
Provider Appeals	VI.1.	By December 31, 2019, the total number of Treatment Authorization Requests (TARs) appeals will be evaluated for trends.	**MET**
Performance Improvement Projects	VII.1	By December 31, 2019, one non-clinical Performance Improvement Project (PIP) will be developed and implemented.	**NOT MET**
	VII.2	By December 31, 2019, one clinical PIP will be developed and implemented.	**MET**

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH hope. recovery. wellbeing.

Monitoring Service Delivery Capacity

Prevalence and Penetration Rates for Fiscal Year 2018-2019

DMH established target benchmarks for the number of African American and Latino consumers served in 2019 at respective and approximate rates of 78 and 49 percent of the population estimated with SED and SMI and living at or below 138% FPL. The prevalence rates utilized to estimate SED and SMI were derived from the California Health Interview Survey (CHIS; CY 2015 and CY 2016). The CHIS rates are estimated from a random sample of the population in LA County. The CHIS collects survey data on mental health utilization patterns from the LA County population every two years, within each SA, and by race/ethnicity. With time, these estimates became increasingly unstable and difficult to interpret.

When the Department's penetration rates were examined by race/ethnicity for the population living at or below 138% FPL, based on prevalence rates from CHIS for FY 15-16 to 17-18, the African American and Latino communities appeared to have the greatest need for mental health outreach and services. Moreover, the penetration rates for the African American group decreased from 150% in FY 15-16 to 78.7% in FY 17-18 and decreased from 53.2% in FY 15-16 to 50.0% in FY 17-18 for the Latino group. These findings diverged from the penetration rates reported for other large counties and statewide, where the Latino and Asian/Pacific Islander communities demonstrate the greatest need. Of note, DMH reported a significant increase in penetration rates for the Asian/Pacific Islander group, from 35.6% in FY 15-16 to 52.0% in FY 17-18.

Under the advisement of CalEQRO, DMH will discontinue the use of CHIS estimates to calculate prevalence and penetration rates. Moreover, the 2019 Work Plan penetration rate goals, which were established using the former CHIS methodology, could not be rated.

Moving forward, DMH will rely on service utilization data derived from information on the number of consumer/beneficiaries served and penetration rate data provided by CalEQRO to measure the Department's service delivery capacity.

Goal I.1.:	By June 30, 2019, between 78.2% and 79.2% of the total LA County African American population estimated with SED and SMI and at or below the 138% FPL will be served in DMH outpatient programs.
Population:	African American population estimated with SED and SMI and living at or below 138% FPL.
Indicator:	African American consumers receiving mental health treatment services in DMH outpatient programs.
Evaluation:	Unrated due to reasons listed above.

Goal I.2.:	By June 30, 2019, between 49.7% and 50.3% of the total LA County Latino population estimated with SED and SMI and at or below the 138% FPL will be served in DMH outpatient programs.
Population:	Latino population estimated with SED and SMI and living at or below 138% FPL
Indicator:	Latino consumers receiving mental health services in DMH outpatient programs.
Evaluation:	Unrated due to reasons listed above.

Community Mental Health Needs Assessment

Goal I.3.:	By December 31, 2019, a Community Mental Health Needs Assessment that identifies gaps in service delivery for the deaf, hard-of-hearing, and blind communities as well as people with physical disabilities will be implemented.
Population:	Deaf, hard-of-hearing, and blind communities as well as people with physical disabilities.
Indicator:	Community Mental Health Needs Assessment.
Evaluation:	This goal is not rated

The Deaf, Hard-of-Hearing, Blind, and Physical Disabilities Underserved Cultural Committees' (UsCC) subcommittee was established January 1, 2018 and held its first UsCC subcommittee meeting on January 30, 2018. The goal of this subcommittee is to reduce disparities and increase mental health access for the deaf, hard-of-hearing, blind, and physically-disabled communities. This group works closely with community partners and consumers in order to increase the capacity of the public mental health system, to develop culturally relevant recovery-oriented services specific to the targeted communities, and to develop capacity-building projects.

The statement of work and service request that were drafted for the Community Mental Health Needs Assessment presented the deaf, hard-of-hearing, blind communities, and people with physical disabilities as a combined effort. As a result, the solicitation was met with some delays and had not been fulfilled by the end of the 2019 year. The Department has learned from this process. Future solicitations will take into account the unique service needs of each community.

Telemental Health

Goal I.4.:	By December 31, 2019, at least 500 DMH consumers will receive TMH services.
Population:	Consumers receiving TMH services at various end-points in DMH DO clinics.
Indicator:	Service delivery capacity for psychiatry appointments via the TMH program.
Evaluation:	This goal was met.

In Calendar Year 2019, 1175 unique clients received Telemental Health (TMH) services in directly-operated clinics. There were two permanent psychiatrists and one nurse providing TMH services in these clinics and the most common services provided were evaluation and management (N = 937) and targeted case management (N = 502). Consumers who received TMH were predominately female (63.8%) and in the adult age range. The majority of consumers served were Latino (57.5%) followed by White (17.1%), Black (7.6%), Two or more races (6.4%), Asian (4.8%), Unknown (4%), and Other (2.6%). Most consumers reported English (69.6%) or Spanish (26.5%) as a primary language with 3.9% unknown.

These data are restricted to the TMH program within directly-operated clinics. There are multiple contract providers within the larger mental health system that are also using TMH and the data from these sites will be included in the evaluation for CY 2020.

Health Promoters

Goal I.5.:	By December 31, 2019, Promotores de Salud (Health Promoters) trained in delivering community-designed, peer-based engagement and education will serve the Latino population in all eight Service Areas (SAs) of Los Angeles County.
Population:	LA County residents living in Latinx/Spanish-speaking communities.
Indicator:	Promotion of behavioral health awareness, education, and available resources for Los Angeles County's Latino population.
Evaluation:	This goal was met.

The Mental Health Promoters program aims to address the stigma associated with mental illness and treatment and improve access to care by educating the community on mental health issues and providing linkages to mental health resources. Mental Health Promoters receive over 120 hours of training and coaching to be able to provide educational workshops to primarily Spanish-speaking and underserved communities within LA County.

In CY 2019, the Mental Health Promoters program expanded significantly. The team grew to 21 staff members co-located throughout LA County and 150 trained Mental Health Promoters, approximately 20 per SA. In total, in CY 2019, these team members conducted 7,027 presentations for 67,177 Latinx individuals across all eight SAs. These two numbers increased from 5,521 presentations for 44,242 people in CY 2018, representing a 22% and a 34% improvement, respectively. Table 18 demonstrates the number of presentations and people served by SA in CY 2019. The topics of community presentations ranged widely. Some examples included mental health and stigma, suicide prevention, domestic violence, grief and loss, alcohol and drugs, as well as specific mental health problems (i.e., depression, anxiety, childhood disorders).

Table 18. Mental Health Promoters Presentations and People Served by Service Area

SA	Number of Presentations	Number of People Served
SA 1	361	3,116
SA 2	1,174	12,310
SA 3	604	4,887
SA 4	1,313	13,720
SA 5	174	1,516
SA 6	1,009	9,667
SA 7	1,237	11,071
SA 8	1,155	10,890
Total	7,027	67,177

Data Source: Promotores de Salud program training reports, CY 2019.

In addition to these targeted classes, the Mental Health Promoters also participated in 522 outreach events hosted by cities, the County, and non-profit organizations countywide. A partnership with DPH also allowed the Mental Health Promoters to educate the Latinx community on larger health issues, such as soil contamination and lead paint intoxication, and provide door-to-door outreach. These 21 events and neighborhood outreach opportunities involved 650 hours of work and occurred primarily in SA 7, the site of the Exide battery plant ground contamination. For this work, the Mental Health Promoters program received a TOP 10 award from the County's Annual Quality and Productivity Awards. Finally, Mental Health Promoters worked in three consulates through which Latinx individuals sought support services, participated in a one-day conference attended by over 300 people, and received an additional award from Vision Y Compromiso for being the first program sponsored by a County agency.

Overall, CY 2019 was a year of significant growth for the Mental Health Promoters program. The number of trained Promoters increased, allowing for a similar increase in the number of community presentations and individuals served. This CY was also the first time Mental Health Promoters expanded to SAs 1 and 5, making the program available countywide. Given the success of the program for Spanish-speaking Latinx individuals, there are plans to expand the Mental Health Promoters approach to the English-speaking Latinx group and other cultures pending additional funding and staff.

Monitoring Accessibility of Services

Psychiatric Mobile Response Teams (PMRT)

Goal II.1.:	Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 60% for Calendar Year (CY) 2019.
Population:	Consumers receiving urgent after-hours care from PMRT.
Indicator:	Consumers receiving urgent after-hours care from PMRT.
Evaluation:	This goal was not met.

In CY 2019, PMRT was dispatched and on scene within one hour or less, from acknowledgement of receipt of the call, for 56% of PMRT after-hours calls. This represents a 1 percentage point increase in ACCESS Center PMRT responsiveness when compared to CY 2018 and a 15 PP decline from 71% in CY 2015.

In CY 2019, the increase in LA County's traffic during after-hours continued to negatively impact PMRT responsiveness. The majority of PMRT dispatched during after-hours were noted to occur on weekdays and between 5:00 PM and 7:00 PM; these were the County's peak traffic hours. The Department's after-hours field response teams are assigned to each SA. However, after-hours PMRT is often dispatched to other SAs to meet the demand. This contributed to delays in arrival and an overall decline in PMRT responsiveness from CY 2017 to CY 2019. The number of dispatches also increased by 13% from CY 2018 to CY 2019 and by 43% from CY 2015 to CY 2019. Table 19 presents the five-year trend in PMRT response rates of one hour or less.

