ANNUAL REPORT ON QUALITY IMPROVEMENT

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

Reporting Period: July 1, 2019 to December 21, 2020

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

EXECUTIVE SUMMARY

The Los Angeles County – Department of Mental Health (Department, DMH) is the country's largest county mental health plan (MHP). 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 Los Angeles County residents under the care of DMH staff, non-governmental agencies (NGA), and individual practitioners who provide a wide variety of services.

Los Angeles County is the most populated county globally, with an estimated population of 10,260,237 in Calendar Year (CY) 2019. The estimated distribution by race/ethnicity comprises Latinos representing 48.7%, Whites 27.9%, Asian/Pacific Islanders 14.7%, African Americans 8.5%, and Native Americans representing 0.23%. Approximately 50% of our service recipients are in the child and transition age youth groups, 40% are adults, and 10% are older adults. During Fiscal Year (FY) 2019-20, a full array of mental health services was 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 Department's Work Plan goals focused on the DO and LE/Contracted outpatient programs that served approximately 240,284 individuals countywide.

The Office of Administrative Operations – Quality, Outcomes, and Training Division (QOTD) shares responsibility with providers to maintain and improve the quality of service and the delivery infrastructure. The Quality Improvement (QI) Unit, under QOTD, establishes annual quality improvement goals, monitors Departmental activities for effectiveness, and conducts processes for continuous quality improvement (CQI) of services countywide. The QI Unit relies on its partnerships with other programs, divisions, and stakeholders to establish objectives, strategies, and relevant and timely summaries. The Department's Strategic Plan and QI Work Plan (QIWP) activities are interconnected and similarly CQI-oriented.

The purpose of the design and implementation of the annual QIWP is to ensure an organizational culture of continuous self-monitoring through effective strategies, best practices, and activities countywide. The Department's annual QIWP is organized into seven major domains: 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.

In CY 2020, 12 out of 18 of the QIWP objectives were met, two were partially met, and four were not met. The QIWP goals focused on increasing services for individuals from underserved groups, including pregnant women and recent mothers, expanding telemental health care, using consumer feedback to drive outpatient service priorities, developing new and ongoing Performance Improvement Projects (PIPs), and improving tracking mechanisms for important topics like access to care, beneficiary grievances, and medication monitoring. The QIWP Evaluation report details the progress DMH has made concerning the CY 2020 QIWP activities.

In CY 2021, QOTD will continue to promote a QI culture through departmental-wide partnerships, including planned collaborative efforts with Access to Care Leadership, the Office of Clinical Operations, including Pharmacy Services and the Intensive Care Division, the Cultural Competency, Quality Assurance, and Outcomes Units, Outpatient Services, the Homeless Outreach, and Mobile Engagement team, multidisciplinary PIP committees, and QI stakeholders. In 2021, DMH will strive for equitable and accessible services by targeting service gaps to the Asian, Black/African Americans, and Native Hawaiian/Pacific Islander communities and monitoring systemwide timeliness rates; providing resources and support to programs, such as client data reports, knowledge assessments and chart review checklists; and reevaluating the Department's survey collection strategies. Notable CQI efforts will include evaluating grievances and appeals and inpatient provider complaints for trends and expanding internally tested peer review and medication monitoring protocols to LEs. Meaningful clinical and continuity of care performance objectives surrounding medicated assisted treatment and street psychiatry will directly impact adverse clinical outcomes for high-risk individuals. QIWP activities are reviewed biannually by the Department's QI Council.

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INTRODUCTION

The Department of Mental Health (Department, DMH) authorizes inpatient and outpatient specialty mental health services (SMHS) for beneficiaries. DMH is the largest county mental health plan (MHP) 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 Los Angeles County residents under the care of DMH staff, non-governmental agencies (NGA), and individual practitioners who provide a wide variety of services. With a $2.4 billion budget, DMH aims to provide *hope, recovery, and wellbeing* for everyone in Los Angeles County and beyond.

Mission

• Our mission is to optimize the hope, 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.

Vision

• We envision an Los Angeles County unified by shared intention and cross-sector collaboration that helps those suffering from serious mental illness heal, grow and flourish by providing easy access to the right services and the right opportunities at the right time in the right place from the right people.

Services

• Mental health services provided include assessments, case management, crisis intervention, medication support, peer support, psychotherapy and other rehabilitative services. Services are provided in a variety of settings including residential facilities, clinics, schools, hospitals, juvenile halls and camps, mental health courts, board and care homes, in the field and in people's homes. We also provide counseling to victims of natural and man-made disasters, their families and emergency first responders.

• The Director of Mental Health is responsible for protecting patients' rights in all public and private hospitals, programs providing voluntary mental health care and treatment, and all contracted community-based programs. The Director also serves as the public guardian for individuals gravely disabled by mental illness, and is the conservatorship investigation officer for the County.

Service Recipients

• Our services to adults and older adults are focused on those who are functionally disabled by severe and persistent mental illness, including those who are low-income, uninsured, temporarily impaired, or in situational crises. Services to children and youth are focused on those who are emotionally disturbed and diagnosed with a mental disorder. They include wards or dependents of the juvenile court, children in psychiatric inpatient facilities, seriously emotionally disturbed youth in the community, and special education students referred by educational institutions.

Purpose and Intent

The California Code of Regulations (CCR), Title 9, Section 1810.440, requires all county MHPs to establish a Quality Management Program as defined by their contract with the Department of Health Care Services (DHCS). The Department's contract with DHCS also requires establishing a Quality Improvement Work Plan (QIWP) that contains goals and needs identified by triennial oversight reviews and the DMH system at large. The annual report and QIWP reflect countywide partnerships and shared intentions to support individuals managing a Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) to *heal, grow, and flourish*. The Department evaluates the QIWP on an annual basis and with the active involvement of DMH staff, providers, and consumers/families.

At DMH, the Quality Improvement (QI) Unit facilitates the planning, design, and execution of the QIWP and publishes a summary of these activities annually. Past QI reports are available via the QI website at https://dmh.lacounty.gov/qid/ and upon request.

Structure of Report

There are four sections in the following report. Section I provides a detailed overview of the QI Unit within the Quality, Outcomes, and Training Division. The QI Unit is responsible for reviewing the quality of SMHS provided to DMH consumers. This section describes the Unit's organizational structure and elements. Section II provides a demographic profile of Los Angeles County's residents and DMH consumers. In this section, race/ethnicity, age group, gender, language, and Service Area (SA) represent strategic data categories. Section III contains the Department's annual QIWP Evaluation Report. This section details the progress DMH has made concerning the calendar year (CY) 2020 QIWP goals. The final section (IV) of this report presents the QIWP for CY 2021. Section IV details measurable goals and objectives to aid in evaluating the Department's follow-up performance improvement activities.

SECTION I: ORGANIZATIONAL STRUCTURE OF THE QUALITY, OUTCOMES, AND TRAINING DIVISION

Last Revised Date: 3/22/2021

The QI Unit has reporting responsibilities to the DMH Director, Chief Deputy Director of Administrative Operations, and the Quality, Outcomes, and Training Division (QOTD; Figure 1). The Deputy Director of QOTD oversees the quality of the Department's services, coordinates training as indicated for continuous quality improvement (CQI), and conducts ongoing assessments of countywide performance outcomes. The QOTD's organizational structure facilitates a downward and upward communication loop between SMHS providers countywide, the Countywide, SA, and internal QI programs, Cultural Competency Unit, and DMH executive management. The Division combines four units, namely Quality Assurance (QA), Quality Improvement, Outcomes, and Training. The reorganization of DMH and State mandates on access and timeliness has offered multiple opportunities to highlight the value of QI practices in our collaborative work.

Figure 1. Quality, Outcomes, and Training Division
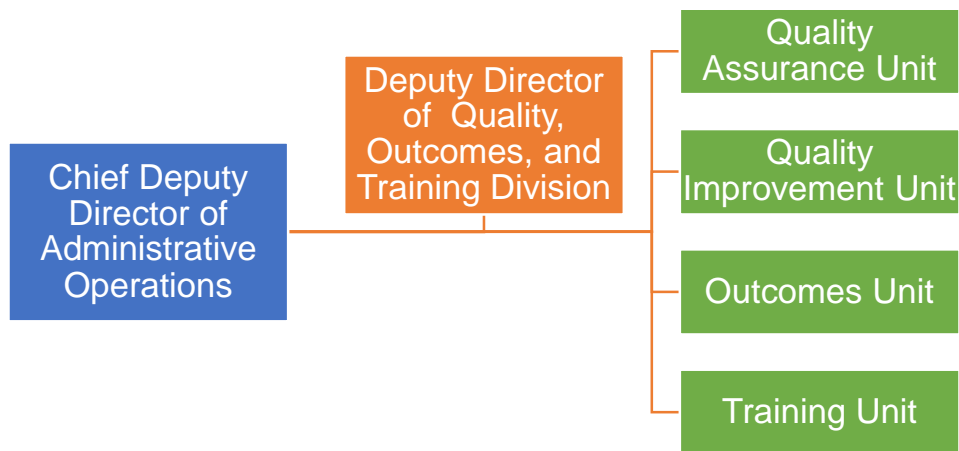
Note: QOTD launched in January 2020.

Quality Assurance Unit

The QA Unit is responsible for ensuring the adherence of the County MHP's directly-operated (DO) and contracted providers to federal, state, and local laws, regulations, and requirements associated with the provision, documentation, and claiming of Medi-Cal SMHS. The QA Unit develops policies and guidelines; monitors adherence to governmental mandates; provides training and technical support; certifies the MHP's SMHS providers; supports the clinical functions of the Department's electronic health record (EHR) system; oversees the integrity, retention, and release of the Department's clinical records; acts as a liaison between the MHP and the State DHCS including during the DHCS Triennial System/Chart review and Short/Doyle Medi-Cal Hospital audits; and advocates for the MHP's position on SMHS-related issues with DHCS, the County Behavioral Health Director's Association (CBHDA), and other entities.

Outcomes Unit

The Outcomes Unit is responsible for selecting and developing, disseminating, training, collecting, and reporting outcome measures associated with the Department's mental health programs, including those that are mandated. The Outcomes Unit provides operational elements and business rules to the Chief Information Office Bureau (CIOB) to develop or customize data collection and reporting systems. The Outcomes Unit conducts data queries and creates dashboards to display outcomes and other elements of data.

Training Unit

The Training Unit is responsible for workforce development, focusing on ensuring a diverse workforce reflective of the clients served, education, and the provision of training and technical assistance for the clinical and non-clinical public mental health workforce.

Quality Improvement Unit

The QI Unit strives to coordinate program development and QI activities that effectively measure, assess, and continuously improve access to and quality care provided to DMH clients. The QI Unit's vision 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. The QI Unit is client/family-focused and supports the Department's culture of CQI and total organizational involvement. QI and QA collaboration is a priority as QA focuses on testing and implementing State mandates. At DMH, the QA and QI Units maintain a collaborative approach to CQI work, including but not limited to efforts to improve access to our services.

Continuous Quality Improvement

CQI is a concept that incorporates QA, problem resolution, and quality improvement. At DMH, CQI is the science of provisioning services to meet local, State, or Federal standards; engaging countywide programs and service providers in QI work; and coordinating improvement activities involving all DMH levels. The purpose of the departmental QI unit's design and implementation is to ensure an organizational culture of continuous self-monitoring through practical strategies, best practices, and collaborative QI activities. The Department's annual QIWP serves as our primary tool for CQI.

Most Salient Quality Improvement Collaborations

The QIWP fosters opportunities for input and active involvement of clients/families, licensed and paraprofessional DMH staff, contracted providers, and other interested stakeholders. The Department's Quality Improvement Council (QI Council) and QA/QI liaisons are heavily involved with providing oversight on QI efforts. Still, our targeted improvement strategies benefit the most from ongoing data-driven discussions with other DMH staff and stakeholders across the entire system of care. The following QI partnership examples reflect the Department's effort to promote CQI countywide through shared knowledge, including lessons learned.

Annual Test Calls Study. The Department's Annual Test Calls Study identifies potential areas for QI and strengths in the ACCESS Center's 24/7-line responsiveness. The DMH Test Calls Study supports the ACCESS Center and the QI Unit in their collaborative efforts to improve cultural and linguistic responsiveness, customer service, referrals to SMHS, tracking/monitoring, and adequate documentation of call information. ACCESS Center management and staff collaborate with the QI Unit and QI Council on this project and disseminate findings.

Access to Care Leadership Committee. The Access to Care Leadership committee comprises core managers from various sectors of DMH's outpatient system of care. The committee meets on a bimonthly basis, with system-wide data review occurring at least monthly. The committee members work collaboratively to address the external (systemic) factors contributing to timely access challenges seen in the data or as identified by providers. The Access to Care Leadership committee's developers ensured QI unit presence early on to bring QI strategies to the workgroup. This inclusion was part of an overall effort to promote a culture of quality improvement within the Department. This collaboration has evolved, beginning with the development of a Performance Improvement Project focused on timeliness. The Access to Care Leadership committee has also become a platform for presenting data, exchanging feedback from external quality reviewers (EQRs), and gaining leadership and input on QI projects related to access and timeliness. The group continues to meet regularly to tackle access and timeliness needs across the Department.

All Programs of Excellence (APEX). APEX is a forum that brings together supervisors, managers, and multiple divisions to address areas of the Outpatient Services Division (OSD) Performance Dashboard indicators where improvement is needed. OSD organizes APEX meetings by SA. The QI Unit provides SA, diagnosis, and homelessness data at the start of each session. Qualitative data, such as that retrieved from programs via post-APEX participation surveys, are analyzed by QI and shared as a resource tool in brochure and presentation format. The APEX process is grounded in the following values: maintain a problem-solving approach, support positive change, remove systemic challenges, enhance coordination and communication between divisions, share evolving procedures, scale best practices, and excellent customer service (internal/external).

Chief Information Office Bureau. A large portion of the Department's CQI work requires ongoing coordination with CIOB, namely:

- Compiling countywide information on clients served and beneficiary populations;
- Developing an internal application to collect annual client satisfaction data electronically in multiple languages; and
- Submitting quarterly Test Calls data to State.

CIOB's Clinical Informatics team holds essential roles in both PIPs, from aggregating timeliness data on clients seeking routine, urgent, and follow-up appointments from outpatient providers or offering technical assistance to the clinical PIP lead tasked with analyzing client data within the EHR.

Cultural Competency Unit (CCU). The Department's Ethnic Services Manager (ESM) oversees the CCU, provides technical assistance to the Cultural Competency Committee (CCC), and is a standing member of the Departmental QI Council. This structure facilitates communication and collaboration for attaining the goals outlined in the QIWP and CC Plan to reduce disparities, increase capacity, and improve the quality and availability of services. Additional information on the CCU and its functions, the CCC, the Institute for Cultural Linguistic Inclusion and Responsiveness (ICLIR), a tri-Countywide Cultural and Linguistic Competency workgroup, and our most recent CC Plan is available via the CCU website at https://dmh.lacounty.gov/ccu/.

Performance Improvement Project (PIP) teams. The Department conducts PIPs to review selected administrative and clinical processes designed to improve performance outcomes. The QI Unit collaborates and coordinates related QI activities with many Divisions, Programs, and Units within DMH. The QI Unit and the QA Unit, ACCESS Center, Access to Care Leadership committee, APEX, OSD, and the Outcomes Unit contribute to meaningful change in access to care and clinical outcomes for DMH beneficiaries. DMH strives for PIP teams that are diverse and inclusive. Each committee member participates on a volunteer basis due to special interests. The QI Unit works to engage and support QI Council members in QI processes related to the QIWP, specific PIP activities, and other QI projects conducted at the SA level.

Quality Assurance Unit. QI and QA collaboration is a priority as QA oversees the implementation of State mandates and QI monitors the impact of change on client care and outcomes. The QA and QI Units co-facilitate countywide QA/QI Liaisons' meetings monthly to integrate discussions of departmental QA goals alongside discussions of QI practices.

Stakeholder Engagement Projects. The QI Council encourages stakeholder involvement in all QI activities. More recently, DMH QI engaged staff, providers, clients, and family members in a project to improve the Department's Consumer Perception Survey (CPS) data reports. Via in-person focus groups with Service Area Leadership Teams (SALTs) and a brief survey, stakeholders helped the QI Unit identify barriers to more user-friendly and accessible client satisfaction data. The QI Council will seek help from stakeholders to evaluate summarized data whenever possible and identify opportunities to design meaningful administrative or clinical improvement projects.

Summary

The QI Unit 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 Unit oversees technical reporting related to the annual QIWP and Evaluation Report, 24/7 ACCESS Center Test Calls Study, consumer satisfaction data, PIPs, and collaborative efforts with other programs. The QI Unit also ensures adherence to prescribed site review protocols and timelines, such as those assigned during triennial oversight reviews and CalEQRO visits. QI staff are obligated to maintain up-to-date knowledge on QI concepts and provide technical assistance, consultation, and training for Departmental QI Council and SA Quality Improvement Committees (QICs), SALTs, and other community organizations/agencies as appropriate. Effective communication and collaborative work with other DMH divisions, programs, and providers support the Department's accelerated use of CQI countywide.

Quality Improvement Council Charter

Statement of Purpose

The purpose of the QI Unit is to ensure and improve the quality and appropriateness of SMHS in conformance with established local, State, and Federal service standards. The Departmental QI Council and SA QICs provide opportunities to:

- Identify QI issues and projects.
- Foster an environment where stakeholders can discuss QI activities.
- Identify possible best practices.
- Ensure performance standards align with the Department's mission and strategic plan.

The QI Unit has a shared responsibility with its providers to maintain and improve its service and delivery infrastructure.

Council Membership

DMH has tasked the Departmental QI Council with evaluating the appropriateness and quality of services provided to DMH consumers. Council membership reflects the diverse perspectives of members from DMH administrative programs and provider locations countywide. The QI Council includes representatives from:

- ACCESS Center;
- Compliance, Privacy, and Audit Services;
- Clinical Policy and Standards;
- Cultural Competency Unit;
- Patient's Rights Office;
- Quality Assurance Unit;
- Quality Improvement Unit; and
- DO and LE/Contracted programs.

Authority

A licensed mental health professional supervises the QI Unit and serves as the Departmental QI Council Chair. The QI Council Chair is responsible for chairing and facilitating 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 Legal Entities (LE)/Contracted providers.

Meetings

Providers are required to participate in their local SA QICs. Each SA convenes for a SA QIC meeting at least quarterly. The Departmental QI Council meets monthly and co-hosts a monthly QA/QI meeting with QA. This approach fosters integrative discussions of departmental QA goals in concert with QI practices. Each committee meeting provides a structured forum for identifying QI opportunities to address challenges and barriers unique to their respective SAs. The Chair/Co-Chairs for the council and committee meetings are responsible for agenda/minutes and steering members through the plan.

Meeting minutes and recordings (when applicable) are posted online at https://dmh.lacounty.gov/qid/sa/ for public review.

Responsibilities

The QI Council, QI Unit, and DMH staff collaborate on measurable QIWP goals to evaluate annual performance management activities. The annual QIWP 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 QI Council collaborates and coordinates related QIWP activities with multiple DMH Divisions and programs. Besides providing QOTD and CCU updates, the monthly agendas may reflect performance and outcomes management discussions led by multiple partners and programs across the Department.

Summary

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

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.
- The 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 primary language.
- Penetration rates by race/ethnicity and age group for Medi-Cal beneficiaries served.

These data sets can be applied when evaluating our service delivery to groups that reflect the total population of Los Angeles County and those living at or below the county's federal poverty level. This information also supports the Department's efforts to assess its capacity to serve clients with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) regardless of race/ethnicity, age group, or gender. The use of trend analysis is helpful towards understanding changes in population demographics and performance measures over time, and in this case, over a three or five-year period.

Methods

Population and poverty estimates are available by each SA, race/ethnicity, age group, and gender. CIOB applies the population living at or below the 138% FPL when estimating mental illness prevalence among the population eligible for Medi-Cal benefits. The population and poverty numbers prepared locally and annually by Hedderson Demographic Services accounts for local housing and household income variations. QIWP goals related to accessibility consider the population living at or below 138% FPL to expand 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. The Office of Clinical Informatics applies a deduplication technique with a Dataflux statistical match to eliminate likely duplicate IDs. This process decreases the likelihood of "false positives."

Total Population

The County of Los Angeles is the most populated in the United States (US), with an estimated 10,260,237 people in CY 2019. The county consists of 88 incorporated cities and includes 4,058 square miles of land area. SA 2 is the most populous. Population density, or the average number of people per square mile, is 2,528 compared to 253 in California.

Differences by Race/Ethnicity

According to California's census data, in Los Angeles County, the Latino group is the most represented race/ethnicity, and the Native American group is the smallest (Figure 2). At the SA level, the White (includes non-Hispanic, European Americans, and Middle Eastern Americans) group is the largest in SA 2 and SA 5 (Table 1). In contrast, Latinos are the largest group in all other SAs. The distribution of race/ethnicity for the total population has remained relatively stable, with the White group showing the most growth between CY 2015 and CY 2019. (Figure 3).

Figure 2. Distribution of Total Population for Los Angeles County by Race/Ethnicity, Calendar Year 2019
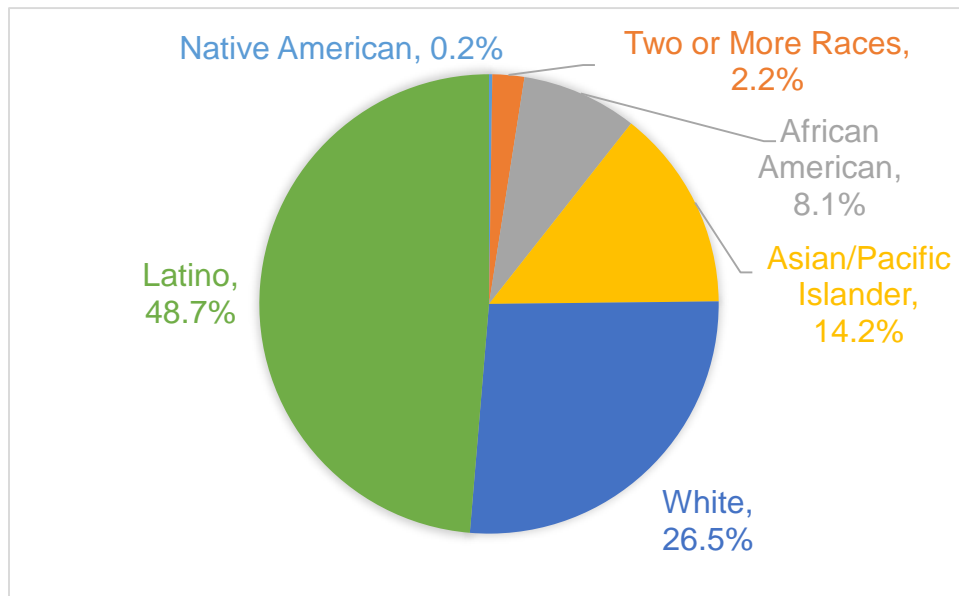
Note: The N for the Latino category is 4,993,673. The N for the White category is 2,719,729. The N for the Asian/Pacific Islander category is 1,457,731. The N for the African American category is 835,191. The N for the Native American category is 23,720. The N for the Two or More Races Category is 230,193. Numbers and percentages may not total to 100% due to rounding. Data Source: ACS, U.S. Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on 11/19/2020.

Table 1. Total Population by Race/Ethnicity and Service Area, Calendar Year 2019

SA	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	61,148	15,464	181,754	1,922	125,684	11,300	397,272
Percent	15.4%	3.9%	45.8%	**0.48%**	31.6%	2.8%	100.0%
SA 2	77,002	254,680	909,678	4,703	943,807	58,441	2,248,311
Percent	3.4%	11.3%	40.5%	0.21%	42.0%	2.6%	100.0%
SA 3	63,409	507,240	846,574	3,720	358,476	35,040	1,814,459
Percent	3.5%	28.0%	46.7%	0.21%	19.8%	1.9%	100.0%
SA 4	59,582	206,948	616,104	2,619	285,102	21,416	1,191,772
Percent	5.0%	**17.4%**	51.7%	0.22%	23.9%	1.8%	100.0%
SA 5	37,299	91,134	110,277	1,184	398,949	28,378	667,220
Percent	5.6%	13.7%	**16.5%**	0.18%	**59.8%**	**4.3%**	100.0%
SA 6	275,338	19,164	717,130	1,825	25,738	11,503	1,050,698
Percent	**26.2%**	**1.8%**	68.3%	**0.17%**	**2.4%**	**1.1%**	100.0%
SA 7	39,210	119,386	974,630	3,344	168,786	15,589	1,320,945
Percent	**3.0%**	9.0%	**73.8%**	0.25%	12.8%	1.2%	100.0%
SA 8	222,204	243,714	637,526	4,403	413,188	48,525	1,569,560
Percent	14.2%	15.5%	40.6%	0.28%	26.3%	3.1%	100.0%
Total	835,191	1,457,731	4,993,673	23,720	2,719,729	230,193	10,260,237
Percent	8.1%	14.2%	48.7%	0.23%	26.5%	2.2%	100.0%

Note: N=10,260,237. Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial category and across all SAs. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on 11/19/2020.

Figure 3. Total Population Percentage Changes by Race/Ethnicity, Calendar Years 2015 to 2019

Latino
- 48.2% (CY 2015)
- 48.4% (CY 2016)
- 48.7% (CY 2017)
- 48.8% (CY 2018)
- 48.7% (CY 2019)

White
- 28.4% (CY 2015)
- 28.3% (CY 2016)
- 26.6% (CY 2017)
- 26.5% (CY 2018)
- 26.5% (CY 2019)

Asian/Pacific Islander
- 14.6% (CY 2015)
- 14.6% (CY 2016)
- 14.1% (CY 2017)
- 14.2% (CY 2018)
- 14.2% (CY 2019)

African American
- 8.6% (CY 2015)
- 8.5% (CY 2016)
- 8.1% (CY 2017)
- 8.1% (CY 2018)
- 8.1% (CY 2019)

Two or More Races
- 2.3%
- 2.2%
- 2.2%

Native American
- 0.2%
- 0.2%
- 0.2%
- 0.2%
- 0.2%

Legend: CY 2015, CY 2016, CY 2017, CY 2018, CY 2019

Axis: 0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0%
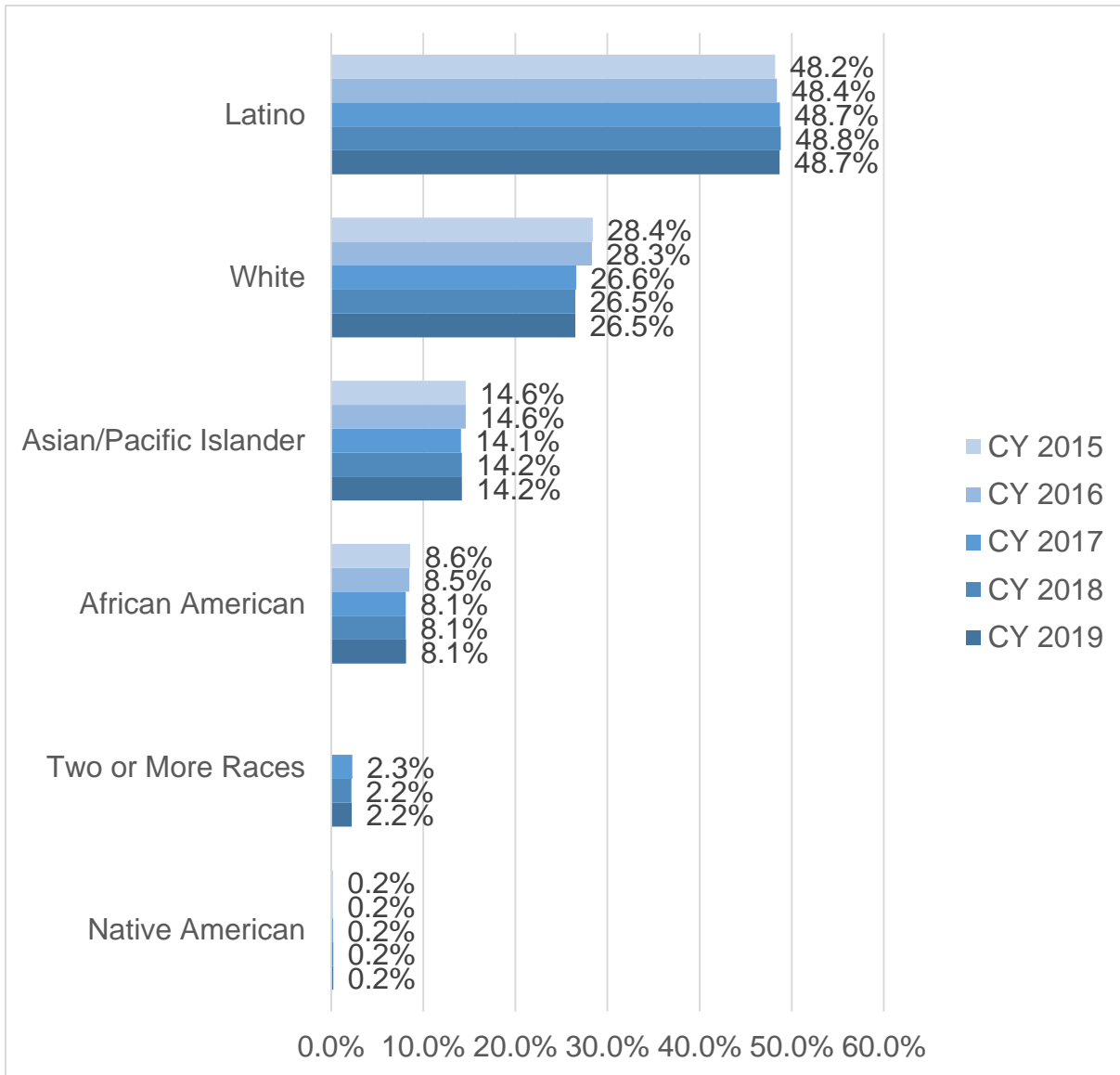
Note: The "Two or more races" group was added in CY 2016. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2015 to 2019; last revised by DMH CIOB on 11/19/2020.

Differences by Age Group

In Los Angeles County, adults make up the largest age group, and transition age youth (TAY) is the smallest (Figure 4). Across all eight SAs, people aged 26-59 years are more represented than those aged 19 to 20, the smallest age group (Table 2). Between CY 2015 and CY 2019, the proportion of children declined by 1.3 Percentage Points (PP), with older adults demonstrating the most growth (1.7 PP, Figure 5).

