# LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

## OFFICE OF ADMINISTRATIVE OPERATIONS
## QUALITY IMPROVEMENT DIVISION

# QUALITY IMPROVEMENT WORK PLAN EVALUATION REPORT CALENDAR YEAR 2017

# AND

# QUALITY IMPROVEMENT WORK PLAN CALENDAR YEAR 2018

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

**August 2018**

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# Executive Summary

# August 2018

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

The Los Angeles County Department of Mental Health (LACDMH) Quality Improvement Annual Work Plan is organized into six major domains, which include: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, and Provider Appeals. Each domain is designed to address service needs and the quality of services provided. The Quality Improvement Program is dedicated to fostering consumer focused, culturally competent services and improving access to underserved populations.

Los Angeles County is the most populated county in the nation with an estimated population of 10,227,450 in Calendar Year (CY) 2016. The estimated distribution by Race/Ethnicity in the major designated ethnic categories includes: Latinos representing 48.8%, Whites 26.7 %, Asian Pacific Islanders 14.0%, African Americans 8.5 %, Two or More Races 2.2%, and Native Americans representing 0.2%. During Fiscal Year (FY) 16-17, a full array of mental health services were provided to approximately 247,000 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, LACDMH Directly Operated (DO) and Legal Entity (LE) Contracted outpatient programs and by Fee-For-Service (FFS) outpatient network providers. The Work Plan goals focused on the Directly Operated and Legal Entity Contracted outpatient programs that served approximately 206,383 persons Countywide.

This Quality Improvement Work Plan Evaluation Report details the progress LACDMH has made with respect to the 2017 Annual Work Plan Goals. For CY 2017, 18 out of 19 of the QI Work Plan Goals were met

In addition to the analysis of unmet needs via Penetration Rates, trending analysis of data for the last three years was used to further understand and assess the adequacy of meeting the mental health service needs of the population. Service Delivery Capacity Work Plan goals for CY 2018 are based on the population living at or below 138% Federal Poverty Level and include services to newly eligible under the Medicaid Expansion as of January 2014. The expansion of services that accompanied healthcare reform is significant for LACDMH and required the integration of physical health, mental health, and substance use services.

The 2018 Quality Improvement Work Plan Goals are set by the Office of Administrative Operations – Quality Improvement Division under the authorization of the LACDMH Executive Management Team and in collaboration with LACDMH Bureaus and Divisions including: ACCESS Center, Emergency Outreach and Triage Division, LACDMH outpatient programs, Office of the Medical Director, Patients' Rights Office, Systems of Care, Service Area Quality Improvement Committees, Underserved Cultural Communities, and the Workforce Education and Training Division who have all contributed to this report.

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## INTRODUCTION

In partnering with consumers, families, and communities to provide culturally competent opportunities for Hope, Wellbeing, and Recovery, the Los Angeles County Department of Mental Health (LACDMH) is committed to serving, improving, and making a difference in the lives of Los Angeles County residents who have been diagnosed with mental illness.

The National Strategy for Quality Improvement in Health Care (Affordable Care Act, 2011) has guided our efforts to achieve the three aims of improving the quality of care, improving the health of consumers and their families, and providing affordable care. Through ongoing innovation, we strive for an integrated model of healthcare that encompasses mental health, physical health, and substance abuse services. LACDMH is working to design and implement a next generation behavioral health service delivery system, which provides an integrated array of high-quality and resiliency/recovery-focused behavioral health services achieving the triple aim. We embrace the cultural diversity of the communities we serve and recognize the highly diverse and interconnected set of communities with unique cultures, strengths, challenges, and behavioral health needs.

The QI Work Plan includes areas of performance measurement, monitoring, and management regarding service delivery capacity; timeliness, accessibility, and quality of services; cultural competency; and consumer and family satisfaction. The data collected is analyzed and used for decision making, monitoring change, and for performance management aimed at improving services and the quality of care.

## SECTION 1

## QUALITY IMPROVEMENT PROGRAM DESCRIPTION

### Quality Improvement Program Structure

The Office of Administrative Operations (OAO; formerly known as the Program Support Bureau), Quality Improvement Division (QID) is under the administration and direction of the Chief Deputy of Administrative Operations. OAO-QID shares responsibility with providers to maintain and improve the quality of service and the delivery infrastructure. QID establishes annual Work Plan goals, monitors Departmental activities for effectiveness, and conducts processes for continuous improvement of services in collaboration with other Departmental Bureaus. The structure and process of the LACDMH Quality Improvement (QI) Program are outlined in Policy and Procedure 1100.01, Quality Improvement Program Policy. QID works to ensure that the quality and appropriateness of care delivered to consumers meets or exceeds local, State, and Federal service standards. The QI Program is organized and implemented in support of an organizational culture of continuous quality improvement that: fosters hope, wellbeing, resilience and recovery; reduces disparities; promotes consumer and family involvement; improves cultural competency; and integrates the treatment of mental health and substance use disorders with physical healthcare.

OAO-QID includes the following three (3) Units: the Cultural Competency Unit (CCU), the Underserved Cultural Communities (UsCC)/Innovations (INN 2) Unit, and the QI Unit. The CCU promotes the development of appropriate mental health services that will meet the diverse needs of Los Angeles County's racial, ethnic, cultural, and linguistic populations. The CCU provides technical assistance and training necessary to integrate cultural competency into Departmental operations and works to implement the Cultural Competency Plan for LACDMH. The UsCC/INN 2 Unit has the responsibility for implementing one-time funded projects within our system of care to build capacity and increase access for underserved cultural communities; specifically, the African/African American, the American Indian/Alaska Native, Asian Pacific Islander, Eastern European/Middle Eastern, Latino and the Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, Two Spirit (LGBTQI2-S) communities. The UsCC/INN 2 Unit also implements Community-Designed Recovery Resilience and Reintegration (RRR) Services which promote the establishment of networks of care that include formal providers, non-traditional healers, and community-based organizations to integrate physical healthcare, mental health care, and substance use treatment for the five ethnic UsCC groups. The functions of the QI unit include QI leadership, QI coordination, data management, reporting, and support services for Departmental Bureaus, Divisions, and programs in the adoption and execution of QI Work Plans. QID and QI staff are responsible for coordinating and presenting the annual QI Evaluation Report.

**Quality Improvement Program Processes**
The purpose of the design and implementation of the Countywide QI Program is to ensure an organizational culture of continuous self-monitoring through effective strategies, best practices, and activities at all levels of the system.

OAO-QID works in collaboration with Departmental staff to establish annual and measurable QI Work Plan goals to evaluate performance management activities. The QI Work Plan Goals are categorized into six domains of State and Federal requirements including the following: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care and Provider Appeals. Evaluation of the Work Plan goals is published annually in a report and is available online at http://psbqi.dmh.lacounty.gov/QI.htm.

OAO-QID is responsible for the formal reporting on annual measurement of consumer perception of satisfaction in six areas namely General Satisfaction, Perception of Access, Perception of Quality and Appropriateness, Perception of Participation in Treatment Planning, Perception of Outcomes of Services, Perception of Functioning and Perception of Social Connectedness. The results are reported annually in the State and County Performance Outcomes Report and are available online at http://psbqi.dmh.lacounty.gov/QI.htm.

Departmental Performance Improvement Projects (PIPs) are conducted to ensure that selected administrative and clinical processes are reviewed to improve performance outcomes. The QI Division collaborates and coordinates related QI activities with many of the Bureaus, Divisions and Units within LACDMH including: the Quality Assurance (QA) Division; ACCESS Center; Children's System of Care (CSOC) Administration; Patients' Rights Office (PRO); Office of Strategies for Total Accountability and Total Success (STATS) and Informatics; Office of the Medical Director (OMD); Mental Health Services Act (MHSA) Implementation and Outcomes Division; Emergency Outreach and Triage Division (EOTD); Service Area Quality Improvement Committees (SA QICs) and the multidisciplinary PIP teams. The OAO-QID team works to engage and support the SA QIC members in QI processes related to the QI Work Plan, specific PIP activities, and other QI projects conducted at the SA level.

The Departmental Countywide Quality Improvement Council (QIC) is chaired by the OAO-QID Mental Health Clinical Program Manager and Co-Chaired by a Regional Medical Director from the Office of the Medical Director (OMD). The OAO-QID Mental Health Clinical Program Manager also participates in the Southern California QIC, the Statewide QIC, the LACDMH STATS, the Clinical Policy Committee, and the Executive Dashboard. The supervisor of the CCU serves as the LACDMH Ethnic Services Manager and is a standing member of the Departmental Countywide QIC, the Departmental Countywide Cultural Competency Committee (CCC), and the Cultural Competency, Equity, and Social Justice Committee (CCESJC).

The QI Program acts in coordination with the service delivery system. The Departmental Countywide QIC meets monthly and includes standing representation from each of the 8 Services Areas (SAs), LACDMH programs and divisions, and other stakeholders. All SAs

facilitate their own SA QICs. Each SA QIC has a Chairperson representing Directly Operated (DO) Providers and most have a Co-Chairperson who represents the Legal Entity (LE) Contracted providers. The SA QIC Chairperson and Co-Chairperson are representative members of the Departmental Countywide QIC. SA QIC meetings provide a structured forum for the identification of QI opportunities to address challenges and barriers unique to a SA.

At the provider level, all DO and LE Contracted providers participate in their own Organizational QIC. In order to ensure the QIC communication feedback loop is complete, all SA Organizational Providers are required to participate in their local SA QIC. This constitutes a structure that supports effective communication between Providers and SA QICs, up to the Departmental QIC, and back through the system of care. An additional communication loop exists between the SA QIC Chairperson and/or Co-Chairpersons and the respective SA District Chiefs and Service Area Advisory Committee (SAAC). The SAACs are comprised of consumers, family members, providers and LACDMH staff. The SAACs provide valuable information for program planning and opportunities for program and service improvement. SAACs are a centralized venue for consumers and family members to participate.

**Performance Improvement Projects (PIPs)**

As a part of the External Quality Review Organization (EQRO) requirements and mandated by the Code of Federal Regulations, Title 42, the QI program is responsible for collaborating on SA QI projects and PIPs. The QI Division is responsible for coordinating, organizing, and supporting PIPs from and throughout the organization. Each year, QID conducts a Clinical and Non-Clinical PIP.

**Clinical PIP**

Addressing Drivers of Rehospitalization for Intensive Service Recipients (ISRs) – COD Related Issues and Inadequate Bridging Services: This project was approved as a Clinical PIP for Fiscal Year (FY) 17-18 by the EQRO Review team, in July 2017.

This PIP aimed to address two important drivers of rehospitalizations for Intensive Service Recipients (ISRs): 1) Co-Occurring Disorder (COD) related issues, and 2) lack of supportive bridging services to assist the consumer with a successful transition from an inpatient to an outpatient setting. The target population for this project included Transition Age Youth and Adults (≥ 18 years of age) ISRs who had been hospitalized four or more times in the prior 13 months. This PIP executed two interventions in FY 16-17: 1) Implemented trainings on Conducting Effective Counseling Groups with Consumers with COD for direct service providers who facilitated COD groups for ISRs from the skills and knowledge gained at these trainings, and 2) Prioritized access to crisis residential beds for ISRs discharged from acute inpatient settings to provide bridging services that enabled a successful transition from an inpatient to an outpatient setting. Proposed outcomes to track include: reduction in 7 day and 30 day rehospitalization rates; reduction of hospital days for acute inpatient hospitalizations; improved 7 day outpatient follow up following discharge rates; increased engagement in outpatient services; and increased engagement in COD groups and resultant improved outcomes related to substance use.

**Non-Clinical PIP**

Improving the Responsiveness of the LACDMH 24/7 Hotline by Implementing the ACCESS Center QA Protocol: The ACCESS Center QA Protocol PIP ended in December 2017.

In Los Angeles County, the ACCESS Center 24/7 Hotline serves as the entry point for mental health services. Due to the breath and nature of the requests/calls to the Hotline, the ACCESS Center serves as an appropriate point of focus in LACDMH's efforts to systemically address barriers to access to care. In FY 16-17, the Non-Clinical PIP involved the implementation of a QA Protocol for the LACDMH ACCESS Center.

The ACCESS Center operates the 24/7, Statewide, toll free number (1-800-854-7771) for both emergency and non-emergency calls. The QA Protocol process was non-punitive and designed to improve: cultural responsiveness; customer service; appropriate screening of calls and referrals to specialty mental health services; appropriate resources resulting in better clinical care; and documentation of call information critical to track current services being provided and history of services already received. The PIP implementation focused on: 1) monthly evaluations of recorded and random calls from the entire consumer population that called the ACCESS Center on the 1 (800) line during the study period; 2) training all agents on the QA Protocol and providing feedback following the QA reviews that addressed areas of improvement; 3) training all ACCESS Center supervisors on the QA Protocol, validation of the calibration process and identifying areas of training for staff based on QA reviews; 4) review of outcomes on the performance indicators selected for the PIP on a monthly/quarterly basis at PIP meetings; and 5) reviewing and addressing barriers that impeded performance improvement through Plan Do Study Act (PDSA) cycles and Continuous Quality Improvement (CQI) efforts.

In FY 16-17, the Non-Clinical PIP reviewed data related to three clinical care outcome measures – identifying presenting problem, medical needs, and substance use issues. Data analysis presented data by the type of call (Crisis versus Referral); and based on the time of the call – Business hours versus Afterhours. This Non-Clinical PIP yielded several quantitative improvements in the QA Protocol at ACCESS Center.

A total of 96 ACCESS Call Center agents were trained on the QA Protocol between March 9, 2016 and May 17, 2017. There were also improvements in processes as evidenced by: 1) the addition of new resource information to the Electronic Resource Directory (ERD) for In Home Supportive Services (IHSS) insurance coverage for mental health services; 2) Formalized instructions regarding documentation of calls with an unknown date of birth; and 3) Focused review of barriers in documentation on the Department's Integrated Behavioral Health Information System (IBHIS) by the Chief Information Office Bureau (CIOB). Quantitative improvements were documented between the first Quarter of FY 16-17 and the last Quarter of FY 16-17 for the following outcome measures:

1. The percent of non-English calls where language interpreter services were offered increased from 84% to 86%. Compared to Quarter (Q) I, there was an initial 5 Percentage Points (PP) increase in Q2 and a 11 PP increase in Q2 overall. However,

there was a 9 PP decline in performance between Q3 (96%) and Q4 (86%) due to high call volume in May, staffing shortage for both supervisors and staff that resulted in a small overall PP increase of 2 PP in Q4. The expected achievement was 10 PP.

2. The percent of calls showing demonstrated respect for the caller increased from 95% to 96%. Compared to QI, there was an initial increase of 4 PP in Q1 and 3 PP in Q2. A 2 PP decline in performance between Q3 (98%) and Q4 (96%), due to increased call volume and staffing issues, resulted in a small overall increase of 2 PP for Q4 compared to Q1. The expected achievement was 5 PP.
3. The percent of calls where the caller's information was documented increased from 60% to 77%. The expected achievement was 10 PP. On this measure and compared to baseline, there was a significant improvement for Q2 by 17 PP, a 11 PP increase in Q3, and a 17 PP in Q4. In Q4, the evaluation criteria for documentation were expanded to make this more stringent. Despite this change, the PP increase was most significant for this measure.
4. On the Test Calls study findings for CY 2016 versus CY 2017 (February through August), there was a 11 PP increase from 63% to 74% on the measure related to caller's name was requested, and a 2 PP increase on the measure related to reported satisfaction with ACCESS Agent from 84% to 86%. These findings indicate parallel improvement related to the implementation of the PIP and focused efforts on performance in these areas.

**Cultural Competency Committee**
The Cultural Competency Committee (CCC) serves as an advisory group for the infusion of cultural competency in all of LACDMH operations. Administratively, the CCC is housed within the OAO-QID, formerly known as Program Support Bureau (PSB) -QID - Cultural Competency Unit (CCU). Comprised of 74 members, the CCC membership includes the cultural perspectives of consumers, family members, advocates, DO providers, Contracted providers, and community-based organizations. Additionally, the CCC considers the expertise from the Service Areas' clinical and administrative programs, front line staff, and management essential for sustaining the mission of the Committee.

**CCC Mission Statement**
"Increase cultural awareness, sensitivity, and responsiveness in the County of Los Angeles Department of Mental Health's response to the needs of diverse cultural populations to foster hope, wellness, resilience, and recovery in our communities."

**Leadership**
The CCC is led by two Co-Chairs elected annually by members of the Committee. The roles and responsibilities of the Co-Chairs include:

- Facilitate all meetings
- Engage members in Committee discussions
- Collaborate with the CCU in the development of meeting agendas
- Appoint ad-hoc subcommittees as needed
- Communicate the focus of the CCC activities and recommendations made to diverse LACDMH entities
- Represent the CCC at the departmental System Leadership Team (SLT)

The LACDMH Ethnic Services Manager (ESM) monitors all activities pertaining to the CCC and provides technical support. The ESM is also the supervisor for the CCU and is a member of the Departmental Countywide QIC. This structure facilitates communication and collaboration for attaining the goals as set forth in the Departmental QI Work Plan and the Cultural Competence (CC) Plan to reduce disparities, increase capacity, and improve the quality and availability of services. Additionally, relevant CCC decisions and activities are reported to the membership at each Departmental QIC meeting.

For CY 2017, the CCC leadership was composed of:

- CCC Co-Chairs (LACDMH and Community representatives)
- LACDMH OAO Deputy Director
- LACDMH ESM

The CCC Co-Chairs and the ESM meet on a monthly basis with the OAO Deputy Director to discuss CCC activities and projects. The CCC Co-Chairs are also members of the UsCC Leadership Group.

**Membership**
The membership of the CCC is culturally and linguistically diverse. For CY 2017, the CCC membership reached 74 members. Of this number, 18 are males and 56 are females. The CCC members described their racial/ethnic identity as follows: African,

African American and American Indian, African American, American Indian, Asian, Asian and Caucasian, Black and Mexican, Black, Black American, Caucasian, Chinese, Filipino-American, German, Hispanic, Irish and German, Italian, Japanese, Jewish, Latina Indian, Latino, Latino Chinese, Mexican, Mexican American, Native American, Spaniard/Latino/American Indian, Spanish and White. Additionally, the following 11 languages are represented in the CCC membership: American Sign Language (ASL), Chinese, English, German, Hebrew, Japanese, Korean, Portuguese, Spanish, Swahili, and Tagalog.

**CCC Goals and Objectives**

At the end of each CY, the Committee holds an annual retreat to review its goals, activities and accomplishments; vote on cultural competency objectives to be undertaken for the next year; and reinforce the collaborative team atmosphere among Committee members. Once the CCC identifies areas of organizational cultural competency to be addressed, it proceeds to operationalize its goals and objectives in the form of workgroups. Each CCC workgroup identifies two co-leads and determines their goals, projects, and meeting frequency. Throughout the CY, the co-leads from each workgroup provide updates to the Committee at large during the monthly meetings for purposes of receiving feedback.

For CY 2017, CCC membership organized under two workgroups:

1) Needs of Persons with Physical Disabilities Workgroup – The goals of this workgroup included: 1. Promote awareness and sensitivity to the broad range of needs and ability levels among persons with physical disabilities and 2. Develop a report that features resources, tips, and recommendations relevant for the implementation of the Physical Disabilities UsCC subcommittee

   Accomplishments:
   - Promoted awareness of the needs of persons with physical disabilities within the CCC
   - Developed a comprehensive report that summarized the literature review findings on:
     - Definition of disability
     - The culture of disability and its current terminology
     - Theoretical models and approaches that explain the complexity of physical disabilities
     - Worldviews and cultural perceptions about physical disabilities
   - Established a connection with the QID-UsCC Unit to collaborate in the implementation of the UsCC subcommittee for persons with disabilities projected for early CY 2018

   For additional details, please refer to Appendix A.

2) Systems Transformation Workgroup – This workgroup was composed primarily of CCC consumer members. The goal of the workgroup was to provide insightful answers to the following questions:
   - How do you define peer?
   - Where peers could be placed?
   - What could peers do?

- What kind of trainings should peers have?
- How are we going to transform the system with peers?

Accomplishments:

- Completion of a summary report that provided the consumer perspective and comprehensive answers to questions listed above
- The report was shared with the LACDMH Director to influence departmental efforts to incorporate peers into the current workforce

For additional details, please refer to Appendix B.

**Review and Recommendations to County Programs and Services**

As an advisory group to the Department, the CCC provides feedback and recommendations to various programs. The collective voice of the CCC is also represented at the SLT monthly meetings. This practice ensures that the voice and recommendations of the Committee are heard at these system wide decision-making meetings. The voice of the CCC is also strengthened by the Co-Chairs' participation in the UsCC Leadership Team. Together, the CCC and UsCC subcommittees advocate for the needs of underserved cultural groups and the elimination of mental health disparities.

The CCC also has an impact on the system of care by inviting and scheduling presentations from various LACDMH programs. These presentations take place during the monthly meetings. Feedback is either provided via the Committee at large or ad-hoc workgroups, when the Committee deems that an in-depth project review is necessary. The main goal of the CCC is to ensure that cultural competency and linguistic appropriateness are included in new projects and initiatives. In CY 2017, the CCC provided feedback for the departmental programs and projects listed below:

1) <u>Three Year MHSA Program and Expenditure Plan Public Hearing</u>

   In February 2017, the CCC welcomed a presentation pertinent to the Three Year MHSA Program and Expenditure Plan Public Hearing. The CCC engaged in a discussion regarding the benefits of representing the committee at this and other decision-making meetings. Members voiced the importance of having CCC representation to provide recommendations and ensure that cultural and linguistic appropriateness are at the core of all DMH programs funded by MHSA. Specifically, the committee agreed on the following:

   - The CCC needs to be present at the public hearing in order to represent the diversity of Los Angeles County communities
   - Members need to read the draft plan prior to the public hearing for purposes of providing meaningful feedback and recommendations

2) <u>QPR (Question, Persuade, Refer) Train-the-Community Training Project and Other DMH Suicide Prevention Trainings</u>-

   In March 2017, the Workforce, Education and Training (WET) Division provided a presentation on QPR Train-the-Community Project. This presentation informed the committee on the prevalence of suicide in Los Angeles County and training resources available to increase public awareness. The CCC praised the Department for its plan

to make the QPR training available to the community. The CCC provided the following specific feedback and recommendations:

- Include information on the Client Warm Line as a resource at the end of the QPR trainings
- Add e-CPR to the training menu
- Obtain a list of colleges in Los Angeles County and make the QPR training available to decrease the number of suicides in the Transitional Age Youth group
- Offer the QPR training to the Client Coalitions

3) <u>People with Disabilities and Access and Functional Needs (DAFN) Planning in Los Angeles County</u>

In April 2017, the Office of Emergency Management provided a presentation to the CCC on Access and Functional Needs Planning for persons with physical disabilities during disasters. The CCC was informed about the County Emergency Operations Center (CEOC) efforts to be inclusive of persons with physical disabilities and their rights. CCC recommendations include:

- The CEOC needs to be inclusive of and incorporate feedback from the community
- The Emergency Preparedness Plan (EPP) needs to:
  - Develop the plan in all the threshold languages
  - Provide information for medication support services and pharmacies where prescriptions can be filled
  - Include a section on mental health providers and other emergency-related services for distribution in the community
  - Coordinate the EPP with shelters
  - Distribute brochures with information that is relevant to surviving disasters
  - Ensure expedient referrals to mental health services

4) <u>LACDMH's Response to the Community Being Affected by the Immigration Executive Orders</u>

In May 2017, the EOTD's Deputy Director delivered a presentation on LACDMH's Response to the communities being affected by the Immigration Executive Orders. The CCC received this presentation with great interest. Members commended the Department for responding to the communities that are living in fear of deportation. The following recommendations were provided to the presenter:

- The letter needs to be available in all threshold languages
- Provide tips on family preparedness in the event of a deportation
- Include resource information on wellbeing and how families can take care of themselves during these stressful times
- Incorporate information on Deferred Action for Childhood Arrivals (DACA) services and Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) in the website for the Office of Immigrant Affairs

5) <u>Peer Action 4 Change Recommendations to LACDMH Regarding Recommendations for Peer Specialist Trainings</u>

- In June 2017, Peer Action 4 Change was invited by the CCC to present on trainings for peers. This presentation was a follow-up to a letter written to the LACDMH's Director requesting training, language capacity, and utilization of peers to facilitate

recovery. Peer Action 4 Change provided multiple short presentations on topics such as the use of the arts to facilitate rehabilitation and break language barriers, the Wellness Recovery Action Plan (WRAP), Emotional CPR and Neurolinguistic Programming (NLP), the "One-percent Campaign", and peer warmlines.

- In July 2017, the CCC organized a focus group to discuss the following questions regarding trainings for peers:
  - What trainings would be helpful for LACDMH to offer to peers?
  - What are the CCC's recommendations regarding trainings for peers?
  - What are the CCC's recommendations regarding the translation of training materials?
  - How can LACDMH make peer trainings more accessible?
  - What does LACDMH need to do to implement peer trainings?

The training recommendations generated by the CCC focus group were placed on the Committee's voting ballot. The results on the most selected training topics were presented to the CCC and Peer Action 4 Change in December 2017

6) <u>CCC discussion: examples of work related situations in which staff did not demonstrate cultural competency</u>

In July 2017, the ESM solicited stakeholder input from the CCC on real-life situations when LACDMH staff did not display cultural sensitivity and appropriateness. Feedback was gathered for three staff functions as follows:

A. Support/clerical staff
   - Make an effort to connect with consumers as human beings and show respect by addressing consumers by name
   - Allow consumers the opportunity to become involved as volunteers when they sign-up for an activity
   - Be knowledgeable of the clinic activities, such as self-help groups, SAAC meetings, and the work schedules of direct service staff
   - Refrain from asking consumers the nature of their problems while they sign-in
   - Identify themselves by name when answering and assisting consumers over the phone
   - Be knowledgeable about the brochures, flyers, and any other information available in the clinic lobbies
   - Show sensitivity when a Limited English Proficiency (LEP) consumer is trying to communicate in English
   - Refrain from humiliating consumers because they cannot communicate in English
   - Security guards need to be trained on how to communicate with consumers courteously

B. Direct clinical services
   - Consumers need to be informed in writing about internal changes of direct service staff
   - Psychotherapists and other clinical staff need to be knowledgeable and equipped to effectively address the experience of incarceration, oppression, and trauma of the African-American community

- Case managers, psychotherapists and psychiatrists need to communicate in order to eliminate mismanagement of consumer needs
- Clinicians need to follow-up with consumers when they miss appointments instead of disregarding absences as “no shows”
- When consumers’ phone numbers are not operating, staff needs to make an effort to reach them via regular mail or email

C. Management/Administration
- Administrators/managers need to “take care of themselves”, engage in self-help activities, practice relaxation, and take breaks to relieve stress and fatigue
- All administrators/managers need to take the emotional Cardiopulmonary Resuscitation (CPR) training and Mental Health First Aid trainings
- Pair up peers with administrators/managers so that the peers become well-known for their strengths and skills
- Speak to consumers with empathy
- Lower the demands on clinicians so they are emotionally available and receptive to meet the needs of consumers
- Hire staff with lived experience
- Arrange for newly graduated psychotherapists to shadow more seasoned staff
- Have an open-door policy
- Comply when consumers ask for a change of provider
- Evaluate the procedures in place and have flexibility in special circumstances, such as when consumers have physical limitations
- Allow for National Alliance on Mental Illness (NAMI) groups to take place at clinics
- Develop procedures to serve the deaf and hard of hearing community

This information has been utilized by the QID-CCU to inform the SA QICs about these issues and develop cultural competence trainings and presentations.

7) <u>LACDMH Grievance, Appeal, Expedited Appeal Form</u>
A presentation was provided by the PRO Director in October 2017 regarding the draft “Grievance, Appeal, Expedited Appeal” form. The committee was very interested in ensuring that the form is written in language that is understandable and provided several recommendations for the form to be more effective. It was decided that this agenda item become the main discussion for the November 2017 meeting.

As a follow-up to this presentation, the ESM led the CCC in a thorough review of the grievance appeal and expedited appeal form during the November 2017 meeting. The following recommendations were gathered from the CCC membership:
- Present information using bullet points to avoid long paragraphs
- Bold or underline important information such as PRO’s address and telephone number
- Simplify the vocabulary and language by eliminating technical and legal jargon

- Terms such as “beneficiary,” “affected party,” “arbiter”, and “Limited English Proficiency” are too complex
- Specify that “services” refer to mental health services
- “Deaf or Hearing Impaired” should be changed to “Deaf and Hard of Hearing”. Similarly, “hearing impairment” should be changed to “hearing loss”. The word, “impairment” should not be used regarding the Deaf and Hard of Hearing population
- Provide definitions that help consumers differentiate between a grievance and an appeal
- Add a clear timeline for submitting grievance or appeal documents
- Include information on what to do when a grievance is not resolved satisfactorily
- For the fill-in portion of the form, add items to gather information regarding “Who spoke to the consumer about the complaint?” and “What was the consumer told?”

Additionally, the CCC provided these recommendations pertinent to PRO’s general procedures:

- PRO advocates need to be culturally and linguistically sensitive to work with persons from different cultural backgrounds
- Provide training on conflict resolution skills to all PRO staff
- At the end of the complaint process, the PRO advocate should meet with the complainant and ask if he or she understood the results of the grievance or appeal
- Make sure that clinics display the form in their lobbies

These recommendations were submitted by the ESM to the PRO director on behalf of the CCC. Furthermore, PRO was invited to return with the revised form when it becomes available in CY 2018.

8) <u>Wraparound Program</u>

In November 2017, the CCC heard a presentation regarding the LACDMH Wraparound Program. The CCC advocated and made recommendations regarding the need for culturally and linguistically competent services, quality of service delivery, and effective staff training providing Wraparound services.

The specific feedback and recommendations provided by the CCC include:

- Expand specialized services for children ages 0 to 5
- Hire Parent Partners/Parent Advocates as peers to assist families navigate the Department of Children and Family Services (DCFS) system
- Ensure that wraparound clinicians are trained to deal with ethnic/racial issues and how to work with children who have experience trauma
- Build partnerships with culture-specific providers that specialize in serving the Native American community
- Have language interpreters available to meet the needs of families receiving wraparound services, including ASL

**Goals of cultural competence plans**

1) Cultural Competence Plan Requirements (CCPR) Updates
   The ESM provides a monthly update on various cultural competency initiatives at departmental and state levels during all CCC meetings. During CY 2017, the Committee engaged in discussions regarding updates to the Criterion 4 of the CC Plan, "Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System". A template table was circulated for members to report their agency affiliations, racial/ethnic background and linguistic expertise.

2) EQRO Review
   Cultural competence is one of the core areas of content for the annual EQRO Review. The CCC and CCU continue to play an active role by participating in sessions pertinent to the CC Plan and mental health disparities. A detailed presentation regarding the CCU's projects and activities was delivered by the ESM during the April 2017 and September 2017 EQRO reviews. Additionally, the CCC and UsCC subcommittee Co-Chairs participated in the EQRO session on disparities.

3) Medi-Cal Systems Review Protocol Training
   The QID managers attended a training regarding the 2017 Annual Review Protocol for "Consolidated Specialty Mental Health Services and Other Funded Services." The ESM brought information back to the CCC regarding new protocol items that focus on the CC Plan and the Committee's goals and activities.

4) LACDMH Cultural Competence Organizational Assessment Project Update
   In August 2017, the QID-CCU engaged the committee in the review of the focus group tool developed for this project. The membership had the opportunity to read, discuss, and provide feedback on the 32 questions comprising the focus group tool.

   The CCC membership provided the following feedback:
   - Consider using "participant," "community member," or "member" instead of "consumer". If the consumer is a child, then refer to them as "child" or "youth"
   - The word "providers" does not apply to all of LACDMH workforce and should be replaced by "staff"
   - Simplify questions so they are not too wordy
   - Rewrite questions that are confusing
   - Define "culture" at the start of each focus group so that participants are not limited in thinking that culture refers to primarily to ethnicity and language

**Human Resources Report**

In October 2017, the Human Resources Bureau (HRB) was invited to present to the CCC. This presentation included information on the language expertise of DMH staff, number of employees receiving bilingual bonuses, and the process for Program Managers from DO and Administrative programs to request bilingual certification testing of their staff. The Committee's recommendations included:

- The HRB needs to continue expanding the linguistic competency of the Department

- Consumers should always be informed that they have a right to request a language interpreter
- Staff who engage in language interpretation services need to be bilingual certified
- Receptionists and all the front desk staff should be trained on how to assist non-English speaking individuals over the phone
- Bilingual certified staff should know the idioms of the target language to be effective in that role
- Bilingual certified staff should be trained on medical terminology
- Recruit an examiner for ASL

**Training Plans**

Cultural Competence Trainings

The CCC continues to regularly provide information on LACDMH trainings and conferences related to cultural competency that are available to service providers and community members. This information is documented in the CCC minutes, which in turn are distributed to all the SA QICs.

## OAO-QID UNIT PROGRAM DESCRIPTIONS

### The OAO-QID Cultural Competency Unit

The Cultural Competency Unit (CCU) is one of three Units of the OAO-QID, formerly known as PSB-QID. This organizational structure allows for cultural competency to be integrated into QID roles and responsibilities to systematically improve services and accountability to our consumers, their family members, and the communities we serve. Additionally, this structure places the CCU in a position to collaborate with several LACDMH Programs such as the Underserved Cultural Communities (UsCC) Unit, the PRO, the WET Division, MHSA Implementation and Outcomes Division, and the SA QICs. The supervisor for the CCU is also the LACDMH ESM. This strategy facilitates the administrative oversight of CCC activities. It also reinforces the departmental framework for cultural responsiveness via the implementation of the CCPR and the Culturally and Linguistically Appropriate Services (CLAS) standards. The CCU promotes awareness and utilization of this framework to: reduce disparities; combat stigma; promote hope, wellbeing, recovery and resiliency; and serve our communities with quality care.

Most salient activities of the CCU in CY 2017:

1) CC Organizational Assessment
   This project is a system wide effort to evaluate LACDMH's workforce (clerical/support, financial, clinical/direct service, and administration/management at DO and LE Contracted programs) knowledge of cultural and linguistic competency strategies implemented by the Department. A consultant was hired to develop the organizational assessment tool, methodology for data collection and analysis. Additionally, a comprehensive report inclusive of recommendations on how to address knowledge gaps will be developed by the consultant. The Department will utilize these recommendations to improve its system of care in the area of cultural competency. As the lead, the CCU and QID managers worked closely with the consultant team in the construction of the tool. This included coordination and recruitment of consumers and staff to participate in focus groups. A total of nine focus groups were conducted. Four focus groups were conducted with LACDMH staff who represented various job classifications such as support/clerical, direct service providers, and management. Five consumer focus groups were facilitated with representation from the various Service Areas and provider sites including Spanish monolingual speakers. The feedback and recommendations gathered from the focus groups was utilized to develop the assessment tool. The focus groups provided feedback in the areas of:
   - The culture of being a mental health consumer
   - The consumer/service provider relationship and its impact on the consumers' wellbeing and recovery
   - How service providers can demonstrate their cultural and linguistic appropriateness to consumers
   - How service providers can promote a welcoming and respectful atmosphere for consumers and other staff
   - Effects of culturally and linguistically incompetent services on consumers and potential negative outcomes
   - Effects of diagnosis and labeling

- Service provider response to consumers' experience of societal, institutional, and generational trauma
- Stigma reduction
- Trainings to increase the cultural sensitivity of the workforce

The tool consists of 15 demographical and 55 content items that tap into the areas of:

- National Standards for CLAS in Health and Health Care
- The CLAS definition of culture
- CCPR
- LACDMH data regarding mental health disparities
- County of Los Angeles ethnicity demographics and threshold languages
- LACDMH Policies and Procedures (P&Ps) that tap into cultural competency
- LACDMH Strategic Plan goals as related to cultural competency and reduction of disparities
- Cultural competency trainings available through the Department
- Implicit bias
- The concept of client culture, which refers to the clients' personal experience on topics such as wellness, recovery, stigma, discrimination, trauma, medication, hospitalization, etc.
- Mental Health Statistical Improvement Program (MHSIP) consumer satisfaction survey items related to cultural competency and reduction of disparities
- MHSA Plans and programs that advance cultural competency and reduce mental health disparities within LACDMH
- Knowledge of Departmental committees, subcommittees, and taskforces that focus on the needs of underserved populations (i.e. CCC and the UsCC subcommittees)
- Information and recommendations gathered from interviews and focus groups conducted with key consumer/stakeholder groups and Departmental committees identified by LACDMH

The tool is scheduled to be rolled out in the last quarter of FY 18-19. The data outcomes and recommendations from the CC Organizational Assessment will guide future cultural and linguistic competence strategies to reduce mental health disparities.