Table 19. Psychiatric Mobile Response Team After-Hours Response Rates of One Hour or Less (Five Year)

Responses	2015	2016	2017	2018	2019
Annual Total	**3,670**	**3,904**	**4,825**	**4,612**	**5,244**
Annual Average %	**71%**	**71%**	**60%**	**55%**	**56%**

ACCESS Center

The ACCESS Center operates as the entry point for mental health services in Los Angeles County, 24 hours/day and 7 days/week (24/7). Business-hours are 8:00 AM to 5:00 PM, Monday through Friday and excludes holidays. After-hours occur outside of business-hours and include weekends and holidays.

The ACCESS Center strives to meet the cultural and linguistic needs of our communities by providing language assistance services in threshold and non-threshold languages, at the time of first contact. Callers request information related to mental health services and other social needs, and the ACCESS Center provides referrals to providers and services that are conveniently located and appropriate to their cultural and behavioral health needs. The ACCESS Center facilitates a wide array of services, namely:

- Deployment of crisis evaluation teams;
- Information and referrals for Specialty Mental Health Services (SMHS);
- Language Line for interpreter services to serve the caller in their preferred language, including face to face American Sign Language interpreter services for clinic appointments;
- After-hours gatekeeping of acute inpatient psychiatric beds;
- After-hours DMH point of contact for Patient's Rights and special/critical incident reporting;
- 24-hour notification to DMH service providers of after-hours activity;
- Coordination of Out-of-County and Out-of-State referrals for Medi-Cal beneficiaries;
- Collaboration with local Medi-Cal health management organizations (HMOs); and
- Acts as a back-up Disaster Operations Center (DOC) providing assistance and crisis intervention following natural or man-made disasters.

Goal II.2.:	By December 31, 2019, 80% of the calls to the toll-free hotline received during after-hours will be answered by a live agent within one minute from when they present to the VCC.
Population:	Callers using the ACCESS 24/7 toll-free number: 1-800-854-7771.
Indicator:	Timeliness of the DMH's 24/7 ACCESS hotline during after-hours.
Evaluation:	This goal was met.

The ACCESS Center achieved an annual average of 82% of after-hours calls to the toll-free hotline being answered by a live agent within 1 minute.

Goal II.3.:	By December 31, 2019, 80% of the calls to the toll-free hotline received during business-hours will be answered by a live agent within one minute from when they present to the VCC.
Population:	Callers using the ACCESS 24/7 toll-free number: 1-800-854-7771.
Indicator:	Timeliness of the DMH's 24/7 ACCESS hotline during business-hours.
Evaluation:	This goal was met.

The ACCESS Center achieved an annual average of 85% of business-hours calls to the toll-free hotline being answered by a live agent within 1 minute.

Table 20 presents the total calls answered within one minute in CY 2019 by number, percent, and month. Of note, total call volume increased by 1 percentage point (PP) from CY 2018 (N=141,460) to CY 2019 (N=143,258). The highest number of calls were received during month March, September, and October. The lowest number of calls were received in May and June and this may be attributed to the decline in media campaigns for the year.

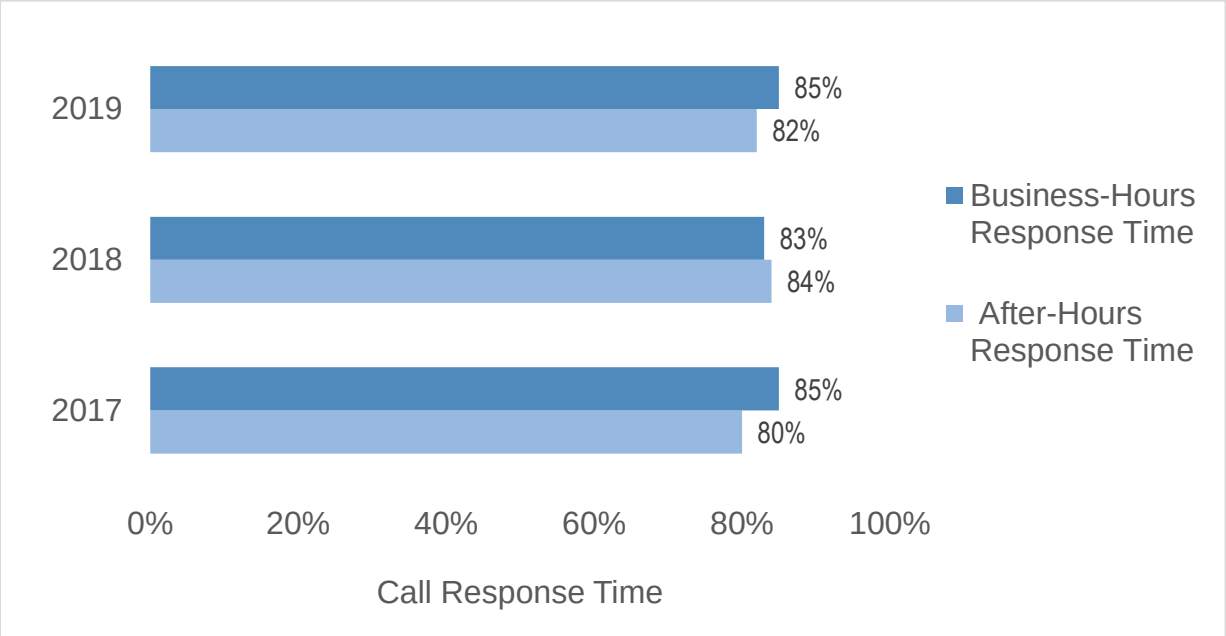
Table 20. Calls Answered Within One (1) Minute by Number and Percent

Month	Total Calls by Shift	Calls Answered Within 1 Minute by Shift	Percentage of Calls Answered Within 1 Minute
January[1, 2, 3]			
Business-Hours	5,273	3,936	75%
After-Hours	6,037	5,219	86%
February			
Business-Hours	5,417	4,314	80%
After-Hours	5,700	4,986	87%
March[1, 2, 3, 4]			
Business-Hours	5,918	4,354	74%
After-Hours	7,037	5,184	74%
April[3]			
Business-Hours	5,624	4,234	75%
After-Hours	5,769	4,536	79%
May			
Business-Hours	5,819	4,701	81%
After-Hours	5,738	4,852	85%
June[5]			
Business-Hours	5,032	4,497	89%
After-Hours	6,232	5,213	84%
July			
Business-Hours	5,849	5,541	95%
After-Hours	6,014	4,921	82%
August			
Business-Hours	6,007	5,579	93%
After-Hours	6,340	5,103	80%
September			
Business-Hours	6,179	5,563	90%
After-Hours	6,924	5,536	80%
October[3, 4]			
Business-Hours	6,532	5,761	88%
After-Hours	6,919	5,397	78%
November			
Business-Hours	5,175	4,902	95%
After-Hours	6,735	5,898	88%
December			
Business-Hours	5,205	4,721	91%
After-Hours	5,783	4,953	86%
Year-to-Date			
Business-Hours	*68,030*	*58,103*	*85%*
After-Hours	*74,802*	*61,798*	*82%*
Total (Overall)	*143,258*	*119,901*	*84%*

[1]VCC experienced maintenance/issues on January 19 from 11:00 PM to January 20 at 3:00 PM; January 21 from 2:00 AM to 3:30 AM; January 25 from 2:00 AM to 3:00 AM; March 5 from 5:10 PM to 7:50 PM; and July 13 from 8:30 AM to 9:00 PM. [2]IBHIS experienced maintenance/issues on January 29 from 2:30 PM to January 29 at 3:30 PM; March 5 from 5:10 PM to 5:15 AM; and March 8 from 2:00 AM to 4:30 AM. [3]Staffing issues occurred causing higher rates of absenteeism, tardiness, and staff turnover. [4]An increase in call volume may have contributed to decline in answered calls within one minute. [5]Business-hours skill set proficiencies were changed on June 24, 2019. Agents assigned to answer informational and referral calls are now backed up by agents assigned to answer calls, and vice versa. This has led to a decrease in queue lengths and answer times. Data Source: DMH ACCESS Center, CY 2019.

Figure 16 presents the three-year trend in ACCESS Center responsiveness for CY 2017, CY 2018, and CY 2019. The ACCESS Center's responsiveness during business-hours declined by 2 PP from 85% (N=59,649) in CY 2017 to 83% (N=56,364) in CY 2018. There was a 2 PP increase to 85% (N=58,103) in CY 2019 due to the skill set proficiencies changes implemented on June 24, 2019. The ACCESS Center's responsiveness during after-hours increased by 4 PP from 80% (N=63,484) in CY 2017 to 84% (N=61,968) in CY 2018. In CY 2019, a 2 PP decline to 82% (N=61,629) occurred due to vacant positions.

Figure 16. Percent Change in ACCESS Center Responsiveness (Three-Year)



Data Source: DMH ACCESS Center data reports, CY 2017 to CY 2019.