Figure 4. Total Population by Age Group, Calendar Year 2019
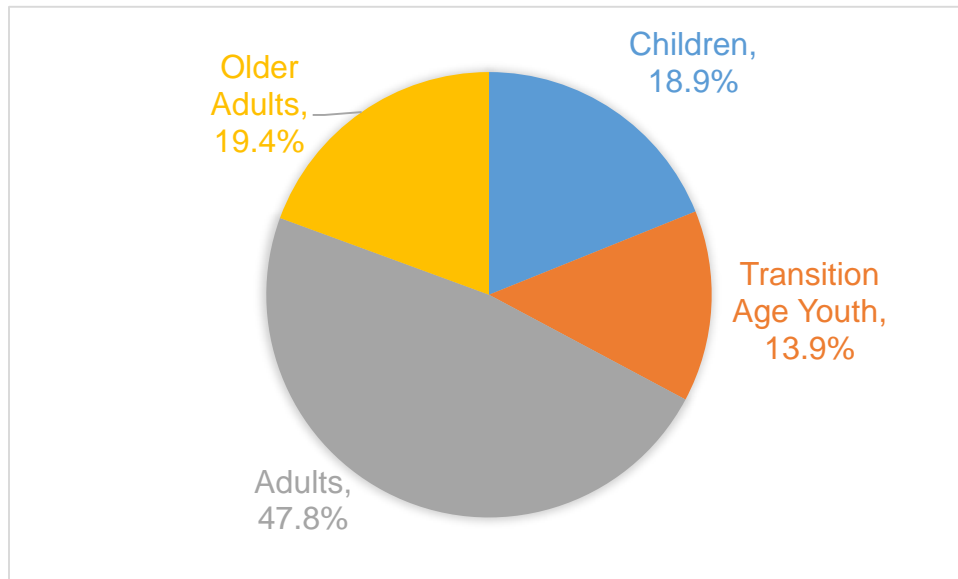
Note: Proposition 63, Mental Health Services Act (MHSA) categories were used to reflect age group distribution. The N for the Children category is 1,934,741. The N for the Transition Age Youth category is 1,428,430. The N for the Adult category is 4,904,764. The N for the Older Adult category is 1,992,302. Numbers and percentages may not total to 100% due to rounding. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on 11/19/2020.

Table 2. Total Population by Age Group and Service Area, Calendar Year 2019

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	104,022	13,206	34,450	176,405	24,364	44,825	397,272
Percent	26.2%	3.3%	**8.7%**	**44.4%**	6.1%	11.3%	100.0%
SA 2	486,825	60,627	152,108	1,085,643	147,042	316,066	2,248,311
Percent	21.7%	2.7%	6.8%	48.3%	6.5%	14.1%	100.0%
SA 3	390,614	54,138	131,937	837,009	119,711	281,050	1,814,459
Percent	21.5%	3.0%	7.3%	46.1%	**6.6%**	15.5%	100.0%
SA 4	239,083	26,350	69,744	643,006	64,200	149,389	1,191,772
Percent	20.1%	**2.2%**	**5.9%**	**54.0%**	5.4%	12.5%	100.0%
SA 5	119,662	23,038	40,973	334,647	41,382	107,518	667,220
Percent	**17.9%**	3.5%	6.1%	50.2%	6.2%	**16.1%**	100.0%
SA 6	298,631	38,452	90,823	477,317	50,349	95,126	1,050,698
Percent	**28.4%**	**3.7%**	8.6%	45.4%	**4.8%**	**9.1%**	100.0%
SA 7	329,651	40,947	103,494	610,331	72,824	163,698	1,320,945
Percent	25.0%	3.1%	7.8%	46.2%	5.5%	12.4%	100.0%
SA 8	361,487	43,443	109,466	740,406	98,813	215,945	1,569,560
Percent	23.0%	2.8%	7.0%	47.2%	6.3%	13.8%	100.0%
Total	2,329,975	300,201	732,995	4,904,764	618,685	1,373,617	10,260,237
Percent	22.7%	2.9%	7.1%	47.8%	6.0%	13.4%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. 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, prepared by DMH CIOB on 11/19/2020.

*Figure 5. Total Population Percent Change by Age Group (Five-Year), Calendar Years 2015 to 2019*
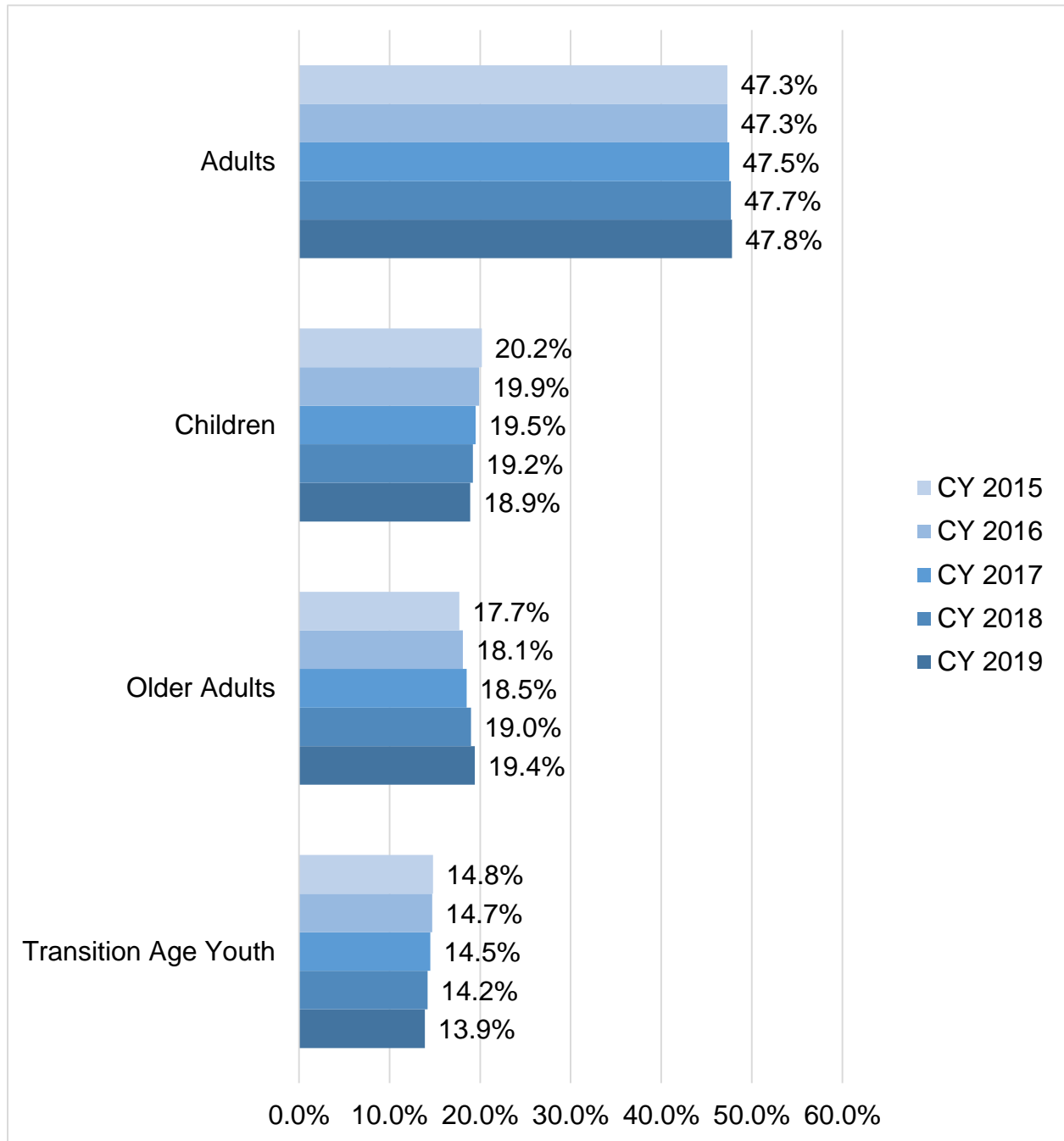
Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2015 to 2019, last revised by DMH CIOB on 11/19/2020.

Differences by Gender

Gender, in terms of Male (49.3%) and Female (50.7%), is almost split evenly between the two groups (Figure 6, Table 3). Gender distribution has remained stable over the last five years (Figure 7).

Figure 6. Total Population by Gender, Calendar Year 2019
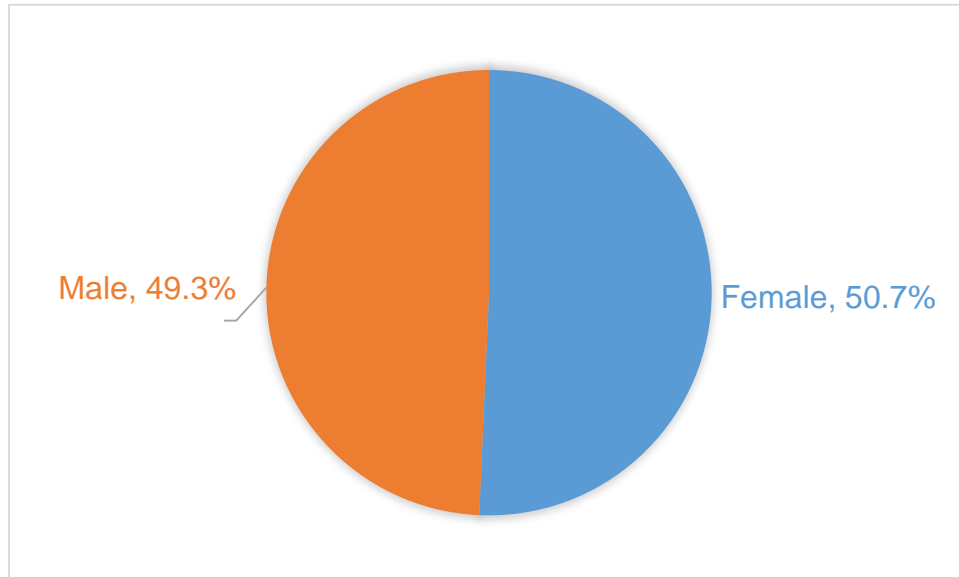
Note: The N for the Female category is 5,200,180. The N for the Male category is 5,060,057. Numbers and percentages may not total to 100% due to rounding. Data Source: ACS, U.S. Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on 11/19/2020.

Table 3. Total Population by Gender and Service Area, Calendar Year 2019

SA	Male	Female	Total
SA 1	196,999	200,273	397,272
Percent	49.6%	50.4%	100.0%
SA 2	1,111,884	1,136,427	2,248,311
Percent	49.5%	50.5%	100.0%
SA 3	885,851	928,608	1,814,459
Percent	48.8%	51.2%	100.0%
SA 4	611,826	579,946	1,191,772
Percent	**51.3%**	**48.7%**	100.0%
SA 5	323,405	343,815	667,220
Percent	**48.5%**	**51.5%**	100.0%
SA 6	512,487	538,211	1,050,698
Percent	48.8%	51.2%	100.0%
SA 7	649,778	671,167	1,320,945
Percent	49.2%	50.8%	100.0%
SA 8	767,827	801,733	1,569,560
Percent	48.9%	51.1%	100.0%
Total	5,060,057	5,200,180	10,260,237
Percent	49.3%	50.7%	100.0%

Note: N=10,260,237. 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, prepared by DMH CIOB on 11/19/2020.

*Figure 7. Total Population Percent Change by Gender (Five-Year), Calendar Years 2015 to 2019*
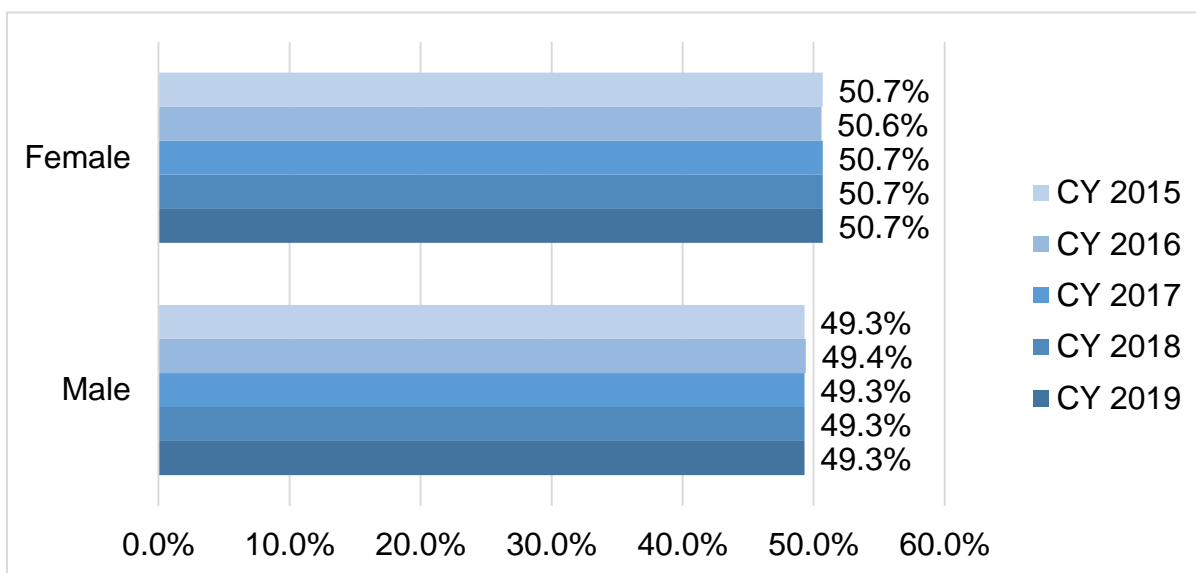
Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2015 to 2019.

Summary

The population of Los Angeles County declined over the last year. The distribution of race/ethnicity and gender has remained the same, but there were noticeable shifts in children and older adults over the previous five years. The age group distribution of children is declining while the older adult group is trending upwards.

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Estimated Population Living at or below Federal Poverty Level

Differences by Race/Ethnicity

Among the population of individuals at or below 138% FPL, the Latino (60.8%) group is the most represented, and the Native American (0.24%) group is the least (Table 4). Of note, the percentage of Latinos declined by 4.1 PP over the past five years and has shown the most considerable shift compared to the remaining race/ethnicity groups (Figure 8). Conversely, the percentage of Native Americans estimated at or below 138% FPL has been stable.

Table 4. Estimated Population Living at or below 138% FPL by Race/Ethnicity and Service Area, Calendar Year 2019

SA	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	17,237	2,552	47,915	485	23,435	2,386	94,010
Percent	18.3%	2.7%	51.0%	**0.52%**	24.9%	2.5%	100.0%
SA 2	14,246	34,531	213,960	755	120,161	7,496	391,149
Percent	3.6%	8.8%	54.7%	0.19%	30.7%	1.9%	100.0%
SA 3	10,610	84,594	172,577	631	42,430	4,100	314,942
Percent	3.4%	**26.9%**	54.8%	0.20%	13.5%	1.3%	100.0%
SA 4	13,002	47,399	186,766	775	48,465	3,833	300,240
Percent	4.3%	15.8%	62.2%	0.26%	16.1%	1.3%	100.0%
SA 5	4,221	11,698	13,440	113	40,243	2,665	72,380
Percent	5.8%	16.2%	**18.6%**	**0.16%**	**55.6%**	**3.7%**	100.0%
SA 6	90,494	6,870	271,691	746	7,571	3,247	380,619
Percent	**23.8%**	**1.8%**	71.4%	0.20%	**2.0%**	0.9%	100.0%
SA 7	7,161	15,442	224,871	681	22,255	1,824	272,234
Percent	**2.6%**	5.7%	**82.6%**	0.25%	8.2%	**0.7%**	100.0%
SA 8	56,495	35,021	165,865	853	43,613	6,823	308,670
Percent	18.3%	11.3%	53.7%	0.28%	14.1%	2.2%	100.0%
Total	213,465	238,106	1,297,085	5,038	348,173	32,374	2,134,241
Percent	10.0%	11.2%	60.8%	0.24%	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, prepared by DMH CIOB on 2/25/2021.

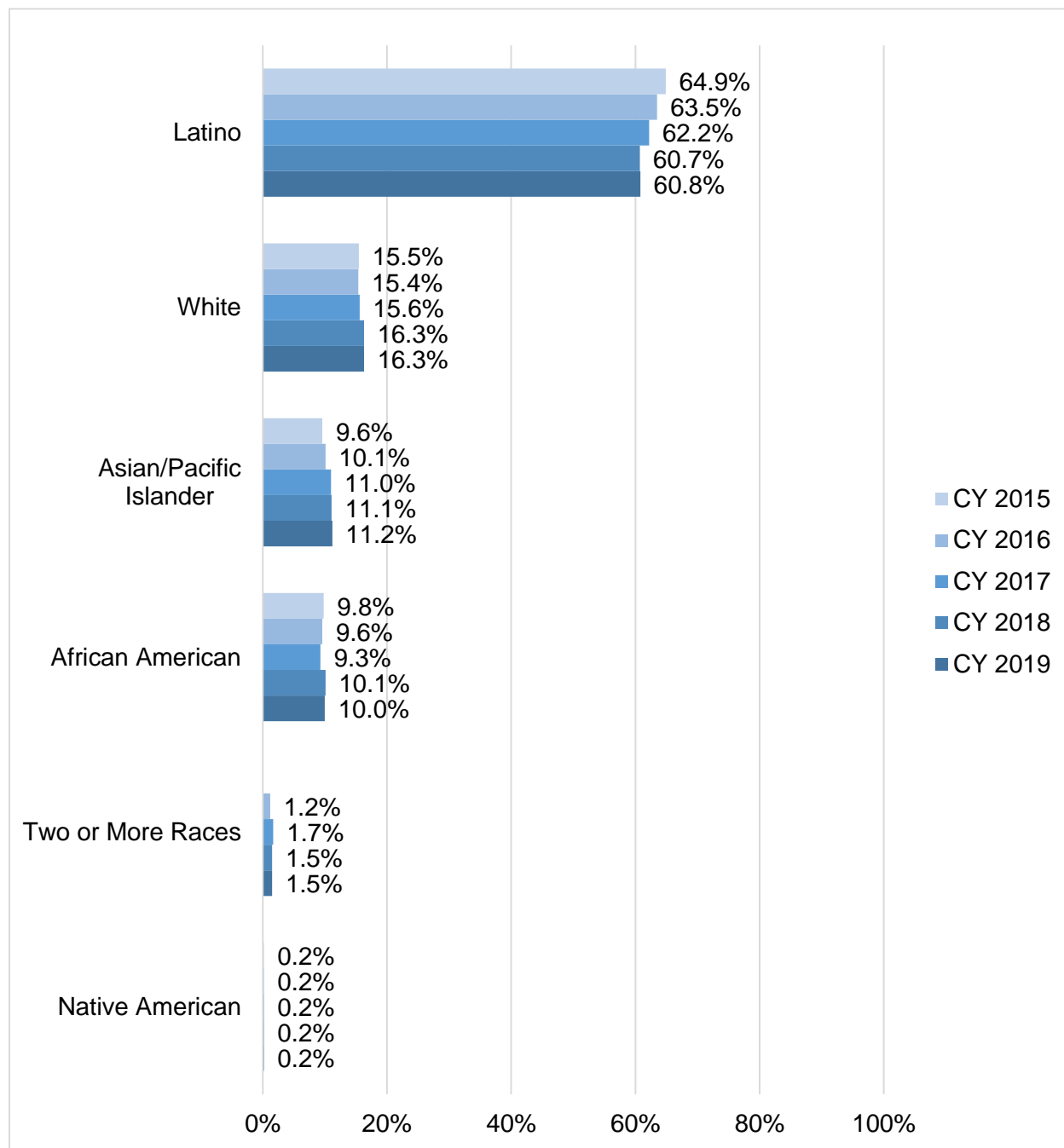*Figure 8. Estimated Percent Change Among Population Living at or below 138% FPL by Race/Ethnicity, Calendar Years 2015 to 2019*

Note: The "Two or More Races" category was added in CY 2016. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, last revised by DMH CIOB on 2/25/2021

Differences by Age Group

At 39.4%, the 26-59 years' group was the most represented among the estimated population at or below 138% FPL (Table 5). People age 19-20 years (2.9%) were the least represented, and five-year trends reveal little to no changes in the age group distribution for Los Angeles County (Figure 9).

Table 5. Estimated Population Living at or below 138% FPL by Age Group and Service Area, Calendar Year 2019

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	34,514	3,006	7,847	36,295	4,262	8,087	94,011
Percent	36.7%	3.2%	8.3%	38.6%	4.5%	8.6%	100.0%
SA 2	118,776	10,814	27,831	173,332	18,571	41,824	391,148
Percent	30.4%	2.8%	7.1%	44.3%	4.7%	10.7%	100.0%
SA 3	93,639	8,881	23,787	131,216	15,413	42,005	314,941
Percent	29.7%	2.8%	7.6%	41.7%	**4.9%**	13.3%	100.0%
SA 4	87,776	6,568	18,877	141,585	12,649	32,784	300,239
Percent	29.2%	**2.2%**	**6.3%**	47.2%	4.2%	10.9%	100.0%
SA 5	12,204	2,796	8,993	36,008	3,355	9,024	72,380
Percent	**16.9%**	**3.9%**	**12.4%**	**49.7%**	4.6%	**12.5%**	100.0%
SA 6	154,301	12,246	31,845	144,762	14,028	23,437	380,619
Percent	**40.5%**	3.2%	8.4%	**38.0%**	**3.7%**	**6.2%**	100.0%
SA 7	101,126	7,781	20,248	107,178	11,059	24,842	272,234
Percent	37.1%	2.9%	7.4%	39.4%	4.1%	9.1%	100.0%
SA 8	104,735	8,823	22,837	129,738	13,691	28,846	308,670
Percent	33.9%	2.9%	7.4%	42.0%	4.4%	9.3%	100.0%
Total	707,071	60,915	162,265	900,114	93,028	210,849	2,134,242
Percent	33.1%	2.9%	7.6%	42.2%	4.4%	9.9%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. 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, prepared by DMH CIOB on 2/25/2021.

Figure 9. Estimated Percent Change among Population Living at or Below 138% FPL by Age Group, Calendar Years 2015 to 2019

Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, CY 2015 to CY 2019, last revised by DMH CIOB on 2/25/2021.
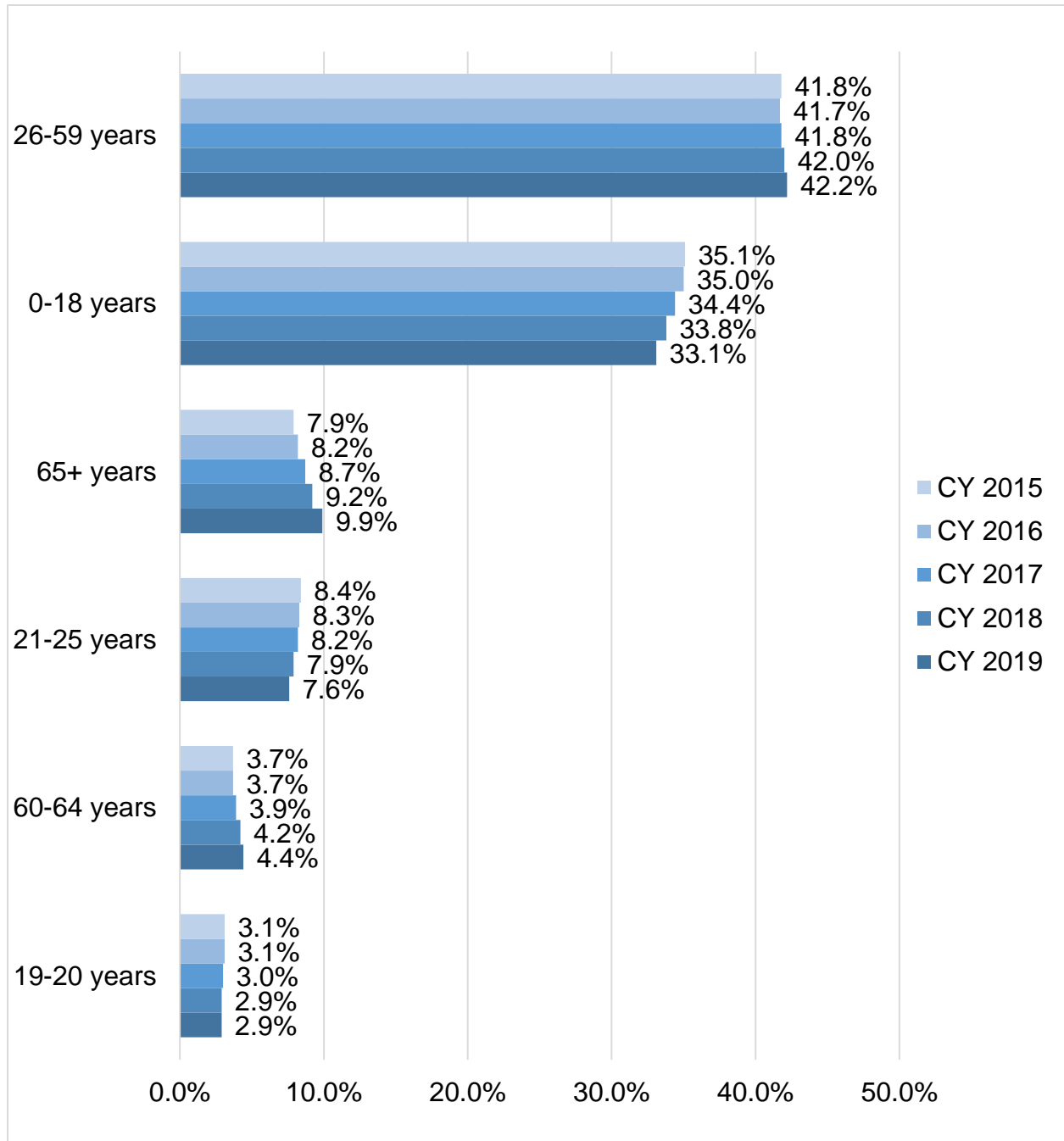
Differences by Gender

Among the estimated population living at or below 138% FPL, and between Females and Males, Females (54.0%) make up a higher percentage (Table 6) and have shown the most growth over the past five years (3.1 PP, Figure 10).

Table 6. Estimated Population Living at or below 138% FPL by Gender and Service Area, Calendar Year 2019

SA	Male	Female	Total
SA 1	43,033	50,978	94,011
Percent	45.8%	54.2%	100.0%
SA 2	180,988	210,160	391,148
Percent	46.3%	53.7%	100.0%
SA 3	143,633	171,308	314,941
Percent	45.6%	54.4%	100.0%
SA 4	141,378	158,861	300,239
Percent	**47.1%**	**52.9%**	100.0%
SA 5	33,168	39,212	72,380
Percent	45.8%	54.2%	100.0%
SA 6	174,204	206,415	380,619
Percent	45.8%	54.2%	100.0%
SA 7	123,947	148,287	272,234
Percent	**45.5%**	**54.5%**	100.0%
SA 8	141,159	167,511	308,670
Percent	45.7%	54.3%	100.0%
Total	981,510	1,152,732	2,134,242
Percent	46.0%	54.0%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. 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, prepared by DMH CIOB on 2/25/2021.

Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, CY 2015 to CY 2019, last revised by DMH CIOB on 2/25/2021.

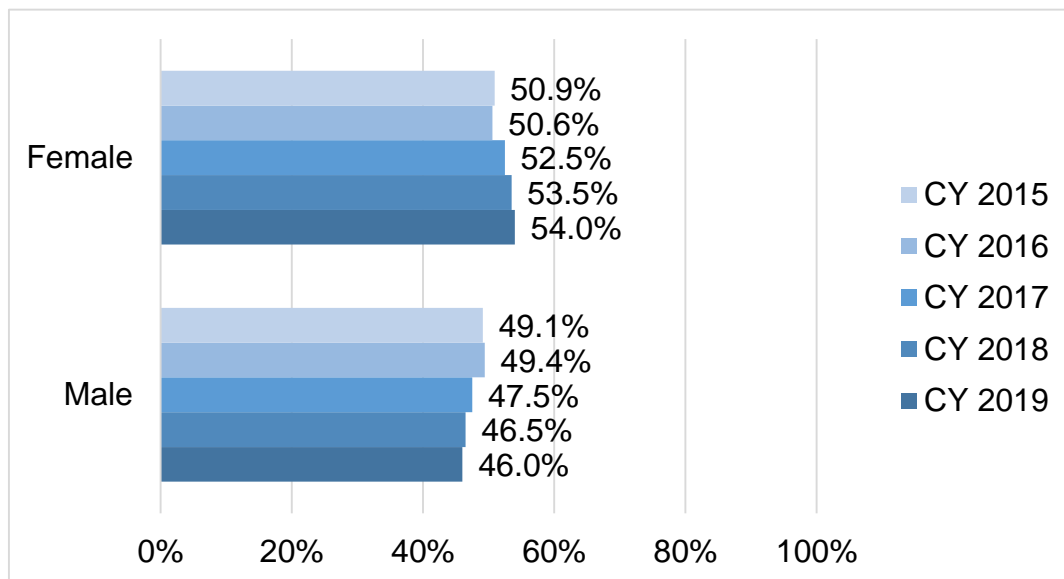Table 7 displays the primary languages for an estimated population living at or below the 138% FPL by threshold language and SA. Among this population, the Spanish (54.7%) language is spoken the most across all eight SAs.

Table 7. Primary Languages of Estimated Population Living at or below 138% FPL by Service Area, Calendar Year 2019

SA	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Other Non-English	Total
SA 1	576	396	64	124	57,839	155	191	26	228	8	31,280	513	245	2,111	93,756
Percent	0.61%	0.42%	0.07%	0.13%	61.69%	0.17%	0.20%	0.03%	0.24%	0.01%	33.36%	0.55%	0.26%	2.25%	100.00%
SA 2	5,314	40,595	95	501	120,048	7,671	3,768	726	3,268	6,756	187,233	6,942	2,130	4,581	389,628
Percent	1.36%	10.42%	0.02%	0.13%	30.81%	1.97%	0.97%	0.19%	0.84%	1.73%	48.05%	1.78%	0.55%	1.18%	100.00%
SA 3	2,651	2,035	743	15,112	90,409	387	2,941	23,794	23,401	199	134,843	3,971	9,644	3,101	313,231
Percent	0.85%	0.65%	0.24%	4.82%	28.86%	0.12%	0.94%	7.60%	7.47%	0.06%	43.05%	1.27%	3.08%	0.99%	100.00%
SA 4	1,538	5,414	494	3,108	76,944	1,220	1,063	1,230	6,384	4,559	169,722	5,106	922	3,326	281,030
Percent	0.55%	1.93%	0.18%	1.11%	27.38%	0.43%	0.38%	0.44%	2.27%	1.62%	60.39%	1.82%	0.33%	1.18%	100.00%
SA 5	1,376	393	70	300	42,651	5,484	1,497	1,413	3,115	1,147	11,769	471	352	2,280	72,318
Percent	1.90%	0.54%	0.10%	0.41%	58.98%	7.58%	2.07%	1.95%	4.31%	1.59%	16.27%	0.65%	0.49%	3.15%	100.00%
SA 6	482	78	98	967	98,779	347	2,744	512	2,181	91	270,186	336	337	4,211	381,349
Percent	0.13%	0.02%	0.03%	0.25%	25.90%	0.09%	0.72%	0.13%	0.57%	0.02%	70.85%	0.09%	0.09%	1.10%	100.00%
SA 7	1,995	700	387	855	59,491	118	2,744	1,090	1,997	149	195,337	2,608	899	2,879	271,249
Percent	0.74%	0.26%	0.14%	0.32%	21.93%	0.04%	1.01%	0.40%	0.74%	0.05%	72.01%	0.96%	0.33%	1.06%	100.00%
SA 8	2,616	351	5,075	84	125,328	601	3,225	534	3,294	377	154,009	4,566	2,176	5,557	307,793
Percent	0.85%	0.11%	1.65%	0.03%	40.72%	0.20%	1.05%	0.17%	1.07%	0.12%	50.04%	1.48%	0.71%	1.81%	100.00%
Total	16,548	49,962	7,026	21,051	671,489	15,983	18,173	29,325	43,868	13,286	1,154,379	24,513	16,705	28,046	2,110,354
Percent	0.78%	2.37%	0.33%	1.00%	31.82%	0.76%	0.86%	1.39%	2.08%	0.63%	54.70%	1.16%	0.79%	1.33%	100.00%

Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on 2/25/2021.

