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

# Quality Assessment and Performance Improvement Evaluation Report 2021 and Work Plan 2022

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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, LACDMH) is the country's largest county mental health plan (MHP). The Department directly operates more than 85 programs, maintains approximately 300 co-located sites, and contracts with close to 1,000 organizations. More than 250,000 Los Angeles County residents are under the care of DMH staff, non-governmental agencies (NGA), and individual practitioners who provide various services.

Los Angeles County is the most populated county globally, with an estimated population of 10,012,414 in Calendar Year (CY) 2020. The estimated distribution by race/ethnicity comprises Latinos representing 48.0%, Whites at 25.9%, Asian/Pacific Islanders at 15.1%, African Americans at 7.7%, and Native Americans representing 0.19%. Approximately 49% of our service recipients are in the child and transition age youth groups, 40% are adults, and 11% are older adults. During Fiscal Year (FY) 2020-21, 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 200,990 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 collaborates with other programs, divisions, and stakeholders to establish objectives, strategies, and relevant and timely summaries. The Department's Strategic Plan and Quality Assessment and Performance Improvement (QAPI) Work Plan activities are interconnected and similarly CQI-oriented.

The annual QAPI aims to ensure an organizational culture of continuous self-monitoring through countywide practical strategies, best practices, and activities. The Department's annual QAPI is organized into seven significant 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 2021, 10 out of 16 QAPI objectives were met, and six were partially met. The QAPI goals focused on increasing services for individuals from underserved groups, including Native Hawaiian/Pacific Islanders and Black/African Americans, maintaining telemental health care, increasing client feedback response rates, developing new and ongoing Performance Improvement Projects (PIPs), and improving tracking mechanisms for essential topics like access to care, beneficiary grievances, and medication monitoring.

In CY 2022, QOTD continued to promote a QI culture through departmental-wide partnerships, including planned collaborative efforts with the Access to Care Leadership Committee, 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 2022, LACDMH continued to strive for equitable and accessible services by identifying service gaps in the Asian, Black/African American, and Native Hawaiian/Pacific Islander communities and monitoring systemwide timeliness rates and youth HEDIS measures; identifying an adult level of care tool; and using consumer feedback to implement data-driven strategies. Notable CQI efforts included evaluating grievances and appeals and inpatient provider complaints for trends, expanding internally tested peer review and medication monitoring protocols to LEs, and developing a systemwide strategy to reduce hospitalization rates. QAPI activities are reviewed biannually by the Department's QI Council.

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## Introduction

The Los Angeles County Department of Mental Health (LACDMH, Department) authorizes inpatient and provides and contracts for outpatient specialty mental health services (SMHS) for beneficiaries. LACDMH 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 1,000 organizations. More than 250,000 Los Angeles County residents are under the care of LACDMH staff, non-governmental agencies (NGA), and individual practitioners who provide various services. With a $2.4 billion budget, LACDMH aims to provide *hope*, *recovery*, *and well-being* to Los Angeles County at large.

### MISSION

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

### VISION

- We envision a 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 oppurtunities at the right time, in the right place, and from the right people.

**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 Assessment and Performance Improvement (QAPI) Work Plan (WP) that contains goals and needs identified by triennial oversight reviews and the LACDMH system. The Department evaluates the QAPI WP annually and with the involvement of LACDMH staff, providers, and consumers/families. The QAPI evaluation report and WP 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.

At LACDMH, the Quality Improvement (QI) Unit facilitates the planning, design, and execution of the QAPI WP and publishes a summary of these activities annually. Upon request, a summary of prior QAPI activities and findings is available via the QI website at https://dmh.lacounty.gov/qid/.

**Structure of Report**

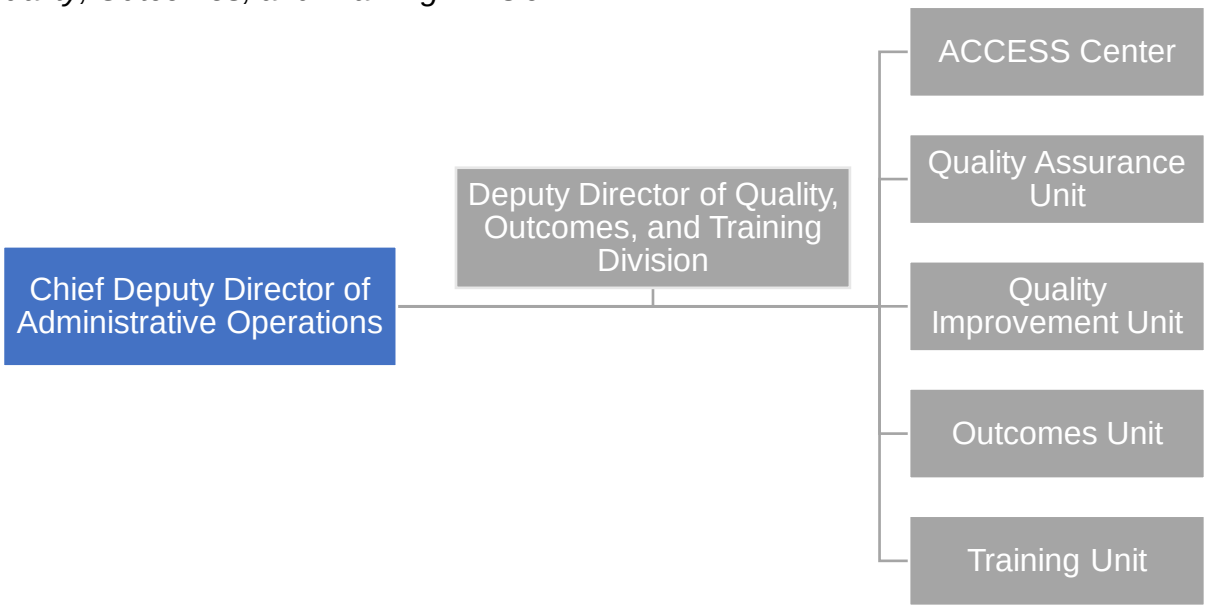
There are five sections in the following report. Section I provides a detailed overview of the QI Unit within the Quality, Outcomes, and Training Division. The QI Unit is responsible for reviewing the quality of SMHS provided to LACDMH consumers. This section describes the Unit's organizational structure and elements. Section II provides a demographic profile of Los Angeles County's residents and LACDMH consumers. This section's race/ethnicity, age group, gender, language, and Service Area (SA) represent strategic data categories. Section III contains the Department's annual QAPI WP Evaluation Report. This section details the progress LACDMH has made concerning the calendar year (CY) 2021 WP goals. Section IV is new to CY 2021 and features the Department's Service Equity Analysis Report. This report's final section (V) presents the QAPI WP for CY 2022.

## Section I. Organizational Structure of the Quality, Outcomes, and Training Division

The reorganization of LACDMH and State mandates on access and timeliness has offered multiple opportunities to highlight the value of QI practices in our collaborative work. The QI Unit has reporting responsibilities to the LACDMH Director, the Chief Deputy Director of Administrative Operations, and the Quality, Outcomes, and Training Division (QOTD; Figure 1). The Division combines four units: Quality Assurance (QA), QI, Outcomes, and Training. 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 centralized, Service Area, and internal QI programs, Cultural Competency Unit, and LACDMH executive management.

**Figure**

1. *Quality, Outcomes, and Training Division*




*Note*: QOTD launched in January 2020.

**Los Angeles County Department of Mental Health's ACCESS Center**

LACDMH's Help Line operates 24/7 and serves as the entry point for mental health services in Los Angeles County. While the majority of calls to the ACCESS Center are for information and referral the line also facilitates the deployment of Field Intervention teams, has a dedicated emotional support line and serves as the gatekeeper for acute inpatient psychiatric beds, interpreter services, and emergency client transportation to psychiatric emergency rooms.

**Quality Assurance Unit**

The QA Unit ensures 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. In addition, the QA Unit is also responsible for the credentialing of clinical staff across the Specialty Mental Health System and manages the electronic data platforms that track and report on timely access and Network Adequacy.

**Outcomes Unit**

The Outcomes Unit is responsible for selecting, developing, disseminating, training, collecting, and reporting outcome measures associated with the Department's mental health programs, including mandated ones. 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 data elements.

**Training Unit**

The Training Unit is responsible for workforce development, ensuring the workforce is trained in effective clinical practice reflective of the clients served. The Training Unit delivers and procures training for the Specialty Mental Health System and manages the Mental Health Loan Repayment Program (through MHSA WET Regional Partnership), the Stipend Program and a host of other financial incentive programs.

**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 of care provided to LACDMH clients. The QI Unit's vision is to promote a QI culture and increase the professional 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 LACDMH, 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 quality assurance, problem resolution, and quality improvement. At LACDMH, 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 LACDMH levels. The departmental QI Unit's design and implementation aim to ensure an organizational culture of continuous self-monitoring through practical strategies, best practices, and collaborative QI activities. The Department's annual QAPI serves as our primary tool for CQI.

Most Salient Quality Improvement Collaborations

The QAPI Work Plan fosters opportunities for input and active involvement of clients/families, licensed and paraprofessional LACDMH staff, contracted providers, and stakeholders. The Department's Quality Improvement Council (QI Council) is centralized with countywide representation and QA/QI liaisons who are heavily involved in providing oversight on QI efforts. Active and ongoing data-driven QI partnerships promote CQI efforts countywide through stakeholder engagement, Plan-Do-Study-Act (PDSA) cycles, and 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 LACDMH 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 LACDMH's outpatient system of care. The committee meets bimonthly, with system-wide data review occurring at least monthly. The committee members work collaboratively to address the internal and external (systemic) factors contributing to timely access challenges seen in the data or identified by providers. The Access to Care Leadership committee's developers ensured QI Unit presence early to bring QI strategies to the workgroup. This inclusion was part of an effort to promote a culture of quality improvement within the Department. This collaboration has evolved, beginning with developing 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 meets 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 provide excellent customer service (internal/external).

### *California Advancing and Innovating Medi-Cal (CalAIM) Implementation*

DHCS released a multilayer approach to simplifying and streamlining the Medi-Cal program, including county Specialty Mental Health Service access criteria, documentation redesign and the implementation of No Wrong Door, the screening and transition tools and eventually payment reform.

### *Chief Information Office Bureau (CIOB)*

A large portion of the Department's CQI work requires ongoing coordination with CIOB, namely:

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

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 QAPI WP 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 engages and supports QI Council members in QI processes related to the QAPI WP, specific PIP activities, and other QI projects conducted at the SA level. 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 LACDMH beneficiaries. LACDMH strives for PIP teams that are diverse and inclusive. Each committee member participates on a volunteer basis due to special interests.

### *Quality Assurance*

QA and QI 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 the Centralized QA/QI Liaisons' broadcast monthly to integrate departmental QA goals alongside discussions of QI practices.

### *Stakeholder Engagement*

The QI Council encourages stakeholder involvement in all QI activities. More recently, LACDMH 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 LACDMH services. In conformance with Federal, State, and local QI requirements, the QI Unit oversees technical reporting related to the annual QAPI WP and Evaluation Report, LACDMH Help Line's Test Calls Study, client/family 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 must maintain up-to-date knowledge of 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. Effective communication and collaboration with other LACDMH 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 is responsible for maintaining and improving its service and delivery infrastructure with its providers.

Council Membership

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

- Compliance, Privacy, and Audit Services;
- Clinical Policy and Standards;
- Cultural Competency Unit;
- Patient's Rights Office;
- LACDMH's Peer Resource Center;
- LACDMH's Help Line;
- 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 representing the 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 the 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 LACDMH staff collaborate on measurable QAPI WP goals to evaluate annual performance management activities. The annual QAPI WP goals 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 QAPI WP 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 various partners and programs across the Department.

Summary

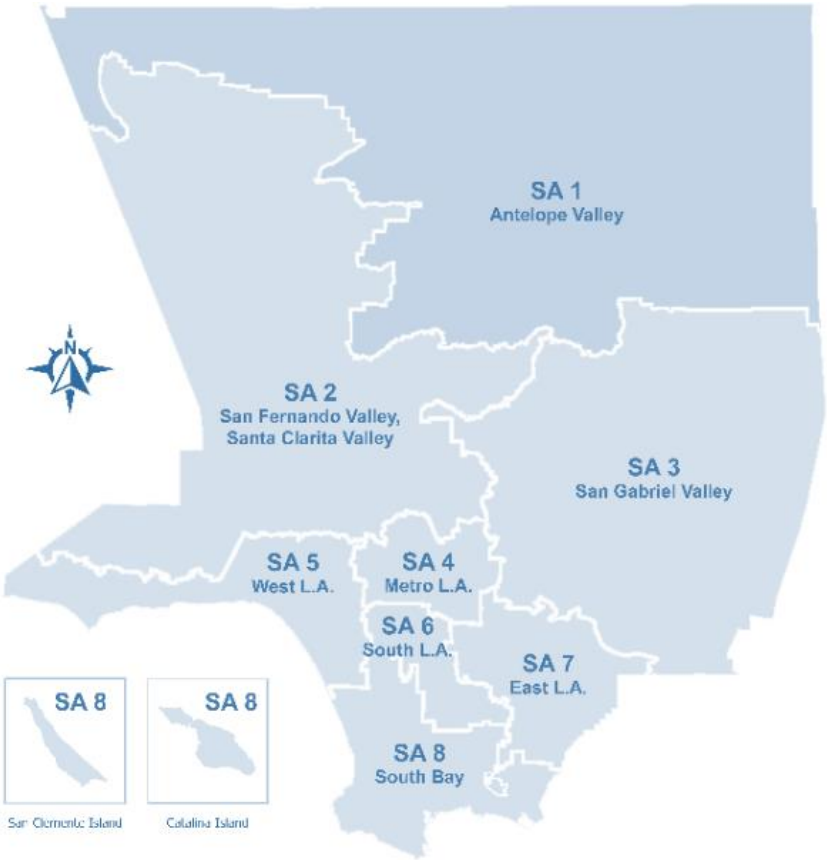
The QI Council charter further supports LACDMH in maintaining a culture of CQI. The QI Council and SA QICs foster the ideal environments to discuss QI activities, identify possible best practices, and maintain performance standards aligned with the Department's mission and DHCS contract. The CCU supervisor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

## Geographical Characteristics of Los Angeles County

Due to its large size, Los Angeles County is organized into eight Service Planning Areas (SA, Figure 2). Each SA is uniquely diverse in demographic and regional characteristics. LACDMH service delivery mirrors the geographical boundaries to support accessibility; however, clients/families are free to seek services in any SA or mental health program within the MHP's network of providers

**Figure**

2. *Map of Los Angeles County Service Planning Areas*




The Antelope Valley area, or SA 1, consists of two legal cities, or 3.9% of all cities in Los Angeles County. SA 1 is the largest geographical but the least densely populated. SA 2, the San Fernando area, consists of 11 legal cities, or 22% of all cities. SA 2 is the most densely populated. The San Gabriel Valley area, or SA 3, consists of 30 legal cities, or 17.6% of all cities. SA 4 is the county's Metro area and consists of two legal cities, or 11.5% of all cities. SA 4 has the highest number of individuals experiencing homelessness within its boundaries. SA 5 represents the West and comprises five legal cities, or 6.5% of all. The South, or SA 6, consists of five legal cities, or 10.3% of all cities. It has the highest poverty rate in the county. The East, or SA 7, consists of 21 legal cities, or 12.9% of all cities. SA 8 is the South Bay area and consists of 20 legal cities, or 15.4% of all cities in Los Angeles County.

## Section II. Population Needs Assessment

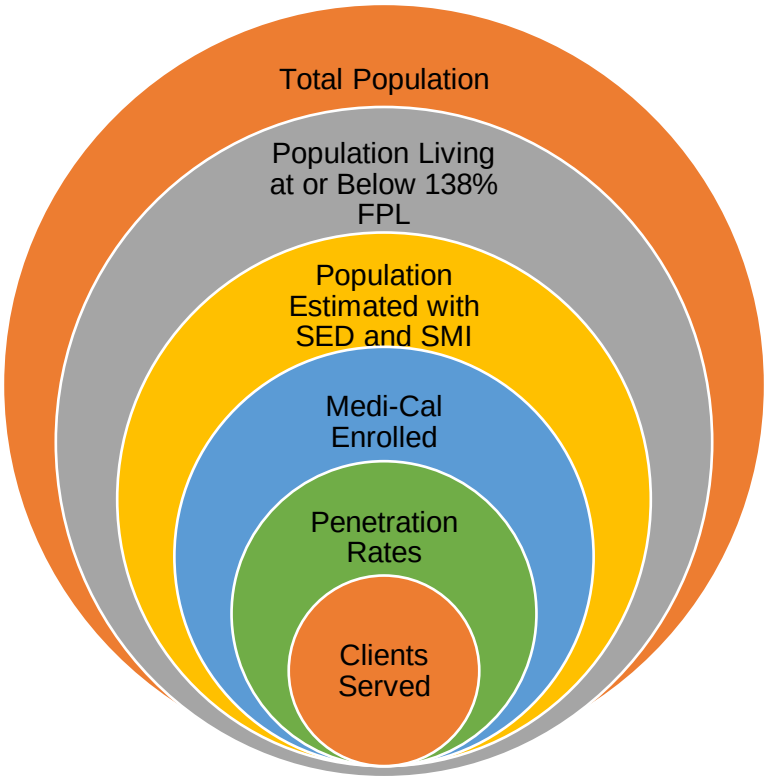
Last Revised Date: 8/4/22

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

LACDMH relies on six core data sets when evaluating our service delivery to groups (Figure 3). They reflect the total population of Los Angeles County and those living at or below the county's federal poverty level. Using trend analysis clarifies changes in population demographics and performance measures over time. This information also supports the Department's efforts to assess its capacity to serve clients with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) regardless of race/ethnicity, age group, or gender.

**Figure**

3. *Strategic Data Sets for Estimating Los Angeles County's Population Demographics and Needs*




Note: Population and poverty estimates are available by each SA, race/ethnicity, age group, and gender. The distribution of primary language is evaluated for the Medi-Cal Enrolled and Clients Served data. CIOB applies to 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.

**Methods**

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

Estimated prevalence rates for individuals with SED and SMI are derived using the prevalence rates estimated through the California Health Interview Survey (CHIS), that are conducted every two years by the University of California, Los Angeles (UCLA). This report includes pooled prevalence estimates by CHIS in CY 2020 and CY 2021.

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

Access to services is assessed by calculating Penetration Rates among clients and beneficiaries served in Outpatient facilities in Fiscal Year (FY) 2020-21. The count of clients served does not include those served in 24 Hour/Residential programs such as inpatient hospitals (both County and Fee-For-Service), residential facilities, Institutions of Mental Disease (IMD), Skilled Nursing Facilities (SNF), Psychiatric Health Facilities (PHF), and clients served in Fee-For-Service 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.”

**Evaluation of Los Angeles County's Population and Mental Health Plan's Demographics by Race/Ethnicity**

Total Population

At 48.0%, the Latino group is the most represented among Los Angeles County's residents. In CY 2020, SA 6 had the highest concentration of Latino residents. The smallest group among residents was Native Americans, at 0.19%. Between CY 2018 and CY 2020, the White group declined by 2.4 PP, the most considerable total population shift among all races/ethnicities.

**Figure**

4. *Race/Ethnicity Distribution for Total Population, Calendar Year 2020*

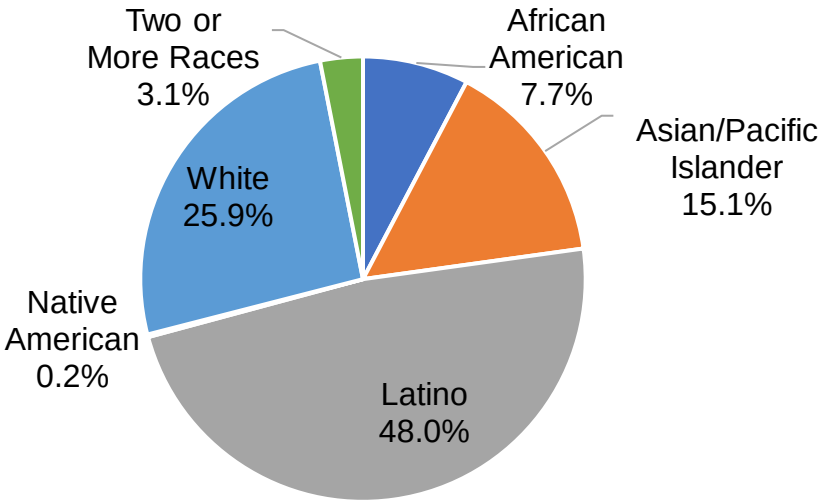



Figure 4 represents the distribution of races/ethnicities among Los Angeles County residents. Latinos are the largest group at 48.0%, Whites at 25.9%, Asian/Pacific Islanders at 15.1%, African Americans at 7.7%, Two or More Races at 3.1%, and Native Americans at 0.2%. The N for the Latino category is 4,803,963. The N for the White category is 2,594,341. The N for the Asian/Pacific Islander category is 1,507,702. The N for the African American category is 773,282. The N for the Two or More Races category is 314,524. The N for the Native American category is 18,602. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services. Prepared by CIOB in May 2022.

**Table**

1. *Total Population by Race/Ethnicity and Service Area, Calendar Year 2020*

| SA | African American | Asian/Pacific Islander | Latino | Native American | White | Two or More Races | Total |
|---|---|---|---|---|---|---|---|
| **SA 1** | 62,383 | 16,691 | 218,503 | 1,471 | 103,725 | 15,273 | 418,046 |
| Percent | 14.9% | 4.0% | 52.3% | **0.35%** | 24.8% | 3.7% | 100.0% |
| **SA 2** | 79,672 | 260,898 | 867,861 | 3,504 | 918,778 | 77,926 | 2,208,639 |
| Percent | 3.6% | 11.8% | 39.3% | 0.16% | 41.6% | 3.5% | 100.0% |
| **SA 3** | 54,476 | 546,511 | 802,885 | 2,877 | 304,911 | 41,922 | 1,753,582 |
| Percent | 3.1% | **31.2%** | 45.8% | 0.16% | 17.4% | 2.4% | 100.0% |
| **SA 4** | 62,046 | 191,774 | 520,983 | 2,300 | 306,752 | 36,686 | 1,120,541 |
| Percent | 5.5% | 17.1% | 46.5% | 0.21% | 27.4% | 3.3% | 100.0% |
| **SA 5** | 33,383 | 91,873 | 105,216 | 952 | 395,198 | 38,168 | 664,790 |
| Percent | 5.0% | 13.8% | **15.8%** | **0.14%** | **59.4%** | **5.7%** | 100.0% |
| **SA 6** | 235,154 | 24,396 | 703,549 | 1,513 | 32,713 | 18,944 | 1,016,269 |
| Percent | **23.1%** | **2.4%** | **69.2%** | 0.15% | **3.2%** | 1.9% | 100.0% |
| **SA 7** | 38,727 | 128,944 | 950,243 | 2,800 | 140,197 | 20,138 | 1,281,049 |
| Percent | **3.0%** | 10.1% | 74.2% | 0.22% | 10.9% | **1.6%** | 100.0% |
| **SA 8** | 207,441 | 246,615 | 634,723 | 3,185 | 392,067 | 65,467 | 1,549,498 |
| Percent | 13.4% | 15.9% | 41.0% | 0.21% | 25.3% | 4.2% | 100.0% |
| **Total** | 773,282 | 1,507,702 | 4,803,963 | 18,602 | 2,594,341 | 314,524 | 10,012,414 |
| Percent | 7.7% | 15.1% | 48.0% | 0.19% | 25.9% | 3.1% | 100.0% |

Table 1 presents race/ethnicity distribution across Los Angeles's total population by Service Area. Bold values represent the highest and lowest percentages within each racial category and across all SAs. The highest percentage of African Americans was in SA 6 (23.1%) compared to SA 7 (3.0%), with the lowest percentage. The highest percentage of API was in SA 3 (31.2%) compared to SA 6 (2.4%), with the lowest. The highest percentage of Latinos was in SA 6 (69.2%) compared to SA 5 (15.8%), with the lowest. The highest percentage of Native Americans was in SA 1 (0.35%) compared to SA 5 (0.14%), with the lowest. The highest percentage of Whites was in SA 5 (59.4%) compared to SA 6 (3.2%), with the lowest. The highest percentage of Two or more races was in SA 5 (5.7%) compared to SA 7 (1.6%) with the lowest. Some totals/percentages may not total 100% due to rounding. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2022.

**Figure**

5. *Three-Year Trends for Total Population by Race/Ethnicity*

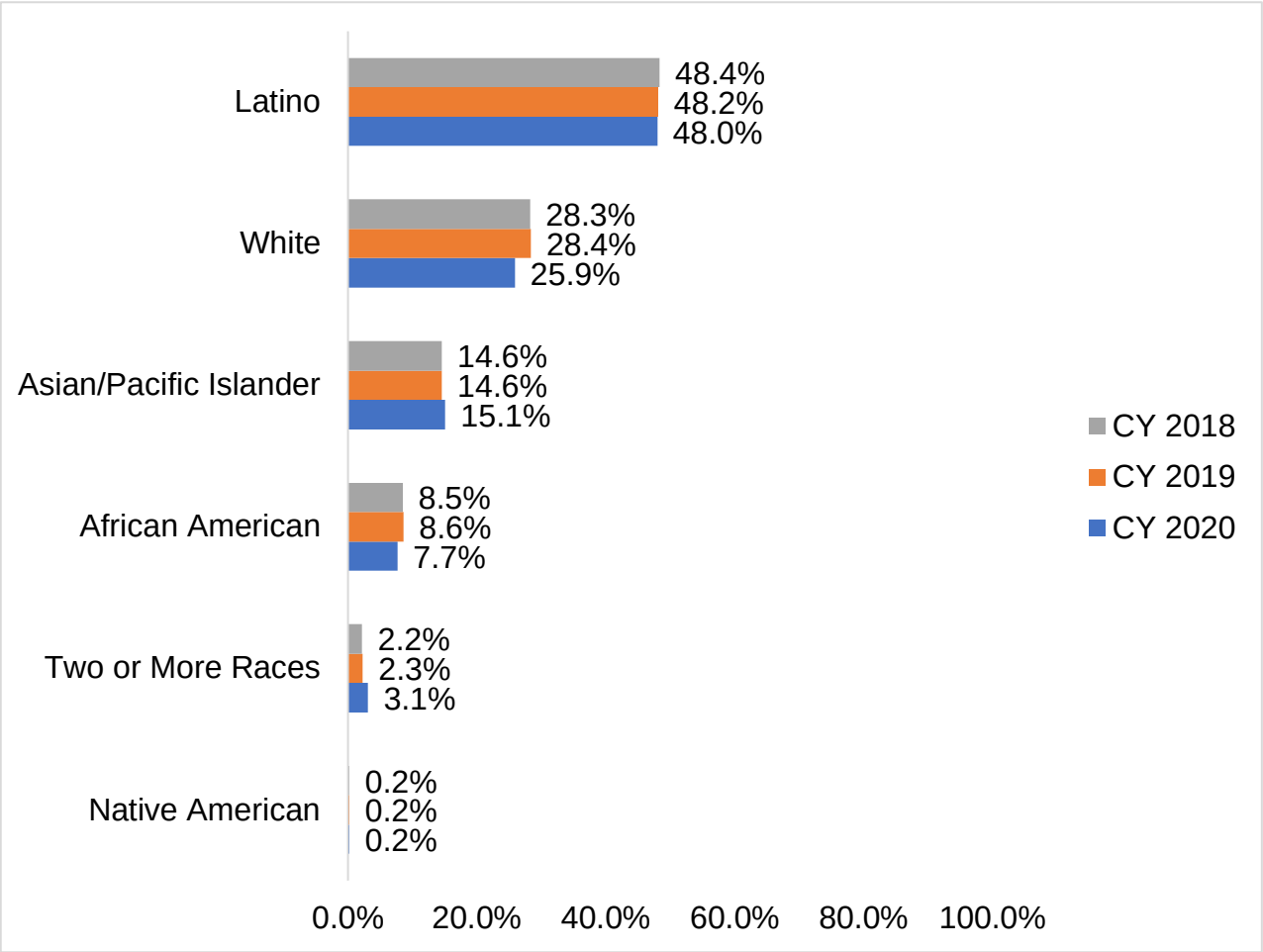



Figure 5 displays the three-year race/ethnicity distribution trends among Los Angeles County's total population. The percentage of Latinos has declined by 0.4 percentage points (PP) between CY 2018 and CY 2020. Whites declined by 2.4 PP during the same three years, API increased by 0.5 PP, and African Americans declined by 0.8 PP. Two or More Races increased by 0.9 PP, and Native Americans remained the same. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, CYs 2018 to 2020, prepared by CIOB in May 2022.

Estimated Population Living at or below 138% FPL

Between CY 2018 and CY 2020, the most notable population shifts concerning poverty estimates were noted for the Asian Pacific Islander (-1.2 PP) and African American (-0.7 PP) groups. At 59.8%, the Latino group was the most represented among Los Angeles County's estimated population living at or below 138% FPL. In CY 2020, SA 7 had the highest number of Latinos, estimated to be at or below 138% FPL. The Native American group had the lowest number of residents, estimated at or below 138% FPL, with the highest concentration residing in SA 1.

**Figure**

6. *Race/Ethnicity Distribution for Estimated Population Living at or below 138% Federal Poverty Level, Calendar Year 2020*

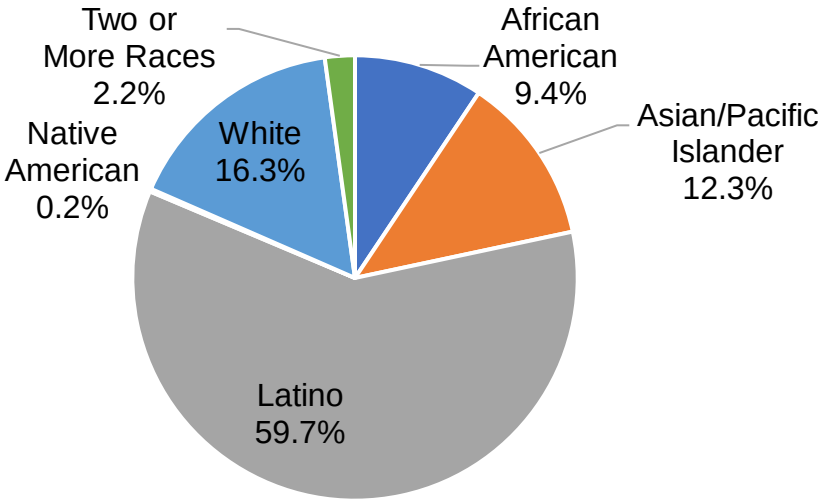



Figure 6 represents the distribution of race/ethnicity among the estimated population living at or below 138% FPL. Latinos are the largest group (59.7%), followed by Whites (16.3%), API (12.3%), African Americans (9.4%), Two or More Races (2.2%), and Native Americans (2.2%). The N for the Latino category is 1,143,924. The N for the White category is 311,293. The N for the Asian/Pacific Islander category is 234,816. The N for the African American category is 179,112. The N for the Two or More Races category is 41,705. The N for the Native American category is 3,249. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services. Prepared by CIOB in May 2022.

**Table**

2. *Distribution of Race/Ethnicity among the Estimated Population Living at or below 138% Federal Poverty Level by Service Area*

| SA | African American | Asian/ Pacific Islander | Latino | Native American | White | Two or More Races | Total |
|---|---|---|---|---|---|---|---|
| **SA 1** | 18,463 | 2,866 | 61,123 | 391 | 19,252 | 3,758 | 105,853 |
| Percent | 17.4% | 2.7% | 57.7% | **0.37%** | 18.2% | 3.55% | 100.0% |
| **SA 2** | 12,305 | 36,061 | 181,524 | 393 | 113,820 | 8,389 | 352,492 |
| Percent | 3.5% | 10.2% | 51.5% | 0.11% | 32.3% | 2.38% | 100.0% |
| **SA 3** | 7,165 | 78,334 | 145,762 | 269 | 29,341 | 3,279 | 264,150 |
| Percent | 2.7% | **29.7%** | 55.2% | 0.10% | 11.1% | 1.24% | 100.0% |
| **SA 4** | 14,079 | 48,124 | 156,058 | 705 | 49,623 | 7,033 | 275,622 |
| Percent | 5.1% | 17.5% | 56.6% | 0.26% | 18.0% | 2.55% | 100.0% |
| **SA 5** | 3,944 | 12,307 | 15,097 | 55 | 42,643 | 4,003 | 78,049 |
| Percent | 5.1% | 15.8% | **19.3%** | **0.07%** | **54.6%** | **5.13%** | 100.0% |
| **SA 6** | 72,496 | 8,912 | 244,064 | 640 | 8,146 | 5,933 | 340,191 |
| Percent | **21.3%** | **2.6%** | 71.7% | 0.19% | **2.4%** | 1.74% | 100.0% |
| **SA 7** | 5,023 | 12,815 | 194,100 | 293 | 11,777 | 1,244 | 225,252 |
| Percent | **2.2%** | 5.7% | **86.2%** | 0.13% | 5.2% | **0.55%** | 100.0% |
| **SA 8** | 45,637 | 35,397 | 146,196 | 503 | 36,691 | 8,066 | 272,490 |
| Percent | 16.7% | 13.0% | 53.7% | 0.18% | 13.5% | 2.96% | 100.0% |
| **Total** | 179,112 | 234,816 | 1,143,924 | 3,249 | 311,293 | 41,705 | 1,914,099 |
| Percent | 9.4% | 12.3% | 59.8% | 0.2% | 16.3% | 2.18% | 100.0% |

Table 2 shows the distribution of race/ethnicity among the estimated population living at or below 138% FPL by SA. Bold values represent the highest and lowest percentages within each racial category and across Service Areas. The highest percentage of African Americans was in SA 6 (21.3%) compared to SA 7 (2.2%), with the lowest percentage. The highest percentage of API was in SA 3 (29.7%) compared to SA 6 (2.6%), with the lowest. The highest percentage of Latinos was in SA 7 (86.2%) compared to SA 5 (19.3%), with the lowest. The highest percentage of Native Americans was in SA 1 (0.37%) compared to SA 5 (0.07%), with the lowest. The highest percentage of Whites was in SA 5 (54.6%) compared to SA 6 (2.4%), with the lowest. The highest percentage of Two or more Races was in SA 5 (5.1%) compared to SA 7 (0.55%) with the lowest. Data Sources: ACS, US Census Bureau, and Hedderson Demographic Services, 2021, prepared by CIOB in May 2022

**Figure**

7. *Race/Ethnicity Trends among the Estimated Population Living at or below 138% Federal Poverty Level, Calendar Years 2018 to 2020*

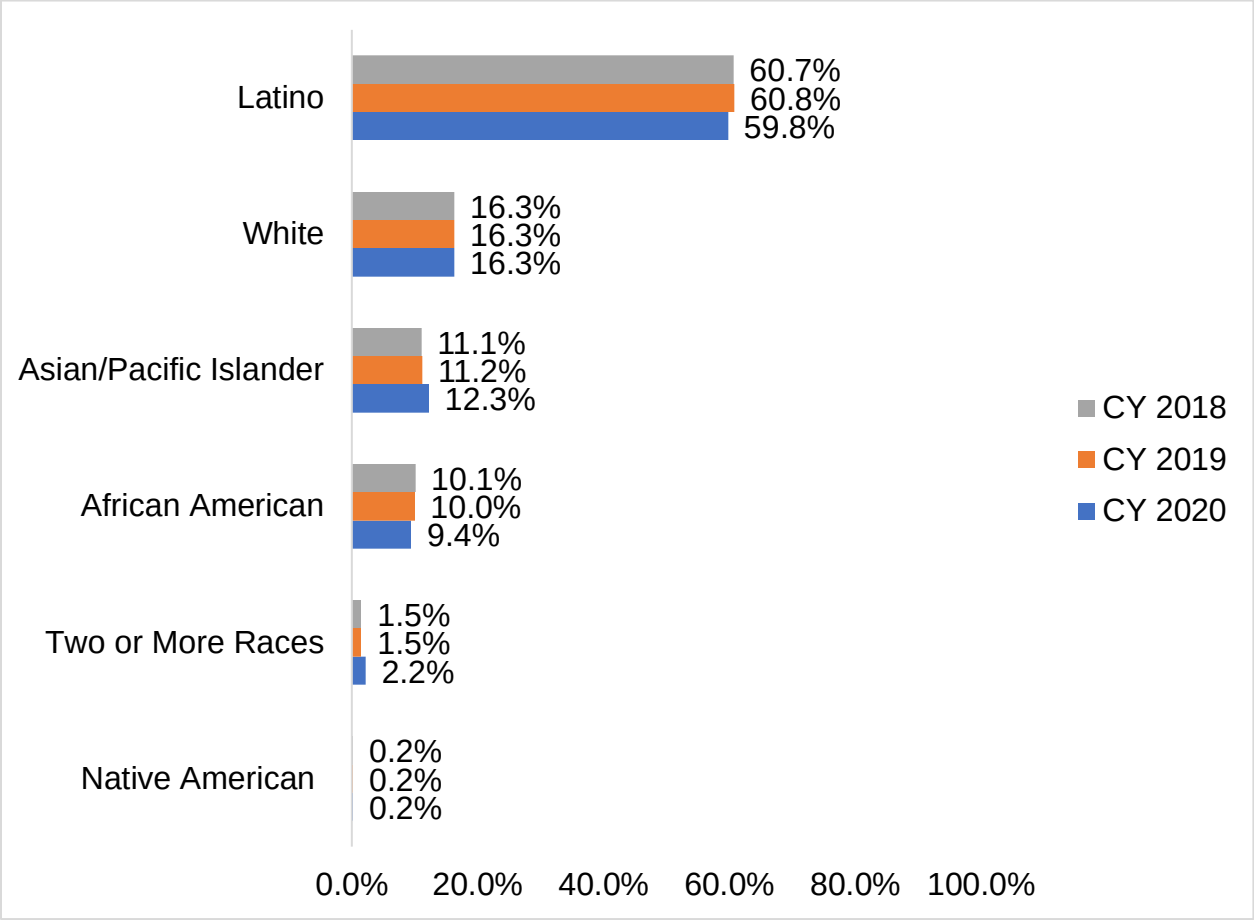



Figure 7 shows a three-year analysis of race/ethnicity for the estimated population at or below 138% FPL. Some totals/percentages may not total 100% due to rounding. The percentage of Latinos has declined by 0.9 PP between CY 2018 and CY 2020. Whites remained the same for three years; API increased by 1.2 PP, and African Americans declined by 0.7 PP. Two or More Races increased by 0.7 PP, and Native Americans remained the same. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB in May 2022.

Estimated Prevalence of SED and SMI

Poverty estimates were evaluated for the prevalence of Severe Emotional Disturbance (SED) in Children and TAY and Serious Mental Illness (SMI) in Adults and Older Adults. At 51.1%, Latinos estimated at or below 138% FPL had the highest prevalence of SED and SMI, and Native Americans (0.4%) had the lowest.

**Figure**

8. *Distribution of Race/Ethnicity for Estimated Prevalence of SED and SMI*

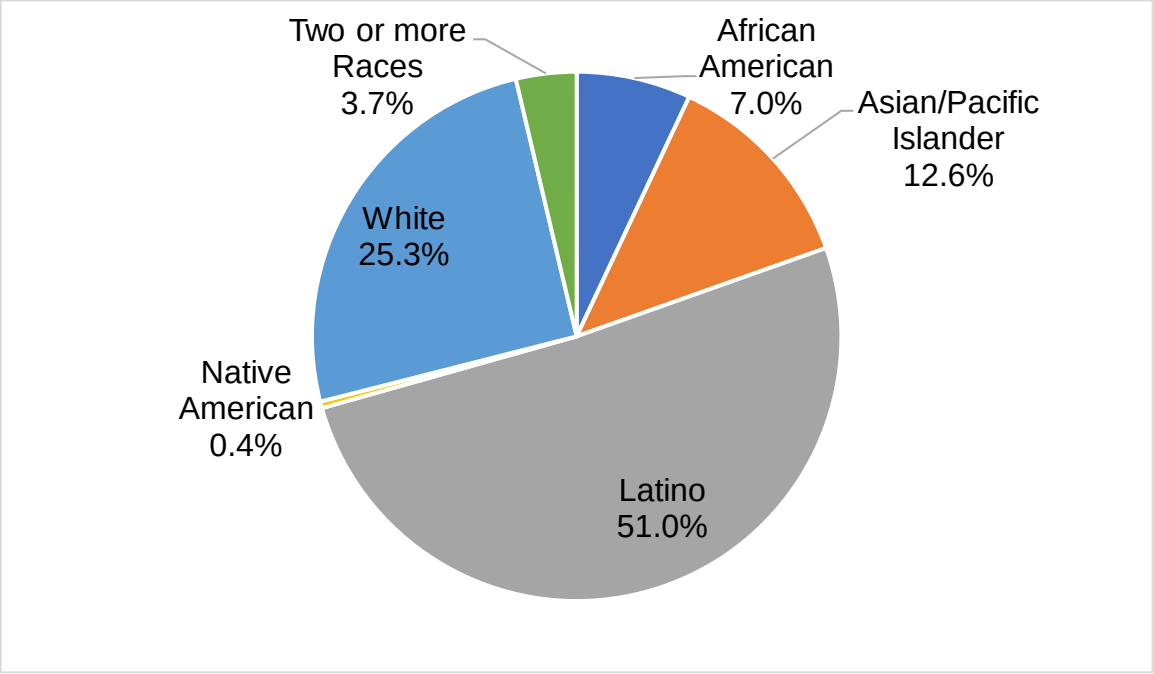



Figure 8 presents the distribution of race/ethnicity among Los Angeles County's population, estimated at or below 138% FPL, and the prevalence of SED or SMI in CY 2020. The Latino group was the largest (51.0%), followed by Whites (25.3%), API (12.6%), African American (7.0%), Two or more Races (3.7%), and Native American (0.4%). The N for the Latino group was 735,006. The N for the White group was 363,208, 180,924 for the Asian/Pacific Islander group, and 100,527 for African Americans. The N for the Two or More Races group was 52,840. The N for the Native American group was 5,860. Estimated prevalence rates of mental illness by Ethnicity for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL

**Table**

3. *Estimated Prevalence of SED and SMI among the Estimated Population Living at or below 138% Federal Poverty Level*

| SA | African American | Asian/Pacific Islander | Latino | Native American | White | Two or More Races | Total |
|---|---|---|---|---|---|---|---|
| **SA 1** | 3,213 | 461 | 10,146 | 183 | 3,966 | 744 | 18,713 |
| Percent | 17.2% | **2.5%** | 54.2% | **0.98%** | 21.2% | 4.0% | 100.0% |
| **SA 2** | 2,141 | 5,806 | 30,133 | 184 | 23,447 | 1,661 | 63,371 |
| Percent | 3.4% | 9.2% | 47.5% | 0.29% | 37.0% | 2.6% | 100.0% |
| **SA 3** | 1,247 | 12,612 | 24,196 | 126 | 6,044 | 649 | 44,874 |
| Percent | 2.8% | **28.1%** | 53.9% | 0.28% | 13.5% | **1.4%** | 100.0% |
| **SA 4** | 2,450 | 7,748 | 25,906 | 329 | 10,222 | 1,393 | 48,047 |
| Percent | 5.1% | 16.1% | 53.9% | 0.69% | 21.3% | 2.9% | 100.0% |
| **SA 5** | 686 | 1,981 | 2,506 | 26 | 8,784 | 793 | 14,777 |
| Percent | 4.6% | 13.4% | **17.0%** | **0.17%** | **59.4%** | **5.4%** | 100.0% |
| **SA 6** | 12,614 | 1,435 | 40,515 | 299 | 1,678 | 1,175 | 57,715 |
| Percent | **21.9%** | **2.5%** | 70.2% | 0.52% | **2.9%** | 2.0% | 100.0% |
| **SA 7** | 874 | 2,063 | 32,221 | 137 | 2,426 | 246 | 37,967 |
| Percent | **2.3%** | 5.4% | **84.9%** | 0.36% | 6.4% | **0.6%** | 100.0% |
| **SA 8** | 7,941 | 5,699 | 24,269 | 235 | 7,558 | 1,597 | 47,299 |
| Percent | 16.8% | 12.0% | 51.3% | 0.50% | 16.0% | 3.4% | 100.0% |
| Total | 31,165 | 37,805 | 189,891 | 1,517 | 64,126 | 8,258 | 332,763 |
| Percent | 9.4% | 11.4% | 57.1% | 0.46% | 19.3% | 2.5% | 100.0% |

Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL. They are pooled estimates for CY 2019 and CY 2020. Note: Bold values represent the highest and lowest percentages across all SAs. The highest SED and SMI prevalence rate among the African American group was in SA 6 (20.5%) compared to SA 7 (2.7%), with the lowest. The highest SED and SMI prevalence rate among the API group was in SA 3 (26.6%) compared to SA 6 (2.0%), with the lowest. The highest SED and SMI prevalence rate among the Latino group was in SA 7 (76.6%) compared to SA 5 (17.2%), with the lowest. The highest SED and SMI rate among the Native American group was in SA 1 (0.8%), whereas SAs 2, 5, and 7 (0.3%) had the lowest. The highest prevalence rate of SED and SMI among the White group was in SA 5 (59.2%) compared to SA 6 (3.1%) with the lowest. The highest prevalence rate of SED and SMI among the Two or more Races group was in SA 5 (6.9%) compared to SA 7 (1.8%) with the lowest. Trending data was not included as QI did not examine prevalence rates for CY 2018, CY 2019, and CY 2020. Due to rounding, some estimated numbers and percentages may not total 100%. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2021

Population Enrolled in Medi-Cal

The Hispanic group was the race/ethnicity with the highest Medi-Cal enrollment (58.3%). At less than 0.1% of the total population deemed eligible for Medi-Cal benefits, American Indian/Alaska Native was the lowest. The percent of not reported races/ethnicities increased by 1.4 PP between CY 2020 and CY 2021, with little to no shifts in Medi-Cal enrollment across the remaining groups.

**Figure**

9. *Distribution of Race/Ethnicity among Los Angeles County's Medi-Cal Eligibles*

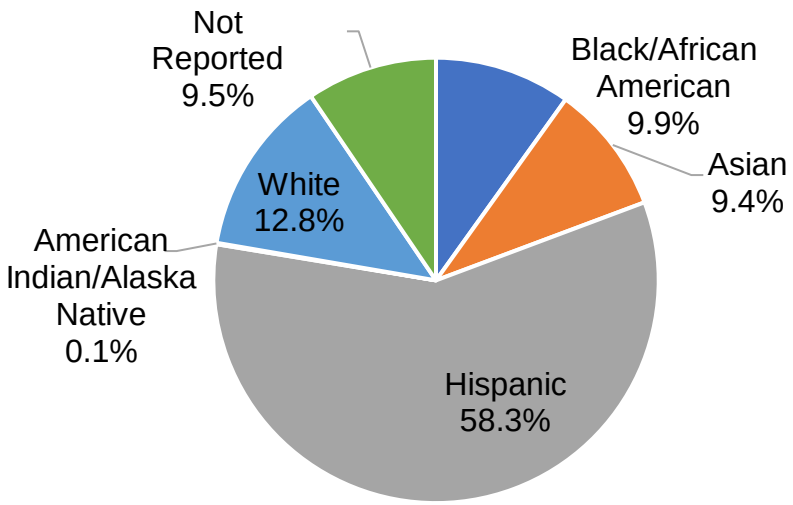



Figure 9 presents the estimated Los Angeles County population deemed eligible for Medi-Cal based on valid eligibility determination by racial categories. Approximately 389,312 Medi-Cal eligible had unreported races/ethnicities. The Hispanic (58.3%) group was the largest, followed by Whites (12.8%), Black/African American (9.9%), Not Reported ethnicities (9.5%), Asian (0.1%), and American Indian/Alaska Native (0.1%). The N for the White group was 525,480, followed by 404,603 Black/African Americans, 385,506 Asians, and 5,020 AI/ANs. The N for the Hispanic group was 2,386,900. Data were not available by SA. 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 December 28, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

**Figure**

*10. Three-year Trends for Population Enrolled in Medi-Cal by Race/Ethnicity, CY 2019 to CY 2021*

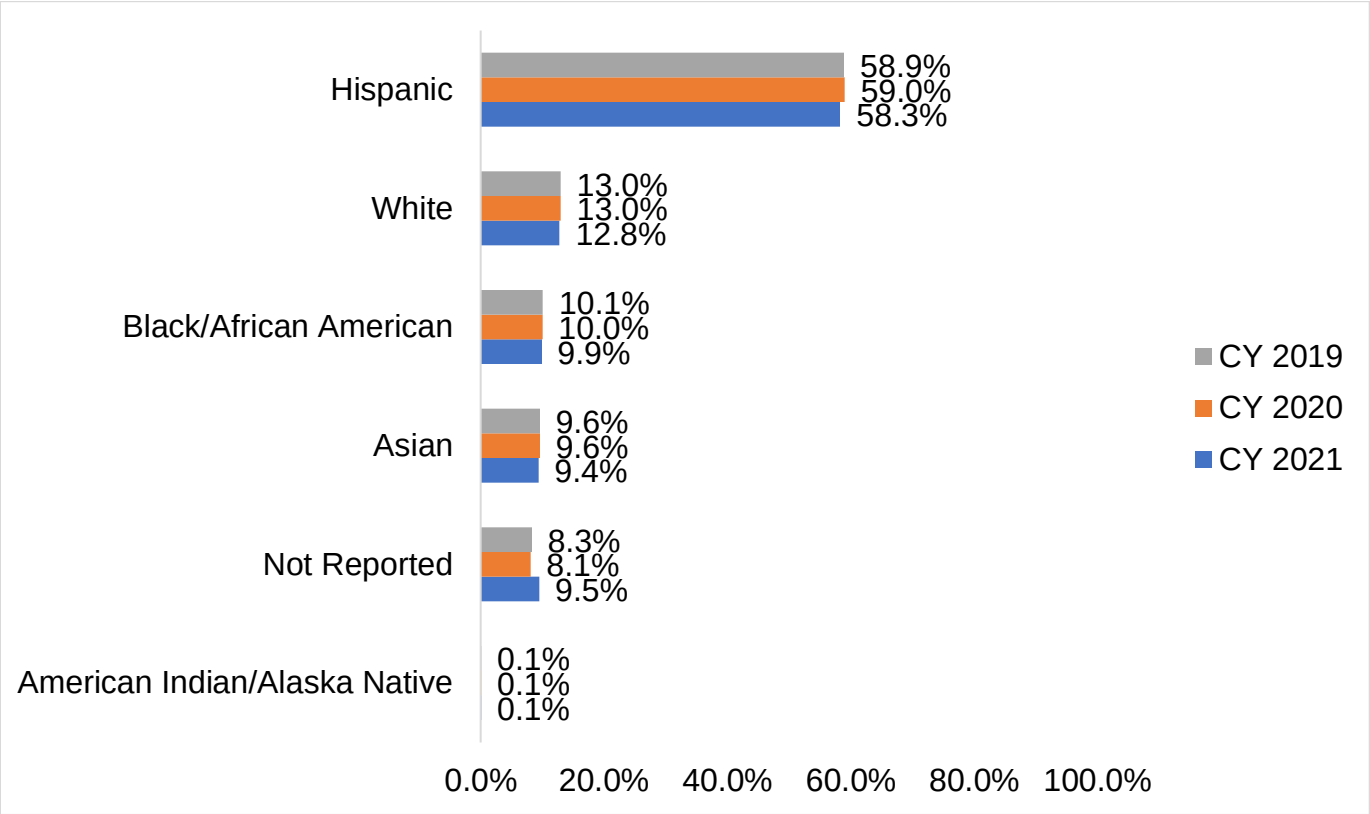



Figure 10 presents Los Angeles County's three-year trends in Medi-Cal Eligibles by race/ethnicity. Between CY 2019 to CY 2021, The Hispanic group declined by 0.6 PP, the White group declined by 0.2 PP, the Black /African American and Asian groups each declined by 0.2 PP, and the American Indian/Alaska Native group remained the same. Of note, the Not Reported category increased by 1.2 PP. 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, CY 2019 to CY 2021. Due to rounding, some estimated totals and percentages may not total 100%.

Clients Served

The Latino community is the most represented among clients receiving outpatient services with a LACDMH program. The API and Native American communities are the least represented and most unchanged among clients served.

**Figure**

*11. Distribution of Races/Ethnicities for Clients Served in LACDMH Outpatient Clinics*

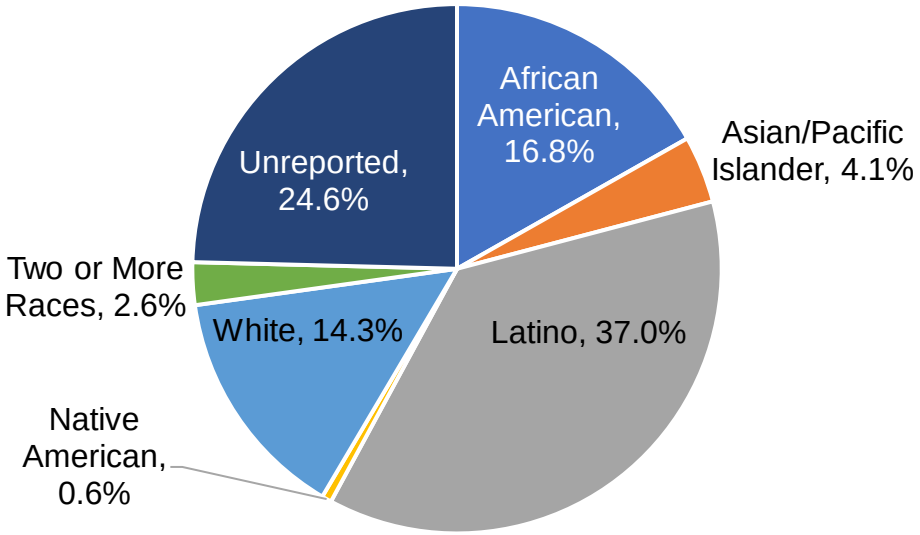



Figure 11 presents the distribution of race/ethnicity for clients served in LACDMH's outpatient clinics. The Latino group is the largest at 37.0%, African American at 16.8%, White at 14.3%, API at 4.1%, Two or more Races at 2.6%, and Native American at 0.6%. Approximately 25% of our clients served have unknown races/ethnicities. The N for the Latino group is 74,336. The N for the Unreported category is 49,508. The N for the African American group is 33,771. The N for the White group is 28,755. The N for the Two or more Races group is 5,311. The N for the Native American group is 1,112. Data Source: LACDMH-IS-IBHIS, August 2022.