Non-English Language Calls

Table 21 summarizes the total number of non-English language calls received by the ACCESS Center, from CY 2015 through CY 2019. Over the past five years, the majority of the requests for non-English language calls, other than Spanish, were for Korean (N=737), followed Mandarin (N=522), Armenian (N=435), Farsi (N=391), and Cantonese (N=264).

In CY 2019, ACCESS Center staff provided language interpreter services in the Spanish language for 6,398 calls. An additional 1,373 Spanish language calls were interpreted through a language interpreter service vendor. Approximately, 94% of the non-English calls received by ACCESS Center staff were in Spanish (N=7,771), followed by Korean (N=149) at 1.8%, and Mandarin (N=126) at 1.6%. For the remaining languages, a total of 262 calls were received in CY 2019 and accounted for 3.2% of all non-English calls.

Table 21. Five-Year Trend in non-English Language Calls Received by ACCESS Center

Language	CY 2015	2016	2017	2018	2019
Albanian	0	0	0	0	1
Amharic	0	0	1	0	2
Arabic	6	16	8	18	21
Armenian	80	130	128	65	32
Bahasa	0	1	0	0	0
Bengali	0	1	0	2	5
Burmese	0	0	0	2	2
Cambodian	0	7	10	26	19
Cantonese	46	40	46	73	59
Farsi	58	56	178	59	40
French	2	2	1	1	1
German	1	0	0	0	0
Greek	1	0	0	0	0
Hebrew	1	0	0	0	0
Hindi	0	0	0	1	1
Hmong	0	0	0	0	1
Hungarian	3	0	0	0	0
Japanese	2	4	2	6	6
Khmer	3	1	0	0	0
Korean	108	116	140	224	149
Luganda	0	0	0	1	0
Mandarin	62	86	82	166	126
Persian	0	1	5	4	3
Polish	0	1	0	1	0
Portuguese	0	1	1	1	1
Punjabi	1	0	2	1	1
Romanian	0	1	0	0	0
Russian	12	16	37	13	25
Serbian	0	2	0	0	0
Slovak	0	1	0	0	0
*Spanish (LISMA)	1,089	1,474	2,303	1,370	1,373
**Spanish ACCESS Center	6,159	6,040	6,150	6,612	6,398
Spanish Subtotal	7,248	7,514	8,453	7,982	7,771
Tagalog	7	10	9	16	10
Thai	1	0	7	0	5
Urdu	0	0	0	1	1
Vietnamese	17	28	195	34	26
Total	7,659	8,035	9,305	8,697	8,308

Note:* Effective 10/13/2016 at 12:01 am, the new Language Interpretation Services Master Agreement (LISMA) is provided by the following: Language Line Services Inc, TransPerfect Translations International, Inc, and Worldwide Interpreters, Inc. **ACCESS Center Spanish speaking employee assisted with interpreter services. Data Source: Virtual Contact Center (VCC) effective 11/29/2013; DMH ACCESS Center, CY 2015 to CY 2019.

Interpreter Services for the Deaf and Hard-of-Hearing Communities

In accordance with applicable Federal, State, and County policies and agreements, DMH provides equal access to services for consumers who are Deaf and Hard-of-Hearing seeking mental health services at all DO and LE/Contracted provider sites. Access to sign language interpreter services is managed by contacting the Department's 24/7 ACCESS Center hotline.

Goal II.4.:	By June 30, 2019, a report on the number of sign language interpreter services appointments coordinated by the toll-free hotline will be evaluated for trends.
Population:	Consumers who need sign language interpreter services.
Indicator:	Cultural and linguistic access to care.
Evaluation:	This goal was met.

The toll-free hotline coordinated 983 requests for sign language interpreter services in FY 18-19. There was a 16% decrease in the assigned American Sign Language (ASL) appointments from 1140 in FY 17-18 to 983 in FY 18-19 with an average monthly decrease of about 13 appointments in FY 18-19.

It is unclear what exactly contributed to this decrease. However, it is expected that the requests for sign language interpreter services may vary slightly each year based on the number of clients requesting these services. For example, some new clients who had a greater frequency of treatment sessions the previous year may have a reduction in the frequency in the next year resulting in fewer requests for sign language services. Additionally, some clients may have ended treatment and no longer need sign language interpreter services. The number of new clients requesting ASL services may vary each year based on the need for these services**.** For FY 18-19, the Los Angeles County Department of Mental Health ACCESS Center accommodated all requests for sign language interpreter services with some minor exceptions: 1) instances in which the client requested a specific interpreter and when this interpreter was not available, ACCESS offered another interpreter but the client declined as they wanted only the one they requested; 2) the request was at short notice and made outside of the specified timelines per policy and procedure.

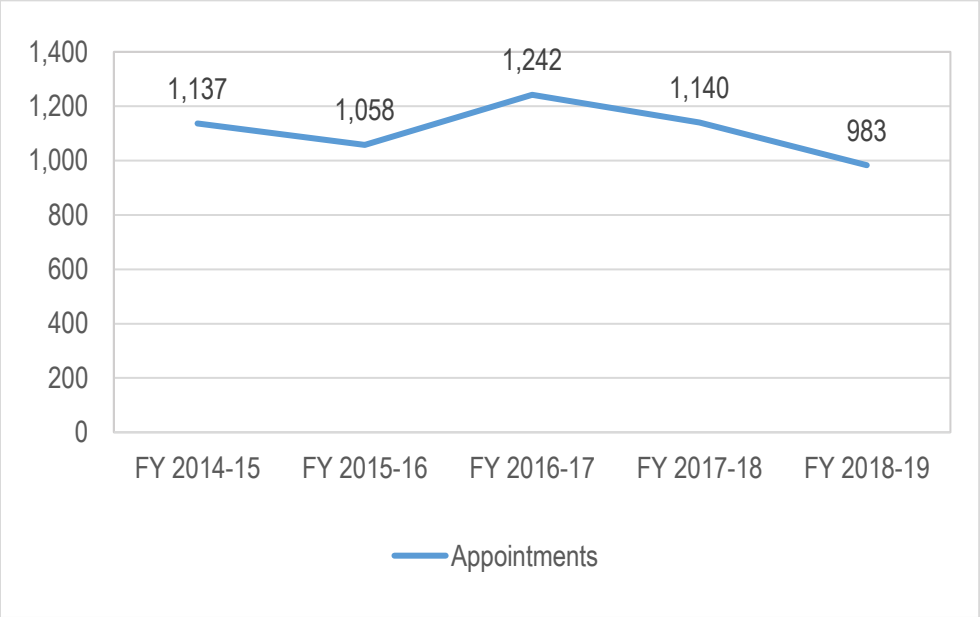
Table 22 shows the number of assigned sign language interpreter services appointments for the five prior fiscal years and Figure 17 depicts the trend in appointments over time, which indicates fluctuation year to year.

Table 22. Summary of Appointments for Deaf and Hard of Hearing Communities by Fiscal Year

FY	Number of Assigned Appointments
14-15	1,137
15-16	1,058
16-17	1,242
17-18	1,140
18-19	983
Total	5,560

Note: Data includes only interpreter services requests assigned to ASL interpreters available to provide service on a given date. Data Source: DMH, EOTD, ACCESS Center, FY 14-15 to FY 18-19.

Figure 17. Number of Assigned American Sign Language (ASL) Appointments by Fiscal Year



Data Source: DMH, EOTD, ACCESS Center, FY 14-15 to FY 18-19.

Consumer/Family Satisfaction Goals

The Consumer Perception Surveys (CPS) were distributed at randomly selected outpatient and day treatment programs between May 13, 2019 and May 17, 2019. Survey data was gathered from youth (ages 13-17) using the Youth Services Survey (YSS, Youth), from adults (ages 18–59) using the Adult Survey, and from older adults (ages 60 and older) using the Older Adult Survey. The families of Youth (ages 0-17) completed surveys for services received by their children using the Youth Services Survey for Families (YSS-F, Families).

Results show that on average, consumers/families agreed or strongly agreed that their services were sensitive to their cultural and linguistic needs, and that services were provided at convenient times and locations.

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Goal II.5.:	In May 2019, between 86.5% and 87.7% of DMH consumers/families will report satisfaction with location of their outpatient programs.
Population:	Consumers served in DMH outpatient clinics.
Indicator:	Convenience of service locations.
Evaluation:	This goal was met.

Approximately, 86.6% (N = 11,769) of the consumers/families who participated in the May 2019 survey period reported they agreed or strongly agreed with the statement, "Location of services was convenient." This represents a 0.3 PP decline from May 2018 and a 0.4 PP decrease from May 2017.

Table 23 reports the percentage of consumers and families in CY 2017, CY 2018, and May 2019 that agreed or strongly agreed with the statement, "Location of services was convenient." Among Families and Adults, there was a decline in percentages over the Spring and Fall survey periods. More specifically, for Families, for the Spring survey periods, there was a 1.6 PP decrease from May 2018 (92.8%) to May 2019 (91.2%), and, for Adults, there was a 0.1 PP decrease from May 2017 and 2018 (83.7%) to May 2019 (83.6%). For Youth, there was a 0.5 PP increase from May 2017 and 2018 (84.3%) to May 2019 (84.8%). For Older Adults, the percentages fluctuated over time in that there was a 2.9 PP decline from May 2017 (89.5%) to May 2018 (86.6%) and then an increase of 2.5 PP from May 2018 to May 2019 (89.1%). Overall, in the May 2019 survey period, Adults were the least satisfied age group and Families were the most satisfied age group in terms of location of services.