Summary

Of the estimated population living at or below the 138% FPL by race/ethnicity, the Latino group is the largest and has experienced the most change over the last five years. All other race/ethnicity groups, except for the Native American group that has remained stable, experienced increases.

The 26-59 years group was the highest of the age groups, and the 19-20 years group was the lowest. Over the last five years, little change occurred with the 26-59 and 19-20 age groups. The other age groups showed more variation.

The estimated population living at or below the 138% FPL by gender shows a higher percentage of Females. During the last five years, a large shift occurred as the Female group experienced an increase of 3.1 PP.

A total of 97.6% (N=2,082,308) of the estimated population living at or below 138% FPL spoke one of the Department's threshold languages, and 54.7% spoke Spanish.

Population Enrolled in Medi-Cal

This section presents the demographic trends for Los Angeles 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. Refer to Appendix A for month-to-month trends.

Differences by Race/Ethnicity

Table 8 presents the Los Angeles County Medi-Cal enrolled population by racial categories averaged across monthly estimates for CY 2020. The Hispanic group is the race/ethnicity with the highest Medi-Cal enrollment (59.0%), followed by the White group (13.0%), Black/(African American) group (10.1%), Asian group (9.6%), and American Indian/Alaska Native (AI/AN) group (0.1%). A sizeable proportion (8.1%) did not report a specific race/ethnicity.

Table 8. Population Enrolled in Medi-Cal by Race/Ethnicity, Calendar Year 2020

CY 2020	Black	Asian	Hispanic	AI/AN	White	Not Reported	Total
End of Year Average	387,016	366,209	2,252,111	4,718	498,190	310,596	3,818,839
Percent	10.1%	9.6%	59.0%	0.1%	13.0%	8.1%	100%

Note: Race/ethnicity categories as defined by State. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded on May 6, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

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Figure 11. Population Enrolled in Medi-Cal by Race/Ethnicity, Calendar Year 2020
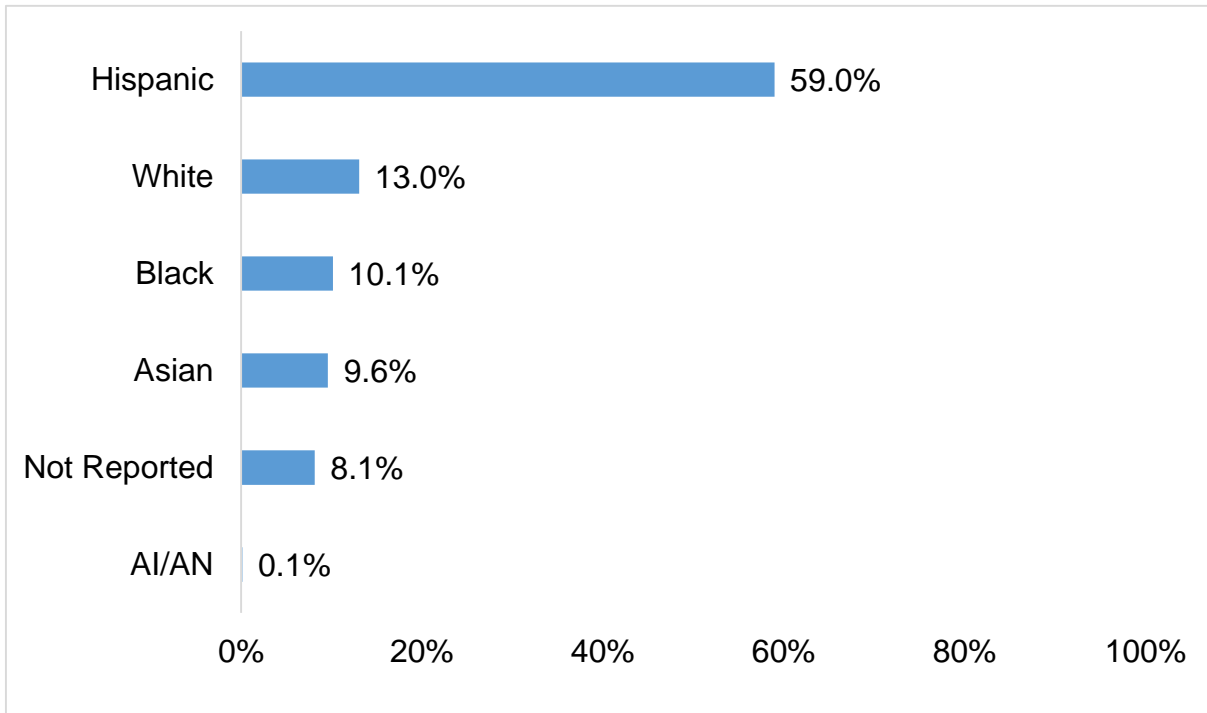
Note: Data above represents a calendar year average based on Los Angeles County's Medi-Cal enrolled population between January 2020 and December 2020. Note: Race/ethnicity categories as defined by State. Refer to Table 8 for the numbers in each racial group.

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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 44 (34.8%), followed by youth ages 0 to 18 (34.1%), adults ages 45 to 64 (20.0%), and older adults ages 65 and above (11.2%).

Table 9. Population Enrolled in Medi-Cal by Age Group, Calendar Year 2020

CY 2020		Age Group				
		0-18	19-44	45-64	65+	Total
End of Year Average		1,300,993	1,329,736	762,253	425,857	3,818,839
Percent		34.1%	34.8%	20.0%	11.2%	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Age Group, and Sex. Downloaded on May 6, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

Figure 12. Population Enrolled in Medi-Cal by Age Group, Calendar Year 2020
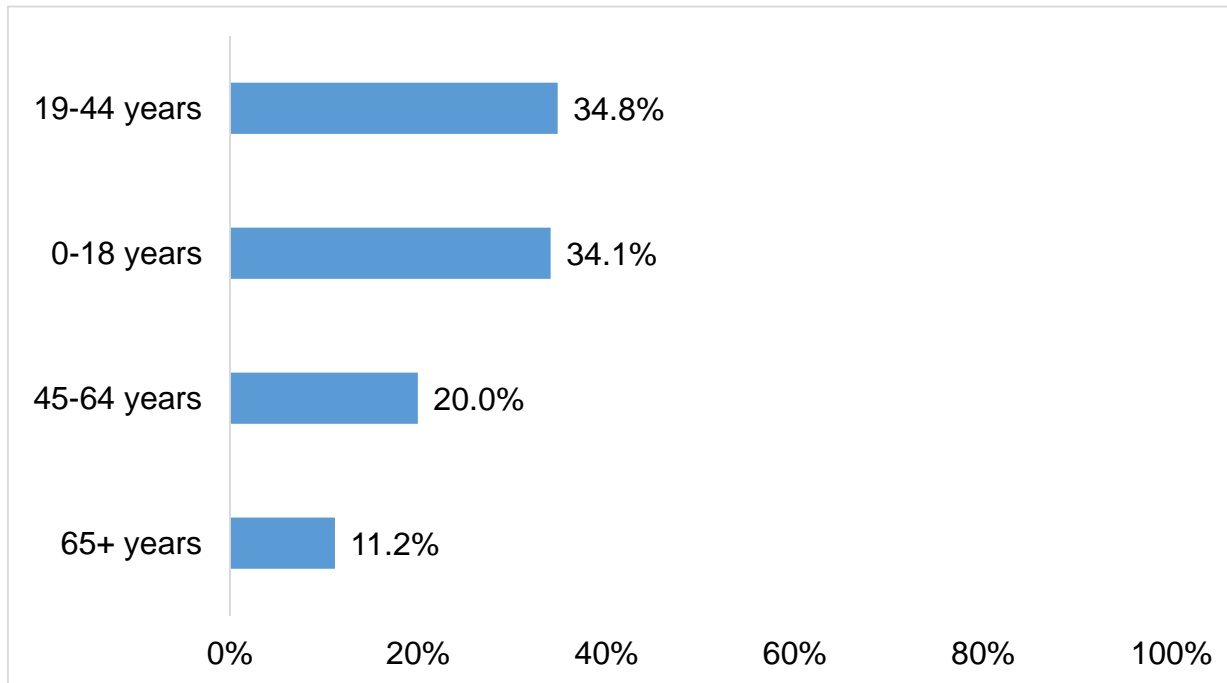
Note: Data above represents a calendar year average based on Los Angeles County's Medi-Cal enrolled population between January 2020 and December 2020. Refer to Table 9 for the numbers in each age group.

Differences by Gender

Table 10 presents the monthly Medi-Cal enrolled population by gender. Females had higher representation across twelve months (53.9%), followed by Males (46.1%).

Table 10. Population Enrolled in Medi-Cal by Gender, Calendar Year 2020

CY 2020	Gender		
	Female	**Male**	**Total**
End of Year Average	2,058,588	1,760,251	3,818,839
Percent	53.9%	46.1%	100%

Note: Gender categories as defined by State. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Age Group, and Sex. Downloaded on May 6, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

Figure 13. Population Enrolled in Medi-Cal by Gender, Calendar Year 2020

Note: Gender categories as defined by State. Data above represents a calendar year average based on Los Angeles County's Medi-Cal enrolled population between January 2020 and December 2020. Refer to Table 10 for the numbers in each gender.
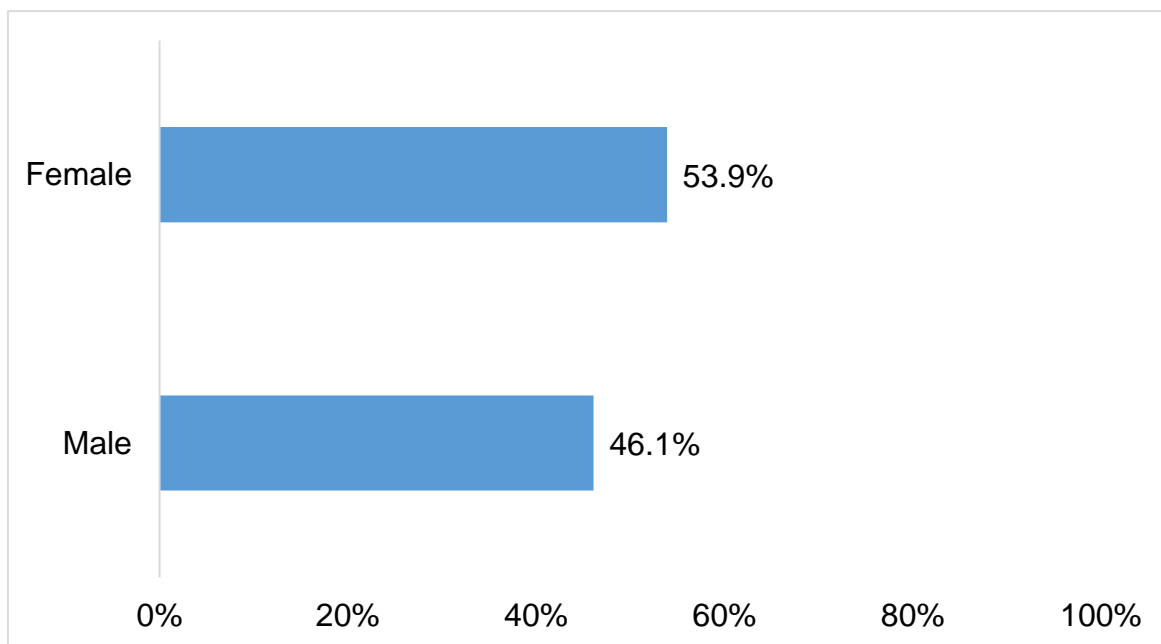
Differences by Primary Language

Table 11 presents the Medi-Cal enrolled population by primary language. The primary language with the highest percentage of Medi-Cal enrollees is English (57.3%), followed by Spanish (34.1%), Armenian (2.1%), Mandarin (1.3%), Cantonese (1.1%), Korean (0.9%), Vietnamese (0.8%), Unknown (0.7%), Farsi (0.4%), Russian (0.4%), Tagalog (0.3%), Cambodian (0.2%), Arabic (0.2%), and Other Non-English (0.2%). The remaining languages represented under 0.1%.

Table 11. Population Enrolled in Medi-Cal by Primary Language, Calendar Year 2020

Language	CY 2020 Avg	Avg %
English	2,186,919	57.27%
Spanish	1,302,412	34.11%
Armenian	79,069	2.07%
Mandarin	47,906	1.25%
Cantonese	43,516	1.14%
Korean	34,635	0.91%
Vietnamese	31,075	0.81%
Unknown	26,152	0.68%
Farsi	15,089	0.40%
Russian	14,214	0.37%
Tagalog	9,708	0.25%
Cambodian	8,661	0.23%
Arabic	6,120	0.16%
Other Non-English	5,805	0.15%

Note: "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. "Other Chinese" no longer meets the definition of a threshold language. The "Other non-English" category met the criteria of a threshold language and was included in this table. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Primary Language. Downloaded on May 6, 2021.

Figure 14. Population Enrolled in Medi-Cal by Primary Language, Calendar Year 2020

Note: Data above represents a calendar year average based on Los Angeles County's Medi-Cal enrolled population between January 2020 and December 2020. Refer to Table 11 for the Ns in each primary language.

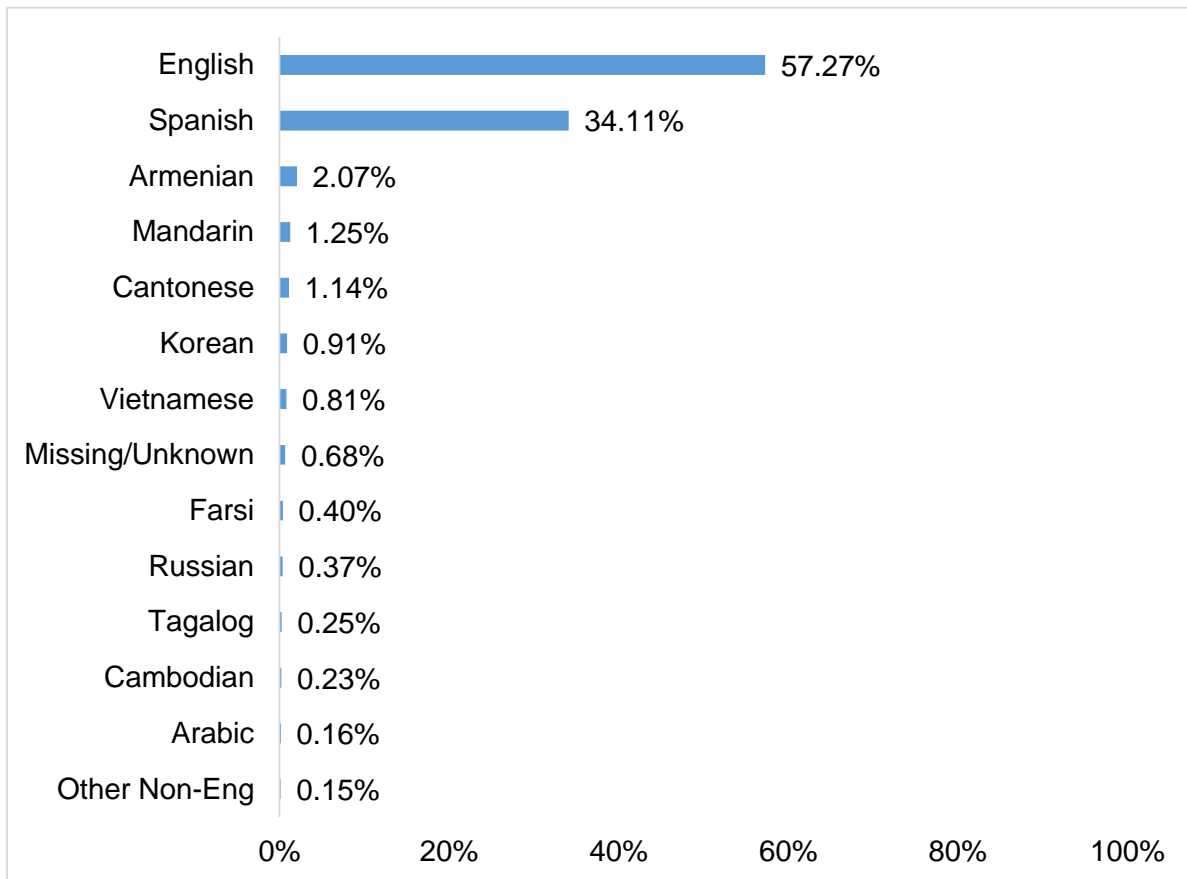## Consumers Served in Outpatient Programs, Fiscal Year 2019-20

In FY 2019-20, DMH served approximately 240,284 consumers in outpatient programs. Fee-For-Service outpatient network providers served approximately 21,330, another 3,292 were served in jails and juvenile halls, and 22,288 were served in 24-Hour acute psychiatric care or residential facilities.
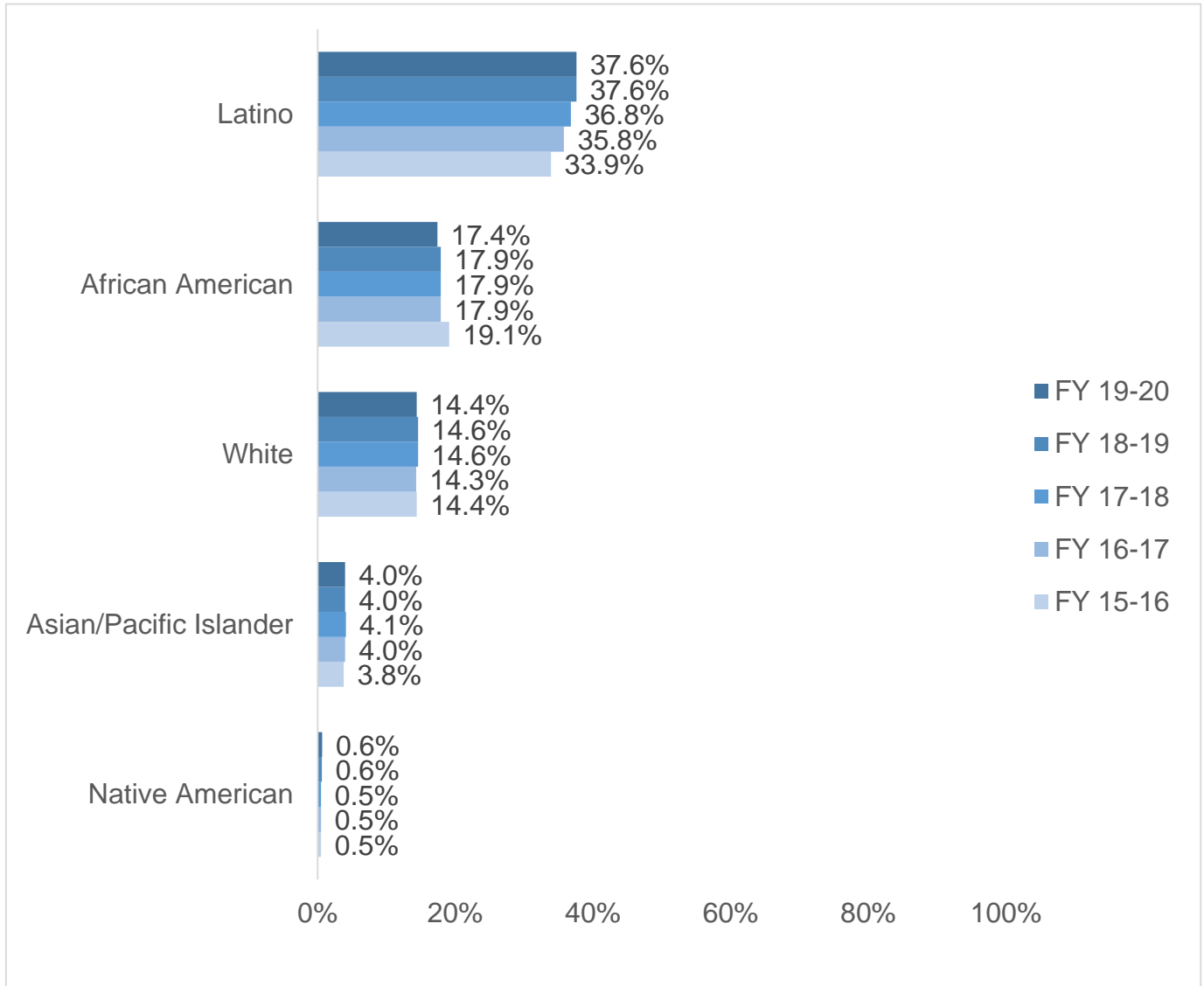
Differences by Race/Ethnicity

Table 12 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 SAs 2 and 7. Whereas the African American group is the highest in SAs 1 and 6, the White group is highest in SA 5, and Unknown is the highest in SA 3. The Native American group is the least represented race/ethnicity among consumers served and across all SAs except SA 6 where Asian/Pacific Islanders were the least represented. In the past five years, among consumers served, the Latino group showed the most growth and the African American group showed the least (Figure 15).

Table 12. Consumers Served in Outpatient Programs by Race/Ethnicity and Service Area, Fiscal Year 2019-20

SA	African American	Asian/ Pacific Islander	Latino	Native American	Two or More Races	Unknown	White	Total
SA 1	7,245	209	6,531	140	1,063	2,211	4,415	21,814
%	33.2%	**1.0%**	29.9%	0.64%	**4.9%**	**10.1%**	20.2%	100.0%
SA 2	4,018	1,579	22,156	145	1,469	10,211	12,557	52,135
%	**7.7%**	3.0%	42.5%	**0.28%**	2.8%	19.6%	24.1%	100.0%
SA 3	3,519	2,971	15,655	215	869	17,111	5,331	45,671
%	**7.7%**	**6.5%**	34.3%	0.47%	1.9%	**37.5%**	**11.7%**	100.0%
SA 4	6,545	2,336	17,468	268	795	8,202	5,627	41,241
%	15.9%	5.7%	42.4%	0.65%	1.9%	19.9%	13.6%	100.0%
SA 5	2,009	386	2,173	53	344	2,585	3,821	11,371
%	17.7%	3.4%	**19.1%**	0.47%	3.0%	22.7%	33.6%	100.0%
SA 6	20,102	608	22,601	754	836	10,703	2,664	58,268
%	**34.5%**	**1.0%**	38.8%	**1.29%**	1.4%	18.4%	**4.6%**	100.0%
SA 7	2,019	951	20,329	244	940	12,789	3,120	40,392
%	5.0%	2.4%	**50.3%**	0.60%	2.3%	31.7%	7.7%	100.0%
SA 8	11,786	2,345	15,067	287	1,369	9,236	6,509	46,599
%	25.3%	5.0%	32.3%	0.62%	2.9%	19.8%	14.0%	100.0%
Total	35,573	8,599	81,902	1,361	5,059	48,881	30,086	211,461
%	16.8%	4.1%	38.7%	0.64%	2.4%	23.1%	14.2%	100.0%

Note: Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. The total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, prepared by DMH CIOB in April 2021.

Figure 15. Percent Change in Consumers Served in Outpatient Programs by Race/Ethnicity, Fiscal Years 2015-16 to 2019-20

Latino
- 37.6%
- 37.6%
- 36.8%
- 35.8%
- 33.9%

African American
- 17.4%
- 17.9%
- 17.9%
- 17.9%
- 19.1%

White
- 14.4%
- 14.6%
- 14.6%
- 14.3%
- 14.4%

Asian/Pacific Islander
- 4.0%
- 4.0%
- 4.1%
- 4.0%
- 3.8%

Native American
- 0.6%
- 0.6%
- 0.5%
- 0.5%
- 0.5%

Legend:
- FY 19-20
- FY 18-19
- FY 17-18
- FY 16-17
- FY 15-16

X-axis: 0% 20% 40% 60% 80% 100%

Note: Data above does not include the Two or More Races or Unknown categories. Data Source: DMH, IS-IBHIS, last revised by DMH CIOB on 3/19/2021.

Differences by Age Group

Table 13 shows the unduplicated count of consumers served in outpatient programs by age group and SA. Individuals ages 26 to 59 years old were the most represented age group among consumers served. Of note, the 0-15 age group was the highest in SAs 1 and 7. The 16-25 age group was the highest in SAs 2, 3, and 7. Individuals ages 60 and above were the least represented age group among consumers served and across all SAs. Between FY 2019-20 and FY 2015-16, the child age group increased by 3.9 PP and has shown the most growth (Figure 16). Conversely, in the same time frame, the adult age group demonstrated the smallest growth (0.9 PP) but remained the most represented age group across all five years.

Table 13. Consumers Served in Outpatient Programs by Age Group and Service Area, Fiscal Year 2019-20

SA	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	9,189	3,655	7,592	1,378	21,814
Percent	**42.1%**	16.8%	34.8%	**6.3%**	100.0%
SA 2	16,876	10,959	19,266	5,034	52,135
Percent	32.4%	21.0%	37.0%	9.7%	100.0%
SA 3	17,357	10,952	14,215	3,147	45,671
Percent	38.0%	24.0%	**31.1%**	6.9%	100.0%
SA 4	11,399	7,339	17,548	4,955	41,241
Percent	27.6%	17.8%	42.5%	12.0%	100.0%
SA 5	2,160	1,710	5,832	1,669	11,371
Percent	**19.0%**	**15.0%**	**51.3%**	**14.7%**	100.0%
SA 6	20,612	11,322	21,549	4,784	58,267
Percent	35.4%	19.4%	37.0%	8.2%	100.0%
SA 7	16,606	8,889	12,196	2,701	40,392
Percent	41.1%	**22.0%**	30.2%	6.7%	100.0%
SA 8	15,385	8,457	18,165	4,591	46,598
Percent	33.0%	18.1%	39.0%	9.9%	100.0%
Total	67,250	40,057	83,740	22,412	213,459
Percent	31.5%	18.8%	39.2%	10.5%	100.0%

Note: Bold values represent the highest and lowest percentage within each age group across Service Areas. The table excludes Out of County consumers, N = 3,663. The total reflects the unduplicated count of consumers served. Data Source: LACDMH IS-IBHI, prepared by DMH CIOB, April 2021.

Figure 16. Percent Change in Consumers Served in Outpatient Programs by Age Group, Fiscal Years 2015-16 to 2019-20
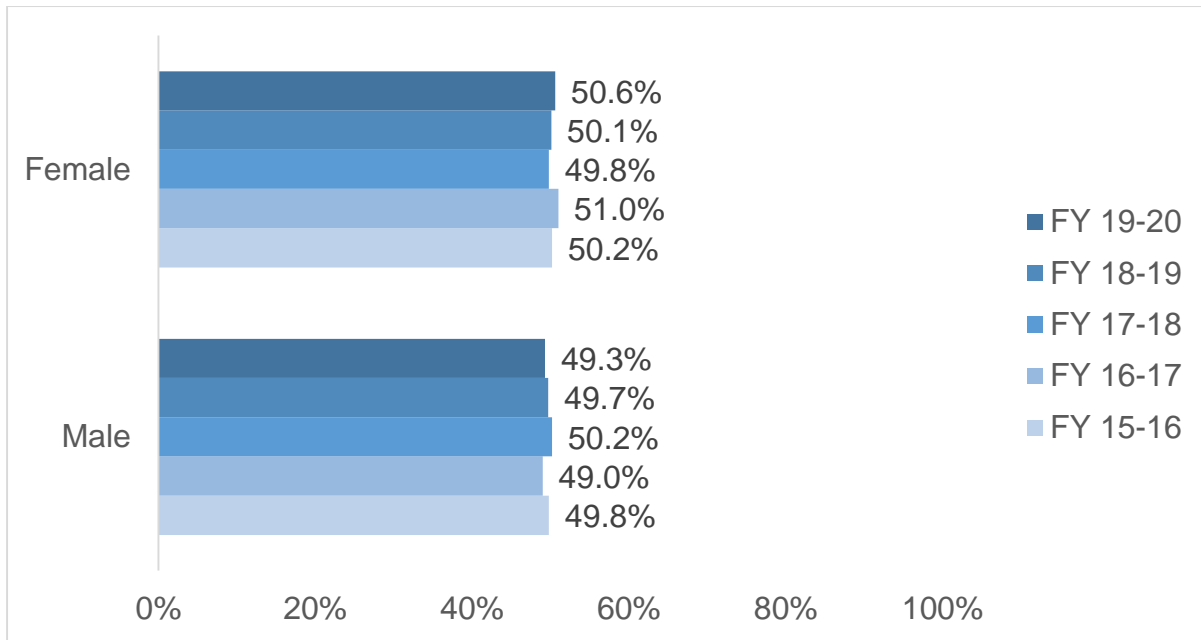
Note: Transgender and Unknown are not represented as FY 2018-19 is the first year that these numbers are reported. Data Source: DMH, IS-IBHIS, last revised by DMH CIOB, April 2021.

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Differences by Gender

Table 14 presents the unduplicated count of consumers served in outpatient programs by gender and SA. The highest number of consumers served identified as female in all SAs except for SA 4. Gender, in terms of Male and Female, has remained relatively stable over the past five years (Figure 17).

Table 14. Consumers Served in Outpatient Programs by Gender and Service Area, Fiscal Year 2019-20

SA	Male	Female	Transgender (F to M)	Transgender (M to F)	Unknown	Total
SA 1	10,766	11,022	17	5	4	21,814
Percent	49.4%	50.5%	**0.08%**	0.02%	0.02%	100.0%
SA 2	25,606	26,462	36	25	6	52,135
Percent	**49.1%**	**50.8%**	0.07%	0.05%	**0.01%**	100.0%
SA 3	22,870	22,760	17	16	8	45,671
Percent	50.1%	49.8%	**0.04%**	0.04%	0.02%	100.0%
SA 4	21,968	19,192	**32**	42	7	41,241
Percent	**53.3%**	**46.5%**	**0.08%**	**0.10%**	0.02%	100.0%
SA 5	5,805	5,548	7	4	7	11,371
Percent	51.1%	48.8%	0.06%	0.04%	**0.06%**	100.0%
SA 6	29,589	28,593	31	38	17	58,268
Percent	50.8%	49.1%	0.05%	0.07%	0.03%	100.0%
SA 7	19,958	20,401	20	6	7	40,392
Percent	49.4%	50.5%	0.05%	**0.01%**	0.02%	100.0%
SA 8	23,335	23,170	39	36	19	46,599
Percent	50.1%	49.7%	**0.08%**	0.08%	0.04%	100.0%
Total	105,244	107,918	133	116	50	213,461
Percent	49.3%	50.6%	0.06%	0.05%	0.02%	100.0%

Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. The table excludes Out of County consumers, N=3,988. Data Source: LACDMH-IS-IBHIS, prepared by DMH CIOB, April 2021.