**Table**

4. *Distribution of Races/Ethnicities for Clients Served in LACDMH Outpatient Clinics by Service Area*

| SA | African American | Asian/ Pacific Islander | Latino | Native American | White | Two or More Races | Unreported | Total |
|---|---|---|---|---|---|---|---|---|
| **SA 1** | 6,976 | 245 | 6,423 | 135 | 4,672 | 1,100 | 2,651 | 22,202 |
| Percent | 31.4% | 1.1% | 28.9% | 0.6% | 21.0% | **5.0%** | **11.9%** | 100.0% |
| **SA 2** | 3,629 | 1,464 | 19,972 | 161 | 11,784 | 1,483 | 11,633 | 50,126 |
| Percent | 7.2% | 2.9% | 39.8% | **0.3%** | 23.5% | 3.0% | 23.2% | 100.0% |
| **SA 3** | 2,892 | 3,056 | 12,805 | 212 | 4,912 | 1,140 | 17,324 | 42,341 |
| Percent | 6.8% | **7.2%** | 30.2% | 0.5% | 11.6% | 2.7% | **40.9%** | 100.0% |
| **SA 4** | 6,021 | 2,065 | 15,908 | 194 | 5,769 | 800 | 8,393 | 39,150 |
| Percent | 15.4% | 5.3% | 40.6% | 0.5% | 14.7% | 2.0% | 21.4% | 100.0% |
| **SA 5** | 1,805 | 347 | 2,116 | 50 | 3,294 | 309 | 2,659 | 10,580 |
| Percent | 17.1% | 3.3% | **20.0%** | 0.5% | **31.1%** | 2.9% | 25.1% | 100.0% |
| **SA 6** | 18,451 | 476 | 20,788 | 564 | 2,693 | 867 | 10,004 | 53,843 |
| Percent | **34.3%** | **0.9%** | 38.6% | **1.0%** | **5.0%** | **1.6%** | 18.6% | 100.0% |
| **SA 7** | 1,970 | 949 | 18,625 | 195 | 3,589 | 1,062 | 11,889 | 38,279 |
| Percent | **5.1%** | 2.5% | **48.7%** | 0.5% | 9.4% | 2.8% | 31.1% | 100.0% |
| **SA 8** | 10,616 | 2,185 | 13,690 | 229 | 6,066 | 1,373 | 9,154 | 43,313 |
| Percent | 24.5% | 5.0% | 31.6% | 0.5% | 14.0% | 3.2% | 21.1% | 100.0% |
| **Total** | 33,771 | 8,197 | 74,336 | 1,112 | 28,755 | 5,311 | 49,508 | 200,990 |
| Percent | 16.8% | 4.1% | 37.0% | 0.6% | 14.3% | 2.6% | 24.6% | 100.0% |

Table 4 presents race/ethnicity distribution across LACDMH's clients served by Service Area. Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. The highest percentage of African Americans served was in SA 6 (34.3%) compared to SA 7 (5.1%), with the lowest. The highest percentage of API clients served was in SA 3 (7.2%) compared to SA 6 (0.9%), with the lowest. The highest percentage of Latino clients were served in SA 7 (48.7%) compared to SA 5 (20.0%), with the lowest. The highest percentage of Native American clients served was in SA 6 (1.0%) compared to SA 2 (0.3%), with the lowest. The highest percentages of Whites were served in SA 5 (31.5%) compared to SA 6 (5.0%), with the lowest. The highest percentage of clients with Two or more Races was in SA 1 (5.0%) compared to SA 6 (1.6%). Almost 41% of clients served in SA 3 have unreported races/ethnicities, the highest of all SAs. The table excludes Unknown addresses (N= 12,547), Out of LA, and Out of State (N = 3,227). The total reflects an unduplicated count of clients served. Data Source: LACDMH-IS-IBHIS, August 2022.

**Figure**

*12. Three-Year Trend in Distribution of Races/Ethnicities for Clients Served in LACDMH Outpatient Clinics*

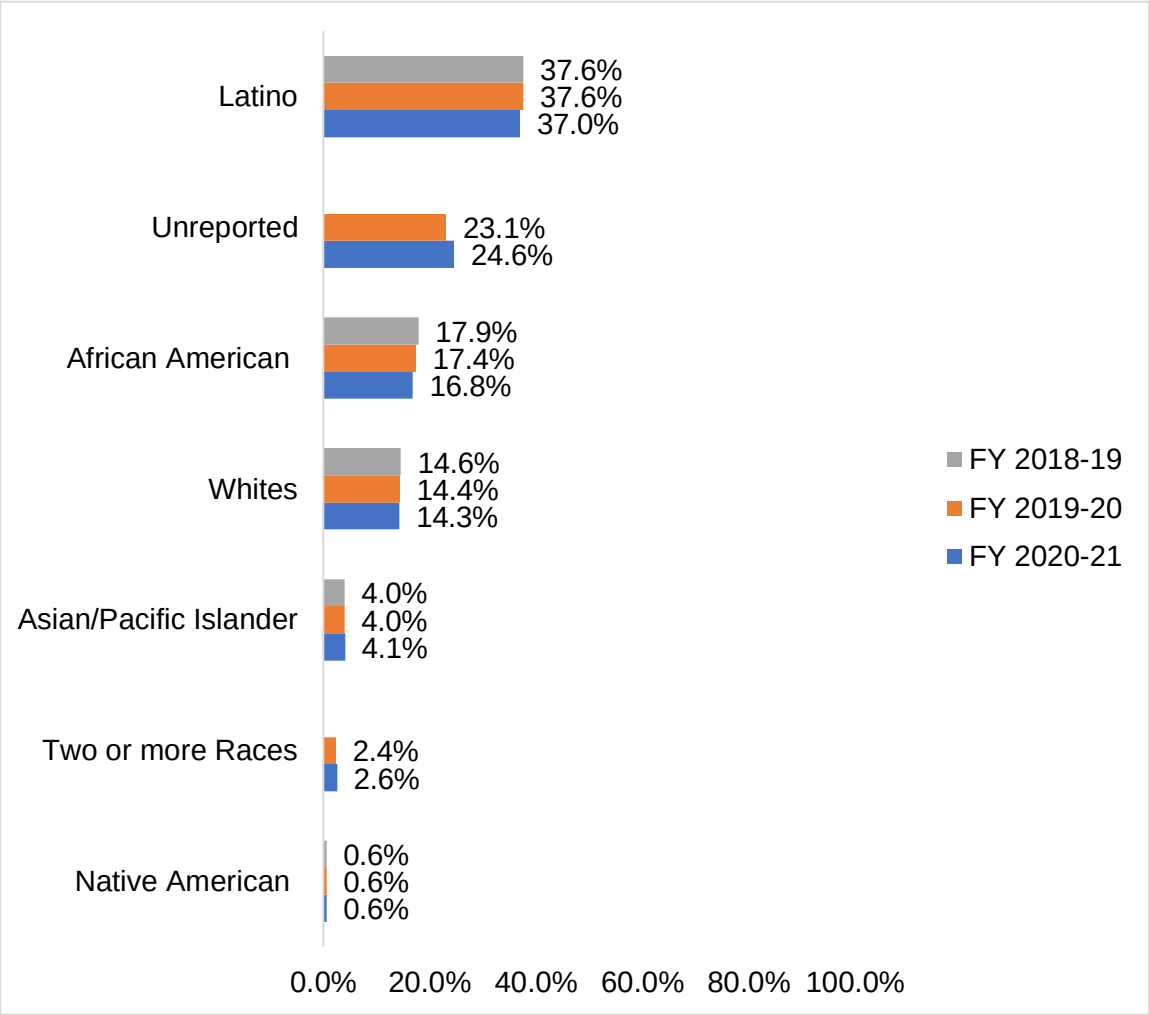



Figure 12 presents the distribution of race/ethnicity among LACDMH clients between FY2018-19 to FY 2020-21. Between FY 2018-19 and FY 2020-21, the Latino group increased by 0.6 PP, African Americans declined by 1.1 PP, White declined by 0.3 PP, API declined by 0.1%, and the Native American group remained the same. QI began evaluating unknown/unreported and Two or more Races as of FY 2019-20. Over the last two years, the Two or more Races category increased by 0.2 PP, and the percentage of LACDMH clients with unknown/unreported ethnicities showed the most notable increase of 1.5 PP. Data Source: LACDMH-IS-IBHIS, August 2022.

Summary

The Latino category was Los Angeles County's most common racial group across all demography data sets between CY 2018 and 2020. Conversely, the Native American group has remained the smallest and most stable during the same time frame and across similar data sets.

At 48.0%, the Latino group is the largest community, followed by the White group at 25.9% of all county residents. The White group declined by three percentage points (PP) in CY 2020, representing all racial groups' most considerable population shift in the prior three years. Similarly, the Latino and White groups comprised most of the Los Angeles County's population living at or below the 138% Federal Poverty Level (poverty estimates) or eligible for Medi-Cal. CY 2020 showed an increase in poverty estimates among the Asian/Pacific Islander and Two or More Races groups and a decline for the African American group. Notably, more than eight out of ten Latinos residing in SA 7 live at or below 138% FPL, the highest rate of all SAs. Trend analysis on the Medi-Cal Eligibles should be interpreted cautiously as all racial groups declined except for the Not Reported category, which increased by 1.2 PP. The distribution of race/ethnicity has been relatively stable among LACDMH's clients, with the most significant decline seen for the African American community, which declined by 1.1 PP over the last three years. Native Americans in SA 6 seek LACDMH services more often than those in other SAs.

**Evaluation of Los Angeles County's Population and Mental Health Plan's Demographics by MHSA Age Groups**

Total Population

Approximately 47% of Los Angeles County residents are between 25 and 59 years old, with the largest proportion residing in SA 1. The Children and TAY groups increased by 3 PP each between CY 2018 and CY 2020; TAY, or ages 16-25 years, made up the smallest portion of residents.

**Figure**

*13. Age Group Distribution for Total Population, Calendar Year 2020*

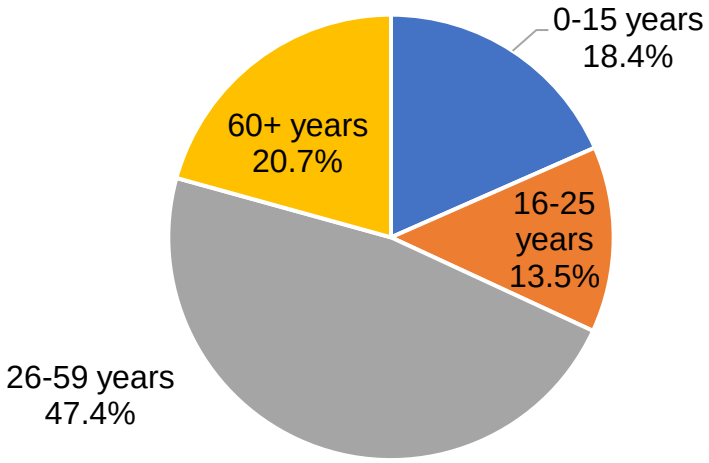



Figure 13 presents the age group distribution for Los Angeles County's total population. Adults (26-59 years) made up the largest age group at 47.4%, followed by Older Adults (60+ years) at 20.7%, Children (0-15 years) at 18.4%, and TAY (16-25 years) at 13.5%. The N for the 0-15 years category is 1,807,632. The N for the 16-25 years category is 1,377,491. The N for the 26-59 years category is 4,823,661. The N for the 60+ years category is 2,003,630. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services. Prepared by CIOB in May 2022.

**Table**

5. *Total Population by Age Group and Service Area, Calendar Year 2020*

| SA | Age Group 0-15 years | 16-25 years | 26-59 years | 60+ years | Total |
|---|---|---|---|---|---|
| **SA 1** | 98,058 | 69,473 | 181,543 | 68,972 | 418,046 |
| Percent | **23.5%** | 16.6% | **43.4%** | 16.5% | 100.0% |
| **SA 2** | 389,938 | 285,219 | 1,063,968 | 469,514 | 2,208,639 |
| Percent | 17.7% | 12.9% | 48.2% | 21.3% | 100.0% |
| **SA 3** | 303,349 | 243,208 | 811,066 | 395,959 | 1,753,582 |
| Percent | 17.3% | 13.9% | 46.3% | 22.6% | 100.0% |
| **SA 4** | 157,283 | 117,989 | 628,240 | 217,029 | 1,120,541 |
| Percent | 14.0% | **10.5%** | **56.1%** | 19.4% | 100.0% |
| **SA 5** | 85,539 | 86,954 | 339,179 | 153,118 | 664,790 |
| Percent | **12.9%** | 13.1% | 51.0% | **23.0%** | 100.0% |
| **SA 6** | 231,070 | 172,510 | 469,180 | 143,509 | 1,016,269 |
| Percent | 22.7% | **17.0%** | 46.2% | **14.1%** | 100.0% |
| **SA 7** | 257,060 | 193,466 | 596,356 | 234,167 | 1,281,049 |
| Percent | 20.1% | 15.1% | 46.6% | 18.3% | 100.0% |
| **SA 8** | 285,335 | 208,672 | 734,129 | 321,362 | 1,549,498 |
| Percent | 18.4% | 13.5% | 47.4% | 20.7% | 100.0% |
| **Total** | 1,807,632 | 1,377,491 | 4,823,661 | 2,003,630 | 10,012,414 |
| Percent | 18.1% | 13.8% | 48.2% | 20.0% | 100.0% |

Table 5 shows age group distribution for LA County residents and by SA. Bold values represent the highest and lowest percentage within each Age Group across Service Areas. The highest percentage of individuals between 0 and 15 years was in SA 1 (23.5%) compared to SA 5 (12.9%), with the lowest. The highest percentage of individuals between 16 and 25 years was in SA 6 (17.0%) compared to SA 4 (10.5%), with the lowest. The highest percentage of individuals between 26 and 59 years was in SA 4 (56.1%) compared to SA 1 (43.4%), with the lowest. The highest percentage of individuals 60 years or more was in SA 5 (23.0%) compared to SA 6 (14.1%), with the lowest. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2022.

**Figure**

*14. Three Year Trends for Total Population by MHSA Age Group, CY 2018 to CY 2020*

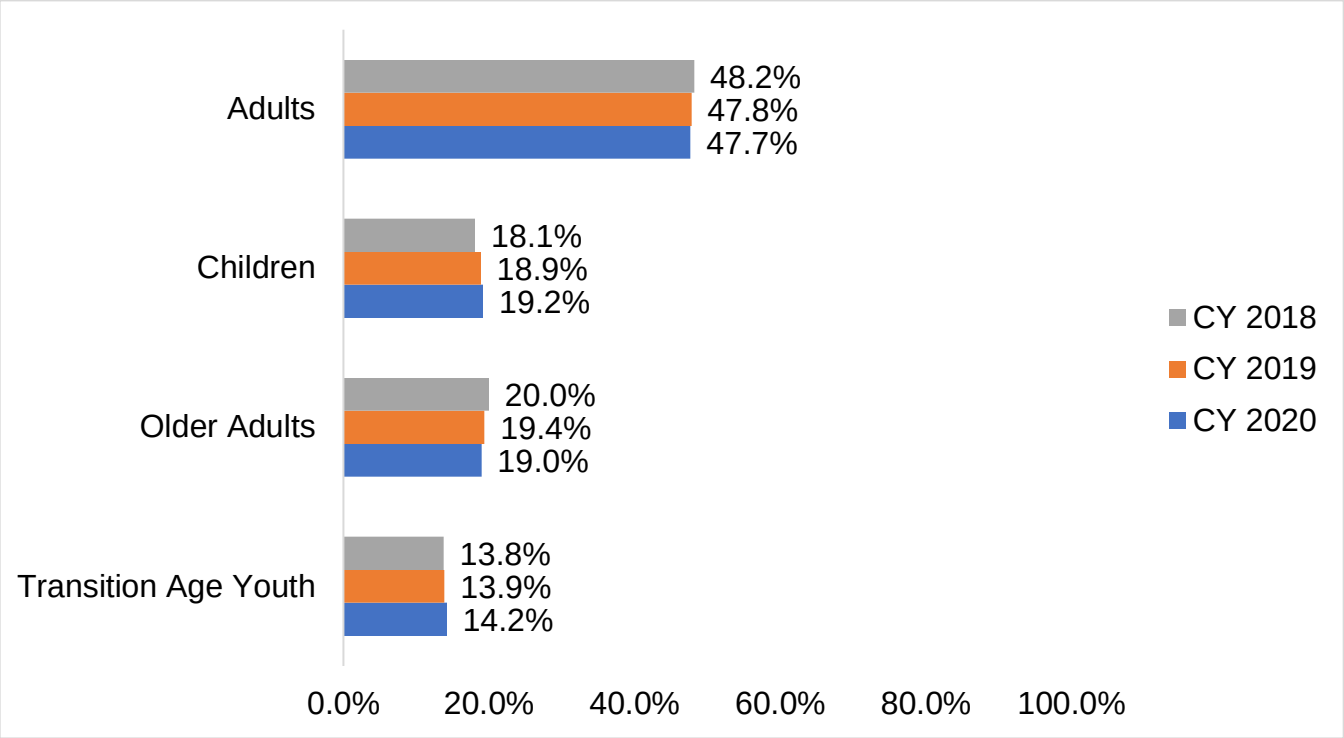



Figure 14 summarizes the three-year trends for age groups. Between CY 2018 and CY 2020, the percentage of adults declined by 0.5 PP, children increased by 1.1 PP, older adults declined by 1.0 PP, and TAY increased by 0.4 PP. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2018 to 2020, prepared by CIOB in May 2022.

Estimated Population living at or below 138% FPL

Much of Los Angeles County's estimated population at or below 138% FPL are between 26 and 59 years old (42.3%) or 0 and 15 years old (26.9%).

**Figure**

*15. Age Group Distribution for the Estimated Population Living at or below 138% FPL, CY 2020*

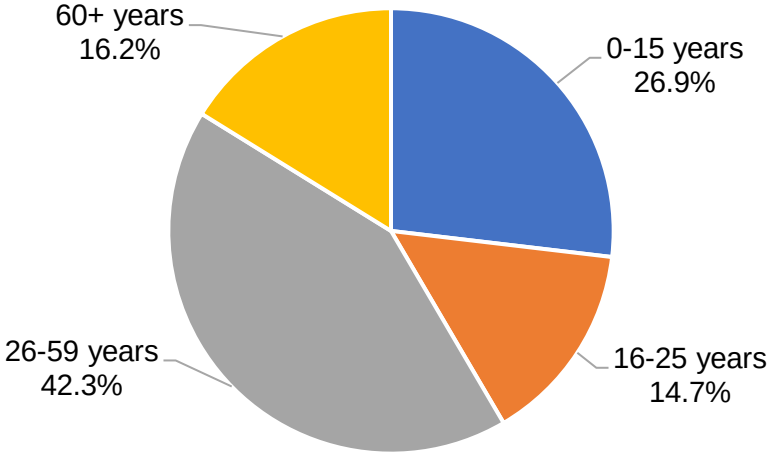



Figure 15 presents the age group distribution for Los Angeles County's total population. Adults (26-59 years) made up the largest group at 42.3%, followed by Children (0-15 years) at 26.9%, Older Adults (60+ years) at 16.2%, and TAY (16-25 years) at 14.7%. The N for the 0-15 years category is 514,242. The N for the 16-25 years category is 280,628. The N for the 26-59 years category is 809,591. The N for the 60+ years category is 309,638. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services. Prepared by CIOB in May 2022.

**Table**

6. *Estimated Population Living at or below 138% Federal Poverty Level by MHSA Age Group and Service Area*

| SA | Age Group | | | | Total |
|---|---|---|---|---|---|
| | 0-15 years | 16-25 years | 26-59 years | 60+ years | |
| **SA 1** | 35,444 | 17,397 | 38,759 | 14,253 | 105,853 |
| Percent | **33.5%** | 16.4% | **36.6%** | 13.5% | 100.0% |
| **SA 2** | 86,067 | 47,975 | 155,875 | 62,575 | 352,492 |
| Percent | 24.4% | 13.6% | 44.2% | 17.8% | 100.0% |
| **SA 3** | 64,555 | 38,034 | 108,499 | 53,062 | 264,150 |
| Percent | 24.4% | 14.4% | 41.1% | **20.1%** | 100.0% |
| **SA 4** | 59,000 | 31,733 | 133,992 | 50,897 | 275,622 |
| Percent | 21.4% | **11.5%** | 48.6% | 18.5% | 100.0% |
| **SA 5** | 10,756 | 13,244 | 38,944 | 15,105 | 78,049 |
| Percent | **13.8%** | 17.0% | **49.9%** | 19.4% | 100.0% |
| **SA 6** | 113,099 | 58,064 | 130,861 | 38,167 | 340,191 |
| Percent | 33.2% | **17.1%** | 38.5% | **11.2%** | 100.0% |
| **SA 7** | 70,053 | 34,575 | 88,518 | 32,106 | 225,252 |
| Percent | 31.1% | 15.3% | 39.3% | 14.3% | 100.0% |
| **SA 8** | 75,268 | 39,606 | 114,143 | 43,473 | 272,490 |
| Percent | 27.6% | 14.5% | 41.9% | 16.0% | 100.0% |
| **Total** | 514,242 | 280,628 | 809,591 | 309,638 | 1,914,099 |
| Percent | 26.9% | 14.7% | 42.3% | 16.2% | 100.0% |

Table 6 outlines the SA distribution of age groups for the estimated population living at or below 138% FPL. Bold values represent the highest and lowest percentages within each Age Group across Service Areas. The highest percentage of individuals between 0-15 years was in SA 1 (33.5%) compared to SA 5 (13.5%), with the lowest. The highest percentage of individuals between 16 and 25 years was in SA 6 (17.1%) compared to SA 4 (11.5%), with the lowest. The highest percentage of individuals between 26 and 59 years was in SA 5 (49.9%) compared to SA 1, with the lowest. The highest percentage of individuals 60 years or more was in SA 5 compared to SA 6, with the lowest. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2022.

**Figure**

*16. Three Year Trends for Estimated Population Living at or below 138% FPL by MHSA Age Groups, CY 2018 to CY 2020*

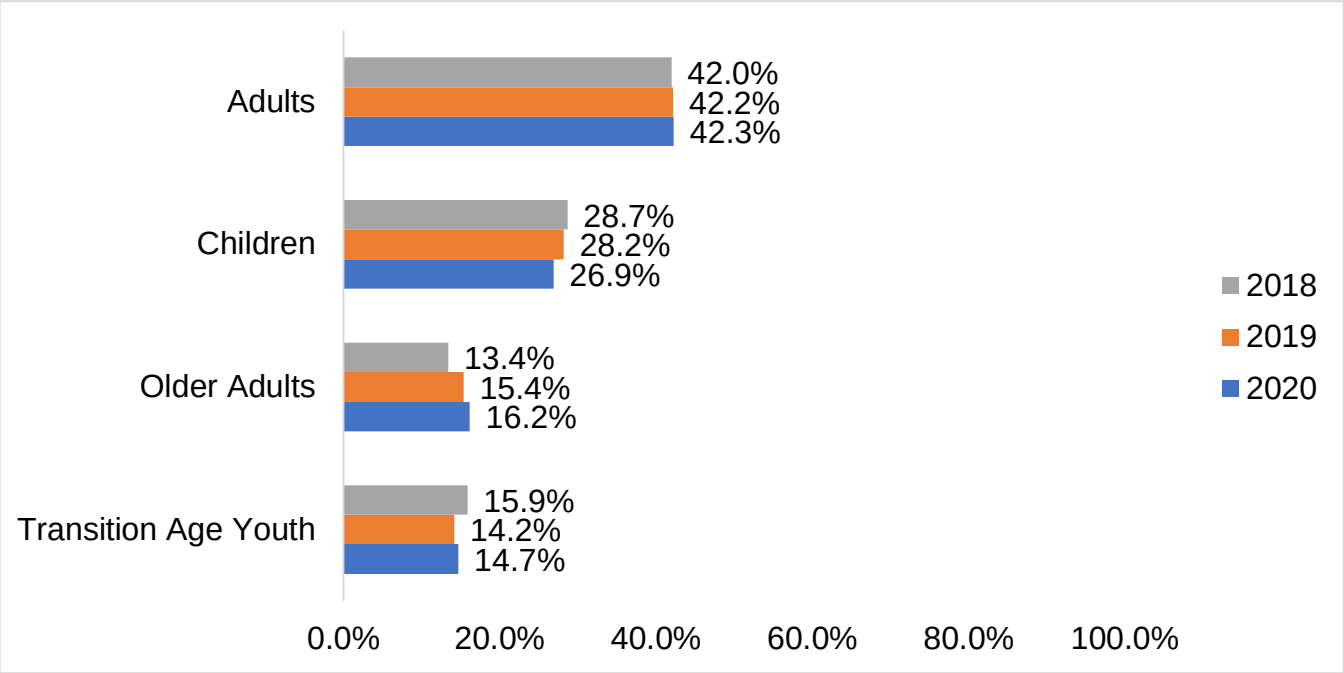



Figure 16 displays a trend analysis for the past three years. Between CY 2018 and CY 2020, adults estimated at or below 138% FPL increased by 0.3 PP, children increased by 1.8 PP, older adults increased by 2.8 PP, and TAY declined by 1.2 PP. Data source: ACS, US Census Bureau, and Hedderson Demographic Services, CY 2018 to CY 2020, last revised by CIOB in May 2022.

Estimated Prevalence of SED or SMI

At 45.1%, residents between 26 and 59 years old and estimated at or below 138% FPL had the highest prevalence of SED and SMI, with the higher majority residing in SA 4. Residents ages 60+ years (5.8%) had the lowest prevalence rates when applied to poverty estimates.

**Figure**

*17. Estimated Prevalence of SED or SMI by Age Group*

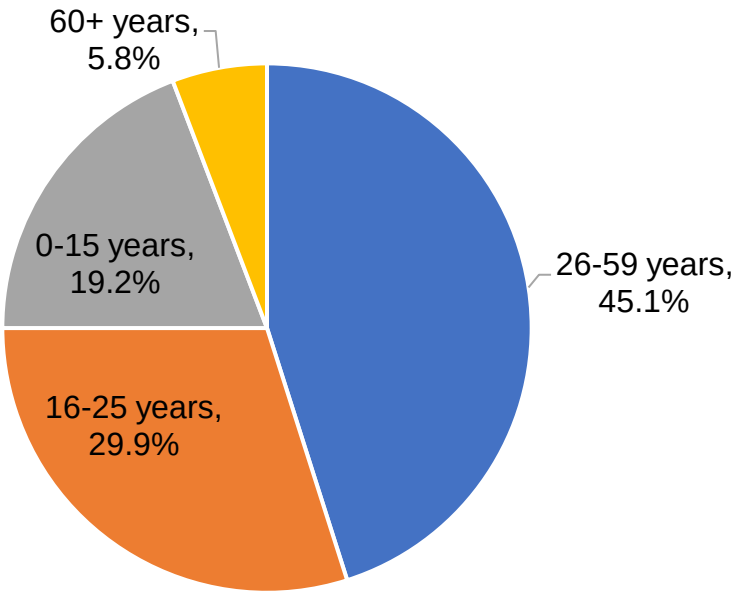



Figure 17 presents the estimated population at or below 138% FPL with SED or SMI prevalence and by MHSA age categories. Adults comprised the largest group at 45.1%, followed by TAY at 29.9%, children at 19.2%, and older adults at 5.8%. The N for the 0-15 years was 260,299. The N for the 16-25 years group was 406,360 and 612,605 for the 26-59 years group. The N for the 60+ years group was 78,142.

**Table**

7. *Estimated Prevalence of SED or SMI by Age Group and Service Area*

| SA | Age Group | | | | Total |
|---|---|---|---|---|---|
| | 0-15 years | 16-25 years | 26-59 years | 60+ years | |
| **SA1** | 4,466 | 5,532 | 5,543 | 713 | 16,253 |
| Percent | **27.5%** | 34.0% | **34.1%** | 4.4% | 100.0% |
| **SA2** | 10,844 | 15,256 | 22,290 | 3,129 | 51,519 |
| Percent | 21.0% | 29.6% | 43.3% | 6.1% | 100.0% |
| **SA3** | 8,134 | 12,095 | 15,515 | 2,653 | 38,397 |
| Percent | 21.2% | 31.5% | 40.4% | **6.9%** | 100.0% |
| **SA4** | 7,434 | 10,091 | 19,161 | 2,545 | 39,231 |
| Percent | 18.9% | **25.7%** | **48.8%** | 6.5% | 100.0% |
| **SA5** | 1,355 | 4,212 | 5,569 | 755 | 11,891 |
| Percent | **11.4%** | **35.4%** | 46.8% | 6.4% | 100.0% |
| **SA6** | 14,250 | 18,464 | 18,713 | 1,908 | 53,336 |
| Percent | 26.7% | 34.6% | 35.1% | **3.6%** | 100.0% |
| **SA7** | 8,827 | 10,995 | 12,658 | 1,605 | 34,085 |
| Percent | 25.9% | 32.3% | 37.1% | 4.7% | 100.0% |
| **SA8** | 9,484 | 12,595 | 16,322 | 2,174 | 40,575 |
| Percent | 23.4% | 31.0% | 40.2% | 5.4% | 100.0% |
| **Total** | 64,794 | 89,240 | 115,772 | 15,482 | 285,288 |
| Percent | 22.7% | 31.3% | 40.6% | 5.4% | 100.0% |

Table 7 shows the SA distribution of age groups. Bold values represent the highest and lowest percentages. The highest percentage of individuals between 0 and 15 years was in SA 1 (23.4%) compared to SA 5, with the lowest. The highest percentage of individuals between 16 and 25 years was in SA 6 (34.1%) and SA 1 (34.0%) compared to SA 4 (23.9%), with the lowest. The highest percentage of individuals between 26 and 59 years was in SA 4 (54.8%) compared to SA 1 (38.2%), with the lowest. The highest percentage of individuals 60 years or more was in SA 5 (6.9%) compared to SA 1 (4.5%), with the lowest. Trending data was not included as QI did not examine prevalence rates for CY 2018, CY 2019, and CY 2020. Due to rounding, some estimated numbers and percentages may not total 100%. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2022.

Population Enrolled in Medi-Cal

Individuals ages 19-44 years were more frequently deemed eligible for Medi-Cal. Conversely, individuals ages 65+ years were eligible for Medi-Cal at the lowest rate.

**Figure**

*18. Age Group Distribution among Medi-Cal Eligibles*

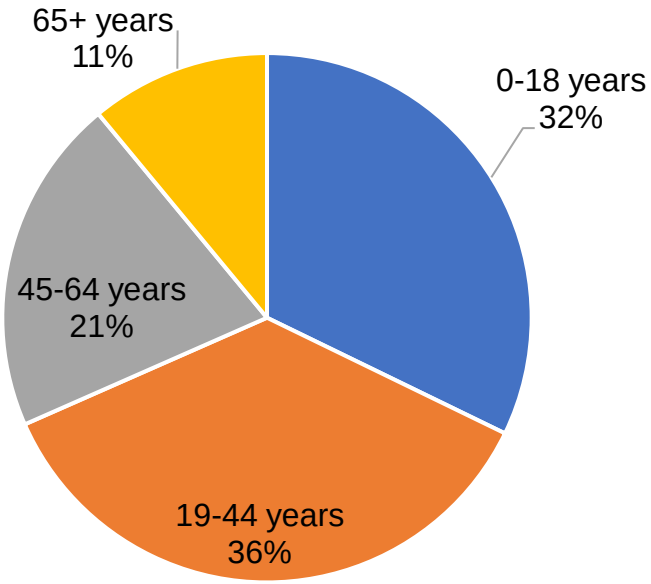
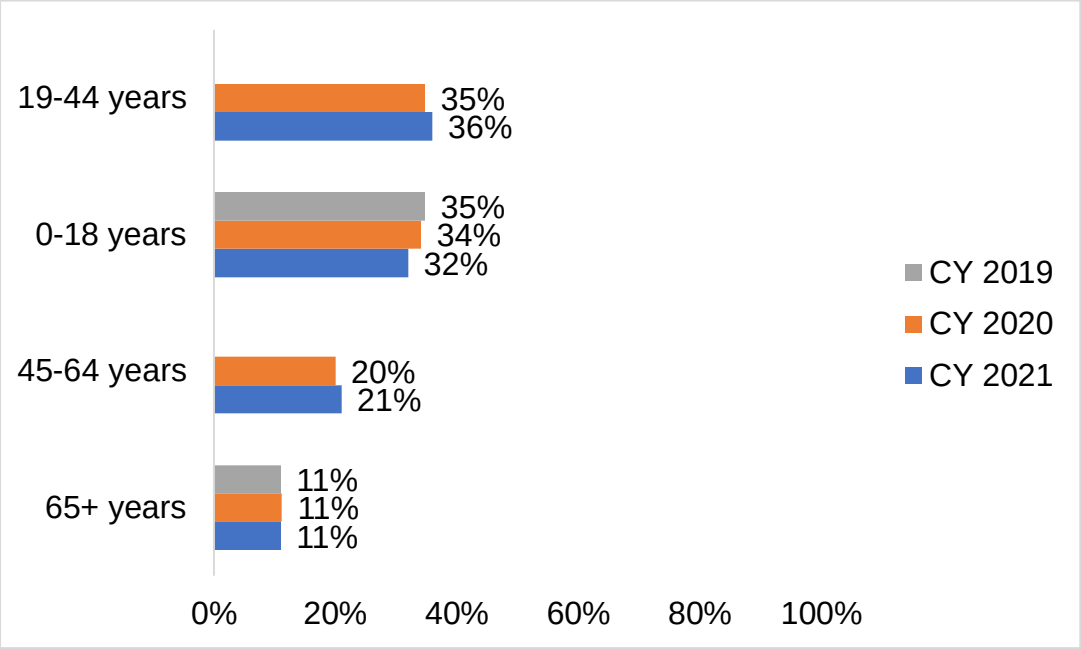



Figure 18 presents the Medi-Cal enrolled population by age group. Individuals between 19 and 44 years were the largest group (36%), followed by individuals between 0 and 18 years (32%), individuals between 45 and 64 years (21%), and individuals 65 years or more (11%). The N for the 19-44 years group was 1,481,100. The N for the 0-18 years group was 1,318,031. The N for the 45-64 years group was 845,292, and the N for the 65+ group was 452,398. Note: Race/ethnicity categories as defined by State. Due to rounding, some estimated totals and percentages may not total 100%. 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 December 28, 2021.

**Figure**

*19. Three-year trends for Population Enrolled in Medi-Cal by Age Categories*




In 2019, the Medi-Cal eligibility data was presented for three age categories, namely 0-18 years, 19-64 years, and 65+ years. Figure 19 breaks down the three-year trend for age categories among Medi-Cal enrollees. Most notably, the 0-18 years category declined by 2 PP. This trend data is limited to the last two years for the 19 to 44 and 45 to 64 groups. 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, CY 2019 to CY 2021

Client Served

At 40.1%, clients between ages 26 and 59 comprised the highest percentage of clients served in LACDMH outpatient services. Despite demonstrating the most considerable client population growth in the past three years, older adults were the smallest age group served in FY 2020-21.

**Figure**

*20. Age Group Distribution for Clients Served in Outpatient LACDMH Clinics*

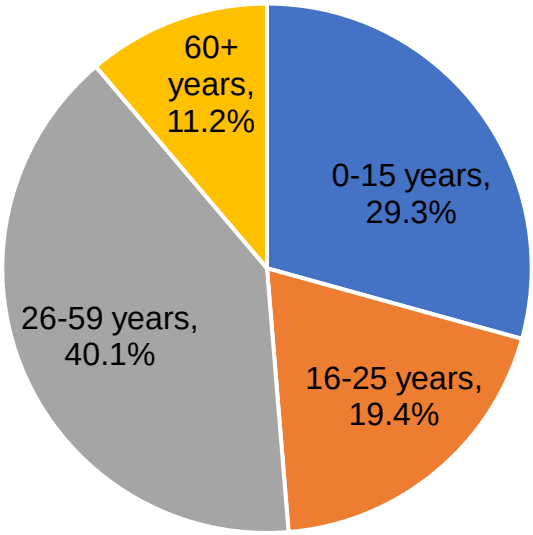



Figure 20 introduces the FY 202-21 distribution of clients served by age group. Most clients are Adults ages 26-59 years at 40.1%, Children ages 0-15 years at 29.3%, TAY ages 16-25 years at 19.4%, and Older Adults ages 60 and above at 11.2%. The N for Children is 58,906. The N for TAY is 39,041. The N for Adults is 80,549. The N for Older Adults is 22,491. Data Source: LACDMH IS-IBHIS, August 2022.

**Table**

8. *Clients Served in Outpatient Programs by Age Group and Service Area.*

| SA | Age Group | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | Total |
| **SA 1** | 7,989 | 3,992 | 8,476 | 1,745 | 22,202 |
| Percent | 36.0% | 18.0% | 38.2% | 7.9% | 100.0% |
| **SA 2** | 14,561 | 10,686 | 19,591 | 5,288 | 50,126 |
| Percent | 29.0% | 21.3% | 39.1% | 10.5% | 100.0% |
| **SA 3** | 14,872 | 10,393 | 13,819 | 3,257 | 42,341 |
| Percent | 35.1% | **24.5%** | 32.6% | 7.7% | 100.0% |
| **SA 4** | 9,757 | 7,105 | 17,446 | 4,839 | 39,147 |
| Percent | 24.9% | 18.1% | 44.6% | 12.4% | 100.0% |
| **SA 5** | 2,027 | 1,711 | 5,286 | 1,556 | 10,580 |
| Percent | **19.2%** | **16.2%** | **50.0%** | **14.7%** | 100.0% |
| **SA 6** | 16,811 | 10,637 | 21,414 | 4,981 | 53,843 |
| Percent | 31.2% | 19.8% | 39.8% | 9.3% | 100.0% |
| **SA 7** | 14,480 | 8,986 | 12,201 | 2,612 | 38,279 |
| Percent | **37.8%** | 23.5% | **31.9%** | **6.8%** | 100.0% |
| **SA 8** | 12,989 | 8,250 | 17,516 | 4,558 | 43,313 |
| Percent | 30.0% | 19.0% | 40.4% | 10.5% | 100.0% |
| **Total** | 58,906 | 39,041 | 80,549 | 22,491 | 200,987 |
| Percent | 29.3% | 19.4% | 40.1% | 11.2% | 100.0% |

Table 8 presents the SA distribution of age groups for LACDMH clients. Bold values represent the highest and lowest percentages for each age group. The highest percentage of children LACDMH served was in SA 7 (37.8%) compared to SA 5 (19.2%), with the lowest. The highest percentage of TAY served by LACDMH was in SA 7 (24.5%) compared to SA 5 (16.2%), with the lowest. The highest percentage of Adults served by LACDMH was in SA 5 (50.0%) compared to SA 7 (31.9%), with the lowest. The highest percentage of older adults served by LACDMH was in SA 4 (14.7%) compared to SA 7 (6.8%), with the lowest. Data Source: LACDMH IS-IBHIS, August 2022.

**Figure**

*21. Three-Year Trend in Clients Served by Age Group (MHSA)*

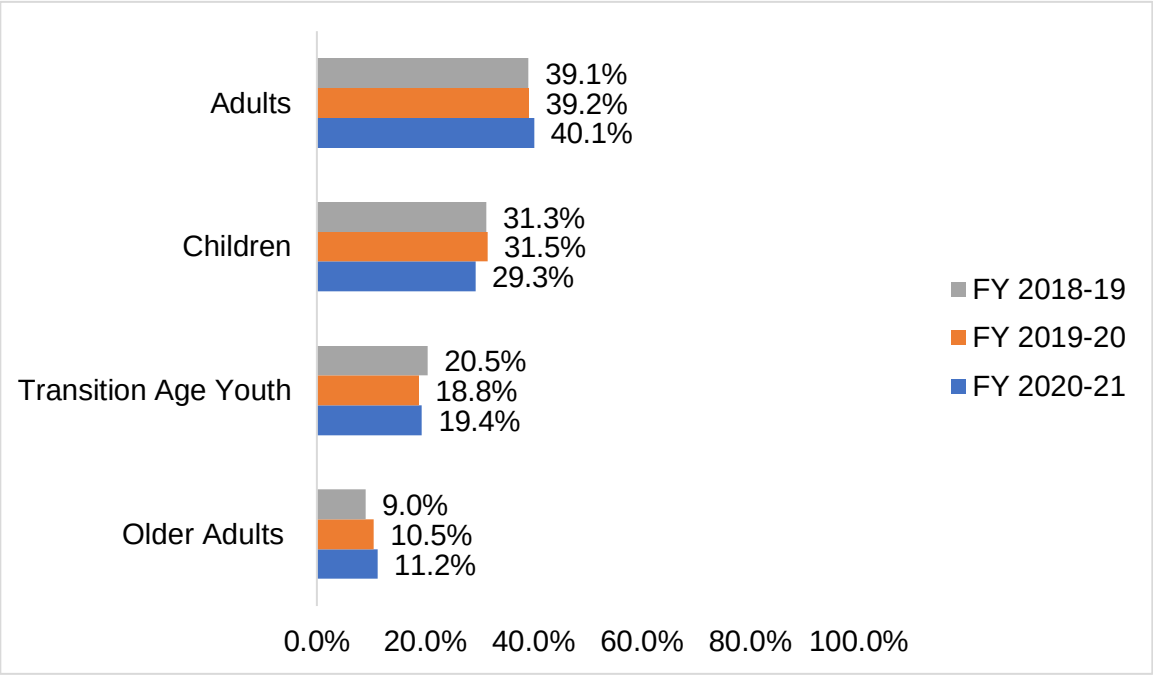



Figure 21 presents the distribution of age groups for clients served over the prior three fiscal years. All age groups declined except for Older Adults, which increased by 2.2 PP. Adults declined by 1.1 PP, children by 2 PP, and TAY by 1.1 PP. Data Source: LACDMH IS-IBHIS, FY 2019-19 to FY 2020-21.

Summary

At 47.4%, the highest percentage of Los Angeles residents fell in the 26 to 59 age group. Poverty estimates show ages 0-18 years and 26-59 years as the largest age groups likely meeting the Medi-Cal eligibility criterion, and similar rates were observed among the clients served. According to California DHCS, an estimated 68% of LA County's Med-Cal eligibles are between 0 and 44 years old. Despite making up the lowest percentage of the total population and estimated population at/or below 138% FPL, TAY had the second highest SED and SMI prevalence rate.

Most LACDMH outpatient clinics primarily serve adults. SA 5 serves primarily adults; however, in SAs 3 and 7, children are the most represented age group served. The Older adult LACDMH client population is the only age group trending upwards. Notably, Older Adults estimated at or below 138% FPL poverty increased by almost 3 PP in three years, and conversely, the percentage of older adult residents declined by 1 PP.

**Evaluation of Los Angeles County's Population and Mental Health Plan's Demographics by Gender**

Total Population

Over the past three years, gender, in terms of Male and Female, has been relatively split among LA County residents.

**Figure**

*22. Gender Distribution for Total Population, CY 2020*

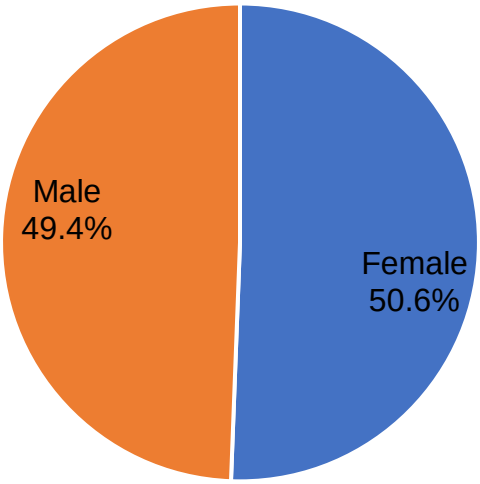



Figure 22 presents the ratio of Males and Females among LA County residents. The N for the Male group is 4,941,542. The N for the Female group is 5,070,872. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2021.

**Table**

9. *Total Population by Gender and Service Area, CY 2020*

| SA | Male | Female | Total |
|---|---|---|---|
| **SA 1** | 206,513 | 211,533 | 418,046 |
| Percent | 49.4% | 50.6% | 100.0% |
| **SA 2** | 1,093,609 | 1,115,030 | 2,208,639 |
| Percent | 49.5% | 50.5% | 100.0% |
| **SA 3** | 854,807 | 898,775 | 1,753,582 |
| Percent | 48.7% | 51.3% | 100.0% |
| **SA 4** | 579,602 | 540,939 | 1,120,541 |
| Percent | **51.7%** | **48.3%** | 100.0% |
| **SA 5** | 321,775 | 343,015 | 664,790 |
| Percent | **48.4%** | **51.6%** | 100.0% |
| **SA 6** | 497,397 | 518,872 | 1,016,269 |
| Percent | 48.9% | 51.1% | 100.0% |
| **SA 7** | 629,722 | 651,327 | 1,281,049 |
| Percent | 49.2% | 50.8% | 100.0% |
| **SA 8** | 758,117 | 791,381 | 1,549,498 |
| Percent | 48.9% | 51.1% | 100.0% |
| **Total** | 4,941,542 | 5,070,872 | 10,012,414 |
| Percent | 49.4% | 50.6% | 100.0% |

Table 9 presents the SA distribution of Male and Female LA County residents. Bold values represent the highest and lowest percentage within each gender group across Service Areas. The highest percentage of Males reside in SA 4 (51.7%) compared to SA 5 (48.4%), with the lowest. Contrarily, the highest percentage of Females reside in SA 5 (51.6%) compared to SA 4 (48.3%) with the lowest. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2021.

**Figure**

*23. Three Year Gender Trends for Total Population, CY 2018 to CY 2020*

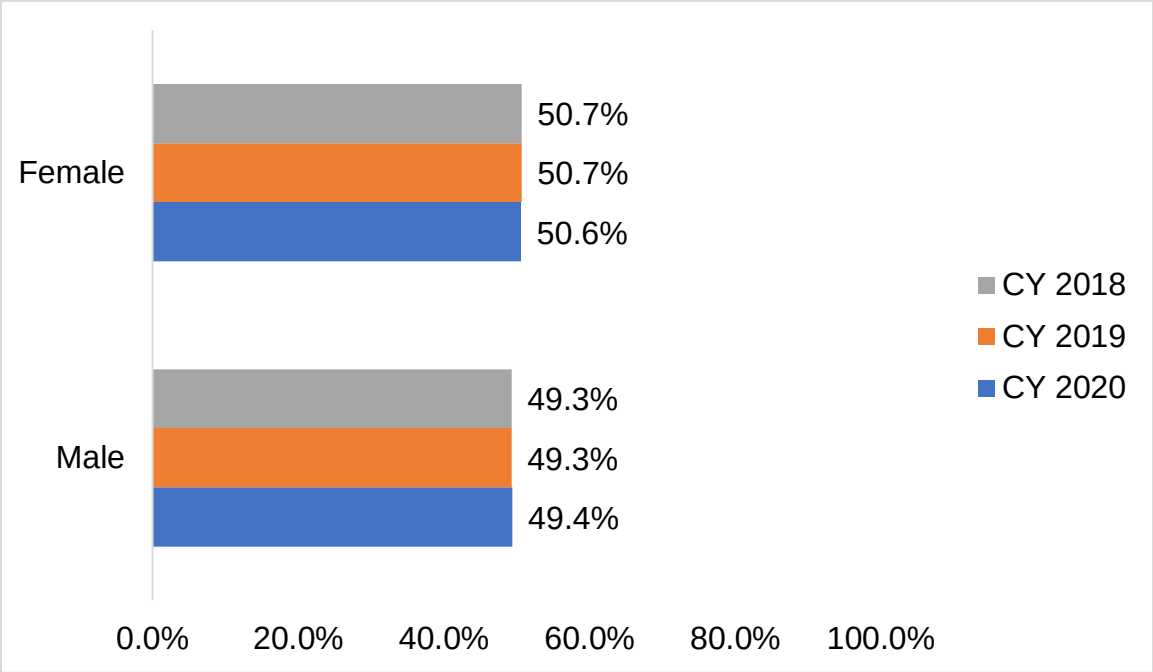



Figure 23 displays the three-year trends for gender distribution among LA County residents, and no major population shifts were observed. Across these three years, Females remained slightly more represented than Males. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2021.

Estimated Population at or Below 138% Federal Poverty Level

There was a shift to Females as the most represented gender among the estimated population living at or below 138% FPL.

**Figure**

*24. Gender Distribution for the Estimated Population Living at or below 138% FPL, CY 2020*

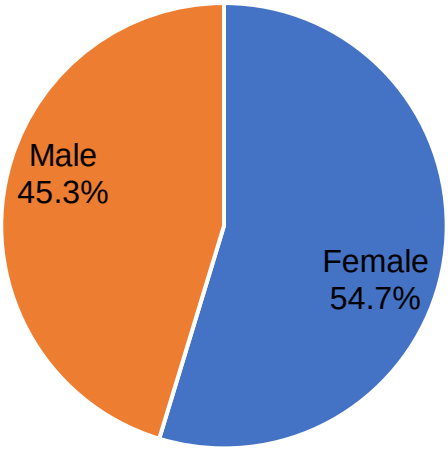



Figure 24 shows the gender distribution for the estimated population living at or below 138% FPL. Females were the largest at 54.7%. The N for the Female category was 1,046,879. The N for the Male category was 867,220. Data Source: Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2021.

**Table 10.** *Estimated Population Living at or below 138% FPL by Gender and Service Area, CY 2020*

| SA | Male | Female | Total |
|---|---|---|---|
| **SA 1** | 47,952 | 57,901 | 105,853 |
| Percent | 45.3% | 54.7% | 100.0% |
| **SA 2** | 160,021 | 192,471 | 352,492 |
| Percent | 45.4% | 54.6% | 100.0% |
| **SA 3** | 118,267 | 145,883 | 264,150 |
| Percent | 44.8% | 55.2% | 100.0% |
| **SA 4** | 129,083 | 146,539 | 275,622 |
| Percent | **46.8%** | **53.2%** | 100.0% |
| **SA 5** | 34,599 | 43,450 | 78,049 |
| Percent | **44.3%** | **55.7%** | 100.0% |
| **SA 6** | 154,097 | 186,094 | 340,191 |
| Percent | 45.3% | 54.7% | 100.0% |
| **SA 7** | 100,570 | 124,682 | 225,252 |
| Percent | 44.6% | 55.4% | 100.0% |
| **SA 8** | 122,631 | 149,859 | 272,490 |
| Percent | 45.0% | 55.0% | 100.0% |
| **Total** | 867,220 | 1,046,879 | 1,914,099 |
| Percent | 45.3% | 54.7% | 100.0% |

Table 10 shows the gender distribution by SA for the estimated population living at or below the 138% FPL. The highest percentage of Males was in SA 4 (46.8%) compared to SA 5 (44.3%) with the lowest. Contrarily, the highest percentage of Females was in SA 5 (55.7%) compared to SA 4 (53.2%) with the lowest. 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 in May 2022

**Figure**

*25. Three Year Gender Trends for Estimated Population Living at or below 138% FPL, CY 2018 to CY 2020*

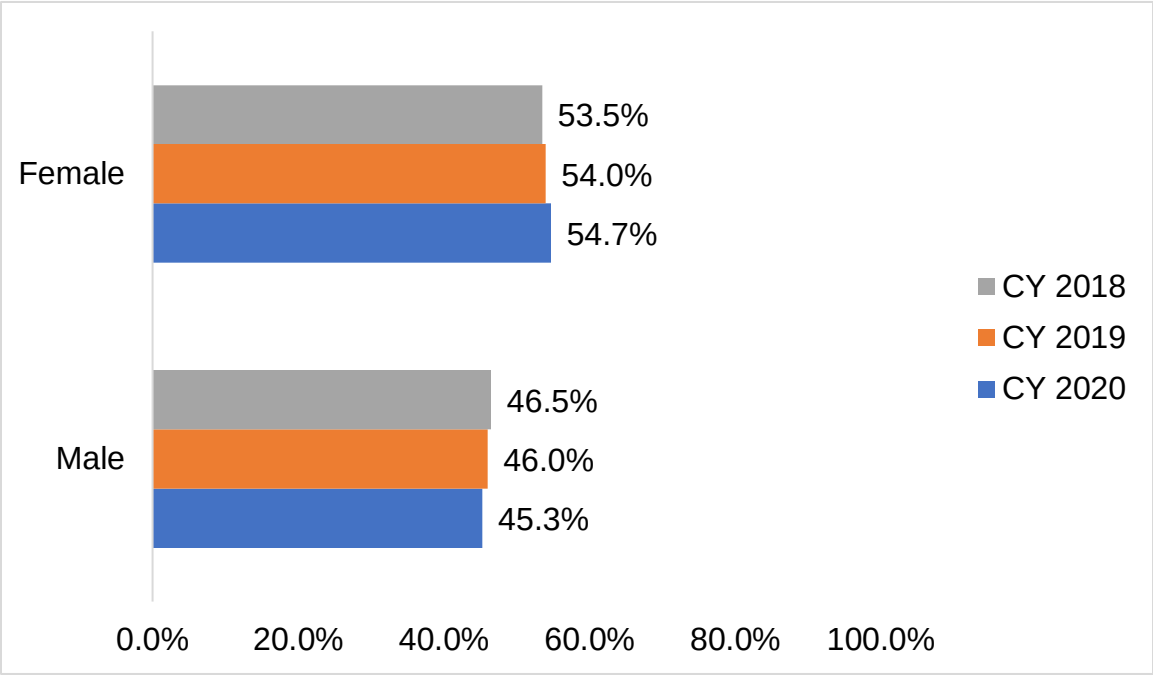



Figure 25 evaluates trends for gender between CY 2018 and 2020. The percentage of Females within the estimated population at or below 138% FPL increased by 1.2 PP, and there was a 1.2 decline in the percentage of Males. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB in May 2022.

Estimated Prevalence of SED and SMI among Population Estimated at or Below 138% FPL

Females were most represented among the estimated population living at or below 138% FPL with an estimated prevalence of SED and SMI. The highest and lowest distribution of Males and Females are found in SAs 4 and 5.

**Figure**

*26. Estimated Prevalence of SED or SMI by Gender*

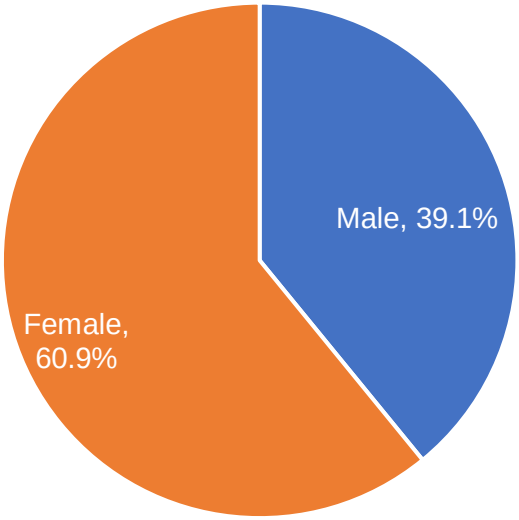



Figure 26 presents the estimated prevalence of SED and SMI among LA county's population, estimated at or below 138% FPL., At 60.9%, the majority are Female. The N for the Female category is 196,813, and the N for the Male category is 126,614. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on October 2022

**Table**

*11. Estimated Prevalence of SED or SMI by Gender and Service Area*

| SA | Male | Female | Total |
|---|---|---|---|
| **SA 1** | 7,001 | 10,885 | 17,886 |
| Percent | 39.1% | 60.9% | 100.0% |
| **SA 2** | 23,363 | 36,185 | 59,548 |
| Percent | 39.2% | 60.8% | 100.0% |
| **SA 3** | 17,267 | 27,426 | 44,693 |
| Percent | 38.6% | 61.4% | 100.0% |
| **SA 4** | 18,846 | 27,549 | 46,395 |
| Percent | **40.6%** | **59.4%** | 100.0% |
| **SA 5** | 5,051 | 8,169 | 13,220 |
| Percent | **38.2%** | **61.8%** | 100.0% |
| **SA 6** | 22,498 | 34,986 | 57,484 |
| Percent | 39.1% | 60.9% | 100.0% |
| **SA 7** | 14,683 | 23,440 | 38,123 |
| Percent | 38.5% | 61.5% | 100.0% |
| **SA 8** | 17,904 | 28,173 | 46,078 |
| Percent | 38.9% | 61.1% | 100.0% |
| **Total** | 126,614 | 196,813 | 323,427 |
| Percent | 39.1% | 60.9% | 100.0% |

Table 11 presents the estimated prevalence of SED and SMI for LA County's estimated population living at or below 138% FPL by gender and SA. Bold values represent the highest and lowest percentages. SA 4 (40.6%) had the highest population of Males, estimated at or below 138% FPL and prevalence of SED or SMI, compared to SA 5 (38.2%) with the lowest. Contrarily, SA 5 (61.8%) had the highest population of Females estimated at or below 138% FPL and prevalence of SED or SMI compared to SA 4 (59.4%) with the lowest. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on October 2022

Population Enrolled in Medi-Cal

In CY 2021, more than half of Los Angeles County's Medi-Cal eligibles were Female. The ratio of Males to Females was similar between CY 2020 and CY 2021.