2) <u>CC Plan Presentations</u>

The ESM, in collaboration with the OAO-QID managers, developed a PowerPoint presentation to introduce the LACDMH Cultural Competence Plan to all the SA QICs. Presentations started in November 2017 and were completed by March 2018. The presentation covered the following topics focusing on the eight criteria of the CC Plan:

- Departmental commitment to cultural competence
- Updated assessment of service needs
- Strategies and efforts for reducing racial, ethnic, cultural and linguistic mental health disparities
- Client/family member/community committee: Integration of the committee within the County mental health system
- Culturally competent training activities

- County's commitment to growing a multicultural workforce: hiring and retaining culturally and linguistically competent staff
- Language capacity
- Adaptation of services

This presentation was also utilized as a tool to educate providers about the requirement for 100% of the LACDMH workforce to receive annual cultural competence training inclusive of clerical/support, financial, clinical/direct service, and administration/ management at DO and LE Contracted programs.

3) UsCC Graduate Recruitment Program

This college reimbursement program was designed for individuals from unserved/underserved communities to become Master's level mental health providers. Awardees received up to $37,000 for two years of Master's program education and were representative of the following underserved groups: African/African American (AAA), American Indian/Alaska Native (AI/AN), Asian Pacific Islander (API), Eastern European/Middle Easterner (EE/ME), Latino, and Lesbian/Gay/Bisexual/ Transgender/Questioning/ Intersex/Two-Spirit (LGBTQI2-S).

A total of sixty applications were received. The distribution of applications received by underserved group is listed below. In parenthesis, is the number of individuals awarded:

- Latino – 27 (4)
- AAA – 6 (1)
- API – 13 (5)
- EE/ME – 4 (0)
- AI/AN – 4 (2)
- LGBTQI2-S – 6 (3)
- Deaf/Hard of Hearing – (0)

No applications were received from the deaf/hard of hearing community, although outreach was extensive and targeted to the following agencies/universities: Greater Los Angeles Deaf, Five Acres, John Tracy Clinic, Awakenings, Mount San Antonio College, and CAL State Northridge.

In collaboration with the WET Division, the ESM from the CCU was one of six LACDMH employees who assisted with the scoring of applications. The ESM reviewed the 27 applications received for the Latino UsCC group and conducted face-to-face interviews for candidates with the highest application scores.

4) EQRO Review

The CCU actively participated in the annual EQRO Reviews that took place in April 2017 and September 2017. The Unit coordinated the collection of reports from 25 programs regarding strategies to reduce mental health disparities, consumer utilization data, and cultural competence staff trainings. The CCU also provided technical assistance to these programs for the proper completion of these reports. The collective information gathered was utilized for the 2017 LACDMH CC Plan

Update and EQRO evidentiary documentation. Additionally, the ESM provided a presentation on the CCU's activities in the disparities session of the EQRO Reviews.

5) Cultural Competency Trainings and Community Presentations

A. New Employee Orientation (NEO)

The CCU participated in NEO by providing bi-monthly one-hour long cultural competence trainings that introduce new employees to the functions of the CCU, the County of Los Angeles demographics, threshold languages, the CLAS Standards, the CCPR, and the Department's strategies to reduce mental health disparities.

B. University of Southern California (USC) Suzanne Dworak - Peck School of Social Work – October 18, 2017. This cultural competence training was developed for approximately 20 Master's level students. The ESM conducted the training and covered the following topics:

- Introduction and definitions
- Federal, State and County regulations pertinent to cultural competency
- The CLAS Standards
- LACDMH strategies to reduce mental health disparities
- Cultural humility
- The client culture and stigma
- Elements of cultural competency in service delivery
- County of Los Angeles and LACDMH demographics
- How cultural competency applies to service delivery

C. Public Defender – June 22, 2017

The training was provided to 38 Public Defenders Office staff inclusive of the Division Chiefs, Head Deputies, Administration, Supervising Paralegals, and Assistant Public Defenders. Topics of the presentation included concept of cultural competency at the individual and organizational levels, Los Angeles County demographics, threshold languages, cultural humility, and stigma.

6) May Mental Health Community Event

A. Know the Five Signs/Change Direction Campaign – May 2017

LACDMH was a co-sponsor for the Change Direction Campaign. This national initiative promoted the recognition of the five signs of emotional suffering (i.e. not feeling like oneself, feeling agitated, withdrawing from others, not taking care of oneself, and feeling hopeless). It also highlighted the five healthy habits of emotional wellbeing (i.e. taking care of oneself, checking in with someone who cares, engaging with others, making time to relax, and knowing the signs of emotional suffering). The CCU recruited LACDMH bilingual certified staff to review the quality of campaign materials translated in six threshold languages: Cambodian, Farsi, Simplified Chinese, Russian, Tagalog, and Vietnamese.

B. Radio Campaign on Mental Health

- Pierce College – May 2017: a live 30 minute segment aired by the radio station on campus which promoted mental health among college students, highlighted the

effects of untreated mental illness, addressed stigma reduction, and identified nearby mental health resources.

- The Latino UsCC Media Campaign Project - KTNQ, Dr. Navarro – May to July 2017: a series of eight segments dedicated to topics relevant to the Latino community such as:
    - Reasons for underutilization of mental health services by the Latino community
    - The impact of bullying on children and adolescents
    - Cultural diversity within Los Angeles County
    - Promoting healthy self-esteem in children
    - Sibling relationships
    - The quality of spousal relationships and their influence on children's emotional wellbeing
    - Communication and conflict resolution techniques
    - Workplace stress and its impact on family dynamics
- Univision – May 2017: a pre-recorded 30 minute segment in Spanish on the importance of mental health and stigma reduction

7) CCC Administrative Oversight

The CCU continued providing on-going technical assistance and administrative oversight conducive to the attainment of the Committee's goals and objectives. The ESM monitored all activities pertaining to the CCC and provided updates on the CCU's projects as well as cultural competency initiatives at the State and County levels during CCC meetings. The ESM also participated in the CCC Leadership meetings with the Co-Chairs and the OAO Director to plan meeting agendas, objectives and activities of the committee. Additionally, the ESM developed the CCC annual report which included demographics regarding the ethnicity, gender, cultural expertise, and languages represented by the membership as well as the goals and activities of the committee.

8) Provision of Technical Assistance for Various LACDMH Programs

- SA QICs and Service Providers: provided guidance regarding the Title IX requirements for annual cultural competence trainings and facilitating access to the QID-CCU's Cultural Competence 101 training videos
- Emergency Operations Bureau – Disaster Services Unit: assisted in the development of the fact sheet titled "Providing Effective Services to Members of the LGBTQI2-S Community Following Disasters, Public Health Emergencies, and Mass Fatality Events"
- UsCC Unit: reviewed and provided feedback for the INN 2 Strategy 7 service exhibit: "Culturally Competent Non-Traditional Self-Help Activities for Families with Multiple Generations Experiencing Trauma"
- Participated in the Implicit Bias/Cultural Competence Summit planning committee from July to August 2017
- Participated in the Latino Coalition question-and-answer segment with the Office of Performance Data managers

9) Data Collection, Analysis and Reporting of Preferred Language Requests

The CCU continued the collection and analysis of all the preferred language requests reported by LACDMH providers via their Initial Request & Referral Logs for Culture Specific Mental Health Services. The Unit produced monthly and annual summaries of the total requests for preferred threshold and non-threshold languages by SA. These reports are utilized to track the language requests from LEP consumers at the time they access mental health services.

**The OAO-QID Underserved Cultural Communities (UsCC) / Innovations (INN 2) Units**

Background: One of the cornerstones of the Mental Health Services Act (MHSA) is to empower Under Represented Ethnic Populations (UREP). In June 2007, the Department established an internal UREP Unit. As of January 2016, UREP was renamed as Underserved Cultural Communities Unit (UsCC) to be inclusive of all cultural communities. The UsCC Unit has established subcommittees dedicated to working with the various underserved ethnic and cultural populations in order to address their individual needs. These subcommittees are: African/African American; American Indian/Alaska Native; Asian Pacific Islander; Disabilities; Eastern European/Middle Eastern; Latino; and Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two Spirit (LGBTQI2-S).

Each UsCC subcommittee is allotted one-time funding totaling $100,000 per FY to focus on Community Services and Supports (CSS) based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals are created and submitted via a participatory and consensus-based approach. The following are the projects implemented:

**I. African/African-American (AAA) UsCC Subcommittee**

**For FY 16-17** the following projects have been approved and implementation has been underway since September 1, 2016:

Black Male Mental Health Awareness Campaign – This project will increase mental health awareness and spread learning through community presentations in Los Angeles County. The project will outreach to Black males 16 years old and older via community presentations. It will target those who are not currently involved in the public mental health system, but who might benefit from learning more about mental health.

**Outcomes:**

- A total of 144 community members attended a community Town Hall meeting to discuss the mental health needs of Black males ages 16 and older.
- Of those who attended the Town Hall meeting, 19 Black males were recruited and trained on basic mental health education. After their training, they became Community Advocates for Mental Health.
- Once trained, the Community advocates for Mental Health conducted a total of 12 different countywide community presentations between February 20, 2017 and May 19, 2017.
- A total of 318 community members attended the mental health presentations conducted by the Community Advocates and learned about basic mental health issues affecting Black males and how to access mental health services.

African American Women Leadership and Wellness Mental Health Outreach Project - The objective of this project is to engage and empower African American women to seek mental health services. This is a countywide advocacy, leadership, holistic wellness,

spirituality and mental health outreach project for African American women ages 18 years and older. It aims to break down stigma related to mental health services among African American women.

**Outcomes:**

- A total of 24 countywide community workshops were conducted on basic mental health education and wellness activities that incorporated spirituality & traditional cultural practices.
- A total of 128 community members participated in the workshops.
- A Mental Health Resource Guide was distributed during the workshops to encourage community members to access mental health services.
- The workshops took place in schools, churches, counseling agencies, universities, and community based organizations.

African Immigrants and Refugees Mental Health Outreach Projects: This was a mental health outreach project for African immigrants and refugees from Nigeria, Somalia, Ethiopia, Liberia, and Ghana. The purpose of this project was to outreach and provide mental health awareness, education, linkage and referral services to these underserved groups in a non-stigmatized manner using culturally sensitive techniques designed to improve and sustain their quality of life.

**Outcomes:**

- By implementing grassroots outreach and engagement methods, 15 community mental health workshops were completed.
- A total of 400 community members, who identified as Nigerian, Somali, Ethiopian, Liberian, and/or Ghanaian were outreached to as a result of this project.
- Overall, this project engaged and empowered African immigrants and refugees, who may have a history of pre and post migration trauma as a result of political conflicts in their country of origin.
- The project enabled underserved and marginalized African immigrant groups to access mental health services for themselves and empower other members of their communities to access services.

AAA Mental Health Informational Brochures: This project was initiated in FY 15-16 and it was implemented in FY 16-17. Brochures were used to outreach and engage underserved, inappropriately served and hard-to-reach AAA ethnic communities such as African-American, African immigrants, and Pan-African community members. The brochures were used to educate and inform these ethnically diverse communities on the benefits of utilizing mental health services and provided referrals and contact information. The informational brochures were translated into two different African languages: Amharic and Somali.

**Outcomes:**

- 5,000 Brochures were printed.
- 4,700 have been distributed as of May 2018.

Life Links: Resource Mapping Project: This project has been continued for four consecutive years since the initial implementation. Funds were allocated to develop a community resource directory called Life Links. Community resources, service providers, and agencies were identified in South Los Angeles County, where there is a large African/African-American (AAA) population. This directory, of approximately 300 services and listings of unique interest to specific cultural groups, includes names, addresses, contact information, hotlines and toll-free numbers. This community resource directory has been updated 4 times and the fifth reprint is scheduled for June 2018.

**Outcomes:**
- 7,000 booklets were printed.
- Over 6,670 booklets have been distributed as of May 2018.

**American Indian/Alaska Native (AI/AN) UsCC Subcommittee**
AI/AN TV and Radio Media Campaign: The AI/AN UsCC subcommittee funded a TV and Radio Media Campaign for FY 16-17. The campaign was launched on May 4, 2017 and was completed on July 2, 2017. The AI/AN commercials were aired on CBS, KCAL, and KNX 1070.

**Outcomes:**
- KCAL and CBS ran a total of 542 commercials, Billboards and Snipes
- These commercials reached 85.7% of the Los Angeles Households with 37,742,000 Impressions
- These Households saw the TV exposure with a frequency of 2.9 times
- KNX 1070 ran a total 671 commercials and 260 streaming commercials
- Of these, 98 were included as added value
- The radio commercials delivered 21,668,000 Impressions and reached 2,870,400 unduplicated adults an average of 9.7 times during the campaign period
- The digital ad banners and streaming on the companion cbsla.com website provided 611, 296 Impressions

AI/AN Bus Advertising Campaign: The bus advertising campaign took place during 12 weeks in March-May, 2017. It included the following: 40 taillight bus displays, 10 king-size bus posters, and 400 interior bus cards. It also included an additional 400 interior bus cards for 12 weeks from June-August, 2017 at no additional cost. The goal of this advertising campaign was to promote mental health services, increase the capacity of the public mental health system in Los Angeles County, increase awareness of the signs and symptoms of mental illness, and reduce the stigma associated with mental health conditions for the AI/AN community. This 12-week advertising campaign educated and provided linkage and referrals to AI/AN community members.

**Outcomes:**
- A total of 28,128,300 impressions were delivered
- Advertising took place primarily in the following cities: Bell, Bell Gardens, Cerritos, City of Commerce, Downtown Los Angeles, Gardena, Long Beach, Los Angeles, Santa Fe Springs, South Gate, and Whittier.

AI/AN Mental Health Conference: One of the recommendations of the AI/AN UsCC subcommittee was to plan and coordinate the 2017 American Indian / Alaska Native Mental Health Conference: "Bridging the Gaps – Systems, Cultures, and Generations."

**Outcomes:**
The purpose of the conference included the following: to inform participants of mental health issues unique to the AI/AN community, to improve participants' ability to recognize when to refer an AI/AN community member for mental health services, to provide participants with useful information on available mental health resources for AI/AN community members, and to improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers. A survey was handed out to all participants at the start of the conference. The survey was anonymous and voluntary. In total, 265 individuals attended the conference and of those, 119 completed surveys.

- 95% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the AI/AN community.
- 88% agreed or strongly agreed that the conference improved their ability to recognize when to refer an AI/AN community member for mental health services.
- 95% agreed or strongly agreed that they received useful information on mental health resources for AI/AN community members.
- 97% agreed or strongly agreed that as a result of the conference, they had a better understanding of where to refer AI/AN community members to mental health services.
- 95% agreed or strongly agreed that the conference improved their ability to provide culturally-appropriate mental health treatment to AI/AN consumers.

## III. Asian Pacific Islander (API) UsCC Subcommittee

The Multimedia Mental Health Awareness Campaign for the Cambodian and Vietnamese Communities: This project was implemented on September 1, 2016 and was completed on September 30, 2017. The Multimedia Mental Health Awareness Campaigns included linguistically and culturally appropriate mental health education and engagement workshops and an ethnic media campaign, including mental health awareness Advertisements (Ads) on Television and Radio and Newspaper Articles, that targeted the Cambodian and Vietnamese communities in Los Angeles County. The purpose of this project was to increase awareness and knowledge of the signs and symptoms of mental illness, and for improved access to mental health services for the Cambodian and Vietnamese communities in Los Angeles County.

**Outcomes:**

- 22 mental health education workshops were held, 11 in Khmer for the Cambodian community and 11 in Vietnamese for the Vietnamese community.
    - Of the 238 participants surveyed, 58% were female and 42% were male
    - Of the 238 participants surveyed, 55% were older adults, 37% were adults, and 8% were TAY (16-25)
    - Of the 238 participants surveyed, 45% were Cambodian, 29% were Vietnamese, and 26% were Chinese

- 238 Pre-Test and 238 Post-Test surveys were collected by workshop participants to assess the impact on their knowledge about the risk factors related to mental illnesses and the importance of prevention.
- Before the workshops, 42% of participants were aware of risk factors that can affect a person's mental health. After the workshops, 97% of participants were aware of the risk factors that can affect a person's mental health, which is an increase of 55%.
- Before the workshops, 36% of participants were aware of how biological factors can affect a person's mental health. After the workshops, 98% of participants were aware of how biological factors can affect a person's mental health, which is an increase of 62%.
- Before the workshops, 39% of participants understood how a person's mood can affect their mental health. After the workshops, 98% of participants understood how a person's mood can affect their mental health, which is an increase of 59%.
- Before the workshops, 38% of participants understood how a person's environment can affect their mental health. After the workshops, 95% of participants understood how a person's environment can affect their mental health, which is an increase of 57%.
- Before the workshops, 35% of participants were aware of how they can help prevent mental health problems. After the workshops, 98% of participants were aware of how they can help prevent mental health problems, which is an increase of 63%.
- A Cambodian Mental Health Radio Ad and a Vietnamese Mental Health TV Ad were developed. The Cambodian Ad was aired 257 times on FM 106.3, which airs a Khmer Radio program. The Vietnamese TV Ad was aired 5,320 times on Saigon TV, which targets the Vietnamese community.
- Four (4) newspaper articles were published in local newspapers. Two articles were published to target the Cambodian community using the Khmer Post and Khmer Voice newspapers. The other two articles were published targeting the Vietnamese communities using the Viet Bao newspaper.

<u>The Samoan Outreach and Engagement Program:</u> In 2017, LACDMH utilized CSS funds to continue the Samoan Outreach and Engagement Program in order to increase awareness of mental illness, knowledge of mental health resources and decrease stigma related to mental health in the Samoan community. LACDMH contracted with Special Services for Groups (SSG) who partners with two Samoan community-based agencies to conduct individual and group outreach and engagement activities with the Samoan community in Service Area 8, which has the largest concentration of Samoans within the County of Los Angeles. This program completed its second year of implementation on June 30, 2017 during which 483 mental health education workshops were conducted and 2,182 individuals were reached. Workshop activity topics included mental health awareness, stress management, depression, peer pressure, grief and loss, mental health myths and facts, mental health stigma, mental health resources, and suicide. Most of the activities were provided in Samoan (51%). Activities were held at various community locations including: churches (61% of activities), community member homes (18%), Samoan agency offices, community centers, and other community locations (parks, etc.). Attendees were mostly adults (84%), females (59%) and Samoans (94%) who speak English as their primary language (55%).

**Outcomes:**

- For FY 16-17, all workshop attendees were given a survey to complete to assess the impact of the workshops.
- 100% strongly agree or agree that their knowledge of mental health issues in the community has increased as a result of the activity.
- 100% strongly agree or agree that their knowledge about mental health services available for the Samoan community has increased as a result of the activity.
- 100% strongly agree or agree that they can better recognize the signs of mental health issues as a result of the activity.
- 99% strongly agree or agree that they know where to go for help with mental health issues (for themselves or others) as a result of the activity.
- 99% strongly agree or agree that they can be more accepting of someone with mental health issues (themselves included) as a result of the workshop.
- 98% strongly agree or agree that Samoan culture can influence how one views mental health.
- 99% strongly agree or agree that stigma (shame) can keep individuals from getting help for mental health issues.
- 99% strongly agree or agree that stigma (shame) can keep individuals feeling bad about themselves if they experience mental health issues.
- 99% strongly agree or agree that seeking help for mental health issues is important.
- Starting FY 17-18, enrollment data was collected instead of survey data. There were two individuals enrolled into mental health services, as a result of the workshops as of August 2017.

## IV. Disabilities UsCC Subcommittee

The Physical Disabilities UsCC was established January 1, 2018 and held its first UsCC subcommittee meeting on January 30, 2018. The goal of this subcommittee is to reduce disparities and increase mental health access for those affected by Physical Disabilities. This group will work closely with community partners and consumers in order to increase the capacity of the public mental health system, to develop culturally relevant recovery oriented services specific to the Physically Disabled community, and to develop capacity building projects. As of March 1, 2018 this subcommittee is actively recruiting new members and exploring future capacity building project ideas.

## V. Eastern European/Middle Eastern (EE/ME) UsCC Subcommittee

Mental Health Education and Stigma Reduction Project for Arabic Speaking College Students: This project was funded to increase mental health awareness, and reduce disparities among Arabic-speaking community members in the County of Los Angeles. It was implemented on September 15, 2016 and continued until June 19, 2017. The project included presentations conducted at local colleges and universities, with the goal to increase awareness and educate Arabic speaking college students (ages 18-30) about mental health, recognition of mental health signs and symptoms and how to access services from Los Angeles County Department of Mental Health. These presentations were conducted by college students (using a Peer-to-Peer model), who were trained by a mental health expert. Some of the topics presented in the project were the following:

anxiety, depression, mental health awareness, and stigma to mental health. This project educated Arabic speaking college students who may need mental health services, but are unable or unwilling to access these services due to stigma, lack of education and awareness, and/or cultural/religious barriers.

**Outcomes:**

- In total, 17 one-hour mental health presentations were conducted at local colleges and universities across Los Angeles County.
- Eight (8) Arabic speaking college students were recruited and trained on basic mental health education. The students were provided with a total of 6 hours of training.
- The presentations took place at University of Southern California, Cal Poly Pomona, University of California, Los Angeles, and Glendale Community College. There were also presentations conducted at a local mosque.
- Attendees of these presentations were asked to complete a pre and posttest survey to capture the level of knowledge gained and if their attitude towards mental health changed.
- A total of 103 matched pair (pre and post) surveys were collected.
- The post-test results indicated that the participants had an increase in knowledge about mental health issues and there was a positive improvement in their attitude toward mental health.
- The post-test results indicated that after attending a mental health presentation, most students reported that they would feel more comfortable living next door to a person with a mental illness.
- The results of the pre and posttest indicated a positive shift in the attitude toward receiving psychotherapy among all those students who participated and completed the surveys.
- In general, the presentations had a positive impact on the Arabic Speaking Students. Many of the participants were grateful to have learned about the most prevalent mental health issues. Due to the knowledge gained from the presentations, participants reported an understanding of some basic mental health symptoms, and ability to recognize when to ask for mental health assistance for themselves and/or someone else.
- A total of 112 students participated in the community presentations and their age ranged from age 14 to age 42.

<u>The Armenian Talk Show Project Part II:</u> This project consisted of 44 DMH approved mental health TV talk shows to inform the Armenian community about common mental health issues and how to access services in the County of Los Angeles. The media project was an expansion of a similar project that was funded in FY 14-15. The Armenian Talk Show Project Part II included mental health topics such as eating disorders, terminal illness and mental health, intergenerational conflict, mental illness and family support and caregiver stress. These mental health topics provided an opportunity for the Armenian Community to be further educated and informed of the mental health issues that are currently impacting their community. These shows also provided the viewers with linkage and information about mental health services in the County of Los Angeles, including the LACDMH 24-hour ACCESS line phone number. In addition, the most popular 44 episodes of the Armenian Mental Health Show from two seasons were re-aired from April

15, 2017 to September 9, 2017. The shows were broadcasted in areas in the County of Los Angeles with the largest concentration of Armenians such as La Canada, Burbank, North Hollywood, Glendale, Pasadena, Los Angeles, and Montebello).

**Outcomes:**

- The mental health shows had great success within the Armenian community living in Los Angeles County.
- Between September 16, 2016 and April 5, 2017, a total of 44 half an hour mental health shows aired on the local Armenian television station.
- Based on the feedback provided by TV viewers, Armenian community members felt that the talk shows were culturally relevant, educational and thought-provoking.
- The community expressed gratitude for airing the reruns of this show and reported that it expanded their knowledge regarding mental health, how these issues present within the Armenian Community, and how community could access services from LACDMH.
- It was reported by LACDMH's 24/7 ACCESS line that Armenian community members were calling and asking to speak with the clinical psychologist who served as a co-host of these shows.

Farsi Peer-Run Outreach Project: This project trained Farsi speaking volunteers to conduct mental health presentations and provide linkage and referral services. The purpose of the project was to assist Farsi speaking community members in need of mental health services, since they were unable or unwilling to obtain the information and resources due to stigma, lack of education or awareness, and/or language barriers. The project included a 20-hour training curriculum to train Farsi speaking volunteers to conduct the mental health presentations. These volunteers were trained to become Peer Outreach Workers. Their primary role was to educate Farsi speaking community members on basic mental health information and available resources. Due to this training, the community members had the opportunity to work with and learn from someone (peer) from their community, who speaks the Farsi language and has an understanding of the cultural barriers to accessing mental health services.

**Outcomes:**

- A total of sixty (60) presentations were completed by the volunteers
- The pre and post survey questionnaires were provided at the beginning and at the end of the presentations. It included 5 closed ended questions
- A total of 407 matched pair (pre and post) surveys were collected
- The pre-tests indicated that the majority of the community members (56%) either "disagreed," "strongly disagreed" or had "no opinion" in regards to therapy being as beneficial for healthy, stable, successful people, as much as it is for people suffering from serious mental illness.
- In contrast, the post tests indicated a high number of participants (96%) who "strongly agreed" or "agreed" with this same statement.
- The pre-tests also indicated that a large number of community members (97%), did not know the difference between psychologists, therapists, psychiatrists, and social workers. Additionally, they were not aware of two places where they can find affordable mental health services that are culturally and linguistically appropriate for

them (97%).

- In contrast, the post-tests indicated that the majority of participants (90%) had gained knowledge about the differences between mental health professionals. Also, 98% had gained knowledge on where to access culturally and linguistically appropriate mental health services.
- In regards to "accessing mental health services is not a sign of weakness," again, the pre-tests indicated that only 16% of participants either "agreed" or "strongly agreed" with this statement; while the post-tests indicated that the overwhelming majority (98%) either "agreed" or "strongly agreed" with this statement.
- The pre-tests indicated that the majority of participants (66.5%), either had "no opinion," "strongly disagreed," or "disagreed" with the statement that "problems like depression and anxiety can get better if a person attends therapy;" while the vast majority (90%), indicated in post-tests that they "strongly agreed" or "agreed" with this statement.
- The results indicated that the majority of Farsi-speaking community members had little information about mental health, and there is cultural stigma related to mental illness and accessing mental health services. However, after the peer-run presentations were completed, majority of participants had a better understanding about mental health services and where to access these services in their communities.
- Participants gained a new awareness of how mental health services can benefit everyone and how they can access services and resources.
- A total of 415 community members participated in the presentations.

Mental Health Farsi Language Radio Media Campaign: This project consisted of three (3) different Public Service Announcements (PSA) in the Farsi language. The PSAs aired on a Farsi radio station 5 times – 8 times daily, from May 4, 2017 to July 30, 2017. The PSAs targeted Iranian/Persian communities of Los Angeles County. Each PSA provided culturally sensitive information, education, and resources about a specific mental health topic. The topics presented in the project were the following: mental health awareness, and domestic violence. The purpose of this Farsi language PSA project was to provide mental health education and information to the Farsi speaking community on how to access mental health services as stigma, lack of education and language barriers continue to be obstacles for this underserved community.

**Outcomes:**

- The PSAs had a large impact on the Farsi speaking community
- According to the ACCESS Center Language Line report, there was a significant increase in calls from Farsi speaking community members during the months of May 2017, June 2017, and July 2017, which was when the PSAs were aired.
- For example, there were a total of 31 Farsi speaking calls for the first four months of 2017 (January – April) and for May 2017 alone, there were 49 calls, 44 calls in June of 2017, and 25 calls in July of 2017.
- The PSAs offered the Farsi speaking community members the opportunity to learn of the services offered by Los Angeles County Department of Mental Health and it helped to increase awareness about several mental health issues within this community.

Mental Health Russian Language Television Media Campaign: This project consisted of four (4) different PSAs in the Russian language. The PSAs helped educate the Russian community and increase awareness of the signs and symptoms of mental illness, as well as reduce the stigma associated with mental health conditions with this underserved subgroup. The PSA's aired in a rotation and one PSA aired at least six times a day for three months, from April 25, 2017 to July 29, 2017, between the hours of 7 a.m. and 11 p.m. The PSAs included mental health education and information on topics such as general mental health information, depression, and anxiety. The PSAs informed consumers of existent mental health issues in the Russian community and resources available within the LACDMH.

**Outcomes:**

- As reported by the television station, the airing of the Russian PSAs had a great impact on the Russian and Russian-Armenian community.
- Four PSAs aired 6 times day between April 25, 2017 and July 29, 2017.
- As reported by the television station, they received many calls from viewers requesting information and referrals regarding the services offered by LACDMH.

**VI. Latino UsCC Subcommittee**

Latino 2017 Mental Health Awareness Media Outreach Campaign: For FY 16-17, the Latino UsCC subcommittee funded an additional Television and Radio Media Campaign. Univision Communications, Inc. was contracted to launch the Media Campaign that included TV, Radio and Digital elements. The project was launched on May 1, 2017 and completed on July 16, 2017. The commercials were aired on KMEX television station and KLVE, KRCD, and KTNQ radio stations. KMEX ran a total of 138 television commercials, a 2-day Homepage takeovers and Univision.com geo-LA/Local Los Angeles Rotation – in banner video, and Social Media. KLVE, KRCD, and KTNQ radio stations ran 501 commercials, and a 2-day Homepage takeovers and social media. In addition, a 3- minute interview with DMH's Ethnic Service Manager (ESM) was aired weekly on Dr. Navarro's program at KTNQ – 1020 Radio Station for nine (9) weeks from May 11, 2017 through July 2, 2017. Another 30-minute interview was aired on four (4) radio stations on June 12, 2017 and June 25, 2017.

**Outcomes:**

- The KMEX report shows that the television campaign delivered a total of 14,501,956 Impressions (the total number of times households were exposed to the commercials)
- The KLVE, KRCD, and KTNQ reports show that the radio campaign delivered a total of 12,200 impressions.
- Digital campaign delivered 1,106,234 impressions.
- A gross total of 15,620,390 Impressions were delivered from viewers and listeners.
- The media campaign reached millennials via digital, KLVE Motivational Monday social media posts and homepage takeovers via Univision.com and at the same time personally touched the 25-54 age group with their message on KMEX news and novellas.
- KTNQ 1020 AM live interviews on Tuesdays with DMH's ESM aired weekly on Dr. Eduardo Navarro's program were considered by Univision Communications, Inc.,

"jewels for the community" as it offered advice on topics of importance to the functioning of a happy family.

Latino UsCC Bus Advertising Campaign: For FY 16-17, the Latino UsCC subcommittee funded a Bus Advertising Campaign to promote mental health services, increase the capacity of the public mental health system, and reduce stigma. The campaign began on February 27, 2017 and ended on October 8, 2017. It includes the following: 172 taillight bus displays, 56 king-size bus posters, and 4,000 interior bus cards for a total of 32 weeks (that includes an additional 2,000 interior bus cards for 12 weeks at no additional cost).

**Outcomes:**

- 43 Bus tails, 16 weeks = 3,832,332 impressions
- 14 Bus kings, 16 weeks = 4,410,672 impressions
- 500 Interior bus cards, 32 weeks = 13,676,000 impressions
- The campaign delivered a total of 21,919,004 impressions

**VII. Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning, Intersex, Two-Spirit (LGBTQI2-S) UsCC Subcommittee**

LGBTQI2-S Radio Media Campaign: The LGBTQI2-S UsCC subcommittee funded a Radio Media Campaign for FY 16-17. The campaign was launched on May 4, 2017 and was completed on July 2, 2017. The LGBTQI2-S commercials were aired on KNX 1070, KRTH 101, KCBS FM 93.1, KROQ 106.7, KAMP 97.1, and 94.7 The Wave.

**Outcomes:**

- In total, 878 commercials were aired
- KAMP 97.1 ran 136 commercials, KCBS 93.1 ran 132 commercials, KNX 1070 ran 161 commercials, KROQ 106.7 ran 129 commercials, KRTH 101 ran 136 commercials, and 94.7 The Wave ran 184 commercials
- The combined radio campaign reached an estimated 7,664,200 people
- 73.8% of the Los Angeles County population was reached an average of 4.3 times
- Total radio Impressions were 32,244,000
- The digital display banners on the companion websites to the radio stations delivered approximately 1,530,607 Impressions
- The audio streaming commercials delivered an additional 1,000,576 Impressions (2,531,183 digital Impressions total)

Community Mental Health Needs Assessment: The objective of the LGBTQI2-S Community Mental Health Needs Assessment Project was to outreach and engage people of color within the LGBTQI2-S population into a discussion regarding the needs of the community, as well as reduce stigma associated with mental health services. Additionally, this project aimed to increase awareness of the mental health needs of LGBTQI2-S individuals, increase connections with mental health providers, and provide opportunities to address concerns about mental health services. This project targeted both leaders and providers within the LGBTQI2-S community, as well as community members. The project included two components: a Community Leaders

Forum made up of leaders and providers who were brought together into a learning collaborative to discuss the needs of the community, as well as seven focus groups made up of people of color within the LGBTQI2-S community with the purpose of assessing the needs of LGBTQI2-S individuals, identifying gaps in access to mental health services, and identifying how to engage community members into mental health services provided by Los Angeles County Department of Mental Health.

**Outcomes**:

- Individuals were recruited from the following six communities: African-American, American Indian/Alaska Native, Armenian, Asian Pacific Islander, Iranian, Latinx
- Seven focus groups were conducted in total
- 61 people participated in the focus groups – 10 African-American participants, 10 American Indian/Alaska Native, nine Armenian, 12 Asian Pacific Islander, 11 Iranian, and nine Latinx
- The participants ranged in age from 18 to 60 and were representative of a broad gender spectrum
- The Community Leaders Forum took place on August 24, 2017 and was attended by 20 community leaders, providers, and community members
- As a result of the focus groups, numerous barriers were identified with regards to access to mental health services: stigma, transgenerational trauma, and limited availability of resources
- Recommendations were given related to engagement and marketing including developing culturally relevant materials, marketing on cultural and ethnic television stations and networks, marketing on social media for younger generations, conducting outreach at universities and schools, and attending culturally significant events such as pow wows
- Additionally, recommendations were given for the upcoming LGBTQI2-S Mental Health Conference being hosted by LACDMH. These recommendations included making the conference free to attend for community members, conducting intergenerational panels, providing information on how to address and treat transgenerational trauma, addressing homelessness, and many others.

Speak Your Mind Academy: The objective of the LGBTQI2-S Youth Speak Your Mind Academy Mental Health Outreach Project was to engage, empower, enlist, and enlighten the LGBTQI2-S Youth community, as well as to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County. The project included two components: training of 50 LGBTQI2-S Youth Advocates and, once trained, the Advocates conducted two community mental health presentations. The Youth Advocates were to be aged 18-25 years and from all eight Service Areas. The LGBTQI2-S Youth Advocates were individuals who identified as LGBTQI2-S and who had limited or no experience with LACDMH mental health services. The Academy covered basic mental health education including common diagnoses and symptoms, the power of advocacy, storytelling and public speaking, crisis identification/resolution, and outreach and engagement.

**Outcomes:**

- Twenty-three (23) LGBTQI2-S Youth were trained to become Mental Health Advocates and graduated from the Speak Your Mind Academy
- A total of 38 community presentations were completed by 10 of the Advocates
- The presentations took place in all eight Service Areas
- A total of 259 community members attended the presentations
- Participants of the presentations were asked to complete a survey/evaluation at the end of the presentation. In total, 132 surveys were completed and were overall very favorable
- Resources were provided at the presentations and included mental health resources, social support resources, and physical health resources

**QID Collaboration with CIOB**

In October 2017, the Data-GIS Unit was assigned to the Department's CIOB. The following QID activities require ongoing coordination and collaboration with CIOB:

1. Compiling system-wide information on consumers served and estimating populations in need of mental health services. The Data GIS Unit under CIOB oversight will annually calculate the population estimates for persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI), in addition to penetration rates by demographic categories: Age group, Gender, and Race/Ethnicity. Trend analysis is conducted on the Penetration Rate to assess fluctuations in service utilization by consumers. The Prevalence and Penetration Rates are also calculated for the eight (8) Service Areas and disseminated to the respective District Chiefs and Quality Improvement Liaisons for assessing unmet needs and related QI activities to address their needs.