Figure 17. Percent Change in Consumers Served in Outpatient Programs by Gender, Fiscal Years 2015-16 to 2019-20
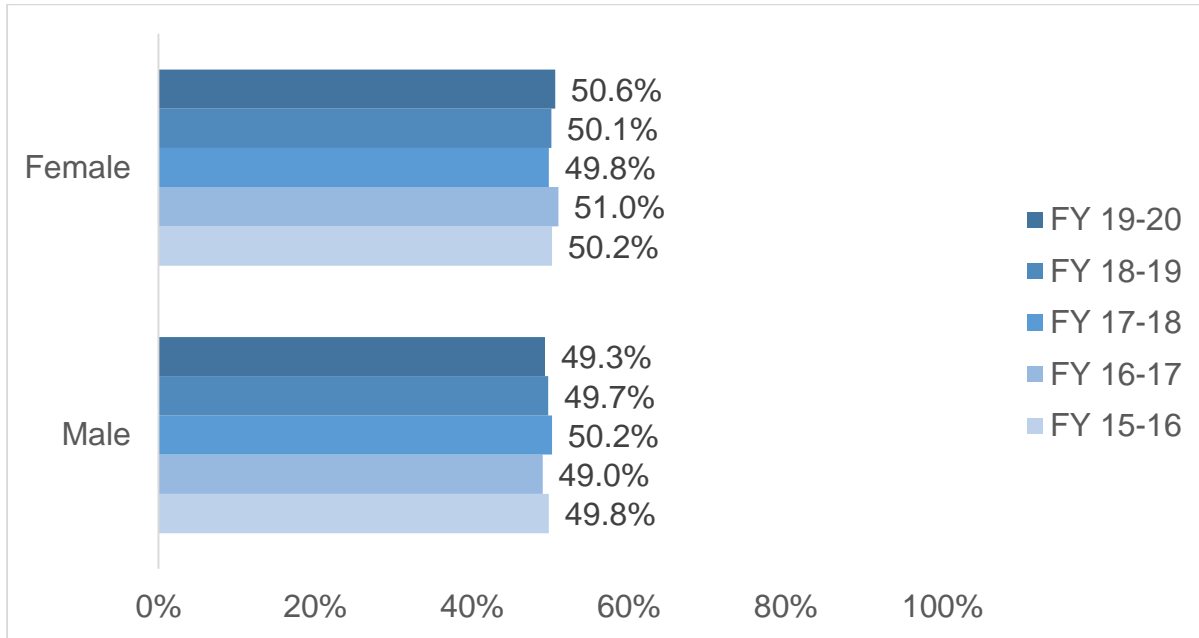
Data Source: DMH, IS-IBHIS, FY 2015-16 to FY 2019-20, last revised by DMH CIOB on 2/24/2021.

Differences by Primary Language

Table 15 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 166,476 (80.9%) English-speaking consumers were served, followed by 32,970 (16.0%) Spanish-speaking consumers. The remaining 6,349 (3.1%) consumers served spoke the Department's other threshold languages. A total of 39,319 (19.1%) of the consumers served reported a primary language other than English. SA 1 (93.0%) had the highest percentage of English-speaking consumers compared to SA 7 (77.8%), 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 to report Spanish as their primary language was in SA 7 (21.5%), and the lowest percentage was in SA 5 (6.0%).

Table 15. Primary Language of Consumers Served in Outpatient Programs by Service Area and Threshold Language, Fiscal Year 2019-20

SA	Arabic	Arme-nian	Cambo-dian	Canton-ese	English	Farsi	Korean	Man-darin	Other Non-English	Russian	Spanish	Tagalog	Vietna-mese	Total
SA 1	7	15	3	0	19,981	7	0	1	3	6	1,448	4	1	21,476
%	0.03%	0.07%	0.01%	0.0%	**93.0%**	0.03%	0.0%	0.0%	0.01%	0.03%	**6.7%**	0.02%	0.0%	100.00%
SA 2	110	1,456	23	7	40,826	575	123	11	8	292	6,933	94	67	50,525
%	0.2%	**2.9%**	0.0%	0.0%	**80.8%**	**1.1%**	**0.2%**	0.0%	0.0%	**0.6%**	**13.7%**	**0.2%**	**0.1%**	100.0%
SA 3	27	62	78	571	35,002	17	101	601	10	5	7,075	42	459	44,050
%	0.1%	0.1%	0.2%	**1.3%**	**79.5%**	0.0%	**0.2%**	**1.4%**	0.0%	0.0%	**16.1%**	0.1%	**1.0%**	100.0%
SA 4	11	198	67	93	31,059	47	626	44	6	189	6,952	85	75	39,452
%	0.0%	**0.5%**	0.2%	**0.2%**	**78.7%**	0.1%	**1.6%**	0.1%	0.0%	**0.5%**	**17.6%**	0.2%	0.2%	100.0%
SA 5	12	6	0	2	9,901	154	29	4	1	36	649	4	7	10,805
%	0.1%	0.1%	0.0%	0.0%	**91.6%**	**1.4%**	0.3%	0.0%	0.0%	0.3%	**6.0%**	0.0%	0.1%	100.0%
SA 6	7	7	17	17	47,222	9	67	15	10	5	9,260	10	26	56,672
%	0.01%	0.01%	0.03%	0.03%	**83.3%**	0.02%	0.1%	0.03%	0.02%	0.01%	**16.3%**	0.02%	0.05%	100.00%
SA 7	19	18	94	22	30,561	3	52	31	2	3	8,440	25	29	39,299
%	0.05%	0.05%	0.2%	0.06%	**77.8%**	0.01%	**0.1%**	0.08%	0.01%	0.01%	**21.5%**	0.06%	0.07%	100.00%
SA 8	17	15	557	16	37,982	7	99	23	4	5	6,166	73	117	45,081
%	0.04%	0.03%	**1.2%**	0.04%	**84.3%**	0.02%	**0.2%**	0.05%	0.01%	0.01%	**13.7%**	0.2%	**0.3%**	100.00%
Total	162	1,333	794	610	166,476	661	895	580	34	393	32,970	270	617	205,795
%	0.1%	0.6%	0.4%	0.3%	80.9%	0.3%	0.4%	0.3%	0.0%	0.2%	16.0%	0.1%	0.3%	100.0%

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 1,129 consumers served in Outpatient Programs specified another non-threshold primary language shown in Table 16. Another 1,392 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, prepared by DMH CIOB on 2/24/2021.

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

- SA 1: Spanish (6.7%)
- SA 2: Armenian (2.9%), Farsi (1.1%), Korean (0.2%), Russian (0.6%), Spanish (13.7%), Tagalog (0.2%), and Vietnamese (0.1%)
- SA 3: Cantonese (1.3%), Korean (0.2%), Mandarin (1.4%), Spanish (16.1%), and Vietnamese (1.0%)
- SA 4: Armenian (0.5%), Cantonese (0.2%), Korean (1.6%), Russian (0.5%), and Spanish (17.6%)
- SA 5: Farsi (1.4%) and Spanish (6.0%)
- SA 6: Spanish (16.3%)
- SA 7: Korean (0.1%) and Spanish (21.5%)
- SA 8: Cambodian (1.2%), Korean (0.2%), Spanish (13.7%), and Vietnamese (0.3%)

Differences by "Other" non-Threshold Language

Table 16 reports the distribution of "Other" non-threshold languages spoken by consumers served in FY 2019-20 by SA. The highest number of consumers who spoke "Other" non-threshold languages was in SA 3 (N = 178), followed by SA 8 (N = 142).

The language with the highest number of speakers was Other Chinese (N= 123). SA 3 (N = 93) served the highest number of consumers who spoke Other Chinese, followed by SA 7 (N = 19).

The second-highest number of non-English speakers was Japanese (N = 99), followed by 71 consumers who preferred Thai and 69 consumers who preferred American Sign Language (ASL).

Table 16. "Other" non-Threshold Language Spoken by Consumers Served in Outpatient Programs by Service Area, Fiscal Year 2019-20

Languages	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Total
Afghan, Pashto, Pusho	1	18	1	2	0	1	0	1	24
Percent	5.9%	15.7%	0.6%	1.4%	0.0%	2.0%	0.0%	0.7%	3.7%
American Sign Language	8	9	14	9	6	16	15	10	69
Percent	47.1%	7.8%	7.9%	6.4%	14.6%	31.4%	23.1%	7.0%	10.7%
Burmese	0	1	10	1	0	0	0	2	11
Percent	0.0%	0.9%	5.6%	0.7%	0.0%	0.0%	0.0%	1.4%	1.7%
Ethiopian	0	6	4	19	2	13	7	10	48
Percent	0.0%	5.2%	2.2%	13.5%	4.9%	25.5%	10.8%	7.0%	7.4%
French	1	6	2	3	7	1	1	6	26
Percent	5.9%	5.2%	1.1%	2.1%	17.1%	2.0%	1.5%	4.2%	4.0%
Hebrew	0	16	0	4	0	0	1	3	18
Percent	0.0%	13.9%	0.0%	2.8%	0.0%	0.0%	1.5%	2.1%	2.8%
Hindi	1	4	4	1	5	0	4	5	22
Percent	5.9%	3.5%	2.2%	0.7%	12.2%	0.0%	6.2%	3.5%	3.4%
Japanese	0	7	10	36	10	4	3	44	99
Percent	0.0%	6.1%	5.6%	25.5%	24.4%	7.8%	4.6%	31.0%	15.3%
Lao	0	2	11	14	0	5	1	23	50
Percent	0.0%	1.7%	6.2%	9.9%	0.0%	9.8%	1.5%	16.2%	7.7%
Portuguese	3	2	2	6	7	5	1	8	28
Percent	17.6%	1.7%	1.1%	4.3%	17.1%	9.8%	1.5%	5.6%	4.3%
Punjabi	0	5	2	0	0	0	5	3	11
Percent	0.0%	4.3%	1.1%	0.0%	0.0%	0.0%	7.7%	2.1%	1.7%
Romanian	2	5	3	2	0	0	0	1	9
Percent	11.8%	4.3%	1.7%	1.4%	0.0%	0.0%	0.0%	0.7%	1.4%
Thai	1	22	9	25	0	3	7	10	71
Percent	5.9%	19.1%	5.1%	17.7%	0.0%	5.9%	10.8%	7.0%	11.0%
Toisan	0	2	10	2	0	2	1	0	16
Percent	0.0%	1.7%	5.6%	1.4%	0.0%	3.9%	1.5%	0.0%	2.5%
Urdu	0	10	3	1	0	0	0	9	21
Percent	0.0%	8.7%	1.7%	0.7%	0.0%	0.0%	0.0%	6.3%	3.3%
Other Chinese	0	15	93	16	4	1	19	7	123
Percent	0.0%	13.0%	52.2%	11.3%	9.8%	2.0%	29.2%	4.9%	19.0%
Total	17	115	178	141	41	51	65	142	646
Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Row total is for the unduplicated count of consumers reporting a non-threshold language. Data source: DMH-IS-IBHIS, April 2021.

Summary

The number of consumers served in DMH outpatient programs increased from FY 2018-19 to FY 2019-20. The percentage of consumers served in outpatient programs differed by race/ethnicity from FY 2015-16 to FY 2019-20. The Latino ethnic group increased by 3.7 PP, the Asian/Pacific Islander ethnic group increased by 0.2 PP, and the Native American ethnic group increased by 0.1 PP. The African American ethnic group decreased by 1.7 PP, and the White ethnic group remained the same. At 50.3%, the Latino group was the highest in SA 7 compared to SA 5 (19.1%), with the lowest in FY 2019-20.

The largest changes over the past five fiscal years were seen in the age groups. Children decreased by 5.1 PP representing fewer youth served over time. Adults served decreased minimally over time by 0.1 PP. Conversely, older adults increased by 2.9 PP, and TAY increased by 2.3 PP. Despite these shifts, adults remained the largest population with the highest concentration (39.2%) across age groups in FY 2019-20.

Gender distribution changed minimally from FY 2015-16 to FY 2019-20. Males served decreased by 0.5 PP, and females served increased by 0.4 PP. Females were the most represented gender in FY 2019-20 (50.6%).

Threshold language distribution for consumers served remained relatively stable across SAs from CY 2018 to CY 2019.

Penetration Rates, Fiscal Year 2019-20

The Mental Health Services Division at DHCS contracts with Behavioral Health Concepts, Inc. (BHC) to provide CalEQRO 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) Report. Reports are made public and accessible via their [CalEQRO for Medi-Cal Specialty Mental Health Services website](#).

The Department refers to the BHC reports for penetration rate changes and trends by age group and race/ethnicity. Of note, the penetration rates that follow are limited to the Medi-Cal enrolled population of clients served. BHC calculates penetration rate by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The County's total number of yearly unduplicated Medi-Cal eligibles is 4,448,448 and includes the population eligible through Affordable Care Act Expansion.

Penetration Rate Changes for Medi-Cal Beneficiaries by Age Group

In FY 2019-20, the adult population had the highest penetration rate, and children between 0 and 5 had the lowest (Figure 18). Little variability was observed in penetration rates for adult and older adults between DMH, other Large MHPs, and California (Figure 19). However, for children between 0 and 5 or 6 and 17, DMH penetration rates were higher by approximately two and three percent. Of note, children between 6 and 17 showed the largest increase in penetration rate between July 2018 and July 2019 and continued to register a higher penetration rate through July 2020 (Figure 20). Penetration rates showed slower increases for the remaining age groups.

Figure 18. Age Group Distribution (%) of Medi-Cal Beneficiaries Served in Fiscal Year 2019-20
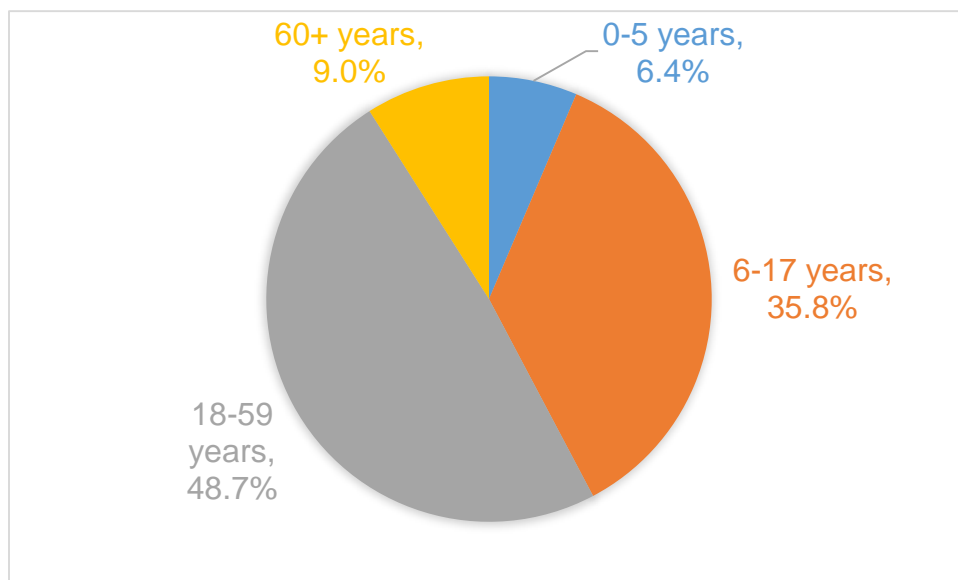
Note: The N for the 0-5 years category is 14,178. The N for the 6-17 years category is 79,272. The N for the 18-59 years category is 107,761. The N for the 60 years or above category is 19,925. Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2019, prepared by BHC/CalEQRO, July 2020.

Figure 19. County to Statewide Comparison for Penetration Rates by Age Group, Fiscal Year 2019-20

	0 - 5 years	6 - 17 years	18 - 59 years	60 years +
Los Angeles	3.6%	9.3%	5.5%	3.2%
Large MHPs	1.8%	6.0%	4.7%	2.6%
Statewide	2.2%	6.9%	5.1%	2.9%
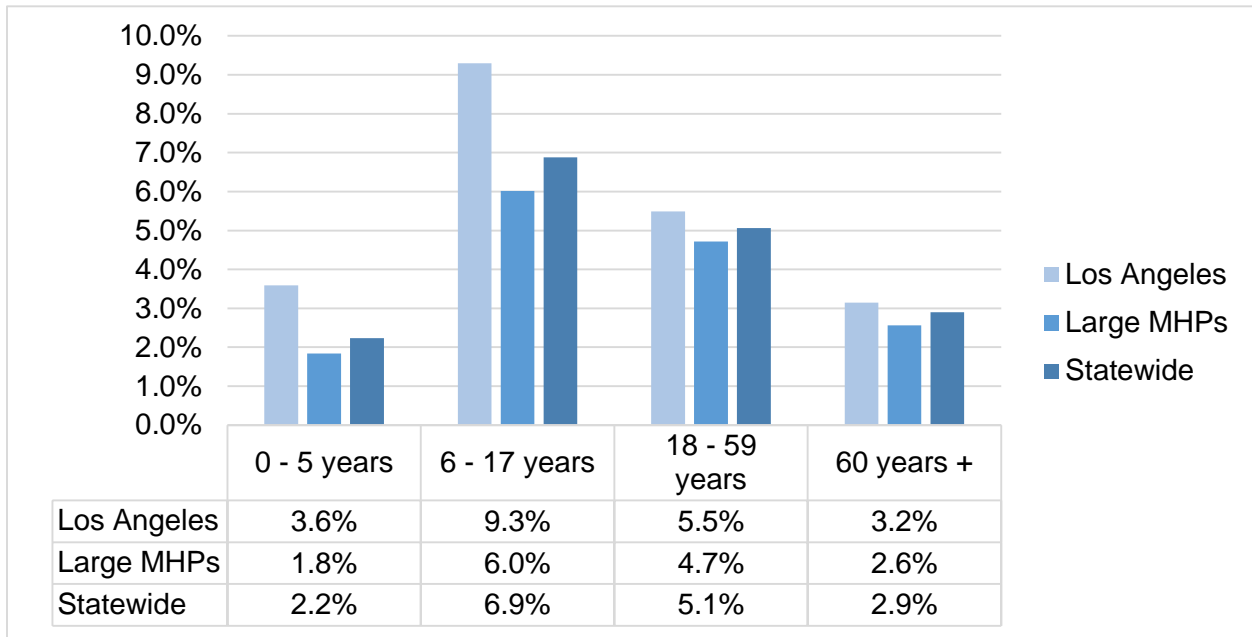
Note: Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2019, prepared by BHC/CalEQRO, July 2020.

Figure 20. Three-Year Trends in Penetration Rates by Age Group, July 2018 to July 2020
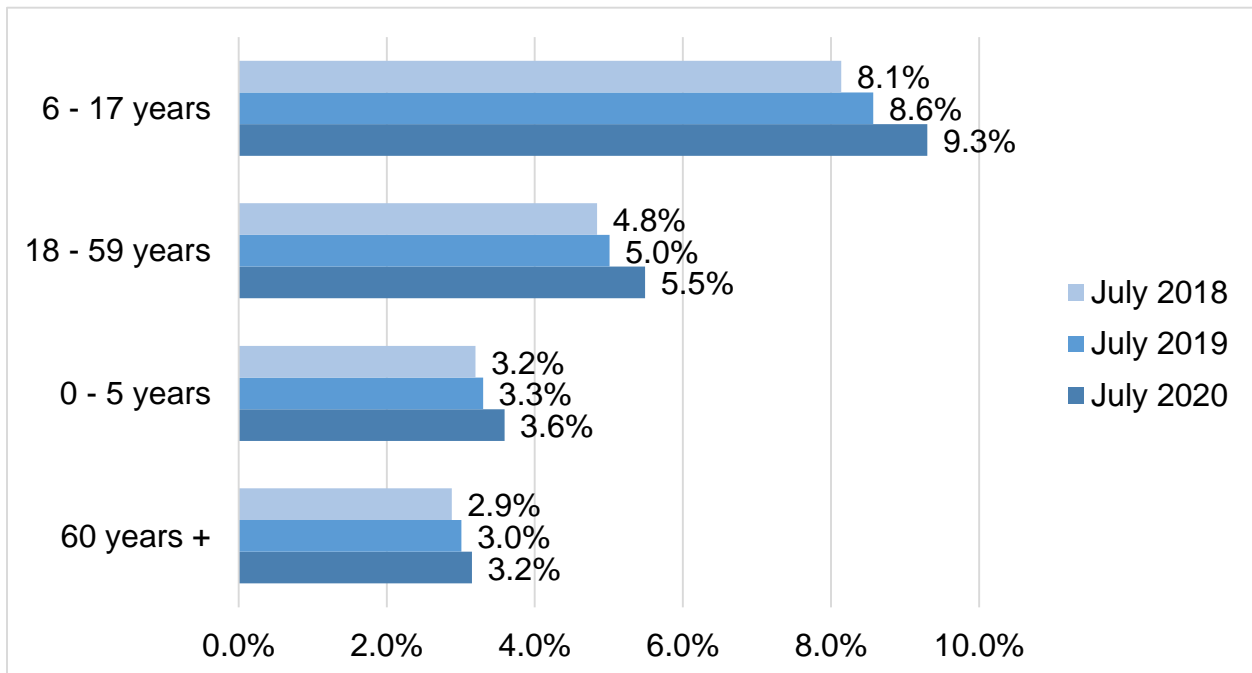
Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2017 to CY 2019, prepared by BHC/CalEQRO, July 2020.

Penetration Rate Changes for Medi-Cal Beneficiaries by Race/Ethnicity

In FY 2019-20, penetration rates were the highest for the Hispanic/Latino group and the lowest for the Native American group (Figure 21). DMH has taken the lead in improving the Hispanic/Latino, African American, and Native American penetration rates (Figure 22). With the exclusion of the Other group, between July 2018 and July 2020, penetration rates have been steadily but unevenly increasing across all races/ethnicities (Figure 23).

Figure 21. Race/Ethnicity Distribution for Medi-Cal Beneficiaries Served in Fiscal Year 2019-20
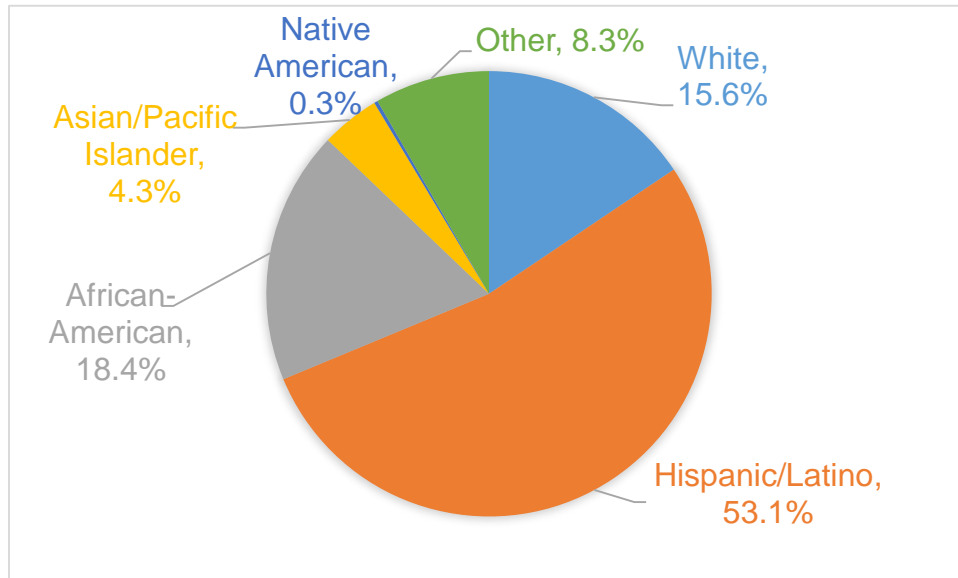
Note: The N for the Latino/Hispanic category is 117,531. The N for the African American category is 40,669. The N for the White category is 34,467. The N for the Other category is 18,458. The N for the Asian American/Pacific Islander category is 9,430. The N for the Native American category is 581. Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2019, prepared by BHC/CalEQRO, July 2020.

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Figure 22. County to Statewide Comparison for Penetration Rates by Race/Ethnicity
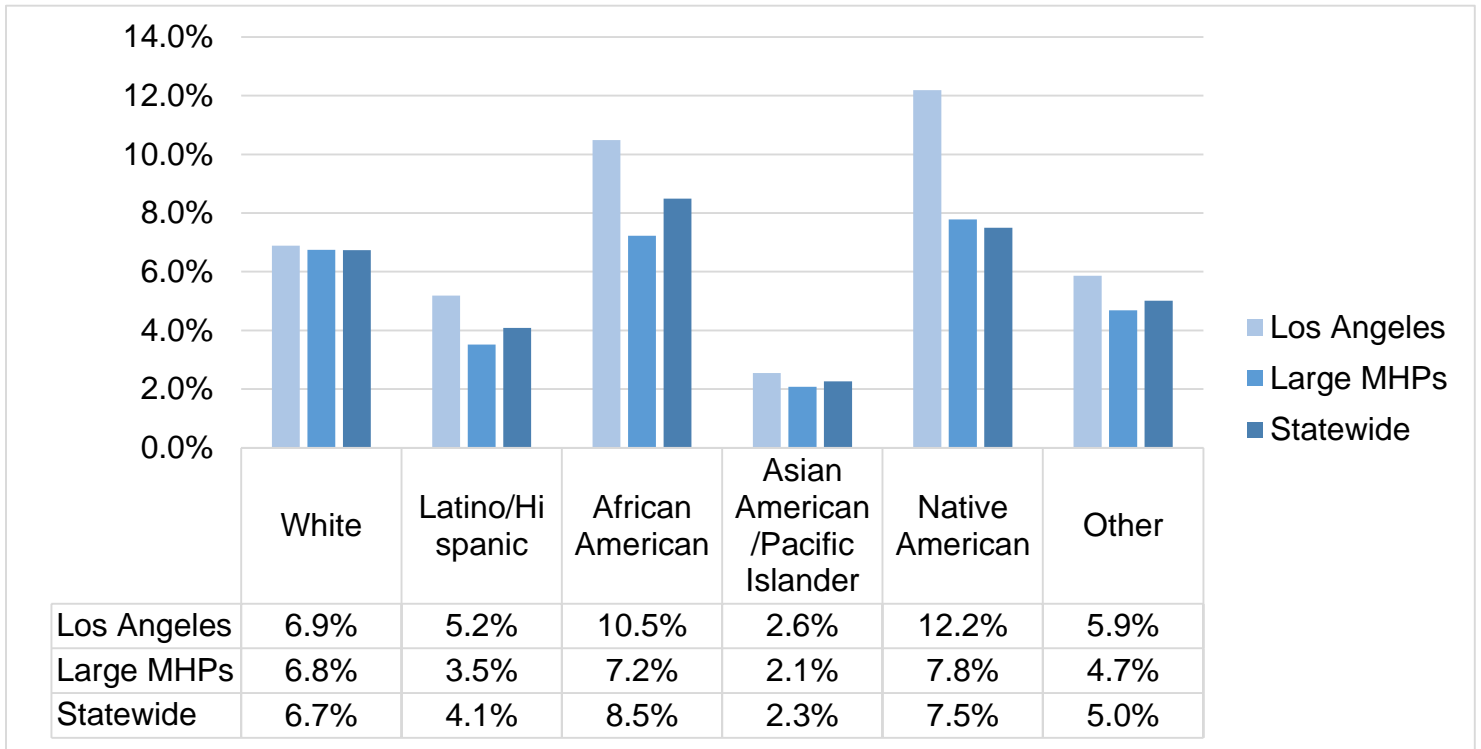
	White	Latino/Hispanic	African American	Asian American /Pacific Islander	Native American	Other
Los Angeles	6.9%	5.2%	10.5%	2.6%	12.2%	5.9%
Large MHPs	6.8%	3.5%	7.2%	2.1%	7.8%	4.7%
Statewide	6.7%	4.1%	8.5%	2.3%	7.5%	5.0%

Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2017 to CY 2019, prepared by BHC/CalEQRO

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Figure 23. Three-Year Trends in Penetration Rates by Race/Ethnicity
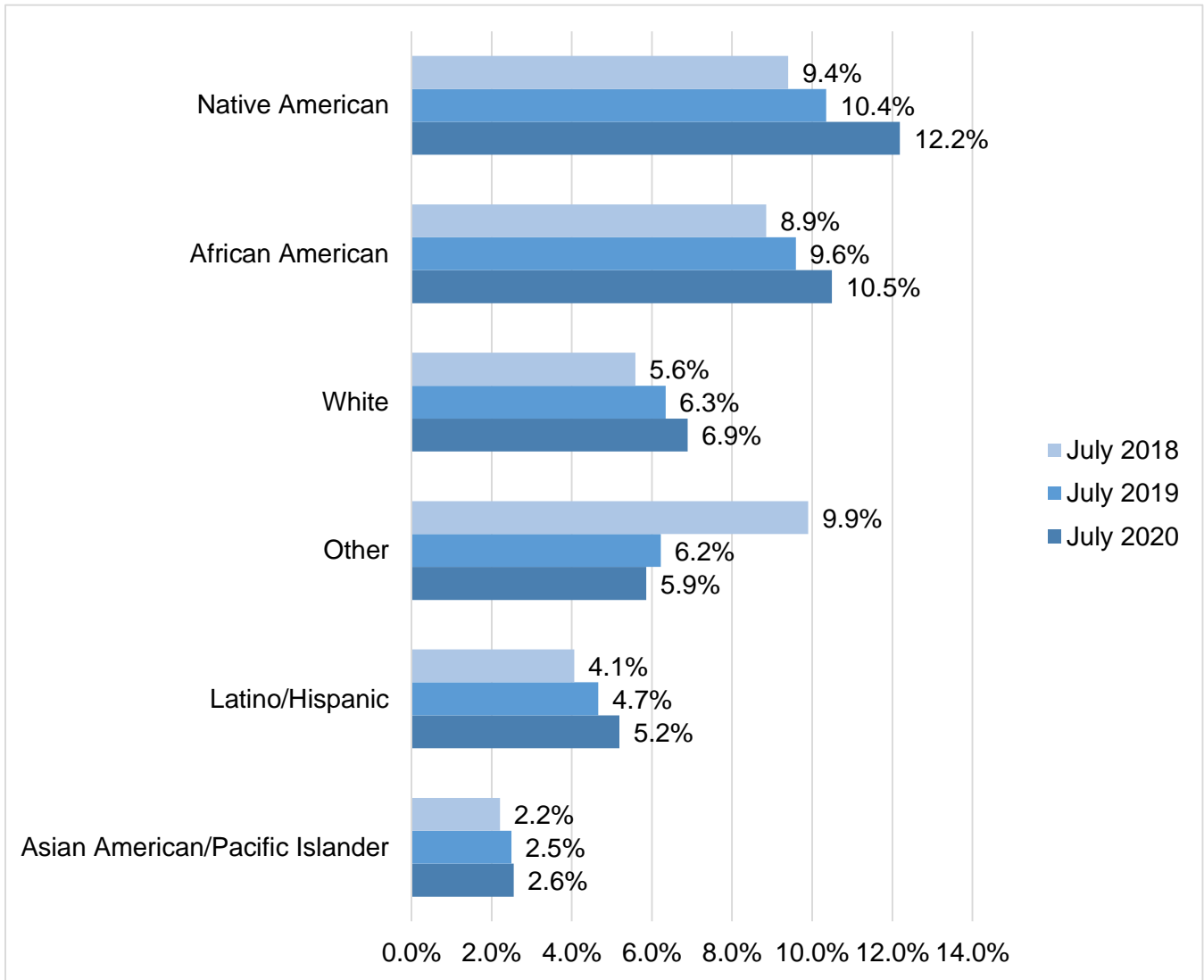
Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2017 to CY 2019, prepared by BHC/CalEQRO, July 2020.