**Figure**

*27. Distribution of Gender for Population Enrolled in Medi-Cal*

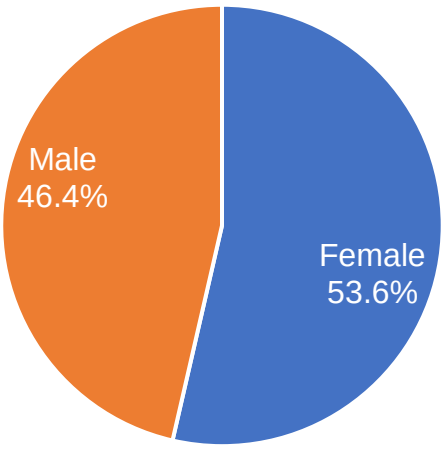



Table 27 shows the distribution of Male and Female Medi-Cal eligibles in CY 2021. The majority of Medi-Cal eligibles are Female. The N for the Male category is 1,900,024. The N for the Female category is 2,196,796. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on October 2022

**Figure**

*28. Three Year Trend in Population Enrolled in Medi-Cal by Gender*

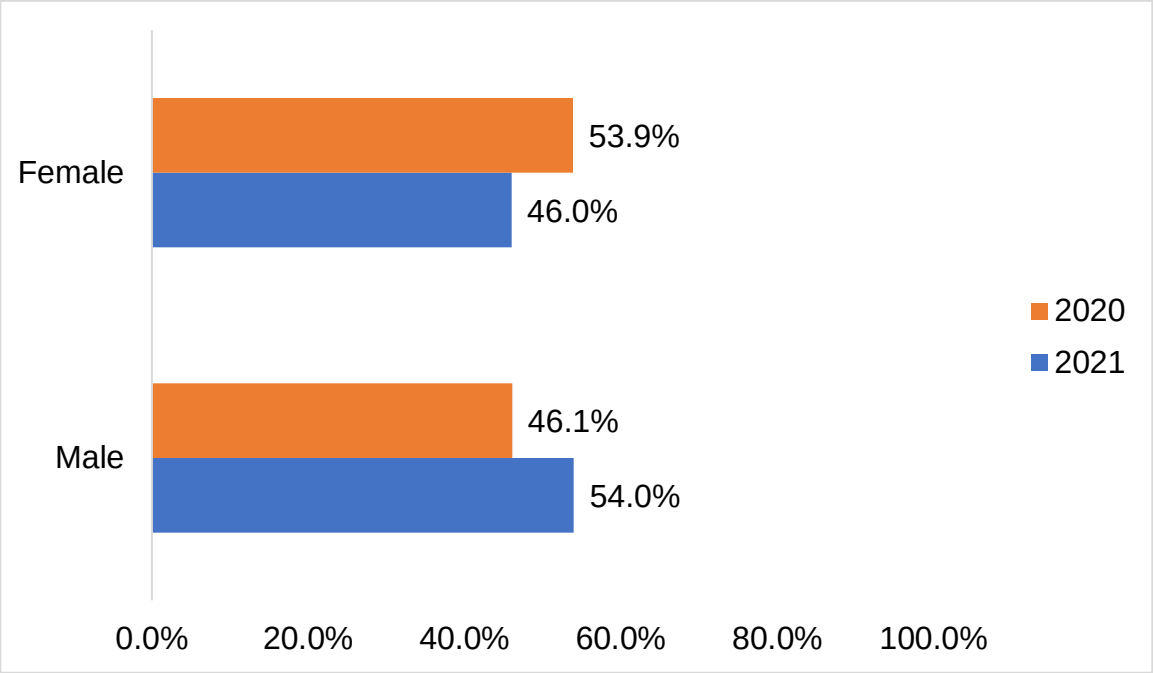



Figure 28 presents the two-year trend in Medi-Cal eligibles by gender, and there were no notable shifts. Gender was not evaluated in 2020.

Clients Served

Females are the most represented among clients served in LACDMH outpatient clinics.

**Figure**

*29. Clients Served in Outpatient LACDMH Programs by Gender*

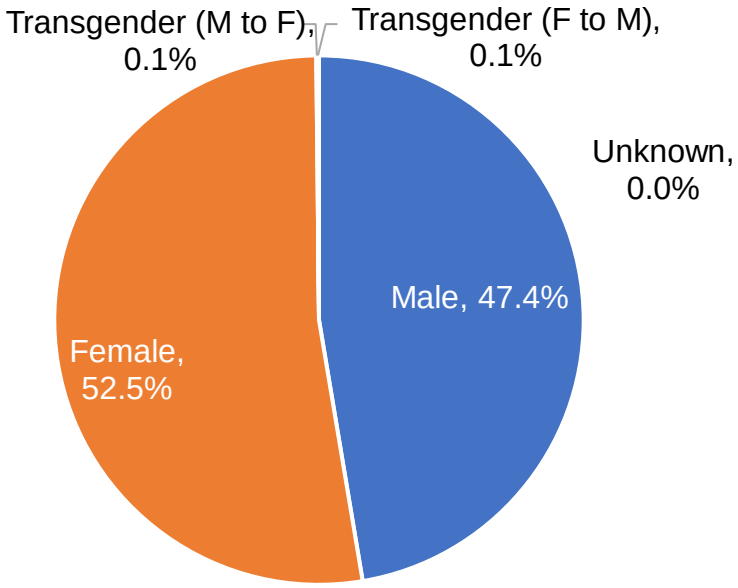



Figure 29 presents the distribution of gender among clients served in LACDMH outpatient clinics. At 52.5%, most clients are categorized as Female, Male at 47.4%, and Transgender or Unknown at less than 5%.

**Table**

*12. Gender Distribution for Clients Served in LACDMH Clinics by Service Area*

| SA | Gender | | | | | |
|---|---|---|---|---|---|---|
| | Male | Female | Transgender (M to F) | Transgender (F to M) | Unknown | Total |
| **SA 1** | 10,179 | 11,984 | 21 | 14 | 4 | 22,202 |
| Percent | **45.8%** | **54.0%** | 0.1% | 0.1% | 0.0% | 100.0% |
| **SA 2** | 23,588 | 26,452 | 26 | 47 | 13 | 50,126 |
| Percent | 47.1% | 52.8% | 0.1% | **0.1%** | 0.0% | 100.0% |
| **SA 3** | 20,327 | 21,954 | 22 | 29 | 9 | 42,341 |
| Percent | 48.0% | 51.9% | 0.1% | 0.1% | 0.0% | 100.0% |
| **SA 4** | 20,094 | 18,969 | 61 | 19 | 7 | 39,150 |
| Percent | **51.3%** | **48.5%** | **0.2%** | 0.0% | 0.0% | 100.0% |
| **SA 5** | 5,260 | 5,293 | 3 | 22 | 2 | 10,580 |
| Percent | 49.7% | 50.0% | 0.0% | 0.2% | 0.0% | 100.0% |
| **SA 6** | 26,444 | 27,325 | 27 | 33 | 14 | 53,843 |
| Percent | 49.1% | 50.7% | 0.1% | 0.1% | 0.0% | 100.0% |
| **SA 7** | 18,131 | 20,108 | 10 | 23 | 7 | 38,279 |
| Percent | 47.4% | 52.5% | 0.0% | 0.1% | 0.0% | 100.0% |
| **SA 8** | 20,808 | 22,413 | 42 | 39 | 11 | 43,313 |
| Percent | 48.0% | 51.7% | 0.1% | 0.1% | 0.0% | 100.0% |
| **Total** | 95,189 | 105,471 | 143 | 137 | 50 | 200,990 |
| Percent | 47.4% | 52.5% | 0.1% | 0.1% | 0.0% | 100.0% |

Table 12 shows the gender distribution of clients served by SA. Bold values represent the highest and lowest percentages for each gender. The highest percentage of Males was in SA 4 (51.3%) compared to SA 1 (45.8%) with the lowest. The highest percentage of Females was in SA 1 (54.0%) compared to SA 4 (48.5%) with the lowest. With 61 clients, SA 4 had the highest number of clients identifying as Transgender (M to F); with 47 clients, SA 2 had the highest number of clients identifying as Transgender (F to M). Data Source: DMH IS/IBHIS

Summary

Females were the larger majority across all data sets.

**Evaluation of Los Angeles County's Population and Mental Health Plan's Demographics by Primary Language**

Estimated Population at or Below 138% Federal Poverty Level

Spanish (54.3%) is the most common language among the estimated population living at or below 138% FPL, followed by English (33.6%).

**Table**

*13. Primary Language Distribution among the Estimated Population at or Below 138% FPL, Service Areas 1 through 4*

| SA | SA 1 | Percent | SA 2 | Percent | SA 3 | Percent | SA 4 | Percent |
|---|---|---|---|---|---|---|---|---|
| **Arabic** | 406 | 0.4% | 3,131 | 1.0% | 1,089 | 0.5% | 805 | 0.3% |
| **Armenian** | 360 | 0.4% | 26,737 | **8.7%** | 1,235 | 0.5% | 3,565 | 1.5% |
| **Cambodian** | 63 | 0.1% | 121 | 0.0% | 502 | 0.2% | 308 | 0.1% |
| **Cantonese** | 74 | 0.1% | 482 | 0.2% | 11,607 | 5.0% | 2,700 | 1.1% |
| **English** | 55,140 | **60.1%** | 111,830 | **36.5%** | 73,737 | **31.8%** | 71,134 | **29.7%** |
| **Farsi** | 97 | 0.1% | 4,175 | **1.4%** | 281 | 0.1% | 697 | 0.3% |
| **Korean** | 224 | 0.2% | 3,776 | **1.2%** | 2,359 | 1.0% | 16,200 | **6.8%** |
| **Mandarin** | 58 | 0.1% | 1,160 | 0.4% | 15,803 | **6.8%** | 1,387 | 0.6% |
| **Other Chinese** | 144 | 0.2% | 2,244 | 0.7% | 19,406 | **8.4%** | 5,668 | 2.4% |
| **Russian** | 50 | 0.1% | 4,373 | **1.4%** | 163 | 0.1% | 2,422 | **1.0%** |
| **Spanish** | 34,541 | **37.6%** | 139,655 | **45.5%** | 93,792 | **40.4%** | 128,561 | **53.7%** |
| **Tagalog** | 404 | 0.4% | 5,536 | **1.8%** | 2,928 | 1.3% | 4,252 | 1.8% |
| **Vietnamese** | 212 | 0.2% | 3,452 | **1.1%** | 9,199 | **4.0%** | 1,548 | 0.6% |
| **Total** | 91,773 | 100.0% | 306,672 | 100.0% | 232,101 | 100.0% | 239,247 | 100.0% |

Table 13 shows Service Areas 1 through 4's estimated population living at or below 138% FPL whose primary language met the criteria of a threshold language for LACDMH. In SA 1, 97.7% of the estimated population at or below 138% FPL spoke English (60.1%) or Spanish (37.6%). The remaining 3% were spread among the other languages at a rate of 0.5% of the population or lower. In SA 2, 90.7% of the estimated population spoke Spanish (45.5%), English (36.5%), or Armenian (8.7%) languages. In SA 3, 92.4% of the estimated population spoke Spanish (40.4%), English (31.8%), Other Chinese (8.4%), Mandarin (6.8%), Cantonese (5.0%), or Vietnamese (4.0%) languages. In SA 4, 90.2% of the estimated population spoke Spanish (53.7%), English (29.7%) or Korean (6.8%) languages.

**Table**

*14. Primary Language Distribution among the Estimated Population at or Below 138% FPL, Service Areas 5 through 8 and Totals*

| SA | SA 5 | Percent | SA 6 | Percent | SA 7 | Percent | SA 8 | Percent | Total | Percent |
|---|---|---|---|---|---|---|---|---|---|---|
| **Arabic** | 700 | 1.1% | 202 | 0.1% | 1,243 | 0.6% | 1,684 | 0.7% | 9,260 | 0.6% |
| **Armenian** | 376 | 0.6% | 46 | 0.0% | 479 | 0.2% | 263 | 0.1% | 33,061 | 2.0% |
| **Cambodian** | 48 | 0.1% | 83 | 0.0% | 281 | 0.1% | 2,945 | **1.2%** | 4,351 | 0.3% |
| **Cantonese** | 603 | 0.9% | 187 | 0.1% | 406 | 0.2% | 302 | 0.1% | 16,361 | 1.0% |
| **English** | 42,624 | **64.9%** | 83,054 | **27.8%** | 47,032 | **23.9%** | 102,124 | **43.1%** | 586,675 | 35.2% |
| **Farsi** | 3,317 | **5.1%** | 203 | 0.1% | 93 | 0.0% | 441 | 0.2% | 9,304 | 0.6% |
| **Korean** | 990 | 1.5% | 1,367 | 0.5% | 1,482 | 0.8% | 3,310 | 1.4% | 29,708 | 1.8% |
| **Mandarin** | 2,004 | 3.1% | 762 | 0.3% | 674 | 0.3% | 790 | 0.3% | 22,638 | 1.4% |
| **Other Chinese** | 2,284 | 3.5% | 1,993 | 0.7% | 1,390 | 0.7% | 1,670 | 0.7% | 34,799 | 2.1% |
| **Russian** | 850 | 1.3% | 66 | 0.0% | 107 | 0.1% | 254 | 0.1% | 8,285 | 0.5% |
| **Spanish** | 10,974 | **16.7%** | 209,418 | **70.2%** | 141,323 | **71.7%** | 116,562 | **49.2%** | 874,826 | 52.5% |
| **Tagalog** | 306 | 0.5% | 411 | 0.1% | 1,726 | 0.9% | 4,080 | 1.7% | 19,643 | 1.2% |
| **Vietnamese** | 597 | 0.9% | 468 | 0.2% | 895 | 0.5% | 2,533 | **1.1%** | 18,904 | 1.1% |
| **Total** | 65,673 | 100.0% | 298,260 | 100.0% | 197,131 | 100.0% | 236,958 | 100.0% | 1,667,815 | 100.0% |

Table 14 shows the grand totals and Service Areas 5 through 8's estimated population living at or below 138% FPL whose primary language met the criteria of a threshold language for LACDMH. In SA 5, 93.3% of the estimated population living at or below 138% FPL spoke English (64.9%), Spanish (16.7%), Farsi (5.1%), Other Chinese (3.5%) and Mandarin (3.1%) languages. In SA 6, 98% of the population spoke Spanish (70.2%) or English (27.8%). In SA 7, 95.6% of the estimated population spoke Spanish (71.7%) or English (23.9%). In SA 8, 92.3% of the estimated population spoke Spanish (49.2%) or English (43.1%). Across all eight Service Areas, much of the estimated population spoke Spanish (52.5%) or English (35.2%).

SED and SMI Prevalence

Similarly, Spanish (54.3%) is the most common language among the estimated population living at or below 138% FPL estimated with SED or SMI, followed by English (33.6%).

**Table**

*15. Primary Language Distribution among the Estimated Population at or Below 138% FPL with Prevalence of SED or SMI, Service Areas 1 through 4*

| Service Area | SA 1 | Percent | SA 2 | Percent | SA 3 | Percent | SA 4 | Percent |
|---|---|---|---|---|---|---|---|---|
| **Arabic** | 108 | 0.56% | 995 | 1.51% | 447 | 0.90% | 291 | 0.54% |
| **Armenian** | 81 | 0.42% | 6,365 | 9.63% | 340 | 0.68% | 1,000 | 1.85% |
| **Cambodian** | 14 | 0.07% | 23 | 0.04% | 89 | 0.18% | 82 | 0.15% |
| **Cantonese** | 32 | 0.17% | 166 | 0.25% | 5,010 | 10.08% | 1,235 | 2.29% |
| **English** | 12,543 | **64.80%** | 21,699 | **32.84%** | 15,382 | **30.96**% | 14,444 | **26.74%** |
| **Farsi** | 27 | 0.14% | 1,065 | 1.61% | 79 | 0.16% | 195 | 0.36% |
| **Korean** | 47 | 0.24% | 697 | 1.06% | 457 | 0.92% | 2,994 | 5.54% |
| **Mandarin** | 12 | 0.06% | 214 | 0.32% | 3,292 | 6.63% | 287 | 0.53% |
| **Other Chinese** | 10 | 0.05% | 130 | 0.20% | 1,227 | 2.47% | 395 | 0.73% |
| **Russian** | 12 | 0.06% | 1,054 | 1.59% | 47 | 0.09% | 699 | 1.29% |
| **Spanish** | 6,293 | 32.51% | 31,894 | 48.27% | 20,945 | 42.16% | 31,162 | 57.69% |
| **Tagalog** | 94 | 0.49% | 1,170 | 1.77% | 591 | 1.19% | 925 | 1.71% |
| **Vietnamese** | 84 | 0.43% | 605 | 0.92% | 1,778 | 3.58% | 310 | 0.57% |
| **Total** | 19,357 | 100.00% | 66,077 | 100.00% | 49,683 | 100.00% | 54,019 | 100.00% |

Table 15 presents SED and SMI prevalence for poverty estimates in Service Areas 1 through 4. In SA 1, prevalence and poverty estimates were the highest among those who spoke English (64.8%) and Spanish (32.5%) languages. In SA 2, prevalence and poverty estimates were highest among those who spoke Spanish (48.3%), English (32.8%), and Armenian (9.6%) languages. In SA 3, prevalence and poverty rates were highest for those who spoke Spanish (42.2%), English (31.0%), Cantonese (10.1%), Mandarin (6.6%), Vietnamese (3.6%), and Other Chinese (2.5%) languages. In SA 4, prevalence and poverty estimates were the highest among those who spoke Spanish (57.7%), English (26.7%), Korean (5.5%), and Cantonese (2.3%) languages.

**Table**

*16. Primary Language Distribution among the Estimated Population at or Below 138% FPL with Prevalence of SED or SMI, Service Areas 5 through 8 and Totals*

| Service Area | SA 5 | Percent | SA 6 | Percent | SA 7 | Percent | SA 8 | Percent | Total | Percent |
|---|---|---|---|---|---|---|---|---|---|---|
| **Arabic** | 268 | 1.83% | 92 | 0.13% | 375 | 0.83% | 482 | 0.89% | 3,058 | 0.81% |
| **Armenian** | 90 | 0.61% | 17 | 0.02% | 129 | 0.29% | 65 | 0.12% | 8,088 | 2.15% |
| **Cambodian** | 12 | 0.08% | 115 | 0.16% | 172 | 0.38% | 127 | 0.23% | 1,076 | 0.29% |
| **Cantonese** | 243 | 1.66% | 115 | 0.16% | 172 | 0.38% | 127 | 0.23% | 7,099 | 1.89% |
| **English** | 9,291 | 63.38% | 19,980 | 27.65% | 9,887 | 22.00% | 23,228 | 42.91% | 126,455 | 33.61% |
| **Farsi** | 911 | 6.21% | 58 | 0.08% | 24 | 0.05% | 113 | 0.21% | 2,081 | 0.55% |
| **Korean** | 211 | 1.44% | 273 | 0.38% | 377 | 0.84% | 567 | 1.05% | 6,678 | 1.77% |
| **Mandarin** | 475 | 3.24% | 232 | 0.32% | 162 | 0.36% | 185 | 0.34% | 4,859 | 1.29% |
| **Other Chinese** | 162 | 1.10% | 184 | 0.25% | 107 | 0.24% | 126 | 0.23% | 2,340 | 0.62% |
| **Russian** | 212 | 1.45% | 19 | 0.03% | 30 | 0.07% | 69 | 0.13% | 2,141 | 0.57% |
| **Spanish** | 2,563 | 17.49% | 51,003 | 70.59% | 32,888 | 73.16% | 27,581 | 50.95% | 204,330 | 54.31% |
| **Tagalog** | 93 | 0.63% | 60 | 0.08% | 389 | 0.86% | 834 | 1.54% | 4,155 | 1.10% |
| **Vietnamese** | 127 | 0.87% | 107 | 0.15% | 240 | 0.53% | 627 | 1.16% | 3,878 | 1.03% |
| **Total** | 14,658 | 100.00% | 72,255 | 100.00% | 44,952 | 100.00% | 54,130 | 100.00% | 376,237 | 100.00% |

Table 16 presents SED and SMI prevalence for poverty estimates in Service Areas 5 through 8. In SA 5, prevalence and poverty rates were the highest among those who spoke English (63.4%), Spanish (17.5%), Farsi (6.2%), and Mandarin (3.2%) languages. In SA 6, prevalence and poverty rates were the highest among those who spoke Spanish (71.0%) and English (27.7%). In SA 7, prevalence and poverty rates were the highest among those who spoke Spanish (73.2%) and English (22.0%). In SA 8, prevalence and poverty rates were the highest among those who spoke Spanish (51.0%) and English (43.0%). Across all eight Service Areas, prevalence and poverty rates were the highest among those who spoke Spanish (54.3%), English (33.6%), and Armenian (2.2%) languages.

Population Enrolled in Medi-Cal

In CY 2021, the majority of Medi-Cal eligibles spoke English (57.6%) and Spanish (33.6%).

**Figure**

*30. Distribution of Threshold Languages among Population Enrolled in Medi-Cal*

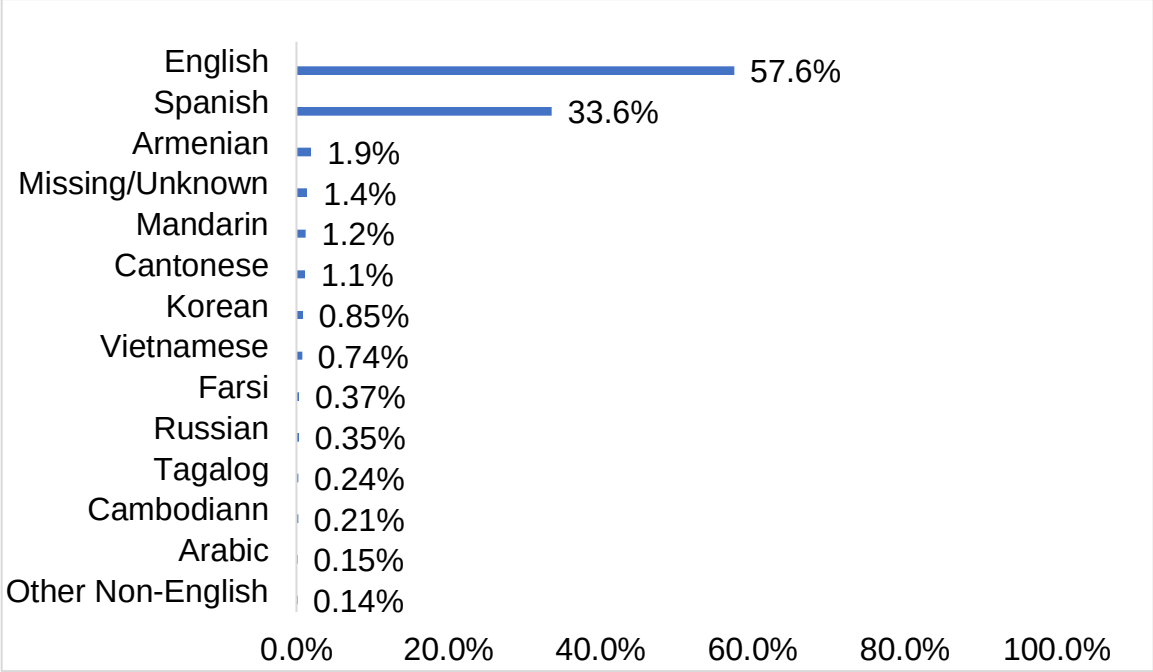



Figure 30 presents the distribution of languages spoken by 5% or 3,000 Medical Eligibles. At 57.6%, most spoke English.

Clients Served

**Table**

*17. Primary Languages of Clients Served in Outpatient LACDMH clinics in Service Areas 1 through 4*

| Language | SA 1 | Percent | SA 2 | Percent | SA 3 | Percent | SA 4 | Percent |
|---|---|---|---|---|---|---|---|---|
| **Arabic** | 4 | 0.02% | 89 | 0.2% | 33 | 0.1% | 11 | 0.0% |
| **Armenian** | 13 | 0.06% | 1,272 | 2.6% | 61 | 0.2% | 180 | 0.5% |
| **Cambodian** | 1 | 0.00% | 22 | 0.0% | 65 | 0.2% | 63 | 0.2% |
| **Cantonese** | 1 | 0.00% | 5 | 0.0% | 518 | 1.3% | 79 | 0.2% |
| **English** | 20,119 | 93.08% | 39,470 | 82.0% | 32,609 | 80.8% | 30,044 | 80.3% |
| **Farsi** | 10 | 0.05% | 579 | 1.2% | 15 | 0.0% | 34 | 0.1% |
| **Korean** | 1 | 0.00% | 112 | 0.2% | 86 | 0.2% | 538 | 1.4% |
| **Mandarin** | 1 | 0.00% | 10 | 0.0% | 541 | 1.3% | 30 | 0.1% |
| **Other Chinese** | | 0.00% | 12 | 0.0% | 68 | 0.2% | 16 | 0.0% |
| **Other Non-English** | 2 | 0.01% | 10 | 0.0% | 14 | 0.0% | 5 | 0.0% |
| **Russian** | 8 | 0.04% | 207 | 0.4% | 4 | 0.0% | 139 | 0.4% |
| **Spanish** | 1,449 | 6.70% | 6,183 | 12.8% | 5,912 | 14.6% | 6,151 | 16.4% |
| **Tagalog** | 6 | 0.03% | 96 | 0.2% | 42 | 0.1% | 73 | 0.2% |
| **Vietnamese** | | 0.00% | 72 | 0.1% | 410 | 1.0% | 51 | 0.1% |
| **Total** | 21,615 | 100.00% | 48,139 | 100.0% | 40,378 | 100.0% | 37,414 | 100.0% |

Table 17 shows the distribution of primary languages for clients served in Service Areas 1 through 4. In SA 1, 93.1% of clients spoke English, 6.7% spoke Spanish, and less than 4% spoke Armenian, Arabic, Farsi, Russian, Tagalog, and Other non-English languages. In SA 2, 82.0% of clients spoke English, 12.8% spoke Spanish, 2.6% spoke Armenian, 1.2% spoke Farsi, and 11% spoke Other non-English languages. In SA 3, 80.8% of clients spoke English, 14.6% spoke Spanish, 1.3% spoke Cantonese or Mandarin, 1.0% spoke Vietnamese, and 1.2% spoke Other non-English languages. In SA 4, 80.3% of clients spoke English, 16.4% spoke Spanish, 1.4% spoke Korean, and 1.8% spoke Other non-English languages.

**Table**

*18. Primary Languages of Clients Served in Outpatient LACDMH Clinics in Services Areas 5 through 8 and Overall*

| Language | SA 5 | Percent | SA 6 | Percent | SA 7 | Percent | SA 8 | Percent | Total | Percent |
|---|---|---|---|---|---|---|---|---|---|---|
| **Arabic** | 18 | 0.2% | 3 | 0.01% | 22 | 0.06% | 19 | 0.05% | 157 | 0.1% |
| **Armenian** | 5 | 0.1% | 7 | 0.01% | 10 | 0.03% | 8 | 0.02% | 1,262 | 0.7% |
| **Cambodian** | | 0.0% | 11 | 0.02% | 91 | 0.24% | 524 | 1.25% | 736 | 0.4% |
| **Cantonese** | 2 | 0.0% | 28 | 0.05% | 23 | 0.06% | 13 | 0.03% | 552 | 0.3% |
| **English** | 9,152 | 92.3% | 43,925 | 84.01% | 29,348 | 78.61% | 35,781 | 85.62% | 157,061 | 81.6% |
| **Farsi** | 137 | 1.4% | 18 | 0.03% | 12 | 0.03% | 11 | 0.03% | 661 | 0.3% |
| **Korean** | 18 | 0.2% | 57 | 0.11% | 57 | 0.15% | 84 | 0.20% | 808 | 0.4% |
| **Mandarin** | 3 | 0.0% | 15 | 0.03% | 34 | 0.09% | 26 | 0.06% | 544 | 0.3% |
| **Other Chinese** | 1 | 0.0% | 1 | 0.00% | 16 | 0.04% | 7 | 0.02% | 106 | 0.1% |
| **Other Non-English** | | 0.0% | 10 | 0.02% | 2 | 0.01% | 10 | 0.02% | 37 | 0.0% |
| **Russian** | 38 | 0.4% | 5 | 0.01% | 2 | 0.01% | 10 | 0.02% | 360 | 0.2% |
| **Spanish** | 529 | 5.3% | 8,177 | 15.64% | 7,670 | 20.55% | 5,128 | 12.27% | 29,441 | 15.3% |
| **Tagalog** | 8 | 0.1% | 12 | 0.02% | 26 | 0.07% | 68 | 0.16% | 261 | 0.1% |
| **Vietnamese** | 1 | 0.0% | 15 | 0.03% | 19 | 0.05% | 102 | 0.24% | 550 | 0.3% |
| **Total** | 9,912 | 100.0% | 52,284 | 100.00% | 37,332 | 100.00% | 41,791 | 100.00% | 192,536 | 100.0% |

Table 18 shows the distribution of primary languages for clients served in Service Areas 5 to 8. In SA 5, 92.3% of clients spoke English, 5.3% spoke Spanish, and 1.4% spoke Farsi languages. In SA 6, 84.0% spoke English, and 15.6% spoke Spanish. In SA 7, 78.6% of clients spoke English, and 20.6% spoke Spanish. In SA 8, 85.6% spoke English, 12.3% spoke Spanish, and 1.3% spoke Cambodian languages. Overall, English was spoken at 81.6%, and Spanish was spoken at 15.3%. The remaining 3.1% spoke other non-English languages.

**Table**

*19. Other Non-English Languages for Clients Served in LACDMH Outpatient Clinics*

| Languages | SA 1 | SA 2 | SA 3 | SA 4 | SA 5 | SA 6 | SA 7 | SA 8 | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Afghan, Pashto, Pusho** | 2 | 18 | | 1 | | | | 1 | 19 |
| Percent | 11.1% | 11.2% | 0.0% | 0.7% | 0.0% | 0.0% | 0.0% | 0.8% | 3.2% |
| **American Sign Language** | 11 | 11 | 7 | 14 | 3 | 17 | 14 | 14 | 69 |
| Percent | 61.1% | 6.8% | 4.8% | 10.4% | 11.1% | 35.4% | 25.0% | 10.9% | 11.7% |
| **Burmese** | | 1 | 9 | 1 | | | | | 11 |
| Percent | 0.0% | 0.6% | 6.2% | 0.7% | 0.0% | 0.0% | 0.0% | 0.0% | 1.9% |
| **Ethiopian** | | 4 | 7 | 16 | 1 | 16 | 3 | 3 | 33 |
| Percent | 0.0% | 2.5% | 4.8% | 11.9% | 3.7% | 33.3% | 5.4% | 2.3% | 5.6% |
| **French** | | 13 | 2 | 3 | 3 | 3 | | 4 | 22 |
| Percent | 0.0% | 8.1% | 1.4% | 2.2% | 11.1% | 6.3% | 0.0% | 3.1% | 3.7% |
| **Hebrew** | | 18 | | 2 | 2 | | 1 | 2 | 19 |
| Percent | 0.0% | 11.2% | 0.0% | 1.5% | 7.4% | 0.0% | 1.8% | 1.6% | 3.2% |
| **Hindi** | | 6 | 2 | 1 | 2 | | 6 | 6 | 22 |
| Percent | 0.0% | 3.7% | 1.4% | 0.7% | 7.4% | 0.0% | 10.7% | 4.7% | 3.7% |
| **Japanese** | | 11 | 10 | 22 | 6 | 3 | 1 | 42 | 83 |
| Percent | 0.0% | 6.8% | 6.8% | 16.3% | 22.2% | 6.3% | 1.8% | 32.8% | 14.1% |
| **Lao** | | 2 | 7 | 23 | | 4 | 1 | 19 | 45 |
| Percent | 0.0% | 1.2% | 4.8% | 17.0% | 0.0% | 8.3% | 1.8% | 14.8% | 7.6% |
| **Portuguese** | 3 | 7 | 2 | 4 | 8 | 2 | 2 | 5 | 24 |
| Percent | 16.7% | 4.3% | 1.4% | 3.0% | 29.6% | 4.2% | 3.6% | 3.9% | 4.1% |
| **Punjabi** | | 7 | | | | | 3 | | 8 |
| Percent | 0.0% | 4.3% | 0.0% | 0.0% | 0.0% | 0.0% | 5.4% | 0.0% | 1.4% |
| **Romanian** | | 3 | | 2 | 1 | | | | 6 |
| Percent | 0.0% | 1.9% | 0.0% | 1.5% | 3.7% | 0.0% | 0.0% | 0.0% | 1.0% |
| **Thai** | | 25 | 7 | 22 | | | 8 | 6 | 60 |
| Percent | 0.0% | 15.5% | 4.8% | 16.3% | 0.0% | 0.0% | 14.3% | 4.7% | 10.2% |
| **Toisan** | | 1 | 9 | 2 | | 2 | 1 | | 14 |
| Percent | 0.0% | 0.6% | 6.2% | 1.5% | 0.0% | 4.2% | 1.8% | 0.0% | 2.4% |
| **Urdu** | | 12 | 2 | 1 | | | | 9 | 20 |
| Percent | 0.0% | 7.5% | 1.4% | 0.7% | 0.0% | 0.0% | 0.0% | 7.0% | 3.4% |
| **Other Chinese** | | 12 | 68 | 16 | 1 | 1 | 16 | 7 | 105 |
| Percent | 0.0% | 7.5% | 46.6% | 11.9% | 3.7% | 2.1% | 28.6% | 5.5% | 17.8% |
| **Other Non - English** | 2 | 10 | 14 | 5 | | | 2 | 10 | 30 |
| Percent | 11.1% | 6.2% | 9.6% | 3.7% | 0.0% | 0.0% | 3.6% | 7.8% | 5.1% |
| **Total** | 18 | 161 | 146 | 135 | 27 | 48 | 56 | 128 | 590 |
| Percent | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Table 19 shows the percentage of clients served who spoke “Other non-English” languages by Service Area. American Sign Language (ASL) was the preferred language of clients in SA 1 (61.1%) the most, followed by SA 6 (35.4%) and SA7 (25.0%).

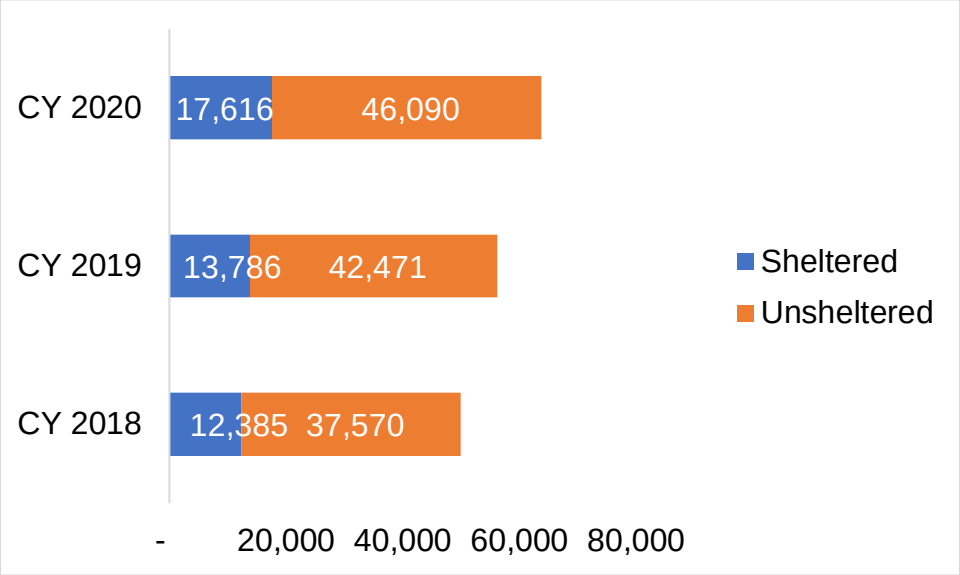
**Los Angeles Homeless Services Authority's 2020 Greater Los Angeles Homeless Counts**

The Los Angeles Homeless Services Authority's (LAHSA) results of the 2020 Greater Los Angeles Homeless Count showed 66,436 individuals in Los Angeles County were experiencing homelessness. The city of Los Angeles saw a 16.1% rise to 41,290.

The 2020 Homeless Counts were conducted in January 2020, before the impacts of the COVID-19 pandemic could be felt, measured, or responded to through efforts such as Project Roomkey, rent freezes, and eviction moratoriums

**Figure**

*31. Three-year Trend for Sheltered versus Unsheltered Individuals Experiencing Homelessness*

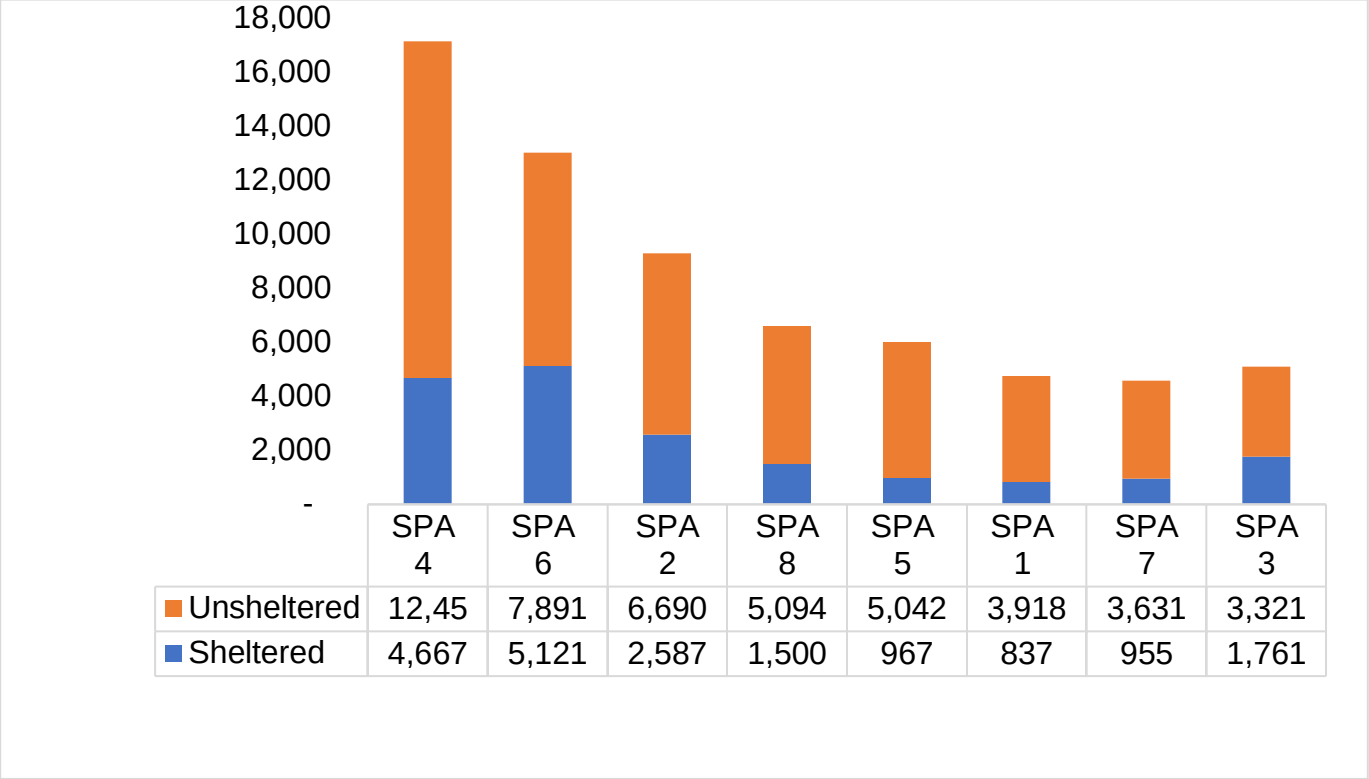



Note: Data reflects individuals ages 18 years and older and households with no adults over age18 years (unaccompanied minors).

At the SPA level, percentage point (PP) changes ranged from 44% to -10% between CY 2019 and CY 2020. Homeless counts increased by 44% in SPA 1, 36% in SPA 2, 16% in SPA 3, and 14% in SPA 5. Homeless counts increased by five, four, and one PPs in SPAs 8, 4, and 3, respectively. Conversely, homeless counts declined by 10% in SPA 7 from CY 2019 to CY 2020. SPA 4 had the highest distribution of unsheltered individuals, whereas SPA 6 had the highest allocation of sheltered individuals. Across all eight SPAs, SPA 1 had the lowest allocation of homeless, and SPA 3 had the lowest distribution of unsheltered homeless.

**Figure**

*32. Individuals Experiencing Homelessness by Shelter Status and SPA, Calendar Year 2020*

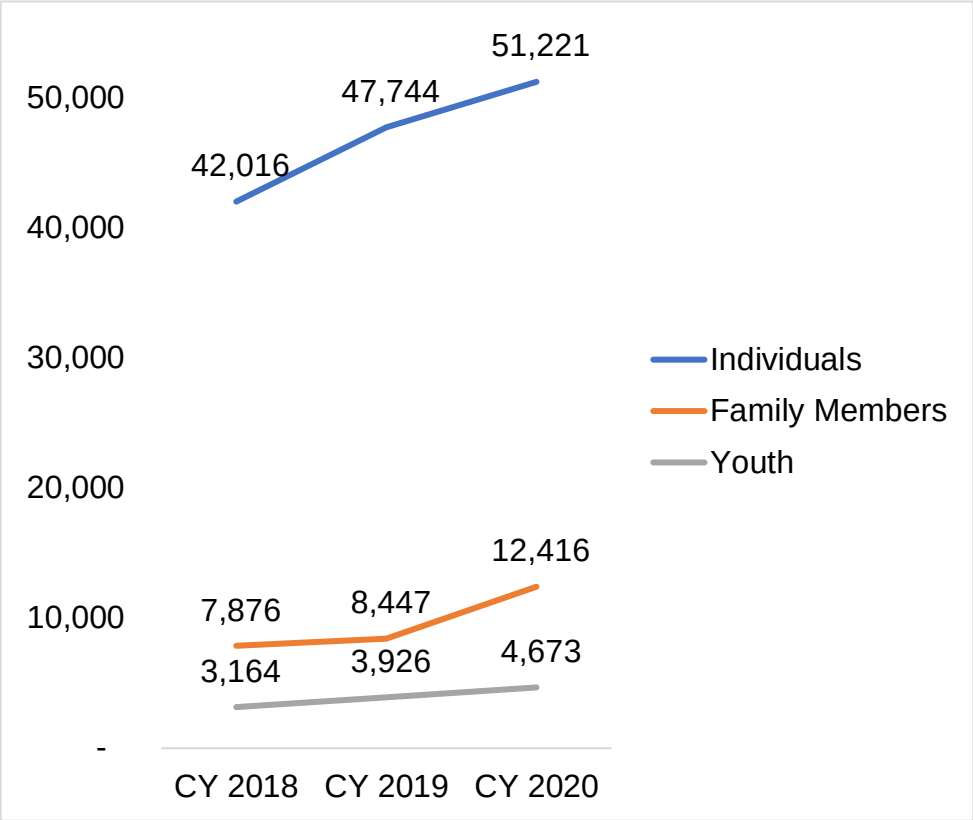



| | SPA 4 | SPA 6 | SPA 2 | SPA 8 | SPA 5 | SPA 1 | SPA 7 | SPA 3 |
|---|---|---|---|---|---|---|---|---|
| Unsheltered | 12,45 | 7,891 | 6,690 | 5,094 | 5,042 | 3,918 | 3,631 | 3,321 |
| Sheltered | 4,667 | 5,121 | 2,587 | 1,500 | 967 | 837 | 955 | 1,761 |

Most SPAs had a higher proportion of unsheltered individuals experiencing homelessness, with those sheltered in the 4,000 to 800 range. In CY 2020, SPA 4 had greater than 17,000 individuals experiencing homelessness, the highest of all SPAs. SPA 6 had greater than 5,000 individuals experiencing homelessness who are sheltered.

**Figure**

*33. Three-Year Trends for Individuals, Youth, and Families Experiencing Homelessness*




The number of individuals, youth, and families experiencing homelessness trends upward. Over the past three years, the number of families experiencing homelessness showed the most significant increase between CY 2019 and CY 2020.

**Penetration Rates, Fiscal Year 2020-21**

Penetration Rates for Los Angeles County Residents and Clients Served

Penetration rates are derived by applying prevalence rates for the racial/ethnic, gender, or age groups to the demographic data for clients served. These tables aid in identifying our target and underserved populations.

***Differences by Ethnicity***

**Table**

*20. Service Areas 1 through 3 Penetration Rates by Race/Ethnicity for Total Population and Population Living at or Below 138% FPL*

| Ethnicity and SA | Number of Clients Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3] | Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2] |
|---|---|---|---|---|---|
| **SA 1** | | | | | |
| **African American** | 6,976 | 8,110 | 86.0% | 3,213 | 217.1% |
| **Asian/Pacific Islander** | 245 | 2,003 | 12.2% | 461 | 53.1% |
| **Latino** | 6,423 | 33,431 | 19.2% | 10,146 | 63.3% |
| **Native American** | 135 | 463 | 29.2% | 183 | 73.8% |
| **White** | 4,672 | 14,522 | 32.2% | 3,966 | 117.8% |
| **Two or more races** | 1,100 | 2,566 | 42.9% | 744 | 147.8% |
| **Total** | 19,551 | 61,095 | 32.0% | 18,713 | 104.5% |
| **SA 2** | | | | | |
| **African American** | 3,629 | 10,357 | 35.0% | 2,141 | 169.5% |
| **Asian/Pacific Islander** | 1,464 | 31,308 | 4.7% | 5,806 | 25.2% |
| **Latino** | 19,972 | 132,783 | 15.0% | 30,133 | 66.3% |
| **Native American** | 161 | 1,104 | 14.6% | 184 | 87.5% |
| **White** | 11,784 | 128,626 | 9.2% | 23,447 | 50.3% |
| **Two or more races** | 1,483 | 13,092 | 11.3% | 1,661 | 89.3% |
| **Total** | 38,493 | 317,272 | 12.1% | 63,371 | 60.7% |
| **SA 3** | | | | | |
| **African American** | 2,892 | 7,082 | 40.8% | 1,247 | 231.9% |
| **Asian/Pacific Islander** | 3,056 | 65,581 | 4.7% | 12,612 | 24.2% |
| **Latino** | 12,805 | 122,841 | 10.4% | 24,196 | 52.9% |
| **Native American** | 212 | 906 | 23.4% | 126 | 168.3% |
| **White** | 4,912 | 42,688 | 11.5% | 6,044 | 81.3% |
| **Two or more races** | 1,140 | 7,043 | 16.2% | 649 | 175.7% |
| **Total** | 25,017 | 246,141 | 10.2% | 44,874 | 55.7% |

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, and Inpatient-Fee-For Service and County Hospitals.
[2]Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI.* Duplicated clients by ethnicity/unduplicated consumers by ethnicity (18,359/33,771 = 55.0% for African Americans.)
[3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness.Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2019-2020 pooled.

**Table**

*21. Service Areas 4 through 6 Penetration Rates by Race/Ethnicity for Total Population and Population Living at or Below 138% FPL*

| Ethnicity and SA | Number of Clients Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3] | Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2] |
|---|---|---|---|---|---|
| **SA 4** | | | | | |
| **African American** | 6,021 | 8,066 | 74.6% | 2,450 | 245.8% |
| **Asian/Pacific Islander** | 2,065 | 23,013 | 9.0% | 7,748 | 26.7% |
| **Latino** | 15,908 | 79,710 | 20.0% | 25,906 | 61.4% |
| **Native American** | 194 | 725 | 26.8% | 329 | 59.0% |
| **White** | 5,769 | 42,945 | 13.4% | 10,222 | 56.4% |
| **Two or more races** | 800 | 6,163 | 13.0% | 1,393 | 57.4% |
| **Total** | 30,757 | 160,622 | 19.1% | 48,047 | 64.0% |
| **SA 5** | | | | | |
| **African American** | 1,805 | 4,340 | 41.6% | 686 | 263.1% |
| **Asian/Pacific Islander** | 347 | 11,025 | 3.1% | 1,981 | 17.5% |
| **Latino** | 2,116 | 16,098 | 13.1% | 2,506 | 84.4% |
| **Native American** | 50 | 300 | 16.7% | 26 | 192.3% |
| **White** | 3,294 | 55,328 | 6.0% | 8,784 | 37.5% |
| **Two or more races** | 309 | 6,412 | 4.8% | 793 | 39.0% |
| **Total** | 7,921 | 93,503 | 8.5% | 14,777 | 53.6% |
| **SA 6** | | | | | |
| **African American** | 18,451 | 30,570 | 60.4% | 12,614 | 146.3% |
| **Asian/Pacific Islander** | 476 | 2,928 | 16.3% | 1,435 | 33.2% |
| **Latino** | 20,788 | 107,643 | 19.3% | 40,515 | 51.3% |
| **Native American** | 564 | 477 | 118.2% | 299 | 188.6% |
| **White** | 2,693 | 4,580 | 58.8% | 1,678 | 160.5% |
| **Two or more races** | 867 | 3,183 | 27.2% | 1,175 | 73.8% |
| **Total** | 43,839 | 149,381 | 29.3% | 57,716 | 76.0% |

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, and Inpatient-Fee-For Service and County Hospitals.
[2]Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI.* Duplicated clients by ethnicity/unduplicated consumers by ethnicity (18,359/33,771 = 55.0% for African Americans.)
[3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness.Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2019-2020 pooled.

**Table**

*22. Service Areas 7 through 8 and Unduplicated Counts Penetration Rates by Race/Ethnicity for Total Population and Population Living at or Below 138% FPL*

| Ethnicity and SA | Number of Clients Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3] | Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2] |
|---|---|---|---|---|---|
| **SA 7** | | | | | |
| **African American** | 1,970 | 5,035 | 39.1% | 874 | 225.4% |
| **Asian/Pacific Islander** | 949 | 15,473 | 6.1% | 2,063 | 46.0% |
| **Latino** | 18,625 | 145,387 | 12.8% | 32,221 | 57.8% |
| **Native American** | 195 | 882 | 22.1% | 137 | 142.3% |
| **White** | 3,589 | 19,628 | 18.3% | 2,426 | 147.9% |
| **Two or more races** | 1,062 | 3,383 | 31.4% | 246 | 431.7% |
| **Total** | 26,390 | 189,788 | 13.9% | 37,967 | 69.5% |
| **SA 8** | | | | | |
| **African American** | 10,616 | 26,967 | 39.4% | 7,941 | 133.7% |
| **Asian/Pacific Islander** | 2,185 | 29,594 | 7.4% | 5,699 | 38.3% |
| **Latino** | 13,690 | 97,113 | 14.1% | 24,269 | 56.4% |
| **Native American** | 229 | 1,003 | 22.8% | 235 | 97.4% |
| **White** | 6,066 | 54,889 | 11.1% | 7,558 | 80.3% |
| **Two or more races** | 1,373 | 10,998 | 12.5% | 1,597 | 86.0% |
| **Total** | 34,159 | 220,565 | 15.5% | 47,299 | 72.2% |
| **Unduplicated Clients Served in At least 1 Service Area.** | | | | | |
| **African American** | 30,438 | 100,527 | 30.3% | 31,165 | 97.7% |
| **Asian/Pacific Islander** | 6,855 | 180,924 | 3.8% | 37,805 | 18.1% |
| **Latino** | 59,791 | 735,006 | 8.1% | 189,891 | 31.5% |
| **Native American** | 1,063 | 5,860 | 18.1% | 1,517 | 70.1% |
| **White** | 23,937 | 363,208 | 6.6% | 64,126 | 37.3% |
| **Two or more races** | 3,914 | 52,840 | 7.4% | 8,258 | 47.4% |
| **Total** | 125,998 | 1,438,365 | 8.8% | 332,762 | 37.9% |
| **Duplicated Countywide Clients Served in More Than one Service Area*** | | | | | |
| **African American** | 18,589 | 55.0% | | | |
| **Asian/Pacific Islander** | 2,590 | 31.6% | | | |

| | | | |
|---|---|---|---|
| **Latino** | 35,991 | 48.4% | |
| **Native American** | 628 | 56.5% | |
| **White** | 14,024 | 48.8% | |
| **Two or more races** | 2,823 | 53.2% | |
| **Total** | 74,645 | 49.3% | |

***Differences by Age***

**Table**

*23. Service Areas 1 through 3 Penetration Rates by Age Group for Total Population and Population Living at or Below 138% FPL*

| Age Group (Years) and SA | Number of Clients Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3] | Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2] |
|---|---|---|---|---|---|
| **SA 1** | | | | | |
| **0-18** | 10,083 | 17,909 | 56.3% | 3,654 | 275.9% |
| **19-20** | 641 | 4,659 | 13.8% | 1,144 | 56.0% |
| **21-25** | 1,257 | 8,272 | 15.2% | 2,793 | 45.0% |
| **26-59** | 8,476 | 23,056 | 36.8% | 5,543 | 152.9% |
| **60-64** | 1,080 | 1,079 | 100.1% | 330 | 327.3% |
| **65 and above** | 665 | 1,689 | 39.4% | 401 | 165.8% |
| **Total** | 22,202 | 56,664 | 39.2% | 13,864 | 160.1% |
| **SA 2** | | | | | |
| **0-18** | 20,038 | 71,836 | 27.9% | 8,953 | 223.8% |
| **19-20** | 2,024 | 19,286 | 10.5% | 3,262 | 62.0% |
| **21-25** | 3,185 | 33,502 | 9.5% | 7,974 | 39.9% |
| **26-59** | 19,591 | 135,124 | 14.5% | 22,290 | 87.9% |
| **60-64** | 2,722 | 6,466 | 42.1% | 1,256 | 216.7% |
| **65 and above** | 2,566 | 12,257 | 20.9% | 1,875 | 136.9% |
| **Total** | 50,126 | 278,471 | 18.0% | 45,610 | 109.9% |
| **SA 3** | | | | | |
| **0-18** | 20,526 | 56,325 | 36.4% | 6,750 | 304.1% |
| **19-20** | 2,101 | 17,679 | 11.9% | 2,650 | 79.3% |
| **21-25** | 2,638 | 28,485 | 9.3% | 6,357 | 41.5% |
| **26-59** | 13,819 | 103,005 | 13.4% | 15,515 | 89.1% |
| **60-64** | 1,621 | 5,122 | 31.6% | 919 | 176.4% |
| **65 and above** | 1,636 | 10,623 | 15.4% | 1,677 | 97.6% |
| **Total** | 42,341 | 221,239 | 19.1% | 33,868 | 125.0% |

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, Inpatient Fee-For-Service, and County Hospitals.

[2]Penetration Rate = Number of Clients Served / Number of People Estimated with SED & SMI. * Duplicated clients by age/unduplicated clients by age (For example, 47,181/78,459 = 60.1% for ages 0-18).

[3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2019-2020 pooled.

**Table**

*24. Service Areas 4 through 7 Penetration Rates by Age Group for Total Population and Population Living at or Below 138% FPL*

| Age Group (Years) and SA | Number of Clients Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3] | Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2] |
|---|---|---|---|---|---|
| **SA 4** | | | | | |
| **0-18** | 13,111 | 28,490 | 46.0% | 6,055 | 216.5% |
| **19-20** | 1,330 | 8,476 | 15.7% | 2,181 | 61.0% |
| **21-25** | 2,421 | 14,451 | 16.8% | 5,443 | 44.5% |
| **26-59** | 17,446 | 79,786 | 21.9% | 19,161 | 91.0% |
| **60-64** | 2,529 | 2,812 | 89.9% | 890 | 284.2% |
| **65 and above** | 2,310 | 5,819 | 39.7% | 1,604 | 144.0% |
| **Total** | 39,147 | 139,835 | 28.0% | 35,334 | 110.8% |
| **SA 5** | | | | | |
| **0-18** | 2,815 | 16,141 | 17.4% | 1,116 | 252.2% |
| **19-20** | 286 | 8,463 | 3.4% | 956 | 29.9% |
| **21-25** | 637 | 9,508 | 6.7% | 2,970 | 21.4% |
| **26-59** | 5,286 | 43,076 | 12.3% | 5,569 | 94.9% |
| **60-64** | 752 | 1,854 | 40.6% | 263 | 285.9% |
| **65 and above** | 804 | 4,218 | 19.1% | 477 | 168.6% |
| **Total** | 10,580 | 83,259 | 12.7% | 11,350 | 93.2% |
| **SA 6** | | | | | |
| **0-18** | 22,496 | 42,196 | 53.3% | 11,635 | 193.3% |
| **19-20** | 1,818 | 12,865 | 14.1% | 3,979 | 45.7% |
| **21-25** | 3,134 | 20,246 | 15.5% | 9,570 | 32.7% |
| **26-59** | 21,414 | 59,586 | 35.9% | 18,713 | 114.4% |
| **60-64** | 2,928 | 2,166 | 135.2% | 912 | 321.1% |
| **65 and above** | 2,053 | 3,582 | 57.3% | 1,056 | 194.4% |
| **Total** | 53,843 | 140,641 | 38.3% | 45,866 | 117.4% |

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, Inpatient Fee-For-Service, and County Hospitals.

[2]Penetration Rate = Number of Clients Served / Number of People Estimated with SED & SMI. * Duplicated clients by age/unduplicated clients by age (For example, 47,181/78,459 = 60.1% for ages 0-18).

[3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2019-2020 pooled.