Table 23. Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Location of Services was Convenient" Item

Survey Period	Families		Youth		Adult		Older Adult		Total	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
2019										
May	4,170	91.2%	1,817	84.8%	5,138	83.6%	644	89.1%	11,769	86.6%
2018										
Nov	2,755	90.3%	1,213	84.9%	4,297	82.2%	455	85.6%	8,720	85.8%
May	4,213	92.8%	1,979	84.3%	5,422	83.7%	609	86.6%	12,223	86.9%
2017										
Nov	4,158	91.7%	1,944	82.5%	5,119	82.5%	499	88.4%	11,720	86.0%
May	2,209	92.8%	1,107	84.3%	3,299	83.7%	432	89.5%	7,047	87.0%

Note: The "N" represents the number of responses with a value of 4 or 5 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses for that item. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2017 and May 2019.

Goal II.6.: In May 2019, between 90.2% and 91.2% of DMH consumers/families will report satisfaction with the times of their outpatient services.

Population: Consumers served in DMH outpatient clinics.

Indicator: Convenience of appointment times.

Evaluation: This goal was met.

A total of 90.5% (N = 12,284) of the consumers and families that participated in the May 2019 survey period reported they agreed to strongly agreed with the statement, "Services were available at times that were convenient." There was a 0.3 PP decline from 90.8% in May 2017 and a 0.1 PP decline from 90.6% in May 2018.

Table 24 reports the percentage of consumers and families in CY 2017, CY 2018, and May 2019 that agreed or strongly agreed with the statement, "Services were available at times that were convenient." Among Families and Adults, there was a slight decline in percentages over the Spring and Fall survey periods. More specifically, for Families, there was a 0.8 PP decrease from May 2018 (93.5%) to May 2019 (92.7%), and, for Adults, there was a 0.2 PP decrease from May 2018 (90.5%) to May 2019 (90.3%). For Older Adults, there was a 0.4 PP increase from May 2018 (93.8%) and a 0.2 PP increase from May 2017 (94.0%) to May 2019 (94.2%). For Youth, the percentages fluctuated over time in that there was a 1.8 PP decline from May 2017 (86.3%) to May 2018 (84.5%) and then increase of 0.6 PP from May 2018 to May 2019 (85.1%). Overall, in the May 2019 survey period, Youth were the least satisfied age group and Older Adults were the most satisfied age group in terms of time of services.

Table 24. Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Services Were Available at Times That Were Convenient" Item

Survey Period	Families		Youth		Adult		Older Adult		Total	
	N	%	N	%	N	%	N	%	N	%
2019										
May	4,230	92.7%	1,817	85.1%	5,549	90.3%	688	94.2%	12,284	90.5%
2018										
Nov	2,801	91.8%	1,206	84.4%	4,669	89.3%	493	92.8%	9,169	89.6%
May	4,213	93.5%	1,979	84.5%	5,422	90.5%	609	93.8%	12,223	90.6%
2017										
Nov	4,158	92.7%	1,944	83.1%	5,119	90.2%	499	95.2%	11,720	90.0%
May	2,209	93.4%	1,107	86.3%	3,299	90.3%	432	94.0%	7,047	90.8%

Note: The "N" represents the number of responses with a value of 4 or 5 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses for that item. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2017 and May 2019.

Monitoring Beneficiary Satisfaction

Goal III.1.:	In May 2019, between 88.0% and 89.2% of DMH consumers/families will report satisfaction with their outpatient program staff's sensitivity to their cultural/ethnic background.
Population:	Consumers served in DMH outpatient clinics.
Indicator:	Sensitivity of staff to consumers' cultural/ethnic backgrounds.
Evaluation:	This goal was met.

A total of 88.3% (N = 11,102) of the consumers and families who participated in the May 2018 survey period reported they strongly agreed or agreed that staff were sensitive to their cultural/ethnic background. This number did not change from the May 2018 survey period and is a 0.1 PP increase from May 2017 (88.2%).

Table 25 reports the percentage of consumers and families in CY 2017, CY 2018, and May 2019 that agreed or strongly agreed with the statement, "Staff were sensitive to my cultural/ethnic background." Among Families and Adults, there was a slight decline in the percentages over the Spring and Fall survey periods. More specifically, for Families, there was a 0.6 PP decrease from May 2018 (94.9%) to May 2019 (94.3%), and, for Adults, there was a 0.5 PP decrease from May 2018 (86.1%) to May 2019 (85.6%). For Older Adults, there was a 0.1 PP increase from May 2018 (89.6%) and a 0.3 PP increase from May 2017 (86.4%) to May 2019 (89.7%). For Youth, the percentages fluctuated over time in that there was a 3.6 PP decline from May 2017 (86.0%) to May 2018 (82.4%) and then an increase of 0.5 PP from May 2018 to May 2019 (82.9%). Overall, in the May 2019 survey period, Youth were the least satisfied age group and Families were the most satisfied age group in terms of the cultural sensitivity of services.

Table 25. Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the " Staff Were Sensitive to My Cultural/Ethnic Background" Item

Survey Period	Families		Youth		Adult		Older Adult		Total	
	N	%	N	%	N	%	N	%	N	%
2019										
May	3,885	94.3%	1,619	82.9%	4,982	85.6%	616	89.7%	11,102	88.3%
2018										
Nov	2,886	94.6%	1,185	82.9%	4,470	85.5%	472	88.8%	9,013	88.0%
May	4,213	94.9%	1,979	82.4%	5,422	86.1%	609	89.6%	12,223	88.3%
2017										
Nov	4,158	94.7%	1,944	82.6%	5,119	85.2%	499	91.0%	11,720	88.3%
May	2,209	95.4%	1,107	86.0%	3,299	84.5%	432	86.4%	7,047	88.2%

Note: The "N" represents the number of responses with a value of 4 or 5 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses for that item. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2017 and May 2019.

Goal III.2.:	In May 2019, between 88.5% and 89.6% of DMH consumers/families will report overall satisfaction with their outpatient program.
Population:	Consumers served in DMH outpatient clinics.
Indicator:	Overall satisfaction with services provided.
Evaluation:	This goal was met.

Overall, during the May 2019 survey period, 89.9% (N = 12,458) of consumers and families reported high overall satisfaction as determined by an average score of 3.5 or greater on all survey items. All of the age groups were above the goal range except for Adults, who were below the lower threshold (86.7%).

Table 26 presents the three-year trends in overall satisfaction for the May 2017, May 2018, and May 2019 survey periods by age group. For Youth and Older Adults, the percent of those who are highly satisfied has increased over the past survey period. For Families and Adults, this percentage has decreased slightly.

Table 26. Three-Year Trend in Overall Satisfaction for May Survey Periods by Age Group

Year	Families		Youth		Adult		Older Adult		Total	
	N	%	N	%	N	%	N	%	N	%
2019	4,334	93.0%	1,996	90.4%	5,444	86.7%	684	91.6%	12,458	89.9%
2018	4,340	93.1%	2,061	86.7%	5,553	87.0%	618	90.3%	12,572	89.3%
2017	2,279	94.2%	1,151	88.3%	3,385	87.3%	450	89.7%	7,265	89.9%

Note: The "N" represents the number of responses with an average value of 3.5 or higher on a Likert scale from one to five. The denominator is the sum of all survey responses for that item. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2017 and May 2019.

Beneficiary Problem Resolution

Grievances, appeals, expedited appeals, state fair hearings, expedited fair hearings, Notice of Actions (NOAs), and requests for change of provider are consumer and provider activities that DMH monitors, evaluate for trends, and report to the Departmental QIC. This is an on-going Quality Improvement Work Plan monitoring activity, as specified by our DHCS contract.

Notices of Action

NOAs are required when any of the following actions occur with a Medi-Cal beneficiary

- NOA-A: Denial of Services Following Assessment.
- NOA-B: Reduction of Services.
- NOA-C: Post Service Denial of Payment.
- NOA-D: Delay in Processing a Beneficiary Grievance or Appeal.
- NOA-E: Lack of Timely Services.

In accordance with Title 9, CCR, Chapter 11, Subchapter 5, and the MHP Contract, DMH must have problem resolution processes that enable beneficiaries to resolve problems or concerns about any issues related to performance, including the delivery of SMHS. The Department is required to meet specific timeframes and notification requirements related to these processes. The Department's PRO reports to the DHCS annually, on October 1st, the total number of grievances, appeals, and expedited appeals filed during the previous fiscal year.

As mandated by the DHCS, Program Oversight and Compliance (2012-2013), QID facilitates the annual evaluation of beneficiary grievances, appeals, and State Fair Hearings. As a MHP, DMH shall insure that a procedure is in place where by issues identified as a result of grievance, appeal, or expedited appeal processes are transmitted to the MHP's QIC, the MHP's administration, or another appropriate body within the MHP (DHCS, Oversight and Compliance 2012-2013).

Goal III.3.:	By June 30, 2019, a report on the number of grievances, appeals (standard and expedited), and State Fair Hearings will be categorized by type and disposition and evaluated.
Population:	Consumers/families served by DMH.
Indicator:	Number and type of the beneficiary grievances, appeals, and State Fair Hearings resolved and referred out, and pending in FY 18-19.
Evaluation:	This goal has been met.

In FY 2018-19, grievances and appeals were collected and reviewed by the PRO and recorded on the Annual Medi-Cal Beneficiary and Grievance and Appeal Report (ABGAR) form. The ABGAR form is required by California's DHCS for Medi-Cal beneficiaries only.