2. Mental Health Service Utilization Rates are calculated by census tracts to conduct spatial analysis to estimate geographic areas in need of services. This information is used to estimate service delivery capacity and set targets for meeting the needs of underserved populations. CIOB will provide mapping support to all Divisions in the Department and conduct data analysis of services received by consumers by various geo-political boundaries in the County such as Supervisorial Districts, Service Areas, and Health Districts, Medically Underserved Areas, as well as Senate and Congressional boundaries. CIOB will continue to provide mapping support to the Health Neighborhood Project, EOTD and the Legislative Analyst Office for maps showing providers and consumers served by various jurisdictional boundaries.

3. CIOB will maintain and update the LACDMH Provider Directory of Specialty Mental Health Services (SMHS). The provider directory has information on Age Groups served, contact information, hours of operation and SMHS provided at each service location to enable consumers and the public to find appropriate mental health services in Los Angeles County. The provider directory by SA was disseminated as a hard copy to the SA QI Liaisons for distribution to providers for use by consumers and their family members, provider staff, and other stakeholders. This provider directory was also translated into 11 threshold languages and produced in large print format in February 2016. It is available on the internet at http://psbqi.dmh.lacounty.gov/providerdirectory.htm.

   The provider information can also be searched via the LACDMH Service Locator at http://maps.lacounty.gov/dmhSL/.

   Information on this Online Service Locator can be translated into 90 or more languages, including the LACDMH threshold languages. This enables increased access for consumers seeking mental health services in non-English languages.

4. CIOB will facilitate the process of selecting a random sample for the bi-annual consumer satisfaction survey administration in Outpatient and Day Treatment Programs. The Bureau is also responsible for conducting data analysis of the seven

(7) domains of perception, consumer satisfaction, and preparing a final report. Additionally, CIOB will provide assistance with survey design and implementation and data support to LACDMH Divisions and Bureaus. In CY 2017, Consumer Perception Surveys (CPS) were conducted in May and November 2017. A data report for the May 2017 Consumer Perception Survey results was completed.

5. CIOB provides assistance with the 24/7 ACCESS Line Test Calls Project. The Test Calls Project is conducted annually in collaboration with the ACCESS Center and in accordance with California Code of Regulations, Title 9, Section 1810.405(d) and the State Performance Contract for timeliness and access to services requirements (Section A, 9a. and Section I, 4b. 1-4). Data for the project is gathered from SA QIC chairs via an online survey. The Data GIS Unit utilizes VOVICI, an online survey software, to develop and monitor test call data received. Results from the project are summarized on a quarterly basis.

**Summary**

The QI Work Plan Evaluation report that follows assesses the goals identified in the LACDMH Quality Improvement Work Plan for CY 2017. The foundation for this evaluation is presented in the context of population demographics, both Countywide and by Service Area, as well as other clinical and consumer satisfaction data, including trend data. Evaluation of the QI Work Plan provides a basis for establishment of goals and objectives for CY 2018.

## SECTION 2

## POPULATION NEEDS ASSESSMENT

The County of Los Angeles is the most populated county in the United States (US) with an estimated population of 10,227,450 people in Calendar Year (CY) 2016. The County consists of 88 incorporated cities and includes 4,058 square miles of land area.

Population density in the County, or the average number of people per square mile, is 2,440 as compared to 244 in the State of California.

Population distribution by Race/Ethnicity in the County of Los Angeles, as shown in Figure 1, is the highest among Latinos at 48.8%, followed by Whites at 26.7%, Asian Pacific Islanders (API) at 14.0%, and African Americans (AA) at 8.1%, Two or more races at 2.2% and Native Americans (NA) at 0.19%. The Two or more races group was added in CY 2016. In previous years, this Ethnic/race group was distributed among other non-Hispanic ethnic groups.

### Methods

Population and poverty estimates are derived from the American Community Survey (ACS) conducted by the US Census Bureau in CY 2016. Data for the Federal Poverty level (FPL) is reported for population living at or below 138% FPL. The population and poverty numbers were further adjusted locally by Hedderson Demographic Services and standardized to annual data provided by California's Department of Finance to account for local variations in housing and household income in the County of Los Angeles. Data for population living at or below 138% FPL is used to estimate prevalence of mental illness among the population eligible for Medi-Cal benefits under the Affordable Care Act (ACA). Population and poverty data is reported by each Service Area (SA), Race/Ethnicity, Age group, and Gender.

Threshold languages for each SA are identified for the population enrolled in Medi-Cal and consumers served by LACDMH. Title 9 of the California Code of Regulations (CCR) defines beneficiaries to be served in 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 consumers served in Outpatient Programs in Fiscal Year (FY) 16-17. The count of consumers served does not include those served in 24 Hour/Residential programs such as inpatient hospitals (both County and Fee-For-Service), residential facilities, Institutions of Mental Disease (IMD), Skilled Nursing Facilities (SNF), Psychiatric Health Facilities (PHF), and consumers served in Fee-For-Service (FFS) Outpatient settings.

The data presented in this section includes the following:

- Estimated Total Population by Race/Ethnicity, Age group, and Gender, in CY 2016
- Estimated Total Population living at or below 138% Federal Poverty Level (FPL) by Race/Ethnicity, Age group, and Gender, in CY 2016
- Estimated Prevalence of Serious Emotional Disturbance (SED) in Children and Youth, and Serious Mental Illness (SMI) in Adults and Older Adults for Total Population and Population living at or below 138% FPL
- Population enrolled in Medi-Cal by Race/Ethnicity, Age group, and Gender
- Estimated Prevalence of SED and SMI among population enrolled in Medi-Cal by Race/Ethnicity, Age group, Gender, and Threshold Language
- LACDMH Threshold Languages spoken by Population enrolled in Medi-Cal
- Consumers served in Outpatient Programs by Race/Ethnicity, Age group, and Gender
- Primary Language of consumers served in Outpatient Programs by Service Area (SA) and Threshold Language

These data sets provide a basic foundation for estimating target population needs for mental health services.

Estimated Prevalence Rates for persons with SED and SMI are derived by using Prevalence Rates estimated by 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 2015 and CY 2016.

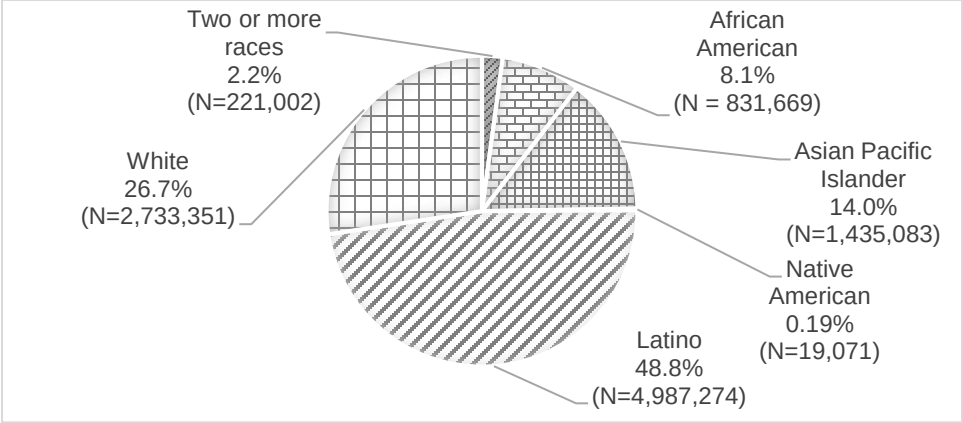
Penetration Rates are derived by applying Prevalence Rates for the ethnic, gender, or age groups to the demographic data for consumers served. These figures are helpful in understanding the needs of the target and underserved populations.

The use of trend analysis is useful towards understanding changes in population demographics and performance measures over a five-year period.

As of CY 2014, QI Work Plan goals related to Access and Penetration Rates have been set for population living at or below 138% FPL to account for expansion of services under the ACA.

## Total Population

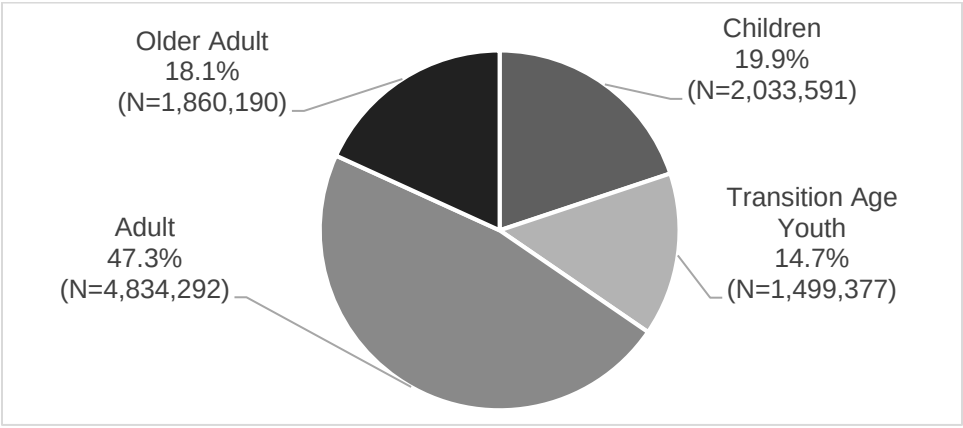
**FIGURE 1: POPULATION BY RACE/ETHNICITY**
**(N = 10,227,450)**
**CY 2016**




Data Source: American Community Survey (ACS), US Census, Bureau and Hedderson Demographic Services, 2017.

Figure 1 shows population by Race/Ethnicity for CY 2016. Latinos are the largest Ethnic group at 48.8%, followed by Whites at 26.7%, Asian Pacific Islanders (API) at 14.0%, African Americans at 8.1%, and Native Americans at 0.19%. Total population with two or more races was at 2.2%.

**FIGURE 2: POPULATION BY AGE GROUP**
**CY 2016**




Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2017.

Figure 2 shows population by Age group for CY 2016. Adults (26-59 years old) made up the largest Age group at 47.3%, followed by Children (0-15 years old) at 19.9%, Older Adults (greater than 60 years old) at 18.1%, and Transition Age Youth (TAY; 16-25 years old) at 14.7%.

**TABLE 1: POPULATION BY RACE/ETHNICITY AND SERVICE AREA**
**CY 2016**

| Service Area (SA) | African American | Asian/ Pacific Islander | Latino | Native American | White | Two or More Races | Total |
|---|---|---|---|---|---|---|---|
| **SA 1** | 59,641 | 15,195 | 177,425 | 1,524 | 127,772 | 10,853 | 392,410 |
| Percent | 15.2% | 3.9% | 45.2% | **0.39%** | 32.6% | 2.8% | 100.0% |
| **SA 2** | 75,808 | 248,161 | 910,155 | 3,762 | 944,468 | 56,726 | 2,239,080 |
| Percent | 3.4% | 11.1% | 40.6% | 0.17% | 42.2% | 2.5% | 100.0% |
| **SA 3** | 63,246 | 498,591 | 828,323 | 2,965 | 360,341 | 33,174 | 1,786,640 |
| Percent | 3.5% | **27.9%** | 46.4% | 0.17% | 20.2% | 1.9% | 100.0% |
| **SA 4** | 59,438 | 204,812 | 616,091 | 2,072 | 279,611 | 20,510 | 1,182,534 |
| Percent | 5.0% | 17.3% | 52.1% | 0.18% | 23.6% | 1.7% | 100.0% |
| **SA 5** | 35,962 | 90,209 | 106,686 | 982 | 402,530 | 27,567 | 663,936 |
| Percent | 5.4% | 13.6% | **16.1%** | 0.15% | **60.6%** | **4.2%** | 100.0% |
| **SA 6** | 277,813 | 19,043 | 734,900 | 1,491 | 24,813 | 10,900 | 1,068,960 |
| Percent | **26.0%** | **1.8%** | 68.7% | **0.14%** | **2.3%** | **1.0%** | 100.0% |
| **SA 7** | 38,424 | 116,306 | 968,103 | 2,676 | 172,795 | 14,646 | 1,312,950 |
| Percent | **2.9%** | 8.9% | **73.7%** | 0.20% | 13.2% | 1.1% | 100.0% |
| **SA 8** | 221,337 | 242,766 | 645,591 | 3,599 | 421,021 | 46,626 | 1,580,940 |
| Percent | 14.0% | 15.4% | 40.8% | 0.23% | 26.6% | 2.9% | 100.0% |
| **Total** | 831,669 | 1,435,083 | 4,987,274 | 19,071 | 2,733,351 | 221,002 | 10,227,450 |
| Percent | 8.1% | 14.0% | 48.8% | 0.19% | 26.7% | 2.2% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Ethnic group across Service Areas.
Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Race/Ethnicity

The highest percentage of African Americans (AA) was in SA 6 (26.0%) compared to SA 7 (2.9%) with the lowest percentage.

The highest percentage of Asian Pacific Islanders (API) was in SA 3 (27.9%) compared to SA 6 (1.8%) with the lowest percentage.

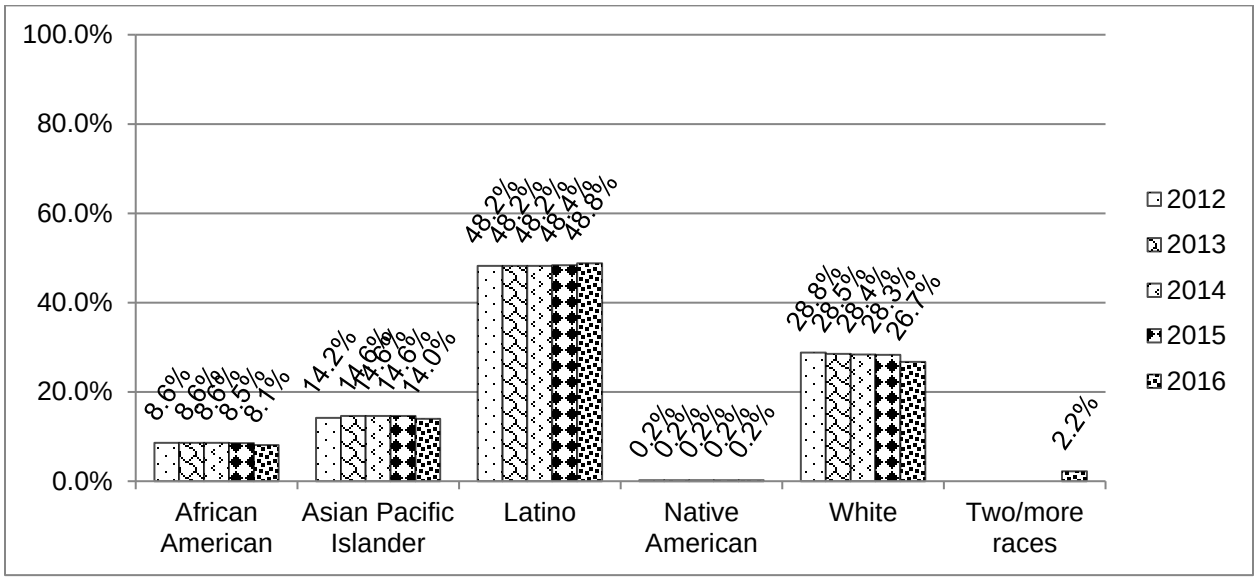
The highest percentage of Latinos was in SA 7 (73.7%) compared to SA 5 (16.1%) with the lowest percentage.

The highest percentage of Native Americans (NA) was in SA 1 (0.39%) compared to SA 6 (0.14%) with the lowest percentage.

The highest percentage of Whites was in SA 5 (60.6%) compared to SA 6 (2.3%) with the lowest percentage.

The highest percentage of Two or More Races was in SA 5 (4.2%) compared to SA 6 (1.0%) with the lowest percentage.

**FIGURE 3: POPULATION PERCENT CHANGE BY RACE/ETHNICITY**
**CY 2012 – CY 2016**




Note: The "Two or more races" Race/ethnic group was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

The percentage of African Americans in Los Angeles County has decreased by 0.5 Percentage Points (PP) over the past five years. African Americans represented 8.6% of the total population in CY 2012 and represented 8.1% of the population in CY 2016.

The percentage of Asian Pacific Islanders in Los Angeles County has decreased by 0.2 PP over the past five years. Asian Pacific Islanders represented 14.2% of the total population in CY 2012 and represented 14.0% in CY 2016.

The percentage of Latinos in Los Angeles County has increased by 0.6 PP over the past five years. Latinos represented 48.2% of the total population in CY 2012 and represented 48.8% in CY 2016.

The percentage of Native Americans in Los Angeles County has remained the same over the past five years. Native Americans represented 0.2% of the total population in CY 2012 and in CY 2016.

The percentage of Whites in Los Angeles County has decreased by 2.1 PP over the past five years. Whites represented 28.8% of the total population in CY 2012 and represented 26.7% in CY 2016.

Two or More Races in Los Angeles County represented 2.2% of the total population in CY 2016.

**TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA**
**CY 2016**

| Service Area (SA) | AGE GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0-18 | 19-20 | 21-25 | 26-59 | 60-64 | 65+ | Total |
| **SA1** | 110,197 | 13,981 | 35,874 | 171,312 | 20,585 | 40,461 | 392,410 |
| Percent | 28.1% | 3.6% | 9.1% | **43.7%** | 5.2% | 10.3% | 100.0% |
| **SA2** | 514,262 | 61,669 | 160,524 | 1,075,135 | 131,199 | 296,292 | 2,239,081 |
| Percent | 23.0% | 2.8% | 7.2% | 48.0% | 5.9% | 13.1% | 100.0% |
| **SA3** | 407,400 | 55,077 | 135,913 | 815,750 | 108,253 | 264,247 | 1,786,640 |
| Percent | 22.8% | 3.1% | 7.6% | 45.7% | **6.1%** | 14.7% | 100.0% |
| **SA4** | 245,571 | 27,711 | 76,283 | 631,047 | 58,802 | 143,120 | 1,182,534 |
| Percent | 20.8% | **2.3%** | 6.5% | **53.4%** | 5.0% | 12.0% | 100.0% |
| **SA5** | 117,865 | 22,615 | 42,100 | 338,176 | 39,068 | 104,111 | 663,935 |
| Percent | **17.8%** | 3.4% | **6.3%** | 50.9% | 5.9% | **15.7%** | 100.0% |
| **SA6** | 322,722 | 40,709 | 97,960 | 471,306 | 44,267 | 91,996 | 1,068,960 |
| Percent | **30.2%** | **3.8%** | **9.2%** | 44.1% | **4.1%** | **8.6%** | 100.0% |
| **SA7** | 348,313 | 42,628 | 108,455 | 590,669 | 65,345 | 157,541 | 1,312,951 |
| Percent | 26.5% | 3.2% | 8.2% | 45.0% | 5.0% | 12.1% | 100.0% |
| **SA8** | 384,931 | 44,807 | 115,401 | 740,897 | 87,525 | 207,378 | 1,580,939 |
| Percent | 24.3% | 2.8% | 7.2% | 46.9% | 5.5% | 13.2% | 100.0% |
| **Total** | 2,451,261 | 309,197 | 772,510 | 4,834,292 | 555,044 | 1,305,146 | 10,227,450 |
| Percent | 24.0% | 3.0% | 7.6% | 47.3% | 5.4% | 12.8% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Age group across Service Areas. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Age Group

The highest percentage of individuals between 0 and 18 years old was in SA 6 (30.2%) compared to SA 5 (17.8%) with the lowest percentage.

The highest percentage of individuals between 19 and 20 years old was in SA 6 (3.8%) compared to SA 4 (2.3%) with the lowest percentage.

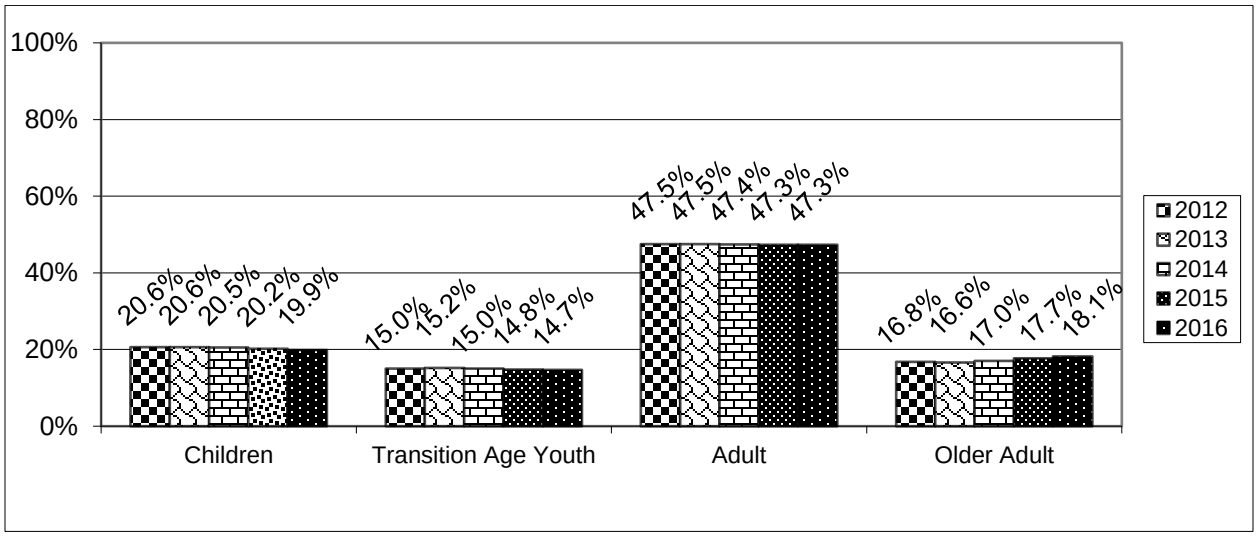
The highest percentage of individuals between 21 and 25 years old was in SA 6 (9.2%) compared to SA 5 (6.3%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old was in SA 4 (53.4%) compared to SA 1 (43.7%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old was in SA 3 (6.1%) compared to SA 6 (4.1%) with the lowest percentage.

The highest percentage of individuals age 65 years and older was in SA 5 (15.7%) compared to SA 6 (8.6%) with the lowest percentage.

**FIGURE 4: POPULATION PERCENT CHANGE BY AGE GROUP**
**CY 2012 – CY 2016**




Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

The percent of Children in Los Angeles County has decreased by 0.7 PP over the past five years. Children represented 20.6% of the total population in CY 2012 and represented 19.9% in CY 2016.

The percent of Transition Age Youth (TAY) in Los Angeles County has decreased by 0.3 PP over the past five years. TAY represented 15.0% of the total population in CY 2012 and represented 14.7% in CY 2016.

The percent of Adults in Los Angeles County has decreased by 0.2 PP over the past five years. Adults represented 47.5% of the total population in CY 2012 and represented 47.3% in CY 2016.

The percent of Older Adults in Los Angeles County has increased by 1.4 PP over the past five years. Older Adults represented 16.8% of the total population in CY 2012 and represented 18.1% in CY 2016.

**TABLE 3: POPULATION BY GENDER AND SERVICE AREA CY 2016**

| Service Area (SA) | Male | Female | Total |
|---|---|---|---|
| **SA1** | 195,044 | 197,366 | 392,410 |
| Percent | 49.7% | 50.3% | 100.0% |
| **SA2** | 1,109,320 | 1,129,761 | 2,239,081 |
| Percent | 49.5% | 50.5% | 100.0% |
| **SA3** | 872,756 | 913,884 | 1,786,640 |
| Percent | 48.8% | 51.2% | 100.0% |
| **SA4** | 607,499 | 575,035 | 1,182,534 |
| Percent | **51.4%** | **48.6%** | 100.0% |
| **SA5** | 322,044 | 341,891 | 663,935 |
| Percent | **48.5%** | **51.5%** | 100.0% |
| **SA6** | 522,008 | 546,952 | 1,068,960 |
| Percent | 48.8% | 51.2% | 100.0% |
| **SA7** | 645,437 | 667,514 | 1,312,951 |
| Percent | 49.2% | 50.8% | 100.0% |
| **SA8** | 774,282 | 806,657 | 1,580,939 |
| Percent | 49.0% | 51.0% | 100.0% |
| **Total** | 5,048,390 | 5,179,060 | 10,227,450 |
| Percent | 49.4% | 50.6% | 100.0% |

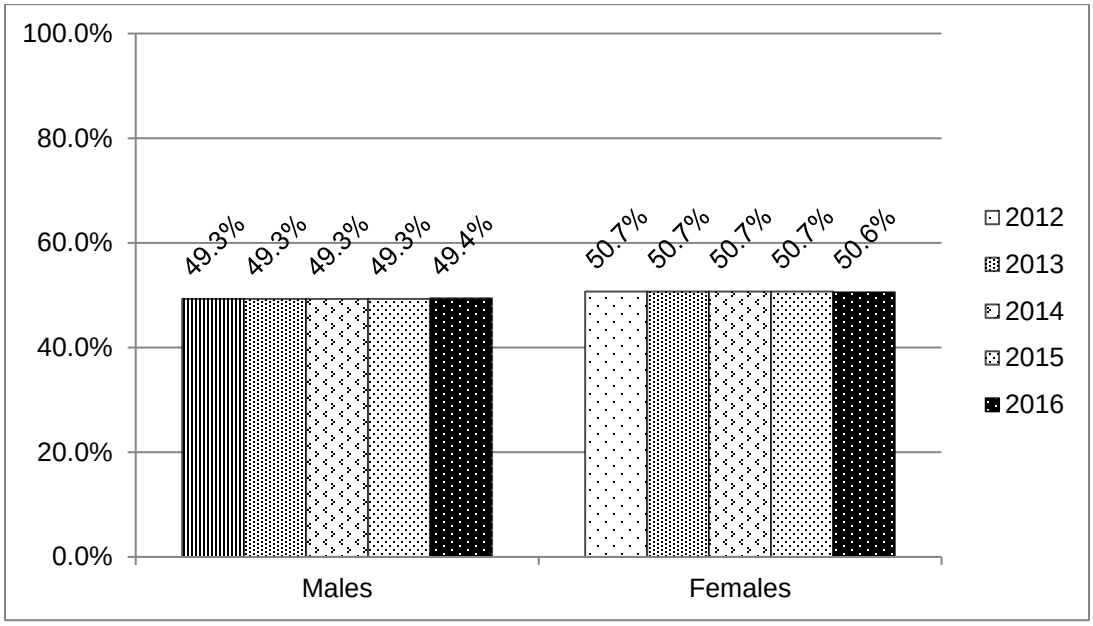
Note: Bold values represent the highest and lowest percentages within each Gender across Service Areas. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Gender

The highest percentage of Males was in SA 4 (51.4%) compared to SA 5 (48.5%) with the lowest percentage.

The highest percentage of Females was in SA 5 (51.5%) compared to SA 4 (48.6%) with the lowest percentage

**FIGURE 5: ESTIMATED PERCENT CHANGE AMONG TOTAL POPULATION BY GENDER CY 2012 – 2016**




Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

The percent of Males in Los Angeles County has increased by 0.1 PP over the past five years. Males represented 49.3% of the total population in CY 2012 and represented 49.4% in CY 2016.

The percent of Females in Los Angeles County has decreased by 0.1 PP over the past five years. Females represented 50.7% of the total population in CY 2012 and represented 50.6% in CY 2016.

## Estimated Population Living at or below 138% Federal Poverty Level (FPL)

**TABLE 4: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY RACE/ETHNICITY AND SERVICE AREA**
**CY 2016**

| Service Area (SA) | African American | Asian Pacific Islander | Latino | Native American | White | Two or More Races | Total |
|---|---|---|---|---|---|---|---|
| **SA 1** | 21,649 | 2,838 | 63,039 | 473 | 27,742 | 2,256 | 117,997 |
| Percent | 18.4% | 2.4% | 53.4% | **0.40%** | 23.5% | 1.9% | 100.0% |
| **SA 2** | 15,333 | 35,413 | 255,007 | 694 | 130,628 | 6,699 | 443,773 |
| Percent | 3.5% | 8.0% | 57.5% | 0.16% | 29.4% | 1.5% | 100.0% |
| **SA 3** | 11,588 | 86,424 | 193,457 | 492 | 45,217 | 3,364 | 340,543 |
| Percent | 3.4% | **25.4%** | 56.8% | 0.14% | 13.3% | 1.0% | 100.0% |
| **SA 4** | 15,988 | 56,116 | 238,115 | 764 | 58,108 | 3,852 | 372,943 |
| Percent | 4.3% | 15.1% | 63.8% | 0.20% | 15.6% | 1.0% | 100.0% |
| **SA 5** | 5,989 | 15,922 | 20,318 | 131 | 53,615 | 3,002 | 98,977 |
| Percent | 6.1% | 16.1% | **20.5%** | **0.13%** | **54.2%** | **3.0%** | 100.0% |
| **SA 6** | 105,516 | 8,063 | 351,269 | 778 | 8,577 | 3,177 | 477,380 |
| Percent | **22.1%** | **1.7%** | 73.6% | 0.16% | **1.8%** | 0.7% | 100.0% |
| **SA 7** | 7,843 | 14,519 | 291,231 | 658 | 23,699 | 1,374 | 339,325 |
| Percent | **2.3%** | 4.3% | **85.8%** | 0.19% | 7.0% | **0.4%** | 100.0% |
| **SA 8** | 59,767 | 37,895 | 200,821 | 849 | 44,538 | 5,790 | 349,661 |
| Percent | 17.1% | 10.8% | 57.4% | 0.24% | 12.7% | 1.7% | 100.0% |
| **Total** | 243,674 | 257,191 | 1,613,257 | 4,840 | 392,124 | 29,514 | 2,540,599 |
| Percent | 9.6% | 10.1% | 63.5% | 0.19% | 15.4% | 1.2% | 100.0% |

Note: Bold values represent the highest and lowest percentage within each Race/Ethnic group across Service Areas.
Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

### Differences by Race/Ethnicity

The highest percentage of African Americans living at or below 138% FPL was in SA 6 (22.1%) compared to SA 7 (2.3%) with the lowest percentage.

The highest percentage of Asian Pacific Islanders living at or below 138% FPL was in SA 3 (25.4%) compared to SA 6 (1.7%) with the lowest percentage.

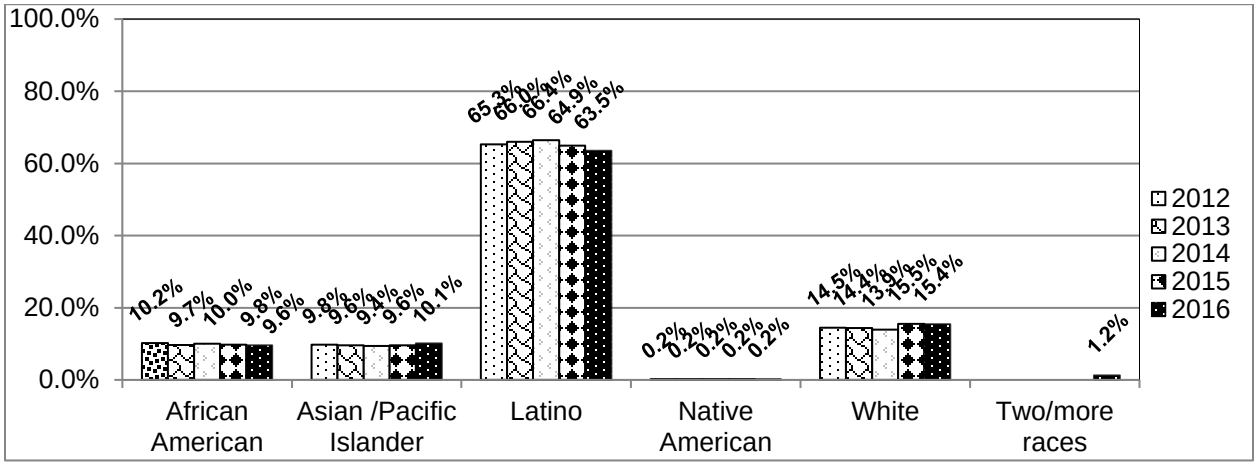
The highest percentage of Latinos living at or below 138% FPL was in SA 7 (85.8%) compared to SA 5 (20.5%) with the lowest percentage.

The highest percentage of Native Americans living at or below 138% FPL was in SA 1 (0.40%) compared to SA 5 (0.13%) with the lowest percentage.

The highest percentage of Whites living at or below 138% FPL was in SA 5 (54.2%) compared to SA 6 (1.8%) with the lowest percentage.

The highest percentage of Two or More Races living at or below 138% FPL was in SA 5 (3.0%) compared to SA 7 (0.4%) with the lowest percentage.

**FIGURE 6: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FPL BY RACE/ETHNICITY CY 2012-CY 2016**




Note: The "Two or more races" category was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

The percent of African Americans living at or below 138% FPL has decreased by 0.6 PP, from 10.2% in CY 2012 to 9.6% in CY 2016.

The percent of Asian Pacific Islanders living at or below 138% FPL has increased by 0.3 PP, from 9.8% in CY 2012 to 10.1% in CY 2016.

The percent of Latinos living at or below 138% FPL has decreased by 1.8 PP, from 65.3% in CY 2012 to 63.5% in CY 2016.

The percent of Native Americans living at or below 138% FPL has remained the same at 0.2% from CY 2012 to CY 2016.

The percent of Whites living at or below 138% FPL has increased by 0.9 PP, from 14.5% in CY 2012 to 15.4% in CY 2016.

Two or More Races living at or below 138% FPL represented 1.2 % in CY 2016.

**TABLE 5: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY AGE GROUP AND SERVICE AREA CY 2016**

| Service Area (SA) | Age Group | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0-18 | 19-20 | 21-25 | 26-59 | 60-64 | 65+ | Total |
| **SA 1** | 45,942 | 4,277 | 10,854 | 44,477 | 4,338 | 8,109 | 117,997 |
| Percent | 38.9% | 3.6% | 9.2% | 37.7% | 3.7% | 6.9% | 100.0% |
| **SA 2** | 143,401 | 12,712 | 35,242 | 194,636 | 18,202 | 39,580 | 443,773 |
| Percent | 32.3% | 2.9% | 7.9% | 43.9% | 4.1% | 8.9% | 100.0% |
| **SA 3** | 108,474 | 10,190 | 27,593 | 141,453 | 14,967 | 37,866 | 340,543 |
| Percent | 31.9% | 3.0% | 8.1% | 41.5% | **4.4%** | **11.1%** | 100.0% |
| **SA 4** | 112,323 | 9,063 | 26,622 | 175,414 | 14,154 | 35,367 | 372,943 |
| Percent | 30.1% | **2.4%** | **7.1%** | 47.0% | 3.9% | 9.5% | 100.0% |
| **SA 5** | 16,448 | 3,672 | 12,554 | 51,314 | 4,247 | 10,742 | 98,977 |
| Percent | **16.6%** | **3.7%** | **12.7%** | **51.8%** | 4.3% | 10.9% | 100.0% |
| **SA 6** | 201,091 | 16,431 | 43,542 | 177,312 | 14,543 | 24,461 | 477,380 |
| Percent | **42.1%** | 3.4% | 9.1% | **37.1%** | **3.2%** | **5.1%** | 100.0% |
| **SA 7** | 134,403 | 10,482 | 27,313 | 130,140 | 11,784 | 25,203 | 339,325 |
| Percent | 39.6% | 3.1% | 8.0% | 38.4% | 3.5% | 7.4% | 100.0% |
| **SA 8** | 126,013 | 10,820 | 28,647 | 144,607 | 12,979 | 26,595 | 349,661 |
| Percent | 36.0% | 3.1% | 8.2% | 41.4% | 3.7% | 7.6% | 100.0% |
| **Total** | 888,095 | 77,647 | 212,367 | 1,059,353 | 95,214 | 207,923 | 2,540,599 |
| Percent | 35.0% | 3.1% | 8.3% | 41.7% | 3.7% | 8.2% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Age group across Service Areas. Age groups relevant to the ACA are used in the 138% FPL table by contrast with other Age group tables. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Age Group

The highest percentage of individuals between 0 and 18 years old and estimated to be living at or below 138% FPL was in SA 6 (42.1%) compared to SA 5 (16.6%) with the lowest percentage.

The highest percentage of individuals between 19 and 20 years old and estimated to be living at or below 138% FPL was in SA 5 (3.7%) compared to SA 4 (2.4%) with the lowest percentage.