**Table**

*25. Service Areas 7 through 8 and Unduplicated Counts Penetration Rates by Age Group for Total Population and Population Living at or Below 138% FPL*

| Age Group (Years) and SA | Number of Clients Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3] | Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2] |
|---|---|---|---|---|---|
| **SA 7** | | | | | |
| **0-18** | 19,417 | 47,303 | 41.0% | 7,258 | 267.5% |
| **19-20** | 1,744 | 13,264 | 13.1% | 2,258 | 77.2% |
| **21-25** | 2,305 | 23,045 | 10.0% | 5,449 | 42.3% |
| **26-59** | 12,201 | 75,737 | 16.1% | 12,658 | 96.4% |
| **60-64** | 1,369 | 3,119 | 43.9% | 655 | 209.0% |
| **65 and above** | 1,243 | 6,205 | 20.0% | 956 | 130.0% |
| **Total** | 38,279 | 168,673 | 22.7% | 29,233 | 130.9% |
| **SA 8** | | | | | |
| **0-18** | 17,154 | 52,369 | 32.8% | 7,788 | 220.3% |
| **19-20** | 1,539 | 14,461 | 10.6% | 2,675 | 57.5% |
| **21-25** | 2,546 | 24,567 | 10.4% | 6,499 | 39.2% |
| **26-59** | 17,516 | 93,234 | 18.8% | 16,322 | 107.3% |
| **60-64** | 2,414 | 4,393 | 55.0% | 913 | 264.4% |
| **65 and above** | 2,144 | 8,418 | 25.5% | 1,278 | 167.8% |
| **Total** | 43,313 | 197,442 | 21.9% | 35,475 | 122.1% |
| **Unduplicated Clients Served in At least 1 Service Area** | | | | | |
| **0-18** | 78,459 | 332,569 | 23.6% | 53,209 | 147.5% |
| **19-20** | 7,439 | 99,153 | 7.5% | 19,104 | 38.9% |
| **21-25** | 12,049 | 162,076 | 7.4% | 47,056 | 25.6% |
| **26-59** | 80,549 | 612,605 | 13.1% | 115,772 | 69.6% |
| **60-64** | 11,549 | 27,011 | 42.8% | 6,137 | 188.2% |
| **65 and above** | 10,942 | 52,810 | 20.7% | 9,323 | 117.4% |
| **Total** | 200,987 | 1,286,225 | 15.6% | 250,601 | 80.2% |
| **Duplicated Countywide Clients Served in More Than one Service Area*** | | | | | |
| **0-18** | 47,181 | 60.1% | | | |
| **19-20** | 4,044 | 54.4% | | | |
| **21-25** | 6,074 | 50.4% | | | |
| **26-59** | 35,200 | 43.7% | | | |
| **60-64** | 3,866 | 33.5% | | | |
| **65 and above** | 2,479 | 22.7% | | | |
| **Total** | 98,844 | 49.2% | | | |

***Differences by Gender***

**Table**

*26. Service Areas 1 through 5 Penetration Rates by Gender for Total Population and Population Living at or Below 138% FPL*

| Age Group and Service Area | Number of Clients Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3] | Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2] |
|---|---|---|---|---|---|
| **SA 1** | | | | | |
| **Male** | 10,179 | 24,782 | 41.1% | 7,001 | 145.4% |
| **Female** | 11,984 | 35,114 | 34.1% | 10,885 | 110.1% |
| **Total** | 22,163 | 59,896 | 37.0% | 17,886 | 123.9% |
| **SA 2** | | | | | |
| **Male** | 23,588 | 131,233 | 18.0% | 23,363 | 101.0% |
| **Female** | 26,452 | 185,095 | 14.3% | 36,185 | 73.1% |
| **Total** | 50,040 | 316,328 | 15.8% | 59,548 | 84.0% |
| **SA 3** | | | | | |
| **Male** | 20,327 | 102,577 | 19.8% | 17,267 | 117.7% |
| **Female** | 21,954 | 149,197 | 14.7% | 27,426 | 80.0% |
| **Total** | 42,281 | 251,773 | 16.8% | 44,693 | 94.6% |
| **SA 4** | | | | | |
| **Male** | 20,094 | 69,552 | 28.9% | 21,395 | 93.9% |
| **Female** | 18,969 | 89,796 | 21.1% | 27,549 | 68.9% |
| **Total** | 39,063 | 159,348 | 24.5% | 48,944 | 79.8% |
| **SA 5** | | | | | |
| **Male** | 5,260 | 38,613 | 13.6% | 6,344 | 82.9% |
| **Female** | 5,293 | 56,940 | 9.3% | 8,169 | 64.8% |
| **Total** | 10,553 | 95,553 | 11.0% | 14,512 | 72.7% |

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, Inpatient Fee-For-Service, and County Hospitals.

[2]Penetration Rate = Number of Clients Served / Number of People Estimated with SED & SMI. * Duplicated clients by age/unduplicated clients by age (For example, 47,181/78,459 = 60.1% for ages 0-18).

[3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2019-2020 pooled.

**Table**

*27. Service Areas 6 through 8 and Unduplicated Counts Penetration Rates by Gender for Total Population and Population Living at or Below 138% FPL*

| Age Group and Service Area | Number of Clients Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3] | Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2] |
|---|---|---|---|---|---|
| **SA 6** | | | | | |
| **Male** | 26,444 | 59,688 | 44.3% | 27,170 | 97.3% |
| **Female** | 27,325 | 86,133 | 31.7% | 34,986 | 78.1% |
| **Total** | 53,769 | 145,820 | 36.9% | 62,155 | 86.5% |
| **SA 7** | | | | | |
| **Male** | 18,131 | 75,567 | 24.0% | 18,204 | 99.6% |
| **Female** | 20,108 | 108,120 | 18.6% | 23,440 | 85.8% |
| **Total** | 38,239 | 183,687 | 20.8% | 41,644 | 91.8% |
| **SA 8** | | | | | |
| **Male** | 20,808 | 90,974 | 22.9% | 21,879 | 95.1% |
| **Female** | 22,413 | 131,369 | 17.1% | 28,173 | 79.6% |
| **Total** | 43,221 | 222,343 | 19.4% | 50,053 | 86.4% |
| **Unduplicated Clients Served in At least 1 Service Area** | | | | | |
| **Male** | 95,189 | 592,985 | 16.1% | 152,844 | 62.3% |
| **Female** | 105,471 | 841,765 | 12.5% | 196,813 | 53.6% |
| **Total** | 200,660 | 1,434,750 | 14.0% | 349,658 | 57.4% |
| **Duplicated Countywide Clients Served in More Than one Service Area*** | | | | | |
| **Male** | 49,642 | 52.2% | | | |
| **Female** | 49,027 | 46.5% | | | |
| **Total** | 98,669 | 49.2% | | | |

Penetration Rate Changes for Medi-Cal Beneficiaries

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.

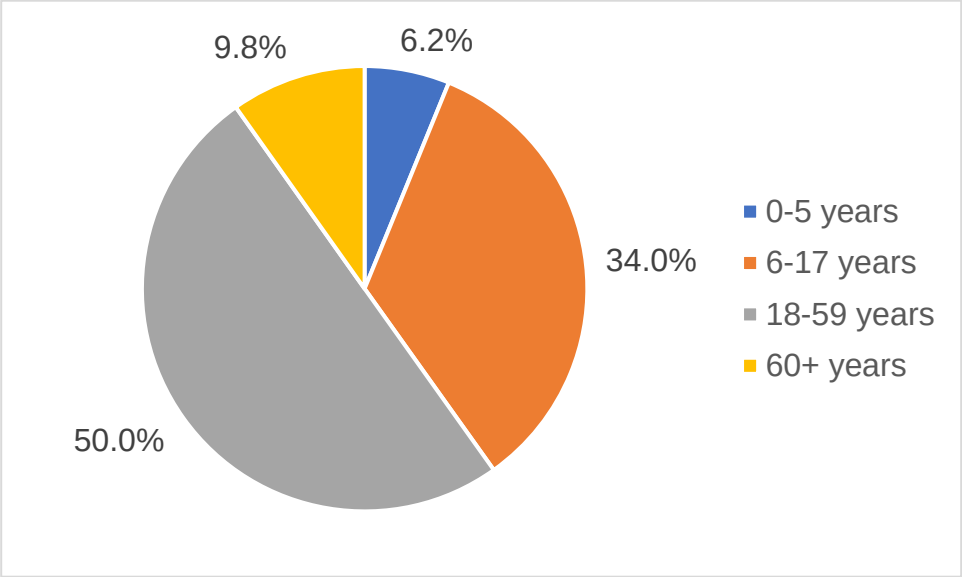
The Department refers to the BHC reports for penetration rate changes and trends by age group and race/ethnicity. Of note, the penetration rates that follow are limited to the Medi-Cal enrolled population of clients served. BHC calculates penetration rate by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The County's total number of yearly unduplicated Medi-Cal eligibles is 4,363,953 and includes the population eligible through Affordable Care Act Expansion.

Due to a declining number of beneficiaries, penetration rates increased in 2020 across all regions. Because of its declining number of eligible beneficiaries and the significant increase in the number of beneficiaries served, LACDMH showed the highest penetration rate and continued to have the second-highest penetration rate in the state. Of note, Los Angeles County accounts for almost one-third of the state's Medi-Cal eligible beneficiaries.

***Differences by Age Group***

**Figure**

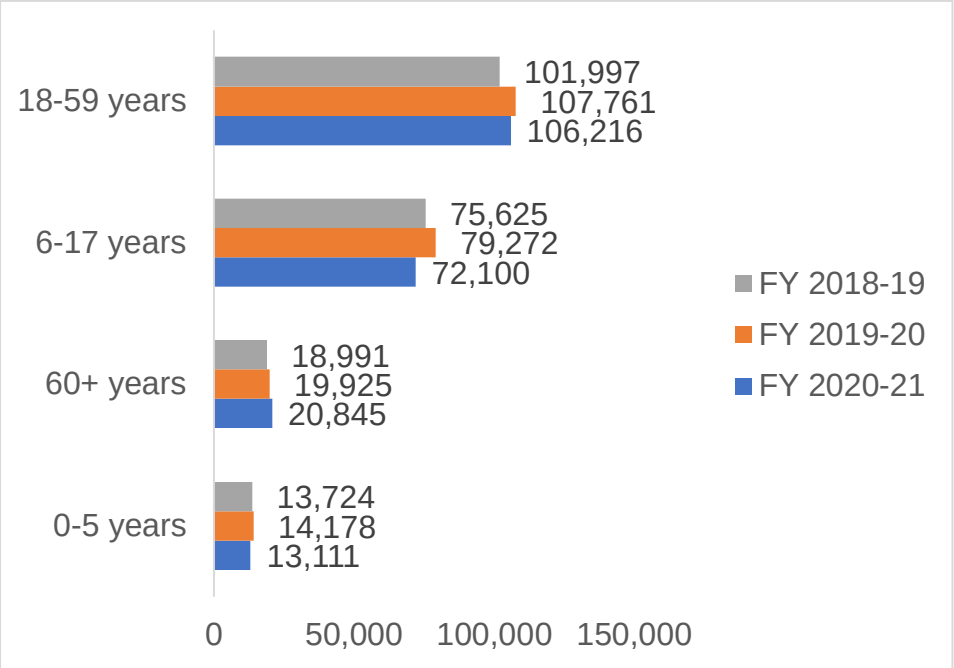
*34. Age Group Distribution for Medi-Cal Beneficiaries Served, Fiscal Year 2020-21*




*Note:* The N for the 0-5 years category is 13,111, 72,100 for 6-17 years, 107,761 for 18-59 years, and 19,925 for 60 years and above.

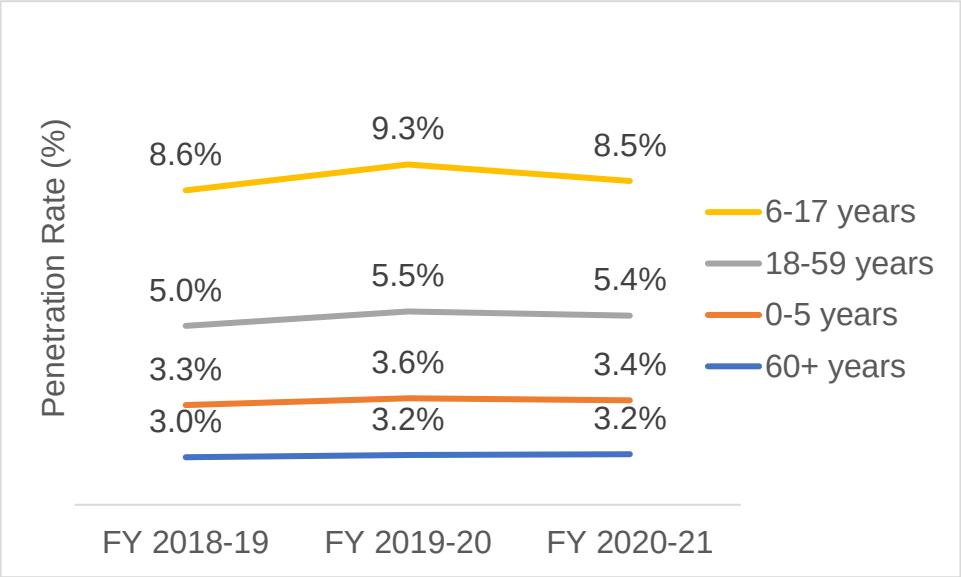
**Figure**

*35. Three-Year Trend in Medi-Cal Beneficiaries Served by Age Group, Fiscal Years 2018-19 to 2020-21*



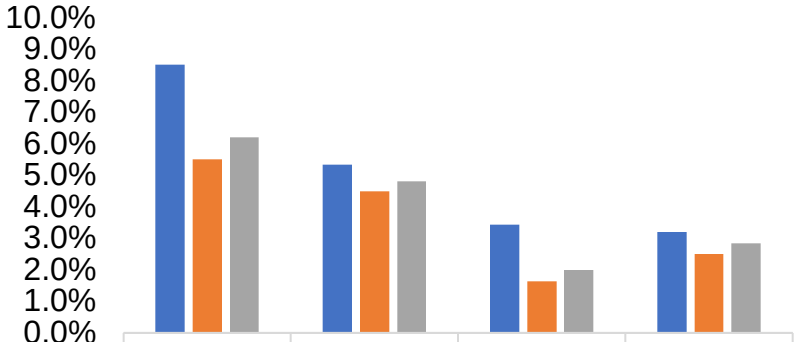

**Figure**

*36. Three-Year Trend in Penetration Rates by Age Group, Fiscal Years 2018-19 to 2020-21*



**Figure**

*37. Rate Comparison of Age Groups for Los Angeles County, Large Mental Health Plans, and Statewide*




| | 6-17 years | 18-59 years | 0-5 years | 60+ years |
|---|---|---|---|---|
| Los Angeles | 8.5% | 5.4% | 3.4% | 3.2% |
| Large | 5.5% | 4.5% | 1.6% | 2.5% |
| Statewide | 6.2% | 4.8% | 2.0% | 2.8% |

<u>Summary</u>

Ages 6-17 years showed the highest penetration rates, with LACDMH showing higher penetration rates of any MHP for Medi-Cal beneficiaries ages 0-5 years.

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***Differences by Race Ethnicity***

**Figure**

*38. Race/Ethnicity Distribution for Medi-Cal Beneficiaries Served, Fiscal Year 2020-21*

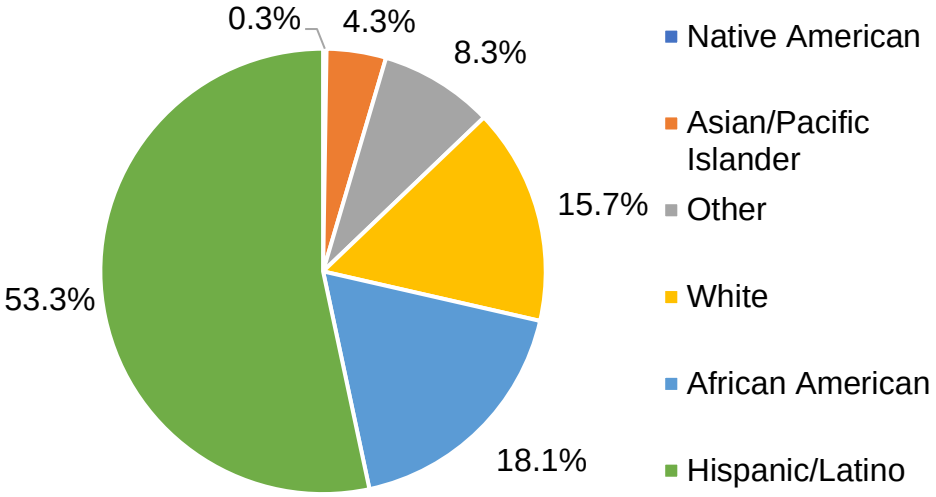


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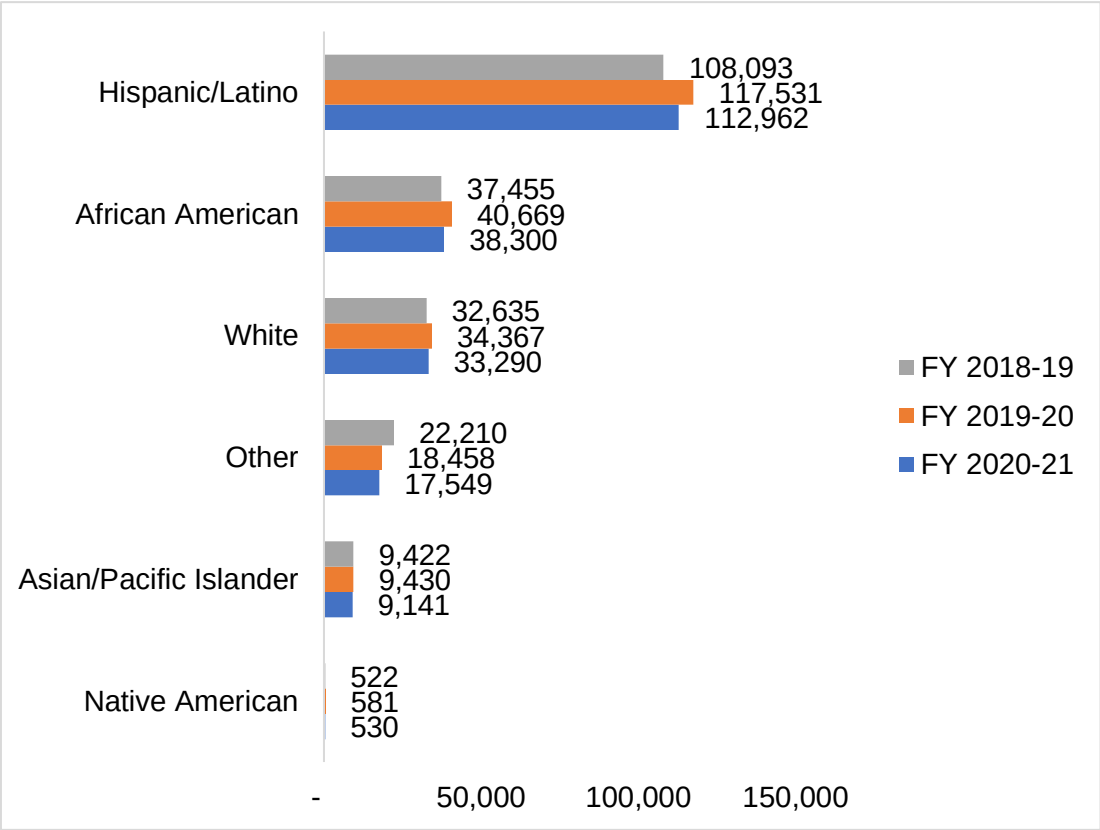
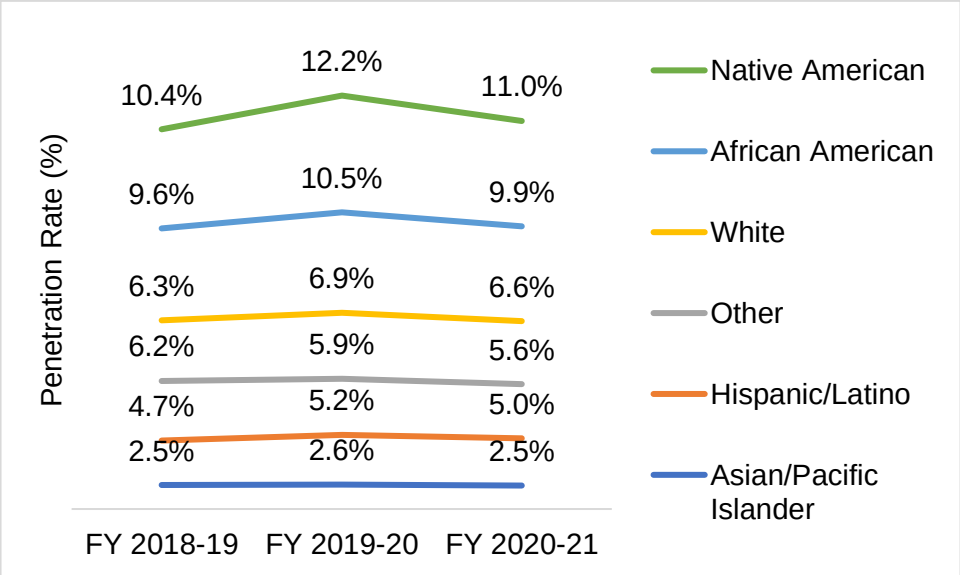
**Figure**

*39. Three-Year Trend in Medi-Cal Beneficiaries Served by Race/Ethnicity, Fiscal Years 2018-19 to 2020-21*



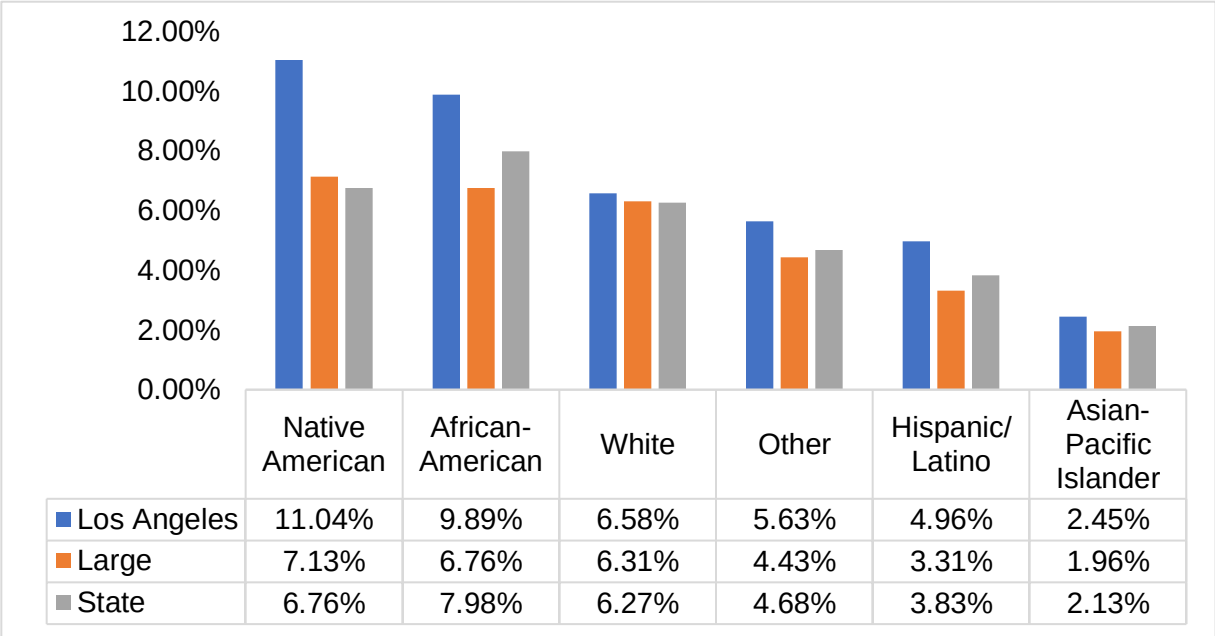

**Figure**

*40. Three-Year Trend in Penetration Rates by Race/Ethnicity, Fiscal Years 2018-19 to 2020-21*



**Figure**

*41. Rate Comparison of Race/Ethnicity for Los Angeles County, Large Mental Health Plans, and Statewide*




| | Native American | African-American | White | Other | Hispanic/ Latino | Asian-Pacific Islander |
|---|---|---|---|---|---|---|
| Los Angeles | 11.04% | 9.89% | 6.58% | 5.63% | 4.96% | 2.45% |
| Large | 7.13% | 6.76% | 6.31% | 4.43% | 3.31% | 1.96% |
| State | 6.76% | 7.98% | 6.27% | 4.68% | 3.83% | 2.13% |

<u>Summary</u>

Statewide, Hispanics/Latinos constitute over half of the Medi-Cal eligible beneficiaries. Similarly, Hispanics/Latinos comprised 53% of the beneficiaries served by LACDMH, followed by African Americans and Whites. Hispanic/Latino penetration rates have been historically low, but their increases have been slow and steady over the past three years. LACDMH has maintained its position as the MHP region with the highest Hispanic/Latino penetration rate increase for the last three years.

API Medi-Cal eligible beneficiaries are the least likely to receive or access specialty mental health services, with penetration rates stagnating over the past three years.

## Section III. Quality Improvement Work Plan Evaluation Report

Last Revised Date: 9/07/2022

QAPI Work Plan goals are set to monitor and evaluate the service delivery system's access, timeliness, and quality. Under the MHP's reporting requirements of the CCR Title 9, Chapter 11, Section 1810.440, concerning QI, the Department's evaluation of QAPI 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 Provider Appeals
VI. Monitoring Performance Improvement Projects

The QAPI Work Plan Evaluation report assesses the 16 goals and 32 objectives identified in the QAPI Work Plan for CY 2021. These goals were established, monitored, and evaluated by the QI Unit. The CY 2021 QAPI Work Plan goals focused on increasing services for individuals from underserved groups by targeting clients and community members from Asian, Black/African American, and Native Hawaiian/Pacific Islander communities, sustaining telehealth delivery in response to the COVID-19 pandemic, using client/family feedback and concerns to drive outpatient service priorities, increasing Medication-Assisted Treatment (MAT) utilization, ensuring timely access to care and resources for potential and would-be clients, including individuals in crisis or deemed gravely disabled, and improving tracking mechanisms critical to the timeliness, beneficiary grievances, and medication monitoring (Table 28). The QI Unit partnered with the Department's Cultural Competency Unit, Chief Information Office Bureau, Intensive Care Division, Outpatient Services Division, Psychiatry, and Pharmacy Services, Patients' Rights Office, Quality, Outcomes, and Training Division, QI Council, SA QICs, and the multidisciplinary PIP teams to accomplish meaningful change. The evaluation of the QAPI Work Plan provides a basis for establishing goals and objectives for CY 2022.

**Table**

*28. Quality Assessment and Performance Improvement Work Plan Goals and Year-to-Date Status*

| Domain | No. | Goal | Status of Objective(s) |
|---|---|---|---|
| Service Delivery Capacity | I.1. | Analyze root causes in the underrepresentation of self-identified Native Hawaiian/Pacific Islanders and Black/African Americans receiving DMH services. | Met |
| | I.2. | Share findings on the Department's capacity to deliver culture-specific services. | Met |
| | I.3. | Maintain the number of clients receiving telehealth services. | Met |
| Accessibility of Services | II.1. | LACDMH will meet 80% of initial outpatient specialty mental health services (SMHS) requests with a timely appointment. | Partially Met |
| | II.2. | Reduce wait times for after-hours Psychiatric Mobile Response Teams (PMRT). | Partially Met |
| Beneficiary Satisfaction | III.1. | LACDMH will increase the response rate on Consumer Perception Surveys (CPS) by 5% for Adults and Families and 10% for Youth and Older Adults. | Partially Met |
| | III.2. | Investigate and resolve 100% of Grievances and Appeals within regulation timelines. | Met |
| | III.3. | Monitor requests for a Change of Provider (COP). | Met |
| Clinical Care | IV.1. | Roll out CANS-50 and PSC-35 aggregate reporting to support children and youth program operations. | Partially Met |
| | IV.2. | Facilitate medication monitoring activities through ongoing data evaluation and prescriber-to-prescriber peer reviews. | Partially Met |
| | IV.3. | Facilitate data-driven continuous quality improvement (CQI) discussions with DMH DO program managers annually. | Met |
| | IV.4. | Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS. | Met |
| 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. | Met |
| Provider Appeals | VI.1. | Monitor Provider Appeals. | Met |
| 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. | Partially Met |
| | VII.2. | By the end of CY 2021, LACDMH 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. | Met |

*Note*: Reporting period varies by objective.

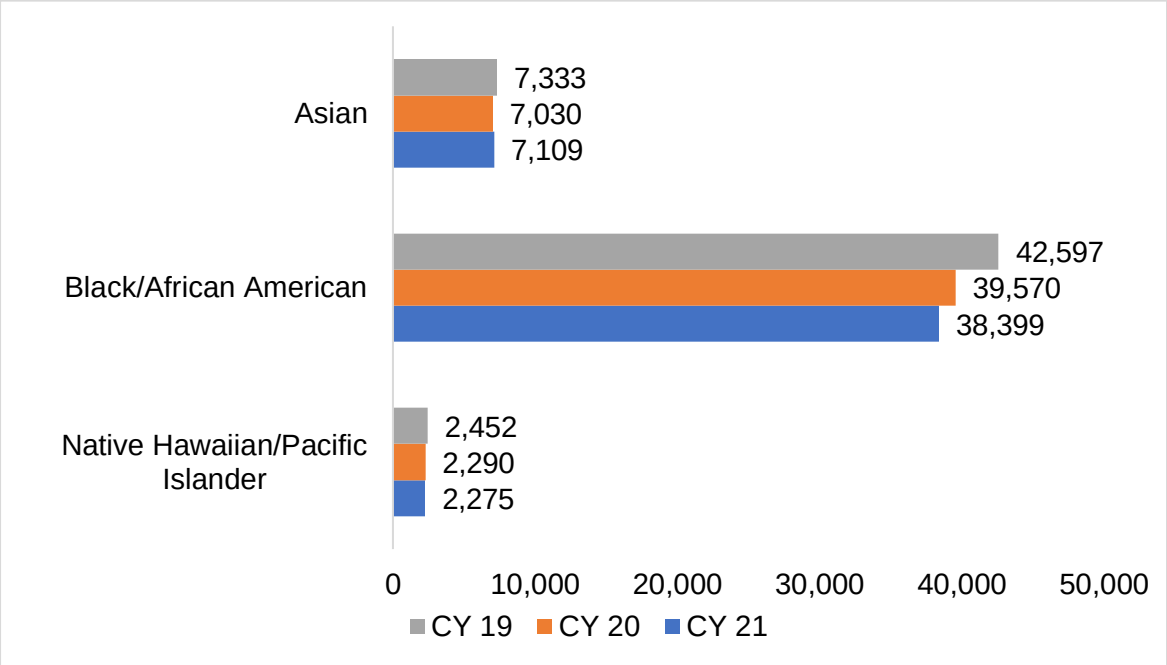
**Monitoring Service Delivery Capacity, Calendar Year 2021**

Service Equity

| Goal I.1. | Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving LACDMH services. |
|---|---|
| Objectives | 2021 Work Plan Evaluation:<br><br>a. Examine service utilization patterns (i.e., retention rates) to inform programs and leadership.<br><br>Met objective. The total number of Black/African American and Native/Hawaiian clients served decreased slightly over the past three calendar years, with the largest decrease in Black/African American clients (9.9% decrease from CY 2019 to 2021 as opposed to a 7.2% for Native Hawaiian/Pacific Islander clients and 3.1% for Asian clients, Figure 42). The number of Asian clients served initially decreased by 4.1% from CY 2019 to 2020 and increased slightly by 1.1% from CY 2020 to 2021. For the total number of services received by the group, services initially increased from CY 2019 to CY 2020. They then decreased from CY 2020 to CY 2021 for Black/African American, Native Hawaiian/Pacific Islander, and Asian clients. From CY 2019 to 2021, the total number of services increased by 9.0% for Asian clients and 3.0% for Native Hawaiian/Pacific Islander clients and decreased by 2.7% for Black/African American clients (Figure X). Penetration rates, which are calculated as the number of unduplicated beneficiaries served out of the monthly average Medi-Cal enrollee count and combined the Asian and Native Hawaiian/Pacific Islander groups, also initially increased from FY 18-19 to FY 19-20 and then decreased from FY19-20 to FY 20-21. From FY 18-19 to FY 20-21, the rate improved most for Native Americans (5.8%) as opposed to a 3.1% increase for Black/African Americans and no change to the rate for Asian/Pacific Islander clients. |

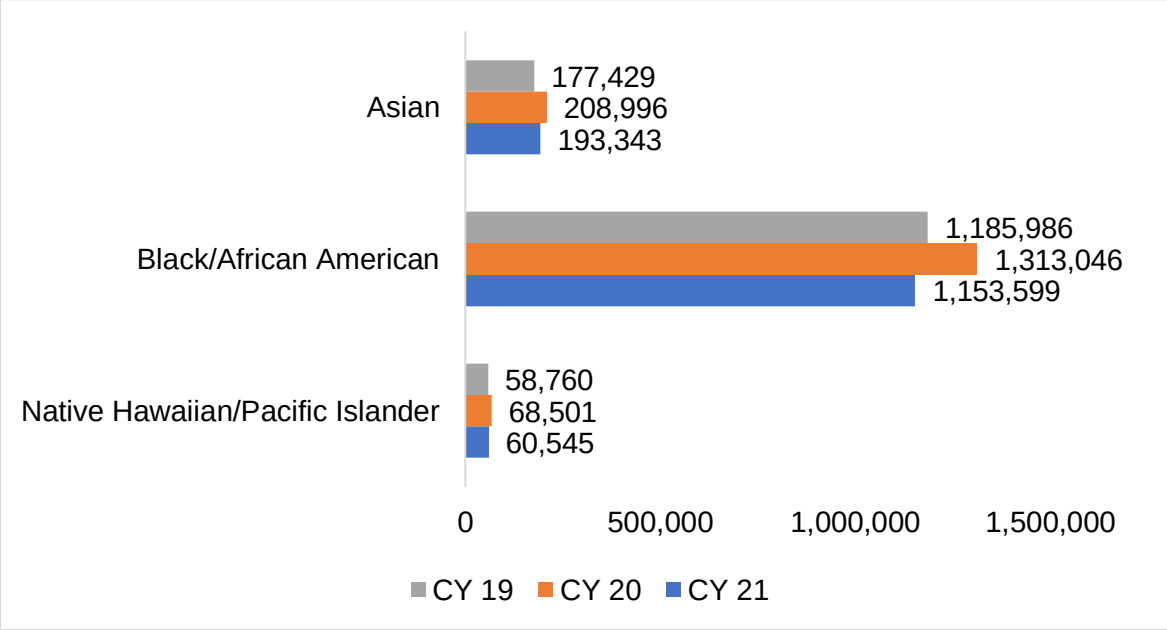
**Figure**

*42. Three-year trends in clients served who are Asian, Black/African American, and Native Hawaiian/Pacific Islander*



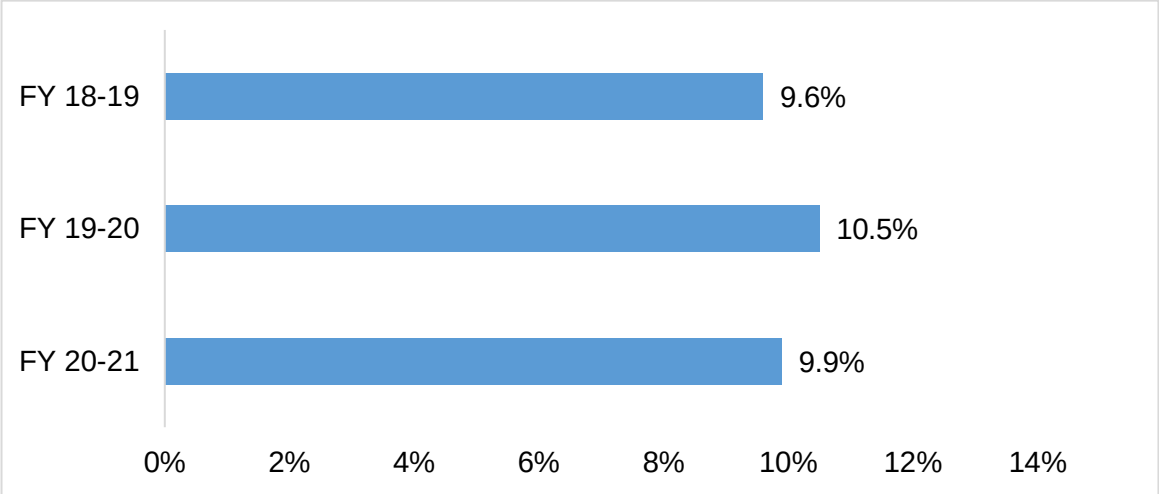

**Figure**

*43. Total Services Received for Asian, Black/African American, and Native Hawaiian/Pacific Islander*



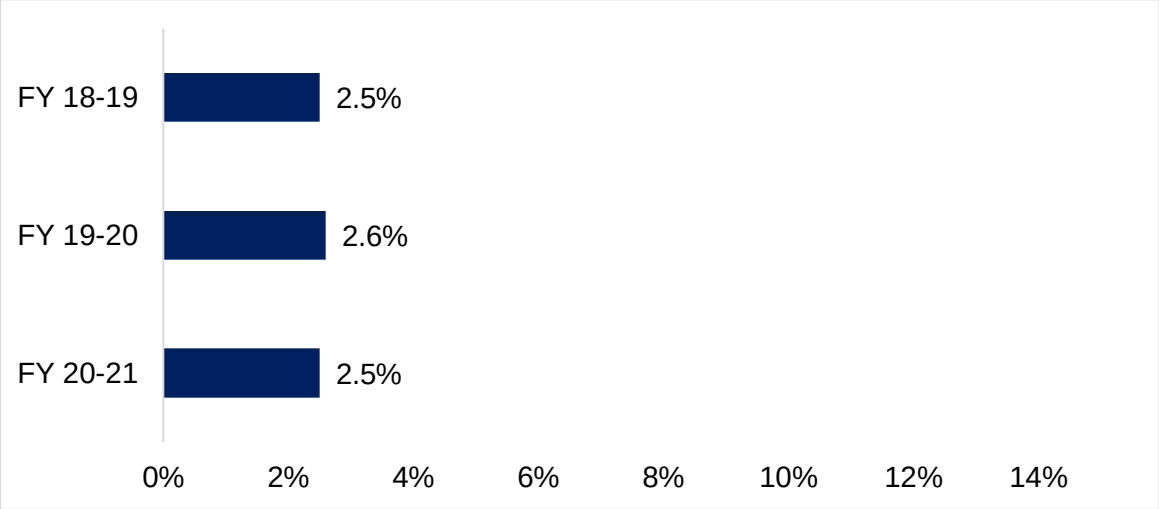
**Figure**

*44. Three-year trends in penetration rates for Medi-Cal Beneficiaries Served who are Black/African American*



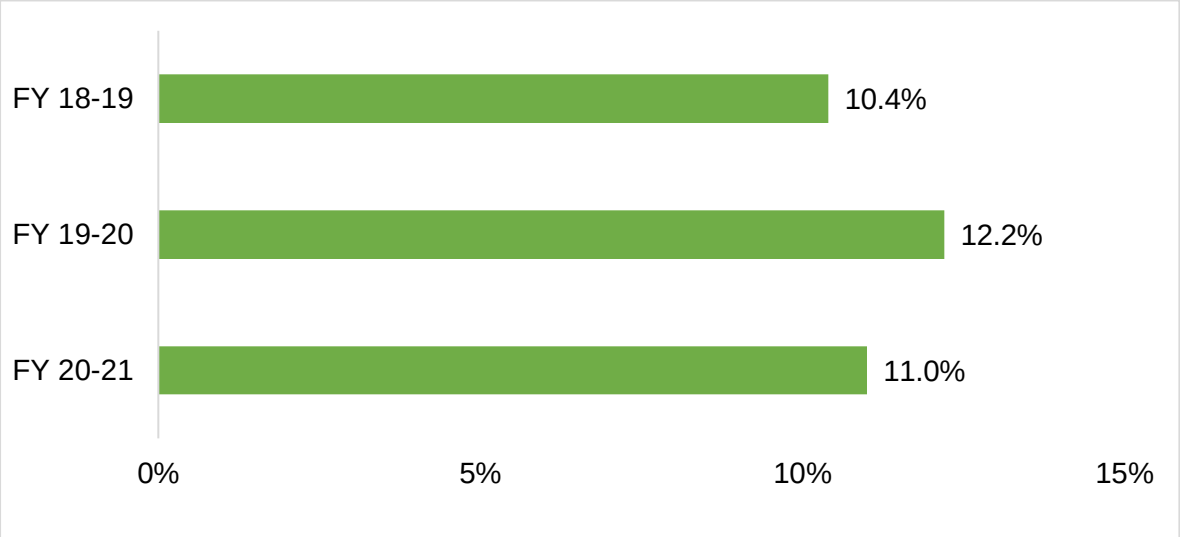

**Figure**

*45. Three-year trends in penetration rates for Medi-Cal Beneficiaries Served who are Asian/Pacific Islander*



**Figure**

*46. Three-year trends in penetration rates for Medi-Cal Beneficiaries Served who are Native American*




These three metrics show a slightly different pattern for each underrepresented group. For Black/African Americans, the number of clients served decreased each year from 2019 to 2021. The number of services received initially increased from CY 2019 to CY 2020 and then decreased from CY 2020 to CY 2021, and penetration rates similarly increased from FY 18-19 to FY 19-20 and then decreased from FY 19-20 to FY 20-21. The penetration rate increased overall comparing FY 18-19 to FY 20-21, suggesting that a greater percentage of Black/African-American Medi-Cal beneficiaries are being served over time. For Asian clients, there was an increase in clients served from CY 2020 to CY 2021, although there was an overall decrease from CY 2019 to CY 2021. Services received increased over time from CY 2019 to CY 2021. For Native Hawaiian/Pacific Islander clients, the number of clients served decreased each year, and, as with Asian clients, services received increased from CY 2019 to CY 2021. Penetration rates for the combined Asian/Pacific Islander group stayed roughly the same over time, suggesting that a similar percentage of Asian/Pacific Islander Medi-Cal beneficiaries are being served. The penetration rates for this group are also much lower than those of the Black/African American and Native American groups. Native Americans had the most considerable penetration rates compared to the other groups, which grew by 5.8% from FY 18-19 to FY 20-21. Overall, although some gains were made in terms of a greater number of clients served and greater numbers of services received for some groups, this continues to be an important area of inquiry and focus for quality improvement. Outreach efforts

will continue to target these specific groups, identify barriers to entering services, and monitor trends in the group over time.

b. Examine diversity in the LACDMH workforce by race/ethnicity and language fluency (or the rate at which direct service staff reflects the clients' racial identity and threshold languages).

**Table**

*29. Practitioners Proficient in Non-English Languages by Service Area, May 2022*

| | SA 1 | SA 2 | SA 3 | SA 4 | SA 5 | SA 6 | SA 7 | SA 8 | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Arabic** | 1 | 7 | 10 | 6 | 1 | 2 | 5 | 3 | 35 |
| Percent | 0.4% | 0.8% | 0.9% | 0.6% | 0.5% | 0.2% | 0.7% | 0.4% | 0.6% |
| **Armenian** | 6 | **59** | 15 | **20** | 4 | 5 | 4 | 5 | 118 |
| Percent | 2.3% | **6.3%** | 1.4% | **2.0%** | 1.8% | 0.5% | 0.5% | 0.7% | 1.9% |
| **ASL** | 2 | 2 | 8 | 2 | 0 | 1 | 0 | 3 | 18 |
| Percent | 0.8% | 0.2% | 0.7% | 0.2% | 0.0% | 0.1% | 0.0% | 0.4% | 0.3% |
| **Cambodian** | 0 | 4 | 5 | 6 | 0 | 2 | 5 | **25** | 47 |
| Percent | 0.0% | 0.4% | 0.5% | 0.6% | 0.0% | 0.2% | 0.7% | **3.4%** | 0.8% |
| **Cantonese** | 1 | 1 | **41** | 14 | 0 | 4 | 6 | 3 | 70 |
| Percent | 0.4% | 0.1% | **3.8%** | 1.4% | 0.0% | 0.4% | 0.8% | 0.4% | 1.2% |
| **Chinese** | 1 | 5 | 26 | 13 | 2 | 3 | 6 | 4 | 60 |
| Percent | 0.4% | 0.5% | 2.4% | 1.3% | 0.9% | 0.3% | 0.8% | 0.6% | 1.0% |
| **Farsi** | 6 | **35** | 6 | 17 | **6** | 4 | 4 | 7 | 85 |
| Percent | 2.3% | **3.8%** | 0.6% | 1.7% | **2.7%** | 0.4% | 0.5% | 1.0% | 1.4% |
| **Hmong** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Percent | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.1% | 0.0% |
| **Korean** | 2 | **18** | **21** | **86** | 12 | 6 | **9** | **27** | 181 |
| Percent | 0.8% | **1.9%** | **1.9%** | **8.4%** | 5.4% | 0.6% | **1.2%** | **3.7%** | 3.0% |
| **Mandarin** | 1 | 10 | **58** | 24 | 4 | 5 | 16 | 8 | 126 |
| Percent | 0.4% | 1.1% | **5.3%** | 2.4% | 1.8% | 0.5% | 2.2% | 1.1% | 2.1% |
| **Russian** | 3 | **21** | 6 | **7** | 4 | 1 | 2 | 5 | 49 |
| Percent | 1.2% | **2.3%** | 0.6% | **0.7%** | 1.8% | 0.1% | 0.3% | 0.7% | 0.8% |
| **Spanish** | **229** | **741** | **850** | **794** | **187** | **1,032** | **652** | **608** | 5,093 |
| Percent | **88.8%** | **79.7%** | **78.3%** | **77.9%** | **83.5%** | **95.4%** | **89.3%** | **83.9%** | 84.1% |
| **Tagalog** | 6 | **22** | 21 | **18** | 3 | 10 | 18 | 14 | 112 |
| Percent | 2.3% | **2.4%** | 1.9% | **1.8%** | 1.3% | 0.9% | 2.5% | 1.9% | 1.9% |
| **Vietnamese** | 0 | **5** | **18** | 12 | 1 | 7 | 3 | **12** | 58 |
| Percent | 0.0% | **0.5%** | **1.7%** | 1.2% | 0.4% | 0.6% | 0.4% | **1.7%** | 1.0% |
| **Total** | 258 | 930 | 1,085 | 1,019 | 224 | 1,082 | 730 | 725 | 6,053 |
| Percent | 4.3% | 15.4% | 17.9% | 16.8% | 3.7% | 17.9% | 12.1% | 12.0% | 100% |

Note: Languages that meet threshold criteria for the SA are bolded.

Met Objective. Most practitioners proficient in non-English languages as of May 2022 spoke Spanish (84.1%). The following most common proficient languages were Korean (3.0%), Mandarin (2.1%), Armenian (1.9%), Tagalog (1.9%), and Farsi (1.4%).

SAs 3 and 6 had the largest percentage of non-English speakers at 17.9%, and SA 5 had the lowest at 3.7%.

Over a third of practitioners and clients identified as Hispanic or Latino. It should be noted that about a quarter of practitioners and clients were missing race/ethnicity data or reported their status as unknown/not reported (Table 30).

**Table**

*30. Practitioners by Ethnic Origin and Race*

| | Practitioners (As of December 2021) | | Clients (CY 2021) | |
|---|---|---|---|---|
| **Ethnic Origin** | **N** | **%** | **N** | **%** |
| *African-American* | 2 | 0.01% | 38,743 | 16.7% |
| *Hispanic or Latino* | 5,370 | 35.5% | 82,728 | 35.8% |
| *Not Hispanic or Latino* | 5,082 | 33.6% | 16,697 | 7.2% |
| *Other* | 2 | 0.01% | -- | |
| *Unknown/Not Reported* | 3,686 | 24.3% | 59,832 | 25.9% |
| *White* | 1 | 0.01% | 33,324 | 14.4% |
| *Missing* | 989 | 6.5% | -- | -- |
| *Total* | 15,132 | 100% | 231,324 | 100% |
| **Race** | **N** | **%** | **N** | **%** |
| *Alaskan Native* | 10 | 0.1% | 189 | 0.1% |
| *American Indian/Alaskan Native* | 18 | 0.1% | 996 | 0.4% |
| *Armenian* | 76 | 0.5% | 1,232 | 0.5% |
| *Asian Indian* | -- | -- | 52 | 0.02% |
| *Asian Native* | 53 | 0.4% | 413 | 0.2% |
| *Black/African-American* | 1,185 | 7.8% | 6,419 | 13.7% |
| *Cambodian* | 37 | 0.2% | 863 | 0.4% |
| *Central African* | 1 | 0.0% | 46 | 0.02% |
| *Central American* | 184 | 1.2% | 7,185 | 3.1% |
| *Chinese* | 203 | 1.3% | 1,776 | 0.8% |
| *Cuban* | 10 | 0.1% | 316 | 0.1% |
| *East African* | 3 | 0.0% | 33 | 0.01% |
| *Eastern European* | 9 | 0.1% | 105 | 0.1% |
| *Filipino* | 132 | 0.9% | 1,562 | 0.7% |
| *Guamanian* | 5 | 0.0% | 133 | 0.1% |
| *Hawaiian* | 3 | 0.0% | 327 | 0.1% |
| *Hmong* | -- | -- | 6 | 0.00% |
| *Iranian* | 31 | 0.2% | 625 | 0.3% |
| *Japanese* | 44 | 0.3% | 296 | 0.1% |
| *Korean* | 183 | 1.2% | 1,366 | 0.6% |
| *Laotian* | 1 | 0.0% | 274 | 0.1% |
| *Mexican* | 1,560 | 10.3% | 41,166 | 17.8% |

| | | | | |
|---|---|---|---|---|
| *Mien* | 1 | 0.0% | 19 | 0.01% |
| *North African* | 5 | 0.0% | 45 | 0.02% |
| *Other* | 730 | 4.8% | -- | -- |
| *Other Asian* | 120 | 0.8% | 1,134 | 0.5% |
| *Other Black* | 44 | 0.3% | 382 | 0.2% |
| *Other Hispanic or Other Latino* | 1,411 | 9.3% | 30,542 | 13.2% |
| *Other Middle Eastern* | 35 | 0.2% | 470 | 0.2% |
| *Other Pacific Islander* | 13 | 0.1% | 172 | 0.1% |
| *Other Race* | 42 | 0.3% | 612 | 0.3% |
| *Other White* | -- | -- | 370 | 0.2% |
| *Puerto Rican* | 20 | 0.1% | 355 | 0.2% |
| *Samoan* | 10 | 0.1% | 103 | 0.04% |
| *South American* | 58 | 0.4% | 785 | 0.3% |
| *Southern African* | 1 | 0.0% | 91 | 0.04% |
| *Two or More Races* | -- | -- | 8,914 | 3.9% |
| *Unknown/Not Reported* | 4,519 | 29.9% | 59,263 | 25.6% |
| *Vietnamese* | 62 | 0.4% | 819 | 0.4% |
| *West African* | 6 | 0.0% | 35 | 0.02% |
| *White* | 1,470 | 9.7% | 30,236 | 13.1% |
| *Missing* | 2,837 | 18.7% | -- | -- |
| *Total* | 15,132 | 100% | 231,324 | 100% |

Overall, the percent of practitioners fluent or certified in non-English languages essentially mapped onto the threshold languages for the SA. The largest number and percent of practitioners fluent or certified in non-English languages in each SA tended to be those speaking the SA's threshold languages, with some notable exceptions. In SA 2, more practitioners spoke Arabic and Mandarin than Vietnamese, a threshold language; in SA 3, more practitioners spoke Chinese and Tagalog than Vietnamese, which is also a threshold language for that area. In SA 4, the number of practitioners fluent or certified in Russian, a threshold language, was lower than in the other non-threshold languages in the SA. There were also more Mandarin-speaking practitioners than Armenian, Russian, and Tagalog, all threshold languages. SA 5 had twice as many practitioners fluent or certified in Korean than in Farsi, a threshold language. SA 7 had more Mandarin and Tagalog fluent or certified practitioners than Korean, a threshold language. For SA 8, the number of practitioners fluent or certified in Tagalog was slightly higher than in Vietnamese, a threshold language.

Direct comparisons between the number of clients served and the number of practitioners by ethnic origin were not possible due to differences in the ethnic categories and the varying timeframes of data collection (i.e., NAPPA data are based on a particular point in time when the data are extracted). However, using the data to look at broader trends in the number of staff available to serve consumers by ethnic origin, there are some areas of note. The percent of clients served in CY 2021 that identify as Black/African American, Mexican, and Other Hispanic or Latino are at least 4 percentage points higher than the percent of practitioners that identify as those ethnicities as of December 2021. Hiring more Black/African American, Mexican, and Other Hispanic or Latino staff would help ensure that the LACDMH practitioners

represent the clients served. A higher percentage of practitioners identify as Chinese, Korean, and Other Asian than the percent of clients served in CY 2021. As penetration rates have been historically low for the Asian/Pacific Islander community, it may be helpful to engage practitioners from this community to assist with outreach efforts.

c. Establish a disproportionality and disparities report to provide insight into system capacity for existing and potential clients by race/ethnicity.

Met objective. A Service Equity report was created as part of the QAPI 2021 to support the analysis of various metrics by important demographic variables, such as race/ethnicity, age group, and primary language. The report includes data on total services received, practitioner language capacity, prescription rates, hospitalization and rehospitalization rates, and telehealth services. The Service Equity report will investigate areas for further inquiry and potential quality improvement goals for the following calendar year.

d. Designate mental health promoters to reach the Asian Pacific Islander, African American, and Native American communities.