The Department's PRO continued to finalize the electronic Grievance and Appeals reporting system. This system will be available to beneficiaries and providers who file complaints on behalf of beneficiaries. Hard copies will continue to be accepted by PRO.

The system required many modifications to be in line with Final Rule regulations, which was a collaborative effort with the Department's QA program and CIO.

Table 27 shows the total number of inpatient and outpatient beneficiary grievances and appeals by category. Ninety-one grievances were received in FY 2018-19. Of the beneficiary grievances received, 81.3% (N=74) were related to Quality of Care and the remaining 18.7% (N=7) were categorized as Other. In FY 2018-19, there were no inpatient and outpatient grievances related to Access, Change of Provider, or Confidentiality Concerns.

Table 27. Inpatient and Outpatient Grievances and Appeals

Category	Process			
	Grievance	Exempt Grievances	Appeal	Expedited Appeal
Access				
Service not Available	0	0		
Service not Accessible	0	0		
Timeliness of Services	0	0		
24/7 Toll-Free ACCESS Line	0	0		
Linguistic Services	0	0		
Other Access Issues	0	0		
Access – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**	**N/A**	**N/A**
Quality of Care				
Staff Behavior Concerns	**23**	**0**		
Treatment Issues or Concerns	**43**	**0**		
Medication Concern	**8**	**0**		
Cultural Appropriateness	**0**	**0**		
Other Quality of Care Issues	**0**	**0**		
Quality of Care – Total by Category	**74**	**0**	**N/A**	**N/A**
Percent	**81.3%**	**0%**		
Change of Provider – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**		
Confidentiality Concern – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**	**N/A**	**N/A**
Other				
Financial	0	0		
Lost Property	0	0		
Operational	0	0		
Patients' Rights	0	0		
Peer Behaviors	0	0		
Physical Environment	2	0		
Other Grievance not Listed Above	15	0		
Other – Total by Category	**17**	**0**	**N/A**	**N/A**
Percent	**18.7%**	**0%**	**N/A**	**N/A**
Grand Totals	**91**	**0**	**N/A**	**N/A**

Note: Grievances and Appeals Data is limited to Medi-Cal beneficiaries. Data Source: DMH PRO – ABGAR Form FY 18-19, Oct 2019

Notifications of Medi-Cal beneficiary complaints are received from DHCS by DMH. The Office of Strategic Communications consults with PRO to determine if a grievance was filed regarding the complaint submitted to DHCS requesting a State Fair Hearing. The Office of Strategic Communications then investigates the DHCS complaint and summarizes the findings. A Statement of Position (SOP) is drafted and approved. State Fair Hearings are provided by the Department of Social Services (DSS) administrative law judges and are scheduled in-person or by telephone. There were six State Fair Hearings for FY 18-19 that were closed/dismissed or redirected.

Table 28 reports the total number of Notice of Adverse Benefit Determination (NOABDs), formerly known as Notice of Action (NOAs), as well as the dispositions for appeals and expedited appeals. There were 10,775 NOABDs or NOAs issued in FY 18-19. Fifty-two percent of the NOABDs or NOAs determined were Timely Access Notices (N=5,632), followed by Denial Notices (N=2,579) at 24%, and Payment Denial Notices (N=2,354) at 22%. There were no beneficiary appeals resulting from a NOABD or NOA in FY 18-19.

Table 28. **Inpatient and Outpatient Appeals' Disposition and Total Notice of Adverse Benefit Determination/Notice of Action Issued Fiscal Year 2018-2019**

Category	APPEAL DISPOSITION			EXPEDITED APPEAL DISPOSITION			NOABD/NOA
	Appeals Pending as of June 30	Decision Upheld	Decision Overturned	Expedited Appeals Pending as of June 30	Decision Upheld	Decision Overturned	Total Number of NOABD/NOAs Issued
Appeals Resulting from NOABD NOA							
Denial Notice	0	0	0	0	0	0	2,579
Payment Denial Notice	0	831	430	0	0	0	2,354
Delivery System Notice	0	0	0	0	0	0	194
Modification Notice	0	0	0	0	0	0	16
Termination Notice	0	0	0	0	0	0	0
Authorization Delay Notice	0	0	0	0	0	0	0
Timely Access Notice	0	0	0	0	0	0	5,632
Financial Liability Notice	0	0	0	0	0	0	0
Grievance and Appeal Timely Resolution Notice	0	0	0	0	0	0	0
Total	**0**	**831**	**430**	**0**	**0**	**0**	**10,775**

Note: Data Source: DMH PRO – ABGAR Form FY 18-19, October 2019

Table 29 shows the disposition of 91 grievances in FY 18-19. Out of the 76 grievances that were resolved, 97.3% pertained to Quality of Care (N=74) and the remaining 2.6% were categorized as Other (N=2). Out of the 15 grievances that were referred, 100% were categorized as Other (N=15). There were no grievances pending as of June 30, 2019.

Table 29. Inpatient and Outpatient Grievances' Disposition Fiscal Year 2018-2019

Category	Grievance Disposition		
	Grievances Pending as of June 30	Resolved	Referred
Access			
Service not Available	0	0	0
Service not Accessible	0	0	0
Timeliness of Services	0	0	0
24/7 Toll-Free Line	0	0	0
Linguistic Services	0	0	0
Other Access Issues	0	0	0
Access – Total by Category	0	0	0
Percent	**0%**	**0%**	**0%**
Quality Of Care			
Staff Behavior Concerns	0	23	0
Treatment Issues or Concerns	0	43	0
Medication Concern	0	8	0
Cultural Appropriateness	0	0	0
Other Quality of Care Issues	0	0	0
Quality of Care – Total by Category	**0**	**74**	**0**
Percent	**0%**	**97.3%**	**0%**
Change of Provider – Total by Category	**0**	**0**	**0**
Percent	**0%**	**0%**	**0%**
Confidentiality Concern – Total by Category	**0**	**0**	**0**
Percent	**0%**	**0%**	**0%**
Other			
Financial	0	0	0
Lost Property	0	0	0
Operational	0	0	0
Patients' Rights	0	0	0
Peer Behaviors	0	0	0
Physical Environment	0	2	0
Other Grievance not Listed Above	0	0	15
Other – Total by Category	**0**	**2**	**15**
Percent	**0%**	**2.6%**	**100%**
Grand Totals	**0**	**76**	**15**

Data Source: DMH PRO – ABGAR Form FY 18-19, October 2019.

Goal III.4.:	By June 30, 2019, a report on the number of beneficiary requests for a Change of Provider (COP) including reasons given by consumers for their requests as well as changes to the providers' COP submission process will be monitored and evaluated.
Population:	Consumers/families served by DMH.
Indicator:	Number and type of Requests for COP.
Evaluation:	This goal was met.

The QI program monitored the reporting of COP requests by providers. The number of COP requests decreased from 5,269 requests during FY 17-18 to 5,058 requests in FY 18-19. The percent of COP requests that were approved increased by 1.5 PP from 89.1% (N=4,685) in FY 17-18 to 90.6% (N=4,580) in FY 18-19.

Table 30 shows the number of requests for COP by reasons and percent approved for FY 16-17, FY 17-18, and FY 18-19. Data on the requests for COP is based on monthly COP logs submitted to PRO. According to the FY 18-19 data, the most frequent reason for a COP request was "Not a Good Match (N=781)," and the least frequent reason for a COP request was "Treating a Family Member (N=36)."

PRO instituted an electronic COP form submission process for all DO clinics, on November, 2018. Trainings on the electronic form were provided to DO Liaisons and managers identified by the District Chiefs. Monthly reports are provided to District Chiefs for follow-up. Challenges to the DO rollout were habituating providers to entering the electronic information and staff turnover which created a barrier to regular monitoring.

In preparation for rollout to LE/Contracted programs, CIO assisted in providing log-in credentials to LE/Contracted Liaisons to access the electronic COP submission program. This rollout has been met with some delays. QI will continue to monitor COP requests by providers and the implementation of electronic COP submission for LE/Contracted providers.

Table 30. Request for Change of Provider by Reasons and Percent Approved

Reason(s)[1]	FY 16-17		FY 17-18		FY 18-19	
	Number of Requests	Percent Approved	Number of Requests	Percent Approved	Number of Requests	Percent Approved
A – Time/Schedule	148	90.8%	235	87.2%	181	91.2%
B – Language	128	96.2%	144	88.9%	171	94.2%
C – Age	76	87.4%	85	89.4%	81	90.1%
D – Gender	172	91.5%	246	94.3%	208	90.4%
E – Treating Family Member	25	92.6%	32	93.8%	36	91.7%
F – Treatment Concerns	330	92.7%	430	89.8%	355	88.2%
G – Medication Concerns	222	91.0%	276	87.0%	82	87.8%
H – Lack of Assistance	332	91.2%	427	85.9%	386	88.6%
I – Want Previous Provider	84	92.3%	89	83.1%	96	86.5%
J – Want 2nd Option	98	89.9%	155	89.0%	135	91.9%
K – Uncomfortable	553	92.0%	613	89.6%	584	90.8%
L – Insensitive/ Unsympathetic	330	92.2%	398	89.7%	389	91.3%
M – Not Professional	240	91.6%	309	90.9%	305	91.8%
N – Does Not Understand Me	424	91.2%	509	88.8%	472	90.9%
O – Not a Good Match	555	91.7%	693	90.3%	781	90.9%
P – Other	373	92.6%	509	87.2%	669	91.9%
R – No Reason Given	102	86.4%	109	91.7%	127	84.3%
Total	4,192	91.7%	5,259	89.1%	5,058	90.6%

Note: [1]Multiple reasons may be given by a consumer. Data Source: DMH, PRO, October 2019

Monitoring Clinical Care

Goal IV.1.:	By June 30, 2019, the number and reasons for approved, denied, and returned Prescription Drug Prior Authorization (PA) Requests will be evaluated for trends.
Population:	Consumers receiving Pharmacy Benefits Management (PBM) services.
Indicator:	Prescribing standards and parameters.
Evaluation:	This goal was met.