Impact of the Coronavirus Disease (COVID-19) Pandemic on Department of Mental Health's Service Delivery

On January 30, 2020, the World Health Organization (WHO) declared the novel coronavirus outbreak a pandemic. On February 11, 2020, the novel coronavirus was named COVID-19. On April 4, 2020, WHO confirmed over one million reported cases of COVID-19 worldwide, a more than tenfold increase in less than one month. With the safety of its workforce and client population in mind, in 2020, DMH was challenged with necessary shifts in service delivery, including but not limited to a major pivot towards telehealth services.

The Department's OSD programs and clinics remained opened throughout the pandemic. With its "no wrong door" perspective, DMH ensured our underserved populations' needs were addressed via telephone, telemental health through VSee, or in-person. Through regular outreach and engagement with all clients, their unique needs and preferences were incorporated into their treatment remotely and without delays. Blended service delivery – where remote and in-person services are available – is advantageous and contributed to declines in missed appointments.

In support of continuity of care, DMH employed VSee, telephone, and in-person visits with proper Personal Protective Equipment (PPE). Staff was supported in the use of VSee by participating in numerous VSee training, VSee technical support, and the integration of VSee workflows at the clinic level. VSee leads were assigned at the program level and were trained to offer technical assistance and support to staff. A kiosk model was also developed in instances where services were best provided in the clinic setting. Between July 2020 and December 2020, service levels increased significantly from face-to-face/in-person services to delivery via telemental health and telephone.

Impact of Remote Service Delivery on Outpatient Services, July 2020 to December 2020

DMH developed a strategic dashboard to track the impact of COVID-19 on service utilization. At the close of 2020, service levels were up, with a significant shift from in-person to telemental health and telephone services. Between July 2020 and December 2020, a larger portion of service delivery occurred via telephone (Figure 24). LE/Contracted providers more frequently utilized telehealth service delivery, where DO providers showed higher rates of telephone service delivery (Figures 25 and 26). Remote service delivery climbed steadily into the new year and warranted additional QIWP objectives in CY 2021 (Figure 27).

Figure 24. Use of Telehealth and Telephone Service Delivery (Pct) by Service Area, July to December 2020
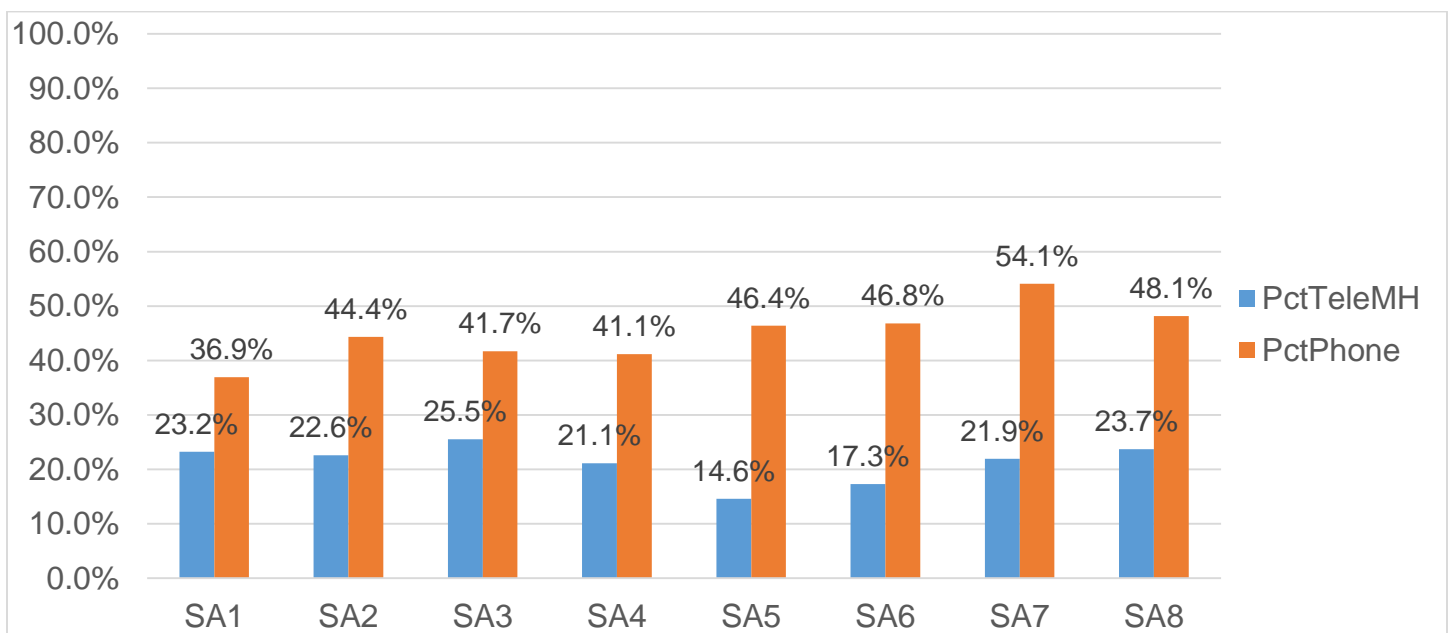
Note: GT modifiers were used to identify TeleMH in services/claims data. Data Source: Approved claims data/IBHIS, prepared by CIOB on 1/13/21.

Figure 25. Percent of Outpatient Services Delivered via Telemental Health (Video), Calendar Year 2020
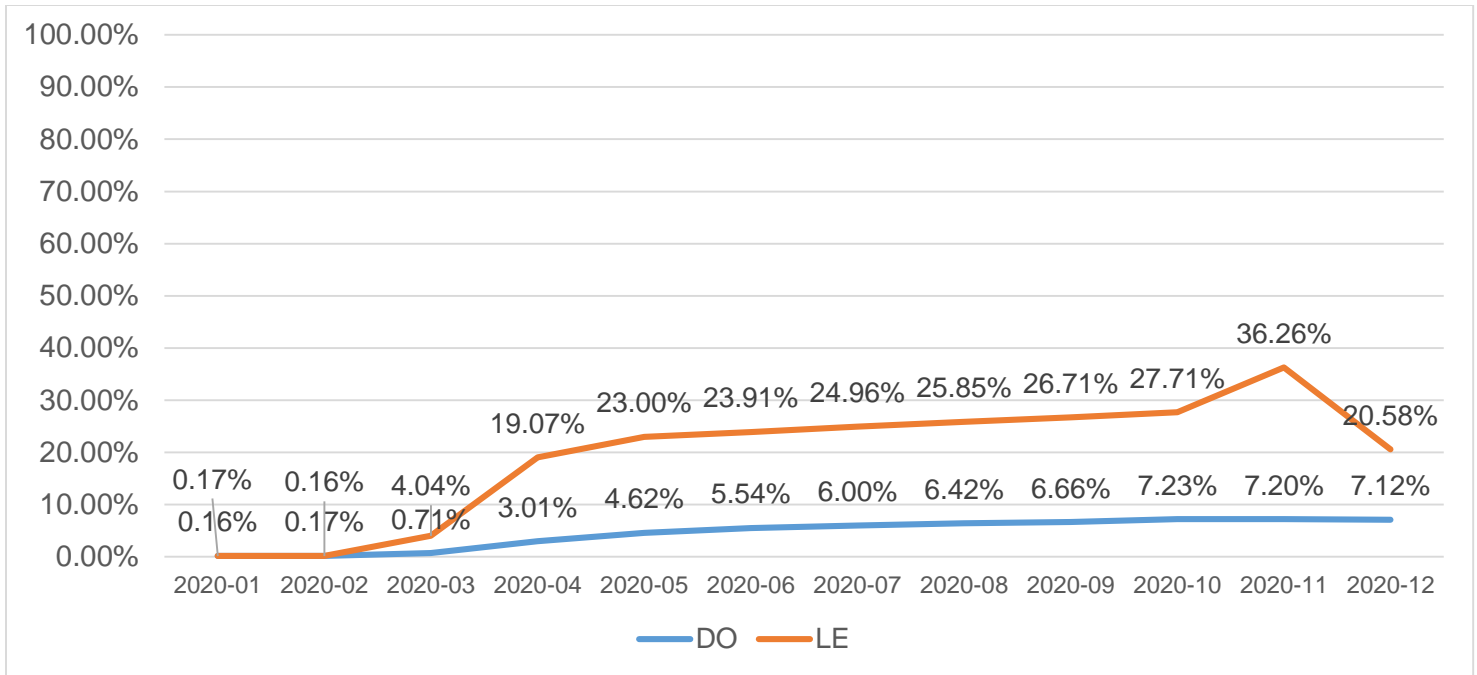
Note: GT modifiers were used to identify TeleMH in services/claims data. Data Source: Approved claims data/IBHIS, prepared by CIOB on 1/13/21.

Figure 26. Percent of Outpatient Services Delivered via Telephone, Calendar Year 2020
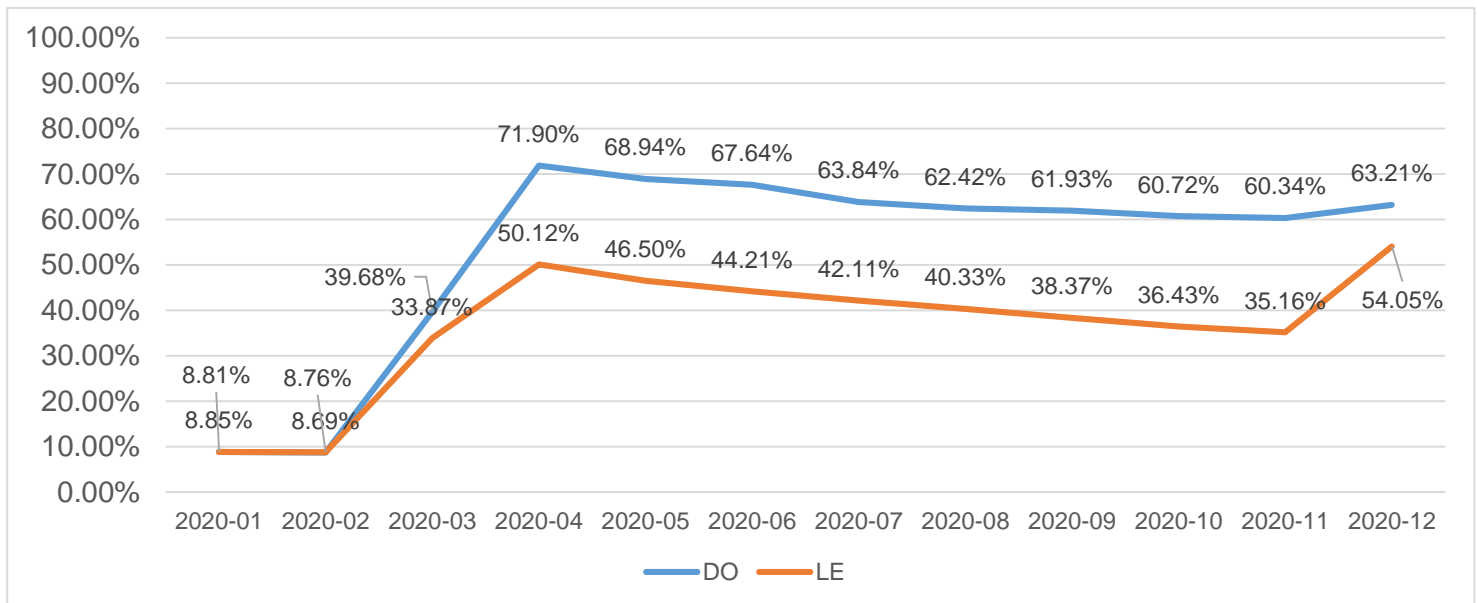
Note: GT modifiers were used to identify TeleMH in services/claims data. Data Source: Approved claims data/IBHIS, prepared by CIOB on 1/13/21.

Figure 27. Overview of Remote Service Delivery for DMH Outpatient Services, Calendar Year 2020
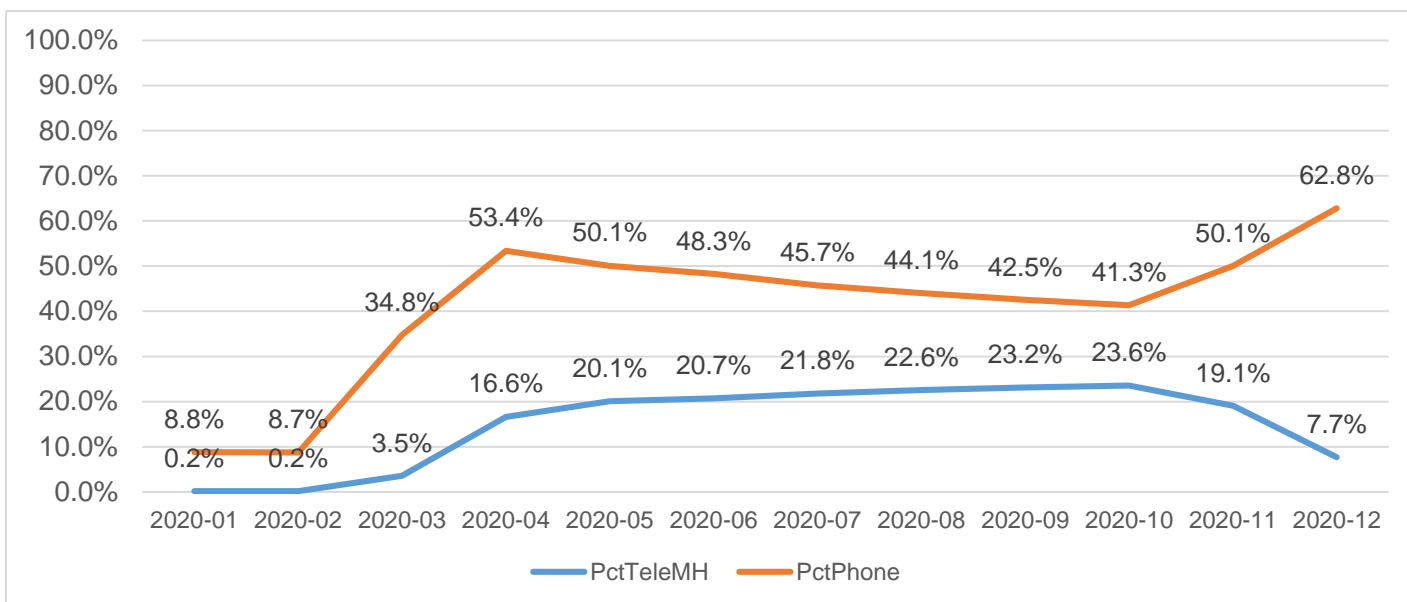
Note: GT modifiers were used to identify TeleMH in services/claims data. Data Source: Approved claims data/IBHIS, prepared by CIOB on 1/13/21.

DMH Legal Entity (LE) "Impact of COVID-19 Survey" Findings, May and December 2020

DMH conducted two surveys requesting information from the network of providers on service provision during the COVID-19 pandemic. Approximately 110 LE/Contracted providers participated in the initial survey in May 2020, and 115 participated in the December 2020 survey.

The treatment modalities provided by the LE/Contracted providers through telehealth primarily included individual and group therapy, medication support services, and case management. The use of telehealth grew amongst LEs as the pandemic progressed. Telehealth utilization began to expand to screening and assessment services, as well as crisis intervention. Providers equipped with PPE could continue in-person services for high-intensity clients within Full Service Partnership programs while complying with Public Health guidelines.

Due to the pandemic, challenges with service provision included a decrease in referrals specifically in school-linked and school-based programs, a drop-in client attendance (due to technical issues), hiring difficulty, and decreased staff attendance (due to the childcare and medical leaves). LE/Contracted providers reported having to lay off or furlough staff at some point during the pandemic. Many providers reported having staff who were exposed to COVID-19 as a result of in-person service delivery.

The majority of LE/Contracted providers are expected to return to 100% in-person services by the summer of 2021.

Quality Improvement Work Plan Evaluations, Calendar Year 2020

Quality Improvement Work Plan (QIWP) goals are set in place to monitor and evaluate the quality of the service delivery system. Under 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; and
VII.   Monitoring Performance Improvement Projects.

The QIWP Evaluation report that follows provides an assessment of the ten goals and 18 objectives identified in the QIWP for CY 2020. These goals were established, monitored, and evaluated by the QI Unit. The CY 2020 QIWP goals focused on increasing services for individuals from underserved groups, including pregnant women and recent mothers, expanding telemental health care, using consumer feedback to drive outpatient service priorities, developing new and ongoing PIPs, and improving tracking mechanisms for important topics like access to care, beneficiary grievances, and medication monitoring (Table 17). The QI Unit partnered with the Department's ACCESS Center, Emergency Outreach and Triage Division, DO and LE/Contracted outpatient programs, Office of Clinical Operations, Patients' Rights Office, QI Council, SA QICs, and the multidisciplinary PIP teams to accomplish meaningful change. The evaluation of the QIWP provides a basis for the establishment of goals and objectives for CY 2021.

Table 17. Quality Improvement Work Plan Goals and Year to Date Status, Calendar Year 2020

Domain	No.	Goal	Status Year-to-Date (per Objective)
SERVICE DELIVERY CAPACITY	I.1.	DMH will increase the number of beneficiaries served from the Hispanic/Latino and API communities by 1%.	**Partially Met**
	I.2.	DMH's Telemental Health (TMH) program will deliver real-time psychiatric care and consultations via secure audio and visual communications.	**Met** **Met** **Met**
ACCESSIBILITY OF SERVICES	II.1.	DMH will monitor timely access to care and services.	**Met**
BENEFICIARY SATISFACTION	III.1.	DMH will assess beneficiary satisfaction via Consumer Perception Surveys (CPS) twice a year.	**Met** **Met**
	III.2.	DMH PRO will track beneficiary grievances, appeals, requests for change of providers and fair hearings.	**Met** **Met** **Not Met**
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.	**Not Met** **Not Met**
CONTINUITY OF CARE	V.1.	DMH will develop medication monitoring protocols for DO and LE/Contracted providers.	**Met** **Partially Met**
PROVIDER APPEALS	VI.1.	DMH will conduct a concurrent review of treatment authorizations for all psychiatric inpatient hospital services and psychiatric health facility services.	**Not Met**
PERFORMANCE IMPROVEMENT PROJECTS	VII.1.	DMH will continue to develop and implement meaningful clinical PIP interventions targeting COD and trauma issues.	**Met** **Met**
	VII.2.	DMH will develop and implement a meaningful non-clinical PIP to improve timely access to SMHS for the entire outpatient system of care.	**Met**

Note: Goals and objectives above cover the Fiscal Year 2019-20 and Calendar Year 2020 reporting periods.

Goal I.1.:	**DMH will increase the number of beneficiaries served from the Hispanic/Latino and AAPI communities by 1%.**
Objective:	Establish no fewer than one Community and Services Supports (CSS)-based capacity project to increase service delivery capacity for these communities. ***Partially Met.***
Population:	Medi-Cal eligible youth, adults, and older adults from the Hispanic/Latino and API communities.
Performance Indicators:	• Number of beneficiaries served from Latino/Hispanic communities • Number of beneficiaries served from API communities
Frequency of Collection:	Annual

DMH services are accessible as, year to year, the total number of clients/families served from API and Latino/Hispanic groups and penetration rates increase slightly. In FY 2019-20, DMH served approximately 240,284 consumers in outpatient programs. Approximately 39% of our clients served population identified as Latino, and 4% identified as Asian/Pacific Islander. Of note, Latinos make up approximately 48% of Los Angeles County's total population (Table 1), and around 61% live at or below the 138% FPL (estimated, Table 4). In CY 2020, 59% of said residents were enrolled in Medi-Cal (Figure 11). Asian and Pacific Islanders make up about 15% of the county's total population (Table 1). Eleven percent live at or below 138% FPL (estimated, Table 4), and in CY 2020, less than 10% of the county's Asian population were enrolled in Medi-Cal (Figure 11). Three-year trends demonstrate penetration rate improvements across all ethnicities. However, with rate changes at less than one percent for the AAPI and Latino groups, the number of beneficiaries receiving service is not compatible with the population growth being seen for these populations.

DMH did not meet its goal to increase penetration rates by one percent for the API and Latino communities. The API penetration rate increased by 0.1 PP between FY 2018-19 and FY 2019-20, and Latino rates increased by 0.5 PP (Figure 28). In CY 2020, the Department initiated two CSS-based capacity projects to reduce population need and service utilization gaps. Since the goal was not met, even with accomplishing the objective, the status of this effort was deemed partially met.

Figure 28. Three-Year Penetration Rates Changes for Asian American and Pacific Islander and Latino/Hispanic Populations

28a: API
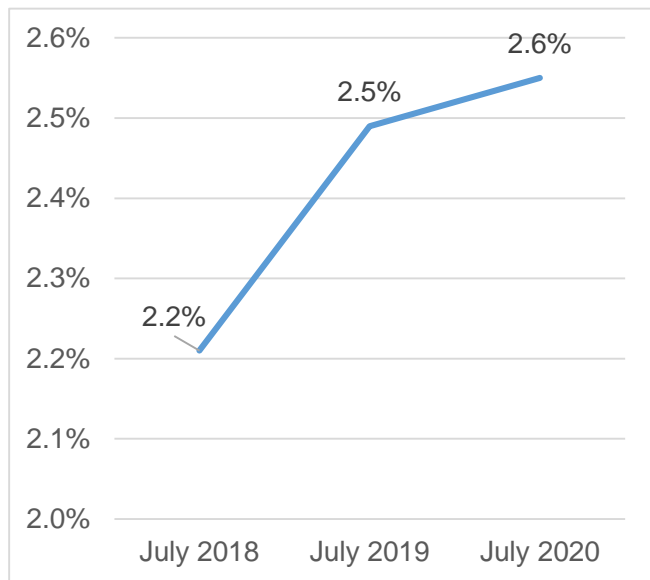
28b: Latino/Hispanic
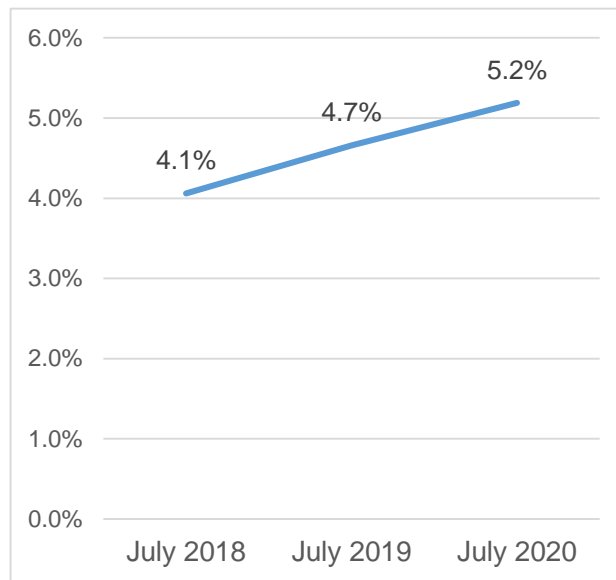
Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2017 to CY 2019, prepared by BHC/CalEQRO.

Community and Services Supports Based Capacity Projects, Calendar Year 2020

Capacity Project 1 for Asian American and Pacific Islander Communities: DMH developed a Mental Health Informational Booklet for API family members and friends. The booklet was designed to aid API clients, families, and community members in:

- understanding the scope of mental illness through a cultural lens;
- clarifying and addressing common fears and questions; and
- offering suggestions on how to care for and assist their loved ones.

This objective was partially met. Due to COVID19, the Department scheduled a "soft" distribution deadline of January 31, 2021.

Capacity Project 2 for Latino/Hispanic Communities: DMH hired a consultant to implement and develop the Latino Youth Mental Health Comic Book Contest in Los Angeles County. This portion of the objective was met. The project recruited Latino Transition Age Youth, ages 16-25 countywide, and 100% indicated that they learned something new about mental health.

Goal I.2.:	**DMH's Telemental Health (TMH) program will deliver real-time psychiatric care and consultations via secure audio and visual communications.**
Objectives:	A. Increase the number of consumers receiving TMH services by 10%. ***Met*** B. Conduct a TMH psychiatry needs assessment to determine the DO clinics with the greatest need. ***Met*** C. Track medication appointment wait times for clinics with psychiatry registry items/hours and establish a baseline. ***Met***
Population:	DMH clients receiving outpatient psychiatry services in DO clinics.
Performance Indicators:	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

Objective A: Due to the COVID-19 pandemic, the target number was significantly exceeded. In CY 2019, 1,175 unique consumers received telehealth services across DO clinics and, in CY 2020, this increased to 13,124, which is a 1,017% increase. The number of telemental health services provided across DO clinics also increased from 2,608 in CY 2019 to 79,156 in CY 2020. The top 5 DO clinics utilizing telemental health services in CY 2020 were Harbor UCLA Medical Center (Number of services = 11,886), Augustus Hawkins Mental Health Services (N = 6,208), Long Beach Child and Adolescent Clinic (N = 5,225), TIES for Families (N = 4,514), and West Valley Mental Health Center (N = 4,372). Across LE programs, in CY 2020, a total of 1,953,443 services were provided through telemental health to 70,682 consumers. Fee-for-service programs provided 14,076 services to 1,825 consumers.

Further analysis of telehealth modifier codes indicated that LEs have been using more videoconferencing, whereas DO clinics primarily deliver telephone services in CY 2020. On average, LEs delivered 19.4% of services through videoconferencing, and DOs delivered 5% of services through videoconferencing. On the other hand, DO clinics delivered an average of 52% of services through telephone compared to LEs, which delivered 36.6% of services through telephone in CY 2020. Early use of videoconferencing in DO clinics was impacted by several technical issues with the telehealth vendor, VSee. DMH initiated multiple significant efforts to increase the use of videoconferencing through VSee in DO clinics in the latter half of CY 2020, including training in the use of Vsee, expanded licensing to multiple disciplines, creation of a provider handbook and other tools, implementation of super users, and collaboration with the vendor to address specific barriers. Between June 1 and August 31, 2020, 1,374 DO direct care staff members demonstrated VSee logins and 32.2% provided at least

one service through VSee. By December 31, 2020, the number of DO direct care staff members with VSee accounts had increased to 1,707 and 41.0% provided at least one service, representing a 27.3% increase. The efforts to increase the use of VSee will continue in CY 2021. Within the Telemental Health (TMH) program specifically, the most common services provided were medication support by phone (N = 2,856) and medication support by telemedicine (N = 897). Consumers who received services through the TMH program were predominately female (55.4%) and in the adult age range. The majority of consumers served were Latino (35.7%) followed by Black/African American (27.2%), White (20.8%), Two or more races (8.0%), Asian (1.4%), Unknown (5.4%), and Other (1.5%). Most consumers reported English (85.3%) or Spanish (10.8%) as a primary language with 2.0% unknown and 1.9% Other.

Objectives B and C: The TMH program administered a survey to DO clinics in June 2020 to assess TMH psychiatry needs and 17 clinics across all SAs submitted a response. Program managers at these clinics indicated that an average of 56.5 patient hours (range: 0-240) was needed per week and that the estimated camera availability time was 55.8 hours on average (range: 0-220 hours). The average wait time for an initial medication evaluation appointment was 30 days (range: 0-180) and for a follow-up appointment with an established client was 38.5 days (range: 4-90). Leaders reported an average of 1.1 vacant psychiatry FTEs (range: 0-4). Ratio of full-time employee (FTE) psychiatrists to the number of open clients could not be determined as the survey assessed vacancies rather than full-time staff. Another needs assessment was administered in Fall 2020 and 32 DO clinics submitted a response. At this time, program managers indicated an average maximum number of patient services hours per week of 154.7 (range: 10-418.5). The average wait time for an initial medication evaluation appointment was 27.6 days (range: 0-169) and for a follow-up appointment with an established client was 34.1 days (range: 0-180).

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 ten business days of the initial request. ***Met***
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 ten business day target.
Frequency of Collection	Monthly

The Department's QA Unit and CIOB worked collaboratively on improving system-wide access to care by implementing a timely access monitoring process. Data collected from DO and LE providers was funneled into a Power BI dashboard for improved accessibility and timeliness of reviewing. Upon annual evaluation, timeliness rates were deemed best observed as a percent of offered appointments that met the ten business day target. In CY 2020, the percent of timely appointments was 58.3% for children (N=24,127) and 86.5% (N=41,744) for adults. The Department's access to care improvement efforts are ongoing, with a dedicated QIWP goal and related nonclinical PIP slated for CY 2021.

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

Note: Per the DHCS MHSUDS Information Notice No. 19-006 the spring 2020 submission of data for the CPS Data Collection requirement was postponed until June 2020.

Objective A: As the largest and most linguistically diverse county mental health plan in the nation, the number of completed surveys during CPS is typically in the ten to fifteen-thousand range. With these numbers, the disadvantages associated with paper-based survey administration outweighed the advantages.

As a resource tool for DMH outpatient providers from directly operated and contracted programs, the QI Unit partnered with CIOB to develop a CPS User Portal to cut costs, labor, and human errors associated with managing paper-based surveys. The portal also allows providers to reach clients receiving telemental health or field-based services. In the outpatient programs, CPS Portal Users can use the application to email or text CPS forms to clients and their families in their preferred languages (English, Arabic, Spanish, Persian, Filipino, Korean, Russian, Vietnamese, Chinese simplified and traditional, and Khmer). The electronic version of CPS that providers send uses logic branches/skip logic according to the clients and their families' responses. In addition, the survey type (Youth, Families, Adult, Older Adult) will automatically match the clients' age. CPS Portal Users in Administrative roles, such as the DMH QI Unit, will use the Microsoft Dynamic version of the application to manage provider participation and track trends in survey return rates by survey type, language, and Service Area. The CPS User portal will be available for the June 2021 data collection period.

Objective B: The QI Unit formalized the CPS report redesign process in early 2020. The aims of the redesign included:

- Determining meaningful data elements that are meaningful for various audiences, stakeholders, and the community at large;
- Reducing redundant or unnecessary information from the data reports; and
- Ensure data and findings are readily accessible to the public in a timely matter.