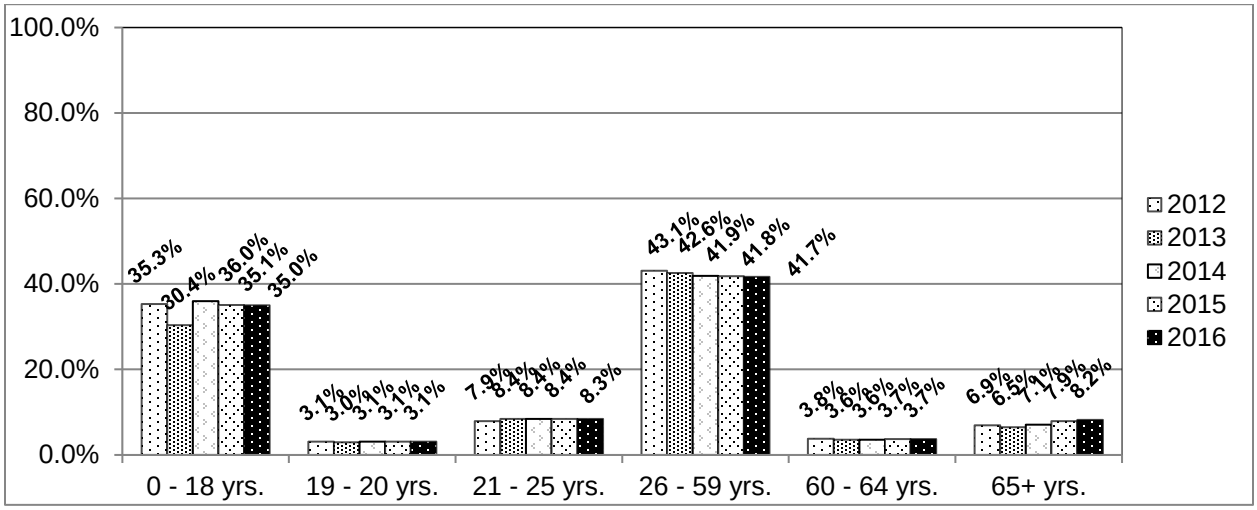
The highest percentage of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL was in SA 5 (12.7%) compared to SA 4 (7.1%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL was in SA 5 (51.8%) compared to SA 6 (37.1%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL was in SA 3 (4.4%) compared to SA 6 (3.2%) with the lowest percentage.

The highest percentage of individuals age 65 years and older and estimated to be living at or below 138% FPL was in SA 3 (11.1%) compared to SA 6 (5.1%) with the lowest percentage.

**FIGURE 7: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FPL BY AGE GROUP CY 2012 – 2016**




Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

The percent of individuals between 0 and 18 years old and estimated to be living at or below 138% FPL decreased by 0.3 PP, from 35.3% in CY 2012 to 35.0% in CY 2016.

The percent of individuals between 19 and 20 years old and estimated to be living at or below 138% FPL remained the same at 3.1% in CY 2012 and CY 2016.

The percent of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL increased by 0.4 PP, from 7.9% in CY 2012 to 8.3% in CY 2016.

The percent of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL decreased by 1.4 PP, from 43.1% in CY 2012 to 41.7% in CY 2016.

The percent of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL decreased by 0.1 PP, from 3.8% in CY 2012 to 3.7% in CY 2016.

The percent of individuals age 65 years and older and estimated to be living at or below 138% FPL increased by 1.3 PP, from 6.9% in CY 2012 to 8.2% in CY 2016.

**TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY GENDER AND SERVICE AREA CY 2016**

| Service Area (SA) | Male | Female | Total |
|---|---|---|---|
| **SA 1** | 57,497 | 60,500 | 117,997 |
| Percent | 48.7% | 51.3% | 100.0% |
| **SA 2** | 220,249 | 223,524 | 443,773 |
| Percent | 49.6% | 50.4% | 100.0% |
| **SA 3** | 167,121 | 173,422 | 340,543 |
| Percent | 49.1% | 50.9% | 100.0% |
| **SA 4** | 189,337 | 183,606 | 372,943 |
| Percent | **50.8%** | **49.2%** | 100.0% |
| **SA 5** | 48,082 | 50,895 | 98,977 |
| Percent | **48.6%** | **51.4%** | 100.0% |
| **SA 6** | 234,666 | 242,714 | 477,380 |
| Percent | 49.2% | 50.8% | 100.0% |
| **SA 7** | 167,505 | 171,820 | 339,325 |
| Percent | 49.4% | 50.6% | 100.0% |
| **SA 8** | 171,106 | 178,555 | 349,661 |
| Percent | 48.9% | 51.1% | 100.0% |
| **Total** | 1,255,563 | 1,285,036 | 2,540,599 |
| Percent | 49.4% | 50.6% | 100.0% |

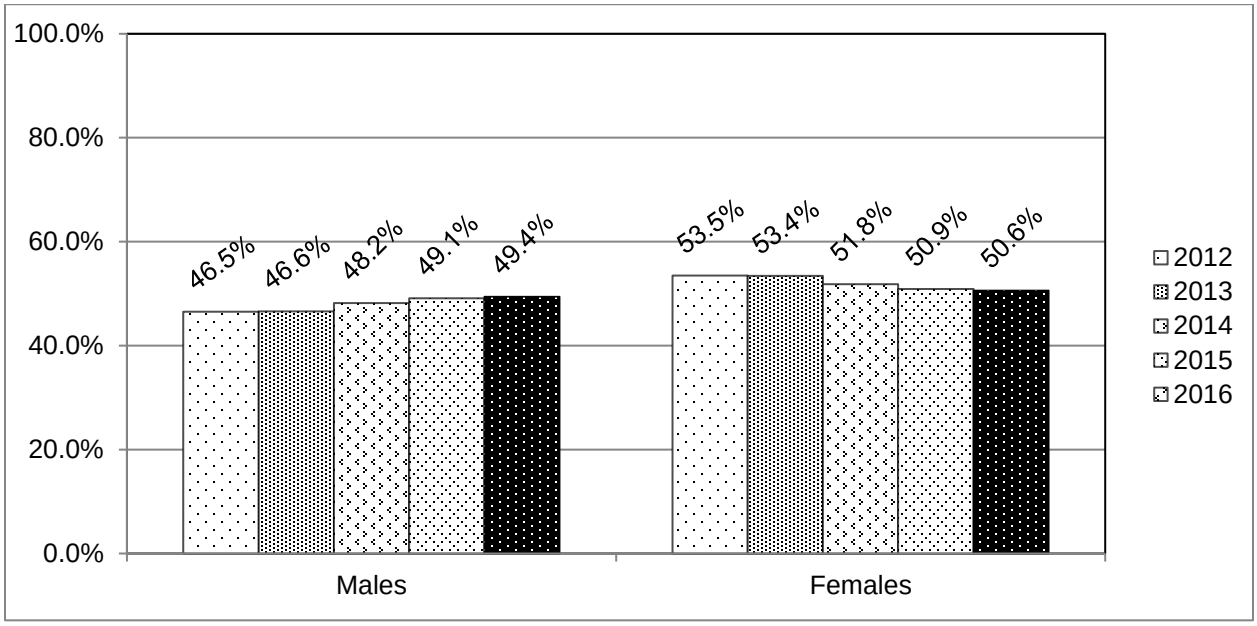
Note: Bold values represent the highest and lowest percentages within each gender across Service Areas. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Gender

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (50.8%) compared to SA 5 (48.6%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SA 5 (51.4%) compared to SA 4 (49.2%) with the lowest percentage.

**FIGURE 8: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FPL BY GENDER CY 2012 – CY 2016**




Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Gender

The percent of Males in Los Angeles estimated to be living at or below 138% FPL, increased by 2.9 PP from 46.5% in CY 2012 to 49.4% in CY 2016.

The percent of Females in Los Angeles estimated to be living at or below 138% FPL, decreased by 2.9 PP from 53.5% in CY 2012 to 50.6% in CY 2016.

## TABLE 7: PRIMARY LANGUAGES[1] OF ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY SERVICE AREA AND THRESHOLD LANGUAGE
## CY 2016

| Service Area (SA) | Arabic | Armenian | Cambodian | Cantonese | English | Farsi | Korean | Mandarin | Other Chinese | Russian | Spanish | Tagalog | Vietnamese | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SA1** | 670 | 387 | 85 | 141 | 66,366 | 195 | 226 | 127 | 73 | 65 | 38,341 | 627 | 375 | 107,678 |
| Percent | 0.6% | 0.4% | 0.1% | 0.1% | **61.6%** | 0.2% | 0.2% | 0.1% | 0.1% | 0.1% | **35.6%** | 0.6% | 0.3% | 100.0% |
| **SA2** | 5,554 | 37,473 | 183 | 327 | 124,359 | 7,318 | 4,792 | 540 | 2,799 | 5,488 | 215,440 | 7,292 | 2,667 | 414,232 |
| Percent | **1.3%** | **9.0%** | 0.0% | 0.1% | **30.0%** | **1.8%** | **1.2%** | 0.1% | 0.7% | **1.3%** | **52.0%** | **1.8%** | **0.6%** | 100.0% |
| **SA3** | 2,513 | 1,767 | 1,019 | 13,764 | 93,379 | 498 | 3,160 | 20,267 | 22,568 | 189 | 145,974 | 3,947 | 10,319 | 319,364 |
| Percent | 0.8% | 0.6% | 0.3% | **4.3%** | **29.2%** | 0.2% | **1.0%** | **6.3%** | **7.1%** | 0.1% | **45.7%** | **1.2%** | **3.2%** | 100.0% |
| **SA4** | 1,548 | 5,625 | 730 | 2823 | 81,232 | 1,519 | 21,934 | 1003 | 7,957 | 4,537 | 212,589 | 6,018 | 1,894 | 349,409 |
| Percent | 0.4% | **1.6%** | 0.2% | **0.8%** | **23.2%** | 0.4% | **6.3%** | 0.3% | **2.3%** | **1.3%** | **60.8%** | **1.7%** | 0.5% | 100.0% |
| **SA5** | 1,698 | 543 | 90 | 930 | 52,645 | 5,985 | 1,708 | 1976 | 2,457 | 1,247 | 17,377 | 626 | 587 | 87,869 |
| Percent | 1.9% | 0.6% | 0.1% | 1.1% | **59.9%** | **6.8%** | 1.9% | 2.2% | 2.8% | 1.4% | **19.8%** | 0.7% | 0.7% | 100.0% |
| **SA6** | 424 | 152 | 182 | 357 | 116,144 | 355 | 1,963 | 697 | 3,034 | 97 | 331,846 | 362 | 440 | 456,053 |
| Percent | 0.1% | 0.03% | 0.04% | 0.1% | **25.5%** | 0.1% | 0.4% | 0.2% | **0.7%** | 0.0% | **72.8%** | 0.1% | 0.1% | 100.0% |
| **SA7** | 1,709 | 772 | 560 | 368 | 63,261 | 185 | 2,895 | 977 | 1,811 | 146 | 253,439 | 2,306 | 1061 | 329,490 |
| Percent | 0.5% | 0.2% | 0.2% | 0.1% | **19.2%** | 0.1% | 0.9% | 0.3% | 0.5% | 0.0% | **76.9%** | 0.7% | 0.3% | 100.0% |
| **SA8** | 2,376 | 446 | 5,915 | 187 | 127,883 | 766 | 3,628 | 483 | 2,820 | 328 | 171,839 | 4,770 | 2,725 | 324,166 |
| Percent | 0.7% | 0.1% | **1.8%** | 0.1% | **39.4%** | 0.2% | **1.1%** | 0.1% | 0.9% | 0.1% | **53.0%** | **1.5%** | 0.8% | 100.0% |
| **Total** | 16,492 | 47,165 | 8,764 | 18,897 | 725,269 | 16,821 | 40,306 | 26,070 | 43,519 | 12,097 | 1,386,845 | 25,948 | 20,068 | 2,388,261 |
| Percent | 0.7% | 2.0% | 0.4% | 0.8% | 30.4% | 0.7% | 1.7% | 1.1% | 1.8% | 0.5% | 58.1% | 1.1% | 0.8% | 100.0% |

Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017. [1]Data reported only for LACDMH threshold languages. SA Threshold Languages are in bold. "Threshold Language" means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. For SA 2, the total count for Arabic is 5,554.

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

A total of 94% (N = 2,388,261) of the estimated population living at or below 138% FPL (N = 2,540,599) spoke a LACDMH threshold language. Among these, 30.4% (N = 725,269) were English speaking, 58.1% were Spanish speaking (N = 1,386,845) and the remaining 11.6% spoke the remaining LACDMH threshold languages.

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

SA 1 reported two (2) LACDMH SA threshold languages as their primary languages: English (61.6%) and Spanish (35.6%).

SA 2 reported eight (8) LACDMH SA threshold languages as their primary languages: Arabic (1.3%), Armenian (9.0%), English (30.0%), Farsi (1.8%), Korean (1.2%), Russian (1.3%), Spanish (52.0%), and Tagalog (1.8%).

SA 3 reported eight (8) LACDMH SA threshold languages as their primary languages: Cantonese (4.3%), English (29.2%), Korean (1.0%), Mandarin (6.3%), Other Chinese (7.1%), Spanish (45.7%), Tagalog (1.2%) and Vietnamese (3.2%).

SA 4 reported seven (7) LACDMH SA threshold languages as their primary languages: Armenian (1.6%), English (23.2%), Korean (6.3%), Other Chinese (2.3%), Russian (1.3%), Spanish (60.8%), and Tagalog (1.7%).

SA 5 reported three (3) LACDMH SA threshold languages as their primary languages: English (59.9%), Farsi (6.8%), and Spanish (19.8%).

SA 6 reported three (3) LACDMH SA threshold languages as their primary languages: English (25.5%), Other Chinese (0.7%) and Spanish (72.8%).

SA 7 reported two (2) LACDMH SA threshold languages as their primary languages: English (19.2%), and Spanish (76.9%).

SA 8 reported five (5) LACDMH SA threshold languages as their primary languages: Cambodian (1.8%), English (39.4%), Korean (1.1%), Spanish (53.0%) and Tagalog (1.5%).

**TABLE 8: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY RACE/ETHNICITY AND SERVICE AREA CY 2016**

| Service Area (SA) | African American | Asian/Pacific Islander | Latino | Native American | White | Two or More Races | Total |
|---|---|---|---|---|---|---|---|
| **SA 1** | 5,001 | 193 | 6,682 | 83 | 4,300 | 338 | 16,597 |
| Percent | 30.1% | 1.2% | 40.3% | **0.50%** | 25.9% | 2.0% | 100.0% |
| **SA 2** | 3,542 | 2,408 | 27,031 | 121 | 20,247 | 1,005 | 54,354 |
| Percent | 6.5% | 4.4% | 49.7% | 0.30% | 37.3% | 1.8% | 100.0% |
| **SA 3** | 2,677 | 5,877 | 20,506 | 86 | 7,009 | 505 | 36,660 |
| Percent | 7.3% | **16.0%** | 55.9% | 0.30% | 19.1% | 1.4% | 100.0% |
| **SA 4** | 3,693 | 3,816 | 25,240 | 134 | 9,007 | 578 | 42,468 |
| Percent | 8.7% | 9.0% | 59.4% | 0.30% | 21.2% | 1.4% | 100.0% |
| **SA 5** | 1,383 | 1,083 | 2,154 | 23 | 8,310 | 450 | 13,403 |
| Percent | 10.3% | 8.1% | **16.1%** | **0.10%** | **62.0%** | **3.4%** | 100.0% |
| **SA 6** | 24,374 | 548 | 37,235 | 136 | 1,329 | 477 | 64,099 |
| Percent | **38.0%** | **0.9%** | 58.1% | 0.20% | **2.1%** | 0.7% | 100.0% |
| **SA 7** | 1,812 | 987 | 30,870 | 115 | 3,673 | 206 | 37,663 |
| Percent | **4.8%** | 2.6% | **82.0%** | 0.30% | 9.8% | **0.5%** | 100.0% |
| **SA 8** | 13,806 | 2,577 | 21,287 | 149 | 6,903 | 869 | 45,591 |
| Percent | 30.3% | 5.7% | 46.7% | 0.30% | 15.1% | 1.9% | 100.0% |
| **Total** | 56,289 | 17,489 | 171,006 | 847 | 60,779 | 4,427 | 310,837 |
| Percent | 18.1% | 5.6% | 55.0% | 0.30% | 19.6% | 1.4% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Racial/ethnic group and across the Service Areas. 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 138% FPL and are pooled estimates for CY 2015 and CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Race/Ethnicity

The highest rate of prevalence of SED and SMI among the African American ethnic group was in SA 6 (38.0%) compared to SA 7 (4.8%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Asian Pacific Islander ethnic group was in SA 3 (16.0%) compared to SA 6 (0.9%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Latino ethnic group was in SA 7 (82.0%) compared to SA 5 (16.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Native American ethnic group was in SA 1 (0.50%) compared to SA 5 (0.10%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the White ethnic group was in SA 5 (62.0%) compared to SA 6 (2.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Two or More Races group was in SA 5 (3.4%) compared to SA 7 (0.5%) with the lowest percentage.

**TABLE 9: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY AGE GROUP AND SERVICE AREA CY 2016**

| Service Area (SA) | Age Group | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0-18 | 19-20 | 21-25 | 26-59 | 60-64 | 65+ | Total |
| **SA1** | 7,994 | 864 | 1,346 | 5,337 | 460 | 657 | 16,658 |
| Percent | 48.0% | 5.2% | 8.1% | 32.0% | 2.8% | 3.9% | 100.0% |
| **SA2** | 24,952 | 2,568 | 4,370 | 23,356 | 1,929 | 3,206 | 60,381 |
| Percent | 41.3% | 4.3% | 7.2% | 38.7% | 3.2% | 5.3% | 100.0% |
| **SA3** | 18,874 | 2,058 | 3,422 | 16,974 | 1,587 | 3,067 | 45,982 |
| Percent | 41.0% | 4.5% | 7.4% | 36.9% | 3.5% | 6.7% | 100.0% |
| **SA4** | 19,544 | 1,831 | 3,301 | 21,050 | 1,500 | 2,865 | 50,091 |
| Percent | 39.0% | **3.7%** | **6.6%** | 42.0% | 3.0% | 5.7% | 100.0% |
| **SA5** | 2,862 | 742 | 1,557 | 6,158 | 450 | 870 | 12,638 |
| Percent | **22.6%** | **5.9%** | **12.3%** | **48.7%** | **3.6%** | **6.9%** | 100.0% |
| **SA6** | 34,990 | 3,319 | 5,399 | 21,277 | 1,542 | 1,981 | 68,508 |
| Percent | **51.1%** | 4.8% | 7.9% | **31.1%** | **2.3%** | **2.9%** | 100.0% |
| **SA7** | 23,386 | 2,117 | 3,387 | 15,617 | 1,249 | 2,041 | 47,798 |
| Percent | 48.9% | 4.4% | 7.1% | 32.7% | 2.6% | 4.3% | 100.0% |
| **SA8** | 21,926 | 2,186 | 3,552 | 17,353 | 1,376 | 2,154 | 48,547 |
| Percent | 45.2% | 4.5% | 7.4% | 35.7% | 2.8% | 4.4% | 100.0% |
| **Total** | 154,529 | 15,685 | 26,334 | 127,122 | 10,093 | 16,842 | 350,605 |
| Percent | 44.1% | 4.5% | 7.5% | 36.2% | 2.9% | 4.8% | 100.0% |

Note: Bold values represent the highest and lowest percentage within each Age group across Service Areas. Estimated prevalence rates of mental illness for Los Angeles County are provided by the CHIS for the population living at or below 138% FPL and are pooled estimates for CY 2015 and 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Age Group

The highest rate of prevalence of SED and SMI among individuals between 0 and 18 years old was in SA 6 (51.1%) compared to SA 5 (22.6%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals between 19 and 20 years old was in SA 5 (5.9%) compared to SA 4 (3.7%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals between 21 and 25 years old was in SA 5 (12.3%) compared to SA 4 (6.6%) the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals between 26 and 59 years old was in SA 5 (48.7%) compared to SA 6 (31.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals between 60 and 64 years old was in SA 5 (3.6%) compared to SA 6 (2.3%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals age 65 years and older was in SA 5 (6.9%) compared to SA 6 (2.9%) with the lowest percentage.

**TABLE 10: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY GENDER AND SERVICE AREA CY 2016**

| Service Area (SA) | Male | Female | Total |
|---|---|---|---|
| **SA 1** | 7,072 | 7,139 | 14,211 |
| Percent | 49.8% | 50.2% | 100.0% |
| **SA 2** | 27,091 | 26,376 | 53,467 |
| Percent | 50.7% | 49.3% | 100.0% |
| **SA 3** | 20,556 | 20,464 | 41,020 |
| Percent | 50.1% | 49.9% | 100.0% |
| **SA 4** | 23,288 | 21,666 | 44,954 |
| Percent | **51.8%** | **48.2%** | 100.0% |
| **SA 5** | 5,914 | 6,006 | 11,920 |
| Percent | **49.6%** | **50.4%** | 100.0% |
| **SA 6** | 28,864 | 28,640 | 57,504 |
| Percent | 50.2% | 49.8% | 100.0% |
| **SA 7** | 21,134 | 20,275 | 41,409 |
| Percent | 51.0% | 49.0% | 100.0% |
| **SA 8** | 21,046 | 21,069 | 42,115 |
| Percent | 50.0% | 50.0% | 100.0% |
| **Total** | 154,434 | 151,635 | 306,600 |
| Percent | 50.5% | 49.5% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Gender across Service Areas. Estimated prevalence rates of mental illness for Los Angeles County are provided by the CHIS for the population living at or below 138% FPL and are pooled estimates for CY 2015 and CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2017.

## Differences by Gender

The highest rate of prevalence of SED and SMI among Males was in SA 4 (51.8%) compared to SA 5 (49.6%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among Females was in SA 5 (50.4%) compared to SA 4 (48.2%) with the lowest percentage.

## Population Enrolled in Medi-Cal

**TABLE 11: POPULATION ENROLLED IN MEDI-CAL BY ETHNICITY AND SERVICE AREA MARCH 2017**

| Service Area (SA) | African American | Asian/Pacific Islander | Latino | Native American | White | Total |
|---|---|---|---|---|---|---|
| **SA 1** | 37,649 | 3,839 | 92,601 | 309 | 29,433 | 163,831 |
| Percent | **23.0%** | 2.3% | 56.5% | 0.20% | 18.0% | 100.0% |
| **SA 2** | 24,774 | 48,915 | 377,897 | 758 | 208,778 | 661,122 |
| Percent | 3.7% | 7.4% | 57.2% | 0.11% | 31.6% | 100.0% |
| **SA 3** | 20,096 | 150,435 | 317,630 | 571 | 53,667 | 542,399 |
| Percent | 3.7% | **27.7%** | 58.6% | 0.11% | 9.9% | 100.0% |
| **SA 4** | 25,204 | 57,915 | 277,496 | 700 | 57,602 | 418,917 |
| Percent | 6.0% | 13.8% | 66.2% | 0.20% | 13.8% | 100.0% |
| **SA 5** | 10,380 | 7,161 | 28,451 | 200 | 36,595 | 82,787 |
| Percent | 12.5% | 8.6% | **34.4%** | **0.24%** | **44.2%** | 100.0% |
| **SA 6** | 128,803 | 5,467 | 411,271 | 484 | 14,533 | 560,558 |
| Percent | **23.0%** | **1.0%** | 73.4% | **0.09%** | **2.6%** | 100.0% |
| **SA 7** | 11,810 | 25,029 | 388,174 | 518 | 32,013 | 457,544 |
| Percent | **2.6%** | 5.5% | **84.8%** | 0.11% | 7.0% | 100.0% |
| **SA 8** | 80,527 | 49,021 | 256,621 | 798 | 51,093 | 438,060 |
| Percent | 18.4% | 11.2% | 58.6% | 0.18% | 11.7% | 100.0% |
| **Total** | 339,243 | 347,782 | 2,150,141 | 4,338 | 483,714 | 3,325,218 |
| Percent | 10.2% | 10.5% | 64.7% | 0.13% | 14.5% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Ethnic group across Service Areas. Unknown Service Area (N= 129,104), Unknown Ethnicity (N= 32,617), and "Other" Ethnicity (N= 57,503) were not included in the Ethnicity table. Data Source: State MEDS File, March 2017.

## Differences by Ethnicity

The highest percentage of African Americans enrolled in Medi-Cal was in SA 1 and SA 6 (23.0%) compared to SA 7 (2.6%) with the lowest percentage.

The highest percentage of Asian Pacific Islanders enrolled in Medi-Cal was in SA 3 (27.7%) compared to SA 6 (1.0%) with the lowest percentage.

The highest percentage of Latinos enrolled in Medi-Cal was in SA 7 (84.8%) compared to SA 5 (34.4%) with the lowest percentage.

The highest percentage of Native Americans enrolled in Medi-Cal was in SA 5 (0.24%) compared to SA 6 (0.09%) with the lowest percentage.

The highest percentage of Whites enrolled in Medi-Cal was in SA 5 (44.2%) compared to SA 6 (2.6%) with the lowest percentage.

**TABLE 12: POPULATION ENROLLED IN MEDI-CAL BY AGE GROUP AND SERVICE AREA MARCH 2017**

| Service Area (SA) | AGE GROUP | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0-18 | 19-20 | 21-25 | 26-59 | 60-64 | 65+ | Total |
| **SA1** | 72,321 | 6,690 | 14,663 | 65,829 | 6,569 | 11,974 | 178,046 |
| Percent | **40.6%** | **3.8%** | **8.2%** | 37.0% | **3.7%** | **6.7%** | 100.0% |
| **SA2** | 232,154 | 23,359 | 51,530 | 290,105 | 35,674 | 98,646 | 731,468 |
| Percent | 31.7% | 3.2% | 7.0% | 39.7% | 4.9% | 13.5% | 100.0% |
| **SA3** | 200,464 | 20,455 | 44,993 | 229,023 | 28,837 | 83,479 | 607,251 |
| Percent | 33.0% | 3.4% | 7.4% | 37.7% | 4.7% | 13.7% | 100.0% |
| **SA4** | 132,993 | 12,850 | 31,608 | 194,440 | 23,530 | 67,485 | 462,906 |
| Percent | 28.7% | 2.8% | 6.8% | 42.0% | 5.1% | 14.6% | 100.0% |
| **SA5** | 22,988 | 2,447 | 6,481 | 46,895 | 5,607 | 15,518 | 99,936 |
| Percent | **23.0%** | **2.4%** | **6.5%** | **46.9%** | **5.6%** | **15.5%** | 100.0% |
| **SA6** | 241,200 | 21,290 | 47,779 | 229,575 | 23,915 | 46,205 | 609,964 |
| Percent | 39.5% | 3.5% | 7.8% | 37.6% | 3.9% | 7.6% | 100.0% |
| **SA7** | 188,110 | 17,823 | 38,428 | 182,265 | 20,175 | 52,809 | 499,610 |
| Percent | 37.7% | 3.6% | 7.7% | **36.5%** | 4.0% | 10.6% | 100.0% |
| **SA8** | 177,045 | 16,500 | 38,296 | 194,965 | 22,432 | 50,318 | 499,556 |
| Percent | 35.4% | 3.3% | 7.7% | 39.0% | 4.5% | 10.1% | 100.0% |
| **Total** | 1,267,275 | 121,414 | 273,778 | 1,433,097 | 166,739 | 426,434 | 3,688,737 |
| Percent | 34.4% | 3.3% | 7.4% | 38.9% | 4.5% | 11.6% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Age group across Service Areas. Unknown Service Area (N=129,287). Data Source: State MEDS File, March 2017.

## Differences by Age Group

The highest percentage of individuals between 0 and 18 years old enrolled in Medi-Cal was in SA 1 (40.6%) compared to SA 5 (23.0%) with the lowest percentage.

The highest percentages of individuals between 19 and 20 years old enrolled in Medi-Cal were in SA 1 (3.8%) compared to SA 5 (2.4%) with the lowest percentage.

The highest percentage of individuals between 21 and 25 years old enrolled in Medi-Cal was in SA 1 (8.2%) compared to SA 5 (6.5%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old enrolled in Medi-Cal was in SA 5 (46.9%) compared to SA 7 (36.5%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old enrolled in Medi-Cal was in SA 5 (5.6%) compared to SA 1 (3.7%) with the lowest percentage.

The highest percentage of individuals age 65 years and older enrolled in Medi-Cal was in SA 5 (15.5%) compared to SA 1 (6.7%) with the lowest percentage.

**TABLE 13: POPULATION ENROLLED IN MEDI-CAL BY GENDER AND SERVICE AREA MARCH 2017**

| Service Area (SA) | Male | Female | Total |
|---|---|---|---|
| **SA1** | 81,447 | 96,599 | 178,046 |
| Percent | 45.7% | 54.3% | 100.0% |
| **SA2** | 335,286 | 396,182 | 731,468 |
| Percent | 45.8% | 54.2% | 100.0% |
| **SA3** | 277,295 | 329,956 | 607,251 |
| Percent | 45.7% | 54.3% | 100.0% |
| **SA4** | 216,554 | 246,352 | 462,906 |
| Percent | 46.8% | 53.2% | 100.0% |
| **SA5** | 47,266 | 52,670 | 99,936 |
| Percent | **47.3%** | **52.7%** | 100.0% |
| **SA6** | 277,085 | 332,879 | 609,964 |
| Percent | 45.4% | 54.6% | 100.0% |
| **SA7** | 224,305 | 275,305 | 499,610 |
| Percent | **44.9%** | **55.1%** | 100.0% |
| **SA8** | 227,034 | 272,522 | 499,556 |
| Percent | 45.4% | 54.6% | 100.0% |
| **Total** | 1,686,272 | 2,002,465 | 3,688,737 |
| Percent | 45.7% | 54.3% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Gender across Service Areas. Unknown Service Area (N=129,287). Data Source: State MEDS File, March 2017.

## Differences by Gender

The highest percentage of Males enrolled in Medi-Cal was in SA 5 (47.3%) as compared with the lowest in SA 7 (44.9%).

The highest percentage of Females enrolled in Medi-Cal was in SA 7 (55.1%) compared to SA 5 (52.7%) with the lowest percentage.

**TABLE 14: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY ETHNICITY AND SERVICE AREA MARCH 2017**

| Service Area (SA) | African American | Asian Pacific Islander | Latino | Native American | White | Total |
|---|---|---|---|---|---|---|
| **SA 1** | 10,730 | 311 | 10,279 | 109 | 4,680 | 26,109 |
| Percent | 41.1% | 1.2% | 39.4% | 0.40% | 17.9% | 100.0% |
| **SA 2** | 7,061 | 3,962 | 41,947 | 268 | 33,196 | 86,434 |
| Percent | 8.2% | 4.6% | 48.5% | 0.31% | 38.4% | 100.0% |
| **SA 3** | 5,727 | 12,185 | 35,257 | 202 | 8,533 | 61,904 |
| Percent | 9.3% | **19.7%** | 57.0% | 0.33% | 13.8% | 100.0% |
| **SA 4** | 7,183 | 4,691 | 30,802 | 247 | 9,159 | 52,082 |
| Percent | 13.8% | 9.0% | 59.1% | 0.50% | 17.6% | 100.0% |
| **SA 5** | 2,958 | 580 | 3,158 | 71 | 5,819 | 12,586 |
| Percent | 23.5% | 4.6% | **25.1%** | **0.56%** | **46.2%** | 100.0% |
| **SA 6** | 36,709 | 443 | 45,651 | 171 | 2,311 | 85,285 |
| Percent | **43.0%** | **0.5%** | 53.5% | **0.20%** | **2.7%** | 100.0% |
| **SA 7** | 3,366 | 2,027 | 43,087 | 183 | 5,090 | 53,753 |
| Percent | **6.3%** | 3.8% | **80.2%** | 0.34% | 9.5% | 100.0% |
| **SA 8** | 22,950 | 3,971 | 28,485 | 282 | 8,124 | 63,812 |
| Percent | 36.0% | 6.2% | 44.6% | 0.44% | 12.7% | 100.0% |
| **Total** | 96,684 | 28,170 | 238,666 | 1,533 | 76,912 | 441,965 |
| Percent | 21.9% | 6.4% | 54.0% | 0.3% | 17.4% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Race/Ethnic group across Service Areas. Estimated prevalence rates of mental illness by Ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016.

## Differences by Ethnicity

The highest prevalence of SED and SMI among the African American group was in SA 6 (43.0%) compared to SA 7 (6.3%) with the lowest percentage.

The highest prevalence of SED and SMI among the Asian Pacific Islander group was in SA 3 (19.7%) compared to SA 6 (0.5%) with the lowest percentage.

The highest prevalence of SED and SMI among the Latino group was in SA 7 (80.2%) compared to SA 5 (25.1%) with the lowest percentage.

The highest prevalence of SED and SMI among the Native American group was in SA 5 (0.56%) compared to SA 6 (0.20%) with the lowest percentage.

The highest prevalence of SED and SMI among the White group was in SA 5 (46.2%) compared to SA 6 (2.7%) with the lowest percentage.

**TABLE 15: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY AGE GROUP AND SERVICE AREA MARCH 2017**

| Service Area (SA) | Age Group | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0-18 | 19-20 | 21-25 | 26-59 | 60-64 | 65+ | Total |
| **SA1** | 13,813 | 1,472 | 1,760 | 8,821 | 907 | 910 | 27,682 |
| Percent | **49.9%** | **5.3%** | **6.4%** | **31.9%** | **3.3%** | **3.3%** | 100.0% |
| **SA2** | 44,341 | 5,139 | 6,184 | 38,874 | 4,923 | 7,497 | 106,958 |
| Percent | 41.5% | 4.8% | 5.8% | 36.3% | 4.6% | 7.0% | 100.0% |
| **SA3** | 38,289 | 4,500 | 5,399 | 30,689 | 3,980 | 6,344 | 89,201 |
| Percent | 42.9% | 5.0% | 6.1% | 34.4% | 4.5% | 7.1% | 100.0% |
| **SA4** | 25,402 | 2,827 | 3,793 | 26,055 | 3,247 | 5,129 | 66,453 |
| Percent | 38.2% | 4.3% | 5.7% | 39.2% | 4.9% | 7.7% | 100.0% |
| **SA5** | 4,391 | 538 | 778 | 6,284 | 774 | 1,179 | 13,944 |
| Percent | **31.5%** | **3.9%** | **5.6%** | **45.1%** | **5.5%** | **8.5%** | 100.0% |
| **SA6** | 46,069 | 4,684 | 5,733 | 30,763 | 3,300 | 3,512 | 94,061 |
| Percent | 49.0% | 5.0% | 6.1% | 32.7% | 3.5% | 3.7% | 100.0% |
| **SA7** | 35,929 | 3,921 | 4,611 | 24,424 | 2,784 | 4,013 | 75,683 |
| Percent | 47.5% | 5.2% | 6.1% | 32.3% | 3.7% | 5.3% | 100.0% |
| **SA8** | 33,816 | 3,630 | 4,596 | 26,125 | 3,096 | 3,824 | 75,086 |
| Percent | 45.0% | 4.8% | 6.1% | 34.8% | 4.1% | 5.1% | 100.0% |
| **Total** | 242,050 | 26,711 | 32,853 | 192,035 | 23,010 | 32,409 | 549,068 |
| Percent | 44.1% | 4.9% | 6.0% | 35.0% | 4.2% | 5.9% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Age group across Service Areas. Estimated prevalence rates of mental illness by Age group for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016.

## Differences by Age Group

Table 15 compares the prevalence of SED and SMI among Medi-Cal enrolled population for each Age group.

The highest prevalence of SED and SMI among the Age group 0-18 years was in SA 1 (49.9%) compared to SA 5 (31.5%) with the lowest percentage.

The highest prevalence of SED and SMI among the Age group 19-20 years was in SA 1 (5.3%) compared to SA 5 (3.9%) with the lowest percentage.

The highest prevalence of SED and SMI among the Age group 21-25 years was in SA 1 (6.4%) compared to SA 5 (5.6%) with the lowest percentage.

The highest prevalence of SED and SMI among the Age group 26-59 years was in SA 5 (45.1%) compared to SA 1 (31.9%) with the lowest percentage.

The highest prevalence of SED and SMI among the Age group 60-64 years was in SA 5 (5.5%) compared to SA 1 (3.3%) with the lowest percentage.

The highest prevalence of SED and SMI among the Age group 65+ years was in SA 5 (8.5%) compared to SA 1 (3.3%) with the lowest percentage.