During FY 18-19, QI monitored the number of approved, denied, and returned Prescription Drug PA requests.

Table 31 presents a monthly breakdown of the 580 Prescription Drug PA requests that were approved or denied during FY 18-19. A total of 57.9% of Prescription Drug PA requests were approved. The highest number of approved Prescription Drug PA requests occurred in October 2018 with a monthly total of 37. The lowest number of approved Prescription Drug PA requests occurred in July 2018 with a monthly total of 16. A total of 42.1% Prescription Drug PA requests were denied. The highest number of denied Prescription Drug PA requests occurred in April 2019 with a monthly total of 41. The lowest number of Prescription Drug PA requests denied occurred in January 2019 with a monthly total of eight.

The three most common reasons for denied Prescription Drug PA requests included: no documentation of medication trial/failure of two formulary antipsychotic agents; no medication history/chart notes submitted; and submission of an incomplete Prescription Drug PA form or submission of the old form.

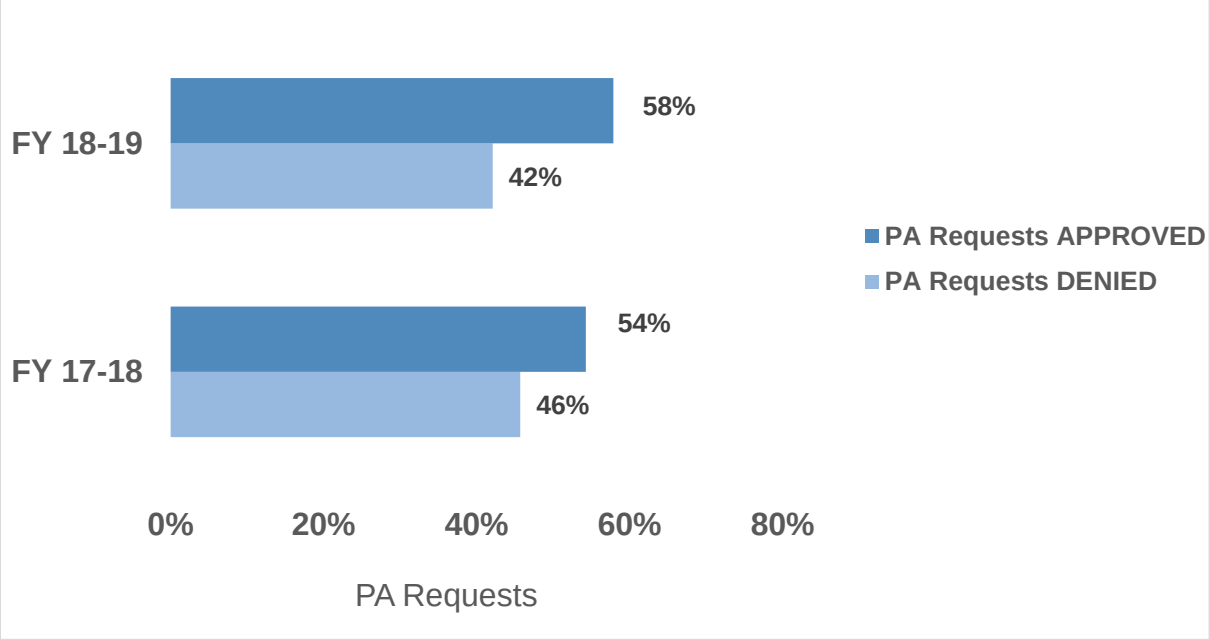
Figure 18 displays the trend of Prescription Drug PA requests for FY 17-18 and 18-19. There was an increase in approved requests from FY 17-18 at 54% to FY 18-19 at 58%. There was a concurrent decrease in denied requests from FY 17-18 at 46% to FY 18-19 at 42%.

Table 31. Approved and Denied Prescription Drug Prior Authorization Requests by Month Fiscal Year 2018-2019

Month	Prescription Drug PA Requests APPROVED	Prescription Drug PA Requests DENIED	Total Prescription Drug PA Requests by Month
July 2018	16	37	53
August 2018	28	16	44
September 2018	35	11	46
October 2018	37	16	53
November 2018	21	9	30
December 2018	22	16	38
January 2019	27	8	35
February 2019	28	22	50
March 2019	30	18	48
April 2019	31	41	72
May 2019	35	28	63
June 2019	26	22	48
Total	**336**	**244**	**580**
Percent	**57.9%**	**42.1%**	**100%**

Data Source: DMH Office of the Discipline Chiefs – Pharmacy Services, FY 18-19.

Figure 18. Approved and Denied Prescription Drug Prior Authorization Requests FY 17-18 and FY 18-19



Data Source: DMH Office of the Discipline Chiefs – Pharmacy Services, FY 17-18 and 18-19.

Monitoring Continuity of Care

Goal V.1.: By December 31, 2019, at least 93% of the consumers referred to DMH Directly-Operated (DO) programs by the toll-free line will be offered priority appointments for Specialty Mental Health Services (SMHS) assessments within five business days.

Population: Consumers referred for urgent appointments by DMH Collaboration programs, Department of Health Services (DHS) eConsult, Medi-Cal Managed Care Plans, and Psychiatric Emergency Services (PES).

Indicator: Continuity of Care for consumers referred for SMHS by primary care providers and behavioral health network providers of the DMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES.

Evaluation: This goal was met.

In CY 2019, the percentage of consumers referred to DO programs through the 855 appointment line who received an appointment within five business days was 94.1%.

Goal V.2.: By December 31, 2019, at least 96% of the consumers referred to DMH LE/Contracted programs by the toll-free line will be offered priority appointments for SMHS assessments within five business days.

Population: Consumers referred for urgent appointments by DMH Collaboration programs, Department of Health Services (DHS) eConsult, Medi-Cal Managed Care Plans, and Psychiatric Emergency Services (PES).

Indicator: Continuity of Care for consumers referred for SMHS by primary care providers and behavioral health network providers of the DMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES.

Evaluation: This goal was met.

In CY 2019, the percentage of consumers referred to LE/Contracted programs through the 855 appointment line who received an appointment within five business days was 96.2%.

Monitoring Provider Appeals

All FFS Medi-Cal acute psychiatric inpatient providers/hospitals submit inpatient Treatment Authorization Requests (TARs) to the Department. A TAR is a State Form (18-3), each with a unique number, used statewide for authorization of inpatient psychiatric hospital days. A hospital TAR is submitted in the process of an Alternative Dispute Resolution (ADR) to resolve a fiscal appeal. Appeals are submitted by network providers or billing agents in order to resolve disputed processing or payment of claims. DMH is required to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in-person, or in-writing) complies with all regulatory requirements.

Goal VI.1.: By December 31, 2019, the total number of Treatment Authorization Requests (TARs) appeals will be evaluated for trends.

Population: LE/Contracted Providers.

Indicator: Timeliness of DMH's responses to Provider Appeals.

Evaluation: This goal was met.

The Intensive Care Division – Compliance Unit monitors provider complaints and appeals and reports findings to the QI program at least annually. The unit's annual data reports include information on the number of TARs, days requested and approved, including approval rates, and the appeals received on a monthly basis.

Table 32 presents the three-year trend in the number of TARs received and percent approved. The number of TARs received between CY 2017 (N=33,797) and CY 2019 (N=34,633) increased slightly. Of note, the percent approved declined from 92.0% in CY 2018 to 58.3% in CY 2019.