In the data collection phase of the redesign, the QI Unit administered a survey to SA QIC Chairpersons, stakeholders, and clients, asking them to rate the importance of reporting on the following sections:

- Open-ended comments;
- Services and written materials in preferred language;
- Demographics;
- Percent agree/strongly agree by survey domain;
- Individual item ratings
- Number of completed and declined surveys
- Length of program enrollment
- Assistance needed to complete
- Legal and arrest history; and
- Optional county questions.

Stakeholders and QIC Chairpersons agreed that information on whether clients/families perceived their services and written materials were available in their preferred languages, satisfaction levels with each domain, and open-ended comments were important to include in the annual findings report. Stakeholders showed more interest in the length of enrollment, whereas QIC Chairs found demographics of higher importance. Survey respondents were the least interested in legal and arrest history or results from the optional county questions. Stakeholders ranked all domains equally important with Quality and Appropriateness, Treatment Planning, and General Satisfaction ranked the highest (rated mostly interested/very interested at 92.6%) and Social connectedness the lowest (87.0%).

This objective was met with accomplishments such as one-page CPS summary handouts for client/family use and translated in county threshold languages, countywide and Service Area-specific data presentations with QI Unit-led discussions, and a revised summary report format in CY 2020.

Beneficiary Problem Resolution

Per 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), DMH QI facilitates the annual evaluation of beneficiary grievances, appeals, and State Fair Hearings. As an MHP, DMH shall ensure that a procedure is in place whereby issues identified as a result of the 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).

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Goal III.2.:	**DMH PRO will track beneficiary grievances, appeals, requests for change of providers and fair hearings.**
Objectives:	A. DMH will maintain a grievance and appeal log and record grievances, appeals, and expedited appeals. *Met* B. DMH will continue to track COP requests and reasons. *Met* C. DMH will evaluate for trends. *Not Met*
Population:	Medi-Cal beneficiaries receiving DMH services.
Performance Indicators:	Stratify PRO data by: • Number of grievances; • Number of appeals; • Number of expedited appeals • Number of COP requests; and • Reasons for COP requests.
Frequency of Collection:	Annual

Objectives A and C: Sixty-three grievances were received in FY 2019-20. Of the beneficiary grievances received, 73% were related to Quality of Care, and the remaining 27% were categorized as Other (Table 18). In FY 2019-20, there were no inpatient and outpatient grievances related to Access or Change of Provider. Out of all the grievances, 65.1% pertained to Quality of Care (N=41), 27.0% were categorized as Other (N=17), and the remaining 7.9% were Confidentiality Concerns (N=5; Table 19). Zero grievances were referred, and all were resolved. No grievances were pending as of June 30, 2020. Three-year trends show grievances commonly fell in the Quality of Care category and were not present in the Access and Change of Provider categories (Figures 30). In addition, annual grievances from DMH's beneficiary population are trending downwards (Figure 31).

There were 7,560 NOABDs or NOAs issued in FY 2019-20 (Table 20). Of the NOABDs or NOAs determined, 56% were Timely Access Notices (N=4,224), followed by Delivery System Notices (N=1,932) at 26%, and Payment Denial Notices (N=1,404) at 19%. No beneficiary appeals were resulting from a NOABD or NOA in FY 2019-20.

Table 18. Inpatient and Outpatient Grievances and Appeals for DMH Medi-Cal Beneficiaries by Category, Fiscal Year 2019-20

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	**18**	**0**		
Treatment Issues or Concerns	**19**	**0**		
Medication Concern	**2**	**0**		
Cultural Appropriateness	**0**	**0**		
Other Quality of Care Issues	**2**	**0**		
QUALITY OF CARE – Total by Category	**41**	**0**	**N/A**	**N/A**
Percent	**65.1%**	**0%**		
CHANGE OF PROVIDER – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**		
CONFIDENTIALITY CONCERN – Total by Category	**5**	**0**	**N/A**	**N/A**
Percent	**7.9%**	**0%**	**N/A**	**N/A**
OTHER				
Financial	2	0		
Lost Property	0	0		
Operational	0	0		
Patients' Rights	4	0		
Peer Behaviors	2	0		
Physical Environment	0	0		
Other Grievance not Listed Above	9	0		
Other – Total by Category	**17**	**0**	**N/A**	**N/A**
Percent	**27%**	**0%**	**N/A**	**N/A**
Grand Totals	**63**	**0**	**N/A**	**N/A**

Note: Data above reflects the grievances and appeals for/by Medi-Cal beneficiaries. Data Source: DMH, ABGAR Form FY 2019-20, prepared by PRO in October 2020.

Table 19. Inpatient and Outpatient Grievance Dispositions for DMH Medi-Cal Beneficiaries, Fiscal Year 2019-20

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	18	0
Treatment Issues or Concerns	0	19	0
Medication Concern	0	2	0
Cultural Appropriateness	0	0	0
Other Quality of Care Issues	0	2	0
QUALITY OF CARE – Total by Category	**0**	**41**	**0**
Percent	**0%**	**65.1%**	**0%**
CHANGE OF PROVIDER – Total by Category	**0**	**0**	**0**
Percent	**0%**	**0%**	**0%**
CONFIDENTIALITY CONCERN – Total by Category	**0**	**5**	**0**
Percent	**0%**	**7.9%**	**0%**
OTHER			
Financial	0	2	0
Lost Property	0	0	0
Operational	0	0	0
Patients' Rights	0	4	0
Peer Behaviors	0	2	0
Physical Environment	0	0	0
Other Grievance not Listed Above	0	9	0
OTHER – Total by Category	**0**	**17**	**0**
Percent	**0%**	**27%**	**0%**
Grand Totals	**0**	**63**	**0**

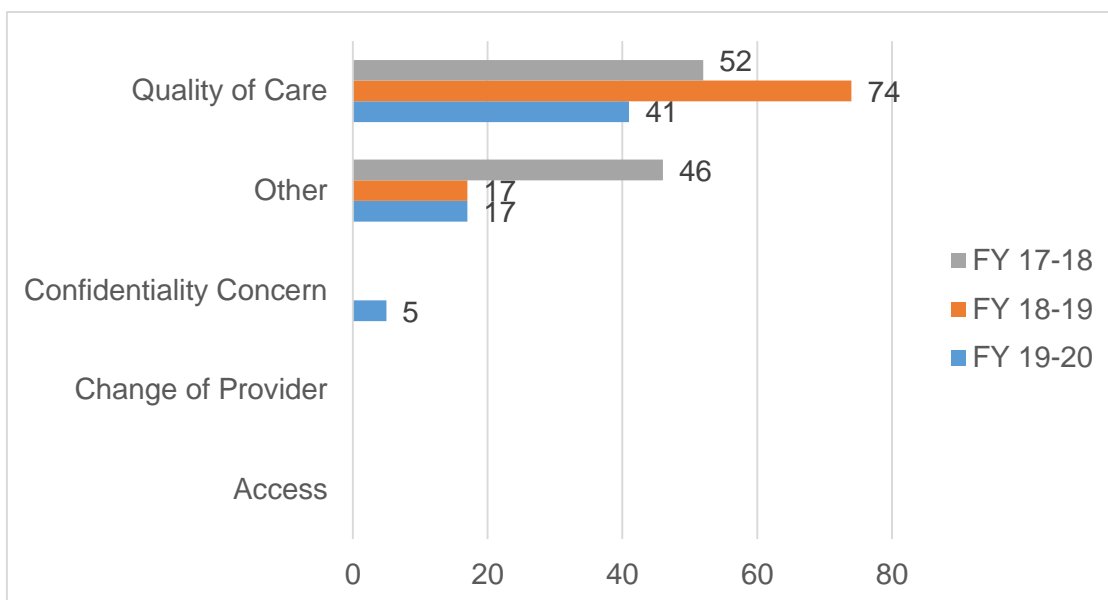Data Source: DMH ABGAR Form FY 2019-20, prepared by PRO in October 2020.

Table 20. Inpatient and Outpatient Appeal Dispositions and Total Notice of Adverse Benefit Determination/Notice of Action Issued, Fiscal Year 2019-20

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	0
Payment Denial Notice	0	601	309	0	0	0	1,404
Delivery System Notice	0	0	0	0	0	0	1,932
Modification Notice	0	0	0	0	0	0	0
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	4,224
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**	**601**	**309**	**0**	**0**	**0**	**7,560**

Data Source: DMH, ABGAR Form FY 2019-20, prepared by PRO in October 2020.

Figure 30. Three Year Trends in Inpatient and Outpatient Grievances by Category

Data Source: DMH, ABGAR Form FYs 2017-18 to 2019-20.

Figure 31. Total Inpatient and Outpatient Grievances per Fiscal Year (Three-Year)

Figure 32 displays the three-year trends for the inpatient and outpatient total appeals and total NOABDs/NOAs issued. FY 2018-19 had the highest number of appeals at 1,261 and the highest number of NOAs at 10,775. Conversely, FY 2017-18 had the lowest number of appeals at 0 and FY 2019-20 had the lowest NOAs at 7,560.

Figure 32. Trends in Inpatient and Outpatient Appeals and Notice of Adverse Benefit Determination/Notice of Action Issued (Three-Year)

State Fair Hearings

Notifications of Medi-Cal beneficiary complaints are received from the Department of Health Care Services (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 nine State Fair Hearings for FY 2019-20. Three were heard, one was closed for non-appearance, two had administrative dismissals for non-appearance, two were redirected to appropriate agencies, and one had no record. A common theme among the nine State Fair Hearings was a denial of services, benefits, or medications.

Recent Developments

The Department's PRO published an electronic Grievance and Appeals reporting system webpage. A portal is being created for consumers and providers to file grievances electronically. An electronic complaint form can be completed, which is identical to the hard copy form. Hard copies and phone reports will continue to be accepted by PRO. English forms have been rolled out, and other languages will be rolled out in 2021. PRO intends to begin capturing complaints that are resolved at the clinic level. A public-facing website is being built for Notice of Adverse Benefit Determination (NOABDs). LE/Contracted providers will be able to submit and print NOABDs. DOs will still receive them through IBHIS.

Objective B: COP requests were down during the COVID-19 pandemic (Table 21). There was a 30% decline in COP requests between FY 2018-19 (N=5,259) and FY 2019-20 (N=3,797). In FY 2019-20 and similarly to prior years, the most frequent reason for a COP request was "Not a Good Match (N=585)," and the least frequent reason for a COP request was "Treating a Family Member (N=27)".

The QI Unit will work collaboratively with PRO to monitor COP requests and the electronic COP submission rollout for LE/Contracted providers. The DO COP log submissions now occur electronically.

Table 21. Request for Change of Provider by Reason and Percent Approved (Three-Year)

Reason(s)[1]	FY 17-18		FY 18-19		FY 19-20	
	Number of Requests	Percent Approved	Number of Requests	Percent Approved	Number of Requests	Percent Approved
A – Time/Schedule	235	87.2%	235	87.2%	136	91.9%
B – Language	144	88.9%	144	88.9%	129	93.8%
C – Age	85	89.4%	85	89.4%	61	90.2%
D – Gender	246	94.3%	246	94.3%	156	90.4%
E – Treating Family Member	32	93.8%	32	93.8%	27	92.6%
F – Treatment Concerns	430	89.8%	430	89.8%	267	88.0%
G – Medication Concerns	276	87.0%	276	87.0%	62	87.1%
H – Lack of Assistance	427	85.9%	427	85.9%	290	88.6%
I – Want Previous Provider	89	83.1%	89	83.1%	72	86.1%
J – Want 2nd Option	155	89.0%	155	89.0%	101	92.1%
K – Uncomfortable	613	89.6%	613	89.6%	438	90.1%
L – Insensitive/ Unsympathetic	398	89.7%	398	89.7%	292	91.1%
M – Not Professional	309	90.9%	309	90.9%	229	91.7%
N – Does Not Understand Me	509	88.8%	509	88.8%	354	91.0%
O – Not a Good Match	693	90.3%	693	90.3%	585	90.8%
P – Other	509	87.2%	509	87.2%	502	91.8%
R – No Reason Given	109	91.7%	109	91.7%	95	84.2%
Total	5,259	89.1%	5,259	89.1%	3,797	90.1%

Note: A consumer may give multiple reasons. Data source: DMH PRO, October 2020.

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 postpartum (CA AB 2193).	
Objectives:	A. Explore strategies to track clients that meet the criteria for maternal mental health services. ***Not Met*** B. Establish eight Maternal Mental Health specialty clinics in SAs across Los Angeles County. ***Not Met*** • 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:	Number of women identified to be pregnant or recently having had a baby.	
Frequency of Collection:	Annual	

Objective A: DMH does not have a mechanism to consistently monitor for perinatal women or those who are treating them. The Department will continue its efforts to establish a process in IBHIS to capture how many pregnant women are in the system. Currently, the only information reported in IBHIS is gathered from a Medi-Cal form completed once a woman is pregnant, as her coverage often changes.

Objective B: Now that DMH is doing much more with telehealth, we are re-thinking the place-based model and the possibility of shifting this to a more virtual network of providers. Given that, an adjustment to this objective could be "increasing capacity of DMH providers to conduct perinatal-specific treatment, through specialized psychotherapy and medication management." This would capitalize on the series of six virtual reproductive psychiatry lectures conducted - with well over 100 prescribers attending each one - and the planned Maternal Mental Health (MMH) Now-led training for clinicians interested in MMH care.

Maternal Mental Health support and training are ongoing; however, in 2021, DMH will focus its clinical care monitoring efforts on CANS (or NET) data reporting, communication, and use in supervision.

Goal V.1.:	**DMH will develop medication monitoring protocols for DO and LE/Contracted providers.**
Objectives:	A. Identify performance indicators and metrics to include in a dashboard. ***Met*** B. Establish peer review protocols for DO and LE/Contracted providers. ***Partially Met***
Population:	DMH clients receiving outpatient medication support services from DO and LE/Contracted providers.
Performance Indicators:	Number of peer reviews completed.
Frequency of Collection:	Annual

Objective A: In FY 2019-20, the Department's Office of the Chief Medical Director - Pharmacy and Laboratory Services and CIO collaborated to develop medication monitoring protocols for DO and LE/Contracted providers. DMH Pharmacy and Laboratory Services created several reports for supervising psychiatrists at DO clinics to review during their monthly meetings. The following HEDIS measures and additional quality indicators are regularly reviewed by the Department's Pharmacy Medication Monitoring and Drug Utilization Review Committee:
- Use of multiple concurrent antipsychotics in children and adolescents;
- Metabolic monitoring for children and adolescents prescribed antipsychotics;
- Documentation of current medications in the medical record;
- Diabetes screening for consumers diagnosed with Schizophrenia or Bipolar Disorder who are prescribed antipsychotics;
- Diabetes monitoring for consumers diagnosed with Schizophrenia and diabetes;
- Cardiovascular monitoring for consumers diagnosed with Schizophrenia and cardiovascular disease;
- Patients with a documented primary care provider (PCP); and
- Medications with a narrow therapeutic index.

Objective B: DMH established a peer review process in August 2020. The peer reviews were designed to monitor the quality of care, promote practices within contemporary standards and guidelines, and consolidate and institutionalize Departmental protocols. The Office of the Chief Medical Director matched peers in September 2020. During this process, the matched peers completed and submitted a Peer Review Referral Form online after reviewing 1) one or more client records with a new evaluation and 2) two follow-up notes in the last six months or one chart with a new evaluation completed by a new psychiatrist and psychiatric nurse practitioners. The system was initiated with DOs as a model and is pending LE/Contracted provider implementation.

Goals for CQI include: implementation of administrative support, improving the peer response rate, obtain continuing medical education (CME) approval, obtain Performance-In-Practice (PIP) approval from the American Board of Psychiatry and Neurology (ABPN), expanding the review to five charts, and extending the review to LEs. Future goals for improvement include increasing access to lab and

phlebotomy services, beginning a quality assurance project, and involving clinical pharmacists in specific monitoring.

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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. Network providers or billing agents submit appeals to settle disputed processing or payment of claims.

Goal VI.1.:	**DMH will conduct a 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. ***Not Met***
Population:	DMH clients receiving inpatient psychiatric services.
Performance Indicators:	Stratify DMH treatment authorization data by: • Denials for acute and administrative days; • Concurrent versus retrospective; and • Reasons for denials.
Frequency of Collection:	Monthly

Implementation of concurrent review has been slower than expected as DMH is awaiting an MHSUDS Information Notice (IN) that outlines the concurrent review process from the Department of Health Care Services (DHCS). As a result, the full implementation of concurrent review will take at least six months and probably closer to one year. As of December 2020, 14 out of approximately 30 acute inpatient hospitals are on-boarded to do concurrent authorization and five additional hospitals are in various stages of preparation. The COVID-19 pandemic has also been a significant challenge to implementing concurrent review as many staff members have been out of the office or working remotely, particularly starting in November 2020. The pilot of concurrent review in Service Area 3 also experienced some difficulties with the tracking log being addressed in the 2021 calendar year.

To prepare for the implementation of concurrent review, the Intensive Care Division – Compliance Unit collected baseline data on NOABD denials. The unit monitors TARS monthly and reports findings to the QI program at least annually. The unit's annual data reports include TARs, the number of unique consumers for whom TARS are requested, days requested, denied, approved, including approval rates, the appeals received monthly, and, more recently, reasons for denials.

Table 22 presents the three-year trend in the number of TARs received and percent approved. The number of TARs received between CY 2017 (N=33,714) and CY 2020 (N=28,645) decreased by 15.5% and the percent approved improved from 58.3% in CY 2019 (34,633) to 81.4% in CY 2020. The TARs in CY 2019 were impacted by how the DMH electronic health record recorded concurrent reviews. This was addressed in early 2020 and approvals in 2020 have returned to close to previous rates.

Table 22. Three-Year Trend in TARs Received and Percent Approved

	CY 2018	CY 2019	CY 2020
TARs Received	33,714	34,633	28,465
% Approved	92.0%	58.3%	81.4%

Data Source: TARs and Appeals COGNOS reports, CY 2018- CY 2020

Figure 33 displays the percentage of TARs denied out of those requested each month for CY 2020. There was a 63% decline in percent approved from January and February 2020 (69%) to March (6%) due to the issue with the electronic health record. Denial rates were lower in March and April 2020 due to the COVID-19 pandemic and increased to typical levels for the remainder of the calendar year. The percent ranged from 11% to 10% from May to December 2020.

Figure 33. Percent of Treatment Authorization Requests Denied by Month for Calendar Year 2020
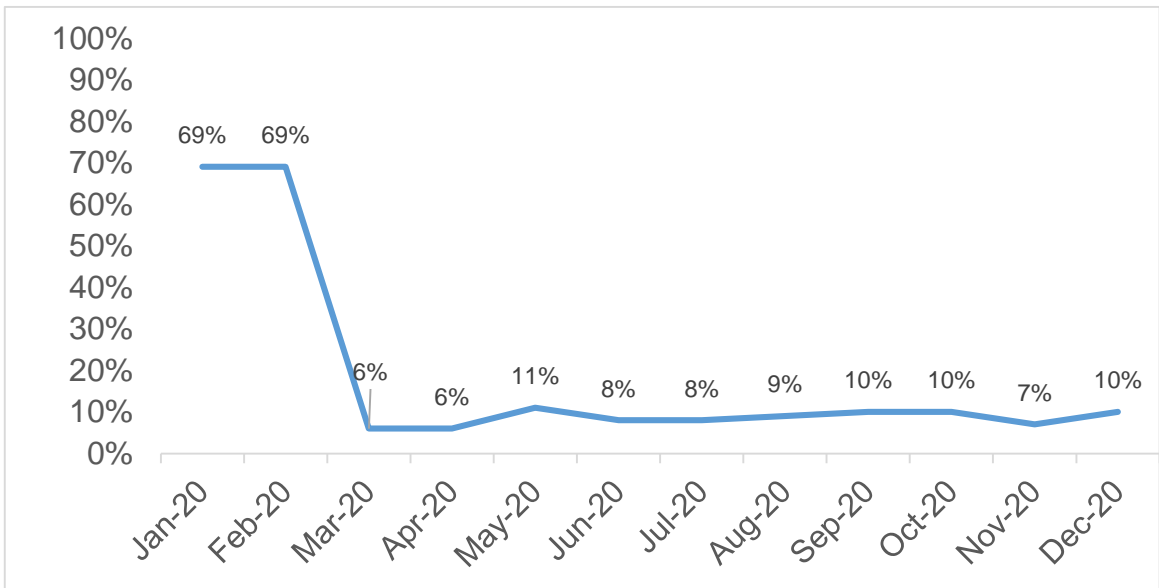
Note: The sudden change in data between January/February 2020 and March 2020 reflects calculation errors caused by a change in the use of the electronic health record, based on the introduction of a concurrent authorization pilot. Data Source: TARs and Appeals COGNOS report, CY 2020.

Treatment authorization data could not yet be stratified by denials for acute and administrative days and concurrent versus retrospective days as these were not yet tracked. Analysis of the reasons for TARs denials indicated several general themes. Reasons for denial tended to vary somewhat by the hospital. The most common theme was that the consumer did not meet medical necessity or demonstrate acuity commensurate with a continued inpatient hospital stay (e.g., no ongoing risk to self or others, consumer returned to baseline, consumer awaiting placement to a lower level of care). For some cases, the reason pointed to a lack of documentation on the consumer's status that made it difficult to determine ongoing needs. Other reasons for denial of acute days were discrepancies between the days requested and the days the consumer could be documented as present on the inpatient unit (e.g., the consumer was in the emergency room overnight and admitted the following day,

the consumer was released within a day, no documentation to showed the consumer was present on the unit that day), the consumer is out of the county, a lack of Medi-Cal eligibility, and DMH did not credential the hospital or doctor. For denied administrative days, which were much more frequent, the most common reason for denial was not properly following the protocol for making placement calls. It is recommended that data be captured according to these higher-level codes using drop-down menus in the future to ease the collection and tracking of NOABD denials regularly.

The Intensive Care Division – Compliance Unit engages in several quality improvement efforts to address the NOABD data trends. They conduct numerous Technical Assistance training with hospital staff to ensure understanding of the procedures that must be followed to approve acute and, particularly, administrative days, improve documentation so that the need for continuing days is supported in the notes, and increase communication around discharge planning. The unit also has a weekly standing call with the hospitals participating in concurrent review to track the data and address any issues as they arise. The unit has been improving communication with hospitals by sending the Treatment Authorization Status form within 24 hours.

Goal VII.1.:	**DMH will continue to develop and implement meaningful clinical PIP interventions targeting COD and trauma issues.**
Objectives:	A. Increase the number of consumers receiving Seeking Safety in a group or individual format. *Met* B. Establish protocols for Integr8Recovery groups in select DO clinics and actively recruit group participants. *Met*
Population:	DMH clients receiving outpatient COD services.
Performance Indicators:	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.
Frequency of Collection:	Quarterly

The Clinical Performance Improvement Project entitled "Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)" was in place from Quarter 3 of FY 18-19 to the end of Quarter 2 of FY 20-21. The improvement strategy was focused on delivering integrated treatment models to consumers with CODs to directly address and mitigate the impact of substance use on mental health. The intent was to address mental health symptoms and enhance COD consumers' ability to reduce substance use and improve functioning by coping and practicing safety in relationships, feelings, thoughts and actions. In Phase I (year one) of the project, interventions included implementing treatment strategies with Seeking Safety (SS), a specific evidence-based practice (EBP) for trauma and substance use, broader education of Substance Abuse Counselor (SAC) staff in substance use disorder (SUD) treatment through the University of California, Los Angeles (UCLA) extension classes, and initial implementation of Integr8Recovery groups. In Phase II (year two) of the project, interventions focused on improved teaming and the use of multidisciplinary groups.

Regarding the objectives, the number of consumers documented as receiving Seeking Safety from a Substance Abuse Counselor increased minimally from quarter to quarter as 19 consumers received Seeking Safety in Quarter 2 and 28 received Seeking Safety in Quarter 3. Integr8Recovery groups started in January 2020 in two clinics and the protocol for these groups was adapted over time to fit the workflow and recruitment process for each clinic. There were no significant changes to 7- and 30-day hospitalization rates for any of the interventions in terms of project findings. Some interventions (i.e., Integr8Recovery, documented use of SS) were associated with significant changes in consumer engagement and retention rates and the number of mental health services received. However, the sample sizes for these groups were generally small (~30 consumers). At the recommendation of the EQRO, this PIP was converted to a general system improvement process for SAC services to individuals with COD. A new Clinical PIP topic will be selected in CY 2021.

Goal VII.2.:	**DMH will develop and implement a meaningful non-clinical PIP to improve 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. *Met*
Population:	LA County residents seeking DMH outpatient SMHS.
Performance Indicators:	To be developed by the PIP.
Frequency of Collection:	To be developed by the PIP.

In FY 2019-20, the non-clinical PIP concept, *Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected*, was developed in collaboration with the QA and QI Units to improve the timeliness of outpatient SMHS at a system-wide level. QA discovered that despite meeting State requirements of 70% timeliness, a more in-depth look at the data suggested many providers struggled to provide beneficiaries with timely appointments. The PIP committee aimed to determine if implementing an Audit and Feedback (A&F) process (i.e., access to care monitoring reports, timeliness template, and conference call) would improve the rate at which beneficiaries received timely appointments. The concept focused on comparing timeliness percentages and facilitating provider-level improvement strategies.

An implementation team, also known as the Access to Care Leadership committee, was developed to establish clear processes for monitoring timely access and compliance, identifying and monitoring issues to be addressed, and ensuring all efforts are distributed equally across the network. This team of core managers from various sectors of DMH's outpatient system of care met on a bimonthly basis, with system-wide data review occurring at least monthly. The Leadership committee worked collaboratively to address the external (systemic) factors contributing to timely access challenges seen in the data or as identified by providers. The Deputy Director of QOTD is the Chairperson for the Access to Care Leadership committee. The committee collaborated on a plan before each meeting, and QA maintained the meeting minutes.

During the annual External Quality Review in September 2020, the quality reviewers determined the PIP as concept-only – requiring additional refinements before validation. Therefore, as a continuation, the FY 2020-21 PIP project is shifting focus on the effectiveness of provider-developed interventions to address timeliness barriers.

The FY 2020-21 PIP efforts will continue to target improvements in timely access. CalEQRO recommended an increased focus on beneficiary impact and developing a catalog of best practices addressing various timeliness access issues. The Access to Care Leadership committee will continue to support problem identification and implementation. The QI unit will play a role in data analysis, tool development, and tracking Plan-Do-Study-Act cycles. The QA unit will facilitate access to care monitoring processes intended to inform, assist in problem-solving, and support DO and LE/Contracted providers with making timely appointments available. By September 2021, DMH should be better able to speak to the effectiveness of agency-driven and provider-developed improvement strategies.

QUALITY IMPROVEMENT GOALS TO DRIVE CHANGE IN SUPPORT OF THE STRATEGIC PLAN

Date Last Revised: 4/29/21

The Quality Improvement (QI) Unit coordinates the Department's performance-monitoring activities countywide. The Department's continuous quality improvement (CQI) and data-driven activities include utilization review, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, assessment of beneficiary satisfaction, performance improvement projects (PIPs), and timely access to specialty mental health services (SMHS). The Quality Improvement Work Plan (QIWP) activities for the calendar year (CY) 2021 provide a blueprint of QI actions to ensure the overall quality of services. Through practical QI activities, data-driven decision-making, and collaboration amongst staff and clients/families, DMH meets State regulations for evaluating the appropriateness and quality of services.

The QWIP functions as the foundation of DMH's efforts to improve services delivered to potential and existing clients. The Department's Strategic Plan functions to prioritize and organize our work ahead. Thus, the Strategic Plan and QIWP activities are interconnected and similarly CQI-oriented. To succeed, the Strategic Plan and QIWP embody the following values and principles:

- **Client Driven** – where we engage consumers, families, communities, and grassroots stakeholders as full collaborators in transformation, from care delivery to systems redesign.
- **Community Focused** – where the needs and preferences of the communities are recognized and where resources are specially designed and aggressively deployed to meet them.
- **Equitable and Culturally Competent** – where consumers, family members, and communities are cared for equitably and where services are delivered with cultural respect.
- **Accessible and Hospitable** – where all services and opportunities are readily available, easy to find, timely, and welcoming to everyone.
- **Dedicated to Customer Service** – where our core calling is to provide premier services to all of our customers, from consumers and families to DMH staff and the vast network of contractors.
- **A Heart-Forward Culture** – where we hold sacred the humanity, dignity, and autonomy of those we serve because everyone has the right to flourish and to live a healthy, free, and fulfilling life.
- **Collaborative** – where we recognize that we cannot go it alone. We need the expertise, dedication, and teamwork of many other departments and the full range of community partners.
- **Continuous Improvement** – where care is focused on meeting the needs of those we serve through best practices, where decisions are tailored and informed by outcomes, and where ongoing efforts to increase our impact are built into our work at every level, every day.

Los Angeles County – Department of Mental Health's Strategic Plan

The Department's Strategic Plan (2020-2030) aligns with the broader vision of the 2016-2021 County of Los Angeles Strategic Plan. Our strategic approach is divided into four domains, namely: Community, Crisis System, and Institutions (clinical), and Infrastructure (administrative) (Figure 1).