**Table**

*31. Mental Health Promoters by Target Population, Fiscal Year 2020-2021*

| Target Population | Mental Health Promoters | |
|---|---|---|
| | Number | Percent |
| American Indian/Alaska Native | 2 | 2.3% |
| Asian Pacific Islander | 13 | 15.2% |
| Black/African Heritage | 14 | 16.5% |
| Hispanic/Latino | 56 | 65.9% |
| Total | 85 | 100% |

Met objective. In Fiscal Year 20-21, 29 Mental Health Promoters were hired to expand support to the Asian Pacific Islander, African American, and Native American communities. Most Mental Health Promoters target the Hispanic/Latino population, the largest group of clients served. Mental Health Promoters could also provide support in the following languages to better serve the community: Amharic, Chinese, English, Khmer, Korean, and Spanish.

| | |
|---|---|
| Population | LACDMH 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<br>2. Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity<br>3. Service Equity Analysis Report |
| Frequency of Collection | Varied by data source |

| 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, QI Council, and all eight Service Area Quality Improvement Committees.<br>• Each presentation will highlight knowledge gaps, document feedback from clients/families and stakeholders (if any), and identify potential next steps.<br><br><u>2021 Work Plan Goal Evaluation:</u><br>Met objective. Between February and October 2021, LACDMH's Anti-Racism, Diversity, and Inclusion (ARDI) Division - Cultural Competency Unit delivered ten presentations summarizing findings from the 2019 Cultural Competence Organizational (CC Org) Assessment. These presentations took place at monthly meetings held by the Quality Improvement Council, all eight Service Area Quality Improvement Committees, and the Cultural Competency Committee (CCC). Attendees included members from the Access for All, American Indian/Alaska Native, Asian Pacific Islander, Black and African Heritage, Eastern European/Middle Eastern, Latino, and LGBTQIA2S Underserved Cultural Community Subcommittees (UsCC), Faith-Based Advocacy Council (FBAC), and the eight Service Area Leadership Teams (SALT). The feedback received during the CC Org Assessment presentations was consistently positive. Common areas of interest focused on the range of participants' years in Los Angeles County service, job function, education, age, gender and sexual orientation, and experience with mental illness.<br><br>These presentations successfully reviewed CC Org's quantitative and qualitative outcomes, including perceived knowledge gaps in LACDMH's workforce. The CCU organized each presentation into three major sections:<br>• Purpose and Intent:<br>• Approach and Methodology; and<br>• Demographic information of participants inclusive of race and ethnicity, education, gender identity and sexual orientation, language proficiency other than English, staff function within LACDMH, clinical areas of specialty, SA, years of Los Angeles County DMH service, lived and shared experience with mental illness, annual completion of cultural competence training, and feedback regarding training needs to enhance the workforce's cultural competence.<br><br>Initially, the CC Org aimed to address knowledge gaps, document stakeholder feedback, and identify the next steps. However, as the goal evolved, a need was presented for the inclusion of qualitative and quantitative outcomes. The goal was also expected to be an annual assessment. At this time, the frequency has yet to be determined. |

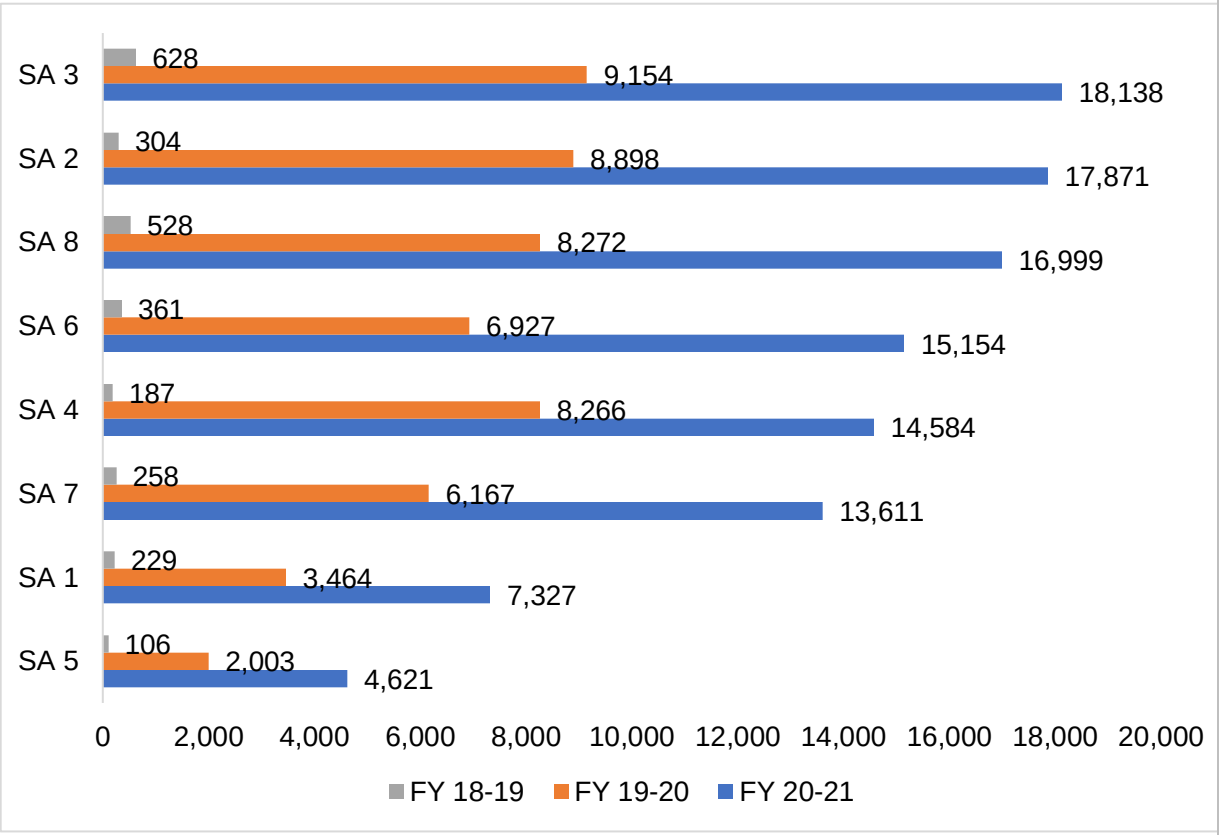
| | |
|---|---|
| Population | DMH DO staff (administrative and clinical) overseeing the quality or delivery of SMHS to DMH clients/families. |
| Performance Indicators | The number of CC Org Assessment presentations facilitated in CY 2021. |
| Frequency of Collection | To Be Determined |

Telemental Health

| Goal I.3. | Maintain the number of clients receiving telehealth services. |
|---|---|
| Objectives: | 2021 Work Plan Goal Evaluation<br><br>a. Establish a demographic profile of the clients served through tele-mental health (TMH), including location, age, and preferred language.<br><br>This goal was exceeded. In CY 2021, the number of clients who received tele-mental health services increased to 96,330 from 88,254 in CY 2020, representing a 9.2% increase. LACDMH examined the location, age, and service language of clients served through tele-mental health over the past three fiscal years. Over the past three fiscal years, the number of clients served through tele-mental health increased in all SAs. SA 3 consistently served the most significant number of clients year to year, and SAs 1 and 5 consistently served the smallest, in keeping with their size. Most clients served through telemental health were children and youth, followed by adults and older adults. The discrepancy between child and youth versus adult clients became more pronounced in FYs 2019-20 and 2020-21 compared to FY 2018-19. Older adults consistently represented a much smaller portion of the clients served through tele-mental health compared to adults and children/youth. Language of service was only available for DO clinics. The number of clients who had tele-mental health sessions in Spanish significantly increased yearly. For other non-English languages, clients speaking Farsi, Armenian, Cambodian, and Russian were the most common. Five or fewer clients also received services in the following languages in FY 2020-21: Afghan/Pashto/Pusho, Bengali, Bulgarian, Hindi, Hindustani, Hmong, Ilocano/Iloko, Lao, Mandarin, Other Chinese, Other Non-English, Other Sign, Portuguese, Sinhalese, Swahili, Swedish, Toisan, Urdu, and Visayan.<br><br>[intentionally left blank] |

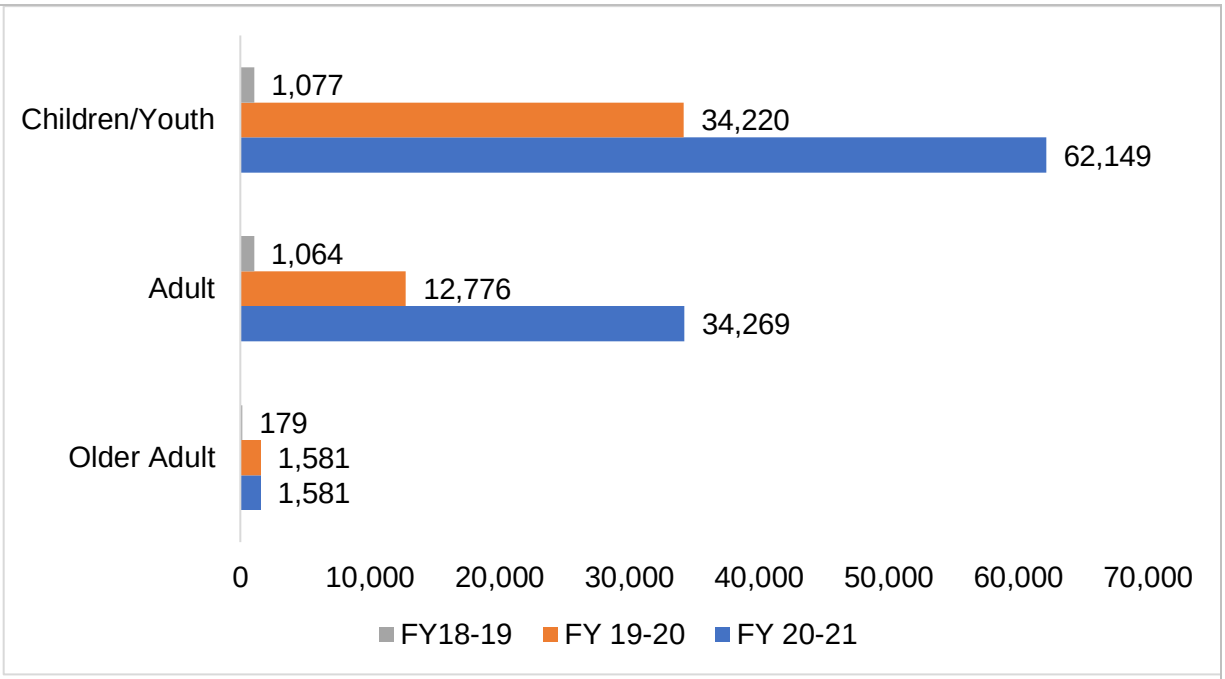
**Figure**

*47. Three-year Trend in Unique Clients Served via Tele-mental Health by Service Area*



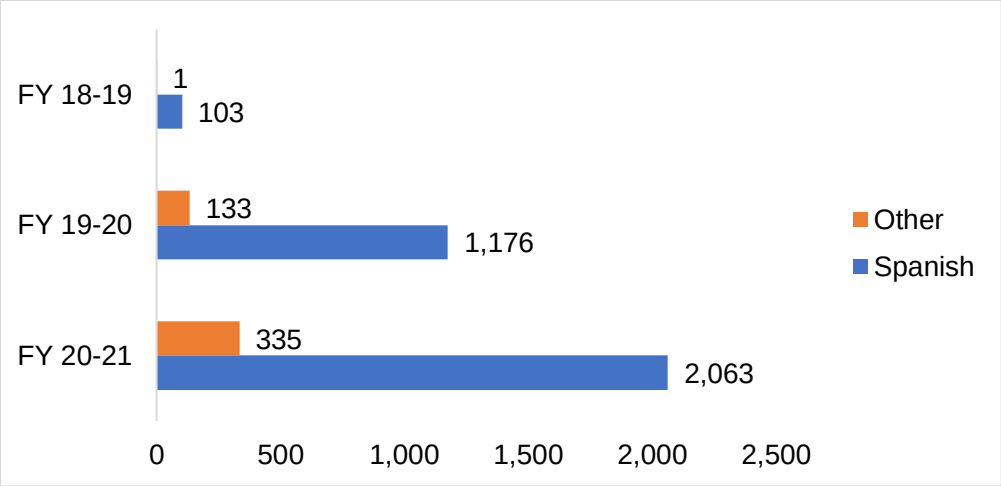

**Figure**

*48. Three-year Trend in Unique Clients Served via Tele-mental Health by Age*



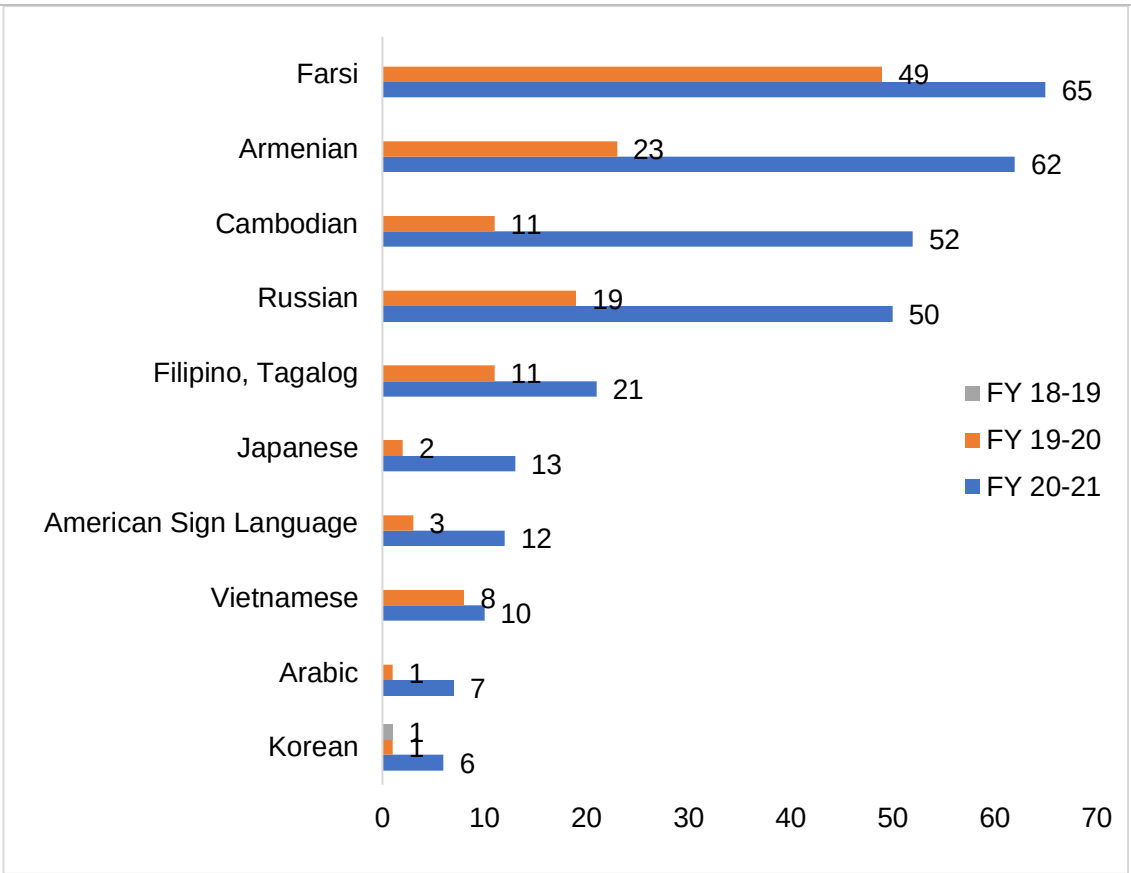

**Figure**

*49. Three-year Trend in Unique Clients Served via Tele-mental Health in DO Clinics by Language of Service (Broad Categories)*




**Figure**

*50. Three-year Trend in Unique Clients Served via Tele-mental Health in DO Clinics by Language of Service (Other Language Highlight)*

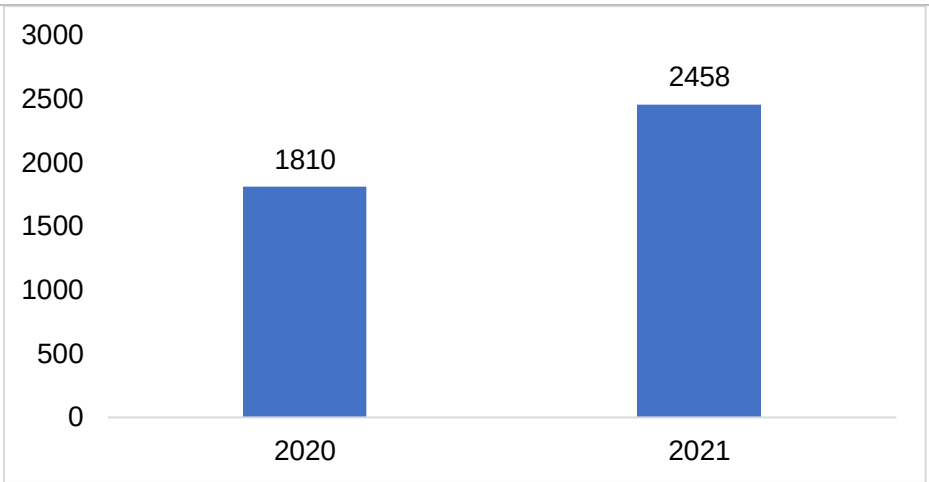



b. Increase the number of telehealth encounters in DO programs via video, specifically VSee, a HIPAA-compliant telehealth application.

This objective was met. The Outpatient Services Division (OSD) led several efforts to increase the use of video telehealth appointments through VSee, the telehealth platform selected for DO programs in CY 2020 and 2021. OSD developed an internal Share Point site to distribute training resources, including how-to guides and videos highlighting strategies to enhance treatment groups. Telehealth data was monitored regularly through a strategic dashboard in Power BI and at the program level during the monthly APEX meetings. The total number of VSee licenses assigned to DO staff increased by 37.9%, from 1810 in 2020 to 2496 in 2021. Although 2,124 new accounts were created in 2020, 12 were duplicate accounts, and 302 of these were subsequently terminated due to staff turnover. A total of 648 new licenses were assigned in 2021. The number of telehealth encounters through VSee significantly expanded from 2020 to 2021. After a relatively steady increase from April 2020 to October 2020, there was a slight dip at the end of 2020, followed by a peak in Spring 2021. Over the latter half of CY 2021, VSee visits decreased as staff turnover increased from the Spring 2021 peak. However, these numbers continue to represent an increase from the latter half of CY 2020, suggesting that efforts to encourage and support the use of VSee in directly operated clinics have been largely successful.

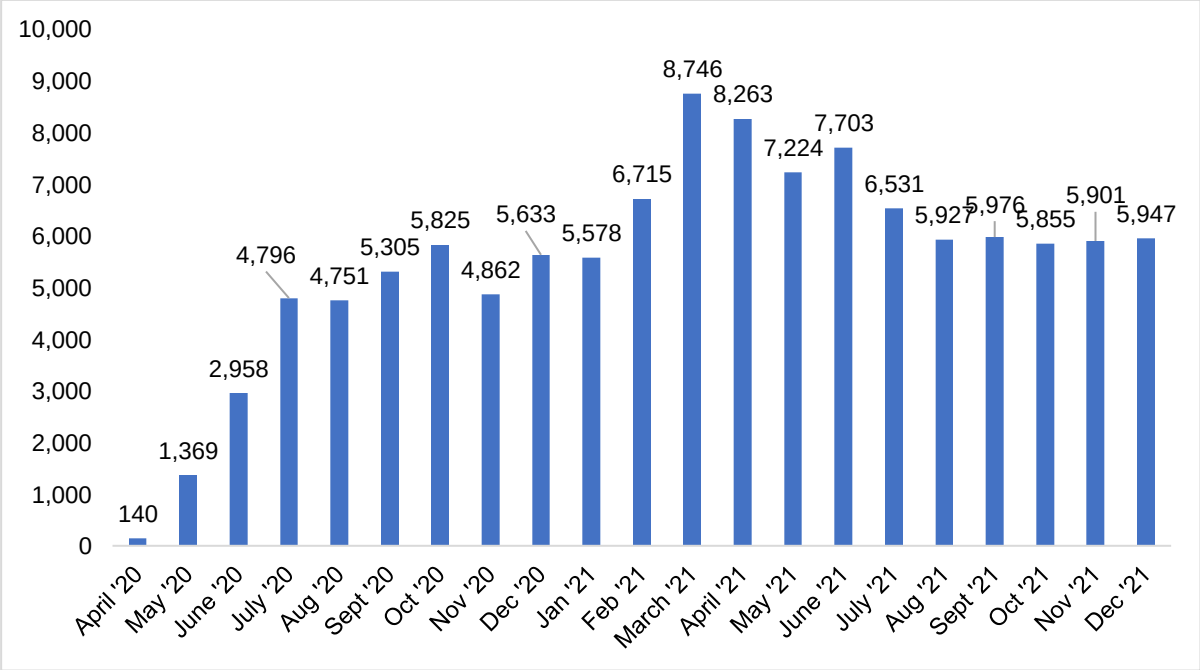
**Figure**

*51. Number of VSee Staff License Assignments*



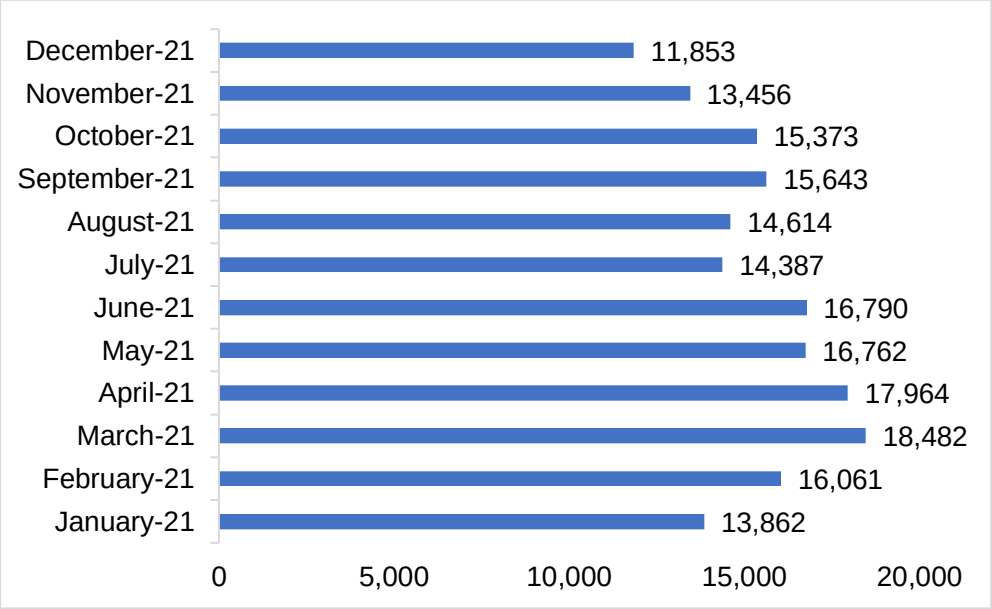

**Figure**

*52. Total VSee Encounters by Month*



| | |
|---|---|
| Population: | Clients/families receiving LACDMH outpatient SMHS services. |
| Performance Indicators: | 1. Total clients served, including the number of telehealth encounters (services) provided in FY 2020-21.<br>2. Total Count of VSee Licenses Assigned in CY 2021.<br>3. VSee utilization (active accounts, logins, visits). |
| Frequency of Collection: | Annual |

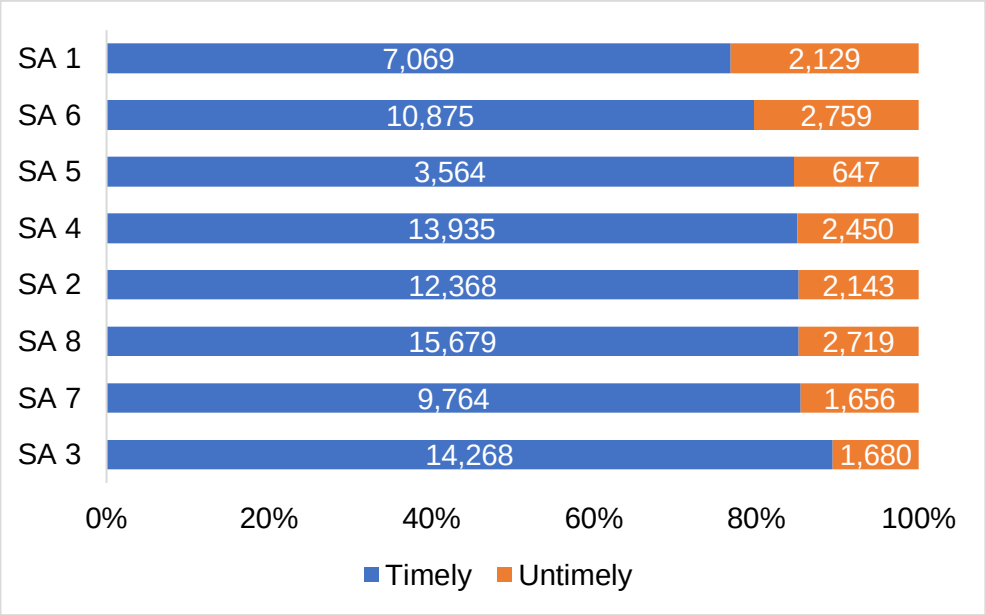
**Monitoring Accessibility of Services, Calendar Year 2021**

| Goal II.1. | LACDMH will meet 80% of initial outpatient specialty mental health services (SMHS) requests with a timely appointment. |
|---|---|
| Objective | 2021 Work Plan Goal Evaluation:<br><br>a) Monitor time to first offered appointment.<br>• Providers should offer routine (non-urgent) appointments within ten business days (not including weekends and holidays) of the initial request.<br>• Providers should offer urgent appointments within 48 hours (including weekends and county holidays) of the initial request.<br>• Providers should offer follow-up hospital discharge or jail release appointments within five business days (not including weekends and holidays) of the initial request.<br><br>Met objective. The QA Unit implemented its access to care monitoring process, which reviewed the percent of untimely versus timely appointments for all providers across quarterly initial requests for routine, urgent, and hospital discharge services.<br><br>**Figure**<br>*53. Total Number of Requests for Service Received by Month, Calendar Year 2021*<br><br>  <br><br><br>Note: The information above reflects data from multiple sources, including Contractor Service Request Log (SRL) web services (N=61,642), IBHIS (DO) SRL (N=77,223), KAEMS (N=16,811), and Service Request Tracking System (SRTS, N=28,571). The highest number of requests were received in March |

2021 (N=18,482), with December 2021 (N=11,853) seeing the lowest. Data Source: Power BI Timely Access to Care Reporting Dashboard for CY 2021, retrieved on 01/28/22

**Figure**

*54. Percent of Appointments by Status Category and Service Area*

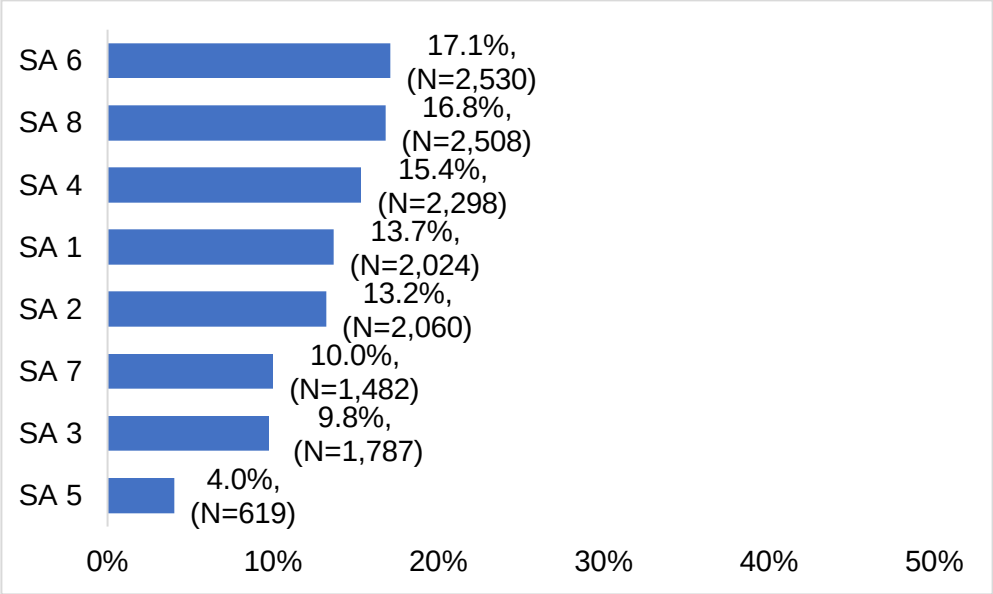



Note: In CY 2021, SA 1 (23.1%) had the highest percentage of untimely appointments, followed by SA 6 (20.2%). SA 3 (89.5%) had the highest rate of timely appointments, followed by SA 7 (85.5%). The "Untimely, referral declined" values are included in the "Timely" category. Data Source**:** Power BI Timely Access to Care Reporting Dashboard for CY 2021, retrieved on 01/28/22

[intentionally left blank]

**Figure**

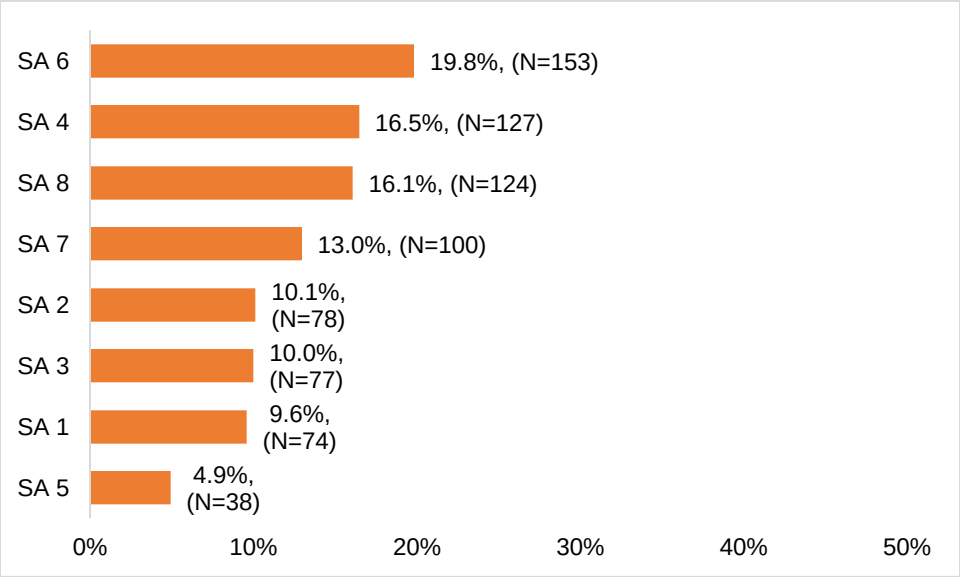
*55. Percent of Requests for Routine Services with Untimely Appointments by Service Area, Calendar Year 2021*




Note: In CY 2021, SA 6 (17.1%) had the highest percentage of requests for routine services met with an untimely appointment, and SA 5 (4.0%) had the lowest. Data Source: Power BI Timely Access to Care Report Dashboard for CY 2021, retrieved on 01/28/22.

**Figure**

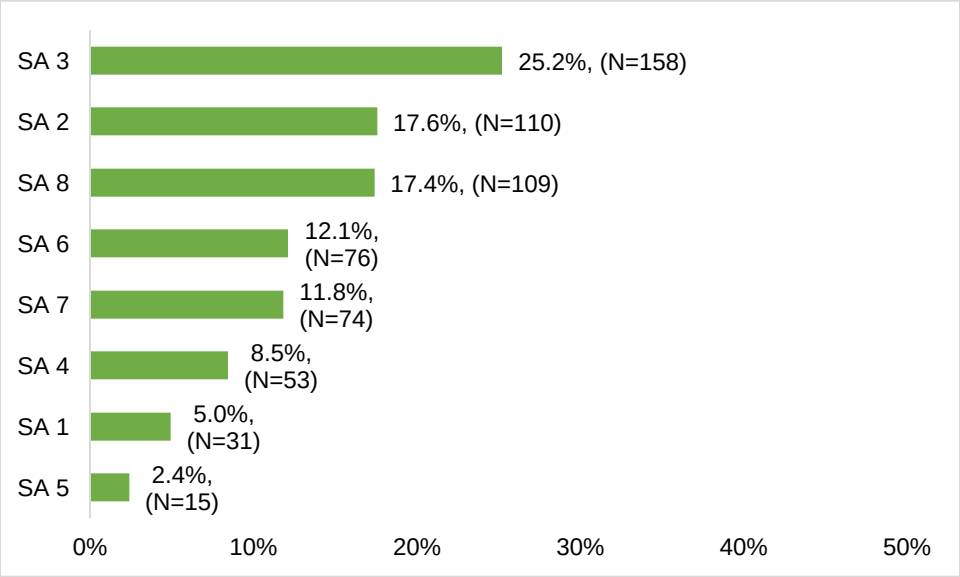
*56. Percent of Requests for Urgent Services with Untimely Appointments by Service Area, Calendar Year 2021*




Note: In CY 2021, SA 6 (19.8%) had the highest percentage of requests for urgent services met with an untimely appointment and SA 5 (4.9%) had the lowest. Data Source: Power BI Timely Access to Care Report Dashboard for CY 2021, retrieved on 01/28/22.

**Figure**

*57. Percent of Requests for Inpatient/Jail Discharge Services with Untimely Appointments by Service Area, Calendar Year 2021*




Note: In CY 2021, SA 3 (25.2%) had the highest percentage of requests for inpatient/jail discharge services met with an untimely appointment, and SA 5 (2.4%) had the lowest. Data Source: Power BI Timely Access to Care Report Dashboard for CY 2021, retrieved on 01/28/22.

| | |
|---|---|
| | b) System-wide timeliness data will be aggregated by SA, provider, and age group and tracked for trends.<br><br>Met objective. LACDMH's *Timely Access to Care Reporting* dashboard is active in Microsoft Power BI and efficiently tracks the following timeliness metrics by SA, month, age group, and request type:<br>• Sum of Appointments by Status Category<br>• Percentage of Appointments by Status Category<br>• Program of Service by Month<br>• Assessment Attendance by Directly-Operated Program<br>• Requests Resulting in an Appointment by Referring Party Role<br><br>Figure 58 provides an example of the information complied by the Timely Access to Care Report Dashboard. The information can be tracked over time to view trends. Data can also be viewed at the SA level by age group and type of referral.<br><br>**Figure**<br>*58. Timely Access to Care Reporting Dashboard by Service Area, Calendar Year 2021* |

Access to Care Leadership and the QA and QI units can access this dashboard

c) Implement centralized scheduling in SA 3 for LACDMH clients seeking follow-up hospital discharge appointments coordinated between their inpatient provider and ACCESS Center.

Met objective. LACDMH QA, Intensive Care, ACCESS Center, and SA 3 established a centralized scheduling process to improve referrals, linkages, and timeliness rates for clients seeking follow-up outpatient mental health services post-hospital discharge. SA 3 has been host to the pilot since February 2021 with an end goal of reducing the number of days to an appointment for an inpatient discharge referral to five days. The pilot includes both DO and LE/Contracted providers. Providers with less than 10 clinicians or intensive services, such as FSP, STRTPs, IFCCS, and Wraparound programs, were excluded.

In September-December 2021, the mean number of days to an appointment for an inpatient discharge referral was three days before the implementation of the pilot.

The next steps for the project include recruiting additional staff, training staff on centralized scheduling workflows, and expanding centralized scheduling to additional service areas.

| | |
|---|---|
| | d) Establish a learning collaborative among SA 2 providers to define best practices related to improving the timeliness of services.<br><br>Partially Met. The SA 2 Learning Collaborative ran from April to October 2021. The group consisted of five SA 2 providers and members of the QI and QA units, including managers. The group met to review challenges to timely access to care for the participating providers and develop a Plan-Do-Study-Act (PDSA) process to improve client access to timely appointments at the regional level. As the group began developing an agreed strategy for implementation, LACDMH and LE/Contracted providers began experiencing significant gaps in staffing that negatively impacted timely access to services. The SA 2 Learning Collaborative agreed that the staffing challenges were too great to move forward with the implementation plan. Access to Care leadership placed the project on hold to return until LACDMH's outpatient system's staffing issues have improved. |
| Population | Los Angeles County residents seeking outpatient SMHS from a LACDMH provider. |
| Performance Indicators | Rates of timeliness by service request type (routine, urgent, and hospital discharge/jail release). |
| Frequency of Collection | Quarterly |

| 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, including peers, to support five mobile mental health vans that operate 24 hours a day and seven days a week.<br><br>Two interventions were used to target reducing PMRT after-hours wait times: Improvement in PMRT staffing and implementation of the TT teams.<br><br>**Psychiatric Mobile Response Team**<br><br>*Program Overview*<br><br>The Psychiatric Mobile Response Team (PMRT) provides 24/7 crisis support and evaluation for hospitalization placement across Los Angeles County. The program typically operates with teams assigned to serve specific SAs, though PMRT teams help other SAs during high call volume.<br><br>*Program Status*<br><br>In FY 2020-21, PMRT and the TT program logged data using separate systems. At this time, TT calls are logged but do not include the time PMRT or the LACDMH 24/7 Helpline receives the call. These calls originate from the community, shelters, board and care homes, emergency rooms, individuals experiencing homelessness, etc. In FY 2020-21, PMRT completed 21,118 field visits (Figure 59), many of which were logged over four hours between call receipt and dispatch (Figure 61). Family members often made referrals for field visits (Figure 60), and more than half of field visits were for Medi-Cal beneficiaries. Across SAs, SA 7 resulted in the highest number of PMRT visits, and SA 1 had the lowest (Figure 63). Most calls did not result in hospitalization (Figure 65) or transport to a facility (Figure 66). |

**Figure**

*59. Number of PMRT Field Visits by Insurance Status FY 2020-21*

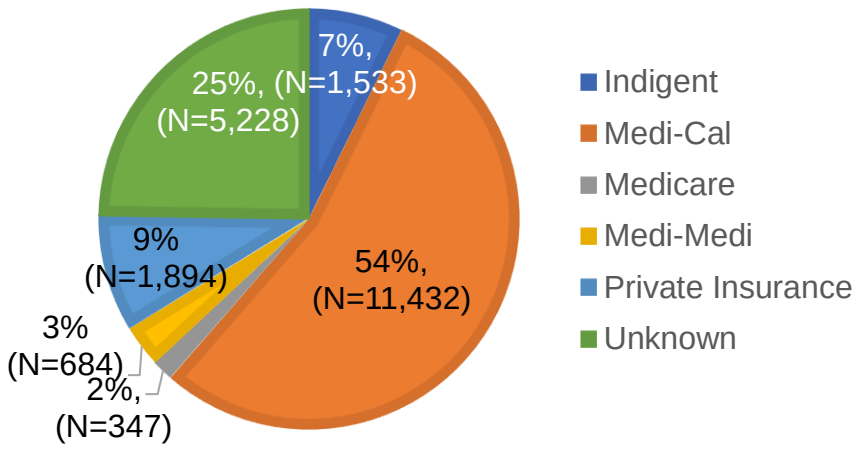



Figure 59 shows the number of field visits by insurance status of the client. The highest percentage of clients were Medi-Cal beneficiaries at 54% (N=11,432) followed by unknown at 25% (N=5,228), private insurance at 9% (N=1,894), Indigent at 7% (N=1,533), Medi-Medi at 3% (N=684), and Medicare at 2% (N=347). Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

**Figure**

*60. Number of PMRT Field Visits by Referral Source FY2018-19 – 2020-21*

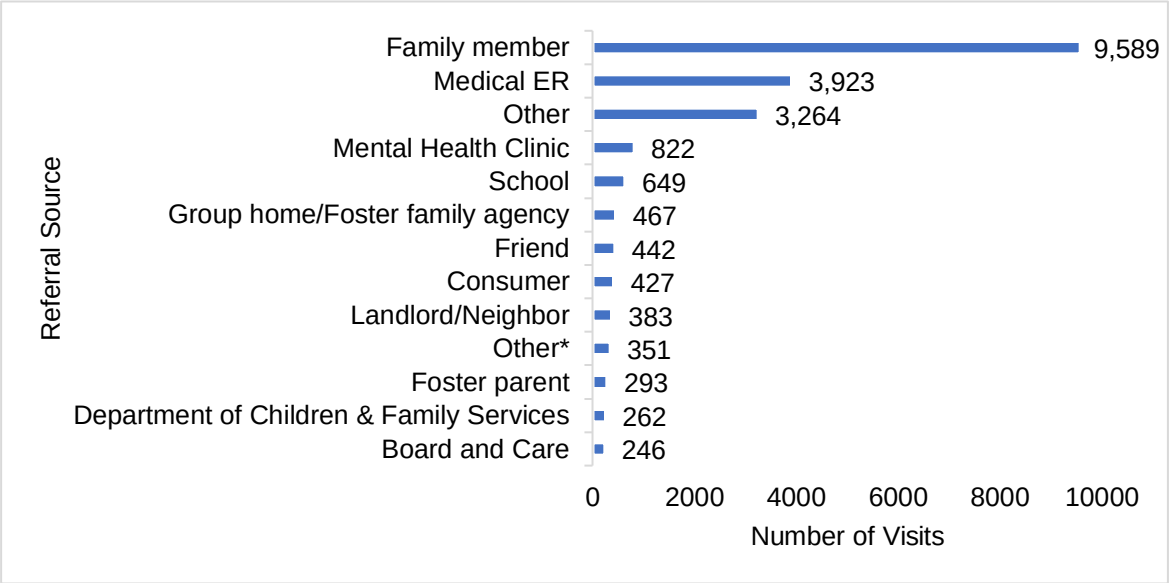



Figure 60 displays the number of field visits by referral source. The highest referrals were from family members at 9,589, medical ERs at 3,923, and Other at 3,264. The lowest referrals came from foster parents at 293, Department of Children and Family Services (DCFS) at 262, and Board and Care facilities at 246. Note: *Includes Skilled Nursing Facility, Primary Care Physician, Law Enforcement, APS, Probation, etc. Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

**Figure**

*61. Number of PMRT Field Visits by Dispatch Time Category FY 2020-21*

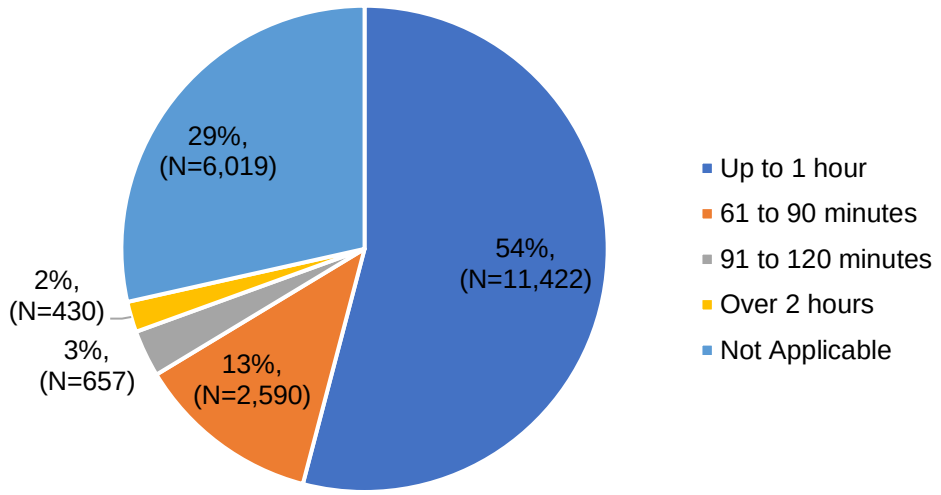



Figure 61 shows the number of field visits by dispatch time. The highest percentage of field visits were dispatched Up to 1 hour at 54% (N=11,422), followed by not applicable at 29% (N=6,019), 61 to 90 minutes at 13% (N=2,590), 91 to 120 minutes at 3% (N=657), and Over 2 hours at 2% (N=430). Note: *Not applicable refers to calls that did not result in a dispatch. These calls did not have a call duration. Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

**Figure**

*62. Number of PMRT Field Visits by Call Duration FY2020-21*

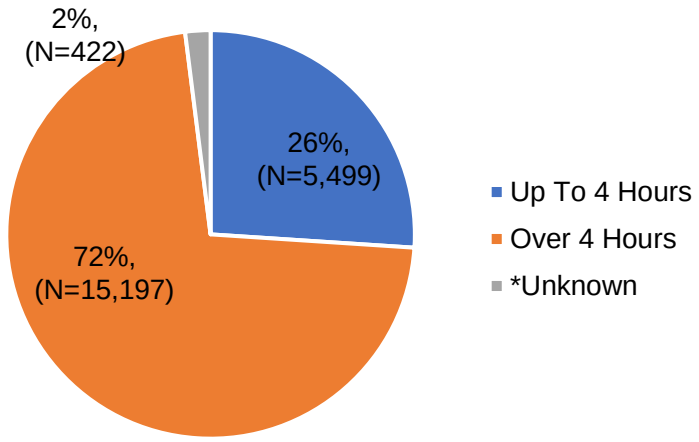



Figure 62 shows the number of field visits by call duration. The highest percentage of calls were Over 4 hours at 72% (N=15,197), followed by Up to 4 hours at 26% (N=5,499), and Unknown at 2% (N=422). Note: *Unknown refers to those that did not

result in a dispatch. These calls did not have a call duration. Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

**Figure**

*63. Number of PMRT Field Visits by Service Area FY2020-21*

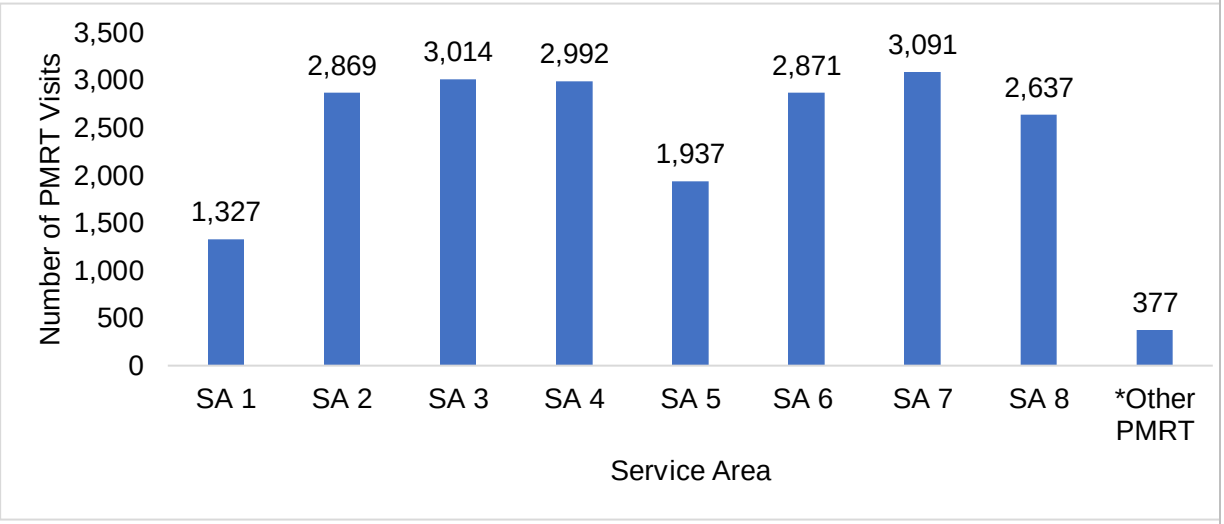



Figure 63 displays the distribution of PMRT visits by Service Area (SA). The total number of visits received was 21,118. The highest number of visits occurred in SA 7, with 3,091, and the lowest occurred in SA 1. There were 377 visits that PMRT teams responded to outside their typical service area. Note: *Includes PMRT teams that responded to SAs other than the one they typically serve. This table also includes records with missing data. Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

**Figure**

*64. PMRT Daytime and After-hours Field Visits FY2020-21*

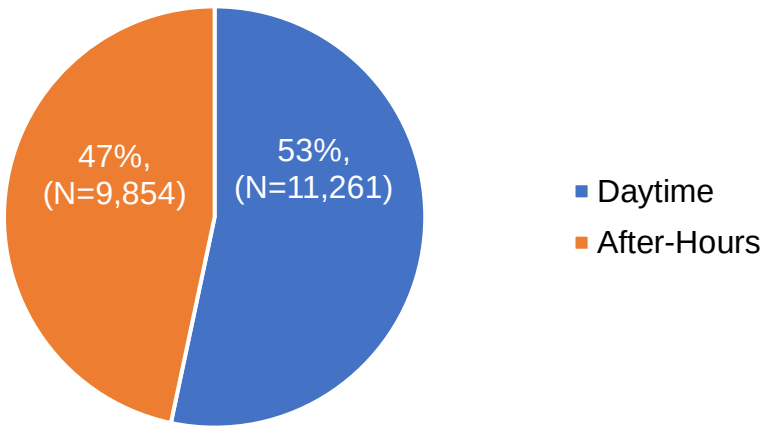


Figure 64 displays the distribution of field visits conducted during daytime and after-hours. The percentage of daytime field visits is higher at 53% (N=11,261) than the after-hours at 47% (N=9,854). Note: *Includes PMRT teams that responded to other SA than the one they typically serve due to availability. Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

**Figure**

*65. Number of PMRT Field Visits by Outcome FY 2020-21*

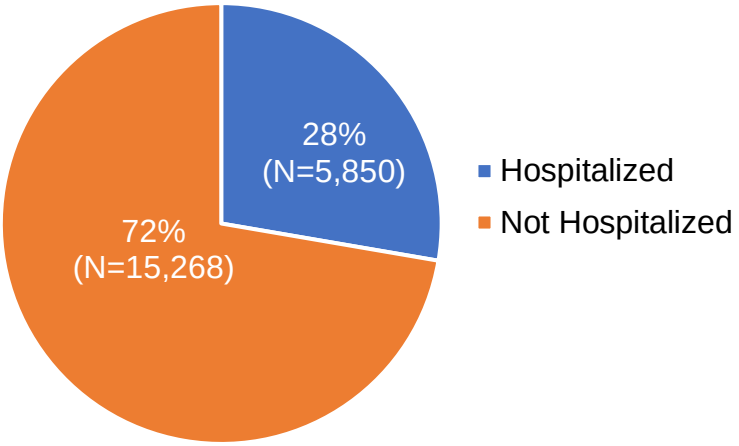



Figure 65 displays the number of field visits that resulted in hospitalization. The number of visits that did not result in hospitalization was higher than those in hospitalization. Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

**Figure**

*66. Number of PMRT Field Visits by Transport to Facility FY 2020-21*

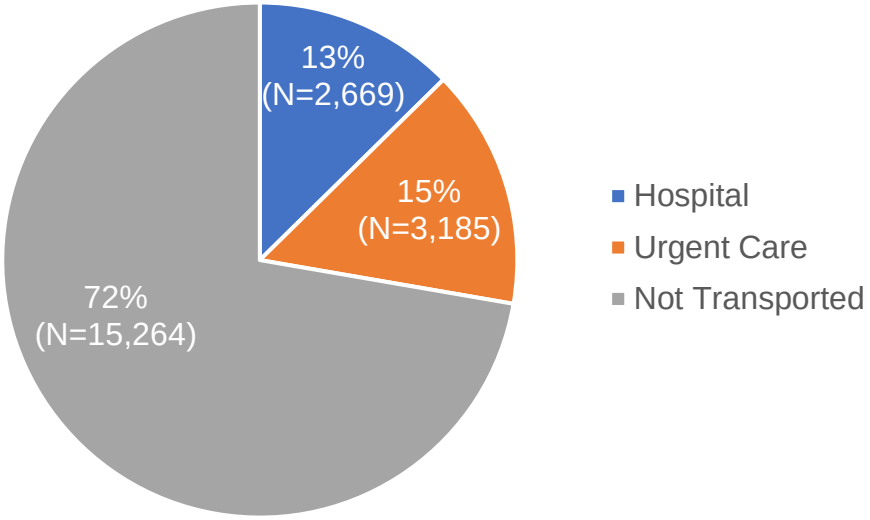


Figure 66 displays the number of field visits transported to a facility. The percentage of visits that were not transported to a facility was highest at 72% (N=15,264), followed by transports to Urgent Care at 15% (N=3,185) and hospitals at 13% (N=2,669). Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

The PRMT program's most significant barriers in FY 2020-21 were staffing challenges due to the COVID-19 pandemic and long estimated arrival times for ambulances. Plans for improvement in FY 2021-22 include the addition of peer support to PMRT teams and the potential for adding LE/Contracted providers for additional crisis support.

*Next Steps*

In FY 2021-22, PRMT will collaborate with the QA unit to develop strategies to analyze and decrease the response times to calls requiring PRMT presence. Several interventions are being explored, such as an electronic, real-time county-wide dispatch and call board to provide a uniform, coordinated, and efficient PMRT dispatch process for both daytime and nighttime to maximize the capacity of PMRT resources and ensure calls are responded to as quickly as possible. Other interventions include workflow redesign, piloting "urgent" slots for appointments in SA 3, using contractors as additional PRMT, and coordinating with new ambulance providers.

**Therapeutic Transport Pilot Program**

*Program Overview*

The Therapeutic Transport (TT) Program is a pilot program created to place specialized staff and transport vans at five Los Angeles County fire stations. The TT teams aim to provide 24/7 transportation with therapeutic support, de-escalation, and safe transport to mental health centers.

*Program Status*

In October 2020, DMH TT hired staff but delayed implementation due to the COVID-19 pandemic. Staff participated in the training, were deployed to vaccination Points of Distribution (PODs) or as Disaster Service Workers (DSWs), and supported the Project Room Key (PRK) sites, HOME unit, Whole Person Care, and Spring Refuge Shelter. TT Drivers assisted the DMH warehouse, HOME units, DHS Food Distribution Center, Men's Central Reintegration Program, Veterans Program, and other DMH programs.

In September 2021, the TT program was expected to begin, and staff returned from temporary assignments and began responding to PMRT crisis calls. However, the program has yet to be executed.

The TT program is funded by 60 staff divided into 20 teams. However, the program is affected by multiple extended medical leaves and vacancies. As of January 2022, 12 TT teams are functioning, each with an LPT, Community Health Workers (CHWs), and 20 drivers. Licensed Psychiatric Technicians (LPTs) are responding to PMRT crisis calls, triaging calls, completing the LACDMH Helpline Field Response Operation (FRO) Form, responding to field calls and evaluating clients for 5150, and completing appropriate documentation, writing 5150 holds when appropriate. They provide case management services and transport appropriate clients deemed safe to transport to various Urgent Care Centers (UCCs), Lanterman-Petris-Short (LPS) designated hospitals, and County psychiatric emergency rooms. CHWs provide peer support while responding to PMRT crisis calls, assist the LPT with providing resources to the client, open pre-admits into IBHIS, locate an LPS facility, and engage the client. Clinic Drivers drive the vans, complete vehicle logs, and assist when appropriate with transporting clients. They will also engage clients if appropriate and have been trained in de-escalation techniques and other interventions that may assist the client.

*Program Data FY2020-21*

There is currently a TT log used to track PMRT calls. However, the time the call is received by PMRT or ACCESS is not recorded. The TT program records when the TT team is dispatched and arrives. TT dispatch times for FY2020-21 are illustrated in Table # below. The total number of calls received was 1,448.

**Table**

*32. Therapeutic Transportation Dispatch Times FY 2020-21*

| Dispatch Time Category* | Jul | Aug | Sep | Oct | Nov | Dec | Total | Percent of Calls |
|---|---|---|---|---|---|---|---|---|
| **Up to 1 Hour** | 2 | 14 | 96 | 98 | 135 | 138 | 483 | 67% |
| **61 to 90 Minutes** | 1 | 2 | 7 | 10 | 12 | 12 | 44 | 6% |
| **91 to 120 Minutes** | 1 | 1 | 0 | 1 | 6 | 2 | 11 | 2% |
| **Over 2 Hours** | 0 | 0 | 3 | 4 | 6 | 3 | 16 | 2% |
| ***Not Applicable** | 2 | 5 | 33 | 31 | 39 | 60 | 170 | 23% |
| **Total** | 6 | 22 | 139 | 144 | 198 | 215 | 724 | 100% |

Table 32 shows the dispatch times for the TT program for FY2020-21. The majority of calls were dispatched in an hour or less at 67%. Note: Calls are logged from when the call is received to when the team is dispatched. * Not applicable refers to calls that did not result in a dispatch. These calls did not have a call duration. Data source: Psychiatric Mobile Response Team (PMRT) FY 20-21.