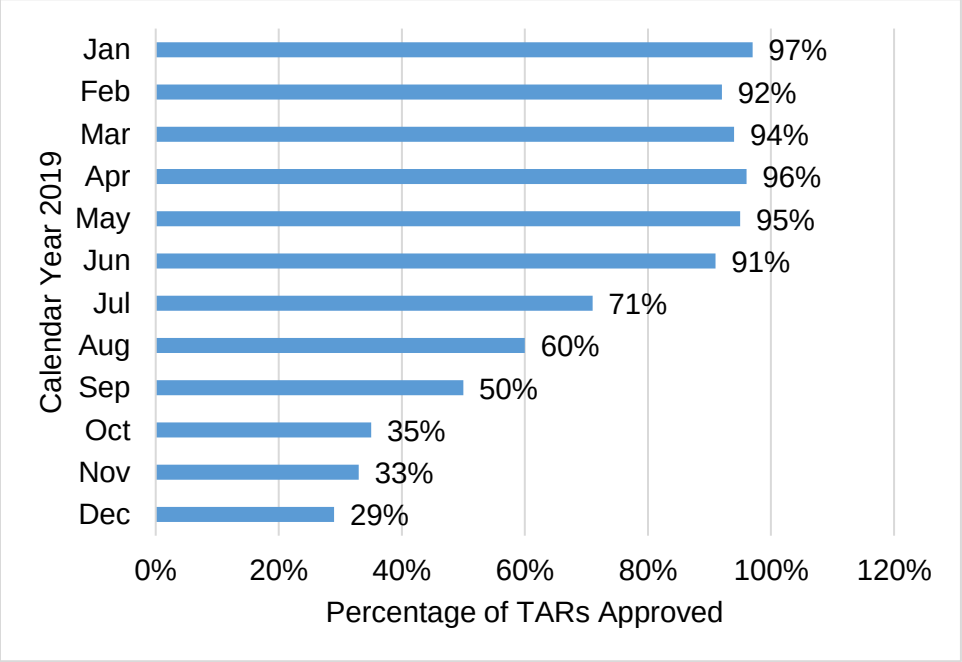
Table 32. Three-Year Trend in TARs Received and Percent Approved

	CY 2017	CY 2018	CY 2019
TARs Received	33,797	33,714	34,633
% Approved	92.0%	92.0%	58.3%

Data Source: TARs and Appeals COGNOS reports, CY 2017- CY 2019

Figure 19 displays the percentage of TARs that were approved each month for CY 2019. There was a 20 PP decline in percent approved from June (91%) to July (71%) and a noticeable pattern of lower approval rates for the remainder of the calendar year. Between January (97%) and December (23%) there was a 74 PP decline in approved days when the amount of days requested remained relatively stable.

Figure 19. Percent of Treatment Authorization Requests Approved by Month for Calendar Year 2019



Note: The sudden change in data, between July 2019 and December 2019, is a reflection of calculation error caused by a change in the use of the electronic health record, based on the introduction of concurrent authorization pilot. Data Source: TARs and Appeals COGNOS report, CY 2019

The Department piloted concurrent authorization in June 2019. Subsequently, it became evident that the interaction between DMH's electronic health record and the concurrent authorization system led to incomplete data and a steady decline in approval rates. While some progress has been made to resolve the initial data issues, DMH will work to establish a new logging system for concurrent reviews and increase the use of Power BI data sets to monitor provider appeals related to the authorization of services and processing/payment of claims. Collecting baseline data on NOABDs will provide a better understanding of provider satisfaction and where to direct performance management activities.

Page Break

Monitoring Performance Improvement Projects

A PIP is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner[6]." The CMS EQR protocol mandates that the assigned EQRO validate one clinical and one non-clinical PIP for each MHP.

As a part of the EQRO requirements and mandated by the CCR, Title 42, the QI program is responsible for collaborating on SA QI projects and PIPs. The QID is responsible for coordinating, organizing, and supporting PIPs from and throughout the organization.

Non-Clinical Performance Improvement Project

Goal VII.1.:	By December 31, 2019, one non-clinical PIP will be developed and implemented.
Population:	Medi-Cal beneficiaries receiving outpatient SMHS from DMH.
Indicator:	Non-clinical PIP-related interventions and outcomes targeting a problem identified following a review of system-level facts and data.
Evaluation:	This goal was not met.

Peer Resource Center Pilot

The Peer Resource Center (PRC) pilot was developed to support community members residing-in, working-in, or visiting the neighborhood directly surrounding the DMH Headquarters (HQ). Community members regularly visited the administrative building seeking mental health and other community resources. They would receive general information assistance from the Emergency Outreach and Triage Division (EOTD), PRO, and other rotating programs. Additionally, a large number of homeless individuals, who appeared to be in need of assistance and were prime candidates for engagement efforts, also resided in the area.

The PRC is the Department's first DO peer-run program. The staff roster included five, full-time, DMH employees and five, Wellness Outreach volunteers all dedicated to providing peer support services. The PRC's visitors receive referrals/linkages to services and participate in the PRC's daily activities (i.e., Movie Mondays, chess and guitar lessons, and job readiness) at any given visit. The PRC also offers mental health resources, information on DMH programs and services, linkages to essential public assistance and social service programs inclusive of housing support, job training, legal

[6] Retrieved from: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf .

aid, and volunteer opportunities. The goal of the PRC was for all visitors to have a positive experience, which led to the development of its motto: "Heart forward" and its service philosophy of "Everyone leaves with something."

Non-Clinical Performance Improvement Project Proposal for External Quality Review

In December 2018, the PRC non-clinical PIP concept was proposed and developed to ensure PRC services were peer-driven, promote resiliency/recovery, and embrace the cultural, linguistic, and historical differences of the neighboring community. Baseline data collection using a PRC Improvement Survey with PRC visitors indicated a need for support with making healthy choices, developing autonomy and independence, and engaging in society through maintaining relationships and purposeful activity. Data also suggested a need for the PRC program to emphasize relationship building and incorporation of the community's diverse cultural and linguistic needs. Lower general satisfaction scores and limited support in crisis prevention strategies were also identified as target areas for improvement. In April 2019, EQR approved the project as a FY 2018-19 non-clinical PIP concept. The EQR team offered their technical assistance (TA) in April 2019, May 2019, and August 2019.

Concept Design and Overview of Findings

The stakeholders involved in the non-clinical PIP concept were the Office of the Discipline Chiefs, Peer Services, the PRC Staff, SSA 5 LE/Contracted providers, peer employees, and one peer volunteer. Development of the PIP concept included interviews with management and staff and gathering consumer feedback. Information gathered through interviews with PRC management and staff supported the addition of an onsite supervisor and supplementary training for peer staff and supervisors. Consumer participation was facilitated through reviewing open-ended suggestions from the PRC Suggestion Box and the development and administration of the PRC Improvement Survey. This survey collected PRC visitor experiences of the PRC staff, programs, and overall program satisfaction. The survey was administered over a two-week period once prior to the intervention in July 2019 and once just after the initial intervention, training PRC staff to use the skills of the Intentional Peer Support (IPS) model, in September 2019.

Most Salient Activities in Fiscal Year 2018-2019

The non-clinical PIP concept FY 2018-19 activities and interventions included implementation of a training series for the PRC staff beginning with the IPS training model, reorganizing the PRC program oversight and management to include executive staff who had experience with peer services, and surveying PRC visitors at regular intervals to receive feedback about the program services and staff.

Results from the post-intervention PRC Improvement Survey suggested an improvement in general satisfaction and in PRC staff being respectful of PRC visitors' cultures. However, these results should be interpreted with caution due to different samples of PRC visitors in the baseline and post-intervention collection periods. There was no evidence that the IPS model training intervention had an impact on the PRC visitor

responses, as there was a short period of time between the intervention and survey collection and the impact may need more time to be fully implemented.

Summary

In September 2019, this project was submitted for an EQRO review. Although, it was determined an important project, it did not meet DHCS' standards for an active non-clinical PIP. This was attributed to the project's limited focus on engagement and linkage to SMHS for Medi-Cal beneficiaries.

The project concluded in September 2019. DMH will continue to support the PRC's expansion and improvements as a quality improvement activity in collaboration with the Discipline Chief of Peer Services. Related ongoing activities include the Supervisors and Peers (SuPeers) Learning Community and PRC expansion workgroup. The PRC program is developing its own activities for continued improvement which include the PRC's development of a program Quality Improvement Project (QIP) focused on trainings for PRC staff to bill for Community Outreach Services (COS).

Clinical Performance Improvement Project

Goal VII.2.:	By December 31, 2019, one clinical PIP will be developed and implemented.
Population:	Medi-Cal beneficiaries receiving outpatient SMHS from DMH.
Indicator:	Clinical PIP-related interventions and outcomes targeting a problem identified following a review of system-level facts and data.
Evaluation:	This goal was met.

The Department's clinical PIP entitled "Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)" was rated as active and ongoing by the EQRO at the FY 2019-20 site visit. The goal of this project is to improve the quality of services delivered to DMH consumers experiencing CODs by improving access to integrative, multidisciplinary treatment models that address mental health (MH) and substance use simultaneously. These treatment models are intended to directly address and mitigate the impact of substance use upon consumers' MH symptoms as well as enhance their ability to reduce substance use and improve MH functioning by coping and practicing safety. Out of 16 applicable standards in EQRO's validation tool, 14 were considered met and two were considered partially met, resulting in a rating of 93.75%.

However, the EQRO team also made suggestions to improve the PIP, including tracking service utilization for Mental Health Services and Targeted Case Management as performance indicators, examining whether Seeking Safety is associated with decrease in these services, creating a code in IBHIS to specifically track Seeking Safety utilization, and comparing hospitalization rates to LE and contract sites that are not using Seeking Safety as a reference group.

In Phase I of this project, which began in February 2019, interventions targeted the services consumers receive from Substance Abuse Counselors (SACs) in 12 DO clinics. Specifically, the SACs started implementing treatment strategies targeting co-occurring MH and substance use problems, including Seeking Safety (SS), a specific evidence-based practice (EBP) for trauma and substance use. Other interventions included SS theme-based consultation calls, an expanded curriculum on interventions for COD, and administrative documents to define and provide guidance on the role of the SACs.

Phase II of this project includes the rollout of multidisciplinary treatment groups co-led by SACs, Clinicians, and Clinical Pharmacists. These groups are intended to address the lack of cohesion among treatment team members and to ensure that consumers receive interventions that target mental health and substance use simultaneously. Progress is evaluated by improvement in 7-day and 30-day re-hospitalization rates as well as engagement and retention of consumers with CODs in mental health services.