**TABLE 16: ESTIMATED PREVALENCE OF SED AND SMI MEDI-CAL ENROLLED POPULATION BY GENDER AND SERVICE AREA MARCH 2017**

| Service Area (SA) | Male | Female | Total |
|---|---|---|---|
| **SA 1** | 12,054 | 11,495 | 23,549 |
| Percent | 51.2% | 48.8% | 100.0% |
| **SA 2** | 49,622 | 47,146 | 96,768 |
| Percent | 51.3% | 48.7% | 100.0% |
| **SA 3** | 41,040 | 39,265 | 80,304 |
| Percent | 51.1% | 48.9% | 100.0% |
| **SA 4** | 32,050 | 29,316 | 61,366 |
| Percent | 52.2% | 47.8% | 100.0% |
| **SA 5** | 6,995 | 6,268 | 13,263 |
| Percent | **52.7%** | **47.3%** | 100.0% |
| **SA 6** | 41,009 | 39,613 | 80,621 |
| Percent | 50.9% | 49.1% | 100.0% |
| **SA 7** | 33,197 | 32,761 | 65,958 |
| Percent | **50.3%** | **49.7%** | 100.0% |
| **SA 8** | 33,601 | 32,430 | 66,031 |
| Percent | 50.9% | 49.1% | 100.0% |
| **Total** | 249,568 | 238,293 | 487,862 |
| Percent | 51.2% | 48.8% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Gender across Service Areas. Estimated prevalence rates of mental illness by Gender for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016.

## Differences by Gender

The highest prevalence of SED and SMI among Males was in SA 5 (52.7%) compared to SA 7 (50.3%) with the lowest percentage among the Medi-Cal enrolled population.

The highest prevalence of SED and SMI among Females was in SA 7 (49.7%) compared to SA 5 (47.3%) with the lowest percentage among the Medi-Cal enrolled population.

## TABLE 17: PRIMARY LANGUAGE OF POPULATION ENROLLED IN MEDI-CAL BY SERVICE AREA AND THRESHOLD LANGUAGE MARCH 2017

| Service Area (SA) | Arabic | Armenian | Cambodian | Cantonese | English | Farsi | Korean | Mandarin | Other Chinese | Russian | Spanish | Tagalog | Vietnamese | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SA 1** | 245 | 209 | 41 | 42 | 130,816 | 76 | 151 | 69 | 22 | 15 | 45,019 | 154 | 171 | 177,030 |
| Percent | 0.14% | 0.12% | 0.02% | 0.02% | **73.89%** | 0.04% | 0.09% | 0.04% | 0.01% | 0.01% | **25.43%** | 0.09% | 0.10% | 100.00% |
| **SA 2** | 2,761 | 61,972 | 179 | 342 | 378,771 | 9,911 | 5,289 | 619 | 153 | 5,607 | 249,475 | 3,330 | 3,583 | 721,992 |
| Percent | 0.38% | **8.58%** | 0.02% | 0.05% | **52.46%** | **1.37%** | **0.73%** | 0.09% | 0.02% | **0.78%** | **34.55%** | **0.46%** | **0.51%** | 100.00% |
| **SA 3** | 1,181 | 2,064 | 1,019 | 33,545 | 321,009 | 366 | 3,370 | 43,425 | 4,732 | 140 | 163,694 | 1,852 | 20,933 | 597,330 |
| Percent | 0.20% | 0.35% | 0.17% | **5.62%** | **53.74%** | 0.06% | **0.56%** | **7.27%** | **0.79%** | 0.02% | **27.40%** | 0.31% | **3.50%** | 100.00% |
| **SA 4** | 239 | 6,656 | 633 | 7,725 | 208,960 | 593 | 19,046 | 1,314 | 586 | **5,171** | 199,134 | 3,050 | 1,626 | 454,733 |
| Percent | 0.05% | **1.46%** | 0.14% | **1.70%** | **45.95%** | 0.13% | **4.19%** | 0.29% | 0.13% | **1.14%** | **43.79%** | **0.67%** | 0.36% | 100.00% |
| **SA 5** | 297 | 69 | 19 | 103 | 72,888 | 4,026 | 539 | 319 | 75 | 1,529 | 17,335 | 115 | 134 | 97,448 |
| Percent | 0.30% | 0.07% | 0.02% | 0.11% | **74.80%** | **4.13%** | 0.55% | 0.33% | 0.08% | 1.57% | **17.79%** | 0.12% | 0.14% | 100.00% |
| **SA 6** | 59 | 20 | 114 | 143 | 302,174 | 41 | 1,577 | 80 | 22 | 48 | 299,092 | 144 | 79 | 603,593 |
| Percent | 0.01% | 0.00% | 0.02% | 0.02% | **50.06%** | 0.01% | 0.26% | 0.01% | 0.00% | 0.01% | **49.55%** | 0.02% | 0.01% | 100.00% |
| **SA 7** | 678 | 588 | 1,050 | 1,016 | 258,233 | 67 | 3,092 | 1,518 | 256 | 80 | 224,470 | 1,017 | 880 | 492,945 |
| Percent | 0.14% | 0.12% | 0.21% | 0.21% | **52.39%** | 0.01% | **0.63%** | 0.31% | 0.05% | 0.02% | **45.54%** | 0.21% | 0.18% | 100.00% |
| **SA 8** | 623 | 95 | 5,635 | 422 | 324,081 | 442 | 3,693 | 790 | 163 | 244 | 160,592 | 2,085 | 2,938 | 501,803 |
| Percent | 0.12% | 0.02% | **1.12%** | 0.08% | **64.58%** | 0.09% | **0.74%** | 0.16% | 0.03% | 0.05% | **32.00%** | 0.42% | **0.59%** | 100.00% |
| **Total** | 6,083 | 71,673 | 8,690 | 43,338 | 1,996,932 | 15,522 | 36,757 | 48,134 | 6,009 | 12,834 | 1,358,811 | 11,747 | 30,344 | 3,646,874 |
| Percent | 0.17% | 1.97% | 0.24% | 1.19% | 54.76% | 0.43% | 1.01% | 1.32% | 0.16% | 0.35% | 37.26% | 0.32% | 0.83% | 100.00% |

Note: "Threshold Language" means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. SA Threshold Languages are in bold. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. A total of 6,083 (0.2%) individuals enrolled in Medi-Cal reported Arabic as their primary language in March 2017. Unknown Service Area is (129,015). A total of 4,858 (0.2%) individuals enrolled in Medi-Cal reported "Other" as a primary language. Data Source: State Medi-Cal Eligibility Data System (MEDS) File, March 2017.

Table 17 shows the 13 LACDMH threshold languages by SA.

A total of 54.8% (N=1,996,932) of the Medi-Cal enrolled population spoke English. The SA with the highest percentage of Medi-Cal enrolled population with English as the primary language was SA 5 (74.8%) and the lowest percentage was SA 4 (46.0%). Of the 12 non-English threshold languages spoken among the population enrolled in Medi-Cal, Spanish (37.3%) had the highest percentage, followed by Armenian (2.0%), Mandarin (1.3%), Cantonese (1.2%), and Korean (1.0%). Remaining languages were spoken by less than 1.0% of the Medi-Cal enrolled population. All other threshold languages range between 0.2% (Arabic, Cambodian, and Other Chinese) and 2.0% (Armenian).

The following identifies the LACDMH threshold languages of Medi-Cal enrollees in each SA:

SA 1 has two (2) threshold languages: English (73.9%) and Spanish (25.4%).

SA 2 has eight (8) threshold languages: Armenian (8.6%), English (52.5%), Farsi (1.4%), Korean (0.7%), Russian (0.8%), Spanish (34.6%), Tagalog (0.5%), and Vietnamese (0.5%).

SA 3 has seven (7) threshold languages: Cantonese (5.6%), English (53.7%), Korean (0.6%), Mandarin (7.3%), Spanish (27.4%), Other Chinese (0.8%), and Vietnamese (3.5%).

SA 4 has seven (7) threshold languages: Armenian (1.5%), Cantonese (1.7%), English (46.0%), Korean (4.2%), Russian (1.1%), Spanish (43.8%), and Tagalog (0.7%).

SA 5 has three (3) threshold languages: English (74.8%), Farsi (4.1%), and Spanish (17.8%).

SA 6 has two (2) threshold languages. SA 6: English (50.1%), and Spanish (49.6%).

SA 7 has three (3) threshold languages: English (52.4%), Korean (0.6%), and Spanish (45.5%).

SA 8 has four (4) threshold languages: Cambodian (1.1%), English (64.6%), Korean (0.7%), and Spanish (32.0%).

Countywide, the highest percentage of Medi-Cal Enrolled persons reported English as the primary language (54.8%) and the second highest percentage reported Spanish (37.3%).

## TABLE 18: DISTRIBUTION OF "OTHER" LANGUAGES SPOKEN BY POPULATION ENROLLED IN MEDI-CAL BY SERVICE AREA MARCH 2017

| Service Area (SA) | SA 1 | SA 2 | SA 3 | SA 4 | SA 5 | SA 6 | SA 7 | SA 8 | Total |
|---|---|---|---|---|---|---|---|---|---|
| **American Sign Language (ASL)** | 85 | 233 | 142 | 125 | 11 | 89 | 137 | 61 | 883 |
| Percent | 9.6% | 26.4% | 16.1% | 14.2% | 1.2% | 10.1% | 15.5% | 6.9% | 100.0% |
| **French** | 3 | 35 | 10 | 25 | 23 | 43 | 0 | 26 | 165 |
| Percent | 1.8% | 21.2% | 6.1% | 15.2% | 13.9% | 26.1% | 0.0% | 15.8% | 100.0% |
| **Hebrew** | 1 | 244 | 5 | 45 | 32 | 0 | 1 | 3 | 331 |
| Percent | 0.3% | 73.7% | 1.5% | 13.6% | 9.7% | 0.0% | 0.3% | 0.9% | 100.0% |
| **Hmong** | 1 | 2 | 8 | 1 | 0 | 2 | 0 | 20 | 34 |
| Percent | 2.9% | 5.9% | 23.5% | 2.9% | 0.0% | 5.9% | 0.0% | 58.8% | 100.0% |
| **Italian** | 1 | 20 | 11 | 8 | 3 | 0 | 1 | 16 | 60 |
| Percent | 1.7% | 33.3% | 18.3% | 13.3% | 5.0% | 0.0% | 1.7% | 26.7% | 100.0% |
| **Japanese** | 1 | 83 | 95 | 184 | 80 | 32 | 24 | 303 | 802 |
| Percent | 0.1% | 10.3% | 11.8% | 22.9% | 10.0% | 4.0% | 3.0% | 37.8% | 100.0% |
| **Lao** | 1 | 15 | 79 | 31 | 4 | 2 | 24 | 38 | 194 |
| Percent | 0.5% | 7.7% | 40.7% | 16.0% | 2.1% | 1.0% | 12.4% | 19.6% | 100.0% |
| **Mien** | 1 | 1 | 3 | 0 | 1 | 0 | 0 | 0 | 6 |
| Percent | 16.7% | 16.7% | 50.0% | 0.0% | 16.7% | 0.0% | 0.0% | 0.0% | 100.0% |
| **Other Sign Language** | 9 | 47 | 29 | 12 | 8 | 9 | 9 | 23 | 146 |
| Percent | 6.2% | 32.2% | 19.9% | 8.2% | 5.5% | 6.2% | 6.2% | 15.8% | 100.0% |
| **Polish** | 1 | 26 | 5 | 13 | 6 | 2 | 4 | 5 | 62 |
| Percent | 1.6% | 41.9% | 8.1% | 21.0% | 9.7% | 3.2% | 6.5% | 8.1% | 100.0% |
| **Portuguese** | 2 | 33 | 19 | 15 | 25 | 2 | 21 | 18 | 135 |
| Percent | 1.5% | 24.4% | 14.1% | 11.1% | 18.5% | 1.5% | 15.6% | 13.3% | 100.0% |
| **Samoan** | 6 | 60 | 16 | 10 | 0 | 46 | 30 | 61 | 229 |
| Percent | 2.6% | 26.2% | 7.0% | 4.4% | 0.0% | 20.1% | 13.1% | 26.6% | 100.0% |
| **Thai** | 4 | 614 | 286 | 511 | 28 | 21 | 102 | 79 | 1,645 |
| Percent | 0.2% | 37.3% | 17.4% | 31.1% | 1.7% | 1.3% | 6.2% | 4.8% | 100.0% |
| **Turkish** | 3 | 37 | 10 | 14 | 9 | 3 | 15 | 5 | 96 |
| Percent | 3.1% | 38.5% | 10.4% | 14.6% | 9.4% | 3.1% | 15.6% | 5.2% | 100.0% |
| **Ilocano** | 3 | 13 | 12 | 4 | 2 | 4 | 11 | 21 | 70 |
| Percent | 4.3% | 18.6% | 17.1% | 5.7% | 2.9% | 5.7% | 15.7% | 30.0% | 100.0% |
| **Total** | 122 | 1,463 | 730 | 998 | 232 | 255 | 379 | 679 | 4,858 |
| Percent | 2.5% | 30.1% | 15.0% | 20.5% | 4.8% | 5.2% | 7.8% | 14.0% | 100.0% |

Data Source: State MEDS File, March 2017

Table 18 shows the distribution of “Other” non-threshold languages spoken by population enrolled in Medi-Cal in March 2017 by SA.

The highest number of Medi-Cal enrollees that spoke “Other” non-threshold languages was Thai (N = 1,645) with the highest percentage residing in SA 2 at 37.3%. The next highest number of Medi-Cal enrollees spoke ASL (N = 883) with the highest percentage also residing in SA 2 at 26.4%.

Remaining languages spoken by Medi-Cal enrollees were:

Japanese (N = 802) with the highest percentage residing in SA 8 at 37.8%; Hebrew (N = 331) with the highest percentage residing in SA 2 at 73.7%; Samoan (N = 229) with the highest percentage residing in in SA 8 at 26.6%; Lao (N = 194) with the highest percentage residing in SA 3 at 40.7%; French (N = 165) with the highest percentage residing in SA 6 at 26.1%; Other Sign Language (N = 146) with the highest percentage residing in SA 2 at 32.2%; and Portuguese (N = 135) with the highest percentage residing in SA 2 at 24.4%.

The remaining languages shown in Table 18 were spoken by less than 100 Medi-Cal enrollees.

## Consumers Served in Outpatient Programs

In FY 16-17, LACDMH served approximately 247,000 consumers (de-duplicated). A majority were served in outpatient programs (N=206,378). Approximately, 23,000 were served by Fee-For-Service (FFS) outpatient network providers, another 5,000 were served in jails and juvenile halls and approximately 23,000 were served in 24 Hour acute psychiatric care or residential facilities.

In previous years, unique Client ID counts were used when reporting on the number of consumers served Countywide. As recommended by the Office of Clinical Informatics, it was important to report on the de-duplicated number of consumers served Countywide. The deduplication technique involved a Dataflux statistical match to eliminate likely duplicate IDs.

**TABLE 19: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY ETHNICITY AND SERVICE AREA FY 16-17**

| Service Area (SA) | African American | Asian Pacific Islanders | Latino | Native American | White | Total |
|---|---|---|---|---|---|---|
| **SA 1** | 4,288 | 121 | 4,674 | 96 | 2,925 | 12,104 |
| Percent | 35.4% | 1.0% | 38.6% | 0.79% | 24.2% | 100.0% |
| **SA 2** | 3,837 | 1,647 | 25,217 | 214 | 13,085 | 44,000 |
| Percent | 8.7% | 3.7% | 57.3% | 0.49% | 29.7% | 100.0% |
| **SA 3** | 3,551 | 3,447 | 21,468 | 218 | 5,277 | 33,961 |
| Percent | 10.5% | **10.1%** | 63.2% | 0.64% | 15.5% | 100.0% |
| **SA 4** | 6,230 | 2,583 | 21,656 | 191 | 5,418 | 36,078 |
| Percent | 17.3% | 7.2% | 60.0% | 0.53% | 15.0% | 100.0% |
| **SA 5** | 1,609 | 334 | 2,662 | 49 | 4,023 | 8,677 |
| Percent | 18.5% | 3.8% | **30.7%** | 0.56% | **46.4%** | 100.0% |
| **SA 6** | 21,883 | 442 | 24,883 | 120 | 1,666 | 48,994 |
| Percent | **44.7%** | **0.9%** | 50.8% | **0.24%** | **3.4%** | 100.0% |
| **SA 7** | 1,579 | 725 | 27,451 | 272 | 2,921 | 32,948 |
| Percent | **4.8%** | 2.2% | **83.3%** | **0.83%** | 8.9% | 100.0% |
| **SA 8** | 12,271 | 1,885 | 18,664 | 274 | 7,399 | 40,493 |
| Percent | 30.3% | 4.7% | 46.1% | 0.68% | 18.3% | 100.0% |
| **Total** | 38,984 | 7,252 | 103,172 | 989 | 29,844 | 180,241 |
| Percent | 21.6% | 4.0% | 57.2% | 0.55% | 16.6% | 100.0% |

Note: Bold values represent the highest and lowest percentages within each Ethnic group across Service Areas. The total served excludes those whose ethnicity is unknown (N = 13,786) and "Other" (N = 7,818). Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, November 2017.

**Differences by Ethnicity**

The highest percentage of African American consumers served in outpatient programs was in SA 6 (44.7%) as compared to SA 7 (4.8%) with the lowest percentage.

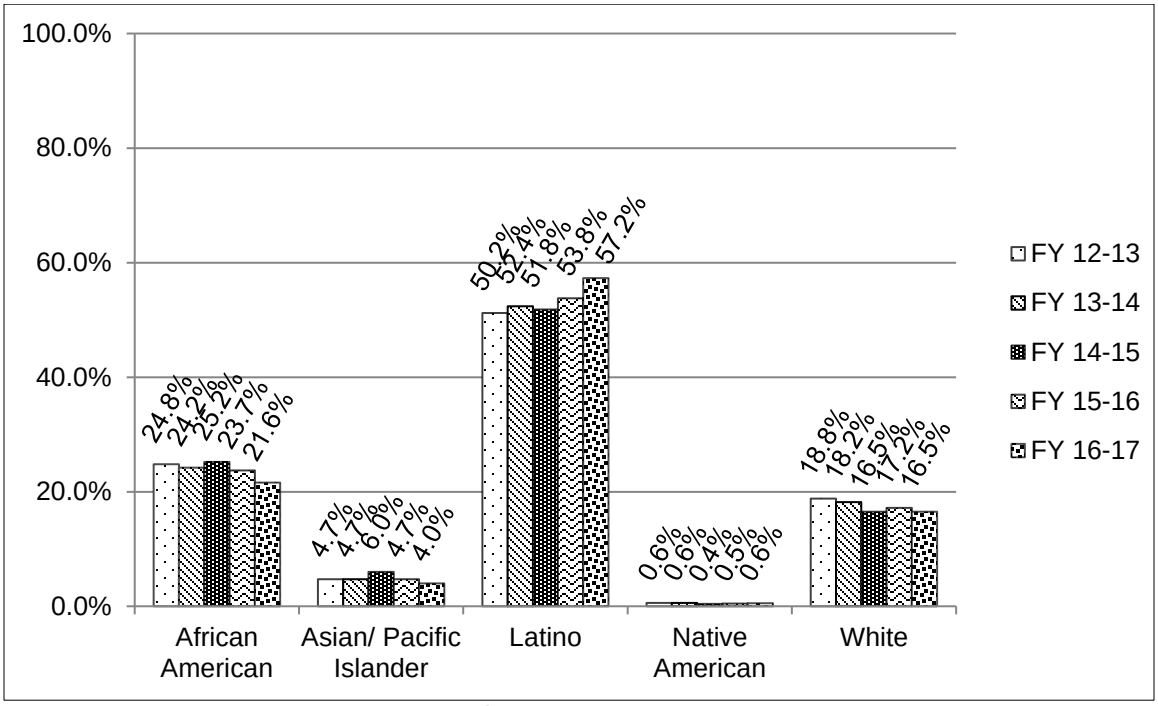
The highest percentage of Asian Pacific Islander consumers served in outpatient programs was in SA 3 (10.1%) as compared to SA 6 (0.9%) with the lowest percentage.

The highest percentage of Latino consumers served in outpatient programs was in SA 7 (83.3%) as compared to SA 5 (30.7%) with the lowest percentage.

The highest percentage of Native American consumers served in outpatient programs was in SA 7 (0.83%) as compared to SA 6 (0.24%) with the lowest percentage.

The highest percentage of White consumers served in outpatient programs was in SA 5 (46.4%) as compared to SA 6 (3.4%) with the lowest percentage.

**FIGURE 9: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY ETHNICITY FY 12-13 TO FY 16-17**




Data Source: LACDMH-IS-IBHIS November 2017

As a percentage of consumers served, African Americans served in outpatient programs decreased by 3.2 PP, from 24.8% to 21.6% between FY 12-13 and FY 16-17.

As a percentage of consumers served, Asian Pacific Islanders served in outpatient programs decreased by 0.7 PP, from 4.7% to 4.0% between FY 12-13 and FY 16-17.

As a percentage of consumers served, Latinos served in outpatient programs increased by 7.0 PP, from 50.2% to 57.2% between FY 12-13 and FY 16-17.

As a percentage of consumers served, Native Americans served in outpatient programs has remained unchanged at 0.6% between FY 12-13 and FY 16-17.

As a percentage of consumers served, Whites served in outpatient programs decreased by 2.3 PP, from 18.8% to 16.5% between FY 12-13 and FY 16-17.

**TABLE 20: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP AND SERVICE AREA FY 16-17**

| Service Area (SA) | Age Group | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | Total |
| **SA1** | 5,268 | 2,277 | 5,175 | 663 | 13,383 |
| Percent | 39.3% | 17.0% | 38.7% | **5.0%** | 100.0% |
| **SA2** | 16,491 | 9,141 | 19,721 | 4,708 | 50,061 |
| Percent | 32.9% | 18.3% | 39.4% | 9.4% | 100.0% |
| **SA3** | 16,250 | 7,483 | 13,770 | 2,837 | 40,340 |
| Percent | 40.3% | **18.5%** | 34.1% | 7.0% | 100.0% |
| **SA4** | 12,116 | 6,348 | 17,576 | 4,253 | 40,293 |
| Percent | 30.1% | 15.8% | 43.6% | 10.5% | 100.0% |
| **SA5** | 2,177 | 1,398 | 5,022 | 1,494 | 10,091 |
| Percent | **21.6%** | **13.9%** | **49.8%** | **14.8%** | 100.0% |
| **SA6** | 19,839 | 9,058 | 21,398 | 3,490 | 53,785 |
| Percent | 36.9% | 16.8% | 39.8% | 6.5% | 100.0% |
| **SA7** | 15,670 | 6,623 | 12,178 | 2,388 | 36,859 |
| Percent | **42.5%** | 18.0% | **33.0%** | 6.5% | 100.0% |
| **SA8** | 14,916 | 7,236 | 20,282 | 4,291 | 46,725 |
| Percent | 31.9% | 15.5% | 43.4% | 9.2% | 100.0% |
| **Total** | 74,321 | 36,103 | 80,317 | 15,637 | 206,378 |
| Percent | 36.0% | 17.5% | 38.9% | 7.6% | 100.0% |

Note: Bold values represent the highest and lowest percentage within each Age group across Service Areas. Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, November 2017.

## Differences by Age Group

Table 20 shows the number of consumers served in outpatient programs by Age group and SA.

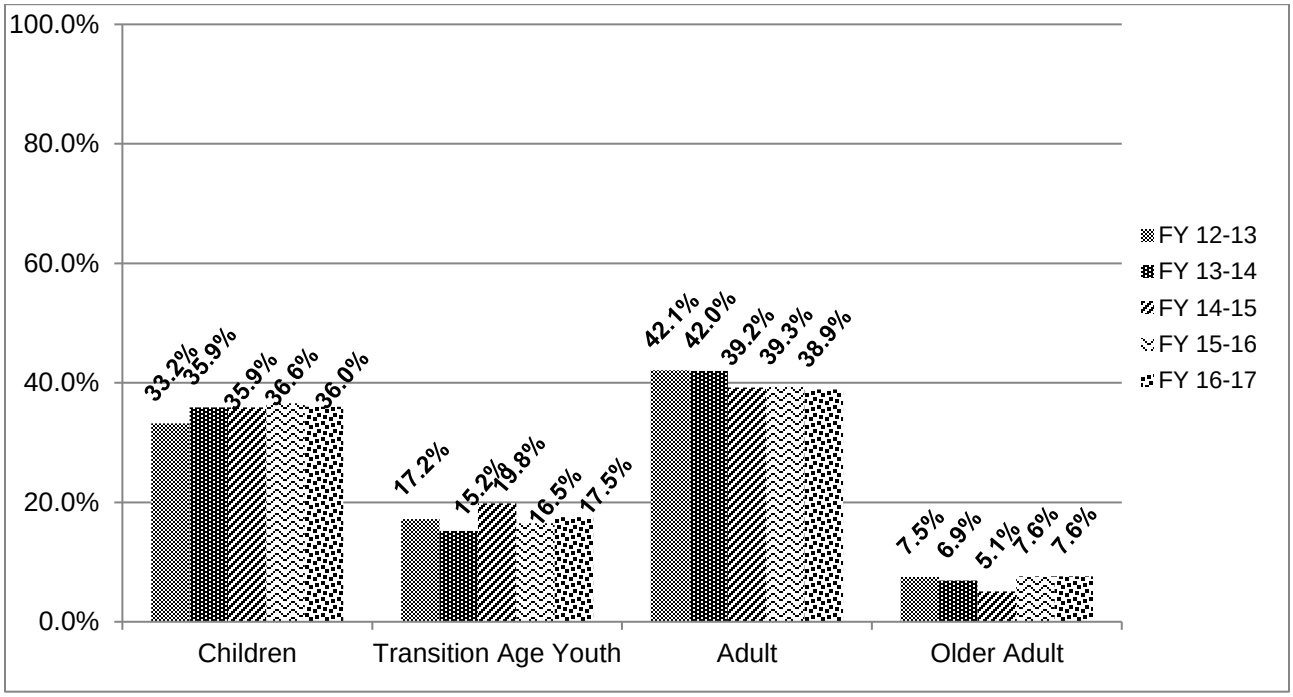
The highest percentage of Children (0-15 years old) served was in SA 7 (42.5**%)** compared to SA 5 (21.6%) with the lowest percentage.

The highest percentage of TAY (16-25 years old) served was in SA 3 (18.5%) when compared to SA 5 (13.9%) with the lowest percentage.

The highest percentage of Adults (26-59 years old) served was in SA 5 (49.8%) compared to SA 7 (33.0%) with the lowest percentage.

The highest percentage of Older Adults (60+ years old) was in SA 5 (14.8%) compared to SA 1 (5.0%) with the lowest percentage.

**FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP FY 12-13 TO FY 16-17**




Data Source: LACDMH-IS-IBHIS, November 2017.

As a percentage of consumers served, Children served in outpatient programs increased by 2.8 PP, from 33.2% to 36.0% between FY 12-13 and FY 16-17.

As a percentage of consumers served, TAY served in outpatient programs increased by 0.3 PP from 17.2% to 17.5% between FY 12-13 and FY 16-17.

As a percentage of consumers served, Adults served in outpatient programs decreased by 3.2 PP, from 42.1% to 38.9% between FY 12-13 and FY 16-17.

As a percentage of consumers served, Older Adults served in outpatient programs increased by 0.1 PP, from 7.5% to 7.6% between FY 12-13 and FY 16-17.

## TABLE 21: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 16-17

| Service Area (SA) | Male | Female | Total |
|---|---|---|---|
| **SA1** | 6,667 | 6,688 | 13,355 |
| Percent | 49.9% | 50.1% | 100.0% |
| **SA2** | 24,928 | 25,115 | 50,043 |
| Percent | 49.8% | 50.2% | 100.0% |
| **SA3** | 20,665 | 19,665 | 40,330 |
| Percent | 51.2% | 48.8% | 100.0% |
| **SA4** | 21,495 | 18,783 | 40,278 |
| Percent | **53.4%** | **46.6%** | 100.0% |
| **SA5** | 4,983 | 5,106 | 10,089 |
| Percent | **49.4%** | **50.6%** | 100.0% |
| **SA6** | 27,300 | 26,471 | 53,771 |
| Percent | 50.8% | 49.2% | 100.0% |
| **SA7** | 18,830 | 18,018 | 36,848 |
| Percent | 51.1% | 48.9% | 100.0% |
| **SA8** | 23,178 | 23,525 | 46,703 |
| Percent | 49.6% | 50.4% | 100.0% |
| **Total** | 101,053 | 105,230 | 206,283 |
| Percent | 49.0% | 51.0% | 100.0% |

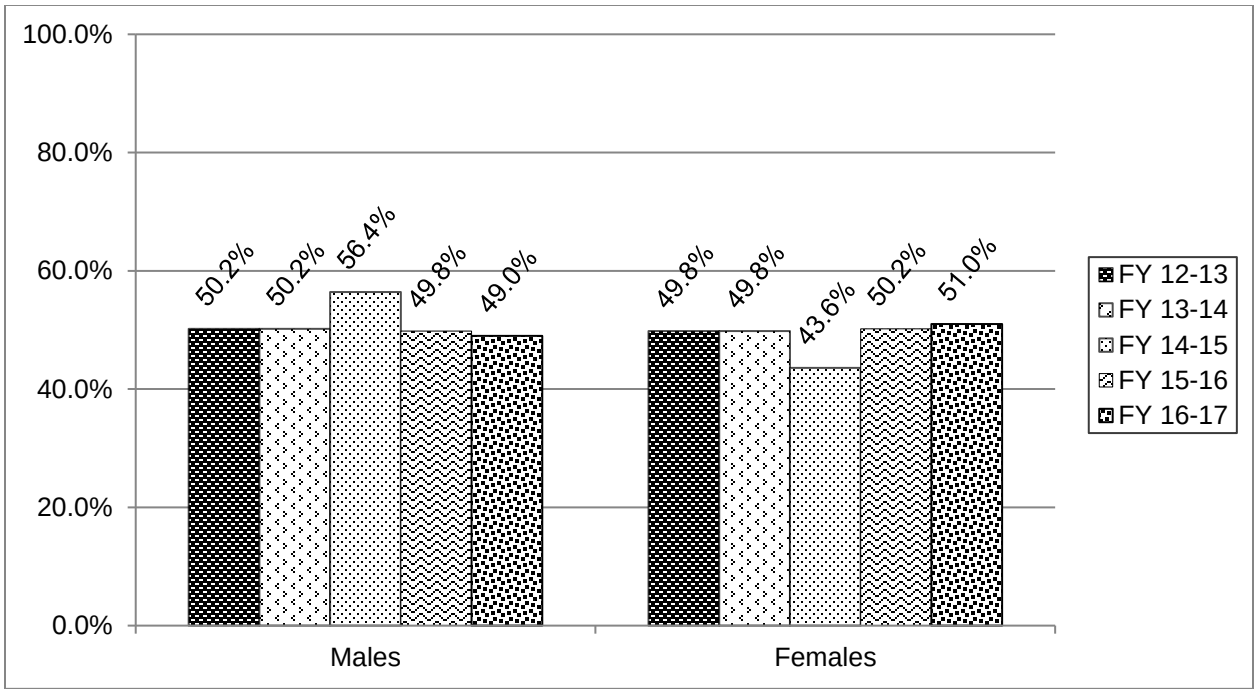
Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. Unknown/Not reported Gender (N= 100) were not included in this table. Data Source: LACDMH-IS-IBHIS, November 2017.

### Differences by Gender

The highest percentage of Males served in outpatient programs was in SA 4 (53.4%) compared to SA 5 (49.4%).

The highest percentage of Females served in outpatient programs was in SA 5 (50.6%) compared to SA 4 (46.6%) with the lowest percentage.

**FIGURE 11: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER**
**FY 12-13 TO FY 16-17**




Data Source: LACDMH-IS-IBHIS Database, November 2017

As a percentage of consumers served, Males served in outpatient programs decreased by 1.2 PP, from 50.2% to 49.0% between FY 12–13 and FY 16–17.

As a percentage of consumers served, Females served in outpatient programs increased by 1.2 PP, from 49.8% to 51.0% between FY 12–13 and FY 16–17.

## TABLE 22: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY SERVICE AREA AND THRESHOLD LANGUAGE FY 16-17

| Service Area (SA) | Arabic | Armenian | Cambodian | Cantonese | English | Farsi | Korean | Mandarin | Other Chinese | Russian | Spanish | Tagalog | Vietnamese | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SA 1** | 5 | 4 | 2 | 0 | 11,774 | 5 | 2 | 2 | 2 | 2 | 1,090 | 6 | 2 | 12,896 |
| Percent | 0.04% | 0.03% | 0.02% | 0.00% | **91.3%** | 0.04% | 0.02% | 0.02% | 0.02% | 0.02% | **8.5%** | 0.05% | 0.02% | 100.0% |
| **SA 2** | 144 | 1,873 | 39 | 10 | 35,199 | 632 | 165 | 25 | 17 | 169 | 9,360 | 192 | 74 | 47,899 |
| Percent | 0.3% | **3.9%** | 0.1% | 0.02% | **73.5%** | **1.3%** | **0.3%** | 0.1% | 0.04% | **0.4%** | **19.5%** | **0.4%** | **0.2%** | 100.0% |
| **SA 3** | 31 | 69 | 92 | 791 | 28,840 | 15 | 90 | 639 | 189 | 2 | 7,541 | 57 | 503 | 38,859 |
| Percent | 0.1% | 0.2% | 0.2% | **2.0%** | **74.2%** | 0.04% | **0.2%** | **1.6%** | **0.5%** | 0.01% | **19.4%** | 0.1% | **1.3%** | 100.0% |
| **SA 4** | 16 | 258 | 126 | 158 | 26,164 | 69 | 947 | 67 | 35 | 121 | 9,516 | 139 | 108 | 37,724 |
| Percent | 0.04% | **0.7%** | 0.3% | **0.4%** | **69.4%** | 0.2% | **2.5%** | 0.2% | 0.1% | **0.3%** | **25.2%** | **0.4%** | 0.3% | 100.0% |
| **SA 5** | 20 | 6 | 0 | 6 | 8,335 | 185 | 27 | 10 | 3 | 22 | 775 | 10 | 2 | 9,401 |
| Percent | 0.2% | 0.1% | 0.0% | 0.1% | **88.7%** | **2.0%** | 0.3% | 0.1% | 0.03% | 0.2% | **8.2%** | 0.1% | 0.02% | 100.0% |
| **SA 6** | 1 | 2 | 39 | 21 | 40,163 | 10 | 94 | 32 | 6 | 3 | 11,271 | 7 | 25 | 51,674 |
| Percent | 0.002% | 0.0% | 0.1% | 0.04% | **77.7%** | 0.02% | 0.2% | 0.1% | 0.01% | 0.01% | **21.8%** | 0.0% | 0.05% | 100.0% |
| **SA 7** | 20 | 14 | 133 | 27 | 24,699 | 4 | 65 | 73 | 21 | 3 | 10,206 | 41 | 44 | 35,350 |
| Percent | 0.1% | 0.04% | 0.4% | 0.1% | **69.9%** | 0.01% | **0.2%** | 0.2% | 0.1% | 0.01% | **28.9%** | 0.1% | 0.1% | 100.0% |
| **SA 8** | 36 | 3 | 1077 | 13 | 34,348 | 17 | 167 | 39 | 16 | 5 | 8,039 | 142 | 223 | 44,125 |
| Percent | 0.1% | 0.01% | **2.4%** | 0.03% | **77.8%** | 0.04% | **0.4%** | 0.1% | 0.04% | 0.01% | **18.2%** | 0.3% | **0.5%** | 100.0% |
| **Total** | 187 | 1,445 | 882 | 615 | 148,974 | 617 | 963 | 574 | 191 | 209 | 40,167 | 379 | 596 | 195,799 |
| Percent | 0.1% | 0.7% | 0.5% | 0.3% | 76.1% | 0.3% | 0.5% | 0.3% | 0.1% | 0.1% | 20.5% | 0.2% | 0.3% | 100.0% |

Note: “Threshold Language” means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. A total of 802 consumers served in outpatient programs specified another non-threshold primary language show in in Table 23. Another 3,791 consumers had primary languages that were “Unknown” or “Missing”. Data Source: LACDMH-IS-IBHIS, November 2017.

Table 22 shows the primary language of consumers served by SA and threshold language. Below is a discussion of the threshold languages by SA.