*Next Steps*

| | |
|---|---|
| | The TT program is a 24/7 program that may have only one to two full teams on a 12-hour shift at a time. The number of teams will likely increase once the LACFD initiates the program. There will be five fire stations that will each be staffed with four TT teams. |
| Population | Los Angeles County residents seeking crisis support services. |
| Performance Indicators | 1. The number of complete TT teams (Peer, Psychiatric Technician, and Clinical Driver).<br>2. Metrics on wait and transport times TBD at annual evaluation. |
| Frequency of Collection | Annual |

**Monitoring Beneficiary Satisfaction, Calendar Year 2021**

Client/Family Satisfaction

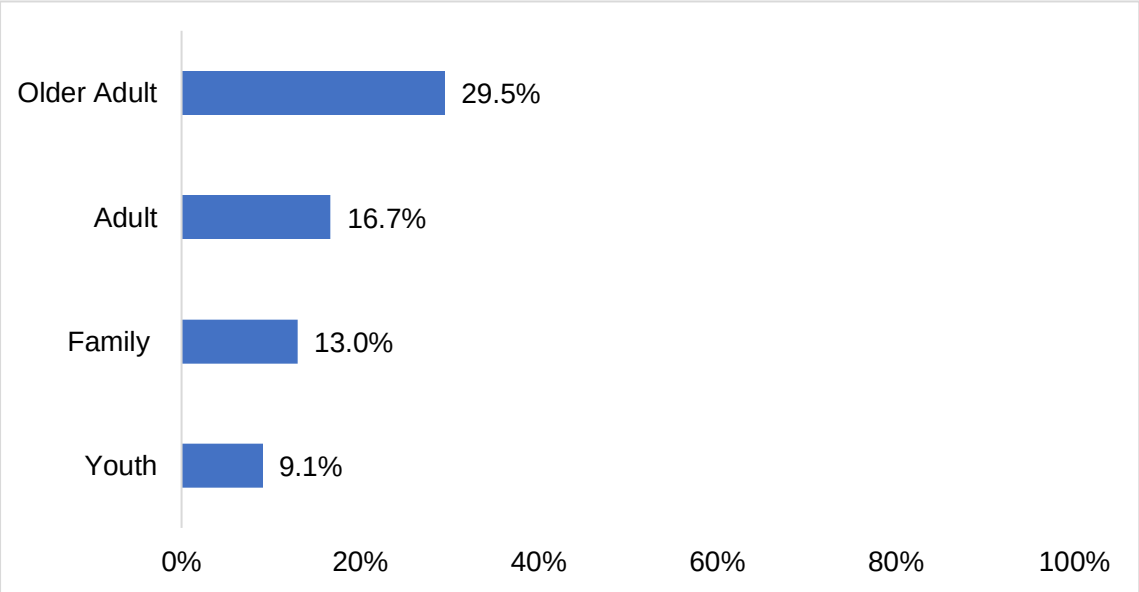
| Goal III.1. | LACDMH will increase the response rate on Consumer Perception Surveys (CPS) by 5% for Adults and Families and 10% for Youth and Older Adults. |
|---|---|
| Objective | Increase efforts to reach a more significant percentage of all consumers seen during the survey week by expanding eligible populations (e.g., field-based consumers) and introducing a LACDMH-specific electronic survey version.<br>• Target age groups that historically have lower response rates (i.e., Older Adults and Youth)<br><br>2021 Work Plan Evaluation:<br>This objective was partially met. LACDMH developed an internal user portal for DMH outpatient providers from directly operated and contracted programs to collect electronic survey responses and piloted it during the Spring 2021 survey period. The portal was designed to address many issues affecting previous survey collection periods, including minimizing time and staff burden, increasing privacy and language availability, and expanding the survey availability to consumers receiving telemental health or field-based services. There were several advantages to the internal portal, including the ability to pre-populate consumer information, translate almost all languages consumers speak, text or email surveys in multiple languages, and enhance tracking features for providers and the QI unit. However, several issues were identified in the pilot, including difficulty gaining initial access, a cumbersome process for creating and managing consumer records, a lack of automation in sending surveys during the survey week, and a lack of provider-level summary metrics to aid survey collection. The portal development team and the QI unit plan to address these issues for the next survey period in Spring 2022. More specifically, quality improvement efforts will be focused on streamlining the setup process for end users, improving the user-friendliness and utility of the portal interface, and enhancing the tracking features to include metrics relevant to provider sites.<br><br>Despite the efforts to improve the accessibility of the survey through electronic means, response rates (i.e., the number of surveys with responses out of those that were sent) for all age groups decreased from the prior survey period (Figures 69 to 72). The decrease was most minor for Older Adults and was largest for Families and Youth. Adults surveys decreased by about a fourth from Spring 2020 to Spring 2021. |

Response rates were likely impacted by the COVID-19 pandemic and the reduced number of consumers attending in-person services. Electronic surveys were available for the Spring 2020 and Spring 2021 survey periods. However, given that these were two new systems unfamiliar to staff members and consumers, there were some barriers to uptake. Trend analysis revealed that most electronic surveys were delivered to consumers' email addresses or cellular phones and were not opened by the consumer (Figure 68). A significant percentage of consumers clicked the link to access the survey and did not submit it, and a smaller percentage of consumers read the email or text message and did not click the survey link. The survey periods were also delayed from May to late June, which may have limited the number of families and youth receiving services through school-based programs that could participate. Quality improvement efforts regarding increased consumer participation will include improved follow-up and education regarding accessing and completing the survey with consumers and increased training and tracking of provider responses during the survey week. The Spring 2022 survey period will also include all outpatient providers (excluding urgent care and other short-term services) rather than a randomly-selected sample of providers, increasing the pool of participating clients.

Although response rates for age groups decreased, there was some expansion to other target populations. Response rates increased for six field-based programs that had previously participated, with only those consumers seen in-office during the survey week. Several new programs participated in the survey (i.e., juvenile justice, and school-based programs).

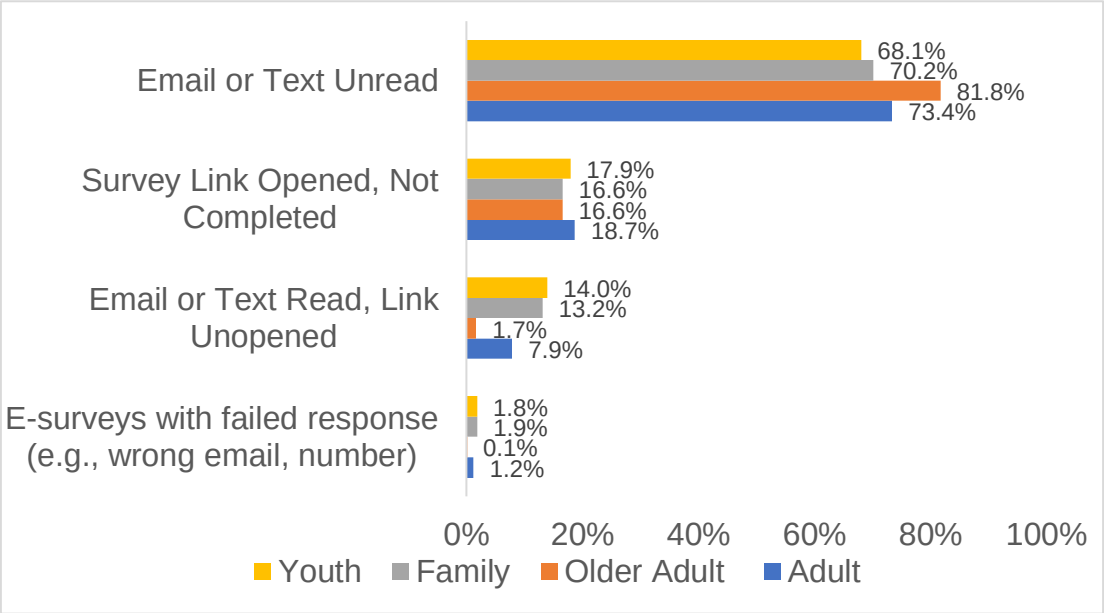
**Figure**

*67. User Portal Response Rates*



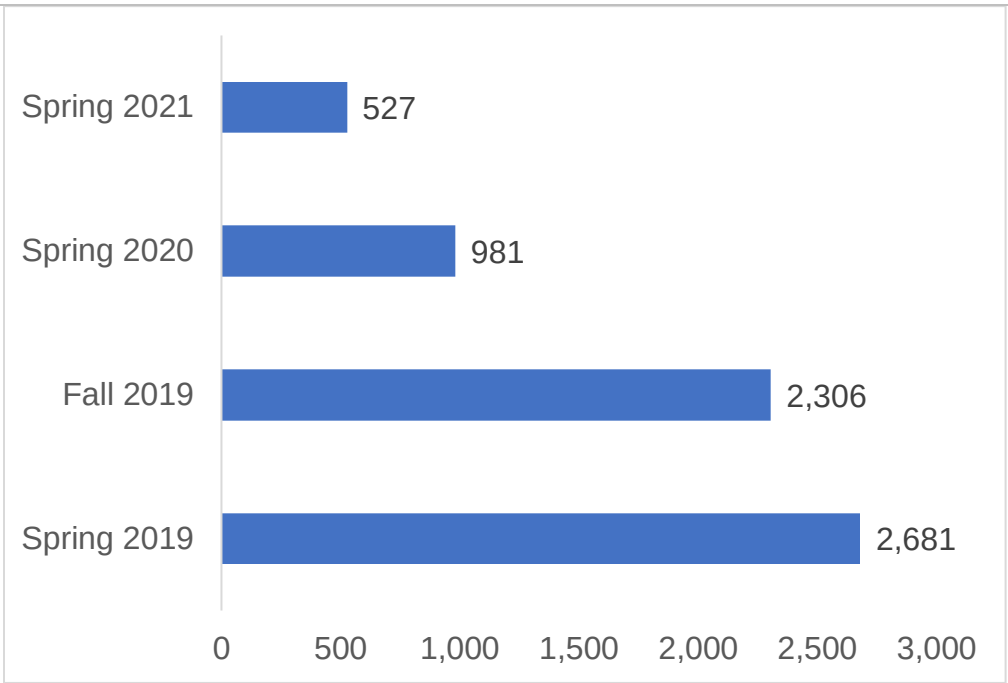
**Figure**

*68. Survey Non-Response Reasons by Form Type*



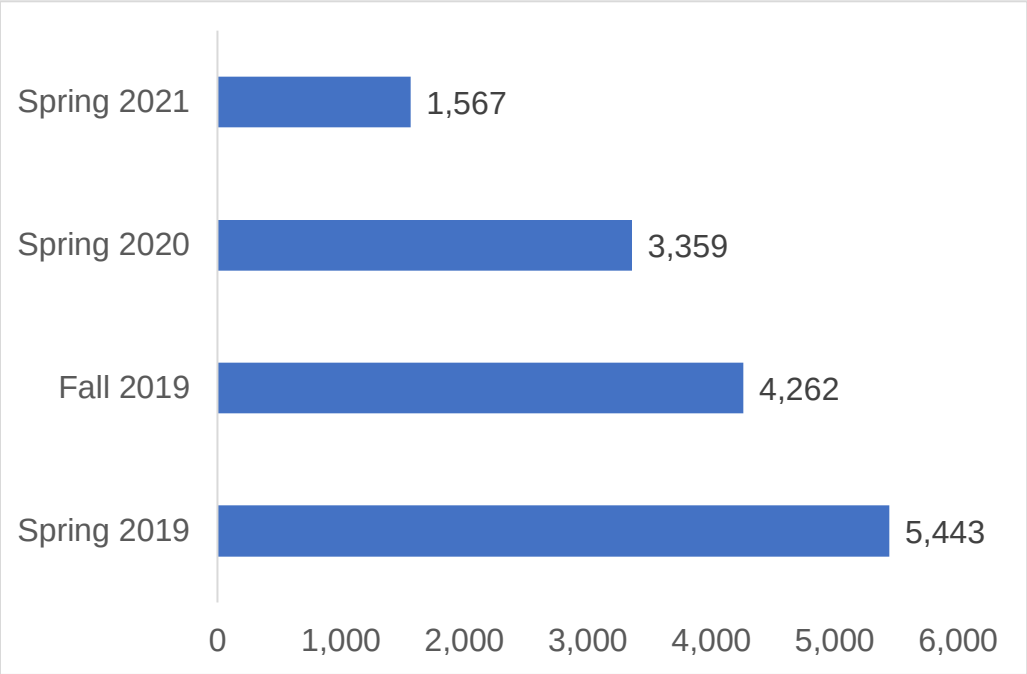

**Figure**

*69. Three Year Trend in Returned YSS*

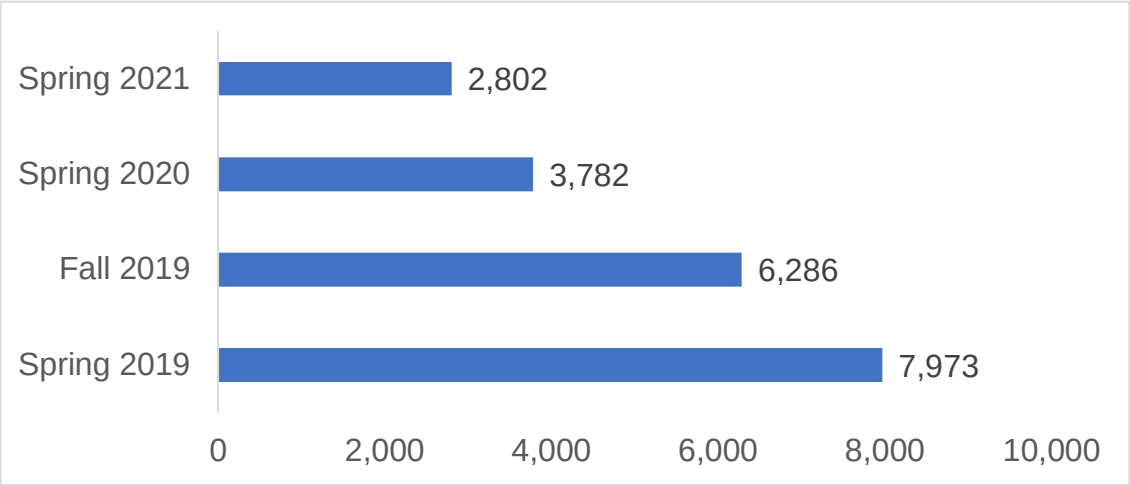
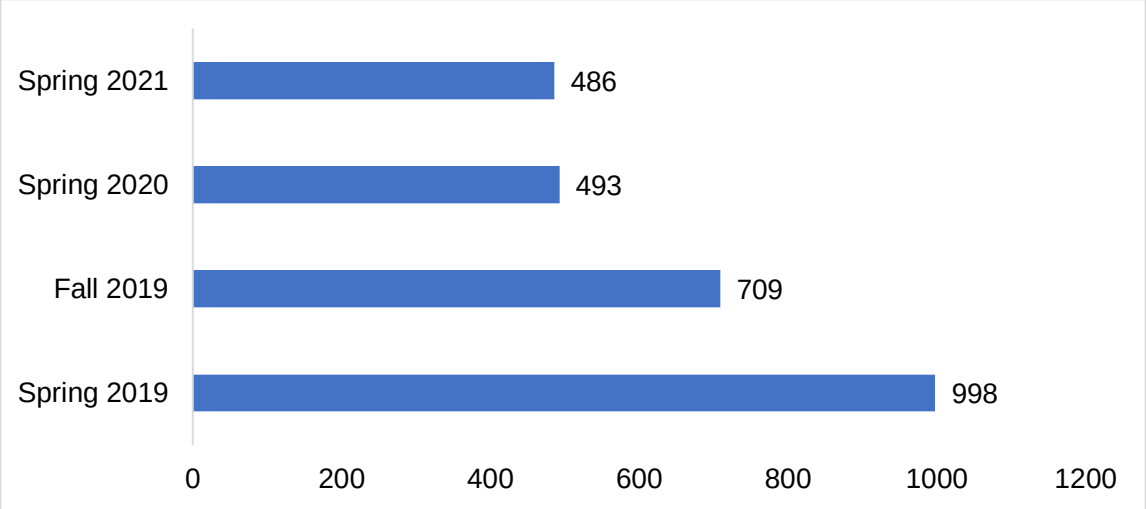



**Figure**

*70. Three Year Trend in Returned YSS-F*




**Figure**

| | |
|---|---|
| | *71. Three Year Trend in Returned Adult Surveys*<br>  <br><br>**Figure**<br>*72. Three Year Trend in Returned Older Adult Surveys*<br>  <br> |
| Population | Los Angeles County residents seeking outpatient SMHS from a LACDMH provider. |
| Performance Indicators | Number of returned CPS forms by age group. |
| Frequency of Collection | Annual |

Client Grievance

| Goal III.2. | Investigate and resolve 100% of Grievances and Appeals within regulation timelines. |
|---|---|
| Objective | 2021 Work Plan Evaluation: |

a) Maintain a written log of all Grievances, Appeals, and Expedited Appeals, including the timeliness of responses.

Met objective. One hundred forty-seven grievances were received in FY 2020-21. Of the beneficiary grievances received, 60.5% (N=89) were related to Quality of Care, 34% (N=50) were in the Other category, 2.7% (N=4) were related to Change of Provider, 2% (N=3) were related to Access, and the remaining 0.7% (N=1) were categorized as Confidentiality Concern (Table 33). Zero grievances were referred to, and two were resolved.

**Table**

*33. Number and Percent of Grievances by Category*

| Category | Grievance Disposition | | |
|---|---|---|---|
| | Grievances | Resolved | Referred |
| **ACCESS** | | | |
| Service not Available | 0 | 0 | 0 |
| Service not Accessible | 2 | 2 | 0 |
| Timeliness of Services | 1 | 1 | 0 |
| 24/7 Toll-Free Line | 0 | 0 | 0 |
| Linguistic Services | 0 | 0 | 0 |
| Other Access Issues | 0 | 0 | 0 |
| **ACCESS** – Total by Category | **3** | **3** | **0** |
| Percent | **2%** | **2.1%** | **0%** |
| **QUALITY OF CARE** | | | |
| Staff Behavior Concerns | 48 | 48 | 0 |
| Treatment Issues or Concerns | 35 | 34 | 0 |
| Medication Concern | 6 | 6 | 0 |
| Cultural Appropriateness | 0 | 0 | 0 |
| Other Quality of Care Issues | 0 | 0 | 0 |
| **QUALITY OF CARE** – Total by Category | **89** | **88** | **0** |
| Percent | **60.5%** | **60.7%** | **0%** |
| **CHANGE OF PROVIDER** – Total by Category | **4** | **4** | **0** |
| Percent | **2.7%** | **2.8%** | **0%** |
| **CONFIDENTIALITY CONCERN** – Total by Category | **1** | **1** | **0** |
| Percent | **0.7%** | **0.7%** | **0%** |

| OTHER | | | |
|---|---|---|---|
| Financial | 0 | 0 | 0 |
| Lost Property | 4 | 4 | 0 |
| Operational | 4 | 4 | 0 |
| Patients' Rights | 7 | 7 | 0 |
| Peer Behaviors | 15 | 15 | 0 |
| Physical Environment | 1 | 0 | 0 |
| Other Grievances not Listed Above | 19 | 19 | 0 |
| **OTHER** – Total by Category | **50** | **49** | **0** |
| Percent | **34%** | **33.8%** | **0%** |
| Grand Totals | **147** | **145** | **0** |

Data Source: DMH ABGAR Form FY 2020-21, prepared by PRO in October 2021.

In FY 2020-21, the Patients' Rights Office (PRO) experienced significant losses to management and staff due to the COVID-19 pandemic. This resulted in the delay of many PRO goals and projects. In September 2021, management was restored, and PRO resumed processing and investigating all incoming grievances. The PRO is now working to ensure that the clients who submitted a grievance or complaint during the CY 2020 and 2021 have been contacted and the grievance resolved. This process was complete by October 2021. The Program Director of the PRO manages oversight for LACDMH grievances and appeals. The Director is working with staff to establish workflows for documenting response times and with CIOB to roll out a grievance and complaints portal that will track these response times electronically versus manually.

[intentionally left blank]

**Table**

*34. Number and Percent of Appeals and Expedited Appeals by Category*

| Category | Process | | | |
|---|---|---|---|---|
| | Grievance | Exempt Grievances | Appeal | Expedited Appeal |
| **ACCESS** | | | | |
| Service not Available | 0 | 0 | | |
| Service not Accessible | 2 | 0 | | |
| Timeliness of Services | 1 | 0 | | |
| 24/7 Toll-Free ACCESS Line | 0 | 0 | | |
| Linguistic Services | 0 | 0 | | |
| Other Access Issues | 0 | 0 | | |
| ACCESS – Total by Category | **3** | **0** | **N/A** | **N/A** |
| Percent | **2%** | **0%** | **N/A** | **N/A** |
| **QUALITY OF CARE** | | | | |
| Staff Behavior Concerns | 48 | 0 | | |
| Treatment Issues or Concerns | 35 | 0 | | |
| Medication Concern | 6 | 0 | | |
| Cultural Appropriateness | 0 | 0 | | |
| Other Quality of Care Issues | 2 | 0 | | |
| QUALITY OF CARE – Total by Category | **89** | **0** | **N/A** | **N/A** |
| Percent | **60.5%** | **0%** | | |
| CHANGE OF PROVIDER – Total by Category | **4** | **0** | **N/A** | **N/A** |
| Percent | **2.7%** | **0%** | | |
| CONFIDENTIALITY CONCERN – Total by Category | **1** | **0** | **N/A** | **N/A** |
| Percent | **0.7%** | **0%** | **N/A** | **N/A** |
| **OTHER** | | | | |
| Financial | 0 | 0 | | |
| Lost Property | 4 | 0 | | |
| Operational | 4 | 0 | | |
| Patients' Rights | 7 | 0 | | |
| Peer Behaviors | 15 | 0 | | |
| Physical Environment | 1 | 0 | | |
| Other Grievances not Listed Above | 19 | • 0 | | |
| Other – Total by Category | **50** | **0** | **N/A** | **N/A** |

| | | | | |
|---|---|---|---|---|
| Percent | **34%** | **0%** | **N/A** | **N/A** |
| Grand Totals | **147** | **0** | **N/A** | **N/A** |

Note: Data above reflects the grievances and appeals for/by Medi-Cal beneficiaries. Data Source: DMH, ABGAR Form FY 2020-21, prepared by PRO in October 2021.

LACDMH believes the increase in grievances is due to the Department's adherence to the DHCS guidance regarding what constitutes a grievance. The federal regulations redefined the term "grievance" to mean an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. *The definition specifies that grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the Plan to make an authorization decision.* There is no distinction between an informal and formal grievance. A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an "adverse benefit determination."

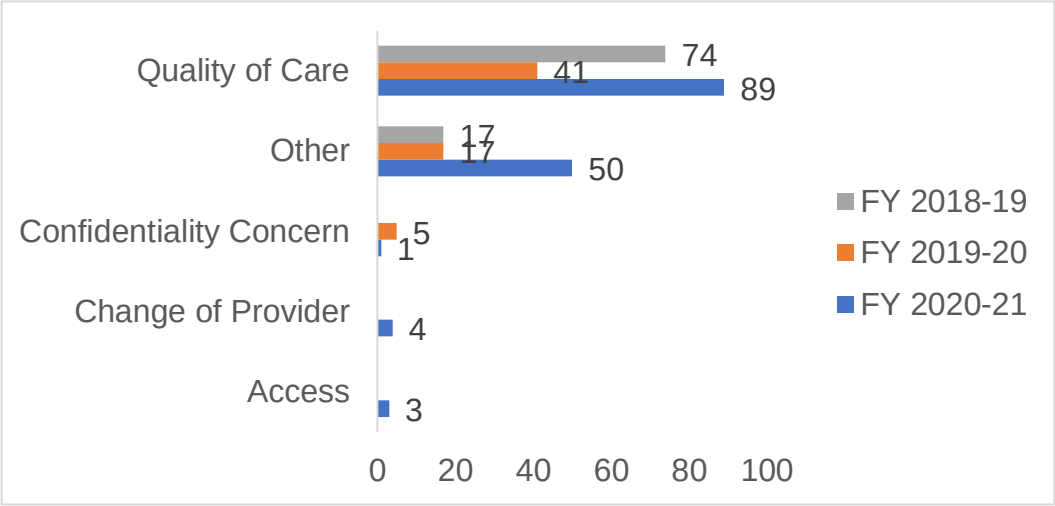
The grievance count submitted on the ABGAR includes every grievance form received by a consumer during that reporting period.

a) Review the nature of complaints and resolutions for significant trends that may warrant policy recommendations or system-level improvement strategies.

Met objective. In FY 2020-21, there were 89 inpatient and outpatient grievances related to Quality of Care; 50 were categorized as Other, four were related to Change of Provider, three were related to Access, and one was related to Confidentiality Concerns.

**Figure**

*73. Three Year Trends in Inpatient and Outpatient Grievances by Category*



| | |
|---|---|
| | Figure 73 shows the three-year trends in inpatient and outpatient grievances by category. Grievances appear to have increased in all categories since FY 2018-19. Data Source: DMH, ABGAR Form FYs 2018-19 to 2020-21.<br><br>Over the last three years, the number of grievances has increased, particularly in FY 2020-21, as noted in the section above. Since the log was partially complete, PRO does not have the level of data needed to identify significant trends. Going forward, the Director will ensure we have the data to look at trends. |
| Population | Los Angeles County residents engaging in DMH services (outpatient, inpatient, FFS) |
| Performance Indicators | Beneficiary complaints and resolutions in FY 2020-21 as documented in the Grievance log. |
| Frequency of Collection | Annual |

| Goal III.3. | Monitor requests for Change of Provider (COP). |
|---|---|
| Objective | Review COP reasons and track client request trends to change practitioners/providers.<br><br>All COP requests are entered into the online application for the Directly Operated Programs. PRO can review the data to identify reasons and trends for COP requests from directly operated programs. For the LE/Contracted providers, PRO is still using a spreadsheet. The goal is to start using the online application for contract providers in FY2021-22. |
| Population | Beneficiaries receiving outpatient LACDMH services. |
| Performance Indicators | COP requests in FY 2020-21 by reason. |
| Frequency of Collection | Annual |

**Monitoring Clinical Care, Calendar Year 2021**

Reporting

| Goal IV.1. | Rollout Child and Adolescent Needs and Strengths – 50 (CANS50) 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<br>• Gather input on report elements from providers<br>• Consolidate the CANS-50 and PSC-35 data sets for reporting<br><br>2021 Work Plan Evaluation:<br>The objectives for this goal were partially met. The Outcomes unit consulted several local and statewide sources in developing the metrics for the CANS-50 report, including an outcomes workgroup of directly-operated and legal entities representatives that are involved in outcomes reporting in their organizations, contracted sites that had developed their reports and participate in an expert task force, a workgroup of directly-operated supervisors and programs managers, a statewide workgroup through the California Department of Social Services (CDSS), and previous experience customizing provider reports for other outcomes tools (e.g., PHQ-9, GAD-7, PCL-5). Following this information-gathering process, in CY 2021, the Outcomes unit developed a dynamic client-level Power BI report that aggregates individual client CANS-50 data over multiple time points. The report includes two pages. The first displays the score for each CANS-50 item by domain at each time point and uses heat mapping to indicate items that require immediate intervention or monitoring. The second page of the report graphs the number of actionable items by domain over time to allow providers to visualize progress and areas for improvement. The CANS-50 report is available to all provider sites systemwide through a secure web portal. In CY 2022, the Outcomes unit plans to continue an iterative feedback process to revise the current report, develop a report that can aggregate CANS-50 data at the provider level, and create an additional report for the PSC-35 data. |
| Population | LACDMH Directly Operated (DO) and LE/Contracted programs providing SMHS to children and youth between ages 3 and 21 years. |
| Performance Indicators | 1. At least one report is available for provider use (Goal) |
| Frequency of Collection | Annual |

Medication Monitoring

| Goal IV.2. | Facilitate medication monitoring activities through ongoing data evaluation and prescriber-to-prescriber peer reviews. |
|---|---|
| Objective | a) Develop dashboard review procedures highlighting data evaluation, the rollout for LE/Contracted programs in one SA, and recommended use of a review committee. ***Not met***<br>b) Establish peer review procedures highlighting tracking administrative reminders, matching, records review, and replicability for prescribers in LE/Contracted programs. ***Met***<br><br>In 2022, Pharmacy Services will work collaboratively with the West Valley clinic to establish a primary integration workflow. Clinical pharmacists will identify clients on antipsychotics and educate them on the criticality of glycemic control treatment of dyslipidemia and hypertension. Clinical pharmacists will link clients to primary care services for proper diagnosis and other primary care screening. Clinical pharmacists will continue to monitor for HgbA1c and may co-manage treatment and optimize medication therapy and therapeutic outcomes.<br><br>The FY 2020-21 goal to develop a dashboard to evaluate data was not met due to staffing challenges. The interviews for staff taking on the role and project are underway. Once the dashboard is established among DO providers, it will be rolled out for LE/Contracted providers.<br><br>**Prescriber Peer Review**<br><br>In FY 2018-19 annual review, the External Quality Review Organization (EQRO) recommended that LACDMH finalize and implement a Medication Monitoring and Peer Review plan. They recommended targeting one SA for LE/Contracted provider implementation.<br><br>In response, an annual Prescriber Peer Review process comprised of DO psychiatrists, pharmacists, the Chief of Nursing, Mental Health Transformation Advocates, and the QI unit. Psychiatrists are randomly matched with other psychiatrists of similar backgrounds. The reviewing psychiatrists review five charts of a matched provider, or reviewee, that have an intake completed in the last 12 months for standards based on Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS criteria are specific to Adults or Child/Adolescent populations.<br><br>At the FY 2020-21 annual review, LACDMH reported that 127 psychiatrists participated in the 2021 Prescriber Peer Review. A description of the participants is below in Table 35. |

**Table**

*35. Description and Response Rate of Psychiatry Staff Participation in the Prescriber Peer Review 2021*

| | Position Breakdown | Number of Providers/Total Number of Providers | Response Rate (%) |
|---|---|---|---|
| **Adult Providers** | Psychiatrists | 98/160* | 61% |
| | Supervising Psychiatrists | 16/24 | 67% |
| **Child/Adol. Providers** | Psychiatrists | 13/16 | 83% |
| **Total** | | 127/200 | 64% |

Note: Data above reflect providers from DO programs only. Data source: Prescriber Peer Review PowerPoint presentation, September 2021.

Table 35 describes the DO psychiatry staff's participation level in the Prescriber Peer Review 2021. Sixty-four percent (N=13) of psychiatry staff participated in the review. Child/Adolescent Psychiatrists made up the largest portion at 83%. Adult Supervising Psychiatrists followed at 67% (N=16), and Adult Psychiatrists were 61% (N=98).

**Table**

*36. Number of Charts and Items Reviewed in the Prescriber Peer Review 2021*

| | Position Breakdown | Total Charts | Total Items |
|---|---|---|---|
| **Adult Providers** | Psychiatrists/ Supervising Psychiatrists | 570 | 5,700 |
| **Child/Adol. Providers** | Psychiatrists | 65 | 845 |
| **Total** | | 635 | 6,545 |

Note: Data above reflect providers from DO programs only. Data source: Prescriber Peer Review PowerPoint presentation, September 2021.

Table 36 displays the number of charts and items reviewed by the reviewers in the Prescriber Peer Review 2021. A total of 635 charts were reviewed, with Adults' charts making up the largest portion of charts at 89.8% (N=570) and items at 87.1% (N=5,700). Child charts were at 10.2% (N=65), and items were at 12.9% (N=845).

Future goals for the Prescriber Peer Review are increasing psychiatrist participation and creating peer review guidelines to expand the process to LE/Contracted providers.

| | |
|---|---|
| Population | Prescribers in DO and LE/Contracted programs providing outpatient SMHS to DMH clients. |
| Performance Indicators | The number of peer reviews completed for prescribers in DO programs. |

| | |
|---|---|
| Frequency of Collection | Annual |

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, DMH-DHS Collaboration programs, TAY Enhanced Emergency Shelter Program (EESP) Navigation program, Men's & Women's Re-Integration, and the DO clinics in each Service Area. ***Met***<br>• Review aggregate and program-specific data, such as client financial information updates (UMDAPs), client treatment plans, and timeliness, and identify barriers, challenges, and successes. ***Met***<br>• Review demographic data on the total population, poverty estimates, clients served, and data on individuals experiencing homelessness. ***Met***<br>• Examine post-APEX surveys for tools and helpful recommendations, and forward findings to program managers. ***Met***<br><br>2021 Work Plan Goal Evaluation: The objectives for this goal were all met. Over Calendar Year 2021, the Outpatient Services Division (OSD) held 11 monthly APEX meetings focusing on the individual Service Areas, the Men's and Women's Re-Integration Programs, the GENESIS program, DMH/DHS collaboration programs, the TAY EESP Navigation program, and adult/child/adolescent programs across the SAs. The structure of each meeting allotted equal time to each program. It began with a data overview followed by program managers responding to prompts regarding their strengths, limitations, planned solutions to address them, and specific requests for OSD support. The QI unit and the Clinical Informatics unit collaborated with OSD to provide data on metrics related to program operations, including active clients, client financial information updates (UMDAPs), documentation completion and timeliness, and telehealth usage. For the first half of CY 2021, the QI unit and Clinical Informatics unit additionally presented on the region- or program-specific demographic data, active diagnoses, and homelessness rates. Based on discussions between QI and OSD to improve the utility of the data, these metrics were revised to focus on more relevant clinical data and demographics. For the second half of CY 2021, presentations also included program-specific service mix and diagnoses for active clients, outcome measure completion rates and average scores over time, use of medication-assisted treatment (MAT), and hospitalization/re-hospitalization rates. Data review is a crucial feature of APEX meetings and often prompts further discussion of program successes or areas for improvement among program managers and executive/OSD leadership.<br><br>Program managers complete a voluntary survey after APEX participation to reflect on their experiences and provide feedback on the meeting format, utility, and best practices. The QI and OSD units analyzed the qualitative APEX survey data from the 2020 calendar year using a rapid assessment process. Helpful practices across sites were sorted into seven themes: monitoring, coaching, training, enhancing quality, staffing, workflows, and tools. Common barriers and recommendations for support were also outlined and included themes related to staffing, COVID-19, equipment, |

| | |
|---|---|
| | facilities, workflow, consumer issues, tools, resources, data reports, and training. A one-page handout summarizing the findings was disseminated to program managers and presented during a leadership meeting in March 2021. OSD also used this feedback to make data-driven changes to the meeting structure. For example, based on feedback that child/adolescent providers found it difficult to discuss their unique challenges in the SA-level meetings, the October, November, and December 2021 APEX meetings featured groupings of child/adolescent providers across service areas. To further collaboration in this area, the QI unit began developing an interactive SharePoint site to compile best practice resources and allow programs to communicate effective strategies more regularly. This project will continue into 2022. |
| Population: | DO programs providing outpatient SMHS to LACDMH clients/families |
| Performance Indicators: | Number and location of APEX meetings conducted in CY 2021 |
| Frequency of Collection: | Annual |

| Goal IV.4. | Develop and refine the processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS. |
|---|---|
| Objective | 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. ***Met***<br><br>Met objective. The QA unit developed a Knowledge Assessment survey to assist the QA unit and providers in evaluating and troubleshooting gaps in knowledge for LE/Contracted provider staff.<br><br>Four separate QA Knowledge Assessment surveys were administered, with an average of about 20% of LE/Contracted providers responding in each survey period. The surveys each focused on specific documentation themes identified by QA Reviewers commonly identified as misconstrued by LE/Contracted providers. These themes included Progress Notes Reimbursement Requirements, Treatment Plan Requirements, Targeted Case Management on the Treatment Plan, and Assessment Purpose and Requirements. Providers have discussed in SA QIC meetings the different ways the Knowledge Assessment surveys are used in the QA Process of their clinics. |

**Table**

*37. Total Correct for Assessment 1 by Service Area*

| Service Area | Total Respondents | Percent of Question 1 Correct | Percent of Question 2 Correct | Percent of Question 3 Correct | Percent of Question 4 Correct | Average Percent Correct |
|---|---|---|---|---|---|---|
| **SA 1 (N=40)** | 40 | 85% | 80% | 85% | 68% | 80% |
| **SA 2 (N=25)** | 25 | 92% | 76% | 60% | 80% | 77% |
| **SA 3 (N=53)** | 53 | 81% | 68% | 83% | 85% | 79% |
| **SA 4 (N=44)** | 44 | 98% | 91% | 84% | 80% | 88% |
| **SA 5 (N=44)** | 44 | 91% | 80% | 91% | 86% | 87% |
| **SA 6 (N=41)** | 41 | 93% | 73% | 76% | 61% | 76% |
| **SA 7 (N=33)** | 33 | 97% | 79% | 79% | 73% | 82% |
| **SA8 (N=60)** | 60 | 93% | 75% | 93% | 83% | 86% |
| **Average Percent Correct** | | 91% | 78% | 81% | 77% | 82% |

**Table**

*38. Total Correct for Assessment 1 by Discipline*

| Discipline | Percent of Question 1 Correct | Percent of Question 2 Correct | Percent of Question 3 Correct | Percent of Question 4 Correct | Average Percent Correct |
|---|---|---|---|---|---|
| **Agency Director/Clinical Director (N=35)** | 91% | 63% | 86% | 86% | 82% |
| **Case Manager (N=5)** | 100% | 80% | 100% | 100% | 95% |
| **Clinical Supervisor (N=78)** | 95% | 82% | 74% | 74% | 81% |
| **Licensed Therapist (N=43)** | 81% | 84% | 79% | 79% | 81% |
| **Other (N=51)** | 84% | 61% | 73% | 73% | 73% |
| **QA Manager/Director (N=38)** | 100% | 79% | 71% | 71% | 80% |
| **Unlicensed Therapist/Intern (N=90)** | 91% | 84% | 81% | 81% | 84% |
| **Average Percent Correct** | 92% | 76% | 81% | 81% | 82% |

**Table**

*39. Total Correct for Assessment 2 by Service Area, March 2020*

| Service Area | Percent of Question 1 Correct | Percent of Question 2 Correct | Percent of Question 3 Correct | Percent of Question 4 Correct | Average Percent Correct |
|---|---|---|---|---|---|
| **SA 1 (N=9)** | 67% | 78% | 56% | 11% | 32% |
| **SA 2 (N=8)** | 50% | 75% | 63% | 25% | 34% |
| **SA 3 (N=48)** | 65% | 83% | 56% | 29% | 36% |
| **SA 4 (N=50)** | 62% | 76% | 62% | 30% | 37% |
| **SA 5 (N=44)** | 61% | 84% | 57% | 34% | 37% |
| **SA 6 (N=33)** | 64% | 85% | 67% | 39% | 37% |
| **SA 7 (N=29)** | 59% | 90% | 69% | 52% | 36% |
| **SA8 (N=61)** | 62% | 85% | 48% | 33% | 32% |
| **Average Percent Correct** | 61% | 82% | 60% | 32% | 34% |

**Table**

*40. Total Correct for Assessment 2 by Disciplines*

| Discipline | Percent of Question 1 Correct | Percent of Question 2 Correct | Percent of Question 3 Correct | Percent of Question 4 Correct | Average Percent Correct |
|---|---|---|---|---|---|
| **Agency Director/Clinical Director (N=37)** | 62% | 70% | 54% | 35% | 55% |
| **Case Manager (N=19)** | 58% | 79% | 53% | 32% | 56% |
| **Clinical Supervisor (N=69)** | 61% | 86% | 52% | 32% | 58% |
| **Licensed Therapist (N=29)** | 72% | 79% | 55% | 31% | 59% |
| **Other (N=44)** | 52% | 91% | 66% | 43% | 63% |
| **Psychiatrist/Nurse (N=1)** | 100% | 100% | 0% | 0% | 50% |
| **QA Manager/Director (N=37)** | 62% | 84% | 70% | 32% | 62% |
| **Unlicensed Therapist/Intern (N=46)** | 67% | 85% | 59% | 30% | 60% |
| **Average Percent Correct** | 67% | 84% | 51% | 29% | 58% |

**Table**

*41. Total Correct for Question 3 by Service Area*

| Service Area | Percent of Question 1 Correct | Percent of Question 2 Correct | Percent of Question 3 Correct | Percent of Question 4 Correct | Percent of Question 5 Correct | Average Percent Correct |
|---|---|---|---|---|---|---|
| **SA 1 (N=12)** | 33% | 25% | 75% | 75% | 42% | 50% |
| **SA 2 (N=13)** | 62% | 31% | 77% | 62% | 54% | 57% |
| **SA 3 (N=54)** | 67% | 54% | 81% | 65% | 74% | 68% |
| **SA 4 (N=27)** | 67% | 48% | 89% | 67% | 81% | 70% |
| **SA 5 (N=33)** | 48% | 45% | 58% | 58% | 55% | 53% |
| **SA 6 (N=79)** | 58% | 52% | 80% | 68% | 57% | 63% |
| **SA 7 (N=50)** | 38% | 30% | 88% | 58% | 56% | 54% |
| **SA8 (N=40)** | 73% | 53% | 85% | 60% | 65% | 67% |
| **Average Percent Correct** | 56% | 42% | 79% | 64% | 61% | 60% |

**Table**

*42. Total Correct for Question 3 by Discipline*

| Discipline | Percent of Question 1 Correct | Percent Question 2 Correct | Percent Question 3 Correct | Percent Question 4 Correct | Percent Question 5 Correct | Average Percent Correct |
|---|---|---|---|---|---|---|
| **Case Manager (N=29)** | 45% | 34% | 62% | 55% | 41% | 47% |
| **Clinical Director (N=19)** | 74% | 53% | 95% | 96% | 95% | 83% |
| **Clinical Supervisor (N=42)** | 62% | 57% | 88% | 76% | 88% | 74% |
| **Licensed Therapist (N=35)** | 60% | 49% | 77% | 49% | 69% | 61% |
| **Other (N=45)** | 62% | 47% | 80% | 69% | 56% | 63% |
| **QA Manager/Director (N=25)** | 76% | 56% | 96% | 80% | 96% | 81% |
| **Unlicensed Therapist/Intern (N=113)** | 49% | 40% | 77% | 55% | 45% | 53% |
| **Average Percent Correct** | 61% | 48% | 82% | 69% | 70% | 66% |

| | |
|---|---|
| | b) Pilot a chart review checklist that tracks the number (and percent) of criteria complying or improving over time. ***Met***<br><br>Met objective. QA developed a Chart Review Summary Report to designate Checklist (chart review tool) ratings for each clinical record. The report summarizes the level of compliance by criterion at each LE/Contracted provider's review. The Chart Review Summary Report includes comments made by reviewers on the corresponding criteria and quantitative ratings. Different formats have been developed to best highlight and present the findings of a Chart Review for a LE/Contracted provider. |
| Population | LE/Contracted programs providing outpatient SMHS to DMH clients/families. |
| Performance Indicators | Provider participation and accuracy rates |
| Frequency of Collection | Annual |

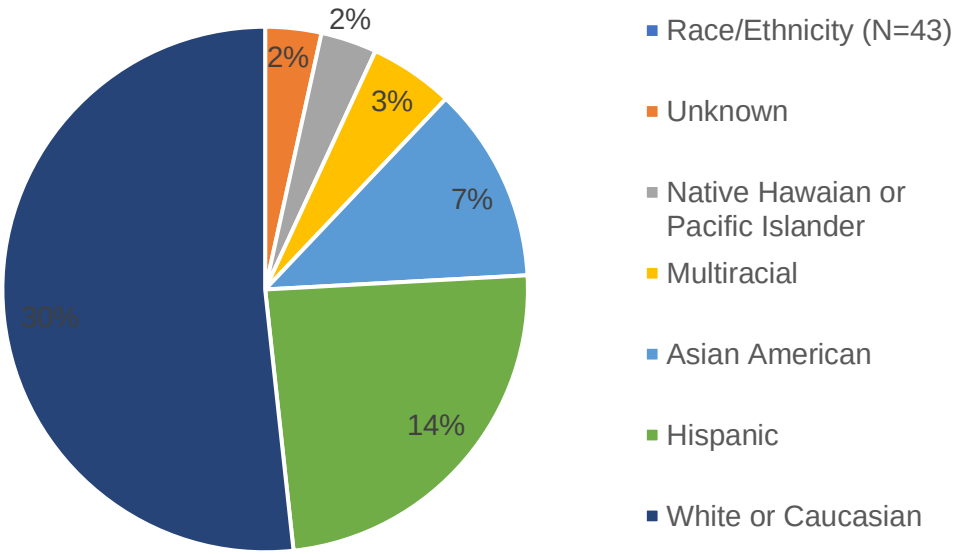
**Monitoring Continuity of Care, Calendar Year 2021**

| 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) LACDMH will apply for outpatient conservatorship for homeless individuals who are gravely disabled but refusing voluntary mental health services.<br>b) Establish baseline Health of the Nation Outcome Scale (HoNOS) and Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) data towards a demographic profile of those served.<br><br><u>2021 Work Plan Evaluation</u>:<br>Met objective. The Homeless Outreach and Mobile Engagement (HOME) Team, under the LAC Coordinated Outreach Teams umbrella, is meant to engage individuals struggling with homelessness and release/reentry from incarceration with the complication of severe mental illness and willingness to engage in treatment. The HOME team provides general and specialty mental healthcare to this category of individuals connecting them to outpatient mental healthcare.<br><br>*Outpatient Conservatorship Pilot*<br>In June 2020, the Board of Supervisors motioned for HOME Team to pursue conservatorships in outpatient settings rather than inpatient settings, specifically for those designated as Gravely Disabled or unable to provide food, clothing, or shelter. Lanterman Petris Short (LPS) conservatorship for Gravely Disabled individuals is typically completed in an inpatient setting during an acute mental health crisis. It proceeds through a series of lengthy steps: a 5150 temporary hold, a court-ordered 72-hour hold, a 14-day hold, a 30-hold, and possible trial, and then a conservator can be appointed to manage the client's affairs and treatment.<br><br>The Outpatient Conservator Pilot (OCP) began on July 1, 2020, and ended on June 30, 2021. The pilot aimed to understand the needs of HOME Team clients experiencing or at risk for Grave Disability designation, to discover how the HOME Team can create new trajectories for individuals experiencing or at risk for Grave Disability, and summarize lessons learned to inform ongoing efforts. The OCP committee assumed recovery was possible, sought the least restrictive housing, maintained a continuity of care throughout the process, provided testimony for hearings informed by the HOME Team relationship, used collaborative planning as the foundation, aimed to avoid lengthy and costly stays in acute settings, and attempted the reduction of trauma experience as relates to obtaining care.<br><br>*LACDMH and UCLA Public Mental Health Partnership Findings*<br>Data for the pilot was collected and analyzed by the University of California Los Angeles (UCLA) through the Public Mental Health Partnership with LACDMH. The UCLA team used semi-structured, open-ended client interviews, reviewed committee notes, and other structured data to complete the assessment. |

The OCP Committee reviewed 43 individuals for the pilot. Most individuals involved in the pilot met at least one standard for conservatorship. Some of the most common mental health diagnoses for individuals participating in the pilot were Schizophrenia, Schizoaffective Disorder, Delusional Disorder, and Co-occurring Substance Use. The most common physical health issues were HIV, extremity infections, atrial fibrillation, wheelchair dependence, traumatic brain injury, and pulmonary embolism. Below three figures describe the 43 pilot participants' race/ethnicity, gender, and age groups.

**Figure**

*74. Outpatient Conservator Pilot Participants by Race/Ethnicity*




Data source: DMH and UCLA Public Mental Health Partnership HOME Outpatient Conservatorship Pilot: Findings & Future Directions, August 17, 2021.

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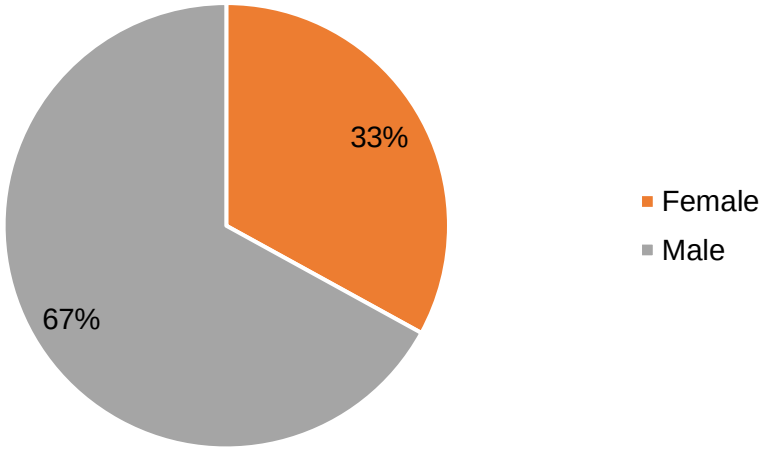
**Figure**

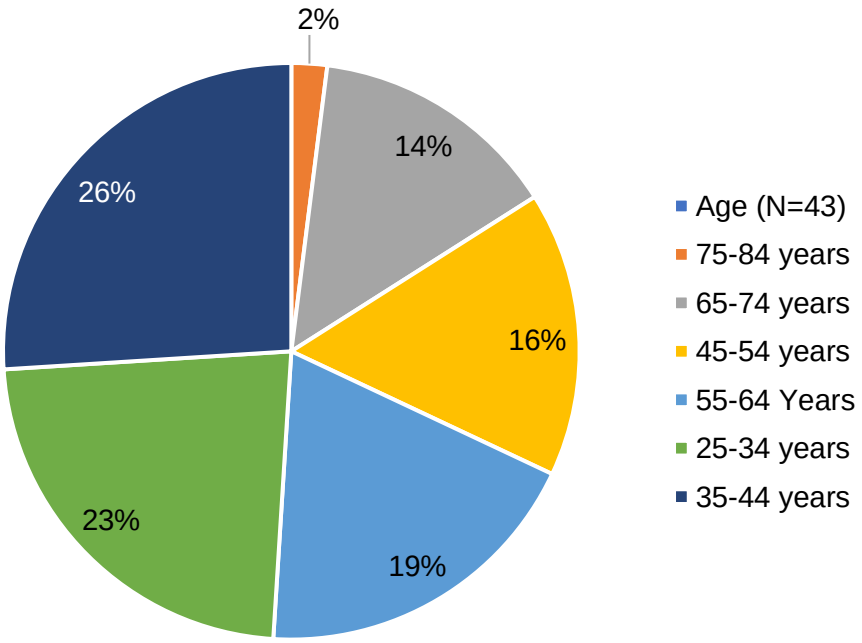
*75. Outpatient Conservator Pilot Participants by Gender*




Data source: DMH and UCLA Public Mental Health Partnership HOME Outpatient Conservatorship Pilot: Findings & Future Directions, August 17, 2021.

**Figure**

*76. Outpatient Conservator Pilot Participant by Age Group*

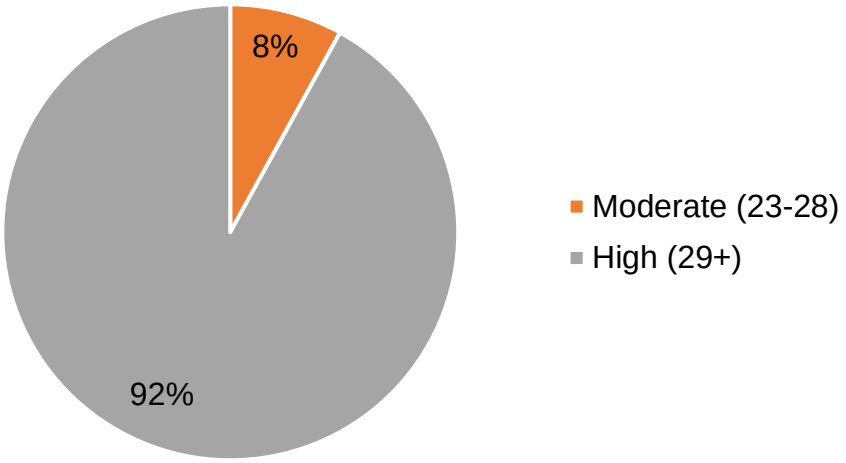



Data source: DMH and UCLA Public Mental Health Partnership HOME Outpatient Conservatorship Pilot: Findings & Future Directions, August 17, 2021.

The Home Team used the Vulnerability Assessment Tool (VAT) to estimate a client's vulnerability score. Based on a structured interview and review of collateral information, clients were rated on the tool by social workers on ten domains of functioning: Basic Needs, Survival Skills, Indicated Mortality Risk, Medical Risk, Organization/Orientation, Mental Health, Substance Use, Communication, Social Behaviors, and Homelessness. High scores indicated more vulnerability with high (29+), moderate (23-28), or less (22 and under) vulnerability. It is important to note that the VAT is typically used as a housing matching measure. Approximately 36 participants were evaluated with the VAT tool. Figure # is a description of the 36 pilot participants' VAT scores. No participant scored in the less (22 and under) category.

**Figure**

*77. Outpatient Conservator Pilot Participant by VAT Scores*

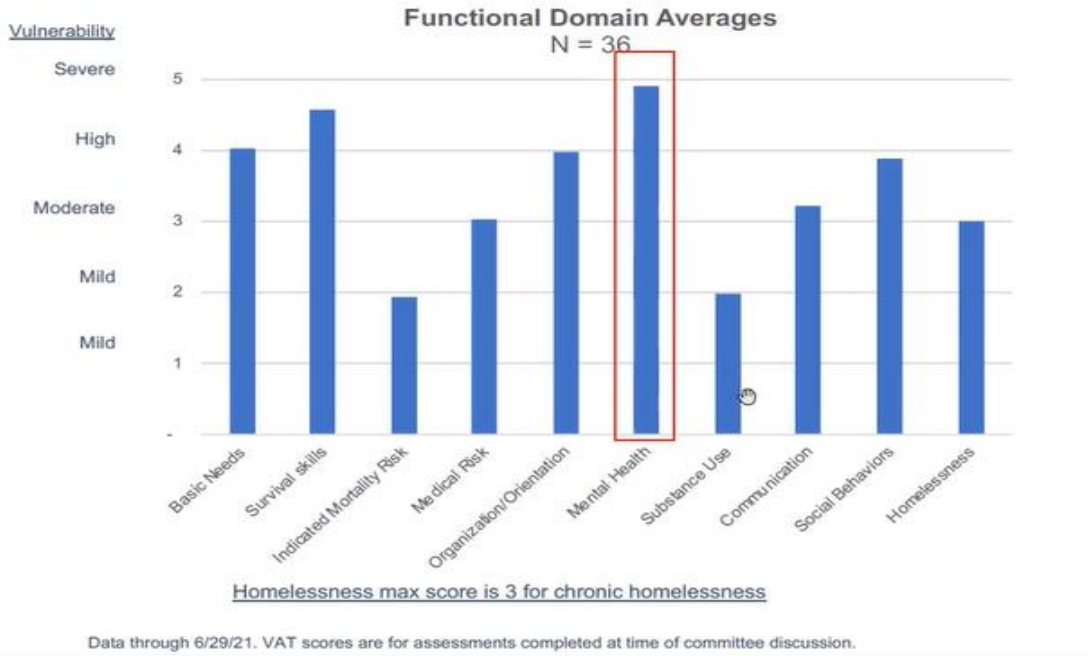



Data source: DMH and UCLA Public Mental Health Partnership HOME Outpatient Conservatorship Pilot: Findings & Future Directions, August 17, 2021.

As seen in Figure 77, most of the 36 participants with VAT scores had High to Severe scores in Mental Health, Survival Skills, and Basic Needs domains. Mild scores were indicated in the Indicated Mortality Risk and Substance Use categories.

**Figure**

*78. Outpatient Conservatorship Pilot Participants by VAT Functional Domain Averages*




Data source: DMH and UCLA Public Mental Health Partnership HOME Outpatient Conservatorship Pilot: Findings & Future Directions, August 17, 2021.

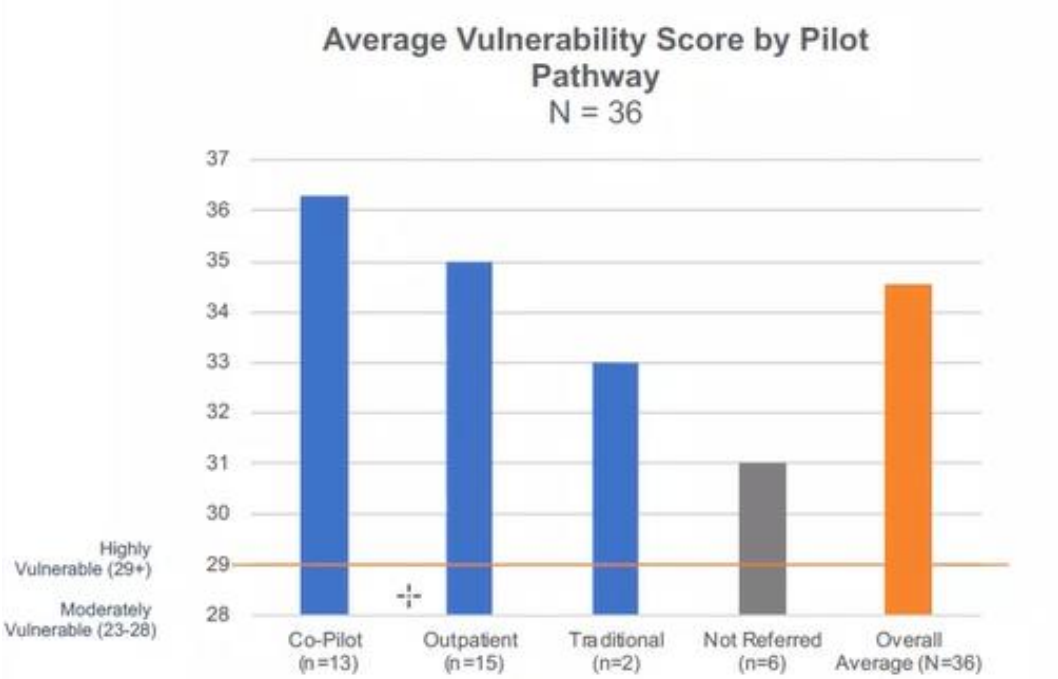
Some of the participants' vulnerabilities did not allow for all conservatorships to be sought through outpatient settings. Inpatient settings were needed for medical concerns, combativeness, etc. The 36 participants with vulnerabilities were placed in four categories:

- Co-pilot – participants with the highest VAT required immediate hospitalization for acute crises. HOME Team was involved; HOME or the hospital made the referral, testified and facilitated the placement
- Outpatient – HOME Team referred, testified, and facilitated the placement
- Traditional – HOME Team was involved, the hospital referred and testified, HOME or hospital facilitated placement depending on the level of care
- Not referred – HOME discussed with the OPC committee, but the client was either not Gravely Disabled or voluntarily engaged in care

Figure 79 shows the number of participants in each vulnerability category.