SECTION IV

Quality Improvement Work Plan Goals
Calendar Year 2020

In this Section:

Quality Improvement Goals

Section IV: Quality Improvement Work Plan
Calendar Year 2020

Measurement Period: July 1, 2019 to December 31, 2020

The QI Program coordinates countywide performance-monitoring activities that include but are not limited to: utilization review, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, assessment of beneficiary satisfaction, PIPs, and timely access to SMHS.

The QI Work Plan functions as the foundation of DMH efforts to improve the quality of services delivered to consumers. The QI Work Plan activities for CY 2020 will serve to reinforce an organizational culture of CQI through effective strategies, best practices, and activities at all levels of the system.

DMH QI Work Plan goals are structured and organized according to the following domains:

I. Monitoring Service Delivery Capacity;
II. Monitoring Accessibility of Services;
III. Monitoring Beneficiary Satisfaction;
IV. Monitoring Clinical Care;
V. Monitoring Continuity of Care;
VI. Monitoring Provider Appeals; and
VII. Monitoring Performance Improvement Projects.

2020 Quality Improvement Work Plan Goals Summary

Domain	No.	Goal
Service Delivery Capacity	I.1.	DMH will increase the number of beneficiaries served from the Hispanic/LatinX and API communities by 1%.
	I.2.	DMH's Telemental Health (TMH) program will deliver real-time psychiatric care and consultations via secure audio and visual communications.
Accessibility of Services	II.1.	DMH will monitor timely access to care and services.
Beneficiary Satisfaction	III.1.	DMH will assess beneficiary satisfaction via Consumer Perception Surveys (CPS) twice a year.
	III.2.	DMH PRO will track beneficiary grievances, appeals, requests for change of providers and fair hearings.
Clinical Care	IV.1.	DMH will continue to support LA County in its efforts to provide timely, high quality, and easily accessible mental health care for pregnant women and women up to one year after delivering a baby.
Continuity of Care	V.1.	DMH will develop medication monitoring protocols for DO and LE/Contracted providers.
Provider Appeals	VI.1.	DMH will conduct concurrent review of treatment authorizations for all psychiatric inpatient hospital services and psychiatric health facility services.
Performance Improvement Projects	VII.1.	DMH will continue to develop and implement meaningful clinical PIP interventions targeting COD and trauma issues.
	VII.2.	DMH will develop and implement a meaningful non-clinical PIP aimed at improving timely access to SMHS for the entire outpatient system of care.

Monitoring Service Delivery Capacity

Goal I.1.:	**DMH will increase the number of beneficiaries served from the Hispanic/LatinX and API communities by 1%.**
Objectives:	Establish no fewer than one Community and Services Supports (CSS)-based capacity project aimed at increasing service delivery capacity for these communities.
Population:	Medi-Cal eligible youth, adults, and older adults from the Hispanic/LatinX and API communities.
Performance Indicators:	• Number of beneficiaries served from Hispanic/LatinX communities • Number of beneficiaries served from API communities
Frequency of Collection:	Annual
Sources of Data:	• CalEQRO report, *Medi-Cal Approved Claims Data for Los Angeles County MHP,* September 2020 • Annual data on DMH Consumers Served, March 2021 • CSS project updates and annual reports

Goal I.2.:	**DMH's Telemental Health (TMH) program will deliver real-time psychiatric care and consultations via secure audio and visual communications.**
Objectives:	1. Increase the number of consumers receiving TMH services by 10%. 2. Conduct a TMH psychiatry needs assessment to determine the DO clinics with the greatest need. 3. Track medication appointment wait times for clinics with psychiatry registry items/hours and establish a baseline.
Population:	DMH clients receiving outpatient psychiatry services in DO clinics.
Performance Indicator:	Stratify TMH needs assessment data by: • Estimated number of patient hours needed; • Average wait time for new client medication evaluation; • Average wait time for established client follow-up; and • Ratio of full time employee (FTE) psychiatrists to number of open clients.
Frequency of Collection:	Annual
Sources of Data:	DMH TMH program summary report, CY 2020

Monitoring Accessibility of Services

Goal II.1.:	**DMH will monitor timely access to care and services.**
Objective:	Monitor and track the percent of non-urgent child and adult SMHS appointments offered within 10 business days of the initial request.
Population:	DMH clients receiving SMHS from DO and LE/Contracted providers.
Performance Indicators:	Stratify timeliness data by: • Number of appointments offered within 1-10 days of the request; • Number of appointments offered within 11+ days of the request; and • Percent of offered appointments that met the 10 business day target.
Frequency of Collection	Monthly
Sources of Data:	System wide access to care reporting, CY 2020

Note: "Offered" = date an appointment time is offered, not the date of the appointment.

Monitoring Beneficiary Satisfaction

Goal III.1.:	**DMH will assess beneficiary satisfaction via Consumer Perception Surveys (CPS) twice a year.**
Objectives:	1. To ensure greater representation from field-based consumers/families, DMH will explore revisions to current administration protocols. 2. Re-establish key domains/performance indicators.
Population:	DMH clients receiving SMHS from DO and LE/Contracted providers.
Performance Indicator: Frequency of Collection	To be developed. Annual
Sources of Data:	Spring 2020 CPS data report

Goal III.2.:	**DMH PRO will track beneficiary grievances, appeals, requests for change of providers and fair hearings.**
Objectives:	1. DMH will maintain a grievance and appeal log and record grievances, appeals, and expedited appeals. 2. DMH will continue to track COP requests and reasons. 3. DMH will evaluate for trends.
Population:	Medi-Cal beneficiaries receiving DMH services.
Performance Indicators: Frequency of Collection:	Stratify PRO data by: • Number of grievances; • Number of appeals; • Number of expedited appeals • Number of COP requests; and • Reasons for COP requests. Annual
Sources of Data:	• Annual Medi-Cal Beneficiary and Grievance and Appeal Report form, FY 2019-20 • PRO data reports

Monitoring Clinical Care

Goal IV.1.:	**DMH will continue to support LA County in its efforts to provide timely, high quality, and easily accessible mental health care for pregnant women and women up to one year after delivering a baby.** As of July 1, 2019, all prenatal providers must screen for depression in pregnancy and the postpartum (CA AB 2193).
Objectives:	1. Explore strategies to track clients that meet criteria for maternal mental health services. 2. Establish eight Maternal Mental Health specialty clinics in SAs across Los Angeles County. a. Each clinic will develop a protocol for treating clients who become pregnant or who have had a baby.
Population:	DMH clients (Female) receiving outpatient SMHS at DO programs.
Performance Indicators: Frequency of Collection:	Number of women identified to be pregnant or recently having had a baby. Annual
Data Sources:	DMH Maternal Mental Health services data reports, CY 2020

Monitoring Continuity of Care

Goal V.1.:	**DMH will develop medication monitoring protocols for DO and LE/Contracted providers.**
Objectives:	1. Identify performance indicators and metrics to include in a dashboard. 2. Establish peer review protocols for DO and LE/Contracted providers.
Population:	DMH clients receiving outpatient medication support services from DO and LE/Contracted providers.
Performance Indicators: Frequency of Collection:	Number of peer reviews completed. Annual
Data Sources:	DMH Pharmacy Services data reports, CY 2020

Monitoring Provider Appeals

Goal VI.1.:	**DMH will conduct concurrent review of treatment authorizations for all psychiatric inpatient hospital services and psychiatric health facility services.**
Objective:	Starting Feb 1, 2020, DMH will establish a baseline for the NOABD denials.
Population:	DMH clients receiving inpatient psychiatric services.
Performance Indicators: Frequency of Collection:	Stratify DMH treatment authorization data by: • Denials for acute and administrative days; • Concurrent versus retrospective; and • Reasons for denials. Monthly
Data Sources:	Central Authorization Unit (CAU) – Intensive Services Division data reports, CY 2020

Note: Baseline data/metrics to be developed.

Monitoring Performance Improvement Projects

Goal VII.1.:	**DMH will continue to develop and implement meaningful clinical PIP interventions targeting COD and trauma issues.**
Objectives:	1. Increase the number of consumers receiving Seeking Safety in group or individual format. 2. Establish protocols for Integr8Recovery groups in select DO clinics and actively recruit group participants.
Population:	DMH clients receiving outpatient COD services.
Performance Indicators: Frequency of Collection:	Hospitalization (7-day and 30-day readmission rates) and engagement/retention (number of visits within 30 and 90 days) data for DMH clients with co-occurring mental health and substance use disorders. Quarterly
Data Sources:	• PIP Development Tool FY 2020-21, *Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)* • CalEQRO report, *Los Angeles County MHP CalEQRO Report*, FY 2019-20

Goal VII.2.:	**DMH will develop and implement a meaningful non-clinical PIP aimed at improving timely access to SMHS for the entire outpatient system of care.**
Objective:	Establish an Access to Care Leadership committee to discuss and review system wide access to care issues.
Population:	LA County residents seeking DMH outpatient SMHS.
Performance Indicators: Frequency of Collection:	To be developed by the PIP. To be developed by the PIP.
Data Sources:	• PIP Development Tool FY 2020-21, *Timely Access* • CalEQRO report, *Los Angeles County MHP CalEQRO Report*, FY 2019-20

Appendix: CalEQRO Performance Measures FY19-20 – Los Angeles MHP