English was the highest reported primary language among consumers served in outpatient programs, in all SAs. A total of 148,974 (76.1%) English speaking consumers were served, followed by 40,167 (20.5%) Spanish speaking consumers and the remaining 6,658 (3.4%) consumers served spoke other LACDMH threshold languages. A total of 46,825 (23.9%) of the consumers served reported a primary language other than English.

SA 1 (91.3%) had the highest percentage of English speaking consumers, as compared to SA 4 (69.4%) which had the lowest percentage.

Spanish was the highest reported non-English threshold language for consumers served in all SAs. The SA with the highest percentage of consumers served reporting Spanish as their primary language was in SA 7 (28.9%) and the lowest percentage was in SA 5 (8.2%).

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

- SA 1: Spanish (8.5%)
- SA 2: Armenian (3.9%), Farsi (1.3%), Korean (0.3%), Russian (0.4%), Spanish (19.5%), Tagalog (0.4%), and Vietnamese (0.2%)
- SA 3: Cantonese (2.0%), Korean (0.2%), Mandarin (1.6%), Other Chinese (0.5%), Spanish (19.4%), and Vietnamese (1.3%)
- SA 4: Armenian (0.7%), Cantonese (0.4%), Korean (2.5%), Russian (0.3%), Spanish (25.2%), and Tagalog (0.4%)
- SA 5: Farsi (2.0%) and Spanish (8.2%)
- SA 6: Spanish (21.8%)
- SA 7: Korean (0.2%) and Spanish (28.9%)
- SA 8: Cambodian (2.4%), Korean (0.4%), Spanish (18.2%), and Vietnamese (0.5%)

## TABLE 23: "OTHER" NON-THRESHOLD LANGUAGES SPOKEN BY CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY SERVICE AREA FY 16-17

| Languages | SA 1 | SA 2 | SA 3 | SA 4 | SA 5 | SA 6 | SA 7 | SA 8 | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Afghan, Pashto, Pusho** | 1 | 43 | 1 | 3 | 0 | 0 | 0 | 2 | 50 |
| Percent | 2.0% | 86.0% | 2.0% | 6.0% | 0.0% | 0.0% | 0.0% | 4.0% | 100.0% |
| **American Sign Language** | 7 | 37 | 14 | 25 | 8 | 29 | 30 | 28 | 178 |
| Percent | 3.9% | 20.8% | 7.9% | 14.0% | 4.5% | 16.3% | 16.9% | 15.7% | 100.0% |
| **Burmese** | 0 | 5 | 16 | 1 | 0 | 2 | 4 | 1 | 29 |
| Percent | 0.0% | 17.2% | 55.2% | 3.4% | 0.0% | 6.9% | 13.8% | 3.4% | 100.0% |
| **Ethiopian** | 0 | 6 | 2 | 23 | 4 | 9 | 0 | 5 | 49 |
| Percent | 0.0% | 12.2% | 4.1% | 46.9% | 8.2% | 18.4% | 0.0% | 10.2% | 100.0% |
| **French** | 1 | 12 | 12 | 11 | 14 | 4 | 5 | 4 | 63 |
| Percent | 1.6% | 19.0% | 19.0% | 17.5% | 22.2% | 6.3% | 7.9% | 6.3% | 100.0% |
| **Hebrew** | 0 | 23 | 0 | 7 | 2 | 0 | 2 | 5 | 39 |
| Percent | 0.0% | 59.0% | 0.0% | 17.9% | 5.1% | 0.0% | 5.1% | 12.8% | 100.0% |
| **Hindi** | 1 | 24 | 6 | 11 | 6 | 0 | 5 | 15 | 68 |
| Percent | 1.5% | 35.3% | 8.8% | 16.2% | 8.8% | 0.0% | 7.4% | 22.1% | 100.0% |
| **Japanese** | 1 | 13 | 17 | 47 | 14 | 7 | 6 | 72 | 177 |
| Percent | 0.6% | 7.3% | 9.6% | 26.6% | 7.9% | 4.0% | 3.4% | 40.7% | 100.0% |
| **Lao** | 0 | 10 | 19 | 27 | 0 | 11 | 5 | 48 | 120 |
| Percent | 0.0% | 8.3% | 15.8% | 22.5% | 0.0% | 9.2% | 4.2% | 40.0% | 100.0% |
| **Portuguese** | 1 | 11 | 2 | 2 | 12 | 0 | 4 | 10 | 42 |
| Percent | 2.4% | 26.2% | 4.8% | 4.8% | 28.6% | 0.0% | 9.5% | 23.8% | 100.0% |
| **Punjabi** | 0 | 16 | 3 | 2 | 0 | 0 | 7 | 0 | 28 |
| Percent | 0.0% | 57.1% | 10.7% | 7.1% | 0.0% | 0.0% | 25.0% | 0.0% | 100.0% |
| **Romanian** | 1 | 6 | 0 | 4 | 0 | 0 | 2 | 0 | 13 |
| Percent | 7.7% | 46.2% | 0.0% | 30.8% | 0.0% | 0.0% | 15.4% | 0.0% | 100.0% |
| **Thai** | 2 | 23 | 10 | 50 | 2 | 1 | 7 | 15 | 110 |
| Percent | 1.8% | 20.9% | 9.1% | 45.5% | 1.8% | 0.9% | 6.4% | 13.6% | 100.0% |
| **Toisan** | 0 | 2 | 38 | 4 | 0 | 2 | 2 | 0 | 48 |
| Percent | 0.0% | 4.2% | 79.2% | 8.3% | 0.0% | 4.2% | 4.2% | 0.0% | 100.0% |
| **Urdu** | 3 | 11 | 1 | 4 | 0 | 0 | 3 | 19 | 41 |
| Percent | 7.3% | 26.8% | 2.4% | 9.8% | 0.0% | 0.0% | 7.3% | 46.3% | 100.0% |
| **Other Non-English** | 2 | 18 | 8 | 18 | 6 | 5 | 6 | 11 | 74 |
| Percent | 2.7% | 24.3% | 10.8% | 24.3% | 8.1% | 6.8% | 8.1% | 14.9% | 100.0% |
| **Total** | 20 | 260 | 148 | 239 | 68 | 70 | 88 | 235 | 1128 |
| Percent | 1.8% | 23.0% | 13.1% | 21.2% | 6.0% | 6.2% | 7.8% | 20.8% | 100.0% |

Data Source: LACDMH-IS-IBHIS, November 2017

Table 23 shows the distribution of “Other” non-threshold languages spoken by consumers served in FY 15-16. The highest number of consumers that spoke “Other” non-threshold languages was in SA 2 (N = 260), followed by SA 4 (N = 239).

There were a total of 178 consumers whose primary language was American Sign Language (ASL). SA 2 served the highest number of ASL consumers (37), followed by SA 7 (30), and SA 6 (29). The lowest number of ASL consumers served was in SA 1 (7).

Nearly 177 consumers spoke Japanese, followed by 120 consumers who spoke Lao and 110 consumers who spoke Thai.

## SECTION 3

## QI WORK PLAN EVALUATION REPORT FOR CY 2017

LACDMH provides a full array of treatment services as required under Welfare and Institutions Code (W&IC) Sections 5600.3, State Medi-Cal Oversight Review Protocol. The QI Work Plan Goals are in place to monitor and evaluate the quality of the service delivery system. In accordance with the Mental Health Plan's reporting requirements of the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440, concerning QI, the LACDMH evaluation of QI activities are structured and organized according to the following domains:

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

The QI Work Plan Goals for CY 2017 were focused on monitoring access to services for target populations; service delivery capacity; timeliness of the services provided; language needs of consumers; consumer satisfaction with the services received; the quality of services provided; and other areas of quality improvement as identified by LACDMH.

Section 3 provides an evaluation summary on the progress made by LACDMH in reaching each goal.

## QUALITY IMPROVEMENT WORK PLAN EVALUATION SUMMARY – CY 2017

***I. MONITORING SERVICE DELIVERY CAPACITY***

1. *Between 52.9% and 53.5% of Latinos estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH outpatient programs in Fiscal Year (FY) 16-17.* **Goal met.**
2. *Between 34.6% and 36.6% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% FPL will be served in LACDMH outpatient programs in FY 16-17.* **Goal met.**
3. *Provide tele-psychiatry services to at least 1,000 clients in Calendar Year (CY) 2017.* **Goal met.**
4. *Improve service delivery capacity for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth with mental illness through providing a series of trainings to staff of both Directly Operated (DO) and/or Legal Entity (LE) Contracted agencies to improve their skills for assessment and treatment of this population with a special focus on ethnic differences, the issues of aging among the LGBTQ community and generational differences, and issues specific to transgender consumers and their families.* **Goal met.**
5. *Improve service delivery capacity for the American Indian and Alaska Native (AI/AN) population with mental illness through providing a series of trainings to staff of both DO and/or LE Contracted agencies to improve their skills for effective screening, engagement, treatment and best practices for this population.* **Goal met.**

***II. MONITORING ACCESSIBILITY OF SERVICES***

1. *Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 71% for CY 2017.* **Goal not met.**

*2a. Seventy-five percent of after-hours calls to the toll-free hotline for CY 2017 are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll-free hotline.* **Goal met.**

*2b. Seventy percent of daytime calls to the toll-free hotline for CY 2017 are answered by a live agent within 1 minute from when they present to the VCC of the toll-free hotline.* **Goal met.**

3. *Monitor the number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 16-17.* **Goal met.**
4. *Maintain the percentage of consumers/families reporting that they are able to receive services at convenient locations between 86% and 87% for the May 2017 survey period.* **Goal met.**
5. *Maintain the percentage of consumers/families reporting that they are able to receive services at convenient times between 90% and 91% for the May 2017 survey period.* **Goal met.**

***III. MONITORING BENEFICIARY SATISFACTION***

1. *Maintain the percentage of consumers/families reporting that staff was sensitive to their cultural/ethnic background between 87% and 89% for the May 2017 survey period.* **Goal met.**
2. *Maintain the percentage of consumers/families reporting overall satisfaction with services provided between 89% and 91% for the May 2017 survey period and continue year to year trending of the data.* **Goal met.**

*3a. Monitor the grievances, appeals and requests for State Fair Hearings for FY 16-17.* **Goal met.**

*3b. Resolve all standard appeals within 45 calendar days of receipt of appeal by Patients' Rights Office (PRO).*

*3c. Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log.* **Goal met.**

4. *Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests.* **Goal met.**

***IV. MONITORING CLINICAL CARE***

1. *Address evolving standards and requirements associated with the use of medication in mental health programs through systemic application of DMH Medication Parameters to supervision of prescribing practices, and through provision of ongoing training by clinical experts in state-of-the-art use of medication.* **Goal met.**

***V. MONITORING CONTINUITY OF CARE***

1. *At least 85% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center will receive appointments for a Specialty Mental Health Service Assessment within 5 business days in CY 2017.* **Goal met.**

***VI. MONITORING OF PROVIDER APPEALS***

1. *The Mental Health Plan (MHP) will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal.* **Goal met.**

## I. MONITORING SERVICE DELIVERY CAPACITY

**Goal I.1.**

***Between 52.9% and 53.5% of Latinos estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH outpatient programs in Fiscal Year (FY) 16-17.***

**Penetration Rate Numerator:** Unduplicated number of Latino consumers served in LACDMH outpatient programs during the fiscal year.

**Penetration Rate Denominator:** Total Los Angeles County Latino population living at or below 138% FPL estimated with SED and SMI.

Prevalence rates utilized to estimate SED and SMI were derived from the California Health Interview Survey (CHIS; CY 2015 and CY 2016). The CHIS rates are estimated from a random sample of the population in Los Angeles County. The CHIS collects survey data on mental health utilization patterns from the Los Angeles County population every two years, within each SA, and by Ethnicity. This allows for more precise estimates of prevalence and provides the ability to conduct trend analysis.

**EVALUATION**

This goal was met. A total of 59.7% of Latinos estimated with SED and SMI and at or below 138% FPL were served in FY 16-17. Table 24 shows the penetration rates for FY 14-15, FY 15-16, and FY 16-17 using prevalence estimates from CHIS survey data.

**Goal I.2.**

***Between 34.6% and 36.6% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% FPL will be served in LACDMH outpatient programs in FY 16-17.***

**Penetration Rate Numerator:** Unduplicated number of API consumers served in LACDMH outpatient programs during the fiscal year.

**Penetration Rate Denominator:** Total Los Angeles County API population living at or below 138% FPL estimated with SED and SMI.

**EVALUATION**

This goal was met. A total of 41.0% of API estimated with SED and SMI and at or below 138% FPL were served in FY 16-17. Table 24 shows the penetration rates for FY 14-15, FY 15-16, and FY 16-17 using prevalence estimates from CHIS survey data.

## TABLE 24: THREE YEAR TREND IN PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 138% FPL BASED ON PREVALENCE RATE FROM CHIS[1] FY 14-15 TO FY 16-17

| Ethnicity | FY 14-15 | FY 15-16 | FY 16-17 |
|---|---|---|---|
| **African American** | 129.0% | 129.0% | 68.8% |
| Consumers Served | 56,011 | 46,800 | 38,984 |
| Estimated population with SED/SMI | 43,419 | 31,201 | 56,701 |
| **Asian Pacific Islander** | 48.5% | 35.6% | 41.0% |
| Consumers Served | 9,171 | 9,340 | 7,252 |
| Estimated population with SED/SMI | 18,918 | 26,233 | 17,709 |
| **Latino** | 51.5% | 53.2% | 59.7% |
| Consumers Served | 106,891 | 106,094 | 103,172 |
| Estimated population with SED/SMI | 207,651 | 199,531 | 172,795 |
| **Native American** | 95.9% | 31.9% | 116.2% |
| Consumers Served | 1,184 | 1,065 | 989 |
| Estimated population with SED/SMI | 1,235 | 3,340 | 851 |
| **White** | 97.0% | 31.8% | 48.2% |
| Consumers Served | 40,810 | 33,982 | 29,844 |
| Estimated population with SED/SMI | 42,052 | 107,004 | 61,956 |

Note: Ethnic specific Prevalence Rate for SED and SMI from pooled estimates for CY 2015 and CY 2016 California Health Interview Survey (CHIS) [1] were applied to calculate Penetration Rate. Data Source: LACDMH-IS Database, November 2017.

## TABLE 25: PENETRATION RATE AMONG TOTAL POPULATION AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND SERVICE AREA FY 16-17

| Ethnicity and Service Area | [1]Number of Consumers Served[1] | Total Population Estimated with SED and SMI[3] | Penetration Rates for Total Population[2] | Population Living at or Below 138% FPL and Estimated with SED and SMI | Penetration Rates for Population Living at or Below 138% FPL |
|---|---|---|---|---|---|
| **SA 1** | | | | | |
| **African American** | 4,288 | 8,825 | 48.6% | 5,083 | 84.4% |
| **Asian/Pacific Islander** | 121 | 1,162 | 10.4% | 198 | 61.1% |
| **Latino** | 4,674 | 15,436 | 30.3% | 6,816 | 68.6% |
| **Native American** | 96 | 196 | 49.0% | 84 | 114.3% |
| **White** | 2,925 | 11,027 | 26.5% | 4,386 | 66.7% |
| **Total** | 12,104 | 36,646 | 33.0% | 16,567 | 73.1% |
| **SA 2** | | | | | |
| **African American** | 3,837 | 10,784 | 35.6% | 3,574 | 107.4% |
| **Asian/Pacific Islander** | 1,647 | 19,268 | 8.5% | 2,447 | 67.3% |
| **Latino** | 25,217 | 79,183 | 31.8% | 27,387 | 92.1% |
| **Native American** | 214 | 490 | 43.7% | 123 | 174.0% |
| **White** | 13,085 | 81,231 | 16.1% | 20,653 | 63.4% |
| **Total** | 44,000 | 190,956 | 23.0% | 54,183 | 81.2% |
| **SA 3** | | | | | |
| **African American** | 3,551 | 9,122 | 38.9% | 2,715 | 130.8% |
| **Asian/Pacific Islander** | 3,447 | 38,563 | 8.9% | 5,931 | 58.1% |
| **Latino** | 21,468 | 72,064 | 29.8% | 20,684 | 103.8% |
| **Native American** | 218 | 386 | 56.5% | 87 | 250.6% |
| **White** | 5,277 | 30,794 | 17.1% | 7,120 | 74.1% |
| **Total** | 33,961 | 150,928 | 22.5% | 36,537 | 92.9% |
| **SA 4** | | | | | |
| **African American** | 6,230 | 8,505 | 73.3% | 3,717 | 167.6% |
| **Asian/Pacific Islander** | 2,583 | 15,853 | 16.3% | 3,840 | 67.3% |
| **Latino** | 21,656 | 53,600 | 40.4% | 25,501 | 84.9% |
| **Native American** | 191 | 271 | 70.5% | 134 | 142.5% |
| **White** | 5,418 | 23,926 | 22.6% | 9,151 | 59.2% |
| **Total** | 36,078 | 102,155 | 35.3% | 42,343 | 85.2% |

Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2015-2016 pooled. Notes: [1] Numbers Served represent consumers served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include consumers served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps as well as Inpatient Fee-For Service and County Hospitals. [2] Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI. * Duplicated consumers by ethnicity/unduplicated consumers by Ethnicity (For example, 16,264/38,984 = 41.7% for African American.)[3] SED and SMI = Severe Emotional Disturbance and Severe Mental Illness.

## TABLE 25 (CONT'D): PENETRATION RATE AMONG TOTAL POPULATION AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND SERVICE AREA FY 16-17

| | | | | | |
|---|---|---|---|---|---|
| **SA 5** | | | | | |
| **African American** | 1,609 | 5,209 | 30.9% | 1,426 | 112.8% |
| **Asian/Pacific Islander** | 334 | 7,078 | 4.7% | 1,118 | 29.9% |
| **Latino** | 2,662 | 9,282 | 28.7% | 2,219 | 120.0% |
| **Native American** | 49 | 128 | 38.3% | 24 | 204.2% |
| **White** | 4,023 | 34,802 | 11.6% | 8,571 | 46.9% |
| **Total** | 8,677 | 56,498 | 15.4% | 13,358 | 65.0% |
| **SA 6** | | | | | |
| **African American** | 21,883 | 39,982 | 54.7% | 24,391 | 89.7% |
| **Asian/Pacific Islander** | 442 | 1,467 | 30.1% | 553 | 79.9% |
| **Latino** | 24,883 | 63,936 | 38.9% | 37,551 | 66.3% |
| **Native American** | 120 | 192 | 62.5% | 136 | 88.2% |
| **White** | 1,666 | 2,080 | 80.1% | 1,336 | 124.7% |
| **Total** | 48,994 | 107,658 | 45.5% | 63,968 | 76.6% |
| **SA 7** | | | | | |
| **African American** | 1,579 | 5,565 | 28.4% | 1,820 | 86.8% |
| **Asian/Pacific Islander** | 725 | 9,074 | 8.0% | 995 | 72.9% |
| **Latino** | 27,451 | 84,225 | 32.6% | 31,006 | 88.5% |
| **Native American** | 272 | 347 | 78.4% | 113 | 240.7% |
| **White** | 2,921 | 14,853 | 19.7% | 3,667 | 79.7% |
| **Total** | 32,948 | 114,064 | 28.9% | 37,602 | 87.6% |
| **SA 8** | | | | | |
| **African American** | 12,271 | 32,289 | 38.0% | 13,973 | 87.8% |
| **Asian/Pacific Islander** | 1,885 | 19,142 | 9.8% | 2,627 | 71.8% |
| **Latino** | 18,664 | 56,166 | 33.2% | 21,629 | 86.3% |
| **Native American** | 274 | 466 | 58.8% | 151 | 181.5% |
| **White** | 7,399 | 36,425 | 20.3% | 7,072 | 104.6% |
| **Total** | 40,493 | 144,489 | 28.0% | 45,452 | 89.1% |

Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2015-2016 pooled. Notes: [1] Numbers Served represent consumers served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include consumers served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps as well as Inpatient Fee-For Service and County Hospitals. [2] Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI. * Duplicated consumers by ethnicity/unduplicated consumers by Ethnicity (For example, 16,264/38,984 = 41.7% for African American.)[3] SED and SMI = Severe Emotional Disturbance and Severe Mental Illness.

## TABLE 25 (CONT'D): PENETRATION RATE AMONG TOTAL POPULATION AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND SERVICE AREA FY 16-17

| | | | | | |
|---|---|---|---|---|---|
| **Unduplicated Consumers Served in At least 1 Service Area** | | | | | |
| **African American** | 38,984 | 120,281 | 32.4% | 56,701 | 68.8% |
| **Asian/Pacific Islander** | 7,252 | 111,608 | 6.5% | 17,709 | 41.0% |
| **Latino** | 103,172 | 433,893 | 23.8% | 172,795 | 59.7% |
| **Native American** | 989 | 2,477 | 39.9% | 851 | 116.2% |
| **White** | 29,844 | 235,138 | 12.7% | 61,956 | 48.2% |
| **Total** | 180,241 | 903,397 | 20.0% | 310,011 | 58.1% |
| **Duplicated Countywide Consumers Served in More Than one Service Area** | | | | | |
| **African American** | 16,264 | 41.7% | | | |
| **Asian/Pacific Islander** | 932 | 12.9% | | | |
| **Latino** | 43,503 | 42.2% | | | |
| **Native American** | 445 | 45.0% | | | |
| **White** | 12,870 | 43.1% | | | |
| **Total** | 77,014 | 42.7% | | | |

Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2015-2016 pooled. Notes: [1] Numbers Served represent consumers served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include consumers served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps as well as Inpatient Fee-For Service and County Hospitals. [2] Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI. [3] SED and SMI = Severe Emotional Disturbance and Severe Mental Illness.

## TABLE 26: ESTIMATED PREVALANCE RATES FOR SED AND SMI BY CHIS WITH CONFIDENCE INTERVALS: 2013-2014 TO 2015-2016

| Total Population | | | | | | |
|---|---|---|---|---|---|---|
| | 2013-14 | Confidence Interval | 2014-15 | Confidence Interval | 2015-16 | Confidence Interval |
| Total | 9.1% | (8.0 - 10.1) | 9.7% | 8.5 - 10.8 | 8.9% | 7.6 - 10.1 |
| African American | 7.7% | (4.1 - 11.2) | 9.0% | 4.6 - 13.4 | 13.9% | 8.1 - 19.7 |
| API | 5.5% | (3.1 - 7.9) | 6.3% | 3.0 - 9.7 | 7.5* | 2.9 - 12.1 |
| Latino | 10.0% | (8.2 - 11.9) | 10.9% | 9.0 - 12.7 | 8.7% | 7.1 - 10.2 |
| Native American | 73.0%* | (46.3 - 99.6) | 45.7* | 16.2 - 75.1 | 12.9* | 0 - 27.1 |
| White | 9.3% | (7.1 - 11.6) | 9.6% | 7.1 - 12.1 | 8.2% | 5.9 - 10.5 |
| Two or More Races | 13.7%* | (1.0 - 26.4) | 6.0* | 0.7 - 11.3 | 13.6* | 3.6 - 23.5 |
| **Population at or Below 138% FPL** | | | | | | |
| | 2013-14 | Confidence Interval | 2014-15 | Confidence Interval | 2015-16 | Confidence Interval |
| Total | 12.5% | (10.2 - 14.9) | 13.1% | 10.8 - 15.3 | 12.0% | 9.6 - 14.4 |
| African American | 11.6%* | (3.6 - 19.6) | 12.2* | 3.3 - 21.1 | 23.1% | 9.5 - 36.6 |
| API | 9.9%* | (3.0 - 16.9) | 6.4* | 0.8 - 12.0 | 6.8* | 0.8 - 12.7 |
| Latino | 11.2% | (8.5 - 13.8) | 12.5% | 9.8 - 15.2 | 10.6% | 8.0 - 13.3 |
| Native American | 63.1%* | (41.9 - 84.3) | 43.8* | 7.1 - 80.5 | 17.5* | 0 - 51.4 |
| White | 25.1% | (13.5 - 36.7) | 23.7% | 15.1 - 32.4 | 15.5% | 7.8 - 23.2 |
| Two or More Races | 16.8%* | (0 - 36.6) | 10.0* | 0 - 23.5 | 15.0* | 0 - 32.3 |
| **Population at or Below 200% FPL** | | | | | | |
| | 2013-14 | Confidence Interval | 2014-15 | Confidence Interval | 2015-16 | Confidence Interval |
| Total | 11.7% | (9.5 - 13.8) | 12.6% | 10.5 - 14.7 | 10.7% | 8.8 - 12.6 |
| African American | 10.2% | (4.4 - 16.0) | 13.5% | 6.5 - 20.5 | 22.3% | 11.1 - 33.5 |
| API | 7.3%* | (3.0 - 11.5) | 5.5* | 1.4 - 9.7 | 6.2* | 1.6 - 10.8 |
| Latino | 10.3% | (8.0 - 12.7) | 12.0% | 9.6 - 14.5 | 9.4% | 7.3 - 11.5 |
| Native American | 62.8%* | (41.7 - 84.0) | 38.5* | 9.5 - 67.4 | 13.3* | 0 - 38.3 |
| White | 23.5% | (14.6 - 32.3) | 22.7% | 15.1 - 30.3 | 12.7% | 6.9 - 18.5 |
| Two or More Races | 24.2%* | (0 - 49.6) | 7.9* | 0 - 15.7 | 17.4* | 0.3 - 34.6 |

Data Source: 2015, 2016 CHIS. * = statistically unstable

**Goal I.3.**

***Provide tele-psychiatry services to at least 1,000 clients in Calendar Year (CY) 2017.***

**EVALUATION**

This goal was met. In CY 2017, 1,316 consumers received tele-psychiatry services through the Telemental Health (TMH) program. There was a slight decline from the 1,338 consumers served by the TMH program in CY 2016.

The TMH program uses video-teleconferencing equipment to provide mental health services to individuals with a Serious Mental Illness (SMI) at a distance. The program allows consumers who live in medically underserved areas greater access to specialty care. In CY 2017, there were staffing changes that resulted in the lack of stable staff. Since August 2017, there has been one permanent psychiatrist. The program no longer has a bilingual psychiatrist on staff. Another reason for a slight decline in the number of clients is due to the withdrawal of all Antelope Valley Mental Health Center (AVMHC) clients from TMH services. AVMHC was a primary end point to the TMH program and they have opted to assign their clients to newly hired psychiatrists within their clinic. As the program is being re-envisioned, the plan is to increase the client census.

**Goal I.4.**

***Improve service delivery capacity for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth with mental illness through providing a series of trainings to staff of both Directly Operated (DO) and/or Legal Entity (LE) Contracted agencies to improve their skills for assessment and treatment of this population with a special focus on ethnic differences, the issues of aging among the LGBTQ community and generational differences, and issues specific to transgender consumers and their families.***

**EVALUATION**

This goal was met. Trainings were provided by the WET Division on May 31, 2017 and June 29, 2017. Staff from both DO and LE Contracted programs were invited to attend.

The “Providing Mental Health in the Transgender Community” training was held on May 31, 2017. It was a full day (six-hour) training and took place in SA 4. A total of 69 individuals attended. At the time of this training, 53% of the participants were providing direct services to consumers. Approximately 47% of the attendees were Licensed Clinical Social Workers (LCSWs), Licensed Psychologists, and Licensed Marriage and Family Therapists (LMFTs). Training evaluations were developed and 56 evaluations were collected at the end of the training.

Ninety-five percent of the attendees of the “Providing Mental Health in the Transgender Community“ training ‘strongly agreed’ or ‘agreed’ they were equipped to “Describe the biology behind Intersex conditions and the development of a Transgender identity.” Ninety-two percent of attendees reported improved confidence in their ability to, “Discuss

the disparities in health and mental health care for Intersex and Transgender people." Ninety-three percent of attendees positively endorsed an increased ability to "Describe how to support relationships where one person transitions to a different gender." Ninety-eight percent of attendees 'strongly agreed' or 'agreed' that the trainer was knowledgeable. The training received positive feedback from its attendees. Examples of post-training statements from attendees include: "It was an eye opener to the LGBT community;" "All of the material was insightful, the videos and discussion helped me understand further;" and "Fantastic [training] and should be encouraged or required for all DMH employees."

The "Providing Culturally Responsive Services to LGBT Individuals and Intergenerational Issues Faced among the LGBT Community" training was held on June 29, 2017. It was also a full day (six-hour) training and took place in SA 4. A total of 70 individuals attended. Of those who attended, 61% were direct service providers and 44% were LCSWs, Licensed Psychologists, and LMFTs. Training evaluations were developed and 63 evaluations were collected at the end of the training.

Eighty-nine percent of the attendees of the "Providing Culturally Responsive Services to LGBT Individuals and Intergenerational Issues Faced among the LGBT Community" training 'strongly agreed' or 'agreed' they gained the knowledge and skills needed to, "Identify two factors that might contribute to substance use among LGBT clients." Ninety-two percent of attendees reported improved confidence in their ability to, "Identify two barriers for health screening and check-ups for LGBT clients." Ninety-six percent of attendees endorsed enhanced skills in "Identify[ing] two health issues/behaviors for which LGBT clients have a higher risk." Ninety-seven percent of attendees 'strongly agreed' or 'agreed' that the trainer was knowledgeable and well prepared. The training was well-received by its attendees. Examples of post-training statements from attendees include: "I felt I got the most up to date information and great discussion;" "Presentation was engaging and very informative;" "I was very interested in the cultural aspects and really everything discussed." "The discussion and PowerPoint helped me understand;" "All of this will be useful to my work;" and "I am more sensitive and understanding of issues facing LGBT and feel better prepared to help them."

**Goal I.5.**

***Improve service delivery capacity for the American Indian and Alaska Native (AI/AN) population with mental illness through providing a series of trainings to staff of both DO and/or LE Contracted agencies to improve their skills for effective screening, engagement, treatment and best practices for this population.***

**EVALUATION**

This goal was met. The AI/AN Clinical Mental Health Training was developed to provide mental health clinicians with an unprecedented opportunity to become trained in identifying and treating the unique mental health needs and challenges faced by the AI/AN population. This capacity building project included facilitation of a two-day clinical training for mental health clinicians. The majority of participants were LCSWs at 47%, Licensed Psychologists at 11%, LMFTs at 17%, unlicensed at 16%, Registered Nurses (RNs) at 5%, students were 1%, and addiction counselors at 1%. There were 205 participants in total for the 11 trainings. The training was conducted once in SAs 2, 3, 4, 5, and 6 and twice in SAs 1, 7, and 8.

The majority of the participants (90%) gave the training a score of 4.5 or higher (5 being the highest). At all the trainings, the participants were engaging and had many questions. The rating for the overall training was: 90% said Excellent, 9% Good, and 1% was Fair. The pre/post-tests ranged from a score of 1 for none to 5 for a lot. The overall pre-test had an average score of 2.20 and the post-test was 4.29, showing that participants did learn a great deal about Clinical Mental Health with AI/ANs at the two-day trainings.

The majority of the participants' comments/quotes received were positive. One participant stated, "This is absolutely amazing and eye opening training. I have a whole new perspective about a community that has been extremely underserved. I have been motivated to find ways of helping in my community. Thank you so much." Another participant reported, "This was a pleasure. I was provided an abundance of information which I will utilize with clients. The speakers were awesome, professional & knowledgeable. I feel/believe that they are doing a great service to those in need." Several participants designated the AI/AN Clinical Mental Health Training as, "the best training ever."

## II. MONITORING ACCESSIBILITY OF SERVICES

### Goal II.1.

***Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 71% for CY 2017.***

**Numerator:** The number of after-hours PMRT responses with a response time of one hour or less.

**Denominator:** Total number of after-hours PMRT responses.

### EVALUATION

This goal was not met. Table 27 summarizes PMRT responsiveness between CY 2013 and CY 2017. In CY 2017, PMRT was dispatched and on scene within one hour or less from acknowledgement of receipt of the call for 60% of PMRT after-hours calls. This represents an 11 PP decline in ACCESS Center PMRT responsiveness when compared to CY 2016.

There was an increase in the number of requests for after-hours PMRT visits with no parallel increase in staffing. The number of after-hours calls for PMRT visits has trended upwards over the past three years. There were 3,670 after-hours PMRT calls in CY 2015, 3,904 calls in CY 2016, and 4,825 calls in CY 2017. In CY 2017, there was a 24 percent increase in after-hours PMRT requests when compared to CY 2016.

**TABLE 27: PSYCHIATRIC MOBILE RESPONSE TEAM (PMRT)**
**AFTER-HOURS RESPONSE RATES OF ONE HOUR OR LESS**
**CY 2013–2017**

| Month | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| **January** | 75% | 75% | 72% | 70% | 63% |
| **February** | 68% | 73% | 70% | 74% | 61% |
| **March** | 68% | 73% | 69% | 74% | 62% |
| **April** | 72% | 72% | 68% | 73% | 63% |
| **May** | 71% | 71% | 70% | 73% | 62% |
| **June** | 71% | 73% | 73% | 73% | 59% |
| **July** | 71% | 74% | 75% | 74% | 59% |
| **August** | 71% | 76% | 72% | 75% | 58% |
| **September** | 74% | 73% | 69% | 70% | 59% |
| **October** | 75% | 74% | 71% | 66% | 58% |
| **November** | 73% | 67% | 70% | 63% | 58% |
| **December** | 74% | 73% | 71% | 71% | 56% |
| **Annual Total** | **4,859** | **5,824** | **3,670** | **3,904** | **4,825** |
| **Annual Average %** | **72%** | **73%** | **71%** | **71%** | **60%** |

Data Source: LACDMH ACCESS Center, CY 2013 – CY 2017.

LACDMH utilizes the EOTD PMRT responsiveness as an indicator of timeliness of field visits requiring rapid intervention and assistance. The rationale for this indicator stems from concerns about providing alternatives to hospitalization and linkage with other appropriate levels of care such as Urgent Care Centers.

**ACCESS Center Response Times**

The LACDMH ACCESS Center provides emergency and non-emergency services. The ACCESS Center strives to meet the cultural and linguistic needs of our communities by providing language assistance services in threshold and non-threshold languages, at the time of first contact. Callers request information related to mental health services and other social needs, and the ACCESS Center provides them with referrals to cultural-specific providers and services that are conveniently located and appropriate to their needs.

**Goal II.2a.**

***Seventy-five percent of after-hours calls to the toll-free hotline for CY 2017 are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll-free hotline.***

**Numerator:** Total number of after-hours calls in which caller reached a live agent within 1 minute.

**Denominator:** Total number of after-hours calls to the ACCESS Center.

**EVALUATION**

This goal was met. The ACCESS Center achieved an annual average of 80% of after-hours calls to the toll-free hotline being answered by a live agent within 1 minute. The improvement in ACCESS Center responsiveness to calls in CY 2017 can be attributed to the implementation of the non-clinical PIP that led to closer monitoring of the call handling. Additionally, four staff vacancies were filled in CY 2017 (two after hours supervisors and two after hours staff).

**Goal II.2b.**

***Seventy percent of daytime calls to the toll-free hotline for CY 2017 are answered by a live agent within 1 minute from when they present to the VCC of the toll-free hotline.***

**Numerator:** Total number of daytime-hours calls in which caller reached a live agent within 1 minute.

**Denominator:** Total number of daytime-hours calls to the ACCESS Center.

**EVALUATION**

This goal was met. The ACCESS Center achieved an annual average of 85% of daytime hours calls to the toll-free hotline being answered by a live agent within 1 minute. The improvement in ACCESS Center responsiveness to calls in CY 2017 can be attributed to the implementation of the non-clinical PIP that led to closer monitoring of the call handling. Additionally, four staff vacancies were filled in CY 2017 (one daytime supervisor and three day time staff – two are Spanish speaking).