Figure 34. DMH Strategic Plan 2020-2030, Domains for our Strategy
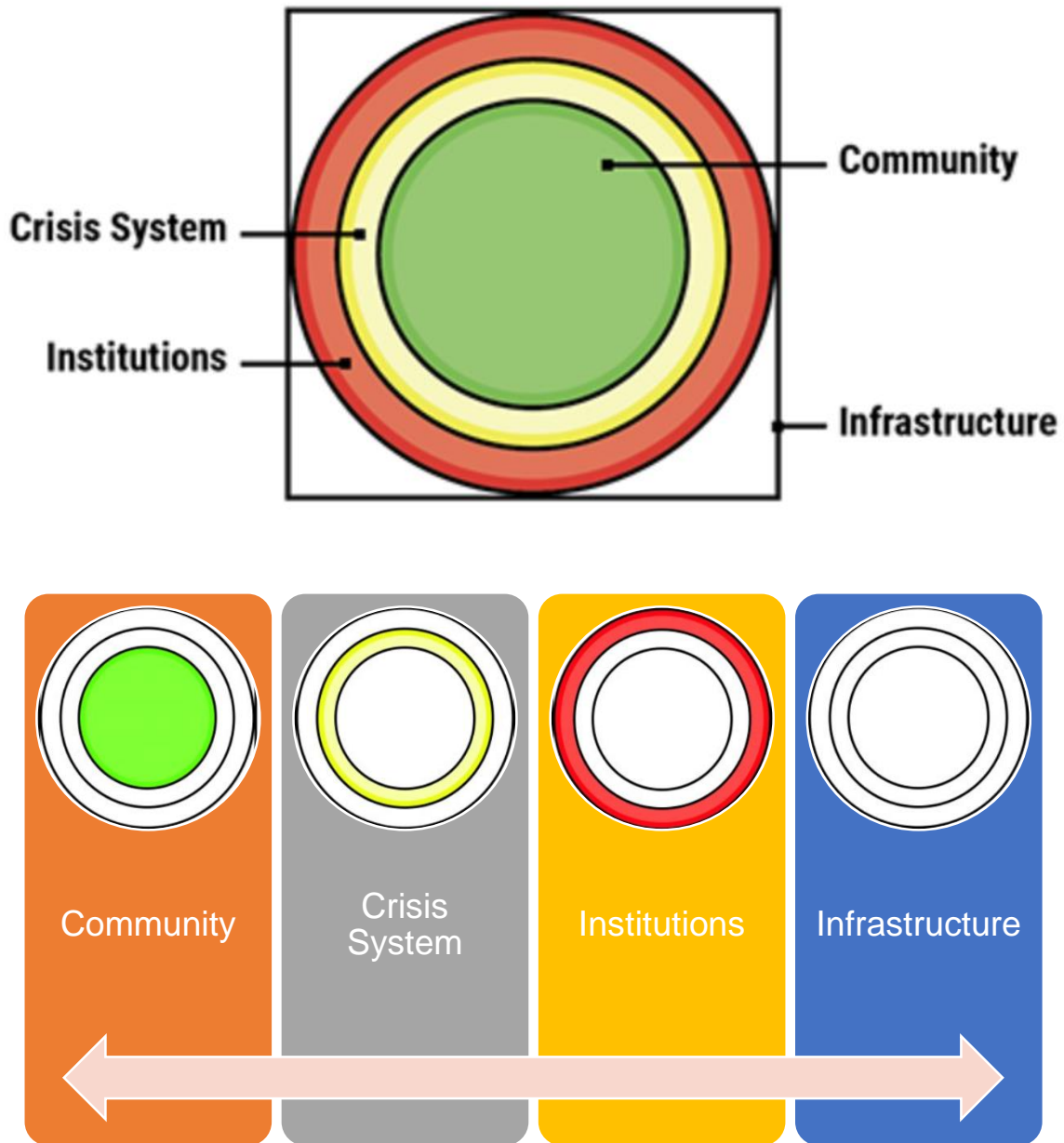
The Strategic Plan focuses on the change required to drive change across the system. The system is fundamentally based on three clinical domains and one administrative. The domains of our strategy are branded as follows:

- The first domain, **Community**, is represented by the green circle in the figure. This domain signifies the North Star, where we will always prefer to provide services and opportunities. A larger portion of the Strategic Plan focuses on Community and ways in which proactive and therapeutic resources can be built up countywide.
- The second domain, the **Crisis System**, is represented by the yellow ring. This domain includes the intensive care resources needed to help individuals in crisis who are falling out of the community.
- The third domain, **Institutions**, is represented by the red ring. This domain characterizes the Department's broad portfolio of re-entry resources (including compelled treatment) deployed to help clients who have fallen out of the community into the "open-air" asylum of the street, the "closed-air" asylum of the jail, and the personal asylum of deep isolation.
- The people and processes that guide our work across all three domains create our ever-present departmental **Infrastructure**, represented by the square and circular lines.

SECTION IV: QUALITY IMPROVEMENT WORK PLAN, CALENDAR YEAR 2021

Date Last Revised: 5/27/21

The Department's QIWP is organized into seven major domains: 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 service needs and the quality of services provided. Table 23 summarizes QIWP goals and their comparable strategic plan domain.

The QIWP is a living document. The Department's Quality Improvement Council (QI Council) will review QIWP goals and related progress at least bi-annually to ensure coverage of all components of the QIWP. Moreover, the Quality Assurance/QI liaisons will be tasked with reviewing and assessing the results of QIWP activities, recommending policy decisions, and monitoring the progress of the clinical and non-clinical PIPs. Stakeholders can use the following QIWP as a resource for informed decision-making and planning**.**

Table 23. Summary of Quality Improvement Work Plan Goals and Comparable Strategic Plan Domain(s), Calendar Year 2021

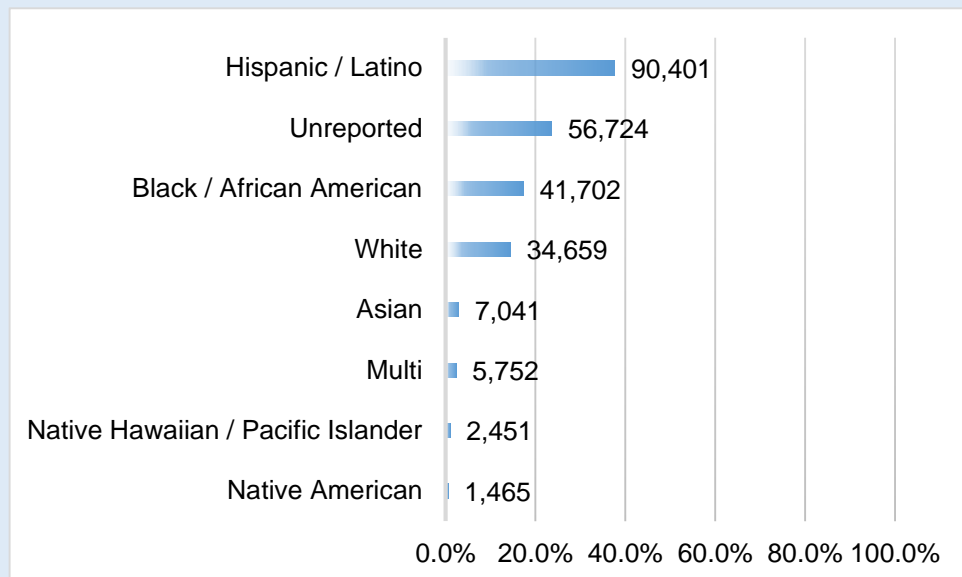| DOMAIN	NO.	GOAL	Community	Crisis System	Institutions	Infrastructure
SERVICE DELIVERY CAPACITY	I.1.	Analyze root causes in the underrepresentation of self-identified Native Hawaiian/Pacific Islander and Black/African Americans receiving DMH services.	✓	✓	✓	✓
	I.2.	Share findings on the Department's capacity to deliver culture-specific services.	✓	✓	✓	✓
	I.3	Maintain the number of clients receiving telehealth services.	✓			
ACCESSIBILITY OF SERVICES	II.1.	DMH will meet 80% of initial requests for outpatient specialty mental health services (SMHS) with a timely appointment.	✓			
	II.2.	Reduce wait times for after-hours Psychiatric Mobile Response Teams (PMRT).		✓		
BENEFICIARY SATISFACTION	III.1.	DMH will increase the response rate on Consumer Perception Surveys (CPS) by 5% for Adults and Families and 10% for Youth and Older Adults.				✓
	III.2.	Investigate and resolve 100% of Grievances and Appeals within regulation timelines.				✓
	III.3.	Monitor requests for a Change of Provider (COP).				✓
CLINICAL CARE	IV.1.	Roll out CANS-50 and PSC-35 aggregate reporting to support children and youth program operations.	✓			
	IV.2.	Facilitate medication monitoring activities through ongoing data evaluation and prescriber to prescriber peer reviews.	✓			
	IV.3.	Facilitate data-driven continuous quality improvement (CQI) discussions with DMH DO program managers at least annually.	✓		✓	
	IV.4.	Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS.	✓		✓	
CONTINUITY OF CARE	V.1.	Multidisciplinary Homeless Outreach Mobile Engagement (HOME) teams will provide intensive outreach, linkage to services and resources, and service-enriched housing (as needed) to no less than ten clients.			✓	
PROVIDER APPEALS	VI.1.	Monitor Provider Appeals.				✓
PERFORMANCE IMPROVEMENT PROJECTS	VII.1.	Implement a provision of staff training, a peer mentoring network, and interdisciplinary treatment groups focused on medication-assisted treatment (MAT) to increase the percentage of consumers with co-occurring substance use problems by four percent from Calendar Year 2020 to Calendar Year 2021.	✓			
	VII.2.	By the end of CY 2021, DMH will develop and implement a non-clinical PIP to improve the rate of timeliness to initial appointments from 61.5% to 70.0% for children seeking outpatient services.	✓			

Note: The data collection periods vary by objective.

Service Equity

Goal I.1.	Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving DMH services.
Objectives:	a) Examine service utilization patterns (i.e., retention rates) to inform programs and leadership. b) Examine diversity in the DMH workforce by race/ethnicity and language fluency (or the rate at which direct service staff reflects the consumers' racial identity and threshold languages). c) Establish a disproportionality and disparities report to provide insight on system capacity for existing and potential clients by race/ethnicity. d) Designate mental health promoters to reach the Asian Pacific Islander, African American, and Native American communities.
Population:	DMH and Legal Entity (LE)/Contracted programs providing outreach and outpatient SMHS to DMH clients and the Los Angeles County community at large.
Performance Indicators:	1. Unique Client Counts by Race/Ethnicity 2. Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity 3. Service utilization rates to be developed (TBD) at annual evaluation *Figure 35. Unique Client Counts by Race/Ethnicity, Fiscal Year 2019-20* **Note:** A total of 240,195 unique clients received outpatient DMH services in FY 2019-20. Of which, 23.6% (N=56,724) had unreported race/ethnicities. At 37.6% (N=90,401), the Hispanic/Latino group was the most represented than the Native American group that at 0.6% (N=1,465) made up the smallest portion of our client population. Data includes all clients, no matter the funding source. **Data Source:** DMH IS/IBHIS, retrieved on 3/19/2021 by Chief Information Office Bureau (CIOB).
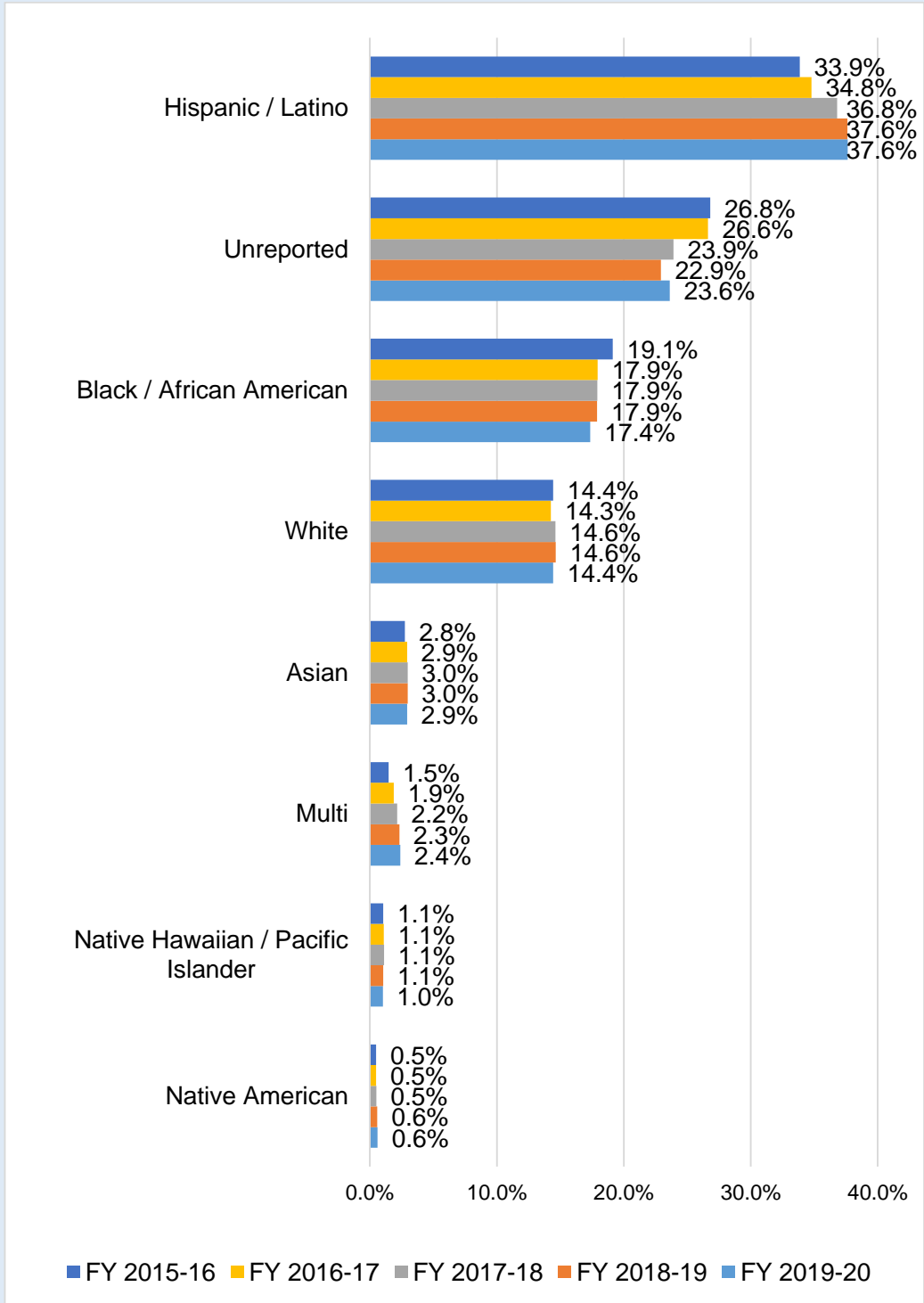
Note: In the last five fiscal years, the number of clients served from the Hispanic/Latino group has increased by 3.8 Percentage Points (PP, N=4,930). Conversely, the client population who self-identifies as Black/African American has declined by 1.8 PP (N=6,581). Of note, the number of clients from the Native Hawaiian/Pacific Islander group, who represents a smaller portion of our client population, is trending downwards. Between FY 2015-16 and FY 2016-17, Native Hawaiian/Pacific Islanders decreased by ten (10) clients, and in FY 2019-20, DMH saw 171 fewer Native Hawaiian/Pacific Islander clients than the previous FY. **Data Source:** DMH IS/IBHIS, retrieved on 3/19/2021 by CIOB.

Figure 37. Three-Year Trend in Penetration Rates for the Medi-Cal Beneficiaries Served Population by Race/Ethnicity, Fiscal Year (FY) 2017-18 to FY 2019-20
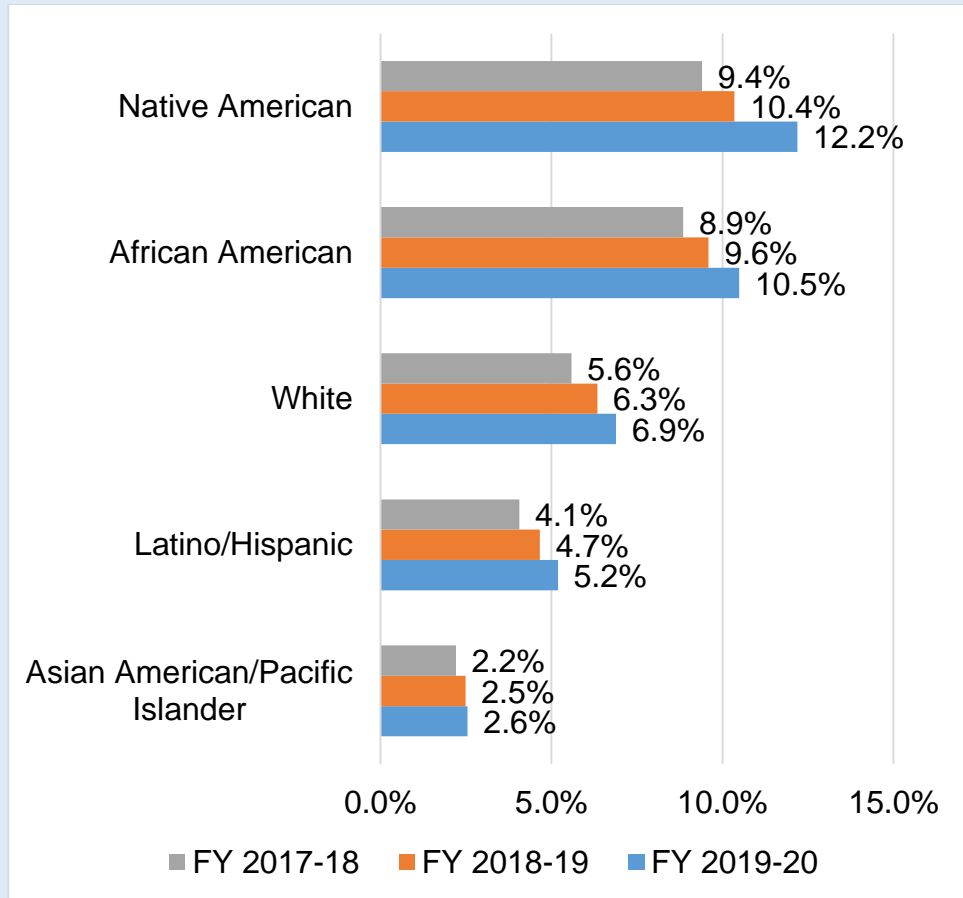
Note: Penetration rates are trending upwards for the Medi-Cal enrolled population across all races/ethnicities. Penetration rate changes were the largest for the Native American group, at a 2.8 PP increase in the last three fiscal years. At a 0.3 PP penetration rate increase over the last three years, the Asian American/Pacific Islander group showed the smallest growth. Information on the "Other" group was not included in this table. **Data Source:** Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2017 to CY 2019, prepared by BHC/CalEQRO in July 2018, July 2019, and July 2020.

Frequency of Collection:	Annually
Data Sources:	IS-IBHIS Approved Claims, QI Unit; Network Adequacy: Provider and Practitioner Administration (NAPPA) application data, QA Unit; Medi-Cal Approved Claims Data for LOS ANGELES County MHP, BHC, Inc.

Goal I.2.	Share findings on the Department's capacity to deliver culture-specific services.
Objective:	Evaluate and disseminate results from the 2019 Cultural Competency Organizational (CC Org) Assessment through presentations with the Cultural Competency Committee, Countywide QI Council, and all eight Service Area Quality Improvement Committees. • Each presentation will highlight knowledge gaps, document feedback from clients/families and stakeholders (if any), and identify potential next steps.
Population:	DMH DO staff (administrative and clinical) overseeing the quality or delivery of SMHS to DMH clients/families.
Performance Indicator:	The number of CC Org Assessment presentations facilitated in CY 2021.
Frequency of Collection:	Annually
Data Source:	Cultural Competency Unit (CCU) activity report, CCU.

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Telemental Health

Goal I.3.	**Maintain the number of clients receiving telehealth services.**
Objectives:	a) Establish a demographic profile of the clients served through tele-mental health (TMH), including location, age, and preferred language. b) Increase the number of telehealth encounters in DO programs via video, specifically, VSee, a HIPAA compliant telehealth application.
Population:	Clients/families receiving outpatient SMHS.
Performance Indicators:	1. Total clients served, including the number of telehealth encounters (services) provided in FY 2020-21. 2. Total Count of VSee Licenses Assigned in CY 2021. 3. VSee utilization (active accounts, logins, visits).

Figure 38. Overview of Telehealth Services by Client Counts and Telehealth Encounters, Fiscal Year (FY) 2018-19 and FY 2019-20
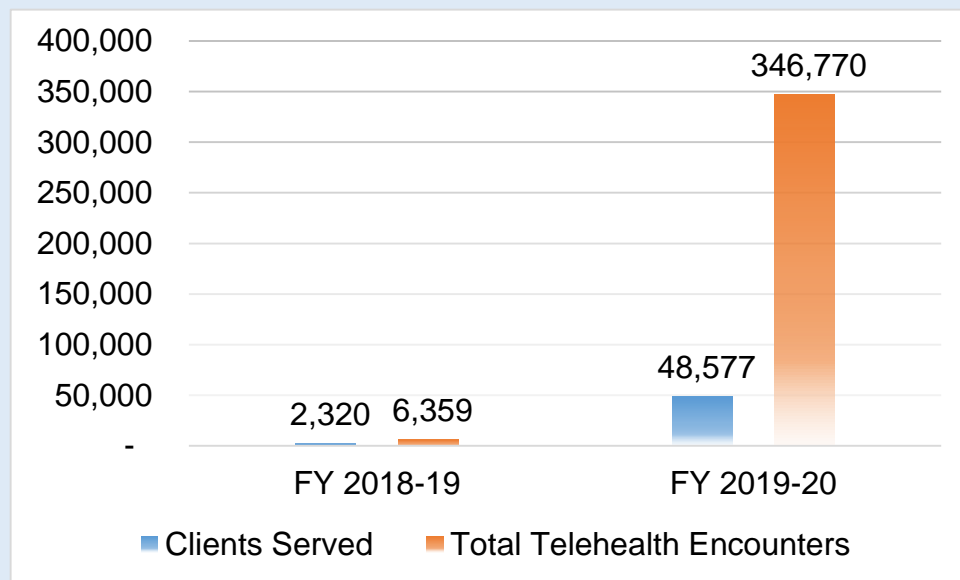
Note: Between FY 2018-19 and FY 2019-20, the number of clients receiving telehealth services increased by approximately 1994%, and telehealth encounters increased by more than 5000%. Data above includes indigent and uninsured clients. **Data Source**: Information Systems Capabilities Assessment (ISCA), dated August 2020.

Figure 39. Status of VSee License Assignments, Calendar Year 2020
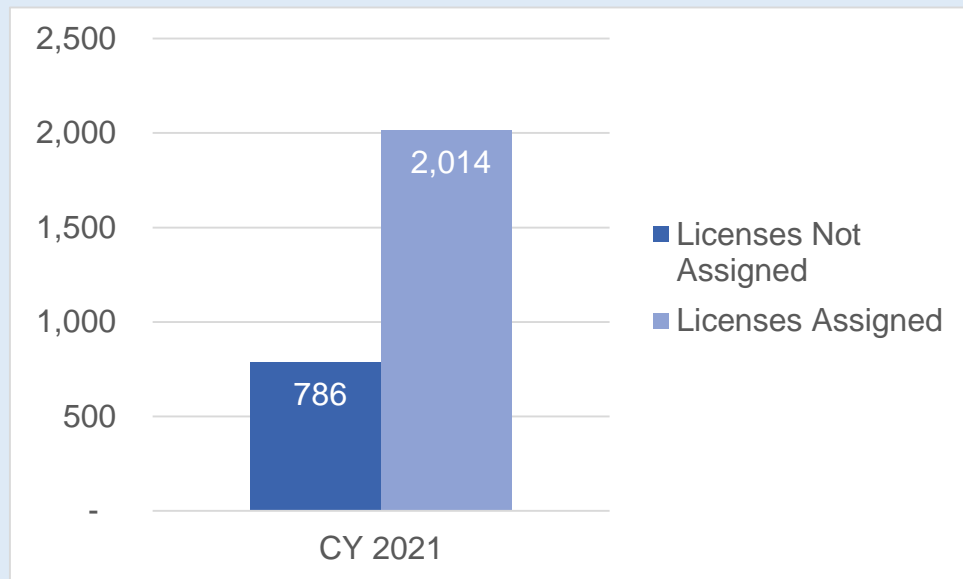
Note: Data above includes directly-operated program staff only. DMH CIOB has assigned approximately 72% of the Department's available VSee licenses. **Data Source:** VSee Status Report, prepared by CIOB on 1/5/2021.

Figure 40. Active VSee Accounts with Log-ins by Staff/Discipline, Calendar Year 2020
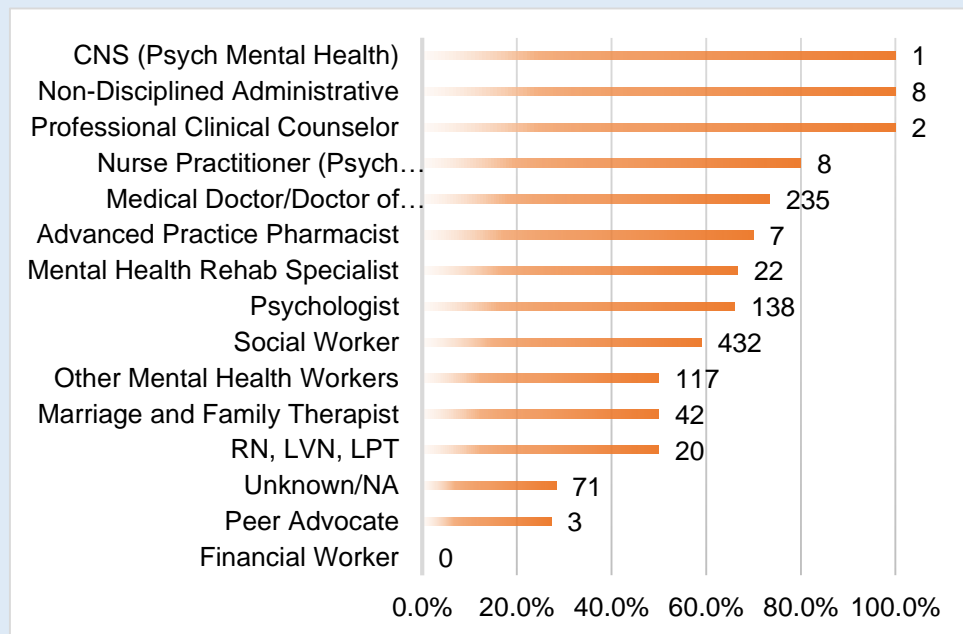
Note: Among the disciplines with greater than 20 active accounts, DMH MD/DOs (73.4%) had the highest number of staff who logged into their VSee accounts, followed by mental health rehab specialists (66.7%), psychologists (66.0%), and social workers (59.0%). "Unknown/NA" Discipline occurs when IT could not link the VSee User Account to an IBHIS Practitioner record. **Data Source**: VSee Utilization Report, prepared by CIOB on 12/30/2020.

Figure 41. Active VSee Accounts with Any Visit(s) by Staff/Discipline, Calendar Year 2020
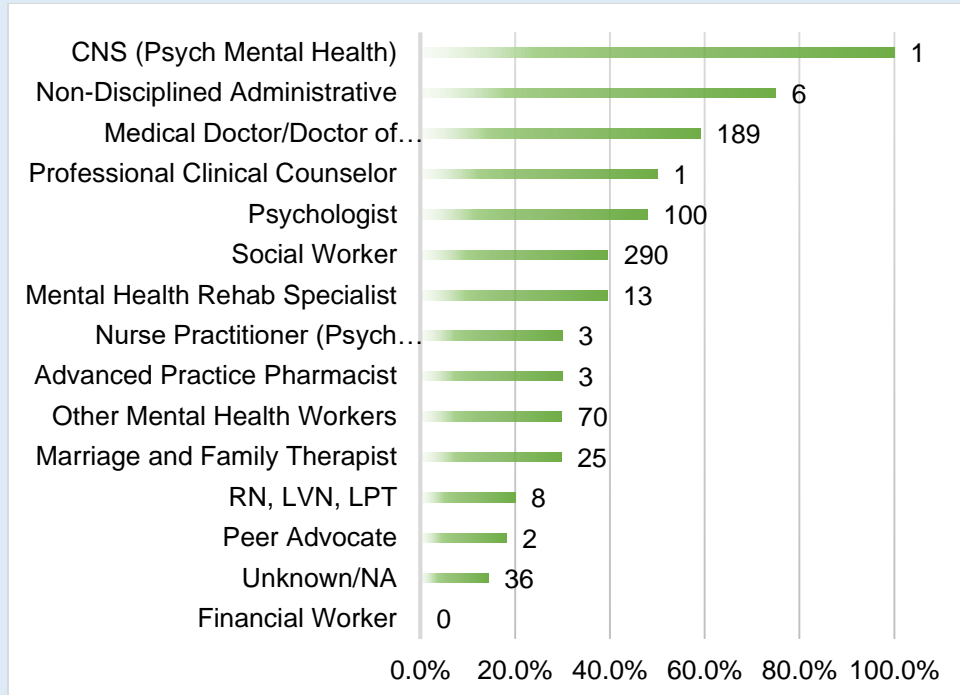
Note: 38% (N=747) of staff with active accounts have initiated a "Visit (VSee session was initiated and may include practice/training sessions)." Among the disciplines with greater than 25 active accounts (excluding Unknown/NA disciplines), DMH MD/DOs (59.1%) showed the highest number of active accounts where staff initiated at least one visit, followed by psychologists (47.8%), social workers (39.6%), and mental health rehab specialists (39.4%). **Data Source**: VSee Utilization Report, prepared by CIOB on 12/30/2020.

Frequency of Collection:	Annually
Data Sources:	IS-IBHIS Approved Claims Data, Chief Information Office Bureau (CIOB), Clinical Informatics Team

Goal II.1.	DMH will meet 80% of initial requests for outpatient SMHS with a timely appointment.

Objectives:	a) Monitor time to first offered appointment.
	  • Providers should offer routine (non-urgent) appointments within ten business days (not including weekends and holidays) of the initial request.
	  • Providers should offer urgent appointments within 48 hours (including weekends and county holidays) of the initial request.
	  • Providers should offer follow-up hospital discharge or jail release appointments within five business days (not including weekends and holidays) of the initial request.
	b) System-wide timeliness data will be aggregated by SA, provider, and age group and track for trends.
	c) Implement centralized scheduling in Service Area (SA) 3 for DMH clients seeking follow-up hospital discharge appointments coordinated between their inpatient provider and ACCESS Center.
	d) Establish a learning collaborative among SA 2 providers to define best practices related to improving the timeliness of services.

Population:	Los Angeles County residents seeking outpatient SMHS from a DMH provider.
Performance Indicators:	Rates of timeliness by service request type (routine, urgent, and hospital discharge/jail release). *Figure 42. Total Number of Requests for Service Received by Month, Calendar Year 2020*

December 2020 — 15,464
November 2020 — 15,323
October 2020 — 19,476
September 2020 — 18,174
August 2020 — 16,418
July 2020 — 16,590
June 2020 — 15,708
May 2020 — 11,911
April 2020 — 10,662
March 2020 — 14,661
February 2020 — 17,679
January 2020 — 18,756
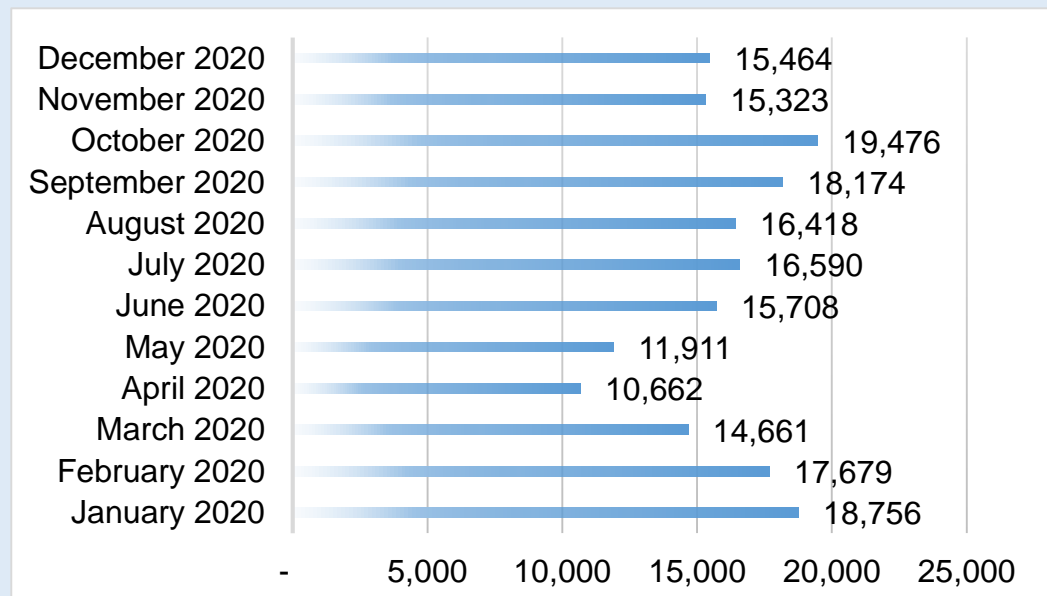
Note: Information above reflects data from multiple sources, including Contractor Service Request Log (SRL) web services (N=62,407), IBHIS (DO) SRL (N=70,315), KAEMS (N=20,924), and Service Request Tracking System (SRTS, N=18,588). The highest number of requests were received in October 2020 (N=19,476), with April 2020 (N=10,662) seeing the lowest. **Data Source**: System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 3/30/21.