**Figure**

*79. Outpatient Conservatorship Pilot Participant by Vulnerability Scores and HOME Team Support Category*




Data source: DMH and UCLA Public Mental Health Partnership HOME Outpatient Conservatorship Pilot: Findings & Future Directions, August 17, 2021.

Thirty participants petitioned for conservatorship. Of the 43 pilot participants, 35 were referred for conservatorship investigation by the Public Guardian. Of the 35 referred individuals, 71% needed placement in a locked facility, and 26% were placed in an open-setting residential facility or board and care. For conserved participants (N=20), 70% needed locked placement, and 30% needed an Enriched Residential Care (ERC) program. The OPC committee concluded that completing conservatorship in an outpatient setting is possible.

An unexpected positive impact of the pilot occurring during the COVID-19 pandemic was the courts' use of telecommunication and increased telehealth services. The increased use of technology improved participant attendance at court and received health and mental health services in their location without transport. This increased participant engagement in services, a typical barrier.

| | |
|---|---|
| Population | Los Angeles County residents deemed gravely disabled. |
| Performance Indicators | 1. The number of clients engaged and successfully enrolled in HOME program services.<br>2. The number of successful conservatorships in each supervisorial district. |
| Frequency of Collection | Annual |

**Monitoring Provider Appeals, Calendar Year 2021**

| Goal VI.1. | Monitor Provider Appeals. |
|---|---|
| Objectives | a) Develop a Provider Appeal Tracking Log to record provider appeals, resolutions, and dates of responses.<br><br>Met objective. In CY 2021, the Intensive Care Division – Compliance Unit developed a Provider Appeal Tracking log to keep track of dates of submitted appeals, resolutions, reasons for denial, and next steps, if any. The log was submitted quarterly to the QI unit and the Denials Tracking log. These two logs supplement the unit's macro-level data reports, the Hospital Association of Southern California (HASC) report, and the Treatment Authorization Request (TAR) summary report. The HASC includes monthly data regarding the number of TARs, the number of unique consumers for whom TARS are requested, days requested, days denied, days approved, and the percent of days approved overall for the first request and first and second appeals. The TAR summary report includes the same metrics as the HASC on overall TARS (i.e., number of TARs, the number of unique consumers for whom TARS are requested, days requested, days denied, days approved, and percent of days approved) in addition to the average requested and approved length of stay and cost by the hospital.<br><br>b) Review the log for trends and share findings with appropriate entities.<br><br>Met objective. Table 43 presents the three-year trend in the number of TARs received, the percent approved, and the number of first appeals received and approved. The number of TARs received between CY 2019 (N=34,633) and CY 2021 (N=27,939) decreased by 19.3%, and the percent approved improved 35 percentage points (PP) from 58.3% in CY 2019 to 93.0% in CY 2021. The number of first appeals TARs received decreased by 37% from CY 2019 to CY 2021, whereas the first appeal TARs approved was reduced by two PPs.<br><br>**Table**<br>*43. Three-Year Trend in TARs Received and Percent Approved* |

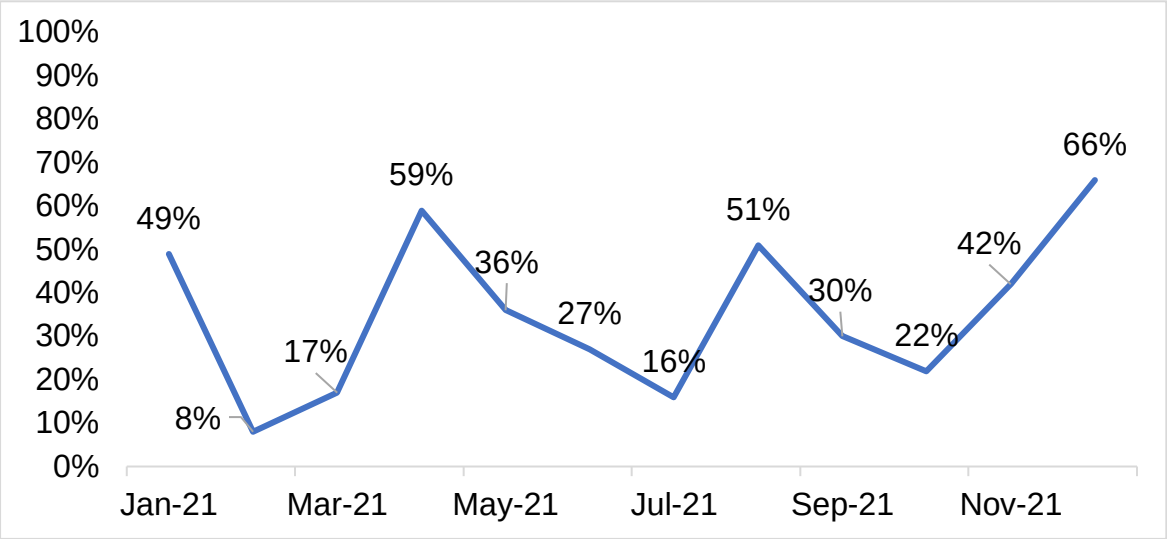
| | CY 2019 | CY 2020 | CY 2021 |
|---|---|---|---|
| **Overall TARs Received** | 34,633 | 28,501 | 27,939 |
| **% Overall Approved** | 58.3% | 67.7% | 93.0% |
| **First Appeal TARs Received** | 1,094 | 660 | 689 |
| **% First Appeal Approved** | 36.1% | 29.7% | 34.1% |

Data Source: TARs and Appeals COGNOS reports, CY 2019- CY 2021

Figure 80 displays the percentage of appealed days approved out of those requested for each month in CY 2021. The percent approved first appeal days varied widely from month to month. January, April, August, and December 2021 were the months with the highest percentage of first appeals approved, with much lower rates in February, July, and October 2021.

**Figure**

*80. Percent of Treatment Authorization Requests Appealed Days Approved by Month for Calendar Year 2021*




Data Source: Hospital Association of Southern California (HASC) Report, CY 2021.

In cases where a first appeal TARs was denied, the ICD unit logged the reason for denial in the Provider Appeal Tracking log (see Figure X). Analysis of these reasons indicated that the most common category for denied appeals is that medical necessity or the inability to treat the consumer at a lower level of care was not established. Other common reasons were a discrepancy between provider notes or missing notes, late appeal submission, and the provider or facility not being credentialed.

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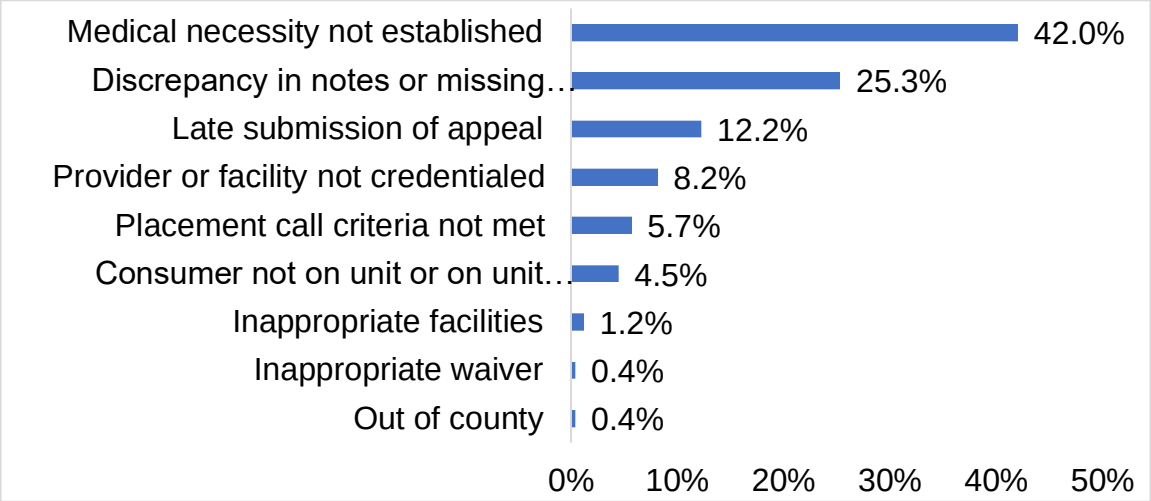
**Figure**

*81. Percent of Denied Provider Appeals by Reason*

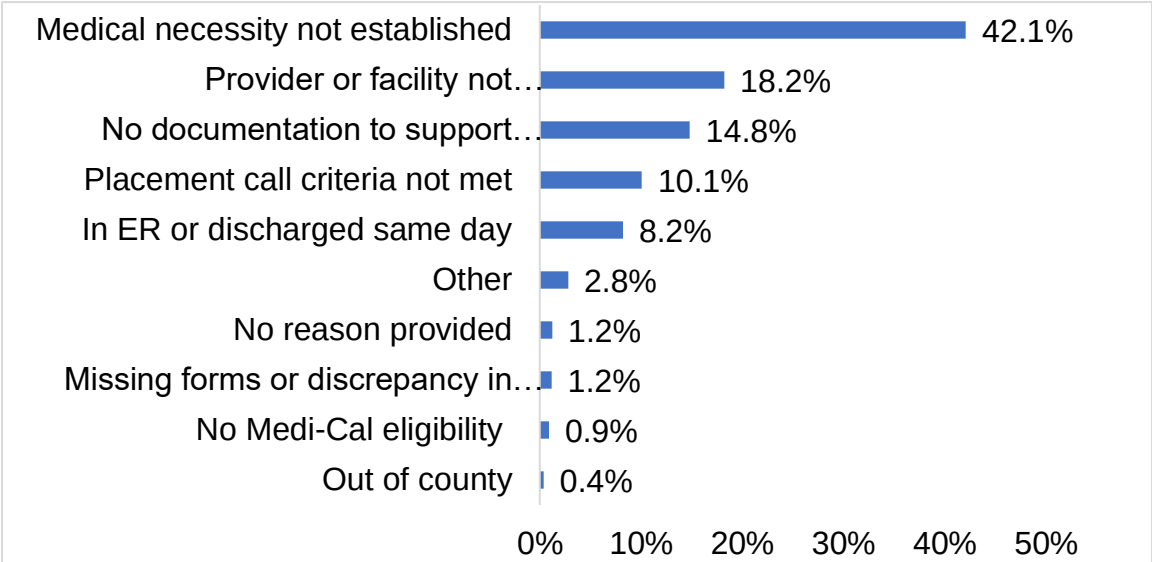



Data Source: Provider Appeals Tracking log, CY 2021.

The reasons for denial were similar to those for the initial TAR, although some categories were more common. The lack of documented medical necessity or inability to treat the consumer at a lower level of care was again the most common reason, with a similar percentage. However, the following most common reasons were the facility or provider not being credentialed, lack of documentation to show presence on the inpatient unit, and placement call criteria not being followed.

**Figure**

*82. Percent of Denied TARs by Reason*




Data Source: Notice of Adverse Benefit Determination log, CY 2021.

| | |
|---|---|
| | 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 administrative days, to improve documentation so that the need for continuing days is supported in the notes, and to increase communication around discharge planning. The unit also has a weekly standing call with the hospitals participating in concurrent reviews to track the data and address any issues. The unit has been improving communication with hospitals by sending the Treatment Authorization Status form within 24 hours. |
| Population | LACDMH clients receiving inpatient psychiatric services from the Department of Health Service (DHS), Fee-for-Service (FFS) Contracted, Non-Contracted, Non-Governmental Agency (NGA), and Contracted IMD Exclusion Hospitals. |
| Performance Indicators | Number of Notice of Adverse Benefits Determinations (NOABDs) issued, including the percentage of upheld or overturned appeals. |
| Frequency of Collection | Quarterly |

**Monitoring Performance Improvement Projects, Calendar Year 2021**

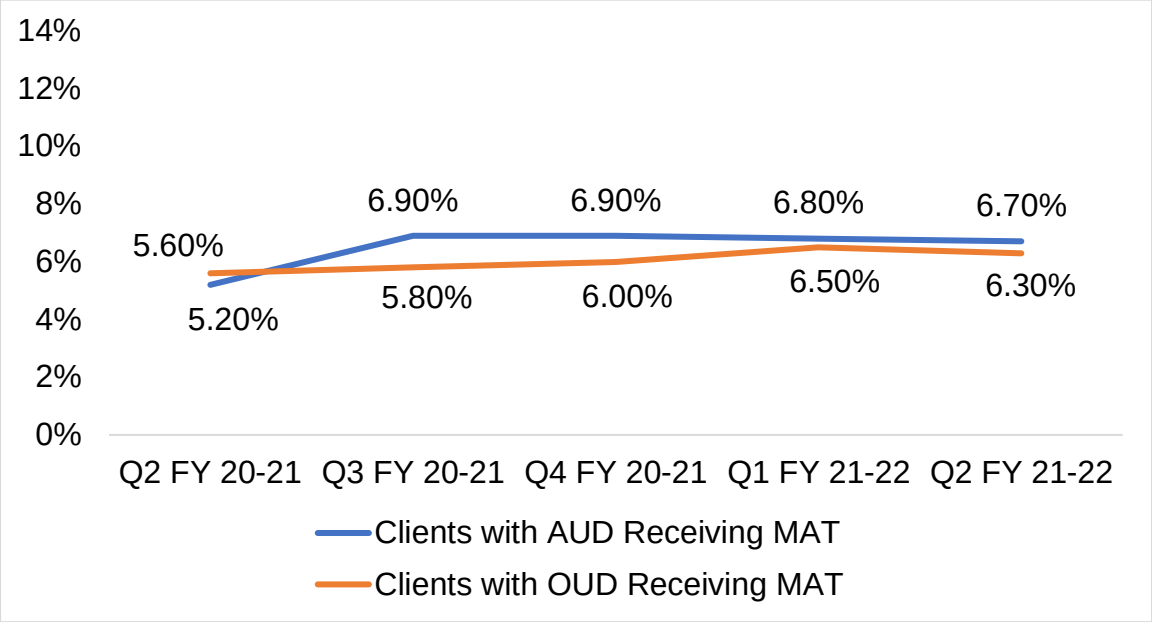
Clinical Performance Improvement Project

| **Goal VII.1:** | **LACDMH will implement staff training, a peer mentoring network, and interdisciplinary treatment groups focused on medication-assisted treatment (MAT) to increase the percent of clients with co-occurring substance use problems MAT by four percent from Calendar Year 2020 to Calendar Year 2021.** |
|---|---|
| Objective: | 2021 Work Plan Evaluation: The overall goal was not met, although several objectives were achieved. The Clinical Performance Improvement Project entitled "Improving the Use of Medication-Assisted Treatment (MAT) for Consumers with Co-Occurring Mental Health Disorders and Substance Use (COD)" occurred from Quarter 2 of FY 20-21 to the end of Quarter 2 of FY 2021-22. The improvement strategy was focused on increasing the administration of medication-assisted treatment (MAT), or medications used to manage cravings, to consumers with Alcohol Use Disorders (AUDs) and Opioid Use Disorders (OUDs). Interventions included the MAT medications used to treat AUDs and OUDs (i.e., buprenorphine, naltrexone, acamprosate, and disulfiram) and Integr8Recovery, a group treatment model designed to provide cognitive-behavioral skills and education on MAT for clients with CODs. Overall, findings indicated that the percentage of hospitalized clients receiving MAT generally decreased over time from baseline, and these rates significantly differed from the baseline to the final measure. The percent of clients receiving MAT who were re-hospitalized within 30 days of discharge varied over time and decreased slightly from baseline to the last remeasure. The sample sizes were so small that these findings were not statistically significant for re-hospitalization rates. LACDMH will continue this project as a quality improvement project (QIP) and select a new clinical PIP topic at the project's close in February 2022. The initial pilot versions of the interventions resulted in mixed outcomes. Due to small sample sizes and delayed implementation due to the COVID-19 pandemic, these results should be interpreted with caution. Data analysis regarding the interventions will continue with ongoing implementation, although the PIP will be discontinued.<br><br>a) Increase the number of clients receiving MAT overall.<br><br>Met objective. The number of clients receiving MAT increased from 438 in the baseline period of the PIP (Q2 FY 2020-21) to 587 in the final period (Q2 FY 2021-22). Although there was a slight dip in Q1 FY 2021-22, the number generally increased over time. The percentage of clients receiving MAT out of the total clients served rose from 0.6% to 0.8% between baseline and final remeasure, significantly smaller than the goal of four percent.<br><br>b) Increase the number of clients with identified AUD and OUD receiving MAT.<br><br>Met objective. The number and percentage of clients with AUDs and OUDs receiving MAT increased from the baseline to the final measure, although the percentage increase did not achieve the PIP target of five percent. AUD prescription rates initially increased from Q2 FY 2020-21 to Q3 FY 2020-21 and were more steady over time. OUD rates generally increased slowly over time, slightly decreasing at the final |

measure. Figure 83 displays the AUD and OUD prescription rates by quarter. The AUD and OUD MAT prescription rates showed statistically significant changes from the baseline to the final measure.

**Figure**

*83. Percent of Clients that Received MAT for an AUD or OUD Diagnosis, Q2 FY 2020-21 to Q2 FY 2021-22*




c) Increase the number of prescribers that are eligible to prescribe MAT.

Objective not met. The number of prescribers eligible to administer buprenorphine, a MAT that requires an X-waiver from the Drug Enforcement Agency (DEA), increased from 47 in Q2 FY 2020-21 to 72 following the first training in Q3 FY 2020-21. Due to staff turnover, this number decreased to 65 by the final remeasure.

d) Increase the number of prescribers administering MAT to at least one client.

Met Objective. Early pilot data from the MAT mentorship pilot groups at Edelman Mental Health Center and the Women's Re-Integration Program show promising results about these programs, generally increasing the number of consumers receiving MAT prescriptions from baseline. The percent of prescribers administering MAT to at least one client increased over time and met the target percent increase of five percent from baseline to final measure. At the end of this PIP, over half of the prescribing staff in LACDMH have prescribed MAT to at least one client with COD, and we anticipate that number will increase with greater mentorship.

| | |
|---|---|
| Population: | LACDMH clients receiving outpatient co-occurring disorder (COD) services |
| Performance Indicators: | 1. Number of prescribers eligible to administer MATs<br>2. Number of prescribers administering MAT to at least one client<br>3. Number of clients prescribed MAT (also separated by clients with identified AUDs and OUDs)<br>4. Number of clients with improved mood or anxiety ratings on Weekly Check-in |

| | |
|---|---|
| | 5. Number of clients with decreased substance use and interference rating on Weekly Check-in |
| Frequency of Collection: | Monthly |

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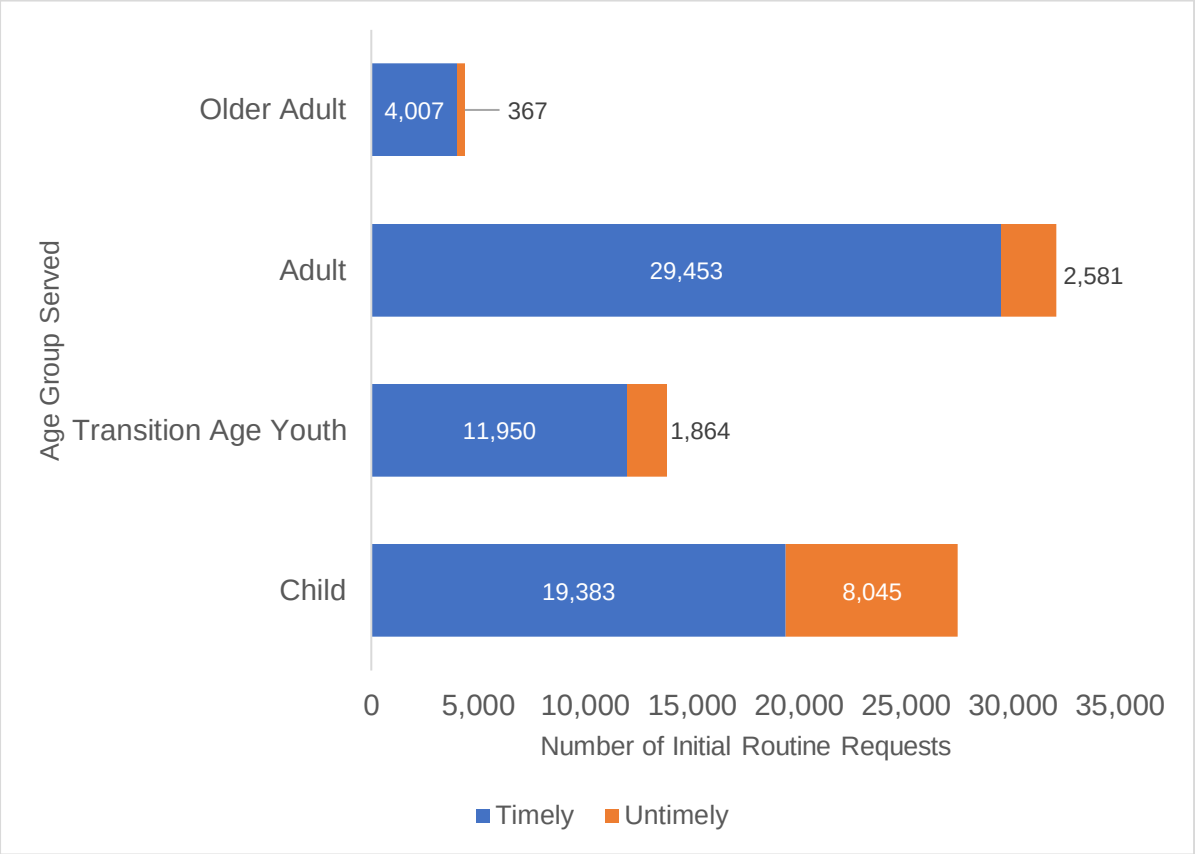
Non-Clinical Performance Improvement Project

| Goal VII.2. | By the end of CY 2021, LACDMH will develop and implement a nonclinical PIP to improve the rate of timeliness to initial appointments from 61.5% to 70.0% for children seeking outpatient services. |
|---|---|
| Objectives: | 2021 Work Plan Goal Evaluation:<br><br>The FY 2020-21 non-clinical PIP, "Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected," reflects LACDMH's targeted efforts to improve its outpatient network's access to care monitoring process. Using themes gathered from provider data, these interventions would assist providers in assessing and problem-solving for challenges in scheduling timely routine, urgent, and hospital discharge/jail follow-up appointments. The project's latest developments aimed to establish a standardized menu of provider-tested best practices. A set of improvement strategies were evaluated collaboratively with providers through qualitative analysis, guidelines from the Access to Care Leadership Committee, and findings from a planned Access to Care Learning Collaborative for child services providers in SA 2.<br><br>a) Establish a demographic profile (i.e., size, modes of service delivery, location, etc.) of providers who struggle to meet LACDMH timeliness standards for clients/families seeking child services.<br><br>Met objective. Upon review of the data, it was observed there was a need beyond the children's programs, and system-wide timely access required intervention. Therefore, the target population includes individuals from all age groups who could be experiencing mental health symptoms ranging from mild to severe mental health symptoms. The study population also encompassed potential consumers who urgently need connections to services, resources, and support. This includes high-risk consumers whose immediate support could save lives or mitigate high-cost service utilization.<br><br>Figure 84 displays the PIP study data evaluation period, May 2020 through January 2021. The MHP received 77,350 initial routine service requests, of which 64,793 (83.8%) were timely, and 12,557 (16.2%) were untimely. This and the following totals are not exclusive to beneficiaries and may include insured or indigent consumers. Child referrals totaled 27,428 (35.5%) with 19,383 (70.7%) timely and 8,045 (29.3%) untimely. Transition Age Youth totaled 13,814 (17.9%) with 11,950 (86.5%) timely and 1,864 (13.5%) untimely. Adults totaled 32,034 (41.4%) with 29,453 (91.9%) timely and 2,581 (8.1%) untimely. Older adults totaled 4,374 (5.7%) with 4,007 (91.6%) timely and 367 (8.4%) untimely. The average number of requests resulting in appointments from May 2020 through January 2021 was 69.3%.<br><br>**Figure** |

*84. Mental Health Plan Initial Routine Service Request Timeliness Percentages from May 2020 to January 2021*




Data source: FY 2020-2021 non-clinical Performance Improvement Project (PIP) Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected.

Referrals for initial routine services were received through one of four systems. From May 2020 to January 2021, the contractor Service Request Log (SRL) web service system received 43,179 referrals. The average percentage of SRL requests that resulted in an appointment was 74%. The IBHIS SRL received a total of 52,691 referrals. The average percentage of IBHIS SRL requests that resulted in an appointment was 82.7%. The Katie A. Enterprise Monitoring System (KAEMS) received 14,419 referrals. The average percentage of KAEMS requests that resulted in an appointment was 45.3%. The Service Request Tracking System (SRTS) received 13,367 referrals. The average percentage of SRTS requests that resulted in an appointment was 27.4%.

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.

In CY 2021, LACDMH's QA Unit established a systemwide Access to Care Monitoring report to identify programs whose performance fell below 80% for first offered routine, urgent, or follow-up care appointments. The QA support and intervention level are performance-based and occur quarterly (Figure 85). As an effort in the FY 2020-21 nonclinical PIP, LACDMH's QI Unit collaborated with QA to monitor performance changes and provider-tested best practices.

**Figure**

*85. Performance-Based Timeliness Rates Improvement for Outpatient Programs*

| | |
|---|---|
| **IF:** Timeliness Rates are between 70-79% | **THEN:** Program and their Service Area Lead(s) receives email notification |
| **IF:** Timeliness Rates are below 69% | **THEN:** Program completes a QI Plan of Correction - a form that prompts providers to identify workflow challenges or barriers impacting timeliness rates and develop strategies to address them |
| **IF:** Timeliness Rates are below 59% | **THEN:** Program completes a QI Plan of Correction and participates in at least one teleconference meeting with QA |

*Findings*

All providers were rated for timeliness on routine appointments. The PIP focus was placed on the providers with the lowest timeliness performance to have the highest impact on beneficiary access. Baseline data was determined to be Cohort A, Cohort B, and Cohort C. The number of providers in the group with a 69% and below rating was 50.

With the range of improvement seen among the A, B, and C cohorts (+ 40 PP, 32.2 PP, and +30.7 PP, respectively), it is concluded that the implementation of the timely access monitoring process appears to have a positive impact on the study population. Timeliness rates were trending upwards within three months. Ideally, a review of any change in the number of requests for referrals during the entire measurement period would provide additional support to the impact of the interventions.

**Table**

*44. Summary of non-Clinical PIP Findings*

| | Baseline Timeliness Rating | Baseline Time Period | First Collection Period (May-July 2020) | Second Collection Period (Aug-Sept 2020) | Third Collection Period (Jan-Mar 2021) | Total Percentage Point (PP) Change |
|---|---|---|---|---|---|---|
| **Cohort A (N=17)** | 49.7% | May-July 2020 | 61.1% (+11.4 PP) | 69.9% (+8.8 PP) | 89.7%[1] (+19.8 PP) | +40 PP |
| **Cohort B (N=16)** | 49.0% | August-September 2020 | | 63.1% (+14.1 PP) | 81.2% (+18.1 PP) | +32.2 PP |
| **Cohort C (N=17)** | 50.9% | October-December 2020 | | | 81.6%[2] (+30.7 PP) | +30.7 PP |

SA improvements mirrored the improvements seen system-wide. For a description of SA performance, please refer to the External Quality Review Report FY2021-21.

Overall, timely access to care monitoring effectively promoted the implementation of impactful interventions. Engaging in timely access to care monitoring and quality improvement improved the timely access ratings of providers who fell below 69%. The LE/Contracted and DO providers took a quality improvement approach to timely appointments by reviewing internal and external factors and developing an Action Plan to address their specific challenges.

Results from the survey suggest providers benefit from 1) program-specific strategies, 2) immediate capacity adjustments such as increasing intake slots or clinician caseloads, 3) administrative changes such as revising referral and intake workflows, and 4) SRTS/SRL or timeliness standard training and monitoring for staff.
Child/TAY providers may have unique needs compared to other age groups. This group would likely benefit from further exploration of their specific challenges to timely access.

This non-clinical PIP concluded in September 2021. Valuable work will continue improving timely access to care with the continued work of the Access to Care Leadership Committee and QA's established access to care monitoring process.

| | |
|---|---|
| Population | Los Angeles County residents seeking outpatient LACDMH services |
| Performance Indicators | 1. Rate of timeliness (%) for urgent appointment requests.<br>2. Rate of timeliness (%) for routine appointment requests.<br>3. Rate of timeliness (%) for inpatient/jail discharge appointment requests.<br>4. Percent of no-shows to initial appointments by service request type. |
| Frequency of Collection | Quarterly |

## Section IV. Service Equity Analysis Report, Calendar Year 2021

### Access

Services received

Analyses included all Mode 15 Specialty Mental Health services such as Mental Health Services, Targeted Case Management, Medication Support Services, and Crisis Intervention. Community Outreach Services (COS) and Medi-Cal Administrative Activities (MAA) were omitted.

#### *Race/Ethnicity*

Race/Ethnicity categories for this report mirror those used in the U.S. Census and the sections on the estimated population living at or below the 138% Federal Poverty Level and LACDMH clients served for consistency and comparison. In Calendar Year (CY) 2021, Hispanic/Latino individuals were the group with the largest number of clients served and the highest total number of services received, followed by Black/African American, White, Asian, Two or More Races, Native Hawaiian/Pacific Islander, and Native American individuals (Table 45). It should be noted that a significant number of clients for whom race/ethnicity information is missing or unreported. Efforts are underway to improve the accuracy of this information. Black/African Americans had the highest average number of total services, followed by Native Americans, individuals of Two or More Races, Hispanic/Latinos, Whites, Asians, and Native Hawaiians/Pacific Islanders. The median number of services, which accounts for the large range of services received within each race/ethnicity, indicated that Native Americans had the best rate at 15 compared to Whites, with the lowest rate at 11 median services (Figure 86).

**Table**

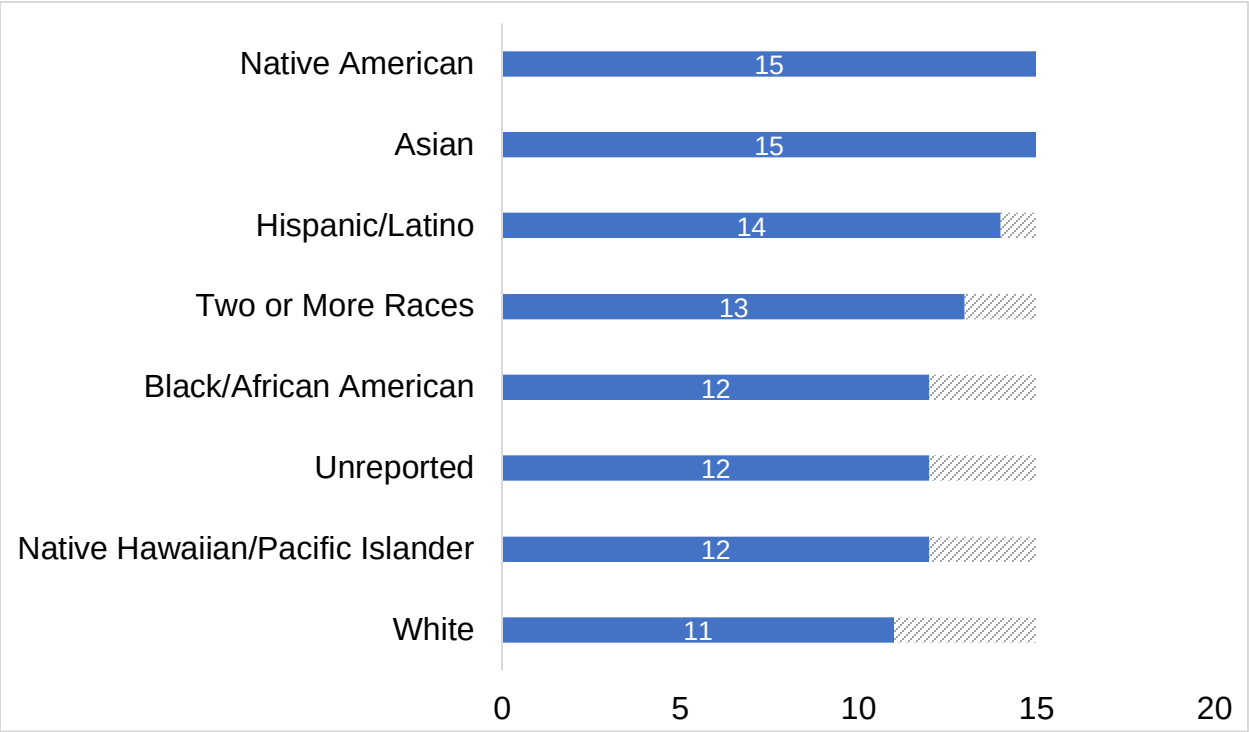
*45. Services Received by Race/Ethnicity, Calendar Year 2021*

| Race/Ethnicity | Number of Distinct Clients | Total Services Received | Average Services Received | Median Services Received |
|---|---|---|---|---|
| **Asian** | 7,109 | 193,343 | 27.2 | 15 |
| **Black/African American** | 38,339 | 1,153,599 | **30.0** | 12 |
| **Hispanic/Latino** | **81,875** | **2,317,319** | 28.3 | 14 |
| **Native American** | **1,188** | **34,438** | 29.0 | **15.5** |
| **Native Hawaiian or Pacific Islander** | 2,275 | 60,545 | 26.6 | 12 |
| **Two or More Races** | 5,986 | 172,393 | 28.6 | 13 |
| **Unreported** | 58,693 | 1,545,511 | **26.3** | 12 |
| **White** | 32,911 | 897,179 | 27.2 | **11** |

Note: Bolded numbers represent the highest and lowest values for that column.

**Figure**

*86. Median Number of Services Received by Race/Ethnicity, CY 2021*




Age Group

Children received the largest number of total services and are the second-largest age group (Table 46). Adults are the largest age group and have the second-highest total services. Children and Transition-Age Youth had both the highest average and median services received. The median number of services for Children at 20 was double that of Adults at 10 and Older Adults at 9 (Figure 87).

**Table**

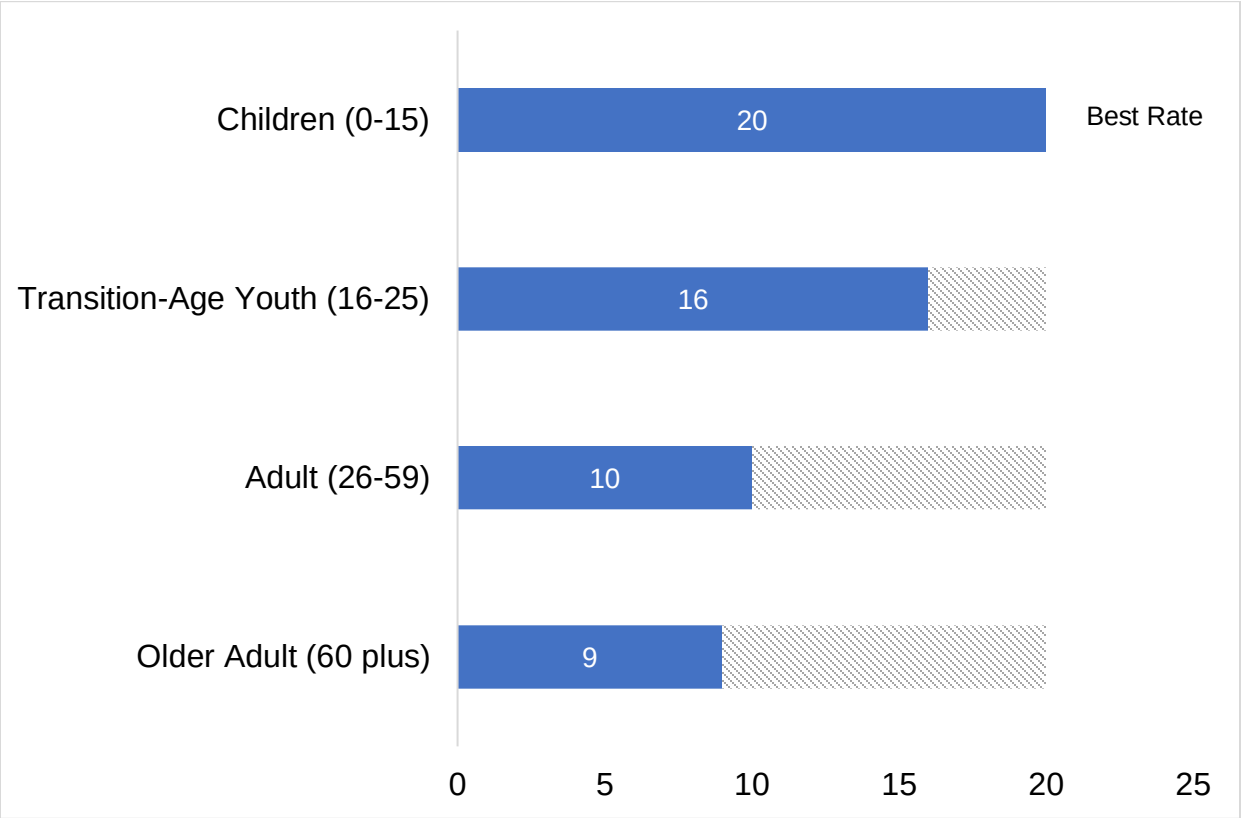
*46. Services Received by Age Group, Calendar Year 2021*

| | Number of Distinct Clients | Total Services Received | Average Services Received | Median Services Received |
|---|---|---|---|---|
| **Children (0-15 years)** | 64,581 | **2,410,058** | **25.5** | **20** |
| **Transition Age Youth (16-25 years)** | 41,207 | 1,398,749 | 22.8 | 16 |
| **Adult (26-59 years)** | **96,297** | 2,063,545 | 14.1 | 10 |
| **Older Adult (60 years and up)** | **26,558** | **501,975** | **12.0** | **9** |

Note: Bolded numbers represent the highest and lowest values for that column.

**Figure**

*87. Median Number of Services Received by Mental Health Services Act Age Group, CY 2021*




Threshold languages

Clients with English as a primary language were the largest group and received the highest total services in CY 2021, followed by consumers speaking Spanish as a primary language (Table 47). Primary languages with the highest median services received across clients were Cambodian, Mandarin, Cantonese, Korean, and Vietnamese, all of which had a median of 15 services or higher. This was double the median number of services Armenian and Russian clients received at 7 and 6, respectively (Figure 88).

## Table

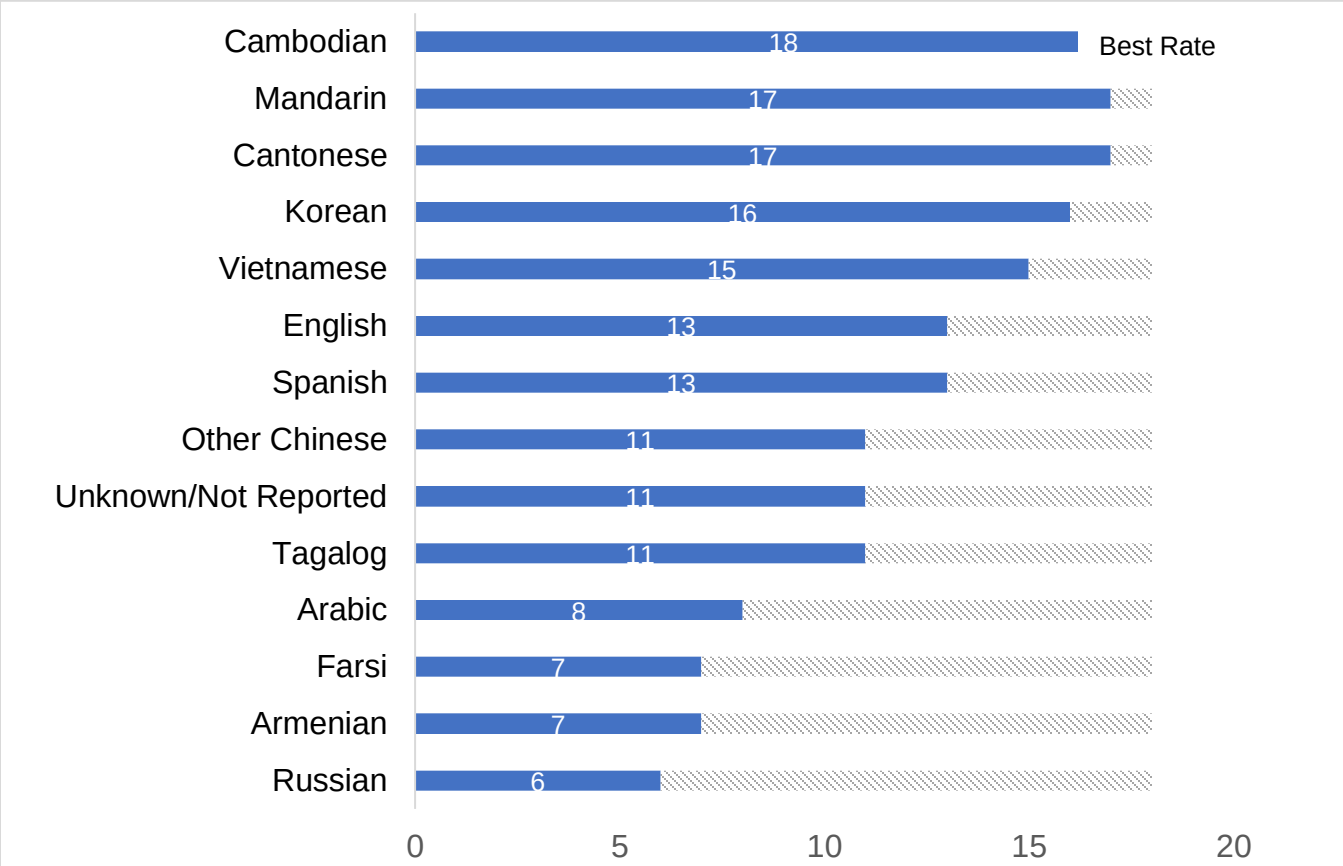
*47. Services Received by Primary Language, Calendar Year 2021*

| | Number of Distinct Clients | Total Services Received | Average Services Received | Median Services Received |
|---|---|---|---|---|
| **Arabic** | 172 | 3,388 | 19.7 | 8 |
| **Armenian** | 1,272 | 19,735 | 15.5 | 7 |
| **Cambodian** | 769 | 21,051 | 27.4 | **18** |
| **Cantonese** | 567 | 15,917 | 28.1 | 17 |
| **English** | **175,982** | **5,259,529** | **29.9** | 13 |
| **Farsi** | 735 | 12,261 | 16.7 | 7 |
| **Korean** | 885 | 23,355 | 26.4 | 16 |
| **Mandarin** | 607 | 17,445 | 28.7 | 17 |
| **Other Chinese** | **119** | **2,360** | 19.8 | 11 |
| **Russian** | 376 | 3,926 | **10.4** | **6** |
| **Spanish** | 33,355 | 829,579 | 24.9 | 13 |
| **Tagalog** | 291 | 6,380 | 21.9 | 11 |
| **Vietnamese** | 584 | 14,348 | 24.6 | 15 |

Note: Bolded numbers represent the highest and lowest values for that column.

## Figure

*88. Median Number of Services by Primary Language, CY 2021*



**Staff Language Capacity**

Threshold languages

Practitioners speaking a non-English threshold language most commonly spoke Spanish (84.2%), followed by Korean (3.0%), Mandarin (2.1%), Armenian (1.9%), Tagalog (1.9%), and Farsi (1.4%). Spanish, Korean, Mandarin, Armenian, and Farsi were the primary languages most frequently spoken by clients in CY 2021 other than English.

**Table**

*48. Practitioners Fluent and Certified in Non-English Threshold Languages, May 2022*

| | Number of Certified Practitioners | Number of Fluent Practitioners | Total | Percent |
|---|---|---|---|---|
| **Arabic** | 9 | **26** | **35** | **0.6%** |
| **Armenian** | 29 | 89 | 118 | 1.9% |
| **Cambodian** | 7 | 40 | 47 | 0.8% |
| **Cantonese** | 8 | 62 | 70 | 1.1% |
| **Farsi** | 10 | 75 | 85 | 1.4% |
| **Korean** | 20 | 161 | 181 | 3.0% |
| **Mandarin** | 17 | 109 | 126 | 2.1% |
| **Other Chinese** | **5** | 55 | 60 | 1.0% |
| **Russian** | 10 | 40 | 50 | 0.8% |
| **Spanish** | **544** | **4,594** | **5,138** | **84.2%** |
| **Tagalog** | 18 | 96 | 114 | 1.9% |
| **Vietnamese** | 8 | 50 | 58 | 1.0% |

Note: Bolded numbers represent the highest and lowest values for that column.

*Prescribing Rates*

Prescribing rates include clients that were prescribed any medication through the Order Connect system in CY 2021. The best rate was not included in comparisons as medications might not be needed for all clients, and the medication target may vary widely (targeting a psychiatric condition vs. managing a medical condition).

Race/Ethnicity

Native Hawaiian/Pacific Islander, White, and clients of Two or More Races had the highest percentage of clients prescribed any medication out of all clients served. Hispanic/Latino and Native American clients had the lowest percentage of prescribed medication overall (Figure 89). In examining specific medication classes, Antidepressants were the most prescribed across all racial/ethnic groups, except for Black/African American and Hispanic/Latino clients, where a larger percentage of clients received Antipsychotic medication. Black/African Americans were the largest group prescribed Antipsychotic medication. The percentage was a fifth higher than Whites. The lowest group prescribed Antipsychotic medication. Antianxiety medications were prescribed most to Native Americans and least to Black/African American clients. The combination of Antipsychotic and Antidepressant medication was most common across all racial/ethnic groups, with Black/African Americans having the highest rate (45.1%) and Hispanic/Latinos having the lowest rate (32.2%) prescribed both of these medications (other than Unreported). The combination of Antidepressant and Antianxiety medication was somewhat expected, with White (11.9%) and Native American (11.6%) clients having the highest rates and Black/African American clients having the lowest rate (5.8%) prescribed both of these medications. The combination of Antipsychotic and Antianxiety medications was the lowest of those presented in this report, with White clients having the highest rate (7.9%) and Asian and Native Hawaiian/Pacific Islanders clients having the lowest rate (4.1%, respectively) prescribed both of these medications.

**Table**

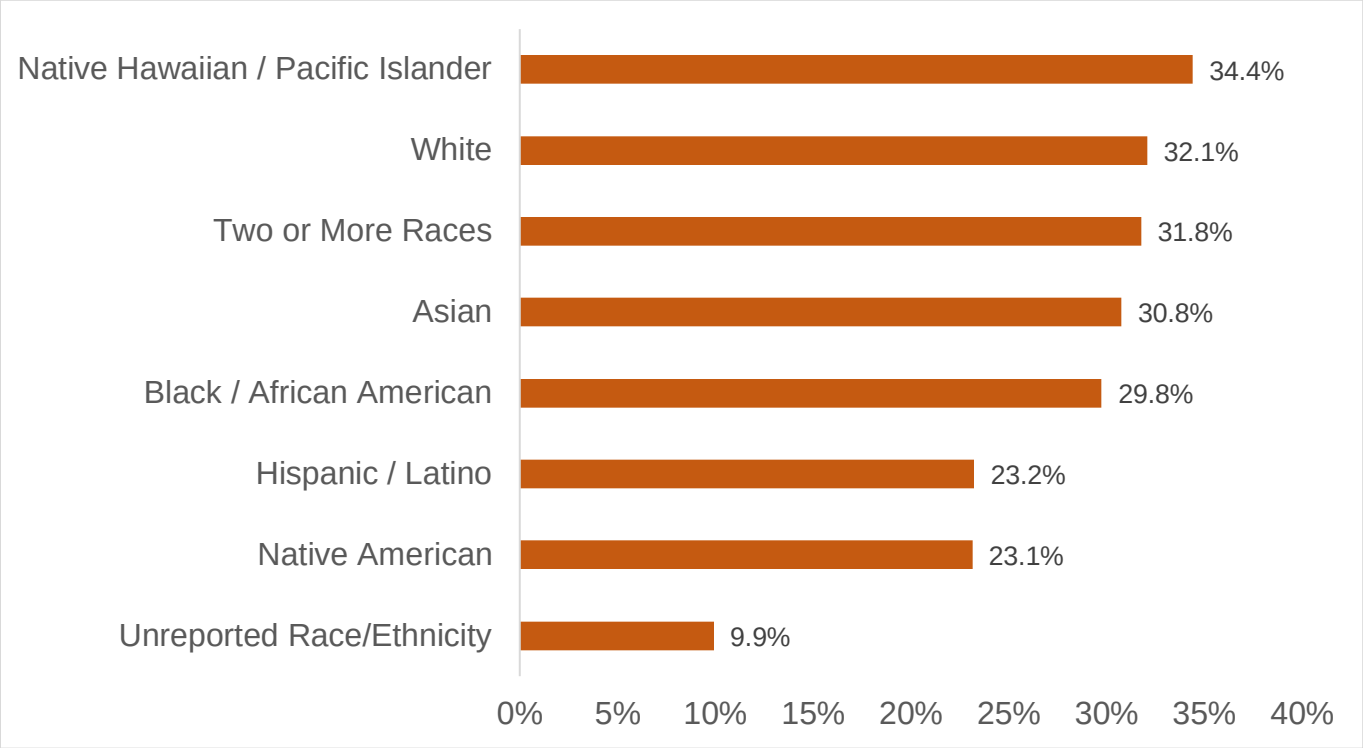
*49. Prescription Rates by Race/Ethnicity, Calendar Year 2021*

| | Number of Distinct Clients Served | Number of Clients Prescribed Medication | Number of Clients Prescribed Antidepressant Medication | Number of Clients Prescribed Antipsychotic Medication | Number of Clients Prescribed Antianxiety Medication |
|---|---|---|---|---|---|
| **Asian** | 7,109 | 2,188 | 1,539 | 1,486 | 168 |
| **Black/African American** | 38,339 | 11,410 | 7,912 | 8,234 | 863 |
| **Hispanic/Latino** | **81,875** | **19,023** | **14,037** | **10,361** | **1,909** |
| **Native American** | **1,188** | **275** | 1,380 | 1,037 | 196 |
| **Native Hawaiian or Pacific Islander** | 2,275 | 783 | **209** | **161** | **38** |
| **Two or More Races** | 5,986 | 1,902 | 516 | 522 | 71 |
| **Unreported** | 58,693 | 5,826 | 4,273 | 2,990 | 583 |
| **White** | 32,911 | 10,561 | 8,024 | 5,953 | 1,564 |

Note: Bolded numbers represent the highest and lowest values for that column

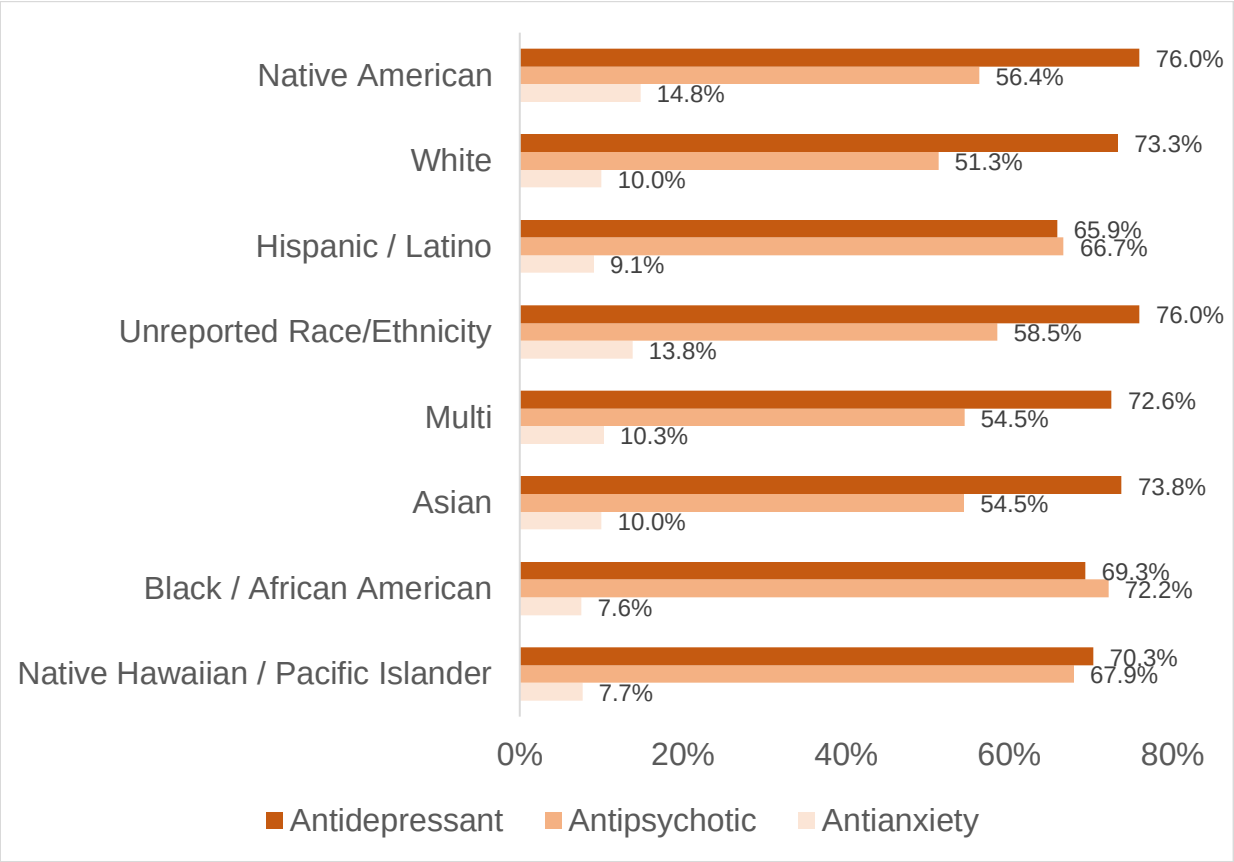
**Figure**

*89. Percent of Clients Prescribed Medications of Total Served by Race/Ethnicity, CY 2021*




**Figure**

*90. Percent of Clients Prescribed Specific Medications by Race/Ethnicity, CY 2021*




<u>Threshold languages</u>

Clients speaking Cambodian as a primary language were the largest group prescribed medication out of all those served at 57.9% in CY 2021 (Figure 91). In addition to Cambodian, over half of the individuals who spoke Farsi and Tagalog as their primary language were prescribed medication. Only between a fifth and a quarter of individuals speaking English and Spanish as a primary language were prescribed medication out of the total served, as these are the two languages with the largest number of distinct clients. Cantonese, Mandarin, and Korean-speaking individuals were the smallest groups prescribed medication, with less than a fifth of those served prescribed.