## TABLE 28: CALLS ANSWERED WITHIN 1 MINUTE BY NUMBER AND PERCENT CY 2017

| Month | Total Calls By Shift | Calls Answered Within 1 Minute by Shift | Percentage of Calls Answered Within 1 Minute |
|---|---|---|---|
| **January** | | | |
| Daytime | 5,656 | 4,718 | 83% |
| After-Hours | 6,997 | 5,841 | 83% |
| **February** | | | |
| Daytime | 5,772 | 4,650 | 81% |
| After-Hours | 6,445 | 5,197 | 81% |
| **March** | | | |
| Daytime | 6,462 | 5,610 | 87% |
| After-Hours | 7,722 | 6,048 | 78% |
| **April** | | | |
| Daytime | 5,964 | 4,474 | 75% |
| After-Hours | 7,088 | 5,310 | 75% |
| **May** | | | |
| Daytime | 7,743 | 5,700 | 74% |
| After-Hours | 7,106 | 4,957 | 70% |
| **June** | | | |
| Daytime | 6,550 | 5,810 | 89% |
| After-Hours | 6,694 | 5,211 | 78% |
| **July** | | | |
| Daytime | 5,634 | 4,949 | 88% |
| After-Hours | 7,211 | 5,525 | 77% |
| **August** | | | |
| Daytime | 5,287 | 5,119 | 97% |
| After-Hours | 6,181 | 5,418 | 88% |
| **September** | | | |
| Daytime | 5,516 | 4,729 | 86% |
| After-Hours | 6,114 | 5,149 | 84% |
| **October** | | | |
| Daytime | 5,915 | 4,993 | 84% |
| After-Hours | 6,647 | 5,152 | 78% |
| **November** | | | |
| Daytime | 5,226 | 4,442 | 85% |
| After-Hours | 6,053 | 5,052 | 83% |
| **December** | | | |
| Daytime | 4,849 | 4,455 | 92% |
| After-Hours | 5,525 | 4,624 | 84% |
| ***Year-to-Date*** | | | |
| *Daytime* | *70,574* | *59,649* | *85%* |
| *After-Hours* | *79,783* | *63,484* | *80%* |
| *Grand Total* | *150,357* | *123,133* | *82%* |

Note: Daytime hours are 8:00 AM to 5:00 PM, Monday through Friday, excluding holidays. After-hours are outside of daytime hours and include weekends and holidays. Data Source: LACDMH ACCESS Center, CY 2017.

**Goal II.3.**

**Monitor the number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 16-17.**

## EVALUATION

This goal was met. A total of 1,242 requests for hearing impaired interpreter services were coordinated by the toll free hotline in FY 16-17.

**TABLE 29: SUMMARY OF APPOINTMENTS FOR HEARING IMPAIRED SERVICES BY FISCAL YEAR FY 12-13 TO FY 16-17**

| Fiscal Year (FY) | Number of Assigned Appointments |
|---|---|
| FY 12-13 | 1,025 |
| FY 13-14 | 937 |
| FY 14-15 | 1,137 |
| FY 15-16 | 1,058 |
| FY 16-17 | 1,242 |
| **TOTAL** | 5,399 |

Note: Data includes only interpreter services requests assigned to ASL interpreters available to provide service on a given date. Data Source: LACDMH ACCESS Center, FY 12-13 to FY 16-17.

**TABLE 30: NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FIVE YEAR TREND CY 2013–2017**

| *Language | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| AMHARIC | 0 | 1 | 0 | 0 | 1 |
| *ARABIC | 21 | 24 | 6 | 16 | 8 |
| *ARMENIAN | 48 | 225 | 80 | 130 | 128 |
| BAHASA | 0 | 0 | 0 | 1 | 0 |
| BENGALI | 1 | 0 | 0 | 1 | 0 |
| BOSNIAN | 0 | 1 | 0 | 0 | 0 |
| BULGARIAN | 0 | 0 | 0 | 0 | 0 |
| BURMESE | 0 | 0 | 0 | 0 | 0 |
| CAMBODIAN | 0 | 0 | 0 | 7 | 10 |
| *CANTONESE | 46 | 60 | 46 | 40 | 46 |
| CEBUANO | 0 | 1 | 0 | 0 | 0 |

## TABLE 30 (CONT'D): NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FIVE YEAR TREND CY 2013–2017

| *Language | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| *FARSI | 70 | 81 | 58 | 56 | 178 |
| FRENCH | 1 | 2 | 2 | 2 | 1 |
| GERMAN | 0 | 0 | 1 | 0 | 0 |
| GREEK | 0 | 0 | 1 | 0 | 0 |
| HEBREW | 1 | 2 | 1 | 0 | 0 |
| HINDI | 0 | 1 | 0 | 0 | 0 |
| HUNGARIAN | 0 | 0 | 3 | 0 | 0 |
| ITALIAN | 0 | 0 | 0 | 0 | 0 |
| JAPANESE | 3 | 2 | 2 | 4 | 2 |
| KHMER | 10 | 5 | 3 | 1 | 0 |
| *KOREAN | 109 | 132 | 108 | 116 | 140 |
| KURDISH-BEHDINI | 0 | 1 | 0 | 0 | 0 |
| LAOTIAN | 0 | 2 | 0 | 0 | 0 |
| *MANDARIN | 57 | 30 | 62 | 86 | 82 |
| MONGOLIAN | 1 | 0 | 0 | 0 | 0 |
| NEPALI | 1 | 2 | 0 | 0 | 0 |
| PASHTO | 0 | 0 | 0 | 0 | 0 |
| PERSIAN | 0 | 0 | 0 | 1 | 5 |
| POLISH | 0 | 0 | 0 | 1 | 0 |
| PORTUGUESE | 0 | 1 | 0 | 1 | 1 |
| PUNJABI | 0 | 0 | 1 | 0 | 2 |
| ROMANIAN | 0 | 0 | 0 | 1 | 0 |
| *RUSSIAN | 15 | 11 | 12 | 16 | 37 |
| SAMOAN | 5 | 0 | 0 | 0 | 0 |
| SERBIAN | 0 | 0 | 0 | 2 | 0 |
| SLOVAK | 0 | 0 | 0 | 1 | 0 |
| *SPANISH (LISMA) | 2,509 | 1,402 | 1,089 | 1,474 | 2,303 |
| SPANISH ACCESS CTR | 11,240 | 6,135 | 6,159 | 6,040 | 6,150 |
| **SPANISH SUBTOTAL** | 13,749 | 7,537 | 7,248 | 7,514 | 8,453 |
| *TAGALOG | 16 | 18 | 7 | 10 | 9 |
| THAI | 1 | 2 | 1 | 0 | 7 |
| TURKISH | 0 | 0 | 0 | 0 | 0 |
| URDU | 2 | 1 | 0 | 0 | 0 |
| *VIETNAMESE | 24 | 24 | 17 | 28 | 195 |
| **TOTAL** | **14,186** | **8,169** | **7,659** | **8,035** | **9,305** |

Note: *LACDMH Threshold Languages excludes 'Other Chinese' and 'English' in CY 2016 and CY 2017. [1] The total for non-English calls and Spanish ACCESS Center Calls for CY 2013 is inaccurate and over reported due to errors in the Web Center System in effect at that time. [2]Telephone Interpreter Line Calls. Data Source: LACDMH ACCESS Center, CY 2013 - CY 2017.

Table 30 summarizes the total number of non-English language calls received by ACCESS Center for CY 2013 through CY 2017. The trend over the past five years indicates that the majority of non-English callers have requested Spanish language interpretation services, followed by Vietnamese and Farsi language services.

In CY 2017, ACCESS Center staff provided interpreter services for 6,150 calls in Spanish. Telephone interpretation services were utilized for an additional 2,303 Spanish calls. Among all non-English calls, 90.8% were Spanish language calls, followed by Vietnamese (195 calls) at 2.1% of all non-English calls and Farsi (178 calls) at 2.0% of all non-English calls.

From CY 2016 to CY 2017, there was an increase in the number of non-English calls and the top three non-English language calls changed. Spanish language calls remained the highest with an increase of 7,514 calls in CY 2016 to 8,453 calls in CY 2017. Armenian and Korean language calls were in the top-three for CY 2016. The total Armenian calls were consistent for CYs 2016 and 2017. The ongoing TV talk shows and media outreach contributed to this consistent call volume in CY 2017. Korean calls increased from116 calls in CY 2016 to 140 calls in CY 2017; however, the Farsi calls tripled in CY 2017 compared to the CY 2016 call volume (178 versus 56) and Vietnamese calls showed a very significant increase in CY 2017 compared to CY 2016 (195 versus 28).

Languages in which at least 10 or more callers requested interpretation services in CY 2017 include: Cambodian; Cantonese; Mandarin; and Russian.

## Consumer Satisfaction Survey Goals

Consumer Perception Survey (CPS) forms are collected twice per year. The Youth Services Survey for Families (YSS-F) form was administered to families of individuals who are 0 to 17 years of age. The Youth Services Survey (YSS) form was administered to individuals who are 13 to 17 years of age. The Adult Survey form was administered to individuals who are 18 to 59 years of age. The Older Adult Survey form was administered to individuals who are 60 years of age or older.

### Goal II.4.

***Maintain the percentage of consumers/families reporting that they are able to receive services at convenient locations between 86% and 87% for the May 2017 survey period.***

### EVALUATION

This goal was met. The Spring 2017, Mental Health Consumer Perception Survey data was collected between May 15, 2017 and May 19, 2017. Approximately, 87% of the consumers/families who participated in the May 2017 survey period reported they strongly agreed or agreed the location of services were convenient for them. This represents a 0.2 PP decline from May 2016 and a 2.9 PP increase from May 2015.

**TABLE 31: PERCENT OF CONSUMERS / FAMILIES BY AGE GROUP WHO STRONGLY AGREE OR AGREE WITH "LOCATION OF SERVICES WAS CONVENIENT FOR ME" CY 2015 TO MAY 2017**

| Age Group | CY 2015 | | CY 2016 | | CY 2017 |
|---|---|---|---|---|---|
| | May | November | May | November | May |
| **YSS-F** | | | | | |
| Number | 2,622 | 1,977 | 2,622 | 2,684 | 2,209 |
| Percent | 91.0% | 92.2% | 92.4% | 91.2% | 92.8% |
| **YSS** | | | | | |
| Number | 1,223 | 894 | 1,223 | 1,263 | 1,107 |
| Percent | 78.3% | 83.0% | 80.8% | 83.7% | 84.3% |
| **Adult** | | | | | |
| Number | 3,346 | 2,743 | 3,346 | 3,620 | 3,299 |
| Percent | 82.5% | 84.3% | 84.2% | 83.9% | 83.7% |
| **Older Adult** | | | | | |
| Number | 427 | 235 | 427 | 514 | 432 |
| Percent | 84.5% | 87.6% | 91.5% | 88.7% | 89.5% |
| **Total** | | | | | |
| Number | 7,618 | 5,849 | 7,618 | 8,081 | 7,047 |
| Percent | 84.1% | 86.8% | 87.2% | 86.9% | 87.0% |

Note: The Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses on the 5 point Likert scale. Data Source: CPS forms completed by consumers/families served in LACDMH outpatient programs between CY 2015 and May 2017.

Table 31 reports the percentage of consumers and families in CY 2015, CY 2016, and May 2017 that strongly agreed or agreed with the statement, “Location of services was convenient.” Among YSS-F, there was a 0.4 PP increase from 92.4% in May 2016 to 92.8% in May 2017. Among YSS, there was a 4 PP increase from 80.8% in May 2016 to 84.3% in May 2017. Among Adults, there was a 0.5 PP decline from 84.2% in May 2016 to 83.7% in May 2017. Among Older Adults, there was a 2 PP decline from 91.5% in May 2016 to 89.5% in May 2017.

**Goal II.5.**

**Maintain the percentage of consumers/families reporting that they are able to receive services at convenient times between 90% and 91% for the May 2017 survey period.**

**EVALUATION**

This goal was met. A total of 90.8% of the consumers and families that participated in the May 2017 survey period reported they strongly agreed or agreed that services were provided at times that were convenient. There was no notable change in reported satisfaction from May 2016 to May 2017.

**TABLE 32: PERCENT OF CONSUMERS / FAMILIES BY AGE GROUP WHO STRONGLY AGREE OR AGREE WITH "SERVICES WERE AVAILABLE AT TIMES THAT WERE GOOD FOR ME" CY 2015 TO CY 2017**

| Age Group | CY 2015 | | CY 2016 | | CY 2017 |
|---|---|---|---|---|---|
| | May | November | May | November | May |
| **YSS-F** | | | | | |
| Number | 2,622 | 1,977 | 2,622 | 2,684 | 2,209 |
| Percent | 92.1% | 93.4% | 94.0% | 92.3% | 93.4% |
| **YSS** | | | | | |
| Number | 1,223 | 894 | 1,223 | 1,263 | 1,107 |
| Percent | 81.1% | 84.3% | 82.3% | 83.3% | 86.3% |
| **Adult** | | | | | |
| Number | 3,346 | 2,743 | 3,346 | 3,620 | 3,299 |
| Percent | 90.0% | 89.9% | 90.6% | 89.3% | 90.3% |
| **Older Adult** | | | | | |
| Number | 427 | 235 | 427 | 514 | 432% |
| Percent | 94.1% | 92.6% | 95.1% | 93.3% | 94.0% |
| **Total** | | | | | |
| Number | 7,618 | 5,849 | 7,618 | 8,081 | 7,047 |
| Percent | 89.3% | 90.0% | 90.5% | 89.6% | 90.8% |

Note: The Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses on the 5 point Likert scale. Data Source: CPS forms completed by consumers/families served in LACDMH outpatient programs between CY 2015 and May 2017.

Table 32 reports the percentage of consumers and families in families in CY 2015, CY 2016, and May 2017 that strongly agreed or agreed with the statement, "services were available at times that were convenient." Among YSS-F, there was a 0.6 PP decline from 94.0% in May 2016 to 93.4% in May 2017. Among YSS, there was a 4 PP increase from 82.3% in May 2016 to 86.3% in May 2017. Among Adults, there was no notable change in reported satisfaction. Among Older Adults, there was a 1 PP decline from 95.1% in May 2016 to 94.0% in May 2017.

## III. MONITORING BENEFICIARY SATISFACTION

### Goal III.1.

***Maintain the percentage of consumers/families reporting that staff was sensitive to their cultural/ethnic background between 87% and 89% for the May 2017 survey period.***

### EVALUATION

This goal was met. A total of 88.2% of the consumers and families who participated in the May 2017 survey period reported they strongly agreed or agreed that staff were sensitive to their cultural/ethnic background. There was no notable change in reported satisfaction from May 2016 to May 2017.

**TABLE 33: PERCENT OF CONSUMERS / FAMILIES BY AGE GROUP WHO STRONGLY AGREE OR AGREE WITH "STAFF WERE SENSITIVE TO MY CULTURAL/ETHNIC BACKGROUND" CY 2015 TO CY 2017**

| Age Group | CY 2015 | | CY 2016 | | CY 2017 |
|---|---|---|---|---|---|
| | May | November | May | November | May |
| **YSS-F** | | | | | |
| Number | 2,622 | 1,977 | 2,622 | 2,684 | 2,209 |
| Percent | 94.9% | 95.2% | 94.9% | 94.7% | 95.4% |
| **YSS** | | | | | |
| Number | 1,223 | 894 | 1,223 | 1,263 | 1,107 |
| Percent | 81.5% | 84.2% | 81.5% | 84.7% | 86.0% |
| **Adult** | | | | | |
| Number | 3,346 | 2,743 | 3,346 | 3,620 | 3,299 |
| Percent | 85.1% | 85.3% | 86.0% | 84.1% | 84.5% |
| **Older Adult** | | | | | |
| Number | 427 | 235 | 427 | 514 | 432 |
| Percent | 87.6% | 89.0% | 91.2% | 92.0% | 86.4% |
| **Total** | | | | | |
| Number | 7,618 | 5,849 | 7,618 | 8,081 | 7,047 |
| Percent | 87.3% | 88.4% | 88.4% | 88.9% | 88.2% |

Note: The Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses on the 5 point Likert scale. Data Source: CPS forms completed by consumers/families served in LACDMH outpatient programs between CY 2015 and May 2017.

Table 33 reports the percentage of consumers and families in families in CY 2015, CY 2016, and May 2017 that strongly agreed or agreed with the statement, “staff were sensitive to my cultural/ethnic background.” Among YSS-F, there was a 0.5 PP increase from 94.9% in May 2016 to 95.4% in May 2017. Among YSS, there was a 4.5 PP increase from 81.5% in May 2016 to 86.0% in May 2017. Among Adults, there was a slight decline

from 86.0% in May 2016 to 84.5% in May 2017. Among Older Adults, there was a 4.8 PP decline from 91.2% in May 2016 to 86.4% in May 2017.

**Goal III.2.**

***Maintain the percentage of consumers/families reporting overall satisfaction with services provided between 89% and 91% for the May 2017 survey period and continue year to year trending of the data.***

**EVALUATION**

This goal was met. Overall, in May 2017, 89.6% of consumers/families who completed the YSS-F (94.2%), YSS (88.3%), Adult (87.3%), and Older Adult (89.7%) CPS forms positively endorsed an overall satisfaction in services.

**Goal III.3a.**

***Monitor the grievances, appeals and requests for State Fair Hearings for FY 16-17.***

**EVALUATION**

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

This goal has been met. Grievances and appeals are collected and reviewed by the Patients' Rights Office (PRO) and recorded on the Annual Medi-Cal Beneficiary and Grievance and Appeal Report (ABGAR) form. The ABGAR form is required by the State Department of Health Care Services (DHCS) for Medi-Cal beneficiaries only.

## TABLE 34: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FY 16-17

| CATEGORY | PROCESS | | |
|---|---|---|---|
| | GRIEVANCE | APPEAL | EXPEDITED APPEAL |
| **ACTIONS** | | 0 | 0 |
| NOTICE OF ACTION - A | | 0 | 0 |
| NOTICE OF ACTION - B | | 0 | 0 |
| NOTICE OF ACTION - C | | 0 | 0 |
| NOTICE OF ACTION - D | | 0 | 0 |
| NOTICE OF ACTION - E | | 0 | 0 |
| NOTICE OF ACTION - ALL OTHER ACTIONS | | 0 | 0 |
| ACTIONS –TOTAL BY CATEGORY | **N/A** | **0** | **0** |
| PERCENT | **N/A** | **0.0%** | **0.0%** |
| **ACCESS** | | | |
| SERVICE NOT AVAILABLE | 0 | | |
| SERVICE NOT ACCESSIBLE | 0 | | |
| TIMELINESS OF SERVICES | 0 | | |
| 24/7 TOLL FREE ACCESS LINE | 0 | | |
| LINGUISTIC SERVICES | 0 | | |
| OTHER ACCESS ISSUES | 9 | | |
| ACCESS – TOTAL BY CATEGORY | **9** | **N/A** | **N/A** |
| PERCENT | **3.9%** | | |
| **QUALITY OF CARE** | | | |
| STAFF BEHAVIOR CHANGES | 48 | | |
| TREATMENT ISSUES OR CONCERNS | 96 | | |
| MEDICATION CONCERN | 15 | | |
| CULTURAL APPROPRIATENESS | 0 | | |
| OTHER QUALITY OF CARE ISSUES | 10 | | |
| QUALITY OF CARE – TOTAL BY CATEGORY | **169** | **N/A** | **N/A** |
| PERCENT | **73.5%** | | |
| **CHANGE OF PROVIDER** | | | |
| CHANGE OF PROVIDER – TOTAL BY CATEGORY | **0** | **N/A** | **N/A** |
| PERCENT | **0.0%** | | |
| **CONFIDENTIALITY CONCERN** | | | |
| CONFIDENTIALITY CONCERN – TOTAL BY CATEGORY | **2** | **N/A** | **N/A** |
| PERCENT | **0.01%** | | |
| OTHER | | | |
| FINANCIAL | 0 | | |
| LOST PROPERTY | 8 | | |
| OPERATIONAL | 2 | | |
| PATIENTS' RIGHTS | 22 | | |
| PEER BEHAVIORS | 3 | | |
| PHYSICAL ENVIRONMENT | 0 | | |
| OTHER GRIEVANCE NOT LISTED ABOVE | 15 | | |
| OTHER – TOTAL BY CATEGORY | **50** | **N/A** | **N/A** |
| PERCENT | **21.7%** | | |
| **GRAND TOTALS** | **230** | **0** | **0** |

Note: Grievances and appeals data is limited to Medi-Cal beneficiaries. Data Source: LACDMH Patients' Rights Office (PRO), October 2017.

Table 34 shows the total number of inpatient and outpatient grievances and appeals by category for FY 16-17. The majority of inpatient and outpatient grievances were related to Quality of Care (73.5%), followed by Other (21.7%), Access (3.9%), Confidentiality Concern (0.01%), and Change of Provider (0.0%). Table 34 also shows that among the inpatient and outpatient grievances and appeals in FY 16-17, there were 230 grievances and no appeals. In FY 16-17 there were 11 State Fair Hearings that were closed/dismissed prior to the end of the fiscal year.

## TABLE 35: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS' DISPOSITION FY 16-17

| CATEGORY | DISPOSITION | | |
|---|---|---|---|
| | COMPLETED | *REFERRED OUT | PENDING AS OF JUNE 30 |
| **ACTIONS** | | | |
| NOTICE OF ACTION - A | 0 | 0 | 0 |
| NOTICE OF ACTION - B | 0 | 0 | 0 |
| NOTICE OF ACTION - C | 0 | 0 | 0 |
| NOTICE OF ACTION - D | 0 | 0 | 0 |
| NOTICE OF ACTION - E | 0 | 0 | 0 |
| NOTICE OF ACTION - ALL OTHER ACTIONS | 0 | 0 | 0 |
| ACTIONS – TOTAL BY CATEGORY | 0 | 0 | 0 |
| **ACCESS** | | | |
| SERVICE NOT AVAILABLE | 0 | 0 | 0 |
| SERVICE NOT ACCESSIBLE | 0 | 0 | 0 |
| TIMELINESS OF SERVICES | 0 | 0 | 0 |
| 24/7 TOLL FREE ACCESS LINE | 0 | 0 | 0 |
| LINGUISTIC SERVICES | 0 | 0 | 0 |
| OTHER ACCESS ISSUES | 0 | 0 | 0 |
| ACCESS – TOTAL BY CATEGORY | 9 | 0 | 0 |
| **QUALITY OF CARE** | | | |
| STAFF BEHAVIOR CHANGES | 48 | | |
| TREATMENT ISSUES OR CONCERNS | 86 | 6 | 10 |
| MEDICATION CONCERN | 15 | | |
| CULTURAL APPROPRIATENESS | 0 | | |
| OTHER QUALITY OF CARE ISSUES | 10 | | |
| QUALITY OF CARE – TOTAL BY CATEGORY | 159 | 6 | 10 |
| **CHANGE OF PROVIDER** | 0 | | |
| CONFIDENTIALITY CONCERN | 2 | | |
| OTHER | | | |
| FINANCIAL | 0 | | |
| LOST PROPERTY | 8 | | |
| OPERATIONAL | 2 | | |
| PATIENTS' RIGHTS | 21 | | 1 |
| PEER BEHAVIORS | 3 | | |
| PHYSICAL ENVIRONMENT | 0 | | |
| OTHER GRIEVANCE NOT LISTED ABOVE | 14 | 2 | 1 |
| OTHER – TOTAL BY CATEGORY | 48 | 2 | 2 |
| PERCENT | | | |
| **GRAND TOTALS** | **218** | **8** | **12** |
| PERCENT | 91.6% | 3.4% | 5.0% |

Note: Grievances and appeals data is limited to Medi-Cal beneficiaries. Data Source: LACDMH Patients' Rights Office (PRO), October 2017. *The number of" Referred Out" are reflected in the number of "Pending".

Table 35 shows the disposition of 230 grievances and appeals in FY 16-17, of which 218 (91.6%) were resolved, eight (3.4%) were referred out, and 12 (5.0%) were reported as pending.

**Goal III.3b.**

***Resolve all standard appeals within 45 calendar days of receipt of appeal by Patients' Rights Office (PRO).***

**EVALUATION**

There were no standard appeals in FY 16-17.

**Goal III.3c.**

***Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log.***

**EVALUATION**

This goal has been met. In FY 16-17, 100% of grievances were resolved within 60 calendar days.

**Goal III.4.**

***Monitor Beneficiary Requests for Change of Provider (COP) including reasons given by consumers for their Change of Provider requests.***

**EVALUATION**

This goal was met. QID has monitored the consistent reporting of COP requests from providers to PRO. The number of COP decreased from 4,305 requests during FY 15-16 to 4,192 requests in FY 16-17. The percent of COP that were approved declined by 1 PP between FY 15-16 (92.7%) and 16-17 (91.7%).

There were marked efforts to improve the process of COP log submissions in FY 16-17. As of June 2017, all COP logs were forwarded to the COP mailbox at DMHCOP@dmh.lacounty.gov. The mailbox served as a central and secure location for COP log submissions with oversight by designated LACDMH staff. Fax transmissions of COP logs are no longer accepted. On June 22, 2017, PRO released a memo titled, "Summary of the Change of Provider Reporting Process Discussion," that further outlined this process. A SharePoint site will be made available for COP log submissions from DO clinics in FY 18-19 and rolled out to LE Contracted agencies soon after.

## TABLE 36: REQUEST FOR CHANGE OF PROVIDER BY REASONS AND PERCENT APPROVED FY 14–15 TO FY 16–17

| Reason[1] | FY 14-15 | | FY 15-16 | | FY 16-17 | |
|---|---|---|---|---|---|---|
| | Number of Requests | Percent Approved | Number of Requests | Percent Approved | Number of Requests | Percent Approved |
| Age | 62 | 75.8% | 58 | 91.4% | 76 | 87.4% |
| Does Not Understand Me | 408 | 77.2% | 382 | 92.4% | 424 | 91.2% |
| Gender | 184 | 84.8% | 188 | 95.7% | 172 | 91.5% |
| Insensitive/unsympathetic | 323 | 78.6% | 347 | 90.5% | 330 | 92.2% |
| Lack of Assistance | 385 | 80.5% | 331 | 91.5% | 332 | 91.2% |
| Language | 199 | 82.9% | 116 | 93.1% | 128 | 96.2% |
| Medication Concerns | 270 | 74.8% | 230 | 90.9% | 222 | 91.0% |
| No Reason Given | 155 | 82.6% | 107 | 93.3% | 102 | 86.4% |
| Not a Good Match | 642 | 82.2% | 658 | 92.9% | 555 | 91.7% |
| Not Professional | 237 | 82.7% | 246 | 91.9% | 240 | 91.6% |
| Other | 378 | 84.7% | 349 | 94.8% | 373 | 92.6% |
| Time/Schedule | 317 | 92.7% | 160 | 93.8% | 148 | 90.8% |
| Treating Family Member | 23 | 74.0% | 33 | 93.9% | 25 | 92.6% |
| Treatment Concerns | 356 | 77.2% | 361 | 91.7% | 330 | 92.7% |
| Uncomfortable | 507 | 80.1% | 529 | 92.4% | 553 | 92.0% |
| Want 2nd Option | 98 | 77.6% | 116 | 89.7% | 98 | 89.9% |
| Want Previous Provider | 66 | 72.7% | 94 | 95.7% | 84 | 92.3% |
| **Total** | **4,610** | **81.1%** | **4,305** | **92.7%** | **4,192** | **91.7%** |

Note: Data Source: Patients' Rights Office (PRO), October 2016. [1]Multiple reasons may be given by a consumer.

Table 36 compares the number of Requests for COP by reasons and percent approved for FY 14-15, FY 15-16, and FY 16-17. Data on the requests for Change of Provider are based on information from COP logs that agencies are required to submit to the Patients' Rights Office (PRO), on a monthly basis. The data for FY 16-17 shows the most frequent reason for a COP request was "Not a Good Match (N=555)" and the least frequent reason for a COP request was "Treating a Family Member (N=25)."

## IV. MONITORING CLINICAL CARE

**Goal IV.1.**

***Address evolving standards and requirements associated with the use of medication in mental health programs through systemic application of DMH Medication Parameters to supervision of prescribing practices, and through provision of ongoing training by clinical experts in state-of-the-art use of medication.***

**EVALUATION**

This goal was met. During CY 2017, LACDMH initiated or revised the following policies and parameters regarding medications through the work of an internal group and in consultation with outside experts.

A. Policies and Procedures:

1. New:
    a. DMH Policy 306.09, External Laboratory Testing, Signed May 2018

B. DMH Parameters:
1. New
    a. Parameter 3.10 Use of Medications for Addiction Treatment in Individuals with Co-Occurring Substance Use Disorders

C. CME Trainings re: Medication Practices:

During CY 2017, seven (7) trainings, which included medication practices, were sponsored by the Department, for which a total of 129 physicians attended.

## V. MONITORING CONTINUITY OF CARE

### Goal V.1.

***At least 85% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center will receive appointments for a Specialty Mental Health Service Assessment within 5 business days in CY 2017.***

### EVALUATION

This goal was met. Urgent appointment referrals from the Medi-Cal Managed Care plans are recorded in two locations: the Service Request Log form in the Integrated Behavioral Health Information System (IBHIS) and in the Service Request Tracking System (SRTS). Between January 1, 2017 and December 31, 2017, 272 appointments were provided referrals from Managed Care plans, in IBHIS. The average (mean) business days to appointment was 3.55 days. The median number of business days to appointment was three (3) days. Across all 272 appointments, 96% were provided in less than or equal to five (5) business days. From SRTS, 686 appointments were provided referrals from Managed Care plans. The average (mean) business days to appointment was 3.62 days. The median number of business days to appointment was 3 days. Overall, 97% of the 958 referrals from Managed Care Health Plans received urgent appointments within five (5) business days.

## VI. MONITORING PROVIDER APPEALS

**Goal.VI.1.**

***The Mental Health Plan (MHP) will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal in CY 2017.***

**EVALUATION**

This goal has been met. In CY 2017, 100% of appeals from providers were responded to within 60 calendar days.

**TABLE 37: PROVIDER APPEALS**
**CY 2017**

| Appeals | Day Treatment | Network Inpatient | Network Outpatient |
|---|---|---|---|
| Total | 0 | Total TARs: 1,233<br>Total Days: 9,541 | 0 |
| Approved | 0 | TARs Approved: 339<br>Total Approved Days: 2,617 | 0 |
| Denied | 0 | TARs Denied: 894<br>Total Denied Days: 6,924 | 0 |
| Pending | 0 | 0 | 0 |

Note: All Fee-For-Service (FFS) Medi-Cal acute psychiatric inpatient providers/hospitals submit inpatient Treatment Authorization Requests (TARs) to LACDMH. A TAR is a State Form (18-3), each with a unique number, used statewide for authorization of inpatient psychiatric hospital days. Data Source: LACDMH Office of the Medical Director, CY 2017.

There were 1,233 Treatment Authorization Requests (TARs) appealed in CY 2017. Twenty-eight percent of the TARs were approved (N=339) and the remaining 72% (N=894) were denied.

## QUALITY IMPROVEMENT WORK PLANS GOALS SUMMARY – CY 2018

***I. MONITORING SERVICE DELIVERY CAPACITY***

1. *Between 52.9% and 53.5% of Latinos estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH outpatient programs in Fiscal Year (FY) 17-18.*
2. *Between 34.8% and 36.4% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% FPL will be served in LACDMH outpatient programs in FY 17-18.*
3. *Develop and implement a Community Mental Health Needs Assessment in order to assess the mental health needs of the deaf, hard of hearing, and blind communities as well as people who have physical disabilities and identify gaps in service delivery for Calendar Year (CY) 2018..*
4. *Provide Telemental Health (TMH) services to at least 500 clients in CY 2018.*

***II. MONITORING ACCESSIBILITY OF SERVICES***

1. *Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 60% for CY 2018.*

*2a. Seventy-five percent of after-hours calls to the toll-free hotline for CY 2018 are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll-free hotline.*

*2b. Seventy-five percent of business hours calls to the toll-free hotline for CY 2018 are answered by a live agent within 1 minute from when they present to the VCC of the toll-free hotline.*

3. *Monitor the number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 17-18.*
4. *Maintain the percentage of consumers/families reporting that they are able to receive services at convenient locations between 86% and 88% for the May 2018 survey period.*
5. *Maintain the percentage of consumers/families reporting that they are able to receive services at convenient times between 90% and 91% for the May 2018 survey period.*

***III. MONITORING BENEFICIARY SATISFACTION***

1. *Maintain the percentage of consumers/families reporting that staff was sensitive to their cultural/ethnic background between 87% and 89% for the May 2018 survey period.*
2. *Maintain the percentage of consumers/families reporting overall satisfaction with services provided between 89% and 90% for the May 2018 survey period and continue year to year trending of the data.*

*3a. Monitor the grievances, appeals and requests for State Fair Hearings for FY 17-18.*

*3b. Resolve all standard appeals within 30 calendar days and all expedited appeals within 72 hours of receipt of appeal by Patients' Rights Office (PRO) for FY 17-18.*

*3c. Resolve all grievances within 90 calendar days from the date the grievance was logged on the Problem Resolution Log for FY 17-18.*

4. *Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests.*

***IV. MONITORING CLINICAL CARE***

1. *Monitor the number and reasons for approved, denied, and returned Prescription Drug Prior Authorization (PA) Requests in FY 17-18.*

***V. MONITORING CONTINUITY OF CARE***

1. *At least 94% of the consumers referred to the Urgent Appointment Line at the ACCESS Center for CY 2018 will receive urgent appointments for a Specialty Mental Health Service Assessment within 5 business days.*

***VI. MONITORING OF PROVIDER APPEALS***

1. *The Mental Health Plan (MHP) will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal in CY 2018.*

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMINISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

## DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

**GOAL 1:** **Between 52.9% and 53.5% of Latinos estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) living at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH outpatient programs in Fiscal Year (FY) 17-18.**

Population: Latino population estimated with SED and SMI and living at or below 138% FPL

Indicator: Latino consumers receiving outpatient services in LACDMH outpatient programs

Measure: Unduplicated number of Latino consumers served in LACDMH outpatient programs / Latino population estimated with SED and SMI and living at or below 138% FPL multiplied by 100. The estimated goal is derived from calculating a statistically significant change for number of Latinos served at 99% Confidence Level with a .3 (+/ - %) margin of error.

Source(s) of Information:
1. Prevalence: California Health Interview Survey (CHIS)
2. Consumers Served: LACDMH Integrated System (IS) and Integrated Behavioral Health Information Systems (IBHIS) approved claims data
3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau and Hedderson Demographic Services.

Responsible Entity: Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

**DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY**

**GOAL 2: Between 34.8% and 36.4% of Asian Pacific Islanders (API) estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) living at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH outpatient programs in Fiscal Year (FY) 17-18.**

Population: API population estimated with SED and SMI and living at or below 138% FPL

Indicator: API consumers receiving outpatient services in LACDMH outpatient programs

Measure: Unduplicated number of API consumers served in LACDMH outpatient programs / API population estimated with SED and SMI and living at or below 138% FPL multiplied by 100. The estimated goal is derived from calculating a statistically significant change for number of API served at 99% Confidence Level with a 1.0 (+/- %) margin of error.

Source(s) of Information:
1. Prevalence: California Health Interview Survey (CHIS)
2. Consumers Served: LACDMH Integrated System (IS) and Integrated Behavioral Health Information Systems (IBHIS) approved claims data
3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau and Hedderson Demographic Services.

Responsible Entity: Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY**

**GOAL 3: Develop and implement a Community Mental Health Needs Assessment in order to assess the mental health needs of the deaf, hard of hearing, and blind communities as well as people who have physical disabilities and identify gaps in service delivery for Calendar Year (CY) 2018.**

Population: Deaf, hard of hearing, and blind communities as well as people who have physical disabilities

Indicator: Community Mental Health Needs

Measure: Unmet needs of the deaf, hard of hearing and blind communities and people with physical disabilities as identified by the Mental Health Needs Assessment

Source(s) of Information: Office of Administrative Operations – Quality Improvement Division (OAO-QID), Underserved Cultural Communities (UsCC)

Responsible Entity: OAO-QID

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

**DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY**

**GOAL 4: Provide Telemental Health (TMH) services to at least 500 clients in Calendar Year (CY) 2018.**

Population: Consumers receiving TMH services at various end points in LACDMH Directly Operated (DO) Clinics

Indicator: Service delivery capacity for psychiatry appointments via the TMH program

Measure: Number of consumers receiving mental health services through the TMH program in CY 2018

Source(s) of Information: LACDMH Integrated System (IS) and Integrated Behavioral Health Information Systems (IBHIS) approved claims data

Responsible Entity: Office of the Medical Director, Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

## DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

**GOAL 1:** **Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 60% for Calendar Year (CY) 2018.**

Population: Consumers receiving urgent after-hours care from PMRT of LACDMH – Emergency Outreach and Triage Division (EOTD)

Indicator: Timeliness of after-hours care

Measure: The number of after-hours PMRT responses with response times of one hour or less / the total number of after-hours PMRT responses for the CY 2018 multiplied by 100

Source(s) of Information: EOTD, LACDMH Integrated System (IS) and Integrated Behavioral Health Information Systems (IBHIS) approved claims data

Responsible Entity: EOTD, Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

## DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

**GOAL 2a:** **Seventy-five percent of after-hours calls to the toll-free hotline for Calendar Year (CY) 2018 are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll-free hotline.**

**GOAL 2b:** **Seventy-five percent of business hours calls to the toll-free hotline for CY 2018 are answered by a live agent within 1 minute from when they present to the VCC of the toll-free hotline.**

Population: Callers using the ACCESS 24/7 Toll Free number: 1-800-854-7771

Indicator: Timeliness of the Mental Health Plan's (MHPs) toll free hotline

Measure: 2a. The number of after-hours calls for the CY 2018 that are answered within one minute from when they present to the VCC / the total number of after-hours calls extended to the VCC for the CY 2018 multiplied by 100.