Figure 43. Percent of Appointments by Status Category and Service Area
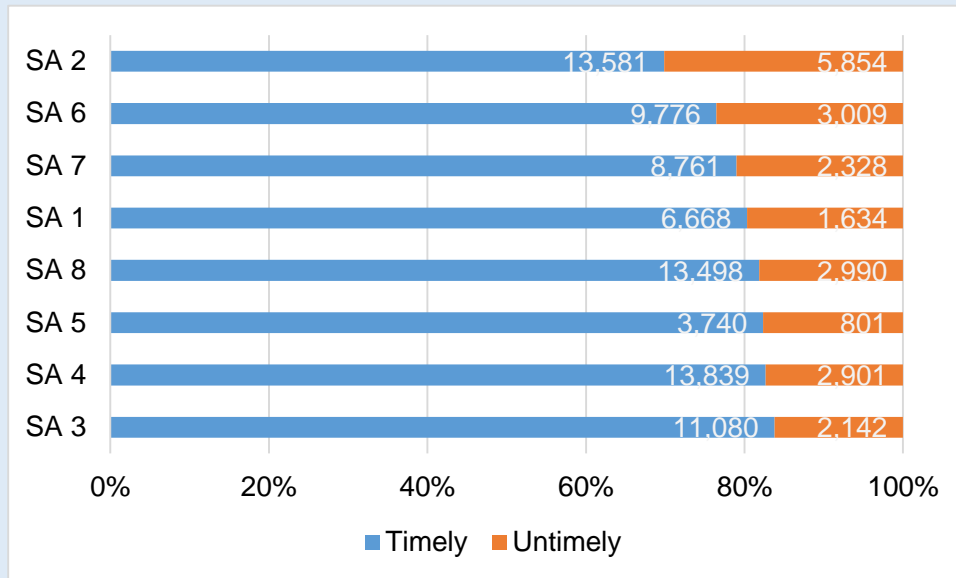
Note: In CY 2020, SA 2 (30.1%) had the highest percentage of untimely appointments, followed by SA 6 (23.5%). SA 3 (83.8%) had the highest rate of timely appointments, followed closely by SA 4 (82.7%). The "Untimely, referral declined" values are included in the "Timely" category. **Data Source**: System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 4/26/21.

Figure 44. Percent of Requests for Routine Services with Untimely Appointments by Service Area, Calendar Year 2020
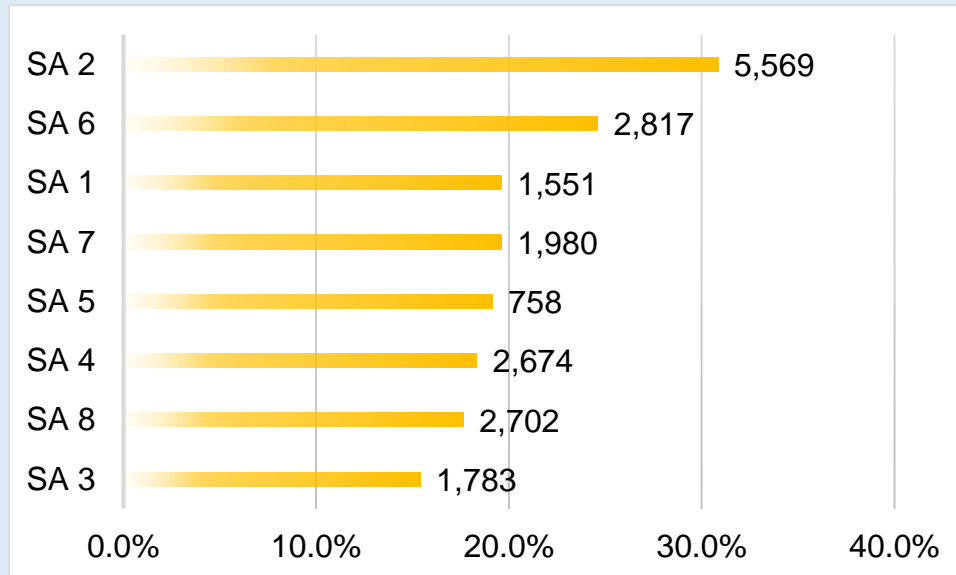
Note: In CY 2020, SA 2 (30.9%) had the highest percentage of requests for routine services met with an untimely appointment and SA 3 (15.4%) had the lowest. **Data Source**: System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 4/15/21.

Figure 45. Percent of Requests for Urgent Services with Untimely Appointments by Service Area, Calendar Year 2020
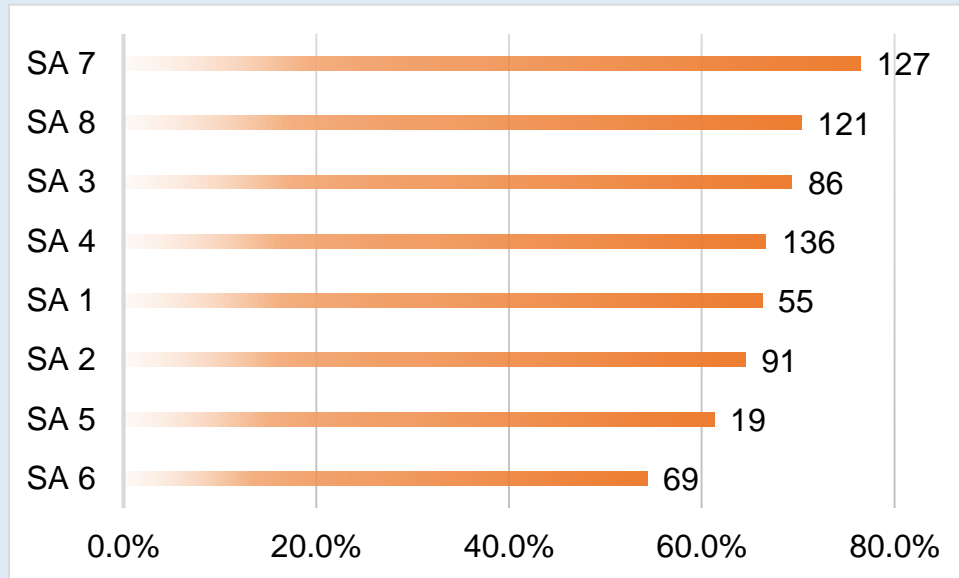
Note: In CY 2020, SA 7 (76.5%) had the highest percentage of requests for urgent services met with an untimely appointment and SA 6 (54.3%) had the lowest. **Data Source:** System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 4/15//21.

Figure 46. Percent of Requests for Inpatient/Jail Discharge Services with Untimely Appointments by Service Area, Calendar Year 2020
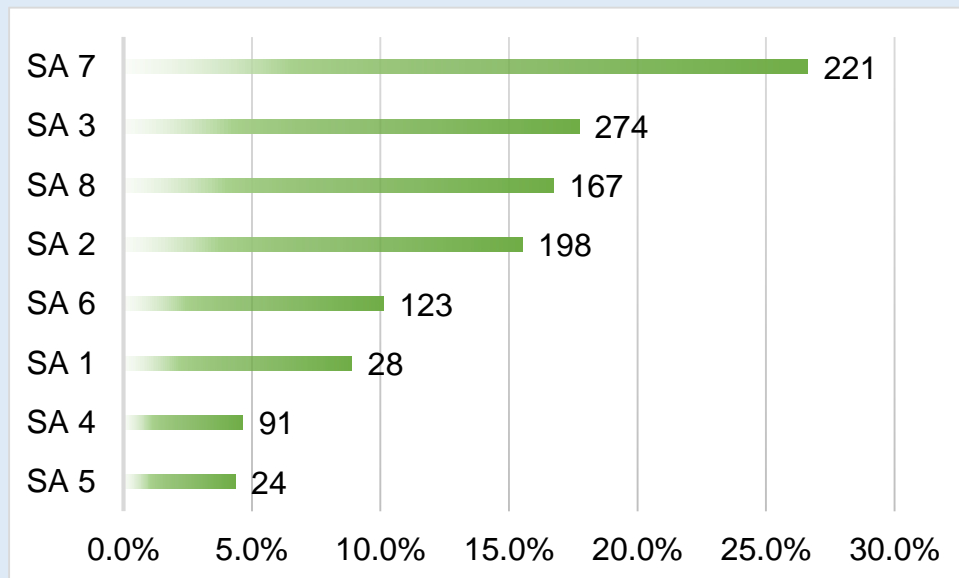
Note: In CY 2020, SA 7 (26.6%) had the highest percentage of requests for inpatient/jail discharge services met with an untimely appointment and SA 5 (4.3%) had the lowest. **Data Source:** System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 4/15/21.

Frequency of Collection:	Quarterly
Data Source:	System-wide Access to Care Monitoring Reports, DMH Dashboard

Goal II.2.	Reduce wait times for after-hours Psychiatric Mobile Response Teams (PMRT).
Objective:	Complete hiring and facilitate the onboarding process for multidisciplinary Therapeutic Transportation (TT) team members that include peers to support five mobile mental health vans that operate 24 hours a day and seven days a week.
Population:	Los Angeles County residents seeking crisis support services.
Performance Indicators:	1. The number of complete TT teams (Peer, Psychiatric Technician, and Clinical Driver). 2. Metrics on wait and transport times TBD at annual evaluation.
Frequency of Collection:	Annually
Data Source:	TT Program data reports, Intensive Care Division

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Consumer Perception

Goal III.1.	**DMH will increase the response rate on Consumer Perception Surveys (CPS) by 5% for Adults and Families and 10% for Youth and Older Adults.**
Objective:	Increase efforts to reach a more significant percentage of all consumers seen during the survey week by expanding eligible populations (e.g., field-based consumers) and introducing a DMH-specific electronic survey version. • Target age groups that historically have lower response rates (i.e., Older Adults and Youth)
Population:	Clients and families receiving outpatient SMHS.
Performance Indicator:	Number of returned surveys/respondents by CPS form. *Table 24. Completed Consumer Perception Surveys by Age Group over the Past Five Survey Periods and Estimated Goal Numbers* <table><tr><th>Time Period</th><th>Youth</th><th>Family</th><th>Older Adult</th><th>Adult</th></tr><tr><td>Spring 2018</td><td>2,420</td><td>5,124</td><td>781</td><td>6,791</td></tr><tr><td>Fall 2018</td><td>1,684</td><td>3,464</td><td>706</td><td>7,158</td></tr><tr><td>Spring 2019</td><td>2,681</td><td>5,443</td><td>998</td><td>7,973</td></tr><tr><td>Fall 2019</td><td>2,306</td><td>4,262</td><td>709</td><td>6,286</td></tr><tr><td>Spring 2020</td><td>981</td><td>3,359</td><td>493</td><td>3,782</td></tr><tr><td>Average</td><td>2,014</td><td>4,330</td><td>737</td><td>6,398</td></tr><tr><td>Goal</td><td>(+10%) 201 2,215</td><td>(+5%) 217 4,547</td><td>(+10%) 74 811</td><td>(+5%) 320 6,718</td></tr></table> **Note:** Given that Spring 2020 was an outlier survey period during the early stages of the COVID-19 pandemic, DMH will develop goals based on average completed surveys over the past five survey periods. **Data Source:** DMH CPS data, CY 2018 to CY 2020.
Frequency of Collection:	Annually
Data Source:	Performance Outcomes and Quality Improvement (POQI) Reports aggregated by DHCS and Microsoft Dynamics reports in the electronic CPS application, QI Unit

Consumer Grievance

Goal III.2.	Investigate and resolve 100% of Grievance and Appeals within regulation timelines.
Objectives:	a) Maintain a written log of all Grievances, Appeals, and Expedited Appeals, including the timeliness of responses. b) Review the nature of complaints and resolutions for significant trends that may warrant policy recommendations or system-level improvement strategies.
Population:	Los Angeles County residents engaging in DMH services (outpatient, inpatient, FFS)
Performance Indicator:	Beneficiary complaints and resolutions in FY 2020-21 as documented in the Grievance log.
Frequency of Collection:	Annually
Data Source:	Grievance Log, Patient's Rights Office (PRO)

Goal III.3.	Monitor requests for a Change of Provider (COP).
Objective:	Review COP reasons and track trends in clients' requests to change practitioners/providers.
Population:	Beneficiaries receiving outpatient DMH services.
Performance Indicator:	COP requests in FY 2020-21 by reason.
Frequency of Collection:	Annually
Data Source:	Change of Provider Logs, PRO

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Monitoring Clinical Care, Calendar Year 2021

Reporting

Goal IV.1.	**Rollout Child and Adolescent Needs and Strengths – 50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.**
Objective:	Develop a CANS-50 and PSC-35 aggregate report • Gather input on report elements from providers • Consolidate the CANS-50 and PSC-35 data sets for reporting
Population:	DMH Directly Operated (DO) and LE/Contracted programs providing SMHS to children and youth between ages 3 and 21 years.
Performance Indicator:	1. At least one report is available for provider use (Goal) 2. Additional targets TBD at annual evaluation
Frequency of Collection:	Annually
Data Source:	Program data report, Outcomes Unit

Medication Monitoring

Goal IV.2.	**Facilitate medication monitoring activities through ongoing data evaluation and prescriber to prescriber peer reviews.**
Objectives:	a) Develop dashboard review procedures highlighting data evaluation, the rollout for LE/Contracted programs in one SA, and recommended use of a review committee. b) Establish peer review procedures highlighting tracking administrative reminders, matching, records review, and replicability for prescribers in LE/Contracted programs.
Population:	Prescribers in DO and LE/Contracted programs providing outpatient SMHS to DMH clients.
Performance Indicator:	The number of peer reviews completed for prescribers in DO programs.
Frequency of Collection:	Annually
Data Source:	Program data reports, Pharmacy Services and DMH Psychiatrists

Provider-Level Improvement

Goal IV.3.	Facilitate data-driven continuous quality improvement (CQI) discussions with DMH DO program managers at least annually.
Objective:	Conduct at least one All Programs of Excellence (APEX) meeting for the DO Older Adult (GENESIS) program, collaboration programs, and combined meetings for programs in shared SAs. • Review aggregate and program-specific data, such as client financial information updates (UMDAPs), client treatment plans, and timeliness, and identify barriers, challenges, and successes. • Review demographic data on total population, poverty estimates, clients served, and homeless data. • Examine post-APEX surveys for tools and helpful recommendations, and forward findings to program managers.
Population:	DO programs providing outpatient SMHS to DMH clients/families
Performance Indicator:	Number and location of APEX meetings conducted in CY 2021
Frequency of Collection:	Annually
Data Source:	Outpatient Services Division (OSD) APEX activity reports and survey data, OSD

Goal IV.4.	Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS.
Objectives:	a) Implement a Quality Assurance (QA) Knowledge Assessment survey to identify themes in the documentation guidelines most misunderstood by providers while granting LEs data-driven opportunities for self-directed training/improvement strategies. b) Pilot a chart review checklist that tracks the number (and percent) of criteria complying or improving over time.
Population:	LE/Contracted programs providing outpatient SMHS to DMH clients/families.
Performance Indicator:	Performance targets TBD at annual evaluation.
Frequency of Collection:	• QA will collect QA Knowledge Assessment survey data quarterly. • DMH QA will complete at least one chart review per LE every three years (Goal).
Data Source:	Completed surveys and chart review summary reports, QA Unit, Training and Operations Team

Goal V.1.	Multidisciplinary Homeless Outreach Mobile Engagement (HOME) teams will provide intensive outreach, linkage to services and resources, and service-enriched housing (as needed) to no less than ten clients.
Objectives:	a) DMH will apply for outpatient conservatorship for homeless individuals who are gravely disabled but refusing voluntary mental health services. b) Establish baseline Health of the Nation Outcome Scale (HoNOS) and Vulnerability Index-Service Prioritization Decision Assistance. c) Tool (VI-SPDAT) data towards a demographic profile of those served.
Population:	Los Angeles County residents deemed gravely disabled.
Performance Indicator:	1. The number of clients engaged and successfully enrolled in HOME program services. 2. The number of successful conservatorships in each supervisorial district.
Frequency of Collection:	Annually
Data Source:	HOME Program data, HOME program

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Goal VI.1	Monitor Provider Appeals.
Objectives:	a) Develop a Provider Appeal Tracking Log to record provider appeals, resolutions, and dates of responses. b) Review the log for trends and share findings with appropriate entities.
Population:	DMH clients receiving inpatient psychiatric services from Department of Health Service (DHS), Fee-for-Service (FFS) Contracted, Non-Contracted, Non-Governmental Agency (NGA), and Contracted IMD Exclusion Hospitals.
Performance Indicator:	Number of Notice of Adverse Benefits Determinations (NOABDs) issued, including the percentage of upheld or overturned appeals.
Frequency of Collection:	Quarterly
Data Source:	Hospital Association of Southern California (HASC) TAR Report and Provider Appeal Tracking Log, ICD

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Clinical Performance Improvement Project

Goal VII.1.	DMH will implement a provision of staff training, a peer mentoring network, and interdisciplinary treatment groups focused on medication-assisted treatment (MAT) to increase the percentage of consumers with co-occurring substance use problems MAT by four percent from Calendar Year 2020 to Calendar Year 2021.
Objectives:	a) Increase the number of consumers receiving MAT overall. b) Increase the number of consumers with identified alcohol use disorder (AUD) and opioid use disorder (OUD) receiving MAT. c) Increase the number of prescribers that are eligible to prescribe MAT. d) Increase the number of prescribers administering MAT to at least one consumer.
Population:	DMH clients receiving outpatient co-occurring disorder (COD) services.
Performance Indicator:	1. Number of prescribers eligible to administer MATs 2. Number of prescribers administering MAT to at least one consumer 3. Number of consumers prescribed MAT (also separated by consumers with identified AUDs and OUDs) 4. Number of consumers with improved mood or anxiety ratings on Weekly Check-in 5. Number of consumers with decreased substance use and interference rating on Weekly Check-in
Frequency of Collection:	Monthly
Data Source:	PIP Development Tool FY 2021-22, *Improving the Use of Medication-Assisted Treatment for Consumers with Co-Occurring Mental Health Disorders and Substance Use,* Order Connect Data Tables, and Weekly Check-In Microsoft Forms data

Non-Clinical Performance Improvement Project

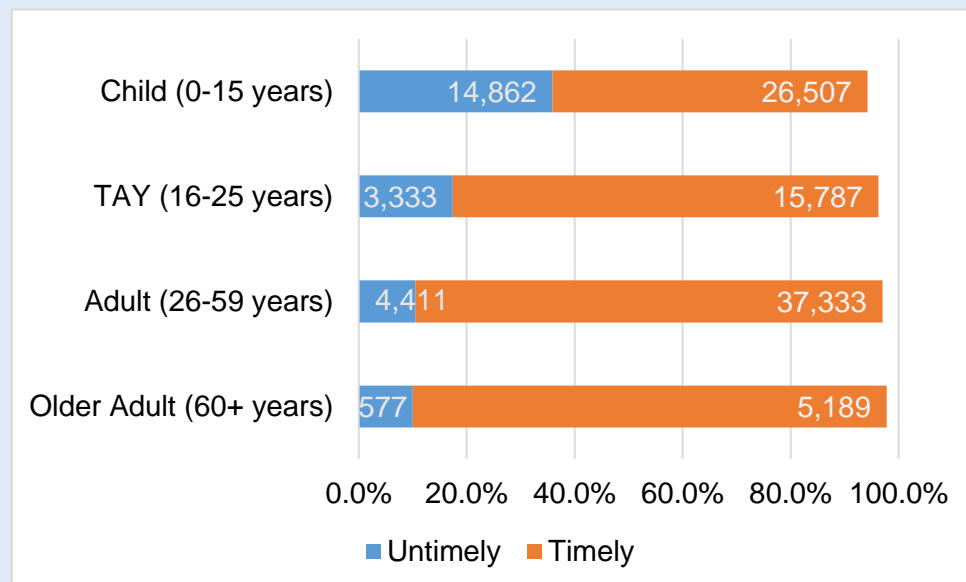|	
Goal VII.2.	**By the end of CY 2021, DMH will develop and implement a non-clinical PIP to improve the rate of timeliness to initial appointments from 61.5% to 70.0% for children seeking outpatient services.**
Objectives:	a) Establish a demographic profile (i.e., size, modes of service delivery, location, etc.) of providers who struggle to meet DMH timeliness standards for clients/families seeking child services. b) Implement a required QI Plan of Correction process for providers with timeliness in the 69% or less range, including identifying internal and external factors contributing to their untimely appointments and establishing an action plan.
Population:	Los Angeles County residents seeking outpatient DMH services
Performance Indicators:	1. Rate of timeliness (%) for urgent appointment requests. 2. Rate of timeliness (%) for routine appointment requests. 3. Rate of timeliness (%) for inpatient/jail discharge appointment requests. 4. Percent of no-shows to initial appointments by service request type. *Figure 47. Percent of Untimely versus Timely Initial Appointments by Age Group, Calendar Year 2020* **Note:** At a rate of 35.9%, clients/families seeking child outpatient services are more likely to receive an untimely appointment when compared to individuals seeking TAY (17.4%), adult (10.6%), or older adult (10.0%) services. "Untimely, referral declined" values were added to the "Timely" category. **Data Source**: System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 3/31/21.
Frequency of Collection:	Quarterly
Data Source:	Non-clinical PIP Development Tool FY 2021-22, System-wide Access to Care Dashboard

DATA COLLECTION AND COMMUNICATION PLAN OVERVIEW
Date Last Revised: 2/22/21

Domain	Performance Indicators	Data Sources	Frequency of Collection	Responsible Entity	Communication Plan
Service Delivery Capacity	• Unique Client Counts by Race/Ethnicity • Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity • Total clients served, including the number of telehealth encounters (services) provided in FY 2020-21 • Total Count of VSee Licenses Assigned in CY 2021 • VSee utilization (active accounts, logins, visits) • Number of CC Org Assessment presentations facilitated in CY 2021	DMH Integrated Behavioral Health Information System	Annually	Quality Improvement Unit Chief Information Office Bureau	Monthly All Programs of Excellence Meetings, Quality Improvement Council meetings at least annually, and Service Area Quality Improvement Committee meetings as applicable
Accessibility of Services	• Rates of timeliness by service request type (routine, urgent, discharge/jail release) • Number of complete TT teams (Peer, Psychiatric Technician, and Clinical Driver)	System-wide Timely Access to Care Dashboard	Quarterly Annually	Quality Assurance Unit Intensive Care Division	Monthly Access to Care Leadership Committee meetings, Central Quality Assurance/Quality Improvement meetings at least quarterly, and Quality Improvement Council meetings at least annually
Beneficiary Satisfaction	• Number of returned surveys/respondents by Consumer Perception Survey form. • Beneficiary complaints and resolutions in FY 2020-21	DMH Consumer Perception Survey data Grievance Log	Annually	Quality Improvement Unit Patient's Rights Office	Quality Improvement Council and Service Area Quality Improvement Committee meetings at least annually

Domain	Performance Indicators	Data Sources	Frequency of Collection	Responsible Entity	Communication Plan
Clinical Care	• Number of aggregated CANS-50 or PSC-35 reports available for provider use • Number of peer reviews completed for prescribers in DO programs • Number and location of APEX meetings conducted in CY 2021	Program-specific data reports	Annually	Outcomes Unit Office of Clinical Operations Outpatient Services Division and Leads for Directly Operated Programs	Providers as applicable and Quality Improvement Council meetings at least annually
Continuity of Care	• Number of clients engaged and successfully enrolled in services. • Number of successful conservatorships in each supervisorial district.	Program-specific data reports	Annually	Homeless Outreach Mobile Engagement Program	Quality Improvement Council meetings at least annually
Provider Appeals	• Number of NOABDs issued, including the percentage of appeals that were upheld or overturned.	Hospital Association of Southern California Treatment Authorization Request Report and Provider Appeal Tracking Log	Quarterly	Intensive Care Division	Quality Improvement Council meetings at least annually

Domain	Performance Indicators	Data Sources	Frequency of Collection	Responsible Entity	Feedback/Input Plan
Clinical Performance Improvement Project	• Number of prescribers eligible to administer MATs • Number of prescribers administering MAT to at least one consumer • Number of consumers prescribed MAT (also separated by consumers with identified AUDs and OUDs) • Number of consumers with improved mood or anxiety ratings on Weekly Check-in • Number of consumers with decreased substance use and interference rating on Weekly Check-in	PIP Development Tool FY 2021-22, Order Connect Data Tables, and Weekly Check-In Microsoft Forms data	Monthly	Clinical PIP committee	Monthly PIP committee meetings and Quality Improvement Council meetings at least quarterly
Non-Clinical Performance Improvement Project	• Rate of timeliness (%) for urgent appointment requests. • Rate of timeliness (%) for routine appointment requests. • Rate of timeliness (%) for inpatient/jail discharge appointment requests. • Percent of no shows to initial appointments by service request type	Non-clinical PIP Development Tool FY 2021-22 and System-wide Timely Access to Care Dashboard	Quarterly	Access to Care Leadership committee, Nonclinical PIP committee, and Quality Assurance Unit	Monthly PIP committee meetings and Quality Improvement Council meetings at least quarterly

Appendix A. Los Angeles County Month to Month Trends in Medi-Cal Eligibility, Calendar Year 2020

Table A: Monthly Population Enrolled in Medi-Cal by Race/Ethnicity, Calendar Year 2020

	African American	Asian/ Pacific Islander	Latino	Native American	White	Not Reported	Total
January	381,312	361,800	2,211,041	4,610	488,097	299,896	3,746,756
February	379,410	358,840	2,199,422	4,569	484,814	298,491	3,725,546
March	378,545	357,730	2,189,282	4,567	484,260	291,635	3,706,019
April	381,782	360,038	2,203,783	4,685	489,621	288,557	3,728,466
May	383,605	361,989	2,221,316	4,717	493,271	295,111	3,760,009
June	385,803	364,373	2,241,228	4,734	496,348	301,771	3,794,257
July	388,213	367,107	2,260,795	4,761	500,207	310,863	3,831,946
August	389,705	369,086	2,276,059	4,774	503,284	316,346	3,859,254
September	391,586	370,895	2,289,750	4,794	506,076	321,373	3,884,474
October	393,337	372,394	2,301,131	4,809	508,441	326,590	3,906,702
November	393,799	373,257	2,306,092	4,783	509,188	332,104	3,919,223
December	397,090	376,998	2,325,430	4,813	514,669	344,416	3,963,416

Table B: Monthly Population Enrolled in Medi-Cal by Age Group, Calendar Year 2020

	Age Group				
	0-18	19-44	45-64	65+	Total
January	1,302,445	1,286,294	740,482	417,535	3,746,756
February	1,296,021	1,275,316	735,971	418,238	3,725,546
March	1,288,624	1,266,607	732,083	418,705	3,706,019
April	1,287,701	1,281,825	738,489	420,451	3,728,466
May	1,290,943	1,299,914	747,570	421,582	3,760,009
June	1,297,809	1,317,179	755,793	423,476	3,794,257
July	1,303,846	1,337,404	764,646	426,050	3,831,946
August	1,307,727	1,352,029	771,768	427,730	3,859,254
September	1,309,831	1,366,556	778,694	429,393	3,884,474
October	1,310,363	1,379,433	785,643	431,263	3,906,702
November	1,307,879	1,387,069	791,702	432,573	3,919,223
December	1,308,730	1,407,202	804,192	443,292	3,963,416

Table C: Monthly Population Enrolled in Medi-Cal by Gender, Calendar Year 2020

	Gender		
	Female	Male	Total
January	2,022,822	1,723,934	3,746,756
February	2,011,467	1,714,079	3,725,546
March	2,000,924	1,705,095	3,706,019
April	2,012,104	1,716,362	3,728,466
May	2,028,130	1,731,879	3,760,009
June	2,045,406	1,748,851	3,794,257
July	2,065,098	1,766,848	3,831,946
August	2,079,273	1,779,981	3,859,254
September	2,092,337	1,792,137	3,884,474
October	2,103,712	1,802,990	3,906,702
November	2,109,860	1,809,363	3,919,223
December	2,131,926	1,831,490	3,963,416

Table D: Monthly Population Enrolled in Medi-Cal by Primary Language, Calendar Year 2020

	January	February	March	April	May	June	July	August	September	October	November	December
English	2,136,396	2,124,737	2,118,905	2,132,785	2,152,099	2,172,653	2,195,680	2,212,872	2,229,248	2,243,302	2,249,882	2,274,474
Spanish	1,286,486	1,279,296	1,269,067	1,273,665	1,282,908	1,294,535	1,305,997	1,314,055	1,321,049	1,327,150	1,330,634	1,344,098
Armenian	78,500	78,343	77,700	78,942	79,098	79,234	79,386	79,501	79,562	79,523	79,443	79,600
Mandarin	48,208	47,611	47,142	47,276	47,375	47,642	47,906	48,062	48,194	48,342	48,399	48,714
Cantonese	43,627	43,328	43,129	43,264	43,315	43,446	43,562	43,650	43,696	43,704	43,658	43,812
Korean	34,187	33,946	33,726	33,992	34,051	34,109	34,204	34,215	34,307	34,353	34,825	39,699
Vietnamese	30,234	30,113	29,946	30,015	30,059	30,169	30,305	30,368	30,433	32,227	34,382	34,654
Unknown	22,299	21,862	21,177	21,429	23,897	25,184	27,424	28,915	30,320	30,413	30,395	30,505
Farsi	15,081	14,931	14,754	15,132	15,130	15,119	15,152	15,154	15,151	15,148	15,152	15,164
Russian	14,060	14,013	13,896	14,185	14,216	14,248	14,282	14,304	14,330	14,346	14,320	14,369
Tagalog	9,514	9,481	9,167	9,821	9,809	9,787	9,819	9,836	9,825	9,811	9,779	9,845
Cambodian	8,671	8,588	8,468	8,660	8,655	8,670	8,687	8,704	8,700	8,705	8,702	8,724
Arabic	6,123	6,064	5,944	6,108	6,122	6,138	6,145	6,161	6,160	6,168	6,148	6,163
Other Non-English	5,746	5,696	5,568	5,740	5,767	5,808	5,857	5,883	5,897	5,887	5,886	5,926