**Table**

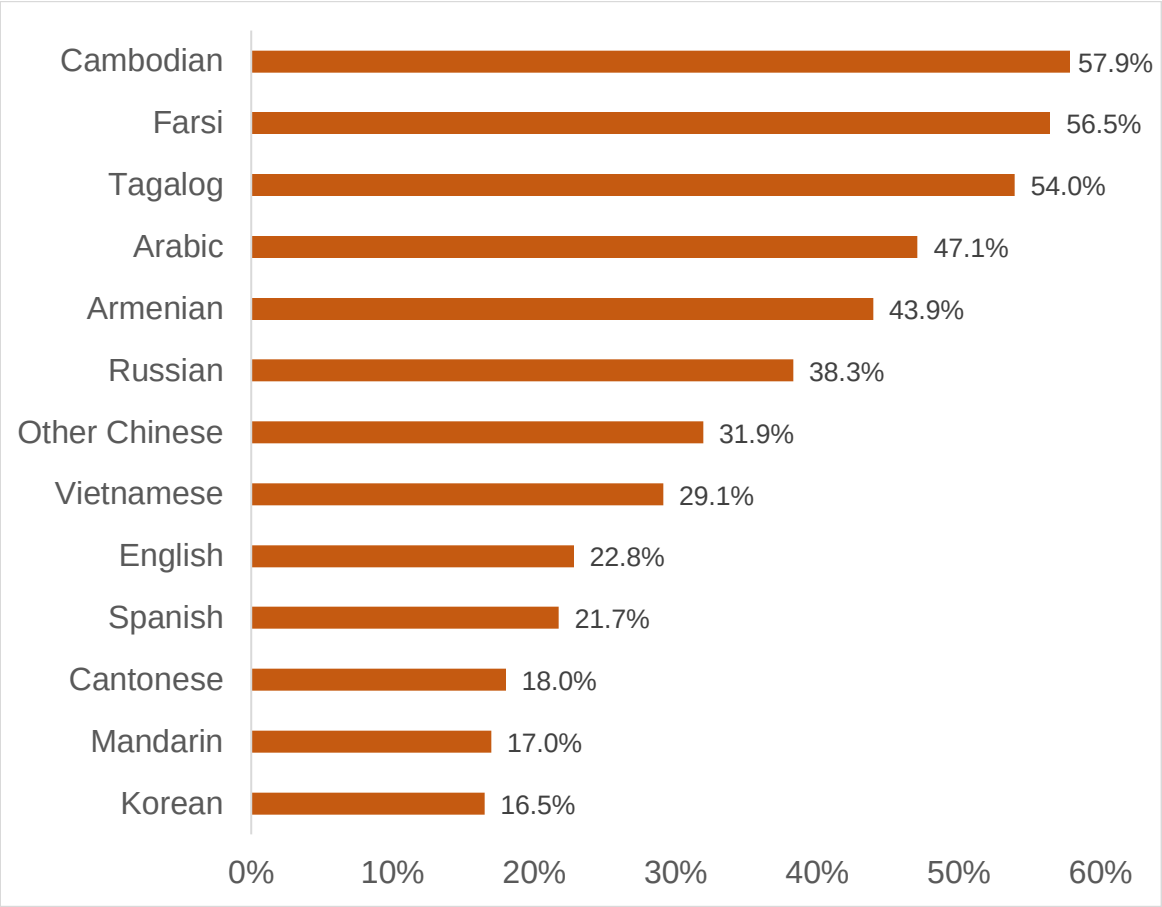
*50. Clients Prescribed Medication by Primary Language, CY 2021*

| | Number of Distinct Clients | Number of Clients Prescribed Medication |
|---|---|---|
| **Arabic** | 172 | 81 |
| **Armenian** | 1,272 | 559 |
| **Cambodian** | 769 | 445 |
| **Cantonese** | 567 | 102 |
| **English** | **175,982** | **40,135** |
| **Farsi** | 735 | 415 |
| **Korean** | 885 | 146 |
| **Mandarin** | 607 | 103 |
| **Other Chinese** | **119** | **38** |
| **Russian** | 376 | 144 |
| **Spanish** | 33,355 | 7,254 |
| **Tagalog** | 291 | 157 |
| **Vietnamese** | 584 | 170 |

Note: Bolded numbers represent the highest and lowest values for that column.

**Figure**

*91. Percent of Clients Prescribed Specific Medications by Race/Ethnicity, CY 2021*



## Healthcare Effectiveness Data and Information Set

*Hospital and readmission rates*

Race/Ethnicity

Hispanic/Latino, Native American, and Asian clients had the lowest hospitalization rates compared to Black/African American and White clients, with the highest rates with a difference of about 2% between the best and worst rates (Figure 92). The largest group of hospitalized clients was Unreported Race/Ethnicity, which reflects a large pool of missing data. For re-hospitalization rates, which capture those clients re-admitted to a hospital within 30 days of discharge, Native Hawaiian/Pacific Islander clients had the best rate (Figure 93). Black/African American and White clients again had the highest percentage of those re-admitted within 30 days. Notably, the percentage of Black African/American clients re-admitted within 30 days was more than double that of the lowest group.

**Table**

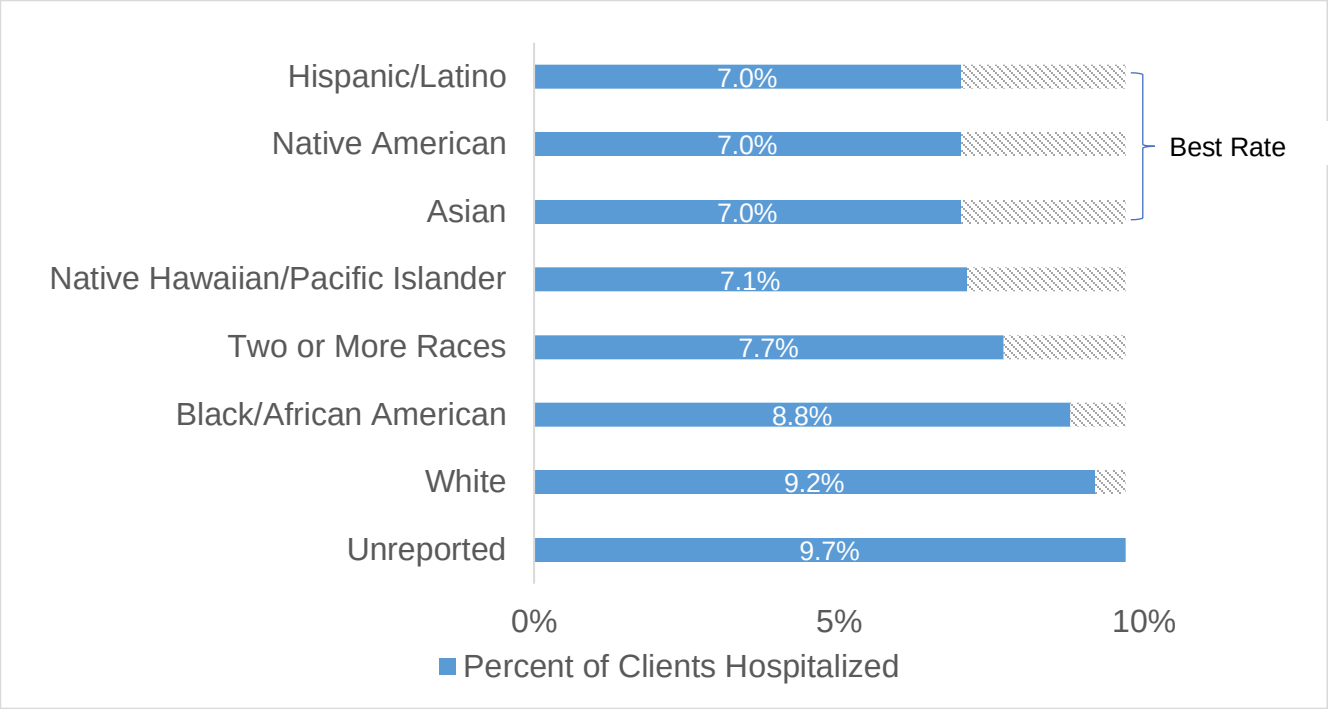
*51. Services Received by Race/Ethnicity, Calendar Year 2021*

| | Number of Distinct Clients | Total Number of Clients Hospitalized | Total Number of Clients Re-admitted within 30 Days |
|---|---|---|---|
| **Asian** | 7,109 | 495 | 85 |
| **Black/African American** | 38,339 | 3,387 | 857 |
| **Hispanic/Latino** | **81,875** | **5,739** | **1,024** |
| **Native American** | **1,188** | **83** | **11** |
| **Native Hawaiian or Pacific Islander** | 2,275 | 162 | 19 |
| **Two or More Races** | 5,986 | 462 | 87 |
| **Unreported** | 58,693 | 5,682 | 971 |
| **White** | 32,911 | 3,024 | 682 |

Note: Bolded numbers represent the highest and lowest values for that column.

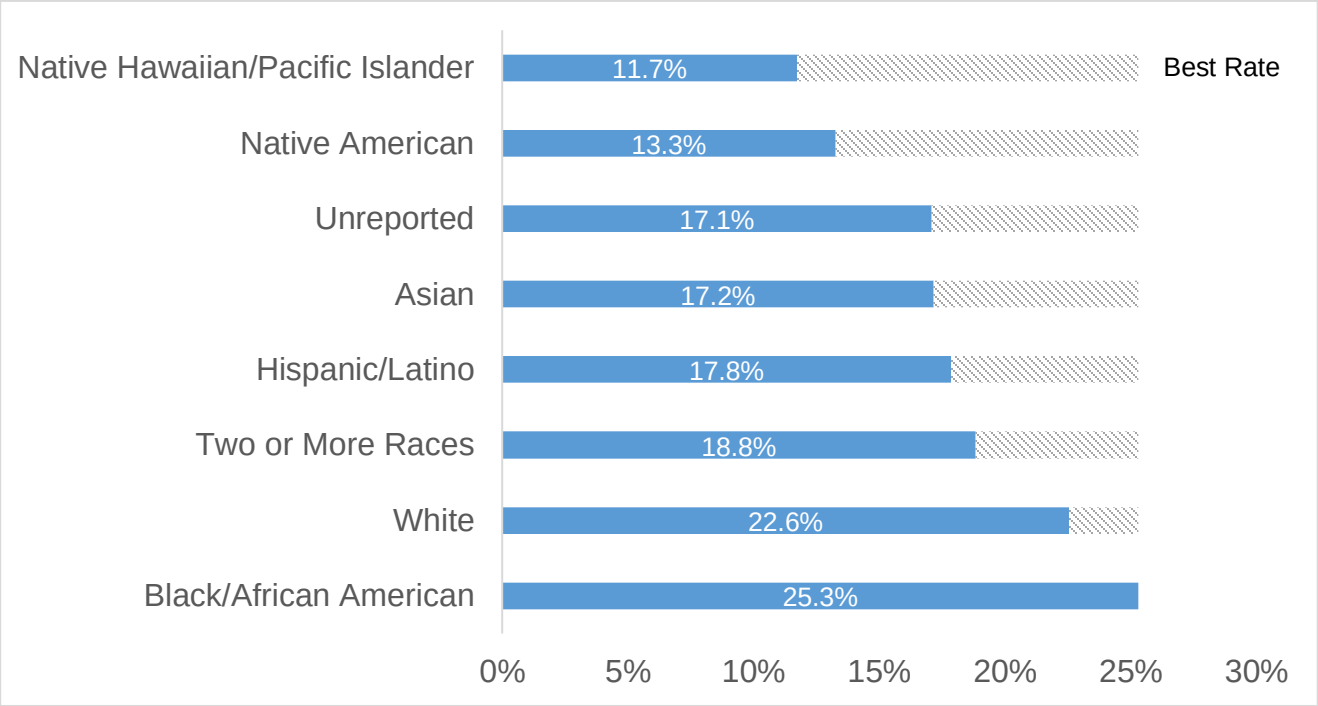
**Figure**

*92. Hospitalization Rates by Race/Ethnicity, CY 2021*




**Figure**

*93. Re-Admission Within 30 Days of Discharge Rates by Race/Ethnicity, CY 2021*



## Information Systems

*Telemental Health participation*

Telemental health research indicates that video-delivered psychotherapy can be as effective as in-person therapy[1] (Fernandez, Woldgabreal, Day, et al., 2021; Hilty, Ferrer, Parish, et al., 2013) and is the most similar comparison to in-person therapy as opposed to services via telephone. The data in this section are based on claims data with a clinical procedure code modifier indicating telephone or video services. They do not reflect client preferences or barriers in accessing technology (i.e., lack wireless internet, limited phone data plans), which may have influenced the modality used for the session.

Race/ethnicity

Other than Unreported, Hispanic/Latino clients had the highest percentage of receiving at least one video session and had the highest average number of video sessions. Native Americans had the lowest percentage of clients receiving at least one video session and the lowest average number of video sessions.

**Table**

*52. Telehealth Services Received by Format and Race/Ethnicity, CY 2021*

| | Number of Distinct Clients Receiving Telehealth | Total Telephone Services Received | Total Video Services Received | Clients with At Least 1 Telephone Session | Clients with At Least 1 Video Session |
|---|---|---|---|---|---|
| **Asian** | 6,997 | 20,147 | 8,832 | 5,631 | 2,592 |
| **Black/African American** | 37,142 | 97,143 | 44,667 | 29,821 | 13,596 |
| **Hispanic/Latino** | **80,677** | **201,806** | **147,292** | **63,758** | **39,094** |
| **Native American** | **1,171** | **3,568** | **1,227** | **1,017** | **418** |
| **Native Hawaiian or Pacific Islander** | 2,239 | 5,818 | 2,719 | 1,832 | 819 |
| **Two or More Races** | 5,865 | 16,360 | 10,118 | 4,891 | 2,662 |
| **Unreported** | 53,242 | 124,068 | 103,713 | 39,632 | 28,251 |
| **White** | 31,478 | 79,895 | 40,313 | 24,850 | 11,860 |

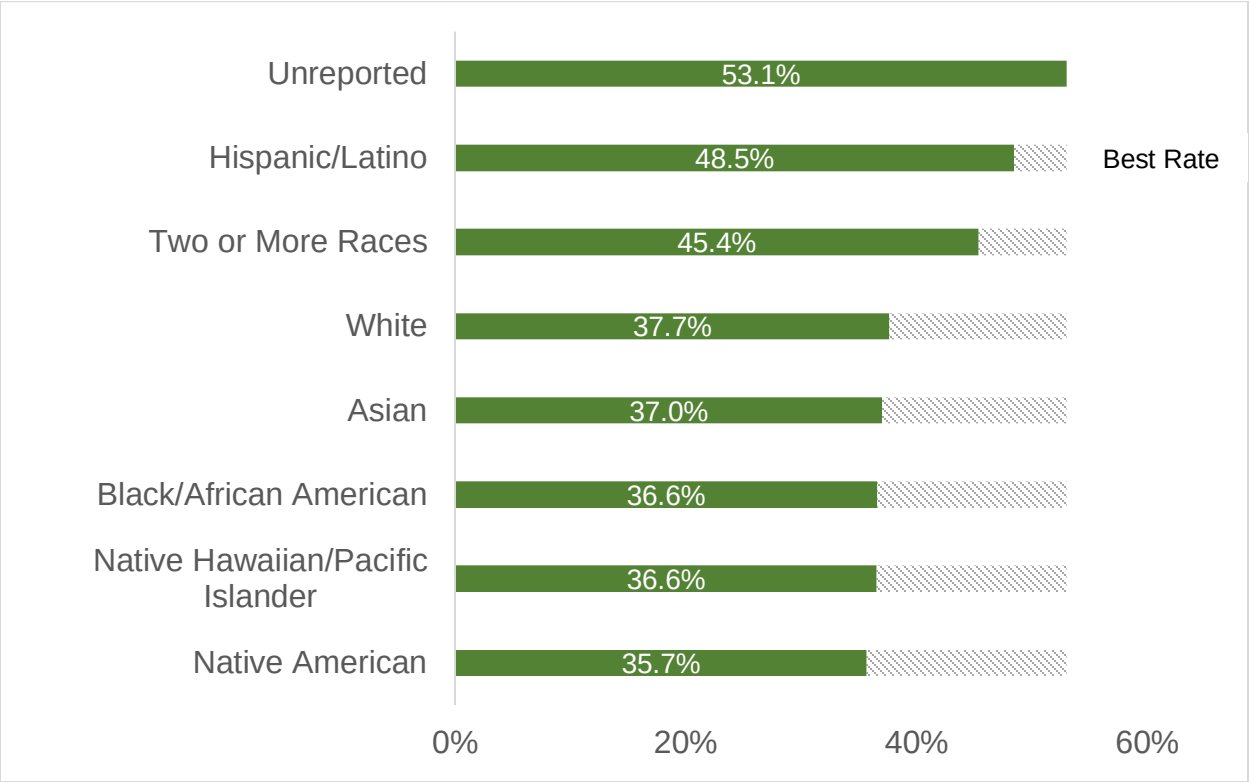
Note: Bolded numbers represent the highest and lowest values for that column.

[1] Fernandez, E., Woldgabreal, Y., Day, A., Pham, T., Gleich, B., & Aboujaoude, E. (2021). Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment. Clinical Psychology & Psychotherapy, 28(6), 1535-1549.

Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: a 2013 review. Telemedicine and e-Health, 19(6), 444-454.

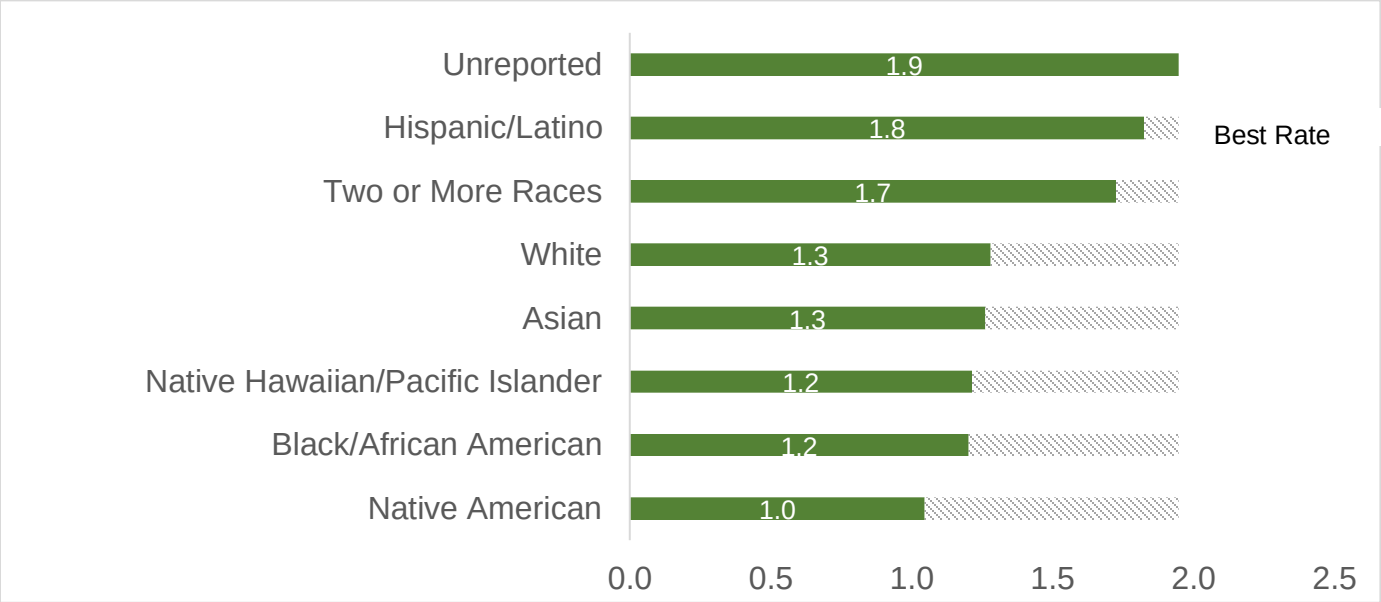
**Figure**

*94. Percent of Clients Receiving At Least 1 Video Service by Race/Ethnicity, CY 2021*




**Figure**

*95. Average Number of Video Sessions by Race/Ethnicity, CY 2021*



MHSA age group

Over three-fourths of the Children and over half of the Transition-Age Youth (TAY) served in CY 2021 had a least one video session. In the case of Children, this was three times and, in the case of TAY, double the percent of Adults with at least one video session. This pattern was the same for the average number of video sessions per age group. Less than a fifth of older adults received at least one video session.

**Table**

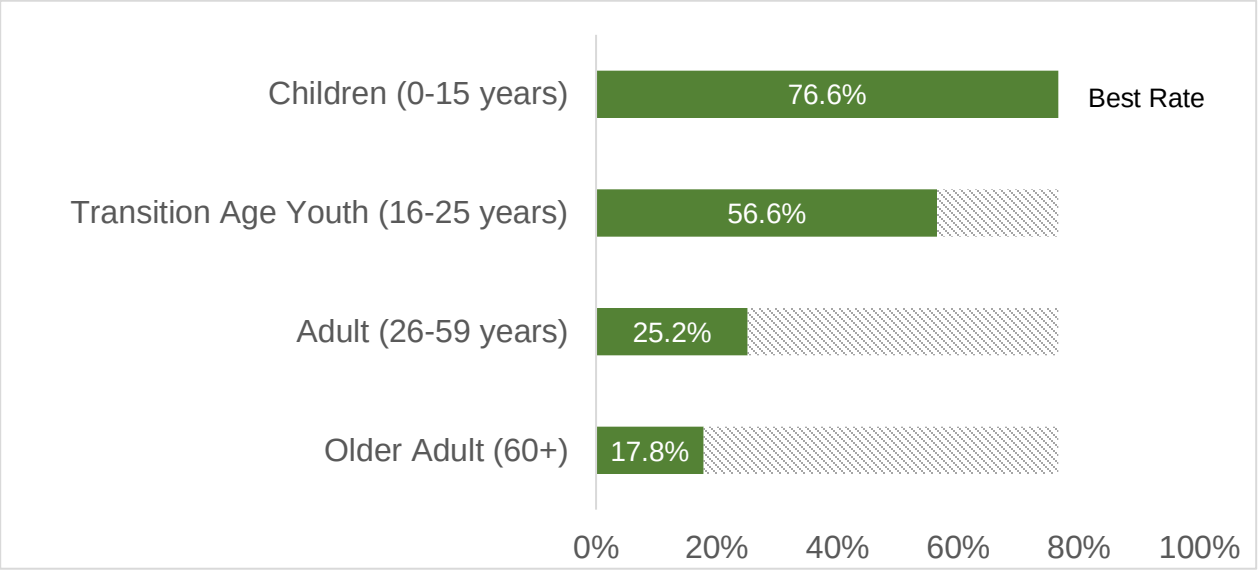
*53. Telehealth Services Received by Age Group, Calendar Year 2021*

| | Number of Distinct Clients Receiving Telehealth | Total Telephone Services Received | Total Video Services Received | Clients with At Least 1 Telephone Session | Clients with At Least 1 Video Session |
|---|---|---|---|---|---|
| **Children (0-15 years)** | 64,219 | 177,169 | **253,084** | 48,552 | **49,190** |
| **Transition Age Youth (16-25 years)** | 41,059 | 126,669 | 104,553 | 31,759 | 23,226 |
| **Adult (26-59 years)** | **90,529** | **286,079** | 56,107 | **71,333** | 22,789 |
| **Older Adult (60 years and up)** | **22,965** | **80,321** | **8,546** | **19,784** | **4,084** |

Note: Bolded numbers represent the highest and lowest values for that column.

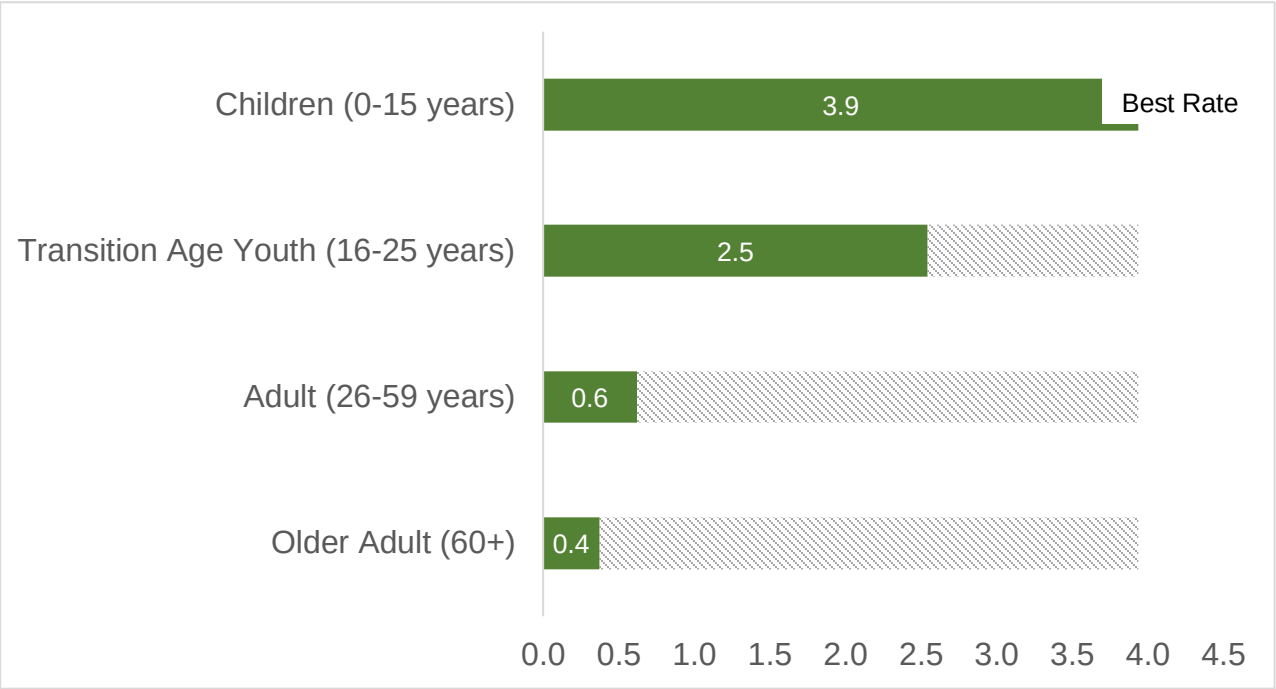
**Figure**

*96. Percent of Clients Receiving At Least 1 Video Service by Age Group, CY 2021*



**Figure**

*97. Average Number of Video Sessions by Age Group, CY 2021*




Threshold languages

Mandarin-speaking clients had the largest percentage of those who received at least one video session out of the total served and the highest average number of video sessions in CY 2021. Spanish- and English-speaking individuals had similarly higher percentages of clients receiving at least one video session and an average number of video sessions. Russian and Farsi-speaking clients similarly had the lowest average number of video sessions. Less than a quarter of clients with Russian and Farsi as a primary language received at least one video session.

**Table**

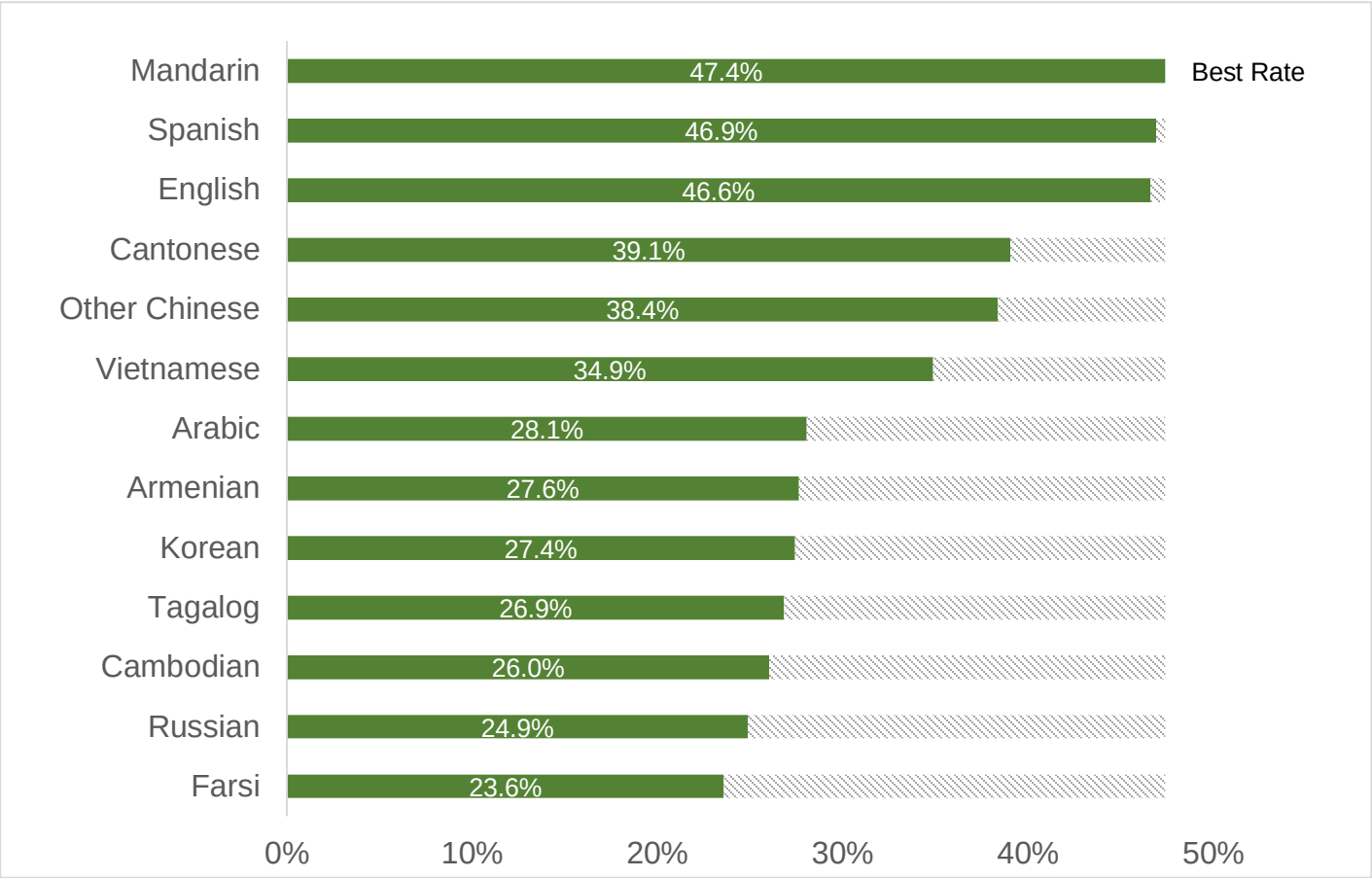
*54. Telehealth Services Received by Age Group, Calendar Year 2021*

| | Number of Distinct Clients | Total Telephone Services Received | Total Video Services Received | Clients with At Least 1 Telephone Session | Clients with At Least 1 Video Session |
|---|---|---|---|---|---|
| **Arabic** | 171 | 517 | 164 | 147 | 48 |
| **Armenian** | 1,223 | 3,611 | 979 | 1,129 | 338 |
| **Cambodian** | 764 | 3,810 | 623 | 704 | 199 |
| **Cantonese** | 553 | 2,716 | 983 | 507 | 216 |
| **English** | **171,514** | **533,972** | **342,533** | **135,265** | **79,917** |
| **Farsi** | 733 | 2,409 | 432 | 683 | 173 |
| **Korean** | 864 | 2,652 | 830 | 647 | 237 |
| **Mandarin** | 601 | 2,358 | 1,291 | 492 | 285 |
| **Other Chinese** | **112** | **355** | 171 | **91** | **43** |
| **Russian** | 229 | 580 | **144** | 192 | 57 |
| **Spanish** | 33,289 | 96,973 | 67,568 | 25,895 | 15,618 |
| **Tagalog** | 283 | 899 | 211 | 231 | 76 |
| **Vietnamese** | 539 | 2,327 | 729 | 491 | 188 |

Note: Bolded numbers represent the highest and lowest values for that column.

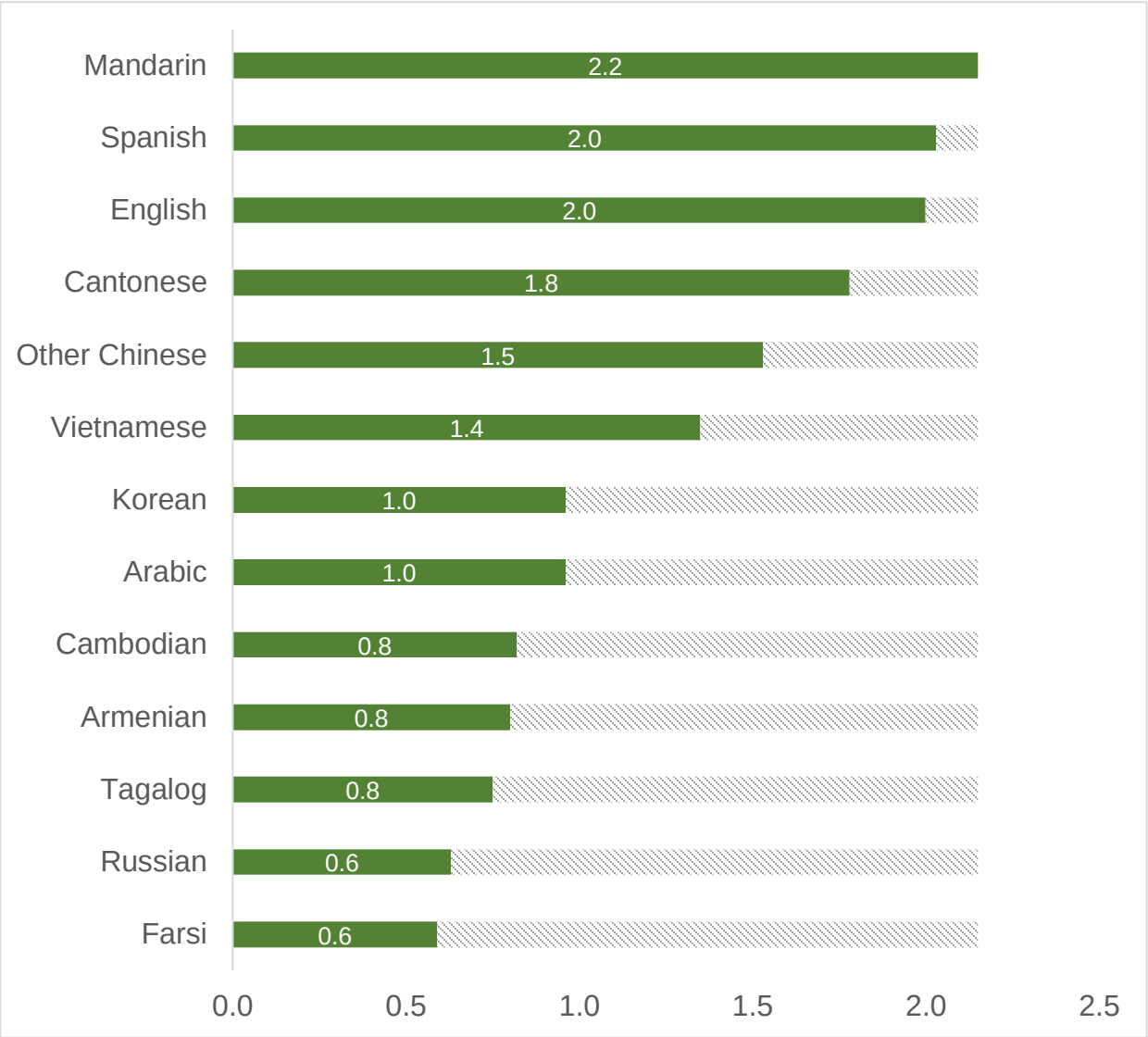
**Figure**

*98. Percent of Clients with At Least 1 Video Visit by Primary Language, CY 2021*



**Figure**

*99. Average Number of Video Visits by Primary Language, CY 2021*



**Quality Assurance and Performance Improvement Goals to Drive Change in Support of the Strategic Plan**

Last Revised Date:7/22/22

The QI Unit coordinates the Department's performance-monitoring activities countywide. The Department's CQI and data-driven activities include utilization review, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, assessment of beneficiary satisfaction, PIPs, and timely access to SMHS. The QAPI Work Plan activities for CY 2022 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, LACDMH meets State regulations for evaluating the appropriateness and quality of services.

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

- **A caring, respective and empowering 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.
- **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.
- **Client-driven** – where we engage consumers, families, communities, and all of our 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.
- **Accessible and hospitable** – where all services and opportunities are readily available, easy to find, timely, and welcoming to everyone.
- **Equitable and culturally competent** – where consumers, family members, and communities are cared for equitably, and services are delivered with cultural humility, respect, and competence.
- **Anti-racist, diverse, and inclusive** – where services are delivered with sensitivity and understanding to the impact of collective racism against Black and other communities of color.
- **Collaborative** – where we recognize that we cannot go it alone and 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 2020-2030**

LACDMH is a committed partner and contributor whose Strategic Plan (Plan) intentionally aligns with the County's broader vision for addressing critical challenges and helping communities thrive. To ensure the diverse needs and perspectives of the community were reflected in the strategic plan, LACDMH engaged the Board of Supervisors, staff, stakeholders, and the community through the Mental Health Commission, the Service Area Leadership Teams (SALTs), Underserved Cultural Communities (UsCCs), the Faith-Based Advocacy Council, and the Coalitions. The plan is centered around the transformational goals LACDMH strives for within the organization and support of the system (Infrastructure) as well as our three modes of service delivery (Community Services, Crisis Care, and Re-Entry Initiatives) (Figure 100). The Plan focuses on the community-centric and inclusive systems we must build in Los Angeles County to prevent people with serious mental health challenges from falling out of the community due to their condition and to bring those who fall out back in to stay.

Domains for Our Strategy

The Plan is organized around three essential domains where we interface with our clients and a fourth that describes the people, places, and processes that support our work (Figure 101).

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**Figure 100**

*Domains for Our Strategy (Illustration)*

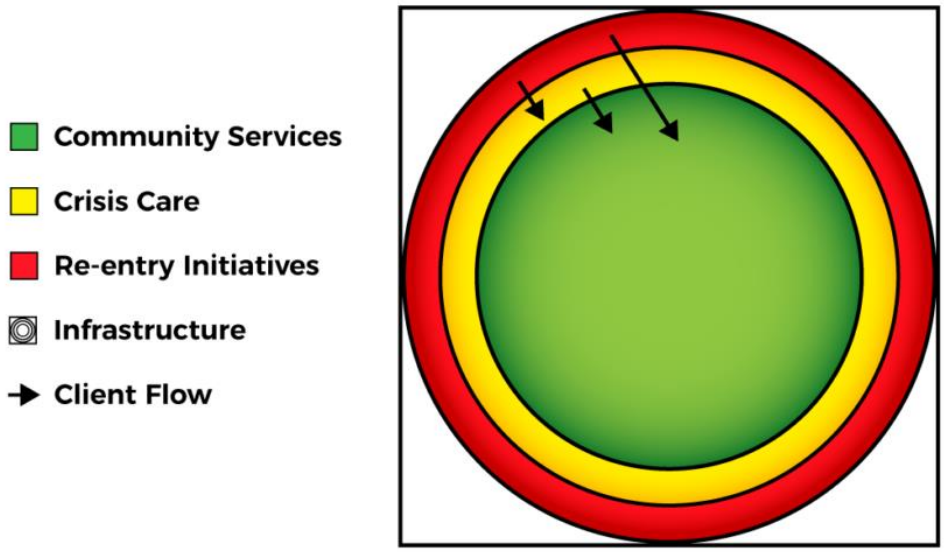

**Figure**
*101..... Domains for Our Strategy (Brief Overview)*

## Section V. Quality Improvement Work Plan, Calendar Year 2022

Date Last Revised: 5/27/21

The Department's QAPI Work Plan is organized into seven significant 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 service quality. Table 55 summarizes QAPI Work Plan goals and their comparable strategic plan domain.

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

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**Table**

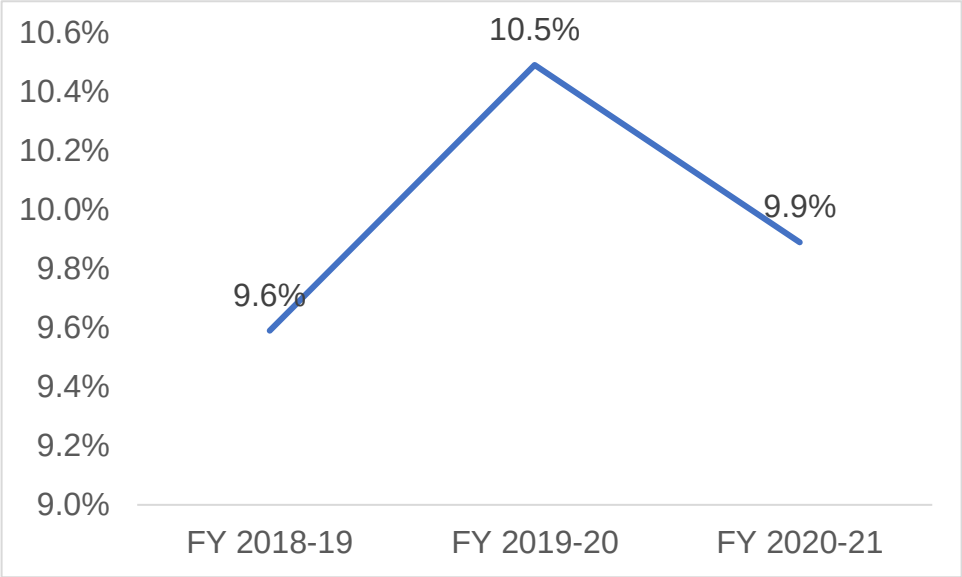
*55. Summary of QAPI Work Plan Goals and Comparable Strategic Plan Domain(s), Calendar Year 2022*

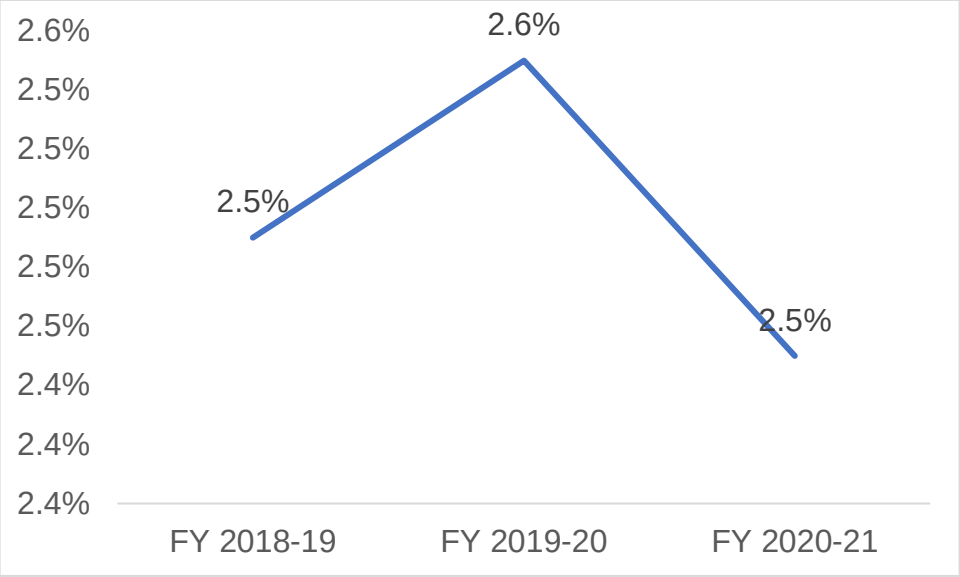
| Domain | No. | Goal | Strategic Plan Domain | | | |
|---|---|---|---|---|---|---|
| | | | Community Services | Crisis Care | Re-Entry Initiatives | Infrastructure |
| Service Delivery Capacity | Ia. | Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving DMH services. | X | X | X | X |
| | Ib. | Share findings on the Department's capacity to deliver culture-specific services. | X | X | X | X |
| | Ic. | Maintain the number of clients receiving telehealth services. | X | | | |
| Accessibility of Services | II. | DMH will meet 80% of initial requests for outpatient SMHS with a timely appointment. | X | | | |
| Beneficiary Satisfaction | IIIa. | Evaluate Consumer Perception Survey (CPS) findings and develop data-driven improvement strategies at the Service-Area level. | | | | X |
| | IIIb. | Monitor grievances, appeals, and requests for a Change of Provider. | | | | X |
| Clinical Care | IVa. | 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. | X | | | |
| | IVb. | Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS. | X | | | |
| | IVc. | Develop a mechanism to measure and track HEDIS Measures for children and youth. | X | | | |
| | IVd. | Roll out an Adult Level Care Tool. | X | X | | |
| Continuity of Care | V. | Develop a systemwide strategy to reduce seven- and 30-day rehospitalization rates. | | X | | |
| Provider Appeals | VI. | Monitor Provider Appeals. | | | | X |
| Performance Improvement Projects | VII. | Develop and implement two (clinical, administrative) data-driven performance improvement projects to improve client access, service quality, timely access to care, or information systems with direct beneficiary impact. | X | X | X | X |

*Note*: Reporting periods will vary by objective.

**Monitoring Service Delivery Capacity, Calendar Year 2022**

Service Equity

| | |
|---|---|
| Goal Ia. | Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving DMH services. |
| Objective (s) | 1. Work collaboratively with LACDMH stakeholders to develop a United Mental Health Promoters program curriculum for the Black/African American and Asian Pacific Islander communities.<br>• Prioritize unique community needs, current affairs (i.e., community violence and COVID-19 response), and fluid resources<br>2. Utilize the Speakers Bureau for ongoing outreach and engagement. |
| Population | LACDMH and Legal Entity (LE)/Contracted programs providing outreach and outpatient SMHS to LACDMH clients and the Los Angeles County community at large. |
| Performance Indicator(s) | 1. Unique Client Counts by Race/Ethnicity<br>2. Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity<br>3. Service Equity Analysis Report Findings<br><br>Penetration Rates<br><br>**Figure** *102. ..... enetration Rates for Medi-Cal Beneficiaries in the African American Group*<br>  <br><br>Note: The Ns for Medi-Cal Beneficiaries from the African American group served in FY 2018-19 was 37,455, 40,669 in FY 2019-20, and 38,300 in FY 2020-21. Uninsured/indigent clients are not reflected in this data. Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2019 to CY 2021, prepared by BHC/CalEQRO in July 2019, July 2020, and July 2021.<br><br>**Figure** *103. ..... enetration Rates for Medi-Cal Beneficiaries in the Asian Pacific Islander Group* |




Note: The Ns for Medi-Cal Beneficiaries from the Asian Pacific Islander group served in FY 2018-19 was 9,422, 9,430 in FY 2019-20, and 9,141 in FY 2020-21. Uninsured/indigent clients are not reflected in this data. Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2019 to CY 2021, prepared by BHC/CalEQRO in July 2019, July 2020, and July 2021.

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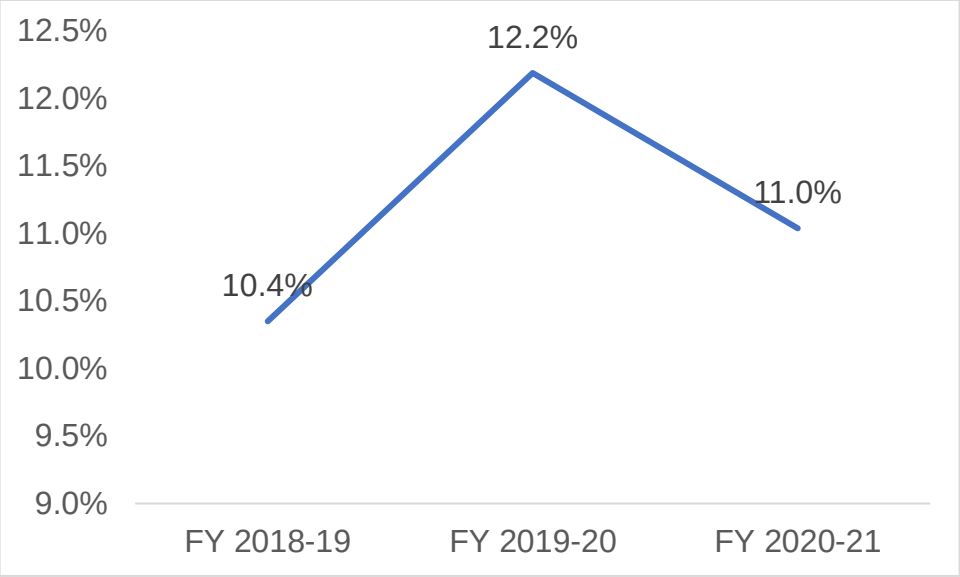
**Figure**

*104. ..... enetration Rate Changes for Medi-Cal Beneficiaries in the Native American Group*

| | |
|---|---|
| |  <br>Note: The Ns for Medi-Cal Beneficiaries from the Native American group served in FY 2018-19 was 522, 581 in FY 2019-20, and 530 in FY 2020-21. Uninsured/indigent clients are not reflected in this data. Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2019 to CY 2021, prepared by BHC/CalEQRO in July 2019, July 2020, and July 2021. |
| Frequency of Collection | Annually |
| Responsible Entity | Quality, Outcomes, and Training Division – QA and QI Units |

Delivering Culture-Specific Services

| | |
|---|---|
| Goal Ib. | Share findings on the Department's capacity to deliver culture-specific services. |
| Objective(s) | Evaluate client satisfaction with American Sign Language (ASL) interpretation services, identify areas for improvement, and review findings with providers. |
| Population | Los Angeles County's deaf and hard of hearing communities, specifically LACDMH DO clients and families receiving outpatient SMHS in ASL. |
| Performance Indicator(s) | Client satisfaction with ASL interpretation |
| Frequency of Collection | Annually |
| Responsible Entity | Cultural Competency Unit (CCU) |

Telemental Health

| | |
|---|---|
| Goal Ic. | Maintain the number of clients receiving telehealth services. |
| Objective(s) | 1. Explore and resolve barriers to telehealth services, including but not limited to client and staff-related issues with video or telehealth platforms.<br>2. Survey client/family telehealth service delivery preference. |
| Population | DO and LE/Contracted clients/families receiving outpatient SMHS. |
| Performance Indicator(s) | Number and percent of telehealth encounters by delivery type |
| Frequency of Collection | Annually |
| Responsible Entity | Chief Information Office Bureau (CIOB), Clinical Informatics Team |

**Monitoring Accessibility of Services, Calendar Year 2022**

Timely Access to Services

| | |
|---|---|
| Goal II. | DMH will meet 80% of initial requests for outpatient SMHS with a timely appointment. |
| Objective(s) | 1. Monitor time to first offered appointment.<br>• Providers should offer routine (non-urgent) appointments within ten business days (not including weekends and holidays) of the initial request.<br>• Providers should offer urgent appointments within 48 hours (including weekends and county holidays) of the initial request.<br>• Providers should offer follow-up hospital discharge or jail release appointments within five business days (not including weekends and holidays) of the initial request.<br>2. Monitor wait times to initial medication evaluation appointments. |
| Population | Los Angeles County DMH clients receiving inpatient psychiatric services from the Department of Health Service (DHS), Fee-for-Service (FFS) Contracted, Non-Contracted, Non-Governmental Agency (NGA), and Contracted IMD Exclusion Hospitals seeking outpatient SMHS from a DMH provider. |
| Performance Indicator(s) | Rates of timeliness by service request type (routine, urgent, and hospital discharge/jail release).<br>Wait times to initial medication evaluation appointments |
| Frequency of Collection | Quarterly |
| Responsible Entity | Quality Assurance Unit |

**Monitoring Beneficiary Satisfaction, Calendar Year 2022**

Client/Family Satisfaction

| | |
|---|---|
| Goal IIIa. | Evaluate findings and develop data-driven improvement strategies at the Service-Area level. |
| Objective(s) | 1. Review methodology concerning sample size and participants<br>2. Gather Sexual Orientation and Gender Identity (SOGI) related demographics and assess for the quality and delivery of affirming care<br>3. Roll out a Power BI portal to evaluate provider-level performance trends<br>4. Monitor response rates and review the mechanism for tracking participation history and program types |
| Population | DO and LE/Contracted clients/families receiving outpatient SMHS. |
| Performance Indicator(s) | Number of returned surveys/respondents by CPS form. |
| Frequency of Collection | Annually |
| Responsible Entity | QI Unit |

Client Grievances, Appeals, and Change of Provider Requests

| | |
|---|---|
| Goal IIIb. | Monitor grievances, appeals, and requests for a Change of Provider. |
| Objective(s) | 1. Automate data collection processes to eliminate waste and improve the availability of real-time data.<br>• Implement a public-facing portal to receive client grievances and complaints<br>• Develop a provider application to track monthly submissions of COP requests<br>2. Review the nature of complaints, resolutions, and COP requests 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(s) | 1. Total beneficiary complaints and resolutions by type in FY 2021-22<br>2. COP requests by type in FY 2021-22 |
| Frequency of Collection | Annually |
| Responsible Entity | Patient's Rights Office |

**Monitoring Clinical Care, Calendar Year 2022**

Clinical Reporting

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|---|---|
| Goal IVa. | 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(s) | 1. Providers will have access to client-level aggregate reports<br>2. Identify and develop the mechanism for generating program-level reports<br>3. Run tests with a sample of providers<br>4. Develop and implement training for DO staff and supervisors (Year One)<br>5. Research and explore relevant and user-friendly reporting elements to include on an LACDMH public-facing dashboard |
| Population | DMH Directly Operated (DO) and LE/Contracted programs providing SMHS to children and youth between ages 3 and 21 years. |
| Performance Indicator(s) | 1. One client-level report<br>2. One provider-level report<br>3. Clinical utility training with supporting materials |
| Frequency of Collection | Annually |
| Responsible Entity | Outcomes Unit |

Provider-Level Improvement

| | |
|---|---|
| Goal IVb. | Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS. |
| Objective(s) | 1. Within one year, 50% of LACDMH outpatient treatment providers will participate in the QA Knowledge Assessment Surveys.<br>2. Within one year, 90% of chart reviews will meet criteria pertaining to the Assessment, Treatment Plan/Problem List, and Progress note; namely:<br>a. The assessment contains information that reasonably supports the beneficiary's entry into the SMHS system.<br>b. The issues to be addressed in treatment are included in the documentation (treatment plan, problem list, and/or progress note).<br>c. The service provided is relevant to the information in the clinical record and is a valid SMHS. |
| Population | Outpatient programs providing outpatient SMHS to LACDMH clients/families. |
| Performance Indicator(s) | 1. Number and percent of providers completing the QA Knowledge Assessment Surveys;<br>2. Compliance rates concerning Assessment, Treatment Plan, and Progress Notes (average compliance rate per item in CY 2022); and<br>3. Qualitative data from providers on the effectiveness and efficiency of these processes. |
| Frequency of Collection | • QA will collect QA Knowledge Assessment Survey data quarterly.<br>• At least 20 LE/Contracted chart reviews are completed annually. |
| Responsible Entity | Quality Assurance Unit |

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

| | |
|---|---|
| Goal IVc. | Develop a mechanism to measure and track HEDIS Measures for children and youth. |
| Objective(s) | Identify and pilot a data collection process for dependent foster Child/Youth HEDIS data. |
| Population | Dependent foster youth |
| Performance Indicator(s) | Summarize results in an Annual Findings Report |
| Frequency of Collection | Ongoing, as medications are prescribed |
| Responsible Entity | Chief Medical Director, Psychiatry Services |

Level of Care

| | |
|---|---|
| Goal IVd. | Roll out an Adult Level Care Tool. |
| Objective(s) | Review common clinical tools and identify modifications that would best meet the needs of LACDMH's adult population |
| Population | Adult clients |
| Performance Indicator(s) | One adult clinical level of care tool |
| Frequency of Collection | Annual |
| Responsible Entity | Outpatient Services |

**Monitoring Continuity of Care, Calendar Year 2022**

| | |
|---|---|
| Goal V. | Develop a systemwide strategy to reduce seven- and 30-day rehospitalization rates. |
| Objective(s) | 1. Establish a committee to review data monthly<br>2. Identify and implement at least one intervention targeting systemwide readmission rates |
| Population | LACDMH clients receiving outpatient SMHS |
| Performance Indicator(s) | Rates of rehospitalization at seven- and 30-day post-inpatient discharge |
| Frequency of Collection | Monthly |
| Responsible Entity | Intensive Care Division and Outpatient Services |

**Monitoring Provider Appeals, Calendar Year 2022**

| | |
|---|---|
| Goal VI. | Monitor Provider Appeals. |
| Objective(s) | 1. Review the Provider Appeal Tracking Log for trends and share findings with appropriate entities.<br>2. Concurrent authorization will be operational at all hospitals. |
| Population | LACDMH clients receiving inpatient psychiatric services from the Department of Health Service (DHS), Fee-for-Service (FFS) Contracted, Non-Contracted, Non-Governmental Agency (NGA), and Contracted IMD Exclusion Hospitals. |
| Performance Indicator(s) | Number of Notice of Adverse Benefits Determinations (NOABDs) issued, including the percentage of upheld or overturned appeals. |
| Frequency of Collection | Monthly |
| Responsible Entity | Intensive Care Division – Treatment Authorization Requests Unit |

**Monitoring Performance Improvement Projects, Calendar Year 2022**

| | |
|---|---|
| Goal VII. | Develop and implement two (clinical, administrative) data-driven performance improvement projects to improve client access, service quality, timely access to care, or information systems with direct beneficiary impact. |
| Objective | Identify concepts, review data, and establish committees. |
| Population | To be determined |
| Performance Indicator(s) | To be determined |
| Frequency of Collection | To be determined |
| Responsible Entity | Quality, Outcomes, and Training Division (QOTD) - Quality Improvement Unit |