2b. The number of business hours calls for the CY 2018 that are answered within one minute from when they present to the VCC / the total number of daytime calls extended to the VCC for the CY 2018 multiplied by 100.

Source(s) of Information: ACCESS Center Data

Responsible Entity: ACCESS Center, Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

## DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

**GOAL 3: Monitor the number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for Fiscal Year (FY) 17-18.**

Population: Consumers who need hearing impaired interpreter services

Indicator: Cultural and Linguistic Access to Care

Measure: Number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 17-18

Source(s) of Information: ACCESS Center Hearing Impaired Interpreter Services Appointment Schedules

Responsible Entity: ACCESS Center, Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

**DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES**

**GOAL 4: Maintain the percentage of consumers/families reporting that they are able to receive services at convenient locations between 86% and 88% for the May 2018 survey period.**

Population: Consumers served in LACDMH outpatient programs

Indicator: Convenience of service locations

Measure: The number of consumers/families that agree or strongly agree on the Consumer Perception Survey (CPS) forms that they are able to receive services at convenient locations / the total number of consumers/families completed the survey during the survey period multiplied by 100. The estimated goal is derived from calculating the range for true population proportion of the May 2017 response rate of 87.0%. At 95% Confidence Level, the Clopper-Pearson (or exact) confidence interval for a 86.99% response rate is between 86.18% and 87.77%.

Source(s) of Information: CPS forms

Responsible Entity: Office of Administrative Operations – Quality Improvement Division, LACDMH outpatient programs

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

**DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES**

**GOAL 5: Maintain the percentage of consumers/families reporting that they are able to receive services at convenient times between 90% and 91% for the May 2018 survey period.**

Population: Consumers served in LACDMH outpatient programs

Indicator: Convenience of appointment times

Measure: The number of consumers/family members that agree or strongly agree on the Consumer Perception Survey (CPS) forms that they are able to receive services at convenient times / the total number of consumers/family members that completed the survey during the survey period multiplied by 100. The estimated goal is derived from calculating the range for true population proportion of the May 2017 response rate of 90.8%. At 95% Confidence Level, the Clopper-Pearson (or exact) confidence interval for a 90.83% response rate is between 90.13% and 91.49%.

Source(s) of Information: CPS forms

Responsible Entity: Office of Administrative Operations – Quality Improvement Division, LACDMH outpatient programs

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

## DOMAIN III: MONITORING BENEFICIARY SATISFACTION

**GOAL 1:** **Maintain the percentage of consumers/families reporting that staff was sensitive to their cultural/ethnic background between 87% and 89% for the May 2018 survey period.**

Population: Consumers served in LACDMH outpatient programs

Indicator: Sensitivity of staff to consumers' cultural/ethnic backgrounds

Measure: The number of consumers/family members that agree or strongly agree that staff is sensitive to their cultural/ethnic background on the Consumer Perception Survey (CPS) forms / the total number of consumers/family members that completed the survey during the survey period multiplied by 100. The estimated goal is derived from calculating the range for true population proportion of the May 2017 response rate of 88.2%. At 95% Confidence Level, the Clopper-Pearson (or exact) confidence interval for an 88.20% response rate is between 87.39% and 88.97%.

Source(s) of Information: CPS forms

Responsible Entity: Office of Administrative Operations – Quality Improvement Division
LACDMH outpatient programs

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

**DOMAIN III: MONITORING BENEFICIARY SATISFACTION**

**GOAL 2: Maintain the percentage of consumers/families reporting overall satisfaction with services provided between 89% and 90% for the May 2018 survey period and continue year to year trending of the data.**

Population: Consumers served in LACDMH outpatient programs

Indicator: Overall satisfaction with services provided

Measure: The numbers of consumers/families that agree or strongly agree they are satisfied overall with the services they have received on the Consumer Perception Survey (CPS) forms / the total number of consumers/families that completed the survey during the survey period multiplied by 100. The estimated goal is derived from calculating the range for true population proportion of the May 2017 response rate of 89.6%. At 95% Confidence Level, the Clopper-Pearson (or exact) confidence interval for 89.55% response rate is between 88.83% and 90.25%.

Source(s) of Information: CPS forms

Responsible Entity: Office of Administrative Operations – Quality Improvement Division
LACDMH outpatient programs

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

**DOMAIN III: MONITORING BENEFICIARY SATISFACTION**

**GOAL 3:** **a. Monitor the grievances, appeals and requests for State Fair Hearings for Fiscal Year (FY) 17-18.**

**b. Resolve all standard appeals within 30 calendar days and all expedited appeals within 72 hours of receipt of appeal by Patients' Rights Office (PRO) for FY 17-18.**

**c. Resolve all grievances within 90 calendar days from the date the grievance was logged on the Problem Resolution Log for FY 17-18.**

Population: Consumers/families served by LACDMH

Indicator: Resolution of beneficiary grievances, appeals, and requested State Fair Hearings

Measure: Number and type of the beneficiary grievances, appeals, and State Fair Hearings resolved and referred out, and pending for FY 17-18

Source(s) of Information: Patients' Rights Office (PRO) Data Reports

Responsible Entity: PRO, Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

**DOMAIN III: MONITORING BENEFICIARY SATISFACTION**

**GOAL 4: Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests in FY 17-18.**

Population: Consumers and their families served by LACDMH

Indicator: Number and type of Requests for Change of Provider

Measure: Number of providers reporting consumers' requests for change of provider for Fiscal Year (FY) 17-18

Source(s) of Information: Patients' Rights Office (PRO) Data Reports

Responsible Entity: PRO, Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

## DOMAIN IV: MONITORING CLINICAL CARE

**GOAL 1: Monitor the number and reasons for approved, denied, and returned Prescription Drug Prior Authorization (PA) Requests in FY 17-18.**

Population: Consumers receiving Pharmacy Benefits Management (PBM) services

Indicator: Prescribing standards and parameters

Measure: Monthly PA Summary Reports

Source(s) of Information: Clinical Operations Bureau – Pharmacy Services Data Reports

Responsible Entity: Clinical Operations Bureau – Pharmacy Services,
Office of Administrative Operations – Quality Improvement Division

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

## DOMAIN V: MONITORING CONTINUITY OF CARE

**GOAL 1: At least 94% of the consumers referred to the Urgent Appointment Line at the ACCESS Center for Calendar Year (CY) 2018 will receive urgent appointments for a Specialty Mental Health Service Assessment within 5 business days.**

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

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

Measure: Number of Urgent Appointments received within five (5) business days from the date referred by the LACDMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES to the Urgent Appointment Line for Calendar Year (CY) 2018 divided by the Total Number of Urgent Appointment Referrals received from the LACDMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES to the Urgent Appointment Line for the CY 2018 multiplied by 100

Source(s) of Information: ACCESS Center, Integrated Behavioral Health Information Systems (IBHIS), Service Request Tracking System (SRTS)

Responsible Entity: ACCESS Center, IBHIS, Office of Administrative Operations – Quality Improvement Division, SRTS

**LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**OFFICE OF ADMISTRATIVE OPERATIONS – QUALITY IMPROVEMENT DIVISION**

**QI WORK PLAN GOALS FOR CALENDAR YEAR 2018**

## DOMAIN VI: MONITORING PROVIDER APPEALS

**GOAL 1: The Mental Health Plan (MHP) will respond in writing to 100% of all appeals from providers in Calendar Year (CY) 2018 within 60 calendar days from the date of receipt of the appeal.**

Population: Legal Entity (LE) Contracted Providers

Indicator: Timeliness of the MHP's written response to Provider Appeals

Measure: Number of MHP's responses to Provider Appeals (Day treatment, inpatient, and outpatient) within 60 calendar days for CY 2018 / the total number of provider appeals for CY 2018 multiplied by 100

Source(s) of Information: Office of the Medical Director (OMD) – Intensive Care Division.

Responsible Entity: OMD - Intensive Care Division, Office of Administrative Operations – Quality Improvement Division

**APPENDIX A**

# CULTURAL COMPETENCY COMMITTEE 2017

Many cultures, one world.
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

## Needs of Persons with Physical Disabilities Workgroup

Workgroup co-Leads: Bernice Mascher and Sunnie Whipple. Other participants include the following: Wendy Cabil, Insung Phil Cho, Sandra Clayton, Elizabeth S. Dandino, JoAnn Freeman, Jacqueline Glass, Haydee Guevara, Pam Inaba, DJ (Denise) Johnson, Aurenda Jones, Amy Kay, Junko Nagamatsu, Lolita S. Namocatcat, Marina Del Ray, Jenny Rosales, Lisa Schoyer.

**Workgroup Goals and Objectives:**

- Promote awareness, inclusion, and partnerships with persons with disabilities.
- Find and address physical disability gaps and barriers in LACDMH.
- Determine how to close these gaps and address the barriers and overcome stigmas.
- Hire more persons with disabilities and create work environments with reasonable accommodations.
- Educate and prepare staff and peers to work more effectively and legally with persons with disabilities.
- Inform the CCC and UsCCs and ask them to assist in this process.
- Develop a new UsCC for Persons with Disabilities to create annual capacity building projects.
- Create a handout with resources, tips and recommendations to reach these goals in 2018.

**Goal of Section I:** To define language, approaches, and worldviews that surround "disability." This information has been collected via workgroup discussion and experience, together with articles and other sources.

**Goal of Section II:** To promote disability awareness, participation and inclusion through education, events, and partnerships. Suggestions inform able-bodied persons, potential employers and agencies on disability culture; and offer persons with disabilities opportunities to engage and pursue new levels of involvement.

**Goal of Section III:** To introduce the amazing world of technology via apps, software and the neurosciences, which is moving persons with disabilities into realms of accessibility, ability, and "super-abilities". It also creates opportunities for able-bodied persons to communicate, participate and partner with the world of disabilities.

**Goal of Section IV:** To supply resources via books, journal articles, and links that will further inform, prepare, and engage individuals and agencies on disability culture.

**Goal of Section V:** To use the gathered information to make useful recommendations to the Department of Mental Health, Los Angeles (LACDMH), the Cultural Competency Committee (CCC), and the newly formed Disability Underserved Cultural Committee (Disability UsCC).

**NOTE 1:** Each section offers only small bits of information that serve as an overview and introduction to a very broad and complex topic and culture. It is a starting point, which will hopefully become a stepping stone to further learning, growth, understanding and awareness. Links, resources, and references are included for further engagement and research. **NOTE 2**: The original name "Needs of Persons with Physical Disabilities Workgroup" was changed to just "Disabilities Workgroup". Several discussions led to a decision to keep the topic broad as many individuals deal with a mix of disabilities that are both physical and cognitive and vary in complexity. This complicates their life considerably as medical programs and places of employment are greatly challenged in how to care and accommodate their many needs.

# I. Disability Definitions, Terms and Language

## *A. Definition Quotes*

### 1. Disabled World: https://www.disabled-world.com/disability/types/

A disability is defined as a condition or function judged to be significantly impaired relative to the usual standard of an individual or group. The term is used to refer to individual functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment mental illness, and various types of chronic disease.

Disability is conceptualized as being a multidimensional experience for the person involved. There may be effects on organs or body parts and there may be effects on a person's participation in areas of life.

Correspondingly, three dimensions of disability are recognized in ICF: body structure and function (and impairment thereof), activity (and activity restrictions) and participation (and participation restrictions). The classification also recognizes the role of physical and social environmental factors in affecting disability outcomes.

### 2. WHO: http://www.who.int/topics/disabilities/en/

Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.

Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers.

People with disabilities have the same health needs as non-disabled people – for immunization, cancer screening etc. They also may experience a narrower margin of health, both because of poverty and social exclusion, and also because they may be vulnerable to secondary conditions, such as pressure sores or urinary tract infections. Evidence suggests that people with disabilities face barriers in accessing the health and rehabilitation services they need in many settings.

### 3. ADA: https://adata.org/faq/what-definition-disability-under-ada

It is important to remember that in the context of the ADA, "disability" is a legal term rather than a medical one. Because it has a legal definition, the ADA's definition of disability is different from how disability is defined under some other laws.

The ADA defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activity. This includes people who have a record of such an impairment, even if they do not currently have a disability. It also includes individuals who do not have a disability but are regarded as having a disability. The ADA also makes it unlawful to discriminate against a person based on that person's association with a person with a disability.

## *B. Terminology and Tips*

### 1. Dictionaries and lists of Disability Terms (CRPD)

**a. Disability or Disabled—Which Term is Right?**
https://www.disabled-world.com/definitions/disability-disabled.php
This article by Disabled World compares words such as disability versus disabled, as well as other terms that have become outdated or offensive. They also give a comprehensive list of health and medical terms at https://www.disabled-world.com/definitions/medical-glossary.php, and organization acronyms at https://www.disabled-world.com/definitions/

**b. Respectful Disability Language: Here's What's Up!**
http://www.miusa.org/sites/default/files/documents/resource/Respectful%20Disability%20Language.p df This article by National Youth Leadership Network and Kids As Self Advocates, uses everyday language to explain the power of language and how it has change over time. A chart compares outdated language with respectful language, and guidelines are given on how to talk about disability.
(not found)

**c. The Language of Disability**
http://www.acedisability.org.au/information-for-providers/language-disability.php
This article by ACE DisAbility Network, also discusses the language of disability and political correctness. A chart gives words and phrases to avoid, and the acceptable alternative.

**d. Disabled People's Association's Dictionary of Disability Terminology:** http://www.dpa.org.sg/wp-content/uploads/2013/01/Dictionary.pdf
Published in Singapore in 2003, this thorough list of terms and definitions is set in large print for easy readability. The format is set up to easily read on a computer or mobile devices.

**e. Glossary of ADA Terms**
https://adata.org/glossary-terms This list defines the terms used by the Americans with Disabilities Act.

**f. Disability Language Style Guide**
http://ncdj.org/style-guide/ Intended for professional writers and journalists, and anyone who wants to know what the appropriate and accurate language is when writing about people living with disabilities.

### 2. Chart

### 3. Tips

## *C. Concepts and Approaches*

There is a whole history behind the development of the various theoretical models and approaches that address disabilities. For the sake of time and simplicity, we have narrowed down the concepts and include links and other resources for further reading. Please note that there are strengths, weaknesses and assumptions in each approach which we have not taken time to explain. The great diversity of disabilities and wanted outcomes, make it difficult to narrow solutions to one approach. It is more realistic to be flexible and support a mix of various models to find the best solution for different communities, cultures, policies, events and so on. This section serves as an introduction and overview only.

## 1. The Convention on the Rights of Persons with Disabilities (CRPD)

http://www.ohchr.org/Documents/Publications/CRPDTrainingGuidePTS19EN%20Accessible.pdf Below are four approaches to disability that are most common around the world.

### a. Charity:

This approach considers persons with disabilities unable to help themselves due to their impairment. Society must therefore take care of them through charitable organizations, homes, special schools, foundations and churches. Their care will depend very much on the goodwill and available resources of others. This places a burden on society, and disempowers those with disabilities, marginalizes them further, and promotes inequality.

### b. Medical:

This approach focuses on the impairment of the person, and their capacity to become well or "good" by fixing them through medicine, rehabilitation, or therapy. Medical staff and other professionals often impose extensive power and their "best interest" on their patients. Failure or achievement is directly linked to the impairment of the individual. This model usually pairs with charities who raise funds or create living spaces for persons with disabilities. They often remain in institutions, disempowered and not in control of their lives. In the worst instances, abuse, exploitation, and violence can result.

### c. Social:

This approach puts the person in the center, rather than their impairment. It recognizes their values and rights as a member of society. The disability of the individual is directly linked to the environment that is unable to accommodate the differences of the person and impedes their participation. Inequality is therefore a result of the barriers society is unable to eliminate. Medical care is still important, but treatment and care are based on a dialogue between medical staff and the expectations of the patient. The disability is seen as a social construct and an element of diversity. All attitudes, practices, polices, and laws are created around the participation of persons with disabilities. They are empowered and seen as equals, and the burden of the disability rests on society.

### d. Human Rights:

This approach builds on the social model. It ensures the rights and complaints of persons with disabilities are recognized and their dignity and freedom are respected. It seeks to assist people so they can help themselves and they can participate as co-equals in society. It celebrates human diversity and provides the tools, conditions and policies designed to comply with their full participation.

## 2. Complexities in the Definitions

Below are several more articles on the approaches and complexities of defining disability:

### a. Disability Models and the ADA Definition of Disability:

Deborah Kaplan, The Definition of Disability: Perspective of the Disability Community, Vol3Issue2 Journal of Health Care Law & Policy 352 (2000). Retrieved form http://digitalcommons.law.umaryland.edu/jhclp/vol3/iss2/5/

### 3. Worldviews and Cultural Perception

It is important to be aware that global societies perceive disabilities differently—both historically and culturally. Defining disability varies greatly in how it is viewed or addressed. Each country or cultural community either reinforces or combats these views via values, attitudes, stereotypes, education, laws, policies and outreach. Legal support and law enforcement is also diverse. Examples are below:

**a. Global Disability Rights**
http://www.globaldisabilityrightsnow.org
This organization offers expertise in inclusive international development. It trains leaders and activists, and empowers woman. Extensive reports about law, practice and current impact is available, as well as a collection of infographics, videos, and other stats on disability rights from various countries.

**b. Past and Present Perceptions Towards Disability: A Historical Perspective** http://www.dsq-sds.org/article/view/3197/3068
In this paper, Chomba Wa Munyi looks at disability across time and culture, to trace the changing perceptions of disability, and variations in treatment. Munyi also addresses positive steps that are being taken by the international community to improve disability perceptions.

**c. Toolkit on Disability for Africa: Culture, Beliefs, and Disability**
https://www.un.org/development/desa/disabilities/news/dspd/toolkit-on-disability-for-africa.html This toolkit looks at various disability-related issues "for government officials, members of parliament, civil and public servants at all levels." Attitudes about disability vary greatly in that some views are positive and others are harmful. Learning exercises and resources are available to understand the causes and measures that may be taken to combat the stigmas.

**d. Disability in South American Countries**
https://www.disabled-world.com/disability/dsa-print.html
This article by Disabled World, gives a quick overview of population and disability stats, disability definitions, challenges, legal issues and progress reports in various South American countries.

**e. Disability Updates in Singapore**
http://hwa.org.sg and http://hwa.org.sg/news/annual-reports/
This website gives a good sense of the work being done to promote self-help and provide support among the disabled in Singapore. It is an organization run by people with disabilities who work on a wide range of projects to meet the changing needs of its members. Annual reports are available.

## II. Promoting Disability Awareness, Participation and Inclusion

Disability awareness is a means of breaking some of the stereotypes and overcoming misconceptions about disabilities. This is important because of the large number of people who have some type of

disability, and because everyone will eventually experience some form of inability in their life due to illness, broken limbs, accidents, trauma, and aging.

Participation is about the right of persons with disabilities to be included in all areas of life. Some examples are education, employment, independent living, politics, sports, decision-making, policy formation and so on. On the flip side, it also invites all able-bodied persons to get informed, involved, and working beside people with disabilities. Below are several considerations, ways to engage, and events to participate in, some of which we as a workgroup took part in.

## *A. Stats*

## *B. Education*

There are preconceptions in society regarding disabilities that need to be addressed. This includes overcoming fears and avoidance of disabilities, understanding that disability discrimination is unlawful, and building knowledge and understanding about disability culture. More educators are creating curriculums that include teaching about disabilities. More parents are informing their children about the importance of inclusion and acceptance. More employers are educating themselves about the laws surrounding disabilities, providing equal employment opportunities, and developing resources for their staff. More agencies and administrations are rewriting their policies and hiring people with disabilities.

### 1. The Convention on the Rights of Persons with Disabilities Training Guide: Professional Training Series No 19.

http://www.ohchr.org/Documents/Publications/CRPDTrainingGuidePTS19EN%20Accessible.pdf
This ratification of the Convention took place in 2014. It was originally adopted in 2006 as a result of persons with disabilities around the world wanting their human rights respected and protected. It supports the diversity and dignity of others and challenges the perceptions of disability that disempowers others. It seeks to implement new and innovative solutions that empower a human rights-based approach to disability. Navanethem Pillay, the UN High commissioner for Human Rights, encourages wide dissemination of this training guide, and "its use by all those who want to embark upon the essential journey towards greater awareness and effective implementation of the rights of persons with disabilities and, ultimately, the building of an inclusive society for all." (does not open)

### 2. Education Opportunities for Persons with Disabilities

Education also provides the knowledge and tools for persons with disabilities to learn complex skills and carry out various tasks to live independently. They can also receive the education and training necessary to find employment and succeed. Below are a few resources:

#### a. RespectAbility:

https://www.respectability.org
RespectAbility educates and provides free tools and factual resources so people with disabilities can achieve the education, training, jobs, security and good health, that everyone needs and deserves. This nonprofit, nonpartisan organization is led by people with disabilities and works widely with the community to help reshape disability attitudes so there is inclusion. Everyone is invited to become involved. They include resources and welcome partnerships with educators, nonprofits, faith-based organizations, policy makers, philanthropists, employers, advocates, entertainers, journalists, on-line media and job seekers. Volunteers are also welcomed.

**b. College Resources for Students with Disabilities, the Ultimate Guide:** https://www.collegechoice.net/college-resources-for-students-with-disabilities/
This resource discusses the rights of students with disabilities, and how to choose a college and university, listing 50 by name as being disability friendly. Crucial questions to ask the admissions counselors and the availability of adaptive and assistive technology are part of the application and preparation process. Information about online learning and scholarships are included, as well as a list of the best U.S. cities for people with disabilities to live and navigate.

### 3. Teaching Children:

#### Disability Awareness Activity Packet:

https://www.dvusd.org/cms/lib/AZ01901092/Centricity/Domain/1318/Disability%20Awareness%20Packet %202.pdf This packet provides activities for teaching students about disabilities.

### 4. Employers

In the employment world, learning acceptance, ADA compliance, and good practice are all required.

Employers can educate themselves in a variety of ways. Below are a few links to start. Enrolling in courses is another way to learn about disability awareness, laws and inclusion.

#### a. United States Department of Labor (DOL):

https://www.dol.gov/general/topic/disability
DOL provides disability resources that include employee rights and employer responsibilities in hiring people with disabilities. There are laws, regulations and obligations involved, as well as financial assistance. The department also advices employers on effective strategies to recruit, retain and advance qualified people with disabilities, and develops policies and shares information about effective practices.

#### b. Americans with Disabilities Act (ADA):

There is a portion in the Americans with Disabilities Act titled "Your Responsibilities as an Employer" that covers employment practices under the act. It discusses who is protected, who is covered, and – what reasonable accommodation means.

## *C. Work Opportunities, Job Accommodations and Fairness*

## *D. Advocate, Social Connections, and Independent Living*

### *Skills* 1. Connect with Advocates and Activists:

**There are many opportunities to advocate for persons with disabilities. Here are a few leads.**

#### a. HolLynn D'Lil, Author of the book, "*Becoming Real in 24 Days*":

**http://becomingrealin24days.com/ (707) 829 9440**

## *E. Participating in Disability Events*

## *F. Mobilizing Partners and Allies*

## *G. Creating Visibility, Awareness, and Inclusion*

**Here are a few ways to increase awareness, promote independence and inclusion of all people with disabilities.**

### 1. Celebrate Disability Awareness Days, Weeks and Month

**October is Disability Employment Awareness Month, July 16th is Disability Awareness Day, and Disability Awareness Week takes place every year towards the end of May and the beginning of June. Although disability awareness can be promoted throughout the year, these days create opportunities to plan events and campaigns, and educate people about the Americans with Disabilities Act.**

#### Disabled World

**https://www.disabled-world.com/disability/awareness/awareness-dates.php**
**Disabled World gives a synopsis of U.S. National and U.N. International days, weeks and months to commemorate medial research or ethical causes.**

### 2. Awareness Ribbons and Symbols

**Awareness ribbons are used in various parts of the world to support a cause or make a statement. They have also become universal symbols for social and disease awareness. Because there are many meanings for each ribbon color, Disabled World created a list of ribbons that are only associated with health and disability meanings and causes. This link can be found at: https://www.disabled-world.com/disability/awareness/ribbons.php**

#### Disabled World

**https://www.disabled-world.com/disability/awareness/ribbons.php**
**Disabled World gives a synopsis of U.S. National and U.N. International days, weeks and months to commemorate medial research or ethical causes.**

# III. Ability and Accessibility (Technology, codes, )

## *A. Ability*

## *B. Adaptive and Assistive Technology*

### 1

### 2 Ava

### 3 Essential Accessibility

Disabled World offers assistive technology that empowers the disability community by providing the tools and a means to connect with the Internet, without modification of the website. Find it at https://www.disabled-world.com/assistivedevices/computer/essential-accessibility.php

# IV. Resources

## *A. Key Links*

1. **AAPD:**
2. **ADA**
3. **Disability.gov**
4. **V**

### *B. Books*

1. *The Body Silent*, by Robert F. Murphy. He is an anthropologist and teacher who finds out he has a tumor of the spinal cord and slowly enters the world of paralysis and disability. He does a study on himself (and others) and shares how his world changes. This book gives valuable insights to how perceptions change as an individual enters into the world of disability
2. *Alone in the Mainstream: A Deaf Woman Remembers Public School*, by Gina A. Oliva. A woman shares her personal story. It offers insight, that includes research on deaf children in public schools and how teachers and administrators are ill-prepared to teach them.

## V. Recommendations

Our goal as a workgroup was to find gaps and barriers in the Department of Mental Health, Los Angeles, regarding physical disabilities, and to recommend some solutions. This handout is the outcome of this research project and it offers some practical tips and various ways to engage with the Disability Culture. The biggest first step is education and awareness. The greatest final outcome is the creation and development of an Underserved Cultural Community for Persons with Disabilities, which will continue to partner and educate the department, and empower the community through capacity building projects. We offer recommendations below as a way to meet the original goals and objectives.

## *A. Training and Awareness for All Involved*

Training needs to be included at all levels of the Department. Workshops and events can further the awareness of disability culture. We recommend that everyone become more informed so they in turn can pass on information and awareness to others.

### 1. Learn the Language of Disability

Many of these points are covered in Section I, and the links there will give further information.

a. Understand how disability is defined and that definitions vary
b. Learn respectful language and what terms to avoid (see chart in Appendix A).
c. Be aware that there are different models and approaches, and different worldviews.

### 2. Plan Education Opportunities for Staff, Peers and Consumers.

See section II.

a. Train your administrators, managers, staff, community workers and volunteers.
b. Educate yourself. Each section of this handout offers helpful information.
c. Invite speakers and presenters from the disability community to be the trainers of your workforce and the keynotes at your conferences.
d. Create activities, training and awareness during Mental Health Awareness Month (May), and Global Accessibility Awareness Day.

### 3. Create Visibility and Dialogue

See section II.

a. Focus on awareness and ways to create dialogue, for example wearing a wristband or ribbon or a button. The workgroup discussed the creation of an awareness ribbon or bow or shoestring with 2-3 colors to represent different disabilities. A design was not finalized.
b. Plan activities and training during awareness days, weeks and months. Examples are
    - May is Mental Health Awareness Month
    - October is Disability Employment Awareness Month
    - Disability Awareness Week occurs at the end of May and the beginning of June
    - Global Accessibility Awareness Day is the third Thursday of May
    - July 16th is Disability Awareness Day

## *B. Recommendations to the Disability Community*

### 1. Get involved!.

a. Provide resources
b. Plan workshops and presentations at events and conferences.
c. Come “to the table” and be a voice.
d. Rally and write letters that will get bills passed in Sacramento and benefit the disability community.

### 2.

## *C. Recommendations to DMH and the CCC*

Physical disability population in Los Angeles County is under-reported and underserved. More job opportunities need to be made, and accommodations need to be made to the environment. Communication devices and methods need to be improved and enhanced.

### 1. Open the door to others with disabilities

a. Hire more persons with disabilities in all departments.
b. Train mental health staff or well-versed peers as interpreters of the threshold languages (including ASL). Contracted interpreters may not be well prepared to interpret mental health terms, or to understand client issues. Also, since most staff will be unavailable during off hours (nighttime, weekends) when a crisis occurs, preparing professional interpreters to fill in when necessary can create a better support system for clients at risk due to disabilities and mental illness.
c. Invite Persons with Disabilities to all open meetings (i.e. CCC, SLT), to have a voice “at the table” and be part of decisions and policy changes.
d. Enhance accessibility to services in the environment.

### 2. Disperse Information

a. We recommend more disability Cultural material is made available at the Peer Resource Center.
b. We encourage the CCC to invite at least 2 guests each year from the disability community to educate their members about various programs, disability issues, policies, and ways to promote awareness.
c. Ms. Junko Nagamatzu will provide the CCC with a presentation from Greater Los Angeles Council on Deafness, Inc. (GLAD), to bring deaf and hard of hearing awareness.

### 3. Enhance Environmental Factors

## *D. Recommendations to the New UsCC for Persons with Disabilities*

### 1. Naming the UsCC

#### a. Removal of Terms

In the original name of our workgroup, “Needs of Persons with Physical Disabilities”, we removed “needs” as it sounded “needy”, and we removed “physical” as many individuals deal with multiple and complex disabilities.

#### b. Clear Designation:

We discussed having a clear designation of the cultural group by either naming them the “Disability UsCC”, or the “UsCC for Disability Culture”, or “UsCC for Persons with Disabilities”. The final decision on the name of the new UsCC can rest on the members that begin to attend the new UsCC regularly and make it theirs.

## 2. A Broad or Narrow Focus?

In the original recommendations that formed this workgroup, it was suggested our focus was to concentrate on the physical disabilities of the members. This focus was further divided into three specific groups: Deaf, Blind and Immobility. However, after extensive group discussions, the workgroup decided to broaden the focus to include all kinds and levels of disabilities, such as visual, hearing and other physical and cognitive impairments. Several reasons are discussed below.

### a. Complexity:

Most individuals deal with more than one disability, and sometimes even multiple disabilities. This complicates their lives in many ways as they have to see different specialists for each disability, and often doctors, clinicians and insurance companies are ill prepared to help and support consumers with multiple complexities.

### b. A Personal Quote From A Mom:

I advocate for a holistic approach that is inclusive, and not exclusive(ly 3 areas/categories)! As the parent of a child with a rare disease who had "multiple" issues, he was not eligible for a number of specialty wraparound programs. He was seen by multiple specialists—each responsible for only their part of his body. They couldn't see the whole of him, and how treating one part might affect another....he just didn't fit, but clearly he had immense needs. Much as I tried to find support, it fell squarely and only on me to coordinate all his services, despite the 9 Service Coordinators (who also had to be coordinated). California Childrens Services program for children with special healthcare needs, authorizes for medical team consultations, but they were restricted to discrete specialty areas, like craniofacial, cardiac, pulmonary, orthopedic, GI, orthotics. If you picked my son's needs apart, he'd have been eligible for each of these—but he wasn't eligible for *any* because of all his other problems.I wish we could get away from specifics and "truly" address the needs of the whole person

### c. Recommendation for the UsCC:

We therefore recommend that the new UsCC keep its focus holistic and broad to include ALL Peoples with Disabilities, and all kinds of disabilities, whether physical, mental, visible, invisible, and so on. Whereas other UsCC groups deal with many tribes and nations, but focus on unique capacity building projects that reach out or educate a part of their population, so too the area of concentration can vary year-to-year in the Disability UsCC. For example, they may want to reach out and bring awareness to the needs and strengths of the Deaf community one year, and plan a conference on Immobility and Environmental Enhancements in another year.

# References

**United Nations (2014). The Convention on the Rights of Persons with Disabilities Training Guide: Professional Training Series No. 19. New York and Geneva. Retrieved April 11, 2017, from http://www.ohchr.org/Documents/Publications/CRPD_TrainingGuide_PTS19_EN%20Accessible.pdf**

**APPENDIX B**

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH**

# CULTURAL COMPETENCY COMMITTEE
# 2017 System Transformation Workgroup
## Recommendations for Working with Peers to Transform the Mental Health System

## DRAFT

### WHO ARE PEERS?

A Peer is a Villager of Resiliency of Hope. A Whole Person, who remembers, relives and relates to a Peer(s) Physically, Mentally, Emotionally, Socially, Culturally, Spiritually, Traumatically, Systemically, and Environmentally. A Peer is a living survivor of the Stigmatic, Systemic communities of disparities in which he/she lives, works, serves and worships. A Peer:

1. Understands
2. Has empathy
3. Is living and dealing with Mental Illness
4. Is a Survivor
5. Understands the Mental Health System
6. Listens & Supports the Mental Health System
7. Is a Mentor
8. Advocates
9. Is Culturally Competent
10. Has lived experience
11. Is culturally diverse

### WHAT CAN PEERS DO?

1. Work on personal goals
2. Help with treatment planning
3. Advocate for medication management
4. Help design programs and implement policies and procedures
5. Share their lived experience
6. Help build the 5th component of delivery of care. 5th, which is Peer Advocacy, in addition to Psychiatrists, Nurses, Clinicians/Therapists, Case Managers
7. Can support other peers
8. Be mentors to other peers
9. Advocate for other peers
10. Help navigate the system
11. Help inform the community

12. Help with outreach and engagement
13. Help with treatment planning
14. Support peers in their personal and treatment goals
15. Facilitate Support Groups
16. Facilitate Self-Help Groups

## WHERE CAN PEERS BE PLACED?

1. Wellness Center
2. Outpatient Mental Health Centers
3. Workforce Education & Training Division
4. Judicial System
5. Jails
6. Library
7. Police Department
8. Schools
9. Veteran's Administration
10. Domestic Violence Shelters
11. Mental Health Courts
12. Assisted Living Housing
13. Public Guardian
14. Homeless Agencies (LAHSA)
15. Board and Care
16. Board of Supervisors' Liaisons
17. Service Area Advisory Committee (SAAC) Liaison
18. Work with on-call teams
19. Parks and Recreation
20. Peer Resource Centers
21. Public Health agencies
22. Health agencies
23. DPSS

## WHAT DO PEERS NEED?

1. Create peer job pool
2. Peer Specialist Supervision
3. Shadowing and internship
4. Support by Peer Specialist on site
5. Enhanced County activity fund
6. Connect with Local and Federal Legislators
7. Peer Specialist on Site in case of crisis
8. Get credit for hours worked – volunteer accountability log

9. Peer Certification
10. Specialty Trainings
11. Mental health staff to be trained on how to understand, support and work with Peers who have a WRAP Plan (Wellness Recovery Action Plan)

## PEER SPECIALTIES TRAININGS COUNTYWIDE

1. Mental Health First Aid
2. Recovery Principles
3. Stigma reduction
4. Culture Competency
5. De-Escalation
6. Crisis Intervention
7. Suicide Prevention
8. Trauma
9. Interoffice Training
10. Pathways to Independence
11. WRAP Plan (Wellness Recovery Action Plan)
12. Formerly Incarcerated
13. Training of Empowerment
14. Patients' rights –Local / Stat Legislation
15. Human Resources
16. Navigating the System
17. NAMI Partnering with other organizations
18. Triggers-Side effects of medications while working
19. Stress management
20. Avoidance of burnout
21. Self-Care
22. Holistic Techniques
23. Self-advocacy
24. Employment support groups
25. Emotional CPR
26. Procovery Training – How to be proactive?
27. Navigating for yourself –finding available resources
28. Cross Training – across programs and Service Areas
29. Peer Specialist Training
30. Strategic Communication
31. Public Speaking
32. QCPR
33. HIPAA
34. 12 Step Anonymous
35. How to work with MH staff

We recommend that trainings also be developed and offered for mental health staff on how to understand, support, and work with Peers who have a WRAP plan.